N National
V Vulvodynia
A Association

NVA News

Volume X, Issue III Summer 2005

The Vulvodynia Guideline

By Hope K. Haefner, MD, Michael E. Collins, RPh, FIACP, Gordon D. Davis, MD, Libby Edwards, MD, David C. Foster, MD, MPH, Elizabeth Heaton Hartmann, PT, Raymond H. Kaufman, MD, Peter J. Lynch, MD, Lynette J. Margesson, MD, Claudia K. Piper, ACSW, Micheline Moyal-Barracco, MD, Barbara D. Reed, MD, MSPH, Elizabeth G. Stewart, MD, and Edward J. Wilkinson, MD

Millions of women suffer from vulvodynia and a variety of treatments have been recommended over the years. Recently, many vulvar specialists have expressed the need for a formal guideline in the treatment of vulvodynia. In 2004, fourteen specialists from different disciplines worked together, under the direction of the American Society for Colposcopy and Cervical Pathology (ASCCP), to form *The Vulvodynia Guideline*. This article summarizes the guideline, published in its entirety in the January 2005 issue of the ASCCP's *Journal of Lower Genital Tract Disease*.

ISSVD Terminology

The most recent terminology and classification of vulvar pain by the International Society for the Study of Vulvovaginal Disease (ISSVD) defines vulvodynia as "vulvar discomfort, most often described as burning pain, occurring in the absence of relevant visible findings or a specific, clinically identifiable, neurologic disorder." It is not caused by common infections (e.g.,candidiasis, herpes), inflammation (e.g., lichen planus), neoplasia (e.g., Paget's disease), or a neurologic disorder (e.g., herpes neuralgia). The classification of vulvodynia is based on the site of the pain, whether it is generalized or localized, and whether it is provoked, unprovoked, or mixed.

Causes

Several causes have been proposed for vulvodynia, including embryologic abnormalities, genetic or immune factors, hormonal factors, inflammation, in-

See GUIDELINE, page 2

Advice on Conception for Women with Vulvodynia

By Andrea Hall and Elizabeth Stewart, M.D.

Andrea Hall, an NVA Executive Board member, is the mother of two young children. Dr. Stewart is a vulvovaginal specialist at Harvard Medical School and an NVA Medical Advisory Board member.

One of the primary concerns of some women recently diagnosed with vulvodynia is, "Will I be able to have children?" Fortunately, the answer is "Yes," unless you have another health condition that impairs your fertility. If you were fertile before you had vulvodynia, you are still fertile, assuming everything else is normal. The most common problem in conceiving lies in the fact that it may be difficult, if not impossible, to engage in sexual intercourse. Before you start trying to conceive, here are some issues to consider.

Oral Medications

Vulvodynia is often treated with oral medication, primarily tricyclic antidepressants or anticonvulsants.

See CONCEPTION, page 8

Guideline

(from page 1)

fection, neuropathic changes, and increased urinary oxalates. Most likely, there is not a single cause. However, none of these causes have been proven at this point in time. Further studies evaluating the cause(s) of vulvodynia are needed.

Diagnosis And Evaluation

A history should be taken to identify the patient's duration of pain, previous treatments, allergies, past medical and surgical history, and sexual history. The sexual history is best taken when the patient is clothed and has spent some time interacting with the physician or other health care provider.

Cotton swab testing is used to localize painful areas of the vulva and introitus, and if pain is present, to classify the area as having mild, moderate, or severe pain. A diagram of the pain locations is helpful in assessing the pain over time. The vagina is examined and a wet prep, vaginal pH, fungal, and gram stains are performed as indicated. Fungal culture may identify less common strains that may be resistant to typical treatments.

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

NVA News is published three times per year.

Editor:
Phyllis Mate

Layout: Andrea Hall

The National Vulvodynia Association is an educational, nonprofit organization founded to disseminate information on treatment options for vulvodynia. The NVA recommends that you consult your own health care practitioner to determine which course of treatment or medication is appropriate for you.

Vulvodynia Treatments

Multiple treatments have been used for vulvodynia, including vulvar care measures; topical, oral, and injectable medications; biofeedback; physical therapy; low-oxalate diet and calcium citrate supplementation; and surgery. Other treatments suggested by some practitioners include acupuncture, hypnotherapy, nitroglycerin, and botulinum toxin.

Vulvar Care Measures

Gentle care of the vulva is advised. Common suggestions include wearing cotton underwear in the daytime and none at night, avoiding vulvar irritants (perfumes, dyed toilet articles, shampoos, douches, and detergents), and use of mild soaps, with none applied to the vulva. The vulva can be cleaned gently with water and patted dry. After cleansing, an emollient without preservatives such as vegetable oil or plain petrolatum helps to hold moisture in the skin and improve the barrier function. If menstrual pads are irritating, cotton pads may be better tolerated. Adequate lubrication for intercourse is recommended. Ice packs are helpful in some patients, but produce irritation when overused. Cool gel packs may be preferable. Rinsing and patting dry the vulva after urination may be helpful.

Topical Therapies

Different topical medications have been tried as treatments for vulvar pain. In women who have been using multiple topical medications for a prolonged period, stopping all medications may alleviate symptoms. The most commonly prescribed topical medication is lidocaine ointment 5% (Xylocaine ointment 5%), applied as required for symptoms and 30 minutes before sexual activity. EMLA (eutectic mixture of local anesthesia, comprised of lidocaine 2.5% and prilocaine 2.5%) and ELA-Max (lidocaine 4% or 5%) also are used by some patients, but may cause stinging or sensitization. On occasion, male sexual partners may

See GUIDELINE, page 3

Guideline

(from page 2)

experience a transient decrease in penile sensation. Oral contact should be avoided after the lidocaine has been applied. Long-term use of overnight topical lidocaine has been studied and may minimize feedback amplification of pain and decrease pain with sexual activity, however further studies are needed. It is important not to use excessive amounts of lidocaine, because reports on lidocaine toxicity exist. Benzocaine, the anesthetic in Vagicaine and Vagisil, has a tendency to produce allergic contact dermatitis and should be avoided. Diphenhydramine, e.g., Benadryl, present in many topical anesthetic and anti-itch preparations, is also a common sensitizer to be avoided. Some patients benefit symptomatically from the application of plain petrolatum, e.g.,Vaseline. Additionally, for women who are able to insert medication via the vagina, the intravaginal estrogen ring may be considered.

Capsaicin is available to treat neuropathic pain but its usefulness is limited by its extreme irritant effects. In a pilot study, topical nitroglycerin has been reported temporarily to improve vulvar pain and dyspareunia, however, headache was a limiting side effect. For some patients with localized pain and vaginismus, a combination of topical amitriptyline 2% and baclofen 2%, in a water washable base, has been useful for point tenderness and vaginismus. A compounding pharmacy is used to formulate these topical medications. Topical therapies *not* shown to benefit vulvodynia include topical corticosteroids, topical testosterone, and topical antifungal medications.

Generally, the side effects of topical medications are less than those of medications taken systemically. Choosing the proper vehicle of delivery is as important as choosing the proper medications (or combinations). In general, creams contain more preservatives and stabilizers and often produce burning on application, whereas ointments are usually better tolerated. Some clinicians prefer commercially available topical medications, whereas others prefer to compound the medications. It is important to use a compounding pharmacist who can help to determine the proper combination of ingredients. Specific instructions should be included, emphasizing the area where the medication should be applied, i.e., the vestibule, other areas of the vulva and/or the vagina.

Oral Medications

A variety of oral medications are used to treat vulvodynia. Examples are listed below.

Antidepressants. Oral tricyclic antidepressants are commonly used as treatment for vulvar pain. This group of medications, e.g., amitriptyline (Elavil), nortriptyline (Pamelor), and desipramine (Norpramin), has been used primarily for generalized vulvodynia, but recent reports also have found them to be helpful in relieving more localized pain.[1] Often, amitriptyline is used as a first-line agent. It is started at an oral dose of 5 mg to 25 mg nightly and increased by 10 to 25 mg weekly, generally not to exceed 150 mg daily. (A 5- to 10-mg initial dose should be used for both the elderly population and patients who show sensitivity.) Nortriptyline and desipramine are dosed in a similar fashion. Tricyclic medications are available as syrups so that very small doses can be used to start patients who are very sensitive to medications. Alcohol should be limited to one drink daily. Contraception should be provided to patients in the reproductive age group. These medications should not be used in patients with abnormal heart rates (such as tachycardia or arrhythmia), or in patients taking monoamine oxidase inhibitors. Often, the full pain relief response is not evident until four or more weeks of medication use. Tricyclic antidepressants should not be stopped suddenly, but rather weaned by 10 to 25 mg every few days. Other medications that have been prescribed for treatment in women with vulvodynia are the selective serotonin reuptake inhibitors and the selective serotonin norepinephrine reuptake inhibitors, such as Effexor XR.

Anticonvulsants. Gabapentin (e.g., Neurontin®) and carbamazepine (e.g., Tegretol®) have been used to treat vulvodynia. Gabapentin is initiated at a dose of 300 mg daily for three days and gradually increased to a maximum of 3,600 mg daily dosage. The medication is usually taken three times a day. One should never take more than 1200 mg in a single dose. Monitoring and dosage adjustment are required for side effects, but in most cases the drug does not need to be discontinued. In the elderly, however, gabapentin may cause or exacerbate gait and balance problems as well as cognitive impairment. As with tricyclic antidepressants, allow three to eight weeks for titra-

See GUIDELINE, page 4

Guideline

(from page 3)

tion of gabapentin to promote development of tolerance to possible adverse effects. As soon as the maximum tolerated dosage is reached, allow one to two weeks of medication before conducting a final assessment of pain improvement. The anticonvulsants Tegretol® and Trileptal® (a newer form of Tegretol that may involve fewer side effects and toxicity risks) may be used for resistant cases.

Biofeedback and Physical Therapy

Biofeedback and physical therapy may be used in the treatment of both localized and generalized vulvar pain. [2] These techniques are particularly helpful if there is concomitant vaginismus. Biofeedback aids in developing self-regulation strategies for confronting and reducing pain. The time required for biofeedback and physical therapy, and the frequencies of visits, will vary with each person. Physical therapists with experience in vulvar pain are preferable. Abnormally high muscle tone or spasm, poor contraction and relaxation cycles, and instability within the muscular structure of the pelvic floor can be identified and relieved with specific exercises. Vulvar pain also can be related to other parts of the body, such as the back or hips, so a thorough musculoskeletal evaluation should be performed. Physical therapy also may improve intercourse frequency and may decrease pain with intercourse and gynecological examinations

Physical therapy treatment techniques include internal (vaginal and rectal) and external soft tissue mobilization and myofascial release; trigger-point pressure; visceral, urogenital, and joint manipulation; electrical stimulation; therapeutic exercises; active pelvic floor retraining; biofeedback; bladder and bowel retraining; instruction in dietary revisions; therapeutic ultrasound; and home vaginal dilation. Intravaginal electrical stimulation of the pelvic floor muscles recently has been shown to help alleviate the pain caused by pelvic muscle spasm. A study by Glazer et al. used surface electromyography (sEMG) to assist pelvic floor rehabilitation by calming pelvic floor spasms and renewing pelvic floor neuromuscular functioning in women diagnosed with vestibulodynia. With an average 16-week treatment time, 22 of 28 women studied returned from abstinence to sexual activity. Seventeen of 33 patients reported pain-free intercourse at the 6-month follow-up.[3] Other studies examining the use of sEMG have further validated pelvic floor rehabilitation using biofeedback as a successful treatment approach to vestibulodynia. The randomized outcomes study comparing cognitive-behavioral sex therapy and pain management, sEMG biofeedback, and vestibulectomy found that all three groups reported statistically significant reductions on pain measures at post-treatment and sixth month follow-up. A successful outcome was achieved in about 35 percent of biofeedback participants. However, they were significantly less satisfied and had a greater dropout rate compared to the other experimental groups, possibly because of long-term home treatment protocols and the repetitive nature of the treatment itself. Interestingly, vestibulectomy was significantly more successful than sEMG biofeedback. However, these results need to be interpreted with caution because there were significantly more participants in the vestibulectomy category who declined to undergo the treatment to which they had been randomized, as compared to participants in the two other treatment conditions.

Intralesional Injections

Although topical steroids generally do not help patients with vulvodynia, trigger point steroid and local anesthetic injections have been successful for some patients with localized vulvodynia. A common regimen uses the steroid triamcinolone acetonide 0.1% and the local anesthetic bupivacaine. (No more than 40 mg of triamcinolone acetonide 0.1% should be injected monthly.) The combined drugs are injected into a specific area or as a pudendal block. Generally, patients do not tolerate more than three or four injection trials. Another regimen that has been reported uses submucosal methylprednisolone and lidocaine.

Several practitioners have used Interferon-alpha (IFN-α) as a treatment for vestibulodynia. Long-term improvement after IFN-α therapy is variable. Side effects of this treatment include flu-like symptoms such as fever, malaise and myalgias. There is little data to indicate the effectiveness of interferon use for vestibulodynia.

See GUIDELINE, page 5

Evaluating Candidates for Surgery

Surgical excision is used as the last treatment option for patients with vestibulodynia. Before vestibulectomy, patients should be evaluated for vaginismus. If present, the vaginismus should be treated before surgery, because surgery is less successful in this subgroup. Vaginal dilators as well as various forms of physical therapy are beneficial for vaginismus. Sexual counseling may enhance postoperative improvement by reducing vaginismus and poor sexual arousal, which can develop after long-standing dyspareunia.

Excision of the vulvar vestibule has met with a variety of success rates. Lower success rates most likely are to be found in studies that operate on patients with long-standing problems that have failed numerous treatments. However, despite the high success rates of vestibulectomy in various studies, most experts believe that surgery should be reserved for women with longstanding and severe localized vestibular pain after other managements have yielded inadequate pain relief.

Surgical Techniques

Surgical approaches to introital dyspareunia caused by vestibulodynia can be grouped into the broad categories of 1) local excision, 2) total vestibulectomy, and 3) perineoplasty. Vestibuloplasty, a surgical procedure aimed at denervation of the vestibule without excision of the painful tissue, has been shown to be ineffective.

Local Excision. This technique requires precise localization of small painful areas outlined with a marking pen at surgery. The tissue is excised shallowly and is closed in an elliptical fashion. It may be necessary to undermine the margins for wound closure.

Total Vestibulectomy. The traditional vestibulectomy is an outpatient procedure most often performed under spinal or general anesthesia. A review of this technique with illustrations is described in a recent article. [4] The areas of pain on the vestibule are determined with cotton swab testing and marked in the operating room prior to anesthesia. After anesthesia is placed, sharp dissection is performed to remove the painful area. The area of excision is then closed with absorbable stitches. Often the vaginal mucosa is undermined to help cover the area of excision.

Perineoplasty. In the perineoplasty, the vestibulectomy is performed and includes removal of tissue on the perineum, usually terminating just above the anal orifice. Again, the vaginal mucosa is undermined and advanced to cover the defect.

Complications of surgery can include blood loss, wound infection or separation, granulation tissue, chronic fissuring, Bartholin's duct cyst formation, decrease in lubrication, and continued pain.

Surgery for Pudendal Nerve Entrapment. Perineal pain caused by pudendal nerve entrapment is a rare entity. The pain is exacerbated particularly by assuming a sitting position and is relieved by standing. Bowel function may be abnormal, as well as painful. When the pudendal nerve is entrapped and the patient has failed guided nerve blocks with corticosteroids, tricyclic antidepressants, anticonvulsants, and physical therapy, surgical treatment is an option. It is important to find a surgeon with experience in performing this procedure.

Postoperative Care. Adequate analgesia is required during the 72 hours immediately after vestibular operations. Peri-incisional and labial injection of bupivacaine (with epinephrine in the nonclitoral areas) can reduce pain and intraoperative bleeding. Narcotics may be required for larger excisions. Local ice packs and topical lidocaine also are used. A hypnotic may be useful because the patient often is unable to sleep during the early postoperative period. The pain is maximal for 72 hours and then regresses. By one to two weeks after surgery, the patient is able to resume most activities. Intercourse should not occur until the health care provider has seen the patient for the postoperative visit and has verified adequate healing.

The vulva may be rinsed with Betadine or other gentle disinfectants after bowel movements. Patients should avoid constipating pain medicines if possible, take stool softeners, and eat bulk-forming foods. Warm sitz baths should begin after 24 to 48 hours. Vaginal dilator use may be required after surgery to minimize vestibular contraction and pain.

See GUIDELINE, page 6

Guideline

(from page 5)

Complementary Therapies

Many women use other types of treatments before, during, and after seeking conventional medical diagnosis and treatment for their vulvar pain symptoms. In a study of 26 women diagnosed with vulvodynia, more than 85 percent had used at least one complementary health method and 77 percent reported using complementary health products. The most common self-help strategies included clothing alterations and dietary modification. The less commonly used methods included reduction in smoking and drinking alcohol, relaxation and massage techniques, localized use of ice, saltwater baths and exercise. The various products used included skin care products, herbal and nutritional supplements, antiseptics and anesthetic creams. In a population of 24 women with chronic vulvar pain, a study reported that more than 60 percent of those questioned had used biofeedback, 41 percent had used a low-oxalate diet, and 35 percent had used ice for the treatment of their symptoms. Less than 25 percent of women tried acupuncture, heat and psychiatric care.[5] The overall success of self-diagnosis and treatment remains unclear.

Low-Oxalate Diet with Calcium Citrate

The use of a low-oxalate diet and oral calcium citrate is controversial, but may help some women. Oxalate is an irritant, and it has been suggested that vulvar burning may be associated with elevated levels of oxalates in the urine. A controlled study, however, did not find any difference in oxalate levels in vulvodynia patients and pain-free controls. [6]

Multidimensional Aspects

Sexual pain, regardless of the cause, often involves physical, psychological, and relationship aspects. A comprehensive treatment approach is beneficial. When managing patients with vulvodynia, psychosexual and psychological issues must be considered in addition to the patients' other needs. Initial counseling and education can be accomplished in conjunction with the medical appointment. This includes conducting a basic sexual functioning assessment; offering reassurance and simple suggestions regarding sexual positions, lubrication, temporary cessation of intercourse, alternatives to intercourse; and offering resource information such as reading materials, web sites, and support groups. An assessment should include an inquiry of the patient's relationship concerns and previous history of mental health problems, physical and sexual abuse, and substance abuse.

Patients with localized and generalized vulvar pain need varying degrees of sexual counseling and emotional support. They need to know that referral for therapy does *not* mean that the clinician thinks that the pain is all in the patient's mind. Sharing a model that integrates both the physical and emotional aspects often seen in this disorder can help allay fears the patient may have about her pain being psychological. Sex therapy, couples counseling, psychotherapy, or a combination thereof, may be helpful, and often will be short-term. Certified sex therapists can be found through the American Association of Sex Educators Counselors and Therapists (www.aasect.org).

Summary

Vulvar pain is a complex disorder that frequently is frustrating to both patients and practitioners. It can be a difficult process to treat. Many treatments for vulvodynia, both generalized and localized, have been discussed. No single treatment is successful in all women. It is important to recognize that rapid resolution of symptomatic vulvar pain is unusual even with appropriate therapy. Improvement in pain may take weeks to months and the rate of improvement needs to be addressed realistically with patients. Concurrent emotional and psychological support can be invaluable.

Footnotes:

1. Munday PE. Response to treatment in dysaesthetic vulvodynia. *J Obstet Gynaecol* 2001;6:610–13.

2. Hartmann EH and Nelson C. The perceived effectiveness of physical therapy treatment on women complaining of chronic vulvar pain and diagnosed with either vulvar vestibulitis syndrome or dysesthetic vulvodynia. *J Sect Women's Health* 2001;25:13–18.

See GUIDELINE, page 12

NVA Spearheads Advocacy Week Campaign

By Chris Veasley and Phyllis Mate

In an effort to raise awareness and solicit Congress' support for federal funding of vulvodynia research, the NVA launched its first Grassroots Advocacy Week in May 2005. The campaign's aim was to convince legislators that their constituents care about women's health, specifically the suffering caused by vulvodynia. NVA participants across the country met with the health staffers of 17 US Senators and 8 US Representatives, explaining how the condition impacts their lives and conveying the urgent need for federal research funding. In addition, women who have vulvodynia, their relatives, friends and health care providers, wrote more than 5,000 letters or e-mails to members of Congress. Of the 535 Senators and Representatives in the United States Congress, 486 offices were contacted by our volunteers during Advocacy Week. (Thank you!)

This advocacy campaign preceded the June 9th Congressional briefing on chronic pelvic pain and vulvodynia, organized by the Society for Women's Health Research (SWHR). The briefing was attended by over 100 Congressional staff members and healthcare groups, making it the most highly attended Capitol Hill briefing ever held by SWHR. We owe special thanks to Senator Tom Harkin (D-Iowa) and Representatives Hilda Solis (D-CA), and Lois Capps (D-CA) for sponsoring the Capitol Hill briefing, and to SWHR for its ongoing commitment to promoting awareness of vulvodynia.

Following the success of the briefing, we worked with Senators Arlen Specter, chairman, and Tom Harkin, ranking member, of the US Senate Appropriations Subcommittee on Labor, Health and Human Services, and Education, to revise and include new language on vulvodynia in the 2006 US Senate Appropriations Bill. For the first time, this year's report language was directed at the Office of the NIH Director as well as two Institutes, the National Institute of Child Health and Human Development (NICHD) and the National Institute of Neurological Disorders and Stroke (NINDS, which funds most pain research at NIH). The following is an excerpt of the language addressed to the Office of the Director:

Since fiscal year 1998, the Committee has highlighted the need for research on the prevalence, causes and treatment of vulvodynia, a painful and often debilitating disorder of the female reproductive system. The Committee is pleased that some progress has been made since that time. For example, the NICHD has supported a major study of the prevalence of this disorder. The published results of this study found that as many as 6 million women suffer from vulvodynia, making it one of the most prevalent chronic pain conditions affecting women. The Office of Research on Women's Health (ORWH) was crucial in supporting an important 2003 research conference on vulvodynia. These efforts have both clearly demonstrated the need for substantial additional research and served to heighten the research community's level of interest in studying vulvodynia. The Committee calls upon the Director to build upon these initial successes by coordinating through the ORWH an expanded and collaborative extramural and intramural research effort into the causes of and treatments for vulvodynia. This expanded effort should involve ORWH, NICHD, NINDS and other relevant ICs as well as the NIH Pain Consortium.

In addition, the Committee notes that 40 percent of women with vulvodynia remain undiagnosed after visiting three or more physicians. To address this shortcoming, the Committee urges that NIH include information about vulvodynia on its website and work with the National Vulvodynia Association and the American College of Obstetricians and Gynecologists to implement a national education program for primary care health professionals, patients and the public on vulvodynia's symptoms, diagnosis and treatment options.

Peter Reinecke, a healthcare strategist who served as Senator Harkin's Legislative Director (and then Chief of Staff) for 15 years, donated his professional services to NVA to help secure this year's extensive report language. We are very grateful to Peter for continuing to guide us through the Capitol Hill process. The NVA would also like to express its appreciation to volunteer Lindsey Rossler, who initiated and helped to coordinate last spring's Advocacy Week.

The second NVA Advocacy Week will be held in spring 2006. If you want to meet with your US Senators and/or Representative (in their state offices or in DC), please e-mail Chris Veasley (chris@nva.org) or call 401-398-0830. Chris will contact you in January. (*Editor's note: The NVA Board wishes Chris a happy, healthy maternity leave this fall!)* ■

Conception

(from page 1)

It is best not to take any medications when attempting to conceive (and throughout the first trimester, at a minimum); however, this may not be possible for all women with vulvodynia. If your pain is too severe without medication use, there may be acceptable medications you can use. There is not, however, a "one size fits all" rule to guide you in this area. Whenever a medication is used during pregnancy, its benefits to the mother should be weighed against any risk to the baby. Although the FDA classifies the fetal risk of medication use during pregnancy, there is a great deal of recent information that has not yet been incorporated into this classification. Some medications that are frequently used to treat depression and pain, such as tricyclic antidepressants and Selective Serotonin Reuptake Inhibitors (SSRIs), may not necessarily be harmful. It is very important that you discuss any current medication use with your provider *well in advance* of trying to conceive. He/she will help you determine the best course of action for your individual situation.

The FDA has categorized the risk involved in using medications to guide a woman and her provider throughout pregnancy:

Category A: Adequate and well-controlled studies have failed to demonstrate a risk to the fetus in the first trimester of pregnancy (and there is no evidence of risk in later trimesters).

Category B: Animal reproduction studies have failed to demonstrate a risk to the fetus and there are no adequate and well-controlled studies in pregnant women, or animal studies have shown an adverse effect, but adequate and well-controlled studies in pregnant women have failed to demonstrate a risk to the fetus in any trimester.

Category C: Animal reproduction studies have shown an adverse effect on the fetus and there are no adequate and well-controlled studies in humans, but potential benefits may warrant use of the drug in pregnant women despite potential risks.

Category D: There is positive evidence of human fetal risk based on adverse reaction data from investigational or marketing experience or studies in humans, but potential benefits may warrant use of the drug in pregnant women despite potential risks.

Category X: Studies in animals or humans have demonstrated fetal abnormalities and/or there is positive evidence of human fetal risk based on adverse reaction data from investigational or marketing experience, and the risks involved in use of the drug in pregnant women clearly outweigh potential benefits.

The chart on the next page contains a list of oral medications frequently used to treat chronic vulvar pain and their respective FDA risk categorization. Further information on oral medications not listed in the chart can be found at: www.rxlist.com. (Enter the name of the medication in the search field and read sections on 'warnings/precautions' and 'pregnancy/nursing').

Tapering the Dosage

Drug-free treatments for vulvodynia, including EMG biofeedback and physical therapy, are being used and are safe during pregnancy. However, if these treatments are not helpful enough and complete cessation of medication is impossible, your doctor may be able to advise you how to reduce your dosage to an effective, but relatively safe level. It may also be possible to lower your dosage while you attempt to conceive and then discontinue the medication once a positive, early pregnancy test result is obtained (and if necessary, restart the medication after the first trimester).

Be sure to ask your doctor how quickly you may taper off a drug and how long it will take a particular medication to leave your system. In some cases, it may take several weeks to completely rid your system of a drug before you should attempt to get pregnant. The prospect of weaning yourself off a medication that has helped lessen or eliminate your pain can be daunting. However, some women find that taking a drug for an extended period breaks the pain cycle, and that once they stop taking the drug, they no longer need it to remain comfortable.

See CONCEPTION, page 9

Medication Class	Name	FDA Risk Category
Tricyclic Antidepressant	Elavil ® (amitriptyline)	C/D (depends on source)
	Norpramin ® (desipramine)	C
	Pamelor ® (nortriptyline)	C/D (depends on source)
	Sinequan ® (doxepin)	C
	Tofranil ® (imipramine)	D
Selective Serotonin Reuptake Inhibitor	Prozac ® (fluoxetine)	C
	Paxil ® (paroxetine)	C
	Zoloft ® (sertraline)	C
Selective Serotonin Norepinephrine Reuptake Inhibitor	Cymbalta ® (duloxetine HCl)	C
	Effexor XR ® (venlafaxine)	C
Anticonvulsant	Tegretol ® (carbamazepine)	C/D (depends on source)
	Neurontin ® (gabapentin)	C
	Trileptal ® (oxcarbazepine)	C
	Dilantin ® (phenytoin)	D
Muscle Relaxant	Flexeril ® (cyclobenzaprine)	B
	Norflex ® (orphenadrine)	C
	Soma ® (carisoprodol)	C
	Valium ® (diazepam)	D
Narcotic & Narcotic-like Medication	Ultram ® (tramadol)	C
	Demerol ® (meperidine)	B (D if used for prolonged periods or in high doses at term)
	Percocet ® (oxycodone)	C

(Source: Silverman, The Pill Book, 11th Edition, Bantam Books 2004; Nursing 2002 Handbook; www.perinatology.com/exposures/druglist.htm; www.rxlist.com)

See CONCEPTION, page 10

Online Teaching Program on Chronic Vulvar Pain

The National Vulvodynia Association (www.nva.org) is pleased to announce the release of its online vulvodynia teaching program for healthcare professionals. Available at no cost, the program includes a self-guided presentation on the differential diagnosis, treatment and etiology of vulvodynia. After viewing the program, other valuable resources, such as selected medical journal articles and patient handouts, can be downloaded for future use.

To access the program, visit http://learn.nva.org. If you have any questions or experience any problems viewing the program, please contact Christin Veasley by e-mail (chris@nva.org) or phone (401-398-0830).

The NVA gratefully acknowledges Inlet Medical, Inc., Endo Pharmaceuticals and all NVA donors whose financial contributions helped to support this project. Thank you! ■

Conception

(from page 9)

Topical Medications

Topical anesthetics, such as lidocaine, that are commonly used by women with vulvodynia, are safe to use throughout pregnancy. Topical estrogen use, however, is contraindicated. Many oral medications, such as tricyclic antidepressants and anticonvulsants, are now being compounded into ointments and used topically. Because systemic absorption can occur with any topical, and absorption levels of these newly compounded preparations have not been greatly studied, it is essential that you consult your provider about continuation of *any* topical before trying to conceive.

Low-Oxalate Diet/Calcium Citrate Supplementation
Some women with vulvodynia follow the low-oxalate diet and take calcium citrate. Consumption of up to 1,500 milligrams of calcium daily during pregnancy is safe. Higher amounts are not necessarily harmful to the fetus, but may be harmful to the mother because of the risk of kidney stones. Many essential nutrients are lacking in the low-oxalate diet and it is not recommended during pregnancy.

Oral contraceptives
As soon as you stop taking the birth control pill (*Category X*), you are fertile. However, even a small residue of an oral contraceptive in your system may present an increased risk of birth defects. Most doctors recommend stopping the pill and using another form of birth control, for two to three months before trying to conceive.

Timing is Everything

You're now ready to attempt to conceive. Most women with vulvodynia are able to resume sexual relations at some point, at least occasionally. Hopefully, stopping or reducing oral medication does not prevent you from having intercourse.

If you are only able to have intercourse once or twice a month, you can maximize your chance of conception by having intercourse shortly before ovulation. There are three methods of predicting ovulation described below. You can choose the method that suits you best or simultaneously try all three: using an ovulation test kit, recording basal metabolic temperature and observing changes in vaginal discharge. An ovulation test kit can be purchased at any drugstore for about $25 and includes five test sticks that you hold under your urine stream. The sticks react to the surge in luteinizing hormone that occurs immediately before ovulation. The best time to have intercourse is on the day the test turns positive, which is 24 to 36 hours before ovulation.

Alternately, you can record your basal metabolic temperature by taking a rectal reading each morning for two months, starting on the first day of your menstrual cycle. Your temperature will rise (about half a degree) 24 to 48 hours after you ovulate. Record this information on a graph that also tracks your monthly cycle (note the start date of your period and its duration). After you've used this graph to determine when you ovulate, you can then appropriately time your intercourse. The third method for estimating ovulation is to observe changes in your cervical/vaginal discharge. When the discharge becomes watery, stretchy and clear, ovulation is imminent. This type of discharge aids transport of the sperm through the vaginal canal.

These methods work best for women who have regular cycles. A normal cycle is between 26 and 33 days long and lasts the same number of days every month, although irregularities may occur occasionally. If your irregular cycles last no more than two consecutive months, they should not affect your ability to conceive. On the other hand, if your menstrual cycle is often irregular, talk to your doctor. It could be the sign of an infertility problem. Your doctor can best advise you on how to predict ovulation when your cycle is irregular.

Minimizing Discomfort during Intercourse

Attempting to conceive may mean having intercourse more frequently than you find comfortable, but there are several comfort measures you can use during and after intercourse.

See CONCEPTION, page 11

Conception

(from page 10)

Some women who only have focal tenderness at the vestibule do well with topical Xylocaine which numbs the vulvar tissue. It may be used as a solution (liquid) or an ointment, but the solution is recommended because an ointment is more likely to transfer onto your partner, decreasing his level of stimulation and thereby increasing the amount of time it takes him to ejaculate. Experts recommend placing a cotton ball that has been soaked in 4-percent Xylocaine solution at the introitus 10 to 30 minutes before intercourse. Experiment with the Xylocaine *before* the day/night you are trying to conceive, so you can pinpoint the timing that works best for you. Some women also benefit from a nightly application of 5-percent lidocaine ointment for several weeks as an ongoing treatment to decrease pain during intercourse.

Using a lubricant also cuts down on friction in the vulvar area during intercourse. When attempting to conceive, avoid lubricants that contain chlorohexadine (e.g., KY Jelly), which is toxic to sperm. An example of a lubricant that does not contain chlorohexadine is Astroglide. In addition, avoid oil-based lubricants because they decrease sperm's ability to swim, or may even block passage to a woman's egg. Opt for lubricants that are water-based. If you are unsure which products are water-based, check the contents on the label or choose a product that states it is safe to use with condoms. Because oil can break down the latex in condoms, water-based lubricants are recommended for that purpose as well.

Increasing the duration of foreplay can also help to decrease the length of time of actual intercourse. In addition, many women find that some sexual positions are more comfortable than others. Because different positions work for different women, you should experiment until you find what works best for you.

Following intercourse, you can use ice or a frozen gel pack,wrapped in a towel, on the vulvar area. This will suppress any reflex redness or swelling before it causes a flare-up. If needed, the wrapped ice may be used for 15-20 minutes every one to two hours.

Boosting Your Fertility

Although vulvodynia doesn't directly affect fertility, trying to conceive with the additional challenge of vulvar pain can create stress, which may in turn affect your fertility. Stress can cause a brief menstrual upset or completely stop menstruation. The hypothalamus gland, that is responsible for the flow and timing of your reproductive hormones, is very sensitive to physical and emotional stresses. Luckily, short-term stress only causes a temporary disruption to your reproductive system and is a fertility factor within your control. Try to keep both physical and emotional stress at bay while trying to conceive (and throughout your pregnancy) by eating healthy foods, drinking plenty of water, getting enough sleep and engaging in moderate exercise. Try to identify sources of stress in your life and determine whether any of them can be eliminated. Take extra time for yourself with a warm bath, a massage, or doing something you enjoy such as a trip to the movies, shopping or a hike in the woods. Many women who have had difficulty conceiving discover they are pregnant upon returning from a vacation! Other women become pregnant once they stop "trying" to get pregnant, in essence, when the stress of trying to conceive is eliminated. In fact, some couples learn they are pregnant after filing papers to adopt a child.

Your age also can affect your fertility. Some women with vulvodynia delay childbearing while seeking treatment for their pain and then try to conceive in their thirties or forties, when fertility is lower. Women over 35 can have a normal pregnancy and healthy baby, especially if they follow recommended pre-pregnancy and prenatal care. How-

See CONCEPTION, page 12

Moving? New E-Mail?

If you are moving, or changing your e-mail address, please notify Gigi Brecheen at gigi@nva.org or 301-649-2236.

Conception

(from page 11)

ever, as women age, conditions such as high blood pressure and diabetes tend to occur more often and the risk of pregnancy complications may be higher. In addition, the risk of birth defects increases with age, although it remains low well into a woman's thirties. If your pain has been disruptive to your relationship with your husband or partner, making a decision to commit to childrearing more difficult, a psychotherapist or other counselor may help the two of you sort out your needs, desires and roadblocks. A therapist also can teach you how to cope with many of the stresses you are facing.

Conception without Sex

Even if you cannot engage in sexual intercourse, you can still get pregnant. Creativity and careful planning can easily take the place of making babies the old-fashioned way. If penetration is not possible, manual or oral stimulation of your partner with ejaculation at the introitus may suffice. You can then lie on your back with your knees up, which helps the sperm travel up the vagina and vaginal pool near the cervix.

The next alternative is artificial insemination around the time of ovulation. To do so without the help of a fertility specialist, have your spouse or partner ejaculate into a sterile container, such as a turkey baster. (Note that even if a container is brand new, it still must be sterilized. This can be done by submerging the container in boiling water for 20 minutes.) Then lie down and elevate your hips by placing a pillow under them, and have your partner pour his semen into your vagina. It is important to keep in mind that the semen must reach the cervix and travel into the uterus for conception to occur. Another similar method involves using an unused vaginal diaphragm to place the pool of sperm (instead of spermicide) over the cervix.

Most women do not require artificial insemination with a physician's assistance unless there are other fertility issues, such as reduced volume or number of sperm, or blocked fallopian tubes. However, some women may prefer to undergo artificial insemination with their physician's assistance rather than attempting it on their own. If you do not conceive after undergoing artificial insemination (with the help of a physician) for three cycles, there is likely a fertility problem other than the inability to engage in frequent intercourse. Then you become a standard fertility patient and various therapies or in-vitro fertilization may be attempted.

Surrogacy or Adoption

If you want children, but cannot eliminate high-risk medication, you might consider a surrogate birth mother or adoption. In surrogacy, a fertilized egg is implanted in a woman who volunteers to carry the fetus to term. Another alternative is adoption. It doesn't take long for adoptive parents to realize that when you raise a child, she/he quickly becomes your own.

Editor's note: The above article is an excerpt from the NVA's guide to pregnancy for women with vulvodynia, to be published in spring 2006. ■

Guideline

(from page 6)

3. Glazer HI et al. Treatment of vulvar vestibulitis syndrome with electromyographic biofeedback of pelvic floor musculature. *J Reprod Med* 1995;40:283–90.

4. Haefner HK. Critique of new gynecologic surgical procedures: surgery for vulvar vestibulitis. *Clin Obstet Gynecol* 2000;43:689–700.

5. Trutnovsky G, et al. Use of complementary therapies in a sexual health clinic setting. *Int J Sexually Trans Dis AIDS* 2001;12:307–9.

6. Baggish MS, et al. Urinary oxalate excretion and its role in vulvar pain syndrome. *Am J Obstet Gynecol* 1997;177:507–11.

Editor's note: The original article and reference list can be obtained at www.jlgtd.com, by clicking on Archive, January 2005, The Vulvodynia Guideline.■