VULVAR DYNIA

Keywords: Dyspareunia, vaginitis, vulvodynia, vestibulitis

AIM

• To describe the diagnosis and management of vulvar vestibulitis.

BACKGROUND

Vulvar dynia is uncommon, however is the most common cause of vulvodynia seen in the sexual health clinic and an important cause of dyspareunia. The characteristic features are of introital dyspareunia, vestibular erythema, focal inflammation, and localised tenderness confined to the vulvar vestibule. To diagnose the condition, other causes of vulvodynia such as vulval dermatoses, herpes vulvitis, atrophic vaginitis, cyclic vulvovaginitis and dysthetic vulvodynia need to be excluded. Candida has been reported in up to 43% of women with this condition.

DIAGNOSIS

MEDICAL HISTORY

Enquire about the following points in addition to a standard medical history:

• Presenting symptoms specifically pain, times the pain is experienced, location, duration, precipitating and alleviating factors
• Duration of symptoms
• Sexual activity record the frequency and severity of pain with sexual intercourse
• Severity of symptoms:
  ➢ Grade 0 - no pain with sexual intercourse.
  ➢ Grade 1 - some pain with sexual intercourse.
  ➢ Grade 2 - has to stop sexual intercourse because of pain.
  ➢ Grade 4 - avoiding sexual intercourse.
• Is the woman able to insert a tampon?
• Attend a personal / family history (e.g. autoimmune or atopic conditions, incontinence, smoking) and drug history.

The following conditions should also be enquired about:

• Has the woman ever had pain free sexual intercourse?
• Candidiasis
• Skin disorders i.e. psoriasis, eczema, lichen sclerosus, lichen planus, dermatitis
• Other gynaecological conditions
• Medication which is associated with genital oestrogen deficiency – Depo-Provera, implanon, conditions associated with a high prolactin level prolonged breast feeding, phenothiazines.
• Current medications and known drug allergies
• Allergies, hay-fever, asthma
• Sexual assault
• Consider whether the pain might be referred any history of back injury through sport or a motor vehicle injury or arthritis.
MEDICAL ASSESSMENT

- Perform a standard symptomatic STI screen (See Clinical Guideline Screening Tests for Symptomatic Females), including PAP smear and HSV2 serology.
- Exclude other conditions i.e. atrophic vaginitis, non specific vaginitis, cervicitis. Consider testing for other conditions e.g. thyroid disease, diabetes, iron deficiency.
- Look for dermatitis, and examine skin at other sites
- Document clinical signs of vestibulitis:
  - Peri-vestibular erythema
  - Tenderness on touching the vestibular glands with a dry cotton bud.
- Document any tenderness in a clockwise manner at 7 points of the vestibule via a patient self rating scale out of 10 for pain (0 = no pain, 10 = severe pain). Both sides of urethra and at 0200, 0400, 0600, 0800, 1000 of vaginal orifice.

MANAGEMENT

- Prescribe Fluconazole 150mg per week for 6 weeks unless contraindicated, even if Candida is not isolated.
- Prescribe Ovestin cream topically (a tiny smear) to introitus bd for 6-9 months (If there is a history of breast cancer, consult with their oncologist, if there is a history of a thromboembolic condition, consult with their haematologist).
- Provide medical counselling as appropriate. In particular provide information about the disease, and information on sexual activity.
- Discuss soothing products, wearing loose fitting clothing and perineal hygiene, keeping the area clean, dry and ventilated.
- Referral to physiotherapy.
- Transcutaneous electrical nerve stimulation (TENS) may be effective for reducing pain associated with vestibulodynia.
- Review in 6 weeks.

6 WEEK REVIEW

- Provide the results from the first appointment.
- Assess clinical response.
- Discuss the condition and treatment and compliance to date.
- Assess sexual intercourse and pain levels.
- If Candida is present, consider fluconazole prophylaxis 150mg/ week for 6 months.
- If the patient is not prescribed fluconazole
  - Explain the importance of diagnosis and treatment of candidiasis if recurrences occur.
  - Inform the woman that she should present to the clinic for diagnostic testing if she develops symptoms of Candida or her vulval pain worsens.
- If HSV 2 serology is positive prescribe antiviral therapy for at least 12 months and then review.
- Ensure the patient has attended physiotherapy.

12 WEEK REVIEW

- Do a medical assessment.
- Exclude candidiasis.
- Encourage the physiotherapy programme and enquire about progress.
- If the woman is in a sexual relationship, enquire about her partner’s response to the condition and treatment.
- Consider antihistamines for the atopic group.
Consider vagifem for localised oestrogen deficiency in addition to topical ovestin (3-6 months supplemental course of 25mcg two times a week).

4 MONTH REVIEW

- If there is no significant improvement, commence on analgesics i.e. Low dose amitryptiline. Commence at 10mg / day and increase by 10mg per fortnight until the pain is controlled or side effects up to a dose of 200mg/ day. Topical anaesthetics and antidepressants (amitriptyline hydrochloride) may be prescribed to reduce itch and discomfort. NB: ideally the woman should have had approximately 3 months of physiotherapy before being commenced on analgesia. Women who gain weight on amitryptiline can be given roboxetine.
- For women unable to tolerate either of the above medications, gabapentin or pregabalin can be given.
- Advise the woman that the treatment is usually given for over 12 months and is continued for 6 months after the pain levels have reduced or gone before the drug is discontinued. Surgical intervention can be considered if symptoms remain unrelieved after medical treatment.
- Frequent follow-up is suggested to monitor progress. Continue to review the woman at 6-8 week intervals to monitor progress, therapy compliance and provide support / encouragement.
- Consider assessing urine for evidence of oxalate crystalluria.
- Consider psychosexual counselling with referral to a clinical psychologist. A clinical psychologist can assist with a number of concerns common to women with Vulvar Vestibulitis including current sexual functioning, self esteem and the development of a graduated sexual reintroduction programme.

REFERENCES (STANDARDS)


Do not keep printed versions of guidelines as currency of information cannot be guaranteed.
Access the current version from the WNHS website.