The Current State of Vulvodynia

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Ann Arbor, Michigan, USA
September, 2016

Objectives:

To understand the current classification system for vulval pain (2015 Consensus Terminology and Classification of Persistent Vulvar Pain) developed by the International Society for the Study of Women’s Sexual Health, International Society for the Study of Vulvovaginal Disease, and the International Pelvic Pain Society with support from the National Vulvodynia Association.

-To explore the various causes of vulvodynia

-To gain knowledge on the treatments utilized for localized and generalized vulvodynia

Additional information available at:

http://obgyn.med.umich.edu/patient-care/womens-health-library/vulvar-diseases/information
Introduction

Vulvodynia is a condition that is challenging for patients and health care providers. The pain and discomfort of vulvodynia affects the quality of life of women with this condition. Pain can be continuous or intermittent, often aggravated by activities such as sitting at a desk, bicycle riding, and sexual intercourse.

Historical Information on Vulvar Pain Terminology

Vulvar pain discussion first appeared in the literature in the late 1861 in an article by J. Marion Sims, MD. He describes a patient he saw in 1857 with vaginismus, but upon further analysis of her history, she appears to have vulvodynia.¹ In 1874 Dr. T.G. Thomas described a patient with “excessive sensibility of the nerves supplying the mucous membrane of some portion of the vulva….”² In 1889, A.J. C. Skene commented on a condition characterized by “a supersensitiveness of the vulva. When, however, the examining finger comes in contact with the hyperaesthetic part, the patient complains of pain, which is sometimes so great as to cause her to cry out…..³ In the same year, Kellogg wrote about a patient with “sensitive points about the mouth of the vagina”. The topic was not readdressed until 1928, when Howard Kelly mentioned “exquisitely sensitive deep red spots in the mucosa of the hymeneal ring are a fruitful source of dyspareunia”.⁴ In 1983, Friedrich reported on 13 patients with “vestibular adenitis”.⁵ The International Society for the Study of Vulvovaginal Disease (ISSVD) popularized a definition of vulvar pain in the 1980’s (essential or dysesthetic vulvodynia) describing patients with a chronic discomfort, burning, stinging, irritation, and rawness of the vulva. In 1987, Friedrich developed the term “vulvar vestibulitis syndrome”.⁶ The terminology of vulvar pain continues to undergo change. The most recent terminology changes, developed by the ISSVD are described below.
### Table 1
PREVIOUS ISSVD TERMINOLOGY AND CLASSIFICATION FOR VULVAR PAIN

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Santa Fe, New Mexico ISSVD World Congress</td>
<td>Portugal ISSVD World Congress</td>
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<tr>
<td>(Of note: this is a provisional terminology system)</td>
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</tr>
</tbody>
</table>

**Generalized Vulvar Dysesthesia**
- Provoked vulvar dysesthesia
  - Generalized
  - Localized (vestibule, clitoris, other)

**Localized Vulvar Dysesthesia**
- Vestibulodynia (formerly vulvar vestibulitis)
- Clitorodynia
- Other localized forms of vulvar dysesthesia

**Spontaneous vulvar dysesthesia**
- Generalized
- Localized (vestibule, clitoris, other)

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**Salvador, Brazil October 2003**

**THE CURRENT TERMINOLOGY** The 2003 ISSVD Terminology and Classification

Many ISSVD members were displeased by both the 1999 and 2001 nomenclature and, prior to the 2003 World Congress, the ISSVD leadership requested that two members, Micheline Moyal-Barracco, M.D. and Peter Lynch, M.D. develop, with widespread input from the membership, a proposal for new nomenclature, which would then be voted on at the forthcoming Congress. This was accomplished, and at the 2003 meeting, the membership voted to accept a reversion to the use of the well-accepted term “vulvodynia” and accept a slightly modified definition of 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.” A classification of vulvodynia based on the site of the pain was also adopted. The official new terminology and classification system is diagramed below. It was recently published in the Journal of Reproductive Medicine (Moyal-Barracco M, Lynch PJ. 2003 ISSVD Terminology and Classification of Vulvodynia: A Historical Perspective, J Reprod Med 2004;49:772-777.)
A) Vulvar Pain Related to a Specific Disorder
   1) Infectious (e.g. candidiasis, herpes, etc.)
   2) Inflammatory (e.g. lichen planus, immunobullous disorders, etc.)
   3) Neoplastic (e.g. Paget’s disease, squamous cell carcinoma, etc.)
   4) Neurologic (e.g. herpes neuralgia, spinal nerve compression, etc.)

B) Vulvodynia
   1) Generalized
      a) Provoked (sexual, nonsexual, or both)
      b) Unprovoked
      c) Mixed (provoked and unprovoked)
   2) Localized (vestibulodynia, clitorodynia, hemivulvodynia, etc.)
      a) Provoked (sexual, nonsexual, or both)
      b) Unprovoked
      c) Mixed (provoked and unprovoked)

ISSVD, ISSWSH, and IPPS 2015 Consensus Terminology and Classification of Persistent Vulvar Pain and Vulvodynia
A. Vulvar pain caused by a specific disorder*
   • Infectious (eg, recurrent candidiasis, herpes)
   • Inflammatory (eg, lichen sclerosus, lichen planus, immunobullous disorders)
   • Neoplastic (eg, Paget disease, squamous cell carcinoma)
   • Neurologic (eg, postherpetic neuralgia, nerve compression or injury, neuroma)
   • Trauma (eg, female genital cutting, obstetric)
   • Iatrogenic (eg, postoperative, chemotherapy, radiation)
   • Hormonal deficiencies (eg, genitourinary syndrome of menopause [vulvovaginal atrophy], lactational amenorrhea)
B. Vulvodynia—Vulvar pain of at least 3 months’ duration, without clear identifiable cause, which may have potential associated factors

The following are the descriptors:
   • Localized (eg, vestibulodynia, clitorodynia) or Generalized or Mixed (Localized and Generalized)
   • Provoked (eg, insertional, contact) or Spontaneous or Mixed (Provoked and Spontaneous)
   • Onset (primary or secondary)
   • Temporal pattern (intermittent, persistent, constant, immediate, delayed)

* Women may have both a specific disorder (eg, lichen sclerosus) and vulvodynia.
Potential Factors Associated with Vulvodynia\textsuperscript{a}

- Comorbidities and other pain syndromes (e.g., painful bladder syndrome, fibromyalgia, irritable bowel syndrome, temporomandibular disorder; level of evidence 2)
- Genetics (level of evidence 2)
- Hormonal factors (e.g., pharmacologically induced; level of evidence 2)
- Inflammation (level of evidence 2)
- Musculoskeletal (e.g., pelvic muscle overactivity, myofascial, biomechanical; level of evidence 2)
- Neurologic mechanisms
  - Central (spine, brain; level of evidence 2)
  - Peripheral: neuroproliferation (level of evidence 2)
- Psychosocial factors (e.g., mood, interpersonal, coping, role, sexual function; level of evidence 2)
- Structural defects (e.g., perineal descent; level of evidence 3)

\textsuperscript{a} The factors are ranked by alphabetical order.


 Patients with pain localized to the vestibule have a normal appearing vulva, other than erythema at times. The erythema tends to be most prominent at the duct openings (Bartholin’s, Skene’s and vestibular ducts). There are two major forms of vulvar pain, hyperalgesia (low pain thresholds) and allodynia (pain to light touch). There are many diseases that can cause vulvar pain (Table 2). Since these diseases are associated with an abnormal appearance of the vulva, they do not qualify for the condition known as vulvodynia.

**Table 2  Diseases that may be associated with vulvar pain, not qualifying for the diagnosis of vulvodynia**

<table>
<thead>
<tr>
<th>Disease</th>
<th>Condition</th>
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<tbody>
<tr>
<td>Podophyllin overdose</td>
<td>Pemphigus</td>
</tr>
<tr>
<td>Condylox overdose</td>
<td>Pemphigoid</td>
</tr>
<tr>
<td>Behcet’s disease</td>
<td>Atrophy</td>
</tr>
<tr>
<td>Apthous ulcers</td>
<td>Lichen sclerosus</td>
</tr>
<tr>
<td>Herpes (simplex and zoster)</td>
<td>Lichen planus</td>
</tr>
<tr>
<td>Candidiasis</td>
<td>Sjorgen’s disease</td>
</tr>
<tr>
<td>Trichomonas</td>
<td>Contact dermatitis</td>
</tr>
<tr>
<td>Chancroid</td>
<td>Endometriosis</td>
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</table>
Etiologic theories on vulvodynia

The exact etiology of vulvodynia is unknown. There most likely is not one single etiology. Etiologic theories proposed include abnormalities of embryologic development, infection, inflammation, genetic/immune factors, neurologic mechanisms (both central and peripheral, hormonal factors, inflammation, musculoskeletal changes, and psychosocial factors). (Review on Etiologies of Vulvodynia in Crum, Diagnostic Gynecologic and Obstetric Pathology, Chapter on Vestibulodynia).

<table>
<thead>
<tr>
<th>Theory</th>
<th>Descriptions</th>
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<tbody>
<tr>
<td>Embryologic development</td>
<td>It has been noted that tissues from these two distinct anatomic sites have a common embryologic origin, and therefore are predisposed to similar pathologic responses when challenged.</td>
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<tr>
<td>Infection</td>
<td>Candida infections in patients with vestibular pain have been studied. The exact association is difficult to determine since many patients report candida infections without verified testing for yeast. Bazin et al. found little association of infection and pain on the vestibule.</td>
</tr>
<tr>
<td>Inflammation</td>
<td>“-itis” (as in vestibulitis) has been excluded from the recent ISSVD terminology since studies found a lack of association between excised tissue and inflammation. Bohm-Starke et al. found a low expression of the inflammatory markers cyclo oxygenase 2 and inducible nitric oxide synthase in the vestibular mucosa of women localized vestibular pain as well as in healthy control subjects.</td>
</tr>
<tr>
<td>Genetic/Immune Factors</td>
<td>Goetsch was one of the first researchers to question a genetic association of localized vulvar pain. Fifteen percent of patients questioned over a 6 month period were found to have localized vestibular pain. Thirty-two percent had a female relative with dyspareunia or tampon intolerance, raising the issue of a genetic predisposition. Another genetic connection was found in a study evaluating gene coding for interleukin 1 receptor antagonist.</td>
</tr>
<tr>
<td>Neuropathways</td>
<td>Kermit Krantz examined the nerve characteristics of the vulva and vagina. The region of the hymeneal ring was richly supplied with free nerve endings. No corpuscular endings of any form were observed. Only free nerve</td>
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</table>
endings were observed in the fossa navicularis. A sparsity of nerve endings occurred in the vagina as compared to the region of the fourchette, fossa navicularis and hymeneal ring. More recent studies have analyzed the nerve factors, thermoreceptors and nociceptors in women with vulvar pain.  

**Vaginismus**

It is important to evaluate for vaginismus in the patients with vulvodynia, particularly localized vulvodynia. It is an involuntary spasm of the pelvic floor muscles affecting the vaginal entranceway. It can make penetration painful or even impossible. One of the main causes is fear or anticipation of pain. When painful penetration has been experienced, this pain may be expected in further sexual intercourse attempts. The degree of vaginismus may then increase the amount of pain, and a vicious circle is established.

**Treatment of localized vulvar pain (vestibulodynia)**

Many treatment regimens exist for localized vulvodynia. Patients often combine a variety of the following regimens:

**Vulvar care measures**

Cotton underwear is recommended. No underwear should be worn at night. If the patient is sweating with exercise, Wicking underwear has been used by some patients. Vulvar irritants and douching should be avoided. The patient should use mild soaps for bathing and not apply soaps to the vulva. If menstrual pads are irritating, 100% cotton pads may be helpful. Adequate lubrication for intercourse is recommended (Olive oil, Replens, Astroglide, KY Liquid, Probe, Pjur women, Slippery Stuff, uncooked egg whites, vegetable oil, Vitamin E oil, Surgilube, Sylk (Kiwi fruit vine), Moist Again Natural Feeling, Lubrin, Femigel Natural product from tea trees (http://www.med.umich.edu/sexualhealth/resources/guide.htm)

Other lubricant information

www.drugstore.com Search lubricants

Cool gel packs are helpful in some patients.
**Topical medications**

The use of lubricants should be discussed with the patient. For minor degrees of vulvar pain, consider 5% lidocaine ointment. Lidocaine/prilocaine (eutectic mixture of local anesthesia or LMX) may be used, but any of these agents can be irritating. Doxepin 5 % cream can be applied to skin daily with gradual increase not to exceed four times daily. Topical amitriptyline 2% with Baclofen 2% in a water washable base (WWB) (squirt ½ cc from syringe onto finger and apply to affected area daily to three times a day) has also been used for point tenderness. Topical estrogens have been used by some for treatment of vulvar pain. Estrogen is applied to the vulva twice daily, with a gradual decrease to daily use, then every other day use.

**Tricyclic antidepressants**

A common treatment for vulvar pain is the use of a tricyclic antidepressant. This group of drugs (e.g., amitriptyline (Elavil®), nortriptyline (Pamelor®), desipramine (Norpramin®) has been used to treat many chronic pain conditions where a cause cannot be found. Published and presented reports indicate about a 60% response rate for various pain conditions. Currently, a NIH trial is analyzing antidepressants in patients with vulvar pain. While traditionally this treatment has been used for generalized vulvodynia, recent reports have found it to be helpful in the treatment of vestibular pain also. The mechanism of action is believed to be associated with blockage of re-uptake of transmitters; specifically, norepinephrine and serotonin. Yet, the mechanism may actually be from the anti-cholinergic effects. They affect the sodium channels and have effects on the N-methyl-d-aspartate (NMDA) receptor. If you choose to use a tricyclic antidepressant, to aid in patient compliance you might consider emphasizing its effect in altering the sensation of pain rather than its effect on depression. Patients should not be pregnant or intend to become pregnant or breast feed while using tricyclic antidepressants. These medicines will add to the effects of alcohol and other CNS depressants.

Dosage for pain control varies dependant on the age of the patient and the agent used. Often amitriptyline is used as a first line agent. It is started at 10 to 25 mg nightly and increased by 10-25 mg weekly, not to exceed 150 mg qhs. A sample prescription follows:
Initial Amitriptyline prescription:

Amitriptyline HCL  25 mg  
Sig:  1 po qhs x 1 week;  If sxs persist, 2 po qhs x 1 wk, if sxs persist, 3 po qhs x 1 wk; if sxs persist, 4 po qhs.  Maintain nightly dose that relieves symptoms (Not to exceed 4 po qhs).  Do not stop suddenly (i.e. wean)

Start at 5-10 mg in patients age 60 or older and increase by 10 mg weekly 
It is important to have patients avoid more than 1 drink of alcohol daily while on this medication.  Contraception should be utilized in the reproductive age population.  For the elderly patient, lower doses should be used or other medications considered.

Other antidepressants

Cymbalta
Start at 30 mg po qd for 1 week.  If symptoms persist increase to a total of 60 mg po qd.  (If there is no depression, use Cymbalta as 60 mg po q am.  If there is depression, use Cymbalta as 30 mg po bid.)
Effexor XR is also utilized at times for pain control.

Anticonvulsants

Gabapentin (Neurontin®) has been used to treat chronic pain conditions.\textsuperscript{36,37} 
Gabapentin comes in 100 mg, 300 mg, 400 mg, 600 mg and 800 mg tablet sizes. 
Generally it is started at 300 mg po qd x 3 days, then 300 mg po bid x 3 days, then 300 mg po tid.  It can gradually be increased to 3600 mg po total daily (usually in a tid regimen).  No more than 1200 mg should be given in a dose.  Neurontin side effects include:  somulence, mental change, dizziness, weight gain.

The newest anticonvulsant utilized for chronic pain is pregabalin (Lyrica®).

Lyrica
-50 mg po qd x 4 days, if sxs persist, 50 mg po bid x 4 days, if sxs persist, 50 mg po tid 
  -Can gradually increase up to 100 mg po tid; some reports using 300 mg po bid exist (maximum).
Biofeedback and physical therapy
Biofeedback and physical therapy are also currently used in the treatment of vulvar pain. These techniques are particularly helpful if there is concomitant vaginismus, not uncommon in this population. Biofeedback and physical therapy have been used successfully in the treatment of a number of disorders, including migraine and tension headaches, asthma, chronic pain and anxiety disorders. Biofeedback aids in developing self-regulation strategies for confronting and reducing pain. Patients with vestibular pain in general have an increased resting tone and a decreased contraction tone. With the aid of an electronic measurement and amplification system or biofeedback machine, an individual can view a display of numbers on a meter, or colored lights to assess nerve and muscle tension. In this way it is possible to develop voluntary control over those biological systems involved in pain, discomfort, and disease. The time required for biofeedback and the frequencies of visits will vary with each person. Success rates in the 60 to 80 percent range have been reported. Physical therapists with experience in vulvar pain can frequently be helpful.

Low oxalate diet with calcium citrate supplementation
It has been suggested that vulvar burning may be associated with elevated levels of oxalates in the urine. Oxalate is an irritating material. It is produced by several tissues in the human body during normal metabolism. It can enter the body through digestion of foods containing oxalate. The use of oral calcium citrate along with a low oxalate diet is controversial but may help some women. The "natural" and nutritional approach is certainly attractive to many people. The time for symptom relief varies. However, another study cast doubt on this theory.

Intralesional and trigger point injections:
Trigger point steroid and bupivacaine injections have been successful for some patients with localized vulvodynia. It is recommended that not over 40 mg of triamcinolone be injected monthly. Draw up the triamcinolone prior to the bupivacaine to prevent contamination of the triamcinolone. Combine it with bupivacaine (large area use 0.25%; small area use 0.5%) Inject the combined drugs into specific area or use as a pudendal
This regimen can be repeated monthly. Generally patients do not tolerate more than three or four injections. Consider topical anesthetic use prior to the injection. Interferon has also been studied and utilized for vestibular pain. It has a varied response long term and is used less frequently today.

**Acupuncture**

Very few studies have been done using acupuncture for vulvar pain. Three studies have evaluated acupuncture for vulvar pain therapy, with a variety of outcomes.

**Hypnotherapy**

A recent article by Kandyba and Binik describes the use of hypnotherapy as a treatment for pain localized to the vestibule. The patient received 8 sessions of hypnosis and is pain free at a 12-month follow-up.

**Vestibulectomy  Surgical excision**

Surgical excision of the vulvar vestibule has met with success in up to 80% of reported cases, but should be reserved for women with long standing and localized vestibular pain where other management has failed. The patient should undergo Q-tip testing to outline the areas of pain prior to anesthesia while in the operating room. Often the incision will need to extend to the opening of Skene's ducts onto the vestibule. It is carried down laterally along Hart’s line to the perianal skin and the mucosa should be undermined above the hymeneal ring. The specimen should be excised superior to the hymeneal ring. The vaginal tissue is further undermined and brought down to close the defect. The defect should be closed in two layers using absorbable 3’0 and 4’0 sutures. A review of this technique with illustrations is described.
Vulvodynia algorithm

Physical examination

Cutaneous or mucosal surface disease present

No

Cotton swab test

Not tender; no area of vulva touched described as area of burning

Alternative diagnosis (incorrect belief that vulvodynia present)

Tender, or patient describes area touched as area of burning

Yeast culture

Positive

Antifungal therapy

Inadequate relief

Adequate relief

Good relief

No additional treatment; stop treatment when indicated

Treat abnormal visible condition present (infections, dermatoses, premalignant or malignant conditions, etc.)

Other Treatments

Nitroglycerin – Topical nitroglycerin has been used for the treatment of localized vulvar pain. Unfortunately, a significant number of patients developed headaches with its use.

Botox- Botulinum toxin type A is used as a treatment for many chronic pain disorders. Research has been done on injectable Botox for vulvar pain. Further studies are being performed.

Internet Addresses of Interest

<table>
<thead>
<tr>
<th>National Vulvodynia Association</th>
<th><a href="http://www.nva.org/">http://www.nva.org/</a></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Everything You Need to Know About Vulvodynia.</strong> <a href="http://learnpatient.nva.org">http://learnpatient.nva.org</a></td>
<td></td>
</tr>
<tr>
<td>Physical Therapy</td>
<td><a href="http://www.apta.org/">http://www.apta.org/</a></td>
</tr>
<tr>
<td>International Society for the Study of Vulvovaginal Disease</td>
<td><a href="http://www.issvd.org">www.issvd.org</a></td>
</tr>
<tr>
<td>The University of Michigan Center for Vulvar Diseases</td>
<td><a href="http://obgyn.med.umich.edu/patient-care/womens-health-library/vulvar-diseases">http://obgyn.med.umich.edu/patient-care/womens-health-library/vulvar-diseases</a></td>
</tr>
<tr>
<td>Pudendal Nerve Information</td>
<td><a href="http://www.pudendalnerve.com/">http://www.pudendalnerve.com/</a></td>
</tr>
</tbody>
</table>
Prescriptions for Vulvar Pain

Pain Medications

Xylocaine
5% Xylocaine ointment
sig: apply to vulva prn
Disp: 35 grams

Amitriptyline
Initial Amitriptyline prescription:
Amitriptyline HCL 10 mg
Sig: 1 po qhs x 1 week; If sxs persist, 2 po qhs x 1 wk, if sxs persist, 3 po qhs x 1 wk; if sxs persist, 4 po qhs. Maintain nightly dose that relieves symptoms (Generally not to exceed 4 po qhs) Do not stop suddenly.

You should start at 10 mg in patients age 60 or older; increase by 10 mg weekly, as above. In younger women, you can start at 25 mg po qhs, with 25 mg weekly increases if desired. More side effects may occur. Do not exceed 150 mg po qhs on either regimen. Do not stop suddenly.

Future Amitriptyline prescriptions
Amitriptyline HCL ____mg
Sig: i po qhs (comes in 10 mg, 25 mg, 50 mg, 75 mg, 100 mg and 150 mg tablets)

(Other tricyclics, such as desipramine are dosed in a similar manner)

Cymbalta® (duloxetine)
Cymbalta 30 mg
Sig: 1 po q am x 1 week. If sxs persist, 2 po q am. (If the patient is depressed, it is better to increase after one week to a bid dose such as 30 mg po bid).
(also comes in 20 mg; can start at this dose if desired)

Neurontin
Neurontin® (gabapentin)
Sig: 300 mg po qd x 3 days; if sxs persist, 300 mg po bid x 3 days; if symptoms persist, 300 mg po tid. Stay on this dose for a month and increase gradually, by 300 mg weekly, if needed.
It comes in 100, 300, 400, 600 and 800 mg doses
Do not exceed 2700 to 3600 mg total dose per day. Do not give more than 1200 mg in a single dose. Do not stop suddenly, wean when stopping.

Gabapentin ointment 3% or 6%
Sig: apply to affected area bid-tid
Disp: 3 month supply
**Lyrica**
- 50 mg po qd x 4 days, if sx persist, 50 mg po bid x 4 days, if sx persist, 50 mg po tid
- Can gradually increase up to 100 mg po tid (Some report utilizing up to a maximum of 300 mg po bid). Do not stop suddenly. Wean when stopping.

Recent paper regarding the use of lamotrigine for vulvodynia.

**Blocks**
Bupivacaine (0.25% or 0.5%) and Kenalog® (triamcinolone acetonide)
Draw up Kenalog® first (40 mg/cc) (can use up to 40 mg steroid in single dose per month. Must be a large area however, or tissue can erode). Combine with Bupivacaine (large area use 0.25%; small area use 0.5%) Inject into specific area or use as a pudendal block
Can be repeated monthly

**Medications for localized pain or itching**
Zonalon® (Doxepin) 5% cream
Sig: apply to skin qd with gradual increase not to exceed qid Disp: 30 gms

Topical amitriptyline 2% with baclofen 2% in WWB (water washable base)- squirt ½ cc from syringe onto finger and apply to affected area qd to tid Disp: 30 day supply

**Vaginal pain**
Intravaginal valium Start at 5 mg per vagina qhs. If symptoms persist, gradually increase by 5 mg qhs, not to exceed 20 mg per vagina qhs.

**Summary**
Vulvar pain is a complex disorder that is frequently frustrating to both practitioner and patient. It can be a difficult process to treat. Improvement may take weeks to months. Spontaneous remission of symptoms has occurred in some women, while with others, multiple attempts with medical management have proven unsuccessful in relieving 100% of the symptoms. The treatment of vulvar pain is confounded by the fact that the cause is unknown in a great majority of cases. It is important to recognize that rapid resolution of symptomatic vulvar pain is unusual even with appropriate therapy. Additionally, no single treatment program is successful in all women. Concurrent emotional and psychological support can be invaluable.
Self-help books

**Sex Matters for Women**
A Complete Guide to Taking Care of Your Sexual Self

Sallie Foley, Sally A. Kope, and Dennis P. Sugrue

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**A Woman's Guide to Confronting, Diagnosing, and Treating Sexual Pain**

HEALING PAINFUL SEX

CONDITIONS COVERED INCLUDE:
- vulvodynia and clitorodynia
- pelvic floor dysfunction
- pudendal nerve pain
- orthopedic pain
- painful bladder syndrome
- endometriosis
- and many others

DEBORAH COADY, MD
& NANCY FISH, MSW, MPH
Self-help Website Information

www.nva.org
I Have Vulvodynia-What Do I Need to Know

Vulvodynia, Pregnancy and Childbirth

My Partner Has Vulvodynia-What Do I Need to Know

http://www.uofmhealth.org/medical-services/sexual-health
References

Overview/Treatment

2005


2006


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2010


2011


Carrico DJ, Peters KM. Vaginal diazepam use with urogenital pain/pelvic floor dysfunction; serum diazepam levels and efficacy data. Urol Nurs 2011;31:279-84.


Lonkey NM, Edwards L, Gunter J, Haefner HK. Vulvar pain syndromes: A bounty of treatments—but not all of them are proven. OBG Management 2011;23:29-30, 32,34-6,38,40-1.


2012


Milani M, Iacobelli P. Vaginal use of ibuprofen isobutanolammonium (Ginenorm): Efficacy, tolerability, and pharmacokinetic data: A review of available data. Int Scholarly Res Net 2012;


2013


2014


2015


2016


**Vaginismus**

**2004**


**2005**


2006


2008

2009

2010

2011

2012

Terminology
2004

2006

Tuma R, Bornstein J. Vulvar pain syndrome (vulvodynia)—dilemmas in terminology. Harefuah. 2006;145:215-8, 244. (Hebrew)
2013

2016


Prevalence/Incidence

2003


2007
2008


2011

2014

2016

Measuring Pain
2004
2005

2006


2007

2009

2011

Pathophysiology
1958

1986
1988

1989

1990

1991

1993


1994

1995

1997


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2001

2002


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2004


2005


2006


2007


2008


2009


2010


2011


2012


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2013


2014
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2017


difference in generalized pain and localized pain

2004

Psychosexual research

2008


2009


2010


2011


2012

2013

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