# Vulvodynia: a multidisciplinary approach – webinar transcript

**Host (00:00:04):**

My pleasure to introduce our panellists for tonight. From Jean Hailes, we have pelvic health physiotherapist Janetta Webb, and women's health GP and sex therapist Dr Wendy Vanselow. Joining them is Dr Sara Whitburn, women's health GP and medical educator at Family Planning Victoria. We also have Dr Megan Eddy, who's a specialist pain medicine physician. I'll now hand over to Sara, who'll be starting tonight's presentation. Thank you, Sara.

**Dr Sara Whitburn (00:00:32):**

Thank you Tracy. So tonight we're going to talk about vulvodynia, a multidisciplinary approach. So what is vulvodynia? The International Society for the Study of Vulval Disease defines vulvodynia as 'a vulval pain that lasts longer than three months without a clear cause', which means that it is a diagnosis of exclusion, though there can be some triggers that may have precipitated vulvar pain, such as inflammation of the vulval skin, dermatitis, candidiasis, urinary tract infections, or other sort of skin problems or infections. However, there can also be vulvodynia where no cause is found. The vulva appears normal most of the time, and so this means that it is a type of chronic pain.

**Dr Sara Whitburn (00:01:25):**

There are two types of vulvodynia. One is the generalised, unprovoked vulvodynia. This does occur more in older people, and is often a poorly localised, hard to often describe, but can be an irritation or an awareness, or can be a burning pain, that is often felt over the whole vulval area, the mons pubis and the perineum and the anal area. There is also localised provoked, or sometimes called 'vestibulodynia', which is often felt around the introitus or vestibule in the vulva, and is much more related to a response to touch. And so it can often be found when people have tried to use tampons. It is definitely associated with penetrative intercourse, but can also be found to occur if someone's having a gynaecological procedure. And that might be something like having a speculum. It's a very marked sensitivity to that touch, and sometimes there can even be a pelvic floor muscle overactivity or vaginismus, which can occur at the same time.

**Dr Sara Whitburn (00:02:44):**

There are four screening questions that can be very helpful when trying to assess if someone has vulvodynia. These questions you can see right in front of you now. Does someone experience genital 'pain'? Now that's in quotation marks because it is worth talking about pain, because people can say that it is a burning sensation, a sharp sensation, an irritating situation. So it's more about asking them about what discomfort they're having, trying to flesh that out a little bit more. Have they experienced that burning or pain for greater than three months? Is there many episodes of pain on contact, which we've just mentioned with the provoked vulvodynia, has it been tampon insertions, penetrative intercourse or gynaecological exam? And does the pain on contact limit or prevent intercourse? If someone answers 'yes' to these questions, then it is important to go on and take a further history of the pain, talking about when did occur, what things make it worse, what makes it better, and to get a more of a sense of a pain history.

**Dr Sara Whitburn (00:03:52):**

Also looking at, as I said, screening for any of those other conditions that might be a trigger, because it's important to identify them and treat them if we are going to manage vulvodynia. On examination, as I said, often people will have a normal-appearing vulva. There can sometimes be some erythema at the openings of the minor vestibular glands, and that can be because there's been a inflammatory response to the pain that's being occurred. But quite often the vulva will appear very normal. In fact, if you do see signs of dermatitis or other skin conditions or discharge, then the first thing is to try and to investigate that further and manage those conditions appropriately. When looking for vulvodynia, I always do a cotton tip test for sensitivity. So that's a normal cotton tip, you can see here on the picture. And I often will just dampen it with a little bit of normal saline, because that can be a little bit more comfortable on the skin than a dry cotton tip.

**Dr Sara Whitburn (00:04:55):**

I'll start by moving away from the area that's most uncomfortable. I'll actually, perhaps, just at the groin or on the mons pubis, just test very lightly with the cotton tip, and ask the person how that feels. Does it feel like a cotton tip? Does it feel soft? Does it feel painful? And then I will work my way around the anatomy of the vulva. So I will be checking the groin area, the labia majora, the labia minora, the clitoral area, the clitoral hood, the introitus and vestibule, and asking the person to rate the sensation. So really asking them to talk about, in their own language, what that pain feels like. And if they can, they can't always, but I do ask them to try and rate it out of 10, or at least give it some words that it's mild, moderate, severe, and that way I can then try and localise where that pain is occurring. There's often a marked tenderness to gentle pressure in the vulva vestibule, but just a word of warning, this can be present in asymptomatic people if you are using enough pressure. So it is about making sure that you put this together with history as well as examination.

**Dr Sara Whitburn (00:06:07):**

Vulvodynia is often not discussed, and this can be both on the part of the consumer, but also part of the health practitioner. And it's really important to talk about vulvodynia because of its impact on quality of life. Why might it not be discussed? Consumers might be embarrassed, or they might not have the words. As I said, often I really encourage people just to use the words about whatever they feel, what makes sense to them, because I think sometimes people can be very embarrassed about wanting to say words of 'burning' or 'stabbing' or 'sharp', and I just say, 'Use whatever words come. I'm really interested to know what it feels like for you.' And sometimes people can have concerns about whether their body's normal, or if there's something wrong with them, and so it might be hard for them to discuss.

**Dr Sara Whitburn (00:06:49):**

And health practitioners may find this an uncomfortable discussion because it's uncomfortable to talk about the vulva, or might not be sure how to assess or manage. But I hope after this webinar you'll be able to feel more comfortable in that. There is a Jean Hailes webinar about how to talk about vulval health, which can give you more insights if you feel you'd like to build on this. But why is it important to talk about vulvodynia? There are some clinical implications for not talking about vulvodynia. Chronic pain, like many other chronic pains, vulval pain being a chronic pain, can really impact on somebody's quality of life. People can have pain that interferes with their ability to do daily activities or work. It can cause depression, anxiety and self-esteem. But you often find that vulvodynia can cause problems with sexual relationships and the overall relationship. So it's really important to talk about, to be able to address people's concerns and start to talk about management.

**Dr Sara Whitburn (00:07:55):**

So what can we do for vulvodynia? The first thing is to believe and validate that somebody is having vulvodynia. Quite often people haven't felt that they've had a good explanation of what is occurring, and it can be very empowering to talk about that this is a known condition with known treatments. Explaining and naming the pain syndrome can also really help with that feeling of empowerment, and giving resources is really useful. And we have some resources at the end of our webinar tonight, for both consumers and for health practitioners. I do explain the chronic nature of vulvodynia, and I do warn that response is not immediate. But many people can get improvement with treatment, and some people can even be pain-free. Relapses and flare-ups do occur, but just as the pain pathways can be wound up, they can be wound back down again. So it's important to encourage someone to be very active in their self-management, and to be aware of their triggers.

**Dr Sara Whitburn (00:08:56):**

One of the things that I do do is when I'm talking to someone about vulvodynia and vulval pain, I do ask them to consider abstaining from the things that cause pain, or the stimuli that cause pain. And as I said, that can quite often be penetrative intercourse. And so, I often talk about, can we decrease or stop that? But not have to give up on intimacy, that there are other activities that can occur to keep people close and intimate, or if they're using tampons or products or talking to their practitioner about ways of trying to manage gynaecological procedures, but really talking about decreasing that painful stimuli. And as I've said before, you need to consider some of the other conditions that can cause vulvodynia and actively treat them. And so obviously dermatitis in the vulva, lichen sclerosus and candidiasis are conditions that I do look out for and treat if I see that that's happening at the same time.

**Dr Sara Whitburn (00:09:56):**

But what about treatment a general practitioner can do for vulvodynia? The first thing I do is I really discuss genital skincare. I talk about removing irritants, what can be healthy for genital skincare, trying to make sure that skin is moist but not wet, trying to decrease friction, trying to remove things like products that are not good for the skin, or tight trousers, or anything that might flare up the skin and cause more pain. I do discuss referring to a multidisciplinary team, and you will be hearing from my colleagues today about how that can really support someone with vulvodynia. So I start the conversation about referral to physiotherapy, sexual therapy, pain management if that's appropriate for the person in front of me. What I can also offer while we are managing that is some of the topical and oral treatments, and Megan, who's following me after, will talk a little bit more about some of these medications in more detail, but I do often talk to people about using topical anaesthetic.

**Dr Sara Whitburn (00:10:55):**

You can get 2% or 5% lignocaine over the counter, Xylocaine jelly is one product. Sometimes you can use topical ointments that are used for haemorrhoids like such as SOOV haemorrhoid cream, and that can be used two times or three times a day, probably only for a few months before you want to review and see if there are other options. But it can also be used if someone is going to have penetrative intercourse. But as I said, I do really try to encourage people to find ways to avoid the stimuli that's causing pain and to try to do other activities. I do talk to people about tricyclic antidepressants, often as an adjunct to physiotherapy or other therapy. And there's different ways we can use tricyclics, antidepressants. One that is quite popular is topical tricyclics, which is compounded 1% or 2% amitriptyline. It can compounded in creams, emollients or oils, and then it's used twice daily. I will often ask for a hypoallergenic base like derma base, but I find that compounding chemists are very good about giving people different bases to try, and so they can try the base before they make it compounded up with amitriptyline.

**Dr Sara Whitburn (00:12:14):**

And that's then applied to the vulva, and I'm sure Megan's going to add in a moment, but I must admit, I tend to obviously ask people to come back if they're having any side effects, but I'll review them somewhere between four and six weeks just to see how things are going, but they often do need to use it more. But I'm looking forward to Megan, for you to clarify that for me. You can also use amitriptyline or nortriptyline as an oral dose, often in the evening, because it can make you feel quite sedated or have dry mouth. I find people quite like that if they're not comfortable putting on topical treatment, or if they feel more comfortable with oral tablets. And I have used gabapentin, both as an oral tablet, but that can be compounded as well, 3% to 6%, compounded in the same basis as amitriptyline, used twice a day, and there's also pregabalin as another oral option. So I'm going to leave it there, and obviously we will come back and talk about general practice care when we come to the cases, but I'm now going to hand over to my colleague Megan, who will discuss chronic pain in further details. Thank you very much.

**Dr Megan Eddy (00:13:33):**

Thanks, Sara. Talking with patients about a chronic pain state, or any pain state, is not easy, and it's helpful to reflect about what you think pain actually is. This is the International Association for the Study of Pain's definition, and I highlight those first six words with patients. That it's a unpleasant sensory experience, meaning you feel it in your body, but the emotional experience means that your brain and consciousness has to be involved. I tend to sum up pain in a nutshell as a fundamental part of our ability to survive, and it's our ability to protect our physical self. These are the explanatory notes that come along with the IASP definition, and that second point's really important, that pain and nociception are different phenomenon, and pain is not simply activity in sensory neurons. This is an extremely busy and complicated-looking slide. This is just a brief reminder about our nociceptive pathways, remembering that our nociceptive system is part of our sensory nervous system.

**Dr Megan Eddy (00:14:45):**

The important things to note is we don't have pain signals or pain nerves. We have nociceptive activity. The nociceptive signals come in through the A delta and C fibres, synapse in the dorsal horn. These complex diagrams still can't show us the complexity of what's going on in the dorsal horn. And one thing that's particularly often missed is take note of those descending pathways that also synapse on the dorsal horn. The other thing to remember is we have the ability to modulate nociceptive information in the central nervous system, that's the spinal cord and the brain, like we do any other sensory nervous information.

**Dr Megan Eddy (00:15:28):**

So what actually is chronic pain then? Chronic pain is an arbitrary definition of pain that's persisting for more than three months, and that doesn't really talk about what's going on. I view chronic pain as pain that persists, and the mechanisms that are sustaining the patient's current pain experience are now multifactorial. The way the central nervous system is processing sensory information, that afferent information that's coming in, is different. The sensory input that is coming in is often different from when pain began. It's often a lot more. And then we've also got the consequences of someone having persistent pain all the time on their sleep, on their mood, on their wellbeing, on their relationships, which will all then double back into the pain experience.

**Dr Megan Eddy (00:16:17):**

So what does happen in the central nervous system? Most people when talking about the chronic pain state have heard of the term 'central sensitisation'. What actually are we talking about when that happens? I'd encourage anyone who's interested in this to have a look at this paper where these diagrams come from, from Woolf in 2011, and look what happens in normal sensation. Those, if we look at the dorsal horn represented by that synapse there, we note that nociceptive and touch neurons synapse together. And when you have nociceptive activity that will get, they'll synapse on second order neurons, and then that information will go up to the brain. And depending on everything else that's going on, you may have a pain experience, similarly with touch. But in central sensitisation, what happens in the nociceptive system when lots of activities happen is the phenomenon of long-term potentiation and wind-up.

**Dr Megan Eddy (00:17:22):**

And that means that those second order neurons become hyperexcitable, and once they can continue to signal, even when the afferent information coming in from the nociceptor has stopped or reduced. And so these are part of the mechanisms that we think lead to hyperalgesia and allodynia. And allodynia is when light touch, in the second part of that diagram, by those synapses in the dorsal horn, can activate the second order neurons in the nociceptive system, so light touch causes pain. And that's what a lot of people think about with vulvodynia. Okay, so central sensitisation is not a diagnosis, it's a function and a process that can contribute to the chronic pain experience. Allodynia and hyperalgesia suggest that it's there but it doesn't confirm its presence. But often we hear the term 'central sensitisation' being used in a negative way about a very distressed patient. The terms use much more globally. And peripheral sensitisation also happens as well.

**Dr Megan Eddy (00:18:34):**

And so this is unfortunately what I see with a lot of patients who, when they've talked about their chronic pain condition, they've come away thinking that they're not believed, that it's in their head, you've just said it's chronic pain because you don't know what's going on. And often what they're thinking is that you don't want to help me or you're not listening to me. So what can you do? Establishing a therapeutic relationship is critical. I spend a lot of time exploring what people believe is the cause of their pain. Often that's hard. The first thing people often say to me is 'I don't know', but really delving into what the background beliefs and concerns are can be really helpful. At the end of the day, most people still believe, deep down in their gut, that pain is there because something is wrong in the place that they feel the pain, and it can really take a while to understand the contributors to their pain.

**Dr Megan Eddy (00:19:34):**

It's a big schema shift for most people, and so we need to revisit the education, and the education happens over several sessions, and then you're rechecking in. I spend time talking about all the contributors that I can see to the pain experience. Metaphors are very helpful, and the importance, as Sara said, about giving people hope and reassurance that although it's a chronic condition, people can get a lot better. So what are our medical management options? Neuromodulation medications, I'll talk a little bit more in detail in a minute, as some of the options to reduce the central sensitisation process. We can also target contributors to the vulval pain experience to complement our other members of the team, such as Botox to the pelvic floor. We've got to look at all of those other contributors, such as painful periods and those things as well. But in terms of neuromodulation medications, I tend to use topical medications when their pain is provoked only, so they don't have pain without touch, that the area is really small, so it's confined mainly to the fourchette. That's when I find the topical medications the most helpful.

**Dr Megan Eddy (00:20:58):**

It's always worthwhile getting some amitriptyline cream if you can, and rubbing a little bit on your own skin, and you'll notice that it tingles. And you've got to warn patients about that, that it tingles for a few minutes when you put it on, but it shouldn't be more than a couple of minutes. I would generally offer and consider an oral medication when people have constant or very, very frequent pain. So most days or most of the day. And I would, sorry, I've lost my train of thought. And then the choice of what I would use really depends on the patient in front of me. Most of the neuromodulation medications come from the neuropathic pain space. Unfortunately, the research into most chronic pain conditions, but particularly vulval pain, is relatively sparse. There's not a lot of evidence to guide us, particularly. Most of the medications come from the tricyclic, or the serotonin noradrenaline reuptake inhibitor family.

**Dr Megan Eddy (00:22:07):**

We know these work by probably increasing descending inhibitory control through the spinal cord, and mainly through the noradrenaline transmitter. Pregabalin and gabapentin, we also know reduce neural signalling, and we know the receptors that it works on, but how that actually reduces pain we're not clear on. So the choice of which one you would offer really depends on the patient in front of you. If they're already on an antidepressant such as an SSRI, then it's difficult to add in amitriptyline. There's the risk of serotonin syndrome. You may consider swapping them to an SNRI, but it's going depend on how stable their mental health is. I often, if I'm going to use gabapentin or pregabalin, I generally choose gabapentin as I find in the young women in particular, it's much more tolerable, less mood side effects and less weight gain.

**Dr Megan Eddy (00:23:05):**

These medications take quite a bit of counselling with the patient. The first part of the medication is actually saying if they tolerate it. So very slow introduction. As you can see from what I've got there, I only ever go up to 300 milligrams of gabapentin, three times a day. And then my hope is that I'm going to withdraw these medications after a period of time. The medication is only one part of the overall approach, and my hope is that once we're in a stable place with minimal symptoms, and my rough rule of thumb is about three months, I then tend to withdraw the medication. Okay, we will talk further about in the question some of those other treatment options such as nerve blocks and Botox to the pelvic floor, for example. But now I'd like to hand over to Wendy, who is going to look at the psychosexual aspects of vulval pain. Thank you.

**Dr Wendy Vanselow (00:24:11):**

So with vulval pain, it's difficult often to, for the patient to even imagine having pleasant experiences again, and I feel the role of the psychosexual counsellor is to at least allow them the option of considering pleasure in the future. We know that long-term chronic pain can lead to depression and feelings of hopelessness, and that early intervention can overcome learned helplessness, as well as preventing women from continuing to inflict pain on themselves. A good outcome is possible, and one of the reasons I probably use the term 'vulva pain' rather than 'vulvodynia' is that if they go looking on the internet with vulvodynia, I think the overall impression in a lot of chat rooms is you're never going to get better, it's incurable. So I try and instil a bit of hope. And many women actually do very well with treatment. I think often we concentrate on the very worst examples when we're talking about vulval pain, but in fact most women actually don't have very severe forms.

**Dr Wendy Vanselow (00:25:42):**

The ones actually that come and see me have often been unwell, though, for a long time, and so there's a lot of psychological overlay that needs to be stripped back and worked on. So we try and draw on the women's strengths and education. I mean, I think we're all going to be talking about education tonight, about how often we have to help women understand their own bodies and tune in to their own bodies, and learn about sexual responsiveness. We know that pain imprints negatively, so we are not going to inflict any, so we encourage slow desensitisation.

**Dr Wendy Vanselow (00:26:32):**

One thing that's for sure is that unaroused intercourse is a major contributor to sexual pain. And there's very little research on this factor, which is often left out altogether. Arousal creates a lot more cushioning of the vulval area, with increased blood flow to the clitoral apparatus and the bulbs, it creates natural lubrication, and there's elongation and ballooning of the proximal vagina that lifts the cervix away from direct contact with the penis, so that it's a lot more comfortable for the woman to be aroused. I encourage the women to tune in to these changes. And also show them diagrams of the clitoris for them to realise that it's not just the little love button of women's magazines perhaps, but there's a big apparatus, and a lot of the processes that happen in the male are also happening in the female. So there's engorgement, there's erectile tissue, and it all contributes to a more comfortable experience.

**Dr Wendy Vanselow (00:27:55):**

To understand why people follow their sexual inclinations, we have to look at a dual model of control, because libido starts in the brain. And there's a balance, always, between inhibitory factors and excitatory factors. So what are some of the inhibitors of desire? Lack or loss of attraction to the partner, low self-esteem, body image is huge in this day and age. I guess with more pornography in the society, there's more emphasis on what the vulva looks like rather than what it feels like. There may be negative attitudes to sex, a lack of trust in response to previous negative experiences, unresolved conflicts, jealousies, lack of privacy, and again, I think with lockdown a lot of young people are living with their parents and that can be a really difficult situation for them. Discomfort, distractions, intrusions. Well, just like kids running in on your Zoom meeting, they can also run into the bedroom.

**Dr Wendy Vanselow (00:29:19):**

Pain, fatigue, vaginal dryness, and there may be general health issues that are contributing, both physical and mental. And of course medications, particularly SSRIs, antipsychotics and the contraceptive pill are implicated, and drugs and alcohol. What enhances sexual desire? Attraction, sexual chemistry, compatibility, companionship, communication. A lot of what enhances desire is not actually in the bedroom, it's not direct contact with the vulva, but what happens in the days and hours beforehand, instilling confidence. Intimate contact and positive feedback, frequent non-demand affection and enjoyable sensuality. A lot of women will say, 'I've got to the point where I can't bear him to touch me anymore, because I know he is going to want to go all the way', and that's stopping them from really enjoying themselves. So trust, respect, goodwill are all of benefit to a positive sexual experience. And good conflict resolution and resolve, balance of power and jealousy issues.

**Dr Wendy Vanselow (00:30:50):**

I think too, it's a gendered discussion, often, in this because for many women, a man's sexuality is sort of seen as the important thing, and the woman obliges. And I think it's very important that we change that viewpoint, so that both partners are having an enjoyable experience. So with counselling, especially if we bring in both parties, and I think for all of us, we'll often start clearly with just the woman by herself. But I think it's valuable, particularly if we're planning a course of action, to bring in the partner and let them know what's happening, and also get their viewpoint on what's happening, and give them some education about what's being done and the plan. We, I guess, base mostly on family therapy type of systems theory to work through what the balance of views is, taking into account past history, the dynamic, and communication skills are very important. So sometimes, too, it's about also knowing how each person is viewing the situation, and how much behavioural change is possible. Quite often we may be too late to save the relationship. Nevertheless, we try and teach people strategies to improve their outcome. Now I'm going to introduce the fabulous Janetta Webb, physiotherapist extraordinaire.

**Janetta Webb (00:32:49):**

Thanks very much, Wendy. So first of all, I'd just like to do a quick review of anatomy. So this is an inferior view of the perineum, and the things of course to particularly look at are the superficial pelvic floor muscles. So ishiocavernosus, bulbospongiosus, and the superficial transverse perineal muscles. And I'd also just like to say that anyone who has a vulva can experience vulvodynia. So even someone who doesn't identify as female gender, they may still come to you with the issue of vulvodynia. If we look at the deeper layer of the pelvic floor muscles, so particularly then considering pubococcygeus, ilococcygeus and also coccygeus or sometimes known as ischiococcygeus. And I'd also just like to mention our friends, obturator internus and piriformis, that aren't considered specifically parts of the pelvic floor muscles, but certainly are implicated often in vulval pain and pelvic pain, and increased tone in the pelvic floor.

**Janetta Webb (00:34:11):**

So if you think about pelvic floor muscle dysfunction, it's frequently associated with pelvic pain conditions including vulvodynia, and most commonly what we find is what we term now 'increased tone'. So we tend not to use the word 'hypertonic' because hypertonic would suggest an upper motor neurone lesion, whereas that's not the case with transient increased tone in the pelvic floor. And there are two components of tone in muscle, which is the resting tension in a muscle and its resistance to passive movement. So of course there's the viscoelastic component and also the contractile component. And I see pelvic floor muscle dysfunction as sometimes a trigger for vulvodynia, or possibly a consequence of vulvodynia. The term 'vaginismus', which has already been mentioned tonight, is an example of a transient increase in pelvic floor muscle tone, and it's an inability to maintain relaxation of the pelvic floor muscles with attempted vaginal penetration, whether this is with a finger, toy, tampon, penis. But it can reduce with stopping the attempt at penetration, or with verbal cues, or gentle pressure in some people.

**Janetta Webb (00:35:33):**

And it's a protective response, often a response to pain or to fear. And we know from research that it's actually a part of the fight, flight or freeze response. So women who have no pelvic floor muscle dysfunction may still exhibit pelvic floor muscle contraction when they are in fight, flight or freeze. So education's been mentioned many times, and CNS calming is the first place that we need to start. As you've already heard, really take care with the language. So lots of women will come in and say, 'I feel like I'm broken', 'My vulva is damaged', 'My pelvic floor muscles are shot', all sorts of unhelpful words like that. So it's really good to perhaps replace those with more positive words, but realistic words, understanding your patient's issues.

**Janetta Webb (00:36:30):**

Pain science education is so important. You can't see a person with persistent pain without educating them about pain science, as Megan started to talk about. And we've certainly got some resources tonight for you that will help you to read and also to pass on to patients. But remember also to reassure your patients, as you've already heard, that pain does not necessarily equal tissue damage, and that change is possible. So it's really important to address these factors that I've listed here that can sustain the pain cycle.

**Janetta Webb (00:37:12):**

This is a very busy slide, but wow, look at all these things. All of these conditions that can also contribute to the development of increased tone in the pelvic floor, and vulvodynia, that can be addressed by a pelvic floor physio. So I won't read through them all, you can read through them yourselves, but other pain syndromes in the area can cause an increased tone in the pelvic floor. But so, too, can hypermobile situations like EDS. For a lot of women if they have fibromyalgia, well it's possible to also have the pelvic floor muscles involved in fibromyalgia. I'll talk a little bit more about the core a little bit later on, but also lower urinary tract symptoms, and also evacuation disorders, commonly occur with vulval pain and also with increased tone in the pelvic floor. And it's important for us, as physios, but for all of us as healthcare practitioners, to address these issues.

**Janetta Webb (00:38:22):**

If we think about pelvic organ prolapse, someone sent in a question about that. So if you have a patient that has that terrible feeling of sagging, dragging pelvic floor, due to pelvic organ prolapse, then a constant contraction, involuntarily contracting the pelvic floor muscles, is something that they may be doing without knowing. So in the physio consultation, yet again, as you've heard before, important to listen to the story, and patients do like a name for their condition. And also to have goals and a plan, that aren't your goals and plan, but are their goals and plan. I've talked about pain science education. Posture is very important. And also respiration. So I think of the diaphragm and the pelvic floor muscles as being buddies. And so we know that with really good diaphragmatic excursion, as the diaphragm moves down, so do the pelvic floor muscles. And so often, women with vulval pain will be upper chest breathers, because everything in the core area, which is your diaphragm, your abs, your pelvic floor and your back muscles, may be overactive and not have a very good range of movement.

**Janetta Webb (00:39:39):**

Do take care with consent, give full explanation. And perhaps when you see someone for the first time with vulval pain, you may not even examine them. You might just start with taking history and things that have already been mentioned. But these are some of the things that you may initially see if you do a visual examination. But sometimes even for a patient to get up onto the bed and have their abdomen or their legs touched through a sheet is enough in an initial consultation. It can be pretty scary for someone with vulval pain to go straight to a vaginal examination. So all of these things we can see.

**Janetta Webb (00:40:20):**

So here's a diagram of the core, just reminding you, diaphragm, pelvic floor muscles underneath, and also back muscles, abdominal muscles, that all work together. So we know that the abdominal muscles and the pelvic floor work together, and remember the diaphragm and the pelvic floor muscles being buddies. So really important to get a good range of movement in all of those muscles. And I'm going to talk more about that when we go on to our case studies. So I'd now like to reintroduce again Megan, who's going to present our first case study. Thanks, Megan.

**Dr Megan Eddy (00:41:01):**

Thanks, Janetta. Anna's been a patient of mine for a while and she very kindly consented for me to tell her story. She was 25 years old when I'd met her, and she'd been struggling with unprovoked pain daily for two years. It was very generalised vulva pain from her urethra, all the way through to her fourchette and even sometimes further, she had pain on sitting with clothing, and vaginal penetration in particular she described as awful. Anna's also had painful periods since menarche. She also suffers from frequent abdominal pain, low back pain. She has a tendency to constipation. She had an eating disorder in her mid-adolescence, after a tragic series of deaths in her family around age 14. She was pretty susceptible to pain, to her medication side effects. She'd had a stint on antidepressants in her teenage years, which she actually felt contributed to her eating disorder.

**Dr Megan Eddy (00:42:02):**

But on the positive, she was a very regular exerciser. She was working full time, she had good insight and she was actually proactive. She started seeking care when she first attempted intercourse, which was the two year previously. She had a steady partner who she said was supportive, though they continued to have sex that was unpleasant and painful. When she saw me, she tried lidocaine gel, amitriptyline cream for a year, and that burnt every time she put it on, but persisted. She'd seen three physios. She'd had psychology on and off since her teens, wasn't seeing someone currently as she couldn't afford it. She was on oral gabapentin and seeing two gynaecologists. She hadn't really had any progress in her symptoms, but she remained on the gabapentin when we first met.

**Dr Megan Eddy (00:42:55):**

So we spent a lot of time talking. We came up with some goals, which was really about being able to wear jeans, sitting more, and she wanted to be able to have pain-free intercourse. So we started her on oral amitriptyline, and we tried to, we increased the gabapentin, and I felt general anxiety was a big driver of a lot of what was going on, and she agreed to see a psychologist, and I referred her to someone who works in the pain space.

**Dr Megan Eddy (00:43:29):**

So what happened with Anna? Within the first couple of months, there was no change on the amitriptyline or the increased gabapentin, no change in her symptoms at all. And so we reduced them back down. She really enjoyed her psychologist, and within the first three months or so of seeing her, she actually broke up with her long-term partner. At six months we did Botox to the pelvic floor. That gave no meaningful change to her pain, but her examination was a lot better. Over the first few months as we'd been stopping and starting medications and working with psychology, her anxiety had increased or become much more aware of how much it was impacting on her. And so we agreed, decided to start duloxetine, both from an anxiety and pain perspective. Within the next couple of months, her burning was a bit easier, that sensation. We were coming off the gabapentin as we started with duloxetine, and she was able to start wearing jeans a little bit.

**Dr Megan Eddy (00:44:33):**

She continued working closely with her psychologist. And then at 11 months she met a new partner. One of her big fears was, how do I talk to prospective partners about this pain that I've got? And that was something that they worked on closely. When I next met her at 14 months, she was having no pain, and enjoying a really fulfilling sexual relationship. And then at 18 months, she's still got no pain. She's had some major stressors in her life since then, Covid notwithstanding, and still hasn't gone backwards. She still has no pain. She also has no abdominal or back pain either. And her periods have remained manageable on the oral contraceptive pill. And our plan is to cease the duloxetine shortly. So she's done very well. Wendy, I wanted to point out something and ask you something. It really struck me that this patient continued to have painful intercourses, and I wondered how much that was a contributor, and a lot of her recovery seemed to come about when she was able to explore her sexuality with a really supportive partner.

**Dr Wendy Vanselow (00:45:52):**

Yes, look, I really find that's such a positive sign. If they've got a supportive partner, they almost always get better eventually. It could be that the body is actually signalling the end of a relationship sometimes, but not universally of course, but sometimes it's the change of partner that makes all the difference. Where they feel free to make their own choices and tune into their own body. That's why.

**Dr Megan Eddy (00:46:30):**

Thank you.

**Dr Sara Whitburn (00:46:38):**

Thank you Megan. I'll take over again and we'll present case 2 study, Jess. So Jess is a 22-year-old person who uses the she/her pronouns. And I've said 'initially came to see you', because I'm feeling that, I'm thinking of you as a greater group of seeing people of vulvodynia. But she came to see a GP, and had recurrent symptoms of candida and was diagnosed with recurrent vulvovaginal candidiasis. Unfortunately, we don't have the time to talk about recurrent vulvovaginal candidiasis tonight. It's always a really hot topic and we could probably do a whole webinar on that, but we will link some resources when this webinar goes up. But what we will say is that Jess was diagnosed with that, and as I said before, that's quite a trigger for vulval pain. And so had discharge, and had itch, and used over-the-counter treatments on her own for quite a while.

**Dr Sara Whitburn (00:47:37):**

And sometimes if over-the-counter treatments aren't able to suppress the thrush, then people can get go on to vulvodynia, vulval pain, as I said. Started to have provoked and unprovoked vulvodynia. So initially just light touch, and then that generalised discomfort. And started to also get superficial dyspareunia, and started to get sexual pain. So the diagnosis was made, and Jess was treated with six months of candidiasis suppression to really decrease that trigger. And so she was on 150 milligram fluconazole weekly as her first line management. She started to have less discharge, and the unprovoked vulval pain started to settle down, that generalised. But during intercourse, she started to feel her muscles were very tight, and it became that she was unable to tolerate penetration. And as I mentioned briefly, and Janetta explained in so much better detail, vulval pain can lead to vaginismus, and vaginismus can be part of vulval pain with that pelvic floor overactivity. And post intercourse, Jess was starting to have that burning pain.

**Dr Sara Whitburn (00:48:52):**

So she's starting to have vulval pain afterwards. And she wasn't able to have sex because of that pain, it was so intense. And started to not desire sex at all, just felt her libido dropping. And she started to say, 'I don't actually want any intimate touch at all,' because as I think Wendy quite explained, started to feel that that was going to lead to intercourse, and that was the last thing that she wanted, which then in turn impacted on a relationship. And so you can see how I talked about the clinical outcomes of vulval pain and the social outcomes. Very tearful, thinks she might break up with her partner, even though she wants to continue the relationship, but just feels really uncomfortable when it comes to any sort of physical touch. So from a GP point of view, going back to that slide I had about our role, the first thing that I did for Jess, or we could do for Jess, is to acknowledge this pain and the impact on her relationship and her sexual life and her quality of life.

**Dr Sara Whitburn (00:49:51):**

And you've heard a couple of times we've talked about psychology and anxiety, and if someone's got such pain that's impacting them on so many facets of their life, I will screen for the impact on mental health and actually do a mental health assessment, and sometimes even focusing on that mental health, so someone's in a good space for therapy and treatment. I did offer an examination, but as we heard from Janetta, it may be that I reschedule or stage that examination. Continue to think about the triggers, review if there's any other skin conditions contributing, and doing a pelvic floor muscle examination to look for that overactivity to then support the discussion of referring for physiotherapy support. So I would definitely use the words 'vulval pain' or 'vulvodynia'. I did take your point, Wendy, and I'll think about those chat groups from now on, but I would definitely say this is vulval pain and that there is also vaginismus. I would discuss about abstaining from penetrative intercourse.

**Dr Sara Whitburn (00:50:52):**

And there was a fantastic question that came up asking me, but what about the partner if you use topical lidocaine, so great pickup. I normally recommend that you use it 30 minutes before sex and then dab off any excess. So fantastic pickup there. So yes, we do need to think about making sure that there's no exposure to other partners. I would talk about topical amitriptyline, because there's definitely provoked, has been unprovoked, but obviously thinking about reviewing that and thinking about whether there needs to be any change. And I would refer for physiotherapy and sexual therapy. So with that referral, Janetta, I'm going to hand over to you.

**Janetta Webb (00:51:37):**

Great, thanks very much, Sara. So lots of people haven't heard about pelvic floor physios before. So the first thing that I want them to know is, what's today's consultation going to look like, and this is what pelvic floor physio is all about. And again, listening to Jess's story, what does she think is going on? What does she think is contributing to her pain? And start pain science, as I mentioned before. I'm also really interested in if the vulvodynia actually preceded the current times that she has had candida. Because a lot of women actually, when you ask, will reveal, well actually it's been a problem for a long time, or, 'I've had it in the past, it went away, but now it's come back.' And I'm also of course, as we've already talked about, interested in other triggers, particularly things that have been happening in Jess's life around the time that this pain started.

**Janetta Webb (00:52:39):**

Anatomy education is just so important, but seeing the pelvic floor muscles as protectors in response to fear or pain. So it's so important in our education and treatment, the most important thing that we're trying to do is really to reduce that cycle of fear, pain and pelvic floor muscle overactivity. Remember that she doesn't only have provoked vulvodynia, she also has unprovoked vulvodynia, so we're not only looking at the discomfort with sex, we're looking at the discomfort the rest of the time. But there are a few other questions. 'Will having receptive sex give me thrush again?' 'I'm scared to do it.' The relationship challenges that she possibly could have, and most women come along and say that their partners are very understanding, but sometimes it's more, 'Will you just go away and get fixed and then let me know when you're ready to go again.'

**Janetta Webb (00:53:39):**

The number one thing is, we've all talked about, is to avoid painful activities. But I talk a lot to my patients about the 'menu of intimacy'. So entree, main course and dessert. But at the moment we just don't have this particular thing for main course available on the menu, but we've got everything else on. Because a lot of people feel, well, you're not really having sex if you're not having receptive intercourse, so we may as well do nothing at all. Or, if we start with entree, then my partner will think that we are going on to main course, and this is all we do with main course. And so then they'll avoid all intimacy. And of course involving partners, it's really important to involve Jess's partner in the education.

**Janetta Webb (00:54:23):**

With pelvic floor muscle training, initially you may just gain consent to do a visual examination, but you can still get a lot from that. So if you don't feel confident doing a pelvic floor examination, then even a visual examination, as in to assess the tone, if you're still learning to do that, then a visual examination can give you a lot of information. Because we're really keen for Jess to get some awareness of pelvic floor movements. So I'm always really keen on a good range of movement of the pelvic floor. Not only letting go, but just a good range of movement, to be able to work it, but to be able to release it. But often you'll hear the terms 'pelvic floor down training', which is the term that we give for exercises that are really focusing on the release of the pelvic floor. But it's also important, as I alluded to before with looking at the core, that Jess learns to release her abdominal muscles, because the abdominals and the pelvic floor work together.

**Janetta Webb (00:55:28):**

And also quite often in a physio treatment session, we will just start off with sitting in the chair or lying up on the bed, sheet over, and just learning diaphragmatic breathing. Because if you can get good diaphragmatic excursion then it's going to enhance your pelvic floor excursion. When we think about biofeedback, it doesn't necessarily have to be fancy tools. It can be the use of a mirror, if Jess feels comfortable to, to actually watch the movement of her pelvic floor. And some physios may use transperineal ultrasound as a biofeedback tool. So again, it's not internal, it's external. And I'm really keen on body scanning, which is 'drop your jaw, long shoulders, soft belly, pelvic floor down, and one belly breath' to be done, I usually say, every hour, or as often as you think of it, to really that throughout the day, I'm just checking in that everything is released, especially with unprovoked vulvodynia.

**Janetta Webb (00:56:33):**

A few things just to check in terms of clothing that have already been mentioned. Cool packs can be really helpful, especially for that burning vulval pain. And this could be really helpful for Jess after she has sex, because the pain continues for some time. So having a cool pack ready to go and putting it on, then undies on up over the top of that, can be really calming. And we may then use to move on to some desensitisation techniques, so just touching externally on the vulva, maybe by the physio, maybe by Jess, maybe then progressing onto her partner doing it, but only with her consent and only if she's happy with that. Because we have to break the cycle of 'my partner touching my vulva always causes pain, therefore I don't want my partner to touch my vulva or my pelvic floor muscles are going to be triggered to contract in a protective mode'.

**Janetta Webb (00:57:30):**

Sometimes we use vibration therapy, but most often of course in the vulva area using a vibrator. But that can be externally. To put in a different sensation to the vulva other than pain or nothing, here's a different sensation. So that can just help to wind down the pain sensations. And sometimes we use what physios in Australia tend to call 'trainers', as opposed to 'dilators', but they are in the literature referred to as 'dilators', which are graduated sizes of tubes, sometimes, and most often plastic, sometimes silicon, they can be vibrating or not, which are all helping Jess's pelvic floor muscles and her skin and nerves to accommodate and get a tolerance to gentle stretch. But no treatment should ever, whether it's with a physio, with a GP, or Jess herself, should ever be painful. So what we are trying to get is this experience of no discomfort.

**Janetta Webb (00:58:36):**

At times we may use manual therapy techniques, unfortunately there's not a lot of evidence for them at the moment, but there are sometimes indications in patients who have particularly tender spots in the muscles for internal treatment. But it's also really important, not only do we progress to pain-free, but also pleasurable sensations, both externally and internally, and always talking about, Wendy alluded to it before, the arousal response, of the opening, the lengthening, the widening, the swelling of the clitoris, and of course the lubrication. It can be really helpful to talk to Jess about using different positions when she does progress to receptive intercourse, in which she can control penetration. Sometimes using trainers or a vibrator before any sort of receptive intercourse. And also the importance of lubricants. And everyone always asks about appropriate lubricants, so we've actually got them in our resources for you. But also with unprovoked vulvodynia, there can be often a fear of, well, what's going to make it worse?

**Janetta Webb (00:59:51):**

So if I exercise, it seems to get worse. If I wear tight clothing, it seems to get worse. And a lot of women will reduce down the amount of exercise or movement that we're doing. So it's important, that they're doing, sorry, so it's important that we help them to pace, as Megan talked about before, pacing with getting back into jeans, this return to activity. With physiotherapy, treatment, with any management, the use of outcome measures, we've got some in our resources tonight, are really helpful so that you can actually measure how things are improving. A little bit like when Sara was talking about the Q-tip test, if she first assessed someone and pain in these locations was a six out of 10 or an eight out of 10, and then she's reassessing and it's now a two out of 10, that we know that things have reduced.

**Janetta Webb (01:00:49):**

It can be really helpful for patients to draw them what's called a 'mind map', just to really draw everything together. All of these things are contributing to increasing your pain, and these are all the things that are going to help to contribute to reducing your pain. General body relaxation can be really helpful. And as a GP, the things that you could start with Jess are learning some belly breathing, getting some movement in her pelvic floor. There's a podcast in our resources that Jess could listen to to learn about pelvic floor movement, and starting that body scanning. So I'm now I'd like to hand back to Wendy.

**Dr Wendy Vanselow (01:01:33):**

Thanks, Janetta. So I think as general practitioners, general practitioners are multidisciplinary practitioners and they're often in the best position to tie everything together in terms of understanding how medications may be contributing or helping vulval pain, the psychological overlay and/or background for the person, and the cultural considerations. I mean, in some cultures, penetrative sex is the only sex, and that does limit our treatment sometimes when we can't look at outercourse options, for instance. And relationship dysfunction and transgenerational traumas can all contribute, and I think being able to tie that together for the individual is very helpful to see how that's all playing a part.

**Dr Wendy Vanselow (01:02:34):**

This is really a reemphasis on empathic listening, which I think we've all been talking about in one way or another, and how, I guess, in the most traumatised patients, we really take a lot of time to ask our questions and read the patient, not only in what they say but in their body language and so forth. And that we also let them know that they're in charge. So just as Janetta said, even just getting onto the bed may take several sessions in the most severely affected person. And it's okay that you can take time. It can take many weeks sometimes to be able to actually examine the vulva. And when we are looking at their response, how much is pain and how much is fear? Because that can make a difference to our management. I encourage them to nurturing self touch. Often if they start to quickly, on trainers, without feeling that they can actually touch themselves, I feel that they're not getting the biggest advantage.

**Dr Wendy Vanselow (01:03:56):**

And Janetta also mentioned this body map, and I think you get a lot of feedback from the fingertips that helps the woman understand her body. I use a lot of diagrams, and also get them to look with the mirror, and assistance to look at where they're touching and what's going on. And I think it helps them see, too, that this isn't an insurmountable problem. We're not looking at a whole vagina shutting down, for instance. Sometimes that term 'vaginismus' implies that the vagina shut down, and really we're only talking about the lower third of the vagina being surrounded by the pelvic floor muscles. And beyond that it's a very stretchy part of the body.

**Dr Wendy Vanselow (01:04:46):**

And so I educate the individual and their partner, because I think that's a very positive, we can model something positive about the body, how fascinating it is to understand the anatomy and physiology of the sexual response. And I think it's also a very non-threatening way to engage both parties, and start a conversation about their sexual relationship. Often just even using the words makes it easier for them to be able to talk to each other and to negotiate outercourse options, for instance, and maximise their arousal. And I hope that when we give them homework, it's always pleasurable. You'll often find the person who finds sex is a chore will then find using the trainer as a chore as well, and they'll keep inflicting pain. And so we have to sort of often wind that back and give them pleasurable exercise to do first. And I also give them a lot of resources to draw on, videos and readings to assist. And here we are. Key messages.

**Dr Sara Whitburn (01:06:10):**

Thank you very much, Wendy. I'll start with my key message, and that is that vulval pain is a chronic pain, and that there are some triggers, but it can also occur with no clear cause, but that it can have severe impacts on quality of life, as Wendy said, for the whole range of facets of someone's life. So we can assist with validation, acknowledgement, names of the condition, examination, initial management, and discussion of the role that multidisciplinary referrals can help. And we also got a role in that ongoing review and support. Megan.

**Dr Megan Eddy (01:06:53):**

Thanks, Sara. I would follow up by saying that any chronic pain is a complex situation, and that it requires a multimodal approach, which means we look at all of the factors that are contributing to the pain state. The multimodal aspect can be done sometimes by one practitioner addressing all the factors, or two. It doesn't mean we need to have five practitioners involved, but we need to look at all of the contributors to why the patient is feeling pain and why they're unhappy at the moment. Thank you.

**Dr Wendy Vanselow (01:07:34):**

Oh sorry. Did I do something? I guess from my point of view, my key message is unroused intercourse contributes significantly to the cycle of pain, and we have to intervene in that cycle. And also just to really get some detail about what's happening between the partners. Are they able to talk to each other? Are they following a script that needs to be altered? Just not understanding how female orgasm can shut down the woman just as it does in the male. You can't keep going, and often penetration straight after a female orgasm is quite painful. Next one is Janetta.

**Janetta Webb (01:08:32):**

Thanks, Wendy. So firstly, I'd just like to quickly say thanks everyone for tuning in tonight. And just to remember that pelvic floor muscle dysfunction is commonly associated with vulvodynia, so it must be considered. But don't dismiss telehealth, because we've all become so good at telehealth over the last 18 months, as an option for the commencement of education and a physio program. And of course at some stage a physical examination, if you are going to refer to physio, is really beneficial. But there are so many things in terms of education and guidance and the desensitisation and self touch that we can start your patients with. So you can certainly refer to get started. And the other thing is that in a lot of continence clinics in regional Australia, the physiotherapists there, often as a continence physiotherapist, they will also have significant experience in the management of pelvic and vulval pain. So do seek out those physios. Thank you.

**Dr Sara Whitburn (01:09:44):**

So thank you very much everyone. We've now got time for questions. Now, there's always so many fabulous questions. I don't think I've ever been to a webinar where anyone's ever got to them all. So we can reassure you that if we can't get to your question, we will try and answer it and put those answers to those questions up when the recording is available. But we will do some questions now. I'm actually going to start with a GP question because I feel like I really should have explored it further. So I'm going to point one towards me, and then I will get my panel to join me. But I was asked about how we can assess the pelvic floor muscles as a GP. So I'm just going to go into that a little bit more. Janetta mentioned it and I thought, oh yes, I should have gone into that.

**Dr Sara Whitburn (01:10:30):**

I do start with observation, and if someone's got a lot of overactivity, you can often see it just by looking at the vulva, at the groin muscles, it's often got a real tense, you feel like all their muscles are being held up. And so that's something that I can see straight away. And I'll often ask people to see if they can drop their pelvic floor. So I might ask them to take a big breath in and ask them to just let their muscles, so their abs and their glutes and their thighs, heavy onto the bed. And some people can do it, some people can't. I might ask them to do a cough, as a Valsalva, which can also let me know if there's any laxity, but I'm just trying to get them to move and use different pressures. And finally I will, with their permission and if they're not too uncomfortable, I think we've all said it, sometimes this has to be done later, but I'll very gently put my finger into the opening of the vagina. And initially I'll ask them if they get any burning pain or if it feels similar to any penetrative pain that they get.

**Dr Sara Whitburn (01:11:35):**

But if they're okay with that, I'll ask them to give my finger a squeeze. And I might say, as if you were stopping wee. or if the muscles around your vagina was an elevator and I was asking you to lift it up. Aome people can't do that, and of course, I'm sure Janetta, I can see Janetta is smiling at me, that some people really, just learning how to do this is really important. But if they can do it, I'll see if they can make a contraction, and if they can, great, I'll ask them then to relax. And I often find that some people can contract but can never relax, and it's like I can feel things are getting ratcheted up. But really I'm just doing a bit of an assessment to say, look, I think the muscles are tense. I'm really asking about pain as well while I'm doing that because that lets me know if this sort of touch or asking muscles to move as pain. But it's more of a screening, a bit like my screening history. So I hope that that's helpful, and that's what I do in my general practice. I might give a question to Megan. There was a question about pregabalin and concerns about addiction or misuse.

**Dr Megan Eddy (01:12:45):**

Any medication that can cause a sedative effect can sometimes be misused, or people can become addicted to. And we certainly, we know that pregabalin is misused. It's one of the prescription medications that is used illicitly, if you'd like. Generally in the field that I'm using it, I would've screened for someone who has got those tendencies, and there's a very lengthy education process about the purpose of this medication and how we are going to use it, but it is a consideration.

**Dr Sara Whitburn (01:13:29):**

Thank you. Wendy, we've had a question. Vulval pain and the impact of sexual trauma. I know in one of your slides, obviously we think about past sexual history, past sexual experiences. The question was just wondering, vulval pain in the context of sexual trauma, would you be able to just elaborate a little bit more on how that might present or how that might feature for someone?

**Dr Wendy Vanselow (01:14:00):**

Yes. Well, in a number of ways. I mean sometimes people will come and say, 'I haven't been sexually abused,' or, 'I haven't had sexual trauma, so how come I've got this?' And sometimes it's a matter of explaining that, as Janetta has outlined, there's a hell of a lot of different reasons why they might have a tight pelvic floor or be experiencing discomfort. In terms of women with, I suppose, severe sexual trauma, often they can't say very much at all. I have had patients who will really just not talk about it, and they don't want to talk about it, and I don't press it. I will just give them time to talk when they want to. Just as we say, we do a very graded examination, even talking about it can be an issue for a lot of women who've been severely traumatised. And even showing a diagram, I've had people say, 'Don't show me that, I can't even look at that.' So we sometimes have to be very mindful to say, 'How do you feel about seeing a picture, just a diagram of the vulva?' and gradually desensitise people that way.

**Dr Wendy Vanselow (01:15:27):**

And try and make it, this is just on the physical side of it, just try and reassure them and allow them to calm their emotions. And also for them to, I give them instruction, 'If anything becomes too much for you, I want you to tell me. We just stop. You can just say stop and I'll stop.' So I think it just gives them the confidence of being back in control of the situation. How often does, say, repressed memory syndrome pop up? Look, I really can't say for sure, because I think most people actually, well, I really don't know about that. I guess I tend to see people who have a memory of something, and maybe it's just an image, or I had one woman recently who said, 'I was a very small child, but I remember this man's face down near my genitals.' So just the vision is there but not understanding what it was. But these flashbacks will be typical of a trauma.

**Janetta Webb (01:16:43):**

Thank you, Wendy. Janetta, I wondered if there is anything you'd like to add when providing physiotherapy to someone with vulval pain and trauma.

**Dr Wendy Vanselow (01:16:55):**

Well, I think the first, the most important thing is that you do ask about it. And I always say to patients, 'If there are any questions that I ask you that you don't want to answer or you don't want to talk about, it's fine to say 'I don't want to talk about it'.' So exactly as Wendy said, but it's really important to ask, because we don't want to be re-triggering any past experiences. So for example, if I do have a patient up on the bed and I'm examining them, and I always encourage them to look at me, so I make sure that their head is in a position on the pillow that we have good eye contact, so I can keep them with me as their physio in the room.

**Dr Wendy Vanselow (01:17:41):**

If a patient closes her eyes or turns her head away, or extends her neck and won't look at me, then I'll gently encourage her to just stay with me and let's talk about what you're feeling, because I don't want to re-trigger any memories in the past. Because of course then that's just going to contribute to further pain, and the pain cycle of increasing tone of the pelvic floor, to then in a protective mechanism. So I just think that's so important to always ask the question and be very mindful. Now some patients will say, 'Well of course you're going to examine me, that's what I'm here for.' But they are fewer in women who are experiencing vulvodynia.

**Dr Sara Whitburn (01:18:35):**

Thank you. A question about how do we access chronic pain psychologists. I know as a GP that obviously the first, if I haven't got my local network, that I can use the Australian Psychology Association search, and you can look for specific conditions. But Megan, I was wondering if you had any tips for people about how to build up a network with psychologists who work with chronic pain conditions?

**Dr Megan Eddy (01:19:09):**

I use the Pelvic Pain Foundation's website as well, has a list of practitioners in Australia who are interested in pelvic pain. And that's from general practitioners to physios to psychologists throughout Australia, to gynaecologists, a whole range of practitioners. I often have a number, a lot of patients I see are already seeing a psychologist and I ask them, 'Are you talking to your psychologist about pain?' And it's amazing how often that that is divorced. So sometimes I get on the phone and have a talk to the psychologist that they're already seeing. And it's not easy, because there's not a lot of psychologists that are working in the pain space. There are some online resources such as through MindSpot, which has a chronic pain cognitive behavioural program that has some psychology aspects. So there are some pain programs where some of those general aspects can be helpful. Yeah.

**Dr Sara Whitburn (01:20:16):**

Thank you. Wendy, what about psychosexual counselling or sexual therapy? How can GPs access sexual therapists to support their work?

**Dr Wendy Vanselow (01:20:28):**

Well, it's a moot point. I mean, we have obviously in the public hospital system, but at the moment where I'm working at the Women's, that's pretty much closed to external referrals at the moment. And I hope the situation changes very soon. But also of course at Jean Hailes, and there are practitioners in private as well.

**Dr Sara Whitburn (01:20:57):**

Thank you. And you can sometimes find those people on Australian Psychology Association, but there's also the, is it the psychosexual group as well? I might have that wrong Wendy, but—

**Dr Wendy Vanselow (01:21:10):**

There used to be a psychosexual society that no longer exists, not here anyway, in the UK there's the Institute of Psychosexual Medicine and that's quite an active group of people training in this field. There is the Society of Australian Sexologists, but some will be medical, some will not be. I mean there's mostly non-medical, I would think, in that group.

**Dr Sara Whitburn (01:21:44):**

Thank you. Megan, this is a question for you. I wondered if you could talk about how successful Botox can be for vaginismus.

**Dr Megan Eddy (01:21:57):**

It can be a really helpful adjunct. Botox, when we do Botox to the pelvic floor, where you are putting some botulism toxin into the levator ani and obturator internus, and Janetta mentioned obturator internus, which I agree is really part of the pelvic floor even though it's technically not. And what we're essentially doing is we're forcing those muscles to undergo a state of relaxation. So it only lasts for somewhere between three to six months while the body processes the toxins away. And so really it is an adjunct for those patients who haven't been able to progress with pelvic four physio, or they've got to a point and they've plateaued. So I use it in conjunction with the physios that I'm working with, really, as a springboard, as a way of moving a patient further forward. And the results are really variable. When most of their vulval pain is due, primarily due, to the pelvic floor overactivity is when you're most likely to have the best result. And you can have great success with it, but need to think about the limitations of it, as it's not a cure, the Botox will wear off. So we're trying to use that experience to springboard further. It's also an off-label use of Botox, so the costs can be more significant for some patients to access as well.

**Dr Sara Whitburn (01:23:41):**

Thank you. Well, we might need to wrap it up there. So thanks again for everyone for joining us tonight. In the presentation handout, you will find all the links to all the resources mentioned tonight, and we will answer questions that may need, some of these may need a little bit of a longer answer, which is why I've sort of kept few of them, but also any that we couldn't get to, we will respond to. And any resources. You will receive an email once the recording is available to view in the Jean Hailes webinar library. And don't forget to complete the evaluation. If you need CPD points or a certificate, a link will pop up on the screen shortly. I'd like to thank everyone in the panel with me tonight. I have learned a lot as well, and I really appreciate that. So thank you so much. And thank you to Jean Hailes for having us tonight. And thank you everyone for joining, and we look forward to seeing you next time.

**End of transcript**

**Information about Jean Hailes for Women’s Health**

Jean Hailes for Women's Health is a national not-for-profit organisation dedicated to improving the health of all women, girls and gender-diverse people. For free, evidence-based and easy-to-understand health information, visit [www.jeanhailes.org.au](http://www.jeanhailes.org.au).

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