Outline on a page for clinicians - What to do at a lichen sclerosus follow-up visit (*and why*)

(for GPs, general gynaecologists, GUM and dermatology)

Desired outcomes of treatment

- Reduction in symptoms *including prevention of flare-ups*.
- Optimise function eg sexual, urinary function.
- Promote self-management of disease to include the management of flare-ups and to report new lesions.

History points

- Enquire about symptoms:
- Number and severity of flare-ups in the last period since review? (*To assess disease control*).
- Impact on function (*urinary tract and sexual function may be affected*).
- Vaginal discharge? (*may indicate candidiasis*).
- Current topical treatments? (*Over the counter use of treatments is common*)
- How frequently and what amount of steroid is used? (*Appropriate treatment for the disease is needed. Ask the patient to show you with a sample. A 30g tube of clobetasol propionate 0.05% ointment should be sufficient for the 3 month initial treatment and 30g should be enough for 6 months' maintenance treatment. If more than 30g per quarter is required then this implies poor control and the patient should be reviewed).*
- Use of emollients? (*Provide a barrier to potential irritants (e.g. urine) and keep the skin hydrated)*
- Issues with urinary incontinence or potential irritants? (*These can compound the problem*)

Examination

- Confirm the diagnosis of LS (pallor of the skin, loss of anatomy to include labial resorption, fusion, adhesions, scarring over the clitoral hood) (*So to enable ongoing treatment*)
- Is there active disease? Fissures, erosions, ecchymoses (subcutaneous purpura), hyperkeratosis (thickening) (*These suggest under-treatment and poor control*)
- Exclusion of cancer and precancer (Are there areas requiring biopsy? Persistent areas of ulceration, lumps, concerning areas of induration?) (*Noting that cancer is not present is reassuring to the patient*)
- Look for steroid atrophy. This may happen if topical steroid is being applied to an unaffected area – look for erythema and telangiectasia, patients may feel sore *(Over treatment or treatment applied to the wrong site may be a problem*)
- Take a high vaginal swab if the patient complains of, or discharge is seen (*to exclude candidiasis*)

Treatment and discussion points

- Optimise use of topical steroids and consider twice a week maintenance (*this can prevent flare-ups and steroid atrophy is uncommon*) Use daily treatment for flare-ups until symptoms subside (the initial treatment regime below may be needed). Another option to consider is as-required treatment.
- Explore any concerns about steroid use (*aka steroid phobia which can lead to under-treatment*) and the cancer risk (*approximately 3% of women who have had lichen sclerosus over many years*).
- Consider treatment of urinary incontinence (e.g. referral).
- Give patient information sheet if necessary.
- Emphasize the value of emollients.
- Follow-up in one year.

When to refer

- Complicated disease
    - Suspicious lesions consider a 2ww (eg persistent (i.e. more than 4 weeks) sore, ulceration, induration, lumps)
    - Symptomatic scarring
    - Pseudocyst of clitoris
    - Dysaesthesia
    - Psychosexual problems (advise that lubricants can be used)
    - Symptomatic despite initial treatment
    - Poor treatment response
    - Diagnosis uncertain

Tips

- Incontinence patients often use sanitary pads. These can irritate genital skin especially scented pads. Consider scent free pads and use emollients and barrier creams.
- A lack of vaginal oestrogen may cause dryness and dyspareunia. Consider local vaginal oestrogen replacement (eg Vagifem pessaries/Ovestin cream) and lubricants for intercourse (eg Yes)
- Initial treatment - Superpotent topical steroid (e.g clobetasol proprionate ointment 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. Maintenance treatment i.e. twice/weekly is recommended for most patients. Some patient with extensive disease or hyperkeratotic disease may require more frequent treatment.

National guidance - Lewis FM et al Br J Dermatol. 2018 Apr;178(4):839-853. British Association of Dermatologists guidelines for the management of lichen sclerosus, 2018. http://www.bad.org.uk/shared/get-file.ashx?id=6039&itemtype=document