



**NAPS**

National Association for  
Premenstrual Syndrome

# Vulval Skin

Miss Elaine Louise Palmer: Consultant Gynaecologist  
Chelsea and Westminster NHS Trust

# Agenda



- Introduction
- Vulva Clinical Assessment
- The 'Normal' Vulva
- Skin
- Lichen Sclerosus
- Treatment and Care

# Introduction

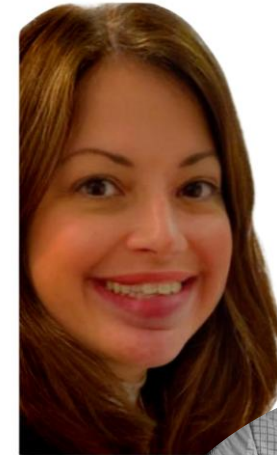
- **MBBS:** Imperial College London
- **BSc in Social Medicine & General Practice**
- **Speciality & Advanced Training:** North-West Thames Region of London
- **Private Practice: One Welbeck Women's Health: Vulva & Menopause**
- NHS Consultant at Chelsea and Westminster NHS Trust (C&W)
- NHS Honorary Consultant at Royal Marsden Hospital London
- **Vulva**
  - Vulval Disease RCOG Advanced Speciality Training
    - Gynaecology, Dermatology, Plastics, Colo-rectal
  - North-West London RCOG Vulval Training Preceptor
  - Lead Gynaecologist for Gynaecological Vulval Disease at C&W
    - Tertiary referral centre for general and complex vulval issues
    - Medical, Surgical, Laser, Oncological
  - Lead Gynaecologist the Chelsea Ano-Genital Neoplasia Service (CANS)
    - Multi-zonal HPV (vulva, vagina, cervix, anus, penis, scrotal)
    - HPV/LS causing HSIL
    - Laser/Medical/Conservative/Surgical Treatments
- **Menopause**
  - Advanced Speciality RCOG Training in Menopause
  - BMS Advanced Menopause Specialist
  - Menopause Trainer for BMS and the FSRH
- **Education**
  - Honorary Clinical Lecturer, Imperial College London
  - Joint Site Lead for Undergraduate O&G Education
  - O&G PA Supervisory Lead, St George's Hospital London
- **Family, Art, Colours in Nature, Science & Communication**





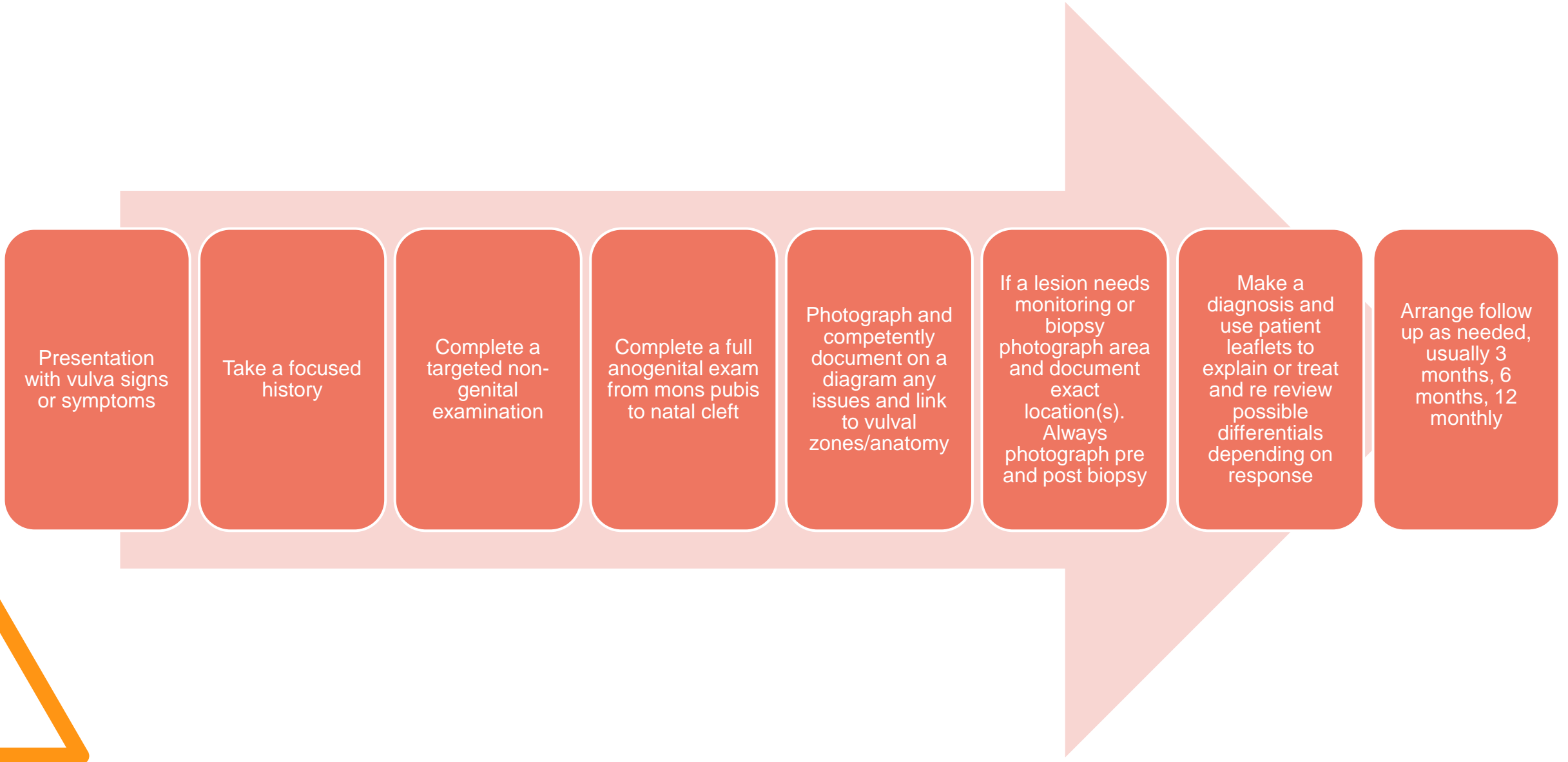
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    - HPV/LS causing HSIL, LSIL, CIN, LSIL, LSIL
    - Laser/Medical/Conservative management
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# Clinical Assessment





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graph LR; A[Presentation with vulva signs or symptoms] --> B[Take a focused history]; B --> C[Complete a targeted non-genital examination]; C --> D[Complete a full anogenital exam from mons pubis to natal cleft]; D --> E[Photograph and competently document on a diagram any issues and link to vulval zones/anatomy]; E --> F[If a lesion needs monitoring or biopsy photograph area and document exact location(s). Always photograph pre and post biopsy]; F --> G[Make a diagnosis and use patient leaflets to explain or treat and re review possible differentials depending on response]; G --> H[Arrange follow up as needed, usually 3 months, 6 months, 12 monthly];
```

Presentation with vulva signs or symptoms

Take a focused history

Complete a targeted non-genital examination

Complete a full anogenital exam from mons pubis to natal cleft

Photograph and competently document on a diagram any issues and link to vulval zones/anatomy

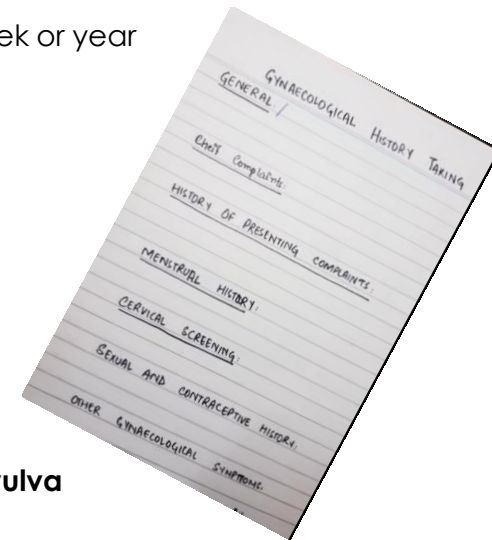
If a lesion needs monitoring or biopsy photograph area and document exact location(s). Always photograph pre and post biopsy

Make a diagnosis and use patient leaflets to explain or treat and re review possible differentials depending on response

Arrange follow up as needed, usually 3 months, 6 months, 12 monthly

# History

- **Presenting complaint(s)**
  - Specific symptoms including impact on QOL
- **Age, Ethnicity, SKIN AND HAIR TYPE**
- **Full past O&G history**
  - LMP/Regular periods/Last period >1 yr. ago
  - Contraceptive history
  - Bleeding issues- blood and sanitary towels (irritants)
  - Smear history (HPV)
  - Endometriosis, PMS, urinary/bowel issues (pain syndromes, incontinence)
  - Contraception/Fertility wishes & lubrication (past, present and ongoing need for including likes/dislikes/side-effects, barrier non barrier)
  - Babies, mode of delivery, weight, scars, breastfeeding
  - Use of HRT previously, what, how-long, side-effects, symptom control (?progestogen side effects)
  - Sexual Health, practices and preferences
- **Past medical history & comorbidities**
  - Skin
  - Thyroid
  - CIN, AIN, VaIN, VIN & Cancers (melanoma, breast, Parkinson's etc)
  - Immunocompromise (viral, rheumatological, medication, other)
- **Medications**
  - Esp. Skin Treatments, what, how long, what regimen, effects
  - Any immunosuppressants/skin irritants
- **Social History**
  - Smoking & Alcohol (>2u/day?)
  - Sex & Relationship
  - Family situation
  - Work
  - Sleep
- **Looking, Washing, Cleansing & Religious Practices**
  - How often do you look at your genitals, how do you wash your genitals
  - With what, how many times per day, week or year
  - Wet-wipes, Dettol, bleach ??
  - Lotions and potions
  - Steaming
  - Hair removal
- **Family History**
  - Menopause age/Osteoporosis
  - Cancer
  - Autoimmune
  - Lichen
  - SCC
- **What are their views/beliefs/myths about their vulva**
- **Allergies**





# Documentation is vital...





# Ano-Genital Examination



# Main Questions:

Is the vulva skin 'normal' in colour, texture,  
integrity and sensation?

If it is not, how will I describe and document  
my findings?

Then... how will I manage?



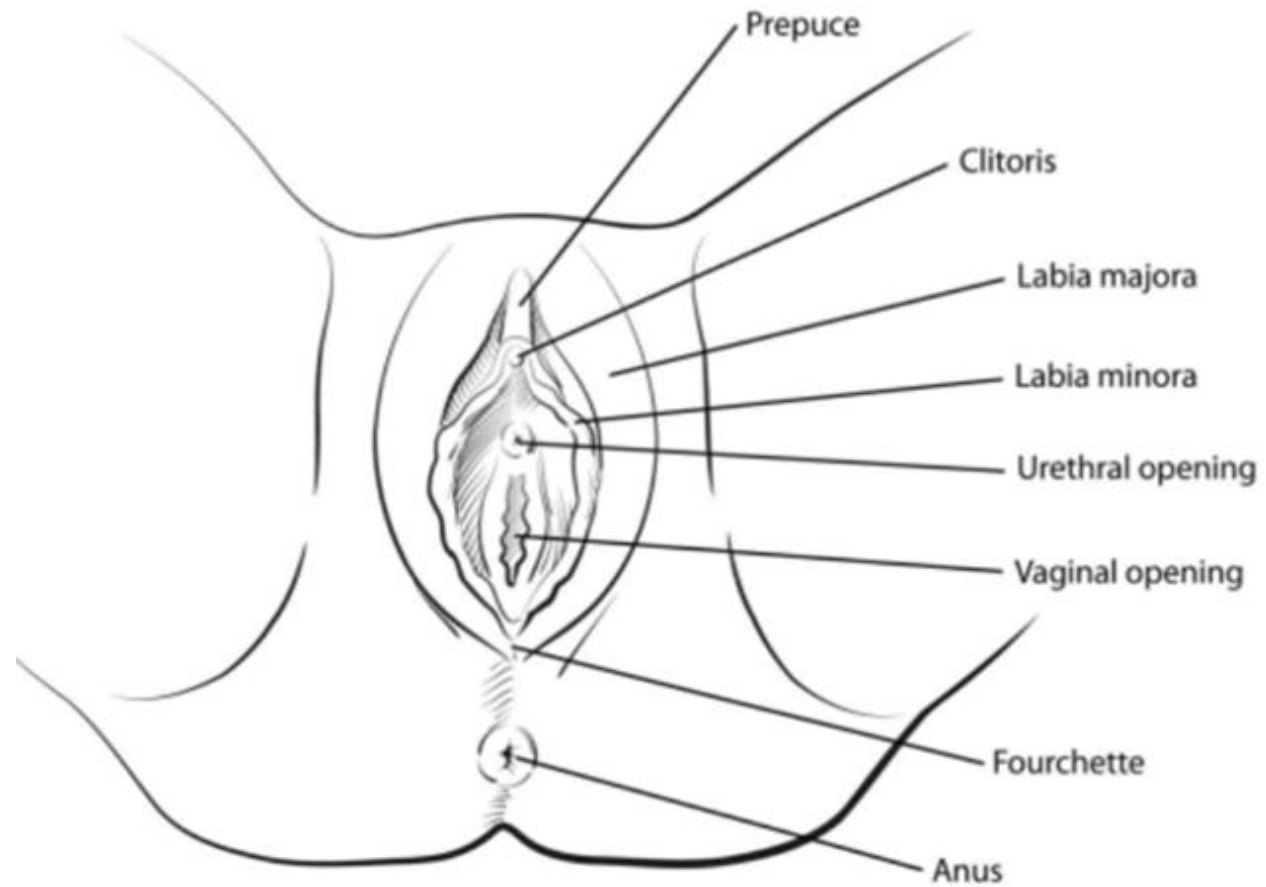
<https://vulvovaginaldisorders.org/algorithm/>

# The “Normal” Vulva

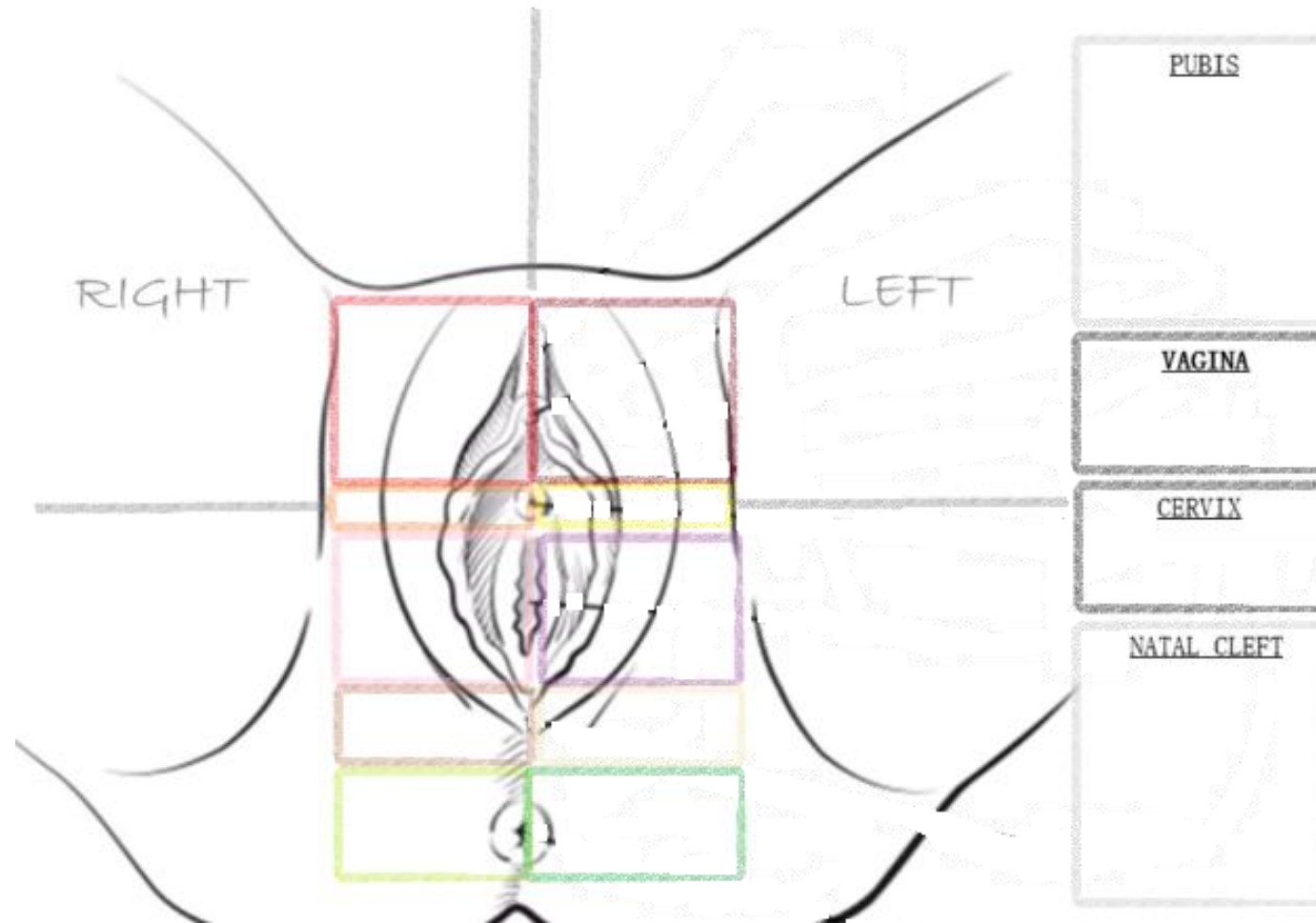




# Vulval Anatomy



# Vulval Zones



# Normal Vulva



# Normal Vulva





# Normal Vulva



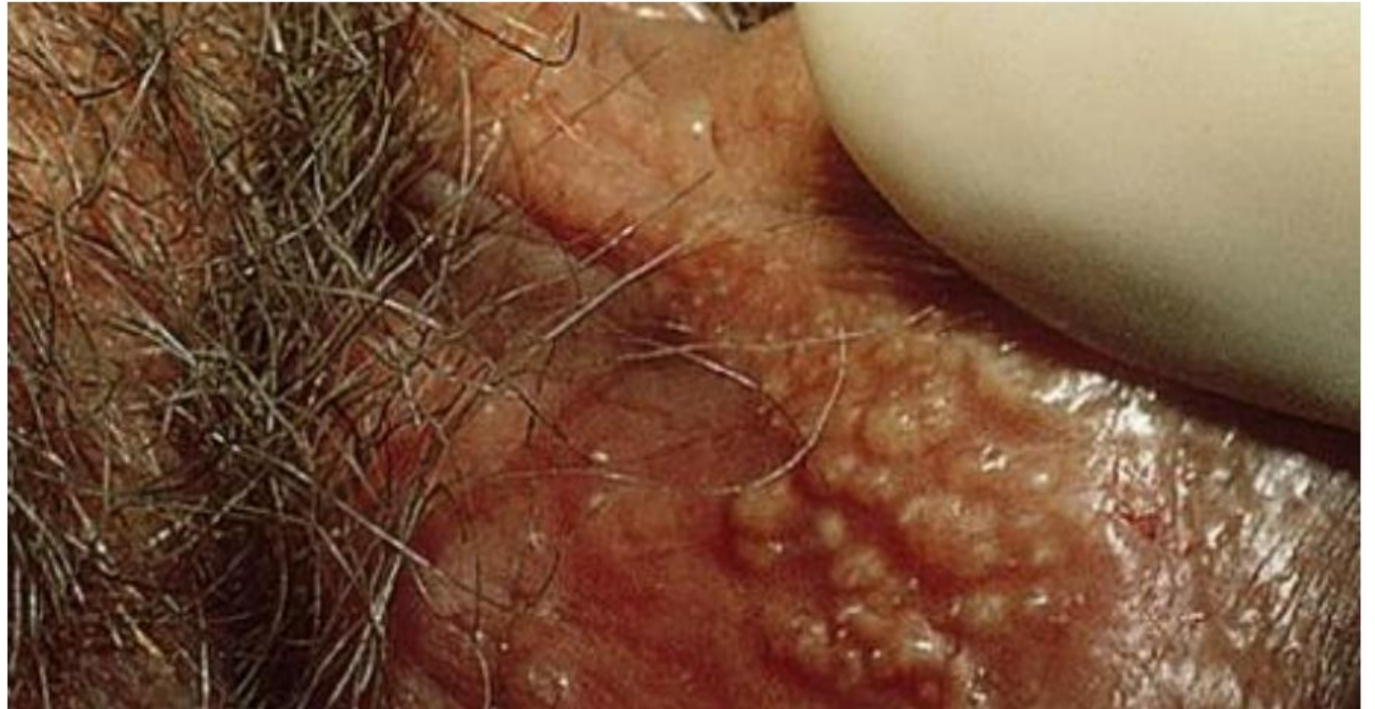
# Clitoris & Hood

The clitoral hood (prepuce) is pulled back to show the body of the clitoris.



# Fordyce Spots

Multiple small smooth yellow papules on the inner right labial minora. These are visible sebaceous glands and a normal anatomical feature of the vulva.



Labia



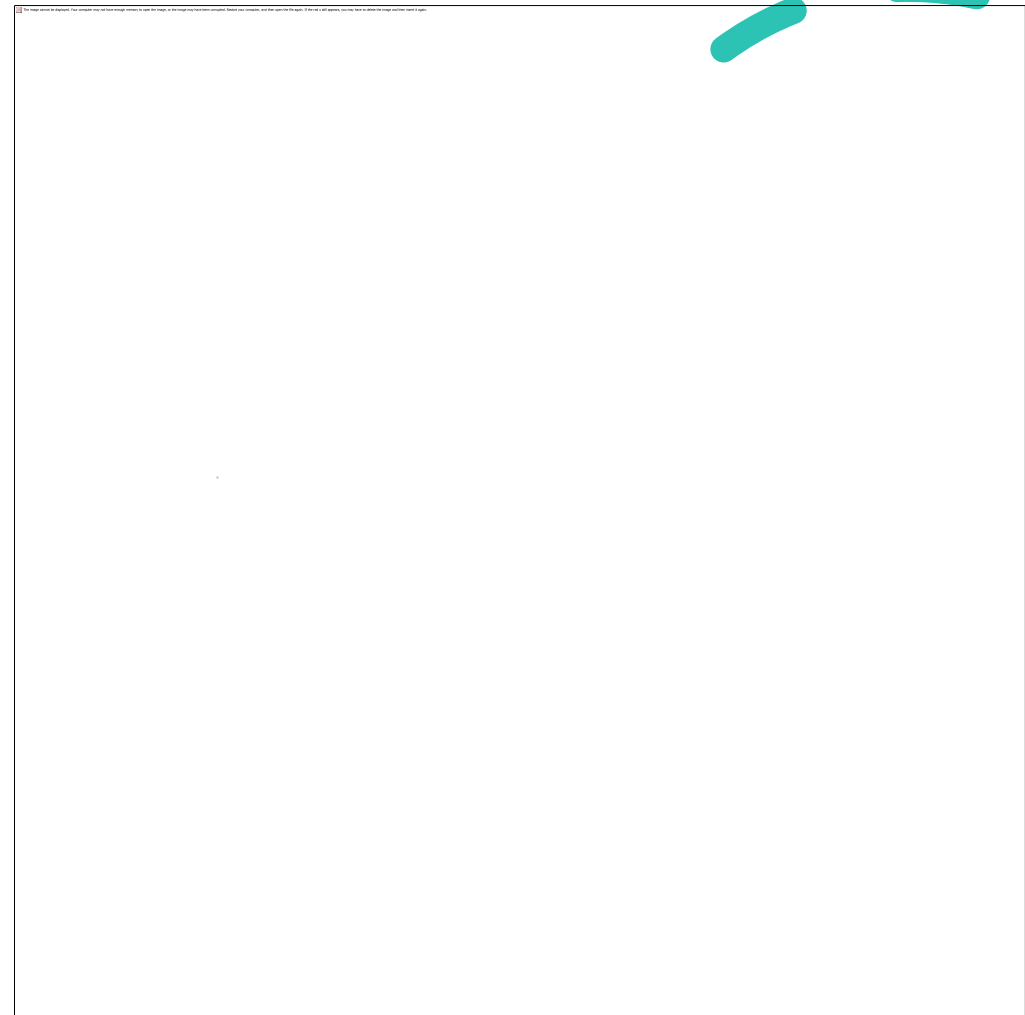


Similar  
Mucosa!?





# Intralabial Areas



# Vestibule Papillomatosis

Multiple small soft papillae, variable in number, located in the vestibule and medial labia minora. They can vary in size with some being up to 6mm in length and 1-2 mm wide. They are skin coloured and can occur in isolation or can cover the vestibule. As they are a normal finding no treatment is required.



# Vestibule Papillomatosis

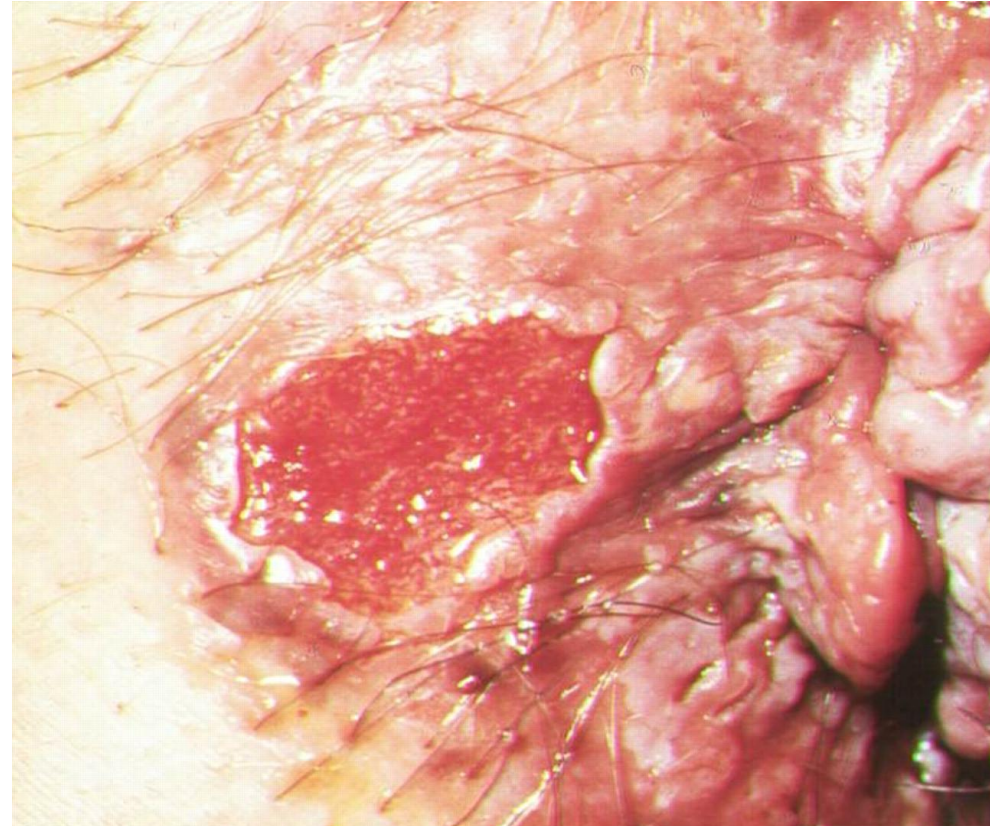




# Posterior Fourchette



# Anus/ Peri-anal region



# Natal Cleft





# Skin



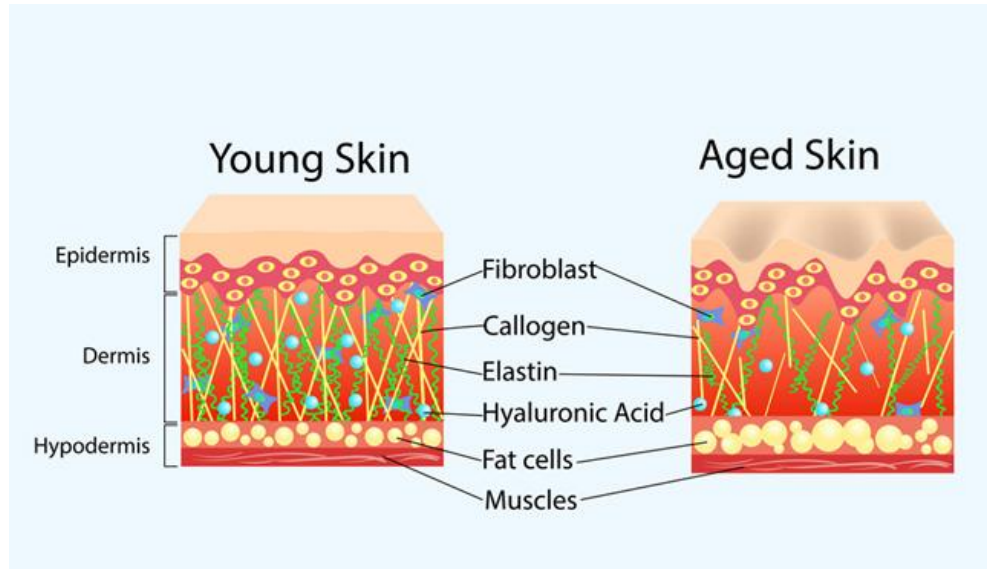
# Skin Type







# Aging



Cherry Hemangiomas



Telangectasias



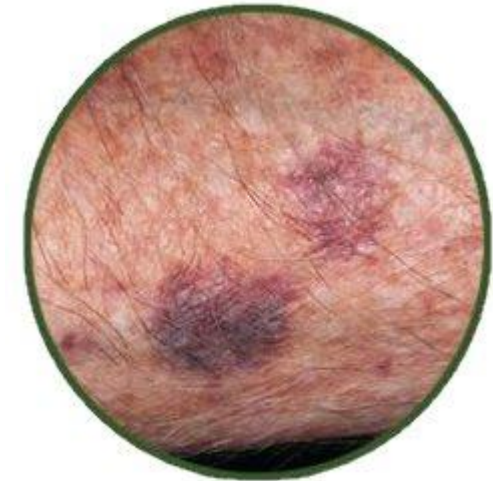
Seborrheic Keratoses



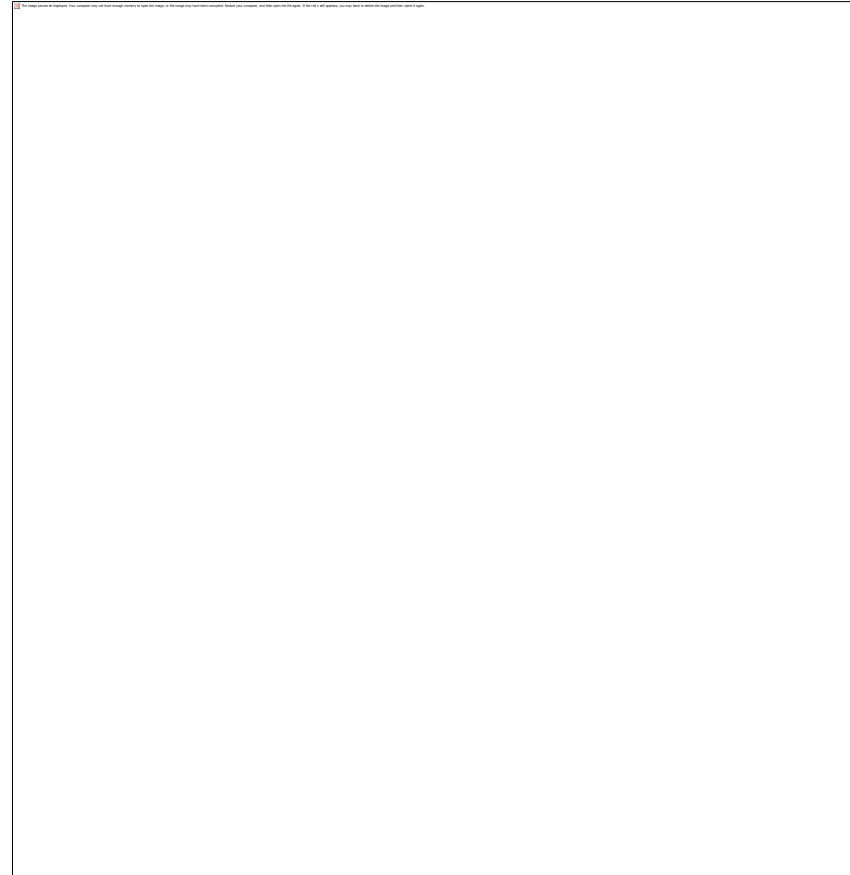
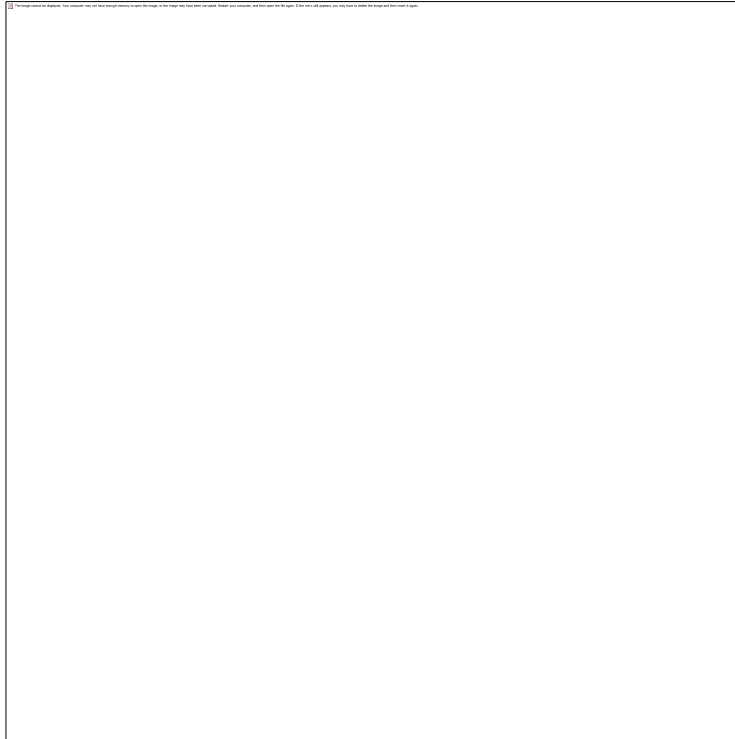
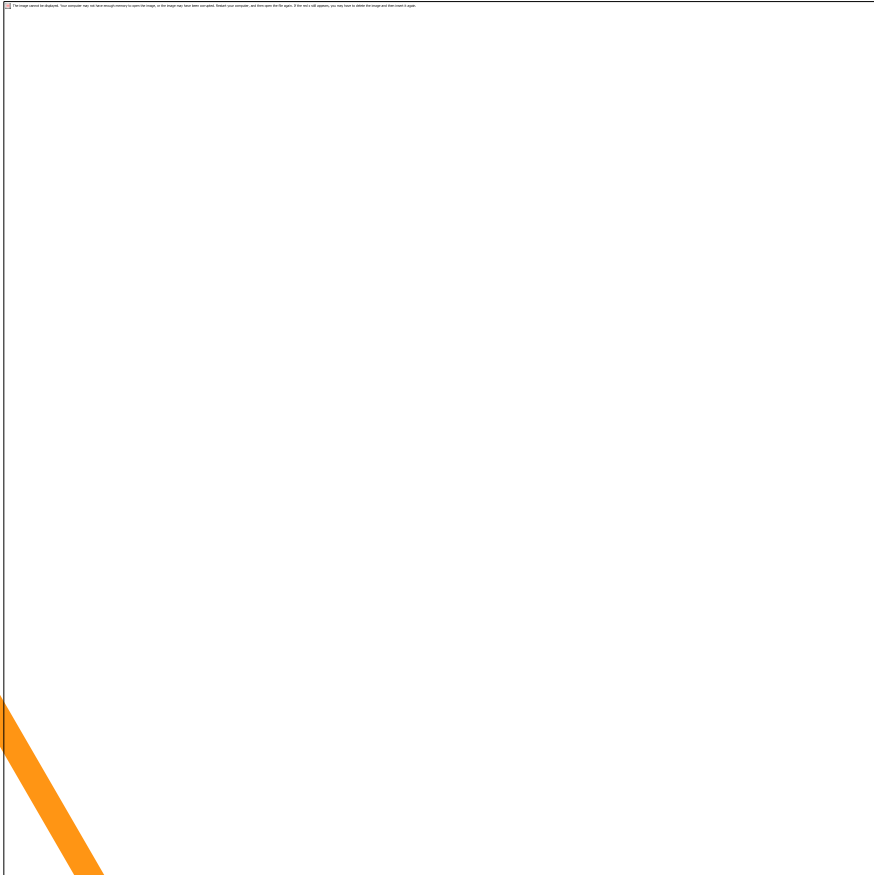
Sebaceous Hyperplasias



Skin Tags

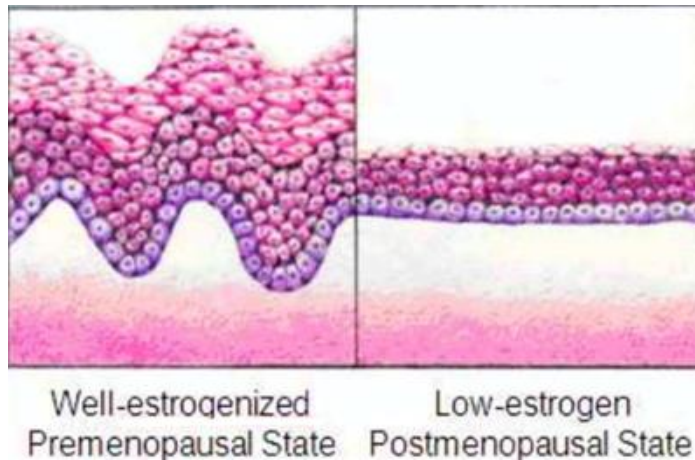


# Atrophy....Aging?

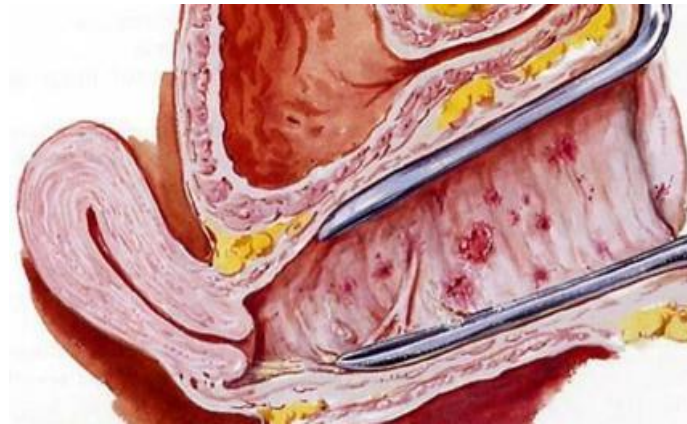


# Atrophy (low-oestrogen states)

## Mucosal Atrophy



## Atrophic Vagina



## Atrophic Cervix



## Vaginal/Cervical Atrophy



## Posterior Fourchette Fissuring



## Microfissures





# Breaks in the skin barrier

**Dry skin**  
**Dermatitis**

**Lichenification**  
**Excoriation & Fissuring**



ulcer



fissure



scale



lichenification



erosion

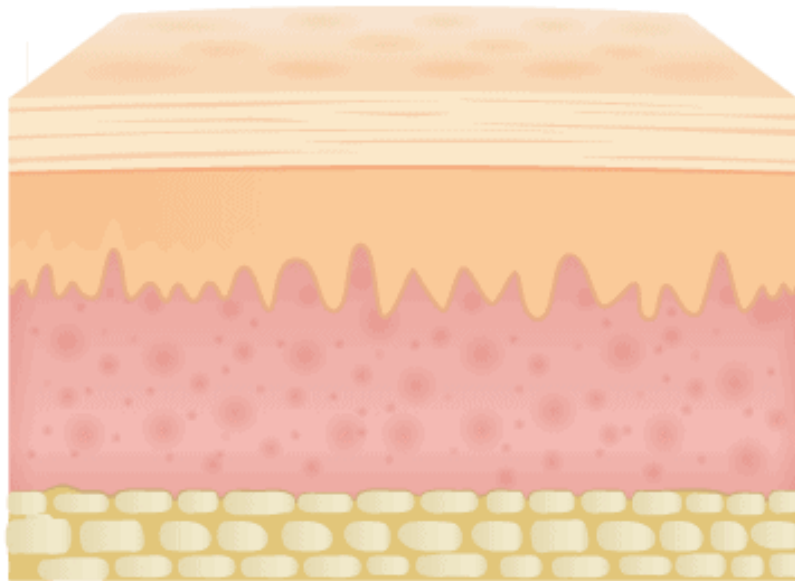


atrophy



# Skin

## Layers Of The Skin



### Epidermis

Protects underlying tissue from infection, dehydration, chemicals, and mechanical stress.

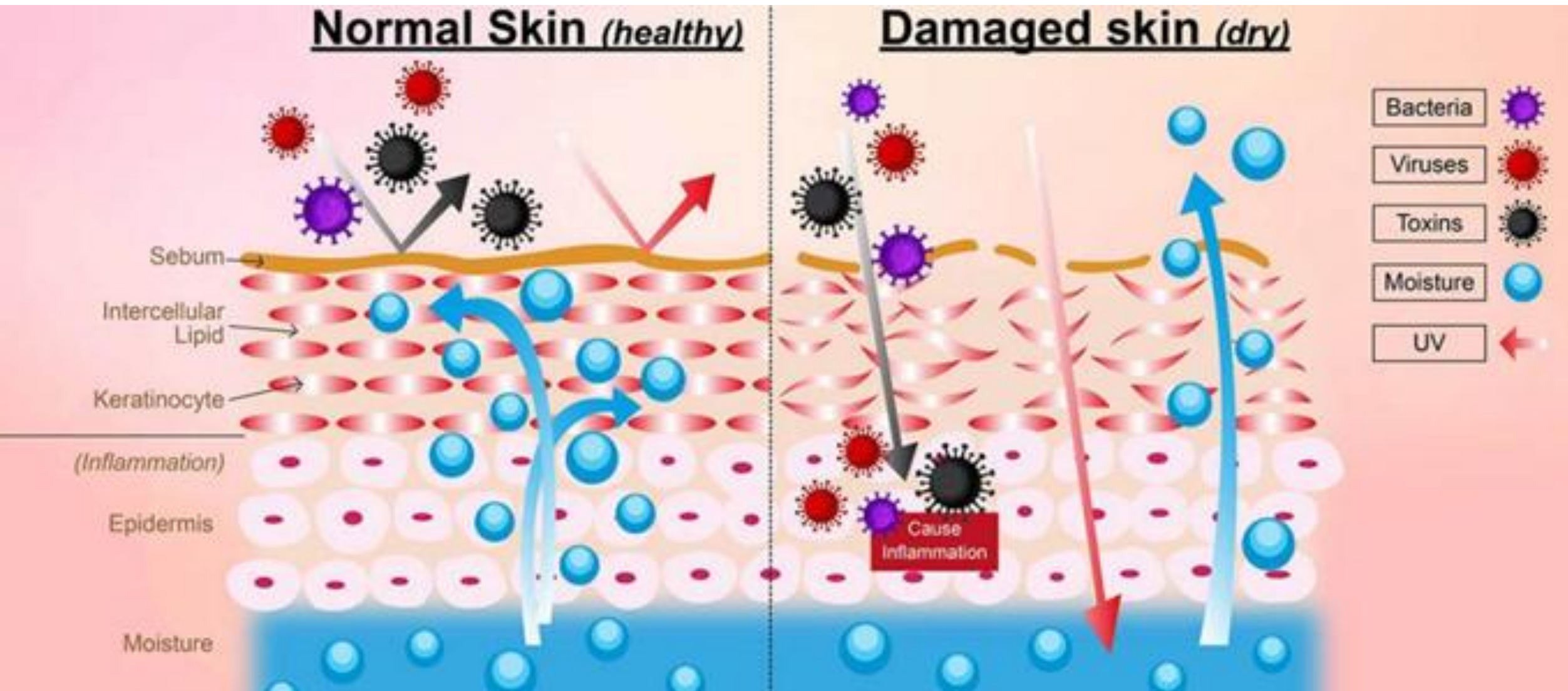
### Dermis

Contains tough connective tissue as well as different types of cells and glands.

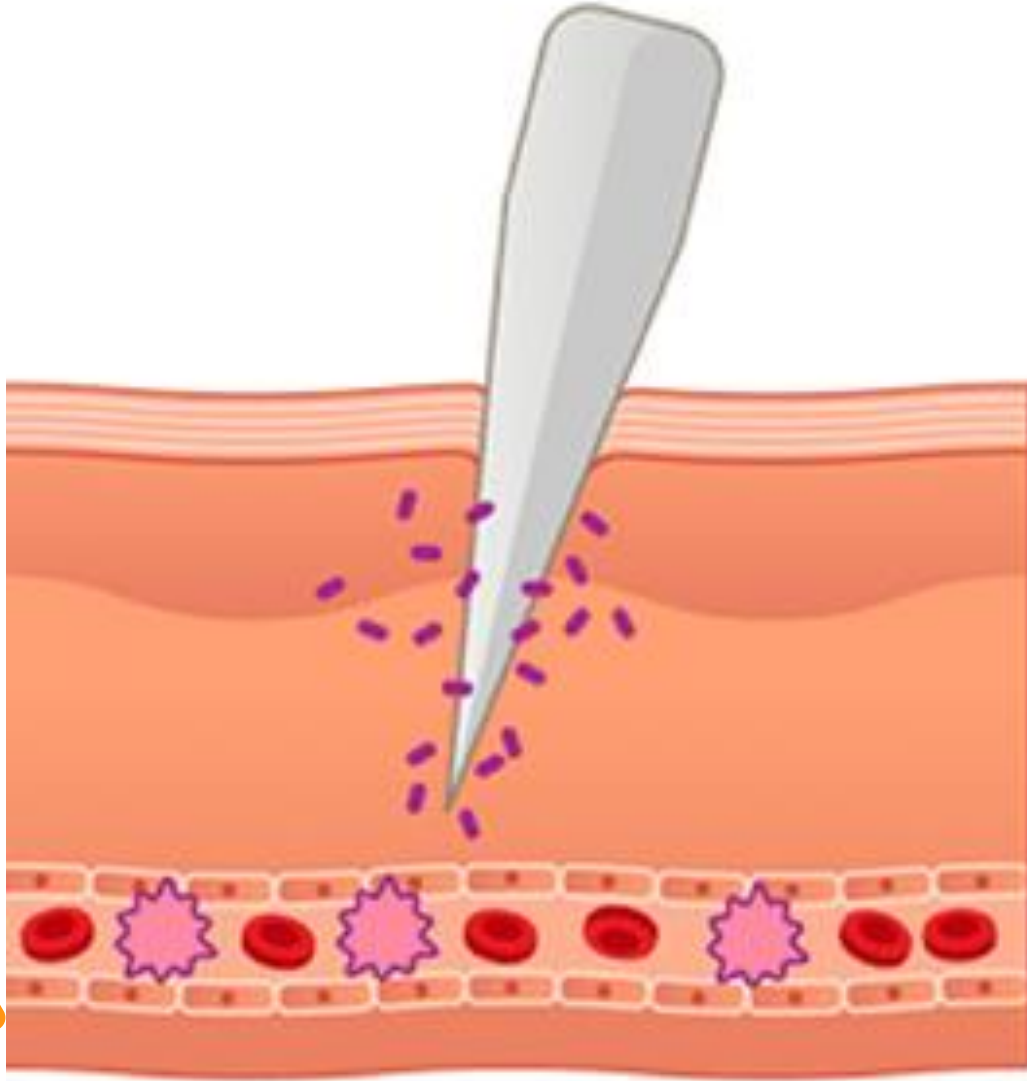
### Subcutaneous tissue

Made up of fat and connective tissue, this layer plays many important roles in your body.



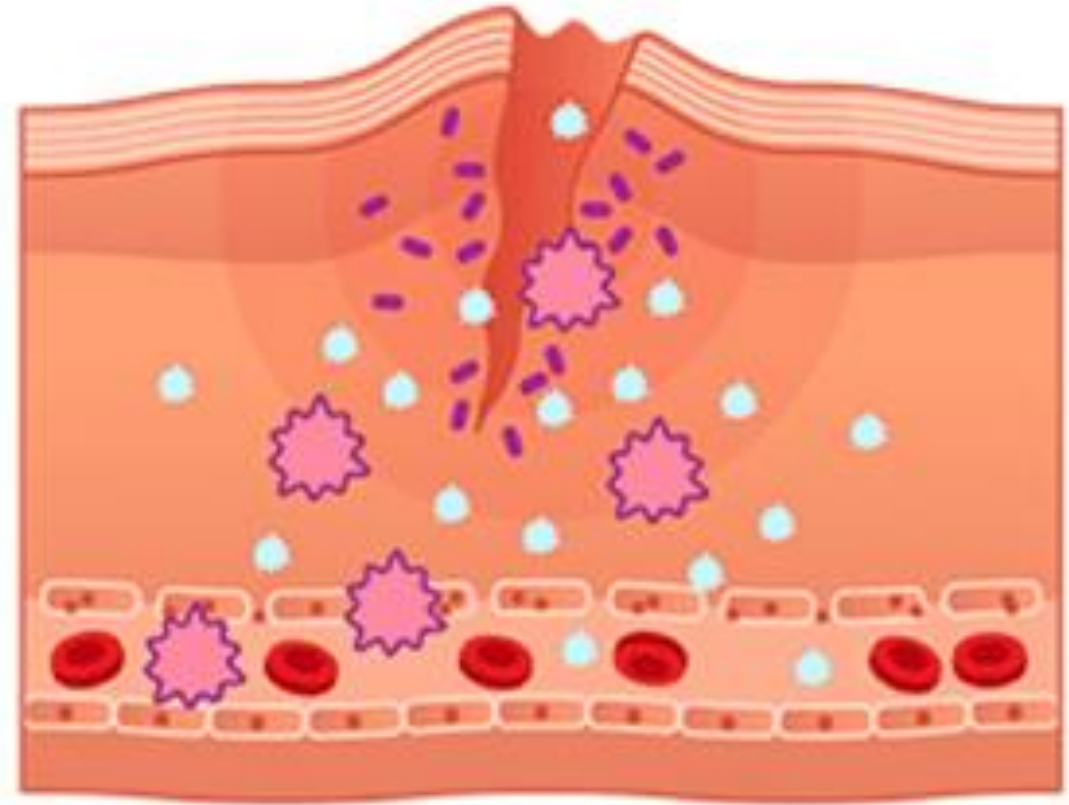


Harmful things enter the body

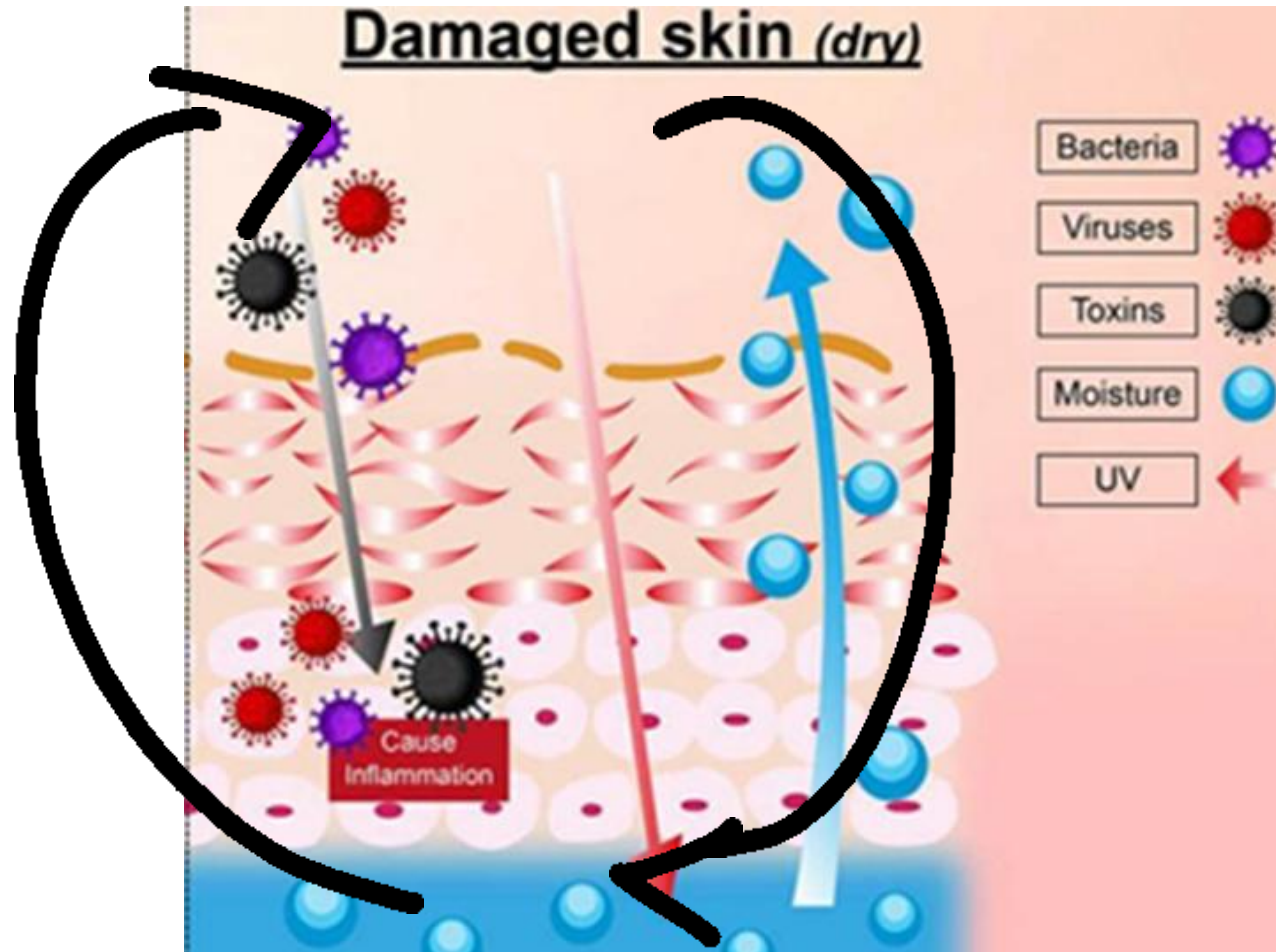


The body issues an immune response that causes:

- Swelling
- Warmth
- Redness
- Pain

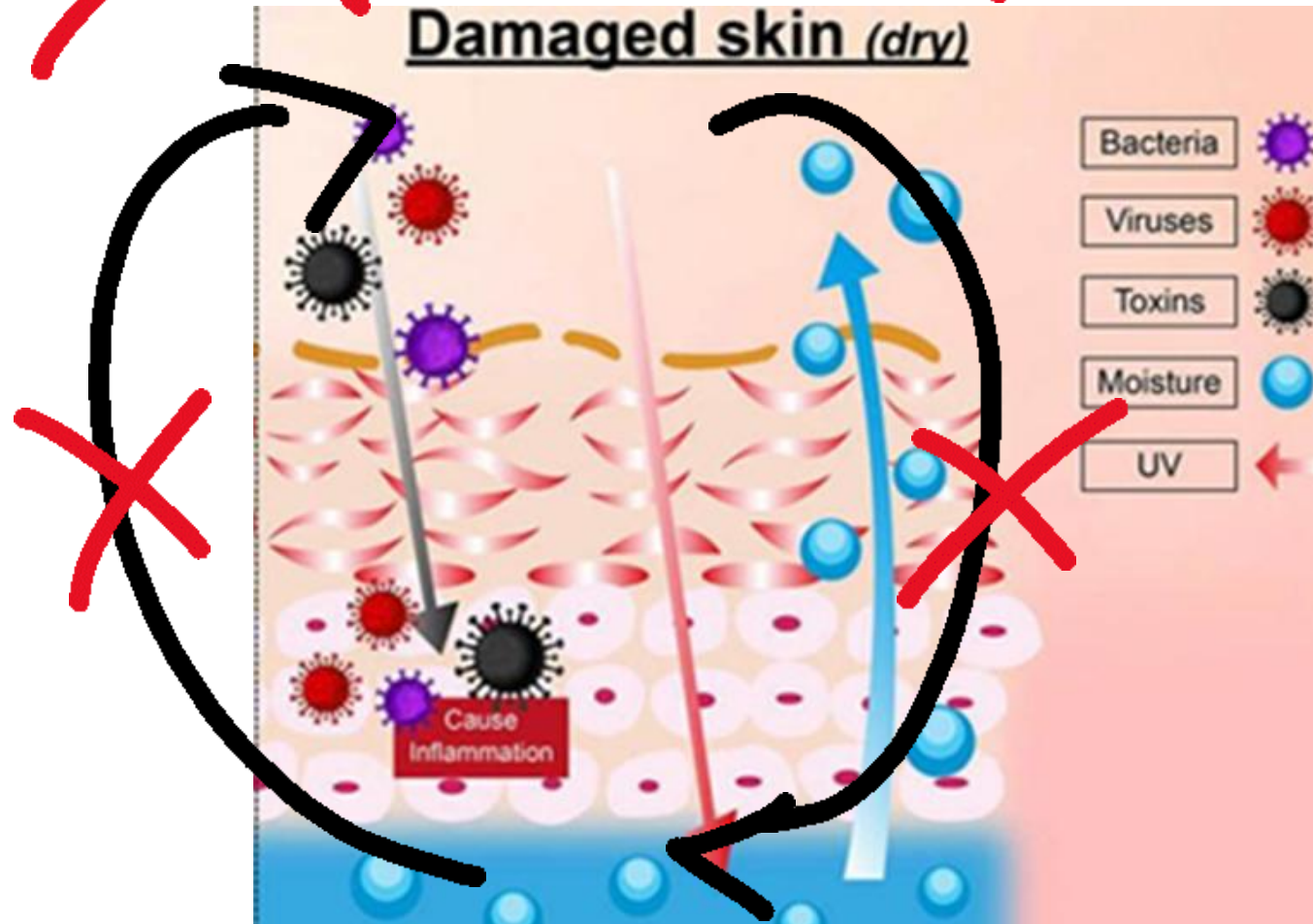


# The Vicious Skin Damage Cycle





# The ~~Violous~~ Skin Damage Cycle



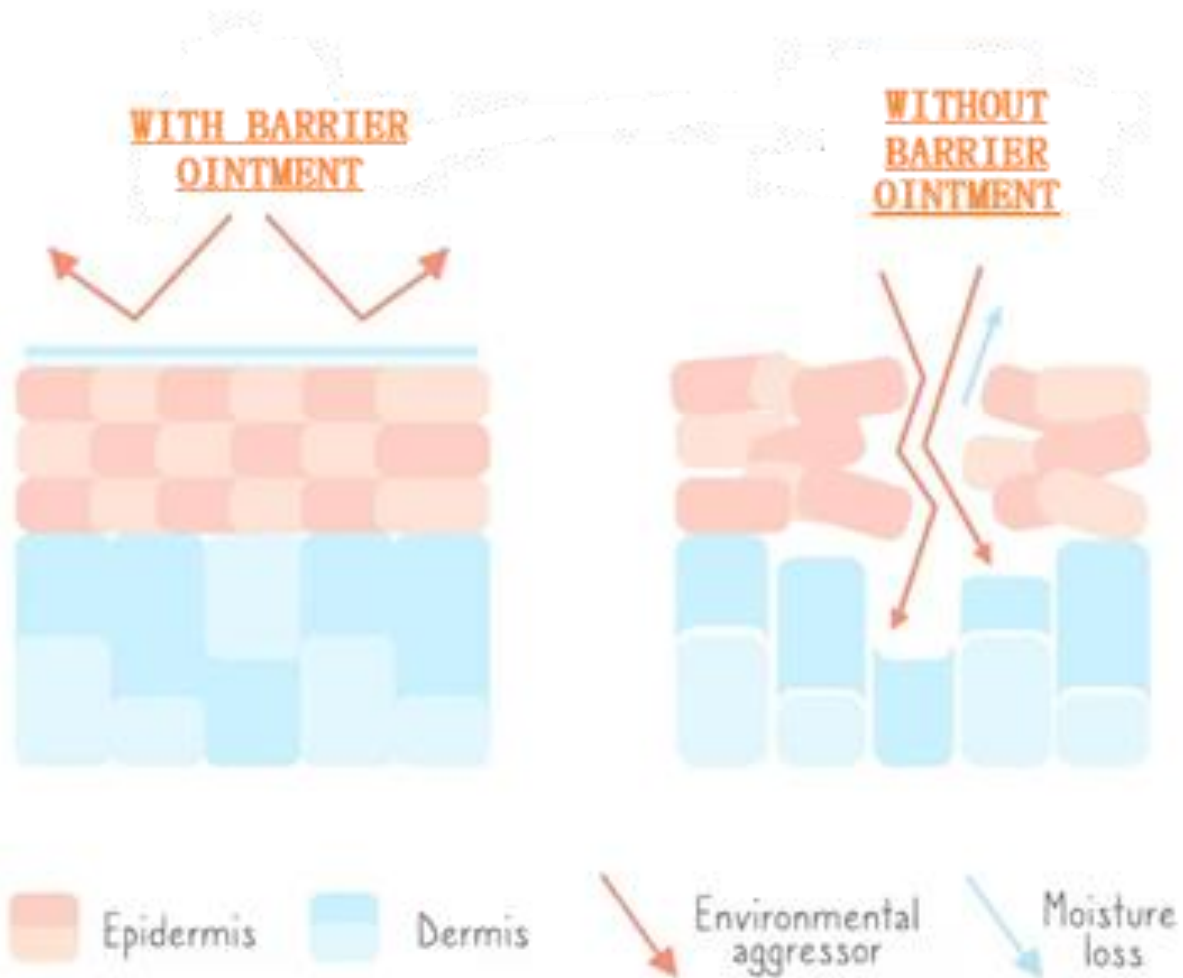
# STOP The Cycle



Halt the inflammatory cascade at its cause, stop its fire, reduce the accelerants and soothe burns,

1. Reduce inflammation (primary and secondary)
2. Avoid irritants
3. Stop irritants affecting the skin and replace and protect the skin surface barrier



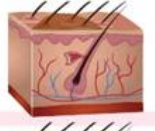



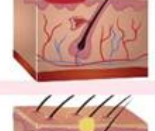





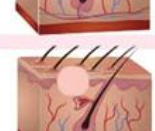









# SKIN BARRIER





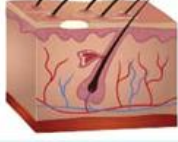
# STOP The Cycle



1. BARRIER
2. WASH
3. STEROIDS (REDUCING COURSES FOR FLARES & MAINTENANCE TREATMENT TO AVOID FLARES)

<b>MACULE</b> Flat lesion less than 1 cm		
<b>PATCH</b> Flat lesion, more than 1 cm		
<b>PAPULE</b> Raised lesion, less than 1 cm		
<b>PLAQUE</b> Raised lesion, more than 1 cm		
<b>PUSTULE</b> Pus filled lesion, usually less than 1 cm		
<b>VESICLE</b> Fluid filled lesion, less than 0.5 cm		
<b>BULLA</b> Fluid filled lesion, more than 0.5 cm		
<b>NODULE</b> Firm lesion, more than 1 cm		
<b>TUMOR</b> Firm lesion, more than 2 cm		
<b>CYST</b> Cavity filled with air, fluid or semisolid material		
<b>WHEAL</b> Superficial raised lesion		



<b>SKIN ATROPHY</b> Thin and wrinkled skin		
<b>CRUST</b> Dried fluid over injured skin		
<b>EXCORIATION</b> Scratches with loss of top layer of skin.		
<b>LICHENIFICATION</b> Thick skin with prominent skin markings		
<b>EROSION</b> Loss of the top layer of skin		
<b>ULCER</b> Loss of the epidermis along with part of dermis		
<b>FISSURE</b> Linear breaks extending to the dermis		
<b>SCALE</b> White flakes due to increased cell turnover		
<b>SCAR</b> Replacement of normal tissue with fibrous tissue		



**Skin Cancer**



**Acne**



**Rosacea**



**Eczema**



**Psoriasis**



**Birthmarks**



**Cysts**



**Hair Loss**



**Rashes**



**Skin Tags**



**Warts**



**Melasma**

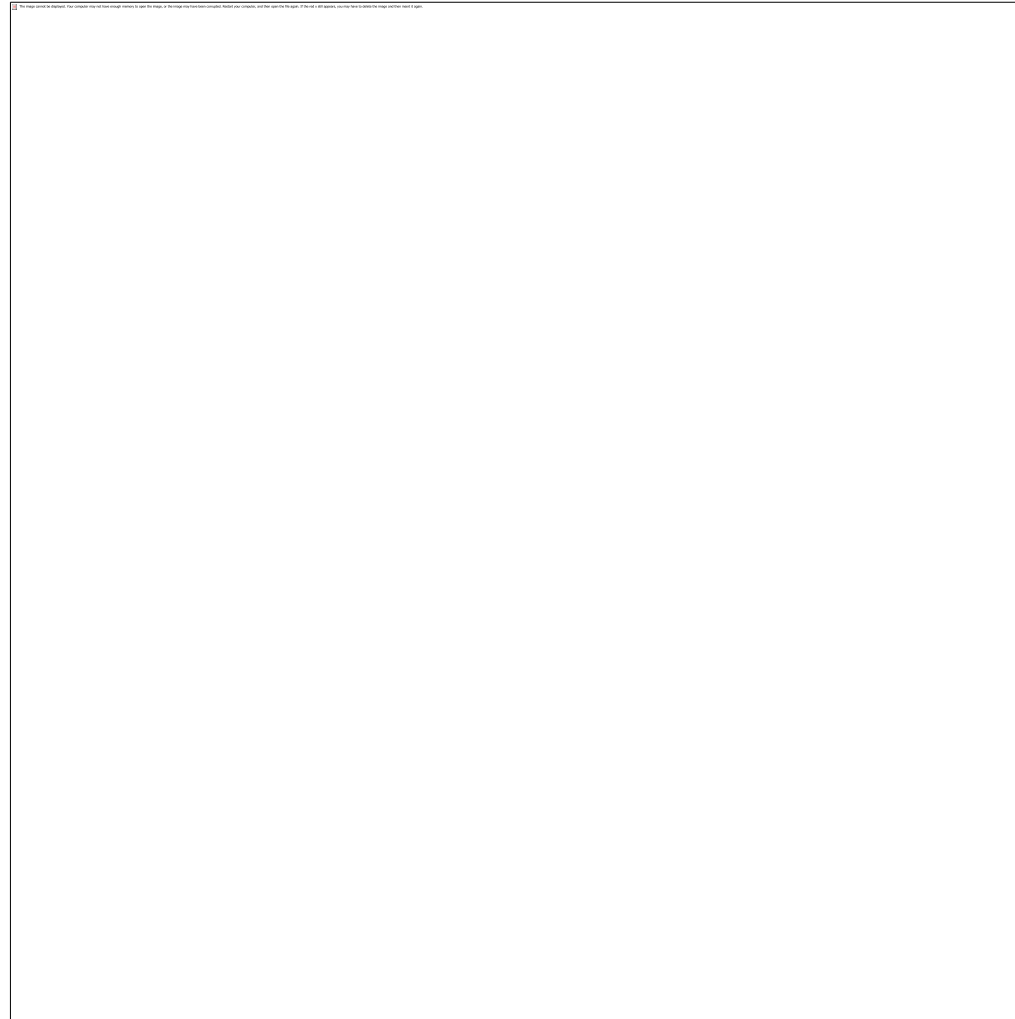


**Sun Exposure  
Damage**

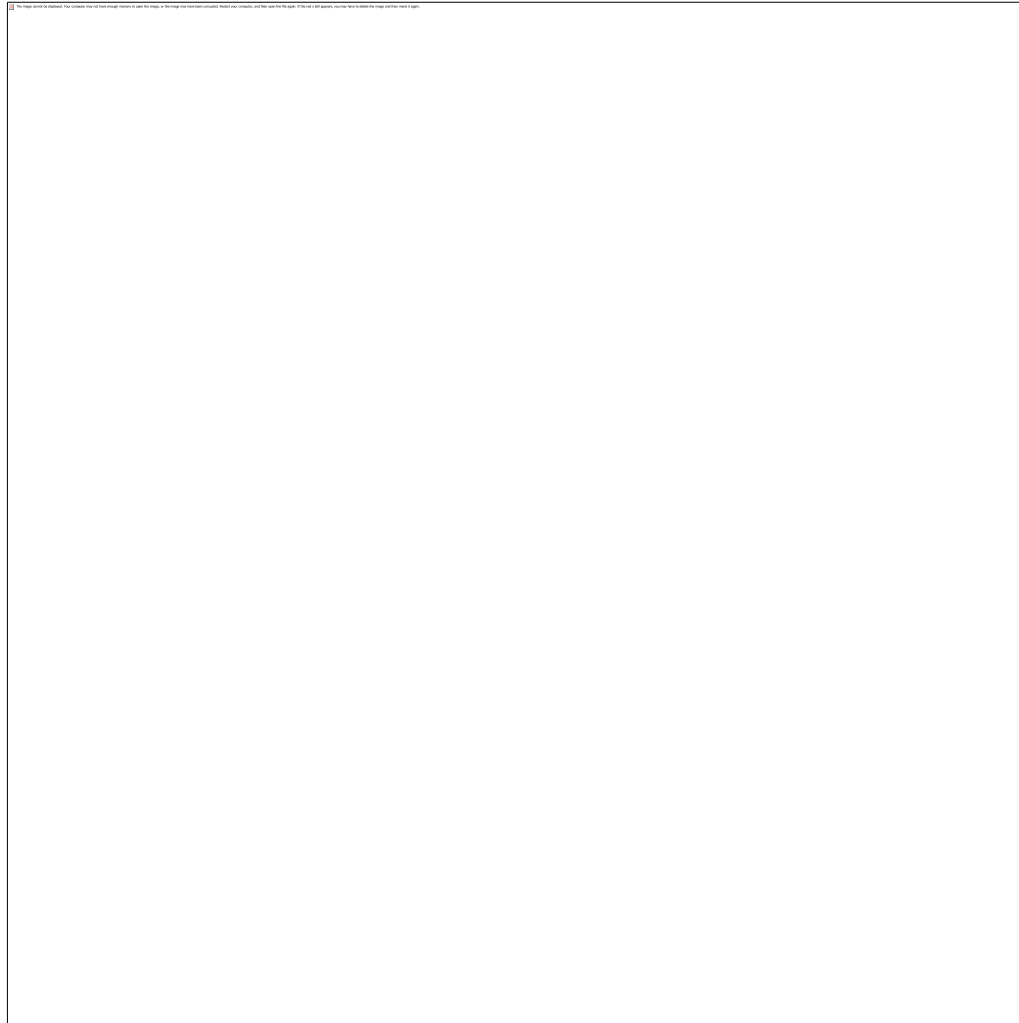
# Angiokeratoma



# Eczematous Change

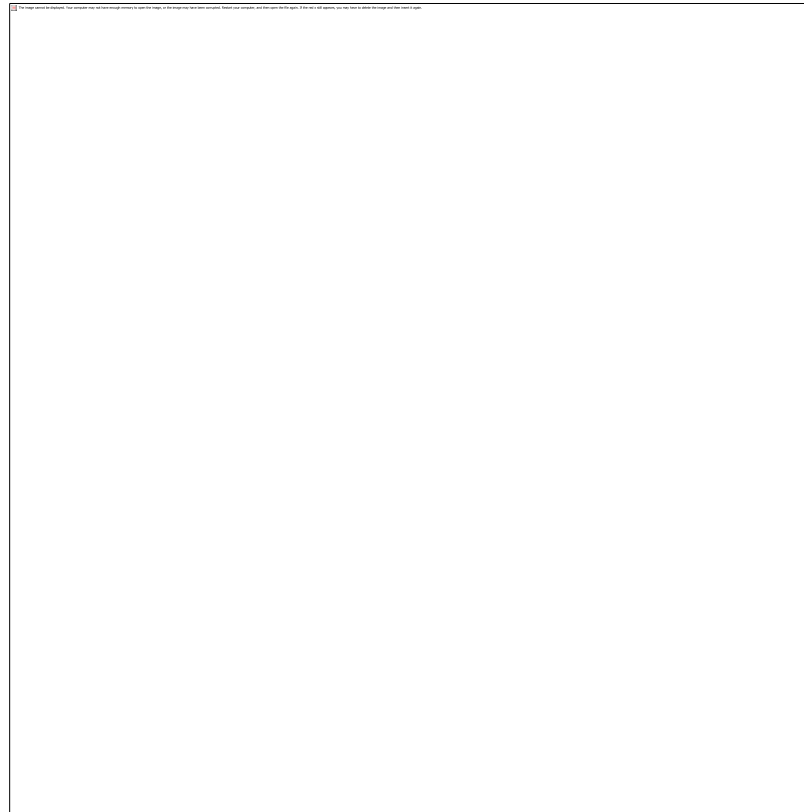


# Contact Dermatitis

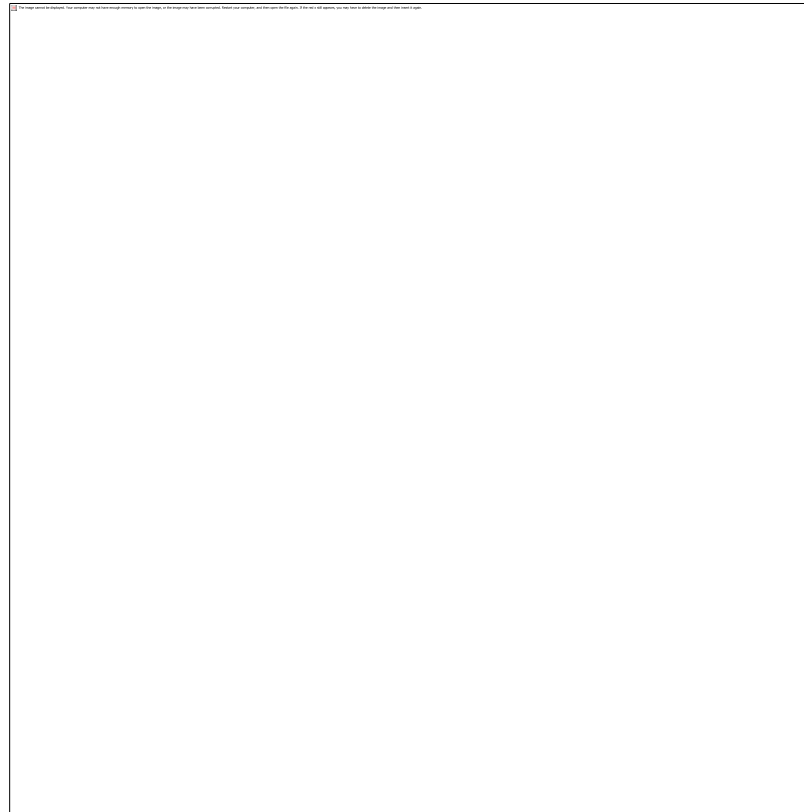




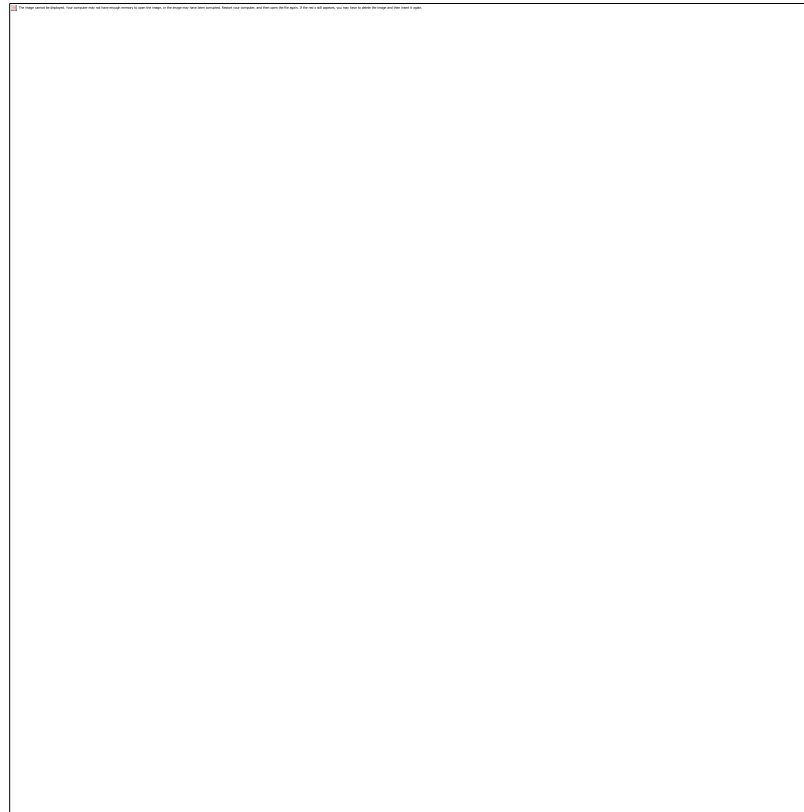
# Swelling and excoriations



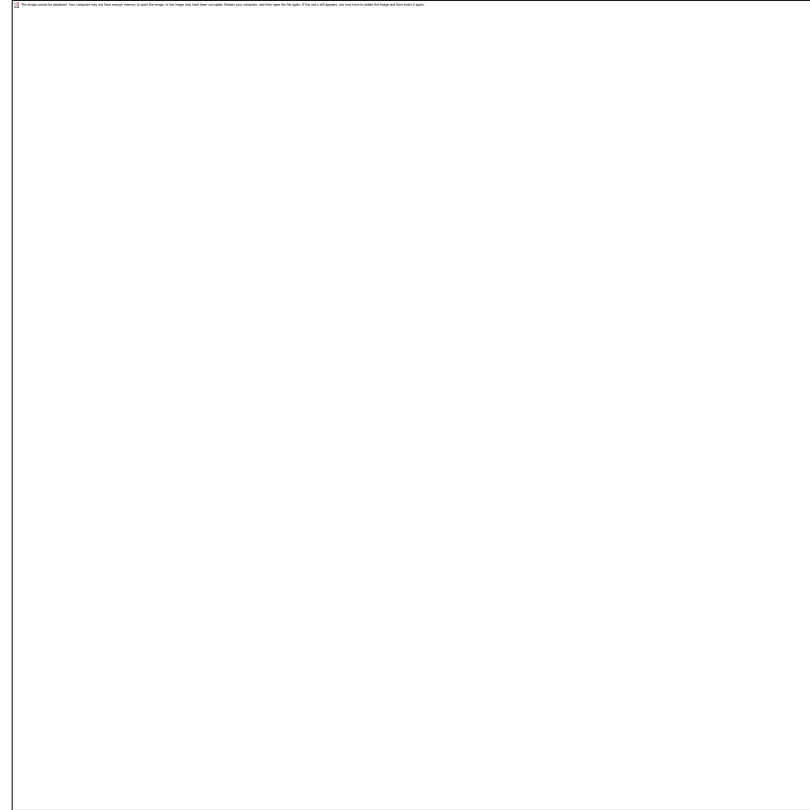
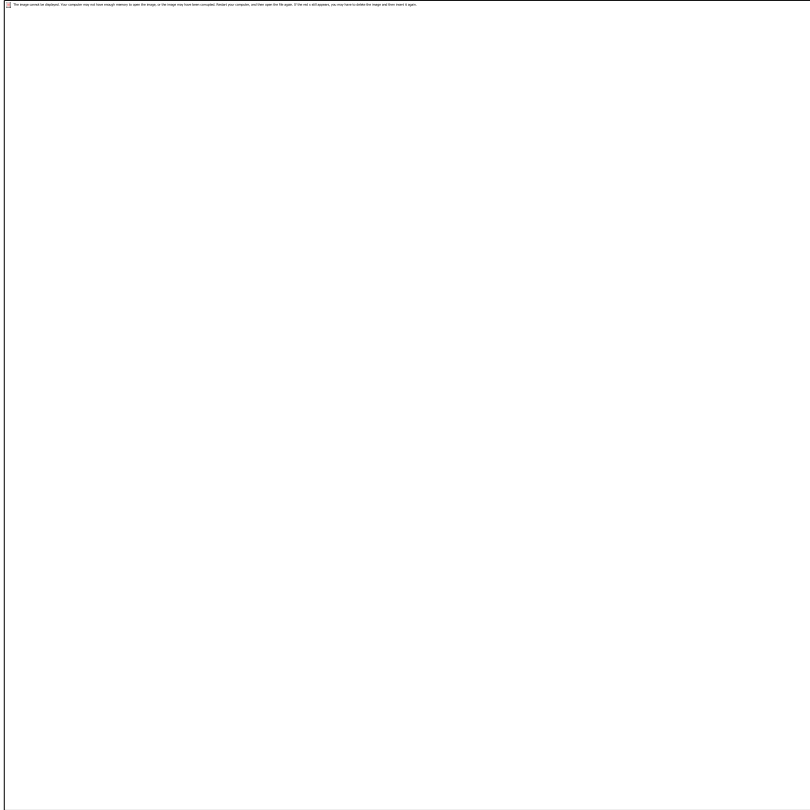
# Herpes



# Warts

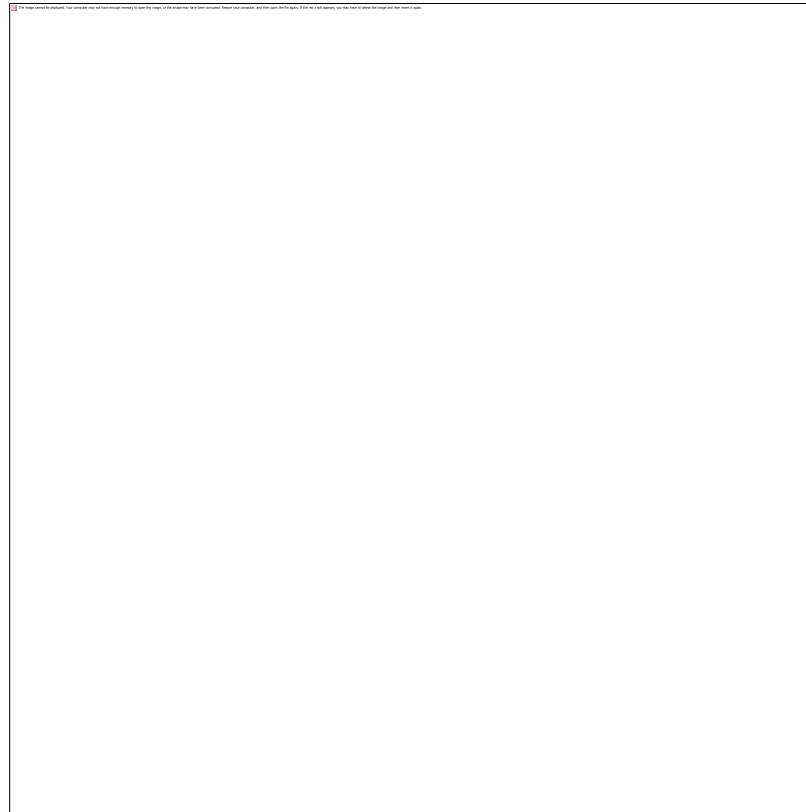


# HSIL/VIN

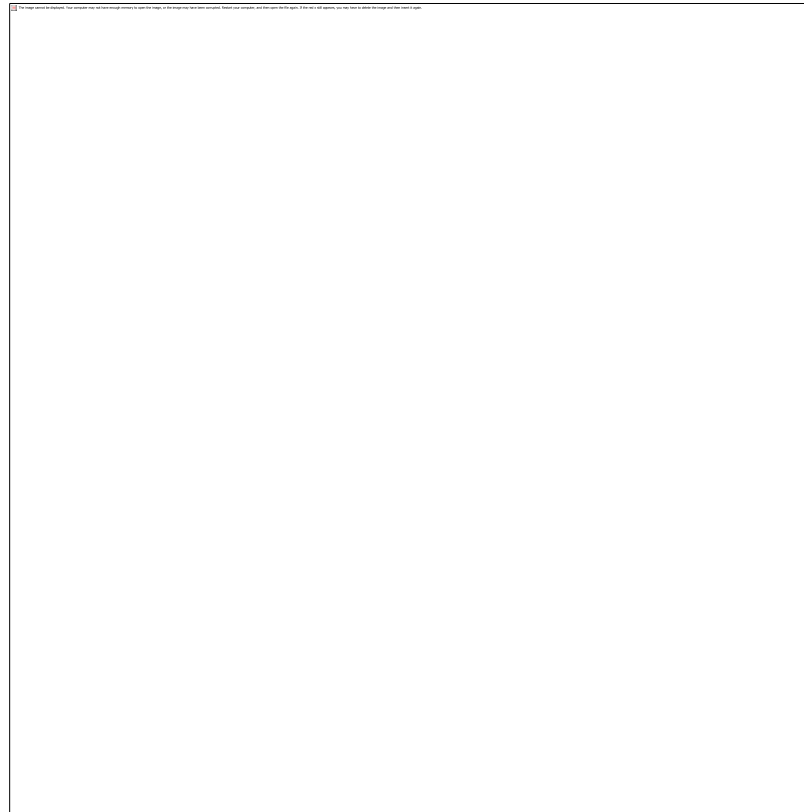




# Acute Intertrigo



# Psoriasis





# Lichen Sclerosus

# Lichen Sclerosus Timeline

1

Nature or Nurture?  
Genetics or  
Environmental?

2

Urine/ Skin Barrier  
Irritants

3

Inflammatory Skin  
Response

4

Inflammatory Cycle

5

Acute then Chronic  
Change  
Occasional  
progression to  
Cancer.



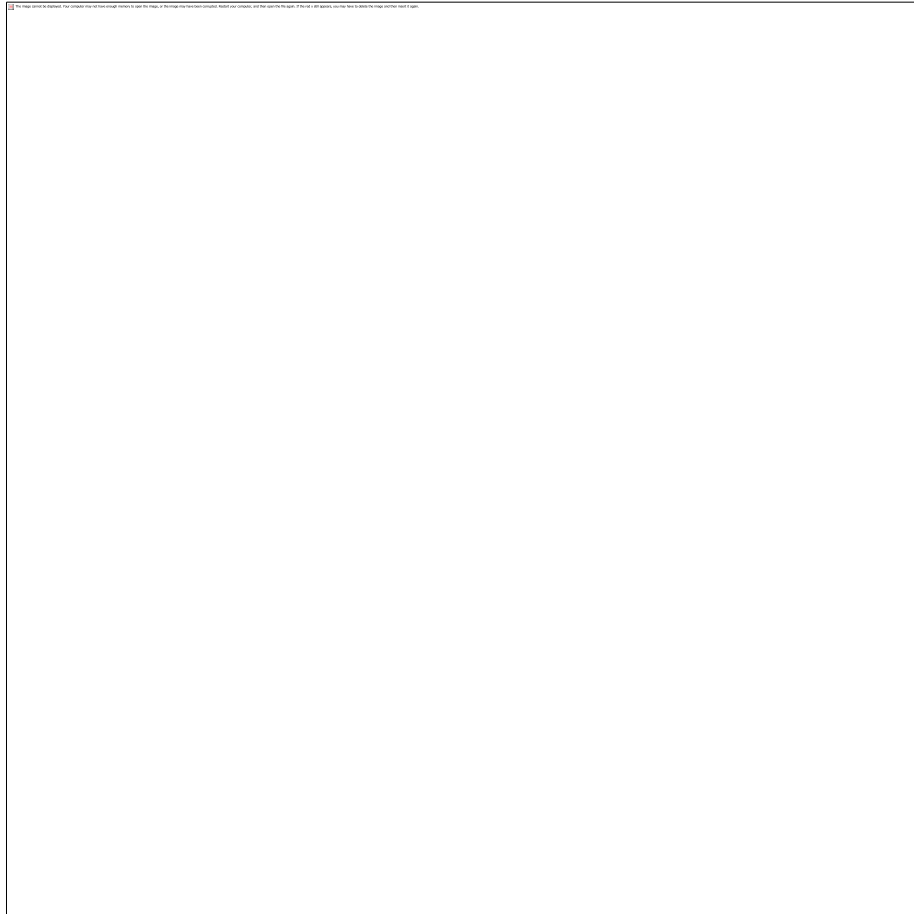
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# Lichen Sclerosus



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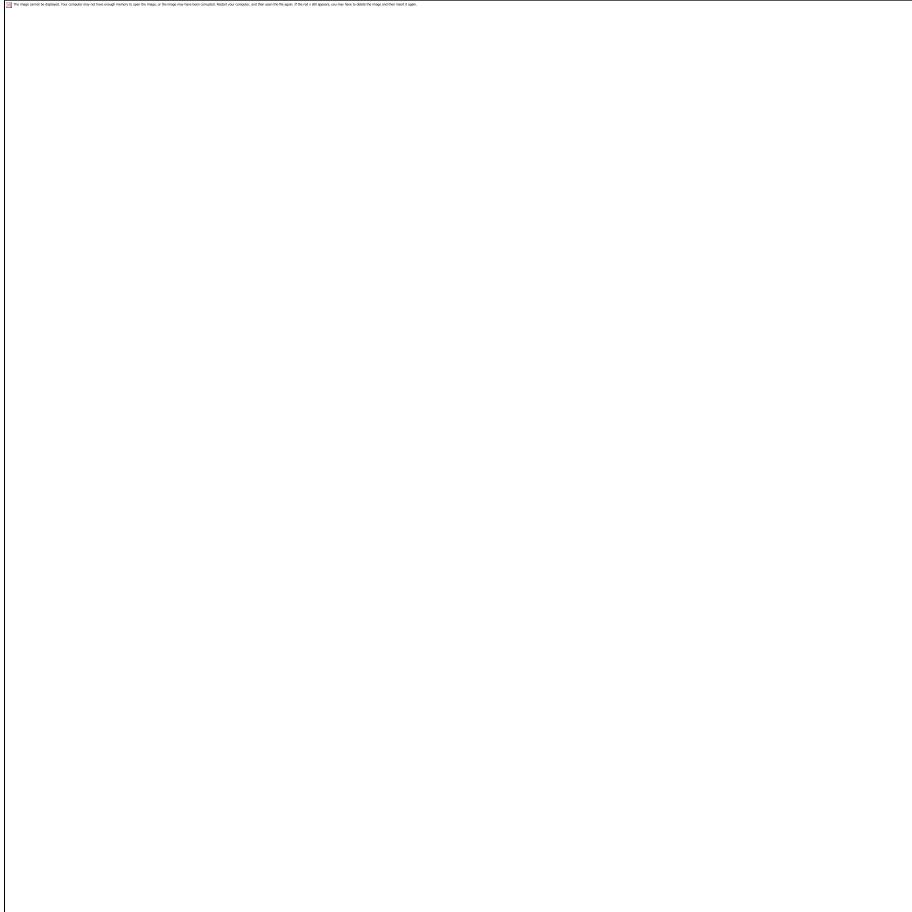


# LS: Treat or Refer for Biopsy/Do a biopsy?...

- As a Lichen sclerosus is a long-lasting inflammatory skin condition, there is a slight increased risk of developing a skin cancer in the area compared to women without lichen sclerosus (less than 5 percent).
- Any new raised, bleeding or non-healing areas in your genital area should be reported to a specialist healthcare provider.
- It is important that LS is monitored and that follow-up visits with your GP are provided at least once per year.



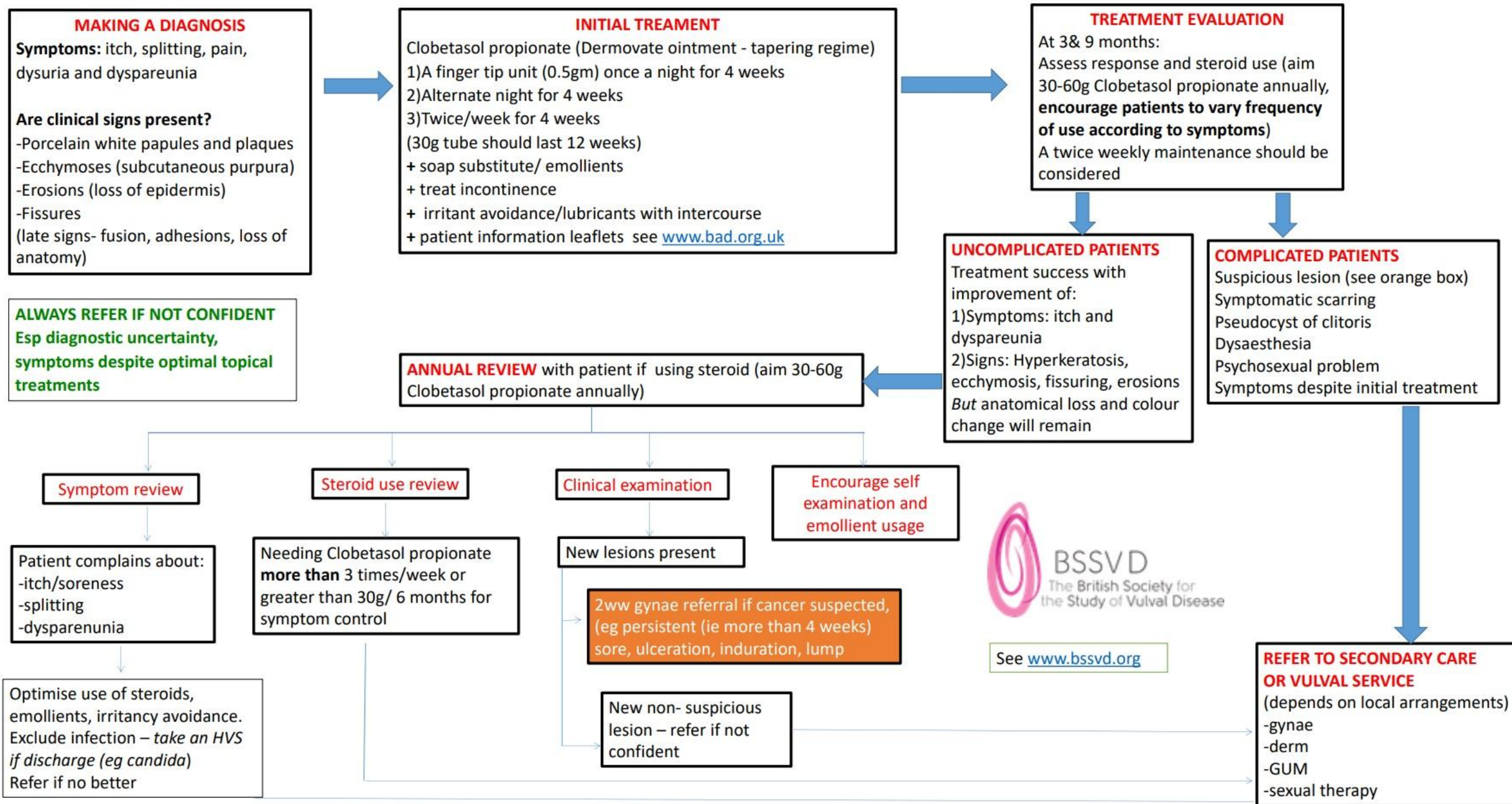
# Lichen Sclerosus



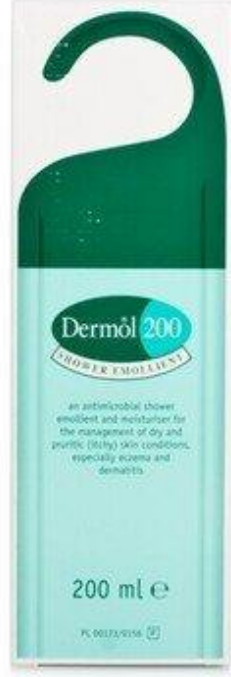
# HSIL/dVIN and SCC associated with LS



# ADULT FEMALE LICHEN SCLEROSUS- GUIDANCE FOR HEALTH CARE PROFESSIONALS (HOSPITAL TEAM OR GP SPECIAL INTEREST)



# Washing



Incontinence



Sensitive skin?



Thicker/lighter



# Barrier OINTMENT



Individualised Care



Daytime Barrier



Night-time Barrier

# Steroid OINTMENTS



Individualised Care &  
Regimens for Flares vs  
maintenance



Strength: Disease



OINTMENTS never  
CREAMS!

# Oestrogen...



Individualised Care



Vulva? Vagina?  
Vestibule? Urogenital?



Talk about sex...

Conservative,  
Medical,  
Ablative  
Medical  
Laser &  
Excision



# Summary

## Look, learn and educate

- Knowing your own and your patient's 'normal' genital appearance is key

## Every vulva needs care

- Cradle to grave
- Nappies, Potty training, puberty, first sexual relations, pregnancy, birth, postpartum care, menopause, natural aging, end of life

1. Wash with care
2. Barrier with ointments
3. Use topical steroid flare treatment in adequate reducing courses and consider maintenance doses to avoid flares
4. Lubricate & Love

\*Always look for cancer, pre-cancer & skin change\*





# Thank you



## NAPS

National Association for  
Premenstrual Syndrome

**Miss Elaine Louise Palmer MBBS BSc MRCOG AICSM**

[elaine.palmer6@nhs.net](mailto:elaine.palmer6@nhs.net)

[thevulvaandmenopauseclinic@outlook.com](mailto:thevulvaandmenopauseclinic@outlook.com)



**BSSVD**  
The British Society for  
the Study of Vulval Disease