



Vulval and Genital Pain

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Trump approach

- + Infections -- kill the bug (after a quick witch hunt) = antibiotics or antivirals
- + Skin – smother it = fungal or steroid creams
- + Muscle spasm – tell them to relax (on twitter and in capitals)
- + Nerve pain – quash it with amitrip or gabapentin



More complex world view

Web of physical, emotional, environmental
and little-understood pain pathways....



How common?

+ Vulval pain:

-- 4-16% of women

-- first described in 1880s

+ Male pelvic pain:

-- 8-10% of men

-- prostate first described in 300 AD; 1500's when first pathology described (Andre du Laurens, French anatomist)



Medical baggage:

- + Historically female pelvic pain often attributed to hysteria
- + For men, often equated with prostatitis or testicular problems

And patients bring their own.....

- + Often wary, frustrated, despondent
- + Have seen several doctors
- + Worried that it may mean something nasty or that they caught something and can pass it on
- + Have trouble describing their symptoms and location
- + Want it cured
- + Often become quite fixated and hypersensitive

Starting point:

- + Focus on the patient, not just the pain
- + Reassure you take their pain seriously
- + Reassure them it can be improved
- + Explain that we are aiming for improvement rather than “cure”
- + Explain that it is often complex and one fix doesn't work for everyone
- + Be positive, supportive and don't give up

Terminology of pelvic pain

+ Women:

Vulval pain rather than vulvodynia,
vestibulitis, vaginismus

+ Male genital pain:

Often described by site: urethral, testicular, prostate, perineal, skin but also overlapping (Upoint system)

A practical approach to genital pain

+ Good hx:

- acute vs chronic
- nature of pain,
- unilateral or bilateral
- triggers.



First things first:



+ Is the examination **abnormal**?

--**infections** (HSV, candida, staph cellulitis, trichomonas, syphilis, scabies)

-- **dermatological** (eczema, trauma, lichen sclerosis, lichen planus, aphthous ulcers, Crohn's, psoriasis)

-- **neoplastic** - pre-malignant or malignant conditions

Not always easy to treat but at least some clear pathways.

If examination is normal:

Then – left with two main groups:

1. Neuropathic but no specific pattern - bilat, cause not understood
2. Referred – from pudendal and genito-femoral nerve compression tight pelvic floor muscles, from lumbar spine or from bowels or bladder

These are the real challenges.....



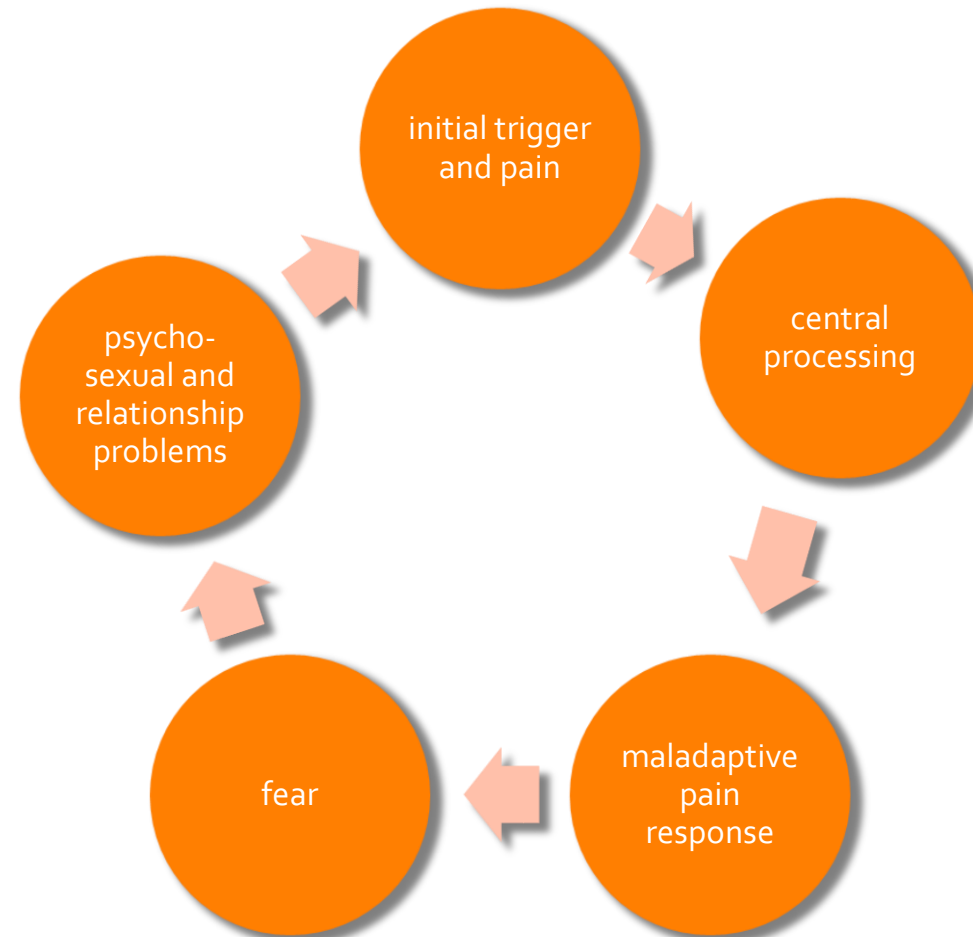
Aetiology of pelvic pain:

- + Altered inflammatory response due to genetics
- + Often alongside other complex pain syndromes (IBS, fibromyalgia, ME)
- + Muscular – eg increased pelvic floor tone
- + Neuro pathways – eg more pain fibres, hypersensitivity
- + Previous past experiences of chronic pain

Pain begets pain

Patient's perception
of what pain means -
above/below the line
view →

Contributors –
depression, other
chronic pain
syndromes →



Start simple:

1. Good genital skin care (no soaps, deodorants, pads, tight underwear jeans, no face clothes, scrubbing or antiseptics)

Basic tenet – wash with water and hands only.

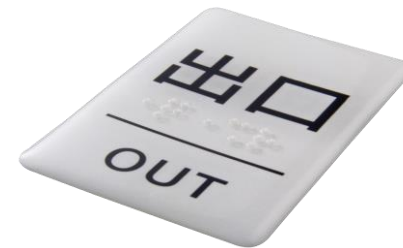
2. Emollients – avoid perfumed ones and most “natural” ones eg pawpaw, aloe vera, tea tree oil etc; use aqueous cream or vaginal thrush creams.

(my favourite: micreme H, 1:3 dilution with vaseline bd x week at a time)

3. Lube ++ always when having sex
4. Course of topical anaesthetic cream (5% lidocaine x 8-12 weeks)- not before sex.

Then move onto:

- + Amitrip low dose (10 -25mg)
- + Gabapentin (100mg at night and increase every 3-4 days)
- + ?Antidepressant
- + Pelvic floor exercises – need to reverse the increased resting tone/poor contraction tone syndrome – do before and after sex and enlist a physiotherapist's help
- + Avoid surgery, Botox, steroid injections etc.



Specific pain syndrome - pudendal nerve pain – “numb nuts syndrome”

- + Men and women = pain in the saddle area
- + Ok on waking, worse as day goes on
- + Better standing or lying, worse sitting
- + Burning, tightening, intensely sensitive to touch
- + May describe it as a itchy, sore anus with normal examination
- + Bilateral or unilateral

Pudendal nerve symptoms:

Sensory, motor or autonomic:

- numbness of testes or perineum
- urinary frequency
- feels like sitting on a golf ball
- buttock pain
- difficulty passing bowel motion
- pain after ejaculation
- pain during sex

Pudendal nerve pain – continued.

- + Triggers: childbirth, biking, trauma, sitting on hard seats, malignancy
- + Caused by pudendal nerve being squashed as it goes through tight places and planes of the pelvis
- + Treatment:
 - remove trigger – no horse or bike riding
 - sit on doughnut cushion and/or standing desk
 - amitrip (or nortrip = less sedating) or gabapentin
 - pelvic floor training - relaxation
 - bowel cares ie stool softeners

Chronic Pelvic Pain Syndrome in Men

+ **Upoint system** – focuses treatment on dominant domain of pain:

U - urinary symptoms

P - psychological

O – organ- specific eg prostate

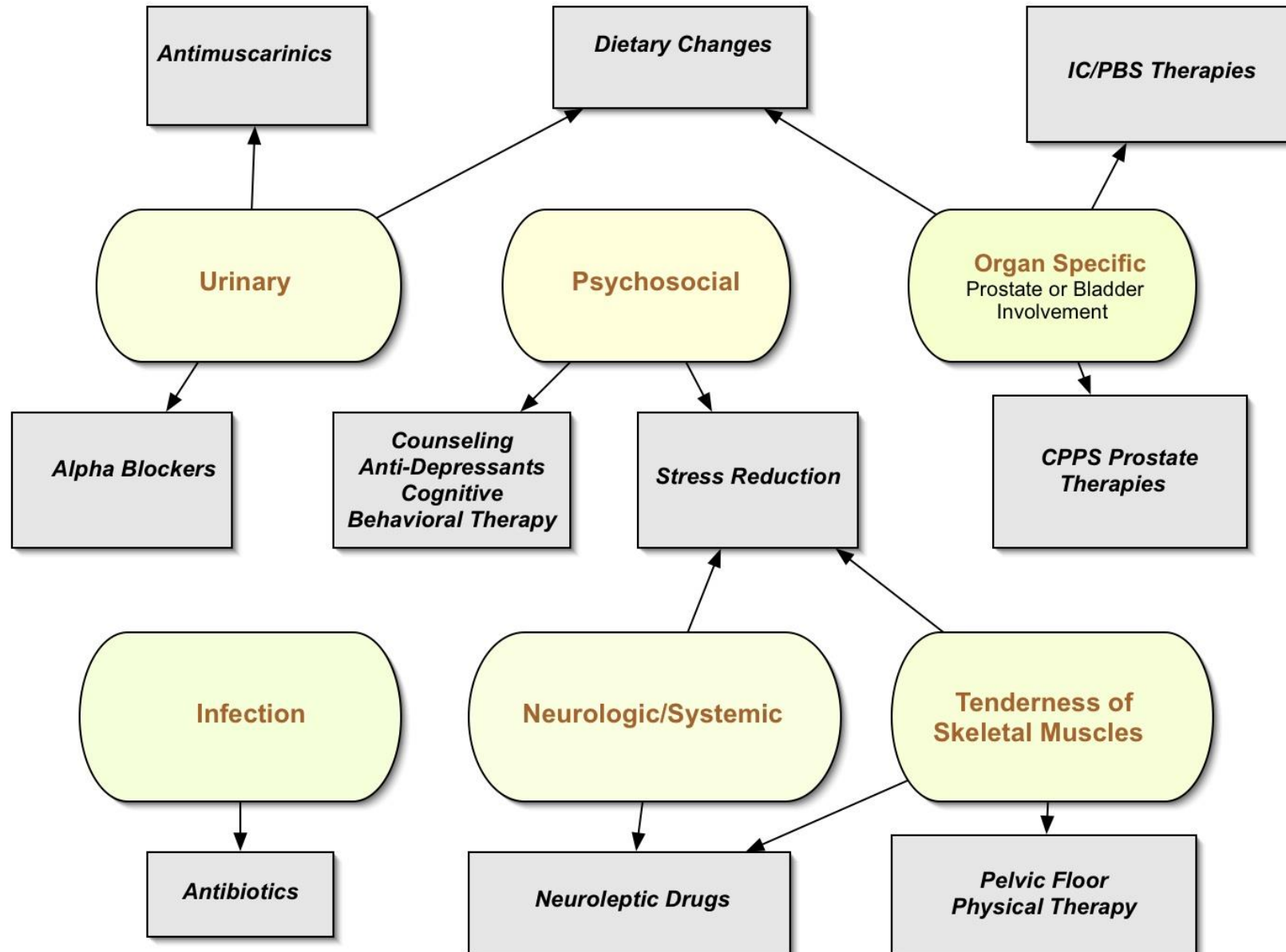
I –infection - related

N – neurological/systemic symptoms

T – tenderness in muscles or pelvic floor

Can be used in females as well:

- + About quarter have pain only in one domain
- + Target treatment- eg:
 - urinary obstruction – alpha blockers to TURP
 - counseling for catastrophising
 - antibiotics for documented infections
 - neuroleptics for neuropathic pain
 - physical therapy for muscle pain



Post infective pain syndrome:

- + Young men
- + Often anxious, inward focused, repeat presentations
- + Have had a documented infection, usually Chlamydia
- + Continue to have symptoms of urethral discomfort (“tingling”) and/or slight urethral discharge for weeks to months afterwards with negative swabs
- + Become quite obsessed with their symptoms

My approach – and not evidence based

- + Reassurance +++ that they are not infective, don't have cancer, will get better
- + Don't fiddle and keep checking for penile discharge
- + Drink more water and less alcohol
- + Course of NSAIDs x 4-6 weeks
- + Last resort: doxycycline 100mg bd x 6 weeks – mostly for its anti-inflammatory effect – explain **NOT** because they are infective
- + Counseling ?? Not often taken up by young men.

When to refer for pelvic pain counseling:

- + Relationship problems
- + Sexual abuse (ACC funds 16 sessions with ACC-accredited counselor)
- + Depression
- + High levels of anger to previous adverse experiences with medical professions
- + Obsession with STIs
- + Patients who lack confidence to do pelvic floor exercises
- + Patients who use their condition to manipulate others

(The Vulva – a Clinician's Practical Handbook. Ed Fischer and Bradford, Family Planning NSW. www.fpnsw.org.au)

Conclusion.

- + Genital and pelvic pain is complex – manage with empathy, common sense and trial and error – no quick fixes and no one approach fits all.
- + Resist referring onto surgical colleagues unless there is a specific procedure you want them to do – otherwise perpetuates the cycle of hopelessness
- + Don't overwhelm the patient but manifest confidence, creative thinking and caring.

People will forget what you said, people will forget what you did, but people will never forget how you made them feel

