



## 2015 Consensus terminology and classification of persistent vulvar pain

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for the consensus vulvar pain terminology committee

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and the International Pelvic Pain Society (IPPS)**

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<sup>1</sup>Representing also the American Society of Cervical Pathology and Colposcopy (ASCCP)

<sup>2</sup>Representing also the National Vulvodynia Association (NVA)

### Table 1: 2015 Consensus terminology and classification of persistent vulvar pain

#### A. Vulvar pain caused by a specific disorder\*

- Infectious (e.g. recurrent candidiasis, herpes)
- Inflammatory (e.g. lichen sclerosus, lichen planus, immunobullous disorders)
- Neoplastic (e.g. Paget disease, squamous cell carcinoma)
- Neurologic (e.g. post-herpetic neuralgia, nerve compression or injury, neuroma)
- Trauma (e.g. female genital cutting, obstetrical)
- Iatrogenic (e.g. post-operative, chemotherapy, radiation)
- Hormonal deficiencies (e.g. genito-urinary syndrome of menopause [vulvo-vaginal atrophy], lactational amenorrhea)

**B. Vulvodynia** – Vulvar pain of at least 3 months duration, without clear identifiable cause, which may have potential associated factors

#### Descriptors:

- Localized (e.g. vestibulodynia, clitorodynia) or Generalized or Mixed (Localized and Generalized)
- Provoked (e.g. insertional, contact) or Spontaneous or Mixed (Provoked and Spontaneous)
- Onset (primary or secondary)
- Temporal pattern (intermittent, persistent, constant, immediate, delayed)

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\*Women may have both a specific disorder (e.g. lichen sclerosus) and vulvodynia

**Table 2: 2015 Consensus terminology and classification of persistent vulvar pain – Appendix: Potential factors associated with Vulvodynia\***

- Co-morbidities and other pain syndromes (e.g. painful bladder syndrome, fibromyalgia, irritable bowel syndrome, temporomandibular disorder) [Level of evidence 2a]
- Genetics [Level of evidence 2b]
- Hormonal factors (e.g. pharmacologically induced) [Level of evidence 2b]
- Inflammation [Level of evidence 2b]
- Musculoskeletal (e.g. pelvic muscle overactivity, myofascial, biomechanical) [Level of evidence 2b]
- Neurologic mechanisms:
  - Central (spine, brain) [Level of evidence 2b]
  - Peripheral [Level of evidence 2b]
- Neuroproliferation [Level of evidence 2b]
- Psychosocial factors (e.g. mood, interpersonal, coping, role, sexual function) [Level of evidence 2b]
- Structural defects (e.g. perineal descent) [Level of evidence 2b]

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\*The factors are ranked by alphabetical order

**Comment to the 2015 Consensus terminology and classification of persistent vulvar pain**

Since the previous terminology of Vulvodynia was accepted by the ISSVD in 2003, studies have been carried out to explore possible causative factors and treatment options.

Several studies and treatments have been introduced, based on putative etiologies of Vulvodynia, for example: tricyclic antidepressants for a neuropathic etiology; nerve surgery for excision of neuroma or removal of compression from branches of the pudendal nerve.

In addition, over the years, several descriptors of Vulvodynia and terms that were not in use at the time of the 2003 terminology have been introduced. For example: Primary and Secondary Vulvodynia, intermittent and persistent pattern.

Therefore, the International Society for the Study of Vulvovaginal Disease (ISSVD), the International Society for the Study of Women's Sexual Health (ISSWSH), and the International Pelvic Pain Society (IPPS) discussed a possible revision to the 2003 terminology, and organized an international meeting in order to reach a consensus on the terminology of vulvar pain, on April 8-9, 2015 in Annapolis, Maryland. In addition, the American College of Obstetricians and Gynecologists (ACOG) and the National Vulvodynia Association (NVA) were represented in that meeting. After discussions, a consensus terminology proposal was unanimously reached at that meeting. It was decided by the three societies that the consensus terminology proposal would be brought to discussion and voted by each Society. Comments regarding the terminology proposal were sent by email to Professor Jacob Bornstein, presented and discussed at the ISSVD world congress. Minor amendments were made in response to these discussions. The final terminology was accepted by all three societies during July and August, 2015.

**Compared to the 2003 terminology, the following has stayed the same:**

- The division to sections – with the first being: "Vulvar pain caused by a specific disorder". This section contains vulvar pain conditions for which a cause has been clearly identified.
- The descriptors of Vulvodynia regarding location (Generalized or Localized) and provocation.

**The following has been revised in the new terminology:**

- "Unprovoked" has been replaced with – "spontaneous", a more appropriate term.
- The title of the terminology has been changed to "Terminology and Classification of Persistent Vulvar Pain..." rather than the 2003 "Terminology and Classification of Vulvodynia...", because it does not pertain to acute vulvar pain or only to Vulvodynia.
- The 2003 definition of Vulvodynia: "Chronic vulvar discomfort, mainly described as burning, occurring in the absence of visible relevant findings", has been changed in 2015 to: "Vulvar pain of at least 3 months duration, without clear identifiable cause, which may have potential associated factors".

**The following is new in the terminology:**

- The main addition is an appendix to the terminology named: "Potential factors associated with Vulvodynia". In the continued search for causation and new treatments for Vulvodynia, some factors have been discussed. The current data were reviewed and the committee concluded that some factors have stronger association with Vulvodynia, while some have weaker associations.
- Please note that once a factor is considered to have a definite causative role of vulvar pain, it will be mentioned in the first part of the Table ("A. Vulvar pain caused by a specific disorder"). For example: Herpes Genitalis or genital cutting. Other factors have not reached that level of causal certainty, but have a significant association and may be used to choose treatment of Vulvodynia. For example – if a musculoskeletal factor is considered to be present, the patient may be referred to undergo physical therapy.

**Why do we add “potential associated factors” to the terminology, although they are not terminology terms?**

Vulvodynia may not be a specific entity, but a multifactorial condition. The inclusion of the associated factors emphasizes that treatment should be chosen according to the characteristics of the individual case and the possible associated factors, rather than be uniform (like surgery for all, physical therapy for all, etc). Instead – choose physical therapy if musculoskeletal factors are present, and prefer specific neural medication or surgery if neuroproliferation exists. The associated factors show that a multidisciplinary approach to vulvar pain is needed and help direct future research.

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Indeed, over the years, factors that were claimed to have a causative role in Vulvodynia have been later found to be only coincidental. This may also happen with the associated factors of the current terminology. Therefore, a level of evidence was assigned to each factor, based on a review of the literature. The associated factors were grouped in an appendix, and not in the main table, because they are not terminology terms, and also to allow future amendment, when research yields further knowledge, without revising the whole terminology.

### **Conclusion**

This 2015 terminology of vulvar pain was reached by a consensus between societies. It is expected to replace the previous terminology and to improve the diagnosis and management of women with vulvar pain, as well as research in the field.