



Global Year Against Pain in Women

real women, real pain

Vulvodynia

What is vulvodynia?

Vulvodynia is a chronic pain syndrome of the vulvar area in the absence of an infectious, dermatological, metabolic, autoimmune or neoplastic process.

Vulvodynia has long been recognized as a common clinical problem and chronic pain of the vulva was already described in American and European gynecological textbooks more than 100 years ago. In 1976 the International Society for the Study of Vulvovaginal Disease (ISSVD) identified idiopathic vulvar pain as a unique entity and subsequently coined the term vulvodynia (1).

In a broader view vulvodynia can be grouped with the chronic non-malignant syndromes of urogenital origin occurring in both men and women (2). These pain syndromes include in addition to vulvodynia: urethral syndrome, coccygodynia, generalized perineal pain, orchialgia, prostatodynia (chronic pelvic pain syndrome in men), chronic penile pain and interstitial cystitis.

What are the symptoms?

Women, who suffer from vulvodynia, typically complain about a hot, burning and stinging sensation and/or a feeling of rawness in the vulvar area. The pain might be localized to a very specific area of the perineum (and the patients can typically identify exactly the painful “spots”), such as the vulvar vestibule, labia or clitoris or it might be affecting the whole perineal area.

These two subtypes of vulvodynia have been termed “localized” and “generalized” vulvodynia.

Vulvar Vestibulitis, one of the subtypes of vulvodynia, refers to localized pain at the vulvar vestibule, the area around the vaginal opening. Women with vulvar vestibulitis typically experience pain when pressure is applied to the vulvar vestibule during sexual intercourse, tampon insertion or a gynecological examination. Clinically two different groups of patients with vulvar vestibulitis have been described: Primary vulvar vestibulitis is defined as dyspareunia from the first attempt of sexual intercourse, whereas in secondary vulvar vestibulitis, the dyspareunia appears after a period of pain-free sexual intercourse.

In women with generalized vulvodynia, the perineal pain is exacerbated by prolonged sitting, and by activities such as bicycle riding and horseback riding.

Who suffers from vulvodynia?

Vulvodynia affects women of all age groups. The incident of symptom onset is highest between the ages 18 and 25 and lowest after age 35 (3). Community studies suggest that vulvar pain is common, and prevalence rates as high as 18% have been reported (4). Vulvar vestibulitis has been described in up to 15% of gynecological outpatients (5). While initial reports postulated that vulvodynia affects primarily Caucasian women, a recent survey of ethnically diverse women showed similar life-time prevalence of chronic vulvar burning pain or pain on contact (3).

How is the diagnosis of vulvodynia made?

Vulvodynia is a diagnosis of exclusion. The differential diagnosis is wide and can include vulvar candidiasis, herpetic infections, lichen planus, Paget’s disease, squamous cell carcinoma, postherpetic neuralgia or spinal nerve compression. Thus, a thorough gynecological evaluation, and in selected cases also a neurological and dermatological assessment are necessary.

What causes vulvodynia?

The etiology of vulvodynia is multi-factorial. There is experimental evidence from several psychophysical studies indicating that the pain sensitivity to mechanical and thermal stimuli in the vulvar area is altered in women with vulvodynia (6, 7). In addition to the peripheral sensitization demonstrated in the vulvar area, there is evidence of central sensitization. There is evidence of a possible genetic component in the etiology of vulvodynia (8). A neuromuscular etiology has been considered, resulting in tightness (spasms) of the pelvic floor. Vulvodynia has been shown to be associated with a history of physical and sexual abuse in a subgroup of women (9).

Diagnosis and Treatment:

Current research studies indicate that vulvodynia is a heterogeneous, multi-system and multi-factorial disorder. Therefore, a multidimensional and multidisciplinary treatment approach is recommended. Currently there is no cure for vulvodynia, although some patients experience spontaneous remission.

The first important step is to recognize that the patient is suffering from vulvodynia. Many women with chronic vulvar pain have remained undiagnosed and untreated, because the clinical presentation and treatment approaches are not widely known to health care professionals. A recent study in the USA demonstrated that 60% of women consult at least three doctors in seeking a medical diagnosis. Astoundingly, 40% of those who seek professional help remain undiagnosed after three medical consultations (3).

As a first measure in the treatment of vulvodynia is important to identify and eliminate local irritants and potential allergens. In patients with localized vulvodynia, where a small area is painful, topical treatment regimens might reduce the pain. Oral medications recommended for the treatment of neuropathic pain management have been considered. Surgical procedures have been advocated to remove the hyperalgesic skin area in patients with localized vulvodynia. Vaginal biofeedback and cognitive behavioral therapy have been reported to reduce the pain. As in many other pain conditions of multi-factorial origin, there is usually not one single treatment approach that consistently reduces pain in women with vulvodynia, but a combination of treatments (10).

References:

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