

VESTIBULITIS/VESTIBULODYNIA

VESTIBULITIS/VESTIBULODYNIA (ves-tib-YOU-lite-iss, ves-tib-you-low-din-ee-ah)

Vestibulitis (vestibulodynia) is one of the chronic pain disorders (vulvar dysethesia or vulvodynia). The pain is localized to the opening of the vagina. The primary symptom of vestibulitis is pain to the opening to the vagina is touched or entered with a finger or tampon; during intercourse; or with your doctor's vaginal speculum examination. Some patients have pain even when wiping the area with toilet tissue, wearing tight clothing, or riding a bicycle. The pain may be severe enough that it causes involuntary tightening of the muscles of the vagina, causing muscular spasms that make the pain worse.

WHAT ARE THE CAUSES OF THIS CONDITION?

Around the entrance to the vagina is a little rim of tissue called the hymenal ring. Just outside the ring are tiny glands that produce fluid to keep the area moist. These little glands become inflamed, red and very tender, but the triggering factors for this condition are not known. Different factors may cause the problem in different patients. Yeast infections, trauma at delivery or during pelvic surgery, and even back injuries have been implicated. In some cases, there may be a genetic predisposition. Some think that high levels of calcium oxalate in the urine may irritate the vulvar tissue, but this association has not been confirmed. The initial inflammation associated with these conditions seems to start an abnormal feedback loop leading to chronic pelvic muscle tension, which keeps the pain going. You try to protect yourself by tensing up the pelvic floor muscles (or this happens as a reflex) and so, even when the pain stimulus is gone, the tension remains, leading to more pain.

HOW IS THE DIAGNOSIS MADE?

To make the diagnosis of vestibulitis/vestibulodynia, a thorough history and physical must be carried out to rule out other causes of vulvar pain such as infections (herpes, candida, etc.), allergic reaction, skin rashes, tumors, etc. The diagnosis is made by excluding those problems, by obtaining a history of pain and by confirming pain when the area is touched with a cotton swab. Usually there is no visible skin problem. A biopsy is usually neither necessary nor helpful.

HOW IS THIS TREATED?

So far, there is no magic "cure" and treatment takes time. You will need to work closely with your doctor, physiotherapist, and pelvic floor specialist. A sexual counselor may be needed.

1. Avoid irritants. Cleanse gently with plain water or a soap substitute such as Cetaphil® cleanser.
2. If the area feels dry, use a bland lubricant such as plain olive oil as needed.
3. Topical estrogen cream (estradiol 0.01%) may be used 2-3 times daily.

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4. A low oxalate diet may remove calcium oxalate from the urine. Such a diet is outlined in appropriate cookbooks or from a local dietician. To this is added 400mg calcium citrate, three times a day.
5. Medications for nerve pain are often prescribed to modify the pain loop. Amitriptyline may be started with 10 mg at bedtime and gradually increased over weeks to months. The effect of these medications is slow and gradual. Dry mouth may occur and there may be some dizziness and/or fatigue.
6. Biofeedback and pelvic floor physiotherapy: by relaxing and strengthening pelvic floor muscles, the pain can be reduced. A knowledgeable pelvic floor specialist must assess you and start you on a home program. This takes time.
7. Topical anesthetic cream can blunt the pain triggered by touching the area so that sexual penetration is possible. Lidocaine (Xylocaine®, Ela-Max®) 5% or lidocaine-prilocaine (EMLA®) cream may be used, in a thick layer covered with plastic wrap, under a sanitary napkin for 10-15 minutes. These creams sting and burn at first.
8. Surgery: for the occasional resistant case there is a surgical procedure to remove the offending inflamed tissue in the hymenal area. This can be discussed further with your doctor.

WILL I BE CURED?

Most patients do well, with sufficient improvement in the discomfort that they can resume normal sexual relations. There may be some residual or intermittent discomfort. Patients with severe pain problems that are generalized or associated with other problems such as irritable bowel syndrome or interstitial cystitis may have more difficulty.

WHAT IS THE DIFFERENCE BETWEEN VULVODYNIA AND VESTIBULODYNIA?

These are both chronic vulvar pain conditions and they can overlap in the same patient. Vulvar vestibulitis is a subset of vulvodynia. The pain is limited to the hymenal ring area and occurs only when it is touched or pressed. The pain in vulvodynia is constant.

WHERE CAN I GET MORE INFORMATION?

The National Vulvodynia Association
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