


A Potpourri of Vulvar Issues and How to Manage Them

Amanda Selk MD, MSc, FRCSC (OBGYN)

Associate Professor, Obstetrics and Gynecology, University of Toronto
Women's College Hospital and Mount Sinai Hospital, University of
Toronto

 @DrAmandaSelk

Host of the podcast "The Vulva Diaries"

Speaker disclosure

- No disclosures
- In this talk there are therapeutic recommendations for medications that have not received regulatory approval (i.e. "off-label" use of medication) because all medications used in vulvar disease are off-label.

Objectives

- Review a basic approach to vulvar conditions
- Review general vulvar care and steroid use
- Review some basics regarding treating inflammatory conditions
- Learn an approach to diagnosing and managing vulvar pain

Basic Approach on History to Vulvar issues

- If they notice a lump/bump/lesion: How long? Growing? Pain? Bleeding? Itchy?
- Other symptoms: cuts, sore, pain, issues with sex
- Cervical dysplasia history?
- Smoking?
- Skin conditions?
- Other history (pain conditions, autoimmune conditions?)

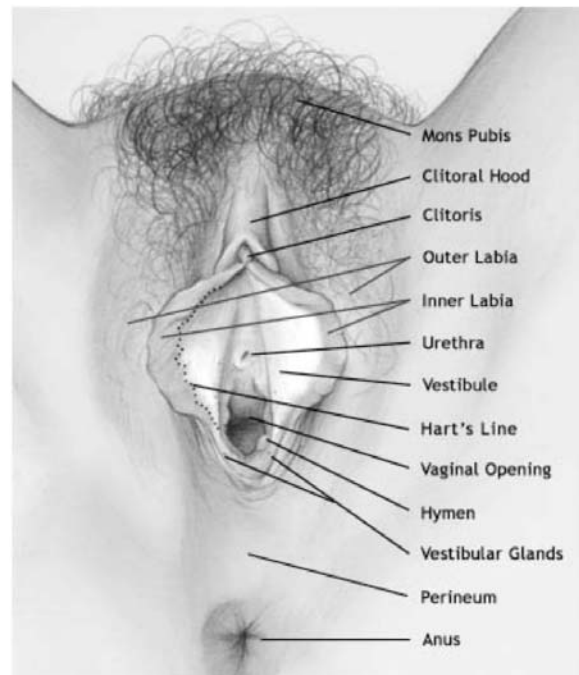
You need to look at the vulva

- NO VIRTUAL VULVA

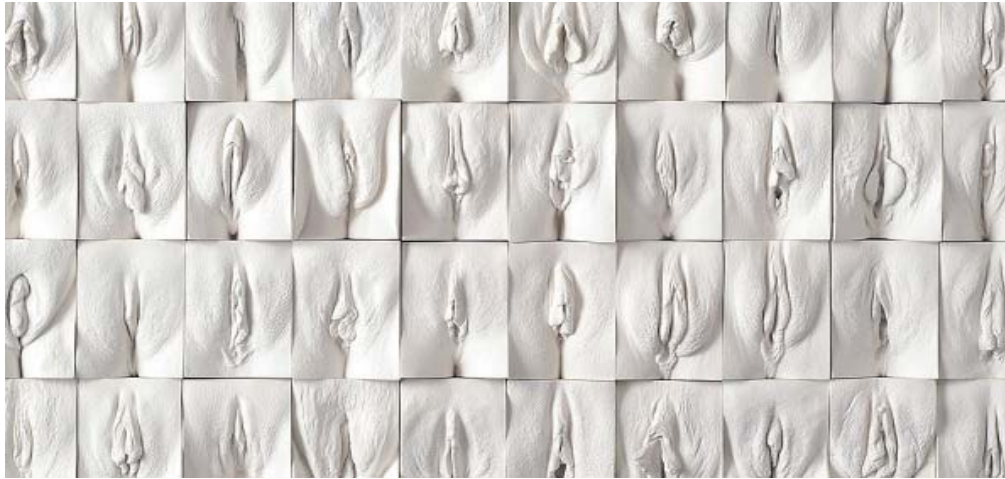


Know Normal Anatomy

- Think about the anatomy
- Scarring?
- Labia minora?
- www.labialibrary.org.au



Need to really “look”/learn what’s normal



Why do we look?

- Because many vulvar complaints are not “just a yeast infection”



If you can biopsy other parts of the body, you can biopsy the vulva

- It's the same
- You don't need a "gynecology" table
- Clitoral lesions should see a gynecologist

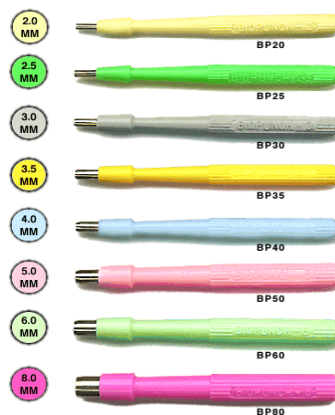
When to biopsy?

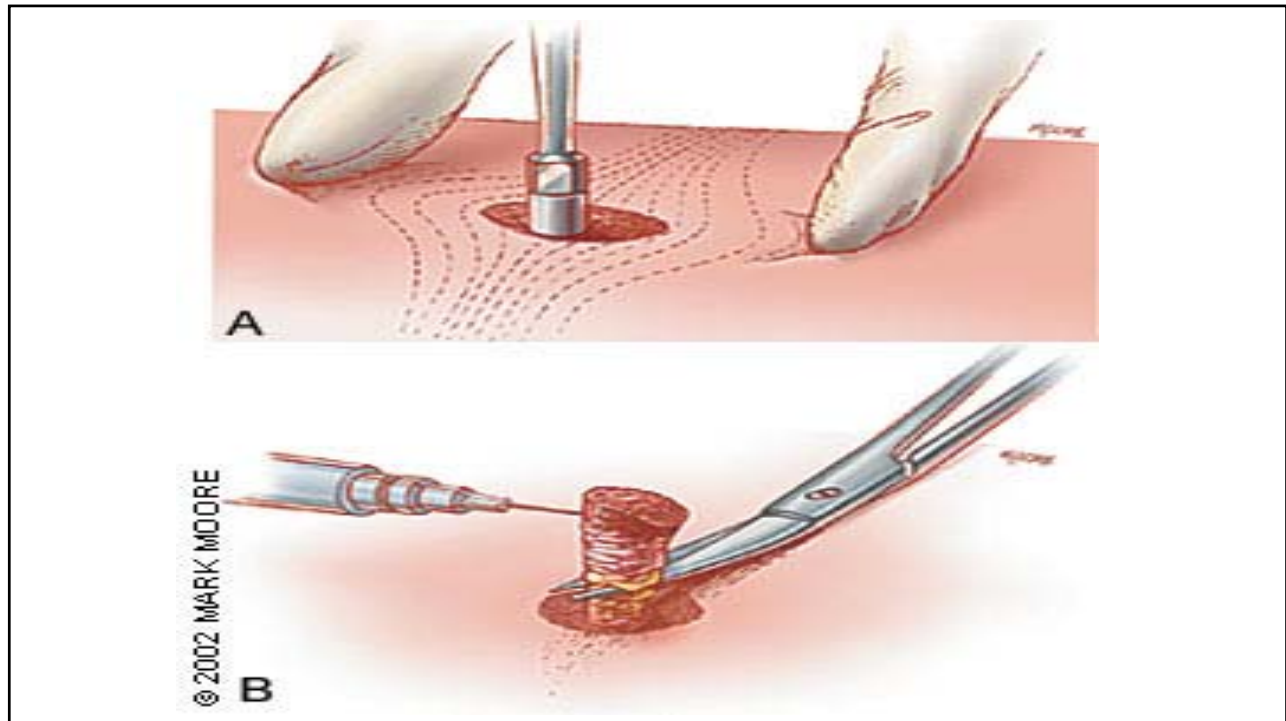
- Rapid growth
- Ulcer (take from edge include normal and abnormal area)
- Bleeding lesion
- Lesion that is painful
- Hard sore areas
- Unsure re: diagnosis
- Not responsive to treatment
- Cuts that don't heal
- Concern for dysplasia/malignancy
- Hyperkeratosis (thick white raised)
- Pigmented (melanoma rules ABCD)
- Atypical appearance

If in doubt...cut it out

- Biopsy *specific* lesions
- Biopsy of a non-specific area often leads to non-specific pathology report
- Sometimes you need more than one biopsy
- Use EMLA if you have time or 5% xylocaine ointment, or inject local (1% lidocaine)
- 3-4 mm often ok but depends on the lesion (try to avoid using forceps)
- Punch, shave, scissors
- Hemostasis: Monsel's (ferric sulphate), silver nitrate, aluminum chloride, pressure for bleeding. Rarely – a suture

Disposable Punches





A common case...

- The patient is itchy “down there” x days, weeks, months, years...
- She’s tried an OTC yeast infection treatment and it didn’t work and she tried it again
- She’s tried probiotics, vagisil, tea tree oil, coconut oil etc. with no relief
- The dairy free, gluten free, sugar free, alcohol free diet might have helped for a while but it’s not anymore

Exam



Other points you might find on history

- History of sensitive skin
- History of eczema, atopy, asthma
- Itch worse at night
- Itch worse with heat
- Scratching feels good but then hurts
- Some patients deny scratching (remember that rubbing counts)
- Ask about vulvar care/products

Exam Findings



- May be one sided
- No major anatomical changes
- Changes from rubbing might be subtle enough you don't notice



Itch-Scratch



Chronic Excoriation



© Copyright 2008 Elsevier Ltd. Black, et al. *Gynecologic and Obstetric Dermatology*, 26.

Principles of Vulvar Care

- Stop all irritants
- The skin is fragile, don't scrub (no washcloths)
- Doesn't need special cleanser (no wipes!!)
- Ideally no soap (non-soap cleansers if they want something)
- Luke-warm water (heat is bad for itch)
- Avoid products (as many cause contact dermatitis e.g. Vagisil contains benzocaine)
- If you don't ask what they are putting on you'll find information isn't often volunteered

Vulvar irritants

- Basically anything
- Includes urine/feces/sweat
- Any topical product
- Soap/body washes/partner products
- Contact from hands

Contact dermatitis → lichen simplex chronicus

- Remove irritants/vulvar care
- Cold compresses (heat bad for itch, cold is good—gel packs, cold wet washcloths)
- Topical steroid taper over 4-6 weeks (strength depends on skin changes/symptoms)
- **Stop itch/scratch cycle (no rubbing, no cheating)**
- Sedating antihistamines 2 hours before bed (hydroxyzine, doxepin)

How much steroid?

- $\frac{1}{2}$ -1 finger tip (green pea, etc)



Inflammatory conditions need steroids

- Steroid fear
- The pharmacist
- Under users vs over users
- Counsel counsel counsel!

Tips with topical therapy

- Creams will burn irritated, inflamed and atrophic skin (because there is alcohol in a cream base)
- Use ointments on the vulva if you are using topical therapy
- Perianal area – use weaker steroids

Topical steroids

- Use the right amount
- Show the patient how much to use and where to put it (MANY PATIENTS WON'T LOOK)
- Some practitioners use a mirror, others use photos/diagrams
- Prescribe only a small amount (30g), reassess in 2-3 months
- No telephone refills (especially at the beginning)
- Watch for yeast, herpes and contact dermatitis

Topical corticosteroids

- There are lots and you don't need to know them all but...
- Clobetasol is an ultra-potent (strongest). Don't give a patient more than 30g. Use of 60g/2 weeks can cause adrenal suppression
- Hydrocortisone is the mildest
- Try to learn a few including a mid-potency one. (ex. Mometasone furoate 0.1% (Elocom))

Topical estrogen

- No studies in the vulva (all topical estrogens (cream, pill, ring) developed for the vagina)
- There are estrogen receptors present on the vulva
- Personal observation: I don't see any effect from vaginal treatment on vulva
- Off-label use topical estrogen creams on vulva but no studies

What about the patient who isn't improving?

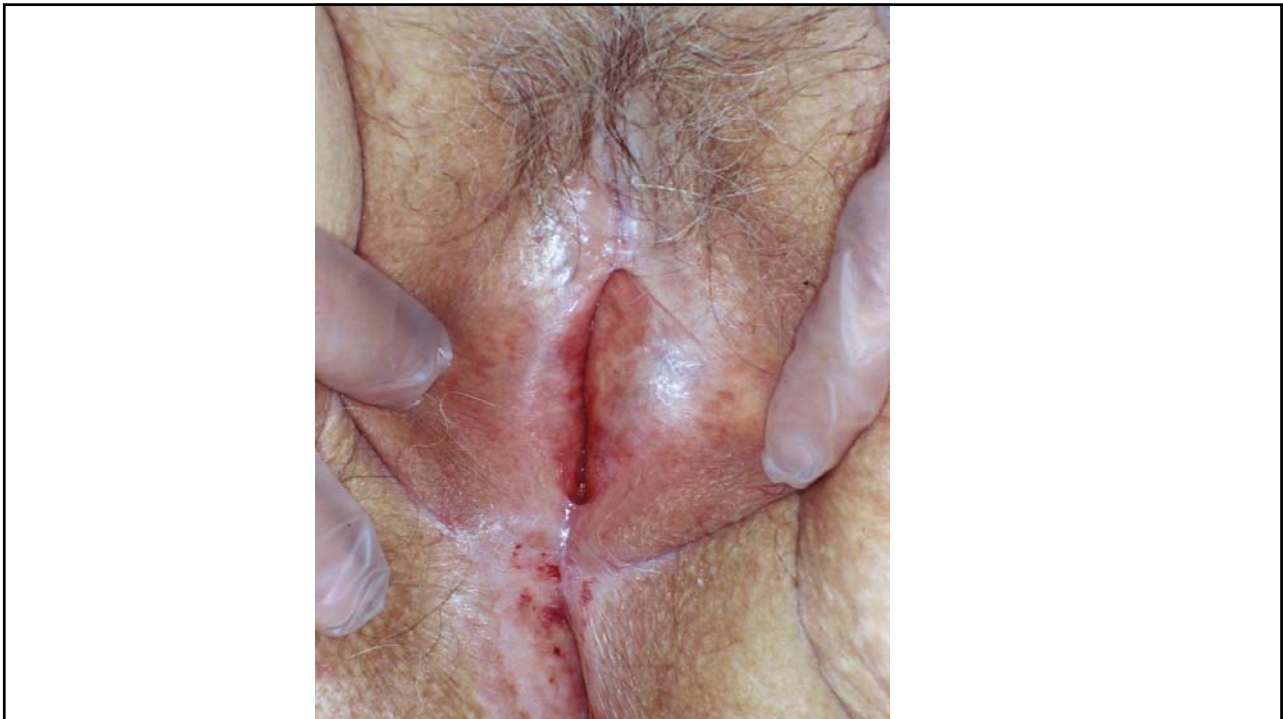
- Compliance (not enough vs too much) (look at the tube/jar, any refills)
- Wrong place
- Irritants
- Infection
- Rethink your diagnosis
- Make sure you aren't missing a cancer

Anatomical changes suggests scarring inflammatory disease (Lichen sclerosus/Lichen Planus)



Lichen Sclerosus

- Any age (pre-pubertal and post menopausal peaks)
- Genital mostly, but extra-genital in 15-20%
- Women > men
- Etiology: autoimmune with genetic component
- 15% have a family member with LS
- Pain/itch/anatomy changes/asymptomatic
- Prevalence 1-3%
- Squamous cell cancer develops in ~5%



Which of these show lichen sclerosus?



Lichen Sclerosus: Advanced Disease

Loss of normal architecture:

- Labial agglutination or flattening: ie absence of labia minora
- Clitoral scarring and agglutination with an inability to retract clitoral hood, or visualize the clitoris
- introital stenosis

Diagnosis

- Symptoms
 - **Itching**, irritation
 - Soreness, dysuria
 - Superficial dyspareunia
 - Fourchette tears, perianal skin cracking with bowel movements
- Signs
 - White plaques
 - Ecchymosis
 - Fissuring
 - Architectural changes

Treatment of Lichen Sclerosus

- Taper a high potency steroid (usually clobetasol 0.05% ointment) ex daily x 1 month, q other day x 1 month then 2x/week
- Watch them long term (5% risk of SCC)
- Other options: mometasone, tacrolimus (RCT evidence for mometasone, tacrolimus **inferior** to clobetasol)
- Taper over 2-3 months
- Then maintenance 1-2x/week steroid, sometimes can drop potency.
- Maintenance aim is to prevent flares, prevent anatomic changes, prevent cancer

Steroid concerns from patients

- Cancer causing --they may prevent cancer by stopping chronic inflammation
- Atrophy –Lee, Bradford, Fischer 2015 study of >500 women with LS on long-term clobetasol had only 7 patient with reversible cutaneous atrophy (4 in one group and 3 in the other). **Long-term steroids are well tolerated.**

When to follow patients with lichen sclerosis?

- British Dermatology Guidelines 2018
- Initially at 3 months
- If better, then see them at 6 months
- If not better then see every 3-6 months and keep following every 6 months until better
- Once better, discharge to GP
- ***50% of patients discharged to GP from vulva clinic in the UK not followed (Balasubramaniam et al, J Obstet Gynaecol 2007))
- Gynecology/Dermatology if : troublesome symptoms, atypical disease, previous cancer, HSIL/dVIN

Bottom line for Lichen Sclerosus

- Standard of care is high potency topical steroids likely forever and everything else should be used in study format only
- Patients need a vulvar exam ~1x/year and this is fine for a family dr/NP to do
- Worry/biopsy if cut won't heal, sore/hard area, hyperkeratosis (thick, raised white skin)

Vulvodynia: A crash course

2015 Consensus Terminology and Classification of Persistent Vulvar Pain (Bornstein, et al)

- A. Vulvar Pain caused by a specific disorder

- B. Vulvodynia



Vulvodynia

- Vulvar pain of at least 3 months duration without a clear identifiable cause, which may have potential associated factors

Epidemiology of Vulvodynia

- Common
- Lifetime prevalence between 8-15% depending on the study
- Affects all ages and ethnic groups
- Causes significant physical, psychological and sexual distress
- Diagnosis of exclusion (Pukall, Goldstein et al J Sex Med. 2016)

Etiology of Vulvodynia

- Exact etiology is unknown
- Likely not one single etiology
- Abnormalities in embryologic development, infection, inflammation, genetic/immune factors, neurologic mechanisms

How do people with vulvodynia present?

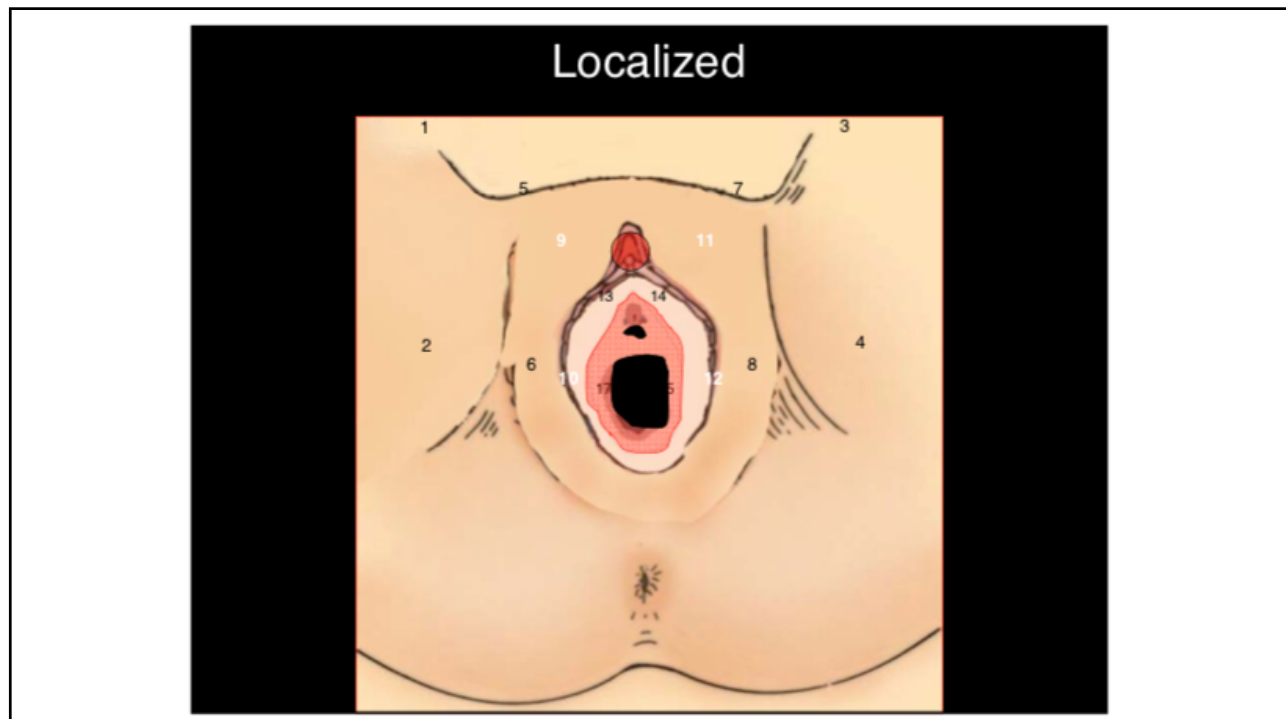
- Pain with sex
- Pain with tampons
- Tears with sex
- Chronic discomfort (Burning, Stinging, Irritation, Rawness)
- Can't wear tight pants, can't wear pants
- Can't bike
- Can't sit

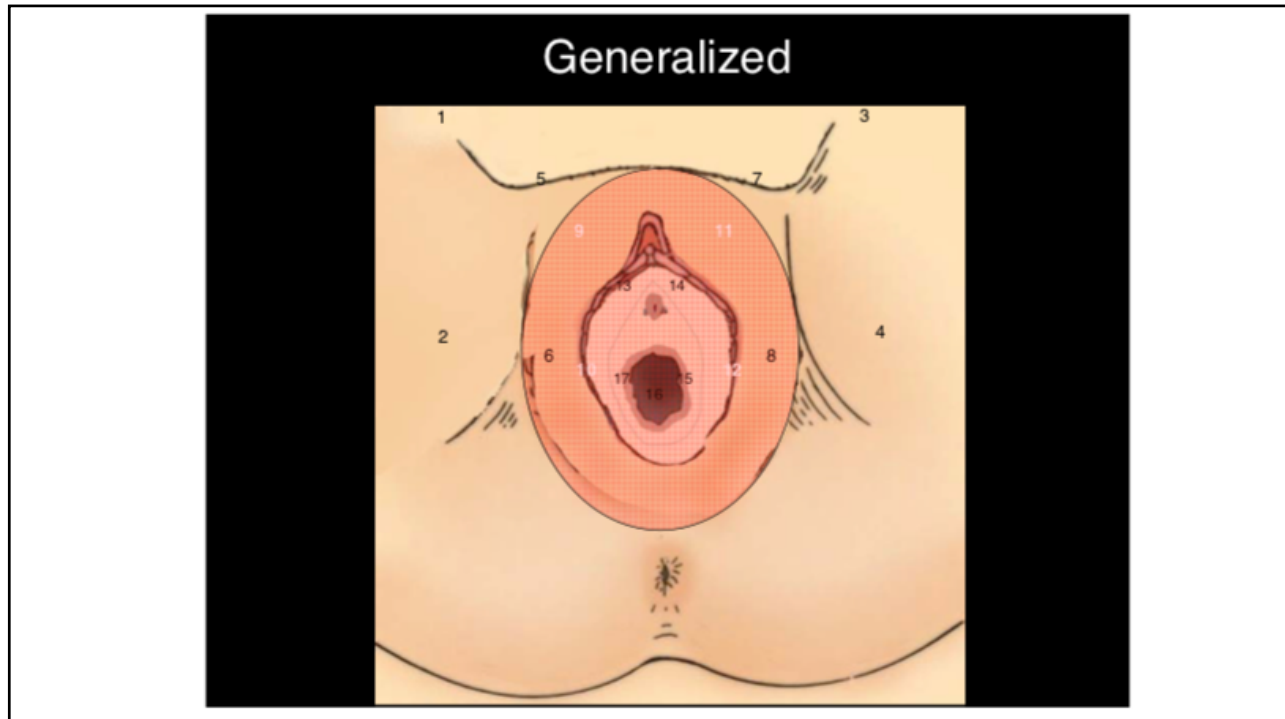
Vaginismus/Pelvic floor dysfunction

- Many women with vulvodynia develop vaginismus
- Involuntary spasms of the pelvic floor muscles
- Vicious circle

Examination

- Any skin conditions present ?
- Cotton swab test
- Yeast culture





General measures

- Patient education (naming the disease, directing to resources, ISSVD handouts, national vulvodynia association nva.org)
- **Validating** the patient
- Emphasizing it's common, that there are treatments
- Multidisciplinary, multimodal approach

Basic principles

- Naming the disease and validating patients can go a long way
- Treatment is a “trial and error” approach
- It can take time to improve
- Goals (improvement in QOL, not necessarily cure)

General principles – Vulvar Care

- No soap (water or non-soap cleansers)
- No feminine hygiene products
- Moisturize (vegetable shortening/petroleum jelly/coconut oil)
- No pads/liners
- Treat coexisting conditions (dermatoses, infections, atrophy)

Medical treatments

- Topicals (lidocaine, gabapentin, CBD, amitriptyline) → weak, small case series/retrospective uncontrolled studies
- Oral agents: RCTs of gabapentin and nortriptyline not effective in vulvodynia
- Many drugs used in vulvodynia seem to work the same as placebo
- Placebo effects can be powerful ~40% get better/see improvement
- Chronic pain data over time brain changes and need central agent. Drugs you can try (Amitriptyline start at 10mg → max 100mg/day, Gabapentin start 300 mg tid up to 3600 mg total/day (min 1200mg/d for effect), venlafaxine, duloxetine)

Pelvic physiotherapy

- Treats secondary vaginismus
- Pelvic floor dysfunction
- “personal trainer” for your vagina
- www.pelvichealthsolutions.ca

Cognitive Behavioural Therapy

- Pain often needs multimodal approach
- RCT data supporting a decrease in pain with cognitive behavior therapy over supportive psychotherapy (Masheb wt al, 2009, Pain)
- Keltys's Key Online CBT/pain support –free from British Columbia
<https://www.keltyskey.com/self-help/>

Other supports

- Sex therapists
- Mindfulness
- Stress relief

Resources

- The vulvodynia guideline (Haefner et al 2005, JLGTD)
- 2013 vulvodynia guideline update (Stockdale and Lewson 2014, JLGTD)
- ACOG Committee opinion “Persistent vulvar pain” 2016

Final thoughts

- Vulvodynia therapy needs to be multimodal
- Studies usually group different vulvodynia types (dilutes possible effects)
- If we can separate out causes of vulvodynia, might be able to better tailor approaches

What do I do for my patients?

- You are a cheerleader for your patients
- Offer support, offer hope: “many people improve”
- Trial and error: “there is no treatment that works for everyone. We can try ____ or ____ first and see how it goes. If it works, great. If not, we can try something else.”
- Handouts: issvd.org
- Support groups: national vulvodynia association nva.org

Final take home points

- Look at the vulva!
- Vulvar care is important – for all symptoms
- You can learn to biopsy the vulva
- Steroids: show people how much and where to put it
- Irritant dermatitis--->lichen simplex chronicus
 - stop the scratching or they never get better
- Sensitive skin is never truly cured so you may need steroids on and off
- Lichen sclerosus is a **CHRONIC condition that needs life-long** therapy and exams for dysplasia/cancer
- Vulvar pain is common and best data is multimodal: i.e. support, vulvar care, pelvic physio, CBT and trial and error of oral pain agents

The Vulva Diaries

- 39 episodes
- 50146 listens, from 109 Countries, 5 star rating on Apple Podcasts
- Short 15 min interviews with world experts on various topics
- Free, unsponsored, no ads
- Any podcast app

