Vulval itch that isn't thrush

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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 as a result of uncontrolled LS and fusion of the vulval tissues.

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 clearer that it can occur at any age, and LS with prepubertal onset does not resolve at puberty even though other changes associated with puberty may make it less symptomatic at this time.

Itch is the most common symptom. All health professionals should be aware that 'thrush' does not occur in healthy prepubertal girls and postmenopausal women not receiving hormone replacement therapy (HRT).

While many treatments have and continue to be trialled, potent corticosteroid applications, such as betamethasone disproportionate 0.05% ointments used with reducing frequency once control of symptoms and disease activity have been achieved, are the mainstay of treatment.

Many women are ultimately able to maintain satisfactory control with twice weekly or weekly applications.

Treatment times also provide an opportunity for each woman to examine her vulva (with their finger) and they should be instructed to take note of any rough or thick areas, bumps or sore spots. These should be reported to their treating practitioner straight away as they may indicate disease progression.

The management of a woman with LS does involve more than giving a diagnosis, potentially fearful prognosis and a prescription.

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 neoplasia 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.

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.

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

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