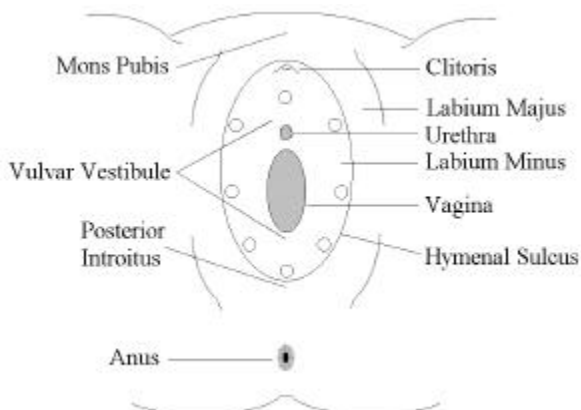


Patients with chronic pelvic pain may complain of recurrent or persistent vulvar burning, rawness, stinging, irritation, or dryness as their only symptoms, or they may complain of these symptoms in combination with others. The International Society for the Study of Vulvar Disease (ISSVD) classifies this condition as vulvodynia. Normal sexual relations and wearing tampons or tight clothing usually aggravates the pain. It is no wonder that patients with these symptoms are usually frustrated and miserable. Compounding the problem is the fact that physicians often miss the diagnosis.

The association of vulvodynia with other pelvic pathology such as interstitial cystitis, endometriosis, and pelvic floor spasm requires careful screening for this condition and careful evaluation for chronic pain. The *sine qua non* for the diagnosis of vulvodynia is extremely painful sensitivity to light touch. This is elicited with a cotton-top applicator lightly touching the vestibular glands in the hymenal sulcus. This physical finding is called allodynia and is typical for neuropathic pain. There may be no skin changes or there may be localized vestibular erythema delineating the most painful areas. This form of vulvar pain is commonly called vestibulitis and remains one of the most frequently misdiagnosed conditions in women with dyspareunia and chronic pelvic pain.



Other conditions causing painful vulva syndrome include chronic vulvovaginitis, periorificial dermatitis, vestibular papillomatosis, lichen sclerosis et atrophicus, dysesthetic vulvodynia, and pudendal neuralgia. These conditions can be a precursor to — or associated with — vestibulitis. The treatment of vulvodynia requires accurate diagnosis and the amelioration of any predisposing pelvic pathology.

The etiology of vestibulitis is multifactorial. Viral agents such as Herpes Simplex and Human Papilloma Virus have been implicated. Trauma from recurrent Candida or bacterial infections may also lead to vestibulitis. Sexual assault or abuse is more common in women with this form of pelvic pain. There is a theory that excessive oxalate crystals in the urine produce this condition.

Treatment of Vulvodynia (Vestibulitis)

- Treat sequentially
 - Topical estrogens intravaginally
 - Acyclovir ointment
 - 5FU (Efudex)
 - Kenalog injections
 - Alferon injections
 - Vestibulectomy
 - Acyclovir ointment (Zovirax)
 - Vegetable oil – put a dollop on the tip of the index finger and rub into the tender area of the vestibule twice each day
- Eliminate tissue injury
 - Infection
 - Endometriosis
 - Treat interstitial cystitis

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- 5FU (Efudex) - Apply 1 tbs to vestibule for 2 hours (no longer) twice per week, wash off thoroughly with soap and water. Remap the allodynia after 4 weeks. If soap and water begin to burn, skip reapplication until healed. Continue treatment if improving or until completely resolved.
 - Triamcinolone (Kenalog) injections
 - Apply benzocaine (Hurricane) ointment to vestibule for 15 minutes
 - Inject 1, 3, 4, 8, 9, and 11 o'clock with a total of 40mg triamcinolone (1 ml) in 1 ml of .5% bupivacaine (Marcaine) in divided doses
 - Remap allodynia in 2 weeks and reinject 10 mg every 2 weeks for one month or until resolved
 - Interferon (Alferon) injections
 - Apply benzocaine ointment to vestibule for 15 minutes
 - Inject 1, 3, 4, 8, 9, and 11 o'clock with 2.5 million units of interferon (Alferon) 1 ml in divided doses twice per week for 4 weeks
 - Remap allodynia before last injection (#8) and before applying benzocaine. Continue injections 1 per week for 4 more weeks if improving (total 12 injections).

Conclusion

Despite the multitude of possible causes, treatment of this disease can be quite successful. The medical regimen includes the sequential application of topical or interstitial drugs until symptoms are relieved. Over 90% of patients gain relief from medical therapy without having to undergo surgical vestibulectomy.

Clinicians who provide health care to women must become more familiar with the diagnosis and management of vulvodynia. Careful examination of the vestibule for allodynia should be routine in every patient who complains of pelvic pain. Awareness of the possible etiologies and the application of successful treatments should also become routine practice. Then will we be able to reduce the suffering endured by so many female patients.

The International Pelvic Pain Society was formed to allow physicians, psychologists, nurses, physical therapists and other professionals to coordinate, collect, and apply a growing body of information on chronic female pelvic pain. In doing this, we hope to be able to provide more relief and insure a more normal lifestyle for our patients. For membership information for healthcare professionals and patients, please contact us.

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