What does the medical system do wrongly when we treat vulvovaginal complaints?

Graeme Dennerstein

This article is part of a longitudinal series on gynaecology.

MY INTEREST in lower female genital tract (LFGT) started as an obstetric and gynaecology trainee when I researched the cytology of the vulva. It resulted in my first publication in 1968.[1] Since then, I have seen a very large number of LFGT disorders referred by general practitioners and my gynaecological colleagues. One thing stands out in my experience, namely the amount of suffering that could have been prevented.

This paper addresses common errors of management, based on my clinical experience and research in the area, in the hope that the teaching of this subject can be improved. I acknowledge that vulvovaginal complaints may make uncomfortable demands on general and specialist medical practitioners. This may be due to lack of training or experience and the concern that their approach may further traumatise the patient. Covering this aspect is an article in itself and I do not have the space here to address it.

Empirical treatment

Treatment without knowing the cause of the presentation is unacceptable. To make an accurate diagnosis or diagnoses is the number one requirement when managing this group of women. LFGT stands out as an area where more than one diagnosis can usually be found.[2] Common examples in younger women are candidiasis plus contact dermatitis plus sexual arousal failure. In older women a dermatosis such as lichen sclerosus plus menopausal atrophy is often seen. Failure to address every diagnosis is likely to result in incomplete resolution of the condition. With an accurate diagnosis, treatment is relatively easy.

Diagnostic requirements

A careful clinical history will often provide much of the diagnosis, particularly with sexual disorders. Clinical examination is essential but seldom gives the final diagnosis. These patients rarely present with an isolated problem. Coexisting disorders are likely to require addressing, including diabetes, other skin disorders, sexually transmissible infections, trauma, domestic violence and mental health issues. If the practitioner is unhappy about performing the examination, after discussion with the patient, it may be best to refer her to someone with more experience in the area. If you see many of these patients, it can be worth learning do-it-yourself microscopy[3] to speed up the correct diagnosis. In any event, liaison with a pathologist is essential. My patients have been strongly warned against using anticandidals without having a swab done first.

Genital care

Women need to be taught how to look after their genitals because vulval skin is particularly sensitive. I often say to my patients, 'You can't put anything down there that you can't put in your eye (including soap!).' Hence my standard instructions (Figure 1) designed for women with chronic vulval symptoms.

Menopause mismanagement

Hormone replacement therapy (HRT) phobia is one of the most common causes of unnecessary suffering.[4] I prefer 'HRT' to menopause hormone treatment (MHT) because the former helps remind us that we are talking about the commonest endocrine disorder (ovarian failure) requiring replacement of a hormone, analogous to diabetes or myxoedema. For the reasons stated below, most of my postmenopausal patients are on systemic HRT and warned against topical oestrogen. HRT is commonly discussed as one and the same treatment. There is a world of difference between the extract of pregnant mares' urine we were using in 1980 when it got its bad name and modern HRT, namely oestradiol, chemically identical to the ovarian product. Offering HRT, as with all treatments, always requires empowering the patient with information and then allowing them to choose their path.

Dosage and choice of progestogen are also important. A significant advantage of modern HRT is that biochemistry

(oestradiol and follicle-stimulating hormone) can be used to get the dosage right, if in doubt. As I say to my patients, 'Modern HRT, done correctly, does nothing but replace what nature has taken away, whereas the untreated menopause is a potentially nasty disease.'

I avoid the use of vaginal oestrogen, except in lactating women and those recently diagnosed with breast or endometrial cancer, because it often fails to work or works too well, predisposing the patient to candidiasis. It can also cause contact dermatitis with prolonged usage.[5]

INSTRUCTIONS FOR SELF CARE

GENITAL HYGIENE

- Treat genital skin gently.
- While you have symptoms, clean only with normal saline solution (2 teaspoons of salt in 1 litre of water) applied with wads of cotton wool.
- When you are better, plain water is sufficient for hygiene purposes.
- Gently pat dry the outside areas only.
- Do not over wash the genitals. Never use soaps, perfumes, perfumed talcs, deodorants, 'feminine' products.
- Do not use douches (internal washing).
- Do not use moisturisers.

PREVENTION OF SEXUAL PROBLEMS

- See a doctor if you feel pain during intercourse or have any sexual difficulties.
- It is important to explain your condition to your partner. Ask our help if this is a problem.
- Ensure proper arousal before penetration (which means you are producing your own natural lubrication and the pelvic floor muscles are relaxed). Teach your partner how to help you become aroused (he cannot read your mind).
- Seek out information if you need help.
- Deal with any stresses or marital problems as they will interfere with sexual activity and reduce the quality of your life.
- When you have recovered from your condition and wish to attempt intercourse again, it is suggested you adopt a position during intercourse which will allow you to control the rate and depth of penetration to prevent discomfort.
- Do not use artificial lubricants (such as 'KY" or petroleum jelly).
- Avoid intercourse when you are feeling symptoms or pain in the genitals.

IMPORTANT POINTS ON THE USE OF MEDICATION

- Only use medication on the genital area that we have prescribed.
- If a flare up of symptoms occurs, a swab for culture should be undertaken *before* any medication is prescribed or used.
- Go to the doctor if you feel any symptoms, see any rashes or other changes. Ask your doctor to carry out the appropriate tests before changing treatment.
- Do not treat any symptoms yourself without seeing a doctor.

Genital skin is very sensitive. It needs protection from chemical and physical damage

The genital area is also affected by the way you feel and symptoms can appear worse when you are stressed.

Figure 1. Genital care.

Sex

Medical practitioners treating these disorders must be prepared to discuss the patient's sexual history, including their relationship status. Discussion on management of sexual difficulties needs to use trauma-informed methods and language that requires a sensitive and appropriate approach. One of my commonest questions to the patient is, 'Is sex a problem?', to which most patients readily reply with important information. Penetrative sex without sufficient arousal commonly leaves women with genital discomfort, and artificial lubricants are not the answer because they can contribute to contact dermatitis. If the patient insists on a lubricant, for example for foreplay or if she is postmenopausal and will not use HRT, liquid paraffin is safe.

Vulvodynia

'Vulvodynia' is a term I avoid because I consider it to be the refuge of the diagnostically destitute.[6] It arose in the USA, where the health system makes diagnostic accuracy difficult and expensive and chronic vulvar pain is almost at epidemic levels. It is so common in the USA that the National Vulvodynia Association was formed. It is common for genital pain to persist for a while after cure of the condition. The correct term for this is 'dysaesthesia', which refers to nerves giving the wrong signals.

Yeast infection

Candida albicans is attracted to the oestrogen-stimulated vagina because of the glycogen in the epithelial cells.[7] Therefore, it is very common in women in their reproductive years. Particularly if inadequately treated, yeast infections frequently become recurrent and self-treatment is very common. Over-the-counter anticandidals are possibly the commonest cause of vulval contact dermatitis.

It is essential to speciate vaginal yeasts because non-*albicans* yeasts, such as *Candida glabrata*, are seldom pathogenic.[8]

Conclusion

Vulvovaginal disorders are common and cause much unnecessary suffering, largely because of self-treatment and/or medical mismanagement. Over half a century with a special interest in the area has taught me that the issues that need to be addressed include the avoidance of empirical treatment, training in diagnostic methods, patient education, better menopause management, addressing sexual disorders and accurate management of yeast infections.

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