

A COMPREHENSIVE PROGRAM TO MANAGE NEUROMUSCULAR DYSFUNCTION OF THE PELVIC FLOOR ASSOCIATED WITH VULVODYNIA WITH OR WITHOUT URINARY SYMPTOMS.

Aims of Study

Vulvodynia is a complex chronic visceral pain syndrome with musculoskeletal, urological, neurological, myofascial and/or psychological components for which there is no effective treatment. Hence, at a holistic program consisting of physical therapy, biofeedback, and cognitive-behavioral therapy was developed for women with vulvar pain referred to the Neurourology Clinic at Stanford University Medical Center.

Methods

From June 1995 until present, 32 women with vulvodynia underwent internal myofascial release/ soft tissue mobilization treatment by a trained physical therapist for 1 to 2 visits weekly for 2 to 3 months, surface electromyography (sEMG) assisted biofeedback using a home electronic unit (performed by patient at home) for 20 minutes daily, and progressive relaxation exercises and counseling administered by a psychologist. Patients were evaluated at each visit with a pain symptom questionnaire (completed by the patient) that assessed pelvic pain, urinary symptoms, and sexual dysfunction; symptomatic improvement was also quantified with a visual analogue scale (minimum: 0 to maximum: 10); and a pelvic exam to identify painful myofascial trigger points. Pelvic floor tension was measured using sEMG at baseline and conclusion of treatment and compared to a cohort of women without vulvodynia.

Results

Of 32 women referred with chronic vulvar pain, all were diagnosed with vulvodynia. The median age of women was 29 (range 23 to 40). The median duration of symptoms before treatment was 3 years (range 1 to 7 years). Twenty-two women completed the program. Nineteen women reported a benefit, 3 did not, and 10 are currently in treatment. At baseline, nearly all women (17 of 19) reported vulvar pain and pain with intercourse and about two-thirds (12 of 19) of women reported urinary symptoms, primarily of the urgency and frequency type. After treatment with myofascial release and biofeedback, nearly one-third ($n=7/19$) of patients had a marked ($\geq 50\%$) reduction in vaginal pain from baseline; three-fifths ($n=12/19$) of the women had a marked ($\geq 50\%$) reduction in pain with intercourse; two-fifths ($n=7/19$) had a marked ($\geq 50\%$) reduction in pain on a visual analog scale; and one-third ($6/19$) had a marked ($\geq 50\%$) reduction in urinary symptom scores. The 19 women who benefitted from treatment received a mean of 12 (range 5 to 26) myofascial release treatments over an average of 3 months (range 1 to 6 months). Changes in sEMG measurements were noted. Durability of responses past six months varied. In some patients the benefits of treatment were sustained beyond 6 months while other patients required additional sessions of treatment. Three women who did not respond were positive for HPV virus and the myofascial release might have aggravated the condition.

Conclusion

In this pilot study, the data suggest that some patients with vulvodynia may experience an improvement in vulvar and/ or urinary symptoms following treatment with a triad of sEMG biofeedback, intrapelvic trigger point deactivation using myofascial release, and progressive relaxation counseling. Based on the encouraging results in this study, a prospective controlled trial is warranted.