A woman's vulva is possibly the most intimate part of her body. It is not generally socially acceptable to talk about the vulva, and women sometimes use words such as “embarrassing” when they consult doctors and apologise for their vulval problems. Generally women do not even use the proper name; instead using euphemisms, slang words or incorrectly labelling it as the vagina. Doctors may collude in this - asking about problems “down below” and rarely discussing or explaining the anatomy and function of the area.

A number of conditions can affect the vulval area and can have a significant impact on quality of life, psychological well-being and sexual function. Vulval discomfort is common with up to 7% prevalence in the United States. (BMJ2012;344:e1723). BASHH have developed guidelines on the management of vulval conditions which are summarized below (BASHH UK guidelines on vulval conditions 2014).

### Symptoms of vulval disease

- Itch.
- Soreness.
- Pain.
- Burning sensation.
- Discharge.
- Dysuria and urinary symptoms.
- Dyspareunia.

### History and examination

#### History

Ask about

- Specific nature of symptoms: pain (superficial/deep) itch, location, vaginal discharge, precipitating/relieving factors, treatments to date.
- STI risk.
- Other generalised skin conditions.
- Gynaecological and obstetric history (?trauma).
- Sexual function ? vaginismus (which can develop secondarily to a primary vulval disorder).
- Potential irritants e.g. feminine hygiene products, soaps, lubricants, etc. Remember urinary incontinence can also be an irritant).

#### Examination is crucial

61% of women presenting to a specialist vulvodynia clinic had a diagnosable vulval dermatological condition.

- Look for changes in anatomical shape, blisters, ulcerations, induration, change in colour.
- Look for skin dermatoses.
- Look carefully for small fissures in the perineal and intra-labial skin.
- Remember herpetic lesions may have cleared by the time the patient is examined.
- Use a cotton bud to elicit allodynia (present in vulvodynia and post-herpetic neuralgia)
- Speculum examination may reveal vaginitis, lichen planus or pemphigoid.
- Take swabs for candida and STIs if appropriate.
- Consider examination of the oral cavity and skin in general.

### Causes

Vulval problems can be divided into two categories:

<table>
<thead>
<tr>
<th>Specific disorders</th>
<th>Idiopathic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Infectious causes

Often cause acute vulval symptoms. Intermittent symptoms are suggestive of recurrent infection.

Dermatitis and psoriasis

Dermatitis is characterized by erythema, excoriation, lichenification and fissuring.

Psoriasis looks like well-demarcated erythematous plaques with no scale and often affects natal cleft.

Excoriated skin may become secondarily infected causing an acute on chronic picture.

The lichens

<table>
<thead>
<tr>
<th></th>
<th>Lichen Sclerosis</th>
<th>Lichen Planus</th>
<th>Lichen Simplex</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cause</strong></td>
<td>inflammatory dermatosis of likely autoimmune aetiology</td>
<td>Inflammatory disorder of mucous membranes and skin of unknown aetiology</td>
<td>Itch-Scratch cycle caused by</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Underlying dermatoses</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Pruritus</td>
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<td></td>
<td></td>
<td></td>
<td>Environmental factors</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Psychiatric illness</td>
</tr>
<tr>
<td><strong>Location</strong></td>
<td>Vulva only</td>
<td>Vulva, vagina,</td>
<td>Vulva</td>
</tr>
<tr>
<td><strong>Characteristics</strong></td>
<td>• white atrophic areas with ecchymosis, fissuring and erosions. Loss of architecture can lead to fusion or loss of the labia minora, and burying of the clitoral head. Changes may be localized or have an “hourglass” distribution.</td>
<td>• Most commonly mucosal erosions with mauve network of “Wickhams’ striae”</td>
<td>• Excoriations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Papules with striae</td>
<td>• Lichenification</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Hypertrophic warty plaques</td>
<td>• Erosions and fissuring</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Involvement of vagina excludes lichen sclerosis</td>
<td>• Loss of pubic hair in the area.</td>
</tr>
<tr>
<td><strong>Diagnosis</strong></td>
<td>Histological confirmation is necessary if the diagnosis is uncertain or to rule out malignancy</td>
<td>Histology</td>
<td>Clinical</td>
</tr>
</tbody>
</table>
Neoplastic lesions

- Malignant lesions rarely present with pain but are evident on examination.
- Premalignant conditions (VIN) can present as pigmented, indurated or ulcerated lesions and can cause discomfort.

Vulvodynia

- Vulval discomfort or pain (often burning in nature) in the absence of visible findings or a clinically identifiable disease.
- Chronic pain syndrome which is a diagnosis of exclusion.
- May occur spontaneously or be provoked by touch or stimulation (even just wearing clothes).

Management

Any vulval condition can become chronic if untreated and this can, in turn, lead to chronic refractory symptoms and psychosexual problems. Reassurance is important!

BASSH guidance on the general management of all vulval conditions is as follows:

- Avoid contact with soap, shampoos and bubble bath.
- Use a simple emollient as soap substitute and moisturizer.
- Avoid tight fitting garments.
- Avoid spermicidally lubricated condoms.
- Give patient a detailed explanation of their condition with written information.

Specific disorders

Depends on the underlying cause:

- Treat precipitants such as candida/HSV/STIs appropriately.
- Treat eczema with emollient and topical steroids.
- Treat psoriasis with emollients, topical steroids, coal tar preparations and vitamin D analogues.
- Refer discrete lesions for biopsy to exclude malignancy and confirm conditions such as lichen sclerosis and lichen planus.

Vulvodynia

May be diagnosed in the absence of any other pathology without further investigations. There is not a strong evidence base for treatments but expert consensus includes:

- Neuropathic painkillers including low dose tricyclics or gabapentin.
- Topical local anaesthetics (though these can be potent sensitisers).
- Psychological and psychosexual therapies may be beneficial to help with vulval desensitisation.
- TENS machines, pelvic floor muscle biofeedback and vaginal trainers.

Surgical excision of the vestibule (vestibulectomy) is sometimes performed on women with provoked vulvodynia.

When should I refer?

- Consider referral for punch biopsy of any abnormal lesions.
- Refer suspected contact dermatitis for patch testing.
- Refer for multidisciplinary team involvement women who do not respond to primary care based management or in whom diagnosis is uncertain.
## Vulval conditions

- There are multiple causes of vulval symptoms, commonly candida, HSV, lichen sclerosus or erosive lichen planus.
- Vulvodynia may be diagnosed where there is persistent vulval pain in the absence of pathology.
- Examination is very important as more than 60% will have a diagnosable dermatological condition.
- Refer abnormal vulval lesions for punch biopsy.
- Treatment depends on underlying cause but includes removal of irritants, skin care with emollients and if vulvodynia is the diagnosis, neuropathic pain killers and psychosexual treatments.
- Consider specialist referral if failure to respond to simple treatments or diagnostic uncertainty.

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London Sat 8 Oct
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Thur 13 Oct

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London
Fri 25 Nov

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- The Medically Unexplained Symptoms Course

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