Vulvodynia: a multidisciplinary approach

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Overview of vulvodynia

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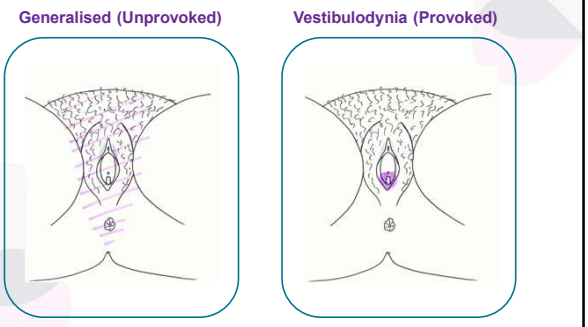
Vulvodynia

- **Vulvar** pain lasting longer than **3 months**, without a clear cause
- The vulva is normal in appearance
- This means it is a type of chronic pain



Ref: AFP (2015) Vol 44, pgs 460-464

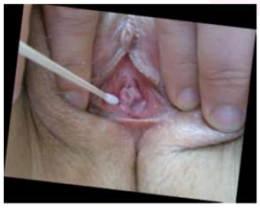
History (screening questions)

Four questions highly predictive for vulvodynia:

1. Do you experience genital "pain"?
2. Do you experience genital burning >3 months?
3. Is there many episodes of pain on contact with tampon insertion, intercourse or gynaecological exam?
4. Does pain on contact limit/prevent intercourse?

Examination

- Normal appearing vulva common, may be erythema at openings of minor vestibular glands
- Cotton tip test for sensitivity
- Marked tenderness to gentle pressure in vulvar vestibule
- Note this may be present in asymptomatic people!



Why it's not discussed

- Consumers may:
  - be embarrassed
  - have a lack of knowledge about what is normal and abnormal vulval anatomy and function
  - have concerns about their body and/or body image
- Health practitioners may:
  - have limited experience with genital and sexual history-taking
  - have a lack of knowledge about treatment options or resources

See Jean Hailes webinar "how to talk about vulval heath" for more insights to how to talk about vulval conditions

Clinical implications or outcomes of not discussing

- Loss of quality of life
- Depression, anxiety, self esteem issues
- Sexual problems
- Relationship problems
- Chronic pain and discomfort

What can a general practitioner do for vulvodynia

- Believe and validate
- Explain and name the pain syndrome and give resources
- Explain the chronic nature and response is not immediate
- Encourage to be active in self-management
- Discuss abstaining from penetrative intercourse while initiating management, discuss outercourse
- Consider other conditions that may be triggering pain
  - dermatitis: atopic, infective (candidiasis), contact
  - dermatosis: lichen sclerosis

What can a general practitioner do for vulvodynia

- Discuss genital skin care
- Discuss referral to multidisciplinary team
- Discuss possible topical or oral treatments
  - 2% or 5% lignocaine topically bd-tds or before intercourse
  - Tricyclic antidepressants
    - topical: 1 or 2% amitriptyline compounded in cream, emollient or oil twice daily
    - can use oral as evening dose, risk of sedation and dry mouth
  - Gabapentin: oral or topical (3-6% compounded)
  - Pregabalin

Discussing chronic pain

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What is pain?

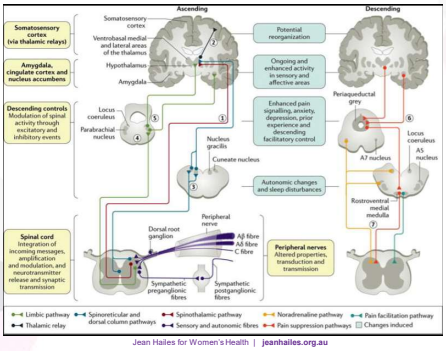
An unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage.

What is pain?

- Pain is always a personal experience that is influenced to varying degrees by biological, psychological and social factors
- Pain and nociception are a different phenomena — the experience of pain cannot be deduced from activity in sensory pathways
- Through their life experiences, individuals learn the concept of pain
- A person's report of an experience as pain should be respected
- Although pain usually serves an adaptive role, it may have adverse effects on function and social and psychological wellbeing

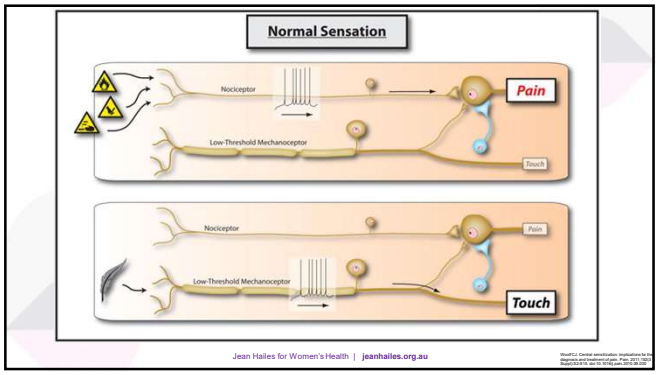
IASP 2017

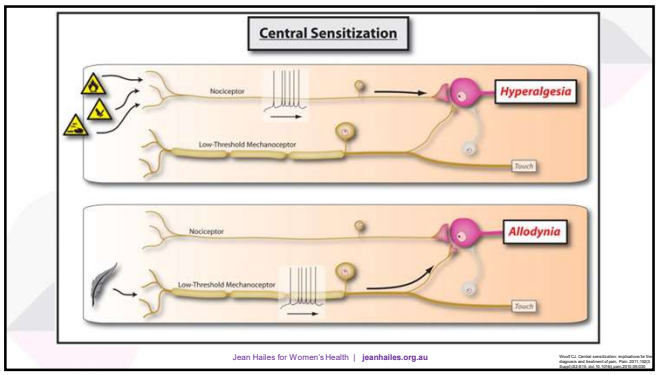
Nociceptive pathways



Chronic (?) pain

- Pain that persists
- Taxonomy nociceptive, neuropathic, nociplastic
- Mechanisms sustaining/perpetuating the current pain experience are now **multifactorial**
  - central processing of sensory input is different
  - sensory input is different from when pain began
    - more - eg MSK
    - inciting inputs may or may not continue
  - consequences of this person's pain (sleep, anxiety, lowered mood, work, relationships, medication, health, wellbeing)





Central sensitisation

- It is not a diagnosis
- It is a neuroimmune function/process that contributes to the chronic pain experience in some
- Hyperalgesia and allodynia infer but do not confirm its presence
- Unfortunately, the term is often used to describe the very distressed patient and used pejoratively

Often heard

- *You don't believe me, you think it's all in my head*
- *Not taking me seriously*
- *Anxiety can't be part of it, when I'm anxious my pain isn't worse*
- *Everything dismissed as 'chronic pain'*
- *My body is telling me I am in pain when I am not*
- *You don't want to help me*
- *You aren't listening to me*

Explaining their pain

- Do they believe that you believe them?
- Understand and address expectations EARLY!
- What are the core beliefs and concerns?
- A story that makes sense to them
- Lay all the components out
- Huge schema shift for most – repeated education, repeated checking in
- Metaphors, physical examination
- Hope

Medical management options

- Neuromodulation medications
  - may be one of the tools to reduce central sensitisation
  - education and explanation crucial
- Target treatment of contributors
  - BonT to the pelvic floor
  - nerve blocks? pudendal nerve, caudal epidural
  - dysmenorrhoea
  - gastrointestinal dysfunction – is it the meds they are on?
  - iatrogenic causes of sensitisation – eg chronic opiate use

Neuromodulation medications

- Amitriptyline 10-25mg – nortriptyline 10-25mg at 6-7pm
- Gabapentin 100-300mg tds
- Duloxetine 60-90mg mane with food
- Pregabalin 75-150mg bd
- Venlafaxine 75-150mg, desvenlafaxine 50-100mg
- PEA palmitoylethanolamide 400mg tds
- Low dose naltrexone 450mg d

Psychosexual aspects of vulval pain

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Women's health GP, sex therapist
Jean Hailes for Women's Health

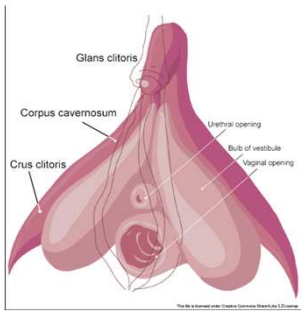
Jean Hailes for Women's Health jeanhailes.org.au

Moving from pain to pleasure

- Long term chronic pain can lead to depression and feelings of hopelessness
- Early intervention and empowerment can overcome learned helplessness as well as self-inflicted pain
- A good outcome is possible (don't believe all the doom and gloom). Many women do well with treatment
- Draw on the woman's strengths and educate them and their partners about women's bodies and sexual response
- Pain imprints negatively so don't inflict any. Desensitize slowly

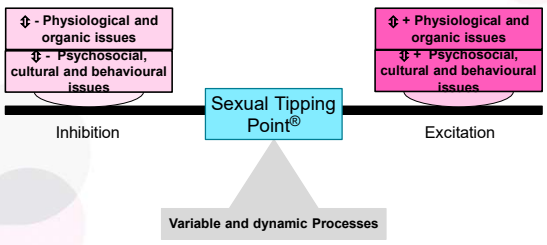
Psychosexual aspects of vulval pain

- Unaroused intercourse is a major contributor to sexual pain
- Little research considers this as a factor
- Arousal creates cushioning with increased blood flow to the clitoral apparatus/bulbs
- Natural lubrication
- Elongation and ballooning of proximal vagina lifts cervix away from direct contact



Dual Control Model

after Perelman



Inhibitors of desire

(after Dr Rosie King)

- Lack or loss of attraction to partner
- Low self esteem, body image issues
- Negative attitude to sex, lack of trust
- Unresolved conflict, jealousy
- Lack of privacy, discomfort, distractions, intrusions
- Pain, fatigue, vaginal dryness
- General health issues-physical and mental
- Medications-antipsychotics, SSRIs, COCP, progestins, beta blockers etc.
- Drugs and alcohol

Enhancers of sexual desire

(after Dr Rosie King)

- Attraction /attractiveness-sexual chemistry
- Compatibility, companionship, communication
- Intimate contact and positive feedback,
- Frequent non-demand affection, enjoyable sensuality
- Satisfying sexual experiences, acceptance, love
- Trust, respect, commitment, goodwill
- Constructive conflict resolution
- Resolved balance of power and jealousy issues
- Boundaries defined

Counselling

- Two sides to every couple's story
- Family therapy / couple therapy tries to provide balance of views, taking into account each individual's past history and sensitivities, the dynamic between them including communication
- How much is depression colouring her view/ his view?
- How much behavioural change is possible? Is it too late?
- What strategies are available to provide a good enough outcome for each partner and their children?

Physiotherapy

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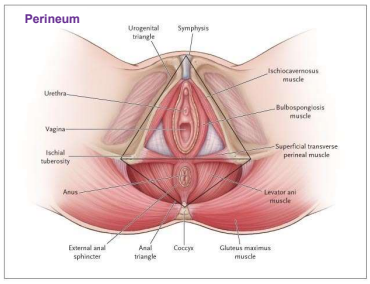
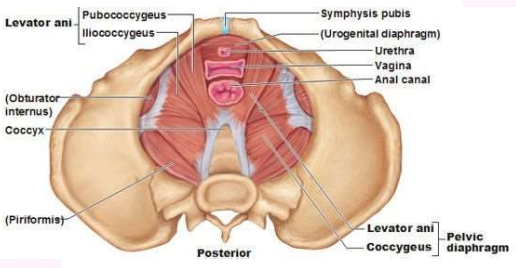
Quick anatomy review



Deeper layer pelvic floor muscles



Pelvic floor muscle dysfunction

- Associated with pelvic pain disorders including vulvodynia
- Most commonly increased tone (not hypertonic)
- Two components of tone (resting tension and resistance to passive movement)
  - viscoelastic
  - contractile
- A trigger for vulvodynia or a consequence

(Goldstein, 2016; Thibault-Gagnon, 2015; Gyang, 2013; Frawley, 2021; Morin, 2017)

Vaginismus

- An example of transient increase in PFM tone
- Inability to maintain relaxation with attempted vaginal penetration - finger, tampon, penis, toy
- Reduces with verbal cues or gentle pressure or cessation of attempt
- Protective response
- Response to pain
- Part of "Fight/Flight/Freeze" response (van der Velde, 2001)

Education, CNS calming

- Care with language
- Pain science education (see resources)
- Pain ≠ damage (Swain, 2018)
- Neuroplasticity – change is possible
- Address factors that sustain pain:
  - lifestyle
  - thoughts about pain
  - stress
  - sleep hygiene
  - fear of movement

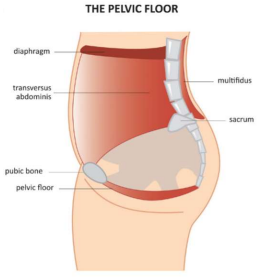
Contributing conditions addressed by physio

- Hip, lumber spine pain, pelvic girdle pain
- Persistent pelvic pain eg endometriosis
- Hypermobility eg Ehlers Danlos syndrome
- Fibromyalgia
- Migraines, TMJ pain
- Overtraining of "core"
- Lower urinary tract symptoms – bladder pain syndrome, frequency, urinary urgency, urinary urge incontinence, voiding dysfunction, dysuria
- Evacuation disorders- constipation, obstructed defecation, faecal urgency or incontinence, flatal incontinence, pain
- Irritable bowel syndrome (IBS)
- Pelvic organ prolapse

The physio consultation

- Listen to the story
- Patients like a name for their condition, have goals and a plan = their goals, not yours
- Pain science education
- Posture
- Respiration (Hodges, 2007)
- Care with consent - full explanation, may not in first consult
- Commonly see indrawn perineum, adductor spasm, slow, incomplete or staggered relaxation post contraction, incoordination, rhythmical contraction, maybe pain
- Palpate for increased tone/tenderness/tender points

The "core"



Continence Foundation of Australia. Pelvic Floor First. 2016. Pelvic Floor and Core Exercises.

Case study one
Anna

Presenting symptoms

- 25 year old, pronouns: she/her
- Vulvodynia, diagnosed by her GP
  - unprovoked pain daily for 2 yrs. urethra to fourchette (sitting, clothing)
  - vaginal penetration 'awful'
- Other
  - painful periods since menarche, abdominal pain, low back pain, tendency to constipation, anxiety, 'mild' endometriosis on laparoscopy
  - eating disorder mid teens
  - series of deaths around age 14
  - medication side effects
  - regular exercise, working, excellent insight, proactive, steady partner

Previous Treatment

- Lidocaine gel
- Amitriptyline cream
- Physio
- Psychology
- Gabapentin
- Gynae x2

Management plan

- Amitriptyline oral
- Increased gabapentin
- Goals & Education +++
- Psychologist who understands chronic pain

On follow up

- Amitriptyline no change, reduced gabapentin back
- Psychology
- 6/12: Botox pelvic floor
  - no meaningful change
  - examination better
  - added duloxetine
- 9/12: Burning bit easier
  - weaning gabapentin, pacing up jeans
- 11/12: New relationship
- 14/12: Virtually no pain, enjoyable fulfilling sexual relationship
- 18/12: Still great - major stressors not gone backwards, plan to cease duloxetine shortly

Case study two
Jess

Presenting symptoms (1)

- 22-year-old, cis gender, pronouns: she/her
- Initially came to see you as had recurrent symptoms of candida and was diagnosed with recurrent vulo-vaginal candidiasis
- Had discharge and itch at the beginning and used over the counter treatments for a while
- After 4 episodes had provoked and unprovoked vulvodynia including superficial dyspareunia
- Jess was treated with 6 months of candidiasis suppression
  - 150 mg fluconazole weekly

Presenting symptoms (2)

- Jess has less discharge and unprovoked vulvodynia post treatment
- During intercourse she feels her muscles are tight and she is unable to tolerate penetration
- Post intercourse she has a burning pain
- Jess states she would be unable to have sex for the next 1-2 days because of the pain
- Jess is starting to not desire sex at all

Presenting symptoms (3)

- Jess does not want to have any intimate touch as worried will lead to intercourse
- Feels is impacting on relationship
- Tearful and thinks about breaking up with partner because of this even though she really loves him and feels that the rest of her relationship is positive

Next steps – how can a GP help?

- Believe and validate
  - acknowledge Jess' pain and impact on her relationship, sexual life and quality of life
  - screen for impact on mental health
- Offer an examination
  - can pause or reschedule if unable to tolerate due to pain
  - review if signs of candidiasis not adequately suppressed
  - review if other skin conditions contributing
  - cotton tip examination for pain
  - pelvic floor muscle examination

Next steps – how can a GP help cont..

- Give the condition a name
  - discuss vulvodynia and vaginismus
- Discuss abstaining from penetrative intercourse while initiating management, discuss outercourse
- Consider topical xylocaine and amitriptyline
- Discuss multidisciplinary referrals
  - refer for physiotherapy and sexual therapy

Physiotherapy

- Explain our role - most people have never heard of pelvic physio and most people are nervous at first visit
- Listen to her story
- What does she think is going on?
- Start pain science education early
- Was vulvodynia present prior to GP consultation and subsequent diagnosis of candidiasis?
- Other triggers, stressors at onset of symptoms and currently

Physiotherapy

- Anatomy - PFMs as protectors in response to fear, pain
- NB unprovoked and provoked vulvodynia, lasts for days
- Will having receptive sex give me thrush again?
- Relationship challenges, resentment, “hurry up”
- Avoid painful activities
- “But that's not real sex” - building the repertoire or “Menu” analogy, understanding the arousal response
- Must involve partner in education

Pelvic Floor Muscle Training

- Use of visual examination v palpation - calming CNS, be aware of triggering
- Awareness
- Restoring range of movement
- Downtraining - use her words for release
- Abdominal release and diaphragmatic breathing enhance PFM movement
- Mirror/TPUS for biofeedback only if desirable to her
- Body scanning

Physiotherapy

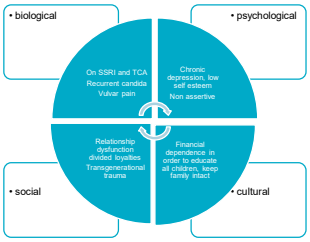
- Address tight clothing, underwear, use of “feminine hygiene” products
- Cool packs
- Desensitisation by physio, Jess, partner
- Trainers, vibrating trainers, vibration therapy
- Accommodating/tolerance to gentle stretch - never forceful/increasing pain
- Experience penetration without pain and muscle guarding

Physiotherapy

- Myofascial, manual therapy techniques
- Progression to arousal and comfort with all intimacy – importance of experiencing pleasure
- Positions, trainers, lubricants
- Conditioning, maximising physical ability, reduce fear of movement or exacerbating pain, pacing

Sexual counselling considerations

Biopsychosocial model



Empathic listening builds trust

- "So tell me about what's been happening?"
- Timeline of events in the patients own words with clarifying questions to facilitate the narrative keeping in mind possible contributing factors to the presenting problem
- Such as menstrual problems, contraception, relationship issues, past unwanted sexual contact/abuse, pregnancies
- General physical and mental health esp anxiety and depression other painful conditions, medications and allergies
- Who's at home with you? Partner, parents, in-laws, children friends-draw genogram. Ask about work and study, future plans

Further questions, examination and goal setting

- What has been the response of partner/s over time?
- Show me where it hurts entry/deep/both? On a diagram (check whether triggering first)
- How are you feeling about sex and penetration?
- What would you like to happen?
- Consent for examination if and when ready. “You are in charge” start with just looking, checking. Can stop at any time
- May take several sessions. Very gentle Q tip mapping (not diagnostic). How much is pain? How much is fear?

Nurturing self-touch

- Discuss the female body and help her visualise through diagrams and mirror her vulva and with gentle palpation the pelvic floor muscles
- Reassure that her vulva and vagina are safe to touch
- Encourage feedback from her own fingertips to her bodymap
- Warm bath or shower, warm hands, nurturing moisturising with olive and bee or coconut oil
- First desensitisation and PFM practice

Education about sexuality for patient /partner

- Most are fascinated to learn about anatomy and physiology of sexual response
- Diagrams with labels help them to identify sites of pain understand the language used, the dynamics of pelvic floor and the arousal process
- Can be a very non-threatening way to engage both parties and start a conversation around their sexual relationship, modelling ways to talk about sex, negotiate outercourse options, maximise arousal
- Start to build goodwill - give pleasurable homework
- Suggest readings, videos

Key messages

Key messages - Sara

- Vulvodynia is a chronic pain that can have severe impacts on quality of life
- GPs can assist with validation, examination, initial management, discussion of the role multidisciplinary referrals and ongoing reviews and support

Key messages - Megan

- Chronic pain is a complex situation that requires multimodal management

Key messages - Wendy

- Unaroused intercourse contributes significantly to the cycle of pain
- We need to explore what is happening between partners
  - are they able to talk to each other?
  - are they following a script or order of physical exchanges that is not working eg oral sex for the female to orgasm first then moving to penetration when it is no longer comfortable for her

Key messages- Janetta

- Pelvic floor muscle dysfunction is commonly associated with vulvodynia so must be considered
- Don't dismiss telehealth as an option for commencement of education and a physio program

Questions

Thank you

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Resources

Jean Halies health professional resources

Health professional tools:

Health professional education:

- e-learning courses:
  - Fertility, infertility and preconception care
  - Managing menopause
  - Diagnosis and management of PCOS
- Webinars:
  - How to talk about vulva health
  - Common vulval conditions
  - Why ask about vulval health
  - Let's talk about sex: midlife sexual function

Jean Hailes consumer resources

- Booklets
- Fact sheets
- Podcasts
- Videos
- Webpage

jeanhailes.org.au/health-a-z/vulva-vagina-ovaries-uterus/vulva-pain/vulvodynia-vestibulodynia

Other resources

Family Planning Victoria's
Vulvovaginal Health online learning course (fee applies)

Other resources

- The National Vulvodynia Association
- Australian New Zealand Vulvovaginal Society
- Vulval Pain Society (UK)

Pain
- International Association for the Study of Pain: pain terminology
- Pelvic Pain Foundation
- Pain Management Network
- Tame the Beast
- ANZCA: opioids and chronic pain

Other resources

Physio

- pelvicpain.org.au - patient information
- pelvicpain.org.au - easy stretches
- pelvicfloorexercise.com.au - products, lubricants
- patricianeumann.com.au - download pelvic floor relaxation for women
- cfaphysios.com.au - mostly Vic
- australian.physio.com.au - find a physio
- Explain pain, explain pain protectometer, explain pain supercharged by Lorimer Moseley and David Butler

Other resources

Sexual counselling reading

- Dr Rosie King: Good Loving Great Sex, Where did my Libido go?
- Dr Vivienne Cass: The Elusive Orgasm
- Jansen and Newman: Really Relating
- Gary Chapman: The 5 Love Languages
- John Gottman /David Schnarch numerous books
- OMGYES

Terminology of Vulval Pain and Vulvodynia (open access)

Bornstein J, Goldstein A, Stockdale CK, Bergeron S, Pukall C, Zolnoun D, Coady D. ISSVD,ISSWSH and IPPS consensus terminology and classification of persistent vulvar pain and vulvodynia. J Low Genit Tract Dis 2016;20:126-30

Bornstein J, Preti M, Simon JA, As-Sanie S, et al. Descriptors of Vulvodynia. A Multisocietal Definition consensus (International Society for the Study of Vulvovaginal Disease, the International Society for the Study of Women Sexual Health and the International Pelvic Pain Society). J Low Genit Tract Dis 2019;23:163-163

Thank you