Learn These Tips to Diagnose Vulvodynia

BY DAMIAN McNAMARA

EXPERT ANALYSIS FROM A SEMINAR ON WOMEN'S AND PEDIATRIC DERMATOLOGY

SAN FRANCISCO – Although identification of the cause of a woman's vulvar pain can be a challenge, once vulvodynia is diagnosed there are many management strategies that can provide relief, according to Dr. Libby Edwards.

Women who present with vulvar pain may describe burning, stinging, aching, irritation, soreness, tingling, or tearing sensations. These painful symptoms generally point to herpes simplex virus infection or vulvodynia, Dr. Edwards said at the seminar sponsored by Skin Disease Education Foundation.

Making the Diagnosis

One diagnostic tip is to distinguish vulvar pain from vulvar itch because the etiologies are usually different. Rule out a yeast infection when patients report acute itching, for example. In contrast, if the itch is more chronic, the woman might have lichen simplex chronicus or, less commonly, lichen sclerosus, she noted.

One tip is to distinguish vulvar pain from vulvar itch, because the etiologies are usually different. Rule out a yeast infection when patients report acute itching, for example.

Skin disease, infection, and specific types of neuropathic pain (such as pudendal neuralgia and postherpetic neuropathy) are other considerations in the differential diagnosis, said Dr. Edwards, chief of dermatology at Carolinas Medical Center, Charlotte, N.C.

Consider skin diseases like lichen planus and desquamative inflammatory vaginitis. Also, if a skin eruption from postherpetic neuralgia is suspected, remember it occurs only with herpes zoster and not simplex virus infections.

Vulvodynia is a symptom, often multifactorial, and not a disease, Dr. Edwards said. Not surprisingly, psychological dysfunction is a prominent feature for some women.

Diagnose the extent of a woman's vulvodynia because surgical excision is indicated for only a subset of patients – those with vestibulodynia or vulvar vestibulitis syndrome. Pain arises only when provoked, versus other localized conditions such as clitorodynia or hemivulvodynia where pain can occur spontaneously as well.

By exclusion, generalized pain is not localized and can be migratory. For more information on localized versus generalized vulvodynia, Dr. Edwards recommended the European Association of Urology guidelines for diagnosis, therapy, and follow-up of patients with chronic pelvic pain (Eur. Urol. 2004;46: 681-9).

Treatment Recommendations

Both general and specific strategies are important for the management of vulvodynia, Dr. Edwards said. For example, instruct the patient to avoid irritants, overwashing the area, and excessive use of topical medications. Educate patients using written materials or handouts and refer them to the National Vulvodynia Association Web site (www.nva.org) for more information.

Xylocaine (lidocaine) jelly 2% or Xylocaine ointment 5%, as needed, can provide relief, Dr. Edwards said. The 5% ointment can be applied to the vestibule overnight with occlusion (using a cotton ball) to break the pain cycle.

Other topical agents to consider include estrogen, nitroglycerin, and amitriptyline 2%/baclofen 2% in an aqueous solution.

On the other hand, avoid topical testosterone preparations, corticosteroids, and anticandidal medications (unless a yeast infection is confirmed), Dr. Edwards advised.

Specific oral medications with efficacy for vulvodynia relief include gabapentin and other anticonvulsants, venlafaxine, and pregabalin.

Women with vulvodynia might also benefit from injections of alpha-interferon, corticosteroids, or botulinum toxin, said Dr. Edwards. Nerve blocks may also provide relief.

Although there are many management strategies, a combination of physical therapy and oral medication to treat neuropathy is the most important intervention, Dr. Edwards said. The patient should be referred to a physical therapist with expertise in pelvic floor therapy.

Approximately 80% of patients improve substantially, although a complete response can take 7-8 months, she said. Regular exercise can optimize outcomes for most women.

Although the description of vulvodynia has changed many times since the late 1970s, the current consensus is that it involves pelvic floor dysfunction that triggers neuropathic pain.

Poor pelvic floor muscle strength, high resting tension, and irritability of muscles can each contribute to the painful sensations. In addition, many women have urinary tract symptoms or comorbid conditions such as irritable bowel syndrome.

Most of the medications mentioned in this article are "off label" for vulvodynia. Dr. Edwards said she had no relevant disclosures. ■

SDEF and this news organization are owned by Elsevier.

DRUGS, PREGNANCY, AND LACTATION

Tracking Topiramate

The use of topiramate – approved in the United States for epilepsy in 1996 and migraine prophylaxis in 2002 – continues to increase. Because the drug is used in women of reproductive age, several registries are collecting data on pregnancy exposures to address the question of the reproductive safety of topiramate in humans, which has not yet been fully characterized.

GIDEON KOREN, M.D.

In different animal species, the drug appears to be generally safe. Yet not much data exist on human pregnancy exposures to topiramate, considering its widespread use. There are reports of major malformations among babies who are exposed to topiramate in utero, but the numbers of cases are small and none of these associations is statistically significant.

At Motherisk, we conducted an analysis of data from four registries published between 2007 and 2010 – the North American AED (Antiepileptic Drug) Pregnancy Registry, the Australian Pregnancy Register, the U.K. Epilepsy and Pregnancy Register, and the Israeli Teratogen Information Service – that included cases that were exposed to topiramate in the first trimester. We compared women who took topiramate monotherapy during pregnancy with a control group of 710 pregnancies in women who were enrolled in 12 published registries of untreated women with epilepsy. We chose women with epilepsy as the "disease control" group to more accurately compare with the women with epilepsy who were treated with topiramate, rather than use healthy women as the control group.

Most cases had been exposed to the recommended topiramate dosage of 200-400 mg/day.

Among the 406 pregnancies that were exposed to topiramate monotherapy in the four registries, the mean rate of major malformations was 3.7%, compared with the mean rate of 3.4% among the pregnancies in the untreated women with epilepsy. The relative risk of 1.09 for topiramate-exposed pregnancies was not statistically significant. Based on these findings, topiramate did not appear to be associated with a malformation rate that exceeded the baseline rate.

In the North American AED Pregnancy Registry, the rate of cleft lip among topiramate-exposed pregnancies was 0.69%, which the authors suggest may exceed the 0.07% background incidence of this malformation. But this difference is not statistically significant, and a higher-than-background rate of cleft lip in pregnancies exposed to topiramate in other registries has not been reported. At present, the North American registry has not yet collected sufficient live-birth cases to have adequate power to confirm an association between topiramate exposure and any malformation.

Of the 64 cases of malformations in topiramate-exposed pregnancies reported to the Food and Drug Administration's Adverse Event Reporting System (AERS), almost 33% (21 cases) were craniofacial abnormalities, which included 11 reports of cleft lip and/or palate reports, 6 reports of facial dysmorphism, 4 reports of micrognathia, 3 cases of skull deformation and ossification abnormalities, and 1 case of macroglossia. Almost 30% (19 cases) were skeletal malformations, and 23% (15) were cardiovascular malformations. Most exposures were in the first trimester, and in half the cases, exposure was only in the first trimester. (The FDA presented these data in July 2010 at an advisory panel meeting on a weight loss drug that combines topiramate with phentermine.)

It must be remembered that this database is based on spontaneous reports, and it is impossible to calculate malformation rates from such data because of an unknown denominator. However, no specific malformation was overrepresented among these cases.

To date, the drug does not appear to elicit a risk for malformations that we have been able to confirm, which may be reassuring to reproductive-age women who use the drug. Although continuous collection of data is warranted, it is not likely that a major teratogenic risk will emerge.

DR. KOREN *is a professor of pediatrics, pharmacology, pharmacy, medicine, and medical genetics at the University of Toronto. He heads the Research Leadership in Better Pharmacotherapy During Pregnancy and Lactation at the Hospital for Sick Children, Toronto, where he is director of the Motherisk Program. He also holds the Ivey Chair in Molecular Toxicology at the department of medicine, University of Western Ontario, London. E-mail him at obnews@elsevier.com. Dr. Koren served as a consultant to the company that has a weight loss drug that contains topiramate that is under review by the FDA for approval, and he presented a review on pregnancy safety data on the drug at an FDA advisory panel in July 2010.*