Menopause and vulval dermatology – approaches to improve patient outcomes

Background:

Menopause is known to be a primary risk factor for several vulval dermatoses seen in both primary and secondary care. As circulating oestradiol decreases, resulting in a deficiency of oestrogen, vulvovaginal skin can atrophy, vaginal secretions may reduce, and the make-up of the microflora can change irreversibly. [1] Conditions which commonly present around the time of menopause include Lichen Sclerosus, Lichen Planus and vulval dermatitis. Pre-existing vulval dermatoses such as genital psoriasis, lichen simplex and chronic candida infections may flare or worsen secondary to the physiological skin changes occurring.

It is known that such conditions can range from being asymptomatic to significantly impacting quality of life, including sexual function. Sexual impact remains an important and often clinically neglected complication of vulval disease. [2]

It is well documented that patients may be symptomatic for a considerable time prior to seeking healthcare support, potentiating an increased disease burden.[3] Reasons for delayed presentation are varied and may include knowledge gaps, perceived stigma around vulval health and self-management behaviours. [4] In inflammatory vulval disease such as lichen sclerosus, serious risks are posed by delayed diagnosis, such as the increased risk of vulval squamous cell carcinoma.[5]

Discussion:

The approach and attitude of a clinician when supporting menopausal patients with vulvovaginal complaints may have a profound impact on the patient's experience of healthcare and likelihood to engage with healthcare professionals in future.

As per any health complaint, good history taking, and examination is key to diagnostic success. The VQLI (Vulvar Quality of Life Index) can be used alongside this as a subjective measure of symptom impact, and it can be useful to help structure a consultation once completed. The use of this score also enables clinicians to highlight and address anxieties held by a patient, fostering a sense of trust and openness in the patient-clinician relationship. Whilst history taking it is important to sensitively inquire about sexual behaviour which may worsen or be worsened by vulval symptoms. Examination should be performed in an organised manner, ensuring consent is gained throughout examination. Clinical photography is often immensely helpful when attempting to diagnose vulval complaints, especially should further referral, e.g., to dermatology, be required. It is key to explain to patients that photography is optional, but it is held privately on clinical records and will be beneficial in the diagnosis and management of their complaint.

Concerns and anxieties will vary from patient to patient and therefore it is essential to engage in open and honest discussions with patients around these.

Although many resources are free and at the disposal of clinicians, it is likely they are being underused and patients may therefore feel undereducated about their own condition. Patient information booklets, such as those provided by the BSSVD, are a good option for providing patients with information. Further education, for example on the pathophysiology of menopause, may assist patients in further understanding their vulval health and the mechanisms and importance of various treatments offered.

Education and self-care measures such as the promotion of oft neglected genital hygiene techniques make up a sizeable proportion of the management of vulval dermatoses. Other medical management may include topical, often ultrapotent, corticosteroids for inflammatory

conditions and topical and oral antifungals for fungal conditions. Additionally, in menopausal patients' oestrogen replacement either topically or systemically can positively impact vulval symptoms. Emphasis should be placed on vulval hydration through liberal emollient and barrier cream use, which also can improve symptomatology for patients.

As always it is important to bear in mind cultural sensitivities and concerns when assessing genital health. Within this it is important to appreciate and acknowledge various stigma and myth that may arise from different backgrounds and provide accurate clinical information whenever appropriate. For all patients, consent and inclusion is an essential part of consultation, particularly when focused on vulval health.

Conclusion:

Amongst the spectrum of vulval disease one common theme emerges, the struggle of patients with various and often lengthy symptoms. As clinicians it is crucial that we provide an environment that encourages open discussion around vulval health enabling patients to confidently seek help and support wherever needed. The vulval landscape is changing, knowledge and recognition of the impact and importance of vulval health is expanding. However, it remains pertinent to maintain and grow knowledge, ensuring we always provide the highest quality of care to patients.

Proactive questioning about vulval symptoms within and outside of dermatological consultations for menopausal patients is essential in empowering patients to come forward with vulval complaints. By creating a safe space for patients to come forward and disclose their anxieties we may begin to uncover the true iceberg of vulval health.

In conclusion, the path to improved vulval outcomes starts with empathy, understanding and continued education. As clinicians we carry an essential role in breaking the stigma and silence engulfing vulval health. It is key to remind ourselves that silence does not indicate the absence of struggle for our patients.

References:

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