Dysmenorrhea dyspareunia vulvar itching

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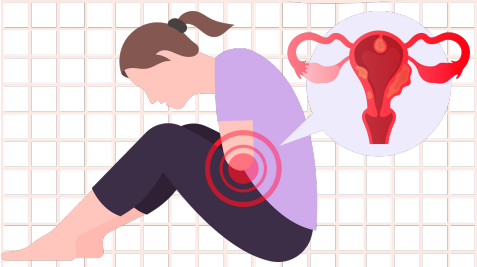
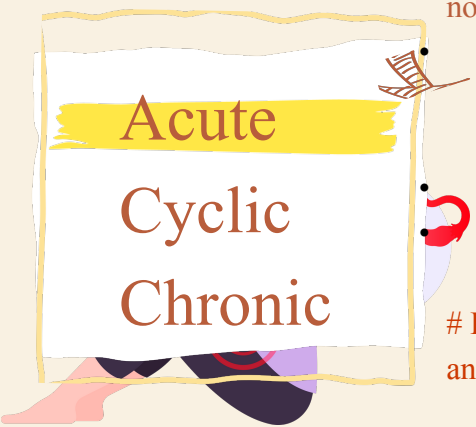
Dysmenorrhea



Pelvic pain

is a frequent complaint in gynecology



Acute pelvic pain is sudden in onset pain , there are several important gynecologic and non-gynecologic causes of acute pain :

Adnexal accidents such as rupture or torsion of ovarian cysts, pelvic infections,tubal rupture of ectopic pregnancies, and aborting intrauterine pregnancies are the more common gynecologic causes.

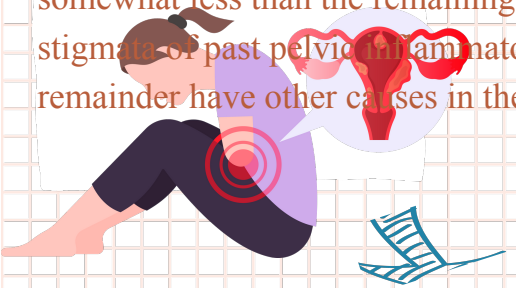
Gastrointestinal conditions, causes such as appendicitis and bowel obstruction

Genitourinary problems, such as cystitis and ureteral stones .

Early diagnosis and and expeditious treatment, often surgical, are important for safe and effective clinical management of acute pelvic pain.

Chronic pelvic pain(CPP) includes reproductive and non-reproductive organ-related pelvic pain that is primarily acyclic and that lasts for 6 months or more that has a significant effect on daily function and quality of life.

women with CPP who are subjected to diagnostic laparoscopy, approximately a third have no apparent pathology, a third have endometriosis,
somewhat less than the remaining third have adhesions or stigmata of past pelvic inflammatory disease(PID), and the small remainder have other causes in the Box



- Acute
- Cyclic
- Chronic

GYNECOLOGIC CAUSES OF CHRONIC PELVIC PAIN
Endometriosis
Salpingo-oophoritis (pelvic inflammatory disease)
Ovarian remnant syndrome
Pelvic congestion syndrome
Cyclic pelvic (uterine) pain
Myomata uteri (degenerating)
Adenomyosis
Adhesions

Acute

Cyclic

Chronic

The most common type among women

Dysmenorrhea

is recurrent painful menstruation with absence of pain between menstrual periods

It may be:

Primary → when there is no readily identifiable cause .

Secondary → to organic pelvic disease.

The typical age range of occurrence for primary dysmenorrhea is between 17-24 (before 20) , whereas secondary dysmenorrhea is more common in older women (>30 years of age)

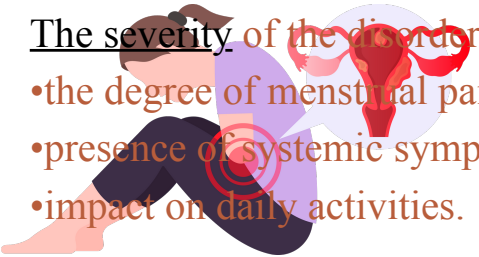
Dysmenorrhea

Primary

Secondary

Painful menstruation in the absence of hormonal or anatomical pathol (no identifiable cause)

Occurs in age range between 17-24 (before 20)



The severity of the disorder can be categorized by a grading system based on :

- the degree of menstrual pain
- presence of systemic symptoms
- impact on daily activities.

There is some evidence to support the assertion that primary dysmenorrhoea improves after childbirth, and it also appears to decline with increasing age

Clinical features :

- usually in the pelvic or lower abdomen
- begins a few hours before or just after the onset of menstruation
- usually last for < 3 days
- pain is described as cramping or colicky in nature
- it may radiate to the thighs and lower back
-associated with nausea, vomiting, diarrhea and headache

Pathophysiology

• The etiology of primary dysmenorrhea has been attributed to uterine contractions with ischemia and the production of prostaglandins

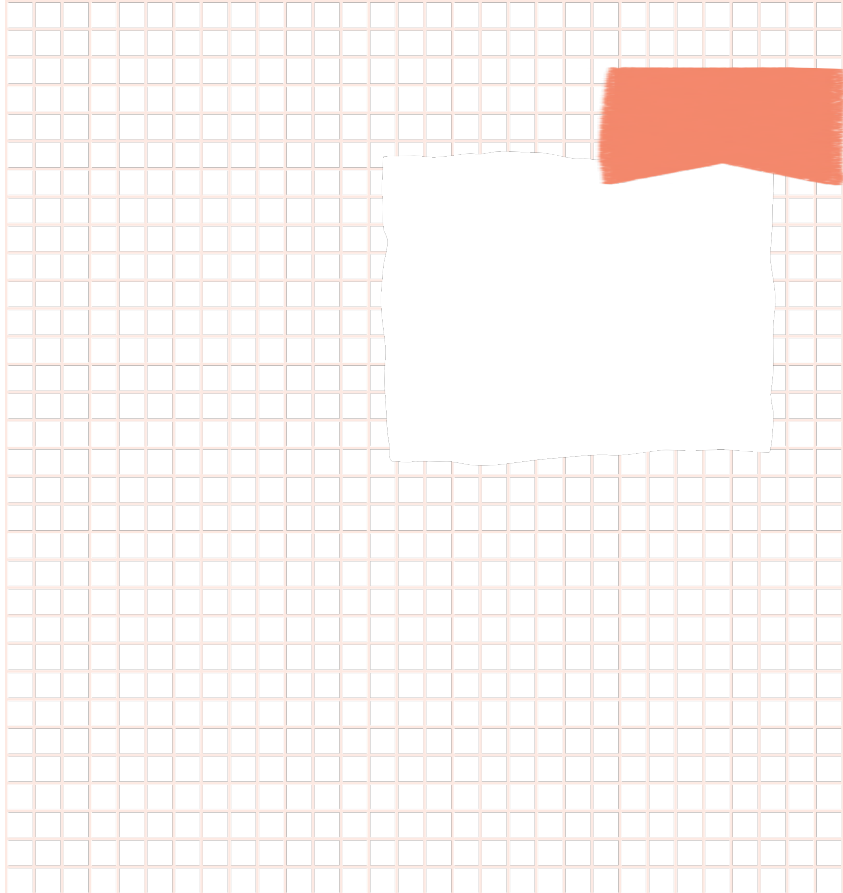
• The evidence that prostaglandins are involved in primary dysmenorrhea is convincing

• Menstrual fluid from women with this disorder has higher than normal levels of prostaglandins

• Symptoms appear to be caused by excess production of endometrial prostaglandin F2a: resulting from the spiral arteriolar constriction and necrosis that follow progesterone withdrawal as the corpus luteum involutes.

• The prostaglandins cause dysrhythmic uterine contractions, hypercontractility, and increased uterine muscle tone, leading to uterine ischemia

• The effect of the prostaglandins on the gastrointestinal smooth muscle also can account for nausea, vomiting, and diarrhea via stimulation of the gastrointestinal tract



Treatment

1. NSAIDS

First-line therapy

Pain relief is better if NSAIDs are started 2-3 days before menstrual flow

Which act as COX inhibitors decreasing prostaglandin production by enzyme inhibition is the basis of all NSAIDs

2. Hormonal contraceptive
3. Progestin
4. Analgesics
5. Transcutaneous electrical nerve stimulation (TENS)
6. Psychotherapy

If the patient fails to respond to NSAIDs and hormonal contraception, Investigation (U/S, Laparoscopy and Hysteroscopy) may be needed.

Dyspareunia is NOT found in patients with primary dysmenorrhea. If present, should suggest secondary cause.

If dysmenorrhea does NOT appear until more than a year after menarche, secondary dysmenorrhea should be suspected

The most common misdiagnosis of primary dysmenorrhea is endometriosis

Secondary dysmenorrhea

Describes painful periods that have developed over time and usually have a se
mechanism of pain depends on the underlying (secondary) cause and in most c

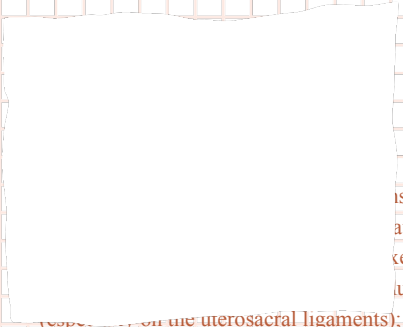
Uterine causes

- Pelvic inflammatory disease (PID) *
- Intrauterine device (IUD)
- Adenomyosis
- Fibroids (intracavitary or intramural)
- Cervical polyps

- Extrauterine causes
- Endometriosis
- Adhesions
- Functional ovarian cysts
- Inflammatory bowel disease

Clinical features

secondary dysmenorrhea is not limited to the menses, and can occur up to 2 weeks before as well as up to a week after the menses.
In addition, secondary dysmenorrhea is less related to the first day of flow, develops in older women (30-40 years) and is usually associated with other symptoms such as dyspareunia, infertility, or abnormal uterine bleeding



…strual
…ave deep
…ked
…ules
…on the uterosacral ligaments); onset is usually in the 20s and 30s but may start in the teens.

Adenomyosis, Fibroid Tumors

Uterus is generally symmetrically enlarged and may be mildly tender; dysmenorrhea is associated with a dull pelvic dragging sensation; hypermenorrhea and dyspa-reunia may be present.

Pelvic Congestion

A dull, ill-defined pelvic ache, usually worse premenstru-ally, relieved by menses; not all investigators agree that this is a cause of chronic pelvic pain.

Investigation

1. Laboratory tests(CBC)
2. U/S(initial),
3. Laparoscopy
4. MRI.
5. Swaps and Cultures

Diagnostic

laparoscopy: It is performed to investigate secondary dysmenorrhea:

- When the history suggests endometriosis.
- When smears and ultrasound scans are normal, yet symptoms persist.
- When the patient wants a specific diagnosis or wants to be reassured that her pelvis is normal. The discussion about laparoscopy should include the risks and the possibility that this investigation may not show clear causes fo their symptoms.

dyspareunia

CONTENTS

1 Introduction

Painful intercourse can occur for reasons that range from structural problems to psychological concerns. Many women have painful intercourse at some point in their lives.

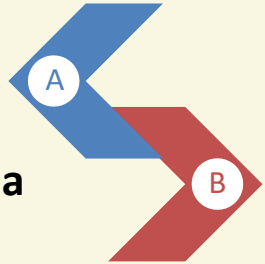
dyspareunia : defined as persistent or recurrent genital pain that occurs just before, during or after intercourse.

Understanding the duration, location, and nature of the pain is important in identifying the causes of the pain.

2 Dyspareunia Classification

Organic dyspareunia

- **Superficial Dyspareunia**
  - With entry .
  - Mid vaginal .
- **Deep Dyspareunia**



Psychological dyspareunia

- **Type-1 (intra-personal)**
- **Type-2 (inter-personal)**

2 Superficial Dyspareunia

With Entry

1. Vulvodynia
2. Vaginismus
3. Inflammation, infection or skin disorders.
4. Congenital conditions.
5. Tight introitus
6. Vulvar lesion

2 Vulvodynia

Vulvodynia is defined by the International Society for the Study of Vulvovaginal Diseases (ISSVD) as vulvar pain of at least 3 months duration, without a clearly identifiable cause.

- Vestibulodynia :

- previously known as vulvar vestibulitis .
- The most common subtype of vulvodynia that affects premenopausal women (10-15%).
- Characterized by severe localized to the vulvar region, burning or cutting type of pain (provoked pain) with attempted penetration of the vaginal orifice that might last for hours either days after sexual intercourse.

2 Vestibulodynia :

Possible causes;

1 Inflammatory; sub-clinical HPV, chronic recurrent (candidiasis, vaginosis)

2 Muscular; chronic hypertonic perivaginal muscles

3 Neural; neuralgia, vestibular neural hyperplasia, hypersensitivity to a subclinical infection

4 Urinary; Ca2+ oxalate crystals in urine

Pelvic Examination; pressure tenderness localized within vestibular region, vestibular erythema of various degrees, usage of the cotton-swab test, Vaginal pH, vaginal culture, U/A.

2 generalised vulvodynia

- generalised vulvodynia :

- previously known as dysaesthetic vulvodynia .
- Generalized vulvodynia describes constant widespread pain throughout the vulvar region where there is no physical explanation for it (unprovoked) .
- may be felt beyond the confines of vulvar vestibule.
- Seen mainly in peri-menopausal and post-menopausal women

2 generalised vulvodynia?

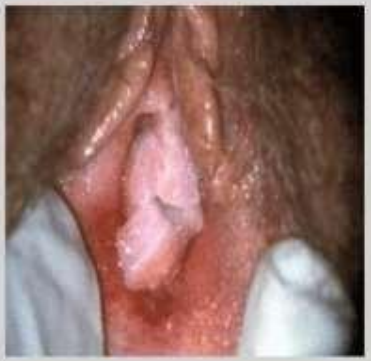
What causes generalised vulvodynia?

By definition, the cause of generalised vulvodynia is unknown. Current theories consider generalised vulvodynia is a chronic pain syndrome related to hypersensitive nerves. One or more of the following may have a role to play in the development of this condition.

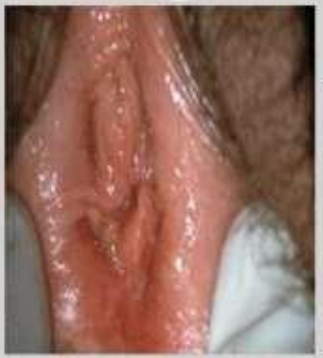
1 Stretched, inflamed nerves in the vulvar area (pudendal nerve entrapment or pudendal bbbb neuralgia), spine or related structures
2 Trigger points where there are proliferating or sensitized nerve endings in the skin itself
3 Previous vulvar skin condition, surgery or childbirth resulting in scarring or another injury
4 Hormonal changes causing vulvar dryness, especially during menopause
5 Previous inflammatory disorders such as herpes simplex or herpes zoster/shingles infection
6 Emotional stress

Vulvodynia Assessment

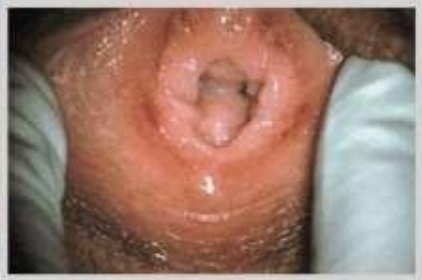
Visual Examination



Patient #1
Severe Erythema



Patient #2
Moderate Erythema



Patient #3
Minimal Erythema / Severe Pain

Pain severity and subsurface inflammation do not consistently correlate with the amount of erythema observed. (Bergeron 2001, Farage 2009)

Treatment

Vulvodynia treatments focus on relieving symptoms. No one treatment works in every case. For many, a combination of treatments works best. It can take time to find the right treatments, and it can take time after starting a treatment before you notice relief.

Treatment options include:

- **Local anesthetics.** Medications, such as lidocaine ointment
- **Medications.** Steroids and tricyclic antidepressants can help lessen chronic pain. Antihistamines might reduce itching.
- **Pelvic floor therapy.** Many women with vulvodynia have tension in the muscles of the pelvic floor, which supports the uterus, bladder and bowel. Exercises to relax those muscles can help relieve vulvodynia pain.
- **Nerve blocks.** Women who have long-standing pain that doesn't respond to other treatments might benefit from local nerve block injections.
- **Surgery.** In cases of localized vulvodynia or vestibulodynia,

.

2 Vaginismus

Involuntary vaginal muscle spasm that usually triggered by anxiety or stress, which makes any kind of vaginal penetration painful or impossible.

➢ Treatment :-

1. **Psychological;** relaxing technique, anxiolytics and anti-depressants
2. **Physical;** Kegel exercises and provide some additional lubricants.
3. **Neuromodulators**

2 Superficial Dyspareunia

Mid-vaginal

- **Inadequate lubrication;**
  Caused by; Drop in estrogen levels esp. after menopause, after child birth or breast-feeding.

- **Surgical Scars;**
  Repaired laceration during vaginal Delivery .

- **Urethral diverticulum;**
  - Localized outpouching of the urethra into the anterior vaginal wall.
  - Most often present in the mid or distal urethra or urethral diverticula may result from cystic enlargement of obstructe peri-urethral glands that communicate with the urethra .

- **Infections**

- **Vaginal Cancer;**
  Squamous-cell carcinoma and Adenocarcinoma

2 Deep Dyspareunia

- **Endometriosis** :-

- Mainly which occur on the utero-vaginal septum or utero-sacral ligaments.
- Associated with :- pelvic pain, secondary dysmenorrhea, chronic lower back or abdominal pain, dyspareunia, Infertility, Urinary symptoms (dysuria, urinary urgency, frequency).

- **Interstitial cystitis;**

- Chronic inflammatory condition of the submucosal and muscular layers of the bladder
- Characterized by Frequency, Urgency and Pelvic Pain.

2 Deep Dyspareunia

- Neoplasm;

- Leiomyoma (Fibroids), if it is located at low level in uterus.
- Cervical Cancer or polyp
- Pelvic malignancies; ovarian lesion, connective tissue neoplasms

- Uterine diseases;

Uterine prolapse (ovarian entrapment syndrome) .

- Pelvic inflammatory diseases (PID)

- Irritable bowel syndrome & inflammatory bowel disease

2 Psychological Dyspareunia

The disturbance is not caused exclusively by Vaginismus or lack of lubrication, is not better accounted for by another Axis I disorder (except another Sexual Dysfunction), and is not due exclusively to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition you should consider Psychological Dyspareunia .

Types :-

- Type-1 (intrapersonal); fear of pain, guilt, feeling shame, misinformation, previous traumatic experiences (sexual abuse), ignorance of sexual anatomy and physiology, fear of pregnancy, anxiety and depression.
- Type-2 (interpersonal); relationship problems, pain occur as an unconscious fear or anger in the relationship providing an excuse to avoid intercourse, stress during intercourse.

3 Investigations

The initial examinations may lead you to request other tests, such as:

- ✓ **pelvic ultrasound, x-ray and MRI**
- ✓ **culture test to check for bacteria or yeast infection**
- ✓ **urine test**
- ✓ **allergy test**
- ✓ **Laparoscopy**
- ✓ **counseling to determine the presence of emotional causes**

3 Treatment

Treatment of dyspareunia highly depends on the underlying cause . For example :-

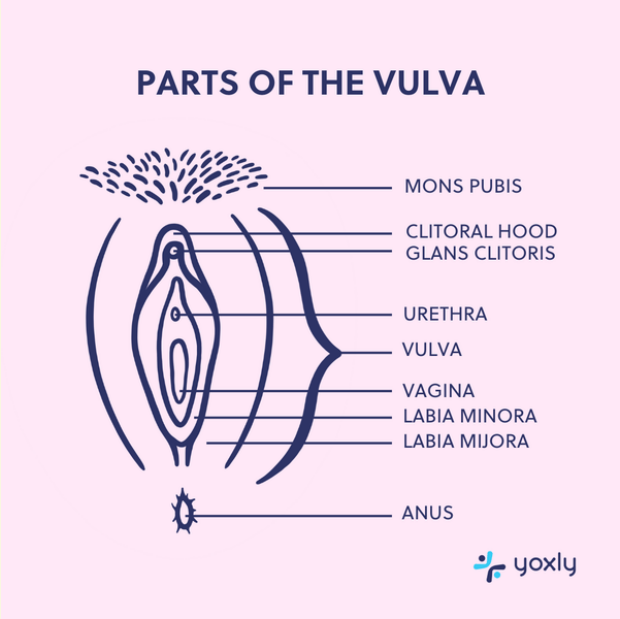
- **- If its infections, use the proper antimicrobial medication.**
- **- if its Endometriosis, medications or surgery are possible options.**
- **- if its sutures or scars, removal of suture and injection of local anesthesia.**
- **- if the pain due to post-menopausal vaginal dryness, use tropical estogen**

Don't forget to relief the symptoms while treating the underling cause by NSAID & Opioids .

- **If the cause of Dyspareunia is psychological, counseling should performed .**

-

Valvar itching



Definition :

Vulvar itching or vulvar pruritus is a tingling or irritation of any part of the vulva, with a desire to scratch.

- Pruritus vulvae is a symptom, not a condition in itself. Pruritus vulvae can be caused by many different conditions.
- 95% of women with vulvar itching have yeast

CAUSES

SKIN DISEASE	INFECTIOUS	OTHERS
Contact Dermatitis	Bacterial vaginosis	Stress
Psoriasis	Herpes simplex virus.	Menopause , pregnancy
Lichen Sclerosus	Scabies.	DM
Lichen Planus.	STDs	Vulvar cancer
Lichen Simplex Chronicus	Fungul infection	Neuropathy

Vaginal candidiasis

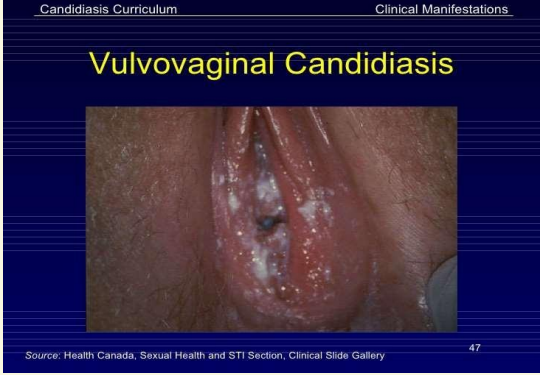
- ❑ **The most common cause** of vulvar itching.
- ❑ affects up to 3 out of 4 women at some point in their lifetimes.
- ❑ 5% suffer from recurrence (4episodes within 1 year)

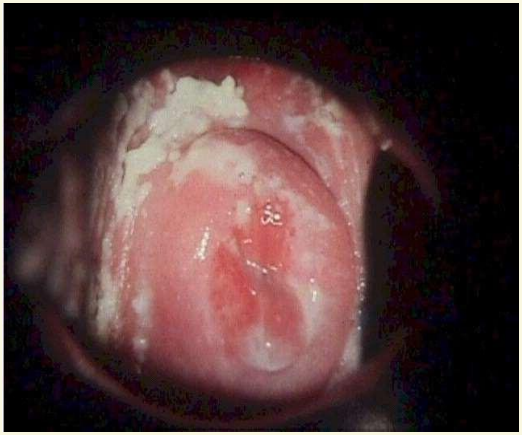
- Risk factors:

High dose OCP
diaphragm use with spermicide
DM
antibiotic use
immunosuppression.

Clinical presentation:

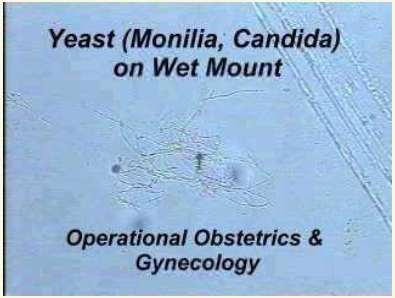
- Itching AND irritation
- burning sensation especially during intercourse or while urinating
- Redness and swelling of the vulva
- Vaginal pain and soreness
- Vaginal rash
- Thick, white vaginal discharge with a cottage cheese appearance
- Watery vaginal discharge





Diagnosis

- 1- Wet mount preparation shows budding yeast pseudohyphae, in 50%-70% of cases
- 2- Fungal culture if negative mount



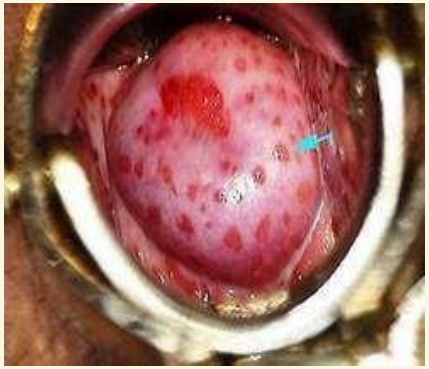
Treatment:

✓ the topically applied **azole**

✓ in severe case we give oral

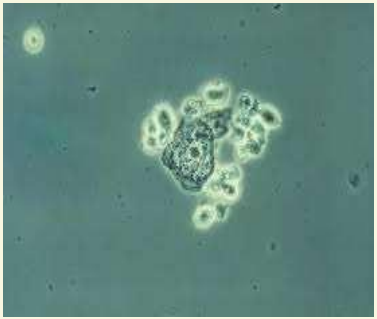
✓ **azole resistant therapy** boric acid. used only to treat candida fungus that is resistant to the usual antifungal agents.

Trichomoniasis :



- Caused by trichomonas vaginalis which is protozoal flagellate
- 20% of infected women are asymptomatic carriers
- Presents usually by foul smelling and frothy vaginal discharge .
- Vaginal examination may reveal strawberry appearance and bubbly discharge

Diagnosis:
Wet mount show pear shaped trophozoits with their jerky movement



Treatment:

Metronidazole is effective in most cases

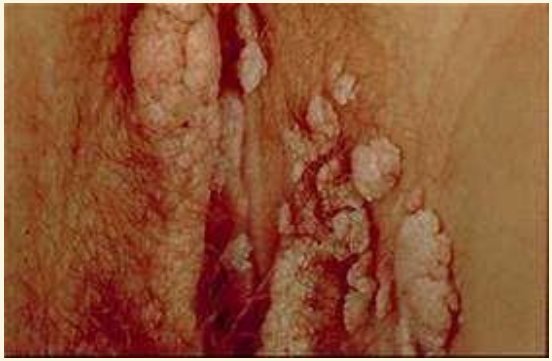
Partner should be treated as its STD

Genital warts:

- Caused by Human Papilloma virus (HPV) , mainly type 6 & 11 (condyloma acuminata).
- Peak incidence among 15 -25 yrs , soon after onset of sexual activity.

- Soft and or verrucous lesions.
- Usually multifocal & asymptomatic , although itching, burning , bleeding & pain can occur.
- External genital warts are highly contagious >75%.

- Usually diagnosed clinically.



Treatment:

The goal of the treatment is the **removal of the warts**, it is not possible to eradicate the viral infection.

Treatment modalities : application of cytotoxic or keratolytic agents , surgical excision cryotherapy , laser & immune modulators (interferon)

Scabies:

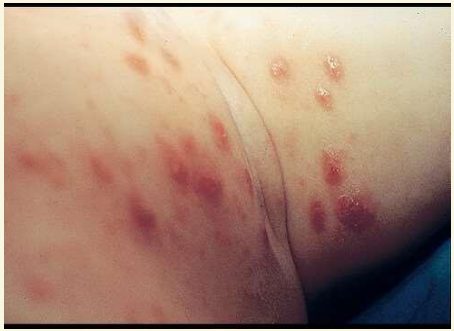
Sarcoptes scabiei (mite)

Usually occur in dirty over crowded areas

Diagnosis is usually made by characteristic lesion and distribution .

Recovery of the mite from their tunnels and examined under microscope.

- **Treatment:**
- Good wash of the area by soap to open the tunnels
- Rubbing with acaricidal solution
- Clothes should also be sterilized by boiling



Lichen Sclerosus

- Lichen sclerosus (LS) is a chronic inflammatory condition of unknown etiology, LS believed to be an autoimmune disorder.

- complex pathogenesis that may genetic, hormonal, and infectious factors
- LS affects both sexes and all areas of the body with the most common site of affection being the genitalia. It is more common in women, manifesting most commonly on the vulva.

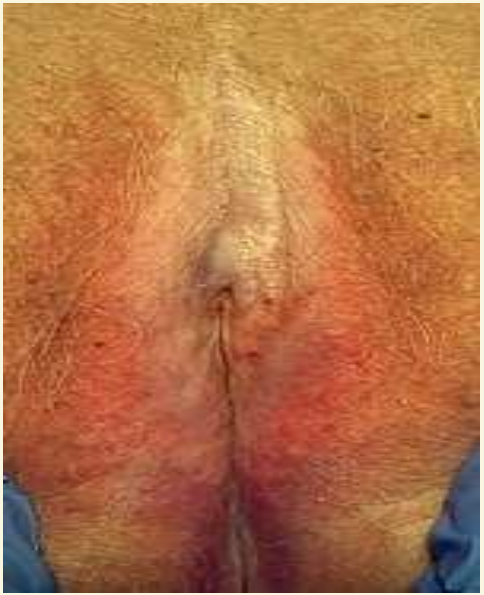
- Onset can occur at any age, but notable bimodal peaks are seen at times of low estrogen in prepubertal girls and menopausal women

- Most patients present complaining of vulvar pruritus or irritation.
- LS can be asymptomatic.
- Physical examination reveals atrophic, hypopigmented-to-white, often atrophic, plaques associated with pruritus and pain that result in genital scarring and adhesion.
- Plaques classically distributed around the vulva, perineal body, and perianal skin.

•Scratching may lead to thickening of the skin which can mask the classic atrophic appearance.

- As the disease progresses, the symptoms may shift from pruritus to pain, including dyspareunia, dysuria, and pain with bowel movements, which can be associated with a late physical finding of purpura, erosions, resorption of the labia minora, and fusion of the clitoral hood.

- **Diagnosis** is confirmed with biopsy showing hyperkeratosis and atrophic epidermis



- Patients with LS have an increased incidence of other autoimmune diseases, particularly thyroid disease, vitiligo, pernicious anemia.

- Approximately 2% to 5% of women with vulvar LS will develop **vulvar squamous cell carcinoma**.

- Treatment is super-potent **topical corticosteroids** (eg, clobetasol propionate) for most cases.

- The essential components of managing vulvar LS include controlling symptoms, minimizing scarring, and preventing, or detecting early, malignancy.

Lichen planus:

- Lichen planus (LP) is another chronic inflammatory dermatosis considered to be an autoimmune condition.
- Lichen planus is the most common chronic erosive vulvar dermatosis
- LP can affect the mucous membranes of the vagina, conjunctiva, urethra, and anus as well as cutaneous skin, scalp, and nails.
- Vulvovaginal LP most commonly presents in postmenopausal woman but can occur earlier in adult women and on rare occasions in children.
- A typical presentation is a menopausal woman reporting vulvovaginal pain or pruritus, dyspareunia.

- Examination of oral mucosa can yield significant diagnostic clues, as many women with vulvar LP also have evidence of oral LP on examination.

- Oral LP, which can be painful or asymptomatic, may manifest as erosions, reticulate striae (wickham striae)on the buccal mucosa, or gingival inflammation

- LP is treated primarily with super-potent topical steroids in a regimen similar to that described above for LS.

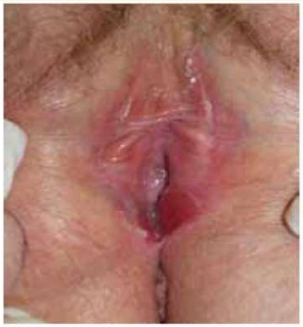
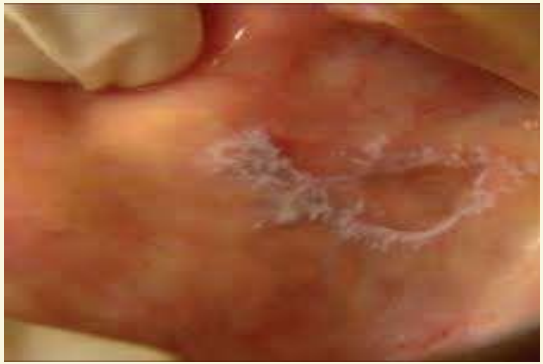
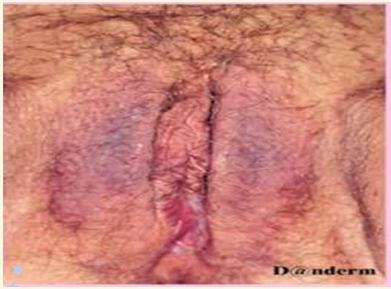


Figure 9. Lichen planus—erythematous plaque with large erosion of the posterior vestibule, resorption of the labia minora, and fusion of the clitoral hood. Note the white peripheral rim surrounding the erosion.



Lichen simplex chronicus:

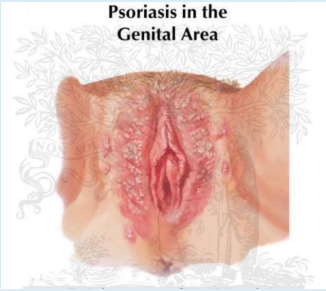


- Lichen simplex chronicus (LSC) is a localized plaque of chronic eczematous inflammation created by repeated rubbing or scratching of the skin in response to a sensation of pruritus.

- While this rubbing and scratching yields relief and feels pleasurable, the act of rubbing and scratching produces more irritation and more itching, giving rise to a phenomenon often referred to as the itch/scratch cycle. It is because of this cycle that the scratching becomes habitual and recurrence is common.

- The itching and inflammation may be treated with a lotions or steroid cream (such as triamcinolone or Betamethasone) applied to the affected area of the skin.

Psoriasis:



- Psoriasis is a complex, chronic, multifactorial, inflammatory disease that involves hyperproliferation of the keratinocytes in the epidermis, with an increase in the epidermal cell turnover rate.
- resulting in characteristic, well-demarcated, erythematous plaques with silvery scale.
- Identifying classic lesions of psoriasis elsewhere on a full-body skin examination can focus the differential diagnosis.
- Typical locations, including the elbows, knees, and scalp, and for psoriatic nail changes, including pitting, oil spots, and onycholysis

Risk factors

- **Family history**
- **Smoking**
- **Alcohol**
- **Obesity**
- **Medication like beta blockers and lithium**
- **Infections like HIV**

Treatment:

- topical CS
- Non-biologic systemic treatments frequently used for psoriasis include methotrexate & ciclosporin
- Topical or systemic Retinoid vitamin A
- These agents are also regarded as first-line treatments for psoriatic erythroderma .

History and examination

History dysmenorrhea

Menstrual history :
- Regulatory
- Frequency
- Duration
- Volume (clot, how many pads)
- Dysmenorrhea :-prior – during
- Vaginal discharge

- Any other bleeding (IMB, PCB)
- IMB: intermenstrual bleeding
- PCB:postcoital bleeding
- Drug :ocp, copper, HRT, anticoagulants
- Previous surgery
- Infection

Characteristics of the pain must be determined, including its location, radiation, intensity, mitigating and exacerbating factors,, stress level, work, exercise and sexual intercourse

Associated Symptoms: Inquire about other symptoms like nausea, vomiting, diarrhea, headaches, or fatigue during menstruation.

-Do you need to take painkillers for this pain? What tablets help?

-Did you need to take time off work / school because of the pain?

-Some cases of primary dysmenorrhea are associated with flushing and nausea, which may be related to prostaglandins.

- Other important clues about aetiology include pain that occurs as clots pass, in which case medication to reduce the flow may be effective.

Secondary dysmenorrhea may be associated with dyspareunia or AUB, which may indicate a pathological diagnosis.

Lifestyle and Social History:Diet and Exercise: Any connection between physical activity and symptoms?Stress Levels: Assess for stress or mental health issues which may exacerbate symptoms.

General Medical History:
Past Medical History: Include chronic conditions like diabetes, hypertension, or thyroid disorders.
Surgical History: Any previous surgeries, especially related to the pelvis or abdomen?
Medications: List all current medications, including over-the-counter drugs and supplements.
Family History: Any family history of gynecological conditions, especially endometriosis or fibroids?

2. Gynecological History:
Contraceptive Use: Ask about current or past use of contraceptives, including hormonal contraceptives, IUDs, or any other method.
Sexual History: Any issues with sexual activity? Pain during intercourse (dyspareunia)?
Previous Gynecological Issues: Any history of conditions like endometriosis, fibroids, or pelvic inflammatory disease?
Obstetric History: If applicable, ask about pregnancies, childbirth, miscarriages, or abortions.

Examination

Pelvic Examination:

Inspection:

Check the external genitalia for any abnormalities.

Speculum Examination: Inspect the cervix and vaginal walls for signs of infection, discharge, or lesions.

Bimanual Examination: Palpate the uterus and adnexa (ovaries and fallopian tubes) to assess size, shape, mobility, and tenderness.

Rectovaginal Examination: This might be necessary if endometriosis or other pelvic pathology is suspected.

a pelvic mass (if an endometrioma is present),

- a fixed uterus (if adhesions are present) and
- an endometriosis nodule (palpable in a Douglas cyst or in the utero-sacral ligaments).
- An enlarged uterus may be found with fibroids.
- Abnormal discharge and tenderness may be seen with PID.
- The "red marks" in the expression of dymenorrhoea lead the physician to suspect serious illnesses and include an abnormal cervix on examination, persistent PCB or IMB, which may indicate endometriosis or cervical disease, or a pelvic mass that is not evident in the uterus

Additional Considerations:

Pap Smear: If indicated, perform a Pap smear for cervical screening.

Ultrasoaund: If abnormalities are suspected, a transvaginal or abdominal ultrasound may be warranted to assess the uterus and adnexa.

Laboratory Tests: Depending on the findings, consider tests like CBC, ESR, or hormone levels (e.g., thyroid function).

History Dyspareunia

- Site
- Onset of pain (before, entry, vaginal, deep or after) • Continuous or intermittent
- Is it pruritic, burning or aching in quality
- Has it been life-long (primary) or acquired (secondary)
- Radiation to back or legs (Ovarian)
- Are there vaginal symptoms as discharge, burning or itching
- Previous Hx of this condition and its reaction • Is it situational or positional
- History of HSV or HPV, STD, PID

- Is she still having periods? LMP?
- Is the patient experiencing vaginal dryness, hot flushes or menstrual disturbance?
- Has the dyspareunia followed childbirth
- Hx sexual abuse, rape or trauma to the genitals, including childbirth?
- Relation to menstrual cycle (endometriosis)
- Is there Post-coital bleeding ?
- Obstetric history; lacerations, episiotomies or trauma
- Prior gynecologic diagnosis: endometriosis, fibroids or chronic pelvic pain
- If there is any medical or psychiatric illnesses ?

pelvic examination

pelvic examination look at the external and internal pelvic area for signs of: - dryness - inflammation or infection - anatomical problems - genital warts - scarring - abnormal masses - endometriosis - tenderness

✓ The internal examination will require a speculum, a device used to view the vagina during a Pap test.
Your doctor also may use a cotton swab to apply slight pressure to different areas of the vagina. This will help determine the location of the pain

Palpation

1. Bimanual pelvic examination
2. Tenderness – Generalized tenderness and cervical excitation, adnexal tenderness. – Unilateral, Bilateral tenderness. – Tenderness in the pouch of Douglas.
3. Mass
4. Palpation of bartholin and periurethral glands
5. PV examination

– Insertion of a single digit into the vagina may elicit vaginismus

. – Deeper insertion, digital examination may trigger mid-vaginal pain, seen with interstitial cystitis, congenital anomalies or following radiation therap

History valve itching

.1 **Onset**:

- When did the itching start?
- Was it gradual or sudden?

.2 **Location**:

- Where exactly is the itching occurring?
- Is it localized to the valve area, or does it spread to surrounding areas?

.3 **Duration**:

- How long has the itching persisted?
- Is it constant or intermittent?

.4 **Character**:

- How would you describe the itching (mild, severe, burning, etc.)?

.5 **Associated Symptoms**:

- Are there any other symptoms like redness, swelling, discharge, or pain around the valve?
- Have you noticed any systemic symptoms like fever, fatigue, or chills?

.6 **Exacerbating/Relieving Factors**:

- Does anything make the itching worse (e.g., movement, pressure)?
- Is there anything that relieves the itching?

.7 **Medical History**:

- Do you have any known allergies, particularly to medications, dressings, or materials used in the valve?
- Have you had previous issues with infections or reactions at this site?
- Are you on any medications, particularly anticoagulants or antibiotics?

.8 **Social History**:

- Do you have any habits (e.g., scratching, exposure to certain chemicals) that might affect the area?

.9 **Previous Interventions**:

- Have you tried any treatments or medications for the itching? If so, what were the outcomes?

.10 **Follow-Up**:

- Have you contacted your healthcare provider about this issue before? What was their response?

This information would help in determining the cause of the itching, whether it's an allergic reaction, infection, or another issue related to the valve or surrounding tissues.

Examination

1. InspectionSite of Itching:
2. Examine the exact location of the itching.
3. Is it directly over the valve or surrounding tissues?
4. Skin Changes:Look for redness, swelling, rash, lesions, or any visible irritation.
5. Note any signs of dermatitis, eczema, or psoriasis.Discharge:Check for any discharge (serous, purulent) which might indicate infection.
6. Wound Healing:If the valve is newly implanted, assess the surgical site for healing progress or signs of dehiscence
7. .Skin Integrity:Look for abrasions, excoriations, or ulcers that might result from scratching.
8. Presence of Foreign Bodies:Check for any sutures, adhesives, or other foreign materials that could be causing a reaction.

2. PalpationTenderness:
Palpate the area to assess for tenderness, which could indicate inflammation or infection.
Temperature:Feel for warmth around the site, which could suggest an infection
.Edema:Assess for localized swelling (edema) around the valve site.
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Thank you for your attention