VULVAL LICHEN SCLEROSUS - GUIDANCE FOR GPS FOLLOWING DISCHARGE FROM SECONDARY LEVEL HEALTH CARE

Lichen sclerosus (LS) is an auto-immune inflammatory scarring skin condition that affects the anogenital area usually in women. National guidance on the management of the condition can be found on the British Association of Dermatologists website using the link below

http://www.bad.org.uk/Portals/_Bad/Guidelines/Clinical%20Guidelines/Lichen%20Sclerosus%20Guidelines%202010.pdf

This guidance suggests that uncomplicated women with LS should be discharged back to primary health care for follow-up. Complicated patients are those who do not respond to treatment, have complications of disease (eg scarring, pain), have higher risk of cancer development and have a history cancer or precancer (VIN) and should be managed in the hospital

Role of secondary health care

1) Assessment, make a diagnosis, manage treatment (ultrapotent topical corticosteroids eg Dermovate ointment, 3 month regime –once daily, at night, for 4 weeks, then on alternate nights for 4 weeks, and then twice weekly for a further 4 weeks, before review).
2) Two follow-up visits after the initial consultation: one at 3 months to assess response to treatment and to ensure that the patient is using the topical corticosteroid appropriately and judiciously, and a second final assessment 6 months later to ensure that the patient is confident in treating their problem and to take the opportunity to discuss any residual problems that the patient might have before discharge
3) Communicate management plan back to the GP
4) Teach the patient vulval self examination and skin care
5) Give written instruction to the patient at the time of their discharge from the clinic warning them that any persistent area of well-defined erythema, ulceration or new growth must be reported to their family practitioner straight away, who will then make an urgent referral back to an appropriate specialist

Aims of GP follow-up

1)Review topical steroid use. Maintenance dosages of topical steroid are acceptable using small amounts (no more than 60gm in 12 months or up to 3 time a week)
3) Review symptoms and refer back to secondary level health care if there are problems with symptom control, concerns about skin appearance or complications.

Frequency of follow-up in primary health care

An annual review is suggested if they continue to use topical corticosteroids.

Trouble shooting for GPs

If symptoms recur, examine the patient and exclude candida (take a swab) and suspicious vulval lesions (do two week referral) The patient is then instructed to use the Dermovate ointment more often until the symptoms resolve. They can then try to reduce the frequency again.

About 60% of patients experience complete remission of their symptoms after the initial three month course. Others will continue to have flares and remissions; they are advised to use Dermovate ointment as required (eg alternate days to twice a week). Most patients with

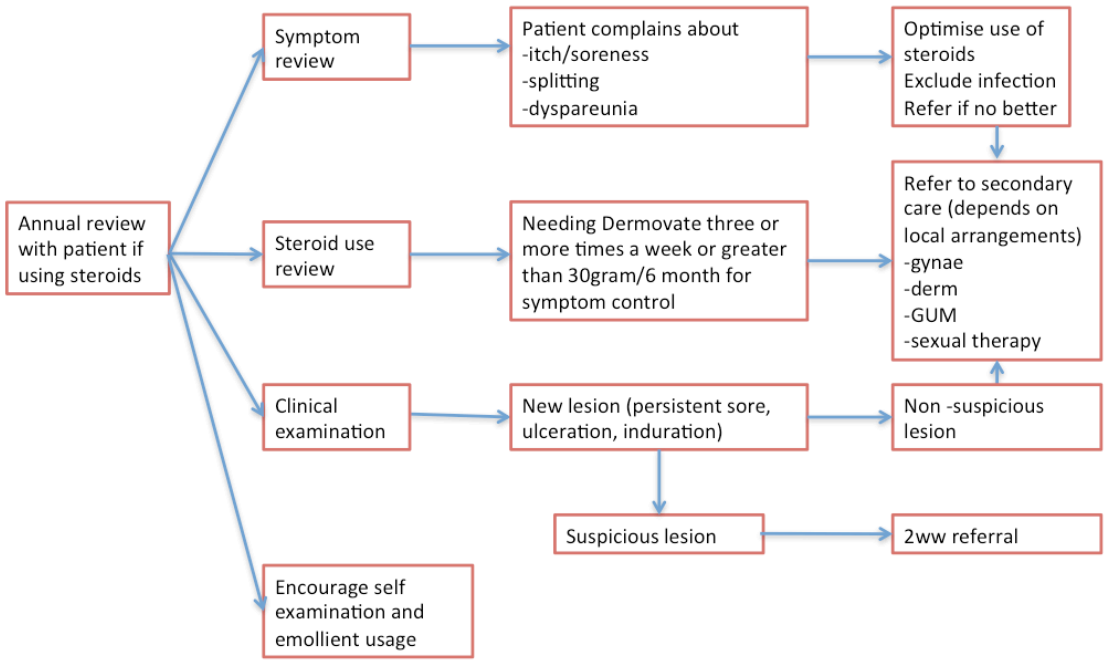
ongoing disease seem to require 30–60 g of Dermovate ointment annually or up to three applications a week.

Longterm use of clobetasol propionate in this way is safe and there has been no evidence of significant steroid damage or an increase in the incidence of SCC.

The risk of malignancy in uncomplicated genital LS that has been diagnosed and treated appropriately is very small.

There is a tendency to undertreatment with steroid ointments (Dermovate packaging warns against genital treatment) so reassure patients and check compliance.

Give patients support information
Worldwide Lichen Sclerosus
http://lichensclerosus.org/



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