Vulvar Vestibulitis Linked to Generalized Pain

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CAMBRIDGE, MASS. — Women with vulvar vestibulitis have more pain-related complaints and lower thresholds for non-genital tactile pain and pressure than women without the condition, a study has shown.

Typically associated with localized vulvar vestibulum pain, vulvar vestibulitis syndrome (VVS) is characterized by entry dyspareunia, discomfort at the opening of the vagina, and severe point tenderness on vestibular touch. The results of this study, however, suggest that it may be inaccurate to define VVS as a highly localized problem with a specific vulvar etiology.

In fact, the condition—which is estimated to affect up to 12% of premenopausal women in the general population—may be indicative of a more generalized sensory abnormality, Caroline F. Pukall, Ph.D., reported at the annual meeting of the Society for Sex Therapy and Research. This research finding could have therapeutic implications for women with VVS who have been referred for psychotherapy, Dr. Pukall said at the meeting, which was also sponsored by the American College of Obstetricians and Gynecologists.

Using a standardized pain sensitivity measure developed for the diagnosis of fibromyalgia, Dr. Pukall and her colleagues in the department of psychology at Queen's University, Kingston, Ont., evaluated the sensitivity to pressure in non-genital areas experienced by women with and without VVS.

Sixteen women with the condition and 16 control participants underwent a physical tender-point examination by an experienced, blinded rheumatologist. The examination included the manual palpation of nine nongenital bilateral body locations, including left and right gluteal, low cervical, and supraspinatus regions. The rheumatologist noted the number of painful tender points and rated pain intensity and unpleasantness on a 0-10 scale.

Variance analyses on the data showed that women with VVS had significantly more painful areas and significantly higher pain intensity and unpleasantness in response to palpation at each area examined, compared with women in the control group, she said.

While there is no “cure” for VVS, therapeutic approaches may include topical medication to suppress pain and/or inflammation, cognitive-behavioral therapy focusing on pain management and coping strategies, and pelvic floor physical therapy to relieve muscle tension, increase muscle strength and voluntary control, and desensitize fears to vulvovaginal touch and penetration, Dr. Pukall said.

She added that by using the proposed definition, clinicians are more apt to focus on efforts to mitigate the patient’s experience of pain, she noted.

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The results of their tender-point examinations suggest that generalized systemic hypersensitivity may be a contributing factor to VVS.

These findings and other recent evidence implicating central and peripheral nervous system processes in the development and maintenance of VVS lend credence to the contention that VVS, which is thought to be the major cause of dyspareunia in premenopausal women, should be considered a pain disorder that interferes with sexuality rather than as a sexual disorder characterized by pain, Dr. Pukall said.

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