Vulval Pain & Entry Dyspareunia: a Clinical Approach

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This is NOT a talk about vulvodynia.

• Vulvodynia is a diagnosis of exclusion
  – like “pyrexia of unknown origin” or “non-specific urethritis”

• My aim is to eliminate the need for this term by achieving accurate diagnoses and effective treatments

• To do this, it is necessary to step outside our gynaecological comfort zone.
Pelvic anatomy facilitates the referral of pain and dysfunction

• Pelvic structures are in close proximity
• The vulva and vagina are in the centre of the action!
• Myo-fascial structures facilitate pain referral
  – Between visceral structures
  – From lumbo-sacral spine and hip joints
• Genital skin disorders often involve peri-anal as well as vulval skin
• Genital skin is in close proximity to the pelvic floor
So vulval pain can be multi-factorial

- Genital skin disorders often lead to bowel, vulval and urinary symptoms
- ... and lower pelvic floor pain
- Lumbosacral, hip joint and lower limb disease & dysfunction may produce referred vulval pain
- Pain/dysfunction is usually referred from posterior to anterior
- Vulval pain *always* leads to secondary psycho-sexual difficulties
... history-taking may be difficult

- The presentation is often of the secondary dysfunction, rather than of the primary cause/s
- The patient often does not volunteer other symptoms
- A detailed systems review is essential
- Enquiry must be made into potentially-embarrassing symptoms
and management requires holistic skills

- Dermatology
- Gynaecology
- Urology
- GIT
- Musculoskeletal
- Pain management
- Sexology
The Aetiology of Vulval Pain

- Dermatological: 61.3%
- Neuromuscular: 34.7%
- Psychological: 4.7%
- Surgical: 1.3%
THE EVIDENCE FOR MY VIEWS
A Review of 525 Consecutive Cases of Chronic Vulval Pain

- Seen by JB or GF in our tertiary referral practice 2011-2015
- Pain only: no other symptoms
- Average age: 47.1 years (17-86)
- Average pain duration: 60 months (3-432)

1Presentation at BSSVD Scientific Meeting 2016
Examination and vaginal culture

Skin and/or culture abnormal

Appropriate treatment

Improved

Not improved

Consider somatisation

Skin and culture normal

Examination for:
- bony tenderness
- muscular hypertonicity
- hyperaesthesia

Physiotherapy and/or neuromodifiers

Not improved

Improved
Whole cohort

All = 525

Skin and/or culture abnormal = 322 (61.3%)

Skin and/or culture normal = 203 (38.7%)
Abnormal skin = a dermatological disease
Dermatologic Diagnoses  N=322

- Chronic candidiasis
- Lichen planus
- Lichen sclerosus
- Psoriasis
- Desquamative vaginitis
- Dermatitis
- Menop. atrophy
- Graft vs. host dis.
- Aphthosis

The rest (1 each):
- fixed drug eruption
- genital herpes
- Extramammary Paget’s disease
- Hyperkeratotic scarring
- Hidradenitis suppurativa
## Results of Dermatological Treatment

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Count (Percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completely/largely improved</td>
<td>214 (66.5%)</td>
</tr>
<tr>
<td>Partly improved</td>
<td>53 (16.5%)</td>
</tr>
<tr>
<td>Not improved</td>
<td>23 (7.1%)</td>
</tr>
<tr>
<td>Lost to follow-up</td>
<td>32 (10%)</td>
</tr>
</tbody>
</table>

N = 322
Why are derm diagnoses being missed?

- Low index of suspicion because the presenting symptom is pain.
- Lack of training in dermatology.
- The same derm. disease often looks very different on genital skin.
- Textbook images are usually of severe disease, whereas most presentations are of mild-moderate severity.
Normal skin = neuromuscular disease or dysfunction
# Results of Neuromuscular Treatment

<table>
<thead>
<tr>
<th>Improvement Category</th>
<th>N</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completely/largely improved</td>
<td>72</td>
<td>39.6%</td>
</tr>
<tr>
<td>Partly improved</td>
<td>35</td>
<td>19.2%</td>
</tr>
<tr>
<td>Not improved</td>
<td>11</td>
<td>6%</td>
</tr>
<tr>
<td>Lost to follow-up</td>
<td>64</td>
<td>36%</td>
</tr>
</tbody>
</table>
What is Neuromuscular Pain?

• Vulval pain which is caused by neural or muscular disease or dysfunction.

• Can be local:
  – eg. pubococcygeus spasm from a vulval dermatosis

• or referred:
  – eg. unilateral labial pain from hip labral tear
  – eg. vulval pain from lumbo-pelvic musculoskeletal dysfunction.
Typical Neuromuscular Pain History

• Often well-localised
• Often unilateral (15.3%)
• Triggered by
  – operations/childbirth (25.5%)
  – by exercise/overuse (16.3%)
• Worse with sitting, tight trousers, sex, day’s end
• Improved with lying, walking
• History of significant spinal, hip or lower limb disease or dysfunction (53%)
Derm. vs Neuromuscular Pain

Dermatological Pain

• Worse in bed
• Worse with walking
• Better with sitting
• No change with tight clothes
• Mostly bilateral
• Mostly no trigger
• Trigger usually medications
• No PH of spinal problems

Neuromuscular Pain

• Better in bed
• Better with walking
• Worse with sitting
• Worse with tight clothes
• Often unilateral/ anterior
• Often a trigger
• Trigger usually operations, childbirth, injury
• PH of spinal problems
Extra-genital Examination

- Stance
- Pedal arches
- Knees
- Anterior superior iliac spines
- Femoral length
- Lumbar lordosis
- Scoliosis
Genital Examination

• Normal skin

• Hyperaesthesia (use finger)

• Tenderness over medial aspect of inferior pubic rami

• Tenderness over tight pubococcygeus muscles

• Tenderness over obturator internus or coccygeus
# Treatment Modalities

<table>
<thead>
<tr>
<th>Treatment Modality</th>
<th>N = 182</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physiotherapy* alone</td>
<td>102 (56%)</td>
</tr>
<tr>
<td>Neuromodulating drugs alone</td>
<td>54 (30%)</td>
</tr>
<tr>
<td>Physiotherapy &amp; neuromodulators</td>
<td>26 (14%)</td>
</tr>
</tbody>
</table>

*experienced in musculoskeletal and pelvic physio & able to perform vaginal examinations*
Why are neuromuscular diagnoses being missed?

- Low index of suspicion.
- Lack of understanding of neuromuscular referral patterns in and into the pelvis.
- Tendency to attribute psychological etiologies to female genital pain when the skin is normal.
Multifactorial Cases

Vulval dermatosis

Neuromuscular disease/dysfunction

Vulval pain
DYSPAREUNIA

...not really a special case
Psychogenic notions about dyspareunia persist

- DSM-5 has a section called genito-pelvic pain/penetration disorder!

- The current literature on dyspareunia continues to emphasise the psycho-sexual aspects, rather than the potential physical causes.
Clinical Classification of Dyspareunia

• Great confusion:
  – superficial/ entry/ deep: ? what do they mean?
  – these definitions do not reflect anatomical realities

• My experience has led to this classification:
  – **vulvovaginal** (felt in the vulva and/or vagina) or
  – **abdominal** (felt in the abdomen)
Abdominal Pain

Upper pelvic floor

Vulvovaginal Pain

Lower pelvic floor
From my Review Series:

- 166 (32%) complained solely of vulval pain with sexual intercourse = vv dyspareunia

- Comparison was made with a group of 232 patients who had both sexual & non-sexual vulval pain.
The Aetiology of VV Dyspareunia

- Dermatological
- Neuromuscular
- Psychological
Dermatological Diagnoses

- All = 322
- Dysp. only N=166
- Dysp.+non-sex pain N=232
## Treatment Outcomes

|                     | Dyspareunia only  
<table>
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</thead>
<tbody>
<tr>
<td></td>
<td>N = 166</td>
<td>Dyspareunia +non-sex pain</td>
<td>N = 232</td>
</tr>
<tr>
<td>Good/mostly</td>
<td>105 (63.3%)</td>
<td>129 (55.6%)</td>
<td>NS</td>
</tr>
<tr>
<td>Partial</td>
<td>16 (9.6%)</td>
<td>39 (16.8%)</td>
<td>NS</td>
</tr>
<tr>
<td>No help</td>
<td>8 (4.8%)</td>
<td>15 (6.5%)</td>
<td>NS</td>
</tr>
<tr>
<td>LTFU</td>
<td>37 (22.3%)</td>
<td>49 (21.1%)</td>
<td>NS</td>
</tr>
</tbody>
</table>
My Conclusion:

- Vulvovaginal dyspareunia is simply another type of vulvovaginal pain, with the same aetiologies and treatments as any other.

- It is no more “psychological” than any other type of pain.
Case Study: 24 year old para 0

• **Presentation:** “sex hurts”

• **History of the presenting illness:**
  
  – 12 months of right-sided vulval pain
    • worse with sex, exercise, at end of the day
    • relieved by rest
  
  – **Started after:**
    • commencing first job
    • wearing high-heeled shoes
    • started kick boxing at the gym
Relevant Past History

• At school wore orthotics to improve anterior knee pain
• Episodic right low back pain since wearing a heavy school bag in senior high school
Examination

Vulva/ vagina NAD:
- no spasm
- no hyperaesthesia

Spinal exam:
- scoliosis
Management

• Cease high heels and high-impact exercise

• Referred to a physiotherapist with skills in spine and pelvis
Review at 6 weeks

• Pain improving, but still lusting after 12cm heels!
Referred vulval pain

Congenital spinal dysfunction

High heels
High-impact exercise
Case Study 2: 42 year old para 2

Referral history:

• Dysuria and entry dyspareunia since a vaginal POP operation
• MSU and urodynamics non-contributory
• Treatments for bladder dysfunction unhelpful
My History

History of present illness:
• burning vulval pain 24/7 since operation
  – worse with sex, micturition
  – much worse in bed
• terminal dysuria, felt in anterior vaginal introitus

Relevant past history:
• Chronic L5/S1 disc pain, worse post-op
• “Sweat rashes” in groins
Examination

• Well-healed operative scars
• Confluent, oedematous vulvo-vaginitis
• Low vaginal culture: C. alb++
Initial Management

• Treat candidiasis: fluconazole 50mg daily
• 1% hydrocortisone ointment PRN for soreness
Review at one month

- Vulval pain and dysuria reduced
- Dyspareunia unchanged

- Examination:
  - genital skin now normal to appearance
  - fixed pubo-coccygeal spasm at posterior vaginal introitus
  - gentle pressure on spasm reproduces pain
Further management

• Continue daily fluconazole
• Physiotherapy with a therapist experienced in both pelvis and spine
Outcome

- Vulval pain, including terminal dysuria and dyspareunia, gradually resolved over some months
- Fluconazole ceased after completion of physiotherapy
Chronic VV candidiasis
Pubo-coccygeus spasm

Local & referred vulval pain

Atopic skin disease
Low spinal dysfunction

Vaginal surgery
Lithotomy position
Heat, sweat, friction
Antibiotics
What about Vulvodynia?

• 2/525 patients could not be assigned a diagnosis = vulvodynia

• 27/525 (5.1%) could not be improved at all: this technically is not vulvodynia.

• The vast majority of my patients had a diagnosis which led to effective treatment.

• Vulvodynia is a ‘diagnosis of exclusion’, and in my experience, is unusual.
What to do now?

- Ask the right questions
- Believe the patient’s history
- Have a high index of suspicion for derm. and neuromuscular causes
- Find an interested dermatologist
- Find an interested physiotherapist
THANK YOU !