I have no conflicts of interest relating to my presentation or to this program.

VULVAR SIGNS & SYMPTOMS

- Visible Skin Changes
- Skin Biopsy for Dermatopathology
- Evaluating Vulvar Pain
- Patterns of Pain
- ICD-9 Coding: Pain
- Approaches to Therapy
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PRIMARY & SECONDARY LESIONS

- PRIMARY lesions represent the pathophysiology of the disease process
  - papules, plaques, blisters, nodules
- SECONDARY lesions occur from trauma or other alterations to primary lesions
  - scratching (excoriation), erosions, ulcers
- BIOPSY PRIMARY LESIONS FOR DIAGNOSIS

PRIMARY LESIONS: PLAQUES

- Inflamed seborrheic keratosis (benign)
- VIN III
- VIN III, microinvasive
SECONDARY LESIONS: ULCERS

Excoriations, not HSV  Pt-applied  Elderly, c/o itching

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Nothing to see?
Erosions/ulcers secondary to scratching or trauma?

A BIOPSY WON’T HELP
CHOOSING BIOPSY SITES

Thick or raised lesion
• Preferably not due to scratching
• Pigment changes rarely show significant pathology
• Biopsy the thickest part

CHOOSING BIOPSY SITES

Chronic ulcer
• Biopsy the edges where the lesion is spreading
• Sample around the ulcer
• The ulcer base often shows only necrosis

CHOOSING BIOPSY SITES

Erosions and scarring
• Look for a fresh, non-traumatized lesion
• Biopsy NEXT TO a blister – the roof will float away in the fix
• Consider CULTURE for virus or fungus, not just bacteria
PUNCH OR SHAVE?

PUNCH BIOPSY WHEN...
- Depth of lesion is critical (e.g. melanoma)
- A rash is inflammatory
- A nodule is deep or raised

PUNCH OR SHAVE?

SHAVE BIOPSY WHEN...
- A lesion is obviously epithelial (wart, keratosis)
- You suspect non-melanoma skin cancer
- You are taking multiple specimens

HISTOPATHOLOGY
- “Spongiosis” is the histologic equivalent of “dermatitis”
- It can be seen with contact allergy, Candida, eczema or irritation
- Nonspecific findings can raise more questions than answers
DERMATOPATHOLOGY

- A subspecialty of Pathology and Dermatology, very helpful for skin disorders.
- Give the pathologist as much information as you can, including a differential diagnosis.
- Be prepared to deal with the results of your biopsy – refer if necessary.

PUNCH BIOPSY

SHAVE BIOPSY
SHAVE BIOPSY

Speared specimen  Sliding into formalin

NEEDLE SHAVE BIOPSY

Which patient would you biopsy?
1. 
2. 
Which patient would you biopsy?

1. The dark lesion is purpura secondary to topical steroid use.
2. The child has lichen sclerosus. It would not be wrong to biopsy either one, but a dermatologist would be unlikely to biopsy.
SKIN BIOPSY TIPS

1. Have a good indication for biopsy
2. Use adequate local anesthesia
3. Take multiple biopsies of multifocal disease

IF YOU CAN'T SEE ANYTHING, A BIOPSY WON'T HELP

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VULVODYNIA

- Chronic burning, rawness, pain, stinging, soreness (not itching)
- in the absence of explainable causes

Vulvodynia is not a disease, it is a multifactorial symptom
USE A DIAGRAM TO TALK WITH PATIENTS

DURING THE EXAMINATION....

Let the patient hold a MIRROR so you can agree on findings.
REASSURE her about normal anatomy and appearance.

VULVAR PAIN EVALUATION

- CHARACTER of pain:
  * Burning or aching, superficial or deep, constant or intermittent
- Do you have pain in OTHER AREAS?
  * Fibromyalgia, sciatica, arthritis
- What makes it BETTER or WORSE?
  * Relation to position or movement, heat or cold
SECONDARY LESIONS

*Erythema ab igne*
Mottled pigmentation and redness from prolonged use of a heating pad in a patient with chronic vulvar pain

VULVODYNIA QUESTIONNAIRE

- How long do bouts of pain last? Do you have days WITHOUT pain?
- Is DYSPAREUNIA a factor?
  *Do you only have pain with intercourse?*
- Does your pain keep you from activities?
- Are you DEPRESSED? Are you being treated?
  *Bring up counseling early in your evaluation.*

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PATTERNS of DISCOMFORT

- **ITCHING**
  - Inflammatory vulvitis
- **DYSpareunia**
  - Erosive vaginitis
- **PAIN**
  - Localized provoked vulvodynia
  - Generalized unprovoked vulvodynia

IRRITANT/INFLAMMATORY DERMATITIS

- Not a true cause of vulvodynia
- Complaint of immediate stinging with soaps, medications, lotions
- Can occur with overwashing, use of harsh soaps, chapping (hair dryer)
- Rx by controlling what patient uses

PROTECT and HEAL

- Gentle cleaning regimen
  - Baby soap, no washcloths, pat dry
- Bland emollients
  - Aquaphor, Vaseline, Crisco
BURNING with ERYTHEMA

Steroid rebound dermatitis (patient on clobetasol)

Review risks for Candida (asthma pt on steroids)

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CYCLIC DYSPAREUNIA

- Cyclic flares, symptom-free intervals
- Post-coital irritation, swelling, fissures
- Complaint of “sensitivity” to topical creams

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CANDIDA SUPPRESSION REGIMEN

FLUCONAZOLE 150 mg, # 16 total
One p.o. weekly for two months, (8 tabs)
Biweekly for two months, (4 tabs)
One p.o. monthly for 4 months (4 tabs)
Inflammatory vulvitis

Erosive vaginitis

**VISIBLE DISORDERS**

- Patients with erosive vaginitis (LP, DIV) complain of pain and dyspareunia.
- Careful examination should be made for lichen planus; biopsy, if indicated.
- Note that vulvar dermatoses are not typically associated with vulvodynia

**DIV: DESQUAMATIVE INFLAMMATORY VAGINITIS**

- Erosive lichen planus or variant with persistent erosions
- Adhesions more likely with LP
- Treat secondary infection: *Candida, bacteria, trichomonas*
EROSIVE VAGINITIS: LP, DIV

- Steroids are the mainstay of Rx
  - Oral prednisone for short periods
  - Hydrocortisone acetate rectal suppositories at bedtime
  - Desoximetasone cream in vagina 3xwk
- Lichen planus Rx (Derm)
  - Hydroxychloroquine, methotrexate, etanercept, azathioprine

DYS Pareunia

Atrophic or Erosive Vaginitis (visible changes)

Interactive Discomfort (Vulvar Vestibulitis)

Localized Provoked Vulvodynia

Urethral Syndrome, Interstitial Cystitis

Generalized Unprovoked Vulvodynia

VULVAR PAIN SPECTRUM
VULVODYNIA 2012

- Pelvic floor dysfunction triggers neuropathic pain of any of several types
- Psychological dysfunction is often a factor

- Generalized Unprovoked Vulvodynia = neuropathic pain, reflex sympathetic dystrophy, complex regional pain syndrome, dysesthesia, pudendal neuralgia

Which pain pattern is more common in patients over 50?

1.  
2.  

Generalized Unprovoked Vulvodynia
CLC point: Age

VULVODYNIA IN THE OLDER PATIENT

- Neurogenic pain: more common over 50
  - low back pain, sciatica, or fibromyalgia
  - usually worsens from morning to night
  - may be localized to one side
- Rx with oral agents: amitriptyline or desipramine, gabapentin

NEUROGENIC PAIN

Map of hyperesthesia in saddle distribution, typical of generalized unprovoked vulvodynia

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- Burning sensation, dysesthesia: 782.0
- Vulvodynia, unspecified: 625.70
  - Vulvar vestibulitis (localized, provoked): 625.71
- Dyspareunia: 625.0 (psychogenic: 302.76)
- Vaginismus: 625.1
- Pelvic floor muscles
  - Spasm: 728.85 (Weakness 728.87)

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Which of the following oral drug groups is LEAST effective for chronic pain?

1. Tricyclic antidepressants (amitriptyline, desipramine)
2. SSRI antidepressants (fluoxetine)
3. Antiepileptics (gabapentin, carbamazepine)
2. SSRI antidepressants (fluoxetine)

AMITRIPTYLINE/DESIPRAMINE
- Begin at 5-10 mg at bedtime, increase gradually to dose of 100-150 mg (may get results with 50 mg)
- Antihistamine side effects: drowsy, jittery, dry mouth, blurred vision, increased appetite, constipation

284 women on tricyclic medication for vulvodynia were analyzed. 49% of those on medication at followup were improved by at least 50%, as compared to 30% of women who were no longer on medication.


GABAPENTIN
- Begin at 100 mg, increase until either comfortable, side effects unacceptable, or 3600 mg/day in 3-4 divided doses
- Side effects: dizzy, groggy, fuzzy, edematous

64% of 152 generalized vulvodynia patients improved by 80% in a retrospective chart review.

INJECTIONS

- Interferon Alpha out of favor (ineffective)
- Vaginismus: botulinum toxin (Botox) to relax levator ani muscle

*Botulinum Toxin A 20-40 units into levator ani muscle, may include vestibule and/or perineal body*

*Multiple references: check PubMed for latest*

PELVIC FLOOR TENSION MYALGIA

- Typically high resting tension, muscle irritability, decreased strength.
- Surface EMG should show abnormality and can be used to monitor progress with daily exercise
- 80% of patients improve, may take 7-8 months

OTHER MODALITIES

- Biofeedback
- Vaginal dilator therapy
- Electrical stimulation
- Transvaginal myofascial release (light stretch technique)
- Ultrasound
- Oral and/or intravaginal muscle relaxers

VESTIBULECTOMY

- Success rates of 80-85% likely reflect better patient selection and concurrent therapy:
  - Pelvic floor physical therapy, incl biofeedback
  - Psychosexual counseling
  - Botulinum toxin A injections for vaginismus and relaxation of levator ani

REFERRAL and CONSULTATION

PSYCHOLOGICAL COUNSELING and...

GYNECOLOGY

PHYSICAL THERAPY

UROLOGY

NEUROLOGY,
PAIN CLINIC

Localized
Provoked
Vulvodynia

Urethral
Syndrome,
Pelvic Floor
Dystonia

Generalized
Unprovoked
Vulvodynia

RECOMMENDED READING

  www.drdunnmd.com/handouts/Educational/19%20vulvodynia%20guideline.pdf