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Vulval lichen sclerosus in primary care:

thinking beyond thrush and genitourinary symptoms of the menopause

BACKGROUND

Vulval lichen sclerosus (VLS) is a chronic inflammatory skin condition. Prevalence remains unclear as it is likely underreported and underdiagnosed. It affected one in 70 women presenting to a general gynaecology clinic.[1] It can have a significant impact on quality of life, affecting sexual function and restricting other activities of daily living such as toileting, sitting, exercising, and socialising. Women may experience a loss of sense of self.[2] If untreated, VLS is a progressive disease, with potential to lead to distressing anatomical changes and malignancy. Early diagnosis and treatment are key to reducing the impact on women's lives, and preventing long-term sequelae. General practice has a key role in enabling timely diagnosis and treatment, but women often report long delays to diagnosis despite repeatedly seeking help. Missed opportunities for diagnosis and the resulting distress were a major theme in the current authors' recent study.[2] VLS may be commonly misdiagnosed as candidiasis or genitourinary symptoms of menopause (GSM). With rising awareness of GSM and the shift to teleconsultations, delayed diagnosis by primary care practitioners is an increasing risk. While not mentioned in detail in the recently published Women's Health Strategy,[3] vulval disease is an important component of a number of its priority areas and must not be forgotten. This article describes practical information for GPs. The words woman/women have been used, but the concepts herein refer to anyone who could experience VLS.

EXAMINATION

To diagnose VLS, examination is key, preferably by a GP with an interest in women's health. Women report not being examined despite multiple presentations with vulval symptoms.[2] Virtual consultation with photography is inappropriate for reasons of acceptability, confidentiality, and practicality. Vulval examination may be daunting and is often painful for those with active LS, as the skin may be fragile and inflamed. If examination by a female GP is important to the woman, it should be facilitated. A chaperone should be offered. It may be extremely difficult for

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Box 1. Differentiation of selected common vulval disorders[4–6]

	Vulval lichen sclerosus	Genitourinary symptoms of menopause	Candidiasis
Itch	Yes, often severe	Yes	Yes
Age	Any but more common pre-puberty and post-menopause	Related to low oestrogen states	More common post-puberty, pre-menopause
Colour	White	Pale pink	Red if inflamed
Vaginal involvement	No	Yes	Yes
Change in architecture	Yes, often severe, may be asymmetrical. Fusion/scarring of clitoral prepuce	Yes, usually mild, symmetrical, gradual. Retraction of clitoral prepuce	No, but may have temporary swelling during flares
Perianal involvement	Yes	No	No
Associated with incontinence	Yes	Yes	No
Discharge	No	Possible	Often

women to speak to anyone, including GPs, about vulval symptoms. Sensitivity when supporting these women is crucial, as they may feel ashamed and vulnerable.

DIAGNOSIS

Women with VLS often seek help on multiple occasions and may be given incorrect diagnoses and treatments for a range of conditions, such as candidiasis and GSM. See Box 1 for ways to differentiate. When reviewing women with vulval symptoms, it is suggested that GPs consider:

1. Has the woman previously presented with these symptoms?
2. Have swabs for candidiasis been negative?
3. Has the woman been prescribed or self-treated with remedies for candidiasis or GSM?
4. Does the woman report any white patches or a change in shape of their vulval skin?

If any answers are yes then VLS should be considered. GPs should be aware that vulval symptoms can be non-specific, women often conflate vulva and vagina when describing symptoms, and vulval conditions (for example, GSM and VLS) can coexist.

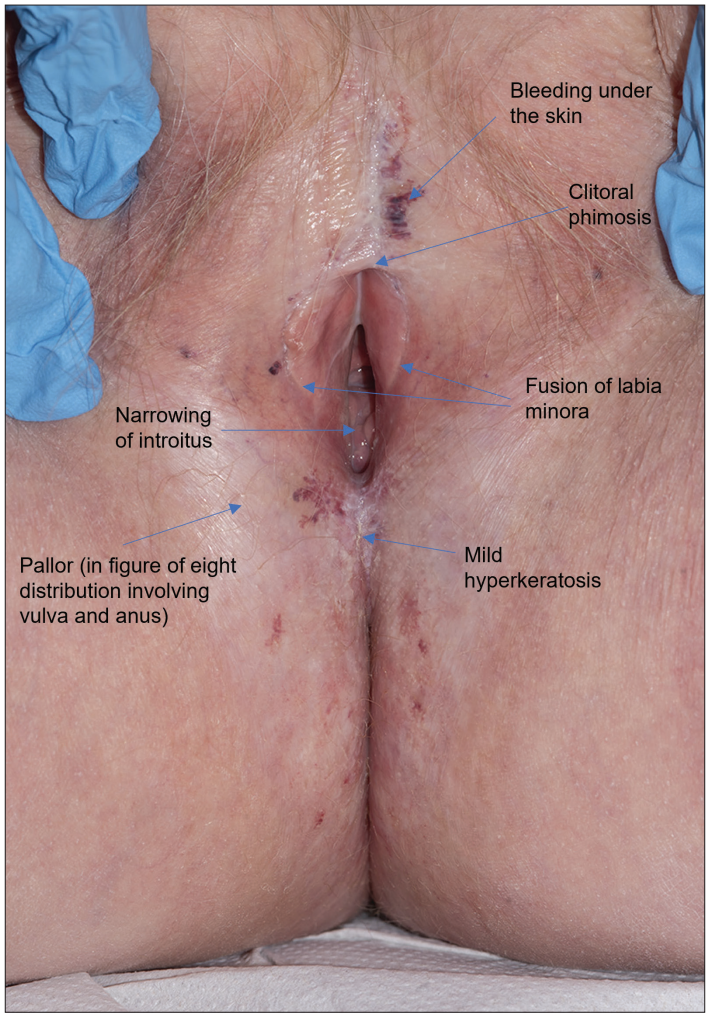
Symptoms

Typically women report intense pruritus and dyspareunia or vulval pain (although occasionally women are asymptomatic).[7,8] Vulval bleeding or a change in appearance or texture may also be described. Urinary incontinence is associated with VLS[9] and is important to ask about as women may not think it relevant to disclose. Vulval cancer, and its precursor (differentiated vulval intraepithelial neoplasia), may present with similar symptoms.

Signs

Signs of VLS are white patches of fragile skin, especially in a 'figure of eight' distribution around the vulva and perianal area (Figure 1). The skin may look sore and inflamed. Bleeding under the skin may be seen and bleeding can also be caused by excoriations, fissuring, or erosions. In advanced disease, anatomical changes can occur such as fusion of the labia minora, clitoral phimosis, and narrowing of the introitus. Visual signs may be detected by practice nurses during routine procedures such as cervical screening, and women with signs/symptoms detected opportunistically should be facilitated to see a GP for diagnosis and management.

Figure 1. Signs of vulval lichen sclerosus.



Treatment

VLS can be managed in primary care if the clinician is confident, but referral to a specialist vulval clinic should be considered if response to treatment is poor, disease is complicated, or diagnosis is uncertain. A persistent area of hyperkeratosis, an eroded or ulcerated area, or a papule or nodule may all be signs of malignancy and require a 2-week-wait referral. Individuals who are particularly struggling with psychosexual issues should be referred to a psychosexual counsellor.[10]

Treatment should be started as soon as possible, and should not be delayed while awaiting a specialist appointment. If the woman is willing, taking a photograph of the affected area before treatment commences can be helpful for the specialist appointment. Recommended treatment is clobetasol propionate (CP) 0.05% ointment once a day for a month, then alternate days for a month, then twice weekly.[8] Potency

can be reduced to betamethasone valerate for long-term use if disease control is good, but the consensus is that long-term use of very potent topical corticosteroids is safe in active disease.[4] An ointment emollient should be used as a soap substitute, moisturiser, and barrier. Vaginal oestrogen may also have a role in improving skin condition in postmenopausal individuals. Skin condition can be improved, but anatomical changes may be irreversible. Patients should be reassured about the safety of using an ultrapotent steroid on the vulva and informed how and where to use it, using a mirror if necessary. Current international consensus favours ongoing proactive, long-term, regular treatment with a topical steroid rather than 'as required' treatment for recurrent symptoms, and a forthcoming National Institute for Health and Care Research study (PEARLS) will compare these treatment regimens.[11]

GPs should explain to women about the risk of malignancy. Women may be understandably alarmed by mention of cancer, but GPs can explain that the risk is low (2.2%),[12] but that self-examination is important and treatment seems to reduce the risk.[12] Resources for patients are available including self-examination instructions.[13] Women with stable symptoms should be examined on an annual basis.

CONCLUSION

VLS is a chronic, progressive disease. It is painful, restricts activities of daily living, and carries the potential for malignancy. Early diagnosis and intervention are crucial to reduce the impact on women's lives. Genital problems are distressing for women, and difficult to talk about. Vulval symptoms should not be accepted as a normal part of ageing or of being a woman. Examination is key, ideally by someone with an interest in women's health. GPs must think beyond candidiasis and GSM when women present with vulval symptoms, and consider the diagnosis of VLS.

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