CLINICAL GUIDELINE

Vulval Pain, Gynaecology

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

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Important Note:

The Intranet version of this document is the only version that is maintained.
Any printed copies should therefore be viewed as ‘Uncontrolled’ and as such, may not necessarily contain the latest updates and amendments.

Management of Vulval Pain

There are many causes of vulval pain. Women are often embarassed by their symptoms and suffer for months or years before seeking medical advice. It can lead to difficulties with intercourse and secondary psychosexual problems are not uncommon. A thorough history and appropriate investigations should lead to the correct diagnosis.

Newly updated terminology from 2015 should be used as it reflects more current ideas regarding the causes of persistent vulval pain. It is expected that it will improve clinical care and streamline effective management options (see Appendix 1).

History

It is important to take a complete history covering the following points before any examination is performed.

Nature of pain	site, intensity (Score 0-10), sleep disturbance
Associated factors	burning, itch, discharge
Provocation factors	intercourse, tampon use, soap/shower gels
Relieving factors	including any previous treatments/creams
Medical history	other dermatoses, smear status, allergies, current drug therapy, auto-immune conditions (thyroid disease, vitiligo, diabetes), vulvovaginal infections, previous surgery for prolapse

Examination

Examination should be performed in a position that allows inspection of the vulva and peri-anal area. It should also include examination of groin nodes, other skin lesions, including oral mucosa if Lichen planus is suspected.

Visual inspection	note any areas of altered architecture, ulceration, thickening, skin fissuring, adhesions, hypopigmentation, atrophy, redness, swelling
Swabs	if indicated, to exclude recurrent infections e.g. Candida, herpes, Gp A strep
Cotton bud	light pressure from the tip of this over areas of the vulva may elicit pain
PV	may be required if vaginal pain or pelvic floor dysfunction suspected
Biopsy	if VIN suspected. Discuss with senior colleague first
Blood tests	Determined by other clinical features only e.g. FBC, thyroid function

Typical features of common vulval disorders

VIN – skin thickened/ulcerated, may be itchy and/or sore, whitish warty/scaly looking lesions

Lichen sclerosis – hypopigmentation, fusion of labia. Loss of architecture, narrowing of introitus

Recurrent candida – lichenification and erythema. Itch often a feature but discharge may be absent

Vulvodynia

Vulval unprovoked pain	Vulval provoked pain
• Spontaneous pain • Burning and sore in nature • Itching not usually a feature • Generalized around vulva or localised	• Pain with light touch eg tampon use/intercourse • Usually no symptoms at other times • Generalized around the vulva or localised

Treatment

Specific treatment depends on the diagnosis. All women should be offered the information leaflet on general Care of the Vulva (see Appendix 2).

Lichen Sclerosus – see specific protocol

Recurrent Candida – Consider prophylaxis if more than 4 or more episodes of symptomatic candidiasis in 12 months with lab confirmation on at least 2 occasions. Induction dose fluconazole 150mg on days 1, 4 & 7, followed by 150mg weekly for 6 months.

Vulvovaginal atrophy – see menopause protocol

Vulvodynia

Due to the complex nature of this condition, treatment usually involves multiple modalities and is often better managed with multidisciplinary involvement: gynaecology, physiotherapy, sexual problems (psychosexual) and chronic pain services. The exact treatment plan for each client should be discussed with a senior clinician and the client.

- Local anaesthetic gels. Temporary relief, but can be used on a regular basis, including prior to intercourse e.g. lidocaine 5% ointment, instillagel

- Pain modifying drugs – see Appendix 3 for doses. Include tricyclic anti-depressants (amitriptyline) and anti-convulsants (gabapentin)
- Physiotherapy – this can be helpful in lowering pelvic floor tone. Modalities include biofeedback and trigger point therapy

- Psychosexual counselling – this can be helpful in the management of secondary sexual problems such as vaginismus, reduced libido and arousal disorders. Includes dilator therapy and desensitization

Key Words

Vulval pain, Vulvodynia, Vaginismus

References and links

UK National guideline on the Management of Vulval Conditions. Clinical Effectiveness Group of the British Association of Sexual Health and HIV. Feb 2014 (accessed online April 2017)

Vulval Pain Society https://vulvalpainsociety.org.uk/

British Society for the Study of Vulval Disease www.bssvd.org

International Society for the Study of Vulval Disease www.issvd.org

British Association Sexual Health and HIV www.bashh.org

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Appendix 1

ISSVD nomenclature and classification

Vulval pain caused by a specific disorder	• Infection (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. menopausal vulvovaginal atrophy, lactational amenorrhoea)

Vulvodynia	Vulval pain of at least 3 months duration, without clear identifiable cause, which may have potential associated factors.
	The following are the descriptors:
	• Location
	  ○ Localised (e.g. vestibulodynia, clitorodynia)
	  ○ Generalised
	  ○ Mixed
	• Stimulation
	  ○ Provoked (e.g. insertional, contact)
	  ○ Spontaneous
	  ○ Mixed
	• Onset
	  ○ Primary
	  ○ Secondary
	• Temporal pattern

	○ Intermittent ○ Persistent ○ Constant ○ Immediate ○ Delayed

Appendix 2

General Care of the Vulva

Genital skin has less of a barrier than other skin surfaces and is more liable to irritation. Many products, even so-called 'low-allergy' products can irritate skin. Perfumed products should be avoided. The vulval area only needs washed once a day

Washing

The vulval area only needs washed once a day. Use a small amount of soap substitute as washing with water on its own tends to cause dry skin. Use your hand, avoiding flannels/sponges or over cleaning, as this will irritate. Do not use a vaginal wash as this is unnecessary and may cause irritation.

- Dry the skin very gently with a soft towel (no rubbing) or use a hairdryer on a cool setting
- Do not use soaps, bubble-baths, deodorants or vaginal/baby wipes in or around the vulval area and avoid antiseptics in the bath
- Shower rather than bathe
- When washing your hair, avoid allowing the shampoo from coming in to contact with the vulval area
- Soap substitutes include Emulsifying Ointment, E45, Hydromol, Dermol

Clothing

- Wear loose fitting, non-coloured cotton or silk underwear and change daily. Dark textile days may irritate the skin
- Sleep without underwear
- Wash underwear using non-biological washing detergent and avoid fabric conditioner

Irritants

- Use unscented unbleached tampons, sanitary pads and panty liners. Avoid plastic coated pads
- If passing urine makes your symptoms worse, wash the urine away from the vulval area using warm water whilst on the toilet (e.g. using a jug or plastic water bottle)
- If you suffer from urinary incontinence, please ask your GP to prescribe a barrier ointment or spray to protect your skin
- When swimming or exercising, protect the vulval area with a barrier cream such as emulsifying ointment or hydromol
- Itching can sometimes be prevented or relieved by just holding the area tightly for several minutes.
- Avoid wearing nail varnish on finger nails if you tend to scratch.

- Some over-the-counter products may contain possible irritants e.g. baby/nappy creams, herbal creams and thrush treatments.
- Aim to use ointments rather than creams as they have fewer preservatives

Sex

- If sex is uncomfortable, lubricants such as Sylk (contains kiwi extract) may help
- Oil based products can cause condoms to break
- Difficulties with sexual intercourse are common. Please discuss with your doctor

Emollients

These soothe the skin and will rehydrate (moisturise) dry areas. They are usually fragrance-free and less likely to irritate. Used daily they can help relieve symptoms and protect the skin. They can be kept in the fridge and dabbed on to cool and soothe the skin as often as you like.

Examples include: Hydromol, Emulsifying Ointment, E45, Dermol, Aveeno, Epaderm

Contacts

The Vulval Pain Society https://vulvalpainsociety.org.uk/

Vulval Health Awareness Campaign www.VHAC.org

The National Lichen Sclerosus Support Group www.lichensclerosus.org

Appendix 3

Dosage schedules for Pain Modifying Drugs. See www.paindata.org for further information. This is the GGC website for clinicians and patients

AMITRIPTYLINE

Available tablets: 10mg, 25mg, 50mg

Dose: Start with 10mg every evening, increasing dose in 10mg increments on a weekly basis until either pain is controlled or a maximum dose of 75mg daily

GABAPENTIN

Available tablets: 600mg, 800mg

Available capsules: 100mg, 300mg, 400mg

Dose:	Day 1	300mg
	Day 2	300mg twice a day
	Day 3	300mg three times a day

Then increase in steps of 300mg daily (ie an extra 100mg three times a day) every 2-3 days until pain is controlled or a maximum dose of 3600mg per day.

PREGABALIN

Available capsules: 25mg, 50mg, 75mg, 100mg, 200mg

Dose: 50mg three times a day, increasing after a week to 100mg three times a day and if pain not controlled, increase after a further week to 200mg three times a day.

DULOXETINE

Available capsules: 30mg, 60mg

Dose: 60mg daily, increasing to 60mg twice daily if required