**Materials and Methods**

*Study Design and Population*

This was a cross-sectional observational pilot study of patients aged ≥18 years with idiopathic vulvar pain, and without other associated vulvar comorbidity, lasting at least 3 months who attended the department of dermatology of a general hospital between 2000 and 2015. We excluded patients who were pregnant, lactating, had given birth within 6 weeks, had undergone vulvar surgery, or were immunosuppressed. All consecutive patients fulfilling the inclusion criteria were invited to participate. After providing written informed consent, patients who agreed to participate filled in the questionnaires described below during or after the visit at which the diagnosis of vulvodynia was established.

The sample size required for 95% confidence and 5% precision given an estimated prevalence of 10% of vulvodynia was 109 patients.

*Variables*

The primary variable was the characteristics of pain. Secondary variables were sociodemographic data (age and employment status), clinical data (vulvodynia-associated symptoms, pain duration, presence of candidiasis), medical and psychiatric comorbidities (anxiety and depression), quality of life, and treatment (drug and/or physical therapy).

*Pain Evaluation*

To assess the intensity and quality of pain, we used two unidimensional scales and one multidimensional scale:

* Unidimensional scales:
	+ Verbal Rating Scale (VRS). The VRS asks patients to describe the intensity of their pain by choosing one of the following descriptors: mild, moderate, severe, very severe, or unbearable. Each term is assigned a score: mild = 1, moderate = 2, severe = 3, very severe = 4, and unbearable = 5.
	+ Visual Analogue Scale (VAS). The VAS is a numerical scale (0–10) on a 10-cm straight line labelled from left (no pain = 0) to right (unbearable pain = 10). Patients situate their pain on the line, and its distance in cm from the 0 value represents the intensity of the pain.
* Multidimensional scale:
	+ The Spanish version of the McGill Pain Questionnaire (SV-MPQ) [29, 30] measures three components of pain: sensory (descriptors of the sensory qualities of the experience in terms of temporal, spatial, pressure, thermal, and other), affective (descriptors of affective qualities, such as tension, fear, and autonomic properties), and evaluative (descriptors of the subjective overall intensity of pain). Two subscales of the SV-MPQ, the Pain Rating Index (PRI) and the Number of Words Chosen (NWC), were employed. PRI scores were calculated for each category (sensory or S-PRI; affective or A-PRI; evaluative or E-PRI) as well as for the total sum of the scale values of the words chosen in all categories (T-PRI). The NWC correlates with the PRI, as the more words chosen, the higher the PRI [30].

*Anxiety, Depression, and Quality of Life Evaluation*

* Anxiety was assessed with the Spanish version of the 14-item Hamilton Anxiety Rating Scale (HAM-A), where each item is scored on a 5-point scale (0 = not present to 4 = severe). The possible total score ranges from 0 to 56; scores ≤17 indicate mild anxiety, 18–24 mild-to-moderate anxiety, and 25–30 moderate-to-severe anxiety [31].
* Depression was assessed with the Spanish version of the Hospital Anxiety and Depression Scale (HADS), a 14-item scale comprising 7 items related to anxiety (HADS-A) and 7 items related to depression (HADS-D). Each item is scored on a 4-point scale (0–3), so the possible score ranges from 0 to 21 for anxiety and from 0 to 21 for depression. Scores ranging from 0 to 7 points are considered normal, from 8 to 10 borderline abnormal, and from 11 to 21 abnormal; thus, a score of 8 is the cut-off point for anxiety or depression [32].
* Quality of life was assessed with the Spanish version of the Dermatology Life Quality Index (DLQI), a 10-item questionnaire where answers to each question are scored on a 4-point scale (0 = not relevant/not at all; 1 = a little; 2 = a lot; 3 = very much), resulting in a possible score range from 0 (no impact on the quality of life) to 30 (maximum impact on the quality of life) [33, 34].

*Data Collection*

All clinical data were obtained from patients’ medical records. Each patient included in the study was assigned a serial number linking data to an external list. Variables were recorded in a data collection logbook, which was later introduced along with the medical records into a double-validated Excel database specially designed for the study.

*Data Analysis*

Categorical variables are expressed as frequencies and percentages. Continuous variables are expressed as means and standard deviations, and ordinal variables are expressed as medians and interquartile ranges. The Kolmogorov-Smirnov test was used to verify the normal distribution of the variables.

To analyse the correlation of total pain scores with anxiety and/or depression and quality of life, we used Spearman’s rho correlation coefficient. To analyse the associations of anxiety/depression score and quality of life with the presence or absence of intense pain, we used Student’s *t* test for two independent variables. To analyse associations of sociodemographic and clinical variables with the presence of severe pain, we used the χ2 test, Fisher’s exact test, or Student’s *t* test for two independent variables, as appropriate.

All tests were two-tailed and statistical significance was set at 0.05. SPSS version 22.0 was used for all analyses.