School of Continuous
Professional Development

17TH ANNUAL WOMEN'S HEALTH UPDATE – 2021

COURSE DIRECTORS:

Juliana M. Kling, MD, MPH
Suneela Vegunta, MD
Ekta Kapoor, MBBS

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SEXUAL/PELVIC PAIN MANAGEMENT

NON-SURGICAL TREATMENT OPTIONS

Johnny Yi MD
Assistant Professor OBGYN
Urogynecologist
Mayo Clinic AZ
11/6/2021

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DISCLOSURE OF RELEVANT FINANCIAL RELATIONSHIP(S) WITH INDUSTRY

- Nothing to disclose

REFERENCES TO OFF-LABEL USAGE(S) OF PHARMACEUTICALS OR INSTRUMENTS

- Botox- Allergan
- Mona Lisa Touch- Hologic

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LEARNING OBJECTIVES

- Expand on the differential diagnosis of pelvic pain disorders based on anatomy
- Identify tools to implement non-surgical treatments for pelvic pain disorders

DYSPAREUNIA

- International Consultation on Sexual Medicine , 2015
  - Classified sexual pain as Genito-pelvic pain-penetration disorder
    - Includes Pain with vaginal penetration
    - Vulovaginal or pelvic pain during intercourse or attempt at penetration
    - Marked fear or anxiety about vulvovaginal or pelvic pain in anticipation of penetration
    - Marked hypertonicity/overactivity of pelvic floor muscles during intercourse

History and Physical exam are Key

McCabe, et al. The Journal of Sexual Medicine. Vol.13, Iss 2. 2016

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WHEN DOES IT HURT?

- Only during intercourse?
  - Throbbing, aching after intercourse?
- With any contact with vulvar skin?
- Everyday, all the time?
- When I’m on my period!
- When I pee or poop!

WHEN DID IT START HURTING?

- Ever since I started having sex.
- Ever since my hysterectomy.
- Ever since my radiation for my cancer.

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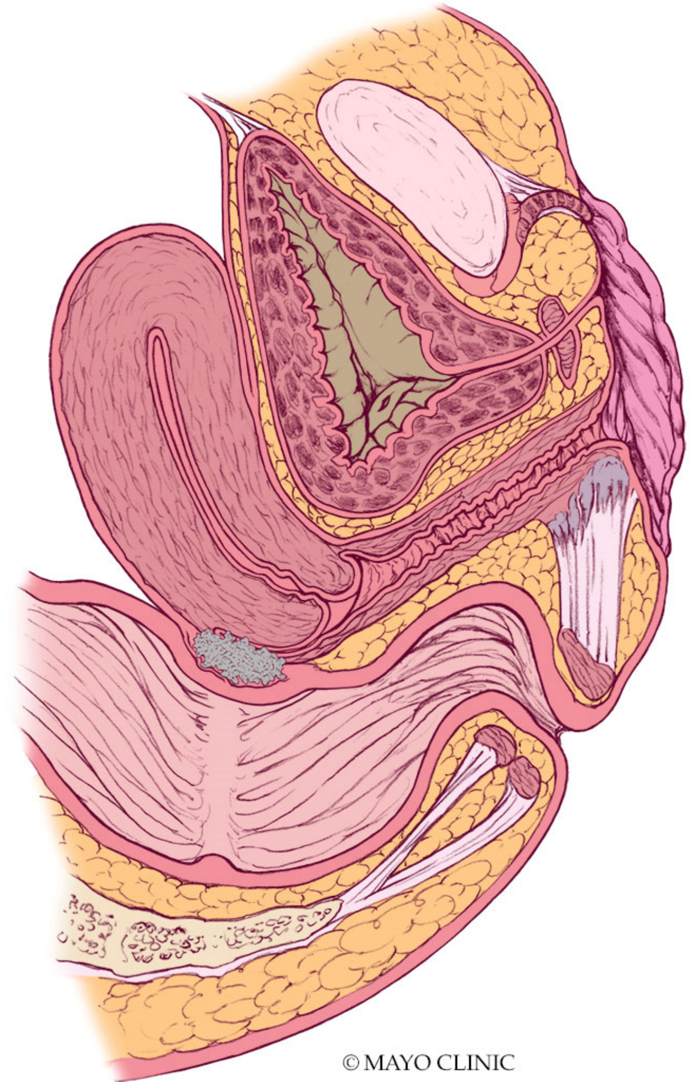
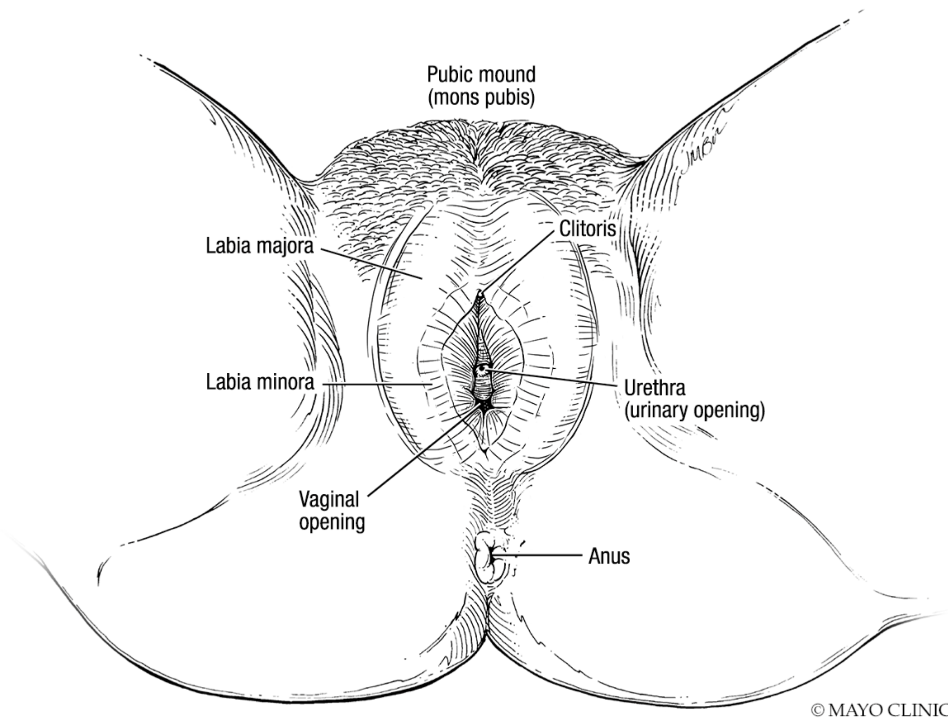
WHERE DOES IT HURT?

History and Physical exam are Key

- Superficial- Vulva, urethra
- Intra-vaginal
- Deep- uterine, uterosacral, pelvic floor





Lichen sclerosus structural changes

SUPERFICIAL DYSPAREUNIA

- Dermatologic conditions
  - Lichen Sclerosus, Atrophy
- Vulvodynia/vestibulitis
- Vaginismus, pelvic floor myofascial pain

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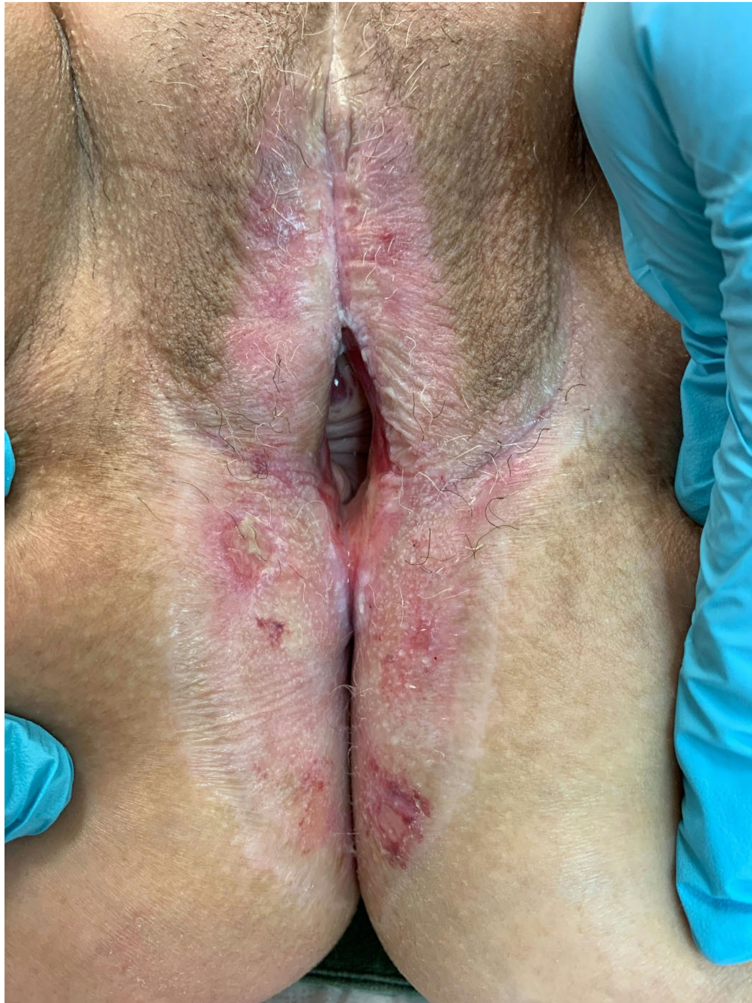

LICHEN SCLEROSUS

- Presentation: Vulvar itching, tearing, post-coital bleeding, pain with entry.
- Diagnosis: Gold standard- biopsy
- Treatment options: high potency steroids + vaginal estrogen

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NOVEL TREATMENTS

- Ogrinc et al (n=40), Burkett et al (n=52)
    - 2 RCT evaluating steroids vs CO2 laser therapy
        - 6 month trials with greater patient satisfaction and improvement in symptoms
        - Safe and well tolerated
        - Potential benefits- does not rely on appropriate application or compliance with medication. Standardized laser technique applied by a trained physician.
- Goldstein et al (n=30)
    - Double blinded, placebo controlled saline vs PRP for LS
    - 19 received PRP- 5 improved, 10 no change, 4 worsened.
    - No better than placebo, not effective for LS

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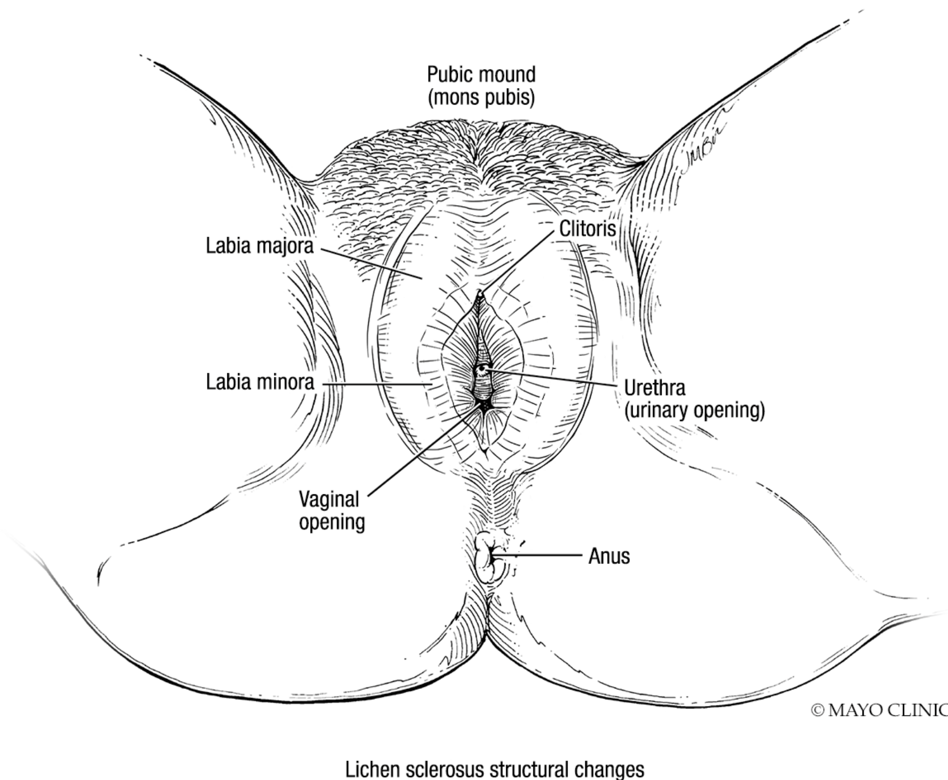


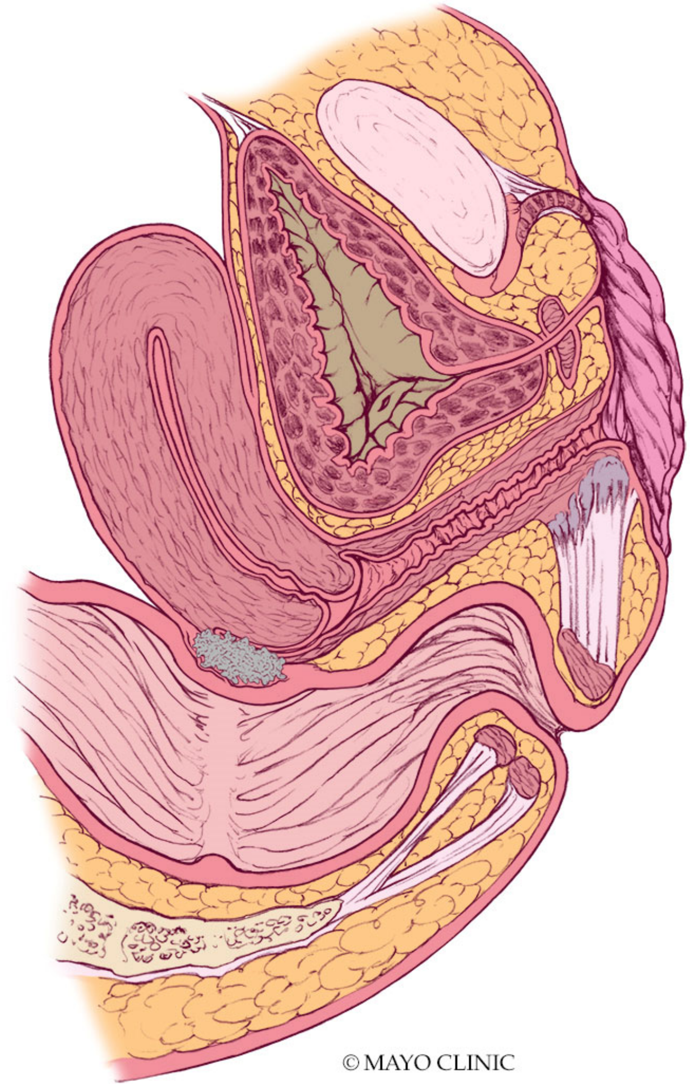
Lichen sclerosus structural changes

VULVODYNIA/VESTIBULITIS

- Presentation: Burning, searing pain at the vestibule
  - Provoked vs spontaneous
  - Intermittent vs persistent
- Diagnosis: Qtip test, pelvic floor exam, inflammation?
- Treatment options: hypocontact precautions
  - Neuropathic pain medications-gabapentin/Lyrica

INTRAVAGINAL PAIN

- Vaginal atrophy
- Vaginal strictures
- Vaginal shortening
- Pelvic floor myofascial pain



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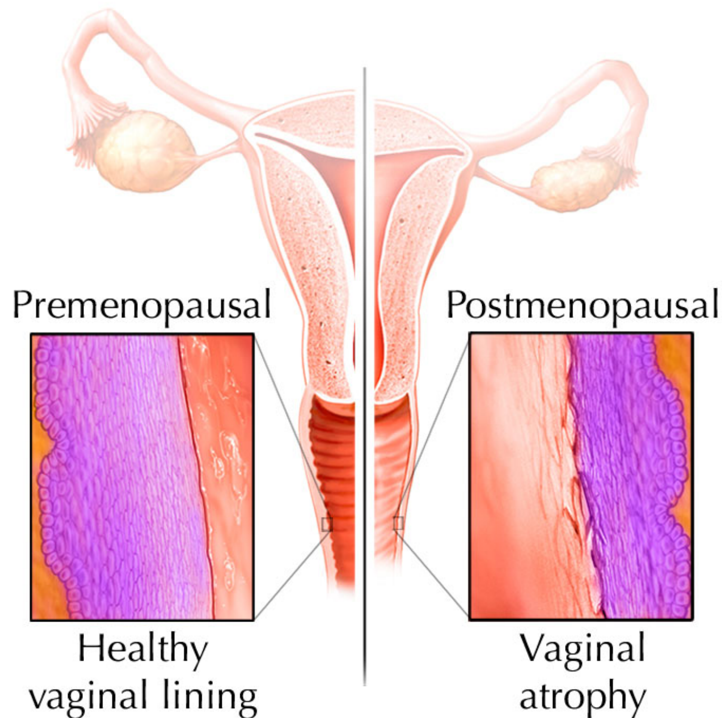

VAGINAL ATROPHY

- Presentation: Dryness, sandpaper sensation with intercourse. Post coital bleeding
- Diagnosis: pH>5.0, parabasal cells, thin, pale epithelium, clinical diagnosis
- Treatment options: vaginal moisturizers, lubricants, vaginal estrogen, DHEA (LASER?)

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ANATOMIC LIMITATIONS

- Presentation: Limitations due to length or caliber.
  - Congenital: vaginal agenesis
  - Iatrogenic: radiation, s/p vaginal surgery
  - Acquired: lichen planus
- Diagnosis:
  - Examination, biopsy/imaging PRN
- Treatment options: Vaginal dilation, pelvic floor PT

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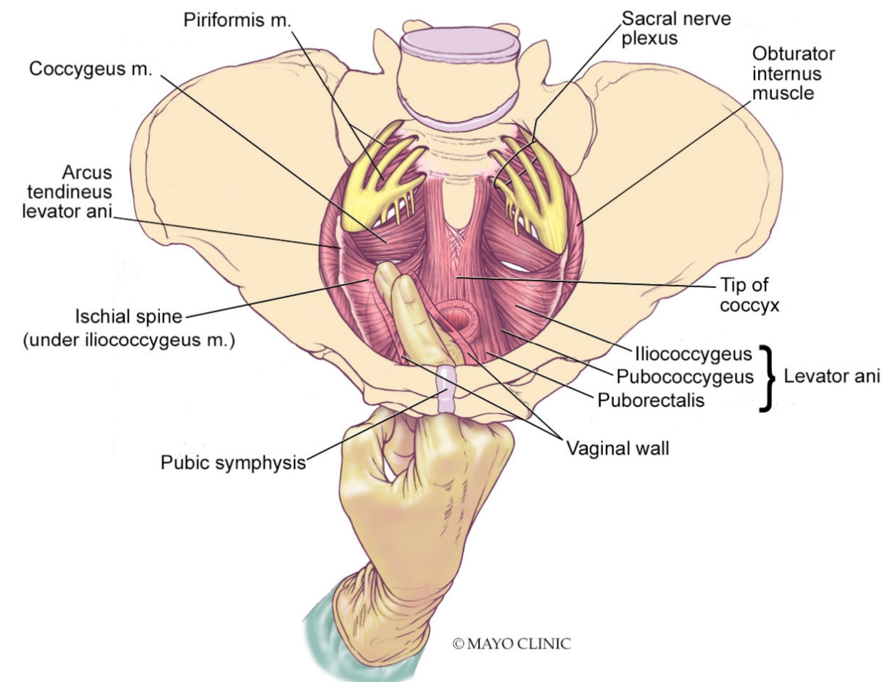
PELVIC FLOOR MYOFASCIAL PAIN

- Presentation:
  - Bladder- urgency with hesitancy, valsalva voiding, pain with urination
  - Bowel- pain with defecation, valsalva defecation, difficult defecation regardless of bowel consistency
  - Dyspareunia- typically deep dyspareunia, during and also lasting hours to days after intercourse
- Diagnosis:
  - Physical exam
- Treatment options:
  - Pelvic floor PT, muscle relaxants, injections



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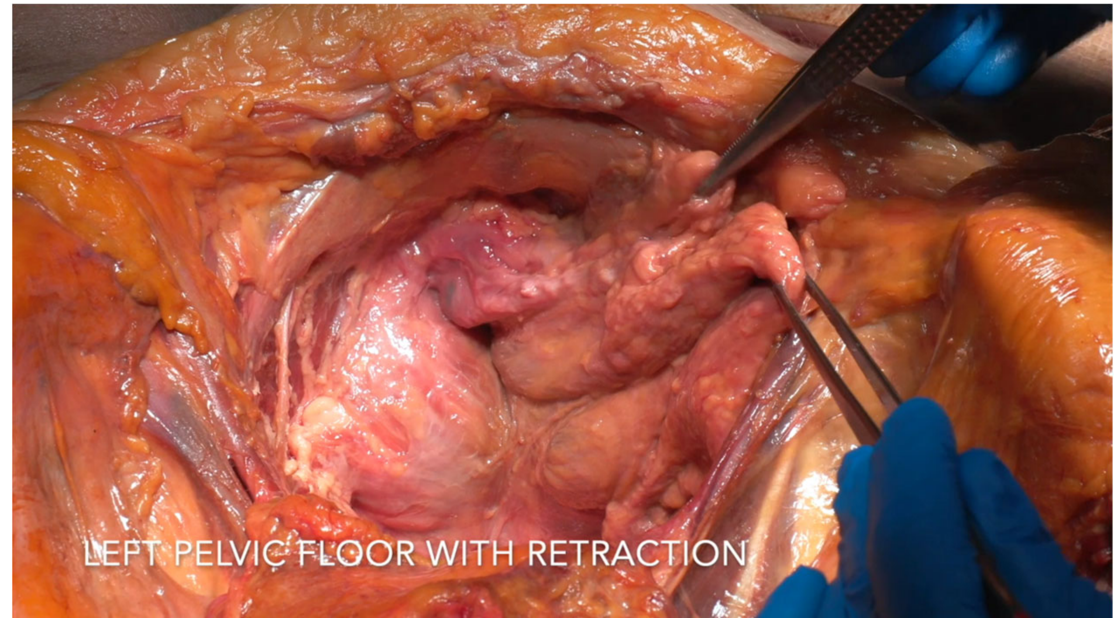
MYOFASCIAL PELVIC PAIN

- Non-articular musculoskeletal pain disorder characterized by “trigger points” of skeletal muscle stemming from the pelvic floor muscles.
- Chronic pelvic pain population 50%
- Urogynecology population up to 24% of patients



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PRIMARY THERAPY FOR MFPP IS PELVIC FLOOR PT

- Strategies to normalize/optimize morphology of pelvic tissues (reduce or eliminate tightness, trigger points, restore optimal length of muscle fibers, and reduce hypertonicity)
- Techniques to ensure optimal bowel and bladder habits (to reduce possible straining, which can contribute to pelvic floor dysfunction).
- Neuro-muscular education to correct posture, body mechanics with lifting, and breathing patterns (diaphragmatic or abdominal breathing)
- Frequency typically 1x/week for 8-12 sessions. Patients with CPP (>6 months) may need further ongoing therapy

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MUSCLE RELAXANTS

- Cyclobenzaprine
  - Cochrane review shows insufficient evidence to support use in MFP (no pelvic floor studies)
- Intravaginal diazepam
  - Crisp et al showed no subjective or EMG improvement in RCT vs placebo
  - Rogalski et al- Retrospective review, sexual function and pain improved with PT vs PT alone

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TRIGGER POINT INJECTIONS

- Zoorob et al describe injection 9ml of 0.5% bupivicaine and 1ml of triamcinolone (40mg/mL)
  - When compared to PT, both improved pain $p>0.05$
  - TPI patients had improvement faster, 4.4 weeks vs 7.3 weeks, $p=0.01$
  - FSFI improved in both groups
  - Limitations: high dropout rate (29%)
- Langford et al 10mL 0.25% bupivicaine, 10mL 2% lidocaine, 1mL triamcinolone (40mg/mL)
  - 13/18 patients improved with 1 injection, 3 pain free

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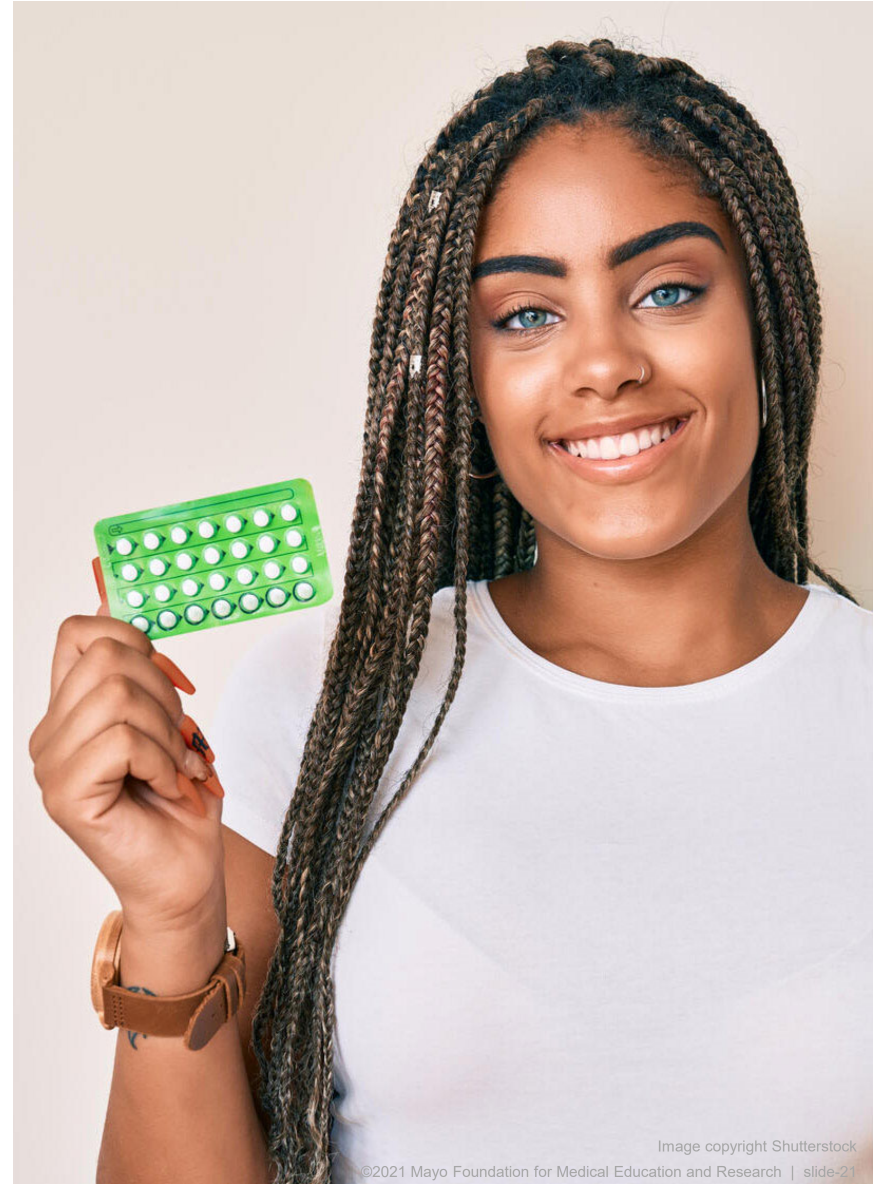
DEEP DYSPAREUNIA

- Endometriosis
- Adenomyosis
- Pelvic floor myofascial pain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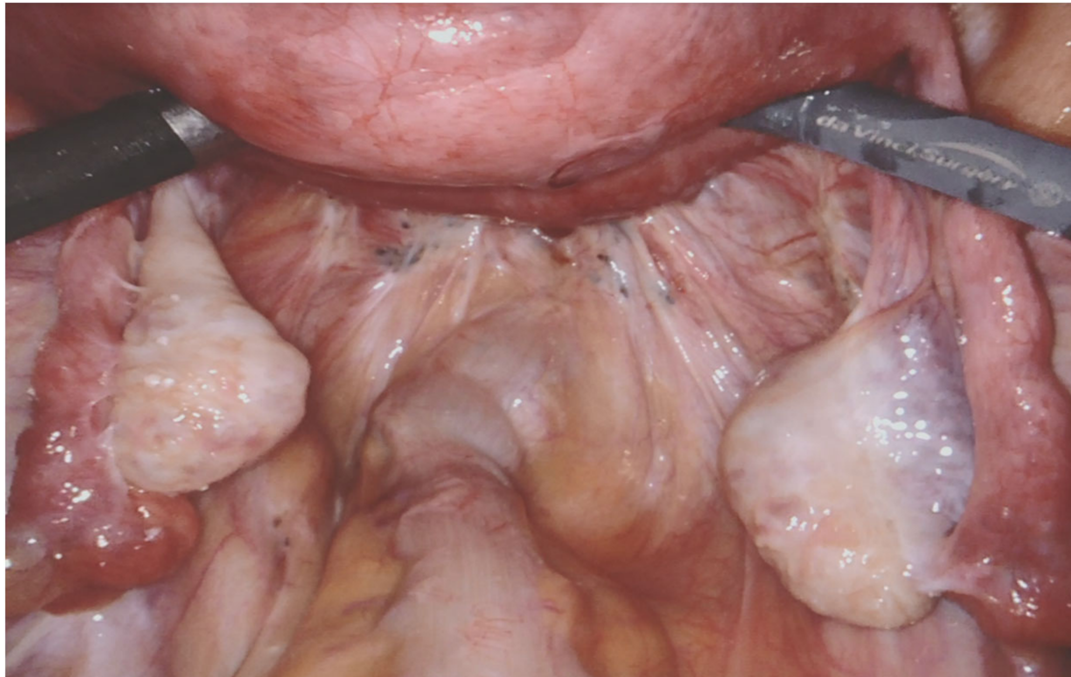
ENDOMETRIOSIS



- Presentation: Classically painful periods. Realistically, can present as chronic daily pain worse with cycles. Deep dyspareunia.
- Diagnosis: Gold standard- surgery/pathology
  - Pelvic US- sliding sign, endometriosis protocol
  - MRI
- Treatment options: Pain management with COC, IUD, P4, GnRH

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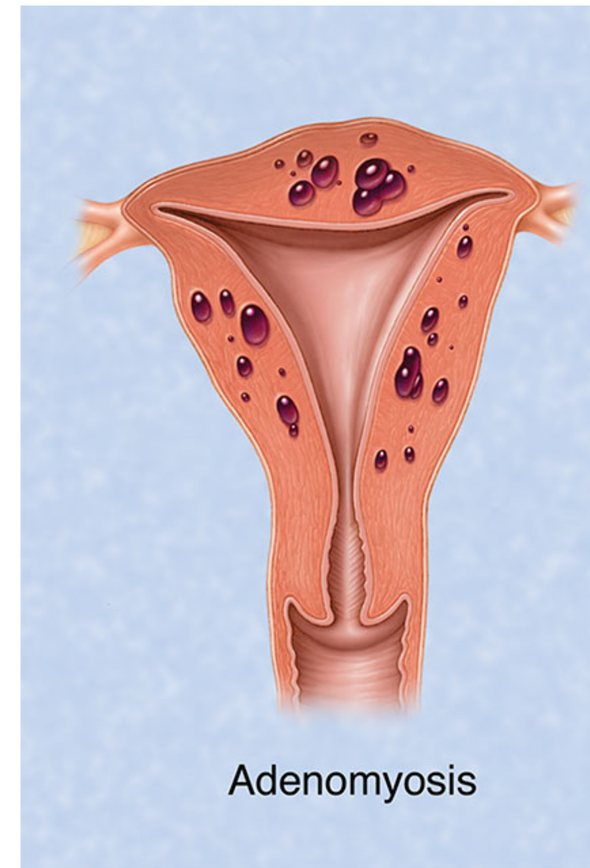
ADENOMYOSIS

- Presentation: Painful menses, abnormal bleeding. Difficult to differentiate from endometriosis, but may also have AUB.
- Diagnosis: Definitive diagnosis pathology. US/MRI very sensitive for evaluation.
  - Uterine tenderness
- Treatment options: Medical suppression similar to IUD. Surgery- Hysterectomy.



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CONCLUSIONS

- Painful intercourse may be multifactorial and taking a thorough history and physical exam can help to differentiate from vulvar, vaginal and deep dyspareunia.
- Nonsurgical options often include pelvic floor rehabilitation, as the pelvic floor muscles often are a source of pain with intercourse.
- If visceral pain is suspected and there is inadequate response to medications, surgical evaluation should be considered.

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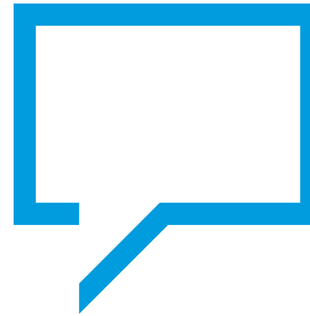
QUESTIONS & DISCUSSION



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