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Original Paper

Clitorodynia in the Dermatology Clinic: Differential Considerations and Current Management Strategies

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Abstract

Clitorodynia, a chronic pain condition affecting the clitoris, is often underrecognized in dermatology clinics despite its potential association with inflammatory, neuropathic, hormonal, and musculoskeletal disorders. Dermatologists frequently encounter patients with vulvar discomfort and are well-positioned to differentiate clitorodynia from conditions such as lichen sclerosus, erosive lichen planus, contact dermatitis, post-herpetic neuralgia, and pudendal neuralgia. A structured diagnostic approach includes a thorough history, dermatologic and neurologic examination, cotton swab testing, biopsy when indicated, and targeted laboratory or microbiologic assessments to rule out infections and hormonal imbalances. Effective management requires an etiology-specific approach, incorporating topical corticosteroids or calcineurin inhibitors for inflammatory dermatoses, neuromodulators such as gabapentin and amitriptyline for neuropathic pain, and hormone therapy for estrogen or androgen-related deficiencies. Emerging interventions, including platelet-rich plasma injections, botulinum toxin, and low-dose naltrexone, may relieve symptoms in refractory cases. A multidisciplinary treatment strategy involving pelvic floor physical therapists, gynecologists, and pain specialists is essential to addressing both peripheral and central pain mechanisms. Patient education on genital skincare, sexual health modifications, and cognitive behavioral therapy can further optimize clinical outcomes. Enhancing dermatologic awareness of clitorodynia and implementing standardized diagnostic and treatment protocols will improve early recognition and expand effective management options in dermatology practice.

Keywords

clitorodynia, vulvodynia, vulvar pain, neuropathic pain, vulvar dermatoses, pelvic floor dysfunction, multidisciplinary care

1. Introduction

Clitorodynia is a chronic pain condition affecting the clitoris, often presenting as burning, stinging, or sharp discomfort. Despite its significant impact on sexual function and quality of life, it remains underrecognized and underdiagnosed in clinical practice (Parada et al., 2015). Clitorodynia is classified as a subtype of localized vulvodynia, sharing features with broader vulvar pain disorders while presenting with unique diagnostic challenges. Research indicates that individuals with clitorodynia experience significant distress, often facing delays in diagnosis due to the lack of visible dermatologic signs (Farage et al., 2010). As a result, affected individuals frequently undergo multiple consultations before receiving an accurate diagnosis and appropriate management. Furthermore, the intimate nature of clitorodynia can lead to reluctance to seek medical care, exacerbating delays in treatment and increasing psychological distress. The limited awareness among healthcare providers about the specific presentation of clitorodynia contributes to its misclassification under broader pain syndromes, such as vulvodynia or psychosomatic pain disorders, further delaying effective intervention.

Dermatology clinics frequently evaluate chronic genital discomfort, including conditions that mimic or contribute to clitorodynia. Inflammatory disorders such as lichen sclerosus, erosive lichen planus, and contact dermatitis may present with overlapping symptoms, necessitating dermatologic expertise to distinguish between these conditions (Farage et al., 2010). Additionally, dermatologists are well-versed in evaluating neuropathic pain syndromes, which may be involved in the pathogenesis of clitorodynia. Studies have demonstrated that patients with chronic genital pain often report increased sensory nerve activity, suggesting that neural hyperresponsiveness may be a key component in clitorodynia's pathophysiology. Dermatologists can play a crucial role in identifying these neuropathic elements, guiding treatment strategies beyond conventional dermatologic therapies.

Given the complex interplay of dermatologic, neurologic, and musculoskeletal factors in this condition, dermatologists are in a critical position to facilitate early recognition and intervention. By conducting thorough skin and nerve examinations, dermatologists can differentiate clitorodynia from coexisting conditions, such as pudendal or post-herpetic neuralgia, requiring distinct management approaches. Additionally, dermatologists can integrate emerging diagnostic tools, such as quantitative sensory testing or high-resolution ultrasound, to evaluate underlying structural and neural contributions to clitoral pain. Increased involvement of dermatologists in assessing genital pain syndromes can help bridge the gap between dermatology, neurology, and gynecology, fostering a more comprehensive approach to patient care.

A key barrier to the effective management of clitorodynia is the frequent misdiagnosis or dismissal of symptoms. Many cases are erroneously attributed to gynecologic conditions, leading to delays in

appropriate treatment (Goldstein et al., 2016). The absence of visible lesions can further complicate diagnosis, with patients often receiving inadequate or inappropriate treatments. Studies indicate that a large percentage of patients initially diagnosed with recurrent infections, such as chronic candidiasis, do not have an infectious etiology but rather an underlying neuropathic pain disorder. This misclassification often leads to prolonged courses of antifungal or antibiotic treatments, failing to address the root cause of pain while exposing patients to unnecessary side effects.

Additionally, psychological distress associated with chronic genital pain is frequently overlooked despite evidence suggesting that individuals with clitorodynia experience significant reductions in sexual function and overall well-being (Parada et al., 2015). The impact of persistent clitoral pain extends beyond physical symptoms, with many patients developing anxiety, depression, and avoidance behaviors related to sexual intimacy. The lack of standardized diagnostic criteria exacerbates these challenges, underscoring the need for increased awareness and structured assessment strategies within dermatology clinics. Without clear diagnostic guidelines, providers may struggle to distinguish clitorodynia from broader vulvodynia subtypes, leading to non-specific treatment approaches that fail to address the patient's specific needs.

This narrative review aims to equip dermatologists with a structured clinical approach to recognizing, diagnosing, and treating clitorodynia within a dermatologic framework. By integrating evidence-based dermatologic, neurologic, and pain management strategies, clinicians can improve patient outcomes and reduce the burden of undiagnosed or mismanaged clitorodynia. A multidisciplinary perspective, incorporating dermatology, gynecology, pain medicine, and physical therapy, is essential to advancing care for individuals with this debilitating condition. This review will also highlight emerging treatment modalities, such as neuromodulatory therapies, hormonal interventions, and regenerative medicine approaches, that promise to improve symptom management in patients with refractory clitorodynia. By fostering interdisciplinary collaboration and raising awareness of this often-overlooked condition, dermatologists can play a pivotal role in improving the diagnostic and therapeutic landscape for individuals experiencing chronic clitoral pain.

2. Discussion

2.1 Clitorodynia in Dermatology: Key Clinical Features

Clitorodynia is characterized by chronic pain localized to the clitoris. The primary symptoms include chronic pain described as burning, tingling, rawness, or electric shock-like sensations (Parada et al., 2015). This pain can significantly impact daily life, leading to distress and discomfort that may persist for months or even years. The severity of symptoms varies, with some individuals experiencing constant pain while others report intermittent flare-ups. External stimuli, such as touch, pressure, or sexual activity, often worsen the pain. Even routine activities like wearing tight clothing or sitting for prolonged periods can provoke discomfort. This heightened sensitivity can lead to avoidance behaviors, causing individuals to shun sexual activity or other actions that might trigger pain, further affecting emotional well-being and

quality of life. In fact, Prada et al. demonstrate that individuals with clitorodynia have significantly lower Female Sexual Function Index (FSFI) scores, with many falling well below the clinical cutoff of 26.55, indicating severe sexual dysfunction. The implications of this research not only underscore the profound impact of clitorodynia on sexual health but also suggest a pressing need for targeted interventions and support for those affected by this condition.

Changes in genital skin associated with clitorodynia, such as clitoral atrophy, erythema, and erosions, significantly contribute to pain and discomfort. Clitoral atrophy, often linked to estrogen depletion, leads to thinning of the clitoral epithelium, resulting in dryness, decreased elasticity, and heightened sensitivity, making the clitoris more prone to microtrauma (Amsterdam & Krychman, 2009). Additionally, a decline in vascular engorgement exacerbates discomfort, while clinical observations may show shrinkage of the clitoral prepuce and narrowing of the vaginal introitus. Erythema and erosions are frequently connected to inflammatory conditions such as lichen sclerosus (LS) and erosive lichen planus (ELP), which can lead to structural alterations like pigmentation changes, dyspareunia, vulvar scarring, and vaginal stenosis. These modifications significantly affect sexual function (Conte et al., 2025; Mauskar, 2017). Such skin manifestations not only intensify symptoms but also play a critical role in the clinical presentation of clitorodynia, underscoring the necessity for comprehensive evaluation and management.

Clitorodynia presents diverse pain characteristics, which can be differentiated based on neuropathic and inflammatory origins. Allodynia, where pain is triggered by ordinarily non-painful stimuli such as light touch or pressure, suggests a neuropathic component, whereas spontaneous pain, occurring without external provocation, may indicate underlying inflammation or central sensitization (Jensen & Finnerup, 2014). Inflammatory processes, including mast cell accumulation, neuronal sprouting, and upregulation of pain channels, can lead to persistent pain without external stimuli (Awad-Igbaria et al., 2025). Neuropathic pain is often described as burning, tingling, or electric shock-like, while inflammatory pain is more commonly associated with erythema, erosions, and localized tissue changes. Central sensitization further amplifies pain by increasing neuronal excitability in the spinal cord, allowing chronic pain to persist independently of its initial cause (Baron et al., 2013; Scarpina et al., 2025). Since neuropathic, inflammatory, and central mechanisms can coexist, understanding these distinctions is crucial for targeted diagnosis and treatment.

Clitorodynia can be categorized into localized and generalized forms based on pain distribution. Localized clitorodynia affects only the clitoris and surrounding tissue. In contrast, generalized clitorodynia extends beyond the clitoris to involve the vulva or even the perineal region, often overlapping with conditions such as vulvodynia and vestibulodynia (Parada et al., 2015). Parada et al. suggest that individuals with more severe clitoral pain are more likely to experience widespread genital pain. In contrast, those with milder symptoms tend to have pain that is isolated to the clitoris. Some individuals endure persistent pain that remains constant with little relief, while others experience episodic flares triggered by factors such as sexual activity, friction, or hormonal fluctuations. Classifying clitorodynia as a subset of localized vulvodynia highlights its relationship to other chronic pain disorders;

however, whether localized and generalized clitorodynia represent separate conditions or different stages of the same syndrome remains unclear (Parada et al., 2015). Understanding these distinctions is crucial for diagnosis and treatment, as the nature and spread of the pain can affect how it is managed.

2.2 Differential Diagnosis of Clitorodynia

Clitorodynia has a broad differential diagnosis that may include one or more of the following etiologies: dermatologic, neuropathic, musculoskeletal, psychogenic, hormonal, infectious, urinary, or neoplastic. Each of these potential causes involves distinct pathophysiological mechanisms and presents unique clinical features. Narrowing the differential and distinguishing between these etiologies requires a thorough understanding of their nuances and a detailed patient history, physical examination, and appropriate diagnostic testing.

2.2.1 Dermatologic Causes

Chronic inflammatory and autoimmune disorders can cause persistent genital pain, often presenting with mucocutaneous changes. These conditions may lead to erosions, ulcerations, scarring, or architectural changes, contributing to clitorodynia.

Lichen Sclerosus—Lichen sclerosus is a chronic inflammatory condition commonly affecting the anogenital region, including the clitoral prepuce. It presents with white, atrophic plaques that can cause significant discomfort, including pruritus, burning, and pain (Shalin et al., 2021). In advanced cases, scarring may lead to clitoral phimosis, further contributing to symptoms (Conte et al., 2025). Diagnosis is typically clinical, though biopsy may be warranted in uncertain cases.

Erosive Lichen Planus—Lichen planus can involve the vulva and clitoral area, presenting as violaceous, flat-topped papules or erosions. The erosive subtype, in particular, can lead to significant pain and scarring, sometimes associated with vaginal stenosis. Histopathology may aid in differentiation from other inflammatory conditions. The "glazed appearance" of lichen planus affecting the vulva and clitoral area is a defining clinical feature that aids in diagnosis (Shalin et al., 2021). It is most commonly seen in the vulvar lichen planus (VLP) 's erosive subtype and appears smooth, shiny, erythematous, and often violaceous flat-topped papules or erosions. This distinct presentation helps differentiate lichen planus from other inflammatory conditions, such as lichen sclerosus, which presents as white, atrophic plaques, and psoriasis, which is characterized by well-demarcated erythematous plaques with silvery scales (Shalin et al., 2021).

Genital Psoriasis—Genital psoriasis usually presents differently from typical cutaneous psoriasis, appearing as well-demarcated, erythematous plaques without the characteristic scale seen on other body sites. This can lead to misdiagnosis, especially in the absence of lesions elsewhere on the body. Symptoms may include pruritus, pain, or burning. The Koebner phenomenon, where psoriasis lesions develop at sites of trauma, may contribute to persistent irritation in affected individuals. Sexual dysfunction in psoriasis with genital involvement is thought to be greater in females than in males (Elmets et al., 2019).

Hidradenitis Suppurativa (HS)—Hidradenitis suppurativa is a chronic inflammatory disorder affecting

the apocrine gland-bearing regions, including the vulva and groin. It presents with recurrent painful nodules, abscesses, and sinus tract formation, often leading to scarring (Sabat et al., 2025). Persistent inflammation and fibrosis can result in chronic pain, including clitorodynia, mainly if lesions develop near the clitoral hood.

Plasma Cell Vulvitis (Zoon's Vulvitis)—Plasma cell vulvitis, or Zoon's vulvitis, is a chronic inflammatory condition characterized by well-demarcated, erythematous, and shiny lesions. It most commonly affects the vulvar mucosa. Patients often report burning pain, irritation, and dyspareunia (Virgili et al., 2015). The pathogenesis is unclear, but it is thought to involve a chronic immune-mediated response.

Irritant Contact Dermatitis—Frequent exposure to soaps, detergents, douches, spermicides, lubricants, or personal hygiene products can disrupt the vulvar epithelium and lead to irritation. Friction from tight clothing, excessive moisture, or prolonged exposure to urine or sweat can also exacerbate symptoms. Clinically, irritant contact dermatitis presents with erythema, edema, and sometimes erosions or fissures. The absence of a delayed hypersensitivity reaction distinguishes it from allergic contact dermatitis (Schlosser et al., 2010).

Allergic Contact Dermatitis (ACD)—Allergic Contact Dermatitis (ACD) is a delayed-type hypersensitivity reaction to allergens such as fragrances, preservatives, latex in condoms, nickel in sex toys, or certain medications. Unlike irritant dermatitis, allergic reactions often develop hours to days after exposure and present with pruritic, erythematous plaques or vesicles. Patch testing can help identify specific allergens contributing to symptoms. Avoiding known triggers and using barrier-protecting emollients or topical corticosteroids are key management strategies (Schlosser, 2010).

2.2.2 Neuropathic & Structural Considerations

Neuropathic pain syndromes and structural abnormalities can contribute to clitorodynia, either independently or in combination with other conditions. These conditions are often characterized by burning, stabbing, or electric shock-like pain, which may be exacerbated by touch or pressure.

Postherpetic Neuralgia (PHN)— PHN is a chronic pain syndrome that occurs following a herpes zoster outbreak. If the sacral dermatomes are involved, patients may experience persistent pain in the genital region, including the clitoris (Oaklander & Rissmiller, 2002). The pain is often neuropathic, and it can be burning, tingling, or hypersensitive to touch.

Pudendal Neuralgia—Pudendal neuralgia is caused by compression or irritation of the pudendal nerve, which provides sensory innervation to the external genitalia (Ploteau et al., 2016). Symptoms may include burning pain, numbness, or hypersensitivity in the clitoral and vulvar regions. Sitting typically exacerbates the pain, which is relieved by standing or lying down. A study on pudendal neuralgia (PN) supports this, demonstrating that pain intensity in PN patients is significantly associated with dorsal clitoris nerve damage and sensory deficits in the S2-S4 dermatome. Among the patients analyzed, pain localized to the dorsal clitoris nerve was identified as a significant prognostic factor for poor response to first-line neuropathic pain treatments. Furthermore, longer pain duration correlated with worse prognosis, reinforcing the need for early and comprehensive management. The study also found that a mixed

analgesic ladder for chronic pain led to improvement in 73% of PN patients, underscoring the necessity of multimodal treatment approaches for managing chronic neuropathic pain conditions like clitorodynia (Pereira et al., 2014).

Surgical or Trauma-Induced Nerve Injury—Nerve damage from childbirth, episiotomy, genital surgeries, or traumatic injuries can lead to chronic clitorodynia. Neuropathic pain may persist long after the initial trauma, often requiring multimodal pain management strategies. The dorsal nerve of the clitoris entrapment, due to repetitive trauma or surgery, can lead to persistent neuropathic pain.

Traumatic neuromas result from the regenerative, disorganized proliferation of the proximal portion of lesioned nerves. These neuromas can form in any anatomical site and are a known cause of neuropathic pain. Post-traumatic neuromas of the clitoris have been identified as an uncommon consequence of female genital mutilation/cutting (FGM/C). FGM/C involves partial or total removal of female genital organs for non-therapeutic reasons, potentially damaging the clitoral nerve and leading to neuropathic pain, psychological distress, and sexual dysfunction. A retrospective review of women diagnosed with traumatic neuromas of the clitoris between April 1, 2010, and June 30, 2016, identified seven cases. Six of these women sought clitoral reconstruction, and three reported clitoral pain. Peri-clitoral fibrosis was excised during the reconstruction, revealing a neuroma in all six cases. Post-surgical outcomes indicated pain relief following neuroma excision. The seventh woman presented with a painful, palpable clitoral mass diagnosed as a neuroma, and surgical excision similarly ameliorated her pain. Improved sexual function was noted in five of the seven women postoperatively, while one remained sexually inactive and another had not resumed sexual activity (Abdulcadir et al., 2017). These findings highlight that post-traumatic clitoral neuromas can present as symptomatic or asymptomatic entities in women with a history of FGM/C. When pain is present, surgical excision of the neuroma, often performed during clitoral reconstruction, has demonstrated efficacy in alleviating symptoms.

Vestibulodynia Overlap—Vestibulodynia, a form of localized vulvodynia, is characterized by burning pain and tenderness in the vulvar vestibule. In some cases, the pain extends to the clitoral region, particularly in patients with a heightened pain response or central sensitization.

2.2.3 Musculoskeletal Causes

Chronic pelvic floor dysfunction and musculoskeletal disorders can lead to referred pain affecting the clitoral region. Pelvic floor dysfunction and musculoskeletal disorders can contribute to chronic genital pain. These conditions may cause myofascial trigger points, referred pain, and abnormal muscle tension.

Levator Ani Syndrome—Increased tone in the levator ani muscles can lead to chronic pelvic pain, often described as a deep aching or pressure sensation. Pain may radiate to the vulva and clitoral region due to shared nerve pathways. Anatomical studies have demonstrated that the levator ani muscles are innervated by sacral nerve roots (S3-S5) rather than the pudendal nerve (Barber et al., 2002). Given this distinct innervation, dysfunction or hypertonicity of the levator ani may contribute to clitorodynia by causing referred pain to the clitoris through these sacral nerve connections. Additionally, tension or spasms in these muscles may exacerbate existing neuropathic pain syndromes by increasing pressure on nearby

nerves, further sensitizing the clitoral region.

Chronic Pelvic Muscle Spasm & Myofascial Pelvic Pain Syndrome—Hypertonicity of pelvic floor muscles can lead to myofascial trigger points with consequential referred pain to the vulvar and perineal region (Kadah et al., 2023). This syndrome often coexists with other pain disorders, complicating diagnosis.

Interstitial Cystitis and Bladder Pain Syndrome—Chronic bladder pain, urinary urgency, and frequency may contribute to clitorodynia through shared nerve pathways. Due to the close anatomical relationship between the bladder and clitoral structures, referred pain may also contribute to clitorodynia. Recent neurophysiological research has demonstrated that the medullary reticular formation (MRF) plays a role in both urogenital function and bladder control, responding to stimulation of the dorsal nerve of the clitoris (DNC) and bladder filling. In animal studies, stimulation of the DNC has been shown to influence bladder reflexes, with neural responses in the MRF occurring just before or during voiding cycles (Hubscher et al., 2013). These findings suggest interconnected neural circuits governing bladder function and clitoral sensation. This may explain why bladder pain syndromes such as interstitial cystitis can contribute to clitorodynia through shared central and peripheral pathways.

2.2.4 Psychogenic Causes

Psychogenic pain disorders, including somatization or central sensitization syndromes, may further complicate the diagnostic process. Psychological and central sensitization disorders may play a role in the perception of clitoral pain, often in the absence of clear physical findings. Psychogenic factors can play a significant role in clitorodynia, either as a primary cause or as a contributor to symptom persistence. Chronic pain syndromes often involve complex interactions between psychological, neurological, and physiological processes.

Somatization Syndromes—Physical symptoms arising from psychological distress, contributing to chronic pain. Somatization refers to the manifestation of physical symptoms that an underlying medical condition cannot fully explain. Patients with somatic symptom disorder may experience persistent genital pain despite a lack of identifiable pathology. These individuals often have a history of multiple unexplained symptoms affecting various organ systems. Psychological stressors, past trauma, or underlying anxiety and depression can contribute to symptom amplification.

Central Sensitization Syndromes—Central sensitization describes a state in which the central nervous system becomes hyperresponsive to stimuli, leading to heightened pain perception. This phenomenon is common in conditions like fibromyalgia, chronic regional pain syndrome, and vulvodynia. Patients with central sensitization often report allodynia and hyperalgesia. In a study of vulvodynia patients, clitorodynia was identified in 6.7% of cases, and patients with this condition usually had more severe pain and longer durations of discomfort. Central sensitization was linked to more intense symptoms and poorer treatment responses. Patients with clitorodynia and central sensitization responded less favorably to standard treatments, requiring more intensive and prolonged therapy (Rubal et al., 2023). Functional MRI studies suggest that altered brain and spinal cord pain processing contributes to symptom

persistence (Hampson et al., 2013).

2.2.5 Hormonal Causes

Hormonal fluctuations and deficiencies can contribute to genital discomfort, particularly in postmenopausal individuals or those with conditions affecting estrogen levels.

Menopause and Genitourinary Syndrome of Menopause (GSM)—GSM encompasses a range of symptoms resulting from estrogen deficiency, including vulvovaginal atrophy, dryness, irritation, and pain. The clitoral region may become hypersensitive or, conversely, less sensitive due to mucosal thinning and decreased vascularization. Patients often report dyspareunia and chronic vulvar discomfort. Examination may reveal pale, fragile, or atrophic mucosa with loss of elasticity. Management typically includes vaginal moisturizers, lubricants, and local estrogen therapy, which has been shown to improve mucosal integrity and reduce symptoms (Shifren, 2018).

Testosterone Deficiency—Testosterone deficiency, which is often overlooked, can also contribute to genital discomfort, particularly in the clitoral area. It may lead to diminished clitoral tissue integrity, reduced sensitivity, and pain. While estrogen therapy improves vaginal and vulvar tissues, addressing testosterone deficiency is crucial for optimal sexual function and clitoral health. Hormonal replacement strategies, including testosterone therapy, may be considered in select cases to restore tissue integrity and reduce pain, especially in postmenopausal women or those with low androgen levels.

2.2.6 Infectious Causes

Infectious etiologies, such as recurrent vulvovaginal candidiasis and herpes simplex virus (HSV) infection, may induce prolonged pain and irritation. Recurrent or chronic infections can lead to inflammation, irritation, and persistent genital pain. Infectious etiologies should be considered, especially in patients with episodic flare-ups of symptoms.

Herpes Simplex Virus (HSV)—HSV-1 and HSV-2 infections can cause painful vesicular eruptions on the genitalia. These eruptions can present on or near the skin of the clitoris, such as the clitoral hood, leading to clitorodynia (Barroso Dos Reis et al., 2020). Primary infections are often severe, with systemic symptoms and extensive ulcerations, while recurrent outbreaks may present with localized burning or tingling. Chronic post-herpetic pain may persist even after lesion resolution due to viral effects on sensory nerves. Antiviral therapy can reduce the frequency of recurrence and alleviate symptoms (Workowski et al., 2021).

Chronic Bacterial Vaginosis—BV is characterized by an overgrowth of anaerobic bacteria, leading to vaginal discharge, irritation, and sometimes burning pain. While BV is typically associated with malodorous discharge, chronic or recurrent infections may contribute to mucosal inflammation and discomfort extending to the clitoral area. Treatment involves metronidazole or clindamycin, but recurrence is common.

Severe Candidiasis—Severe vulvovaginal candidiasis can cause persistent vulvar irritation, erythema, and burning pain. Candida infections are often associated with pruritus and thick, curd-like discharge. Factors such as diabetes, immunosuppression, or antibiotic use may predispose individuals to recurrent

episodes. Antifungal therapy, topical or systemic, is the mainstay of treatment, with prophylactic regimens considered for frequent recurrences (Workowski et al., 2021).

2.2.7 Urinary Causes

Urologic conditions can contribute to genital discomfort due to the proximity of the bladder, urethra, and clitoral structures. These conditions may cause referred pain or direct mucosal irritation.

Interstitial Cystitis/Bladder Pain Syndrome (IC/BPS)—Interstitial cystitis/bladder pain syndrome (IC/BPS) should be considered in the differential diagnosis of clitorodynia, particularly in patients with concurrent bladder symptoms and pelvic pain. IC/BPS is a chronic pain disorder characterized by bladder discomfort, urinary urgency, frequency, and suprapubic or pelvic pain, which often overlaps with vulvar and clitoral pain due to shared nerve pathways and pelvic floor dysfunction. A sensory mapping study of pelvic dermatomes found that women with IC/BPS exhibited hyperalgesia in all pelvic regions, with the clitoral (S4-S5) region showing the highest pain intensity (5/10), surpassing other measured areas, supporting the role of altered central pain processing (Sanses et al., 2018). Unlike primary clitorodynia, which may result from localized nerve irritation or hormonal deficiencies, IC/BPS-related clitoral pain is typically associated with bladder filling, pelvic floor tenderness, and central sensitization, leading to exaggerated pain responses. Proper differentiation is essential, as treatment strategies differ; IC/BPS management may include bladder training, oral medications such as pentosan polysulfate, neuromodulators like amitriptyline, and pelvic floor therapy, whereas primary clitorodynia may require localized interventions such as topical lidocaine, hormonal therapy, or nerve blocks.

Recurrent Urinary Tract Infections (UTIs)—Recurrent urinary tract infections (UTIs) should also be considered in the differential diagnosis of clitorodynia, as bladder inflammation and nerve sensitization can contribute to referred pain in the clitoral region. A mouse study demonstrated that *Uropathogenic E. coli* (UPEC), the primary cause of UTIs, induces bladder hypersensitivity by increasing inflammatory cytokines and sensitizing bladder afferent nerves (Brierley et al., 2020). This heightened sensory input may extend to the clitoris due to shared neural pathways between the bladder and external genitalia, leading to persistent discomfort even after the infection resolves. Clinically, recurrent or chronic UTIs can present with clitoral pain alongside dysuria, urgency, and pelvic discomfort, mimicking primary clitorodynia. Recognizing UTI-related clitorodynia is essential, as symptoms may improve with appropriate antimicrobial treatment and preventive measures such as increased hydration and post-coital voiding.

2.2.8 Neoplastic and Pre-Neoplastic Causes

Vulvar intraepithelial neoplasia (VIN)—Vulvar intraepithelial neoplasia (VIN) is a premalignant condition characterized by dysplastic changes in the vulvar epithelium, which can present with pain, burning, irritation, or pruritus in the clitoral region. VIN may mimic other dermatologic disorders, making biopsy essential for diagnosing suspicious or non-resolving cases. High-grade VIN carries an increased risk of progression to vulvar squamous cell carcinoma, necessitating close monitoring and possible excision. Differentiated VIN (dVIN) should be considered in cases of persistent clitorodynia

that do not respond to conventional treatment. It often arises in individuals with chronic inflammatory skin conditions such as lichen sclerosus or lichen planus, presenting as ill-defined, thickened, or hyperkeratotic plaques that may cause burning, pain, or soreness (Preti et al., 2014). Clitoral involvement can lead to localized hypersensitivity or discomfort, resembling other neuropathic or inflammatory pain disorders. Because dVIN can be challenging to distinguish from its underlying dermatosis, a biopsy is recommended for suspicious, non-healing lesions to rule out neoplastic changes. While not all biopsied plaques confirm dVIN, early detection is crucial due to its higher risk of malignant transformation. Unlike primary clitorodynia, which is often managed with conservative or nerve-targeted therapies, dVIN may require surgical excision or long-term surveillance to prevent cancer progression.

Vulvar Squamous Cell Carcinoma (VSCC)—Vulvar squamous cell carcinoma (VSCC) is the most common malignancy of the vulva, often arising from high-grade VIN or dVIN (Hinten et al., 2015). Clitoral involvement can cause persistent pain, ulceration, or a non-healing lesion, making it a key differential diagnosis in refractory clitorodynia. Unlike neuropathic or hormonal causes, VSCC is often associated with visible lesions, bleeding, or an indurated mass on examination. Diagnosis requires a biopsy, and management includes wide local excision, radiation therapy, or chemotherapy, depending on the disease stage. Patients with clitoral SCC have worse disease-specific survival (DSS) compared to those without clitoral involvement, which may be attributed to larger tumor size, deeper invasion, lymphovascular space involvement (LVSI), positive margins, and a higher rate of lymph node metastasis rather than the location itself (Hinten et al., 2015). A retrospective study analyzing patients with primary vulvar SCC found that while Kaplan-Meier survival analyses showed worse DSS in patients with clitoral SCC, a multivariable analysis suggested that tumor invasion depth, differentiation grade, and lymph node status are the primary prognostic factors rather than clitoral localization alone (Hinten et al., 2015).

2.2.9 Broad Differential Diagnosis in Clitorodynia

This section outlines the most common diagnoses in the differential for clitoral pain, though not exhaustive (Table 1). A thorough evaluation of dermatologic conditions in patients with clitorodynia is crucial for accurate diagnosis and appropriate management. Clinicians should maintain a broad differential, utilize diagnostic tools such as biopsy when needed, and consider multidisciplinary collaboration involving dermatologists, gynecologists, pain specialists, and physical therapists may be required to optimize patient outcomes.

Table 1. Differential Diagnosis of Clitorodynia: Overview of Conditions and Key Features Across Categories that can Present with Clitoral or Vulvar Pain

Category	Conditions	Key Features
Dermatologic	Lichen sclerosus, lichen planus, genital psoriasis, contact dermatitis	Skin changes, itching, white plaques
Neuropathic	Pudendal neuralgia, postherpetic neuralgia, nerve injuries, vestibulodynia	Sharp, burning, or shooting pain in genitals
Musculoskeletal	Pelvic muscle tension, levator ani syndrome	Pain with pelvic muscle contraction, tenderness
Psychogenic	Somatization, central sensitization (e.g., fibromyalgia)	Chronic pain with psychological factors
Hormonal	Menopause, testosterone deficiency	Vaginal dryness, reduced libido
Infectious	HSV, chronic bacterial vaginosis, vulvovaginal candidiasis	Infections causing pain, irritation, discharge
Urinary	Interstitial cystitis, recurrent UTIs	Painful urination, urinary frequency
Neoplastic	Vulvar neoplasia, vulvar carcinoma	Growths, abnormal lesions

2.3 Diagnostic Approach for the Dermatologist

The diagnosis of vulvar pain conditions is usually clinical, requiring comprehensive history taking and physical examination to distinguish differential diagnoses. Primary clitorodynia occurs in the absence of underlying pathologic processes and necessitates a thorough examination to differentiate pain originating from a specific source. The diagnostic approach to clitorodynia begins with the patient characterizing the history of their pain. The 2021 European guideline for managing vulval conditions recommends using an OPQRST mnemonic approach to describe vulvar pain onset, provocation, quality, region, severity, and timing (Van der Meijden et al., 2022). Further investigation should determine whether there are any known associated triggers or functional impairments resulting from pain. Additionally, a detailed characterization of the pain and its chronologic progression is necessary to determine whether there are periods of remission or exacerbations.

Dermatologists are well-positioned to distinguish localized vulvar dermatoses from clitorodynia, including infectious and inflammatory etiologies. To assess potential dermatologic involvement, associated symptomatology, including pruritus, scaling, ulcerations, and dyspareunia, should be discussed. A detailed history of previous treatments and their therapeutic efficacy should be reviewed, which may provide insight into the involvement of underlying processes contributing to pain. Given the association between vulvar pain disorders and sex hormone imbalances (Goldstein et al., 2021; Amirthalingam & Nalliah, 2024), history should include menstrual cycles, hormonal contraceptive use,

and other hormone therapies, including infertility treatments. Importantly, patients presenting with clitorodynia require screening for disordered sleep, anxiety, and depression (Amirthalingam & Nalliah, 2024). Chronic pain can cause significant psychosocial distress, resulting in comorbid psychiatric conditions. Establishing a trusting patient-physician relationship and developing a structured approach to history-taking are essential for excluding secondary causes of clitorodynia and providing patient-centered care.

To conduct a comprehensive dermatologic and neurologic assessment, dermatologists should be well-trained in performing vulvovaginal examinations. A thorough understanding of the anatomy, vasculature, and innervation of the clitoris is necessary to diagnose clitorodynia. While dermatologists receive formal training on conducting genital examinations, many do not include genital examinations as part of routine practices (Comstock et al., 2020; Hosking et al., 2021). As a result, some dermatologists may be uncomfortable conducting diagnostic assessments of the clitoris beyond routine physical examination. Dermatologic inspection includes assessing for color changes, lichenification, ulceration, scarring, and fissures. Clitoral adhesions may indicate an underlying inflammatory process, such as lichen sclerosus (Aerts et al., 2018). A cotton swab can be gently applied to the clitoris to assess for allodynia and to localize the pain response. This procedure can be repeated with localized anesthetic injections to determine whether the pain originates in the clitoris or elsewhere (Amirthalingam & Nalliah, 2024; Goldstein et al., 2021). Results of anesthesia testing may warrant further diagnostic investigation into neuropathic causes.

The clitoris is innervated by terminal branches of the pudendal nerve, specifically the dorsal nerve, which can produce a heightened neurological response as a result of trauma. Genital and perineal trauma, including surgeries, deliveries, clitoral phimosis, and sexual trauma, can damage the pudendal nerve along its pathway, resulting in clitoral hypersensitivity. Pelvic floor dysfunction can result in hypertonic musculature within the perineum that causes pudendal nerve compression. Dermatologists can test for increased contractile activity within the pelvic floor with palpatory techniques, electromyography, and ultrasound (Goldstein et al., 2021). Clitorodynia secondary to myofascial involvement necessitates a multidisciplinary care approach in collaboration with physical therapists who specialize in pelvic floor rehabilitation.

When initial history and physical examinations are inconclusive, dermatologists may rely on adjuvant diagnostic testing, particularly in the presence of risk factors that suggest the potential involvement of underlying pathologic processes. Concerning physical exam findings, such as the presence of atypical lesions, may warrant a biopsy to rule out malignancy, lichen sclerosus, or lichen planus. However, dermatologists may not receive adequate training to confidently perform genital biopsies (Comstock et al., 2020). Furthermore, genital biopsies require shared decision-making between the patient and provider and should only be considered in situations where biopsy results would meaningfully influence subsequent treatment decisions. Allodynia in chronic pruritus and an unidentified trigger may require patch testing for suspected allergic contact dermatitis (Al-Niaimi et al., 2014). Other diagnostic testing

can include microbiological cultures to rule out chronic candidiasis or antibiotic-resistant bacterial vaginosis. A comprehensive diagnostic approach, including clinical evaluation and adjuvant testing when necessary, is essential to appropriately diagnose clitorodynia and determine therapeutic modalities to target the underlying cause or target neuropathic pain pathways.

2.4 Treatment Approaches in the Dermatology Clinic

Managing clitorodynia requires a targeted approach that responds to the underlying dermatologic, neuropathic, and inflammatory mechanisms contributing to symptoms. These approaches may be non-pharmacological (Table 2) or pharmacological (Table 3). Dermatologists play a crucial role in diagnosing and treating cutaneous and neuropathic causes of clitoral pain, often in collaboration with gynecologists, pain specialists, and physical therapists. Treatment strategies should be tailored to the specific etiology, emphasizing restoring skin barrier function, reducing inflammation, and alleviating neuropathic pain.

Table 2. Non-Pharmacologic Options for the Management of Clitorodynia

Sexual Counseling	Address emotional distress related to sexual dysfunction.
Cognitive behavioral therapy	Modifies pain beliefs and enhances coping strategies.
Pelvic Floor Therapy	Relieves pelvic muscle tension, improves pain perception.
Biofeedback	Helps patients regulate muscle tension and pelvic floor activity using real-time feedback.
Mindfulness	Reduces pain sensitivity through stress reduction techniques.

Table 3. Pharmacologic Options for the Management of Clitorodynia

Topical corticosteroids	Reduces inflammation and prevents disease progression in inflammatory dermatoses.
Topical calcineurin inhibitors	Modulates immune response, reduces inflammation.
Neuromodulators	Reduces neuropathic pain by stabilizing nerve function.
Antidepressants	Modulates 5-HT/NE pathways to alleviate pain and emotional distress.
Topical Anesthetics	Provides temporary relief from localized pain and burning.
Estrogen	Restores tissue integrity, reduces hypersensitivity in estrogen-deficient tissues.
Testosterone	Enhances vascularization and reduces discomfort in androgen-deficient tissues.
Naltrexone (low-dose)	Modulates pain pathways by reducing neuroinflammation and central sensitization.

2.4.1 Targeting the Dermatologic Cause

For lichen sclerosus, the first-line treatment is high-potency topical corticosteroids, such as clobetasol propionate 0.05%, applied daily for several weeks before tapering to a maintenance regimen. Long-term corticosteroid use has been shown to prevent disease progression and reduce the risk of scarring and malignant transformation. Alternative management options include calcineurin inhibitors such as tacrolimus or pimecrolimus (Borghi & Corazza, 2021). Patients should be counseled on proper application techniques to minimize adverse effects such as skin thinning.

Treatment of erosive lichen planus typically involves calcineurin inhibitors such as tacrolimus or pimecrolimus (Usatine & Tinitigan, 2011). These inhibitors help modulate the immune response while avoiding the atrophic effects of corticosteroids. In severe cases, systemic corticosteroids or immunosuppressants like methotrexate may be required (Dunaway et al., 2020). Chronic cases often require long-term management to prevent relapses.

Due to the thin, sensitive nature of genital skin, low-potency corticosteroids, such as hydrocortisone or desonide, are often preferred for genital psoriasis. Vitamin D analogs like calcipotriene may also be used, but they should be applied cautiously to avoid irritation. If symptoms persist, biologic therapies targeting interleukin-17 (IL-17) or tumor necrosis factor-alpha (TNF-α) may be considered in patients with widespread disease (American Academy of Dermatology Work Group et al., 2011).

Identifying and eliminating the offending allergen is the cornerstone of management for allergic contact dermatitis. Treatment typically involves short-term topical corticosteroids and barrier-protecting emollients to restore skin integrity.

2.4.2 Neuropathic Pain Management

Neuropathic pain plays a significant role in many cases of clitorodynia, either as a primary contributor or as a consequence of chronic inflammation and nerve sensitization. Treatment should focus on stabilizing nerve function, reducing hyperalgesia, and improving quality of life.

Topical anesthetics, such as lidocaine 5% in a patch or gel, can temporarily relieve the affected area and reduce pain signaling (Usatine & Tinitigan, 2011). Some patients may benefit from pre-applying lidocaine before activities that exacerbate symptoms. However, prolonged use should be monitored, as it may cause irritation or paradoxical sensitization in some individuals.

Systemic neuromodulating agents can target nerve pain and can be effective for chronic clitorodynia. Gabapentin and pregabalin are commonly used anticonvulsants that modulate calcium channels to reduce neuropathic pain (Bachmann et al., 2019). Amitriptyline and duloxetine, both of which affect serotonin and norepinephrine pathways, have also been shown to provide relief in vulvar pain syndromes. Dosing should be titrated gradually to minimize side effects such as drowsiness or dizziness (Kaur et al., 2011).

In refractory cases of clitorodynia with significant neuropathic involvement, pudendal nerve blocks may be considered. These involve injecting local anesthetics and corticosteroids around the pudendal nerve to relieve pain. While not a long-term solution, nerve blocks can help break the cycle of chronic pain and facilitate other rehabilitative treatments, such as pelvic floor therapy (Mamlouk et al., 2014).

2.4.3 Testosterone or Estrogen Therapy

Hormonal deficiencies, particularly in estrogen and testosterone, have been implicated in the development of genital atrophy, which can contribute to clitorodynia. Estrogen therapy, administered either systemically or topically, helps restore vaginal and vulvar mucosal integrity by increasing vascularization, enhancing collagen production, and improving tissue elasticity. This can reduce hypersensitivity and irritation in the clitoral region, providing symptom relief in patients with hormonal deficiency-related atrophy. Cipriani et al. demonstrated that local estrogen therapy significantly improves blood flow to the clitoral and vulvar tissues, reducing atrophy-related discomfort and enhancing tissue resilience (Cipriani et al., 2021). Their study found that estrogen supplementation not only restored epithelial thickness but also improved nerve density, which may have direct implications for reducing clitoral pain and hypersensitivity. Additionally, Krapf et al. reported that estrogen therapy led to increased sexual satisfaction and reduced pain in postmenopausal women experiencing vulvovaginal atrophy, likely due to its effects on mucosal hydration, tissue elasticity, and neurovascular function (Krapf, 2024). These findings suggest that estrogen therapy may help mitigate symptoms of clitorodynia by addressing both structural atrophy and potential neuropathic contributions.

Similarly, testosterone therapy has been explored for its role in maintaining genital tissue health, with topical formulations demonstrating potential benefits in improving clitoral sensitivity and reducing discomfort in individuals with androgen insufficiency. Testosterone has been shown to enhance clitoral vascularization and increase nerve density, potentially alleviating neuropathic components of clitorodynia. Krapf et al. found that testosterone therapy improved arousal and lubrication in women with hypoactive sexual desire disorder, which may translate to benefits in individuals with clitorodynia experiencing diminished sensation and discomfort (Krapf, 2024). Future research should explore optimal dosing regimens and the long-term effects of combined estrogen and testosterone therapies in patients with clitoral pain syndromes.

2.4.4 Low-dose Naltrexone (LDN)

Low-dose naltrexone (LDN) has emerged as a potential treatment for chronic pain syndromes due to its ability to modulate neuroinflammation and central sensitization. A recent case series evaluating LDN for vulvodynia found that patients who had previously failed standard therapies reported subjective improvement in their pain levels after initiating LDN, with some continuing treatment for extended periods due to sustained benefits (Sullender et al., 2024). The proposed mechanisms include modulation of microglial activation in the central nervous system, reducing neuroinflammation and pain hypersensitivity. Additionally, LDN is thought to increase endorphin and enkephalin levels following opioid receptor blockade, contributing to its analgesic effects. Patients in the case series reported minimal side effects, further supporting its potential role as a safe and tolerable adjunctive treatment for chronic clitoral pain (Sullender et al., 2024). Given the overlap in neuropathic mechanisms between vulvodynia and clitorodynia, LDN may serve as a promising therapy for individuals experiencing persistent clitoral pain, particularly those who have not responded to conventional treatments. Future studies should focus

on optimizing dosing strategies and assessing long-term outcomes in this patient population.

2.4.5 Adjunctive Care & Patient Education

Increasing evidence on sexual dysfunction interventions suggests that structured counseling programs can significantly improve sexual function and reduce pain-related distress (Işık & Aslan, 2023). A randomized controlled trial by Işık et al. demonstrated that sexual counseling combined with pelvic floor relaxation therapy significantly improved sexual function scores in women undergoing vaginismus treatment. Participants in the intervention group reported increased desire, arousal, and reduced pain, highlighting the benefits of a comprehensive, structured approach to sexual health education (Işık & Aslan, 2023). These positive results support the potential application of similar counseling strategies in patients with clitorodynia, where avoidance behaviors and anxiety around intimacy are common barriers to recovery. Implementing a tailored counseling model that integrates education, motivation, and behavioral interventions can help patients manage pain while fostering positive sexual experiences.

Chronic genital pain is closely linked to psychological distress, sexual dysfunction, and diminished quality of life. Cognitive behavioral therapy (CBT) is an effective intervention for chronic vulvar pain syndromes by addressing maladaptive pain beliefs, reducing pain catastrophizing, and improving coping strategies (Masheb et al., 2009). Masheb et al.'s work on CBT for vulvodynia demonstrated reductions in pain severity and distress, along with improvements in sexual function and quality of life (Masheb et al., 2009). Since vulvodynia and clitorodynia share similar neuropathic and psychosocial pain mechanisms, CBT may hold promise for clitorodynia by targeting the fear-avoidance behaviors and emotional distress associated with chronic clitoral pain. Techniques such as cognitive restructuring, mindfulness, and exposure therapy have been particularly beneficial in breaking the cycle of pain-related avoidance behaviors. Further studies should explore the specific adaptations needed for CBT interventions targeting clitorodynia, including individualized therapy models and integration with multidisciplinary pain management programs.

3. Future Directions & Research Gaps

3.1 Advancing Dermatology-Specific Guidelines for Clitorodynia

Despite increasing recognition of vulvar pain disorders, there is a notable lack of dermatology-specific guidelines for the evaluation and management of clitorodynia. Current diagnostic pathways primarily focus on gynecological and pain medicine perspectives, often overlooking dermatologic contributions. Developing interdisciplinary guidelines incorporating dermatologic expertise alongside gynecology, urology, and pain medicine will provide a more comprehensive framework for diagnosis and treatment (Van der Meijden et al., 2022). These guidelines should emphasize a structured approach integrating dermatologic examinations, biopsies, contact allergy assessments, and targeted pharmacologic interventions. Further, improving dermatologic training in vulvar examinations and biopsy techniques will enhance early recognition and reduce misdiagnosis (Comstock et al., 2020; Hosking et al., 2021).

3.2 Investigating Emerging Therapies for Clitorodynia

Several novel therapeutic interventions are being explored for clitorodynia, particularly in refractory cases.

3.2.1 Platelet-Rich Plasma (PRP) Injections

PRP therapy involves isolating and concentrating platelets from a patient's blood to enhance tissue repair and neuromodulation. PRP can potentially improve nerve regeneration, increase vascularization, and reduce pain sensitivity in genital tissues (Tognazzo et al., 2023). In clinical applications, PRP has been used for post-female genital mutilation reconstruction, demonstrating benefits in tissue healing and pain relief. PRP's mechanism of action involves the release of growth factors such as platelet-derived growth factor (PDGF) and transforming growth factor-beta (TGF-β), which promote collagen synthesis and tissue remodeling (Tognazzo et al., 2023). While PRP shows promise in addressing neuropathic and atrophic-related clitorodynia, further randomized controlled trials are needed to validate its efficacy and determine optimal injection protocols.

3.2.2 Botulinum Toxin for Neuromodulation

Botulinum toxin type A has demonstrated efficacy in treating pelvic pain conditions characterized by muscular hypertonicity and neuropathic pain, including vaginismus and vestibulodynia (Abbott et al., 2006). Its therapeutic mechanism blocks acetylcholine release at the neuromuscular junction, leading to temporary muscle relaxation and decreased pain sensitivity. Abbott et al. investigated botulinum toxin for pelvic floor dysfunction and found significant reductions in pain scores and muscle tension post-injection (Abbott et al., 2006). Given that some cases of clitorodynia involve pelvic floor hypertonicity, botulinum toxin injections may provide relief by reducing excessive muscle contraction and alleviating pressure on the pudendal nerve. However, additional research is needed to establish dosing strategies, injection sites, and long-term outcomes in clitorodynia-specific applications.

3.2.3 Low-Intensity Laser Therapy (LLLT) and Regenerative Medicine

Low-Intensity Laser Therapy (LLLT) is a non-invasive therapeutic modality that employs low-level laser light to modulate cellular function, reduce inflammation, and promote nerve regeneration. A randomized controlled trial evaluating LLLT for provoked vestibulodynia demonstrated a significant reduction in pain and improved tissue resilience, suggesting a potential role for LLLT in treating vulvar pain syndromes (Lev-Sagie et al., 2017). The biological effects of LLLT include enhanced mitochondrial activity, increased ATP production, modulation of pro-inflammatory cytokines, and improved microcirculation. These mechanisms collectively contribute to tissue healing and pain relief (Lev-Sagie et al., 2017). While LLLT presents a promising treatment avenue for clitorodynia, further investigations are required to determine optimal wavelengths, treatment duration, and patient selection criteria.

3.2.4 Expanding the Role of Digital and Wearable Technologies

The growing integration of digital health tools in dermatology, wearable biosensors, and mobile health applications may provide innovative solutions for clitorodynia management. Digital pain tracking tools can facilitate real-time symptom monitoring, allowing patients to log pain intensity, triggers, and

treatment responses. Mobile health applications can also support patient education on non-pharmacological interventions, including mindfulness, biofeedback, and pelvic floor relaxation techniques (Parada et al., 2015). Future studies should explore how these technologies can enhance patient self-management and improve clinical decision-making.

4. Conclusion

Clitorodynia is a complex pain disorder that requires a comprehensive and multidisciplinary approach for effective management. Dermatologists, given their expertise in evaluating genital skin conditions, play a vital role in differentiating clitorodynia from inflammatory, neuropathic, and hormonal disorders. A structured diagnostic strategy—including history-taking, dermatologic and neurologic examinations, and targeted testing—ensures accurate identification of contributing factors. Treatment must be individualized, integrating topical corticosteroids for inflammatory dermatoses, neuromodulating agents for neuropathic pain, and hormonal therapies when deficiencies are identified. Adjunctive therapies such as pelvic floor physical therapy, cognitive behavioral therapy, and patient education further optimize outcomes. Additionally, emerging interventions, including PRP injections, botulinum toxin, and digital health solutions, hold promise for improving symptom management in refractory cases. Increased awareness, interdisciplinary collaboration, and the development of dermatology-specific guidelines are essential for advancing clinical care and improving patient outcomes for this underrecognized and debilitating condition.

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