The Olafia Vulva Clinic – A New Service at the Centre for STD in Oslo

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Abstract

A new service for vulvar patients has been initiated at the *Olafiaklinikken*, the centre for genitourinary medicine in Oslo. The data presented here refer to the 112 patients seen at the *Olafiaklinikken* from April 2000 to April 2002. Patients' mean and median age were 29.5 and 26.0 years, respectively, ranging from 19 –79 years. Of all patients, 33% were referred from the *Olafiaklinikken* proper, while 67% were external referrals, primarily from gynaecologists. The mean number of visits per patient was 2.6, range 1–9. The greatest percentage of patients, 40.2% (45/112), had a vulvar pain diagnosis, while 28.6% (32/112) had a genital infection, with a genital cutaneous disorder found among a further 20.5% (23/112) patients. The last 10.7% (12/112) were investigated for miscellaneous conditions. Co-operation with sex counsellors in Norway is mandatory in managing patients with vulvar pain caused by vestibulitis and vaginismus, and the practice has become established. Further interdisciplinary co-operation is required to improve the management of this group of patients.

Key words: Vulva clinic, vulvodynia, genitourinary medicine, Norway.

Background

Women with longstanding problems in the vulvar region may find it difficult to find adequate medical care. Usually, the first choice is to consult a general practitioner or a gynaecologist. However, although vulvar problems are not specifically related to sexually transmitted disease, venereologists and specialists in genitourinary medicine may have an appeal to vulvar patients by reason of 'high standards, ready availability, and confidentiality of the clinics, to which there is open access', as pointed out by Ridley 1998 in her review of vulvodynia (1). In the UK, vulvodynia is recognised as a commonly encountered problem within the setting of the genitourinary clinic (2). Consequently, the Medical Society for the Study of Venereal Diseases, MSSVD, has published guidelines on the management of vulvar conditions (3). In Sweden, a multi-disciplinary 'vulva team' with gynaecologists and dermatovenereologists working together with sex counsellors is advocated and is now practised at a certain number of hospitals (4). The problems have not received as much attention in Norway.

During recent years, an increasing number of women with longstanding vulvar discomfort and pain have attended the walk-in centre for STIs in Oslo at the *Olafiaklinikken*. To meet with their needs, a special service for vulvar patients was initiated in 2000.

The aim of this paper is to present the experiences of the first two years at the *Olafiaklinikken*.

Olafiaklinikken – Centre for STD in Oslo

The *Olafiaklinikken* is a Scandinavian equivalent to a clinic for genitourinary medicine. The clinic is situated in the city centre, is open for walk-in visits four hours a day every weekday, and receives about 10,000 new visitors per year. An increasing number of visits are being made by women, comprising 43% of all patients in 2001, most of whom are young adults. A special service for contraceptive counselling is provided for the visitors. The clinic is run by six specialists in dermatovenereology, one of whom (KE) is also specialised in gynaecology, and by one intern and six nurses. The

vulva clinic at the *Olafiaklinikken* is open three hours a week and run by KE. Referrals are required. The patient fee is NOK 200, equivalent to 25 Euro. Due to restricted resources, public information on the new service has been kept limited.

Material and Methods

During the two-year period from April 200 –April 2002, 140 patients were referred to the vulva clinic. The data presented here refer to the first 112 patients seen, including their medical records and patient questionnaires. The local ethics committee has approved publication.

Referrals from the *Olafiaklinikken* proper comprised 33% (37/112) of all patients. The remaining 67% (75/112) were external referrals, see Table I. Mean and median age of the patients were 29.5 and 26.0 years respectively, range 19–79 years. A total of 292 visits have been made, mean number of visits per patient being 2.6, range 1–9. New visitors were assigned 45 minutes for a structured interview, partly based on a patient questionnaire. The intention was to provide time for the patient to present her personal history. The medical examination included a dermatological and gynaecological evaluation. An evaluation of pain reactions with special regard to the vestibulum and pelvic floor was performed. When appropriate, findings were demonstrated to the patient by use of a mirror. As a rule, vaginal inspection and microscopic examinations of wet mounts and methylene blue-stained cervical and urethral samples were performed. A vaginal yeast culture has become a routine test. Herpes cultures and chlamydia swabs for PCR are performed on indication, as well as colposcopic examination, photo documentation and biopsies. Since January 2000, a patient brochure on vulvar problems has been available, including basic advice on management.

Table I: *Referrals to the Olafia vulva clinic (n=112).*

	n	%
Olafiaklinikken proper	37	33.0
Gynaecologists		
·Hospital clinics	38	33.9
·Private practitioners	6	5.4
Dermatologists		
·Hospital clinics	6	5.4
·Private practitioners	4	3.6
General practitioners	8	7.1
Youth health clinics	7	6.3
Sexologists	5	4.5
Others	1	0.8

Results

Vulva pain conditions constitute the major group of diagnoses, comprising 40.2% (45/112) of all patients, followed by genital infections comprising 28.6% (32/112), genital skin conditions 20.5% (23/112) and miscellaneous conditions 10.7% (12/112), see Table II. When several conditions were present, a decision was made as to which one was primary.

Table II: *Diagnoses (n=112).*

	n	%
Vulvar pain conditions	45	40.2
Vulvar vestibulitis	11	
Dysaesthetic vulvodynia	5	
Vaginismus	8	
Clitoridynia	3	
Post laser treatment pain	2	
Pelvic pain	3	
No organic cause found	13	
Genital infections	32	28.6
Recurrent vulvovaginal candidiasis	18	
Episodic candidiasis	6	
Bacterial vaginosis	3	
Genital herpes	3	
Non-specific lower genital tract infection	2	
Genital cutaneous disorders	23	20.5
Irritative dermatitis (non-allergic contact dermatitis)	12	
Lichen sclerosus	5	
Lichen planus	4	
Orogenital aphthae	1	
Mb Beçhet	1	
Miscellaneous conditions	12	10.7

Vulva pain conditions

As demonstrated in Table II, subgroups of vulva pain conditions or 'vulvodynia' or – to use a more up-to-date term – 'vulvar dysaesthesia' have been diagnosed. The terminology is under revision, and terms put within brackets refer to recent suggestions presented at the XVI Congress of the International Society for the Study of Vulvovaginal Disease, ISSVD, in 2001 (5). Vulvar vestibulitis (provoked localised vulvar dysaesthesia), with long-standing entry dyspareunia and pain reaction at the swab-touching test of

the posterior and lateral vestibulum, is an important subset among the vulvar pain conditions among young women, found among 11 patients in the present study. Concurrent and investigated conditions are vaginismus, i.e. increased tension of the pelvic floor, and recurrent vulvovaginal candidiasis. However, a certain number of patients presented with entry dyspareunia, but no organic cause could be identified. Five cases of dysaesthetic vulvodynia (unprovoked generalised vulvar dysaesthesia) were found. Three patients suffered from pain of pelvic rather than vulvar character. Upon referral to a gynaecologist, endometriosis, polycystic ovaries and postinflammatory adhesions were diagnosed.

Genital infections

Longstanding soreness and entry dyspareunia may be caused by genital infections, with recurrent vulvovaginal candidiasis being the most prevalent cause, defined as at least four relapses during the last year, and was diagnosed in 18 patients. Diagnosis was based on history and a positive culture of Candida albicans. Hyfae were identified in direct microscopy of KOH prepared wet mounts in 50% of the cases. No other species of Candida than albicans were cultured, and no cases of resistance or reduced sensitivity to antiyeast agents were found. One patient with recurrent vulvovaginal candidiasis had Ehler-Danlos syndrome, and one presented with lichen simplex. Candidiasis with repeated episodes, but not filling the criteria for recurrent candidiasis, was diagnosed in six cases. Five cases of sexually transmissible infections were found, see Table II.

Genital cutaneous conditions

Irritative dermatitis, or non-allergic contact dermatitis, was the most prevalent diagnosis in this group, found among 12 patients, and commonly related to intensive use of soap and to pubic shaving. Earlier diagnosed cases of lichen sclerosus were referred for second opinion and treatment suggestions, but new cases were also diagnosed at the clinic. All four cases of genital lichen planus were diagnosed at the clinic, all had affected vulvovaginal mucosa, and gingivovulvovaginal disease and cases with desquamative vaginitis were also found. Referral routines to dentists and cooperation routines with the dermatological clinic at Ullevål University Hospital have been established.

Two cases of genital ulcers were found: one diagnosed with orogenital aphthae and one with a possible Mb Beçhet, the latter being a non-European patient who was referred to the dermatological clinic at Ullevål University Hospital.

Miscellaneous conditions

Seven patients were referred for conditions that had spontaneously resolved. Five women came due to a need to discuss sexual matters, e.g. reduced libido and sexual response, or to get help in learning how to cope with a gynaecologic examination.

Discussion

Vulvar conditions represent a disparate group of conditions with a variety of causes, most of them vulvar pain syndromes, presented in a number of reviews, e.g. by Ridley (1), Mc Kay and others (6–9). The need for an effective clinical evaluation of vulvodynia, together with an understanding that anxiety and depression are often the result of a persistently missed diagnosis rather than the cause, are pointed out by Graziottin et al. (10). Treatment options are still far from evidence-based experience. However, infections are the second most frequent cause of vulvodynia in patients seen by dermatovenereologists, as reported by Mroczkowski (11). In 1999, Sullivan et al. (12) reported from a multidisciplinary vulva clinic in London, that despite having genitourinary symptoms, less than half of the patients had been tested for infection prior to being referred to the vulva clinic. Of 135 referred patients, 34% were diagnosed with a genitourinary infection, mostly vulvovaginal candidiasis. Our findings in the present study are in accordance with Sullivan's. Consequently, there is a significant role for genitourinary services in the diagnosis, management and ongoing care of patients in a vulva clinic.

Furthermore, vulvar problems be-

long to the complaints presented among GUM-clinic patients. The prevalence of longstanding vulvar problems and pain has been reported by Denbow & Byrne (13) to be 13.3% among 150 consecutive new female patients attending the walk-in GUM-clinic at St Mary's Hospital in London. In a cross-sectional study of a consecutive sample of 502 walk-in visitors at our own STD-clinic performed in 2002, longstanding vulvar symptoms were reported by 23.1% and superficial dyspareunia by 6.8% (14). Thus, investigation with regard to vulvodynia is required for a certain group of female STD-clinic visitors, and referral to a vulva clinic is beneficial for selected patients.

Longstanding and/or recurrent vulvovaginal candidiasis is frequently reported among vulvar pain patients, and candidasis is one of the few reported background factors for patients with vulvar vestibulitis (1, 6–10, 15). Thus, a recurrent vulvovaginal candidiasis, with insufficient treatment duration according to accepted recommendations and guidelines, can be the true cause of entry dyspareunia (16, 17, 18). A correct diagnosis and follow-up of relapsing vulvovaginal candidiasis is important, as self-diagnosis is not reliable. Antiyeast agents for topical use are sold over the counter in Norway, in fact, increasingly so (19). Unintended misuse of over-the-counter antiyeast agents occurs, as has been reported by Ferris et al. (20). Among 95 women purchasing OTC agents for self-diagnosed vulvovaginal candidiasis, only 33.7% received the actual diagnosis at clinical examination. Women with a previous clinically based diagnoses of vulvovaginal candidiasis were not more accurate in their self-diagnosis. Possibly, skilled/active management of repeated episodes of vulvovaginal candidiasis could prevent longstanding dyspareunia from developing and possibly turning into vestibulitis and/or vaginismus.

Genital skin disorders belong to the conditions for which the expertise of a dermatologist and co-operation with a histopathologist are required. Patients diagnosed with genital lichen planus reported longstanding symptoms, and severe vulvovaginal adhesions occurred (21).

Assessment of patients with vulvar pain relies predominantly on clinical awareness, as has been pointed out by Edwards and Wojnarowska (7). Management is difficult and time-consuming. Vulvar vestibulitis (provoked localised vulvar dysaesthesia) and essential vulvar dysaesthesia (unprovoked generalised vulvar dysaesthesia) are both recognised as pain syndromes, and some overlap occurs (22). Vaginismus may be part of the problem, as pointed out by Abramov (23) and Wijma (24). In spite of the absence of a total cure, patients' status can be improved. The mere provision of a name for the disorder may help patients to cope with it, and limit their doctor-shopping, unnecessary investigations and occasionally useless treatments. The possibilities for proper sexual counselling are mandatory for management and have thus been established with the Institute for Clinical Sexology and Therapy in Oslo. Development of further interdisciplinary co-operation, which has been initiated, would improve management of this patient group.

Acknowledgements

The study was supported by a post-doctoral grant from The Centre for Clinical Research, Section for Epidemiology, Ullevål University Hospital, Oslo. I am grateful to Thore Langfeldt and his colleagues at The Institute for Clinical Sexology and Therapy in Oslo for their co-operation and dedicated care of referred patients.

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