Leading to the Nondiagnosis of Vulvodynia?

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A review of the concepts of

Diagnostic

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have also questioned the validity of "dyspareunia," and "vulvodynia" was performed to understand if the suspicion that the more recent and broader DSM concept can have a negative impact on vulvodynia patients.

Results: The definition and referred associated conditions of the "genito-pelvic pain/penetration disorder" overlap those of provoked vestibulodynia, a form of vulvodynia characterized by mechanical allodynia localized to the vulvar vestibule. Despite the footnote that the diagnosis of the former is made after the exclusion of a better explanation for the complaints, the authors believe that a significant number of vulvodynia patients will be included in the "genito-pelvic pain/penetration disorder," thus risking an inappropriate therapeutic approach. "Vaginismus" and "dyspareunia" may occur together, but it is not always the case; assuming otherwise may have a negative impact in the treatment of these women.

Conclusions: The "genito-pelvic pain/penetration disorder" diagnosis may help the clinical approach of women with dyspareunia and/or an increased pelvic muscle tonus. However, it may have a significant negative impact in the approach and treatment of affected women: treatment cannot be "one size fits all." A significant number of women with this diagnosis will have vulvodynia, and exclusively psychological/psychiatric approach would be suboptimal for the condition.

Key Words: genito-pelvic pain/penetration disorder, vulvodynia, vaginismus, dyspareunia, vulvar pain

Vulvar pain or burning in the absence of an identifiable cause (dermatological, muscular, neurological, etc.), either related or not to coitus, was first reported in the medical literature more than a century ago. According to the International Society for the Study of Vulvovaginal Diseases, this condition is to be called vulvodynia. Its etiology is unknown, but probably multifactorial— including, but not exclusively, psychological factors. It is not to be considered a sexual dysfunction, but rather a chronic dysfunctional pain disorder. Dysfunctional pain is defined as a disease state of the nervous system, which arises by its abnormal function, in the absence of neural structural damage.

Vulvodynia is often associated with other comorbid chronic dysfunctional pain conditions, such as fibromyalgia, irritable bowel syndrome, temporomandibular joint disorder, and interstitial cystitis/painful bladder syndrome.

The condition of painful intercourse is often confounded with "vaginismus”—not only by the public in general but also by doctors. As defined in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, "vaginismus" is the involuntary contraction of the pelvic muscles, making penetration impossible—associated or not with pain (nevertheless, it was included in the subheading "sexual pain disorders"). It is increasingly more common that patients seek for information on the Internet, and most easily accessible Web sites about these topics repeat and perpetuate this confusion. The definition of dyspareunia resembles that of vulvodynia, although the latter was never referred as a differential diagnosis.

"Vaginismus" and "dyspareunia," which had different therapeutic approaches (relaxation/desensitization versus treatment of a medical or psychological underlying condition, respectively), become one single and broader condition in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition: the "genito-pelvic pain/penetration disorder." This fusion was, at least in part, justified by the fact that the key difference between the 2 conditions (muscle spasm) was deemed an unreliable marker. Furthermore, it was felt that classifying sexual pain disorders as sexual dysfunction was an inaccurate approach in which a pain condition was classified according to the activity it interfered with.

The "genito-pelvic pain/penetration disorder" includes both pain during sexual activity and tension or contraction of the pelvic muscles during penetration attempts. In the definition, it is highlighted that it must not be related to another condition. Like in the previous version, vulvodynia was not referred among those other conditions. Interestingly, some authors assume the latter is a form of "genito-pelvic pain/penetration disorder.

Several of the referred characteristics of the condition clearly resemble those of vulvodynia. It is pointed that the pain can be described as burning; its prevalence, in the United States, is referred to be 15%—the association with bladder pain syndrome (referred as interstitial cystitis) and irritable bowel syndrome is common.

In clinical practice, provoked vestibulodynia, a form of vulvodynia characterized by mechanical allodynia localized to the vulvar vestibule, is far more common than "vaginismus," and the treatment approaches are rather different (even deleterious if vulvodynia is approached as "vaginismus"). Noteworthy, in this version of the Diagnostic and Statistical Manual of Mental Disorders, the importance of pelvic assessment by a specialist gynecologist or by a pelvic floor physical therapist is highlighted. Although the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, attempted to reflect the current state of research in the field of sexual disorders, still a lot of work is needed in terms of genital pain.

Lahaye et al. have also questioned the validity of "genito-pelvic pain/penetration disorder" because they reported that fear levels and vaginal muscle tension were significantly higher in women with vaginismus, when compared with those with dyspareunia/vulvodynia and normal controls. In this line of thought, other authors had previously suggested that "vaginismus" should be classified as a "vaginal penetration phobia"—an excessive or unreasonable fear of penetration. In theory, this should lead to a division of vaginismus in 2 groups: primary (without a physical cause, phobic) and secondary (reactive to a physical condition, like vulvodynia).

It is likely that a significant number of the cases classified as "genito-pelvic pain/penetration disorder" correspond to vulvodynia. Some women will end up in that group, despite never having had

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penetration. A purely psychiatric approach can have serious deleterious effects, as we have encountered in clinical practice. These women have a physical condition, manifesting as a chronic pain and, secondarily, a potential sexual disorder, rather than a primary psychiatric disease. All suspected cases of dyspareunia or vaginismus should be evaluated by a medical professional with differentiation in this area before a pure psychological cause for the complaints can be assumed. Even in cases with a confirmed diagnosis of vulvodynia, a multidisciplinary approach and sexual education have proved to lead to better results—13—the same should be generalized to all cases of dyspareunia and/or vaginismus.

REFERENCES