Vulvodynia: Understanding and Managing Chronic, Unexplained Pain or Burning Around the Vulva

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Understanding a Painful Condition That Is Often Misunderstood

One of the most difficult experiences for a woman is to suffer persistent burning, stinging, soreness or pain around the vulva while being repeatedly told:

"Everything looks normal."

Some women are treated several times for a presumed fungal infection. Others are advised that the pain is simply caused by stress. Some stop discussing the problem because they feel embarrassed. Many begin avoiding sexual intimacy because even light touch becomes uncomfortable.

When such a patient comes to me, the first thing I want her to understand is:

Pain can be very real even when the vulvar skin appears completely normal.

A condition known as **vulvodynia** can produce chronic vulvar pain without an obvious infection, skin disease, injury or other clearly identifiable cause.

The current international consensus defines vulvodynia as **vulvar pain lasting at least three months without a clearly identifiable cause**, although several contributing factors may be present. It is distinguished from vulvar pain caused by a specific disease such as infection, inflammatory skin disease, cancer or a clearly defined neurological disorder.

The NHS similarly describes vulvodynia as pain of the vulva lasting at least three months without a specific identifiable cause and notes that it can significantly affect sleep, concentration, relationships and everyday life.

Vulvodynia is therefore not simply "vaginal pain," and it is not automatically an infection.

It is a **chronic pain condition involving the external female genital region**.

What Is the Vulva?

Before understanding vulvodynia, it is useful to understand the anatomy.

The **vulva** is the external female genital area. It includes:

- the labia majora,
- labia minora,
- clitoris,
- vulvar vestibule,
- opening of the urethra,
- and entrance to the vagina.

The **vagina** is the internal canal.

Patients often use the word “vagina” for the entire genital area, but vulvodynia refers specifically to pain involving the **vulva**.

This distinction is important because chronic vulvar pain has different causes and treatment approaches from pain occurring deeper inside the pelvis or vagina.

What Does Vulvodynia Feel Like?

Patients do not all describe the pain in the same way.

Common descriptions include:

burning, stinging, rawness, soreness, throbbing, stabbing, irritation, tenderness or an electric/nerve-like pain.

The NHS notes that pain may be burning, throbbing, stabbing or sore and may affect the whole vulva or only one part.

Some women say:

“It feels as though the skin is burned.”

Another may say:

“Even my underwear touching the area hurts.”

Another may experience pain only during attempted intercourse.

Some women cannot comfortably insert a tampon.

Others feel burning after sitting for a long period, cycling, exercising or wearing tight clothing.

Importantly, there may be **little or no visible abnormality**.

That does not mean the pain is imagined.

Vulvodynia Can Occur in Different Patterns

Modern terminology does not treat all vulvodynia as identical.

International consensus classifies the condition according to where the pain occurs, what triggers it, how it began and its timing.

Localized vulvodynia

The pain is limited to a particular area.

The most common example involves the **vestibule**, the tissue around the vaginal entrance, and is commonly called **vestibulodynia**.

Pain may occur when:

- intercourse is attempted,
- a tampon is inserted,
- the area is examined,
- tight clothing presses on it,
- or direct touch occurs.

Generalized vulvodynia

Pain occurs throughout a broader part of the vulva rather than at one small location.

It may be constant or intermittent and may occur even without touch.

Provoked vulvodynia

The pain appears mainly after contact or pressure.

Examples include:

- intercourse,
- tampon insertion,
- gynecological examination,
- cycling,

- sitting,
- or tight clothing.

Spontaneous or unprovoked vulvodynia

The pain appears without direct touch.

A woman may simply be sitting or lying down when burning begins.

Mixed vulvodynia

Some patients experience both spontaneous pain and pain triggered by touch.

Clinicians may also describe the onset as **primary** or **secondary** and the temporal pattern as intermittent, persistent, immediate or delayed.

Understanding the subtype is important because treatment can differ considerably.

Provoked Vestibulodynia

One particularly important form is **provoked vestibulodynia**.

The pain occurs at or around the vaginal entrance when pressure is applied or penetration is attempted.

This may produce:

- pain during intercourse,
- pain with tampon insertion,
- discomfort during examination,
- burning after sexual activity,
- fear of penetration,
- involuntary tightening of the pelvic-floor muscles,
- and eventually avoidance of intimacy.

A major randomized clinical trial describes provoked vestibulodynia as a common form of chronic vulvar pain involving recurrent pain at the vaginal entrance in response to pressure or attempted penetration.

The important point is that painful intercourse in these patients is **not simply "lack of relaxation."**

Pain, nerve sensitivity and pelvic-floor muscle dysfunction may all contribute.

What Causes Vulvodynia?

There is no single established cause.

This is why I explain to patients that the phrase “unexplained pain” does not mean:

“Nothing is happening.”

It means that there is no single identifiable disease such as candidiasis, herpes, lichen sclerosus or cancer that completely explains the pain.

Modern research considers vulvodynia **multifactorial**.

Possible contributing mechanisms include:

- increased sensitivity of peripheral nerves,
- altered pain processing in the spinal cord and brain,
- pelvic-floor muscle overactivity,
- previous inflammation or tissue injury,
- hormonal influences,
- genetic or immune factors,
- previous infections,
- musculoskeletal problems,
- and psychological or interpersonal effects that can amplify chronic pain.

These factors may interact differently in different women.

This explains why one treatment does not work for everyone.

Nerve Hypersensitivity and Neuropathic Pain

One major theory is that nerves around the vulva become excessively sensitive.

Normally harmless stimulation—such as clothing, touch or pressure—may then be interpreted as painful.

This phenomenon is similar to what happens in some other chronic pain disorders.

A patient may therefore experience severe burning despite normal-looking tissue.

This is one reason why clinicians sometimes use medicines originally developed for neuropathic pain rather than repeatedly treating the woman for infection.

ACOG recognizes nerve irritation or injury among the factors associated with vulvodynia.

Central Sensitization

In some patients, the problem may extend beyond local vulvar nerves.

The central nervous system itself can become more responsive to pain signals, a phenomenon known as **central sensitization**.

A 2023 review found evidence supporting central pain-processing abnormalities in vulvodynia and related chronic pelvic-pain disorders.

Another clinical study found features of central sensitization in a subgroup of women with vulvodynia, particularly those experiencing more extensive pain, dyspareunia, painful urination or bowel-related pain.

This may help explain why some women also experience:

- bladder pain,
- bowel discomfort,
- pelvic pain,
- fibromyalgia-type symptoms,
- migraine,
- or other chronic pain conditions.

This does not mean every woman with vulvodynia has central sensitization.

It means chronic pain sometimes involves the entire pain-processing system rather than only one patch of skin.

Pelvic-Floor Muscle Overactivity

Pelvic-floor dysfunction is extremely important.

When pain occurs repeatedly, the body naturally tries to protect itself.

The muscles surrounding the vaginal opening may tighten.

Initially this is a protective reaction.

Over time, however, the muscles may remain excessively tense.

This can cause:

- pain at the vaginal entrance,
- painful intercourse,
- difficulty inserting tampons,
- difficulty during gynecological examination,
- pelvic aching,
- urinary symptoms,
- and greater sensitivity to touch.

The pain causes tightening.

The tightening produces more pain.

A cycle develops.

ACOG therefore recommends that women with vulvodynia be assessed for pelvic-floor dysfunction.

Previous Inflammation and Infection

Some women report that their symptoms began after repeated episodes of presumed yeast infection or another vulvovaginal condition.

Researchers have investigated whether previous inflammatory or infectious episodes may contribute to abnormal nerve sensitivity in susceptible women.

However, once vulvodynia is established, the patient **does not necessarily continue to have an infection**.

This distinction matters.

Repeated antifungal medicines should not be given indefinitely simply because the symptom is burning.

The diagnosis must be confirmed.

Hormonal Factors

Hormonal changes may contribute in some patients, although the relationship is complex.

Low-estrogen states can themselves cause vulvar and vaginal dryness, irritation and pain—for example around menopause, after childbirth or during breastfeeding.

These conditions need to be distinguished from vulvodynia because hormone-related tissue changes may require their own treatment.

Current vulvodynia terminology recognizes hormonal factors among potential associated mechanisms.

Is Vulvodynia an Infection?

No.

Vulvodynia itself is not an infection.

It is not the same as:

- candidiasis,
- bacterial vaginosis,
- herpes,
- trichomoniasis,
- or another sexually transmitted infection.

However, infections can cause vulvar burning and must sometimes be excluded before diagnosing vulvodynia.

ACOG specifically emphasizes that vulvodynia is a **diagnosis of exclusion** and that infections and other vulvar disorders should be investigated when clinically indicated.

Is Vulvodynia a Sexually Transmitted Disease?

No.

Vulvodynia is not considered a sexually transmitted infection.

A woman should not feel ashamed or believe she has acquired the condition because of sexual behavior.

Sex can trigger pain in provoked vulvodynia, but that is because pressure activates painful tissue or muscles—not because sexual intercourse created an STI.

Is Vulvodynia Cancer?

Vulvodynia itself is not cancer.

However, persistent vulvar pain should not be self-diagnosed because certain vulvar skin disorders, precancerous changes or cancers can also produce pain, itching, sores or skin changes.

Therefore, a proper examination is important.

If there is:

- a persistent ulcer,
- lump,
- unusual bleeding,
- significant skin thickening,
- color change,
- unexplained lesion,
- or another suspicious finding,

the clinician may recommend biopsy.

ACOG notes that biopsy can be appropriate when suspicious skin changes require exclusion of another diagnosis.

Vulvodynia Is Not "Just Psychological"

I want to be particularly careful about this point.

Women with chronic genital pain are sometimes told:

"You are thinking too much."

or

"It is only anxiety."

That is inappropriate.

Vulvodynia is a recognized chronic pain condition.

At the same time, chronic pain naturally affects emotions.

Pain may cause:

- anxiety,
- fear of intercourse,
- frustration,

- depression,
- relationship distress,
- sleep disturbance,
- and avoidance behavior.

Those emotional changes can then increase muscle tension and pain sensitivity.

Therefore, psychology may become **part of the pain cycle without being the original cause of the pain**.

This is why multidisciplinary care may include psychological or psychosexual treatment—not because the clinician thinks the pain is imaginary, but because chronic pain affects the entire person.

ACOG specifically warns clinicians that patients may interpret multidisciplinary treatment as meaning that the practitioner does not believe their pain is real, and recommends clearly explaining the diagnosis and goals of treatment.

How Vulvodynia Affects Sexual Health

Vulvodynia can have a major impact on sexual relationships.

A woman may begin avoiding intimacy because she expects pain.

Her partner may mistakenly interpret this as:

“She no longer desires me.”

The woman may still have normal emotional and sexual desire.

She simply fears the physical pain.

After repeated painful experiences, anticipatory anxiety can develop.

The pelvic floor tightens before penetration.

Pain becomes more intense.

Sexual desire may eventually fall because the brain begins associating sexual activity with pain rather than pleasure.

This is why treatment should consider not only the vulva but also:

- pelvic-floor function,
- sexual confidence,
- relationship communication,

- anxiety,
- and gradual restoration of comfortable intimacy.

Vulvodynia and Infertility

Vulvodynia itself is **not generally considered a direct cause of infertility**.

However, severe provoked vulvodynia may make intercourse difficult or impossible.

In this way, it can create a **functional barrier to conception**.

A couple may want pregnancy, understand ovulation correctly and have otherwise normal fertility—but intercourse during the fertile period becomes extremely painful.

This can generate tremendous pressure.

Because my practice at Saira Health Care focuses on both sexual disorders and infertility, I consider this overlap especially important.

The correct response is not to tell the woman:

"You must tolerate the pain because you want a baby."

Pain deserves diagnosis and treatment.

Where fertility evaluation is required, reproductive management should be coordinated with treatment of the vulvar pain rather than ignoring one problem in favor of the other.

How Is Vulvodynia Diagnosed?

There is no single blood test, scan or laboratory test that proves vulvodynia.

Diagnosis depends on:

a careful history, examination and exclusion of other causes.

NICHD and ACOG both describe vulvodynia as largely a diagnosis of exclusion.

A Detailed Medical History

When I assess a patient with chronic vulvar pain, important questions include:

When did the pain begin?

Is it burning, stabbing, soreness or another sensation?

Where exactly is the pain?

Is it always present?

Does touch trigger it?

Does intercourse trigger it?

Can a tampon be inserted?

Does sitting make it worse?

Are there urinary symptoms?

Is there discharge?

Is itching present?

Were there previous infections?

Did the problem begin after childbirth, surgery or menopause?

Are there bowel or bladder symptoms?

Is there chronic pelvic pain?

What medicines have already been tried?

Has the woman repeatedly used antifungal or steroid creams?

Does sexual activity cause anxiety because of pain?

Is there a history of other chronic pain conditions?

This history often provides more useful information than any single laboratory test.

Vulvar Examination

The vulva should be inspected carefully.

The clinician looks for signs of conditions such as:

- dermatitis,
- infection,
- lichen sclerosus,
- lichen planus,
- trauma,
- ulceration,
- vulvar lesions,

- menopausal tissue changes,
- and other abnormalities.

Importantly, a patient with vulvodynia may have a completely normal-looking examination.

Again:

Normal appearance does not mean absence of pain.

Cotton-Swab Testing

A commonly used examination technique is the **cotton-swab test**.

The clinician gently touches different areas of the vulva and vestibule with a cotton-tipped applicator and asks the patient to describe or rate the pain.

This helps identify whether the pain is:

- localized,
- generalized,
- or particularly severe at the vestibule.

ACOG recommends cotton-swab testing to map the areas of pain and help distinguish localized from generalized disease.

The examination should be gentle and performed with the patient's consent.

A painful patient should never be subjected to an unnecessarily aggressive examination.

Testing for Infection

When symptoms or examination suggest infection, testing may include vaginal microscopy, pH assessment, cultures or modern molecular testing depending on the clinical situation.

The objective is to answer an important question:

Is an infection actually present?

If the answer is no, repeated courses of antifungal or antibiotic treatment may simply expose sensitive tissue to additional irritation.

Pelvic-Floor Assessment

The pelvic-floor muscles should also be considered.

A trained clinician or pelvic-health physiotherapist may evaluate whether there is:

- excessive muscle tone,
- trigger-point tenderness,
- poor relaxation,
- guarding,
- or associated musculoskeletal dysfunction.

ACOG considers pelvic-floor assessment an important component of evaluation.

Conditions That Can Resemble Vulvodynia

Before diagnosing vulvodynia, clinicians may need to consider other explanations including:

- recurrent candidiasis,
- bacterial or sexually transmitted infections,
- contact dermatitis,
- allergic irritation,
- lichen sclerosus,
- lichen planus,
- genitourinary syndrome of menopause,
- vulvar lesions,
- trauma,
- pudendal or other neuralgia,
- pelvic-floor disorders,
- referred back or hip pain,
- and vulvar malignancy.

This is one reason self-diagnosis from internet symptoms is unreliable.

Treatment of Vulvodynia: Why a Multimodal Approach Is Usually Best

There is no single treatment that works for every woman.

That is not because the condition is untreatable.

It is because vulvodynia may involve different combinations of:

nerve sensitivity,

muscle dysfunction,

tissue irritation,

pain processing,

psychological consequences,

and sexual-health effects.

The NHS and ACOG both recommend individualized, multidisciplinary treatment, potentially involving gynecology, pelvic-floor physiotherapy, pain medicine and psychological or psychosexual support.

The aim should usually be:

reduce pain, improve function, restore confidence and improve quality of life.

Complete immediate disappearance of pain may not occur, and improvement often takes time.

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1. Education: Understanding the Pain

Education is one of the first treatments I use.

A patient needs to understand:

The pain is real.

Normal-looking skin does not exclude vulvodynia.

Repeated infection treatment is not appropriate unless infection is present.

Pain may involve nerves and pelvic-floor muscles.

Improvement can take weeks or months.

One treatment may not be sufficient.

ACOG specifically recommends beginning treatment with clear discussion of the diagnosis and realistic treatment goals.

Understanding reduces fear.

Reducing fear helps reduce guarding.

And reducing guarding may reduce part of the pain cycle.

2. Gentle Vulvar Care

The vulvar skin is extremely sensitive.

A patient experiencing burning sometimes tries increasingly strong soaps, antiseptics or feminine washes because she assumes the area is unclean.

This can make symptoms substantially worse.

ACOG and NHS recommendations include avoiding irritants and treating the vulva gently.

Practical measures may include:

- washing gently with plain water,
- avoiding vaginal douching,
- avoiding perfumed intimate washes,
- avoiding deodorant sprays,
- avoiding scented pads or wipes,
- wearing loose clothing,
- choosing breathable cotton underwear,
- and avoiding products known to trigger symptoms.

I particularly discourage repeated experimentation with harsh or strongly fragranced local preparations.

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3. Pelvic-Floor Physiotherapy

This has become one of the most important evidence-based treatments, particularly for **provoked vestibulodynia associated with pelvic-floor overactivity**.

Treatment may involve:

- education,
- pelvic-floor relaxation,
- biofeedback,
- manual therapy,
- myofascial techniques,
- breathing exercises,

- gradual desensitization,
- and carefully supervised dilator therapy when appropriate.

A major multicenter randomized trial involving 212 women compared ten weeks of multimodal pelvic-floor physical therapy with overnight 5% lidocaine for provoked vestibulodynia. Physical therapy produced greater improvements in intercourse-related pain, sexual function and sexual distress; 79% of women receiving physical therapy reported being much or very much improved compared with 39% receiving lidocaine, with benefits maintained at six months.

A 2024 meta-analysis of rehabilitation approaches also found an overall reduction in vulvodynia-related pain, although studies used different interventions and further research remains necessary.

This is a major reason I consider appropriate pelvic-floor physiotherapy far more valuable than simply telling a woman to “relax.”

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4. Psychological and Psychosexual Treatment

Cognitive behavioral therapy, pain-focused psychological approaches and psychosexual therapy may help selected patients.

Again, this does **not** mean vulvodynia is psychological.

These therapies may help patients address:

- fear of pain,
- avoidance,
- catastrophizing,
- relationship distress,
- sexual anxiety,
- and chronic-pain coping.

A recent systematic review published in 2025 evaluated psychotherapy approaches for vulvodynia and found an emerging evidence base, although the number and quality of randomized studies remain limited.

The most useful clinical approach is often to combine physical and psychological rehabilitation rather than pretending that pain belongs exclusively to either the body or the mind.

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5. Topical Treatments

Local anesthetic preparations such as lidocaine are sometimes used to reduce pain, especially around provoked sexual activity.

However, evidence is mixed.

ACOG notes that although topical lidocaine is commonly used, randomized evidence has not consistently shown strong superiority over placebo.

This point has become even more important with newer research.

A 2025 network meta-analysis involving 33 studies and 1,873 women found that commonly used pharmacological strategies did not demonstrate robust superiority over placebo overall, while several non-drug and tissue-based approaches appeared more promising; the authors emphasized differences in evidence quality across treatments.

Therefore, topical anesthetic treatment may be useful for selected women, but it should not automatically be presented as a guaranteed cure.

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6. Medicines Used for Neuropathic Pain

Because nerve sensitization can contribute to vulvodynia, some clinicians use medicines normally prescribed for neuropathic pain.

Historically these have included:

- tricyclic antidepressants,
- gabapentin-type medicines,
- and other neuromodulating treatments.

ACOG includes tricyclic antidepressants and anticonvulsants among possible pain-management options.

However, contemporary evidence is less convincing than early observational experience suggested.

The recent 2025 network meta-analysis concluded that commonly prescribed pharmacological interventions as a group lacked robust evidence of superiority over placebo.

This does not mean such medicines never help an individual patient.

It means they should be selected carefully, monitored appropriately and not represented as universally effective.

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7. Vaginal Dilators or Trainers

In selected women with severe guarding, penetration anxiety or pelvic-floor overactivity, gradual dilator therapy may be incorporated into treatment.

It should usually be supervised by a trained pelvic-health professional.

The objective is not to force penetration.

The objective is gradually teaching the pelvic-floor muscles and nervous system that gentle contact can occur without danger.

The NHS includes vaginal trainers among potential treatment options for vulvodynia.

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8. Lubrication and Sexual Adaptation

When sexual intercourse is painful, adequate lubrication can reduce friction.

Couples may also benefit from:

- slowing down,
- allowing more time for arousal,
- trying positions that place less pressure on painful tissue,
- temporarily avoiding activities that repeatedly trigger severe pain,
- and broadening intimacy beyond penetration.

The aim should be to rebuild comfortable sexuality rather than repeatedly testing whether penetration is still painful.

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9. Address Hormonal or Vulvovaginal Conditions Separately

If menopause, breastfeeding or another low-estrogen state is contributing to dryness or tissue changes, that condition may require specific treatment.

Similarly, dermatitis or another skin disease needs treatment directed at that diagnosis.

The presence of vulvodynia does not prevent a woman from having another vulvar condition at the same time.

Current consensus specifically recognizes that **vulvodynia and another identifiable vulvar disorder may coexist**.

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10. TENS and Other Emerging Treatments

Transcutaneous electrical nerve stimulation, or **TENS**, has been explored for vulvodynia.

ACOG discusses TENS as a potential therapy and cites randomized evidence suggesting improvement in some patients.

A recent 2025 network meta-analysis also evaluated several device- and tissue-based therapies, including photobiomodulation, low-level laser, vaginal electrical stimulation and shockwave treatment. Some demonstrated promising pain effects, but these approaches vary considerably and should not be interpreted as established first-line treatments for every woman.

The evidence continues to develop.

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11. Surgery: Only for Carefully Selected Patients

Surgery is **not** appropriate for most women with vulvodynia.

In a carefully selected patient with severe, localized provoked vestibulodynia that has not responded to appropriate conservative treatment, a procedure called **vestibulectomy** may occasionally be considered.

This involves removal of painful vestibular tissue.

ACOG states that vestibulectomy may be effective when nonsurgical options have failed in appropriately selected women with pain localized to the vestibule.

This should be considered specialist treatment—not an early or routine intervention.

The Importance of Avoiding Repeated Unnecessary Treatment

One of the patterns I see in chronic vulvar complaints is repeated treatment without diagnosis.

The patient has burning.

She is given an antifungal.

The burning continues.

Another antifungal is prescribed.

Then an antibiotic.

Then a steroid.

Then another topical product.

By the time proper assessment occurs, the vulvar tissue may have been exposed to many potentially irritating substances.

I advise patients:

Do not keep treating every episode of vulvar burning as an infection unless infection has actually been demonstrated or is clinically strongly suspected.

Correct diagnosis is more important than repeated medication.

Can Lifestyle Changes Help?

Lifestyle modification cannot cure every case of vulvodynia, but it can help reduce aggravating factors and support recovery.

Useful measures may include:

- avoiding vulvar irritants,
- reducing prolonged pressure on the vulva,
- modifying cycling where necessary,
- regular gentle physical activity,
- adequate sleep,
- stress management,
- management of constipation where present,
- and improving general metabolic health.

The NHS additionally advises minimizing prolonged sitting and avoiding irritating scented products and very hot bathing.

The Role of Unani Medicine in Vulvodynia

As a Unani physician, I believe the Unani system can make an important **supportive contribution** in patients with chronic pain—particularly through its holistic evaluation of lifestyle, temperament, diet, sleep, psychological health and general physical condition.

However, I want to be scientifically clear:

There is currently insufficient high-quality clinical evidence demonstrating that a specific Unani medicine can directly cure vulvodynia.

Therefore, at Saira Health Care I do not believe it is responsible to replace:

- gynecological evaluation,
- pelvic-floor physiotherapy,
- appropriate pain management,
- or psychological/psychosexual rehabilitation

with an unverified herbal remedy.

Instead, I use the strengths of Unani medicine as part of an **integrative approach**.

The Unani Concept of Whole-Person Health

One of the most useful Unani concepts is **Asbab Sitta Daruriyya**, or the six essential factors that influence health.

CCRUM describes these as:

- air and environment,
- food and drink,
- physical movement and rest,
- psychological activity and mental peace,
- sleep and wakefulness,
- and retention and evacuation.

These principles become particularly relevant in chronic pain because patients may simultaneously experience:

poor sleep,

reduced physical activity,

constipation,

anxiety,

sexual stress,

fatigue,

or disturbed eating patterns.

Correcting these problems will not necessarily eliminate nerve pain immediately.

But improving the patient's overall condition can support multidisciplinary pain management.

Ilaj-bil-Ghiza — Dietotherapy

In Unani medicine, dietary management is individualized.

For a patient with vulvodynia, the goal is not to promise that a particular food will cure vulvar pain.

Rather, diet should support:

- general health,
- metabolic health,
- bowel regularity,
- adequate nutrition,
- and healthy body weight.

An unnecessarily restrictive diet should not be imposed without a clear reason.

Dietary claims around vulvodynia have historically been made—for example regarding oxalates—but these theories have not produced a universal dietary treatment.

Therefore, food should support health rather than become another source of anxiety.

Ilaj-bil-Tadbir — Regimental and Lifestyle Therapy

CCRUM recognizes **Ilaj-bil-Tadbir**, or regimental therapy, as one of the major therapeutic approaches within Unani medicine alongside dietotherapy and pharmacotherapy.

For chronic vulvar pain, the most appropriate supportive components may involve:

adequate rest,

sleep correction,

stress reduction,

gentle exercise,

management of bowel habits,

and careful avoidance of known irritants.

These measures can be used alongside modern pelvic-pain treatment rather than in competition with it.

Mental Activity and Peace: Harakat-o-Sukun Nafsani

Traditional Unani medicine considers a balance between psychological activity and mental peace an essential component of health.

CCRUM describes **Harakat-o-Sukun Nafsani** within the six essential factors and emphasizes the importance of mental repose.

This concept is especially relevant to chronic pain.

Persistent vulvar pain can produce:

fear,

anticipatory anxiety,

sleep problems,

marital tension,

loss of confidence,

and reduced sexual desire.

Helping the patient manage these consequences is consistent with both modern chronic-pain medicine and the holistic philosophy of Unani care.

Unani Medicines: A Cautious and Individualized Role

Unani pharmacotherapy may have a supportive role for selected associated problems after proper assessment.

However, I strongly advise patients **not to apply herbal oils, powders, pastes, concentrated extracts or homemade remedies directly to painful vulvar tissue without professional advice**.

The vulvar skin and mucosa can be extremely sensitive.

A product described as “natural” can still produce:

- contact dermatitis,
- burning,
- allergy,
- or further irritation.

This is especially important in vulvodynia because additional irritation can worsen the pain cycle.

If a Unani medicine is considered, I prefer to first establish:

what the diagnosis is,

whether infection or skin disease has been excluded,

which medicines the patient is already using,

whether pregnancy is possible,

and whether the formulation is appropriate for the patient's overall condition.

Responsible Unani practice should support accurate diagnosis—not delay it.

What I Do Not Promise My Patients

I do not tell a woman:

“One medicine will permanently cure vulvodynia in seven days.”

That would not reflect the current scientific understanding of this complex chronic pain condition.

ACOG notes that improvement can take weeks or months and that pain reduction may sometimes be incomplete even with appropriate treatment.

What I can offer is a structured approach:

understand the pain,

exclude serious causes,

identify contributing mechanisms,

reduce irritation,

address pelvic-floor dysfunction,

support general health,

manage associated sexual difficulties,

and follow the patient's progress carefully.

That is a far more realistic and medically responsible pathway.

Dr. Nizamuddin Qasmi's Specialized Integrative Approach at Saira Health Care

At **Saira Health Care**, my approach to a woman presenting with chronic vulvar burning or pain generally has several stages.

Stage 1: Establish whether this is truly vulvodynia

The first priority is not treatment.

It is diagnosis.

We need to consider whether symptoms may instead represent infection, dermatological disease, hormonal tissue changes, neurological pain or another gynecological condition.

When necessary, I recommend appropriate gynecological investigation or specialist referral.

Stage 2: Understand the pain pattern

Is it:

localized,

generalized,

provoked,

spontaneous,

or mixed?

Does intercourse trigger it?

Does sitting trigger it?

Is pelvic-floor tension present?

Does pain occur with urination or bowel movements?

This helps identify which treatments may be most relevant.

Stage 3: Assess sexual and relationship consequences

I ask whether pain has caused:

avoidance of intercourse,

fear of penetration,

reduced sexual desire,

relationship misunderstanding,

or infertility-related pressure.

These effects need treatment just as much as the pain itself.

Stage 4: Use evidence-based multidisciplinary care

Depending on the patient, this can involve:

pelvic-floor physiotherapy,

gynecological care,

pain medicine,

psychosexual counseling,

appropriate medication,

and other specialist management.

Stage 5: Add responsible Unani supportive care

I consider:

diet,

sleep,

physical activity,

stress,

bowel function,

general health,

and other aspects of *Asbab Sitta Daruriyya*.

When appropriate, individualized Unani support may complement the broader treatment plan.

Stage 6: Follow progress rather than expecting instant cure

Pain intensity, sexual comfort, daily functioning, sitting tolerance, sleep and quality of life should all be considered.

A woman does not need to become completely pain-free overnight for treatment to be moving in the right direction.

Contribution of Saira Health Care in Sexual Disorders & Infertility

At **Saira Health Care**, our continuing work in sexual disorders and infertility has shown us that chronic genital pain cannot be treated effectively by considering only one organ.

Vulvodynia may affect:

sexual desire,

arousal,

intercourse,

relationship confidence,

mental health,

and sometimes a couple's ability to attempt natural conception.

Our objective is therefore to offer a confidential clinical environment in which a woman can discuss such symptoms without embarrassment.

We focus not only on whether intercourse is possible but also on:

whether it is comfortable, consensual, emotionally healthy and compatible with the patient's reproductive goals.

Where modern gynecological, pelvic-floor, dermatological, pain or psychological expertise is required, appropriate referral should form part of good integrative care.

About Dr. Nizamuddin Qasmi

Dr. Nizamuddin Qasmi
Founder & Chief Physician, Saira Health Care
Focused Practice in Sexual Disorders & Infertility

Professional qualifications and training include:

BUMS – Hamdard University, Delhi
MD
CGO
Certificate in Infertility – MGBIMS, Delhi
Certificate in Urology – London, UK
Masters in Male Infertility – MasterHealthPro (HealthPro)
Integrated Sexual and Reproductive Health – ISRH, UNFPA

My clinical philosophy is to combine the holistic perspective of Unani medicine with responsible contemporary knowledge of sexual and reproductive health.

For a complex condition such as vulvodynia, this means looking beyond the symptom of pain alone and considering:

the nervous system,

pelvic-floor muscles,

vulvar health,

sexual function,

psychological well-being,

lifestyle,

and relationship health.

Frequently Asked Questions About Vulvodynia

Is vulvodynia curable?

Some women achieve major improvement or become largely symptom-free, while others require longer-term pain management.

No single treatment works for everyone.

ACOG therefore recommends individualized and often multidisciplinary management.

Does vulvodynia always show redness?

No.

The vulva may look completely normal.

Pain without obvious visible disease is one of the reasons diagnosis can be delayed.

Is vulvodynia caused by poor hygiene?

No.

Excessive cleansing may actually worsen symptoms by irritating sensitive vulvar tissue.

Is vulvodynia a yeast infection?

Not necessarily.

Yeast infection can cause burning but is a different condition. Infection should be confirmed when suspected rather than repeatedly assumed.

Can vulvodynia cause painful intercourse?

Yes.

Provoked vestibulodynia is particularly associated with pain at the vaginal entrance during pressure or attempted penetration.

Can pelvic-floor physiotherapy help?

Yes, particularly when pelvic-floor muscle dysfunction accompanies provoked vestibulodynia. A randomized trial demonstrated meaningful superiority of multimodal physical therapy over topical lidocaine for several pain and sexual-health outcomes.

Does needing psychological therapy mean the pain is imaginary?

No.

Chronic pain affects mood, fear, relationships and the nervous system. Psychological or psychosexual treatment addresses these components while accepting that the physical pain is real.

Is vulvodynia dangerous?

Vulvodynia itself is not cancer or a contagious infection. However, a woman should first be properly evaluated because several other conditions can cause similar symptoms.

Can vulvodynia affect pregnancy?

It does not generally directly cause infertility, but severe intercourse-related pain can make natural conception difficult. Treatment may therefore be particularly important in couples trying to conceive.

Can Unani medicine help vulvodynia?

Unani medicine can offer supportive whole-person care through attention to diet, sleep, activity, mental well-being and general health. CCRUM recognizes these lifestyle domains within the *Asbab Sitta Daruriyya* framework. However, high-quality evidence for a specific Unani cure for vulvodynia is currently lacking, so Unani care is best used responsibly alongside necessary gynecological, pelvic-floor and pain treatment.

When Should a Woman Seek Medical Attention?

Do not simply assume that persistent burning is vulvodynia.

Professional evaluation is especially important when vulvar pain or burning lasts for weeks or months, interferes with intercourse or daily activity, repeatedly returns despite infection treatment, or is accompanied by skin changes, sores, unusual bleeding, discharge, fever, urinary problems or a vulvar lump.

ACOG recommends medical review for vulvar itching, burning or pain and evaluation for other vulvar diseases where appropriate.

Persistent genital pain deserves proper diagnosis.

What Does the Latest Evidence Tell Us?

Treatment research continues to evolve.

One of the most important recent developments is that vulvodynia is increasingly being treated as a **multidimensional chronic pain condition rather than simply a local vulvar disease**.

A 2024 systematic review found meaningful benefits from rehabilitation approaches for pain, while a high-quality randomized trial strongly supports multimodal pelvic-floor physical therapy for provoked vestibulodynia.

A 2025 systematic review of psychotherapy identified an expanding evidence base for psychological interventions, although the number of strong trials remains limited.

Most recently, a 2025 network meta-analysis covering 33 studies and nearly 1,900 participants found that several tissue-based therapies showed promising pain reductions, while commonly prescribed pharmacological therapies did not clearly outperform placebo as a group. Multimodal physical therapy and psychological approaches also showed encouraging results in appropriate comparisons. The authors nevertheless emphasized differences in evidence quality and the continuing need for better comparative trials.

For patients, the practical conclusion is straightforward:

There is no single universal vulvodynia medicine. Treatment should be personalized and usually multimodal.

My Final Message to Women With Vulvodynia

If you have suffered burning, soreness or pain around the vulva and repeated tests have failed to reveal a simple infection, please do not conclude that the pain is imaginary.

And please do not feel ashamed.

Vulvodynia is a genuine and recognized chronic pain condition.

You may need more than one form of treatment.

The nerves may require attention.

The pelvic-floor muscles may need rehabilitation.

Vulvar irritants may need to be removed.

Associated hormonal or skin conditions may need treatment.

Pain-related fear and sexual anxiety may need support.

Your relationship may need communication.

And your general health, sleep, stress and lifestyle should not be ignored.

As a Unani physician working with sexual disorders and infertility, my approach is to respect both **traditional whole-person principles and modern scientific evidence**.

At Saira Health Care, I do not believe a woman should be told merely to tolerate painful intercourse or repeatedly take medicines without understanding why she hurts.

The more useful question is:

Where is the pain coming from, what keeps the pain cycle active, and which combination of treatments gives this particular patient the best opportunity to recover?

That is the direction in which modern vulvodynia care is moving.

And that is the approach I believe offers patients the greatest dignity, safety and realistic hope.

Medical Disclaimer

This article is intended for general patient education and professional health information. It does not replace examination by a gynecologist or other appropriately qualified clinician. Vulvar pain can result from infection, inflammatory skin disease, hormonal changes, neurological disorders, trauma and, rarely, precancerous or malignant disease; these should be excluded when clinically indicated. Do not repeatedly use antibiotics, antifungal medicines, steroid creams, herbal oils or other vulvar products without an appropriate diagnosis. Treatment of vulvodynia should be individualized, and pregnancy or plans for conception should be disclosed before starting systemic or topical medication.