PAINWEEK

When Pain Is Not Sexy: Evaluation and Management of Dyspareunia and Vaginal Pain

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Disclosures

- Georgine Lamvu, MD, MPH
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  - Grant/Research Support: Pfizer grants for learning; National Vulvodynia Association
  - Consultant: Abbvie, Uroshape
  - Speakers Bureau: Abbvie

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Objectives

- Review diagnostic criteria for sexual pain
- Explain the impact of this very prevalent chronic pain syndrome
- Describe the benefits of both physical and psychosocial therapies

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Survey Participation Is Fun!

How to join

Web

Text

PaiNweek

Patient Case—Visit 1

- **34 yo** married female G1P1 presents for management of her chronic low back pain. You are done with your visit, and as you are walking out the door she says, *"I know you don't have time but…"* and she proceeds to report that over the **last several months** she has been experiencing pain during intercourse and loss of desire that is worrying her.
  Besides endometriosis she has no other health issues and she takes no medications. UA, UPT, and U/S are negative.

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What would you do with this patient who has longstanding genital pain and negative studies?

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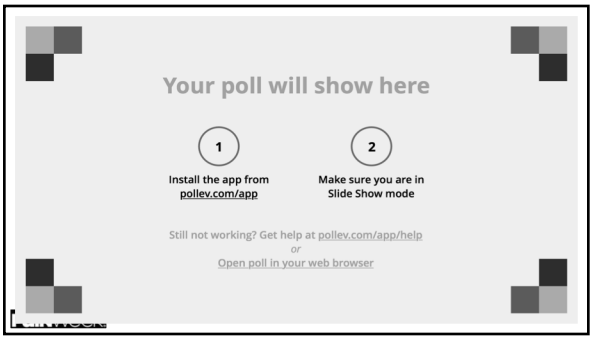

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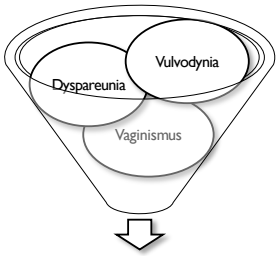
How Would You Classify This Patient’s Pain?

Sexual Pain Terminology



Genital Pain

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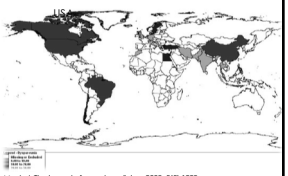
Epidemiology and Impact

- Dyspareunia—12%-21% in women in the US and the world
- Vulvodynia —14 million in the US

54 studies, 35,973 women
Prevalence: 8%-21%; 1.1% (Sweden) to 45% (US)



Pitts M, et al. The journal of sexual medicine. 2008; 5(5):1223.
Reed BD, et al. American Journal of Obstetrics and Gynecology. 2012; 206(2):170.
Latthe P, et al. BMC Public Health. 2006; 6:177.

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Genital Pain Terminology

- **Dyspareunia**– pain with intercourse
  - ***Situational dyspareunia***: pain with intercourse that is limited to specific situations, positions, or a particular partner
  - ***General dyspareunia:*** pain that is not situational
  - ***Primary dyspareunia:*** pain that presents with or since first intercourse
  - ***Secondary dyspareunia:*** pain with intercourse that occurs after a period of pain-free intercourse
  - ***Superficial dyspareunia:*** pain limited to the vulvar vestibule or vaginal introitus
  - ***Deep dyspareunia:*** pain with deep penetration
- ***Vaginismus***– involuntary muscle spams and fear of touch
- **Vulvar pain**
  - Vulvar pain associated with a known etiology
  - Vulvodynia pain of 'unknown' etiology > 3 months
- ***Hypoactive sexual desire disorder, arousal disorder***—diagnoses that **do not involve pain**

MacNeill C. Dyspareunia. Obstetrics and Gynecology Clinics of North America. 2004; 33 (4):565
Howard F. Dyspareunia. In Pelvic Pain: Diagnosis and Management. Lippincott New York 200.

Boardman L, et al. Clinical Obstetrics and Gynecology. 2009; 52(4). 682.
Lamvu G, et al. Vulvodynia: a prevalent yet underdiagnosed chronic pain syndrome. Painweek Journal. 2015; Q1. 14.
Kingsberg S, et al. Female Sexual Dysfunction. Obstetrics and Gynecology. 2013 125(2): 477.

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2015 ISSVD Classification of Vulvar Pain

- Vulvar pain related to a specific disorder: infectious, inflammatory, neoplastic, neurologic
- Vulvodynia: chronic lower genital pain of "unknown etiology" that manifests as pain and occasional erythema of the vulva without obvious infectious, dermatologic, or neurologic disease for > 3 months
  - Generalized vulvodynia – to the entire vulva
  - Localized vulvodynia – to the vestibule
  - Provoked vulvodynia – occurring with touch (tampon, sexual activity)
  - Unprovoked vulvodynia – occurring spontaneously or continuous pain

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Pukall C, et al. Vulvodynia: Definition, Prevalence, Impact and Pathophysiological Factors. J Sex Med 2016; 13:291-304.

2015 ISSVD, ISSWSH, and IPPS Consensus Terminology and Classification of Persistent Vulvar Pain and Vulvodynia

Jacob Bornstein, MD, MPH,[1] Andrew T. Goldstein, MD,[2] Colleen K. Stockdale, MD, MS,[3] Sophie Bergeron, PhD,[4] Caroline Pukall, PhD,[5] Dmytri Zolnoun, MD, MPH,[6] and Deborah Coady, MD[7]

On behalf of the consensus vulvar pain terminology committee of the International Society for the Study of Vulvovaginal Disease (ISSVD), the International Society for the Study of Women's Sexual Health (ISSWSH), and the International Pelvic Pain Society (IPPS)

TABLE 3. 2015 Consensus Terminology and Classification of Persistent Vulvar Pain and Vulvodynia

A. Vulvar pain caused by a specific disorder[a]
- Infectious (e.g., recurrent candidiasis, herpes)
- Inflammatory (e.g., lichen sclerosus, lichen planus, immunobullous disorders)
- Neoplastic (e.g., Paget disease, squamous cell carcinoma)
- Neurologic (e.g., postherpetic neuralgia, nerve compression, or injury, neuroma)
- Trauma (e.g., female genital cutting, obstetrical)
- Iatrogenic (e.g., postoperative, chemotherapy, radiation)
- Hormonal deficiencies (e.g., genitourinary syndrome of menopause [vulvovaginal atrophy], lactational amenorrhea)

B. Vulvodynia—vulvar pain of at least 3 months' duration, without clear identifiable cause, which may have potential associated factors.

The following are the descriptors:
- Localized (e.g., vestibulodynia, clitorodynia) or generalized or mixed (localized and generalized)
- Provoked (e.g., insertional, contact) or spontaneous or mixed (provoked and spontaneous)
- Onset (primary or secondary)
- Temporal pattern (intermittent, persistent, constant, immediate, delayed)

[a]Women may have both a specific disorder (e.g., lichen sclerosus) and vulvodynia.

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TABLE 4. 2015 Consensus Terminology and Classification of Persistent Vulvar Pain and Vulvodynia

Appendix: potential factors associated with vulvodynia[a]

- Comorbidities and other pain syndromes (e.g., painful bladder syndrome, fibromyalgia, irritable bowel syndrome, temporomandibular disorder; level of evidence 2)
- Genetics (level of evidence 2)
- Hormonal factors (e.g., pharmacologically induced; level of evidence 2)
- Inflammation (level of evidence 2)
- Musculoskeletal (e.g., pelvic muscle overactivity, myofascial, biomechanical; level of evidence 2)
- Neurologic mechanisms
  - Central (spine, brain; level of evidence 2)
  - Peripheral: neuroproliferation (level of evidence 2)
- Psychosocial factors (e.g., mood, interpersonal, coping, role, sexual function; level of evidence 2)
- Structural defects (e.g., perineal descent; level of evidence 3)

[a]The factors are ranked by alphabetical order.

If you are confused… don't worry, so are the rest of us!

—Vulvodynia can coexist with other disorders… how is that different than vulvar pain with known etiology?

—"Associated" factors are essentially the same as "specific disorders"

Definition of Vaginismus

Genito-Pelvic Pain/Penetration Disorder DSM5-302.76

- >6 months of recurrent distress and difficulty towards vaginal penetration manifested as at **least one of the following**:
  - Intense **fear/anxiety** in anticipation of, during, or as a result of vaginal intercourse
  - Actual pain experienced in pelvis or vulvovaginal area during attempted or as a result of vaginal penetration
  - Marked **tensing or tightening of the lower pelvic/inner-abdominal muscles** during attempted vaginal penetration
- This condition cannot be better attributed to:
  - A nonsexual mental disorder (ie, posttraumatic stress disorder)
  - Relationship distress (ie, domestic violence)
  - Other life stressors impacting a person's sexual desire
  - Any other medical condition
- Symptoms may have appeared as soon as the person became sexually active or may begin after a period of normal sexual functioning
- The condition can be specified as mild, moderate, or severe depending on the amount of subjective distress it causes

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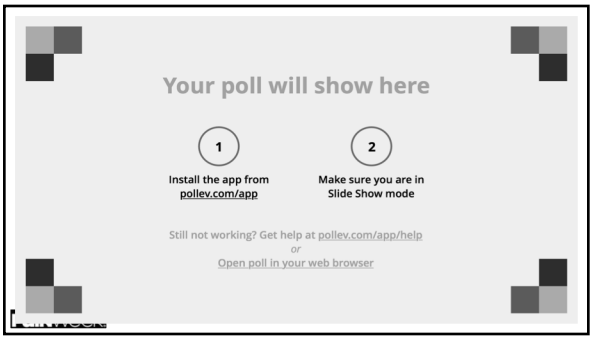

Epidemiology of Vulvodynia

- Affects approximately 8% of women (14 million) in US
- 60% of patients see >3 doctors and <3% receive an appropriate diagnosis
- The average patient suffers on average 5 years without definitive diagnosis
- Economic impact on the US healthcare system is 31-72 billion dollars annually, a sum greater than the individual estimates for IC, fibromyalgia, and endometriosis alone

Lamvu G, et al. Vulvodynia: a prevalent yet underdiagnosed chronic pain syndrome. Painweek Journal. 2015; 01, 14.

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or
Open poll in your web browser

Despite the immense burden of disease and personal distress reported by patients, research shows that they routinely experience…..

- **Social isolation**
- **Feeling invalidated**
- **Dismissive attitudes from healthcare providers**

Price et al. *BJOG: Int J Obstet & Gynaecol* 2006
Nguyen RH, et. al. Psychology, health & medicine 2012;17:589-98.
Nguyen RH, et. al. J Reprod Med 2012;57:109-14.

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Impact on Quality of Life

Sexual Dysfunction

Fatigue

Physical Limitations

Depression

Less than 5% of patients have access to a pain specialist

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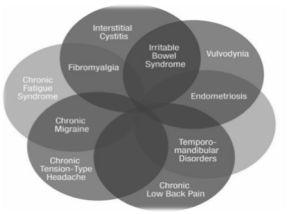
Overlap With Other Chronic Pain Conditions



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Chronic Pain Research Alliance. http://www.chronicpainresearch.org

Communication

Observation

Evaluation of Sexual Pain

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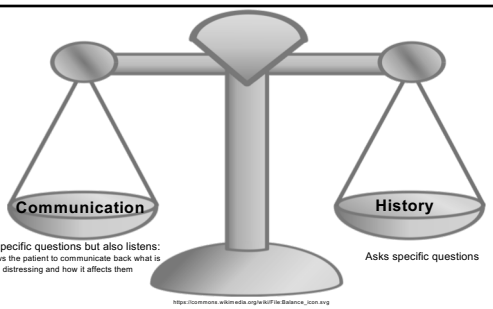

Asks specific questions but also listens:

- Allows the patient to communicate back what is most distressing and how it affects them

Asks specific questions

https://commons.wikimedia.org/wiki/File:Balance_icon.svg

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Essential Elements

History

- Symptom: location, laterality, character, radiation, temporality, duration, onset
- Previous treatments tried: type, duration, multimodal
- Alleviating and exacerbating factors
- Associated symptoms
- Daily function: ability to work
- Quality of life: sleep, fatigue, sexual function

Communication

- Use open-ended questions and allow patients to express how pain affects them
- **A lot of the history is not evident until…**
  - **Allow patient to identify what is most distressing**
  - **Establish trust**
  - **Subsequent visits**

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First Visit Expectations

PATIENT	PROVIDER
Believed and validated	Explanation for the pain, ie, diagnosis
Reassurance	Additional testing
Establish trust	Treatment
Overcome feelings of isolation and invalidation	Efficient/quick visit
Explanation for the pain	Anxiety about inability to provide help
Better quality of life	Need for long-term treatment
Cure	Lack of a cure

INTERACTIONS DURING THE FIRST VISIT MAY INFLUENCE OUTCOME… MORE THAN THE TREATMENTS YOU PRESCRIBE.

Selfe et al. Factors influencing outcome in consultations for chronic pelvic pain. J Womens Health, 7: 1041-8. 1998.
Price et al. Attitudes of women with chronic pelvic pain to the gynecological consultation: a qualitative study. BJOG; 113: 446-52. 2006.
Jamiel et al. Consensus guidelines for the management of chronic pelvic pain. J Obstet Gynaecol Can; 27: 781-826. 2005.
Price et al. Attitudes of women with chronic pelvic pain to the gynecological consultation: a qualitative study. BJOG; 113: 446-52, 2006

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Before You Walk in The Room

- Remember:
  - Chronic pain leads to predictable behavior: the patient is not 'faking it,' not just trying to avoid sex
  - Patients do not know the complexities of pain, even though they live with the pain every day. It is your job to make them understand
  - They are communicating how they experience pain… this is not about how you interpret their pain
- Be patient with the patient and with yourself
- Even though you don't know the answer, be kind!

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Guidelines for the First Visit

- Explain that CPP can be complex and require multiple interventions
- Establish expectations for long-term follow-up, potential for repeat gynecologic examination
- Allow the patient to prioritize what is considered improvement, so she can choose what she wants to work on first
- ***And this must be done before examination—even if it requires a subsequent or prolonged visit***

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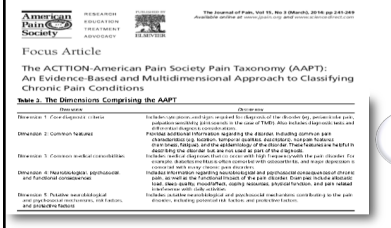
Chronic genital pain is similar to other chronic pain syndromes and should be similarly characterized



Focus Article

The ACTTION-American Pain Society Pain Taxonomy (AAPT): An Evidence-Based and Multidimensional Approach to Classifying Chronic Pain Conditions

Table 2. The Dimensions Comprising the AAPT

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THE BIOPSYCHOSOCIAL MODEL OF PAIN ASSESSMENT

T — Timing
- Chronic pain lasting >3 months
- **Primary vs Secondary; Constant vs Intermittent; Provoked vs Unprovoked**

I — Impact
- Associated with disability, poor QOL (activity, sleep, distress)
- Poor sexual function
- **Associated symptoms, itching vs burning pain, bleeding, discharge, bladder and bowel symptoms**

L — Location
- **Insertional vs Deep; Generalized vs Localized**

T — Therapies
- **Pain not responsive to 'simple' or over the counter therapies**

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SCREENING

SCREEN FOR RED FLAGS

- Bleeding
- Discharge
- Recurrent vulvovaginal infections
- Pregnancy status
- Hormonal status

SCREENING

SCREEN FOR PAIN AND MULTIORGAN DYSFUNCTION

- Urinary: urgency, frequency, dysuria
- Gastrointestinal: constipation, diarrhea, bloating, nausea, dyspareunia
- Comorbid pain syndromes, psychological distress
- Adverse life experiences, trauma, PTSD, MST
- Musculoskeletal
  - Pain with movement, worse at the end of the day, dyspareunia

The Examination

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Communication and Gynecologic Examination for Pain

- Trust
- Relaxation and decrease anxiety
- Get the history with the patient dressed
- Patient should have a sense of control
  - Educate patient on what is examined during the evaluation
  - Explain sensory exam and pain severity scales
  - Explain difference between exam and 'what you feel at home'
  - Give the option to stop at any point; may break up examination into two visits
  - Use the smallest speculum possible

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Trauma-Informed Examination

Providers and Nurses

- Screen for history of trauma before you start
- Make sure the patient is properly covered
- Have a chaperone
- Monitor verbal/nonverbal cues of discomfort
- Employ distractions
- **Stop the exam anytime**
- Get permission before starting/resuming exam
- If signs of distress, ask…
  "Would you like to stop and take a minute?" "Would you like to delay rest of the exam?"

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Conditions Associated With Sexual Pain

Superficial/Insertional
- Vulvar dermatoses
  - Lichen sclerosis
  - Lichen planus
  - Contact dermatitis
- Vaginitis/Infections/Inflammatory
  - Candidiasis
  - Bacterial vaginosis
  - DIV
- Vaginal atrophy/hormonal
- Myalgias
- Neuralgia

Deep
- Reproductive
  - Endometriosis/adenomyosis
  - Uterine or ovarian masses (cysts, fibroids)
  - Pelvic congestion
  - PID
  - Adhesions
- Myalgias/spasm
- Neuralgia
- Trauma (vaginal surgery, mesh, hysterectomy)
  - Obstetrical
  - Surgical
- Urinary
  - IC/PBS
  - Urethral diverticulum
- Bowel
  - IBS
  - IBD
  - Constipation
  - Adhesions

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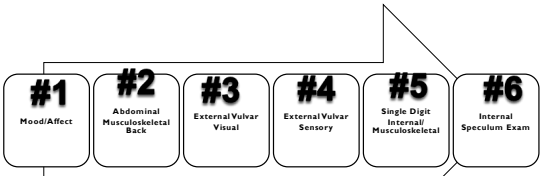
Change the Physical Exam



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During the Examination

- You cannot replicate pain any distress that patients experience in their daily lives or during activities such as heavy lifting or intercourse

During the examination avoid traumatizing the patient just to 'replicate' the pain

Focus on localizing the pain and let the patient tell you whether it is similar to what she feels… *listen to and believe your patient* (Focus on Patient Report)

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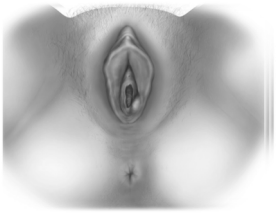
External Visual



- Fissures
- Dryness
- Hyperkeratosis
- Ulcerations or bumps
- Dermatology 101: bad signs
  - Raised, irregular edges; dark discoloration; bleeding

Images by Georgine Lamvu

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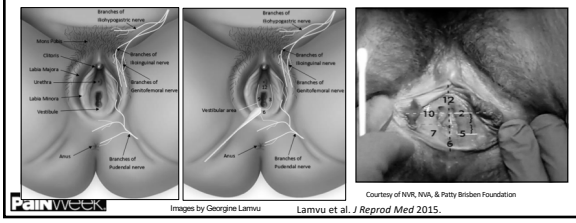
External Sensory

- Sensory test w/cotton-tipped applicator to 'soft' and 'pin prick'
- Anal wink reflex, allodynia, hyperalgesia in S1-T12 distribution
- Allodynia to static 'pressure' or dynamic 'brushing' touch of the vestibule



Images by Georgine Lamvu

Courtesy of NVR, NVA, & Patty Brisben Foundation

Lamvu et al. *J Reprod Med* 2015.

Single Digit Internal/Musculoskeletal

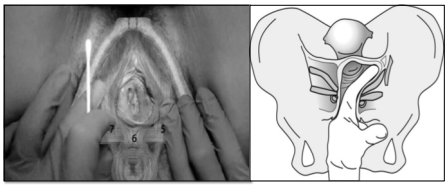


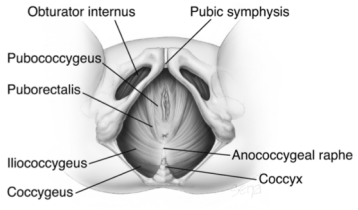
Image courtesy of Dr. Dennis Zolnoun

Reprinted from *Urology*, vol. 70, Peters et al., pp 16-18, ©2007, with permission from Elsevier

- Single well-lubricated digit, slow insertion
- Voluntary contraction, strength and tone
- "Deep" palpation of the pelvic floor muscles along vaginal wall, >2kg
- Palpation of the bladder, cervix, uterus and adnexa; bimanual exam

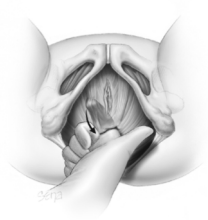
Musculoskeletal Exam

Pelvic Floor Muscles



Hoffman BL, Schorge JO, Bradshaw KD, Halvorson LM, Schaffer JI, Corton MM. *Williams Gynecology*, 3e; 2016

Puborectalis



Palpated at lower third of vagina from 12 to 6 o'clock

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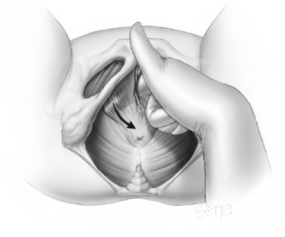
Hoffman BL, Schorge JO, Bradshaw KD, Halvorson LM, Schaffer JI, Corton MM. *Williams Gynecology, 3e*; 2016

Puboccoccygeus

Palpated from 7 to 11 o'clock on the left and 1 to 5 o'clock on the right



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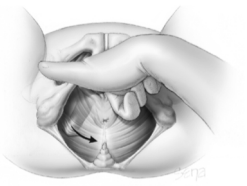
Hoffman BL, Schorge JO, Bradshaw KD, Halvorson LM, Schaffer JI, Corton MM. *Williams Gynecology, 3e*; 2016

Iliococcygeus



Palpated from 4 to 8 o'clock

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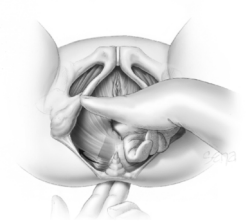
Hoffman BL, Schorge JO, Bradshaw KD, Halvorson LM, Schaffer JI, Corton MM. *Williams Gynecology, 3e*; 2016

Coccygeus



Palpated by identifying the ischial spine and moving the finger medially towards the sacrum, a tight band will be felt, the ischiococcygeus complex (coccygeus muscle and the sacrospinous ligament)

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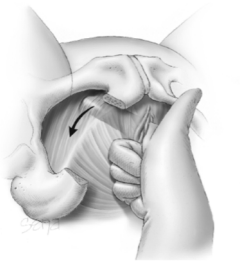
Hoffman BL, Schorge JO, Bradshaw KD, Halvorson LM, Schaffer JI, Corton MM. *Williams Gynecology, 3e*; 2016

Obturator Internus

Palpated just above the 3 and 9 o'clock positions, starting at arcus tendinous and stroking upwards towards pubic bone, superior to ischiopubic rami



Hoffman BL, Schorge JO, Bradshaw KD, Halvorson LM, Schaffer JI, Corton MM. *Williams Gynecology, 3e*; 2016

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Speculum Exam

- Complete only if SD exam is tolerated or
- Use a small well lubricated speculum
- Clear speculum helps visualize the vaginal walls with minimal distension
- Slow insertion
- Avoid the urethra
- Avid pinching the cervix

- Bleeding
- Discharge
- Pelvic masses
- Cervical masses
- Posterior cul-de-sac masses

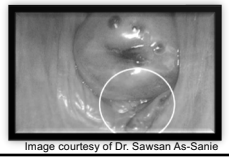

Image courtesy of Dr. Sawsan As-Sanie

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Diagnostic Tests

- Urinalysis
- Vaginal cultures/wet prep
- Pelvic imaging
  - Transvaginal ultrasound
  - Pelvic MRI
- Colposcopy
- Biopsy
- Neural blocks
  - Pudendal and pudendal branches
  - Prineal
  - Genifemoral
  - Ilioinguial
  - Iliohypogastric
- Pelvic function imaging for associated pelvic floor dysfunction
  - Dynamic MRI
  - Defecography
  - Sitz marker study
  - Urodynamics
  - Cystoscopy

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Case

- You explain that sexual pain evaluation can be quite extensive and you schedule a follow-up visit
- When the patient returns you take an extensive biopsychosocial history and perform a gentle examination
- During your exam, you note some nonfoul clear vaginal discharge, a small amount of erythema on the posterior forchette and bilateral levator pain
- Urinalysis, UPT, and pelvic ultrasound were all negative

- **Question:** What do you do next?

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What do you do next?

Start the presentation to see live content. Still no live content? Install the app or get help at PollEv.com/app

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Available Treatments of Dyspareunia

- Education and vulvar care
- Topical applications (lidocaine, estradiol, steroids)
- Oral therapy (analgesics, anticonvulsants, TCA, SSRIs)
- Intravaginal therapy
- *Physical therapy
- *Behavioral therapy:
  cognitive behavioral therapy, sex therapy, relationship counseling
- Injections: neuronal blocks and trigger points
- *Vestibulectomy (for localized vestibular pain only)
- Treatment often involves multiple therapies and is often highly individualized

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Andrews JC. Vulvodynia Interventions- systematic review and evidence grading. Obstet & Gyn Survey, 2011

Education: Vulvar Care

- Avoid over-washing and harsh cleansers
- Avoid 'wiping' emphasize gentle 'pat'
- Avoid drying agents, focus on lubrication during daily activities and intercourse
  - Lubricants should be water based or 'ointment' that are preservative free, alcohol free, nonirritating
- Avoid tight clothing
- Avoid overanalyzing and examination of the vagina
- Resuming intercourse only when pain free

PAINWEEK

Vulvar Pain Treatments

Hormonal Atrophy
- Topical cream, ring, pill estrogen: takes 6-8 weeks for improvement and requires maintenance
- Oral SERMS
- Topical lidocaine (for breast CA survivors)
- Lubrication, vulvar care

Dermatoses
- Topical steroids: triamcinolone, clobetasol
- Lubrication, vulvar care
- Oral steroids
- Antihistamines to prevent scratching

Myalgias
- Pelvic PT
- Muscle relaxants
- Trigger point injections, anesthetic blocks

Chronic Infection
- Long term antimicrobial
- Vulvar care
- Treat associated neuralgia/myalgia

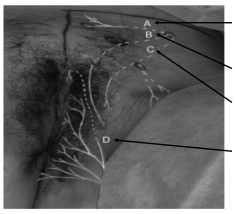
PAINWEEK

What if you can't find 'anything wrong' during examination?

Think Neuralgias

PAINweek

Neuroanatomy of the Vulva



A. Anterior cutaneous branches of the iliohypogastric nerve

B. Anterior labial branches of the ilioinguinal nerve

C. Genitofemoral nerve (both genital and femoral branches)

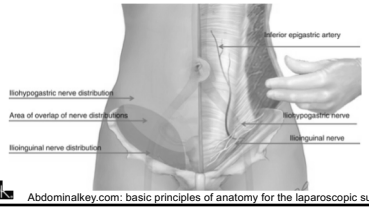
D. Dorsal nerve of clitoris (continuation of pudendal nerve shown as *dashed lines deeper in the* muscles of the urogenital diaphragm)

PAINweek

Parnell Baet al. *Obstet Gynecol* 2012

Neuralgias of Lumbosacral Nerve Plexus

Ilioinguinal, iliohypogastric, pudendal, obturator, genitofemoral neuralgias can all cause pain in the lower abdominal, pelvic, perineal, labial, vaginal regions.
Risk Factors: surgical retractors, low transverse incisions, laparoscopy trocars, mesh implantation, obstetric trauma, spinal injury.



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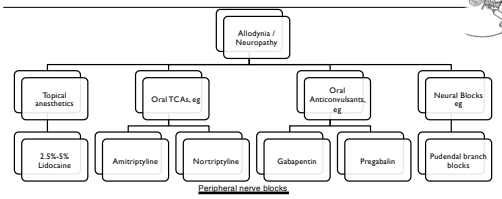
Abdominalkey.com: basic principles of anatomy for the laparoscopic surgeon.

Analgesia



Peripheral nerve blocks

- Genitofemoral
- Inguinal regional block (IH/IL)
- Pudendal nerve (transvaginal or transgluteal done by gynecology)

Muscular pain

- Trigger point injections – Botox

PAINWEEK

Case Visit # 2

- During your exam, you note some nonfoul clear vaginal discharge, a small amount of erythema on the posterior fourchette and bilateral levator pain
- **Question:** What do you do next?
- **Answer:** You add vulvar care, +/- lidocaine, =/- TCA at night, and physical therapy and ask her to follow up in 8 weeks

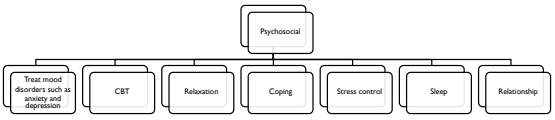
PAINWEEK

Case Visit # 3

- She returns and reports that her pain is much improved, but she still has no libido. Her husband is upset because he thinks they should have sex all the time. She is still visibly distraught.
- **Question:** What do you do next?

PAINWEEK

Treatment

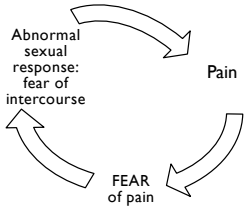


Clinical Pearls

- Many of these psychosocial issues do not become evident until providers really 'get to know' their patients
- Caution: many psychotropic drugs cause loss of libido
- Anxiety, poor coping may be more common than depression
- Relationship therapy involves the partner

PAINWEEK

Sexual Dysfunction
Cognitive Behavioral Therapy "Desensitization"



- Before overcoming fear of pain, patients have to experience nonpainful insertion
  - Vaginal dilators, internal PT, and internal examination should be nonpainful before patients can overcome 'fear of pain'
- Identify factors that help reduce fear but also increase arousal and desire

PAINWEEK

Addressing Sexual Myths

- The bigger the better
- The tighter the better
- Its normal for couple[illegible] all the time
- Some pain is normal

"Some sex and pain sometimes go together" Canadian Federal Court Justice Robin Camp -*Washington Post 2016*

PAINWEEK

Case Visit # 4

- After reassuring her and discussing sexual function and myths, you refer her to a relationship and sexual therapist for her and her husband. You also recommend she bring her husband to the next visit as well.

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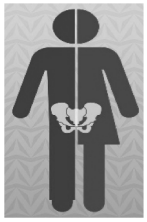
Summary

- Dyspareunia is often multifactorial: rule out vaginitis, but think myalgias, neuralgias, atrophy, and… relationship
- Treatment is usually involves the multidisciplinary approach: organic and psychosocial dysfunctions must be addressed
- Resolution of pain does not ensure return to normal sexual function; psychosocial and 'fear of intercourse' factors must be considered
- Chronic sexual or vaginal pain IS VERY SIMILAR to other chronic pain syndromes

PAINWEEK

Resources

- International Pelvic Pain Society
- www.pelvicpain.org
- Patient education pamphlets
- Video tutorials (for patients) on importance of CBT, PT, and other alternative therapies
- Listserve of experts to ask questions via email
- Observership, research grants, educational grants



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