National Vulvodynia Association

NVA News

Volume IX, Issue II Spring 2004

Pudendal Nerve Block in the Treatment of Vulvodynia

Questions and Answers with B.J. Daneshfar, M.D.

Dr. Daneshfar is the medical director of the Acute and Chronic Pain and Spine Center in Amarillo, Texas. He is also a clinical professor in the Department of Surgery at Texas Tech University Health Sciences Center in Amarillo, Texas.

NVA: What is a pudendal nerve block?

BD: A nerve block is a procedure by which medications that inhibit pain and inflammation are injected into a space around a nerve, thereby preventing pain messages that travel along the nerve pathway from reaching the brain. In an attempt to provide vulvar pain relief, the pudendal nerve is targeted because it is responsible for sensory and motor function in both the vulva and anal region.

NVA: Is the pudendal nerve block a new technique?

BD: The technique has been used for decades, primarily in obstetric anesthesia, to provide pain relief during childbirth. Today, epidurals are the most common pain relief technique employed during childbirth, but pudendal nerve blocks are sometimes used as an adjunctive measure, providing pain relief during the second stage of labor. Today, pudendal nerve blocks are most frequently used to provide anesthesia during surgical procedures involving the vulva and for pain relief in patients with chronic vulvar pain and/or itching that does not respond to topical or oral medications.

NVA: Where is the pudendal nerve?

BD: The pudendal nerve is comprised of fibers from the S2, S3, and S4 spinal nerve roots (in the sacrum or tailbone area) and follows a complicated course through the pelvis. As the nerve approaches the vulva and anal region, it divides into three terminal branches: the inferior rectal

See NERVE BLOCK, page 2

Evaluation and Diagnosis of Chronic Vulvovaginitis

By J. Chris Carey, M.D.

Dr. Carey is chair of the obstetrics and gynecology department at Maricopa Medical Center in Phoenix, Arizona and program director of the Phoenix Integrated Residency Program.

A 34-year-old patient presents to a physician with a nine-month history of vaginal and vulvar irritation. During this period, she has seen five physicians and been treated several times for both "yeast" and "bacteria" without relief. She has searched the Internet and her local bookstore for information and thinks she may have vulvodynia. How should a physician proceed with her evaluation and therapy?

Approach to the patient

Chronic vulvovaginitis is a relatively common condition, but one that is perplexing and frustrating for both physicians and patients. Many physicians do not know how to properly evaluate or diagnose a

See VULVOVAGINITIS, page 5

Nerve Block

(from page 1)

nerve (providing innervation to the anal sphincter and the tissues around the anus), the perineal nerve (innervating the posterior two thirds of the labia majora and muscles of the urogenital triangle or base of the bladder), and the dorsal nerve of the clitoris (providing sensory innervation to the dorsum of the clitoris). Simply stated, the pudendal nerve is involved in orgasm, urination and defecation.

NVA: What is pudendal neuralgia?

BD: Pudendal neuralgia occurs when the pudendal nerve becomes abnormal in its function; it can occur from any injury (blunt trauma, partial or complete laceration), infiltrative diseases such as tumor or metabolic disease, scar or entrapment. The nerve develops abnormal fibers and malfunctions, producing automatic signals that are conducted along the nerve and ultimately to the spinal cord; this causes pain that is typically described as burning and/or crushing. In cases of pudendal neuralgia, the vulvar tissue may either appear abnormal or completely normal.

Pudendal neuralgia is diagnosed by performing a differential (diagnostic) pudendal nerve block. If the patient experiences relief from the procedure, it indicates that the pudendal nerve is the structure responsible for the pain.

NVA: What is pudendal nerve entrapment?

Pudendal nerve entrapment (PNE) is a condition that causes pain in the lower to central perineal area (anal region, perineum, and vulva) without any readily apparent reason. Pain sensations are individualized and may feel like burning, stinging, stabbing, aching, cramping, tightness, numbness, pins and needles and/or crawling on the skin. Pain is typically worse when sitting and less when standing, or sitting on a donut cushion or toilet seat. There may be associated urinary, anal, or sexual dysfunction. As the name suggests, PNE is caused by an *entrapment* of the pudendal nerve, which means that the nerve is constricted for some reason. The nerve responds by becoming irritated and begins to malfunction. PNE can also be caused by stretching or rubbing of the pudendal nerve. Patients are counseled to avoid the offending factor causing pain (e.g., sitting for long periods of time, cycling) and suggested treatments include sequential pudendal nerve blocks, conservative medical treatment with oral pain management medications such as anticonvulsants and tricyclic antidepressants, and in very rare cases, surgery to decompress the nerve.

NVA: When is a nerve block used as a diagnostic procedure?

BD: The differential pudendal nerve block is used in the evaluation of genital pain in cases in which peripheral nerve injury, entrapment, radiculopathy (disorder of the spinal nerve root), or plexopathy (disorder of the nerve network that gives rise to the pudendal nerve) are possible causes of the pain.

See NERVE BLOCK, page 3

NVA News
National Vulvodynia Association
P.O. Box 4491, Silver Spring, Md. 20914-4491
(301) 299-0775; FAX: (301) 299-3999
www.nva.org

The *NVA News* is published three times per year.

Editor:
Phyllis Mate

Layout: Andrea Hall **Contributor:** Christin Veasley

Nerve Block

(from page 2)

A pudendal nerve block should be done as a diagnostic procedure in patients with a diagnosis of generalized vulvodynia. This is especially true in those patients for whom the majority of pain manifests in the vulva, distal vagina and rectum. A differential pudendal nerve block is a technique by which the pudendal nerve is completely blocked with an injected anesthetic medication and the patient's response is assessed over time as different nerve fiber components of the pudendal nerve (autonomic, sensory, and motor) gradually recover from the local anesthetic. In this manner the specific fiber type causing the pain can be identified and an individualized treatment plan can be formulated.

NVA: When should a provider recommend that a nerve block be used to *treat* vulvodynia?

BD: If a patient responds favorably to the differential or diagnostic pudendal block, then it is appropriate to proceed with a series of pudendal blocks as a therapeutic approach. Depending on what information is gleaned from the diagnostic block, other therapies such as pharmacotherapy, i.e., pain management medications such as antidepressants and anticonvulsants, may be used in combination with this treatment.

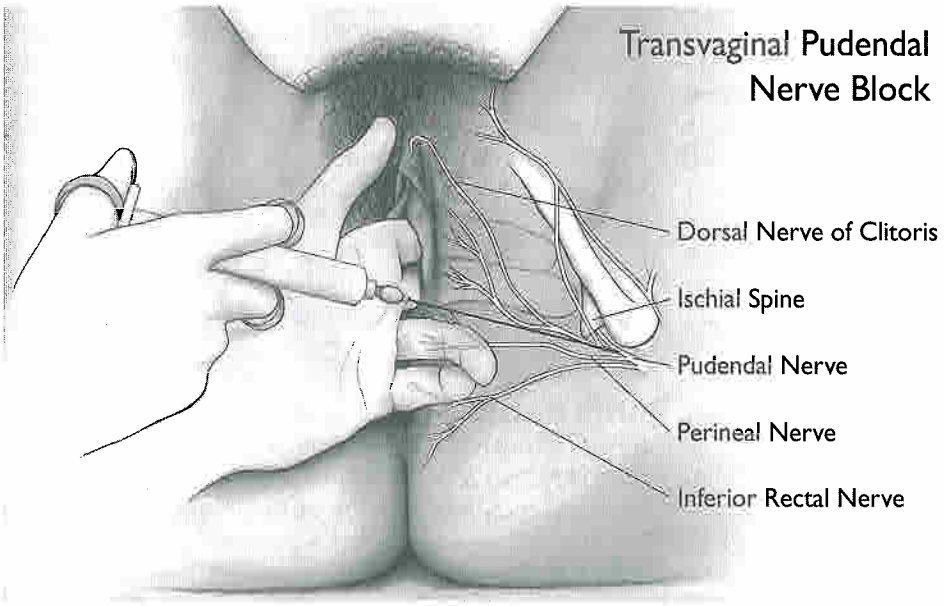
NVA: Is it necessary to use imaging such as X-rays in performing a pudendal nerve block?

BD: It is not absolutely necessary to use imaging while performing a pudendal nerve block, but it does improve the procedure's accuracy rate. Imaging is especially helpful when performing a block on someone who is obese or cannot maintain the lithotomy position (lying on her back with knees bent). If a block is performed without the use of imaging and does not result in pain relief, one should not assume that the block was ineffective, but rather repeat the block using imaging to confirm that the block was properly performed.

NVA: How is the procedure performed? Is the patient simply given a local anesthetic or "put under" for the procedure?

BD: The pudendal nerve block is performed with the patient lying on her back with knees bent, such as during a gynecological exam. For better tolerance, the patient is usually given an intravenous sedative such as Versed or fentanyl just prior to the procedure. There are two procedures for administering the block, transvaginal and transperineal, both of which attempt to block the nerve before it divides into its terminal branches.

During a transvaginal pudendal nerve block (*see diagram, below*), the practitioner inserts the index and middle fingers of the non-dominant hand into the vagina to palpate (feel for or touch) the ischial spine (located next to the ischial tuberosity, a bony landmark on the "hip bone" that you feel when you sit down on a hard chair). A needle guide, usually in the shape of a trumpet, is inserted between the fingers and its tip is placed next to the ischial spine against the vaginal mucosa. The needle is then placed through the guide and is advanced through the tissues just below and next to the ischial spine. Once the needle is in correct position,



See NERVE BLOCK, page 4

Nerve Block

(from page 3)

a local anesthetic medication, sometimes in combination with a steroid, is injected into the area surrounding the nerve.

Alternately, the transperineal approach may be used if the vaginal tissues are painful and the patient cannot tolerate an injection through the vagina. In this case, a needle is advanced through the skin overlying the ischial spine (through the flesh of the buttocks). The ischial spine is identified by insertion of the practitioner's index finger into the patient's rectum.

NVA: What medications are used in the injection?

BD: Local anesthetics such as Marcaine, lidocaine, mepivacaine, or etidocaine are used; steroids such as methylprednisolone, triamcinolone, and betamethasone may be mixed with the local anesthetic. In patients who require anti-inflammatory medication, but cannot tolerate steroid medications due to diabetes or an allergy to these medications, I have used pentoxyfylline with success. Other medications such as gabapentin (Neurontin) may be used, depending on the results of the diagnostic block.

NVA: Is there a standard protocol for how many times a block may be administered?

BD: There is no standard protocol in performing these blocks. The care of every patient should be individualized. If the patient experiences a favorable response after injection of local anesthetic and steroid solutions, then multiple blocks may be performed as long as an acceptable steroid dose is determined for the patient. Generally, a steroid and local anesthetic block can be done once a week for five to six weeks, or even longer in severe cases. The steroid block can be repeated safely once every two weeks for an entire year, provided that no more than 20 mg of methylprednisolone or its equivalent steroid dose is used in each block.

NVA: How soon should a patient experience relief and how long does it last?

BD: If the pudendal nerve is the causative structure producing vulvar pain, then the block will be quite effective and provide immediate relief. At a minimum there will be partial relief, depending on what percentage of pain is produced by the tissues innervated by the pudendal nerve or damage to the nerve itself. Pain relief can vary dramatically from person to person and may last for hours, weeks or months. In some advanced cases, in which the pain has become neuropathic, pain may increase following the procedure (for 2 to 10 days), before improving.

NVA: What should a woman expect following the procedure? Are there any associated complications?

BD: A woman may experience discomfort following the procedure, but this can be managed with the use of local ice packs and non-steroidal anti-inflammatory medications such as ibuprofen. Although there may be complications from the procedure, they tend to be minimal and infrequent. Complications may include infection, bleeding, or possible fistula formation (an abnormal opening between two areas of the body) in patients who may be immuno-compromised from previous radiation or chemotherapy.

NVA: Have any studies been published looking at short or long-term relief?

BD: There are a limited number of peer-reviewed publications on this subject. The majority are either case reports or papers describing the block technique. To my knowledge, there is no large-scale study that reports the percentage of patients that experience short or long term relief with this treatment. In my own clinical practice, 11 out of 15 patients have experienced at least partial relief following a diagnostic pudendal nerve block or series of blocks.

NVA: What recommendation would you make to a vulvodynia patient who wants to consider this treatment?

BD: I would suggest that the patient be evaluated by an experienced interventional pain physician who is familiar with the procedure. If the physician recommends a block, I would strongly encourage the patient to undergo the procedure, because its benefits far outweigh its complications. ■

Vulvovaginitis

(from page 1)

patient with chronic complaints of vulvovaginal itching and/or burning. A rational, orderly approach in evaluating the patient is essential, because an accurate diagnosis is the key to patient management.

The diagnosis in these cases is made in the same way that any other diagnosis is made, i.e., by taking a proper history, performing a physical examination, formulating a differential diagnosis and performing appropriate laboratory tests. Only then should a course of therapy be undertaken. Unfortunately, many patients with chronic vulvar pain or irritation are treated before a diagnosis is made and this often leads to failure of therapy. Accurate diagnosis before treatment is the key to a successful outcome.

Table 1 : Steps in Approach to the Patient

- History
- Physical Exam
- Differential Diagnosis
- Laboratory tests
- Treatment / therapy
- Counseling

Patient History

The history begins with an exploration of the symptoms. It is important to determine if the patient has itching, burning, other pain, and/or discharge. The location of the pain or discomfort may be important. Some patients find it difficult to describe the location or character of their symptoms, i.e., they do not describe their symptoms as itching or burning and say it isn't really pain. Such a description may be a clue to a neurological etiology (cause) of their symptoms. The presence of any associated symptoms should be determined. Burning, itching, rashes or sores in other areas may indicate systemic diseases presenting with vulvar symptoms.

The duration of the symptoms is important. Patients should be asked about prior episodes and particularly about the success or failure of prior treatments. A review of prior records is often helpful because the patient may have been treated with a variety of vaginal creams or antibiotics and may not remember the results of all prior treatments. The physician should obtain a thorough sexual history including age at first intercourse, number of partners (both lifetime and current), frequency of intercourse and pain with intercourse; this information may provide clues regarding the existence of a sexually transmitted disease.

In some cases, childhood sexual abuse may present with vulvar pain in adulthood. Patients with repressed memories of childhood sexual abuse may not be able to remember the first time they had intercourse. Many patients with vulvar pain develop secondary inhibited sexual desire, and some type of sexual counseling may be helpful in patient management.

It is also useful to review a patient's general medical history to determine the presence of conditions that sometimes present with vulvar symptoms. Conditions that cause immunosuppression may lead to chronic vulvovaginitis. Also, repeated antibiotic use for sinusitis, urinary tract infections, acne or other conditions may predispose a woman to fungal vaginitis.

Physical Examination

The physical examination includes a general physical exam as well as a pelvic examination. Examination of the eyes and oral mucosa may reveal lesions of lichen planus, Sjögren's syndrome, or other conditions that may present in the vulva. A careful dermatologic exam, including an inspection of all of the patient's skin, may find dermatologic conditions that present in the vulva.

The pelvic examination includes a careful inspection of the vulva. Magnification with a colposcope or hand held lens may help identify subtle skin changes. Touching the vulva with a cotton tip swab to "map" areas of pain is helpful. Examination of the vagina includes an assessment of any discharge, an assessment of the estrogen effect, and any lesions or inflammation. In some cases, the cervix may show signs of cervicitis or discharge.

See VULVOVAGINITIS, page 6

Vulvovaginitis

(from page 1)

If indicated, a pap smear and cervical cultures for sexually transmitted diseases are performed.

Differential Diagnosis

After the initial history and examination, a differential diagnosis is formed. A differential diagnosis is a "list" of conditions that the patient may have. It is helpful to organize the list into categories.

The first differential is to determine whether the condition is vulvar, vaginal or other. Vulvar conditions are divided into those with inflamed skin or normal appearing skin. Vaginal conditions are divided into those which are infectious versus non-infectious. Other possibilities include cervicitis, sexual dysfunction, and other miscellaneous conditions.

Table 2: Differential Diagnosis for Chronic Vulvovaginitis

- ◆Vulvar
  - Inflamed skin
    - •Infectious
    - •Dermatitis/dystrophy
    - •Irritant/allergic
  - Normal skin
    - •Pudendal neuropathy
    - •Dysesthetic vulvodynia
- ◆Vaginal
  - Infection
    - •Chronic/persistent
    - •Recurrent
  - Non-infectious
- ◆Other
  - Cervicitis
  - Sexual dysfunction
  - Miscellaneous

Appropriate laboratory tests

An appropriate laboratory test is one that can answer a question and help in determining a diagnosis. A wet prep and 10 percent potassium hydroxide preparation of the vaginal secretions can determine whether or not a condition is infectious, if there is adequate estrogen effect, and if there is normal maturation of the mucosa.

The vaginal pH is easily determined with pH paper. The normal vaginal pH is between 3.8 and 4.4. A pH of less than 3.8 may indicate cytolytic vaginosis which is characterized by a white, "clumpy" discharge with itching or burning and thought to be caused by an overgrowth of lactobacilli. A pH greater than 4.5 may indicate bacterial vaginosis (an overgrowth of anaerobic bacteria and Gardnerella characterized by a copious, "fishy" discharge) or desquamative inflammatory vaginitis, a severe inflammatory vaginitis of unknown cause. A Gram stain of the vagina can help determine the predominant vaginal flora and is often more useful than a culture. Cultures are indicated *only if* selective media is available (including appropriate transport media) and the lab can isolate the organism of interest. Many vaginal pathogens are very fastidious and difficult to grow.

The mere presence of an organism in the vagina does not necessarily mean that it is the cause of the patient's symptoms. With careful microbiology, one can usually isolate between 7 and 15 organisms from the vagina of a healthy woman. Group B Streptococcus, *Gardnerella vaginalis,* mycoplasmas and ureaplasmas are commonly found in healthy women. Fungal species also may be found in asymptomatic women, but if a woman has symptoms and a positive fungal culture, it is prudent to assume the fungus is causing the symptoms.

Treatment

To be efficacious, therapy should be directed toward a diagnosis. Treatments may cause side effects or symptoms. Vaginal or vulvar creams may be irritating and actually worsen some conditions. For example, the symptoms of chronic fungal vaginitis may be made worse by steroid creams.

If therapy does not work, reconsider the diagnosis. The most common reason for failure of therapy is an inaccurate diagnosis. It is not always possible to make a definitive diagnosis, however. In such cases, a trial of therapy can sometimes be

See VULVOVAGINITIS, page 7

Vulvovaginitis

(from page 6)

diagnostic; if the patient experiences relief with a certain therapy, it may establish a diagnosis. However, therapeutic trials should only be directed toward a diagnostic possibility and not be prescribed as a "shotgun" approach to treatment.

Counseling

Counseling is often a critical component in managing a patient with chronic vulvar or vaginal symptoms. Patients usually have an internal theory about their condition. For treatment to be successful, a physician should determine the patient's theory and address it. Many patients with chronic symptoms have done independent research about their condition prior to consulting a physician and may well have knowledge, or have thought of something, that the physician overlooked. The patient should be treated as a partner in management and should be encouraged to share her theories with the physician. Unless the physician and patient are in agreement about the diagnosis and plan for therapy, therapy is likely to fail. If the patient and the physician are in disagreement about the diagnosis and/or plan for therapy, then they should discuss the plan until they come to an agreement.

Since patients want a prognosis as well as a diagnosis, the physician should not be afraid to give it, together with an expectation of the results of therapy. Encouraging realistic expectations of therapy is critical because some conditions are difficult to manage and cannot be completely "cured."

Many patients with chronic vulvar pain have been previously abandoned by physicians or told that their pain is "in their head." They may be afraid that, once again, they will either be abandoned or their complaints will be ignored. To address this fear, the physician should reassure the patient that her problem is real and that therapy is available. Although it is important not to give patients false assurances of "cure," it is equally important to give patients hope. Most patients can be assured that, even if their condition is not "curable," they can get to a point at which they resume control of their lives instead of having the condition control them.

Learning to live with a chronic condition does not mean "giving up" to the condition. All patients make some adjustments to their condition, but while some are healthy, others are not. For example, patients with some forms of vulvovaginitis may find it impossible to wear tight jeans or exercise clothes, so adjusting to wearing different clothing may be necessary. On the other hand, it would be an unhealthy adjustment to give up all forms of outside activity and exercise. In some cases, the patient finds it too painful to have vaginal intercourse, so she and her partner may try different forms of sexual activity. It might be an unhealthy adjustment, however, to avoid all forms of sexual activity. Helping a patient learn to recognize the adjustments she has made and how to modify daily life activities can be very helpful.

Chronic vulvovaginitis often leads to sexual dysfunction, including dyspareunia and inhibited sexual desire. Marital distress is common. Even if the patient has a supportive spouse, she may feel guilty because she is unable to have sexual intercourse. Many patients are either angry because they have a "disease," or suffer from low self- esteem because "there is something wrong with me." Therefore, individual or marital therapy is often a necessary component of the treatment program.

Summary

Chronic vulvovaginitis can be a vexing and frustrating condition for both patients and physicians. However, most cases can be diagnosed with a specific cause and treated with therapy directed toward the diagnosis. Counseling is often an important component of therapy and should be directed toward specific problems experienced by the patient.■

Health-Care Guidelines for Women

Some medical experts are concerned that too many women today rely on a specialist as the gatekeeper of their primary and preventive care — without letting that specialist know they are being relied on. "When, a number of years ago, managed care decided to allow women to see their ob/gyn without a referral from a primary-care doctor, it was supposed to make the act of obtaining reproductive and gynecological care easier," says Dr. Steve Goldstein, a professor of obstetrics and gynecology at New York University Medical Center. But, according to Goldstein, one of the consequences of this policy is that the ob/gyn has become the primary-care doctor for many women. "The problem with this concept is that too often women don't tell their ob/gyns that they want them to be their primary-care physicians. So the doctor assumes someone else is in charge," Goldstein says.

While most women know which exams and screenings are required at the gynecologist's office, they are less informed about general health and preventive care, and don't realize that they are missing important primary screenings and evaluations. "The woman thinks her gynecologist is providing primary care while her gynecologist thinks an internist is providing primary care. But in reality, no one is doing it," according to Goldstein.

To help close this knowledge gap, the American College of Obstetricians and Gynecologists (ACOG) has published an updated set of primary and preventive care guidelines, the most comprehensive to date. In the November 2003 issue of *Obstetrics and Gynecology*, ACOG experts detailed exactly what a woman should expect in the way of screenings and preventive care, regardless of who is caring for her.

"We feel it's important that both women and their doctors have a clear understanding of what constitutes primary care — and the kind of screenings and evaluations every woman should have at various stages of her life, beginning in her teens through her senior years," says Dr. Bryan R. Hecht, chairman of the ACOG Committee on Gynecologic Practice that helped draft the new guidelines. Hecht adds that what women may really need most is to have a conversation with their ob/gyn and establish whether he or she will be the one providing that essential primary care. "It is very important that a woman let her ob/gyn know that she views him or her as the primary-care specialist, in order to ensure that she is getting all the care she needs," Hecht says.

More important, Goldstein says, is to give your doctor the choice about what role he or she feels most comfortable playing in your overall health care, since not all ob/gyns believe they are qualified to act as the mainstay of your health care. "The truth is, not all ob/gyns feel equally confident about providing primary care, and many are not even really qualified to do so," Goldstein says. "So if your doctor says he or she recommends that you see an internist for your non-gynecological needs, pay attention, and realize that this suggestion is being made in the best interest of your health."

Regardless of who is providing your primary care, both Goldstein and Hecht say it's still vital to see your gynecologist for a yearly visit — even if you aren't due for a regular screening, such as a Pap smear. To help ensure that you get what you need when it comes to gynecological and primary care, the following are highlights of the recent health-care guidelines from ACOG:

Ages 19 to 39:

- **An initial screening** at 19, featuring a complete health history, including your health status; dietary/nutrition assessment; level of physical activity; use of complementary or alternative medicines; tobacco, alcohol or drug use; sexual practices; abuse or neglect; and urinary or fecal incontinence. This screening should then be updated annually.

- **An annual physical exam**, including height, weight, blood pressure, mouth/dental; check of the neck for swelling/thyroid problems; examination of breasts, abdomen, pelvis and skin.

- **Yearly evaluation and counseling** on issues concerning sexual activity;

See GUIDELINES, page 9

Guidelines

(from page 8)

fitness and nutrition (including folic acid and calcium intake); interpersonal and family relationships; domestic violence; work satisfaction and lifestyle stress; cardiovascular risk factors (including family history, cholesterol profiles, obesity, diabetes); personal hygiene; high-risk behaviors, including occupational and recreational hazards; breast self-exams; skin exposure to ultraviolet rays; suicidal thoughts; depressive symptoms; drug or alcohol use.

• **Laboratory testing** should include Pap smear (annually, beginning no later than age 21; after age 30, every two to three years after three consecutive negative tests and no signs of disease). In addition, you should receive a tetanus booster every 10 years.

• **High-risk groups** (or those with symptoms) may also need: hemoglobin (red blood cell) assessment; bacteriuria testing; mammograms; a fasting blood sugar test; sexually transmitted disease testing; HIV testing; genetic testing/counseling; rubella assessment; tuberculosis skin testing; lipid profiles (for cholesterol); thyroid stimulating hormone testing; hepatitis C testing; colorectal screening; bone density screening. High-risk groups may also need the following vaccines: Hepatitis A and B, pneumonia, varicella and measles, mumps and rubella.

Ages 40 to 64: All of the above, plus:

• **Mammography** every one to two years beginning at age 40; then yearly at age 50 and above.

• **Lipid** (cholesterol) assessment every five years beginning at age 45.

• **Yearly fecal occult blood testing for colorectal cancer** or flexible sigmoidoscopy every five years (or both), or double contrast barium enema every five years, or colonoscopy every 10 years beginning at age 50.

• **Fasting glucose testing** every three years beginning at age 45.

• **Thyroid stimulating hormone screening** every five years beginning at age 50.

• **Counseling and evaluation** on hormone therapy.

• **Influenza vaccine** annually beginning at age 50.

Ages 65 and over: All of the above from both groups, plus:

• Yearly urine analysis, mammogram, bone density screening.

• Evaluation and counseling on visual acuity, hearing, depression.

(Adapted from an article by Colette Bouchez at www.healthday.com.) ■

New Patient Guide

The NVA has published a 24-page guide that contains an overview of vulvodynia from both gynecological and chronic pain perspectives, as well as self-help tips and other gynecological health information. It is free to all current NVA donors if ordered as an e-book (PDF file) by e-mailing gigi@nva.org. (Put "patient guide" on subject line and include your full name in the e-mail). If you want a printed copy, please send a $6 check or money order to NVA, PO Box 4491, Silver Spring, MD 20914-4491. Health care providers may review the guide prior to purchasing copies (at bulk rate) by e-mailing chris@nva.org.

NVA Organizes Symposia at Medical Conferences

In early 2004, the NVA organized two presentations on vulvodynia at the annual meetings of the American Academy of Pain Medicine (AAPM) and the American Medical Women's Association.

At the AAPM meeting, NVA medical advisory board members, Howard Glazer, Ph.D., and Justin Wasserman, M.D., together with Robert Moldwin, M.D., medical advisory board member of the Interstitial Cystitis Association, and NVA's Christin Veasley gave a two-hour presentation on chronic urogenital pain syndromes. It was the first time that the subject has been addressed at the annual AAPM meeting and 200 pain specialists attended the symposium; in fact, the session was so popular that there was standing room only.

Christin Veasley began the session by presenting prevalence estimates in the U.S. for three urogenital pain syndromes: vulvodynia, interstitial cystitis (chronic inflammation of the bladder wall leading to frequent, painful urination) and prostatitis (inflammation of the prostate gland, characterized by perineal pain and irregular urination). She compared the number of research studies funded by the National Institutes of Health (NIH) on each condition to the number of NIH-funded studies on other pain conditions with similar prevalence. Christin pointed out that none of the urogenital pain syndromes has received an appropriate share of NIH funding, adding that vulvodynia has received the least research funding of the three conditions.

Following the introduction, Robert Moldwin, M.D., director of the Interstitial Cystitis Treatment Center at Long Island Jewish Medical Center in New York, covered the diagnosis and treatment of both interstitial cystitis and prostatitis. He also discussed some similarities between interstitial cystitis and vulvodynia, including the frequent finding of surface sensitivity (bladder wall vs. vaginal mucosa), the presence of associated nerve and pelvic floor dysfunction, and the infrequent appearance of visible inflammatory changes.

The next speaker, Justin Wasserman, M.D., associate director of Pain and Rehabilitation Medicine in Bethesda, Maryland, gave a presentation on the pharmacological treatment of vulvodynia. He covered different classes of medication that are used alone, or in combination, to treat chronic vulvar pain, including tricyclic antidepressants, anticonvulsants, and selective serotonin and norepinephrine reuptake inhibitors. The final speaker, Howard Glazer, Ph.D, director of the New York Center for Vulvovaginal Pain, discussed how a multidisciplinary treatment plan best serves patients with chronic urogenital pain. He also summarized the findings of peer-reviewed literature on psychological factors associated with these disorders and noted that an association between physical or sexual abuse and urogenital pain syndromes has not been demonstrated.

The NVA disseminated educational materials on vulvodynia to all session attendees, as well as to other pain specialists who visited the NVA's exhibit booth during the meeting. Clearly, pain specialists are becoming interested in learning more about how to treat these types of disorders.

In February 2004, NVA presented at the American Medical Women's Association annual meeting in San Diego, California. Bernard Harlow, Ph.D., of Harvard University, primary investigator on an NIH-funded epidemiology study on vulvodynia, and Martha Goetsch, M.D., assistant professor at Oregon Health and Sciences University in Portland, joined NVA's Christin Veasley in a one-hour presentation entitled, Vulvodynia – a Highly Prevalent and Under-treated Condition. Christin gave a brief introduction and was followed by Dr. Goetsch, who discussed the diagnosis and treatment of generalized or dysesthetic vulvodynia and vulvar vestibulitis syndrome. Next, Dr. Harlow summarized the epidemiological data on nearly 5,000 women from his ongoing study, revealing that chronic vulvar pain appears to affect as many as 7 percent of American women aged 18 to 64. He also presented preliminary results on possible risk factors for the development of chronic vulvar pain.

In early May, the NVA exhibited at the annual meeting of the American College of Obstetricians and Gynecologists (ACOG) in Philadelphia, Pennsylvania, attended by over 4,500 health care providers specializing in obstetrics and gynecology. There will be a summary of vulvodynia-related events at the ACOG meeting in the next edition of the *NVA News*. ■

Research Participants Needed

Vulvodynia in Post-Menopausal Women Study

Researchers at Johns Hopkins Hospital in Baltimore, Maryland are looking for post-menopausal women to participate in a research study concerning the mechanisms of pain in vulvodynia, a chronic pain syndrome of the vulvar and vaginal area. You may be an appropriate candidate for this study if you:

- are 45 or older
- have been diagnosed with Vulvodynia for at least 6 months
- have not had a menstrual period for at least 12 months
- have been on or off hormone replacement therapy (HRT) for at least 12 months

Women who have had a hysterectomy are ineligible for this study. You will receive an honorarium for participation. For information, call (410) 614-4517 or send an e-mail to women@bme.jhu.edu.

(Support: National Institutes of Health, National Vulvodynia Association; Principal Investigator: Ursula Wesselmann MD, PhD, Dept. of Neurology, Johns Hopkins Hospital.)

Treatment of Vulvodynia/Vulvar Vestibulitis with Botox®

Location: Minnesota Gynecology & Surgery
Edina, Minnesota
Contact: James B. Presthus, M.D., (952) 893-9100
j.presthus@mngyn.com

Inclusion Criteria:

- Female 18 years or older, with concurrent use of reliable method of contraception (if there is child-bearing potential).
- Vulvodynia or Vulvar Vestibulitis.
- Severe pain on vestibular touch or attempted vaginal entry.
- Tenderness to pressure localized within the vulvar vestibule.

Exclusion critera: Women who are pregnant, have had a previous vestibulectomy or have a known sensitivity to Botox® may not participate.

Patients will be enrolled in either the control arm or treatment arm. In the treatment group, Botox® will be injected once by an experienced gynecologist, at doses that have been shown to be well-tolerated. There will be regular patient follow-up and assessment of adverse effects. The study involves three visits over 12 weeks and there are no costs to the participants.

Vulvar Vestibulitis Study

If you experience pain during sex, you may have vulvar vestibulitis. Vulvar vestibulitis is the most common cause of pain during intercourse in younger women. It is an inflammation of the tissues that surround the entrance to the vagina. A woman may have this condition and not know what is wrong or how to cope with it. Many people – medical professionals included – don't understand vulvar vestibulitis or even know it exists. Sometimes women are misdiagnosed or led to believe it is an emotional problem. The cause of vulvar vestibulitis is unknown but there are specialists studying this condition and working to find treatments for it.

If you or your doctor suspects that you may have vulvar vestibulitis, you may be eligible to take part in a study that could lead to a cure. Dr. David C. Foster, an international authority on diagnosing and treating vulvar pain and disease is principal investigator for the first major trial of a medical treatment for vulvar vestibulitis. The study is funded by a $1.2 million grant from the National Institutes of Health. Dr. Foster is an associate professor and director of Ambulatory Care in the Department of Obstetrics and Gynecology at the University of Rochester Medical Center. He has dedicated much of the last 15 years of his career to unraveling the mysteries of vestibulitis in an effort to find a cure.

The study will test two medications, used alone and together, and determine how effective they are at relieving the pain and possibly curing the inflammation. To be eligible for the study, you must be:

- A woman diagnosed with vulvar vestibulitis or who has experienced vaginal pain and suspect you may have it
- Between the ages of 18 and 50
- Available to participate in a 12-week medical trial (4 visits) in Rochester, New York, with follow-up visits at 6 and 12 months.
- Willing to undergo genetic and psychological testing as well as close monitoring of your pain level.

For more information about the study, or to find out if you are eligible to participate, please call (585) 275-7919.■

THE NVA NEEDS YOUR CONTRIBUTION

I WANT TO SUPPORT THE NVA AND RECEIVE MORE INFORMATION ON VULVODYNIA.

Name _____

Address _____

_____

Phone (H) _____ **(O)** _____

E-Mail Address _____

The NVA needs the support of everyone: patients, families, and health care providers.

☐ **$40** ☐ **$60** ☐ **$100** ☐ **Other $** _____

☐ **$60 Health Care Professional**

☐ **Yes, I would like to be contacted by other NVA supporters in my area.**

☐ **No, I do not want to be contacted. Please keep my name confidential.**

Please send your check or money order, payable to NVA, together with your name, address and telephone number to: NVA, P.O. Box 4491, Silver Spring, Md. 20914-4491.

N V A

NATIONAL VULVODYNIA ASSOCIATION

P.O. Box 4491 ❖ Silver Spring, MD 20914-4491