

Vestibulodynia

Causes, Symptoms, Diagnosis, Sexual Health Effects, Treatment and an Integrative Unani Approach

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Medical literature reviewed and updated: September 2026

Understanding Vestibulodynia

When a woman tells me, “Doctor, I experience severe burning or pain whenever intercourse is attempted, but my tests repeatedly come back normal,” I believe the complaint deserves careful attention rather than reassurance alone.

One important condition that can cause this pattern is **vestibulodynia**.

Vestibulodynia is a form of persistent vulvar pain in which pain is localized mainly to the **vulvar vestibule**, the sensitive tissue surrounding the vaginal opening. The internationally accepted definition of vulvodynia is vulvar pain lasting at least three months without a clearly identifiable cause; when that pain is localized to the vestibule, the condition is described as vestibulodynia. It may be provoked by touch or penetration, occur spontaneously, or have both patterns.

For many patients the most noticeable symptom is pain during attempted sexual intercourse. However, the same pain may also occur with insertion of a tampon, gynecological examination, tight clothing, cycling, prolonged sitting or even very light touch.

The discomfort may feel like **burning, rawness, stinging, cutting, soreness or sharp pain**. Importantly, the vulva may look almost completely normal despite significant pain. This difference between what the patient feels and what can be seen is one reason vestibulodynia is sometimes misunderstood or diagnosed late.



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I want patients to understand from the beginning that persistent vulvar pain is a genuine medical problem. It should neither be dismissed as “just psychological” nor automatically treated repeatedly as an infection without establishing the diagnosis.

What Exactly Is the Vulvar Vestibule?

The **vulva** refers to the external female genital structures.

The **vestibule** is the area immediately surrounding the vaginal opening and urethral opening, lying within the inner portions of the vulva.

This tissue contains a rich supply of sensory nerve endings. In some women with vestibulodynia, normally non-painful contact becomes painful because the local tissues, nerves, pelvic-floor muscles and pain-processing pathways become unusually sensitive.

That means something as gentle as touching the area with a cotton swab can sometimes reproduce the patient's characteristic pain.

International vulvodynia terminology uses location, provoking factors, onset and temporal pattern to describe each patient's condition rather than assuming that all vulvar pain is identical.

Vestibulodynia Is a Form of Vulvodynia

Patients frequently ask me whether **vulvodynia** and **vestibulodynia** mean the same thing.

They are related, but not completely identical.

Vulvodynia is the broader term for persistent vulvar pain without an identifiable underlying cause.

Vestibulodynia describes pain specifically localized to the vulvar vestibule.

For example, a woman whose pain affects almost the entire vulva may have generalized vulvodynia. A woman whose tenderness is concentrated around the vaginal opening may have localized vestibulodynia.

Vestibulodynia can then be described further as **provoked, spontaneous or mixed**.

Provoked Vestibulodynia



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The most commonly discussed form is **provoked vestibulodynia**, sometimes abbreviated PVD.

In this condition, pain occurs mainly when the vestibular tissue is touched or pressure is applied.

Typical triggers include intercourse, attempted penetration, inserting a tampon, a gynecological examination, tight clothing and sometimes activities such as cycling.

Provoked vestibulodynia is recognized as a common subtype of chronic vulvar pain and can significantly affect sexual function, relationships and quality of life.

Some women have no pain at all when nothing is touching the area. Others remain uncomfortable for minutes or hours after penetration has ended.

Primary and Secondary Vestibulodynia

Another important distinction concerns when symptoms first began.

In **primary vestibulodynia**, pain has been present from the woman's first attempt at penetration—for example, from the first tampon, first gynecological examination or first attempted intercourse.

In **secondary vestibulodynia**, penetration was previously comfortable and pain developed later.

This difference can provide useful clues about possible contributing mechanisms and should always form part of the clinical history.

Is Vestibulodynia an Infection?

No. Vestibulodynia itself is **not defined as a vaginal infection or sexually transmitted infection**.

This point is extremely important.

Many women experience repeated episodes of burning and are consequently given antifungal or antibiotic medicines again and again. If infection testing remains negative and the pain persists, continuously treating presumed infection may delay the correct diagnosis.

At the same time, infections such as candidiasis, herpes and other infectious conditions can themselves cause vulvar pain and therefore need to be excluded before the diagnosis of vulvodynia is made.



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International consensus terminology specifically separates pain caused by identifiable infections, inflammatory diseases, neurological conditions, trauma, cancer and hormonal deficiency from vulvodynia, which is diagnosed when no such clear cause explains the persistent pain.

This is why vestibulodynia is commonly described as a **diagnosis of exclusion**.

Vestibulodynia Is Not the Same as Vaginismus

These conditions frequently occur together but are not identical.

In vestibulodynia, the major problem is **pain or abnormal sensitivity of the vestibular region**.

In vaginismus or genito-pelvic pain/penetration disorder, there may be involuntary tightening, fear, guarding or difficulty allowing penetration.

A woman with vestibulodynia may understandably begin tightening her pelvic-floor muscles because she anticipates pain. Over time, this protective response can become habitual.

A cycle can then develop:

pain → fear of pain → pelvic-floor tightening → more painful penetration → greater fear.

Therefore, pelvic-floor overactivity and vestibular pain often need to be addressed together rather than treating one while ignoring the other.

What Does Vestibulodynia Feel Like?

Women describe this condition in different ways.

The pain may feel like burning, stinging, rawness, soreness, pressure, cutting, tearing, stabbing or a feeling that the vaginal opening is being injured.

For some patients, intercourse is possible but painful.

For others, penetration becomes extremely difficult or impossible.

A woman may experience pain immediately upon contact with the vaginal entrance, while another develops pain only after intercourse. Some remain sore for hours afterward.

ISSVD terminology therefore recognizes immediate and delayed pain patterns as well as persistent, intermittent and constant symptoms.

Why Does Vestibulodynia Develop?

There is no single established cause that explains every patient.

This is one of the most important concepts to understand.

Current research increasingly describes vestibulodynia as a **multifactorial pain condition** involving different combinations of peripheral nerve sensitivity, central pain processing, pelvic-floor dysfunction, inflammatory pathways, hormonal influences, psychological responses and individual susceptibility.

A 2025 position statement reviewing evidence through April 2025 described possible contributions from vestibular inflammation, increased nerve density, central sensitization, pelvic-floor hypertonicity, sex-hormone changes and psychological distress.

Therefore, two women can have almost identical symptoms while having somewhat different underlying drivers.

This is why treatment must be individualized.

Increased Sensitivity of the Nerves

One proposed mechanism is **peripheral sensitization**.

This means nerves in the vestibular tissue become unusually responsive.

A stimulus that should normally feel like gentle pressure can consequently be interpreted by the nervous system as burning or pain.

Research on vestibular tissue has reported increased nerve-fiber density in some women with provoked vestibulodynia. Neurotrophic and inflammatory processes have also been proposed as possible contributors.

This helps patients understand an important concept:

Pain can be severe even when no wound, ulcer or visible disease is present.

The problem may lie partly in how sensory nerves are responding rather than in obvious tissue damage.

Central Sensitization

Pain is processed not only where it starts, but also in the spinal cord and brain.



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When pain continues for a long period, the nervous system can sometimes become increasingly sensitive. This process is referred to as **central sensitization**.

The nervous system begins responding more strongly to signals that previously would have been minor or non-painful.

Contemporary reviews place central pain sensitization among the mechanisms that may contribute to chronic vulvar pain.

This does not mean that the pain is imaginary.

Quite the opposite: it means that pain-processing pathways themselves have changed.

Pelvic-Floor Muscle Dysfunction

Pelvic-floor muscles play an important role in urination, bowel function, sexual activity and support of the pelvic organs.

In many women with provoked vestibulodynia, these muscles are excessively tense, tender or difficult to relax.

Sometimes muscle tightening may have existed before the pain. In other women it develops as a protective response after intercourse becomes painful.

Once established, pelvic-floor overactivity can make attempted penetration even more uncomfortable.

The association between provoked vestibulodynia and increased pelvic-floor muscle tone is well recognized, and specialized pelvic-floor physiotherapy has consequently become one of the most important treatments.

Inflammation and Previous Infections

Some women report that their symptoms began after repeated episodes of vulvovaginal candidiasis or another episode of genital irritation.

Research has examined whether abnormal local inflammatory responses may contribute to sensitization in susceptible women.

Studies have reported differences in inflammatory markers, mast cells and nerve endings, but the findings have not been sufficiently consistent to establish one universal inflammatory mechanism.

Therefore, I would not tell every patient that vestibulodynia is simply “chronic inflammation.”



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It is considerably more complicated.

Hormones and Vestibular Pain

Hormonal factors may be relevant in certain patients.

Vulvar pain can occur in low-estrogen states such as menopause or lactation, although pain caused directly by hormonal deficiency is classified separately from idiopathic vulvodynia in international terminology.

Researchers have also investigated whether combined hormonal contraceptives may contribute to vestibular symptoms in some susceptible women.

A 2024 review reported possible associations particularly with early exposure, lower-estrogen formulations and antiandrogenic progestins, while emphasizing that available studies are heterogeneous and do not establish a simple cause-and-effect relationship.

A 2025 observational study likewise found an association between oral-contraceptive exposure and reported vulvodynia or vestibulodynia, but because the study was observational and relied partly on self-reported information, it cannot prove that oral contraceptives caused the disorder.

Therefore, a patient should **not stop contraception on her own**. Instead, the clinician should review the timing of symptoms, contraceptive type and other possible causes.

Psychological Factors: Important but Not the Whole Explanation

Chronic pain affects emotional health, and emotional health can influence pain.

A woman who repeatedly experiences severe pain with intercourse may naturally develop fear, anxiety and anticipatory muscle tightening.

She may begin avoiding intimacy.

She may worry that her partner will misunderstand her.

Her partner may interpret avoidance as rejection.

Over time, a physical pain condition can therefore produce major psychological and relationship consequences.

But this does not mean vestibulodynia is “just anxiety.”

Modern understanding considers biological, neurological, muscular, psychological and relationship factors together.



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A 2025 systematic review and meta-analysis also found that psychotherapy can improve aspects of pain, psychological adjustment and sexual function in women with vulvodynia, although the certainty of evidence varies across outcomes.

Psychological care should therefore be considered part of comprehensive pain management, not evidence that the pain is imaginary.

Other Chronic Pain Conditions May Occur Together

Some women with vulvodynia also experience other chronic pain disorders.

These may include painful bladder syndrome, irritable bowel syndrome, fibromyalgia, chronic pelvic pain, temporomandibular pain and other sensitization-related conditions.

ISSVD guidance specifically notes such comorbidities when evaluating chronic vulvar pain.

Recognizing associated pain conditions can influence treatment because a patient may need more comprehensive pain management rather than treatment focused exclusively on the vulva.

Endometriosis and Vestibulodynia

Endometriosis and vestibulodynia are different conditions, but they can coexist.

Both may contribute to painful intercourse and chronic pelvic pain.

Recent reviews of endometriosis-associated pain describe overlapping mechanisms such as peripheral sensitization, central sensitization, inflammatory processes and pelvic-floor dysfunction and recognize vulvar vestibulodynia as an important comorbidity in some patients.

A woman with both deep pelvic pain and pain immediately at the vaginal opening therefore needs careful assessment of both locations.

How Vestibulodynia Affects Sexual Health

Vestibulodynia can have a profound effect on sexual well-being.

If penetration repeatedly causes pain, sexual desire can gradually fall because the brain begins associating sexual activity with discomfort.

A woman may experience adequate desire and arousal initially but become tense as penetration approaches.

Lubrication can decrease.

Pelvic-floor muscles may contract.

Pain increases.

Eventually the couple may avoid intercourse altogether.

This is why treating only the painful point while ignoring arousal, fear, communication and relationship dynamics may produce incomplete results.

Vestibulodynia and Infertility

Vestibulodynia does **not normally damage the ovaries, fallopian tubes or uterus and is not itself a direct biological cause of infertility.**

However, severe pain may make vaginal intercourse difficult or impossible.

For a couple trying to conceive, reduced or unsuccessful penetrative intercourse during the fertile window can become a practical barrier to natural conception.

The resulting pressure to “perform” during ovulation can further increase anxiety, muscle guarding and pain.

At Saira Health Care, I believe this distinction is particularly important.

If a woman has vestibulodynia and is also struggling to conceive, we should evaluate the sexual pain and the couple's fertility separately but simultaneously.

The solution should never be simply telling the couple to have intercourse more frequently despite severe pain.

How Is Vestibulodynia Diagnosed?

There is no single blood test, ultrasound or scan that proves the diagnosis.

The diagnosis depends on a careful medical history, vulvar examination and exclusion of other conditions.

The NHS and ISSVD describe the use of a **cotton-swab test**, in which gentle pressure is applied to different areas of the vulva and vestibule to identify and map painful sites.

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



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For someone already fearful of penetration, a forceful examination can worsen distress and pelvic-floor guarding.

The Cotton-Swab Test

During cotton-swab testing, a clinician gently touches defined areas around the vulva and vestibule.

The patient is asked whether each point produces no pain, mild pain, moderate pain or severe pain.

ISSVD guidance describes mapping different vestibular positions to identify localized tenderness and monitor changes over time.

In a woman with localized provoked vestibulodynia, light pressure at specific vestibular points may reproduce the exact burning or sharp pain that occurs during intercourse.

This is a very useful clinical clue.

Conditions That Must Be Ruled Out

Because vestibulodynia is diagnosed only after specific causes of vulvar pain have been considered, the evaluation may need to exclude conditions such as candidiasis and other infections, herpes, contact dermatitis, lichen sclerosus, lichen planus, vulvar lesions or precancerous disease, genital trauma, hormonal atrophy and neurological disorders.

Swabs, vaginal pH assessment, microscopy, fungal testing or other laboratory investigations may be used when clinically appropriate. A biopsy is not routinely necessary for vestibulodynia itself but may be needed when abnormal skin changes raise concern for another condition.

This is one reason self-diagnosis through symptoms alone can be misleading.

Treatment of Vestibulodynia

One of the most important points I explain to patients is that there is **no single treatment that works for every woman**.

Vestibulodynia is heterogeneous.

One patient may have marked pelvic-floor hypertonicity.

Another may have predominantly neuropathic sensitivity.

A third may have hormonal factors.

Another may have a history of repeated inflammation combined with muscle guarding and severe fear of penetration.

Treatment therefore needs to be individualized and often multidisciplinary.

The NHS describes care involving gynecologists, physiotherapists, psychologists and pain specialists depending on the patient's needs.

Pelvic-Floor Physiotherapy

For provoked vestibulodynia associated with pelvic-floor dysfunction, **specialized pelvic-floor physiotherapy has some of the strongest direct clinical evidence.**

A multicenter randomized clinical trial involving 212 women compared ten weeks of multimodal pelvic-floor physiotherapy with overnight 5% topical lidocaine.

Physiotherapy included education, pelvic-floor exercises with biofeedback, manual therapy and dilation. It produced greater improvement in intercourse-related pain, sexual function, sexual distress and patient-reported improvement than lidocaine, with benefits maintained at six months. Seventy-nine percent of women in the physiotherapy group reported being much or very much improved compared with 39% in the lidocaine group.

A 2024 systematic review also found that rehabilitation approaches can reduce pain associated with vulvodynia, although the evidence differs among individual techniques.

For many patients, pelvic-floor rehabilitation should therefore be considered early rather than only after numerous medication trials.

What Does Pelvic-Floor Therapy Involve?

Good pelvic-floor therapy is not simply telling a woman to perform repeated Kegel exercises.

In fact, some women with vestibulodynia already have excessively tight pelvic-floor muscles, and repeatedly strengthening them without assessing muscle tone may be counterproductive.

Specialized therapy may involve relaxation training, manual release of overactive muscles, breathing techniques, biofeedback, gradual desensitization, education, posture and movement work, and carefully supervised use of vaginal dilators when appropriate.



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The objective is to teach the pelvic floor how to relax and respond normally rather than forcing penetration.

Cognitive Behavioral Therapy and Psychosexual Therapy

When pain has affected confidence, sexual response or the relationship, psychological and psychosexual therapy can be extremely valuable.

Cognitive behavioral approaches can help patients address fear of pain, avoidance, catastrophic expectations and the emotional burden of chronic symptoms.

Couple-based therapy can also help partners understand that avoidance of penetration is not rejection.

A randomized trial of cognitive-behavioral couple therapy for provoked vestibulodynia found improvements in pain-related and psychosexual outcomes, while newer systematic evidence continues to support psychological approaches as one component of multidisciplinary care.

Again, psychotherapy should not be presented as suggesting that the problem is imaginary.

It treats the very real interaction between pain, the nervous system, emotions and sexual behaviour.

Vulvar Care and Avoiding Irritation

For many patients, reducing unnecessary irritation is a simple but useful component of treatment.

The vulvar area should generally be treated gently.

Repeated washing, fragranced soaps, intimate washes, deodorants, harsh detergents and vaginal douching can worsen irritation in susceptible women.

ACOG and the NHS recommend gentle vulvar care and avoidance of potentially irritating products. Cotton underwear, appropriate lubricants and avoidance of unnecessarily tight clothing may also help some patients.

The vagina does not need internal cleansing.

In fact, douching can disturb the local environment and should generally be avoided.

Lubricants and Sexual Activity

When sexual activity is desired, an appropriate unscented lubricant can reduce friction.

However, intercourse should not become an exercise in “pushing through” severe pain.

Repeatedly forcing penetration despite significant vestibular pain can increase fear, muscle guarding and avoidance.

Sometimes a temporary change in sexual activity is helpful while treatment progresses.

Couples can maintain intimacy without making penetration the only measure of a successful sexual relationship.

Topical Lidocaine

Topical lidocaine has long been used in the management of vulvodynia and may reduce superficial pain temporarily in some patients.

However, treatment evidence needs to be interpreted carefully.

The randomized trial discussed above found specialized multimodal physiotherapy superior to overnight 5% lidocaine for provoked vestibulodynia.

More importantly, a large 2026 network meta-analysis incorporating **34 randomized studies and 1,893 participants** found that commonly studied pharmacological interventions as a category did not demonstrate robust superiority to placebo, while multimodal physical and psychological approaches showed potentially useful effects compared with no treatment.

This does not mean lidocaine can never help an individual patient. It means we should not present it as a universally effective treatment.

Oral Medicines for Neuropathic Pain

Medicines such as tricyclic antidepressants, selected serotonin-norepinephrine reuptake inhibitors and gabapentinoids have historically been used for neuropathic vulvar pain.

However, evidence for individual medications is mixed, and the 2026 network meta-analysis found limited robust evidence that pharmacological treatments overall outperform placebo for vulvodynia.

These medicines may nevertheless be considered for selected patients after individual assessment, particularly when a clinician suspects a broader neuropathic pain pattern.

Potential side effects and interactions must be considered.



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Hormonal Treatment

When pain is linked to a clearly identified low-estrogen state—for example, genitourinary syndrome of menopause—the underlying hormonal deficiency should be distinguished from idiopathic vestibulodynia.

Some specialist practices also use localized hormonal treatments in selected cases suspected to be hormonally associated, but the evidence base remains much smaller than for established approaches such as pelvic-floor rehabilitation.

A 2025 clinical review recognizes hormonally associated vestibulodynia as one of several potentially distinct sexual-pain presentations, reinforcing the importance of identifying the phenotype rather than treating every patient identically.

Hormonal treatment should therefore be used only after proper evaluation.

Botulinum Toxin

Botulinum toxin has been investigated because excessive pelvic-floor muscle activity may contribute to pain.

However, evidence remains uncertain.

A 2025 review of randomized controlled trials concluded that the clinical effectiveness and safety of botulinum toxin for provoked vestibulodynia remain uncertain.

It should therefore not be presented as routine first-line treatment.

Nerve Blocks and Other Pain Procedures

Selected patients with severe refractory pain may be evaluated by pain specialists for local injections, nerve blocks or other pain procedures.

ACOG describes nerve-block techniques as one possible component of vulvodynia care in appropriately selected patients.

These interventions are generally reserved for specialist care rather than being used routinely in every patient.

What About Laser, Shockwave and Other New Treatments?

Research is rapidly developing.



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A 2026 network meta-analysis reported promising pain reductions for a broad category of tissue-based interventions that included techniques such as photobiomodulation, low-level laser, electrical stimulation and shockwave therapy. However, the authors cautioned that very different treatments were grouped together, meaning the results should not be interpreted as proof that every individual device or technique is effective.

This is an important example of how new research should be interpreted carefully.

Promising evidence is not the same as definitive evidence.

When Is Surgery Considered?

A **vestibulectomy** involves removal of a portion of painful vestibular tissue.

It may be considered in carefully selected women with persistent localized provoked vestibulodynia who have not improved sufficiently with comprehensive conservative treatment.

ACOG notes that vestibulectomy may be used when vestibular pain persists despite other treatment approaches.

Surgery is irreversible and therefore should generally not be the first treatment offered.

The diagnosis must be secure, contributing pelvic-floor and psychosocial factors should be addressed, and the benefits and potential complications should be discussed carefully.

What the Latest Research Tells Us

The scientific understanding of vestibulodynia is changing.

A major 2025 position statement describes the disorder as a complex condition involving interactions between peripheral nerves, central pain pathways, muscles, hormones, inflammation and psychological factors rather than a simple localized inflammation.

A 2025 scoping review similarly concluded that vulvodynia remains under-recognized and under-researched despite its significant effects on quality of life, sexual health and healthcare experiences.

Then, in 2026, a network meta-analysis of 34 randomized trials reinforced an important clinical point: there is still **no universal medication-based solution**, and multimodal treatment remains highly relevant.



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For me as a clinician, this supports individualized and multidisciplinary care rather than a “one medicine for everyone” approach.

Vestibulodynia and the Unani System of Medicine

As a physician trained in the **Unani System of Medicine**, I consider individualized assessment one of the strengths of Unani clinical practice.

Unani medicine traditionally evaluates the person as a whole, considering constitution or **Mizaj**, diet, sleep, physical activity, psychological state, environment and other lifestyle influences.

The Central Council for Research in Unani Medicine describes Unani treatment as involving approaches including dietotherapy, regimental therapy and pharmacotherapy, together with broader constitutional assessment. CCRUM also states that fundamental Unani concepts continue to be investigated scientifically rather than assuming that traditional theories have already been fully validated by modern biomedical evidence.

That distinction is important for vestibulodynia.

How Unani Medicine May Be Useful in Vestibulodynia

I believe the most responsible role for Unani medicine in a condition such as vestibulodynia is **individualized supportive and integrative care**.

The condition involves far more than one painful spot.

A patient may also have disturbed sleep, anxiety, digestive complaints, chronic stress, relationship difficulties, altered sexual response or broader metabolic and lifestyle concerns.

Unani principles can support attention to these whole-person factors through individualized dietary advice, regulation of sleep and activity, stress reduction and carefully selected treatment where appropriate.

Official Ministry of AYUSH and CCRUM programs also demonstrate the broader use of Unani diet and regimental approaches alongside conventional healthcare in integrative settings.

However, scientific honesty is essential.

At present, high-quality clinical trials proving that a specific Unani medicine cures vestibulodynia are lacking.

Therefore, I would not advise replacing gynecological examination, pelvic-floor physiotherapy or other indicated evidence-based treatment with an unproven herbal preparation.

The Importance of Treating the Cause

A traditional principle that I consider highly relevant is identifying and addressing the causative or maintaining factors.

If a patient actually has candidiasis, that infection needs appropriate treatment.

If the problem is a dermatological disease such as lichen sclerosus, she needs disease-specific management.

If the pelvic floor is severely overactive, physiotherapy should form an important part of treatment.

If menopause-related hormonal deficiency is the principal driver, that needs separate assessment.

If pain has created severe anxiety and sexual avoidance, psychosexual counselling should be considered.

If localized vestibular hypersensitivity remains after these factors are addressed, pain-directed treatment may then be required.

This cause-oriented approach fits well with responsible integrative care.

Unani Dietotherapy — Ilaj-bil-Ghiza

Ilaj-bil-Ghiza, or dietary therapy, is an established component of the traditional Unani therapeutic framework.

In vestibulodynia, diet should not be presented as a direct cure.

However, good nutrition can support general health, bowel function, metabolic health and overall well-being.

Patients with coexisting irritable bowel syndrome, diabetes, nutritional deficiencies or other disorders may require specific dietary planning.

There is no scientifically established “vestibulodynia diet” that works for every patient.

Overly restrictive diets should therefore be avoided unless there is a clear clinical reason.



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Regimental and Lifestyle Care — Ilaj-bil-Tadbir

Lifestyle-oriented Unani principles can complement treatment by paying attention to sleep, physical activity, stress, rest and general health.

For vestibulodynia, useful practical measures may include reducing vulvar irritation, avoiding prolonged painful pressure on the vulva, improving sleep, managing chronic stress and maintaining appropriate physical activity.

When pelvic-floor hypertonicity is present, these principles should complement—not replace—specialized pelvic-floor therapy.

Unani Pharmacotherapy — Ilaj-bil-Dawa

Unani medicine has a long tradition of herbal and compound preparations for women's health concerns.

But vestibulodynia is a modern chronic-pain diagnosis with complex neurological, muscular and psychosexual mechanisms.

For that reason, I believe pharmacotherapy should be individualized and used cautiously.

I particularly discourage patients from repeatedly applying strong oils, irritant herbal preparations, antiseptic solutions or unknown substances to the vulvar vestibule.

The tissue is sensitive, and contact irritation can worsen symptoms.

Any local preparation should be selected with attention to safety, allergy potential, interactions and the actual diagnosis.

The Specialized Saira Health Care Approach

At **Saira Health Care**, my approach to sexual pain is not based on forcing treatment into one system of medicine.

The first responsibility is to understand what the patient is experiencing.

When a woman reports vestibular pain, the evaluation should consider the location and pattern of pain, whether it is provoked or spontaneous, when it began, infection history, menstrual and hormonal history, contraceptive exposure, vulvar skin disorders, urinary and bowel symptoms, pelvic-floor function, sexual history, previous trauma when relevant, fertility plans and the emotional consequences of chronic pain.

The objective is then to develop an **individualized integrative management plan**.

Depending on the findings, that may involve gynecological evaluation, pelvic-floor physiotherapy, pain management, sexual counselling, couple counselling, lifestyle measures, carefully selected Unani supportive treatment and referral to an appropriate specialist when required.

This is what I consider genuine integrative medicine: not replacing one system with another, but choosing appropriate care according to the patient's needs.

Why Sexual Counselling Is Important

Vestibulodynia often damages a woman's sexual confidence long before she receives the correct diagnosis.

Some women begin believing that something is fundamentally wrong with their bodies.

Others feel guilty because intercourse is painful.

Partners may feel rejected.

Attempts to conceive can make matters even more stressful.

At Saira Health Care, counselling should therefore address not only pain but also communication, fear, intimacy and realistic expectations.

The patient should never be pressured to tolerate severe pain merely to maintain intercourse.

Comfortable intimacy can be rebuilt gradually as pain control and confidence improve.

Partner Involvement

Where the patient is comfortable with it, involving the partner can be beneficial.

The partner needs to understand that pain does not mean lack of attraction or affection.

Couples can learn to communicate about comfortable and uncomfortable forms of touch, use adequate lubrication and temporarily avoid painful penetration without abandoning intimacy.

A supportive relationship can reduce the fear-pain cycle.

What I Tell Women Who Are Trying to Conceive

If you have vestibulodynia and are trying for pregnancy, do not repeatedly force painful intercourse simply because an ovulation application says that today is your fertile day.

Doing so can strengthen the association between intercourse, anxiety and pain.

Instead, the underlying pain should be evaluated while fertility factors are also assessed when appropriate.

Sometimes improving pelvic-floor function and reducing pain is enough to restore comfortable intercourse.

If conception remains difficult for additional reasons, fertility evaluation should proceed according to the couple's circumstances.

When Should You Consult a Doctor?

Persistent vulvar pain should be assessed when it continues or repeatedly returns, penetration becomes difficult, tampon insertion is painful, intercourse causes burning or sharp pain, pain appears without obvious infection, or repeated infection treatments have not solved the problem.

The NHS similarly advises medical review for persistent or recurrent vulvar discomfort and pain interfering with tampon use or intercourse.

Visible ulcers, bleeding, persistent sores, new masses, significant skin changes, fever or severe acute pain require particularly prompt assessment because these symptoms may indicate conditions other than vestibulodynia.

Can Vestibulodynia Be Cured?

There is no single answer because vestibulodynia is not one uniform disorder.

Many women improve substantially with appropriate treatment.

Some respond particularly well to pelvic-floor rehabilitation.

Others benefit from combined physical and psychosexual treatment.

Some need treatment of hormonal or dermatological factors.

A minority with carefully diagnosed, highly localized and treatment-resistant disease may be considered for surgery.

The correct expectation is usually **gradual improvement rather than an instant cure**.

Current evidence confirms that multiple treatment approaches can help, but no single method works for everyone.



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Common Mistakes I Encourage Patients to Avoid

The most important mistakes to avoid are repeatedly self-treating every episode of burning as candidiasis, using fragranced intimate washes or vaginal douches, repeatedly forcing painful intercourse, beginning unregulated topical products, performing unsupervised intensive pelvic-floor strengthening despite muscle overactivity, stopping hormonal contraception without medical discussion, and assuming that normal-looking vulvar tissue means the pain cannot be real.

Another important mistake is believing that treatment has failed simply because one medication did not work.

Vestibulodynia frequently requires a multimodal approach.

Frequently Asked Questions About Vestibulodynia

Is vestibulodynia a sexually transmitted infection?

No. Vestibulodynia itself is not an STI. However, infections and other diseases capable of producing vulvar pain should be excluded before making the diagnosis.

Can vestibulodynia occur when the vulva looks normal?

Yes. Many women have little or no visible abnormality despite substantial pain.

Why does intercourse hurt?

Pressure at the vaginal opening can stimulate hypersensitive vestibular nerves, and pelvic-floor muscles may tighten simultaneously, increasing pain.

Can vestibulodynia cause vaginismus?

The two are different conditions, but persistent vestibular pain may lead to protective pelvic-floor tightening and fear of penetration, so they can coexist.

Does vestibulodynia directly cause infertility?

Usually not. It does not normally interfere directly with ovulation or fallopian-tube function. However, severe pain may prevent comfortable vaginal intercourse and therefore make natural conception more difficult.

Can pelvic-floor physiotherapy help?

Yes. Multimodal pelvic-floor physiotherapy has good direct evidence for provoked vestibulodynia and outperformed overnight topical lidocaine in a large randomized trial.

Is vestibulodynia psychological?



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No. It is a genuine pain condition involving biological and pain-processing mechanisms. Psychological factors can affect symptoms and can also develop as a consequence of chronic pain.

Can stress make symptoms worse?

Yes. Stress can increase muscle tension and pain sensitivity, although stress alone does not explain every case.

Does oral contraception cause vestibulodynia?

Research has found associations in some populations, but causality remains uncertain and evidence is not uniform. Contraception should not be stopped without individualized medical advice.

Is surgery always required?

No. Most patients should first receive individualized conservative treatment. Vestibulectomy is generally considered only for carefully selected cases of persistent localized disease after other approaches have failed.

Can Unani medicine help?

Unani medicine may be incorporated as **supportive individualized care**, particularly in diet, lifestyle, sleep, stress management and overall health. However, there is currently insufficient high-quality evidence to claim that a particular Unani medicine specifically cures vestibulodynia. Appropriate gynecological diagnosis and evidence-based treatment should not be delayed.

A Message to My Patients

When a woman says to me:

“Doctor, every report is normal, so why does intercourse still hurt so much?”

I explain that normal routine investigations do not make her pain less real.

Vestibulodynia is often a disorder of **pain processing, nerve sensitivity and pelvic-floor function**, not a condition that necessarily creates a visible wound or appears on ultrasound.

Another patient may ask:

“Is the pain happening because I am afraid of intercourse?”

My answer is that fear can increase pain, but it may also be the **result** of repeatedly experiencing pain. The two can reinforce each other.



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And if a woman tells me:

“Everyone keeps treating me for infection, but treatment never solves the burning,”

I believe that is exactly when the diagnosis needs to be reconsidered.

Repeated treatment without establishing the cause is not good medicine.

My aim is to understand the whole patient: her physical symptoms, pelvic-floor function, hormonal and reproductive history, sexual experience, psychological well-being, relationship circumstances and fertility goals.

Dr. Nizamuddin Qasmi and Saira Health Care

Dr. Nizamuddin Qasmi

Founder & Chief Physician, Saira Health Care

Focused Practice in Sexual Disorders & Infertility

Professional Qualifications and Training

BUMS, Hamdard University, Delhi

MD

CGO

Certificate in Infertility, MGBIMS, Delhi

Certificate in Urology – London, UK

Masters in Male Infertility by MasterHealthPro (HealthPro)

Integrated Sexual and Reproductive Health (ISRH, UNFPA)

At **Saira Health Care**, the clinical approach to sexual and reproductive concerns focuses on confidential consultation, careful differentiation of sexual-pain disorders, infertility assessment where required, counselling and individualized integrative management.

For conditions such as vestibulodynia, a responsible approach also recognizes when gynecology, dermatology, pelvic-floor physiotherapy, pain medicine or psychological/psychosexual services should become part of the patient's care.

Conclusion

Vestibulodynia is a chronic localized vulvar pain condition affecting the sensitive tissue surrounding the vaginal opening. It frequently presents with burning, stinging or severe pain during intercourse, tampon insertion, examination or other contact.

Modern evidence suggests that the disorder is multifactorial. Altered nerve sensitivity, peripheral and central sensitization, pelvic-floor overactivity, inflammatory pathways,



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hormonal influences and psychological factors may contribute in different proportions in different patients.

Diagnosis requires a careful history, gentle examination and exclusion of infections, dermatological disease, hormonal deficiency, trauma and other identifiable causes. Cotton-swab pain mapping is particularly useful in identifying localized vestibular tenderness.

Among current treatments, **specialized multimodal pelvic-floor physiotherapy has particularly useful evidence for provoked vestibulodynia**, while psychosexual or cognitive-behavioral treatment can help address pain-related fear, sexual distress and relationship consequences. Other treatments should be individualized, and surgery is generally reserved for selected refractory localized cases.

The latest 2026 comparative evidence also reminds us that many commonly used drug treatments have less robust evidence than patients may assume, reinforcing the need for individualized multimodal care rather than dependence on a single tablet or cream.

From an **integrative Unani perspective**, attention to the whole individual—diet, sleep, lifestyle, stress, sexual health and general well-being—can complement appropriate modern evaluation and treatment. However, a specific Unani cure for vestibulodynia has not been established in high-quality clinical trials, and responsible Unani practice should therefore work alongside rather than replace appropriate gynecological and pelvic-pain care.

At **Saira Health Care**, the objective is not merely to make intercourse possible. The broader goal is to reduce pain, restore confidence, improve sexual well-being, protect the relationship, address fertility concerns where present, and help the patient return to comfortable everyday life through an individualized and respectful treatment plan.

For more information:

<https://www.sairahealthcare.com/>

Book an appointment:

<https://www.sairahealthcare.com/Appointment.aspx>

Saira Health Care Pharmacy:

<https://pharmacy.sairahealthcare.com/>

Medical Disclaimer: This article is intended for general patient education and professional health awareness. It does not replace an individual examination, diagnosis or treatment plan. Persistent vulvar pain, painful intercourse, genital lesions, unusual discharge, bleeding or recurrent symptoms should be assessed by an appropriately qualified healthcare professional. Unani medicines, topical preparations, hormones and prescription medicines should be used only after appropriate clinical evaluation.



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