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NVA News

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Winter 2001

Surgical Treatment for Vulvar Vestibulitis

By Hope K. Haefner, M.D.

Dr. Haefner is an associate professor at the University of Michigan Hospitals in Ann Arbor, Michigan. She is the director of the University of Michigan Center for Vulvar Diseases.

Vulvar vestibulitis syndrome (VVS) is a subset of vulvodynia that is rapidly gaining public interest. The condition is defined as (a) severe pain upon vestibular touch or attempted vaginal entry, or (b) tenderness to pressure localized within the vulvar vestibule. VVS is often associated with erythema (redness) of varying degrees. Patients frequently report pain or irritation from tampon insertion, sexual intercourse, tight-fitting clothing, prolonged sitting, bicycle riding, and various other activities that involve pressure on the vestibular tissue. Most patients have consulted numerous health care providers and tried multiple treatments for their pain. VVS is often categorized as primary or secondary. Primary VVS is characterized by pain upon first application of pressure to the vestibular area. For example, these patients experienced pain the first time they inserted a tampon or attempted sexual intercourse. Secondary VVS is diagnosed in patients who initially experienced normal sexual function (or vestibular touch) that suddenly became painful. (One comment about terminology is relevant here. The International Society for the Study of Vulvovaginal Disease intends to modify vulvar pain terminology and in its new proposed guidelines, VVS will be classified as "localized vulvar dysesthesia.")

Since there are many different treatment modalities for vulvar vestibulitis, patient education and support are of utmost importance. Vulvar care measures are beneficial to many patients: washing the vulva with water only, sitz baths, loose clothing, 100 percent cotton underwear, and ice packs wrapped in a towel for pain control (no more than 20 minutes at a time). Lubricating agents (Astroglide, Replens) and topical anesthetics such as 5 percent Lidocaine are beneficial to some patients. If the patient suffers from severe or recurrent yeast infections, long-term oral antifungal medication may also be helpful. Sexual counseling is frequently necessary.

See SURGICAL TREATMENT, page 4

Sex Differences in Chronic Pain

Would it surprise you to know that women are more likely to suffer from chronic pain than men? Some conditions that cause chronic pain such as headaches and fibromyalgia are more common in women. Furthermore, women respond differently than men to pain and pain medications. Experts say that women with chronic pain are also more likely to be under-diagnosed, under-treated, and under-medicated.

The effects of pain on a woman's life can be profound. "Chronic pain increases stress to all the major organ systems," says James N. Campbell, MD, professor of neurosurgery at John Hopkins University. "There are also psychological consequences of unrelieved pain. These include depression, insomnia, problems with concentration, increased anxiety and fatigue, reduced appetite, impaired personal relations and reduced activity levels that lead to muscle atrophy."

But it doesn't have to be that way. Emerging knowledge about biological sex differences in treatments can work to your advantage and help you control and possibly conquer chronic pain.

See CHRONIC PAIN, page 3

Frequently Asked Questions About Vulvodynia

By Phyllis Mate, Executive Director of the NVA

For many years I was the only one who answered the NVA phone, so I've spoken to thousands of women, many of whom shared similar concerns and asked the same questions. I have a master's degree in clinical psychology, but am not a medical professional. My "expertise" comes from seven years of working for the NVA, reading medical journal articles, and having extensive discussions with members of the NVA's medical advisory board, including Drs. Stanley Marinoff, David Foster, Ursula Wesselmann, Howard Glazer and Justin Wasserman.

Am I going to have this forever?
That's the hardest question to answer. For some women the condition is chronic and will last years, or possibly "forever." For others, especially those diagnosed with Vulvar Vestibulitis Syndrome, there are many success stories. But for both groups it can be a long road from symptom discovery to diagnosis to effective treatment. One of the greatest challenges for women in the earliest stages is coping with the possibility that they may have a chronic condition. Since most women have never heard of vulvodynia before being diagnosed, it's not the same as discovering you have breast cancer or heart disease. With those catastrophic illnesses, you have some idea of what to expect. A diagnosis of vulvodynia initially causes both bewilderment and anxiety.

My doctor thinks I may have vulvodynia, but isn't sure. How is it diagnosed?
Before a diagnosis of vulvodynia is made, sexually transmitted diseases, bacterial or yeast infections, and dermatological diseases must be ruled out. If a patient is diagnosed with another disorder, it should be thoroughly treated first. There is no definitive test for vulvodynia. If symptoms persist after other conditions are eliminated, a diagnosis of vulvodynia is considered. Confirming the diagnosis may be complicated by the possibility that the patient has another concurrent condition such as a bacterial infection.

I've just been diagnosed with vulvodynia. What is the best treatment?
There is no "best treatment" for vulvodynia, so it's important to inform yourself about all treatment options and discuss them with your gynecologist, dermatologist or pain specialist. In addition to educating yourself by reading medical journal articles and back issues of the *NVA News*, find a medical professional who is knowledgeable about vulvodynia. It's also important to accept that there is no quick fix for this condition. Many patients try several treatment modalities and discover that a combination of measures works best.

I have vulvodynia and haven't had sexual relations with my husband for months. Will I ever be able to have sexual intercourse again?
The goal of treatment is two-fold: to relieve pain and to enable the patient to resume pleasurable sexual relations. Vulvodynia symptoms range from mild to severe. In mild cases, sexual relations may only be slightly affected. In moderate to severe cases, sexual intercourse is difficult, if not impossible. Patients should speak to their gynecologists about measures that can make sexual intercourse comfortable. Some couples find sex therapy helpful because it teaches and encourages them to engage in forms of physical and sexual intimacy that are not painful for women with vulvodynia. As treatment progresses and symptoms dissipate, gradual resumption of sexual intercourse may be attempted.

I can't take antidepressants. My doctor prescribed Elavil (amitriptyline), but I stopped it after a week because I couldn't stay awake. What else can I do?
Call your doctor! When this happens it doesn't necessarily mean you can't tolerate antidepressants. Maybe you need to start at a lower dosage or raise the dosage more slowly. If your problem is waking up in the morning, doctors recommend taking the medication in the early evening instead of at bedtime. Alternately, there are many other antidepressants (and anticonvulsants), which have milder side effects than Elavil. Sometimes you have to try three or four medications (or a combination) before you find the regimen that works best for you and has manageable side effects.

I've been following my doctor's instructions for a month and my vulvodynia is getting worse. What should I do?
Once again, call your doctor! So many patients hesitate to tell their

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Chronic Pain

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Feeling the Pain

A recent Gallup survey found that 46 percent of women report daily pain compared with 37 percent of men.

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Two to three times more women as men experience migraine headaches, nine times more women suffer from fibromyalgia, and more women than men report jaw pain and other symptoms of temporomandibular joint disorders (TMJ). Women are also more likely to have nerve pain, thoracic outlet syndrome (pain in the neck, upper back, and shoulders), irritable bowel syndrome, rheumatoid arthritis, and systemic lupus erythematosus.

"The more pain amplification people have, the more likely they are to have pain even in the absence of painful stimuli, joint damage, or inflammatory syndromes such as lupus or rheumatoid arthritis. Pain symptoms tend to cluster. So it's much more likely for someone who has chronic pain to have irritable bowel or chronic fatigue," Dr. Clauw told the 9th Annual Congress on Women's Health and Gender-Based Medicine in June 2001.

Women with chronic pain are also more likely to be under-diagnosed, under-treated, and under-medicated.

Then there are female-specific problems such as chronic pelvic pain, premenstrual syndrome, endometriosis, and breast cancer-related pain.

Some studies show that women may be more sensitive to pain. This sex difference is demonstrated in patients with osteoarthritic conditions. While almost everyone develops some degree of cartilage degeneration as they age, women seem to be more symptomatic than men, remarked Daniel Clauw, MD, scientific director of the Chronic Pain and Fatigue Research Center at Georgetown University. "There's actually a wide gap between women and men in terms of how much hip or knee damage is seen on radiographic or MRI studies, and how much pain people are experiencing." Psychological differences were once thought to be largely responsible (e.g., men conditioned to be stoic), but recent studies show physiologic pain "amplification" is greater in women.

Hormonal effects

Sex hormones may play a role in pain amplification. Studies in rats showed that females are more vulnerable to nerve pain than males. "We found that when we removed sex hormones in rats, both male and female rats responded the same way to painful stimuli. However, testosterone seems to be protective against pain. Castrated male rats showed more reaction to painful stimuli than did non-castrated male rats," Serge Marchard, Ph.D., a pain researcher at the University of Quebec reported at the 2001 Scientific Meeting of the American Pain Society.

Some studies suggest that younger women have less pain during the follicular phase of the menstrual cycle, and have lower pain thresholds in the luteal phase. The effects

See CHRONIC PAIN, page 10

Surgical Treatment

(from page 1)

Teatments for vulvar vestibulitis include biofeedback, physical therapy, a low-oxalate diet and calcium citrate supplementation, and medical pain management with tricyclic antidepressants (e.g., amitriptyline), or anticonvulsants (e.g, Neurontin). Local injections of interferon have also been used with variable results. Surgical treatment for VVS should only be considered if non-surgical treatment measures have not provided adequate relief.

Vulvar Anatomy

To appreciate the likelihood of positive results with vulvar surgery, it is important to understand nerve fiber anatomy. In 1958, Krantz described the nerve supply of the human vulva and vagina. The vulvar vestibule is richly supplied with nerve fibers in comparison to the vagina, which has fewer nerve endings. A recent study by Nina Bohm-Starke and her colleagues found a higher nerve fiber density in specimens from patients undergoing surgery for VVS than in control specimens. This higher density of nerve fibers in the vestibule may provide an explanation of the pain in VVS.

To make the diagnosis of VVS, knowledge of vulvar anatomy is imperative. The vestibule is the tissue between the hymen (at vaginal opening) and Hart's line (innermost part of labia minora) and extends from the frenulum of the clitoris (directly beneath clitoris) to the fourchette (directly above the perineum) (*see* Diagram 1). Vulvar vestibulitis is diagnosed by a simple procedure known as the Q-tip test. Envisioning the vestibule as a clock, pressure is applied with a Q-tip at the 2, 4, 6, 8, and 10 o'clock positions. It is helpful for the patient to quantify the pain at each site as mild, moderate or severe. Other areas of the vulva such as the labia minora and labia majora are also tested for pain. If pain is reported exclusively within the vestibule, the diagnosis is vulvar vestibulitis. An accurate diagnosis of VVS is essential before surgery should be considered. Women who experience constant vulvar pain and are diagnosed with dysesthetic vulvodynia, i.e., generalized vulvar dysesthesia, are <u>not</u> appropriate candidates for vestibular surgery.

Outcome studies

Surgical outcome studies published in medical journals report that approximately 60 percent to 100 percent of patients who undergo surgery for the treatment of VVS benefit from this therapeutic form. There are many reasons for the wide distribution of reported success rates in the literature. First, the number of patients included in these studies range dramatically; some studies use a sample size of less than 10 while others are based on 100 patients. Additionally, the outcome criterion varies from one study to another. In some studies, "success" is defined as the patient's ability to resume full sexual function, while in others "success" is simply the absence of pain during a Q-tip test.

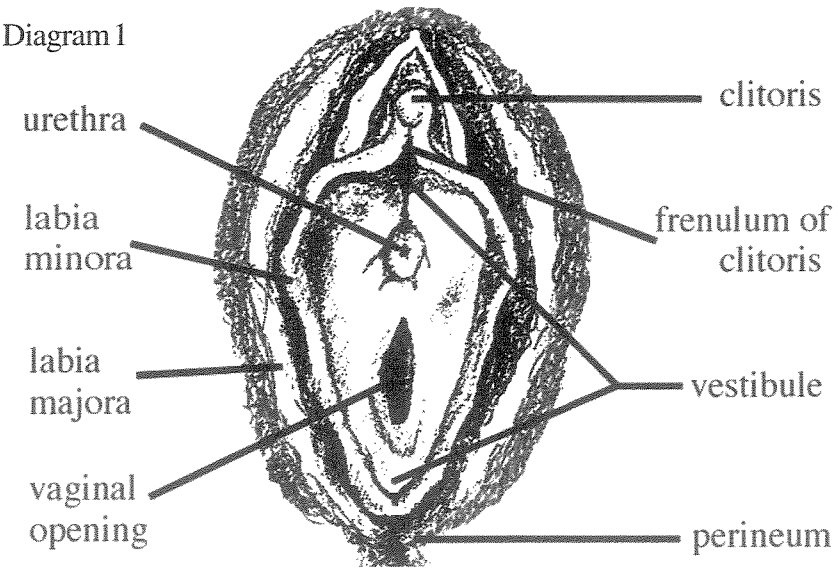
Furthermore, it is difficult to compare surgery results because researchers perform different surgical procedures and use follow-up periods of varying lengths to assess outcome. In general, follow-up periods tend to be short-term, and in some studies they are non-existent. Although the literature is not altogether consistent, it is clear that surgical treatment provides relief for a substantial number of VVS patients who have not benefited from more conservative therapies.

Surgical Procedures

The most common form of surgery for VVS is the vestibulectomy, a procedure in which vestibular tissue

See SURGICAL TREATMENT, page 5

Diagram 1



Surgical Treatment

(from page 4)

is removed and vaginal tissue is advanced to cover the area. A less extensive version is the "modified vestibulectomy," in which the incision is limited to halfway up the vestibule (3 to 9 o'clock position). Before a patient is given anesthesia in the operating room, it is very important to determine the painful areas of the vestibule using the Q-tip test. The surgeon uses a permanent marker to outline the area to be removed. Anesthesia is given and the tissue is prepped for surgery. The outlined tissue is excised and then a portion of vaginal tissue is dissected from underlying tissue. This dissected vaginal tissue is pulled down to cover the vestibular tissue that has been removed and the area is sutured (see diagrams 2 thru 5).

The excision of painful vestibular tissue is not generally a difficult surgery. The surgical procedure may be limited or extensive depending upon the patient's symptoms. If pain is highly localized, a specific area of the vestibule may be excised without vaginal advancement (vestibuloplasty). In some cases, the pain is extensive and portions of the perineum are excised in addition to the vestibule (perineoplasty). Clearly, the purpose of any vestibular operation is to relieve pain and should be as limited as possible. Both extensive and limited types of surgery have been shown to relieve painful intercourse associated with VVS.

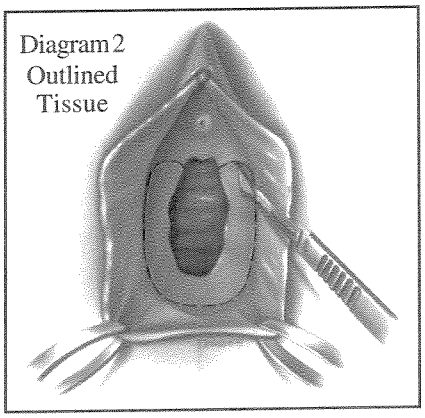
Surgical Concerns and Post-operative Care

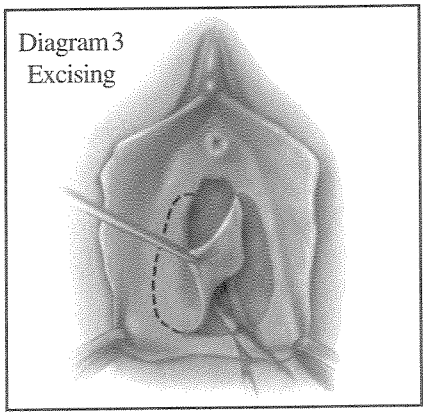
Vestibulectomy is typically performed as outpatient surgery under general anesthesia. Following surgery, ice packs are used to relieve immediate discomfort. Sitz baths, used one to three times a day, help ease discomfort starting 24 hours after surgery. Oral narcotics and non-steroidal anti-inflammatory medication are prescribed for pain management. It is important to educate the patient undergoing vestibulectomy about the need for vulvar exercises, relaxation techniques, and possibly vaginal dilators following the surgical procedure. Healing of the surgical site typically takes up to eight weeks. Patients usually are able to resume daily activities such as light household chores one week after surgery and most are able to return to work by the third week. After the doctor has checked the incision site and six to eight weeks have passed, patients are instructed to gradually resume sexual intercourse (*see page 6 for Dr. Plaut's article on sexual therapy following vestibular surgery).*

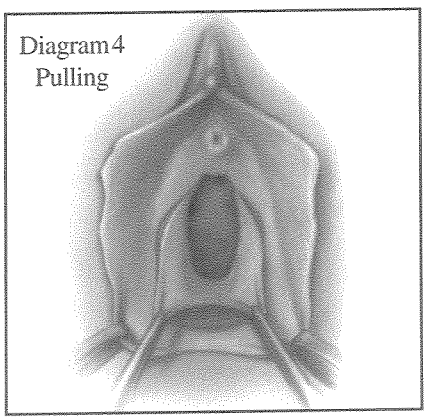
Complications following surgery for VVS may occur, but are rarely life-threatening. Possible complications include bleeding, infection, hematoma, partial or complete wound separation, Bartholin duct cyst formation, uneven healing requiring further surgery, vaginismus (spasm of the musculature surrounding the vagina) and vaginal stenosis (narrowing of the vagina).

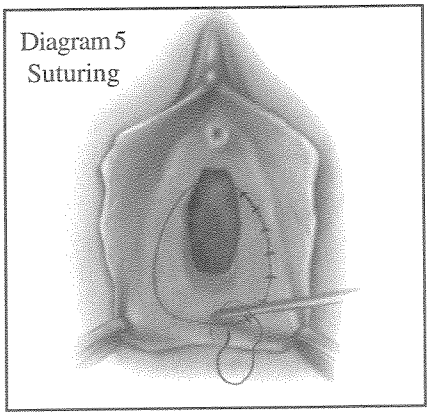
In some cases, the pain may persist or even worsen after surgical treatment. Bornstein and his colleagues analyzed possible factors associated with failure of perineoplasty. Ac-

See SURGICAL TREATMENT, page 7









Re-establishing Sexual Relations After Surgery

By Michael Plaut, Ph.D.

Dr. Plaut is an associate professor of psychiatry at the University of Maryland School of Medicine and editor of the Journal of Sex Education and Therapy.

Surgery for vulvar vestibulitis syndrome has often proven successful, but surgery alone may not be enough to enable the woman to engage immediately in a satisfying sexual relationship. Even if the pain has been totally eliminated by surgery, the "pain memory" remains and may lead the woman to anticipate pain at the thought of anything approaching the vaginal opening, whether it be a penis, tampon, or speculum. This anticipation is often manifested as a condition called vaginismus, an involuntary constriction of the vaginal muscles, which is the brain's way of protecting the body from anticipated pain.

Vaginismus itself may make intercourse difficult, painful, or even impossible. However, it can usually be alleviated with certain behavioral techniques, including Kegel exercises and graduated vaginal dilators. Dilators are latex cylinders that are rounded on one end and have a flange on the other, and usually come in sets of four or more. The woman is instructed to insert these at home, in a certain order, using a lubricant in conjunction with relaxation exercises. This process typically takes a few weeks with the guidance of a trained health professional such as a sex therapist, gynecologist, or physical therapist. Once the woman becomes comfortable inserting the dilators herself, she asks her partner to insert them under her direct guidance. After this goal is accomplished, the woman is usually ready to attempt penile penetration in graded steps.

Even if the woman does not experience vaginismus, she or her partner may be apprehensive about resuming sexual activity for other reasons. There may be problems in the relationship that led the woman to avoid sex even under pain-free circumstances. Factors such as lack of lubrication, diminished interest in sex, or difficulty reaching orgasm may affect the woman or her partner. A qualified sex therapist, often working in conjunction with either a gynecologist or physical therapist, may be of great assistance in helping the woman and her partner address such concerns.

What is a sex therapist? A sex therapist is a licensed health professional, i.e., a nurse, physician, psychologist, or social worker, who has received additional, specialized training in the evaluation and treatment of sexual problems. The therapist typically works with both members of the couple, but in some circumstances, may work with the woman alone. The therapist's first priority is to help the patient talk comfortably about her sexual situation and goals. It is not the therapist's role to set sexual standards for the couple, but to help them achieve their own goals in their relationship.

Once the therapist has evaluated the couple's concerns and taken an appropriate history, he/she may recommend reading, videos, or exercises for the couple to do in the privacy of their own home. The couple typically meets with the therapist for an hour once a week until their issues have been resolved. These therapy sessions are usually covered by health insurance, but this should be confirmed with the insurer before therapy begins.

If the woman's physician cannot recommend a qualified sex therapist in the area, one can be found by contacting a local medical school or by checking with professional societies such as The Society for Sex Therapy and Research (www.sstarnet.org) and the American Association of Sex Educators, Counselors and Therapists (www.aasect.org). Closed consumer chat rooms, such as the vaginismus chat room on www.yahoo.com, may also be good referral sources.

Sex therapy tends to be highly successful in most cases, and has tangible results compared to many other forms of psychotherapy. Although pregnancy may or may not be among a woman's goals in treatment, it is always rewarding for the therapist to receive a birth announcement from the couple some months after therapy has terminated! ■

Thank You

The NVA expresses its appreciation to Lee Jones, president of Inlet Medical Inc. (www.inletmedical.com) for supporting our electronic newsletter research updates for medical professionals.

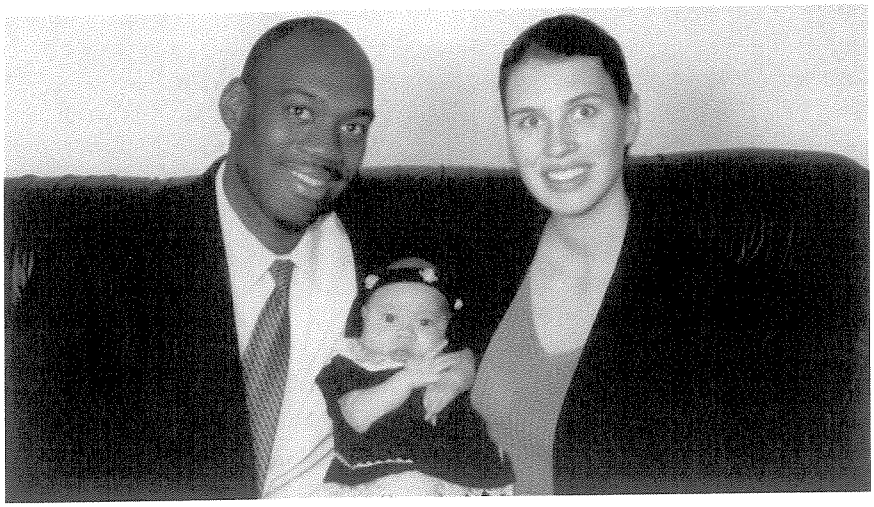
A Personal Perspective on Surgery

By Christin Veasley

I was diagnosed with Vulvar Vestibulitis Syndrome during my freshman year in college. For seven years, I tried to relieve my symptoms with multiple therapies including tricyclic antidepressant medication, topical anesthetics, physical therapy, diet modification (low oxalate diet and calcium citrate supplementation) and biofeedback. Unfortunately, my condition was severe and these treatments only provided minimal relief. Last year, I was faced with choosing between interferon injections (the only treatment I had not tried) or surgery. After discussing these options with my physician, I elected to have a vestibulectomy (surgical removal of the vestibule). I will never know whether or not interferon injection therapy would have worked for me, because I opted for the surgery based on its higher success rate.

My vestibulectomy was performed in September 2000. Although I had a minor complication that prolonged recovery, the surgery was a success. I went back to work two weeks afterwards and was gradually able to resume normal activities, including my exercise routine and sitting throughout the workday. After the stitches dissolved and the tissue healed, my doctor suggested vaginal dilation therapy and seeing a sex therapist with my husband. After a seven-year disruption in my intimate life, it was essential that I confront issues that resulted from having VVS. Even though the surgery was successful, my brain still remembered "pain" with sexual intercourse. As wonderful and loving as my husband had always been, this was something we needed to work through as a couple.

After a few months of using dilators, I was able to attempt intercourse for the first time in seven years. My pain had decreased about 80 percent after the surgery, but was not completely resolved. I'm happy to say that my daughter Grace was conceived one month later and was born in September 2001, a healthy seven-and-a-half pounds. After healing from the vaginal delivery, I received a second, unexpected gift ... the complete resolution of my symptoms. ■



Christin with husband, Melvin, and three-month-old Grace.

Surgical Treatment

(from page 5)

cording to this study, two factors associated with unfavorable surgical outcome are vestibular pain the first time a woman has sexual intercourse and constant, pre-operative vulvar pain (in addition to pure VVS symptoms).

Conclusion

Surgery is a recognized and often successful treatment for Vulvar Vestibulitis Syndrome. Patient selection is of utmost importance; each patient with vestibular pain is unique and treatment should be individualized. Surgical treatment should be reserved as a last resort after conservative treatment measures have failed. It is important to continue with long-term, conscientious follow-up of these patients to assess their outcomes.

Adapted (with permission) from: Haefner, HK. Critique of new gynecologic surgical procedures. *Clin Obstet Gynecol* 2000 Sep;43(3): 689-700 (Lippincott, Williams and Wilkins c. 2000)

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Krantz, K.E., Innervation of the human vulva and vagina. *Obstet Gynecol.* 12 (1958) 382-396. ■

BOOK REVIEW

The Camera My Mother Gave Me

By Susanna Kaysen. New York: Alfred Knopf, 2001.

It's unusual to encounter an entire book devoted to chronic vulvar pain, but that is the subject of Susanna Kaysen's recently released memoir, *The Camera My Mother Gave Me.* Kaysen, author of the best-selling memoir *Girl Interrupted* characterizes her ordeal as follows: "That's how it is. It isn't cancer. It isn't diabetes. It isn't life-threatening. It's just horrible." This highly personal account provides a detailed description of her exasperating experience seeking relief from a condition that no one in the medical profession understands.

The book recounts three years in Kaysen's late forties. Twenty years earlier she underwent a procedure to remove a cyst from one of her Bartholin glands. Subsequently, she enjoyed an active sex life, until she suddenly found herself suffering from unrelenting vulvar pain, eventually diagnosed as vulvar vestibulitis syndrome. The painful sensations were impossible to ignore. The misery varied from just "awful", while driving or wearing pants, to "excruciating," following attempts at sexual intercourse. Although the cyst removal was a suspected contributing factor, no one knew the precise cause, and even more disturbing, none of the recommended treatments provided relief.

Some parts of Kaysen's story will be very familiar to women who suffer from chronic vulvar pain or other physical disorders that are difficult to diagnose and treat. The narrative details numerous interactions with health care providers from a variety of specialties, including gynecology, internal medicine, and alternative medicine. Every practitioner recommends a different therapy, the majority of which her body can't tolerate or make her pain worse. She fails to find relief from Estrogen cream, novocaine, cortisone, or boric acid baths. She is treated for yeast infections and the adverse effects of treating yeast infections. She tries an antidepressant, pelvic floor muscle rehabilitation and biofeedback. One specialist recommends surgery but she decides against it.

The memoir also reveals Kaysen's concerns about her fading sexuality as well as graphic details of her sex life with an insensitive, live-in boyfriend who is less than understanding about her physical inability to engage in sexual activity. Eventually, much to the reader's relief, she terminates the relationship.

Kaysen's style is to use humor and sarcasm rather than engage in self-pity, but she does succeed in portraying the endless frustration of suffering from a condition that has no cure. Do not expect to find any answers here. Kaysen is critical of all treatments and resources available to her and has even characterized *The Camera My Mother Gave Me* as an "anti-self-help" book. Perhaps the book's greatest benefit is simply that it is the first of its kind. Following on the heels of Eve Ensler's "Vagina Monologues," it may help to bring this previously "taboo" subject into the open. That alone would be quite an accomplishment.

(Editor's Note: To purchase this book, please log on to www.nva.org and click on the 'Amazon' logo. A small percentage of the purchase price will be contributed to the NVA.) ■

Treatment of Complicated Candida Vaginitis

A recent multicenter, randomized double-blind study by Jack Sobel, M.D., Division of Infectious Diseases, Harper Hospital, Detroit, Michigan, found that women with severe Candida vaginitis require longer-duration antifungal therapy to achieve clinical cure. In Sobel's study, the effect of a single dose of 150 mg fluconazole (Diflucan) was compared with two sequential 150-mg doses of fluconazole administered three days apart. The two-dose regimen achieved significantly higher clinical cure on both days 14 and 35. The fluconazole therapy was well tolerated and did not cause serious adverse effects. Dr. Sobel's conclusion is that treatment of Candida vaginitis requires individualization and that a two-dose fluconazole regimen achieves superior results in complicated cases.

Sobel, Jack. Treatment of complicated Candida vaginitis: Comparison of single and sequential doses of fluconazole. *Am J Obstet Gynecol*, Vol 185, 363-69, August 2001. ■

FAQs

(from page 2)

doctor that a treatment isn't working because no one wants to be perceived as a "bad patient." For example, if you're prescribed a topical medication and it burns, call your doctor right away. A little common sense goes a long way—using medication that burns (for vulvar burning!) is probably more harmful than helpful. Many topical creams and ointments contain ingredients that can further irritate vulvar tissue.

I'm desperate because I've had constant burning and pain for months. How can I stop the pain?
Too many sufferers adopt a passive approach to seeking treatment for pain. They visit their gynecologist and start using ointments, creams, antidepressants and/or biofeedback, but remain in moderate to severe pain for weeks or months waiting for the treatment to work. If your gynecologist or internist is not comfortable prescribing strong pain-relieving medications on a short-term basis, go see a pain specialist. In addition to prescribing medication, a pain specialist may suggest other complementary pain-relieving techniques. Even after vulvar pain is controlled, patients experience flare-ups. If you explain this to a pain specialist, he/she can prescribe effective pain-relieving medication for limited use during flare-ups.

I have had many yeast infections in the past year that never seem to go away and now I have constant burning. Do I have vulvodynia?
The main symptoms of a yeast infection are itching and a thick, white discharge, but it may also cause burning sensations. The most commonly reported symptom of dysesthetic vulvodynia is burning, although some women also report itching. If you have recurrent yeast infections for many months, you may be at high-risk for developing vulvodynia. If you test positive for yeast, be sure to take the full course of anti-fungal medication your doctor prescribes. (For women with chronic vulvar problems, it is preferable to use oral rather than topical medication.) If yeast symptoms persist, ask your doctor to take another culture. If you've been fully treated for yeast and the culture returns negative, you may have vulvodynia.

I suffer from urinary difficulties, and sometimes experience vulvar burning. How can I tell if I have vulvodynia?
Many women suffer from both chronic urinary and vulvar symptoms. For example, the Interstitial Cystitis Association estimates that 25 percent of interstitial cystitis patients suffer from vulvodynia. Because of the location of the urethra and its similarity to vulvar tissue, it may be difficult to discriminate between urinary and vulvar disorders. Even some women with vulvodynia who do not have urinary difficulties report greater discomfort from the pressure of a full bladder. There are some urologists and urogynecologists who are knowledgeable about vulvodynia and that is a good place to start.

Does vaginal childbirth make vulvodynia worse?
Recently, vulvodynia expert Stanley Marinoff, M.D., was asked this question and he replied that there has not been any research on this issue. Based solely on many years of clinical experience, Dr. Marinoff has observed that most vulvodynia patients who have vaginal deliveries either improve or stay the same, and very few get worse. Furthermore, many women with vulvodynia or vulvar vestibulitis have had positive experiences being pregnant. If you are anxious about childbirth, however, you may want to discuss the option of a Cesarean section with your doctor. (For an in-depth discussion of vulvar pain, pregnancy and childbirth, see Dr. Gae Rodke's article in the Summer 2000 *NVA News*.)

(*Editor's note: This article is an excerpt from* Vulvodynia, A Survival Guide, *an upcoming book by Drs. Glazer and Rodke of the NYC Center for Vulvovaginal Disorders. Release date: June 2002, New Harbinger press.*) ■

Thank You

The NVA gratefully acknowledges the Cora and John H. Davis Foundation for its ongoing support of our educational and patient programs.

Attention New York Readers

If you did not receive the Summer 2001 issue of NVA News because of post office disruptions, please send an e-mail to rose@nva.org or call 301-972-5286.

Chronic Pain

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of opioid drugs also vary during the menstrual cycle, notes Dr. Campbell. "We also found that postmenopausal women using hormone replacement therapy (HRT) are more sensitive to pain than are their postmenopausal counterparts who do not use HRT," says Roger B. Fillingim, PhD, of the University of Florida College of Dentistry, Public Health Services and Research, in Gainesville. In particular, TMJ disorder may be more prevalent in women taking estrogen replacement therapy, he told a pain meeting audience.

Taking Control

The way you cope with pain can also influence how much it hurts. According to Dr. Fillingim, a coping strategy known as "catastrophizing" (having strongly negative, hyperactive emotions about a situation) plays a significant role in pain. Women who catastrophize report more intensity of pain than do women and men who do not catastrophize, he says. Also, women who used "passive coping" (wishing the pain would go away, thinking you can't stand it any longer) reported more pain than women who did not use passive coping.

Therapies that improve coping skills and increase a sense of control can improve pain considerably. One of the most effective is biofeedback, which teaches people to control muscle tension, heart rate, and breathing. Studies show that biofeedback works especially well for migraine and tension headaches.

Medications Are Not Equal

Some pain medications work better in women than in men. Studies have shown that women experience greater pain relief from a class of medications called kappa opioids, such as pentazocine (Talwin, Talwin-NX), and injectable forms such as nalbuphine (Nubain) and butorphanol (Stadol). A 1996 study at the University of California, San Francisco, compared pain-relieving medications in men and women having their wisdom teeth extracted. The study found that, compared to male patients, women experienced twice as much post-operative pain relief from pentazocine. Kappa opioids are not widely used however, and there are no known sex differences in pain relief with the more commonly used mu-opioid drugs such as codeine and Percocet.

On the other hand, it has been shown that women derive less pain relief than men from the use of non-steroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen and topical anesthetic creams. The NSAIDs, however, are widely used among women, and some experts contend that their reduced effectiveness has resulted in the undertreatment of womens' pain. If a woman's pain problem does not stem from an inflammatory condition, it may be better treated with acetaminophen (e.g., Tylenol) than with ibuprofen or other NSAIDs, Dr. Campbell told the Congress on Women's Health. He cautioned, however, that some prescription pain medications are partly composed of acetaminophen, and if people take over-the-counter Tylenol as well as certain prescription medications (e.g., Perocet), it poses a risk of toxicity.

"NSAIDs are not useful in neuropathic pain, such as that caused by diabetic neuropathy. The opioids are helpful in treating most types of pain, but their use is often limited because of concerns about addiction. Drugs that can be effective for long-term treatment of neuropathic pain include tricyclic antidepressants," Dr. Campbell reported.

No "Acceptable Pain"

The first step in breaking the vicious cycle of chronic pain is refusing to accept pain as "just a part of life." Experts emphasize there is no level of "acceptable pain." Too many women are reluctant to complain about pain, fearing they'll be stigmatized or appear weak, said Dr. Campbell.

Pain management requires a positive attitude, a refusal to give up. If one treatment isn't working, try another. It's necessary to understand that, just as women and men respond differently to treatments, individual women will also respond differently to the same treatment. Be open-minded to adjunctive therapy options. Women appear to benefit more than men from non-pharmacological therapies such as physical therapy, exercise, and massage. Finally, certain lifestyle changes – a healthful diet, regular exercise, and plenty of sleep — along with behavior changes, will help you get the best long-term relief. Once you find a strategy that works well for you, stick with it, even when the pain is reduced or eliminated, to maintain its effects on your pain threshold.

Adapted from an article in Jan 2002 Women's Health Advisor *newsletter, from Weill Medical College of Cornell University (1-800-571-1555).* ■

Major Pain Clinics in the United States

ARIZONA

Tucson

The University of Arizona Health Sciences Center, Pain Management Services
• 520-694-9662

CALIFORNIA

Los Angeles

Cedar Sinai Hosp Pain Center
• 310-423-9865

Sacramento

University of California, Davis Pain Clinic
• 916-734-7246

San Francisco

University of California Pain Management Center
• 415-885-7246

Stanford

Stanford University Pain Management
• 650-723-6238

COLORADO

Denver

University of Colorado Pain Medicine Clinic
• 720-848-1970

FLORIDA

Jacksonville

Mayo Pain Clinic
• 904-953-7246

Miami

University of Miami, Pain Relief Center
• 305-585-6283

GEORGIA

Atlanta

Emory University Hospital Pain Ctr.
• 404-778-3952

ILLINOIS

Chicago

Northwestern Pain Management Clinic
• 312-695-2500

IOWA

Iowa City

University of Iowa, Pain Clinic
• 319-356-2320

MARYLAND

Baltimore

Johns Hopkins Univ. Pain Treatment Ctr.
• 410-955-7246

MASSACHUSETTS

Boston

Beth Israel Deaconess Pain Treatment Center
• 617-667-7000

Brigham and Women's Hospital Pain Management
• 617-732-6708

Massachusetts General Hospital Pain Center
• 617-726-8810

New England Medical Center, Pain Management Program
• 617-636-6208

MINNESOTA

Rochester

Mayo Pain Clinic
• 507-266-3636

NEW HAMPSHIRE

Lebanon

Dartmouth College Hitchcock Pain Management
• 603-650-6040

NEW MEXICO

Albuquerque

University of New Mexico, School of Medicine Pain Clinic
• 505-272-2780

NEW YORK

Albany

Albany Medical College, Pain Management
• 518-262-4300

New York

Beth Israel Medical Center, Department of Pain Medicine & Palliative Care
• 212-844-1500

Cornell University Medical College, The New York Hospital
• 212-746-2960

Memorial Sloan-Kettering Pain Center
• 212-639-6594

NORTH CAROLINA

Durham

Duke University Pain Clinic
• 919-684-7246

OHIO

Cleveland

Cleveland Clinic Foundation Pain Management Center
• 216-444-7246 or 1-800-392-3353

OREGON

Portland

Oregon Health Sciences University Pain Management
• 503-494-5370

PENNSYLVANIA

Philadelphia

University of Pennsylvania Health System, Pain Medicine
• 215-662-8640

SOUTH CAROLINA

Charleston

Medical University of South Carolina Pain Management
• 843-792-2500

TENNESSEE

Nashville

Vanderbilt University Pain Control Center
• 615-936-1206

TEXAS

Houston

University of Texas M.D. Anderson Pain Center
• 713-792-6068

Lubbock

Texas Tech University, Intl. Pain Institute
• 806-743-7246

UTAH

Salt Lake City

University of Utah Health Sciences Pain Management
• 801-581-7246

VIRGINIA

Charlottesville

Univ. of Virginia Health Sciences, Pain Management Center
• 434-243-5678

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