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Overnight 5% lidocaine ointment for treatment of vulvar vestibulitis.

Zolnoun DA, Hartmann KE, Steege JF

Obstet Gynecol. 2003 Jul;102(1):84-7

To assess the effectiveness of nightly application of 5% lidocaine ointment for treatment of vulvar vestibulitis. Over 17 months, we assessed women presenting to our pain clinic for evaluation of introital pain; 61 women met the criteria for vulvar vestibulitis and participated in a treatment trial. We measured daily pain and intercourse-related pain using a 100-mm visual analog scale. We compared ability to have intercourse and pain ratings before and after treatment, and investigated whether prior treatment or gynecologic comorbidities predicted response to treatment. After a mean of 7 weeks of nightly treatment, 76% of women reported ability to have intercourse, compared with 36% before treatment ($P = .002$). Intercourse-related pain score was 39.11 (95% confidence interval [CI] 30.39, 47.83) points lower after treatment ($P < .001$), with a decrease of 10.37 (95% CI 3.53, 17.21) points in daily pain score ($P = .004$). We found no association between response to prior episodic use of lidocaine and response to nightly therapy with lidocaine ointment. Few patient characteristics predicted response to treatment; however, women with interstitial cystitis and other vulvar conditions were least likely to benefit. Long-term, nightly application of 5% lidocaine ointment shows promise as a treatment for management of vulvar vestibulitis; a randomized, double-blind, clinical trial is warranted.

Vulvar dysesthesia (vulvodynia). A follow-up study.

Reed BD, Haefner HK, Cantor L

OBJECTIVE: To assess long-term outcome in women treated for vulvar dysesthesia (vulvodynia). **STUDY DESIGN:** Cross-sectional survey via mailed questionnaires of women with vulvar dysesthesia treated at the University of Michigan. Questionnaires addressed symptom characteristics and their predictors, pregnancy response and treatments used. Analysis included t tests, nonparametric tests and multivariate analyses to assess associations between the degree of improvement (in the amount of pain experienced) since diagnosis and potential predictors of that outcome. **RESULTS:** Of 234 questionnaires mailed, 104 were completed. Based on a 7-point pain scale (0-6, with 6 indicating excruciating pain), the level of pain at the time of the survey (1.6 +/- 1.3) was significantly lower than that at the time of diagnosis (4.5 +/- 1.5) ($P < .0001$). Of the 104 women, 56.8% reported > 50% improvement in their pain since diagnosis, and the pain had worsened in 1.9%. Greater improvement was noted with higher pain levels at baseline and with a shorter time since onset. The majority of women who had been pregnant since developing vulvar pain reported improvement (30%) or no change (40%) in symptoms during and after pregnancy. Treatments (nonrandom) rated as most effective included antidepressants (used for pain control) and anticonvulsant medications, biofeedback and counseling. **CONCLUSION:** Most women with vulvar dysesthesia reported markedly less pain at follow-up, although few reported a "cure." Pregnancy was not associated with worsening of vulvar symptoms for most women. Controlled clinical trials will be needed to elucidate treatments that are most effective.

Sexual activities and attitudes of women with vulvar dysesthesia.

Reed BD, Advincula AP, Fonde KR, Gorenflo DW, Haefner HK

Obstet Gynecol. 2003 Aug;102(2):325-31

OBJECTIVE: To assess the relationship between sexual activities and attitudes of women with and without vulvar dysesthesia. **METHODS:** Women with vulvar dysesthesia, 18-60 years old, and ethnically matched women without this disorder were enrolled in this cross-sectional study, completed a 27-page questionnaire, and had a physical examination. We compared sexual activities and attitudes between patients and controls using univariate and multivariable analyses. **RESULTS:** Between January 21, 2001, and December 12, 2002, we enrolled 63 women with vulvar dysesthesia and 62 controls who reported having a current sexual partner. Women with vulvar dysesthesia were less likely than controls to have had, during the previous month, intercourse (66.7% versus 83.9%, $P = .03$) and orgasms (57.6% versus 78.7%, $P = .02$), although the association with intercourse was no longer statistically significant after controlling for age, education, and smoking status ($P = .07$). Of those having had intercourse in the past month, the frequency of this activity was less among patients (3.0 +/- 2.7 versus 6.2 +/- 4.5 episodes, $P < .001$). Frequencies of orgasms, fellatio, cunnilingus, and masturbation did not significantly differ between patients and controls. Patients rated sex less important and rated themselves more negatively as sexual people than did controls ($P < .001$). **CONCLUSION:** Women with vulvar dysesthesia are similar to those without in many

sexual activities but are less likely to have had an orgasm in the past month or to have had intercourse at the same frequency as controls. Although some attitudes were similar, sexual interest and self-concept were decreased among those with this disorder.

Hypnotherapy as a treatment for vulvar vestibulitis syndrome: a case report.

Kandyba K, Binik YM

J Sex Marital Ther. 2003 May-Jun;29(3):237-42

The effectiveness of hypnotherapy in alleviating pain has been demonstrated with several disorders and diseases involving acute and chronic pain. Although hypnosis has been suggested as treatment for dyspareunia resulting from vulvar vestibulitis syndrome (VVS), empirical data and case reports showing its effectiveness have been lacking. This article presents a case report on the use of hypnotherapy to treat a 26-year-old woman suffering from VVS. Psychotherapy consisted of twelve sessions, of which eight were devoted to hypnosis. The goal of hypnosis was to help the client decrease her anticipatory anxiety, create a positive association of pleasure with intercourse, and create a sense of control over her pain. Despite having persistent pain during intercourse for 3 years with several partners, she experienced no more pain following treatment, and remained pain free at a 12-month follow up.

Vulvodynia ... the problem exists here!

Hameed N

J Ayub Med Coll Abbottabad. 2003 Jan-Mar;15(1):58-60

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, dyspareunia 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.

Alferon and vulvar vestibulitis.

Hofmann RG

J Am Med Womens Assoc. 2003 Summer;58(3):131

Chronic Perineal Pain Caused by Pudendal Nerve Entrapment: Anatomy and CT-Guided Perineural Injection Technique.

Hough DM, Wittenberg KH, Pawlina W, Maus TP, King BF, Vrtiska TJ, Farrell MA, Antolak SJ Jr.

AJR Am J Roentgenol. 2003 Aug;181(2):561-567.

Pudendal nerve entrapment as source of intractable perineal pain.

Ramsden CE, McDaniel MC, Harmon RL, Renney KM, Faure A

Am J Phys Med Rehabil. 2003 Jun;82(6):479-84

Perineal pain caused by pudendal nerve entrapment is a rarely reported entity, with only a handful of cases in the modern literature. A 25-yr-old male medical student had refractory unilateral orchialgia for 32 mo and concomitant proctalgia for 14 mo. Pain was positional in nature, exacerbated by sitting and partially relieved when standing or recumbent. Pudendal nerve entrapment was diagnosed clinically, with computed tomography-guided nerve blocks providing temporary relief. A prolonged left pudendal nerve distal motor latency on electrodiagnostic testing later confirmed the diagnosis. At surgery, the left pudendal nerve was found flattened in the pudendal canal of Alcock and in contact with the sharp inferior border of the sacrospinous ligament. After surgical decompression and rehabilitation, the patient experienced significant relief of pain and returned to medical school. This case suggests pudendal nerve entrapment should be considered in the differential diagnosis of chronic urogenital or anorectal pain, particularly if the pain is aggravated by sitting or if there is a history of bicycle riding.

Etiology and diagnosis of coital pain.

Graziottin A

J Endocrinol Invest. 2003;26(3 Suppl):115-21

Coital pain is the leading symptom of two major sexual disorders, dyspareunia and vaginismus. According to the new International Classification on Female Sexual Disorders they are included under the category of "Sexual Pain Disorders". Dyspareunia has long been considered to be psychogenic. On the contrary, it has solid biological bases: location of pain and its characteristics are the strongest predictors of its organicity. Biological factors include hormonal, inflammatory, muscular, iatrogenic, neurologic, vascular, connective and immunitary causes. A specific pathology of pain is in play when the meaning of pain shifts from the "nociceptive" domain, when it signals an ongoing tissue damage, to the "neuropathic" dimension, when pain is generated within the pain system itself, with increased peripheral input and/or lowered central pain threshold, as happens in chronic vulvar vestibulitis. Vaginismus, with its associated defensive contraction of perivaginal muscles when intercourse is attempted, is

credited to be the pelvic expression of a more general muscular defense posture, associated with a variable phobic attitude towards coital intimacy. Vaginismus may prevent intercourse in the most severe degrees, whilst in the milder ones it becomes a cause of dyspareunia. Psychosexual factors--loss of libido and arousal disorders, associated with, or secondary to, sexual pain related disorders--may contribute to the worsening of coital pain over time, alone or when associated to couple problems. The clinical approach should aim at diagnosing biological, psychosexual and context-dependent etiologies. The psychobiology of the experience of sexual pain needs to be addressed in a comprehensive, integrated and patient-centered perspective.

Dyspareunia in gynaecological practice.

Morris E, Mukhophadyay S

Current Obstetrics & Gynaecology, Vol 13, Issue 4, Aug 2003, 232-8

Dyspareunia is a form of sexual dysfunction that can significantly affect quality of life and cause relationship difficulties. It is a symptom of a variety of disease states with components of both physical and organic dysfunction. Obtaining a good sexual history in an outpatient setting requires a high level of professionalism. A systematic examination of the lower genital tract is necessary to rule out any obvious cause, although further investigations such as ultrasound do not often offer additional information. Diagnostic laparoscopy is an invasive procedure that is of limited use in the management of dyspareunia, but may help detect pelvic adhesions or endometriosis in those where this condition is suspected. Before embarking on a laparoscopy, it is important for the patient to be aware of a management plan if the laparoscopy does not show any obvious cause. There are data to suggest that empirical medical treatment after clinical diagnosis of endometriosis is effective and has the advantage of avoiding any invasive procedures. Psychosexual causes are important to consider during assessment of the patient experiencing dyspareunia.

[Article in Swedish]

Danielsson I, Sjoberg I, Stenlund H, Wikman M

Lakartidningen. 2003 Jun 12;100(24):2128-32

Very little is known about the causes of dyspareunia. The aim of this study was to investigate the diagnoses in a non-patient population of women after a short interview and a careful pelvic examination, and to analyze the predictive value of age and different pain characteristics according to Bayesian analysis and Bayes' Theorem. Sixty-four women with severe and prolonged dyspareunia were recruited from the Swedish national screening program for cervical cancer. It was shown that the diagnoses varied with age, and that age and various pain characteristics were very good predictors of the different diagnoses. The study concludes that diagnosing the most common types of severe

dyspareunia is fairly easy and that extensive examinations are not generally required.

An epidemiological survey of vulvovaginal candidiasis in Italy.

Corsello S, Spinillo A, Osnengo G, Penna C, Guaschino S, Beltrame A, Blasi N, Festa A

Eur J Obstet Gynecol Reprod Biol. 2003 Sep 10;110(1):66-72

Eight Italian hospital or University gynecology clinics participated in a prospective survey of patients with culture-confirmed symptomatic vulvovaginal candidiasis (VVC) (October 1999 to March 2001). Of 1138 patients recruited in the study, 931 were evaluable. A recent history of VVC was documented in 43.5% patients (358/823) with a mean number of 2.9+/-2.7 episodes per patient (N=302). A total of 77 patients (10.0%) had a history of recurrent VVC (four and more episodes in a 12-month period). The most frequent associated factors were related to life style: synthetic fabric underwear, vaginal douching and bike, training bike and motorbike (about 1/3 each). Oral contraception was found in 20.8% patients, recent antibiotic use in 15.9% patients, current pregnancy concerned 10.3% patients while 3.4% patients were taking hormonal replacement therapy. Diabetes, corticosteroids or HIV were rarely encountered. Yeast was documented by direct microscopy in 78.3% patients (448/572). A positive culture was obtained in 98.3% patients (909/925). *Candida albicans* was the predominant species (77.1%), followed by *Candida glabrata* (14.6%) and *Candida krusei* (4.0%). With the exception of one center with a lower proportion of *C. albicans*, this latter represented between 75 and 85% of the isolates. Overall, this study confirmed the preponderant role played by *C. albicans* in either sporadic and recurrent VVC.

Quality of life and sexual function after evaluation and treatment at a referral center for vulvovaginal disorders.

Jensen JT, Wilder K, Carr K, Romm J, Hansen A

Am J Obstet Gynecol. 2003 Jun;188(6):1629-35; discussion 1635-7

OBJECTIVES: This study was undertaken to assess sexual function and quality of life of women after evaluation and treatment of vulvovaginal problems at a University Center. **STUDY DESIGN:** Subjects were mailed a cover letter and follow-up survey. All new patients (322) referred for evaluation of vulvar problems at a University Vulvar Specialty Clinic between January 1, 1996, and December 31, 1999, were mailed a survey instrument containing specific questions concerning general, vulvar, and sexual health. Medical records from clinic visits were manually abstracted. Groups defined with descriptive statistics and proportional change in symptoms analyzed with chi(2) statistics. **RESULTS:** Of the 322 women who met the study criteria, 195 returned valid surveys for an overall response rate of 60.5%. The mean duration of follow-up was 28 months. The most common presenting symptoms were vulvar pain (86%), dyspareunia (71%), itching (35%), and skin changes (20%). At follow-up,

128 (66%) reported improvement in symptoms compared with 14 (7%) that worsened ($P < .001$). Although subjects did not report an increase in the frequency of sexual activity, significantly more women reported an increase in enjoyment ($n = 77, 43\%$) of sexual activity than a decrease ($n = 30, 17\%$, $P < .001$). CONCLUSION: Most women presenting for evaluation of vulvar pain will report improvement in symptoms and sexual function after treatment in a Vulvar Specialty Clinic.

Is there a role for the parietal lobes in the perception of pain?

Duncan GH, Albanese MC

Adv Neurol. 2003;93:69-86

Converging lines of evidence confirm a role for the anterior parietal cortex in pain processing and extend the traditional view of SI to include discriminative aspects of somatic stimulation that is potentially tissue-damaging (e.g., painful). Recent studies more specifically implicate SI in the sensory aspect of pain perception by demonstrating that SI activation is modulated by cognitive manipulations that alter perceived pain intensity, but not by manipulations that alter unpleasantness, independent of pain intensity. Nevertheless, despite the probable role of SI in the encoding of the various sensory features of pain, considerable evidence suggests that nociceptive input to SI may also serve to modulate tactile perception. Thus, SI cortex may be involved in both the perception and modulation of both painful and nonpainful somatosensory sensations. Defining a role in pain processing for the parietal operculum is somewhat more problematic. The absence of a fine somatotopic organization of cutaneous (or visceral) receptors virtually eliminates a substantial role for this region in localizing noxious stimuli. Several studies suggest separate representations for pain and touch within the posterior parietal cortex and SII, respectively; however, inter-species differences in cortical anatomy and inconsistencies in the designation of SII proper preclude a clear reconciliation of the data. Likewise, suggestions that SII activation is predominantly related to processing the nociceptive quality of the stimulus (60,61) are inconsistent with many studies in both human and nonhuman subjects, which show a strong functional relationship between SII activity and innocuous (especially, vibrotactile) stimulation. Nevertheless, the numerous studies indicating pain-related activation within the parietal operculum (and/or SII) underscore the potential importance of this region in the perception of pain and the need for continued research. Finally, a possible role of posterior parietal cortex (BA 5/7, 39/40) in orientation and attention toward painful sensory stimuli is consistent with existing literature describing this region as a poly modal association area concerned with intrapersonal and extrapersonal space; however, results from studies that actually manipulate the subjects' level of attention relative to painful stimuli have not uniformly supported this hypothesis (75). Future studies assessing both attentional demand and direct manipulation or motor interactions involving noxious stimuli may help to resolve this issue. In spite of some discrepant results concerning specific details of the nociceptive process, the weight of human pain research now firmly establishes a

role for the parietal lobes in the conscious appreciation of the sensation of pain.

Brain afferents to the lateral caudal ventrolateral medulla: a retrograde and anterograde tracing study in the rat.

Cobos A, Lima D, Almeida A, Tavares I

Neuroscience. 2003;120(2):485-98

The ventrolateral medulla (VLM) modulates autonomic functions, motor reactions and pain responses. The lateralmost part of the caudal VLM (VLMlat) was recently shown to be the VLM area responsible for pain modulation. In the present study, the brain sources of VLMlat afferent fibers were determined by tract-tracing techniques. Following injection of cholera toxin subunit B into the VLMlat, retrogradely labeled neurons in the forebrain occurred at the somatosensory, insular, motor, limbic and infralimbic cortices, and at the central amygdaloid nucleus. Retrogradely labeled neurons in diencephalic regions were observed in the lateral hypothalamus, posterior hypothalamus and paraventricular nucleus. In the brainstem, retrograde labeling occurred at the periaqueductal gray, red nucleus, parabrachial area, nucleus raphe magnus, nucleus tractus solitarii, lateral reticular nucleus and dorsal and ventral medullary reticular formation. In the cerebellum, retrogradely labeled neurons occurred at the lateral nucleus. Following injections of the anterograde tracer biotinylated dextran amine (BDA) into the lateral hypothalamus or paraventricular nucleus, anterogradely labeled fibers were mainly observed in the VLMlat. Injections of BDA into the periaqueductal gray, red nucleus or lateral nucleus of the cerebellum resulted in anterograde labeling in the VLMlat and lateral reticular nucleus. The present study gives an account of the brain regions putatively involved in triggering the modulatory actions elicited from the VLMlat. These include areas committed to somatosensory processing, autonomic control, somatic and visceral motor activity and affective reactions. The findings suggest that the VLMlat may play a major homeostatic role in the integration of nociception with other brain functions.

Positioning women's health curricula in US medical schools.

Sarah Knab Keitt, MPH, Catherine Wagner, BS, Cynthia Tong, BS, Sherry A. Marts, PhD

Medscape General Medicine 5(2), 2003

<http://www.medscape.com/viewarticle/455924>

Purpose: This survey was undertaken to evaluate the status of women's health curricula at US medical schools. Methods: The Society for Women's Health Research surveyed 125 US medical schools to gather information on the existence of and institutional funding and support for women's health curricula. Results: After a minimum of 2 reminder emails, 68 schools returned completed surveys for a positive response rate of 54.4%. Thirty (44%) schools responded that they currently offered a women's health curriculum; 12 (18%) schools stated that they had plans to develop one. Of the 42 schools that either offered a

women's health curriculum or were planning one, two thirds (n = 28) reported having a designated office responsible for overseeing the curriculum; the Associate Dean of Medicine/Associate Dean of the Medical School was most frequently the person responsible for this office. Overall, more than half of the responding schools reported receiving funding for this office either through general medical school funds (15/28) or from a Dean's fund (9/28). Conclusions: Our findings suggest that while US medical schools have made great strides in training medical students in women's health, schools can do more to ensure that women's health has an "academic home" within their institutions. Further, efforts to secure adequate funding and train a cross-section of faculty in women's health should be increased.