Ask an Expert: Vulval Conditions

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Please note:

This presentation contains multiple images of vulval conditions for the purposes of upskilling clinicians in the recognition of these conditions.

Incidence of vulva disorders is unknown.

All statistics are extrapolated from studies of incidence/prevalence in small regions, individual practices, disease registries.

Vulva clinic patients

- Check and elaborate history including:
  - atopy/autoimmune disease
  - relationship/sexual activity
  - medication; immune modulators?
- Examine entire anogenital tract: mons, vulva, inguinal creases, perineum, anus and perianal skin, buttocks
- Offer information to take home; printed, web links

Medical photography

- Photographs taken to provide:
  - education for patient
  - explanation of anatomy, symptoms, difficulties
  - how and where to put their medications
  - allow for more accurate follow-up

Medical photography

- Consent is essential
- Levels of consent:
  - patient's own record only
  - patient record, teaching but not publication
  - patient record, teaching and publication

Every patient

- Ask how they clean their genital area, including opening bowels
- Inquire (appropriately & tactfully) about sexual activity
- advise re; cleansing, lubrication, sexual position (if appropriate)

Useful things to always keep in mind

- Naturally self lubricating
- Meant to be moist
- Own normal microbiome
- 'aroma' varies with cycle and some contraceptive approaches in healthy females
- Minimise exposure to irritants/allergens
- Understand what is normal – this changes over a woman's life

Patient messages

- No soap
- No perfume
- Careful choice of sanitary products/continence aids
- Careful choice of condoms
- Careful choice of lubricants
- Careful choice of toilet paper
- Natural fibre underwear
- Loose fitting underwear ≠ 'thong'/G string
- Protective barrier when exercising

Lichen sclerosus (LS)

Questions sent in:

- Lichen sclerosus etiology
- Lichen planus v lichen sclerosus
- How to safely diagnose lichen sclerosus
- Is biopsy of lichen sclerosus a must before starting treatment?
- Treatment for lichen sclerosus
- Best corticosteroid cream for lichen sclerosus
- Would like to be able to clearly distinguish between lichen sclerosis and other common vulval skin conditions
- Most current treatment of such

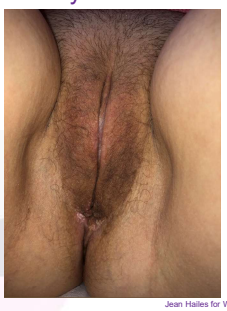
Incidence and cause(s)

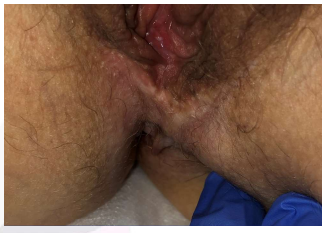
- Neither common or rare
- Male and female, all ages
- Unknown, combination genetic, hormonal, trauma
- Autoinflammatory, antibodies of undetermined significance to date

Lichen sclerosus (LS)

- Most commonly affects external genitalia of postmenopausal women
- Not glycogenated epithelium (vestibule/vagina)
- Extragenital lesions occur, may be the only lesion(s)
- 12-20% incidence of related autoimmune disorders: thyroid, pernicious anaemia, vitiligo, alopecia areata
- Co-morbid lichen planus occurs on vulva and increased incidence of oral LP with vulval LS

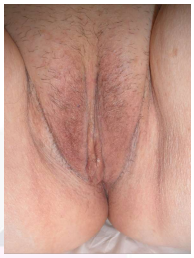
Case 32 year old 8 month itch

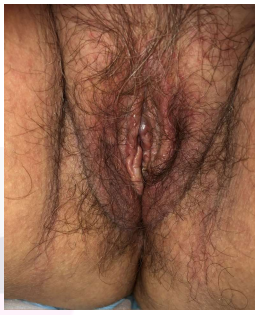
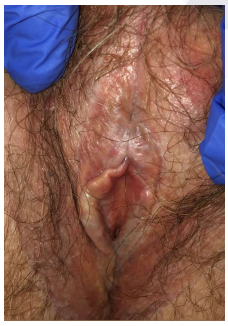




Diagnosis

- Overall visual
- Part the labia minora
- Examine anal area



Case 72 yo

Treatment

- Potent or ultra potent topical corticosteroid preparations
- 'clobetasone dipropionate 0.05%', 'gold standard' ??
- 'clobetasone butyrate 0.05%', Ego Kloxema Eczema is available.
  – NOT the same and NOT a potent preparation NOT for LS
- clobetasone dipropionate 0.05% = betamethasone dipropionate
  – 0.05% in optimised vehicle = Diprosone OV ointment/cream
- Diprosone ointment/Eleuphrat ointment work very well
- Advantan Fatty Ointment not as good in stable, non erythematous LS

Induction

- Betamethasone diproprionate 0.05% ointment
- BD for 10-12 weeks, do not expect physical changes inside that time
- 14-16 week review but reduce to daily application after 12 weeks
- Review in 3-6 months (no further anatomical change)

Maintenance

- Potent topical corticosteroid preparation reducing in frequency not potency; BD/daily/3times a week/twice a week
- Review as indicated by severity of disease or presence of complicating factors (infection) initially
- Ultimately an annual check-up. Specialist review is recommended every second year at minimum,

  LIFE LONG

Guidelines and information

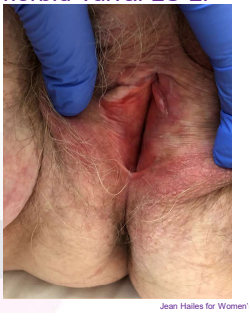
- British Guidelines are the most commonly followed and have the greatest evidentiary basis
- Australian New Zealand Guidelines are under development
- Lichen Sclerosus Worldwide Support Group

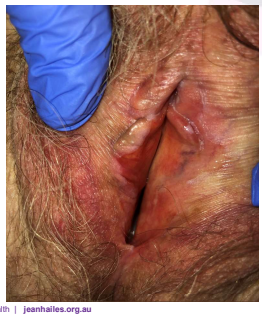
Aims of treatment and follow up

- Control of symptoms (itch is most common 96%)
- Prevention of anatomical loss
- Early detection of neoplasia; typically dVIN
- Early detection of progression of squamous cell carcinoma
- ?? Does good control result in reduced premalignancy and malignancy?? Possibly
- Not all neoplasia in LS patients is dVIN, this population too old to have received HPV vaccine – can develop HSIL (usual VIN)
- Evidence exists to suggest TFT's in all women.

Case 43yo perimenopausal

Comorbid vulval LS LP

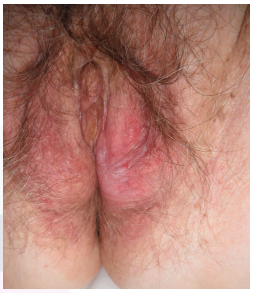


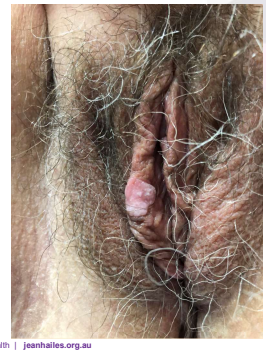


Follow-up

- ITCH - could indicate flare in LS, superinfection with candida, development of complication
- PAIN – may indicate development of comorbid condition, eg LP
- ULCERS – reactivation of HSG
- Vulvo-vaginal atrophy is common, assess for all symptoms of genitourinary syndrome of the menopause, consider menopausal hormone therapy (systemic or local)
- Examine each visit
- Follow-up is for LIFE

87yo long term LS





Questions?

Lichen Planus (LP)

Types of Lichen Planus (LP)

- Cutaneous lichen planus (can involve vulva, surrounding area)
- Mucosal lichen planus; Wickam's striae, erosive
- Lichen planopilaris (mons pubis, labia majora)
- Lichenoid drug eruption (erosive vaginitis)
- LP 1:100 people worldwide, mostly adults over 40 years.
- Approx. 50% oral LP, W>M
- About 10% have lichen planus of the nails
- ?????? vulval Is it even included in the data? 'rare'

Points to note about vulval/genital LP

- Hypertrophic LP is a great mimicker
- Erosive LP (ELP) is painful, can affect multiple mucosal sites in same patient but this may be asynchronous [Hewitt-Pelisse syndrome]
- LP affects all tissue – non glycogenated tissue of vestibule, vagina and vagina
- Look at vagina, cervix and anus
- Comorbid LP and LS occur ion the vulva
- Oral LP is known association with vulval ELP

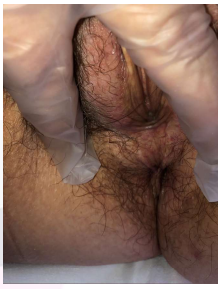
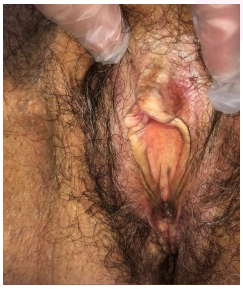
- Lichen planus as part of general eruption
- Multiple recurrences in genital area are common

LP: classis reticulated lesions

Hypertrophic LP

Hypertrophic LP

Case 63 LS, biopsy, 3/12 review

Called 1/12 after last review 'LS flared"

LP Prognosis

- 38% complete resolution
- 30% significant resolution
- 32% ongoing problems

- Does ELP predispose for malignancy? Probably
- Follow up for life unless completely asymptomatic

Treatment

- Challenging - no single agent is universally effective
- Stop irritation and trauma
- Treat infection
- Restore barrier function with Sitz bath or tub bath 1- 2 times a day, bland emollients
- Reduce inflammation with topical potent corticosteroids betamethasone dipropionate 0.05% 2 BD
- Titrate according to response, not as responsive as LS

Treatment cont..

- Vaginal LP difficult to treat and require specialist care
- Methotrexate
- Oral & injectable steroids
- Oral doxycycline
- Cyclosporin, hydroxychloroquine, tacrolimus

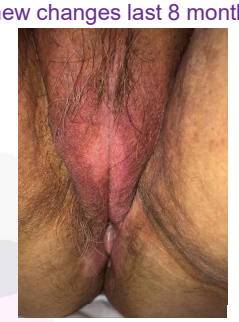
Questions received

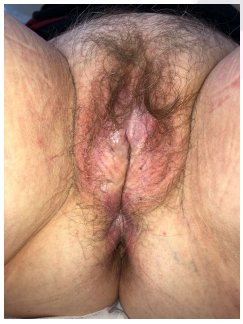
- Identifying difference between lichen planus and sclerosis.
- Is biopsy required?

Comorbid LS LP

63yo ELP V then O then LS

LS new changes last 8 months





Questions

Resources

Health professional resources

Health professional tools:

Health professional education:

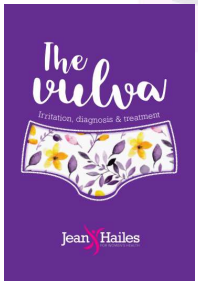
- E-learning course:
  - Fertility, infertility and preconception care
  - Managing menopause: weighing up the evidence
  - Diagnosis and management of PCOS
- Webinars:
  - How to talk about vulval health?
  - Why ask about vulval health?
  - Common vulval conditions

Consumer resources

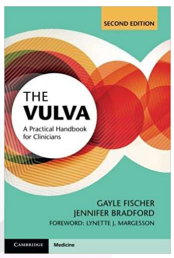
- Booklets
- Fact sheets
- Podcasts
- Videos

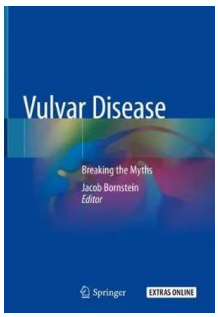
Resources

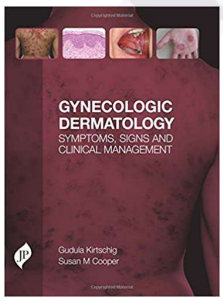
- Jean Hailes websites, booklets
- Melbourne Sexual Health Clinic fact sheets
- Australian New Zealand Vulval Society
- Family Planning Victoria female genital mutilation resources
- Royal Women Hospital (Melbourne) African Women's Clinic
- Labia library



Books







Thank you
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