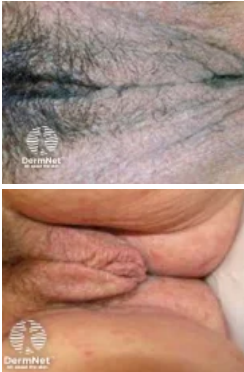


Vulval conditions: a comparison guide

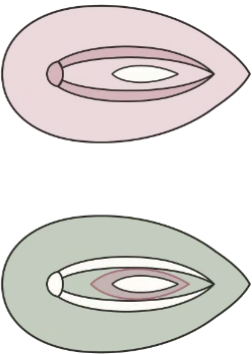
Uncertain, or want a second opinion before treating? I welcome direct GP referrals and calls for advice on any vulval condition.

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CONDITION	PRESENTATION	EXAMINATION	INVESTIGATIONS	INITIAL MANAGEMENT	REFER WHEN
Lichen sclerosus  Classic active vulval lichen sclerosus: porcelain-white change with surface alteration and focal fissuring. Chronic vulval lichen sclerosus: pallor with resorption/fusion of vulval structures and loss of normal architecture.	• Itch (often nocturnal), soreness, dyspareunia • May be asymptomatic	• White/porcelain plaques • Thinning, fissuring • Labial fusion, clitoral hood adhesions, narrowed introitus • Purpura • Figure-of-8 perianal pattern • No vaginal involvement	• Clinical diagnosis usually sufficient • Biopsy if atypical, non-responding, hyperkeratotic, ulcerated or pigmented	• Ultrapotent topical steroid (clobetasol propionate 0.05%) reducing course + emollients • Avoid soap/irritants	• Diagnostic doubt • No response after 3 months of potent steroid • Suspected malignancy • Children
Lichen planus (erosive, vulvovaginal)  Active erosive vulval lichen planus: glazed erythema and sharply defined erosions affecting the vestibule and vaginal introitus. Chronic erosive lichen planus: persistent vestibular inflammation with scarring and loss of normal vulval architecture.	• Pain/burning more than itch • Dyspareunia • Post-coital bleeding • Discharge if vaginal involvement • Oral lesions	• Erosions at the introitus with a fine lacy white (Wickham) border • May involve vagina ± synechiae • Check mouth/gums	• Biopsy more often needed than lichen sclerosus — confirms diagnosis, excludes mimics • Consider oral exam	• Ultrapotent topical steroid • If vaginal involvement, specialist-guided vaginal steroid + dilators	• All erosive or vaginal disease at diagnosis • Diagnostic doubt • Non-response • Suspected malignancy
Vulval dermatitis / lichen simplex chronicus  Vulval lichen simplex chronicus: leathery vulval skin with exaggerated skin markings caused by persistent rubbing and scratching. Lichenification in pigmented skin: brownish streaks with grey-brown post-inflammatory pigment change; this should not be mistaken for the porcelain-white atrophy of lichen sclerosus.	• Itch-dominant, worse at night • Driven by an itch-scratch cycle	• Erythema ± lichenification (thickened skin, exaggerated markings) • Excoriations	• Usually clinical • Patch testing if allergic contact dermatitis suspected • Swabs if secondarily infected	• Remove irritants; soap substitute + bland emollient • Moderate-potent steroid short course • Break the itch-scratch cycle (sedating night-time antihistamine if needed)	• No response to standard measures • Suspected allergic contact dermatitis needing patch testing • Diagnostic doubt

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CONDITION	PRESENTATION	EXAMINATION	INVESTIGATIONS	INITIAL MANAGEMENT	REFER WHEN
Vulvovaginal candidiasis 	- Itch, soreness, thick white discharge - External dysuria, dyspareunia	- Vulval erythema/oedema - Satellite lesions - Curdy white discharge - Fissuring	- Usually clinical - Microscopy/culture if recurrent (≥4/year), atypical, or not responding	- Topical or oral azole (e.g. clotrimazole pessary/cream, or oral fluconazole) - Recurrent disease: induction-maintenance regimen	- Recurrent (≥4/year) or unresponsive disease - Non-albicans species - Diagnostic doubt - Immunocompromise
Vulvodynia At the entrance only 	- Chronic vulval pain/burning ≥3 months without a clear cause - Provoked (touch, intercourse, tampon) or spontaneous	- Skin looks normal - Cotton-swab test tenderness at the vestibule (localised, provoked type) ± pelvic floor muscle hypertonicity	- Diagnosis of exclusion — swabs to exclude infection - Biopsy only if a lesion is actually seen	- Education + irritant avoidance - Topical lidocaine before intercourse - Pelvic floor physiotherapy - Consider amitriptyline or gabapentin if generalised	- Diagnostic doubt - No response to first-line measures - Needs pelvic floor physiotherapy, psychosexual input or a multidisciplinary pain service
Genitourinary syndrome of menopause / Atrophic vaginitis 	- Vaginal dryness, burning, dyspareunia - Urinary urgency/frequency, recurrent UTI - Post-menopausal	- Pale, thin, dry mucosa - Loss of rugae - Reduced elasticity ± petechiae, urethral eversion	- Usually clinical - Consider MSU if UTI symptoms - Exclude infection if discharge present	- Vaginal moisturiser/lubricant first-line - Low-dose vaginal oestrogen (cream/pessary/ring) if inadequate — safe long-term, minimal systemic absorption	- Unexplained bleeding - Treatment failure - Breast-cancer history needing hormone advice - Suspected coexisting dermatosis

Genitourinary syndrome of menopause: the vulval vestibule may be pallid. The vagina may be pale or erythematous, the vaginal walls smoother, and the tissues thinner.

REFER URGENTLY (SUSPECTED VULVAL MALIGNANCY / HSIL) FOR

- A persistent lump, thickened or hyperkeratotic plaque, or pigmented/irregular lesion
 - A non-healing ulcer or erosion (>2 weeks)
- Unexplained vulval bleeding or blood-stained discharge
 - Progressive architectural change (fusion, narrowing) not settling with treatment

General principles

- Examine with good light; note colour, texture, architecture and any vaginal involvement (excludes lichen sclerosis, suggests lichen planus).
- Biopsy under local anaesthetic if diagnosis is uncertain, response to first-line treatment fails, or a lesion looks atypical, ulcerated, hyperkeratotic or pigmented — never delay biopsy for suspected malignancy.
- Chronic itch/soreness can coexist — treat the dominant dermatosis first, then reassess; more than one condition (e.g. lichen sclerosis with secondary candidiasis) is common.
- All potent/ultrapotent topical steroid courses should follow a reducing regimen with planned review, not open-ended repeat prescribing.
- Chronic scarring vulval dermatoses (lichen sclerosis, lichen planus) need long-term follow-up and carry a small increased risk of vulval squamous cell carcinoma — safety-net accordingly.

Image sources for GP reference

Image on this document sourced from [DermNet](#).
Some recommended clinical image libraries for teaching and reference:

- **DermNet NZ** — [dermnetnz.org](#) (searchable by condition, free clinical photo library)
- **Primary Care Dermatology Society (PCDS)** — [pcds.org.uk](#), genital conditions gallery
- **British Society for the Study of Vulval Disease (BSSVD)** — [bssvd.org](#), clinician image resources
- **Vulvovaginal Disorders** — [vulvovaginaldisorders.org](#), clinician image and education resource

SOURCES

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2. van der Meijden WJ, Boffa MJ, ter Harnsel B, et al. 2021 European guideline for the management of vulval conditions. J Eur Acad Dermatol Venerol 2022;36(7):952–72.	5. Saxon C, Edwards A, Rautemaa-Richardson R, et al. BASHH national guideline for the management of vulvovaginal candidiasis. 2019 (updated Jan 2021).	7. Vieira-Baptista P, Pérez-López FR, López-Baena MT, et al. Risk of vulvar cancer in women with lichen sclerosis or lichen planus: a systematic review. J Low Genit Tract Dis 2022;26(3):250–7.
3. Kirtschig G, Kinberger M, Kreuter A, et al. EuroGuiderm guideline on lichen sclerosis. J Eur Acad Dermatol Venerol 2024;38(10):1850–73.		