Vulvar Dermatology

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No commercial disclosures for this lecture
International Society for the Study of Vulvar Disease (ISSVD)

• 2011: Terminology and Classification of Vulvar Dermatological Disorders
• 2006: Classification of Vulvar Dermatoses
• 2004: Vulvar Intraepithelial Neoplasia (VIN)
• 2003: Terminology and Classification of Vulvodynia
<table>
<thead>
<tr>
<th>Type</th>
<th>ISSVD Term</th>
<th>Old Terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atrophic</td>
<td>Lichen sclerosus</td>
<td>• Lichen sclerosus et atrophicicus</td>
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<tr>
<td></td>
<td></td>
<td>• Kraurosis vulvae</td>
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<tr>
<td>Hyperplastic</td>
<td>Squamous cell hyperplasia</td>
<td>• Hyperplastic dystrophy</td>
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<tr>
<td></td>
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<td>• Neurodermatitis</td>
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<td></td>
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<td>• Lichen simplex chronicus</td>
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<tr>
<td>Systemic</td>
<td>Other dermatoses</td>
<td>• Lichen planus</td>
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<tr>
<td></td>
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<td>• Psoriasis</td>
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<tr>
<td>Premalignant</td>
<td>VIN</td>
<td>• Hyperplastic dystrophy/atrophy</td>
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<tr>
<td></td>
<td></td>
<td>• Bowen’s disease</td>
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<tr>
<td></td>
<td></td>
<td>• Bowenoid papulosis</td>
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<td>• Vulvar CIS</td>
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</tbody>
</table>

ISSVD: International Society for the Study of Vulvar Disease
ISSVD Classification of Vulvar Dermatoses: 2006

- No consensus agreement on a system based upon clinical morphology, path physiology, or etiology
- Include only non-Neoplastic, non-infectious entities
- Agreed upon a microscopic morphology based system
- Rationale of ISSVD Committee
  - Clinical diagnosis → no classification needed
  - Unclear clinical diagnosis → seek biopsy diagnosis
  - Unclear biopsy diagnosis → seek clinic pathologic correlation
<table>
<thead>
<tr>
<th>Path pattern</th>
<th>Clinical Corrrelates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spongiotic</td>
<td>Atopic dermatitis, allergic contact dermatitis, irritant contact dermatitis</td>
</tr>
<tr>
<td>Acanthotic</td>
<td>Psoriasis, LSC (primary or superimposed), (VIN)</td>
</tr>
<tr>
<td>Lichenoid</td>
<td>Lichen sclerosus, lichen planus</td>
</tr>
<tr>
<td>Dermal homogenization</td>
<td>Lichen sclerosus</td>
</tr>
<tr>
<td>Vesicobullous</td>
<td>Pemphigoid, linear IgA disease</td>
</tr>
<tr>
<td>Acantholytic</td>
<td>Hailey-Hailey disease, Darier disease, papular genitocrural acantholysis</td>
</tr>
<tr>
<td>Granulomatous</td>
<td>Crohn disease</td>
</tr>
<tr>
<td>Vasculopathic</td>
<td>Apthous ulcers, Behcet disease, plasma c. vulvitis</td>
</tr>
</tbody>
</table>
Lichen Sclerosus: Natural History

- Most common vulvar dermatosis
- Prevalence: 1.7% in a general GYN practice
- Cause: autoimmune condition
- Bimodal age distribution: older women and children, but may be present at any age
- Chronic, progressive, lifelong condition
Lichen Sclerosus: Natural History

- Most common in Caucasian women
- Can affect non-vulvar areas
- Part (or all) of lesion can progress to VIN, differentiated
- Predisposition to vulvar squamous cell carcinoma
  - 1-5% lifetime risk (vs. < 0.01% without LS)
  - LS in 30-40% women with vulvar squamous cancers
Lichen Sclerosus: Findings

• **Symptoms**
  – Most commonly, itching
  – Often irritation, burning, dyspareunia, tearing
  – 58% of newly-diagnosed patients are asymptomatic

• **Signs**
  – Thin white “parchment paper” epithelium
  – Fissures, ulcers, bruises, or submucosal hemorrhage
  – Loss of labia minora, fusion of labia and clitoral hood
  – Depigmentation (white) or hyperpigmentation in “keyhole” distribution: vulva and anus
  – Introital stenosis
Hyperpigmentation due to scarring
 Loss of labia minora

“Early” Lichen Sclerosus
Lichen Sclerosis: Loss of Labia Minora

Photo courtesy of Dr Hope Heafner
Lichen Sclerosus: Cigarette Paper Appearance

Photo courtesy of Dr Hope Heafner
Later Lichen Sclerosus

Thin white epithelium

Fissures
Lichen Sclerosus: “Figure of Eight” or “Hour Glass” Appearance

Photo courtesy of Dr Hope Heafner
Agglutination of clitoral hood
Loss of labia minora
Introital narrowing
Parchment paper epithelium

“Late” Lichen Sclerosus
Late Lichen Sclerosus

Photo courtesy of Dr Hope Heafner
Late Lichen Sclerosus: Peri-Clitoral Changes

Photo courtesy of Dr Hope Heafner
68 year old woman with urinary obstruction

Labial agglutination over urethral meatus
Lichen Sclerosus: Treatment

- Biopsy mandatory for diagnosis, unless classic findings
- **Preferred treatment**
  - Clobetasol 0.05% ointment QD x4 weeks, then QOD x4 weeks, then twice-weekly for 4 weeks
  - Taper to med potency steroid (or clobetasol) 2-4 times per month for life
  - Explain “titration” regimen to patient, including management of flares and recurrent symptoms
  - 30 gm tube of ultrapotent steroid lasts 3-6 mo
  - Monitor every 3 months twice, then annually
Lichen Sclerosus: Treatment

- **Second line therapy**
  - Pimecrolimus, tacrolimus
  - Retinoids, potassium para-aminobenzoate
- Testosterone (and estrogen or progesterone) ointment or cream no longer recommended
- Explain chronicity and need for life-long treatment
- **Adjunctive therapy**: anti-pruritic therapy
  - Antihistamines, especially at bedtime
  - Doxypin, at bedtime or topically
  - If not effective: amitriptyline, desipramine PO
- Perineoplasty may help dyspareunia, fissuring
Lichen Simplex Chronicus = Squamous Cell Hyperplasia

- **Cause:** an irritant initiates a “scratch-itch” cycle
- **LSC classified as**
  - Primary (idiopathic)
  - Secondary (superimposed upon lichen sclerosus, candida vulvitis; vulvar contact dermatitis)
- **Presentation:** always *itching*; burning, pain, tenderness
- **Signs:** Thickened red (white if moisture) raised lesion
- In absence of atypia, no malignant potential
  - If atypia present, classified as VIN
Lichen Simplex Chronicus
L. Simplex Chronicus: Treatment

• Removal of irritants or allergens

• Treatment
  – Triamcinolone acetonide (TAC) 0.1% ointment BID x4-6 weeks, then QD
  – Other moderate strength steroid ointments
  – Intraleisional TAC once every 3-6 months

• Anti-pruritics
  – Hydroxyzine (Atarax) 25-75 mg QHS
  – Doxepin 25-75 mg PO QHS
  – Doxepin (Zonalon) 5% cream; start QD, work up
Lichen Sclerosus + LSC

- “Mixed dystrophy” deleted in 1987
  ISSVD System
- 15% all vulvar dermatoses
- LS is irritant; scratching → LSC
- Consider: LS with plaque, VIN, squamous cell cancer of vulva
- Treatment
  - Clobetasol x12 weeks, then steroid maintenance
  - Stop the itch!!
Lichen Planus

- Autoimmune condition
- Histology and morphology resemble other hyperimmune conditions (GVH, lichenoid drug eruption)
- More difficult to treat than LS
- **Symptoms: both vulva and vagina**
  - Pruritus
  - Rawness, irritation
  - Burning
  - Dyspareunia/apareunia
• **Classic form**
  – Purple, well-demarcated, flat topped papules

• **Erosive form**
  – Erythematous erosive lesions on vestibule or in vagina

• **Desquamative inflammatory vaginitis (DIV)** is erosive LP that involves the vagina but not the vestibule

• **DDX:** Behcet’s syndrome, syphilis, herpes, chancroid

• **DX:** biopsy essential
Very Early Lichen Planus

Photo courtesy of Dr Hope Heafner
Lichen Planus

Photo courtesy of Dr Hope Heafner
Erosive Lichen Planus on Musosa
Always Check the Mouth!
Oral Lichen Planus

Photo courtesy of Dr Hope Heafner
Photo courtesy of Dr Hope Heafner
Desquamative Inflammatory Vaginitis

Photo courtesy of Dr Hope Heafner
Lichen Planus: Treatment

• No one satisfactory treatment exists
• Emollients, vulvar care; treat superinfection
• Vulva: clobetasol ointment with taper
• Vagina: Anusol HC 25 mg supp; ½-1 supp PV BID x4 weeks, then taper
• Short course of oral steroids if necessary
• Vaginal dilators to prevent scarring
• Other Rx: Tacrolimus 0.1% (Protopic) BID, Acitretin, methotrexate, Dapsone
Vulvar Intraepithelial Neoplasia (VIN): Prior to 2004

- Grading of VIN-1 through VIN-3, based upon degree of epithelial involvement
- The mnemonic of the 4 P’s
  - Papule formation: raised lesion (erosion also possible, but much less common)
  - Pruritic: itching is prominent
  - “Patriotic”: red, white, or blue (hyperpigmented)
  - Parakeratosis on microscopy
ISSVD Classification of VIN (2004)

- Since VIN 1 is not a cancer precursor, abandon use of term
  - Instead, use “condyloma” or “flat wart”
- Combine VIN-2 and VIN-3 into single “VIN” diagnosis
- Two distinct variants of VIN

<table>
<thead>
<tr>
<th>ISSVD 1986</th>
<th>ISSVD 2004</th>
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<tbody>
<tr>
<td>VIN 1</td>
<td>Flat condyloma</td>
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<tr>
<td>VIN 2</td>
<td>VIN-usual (VIN-u)</td>
</tr>
<tr>
<td>VIN 3</td>
<td>VIN-usual (VIN-u)</td>
</tr>
<tr>
<td>Differentiated</td>
<td>VIN-differentiated (VIN-d)</td>
</tr>
</tbody>
</table>

VIN-u
- Warty
- Basaloid
- Mixed
ISSVD: VIN, Usual Type (VIN-u)

- Usually HPV-related (mainly type 16)
- More common in younger women (30s-40s)
- Often asymptomatic
- Lesions usually elevated and have a rough surface, although flat lesions can be seen
- Often multifocal (incl periurethral and perianal areas) and multicentric in 50%
- Strongly associated with immunocompromise, smoking
- Low malignant potential (5-20%)
  - Progression more likely with the basaloid type
White VIN-u, Warty type
VIN

Note the raised, whitened, irregular surface

Photo courtesy of Dr M Sideri
VIN-u
Basaloid type
FIGURE 3. Vulvar intraepithelial neoplasia, usual type, with white-gray color changes and irregular borders.

Image courtesy of Natalie A. Saunders, MD.
VIN-u: warty-basaloid type
Hyperpigmented VIN, usual type
Gray-Brown VIN

Photo courtesy of C Dunton, MD
Hyperpigmented VIN, usual type
VIN-u: Hyperpigmented Lesions
Anal Intraepithelial Neoplasia

Photo courtesy of Dr Hope Heafner
VIN-d: Differentiated Type

- Usually in older women with LS, LSC, or LP
- Not HPV related
- Far less common than VIN-usual type
- **Symptoms**: long history of pruritus and burning
- **Findings**
  - Red, pink, or white papule; rough or eroded surfaces
  - A persistent, non-healing ulcer
  - Unifocal, unicentric
- More likely to progress to SCC of vulva than VIN-u (90%)
VIN Differentiated

Photo courtesy of Dr M Preti
Vulvar Intraepithelial Neoplasia

- **Risk of invasion**: greater if immunocompromised (steroids, HIV), >40 years old, previous lower genital tract neoplasia

- **Treatment**
  - Wide local excision: highest cure rate, esp hair-bearing
  - CO$_2$ laser ablation: best cosmetic result
  - Topical agents: imiquimod
  - Skinning or simple vulvectomy rarely used

- **Recurrence** is common (48% at 15 years)
  - Monitor @ 6,12 months, then annually
  - Smoking cessation may reduce recurrence rate

- **Prevention**: HPV-4 vaccine
Treatment of VIN with Imiquimod

- Treatment with 5% imiquimod BIW x16-20 weeks
- *Off-label use of this drug*

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<thead>
<tr>
<th>Study</th>
<th>n</th>
<th>IMQ response</th>
<th>Control response</th>
<th>Comment</th>
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<tbody>
<tr>
<td>vanSeters</td>
<td>52</td>
<td>81%</td>
<td>0%</td>
<td>Progression to cancer in 6% patients over 12 months</td>
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<tr>
<td>2008</td>
<td></td>
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<tr>
<td>Mathiesen</td>
<td>21</td>
<td>81%</td>
<td>10%</td>
<td>67% ↓ dosing 2º to adverse effects</td>
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<td>2007</td>
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<tr>
<td>Le</td>
<td>33</td>
<td>77%</td>
<td>No controls</td>
<td>Recurrence @16 months</td>
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<tr>
<td>2007</td>
<td></td>
<td></td>
<td></td>
<td>- IMQ: 21%</td>
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<td>- Surgery: 53%</td>
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<tr>
<td>Rosen</td>
<td>49</td>
<td>86%</td>
<td>No controls</td>
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<td>2007</td>
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ISSVD Terminology and Classification of Vulvodynia
(Salvador, Brazil, 2003)

- **Vulvar Pain Related to a Specific Disorder**
  - *Infectious* (candidiasis, herpes simplex)
  - *Inflammatory* (Lichen planus, DIV)
  - *Neoplastic* (Paget’s Disease < squamous cell carcinoma)
  - *Neurologic* (post-herpes zoster neuralgia, pudendal n. entrapment, diabetic neuropathy)
  - *Dermatoses*: LS, LSC → pruritis → excoriation → pain
ISSVD Terminology and Classification of Vulvodynia  
(Salvador, Brazil, 2003)

Vulvodynia

- **Generalized** (dysesthetic vulvodynia)
  - Provoked (sexual, nonsexual, both)
  - Unprovoked
  - Mixed (provoked and non-provoked)

- **Localized** (vestibulodynia, clitorodynia)
  - Provoked
  - Unprovoked
  - Mixed
Work-up of a Woman with Vulvar Pain

Pain Alone

Normal on examination
- Pain localized and provoked by pressure
  - Provoked vestibulodynia (PVD) (aka: Vulvar vestibulitis syndrome)

Abnormalities on examination
- Pain poorly localized (generalized pain)
  - Generalized vulvodynia likely
- Pain related to a specific disorder
Provoked Vestibulodynia (PVD)  
Epidemiology

• 15% reproductive age women: introitus painful to touch  
  – ½ “mild”; doesn’t affect activities  
  – ½ have significant dyspareunia; only ½ asked for help

• PVD has two common times of onset  
  – 1º PVD: onset as teen; present in mother  
  – 2º PVD: onset post-partum; no family history

• Many causes investigated, none proven  
  – Chronic candida, HPV not causes  
  – Connection with interstitial cystitis
Provoked Vestibulodynia: Presentation

• **Symptoms**
  – Pain symptoms on touch or vaginal entry
  – Absence of symptoms during daily activities
  – Avoidance of pants with tight inseam
  – Avoidance of tampons due to insertional pain

• **Signs**
  – Inflamed patches of skin or regions of vestibule
  – Positive “swab test”:
    • Intense pain during rolling of moistened cotton swab over red areas on vestibule
    • Skin beyond ½ cm of inflamed area non-tender
Provoked Vestibulodynia: Co-morbidity

- Interstitial cystitis (IC): 68-82%
- Irritable bowel syndrome (IBS)
- Chronic Fatigue Syndrome (CFS)
- Fibromyalgia
- Tempero-mandibular joint syndrome (TMJ)
- Headache
- Anxiety
- Depression
Provoked Vestibulodynia: Diagnosis

- Pain mapping
- KOH suspension for candida
  - If negative, culture and speciate
- That’s it!!!...
- In the absence of lesions, no role for
  - Vestibular or vulvar biopsy
  - HPV screening (Hybrid Capture)
  - HSV culture or antibody testing

Provoked Vestibulodynia: Management

Ineffective Therapies

- Antifungals
- Topical or systemic antibiotics
- Antivirals (acyclovir)
- Dietary restriction of oxalates
- Interferon injections
- Laser therapy
PVD: A Stepwise Approach to Treatment

1. Vulvar skin care measures
2. Local anesthetics: episodic and overnight
3. Steroids
   - Medium/high potency steroid + topical estrogen
   - Intralesional TAC 0.1% (40 mg) + bupivicaine each month
4. Physical therapy and biofeedback
5. Neuropathic pain medications
   - Tricyclic antidepressants
   - Anti-seizure drugs
6. Surgery: Vestibulectomy
General Vulvar Care Measures

- Wear loose fitting clothing
- 100% cotton underwear daytime; none sleeping
  - Rinse underwear twice
  - Low irritant soap; no use of fabric softeners
- 100% cotton menstrual pads (www.gladrags.com)
- Mild bathing soaps: Cetaphil, Kiss-My-Face, Basis (or none)
- Vulvar water rinse (or very soft toilet paper)
  - Pat vulva dry; avoid hairdryer
  - Vulvar emollient: vegetable oil, petrolatum
- Vaginal lubricants: Astroglide, KY Liquid, vegetable oil
Vulvar Pain Measures

- **Acute pain:** cold gel pack applied to vulva
- **Episodic relief** (20 minutes before intercourse)
  - Lidocaine 5% ointment or 2% jelly
  - Lidocaine 5% anorectal cream
  - EMLA cream (lidocaine 2.5% + prilocaine 2.5%)
  - Dispense 30 gm tube; limit to 2.5 gm/application
  - Avoid oral contact of partner
- **Treatment of PVD:** overnight topical anesthetics
  - Apply ½ teaspoon of lidocaine ointment to cotton ball
  - Insert at introitus at bedtime; remove in morning
  - Treat for up to 3 months
Vulvar Pain Measures

• Topical sedatives for relief if itching
  – Doxepin (Zonalon) 5% cream
  – Start once a day, then work up

• Systemic neuropathic pain medications
  – Tricyclics: amitriptyline (10-25 mg) 2 hours before bedtime
    • Nortriptyline, desipramine have fewer side effects
  – Other neuropathic pain medications
    • Gabapentin (Neurontin)
    • Topiramate (Topamax)
    • Duloxetine (Cymbalta)
    • Venlafaxine (Effexor)
Tricyclics for Vulvar Pain

- Must take daily, not “as needed”
- May take weeks to “kick-in”
- May have good days and bad days, even with tx
- Start at low dose, then work up every week
  - Start with 10 mg...progress to 100-150 mg.
- Because of sedation, dry mouth, take at bedtime
  - If excessively tired in am, take after dinner
- Once pain is controlled, slowly taper
  - If too fast, get bounce-back pain, nausea, fatigue
Provoked Vestibulodynia: Treatments

• **Woodruff”s vestibulectomy** (perineoplasty)
  – Surgical excision of entire vestibule, with undermining of vagina and “pull through” to cover excision site
  – 70-89% cure rate
  – Adverse effects
    • 1 month recovery
    • May mildly disfigure vulva
  – Considered “treatment of choice” only when medications have failed, but could be used earlier in some cases
Generalized Vulvodynia

• Pudendal neuralgia is likely cause
• Seen mainly in older women

• **Presentation**
  – Poorly localized pain; diffuse and variable hypersensitivity
  – May cause constant, unremitting burning
  – Altered perception to light touch
  – Vulva and introitus appear normal
  – No effect of topical lidocaine

• **Treatment**
  – TCA (amitriptyline), gabapentin, topirimate
  – Anti-pruritics
### Vulvodynia...Differences

<table>
<thead>
<tr>
<th></th>
<th>Vestibulitis</th>
<th>Neuralgia</th>
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<tbody>
<tr>
<td><strong>Location</strong></td>
<td>Vestibule</td>
<td>Labia, perineum, periclitoral</td>
</tr>
<tr>
<td><strong>Frequency</strong></td>
<td>Cyclic, varies</td>
<td>Constant</td>
</tr>
<tr>
<td><strong>Made worse</strong></td>
<td>Intercourse, tampons, tight pants, biking</td>
<td>Sitting, tight garments</td>
</tr>
<tr>
<td><strong>Improved</strong></td>
<td>No provocation</td>
<td>Loose clothes, limited sitting</td>
</tr>
<tr>
<td><strong>Treatment</strong></td>
<td>Medical, surgical</td>
<td>Medical only</td>
</tr>
</tbody>
</table>

Dr Baggish Clinical ObGyn Newsletter
V Book chapters...
“It Hurts”
“Sexual Healing”

- www.thevbook.com
Vulvodynia Management Guidelines

- www.jlgtd.com
  - Links and Resources
    • ASCCP guidelines
    • The Vulvodynia Guideline
Patient Resources

- International Society for the Study of Vulvovaginal Disease: www.issvd.org
- National Vulvodynia Association: www.nva.org
- Vulvar Pain Foundation: www.vulvarpainfoundation.org
- Interstitial Cystitis Association: www.ichelp.org
- American Physical Therapay Association: apta.org
- Office of Research on Women's Health
- www.orwh.od.nih.gov/health/vulvodynia.html
References


References

- ACOG Practice Bulletin #93. Diagnosis and Management of Vulvar Skin Disorders. Ob Gynecol 2008;111 (5);1243-1253
Appendix
2011 ISSVD Terminology and Classification of Vulvar Dermatological Disorders: An Approach to Clinical Diagnosis

• Step 1: Define the lesion by choosing one or more nouns
  – Blister, nodule, macule, papule, plaque, rash, etc.
• Step 2: Choose appropriate adjectives to modify the noun
  – Color, surface, margination, configuration
• Step 3: Formulate a list of differential dx from 8 groups
• Step 4: Reduce the number to 2-3 possibilities
• Step 5: Confirm the diagnosis
### 2011 ISSVD Terminology and Classification

<table>
<thead>
<tr>
<th>Lesion</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Skin colored lesions</strong></td>
<td></td>
</tr>
<tr>
<td>• Papules and nodules</td>
<td>• Molluscum, warts, cysts</td>
</tr>
<tr>
<td>• Plaques</td>
<td>• LSC, VIN</td>
</tr>
<tr>
<td><strong>Red lesions: patches, plaques</strong></td>
<td></td>
</tr>
<tr>
<td>• Eczematous and lichenified</td>
<td>• LSC, contact dermatitis</td>
</tr>
<tr>
<td>• Red patches and plaques</td>
<td>• Candiasis, psoriasis, VIN</td>
</tr>
<tr>
<td><strong>Red lesions: papules, nodules</strong></td>
<td></td>
</tr>
<tr>
<td>• Papules</td>
<td>• Angiokeratoma, H. suppurativa</td>
</tr>
<tr>
<td>• Nodules</td>
<td>• Furuncles, VIN</td>
</tr>
<tr>
<td><strong>White lesions</strong></td>
<td></td>
</tr>
<tr>
<td>• Papules and nodules</td>
<td>• Fordyce spots, VIN, epidermal cyst</td>
</tr>
<tr>
<td>• Patches and plaques</td>
<td>• Vitiligo, post-inflammation$_n$, LS, LP, VIN</td>
</tr>
<tr>
<td>Lesion</td>
<td>Example</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>----------------------------------------------</td>
</tr>
<tr>
<td>Dark colored lesion</td>
<td>• Nevus, melanosis, LP, VIN</td>
</tr>
<tr>
<td>• Patches</td>
<td>• Nevus, VIN, warts, seb keratosis</td>
</tr>
<tr>
<td>• Papules and nodules</td>
<td></td>
</tr>
<tr>
<td>Blisters</td>
<td>• Herpes, acute eczema, LS</td>
</tr>
<tr>
<td>• Vesicles, bullae</td>
<td>• Candidiasis, folliculitis</td>
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<tr>
<td>• Pustules</td>
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<tr>
<td>Erosions and ulcers</td>
<td>• Erosive LP, fissures, VIN, Paget’s</td>
</tr>
<tr>
<td>• Erosions</td>
<td>• Excoriations, apthae, Crohn dz, 1º syphilis</td>
</tr>
<tr>
<td>• Ulcers</td>
<td></td>
</tr>
<tr>
<td>Edema</td>
<td>• Crohn dz, post-radiation, post-infection</td>
</tr>
<tr>
<td>• Skin colored</td>
<td>• Venous obstruction, Cellulitis, BD abscess</td>
</tr>
<tr>
<td>• Pink or red edema</td>
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</tbody>
</table>
1. An adequate pain history should be taken to assess the degree of symptoms and the impact on the woman
   - Assign subgroup according to the ISSVD definitions
   - If sexual pain, identify nature of sexual dysfunction

2. The diagnosis of vulvodynia is clinical

3. A team approach may be necessary to address the different components of vulvodynia
   - Triage patients and refer to others who have a role: psychosexual med, physiotherapy, pain management
UK Guidelines for the Management of Vulvodynia (2010)

4. Patients should be given an adequate explanation of their diagnosis, relevant written information
   – Clear instruction on how to take medication

5. Combining treatments should be encouraged

6. Topical agents should be used with caution to avoid the problem of irritancy
   – A trial of local anaesthetic agent may be considered in all vulvodynia subsets
7. Surgical excision of the vestibule may be considered in patients with local provoked vulvodynia (vestibulodynia) after other measures have been tried

- Only a minority of patients may be suitable for surgery
- If surgery is offered, adequate counseling and support should be given both pre- and postoperatively
8. TCAs, e.g. amitriptyline or nortriptyline, are an initial treatment for unprovoked vulvodynia
   – Other drugs may be considered (gabapentin, pregabalin) and can be given in addition to a TCA
9. Intrallesional injections or acupuncture may be considered in the treatment of unprovoked vulvodynia
10. Pelvic floor muscle dysfunction should be addressed in patients with vulvodynia who have sex-related pain