Dysmenorrhea, dyspaneuria and vulvar itching

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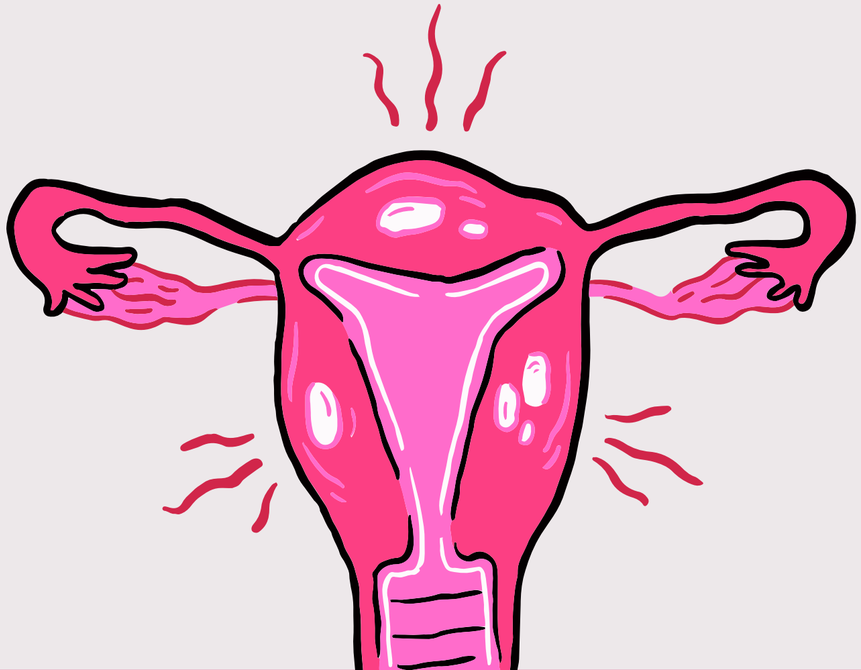
Dysmenorrhea



Definition

- It is Recurrent Painful Menstruation with absence of pain between periods.
- It is the most common pelvic pain among women Affects 43-91% of Menstruating women. 10% of these women have sever symptoms.

CLASSIFICATION

A

Primary Dysmenorrhea

Painful menstruation in the absence of hormonal or anatomical pathology (NO readily identifiable cause). Occurs in age range between 17-24 (before 20).

B

Secondary Dysmenorrhea

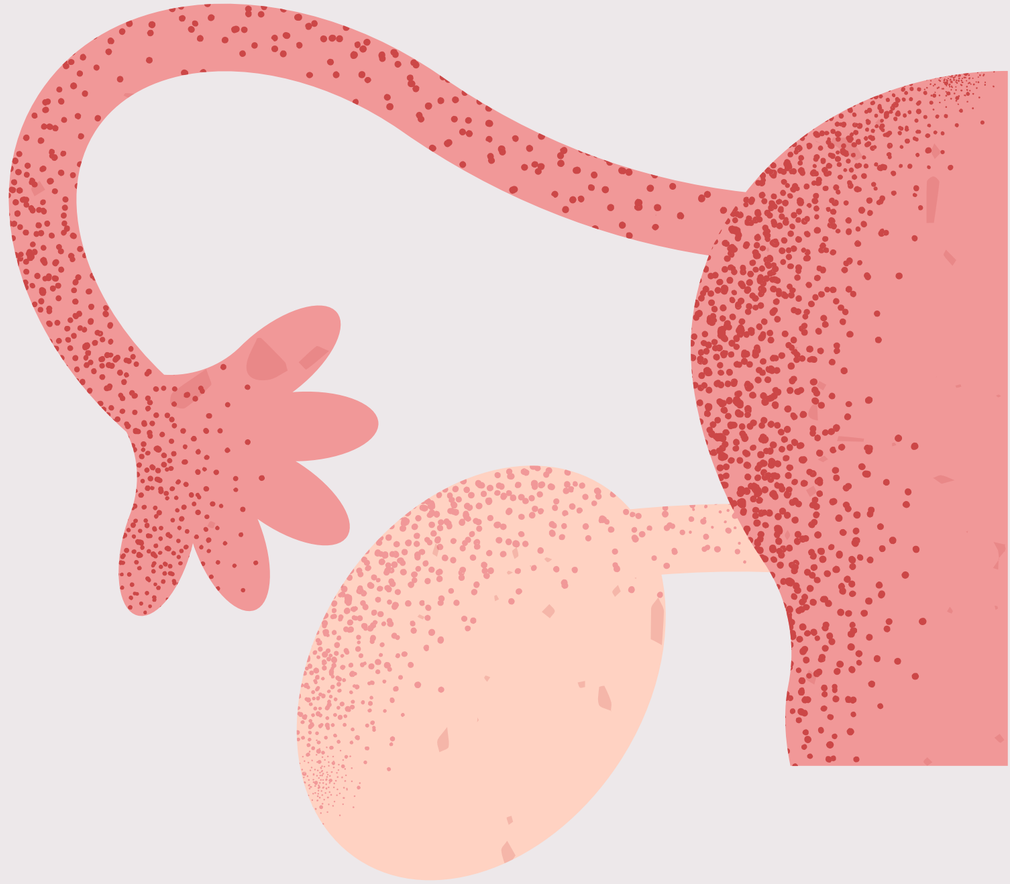
Painful menstruation due to a demonstrable pathology (pelvic disease). More common in women between 30-40 (> 30 years).

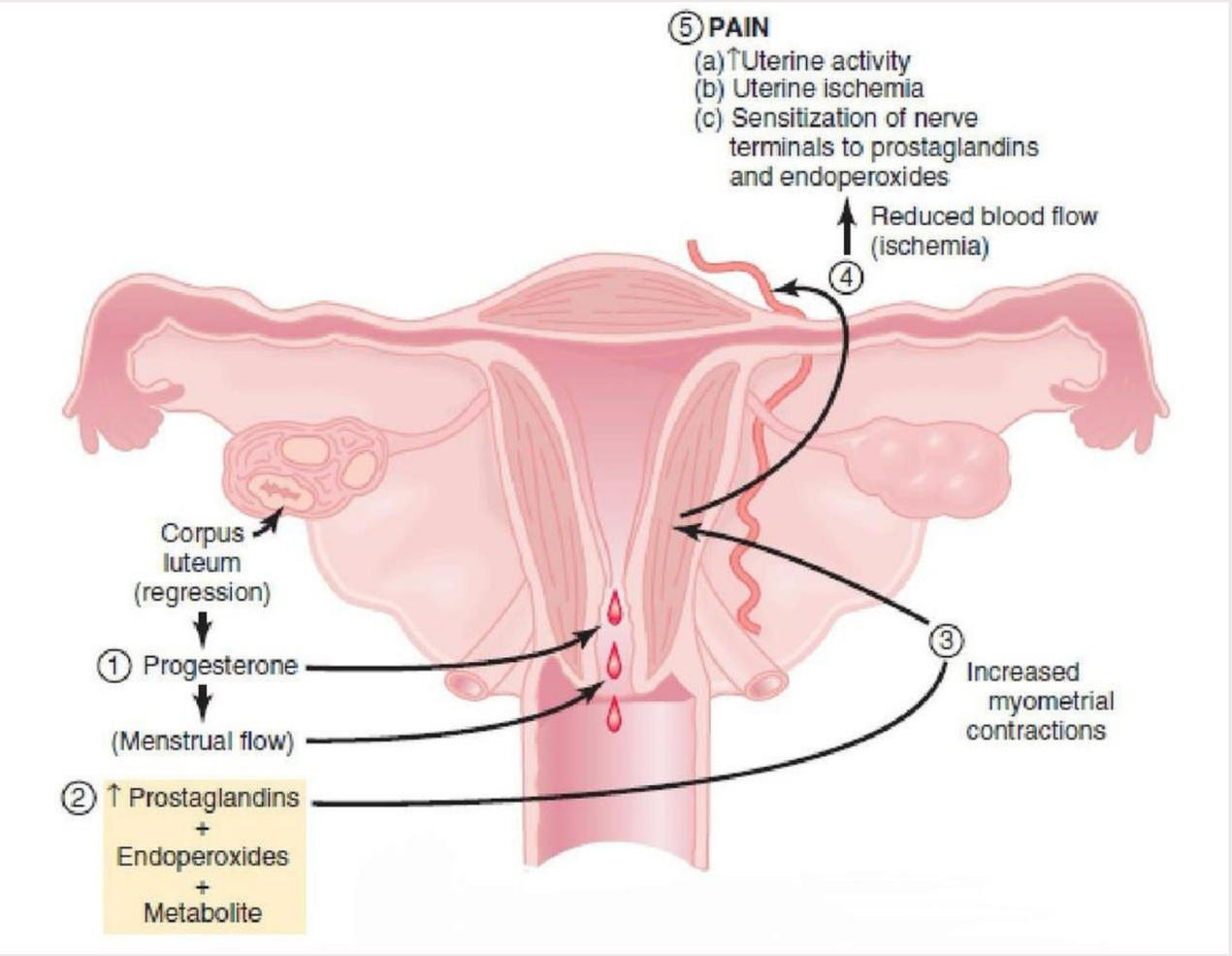
PATHOPHYSIOLOGY

Primary Dysmenorrhea

Primary Dysmenorrhea

- It occurs during ovulatory cycles and usually appear 6-12 months after Menarche.
- Caused by:
- Prostaglandin
- Uterine contraction
- Ischemia





Rule of Prostaglandin in Primary Dysmenorrhea

- Menstrual fluid from women with primary dysmenorrhea has high levels of PG-F2$_{\alpha}$ and PG-E2 than normal.

- Those levels can be reduced to below normal by NSAIDs (suggesting that these women have unregulated COX enzyme).
- Infusion of PG-F2a and PG-E2 reproduces the discomfort and many of the associated symptoms as nausea and vomiting and diarrhea.
- An-ovulatory Endometrium results in painless menses, also the thin endometrium in women on OCPs.

Clinical Features and Diagnosis

1.USUALLY IN THE PELVIC OR LOWER-MIDDLE ABDOMEN.
2.BEGINS A FEW HOURS BEFORE OR JUST AFTER THE ONSET OF MENSTRUATION.
3.USUALLY LAST FOR < 3 DAYS.
4.PAIN IS DESCRIBED AS CRAMP-LIKE, COLICKY OR LABOR-LIKE.
5.IT MAY RADIATE TO THE THIGHS AND LOWER BACK.
6.ASSOCIATED WITH NAUSEA AND VOMITING, NERVOUSNESS, DIZZINESS, DIARRHEA AND HEADACHE.
7.IT IS A CLINICAL DIAGNOSIS.

Treatment

1 NSAIDS

- First-line therapy.
- Start on Day prior to menses or At onset.

2 HORMONAL CONTRACEPTIVE

- Suppress ovulation and endometrial thickening ↓ → ↓ PG → pain (OCP, hormone release IUD).

3 PROGESTIN

4 ANALGESICS

5 PSYCHOTHERAPY

6 TRANSCUTANEOUS NERVE STIMULATION

Primary Dysmenorrhea

- If the patient fails to respond to NSAIDs and hormonal contraception, Investigation (U/S, Laparoscopy and Hysteroscopy) may be needed.
- The most common misdiagnosis of primary dysmenorrhea is Endometriosis.
- 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.

PATHOPHYSIOLOGY

Secondary Dysmenorrhea

Causes

EXTRA-UTERINE CAUSES

- Endometriosis (the most common cause).
- Tumors.
- Inflammation.
- Adhesions.

INTRAMURAL CAUSES

- Adenomyosis.
- Leiomyoma.

INTRA-UTERINE CAUSES

- Leiomyoma.
- Polyps.
- Intrauterine contraceptive device (IUCD).
- Infection.
- Cervical stenosis and lesions

Clinical Features and Diagnosis

CLINICAL FEATURES DEPEND ON THE UNDERLYING CAUSE, BUT IN GENERAL:

- Pain is NOT limited to the Menses; can occur up to 2 weeks before as well as a week after the menses (Less related to the first day of flow).
- Develops in older women (30-40 years).
- Usually associated with other symptoms as Dyspareunia, Infertility and Abnormal uterine bleeding.

History

- Age of Menarche.
- Cycle Length.
- Regularity of the cycle and Duration of bleeding.
- Timing of pain in relation to the cycle.
- Presence of other symptoms as Pelvic pain at other sites,Dyspareunia, Intermenstrual bleeding and Infertility.

Investigations

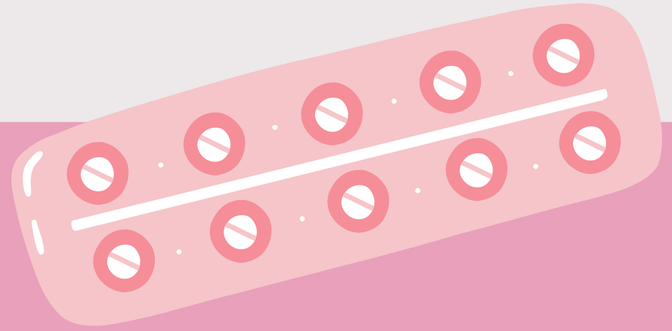
- Guided by clinical suspicion formulated by History and Physical Examination, include:

- Laboratory tests (CBC).
- U/S (initial), Laparoscopy (pelvic infection, adhesions and endometriosis), MRI.
- Swaps and Cultures.

What we can do?

TREATMENT OF THE UNDERLYING DISEASE.

TREATMENTS USED FOR THE PRIMARY DYSMENORRHEA ARE OFTEN HELPFUL.



DYSPAREUNIA

CONTENTS

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 isimportant in identifying the causes of the pain

DYSPAREUNIA CLASSIFICATION

ORGANIC

SUPERFICIAL DYSPAREUNIA

- WITH ENTRY
- MID VAGINAL

DEEP DYSPAREUNIA

PSYCHOLOGICAL

TYPE-1 (INTRA-PERSONAL)

TYPE-2 (INTER-PERSONAL)

SUPERFICIAL DYSPAREUNIA
WITH ENTRY

1.VULVODYNIA

2. VAGINISMUS

3. INFLAMMATION, INFECTION OR SKIN DISORDERS

4. CONGENITAL CONDITIONS.

5. TIGHT INTROITUS

6. VULVAR LESION

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

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

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

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 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

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

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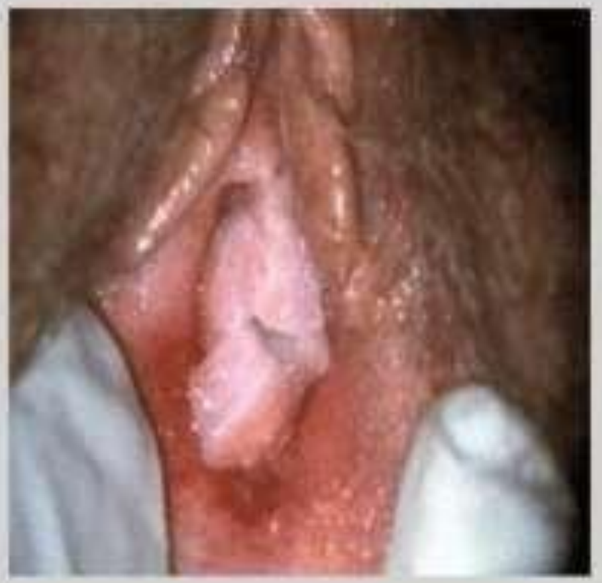
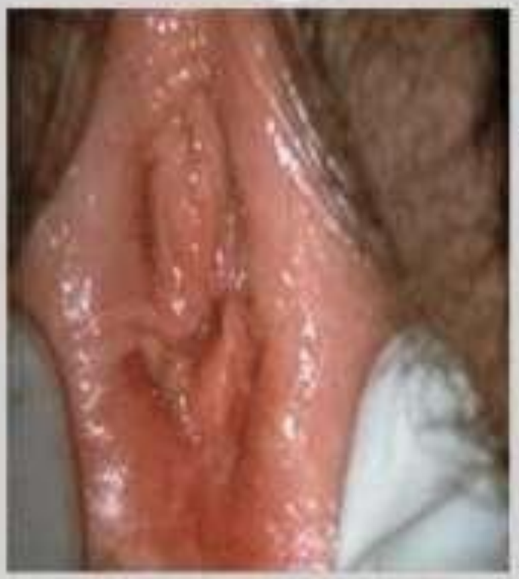
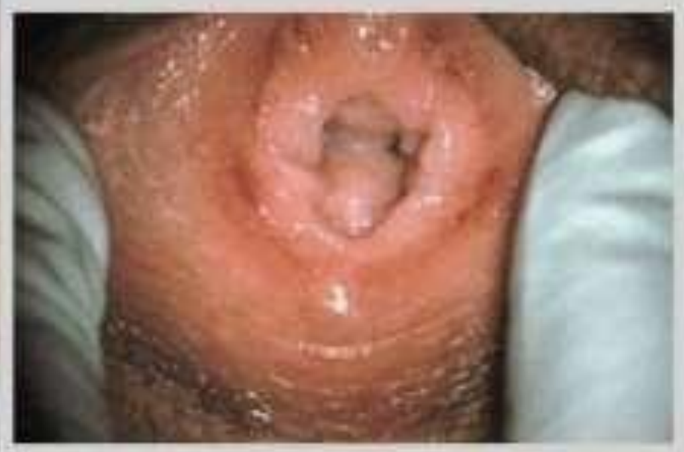


Patient #1
Severe Erythema



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)

MANAGEMENT OF VULVODYNIA

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

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 ANTIDEPRESSANTS

2. **PHYSICAL**; KEGEL EXERCISES AND PROVIDE SOME ADDITIONAL LUBRICANTS.

3. **NEUROMODULATOR**

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 obstructed peri-urethral glands that communicate with the urethra

- **INFECTIONS**
- **VAGINAL CANCER**

Squamous-cell carcinoma and Adenocarcinoma

DEEP DYSPAREUNIA

- **ENDOMETRIOSIS**

-Mainly which occur on the utero-vaginal septum or utero-sacral ligaments.
- Associated with :- pelvic pain, secondary dysmenorrhea, chronic lower 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.

- **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 DISEAS**

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

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

MANAGEMENT

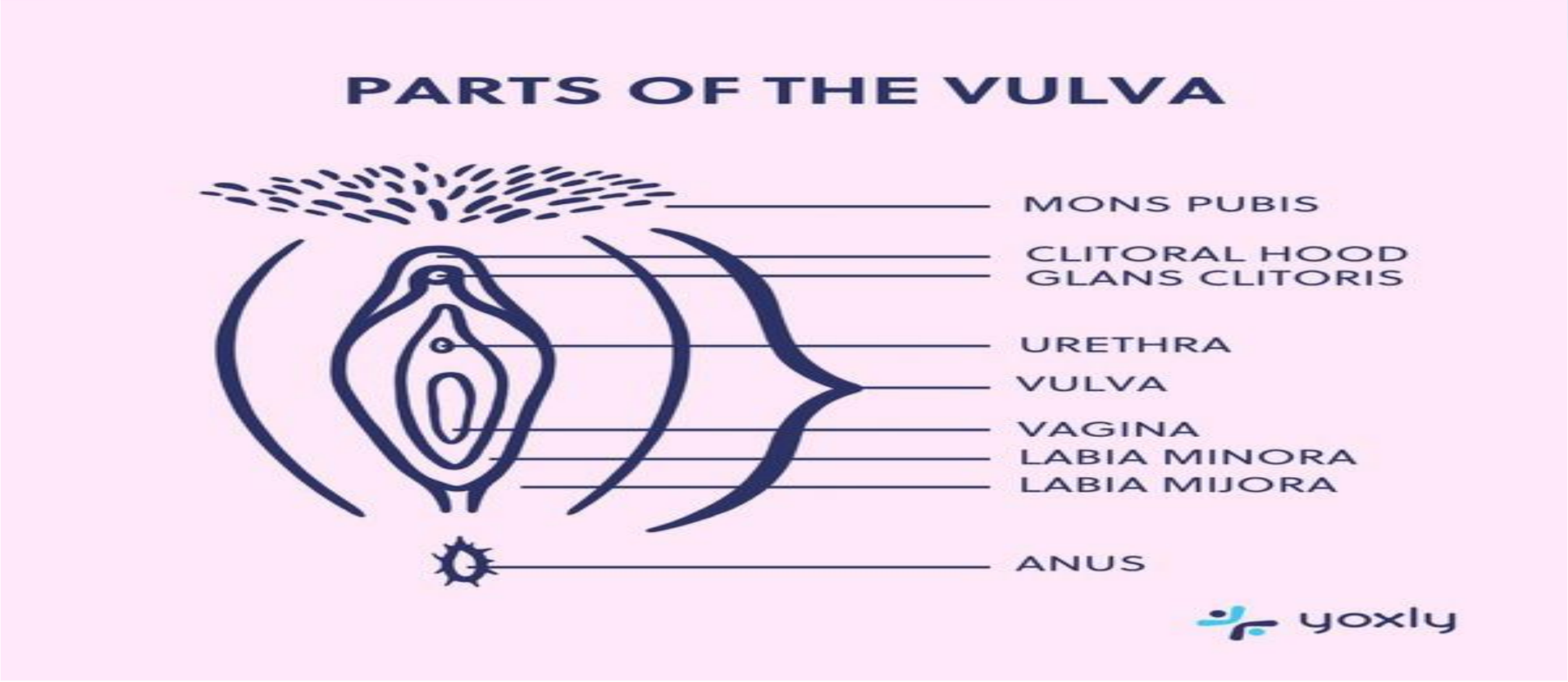
TREATMENT OF DYSPAREUNIA HIGHLY DEPENDS ON THE UNDERLYING CAUSE FOR EXAMPLE : -

- 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 TOPICAL ESTROGEN

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 itchiang



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 Menopause ,
Psoriasis	Herpes simplex virus.	pregnancy
Lichen Sclerosus	Scabies.	DM
Lichen Planus.	STDs Fungul	Vulvar cancer
Lichen Simplex Chronicus	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)

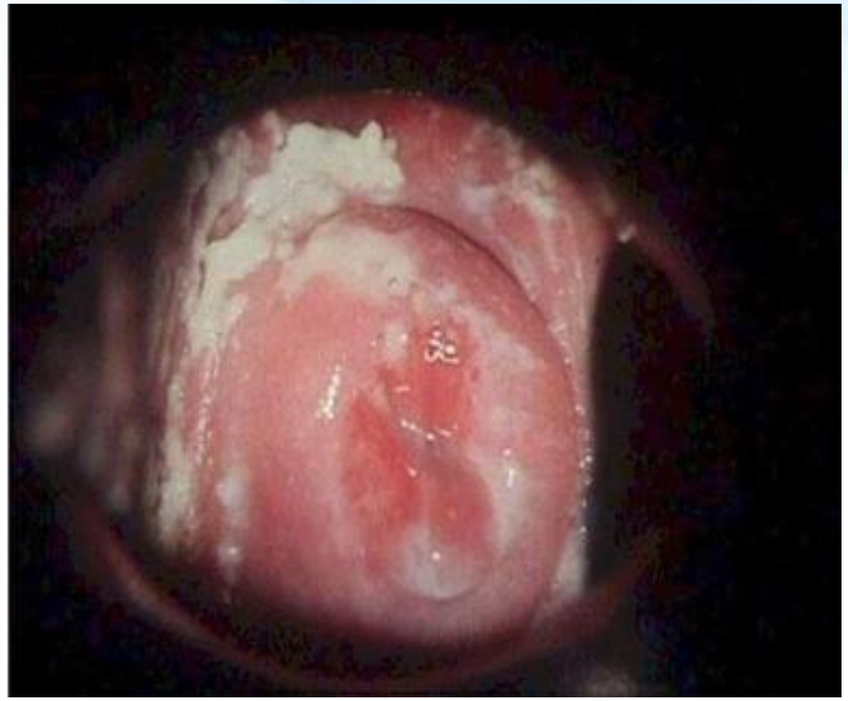
- Risk factors:

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:

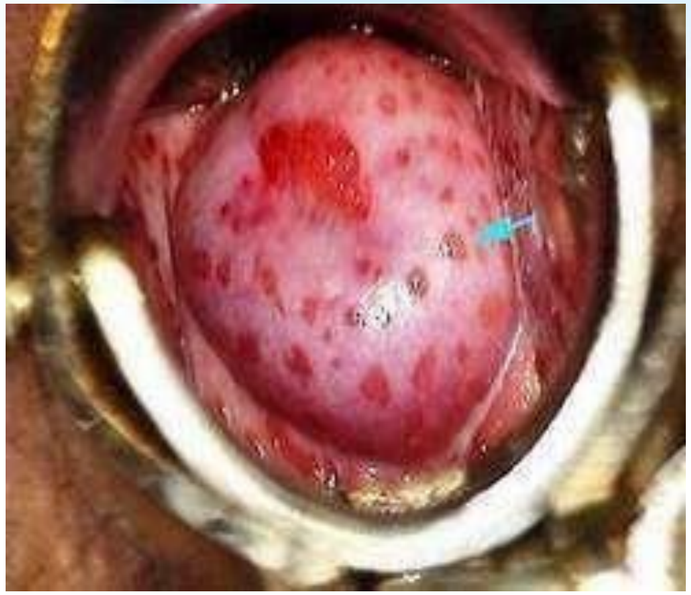
✓ thetopically applied **azole**

✓ **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

Wetmount show pear shaped trophozoits with their jerky movement

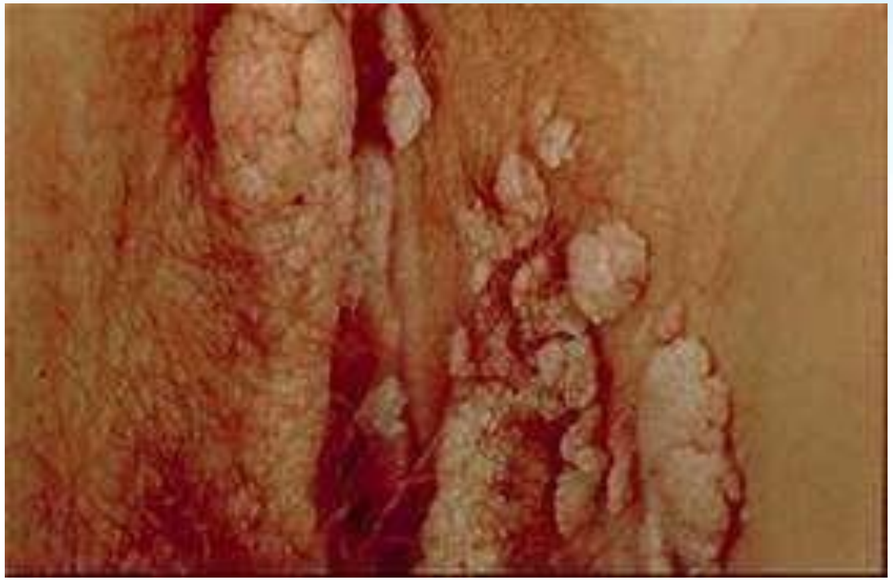
Treatment:

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 andor verrucouslesions.
- Usually multifocal & asymptomatic , although itching, burning , bleeding & pain can occur.
- External genital warts are highly contagious >75%.

- Usually diagnosed clinically.

Treatment

:

Thegoalofthe treatment is the removal of the warts, it is not possible to eradicate the viral infection.

Treatmentmodalities : applicationofcytotoxicorkeratolyticagents , surgical excision cryotherapy , laser & immune modulators (interferon)

Scabies:

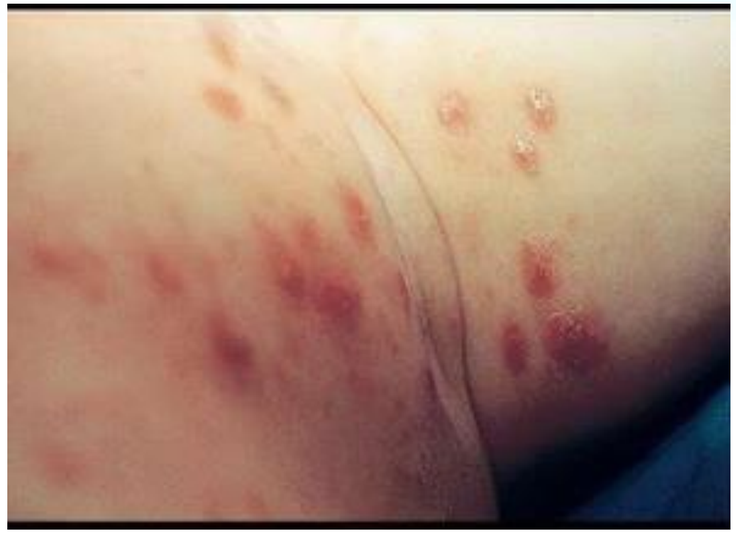
Sarcoptes scabiei (mite)

Usuallyoccurindirtyover crowded areas

Diagnosis is usually made by characteristic lesion and distribution

.

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



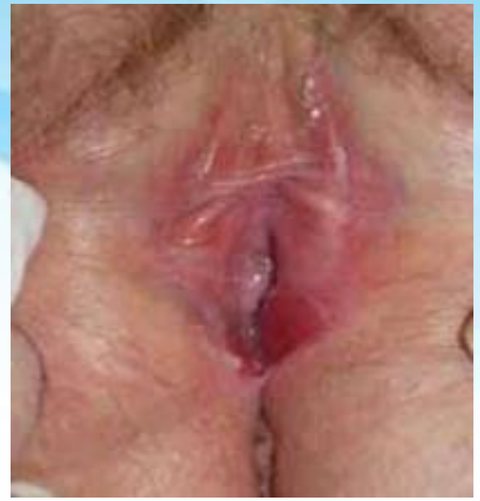
- Treatment:
- Good wash of the area by soap to open the tunnels
- Rubbing with acaricidal solution
- Clothes should also be sterilized by boiling

Lichen planus:

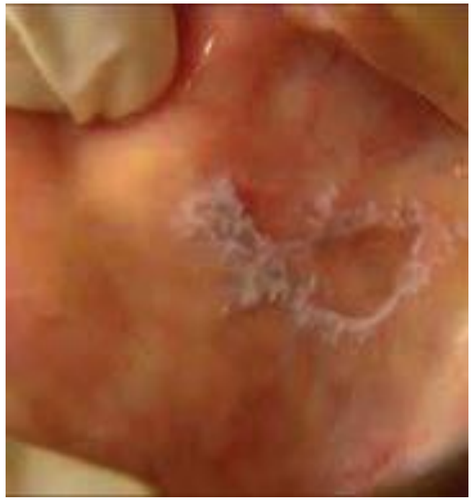
- Lichen planus (LP) is chronic inflammatory dermatosis considered to be an autoimmune condition.
- Lichen planus is the most common chronic erosive vulvar dermatosis
- LP can affect the mucous membranes of the vagina, conjunctiva, urethra, and anus as well as cutaneous skin, scalp, and nails.
- Vulvovaginal 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 yield significant can

diagnostic clues, as many women with vulvar LP also have evidence of oral LP on examination.

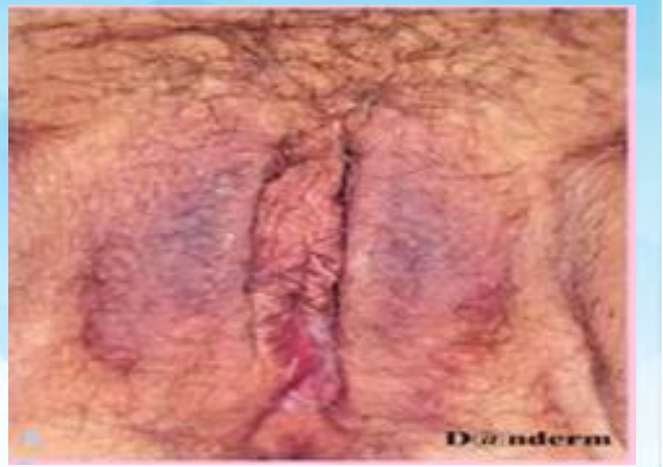


- Oral LP, which can be painful or asymptomatic, may manifest as erosions, reticulate striae (wickham striae)on the buccal mucosa, or gingival inflammation



- LP is treated primarily with super-potent topical steroids

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

- topicalCS
- 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 OF 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,exercis eand 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 etiology 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 stressor mental health issues which may exacerbate symptoms.**

General Medical History:

Past Medical History
Include chronicconditions like diabetes, hypertension,or thyroid disorders.

Surgical History: Any previous surgeries,especially related to the pelvisor abdomen?

Medications:List all current medications,including over-the counter drugs and supplements.

FamilyHistory:
Any family history of gynecological conditions, especially endometriosisor fibroids?

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 assesssize, shape,mobilityand tenderness.

Rectovaginal Examination:

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

EXAMINATION

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:

PapSmear: If indicated,perform a Papsmear 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:

1.look at the external and internal pelvic area for signs of:
2.dryness
3.inflammation or infection
4.anatomical problems
5.genital warts
6.scarring
7.-abnormal masses
8.endometriosis
9.tenderness

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

Palpation

1.Bimanual pelvicexamination

2. Tenderness

–Generalized tenderness and cervical excitation, adnexal tenderness.

Unilateral,Bilateral tenderness.

–Tenderness in the pouchof 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 triggermid-vaginal pain, seen with interstitial cystitis,congenital anomalies or following radiation therapy

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?

Examination

1. Inspection Site of Itching
2. Examine the exact location of the itching.
3. Isit 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.