Itching, burning, pain: navigating vulval skin conditions

Tuesday 17 February 2026

The content in this session is valid at date of presentation

Acknowledgement of Country

North Western Melbourne Primary Health Network would like to acknowledge the Traditional Custodians of the land on which our work takes place, the Wurundjeri Woi Wurrung People, the Boon Wurrung People and the Wathaurong People.

We pay respects to Elders past, present and emerging as well as pay respects to any Aboriginal and Torres Strait Islander people in the session with us today.

Housekeeping – Zoom webinar

All attendees are muted

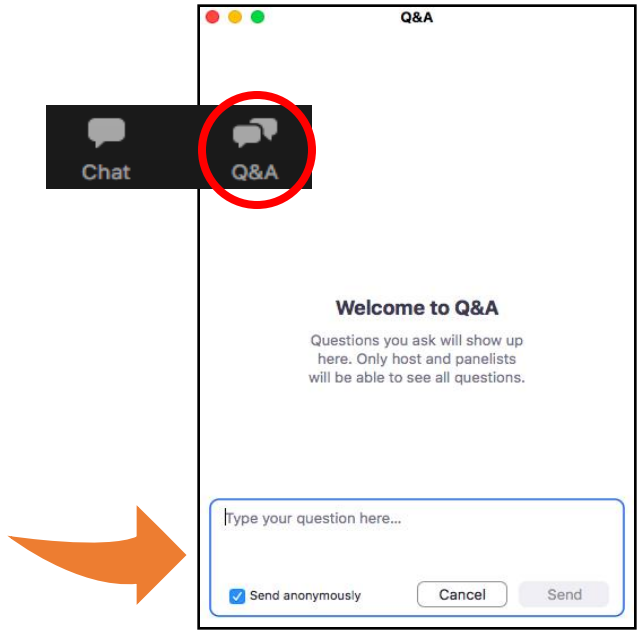
Please ask questions via the Q&A box only

- Q&A will be at the end of each speakers presentation
- Questions will be asked anonymously to protect your privacy

This session is being recorded.

You will receive a link to this recording and copy of slides in post session correspondence.

Type your questions in the Q&A box.



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To ensure we can issue your certificates and CPD please ensure you have joined the session using the same name as your event registration (or phone number, if you have dialled in).

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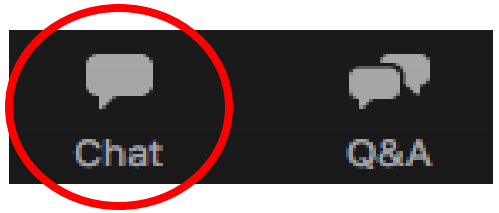

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How to rename yourself

1. Click on **Participants**
2. If using
   - App: click on your name
   - Computer: hover over your name and click the 3 dots
   - Mac: hover over your name and click More
3. Click on **Rename**
4. Enter the name you registered with and click **Done** / **Change** / **Rename**

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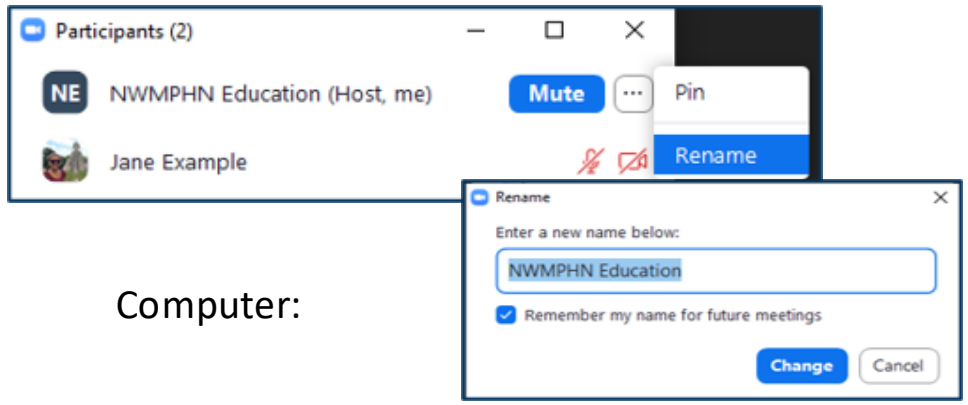

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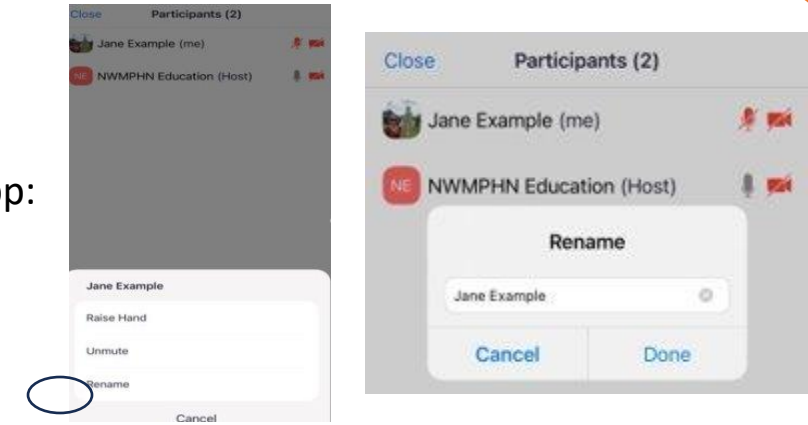
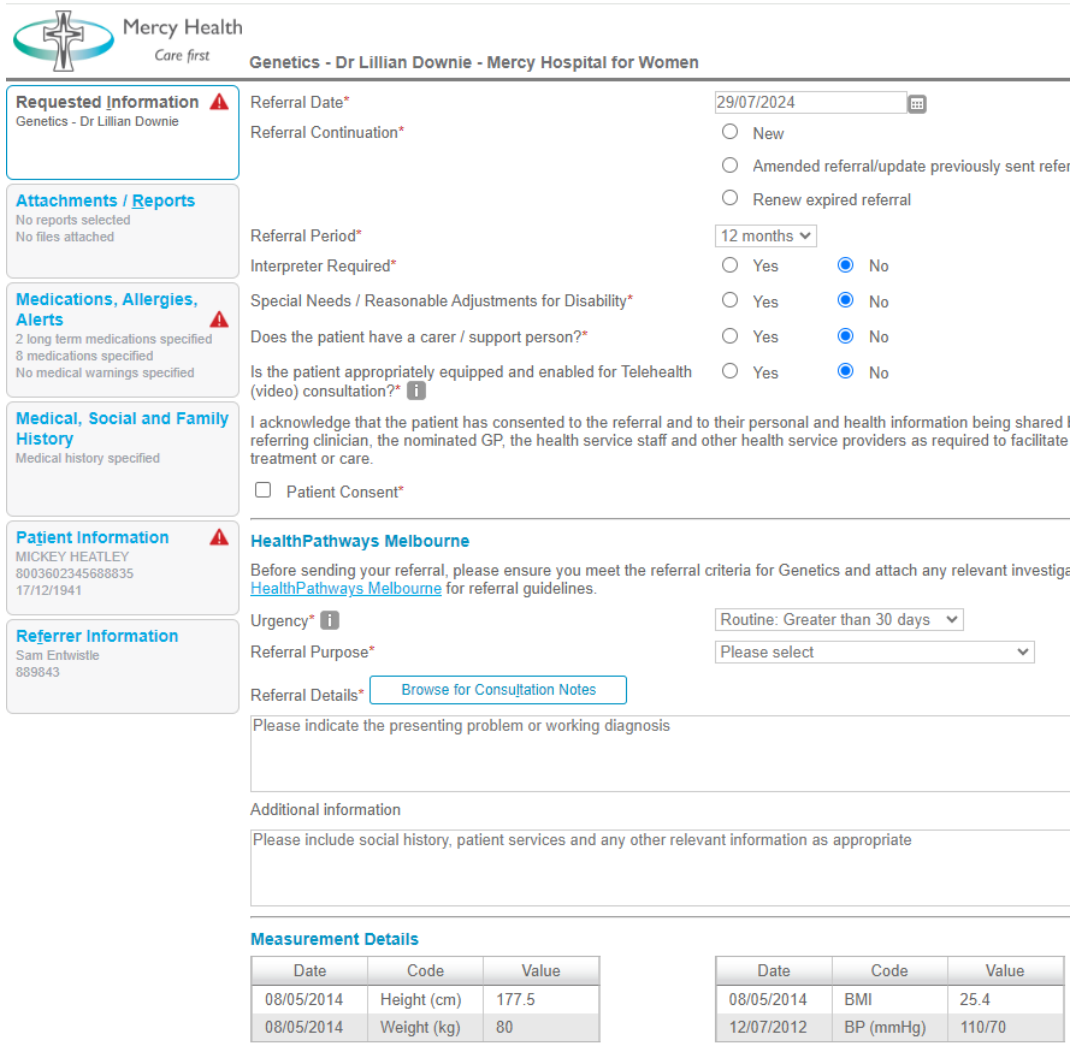


Mercy Health update

Mercy Health prefers referrals to its Outpatient Specialist Clinics are submitted through eReferrals using HealthLink SmartForms.

This method is integrated into most practice software and ensures easy attaching of test results.

For more information, visit our [HealthLink eReferral information website]



Mercy Health Update

Mercy Health
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Feedback form for Health Professionals

The Primary Care Liaison Unit would love to hear from you!

Please provide any feedback easy and quick via our online feedback form.

For any education requests please complete our education request form.

For more information visit our Primary Care Liaison website: https://health-services.mercyhealth.com.au/health-professionals/primary-care-liaison-unit/

Mercy Health update

Stay informed about key updates from the hospital.

Subscribe to our new, mobile-friendly quarterly newsletter to receive essential hospital updates, clinical insights, and upcoming education opportunities tailored for primary care.

[Register for the Primary Care Liaison newsletter today.]

Search for the Vulval Itch Pathway on the Homepage

Use the search bar to **quickly** locate clinical pathways or conditions

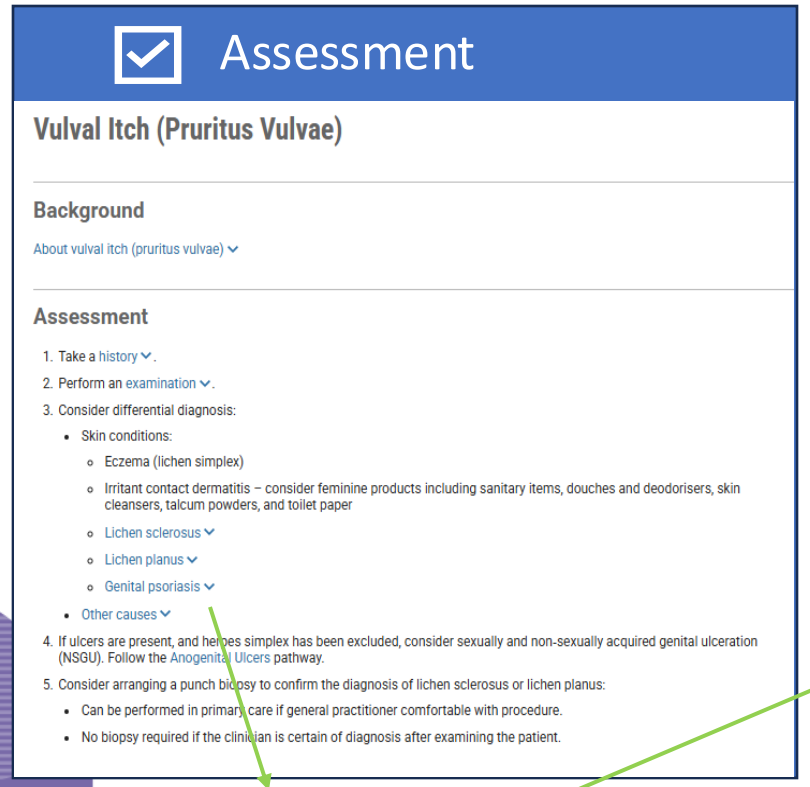
Use the left-hand menu to access clinical categories — **quick and easy to navigate**

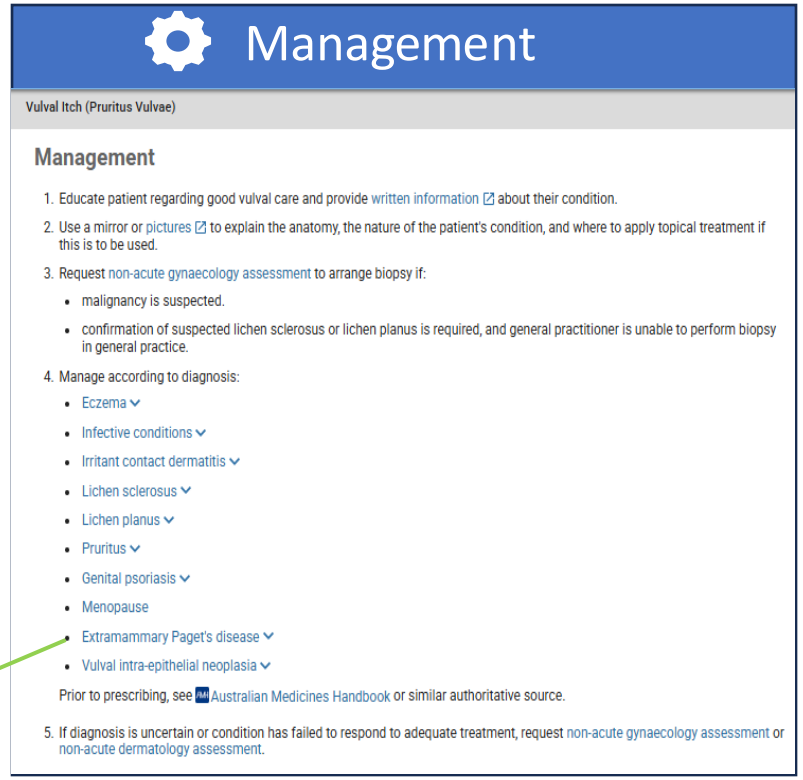
Essential quick-access links for latest updates, Pathway updates, clinical resources and MBS items

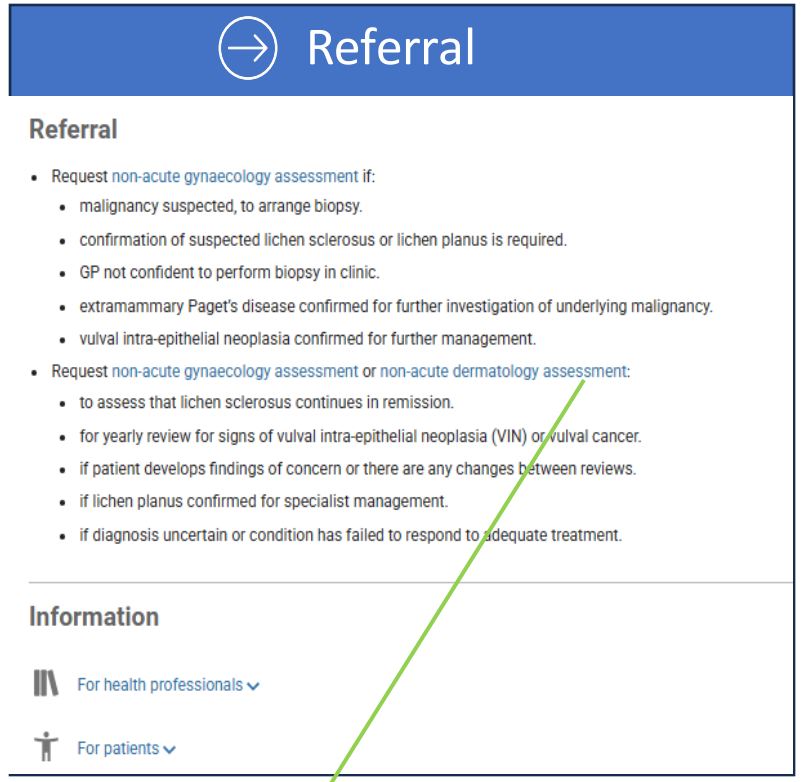
Click '**Send Feedback**' to add comments and questions about this pathway.

Streamlined Navigation of Vulval Itch (Pruritus Vulvae) for General Practice

All Sections in One Place: Assessment, Management, and Referral sections on a single page, making it easy for GPs to quickly navigate the entire clinical pathway without switching screens.







Click to Expand

Drop-down boxes appear throughout the pathway, click them to view supplementary information.

Click on the Links

Use the interactive links to open related pathways and resources

Discover Detailed Management Guidance on Vulval Itch Pathway

Management

1. Educate patient regarding good vulval care and provide written information about their condition.
2. Use a mirror or pictures to explain the anatomy, the nature of the patient's condition, and where to apply topical treatment if this is to be used.
3. Request non-acute gynaecology assessment to arrange biopsy if:
   - malignancy is suspected.
   - confirmation of suspected lichen sclerosus or lichen planus is required, and general practitioner is unable to perform biopsy in general practice.
4. Manage according to diagnosis:
   - Eczema
   - Infective conditions
   - Irritant contact dermatitis
   - Lichen sclerosus
   - Lichen planus
   - Pruritus
   - Genital psoriasis
   - Menopause
   - Extramammary Paget's disease
   - Vulval intra-epithelial neoplasia

   Prior to prescribing, see Australian Medicines Handbook or similar authoritative source.
5. If diagnosis is uncertain or condition has failed to respond to adequate treatment, request non-acute gynaecology assessment or non-acute dermatology assessment.

The Management section provides diagnosis-specific treatment guidance. Users can expand each diagnosis to view recommended management steps, clinical considerations, and links to supporting pathways and trusted resources.

Example: Eczema
- Clear treatment recommendations are displayed when expanded.
- Links to additional pathways (e.g., Eczema in Adults).

Example: Lichen Sclerosus
- Condition-specific management details.
- Links to referral pathways.
- Includes resources such as the AMH handbook.

Relevant and Related Pathways

Relevant Pathways

Vulval Itch (Pruritus Vulvae)
Vulvodynia
Anogenital Ulcers
Bacterial Vaginosis
Candidiasis (Genital)
Chlamydia
Eczema (Atopic Dermatitis) in Adults
Genital Dermatology
Genital Herpes
Gonorrhoea
Menopause
Recurrent or Chronic Vulvovaginal Candidiasis
Trichomoniasis

CPD Hours for HealthPathways Use

Related Pathways

Cervical Cancer
Endometriosis
Female Genital Cutting/Mutilation (FGC/M)
Fibromyalgia
Genital Warts and Human Papilloma Virus (HPV)
Irritable bowel syndrome

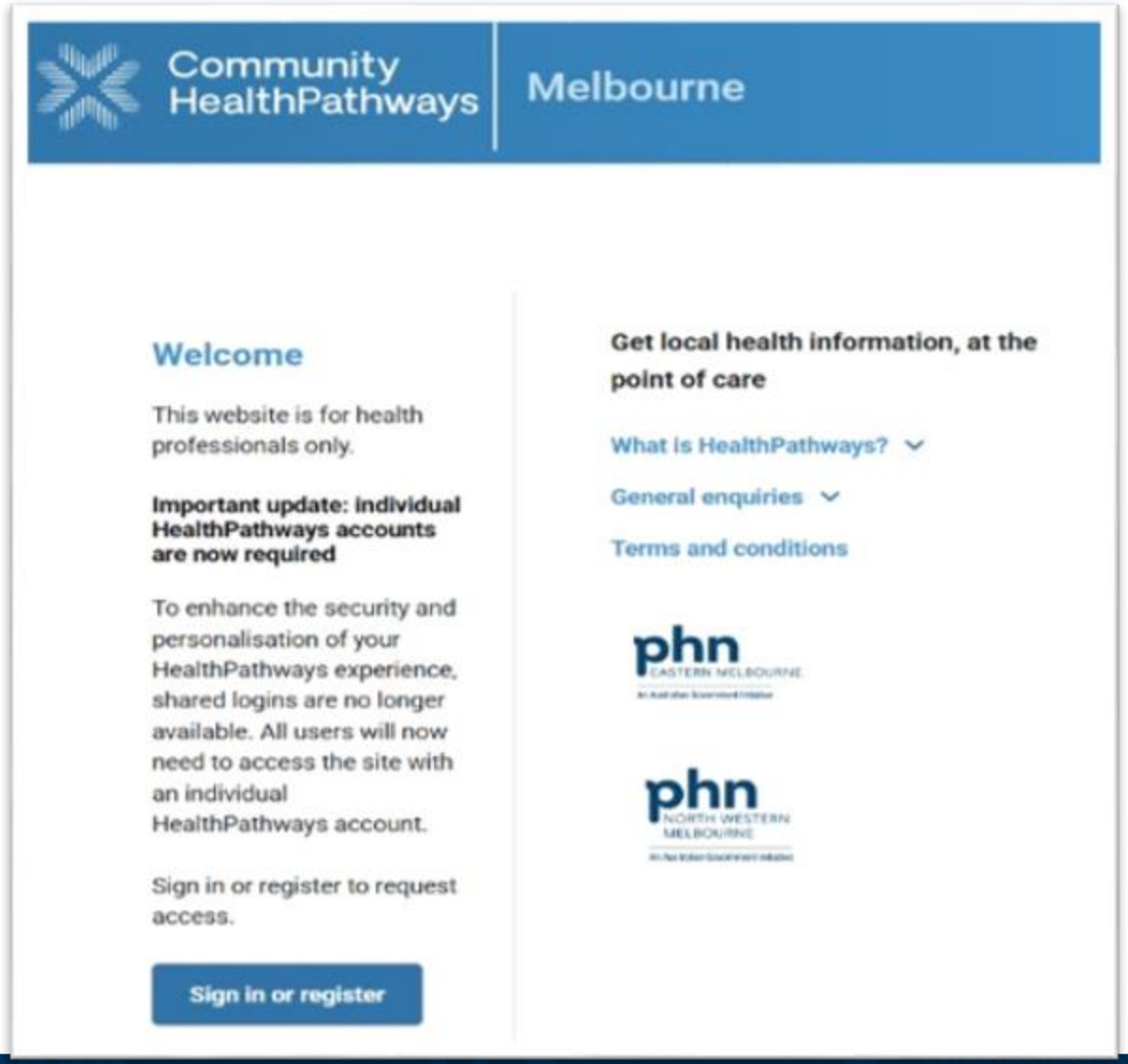
Referral Pathways

Acute Dermatology Referral (Same-day)
Acute Gynaecology Referral (Same-day)
Non-acute Gynaecology Referral (> 24 hours)
Non-acute Dermatology Referral (> 24 hours)

Access Now: Sign In or Scan to Register

Please click on the **Sign in or register** button to create your individual account or scan the QR code below.

If you have any questions, please email the team info@healthpathwaysmelbourne.org.au



Speakers

Dr Kathy Cook

Dr Kathy Cook is one of Melbourne's leading gynaecologists in the field of vulval vaginal conditions. She is also an obstetrician with decades of experience across Melbourne's tertiary women's hospitals. She is also a fellow of the College of Physicians, specialising in Sexual Health Medicine.

To relax, she enjoys craft work, reading and music.

Speakers

Dr Alice Truong

Alice obtained her medical degree at the University of Melbourne and completed her specialist training at the Mercy Hospital for Women. In her advanced fellowship years, she gained further experience in high-risk obstetrics and ultrasound at the Royal Women's Hospital and Joan Kirner Women's and Children's Hospital, and in minimally invasive surgery at Epworth Freemasons. During this time, she obtained a Masters of Public Health and Tropical Medicine and has also completed a Masters of Reproductive Medicine with a focus on fertility.

Alice has a special interest in vulval dermatology and is one of the consultant gynaecologists at the Vulval Dermatology Clinic at Mercy Hospital for Women. She consults privately at Bae Women's Health in Mitcham, and provides general gynaecological, obstetric and fertility care, delivering fertility services through Newlife IVF in Box Hill.

Speakers

Dr Rebecca Shields

Rebecca completed her undergraduate medical degree with honours at Monash University. She has trained and worked across a diverse range of healthcare settings, including large tertiary centres, smaller urban hospitals, and rural hospitals.
Rebecca currently holds a public obstetric/gynaecology appointment with Mercy Health and works as a private gynaecologist at Empower O&G, Bundoora.

Rebecca provides comprehensive private gynaecology services with a focus on patient-centred care. Her clinical interests include colposcopy, perimenopause and menopause management, abnormal menstrual bleeding, vulval skin disorders, ovarian cysts, and IUD insertion and contraceptive counselling.

Outside of medicine, she is passionate about supporting and empowering women in all aspects of life. Her personal interests include sewing, camping and hiking, reading, cooking, and spending time with her family.

Speakers

Dr Stephanie Bond

Dr Stephanie Bond is an obstetrician and gynaecologist and sexual health physician at Melbourne Sexual Health Centre, The Royal Women's Hospital and Mercy hospital for Women. She is the Vice President of ANZVS. She is Clinical Lead for Sexual Health at the Royal Women's Hospital. She is undertaking PhD research into congenital syphilis prevention and is passionate about providing holistic care for people affected by vulvovaginal conditions.

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Vulval Dermatology

Mercy Hospital for Women

OUR TEAM

Dr Alice Truong (O&G)

Dr Rebecca Shields (O&G)

Dr Stephanie Bond (O&G/Sexual Health)

Dr Kathy Cook (O&G/Sexual Health) – Head of Unit

Dr Jacinta Opie (Dermatologist)

Dermatology Registrar, O&G Registrar/Resident

Maddy Redgewell (Gynaecology Nurse)

Case Study

66 year old
Vaginal burning for 10 months
On b/g of admission to hospital with cellulitis and septicaemia after umbilical hernia repair. Prolonged course of IV Abx over 2 months via PICC line and then oral Abx.

Self-treating with topical nystatin. Sx would resolve but then recur

Examined by GP – noted resorbed labia, faint white patch at site of pain ?lichen sclerosus

History

- Also gets itch – changed from using toilet paper to water wipes which helped
- Denied soap use, only using water to wash
- No pad use, no incontinence
- Tried using Sudocream as barrier, but stung, so did not continue
- Not been on any topical steroids

- O&G Hx: 2 vaginal births, TLH/BSO for large ovarian cyst (benign), Menopause mid-40's, no MHT
- PMH/PSH: HTN, sciatica, back pain, Wolf-Parkinson-White syndrome (previous ablation), occasional eczema on hands and arms, denied diabetes (recent HbA1C NAD), BMI 38
- Disclosed history of sexual assault as adolescent – has always found vulval examinations/procedures confronting

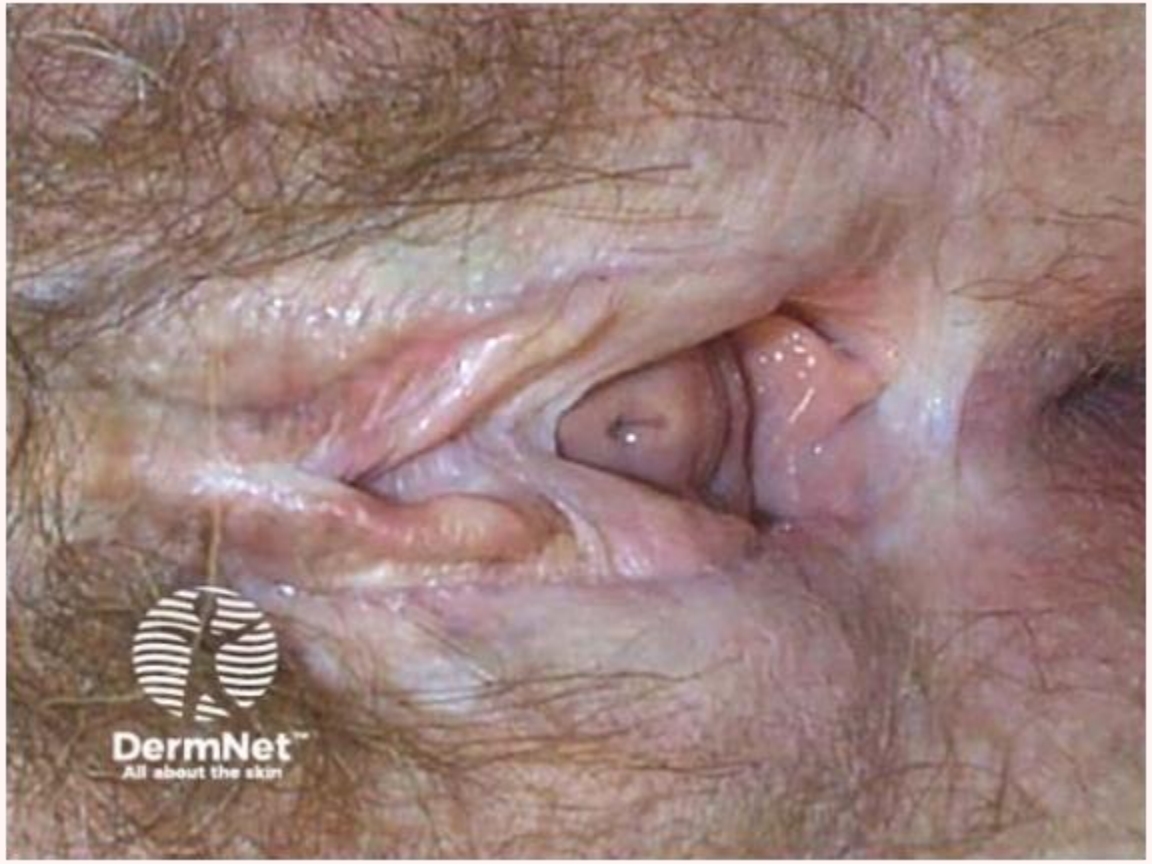
Examination

- Bilateral labial resorption right > left, partial burying of clitoris
- Pallor and some hyperkeratosis periclitorally and at interlabial sulci
- Small skin fissure midline above clitoris
- Patch of pallor on inner right vestibule

- LVS MCS sent again to check for thrush

- Discussed that findings were consistent with lichen sclerosus but recommended biopsy to confirm diagnosis and exclude dysplasia

- 2 x 3mm punch biopsies taken at left anterior fourchette and at right vestibule after local anaesthetic infiltration. Silver nitrate for haemostasis


DermNet™
All about the skin

Management

Advised nothing on vagina for 1 week post-biopsy
Given script for Advantan Fatty Ointment to commence after one week

- Nocte for 1 month
- Then 2nd daily ongoing until review again in 2 months

Suggested Dermeze as emollient/barrier use mane

Results

Vulval biopsy – lichenoid chronic inflammation, similar features may be seen in early lichen sclerosus, no evidence of malignancy or dysplasia

LVS MCS – no candida

Review -2 months later

Felt significant improvement with AFO regime
Forgot to use ointment for 2 weeks, then got vulval burning sensation again.
Resumed 2nd daily use, and burning has again resolved

O/E:
Bilateral labial resorption and partial burying of clitoris c/w previous changes
Pallor resolved
Non tender
Skin appears healthy, no ulceration/erosions or suspicious lesions
Perianal area NAD

Advised to drop AFO to 2-3 times/week depending on symptoms
Review 6 months

Review -6 months later

Had another admission to hospital with sepsis secondary to cellulitis
Was in ICU and again on prolonged Abx (IV then PO)
Dx with heart failure - commenced on Dapagliflozin by cardiologist

After discharge, vulval pain worse again. Had not used AFO while in hospital
Pain with urination, felt like “razor blades”, bleeding on wiping
Back to using AFO 2-3 times/week

O/E:
Anatomical changes as previously seen
Small skin fissure just above clitoris
Labial agglutination at posterior fourchette
Lichenification and erythema on labia majora bilaterally
LVS and vulval swabs sent – HSV neg, but heavy growth of candida

Mx: Advised Deremeze BD, Xylocaine jelly 2% PRN for analgesia, Increase potency of steroid from AFO to Diprosone OV daily for 1 month, then 2nd daily until review in 2 months. Tx with stat PO fluconazole for thrush

Review -2 months later

Felt improvement after a few days on Diprosone OV
Didn't feel that PO fluconazole made much difference

O/E:
Mild erythema on labia majora, non tender
Same anatomical changes
Some agglutination at posterior fourchette
No pallor or hyperkeratosis

Repeat LVS MCS – again heavy growth of candida albicans

Mx:
- Dip OV decreased to 2-3 times/week
- Advised to treat thrush again with PO fluconazole, and can self-treat if flares with symptoms

Review -6 months later

Since last review, having frequent flare ups
Recurrent thrush with discharge
Requiring oral fluconazole every 2-3 weeks, which helps but only short term
Bleeding from vulva
Symptoms settled in the last week with increasing Dip OV use

O/E:
Same anatomical changes
Smooth skin, no signs of active LS

Tx:
Given had >6 episodes of thrush in the last 6 months, suggest suppressive treatment with weekly fluconazole 200mg
Switched from Dip OV to clobetasol, as now on PBS. To use twice/week for maintenance

Review -6 months later

Has been taking oral fluconazole weekly
States has been “life changing”
Essentially has not had any flare ups in the last 6 months
Using clobetasol once a week

O/E:
Same anatomical changes
No active LS – no pallor/hyperkeratosis
Some skin thinning, with signs of steroid atrophy

Tx:
Topical steroid potency reduced back to Advantan Fatty Ointment – advised to use 1-2 a week
Suggest trial coming off oral fluconazole for a month, however if thrush returns, can go back on suppressive treatment

Discussion points

- What were the patient's risk factors in developing her vulval skin issues?
- Why did she keep having recurrent thrush?
- What key education points are important to discuss with the patient after the diagnosis of lichen sclerosus?
- What vulval skin care advice would you give?

History

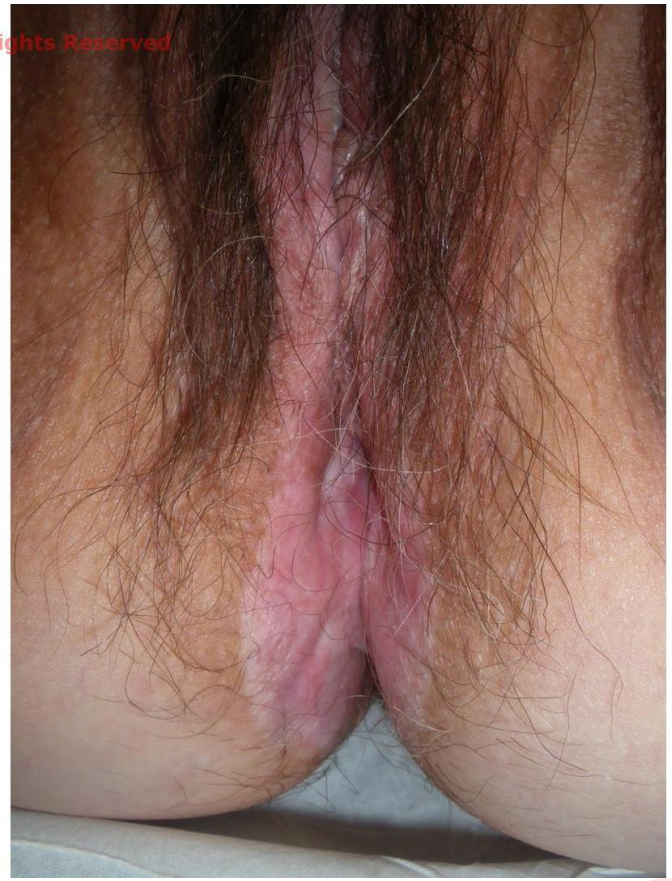
- Symptoms – itch, pain, irritation, dryness, narrowing of the vagina, discomfort with sex, bleeding, palpable lump, rough area
- General health including diabetes, other autoimmune conditions, pain conditions
- History of dermatitis or atopy
- Medications – oral, topical, vaginal pessaries
- Vulval care – washing frequency, water only or soaps, baby wipes
- Use of pads and what underwear
- Any incontinence – urinary or fetal, how often, volume
- What creams or moisturisers are being used
- Mobility – ability to self-apply topical treatments
- Social history – will costs be a limiting factor

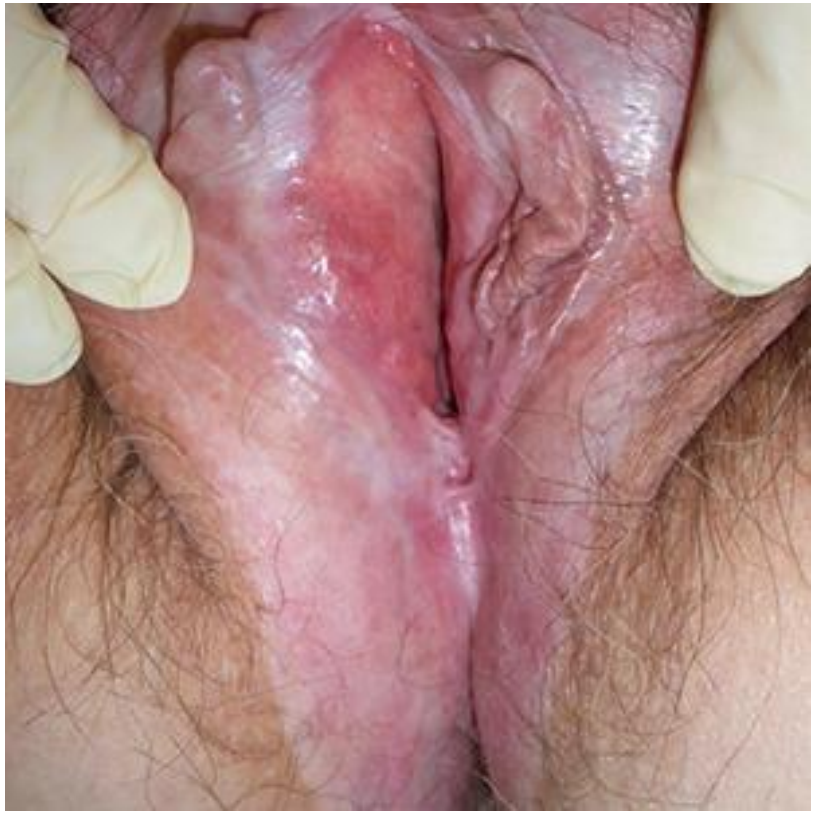
Vulval examination

- With consent and respect, in a safe environment
- Offer a sheet, good lighting
- Offer a mirror to talk the patient through examination findings if they wish, and to teach self-examination at home
- Active examination
  - Be systematic
  - Look at anatomical landmarks and skin. Start anteriorly and move posteriorly
  - Part the labia to examine the labia minora and vaginal mucosa
  - Use cotton tip to pinpoint exact area of discomfort or pain

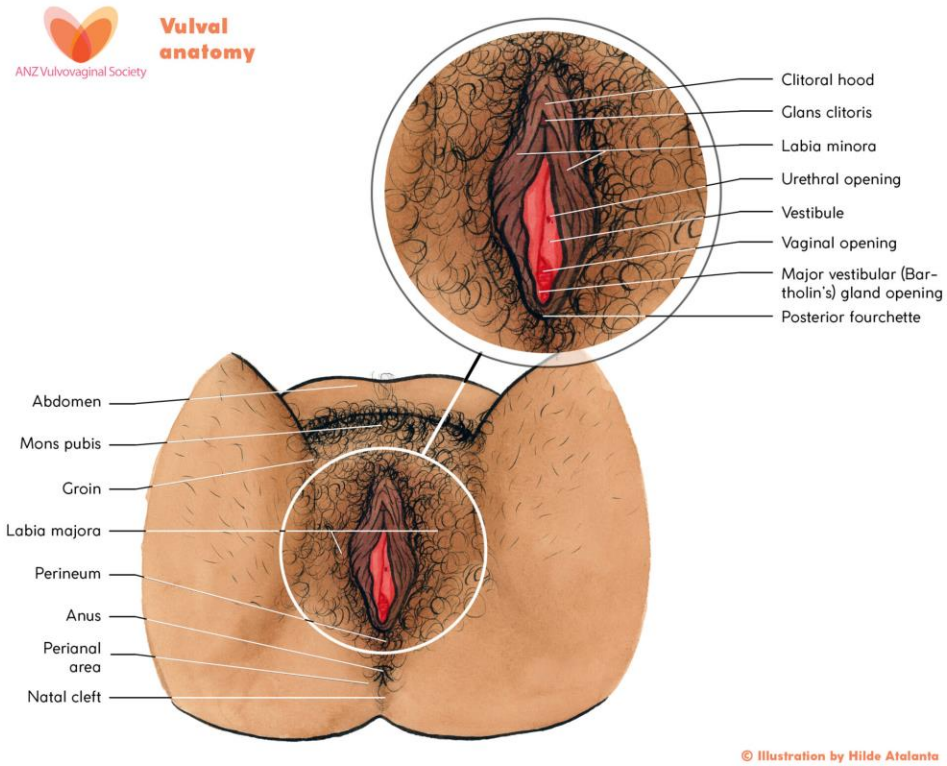
  Compare with previous examination findings to assess for interval change (diagrams or clinical photographs can be very helpful)
- If planning to do a biopsy, have equipment already set up before starting

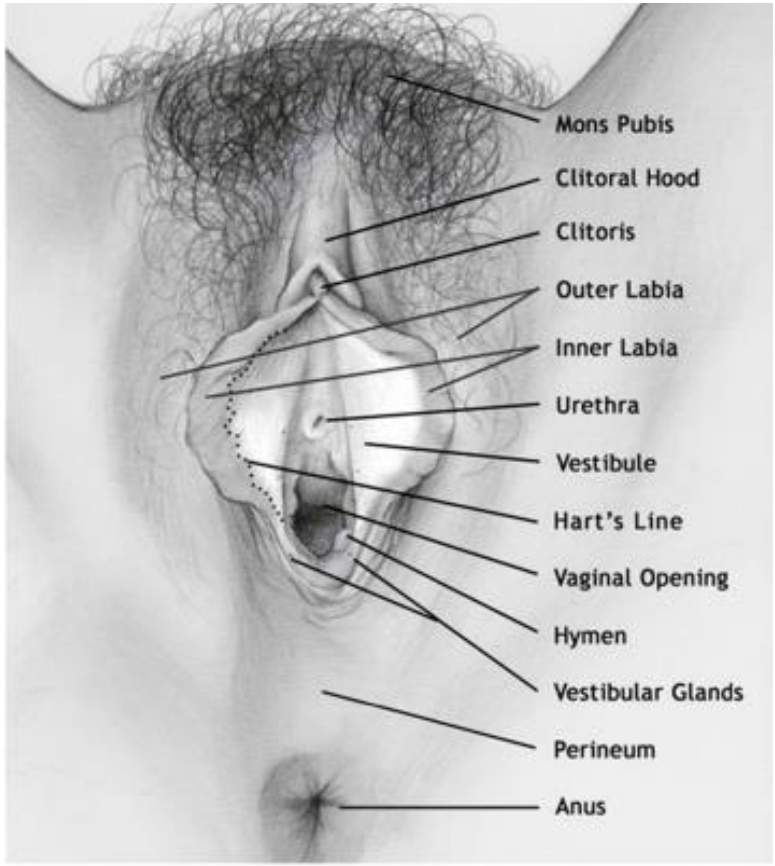
Active Examination





Vulval Anatomy





Vulval skin care

- Use cotton underwear
- Absorbable underwear better than liners or pads
- Use hypoallergenic laundry products to wash underwear, use less detergent
- Avoid fabric softeners
- Avoid tight fitting pants/jeans, especially if made of synthetic fibres
- Remove wet bathing suits as soon as possible
- Showering – avoid soaps on vulva, hands and water only to clean vulva, avoid washcloths and scrubbers. Pat skin dry gently
- Toileting – rinsing with water is less irritating than toilet paper, avoid baby/adult wipes
- Hair removal – avoid creams, and shaving. Trimming with clippers is OK
- Use an emollient to protect and moisturize the skin (Dermeze, Vaseline)
- Avoid scratching, use cool compresses instead

Resources

- ANZVS (Australia New Zealand Vulvovaginal Society) website
  - Great patient handouts on Vulval Care, Lichen Sclerosus, Vulval Biopsy, Vulvodynia, Candidiasis, Dermatitis, Lichen Planus, and Vulval Anatomy diagrams
  - https://www.anzvs.org/patient-information/
- Dermnet NZ
- - https://dermnetnz.org/topics/lichen-sclerosus
  - Covers a wide range of dermatological conditions, including those of the vulva
  - Lots of images to help correlate with examination findings

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Q&A
Vulval Dermatology

Dr Alice Troung

Vulval Disorders

Dr Rebecca Shields
Obstetrician/Gynaecologist

Mercy Health
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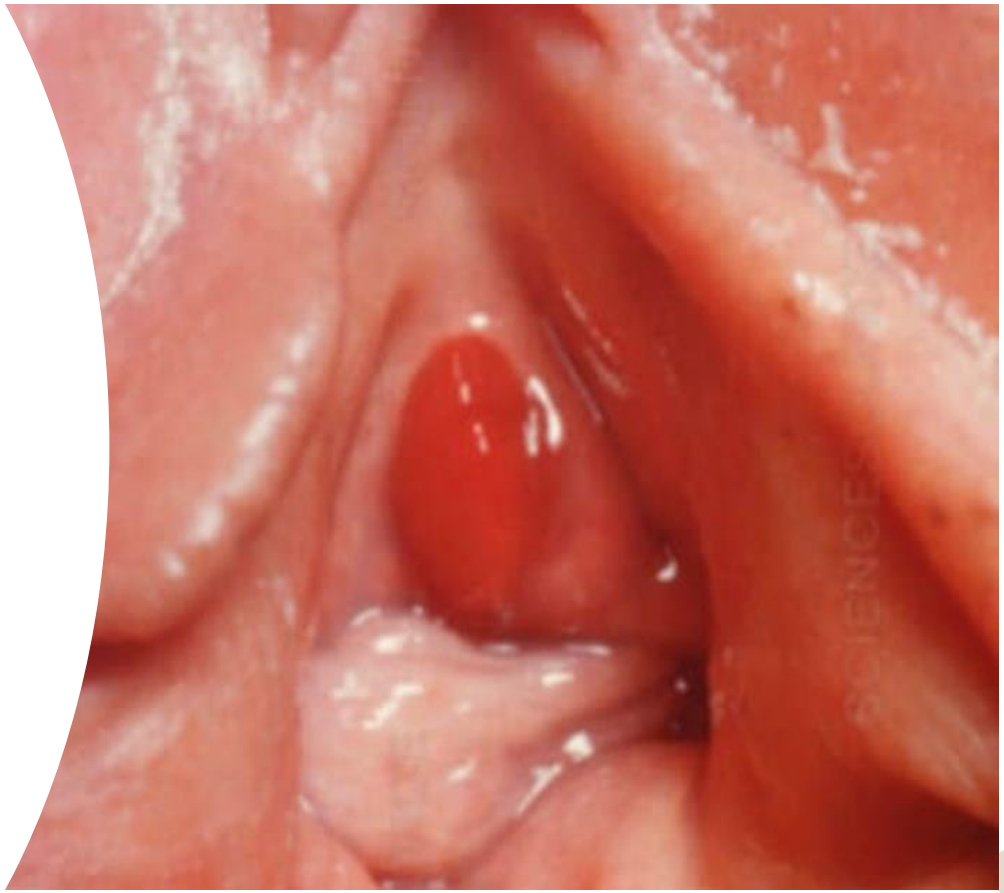
Overview

- Benign vulval lesions
- Lichen simplex chronicus
- Lichen sclerosus/lichen planus
- Vulvovaginal candidiasis
- Pain syndromes

Benign vulval lesions

Urethral caruncle

- Small partial urethral prolapse
- Common and benign
- Usually due to inflammation or reduced estrogen levels
- Tx with topical oestrogens
- Ddx: urethral polyp, para-urethral cyst, urethral diverticulum, condyloma, urethral carcinoma
- Consider biopsy or refer for excision if unsure or symptomatic despite conservative tx



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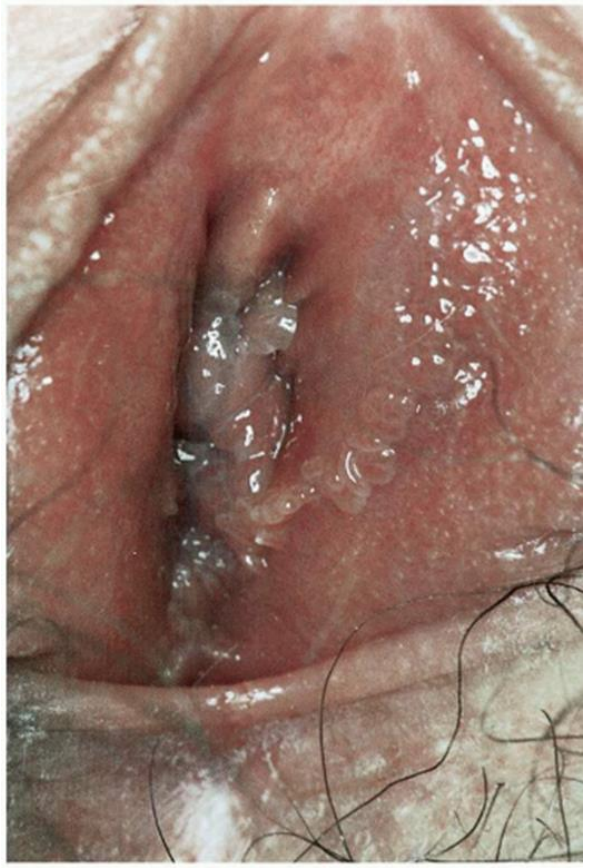
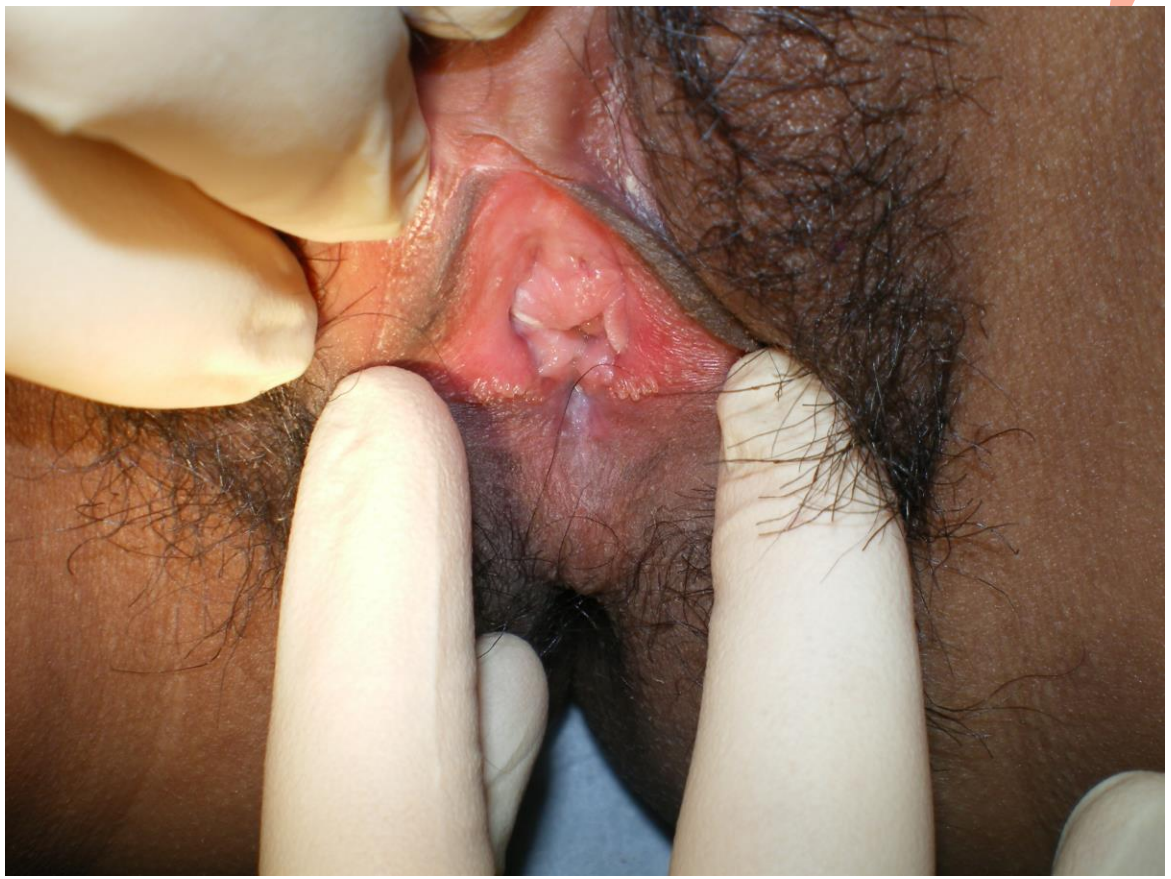
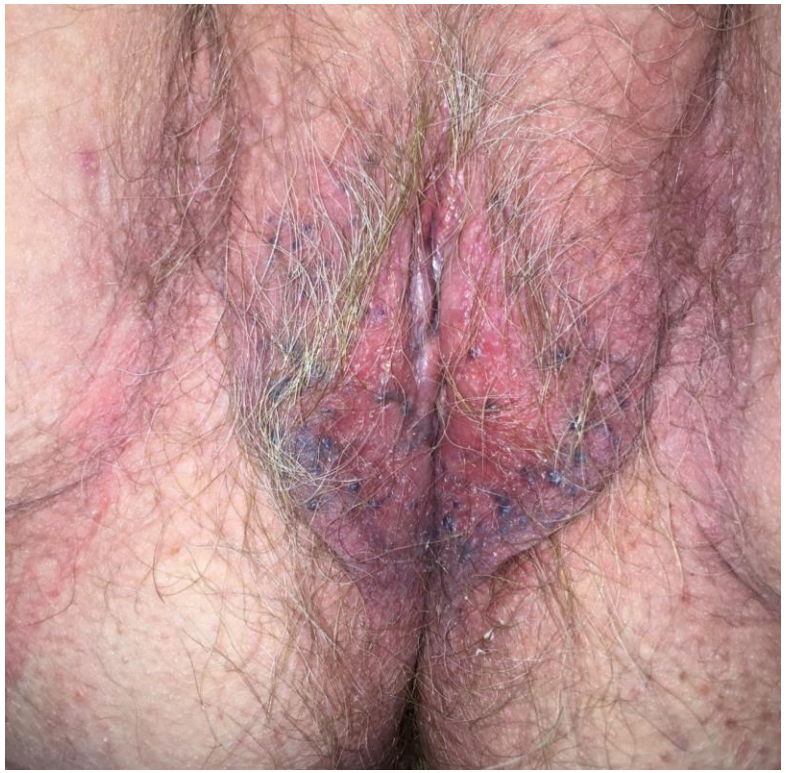
Vulval Papillae





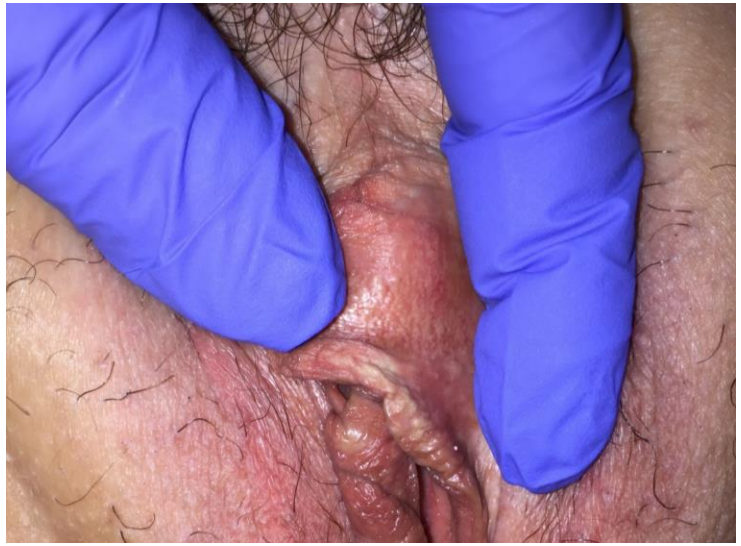
Angiokeratomas

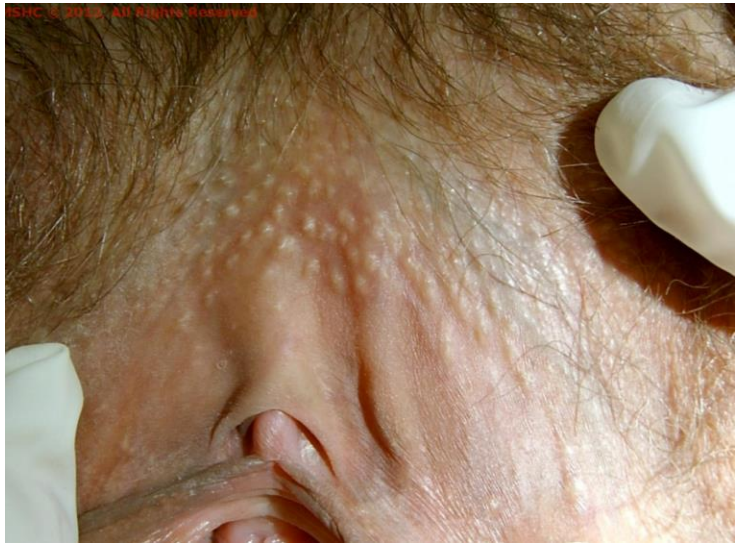
- Benign capillary dilatation in the superficial dermis
- Asymptomatic blue-red hyperkeratotic papule anywhere on the skin



Fordyce spots

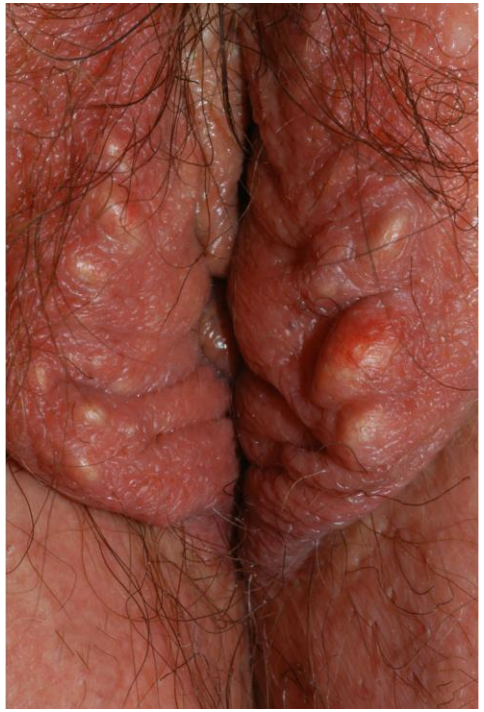
- Cream coloured lobules of enlarged sebaceous glands

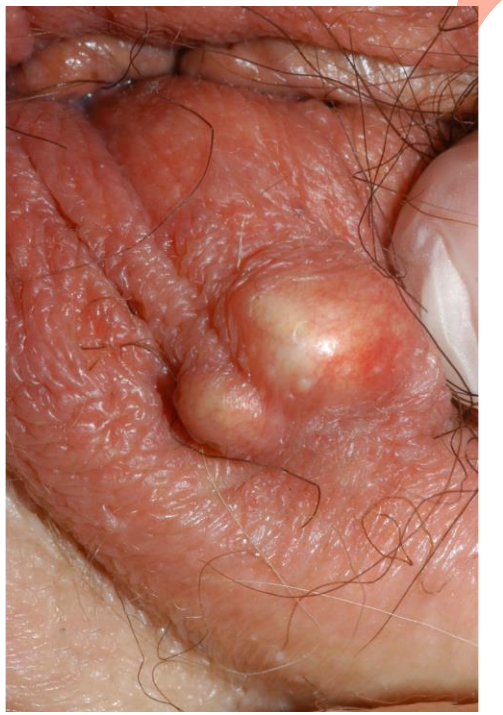




Epidermal inclusion cysts

- Also known as a sebaceous cyst
- Benign encapsulated, subepidermal nodule filled with keratin material
- Freely moveable unless previously inflamed
- Histology – cyst lined by squamous epithelium with a granular layer and filled with compact keratin
- Can become red and tender if infected or traumatized
- Surgical excision can lead to bleeding, secondary infection, and scarring

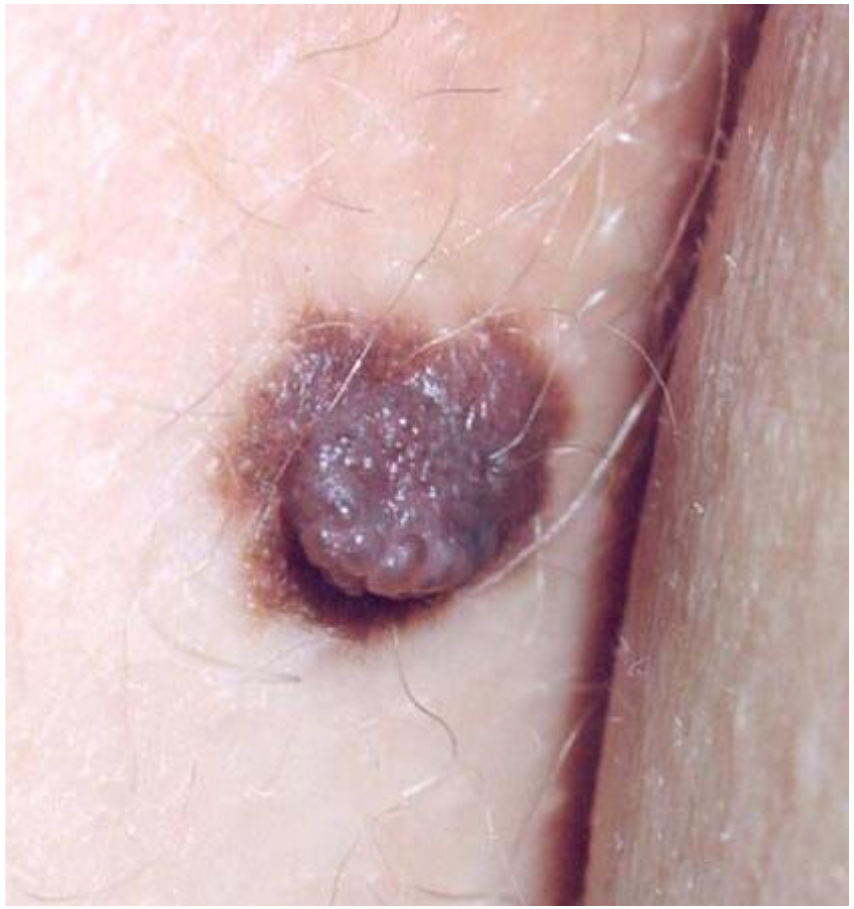




Vulval pigmentation

- Normal variation
- Vulval melanosis
- Post-inflammatory hyperpigm
- Vulval naevi
- Vulval melanoma

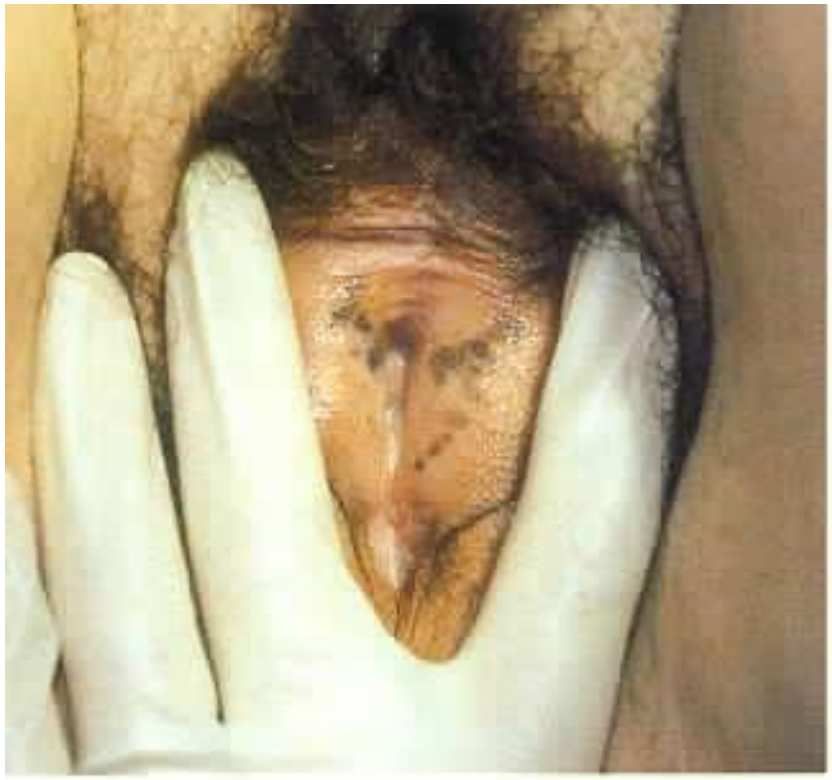
Benign naevus



Vulval Melanosis

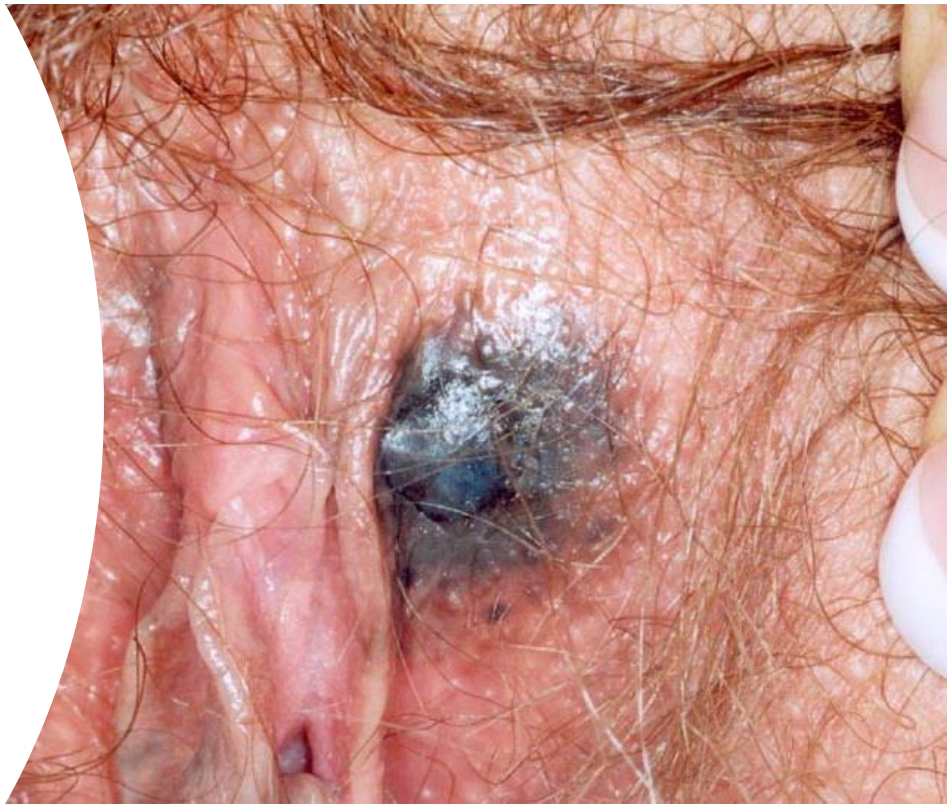
- Benign acquired condition
- Patchy, flat (macular)
- Multiple lesions
- Common usually from middle life

- Ddx is vulval melanoma
- Refer for biopsy if single lesion, significantly asymmetrical distribution or changing



Vulval Melanoma

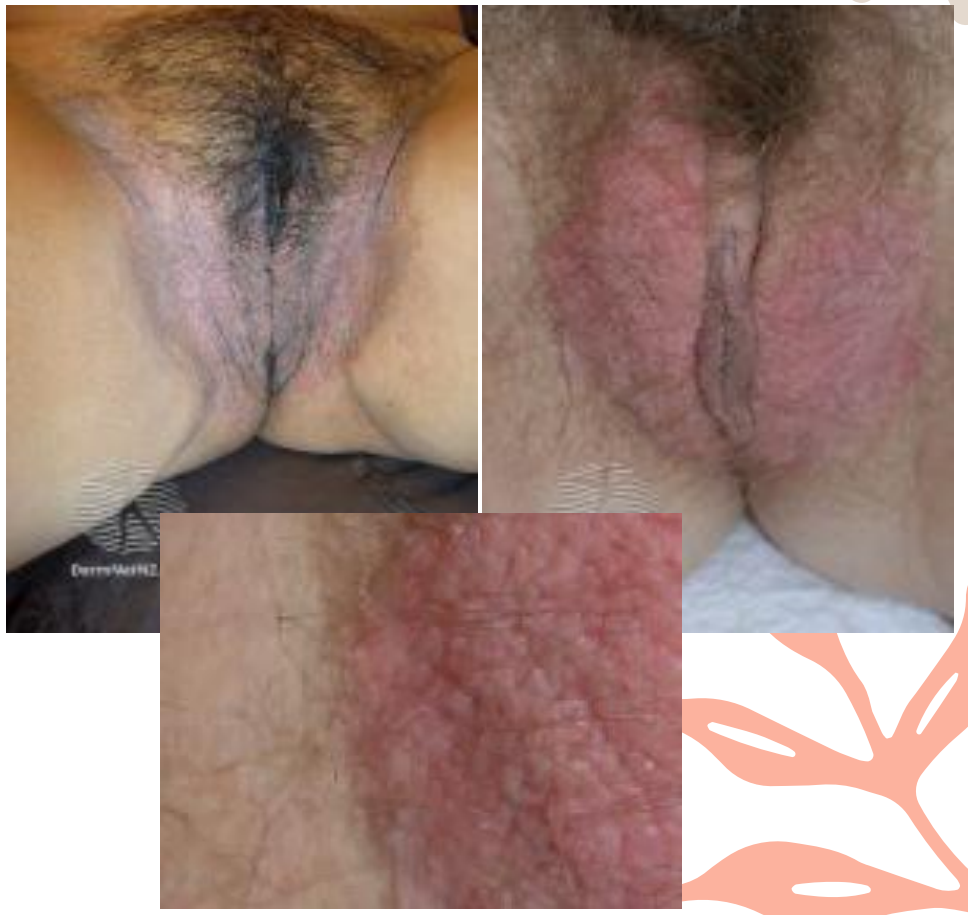
- Accounts for 5% of all vulval cancers, and 1% of all melanomas in women
- Reported incidence is <0.2 cases/100,000 women, predominantly in white women aged 40-60 yrs
- Signs: irregular pigmented macule, papule or nodule on the labia majora or clitoris



Vulval Dermatoses

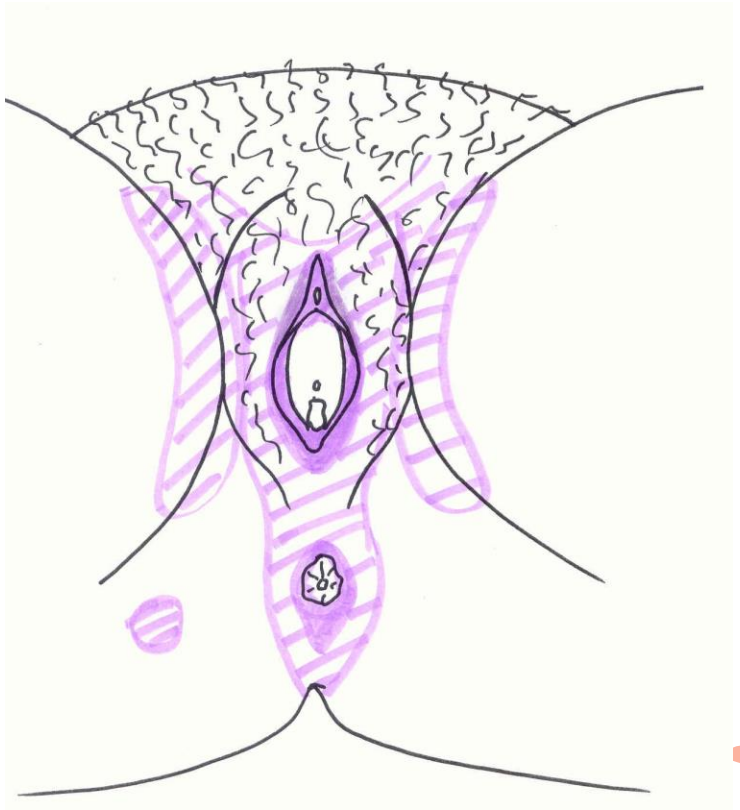
Lichen Simplex Chronicus

- Secondary skin disease caused by chronic scratching
- Lichenification of skin: thickened plaques, excoriation
- Architecture preserved, no increased cancer risk
- May be secondary to atopic/contact dermatitis, thrush, LS/LP – exclude underlying causes
- Intense itch, worse at night
- Treatment
  - Must stop scratching: antihistamines, cotton gloves, address psychological comorbidities
  - Topical steroids for a few weeks
  - Vulval skin care



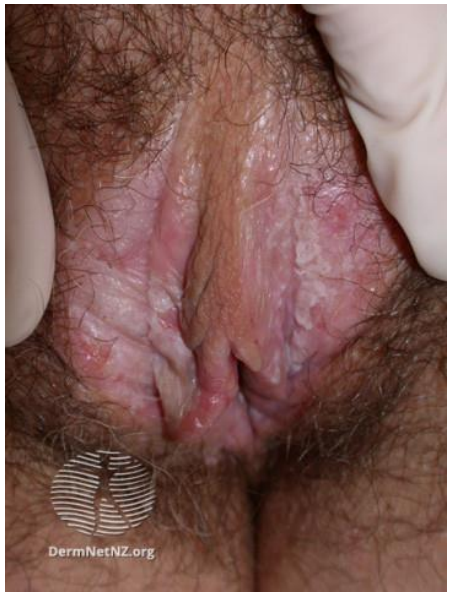
Lichen Sclerosus

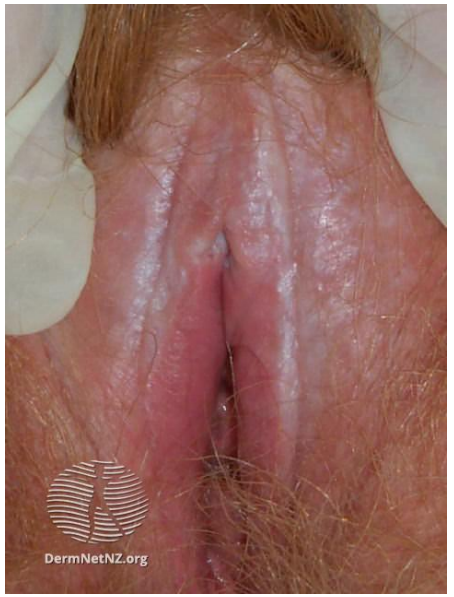
- Any age, but most often in women over 50
- Can occur pre-puberty in children
- 10 x more common in women than men
- Likely autoimmune basis
- 10% of women have a family history
- Can present with itch, burning, dyspareunia, dysuria or be asymptomatic
- Usually only on vulva

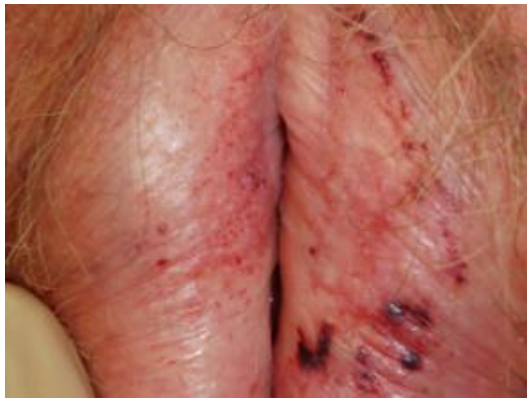


Lichen Sclerosus

- Features
  - White atrophic epidermis
  - Fissures
  - Purpura
  - Sclerotic, thickened dermis
  - Permanent loss of normal architecture
  - 5% lifetime risk of VIN/SCC

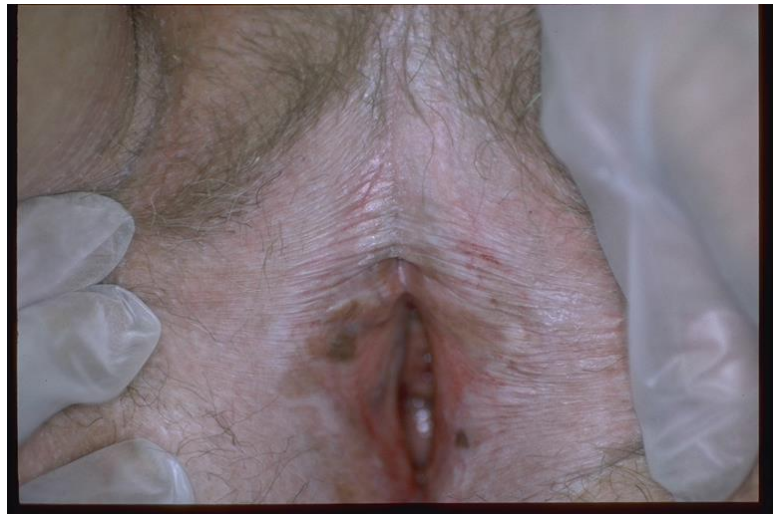


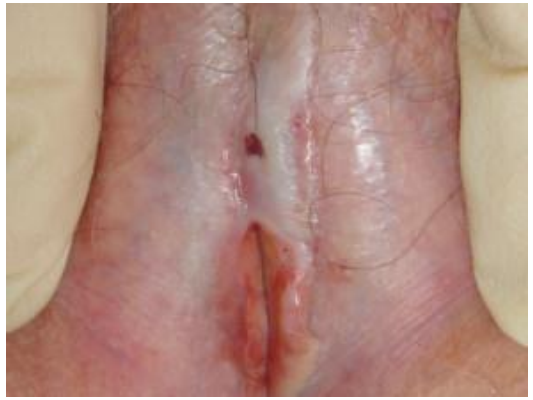




End-stage Lichen Sclerosus

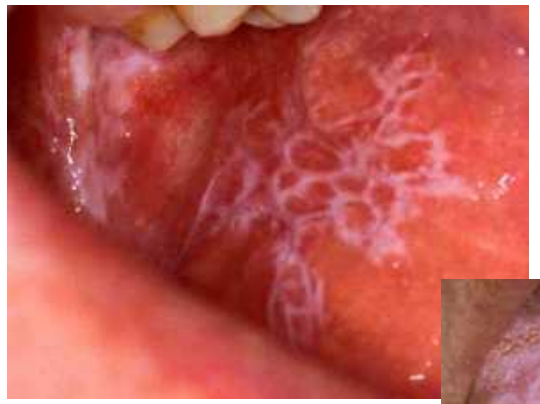
- Complete resorption of labia minora bilaterally
- Complete burying of the clitoris
- Narrowing of the vaginal introitus
- Hyperkeratotic, pale skin

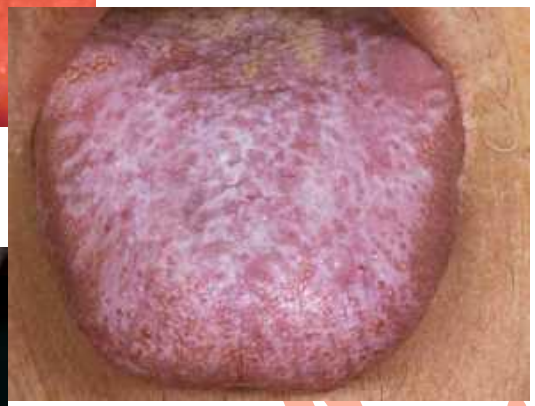


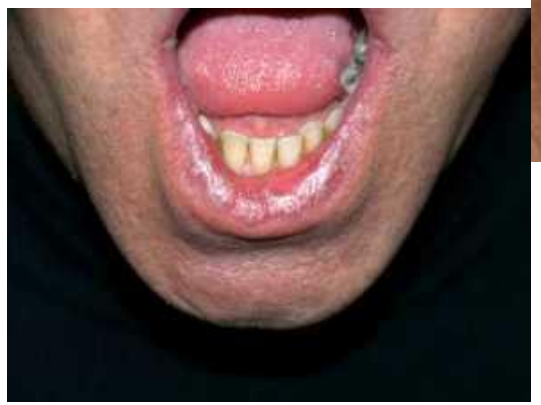


Lichen Planus

- A chronic inflammatory condition affecting the skin and mucosal surfaces – T-cell mediated autoimmune disorder
- Subtypes
  - Cutaneous LP
  - Oral LP
  - Vulval LP
  - Erosive LP can uncommonly affect lacrimal glands, eyelids, ear canal, oesphagus, larynx, bladder and anus
  - Lichen planopilaris – affecting the scalp
  - Nail LP





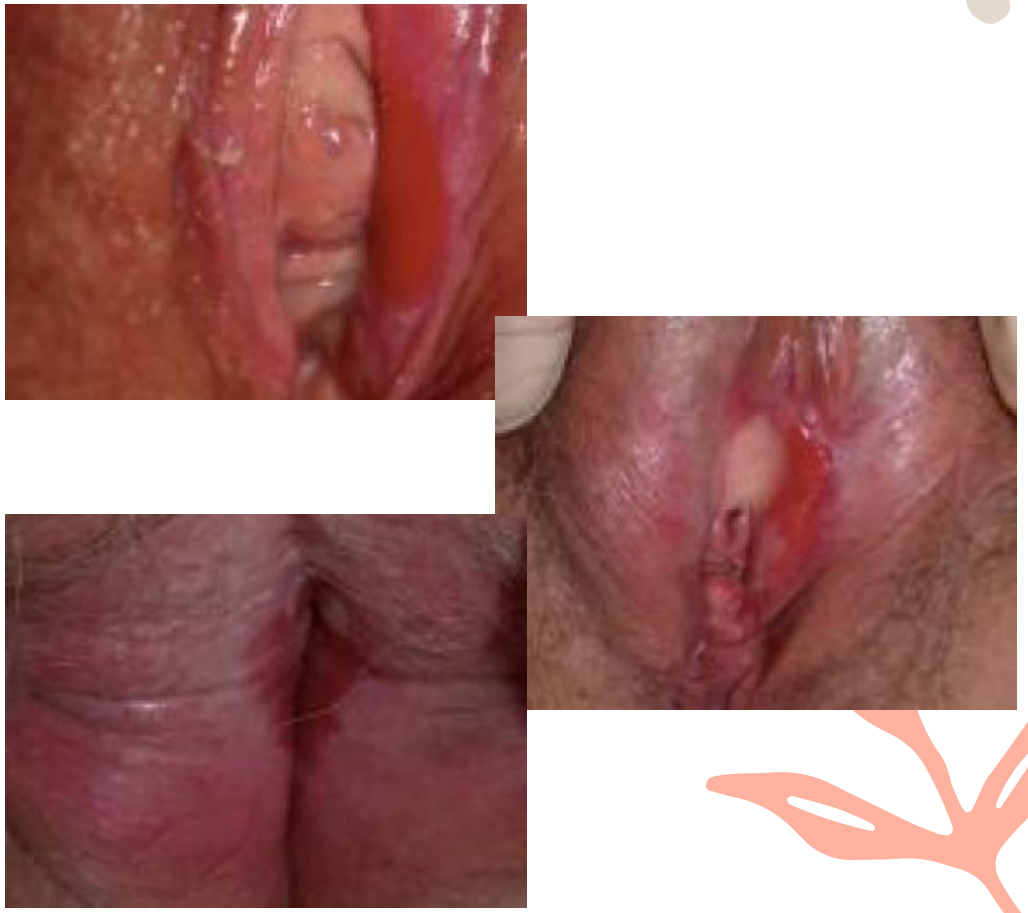


Vulval Lichen Planus

May affect the labia majora, minora and vaginal introitus

Presentation includes:

- Painless white streaks in a lacy/fern-like pattern
- Painful and persistent erosions and ulcers
- Scarring, resulting in adhesions, resorption of labia minora and introital stenosis
- Painful desquamative vaginitis, may bleed easily on contact
- Can overlap with vulval LS



Topical steroids

Topical steroids

BRAND NAME	GENERIC
Mild (Class I)	
Dermaid: C 30g	Hydrocortisone (alcohol) 0.5%
Cortic-DS: O 30g 50g, C 30g 50g Dermaid: C 30g SC: 30g, Sp (30mls), Sol (30mls) Sigmacort: O 30g & 50g, C 30g & 50g	Hydrocortisone (alcohol or acetate) 1%
Moderately Potent (Class II)	
Desowen: AqL 60ml	Desonide 0.05%
Eumovate: C 30g Kloxema: C 30g	Clobetasone butyrate 0.05%
Aristocort: O C 100g 2tubes Tricortone O C 100g 2tubes	Triamcinolone acetonide 0.02%
Antroquoril: C100g 2tubes Betnovate 1/5: C 100g 2tubes Celestone-M: C 100g 2tubes Cortival 1/5: C 100g 2tubes	Betamethasone valerate 0.02%
Betonvate ½: C 15g Cortival ½: O C 15g	Betamethasone valerate 0.05%

Source: Skinhealthinstitute.org.au

Green= PBS/RPBS

*= only PBS for Eczema

Red=RPBS only

Black=Not on PBS

Potent (Class III)	
Advantan FO 15g, O 15g, C 15g, AqL* 20g (not ml)	Methylprednisolone aceponate 0.1%
Elocon: O 15g, 45g, 50g, L 30ml Elocon Alcohol Free Cream: C 5g, 15g, 50g Novasone: O 15g, C 15g, L 30ml Zatamil: HG 15g & 45 g, O 15g 45g, L 30ml	Mometasone furoate 0.1%
Betnovate O C 30g	Betamethasone valerate 0.1%
Diprosone: O 5g, 15g, 50g, C 5g, 15g, 50g, L 30ml Eleuphrat: O 15 g, C 15g	Betamethasone dipropionate 0.05%
Very Potent (Class IV)	
Diprosone OV: O 30g, C 30g	Betamethasone dipropionate 0.05% in optimized vehicle
Clobex Shampoo 125ml	Clobetasol propionate 0.05%
Clobetasol O, C, L	Clobetasol propionate 0.05%

Green= PBS/RPBS

*= only PBS for Eczema

Red=RPBS only

Black=Not on PBS

Source: Skinhealthinstitute.org.au

Topical steroids

- Aim is to
  - Treat symptoms
  - Prevent flare
  - Prevent cancer
  - Maintain function
- Undertreatment is common and leads to progression
- Regime is tailored to the individual
  - Severity of disease
  - Cost
  - Treatments already tried and previous response
  - Compliance with treatment and follow up
- Start with a higher dose to treat flare then reduce
  - Eg clobetasol ointment daily for six weeks then twice weekly - lifelong
- Less potent steroid perianally

Topical Steroid

- Barriers to treatment
  - Patient concern re: steroid use
  - Poor knowledge of anatomy
  - Difficulty reaching vulva
  - Reluctance to touch vulva
  - Poor knowledge of vulval hygiene, incontinence
  - When symptoms controlled, motivation to continue treatment is low
- Suggestions
  - Reassurance re: steroid, “cancer prevention”
  - Diagrams, photos, mirror
  - Education
  - Enlist others to help apply
- Steroid overtreatment possible – often due to incorrect application

Steroid adjuncts

- Vulval skin care
- Vaginal oestrogen
- Pelvic physiotherapy
- Screen for and treat candidiasis
- Moisturisers
- Barrier creams

Vaginal steroids

- Lichen planus can affect the vagina
  - Speculum examination
- Vaginal steroids can be necessary – no specific vaginal steroid available
- Options
  - Compounded pessaries
  - Apply steroid ointment eg clobetasol vaginally
  - Rectal steroids eg budesonide foam

Follow up

- Yearly when stable
- Experienced clinician
- Examination: for flare, HSIL/SCC, steroid overtreatment
- Check steroid application
- Repeat prescription
- Reiterate treatment
- Revisit skin care

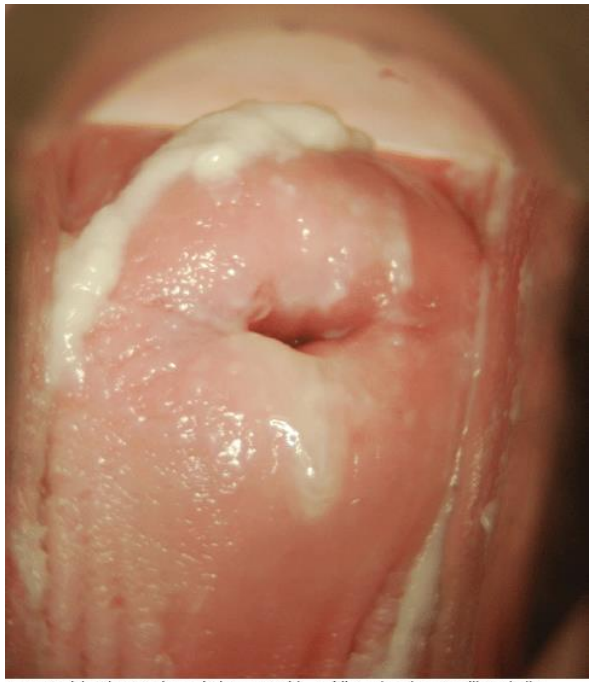
Candidiasis

Candidiasis

- Common! 75% of women will experience thrush
  - 85-90% are candida albicans
  - 10-15% other: candida glabrata (nakaseomyces glabratus), c. parapsilosis, tropicalis, c. krusei and saccharomyces cervisiae
- Asymptomatic in 10-20% of women
- Candida grows in a glycogen rich, oestrogenised environment i.e. reproductive age, OCP usage and pregnancy
- Less likely in children and postmenopause
- Risk factors: antibiotics, MHT, immunosuppressants, diabetes
- Most healthy women have no identifiable cause

Treatments

- Acute candida albicans vulvovaginitis
  - Clotrimazole vaginal cream/pessary 3-6 nights
  - Miconazole vaginal cream/pessary 6 nights
  - Fluconazole 150mg PO stat, every every 72 hours for 2-3 doses if symptoms severe (contraindicated in pregnancy)
  - Nystatin vaginal cream/pessaries daily for 14 days or BD for 7 days
- Acute non-albicans candida:
  - As above but for longer duration e.g. 2 weeks
  - Amphotericin B lozenge PV BD for 2 weeks
  - Boric acid 600mg PV nocte for 2 weeks



Source: Richard P. Usatine, Mindy Ann Smith, Heidi S. Chumley, Camille Sabella, E.J. Mayeaux, Jr., Elumalai Appachi: *The Color Atlas of Pediatrics*: www.accesspediatrics.com
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Recurrent Candidiasis

- Defined as 4 or more episodes of candida in one year
- Can have cyclical pattern with flare pre-menstrually
- May not have vaginal discharge as a feature
- Vulval swabs to confirm diagnosis helpful
- Can co-exist with dermatitis
- Consider diabetes

Recurrent Candidiasis

- Needs long-term suppressive treatment:
  - Induction with 2 weeks topical treatment
  - Fluconazole 100-200mg once or twice a week
- Topical steroids can also be helpful in reducing inflammation and symptoms
- No evidence for treatment of male partners, probiotics, dietary changes etc
- Vulval skin care important

Pain syndromes

Definitions

- Vulvodynia – chronic vulval pain of unknown etiology lasting >3 months in duration
- Dyspareunia – genital pain that can be experienced before, during and after intercourse. Can be superficial or deep
- Vaginismus – involuntary tension of the pelvic floor muscles around the vagina (with attempted vaginal penetration)

Vulval Pain

- Descriptors:
  - Localised/generalized – often localized to vestibule
  - Provoked/spontaneous/mixed
  - Onset – primary/secondary
  - Temporal pattern – intermittent, persistent, constant, immediate, delayed
- Must exclude other causes: genitourinary symptoms of menopause, LS/LP, lichen sclerosus, herpes – examination is key.
- Concomitant pelvic floor dysfunction very common

How can vulvodynia present?

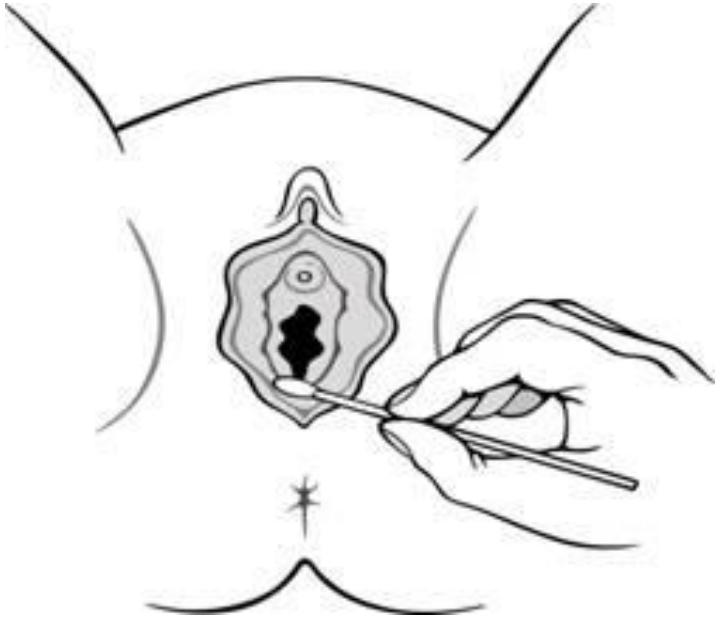
- Burning, soreness, itching
- Dyspareunia, pain with vaginal penetration
- Pain with or inability to use a tampon
- Pain on wiping, with tight clothing, prolonged sitting
- Associated pelvic floor symptoms e.g. bowel or bladder pain
- May be secondary: eg childbirth, recurrent thrush

Associated conditions

- Other pain syndromes e.g. painful bladder syndrome, fibromyalgia, irritable bowel syndrome
- Musculoskeletal e.g. pelvic muscle overactivity, myofascial, biomechanical
- Neurological mechanisms – central and peripheral sensitization
  - Central (spine, brain)
  - Peripheral
  - Neuroproliferatiion
- Psychosocial factors e.g. mood, interpersonal, coping, role, sexual function

Examination

- Cotton tip test to map areas of sensitivity and pain
  - Gentle pressure is applied with a cotton swab starting at the thigh and moving medially to the labia majora, interlabial sulcus, clitoral hood, labia minora and sites within the vulval vestibule (2, 4, 6, 8, 10 and 12 o'clock)
  - Pain is recorded on a numeric ratings scale 0 to 10
  - Helps distinguish between localized and generalized vulvodynia



Examination

- Pelvic floor muscle examination
- Trust/therapeutic relationship very important – examination not mandatory

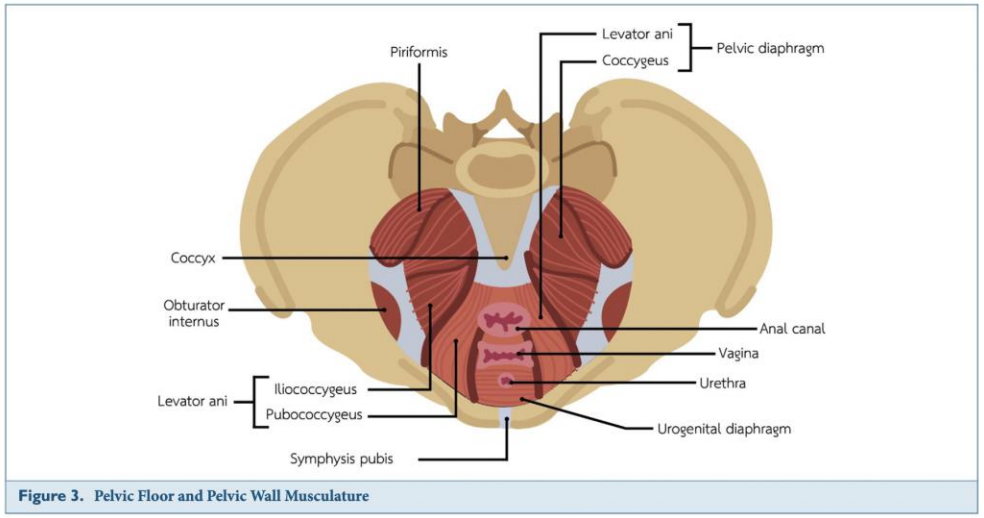


Figure 3. Pelvic Floor and Pelvic Wall Musculature

Evaluation and treatment of vulvodynia: state of the science. Schlaeger et al. *J Midwifery Women's Health 2023;68:9-34*

Treatments

- Education
  - Pain is real, treatable
  - Expect a slow and steady improvement
  - Validation
- Genital skin care
- Pelvic floor physiotherapy, may include dilators, pelvic floor wands, biofeedback
- Local anaesthetic gel
- Consider topical oestrogen
- Medications – tricyclic antidepressants, anticonvulsants, ga
- Psychology/sexual counselling
- Nerve blocks
- Surgery e.g. vestibulectomy

Thank you!

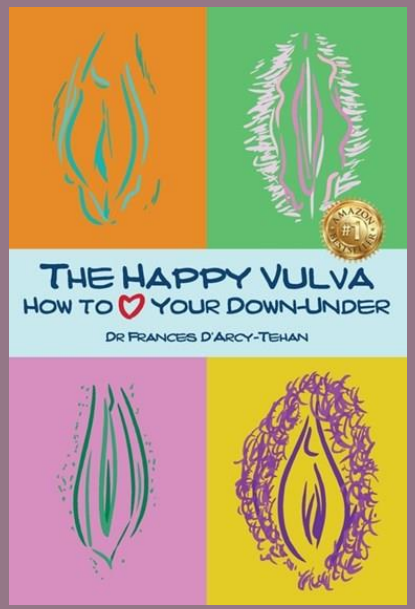
Resources

www.anzvs.org

www.issvd.org

dermnetnz.org

www.mshc.org.au



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Care first

Q&A
Vulval Disorders

Dr Rebecca Shields

Save the Date

ANZVS

Biennial Scientific Conference

Featuring Education Day and Workshops

6 – 8 November 2026

Sofitel Melbourne on Collins

Proudly hosted by ANZ Vulvovaginal Society

Mercy Health

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Vulval Red Flags & When to Refer: VIN, Severe Dermatoses and Systemic Therapy

Mercy Health
Care first

By DR STEPHANIE BOND MBBS FRANZCOG FACHSHM
FEB 2026

Most vulval symptoms are benign
Some are not (& are frequently missed)

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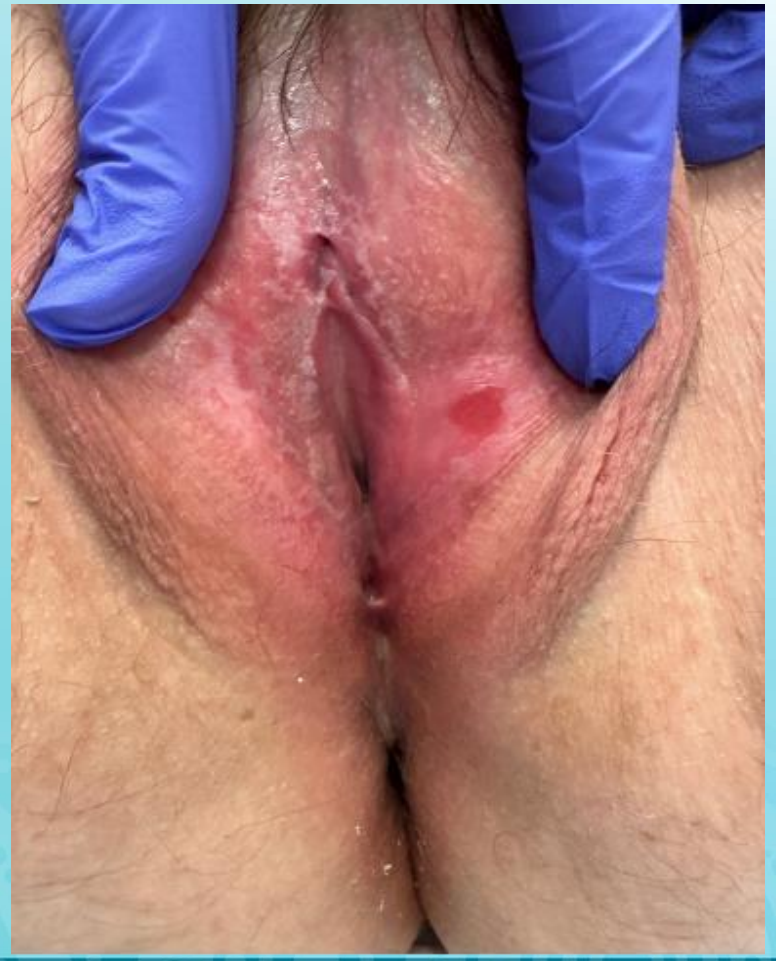
Delayed diagnosis leads to:

Ongoing pain & scarring

Sexual dysfunction

Missed VIN or malignancy



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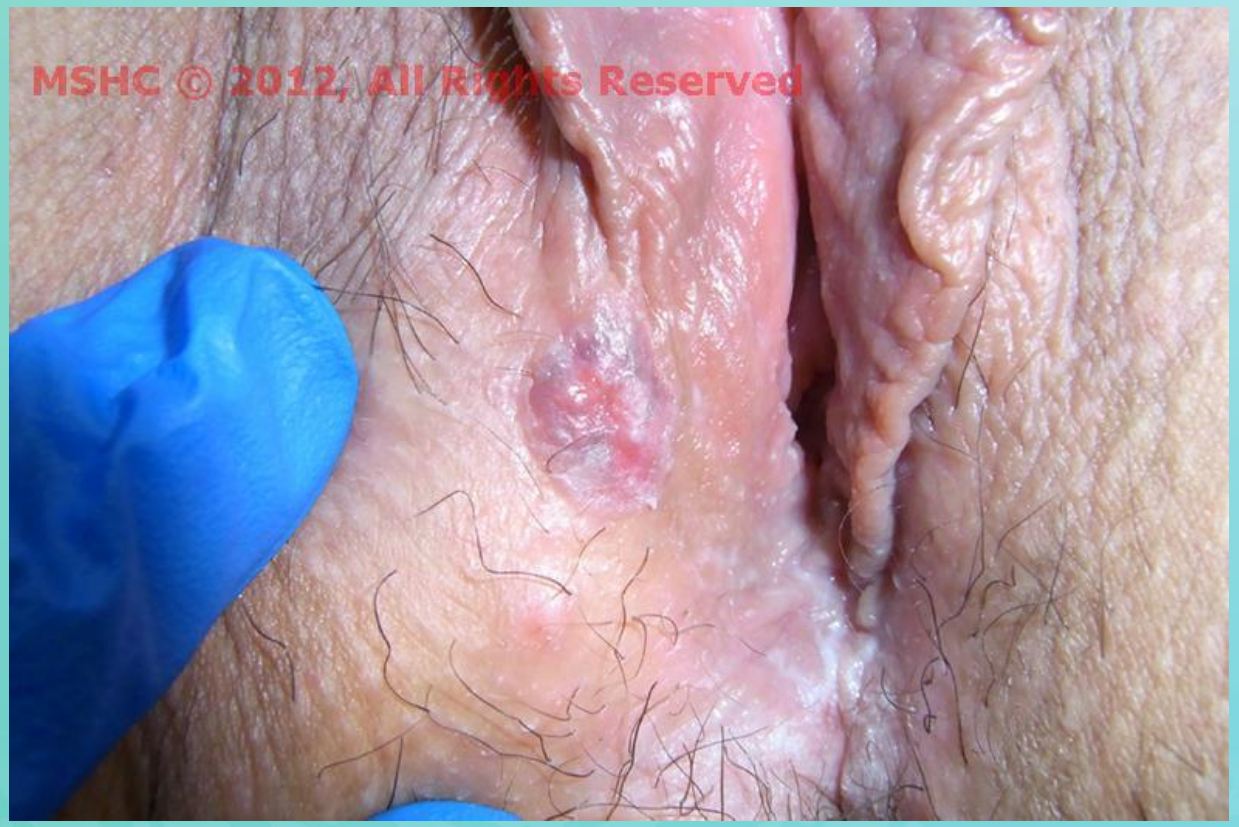


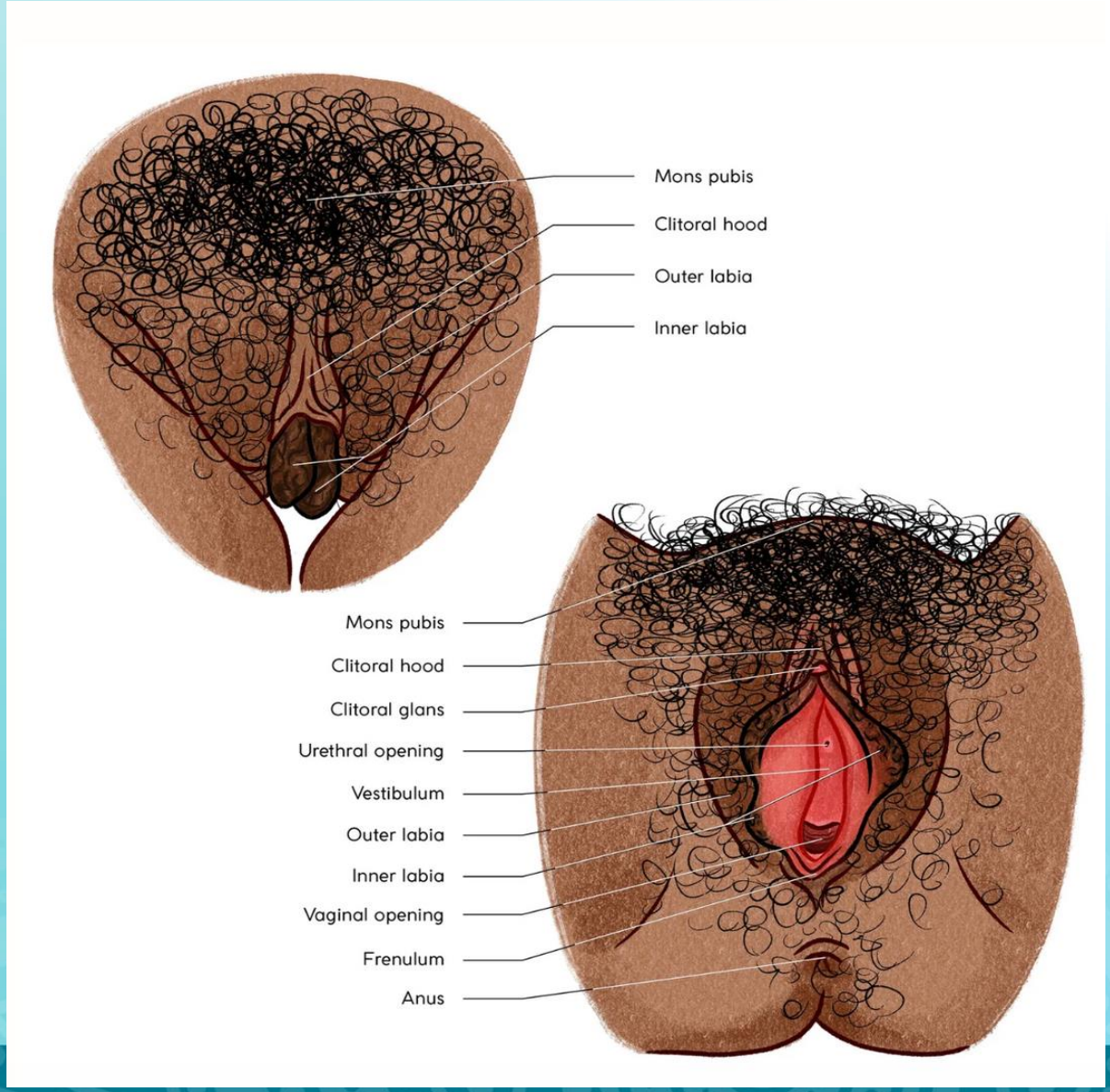
Prevention: general strategies

Smoking cessation

Systemic immunosuppression

“Vulva awareness” and self examination

Regular LS follow up



Jamieson A, Tse SS, Brar H, Sadownik LA, Proctor L. A Systematic Review of Risk Factors for Development, Recurrence, and Progression of Vulvar Intraepithelial Neoplasia. J Low Genit Tract Dis. 2022;26(2):140-146. doi:10.1097/ LGT.0000000000000662

Prevention of HPV-associated neoplasia

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Universal HPV vaccination

Adult vaccination:

Consider in unvaccinated women at ongoing risk

Particularly important before transplantation or immunosuppression

Secondary prevention:

Vaccination around treatment for HSIL may reduce recurrence in cervical disease

Vaccination may still be offered for benefits in HPV acquisition, autoinoculation, and cervical protection

Reuschenbach M, Doorbar J, Del Pino M, et al. Prophylactic HPV vaccines in patients with HPV-associated diseases and cancer. Vaccine. 2023;41(42):6194-6205. doi:10.1016/j.vaccine.2023.08.047

Persistent or focal symptoms should trigger review

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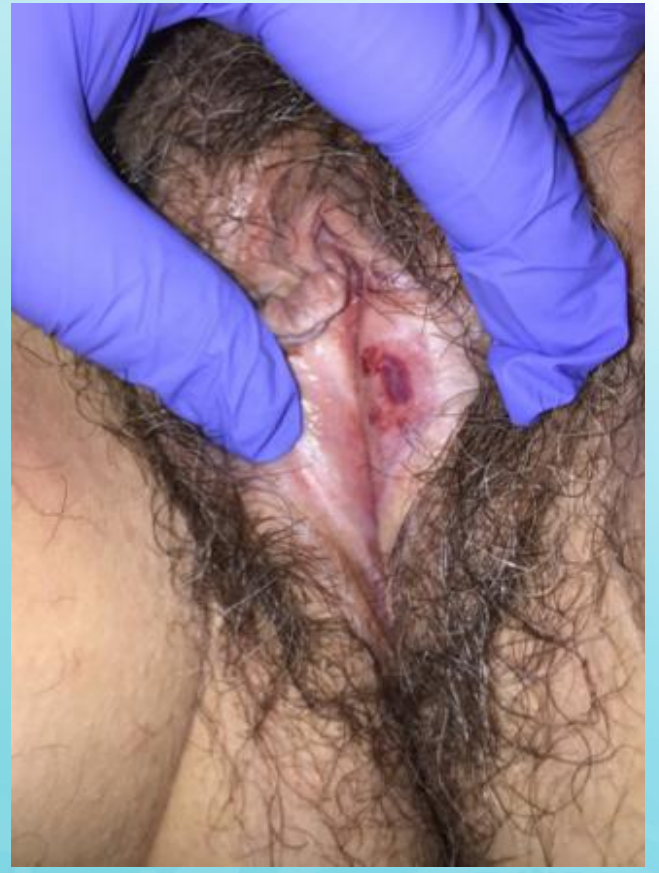
- Unilateral or focal pain
- Non-healing fissures or ulcers
- Bleeding or crusting
- Progressive dyspareunia
- Symptoms despite appropriate treatment



Look carefully/ document clearly

Clinical photos often helpful

Loss of vulval architecture

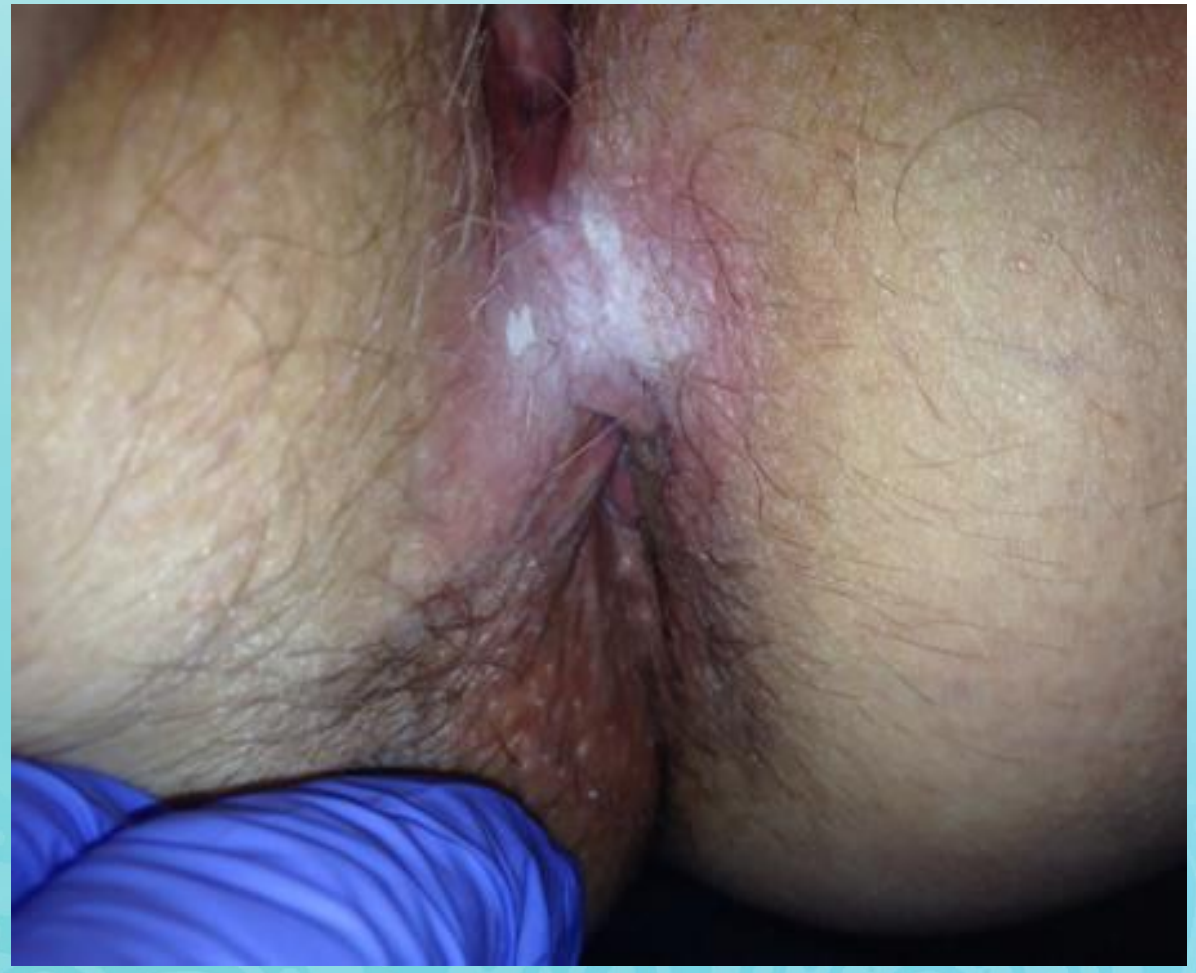
Asymmetry

Pigmented or thickened lesions

Hyperkeratosis

Erythema or ulceration that persists

Palpable induration



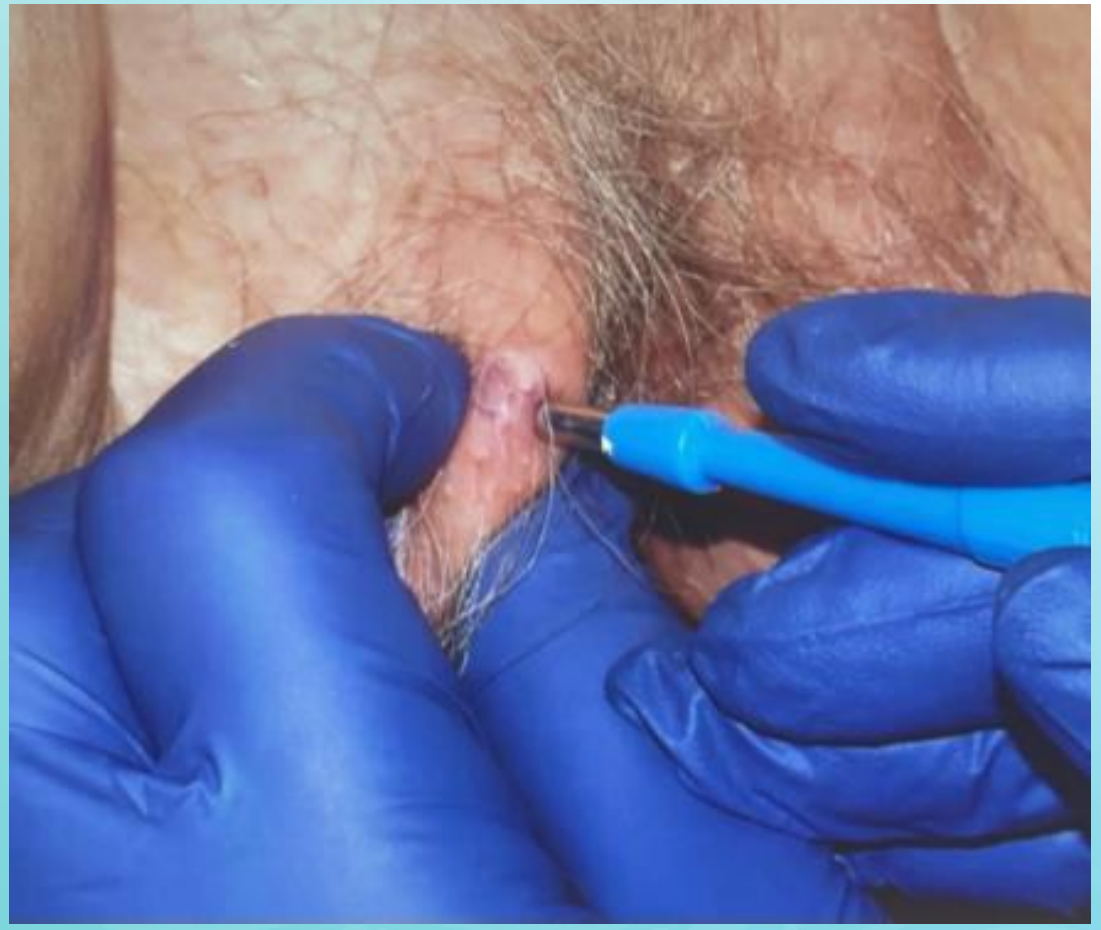
Common Pitfalls

Repeated antifungals

Low-potency steroids only

No reassessment

No biopsy



If you’re escalating treatment because it’s “not improving”

→ stop and reconsider diagnosis

Why it's missed

Does not have a single appearance

Can be:

Pigmented, white, erythematous or thickened

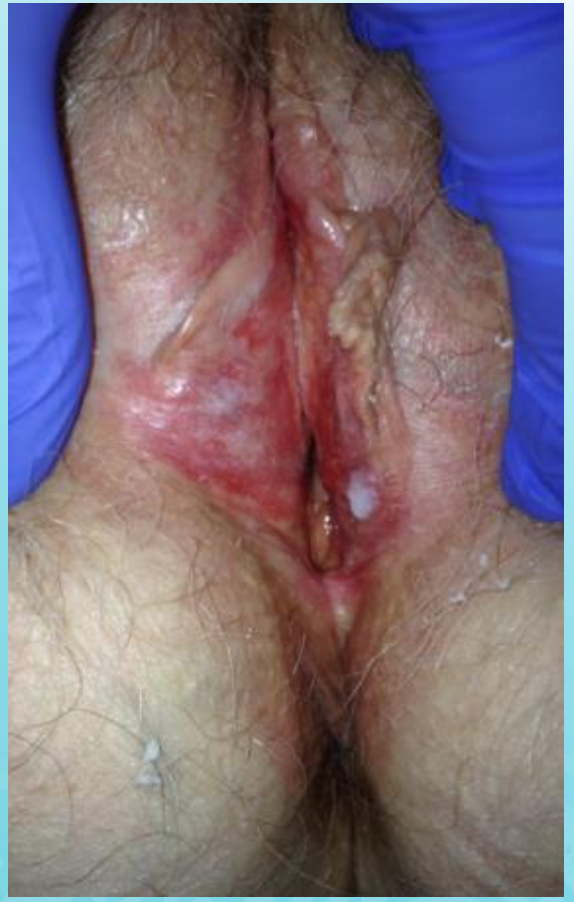
Often misdiagnosed as:

Thrush

Dermatitis

Lichen sclerosus flare

Symptoms may be subtle or focal



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Clinical examination

Mercy Health

Precursor lesions are highly variable:

Colour: white (70–75%), pink or red (25–40%)

Surface: rough, cobblestone, verruciform, eroded

May be multifocal (16–18%)

Common sites: periclitoral, labia minora, vestibule, posterior fourchette, perianal

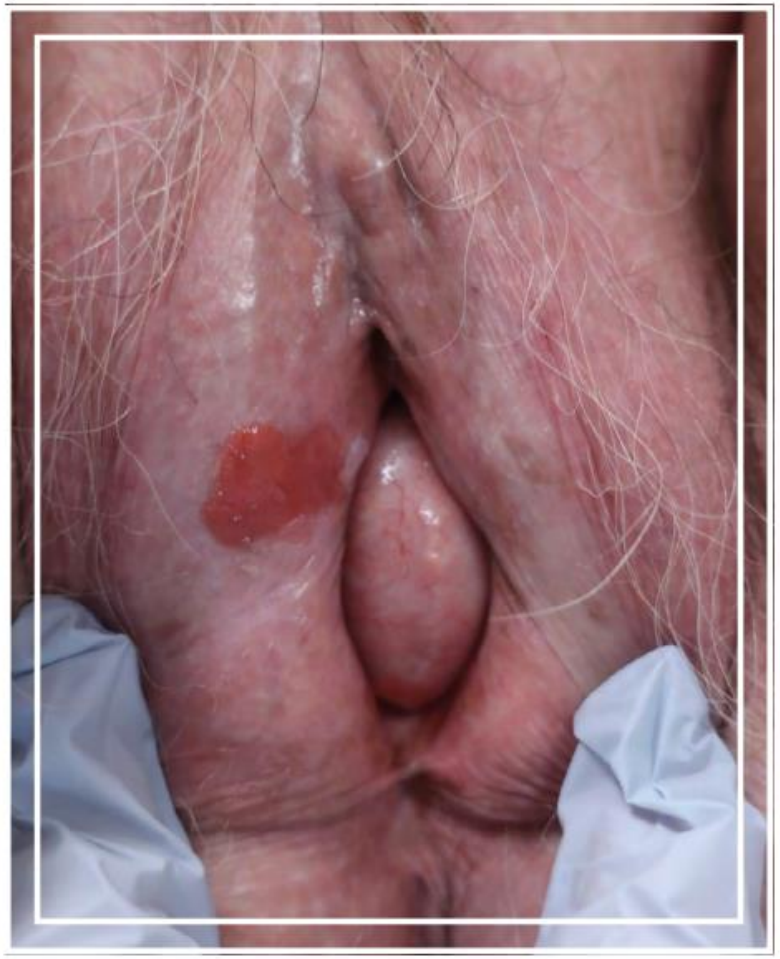

FIGURE 2. HSIL and HPV-associated SCC in a field of LS.

Day T, Mauskar M, Selk A, editors. Lichen sclerosus: ISSVD practical guide to diagnosis and management. Lisbon (Portugal): Ad Médic, Lda on behalf of the International Society for the Study of Vulvovaginal Disease; 2024. doi:10.59153/adm.ls.001.

VIN

VIN is a histological diagnosis

Biopsy before treatment

Low threshold to biopsy or refer

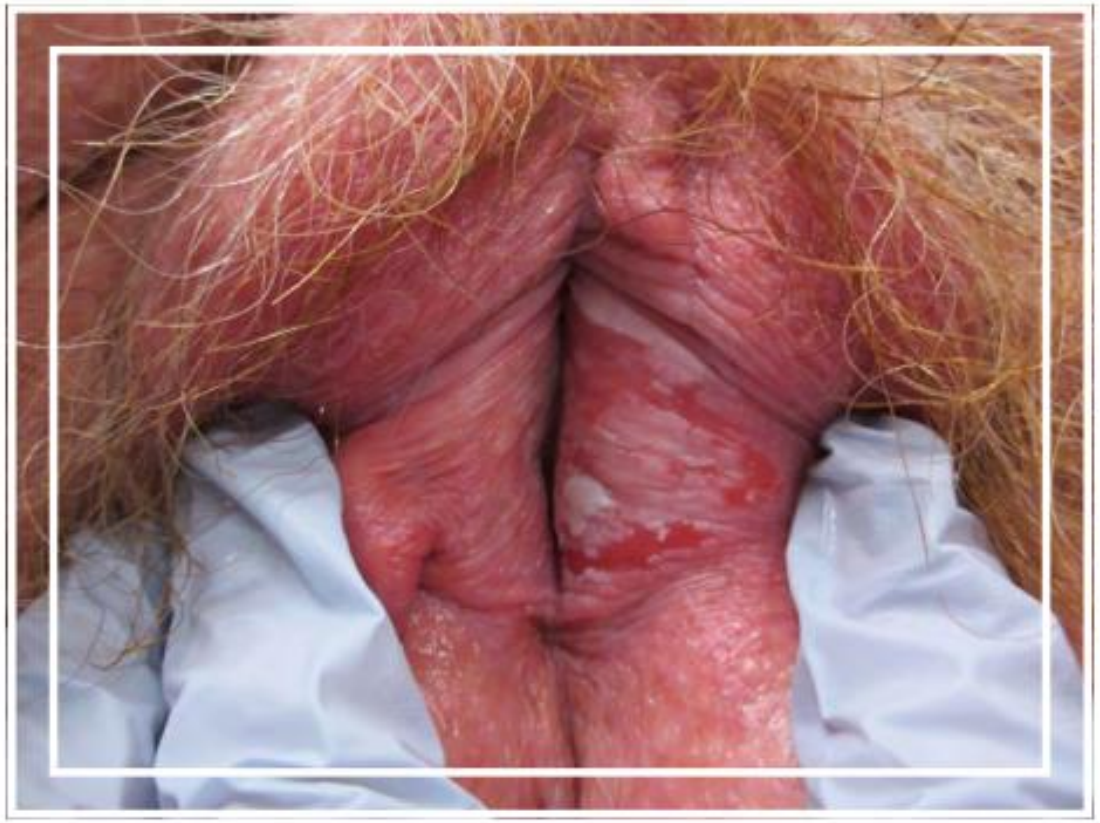

FIGURE 1. HPV-independent (HPV-I) VIN in a field of LS with irregular red patches and white plaques on inner left labium minus and interlabial sulcus.

Day T, Mauskar M, Selk A, editors. Lichen sclerosus: ISSVD practical guide to diagnosis and management. Lisbon (Portugal): Ad Médic, Lda on behalf of the International Society for the Study of Vulvovaginal Disease; 2024. doi:10.59153/adm.ls.001.

Feature	Usual-type VIN (uVIN / HSIL)	Differentiated VIN (dVIN)
HPV association	**Yes**	No
Typical age	Younger women	Older women
Background skin	Often normal	Chronic inflammatory disease
Associated conditions	HPV infection	Lichen sclerosus, erosive lichen planus
Distribution	Often multifocal	Usually unifocal
Natural history	May regress spontaneously (~12%)	Rarely regresses
Risk of progression to SCC	Moderate (over years if untreated)	Very high (up to 85% if untreated)
Time to cancer	~7 years on average	Often rapid

McAlpine JN, Leung SCY, Cheng A, et al. Human papillomavirus (HPV)- independent vulvar squamous cell carcinoma has a worse prognosis than HPV - associated disease: a retrospective cohort study. Histopathology. 2017;71(2):238- 246. doi:10.1111/his.13205
Vieira-Baptista P, Pérez-López FR, López-Baena MT, Stockdale CK, Preti M, Bornstein J. Risk of Development of Vulvar Cancer in Women With Lichen Sclerosus or Lichen Planus: A Systematic Review. J Low Genit Tract Dis. 2022;26(3):250- 257. doi:10.1097/LGT.0000000000000673

Consider escalation if:

Inadequate response to correctly used potent steroids

Progressive scarring

Significant pain or functional impairment

Vaginal involvement

Erosive disease

Conditions Most Likely to Need Escalation

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Erosive lichen planus

Severe or refractory lichen sclerosus

May require:

Specialist-led systemic therapy

Multidisciplinary care

Long-term follow-up

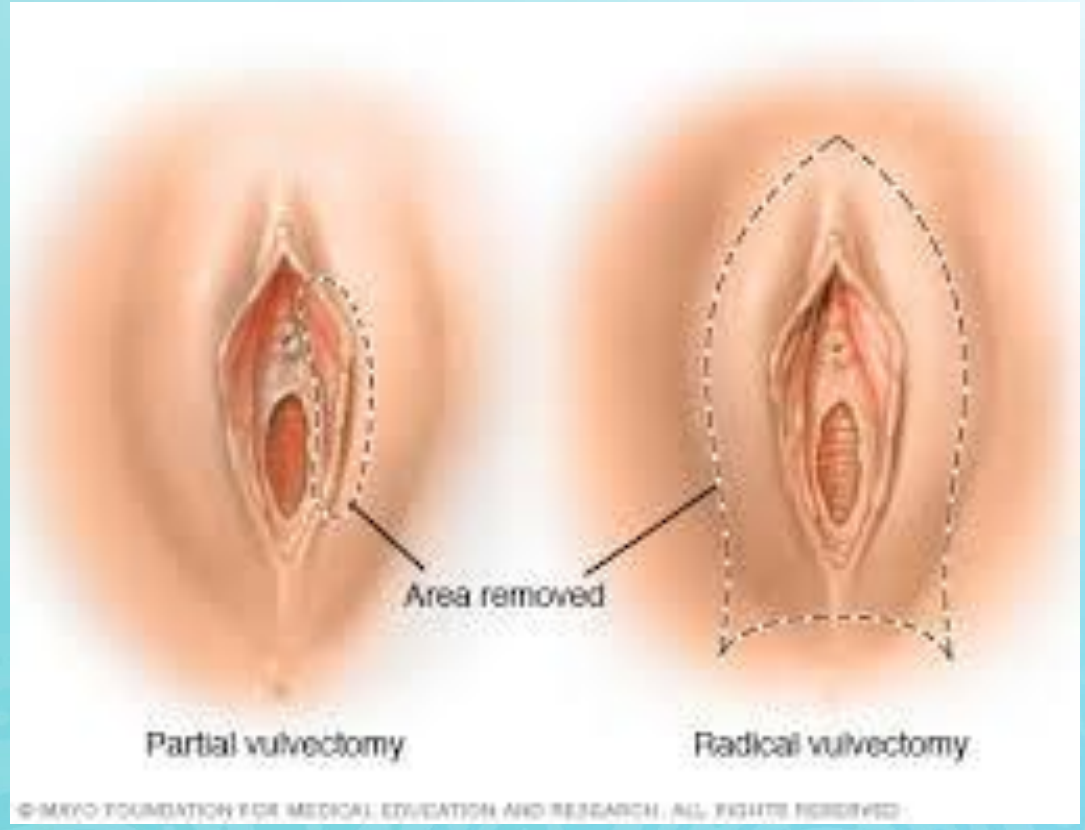
Treatment options

1) Excision
Most commonly used approach
Preferred when:
Suspicion of invasion
Thickened or keratinised lesions
Diagnostic uncertainty

2) Laser ablation
Used in selected cases
Appropriate for:
Superficial disease
Multifocal lesions
Must weigh against:
Poor tissue quality in LS
Healing challenges

3) Topical imiquimod (HSIL)
Challenges in LS
Increased pain and irritation
Reduced treatment adherence
Can cause dermatitis, making LS control difficult

Considerations in LS
Reduced tissue elasticity
Pre-existing scarring/architectural loss
Higher risk of functional impairment



Preti M, Joura E, Vieira-Baptista P, et al. The European Society of Gynaecological Oncology (ESGO), the International Society for the Study of Vulvovaginal Disease (ISSVD), the European College for the Study of Vulval Disease (ECSVD) and the European Federation for Colposcopy (EFC) consensus statements on pre-invasive vulvar lesions. Int J Gynecol Cancer. 2022;32(7):830-845. doi:10.1136/ijgc-2021-003262

Case 1

58-year-old

“Recurrent thrush”

Night itch, fissuring

Partial response to antifungals

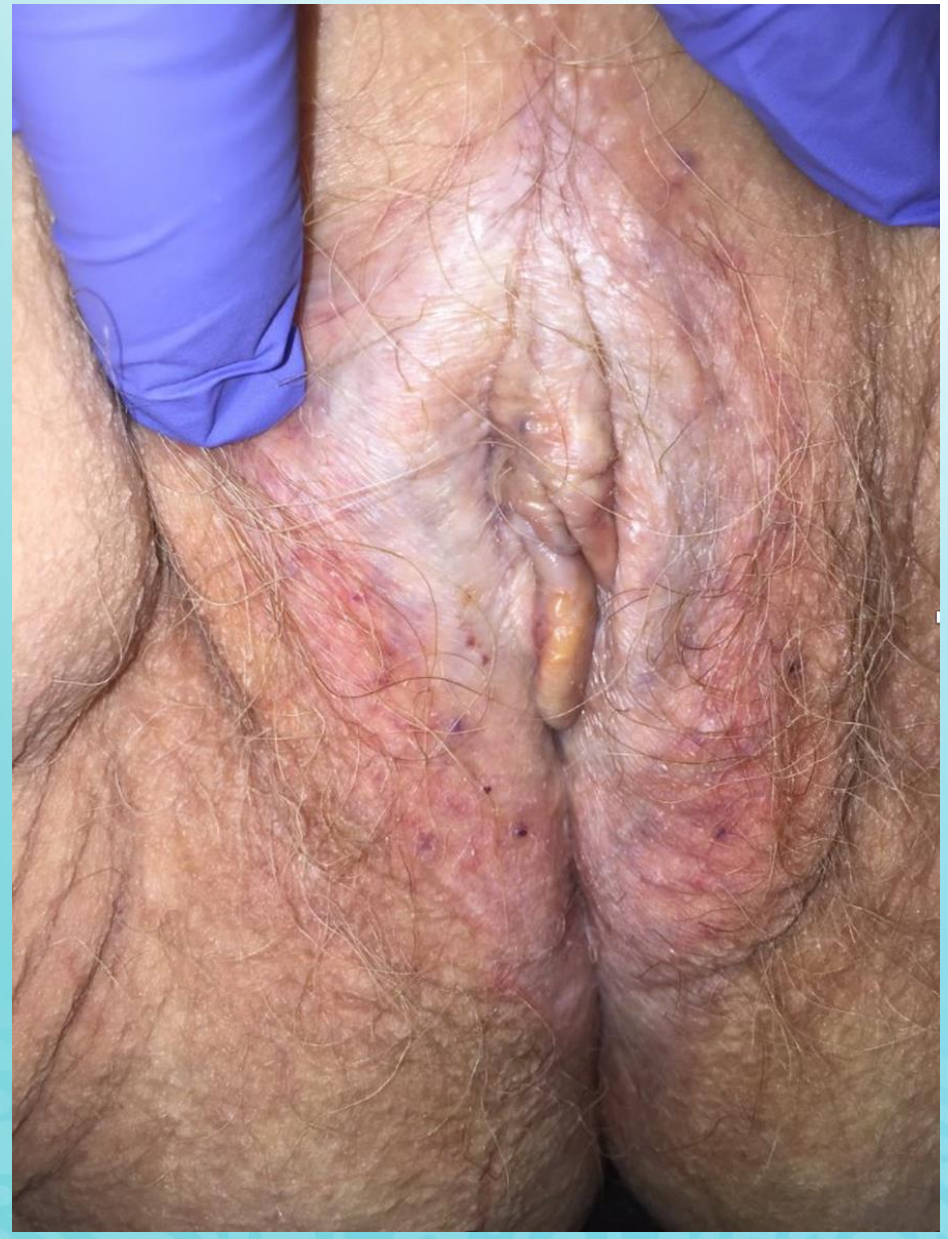
Pale vulval skin

Questions

Most likely diagnosis?

Red flag?

Next step?



Mercy Health

Care first

Case 2

42-year-old

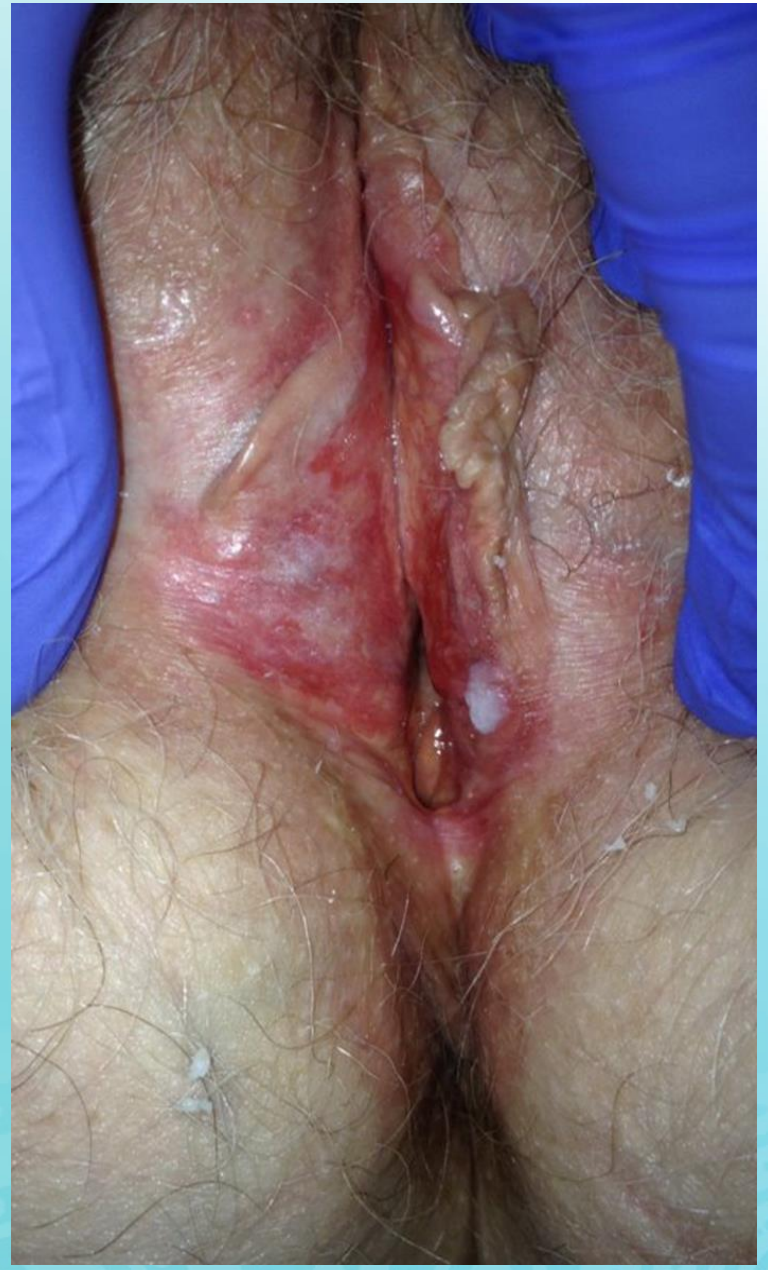
Focal vulval pain

Thickened erythematous lesion

Normal swabs

No response to treatment

What now?



Mercy Health

Care first

Case 3

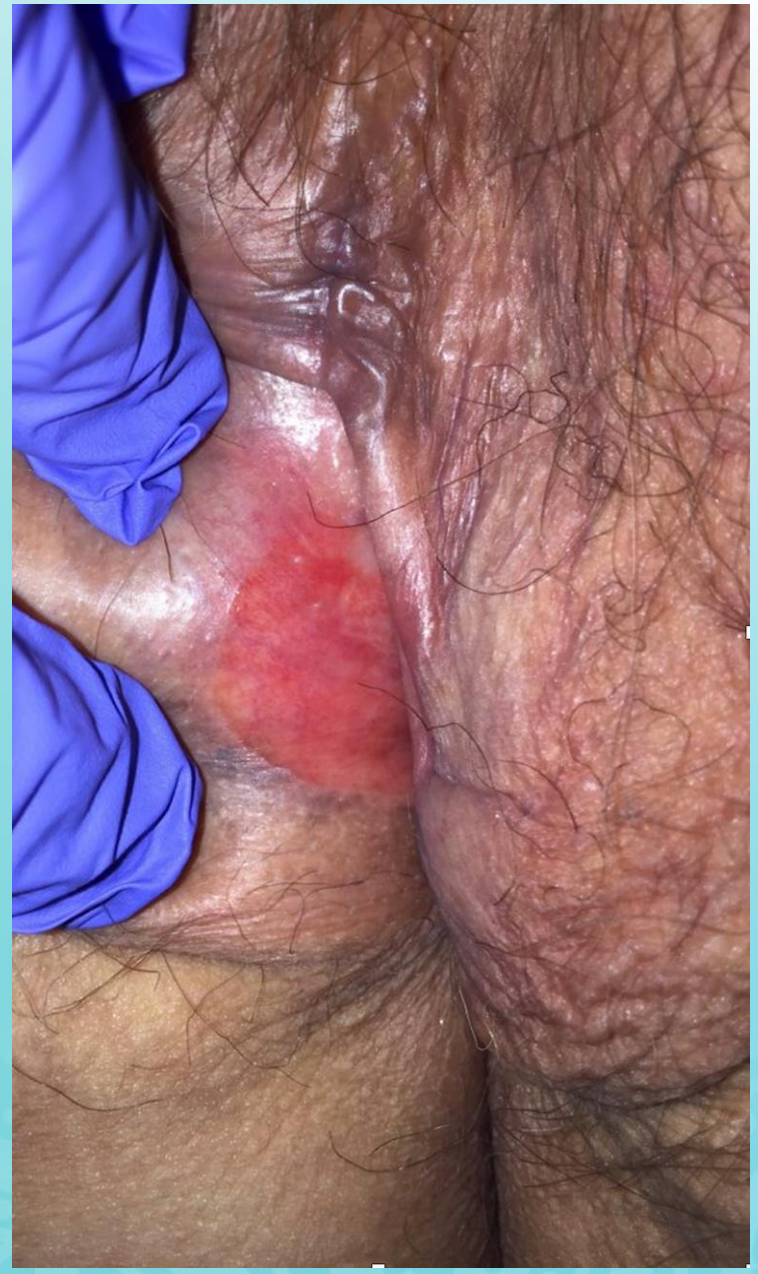
35-year-old

Severe dyspareunia

Erosions

Vaginal involvement

Steroid-refractory



Mercy Health

Care first

When to Refer

Refer if:

Suspected VIN or malignancy

Diagnostic uncertainty

Refractory disease

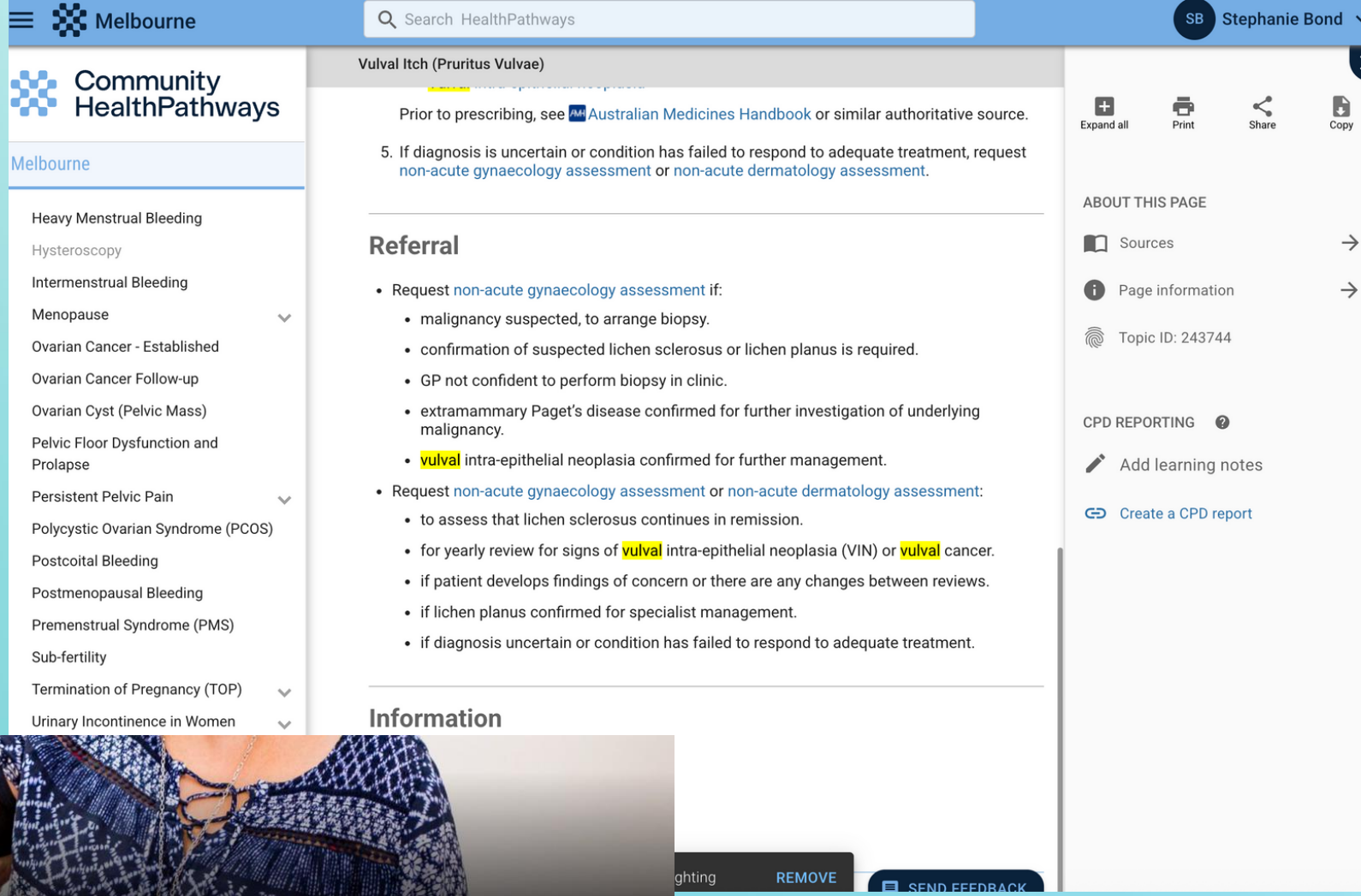
Significant scarring or pain

Vaginal involvement

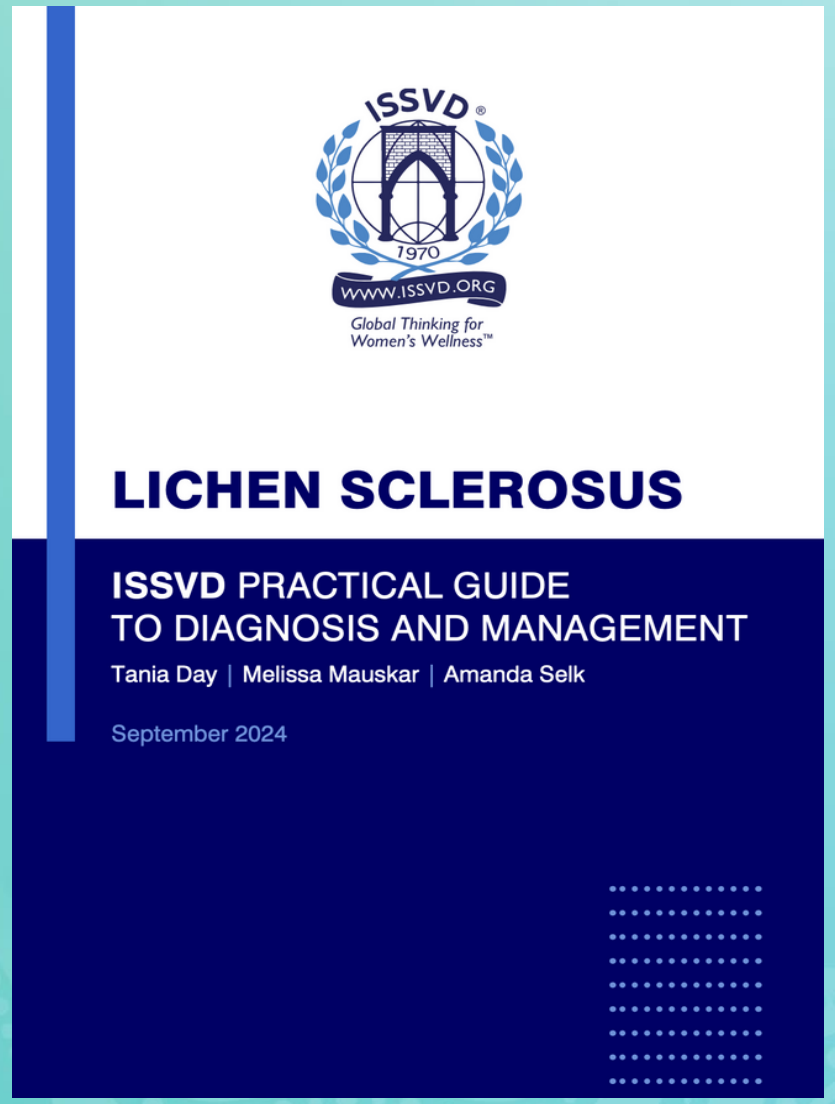
Mercy Health is preferring electronic referrals via HealthLink.

Users of Best Practice, MedDirector and Genie can now send electronic referrals to Mercy Health. Guides and FAQ Sheets can found on the HealthLink, eReferral information page.

We accept GP and specialist referrals for all specialist clinics. Referrals are triaged against clinical information and investigations using HealthPathways Melbourne and Statewide Specialist Clinic Referral Criteria, developed by the Department of Health.



Useful resources



ANZ Vulvovaginal Society

Mercy Health
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Persistent focal symptoms - investigate

VIN is easy to miss — biopsy early

Failure of topical therapy = reassess

Save the Date

ANZVS

Biennial Scientific Conference

Featuring Education Day and Workshops

6 – 8 November 2026

Sofitel Melbourne on Collins

Proudly hosted by ANZ Vulvovaginal Society

Mercy Health

Care first

Mercy Health
Care first

Q&A
Vulval Red Flags and When to Refer

Dr Stephanie Bond

Thank you for attending. What's next?

After this session you will receive:

1. *Slides, resources and the recording of this session within the week*
2. *RACGP CPD hours will be uploaded within 14 days.*
3. *Attendance certificate will be received within 4-6 weeks.*

- ***Register for more education sessions here:*** *nwmphn.org.au/resources-events/events*
- ***Past education sessions can be found here:*** *nwmphn.org.au/resources-events/resources*

Feedback - QR code

We welcome your feedback. Let us know if you got what you needed from this session.