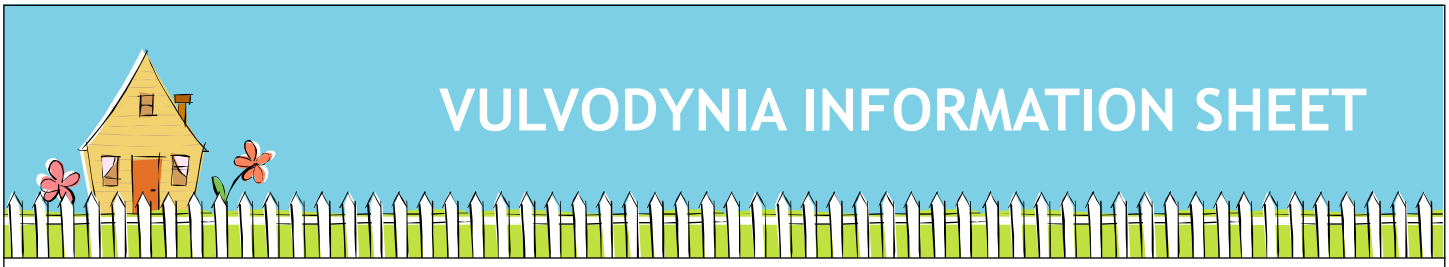


VULVODYNIA INFORMATION SHEET

WHAT IS VULVODYNIA?

Vulvodynia is defined as "vulvar discomfort, most often described as burning pain, occurring in the absence of relevant visible findings or a specific, clinically identifiable, neurologic disorder." Vulvodynia affects an estimated 16% of women in the general population. There are two major types of vulvodynia that are based on pain location. The first is *localized* vulvodynia, in which pain is restricted to a portion of the vulva, such as the vestibule, as in vulvar vestibulitis syndrome (VVS). The second is *generalized* vulvodynia (GVD), in which the pain is more diffuse, involving the whole vulva.

WHAT IS PROVOKED VESTIBULODYNIA?

PVD is the most common cause of dyspareunia (i.e., painful intercourse) in women of child-bearing age. A recent epidemiological study estimated that PVD affects approximately 12% of pre-menopausal women in the general population. Women with PVD report experiencing a highly localized, burning and/or cutting pain at the entrance of the vagina (called the vulvar vestibule) during sexual intercourse, as well as during other activities that involve applying pressure to the vestibule (e.g., tampon insertion, gynecological exams). Although the pain of PVD typically disappears after pressure to the vestibule is removed, many women report lasting pain or discomfort after sexual intercourse or similar activities.

Approximately 50% of women who suffer from PVD have what is called *primary* PVD, indicating that the pain has been present since their first intercourse attempt. The other half has *secondary or acquired* PVD, which develops after a period of pain-free intercourse, and in many cases, after an aggravating factor (e.g., repeated vaginal infections, sexually transmitted diseases). However, little is known about the causes of PVD; most health professionals agree that it is caused by a combination of factors.

How is PVD Treated?

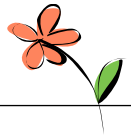
There is scientific evidence that the following treatments are effective for PVD:

- Psychotherapy including a specific focus on pain management and sexuality. This can be done in group, couple, or individual format
- Pelvic floor muscle training/physiotherapy assisted by biofeedback
- Surgical removal of the painful area of the vulvar vestibule (vestibulectomy)

It is generally recommended to begin treatment with either psychotherapy or physiotherapy, or both. Psychotherapy and pelvic floor muscle training via biofeedback are equally successful, with psychotherapy receiving greater rates of satisfaction; both treatments complement each other well. Thirty-five to forty percent of women who followed either of these treatments reported a great decrease in their pain or complete pain relief, as reported in a treatment outcome study published in the journal *Pain* in 2001. As well, another published study indicated that 70% of women who underwent an average of 7 sessions of pelvic floor physiotherapy reported moderate or great improvement in their pain and sexual functioning.

If there is no significant improvement with psychotherapy or physiotherapy, a vestibulectomy may be indicated. This is a relatively minor day procedure carried out under general or spinal anesthesia. Following the operation, women will typically experience some discomfort in the genital region. Neither intercourse nor any other penetrative activity should be attempted for 6-8 weeks post-surgery. Seventy percent of women who underwent this surgery reported a great decrease in their pain or complete pain relief in the treatment outcome study mentioned above.

You may have come across information about other forms of treatment for PVD, such as vaginal creams, diets, and laser surgery. There is no or very little evidence for their effectiveness, and in fact, some of these treatments may have unintended, negative side effects. Reports have suggested that alternative treatments, such as hypnosis, acupuncture and yoga for pain control as well as botox injections have been successful in some women with PVD. However, more research is needed to fully understand the effects of these treatments.



WHAT IS PELVIC-FLOOR PHYSIOTHERAPY?

What are the goals of physiotherapy?

MAIN GOALS:
DECREASE PAIN AND IMPROVE SEXUAL FUNCTION

- ✓ Increase the vaginal opening by progressively stretching the skin and surrounding muscles
- ✓ Reduce pain sensation through desensitization of the vulvar vestibule
- ✓ Increase awareness and control of the pelvic floor muscles (PFMs)
- ✓ Increase relaxation of the PFMs
- ✓ Decrease muscular tension in the PFMs
- ✓ Decrease anxiety related to vaginal penetration activities
- ✓ Provide support and information to you and your partner
- ✓ Help you take control of your condition and your pain
- ✓ Address any additional goals you may have

What are the physiotherapy treatment components?

- ✓ Education (the physiotherapist will give you information on anatomy, recommendations on sexual function, exercises, etc.)
- ✓ Biofeedback (with the use of a vaginal probe, biofeedback will allow you to view your PFM activity on a computer screen)
- ✓ Electro-therapy/Electrical stimulation (light electrical currents will be sent to your PFMs to help you feel what a PFM contraction and relaxation should feel likes)
- ✓ Dilators (4 dilators will be provided for home exercises to allow a progressive stretching of the vaginal opening and the PFMs)
- ✓ Home exercises (you will be expected to perform the dilator and contraction exercises 4 times a week)
- ✓ Manual techniques (the physiotherapist will use her fingers to perform massage techniques, amongst others, in your vagina in order to stretch your PFMs)

Should I avoid penetrative sexual intercourse during physiotherapy?

Yes: During the course of the treatment, it is highly suggested that you avoid sexual intercourse and any sexual activities causing pain or discomfort in order to maximize treatment benefits. The physiotherapist will discuss with you when the best time to re-engage in those activities is based on your progression.

Can I Expect to get better?

So far, studies show a success rate of 50-77% amongst women who undergo physiotherapy treatment (Bergeron et al., 2002; Goldfinger et al., 2009).

What will the physiotherapist do?

The physiotherapist will monitor your home exercises by asking questions such as:

- ✓ *Did you do your exercises? How many times?*
- ✓ *What was your pain intensity when performing the exercises?*
- ✓ *Do you see a change in your symptoms?*

She will also inquire about your psychological and physical status prior to initiating the treatment session.
She will discuss and formulate goals with you for each treatment session based on your progression.

Pre- and Post-Sexual Intercourse Suggestions

- ➢ Use a water-based lubricant that is water-soluble before penetration (e.g., Liquid K-Y®, Astroglide®). If you find that these lubricants irritate you or dry out during intercourse, a pure vegetable oil (such as Crisco®, solid or oil) has no chemicals and is also water-soluble. Please note that Crisco® is not latex-friendly and therefore should not be used in combination with condoms.
- ➢ A topical anesthetic (for example, Xylocaine®) may help before intercourse; discuss this with your doctor and ensure that you know how, where, and when to apply it. It is available over the counter.
- ➢ Apply ice or a frozen blue gel pack wrapped in one layer of a hand towel to relieve burning after intercourse. Other ideas include a bag of frozen peas, or fill a dish-soap bottle with water and freeze it; these fit well against the vulva.
- ➢ Urinate (to prevent infection) and rinse the vulva with cool water after sexual intercourse.

HOW TO GET HELP?

Gynecology: Contact your family doctor for a referral to a local gynecologist

RESOURCES ON THE WEB

www.vulvarhealth.org
www.vulvodynia.com
www.issvd.org
www.nva.org

Sexual Health Research Lab
62 Arch St, Kingston, ON, Canada
Psychology Department, Queen's University
Phone: (613) 533-3276
Email: shrl@queens.ca

We're on the Web! See us at:
http://psyc.queensu.ca/faculty/pukall/sexhealth.htm