

Vulval pain and vulvodynia

Persistent vulval pain where the skin looks normal does not mean the pain is imagined, and it does not mean there is nothing to be done or another condition doesn't coexist

What vulvodynia means

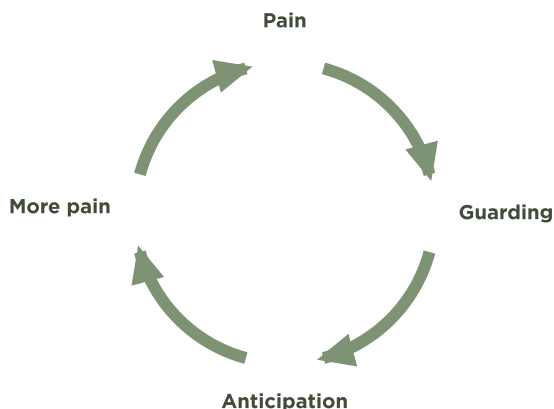
Vulvodynia is defined as **vulval pain lasting three months or longer, without a clear identifiable cause**. Diagnosis is made after careful history, examination, and investigation that has excluded or treated the conditions that do have visible signs — thrush, dermatitis, lichen sclerosus, lichen planus, and skin changes of menopause.

It is common. The pain is real and is not imagined. Mood, stress, fear and relationship effects can amplify or maintain pain, just as they can in other chronic pain conditions, and addressing them is part of treatment.

The pattern matters

Describing your pain precisely helps direct treatment, so we will ask about:

- **Where** — confined to the entrance of the vagina (vestibulodynia, the most common pattern), or spread across the whole vulva
- **When** — only when something touches it, such as sex, a tampon or a bicycle seat (provoked); or present without being touched (spontaneous)
- **Since when** — from the very first time anything was inserted (primary), or after a period of pain-free years (secondary)
- **What pattern** — constant, or coming and going; immediately on contact, or hours afterwards — and what it feels like: burning, rawness, stinging or a knife-like pain



A self-reinforcing loop — treatment interrupts it at more than one point.

WHY IT HURTS WHEN NOTHING LOOKS WRONG

Persistent pain changes the system that carries it. The nerves supplying the vulva become more sensitive, so that ordinary touch is read as pain. The pelvic floor muscles tighten protectively, and tight muscles hurt in their own right and make entry harder — which reinforces the guarding.

By the time you are seen, the original trigger — an episode of thrush, a course of treatment, a skin condition, childbirth — may have resolved completely, while the sensitisation and the muscle response continue. That is why treatment aims at the nerves and muscles rather than at the skin.

Things that contribute

- An overactive, tight pelvic floor
- Previous or recurrent thrush, or a past skin condition
- Hormonal change — menopause, breastfeeding, and sometimes the combined pill
- Other pain conditions: irritable bowel, bladder pain syndrome, fibromyalgia, migraine
- Anxiety about the pain itself, and anticipating it — a consequence as much as a cause, and treatable in its own right

Things that help day to day

- A cool gel pack wrapped in a soft cloth, ten minutes at a time
- Generous silicone or water-based lubricant — more than you think you need
- Loose clothing; avoid sitting for long stretches on hard seats and bicycle saddles
- Rinsing with water while passing urine if it stings, then patting dry
- Positions during sex that let you control depth and pace, and stopping when it hurts rather than pushing through

Treatment

There is no single tablet for vulvodynia — what works is several approaches together, sustained over months. Most women improve substantially and many become pain-free, though recovery is gradual.

APPROACH	WHAT IT INVOLVES
Vulval care	Remove every irritant, moisturise, and stop all over-the-counter anti-itch and anaesthetic creams. See the <i>Looking after your vulval skin</i> sheet.
Pelvic floor physiotherapy	The most useful single intervention for most women with an overactive pelvic floor. A physiotherapist with specific pelvic training teaches downtraining, and uses manual therapy and dilators, over a course of several months. Avoid strengthening (Kegel) exercises unless your physiotherapist recommends them.
Topical hormones	Oestrogen if the tissue is hormonally thin.
Topical local anaesthetic	A trial of 2–5% lignocaine/lidocaine may help selected patients. It can sting or cause dermatitis; use 10–20 minutes before penetration and wash it off first to avoid numbing a partner. Avoid oral contact while the area is numb.
Nerve-modulating medication	Low-dose amitriptyline or similar at night, in some cases can help for spontaneous/generalised pain or sleep problems. It is started low and increased slowly. Though its benefit in provoked pain is less certain. Side effects and response should be reviewed after an adequate trial at a tolerated dose. Allow four to six weeks for benefit.
Psychological support	Cognitive behavioural therapy and mindfulness-based approaches have good evidence in vulval pain. This treats the pain system; it does not imply the pain is in your head.
Sex therapy	Helpful where pain has affected the relationship, or where anticipating it has become part of the problem. Partners are welcome at these appointments.
Surgery	Rarely, and only for provoked pain confined to the vestibule that has not responded to the above and after specialist multidisciplinary assessment.

WHAT TO EXPECT

Improvement is measured in months. Progress is usually uneven, with better and worse weeks, and a bad week is not a relapse. Keep going with the physiotherapy in particular — it is the part that people abandon first and the part that most reliably helps.

Set the aim as being comfortable in daily life first, and comfortable with sex second. That order tends to work better than the reverse.

SOURCES

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4. Melbourne Sexual Health Centre. Vulvodynia treatment guidelines and fact sheet.

5. Jean Hailes. Vulval and vaginal pain.