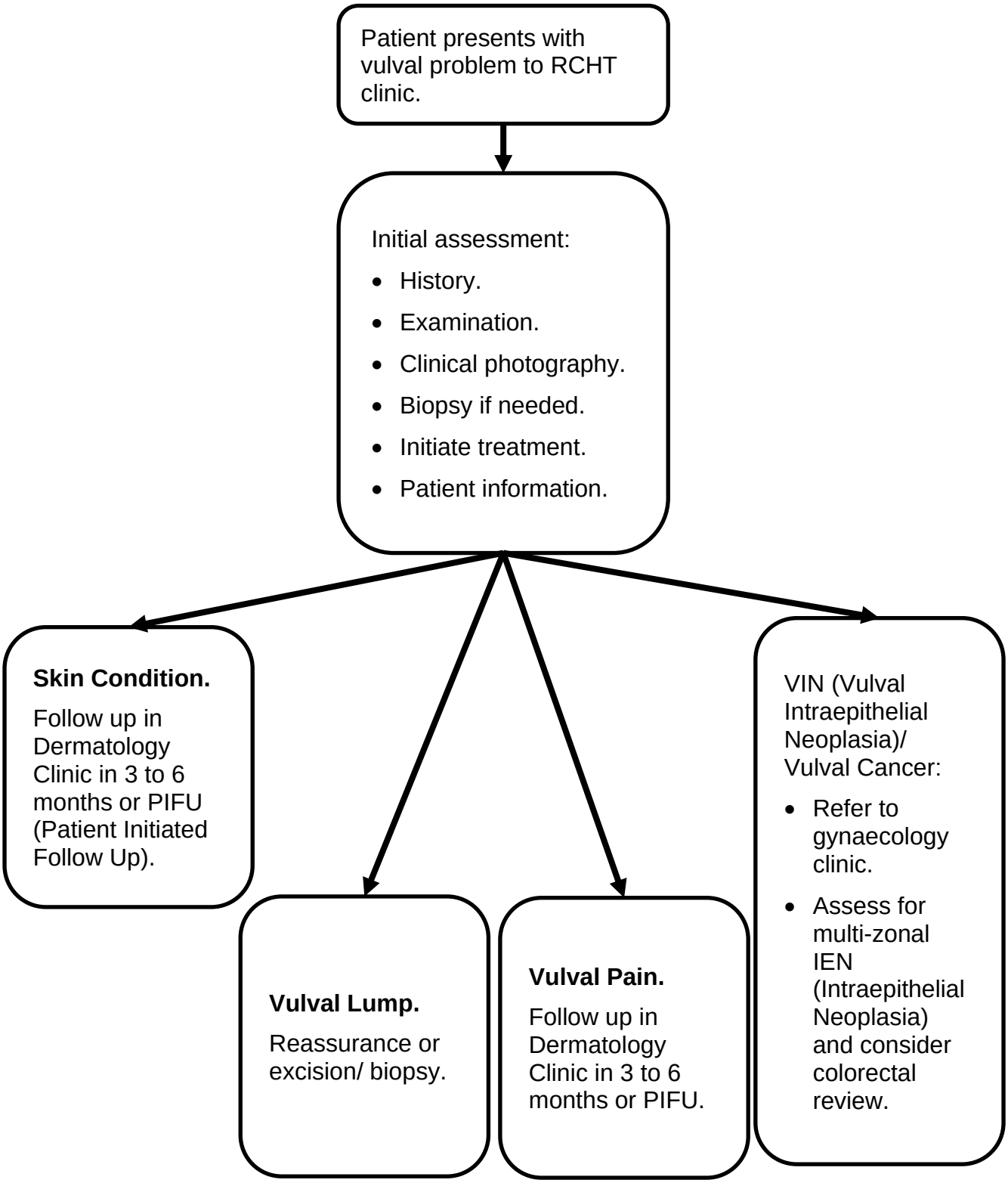
Royal Cornwall Hospitals
NHS Trust

The Initial Management of Benign Vulval Disease

V2.0

January 2025

Summary


Patient presents with vulval problem to RCHT clinic.
Initial assessment:
History.
Examination.
Clinical photography.
Biopsy if needed.
Initiate treatment.
Patient information.
Skin Condition.
Follow up in Dermatology Clinic in 3 to 6 months or PIFU (Patient Initiated Follow Up).
Vulval Lump.
Reassurance or excision/ biopsy.
Vulval Pain.
Follow up in Dermatology Clinic in 3 to 6 months or PIFU.
VIN (Vulval Intraepithelial Neoplasia)/ Vulval Cancer:
Refer to gynaecology clinic.
Assess for multi-zonal IEN (Intraepithelial Neoplasia) and consider colorectal review.

1. Aim/Purpose of this Guideline

1.1. This document is intended to guide clinicians in the assessment and initial management of adults presenting with benign vulval conditions to dermatology or gynaecology clinics.

1.2. This version supersedes any previous versions of this document.

Data Protection Act 2018 (UK General Data Protection Regulation – GDPR) Legislation.

The Trust has a duty under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team.

Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

2. The Guidance

2.1. Assessment of Patients with Vulval Problems

2.1.1. It is usually helpful to cover the following areas in the initial history:

- Details and history of present problem.
- If pain, then score 0-10 (0=no pain 10=worst pain).
- Current and previous treatments to include current vulval hygiene regime, use of “wipes” and other over the counter or prescribed products.
- Enquiry regarding any other skin or mucosal symptoms.
- Gynaecological history to include (where appropriate).
  - Parity and mode of delivery.
  - Menstrual history.
  - Contraceptive history.
  - Cervical screening history.
  - Sexual history/ dysfunction/ sexual assault.
- Enquiry regarding any difficulties with bladder/ bowel especially incontinence and use of incontinence pads.

- Past medical history.
- Drug history and allergies.
- Family history of autoimmune/ skin disease.
- Social history/ occupation/ hobbies.

2.1.2. Examination may include:

- Assessment of non-genital sites if relevant from history.
  - Oral mucosa.
  - Scalp.
  - General skin examination.
  - Nails.
- Palpation of inguinal nodes.
- Vulval examination to include perianal area and natal cleft with specific reference to:
  - Vulval architecture.
  - Vulval skin (colour, texture, integrity).
  - Description of discrete lesions.
- Assessment of vulval pain where indicated.
  - Hypersensitivity to fine touch (Q-tip test).
  - Digital assessment of pelvic floor tone/ tenderness/ trigger points.
- Inspection of vagina and cervix where indicated.

2.1.3. Photography can be helpful in reaching a diagnosis and treatment plan when MDT discussion is required, assessing response to treatment and surveillance of patients at risk of malignancy. Photography should be undertaken in line with the relevant RCHT Policy.

2.1.4. A diagnosis can usually be reached at the first visit following thorough assessment as above. Further investigations may be required to make a diagnosis, and may include microbiology, biopsies, blood tests or imaging.

2.1.5. History and examination findings can be recorded on a template specifically designed for the purpose if desired (Appendix 3).

2.2. General Principles of Management

2.2.1. It is usually helpful to show the patient how to perform self-examination of the vulva with aid of mirror. It may be necessary to describe normal anatomy to the patient. Any deviations from normal, or visible lesions can be described and explained to the patient. The Vulval Health Awareness Campaign leaflet can be offered to reenforce the importance of self-examination for monitoring treatment progress and early identification of new lesions in the future.

2.2.2. Patients should receive a verbal explanation of their diagnosis and treatment, backed up by an appropriate patient information leaflet or website. A list of relevant RCHT patient information leaflets is provided in Appendix 4. Details of local and national patient support groups may be offered, where these exist.

2.2.3. Most patients with vulval conditions will benefit from advice (backed up with written information) about care of vulval skin and the importance of emollients, also to be used as soap substitutes.

2.2.4. Patients who are sexually active may be helped by lubricants during sexual intercourse. Advice about appropriate preparations, backed up by written information can be offered.

2.2.5. Peri and post-menopausal patients with symptoms or signs of vulvovaginal atrophy may benefit from the addition of vaginal ERT (oestrogen replacement therapy) to their treatment regime.

2.2.6. Patients with continence problems may benefit from referral to the appropriate service as addressing continence can have a significant positive impact on vulval symptoms.

2.2.7. Some patients may have an allergic component to their vulval problem. Patch testing may be considered if this is suspected and is likely to alter their management.

2.3. Lichen Sclerosus (LS)

2.3.1. After initial assessment, a 4mm punch biopsy under LA (Local Anaesthetic) may be offered to exclude other pathology e.g., VIN (Vulvar Intraepithelial Neoplasia).

2.3.2. In addition to the principles of general management outlined above, the initial treatment plan should include:

- Offer a Thyroid Function Test (TSH) if this has not been done in the previous 12 months.
- Inform the patient about the risk of SCC (Squamous Cell Carcinoma) (less than 5%). Patients are to be advised to seek urgent medical advice if new suspicious lesions are noted on self-examination.
- Dermovate ointment (or another potent or super-potent topical steroid on case-by-case basis) as per the BAD (British Association for Dermatology) guideline for LS (Lichen Sclerosus), backed up written

instructions about the correct method of application.

If LS is diagnosed in the gynaecology service, patients can be referred for follow-up in the Dermatology Clinic 3-6 months after initiating treatment by copying the Dermatology Department into clinic correspondence and making a referral on Maxims.

2.3.3. At the follow-up visit:

- Check on symptom control and concordance with recommended treatment regime.
- Check if the patient has been able to self-examine and if any concerns have been noted.
- Address any residual issues or outstanding concerns e.g., sexual dysfunction.
- Examine the patient.
- Advise the patient on the on-going management of their chronic condition.

If there has been a good response to treatment, there are no outstanding issues and the patient has good understanding of how to manage their LS, then the patient can either be offered patient initiated follow-up within the dermatology service (for up to 3 years) or discharged to their GP.

2.3.4. Most patients with uncomplicated LS can be managed within 1-2 visits. Long term surveillance in the clinic setting may be required for selected patients.

- Patients at increased risk of developing SCC who cannot self-examine.
- Those with squamous hyperplasia on histology or history of SCC.
- Those with persistent areas of hyperkeratosis despite optimal steroid application.
- Those with co-existing usual type or differentiated VIN.

2.3.5. In patients who do not respond after an adequate trial of Dermovate ointment, consideration may be given to the following strategies:

- Check concordance e.g., application technique, amount, frequency, relation to emollients.
- Review the diagnosis and consider a biopsy (ensure at least 2-week steroid free interval prior).
- Consider secondary infection, swab, and treat.
- Consider and assess for diagnosis of secondary vulvodynia.
- Consider change to alternative topical steroid preparation e.g., elocon

ointment (mometasone).

- Consider tacrolimus 0.1% or 0.03% ointment.

2.3.6. For persistent hyperkeratosis consider:

- Repeat biopsy.
- Oral acitretin 10mg daily, can increase to 20mg daily (cannot be used in pre-menopausal women as highly teratogenic).
  - At baseline: fasting lipids, LFT (Liver Function Test), FBC (Full Blood Count).
  - Thereafter: LFT monthly, lipids 3 monthly.
  - Within the dermatology service, follow up will be in the nurse-led drug monitoring clinics.
- Intralesional steroid injection.
- Surgical excision.

2.3.7. Patients who have been discharged may need to be re-referred by their GP. Indications for review in the appropriate clinic include:

- For suspected malignancy, 2WW (Two Week Wait) referral to gynae-oncology.
- For issues surrounding management of LS, refer to Dermatology Clinic.

2.4. Lichen Planus (LP)

2.4.1. Lichen planus has several clinical manifestations in the genital skin including papules and plaques which are usually symmetrical and may be purplish/ pigmented, shiny red macules/ erosions at introitus with pale/ lilac scalloped edges, loss of architecture, erosive vaginitis (may present as grey, purulent, or blood-tinged vaginal discharge). Clinicians should be vigilant for signs of extra-genital lichen planus, which are often identified for the first time in the vulval clinic. These may include symptoms or signs of oral mucosal involvement, scarring alopecia, frontal fibrosing alopecia, nail changes and skin rashes, these warrant immediate referral to the Dermatology Clinic for ongoing management.

2.4.2. After initial assessment, a 4mm punch biopsy under LA may be offered to exclude other pathology e.g., VIN.

2.4.3. In addition to the principles of general management, the initial treatment plan should include:

- Dermovate ointment (or another topical steroid) as per BAD Guideline for LS backed up with written information.
- Inform the patient that the red, glazed areas on the vulva are not likely to change with treatment, the aim of treatment is symptom control.

- Lichen planus does not respond as well as LS to treatment with ultra-potent topical steroids; often a less potent steroid or a combination preparation such as Trimovate cream can be most effective for symptom control.

2.4.4. If there is a clinical suspicion of Vulvo-Vaginal-Gingival (VVG) syndrome, then a speculum examination can be helpful for diagnosis and to allow subsequent treatment. All patients with VVG-syndrome should be offered at least vaginal dilator therapy to prevent complete vaginal stenosis. Intravaginal antibiotics (e.g., clindamycin vaginal cream), oestrogens, steroids (e.g., predfoam or budesonide enemas) and early recourse to surgical intervention may be considered in cases of vaginal involvement.

2.4.5. Patients can be referred for follow-up in the Dermatology Clinic 3-6 months after initiating treatment by copying the Dermatology Department into clinic correspondence and making a referral on Maxims.

At the follow-up visit:

- Check on symptom control and concordance with recommended treatment regime.
- Enquire about symptoms which may suggest extra-genital LP or VVG-syndrome.
- Check if the patient has been able to self-examine and if any concerns have been noted.
- Address any residual issues or outstanding concerns e.g., sexual dysfunction.
- Examine the patient.
- Advise the patient on the on-going management of their chronic condition.

2.4.6. Some patients with uncomplicated genital LP can be managed within 1-2 visits. If there has been a good response to treatment, there are no outstanding issues and the patient has good understanding of how to manage their condition, then the patient can either be offered patient initiated follow-up or discharged to their GP. However, symptom control may be difficult, and patients often request ongoing secondary care.

2.4.7. For persistent severe inflammation due to LP (rather than secondary infection etc.) consider:

- Short courses of reducing systemic corticosteroids e.g., prednisolone 25mg reducing by 5mg every 5 days to zero.
- Other long term systemic immune suppressive drugs such as mycophenolate or methotrexate.
- Acitretin for hyperkeratotic LP.
- Hydroxychloroquine.

- Treatment for co-existing vulvodynia and/ or vulvovaginal atrophy.
- Monitor for development of possible secondary contact sensitivity and consider referral for patch testing.

2.4.8. If after discharge, re-referral by GP is necessary then indications for review in the appropriate clinic include:

- For suspected malignancy, a 2WW referral to gynae-oncology.
- For issues surrounding management of LP a referral to Dermatology Clinic.

2.5. Vulval Eczematous Dermatitis and Seborrhoeic Dermatitis

2.5.1. The diagnosis of vulval dermatitis will usually be straightforward i.e., intensely itchy, dry scaly, red skin. The changes on the vulva can sometimes be subtle e.g., fissures, especially in the interlabial sulci, and the amount of itching or discomfort can be disproportionate to the clinical findings. Patients may have a history of dermatitis/ eczema in other sites or a history of atopy.

2.5.2. After initial assessment, a 4mm punch biopsy under LA may be offered to exclude other pathology e.g., VIN.

In addition to the principles of general management, the initial treatment plan may include:

- Consideration of the possibility of primary or secondary fungal/bacterial infection (swab and treat as appropriate).
- Stress the importance of emollient use to the patient.
- A moderately potent topical steroid daily, followed by.
- Mildly potent topical steroids as maintenance (or use moderate potency steroid 2-3 times weekly e.g., weekend use).
- Topical calcineurin inhibitors i.e., tacrolimus ointment or pimecrolimus cream as steroid sparing agent (twice weekly maintenance can be useful).
- Oral antihistamines.
- In atopic individuals or if history is suggestive consider referral for patch testing.

2.5.3. Most patients with uncomplicated dermatitis can be managed in 1-2 visits. If there has been a good response to treatment, there are no outstanding issues and the patient has good understanding of how to manage their condition, then the patient can either be offered patient initiated follow-up or discharged to their GP.

2.6. Vulval Lumps

2.6.1. Many referrals for vulval lumps will be for various benign skin changes,

including angiokeratomas, epidermoid (sebaceous) cysts or skin tags.

Most patients can be reassured that the finding is benign and that no further treatment is necessary.

2.6.2. If the lump is bothersome, then it can be excised under local anaesthetic in the outpatient setting.

If there is any uncertainty about the diagnosis or the possibility of cancer, excision should be preceded by an incisional biopsy, taking to care to avoid complete excision of the lesion.

Excision can be performed at a later date once benign histology has been confirmed.

2.6.3. New pigmented lesions should be biopsied routinely to rule out a melanoma, unless in the assessment of a clinician experienced in the management of vulval disease the pigmentation is felt likely to be post-inflammatory or benign in nature (e.g., benign vulval melanosis). Ideally biopsy should be an excisional to remove the entire lesion unless the lesion is large or involving critical structures. Dermatoscopy is useful for diagnosis and for guiding biopsy.

2.6.4. In patients over the age of 40 presenting with lumps or masses in the Bartholin's gland, consideration should be given to requesting a pelvic MRI (Magnetic Resonance Imaging) scan (with diffusion weighted imaging) prior to biopsy to look for features of Bartholin's gland cancer.

2.7. Vulval Intra-epithelial Neoplasia (VIN)

2.7.1. This diagnosis is usually evident from the history and clinical examination. There is usually no benefit in routine application of 5% acetic acid to the vulva and vulvoscopy with a colposcope for diagnosis of HPV (Human Papilloma Virus) associated usual-type VIN. Application of acetic acid can however be very useful for directing biopsies where differentiated VIN (dVIN) is suspected in patients with LS. A 4mm punch biopsy of vulval skin is usually sufficient. Repeat biopsies may be required in cases with high index of clinical suspicion and a negative initial biopsy. Excisional biopsies are to be avoided in all but exceptional circumstances after review by a gynae-oncology Consultant. Where patients present with widespread, florid VIN consideration should be given to undertaking mapping biopsies in an attempt to diagnose occult underlying malignancy prior to commencement of treatment.

2.7.2. Patients with usual-type VIN (HPV associated) should as a minimum have up to date cervical screening within the NHS CSP (Cervical Screening Provider) if age appropriate. Patients with widespread VIN may also benefit from colposcopy/ vaginoscopy and anoscopy NHS CSP (AIN (Anogenital Neoplasia) service run by Colorectal Surgeons) to look for multizonal intra-epithelial neoplasia. Referral to the AIN service is via the internal referral form on Maxims. Patients should be advised that that smoking adversely affects the immune system's ability to clear HPV. Patients should be informed about NHS stop smoking services. Consideration may be given to offering an HIV (Human Immunodeficiency Virus) test.

2.7.3. In addition to the general principles of care offered to all vulval patients, the management of VIN will be determined by the patient's symptoms, the anatomical location and distribution of the condition. In general, for HPV-associated usual type VIN (warty or basaloid) the following can be offered:

- Surveillance alone with regular self-examination and prompt reporting of concerns. The chance of malignant transformation is usually quoted as 1% per year over 10 years for immunocompetent individuals.
- Imiquimod (Catephen ointment is an alternative if Imiquimod unavailable).
- Ablation under LA or regional/ general anaesthesia with argon diathermy in theatre.
- Surgical excision under LA or regional/ general anaesthesia in clinic or theatre.

2.7.4. The preferred first-line treatment for dVIN is wide local excision. The alternative for patients unsuitable for wide local excision, is to increase the frequency/potency of topical steroid along with close surveillance in the clinic.

2.7.5. In patients undergoing surgical treatment, every effort should be made to excise the lesion with clear margins, as this reduces the chance of recurrence. This can usually be achieved by application of 5% acetic acid and marking the area of acetowhite with the aid of a colposcope. The area to be treated/excised should include a 1cm margin of apparently normal tissue where possible.

2.7.6. After treatment, most patients can be offered 6–12-month clinic-based follow-up, usually for up to 5 years after resolution of the problems or patient-initiated follow-up for 5 years depending upon the risk of recurrence and the ability to self-examine and report new lesions promptly.

2.7.7. Patients with VIN may benefit from early review by a Gynaecological Oncologist in the following scenarios:

- VIN in association with HPV-related field change/ multi-zonal IEN (e.g., CIN, VaIN, AIN).
- Multifocal/ widespread VIN or a large lesion.
- Failure to respond to imiquimod.
- Immunosuppression.
- Differentiated VIN (associated with LS and carries an increased chance of progression to SCC).
- Suspicion of concurrent SCC.
- History of previous vulval/ vaginal/ cervical/ anal SCC.

2.8. Vulval Ulcers

2.8.1. Vulval ulcers can be seen with vulval dermatoses (lichen sclerosus and lichen planus), infection, systemic inflammatory conditions, autoimmune blistering skin diseases and malignancy.

If an infectious cause is suspected, then the following investigations should be performed:

- Serum sample (gold topped bottle):
  - HIV 1+2 antibody (found under GU (Genito Urinary) medicine in virology section).
  - Syphilis reference serology (found under GU medicine in virology section).
  - CMV IgG antibody (found under microbiology in virology section).
  - CMV (Cytomegalovirus) IgM antibody (found under microbiology in virology section- other serology/ virology- request in free text).
  - EBV (Epstein Barr Virus) serology (found under microbiology in virology section).
- Viral swab (red swab):
  - Herpes Simplex Virus PCR (found under microbiology in virology section).
  - Syphilis PCR (found under microbiology in virology section - other serology/virology – request in free text).
- Bacterial swab for M, C and S (Microscopy, Culture and Sensitivity) (charcoal skin swab from ulcer).
- Chlamydia and gonorrhoea PCR (Polymerase Chain Reaction) (orange endocervical swab).
- Gonorrhoea culture (charcoal endocervical swab).
- Consider testing for trichomonas if purulent discharge.

2.8.2. The incidence of syphilis is increasing in Cornwall and therefore consideration of a chancre is important in patients presenting with an atypical ulcer on the vulva. It is classically described as a small, firm, red papule that quickly becomes a painless ulcer with a well-defined margin. Multiple ulcers can occur in 30% of cases and the ulcers can be painful, atypical and resemble herpes (co-infection is also possible. Syphilis may be associated with non-tender inguinal lymphadenopathy.

Treatment of suspected syphilis should be co-ordinated through specialised sexual health services (i.e., Brook). Syphilis serology can be negative in primary stage of syphilis and should always be repeated at the sexual health clinic at a three-month interval if syphilis is suspected. Contact tracing/ partner notification is essential. Urgent referral is

required.

2.8.3. Patients with any confirmed sexually transmitted infection should be referred to sexual health services for advice, treatment and contact tracing.

2.8.4. Non-infectious causes of vulval ulceration include:

- Aphthous ulcers (commonly associated with oral ulceration). These are usually small, recurrent and non-scarring.
- Lipschultz ulcers areuncommon, self-limiting, non-sexually transmitted ulcers characterised by rapid onset of painful, necrotic ulcerations of the vulva or lower vagina. They typically occur in sexually inactive adolescent females. They may be preceded by influenza-like or mononucleosis-like symptoms.
- Fixed drug eruption (can occur with any drug but especially NSAIDS (Non-Steroidal Anti-Inflammatory Drugs), sulfonamides, tetracyclines, nicorandil and foscarnet).
- Pyoderma gangrenosum typically presents with rapidly extending painful ulcers with a purplish undermined edge. They can follow very minor trauma (pathergy), and are associated with inflammatory bowel disease, rheumatoid arthritis, myeloid blood dyscrasias. The condition is associated with neutrophilic inflammation on histology.
- Hidradenitis suppurativa.
- Systemic inflammatory conditions.
  - Behcet's disease (vasculitis with oral ulcers, uveitis, arthritis).
  - Crohn's disease (linear "knife cut" ulcers, granulomatous plaques, nodules, papules, oedema).
  - Systemic lupus erythematosus.
  - Myeloproliferative disorders.
  - Graft versus host disease.

2.8.5. Autoimmune blistering skin disease lies outside the remit of this guidance. If there is scarring and loss of architecture associated with recurrent ulcers, consider pemphigus vulgaris or mucous membrane pemphigus. Diagnosis in dermatology is by general examination of skin and other mucosal surface, histology, direct and indirect immunofluorescence.

2.8.6. A biopsy may be considered if needed for diagnostic purposes, or to exclude systemic disease or malignancy.

2.9. Vulval Pain

2.9.1. In most cases it should be possible to confidently make a diagnosis of primary vulvodynia at the time of initial assessment with careful history and examination.

2.9.2. Provoked pain is usually very easy to identify on a Q-tip test, the areas of sensitivity are usually located in the anterior vestibule/ periurethral area but can extend around the whole introitus to the posterior fourchette. There is often an associated increase in tension of the pelvic floor muscles, sometimes with identifiable trigger points.

2.9.3. Unprovoked pain is usually encountered in older patients. The diagnosis is usually made on the basis of the history in conjunction with normal examination findings.

2.9.4. Secondary vulvodynia can arise as a consequence of inflammatory skin conditions. Clinicians should be vigilant for symptoms of secondary vulvodynia, so that appropriate treatment can be offered in addition to treatment for the underlying dermatosis.

2.9.5. In addition to the basic principles of management outline above, a patient centred approach to the problem, with an acknowledgement of the condition and a detailed explanation surrounding the pathophysiology (backed up by information on the Vulval Pain Society website (The Vulval Pain Society) can be enough on its own to help patients to get better.

2.9.6. Strategies for initial management may include (according to the patient's main areas of concern):

- Managing expectations surrounding likelihood of "cure".
- Aiming for "control" rather than "cure".
- Acupuncture.
- For provoked pain:
  - Vulval desensitisation, massage, and dilator therapy.
  - Local anaesthetic preparations e.g., lidocaine ointment, Istillagel.
  - Tricyclic antidepressants for 3-6 months initially (stop after 2-3 months if no improvement).
  - Physiotherapy if there is evidence of pelvic floor dysfunction or the patient requires support with desensitisation, massage, and dilator therapy.
  - Psychosexual therapy.
- For unprovoked pain:
  - Tricyclic antidepressants for 3-6 months.
  - Gabapentin and pregabalin second line.
  - Physiotherapy if there is evidence of pelvic floor dysfunction.
  - Psychosexual therapy.
  - Treatment of atrophy with topical oestrogen preparations.

2.9.7. The majority of patients with vulval pain can one managed in 1-3 visits visit, using the patient-centred model above. Some patients may wish to be followed up or need to be seen again.

2.9.8. Some patients with pain may have a more complex picture, and may benefit from referral to the Pain Management Clinic, either at presentation, or later in their pathway:

- If there is a suspicion of pudendal nerve entrapment, then an MRI (MSK (Musculoskeletal) protocol) of the pelvis should be offered prior to referral.
- Sympathetic nervous system symptoms.
- Pain related distress.

2.10. Sexual Difficulties in Vulval Patients

2.10.1. Patients with a variety of vulval conditions may experience sexual problems as a result.

2.10.2. Older patients in particular may be reluctant to discuss these with healthcare professionals, and consideration may be given to enquiring about potential difficulties at the time of initial assessment, or during follow-up if this is felt to be more appropriate.

2.10.3. Often simple advice about the use of appropriate lubricants is all that is required. Sylk and Yes (water-based) are available on prescription through GP. Oil based lubricants may be better tolerated but cannot be used with condoms, KY Jelly is best avoided, as it is very quick to dry and may be an irritant.

2.10.4. Post-menopausal patients may benefit from vaginal ERT.

2.10.5. Some patients may benefit from vulval massage and vaginal dilators to soften scarred skin and increase confidence with vaginal intercourse.

2.10.6. Patients without active dermatoses, who experience splitting of the skin at the posterior fourchette, and who have failed, or who do not wish to try/are not suitable for conservative measures may be referred to benign gynaecology for consideration of surgical treatment (z-plasty).

2.10.7. Sexual and relationship difficulties may manifest in a couple's relationship with less closeness, less intimacy, sexual pain, anxiety, problematic sexual communication, and general sexual and relationship dissatisfaction between partners. Psychosexual Therapists help individuals and couples to understand, overcome and adjust to their specific problems using simple educational interventions, highly specialised cognitive behavioural therapy, systemic and psychotherapeutic therapies. The aim is to help identify and address the sexual and relationship difficulties, develop effective adaptive strategies, promote psychosexual wellbeing and importantly, improve the intimate relationship. Usually, psychosexual therapy will be brief and focused. Most individuals and couples will have completed therapy with 8 sessions, although successful outcomes may be achieved in fewer sessions.

2.10.8. Integrated medical and psychosexual counselling is no longer available at RCHT. Patients wishing to access counselling in the private sector are advised to visit the College of Sexual and Relationship Therapists website https://www.cosrt.org.uk/ to find an accredited therapist.

3. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Unfortunately given the current IT capabilities within the wider NHS, is not possible to monitor this complex system as a whole, as it encompasses care provided for women between and by multiple specialties including dermatology, gynaecology, gynaecological oncology and the Pain Management Service, in multiple locations.
Lead	Sophia Julian; Consultant Gynaecological Oncologist.
Tool	Incidents will be monitored via Datix system.
Frequency	As dictated by reporting of incidents.
Reporting arrangements	Incidents will be reported to the Gynaecology Business and Governance meeting.
Acting on recommendations and Lead(s)	Clinical Director/ Ward Managers/ Speciality Matron/ Gynaecology Oncology Team.
Change in practice and lessons to be shared	This guideline involves very little change from the status quo. The majority of women with vulval problems are already being managed within this framework. Required changes to practice will be identified and actioned within 3 months, immediately if required. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant staff/ stakeholders.

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the Equality Diversity And Inclusion Policy or the Equality and Diversity website.

4.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	The Initial Management of Benign Vulval Disease V2.0.
This document replaces (exact title of previous version):	The Initial Management of Benign Vulval Disease V1.0.
Date Issued/Approved:	January 2025.
Date Valid From:	January 2025.
Date Valid To:	January 2028.
Directorate / Department responsible (author/owner):	Sophia Julian; Consultant Gynaecological Oncologist.
Contact details:	01872 252315.
Brief summary of contents:	The initial management of benign vulval disease.
Suggested Keywords:	Benign, vulval, disease.
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Medical Officer.
Approval route for consultation and ratification:	Gynaecology Specialty Meeting. Vulval Multi-Disciplinary Team (MDT) Meeting.
Manager confirming approval processes:	Caroline Chappell.
Name of Governance Lead confirming consultation and ratification:	Tamara Thirlby.
Links to key external standards:	British Association for Sexual Health and HIV UK National Guideline on the Management of Vulval Conditions 2014. British Association of Dermatologists guidelines for the management of lichen sclerosus 2018. British Society for the Study of Vulval Disease Guidelines for the Management of Vulvodynia 2010. Standards-of-Care_Vulval-Conditions-Report.pdf.

Information Category	Detailed Information
Related Documents:	None required.
Training Need Identified?	No.
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical/ Gynaecology.

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
February 2020	V1.0	Initial version.	Sophia Julian; Consultant Gynaecologist.
December 2024	V2.0	Ensured current contents up to date. Added additional sections for further information.	Amy Sanders; Gynaecology Doctor. Sophia Julian; Consultant Gynaecologist. Lisa Haddon; Associate Specialist Dermatology.

All or part of this document can be released under the Freedom of Information Act 2000.

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document.

This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity, and Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	The Initial Management of Benign Vulval Disease V2.0.
Directorate and service area:	Gynaecology.
Is this a new or existing Policy?	Existing.
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Gynaecology Specialty Group.
Contact details:	01872 252315.

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	Clinicians involved in the management of adults with benign vulval conditions.
2. Policy Objectives	To ensure consistency in the management of benign vulval conditions. To ensure that patients receive the same high quality of assessment, treatment and information regardless of which clinic they are initially seen in. To ensure that any subsequent treatment or follow-up takes place under the care of the most appropriate clinician to meet the needs of the patient.
3. Policy Intended Outcomes	Patients will be managed efficiently and effectively in accordance with national guidelines.
4. How will you measure each outcome?	There are no plans to measure the outcomes, for the reasons stated previously.
5. Who is intended to benefit from the policy?	Adults with benign vulval conditions.

Information Category	Detailed Information
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: No • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** Gynaecology Specialty Meeting Group.
6c. What was the outcome of the consultation?	Approved.
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff, or patient surveys:** No.

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	The guideline will apply to all adults with benign vulval problems.
Sex (male or female)	No	The guideline will apply to all adults with benign vulval problems regardless of how they identify.
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	The guideline will apply to all adults with benign vulval problems regardless of how they identify.
Race	No	Patients do have access to professional interpreters if these are required during consultations. Patient information leaflets are currently printed in English only but can be made available in other languages if required based on individual need in which case this can be arranged by contacting the general office.

Protected Characteristic	(Yes or No)	Rationale
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	Those patients with additional needs will be referred for additional support as appropriate- i.e., to the Liaison Team or for specialised equipment. Written information will be provided in a format to meet the patient's needs e.g., easy read, audio etc.
Religion or belief	No	The guideline will apply to all adults with benign vulval problems regardless of religion.
Marriage and civil partnership	No	The guideline will apply to all adults with benign vulval problems regardless of marital or civil partnership status.
Pregnancy and maternity	No	The guideline will apply to all adults with benign vulval problems, including those that are pregnant.
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	The guideline will apply to all adults with benign vulval problems regardless of sexual orientation.

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Gynaecology Specialty Group.

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis

Appendix 3: Vulval Clinic Documentation

VULVAL CLINIC NEW PATIENT ASSESSMENT SHEET

Clinic Date:

Age:

Occupation:

GP:

ADDRESSOGRAPH

PC:

PMH:

Skin / Scalp / Nails / Mouth

DH+A

Previous Treatments

Sexual Intercourse:

Menstrual History / LMP:

Cervical Smears:

Contraception:

SH:

Urinary / faecal Incontinence:

Dermatological / autoimmune Disease:

History:	Skin Probs	Thyroid	IDDM	PA	Vitiligo	Alopecia	Atopy
Personal							
Family							

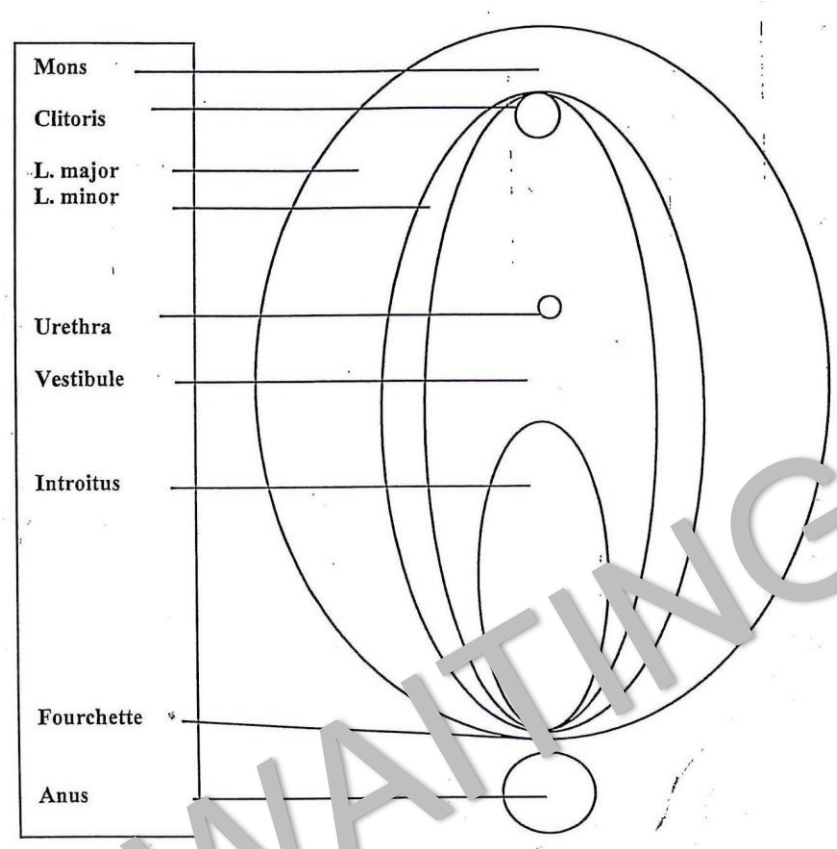
Date:	ADDRESSOGRAPH

Examination Findings:

Scalp / Mouth / Nails

Groins

Vulva



Ima[illegible]on Ma[illegible]s

Diag[illegible]osis:

Management:

Follow-up:

Biopsy:

Skin prep	□
Ametop/EMLA	□
Mepivacaine 3% LA	□
Lignospan 2.2ml	□
4mm Punch biopsy	□
Eppendorf's biopsy	□
Incisional biopsy	□
4/0 Vicryl rapide	□
AgN03 for haemostasi[illegible]	□
After[illegible]are l[illegible]et	□
Consent Form	□

Information Given:

General Vulval Care	□
Self-Examination	□
LS	□
NLSSG	□
2-4% Risk of cancer	□
Dermovate	□
LP	□
VIN	□
Imiquimod	□
Vulval Surgery	□
VPS Website/Leaflet	□
Lubricants	□
Massage/Dilators	□
LA Gels	□
VVA and ERT	□

VULVAL CLINIC FOLLOW-UP SHEET

Date:

Age:

ADDRESSOGRAPH

Diagnosis / Summary:

History:

Appendix 4: Resources for Patients

The Vulval MDT has produced the following information leaflets to support vulval patients. They are available to download from the Trust Intranet from the “Vulval Services” section of the Patient Information Library or order as hard copies using the following order codes:

- After Your Vulval Biopsy (RCHT 1641).
- Local Anaesthetics Gels and Creams (RCHT 1664).
- Using Dermovate Ointment (RCHT 1665).
- General Vulval Care and Emollients (RCHT 1666).
- Imiquimod (RCHT 1667).
- Amitriptyline and Nortriptyline (RCHT 1668).
- Gabapentin and Pregabalin (RCHT 1669).
- Lichen Sclerosus (RCHT 1670).
- Lichen Planus (RCHT 1671).
- Vulvovaginal Atrophy and Low Dose Vaginal Oestrogen Therapy (RCHT 1672).
- Tacrolimus Ointment 0.1% (RCHT 1673).
- Lubricants (RCHT 1674).
- Vulval Intraepithelial Neoplasia (VIN) (RCHT 1675).
- Female Genital Eczema/ Dermatitis (RCHT 1676).
- Vulval Massage, Dilators and Desensitisation (RCHT 1762).
- Vulval Services at RCHT (RCHT 1765).
- Vulval Surgery (RCHT 1780).
- Recurrent Vulvovaginal Candidiasis (RCHT 1919).

Other useful sources of patient information include:

- The Vulval Pain Society: http://www.vulvalpainsociety.org/vps/.
- The British Society for the Study of Vulval Disease: https://bssvd.org/.
- The British Association of Dermatologists: Home Page - British Association of Dermatologists.
- British Association for Sexual Health and HIV: BASHH.
- The College of Sexual and Relationship Therapists: https://www.cosrt.org.uk/.

Appendix 5: List of Abbreviations

AIN	Anal Intraepithelial Neoplasia.
BAD	British Association of Dermatologists.
CIN	Cervical Intraepithelial Neoplasia.
CMV	Cytomegalovirus.
dVIN	Differentiated VIN.
EBV	Epstein Barr Virus.
ERT	Oestrogen Replacement Therapy.
FBC	Full Blood Count.
GA	General Anaesthetic.
GU	Genitourinary.
HIV	Human Immunodeficiency Virus.
HPV	Human Papilloma Virus.
IEN	Intra Epithelial Neoplasia.
IgG	Immunoglobulin G.
IgM	Immunoglobulin M.
LA	Local Anaesthetic.
LFT	Liver Function Tests.
LP	Lichen Planus.
LS	Lichen Sclerosus.
MDT	Multi-disciplinary Meeting.
MRI	Magnetic Resonance Imaging.
MSK	Musculoskeletal.
NHS-CSP	National Health Service Cervical Screening Programme.
RCHT	Royal Cornwall Hospital NHS Trust.
SCC	Squamous Cell Carcinoma.
TSH	Thyroid Stimulating Hormone.
VaIN	Vaginal Intra-epithelial Neoplasia.
VIN	Vulval Intra-epithelial Neoplasia.