VULVAL DISEASE - FLASH CARD SET

British Society for the study of Vulval Disease www.bssvd.org

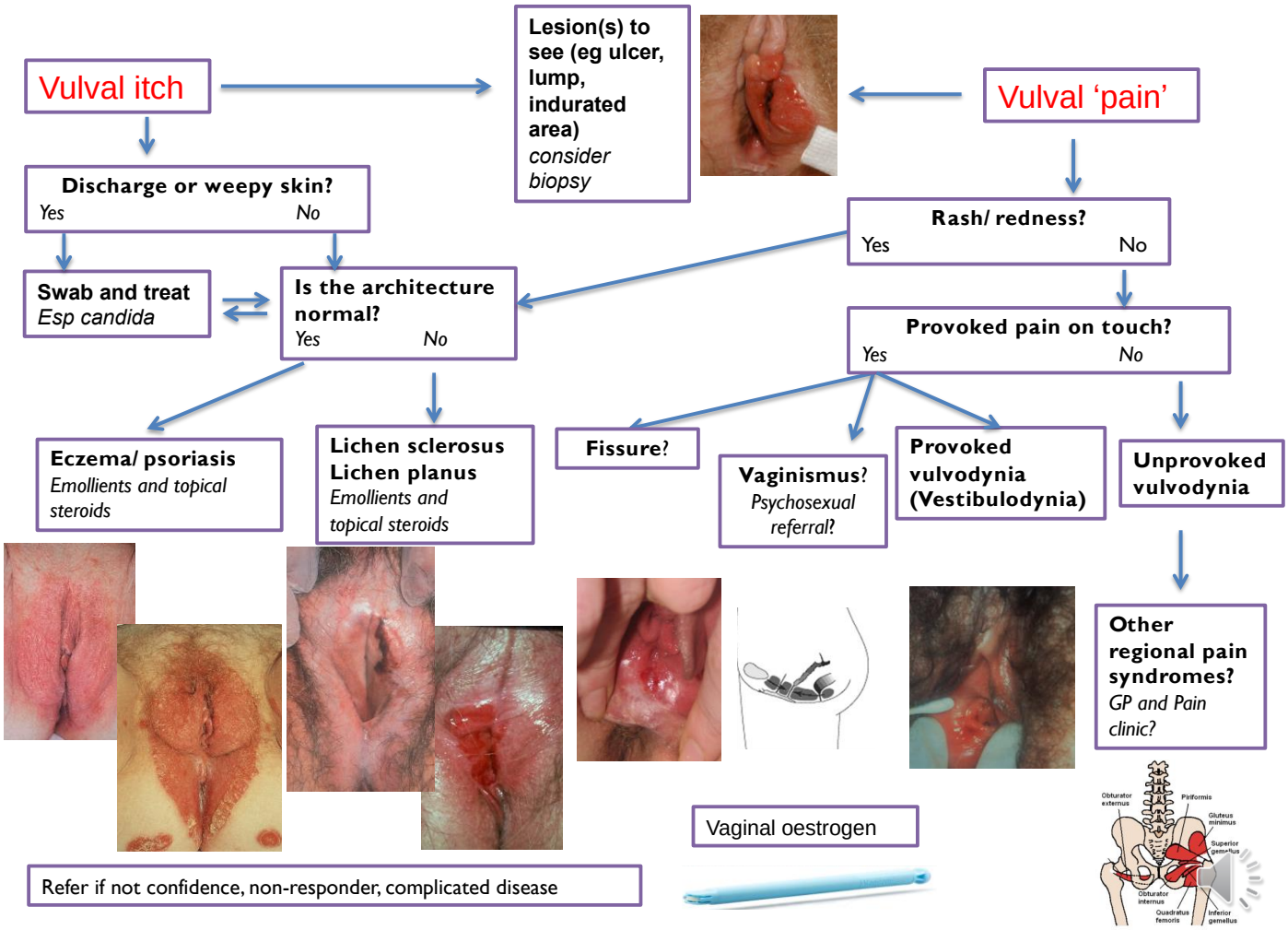
Overview

This set of flash cards was developed to help women's healthcare providers (doctors, nurses) improve their skills in the assessment and management of vulval disease. These cards can be used as a training tool to improve those skills with regards lesion description, making a diagnosis and treatment options. The cards are by no means comprehensive but are designed to stimulate discussion and increase self-knowledge.

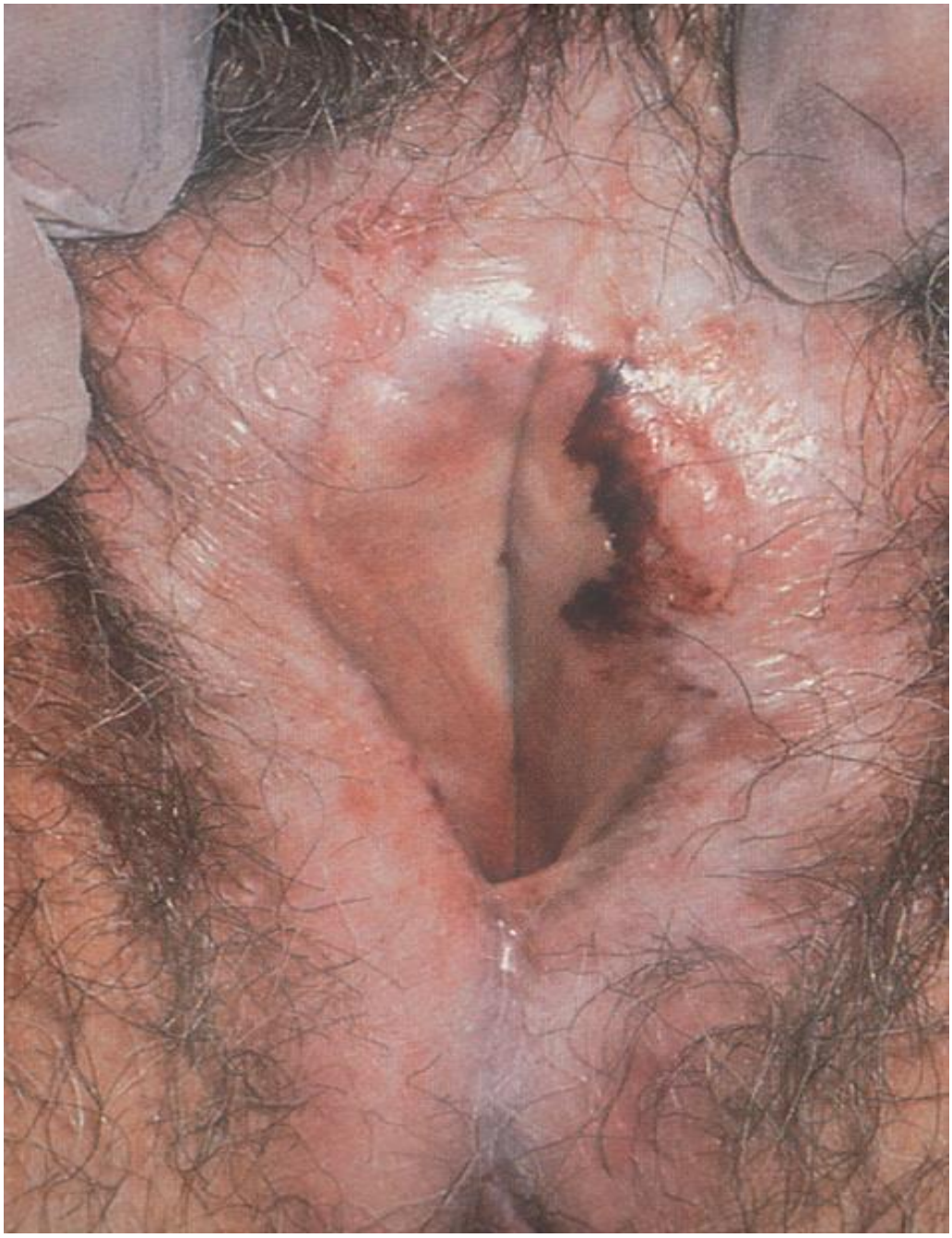
About This Card Set

This card set contains flash cards, which are numbered to allow the trainee or trainer to track which cards were viewed during an exercise. The front of each card displays a colour version of the vulval image and questions. The back of the card has the questions with short note form answers. There are also other relevant points of interest on the disease with additional information on prognosis and complications if relevant.

Algorithm for the management of vulval itch and pain



FLASH CARD No. 1



What is the likely diagnosis?

What signs in the picture suggest this diagnosis?

How is the condition diagnosed?

What is the most likely treatment?

Produced by the Education and Training Group, British Society for the Study of Vulval Disease www.bssvd.org

FLASH CARD No. 1 - ANSWERS

What is the likely diagnosis?

- Advanced vulval lichen sclerosus

What signs in the picture suggest this diagnosis?

- Whiteness
- Ecchymoses (subcutaneous purpura) seen on the left labia
- Loss of anatomy – labial resorption, fusion, adhesions
- Scarring over the clitoral hood

How is the condition diagnosed?

- Clinically if confident or with a 4mm punch biopsy
- Consider a biopsy if there are any indurated or suspicious areas

What is the most likely treatment?

- Superpotent topical steroid ointment (e.g clobetasol proprionate 0.05% Dermovate)- An initial three month course, one finger-tip-unit (from the tip of the finger to the first crease) nightly for 4 weeks, alternate night for 4 weeks and then twice a week for 4 weeks.
- There is a body of opinion that for most patients there should be ongoing maintenance with twice weekly super potent topical steroids to suppress flare-ups and avoid further anatomical change. Another option to consider is as-required treatment.
- Regular usage of emollients should be used to provide a barrier to potential irritants (e.g. urine) and keep the skin hydrated.
- Vulval self-examination if possible.

Other points

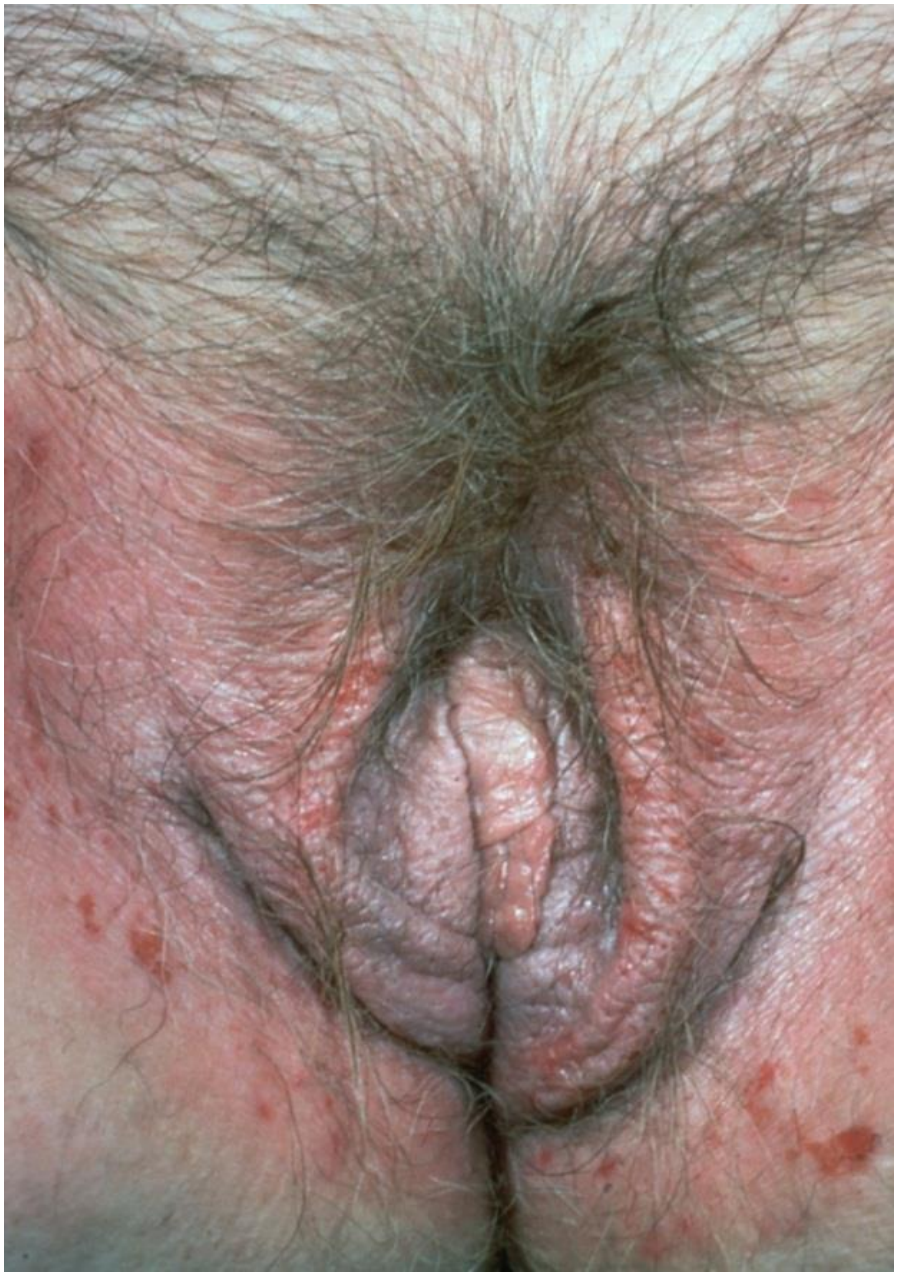
- Lichen sclerosus is a chronic, inflammatory skin condition.
- Symptoms – chronic vulval itching. Pain is a secondary complaint due to skin trauma from itching.
- Early stage disease may be subtle and masked especially if topical steroids have been used prior to referral.
- Complications – there is a small less than 5% chance of a vulval cancer developing.
- Anatomical loss may include of introital narrowing, loss of the labia and clitoral hood fusion especially if the diagnosis is delayed.
- Often associated with incontinence –ask specifically about this and treat/refer as appropriate.
- Please note caution with paraffin based skin emollients which may be a fire risk. Advise patients not to smoke, use naked flames or go near anything that may cause a fire while emollients are in contact with their medical dressing or clothing.

References

Chi CC, Kirtschig G, Baldo M, Brackenbury F, Lewis F, Wojnarowska F. Topical interventions for genital lichen sclerosus. Cochrane Database Syst Rev. 2011(12):CD008240.
Kirtschig G, Becker K, Günthert A, Jasaitiene D, Cooper S, Chi CC, Kreuter A, Rall KK, Aberer W, Riechardt S, Casabona F, Powell J, Brackenbury F, Erdmann R, Lazzeri M, Barbagli G, Wojnarowska F. Evidence-based (S3) Guideline on (anogenital) Lichen sclerosus.J Eur Acad Dermatol Venereol. 2015 Oct;29(10)
Lewis FM et al British Association of Dermatologists guidelines for the management of lichen sclerosus, 2018 Br J Dermatol. 2018 Apr;178(4):839-853

Produced by the Education and Training Group, British Society for the Study of Vulval Disease www.bssvd.org

FLASH CARD No. 2



What is the likely diagnosis?

What signs in the picture suggest this diagnosis?

How is the condition diagnosed?

What is the most likely treatment?

Produced by the Education and Training Group, British Society for the Study of Vulval Disease www.bssvd.org

FLASH CARD No. 2 - ANSWERS

What is the likely diagnosis?

- Vulval eczema

What signs in the picture suggest this diagnosis?

- Poorly defined erythema of the genitocrural skin
- Erosions due to excoriation in the inflamed skin
- White thickening (lichenification) of the labia majora due to scratching.

How is the condition diagnosed?

- Clinically if confident
- Patch testing if allergic contact dermatitis suspected (see below)
- Swabs may be needed to exclude infection

What is the most likely treatment?

- Moderate (e.g clobetasone butyrate 0.05%, Eumovate) or potent (e.g. Mometasone furoate 0.1%, Elocon) topical steroid ointment one finger-tip-unit (from the tip of the finger to the first crease) nightly for 4 weeks then review.
- Regular usage of emollients should be used to provide a barrier to potential irritants (e.g. urine) and keep the skin hydrated.
- Strict avoidance of irritants/allergens.

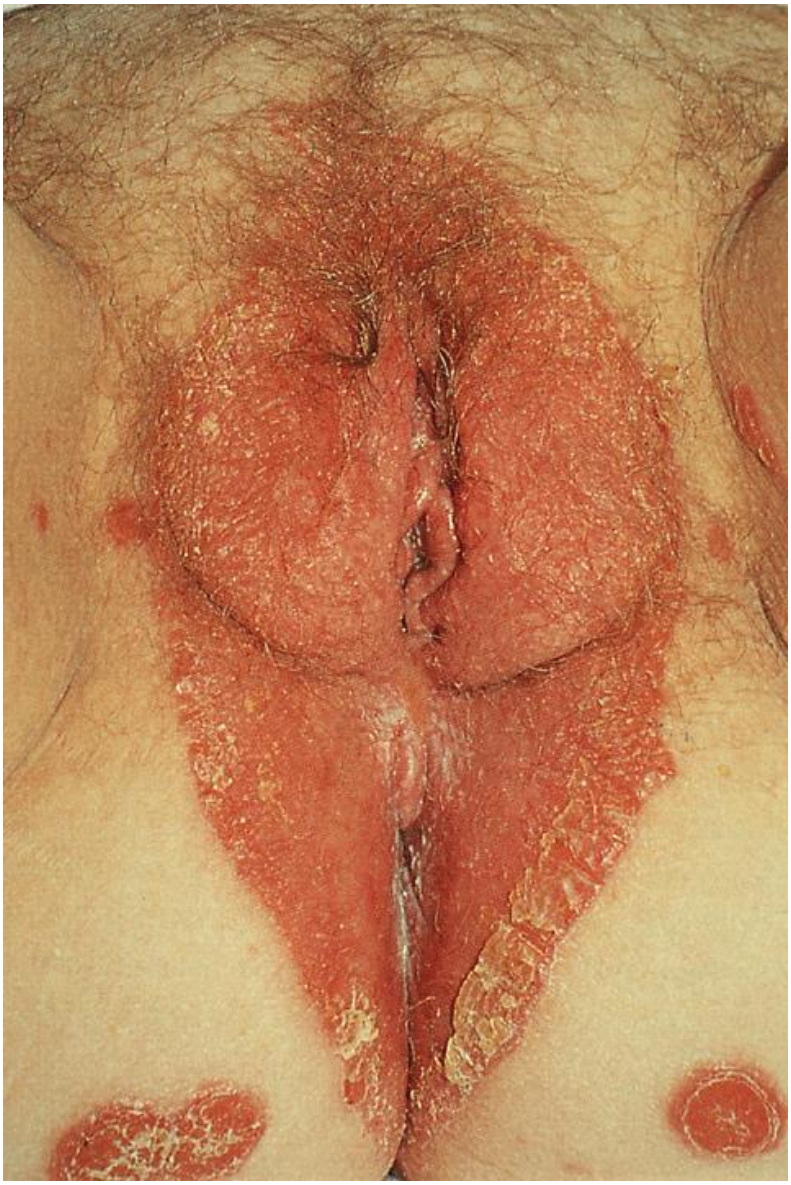
Other points

- Vulval eczema is an inflammatory skin condition. It can be due to an external trigger in which case it is called *contact dermatitis*. There are two forms of contact dermatitis*. Irritant form* - Poorly defined erythema present where an irritant has been applied. *Allergic form* – Erythema extends outside of area where allergen has been applied. The latter is an immune mediated hypersensitivity reaction and less common.
- Symptoms –vulval itching and pain. Discharge may be present if there is associated infection.
- Prognosis – Good if the cause (either irritant or allergen) is identified and avoided.
- The terms *dermatitis* and *eczema* are often used interchangeably.
- Please note caution with paraffin based skin emollients which may be a fire risk. Advise patients not to smoke, use naked flames or go near anything that may cause a fire while emollients are in contact with their medical dressing or clothing.

References
Farage MA, Miller KW, Ledger WJ. Determining the cause of vulvovaginal symptoms. Obstetrical & gynecological survey. 2008;63(7):445-64
Goldsmith PC, Rycroft RJ, White IR, Ridley CM, Neill SM, McFadden JP. Contact sensitivity in women with anogenital dermatoses. Contact Dermatitis. 1997;36(3):174-5.

Produced by the Education and Training Group, British Society for the Study of Vulval Disease www.bssvd.org

FLASH CARD No. 3



What is the likely diagnosis?

What signs in the picture suggest this diagnosis?

How is the condition diagnosed?

What is the most likely treatment?

Produced by the Education and Training Group, British Society for the Study of Vulval Disease www.bssvd.org

FLASH CARD No. 3 - ANSWERS

What is the likely diagnosis?

- Vulval psoriasis

What signs in the picture suggest this diagnosis?

- Well demarcated erythema surrounding the anogenital area with typical psoriatic plaques in surrounding skin.
- The genital plaque has typical scale in the perianal area, but lack of scale in the perineal and vulval areas.

How is the condition diagnosed?

- Clinically if confident or with a 4mm punch biopsy.
- Consider a biopsy if there are indurated or suspicious areas.
- There may be a history of psoriasis.

What is the most likely treatment?

- Moderate (e.g clobetasone butyrate 0.05%, Eumovate) or potent (e.g. Mometasone furoate 0.1%, Elocon) topical steroid ointment one finger-tip-unit (from the tip of the finger to the first crease) nightly for 4 weeks then review. There is a risk of atrophy in groins/ inguinal folds with prolonged potent topical steroid use. Tacrolimus 0.1% applied twice daily for 4 weeks is another option although it is important to warn that it may sting in the first few applications. Second line treatments such as acitretin and methotrexate are sometimes required.
- Regular usage of emollients should be used to provide a barrier to potential irritants (e.g. urine) and keep the skin hydrated.

Other points

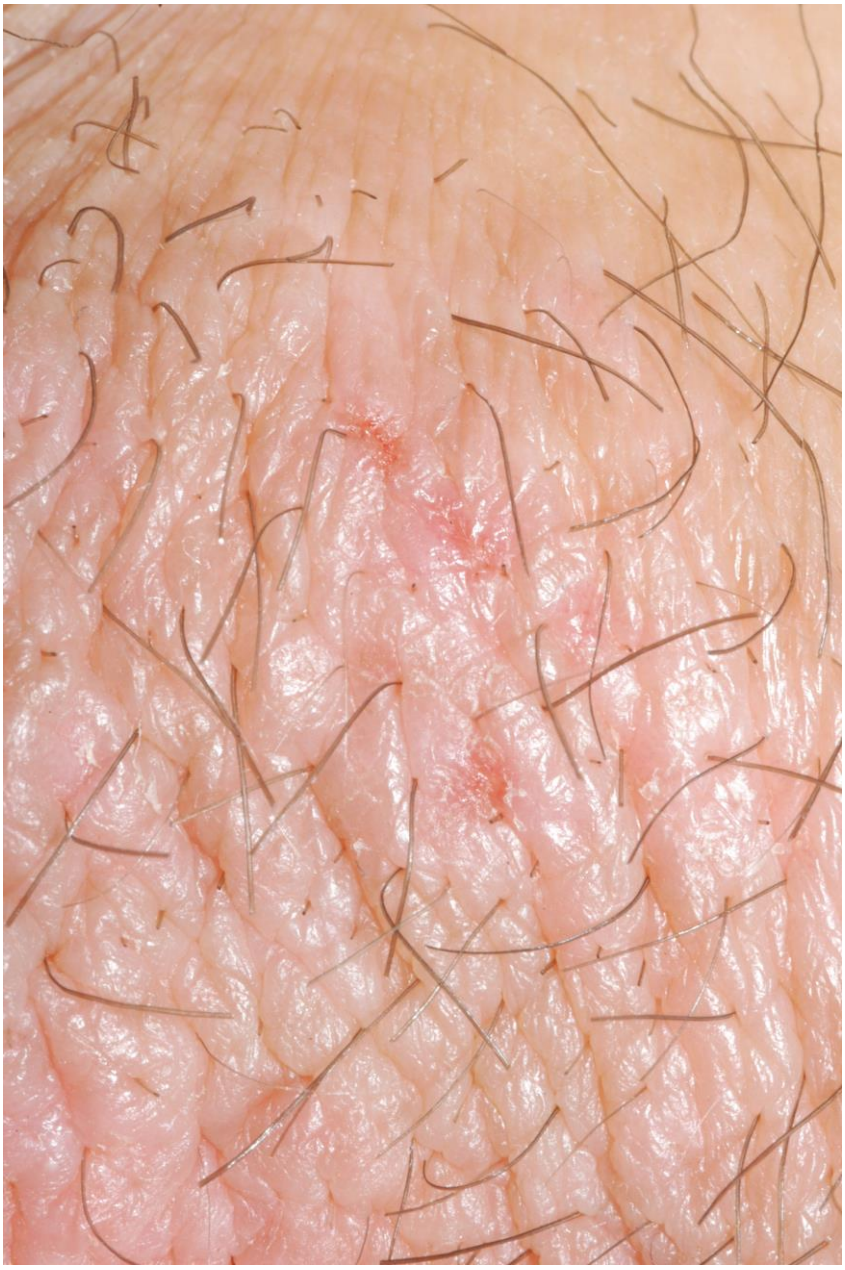
- Psoriasis is a chronic, inflammatory skin condition.
- Symptoms –vulval itching and pain. Discharge may be present if there is associated infection.
- Clinical assessment should include examination of 'hidden sites' for other signs of psoriasis eg . knees, elbows, umbilicus, scalp, ears, lower back and nails.
- As the skin folds can become particularly macerated, there is a chance of secondary bacterial or fungal infection.
- Prognosis – the disease tends to be chronic so management is symptom control and reduction in flare ups. The condition is often chronic and best managed by a dermatologist.
- Please note caution with paraffin based skin emollients which may be a fire risk. Advise patients not to smoke, use naked flames or go near anything that may cause a fire while emollients are in contact with their medical dressing or clothing.

References

NICE. The assessment and management of psoriasis. 2012. guidance.nice.org.uk/cg153.

Produced by the Education and Training Group, British Society for the Study of Vulval Disease www.bssvd.org

FLASH CARD No. 4



What is the likely diagnosis?

What signs in the picture suggest this diagnosis?

How is the condition diagnosed?

What is the most likely treatment?

Produced by the Education and Training Group, British Society for the Study of Vulval Disease www.bssvd.org

FLASH CARD No. 4 - ANSWERS

What is the likely diagnosis?

- Lichen simplex

What signs in the picture suggest this diagnosis?

- Lichenification of the skin with erosions from chronic scratching.
- Usually no loss of anatomy but can give thick 'leathery' skin.

.

How is the condition diagnosed?

- Clinically if confident or with a 4mm punch biopsy.
- Consider a biopsy if there are indurated or suspicious areas

What is the most likely treatment?

- Superpotent topical steroid ointment (e.g clobetasol proprionate 0.05%, Dermovate) or potent (eg Beclomethasone ointment 0.1%) one finger-tip-unit (from the tip of the finger to the first crease) nightly for 4 weeks, then twice a week for 4 weeks.
- Consider checking serum ferritin, thyroid function and urinalysis for glycosuria.
- Regular usage of emollients should be used to provide a barrier to potential irritants (e.g. urine) and keep the skin hydrated.
- Once control of symptoms is achieved, a moderate potency topical steroid ointment may be required intermittently.

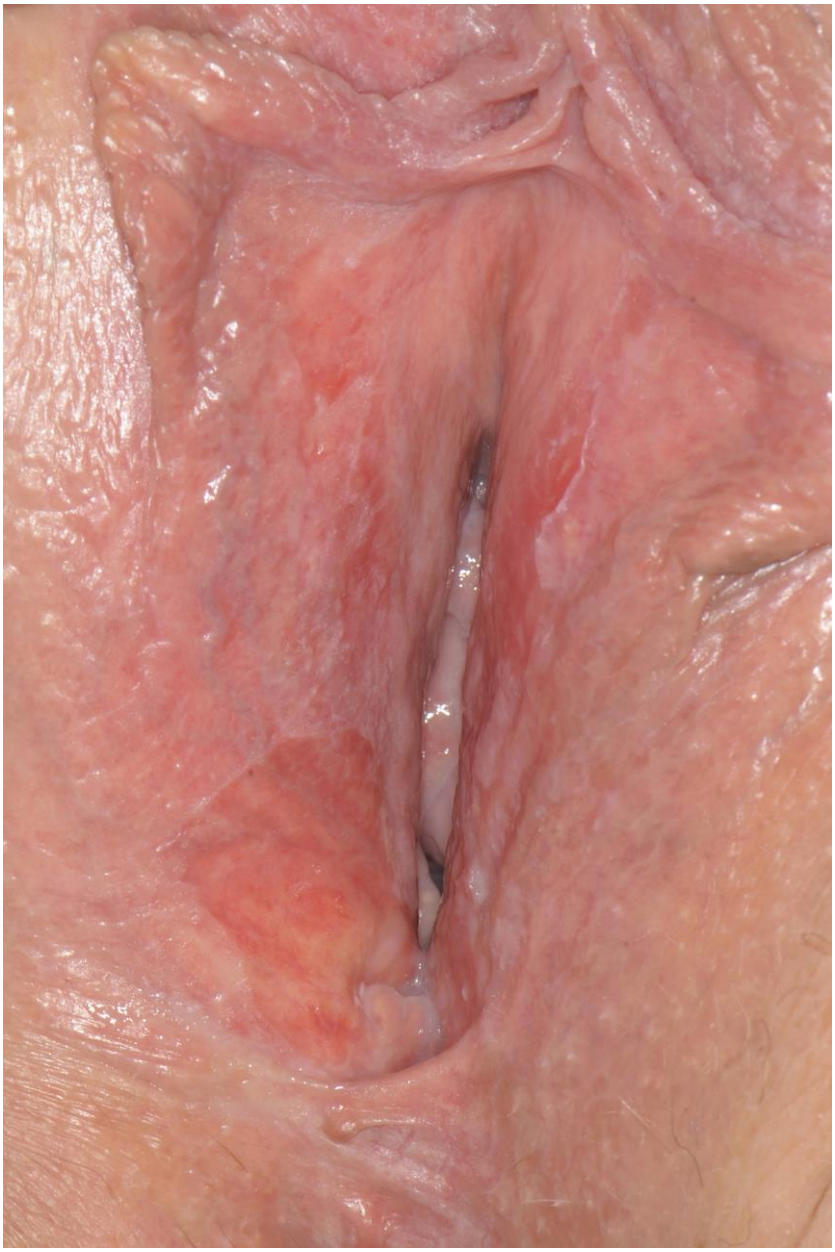
Other points

- Lichen simplex is a chronically, itchy vulva. Can be superimposed on other itchy skin disorders such as eczema and lichen sclerosus. '*Lichenification'* is the term used to describe a leathery thickening of the skin with increased skin markings which occurs in response to persistent rubbing.
- Symptoms – chronic vulval itching especially at night. Often severe. Secondary infection with candida or bacteria is common and may need treatment.
- Prognosis – good with correct treatment.
- Please note caution with paraffin based skin emollients which may be a fire risk. Advise patients not to smoke, use naked flames or go near anything that may cause a fire while emollients are in contact with their medical dressing or clothing.

References
http://www.dermnetnz.org/dermatitis/lichen-simplex.html
https://www.nlm.nih.gov/medlineplus/ency/article/000872.htm

Produced by the Education and Training Group, British Society for the Study of Vulval Disease www.bssvd.org

FLASH CARD No. 5



What is the likely diagnosis?

What signs in the picture suggest this diagnosis?

How is the condition diagnosed?

What is the most likely treatment?

Produced by the Education and Training Group, British Society for the Study of Vulval Disease www.bssvd.org

FLASH CARD No. 5 - ANSWERS

What is the likely diagnosis?

- Erosive lichen planus

What signs in the picture suggest this diagnosis?

- Eroded, glazed appearance to the vulva vestibule
- Well demarcated symmetrical erosions present at the vaginal introitus
- White edge to the area of erosion

How is the condition diagnosed?

- Diagnosed clinically supported by a punch biopsy. The punch biopsy should avoid the eroded area as secondary changes often mask diagnostic features.
- There may be a history of oral lichen planus.

What is the most likely treatment?

- Superpotent topical steroid ointment (e.g clobetasol proprionate 0.05% Dermovate) An initial three month course, one finger-tip-unit (from the tip of the finger to the first crease) nightly for 4 weeks, alternate night for 4 weeks and then twice a week for 4 weeks.
- There is a body of opinion that for most patients there should be ongoing maintenance with twice weekly super potent topical steroids. If patients are in remission then it can be reduced.
- A suggested regime is to continue with a twice a week regime to suppress flare-ups and avoid further anatomical change. Regular usage of emollients should be used to provide a barrier to potential irritants (e.g. urine) and keep the skin hydrated.

Other points

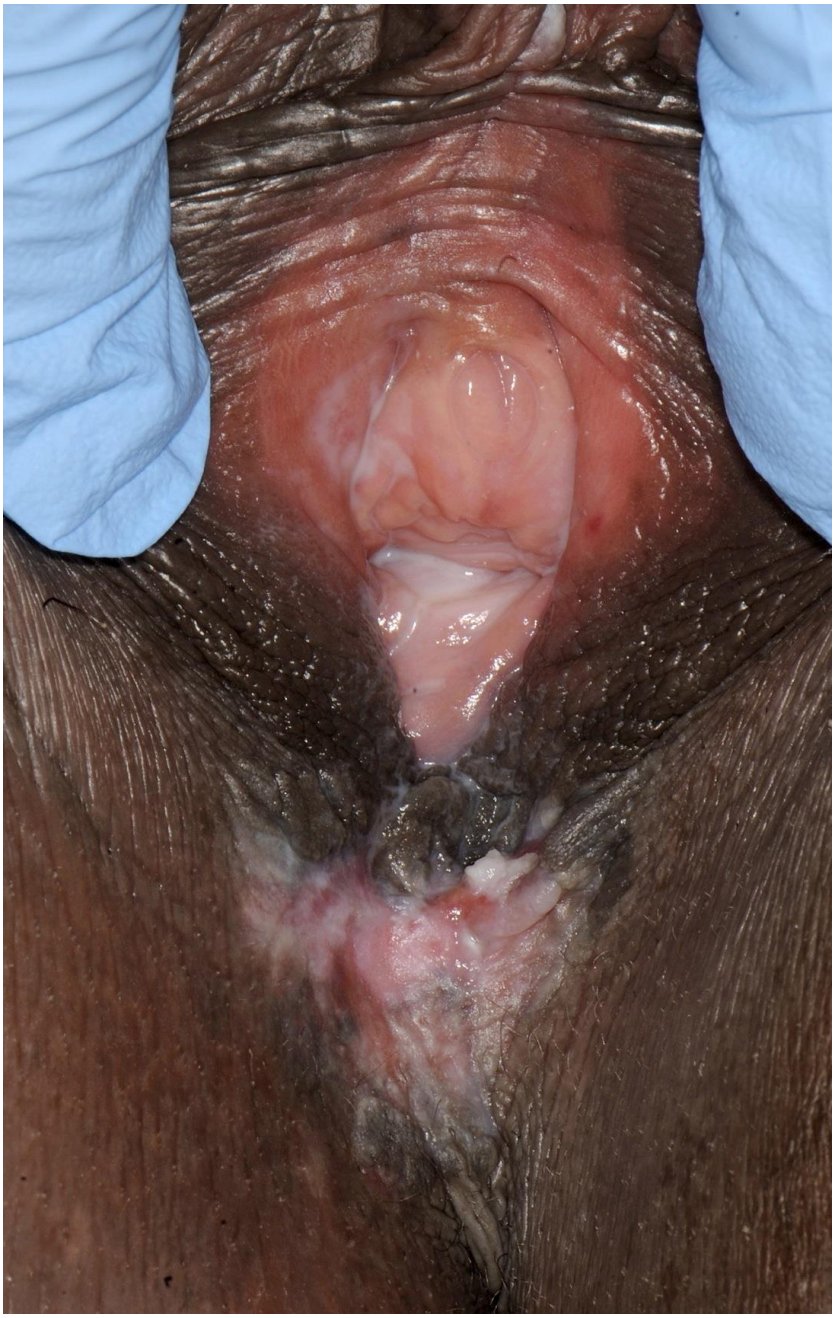
- Lichen planus is an autoimmune chronic condition. Two main forms of lichen planus may affect the vulval area. '*Classical'* lichen planus usually very successfully treated with topical steroid ointment and emollients. In contrast, patients with *erosive* lichen planus (this case) usually present with pain and burning as erosions occur at the entrance to the vagina and may affect the vaginal mucosal surface.
- Symptoms – vulval pain from the eroded areas. Dyspareunia or apareunia. Patients may have symptoms from oral disease.
- Prognosis – *Erosive* lichen planus responds less well to therapy and referral to a vulval specialist is important to optimise disease management.
- Complications – there is a small chance of vulval cancer developing. There is an overlap with lichen sclerosus. Some patients with vaginal disease develop vaginal stenosis which can be chronic.
- Please note caution with paraffin based skin emollients which may be a fire risk. Advise patients not to smoke, use naked flames or go near anything that may cause a fire while emollients are in contact with their medical dressing or clothing.

References

McPherson T, Cooper S. Vulval lichen sclerosus and lichen planus. Dermatologic Therapy. 2010;23(5):523-32
Simpson RC, Murphy R et al. Real life experience from a UK multi-centre case note audit; management of vulval erosive lichen planus. Br J Dermatol. 2012 Jul;167(1):85-91
Simpson RC, Murphy R Is vulval erosive lichen planus a premalignant condition? Arch Dermatol. 2012 Nov;148(11):1314-611.
Simpson RC, Littlewood SM, Cooper SM, Cruickshank ME, Green CM, Derrick E et al. Real-life experience of managing vulval erosive lichen planus: a case-based review and U.K. multicentre case note audit. The British journal of dermatology. 2012;167(1):85-91

Produced by the Education and Training Group, British Society for the Study of Vulval Disease www.bssvd.org

FLASH CARD No. 6 - ANSWERS



What is the likely diagnosis?

What signs in the picture suggest this diagnosis?

How is the condition diagnosed?

What is the most likely treatment?

Produced by the Education and Training Group, British Society for the Study of Vulval Disease www.bssvd.org

FLASH CARD No. 6 - ANSWERS

What is the likely diagnosis?

- High-grade squamous intraepithelial lesion (HSIL)– formerly known as vulval intraepithelial neoplasia.

What signs in the picture suggest this diagnosis?

- Raised, variably pigmented lesion
- No loss of anatomy (loss of anatomy can occur when HSIL is associated with lichen sclerosus)
- Difficult clinically to diagnose HSIL so requires a biopsy for confirmation

How is the condition diagnosed?

- By single or multiple biopsies.

What is the most likely treatment?

- Depends on degree of symptoms.
- Surgical excision with a clear surgical resection margin (5mm) was the management in this case.
- Stopping smoking.
- Exclude other areas of intraepithelial neoplasia (eg cervix – check the last smear).
- Consider HIV testing.
- Observational follow-up for selected patients. Topical 5% Imiquimod may be considered for high grade HPV associated HSIL.

Other points

- High grade squamous intraepithelial lesion (HSIL) – formerly known as vulval intraepithelial neoplasia - this premalignant vulval skin is classified into *usual type (undifferentiated)* HSIL associated with HPV infection and a *differentiated type* that arises in the setting of lichen sclerosus or lichen planus.
- Symptoms – none, itch, soreness.
- Prognosis – variable depending on type, size of lesion, risk factors.
- Complications – there is a small chance of vulval cancer developing probably less than 4% in treated women. Women with *differentiated type* are thought to have a much greater risk of developing vulval cancer. Surgical excision has a high recurrence rate and can lead to loss of function.
- Other treatment options. Observational follow-up for selected patients. Topical 5% Imiquimod may be considered for high grade HPV associated HSIL (not when associated with LS – *differentiated type*).

References
Bornstein et al. The 2015 International Society for the Study of Vulvovaginal Disease Terminology of Vulvar Squamous Intraepithelial Lesions. Journal of Lower Genital Tract Disease. 20(1) 2016 Pg 11-14

https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Gynecologic-Practice/Management-of-Vulvar-Intraepithelial-Neoplasia

Acknowledgments to the Education and Training group of the BSSVD

Produced by the Education and Training Group, British Society for the Study of Vulval Disease www.bssvd.org