Common Chronic Vulvar Itching Causes and Therapy
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**DISCLOSURES**
None

**DISCLAIMERS**
Most medications discussed in this lecture are not FDA approved for these diseases. For example, there are NO topical corticosteroids formulated for the vagina. These are common, but orphan, diseases, with very little adequate research.

WEBSITE for handouts, etc
WWW.libbyedwardsmd.com

**OBJECTIVES**
Develop a comprehensive differential diagnosis and implement an effective treatment plan to manage all factors of chronic vulvar itching

Assess patient’s behavior-change potential and discuss prevention strategies to develop individualized risk-reduction plans with the patient.

**ITCH VS IRRITATION/BURNING/RAWNESS**
- An itch that needs scratching
- Often, feels good to rub or scratch initially
- Rubbing and scratching perpetuate/worsen the condition

**ACUTE ITCHING**
- Candidiasis
- Candidiasis
- Irritant contact dermatitis
- Trichomonas
- HSV

**CHRONIC ITCHING**
is rarely infection
- Lichen simplex chronicus (eczema/atopic dermatitis/neurodermatitis)
- Lichen sclerosus
- Lichen planus (itch and pain/burning)
- Contact dermatitis
- Psoriasis
- Anxiety/depression
Lichen Simplex Chronicus (localized, thickened eczema)

Lichen Simplex Chronicus
The itch that rashes
- About 20% of people feel itching when the skin is irritated, and the vulva is regularly irritated by heat, sweat, urine, sex, friction
  - They rub/scratch
  - It feels WONDERFUL
  - Rubbing/scratching irritates more
  - Itching increases
  - Rubbing increases

Lichen Simplex Chronicus
- The Itch-Scratch cycle is born
- Eventually, this often is stopped by pain of scratching
- Then restarts when pain improves, patient is stressed, nighttime, more irritation
- The rash is from the rubbing

The skin findings are produced by the rubbing and scratching
Thick skin looks white when wet

**THERAPY OF LSC**
(and LS, and LP, and contact dermatitis, and psoriasis)

- Patient education, handouts
- Eliminate irritants (including unnecessary topical agents, soap, panty liners – good luck with that)
- Stop nighttime scratching with sedation
- Ultrapotent corticosteroids (clobetasol) ointment bid and follow-up in a month – don’t stop it too soon
- Search for and treat infections

Baseline  Month 1  Month 2

**LICHEN SCLEROSUS (LS)**
LICHEN SCLEROSUS

- Pruritic skin disease diagnosed most often on vulva of postmenopausal women (*rare)
- Common
- Probably multifactorial etiology
  - autoimmune; associated with vitiligo and hypothyroidism
  - familial tendency
  - environmental
  - hormonal

LICHEN SCLEROSUS
variable morphology

- White, crinkled plaques are classic, but other textures are seen

Crinkled
Waxy
Smooth, shiny
Keratotic

LICHEN SCLEROSUS morphology

- Often begins periclitiorally
- Likes the perineal body
- Likes perianal skin in women
- Doesn’t like mucous membrane (vestibule, vagina, rectal mucosa)

Purpura

Erosions

Pain & dyspareunia

Late disease scars
**LICHEN SCLEROSUS**

Diagnosis

Morphology, confirmed by biopsy or photo, because:

Clinical signs resolve with treatment, and the patient and future clinicians disbelieve the diagnosis and stop therapy.

Treatment is:

not testosterone

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**LICHEN SCLEROSUS THERAPY**

1) Ultrapotent corticosteroid ointment
2) Ultrapotent corticosteroid ointment
3) Ultrapotent corticosteroid ointment

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**LICHEN SCLEROSUS Therapy**

- Differs from that of LSC because it is never stopped
- Superpotent corticosteroid ointment (clobetasol) 1-2X/day until texture is normal
- Then change to midpotency daily
- Or superpotent thrice weekly

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**LICHEN SCLEROSUS THERAPY**

Don’t treat according to symptoms
LIKE FOR LSC, LP, CONTACT DERMATITIS, AND PSORIASIS also important

- Patient education re: chronic nature, prognosis, side effects of therapy, and risk for SCC
- Infection control
- Topical estrogen
- Irritants, contactants

Issue – keratotic LS

LICHEN PLANUS (often more of a rawness or pain issue)

Vaginal photo courtesy of Dr Gordon Davis
Oral disease is usual with LP

CONTACT DERMATITIS

• Irritant contact (common)
  – occurs to anyone exposed to irritating substances
  – urine, diarrhea, creams, over-washing, wart meds
  – often producing more irritant/ rawness/ pain symptoms

• Allergic contact dermatitis (uncommon)
  – occurs only in individuals sensitized to an allergenic
  – neomycin, diphenhydramine, benzocaine, latex are most common in my office
  – itches

CONTACT DERMATITIS

• Diagnosis
  – by appearance (red plaques, round erosions) and ruling out infection
  – history of likely contactant

• Therapy
  – stop contactant
  – soaks (if severe/weeping)
  – topical steroid ointment, petrolatum
  – night-time sedation

CONTACT DERMATITIS

Allergic contact dermatitis to poison ivy (look before you squat)
**PSORIASIS**

- Fairly common autoimmune condition that results in increased cell turnover, thickened skin and heavy scale
- Often preferentially located in areas of irritation (elbows, knees, genitalia)
- Spares the vestibule and vagina

**INVERSE PSORIASIS**

- Psoriasis occurring primarily in skin folds – genital area, axillae, inframammary skin
- Scale is often inapparent
- Frequent “glazed” appearance
- Often unaccompanied by scalp, elbow, and nail disease

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**Psoriasis vulgaris (common psoriasis)**

Classic well demarcated lesions with dense, silvery scale

More typical shiny, subtle scale
Subtle scale, white maceration

Poorly demarcated, scratched, plaque of psoriasis. Indistinguishable from LSC, irritant contact dermatitis. Even a biopsy may not be diagnostic.

Red plaque of psoriasis with satellite papules, mimicking Candida

Look for typical scalp, elbow, knee psoriasis, nail pits
PSORIASIS
Diagnosis

• Usually a clinical diagnosis by the appearance and the identification of typical extragenital psoriasis
• Biopsy is often non-diagnostic, showing “psoriasiform dermatitis.”
• First-line therapy is the same for psoriasis and LSC/eczema

DIFFERENTIAL DIAGNOSIS
(anything red)

• Contact dermatitis
• Eczema/lichen simplex chronicus
• Candidiasis (superinfection with yeast is common, so + culture doesn’t rule out concomitant psoriasis
• Therapy – as for LSC, LS; if severe, systemic immunosuppressants

THERAPY OF LSC
Not Improving
Normal skin

• Psychological factors
• Neuropathic itch (treat like vulvodynia)

Sometimes

• There is a huge element of anxiety and depression
• Itching has significant psychological components in most
  – for example, a patient in the office with scabies produces immediate itching in all staff members
• Occasionally very hard to address
In Conclusion

• Women with vulvovaginal itching are over treated with medication for Candidiasis and BV
• Diagnosis is by appearance, evaluation of vagina, mouth, and extragenital keratinized skin/nails, and history of contactants
• A biopsy can be useful but is often non-diagnostic

In Conclusion

• Nearly all causes can be successfully managed by ruling out infection, then treating with a super-potent corticosteroid, d/c irritants, nighttime sedation
• Most causes are manageable rather than curable
• Remember LS and LP can produce scarring and SCC

Thank you!