Out of Hours
Vestibulitis:

a medic's struggle with vulval pain from the other side of the curtain

Going to the doctor about 'women's things' is never pleasant but it's even worse when, despite everyone's best efforts, your symptoms remain unexplained. I've decided to share my personal experience of vestibulitis, under the guidance of GP Anjana Singh and consultant gynaecologist Gabrielle Downey, in order to raise awareness and facilitate prompt diagnosis for future patients.

A STRUGGLE FOR DIAGNOSIS

On 10 September 2013 I lay on the trolley in an anaesthetic room, petrified at the thought of having surgery but also excited about what the operation would hopefully achieve. Earlier that year I had been in the very same room as a 3rd year medical student, observing the anaesthetic induction of a patient who was about to undergo a procedure called a Fenton's vestibulectomy. The gynaecologist explained that the procedure was for a specific type of dyspareunia called vestibulitis. She diagnosed this by the relief of pain after the application of local anaesthetic cream around the introitus. At this point my mind was racing; I had been experiencing superficial dyspareunia that was relieved by the use of local anaesthetic gel. Could it be that I too had vestibulitis?

My symptoms first began in 2008 when I developed a change in my normal vaginal discharge alongside an intensely sharp pain at the entrance to my vagina whenever I had sex. At this point I hadn't started medical school and I felt too embarrassed to seek help. It was only when I began experiencing postcoital bleeding a few months later that I saw my GP. I was diagnosed with thrush and, although the treatment rid me of the infection, my symptoms remained.

Over the next 4 years I became increasingly distressed due to seeing only minimal improvement following countless additional treatments for thrush, antibiotics, steroid creams, antiviral medication, vaginal moisturiser, and other personal lubricants. I was also treated with cryocautery for a cervical ectropian that was thought to be exacerbating my symptoms. In the end the only medical treatment that helped significantly was the lidocaine gel but it was very unpleasant to use and I still didn't have a diagnosis. After my session in theatre I asked my doctor to refer me to a consultant gynaecologist who, to my immense relief, confirmed that I did indeed have vestibulitis.

WHAT IS VESTIBULITIS?

Vestibulitis otherwise known as 'localised provoked vulvodynia', was first recognised in the late 1980s by gynaecologist Dr Edward Friedrich.[1] It is characterised by a stinging or burning-like pain at the vaginal introitus that is provoked by sexual intercourse and the insertion of objects such as a tampon or speculum into the vagina.[2] Vestibulitis usually develops between the ages of 20 and 50 years, often following an infection of the lower genital tract.[3] Patients may have associated psychological problems and can present with concurrent vaginismus.[2] On examination, the vestibule may appear erythematous,[4] but in many cases, inspection of the vulva is entirely normal. A cotton bud or swab can be pressed onto the vestibular skin to provide a painful stimulus. If this provokes a similar pain to that which the woman experiences during intercourse then the patient is said to have a positive Q-tip test, indicating that she may benefit from a surgical intervention.[5]

A further course of fluconazole and a stronger steroid cream still left me needing to use the lidocaine so the gynaecologist recommended that I have a Fenton's vestibulectomy to excise the painful area. In this procedure the posterior aspect of the vaginal vestibule is removed and the fascia posterior to the vagina is dissected until the fibres of the external anal sphincter are reached. The posterior vaginal wall is then advanced downwards and sutured into position, giving a good chance of complete resolution of symptoms.[5] Medical options such as anti-neuropathic analgesics and steroid infiltration into the introitus can be helpful and may be offered if the clinician and patient feel that these would be more appropriate than surgery.[6]

THE ROAD TO RECOVERY

After the procedure my symptoms were much better but I still had some residual dyspareunia. I required a thorough examination under anaesthesia, some steroid injections, and further surgery to remove some remaining inflamed tissue in August 2014. After 6 very challenging years and one final course of steroid cream, I'm pleased to say that I finally became pain-free in November 2014.

If you suspect that one of your patients has vestibulitis there are a number of things that you can do to help. In primary care, an active infection should be excluded and a Q-tip test can help you to ascertain whether or not the pain is provoked. Since the patient is likely to be distressed by her symptoms she may benefit from emotional support through a psychosexual counsellor or support groups such as the Vulval Pain Society (www.vulvalpainsociety.org/vps/). Once you have a suspicion of vestibulitis it is advisable to refer the patient to a gynaecologist, ideally one with a special interest in vulval conditions, stating your working diagnosis.

Living with vestibulitis has certainly made my 20s very challenging, so I urge you to please remember this article the next time a woman presents with pain during intercourse. You may be able to save her from years of suffering and uncertainty if you can help her to get the right diagnosis early on.

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