An Overview of Vulval Conditions

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Aim

• Review the anatomy of the vulva

• Identify common skin conditions affecting vulval skin

• Discuss treatments used for common vulval conditions
Anatomy
Common skin conditions which can affect the vulval skin

- Psoriasis
- Contact dermatitis
- Seborrhoeic dermatitis
- Infection
- Lichen Sclerosus
- Erosive Lichen Planus
- Vulvodynia
- VIN
Psoriasis

- Well defined scaly plaques
- Skin folds - well demarcated erythema
- Differential diagnoses: eg seb derm, tinea, candida, Paget’s, contact dermatitis
- Check other body sites - scalp, nails, elbows, knees

- Emollients, topical steroid/antiyeast, topical steroid/Vit D analogue
Contact dermatitis

• Irritant avoidance
• Soap substitute
• Emollients
• Topical Steroid
• Patch-test
• Swab to exclude infection
• Biopsy if no improvement
Contact dermatitis

Irritant
• Increased tendency in atopics
• Burning, soreness, redness, itch, medicaments ‘sting’
• Erythema, oedema, exudation
• Wipes, deodorants, cleansers, lubricants, sprays, semen, sweat, soap, urine/faeces, water, vaginal discharge

Allergic
• Medicaments: anaesthetics, antibiotics, anti-candidals, antiseptics, corticosteroids, Tea tree
• Spermicides, semen
• Condoms, diaphragms
• Clothing, panty liners, sanitary towels, wipes
• Personal care products: preservatives, fragrances, emollients, nail polish
Seborrhoeic Dermatitis

- Check other body sites – scalp, eyebrows, nasal folds, chest
- Erythema, scaling mild itch
- Emollients, ketoconazole cream, steroid/antiyeast combination
Candida Infection

• Caused by an overgrowth of yeast

• Erythema
• Fine scale around margin
• Satellite lesions
• Itching, burning
• Heavy white discharge
Candida

Candida Treatment
• Topical antifungal creams/pessaries - clotrimazole or miconazole
• Oral antifungal – fluconazole, itraconazole
• Loose fitting clothing
• Soap substitute

Common triggers
• Flares during pregnancy
• Menstruation
• High dose oral contraceptive
• Oestrogen based HRT
• Antibiotics
• Diabetes
• Obesity
• Iron deficiency anaemia
• Immunodifciency
• Underlying skin condition
Tinea Cruris

- Dermatophyte fungal infection of the groin
- Skin scraping
- Topical anti-fungal cream
- Check other sites e.g. feet, nails and treat as necessary to avoid recurrence
Group B Streptococcal infection

- Erythema
- Swelling
- Swab
- Treat according to sensitivities
Fordyce Spots

• Small sebaceous papules

• Can often be seen in the mouth

• More easily seen if labia are stretched

• More obvious after puberty
Angiokeratoma

- Common on labia majora
- May be up to 100
- In younger patients, bright red & may be crusty
- In older patients, dark red-purple
- May bleed – if so, refer for KTP laser
Lichen Sclerosus

- Lymphocyte-mediated autoimmune condition
- Associated with other auto-immune diseases (up to 20% have co-existing thyroid disease) and family history of autoimmune disease
- Two peaks; pre-pubertal & post-menopausal
- Prevalence 1:300 – 1:1000
- Commonest cause of chronic vulvar disease
Lichen Sclerosus Signs and Symptoms

- Main symptom is severe itch
- If erosions or fissures – can be painful, dysuria
- Sleep loss
- Dyspareunia, psychosexual problems
- Constipation if anal disease
- Often figure of 8 pallor
- Atrophy
- 3.5-5% risk of SCC

- Porcelain-white papules & plaques, erosions, fissures, haemorrhage, loss of architecture
- Interlabial sulci, labia minora, clitoris, perineal body, peri-anal area (30%). NOT vagina & cervix
- Exogenous sites (11% adult females)
- Oral disease (quoted as ‘small’ but possibly under-reported?)
- Can lead to Vulvodynia
Treatments for Lichen Sclerosus

• Clobetasol Propionate 0.05% ointment
• Once daily at night for 1 month, alternate nights for 1 month, twice weekly for 1 month
• Either as required or if symptoms persist regularly try twice weekly
• Use no more than 30g in 3 months
• Education on topical treatment use and how to self examine
• Psychosexual support if required
• Follow-up at 3 months then 6 months after. If controlled discharge to GP

General advice for patient with LS

• Use soap substitute in shower/bath
• Never wash your hair in bath
• When washing your hair in shower, stand out of the water and lean your head into the stream of water
• Avoid bubble baths, essential oils or other perfumed products in the bath
• Wear white cotton pants
• Avoid fabric softeners
Erosive Lichen Planus

- Soreness, burning, rawness
- Dyspareunia
- Discharge (sticky, yellow-green)
- Bleeding after intercourse
- Gingivitis, dysphagia
- Erosions
- Atrophy, fusion, scarring
- Vaginal stenosis
- Cervix and anal canal may be involved
Erosive LP treatments

- Emollients
- Clobetasol propionate 0.05% oint
- Tacrolimus 0.1%
- Short course oral steroids
- Hydroxychloroquine
- Minocin 100mg
- Nicotinamide 500mg bd
- Cyclosporin, Dapsone
Vulvodynia

• Pain in vulva when there is no visible cause
• Affects about 15 in 100 women
• A type of ‘complex regional pain syndrome’, others including migraine and fibromyalgia
• The superficial nerve endings in the vulva seem to become over-sensitive and react abnormally
• Often described as burning, stinging or raw discomfort
• Vestibulodynia is a term used for pain arising at the entrance of the vagina
• It can be generalised or localised and may be described as provoked (caused by touch) or spontaneous (occurring without touch as a trigger).
Treatments

• Local anaesthetic ointment (Lidocaine 5%)
• Amitriptyline (anti-depressant) – initially 10mg at night increasing by 10mg per week (Max 80mg). Once controlled stay on for 3 months then reduce
• Gabapentin (anti-epileptic) – initially 300mg at night gradually increasing to 300mg three times daily if necessary. If required 600mg three times daily can be used
• Gabapentin 6% gel (unlicensed, hospital only prescription) – once daily initially increasing to twice daily if required
• Pregabalin – similar to Gabapentin, initially 75mg increasing to 300mg maximum if required
• Capsaicin cream (related to chilli peppers) gradually build up tolerance

General advice

• Avoid soaps, bubble baths, shower gels, wipes etc
• Use a soap substitute and emollients
• Pelvic floor exercises (refer to physiotherapy if necessary)
• Vaginal dilators
• Relaxation – stress can worsen this condition
• Avoid tight clothing
• Psychosexual counselling
• Referral to pain clinic if necessary
Useful contacts

• Vulval Pain Society Web: http://www.vulvalpainsociety.org/

• British Society for the Study of Vulval Disease Web: http://www.bssvd.org/

• International Society for the Study of Vulvovaginal Disease Web: http://www.issvd.org/

• National Vulvodynia Association Web: http://www.nva.org/
VIN

- Solitary / multiple
- ‘Viral warts’, shiny smooth plaques, erythematous patches, warty pigmented areas (may look like BCP)
- Itch
- 10% risk of progression (increased if elderly or immunocompromised)

- Loss of normal orientation & architecture of epithelium with cellular atypia
- VIN 1 - 111
- If multifocal, strong association with oncogenic HPV (16 & 18) (cig smokers)
VIN Treatment

- Surgery - if solitary. NOT if extensive, multifocal, periclitoral, recurrence post-surgery, poor health
- Laser (+/- Interferon) : CO2 laser; high recurrence
- Metvix PDT - ? Effective, recurrence high, painful
- ? Systemic PDT

- Medical:
  - Emollients, antibacterials
  - 5 FU Need to use for six weeks
  - Acetretin
  - Cidofovir
  - Imiquimod (ten weeks)
  - ? Vaccination V HPV 16
Thank you

Any Questions?

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