

# INTERNATIONAL SOCIETY FOR THE STUDY OF VULVOVAGINAL DISEASE



## A Message From The President

In the previous newsletter we shared with you why team work is essential, and also outlined the first two topics:

- ★ Defining Teamwork
- ★ Why does teamwork matter?
- ★ Characteristics and requirements of teamwork
- ★ Advantages and disadvantages
- ★ Differences between teamwork and group work
- ★ Why might teamwork fail?

This newsletter will address the following two topics: requirements and characteristics of teamwork, as well as its advantages and disadvantages.

### Characteristics and Requirements of Teamwork

The first challenge is to motivate and encourage a sense of commitment on behalf of all members of the group. We will then encounter a new challenge: making teamwork inviting and stimulating.

- **Good interpersonal communication**

The role of every team leader is to help in creating a work environment based on fluid communication and respect, where each participant has a chance to be heard and disagreement may be freely expressed.



President, Claudia Marchitelli, MD

**A person who feels appreciated will always do more than what is expected.**



- **Staying focused on the task**

The atmosphere should be set so that the team can put all focus on the task at hand, allowing individual and group creativity to flourish.

- **Outlining team responsibilities**

It is essential to delineate the role and responsibility that each member shall take on, as well as setting guidelines and general directions. The specific functions of each member must be respected and considered.

- **Establishing the problem which is to be tackled**

An objective program must be prepared, outlining aims and attainable endpoints, in which each goal should be clearly and precisely defined.

- **Common interest in reaching the goal**

There must be common interest in reaching each goal, and agreement is necessary. The motivations and drive of each team member should be taken into account.

- **Creating a democratic atmosphere**

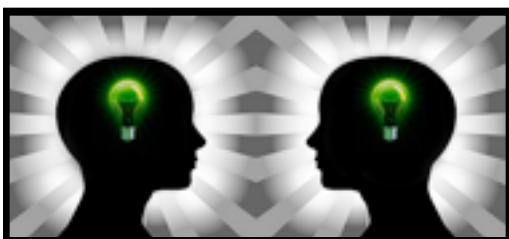
It is crucial for each individual to be able to express themselves freely without risk of judgment by their co-workers. If this is achieved, individual ideas will soon become “group ideas” and their rejection or dismissal will not entail a personal connotation.

- **Exercising consensus in decision-making**

When every member’s opinion is heard and respected, each decision can be made with correct and sufficient available information. Then, each individual member can be convinced through debate and rational exchange rather than simple voting.

- **Disposition for collaboration and exchange of skills and knowledge**

This implies disposing of sufficient time in order to allow each individual member to express to the others what they know, as well as sharing knowledge in order to enlighten the entire group.



### Advantages



The following are some of the advantages that teamwork offers for both individuals and organizations:

***For individuals***

- Relief of tension in the workplace thanks to shared responsibility of the harder aspects.
- Gratification and reward in identification with a job well done.
- Shared financial reward and professional acknowledgment.
- Consensual decisions tend to have greater acceptance than individual ones.
- The team as a whole benefit from greater availability of information and knowledge than each individual.
- Group work allows debate and discussion before decision making, which enriches the team and minimizes frustration.
- Teamwork encourages integration and participation between members, which in return encourages expression of each individual's capacities.

***For companies and organizations***

- Quality of work improves when decisions are made through consensus.
- Group spirit and commitment to the organization are reinforced.
- Research time is reduced when possible solutions are brainstormed and discussed as a team.
- Company expenses are reduced.
- There is greater knowledge and information.
- New strategies and approaches for problem-solving emerge.
- Decisions are better understood.
- Viewpoints are much more varied.
- There is greater acceptance of different solutions.

**Disadvantages of team based problem-solving**

Teamwork can also present a series of disadvantages that must be considered. The following may be some of them:

- Premature decision making.
- Prevalence of the opinions or dominance of a particular member or leader.
- Delay in getting to work because of excessive discussion about how to tackle the task.
- Exertion of coercion or pressure over team members to accept a specific solution.

In order to establish a team, it is necessary to consider the intellectual aspects of its possible members as well as their psycho-social aspects and personality.

Dysfunctional team participation is a clear sign that something is out of line. Some examples are: aggressiveness, unsupportive and negative attitude, resistance, continuous denial, lack of cooperation, constant disagreement, obstruction of work, deviation of attention to unimportant matters, desertion, isolation and unexplained absence.

In teamwork, when encouraging harmony and comradeship, the role of the leaders is essential. They must strive to encourage agreement on the objectives and methods, as well as helping to develop the group's commitment and involvement in the task and outcomes.

## **HPV Prophylactic Vaccine is Also Important in Prevention of Actual and Recurrent VIN**

### **By Marc Steben, MD**

Solid data from the phase 3 studies confirms that the quadrivalent HPV (4HPV) vaccine prevents high-grade disease of the vulva[1]. Solid data from phase 3 study confirms that the protection would be also effective in women already exposed to HPV and would increase in time after vaccination [2]. In the same studies, VIN number was reduced from an incidence of 105 per 10,000 per year in HPV 6-11-16-18 unexposed group to 80 per 10,000 per year in HPV 6-11-16-18 exposed group and biopsy number was reduced from 130 per 10,000 per year in HPV 6-11-16-18 unexposed to 105 per 10,000 in HPV 6-11-16-18 in exposed group [3].

Post-hoc analysis data presents solid evidence that protection of recurrence of any genital warts, VIN or VAIN was decreased by 44% (95% CI 14-64) in recipients of the 4HPV vaccine compared to a decrease of 79% HPV 6-11-16-18 related genital warts, VIN or VAIN[4].

In the 3 studies of the phase 3, 4HPV prophylactic vaccine efficacy in women previously exposed to vaccine-related HPV6-11-16-18 whose infection has cleared, seropositive and DNA negative, the incidence rate for external genital lesions, genital warts as well as VIN and VAIN, was 100% (95% CI: 40-100)[5].

In 4 Nordic countries, in a follow up study of women 16-23 years of age having received 4HPV prophylactic vaccine, effectiveness against HPV 16/18-related CIN2+/VIN2+ and VAIN2+ concluded the 4HPV vaccine is 100% effective up to 8 years following vaccination with a trend of continuing protection up to ~9 years[6].

And what about the protection provided against VIN of the 9valent HPV (9HPV) prophylactic vaccine? We already know that the protection provided against external biopsy for HPV 9 compared to HPV 4 vaccine for HPV 31-33-45-52-58 was 90.9% (95% CI 65.7, 98.5)[7] and protection against VIN1+ and VAIN1+ was 91.7%, (95%CI: 51.3, 99.6), but we do not know yet if the protection for HPV 6-11-16-18-31-33-45-52-58, exposed women whose infection has cleared will be as good as for the 4HPV vaccine?

### **Conclusion**

HPV prophylactic vaccines have a place to prevent actual VIN. 4HPV vaccine has been found to have a great role in reducing lesions as well as medical intervention in both unexposed and exposed women. The future will tell us if the same kind of protection against lesions and medical intervention was seen in exposed women receiving the 9HPV vaccine. In the meantime, it is important to know

that even if a woman was exposed to one HPV type, she can still benefit from the protection of the extra types included in the 9HPV vaccine.

1. Joura, E.A., et al., Efficacy of a quadrivalent prophylactic human papillomavirus (types 6, 11, 16, and 18) L1 virus-like-particle vaccine against high-grade vulval and vaginal lesions: a combined analysis of three randomised clinical trials. *Lancet*, 2007. **369**(9574): p. 1693-702.
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4. Joura, E.A., et al., Effect of the human papillomavirus (HPV) quadrivalent vaccine in a subgroup of women with cervical and vulvar disease: retrospective pooled analysis of trial data. *BMJ*, 2012. **344**: p. e1401.
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6. Nygard, M., et al., Evaluation of the Long-Term Anti-Human Papillomavirus 6 (HPV6), 11, 16, and 18 Immune Responses Generated by the Quadrivalent HPV Vaccine. *Clin Vaccine Immunol*, 2015. 22(8): p. 943-8.
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## Vulvodynia Update -New terminology

### By: Leslie Sadownik, MD

The “2015 Consensus Terminology and Classification of Persistent Vulvar Pain and Vulvodynia”<sup>1</sup> provides guidance on how to describe a woman’s vulvar pain and explicitly recognizes the complex nature of that pain by identifying factors that may be associated with the pain. The new terminology, aligning with the way pain is described in the pain literature, and the inclusion of associated factors represents a “paradigm shift in the approach to vulvodynia”. These factors include: comorbidities and other pain syndromes; genetics; hormonal factors; inflammation; musculoskeletal; neurologic mechanisms; psychosocial factors; and structure defects. Research assessing the association of these factors with vulvodynia will guide individualized and holistic care of affected women. Recent publications lend credence to the association of these intrapersonal and interpersonal factors with vulvodynia.

**Comorbidities** - Lester et al<sup>2</sup> found that women with PVD and other concurrent pain conditions reported different pain characteristics, increased health care use, and higher symptoms of depression and trait anxiety when compared to women with PVD only.

**Genetics** - Morgan et al found that close and distant relatives of women who had undergone vestibulectomy for vestibulodynia had an increased relative risk of vestibulodynia as compared to the general population - suggesting a genetic predisposition to vestibulodynia.<sup>3</sup>

**Psychosocial factors** - Chronic pain is a complex interplay between the patient's perception of her illness and her reaction to the pain. A recent study found that a woman's higher level of perceived "injustice" (why me?) was associated with greater sexual distress - and the same pattern was found for partners.<sup>4</sup> While it has been noted that women react to pain by avoiding sexual intercourse, the majority of women with PVD continue to have sexual intercourse.<sup>5</sup> Women who were motivated to have penetrative sex to avoid a negative consequence (partner's loss of interest or conflict with partner) reported lower sexual and relationship satisfaction, and higher levels of depressive symptoms.<sup>6</sup>

Partners also can react to a woman's pain and thus influence a woman's experience of pain. Bois et al. found that greater empathic responses and disclosures observed from women and their partners discussing the impact of vulvodynia on their lives was associated with less sexual distress and sexual dissatisfaction within the couple.<sup>7</sup> Rancourt et al. reported that how a couple talks about painful sex can influence a woman's level of pain, sexual and psychological health.<sup>8</sup>

### Treatment update

For years now experts have recommended applying a multidisciplinary treatment approach to treating vulvodynia.<sup>9-13</sup> Multidisciplinary (or interdisciplinary) care is a comprehensive approach that involves coordinated interventions amongst a variety of health care providers, in the same facility, with common treatment goals. These providers communicate and collaborate with each other in an integrated way to achieve these goals.

The goals of a multidisciplinary intervention should be: functional restoration (including physical, psychological and social/sexual function); symptomatic relief; and comfort improvement. A paradigm shift in our approach to vulvodynia would be an explicit recognition that the goal for treatment is not necessarily "cure" (elimination of pain) but rehabilitation (pain reduction) and functional restoration (improved psychological and social/sexual health).

There is currently no standard treatment model for the multidisciplinary care of vulvodynia. Experts have suggested that a multidisciplinary program for sexual pain should focus on: "areas such as the mucous membrane, the pelvic floor, the experience of pain, sexual and relational functioning, psychosocial adjustment and genital/sexual abuse".<sup>14</sup>

Several authors have published recent excellent reviews of the vulvodynia treatment literature and proposed treatment algorithms. These algorithms include a range of therapeutic approaches delivered by different health care providers as needed. They are not necessarily delivered under the guidance of a coordinated multidisciplinary team.<sup>9-11</sup> The effectiveness of these algorithms is unknown and need to be studied.

### Single treatment studies

A variety of medical, behavioral, and surgical therapies have all been proposed as “effective treatments” for vulvodynia. Many of these treatments have become “standard” therapy despite their effectiveness only being demonstrated in uncontrolled studies. Limitations of past treatment studies have included: no control/comparison groups; no placebo groups; no random assignment; non-blind treatment evaluation; no definition of therapeutic success; limited if any information on sample characteristics; no treatment adherence evaluation.

The quality of the published studies has steadily improved. In 2013 Simpson<sup>15</sup> conducted a systematic review of randomized controlled trials (RCT) for vulvar skin conditions and identified 14 RCT vulvodynia studies. Since that time, the results of several other vulvodynia RCT's have been published<sup>16, 17</sup> as well as the study design for three upcoming controlled trials<sup>18-20</sup>. The randomized placebo controlled trials in our field have yet to find a significant difference between medical treatments and placebo.<sup>21, 22, 22-25</sup>

There are several interesting points to consider when reviewing the research to date. First, it seems that almost all single interventions have a therapeutic effect (pain reduction) on patients. Secondly, patients who are diagnosed with vulvodynia and choose not to pursue any treatment also report improvement in pain over time. Davis<sup>26</sup> reported that 41% of women with sexual pain secondary to vulvodynia who did not participate in any treatment reported a significant improvement of their pain over a 2-year interval. Furthermore, women who reported trying *any type* of treatment (physical, psychological, sexual, surgical, and/or medical) reported significant reductions in pain and psychosexual improvement over the 2-year interval. There was no difference between the treatments in diminishing pain.

Reed's recent longitudinal population based study found that women who screened positive for vulvodynia and were followed reported: persistence of symptoms (9.6%), remission without relapse (50.6%) and remission with relapse (39.7%).<sup>27</sup> Of those who relapsed, approximately half experienced the relapse within 6-30 months – emphasizing the need for long term follow up after a treatment intervention.

These above observations may suggest: a therapeutic effect in making a diagnosis of vulvodynia, a high placebo rate and or a high background remission rate of vulvodynia. All of these factors make it very challenging to convincingly attribute treatment “success” to an intervention.

### The need to clarify what is “treatment success”

Andrews recently noted that there is a problem of with “inconsistent and inappropriate outcome selection for research studies”.<sup>28</sup> This is a problem in the field of vulvodynia treatment research. First we do not have a set of core outcomes that are consistently measured across studies. Secondly, we do not have standardized measurement tools. Thirdly, we have not defined treatment success.



It is not clear yet how much improvement in patient well being is considered treatment “success”. Clarifying the difference between clinically important improvements versus statistically significant improvements. The IMMPACT recommendations<sup>29</sup> can help guide clinical trials in defining treatment success. More research (quantitative and qualitative) needs to be done in exploring what “treatment success” means to our patients. A successful treatment for women with persistent vulvodynia may be one that; reduces pain to an acceptable level, facilitates her (and her partner’s) ability to cope with the persistent nature of her sexual pain and is acceptable to her. Very few studies ask patients about their satisfaction (cost, convenience, acceptability) with a particular treatment and or adherence to that treatment. As clinicians this additional information would be helpful for us to guide patients in choosing a treatment.

Currently there does not exist a standard disease specific (vulvodynia) quality of life measurement tool. For example, one of the most important treatment outcomes for the patient with provoked vestibulodynia is an improvement in their sexual pain/dyspareunia. Tools that have been used to measure this single outcome include: Female Sexual Function Index, Visual Analog Scale, Marinoff dyspareunia scale, yes/no response, satisfactory/unsatisfactory response, complete/partial/no response etc... Recently, Cyr et al. reported on the validation of a new clinical digital tool to measure quantitative sensitivity.<sup>30</sup>

Finally, if single treatment studies reported the relative improvement in pain for each individual in a study, as compared to the mean improvement of pain for the group, this may help to uncover which vulvodynia patients are responders or non-responders for a specific treatment.<sup>29</sup> Factors that are associated with vulvodynia, as outlined in the new guidelines, may be compared between responders and non-responders and thus guide us to make specific recommendations to individual patients.

### Multiple treatments/multidisciplinary studies

One treatment is unlikely to achieve all of the biopsychosexual health goals of a patient. So what is the evidence for combining treatments using a “multidisciplinary” approach? To date a small number of studies have reported on combining treatment approaches in one setting.  
31-37

While all multidisciplinary programs have reported that the majority of patients improve after participation in the program there are some interesting lessons to be learnt from these reports. Given the choice of therapies many women choose to avoid surgery.<sup>38</sup> Patients feel empowered about having a choice of therapies. However, when women are given a choice of psychotherapy, many choose not to pursue that therapy.<sup>38, 39</sup> Those who do engage in psychotherapy report significant benefits to their psychological and sexual health.

Bergeron in a recent RCT, comparing cognitive behavioral therapy to topical steroid, commented on the lack of confidence patients had in psychological therapy and their reluctance to engage in that therapy.<sup>17</sup> However, the group of women who did participate in counseling at 6 months reported a greater level of pain reduction, higher sexual function and greater treatment satisfaction over the group who had only steroid. Other recent studies



have also reported the significant benefits of cognitive behavioral therapy for women with PVD.<sup>40</sup>

Recently we reported on the outcomes of a set multidisciplinary program where all patients participate in all aspects of the program including psychotherapy. Our program is a 10-week hospital-based treatment integrating education, psychological skills training, pelvic floor physiotherapy, and medical management. Following the MVP (2-3 months post treatment), there were strong significant effects for; the reduction in dyspareunia and sex-related distress, and improvements in sexual arousal and overall sexual functioning.<sup>36</sup> We are currently analyzing our long term (>2 year) outcomes and have found that these results have been maintained and improved further.

#### Limitations of multidisciplinary studies

Similar to the uncontrolled single treatment studies, one cannot assume that the therapeutic effects reported by patients are a direct result of the program. However, given that multidisciplinary care is the “standard of care” recommended by experts for chronic pain conditions there must be a way for us to advance our understanding about how this model of care can best be applied to women with vulvodynia. We need to understand if multidisciplinary care is as effective as single treatment approaches in achieving all of our “treatment goals” but also an efficient use of resources. Specific questions that need to be addressed about multidisciplinary program include: who should be offered this type of care; what should be part of this multidisciplinary care; should the individual or the health care provider “prescribe care”; what is the optimal sequence of care; and how do we study this model of care?

#### **Conclusion**

Rich research is being published that furthers our understanding of vulvodynia. Unfortunately our ability to synthesize and summarize this research is currently limited. Hopefully the ISSVD can serve as a venue for researchers to collaborate and agree on a core set of treatment goals, outcomes, and measures. I appreciate this opportunity to provide a perspective about the current literature and look forward to future discussions.

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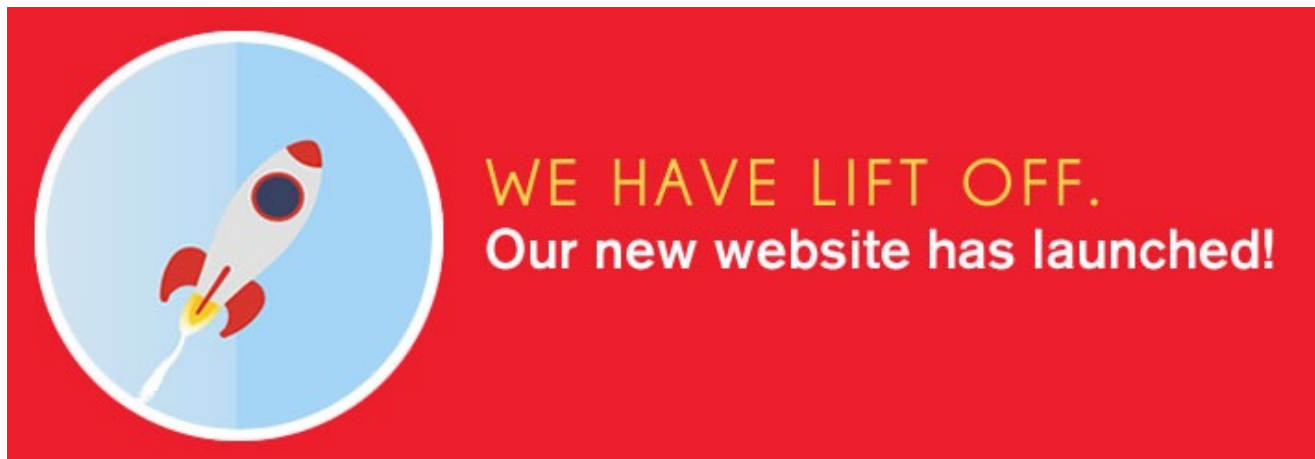
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## SAVE THE DATE: XXIV WORLD CONGRESS MENDOZA, ARGENTINA Intercontinental Mendoza

**International PG Course September 11 & 12, 2017**  
**XXIV World Congress September 13-15, 2017**



We have reserved an excellent room rate at the Intercontinental Mendoza and have begun planning an excellent scientific session for the Postgraduate Course and World Congress. It is time to mark your calendars and save these dates and **begin to prepare your scientific research for presentation.**



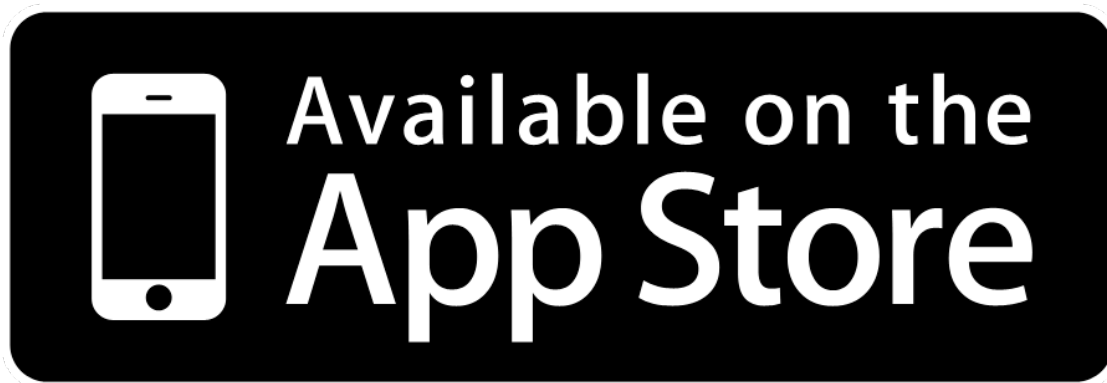
We have been hard at work updating both the website and the registration/payment portal for the ISSVD and the North American Chapter of the ISSVD. You should have received a separate email inviting you to login and update your profile. Please take a few moments to do that.

**Important factors to note:**

1. All ISSVD Communications are done via email, including dues notifications. Please be sure that Constant Contact (our email service) is in your contacts.
2. Dues notifications go out in October of the previous year and are due no later than Jan. 1st of the current dues year.
3. Dues can be paid anytime after October 1, online by accessing your profile after logging in.
4. We now have a single sign on so you only have to sign in one time from the website to access all your membership features. We hope to soon integrate with the Journal of Lower Genital Tract Disease (JLGTD) and the Image Gallery so that you can access them directly without the need to sign on again, but this is in a future update.
5. We have moved all 'Resources' to a Resource library. This resource library is fully searchable and can also use the translate function that has been added. Tags have been added, so you can search by categories such as 'vulvodynia', 'pain', 'newsletter', 'HPV', etc. The resource library includes the patient education files, terminology, newsletters, classifications, etc.
6. The entire website is searchable from the top navigation search bar.
7. The member community/forum has been updated and we hope to have it become more widely used as it can be a very useful tool.
8. There is a member directory. You can use this directory to search for other members by specialty, country, name, etc. If you have not included a photo of yourself, please update your profile.

9. We have added a 'Support Email'. [issvd@issvd.org](mailto:issvd@issvd.org) will go to both Debbie and Marty and goes directly to our support email and will likely be more quickly addressed than if you use our personal email address', please update your contacts to use this address.

If you need assistance updating your profile or accessing any part of the website, please contact us at [issvd@issvd.org](mailto:issvd@issvd.org).



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[Link To Yeast App](#)

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## Registration opening soon for 23rd Biennial Conference on Diseases of the Vulva & Vagina

**27.75 CME ACCME Hours**

**September 9 & 10, 2016 with optional courses September 8th**

***\*Prepare your abstracts now for the NA Chapter Scientific Session***



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We certainly hope that you will join us for the 23rd Biennial Conference on Diseases of the Vulva & Vagina and 5th Biennial Meeting of the North American Chapter of the ISSVD Scientific Abstract Presentations. Please also be sure to share this course information with any colleagues who may be interested in attending. This course is the most comprehensive course that we offer in the US biennially. It includes an optional basic course on Thursday morning followed by an exceptional hands on Physical Therapy Course on Thursday afternoon (also optional). Friday and Saturday offer a comprehensive and complete overview of vulvar disease and treatment options.

This course is ideal for clinicians who treat patients with persistent or recurrent vulvar symptoms not explained by simple yeast infections or bacterial vaginosis. This course is for those practitioners who treat itching, dyspareunia, and pain, as well as vaginal discharge and chronic rashes. The conditions include recurrent candidiasis, lichen simplex chronicus, lichen planus, lichen sclerosus, vulvodynia, ulcers, and desquamative inflammatory vaginitis.

### CONTACT US

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