Management of benign vulval dermatoses in primary care

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Vulval dermatoses can be difficult to manage in primary care, and GPs need to be aware of the risk of malignancy. This article describes the most common types of benign vulval dermatoses encountered in primary care and their management, and discusses when referral to secondary care is required.

The management of vulval dermatoses can be difficult for the GP as many patients have complex needs and clinical signs may be subtle. This article discusses the common benign, pruritic skin conditions affecting the vulva in adults (see Table 1). In this review, we focus on the pharmacological and non-pharmacological treatment of these dermatoses in primary care and explain when patients should be referred to secondary care (see Figure 2).

Vulval dermatitis
Vulval dermatitis is an inflammatory skin condition with a reported incidence of up to 30% in vulval clinics. The main symptoms are vulval soreness and pruritus. Vulval dermatitis can be classified into eczematous or contact subtypes (see below), but the signs are similar. On examination, there is often symmetrically inflamed, erythematous, weepy skin with satellite lesions and poorly-defined edges. Lichenification may be present if the condition is long term. Secondary candidiasis is not uncommon, so a swab to exclude infection is suggested.

- Eczematous subtype – more commonly seen in patients with a history of atopy, although sweat, warmth and rubbing are non-atopic-related triggers.

Figure 1. Allergic contact dermatitis of the vulva
Contact dermatitis – arises secondary to an allergen or irritant. Allergic contact dermatitis (see Figure 1) is a delayed response following prior sensitisation, commonly to antifungals, nickel, topical antibiotics or preservatives in products. Allergic contact dermatitis is diagnosed by patch testing. Irritant dermatitis occurs minutes to hours after contact with triggers including urine, hygienic products, douches and lubricants, but should also be considered in patients with incontinence or a significant hygiene habit, e.g. overwashing.

Management in primary care
A general approach is to restore the skin barrier, provide symptom relief, treat co-existing infection (see Table 2) and reduce inflammation with steroids.

Importantly, patients must avoid any allergens or irritants. A moderate topical steroid can be applied once daily (see Box 1), or a potent topical steroid if the condition is more severe, for 7–10 days until the symptoms resolve. The patient’s serum ferritin should be checked, as iron-deficiency anaemia is found in 20% of cases.

When to refer
In treatment-resistant dermatitis or if atypical characteristics or lesions emerge, then a referral to secondary care is required. Consider a two-week wait referral for patients with suspected vulval cancer. The most common symptom of vulval cancer is chronic pruritus or pain. The most common sign is a vulvar mass or lump, which can be ulcerated or warty in appearance.

Vulval psoriasis
Vulval psoriasis affects 5% of women with vulvar symptoms, presenting with pruritus and a burning sensation, made worse by friction and irritants. Classically in psoriasis, well demarcated, scaly erythematous plaques are seen, but vulval psoriatic plaques are smooth, glossy and often salmon pink in colour. Often no scale in vulval creases are seen but surrounding skin may have the typical scaly lesions of psoriasis. There is no scarring or loss of anatomy (see Figure 3).

Management in primary care
Encourage general vulval care (see Table 2), but most patients require referral to secondary care for management. For acute care or when there is a delay in referral, a moderate topical steroid can be used, or a potent steroid in severe cases (see Box 1). As the skin folds can become particularly macerated, there is a chance of secondary bacterial or fungal infection. A combination topical preparation (e.g. clobetasone butyrate 0.05%/oxytetracycline 3%/nystatin cream) may be helpful.

When to refer
Most patients should to be managed in secondary care or referred if the diagnosis is uncertain. The disease is often

Table 1. Common benign vulval dermatoses
- Vulval dermatitis – atopic eczema and contact dermatitis
- Vulval psoriasis
- Vulval lichen planus
- Vulval lichen sclerosus
- Vulval lichen simplex

Figure 2. Management of vulval pruritus in primary care and when to refer to secondary care

*VIN = vulval intraepithelial neoplasia, a precancerous skin condition (not discussed in this article)
Vulval dermatoses

Vulval lichen simplex chronicus

Vulval lichen simplex chronicus is a chronic inflammatory dermatosis, with the key symptom of severe pruritus leading to vulval pain through skin fissuring (via the itch/scratch cycle). Pruritus can be triggered as a result of dermatitis, an irritant or secondary to a systemic or psychological disorder. A localised eczematous patch can be observed, which can become lichenified with erosions and might be more marked on the side of the vulva opposite the dominant hand. Skin excoriation and pubic hair loss can be seen. Usually, no loss of anatomy is seen but it can result in thick ‘leathery’ skin.

Management in primary care

General vulval care should be encouraged (see Table 2). Treatment with a very potent topical steroid and an emollient is suggested. Once control of symptoms is achieved, a moderate potency topical steroid may be required intermittently.

When to refer

The patient should be referred to secondary care if the diagnosis is indeterminate, where a biopsy may be required. For coinciding psychiatric symptoms, a referral for psychological therapy may provide benefit.

Vulval lichen sclerosus

Lichen sclerosus is a chronic inflammatory condition, with an autoimmune link and an approximate prevalence of 3% in older patients. Key symptoms are pruritus, soreness and dyspareunia. Typically, pearly white papules are observed in a ‘figure-of-eight’ pattern around the vulva, perineal body and perianal skin, and purpura can be seen. This can progress to erosions, hyperkeratosis, ulcers and fissures after prolonged scratching (see Figure 4).

Table 2. General vulval care

- Provide written information on the diagnosis and treatment of vulval conditions
  - See the British Society for the Study of Vulval Disease website for more information (bssvd.org)
- Re-establish the skin barrier:
  - Wash the vulva with water and use fingertips only
  - Do not rub or scrub the genital skin while bathing and gently pat the skin dry
  - Avoid soaps, shampoos, bubble bath and scented wipes. Instead, use a soap substitute such as Hydromol ointment or aqueous cream (the latter needs to be washed off)
  - Avoid using sponges and flannels to clean the vulva
  - Wear light-coloured cotton or loose-fitting silk underwear
  - Avoid wearing sanitary pads or panty liners frequently
  - Avoid using nail varnish and cut nails if you scratch the skin
- Symptom control:
  - Educate the patient on the itch-scratch cycle
  - Gel packs or cooled washcloths can reduce symptoms
  - If symptoms are worse at night, use a tricyclic antidepressant such as amitriptyline starting at 5–10mg or doxepin starting at 25mg and increase based on response, rather than using a sedating antihistamine
- Treat co-existing infection:
  - Take appropriate swabs if an infection is suspected
  - Treat weepy, discharging skin that may indicate secondary bacterial infection with antibiotics such as flucloxacinil
  - Candidiasis can occur with any dermatoses, especially when using topical steroids and if present, treat with an oral antifungal such as fluconazole twice daily
  - Think about co-existing herpes simplex virus infection, which may need oral antiviral treatment

Figure 3. Vulval psoriasis showing ill-defined erythema and a lack of scale

Figure 4. Vulval lichen sclerosus with fusion of the clitoral hood

Management in primary care

All patients need to be notified of the risk of squamous cell carcinoma, and ideally self-examine once a month and present for immediate review if any changes arise. If any clinical findings are indicative, an autoimmune thyroid and pernicious anaemia screen are suggested.

A very potent topical steroid (such as clobetasol propionate 0.05% ointment) daily for one month (see Box 1), then on alternate days for one month and finally twice a week for a month is suggested. The minimum topical steroid required to maintain remission should be used as maintenance, with 30–60g topical steroid daily.
The mucosal skin of the vulva is somewhat resistant to steroids and therefore very potent steroids can be used for a longer duration. However, hair-bearing areas of the vulva are prone to atrophy and require close monitoring. Topical steroids are safe to use in pregnancy and breastfeeding. Topical steroids should be used once daily and an ointment is preferred to reduce irritation. Review all patients using a potent steroid after one month. The amount of topical steroid required for treatment is measured in fingertip units (FTU), measured from the first crease of the finger to the very tip. The number of FTUs required is usually one to two but is specifically tailored to the patient depending upon surface area affected by the condition.

Examples of topical steroids and their potency

**Moderate potency:**
Clobetasone butyrate 0.05%, betamethasone valerate 0.025%

**Potent:**
Mometasone furoate 0.1%, betamethasone valerate 0.1%, betamethasone dipropionate 0.05%

**Very potent:**
Clobetasol propionate 0.05%, diflucortolone valerate 0.3%

Box 1. Topical steroid options for vulval dermatoses

oid normally needed per year for maintenance treatment. In one study, 23% of patients using very potent steroids experienced a reversion to normal skin and 96% found an improvement in their symptoms. The importance of maintenance treatment has been demonstrated in a study showing that no compliant patients developed SCC, compared with 4.7% of partially compliant patients. Patients need to be reviewed after three and nine months and then annually if their condition is stable and uncomplicated.

When to refer
If the diagnosis is indeterminate, a lesion is observed or there is a worry about vulval intraepithelial neoplasia or malignancy, then a biopsy is required. This referral may be urgent or via a two-week wait pathway, depending on the findings.

At each review, if any pseudocyst of the clitoris is observed, if the patient has dyasaesthesia or psychosexual prob-
For lichen sclerosus and lichen planus, a three-month reducing regimen of a very potent topical steroid can be used prior to review if confident about clinical assessment and prescribing.

When to refer
If the diagnosis is unclear, a lesion is observed or there is a worry about vulval intraepithelial neoplasia or malignancy, then referral for a biopsy is required. This referral may be urgent or via a two-week wait pathway, depending on the findings. Patients with erosive disease need referral as they require long-term follow-up. Referral is also required if systemic treatments are needed, including oral prednisolone or retinoids, or immunosuppressants such as methotrexate or azathioprine.

Summary
A variety of benign vulval diseases can present to the primary care physician that are sometimes difficult to diagnose and often require careful management. All patients should be encouraged to undertake general vulval care. If a qualified healthcare professional is confident in prescribing, then potent or very potent steroids can be offered to the patient to be used on the vulva and applied once a day—but cases must be reviewed after a month. If the diagnosis is not known, in treatment resistant cases or if there is concern about malignancy, then always refer to secondary care for assessment.

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References

Declaration of interests
None to declare.

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