Common vulval conditions: all that itches is not thrush

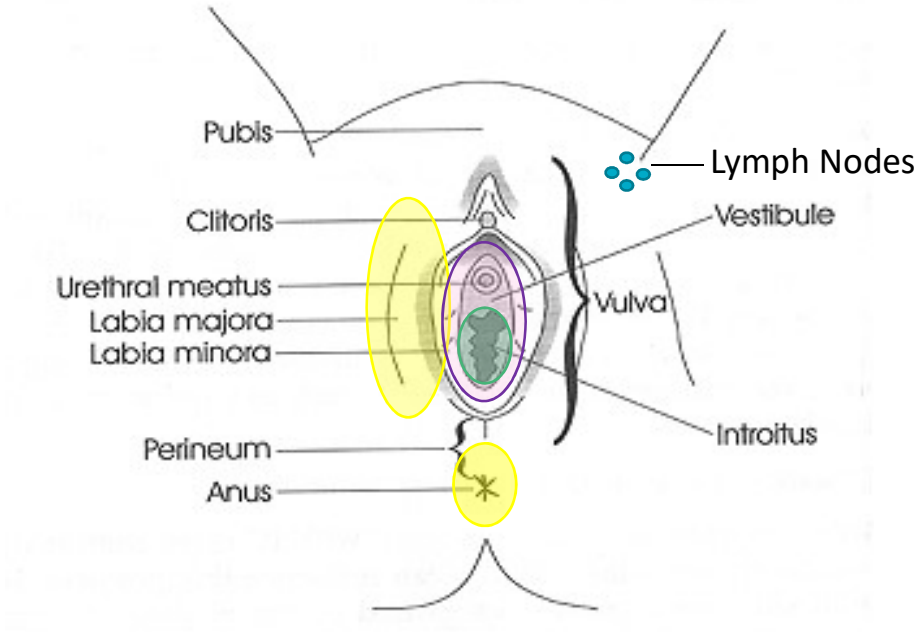
An update for health professionals

Jean Hailes FOR WOMEN'S HEALTH jeanhailes.org.au

Anatomy refresher

Dr Tanja Bohl
MBBS, FACD
Jean Hailes Dermatologist

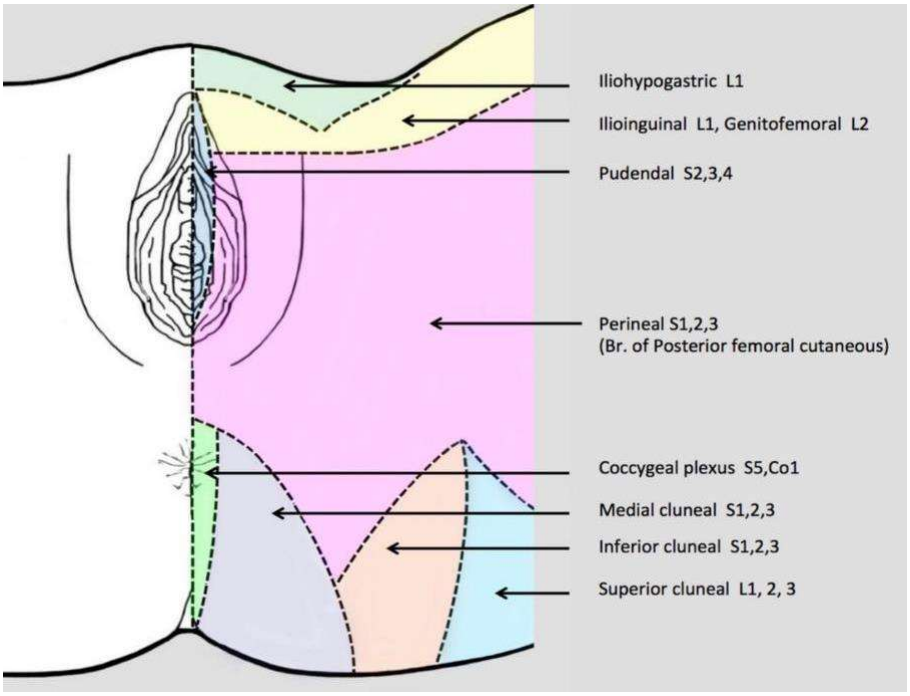
Jean Hailes FOR WOMEN'S HEALTH jeanhailes.org.au



- All three embryological layers present
  - Endoderm, Mesoderm, Ectoderm
- Multiple body systems converge
  - Urinary, gastrointestinal, reproductive
- Multiple tissue types present
  - Glabrous (hair bearing) and non-glabrous skin, mucous membrane
- Multifaceted 'function'
  - Urination, defaecation, menstruation, sexual activity, birthing

Why is this important?

- Embryology helps determine hormonal sensitivity of tissues
- Antigen responsiveness varies with tissue type
- 'Normal' discharge & odour varies
- 'Normal' anatomy includes contamination & irritancy sources
- No solitary nerve supply
- Clitoris is much larger than clinically evident



Innervation of the vulva

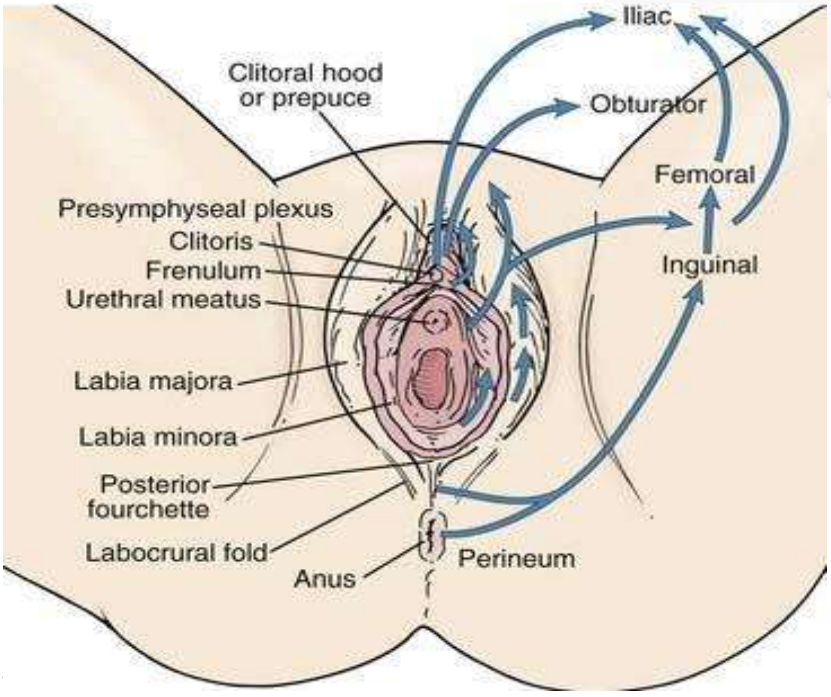
S1,2,3,4 &5
L1,2,3

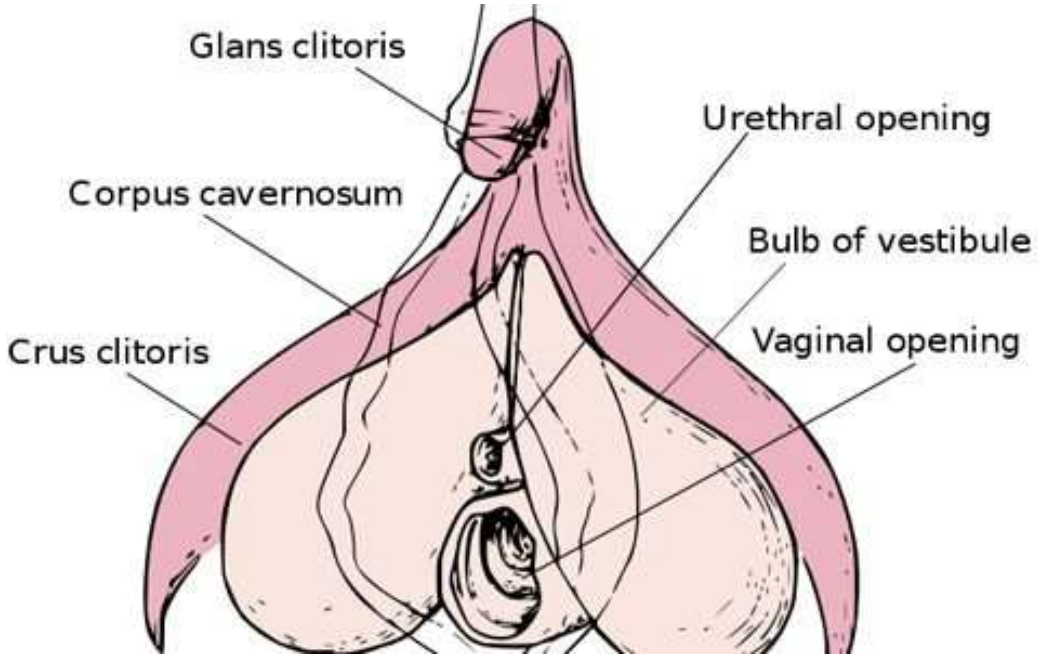
Blood supply of vulva

- Branches internal pudendal arteries
- Branches of the external pudendal arteries
- Venous drainage via the corresponding veins

"no large vessels superficially to be of concern doing a vulvar biopsy"

Lymphatics of vulva

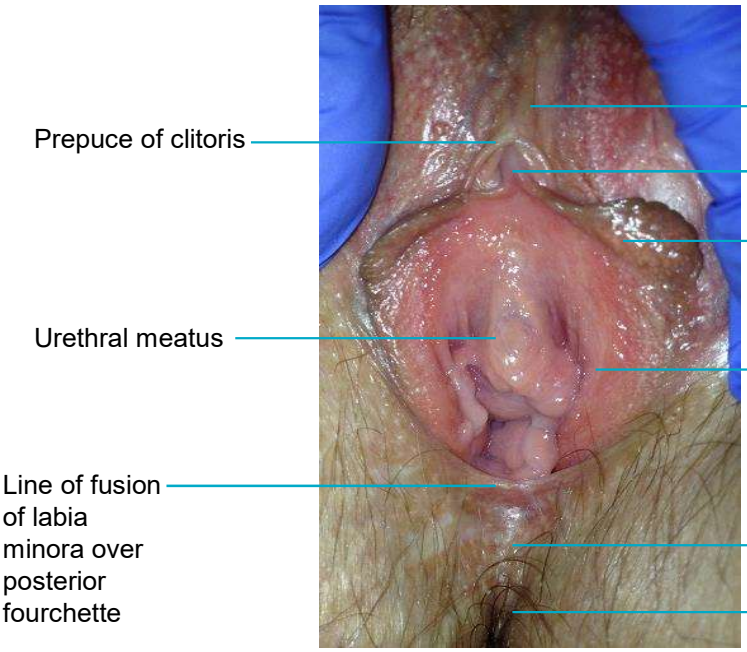


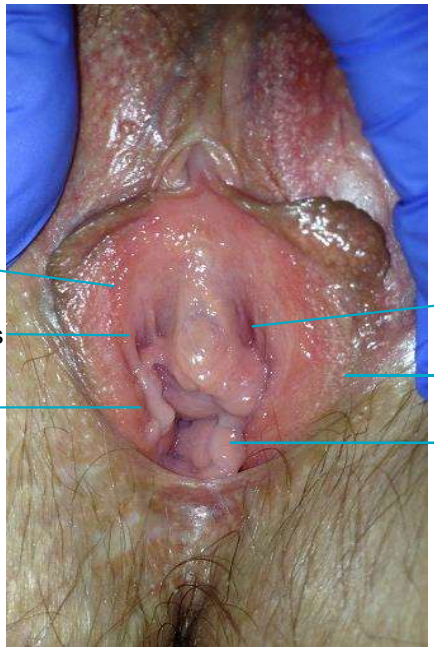


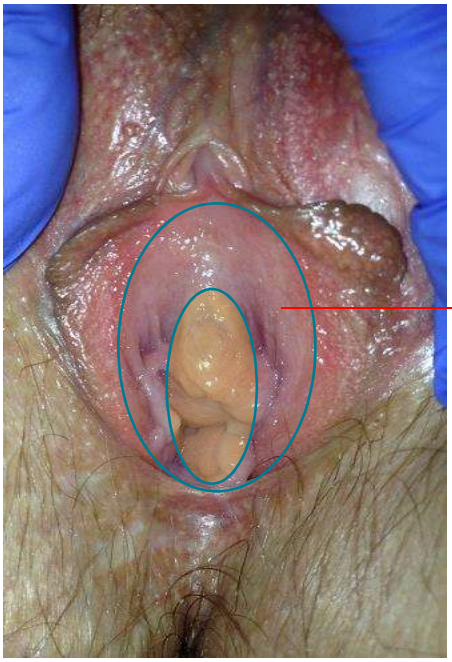
"substantial changes with 'normality' – profound effects on body image & psychosexual well being of women"

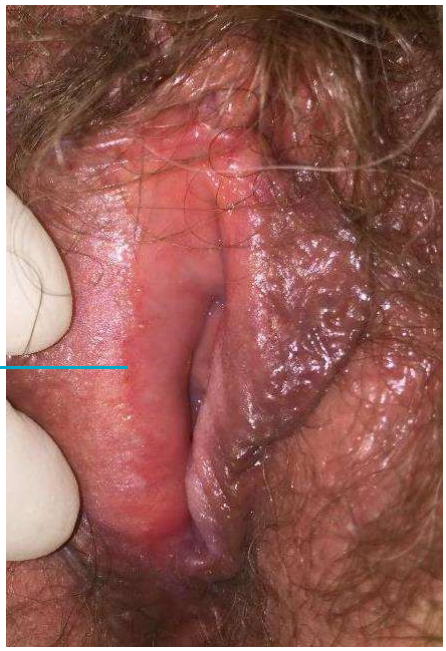
patient: am I normal???

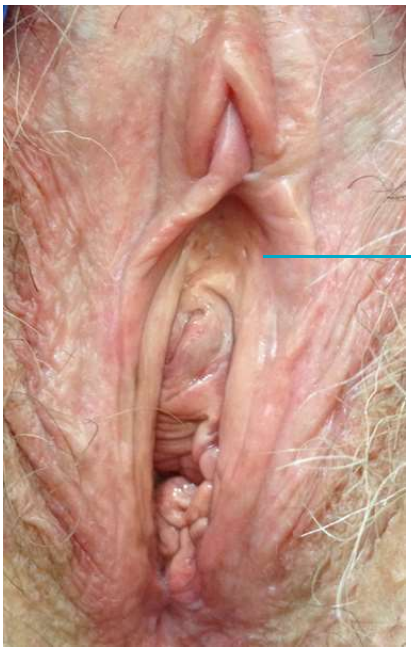
clinician: is this normal??


Prepuce of clitoris
Urethral meatus
Line of fusion of labia minora over posterior fourchette
Shaft of clitoris
Glans clitoris
Labia minora
Hart's line
Perineum
Anus

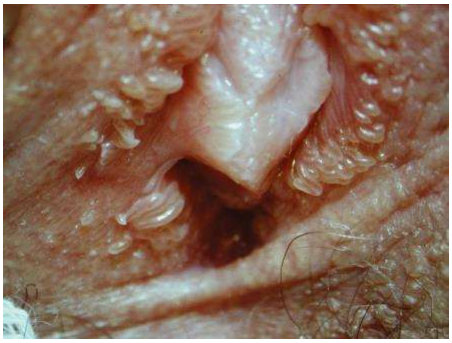

Vestibular papillomatosis
Openings minor vestibular glands
Bartholin's glands orifice
Skene's glands openings
Fordyce spots
Hymenal remnants

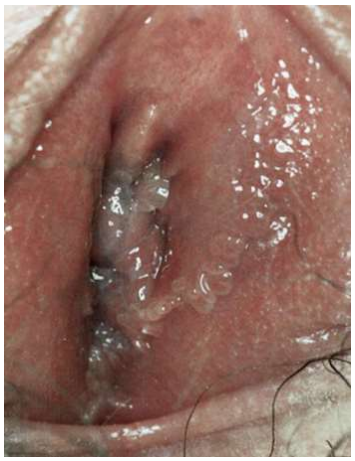

Vestibule

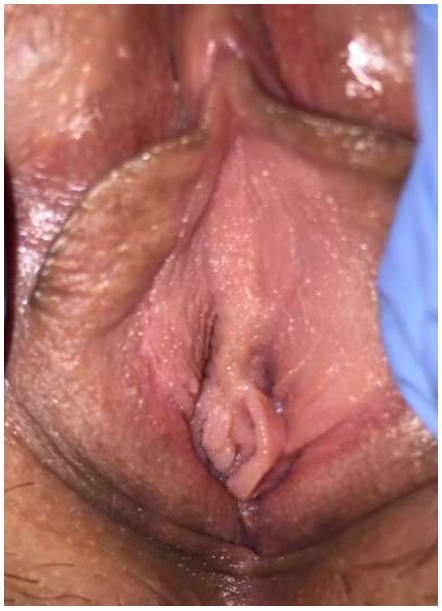

Hart's line


Vestibular glands

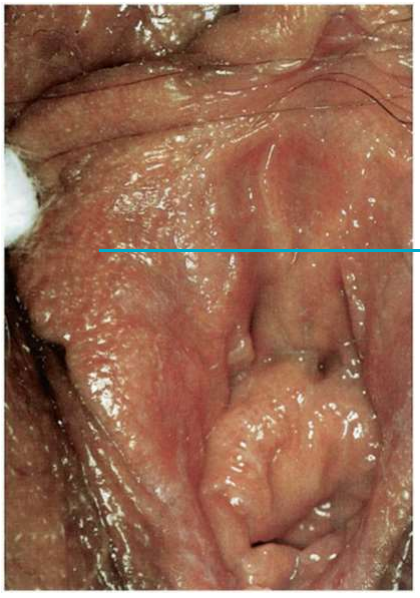
Vestibular papillomatosis



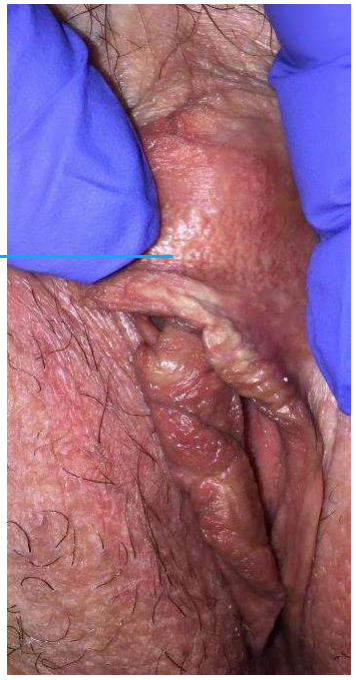


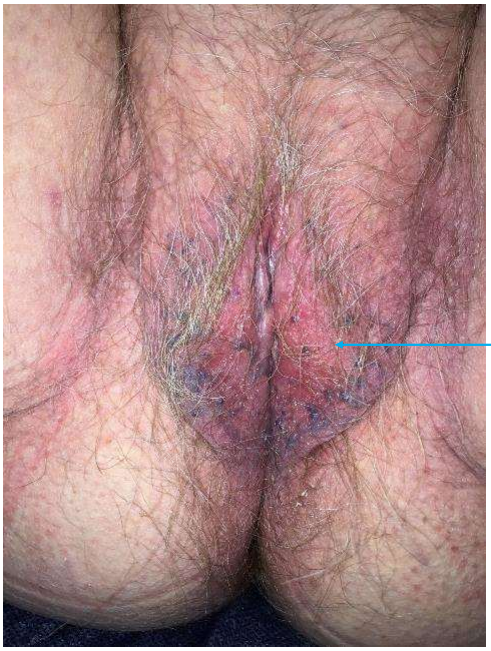


‘cobblestone’ appearance of vestibule

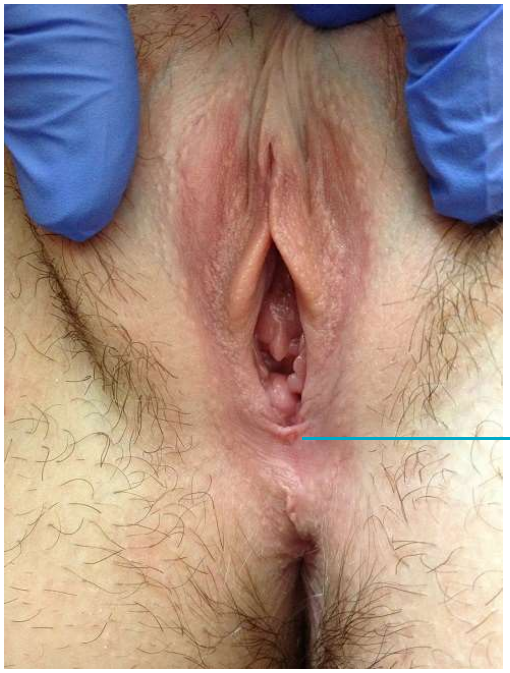


Fordyce spots (apocrine glands)

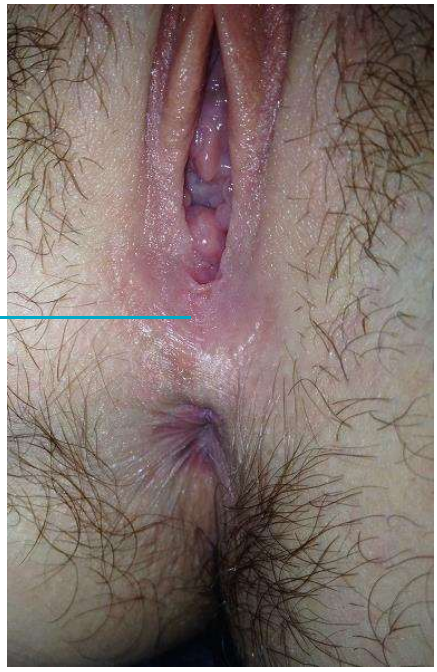


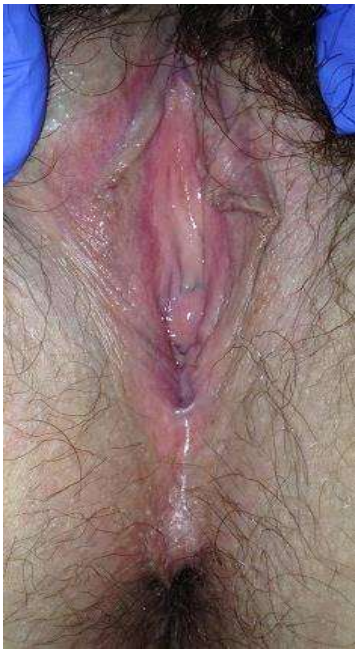


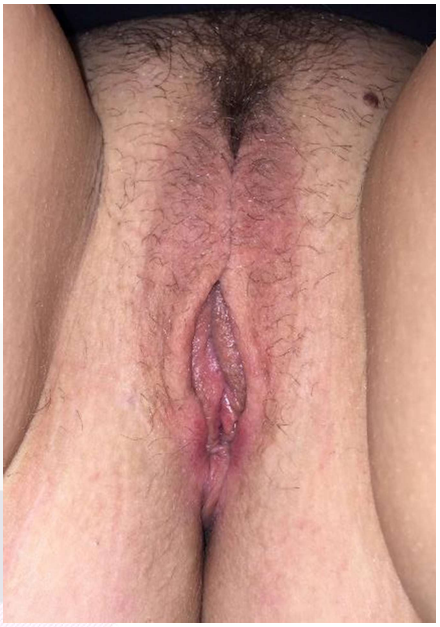
Angiokeratomas

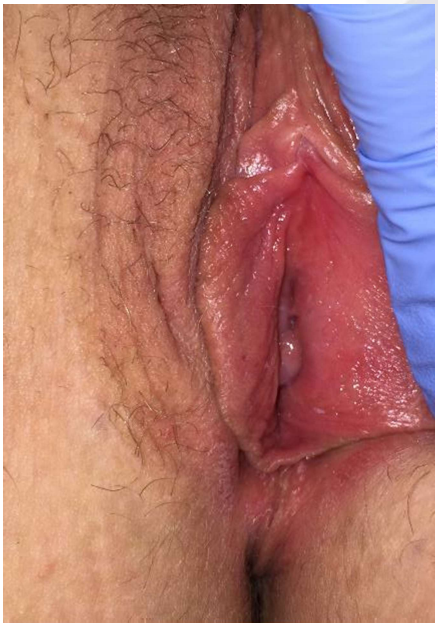


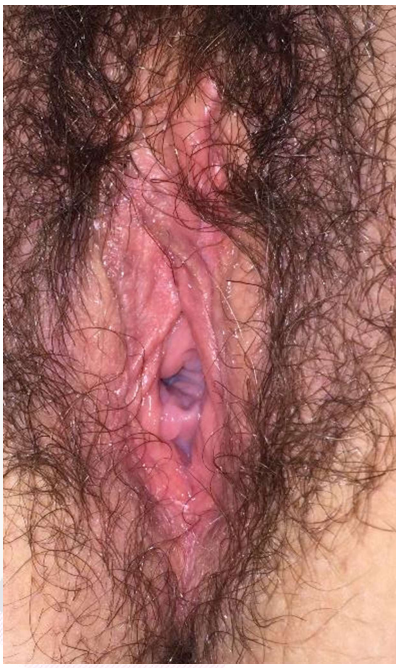
Post coital erosion

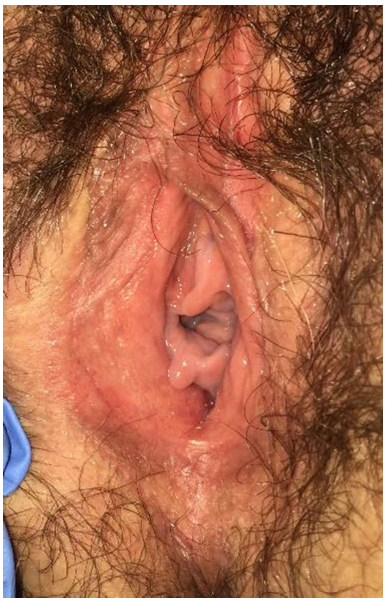


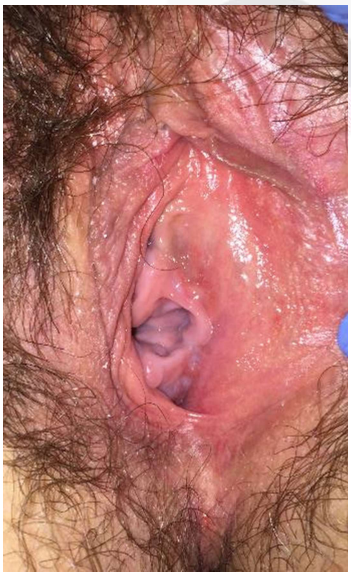




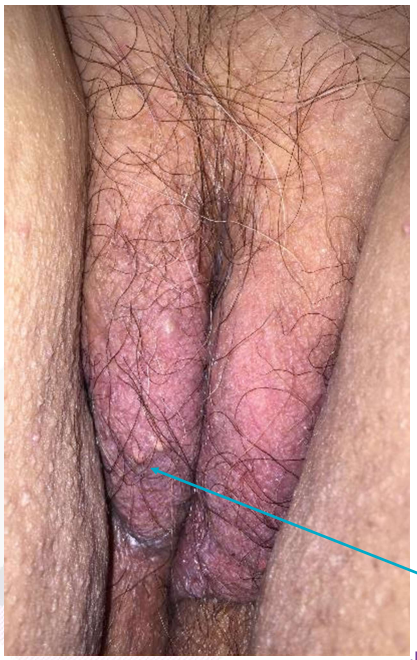






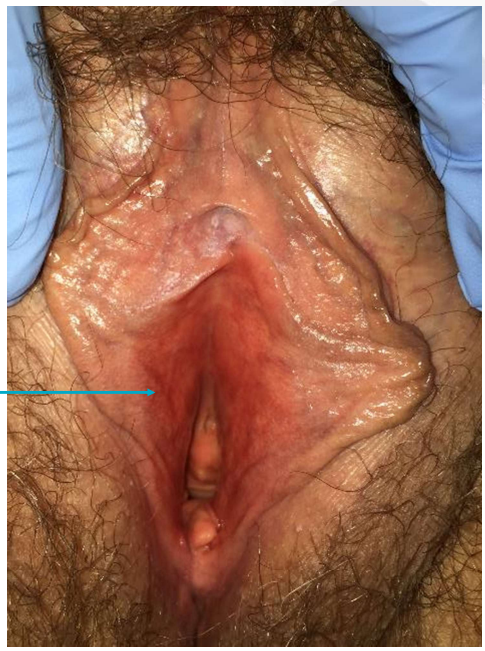


Jean Hailes for Women's Health | **jeanhailes.org.au**



sebaceous cysts

atrophy



Jean Hailes for Women's Health | **jeanhailes.org.au**

Poll 1

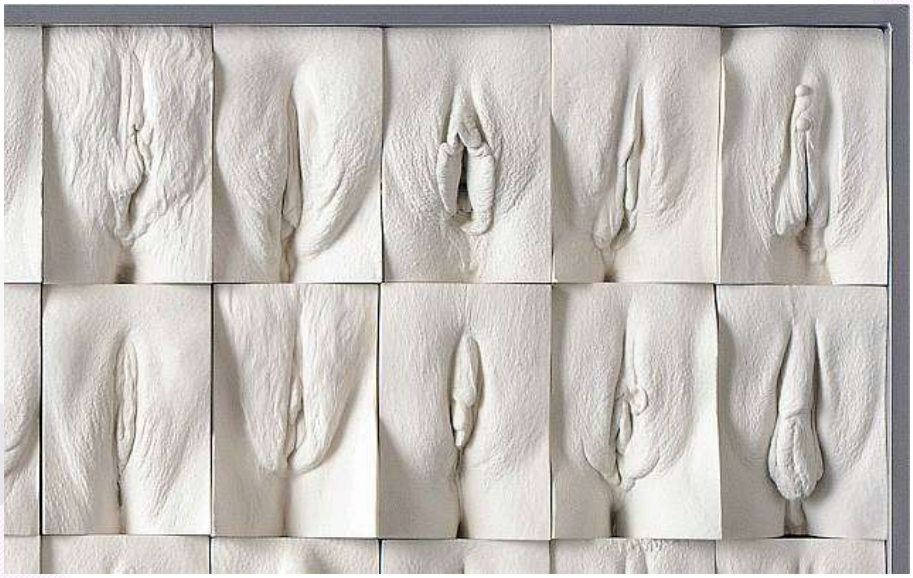
If a female patient comes to see you complaining of vulval/vaginal itch, do you examine her vulva?

Examination essentials

Dr Kathryn Cook
MBBS, FRANZCOG, FChSHM
Obstetrician, Gynaecologist
and Sexual Health Physician
Mercy Hospital for Women,
Melbourne Sexual Health Centre

Jean Hailes FOR WOMEN'S HEALTH **jeanhailes.org.au**

Examination of the vulval skin



When do we examine?

- With symptoms
  - Vulval symptoms , itch, burning, "thrush", discharge, dryness, pain.
  - Incontinence (remember to ask), urinary and faecal
  - With pad wear
- Opportunistic
  - CST (PAP)
  - IUD

Why do we examine?

- To reassure normality
- To diagnose abnormality
- To educate and empower
- To allay fear and ignorance

How do we examine

- With consent and respect.
- With kindness and compassion.
- With a safe environment
- Good lighting
- A sheet to offer
- A mirror to engage our patient
- With equipment set up

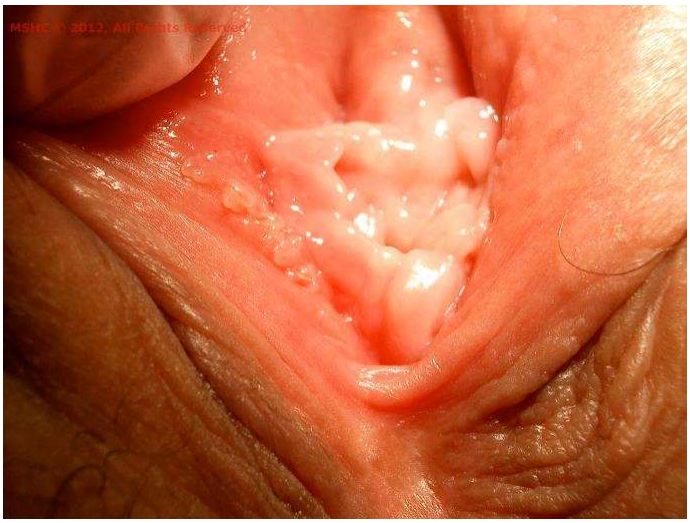
Examination

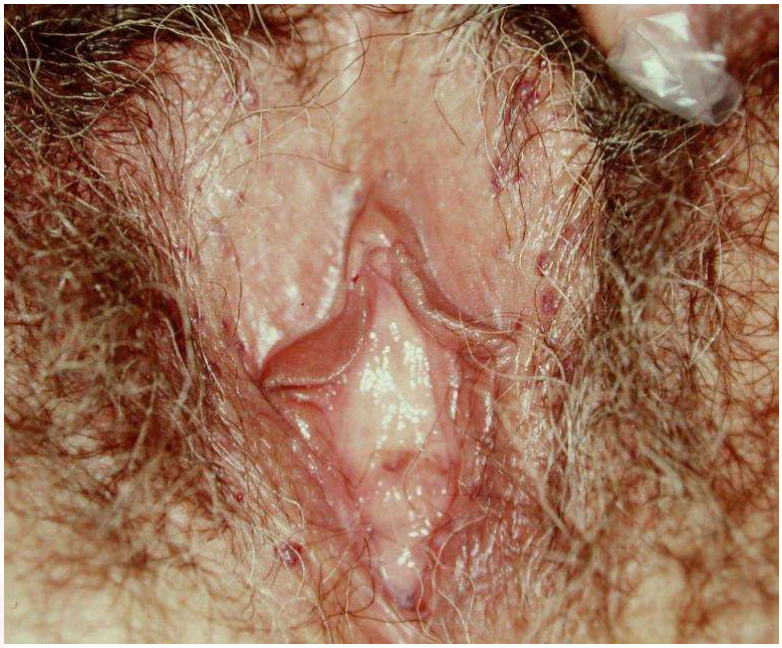
- **Note the anatomy and skin of the vulva**.
- Be aware of what is **abnormal or anatomical variant**.
- **Dermatosis such as Lichen Sclerosus may only be noted incidentally such as at cervical screening (pap smear)**.
- Rarely Vulval intraepithelial Neoplasia (VIN) or even vulval cancer may present as a lump or an itch.
- Genital warts and molluscum contagiosum are common skin infections in this area
- Note if the skin is red, oedematous, tender, the presence of splits, fissures, blisters or ulcers.

Normal variants

- Know normal variants
- Allay distress
- Avoid unnecessary interventions.
- Be positive in language
- Celebrate our individuality

Prominent hymenal remnants and vulval papillomatosis. Normal variant.



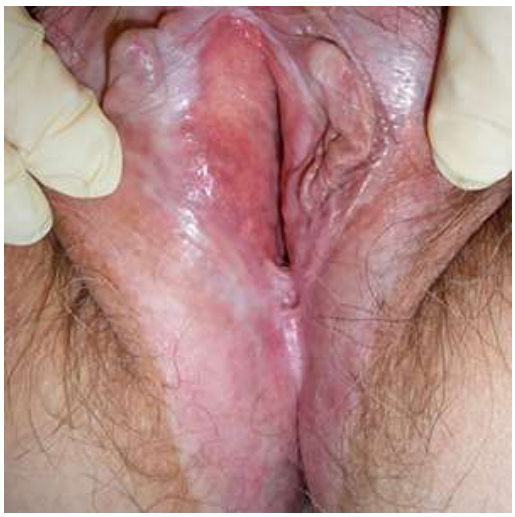


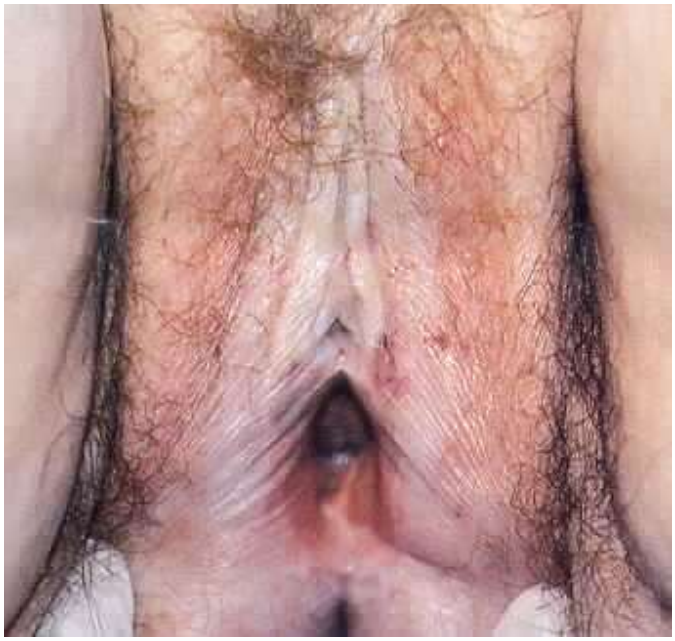
Abnormal Examinations: A Systematic Approach

- **? Anatomy normal**
  - resorption
  - scarring
  - introital opening
  - clitoral hood
- **? Skin normal**
  - **Colour**
    - red,
    - white
    - pigmented
  - **Texture**
    - hyperkeratosis
    - indurated
    - atrophic

Asymptomatic VIN

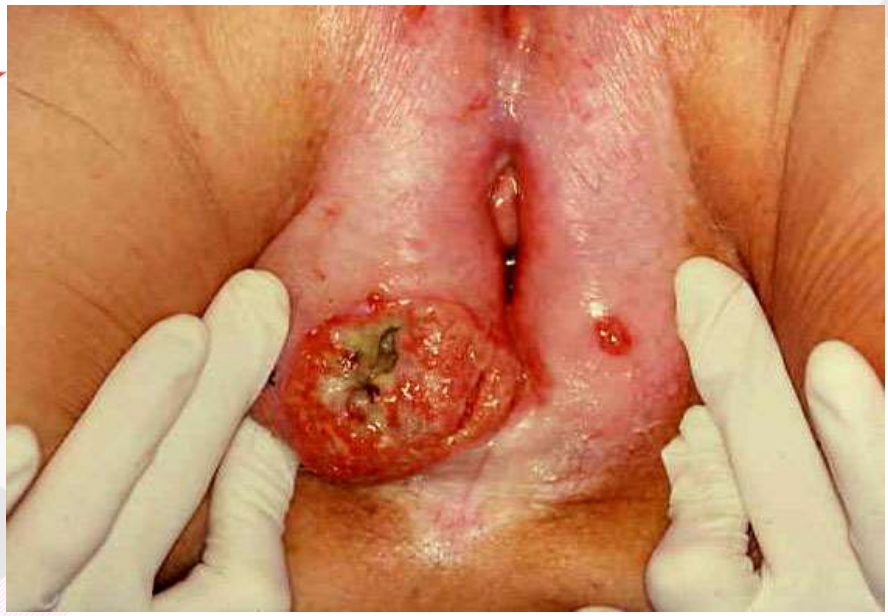
“Active examination”





When to take a vulval biopsy

- Suspicious lesions eg hyperkeratosis, ulcerated
- Diagnosis
- Not responding to treatment
- Atypical lesions



Poll 2

How often do you perform a vulval examination when a woman presents to discuss an issue such as incontinence, IUD, or other sexual/reproductive health matter?

Dr Tanja Bohl

MBBS, FACD

Jean Hailes Dermatologist

Jean Hailes FOR WOMEN'S HEALTH **jeanhailes.org.au**

Case Study 1 - Clare

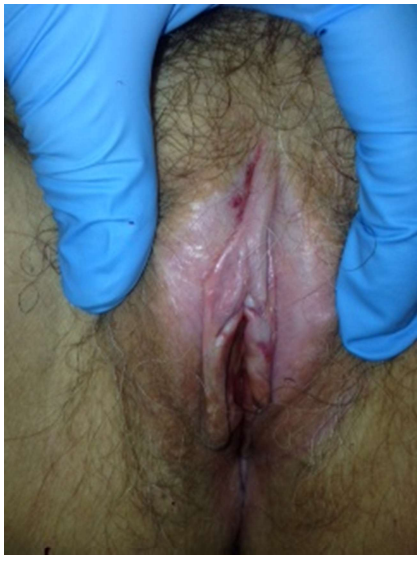
First presentation

- 42 years old
- Itching 5-6 years duration
- Discomfort with intercourse, splitting anteriorly & posteriorly
- External and vaginal application of antifungal + oral fluconazole (mild, short lived improvement)

History

- Injury right knee – arthritis
- Abnormal smear/colposcopy in early 30s: CIN I
- Hygiene practice review; soap & water in shower
- No past or family history of atopy (eczema/asthma/rhinitis/conjunctivitis)

Examination



- Pallour
- White area – thickened (lichenification/hypertrophic)
- Reduced depth interlabial sulci
- Ecchymoses
- **No**
  - erosion
  - elevated plaque
  - lump
  - discharge
  - inflammation

Management

- Clinical diagnosis – lichen sclerosus
- Swab – low vaginal (negative)
- Biopsy – confirmed lichen sclerosus, no evidence of intraepithelial neoplasia, no fungal/candida found
- Examine other areas
- Betamethasone dipropionate ointment BD 10 weeks
- Then 3 times per week for maintenance

Considerations before you start:

- Is patient taking aspirin or any blood 'thinners'?
- History of any cardiac issues
- Mobility (arthritis, obesity) in terms of ability to perform aftercare
- How are they getting home?
- Informed consent
- PHOTOGRAPHIC CONSENT
- Aftercare
- Follow-up: aftercare, results, treatment plan

Punch biopsy:

- Suitable for dermatoses, suspect thickened or pigmented lesions
- 4mm most commonly used
- Monsel's solution, silver nitrate sticks or 4.0 Monoclast/Monocryl absorbable suture with reverse cutting needle

Before next visit

- No specific treatment
- Aftercare instructions
- Resources
  - Print information (MSHC)/dermnz/issvd
  - Tailor to patient
  - Warn – internet has worst cases first!
  - **DO** encourage use of internet but direct reading

Follow-up appointment

- Deliver and discuss diagnosis
- Go through what she has read
- Check wound
- Commence topical corticosteroids
- Clare commenced on betamethasone dipropionate ointment
  - BD for 8-10/52
  - Daily for 8-10/52
  - X3 week until review in three months
- Any sooner appointments may not see improvement
- Itch improves first

Re-presentation

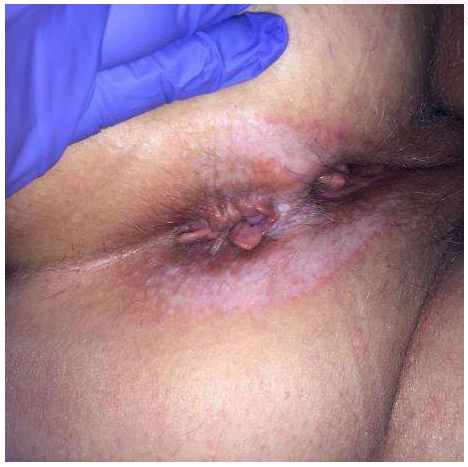
- Got a new job nursing requiring travel to city daily
- Less time for herself
- Not seen for nearly five years
- Increased arthritis – total knee replacement booked six weeks ahead
- Vulva had been periodically itch
- Corticosteroid improved it but 'really knew if she'd forgotten to apply it'
- Up to date with PAP smears & mammograms
- GP gave her more ointment

Re-presentation (2)

- Four year gap
- Knew she should have come earlier
- Keen for review prior to knee surgery

This visit

- Perianal involvement
- Plaques anteriorly
- Different surface to surrounding skin
- Clinical diagnosis - ??VIN



Management

- Biopsy – confirmed VIN III (HSIL)
- Referred to gynae-oncologist
- Laser
- Knee surgery delayed
- Still under gynae-oncologist review

Management (2)

Provide explanation re:

- your suspicion
- progression you see
- importance of getting answer asap
- need for biopsy

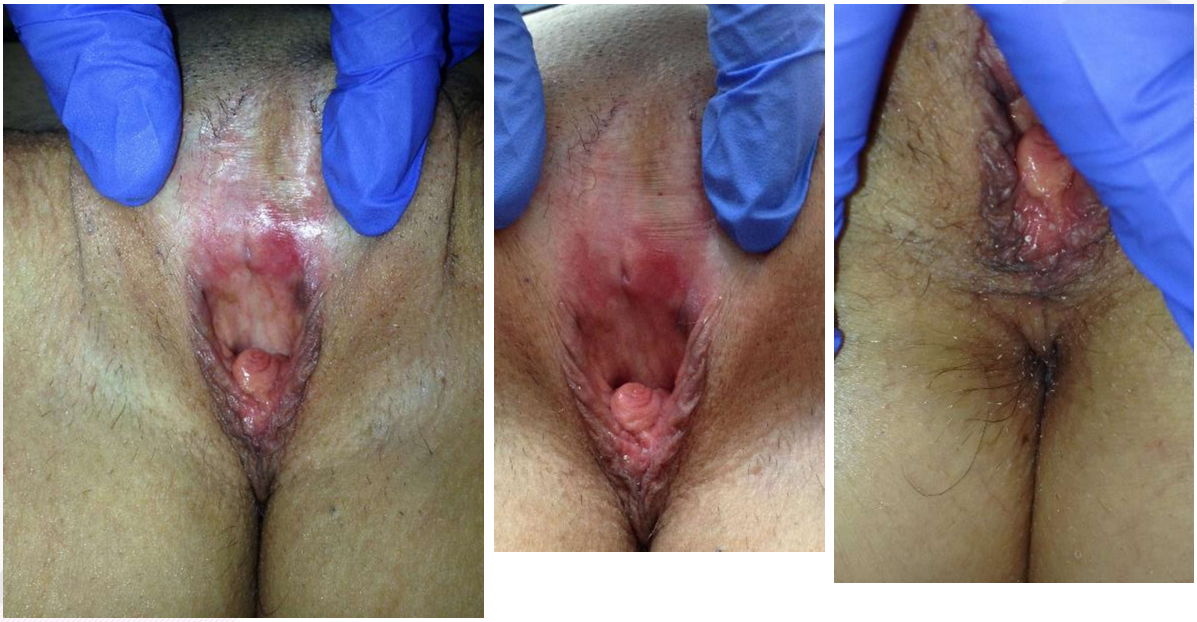
long term outlook for lichen sclerosus

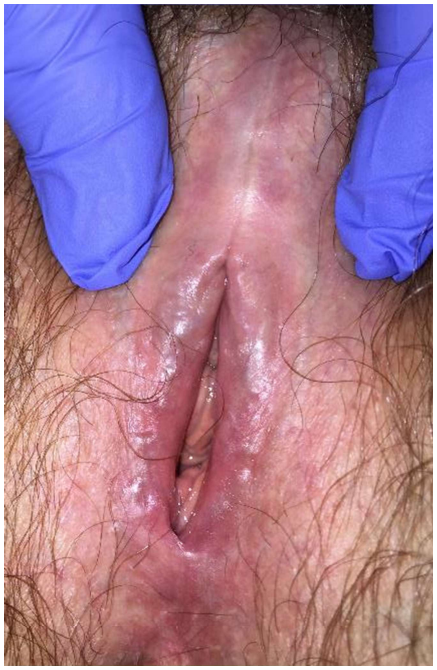
Long term follow-up

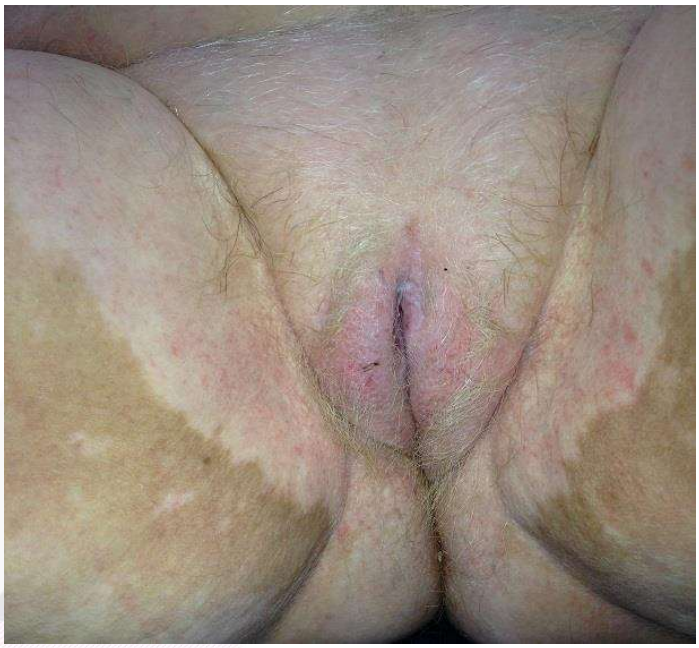
- Look at each visit
- Show patient photographs if possible
- Address 'steroid phobia' first yourself
- Check how much ointment is being used
- If improvement stalls – is therapy being used?
- Recurrence of symptoms
  - Is this lichen sclerosus?
- Altered symptom(s)
  - ? New pathology

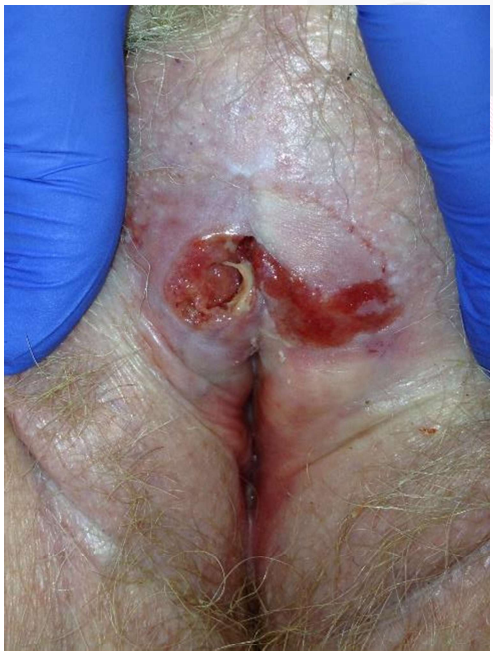
Long term follow-up (2)

- For life
- **NO** unified guideline or protocol
- Same questions as first visit should be redressed each visit
- Ultimately annually









Subsequent reviews

- Should see ecchymoses clear
- Thickened areas improve
- Pink in some areas
- Architectural changes will remain
- Warn patient
  - itch is most common symptom

  BUT
  - loss of architecture and precancer and cancer can occur without it

Poll 3

Is a candida infection likely to occur in a woman post-menopause, who is not using HRT?

Dr Karen Berzins
MBBS Dip Ven FAChSHM
Sexual Health Physician
Melbourne Sexual Health Centre

Jean Hailes FOR WOMEN'S HEALTH jeanhailes.org.au

Case Study 2 - Amal

The Presentation

- 26 year old, referred by a sexual counsellor
- 7/12 of vulvovaginal pain and “something feels blocked” with all attempts at intercourse since marriage. No prior partner.
- Well-educated woman, arrived in Australia shortly after her marriage
- Self-referred to the sexual counsellor
- No self treatments or doctor consultation

History

- **Pain history - pain duration is uncertain**
- **No Pain Complicating Features**
- No previous self or partner touch
- No previous tampon use
- No other chronic pain condition (especially bladder irritability” or childhood “fussiness”)
- No depression/anxiety/trauma history
- Supportive partner (not present)

Pitfalls of a targeted pain history

- Done to confirm the expectation of localised provoked vestibulodynia (LPV) given the referral
- “leucorrhoea” was the only other symptom offered
- Still need to exclude associated and trigger factors
- Direct questioning during examination revealed 7/12 of generalized vulval itching and scratching

Ask…

- Itch/scratching/washing/rubbing/how often/with what
- Continence
- Pads/liners
- Sexual skin comfort/arousal/orgasm
- Tampons ever used or comfortable
- Self touch – yes/no, comfortable? Orgasm?
- Later – attitudes, relationships, ?trauma or fear of ever

Questions to ask

- **WHAT and WHERE on the vulva – use a DRAWING**
- Itch (dermatitis, candida) vs burn/other
- Spontaneous symptoms or provoked by touch (or both)
- PV discharge, urinary symptoms or atopy/dermatitis?
- Sudden or long history?
- Times with no symptoms despite same triggers?
- Effect of prescribed or self medications
- Ever swabs or MSU?

Initial examination

- Little obvious to initial vulval inspection
- Initially too painful to touch with cotton tip as fear was a major factor
- MUST address the fear and take time
- Careful vulval exposure reveals extensive dermatitis, skin fissures and erosions
- Microscopy – pseudohyphae
- CANNOT assess pain at this stage

Jean Hailes for Women's Health | **jeanhailes.org.au**

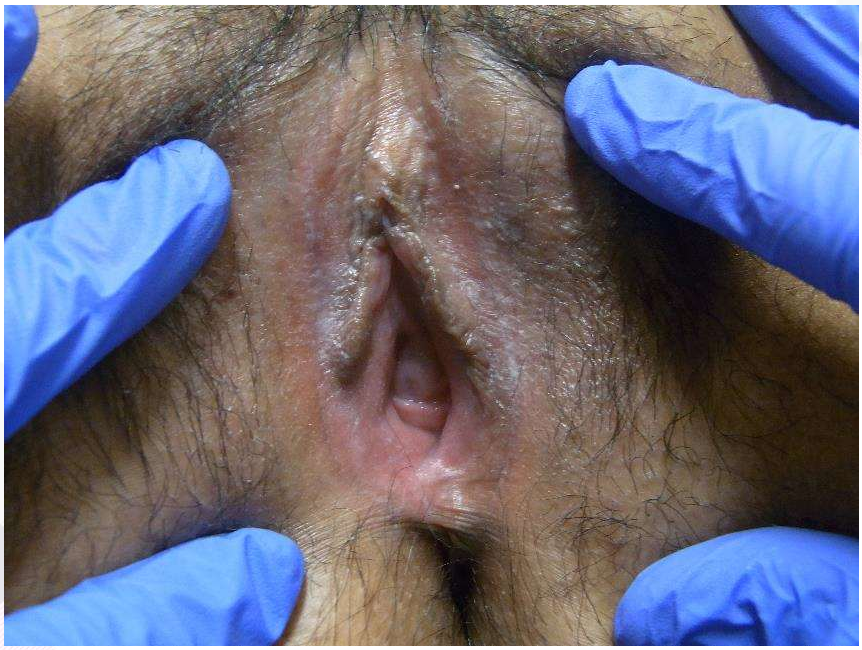
Jean Hailes for Women's Health | **jeanhailes.org.au**

Initial Management

- Treat as acute or chronic candida infection?
- Add a topical steroid?
- If so, what potency and vehicle?
- General skin care advice (soap/shaving avoidance mandatory)
- Advise no attempt at sexual touch until healed, and no attempt at known painful touch

Treatments

- Fluconazole suppressive regimen
  150mg stat, at 3 days then weekly until review in 3 weeks
- Topical methylprednisolone aceponate fatty ointment nightly 1mg/g
- Education – interplay of skin inflammation and pain



Still need confirmation of LPV diagnosis

- Continue to treat with candida suppression
- Taper the topical steroid
- Review for assessment of hymenal band
- Cultural and personal sexual attitudes
- Include the partner
- Multidisciplinary referral – gynaecology, physiotherapy, counsellor for impact of pain

One month review

- No further itch or discharge
- Skin normalised
- No attempt at sexual touch yet
- Greatly reduced fear and cotton tip tenderness
- More pain education
- Physiotherapy referral

REMEMBER PLACEBO

- Deception is an outdated concept
- Has been shown to be effective especially in nausea and pain, but also irritable (functional) bowel disease and Parkinson's disease (30-60% symptom reduction)
- Makes use of clinician empathy and knowledge, and the practitioner-patient relationship
- Expectation of improvement is crucial
- A "ritual" of therapeutic behaviour is important

2 month review - LPV confirmed

- No skin symptoms with tapered treatment
- No dermatitis or candida
- Sex attempted but too painful – hymenal band of significance?
- Had not seen physiotherapist
- Counsellor review – many fears about sex and childbirth
- Partner needs to be seen to include his experience and promote pain education

New beliefs

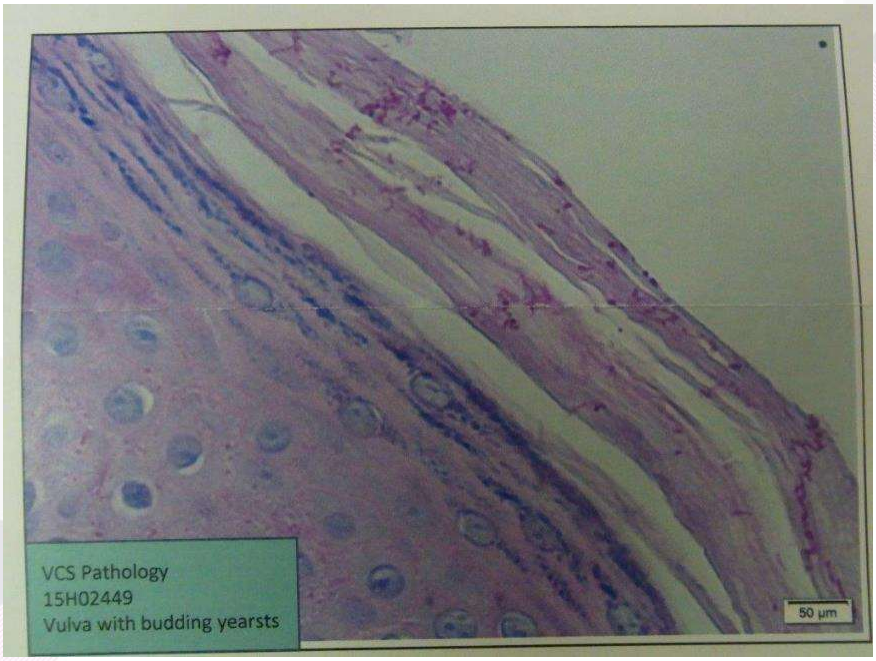
- HURT does NOT equal HARM
- SORE but SAFE
- Accurate KNOWLEDGE and good RELATIONSHIPS reduce FEAR and HELPLESSNESS (catastrophisation)

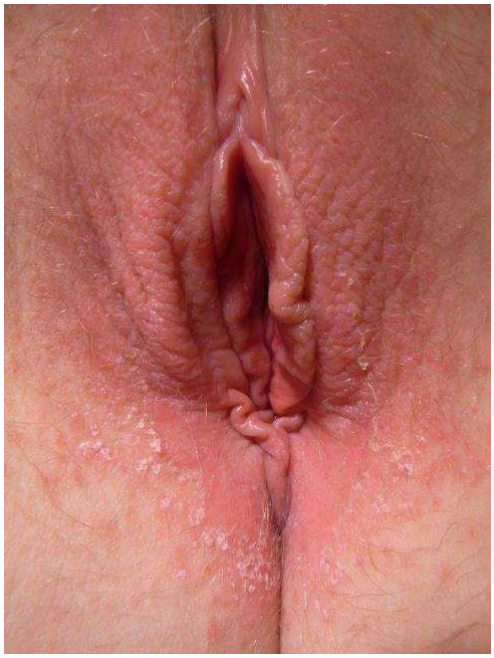
Complicated or uncomplicated

- Long duration and severe pain
- Features of central sensitisation (afterburn=hyperpathia, allodynia=altered "noxious" sensation, other pain conditions, brain fog)
- Difficult to treat dermatitis or candida
- Pre-existing anxiety, depression or post traumatic stress disorder (often associated with abuse or fears for safety)
- Pain as a problem of CNS and peripheral "processing"

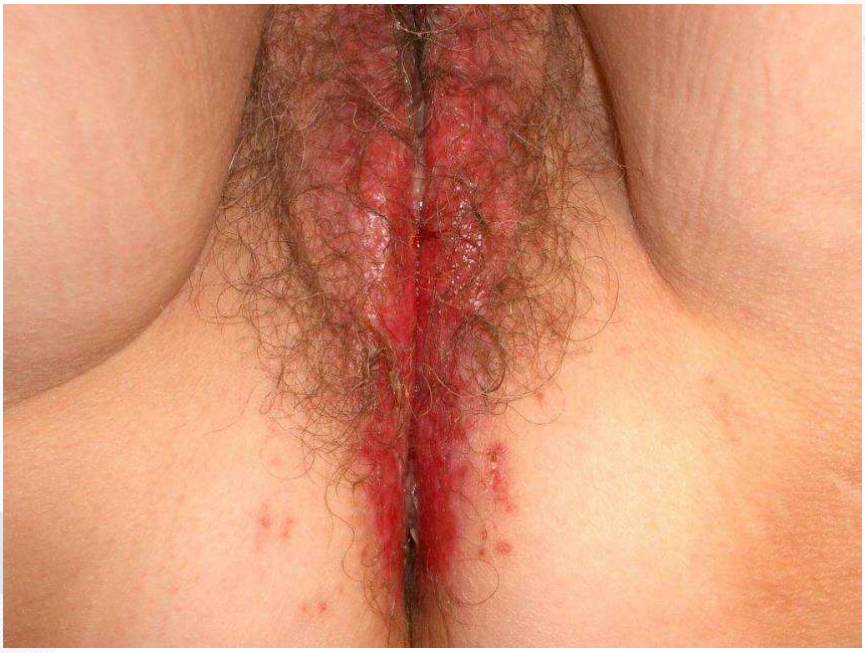
Difficult candidiasis

- Often subtle signs and little discharge
- Biopsy occasionally needed from scaly, lichenified areas
- Swabs from areas of vulvitis and vagina can be negative but histology +ve or vice versa
- Candida is the commonest trigger for localised provoked vulvodynia
- Consider a therapeutic trial of suppression 6-8 weeks





Jean Hailes for Women's Health | **jeanhailes.org.au**



Jean Hailes for Women's Health | **jeanhailes.org.au**

Questions

Jean Hailes FOR WOMEN'S HEALTH jeanhailes.org.au

Take-home points

Take-home point #1

- Vulval conditions
  - You need to take a **thorough history**
  - You need to **examine** the vulva
    - Symptoms
    - Opportunistic

Take-home point #2

- Many vulval conditions are chronic conditions and will require ongoing, long-term management e.g. lichen sclerosus

TIP

Use the practice management patient recall system to ensure regular follow-up occurs

Take-home point #3

- Not everything can be done in the first visit
  - Plan a follow-up in two weeks
  - Plan another review in a month
- Managing vulval conditions requires a team
  - Cross-discipline approach

Take-home point #4

- It may not be a quick fix
- Many vulval conditions have taken months or years to develop and it may take time to get the woman back to good health

Resources

- **2016 European guideline for the management of vulval conditions**

https://www.iusti.org/regions/europe/pdf/2017/Vulvalconditions.pdf

- **Vulvovaginal disorders website**
  - vulvovaginaldisorders.com
    - Endorsed by ISSVD & National Vulvodynia Association
      - Management algorithm
      - Online learning program
      - Case studies
      - Atlas of vulvar disorders

Resources (2)

- **Australian and New Zealand Vulvovaginal Society**
  - http://anzvs.org/
    - Vulval clinics
    - Patient information
    - Meetings - Professional Development

Resources (3)

- **The International Pelvic Pain Society** website. It provides an educational resource for health professionals and also has videos and hand outs for patients
  - www.pelvicpain.org
- **Neuro Orthopaedic Institute (NOI)** Australasia. The organisation's philosophy is to create and provide evidence-based multimedia resources and courses for the treatment of pain. It provides resources to "explain pain" for patients (and clinicians!).
  - www.noigroup.com