

W19: A Multi-Disciplinary Approach to the Treatment of Provoked Vestibulodynia

Workshop Chair: Marie-Josée Lord, Canada
07 October 2015 14:00 - 15:30

Start	End	Topic	Speakers
14:00	14:05	Introduction	Marie-Josée Lord
14:05	14:30	Gyneacological evaluation and medical treatment approach	Dr Samir Khalifé
14:30	14:50	Psychological approach	Sophie Bergeron
14:50	15:10	Physical therapy evaluation and treatment	Claudia Brown
15:10	15:20	Urban model of inter-disciplinary clinic	Marie-Josée Lord
15:20	15:30	Questions	All

Aims of course/workshop

- To explain the incidence and nature of Provoked Vestibulodynia (PVD) and the medical approach to treatment
- To recognize the implications of the psychological aspect of PVD
- To understand the nature of the assessment of the pelvic floor musculature and related structures, and to see the relevance of physiotherapy interventions
- To identify the relevance of inter-disciplinary management of women with PVD

Learning Objectives

1. To explain the nature of Provoked Vestibulodynia (PVD) and the medical approach to treatment.
2. To recognized the implications of the psychological aspects of PVD.
3. To understand the nature of the assessment of the pelvic floor musculature and see the relevance of physiotherapy interventions.

Provoked Vestibulodynia

Gynaecological evaluation and medical treatment approach

Samir Khalifé

OBJECTIVES

- Definition of the most frequent sexual pain disorders
- Clinical evaluation of sexual pain disorders
 - Clinical evaluation of provoked vestibulodynia
- Treatment modalities of provoked vestibulodynia

SEXUAL PAIN DISORDERS

- **Dyspareunia:** Persistent or recurrent pain with attempted or complete vaginal entry or penile–vaginal intercourse
- **Vaginismus**

Basson R: Summary of the recommendations on sexual dysfunctions in women. J Sex Med. 2004 Jul;1(1):24-34

SEXUAL PAIN DISORDERS

- **Vaginismus:** Persistent or recurrent difficulties in allowing vaginal entry of a penis, finger or any object, despite the woman's expressed wish to do so. There is often (phobic) avoidance; anticipation, fear or experience of pain; and variable involuntary contraction of pelvic muscles. *Structural or other physical abnormalities must be ruled out or addressed.*

Basson R: Summary of the recommendations on sexual dysfunctions in women. J Sex Med. 2004 Jul;1(1):24-34

Prevalence of dyspareunia

- Prevalence in the general population: ~15%
 - Laumann et al (1999). JAMA 281(6),p 537-544-
 - Harlow et al (2001). AmJObGyn 186 (3), p.547-550
- If you don' t ask about it, the majority of patients will not mention it

SEXUAL PAIN DISORDERS

- Dyspareunia: 15%
- Vaginismus: 1%

Basson R: Summary of the recommendations on sexual dysfunctions in women. J Sex Med. 2004 Jul;1(1):24-34

ISSVD Terminology and Classification of Vulvar Pain (2003)

- (A) Vulvar pain related to a specific disorder
 - (1) Infectious (e.g., candidiasis, herpes, etc.)
 - (2) Inflammatory (e.g., lichen planus immunobullous disorders)
 - (3) Neoplastic (e.g., Paget disease, squamous cell carcinoma, etc.)
 - (4) Neurologic (e.g., herpes neuralgia, spinal nerve compression, etc.)
- (B) Vulvodynia
 - (1) Generalized
 - (a) Provoked (sexual, nonsexual or both)
 - (b) Unprovoked
 - (c) Mixed (provoked and unprovoked)
 - (2) Localized (vestibulodynia, clitorodynia, hemivulvodynia, etc.)
 - (a) Provoked (sexual, nonsexual or both)
 - (b) Unprovoked
 - (c) Mixed (provoked and unprovoked)

Moyal-Barracco M: 2003 ISSVD terminology and classification of vulvodynia: a historical perspective. J Reprod Med. 2004 Oct;49(10):772-7

ISSVD Terminology and Classification of Vulvar Pain (2003)

VVS

- (A) Vulvar pain related to a specific disorder
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Moyal-Barracco M: 2003 ISSVD terminology and classification of vulvodynia: a historical perspective. J Reprod Med. 2004 Oct;49(10):772-7

CLINICAL APPROACH FOR A DIAGNOSTIC ETIOLOGY

- Where does it hurt
 - Superficial or introital dyspareunia
 - Deep dyspareunia
- When does it hurt
- What are the associated symptoms

Graziottin A: Etiology and diagnosis of coital pain. J Endocrinol Invest. 2003;26(3 Suppl):115-21. Review.

Introital dyspareunia

- Hormonal etiology
- Vulvovaginitis
- Vulvar dystrophy
- Iatrogenic factors Facteurs
- Muscular Factors
- **Provoked localized vulvodinia**
- Others:
 - Neurological (pudendal nerve)
 - Auto-immune (Sjogren' syndrome)
 - Genital trauma

Graziottin A: Etiology and diagnosis of coital pain. J Endocrinol Invest. 2003;26(3 Suppl):115-21. Review.

Deep dyspareunia

- Endometriosis
- Pelvic inflammatory disease
- Levator ani myalgia
- Involution of the vagina and uterus in post menopause

Graziottin A: Etiology and diagnosis of coital pain. *J Endocrinol Invest.* 2003;26(3 Suppl):115-21. Review.

Provoked localized vulvodynia

- Severe pain on vestibular touch or attempted vaginal entry
- Tenderness when pressure is localized within the vestibule
- Physical findings confined to vestibular erythema of various degrees

Friedrich, E. G. (1987). Vulvar vestibulitis syndrome. *Journal of Reproductive Medicine*, 32, 110–114

Sexual history

- Sexual activity (presence?)
- Types of relations
- Individual(s) involved
- Satisfaction? Orgasmic?
- Dyspareunia
- Sexual dysfunction
 - Patient
 - Partner

Stenchever MA: Comprehensive Gynecology, Mosby, 1997

LISTEN AND REACT TO MESSAGES

- Tampons are painful to insert
- The smallest speculum please
- My previous doctor asked me to relax
- I always had a yeast infection that is impossible to treat

HISTORY TAKING FOR DYSPAREUNIA

- Description
- Localization
- Relation with the menstrual cycle
- Complete chronology
- Previous treatments
- Long and free questionnaire

THE TRADITIONAL GYNECOLOGICAL EXAMINATION

- Inspection of the external genital organs and the introitus
- Palpation of the external genital organs and the introitus
- Speculum examination of the vagina and the cervix
- Digital vaginal and bimanual examination
- Rectovaginal examination
- Rectal examination

DIFFERENT APPROACH

- Do not hurt
- Proceed in a stepwise fashion, one visit at a time
- Do not touch the vestibule
- Do not insert a speculum first
- Insert a lubricated Q-tip
- Insert only one finger and then two

Khalifé S: personal communication

GEL LUBRICANT

- Hathaway JK: Is Liquid-Based Pap Testing Affected by Water-Based Lubricant? *Obstet Gynecol* 2006;107:66–70
- Kozakis L: Plastic specula: can we ease the passage? *Sex. Transm. Inf.* 2006;82;263-264
- Griffith WF: Vaginal speculum lubrication and its effects on cervical cytology and microbiology *Contraception* 72 (2005) 60–64
- Tavernier LA: Water versus gel lubricant for cervical cytology specimens. *The Journal of Family Practice* 2003 52;9;701-704

THE MYTH OF THE WATER BASED GEL LUBRICANT

- No difference in cervico-vaginal slide or liquid-based cytology
- No difference in the detection of chlamydia, gonorrhea, vaginal bacteriosis, candida...

GYNECOLOGICAL EXAMINATION

THE FORGOTTEN EXAMINATIONS

- The Q-tip test
- The examination of the pelvic floor musculature



PATIENT'S AND PARTNER PARTICIPATION

- The mirror
- Rating the pain on a scale of 1 to 10

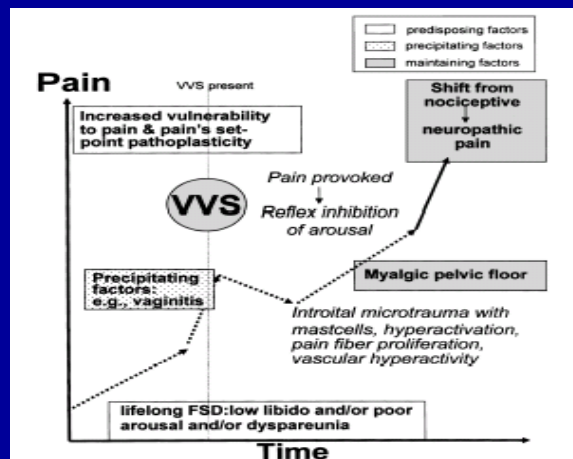
The Q-tip test



GYNECOLOGICAL EXAMINATION

- The sequence of testing: the Q-tip test at the end
- Positive feedback : « it is a real physical pain»
- The control visit

Provoked localized vulvodynia



Graziottin A: Vulvar vestibulitis syndrome: a clinical approach. J Sex Marital Ther. 2004 May-Jun;30(3):125-39. Review.

Treatment of Provoked Vestibulodynia Standard treatments

- Topical Preparations
 - Estradiol may decrease symptom severity
 - Anesthetics
 - Topical compounded formulations with one or more active ingredients (e.g., anesthetic, antidepressant, anticonvulsant)

<http://learnprovider.nva.org/index.htm>

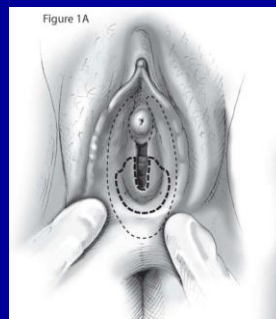
Treatment of Provoked Vestibulodynia Standard treatments

- Oral “Pain-blocking” Medications
 - Tricyclic antidepressants (e.g., amitriptyline)
 - Anticonvulsants (e.g., gabapentin, pregabalin, lamotrigine)
 - SSNRI medications (e.g., duloxetine, venlafaxine)

<http://learnprovider.nva.org/index.htm>

Treatment of Provoked Vestibulodynia Standard treatments

- Pelvic Floor Therapy
- Sequential Nerve Blocks (subcutaneous, pudendal and caudal)
- Surgery
- Psychotherapy



<http://learnprovider.nva.org/index.htm>

Treatment of Provoked Vestibulodynia Efficacy uncertain and debated

- Topical Steroids
- Interferon injections
- Topical Cromolyn
- Subcutaneous Steroid/Anesthetic Injections
- Diet Modification
- Botox Injections

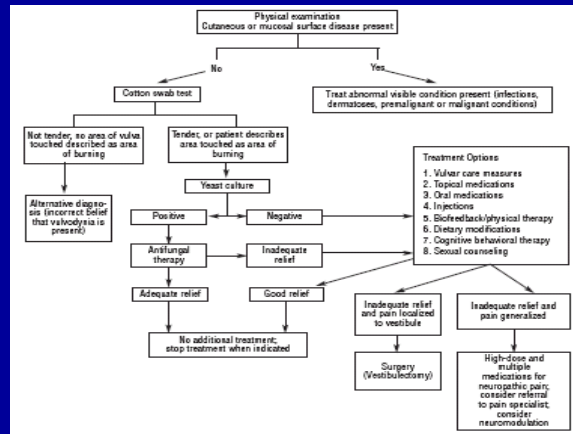
<http://learnprovider.nva.org/index.htm>

Treatment of Provoked Vestibulodynia Experimental

- Leukotriene Receptor Antagonist
- Topical Nitroglycerin
- Topical Capsaicin
- KTP-nd:YAG laser therapy
- Photodynamic Therapy
- Transcutaneous Electrical Nerve Stimulation
- Sacral Neuromodulation

<http://learnprovider.nva.org/index.htm>

Treatment of vulvodynia



Vulvodynia. ACOG Committee Opinion No. 345. Obstet Gynecol 2006;108:1049–52.

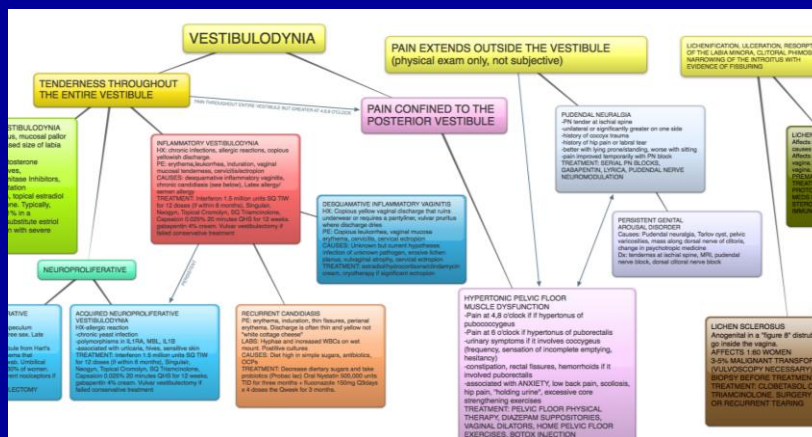
INTROITAL DYSpareunia & Vulvar Pain: A diagnostic and treatment algorithm

King M, Rubin, R, Goldstein, A. Current uses of surgery for the treatment of genital pain. *Current Sexual Health Reports* 2014;6:252-8.

Goldstein A:

http://o.b5z.net/i/u/10023334/i/DYSpareunia-AND-Vulvar-Pain-algorithm_OCTOBER_11_2014.jpg

INTROITAL DYSPAREUNIA & VULVAR PAIN: A diagnostic and treatment algorithm



RCT

Average percentages of pain reduction by dependent measure and treatment condition*

Variable	Vestibulectomy	sEMG biofeedback	GCBT
Vestibular pain index	70.0	23.7	28.6
Pain intensity during intercourse	52.5	35.0	37.5
MPQ-PRI	46.8	22.8	27.7
MPQ – Sensory scale	47.1	19.0	20.7

* sEMG, surface electromyographic; GCBT, group cognitive-behavioral therapy.

As compared with pretreatment, study completers of all treatment groups reported statistically significant reductions on pain measures at post treatment and 6-month follow-up, although the vestibulectomy group was significantly more successful than the two other groups

Treatment gains were maintained at the 2.5-year follow-up

Bergeron S et al: A randomized comparison of group cognitive-behavioral therapy, surface electromyographic biofeedback, and vestibulectomy in the treatment of dyspareunia resulting from vulvar vestibulitis. *Pain*. 2001 Apr;91(3):297-306.

Bergeron S et al: Surgical and Behavioral Treatments for Vestibulodynia: Two-and-One-Half-Year Follow-up and Predictors of Outcome. *Obstetrics & Gynecology*; January 2008 - Volume 111 - Issue 1 - pp 159-16

Treatment of Provoked Vestibulodynia NO QUICK FIX

In clinical practice the only situations where
there a quick fix are

- A new partner
- Local hormonal therapy (cream) in
hormonally mediated vestibulodynia

Khalifé S: personal communication

Treatment of Provoked Vestibulodynia PRIMUM NON NOCERE

- First step: multidisciplinary approach
 - Cognitive behavioral therapy
 - Pelvic Floor Therapy
- Second step:
 - Xylocaine ointment 5%
 - Elavil
- Last resort: vestibulectomy

Khalifé S: personal communication

HOW TO SELL THE PRODUCT

Simple, down to earth explanations

- Women with VVS demonstrated significantly more vaginal hypertonicity, lack of vaginal muscle strength, and restriction of the vaginal opening, compared to women with no pain with intercourse.
- Anal palpation could not confirm generalized hypertonicity of the pelvic floor.

Reissing ED et Al: Pelvic floor muscle functioning in women with vulvar vestibulitis syndrome. J Psychosom Obstet Gynaecol. 2005 Jun;26(2):107-13.

HOW TO SELL THE PRODUCT

Simple, down to earth explanations

Set of 20 Von Frey hairs



Pukall CF et al : Vestibular tactile and pain thresholds in women with vulvar vestibulitis syndrome. Pain. 2002 Mar;96(1-2):163-75.

HOW TO SELL THE PRODUCT

Simple, down to earth explanations

- Apprehension
- Why me
- When am I going to have a sex life like my friends or like before
- Is my relationship going to last
- One more time, we will give it a try, he will have fun and I will have pain...

Khalifé S: personal communication

Tradionnal approach

- **Medecine**
 - Physical pathology (treat the pathology)
 - OR
 - “It is in the head” (refer to psychology)
- **Psychology**
 - Conflict or sexual abuse (treat)
 - OR
 - Physical pathology(refer to gynecology)

Biopsychosocial approach

- Non simplistic
- Simultaneous psychological & physical approach for
 - Diagnosis
 - Etiology
 - Treatment
- Inspired by the contemporary research on pain (Melzack)

SEXUAL PAIN DISORDERS conclusion

- Reliable diagnosis
- Available treatments
- Family physicians and gynecologists: first line
 - Ask questions concerning dyspareunia
 - Ask questions concerning sexual dysfunctions
- If you don' t ask about it, the majority of patients will not mention it

SEXUAL PAIN DISORDERS

conclusion

- Examination could be brief (usually 2 visits)
- Pamphlets, internet resources ...
- Team work, multidisciplinary approach (Family physicians, gynecologists, sexologist, and physiotherapist...)

REFERENCE

<http://www.nva.org/>

Psychological approaches to the treatment of provoked vestibulodynia

Sophie Bergeron, Ph.D.
Department of Psychology
Université de Montréal



Outline of Presentation

- Prevalence, psychological factors and sexual dysfunction
- Group cognitive-behavioral therapy
- Individual cognitive-behavioral therapy
- Interpersonal factors in provoked vestibulodynia
- Couple therapy
- Conclusions

Prevalence, Psychological Factors and Sexual Dysfunction



Prevalence

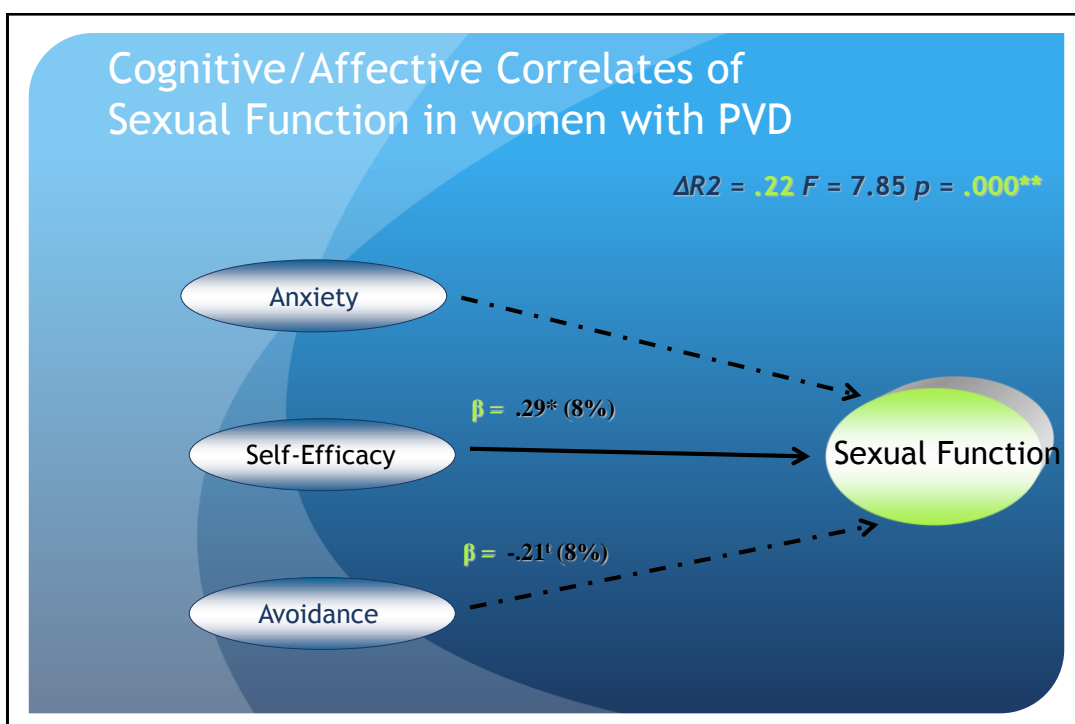
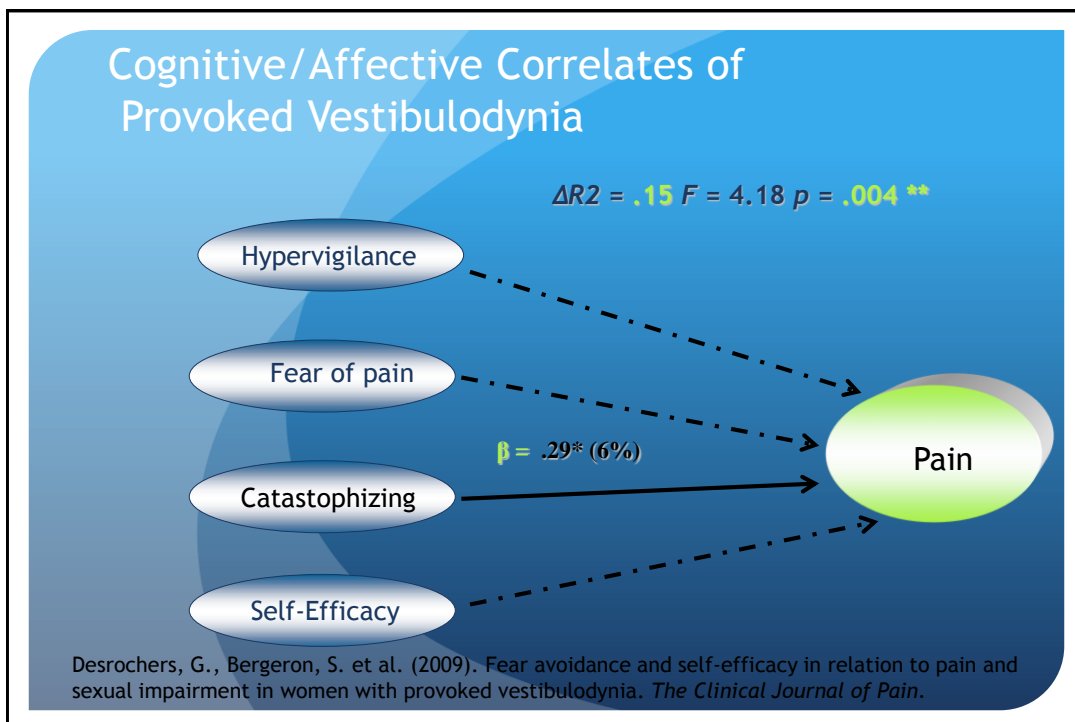
- One in five women aged 18-29 report chronic pain during intercourse (Laumann et al., 1999)
- Only 60% of women who report chronic vulvo-vaginal pain seek treatment for their pain, and over 50% of these never receive a formal diagnosis (Harlow et al., 2014)
- Up to 45% of women with vulvo-vaginal pain report a comorbid-pain condition, and having a comorbidity is associated with increased feelings of isolation and invalidation (Nguyen et al., 2012)

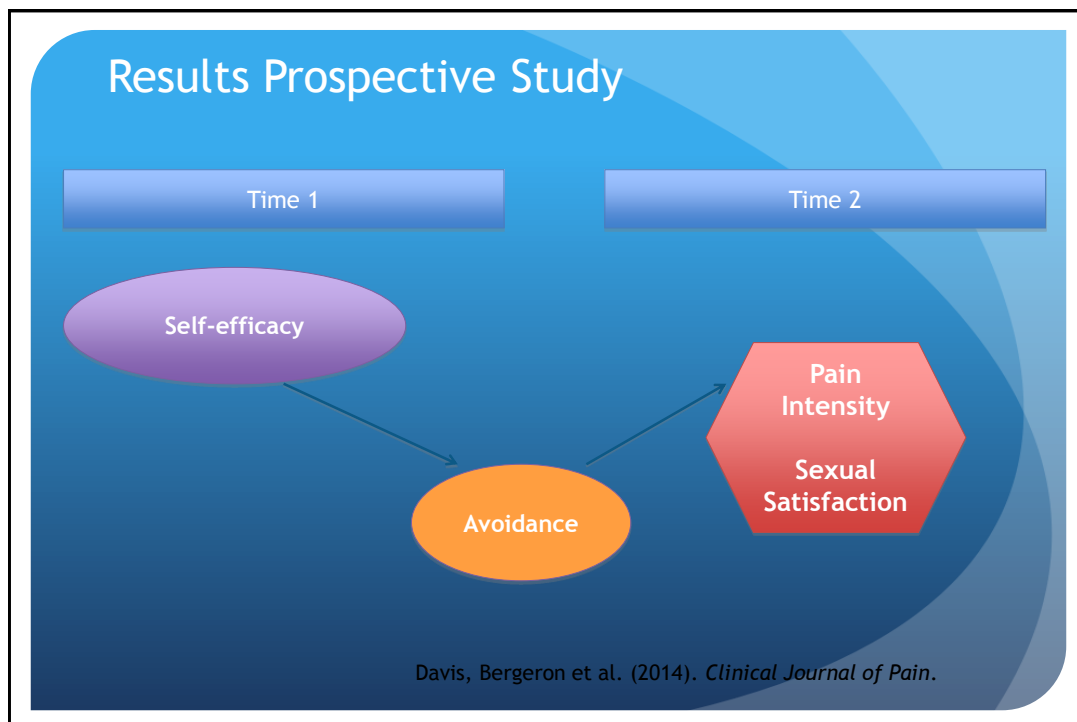
Psychosexual Functioning of Women with PVD

- Lower intercourse frequency, lower levels of desire and arousal, more avoidant of sexual activities, and less orgasmic success (Meana et al., 1997; van Lankveld et al., 1996)
- More anxiety and negative feelings toward sexuality (Meana et al., 1997; Granot et al., 2002)
- Less childhood family support, more physical and sexual abuse as a child (Harlow et al., 2005; 2014)
- More negative sexual self-schema (Gates & Galask, 2001; Reed et al., 2003)

Psychosexual Functioning of Women with PVD

- Uncontrolled and controlled cross-sectional studies show that women with dyspareunia generally report more feelings of depression and anxiety
- A community-based study showed that the odds of vulvo-vaginal pain were 4 times more likely among women with antecedent depression or anxiety compared to women without and that these disorders were also significantly more prevalent as consequences of the vulvar pain when compared to healthy controls (Khandker, et al., 2011)





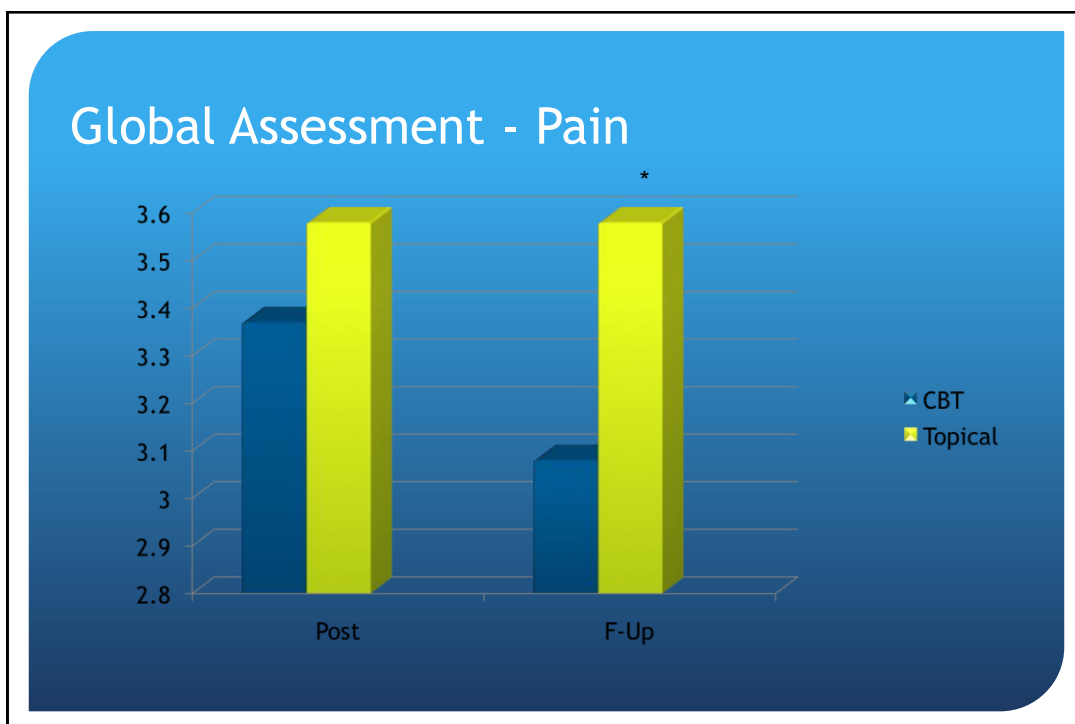
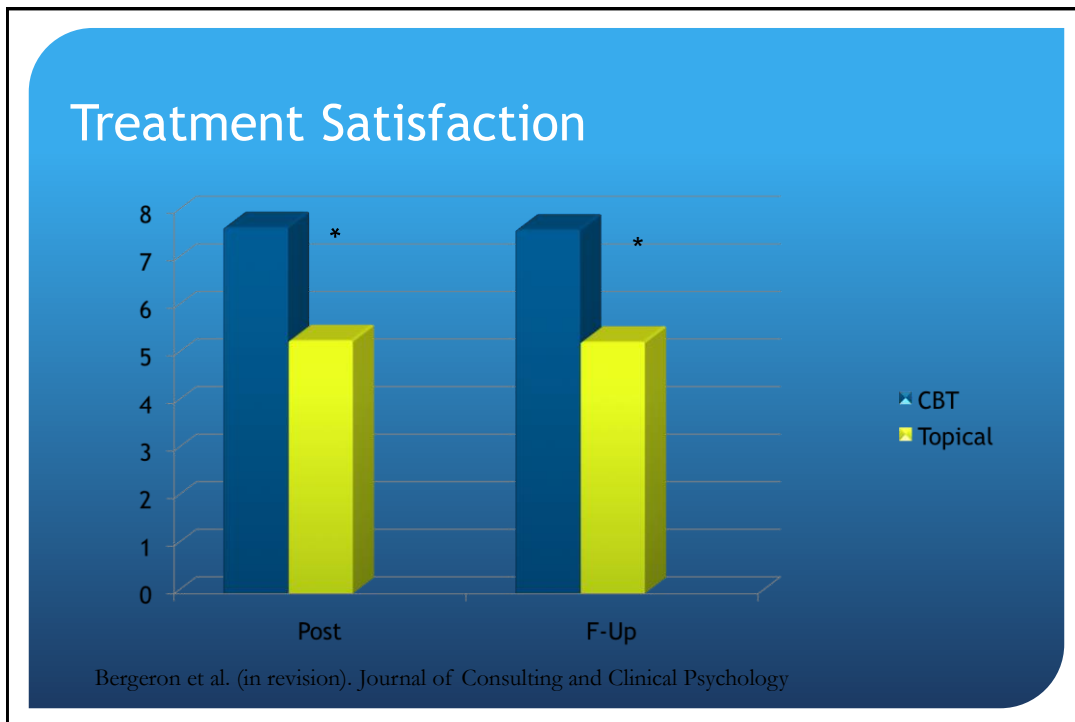
- ### And the Partners?
- More erectile difficulties (Pazmany et al., 2014; Smith & Pukall, 2014)
 - Less sexual satisfaction (Smith & Pukall, 2014)
 - Poorer sexual communication (Smith & Pukall, 2014)
 - 73% report that the pain has a negative impact on their relationship (Smith & Pukall, 2014)

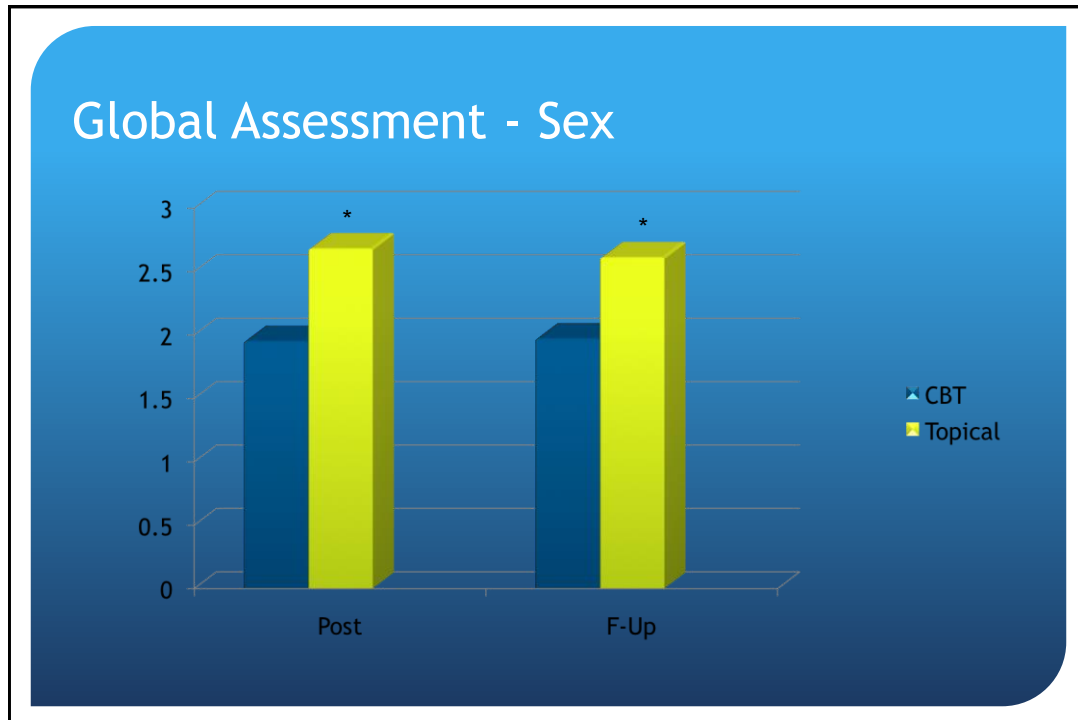
There is a need for targeting
psychological distress and sexual
dysfunction

The patient is traditionally
treated alone, yet the partner
suffers too...

Provoked Vestibulodynia:
A Randomized Comparison
of Group Cognitive-Behavioral
Therapy and Topical Treatment

Sophie Bergeron, Ph.D.
Université de Montréal





Conclusions

- CBT group therapy for vestibulodynia is significantly better than a first line topical treatment in improving pain and sexuality outcomes, in addition to treatment satisfaction
- Gains are maintained at 6-month follow-up

A Randomized Clinical Trial for Women with Vulvodynia: Individual Cognitive-Behavioral Therapy vs. Supportive Psychotherapy

Robin M. Masheb, Ph.D.

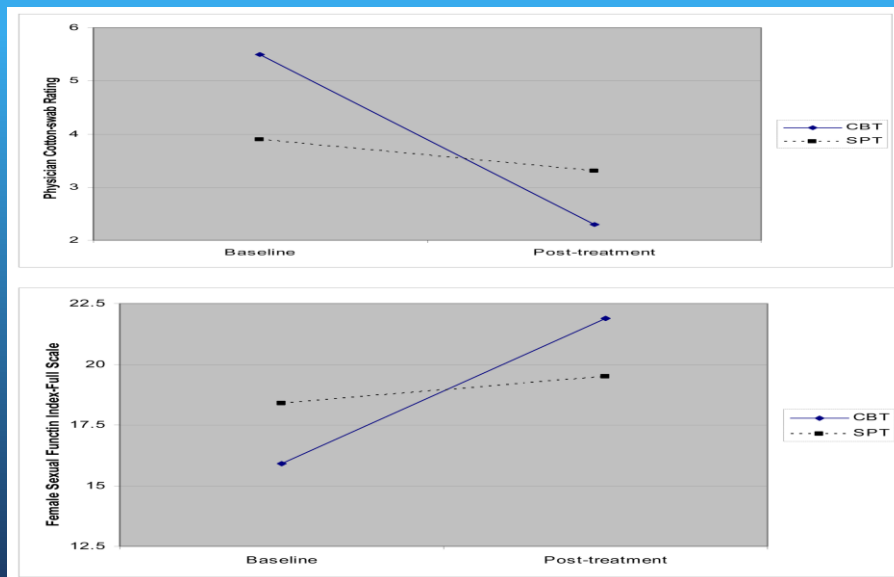
Yale University School of Medicine

Study Design

- 10-week treatments
- Manualized individual CBT or supportive therapy
- 25 women with vulvodynia per condition
- Pre-treatment, post-treatment and 1-year follow-up assessments

Masheb et al. (2009). *Pain*.

Results: Pain and Sexual Function



Conclusions

- Individual CBT is significantly better than supportive therapy in improving pain and sexuality outcomes in women with vulvodynia
- Gains are maintained at 1-year follow-up

Interpersonal Factors in PVD



Interpersonal Context

- Pain typically triggered during sexual activity
 - Partner 'causes' pain
 - Witness woman's reactions to pain
 - Partners suffer negative repercussions



Interpersonal Factors

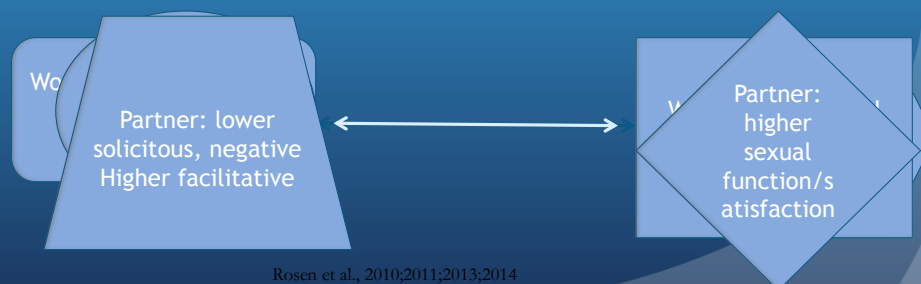
- Relationship satisfaction
 - Most studies typically show it is not lower than controls or scale norms, and not associated with pain
 - Some exceptions
 - Qualitative studies highlight huge strain on relationships

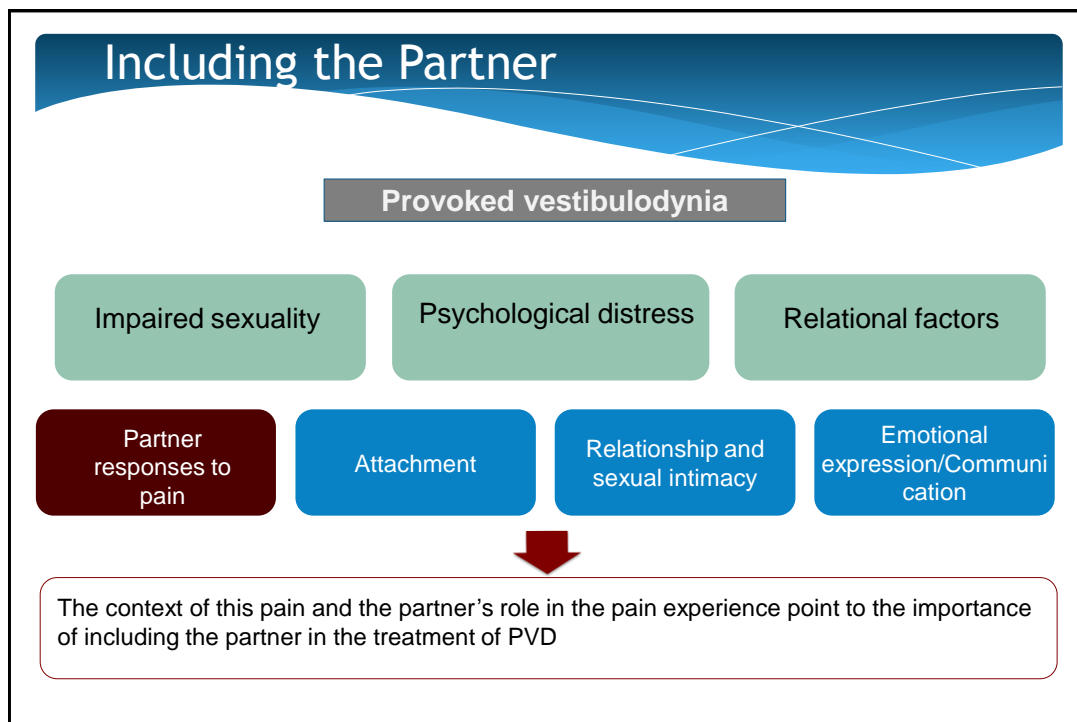
Fears of losing partner
Fears of disappointing partner
Feelings of inadequacy as sexual and romantic partner
Feelings of obligation to have sex

Ayling et al., 2008; Elmerstig et al., 2008,
Smith & Pukall, 2011

Partner behavioral responses

- Solicitous: attention and sympathy
- Negative: hostility and frustration
- Facilitative: encouraging adaptive coping





Pilot Study of CBCT

Feasibility and Preliminary Effectiveness of a Novel Cognitive-Behavioral Couple Therapy for Provoked Vestibulodynia: A Pilot Study
Serena Corsini-Munt, MA, Sophie Bergeron, PhD, Natalie O. Rosen, PhD, Marie-Hélène Mayrand, MD, FRCSC, PhD, and Isabelle Delisle, MD, FRCSC
Journal of Sexual Medicine, 2014, 11, 2515-27

Treatment Goals

1. Provide education about genital pain, sexuality and dyadic factors.
2. Re-conceptualize genital pain as a multidimensional pain disorder that is influenced by biomedical, cognitive, affective, behavioral, and relationship factors.
3. Approach genital pain from a couples perspective - shifting the perspective from the woman as the pain patient to the couple as a unit or system in which both members are affected by and affect the pain.
4. Understand, accept and defuse (as appropriate) the thoughts, feelings, behaviors and couple interactions associated with painful intercourse in order to increase adaptive coping strategies, with a view to decreasing pain.
5. Improve the couple communication process regarding pain during intercourse and its consequences.
6. Facilitate the experience of pleasurable sexual experiences.
7. Strengthen relationship intimacy (e.g. disclosure, empathy, validation).
8. Consolidate and maintain couple and individual skills learned during therapy.

Objectives

Effectiveness

Outcome variable	Measure used
Pain	VAS, 0 – 10 McGill Pain Questionnaire
Sexual function	Derogatis Interview for Sexual Functioning - Self-Report (DISF-SR)
Sexual satisfaction	Global Measure of Sexual Satisfaction (GMSEX)
Pain-related	Pain Catastrophizing Scale (PCS) Painful Intercourse Self-Efficacy Scale (PISES)
Partner/couple-related	West Haven-Yale Multidimensional Pain Inventory (MPI) Couple Satisfaction Index (CSI)
Global improvement	5-pt question during interview

Feasibility

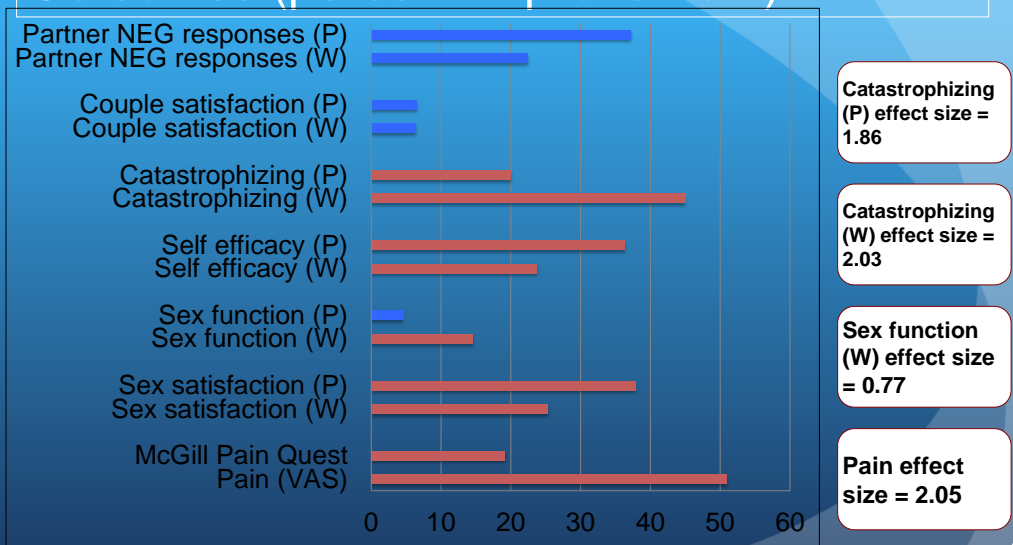
Outcome variable
Treatment satisfaction
Attendance
Homework completion (compliance)
Therapist-manual fidelity
Adverse events

Sample Characteristics (n=8)

	Women	Partners
Age (years)	25.9 (19-35)	28.2 (21-45)
Education (years)	15.6 (13-18)	16.3 (12-21)
Pre-treatment pain rating (0-10)	6.4 (3-8)	
Duration of relationship	40.3 months, or 3.4 years (18 – 97 months)	
Duration of pain	80.1 months, or 6.7 years (30 – 168 months)	

We initially recruited nine couples for this pilot, with one couple separating before completing all 12 sessions, indicating 11% attrition.

Outcomes (percent improvement)



Feasibility

	Women	Partners
Satisfaction with treatment (0-10)	9.0 (7-10)	9.1 (7-10)
Attendance	No missed sessions / 100%	
Homework completion	50% to 78%	29% to 77 %
Treatment fidelity (mean)	89.8% (therapist intervention check-list)	
Most useful or most-liked interventions	Emotional disclosure, building (sexual) communication, the progressive approach of interventions, sensate focus, cognitive defusion.	
Least useful or least-liked interventions	Pain journals, mindfulness body scan, psychoeducation.	

CBCT is a promising and well
accepted treatment for
PVD

Conclusions

- Group and individual CBT are effective for treating PVD
- Couple intervention for PVD is a promising treatment
- More rigorous research is needed
- Can be combined with medical treatment or physical therapy
- Partners can potentially be involved in other treatments, not just psychosocial interventions

Questions



Pelvi-Perineal Re-Education: Physical Therapy Evaluation and Treatment for Vestibulodynia

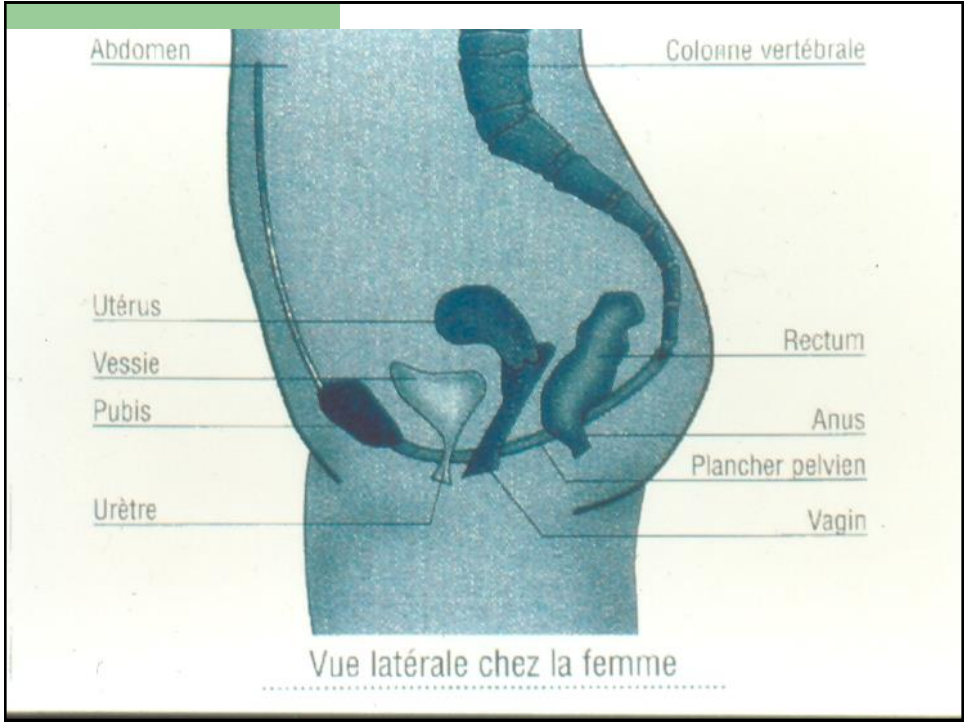
Claudia Brown, M.Sc.P.T.

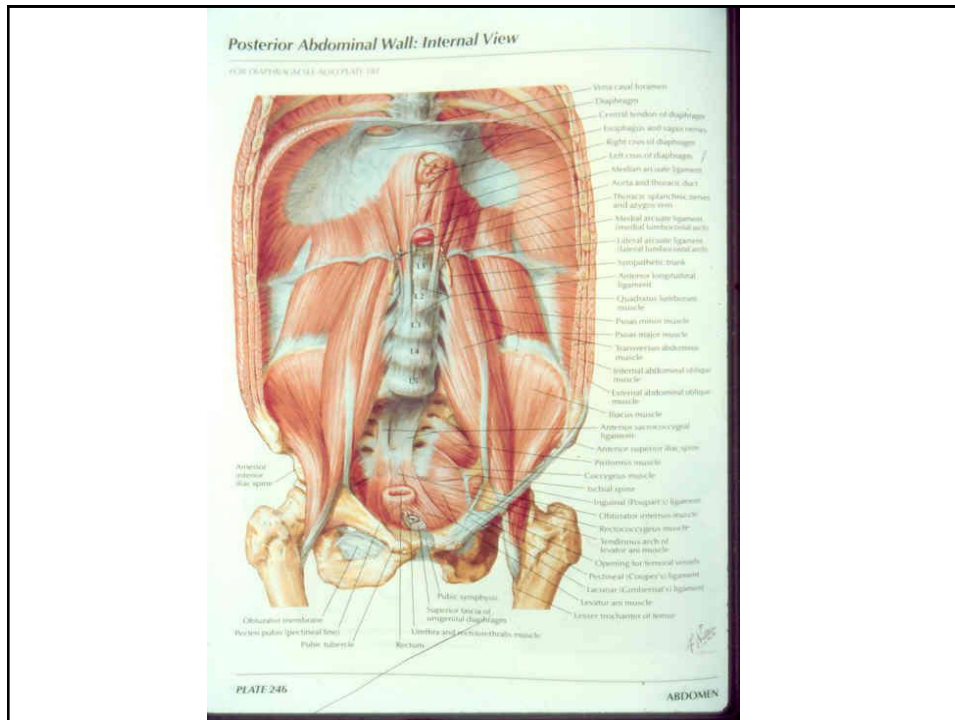
McGill University
Physiothérapie Polyclinique Cabrini
Physiothérapie UroSanté

The Pelvic Floor Musculature

- Multi-functional
- The 'common denominator' to the three major functions at the pelvic outlet
 - Urinary
 - Ano-rectal
 - Sexual
- Static and dynamic roles
- Core stabilization

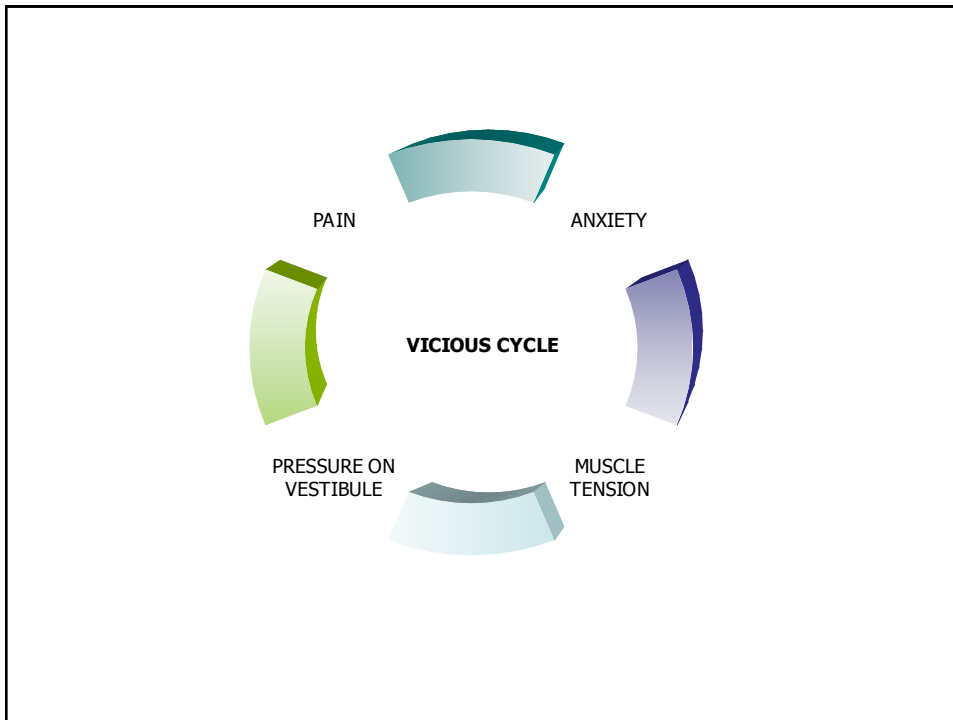
A Multi-Disciplinary Approach to the Treatment of Provoked Vestibulodynia





Reissing, Brown, Lord, 2004

- Both patients with vaginismus and those with vestibulodynia demonstrate hypertonicity of the pelvic floor musculature
- Both demonstrate poor proprioception, poor voluntary control, and poor overall pelvic floor muscle strength
- Both experience significant pain on palpation
- Both demonstrate spasm and guarding reactions upon painful palpation



Evaluation

- Part of treatment process
- Empathetic, non-judgemental approach
- Patient needs reassurance, re:
 - Diagnosis
 - Prevalence of problem
 - Pertinence of physiotherapy consultation
- Dedramatization

Patient History

- PMH, trauma
- Investigations
- Medication
- Menstrual cycle
- Vaginal infection, skin irritation
- Childbirth history

cont'd.....

Patient History

- Bladder function
- Bowel function
- Pain cycle and occurrence
- Sexual activity

...cont'd

Clinical Assessment

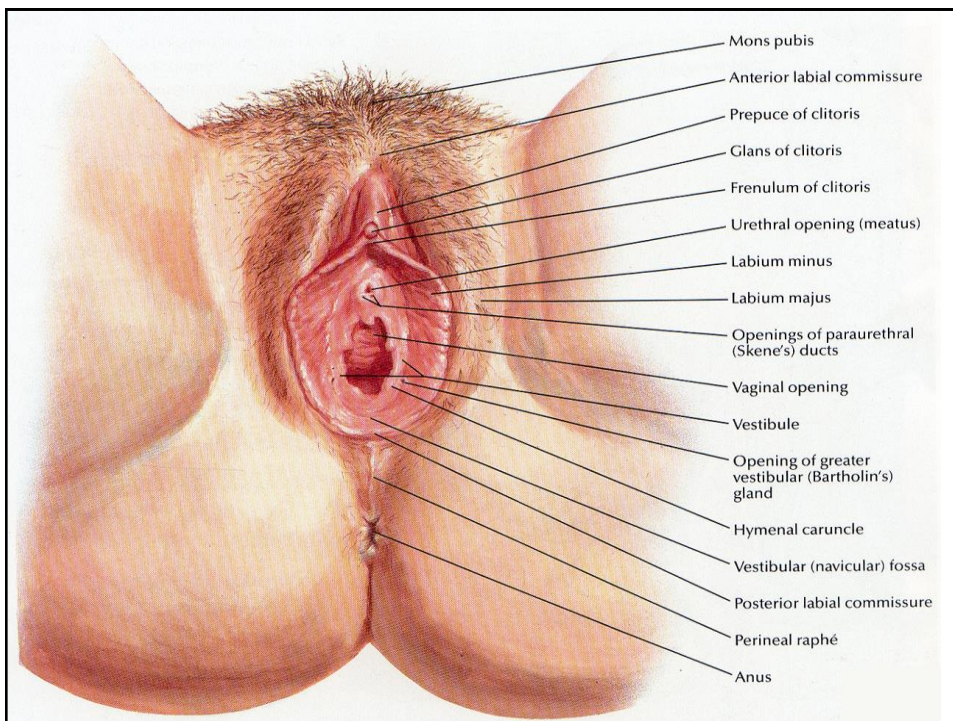
- Internal: VAGINAL
 - Vaginal opening: degree, comfort
 - Tissue elasticity
 - Muscle tone
 - Pelvic floor muscle contractility
 - Post-contractile relaxation
 - Painful sites, protective reactions

Muscle Tone

- Resting tension within the muscle
- Resistance to passive stretch or distension (increased tone or decreased tissue elasticity)
- Compliance on palpatory compression

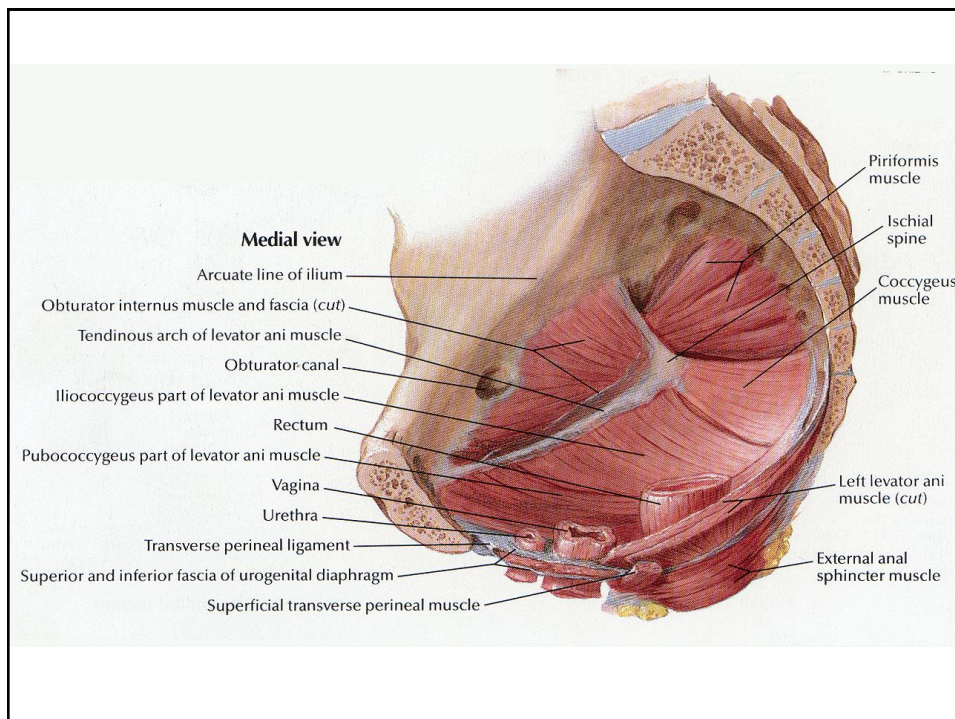
Potential effects of hypertonicity

- Urinary
 - Difficulty in emptying bladder
- Ano-rectal
 - Difficulty and/or pain with stool evacuation
- Sexual
 - Pain at penetration



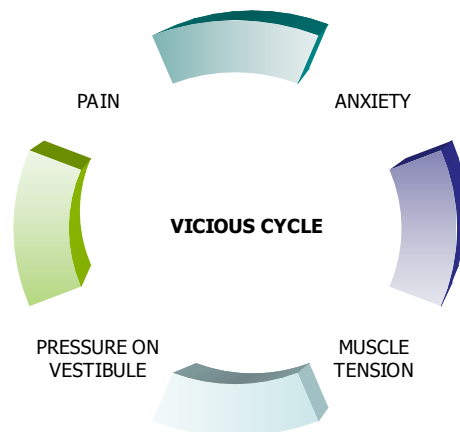
Clinical Assessment

- Internal: ANAL
 - Anal sphincter tone, contractility, post-contractile relaxation
 - Ano-rectal angle
 - Specific tests for posterior pelvic floor muscles
 - Position and mobility of coccyx
 - Pain, protective reactions



Physiotherapy Goals

- To improve sexual function
- To decrease pain
- To decrease anxiety and increase self-efficacy
- To normalize muscle tone
- To improve proprioception, contractility, and post-contraction relaxation of the pelvic floor musculature
- To improve flexibility and elasticity at the vaginal entrance
- To desensitize the vestibule
- To facilitate optimum technique for penetration



Physiotherapy Treatment

- Education
- Exercises
- Manual techniques
- Biofeedback
- Electrical stimulation
- Insertion techniques

Physiotherapy Treatment

- **Education**
- Exercises
- Manual techniques
- Biofeedback
- Electrical stimulation
- Insertion Techniques

Education

- Full explanation of condition
- Dedramatisation
- Description of role of pelvic floor musculature in pain cycle
- Explanation of role of muscle relaxation in pain control, and gate control theory
- Improves confidence and decreases anxiety
- Functional applications

Physiotherapy Treatment

- Education
- **Exercises**
- Manual techniques
- Biofeedback
- Electrical stimulation
- Insertion techniques

Pelvic Floor Exercises

- Identification, proprioception
- Contraction, control
- Relaxation
- Stretch, desensitization
- Insertion techniques
- In clinic and at home

Physiotherapy Treatment

- Education
- Exercises
- **Manual techniques**
- Biofeedback
- Electrical stimulation
- Insertion techniques

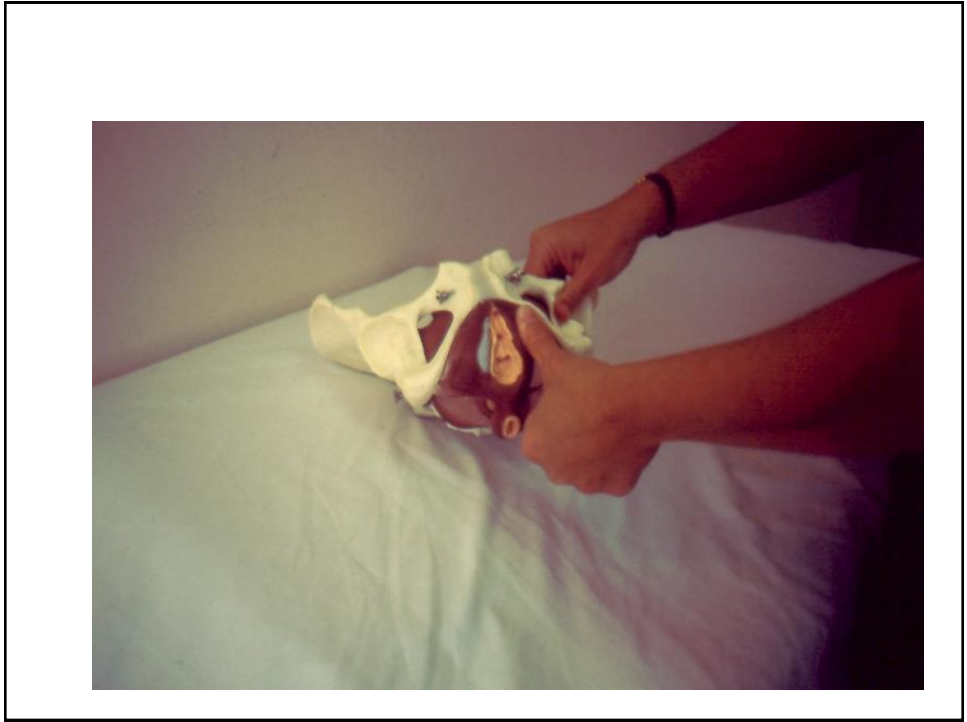
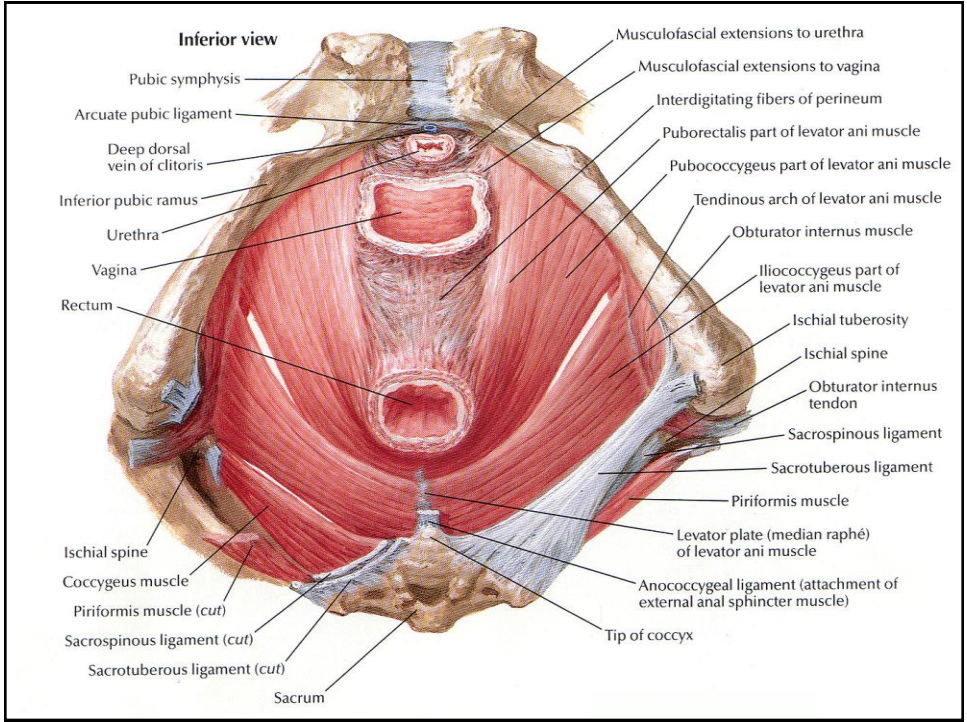
Manual Techniques

- To facilitate pelvic floor contraction and relaxation, to improve proprioception
- To mobilise muscle and soft tissue
- To desensitize area and decrease pain
- To normalize muscle tone
- To improve circulation

Manual Techniques

- External pressures on perineum
- Trigger point pressures
- Myofascial release
- Stretching of muscle, tissue, orifice
- Desensitization
- Connective tissue massage
- Global techniques

A Multi-Disciplinary Approach to the Treatment of Provoked Vestibulodynia





Physiotherapy Treatment

- Education
- Exercises
- Manual techniques
- **Biofeedback**
- Electrical stimulation
- Insertion techniques

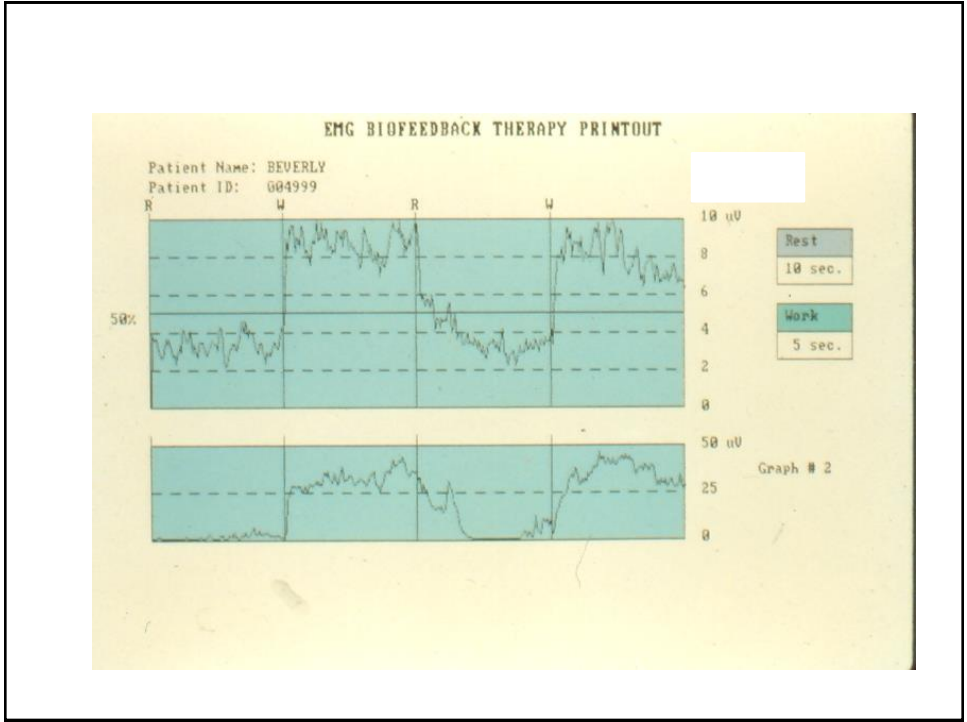
Pelvic Floor
Muscles ????



Biofeedback

- Enables the patient to visualise muscular contraction
- Vaginal probe used to monitor EMG activity at level of pelvic floor
- Muscle activity represented to patient on screen for identification, relaxation and control
- Patient immediately sees changes produced by effort to contract and relax the muscle

A Multi-Disciplinary Approach to the Treatment of Provoked Vestibulodynia



Physiotherapy Treatment

- Education
- Exercises
- Manual techniques
- Biofeedback
- **Electrical stimulation**
- Insertion techniques

Electrical Stimulation

- To increase patient's proprioceptive awareness of pelvic floor
- To desensitize area and decrease protective response

Physiotherapy Treatment

- Education
- Exercises
- Manual techniques
- Biofeedback
- Electrical stimulation
- **Insertion techniques**

Insertion Techniques

- Insertion devices of progressive widths
- Patient learns to relax musculature to allow for insertion. She will later use this technique to allow for penetration
- Functional and psychological preparation for intercourse
- In clinic and at home, with and without partner



Treatment Progression

- Typically, 8 – 10 treatments
- Weekly at first, less frequent once the insertion techniques with dilators have begun
- May involve partner in treatment
- Follow-up if residual pain



Urban Model of Inter-Disciplinary Clinic

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Physiothérapie Uro-Santé



Female Sexual Health Inter-Disciplinary Clinic

- In our clinic, the team is composed of
 - Physician
 - Sexologists
 - Physiotherapist

Initial Contact

- ▶ Sexologist contacts the patient by phone to explain the consultation procedure
- ▶ Patient is sent a series of questionnaires to fill out and bring with her to the first visit
 - ▶ Pain Catastrophizing Scale (PCS)
 - ▶ Pain Anxiety Symptoms Scale (PASS-20)
 - ▶ Female Sexual Function Index (FSFI)
 - ▶ Center for Epidemiologic Studies in Depression Scale (CESD)

Clinic Consultation

- ▶ Patient meets with the sexologist
 - ▶ History taking
 - ▶ Collecting and scoring questionnaires
 - ▶ Sexologist makes her recommendations to the patient
- ▶ It is strongly recommended that the patient is accompanied by her partner

Clinic Consultation

- ▶ Patient is then seen by physician
 - ▶ History taking continues
 - ▶ Physical examination is conducted
 - ▶ Scores on questionnaires are reviewed
 - ▶ Reviews sexologist's recommendations
- ▶ Physician then introduces patient to physiotherapist
 - ▶ Gives physiotherapist description of problem
 - ▶ Scores on questionnaires are reviewed by physician, physio and patient

Clinic Consultation

- ▶ Physiotherapist conducts her own evaluation
 - ▶ History
 - ▶ Physical exam
 - ▶ Advice to patient for exercises
- ▶ Physiotherapist reports her findings and recommendations to the physician with patient present.
 - ▶ Treatment goals are set with patient
- ▶ Physician becomes case coordinator and concludes visit with patient
 - ▶ Will write up referrals, prescriptions if needed
 - ▶ Will establish timeframe for follow-up visit



Inter-Disciplinary Clinic

- Advantages:
 - Patient feels well taken care of
 - All professionals can discuss case right away and with patient
 - No need to make separate appointments and wait in between for each
 - Professionals agree upon intervention goals and propose intervention plans
 - Collectively address problems related to patient's progress



Inter-Disciplinary Clinic

- Disadvantages
 - Professionals outside of the group may hesitate to refer into such a clinic in fear to losing their patients
 - Difficult to tell patient that the treatment received so far by her physician / physio/ sexologist might not have been adequate due to lack of coordinated effort
 - Patient may not want to disclose some private information with all professionals of the team
 - In our model there is no follow-up physio or sexology treatments on site
 - This model may not be practical in rural settings and may involve more cost to the patient





Notes