Report

Re: BSSVD Visiting Fellowship award

(University of Michigan, Center for Vulvar Diseases)

Dimitrios Papoutsis, MD, MSc, PhD

Shrewsbury, 6 July 2015

Contents:

To the British Society for the Study of Vulval Disease (BSSVD)

Dear members of the Education and Training group of the BSSVD,

My name is Dimitrios Papoutsis and I am a Speciality Doctor in Obstetrics-Gynaecology working at the Royal Shrewsbury and Telford Hospital, NHS Trust (permanent post) since April 2012. I am a member of the BSSVD and also a member of the ISSVD (International Society for the Study of Vulvovaginal Disease).

I was given the opportunity to attend an internationally recognised centre of excellence in the study of vulvovaginal diseases in the United States. This was the Centre for Vulvar Diseases at the University of Michigan, Department of Obstetrics and Gynaecology, Ann Arbor, Michigan under the supervision of Professor Hope Haefner who is president of the ISSVD (International Society for the Study of Vulvovaginal Disease) and co-director at the University of Michigan.

This visit was supported by the BSSVD Visiting Fellowship award.

The time period of my attendance was Monday 16th February 2015 to Friday 15th May 2015 (three months).

During the placement I had the opportunity to attend the vulval clinics of the Centre and the operating room procedures that involved the surgical management of vulvovaginal diseases.

I was also involved in research projects, attended grand rounds and participated in other departmental activities (obstetrics, clinical simulation center etc).

The knowledge I gained has furthered my experience and training in the field of diagnosing and treating vulval diseases. This visiting fellowship to the United States was in line with the General Medical Council's (GMC) ethos of promoting women's health, promoting best practice in diseases of the lower genital tract, updating my hospital's clinical practice, and undertaking educational activities to promote high standards of care for women.

The awareness among my American colleagues that I was being supported by the British Society for the Study of Vulval Disease added honour and significant scientific merit to my effort and activities in the United States.

In this report I will provide an overview of my three-month attendance in the Vulvar Diseases Center. My objective is to highlight the differences in clinical practice I came across in the United States with the aim of providing useful input on what would be helpful to practitioners in the United Kingdom.

I would like to stress out from the very beginning however that I have not done yet the ATSM on Vulval Diseases in the UK. This is something to be done in the near future as the goal and agreement with my Head of Department is to set up a dedicated vulval clinic at Shrewsbury and Telford Hospital. My previous knowledge and experience on the diagnosis and management of vulval diseases in the UK was from the general Gynaecology clinics and Colposcopy clinics which I run in my hospital. Therefore, I am not fully aware of how a vulval clinic setting is in the UK and therefore some areas of practice that I may highlight from the US may already be in effect and existence in the specialist vulval clinics in the UK.

Please note in the Appendix the certificate of attendance and also the detailed list of activities performed and the reference letter written by my mentor Professor Hope Haefner.

In brief, over the time period of three-months I attended **31 vulval cinics (183 patients)**, and participated in **12 operating room procedures**. In terms of research, I wrote **(5) scientific papers** that have been submitted or are to be submitted to a peer-reviewed journal, of which one has already been accepted for publication **in the American Journal of Obstetrics & Gynecology.**

Yours sincerely.

Dimitrios Papoutsis, MD, MSc, PhD
Speciality Doctor in Obstetrics Gynaecology,
Shrewsbury and Telford Hospitals, NHS Trust.

Center for Vulvar Diseases:

The University of Michigan Center for Vulvar diseases in Ann Arbor is a well recognised center in the United States for the diagnosis and management of vulval diseases accepting patient referrals from all over the country. The faculty consists of four Obstetricians-Gynaecologists (ObGyn) who run three vulval clinics per week and perform operating room (OR) procedures on a weekly or fortnightly basis.

The faculty consists of:
Professor Hope Haefner, M.D., **Co-Director,** *Vulvar Diseases Gynecologic Pathology*
Professor Natalie Saunders, M.D., **Co-Director,** *Vulvar Diseases*
Dr. Ebony Parker-Featherstone, M.D., *Vulvar Diseases*
Dr. Samar Hassouneh, M.D., *Vulvar Diseases*

Additional faculty (Urogynecology Reconstructive Surgery):
John DeLancey, M.D. ,Dee Fenner, M.D., Daniel Morgan, M.D.

Additional faculty (Vulvar Malignancies):
Rebecca Liu, M.D., Carolyn Johnston, M.D., Kevin Reynolds, M.D., Karen McLean, M.D.

Registered Nurses
Sexual Health Counseling specialists

It should be noted that the faculty of the Center for Vulvar Diseases in Michigan does not include Dermatologists. The Dermatology Department is an independent Department and patients with vulval complaints are in the majority of cases seen or referred directly to ObGyn specialists in vulval diseases.

The University of Michigan health system is not a national health service and its funding is driven by the market-based insurance of each patient. This fact is important to mention from the very beginning of my report for two reasons:
1) The University of Michigan has abundant resources to offer in patient healthcare:
- there are short or no waiting lists,
- complex and expensive investigations are made immediately available (such as CT/MRI the same day),

- high-tech equipment is used (laser equipment, DaVinci Robotic surgery, state of the art operating theatres),
- there are no 10 or 20 minute slots for patients in clinics. A clinical consultation may run up to 90 minutes as this is the maximum the insurance will pay-out etc. Clinics are adequately staffed to manage these long consultations and they seldomly run late.

2) The population of patients seen in the clinic involved women of middle to higher socioeconomic status that were either Michigan residents or flew over from as far away as Florida on the East or California in the West. This created a bias as the general impression I had from the beginning, for example in Lichen Sclerosus (LS) patients. was that they were on average in a much better vulval condition then the British LS patient seen in the general gynae clinic.

Funding of the University of Michigan is also provided by Government funds and private companies and organisations. This means that many innovative devices are trialed in the context of research.

Vulval Clinics:

As a referral center for vulvovaginal diseases, there are three vulval clinics per week. In specific, there is a morning and afternoon session on Thursdays and a morning session on Fridays. The morning session starts at 07:50 am and the last patient is timetabled to be seen at 12:30. Therefore the morning clinic finishes at around 13:00-13:30. The afternoon clinic starts at 13:30 and the last patient is timetabled to be seen at 16:30. Therefore the afternoon clinic finishes at around 17:00-17:30. The Thursday morning clinic is always a double-clinic with two lists running in parallel, with two members of faculty (staff members).

There are no 10-minute slots (follow-up patients) or 20-minute slots (for new patients) like in the gynaecology outpatient clinics in the NHS. In each session there are 6-8 patients to be seen, and the consultation may last up to 90 minutes since that is the maximum the patient's insurance will pay out.

On arrival to the clinic, the patient visits the front desk where the previous medical notes are printed off the electronic database and a folder is created for that visit. The patient also fills in

a 20-page questionnaire regarding her medical history, reason for referral, vulval symptoms and ongoing medication. This questionnaire is most of the times posted or emailed to the patient prior to the visit to save time in the clinic.

In the United States there is no primary care health system with GP's. Therefore, the referrals to the Vulvar Center are made either by other specialties (ie Dermatologists), patient self-referrals with source of information the internet or family members, or primary-care practitioners (ie internists working in local health centers or registered nurses performing the annual gynaecological exam).

The patient arriving in the clinic will usually see first the medical assistant which is the equivalent of the health care assistants (HCA) in the NHS. Vital signs will be taken, the medical folder with questionnaire will be checked, and a patient education leaflet explaining the vulval symptoms and management will be given.

The patient will then be seen by the resident (trainee) who will take the medical history. Each and every patient will then be seen by one of the permanent staff members who will perform the physical examination or will supervise the resident doing it. At the end of the consultation, the patient is provided with a management plan and a letter is transcribed on the computer to be sent to the patient and her attending/referring doctor.

If necessary, the patient will see the sexual health specialists before she leaves.

The differences that I noticed in comparison to the NHS were the following:

1) There was no time rush in speeding up the consultation. The staff and patient were all relaxed even when a procedure was performed and it took more than an hour in the outpatient settings. I was told that patients prefer to wait in the waiting room than to be rushed through their consultation. This sense of being rushed and properly listened to was the main source of patient dissatisfaction. It is also interesting that I was told that you can discharge a patient from the clinic and refer her back to her doctor only if the patient is in agreement with this, otherwise you can be accused of declining the provision of medical services and be sued.

2) All test results, previous letters, medical information etc were on electronic databases. The patient had no hand-held notes or hospital notes. The papers printed for the patient's visit, were destroyed at the end of the consultation for reasons of information governance.

3) The residency (training in Obs-Gynae) in the United States is 4 years. During my three months, the residents at the vulval clinic were rotated on a monthly rota in the outpatient setting. Their level of knowledge and experience in vulval diseases was therefore variable. However, they were well supported by the expert vulval specialists and also through the following sources:

a) The University of Michigan has an electronic database for the "billing and coding" called "MiChart". In this system, all patient encounters are recorded in detail and reports are generated that are used by the insurance companies to cover the expenses and also by the medical professionals for patient management. This electronic database is linked electronically to the national formulary and therefore if a resident or specialist wishes to prescribe a medication then there is a drop-down list of drugs depending on disease/specialty etc. This part of the database is a "smart" database because it takes in consideration the patient's comorbidities and also possible interactions with drugs already taken by the patient. If there is a clash, then this is flagged up and prescription needs to be altered.

b) The University of Michigan Center for Vulvar Diseases has an online website where all protocols, medication regimens, guidelines are posted: (**http://obgyn.med.umich.edu/patient-care/womens-health-library/vulvar-diseases**). These guidelines have been carefully written over the course of many years mainly by my mentor Professor Hope Haefner, and provide guidance material for those providing care in vulvovaginal diseases.

c) There is a drawer with patient information leaflets and also doctors' information leaflets available.

d) Professor Hope Haefner has a 15-year archive of images/videos/lectures that are accessible to whoever is interested.

The vulval clinics are part of the clinics the residents go through their residency. If they have a special interest they can attend more frequently or even do an elective or fellowship at some point following their 4-year training. In hospitals with no dedicated vulval clinics, trainees may attend nearby hospitals with such clinics. This is done with other specialties as well, for example orthopaedic surgeons may train in several hospitals within the area. If vulval clinics are not at all available, then the patients are seen in the general gynae clinic.

4) Medical history and physical examination follow a very structured way and need to be consistent with the proforma on the electronic database you fill in with patient's details. Part of the examination is to take photography of the vulval lesion with the patient signing a consent proforma (image to be used for future reference, lectures and research).

5) Vulval biopsies: If a vulval biopsy is needed this is done there and then during the same consultation. The medical assistant prepares the tray with all materials necessary and the biopsy under local anesthetic is performed in the same session. In most NHS hospitals, a vulval biopsy will be performed on a separate visit in the Day Surgery Unit etc. Patients find this convenient as it saves them the additional travel and visit and are anxious to know the result as soon as possible. If a patient (or family) however needs to stay for a few days, then the University of Michigan provides accommodation within specially designated hotels in the University campus area.

6) Other diagnostic procedures in the vulval clinics: If a patient has VIN-HPV related, the vulval specialists routinely offer an anal smear and anoscopy (±anal biopsy). If the anal smear or anal biopsy comes back as high-grade then the patient is referred to the GI surgeons for further management.

Another common procedure involves taking a “wet mount” or “wet-prep” to exclude or confirm a vaginal infection. The slide is seen by the doctor under light microscopy with use of saline and KOH. No routine swabs are taken. Yeast cultures are frequently taken and sent to Microbiology to check for Candida species.

7) Other procedures in the vulval clinics: If a patient requires an IM injection of hydrocortisone for example because of severe itch-scratch cycle on the vulva, then this injection is prepared and administered by the medical assistant. They do not ask the patient's

primary care physician or doctor to do this. If an intralesional injection of steroids is needed, then this is prepared by the medical assistant and is administred by the vulval specialist.

8) Compounded medication: The vulval specialists have a wide range of medication available that they can administer. There are compounding pharmacies that can make compounded medication which are useful in cases of lichen planus (ie hyrdocortisone acetate 10% compounded in Replens like base) and vulvodynia (amitryptiline and baclofen compounded in water washable base). Before the patient leaves clinic, the doctor has already prescribed the compounded medicine and has electronically contacted the compounding pharmacy of the patient's choice via the database to start preparing it. This medication can either be picked up as the patient leaves or can even be delivered to the patient's home.

9) Use of vaginal dilators: in cases of lichen planus the patients are encouraged to use vaginal dilators as in the UK. What is different is that they are directed to find them on their own through the internet or at local sex shops. They also provide them leaflets with available internet addresses.

10) Patient support groups: National Vulvodynia Association (www.nva.org), vaginismus and dilator information (www.Vaginismus.com), ISSVD (www.issvd.com), U of M center for sexual health (http://www.uofhealth.org/medical-services/sexual-health)

11) It is my personal impression that the average lichen sclerosus patient seen in the vulval clinic at Univeristy of Michigan, has a relatively better controlled disease in the sense that the extent of distorted anatomy is less and the density and spread of white areas are less. In my NHS hospital at Shrewsbury, the LS patients seen are referred to the general gynae clinic by their GP or are followed up on an annual basis at the gynae clinic and they present a relatively greater progression of LS disease. Of course, this is only my personal opinion and subjective impression. We should also take in consideration that the patients seen in the University of Michigan are seen on a very regular basis (sometimes 6-monthly because of patient request) and they represent a different population in comparison to the UK population. The US population attending the University of Michigan is younger in age and there are health inequalities as access to the US health system requires the ability to be able to pay for the healthcare provision.

12) Immediate multidisciplinary consultation: If a patient required a Urogynaecological opinion, this was immediately available as the specialist was bleeped to attend from the respective department. The concept was to have a one-stop clinic where all investigations/tests were carried out. If a patient required a CT for whatever reason, this was done before she left the hospital the same day. One-stop clinics generated greater patient satisfaction and more income for the Department.

Operating Room (OR) procedures:

Professor Hope Haefner was the the lead in performing complex procedures such as:

- Hidradenitis suppurativa stage 3 (partial vulvectomy with skin grafting)
- VIN wide local excisions of the vulva with skin grafting or skin flaps.
- VIN laser ablation.
- Lichen planus vaginal reconstructive surgery.
- Non-healing vulvar ulcers: partial vulvectomy.

Because complex vulvovaginal surgery requires a high-level of training and expertise which is not always available in hospitals, what I would comment as different to the NHS is the wide-spread use of laser equipment in the US. You can get an initial training through a workshop and then in order to retain your license you need to perform at least 6 laser procedures per year. Laser procedures on the vulva were generally considered minor procedures and were performed under supervision by residents after their 2nd year of residency.

Research:

During my stay in Michigan I undertook an e-learning course (PEERS course) so as to be able to conduct research, have access to data and attain IRB approval for my studies.

In total, during my three-month period of attendance the following (5) papers have been accepted, submitted or are getting prepared to be submitted:

- Metastatic adenocarcinoma to the clitoris from the cervix: **already published in the American Journal of Obstetrics & Gynecology.**
- Mast cells and vulvodynia histopathologic study (to be submitted).

- Large vulvar hematoma of traumatic origin (submitted).
- Surgical excision of lymphangioma circumscriptum of the vulva (submitted).
- Large vulvar varicosities in pregnancy (submitted).

I am currently in scientific collaboration with the University of Michigan and continue with ongoing research in the field of vulvovaginal disease. My goal is to present one of my studies in vulvovaginal diseases in a future ISSVD meeting so as to gain the status of "Fellow in vulvovaginal diseases".

The interest I have developed involves investigating the possible underlying mechanism(s) that are associated with vulvodynia. My current study involves the role of mast cells in vulvodynia and a paper will shortly be submitted with me as lead author. My ongoing future study with the Department in the University of Michigan is investigating the role of nerve fiber density (nerve sprouting) in vestibular tissues in women with vulvodynia. The estimated time of completion (submission of article) is within the next 6-12 months.

What is different in the United States in comparison to the UK is:
1) Rapid IRB-Institutional Board Review approval within 2 months even for studies involving tissue handling.
2) Plentiful resources and funding.
3) There is a patent office within the University that assists you in patenting your idea.
4) Research culture within the hospital. In the US you are well-supported to promote your research ideas with abundant funding, mentoring, minimal administrative procedures, multiple team members available to assist in the research process. Despite me being there for only three months, I was fast-tracked and swiftly embedded in all these procedures once I expressed my interest for vulval diseases research.

Other:

Other activities that I participated in are the following:
- Attended Colposcopy clinics. My Phd is in cervical pathology and most of my PubMed publications are within this field. I am also a BSCCP-accredited colposcopist and I run colposcopy clinics in Shrewsbury. Therefore comparing the US practice to the UK practice

was an interesting experience with findings I have already communicated to my colposcopy team colleagues.

Also, the University of Michigan hospital is a referral center for transplantations. There is a group of patients who receive a transplantation and carry on to develop Graft-Versus-Host-Disease (GVHD) that involves vulval and vaginal lesions similar to lichen planus (stenosis, distortion of anatomy, vulval symptoms etc). This group of patients is seen in the colposcopy clinic and is managed in collaboration with the vulval experts of the Department.

- Attended the clinical simulation center (use of Lap-simulators and Davinci robotic surgery simulator-robot).
- Participated in the Department's grand-rounds.
- Observed labour ward activities. I am involved in a research project with University of Birmingham (UK) on the issue of "perineal support in 2nd stage of labour" as post-doctoral research. Comparing the US obstetric practice to the UK practice has therefore been beneficial to me.
- I also interacted with the University of Michigan medical students and Obstetric and Gynecology residents during my multiple activities in the Department and offered my UK experience on several fields.
- I have been a member of the International Society for the Study of Vulvovaginal Disease (ISSVD) since 2014. During my stay I attended meetings that focus on vulvovaginal diseases, including the ACOG (American College of Obstetricians and Gynecologists) 2015 Annual Clinical and Scientific Meeting in San Francisco, California, May 2-6, 2015.

Conclusion:

As I have commented before, my knowledge and experience in vulval diseases management in the UK was from the general gynaecology clinics at Royal Shrewsbury Hospital. I have not done yet the ATSM in vulval diseases and therefore cannot comment on how a specialist vulval clinic in a referral UK center runs and compare it directly with the US referral vulval clinics.

Nevertheless, I believe we could usefully bring several aspects of the US practice into the UK system. I believe the following could be helpful to practitioners in the UK, if they are not already in place:

1) Provsion of a detailed patient education booklet preferably before the appointment (by post or even through the GP).

2) For clinicians during the clinical session: Printed and on-line material (protocols/guidelines) during the clinical session to facilitate diagnosis and management.

3) For clinicians for later study: Archive with images, videos and lectures.

4) Use of compounded medication (this has to probably be arranged with the hospital's pharmacy, if that is possible in the UK).

5) Procedures to be done in clinic (vulval biopsies/IM injections): This saves the patient additional referrals and has been shown to increase patient satisfaction and generate more income over the same time period.

6) Multidisciplinary clinic (with the presence of sexual health counsellors): The attempt should be made to provide a one-stop clinic and not multiple referrals.

7) Research: Unfortunately the ethics approval process in the UK is long and time-consuming in comparison to the US process of IRB approval and funding. This should not discourage however studies to be performed even if they are only observational studies and not RCT trials that require only R&D approval.

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I would like to thank the members of the Education and Training group of the BSSVD, for the opportunity they gave me through the BSSVD Visiting Fellowship award in funding my attendance at the Centre for Vulvar Diseases at the University of Michigan, Department of Obstetrics and Gynaecology, Ann Arbor, Michigan.

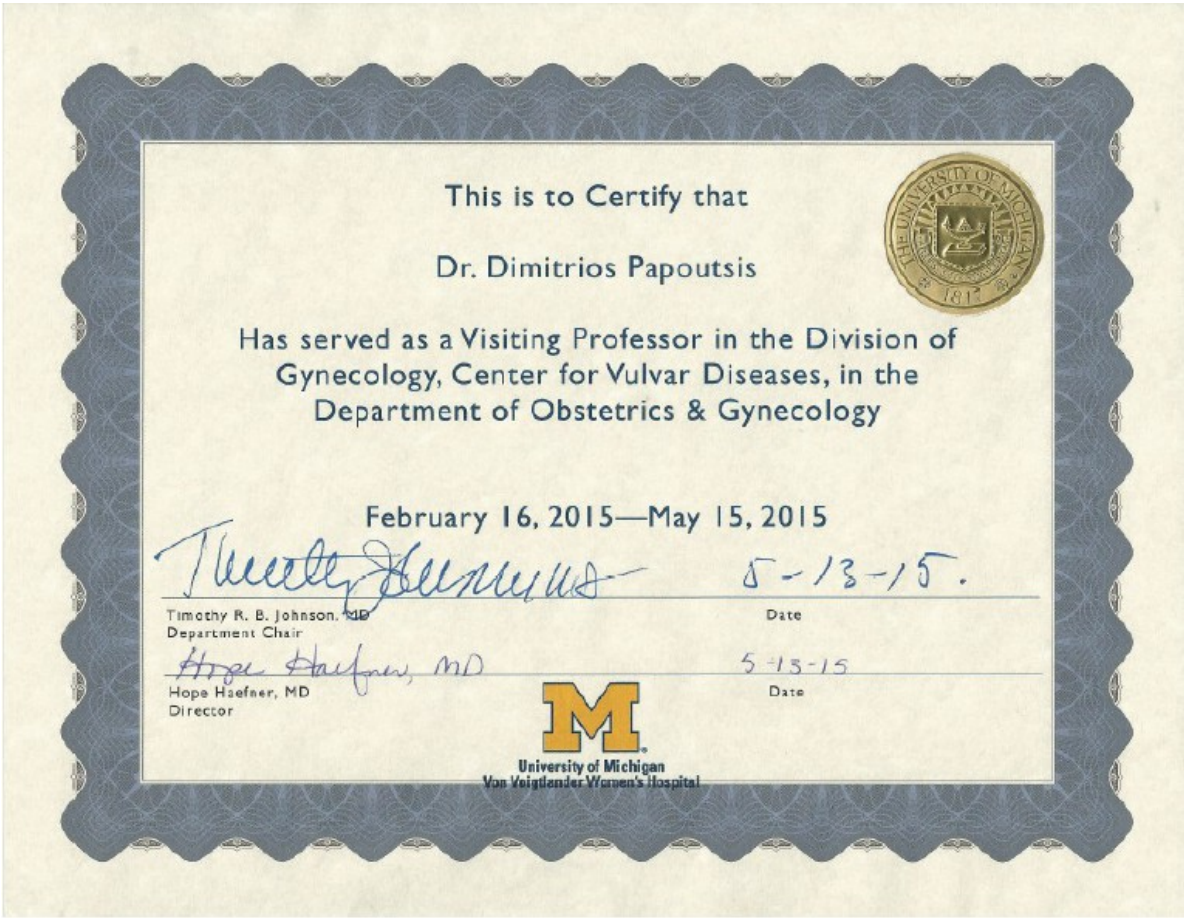
I hope that I have brought back some useful information that may assist our vulval clinical practice in the UK.

I would be more than happy to provide additional comments and information following this report if needed.

Yours sincerely,

Dimitrios Papoutsis, MD, MSc, PhD
Speciality Doctor in Obstetrics Gynaecology,
Shrewsbury and Telford Hospitals, NHS Trust.

APPENDIX:



This is to Certify that

Dr. Dimitrios Papoutsis

Has served as a Visiting Professor in the Division of Gynecology, Center for Vulvar Diseases, in the Department of Obstetrics & Gynecology

February 16, 2015—May 15, 2015

5-13-15.

Timothy R. B. Johnson, MD
Department Chair

Date

Hope Haefner, MD

5-13-15

Hope Haefner, MD
Director

Date

University of Michigan
Von Voigtlander Women's Hospital

Center for Vulvar Diseases
Department of Obstetrics and Gynecology

University of Michigan Medical Center
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Samar Hassouneh, M.D.
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Beth Hall, R.N.

Joyce Glisson, M.S.W., L.M.S.W.
Claudia Kraus Piper. M.S.W., A.C.S.W., L.M.S.W.
Casey O'Gara, B.S.N, M.S.W., L.M.S.W.
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Additional faculty who may participate in your care

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Karen McLean, M.D.
Vulvar Malignancies

Appointments:
Taubman Center
(734) 763-6295

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(734) 615-4270

5-15-15

To whom it may concern:

Dr. Dimitrios Papoutsis served a time period of three months (February 16-May 15, 2015) in the Department of Obstetrics and Gynecology at the University of Michigan Health system. This three-month visit to the University of Michigan was financially supported by a grant from the British Society for the Study of Vulval Disease (BSSVD).

Dr Papoutsis was actively involved in vulvovaginal disease patient care and research. He participated in clinics and surgeries, and also conducted research. I attach a separate detailed list of the variety of vulvovaginal diseases that he encountered in our clinic as well as procedures he attended in the operating room.

Dr Papoutsis has a particular interest in vulvovaginal diseases and has been a member of the International Society for the Study of Vulvovaginal Disease (ISSVD) since 2014. During his stay he attended meetings that focus on vulvovaginal diseases, including the ACOG (American College of Obstetricians and Gynecologists) 2015 Annual Clinical and Scientific Meeting in San Francisco, CA, May 2-6, 2015. He also had access to the Department's large collection of images and lectures over the past 15 years to expand his knowledge of vulvovaginal diseases. He also familiarized himself with the Department's clinical guidelines on the diagnosis and management of vulvovaginal disease.

I was most impressed with his interest in research. From the very beginning of his visit to Ann Arbor, he was involved in an original research project related to "mast cells and vulvodynia", and with great enthusiasm he wrote the paper to be submitted for publication. Moreover, through accessing my vulvovaginal disease interesting photo collection he identified four clinically significant cases of patients which he also prepared to be submitted for publication.

In total, during his three-month period of attendance the following papers have been submitted or are getting prepared to be submitted:
- Mast cells and vulvodynia histopathologic study.
- Metastatic adenocarcinoma to the clitoris from the cervix: accepted and in press by AJOG (American Journal of Obstetrics & Gynecology).
- Large vulvar hematoma of traumatic origin.
- Surgical excision of lymphangioma circumscriptum of the vulva.
- Large vulvar varicosities in pregnancy.

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I hope that future research opportunities will continue. There is one original research histopathologic project, in particular, that would be most interesting for Dr Papoutsis to collaborate on. This is the analysis of S-100 staining of vestibular tissues in the context of investigating the pathogenesis of vulvodynia. It is part of an ongoing research project of our Department with Professor Dr. Barbara Reed in the Department of Family Medicine University of Michigan (IRB-Institutional Review Board approved). Dr Papoutsis will continue his scientific and academic collaboration with our Department in the research field of vulvovaginal disease.

Other activities that Dr. Papoutsis participated in are the following:
- Attended Colposcopy clinics.
- Attended our clinical simulation center (use of Lap-simulators and Davinci robotic surgery simulator-robot).
- Participated in the Department's grand-rounds.
- Observed labor ward activities.

Dr Papoutsis also interacted with the University of Michigan medical students and Obstetric and Gynecology residents during his multiple activities in our Department.

It has been a pleasure working with Dr. Papoutsis for the last three months. I look forward to watching his career progress in the area of vulvovaginal diseases.

Sincerely,

Hope K. Haefner, MD

Hope K. Haefner, MD
President, International Society for the Study of Vulvovaginal Disease
Professor, Department of Obstetrics and Gynecology
University of Michigan Health System

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5-15-2015

To whom it may concern:

Included below is a table of the activities, cases, and procedures that Dr. Dimitrios Papoutsis was present for in his 3-month visit to the University of Michigan Center for Vulvar Diseases.

Time period of attendance: 3 months (Feb 16, 2015 - May 15, 2015):

Activities	Number
Vulvar clinics attended	**31**
Patients seen in vulvar clinics (new/follow-up patients)	**183** (35/148)
Operating room (OR) procedures	**12**
Cases in vulvar clinics	**Number**
Lichen Sclerosus	**90**
Lichen Planus	**19**
VIN (vulvar intraepithelial neoplasia)	**30**
Hidradenitis Suppurativa	**14**
Vulvodynia	**10**
GVHD-graft versus host disease (in colposcopy clinics)	**5**
Vulvar non-healing ulcers	**4**
Lichen simplex chronicus	**3**
Behcet's disease	**2**
Crohn's disease	**2**
Paget's disease on vulva	**3**
AIN (anal intraepithelial neoplasia)	1
Vulvar melanoma	1
Basal cell carcinoma of vulva	1
Atypical melanocytic atypia of vulva	1
Recurrent vulvovaginal Candidiasis	2
Desquamative inflammatory vaginitis (DIV)	1
Genital herpes	1
Lymphangioma Circumscriptum of vulva	1
Stevens Johnson Syndrome with vulvar involvement	1
Cicatricial pemphigoid of vulva	1
Vulvar lipodystrophy	1
Varicosities of labia minora	2
Mons pubis abscess	1

Center for Vulvar Diseases
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Joyce Glisson, M.S.W., L.M.S.W.
Claudia Kraus Piper. M.S.W., A.C.S.W., L.M.S.W.
Casey O'Gara, B.S.N, M.S.W., L.M.S.W.
Sexual Health Counseling

Additional faculty who may participate in your care

John DeLancey, M.D.
Dee Fenner, M.D.
Daniel Morgan, M.D.
Urogynecology
Reconstructive Surgery

Rebecca Liu, M.D.
Carolyn Johnston, M.D.
Kevin Reynolds, M.D.
Karen McLean, M.D.
Vulvar Malignancies

Appointments:
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Procedures in operating room	Number
VIN - vulvar excision/partial vulvectomy	1
VIN - laser ablation	1
Microinvasive carcinoma on skin graft of previous partial vulvectomy for VIN: wide local excision and skin grafting	1
Hidradenitis Suppurativa stage 3: partial vulvectomy+wound vacuum assisted closure	1
Removal of scar tissue from skin graft area from previous surgery for Hidradenitis Suppurativa stage 3	1
Non-healing ulcer (partial vulvectomy)	2
Lichen Planus surgery	1
Labial reduction	1
Excision of Skene's cyst	1
Skin grafting (full or split thickness skin graft) following wide lcal excision (for hidradenits suppurativa st. 3 or non-healing ulcers)	2

Dr Papoutsis was very busy in his time here and learned extensive knowledge that will certainly further his career in vulvovaginal diseases.

Sincerely,

Hope K. Haefner, MD

Hope K. Haefner, MD
President, International Society for the Study of Vulvovaginal Disease
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