

## CASE REPORT

### VULVODYNIA... The problem exists here!

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A case of vulvodynia is being reported here. This is a frustrating disorder affecting young women. A 36 years old lady initially being treated non-specifically for vulval pain, dysparunia and vaginal discharge, for several months was investigated in the gynaecology unit of Combined Military Hospital, Rawalpindi. Examination was possible only under anaesthesia and biopsy report confirmed Erosive lichen Planus. After dermatological consultation she responded well to steroids. She was counselled about the risk of recurrence and small risk of malignancy

**Key words:** Vulvodynia, Lichen planus

## INTRODUCTION

The 'dynias' are a group of chronic focal pain syndromes with a predilection for the orocervical and urogenital regions. The dynias are an enigma in terms of aetiology, which is multifactorial, making clinical investigations difficult and often require liaison with other specialities<sup>1</sup>. Vulvodynia is a symptom of chronic, painful vulval discomfort of multicausal origin<sup>2</sup>. The majority of women presenting with vulval symptoms will complain of pruritis, but a significant number will complain of vulval pain, burning or rawness. Other conditions affecting the vulva can also be present with pain, e.g., systemic disorders with vulval manifestations, infections, congenital anomalies, ageing changes, trauma and drug reactions<sup>3</sup>.

Vulvodynia refers to a specific type of vulvar pain characterised by burning, stinging, irritation or rawness. . The onset is generally acute and mostly becomes a chronic problem lasting months to years<sup>4</sup>. Sexual intercourse, tight clothes, and stress are most often cited as aggravating factors<sup>5</sup>. The most recent classification in 1991<sup>6</sup> from the International Society for the study of Vulvar disease lists the subsets of vulvodynia as Vulvar dermatoses( including erosive lichen planus), cyclic vulvodynia, vestibular papillomatosis, vulvar vestibulitis, Essential vulvodynia, and Idiopathic vulvodynia<sup>3</sup>.

Unfortunately there are no simple tests for its diagnosis. Patients are often reluctant to report vulvar pain. Some are embarrassed to reveal their perceived 'sexual dysfunction' caused by dysparunia. Others have been told in the past 'Its all in your head', or 'Its just a yeast infection'<sup>7</sup>. Here a case of vulvodynia is reported with the background knowledge that no study has reported cases of vulvodynia from anywhere in Pakistan.

## CASE REPORT

A 36 years old lady of middle class background, para 7 (lastborn 4 years), educated till higher secondary school reported to us with a history of burning vulvar pain and raw feeling in the area, specially provoked on attempted entry at intercourse for the last two years. For the last six months she was also having excessive nonitchy vaginal discharge. The couple was not sexually active for the last one year and they never used any contraception. There were no systemic complaints. She had been to various gynaecologists and general practitioners and had been advised all diverse range of systemic and topical antibiotics and at the end was offered antituberculous treatment trial. Her vaginal swabs taken consistently did not reveal any pathological organisms, and pap smear could not be taken due to extreme tenderness. She was referred to our hospital for a review.

Her general physical examination including buccal mucosa did not reveal any abnormality. Systemic examination was unremarkable except local vulval examination. Labia majora were healthy. Labia minora were purplish in colour and inflamed. At the posterior fourchette, on the mucocutaneous junction a flat, purplish white papule was seen. Further examination was restricted by tenderness. These findings were confirmed by examination under anaesthesia which further revealed a very friable vagina. Cervix was hypertrophic and inflamed. Vaginal swab, biopsy from suspicious areas including cervix was taken. Vaginal swabs did not reveal any pathological flora and histopathology revealed 'Erosive lichen planus' and nonspecific chronic cervicitis.

The case was discussed with the dermatologist and the patient was put on a combination of topical and systemic steroids to which she responded well. She was counseled that she will not be completely cured of the disease as it can recur, moreover a small percentage risk of malignancy was explained to her.

## DISCUSSION

The first year vulvodynia was recognized as a diagnosis in the medical literature was 1983<sup>8</sup>, however the first indexed use of word was in 1985<sup>9</sup>. Chronic pelvic pain and vulvodynia are frustrating pelvic disorders seen in young adult women. In the medical literature, these two conditions are linked together under the category of 'chronic pelvic pain syndromes'. Underlying pathophysiology is not well understood, and relatively scant research is available on successful treatment options. Patients often seek the help of specialists who provide nonsurgical treatments for incontinence and related pelvic disorders<sup>10</sup>.

A Canadian study that is so far the most reliable study due to its large sample size reported that the average age was 38 years old, 72% reported post secondary education, 54% were nulligravid, and 55% were married. Average duration of symptoms were 38 months. Patients reported dyspareunia (71%), vulval burning (57%) and vulval itching (46%). One-third reported problems with sexual response.

The majority (64%) reported a "history" of yeast infections. Over 64% of the time all therapeutic interventions tried by patients made the vulval symptoms no better or worse.

Approximately 55% reported another chronic health condition. Positive physical findings were often limited to inflammation in the vestibule(25%) and pain on palpation of the posterior vestibule (69%). Patients reported that their vulvodynia limited their physical activities<sup>11</sup>.

The aetiology is mostly unknown however associations have been described with CO<sub>2</sub> laser treatment<sup>12</sup> and HIV virus ( a solitary study)<sup>13</sup>, dermatographism and irritant contact dermatitis<sup>14</sup>. Triggering factors may include infections like chlamydia and human papilloma virus, excess urinary oxalate, hypersensitivity and psychosexual problems. An unusual cause reported is pudendal nerve compression reported by pudendal nerve decompression<sup>15</sup>. It is a consensus that early histological examination of all visible vulvar lesions is necessary to exclude the presence of malignancy<sup>16</sup>.

Physicians should approach management of vulvodynia using a chronic pain model that emphasizes multidisciplinary health care and “improvement” in health, rather than single interventions and cure of disease<sup>11</sup>. Clinical evaluation should stress attention to detailed ‘pain-mapping’ and evaluation of past and present history. The gynaecological evaluation should include an overall patient evaluation, change in posture due to pain and careful examination of the pelvic floor<sup>17</sup>. There is no evidence that women with vulvodynia experience a higher incidence of sexual or physical abuse during childhood<sup>18</sup>.

Complementary evaluations should be used to exclude infections and vulvar dermatitis<sup>19</sup>. Biopsy of any suspicious area is to be taken<sup>4</sup>.

Each different type of vulvodynia requires specific care. In all cases psychosomatic aspect must be considered. Multidisciplinary care may involve the primary care physician, the gynaecologist, the dermatologist, the pain specialist, the psychologist, the psychiatrist, and the physical therapy specialist<sup>19</sup>. Depending on the specific diagnosis the treatment may include fluconazole, calcium citrate, topical corticosteroids, physical therapy with biofeedback, surgery or laser therapy<sup>4</sup>. Approaches mimicking the therapy of other chronic pain syndromes e.g., the use of low dose tricyclic antidepressants have met with some success<sup>20</sup>. Efficacy of systemic antihistaminic treatment has been observed<sup>5</sup>. Safety and efficacy of topical nitroglycerin in the treatment of introital dyspareunia is being reported<sup>21</sup>. Successful response to Gabapentin has been reported<sup>22</sup>.

Several practical treatments, such as dietary interventions, vitamin supplementation, muscle relaxation training , biofeedback therapy, and electrical stimulation are discussed as options in private practice setting<sup>10</sup>. Psychotropic treatment has been defended<sup>23</sup> and refuted<sup>24</sup>. Sex therapists approach the problem with cognitive-behavioral techniques<sup>25</sup>. Other claimed treatment options include Flashlamp-excited dye laser therapy<sup>26</sup>, acupuncture<sup>27</sup>, surface electromyography-assisted pelvic floor muscle rehabilitation<sup>28</sup>. In the developed countries support groups help patients of vulvodynia<sup>29</sup>.

Until now there is no uniformity in terminology and therapeutic approach. There is a serious need for greater understanding of this disorder since evidence suggests that though not life threatening, vulvodynia appears to have a significant impact on the quality of life.

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