# Ask an Expert: Vulval conditions

**Dr Tanja G Bohl:** And we are fortunate in that we have the luxury of time to a greater degree than anybody in general practice. And we certainly do appreciate that. We do the same things that everybody does and perhaps the things that, for many of us, go back to medical school days, such as, try and take a very thorough history, make sure the historical facts and impressions that you've gleaned from the referral letter are, in fact, correct. It gives the patient, also, an opportunity to bring up something that they think may or may not be relevant but didn't feel that they could say to somebody that they've always known without them thinking they were a bit funny, but a new person is okay. And the other thing is that you really have to examine the entire anogenital tract. It is not okay to just have a quick look from three feet and think, 'Oh yeah, things are fine.'

You've actually got to part the labia, and you've got to look at what you can see of the vagina. For many conditions, if you see healthy vaginal tissue, you don't need to pursue a vaginal exam on every occasion. I have noticed that this will vary according to what different examiners are comfortable with. Gynaecology registrars always have the speculum ready. Dermatology registrars run six miles. So it has to be also within your comfort zone and within the patient's expectations of what they are going to have done to them, be involved in within an examination, and to know that they're going to be secure. Make sure you pull the curtain before anybody is able to come in the door. Those little simple things can make a world of difference to the outcome of your consultation.

We do take a lot of photographs and fortunately patients do give consent for them to be used in addition to being used in their own files. And that is how I'm able to share so many images with you today. The prime reason for taking them, however, is to also include the patient in what we are doing, and also include them when they're sitting down, they're fully dressed and they're able to look at a computer screen. They're not on an examination couch in a position with their knees open, trying to negotiate a mirror in order to see something that's really foreign to them. So it's a very useful tool in that sense as well as providing really accurate documentation of what is seen on exam on that day. And the other thing that I find particularly useful is that it does enable us to show patients the difference, if they've got a prolapse or if they think they've got a prolapse, and you can take a photo with them bearing down and without. Also you can ask them to put their creams on, good to see if they're getting into the right place.

If it they are not, you can also take a photograph of it and show the patient how they put it on, where it got to and suggest any modifications that might be necessary. The levels of consent there are pretty self-explanatory. And the other thing that I cannot stress enough, particularly in looking at some of the questions, it's important to ask the patients how they clean their genital area. We are finding a mixture of responses. Some patients are getting more and more aware that they shouldn't be using soap. Some avoid fragrance, some will still clean themselves inappropriately. Some will say, 'Oh, I don't rub with toilet paper,' but they rub hard with a face cloth. And also at some point in that consultation, if it is appropriate, don't necessarily need to ask a 90-year-old whether they're sexually active if they've come in for lichen sclerosus, if they've already told you that they've been widowed for years and they give you a vibe that no, this is a no-go area for the moment. That might be appropriate several interviews down the way or it may never become appropriate.

So you need to use your own discretion. And the other thing is, you need to be prepared to offer advice on things such as cleansing, lubrication, and sexual position for young people who are sexually active and who may benefit from that sort of advice. You can't take the place of a sexual therapist or a counsellor, but you at least need to be aware that those other ancillary helpful resources do exist and prepare your patient in some way for knocking on that door and being able to make use of them. Okay. I do say this quite often to patients, I think we all need to remember it because we are all bombarded to different degrees by ever-changing but still a large assortment of different messages from different types of media.

And these are my simple messages and it's really like, no, no, no, no, no. Be careful with this, this, this and this. And as I go through, hopefully I'll be able to expand on what I would suggest in place. So we'll start with lichen sclerosus. Now I'm not going to read through this. I will simply say that it is one of the commonest things that we see. It is still often referred to as a rare disease. The reason for that is because it doesn't attract a lot of funding, it doesn't attract a lot of research and by keeping it in the orphan diseases or rare diseases category in a lot of places, particularly in the United States and the United Kingdom, this means that they can apply for off-label use of certain medications as they become available and also apply for funding for particular projects.

And the most interesting fact, I think, is that the statement 'it's neither common nor rare' actually does apply. But the incidences have been reported as high as one in 90, as low as one in 900. And it will vary on the makeup of the population in which this is actually measured. When we have a lot of rates of incidents reported, they are likely to be in the office of either an institution or a particular private practice, and that does already skew the numbers. Okay. So we all, I think, know that it's mainly our postmenopausal patients that will present to us, usually with itch or they can present with dyspareunia, they can present with discharge, they can present with pain, bleeding. They come often not being aware of what's going on. And so the key message of this slide is to remember that they can get lesions anywhere on their body, but that we are looking at the most common area, and that, in fact, you can get both lichen planus and lichen sclerosus together on the genital area.

And there is an autoimmune association to the point where there's growing evidence that perhaps every woman who has lichen sclerosus should at least have her thyroid function test done, particularly even if she's asymptomatic and there's any history of either thyroid disease or pernicious anaemia in her family. And these are now some examples of lichen sclerosus, and this lady presented with an eight month history of itch and increasing roughness of her skin. You can see, I think, simply from this photo, and I tend to, and we tend at the clinic, to have a good overview first, then we go further in. You can see that down here on the perineum things aren't quite right, and when the labia are parted we have this really roughened surface, and on her right here we can see that there are these little papules. And also you can see when you are perhaps examining her better, personally, that the interlabial sulci are not even, which means that there is some fusion already occurring. Structurally, she still has a clitoral hood, she still has her labia minora, so not a lot of architectural change, but there is still architectural change. And you would be concerned, because it is a bit asymmetrical, that perhaps she's already got a little bit of superimposed, lichen simplex chronicus is the most common, but then also intraepithelial neoplasia can occur.

Here we have her perineum a little bit more closely. But here onto the perianal skin, that's not bright white, however, as you go around the edges and you look at the hairs, the hairs are white and there is this perifollicular textural and visual change in terms of colour of the skin. And that is what is described in the dermatology literature as the typical way that lichen sclerosus presents, and it presents as little perifollicular papules that then coalesce. So this is a sign that this is quite extensive, already, quite soon, and active. And a reminder that you should look at the anal area. Now, I'm sorry, diagnosis should mean that this particular patient had actually been itchy for four years. And she'd had a lot of treatment in that time and she came saying, 'And I get temporary improvement, but nothing ever lasts long and the tablets were useless.'

Now this particular patient has been treated for candidiasis. She's only 42, so she is undergoing possibly an early menopause, but her menstruation, periods, she's missed the odd one. She certainly is by no means postmenopausal. And when you have a look, you can see already, down here, in the deep creases next to the labia majora, that there is pallor, and there is tethering. There is involvement of the perineum. There is pallor and fusion under the clitoris that runs along the inner aspect of both labia minora. And again, this goes all the way down but does not include the floor of the vestibule, and down below Hart's line, at which point the mucosa in a lady of this age, and a lady of reproductive age, is going to actually have a lot of oestrogen present and is going to have a lot of glycogen present. And lichen sclerosus doesn't like that sort of tissue. If you see involvement in there, you need to be thinking 'lichen planus'. When we come over here, that shows a little bit more clearly, I beg your pardon, the perineal extension.

Another example. Now surprisingly enough considering what change we can see there, this woman, excuse me, who is in her late sixties, I cannot remember if she's 67 or 68, but she has also been itchy for nearly a decade. And she's been given hydrocortisone. She was actually given Diprosone, she was able to say, on one occasion, but stopped using it when the itch went away. And then she went for a pap smear and then the pap smear nurse at the practice said, 'Things don't look right 'round there', and spoke to the doctor, because she usually saw a male doctor who didn't like to do her pap smears and vice versa. And sometimes that happens, sometimes it happens with females. It's a patient choice issue. So then she was just referred to me as 'persistent vulval itch', query, partially controlled Candida. Now you can see, I hope, quite clearly that what we have here is fusion anterior to the clitoral hood.

The clitoral hood, which is this tissue here is itself swollen and thickened and you can't appreciate it perhaps as well here, but there have been the odd scratch area, particularly anteriorly. So she says she's not itchy and she probably isn't aware of any great itch, but there is some itch occurring. And then you've got all this pallor here, and it almost looks reticulated here, which would make me think possibly a form of lichen planus. But a biopsy showed that no, this was lichen sclerosus. And you can actually see if you have a look on the photo, quite a nice degree of sparing going down into the vestibule. Now if you have a look, this is the same patient, quite a bit of perineal scarring, although some old obstetric scars are giving rise to some of that denting, it isn't all lichen sclerosus induced, but you can see right along here the tissue is white.

Whoops, okay, excuse me one moment. The tissue is white, it looks dull, for want of a better word, and particularly down here on the perineum, and it's not at all uncommon for some lichen simplex chronicus to occur with lichenification or exaggerated markings of the skin, and this dull pink colour, as a consequence of some scratching. And when you have a look at the left lateral view, you can see that there is some extension, and particularly over the perineum, but not going further up the natal cleft. This is a good example of that textural change of fine wrinkling that you see in lichen sclerosus. Many of these photos it is stretched out, but that's that sort of fine wrinkling that, once upon a time when people actually smoked more commonly, was referred to as 'cigarette paper wrinkling', and that's what that, in fact, is. But it's occurring in the context of colour change, fusion and loss of the inner labia minora. And here it's smooth, down here you can already see thickening and white changes that look a little bit concerning.

As you part the labia minora, there is some very superficial bruising which is not at all uncommon, unfortunately, in lichen sclerosus, regardless of the length of the lesions. And this can be also seen in paediatric cases and is the reason why, in paediatric situations, we may find ourselves being concerned that sexual abuse may be happening. Because the minimum amount of trauma can lead to shearing of that atrophic skin over the underlying support tissue, and as a consequence give us the bruising. And then here, fortunately, the vestibule doesn't have any evidence of any disease, but it also doesn't have any evidence of nice oestrogen activity, either, speaking to the fact that she's postmenopausal. Going posteriorly, one very thickened perineum. And if you were going to take a biopsy in this lady, where you would take it would be from the most thickened area, because that felt like a little rough lump, and this area over here also felt rough, and given that she's got evidence of ongoing scratching, it is also not unreasonable in this situation to give her, for example, six weeks of a potent topical corticosteroid to use twice a day, bring her back, see what of these may remain, and then choose where to biopsy.

And sometimes you do need to biopsy more than one site. Around here, there are no areas that look raised or well demarcated or suspicious for any supervening malignant change, and I wouldn't be doing biopsy from there. The other thing to consider is, also, we do a lot of swabs that we send off of the vulva just to make sure Candida isn't present, because we're often surprised. And one thing you really feel embarrassed about is when your pathologist sends back 'lichen simplex chronicus, fungal elements seen in the epithelium, this is interfering with interpretation of the histopathology', which is really saying, treat a little bit of something first before you send it off with the biopsy. Okay. Now, I'm going to spend time on this slide because the most important thing to remember from this slide is you need a potent topical corticosteroid preparation, ideally an ointment, and the patient needs to be on that for the rest of their lives.

At the moment, we don't have clobetasol dipropionate, or clobetasone, which is the gold standard that people read about in the literature, but we actually probably don't need to have it in Australia. We have the equivalent, effective potent steroid in Diprosone OV, or 'optimised vehicle' ointment, not the cream because that smarts a little bit too much because of the added preservative, and propylene glycol that gives it its OV. But if you are thinking that that amount of money that this is going to cost, which is around $40 to $50, sometimes a bit more depending on the pharmacy that they go to, certainly we've found, and I certainly found over the last few decades, that using Diprosone or Eleuphrat ointment, they are all betamethasone dipropionate, 0.05, that they work extremely well.

And the advantages, you can give the patient two 15 gram tubes in one lot, and you can give them repeats, so if they lose it, if the sun makes it ooze because they left it in the car, if the kids find it with the grandkids visit and you're not always in a childproof house anymore and they squish and play with it, it means that they haven't lost their only supply. It's also, I like to tell them, 'Put one tube in your bedside table.' One of the things that will not happen is, if any patient is busy and I defy really to have, us have non-busy patients, you are not going to get up out of bed once you've got there just to put a cream on your vulva. 'It'll be right, I'll do it the morning.' Whereas if all you have to do is reach out and there it is, you're much more likely to comply with the twice-a-day usage, which is what you need.

I've put that note there regarding clobetasol butyrate because I have had patients referred to me, by both gynaecologists and general practitioners, thinking, 'Ah, clobetasol, it's available over the counter, it's the same strength, 0.05%, why would I not use that? It's much cheaper than going through any of the other stuff, and certainly cheaper than having anything compounded for a patient.' Clobetasol butyrate eczema cream that is available over the counter is no more potent than hydrocortisone, and it's an inappropriate treatment. It's not sufficient. It is not a potent steroid. And for those of you who think, and it's again a question we should always ask ourselves, but the covenant evidence would say 'potent, potent, potent'. We don't have any ultrapotent or superpotent steroids freely available in Australia. If we put potent corticosteroids on the vulva, onto lichen sclerosus, the thinned tissue will, to some degree, be thickened, the disease and potential side effects that occur as a consequence of that disease will actually be prevented or lessened.

So there is no reason to back off unless patients are using it inappropriately. And that's why you only give them a small amount, and every time you see them you just check, 'How many tubes have you gone through?' When I get a prescriptions request from a patient to say, 'Oh, but I've gone through all my repeats', and it's only been three months, they've overused it, so they get a phone call and we go through it again. So the regime that most clinicians use who treat lichen sclerosus regularly is betamethasone dipropionate 0.05% ointment, which is branded as Diprosone or Eleuphrat. Some people use Advantan, some people will also use Elocon. They are equipotent. What I will say there is that Advantan is very good when there is a lot of inflammation and the fatty ointment is a really nice soothing base.

However, the patients who I see who progress the most in spite of being really compliant tend to be those who use the Advantan fatty ointment, and it has a dual activation pharmacologically that's a bit different than the other two, and I don't think it works as well, but when things are nicely controlled and the disease is largely burnt out, it's an excellent product in the sense that the base is lovely. I don't like momentasone, which is your Elacon/Novasone, primarily because I've had too many patients sting from it, and it does contain a bit of propylene glycol in it. So the starting induction phase that we use is to use the potent corticosteroid twice a day for 10 to 12 weeks, and then we review patients. You might review somebody sooner if they're really in a bad way or if they've also got Candida and you're putting them on multiple different things, so that you know that they understood what to do, they're not overwhelmed by everything and that they are progressing.

But structurally the only thing you can really expect in that timeframe is less inflammation. We review them when they're reduced down to daily, which is at the 12 week time. So a couple of weeks after that, check how they're getting on. And then, roughly, what is done, and I don't like guidelines to be prescriptive, but what is generally done is it's twice a day, every day for a minimum of 12 weeks is required, so 10 weeks is required, so we go for 12 purely empirically and all the data is just that. I don't know why that keeps doing that, excuse me, I'll just get out of there, and we're back. And then it goes down to once a day, and again, another 10 weeks, roughly. And then after that, if you review them at that point in time and things are fine, then two or three times a week, and the first review then would be in six months’ time.

Now at that point, what you are really looking for is that when you compare the old photos to the patient when they come, that there's been no further anatomical loss in addition to the patient being asymptomatic. And some women can have profound physical loss and pain is their major symptom, or they just are completely asymptomatic. So you have to adjust this for the individual, but they are the principles. Ultimately, I think, a biennial review with a specialist in vulval conditions, plus a twice-a-week application is what you are aiming for to maintain the control that you've achieved.

The guidelines for Australia are just being developed, they should be published probably within the next six months. And in essence the guidelines are, potent topical steroids, and then the current consensus is it has to be for life. We know that in the past when anything less, such as Celestone M or hydrocortisone preparations were used to try and get off the potent steroids, these women came back, the routine management was, 'Just a little bit of steroid when you really need it.' They would come back, they would often be miserable, still itchy, they'd have multiple biopsies under a general anaesthetic annually, that has not been the case for at least two decades now, in general, and anatomical loss would be documented. And biopsies were taken of any area that was slightly thickened, because it was considered inevitable that they will go on to develop neoplasia or invasive cancer.

We now know that that is not inevitable, and the more women that we are seeing, the smaller and smaller and smaller the number of women who are actually developing those changes. The other thing that we're also seeing is that they're miserable and they need control, and it is important that we offer it to them. And it has to be a potent steroid to achieve that. Then the very good trial that Gayle Fischer did up in Sydney over a five-year period, she tried, in one arm of her randomised control trial, using Advantan twice a week, ultimately, and then hydrocortisone in between. And the reason she used the hydrocortisone is that she felt that she was likely to get more compliance if they had to put something on every day and not forget them. I am not somebody who finds that myself in my practice and I don't do that. Gayle is very experienced, keeps a very good eye on her patients, has a good eye for them developing complications, and I'm sure what works for her is fine. But if you are in a general practice and you don't see these people every day, then I think that the most appropriate thing is to stick with the potent steroid and educate your patient to use it appropriately.

These are some of the information sites for you, and also the Lichen Sclerosus Worldwide Support Group is also a very good place for your patients to start, and there are Facebook pages for this and there are also Facebook groups for lichen planus. So to summarise, controlling symptoms, preventing anatomical loss, to pick any change early that requires further intervention, are our main goals of therapy. But this is what her vaginal introitus was down to. You couldn't get the tip of your finger in there and one of her main complaints was that she constantly dribbled. So the message from this particular case is, even incontinence should have you looking at your patients as a possibility for something else being there, as opposed to just a potential for a bladder problem. This is an example of a 43-year-old perimenopausal lady who has much less change. But again, she had a year of itch, temporary relief from anti-Candidal agents, never a swab taken and, please, take a vulval swab.

I can understand people not wanting to take a high vaginal swab through what is clearly a painful, irritated vulva. That's fine, but a high vaginal swab can be negative even when there is active vulval candidiasis. There is a nice study published nearly two years ago, where they looked at high vaginal versus vulval versus anal swabs, and not only found that those patients who had vulval symptoms had most of their Candida at the vulva and had negative swabs, they could also have different Candida than what may have been grown high in the vagina or in the anal area. So you take the swab from where most of the irritation is present and visible. And what you can see, getting back to this individual patient, is, again, pallor, and it really looks as though she's put on a bit of Sudocrem and not quite got it off. I know she hasn't, because I know when I took the photograph that that wasn't in fact the case. But you could see or say, still, even if that pallor hadn't been there, this is likely to be lichen sclerosus because you have interlabial sulci that are not of even depth, the clitoris is somewhat buried, sort of, the glands is underneath there instead of usually poking out a little bit, the labia minora are stuck down and partially lost, and there is perineal involvement.

Now this is another lady who had a biopsy and showed lichen sclerosus 15 years before this particular photo was taken. She rang and she wanted an appointment inside her usual annual checkup. The reason was that the lichen sclerosus was becoming really painful. And what in fact I saw, as you can see here, is that all of this tissue is, I beg your pardon, didn't mean to press the button, here inside is eroded or has that glazed erythema that we refer to as dermatologists as being present in lichen planus. And this is an erosive vulvitis or an erosive vestibulitis. Now I've got the photos slightly back to front, in that this should be there, and that should be her eight week review.

But the message is, this problem with the erosive lichen planus does affect the vestibule, does affect the glycogenated epithelium, but even in postmenopausal women, where the epithelium isn't glycogenated, you will still see a preference for the disease in the vestibule and extending possibly into the vagina. And you need to always consider the possibility of vaginal involvement, that usually will come with the discharge that may or may not be malodorous, and there may be a little bit of blood tinging of it, and generally if you part a little bit further you can see, in a little bit, the tiniest speculum or even a tongue depressor, the plastic ones that have a little light on the end of them, lots of lubricant, and you can get inside enough to see whether or not there's an issue. The issue, of course, may just be severe atrophy, and that's something that you might address locally later on down the line. Okay. So whenever you follow-up a patient with lichen sclerosus, you really ask yourself these questions.

Is there any itch or pain that tells me either I'm not treating it properly or something else is going on, or maybe that something else is that, being postmenopausal I can now say that a lot of her symptoms of burning and stinging are not just the lichen planus, but she actually has raw skin and she also has atrophic skin. So every time you see these patients for a review, you need to ask them those questions and think in your mind, have this little list. And it will be, there are many questions on a day-to-day basis that you ask or don't ask that, you are accustomed to doing so in your practice. And you then just reconsider what else is going on and attach that to your mental image of the patient when you examine them. Vitiligo is another one of the autoimmune diseases with which lichen sclerosus can have an association.

So this is a lady that actually came into Jean Hailes, and she came into Jean Hailes via, I'm not sure if it's her second or her third general practitioner, because at one point the doctors that she was going to at her local clinic change. But she had been seen regularly at a gynaecologist's, and she'd been seen 18 months prior to this with itch being worse and the steroids were increased. When they were increased and there was still no improvement, she was told to put them on three times a day. At that point she went back to her local doctor who did a swab. At one point she grew Candida, she was treated with Nystatin, resolved very nicely, but she was still itchy. So she comes into the clinic with this, and you can see here there's really not a lot of overt changes of lichen sclerosus, but her left labia majora is swollen and there's a clear difference between the two.

There's this little bit of flaking around here that is indicative that there may still be some fungal or candidal infection there that needs to be scraped and swabbed for an examination. You can look at her vulva and have a look. Yes, there's pallor there, there's a little bit of scarring and pallor over the clitoris, but overall her in a labia minora aren't too bad for an 87-year-old who's had this problem for many years. And then you come over to here, and when this area is examined and touched, it's identified as where she's itchy. So this whole area of pallor is what has been itchy, and this all turned out to be Paget's disease on biopsy, and probably unrelated to her lichen sclerosus and her itch and certainly her Candida.

But the assumption had been made, and I'm not saying the assumption is unreasonable if you make it initially, that she had developed the Candida superinfection that was going to be treated and then she should have got better. If that had in fact happened, that would be okay, but if you suddenly have a patient complaining of symptoms, particularly if they're localised, have a closer look, and sometimes if it all looks the same but the patient says, 'It's itchy here', take a biopsy and have a look. Every one of us that we discuss in meetings or we'll chase up and go, 'Okay, have you had your case yet?' And what that means is that biopsies will surprise you, when you look closer or you look, today I look at that and it's so much more evident than when she was in clinic. Retrospect is a wonderful tool clinically, but, if they're not getting better, ask yourself why. If you can't explain it, if it doesn't respond to reasonable treatment, take a biopsy or refer.

Okay. Now I apologise for the whiting out there, but I was trying to get this into vision. I saw this lady last year, and she had known lichen sclerosus. She was given repeats of her cream. However, she had had her lichen sclerosus for over 25 years, I think she was in her late eighties at this point in time. But she couldn't, she could get to sort of scratch with her knickers by pulling on them, then she developed this painful area and so she stopped doing that, but unfortunately because of her arthritis, she couldn't quite get close enough to put the cream exactly where it was needed. That said, this is one great big whopping squamous cell carcinoma. So she's suddenly gone from having really nasty itch, having the right treatment, not always being able to put it on because she can't get there, to having a potentially life-threatening malignancy in the space of, we don't really know because it's been quite a few years that her hands have been that poor and quite a few years that, when somebody has examined, they've actually examined, parted the tissue and parted the buttocks to have a look to see this.

This was six centimetres in size and it was almost hemispherical. On the other side of things, some things that should make you cautious that perhaps what you are dealing with is not lichen sclerosus, this is a lady that I saw earlier this year, and she is in her early sixties, she's 62. She was sent to me with a plaque of lichen sclerosus on her right labia majora. It's quite reasonable to have isolated plaques the first time your lichen sclerosus comes up. It wasn't particularly itchy. She felt this and then it started to be itchy because it rubbed on her underwear. Now what you see here is a well demarcated, keratotic, so it's got the white areas in amongst the pink areas, it's an uneven surface, and it lifts up and stands up to compare to the remainder of the skin, which is quite normal in appearance as is the rest of her vulva.

Now I had a look at this and I felt this was going to be a VIN, differentiated VIN. Now we should call that 'HSIL', because 'vulval intraepithelial neoplasia' can refer to more than just HPV-related disease, HSIL is terminology specifically for HPV-related disease only. And she subsequently had a very wide local excision. It came back as several small foci of just beginning to look as though it might invade, but really at a microscopic level only, but a really wide local excision. And she also had some cervical changes when she had her cytology, because she went on to have full colposcopy, full anogenital examination. She had no areas of vein, but she did have an area of HSIL on the cervix, and so that was also treated, and both of those areas were HPV 16 positive. She hadn't had a smear test, she'd missed the last three, and she hadn't had any done with the new technique of identifying the wart virus being present or not and which strain, so this was all very new for her.

And she had been divorced within the last decade and had, not many, but she'd had a couple of sexual partners. But I would suspect that this is more likely to be something that's developed over a period of her lifetime rather than something that's recent. 'Is there only such discolouration in perianal area, would it be lichen sclerosus?' I would be, more likely, but these things depend on the age of the person and whether or not there's any symptomatology. Eczema is still common, so you have to consider lichen simplex, unless it's a well demarcated plaque of colour change, in which case you also need to consider HSIL. So you can't say that it's going to be LS, you really need to take a biopsy. 'Anal skin tags', I'm assuming that means if we see a lot of anal skin tags, do we think that there's an associated neoplastic lesion? And I think the answer is 'no'. They are there and you do need to try, if you have any thickened, whiter areas around the anus, you need to see if you can see the top of the lesion. If you can't, you should try and biopsy it. But not a harmless-looking skin tag.

Routinely, women who have lichen sclerosus do not need to be referred for a vulvoscopy with a gynaecologist to screen for VIN. They don't get HSIL, excuse me, I need to put this correctly. The usual VIN that women with lichen sclerosus get that we keep an eye out for is 'differentiated VIN', which is not the same as HSIL, and it's not the same as HPV-related VIN/HSIL. Differentiated VIN occurs as an alternate pathway to cancer and it's HPV negative. However, if you find a suspicious lesion, you can biopsy it or refer them on. But you don't need, if we see progression of lichen sclerosus into neoplasia, it usually will be a solitary lesion or it may be an area of unresponsive LS that just doesn't get better with topical therapy. It also tends to feel thickened, but I wouldn't rely on that. I think if you've got something and you say, 'Well, I'm going to give it a burst of six weeks of steroid or something because I think it's just all LS', and it's still there, it needs a biopsy. But not as a matter of routine.

Okay. The question is, there is a question as to how long you should take a patient off topical steroids before taking a biopsy. The steroids are likely to give you a false negative result inside of four weeks, we think, we don't know, we don't have hardcore evidence to say that, but certainly four weeks would be reasonable. The other thing to bear in mind with the topical steroids is if you are looking at early lichen sclerosus, then you should wait a good length of time because you are not going to see a classical atrophic skin, green zone of hylanised collagen with no skin appendages that you see burnt out, or very late stage disease. So it would depend a little bit on what you're going to see, because if a patient comes to you and they've got an old scarred-looking vulva that's had lichen sclerosus for ages, then the steroids are probably not doing much except acting as a maintenance, and hopefully that person would be perhaps asymptomatic or only dry.

So, I would say a month in anybody outside that. I'll get to the area in regional areas towards the end, after I've done lichen planus, to discuss that with you. And I have at the end of the presentation three books that I think you should consider having, and work out which one was likely to best suit your needs. Punch biopsies are fine, and I generally use four millimetre size. Okay. I think that covers those for now, so we can pop those away and move on with lichen planus. Now, just before I do, just one thing to consider, lichen, as in lichen sclerosus, lichen simplex, lichen planus, lichenoid dermatoses, lupus erythematosus, 'lichen' means to the clinician that it looks like lichen on a tree.

So you've got a white sponge nevus in the mouth, or you've got lichen simplex chronicus with its hard, gnarly, trunk-like bark appearance, or to the histopathologist, the dermoepidermal junction is the area where you've got a concentration of inflammatory response, that's called 'lichenoid response'. So if you've just started to have a lichenoid response, there may be just minimal changes in the destruction of the collagen in the upper dermis. And likewise, the production of the classic changes we see in lichen planus throughout the epithelium. So those times when you are not clinically clear, and it just looks all inflamed, and you think, 'I really should have, take a biopsy, but the patient's come in', a month, and that's why. Okay. Now unfortunately, lichen planus is not one disease, perhaps. Perhaps it's in fact different diseases, and the one thing that it has in common is that the inflammatory changes that we see are at the dermoepidermal junction, because we see cutaneous lichen planus, which are what we're taught, in medical school and dermatology school, are your pruritic, purple, pearly papules.

And you certainly can get involvement of the vulva in a generalised eruption, but mucosal lichen planus is completely different, and any mucosal site can be affected. Erosive lichen planus is certainly common in the mouth. The dentists see a lot of that. Lichen planus in the mouth is to them what lichen sclerosus is to us as people examining women's vulvas. Lichen planopilaris, very uncommon full stop, very uncommon in the genital area. And if we see lichenoid drug eruption, it'll be to the usual antibiotics or Plaquenil or the nonsteroidal agents, the same as drug eruptions everywhere. And in the genital area it's been reported, but not substantiated by any more than one report, to be the cause of an erosive vaginitis. In theory, a fixed drug eruption, fixed drug eruptions occur there. So I don't see why it can't, but why it would just cause a vaginitis without other similar mucosa going out in sympathy in the genital area,

I'm not too sure. And unfortunately that one-in-a-hundred incidents in people around the world, mostly in adults, doesn't tend to take in the cutaneous, more common eruption. And also it doesn't include vulvas specifically. If you actually want to look up the incidents of vulval lichen planus, you will find it, but it will not come from any data that would excite anybody apart from perhaps the person writing an article. So we really don't know how many women have this. When I first started, it was called 'rare, rare, rare'. It's certainly nowhere near as common as lichen sclerosus, but I don't know that one person, out of all the people looking at vulvas, seeing as many as I do, that that really fits into being rare. So I think it's reasonable that everybody here is going to see some. Okay. And these are the different types, and I've got pictures to go with these types to give you a feeling for what you're likely to see clinically.

The problem one is the hypertrophic lichen planus because it can just look like a really dreadful eczema. And this is when it becomes important to know your pathologist. If you send that to a gynae pathologist, you'll get back a 'lichenoid non-specific eruption'. You'll get, 'there's evidence of scratching'. It may well come back as differential, including lichen simplex chronicus and including possibly psoriasis and not likely to include lichen planus. But you will hear that there's no evidence of malignancy, because their focus is HPV change and malignancy. So you really need to speak to your pathologist or engage with a pathologist, perhaps, who looks predominantly after skin, or somebody who has a special interest. We're very fortunate that those people are around and they're very happy to see specimens and to discuss them. And discussion with your pathologist, particularly if you see in the body of the report, 'bandlike infiltrate' and then you look down the bottom and it comes back as 'nonspecific'.

What that probably means is that, yeah, there's a lichenoid histology there, but not enough to call it classically lichen planus particularly. So read the body of your report, ask questions. Don't just take the conclusion and think, 'That's it', because it often isn't. And that's not a criticism. That just means you need to ask different questions. Now with respect to mucosal or erosive lichen planus, as I said, it can be the conjunctiva, the inner ear canal, it can be the nasopharynx down quite an extensive portion of the oesophagus to where it changes to gastric mucosa, because squamous cell mucosa is particularly what is attacked. It can be the anus. It can be any one, or all, and it can be any one of those in any order. And that's what Hewitt-Pelisse syndrome was originally coined for, vulvovaginal gingival syndrome. Then came along penile cases, conjunctival cases.

So nowadays what we are saying is, multi mucosal sites affected with erosive lichen planus. And it can affect glycogenated and non-glycogenated hair-bearing areas and non-hair-bearing areas. So it can be responsible for a completely flat atrophic looking vulva that has introital stenosis, with an active vulvovaginitis or even a stenotic vagina, because if you get lichen planus of the erosive type, which is a sort you're going to get in the vagina, it is just going to cause fusion of the sides of the vagina, and it also can cause a profound cervicitis, and you'll see a discharge. So in this case, it's important to be aware that the vulva is not the only place that you're going to see it. Apart from that, you need to remember to look in the mouths of your ladies with vulval lichen sclerosus, because there is a very well-documented association with vulval lichen sclerosus—

I'm sorry, I know that's not what I've put there—and oral lichen planus. I'll correct it. These are examples of really purplish plaques. You can say they're flat-topped or you'd call them plateaued. They're violaceous plaques. And they are in the creases. This one has quite a lot of crusting. It wasn't, in fact, weeping. That was due to the fact that in that crack it just split open, and fortunately we caught it. We covered her with antibiotics because of other areas that were involved. So this is really quite nasty and really quite graphic and really, usually, extremely itchy. And the cases that I have seen, apart from this lady here, have only had it on the vulva, which is meant to be quite unusual, but probably reflects what I get to see rather than anything substantially different in their pathophysiology. So purple plaques or papules equals lichen planus, cutaneous type.

These are, I beg your pardon, two photographs from a friend of mine who's a dermatologist who has some of the best photographs of lichen planus and hydradenitis suppurativa that I've ever seen. This is the really convincing lacy Wickham striae of lichen planus. And this is the sort of change you look for on the buccal mucosal when you are looking for evidence of oral lichen planus. And if you take a biopsy, you take it across there, what in fact is happening is that the lichen planus, for reasons it knows and we haven't been able to work out yet, makes these lacy changes by having these little tentacles of super lichenoid change go out, and then eventually fills out the parts in between. And as you can see, it can be itchy. That's been scratched. And as you come over to this side, more evidence of the scratching, again involvement of the clitoral hood, fusion down onto the glands of the clitoris, fusion underneath the glands, fusion underneath there again. And you can see on this photo, extending down the inner aspect of the labia minora, not right within the vestibule, right near the edge. And they are just lovely photos and I'm very grateful to Lynn for letting me use them. And I think you remember those, and you will have these in your printouts, that when you hear people talking, dermatologists saying, 'Wickham striae, lacy changes', just remember these photos and it will serve you well.

This is an example of hypertrophic lichen planus. This is an example that has been loaned to me by Tania Day in Newcastle who started biopsying all of these ladies, thinking, 'What sort of strange eczema am I seeing?' And, 'Must be something in the water, but not really.' But this is actually lichen planus hypertrophic form. And the hypertrophy indicates, at the naked level or the clinical level, naked-eye level, all this thick roughened looking skin that's paler. There's involvement down here as well. It really looks like a chronic eczema. And it can come back with a partially eczematous histology. You really need to have a good chat with your pathologist and good look with the report to say, 'Could this be hypertrophic lichen planus?' Now don't be upset if somebody comes and says, 'You don't get that on the vulva, you only get it on the leg.' Because up until probably about six years ago, that was very much the thinking. But now we recognise that all these years we've been seeing this and wondering what's going on, that in actual fact this is a form of lichen planus. So I would encourage you that even really nasty chronic eczema that doesn't get better, or only gets partially better with what you do, take a punch biopsy. You've got plenty of tissue to choose from and it might be quite illuminating.

Another example of the same thing. Again, really looks like an eczema. You've got broken hairs, you've got exaggerated skin markings and when you take a biopsy it comes back as lichen planus. Interesting. I don't what else to say except that it makes a great case for biopsy. And this is an example of lichen sclerosus after a biopsy and after a patient—excuse me, I need a drink–being reviewed. Just have a good look at those. This lady is 63 years old. I first saw her going on now just on 20 months ago. She had classic lichen sclerosus clinically, I thought. I took a biopsy. The biopsy report came back as classical lichen sclerosus, and this is the result after three months of treatment with a potent topical corticosteroid, you can just make out that there's a little bit of colour change and a little bit of fusion if you really stretch. But overall she's dramatically improved.

So I said, 'See you in six months.' I think it might've even been, yes, it was six months, because it was just the second time I saw her. So I get this phone call and she said, 'Oh my lichen sclerosus is really flaring up.' And she said, 'It just hurts so much. Why is it hurting? It used to just drive me nuts with the itch. Now it just hurts.' And I thought, well it doesn't matter really what I thought, something's wrong. I had a look at her and this is all I saw. I saw, here, denuded vestibule going up to here, and actually all of this area was altered and when you moved it, again, apologise, but I am a dermatologist, you had that translucent, glazed erythema, over here, denuded, all through the vestibule, down there. Again, you can perhaps see the edges of that lesion a little bit better there.

Now this is old change that I would attribute to her lichen sclerosus. What we see of her vagina, looks fine. No discharge, so I did not do anything other than biopsy here, because there was a slightly elevated area within the erosion, and a biopsy here. And they both came back as erosive lichen planus. So this woman had had lichen sclerosus and now it looks pretty well controlled, and then developed lichen planus of the erosive type. If a patient who has been stable for a long period of time, regardless of what the diagnosis is and what confirmation you've had, if their symptomatology worsens or changes, something's wrong. You have to have a look. And once you are aware of this, it's almost frightening how many times you're likely to see it. So that's the general outcome. But I'll just qualify that to say, that includes all lichen planus and it doesn't particularly isolate out the vulva, doesn't particularly isolate out erosive disease or comorbid disease or disease where there has been fusion, particularly of the vagina.

It can just go on and on and be really debilitating. And unfortunately it's often the disease of women in their reproductive years, and they may need very powerful systemic therapy and very aggressive reconstructive surgery in order to control their disease, and then to have any semblance of a normal life afterwards with respect to reproduction and even being able to conceive in the first place by being sexually active. Now one of the other areas of current debate is, does erosive lichen planus in particular give rise to malignancy? Now if you stop and you think about lichen planus in the mouth, it occurs in people who still have their teeth and where there is the chronic constant ulceration and healing around the gingival line around the teeth, people who are endentulous don't tend to develop the squamous cell carcinoma.

So the answer I think may well be that it does, but perhaps not in the same way that lichen sclerosus does. And this debate currently is raging, people are going back over whatever histology they can get of their vulval diseases that have been pulled, lichen planus histologically, they've gone on to develop squamous cell carcinoma and they are reporting that squamous cell carcinoma is occurring in the context of erosive lichen planus. So for the moment, I think these women are best told that they need to be followed up for life. But unlike lichen sclerosus, they tend to go through remissions more often and it is not essential, in that setting, that you continue maintenance therapy the way you do in lichen sclerosus. So you can say, 'Well great, keep a tube there, I'll see you again if it flares up', and perhaps give her a fast track ID or something into your clinic so that, should that happen, she can come and see you. But they may have a dreadful time and then suddenly they get better and it goes away. And we don't have an explanation for that.

Now when I said their challenging, the really extensive erosive genital lichen planus is very, very challenging. Our first line of therapy is potent topical corticosteroids. This is one of the times where you might compound clobetasol dipropionate at a 0.1% ointment. Simple measures, as always, within any aspect of a patient who has an uncomfortable vulva are always beneficial when there are erosions present. Salt baths or the equivalent of salt mouth rinses, or bicarbonate rinses of the mouth and bland emollients, they're all useful but you really need the potent or ultra potent topical steroid. You may find that that's not going to be enough, and we'll just get onto that. But again, the difference here is you might need to use it for longer than you do in lichen sclerosus. And once you've got control of the erosions and you cut back, the rough guideline is that it's taken three months to get better, you cut one over three months.

But really you just do that as tentatively as you want or as aggressively as you want. But there is not the same guideline protocol that there is for lichen sclerosus. And anything that's difficult that's erosive in the genital area is probably best thought of of, 'Okay, if I've got an erosive lichen planus, I should at least get the specialist involved to make sure that if there's any vaginal involvement or cervicitis that that's looked at', make sure they're up to date with their cervical screening, because the next stage of care is, well, we use methotrexate generally. I don't use a lot of oral steroids. The main reason for using an oral steroid would be to give a patient some control if there's really extensive disease. So you can put the methotrexate on board. It generally takes about 10 to 12 weeks to kick in.

So you don't have a really rapid induction. Doxycycline's a little bit better, and you need to use in the order of a hundred milligrams twice a day. You're using it as an anti-inflammatory, not an anti-infective. Things such as cyclosporin, hydroxychloroquine, they've all been used with varying degrees of reports. It's the same thing that's true for other aspects of medicine, the more treatments you have, the less likely it is that any one is superior. So this is something that I would think, while it's going through its severe phases, does need to be managed by a specialist. And this is an example, another example of comorbid lichen sclerosus and lichen planus. Just to go, that was a bit of an abrupt change, I beg your pardon. What we are looking at are these two questions, and then I'll get onto the others. So what we have here, old established lichen sclerosus, previously biopsied. New discomfort, dysuria and dyspareunia, and this patient has now developed an erosive lichen planus in the vulval vestibule.

The scarring that is up here is really not particularly great. It's not a lot of it. It's predominantly the perineum and the perianal area that's had her lichen sclerosus, and the scratch marks speak to the fact that it is very itchy. So in this area, what would help you to make the diagnosis that she's got comorbid disease is you've had that biopsy done in the past, you've been able to get a copy of the specimen, have it reviewed, histology has come back, 'this is LS'. Histology of that has come back, 'this is LP'. The other option would be, this could have all been lichen planus. Okay. And this is an example of a lady who has multiple mucosal sites affected by lichen planus. She's got a little bit of change there on her right buccal mucosa, a little bit more in that sulcus. This is a really nasty gingivitis.

Now this is with regular dental visits to clean her teeth. She's using Daktarin and betamethasone. Oral Metronidazole gel plus betamethasone dipropionate gel, twice a day, and she gargles every time she eats. And what has progressively been happening is this gingival hyperplasia, this retraction of the gums, this sort of erosion here, change in the confirmation and appearance of the gingiva, and again here pulling away of the gums and a nasty gingivitis as well. And this is her vulva. And she has had vaginal stenosis and she has quite nasty scarring anteriorly. And when those two areas were biopsied in the past, they've been lichen planus. So what she came up with, and I last saw her in April of this year, she started complaining of itch around the bottom, or the anus, or she says—never mind, I won't say that in public—but she describes it as spreading and as being a new problem.

And because she works sitting down most of the time it's really, really uncomfortable. So what we've got here is this new change extending over the perineum and perianally, and that was biopsied, and that was lichen sclerosus. So that's the opposite of what you've seen before. So comorbid disease can occur in either direction. This is another example of two mucosal sites. None on the gingiva in this particular lady, but she has this persistent white plaque here that is static, and it's not particularly thickened or raised. We are just keeping an eye on it for the moment. She's able to have a look, she has a photograph, so she can do a lot of that herself. The question obviously will be whether or not, if there's any change in texture or symptoms or size, she'll need a biopsy. I won't do that.

I don't know why, but even when I have the best of patients, I find that the oral mucosa and tongue are very, very difficult for me to biopsy. And this is her vulva. And this is her vulva when I reviewed her, probably about eight weeks ago. And she's now got these changes here and at the back, and she was doing really, really well and focusing on putting her Eleuphrat, elephant cream, as she and some of the other women call it, but it is betamethasone dipropionate 0.05% ointment, twice a week. And she just, literally, she can show you, she'll show you how she does this nice arc, and dollops it near her introitus and just leaves it there. I will say that amongst the questions was, 'What's my favoured base?' It's lipoidal base. It's in the textual notes. Likewise, my two most favourite formulas, which is your 2% amitriptyline and then your 2% amitriptyline plus ketamine.

And I'll decide depending on how long it goes, and also I will introduce, so a lot of things will be answered in the textual notes. 'Would a bland emollient be something like Vaseline?' Yes, I will give you the thumbs up, or the QV intensive body moisturiser. I like giving women easy-to-use things, and that's where something that comes in a pump pack, that may be on special at the chemist and you can just slop it all over, is really, really good. And in the regional areas where there's almost no access to dermatology, look, I think you need to, many years ago when I had an interest and I did my Dip Obs and decided vulval disease was where I wanted to go, I was given a copy of the book, The Vulva, the only book we had then.

Have a look at the books, I'll talk to you about them a bit more, but you find a good source of pictures, you look, you look, you look and you make a list of questions, or you can get on the phone and ask me, or with patient's permission, and it's not just me, I'd like to think you could do it to all my colleagues, but I certainly am more than happy to make suggestions on individual cases if you would like to send them to me. I have the good fortune of only working two and a half days a week seeing patients, and I don't mind if anybody wanted to ring me and ask me specifically, and I'll elaborate on that. Because I think the answer is that we need a good telehealth distant service. The best place to biopsy hypertrophic lichen planus is any one of those thickened areas. And I do use, sometimes I'll put emla on, usually I find by the time emla is there for a biopsy, if you prepare the patient and you inject local anaesthetic, Xylocaine 1% with adrenaline, one and a half mils, and then you start to prepare or get help to prepare for your biopsy, it's got enough time to work.

End of transcript

Information about the podcast

This podcast series has been made possible by the NSW Government's Menopause Awareness Campaign. For help talking about menopause, download the [Perimenopause and Menopause Symptom Checklist](https://www.jeanhailes.org.au/resources/perimenopause-and-menopause-symptom-checklist) and take it with you to your next medical appointment. For more information visit: <https://www.nsw.gov.au/women-nsw/toolkits-and-resources/perimenopause-and-menopause-toolkit>

Hosted by Dr Sarah White, CEO at Jean Hailes

Produced by May Jasper

Sound engineering by Derek Myers

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