



## An Algorithm for the Management of Vulvodynia

Vulvodynia is a genital pain syndrome defined as sensations of chronic burning, irritation, rawness, soreness in the absence of relevant objective skin disease, specific neuropathic pain such as post-herpetic neuralgia) or infection. Vulvodynia generally is believed to be a multifactorial symptom, occurring as a result of pelvic floor dysfunction predisposing to neuropathic pain, with anxiety/depression issues worsening symptoms. Often, discomfort is worsened by the application of common irritants (anti-yeast creams, panty liners, soaps, some topical anesthetics), and estrogen deficiency is another common exacerbating factor in many women.

Nonspecific measures are important in treating vulvodynia and include the **elimination of irritants**, **replacement of estrogen** when warranted, topical **lidocaine jelly 2%** for comfort and before sexual activity, and the treatment of documented infection.

Specific management requires attention to pelvic floor weakness and tenderness, neuropathic pain, and anxiety/depression, and **improvement generally requires at least 3 months**. Physical therapists with expertise in vulvodynia usually can be identified by calling a women's health care physical therapy incontinence center.

**Pelvic floor physical therapy** by a women's physical therapist experienced in the treatment of vulvodynia. *I believe this is the single most useful therapy.*

**Oral medication** for neuropathic pain. Most women either do not tolerate or do not improve with the first medication tried. All medications should be started at extraordinarily low doses, because women with vulvodynia are often unusually sensitive to the side effect of medications.

The medications I use include, in order of my preference:

- a. amitriptyline or desipramine beginning at half of a 10 mg tablet and titrating up to 150 mg
- b. imipramine sustained release, beginning at 75 mg and titrating up to 150 mg
- c. gabapentin (Neurontin) beginning at 100 mg a day titrating up to 3600 mg per day
- d. venlafaxine (Effexor) beginning at 37.5 mg extended release titrating up to 150 mg daily
- e. pregabalin (Lyrica\*) beginning at 50 mg a day titrating up to 150 mg twice daily
- f. duloxetine (Cymbalta) starting at 30 mg per day, increasing to 60 mg twice a day

\*Not yet available in generic form

We are happy to mail or fax patient handouts for any of these medications; handouts include titrating schedules and side effects. (704) 367-0504 (fax)

Other therapies for discomfort recalcitrant to the above measures include

- 1 **Botulinum toxin**, commonly 40 units injected into levator ani muscles
- 2 Topical therapies (not especially effective in my hands) include:
  - a. **amitriptyline 2%/baclofen 2%** applied three times a day (compounded)
  - b. **amitriptyline 2%/baclofen 2%/ketamine 2%** applied three times a day (compounded)
  - c. topical **gabapentin 4%** applied 2-3 times per day (compounded)
  - d. **lidocaine 5% ointment** applied to the introitus in for vestibulodynia pattern, and held in place overnight with a moist cotton ball. UNC researchers recommend the addition of **estradiol** (Estrace) cream to the lidocaine.

Most compounding pharmacies have recipes for these agents.

The definitive therapy for patients with vestibulodynia (AKA vulvar vestibulitis), or pain always strictly limited to the introitus (vestibule), is a **vestibulectomy** by an experienced surgeon. Many find that a vestibulectomy is more successful following pelvic floor physical therapy and oral medication for neuropathic pain.

**Behavioral/cognitive therapy** and psychotherapy have also been reported beneficial in patients with vulvodynia.

**Sex therapy/couple counseling** is often required for patients to become comfortably sexually active.

Logically, after vulvodynia is diagnosed, referral to a pain clinic for management of medications, blocks, etc. should be sufficient. If there is a careful and flexible pain clinic in your area, this is ideal.

Most flares of symptoms are simply flares of vulvodynia, and only require reassurance and sympathy. Empiric treatment of infections allows patients to focus on infection rather than the underlying factors and therapy of vulvodynia. Recurrent or resistant infections should be confirmed on culture.

Although there is no cure for vulvodynia, about 80 percent of women experience marked improvement, so that activities of daily living and sexual activity are comfortable.

We are happy to see patients back in the office for problems or questions, and we are happy to answer questions by phone or email

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