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# ACOG PRACTICE BULLETIN SUMMARY

Clinical Management Guidelines for Obstetrician–Gynecologists

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**For a comprehensive overview of these recommendations, the full-text version of this Practice Bulletin is available at http://dx.doi.org/10.1097/AOG.0000000000003944.**

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**Committee on Practice Bulletins–Gynecology.** This Practice Bulletin was developed by the Committee on Practice Bulletins–Gynecology in collaboration with Colleen K. Stockdale, MD, MS; Lori A. Boardman MD, ScM; Hope K. Haefner, MD; and Herschel Lawson, MD. ASCCP endorses this document.

# Diagnosis and Management of Vulvar Skin Disorders

*Vulvar skin disorders include a variety of inflammatory conditions of the vulva that also may affect the extragenital area. Pruritus and pain are two of the most common presenting symptoms in vulvar clinics (1). Vulvovaginal symptoms often are chronic and can adversely affect sexual function and sense of well-being. The purpose of this Practice Bulletin is to provide updated diagnostic and management recommendations for the most common vulvar skin conditions associated with inflammation: contact dermatitis, lichen simplex chronicus, lichen sclerosus, and lichen planus. Other vulvovaginal disorders such as vaginitis, vulvar low-grade squamous intraepithelial lesions and vulvar high-grade squamous intraepithelial lesions (previously termed vulvar intraepithelial neoplasia), genitourinary syndrome of menopause (vulvovaginal atrophy), and vulvar pain (vulvodynia) are addressed in other documents from the American College of Obstetricians and Gynecologists (2–6).*

## Clinical Management Questions

- *What is the initial approach to patients with vulvovaginal symptoms?*
- *When and how should a vulvar biopsy be performed?*
- *How is contact dermatitis diagnosed and treated?*
- *How is lichen simplex chronicus diagnosed and treated?*
- *How is lichen sclerosus diagnosed and treated?*
- *How is lichen planus diagnosed and treated?*

# Recommendations

***The following recommendation is based on good and consistent scientific evidence (Level A):***

- A medium-potency or high-potency topical corticosteroid ointment is recommended for the initial treatment of lichen sclerosus.

***The following recommendations are based on limited or inconsistent scientific evidence (Level B):***

- Long-term, individualized topical corticosteroid therapy is recommended to maintain normality of skin color and texture and to prevent scarring in patients with lichen sclerosus.
- For patients with a confirmed diagnosis of lichen sclerosus that does not respond to topical or intralesional corticosteroids or for patients at risk of skin atrophy, topical calcineurin inhibitors (eg, topical tacrolimus or pimecrolimus) can be considered.
- Because oral involvement is common among patients with erosive lichen planus, evaluation of the oral cavity is recommended.
- The recommended initial treatment for lichen planus is a high-potency topical corticosteroid ointment.
- In patients with lichen planus that is resistant to topical corticosteroid therapy, topical calcineurin inhibitors can be considered.

***The following recommendations are based primarily on consensus and expert opinion (Level C):***

- The initial evaluation of patients with vulvovaginal symptoms should include a comprehensive medical history, a physical examination, and evaluation of abnormal vaginal discharge if an infectious etiology is suspected.
- Vulvar biopsy is recommended for visible lesions in any of the following circumstances:
  - lesions are atypical (eg, new pigmentation, indurated, affixed to underlying tissue, bleeding, or ulcerated)
  - there is concern for malignancy
  - lesions in a patient who is immunocompromised (including those infected with HIV)
  - the diagnosis is uncertain
  - lesions do not respond to standard therapy
  - the disease worsens during therapy
- Recommended treatment of contact dermatitis includes patient counseling regarding vulvar care and removal of vulvar irritants and allergens and symptom management with a topical corticosteroid ointment and an oral antipruritic medication as needed.
- The severity and chronicity of contact dermatitis will determine the need for and the potency of the topical corticosteroid chosen for treatment.
- Recommended treatment of lichen simplex chronicus includes patient education on how to stop the "itch-scratch cycle," information regarding vulvar care and hygiene, a medium-potency or high-potency topical corticosteroid ointment, and oral antipruritic medication as needed.
- Monitoring at 3 months following initial therapy for lichen sclerosus is recommended to assess the patient's response to therapy and to ensure proper application of the medication.
- In patients with lichen sclerosus that is poorly controlled or is resistant to topical corticosteroids, intralesional corticosteroid injections can be considered.
- For erosive lichen planus with vaginal involvement, treatment with intravaginal corticosteroids should be considered in addition to topical vulvar treatment.
- In patients with lichen planus, regular use of graded vaginal dilators in conjunction with topical intravaginal corticosteroid therapy is recommended to help prevent vaginal scarring, synechiae, and complete obliteration of the vaginal vault.

# References


1. Hansen A, Carr K, Jensen JT. Characteristics and initial diagnoses in women presenting to a referral center for vulvovaginal disorders in 1996–2000. J Reprod Med 2002;47:854–60. (Level III)
2. Vaginitis in nonpregnant patients. ACOG Practice Bulletin No. 215. American College of Obstetricians and Gynecologists. Obstet Gynecol 2020;135:e1–17. (Level III)
3. Management of vulvar intraepithelial neoplasia. Committee Opinion No. 675. American College of Obstetricians and Gynecologists [published erratum appears in Obstet Gynecol 2017;129:209]. Obstet Gynecol 2016;128:e178–82. (Level III)
4. Management of menopausal symptoms. Practice Bulletin No. 141. American College of Obstetricians and Gynecologists [published errata appear in Obstet Gynecol 2018; 131:604; Obstet Gynecol 2016;127:166]. Obstet Gynecol 2014;123:202–16. (Level III)
5. Female sexual dysfunction. ACOG Practice Bulletin No. 213. American College of Obstetricians and Gynecologists. Obstet Gynecol 2019;134:e1–18. (Level III)
6. Persistent vulvar pain. Committee Opinion No. 673. American College of Obstetricians and Gynecologists. Obstet Gynecol 2016;128:e78–84. (Level III)

The MEDLINE database, the Cochrane Library, and the American College of Obstetricians and Gynecologists' own internal resources and documents were used to conduct a literature search to locate relevant articles published between January 2000–February 2020. The search was restricted to articles published in the English language. Priority was given to articles reporting results of original research, although review articles and commentaries also were consulted. Abstracts of research presented at symposia and scientific conferences were not considered adequate for inclusion in this document. Guidelines published by organizations or institutions such as the National Institutes of Health and the American College of Obstetricians and Gynecologists were reviewed, and additional studies were located by reviewing bibliographies of identified articles. When reliable research was not available, expert opinions from obstetrician–gynecologists were used.

Studies were reviewed and evaluated for quality according to the method outlined by the U.S. Preventive Services Task Force:

- I Evidence obtained from at least one properly designed randomized controlled trial.
- II-1 Evidence obtained from well-designed controlled trials without randomization.
- II-2 Evidence obtained from well-designed cohort or case–control analytic studies, preferably from more than one center or research group.
- II-3 Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments also could be regarded as this type of evidence.
- III Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.

Based on the highest level of evidence found in the data, recommendations are provided and graded according to the following categories:

Level A—Recommendations are based on good and consistent scientific evidence.

Level B—Recommendations are based on limited or inconsistent scientific evidence.

Level C—Recommendations are based primarily on consensus and expert opinion.

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