Vulvodynia, Pregnancy and Childbirth

A Self-Help Guide for Women with Vulvodynia Who Are Pregnant or Want to Become Pregnant

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National Vulvodynia Association

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The National Vulvodynia Association is not a medical authority and strongly recommends that you consult your own health care provider regarding any course of treatment or medication.

Introduction

If you are pregnant or trying to conceive, you have probably discovered that there are hundreds of books on conception, pregnancy and childbirth available to you. Unfortunately, none of these books address women with vulvodynia. We created this guide to fill that void. It is not only a resource for pregnant women with vulvodynia, but for any woman with vulvar pain who wants to become pregnant. This guide covers conception through the postpartum period, dealing with topics such as alleviating pain during pregnancy and minimizing trauma to the vulva during childbirth.

As you read the guide, keep in mind that it is not intended to be a comprehensive resource for your pregnancy and delivery—plenty of books already do that. Instead, it is intended to fill in the gaps for women with vulvodynia. For example, numerous tests are performed during pregnancy, but we will discuss only the ones that may affect your pain. Also, you should be aware that each woman's experience with vulvodynia is unique and that each pregnancy is different. We have tried to address most women's experiences.

You also may find that we discuss topics covered in detail in most pregnancy books, but offer a vulvodynia "slant" on the subject. For example, most books on pregnancy offer suggestions for finding a suitable health care provider. The needs of a pregnant woman with vulvodynia are specific, however, so we emphasize finding a health care provider who will focus on minimizing your discomfort and limiting procedures that exacerbate your symptoms. Our intent is to provide information that will assist you in making decisions and to highlight topics that you should discuss with your health care provider.

We encourage you to share this guide with your health care provider. Your well-being during pregnancy and delivery should be a team effort. To request a hard copy, contact the NVA by e-mail (gigi@nva.org) or phone (301-299-0775).

Section I: Choosing a Health Care Provider

Before you attempt to get pregnant, you should establish a relationship with an obstetrician or midwife who will oversee your prenatal care. At your pre-pregnancy medical visit, you can ask questions about conception, and seek advice about prenatal nutrition and tapering off any medications you are taking.

If a gynecologist who practices obstetrics is already treating your vulvodynia, he/she may be a good choice to handle your prenatal care. You should be aware that some gynecologists do not practice obstetrics at all and others do not deliver many babies. You should find a doctor or midwife who routinely cares for pregnant women and can provide the most up-to-date information on prenatal care and delivery.

You also need a health care provider familiar with vulvodynia, even if he/she does not treat it. You will have questions during your pregnancy about the changes in your vulvar pain and how labor and delivery may affect you. After talking to your provider, you may even decide to decline certain procedures that are too painful. Thus, it is important that he/she understands the basics of vulvodynia and can properly address your concerns. It is also important to choose a provider who will support your pain management preferences during labor and delivery.

Many women with vulvodynia find that becoming an active participant in their medical care is essential. Pregnancy should be no different. You and your health care provider are equally important members of your health care team. Educate yourself and work with your provider. If you decide to interview a few practitioners before choosing one, pay attention to the way they answer your questions. Their tone and demeanor may be just as important as their answers— you want to choose the health care provider that is most willing to address your concerns and allows you to take an active role in your care.

Doctor or Midwife?
First, narrow your search by deciding whether you want your prenatal care managed by an obstetrician-gynecologist (ob-gyn) or a midwife. Ob-gyns are medical doctors who specialize in the reproductive care of women. Nurse-midwives are registered nurses trained to care for pregnant women and their babies throughout pregnancy, labor, delivery and the post-partum period. They must have an arrangement with a doctor whom they can consult or refer patients to if medical problems arise.[i] Direct-entry midwives, who have completed training according to their states' requirements without first becoming nurses, are recognized in less than half the states. In other states, they cannot practice legally.[ii]

One issue you will have to consider is whether you'd like to have an unmedicated childbirth or have pain medication administered during

delivery. You don't have to make the final decision right away, but keep in mind that doctors deliver babies in hospitals, and may attend both medicated and unmedicated births, whereas most midwives deliver babies in stand-alone birth centers or in homes. Some hospitals permit nurse-midwives to practice there, but they are not authorized or trained to administer certain types of anesthesia, such as epidurals, which have to be done in a hospital by an anesthesiologist; they may, however, administer a local or perineal block.[iii] Some ob-gyns have nurse-midwives on their staff, allowing women to see either a doctor or a midwife for their prenatal exams.

When considering your options, remember that it is best to keep an open mind about the use of medications during childbirth. You may decide that you want to use all medications available to ease the pain of childbirth, only to discover that your labor is progressing so quickly you're lucky just to arrive at the hospital before the baby is born, with no time for an epidural. Or you may be sure you'll only have an unmedicated birth, but lose your energy and resolve after 36 hours of labor leaves you exhausted with no end in sight. Many women find that they have to switch to Plan B, and sometimes, Plan C, before their baby is born.

Choosing a Health Care Provider

Once you have decided whether you want a doctor or midwife, hereafter referred to as "health care provider" or "provider," ask for referrals from friends, relatives and coworkers who were satisfied with the obstetrics care they received. If you know other women with vulvodynia in your community, ask them for suggestions. A list of health care providers who treat chronic vulvar pain disorders, including those who practice obstetrics, is available to NVA donors by contacting us at 301-299-0775 or gigi@nva.org. If you are still unable to find a practitioner, check the Internet for ob-gyns at www.ACOG.org or nurse-midwives at www.ACNM.org.

Keep in mind that selecting a health care provider usually means you are choosing a practice, which may be comprised of two or more doctors (or midwives). Thus, you will want to determine how much the other members of the practice (as opposed to one provider) knows about vulvodynia and to what extent they are willing to let you participate in making choices about your prenatal care. In most group practices, you will meet all the providers during the course of your pregnancy, but you will not be able to choose which one delivers your baby (unless you have a scheduled delivery).

Narrow your list of possible providers (or practices) to three or less, and interview each of them. Find out if they are willing to meet with you in person without a charge. If not, you can ask questions over the telephone or perhaps via e-mail. Ask their staff which types of insurance they accept and at what hospital(s) they deliver. You should also ask

providers questions about their knowledge of, and expertise in, treating vulvodynia. Most pregnancy books have sample questions to ask when interviewing providers. Choose the questions that will elicit the information that is most important to you, or tailor them to your needs. Below are some additional sample questions that are specific to vulvodynia. Be sure to read this entire booklet before your interviews, as it may trigger additional questions and help you choose the type of birth experience you want to have. You may not have more than 10 or 15 minutes per interview, so be sure to keep your questions brief.

- I have vulvodynia. Have you (or members of your practice) ever treated a pregnant woman with vulvodynia?

- If not, are you willing to communicate with the health care provider who is currently treating my vulvodynia?

- What specific recommendations do you make for pregnancy, labor and delivery for women with vulvodynia?

- What is your opinion on episiotomy? Do you use perineal massage to help the perineum stretch during delivery?

- How often, and under what circumstances, do you use forceps or vacuum extraction?

- Do you recommend a Cesarean section for women with vulvodynia? Why or why not?

If Your Choices are Limited

For some women, choosing a health care provider is not an option. If you live in a small community or rural area, belong to an HMO, or serve in the armed services, your health care provider may be chosen for you. There are still some steps you can take, however, to increase the likelihood of having the type of pregnancy and delivery you want.

If an ob-gyn currently treats your vulvodynia, you won't have to start from square one, because he/she already knows your medical history. If you are assigned to a new doctor for your prenatal care, you may have to educate her/him about vulvodynia. In either case, it is crucial to communicate effectively and take responsibility for your own health care. Before your first appointment, you will have to do a little homework. Copy articles from the NVA newsletter and/or print out information from the NVA web site (www.nva.org) that is relevant. Educate yourself about vulvodynia in case your provider asks you any questions about it.

Prepare a list of questions about conception, pregnancy and delivery. You can start with the questions suggested above, but may want to rephrase some of them, such as “Because I have vulvodynia, I’d like to avoid having an episiotomy or tearing, if possible. Will you use perineal massage to help the perineum stretch during delivery?” Consider asking your spouse, a family member or friend to accompany you to your first medical appointment to help you remember and/or interpret what is recommended. As your pregnancy progresses, if you find yourself having difficulty talking to your health care provider, bring your spouse or friend to all your checkups. Also, consider asking your new provider to contact your current gynecologist or other provider who treats your vulvodynia to discuss the more technical aspects of your care.

Setting the Stage for a Good Relationship
It is never too early to open the lines of communication. Establishing good rapport with your health care provider increases the likelihood that he/she will treat your care as a partnership, thereby increasing the likelihood of having the type of pregnancy and delivery you want.

Have your medical records transferred to his/her office before your first appointment. Tell your provider how long you have had vulvodynia and the precise location of your pain. Additionally, describe how it feels and its severity, as well as the treatments you have tried and their effectiveness. Disclose all medications you are currently taking. Be completely candid. Withholding information about your medical history or lifestyle will not serve you or your baby well.

Between each prenatal visit, write down questions as they occur to you. Bring the list to your next visit and be prepared to take notes. If something comes up that cannot wait until your next visit, call the office. If you ever suspect that your provider is mistaken, say something. Even with your chart in hand, you cannot expect him/her to remember every detail of your medical history. Some practitioners see hundreds of pregnant women each month. Remember, you share in the responsibility of making sure that errors are not made. Ask questions about all recommended procedures, including the need for laboratory tests. If you have difficulty remembering your provider’s instructions, bring a family member or friend with you. You may also want to consider writing a birth plan, which can help you outline your preferences and provides an opportunity to discuss them with your health care provider.

For additional information on how to effectively communicate with your provider, visit http://learnpatient.nva.org/getting_most_of_medical_care.htm.

Section II: Conception

Many women with vulvodynia ask, “Will I be able to have children?” Fortunately, the answer is “Yes,” unless you have another health condition that impairs your fertility. Two major challenges you may face are conceiving a child when sexual intercourse is painful or impossible, and/or what to do if you take daily medication to control vulvodynia. You should be familiar with the following information before you start trying to conceive.

Oral Medications[iv]
Vulvodynia is often treated with oral medication, primarily tricyclic antidepressants or anticonvulsants. It is best not to take any medications while attempting to conceive (and for the first trimester, at a minimum), however, this may not be possible for you. If your pain is too severe without any medication, there may be acceptable ones that you can take. There is not a “one size fits all” rule to guide you in this area. Whenever medication is used during pregnancy, its benefits have to be weighed against any risk to the mother and baby. It is critical that you discuss all medications you are taking with your provider *well in advance* of trying trying to conceive. Your provider will help you determine the best course of action for your situation. To guide providers, the FDA has categorized the level of risk involved in using various medications during pregnancy:

Category A: Adequate and well-controlled studies have failed to demonstrate a risk to the fetus in the first trimester of pregnancy (and there is no evidence of risk in later trimesters).

Category B: Animal reproduction studies have failed to demonstrate a risk to the fetus and there are no adequate, well-controlled studies in pregnant women, or animal studies have shown an adverse effect, but adequate and well-controlled studies in pregnant women have failed to demonstrate a risk to the fetus in any trimester.

Category C: Animal reproduction studies have shown an adverse effect on the fetus and there are no adequate and well-controlled studies in humans, but potential benefits may warrant use of the drug in pregnant women despite potential risks.

Category D: There is positive evidence of human fetal risk based on adverse reaction data from investigational/marketing experience or studies in humans, but potential benefits may warrant use of the drug in pregnant women despite potential risks.

Category X: Studies in animals or humans have demonstrated fetal abnormalities and/or there is positive evidence of human fetal risk based on adverse reaction data from investigational or marketing experience, and the risks involved in use of the drug in pregnant women clearly outweigh potential benefits.

The chart below contains a list of oral medications frequently used to treat vulvodynia and their respective FDA risk categorization.

Medication Class	Name	FDA Risk Category
Tricyclic Antidepressant	Elavil ® (amitriptyline) Norpramin ® (desipramine) Pamelor ® (nortriptyline) Sinequan ® (doxepin) Tofranil ® (imipramine)	C/D* C C/D* C D
Selective Serotonin Re-uptake Inhibitor (SSRI)	Prozac ® (fluoxetine) Paxil ® (paroxetine) Zoloft ® (sertraline)	C C C
Selective Serotonin Norepinephrine Reuptake Inhibitor (SSNRI)	Cymbalta ® (duloxetine) Effexor ® (venlafaxine) Savella ® (milnacipran)	C C C
Anticonvulsant	Tegretol ® (carbamazepine) Neuronitn ® (gabapentin) Lyrica ® (pregabalin) Trileptal ® (oxcarbazepine) Dilantin ® (phenytoin)	C/D* C C C D
Muscle Relaxant	Flexeril ® (cyclobenzaprine) Norflex ® (orphenadrine) Soma ® (carisoprodol) Valium ® (diazepam)	B C C D
Narcotic & Narcotic-like Medication	Ultram ® (tramadol) Demerol ® (meperidine) Percocet ® (oxycodone) Vicodin ® (hydrocodone/acetominophen)	C B** C C

*Depends on source.

**D if used for prolonged periods or in high doses at term.

More information on medications not listed here can be found at www.rxlist.com. (Enter the medication in the search field, click on Warnings & Precautions and then scroll to ‘Pregnancy & Breastfeeding.’)

Tapering the Dose

There are drug-free treatments for vulvodynia, such as physical therapy and EMG biofeedback, which are safe to use during pregnancy. If these treatments don't provide adequate pain relief and eliminating medication is impossible, your provider may recommend that you taper it to an effective, but relatively safe, level. Another possibility is to lower your dosage while you attempt to conceive and then discontinue medication once a positive pregnancy test result is obtained. If necessary, you may be able to resume taking the medication after the first trimester.

Be sure to ask your provider how to taper a drug and how long it will take for a particular medication to leave your system. In some cases, it may take several weeks to completely rid your system of a drug before you can attempt to get pregnant. The prospect of weaning yourself off a medication that lessens or eliminates your pain can be daunting. Some women find that taking a drug for a long period of time breaks the pain cycle, however, and that once they stop taking the drug, they no longer need it.

Topical Medications

Topical anesthetics that are commonly used by women with vulvodynia, such as lidocaine, are usually safe to use throughout pregnancy. Topical estrogen use is contraindicated, however. Many oral medications, such as tricyclic antidepressants and anticonvulsants, can be compounded into an ointment and used topically. Because systemic absorption can occur with any topical, and absorption levels of these newly compounded preparations have not been well-studied, it is essential that you consult your provider about continuation of *any* topical before trying to conceive.

Low-Oxalate Diet and Calcium Citrate Supplementation

Some women with vulvodynia follow the low-oxalate diet and take calcium citrate. Consumption of up to 1500 milligrams of calcium per day during pregnancy is safe. Higher amounts are not necessarily harmful to the fetus, but may be harmful to the mother because of the risk of kidney stones. Many essential nutrients are lacking in the low-oxalate diet and it is not recommended during pregnancy.

Oral Contraceptives

As soon as you stop taking the birth control pill (Category X), you are fertile, but even a small residue of the pill in your system may present an increased risk of birth defects. Most doctors recommend stopping the pill and using another form of birth control for two to three months before trying to conceive.

Timing is Everything

You are now ready to conceive. Most women with vulvodynia are able to resume sexual relations at some point, at least occasionally.

If you are only able to have intercourse once or twice a month, you can maximize your chance of conception by having intercourse shortly before ovulation. There are three methods of predicting ovulation: recording basal metabolic temperature, using an ovulation test kit and observing changes in vaginal discharge. Choose the method that suits you or try all of them simultaneously. An ovulation kit can be purchased at any drug-store and includes five test sticks that you hold under your urine stream. The sticks react to the surge in luteinizing hormone that occurs immediately before ovulation. The best time to have intercourse is the day the test turns positive, which is 24 to 36 hours before ovulation.

Alternately, you can record your basal metabolic temperature by taking a rectal reading each morning for two months, starting on the first day of your menstrual cycle. Your temperature will rise (about half a degree) 24 to 48 hours after you ovulate. Record this information on a graph that also tracks your monthly cycle (note the start date of your period and its duration). After you've used this graph to determine when you ovulate, you can appropriately time intercourse. (For more information on this method, visit www.ovulation-calendar.com.) The third method is to observe changes in your cervical/vaginal discharge. When the discharge becomes watery, stretchy and clear, ovulation is imminent.

These methods work best for women who have regular cycles. A normal cycle is between 26 and 33 days and lasts the same number of days each month, although irregularities may occur spontaneously. If your irregular cycles last no more than two consecutive months, they should not affect your ability to conceive.[v] On the other hand, if your menstrual cycle is often irregular, it could be the sign of an infertility problem. Talk to your provider, who can best advise you on how to predict ovulation when your cycle is irregular.

Minimizing Discomfort During Intercourse
Attempting to conceive may require having intercourse more often than you find comfortable, but there are several comfort measures you can use during and after intercourse.

Some women who experience only local tenderness in the vestibule usually do well with topical lidocaine, which numbs the area. It may be used as a liquid or an ointment, but the former is recommended because an ointment is more likely to transfer onto your partner, decreasing his level of stimulation and increasing the amount of time it takes him to ejaculate. Some experts recommend placing a cotton ball that has been soaked in lidocaine solution at the vaginal opening 10 to 30 minutes before intercourse. Experiment with it the day before you try to conceive, so you can pinpoint the timing that works best for you. Some women also benefit from a nightly application of lidocaine for several weeks as an ongoing treatment to decrease pain during intercourse.[vi]

Using a lubricant also cuts down on friction in the vulvar area during intercourse, but avoid lubricants that contain chlorohexadine (e.g., KY Jelly), which is toxic to sperm. Also avoid oil-based lubricants because they decrease sperm motility or may even block access to the egg. Opt for lubricants that are water-based and do not contain propelyne glycol, which can irritate sensitive vulvar tissue. If you are unsure which products are water-based, check the contents on the label or choose one that states it is safe to use with condoms.

Increasing the duration of foreplay may also help to decrease the length of time of actual intercourse. Also, many women find that certain sexual positions are more comfortable than others. You should experiment to discover which position works best for you.

Following intercourse you can apply ice or a frozen gel pack wrapped in a towel to the vulvar area, so that any redness or swelling is suppressed before it causes a flare-up. If needed, the wrapped ice may be used for 15 to 20 minutes at a time every one to two hours.

Boosting Your Fertility

Although vulvodynia doesn't directly affect fertility, trying to conceive with the additional challenge of vulvar pain can create stress, which may in turn affect your fertility. Sometimes, stress can cause a brief menstrual upset or completely stop menstruation. The hypothalamus gland, which is responsible for the flow and timing of your reproductive hormones, is very sensitive to physical and emotional stress. Luckily, short-term stress only causes a temporary disruption to your reproductive system and is a fertility factor within your control. Keep stress at bay while trying to conceive (and throughout your pregnancy) by eating healthy foods, drinking plenty of water, getting enough sleep and engaging in moderate exercise. Identify causes of stress in your life and do your best to eliminate them. Many women who have had difficulty conceiving discover they are pregnant upon returning from a vacation or after they stop "trying" to get pregnant.

Your age also can affect your fertility. Some women with vulvodynia delay childbearing while seeking treatment for their pain and try to conceive in their 30s or 40s, when fertility is lower. Women over 35 can have a normal pregnancy and healthy baby, especially if they follow recommended pre-pregnancy and prenatal care. As women age, however, conditions such as high blood pressure and diabetes tend to occur more often and the risk of pregnancy complications is higher. In addition, the risk of birth defects increases with age, although it remains low well into a woman's 30s.[vii] If your pain has been disruptive to your relationship with your partner, making a decision to commit to childbearing more difficult, a couples therapist may help the two of you sort out your needs, desires and roadblocks. Also, a therapist can teach you how to cope with some of the stresses in your life.

Conception Without Sex
Even if you cannot engage in intercourse, you can still get pregnant. If penetration is impossible, manual or oral stimulation of your partner with ejaculation at the vaginal opening may suffice. You can lie on your back with your knees up, which helps sperm travel to the cervix.

Another alternative is artificial insemination around the time of ovulation. To do this without the help of a fertility specialist, have your spouse or partner ejaculate into a sterile container, such as a turkey baster. (Note that even if a container is brand new, it still must be sterilized. You can do so by submerging the container in boiling water for 20 minutes.) Then lie down and place a pillow under your hips, and have your partner pour his semen into your vagina. It is important to keep in mind that the semen must reach the cervix and travel into the uterus for conception to occur. A similar method involves pouring the pool of sperm into an unused vaginal diaphragm and placing it over the cervix.

Most women do not require artificial insemination with a physician's assistance unless there are other fertility issues, such as blocked fallopian tubes. Some women prefer to undergo artificial insemination with their physician's help, however, rather than attempt the methods described above. If you do not conceive after undergoing artificial insemination for three cycles with a physician's assistance, it is likely a fertility problem exists. Then you would become a standard fertility patient and various therapies or in-vitro fertilization may be attempted.

Surrogacy or Adoption
If you want children, but cannot eliminate high-risk medication, you might consider a surrogate birth mother or adoption. In surrogacy, a fertilized egg is implanted in a woman who volunteers to carry the fetus to term. Another alternative is adoption. It doesn't take long for adoptive parents to realize that when you raise a child, she/he quickly becomes your own. For more information on surrogacy or adoption, visit www.adoption.about.com and http://en.wikipedia.org/wiki/Surrogacy.

Section III: Pregnancy

A positive pregnancy test may occur after a single attempt at conceiving or following months, or even years, of trying. No matter how you got to this point, you will be elated when you learn that you will have a baby in your arms in less than nine months. You will soon realize that your body is changing in many ways, e.g., you may feel nauseated or crave certain foods. Most of these changes can be blamed on hormones that help the fetus develop and prepare your body for childbirth. These hormones may also affect the severity and constancy of your vulvodynia.

As soon as you discover that you're pregnant, call your health care provider. The provider's staff will schedule your first visit and tell you what you should be doing, e.g., taking prenatal vitamins, prior to the visit. Until then, relax, get plenty of rest and begin to enjoy this special time.

Prenatal Care and Tests
Remember that good prenatal care is informed care. The more you know about the procedures, tests and exams that your health care provider will perform, the better equipped you are to make decisions. Before you consent to a test or procedure, make sure you know what it is, why it is being performed, how reliable the results will be, and the risks associated with it. If you don't understand your provider's explanation, ask questions. You have the right to decline any procedure.

Your schedule of prenatal visits will depend upon the practice of your provider, your health, and any risks factors you have, such as previous miscarriages or preterm labor, diabetes, high blood pressure or severe anemia. Your first visit will occur either shortly after you learn you're pregnant, between weeks 6 and 8, or as late as week 12. Because home pregnancy tests are highly accurate, doctors no longer ask you to come in immediately to confirm the pregnancy. Typically, you will see your provider once a month until the 28th to 32nd week, after which you will be given an appointment every two to three weeks. Beginning about the 36th week, you will have weekly prenatal visits, which may include pelvic exams. Many women without vulvodynia experience discomfort during these examinations, especially if the health care provider touches the cervix.

The number of tests that you or your baby will undergo during your pregnancy depends upon your age, health status and/or risk factors. Most of them, such as a simple blood draw to check glucose level, will have no impact on your vulvodynia. There are three prenatal tests—transvaginal ultrasound, chorionic villus sampling and Group B Strep screening—that may affect you differently than other pregnant women, however. These tests are painless or mildly uncomfortable for most pregnant women, but they involve access to the vagina or cervix, which can aggravate vulvodynia.

Transvaginal Ultrasound. A transvaginal ultrasound may be performed before the 12th week of pregnancy for many reasons. Your provider may want to assess gestational age, determine whether there has been a miscarriage, confirm the existence of twins, etc. Some providers routinely recommend the test between the 7th and 9th week, but others will do so only if they suspect a problem. This procedure involves the insertion of a probe into the vagina and will be painful for women who are unable to tolerate pelvic exams. Before consenting to this procedure, ask your provider whether he/she suspects a problem or if it is simply routine. If the test is routine, ask if you can skip it. If a problem is suspected, ask if there is an alternative test that can be performed. If not, talk to your health care provider about pain management strategies you can use, such as applying lidocaine to the vulva prior to the test.

Chorionic Villus Sampling (CVS). This test detects chromosomal abnormalities by analyzing the genetic makeup of cells taken from the chorionic villi, the tiny fingerlike projections on the placenta. It is usually done between the 10th and 13th weeks of pregnancy and is 99 percent accurate in detecting hundreds of genetic disorders and chromosomal abnormalities, such as sickle cell anemia and Down syndrome. Typically, it is offered only to women who are at an increased risk of having a baby with a chromosomal abnormality, such as women who are over 35, have a family history of birth defects, or have had a previous pregnancy with chromosomal abnormalities. CVS can be done either transcervically (most common method) or transabdominally. The transabdominal method involves inserting a needle into the abdomen. In the transcervical method, the provider will thread a long, thin tube through the vagina and cervix into the placenta. Using ultrasound as a guide, the provider extracts a sample of the chorionic villi. If you are considering CVS, ask if it can be performed transabdominally. Of course, this decision depends on which method is safest in your case. If it cannot be done that way, you will have to decide whether to undergo a transcervical CVS. In doing so, you should weigh your desire to be informed of your baby's condition against the risk of miscarriage from the test and the pain it may cause. Ask your health care provider about the potential risks of this procedure.

Group B streptococcus (GBS) screening. The American Academy of Pediatrics and Centers for Disease Control (CDC) recommend that all pregnant women be screened for GBS between the 35th and 37th weeks of pregnancy. Providers test for GBS by swabbing the area around the vagina and rectum and examining it for the bacteria. GBS can be found in the vaginas of healthy women (up to 25 percent of pregnant women test positive) and causes no harm to the mother. A newborn baby, however, can pick it up during labor and become infected, increasing the potential for developing pneumonia, meningitis (an inflammation in the brain) or sepsis (a blood infection).[viii] Although the test may be painful for some women with vulvodynia, it is an important one. If you are unable to tolerate pelvic exams, talk to your provider, who may prescribe

antibiotics during labor even if you haven't had the test. If you don't have a positive GBS test result, however, your insurance company may refuse to pay for the antibiotics.

Your Changing Body

In addition to concern about the body changes all women experience throughout pregnancy, many women with vulvodynia are understandably anxious about how it will affect their pain condition. No studies have examined whether vulvodynia becomes more severe over the course of pregnancy. Some vulvodynia experts who practice obstetrics have said that vulvar pain doesn't usually change much during pregnancy. That said, they do acknowledge that symptoms can either improve or worsen in some women.

Below are some pregnancy-related changes that may affect your vulvodynia.

Pelvic Pain and Comfort Measures. As your pregnancy progresses, the increased weight of the baby will put additional pressure on your pelvis. In addition, hormones, particularly relaxin, soften and relax the muscles and ligaments to accommodate your growing uterus and open the pelvis in preparation for childbirth. Some women experience spasms of the muscles that support the pelvis, and this may affect women whose vulvodynia is associated with pelvic floor muscle or sacroiliac joint dysfunction. You may feel pressure in your pelvis, back pain, or both. Additionally, you may experience sharp, stabbing pains in the middle of your pelvis, or "pins and needles" in the cervix. These sensations may feel different than your vulvodynia, or may result in a flare-up of your prior symptoms. If you experience pelvic discomfort, ask your provider about pain relief measures. These may include chiropractic manipulation, physical therapy or massage therapy with clinicians who have experience treating pregnant women.

Some women develop varicose veins in the vulvar area, in addition to those commonly seen in the legs. Pregnancy hormones relax the walls of your veins, causing them to expand so they can accommodate extra blood volume. When veins accumulate extra blood in or near their valves, they may bulge. Varicose veins are harmless, but can be very uncomfortable during pregnancy. They usually subside within a few months after delivery. Do not vigorously massage varicose veins, because you can cause a blood clot.[ix] To ease the discomfort of varicose veins in the legs, you can wear specially designed support stockings; ask your health care provider for advice. For vulvar varicosities or pelvic discomfort, many maternity clothing stores sell belly-support belts, which are designed to take the pressure of the baby's weight off your pelvis. For extra support, you also can try wearing snug-fitting (non-maternity) leggings, with the waistband placed below your belly.

Increased blood volume in the vulvar area also can cause engorgement of the genitalia, which can be painful. If you experience painful pelvic varicosities or genital engorgement, you can try elevating your pelvis by lying down and placing a pillow under your hips. Alternately, you can lie on the floor with your legs up a wall. Scoot your buttocks as close as you can to the wall before lifting your legs, and place a pillow or folded blanket under your hips. This position also can provide relief for varicose veins or swelling in the legs. Come out of the position if you become dizzy or light-headed, and be sure to roll onto your side before attempting to stand up.

If your vulvar pain continues or flares up during pregnancy, remember the non-drug comfort measures that have worked for you in the past. (To view a list of self-help tips, visit http://www.nva.org/Self_Help_Tips.html.) Extra pounds can put more pressure on the pelvis and varicose veins, so try to stay within the weight-gain limits recommended by your health care provider.

Vaginal Health. Vaginal secretions may increase considerably during pregnancy, appear bluish-violet in color and take on a thicker consistency. Tell your health care provider if the discharge contains blood, turns watery, or has a foul odor, because it may represent an incompetent cervix or leakage from the water bag. A pus-like, yellow, green, cheesy, or foul-smelling discharge may be the sign of a yeast or bacterial infection.[x] Pregnancy makes the vagina warmer, moister and sweeter, all of which increase the growth of yeast, the most common type of vaginal infection during pregnancy. If you think you have an infection, resist the temptation to self-diagnose and see your provider, because many women misinterpret the normal increase in vaginal discharge during pregnancy as a yeast infection. *Do not self-medicate during pregnancy.*

In the first trimester, most physicians prefer to treat a yeast infection externally for symptomatic relief only. If drugs are absolutely necessary, using older medications with a long history of safety is preferred. Neither oral Diflucan (a Category C drug) nor Ancobon (flucytosine) should be used during pregnancy. Because terconazole (vaginal suppository/cream or a topical cream) is absorbed systemically, it is generally not used in the first trimester, and is used later in pregnancy only if simpler agents fail. Self-help remedies to battle yeast include cutting down on sugar in your diet, eating yogurt or taking oral acidophilus tablets or powder (check with your health care provider first), and washing off the discharge with a handheld showerhead. Again, consult with your health care provider before using any oral/topical prescription or over-the-counter medication or supplement while pregnant.

Preparing for Childbirth
As you enjoy the pleasures of pregnancy and cope with some discomforts, don't forget the things you need to do to prepare for the birth of your baby. You should decide what type of childbirth class you want to take and sign up early. For information on different types of childbirth classes, see www.pregnancy.about.com/od/childbirthclasse1/p/cbeclasses.htm. Also, consider whether you want to write a birth plan and/or use a doula. All of the above can help you mentally prepare as well. Some providers believe that using perineal massage and/or Kegel exercises during the last weeks of pregnancy can help minimize trauma to the perineum. Although there are no guarantees, you may want to consider using these techniques.

Perineal massage. Some practitioners recommend perineal massage to prepare the tissue for birth and prevent tearing or the need for an episiotomy, but studies have shown varying results. The perineum is the area between the vulva and the anus. There are natural changes in the vulvar, perineal and vaginal tissues at the end of pregnancy, which allow more stretch during birth than would be possible even a few days before or after. Many women with vulvodynia have pain only with touch, or that is exacerbated by touch, so they would find perineal massage painful. If it is not uncomfortable for you to do, it may be reassuring. The possible advantage, however, is not sufficient to justify any significant discomfort.

To perform perineal massage, wash your hands (or have your partner do so if he will be performing it). Lubricate your thumbs with the same lubricant you use for intercourse and insert it just inside your vagina. (Do not use baby oil, mineral oil, petroleum jelly or hand lotion, which are less well absorbed by the body than vegetable- or water-based products.[xi]) Press downward (towards the rectum) and slide your thumbs across the bottom and then up the sides of the perineum. Continue for 10 minutes. Repeat daily from the 34th week of pregnancy until delivery. Your provider may perform this technique during labor as you begin to push the baby out. During labor the tissue will stretch much more easily, and if there is sufficient time, possibly enough to prevent tearing or the need for an episiotomy.[xii]

Kegel exercises. During pregnancy, pelvic floor muscles may sag due to the increased weight of your uterus and the relaxing effect of the pregnancy hormones. In general, many physicians recommend practicing these pelvic floor contractions before the birth to condition the muscles, improve circulation to the perineum and provide better support for the uterus and other pelvic organs. Some women with vulvodynia have pelvic floor muscle dysfunction, however, and Kegel exercises may be contraindicated for them, since they can exacerbate pain or lead to increased muscle spasm. Speak to your health care provider before beginning a regimen of Kegel exercises during pregnancy.

Birth Plan. Writing a birth plan can help you focus on what is most important to you about your baby's birth. Of course, every pregnant woman's first priority is to have a healthy baby. As a pregnant woman with vulvodynia, your next priority may be to avoid anything that might exacerbate your pain. Due to a lack of research, health care providers do not have a specific protocol for the best way to approach labor and delivery when the mother has vulvodynia. After educating yourself about childbirth and talking to your provider, you will be able to form your own opinion about what approach is best for you. A birth plan is the best way to articulate this approach. Once agreed upon with your provider, it can also help you communicate your wishes to the hospital or birthing center staff. Although your provider should be familiar with your medical history by the time you go into labor, the nurses or other birth attendants will not know you have vulvodynia unless you tell them. Once you are in active labor, you may not be able to communicate as effectively as you want. After you have written your birth plan, show it to, and discuss it with, every doctor and nurse in the practice you use for your prenatal care. If you decide to use a doula, you should also give her a copy, and be sure to bring it with you to your hospital or birthing center. (For help in creating a birth plan, visit www.birthplan.com.)

Doula. From the Greek word for "woman's servant," a doula has no medical training. Instead, she provides companionship and moral support, and can act as an advocate for the parents. She can run interference with the hospital staff, allowing the woman's husband or partner to remain by her side. She can help a woman keep her birth wishes in perspective when the unexpected occurs, instruct her in labor comfort measures, answer questions and help her relax. Although she does not give medical advice, she can explain the doctor's suggestions. Studies have shown that women who are supported by a doula had shorter labors and were less likely to need a Cesarean (8% in the supported group vs.18% of non-supported mothers), forceps or vacuum extraction, or epidural anesthesia; these women were also less likely to need an episiotomy and had fewer perineal tears.[xiii] Before choosing a doula, ask about her training and certification. If possible, interview two or three people, either in person or on the phone. Ideally, look for one who lives near the hospital where you will deliver and has worked with your obstetricians before. If you don't interview prospective doulas in person, be sure you and your partner meet with her before the birth to review your birth plan and discuss your preferences and the role she will play in supporting you through childbirth. If you cannot afford the services of a doula, consider asking a close friend or family member, preferably one who has given birth and agrees with your childbirth preferences, to attend the birth. (For more information, and to locate a doula in your area, visit www.dona.org.)

Section IV: Labor and Childbirth

In consultation with your health care provider, you may choose either a vaginal delivery or a Caesarean birth, known as a C-section. “Should I have a C-section?” is typically the first question a pregnant woman with vulvodynia asks her provider. In many cases, surprisingly, the answer is, “Having vulvodynia is not, in itself, a reason to choose a C-section.” Many women assume that vulvodynia sufferers should do everything possible to avoid trauma to the vulvar area, but a vaginal birth does not automatically lead to exacerbation of symptoms, or if a woman is pain-free, to the return of symptoms.

There is no research outcome data on women with vulvodynia who have had vaginal births, but some experts say it is unusual for a permanent increase in vulvar pain to occur. It is even possible that having a vaginal birth may decrease future pain with sex, because the muscles surrounding the vaginal opening are stretched during delivery, and the vaginal opening itself may be larger.

Cesarean Birth
A C-section is major surgery in which the newborn is delivered through an incision in the mother’s abdomen. Compared to other major surgeries, C-sections are very safe, but there are also some risks, including possible infection in the uterus, pelvic organs or abdominal incision; blood loss; blood clots; or injury to the bowel or bladder.[xiv] Women who deliver by C-section face longer hospitalization and recovery time, while dealing with the universal challenges of the postpartum period. In addition, dryness and atrophy of the vagina due to estrogen suppression during breastfeeding are more likely to be problematic for women who deliver by C-section. A vaginal delivery stretches the vaginal walls, which helps to counterbalance the typical tightening of the vagina that occurs during breastfeeding. This tightening may make tender, fragile vaginal tissue more uncomfortable and add to the discomfort already experienced by women with vulvodynia.

On the other hand, when C-sections are necessary, they can save lives. Situations in which a C-section may be necessary include, but are not limited to, a breech presentation (buttocks- or feet-down), placental abruption (the placenta tears away from the wall of the uterus), or a pinched or compressed umbilical cord.[xv] In these situations, the benefits of Cesarean delivery far outweigh the potential risks. Note that none of these precipitating causes have any relationship to vulvodynia.

Most of the topics discussed below apply to women who intend to have a vaginal delivery, but it should be noted that some women plan a vaginal birth and ultimately need a C-section at some point during labor.

Medicated vs. Unmedicated Labor
The first major issue facing a woman who intends to have a vaginal delivery is whether to rely on anesthesia or proceed with unmedicated labor. This decision should be your choice, because no one knows your pain tolerance better than you. Before making a decision, you should educate yourself about the pros and cons of each option and how those factors might affect you. It is perfectly normal to be anxious about the pain of childbirth and it is highly recommended that you discuss your options with your provider. Once you make a decision, however, the matter should not be considered completely closed. During labor and delivery, it is best to keep an open mind about pain control and other procedures. There is no way to anticipate how difficult or long your labor will be, or how fatigued you will become. Deciding that there is only one acceptable way to labor and deliver your baby can set the stage for disappointment. There is no "right" or "wrong" way to have a baby, and even if you end up following Plan B, C or D, remember that you've still given yourself and your child the best possible birth.

For women with vulvodynia, there are two schools of thought on pain relief during labor and delivery. The first approach is to ensure that the vulvar area is as "numb" as possible to avoid any additional discomfort during labor and delivery. If you can't tolerate vaginal exams because of pain, you will also want to eliminate the pain of exams during labor. One way to accomplish this is to use a regional anesthetic, such as an epidural. The other option is to reduce the number of, or entirely eliminate, vaginal exams.

The alternate viewpoint on anesthesia is that it can stall labor, and when labor progresses slowly or is stalled, it is more likely that your health care provider will need to intervene with forceps or vacuum extraction. These interventions may cause trauma to the perineum (area between the vagina and anus). There is also concern that an epidural or other type of regional anesthesia will make the perineal muscles limp, increasing the chance that an episiotomy may be necessary.[xvi] Some women, particularly those struggling with vulvar pain on a constant basis, may simply not want to experience any more pain than is absolutely necessary. For these women, an epidural or other pain relief method during labor and delivery is generally the best choice.

Medications for Pain Relief[xvii]
Even if you hope to have an unmedicated birth, you should educate yourself about the various medical options for pain relief during labor. Again, there is no way to anticipate how long your labor will last or how difficult it will be. Once you request pain relief, an anesthesiologist will determine which type of anesthesia is right for you.

The methods for administering anesthesia include:

Epidural. Probably the most common form of labor anesthesia, this involves the insertion of a catheter into your lower back, in the epidural space near your spine, and it removes most feeling from the lower half of your body. With each contraction, you feel pressure, rather than pain. Although you can still move once the epidural is in place, you are not allowed to walk around.

Walking epidural. This form of epidural anesthesia uses a lower dose and a different mix of medications. Unlike a regular epidural, it does not diminish sensation or motor function, allowing you to walk around. In the opinion of some doctors, this is the ideal pain medication during labor for women with vulvodynia because it gives pain relief without loss of muscle power for the first two to four hours. After that, the infusion of anesthetic through the catheter keeps you comfortable. The dosage of medication can be adjusted during the pushing phase to allow for better control over the speed of delivery. Unfortunately, walking epidurals are not available at many hospitals, because they require the skill of a specifically trained anesthesiologist.

Systemic analgesia. These medications act on the entire nervous system. They include sedatives, hypnotics, amnesics, tranquilizers and narcotics. As with any drug, systemic analgesia may cause side effects, such as drowsiness, stomach upset, or difficulty focusing. Risks to the baby include respiratory depression, impaired sucking ability, changes in fetal heart rate, and a drop in body temperature.

Caudal block. This type of anesthesia is administered into the caudal canal, which is near the top of the buttocks. It numbs the abdomen, back, buttocks, perineum and legs, and carries some of the same risks as an epidural. It is used less often than an epidural.

Pudendal block. An anesthetic is injected through the wall of the vagina into the area surrounding the pudendal nerve. It is given shortly before delivery to block pain in the perineum. A pudendal block is one of the safest forms of anesthesia, but is not always effective, therefore it is rarely used.

Spinal block. A spinal block is an injection of anesthetic into your lower back that numbs the lower half of your body. It is similar to an epidural, except that it lasts only an hour or two. Once the injection is given, you have to stay in bed. It causes total numbness and prevents the muscles used to push the baby out from working. This type of block is often used for Cesarean delivery, or when interventions such as forceps or vacuum extraction are necessary.

Saddle block. Similar to a spinal block, a saddle block numbs only your buttocks, perineum and vagina. It is usually administered via catheter between the third and fourth lumbar vertebrae in your lower back, and is only occasionally used for vaginal birth.

Paracervical block. This block is administered via two injections into the cervix, numbing the area and lower segment of the uterus. It is rarely used due to the possible adverse effects on the baby, such as marked slowing of the fetal heart rate.

Local anesthesia. A local anesthetic is injected into the vulvar skin and perineal muscle to numb a small area. It is often used to numb the perineum before an episiotomy is performed or for repairing an episiotomy or tears after childbirth.

General anesthesia. This form of anesthesia causes loss of consciousness, i.e., puts you to sleep. It is administered through an IV, inhaled through a mask, or both. Usually, it is used either for an emergency C-section or a C-section in which an epidural isn't safe.

Inducing Labor[xviii]

Using medications or interventions to start or speed up labor is called induction. In most cases, providers induce labor to protect the health of the mother or baby if a woman is more than 42 weeks pregnant, has pregnancy-related high blood pressure, develops a uterine infection or doesn't go into labor within a certain time after her water breaks. There are several labor induction methods, the most common of which is an IV injection of Pitocin, a hormone that your body produces during labor. If you cannot tolerate pelvic exams, Pitocin is the most desirable method, because it does not involve access through the vagina. It is often used in combination with a prostaglandin gel that is applied to the cervix. It should be noted, however, that depending upon the dosage given, Pitocin can cause labor to progress rapidly, risking perineal tearing. It also makes contractions stronger and faster, which means you will probably need an epidural for pain, even if you had not planned on having one. If you need to be induced with Pitocin, ask your doctor to start with the lowest dose possible and take you off the IV once contractions are regular. Ideally, but not always, the contractions will then progress on their own.

If Pitocin is not an option, there are other labor induction methods, both of which involve vaginal access. In one method, the provider inserts a gloved finger through the cervix and sweeps it over the thin membranes that connect the amniotic sac to the uterine wall, causing the body to release hormones that ripen the cervix and cause contractions. This technique is relatively non-invasive, but has a low success rate. Alternately, the provider may artificially rupture the amniotic sac by making a small

hole in it with an instrument that looks like a knitting needle. This will usually start contractions or make them stronger.

You can try to induce labor naturally by taking long walks or having sex. Long walks may help, but are better for keeping labor going than starting it. Orgasm causes contractions of the uterus, and the prostaglandins in semen act directly on the cervix. Many couples have boasted of going into labor after engaging in intercourse. Do not engage in intercourse, however, if your water has already broken, as this may risk infection. If you want to try to induce labor on your own to avoid a medical induction, ask your health care provider for some recommendations.

Labor and Delivery

After arriving at the hospital or birthing center, your health care provider will perform a vaginal exam to determine how much the cervix has dilated and check the presentation (head or buttocks down) and position of the baby. Dilation, or the opening of the cervix, is measured in centimeters, from 0 (no dilation) to 10 (fully opened). The cervix must be fully dilated before you can push the baby out. Station is the measurement of where the baby is in relation to the pelvic cavity, from –5 (the baby is floating above the pelvis) to 0 (the baby's head has dropped into the pelvis) to +5 (the baby's head is crowning, or at the vaginal opening). This exam will be repeated just before the pushing phase of labor and possibly again during the course of labor and delivery. Some proponents of intervention-free childbirth claim that these exams are unnecessary and can even increase the risk of infection. If you cannot tolerate pelvic exams, talk to your health care provider about the possibility of reducing the number of exams during labor and delivery. If they cannot be eliminated, a regional anesthetic can be given during labor to lessen discomfort.

There are three stages of labor: first-stage (the cervix dilates to 10 centimeters), second-stage (pushing) and third-stage (delivery of the placenta). The active phase of first-stage labor, in which the contractions are three to five minutes apart and last about 60 seconds each, may last many hours. At this stage, the cervix is likely to be 100 percent effaced (completely thinned) and 5 to 8 centimeters dilated. Then you will enter what is called "transition," the end of first-stage labor. Transition is the most difficult phase of labor, because contractions are now one to three minutes apart, lasting 60 to 90 seconds. (Contractions usually start off mild, intensify to a "peak" and then become milder). Many women describe this phase as "relentless" or "overwhelming" due to its intensity. Although it is challenging, it is normally brief, as your cervix finishes dilating (from 8 cm. to 10 cm.) in as little as 15 minutes, and usually no longer than 1½ hours.

Once the cervix has completely dilated, it's time to push. The first few urges to push may take you by surprise, prompting you to tense your pelvic floor muscles, which is likely to cause pain. It is best to keep the pelvic floor muscles relaxed as the urge to push begins. At this

point, light breathing or panting, and relaxing the perineum are helpful. Slowing the process of pushing the baby out gives the perineum more time to stretch, decreasing the chance of perineal trauma or laceration. Prolonged forceful pushing should be reserved for times when the baby is in distress and interventions are being considered. Some women, including those without vulvodynia, experience a tingling, stretching, burning or stinging sensation as the baby's head crowns, i.e., reaches the vaginal opening. Some women refer to it as a "ring of fire." The pain can be very intense and result in an overwhelming urge to push the baby quickly, but it is still best to ease the baby out gently, if possible. Pushing slowly through contractions when the newborn's head crowns makes it less likely that an episiotomy will be necessary. Some birth attendants massage the perineum at this stage to assist gradual stretching, or maintain steady pressure on the baby's head to keep him/her from coming out too rapidly. Some health care providers will perform an episiotomy at this point. Once your perineum is fully stretched, the pressure naturally numbs the perineum because blood flow to the area is restricted, and the burning will decrease or stop. Lying on your side or remaining upright is preferable because it will decrease pressure on your perineum and allow for maximum stretching.[xix]

Fetal Monitoring

Fetal monitors assess a baby's health status during labor by measuring the response of his/her heartbeat to your contractions. If you deliver your baby in a hospital, you may be monitored at regular intervals, e.g., for 15 minutes once an hour. Most often, it is done using an external fetal monitor, which is a wide belt with two instruments attached; an ultrasound transducer measures the fetal heartbeat and a pressure-sensitive gauge measures the intensity and duration of contractions. These instruments are connected to a monitor that delivers a printed reading.

If there is a reason to suspect fetal distress, the hospital staff may connect you to an internal monitor, which requires attaching an electrode to the baby's scalp to measure its heartbeat. Because there are some slight risks, such as infection, rash or abscess on the baby's head, internal monitoring is used infrequently, only when its benefits outweigh the risks. The use of an internal monitor requires access to the uterus via the vagina and cervix and the procedure may be uncomfortable, or even painful, for a woman with vulvodynia who has not received an epidural or other regional anesthetic. A much newer medical device, the OxiFirst fetal monitor, is a thin probe inserted through the cervix and next to the baby's cheek or temple that measures its blood oxygen levels. It is used in situations where the fetal heart monitor reading is difficult to interpret or is "non-reassuring." With this device, a more accurate decision can be made as to whether labor should continue or a C-section is needed. Again, if pelvic exams are painful for you and you have not received a regional anesthetic, the use of this instrument may also be painful.

Intact Delivery and Perineal Trauma
The prospect of an episiotomy or laceration occurring during delivery is a common cause of anxiety for women with vulvodynia as they approach their due date. If you're feeling this way, you should talk to your health care provider.

There are three possible scenarios involving the perineum during a vaginal birth: intact perineum, spontaneous tearing, and episiotomy. Tearing is described in terms of degrees: a tear of the superficial tissues without injury to the surrounding muscle (1st degree), a rupture of the perineal skin (2nd degree), vaginal and rectal tissue (3rd degree) and anal sphincter (4th degree). Episiotomy is a surgical incision of the perineum performed to enlarge the vaginal opening as the perineum stretches. It also is described in terms of degrees: the incision can be through the skin layer only (1st degree), skin and muscle (2nd degree), skin, muscles and the rectal sphincter (3rd degree) or involve the skin, muscle, rectal sphincter and anal wall (4th degree). Second-degree episiotomy is the most common and 4th degree is the least common. In addition, there are two primary types of episiotomies: median and mediolateral. Most health care providers prefer the mediolateral, which slants away from the rectum. A median incision is made in a straight line toward the rectum, but is used less frequently because it poses a greater risk of extending completely to the rectum.

Clearly, the ideal scenario, for women with or without vulvodynia, is to leave the delivery room with an intact perineum. There is no research data specifically on women with vulvodynia, but studies of women in general have shown that postpartum pain is lowest among those who give birth with an intact perineum. Unfortunately, intact delivery with vaginal birth is not always possible.

During the pushing phase of labor, your health care provider will either attempt to stretch your perineum using perineal massage or will perform a routine episiotomy (as opposed to an elective episiotomy). Women describe the sensation of being stretched as "uncomfortable," rather than painful. Perineal massage during birth is a bit different than the perineal massage that you may practice during the last weeks of your pregnancy. Natural changes in the vulvar, perineal and vaginal tissues allow more stretch during birth than would be possible even a few days before or after. Perineal massage does not, however, guarantee intact delivery. It can take 15 minutes or more of massaging before the tissues stretch and often the perineum doesn't stretch enough before the baby is born. Sometimes, it appears that the tissues have stretched enough, but an unpredictable position of the baby, such as an elbow sticking out, causes a spontaneous tear. Studies have found that approximately 50 percent of women who do not have an episiotomy will spontaneously tear and 50 percent will not.

For many years, it was standard practice for providers to perform a routine episiotomy, because they thought it reduced the risk of significant tearing, pain, urinary and fecal incontinence, and pelvic floor defects. In 2005, however, a review of the medical literature found that the benefits traditionally attributed to episiotomy were non-existent and that the procedure actually increased the risk of severe tearing, pain with intercourse, incontinence and other pelvic problems after delivery.[xx] Research also has shown that when episiotomies are performed, the incisions are almost always larger than the tearing incurred without an episiotomy.Today, many providers do not perform routine episiotomies, but they may still choose to do an elective episiotomy if fetal distress occurs and time is of the essence.

There is no research data on how episiotomies or tearing affect women with vulvodynia. While some providers think that any new scar may be a focus of tenderness, others contend that there is no reason to think that either an episiotomy or spontaneous tear will increase vulvar pain after childbirth. You should talk to your provider about the likelihood of having an intact delivery and express a preference for massage over episiotomy, assuming there is sufficient time.

Forceps and Vacuum Extraction
Forceps or vacuum extraction is used in about 10 percent of vaginal deliveries to speed up delivery when the baby is in distress, or to turn the baby when its position makes delivery more difficult. These procedures also may be used when either pushing has not lead to progress in the baby's descent, or a long period of pushing has left the mother exhausted.

To perform a forceps extraction, two spoon like instruments are inserted into the vagina and applied to each side of the baby's head. The provider turns and/or pulls on the handles to help the baby out of the birth canal. This procedure requires that an episiotomy be performed first and that regional anesthesia be administered. The risk involved is that forceps delivery can tear the vagina or cervix. Research has found that delivery with forceps is associated with a 10-fold increased risk of perineal tissue injury compared to deliveries without the use of instruments. If the baby is in distress and a forceps delivery is being considered, you can request vacuum extraction instead, but the final decision rests with the provider, who is ultimately the best judge of which procedure is the safest.

In a vacuum extraction, a caplike device is applied to the baby's head and a rubber tube extends from the cap to a vacuum pump that creates suction on the head. This procedure may require an episiotomy. Although vacuum extraction also can tear the vagina or cervix, it is less likely to do so than forceps extraction.

The First Few Hours After Childbirth
After your newborn arrives, you must pass the placenta, which usually takes between 10 and 30 minutes. Massaging the uterus and/or nursing the baby during this time can sometimes help speed up the process. Once the birth is complete, your provider will clean the pelvic area by pouring water over it and then will check to see if you have any tears that need to be repaired. If stitches are necessary and the delivery was unmedicated, a local anesthetic can be given to numb the area.

Once complete, a nurse will lead you to the bathroom to urinate. If you cannot do so, she may want to insert a urinary catheter, which you may find uncomfortable if you did not receive a regional anesthetic or if the medication has worn off. Ask about measures to relieve the discomfort of catheter insertion, such as applying a numbing solution to the urethral opening. The nurse will provide a plastic, squeezable bottle of water with holes in the top, which you can use to rinse, rather than wipe the vulva after urinating. You can request a stool softener, such as Colace, to ease bowel movements, which helps reduce straining of the already tender perineum.

After urinating, you will return to your bed and the nurse will provide you with the first of many disposable ice packs. You can apply these cooling packs to the perineum and vulva, on and off, for two to three days. After this initial period, a regimen of warm sitz baths begins. The hospital may provide a sitz bath that fits over a toilet seat or you can purchase one at a medical supply store. Alternatively, a clean bathtub filled with lukewarm water works fine. You can continue sitz baths as long as they are helpful. The nurse also may provide a numbing spray, such as Americaine (also available at drugstores), which helps numb the tender perineum. Ask your provider whether this spray, and other topical treatments, may exacerbate your vulvodynia symptoms, and what other modalities are recommended.

After vaginal delivery, vulvar swelling, soreness and/or bruising are common. The nurse will offer Tylenol, Motrin or a mild narcotic to ease this pain. If you developed hemorrhoids while pushing the baby out, using Tuck's pads (which can be stored in the freezer), along with a prescription cream or over-the-counter ointment such as Anusol, should help them heal. Again, talk to your provider if you are concerned that these preparations might affect your vulvar pain.

You should expect to feel very tired after childbirth. Once you've had the opportunity to start breast- or bottle-feeding your baby, you should try to get some rest. Your baby will fall asleep after a few hours and it's a good idea for you to get as much restorative sleep as you can before leaving the medical center, or if you delivered at home, before your aide leaves.

Section V: Postpartum and Recovery

The first six weeks after your baby's birth, often referred to as the postpartum period, is a time for your body to heal and return to its pre-pregnant state, and for you and your partner to adjust to your new life with your baby.

Before your due date, arrange to have a family member or friend help you at home once you return from the hospital or birth center. If your partner is able to cook, clean, do laundry and shop for groceries, the two of you may be able to tackle the early postpartum challenges on your own. If your partner is unable to take time off from work, or if there are older children in your home, you will need the support of someone outside your immediate family. Don't be afraid to ask for help—other mothers are often willing to assist. You can also consider hiring a visiting nurse or postpartum doula for the first few weeks. Both are able to provide education and support, assist with newborn care and family adjustment, and help with cooking and housekeeping. (For more information, or to locate a visiting nurse or postpartum doula, visit www.vnaa.org or www.dona.org.) Your rest is important not only for your physical and mental health, but also for your ability to care for your new baby.

In addition to lack of sleep, the many challenges of caring for a new baby will cause fatigue. Sleep when the baby sleeps so that you can get enough rest. Your goal should be to get as much total sleep in a 24-hour period as you normally got each night before your pregnancy. Resist the temptation to "get things done" around the house – this can wait. If a constant stream of visitors keeps you from getting the rest you need, politely decline requests to see the new baby until you feel better.

Stay off your feet during the early days and weeks. Long periods of standing may cause your pelvic floor muscles, which have recently been stretched to their maximum, to go into spasm. Give them a chance to rest too. Organize the items you need to care for the baby—diapers, wipes, burp rags and bottles—so that they are within arm's reach. Ask someone to bring meals to you. After a while, you may get tired of staying in the house. Ease into your new routine gradually. (Most pregnancy books contain sections on resuming general activities and exercise in the postpartum period.)

Your health care provider may recommend that you continue taking your prenatal vitamins during the postpartum period, or longer if you are breastfeeding. Continue to eat healthy foods and drink plenty of water as you did during pregnancy. Do not try to lose those excess pregnancy pounds too quickly. Most women shed the weight gradually without going on a diet. If you choose to diet, providers recommend that you lose no more than one to two pounds per week.

Physical Changes and Healing
In the first days and weeks after your baby's birth, your body will undergo a number of dramatic changes. Within five to six weeks after birth, your uterus returns to its pre-pregnant size, helped along by contractions known as afterpains. They can be more painful while breastfeeding, but usually subside within the first week. Your hormones also must do an about-face before your body returns to normal. This shift can cause both physical and emotional changes. Knowing what to expect is your best tool for handling any discomforts.

Lochia and Resumption of Menstruation
For the first six to eight weeks postpartum, you will experience a bloody discharge from the uterus called lochia. Stock up on sanitary pads. (You should not use tampons during the first few weeks after delivery.) The bleeding will be very heavy for a few days, and then slowly taper off. It may contain clots and/or mucus, and become pink, then yellowish, white or brown in color. If it briefly becomes heavier after a period of tapering off, it's probably your body's way of telling you to slow down and stay off your feet. (The amount of lochia can change with your activity, when you change positions, or during breastfeeding.) Your body accumulated extra blood during pregnancy, so do not be alarmed by what seems to be an "endless period."

Heavy bleeding that is difficult to stem may be the sign of a postpartum hemorrhage, however. If the bleeding saturates more than one pad an hour for more than a few hours and doesn't taper off with rest, is extremely bright red after the first week postpartum, or if you see large (bigger than a plum) clots in your flow, call your health care provider.

If you are breastfeeding, menstruation may not resume until after you have weaned your baby. If you bottle feed, it will probably start four to eight weeks after delivery. Ovulation can occur before your period starts again and you can get pregnant during this time, so be sure to use birth control if you engage in intercourse. Breastfeeding is not a form of birth control.

Fluid Loss and Elimination
You also will lose the extra fluid you gained during pregnancy by either urinating frequently or perspiring. This fluid loss will only last a few days at most. At first, urinating may be difficult because of weak muscles or soreness around your urethra. Drink plenty of water or pour warm water over your perineum. You may experience some urinary incontinence, caused by stretching of the pelvic floor muscles during delivery or you may become constipated. Eat fresh fruits, vegetables and whole grains, and drink plenty of water to restore normal bowel function. You can support your perineum during a bowel movement by gently pressing toilet paper against it when bearing down. You also can use a stool softener, such as Colace.

Pelvic Pain and Perineal Care
Most women, with or without vulvodynia, experience some degree of frustration with the healing process after delivery. Remember that it can take six weeks or more for your perineum to heal and even longer for your pelvic floor muscles to regain tone. Vulvar varicosities and hemorrhoids also take time to heal. Whether or not you suffered perineal trauma during delivery, your pelvic area will feel sore because the muscles have been stretched (and even bruised) considerably.

You may feel anxious and wonder whether your vulvodynia will improve, stay the same, or get worse as a result of childbirth. You may start to over-analyze every little twinge of pain or spasm of the pelvic floor muscles. Try not to worry. Remember that women without vulvodynia experience the same discomforts during the postpartum period and each woman heals at her own pace. Only after you heal will you be able to evaluate your vulvar pain. In the meantime, use a donut-shaped pillow to avoid discomfort when sitting.

You will have to care for your perineum, especially if you have stitches from tearing or an episiotomy. You can use sitz baths with cool or lukewarm water for as long as you feel they are helping. If you do not have one, you can sit in a clean bathtub with warm water for 20 minutes three times a day. Then lie down for 15 minutes or more to reduce swelling.

After urinating, use a peri bottle to rinse the vulva instead of wiping. Once you are able to wipe normally, don't forget to wipe from front to back to prevent infecting your perineal tissue, and change your maxi pad at least every four to six hours. Do not use a douche for the first six weeks postpartum. For continued pain, use a cold pack wrapped in a towel for 20 minutes. Talk to your provider about whether you should use witch hazel, often prescribed for hemorrhoids, to relieve perineal soreness, and Tucks pads for the discomfort of hemorrhoids.

At first, you will have no control over your pelvic floor muscles. Talk to your provider about whether Kegel exercises are appropriate for you. These exercises can help heal your episiotomy or tearing, reduce swelling by increasing circulation, and help restore pelvic floor muscle tone.[xxi] Some women with vulvodynia have pelvic floor muscle dysfunction and Kegel exercises may be contraindicated for them. Your vagina will slowly regain its tone, but your labia may be looser, larger and darker than they were before your pregnancy.

Emotional Changes
Due to the dramatic change in hormone production that occurs following birth, you may experience the "baby blues" – sadness, crying, irritability and/or anxiety is experienced by 60 to 80 percent of new mothers during

the early postpartum period. All of these feelings are normal. However, if your symptoms are more serious, you may be suffering from post-partum depression (PPD), which affects 10 to 20 percent of new moms. Although PPD symptoms are similar to the baby blues, they are more distinct and include crying and irritability; sleep problems (insomnia or sleeping all day); eating problems (lack of appetite or an excessive one); persistent sadness, hopelessness or helplessness; lack of desire or inability to care for yourself or your newborn; and memory loss. PPD may begin immediately following the birth, or a month or two later. You are more susceptible to PPD if you've had it before, have a personal or family history of depression or severe PMS, spent a lot of time feeling down during pregnancy, or have a sick or difficult baby. If symptoms last more than a few weeks with no sign of improvement, contact your health care provider, who will likely test you for a thyroid dysfunction. If the test is negative, referral to a therapist and/or treatment with an antidepressant is in order. Don't feel guilty about contacting a health professional about this problem—your health and safety, and that of your newborn, may depend upon it.

Medications and Breastfeeding[xxii]

Like all the choices you made during pregnancy and preparing for birth, the decision whether to breastfeed or bottle-feed your baby is a personal one. Pediatricians and other experts usually recommend breastfeeding, whenever possible. If you used medication to control your vulvar pain before pregnancy, you may have concerns about resuming it while breastfeeding. Before making the decision to resume medication, give your body time to heal, especially if you have vaginal tearing or an episiotomy. Your hormones also need time to adjust before you can determine whether your vulvar pain has changed. In the meantime, if you want to breastfeed your baby, you should do so, and then switch to formula when you resume medications.

In general, medications taken by a breastfeeding mother reach the infant in small quantities through her breast milk. There are instances, however, in which even a tiny amount of a drug can harm an infant. Some drugs that are safe during pregnancy are not safe while breastfeeding, and vice-versa. Therefore, you should talk to your doctor before taking any prescription or over-the-counter drug while breastfeeding. This includes any medication you took before your pregnancy for vulvar pain or any other condition.

If your vulvar pain necessitates that you resume medication, continuing to breastfeed depends on which drug you are taking. Your provider may decide to reduce your dosage to an effective, but relatively safer level, or switch you to a safer alternative medication. Below are the types of drugs discussed in detail in Section II, with some comments on their safety during breastfeeding. Do not rely on this information alone; speak to your doctor or pharmacist before taking any medication while breastfeeding.

Tricyclic antidepressants
This group of medications passes into breast milk. The American Academy of Pediatrics (AAP) has classified tricyclics as drugs for which the "effect on nursing infants is unknown but may be of concern." The World Health Organization Working Group on Human Lactation estimated that two percent of the maternal daily dose of amitriptyline would be ingested by a breastfeeding infant, and concluded that breastfeeding while taking this medication is probably safe.

SSRIs
The AAP has classified SSRIs in the same manner as the tricyclics. A review of the literature on the amount of SSRIs found in breast milk concluded that the relative dose to the breastfed infant is lowest for Zoloft, somewhat higher for Paxil, and highest for Prozac. The maker of Prozac recommends that it not be used while nursing—it passes into breast milk at an amount equal to about 11 percent of the maternal dose. When the use of an SSRI is clearly indicated in a breastfeeding woman, scientific data generally indicates that the positive effects of breastfeeding outweigh the risks of pharmacological effects in the infant.

SNRIs
The SNRIs include Cymbalta, Effexor and Savella. A number of clinical studies have demonstrated that they pass into breast milk. Because of potential serious side effects for the nursing infant, SNRI manufacturers recommend that health care providers carefully weigh the possible risks and benefits before prescribing SNRIs to a woman who is breastfeeding.

Anticonvulsants
These medications may or may not be safe during breastfeeding, depending upon which source you check. It is not known whether Neurontin or Gabitril pass into breast milk. Tegretol, Dilantin and Depakene pass into breast milk, but their potential effects on the infant are unknown. Some sources state that Dilantin and Depakene are compatible with breastfeeding.

Muscle relaxants
Valium, Zanaflex and Soma pass into breast milk, but their effects on the breastfeeding infant are unknown. Soma passes into breast milk in large amounts and should not be used for that reason. The AAP has classified Valium as a drug "for which the effect on nursing infants is unknown, but may be of concern." Norflex and Flexeril have not been studied in pregnant or nursing women, but antidepressants with a similar chemical structure are known to pass into breast milk.

Narcotics and narcotic-like drugs
Ultram is excreted into breast milk in high concentrations, so mothers taking this medication should bottle-feed their infants. Darvocet is considered compatible with breastfeeding, but Percocet is not, because

withdrawal symptoms have been observed in breastfed infants after their mothers stopped taking it.

Topical medications
Topical drugs are less likely to make their way into breast milk than oral medications. Topical corticosteroids and creams, such as lidocaine, are considered compatible with breastfeeding. Some topical medications, however, may be harmful to a breastfeeding infant.

Oral contraceptives
Contraceptive hormones pass into breast milk and some of them reduce the amount of milk produced. Be sure to use some form of contraception, because you can become pregnant while breastfeeding.

Postpartum Checkup
Your health care provider will ask you to schedule a postpartum visit six to eight weeks after delivery. This checkup includes a general physical and a pelvic exam, as well as an opportunity to discuss any problems. You also should discuss future birth control options.

If any of the following occur, you should call your provider, rather than wait until your postpartum checkup: fever; burning with urination or blood in the urine; inability to urinate; swollen, red, painful area on leg that is hot to the touch (could be a clot in a blood vessel); sore, reddened, hot or painful area on breast(s), with fever or flu-like symptoms (could be a breast infection, such as mastitis); large clots (larger than a plum) or pieces of tissue in your lochia; foul odor of the vaginal discharge; increased pain at site of stitches; feeling depressed, unable to sleep or eat, or uncontrollable crying.

Resuming Sexual Relations
Although many practitioners still follow the “no intercourse for six weeks” rule for all postpartum patients, some say that sex can usually be resumed when the woman feels ready, often by four weeks postpartum. If you are concerned about your vulvar pain returning, however, especially if you had tearing or an episiotomy, it is prudent to wait until after your postpartum checkup. If you do choose to have sex in the first six weeks after your baby is born, be sure to use birth control, as many sources indicate that, due to residual pregnancy hormones in your system, you are especially fertile during this time.

You may experience pain and discomfort with intercourse for several months after the baby is born—about half of all women, with or without vulvodynia, do. This does not mean that your vulvar pain has returned, nor is it a result of having an episiotomy or tearing during delivery, or an indication that there is a problem with the repair of your episiotomy or

tearing. A 1999 study found that 45 percent of women experienced painful intercourse at the vaginal opening postpartum, but only six percent had pain at the sites of vulvar repair. The median length of symptoms in the women whose pain was not at the site of vulvar repair was 5 ½ months, one-third of whom experienced severe sexual dysfunction. The study also noted that 29 percent of the women experiencing pain at the vaginal opening had delivered by Cesarean.[xxiii] Don't be discouraged by any pain or increase in pain you experience at first; in most cases it is temporary.

If you are breastfeeding, estrogen suppression may cause vaginal dryness, increasing friction and discomfort. In additional to general self-help measures, a prescription estrogen cream may help—ask your health care provider. Your fatigue as a new mother also may diminish your interest in sex. Eventually, as you begin to feel more rested and stronger, your desire should return. You might try a little foreplay in the meantime to see if that sparks any interest. And, speaking of sparks, don't expect fireworks the first few times you make love after your baby is born. Many women do not experience orgasm for several weeks, or longer, after delivery. Be sure to keep the lines of communication open with your partner to share any fears or other concerns you may have. (For additional information on having a healthy sex life with vulvodynia, please visit: http://learnpatient.nva.org/maintaining_healthy_relationships_1.htm.)

Conclusion

We hope that this guide has been helpful, and that it has answered many of your questions about managing vulvodynia during pregnancy and childbirth. We encourage you to learn as much as you can about vulvodynia and its treatment by reading NVA's self-help guide, *I Have Vulvodynia – What Do I Need to Know?* You can also learn about the latest treatment and research developments by subscribing to NVA's newsletter. (Please see the back cover for more information on these resources.) You can also contact the NVA if you would like to connect with other women with vulvodynia who are pregnant or have already given birth.

Our final piece of advice is that you remain hopeful – there are many options and resources available to assist you in having children. Many women with vulvodynia have been pregnant and given birth without any worsening of their condition. Find the right health care provider for you and remember that you are an important member of your health care team.

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viii www.babycenter.com/refcap/pregnancy/prenatalhealth. Click on "prenatal tests" and then "Group B streptococcus screening."

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x Elizabeth Gunther Stewart, M.D. and Paula Spencer, *The V Book*, Bantam Books 2002; *The Pregnancy Book*, p. 155.

xi *Pregnancy, Childbirth and the Newborn*, p. 127.

xii *What to Expect When You're Expecting*, p. 330. For a list of the articles on perineal massage, see www.childbirth.org/articles/massageref.html. For a more detailed explanation of how to perform perineal massage, check any pregnancy book or web site.

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xvi *What To Expect When You're Expecting*, p. 353.

xvii Information on different types of pain relief during labor and delivery comes from *What To Expect When You're Expecting*, p. 279; *Pregnancy, Childbirth and the Newborn*, pp. 208-214; and *Planning Your Pregnancy and Birth*, pp. 187-192.

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xix *The Birth Book*, p. 224

xx Hartmann K, et al. Outcomes of Routine Episiotomy: A Systematic Review, *JAMA* 2005;293:2141-2148; Viswanathan M, et al. *The Use of Episiotomy in Obstetrical Care: A Systematic Review*. Evidence Report/Technology Assessment No. 112. AHRQ Publication No. 05-E009-2. May 2005.

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Resources

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Self-Help, Pregnancy, Partner and Disability Booklets

NVA has created four educational booklets that can be viewed instantly and downloaded at NVA's Online Resource Center, www.nva.org/join_splash.html. To obtain a printed copy (or copies for your office), please contact the NVA by phone (301-299-0775) or e-mail (gigi@nva.org).

I Have Vulvodynia – What Do I Need to Know?
This self-help guide enables women with vulvodynia to make educated decisions about their health care, build strong partnerships with their health care providers and improve their quality of life. It provides a comprehensive overview of the condition from both the gynecological and chronic pain perspectives. In addition to focusing on the diagnosis and treatment of vulvodynia, it features important self-help tips and coping strategies.

Vulvodynia, Pregnancy and Childbirth
NVA's pregnancy booklet is the first comprehensive resource on the subject for women with vulvodynia who are pregnant or want to become pregnant. It covers material on conception through the postpartum period, dealing with topics such as alleviating pain during pregnancy and minimizing trauma to the vulva during childbirth. The booklet also discusses alternative methods of conception and childbirth options.

My Partner Has Vulvodynia – What Do I Need to Know?
After reading this brief guide, partners should have a better understanding of vulvodynia and the challenges of living with it. In addition to suggesting how a partner can be supportive, it discusses the impact of vulvodynia on relationships and ways to keep sexual intimacy alive.

How to Apply for Disability Benefits
This guide is intended for women who cannot continue to work and are seeking disability benefits from the Social Security Administration. It provides step-by-step guidance that will help vulvodynia sufferers compile and submit a successful claim. Facts and figures on vulvodynia and a list of additional resources are included.

Support the Cause and Get Involved

The NVA, founded by five patients in 1994, is one of the only non-profit organizations in the world dedicated to improving the lives of women who suffer from vulvodynia.

The NVA has many programs and services to help you:

NVA News. NVA publishes its printed newsletter, *NVA News*, three times a year. More than 45 back issues are available. The newsletter contains detailed articles by medical experts on the diagnosis and treatment of vulvodynia, and features articles on maintaining sexual intimacy and coping with chronic pain. You can view a sample issue and a table of contents for back issues on NVA's web site (https://www.nva.org/order_newsletters.htm). All issues of the NVA's newsletter can be immediately accessed through our Online Resource Center, found at: http://nva.org/index-online_center.html.

NVA E-Update. To keep you informed about recent research advances, Capitol Hill efforts and publicity, NVA publishes an electronic newsletter, NVA Update. You can view past issues and sign up to receive the e-newsletter online at: http://nva.org/email_newsletter/.

Health Care Provider Database. The NVA maintains a database of health care providers who treat chronic vulvar pain disorders. Please see: http://www.nva.org/patient_services/physician_referral.html.

Support Services. The NVA has a support network for women who choose this option. Many women find that speaking to others who have vulvodynia is both a good source of information and the best way to deal with the emotional isolation that can result from having this disorder. Please see: http://www.nva.org/patient_services/support_services.html.

To read more about our other programs and services, and how we can help you, please visit: http://www.nva.org/about_nva/programs.html.

How Can You Make A Difference?
Recent research indicates that *millions* of women in the United States alone suffer from vulvodynia. By combining our voices and skills into one collective body, we are making a significant impact, changing the future for ourselves and the women who will come after us. Please make a donation, volunteer your time or be a source of encouragement to other sufferers when you are feeling better. To learn more about what you can do to raise vulvodynia awareness, visit: http://www.nva.org/about_nva/awareness.html.

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