



## Good Practice Statement on lichen sclerosus of the clitoris for health professionals

### What is lichen sclerosus?

Lichen sclerosus is an autoimmune, inflammatory, scarring dermatosis that has a predilection for the genital skin in both sexes, and an association with several other autoimmune diseases. In women, the condition usually affects the labia minora, labia majora, interlabial sulci, perineum and clitoral hood producing porcelain-white papules and plaques, often associated with areas of ecchymosis. Patients commonly are symptomatic from itching and experience pain from skin splitting especially at the fourchette.

### What is the clitoris?

The clitoris and clitoral complex is located at the top of the vulva, just above the urethra and the vaginal opening. The clitoris is involved in sexual function and consists of a visible glans clitoris which is covered by a clitoral hood (also called clitoral prepuce) which is a fold of skin that surrounds, protects and lubricates the glans. The picture below shows the different parts of the vulva including the clitoral complex.

### How does clitoral lichen sclerosus clinically present?

Many women are reluctant to discuss clitoral problems and discussions should be handled with some sensitivity asking the patients about symptoms, function and concerns. Not all patients will complain of clitoral problems and there may be a mismatch between the patient's and the clinician's perception of the problem.

Lichen sclerosus may just affect the clitoral hood or be involved with disease affecting the other areas of the vulva. Clinically it may present with:

- Symptoms - such as itching and splitting (as in other non-clitoral sites) due to altered sensation and a change in the texture of the skin from the disease
- Altered appearance - scarring of the clitoral hood may progress to fusion with the adjacent labia minora which means that the glans is no longer visible. **It is important to understand however that the glans clitoris and the rest of the clitoral complex are still present and is not damaged in any way.**
- Pseudocyst formation – due to collection of skin secretions under the scarred clitoral hood. This is usually asymptomatic, however, occasionally there can be discomfort from the cyst and rarely abscess formation.
- Malignancy – the background malignancy risk for women with LS is approximately 5% and the clitoris can be a site involved with vulval cancer.
- Concern about the clitoral appearance and psychosexual dysfunction.

### How can it be diagnosed?

- It can be diagnosed clinically. Signs include, 1) porcelain white papules and plaques, 2) ecchymoses (subcutaneous purpura), 3) erosions (loss of epidermis), 4) fissures. Late signs include fusion, adhesions, loss of anatomy.
- A skin biopsy may be needed if there is any diagnostic doubt about the changes on the clitoris. A skin biopsy will not damage the underlying clitoris but it may be a slightly more painful procedure because of the high number of nerves present within the glans.

## Management

- Health professionals who manage women with lichen sclerosus are advised to refer to the British Association of Dermatologists (BAD) guidance on lichen sclerosus management (see below). The treatment options for clitoral disease are similar to LS affecting the rest of the vulva. Health professionals not confident in managing lichen sclerosus should refer on to secondary care. An emollient should be used as a soap substitute and applied regularly at least twice a day. Dermovate or Nerisone Forte are the usual topical steroid treatments and these should be used as per BAD guidance.
- Treatment of clitoral hood fusion if there are ongoing symptoms/impact on function (eg urination) despite an initial 3 month course of Dermovate.
- If the skin around the hood and labia minora has started to show signs of sticking together ie 'fusion' then the patient should be advised and shown how to gently pull the skin apart twice daily to divide the adhesions. This is enabled using topical steroids applied under the clitoral hood. The exact frequency of topical treatments to **treat** clitoral hood scarring is not clear. Following the 3 month initial course, treatment twice weekly maintenance regime is recommended (this regime should be in parallel with topical steroids at other non-clitoral sites). 5% lidocaine ointment may be applied 20 minutes before trying to separate the area of fusion. Patients should be warned that this treatment does sting when initially applied.
- For selected patients, surgical division of the adhesions may be needed if self management strategies do not work. This can be under local or general anaesthetic either 1) manually separating the adhesions or 2) using a needle diathermy in order to reveal the glans again. This type of surgery can help improve sexual function but is not needed for every case of clitoral LS. The optimal method of surgical correction is not clear. Intraoperative injection of steroids (eg triamcinolone), post op use of Surgicel (oxidized regenerated cellulose gauze) and post-operative topical oestrogen have been suggested. There is little evidence to support the optimal method of surgical management and there is a risk of inducing further scarring through koebnerisation.
- Pseudocyst management should be individualized. An ultrasound or MRI can be performed to demonstrate the anatomy prior to any surgery. Patients can either be managed conservatively or have surgical drainage depending on symptoms and function.
- Concern about the clitoral appearance and psychosexual dysfunction may occur. A history should be carried out to assess psychosexual dysfunction, ideas, concerns and expectations of treatment. Referral onto sexual therapy may be necessary. Whilst there is acknowledgment about the negative impact of the disease on sexual function, little is known about the impact of clitoral lichen sclerosus on skin sensation and its response to treatment.
- Clitoral abscesses require surgical drainage for symptom relief, resolution of inflammation and exclusion of malignancy or dVIN (differentiated vulval intraepithelial neoplasia). Adequate follow-up is required following drainage.
- Patients with clitoral disease should be encouraged to carry out self-examination of the vulva including the clitoris.

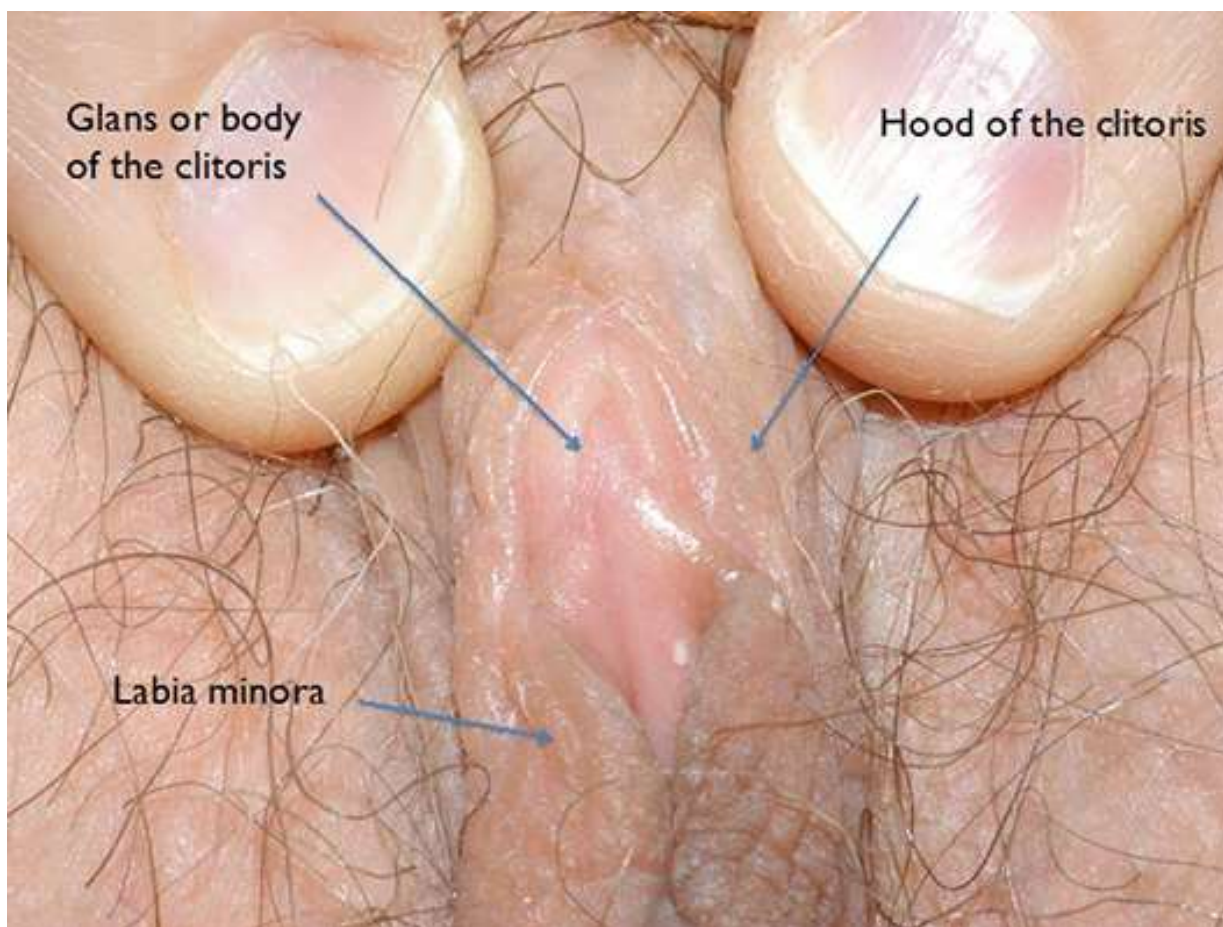
## What about vulval lichen planus?

Vulval lichen planus is a 'sister' condition lichen sclerosus and the two conditions can coexist. Lichen planus can involve the clitoris and the management will be very similar for clitoral lichen sclerosus.

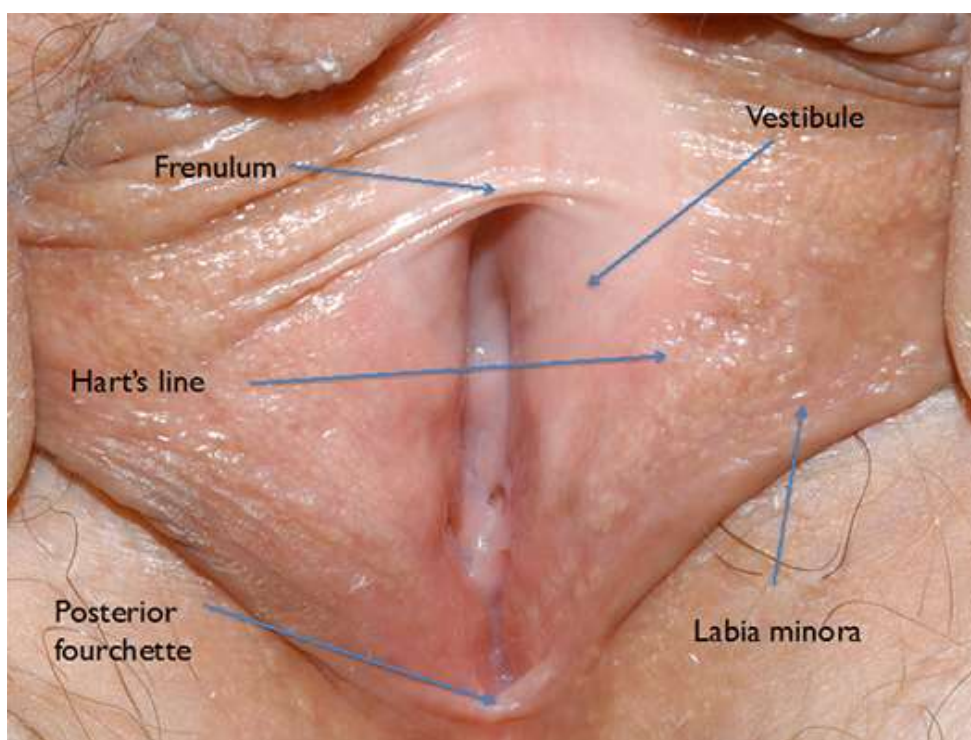
## Further references

Breech LL(1), Laufer MR. Surgicel in the management of labial and clitoral hood adhesions in adolescents with lichen sclerosus. J Pediatr Adolesc Gynecol. 2000 Feb;13(1):21-2.  
Goldstein AT(1), Burrows LJ. Surgical treatment of clitoral phimosis caused by lichen sclerosus. Am J Obstet Gynecol. 2007 Feb;196(2):126.e1-4.  
Kroft J(1), Shier M. A novel approach to the surgical management of clitoral phimosis. J Obstet Gynaecol Can. 2012 May;34(5):465-71.

Neill SM(1), Lewis FM, Tatnall FM, Cox NH; British Association of Dermatologists. British Association of Dermatologists' guidelines for the management of lichen sclerosus Br J Dermatol. 2010 Oct;163(4):672-82.



On behalf of the BSSVD released 10.5.15. Next update 10.5.15 [www.bssvd.org](http://www.bssvd.org)  
Normal clitoris and vulva



Images copyrighted - reprinted c permission from the owner