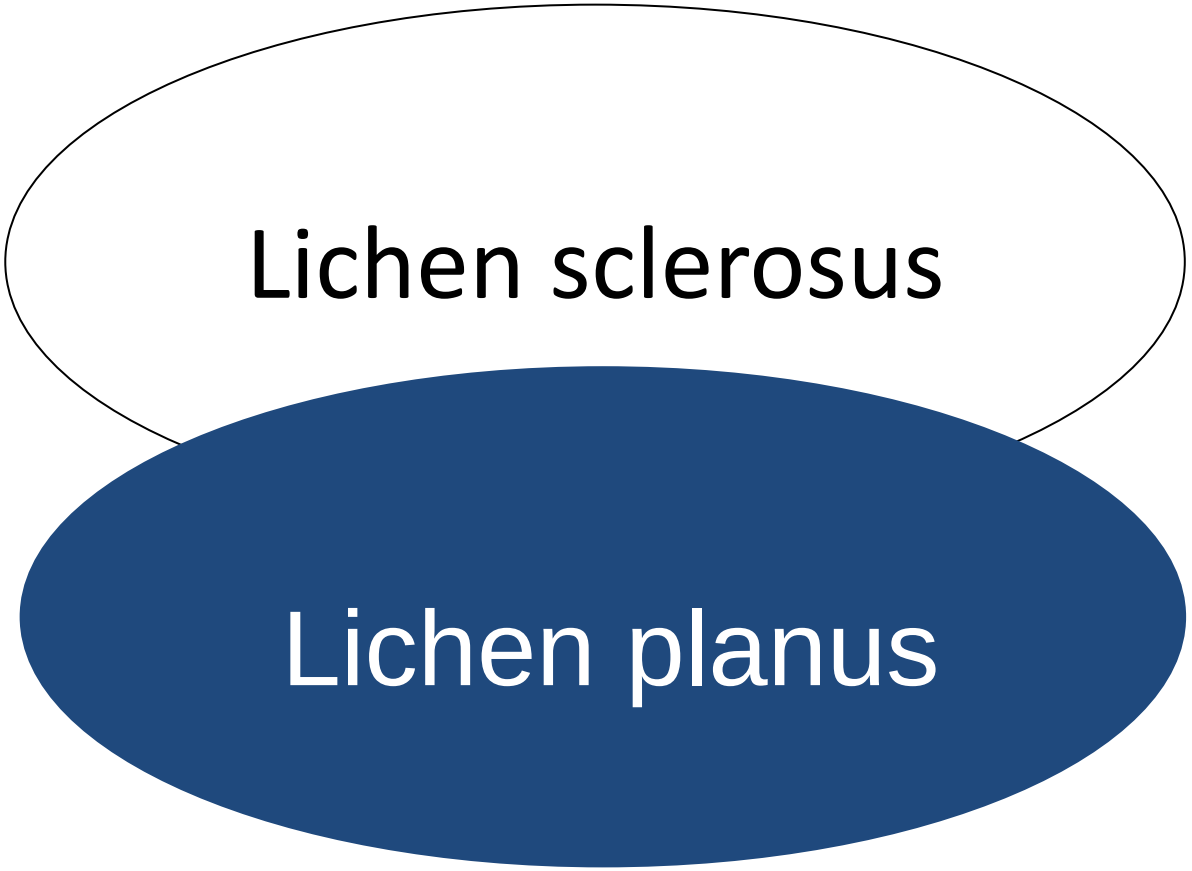


Dr Fiona Lewis,
St John's Institute of Dermatology, GSTT

Outline

- Typical features of lichen sclerosus and lichen planus
- Diagnosis
- Management
- When to refer on

Lichen sclerosus

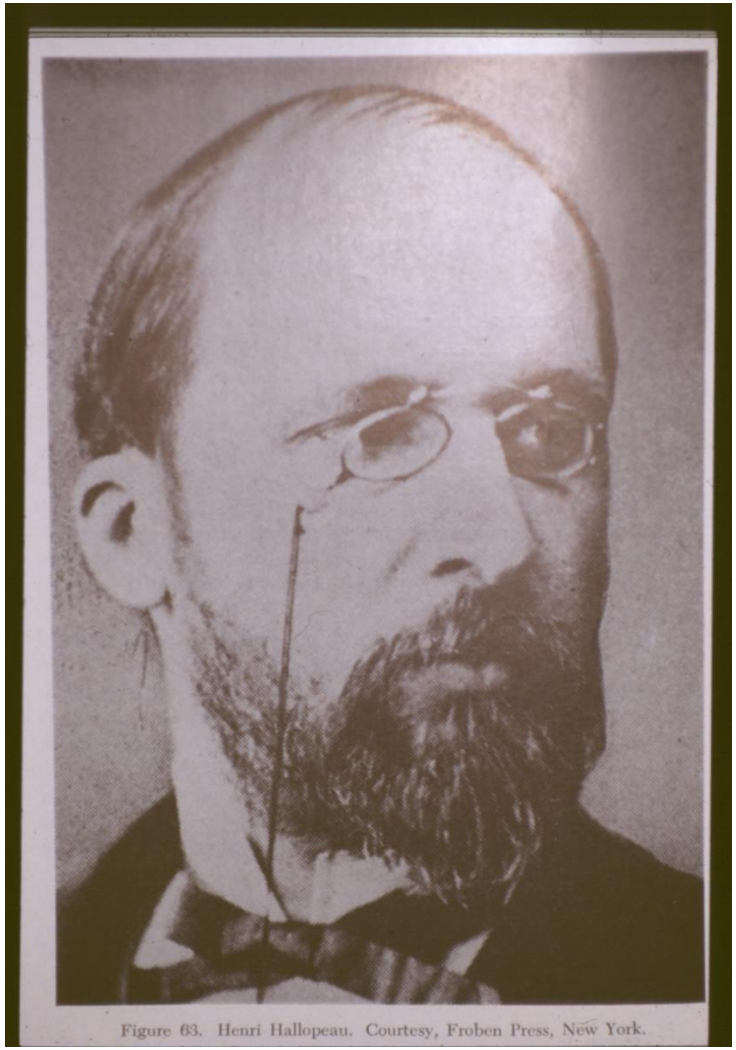


Figure 63. Henri Hallopeau. Courtesy, Froben Press, New York.

1889

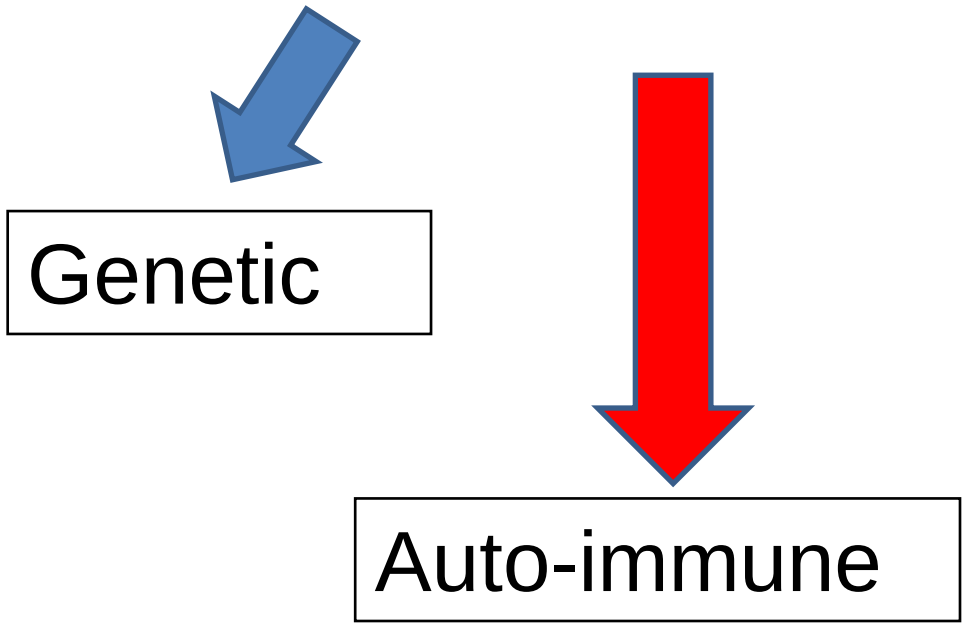
Lichen plan sclereux

LS – aetiology ??

Genetic

- HLA antigens – DQ and DR associated with other auto-immune disease
- DQ7, DR7, 8,9 more common in patients than controls
- Less evidence in males

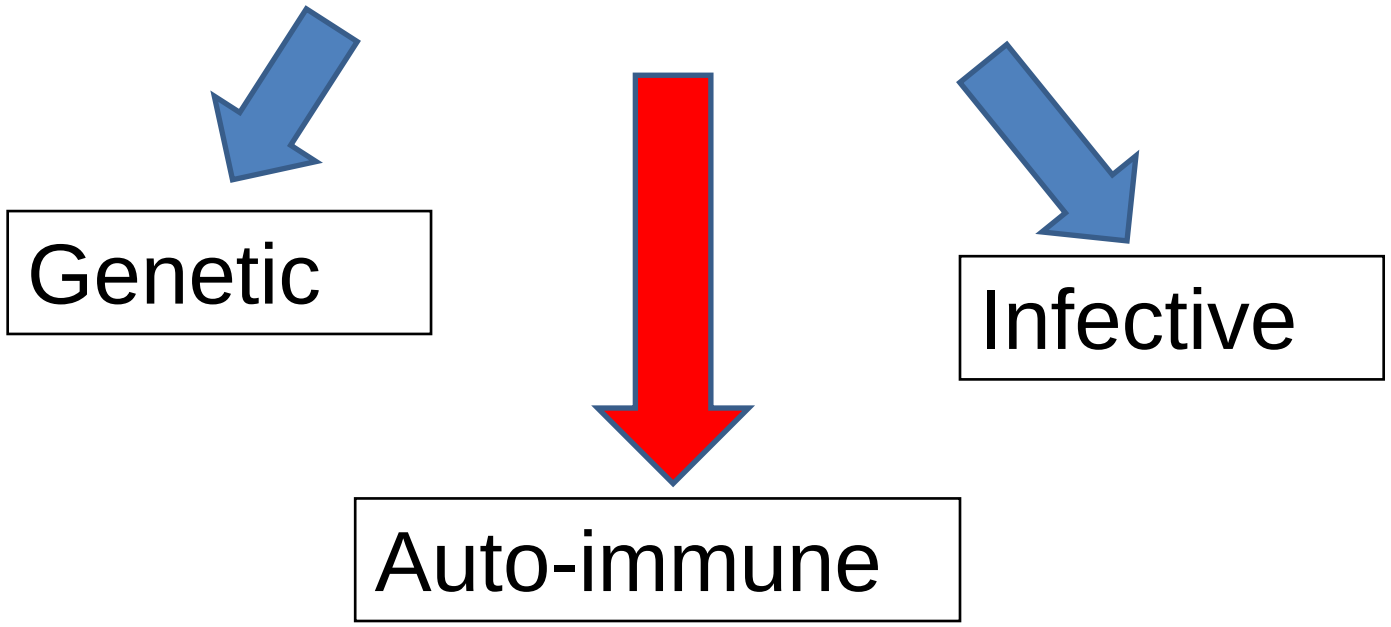
LS – aetiology ??



BMZ antibodies - *Howard et al Australas J Dermatol 2004; 45: 12-5.*

ECM1 protein - *Oyama et al. Lancet 2003; 362: 118-23.*

LS – aetiology ??



Little evidence for Borrelia burgdorferi and HPV

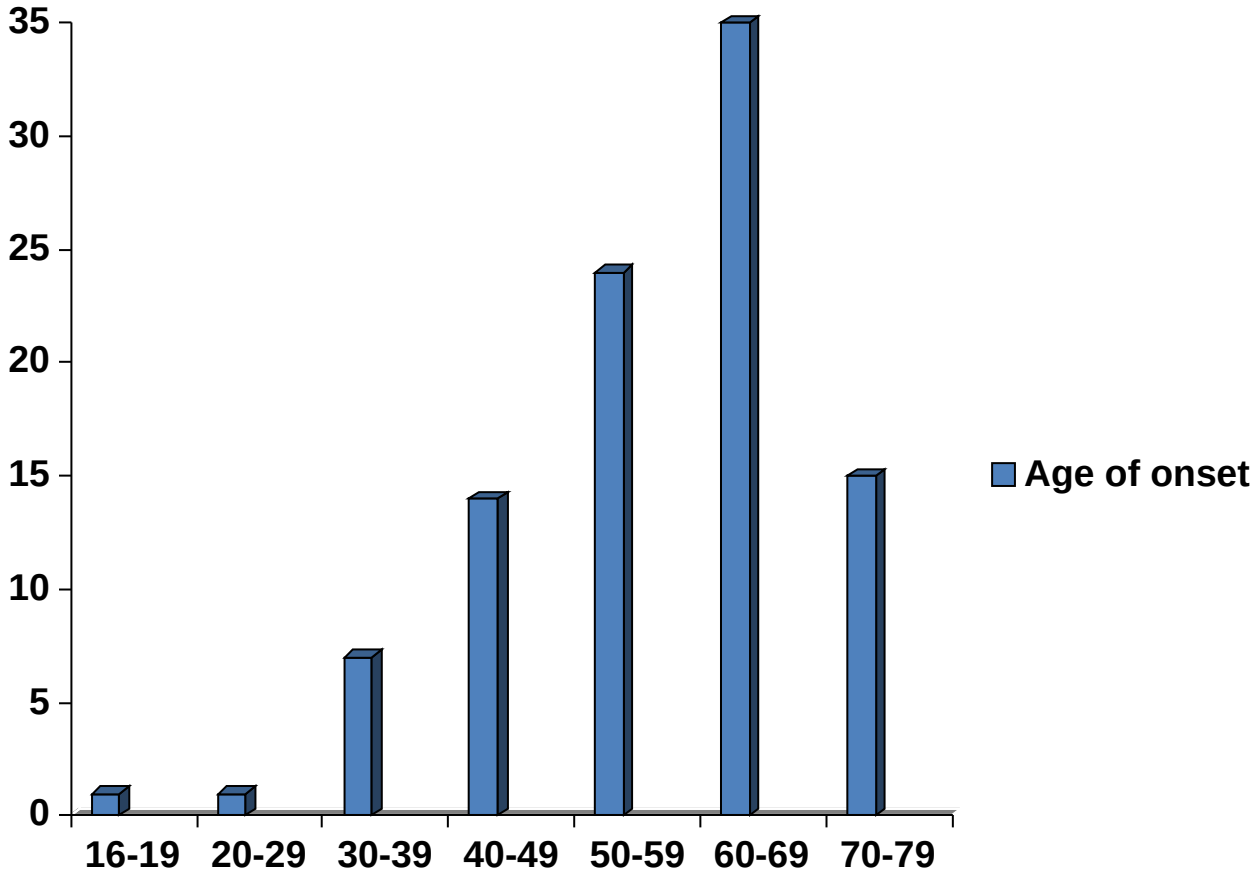
Skin immune system

- Increase in Langerhans cells at all stages of disease
- Increased ICAM1 and HLA-DR expression in treated disease
- Increased cytokine activity

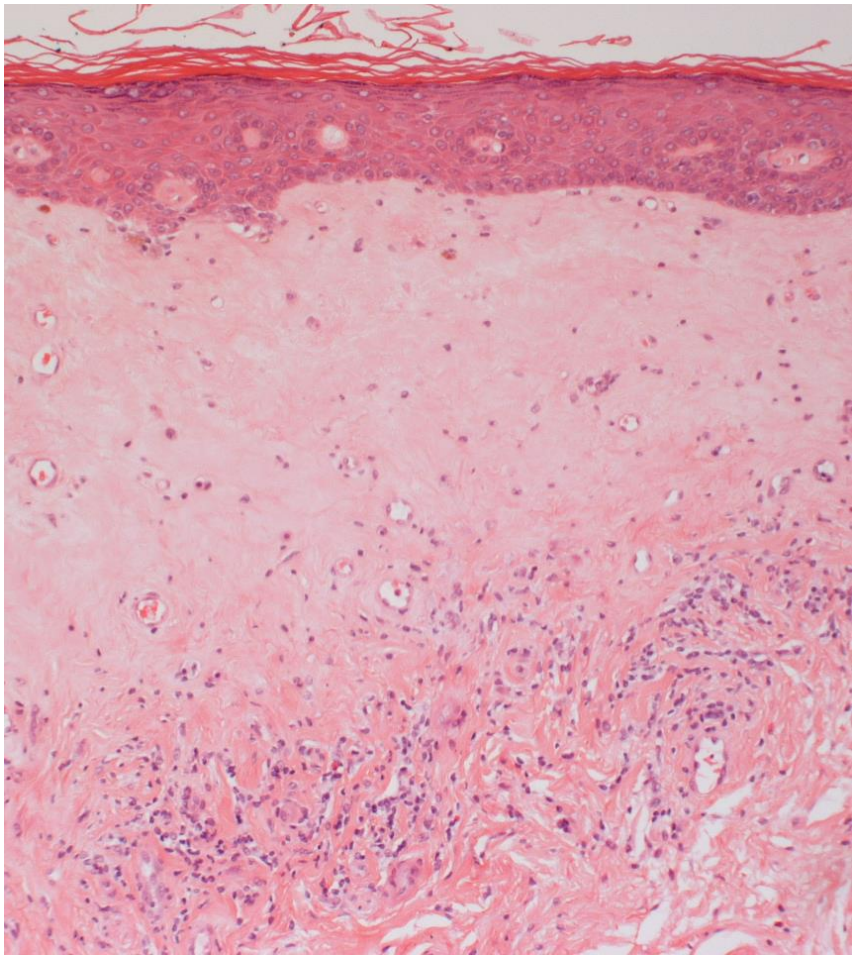
What does NOT cause it?

- Sexually transmitted infection
- Hormone problems
- Allergy
- Diet
- Borelia burgdorferi
- HPV

Who gets LS?


35
30
25
20
15
10
5
0
16-19
20-29
30-39
40-49
50-59
60-69
70-79
Age of onset

Typical LS histology



- Thinned epidermis
- Homogenous band of collagen
- Lymphocytic inflammation

What are the symptoms?

- Pruritus
- Soreness
- Dyspareunia

- Constipation in children

What are the features?

- White plaques
- Ecchymosis
- Architectural change
- Fissures

How to manage a patient with lichen sclerosus

LS – treatment – what not to do!

- Arsenic
- Glycerol pomade of pyrogallol
- Radiotherapy
- Bismuth
- Mercury tattoos
- Testosterone
- Vulvectomy

How is it treated?

- Emollients
- Ultra-potent topical steroids

(*Cochrane reviews, BAD Guidelines 2018 etc*)

- Tapering regime as effective as daily for induction Borghi A, BJD 2015; 1381-6
- Potent topical steroids superior to calcineurin inhibitors RCT Funaro JAAD 2014;84-91
- Longer term compliant treatment reduces scarring and possibly risk of malignancy

Lee, JAMA Dermatol 2015, 151, 1061-7

GUIDELINE

BJD
British Journal of Dermatology

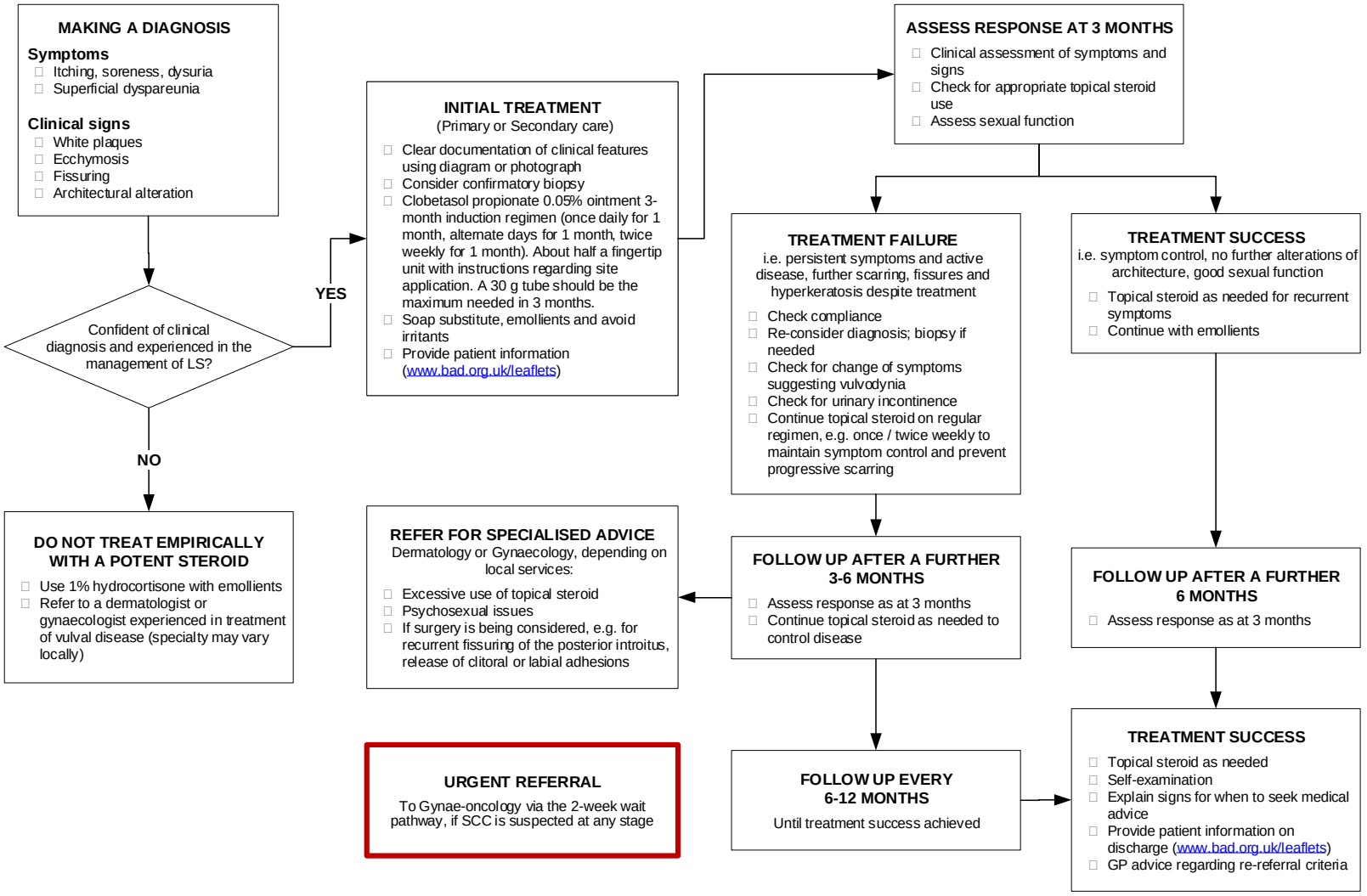
British Association of Dermatologists guidelines for the management of lichen sclerosus, 2018*

F.M. Lewis,[1,2] F.M. Tatnall,[3] S.S. Velangi,[4] C.B. Bunker,[5,6] A. Kumar,[7] F. Brackenbury,[8] M.F. Mohd Mustapa[9] and L.S. Exton[9]

[1]Frimley Health NHS Foundation Trust, Slough SL2 4HL, U.K.
[2]St John's Institute of Dermatology, Guy's & St Thomas' NHS Foundation Trust, London SE1 9RT, U.K.
[3]West Hertfordshire NHS Trust, Watford WD18 0HB, U.K.
[4]University Hospitals Birmingham NHS Foundation Trust, Birmingham B15 2TH, U.K.
[5]University College London Hospitals NHS Foundation Trust, University College Hospital, London NW1 2BU, U.K.
[6]Chelsea & Westminster NHS Foundation Trust, London SW10 9NH, U.K.
[7]King's College London, London SE1 3ER, U.K.
[8]Association for Lichen Sclerosus and Vulval Health, Brighton, U.K.
[9]British Association of Dermatologists, Willan House, 4 Fitzroy Square, London W1T 5HQ, U.K.

PATIENT MANAGEMENT PATHWAY – ADULT FEMALE ANOGENITAL LICHEN SCLEROSUS

Please use in conjunction with the summary of recommendations and discussions in the guideline and supporting information



Treatment regime

Clobetasol propionate 0.05% ointment

once a day for 1 month
alternate days for 1 month
twice a week for 1 month

Then individualised to maintain control of symptoms and signs eg. once/week if needed

Safe amounts of topical steroids

- 30g in 3 months (adults)
- 30g in 6 months (children)

Lichen sclerosus

- Pallor often remains
- Scarring should be stopped
- Symptom control

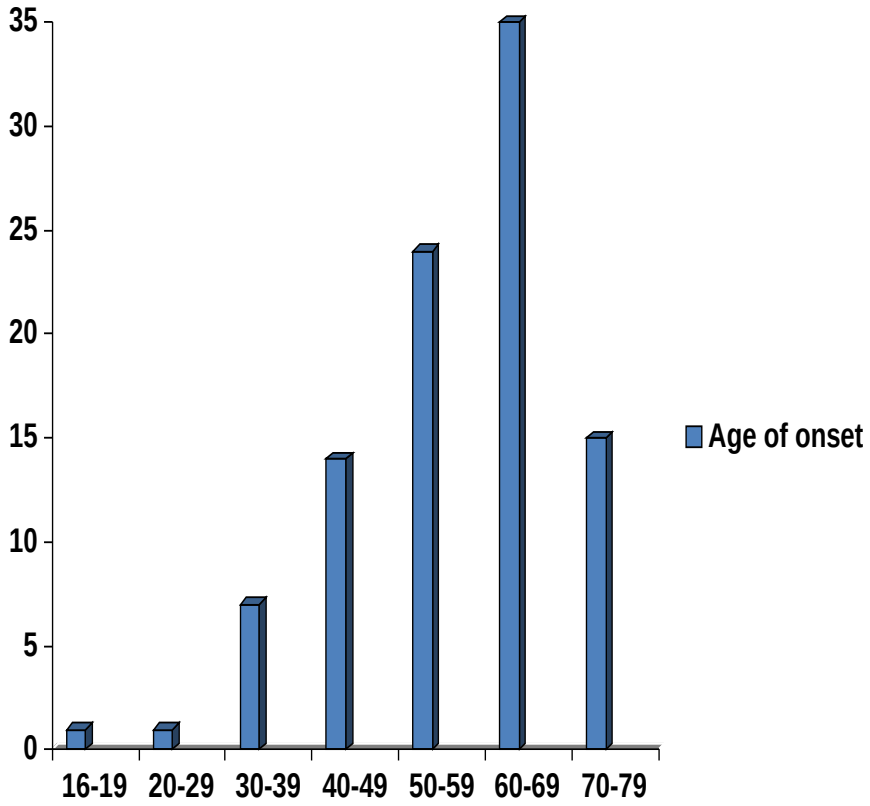
Follow-up

- 3 months, 6 months, 12 months
- Discharge if well controlled with patient information

- Long term follow-up for any patient with atypical disease or history of VIN

LS in pregnancy

- About 20% patients develop LS in reproductive years
- Important issue for young women



LS in pregnancy

- LS does not worsen during pregnancy and may improve
- If well controlled, no contra-indication to vaginal delivery
- No increased scarring in tears or episiotomies
- No problems seen from using topical steroid during pregnancy

Trokoudes JEADV 2018

LICHEN PLANUS

Lichen planus

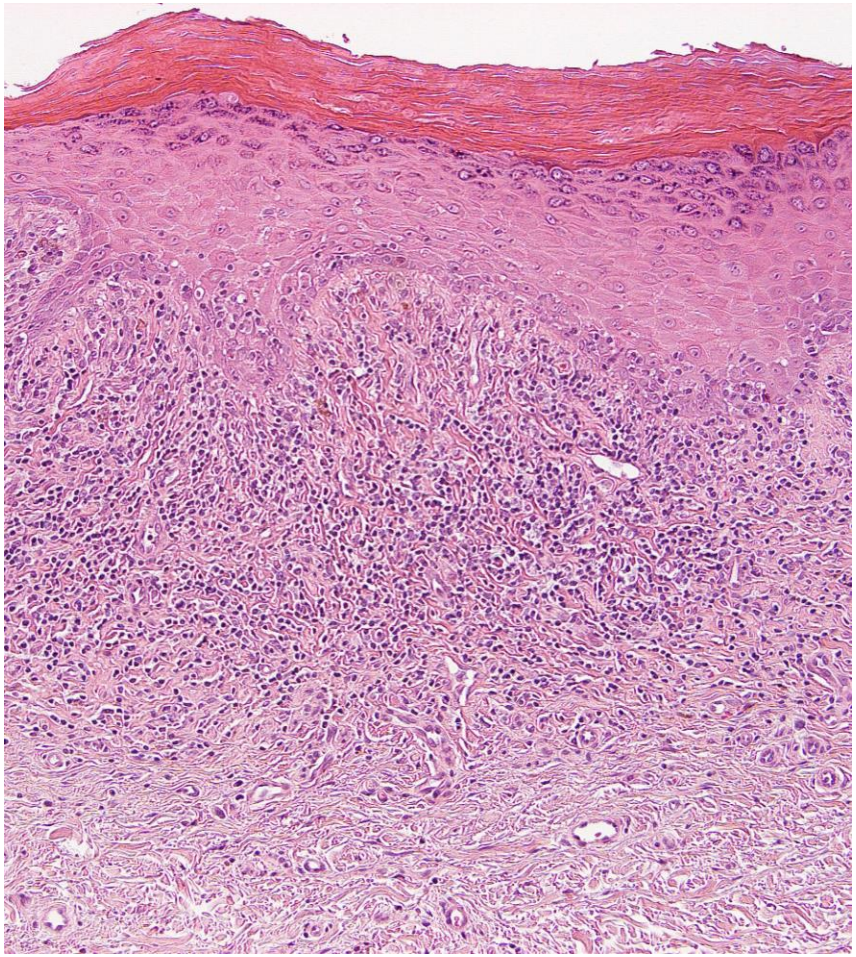
Erasmus Wilson

1865

LP - aetiology

- ? Auto-immune
- T cell mediated
- Antibodies directed against BM antigens

LP histology



- Saw-tooth epidermis
- Dense lymphocytic infiltrate
- Basal cell degeneration

LP - epidemiology

- 55-65% females

- Age of onset – 6th decade

Types of vulval LP

- CLASSIC (papular)
- EROSIVE
  vulvo-vaginal gingival syndrome
- HYPERTROPHIC

Classic (papular) genital LP

- 50% females with cutaneous LP
- May be asymptomatic/pruritic

Erosive LP

- Soreness
- Dyspareunia
- Discharge

Vulvo-vaginal-gingival syndrome

Described by Pelisse

DRB1*0201 allele *Setterfield 1996*

Associated with disease at other important sites

Hypertrophic LP

- Uncommon
- Often perianal
- ?increased risk of SCC

Differential diagnosis

- Lichen sclerosus
- Mucous membrane pemphigoid
- GVHD
- VIN

Vulval

intra-epithelial neoplasia

Complications of LP

Classic

- Hyperpigmentation

Erosive

- Scarring
- Dysaesthesia

Hypertrophic

- SCC

A multi-site disease

LP - management

- Emollients
- Topical steroids – as for LS
- Barriers – for erosive disease
- (calcineurin inhibitors)

- Systemic agents eg. hydroxychloroquine, methotrexate, mycophenolate
- Biologics, but potential side effects

Topical steroids

Reducing regimen

- Once /day for a month, alternate days one month
- Alternate days one month
- Twice a week

Vaginal disease – current options

- Other foam preparations eg. Predfoam. Care with budesonide foams
- Dermovate on small dilator or tampon applicator
- Colifoam may be manufactured in hospital pharmacy

LP –follow-up

- Classic type – can completely resolve so follow-up not needed
- Erosive/VVG – usually require prolonged specialist follow-up eg 3 monthly
- Hypertrophic – often difficult to control, may need systemic treatment

Aims of treatment

- Symptom control
- To stop progressive scarring
- To preserve function

Surgical adhesiolysis

- Expert surgery
- Intense post-operative treatment

- Topical steroids within 24 hours of surgery
- Dilators
- Careful follow-up

Rajkumar J Obstet Gyn 2019. The importance of post-operative topical steroids after surgery of erosive LP and GVHD

Important considerations with LS and LP

- Auto-immune disease
- Scarring
- Malignancy
- Dysaesthesia

Association with auto-immune disease

- 40% circulating antibodies
- Thyroid disease, pernicious anaemia etc

Malignancy

	LS	LP
Taussig 1920	73% in ‘leukoplakia’	
Wallace 1971	4%	
Leibowitch 1990	61% in SCC specimens	
Zaki 1996	50% adjacent to SCC	3/61
Derrick 2000		3/22

LP – what is the risk of malignancy?

- Most cases reported with oral LP

- 3/61 co-existent LP with vulval SCC (Zaki 1996)
- 3/22 SCC had clinical signs of LP(Derrick 2000)

Differentiated VIN

- Non HPV related
- Often found at edge of SCC associated with LS/LP

When to refer on

- LS/LP complicated by VIN
- Erosive LP – multisystem disease
- LS/LP – unreponsive to first line treatment

Summary

- Clinical features of LS and LP
- Basic management
- Look at other sites
- Specialised management is important
- Clinico-pathological correlation is vital