Vulvodynia: a multidisciplinary approach

The below questions were submitted on the night of the webinar, but due to time constraints we were not able to answer.
We thank Janetta Webb, Dr Sara Whitburn, and Dr Megan Eddy for responding to the below questions. You will find other questions and answers in the webinar recording (1.09.44). The answers provided in this document are for your knowledge and education only – they are not intended to provide specific medical advice. You will need to take into consideration each patient and their own presentation when providing medical management.

Dr Sara Whitburn - women's health GP and medical educator at Family Planning, Victoria.

Can you give red flag symptoms we need to watch, or check for, when we are diagnosing vulvodynia	Vulvodynia is a diagnosis of exclusion. It is important to exclude other (or co-existing) conditions such as dermatitis, herpes simplex, vaginismus, candida, bacterial vaginosis, other sexually transmitted infections, lichen sclerosis, lichen planus and other autoimmune skin conditions. Note: these can be co-existing conditions so vulvodynia can be present as well as these conditions, but they need to be addressed and treated to improve vulvodynia management.
Is Vulvodynia more common in a certain age group? How common is the issue of Vulvodynia?	• Provoked vulvodynia tends to occur in younger people 20 –30's. • Unprovoked vulvodynia occurs in older people 50-60's. • 4-8% people have vulvodynia with 10-20 % in their lifetime.
How would a gynaecologist or psychologist manage patients with vulvodynia?	We cannot answer this in detail as we are not gynaecologists or psychologists. However, gynaecologists who specialise in vulval care can be useful for a small number of patients with provoked vulvodynia or vulvodynia that has not responded to other measures. Surgical removal of an isolated tender area can help if all else has failed. Widespread areas of pain are not suitable for surgery. Psychologists can be useful if there is anxiety and depression present or occurs because of chronic pain on the person's quality of life. Psychology can also be useful if they are able to provide sexual or relationship counselling.

What is the current best practice for treating chronic non-Candida Albican vulva thrush? Can these women still be offered Vagifem if they have atrophic vaginitis?	Melbourne Sexual Health has excellent guidelines on treating candidiasis - https://www.mshc.org.au/health-professionals/treatment-guidelines/vulvovaginal-candidiasis-treatment-guidelines Post-menopausal: if someone has candida then it is usually secondary to use of vaginal oestrogen as it is unusual to have candida in a low estrogen environment. Stopping the vaginal estrogen and focusing on genital skincare can help. If genitourinary symptoms of the menopause do not respond to genital skin and vaginal estrogen is required but causes candida then concurrent suppression of candida while on estrogen may have to occur.
Does the use of lignocaine reduce the potential for her pleasure?	Yes, lignocaine can decrease pleasure, but use is usually only recommended when there is provoked pain with penetration, and someone is continuing to have sexual intercourse. The aim is to decrease the association of pain and sexual intercourse.
Should everyone see their GP first before purchasing lignocaine as it's an OTC medicine. Any precautions?	Yes, talking to a GP to aid assessment and management is first line for vulvodynia and being able to provide information about how to use lignocaine and the potential side effects (initial burning, need to applied prior 30 mins to sexual intercourse and dab off excess) is recommended. However, it is available over the counter and is recommend by online patient resources so can be part of a patient's self-care plan. The only precautions would be to patch test first for allergies and that it may sting or burn more on broken skin.

Dr Megan Eddy - specialist pain medicine physician.

Do antispasmodics work as an adjunct to facilitate physiotherapy?	• We use diazepam pessary occasionally as an adjunct for the pelvic floor overactivity. For example, very occasionally pre-penetrative intercourse if a person is able to have intercourse but painful. It isn't a muscle relaxant per se, and the mechanism is probably still systemic absorption. However, using it per vagina may enhance placebo effect. Needs careful patient selection and not for regular use. • Other antispasmodics eg orphenadrine I sometimes find help in the occasional circumstance, eg if penetrative intercourse is no longer painful but they get a post coital flare. Using 37.5mg up to 100mg post. Occasionally may try them pre physiotherapy but it is a short-term strategy only.
Please discuss the use of topical ketamine and topical amitriptyline. Including: • The evidence of use vs real life experience. • What strength and how do you prescribe its use? • How soon do you review its effectiveness? • What advice do you give to patients when prescribing topical amitriptyline, in terms of dose, application, area, etc?	I tend to avoid ketamine topically in vulvodynia, as usually there is some application to mucosal surface and much more absorption therefore occurs. Amitriptyline can be compounded to 1 –2% in a hypoallergenic base, such as dermabase, and applied twice a day. It can take 4-6 weeks to see an improvement. It is often very successful – with good patient education, and review of allodynia findings. As discussed (by Megan) on the night – it can cause stinging/burning when applied and is more useful for localised vulvodynia Often start nocte only, if tingling is more then a few minutes then you may need to choose something else. Another option is second line is gabapentin 4-6%, how this works topically is unclear. The evidence base is very scant but topical application is unlikely to cause harm. If benefit is going to occur it is usually within 2-4 weeks and if getting benefit, I recommend 3 months use before cessation.

Janetta Webb - pelvic health physiotherapist at Jean Hailes.

If there's any benefit to manual therapy. Things that could make it worse with manual therapy	If manual therapy is indicated following your assessment, then, as with any manual therapy, start with a small dosage first then re-assess for irritability at next consultation. Remember you are aiming to break the pain cycle and the patient's association of touch with pain, whether you are using external or internal techniques.
Do issues such as cystocele, rectocele, prolapse, UTI, Thrush have an effect in cases of vulval pain?	(Sara) UTI, candida and other painful stimuli are triggers for vulvar pain. If cystocele, rectocele or prolapse are not painful then no they are not a trigger. (Janetta) If a patient has symptomatic pelvic organ prolapse (POP) symptoms, they may inadvertently get into the habit of engaging their pelvic floor muscles (PFMs) to "hold everything in". Over time, this could contribute to increased tone of the pelvic floor and then to vulvodynia. Just because a patient has POP, many still have increased tone of the pelvic floor for the above reason. You can have an increased levator hiatus and weak pelvic floor muscles but also increased tone at the same time. Don't assume that someone with POP will always have reduced tone. And conversely, PFMs that are overactive are usually weak, not strong. So firstly, we need to get the muscles moving well and then once pain has been managed, ensure that PFMs have the strength to support pelvic organs and give us good sexual sensation as well and bladder and bowel continence.
Where can we find the pelvic floor podcast, you mentioned in the webinar?	The podcast can be found in the bladder and bowel resource section of our Jean Hailes website, or by clicking here.