The diagnosis and treatment of lichen sclerosus in women.

**CASE STUDY**

MARY tried to hold back the tears. Over the last three and a half years she had seen three general practitioners and one gynaecologist before being given her correct diagnosis of lichen sclerosus (LS).

She had been told many times that she had ‘thrush’ and had been advised to use hydrocortisone cream applications when she was itchy. Despite doing this, Mary was always itchy and she could see on examining herself that things were changing.

Physical examination confirmed that her labia minora had ‘disappeared’ as had her clitoris before being given her correct diagnosis of lichen sclerosis (LS).

Over the last three and a half years Mary tried to hold back the tears."

**DISCUSSION**

Potent topical corticosteroid applications have been recognised globally as the most effective treatment to control the symptoms and progress of lichen sclerosus (LS) since the 1980s, but the message is still often lost in translation from the literature to the bedside.

LS isn’t uncommon, affecting approximately 11% of women. The anogenital region is most commonly involved but other skin sites can be affected, and LS does occur in males of all ages.

Currently 3-5% of women with vulval LS will develop vulval cancer, and it is thought that correct early diagnosis and management may reduce this figure.

The aims of treatment are to stop symptoms (usually itch and often misdiagnosed as ‘thrush’); stop loss of normal anatomy that can make sexual enjoyment difficult if not impossible; prevent precancerous changes (vulval intraepithelial neoplasia [VIN]) and invasive cancer.

LS is thought to peak in the prepubertal years and after menopause, although it is becoming a rare disease for women beyond menopause.

The management of a woman with LS need to be reassured that a normal sexual future including possible pregnancies is the probable outcome. Parents of prepubertal girls with LS need to be reassured that a normal sexual future including possible pregnancies is the probable outcome.

Mary’s tears didn’t start to settle until she was reassured that the LS wouldn’t affect her future fertility and ability to deliver normally.

Photography, as part of a woman’s confidential health record provides a useful tool for engaging and teaching her about normal anatomy and LS, and provides a record for future comparison.

At present, once control is established, a woman with vulval LS should be reviewed for the rest of her life.

This is necessary to ensure compliance, examine for evidence of corticosteroid overuse, and the presence of changes of VIN and/ or invasive cancer. Generally this can be an annual event.

LS is an autoimmune disease (AID). Auto-immune thyroiditis (Hashimoto’s) is the most common associated AID. Others include pernicious anaemia, vitiligo, alopecia areata and Addison’s disease.

Genetic testing is not an option at present, but a positive family history can sometimes be present, strongly suggesting a genetic predisposition.

"The vulval area is integral to a woman’s sexuality and possible plans for pregnancy. The fear of pain, slowed arousal and other complications can cripple a woman in the absence of any neoplasm or surgical intervention."

Many questions will arise throughout the course of their management, and treating professionals should be prepared to address such questions when they arise and be prepared to pre-empt them if they think it appropriate.

Other resources for women with LS:
- http://www.dermnetnz.org/immune/lichen-sclerosus.html
- http://lichen-sclerosus.org/

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