Vulval Eczema

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Eczema, or dermatitis, is an inflammatory skin condition. It can affect many parts of the body, including the vulva. The exact prevalence of vulval eczema is unknown, and likely to be underestimated. It can have a great implication on the life of women, and so understanding of the condition is key for clinicians[1].

There are a number of subtypes of eczema including: atopic, seborrheic, irritant contact, and allergic contact. Irritant contact is the most common subtype to affect the vulva, whilst atopic and seborrheic are rare; however, those with atopic eczema are prone to develop allergies[2]. Atopic is due to an endogenous defect in the barrier function of the skin; irritant due to simple exposure to exogenous agents; and allergic due to a type-IV delayed hypersensitivity reaction to other exogenous agents[2,3]. Common irritants are soaps, wipes, liners and urine; whilst common allergens are fragrances and topical treatments - including antibiotics, antifungals and anaesthetics[3]. Unfortunately, once the skin is inflamed further irritation is more likely[4]. Certain features of the vulval region favour eczema including: multiple types of epithelium, folds, humidity and friction[4].

Symptoms generally include itch, soreness and pain. Many women live for years with this, usually self-medicating with anti-thrush treatment which itself can cause irritation. Signs can range from erythema, acute erosions/oedema/discharge, to chronic lichenification; the former reflects the Greek origin of 'eczema', meaning to boil[2]. These signs are often not specific, and differentials include inflammatory lichen planus, psoriasis, pemphigus; malignant VIN; and infectious conditions. Careful personal and family history of skin conditions and irritant exposures is needed, followed by examination[3]. Dignity and consent must be maintained. Further diagnostic tests may include bloods for iron deficiency anaemia, patch testing, microbiology and rarely biopsy. This shows a spongiotic lymphohistiocytic infiltrate[2,3].

Treatment focuses on decreasing inflammation, avoiding irritants and providing symptomatic relief[2,4]. This involves pharmacological, psychological and environmental elements[4]. Pharmacological therapy to decrease inflammation includes emollients, also as soap substitutes; steroids, as ointments with fewer preservatives; and antihistamines[2]. Calcineurin inhibitors can be tried but are limited by stinging[2]. All treatments have the lowest level of evidence rating (IV)[2]. There are no currently registered EU trials of new treatments, although more general advances in therapy for eczema may apply.

Ultimately, the cornerstone of history, examination and treatment should be a recognition of the patient experience of vulval eczema. It can affect body image; relationships, with an

impact on sex; and most daily activities due to pain and restriction of clothing/toiletry choices[1]. Delay to diagnosis due to embarrassment or concern about infectious and malignant causes only increases the length of time of this impact[1]. All of this could feed into a major impact on psychological wellbeing. Despite this, a Pubmed search for 'vulval eczema quality of life' yields only one result and 'or dermatitis' only four, and there are no specific disease impact measures[1]. The astute clinician should look beyond this to the words of William Osler: '*a good physician treats the disease; the great physician treats the patient who has the disease*'[5].

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