Vulvodynia

ABSTRACT: Vulvodynia is a complex disorder that can be difficult to treat. It is described by most patients as burning, stinging, irritation, or rawness. Many treatment options have been used, including vulvar care measures, medication, biofeedback training, physical therapy, dietary modifications, sexual counseling, and surgery. A cotton swab test is used to distinguish generalized disease from localized disease. No one treatment is effective for all patients. A number of measures can be taken to prevent irritation, and several medications can be used to treat the condition.

Vulvodynia is a complex disorder that can be difficult to treat. This Committee Opinion provides an introduction to the diagnosis and treatment of vulvodynia for the generalist obstetrician–gynecologist. It is adapted with permission from the 2005 American Society for Colposcopy and Cervical Pathology publication, “The Vulvodynia Guideline” (1).

Terminology and Classification

Many women experience vulvar pain and discomfort that affects the quality of their lives. Vulvodynia is described by most patients as burning, stinging, irritation, or rawness. It is a condition in which pain is present although the vulva appears normal (other than erythema).

The most recent terminology and classification of vulvar pain by the International Society for the Study of Vulvovaginal Disease defines vulvodynia as “vulvar discomfort, most often described as burning pain, occurring in the absence of relevant visible findings or a specific, clinically identifiable, neurologic disorder” (2). It is not caused by commonly identified infection (eg, candidiasis, human papillomavirus, herpes), inflammation (eg, lichen planus, immunobullous disorder), neoplasia (eg, Paget’s disease, squamous cell carcinoma), or a neurologic disorder (eg, herpes neuralgia, spinal nerve compression). The classification of vulvodynia is based on the site of the pain, whether it is generalized or localized, and whether it is provoked, unprovoked, or mixed. Although the term vulvar dyesthesia has been used in the past, there is now consensus to use the term vulvodynia and subcategorize it as localized or generalized.

Several causes have been proposed for vulvodynia, including embryologic abnormalities, increased urinary oxalates, genetic or immune factors,
hormonal factors, inflammation, infection, and neuropathic changes. Most likely, there is not a single cause.

Because the etiology of vulvodynia is unknown, it is difficult to say whether localized vulvodynia (previously referred to as vestibulitis) and generalized vulvodynia are different manifestations of the same disease process. Distinguishing localized disease from generalized disease is fairly straightforward and is done with the cotton swab test as described in the following section. Early classification to localized or generalized vulvodynia can facilitate more timely and appropriate treatment.

**Diagnosis and Evaluation**

Vulvodynia is a diagnosis of exclusion, a pain syndrome with no other identified cause. A thorough history should identify the patient’s duration of pain, previous treatments, allergies, medical and surgical history, and sexual history.

Cotton swab testing (Fig. 1) is used to identify areas of localized pain and to classify the areas where there is mild, moderate, or severe pain. A diagram of pain locations may be helpful in assessing the pain over time. The vagina should be examined, and tests, including wet mount, vaginal pH, fungal culture, and Gram stain, should be performed as indicated. Fungal culture may identify resistant strains, but sensitivity testing usually is not required. Testing for human papillomavirus infection is unnecessary.

**Treatment**

Most of the available evidence for treatment of vulvodynia is based on clinical experience, descriptive studies, or reports of expert committees. There are few randomized trials of vulvodynia treatments. Outlined here are treatments used by clinicians with an interest in vulvodynia. Multiple treatments have been used (Fig. 2), including vulvar care measures; topical, oral, and injectable medications; biofeedback training; physical therapy; dietary modifications; cognitive behavioral therapy; sexual counseling; and surgery. Newer treatments being used include acupuncture, hypnotherapy, nitroglycerin, and botulinum toxin.

Gentle care of the vulva is advised. The following vulvar care measures can minimize vulvar irritation:

- Wearing 100% cotton underwear (no underwear at night)
- Avoiding vulvar irritants (perfumes, dyes, shampoos, detergents) and douching
- Using mild soaps for bathing, with none applied to the vulva
- Cleaning the vulva with water only
- Avoiding the use of hair dryers on the vulvar area
- Patting the area dry after bathing, and applying a preservative-free emollient (such as vegetable oil or plain petrolatum) topically to hold moisture in the skin and improve the barrier function
- Switching to 100% cotton menstrual pads (if regular pads are irritating)
- Using adequate lubrication for intercourse
- Applying cool gel packs to the vulvar area
- Rinsing and patting dry the vulva after urination

Different medications have been tried as treatments for vulvar pain. These include topical, oral, and intralesional medications, as well as pudendal nerve blocks. Many of these medications are known to interact with other drugs, and many patients with vulvodynia may be taking multiple medications. Clinicians should check for any potential drug inter-
actions before prescribing a new medication. Before prescribing a new course of therapy, clinicians may stop use of all topical medication.

Commonly prescribed topical medications include a variety of local anesthetics (which can be applied immediately before intercourse or in extended use), estrogen cream, and tricyclic antidepressants compounded into topical form. Although topical steroids generally do not help patients with vulvodynia, trigger-point injections of a combination of steroid and bupivacaine have been successful for some patients with localized vulvodynia (3).

Tricyclic antidepressants and anticonvulsants can be used for vulvodynia pain control. When first prescribing drugs, clinicians should avoid polypharmacy. One drug should be prescribed at a time. Before prescribing antidepressants or anticonvulsants for a patient of reproductive age, the clinician

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**Figure 2. Vulvodynia treatment algorithm.** (Adapted from Haefner HK, Collins ME, Davis GD, Edwards L, Foster DC, Hartmann EH, et al. The vulvodynia guideline. J Low Genit Tract Dis 2005;9:40–51.)
should emphasize the need for contraception. Antidepressants have been found to have a 60% response rate for various pain conditions; however, no randomized, controlled studies have been published regarding the use of antidepressants for vulvodynia. Both tricyclic antidepressants and anticonvulsants take time to achieve adequate pain control, which may take up to 3 weeks. Patients usually develop tolerance to the side effects of these medications (particularly sedation, dry mouth, and dizziness).

Biofeedback and physical therapy also are used in the treatment of both localized and generalized vulvodynia (4). Physical therapy techniques include internal (vaginal and rectal) and external soft tissue mobilization and myofascial release; trigger-point pressure; visceral, urogenital, and joint manipulation; electrical stimulation; therapeutic exercises; active pelvic floor retraining; biofeedback; bladder and bowel retraining; instruction in dietary revisions; therapeutic ultrasonography; and home vaginal dilation.

Vestibulectomy has been helpful for many patients with localized pain that has not responded to previous treatments (5). Patients should be evaluated for vaginismus and, if present, treated before a vestibulectomy is performed. For generalized vulvar burning unresponsive to previous behavioral and medical treatments, referral to a pain specialist may be helpful.

Conclusion

Vulvodynia is a complex disorder that frequently is frustrating to both clinician and patient. It can be difficult to treat, and rapid resolution is unusual, even with appropriate therapy. Decreases in pain may take weeks to months and may not be complete. No single treatment is successful in all women. Expectations for improvement need to be realistically addressed with the patient. Emotional and psychologic support is important for many patients, and sex therapy and counseling may be beneficial.

Resources


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References