Below is a summary of the lichen sclerosus (LS) discussion points we covered as well as points we had hoped to cover. Our discussion focused on adult patients with lichen sclerosus.

PREVISIT QUESTIONNAIRE
These can be helpful gaining details in the setting of a fast-placed clinic.
- HPI
- Previous treatment and response
- Change in, nature of vaginal discharge
- Genital hygiene practices
- Menstrual/feminine hygiene practices
- OB/GYN history
- Sexual history

HISTORY
1st triage point – itch vs pain [irritation = nonspecific, must choose itch or pain]
Itch ...usually different than LSC itch description but not always
Scratching LS may be uncomfortable because it isn’t hyperkeratotic like LSC
Pain with urination (acidic pH) and friction
Itch or pain with wiping
Aggressive wiping often used instead of traditional scratching
Dyspareunia – introital narrowing, fissures, erosions, sensitive skin
Difficulty with orgasm (clitoral hooding)
Rectal fissures (pain with bowel movements – not usually constipation in adults)
Bruising
Often many treatments for yeast have been prescribed/used

EXAMINATION
Position – establish one (or two) that provides view of vulvar AND perirectal skin
Establish a repeatable order to exam so structures not missed
Missing “bits” (labia minora, clitoral hood, buried clitoris) key to Dx inflammatory process
Full-expanded skin check to aid in Dx – Mucosal surfaces and skin
Speculum exam - Identify a gynecologist you can work with for referrals
Q-tip
- Aid for manipulating skin (mineral oil to tip if skin very fragile)
- Touch testing for vulvodynia
Pelvic floor tension myalgia
- Can be cause of pain
- Can be result of pain
- Identify a pelvic floor PT you can work with for referrals
EVALUATION

Biopsy
- Always if any doubt
- Good for Pt to have the pathology report to bring to future doctors for care
- If not Bx then get a good photo to document for chart and for patient
- Not required if classic presentation and good treatment response
- Rebiopsy if lack of response or concerning changes
- If Dx unknown and Pt on corticosteroids, stop them to get flare then Bx

Cultures and swabs for HSV PCR not needed unless there is a suspicion on exam

Hypothyroidism more common in women with LS
- Check an sTSH at time of evaluation/diagnosis or confirm one done recently
- Only recheck sTSH if Sx of hypothyroidism reported by patient

STD testing often done many times by the time patient gets to a dermatologist

MANAGEMENT

Identify ALL other products patient is applying to vulva and stop them
Benzocaine in Vagisil a frequent bad actor
Gentle vulvar care – hand and water wash all that is needed
Ointment bases preferred for application to modified mucous membranes
Clobetasol is gold standard but other strength steroids can be used
If propylene glycol an issue: desoximetasone 0.25% ointment, halcinonide 0.1% ointment
Vulvas resistant to steroid side effects
Perianal skin more sensitive to steroid side effects
Achieve disease control with frequent application first
Once controlled, begin ongoing maintenance application of corticosteroid
Pharmacists and other providers may scare the Pt about steroids reducing compliance
Tacrolimus ointment
- Burn on application (especially with open skin) can limit tolerability
- Can be a good placeholder allowing less corticosteroid usage
- Over 65yo often not covered by insurance

Genitourinary syndrome of menopause (GSM) treatment
- Increases resilience of skin by improving dermal substrate
- Improves skin barrier by decreasing sloughing of immature epithelial cells
- Improves the desired acidic pH (decreases pH)
- With decreased pH, yeast overgrowth is more likely (akin to premenopause years)
- Topical estrogen often needed even if Pt on systemic estrogen
- Estradiol (Estrace) cream: pea-sized amnt or 0.5 to 1 gm in applicator Mon + Thur nights
- Conjugated estrogen (Premarin) cream often more irritating
- Estrace and Premarin creams contain propylene glycol
- Insert (Vagifem/Yuvafem) Mon + Thur nights no propylene glycol
- Creams and insert all good effect on vagina
- Creams more effective for vulva than insert and can be applied to vulva if needed
• Cost of topical estrogens very high
• Paper prescriptions allow patients to fill them at their pharmacy of choice
• Some compounding pharmacies have a reasonably-priced topical estradiol cream

Testosterone=vehicle
Barriers can be helpful
Lidocaine – used with caution with sexual activity
Systemic treatments (HCQ, acitretin, MTX, mycophenolate)
Laser (fractionated CO2) = not enough evidence yet
Laser (Erbium/Mona Lisa) = not enough evidence yet
PRP = not enough evidence yet

COMPLICATIONS
A topical or “all topicals” burn
  Propylene glycol sensitivity? (see treatment for options)
  Not due to chemical but due to pressure/contact? i.e. provoked vulvodynia
White petrolatum application
  Help to determine if touch vs chemical the issue
  If Pt tolerates, you can compound into petrolatum if needed
Corticosteroid dermatitis – “the more I apply, the redder I get”
Itch returns...think yeast and get a swab from the vulva NOT vagina for fungal culture
New pain...think possible HSV, secondary bacterial infxn, concomitant erosive LP, GSM
Squamous cell carcinoma – biopsy if any question

FOLLOW-UP
How often?
• More frequently when establishing treatment and getting long term plan established
• Every 6 to 12 months ongoing for monitoring
What looking for/thinking of during follow-up visit?
• Symptom control level
• Physiologic dysfunction
• Disease control level (by exam)
• Progression of scarring
• Concern for malignant transformation