# Vulval Dermatitis and Lichen Simplex Chronicus - Adults - Full Clinical Guideline

Reference no.: CG-DERM/2023

## Introduction

These guidelines have been produced by the Dermatology, GUM and Gynaecology departments.

Patients presenting with vulval dermatitis commonly present with symptoms of itch, soreness and discomfort. Signs to look for include erythema, excoriations, fissuring, serous oozing or crusting. Erosions may be seen if acute and lichenification and pigmentary changes are signs of more chronic disease. Treatment is aimed at targeting the underlying cause. The cause can be subdivided into atopic, allergic and irritant.

Atopic vulval dermatitis (eczema) is often seen in people who also have hay fever or asthma and is due to a defect in the barrier function of the skin.

Allergic contact vulval dermatitis is due to skin contact to a substance to which the individual is sensitive. Type 4 contact allergy can be confirmed by referring the patient for a patch testing via the dermatology department. Common allergens are fragrances and components of some topical treatments.

Irritant contact vulval dermatitis is due to skin contact with irritating chemicals such as cleansing agents, fragrances and a particular problem in those with urinary incontinence.

Other differentials to consider include seborrhoeic dermatitis. Yeast organisms on the skin may have a role in the development of this inflammatory, desquamative dermatosis in predisposed individuals. This form of dermatitis may have features that are similar to psoriasis but the erythema is much less well-defined.

Vulval dermatitis can result in a secondary condition called Lichen simplex chronicus (LSC). This is a chronic condition due to repeated scratching of the skin secondary to symptoms of itchiness or soreness. The clinical signs are lichenification, erosions, excoriations and fissuring. The pubic hair is often lost in the area of scratching.

There are many other causes of LSC. The causes can be divided into underlying dermatoses, systemic conditions, environmental factors and psychiatric disorders. The management strategy is targeted at treating the underlying cause.

Underlying dermatoses causing LSC include atopic dermatitis, allergic contact dermatitis, superficial fungal (tinea and candidiasis) infections. Systemic conditions causing pruritus such as renal failure,

obstructive biliary disease, Hodgkin's lymphoma, hyper- or hypothyroidism and polycythaemia rubra vera should be considered in the differential.

Environmental factors such as heat, sweat, skin care products and rubbing of clothing can all irritate the skin causing LSC.

Psychiatric disorders such as anxiety, depression and obsessive-compulsive disorder can promote itching of skin and result in a chronic itch-scratch cycle leading to LSC.

**Aim and Purpose**

To improve the management of vulval dermatitis/lichen simplex in the hospital setting.

## Definitions, Keywords

Vulval, Atopic eczema, Atopic dermatitis, Lichen Simplex Chronicus

University Hospitals of Derby and Burton NHS Foundation Trust

# Management of Vulval Eczema/ Lichen Simplex Chronicus

| Treatment action | Topical / Behavioural | Oral Meds | Testing/Notes |
|---|---|---|---|
| **Comfort measures/ general care** | Avoidance of irritants and possible allergens that may be precipitating factors for example cleansers, fragrances and wetwipes.<br><br>Gentle cleansing, soap substitute (Dermol 500 lotion or emulsifying ointment) or topical emollient ointment (e.g Cetraben, Diprobase, Hydromol etc) avoidance of irritants/tight/synthetic clothing.<br><br>Application of cool gel packs, crushed ice, or frozen peas or corn in a protective bag applied to the irritated skin may be very soothing (caution as risk of cold burn)<br><br>Advice to keep finger nails short to avoid trauma and risk of infection.<br><br>If Atopic eczema (AD) - teach patient that this condition needs to be controlled, rather than cured<br><br>Atopic-eczema-PIL-July-2020-1-1.pdf (wpengine.com)<br><br>Further educational material can be found in Appendix 2 | | Give BAD patient information leaflets (PIL)<br><br>Vulval skin care PIL<br><br>Vulval-skincare-PIL-May-2023.pdf (wpengine.com)<br><br>Lichen simplex PIL<br><br>Lichen-simplex-PIL-Aug-2023.pdf (wpengine.com)<br><br>If secondary infection suspected consider bacterial culture (MC&S swab) or viral (Swab) or candidiasis(swab) or tinea cruris (skin scrapings)<br><br>If urinary incontinence is present, consider irritant contact dermatitis. This should be addressed and referral to uro-gynaecology is helpful<br><br>If suspecting Contact Dermatitis, refer to Dermatology for Patch testing and avoid positive allergens – should consider testing to standard and medicament series as well as any specific products applied by the patient to the vulva.<br><br>Routine blood tests to rule out iron deficiency or autoimmune conditions like, thyroid disorder or diabetes e.g- Ferritin, TFTs,HbA1c or Random Blood Glucose and ANA<br><br>If suspecting vulval seborrhoeic dermatitis, test for immunodeficiencies such as HIV and hepatitis.<br><br>Punch biopsy only if unsure of diagnosis or non-responsive to initial treatment- with clear indication and site (LEFT/RIGHT; Labia Majora/ Minora/ Skin or Mucosal). The site should be ideally marked with sticker representation in clinical notes. (see Appendix 4) |

| | | | |
|---|---|---|---|
| | | | Clinical photos via Medical Photography are helpful |
| **Anti-inflammatory action** | A topical steroid such as 1% hydrocortisone ointment can be used for mild cases.<br><br>Moderate potency steroids like Eumovate Ointment or Betnovate RD ointment could be used to step up treatment.<br><br>Occasionally potent steroids like Betnovate or Elocon or Dermovate may be initiated for more severe disease.<br><br>This can be applied once daily for 7–10 days until the symptoms and signs settle and can then be used as needed for any recurrent symptoms.<br><br>Treat any co-existing infection with a combination steroid/antifungal or steroid/antibacterial cream. | | Give BAD patient information regarding topical steroid use<br>Topical steroid PIL<br><br>Topical-corticosteroids-update-May-2019-Lay-reviewed-May-20192.pdf (bad.org.uk)<br><br>Topical steroids in ointment form can be more effective than cream form (though consider patient preference). The ointment form also has fewer preservatives to avoid risk of contact dermatitis. |
| **Reduction of itching** | A sedating antihistamine given at night should reduce the damage inflicted by scratching. | **Hydroxyzine (Atarax)** 10 to 25 mg orally 1-2 hrs prior to bedtime; (may start at 10 mg and increase nightly to a maximum of 75 mg) | The newer non-sedating anhihistamines, loratidine (Claritin®), fexofenadine (Allegra®), and Zyrtec have had limited success in the treatment of pruritus |
| **Reduction of the habit of** | Counsel patient regarding the importance of breaking the itch scratch cycle | | Consider recommending a referral for Cognitive Behavioural |

| | | | |
|---|---|---|---|
| **scratching** | | | Therapy (CBT) by the G.P. |
| **Reduction of pain / discomfort during sex** | Rule out fissuring in the vulval and perianal area and treat appropriately.<br>If no fissuring/erosions noted then consider advising 5% Lidocaine ointment (not EMLA or instillagel) applied to the vestibule up to 3 times daily and/or on a cotton ball in the vestibule overnight.<br>Lubricants during sex. | | Vigilance for secondary vulvodynia<br>Lidocaine might burn after application<br><br>Vulvodynia PIL<br>Vulvodynia-updated-December-2021-Lay-reviewed-December-2021.pdf (bad.org.uk) |

Key Standards in Referral Letter

- The proforma found in Appendix 1 should be used for all referrals to the Dermatology vulval service.
- Referral to a specialist Vulval Service/ Dermatology must be considered if no response to topical treatment despite patient complying to treatment.

**References**


- https://bnf.nice.org.uk/treatment-summary/topical-corticosteroids.html
- Issvd.org
- Bssvd.org
- Bad.org.uk
- European guidelines for management of vulval conditions 2022


**Documentation Controls**

| | |
|---|---|
| Development of Guideline:<br><br>Updated By: | Dr Shinhmar, Miss Shuchi Dixit, Dr Maulina Sharma<br><br>Dr. Perin Celebi, Miss Shuchi Dixit, Dr Maulina Sharma |
| Consultation with: | Dr Hayley Wood |
| Approved By: | Dermatology Departmental Meeting - 7/12/2019<br>Medical Division - 12/2/2020<br>Reviewed by department and ACD - Dec 23<br>Medicine Division - December 2023 |
| Review Date:<br><br>Reviewed on:<br><br>New Review Date: | February 2023<br><br>14.12.2023<br><br>December 2026 |
| Key Contact: | Dr. Maulina Sharma |

University Hospitals of Derby and Burton NHS Foundation Trust

## Appendix 1:

**Referral form for Vulval clinic (Dermatology LRCH)**

Patient details

DATE OF REFERRAL:

REFERRING GP:

What is the diagnosis(es)? (if not sure please indicate)

Please indicate previous treatments and responses

| Treatment<br><br>(eg topical treatment, drug treatment) | Dosage<br><br>(eg one finger tip unit etc. If not sure please indicate 'not sure') | Frequency of use<br><br>(ie which treatments have been used) | Duration of use<br><br>(weeks, months) | Response<br><br>(worse, same, slightly better) |
|---|---|---|---|---|
| | | | | |
| | | | | |

| | | | | |
|---|---|---|---|---|
| | | | | |

What is the aim of referral?* (eg second opinion, non responder) *(CONSIDER BIOPSY BEFORE REFERRAL)

| |
|---|
| |

Any other relevant details (eg other skin disease)

| |
|---|
| |

Please ensure that patients are using bland hygiene measures and avoiding vulval irritants.

For fact sheets see www.bssvd.org

Please attach this form to the ERS

**Appendix 2:**

## Education

Information on the different treatments should be given in verbal and written forms. The British Association of Dermatologists has developed video links aimed at patients on the use of steroids (https://www.youtube.com/watch?v=tpethgKQB3U) and emollients (https://www.youtube.com/watch?v=dQaihGo-6gc); these can be given to patients.

Clinicians must address the following factors in each consultation. Any barriers to adherence should be fully explored.

- How to recognise the symptoms and signs of bacterial infection
- How to recognise and manage flares of vulval dermatitis/lichen simplex
- How much of the treatment to use
- How to apply and how often to apply prescribed treatments
- When and how to step treatment up or down

## Emollients

Use **at least** twice daily to hydrate the skin and reduce inflammation. Greasy emollients e.g. Epaderm ointment are more effective than creams, but only work if they are cosmetically acceptable. Emollients can be used as soap substitutes. **Usually 250- 500g of emollients are used weekly and sufficient amounts should be prescribed by clinicians**.

Aqueous cream can be used as a soap substitute but should not be used as an emollient.

**Paraffin-containing emollient products** can come into contact with dressings, clothing, bed linen or hair, there is a danger that a naked flame or cigarette smoking could cause these to catch fire. Patients/parents are advised to avoid naked flames completely, including smoking cigarettes and being near people who are smoking or using naked flames. It is also advisable to wash clothing and bed linen regularly (daily is preferable).

**Appendix 3:**

## Topical steroid regimes for flares and maintenance

Clinician's and patients tend to be cautious over the use of topical steroids due to concerns of skin thinning, this may lead to under usage. The varied potency of steroids is summarised in Table 1.

**Table 1**: The different potency of topical steroids used in eczema, a full summary can be found in the BNF

| Mild | Moderate | Potent |
|---|---|---|
| Hydrocortisone 1–2.5%<br><br>Synalar 1 in 10 dilution<br>*(fluocinolone acetonide 0.0025%)* | Betnovate-RD<br>*(Betamethasone 0.025%)*<br><br>Eumovate<br>(*Clobetasone butyrate 0.05%)*<br><br>Synalar 1 in 4 dilution<br>(*fluocinolone acetonide* 0.00625%) | Elocon<br>*(Mometasone furoate)*<br><br>Betnovate<br>*(Betamethasone valerate 0.1%)*<br><br>Synalar<br>(*fluocinolone acetonide* 0.025%) |

Clinicians must educate patients on how much steroid they should use, the finger tip unit (FTU) is a useful guide. FTU's vary acording to patient age and area of body

FTU

Imagine squeezing a line of cream along the end of your index finger. This is called a fingertip unit (FTU).

A fingertip unit is enough steroid cream to treat an area of skin the size of the front of two adult hands.

Using this measure, you can work out how much steroid is needed.

**Appendix 4:**

Diagram 1 picture of stickers which can be found in vulval and gynaecology clinic. These must be used to clearly mark areas of pathology found during clinic and also mark the site for biopsy.