Vulvodynia Guideline Offers Many Tx Options

Topical and oral medications are included in the recommendations; early treatment is essential.

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Contributing Writer

HOUSTON — A new guideline for the diagnosis and treatment of vulvodynia offers multiple treatment options, including experimental and complementary therapies, for the controversial disorder.

"We have oceans of lotions, potions, and notions out there for vulvodynia. There is not going to be one simple cure," Hope K. Haefner, M.D., the lead author of a paper detailing the guideline, said at a conference on vulvovaginal diseases sponsored by Baylor College of Medicine.

What is clear, she said, is, "We have to do a lot more than say, 'Love burns.' "

Dr. Haefner, director of the University of Michigan Center for Vulvar Diseases in Ann Arbor, recruited a panel of vulvar disease experts to draft the guideline at the request of the American Society for Colposcopy and Cervical Pathology (ASCCP). The guideline is published in the society's journal and can be accessed at www.jlgtd.com (J. Lower Gen. Tract Dis. 2005;9:40-51).

Women's physicians are increasingly aware of vulvodynia but need to start treatment early, according to Dr. Haefner. "The longer a patient has the pain, the less likely we are going to be able to cure" her, she said.

The guideline uses terminology the International Society for the Study of Vulvovaginal Disease (ISSVD) recently adopted for vulvodynia, which has had multiple names, including vulvar vestibulitis syndrome and vulvar dysesthesia. The ISSVD defined vulvodynia as "vulvar discomfort, most often described as burning pain, occurring in the absence of relevant visible findings or a specific, clinically identifiable neurologic disorder."

Symptoms are not necessarily caused by touch or pressure to the vulva, such as with intercourse or bicycle riding, but these activities often exacerbate the symptoms.

The guideline also classified vulvodynia according to whether pain is generalized or localized. (Dr. Haefner cited vestibulodynia, clitorodynia, and hemivulvodynia as examples of localized pain.)

The ASCCP guideline recommends cotton swab testing along with the taking of a complete medical history for diagnosis. Health care providers should use the swab to test various locations of the vulva, including the labia majora, the labia minora, the interlabial sulci, and the vestibule at the clock positions of 2:00, 4:00, 6:00, 8:00, and 10:00. The degree of pain at each location should be recorded. Vaginal culture should be done to rule out conditions such as yeast infection.

Treatment recommendations start with gentle care for the vulva. This includes wearing cotton underwear and nonirritating menstrual pads, avoiding irritants, and using mild soap. Patients are urged to pat the vulva dry. Other suggestions include lubrication during intercourse, cold packs for irritation, and rinsing and drying the vulva after urination.

The guideline lists the following topical medications as useful for vulvar pain but with caveats and suggests that stopping all treatments may bring relief to some women who are using multiple topical medications:

- ► Lidocaine ointment 5% (various forms) is the most commonly prescribed topical treatment.
- ► Plain petroleum jelly can help symptoms.
- ► Estrogen has had variable results; however, Dr. Haefner questions how it works, given that many vulvodynia patients have low estrogen-receptor expression.
- ► Capsaicin is cited for neuropathic pain, but again, Dr. Haefner was skeptical that it works because this agent is an irritant.
- ► Nitroglycerine in one study improved vulvar pain and dyspareunia temporarily but caused headaches.
- ► Baclofen 2% (Lioresal) and amitriptyline 2% in a water-washable base can soothe point tenderness and vaginismus.

Topical corticosteroids, testosterone, and antifungal medications have not benefited vulvodynia patients, according to the guideline. Dr. Haefner also warned against use of benzocaine in these patients, which she said could cause rebound vasodilation and pain.

Oral medications for vulvodynia generally fall into two classes: antidepressants and anticonvulsants. If these are used, the guideline warns health care providers to check for drug interactions with other medications the patient is taking.

Dr. Haefner said tricyclic antidepressants such as amitriptyline, desipramine, and nortriptyline have had a 65%-70% response rate in multiple studies. When they are prescribed for pain management, smaller doses are recommended than for depression. Selective serotonin reuptake inhibitors such as venlafaxine are another option.

Dr. Haefner said she has also used duloxetine (Cymbalta), but a controlled study is needed to assess its efficacy in vulvodynia patients. The guideline also cites the use of anticonvulsants gabapentin (Neurontin) and carbamazepine.

Other guideline recommendations include biofeedback and physical therapy, intralesional injections in patients with localized pain, and surgery as a last resort in patients with vestibulodynia. Surgery is also an option in rare cases of pudendal nerve entrapment.

"The one time I do surgery without trying the other treatments discussed is when they have a lot of redundant tissue that is painful and tears with intercourse. Then I just resect that tissue," Dr. Haefner said.

The guideline notes without judgment that many women use complementary and alternative therapies "before, during, and after seeking conventional medical diagnosis and treatment for their vulvar pain symptoms." These include acupuncture, calcium citrate, low-oxalate diets, oatmeal water and saltwater baths, and, according to Dr. Haefner, hypnosis and botulinum toxin (Botox) injections.

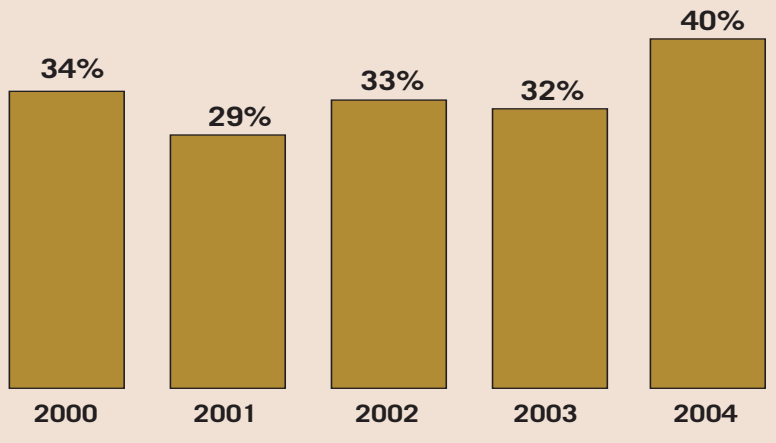
"There are a lot of different things out there that need to be duplicated in different studies," she said, describing low-oxalate diets, in particular, as controversial.

Finally, the guideline says vulvodynia is not a psychopathologic condition, but patients should receive emotional and psychological support during treatment. ■

For more information, contact the International Society for the Study of Vulvovaginal Disease by calling 704-814-9493 or go to www.issvd.org.

DATA WATCH

Percent of Women Who Use Folic Acid Daily



Note: Based on a nationally representative annual survey of about 2,000 women, aged 18-45 years.
Source: March of Dimes

Kevin Foley, Research/Forhad S. Hossain, Design

Experts Dispute Psychosexual Factors

The new vulvodynia guideline rejects the assumption that vulvar pain without a clinically identifiable cause is all in a woman's head but notes that "sex therapy, couples counseling, psychotherapy, or a combination thereof" can be very helpful to patients.

"For years, there were people who thought it was a psychosomatic illness, and there are some people who still do believe that," Dr. Haefner said. "I don't think it is. However, psychologically, many of our patients are depressed."

The first description of vulvodynia in an 1880 medical textbook called the condition "hyperaesthesia of the vulva," she said.

Although it has become more prevalent following recent media attention to women's accounts of the disorder, vulvodynia affects far more women and has been around far longer than has been recognized, she said.

Just what causes vulvodynia is still unclear. Dr. Haefner cited current thinking that the condition is neurologic or inflammatory in origin. (She leans toward neurologic but acknowledged it could be both.) Although she discounted sexual abuse as no more common in vulvodynia patients than in the general population, she said that it could be a factor in individual cases.

Elizabeth "Libby" Edwards, M.D., chief of dermatology of the Southeast Vulvar Clinic in Charlotte, N.C., said that many vulvodynia patients have psychosexual issues but also described them as a result of the illness.

"Depression, anxiety, psychosexual dysfunction is rarely, if ever, a cause of vulvodynia. I don't discount the possibility that it may occasionally happen," said Dr. Edwards, also of the University of North Carolina at Chapel Hill.

Dr. Edwards, a dermatologist who specializes in vulvar disorders, said she encourages patients to go for counseling, but most won't go. She said her message is "not 'You're crazy, and that makes you hurt,' but 'You hurt, and that will make you crazy.' "

Sexual abuse is a major underlying factor for vulvodynia patients, according to Esperanza McKay, M.D., a biofeedback clinician at the Pain Management Center in Houston. That should not cause anyone to underestimate the women's suffering, she advised.

"Their pain is really very real," she said. "The first thing I do is listen to them. You will be amazed at how many have been sexually abused."

Dr. McKay recommended waiting 3 or 4 months until a treatment begins to succeed before bringing up counseling. Many patients do not trust psychiatry and need to develop trust in the clinician before they will agree to go for counseling, she said.

Peter J. Lynch, M.D., a professor emeritus at the University of California, Davis, also advocated psychiatric help, warning that extreme cases can be the result of severe sexual abuse. "I happen to believe that psychosexual issues are an important cause of vulvodynia," he said.