Chronic Vulvar Pain

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Background: Chronic vulvar discomfort due to paucity of clinical signs is often associated with the term “vulvodynia”, perceived as a psychiatric problem.
Case report: A 28-year-old female patient presented for a 2-year history of vulvodynia, without any pathologic vulvar aspects. We investigated this syndrome by means of vulvar cytology, vulvoscopy, histology and ViraPap, too.
Results: Our interdisciplinary consultation indicates that vulvar vestibulitis syndrome co-exists with micropapillomatosis labialis (MPL), due to certain types of HPV. A herpes simplex episode occured 4 months after therapy and recurrent vulvovaginal candidiasis, too. During a period of 8 months, clinical examination showed smooth and well-demarcated whitish shiny plaques, that affected the clitoral hood, labia minora, the posterior fourchette and perineum. The clinical picture suggested a vulvar dystrophy.
Discussions: In this case report we intend a multidisciplinary approach to give a physical support to certain cases of vulvodynia, often associated with an expression of a psychological discomfort.

Keywords: vulvodynia, HPV infection, vulvar dystrophy

Introduction

Vulvar pain, perceived as itchy or burning sensation before or after menstrual periods, remains a diagnostic problem.

The term "vulvodynia" or "burning vulvar syndrome" was introduced in 1983 by the International Society for the Study of Vulvovaginal Diseases (ISSVD), defining the chronic discomfort in the vulvar region, not accompanied by physical signs of abnormality and without an apparent cause [1]. This condition describes the "essential vulvodynia" for a significant percentage of patients. It may be the result of peripheral or central neural sensitization, or more rarely part of a chronic pain syndrome in primary psychiatric disorders [2,3].

In practice, two major entities are described: "vestibulitis" and "dyaesthetic vulvodynia". The first defines a chronic pain syndrome in young women characterized by dyspareunia, vestibular sensitivity to light touch and vestibular mucosal erythema [4]. "Vestibulitis" was described in 1880 as "vulvar hyperesthesia" and associated with a cvasinormal psychosomatic ground and/or episodic anxiety states [5,6]. Some of these women may present pearly papules, visible to the naked eye on the internal faces of the labia minora and vestibule at the back of the vulva, with non-specific acetowhite reaction (after 5% acetic acid brushing, the surface of the papules bleaches), although not associated with HPV infection [1,7,8]. There are authors who suggest that the appearance described by "vestibular papillomatosis", a cvasinormal and usually asymptomatic condition, to be excluded from the vulvodynia category [2,3,9].

"Dyaesthetic vulvodynia" is a diffuse, often spontaneous vulvar pain, which can be aggravated by local touch. It is more common in post-menopausal women, who often have no more sexual activity and it evolves on a depressive ground, primary or secondary to a chronic pain [1,2,9].

Authors of the international circuit consider the line between "vestibulitis" and "dyaesthetic vulvodynia" to be vague. In 1999 the ISSVD recognized the need to change the nomenclature to meet the classification of the general chronic pain syndrome. The term "dyaesthetic vulvodynia" defines a diffuse, permanent and spontaneously occurring vulvar pain. The pain triggered by simple touch was labelled, according to its location, as "vestibulodynia", "clitorodynia", etc. [1,7,9].

There are authors who do not exclude, however, the role of infection with papillomaviruses, and the importance of detection of underlying precancerous lesions in the etiopathogenesis of the chronic vulvar pain syndrome [3,10,11,12,13].

Treatment is non-standard. Patients with long-term psycho-sexual dysfunctions, if confirmed, are diagnosed with psychiatric pathology and treated in specialized clinics [8].

Case presentation

The patient aged 28 years, non-smoking, from an urban environment, with a pruriginous vulvar history of about 2 years, presented for intermittent labial erythema and repeated spikes of pseudoepitheliomatous genital condilomatosis (Figure 1) which was histologically confirmed (Figure 2). After a period of 4 months from the beginning of a topical treatment for condilomatosis with acetic acid solution at a concentration of 70%, the patient presented the first episode of genital herpes eruption (Figure 3). The targeted anamnesis and clinical examinations from the last 6 months showed the presence of Candida albicans in the vaginal exudate, inflammatory and dysplastic modifications on cytological examinations, as well as hormonal abnormalities: low FSH levels (on day 14: 0.209 mU/ml, from 4.7 mU/ml). The reactions for hepatitis viral markers were negative.

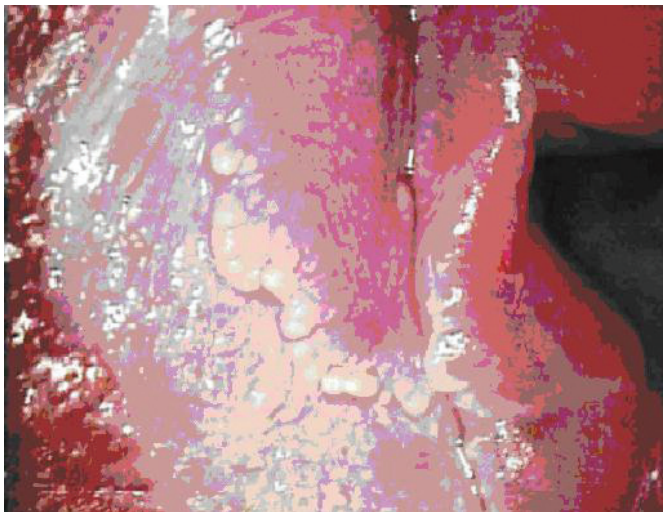

Fig. 1. Vulvoscopic appearance suggestive for HPV infection: vestibular white lesions in snowflakes; pointlike vessels and digitforms extensions on the inner side of the labial epithelium and vulvar vestibule

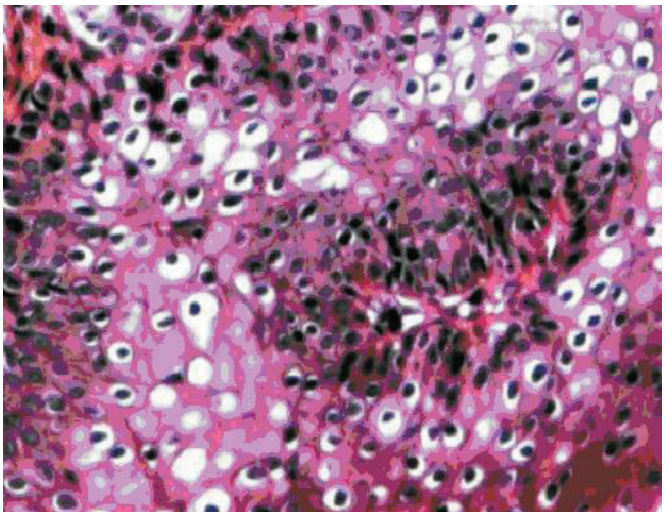

Fig. 2. Malpighian hyperplasia associated with papillomatosis; Focal koilocitosis into the higher malpighian (HE, ob. 20×)

Fig. 3. Primary genital herpes. Vulvoscopic appearance.

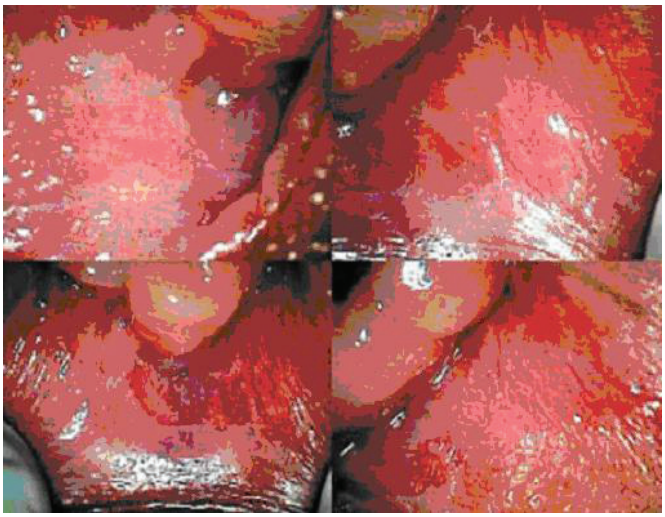

Fig. 4. White, pale and atrophic spots, well delimited on the walls of the vulvar vestibule.

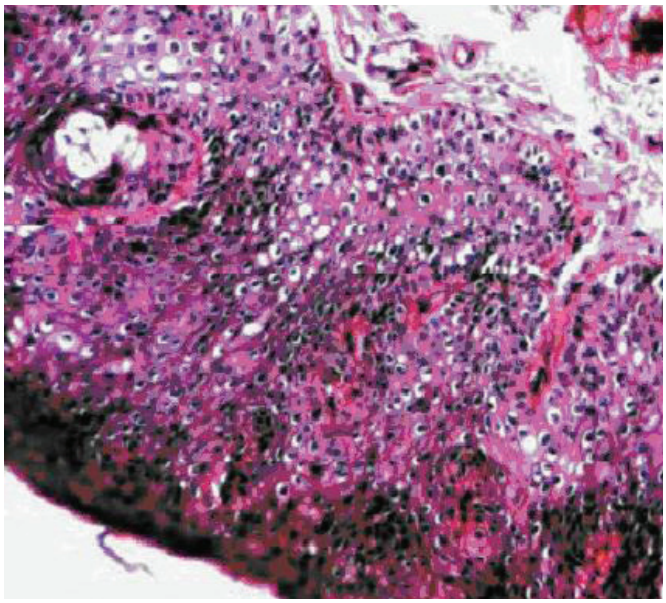

Fig. 5. Histological appearance of intraepithelial vulvar neoplasia (HE, ob. 10×)

Discussions

The term "vulvodynia" describes a multifactorial syndrome that causes chronic discomfort in the vulvar region, expressed by a burning sensation, rarely itching or local pain and dyspareunia. There are authors who consider vulvodynia as an expression of symptomatic dermographism.

In our attempt to find an explanation of chronic vulvar pain in a young woman with a varying history of HPV infection, we used several available investigation methods and initiated an interdisciplinary cooperation appropriate for the clinical situation. A general and topic treatment, specific for candida vaginitis, herpes eruption and the sanitation of the flora from genital superinfection was established.

The hormonal disorders were treated in cooperation with an endocrinologist. During and 3 months after the treatment, the repeated clinical and vulvoscopic examina-

tions showed dysplastic vulvar lesions (Figure 4). Histological examination of the sampled lesion, following a Collins test, showed early keratinization, the presence of Darier's dyskeratotic cells suggestive for HPV infection, squamous type cell irregularity, without the invasion of the lower third of the epithelium (Figure 5).

Taking into account the patient's age, the excisional treatment of the dysplastic lesion was performed, followed by topical chemotherapy with antimitotic agents (5-fluorouracil) in bi-quotidian application for 8 weeks. The post-treatment histological control showed a favorable response, with the disappearance of the dysplastic-type vulvar lesions.

Conclusions

It is certain that non-specific signs and symptoms in the vulvovaginal region must be taken into account. They can occasionally mask an aggresive, insidious pathology, with possible post-treatment relapses.

Also, we cannot neglect the role of the HPV infection in determining a multifocal disease and an associated preneoplastic pathology in the female reproductive tract.

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