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This newsletter is quarterly and contains abstracts from medical journals published between December 2004 and March 2005 (abstracts presented at scientific meetings may also be included). Please direct any comments regarding this newsletter to chris@nva.org.

Vulvodynia / Pain

The vulvodynia guideline.

Haefner, HK, Collins, ME, Davis, GD, Edwards L, Foster DC, Heaton Hartmann E, Kaufman RH, Lynch PJ, Margesson LJ, Moyal-Barracco M, Piper C, Reed BD, Stewart EG and Wilkinson EJ
Journal of Lower Genital Tract Disease, Volume 9, Number 1, 2005, 40-51

Full text article available at:

<http://www.jlgt.com/pt/re/jlgt/webresources.htm?sessionid=CJ54HHRiGE7mWeRvoQvDTC0tsJyTLmvU7gzKWnEQC8H2eVylzjc4!217355589!-949856032!9001!-1>

Subsets of vulvodynia: overlapping characteristics.

Edwards L

J Reprod Med. 2004 Nov;49(11):883-7

OBJECTIVE: To determine the characteristics of vulvar pain as to location and provocation by touch and pressure in order to confirm that current International Society for the Study of Vulvovaginal Disease definitions of vulvar vestibulitis (provoked vestibulodynia) and vulvodynia (generalized vulvodynia) effectively describe and differentiate these 2 subsets. **STUDY DESIGN:** The charts of all women diagnosed with vulvodynia at their initial clinic visit between November 2002 and June 2003 were reviewed for this study. Each patient was evaluated by questionnaire, interview in person and by physical examination to ascertain the location and provoked vs. spontaneous nature of the pain as primary criteria for the differentiation of provoked vestibulodynia from generalized vulvodynia. **RESULTS:** Sixty patients were included in the analysis. Four (6.7%) described provoked pain only in the vestibule (vulvar vestibulitis, provoked vestibulodynia), and 5 women (8.3%) experienced only unprovoked pain that was not confined to the vestibule (dysesthetic vulvodynia, unprovoked generalized vulvodynia). Other patients fell into patterns not specifically recognized or identified by a name. Sixteen (26.7%) experienced both provoked and unprovoked pain always limited to the vestibule, and 21 (35.0%) described provoked and unprovoked pain that extended beyond the vestibule at least occasionally. Six (10.0%) patients described only provoked pain primarily but not limited to the vestibule, and 8 patients each described a unique pattern. **CONCLUSION:** This study suggests that the criteria of location and only provoked vs. only unprovoked pain alone do not describe 2 distinct subsets of vulvodynia; rather, there is overlap in provoked vs. unprovoked pain and location.

Decreased mechanical pain threshold in the vestibular mucosa of women using oral contraceptives: a contributing factor in vulvar vestibulitis?

Bohm-Starke N, Johannesson U, Hilliges M, Rylander E, Torebjork E
J Reprod Med. 2004 Nov;49(11):888-92

OBJECTIVE: To analyze possible differences in somatosensory perception in the vestibular mucosa in healthy women associated with the use of oral contraceptives. **STUDY DESIGN:** Quantitative sensory tests were performed on the vestibular mucosa in 39 healthy women. Twenty women were using oral contraceptives containing 30-40 microg ethinyl estradiol combined with various progestins; 19 women with regular menstrual periods not using oral contraceptives served as controls. The testing included mechanical and heat pain thresholds and detection thresholds of warmth and cold in the anterior and posterior part of the vestibule. **RESULTS:** Significant lower mechanical pain thresholds were observed in both areas tested in women using oral contraceptives. The most sensitive area was the posterior vestibule in the group using oral contraceptives with a mechanical pain threshold of 72 +/- 10 (+/-SEM) mN as compared to 161 +/- 3 mN ($p < 0.01$), in the controls. The result of the thermotest showed no significant differences between the groups. **CONCLUSION:** Oral contraceptives may induce increased sensitivity in the vestibular mucosa in healthy women and might be one contributing factor in the development of vulvar vestibulitis.

Childhood nocturnal enuresis in vulvar vestibulitis syndrome.

Greenstein A, Sarig J, Chen J, Matzkin H, Lessing JB, Abramov L
J Reprod Med. 2005 Jan;50(1):49-52

OBJECTIVE: To define correlations between vulvar vestibulitis syndrome (VVS) and childhood nocturnal enuresis and the effect of biofeedback therapy. **STUDY DESIGN:** Of 104 women diagnosed with VVS, 54 (30 with primary vulvar vestibulitis syndrome [PVVS] and 24 with secondary vulvar vestibulitis syndrome [SVVS], mean age 24.5 years) chose Glazer biofeedback therapy. Information on lower urinary tract symptoms was recorded at the initial and final visits. **RESULTS:** Eight of the 30 women with PVVS (26.6%) had a history of childhood enuresis as compared to none of the women with SVVS ($p < 0.01$). The 8 women developed lower urinary tract symptoms following biofeedback treatment. None of the women with SVVS had urinary symptoms before or following biofeedback therapy. The high, unstable baseline muscle tone revealed by the Glazer technique to be present in all VVS patients underwent substantial reduction and stabilization at the end of biofeedback therapy. **CONCLUSION:** Childhood nocturnal enuresis is apparently common among women with PVVS. New urinary symptoms may develop following biofeedback therapy for PVVS.

Capsaicin and the treatment of vulvar vestibulitis syndrome: a valuable alternative?

Murina F, Radici G, Bianco V
Medscape General Medicine 6(4), 2004
<http://www.medscape.com/viewarticle/493971>

Objective: To assess the efficacy of topical capsaicin in the treatment of vulvar vestibulitis syndrome. **Study Design:** Thirty-three consecutive women referred for vulvar vestibulitis syndrome were treated with topical capsaicin 0.05 %. The capsaicin cream was applied twice a day for 30 days, then once a Day for 30 days, and finally 2 times a week for 4 months. **Results:** In 19 patients (59%), improvement of symptoms was recorded, but no complete remission was observed. Symptoms recurred in all patients after the use of capsaicin cream was discontinued. A return to a twice-weekly topical application of the cream resulted in the improvement of symptoms. Severe burning was reported as the only side effect by all the patients. **Conclusion:** Response to treatment was only partial, possibly due to the concentration of the compound being too low, or to the need for more frequent than daily applications. The therapeutic role of capsaicin should hence be confined to a last-choice medical approach.

Surface electromyography diagnostics in women with partial vaginismus with or without vulvar vestibulitis and in asymptomatic women.

Engman M, Lindehammar H, Wijma B

J Psychosom Obstet Gynaecol. 2004 Sep-Dec;25(3-4):281-94

The aim of this study was to investigate to what extent women with superficial dyspareunia can be diagnosed for both partial vaginismus (PaV) and vulvar vestibulitis (VVS) and to discover to what extent surface electromyography (sEMG) of the pelvic floor muscles (PFM) can distinguish between women with PaV solely, PaV+ VVS, and asymptomatic women. A total of 224 consecutive women with superficial dyspareunia were examined clinically for both PaV and VVS diagnoses. We examined 47 women with PaV+/-VVS and 27 asymptomatic women with sEMG of the PFM. The results showed that 102/224 women with superficial dyspareunia and 33/47 women with PaV in the sEMG part of the study had both PaV and VVS. All women with VVS had vaginismus, while 42/224 had PaV but not VVS. sEMG measurements revealed no significant differences between the three groups of women (PaV solely, PaV + VVS, and asymptomatic). Almost half of the women with superficial dyspareunia referred to our clinic have both the diagnosis PaV and VVS. sEMG was not a method of any value to distinguish between women with PaV solely, PaV + VVS, or asymptomatic women. The increased tone found clinically in the PFM of women with PaV+/-VVS may be of other origin than electrogenic contractions.

The management of vulval pain syndromes.

Innamaa A, Nunns D

Hosp Med. 2005 Jan;66(1):23-6

Vulval problems are common in gynaecological practice. Pain syndromes of the vulva should be considered once infection and dermatological causes of vulval symptoms have been excluded. This article covers vulval vestibulitis and dysaesthetic vulvodinia, the two subgroups of vulval pain syndromes.

Decompression and transposition of the pudendal nerve in pudendal neuralgia: a randomized controlled trial and long-term evaluation.

Robert R, Labat JJ, Bensignor M, Glemain P, Deschamps C, Raoul S, Hamel O

Eur Urol. 2005 Mar;47(3):403-8

BACKGROUND: We assess that pudendal neuralgia is a tunnel syndrome due to a ligamentous entrapment of the pudendal nerve and have treated 400 patients surgically since 1987. We have had no major complication. We conducted a randomized controlled trial to evaluate our procedure. **METHODS::** A sequential, randomized controlled trial to compare decompression of the pudendal nerve with non-surgical treatment. Patients aged 18-70, had chronic, uni/bilateral perineal pain, positive temporary response to blocks at the ischial spine and in Alcock's canal. They were randomly assigned to surgery (n=16) and control (n=16) groups. Primary end point was improvement at 3 months following surgery or assignment to the non-surgery group. Secondary end points were improvement at 12 months and at 4 years following surgical intervention. **RESULTS::** A significantly higher proportion of the surgery group was improved at 3 months. On intention-to-treat analysis 50% of the surgery group reported improvement in pain at 3 months versus 6.2% of the non-surgery group (p=.0155); in the analysis by treatment protocol the figures were 57.1% versus 6.7% (p=.0052). At 12 months, 71.4% of the surgery group compared with 13.3% of the non-surgery group were improved, analyzing by treatment protocol (p=.0025). Only those randomized to surgery were evaluated at 4 years: 8 remained improved at 4 years. No complications were encountered. **CONCLUSIONS::** In this study we demonstrate that decompression of the pudendal nerve is an effective and safe treatment for cases of chronic pudendal neuralgia that have been unresponsive to analgesia and nerve blocks. Following surgery, other medical interventions may be necessary.

Psychological difficulties within a group of patients with vulvodynia.

Wylie K, Hallam-Jones R, Harrington C

J Psychosom Obstet Gynaecol. 2004 Sep-Dec;25(3-4):257-65

This study reviews and reports on some of the psychological difficulties seen in a group of women with vulval pain (vulvodynia). The investigation involved 164 women (82 suffering with Vulvodynia and 82 women in a control group with general dermatology conditions) to establish the prevalence of psychological difficulties using validated questionnaires (SCL-90R and the IBQ) and reports on the possible effect these may have on sexual and relationship function and satisfaction. The level of psychological difficulties revealed significantly higher levels of psychological distress in the vulvodynia group within the domains of somatisation, obsessive-compulsive, depression, anxiety & phobic symptoms as well as with interpersonal sensitivity hostility and paranoia.

Vulvar Dermatoses

Vulvar dermatoses--irritant and allergic contact dermatitis of the vulva.

Bauer A, Rodiger C, Greif C, Kaatz M, Elsner P

Dermatology. 2005;210(2):143-9

Irritant and allergic contact dermatitis are commonly seen in patients complaining about itching, burning and irritation in the vulvar area. Irritation often precedes allergic sensitization. Clinically, irritant and allergic contact dermatitis can be difficult to distinguish. Diagnosis is made by history, clinical investigation and patch testing. Recommended patch test series are the standard series, a medicament series, the patient's own topical medicaments, popular remedies and other suspected products. A skin biopsy may be useful to establish the diagnosis of contact dermatitis, but it is usually not helpful for the differential diagnosis between irritant and allergic dermatitis.

Infectious Disease

Vulvovaginal symptoms in women with bacterial vaginosis.

Klebanoff MA, Schwebke JR, Xhang J, Nanse TR, Yu K, Andrews WW

Obstet Gynecol Surv. 2005 Jan;60(1):26-28

To investigate the symptoms among women with bacterial vaginosis, the authors conducted a longitudinal study comparing symptoms experienced by women with and without a diagnosis of bacterial vaginosis confirmed by Gram stain and Amsel clinical criteria. Subjects were recruited from women making routine healthcare visits to clinics in Birmingham, Alabama. Participating patients were interviewed intensively for information about lower genital tract symptoms, including vaginal wetness, vaginal discharge, vaginal odor, persistent vaginal itch, pain with urination, and abdominal or pelvic pain. All subjects underwent an initial clinical assessment with pelvic examination and lower genital tract microbiologic evaluation, as well as detailed questioning, which included demographic factors, obstetric and gynecologic history, dental symptoms and practices, feminine hygienic and health behaviors, sexual history and practices, history of genital tract infections or sexually transmitted diseases, alcohol and drug use, and psychosocial status. There were 2888 eligible patients who had Gram stain results available. These women were predominantly black, young, parous, unmarried, and of low income. Thirty-seven percent (1063 patients) were positive for bacterial vaginosis by Gram stain. Positivity was more common in black women and women who smoked and increased with decreasing general health status. Women who were married, of higher income, and less than 20 years of age were less likely to have bacterial vaginosis. Few of the total study population reported pelvic or abdominal pain. More women who were positive for bacterial vaginosis reported vaginal wetness and vaginal odor, and more women who were free of bacterial

vaginosis reported dysuria and vaginal irritation. The differences were significant, but the numbers of women in either group who had symptoms were small. The most common symptom was vaginal odor, but only 25% of the patients with and 18% of those without bacterial vaginosis noticed vaginal odor. In all, 58% and 57% of the positive and negative patients, respectively, reported experiencing wetness, discharge, and/or vaginal odor. Among sexually active participants, those who were positive for bacterial vaginosis were more likely to have any odor or fishy odor with sexual intercourse, but less than 20% of either group reported these symptoms. When analyses were performed using Amsel criteria to define bacterial vaginosis, the pattern of reported symptoms was largely unchanged. Participants were asked to describe their usual vaginal odor to clarify their reports of symptoms. No one description was more common than another, but all descriptive terms were more frequent among patients with bacterial vaginosis. The characteristic "fishy" odor was reported by only 6% and 4% of the positive and negative patients, respectively. Thirty-seven percent of the women with no reported symptoms, 26.3% of those with vaginal irritation alone, and 19.4% of those with both irritation and discharge or wetness were positive for bacterial vaginosis. Women who reported vaginal irritation were less likely to have bacterial vaginosis no matter what other symptoms or odor they reported. Vaginal discharge did not indicate the presence of bacterial vaginosis when experienced alone or with other symptoms. Vaginal odor was the only symptom with even a moderate association with bacterial vaginosis. At clinical examination, 35% of patients who reported no discharge, and 49% of those who said they had severe discharge, were described by the examining nurse as having a thin, homogeneous discharge. Similarly, 36% of those reporting no vaginal odor, and 48% of those who felt they had severe vaginal odor, were positive for the "whiff" test.

Basic Science

N/A