Management of lichen sclerosus and intraepithelial neoplasia of the vulva in the UK

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SUMMARY

Women with vulval intraepithelial neoplasia (VIN), lichen sclerosus (LS) and Paget's disease are referred either to gynaecologists or to dermatologists. We have ascertained the caseloads, referral patterns and treatment modalities used in the two specialties.

A postal questionnaire was sent to 540 consultant gynaecologists and 225 consultant and senior registrar members of the British Association of Dermatologists. 350 gynaecologists and 161 dermatologists returned completed questionnaires. The workload of LS and Paget's disease was evenly distributed, with 54% of dermatologists and 58% of gynaecologists seeing more than six cases of LS per annum and less than 1% seeing more than five cases of Paget's disease. 92% of responding gynaecologists saw at least one case of VIN per year whereas 43% of dermatologists saw no cases. Patients with VIN and Paget's were referred to gynaecologists for treatment by 66% of dermatologists. Both groups are equally prepared to treat LS. Indications for treatment of VIN and LS were suspicion of invasion and symptoms. Local excision of VIN is the treatment of choice by both gynaecologists and dermatologists. LS is predominantly treated with topical steroids but gynaecologists also use topical oestrogen and testosterone.

The great majority of responders favoured establishing a national register to study the outcome of vulval lesions.

INTRODUCTION

Vulval disorders cause substantial gynaecological morbidity. Women with these skin conditions may be referred either to gynaecologists or to dermatologists and the distribution of the caseload is unknown. The methods of treatment and the decision about when to treat patients may vary between the two groups, particularly as there is no overlap in the training in these two specialties. A survey of gynaecologists and dermatologists was undertaken to address these questions.

METHODS

A postal questionnaire was sent to all gynaecologists on the consultant register of the Royal College of Obstetricians & Gynaecologists and all consultants and senior registrars in dermatology who were members of the British Association of Dermatologists. Two questionnaires were sent: one allowed the responder to opt out; the second asked detailed questions on the management of vulval intraepithelial neoplasia (VIN), lichen sclerosus (LS) and Paget's disease of the vulva. The questionnaire addressed several topics, including the number of patients seen each year, the number of patients managed or referred, the proportions of patients with each lesion that were treated and the methods currently used for treatment. The questionnaire also asked for factors that influenced the decision to treat patients with VIN and LS and whether a national register of vulval intraepithelial neoplasia, lichen sclerosus and Paget's disease of the vulva should be established to provide follow-up information about the outcome of each condition. Responses to the questionnaire were entered onto a database at Hammersmith Hospital.

RESULTS

Questionnaires were sent to 540 gynaecologists and 225 dermatologists and completed questionnaires were received from 350 gynaecologists (65%) and 161 dermatologists (72%).

92% of responding gynaecologists saw one or more patients with VIN each year but only 10% saw more than 10

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cases. In contrast, 43% of dermatologists saw no patients with VIN. Unlike VIN, LS was referred equally to both specialties. All dermatologists saw at least one case of LS per year as did 99% of gynaecologists. More than five cases per year were seen by 54% of dermatologists and by 58% of gynaecologists.

Gynaecologists managed 84% of patients with VIN, 93% of patients with LS and 81% of patients with Paget's disease themselves. Some patients (11% of those with VIN and 10% of those with Paget's disease) were referred by gynaecologists to dermatologists.

Dermatologists managed 99% of patients with LS themselves but managed only 27% of women with VIN and 30% of those with Paget's disease themselves. They referred 57% of cases of VIN and 66% of cases of Paget's disease to gynaecologists.

The questionnaire asked responders to rank, in order of importance, those features which would influence the decision to treat the case: symptoms, age, concern about invasion, immunosuppression, history, other genital carcinoma, hormone replacement therapy, infection with human papillomavirus, other (specify). When deciding whether to treat women with VIN both gynaecologists and dermatologists were most concerned about the possibility of invasion (gynaecologists 45%, dermatologists 49%), symptoms (gynaecologists 37%, dermatologists 32%) and the knowledge that the women had suffered from another gynaecological malignancy (gynaecologists 17%, dermatologists 20%).

Symptoms were of greatest concern in women with LS (gynaecologists 59%, dermatologists 61%) followed by suspicion of invasion (gynaecologists 19%, dermatologists 14%). In contrast to dermatologists, gynaecologists also ranked a history of immunosuppression and the presence of human papillomavirus as concerns when deciding to treat women with VIN and LS.

Table 1 **Methods usually used to treat vulval intraepithelial neoplasia**

	Usual	*Never*
Gynaecologists	Local excision	Systemic steroids
	Local ablation	Topical oestrogen or testosterone
	Topical steroids	Retinoids
		Radical surgery
Dermatologists	Local excision	Topical oestrogen or testosterone
	Bland emollients	Systemic steroids
	Topical 5-fluorouracil	Retinoids
		Radical surgery

Table 2 **Methods usually used to treat lichen sclerosus and those never used**

	Usual	*Never*
Gynaecologists	Topical steroids	Systemic steroids
	Sex steroids	Topical 5-fluorouracil
	Bland emollients	Retinoids
Dermatologists	Topical steroids	Systemic steroids
	Bland emollients	Excisional methods
		Topical oestrogen or testosterone

The questionnaire asked about the methods currently used in the treatment of VIN and LS and invited responders to indicate whether the treatment listed was their usual method, whether they used it sometimes or whether they never used it. Tables 1 and 2 show the usual methods of treatment and those treatment modalities never used by the two groups of responders.

Allowance was made for a free-text response to the management of Paget's disease. Few dermatologists treat women with Paget's disease; instead most are referred to gynaecologists but some are referred to general and plastic surgeons. Dermatologists who treat women with Paget's disease favour excision of the lesion but cryotherapy (13%), topical 5-fluorouracil (18%) and retinoids (10%) are also used. Most gynaecologists (73%) also favour excising Paget's disease, and 45% of these use wide local excision. However, 27% of gynaecologists use vulvectomy and two gynaecologists use radical vulvectomy. A small number of gynaecologists and dermatologists, 4% in each group, have never seen a case of Paget's disease.

The great majority of gynaecologists and dermatologists expressed a wish to enter patients with VIN, LS and Paget's disease of the vulva into a national register so that the outcome of these conditions can be studied in greater detail.

CONCLUSIONS

This is the first national survey into the management of VIN, LS and Paget's disease of the vulva in the UK. LS is seen frequently by dermatologists and gynaecologists and both groups commonly manage these cases by themselves. Treatment is offered for the control of symptoms, and topical steroids are the first line of treatment in both groups, but gynaecologists are also likely to use topical oestrogen and testosterone whereas dermatologists prefer bland emollients. Surgical excision of LS is rarely performed.

VIN is treated by both dermatologists and gynaecologists if there is concern about the possibility of invasion or if the woman is symptomatic. Both groups favour the use of surgical treatment and, as a result, most dermatologists refer cases to gynaecologists

for treatment. Topical steroids are also used in the management of VIN. Gynaecologists see more cases of VIN per year than dermatologists—partly, perhaps, because dermatologists refer cases but also because women with vulval pruritus are more likely to be referred by their general practitioner to a gynaecologist than to a dermatologist.

This survey confirms that Paget's disease of the vulva is a rare condition, with both groups seeing only a few patients each year. Most dermatologists refer Paget's disease for treatment to gynaecologists since surgical excision is the most common modality used (because of the risk of coexisting malignancy in apocrine glands.)

This study cannot reveal the factors involved in management of individual patients but some important divergences in practice between gynaecologists and dermatologists have emerged. While it is not appropriate to discuss in detail the reasons for these differences, a closer understanding between the specialties is clearly essential. Multidisciplinary vulva clinics may prove helpful, but only if all the participants are adequately trained and responsive to changes in current practice.

A national register to study the long term outcome of vulval intraepithelial neoplasia, lichen sclerosus and Paget's disease of the vulva should be established.