Optimising management of lichen sclerosus and chronic thrush

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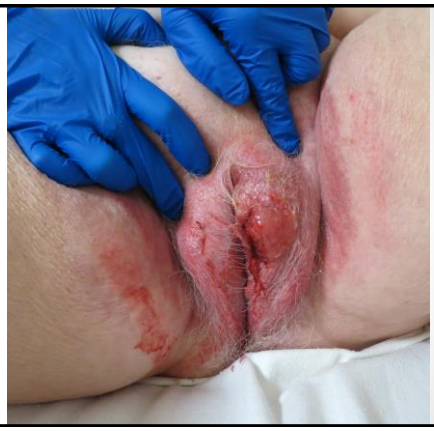
No conflict of interest

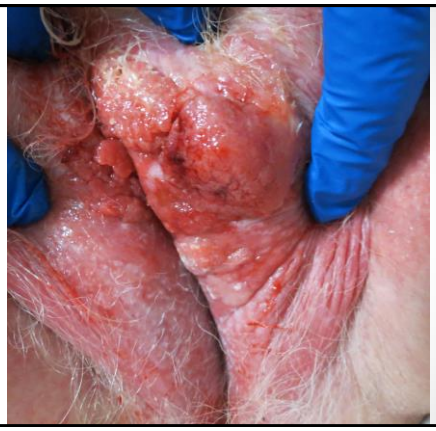
Golden Rules

- Lichen sclerosus is best diagnosed early
- Treatment with potent topical steroids
- works!
- Long-term treatment and follow-up probably decreases cancer risk
- Chronic thrush is due to hypersensitivity to candida albicans
- Longterm oral treatment gives best results

CASE 1

- Mrs VF 48 year-old woman, farmer's wife
- Presented with sore lesion on vulva
- 10 years before had had itchy rash there treated by dermatologist, got better
- Busy on farm, two young children
- Eventually mentioned it to GP, embarrassed





Squamous cell carcinoma with lichen sclerosus

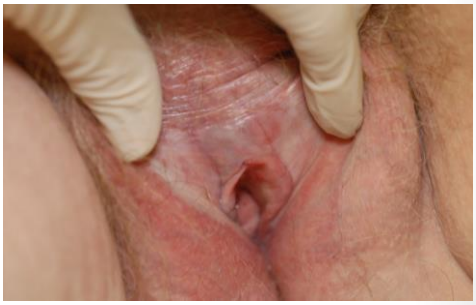
- Surgery and lymph node dissection
- Nodes involved
- Radiotherapy but died 2 years later

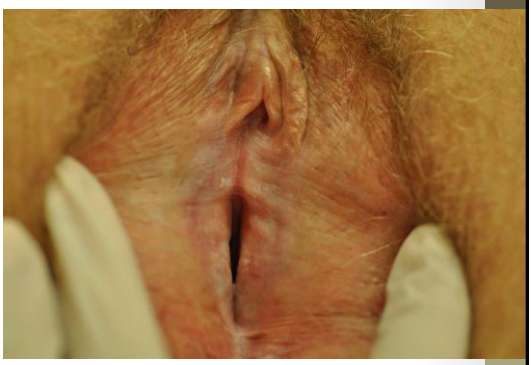
- SCC associated with HPV ?less now
- Lichen sclerosus : 5% SCC
- Does treatment change prognosis?

Case 2 : Mrs JK, 60 year-old lady

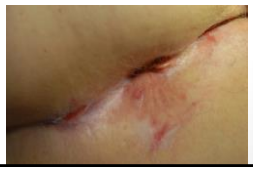
- Itchy vulva for 8 years, waking her at night now
- Treated as thrush : clotrimazole cream, fluconazole
- Treated as atrophic vaginitis : Vagifem
- Intercourse uncomfortable: has stopped last few years.
- Post menopausal, not on HRT

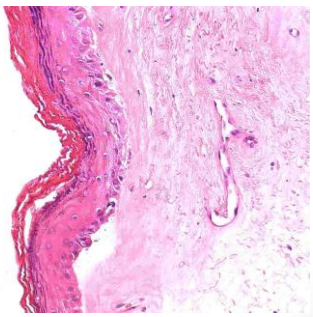
Mrs JK



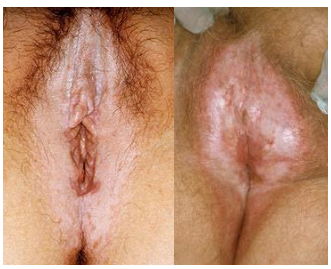


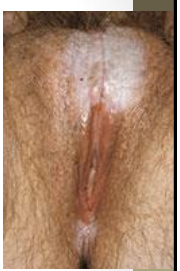
- Mrs JK
- Loss of normal architecture
- White thickened skin over labia majora, perianal area " figure of eight"
- Diagnosis : Lichen sclerosus



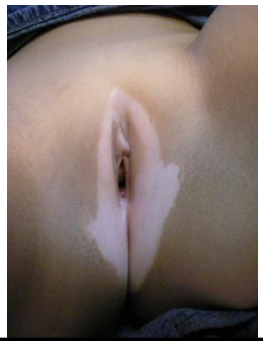


Variations

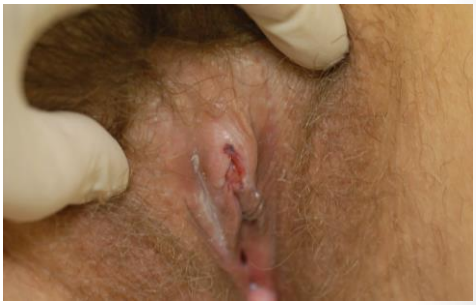




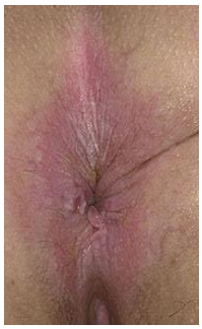
Vitiligo

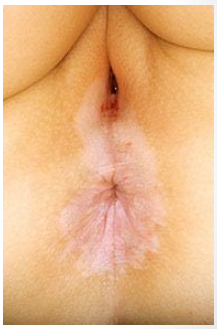


Purpura

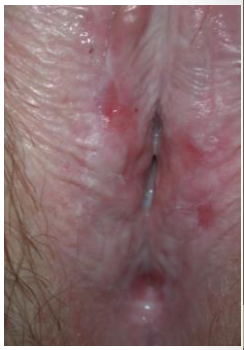


Perianal LS

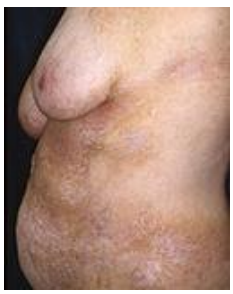




- Erosions
- Severe architectural change
- Post surgery and laser Rx

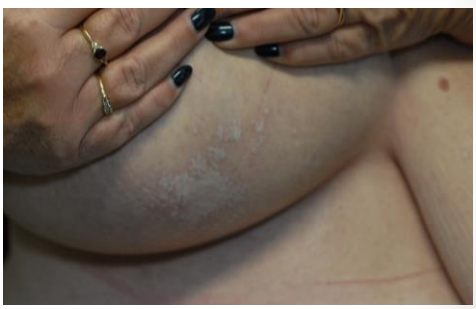


Extra genital lichen sclerosus



- Usually not itchy
- White patches
- Overlap with morphoea

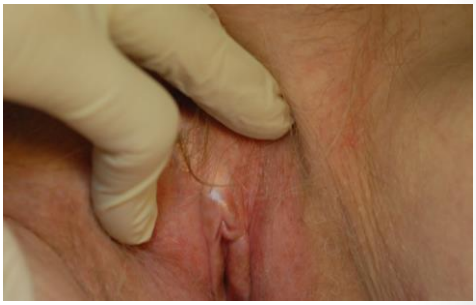
Extragenital lichen sclerosus



Mrs jk : Management

- Biopsy : 3-4mm punch, dissolving suture
- Good skin care
- Diprosone OV or Clobetasol ointment bd for a month, daily for a month then at least 2/week
- Explanation : need strong cream as it needs to penetrate to thick area.
- Review in 3/12
- May change to weaker steroid then
- Long term follow up : 2-5% cancer, probably more if untreated.

Mrs JK



Lichen sclerosus

- Uncommon disease of genital skin
- Prevalence: 3% of female population
- Significant risk (scarring 50%, SCC 5%)
- Autoimmune association: thyroiditis
- Large impact on quality of life
- All age groups including children: mean is 55

Previous treatment guidelines for Lichen Sclerosus (BAD 2010)

- Initial treatment with clobetasol 0.05%
- Then treatment with clobetasol 0.05% to control flares
- 3 visits: presentation, 3/12 and 9/12 then primary care
- Most cases are uncomplicated = <60g clobetasol yearly
- There are no randomised trials to compare treatments
- Risk of SCC is 5% and this is considered "rare".
- It is not known if treatment lessens risk
- Follow up in specialized clinic

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- WHAT WE KNOW

Clobetasol

Patient gets better

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Key questions about Lichen Sclerosus

- Can treatment with topical corticosteroids long-term
  - Reduce CANCER risk?
  - Preserve vulvar ARCHITECTURE?
  - Improve FUNCTION as well as suppress symptoms?
  - Do so without SIDE EFFECTS?

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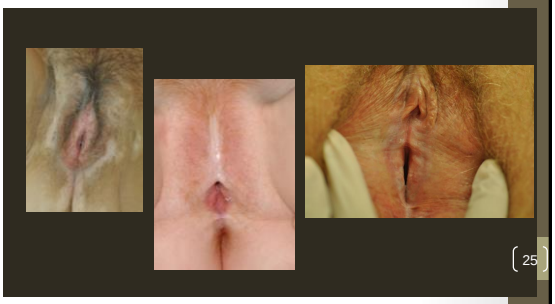
Scarring and loss of vulval architecture



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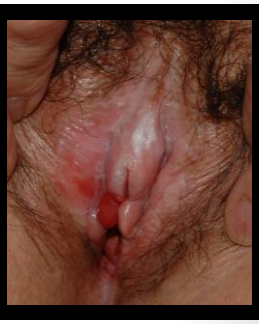
Vulval cancer

Cancer : Untreated 5%



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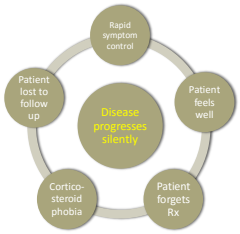
Problems in long-term management



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Latest research

Study aims and Protocol

- Prospective longitudinal cohort study
- 2008-2014
- Intervention: TCS used regularly with follow up
- Induce remission with potent TCS
- Maintain remission with moderate regular TCS
- Titrate to normal skin colour and texture long-term
- Determine outcomes of compliers vs non-compliers

Patient Data

- Patients n = 507 with biopsy proven lichen sclerosus
- Age >18, F/U >2 years
- Compliance: 357 compliant, 150 partially compliant
- Mean age at presentation = 55.4 years (18-86)
- Mean duration of follow up 4.7 years (2.0-6.8)
- Mean duration to onset of neoplasia: 4.2 years

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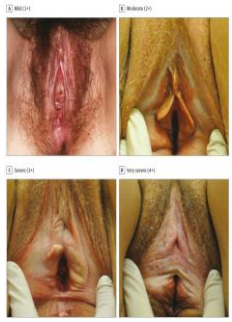
severity



Mild (1+)
TCS strength: **Moderate**

Moderate (2+)
TCS strength: **Super-potent**

Severe (3+)
TCS strength: **Super-potent**

Very severe (4+)
TCS strength: **Ultra-potent**

Choice of induction treatment based on degree

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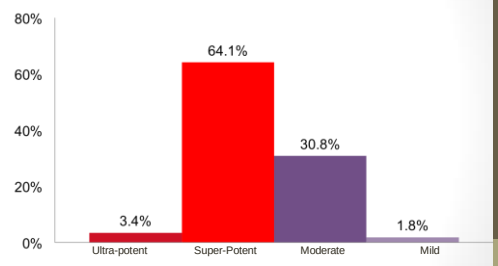

TCS strength used in initial management of VLS

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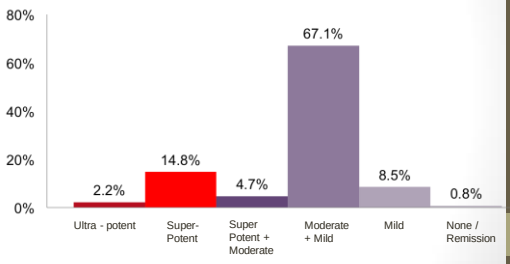
TCS strength used in long-term management of VLS



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Summary of outcomes

	Compliant %	Partially compliant %	*P* value
	N= 357 (70.4)	N= 150 (29.6)	
Symptom resolution	95.3	58	<0.001
Dyspareunia resolution	93.7	65.5	<0.001
Scar progression	3.4	40.0	<0.001
SCC or VIN	0	4.7	<0.001

Is this going to be too expensive?

- Cost of one patient with vulvar cancer

vs

- Cost of regular follow up to prevent cancer

and

- Prevention of morbidity from scarring

NNT to prevent 1 cancer = 21
NNT to prevent scarring = 2.7

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Significance of this research

- This is the first study adequately powered to demonstrate that cancer and scarring can be prevented by regular treatment
- This is now the recommendation in the latest version of Therapeutic Guidelines: Dermatology

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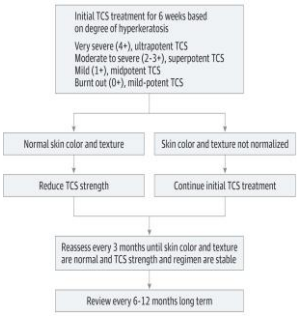

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JAMA Dermatology

The JAMA Network


Long-term Management of Adult Vulvar Lichen Sclerosus
A Prospective Cohort Study of 507 Women

JAMA Dermatology

Andrew Lee, Jennifer Bradford, Gayle Fischer

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Summary: How to treat Lichen Sclerosus

- Start with a confirmatory biopsy and check thryoid
- Induce remission with potent TCS (4-6 months)
- Use preventative treatment ➔ maintain normal skin
- No "as needed" treatment.
- Follow up patients: adjust treatment, encourage compliance
- Titrate TCS to disease severity, response
- Target outcome: normal skin colour and texture.
- Long-term management with TCS is safe, effective
- The course of the disease can be modified by treatment

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Karen, 21 Student

- Itchy, sore, swelling, splitting, discharge, dysuria
- Started after first sexual activity at 19
- Dyspareunia
- Worse before periods and with antibiotics
- Swabs sometimes positive for *C.Albicans* but not consistently
- Partner gets itchy after sex
- Gets almost better with topical and oral antifungals but rapidly recurs

Chronic candidiasis

Jen 52. Menopause at 48. HRT for last 4 years

- For last year itch, dyspareunia, erythema
- No discharge
- Swab +ve for C.albicans
- No response to antifungals
- Continues to take Livial and not keen to stop

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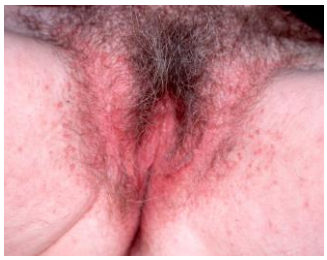

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- *Candida* is a normal commensal of gut and vagina
- Vulvovaginitis from this normal organism is host dependent
- Candidiasis is oestrogen dependent: not seen before menarche and after menopause unless on HRT
- It behaves like a hypersensitivity response to something that is a normal part of the human body
- The threshold for that response is genetic
- In order to suppress the response you need to suppress the antigen for as long as the patient remains hypersensitive

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Diagnosis of chronic thrush

- Clinically a non erosive vulvovaginitis
- Biopsy shows spongiosis
- A low vaginal swab is only +ve in 75% of cases
- pH is normal 4.5
- Office microscopy is time consuming, requires skill that many of us don't have and sensitivity is low
- Take a careful history

History taking in chronic thrush

- Have you ever had a +ve swab for Candida?
- Do your symptoms cycle?
- Do you experience pain with sex?
- Do you get thrush from antibiotics
- Do you experience soreness (itch is non-specific although common)
- Do you have a discharge?
- Do you get better with antifungals?
- Do you experience swelling?

- Hong et al Vulvovaginal candidiasis as a chronic disease: Diagnostic criteria and definition J Lower Genital Tract Disease 2013

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Differential diagnosis of chronic thrush

- Psoriasis
- Oestrogen hypersensitivity vulvovaginitis

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Who gets CVVC?

- Healthy pre-menopausal women mostly
- Majority onset is in late teens – 20's
- Atopic
- Post menopause on HRT who had it before menopause
- Immunosuppressed
- Long term antibiotics
- Mirena
- Diabetics
- Not HIV
- Not children

Impact on quality of life

- CVVC is one of the most devastating vulvovaginal conditions
- Mean DLQI in a cohort of 82 patients was 15 (high impact)
- It affects young, sexually active women
- Major impact on sexuality and activities
- Major impact on clothes

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Managing *Candida*

- Acute candida is easy: topical or stat dose of Diflucan
- Recurrent candida = 4 confirmed attacks per year +ve swabs
- Chronic candida = symptomatic all the time, swabs may be -ve
- Recurrent or chronic candida is very difficult: need prolonged oral antifungal therapy, good skin care and attention to any underlying disease.
- If not better after two courses of antifungals or comes right back: think CVVC

Management of CVVC

- Long term low-dose oral antifungal
- Itraconazole or fluconazole 50-100mg/day for 3 months
- In a group of 82 women mean DLQI went from 15 to 3.4
- Reduce gradually to maintenance dose
- Titrate dose to symptoms
- Treat secondary dermatitis with weak steroid only
- If secondary to HRT, stop it temporarily until recovered then restart under antifungal cover
- ?Depot provera

Long term prognosis of CVVC

- Group of 201 women: 98% still using antifungal treatment, mainly fluconazole, up to 8 years later
- Vulva may always look red even when asymptomatic
- Doses vary from prn to daily
- Most are on 50mg twice a week
- Increase to daily if relapse, antibiotics or travel
- Long-term fluconazole is as safe as long-term valacyclovir
- Fluconazole does not cause drug induced hepatitis
- 95% can tolerate fluconazole long term
- Cost is $30 a month on continuous therapy

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Summary CVVC

- CVVC is a recent concept
- RVVC and CVVC are probably on a spectrum
- This is NOT an infection
- It has a huge impact
- The prognosis is good with long-term suppressive therapy
- Treatment is safe and cost-effective
- This treatment recommendation is now in Therapeutic Guidelines

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Golden Rules

- Lichen sclerosus is best diagnosed early
- Treatment with potent topical steroids works!
- Long-term treatment and follow-up probably decreases cancer risk
- Chronic thrush is due to hypersensitivity to candida albicans
- Longterm oral treatment gives the best outcome