Office Management of Vulvar Conditions

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Disclosures

None
Overview

- Appropriate Vulvar Skin Care/Behavior Modification
- General Principles of Symptom Management
- Medical Management of select conditions
TOOLS

For Clinicians

vulvovaginaldisorders.com

Vulvovaginal Disorders:
An algorithm for basic adult diagnosis and treatment

VulvovaginalDisorders.org
TOOLS
For Patients

- The V Book, by Dr. Elizabeth Stewart
- NVA.org
- ISSVD.org
Vulvar Skin Care

Gentle

Gentle

Gentle
Vulvar Skin Care

FIRST AND FOREMOST

Avoidance (removal) of all irritants, including soaps, shampoos, perfumed laundry detergent, and douching.
Vulvar Skin Care
Vulvar Skin Care

Simple!

- Fingertip washing with warm or cool water and gentle soap on the hair-bearing skin only. Cetaphil or Dove for Sensitive Skin are reasonable options.

- Laundry

- Cotton underwear during the day, none at night.
Vulvar Skin Care

- Menstrual pads, pantyliners and continence pads may be irritating.
- Sexual activity: may consider almond or coconut oil as a lubricant (WITHOUT CONDOMS!)
- Tight clothing against the vulva: pantyhose, Lycra, thongs or wet bathing suits.
Counseling Tip
Vulvovaginal Disorders:
An algorithm for basic adult diagnosis and treatment

VULVAR DIAGRAM

NOTES
Counseling Tip

PATIENCE is a must for both symptom relief and treatment. Many women give up, stop treatment or worse, resume use of irritants when symptoms return or when they don’t see quick results.
Counseling Tip

Progress is rarely linear.
Symptom Relief

General Principles

- Remove all irritants/tight clothing
- Improve Barrier Function with “Soak and Seal”
- Reduce Inflammation
- Reduce Itch
- Reduce Pain
Symptom Relief

Itching

- Topical Agents: Lidocaine 5% OR Lidocaine 2.5%/Prilocaine (EMLA)
- Oral Agents: antihistamines at bedtime
Symptom Relief
Pain

- Ice/Gel Packs

- Topical Agents (lidocaine, lido/prilocaine, various compounded regimens)

- Oral Agents (Tricyclic Antidepressants, Anticonvulsants, Selective Norepinephrine Reuptake Inhibitors)
## Symptom Relief

<table>
<thead>
<tr>
<th>Class</th>
<th>Generic Name</th>
<th>Brand Name</th>
<th>Dose/Frequency/Route</th>
<th>Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Topical Analgesic/Anesthetics</td>
<td>lidocaine 5% Ointment</td>
<td></td>
<td>Apply ½ inch – 1 inch ribbon (1/2 – 1 gram) 3-5 times/day</td>
<td>Ointment is preferable, as it tends to be less irritating. Instruct women to use a small “test spot” first. Lidocaine can be compounded in a neutral/non-irritating base.</td>
</tr>
<tr>
<td>Topical Analgesic/Anesthetics</td>
<td>lidocaine 2.5% with Prilocaine 2.5%</td>
<td>Emla</td>
<td>Apply ½ inch- 1 inch ribbon, 3-5 times/day</td>
<td>See lidocaine considerations. Prilocaine enhances the effectiveness of lidocaine but may increase initial burning sensations. A test spot prior to use is indicated.</td>
</tr>
<tr>
<td>Tricyclic Antidepressants</td>
<td>amitriptyline, nortriptyline, desipramine and others</td>
<td>Elavil, Pamelor, Norpramin and others</td>
<td>Start at 10 mg po, qhs. Slowly titrate up, by 10 mg q 3-5 days as tolerated.</td>
<td>Maximum dose is 150 mg, but many women experience improvement at lower doses. Educate patients about anticholinergic side effects. Monitor for signs/symptoms of serotonin syndrome. Tricyclics may be contraindicated with other medications.</td>
</tr>
<tr>
<td>Anticonvulsants</td>
<td>gabapentin or pregabalin</td>
<td>a)Neurontin or b) Lyrica</td>
<td>a)Start at 100 mg, po, qhs. Slowly titrate up by 100, q 3-5 days. b)Start at 50 mg, slowly titrated up by 50 mg q 3-5 days as tolerated.</td>
<td>Both are off-label for vulvar pain/vulvodynia, but are effective for neuropathic pain. Gabapentin maximum dose is 3600 mg and should be divided into a tid regimen. Educate patients about sedation. There are very few medication interactions. Pregabalin should be divided as a tid regimen. Maximum dosing is 300 mg/day.</td>
</tr>
<tr>
<td>Selective Norepinephrine Reuptake Inhibitors</td>
<td>venlafaxine or duloxetine</td>
<td>Effexor or Cymbalta</td>
<td>a)37.5 mg, slowly titrated up by 37.5 mg increments b)20 mg, slowly titrated up by 20 mg increments</td>
<td>Both are off-label for vulvar pain/vulvodynia but have been studied for neuropathic pain. Venlafaxine maximum dose is 375 mg. Duloxetine maximum dose is 60 mg.</td>
</tr>
</tbody>
</table>
Pelvic floor dysfunction is VERY common in women with other vulvovaginal conditions. The pelvic floor musculature responds to pain by contracting, resulting in a secondary source of pain.
Pelvic Floor Dysfunction

Women may describe itching, burning, tightness, lancinating pain, pain with or without penetration.

Physical therapy has proven to be enormously successful in helping women learn to relax the pelvic floor muscles.
Medical Management of Select Conditions

- Lichen Sclerosus/Lichen Planus, Lichen Simplex Chronicus
- Candida
- Psoriasis
- Ulcerative Conditions
- Contact Dermatitis
Lichen Sclerosus/Lichen Planus/Lichen Simplex Chronicus

- Medical treatment is the same for both LS and LP, and similar for LSC. The differences include length of treatment of choice of topical steroid.
- Patient Education: these conditions are managed, not cured.
- Regular evaluation of the skin
Lichen Sclerosus/Lichen Planus/Lichen Simplex Chronicus

THE HALLMARK OF TREATMENT FOR LS/LP/LSC IS TOPICAL STEROIDS!
A word about steroids...

- Many clinicians are reluctant to prescribe long-term steroid use for the vulvar skin. However, the mucous membranes of the vulvar skin is uniquely adaptable to even superpotent steroids with its rapid mitotic rate.

- Hair-bearing vs non hair-bearing skin

- Impact on local immunity!
General principles of dermatologic therapy and topical corticosteroid use

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Contributor Disclosures

All topics are updated as new evidence becomes available and our peer review process is complete.

Literature review current through: Jul 2017 | This topic last updated: Mar 29, 2016.

GENERAL PRINCIPLES — The success of dermatologic therapies is dependent upon many factors. General issues related to topical therapies will be reviewed here with a particular emphasis upon the use of topical corticosteroids.

There are five components to the successful use of topical therapies:

- Correct diagnosis
- Type of lesion being treated
- Medication
- Vehicle (the base in which the active medication is delivered)
- Method used to apply the medication

The type of lesion being treated is important. In acute contact dermatitis from poison ivy with moist weeping lesions, wet dressing changes or lotions will help "dry up" the dermatitis while providing cool, soothing relief. Thus, for acute exudative dermatoses, bland treatments in liquid vehicles (e.g., lotions) are generally recommended. In contrast, when treating chronic psoriasis, therapeutic agents incorporated into creams or ointments may help to retain native moisture and provide relief to dry, pruritic skin.
Comparison of representative topical corticosteroid preparations (classified according to the US system)

<table>
<thead>
<tr>
<th>Potency group* (group 1)</th>
<th>Corticosteroid</th>
<th>Vehicle type/form</th>
<th>Trade names (United States)</th>
<th>Available strength(s), percent (except as noted)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Super-high potency</td>
<td>Betamethasone dipropionate, augmented</td>
<td>Ointment, optimized</td>
<td>Diprolene</td>
<td>0.05</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lotion</td>
<td>Diprolene</td>
<td>0.05</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Gel</td>
<td>Diprolene</td>
<td>0.05</td>
</tr>
<tr>
<td></td>
<td>Cloobetasol propionate</td>
<td>Ointment</td>
<td>Temovate</td>
<td>0.05</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cream</td>
<td>Temovate</td>
<td>0.05</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cream, emollient base</td>
<td>Temovate E</td>
<td>0.05</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Gel</td>
<td>Temovate</td>
<td>0.05</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lotion</td>
<td>Clobex</td>
<td>0.05</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Foam aerosol</td>
<td>Olux-E</td>
<td>0.05</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Foam aerosol (scalp)</td>
<td>Olux</td>
<td>0.05</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Shampoo</td>
<td>Clobex</td>
<td>0.05</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Solution (scalp)</td>
<td>Temovate, Cormax</td>
<td>0.05</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Spray aerosol</td>
<td>Clobex</td>
<td>0.05</td>
</tr>
<tr>
<td></td>
<td>Diflucortolone valerate (not available in United States)</td>
<td>Ointment, oily cream</td>
<td>Nersone Forte (United Kingdom, others)</td>
<td>0.3</td>
</tr>
</tbody>
</table>
Lichen Sclerosus/Lichen Planus/Lichen Simplex Chronicus

Superpotent Steroid Ointment

- Ointment is recommended
- There is no universal regimen
- Regular evaluation
- Lifelong treatment
- No cure!
One of the biggest mistakes patients and providers make is stopping treatment when symptoms resolve.
There is a known risk between LS and SCC (approx 3-5%). Studies are showing that long-term steroid use and regular follow-up are reducing incidence of SCC occurrence.

Lichen Sclerosus/Lichen Planus/Lichen Simplex Chronicus
Superpotent Steroid Patient Education

- Test spot
- “A little goes a long way.”
- If symptoms worsen/return, return for evaluation.
- LONG-TERM TREATMENT!
- Non-hair bearing vs. hair-bearing: use visual aids!
Application of Steroid
Application of Steroid
Application of Steroid
Application of Multiple Meds
Lichen Sclerosus/Lichen Planus

Alternate Treatment Options

- Compounding, for those who don’t tolerate commercial preparations.
- Topical calcineurin inhibitors (may cause burning)
- Intralesional injections of triamcinolone
- Systemic triamcinolone
- Lichenoid Drug Eruptions
Candidiasis

Controllable risk factors:

- antibiotic use
- diabetes mellitus
- immunosuppressant medication
- vaginal estrogen
- tight or wet clothing
- pad use
Candidiasis

Other risk factors:

hormonal birth control
male colonization?
Candidiasis

Topical Azoles

- Topical azoles may be very irritating!
- Clotrimazole tends to be the least irritating.
- OTC: 1% vs 2% (7 day vs 3 day course).
- May be compounded (weekly dosing) for recurrent yeast:
  - 200 mg clotrimazole suppositories
  - 500 mg clotrimazole suppositories
- CAUTION with higher doses.
Candidiasis
Oral Medication

- Fluconazole for Candida albicans, 150 mg
  1-2 doses (3-4 days apart)
- Fluconazole contraindications:
  - pregnancy
  - medications
- Recurrent yeast:
  - identify the cause
  - weekly dosing
Candidiasis

➢ NON-albicans regimens:
   Boric acid suppositories, 600 mg, pv qhs x 14 days

➢ Recurrent non-albicans regimens:
   Boric acid suppositories, 600 mg qhs pv x 14 day PLUS
   nystatin cream, 100,000 units, pv x 21 days
   OR
   flucytosine cream 10%, 5 grams intravaginally for 14 days,
   OR Amphotericin B compounded suppositories, 50 mg
   intravaginally nightly for 14 days
Psoriasis

- Hallmark of treatment is topical steroids.

- Intermittent treatment will likely be necessary.

- Numerous treatments for NON-vulvar psoriasis are not appropriate for the vulva.
Psoriasis

- Mild to moderate disease: mod potency, i.e. triamcinolone 0.1% ointment or desonide ointment, 0.05%

- For moderate to severe disease: clobetasol or halobetasol ointment for a very limited course.

- Referral to derm for unresponsive disease
Ulcerative Conditions

Aphtha

Herpes
Apthae

Most effective approach is pain/discomfort control.

- Soaks, loose clothing, elimination of irritants
- Topical lidocaine 5% ointment
- Oral NSAIDS or oxycodone/acetaminophen
Apthous Ulcers

Treatment approaches are not always effective.

- 5% amlexanox oral paste applied to vulva QID
- Antiinflammatory action with topical, oral or intralesional steroid
- Colchicine 0.6 mg bid for prophylaxis or at initial symptom onset
Herpes

Comfort Measures

- Soaks, reduction of tight clothing
- Lidocaine or Lidocaine/Prilocaine
Herpes

Primary Outbreak

- Valacyclovir: 1g orally qd or bid x 7 days
- Famciclovir: 250 mg tid x 7 days
- Acyclovir: 400 mg tid or 200 mg 5x/day
Herpes

Intermittent Treatment of Outbreaks

- Valacyclovir: 500 mg bid x 3 days or 1 gram x 5 days
- Famciclovir: 1000mg bid x 1 day or 125 mg bid for 5 days
- Acyclovir: 800 mg tid x 3 days or 800 mg bid for 5 days
Herpes Suppression

- Acyclovir: 400 mg twice daily
- Famciclovir: 250 mg bid
- Valacyclovir: 500 mg qd OR 1 gram qd
Contact Dermatitis

The hallmark of treatment is to remove offenders!
Contact Derm Offenders

- Hygiene products
- Hair removal
- Sexual aides
- Laundry
- Menstrual products
- Incontinence pads
- Clothing
- Bodily Fluids
- Products designed for vulvar use
- Natural remedies
Day Pads

Perfect for daytime use, GladRags Day Pads consist of a holder and two inserts. This unique three part design allows you to customize the absorbency of the pad according to your flow by choosing one or both inserts. With both inserts, the Day Pad is the equivalent of an average disposable maxi pad. You can even add a third insert and make it a super maxi, or wear just a holder for an ultra-thin liner. Our Day Pad is equivalent to a standard-size maxi pad. Our Day Pad Plus features additional length for an extended coverage area.

<table>
<thead>
<tr>
<th>Product</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cloth Pad Club</td>
<td>$14.99</td>
</tr>
<tr>
<td>Color Day Pad</td>
<td>$14.99</td>
</tr>
<tr>
<td>Color Day Pad Plus</td>
<td>$16.99</td>
</tr>
<tr>
<td>Organic Day Pad</td>
<td>$18.99</td>
</tr>
</tbody>
</table>
Contact Dermatitis

- Remove offenders
- Soak and Seal (Vaseline, Aquaphor, coconut or almond oil)
- Topical steroid ointment (low potency)
- Treat superimposed infection (and cover for yeast)
58 year old with Type 2 Diabetes

- Presented with 18 months of vulvar itching, burning and contact dysuria, with increasing severity over the course of the previous few months, especially worse at night, awakening her q 45 minutes. Treatments attempted: Monistat, Boric Acid, Fluconazole, Vagisil sometimes q 45 minutes
- Morbidly obese, had gastric bypass in 2004
- HTN (amlodipine), hyperlipidemia (Simvastatin)
- Type 2 Diabetes (dx 25 years prior, started with oral meds, now on insulin – most recent Hgb A1C was 8.3 down from 10.4)
- No pain with intercourse but with loss of libido secondary to symptoms.
SUMMARY

Make your patient more comfortable!

- Reduce pain
- Reduce scratching/itching: antihistamines
- Get rid of all possible irritants
- Improve/restore barrier function of the skin
SUMMARY

- Reassurance
- Patience
- Small steps are better than no steps
Summary

*Small steps are better than no steps*

(and progress is not always linear!)
Pearls

- Biopsy!!
- Be familiar with a variety of steroid strengths.
- Topicals can irritate.
- Intraleional Kenalog
Pearls

- Reevaluate regularly (4 weeks, 2 months, 4 months, 6 months)

- For “failed” treatment consider North American Series Patch testing
Pearls

- Refer tough cases to vulvar specialists
- PT for secondary pain
- Consider compounding for non-traditional dosing, topical pain combinations or for patients who are unable to tolerate commercial preparations.
Provider Resources

vulvovaginaldisorders.com

ISSVD.org  The International Society for the Study or Vulvovaginal Disease

NVA.org  National Vulvodynia Association

“Your Diagnosis is…” Drs. Lynette Margesson and Hope Haefner (There are several versions of this very informative learning tool and presentation.  Google it for different options.)
Patient Resources


ISSVD.org The International Society for the Study or Vulvovaginal Disease

NVA.org National Vulvodynia Association


References


References


Questions?

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