Learning Objectives

At the end of this presentation, the participant will:

• Understand the current classification system for vulvar pain (2015 Consensus Terminology and Classification of Persistent Vulvar Pain)
  – International Society for the Study of Women’s Sexual Health,
  – International Society for the Study of Vulvovaginal Disease
  – International Pelvic Pain Society
  – Support from the National Vulvodynia Association

• Explore the various causes of vulvodynia

• Gain knowledge on the treatments utilized for localized and generalized vulvodynia
Question 1

I see patients with vulvodynia

- Yes
- No
Question 2

I like to see patients with vulvodynia

- Yes
- No
Definition of Vulvodynia

International Society for the Study of Vulvovaginal Disease (ISSVD)

- Chronic discomfort
- Burning
- Stinging
- Irritation
- Rawness
8.3% of women have vulvodynia

By age 40 years, 7-8% in Boston and Minneapolis/St. Paul reported vulvar pain consistent with vulvodynia.

Diagnosis of Vulvodynia

Define disease
- Cotton swab test
- Vulvoscopy?
- Duration of pain
Not tender; no area of vulva touched described as area of burning

Alternative diagnosis
Diagnosis of Vulvodynia

Define disease

- Cotton swab test
- Vulvoscopy?
- Duration of pain
Various Terms Utilized for Vulvar Pain Prior to 2003

- Essential vulvodynia
- Dysesthetic vulvodynia
- Vulvar vestibulitis syndrome
- Vulvar dysesthesia (generalized or localized)
- Provoked vulvar dysesthesia
- Spontaneous vulvar dysesthesia
Vulvar pain related to a specific disorder

- **Infectious** (e.g. candidiasis, herpes, etc.)
- **Inflammatory** (e.g. lichen planus, immunobullous disorders, etc.)
- **Neoplastic** (e.g. Paget’s disease, squamous cell carcinoma, etc.)
- **Neurologic** (e.g. herpes neuralgia, spinal nerve compression, etc.)
2003 ISSVD Terminology
Salvador, Brazil

Vulvodynia
- Generalized
  - Provoked (sexual, nonsexual, or both)
  - Unprovoked
  - Mixed (provoked and unprovoked)
- Localized (vestibulodynia, clitorodynia, hemivulvodynia, etc.)
  - Provoked (sexual, nonsexual, or both)
  - Unprovoked
  - Mixed (provoked and unprovoked)
2015 Consensus terminology and classification of persistent vulvar pain

Jacob Bornstein MD, MPA, Andrew Goldstein MD, and Deborah Coady MD for the consensus vulvar pain terminology committee

From the International Society for the Study of Vulvovaginal Disease (ISSVD), the International Society for the Study of Women's Sexual Health (ISSWSH), and the International Pelvic Pain Society (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
Appendix:
Potential Factors Associated with Vulvodynia

- 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)

a The factors are ranked by alphabetical order.
Topical review

Vulvodynia: Current state of the biological science

Ursula Wesselmann\textsuperscript{a,b}, Adrienne Bonham\textsuperscript{c}, David Foster\textsuperscript{c,*}

\textsuperscript{a} Department of Anesthesiology/Division of Pain Management, University of Alabama at Birmingham School of Medicine, Birmingham, AL, USA
\textsuperscript{b} Department of Neurology, University of Alabama at Birmingham School of Medicine, Birmingham, AL, USA
\textsuperscript{c} Department of Obstetrics and Gynecology, University of Rochester School of Medicine and Dentistry, Rochester, NY, USA
Theories on Etiologies

- Embryologic derivation
- HPV
- Oxalates
- Hormonal changes
- Chronic inflammation
- Altered immuno-inflammatory process/genetics
- Nerve pathways
Proposed neuroimmunological mechanism of the allodynia/hyperpathia of vulvodynia

Potentially inciting factors:
- Infections
- Irritants
- Toxins
- Medications
- Other

Increased proinflammatory cytokines:
- IL-1, IL-6, IL-8
- IFN-α
- TNF-α

IL-12 and IL-18

Substance P
CGRP

Nerve growth factor increased

Mast cell accumulation

Distal nerve sprouting

Legend:
- = stimulatory
- = inhibitory
Theories on Etiologies

- Embryologic derivation
- HPV
- Oxalates
- Hormonal changes
- Chronic inflammation
- Altered immuno-inflammatory process/genetics
- Nerve pathways
Question 3

The nerve which supplies the major portion of the vulva is the

1. Ilioinguinal nerve
2. Genitofemoral nerve
3. Perineal nerve
4. Pudendal nerve
Pudendal Nerve

Originates from S2, S3, and S4 foramina
Vulvodynia
Management
Evaluating Vulvodynia Patients
A Team Approach
SEXUALITY AND PAIN

150 Positions

175 Excuses
Vulvar Care Measures

No soap on the vulva

Shower heads for rinsing and...
Tender, or patient describes area touched as area of burning

Yeast culture negative or inadequate relief with antifungal

1. Vulvar care measures
2. Topical medications
3. Oral medications
4. Injections
5. Physical therapy
6. Cognitive and behavioral therapy
Cool Gel Packs

YOUR NAME HERE

Promote your company, product or special event

www.customgelpack.com
Tel / Fax: 1 888 812 3353
Vaginal Lubricants

Replens
Astroglide
KY Liquid
Probe
Slippery stuff
Jo Premium

etc.
Topical Anesthetics

• 5% Lidocaine (Xylocaine®) ointment safe, effective short-term symptom relief for vestibulodynia (pre-intercourse)
  – Benzocaine (Vagisil®) not recommended; it is a sensitizing agent, causing rebound vasodilation and pain

• Doxepin (Zonalon®)

• Topical amitriptyline 2% with baclofen 2% in WWB (water washable base)—squirt ½ cc from syringe onto finger and apply to affected area WWB. Apply qhs with increase not to exceed tid

• Topical ketamine 2%, topical gabapentin 6%, topical baclofen 2% in WWB. Apply qhs with increase not to exceed tid
Oral Medications
Tricyclic Antidepressants

• Useful for neuropathic pain syndromes such as postherpetic neuralgia and vulvar dysesthesia
• Doses for pain management less than for depression
  • Tricyclics
  • SSRI’s
  • SSNRI’s (venlafaxine, duloxetine)
Tricyclic Antidepressants

- Amitriptyline or desipramine
  - Advise regarding rationale
  - Start at low dose two hours before bedtime and increase up to 150, until comfortable, or intolerable side effects
  - One drink of ETOH per day
  - Advise slow benefit
Tricyclic Medications

- Adverse effects
  - Drowsy (amitrip > desip) or
  - Jittery (desip > amitrip), tachycardia
  - Dry mouth, eyes
  - Increased appetite
  - Constipation
Other Antidepressants

- Venlafaxine (Effexor)
- Duloxetine (Cymbalta)
Anticonvulsants and Pain Control

The role of anticonvulsant drugs in the treatment of neuropathic pain is evolving and has been clearly demonstrated:

- Gabapentin
- Pregabalin
- Topiramate
- Tiagabene
- Lamotrigine
Gabapentin

- 64% of 152 generalized vulvodynia patients improved by 80% in a retrospective chart review

Pregabalin

- Retrospective chart review of 28 women on pregabalin for vulvodynia.
  - 12 reported improvement averaging 62%
  - 10 discontinued due to AEs
  - 4 had no improvement
  - 2 with vestibulodynia had not tested their pain

Aranda J, Edwards L: presented at the 2007 ISSVD World Congress
Anticonvulsants and Pain Control

The role of anticonvulsant drugs in the treatment of neuropathic pain is evolving and has been clearly demonstrated:

- Gabapentin
- Pregabalin
- Topiramate
- Tiagabene
- Lamotrigine
Oral Pain Medications

- **Ultram®**
  - Tramadol HCl tablets
  - 50 mg

- **Tylox®**
  - Oxycodone and acetaminophen capsules USP
  - 5 mg / 500 mg

- **Vicodin®**
  - Hydrocodone bitartrate, acetaminophen
  - 5 mg / 500 mg
Use the Integrated Index™ System to find quick answers

Search for summaries and detailed monographs for drugs, toxicological managements, reproductive risks, and acute/emergency care.

Enter search term(s) Search

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Search by database
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Find drugs and substances
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- Drug Interactions
  (DRUG-REAX® System)
- Dosing Tools
  (Calculators & Nomograms, Pearls)

Access patient education
- Patient Leaflets

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Epocrates
Specific Point Tenderness

- Bupivacaine / triamcinolone acetonide injections
  - Bupivacaine (0.25% or 0.5%) and triamcinolone acetonide (Kenalog®)
  - Draw up triamcinolone acetonide (Kenalog®) first (40 mg/cc) (can use up to 40 mg steroid in single dose per month). CAUTION ON PERINEUM AND SMALL AREAS. 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
  - 50% efficacy
Nerve Blocks

Pudendal
Genitofemoral
Ilioinguinal
Ganglion impar
Pudendal Nerve Blocks

Originates from S2, S3, and S4 foramina
Genitofemoral and Ilioinguinal Nerve Blocks
Genitofemoral and Ilioinguinal Nerve Blocks
Ganglion Impar Block
Surgical Treatment
New Thoughts and Trends
Novel Therapeutic Approaches

Chemodenervation

Over 1900 reports of botulinum toxin for pain
Minimizes vaginismus-relaxes levator ani muscles

Medline search August 29, 2016
Chemodenervation Bulbocavernosus
Neuromodulation

- Peripheral subcutaneous stimulation
- Sacral nerve stimulator
  - Modulation of efferent signals to spinal cord
  - Refractory pain in distribution of specific nerve root (S3 or S4)
Acupuncture

Acupuncture Today 2001;2:1,16.
Hypnosis
www.asch.net

Report on hypnosis for vestibulodynia
Newer Treatments/Less Commonly Used

- Rejoice trial (Yuvexxy)
- Milnacipran (fibromyalgia)
- Leukotriene receptor antagonist
- Topical nitroglycerin
- Topical capsaicin
- Enoxaparin injections
- Fibroblast cream (Neogyn)
- Passiflora incarnata attenuation (rats)
- Laser treatments
- Motor cortex stimulation (central)
Vulvodynia: Assessment and Treatment
Andrew T. Goldstein, MD,1* Caroline F. Pukall, PhD,2* Candace Brown, PharmD,3 Sophie Bergeron, PhD,4 Amy Stein, DPT,5 and Susan Kellogg-Spadt, PhD5

Sex Med 2016;13:572e590
The Vulvodynia Guideline


- A guideline for treating vulvodynia is described

www.jlgtd.com
- click on archive
- click on Volume 9 (2005)
- Jan 2005 (pp 1–63)
- Scroll down to The Vulvodynia Guideline
- Click on PDF (350 K)
Recent Vulvodynia Update

ACOG  Persistent Vulvar Pain  Committee Opinion Number 673  September, 2016.
Vulvodynia Awareness Campaign
Office of Research on Women’s Health

http://orwh.od.nih.gov/health/vulvodynia.html
General Measures

Written material/handouts
- Patient education regarding the nature and prognosis of vulvodynia
- National Vulvodynia Association
  www.nva.org or 301–299–0775

Online teaching program on chronic vulvar pain
http://learn.nva.org
Oceans of Lotions, Potions, and Notions
No “One Simple Cure”
Serotonin and Norepinephrine in Depression and Pain


5-HT and NE links to pain transmission neurons


The Human Dimension