Diagnosis and Treatment of Vulvar Dermatoses

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Question 1:

Ultrapotent topical steroids are often the first-line therapy for lichen sclerosus, and most vulvar dermatoses. How do you manage patients who have developed contact sensitization or an allergy to clobetasol propionate?

Response from Drs. Stockdale and Boardman:

We often try topical steroids from alternate structural classes or potency to see if they are better tolerated. Clobetasol propionate 0.05% ointment is a class D1 (betamethasone dipropionate type), Class 1 superpotent steroid. Thus, use of a lower potency steroid or steroid from a different structural class may be better tolerated.

Alternatively, the patient may try mixing the clobetasol propionate with a small amount of bland emollient to reduce irritation with application if the concern is irritant contact dermatitis. For those patients who cannot tolerate the commercially available steroid, compounding the product may be considered. We don’t have a reference for this practice, but have found it helpful in the rare patient who cannot tolerate any form of topical steroid.

Question 2:

What is your preferred biopsy technique? Punch? Shave? How large should the specimen be?

Response from Drs. Stockdale and Boardman:

Our preferred biopsy technique is the one a provider is most comfortable performing to obtain a good sample for histological evaluation. In general, biopsy for confirmation of vulvar skin disorders or dermatoses (modified mucous membranes) can be sampled with a shave technique. Thicker keratinized skin can be sampled with either a shave technique or punch biopsy. Punch or excision should be considered when it is important to
evaluate the base of the lesion (ie, concern of preinvasive or invasive process, melanoma) to avoid missing a potentially malignant process.

The proximity of the lesion to the clitoris, urethra, and rectum should be taken into account in selection of the biopsy site if possible. A 3-mm or 4-mm diameter excision is typically adequate for evaluation of a dermatosis. However, a larger excision may be indicated to evaluate areas with multiple features (ie, ulceration, color, raised irregular lesions).

**Question 3:**

While the etiology of lichen sclerosus is not known, it is often associated with autoimmune disorders (thyroid, vitiligo, alopecia), suggesting an autoimmune component. As mentioned in the article, it is known to occur at all ages; however, it has a bimodal age distribution with peaks in postmenopausal women and prepubertal girls. These are times of low estrogen, but lichen sclerosus does not respond to estrogen therapy. Any thoughts about this pattern of distribution?

**Response from Drs. Stockdale and Boardman:**

Agree, the pattern of distribution is perplexing. Unfortunately, while identified, the bimodal age distribution has not been explained, nor has the role for hormones. The long-term outcome for prepubertal girls diagnosed with lichen sclerosus is unclear. However, limited case series have confirmed vulvar lichen sclerosus often extends into adulthood. 2,3,4

**Question 4:**

In the algorithm for treatment of persistent vulvar pain, the article mentions dietary modifications. In your practice, are there particular dietary strategies that you recommend to patients? Is there a role for probiotics?

**Response from Drs. Stockdale and Boardman:**

The algorithm for “Persistent vulvar pain treatment” was adapted from Haefner et al and was originally “Low oxalate diet, calcium citrate supplementation.” This recommendation was based initially on a case report from Solomons et al. Subsequently, case control studies failed to confirm an association between oxalate consumption and excretion and vulvodynia. The use of probiotics has not been evaluated.

**Question 5:**

In regards to topical calcineurin inhibitors, such as tacrolimus and pimecrolimus, how do you counsel patients regarding the 2006 U.S. Food and Drug Administration (FDA) black box warning? How long do you continue maintenance therapy with these medications? When patients initiate topical calcineurin inhibitors such as tacrolimus, they often complain of burning and are hesitant to use the medication. Any recommendations?

**Response from Drs. Stockdale and Boardman:**

The use of many medications, topical as well as systemic, for the treatment of vulvar disorders is off-label (not FDA approved for treatment of specific vulvar disorders). Thus, we often counsel patients that the medications we are discussing are off-label. Regarding the 2006 FDA black box warning for topical calcineurin inhibitors, we advise patients of the warning and the theoretical risk for malignancy based largely on the use of systemic calcineurin inhibitors.

We continue maintenance therapy with the lowest effective dose—including appropriate follow-up and review of the indication for use as well as associated risk—as long as the benefit outweighs the risk to the patient.
As with clobetasol propionate, patients may experience burning with application of calcineurin inhibitors. We recommend mixing with a small amount of bland emollient to reduce irritation. Additionally, the very short term use (less than 10 minutes) of a cool compress may help with these initial symptoms.

**Question 6:**

What is the usual disease course of lichen sclerosus found in prepubertal girls? Does disease improve after puberty?

**Response from Drs. Stockdale and Boardman:**

*Limited case series have found that girls with prepubertal onset are at risk for sequelae of lichen sclerosus despite improvement in symptoms following puberty.*2,3 *In a small case series of 12 patients with childhood lichen sclerosus, 9 (75%) continued to require maintenance therapy following menarche and 6 had persistent changes in vulvar architecture.*3

**Question 7:**

Should patients with lichen sclerosus who are completely asymptomatic still be treated with an initial course of daily therapy followed by long-term maintenance? Do patients with marked improvement of vulvar abnormalities and resolution of symptoms require indefinite maintenance therapy?

**Response from Drs. Stockdale and Boardman:**

*The question regarding long-term maintenance for women with lichen sclerosus was largely unclear until recent evidence by Lee et al demonstrated poorer health outcomes (eg, vulvar neoplasia, occurrence of adhesions, and scarring) among those not adhering to maintenance therapy among a cohort of 507 women.*5 *Based on their findings, long-term treatment should be titrated for individual patients (including the use of any topical corticosteroid regimen that provides relief of signs and symptoms with normalization of skin color and texture) to reduce the risk for associated vulvar cancer.*

**Question 8:**

Is there a role for CO₂ laser in the management of vulvar dermatoses?

**Response from Drs. Stockdale and Boardman:**

*While a recent emergence regarding the use of laser treatment for a variety of vulvar dermatoses (including lichen sclerosus and vaginal atrophy) has been advertised to the lay public, the evidence is based primarily on limited case series. Although short-term outcomes suggest improvement in symptoms among women with recalcitrant lichen sclerosus or vaginal atrophy, long-term outcomes have not yet been reported.*10
References


