1

CHAPTER 1

Historical Perspective of Vulvodynia

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History of Vulvodynia

Vulvodynia, or chronic vulvar pain, is a syndrome that appears to have been recognized for centuries, but was not fully described until recently. It is thought that early Egyptian papyri, including the Kahun Gynecological Papyrus and the Ramesseum Papyrus, were the first texts to address gynecological issues including vulvar pain [1, 2]. The condition may have been described in ancient medical literature by Soranus of Ephesus, who referred to a condition similar to what we call vulvodynia today as “satyriasis in females” [3]. However, no documented, medically accurate descriptions of the condition appear in the medical literature until modern times.

**History of the Term
Provoked Vestibulodynia**

Initial discussions of vulvodynia focused on the main complaint of women presenting to their physicians: dyspareunia (i.e., pain during sexual intercourse), a term coined by Barnes in 1874 [4]. In the late nineteenth century, Thomas [5] and Skene [6] described a condition of hypersensitivity in the vulvar region. Thomas [5] described this condition as an “excessive sensibility of the nerves supplying the mucous membrane of some portion of the vulva, sometimes confined to the vestibule... [and] other times to one labium minus.” He noted that a primary complaint of women with this condition was dyspareunia. Similarly, in 1889, Skene [6] and Kellogg [7] reported that sensitive areas around the vaginal opening could cause problems with sexual intercourse. Very little new information on

dyspareunia was reported for a period of four decades, and then in 1928 the condition reemerged in the literature. Kelly [8] expanded on the damaging effects of vulvar pain on sexual intercourse, describing it “as a fruitful source of dyspareunia.”

Information regarding the specific part(s) of the vulvar area implicated in the pain appeared later in published reports. Dickinson [9] found that almost 75% of his dyspareunic patients had a physical reason for their pain, with many suffering from problems of the hymen, urethral meatus, and fourchette. Hunt [10] stated that the minor vestibular gland structures had no link to the pain, and this claim was supported by Dickinson's report [9]. Over time, assertions regarding the cause of this pain began to appear in the literature. O'Donnell [11] believed that the cause of the pain was chronic inflammation attributed to an incomplete rupture of the hymen. Further supporting the involvement of inflammation in dyspareunia were the reports of Pelisse and Hewitt [12], Davis et al. [13], and Woodruff and Parmley [14]. For example, Pelisse and Hewitt [12] found histopathological evidence of chronic and acute inflammation in the posterior vestibule of affected women. Names for this condition, reflecting the role of inflammation (-itis), began to emerge and included the following: focal vulvitis [15], vestibular adenitis [16], focal vestibulitis vulvae [17], and vulvar vestibulitis syndrome [18].

The term *vulvar vestibulitis syndrome* (VVS) is commonly used to describe a condition in which localized, provoked dyspareunia is the main presenting complaint. According to Friedrich [18], the diagnostic criteria for VVS are “severe pain on vestibular touch or attempted vaginal entry, tenderness to pressure localized within the vulvar vestibule, and physical findings confined to vestibular erythema of various degrees.” Today, the relevance

of Friedrich's criterion is questioned and most clinicians make the diagnosis by the exclusion of other etiologies of pain. Additionally, one major problem with the terminology exists: "vestibulitis" implies inflammation. However, the finding of inflammatory indices in the vestibules of women with VVS is not a consistent finding in the literature. As such, the International Society for the Study of Vulvovaginal Disease (ISSVD) renamed VVS to provoked vestibulodynia (PVD) [19].

History of the Term *Generalized Vulvodynia*

In 1975, the ISSVD described generalized vulvodynia (GVD; also known as "essential" or "dysesthetic" vulvodynia) as "burning vulva syndrome" at its world congress. Eight years later, the ISSVD adopted the first standard definition of GVD as chronic vulvar discomfort, characterized by the patient's complaint of burning and sometimes stinging, irritating, or raw sensations.

The Emergence of Two Major Vulvodynia Subtypes

The first empirical attempt to delineate subtypes of dyspareunia was described by Meana and colleagues in 1997 [20]. These investigators proposed that dyspareunia was a heterogeneous disorder including at least three different diagnostic groups, and they emphasized the importance of the pain component of this condition. As a result of this foundational work, conceptualizations began to shift from focusing on "pain during intercourse" to "vulvar pain" conditions in which dyspareunia could potentially be a symptom. This focus is reflected in the ISSVD's classification of vulvar pain. It describes vulvodynia as "vulvar discomfort, most often described as burning pain, occurring in the absence of relevant and visible findings or specific, clinically identifiable, neurological disorder" and lists dyspareunia as one possible expression of vulvodynia [19]. In addition, this classification system includes temporal pain characteristics and pain location as the main categories into which to classify vulvodynia subtypes.

Depending on pain characteristics, two main types of vulvodynia are recognized: PVD and GVD. PVD refers to provoked pain that is localized to the vaginal opening, whereas GVD refers to unprovoked, diffuse vulvar pain affecting the entire vulvar region. Sometimes the pain in GVD may radiate to the anal region, to the lower back or

thighs, or to other areas consistent with the distribution of the pudendal nerve. PVD appears to be more common in premenopausal women, while GVD is most often diagnosed in peri- and postmenopausal women [21]. The pain of GVD can be intermittent or constant, and although the pain is typically unprovoked, it worsens with provocation in many cases. Periods of unexplained relief and/or flare-ups may occur, and erythema may or may not be present. The ISSVD classification also applies to other forms of vulvar pain, such as clitorodynia, reflecting the fact that multiple subtypes of vulvodynia exist.

Vulvodynia Versus Chronic Vulvar Pain Due to an Existing Condition

In the past (and to a lesser extent today), chronic pain conditions—including vulvodynia—that existed in the absence of physical findings were considered suspicious. Often, women with vulvodynia were told that there was nothing "physically wrong" with their genitals, implying that psychosexual problems were the root of the pain. However, as the field of chronic pain evolved, it became known that identifiable physical findings simply did not exist in most cases of chronic pain. This knowledge has been applied to vulvodynia as well.

The term *vulvodynia* is reserved for those cases of chronic vulvar pain that occur in the absence of physical findings [19]. Only in the event that possible contributors to the pain are ruled out can the diagnosis of vulvodynia be made. Specifically, conditions of infectious, inflammatory, neoplastic, and immunologic origin, as well as evidence for any systemic illness, physical trauma to the vulva, dermatologic conditions, urinary tract syndromes, and neurological disorders should be ruled out prior to making a diagnosis of vulvodynia [19]. However, "chronic vulvar pain" can coexist with several conditions and should still be carefully managed and assessed.

Several conditions can contribute to chronic vulvar pain, including the following: (i) infections due to, for example, Bartholin's gland abscess, vulvovaginal candidiasis, herpes genitalis, herpes zoster, human papillomavirus, molluscum contagiosum, and trichomoniasis; (ii) neoplasms, such as vulvar intraepithelial neoplasia and invasive squamous cell carcinoma; (iii) immunological changes due to, for example, altered levels of interleukin-1, tumor necrosis factor and interferon- α ; (iv) systemic illnesses, such as Bechet's disease, Crohn's disease, Sjogren's

syndrome, and systemic lupus erythematosus; (v) hormonal changes, such as those leading to atrophic vaginitis; (vi) dermatological conditions (e.g., allergic and contact dermatitis, eczema, hidradenitis suppurativa, lichen planus, lichen sclerosus, and psoriasis); and (vii) neurological disorders, such as those resulting from pudendal nerve entrapment, injury, or previous surgery.

Are We There Yet?

There has been a tremendous effort to classify, diagnose, study, and treat vulvodynia over the past 15 years. Because of this movement and the active discussion to improve all aspects of vulvodynia assessment, treatment, and support, it is likely that the terms used and the subtypes will continue to be refined for many years to come.

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