

TOPICAL ESTROGEN TREATMENT FOR GENITAL TISSUE RESTORATION

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Vulvar disease was brought to my attention in 1976 during fellowship training at the Medical College of Wisconsin. Subsequently, I incorporated what was recommended at the time -- primarily surgical excision -- into a general ob/gyn practice at Scripps Clinic and Research Foundation. In 1988, five women were referred to me after having CO2 laser surgery to vaporize red dots in their vulvar skin which their physicians thought had some relation to HPV. Again, I had been taught that removing the area surgically was the accepted solution to the problem.

Toughening the tissue

It is common gynecologic practice to prepare vaginal tissues for surgery with topical estrogen cream. Estrogen tends to thicken or toughen up the skin and provide it with a greater blood supply. Thus, the surgeon not only has better tissue to work with, but post-surgery healing potential is increased. Since vestibular tissue is thin after it has been lasered, I thought it reasonable to prepare it for surgery with a course of topical estrogen.

Prior to surgery, several of the women told me they were feeling much better after using estrogen cream, and asked if they could delay the operation. From that small start, I tried topical estrogen therapy with vulvar vestibulitis patients who had never had laser treatment, and found the same positive results.

Healing Regimens

I instruct my patients to use a small amount of estrogen cream, about the amount of toothpaste one would put on a toothbrush, twice a day. It should be rubbed gently into the painful external skin, not used inside the vagina. The healing process is slow. It often takes at least six weeks for improvement to begin. However, definite progress should be seen within the first six months. As the condition begins to resolve, increased itching may occur, I caution my patients that this is not a yeast infection and they should not use anti-yeast medication or steroid creams, but just persevere until the symptoms subside. Itching is a sign of healing.

In spite of progress, flare-ups or setbacks will continue for a while, especially when a woman is premenstrual or under stress. Gradually, good days outnumber bad days, and the symptoms become less severe. Estrogen cream must be used on an ongoing basis. Whenever my patients discontinue it entirely, they have relapses. Many women, however, are able to decrease the dose to one application a day, then every other day, and so on, until they find their individual maintenance levels.

When on this regimen, only a minuscule amount of estrogen is absorbed into the system. My patients' blood levels have been normal when checked; and none have reported any symptoms of hyperestrogenism, such as increased breast size. During the past eight years, 177 of 201 patients (88%) have experienced good results, including 13 who had undergone unsuccessful full surgical excision of the vestibule (variously termed perineoplasty, vestibuloplasty, and vestibulectomy), and 22 who had undergone laser surgery, five of them repeatedly.

Over time, topical estrogen has the ability to affect tissue remodeling or reconditioning even in severely damaged or scarred tissue.

Biofeedback and other therapies

Since 1993, I have referred nearly every new vulvar pain patient to a biofeedback therapist for evaluation of pelvic floor musculature. Most vulvar pain patients have pelvic floor muscle tension in reaction to their chronic pain. Rehabilitating the muscle is critical in resolving pain when muscle spasms are present.

Biofeedback and Pain Reduction

Chronic spasm, or tension, of the pelvic floor muscle is an automatic response to long-continued, intense pain in the genital area. Since muscle spasm itself causes pain, effective treatment for vulvar pain may not be realized until the muscle is stabilized. Biofeedback for pelvic floor muscle rehabilitation has been used for many years to resolve urinary and fecal incontinence, and other pain syndromes in the pelvic floor muscle. The same skills applied to alleviate vulvar pain have proved quite successful in recent years.

In addition, I often recommend oxalate evaluation and treatment, especially when vulvar pain has been longstanding or urological symptoms are present. A combination of therapies has worked best with the majority of my patients.

Topical estrogen appears to be related to NAG treatment in that it builds up connective tissue, making vulvar skin stronger and more resistant to inflammation. Regardless of the precise etiology (cause), physicians now have some good tools to begin helping women to dramatically reduce their pain and return to normal functioning.

For the vast majority of medical practitioners, just to learn that the vulvar vestibule should not be removed surgically is big news. The message we want to get out is 'Don't Operate, don't laser; don't inject with interferon until you have tried the other non-invasive, non-traumatic modalities.'

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