Management of vulval conditions may not be straightforward and may be coloured by concurrent dermatological, gynaecological, urological and psychosexual problems. An approach that integrates the disciplines of dermatology and gynaecology is optimal.

Vulval disease

Part 1: a dermatogynaecological approach

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The patient presenting with vulval symptoms is familiar to GPs and gynaecologists. However, the vulva is part of the skin and the majority of these patients will be suffering from a dermatological complaint. Management is often challenging and although the basic problem is rarely gynaecological, input from this specialty is invaluable.

Our aim in writing this article is to share our day-to-day experience of vulval disease rather than quote what has been previously described in the medical literature. We believe it is important to demystify this subject and to emphasise that there is an explanation for nearly every clinical situation, provided the history taking and examination are thorough.

This three-part series discusses the diagnosis and management of vulval conditions, some classically dermatological, and others more difficult to categorise, that may be encountered in general practice. Part 1 presents the principles of a dermatogynaecological approach to the evaluation, investigations and management of vulval conditions. Part 2 will describe those conditions that present with a rash and symptoms, and Part 3 will describe those that present with either a rash alone or with symptoms but no (significant) rash.

Why a dermatogynaecological approach?

Management of patients with vulval disease requires first and foremost a sound understanding of dermatological diagnosis and therapy. The vulva is part of the skin and is affected by dermatological diseases with a predilection for this part of the body; however, dermatological knowledge is not enough. An understanding of vaginal bacteriology, hormonal influences, gynae-urology and psychosexual issues is essential to optimal management.

When a patient presents with a vulval complaint, it is not uncommon for her history to be a long one – often going back many years, spanning many consultations with numerous doctors. There are two main reasons for this: firstly, most vulval conditions are chronic dermatological problems that must be controlled long term and secondly, vulval problems remain relatively poorly understood.

'Vulvodynia': help or hindrance?

Part of this poor understanding relates to the widely used term 'vulvodynia'. As defined by the International Society for the Study of Vulvar Disease, vulvodynia means 'burning, rawness, stinging and discomfort'. This is a rather wide-ranging and not very specific definition which means different things to different practitioners. In fact, patients with vulval problems of many aetiologies commonly experience some, or all of these sensations at various times, in addition to itch and sometimes pain.

With the exception of patients who experience only pain, dyspareunia or burning, the nature of the patient's symptoms is rarely a clue to the diagnosis. Therefore, we avoid the term vulvodynia, using a precise description of the patient's symptoms and a diagnostic classification based on our combined experience. Consequently, we do not use a number of current terms as we believe they are imprecise; examples include vulvar vestibulitis syndrome or burning vulva syndrome.

Diagnosis: possible or impossible?

Another problem is the group of patients who appear to defy diagnosis and resist all attempts at treatment; however, we believe this group is very small indeed and that it is possible to classify virtually all patients. This relies upon very thorough history taking and on combining the disciplines of dermatology, gynaecology and occasionally manipulative therapy and psychology. The more difficult vulval cases are often multifactorial.

Patient categorisation

We have found that patients with vulval disease fall broadly into four groups, and find it helpful to place them in one of these categories for diagnostic purposes. The groups are described and listed in Table 1.

Rash and noncyclical symptoms

Many dermatological conditions fall into this category and can usually be differentiated from one another by physical examination with or without biopsy.

Rash and cyclical symptoms

The two main diagnostic possibilities in this category are chronic vulvovaginal candidiasis and oestrogen hypersensitivity vulvitis.

Rash but no symptoms

These patients may present with a rash or lesion

IN SUMMARY

- **The vulva is part of the skin and the majority of patients presenting with vulval symptoms will be suffering from a dermatological complaint. A dermatological history is essential.**
- **With the exception of patients who experience only pain, dyspareunia or burning, the nature of the patient's symptoms is rarely a clue to the diagnosis.**
- **Vulval rashes can be subtle, and initial examination may suggest a normal vulva. Inspect the rest of the skin, the nails, scalp and oral mucosa for clues.**
- **Environmental modification is always the first step in management of any vulval problem. Skin of the vulva, rather like that of the hand, is particularly prone to a number of adverse environmental influences.**
- **Dermatological conditions are often chronic and need ongoing maintenance treatment. This may mean abandonment of cherished but inappropriate personal hygiene routines. Continued positive reinforcement is necessary to encourage compliance.**
- **An understanding of the impact of vulval disease on a patient's life and a supportive clinical relationship are essential.**

Table 1. Vulval diseases: four diagnostic categories

Rash and noncyclical symptoms

Common

Dermatitis (atopic, irritant, contact allergy, seborrhoeic)
Lichen sclerosus
Psoriasis
Genital herpes

Uncommon

VIN III
Lichen planus
Tinea
Desquamative vulvovaginitis
Streptococcal vaginitis
Drug reactions including reaction to hormone replacement therapy
Vulval aphthae

Rare

Extramammary Paget's disease
Bullous disease, such as pemphigus

Rash and cyclical symptoms

Common

Chronic vulvovaginal candidiasis

Uncommon

Oestrogen hypersensitivity vulvitis

Rash but no symptoms

Common

Seborrhoeic keratoses
Angiokeratomas
Molluscum contagiosum
Vulval cysts
Vulval warts

Uncommon

VIN III
Melanosis vulvae
Melanoma and pigmented naevi
Lichen sclerosus

Rare

SCC, BCC

Symptoms but no (significant) rash

Common

Atrophic vaginitis
Vulval varices
Vestibular hypersensitivity

Uncommon

Referred pain
Neuropathic pain

Rare

Psychogenic pain (somatisation disorder)
Gynaecological, urological and colonic pain

without symptoms found either on self-examination or by the GP when presenting for a Pap smear. Otherwise, lesions may be detected when presenting for a Pap smear.

Symptoms but no (significant) rash

This group includes patients with a normal-appearing vulva whose rash has been adequately treated but who still experience symptoms. These symptoms are almost always pain, dyspareunia or burning.

Vestibular hypersensitivity presents with dyspareunia only.

Evaluating the patient

Taking a history from women with vulval symptoms is usually time consuming and requires persistence and patience. Distressed patients often pour out huge amounts of haphazard information that can be confusing; it helps to remind patients to give a chronological history. We suggest addressing systematically the areas described here and listed in Table 2.

Table 2. History taking checklist

- Presenting illness
- Environmental history
- Dermatological history
- Gynae-urological history
- Psychosexual history
- Medical and drug history

Presenting illness

A detailed history of all related symptoms such as itch, irritation, burning, pain, deep and superficial dyspareunia should be sought. Do symptoms cycle and if so, at what stage of the menstrual cycle? The duration of symptoms and the effect of any treatment are also important.

Environmental evaluation

Published clinical audits and our experience suggest that the majority of vulval problems are due to underlying dermatitis and occur most often in atopic individuals. Such patients are easily irritated by many substances that may come into contact with the vulval skin.

Irritants and allergens

Irritants and allergens include:

- perfumed, coloured or patterned toilet paper
- sanitary pads and panty liners, which may be perfumed and contain occlusive plastic backing
- bath additives, such as 'essential oils'
- soaps (even so-called 'hypoallergenic' ones) and shower gels
- powder
- commercial lubricants, which may contain preservatives and antiseptics
- condoms
- over-the-counter and prescribed medications (e.g. tea-tree oil, clotrimazole).

Common irritants and allergens are listed in Table 3.

Heat and friction

Heat and friction contribute signifi-

cantly to vulval skin irritation and are substantially increased by:

- synthetic underwear or gym clothes
- tight underwear (especially G-strings, control panties or pantyhose) or tight trousers (including heavyweight denim jeans)
- sanitary pads – especially with nonbreathable backing
- swimming costumes
- vigorous activity – particularly aerobic (e.g. bicycle riding, walking on a hot day)
- prolonged sitting – as during a long flight.

These sorts of clothing and activities can trigger an attack of dermatitis in a predisposed individual or cause a recrudescence in a previously well-controlled patient with a chronic vulval skin condition.

Other important features of the history

Dermatological history

As the majority of vulval conditions are dermatological, a dermatological history is essential.

Atopy

Previous eczema, asthma or hay fever is often a clue to atopic dermatitis confined to the vulva. Such patients are likely to be more easily irritated by the environmental factors discussed earlier.

Psoriasis

A personal or family history of psoriasis provides a clue that a vulval rash may be due to this condition.

Skin disease

If there is skin disease present at other sites, it is very likely to be related to the vulval condition.

Oral lesions

Oral lesions may provide a clue to a diagnosis of lichen planus.

Drug allergy

Allergies to topical or ingested medication that have previously caused a skin rash elsewhere may provide a clue to the cause of the current vulval condition.

Gynae-urological history

Vulval skin conditions are often modified by the patient's hormonal status and, of course, may be worsened by urinary or faecal incontinence.

Oestrogen status

It is important to know whether the patient is pre- or postmenopausal. Use of the oral contraceptive pill or hormone replacement therapy is also relevant.

Menstruation

The more days per month that a woman wears pads, the more severe vulvitis may become. Tampons can also irritate the vulva via the string of the tampon rubbing against the introital skin.

Faecal incontinence

Faecal incontinence not only increases maceration and infection but also forces the patient to wash the affected skin more frequently, causing even further irritation.

Urinary incontinence

Urinary incontinence increases maceration and stinging. Such incontinence can be a major barrier to improvement; therefore, a careful history should be taken to identify any relevant factors that can be modified, including drug, alcohol, cigarette and caffeine consumption, and urinary tract infection.

Obstetric history

The combined effects of perineal trauma, sutures, lochia, pads and the hypooes-trogenic effects of breastfeeding can create many months of postpartum vulval dermatitis.

Surgical history

Any vaginal or anal procedures may be particularly relevant. Once again, the combination of antiseptics, surgical trauma, sutures and pads may lead to chronic vulvoanal dermatitis.

Vaginal discharge

Many women find a normal, but heavy, vaginal discharge aesthetically unacceptable and resort to the daily use of panty liners. Unfortunately, this practice often leads to chronic irritant contact dermatitis.

Use of an intrauterine contraceptive device will also tend to increase physiological discharge and may be a factor in such a situation.

'Thrush'

It is important to enquire about a past history of 'thrush' and whether this diagnosis has ever been confirmed by swabs. Women (and sometimes their

Table 3. Common allergens and irritants

Allergens

- Benzocaine
- Neomycin
- Chlorhexidine
- Perfume, dyes
- Preservatives
- Disinfectants
- Tea-tree oil
- Antifungals
- Condoms, semen

Irritants

- Soap, shampoo, gels, both oils and bubble bath
- Sanitary pads, tampon strings
- Toilet paper
- Occlusive clothes
- Sweat, secretions
- Douches
- Antifungal creams
- Lubricants, spermicides
- Tea-tree oil, disinfectants

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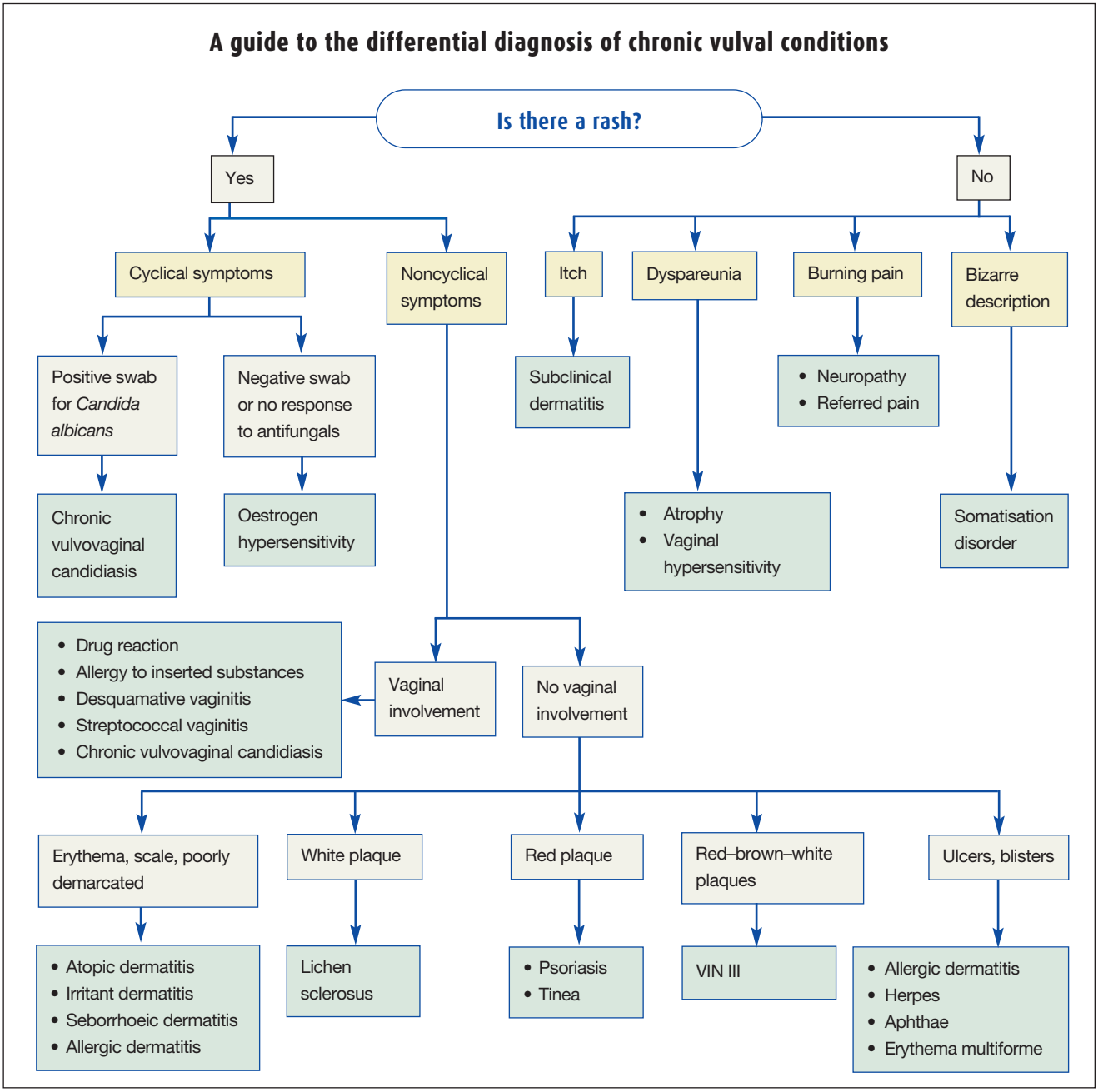

doctors) often assume that any vulval itch or discomfort is due to vaginal candidiasis. This leads to the inappropriate, repeated use of topical (or even oral) antifungal agents. Treating presumed 'thrush' empirically is acceptable at a first presentation, but treatment should never be repeated for recurrent symptoms unless confirmation is first obtained using vaginal swab. If the patient is embarrassed, she can perform her own low vaginal swab. The important point here is that one must never assume that recurrent vulvovaginal itch is due to candidiasis, even if a proven episode has occurred previously.

Psychosexual history

Conditions that would provoke little anxiety on other parts of the skin may cause great distress if found on the vulva. Obviously, there is the issue of interference with sexual function, and menstruation becomes more difficult to cope with, but patients often find dis-

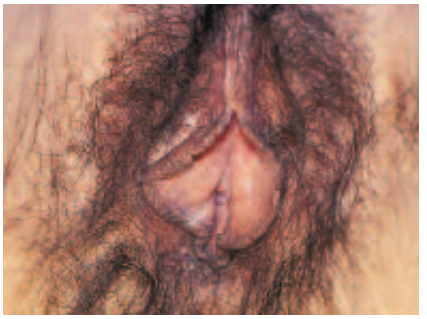

Figure 1. Normal vulva.

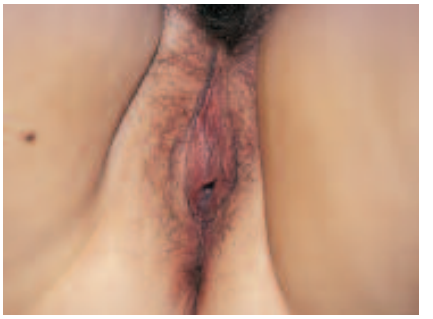

Figure 2. Mild erythema and desquamation of the sulcus between labia minora and majora is associated with some perianal erythema in this patient with dermatitis.

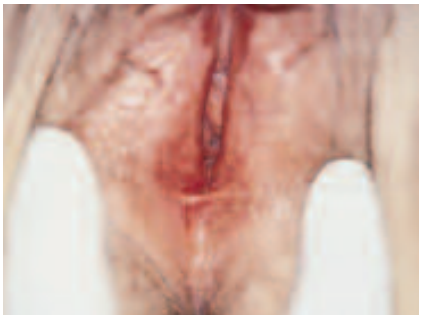

Figure 3. Some subtle signs of dermatitis: a split at 6 o'clock on the vaginal introitus associated with erythema and splitting of the mucosal surface.

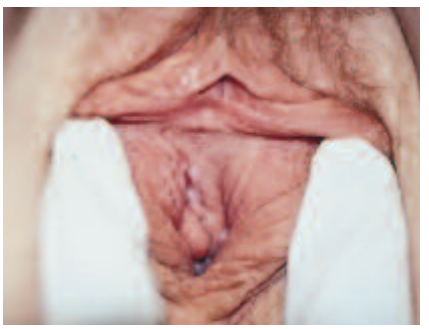

Figure 4. Dermatitis secondary to chronic heavy vaginal discharge. The vulval skin is lichenified as well as fissured.

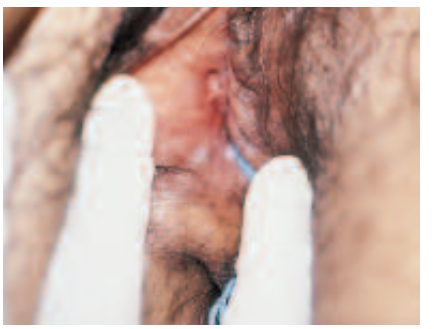

Figure 5. An aphthous ulcer. Like its oral counterpart, the ulcer is small, punched out, with a sloughy base.

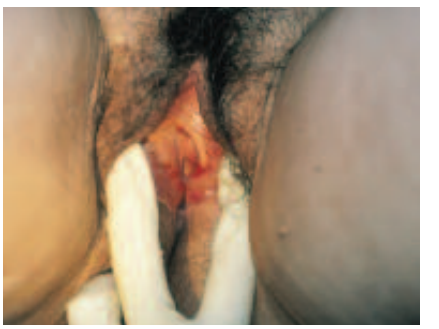

Figure 6. Desquamative vulvitis. The mucosal surface is erythematous and studded with petechiae. There is a heavy vaginal discharge.

comfort in this area interferes with everything they do. For example, exercise and even long car trips can exacerbate vulval symptoms. These women often have unspoken fears of cancer and sexually transmitted disease. Ambivalence about sexual activity or memories of childhood sexual abuse may come to the fore when experiencing a vulval skin condition.

Chronic skin conditions such as eczema and psoriasis may be exacerbated at times of stress. We have noticed that depressed and anxious patients tend to have symptoms that lag behind objective improvement of their rash.

When questioning patients ask about:

- dyspareunia – superficial or deep, immediate or delayed
- sexual difficulties – with previous partners, and the present partner's reaction to current sexual difficulties
- stressors – particularly those that may coincide with the onset or continuation of symptoms
- depression.

The psychosexual aspects of history taking do not have to be painstaking but it is essential to have an idea of how stressful the patient perceives her life to be and to understand how the problem has affected her life. You will also be able to form an opinion regarding the possibility that the patient's condition may have been precipitated by psychological factors.

Medical and drug history

The patient's past medical history may occasionally relate to vulval disease. For example, diabetes or immunosuppressive illnesses may cause susceptibility to infection). It is important to know the drug history because of potential interactions with oral antifungals or tricyclic anti-depressants. Occasionally, oral medications may cause vulvovaginitis.

Present medications and topical applications, including over-the-counter therapies are potential sources of contact dermatitis.

Physical examination

Examination should include inspection of the vulva, perianal area, vagina and surrounding skin. It is important to remember than vulval rashes can be subtle, and initial examination may suggest a normal vulva (Figure 1). Specific signs

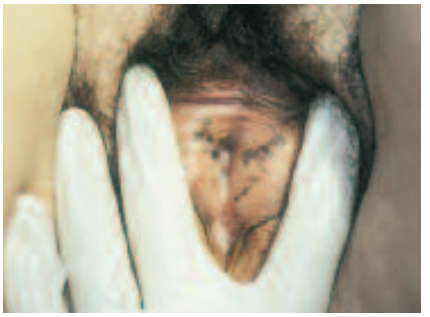

Figure 7. Melanosis vulvae showing multifocal hyperpigmented patches. A biopsy is required to rule out melanoma.

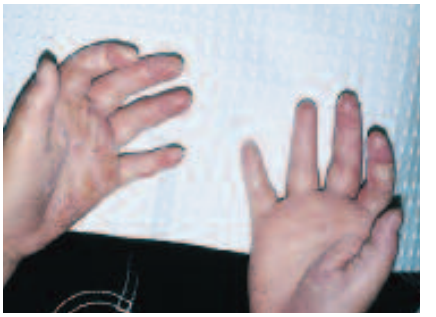

Figure 8. Hand dermatitis may be a clue to a tendency to atopic dermatitis of the vulva.

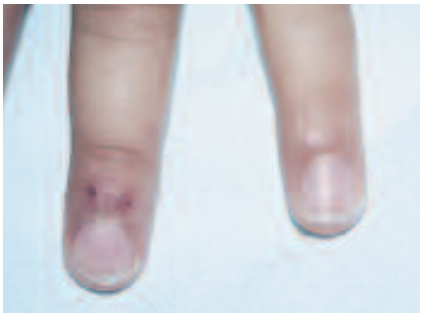

Figure 9. Nail pits are a subtle sign of psoriasis.

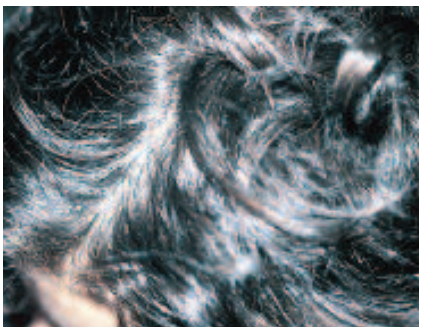

Figure 10. Severe 'dandruff' may indicate psoriasis or seborrhoeic dermatitis.

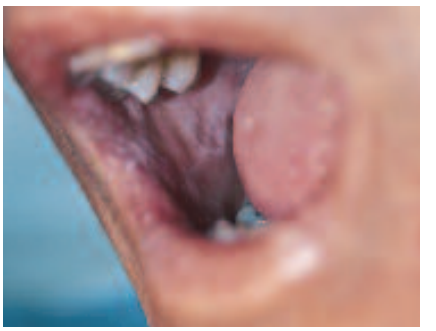

Figure 11. Oral lesions of lichen planus are a clue to vaginal disease.

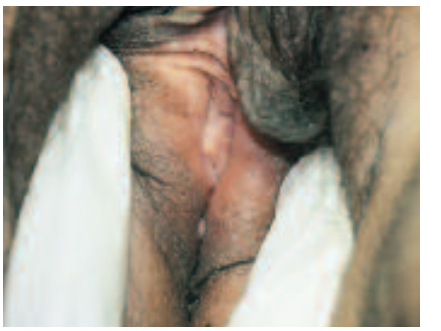

Figure 12. Vulval papillomatosis. This normal variant has been confused in the past with warts.

that should be sought include:

- increased erythema (Figure 2) of the labia minora and/or the sulcus between the labia minora and majora
- fissuring (skin splits, see Figure 3), usually seen around the introitus and paraclitoral area
- lichenification (Figure 4) of labia and perianal skin, evidenced by thickening, folding and pallor
- small erosions or ulcers (Figure 5)
- mucosal petechiae (Figure 6)
- colour change (either light or dark – see Figure 7)
- discharge (either vaginal discharge or desquamation from skin surface).

In performing a vulval examination, it is not always possible to perform a speculum examination if the patient is too uncomfortable; however, it is important to at least visualise part of the vagina by gently inserting two fingers through the introitus and spreading them slightly. In addition, inspect the rest of the skin (Figure 8), the nails (Figure 9), scalp (Figure 10) and the oral mucosa (Figure 11) for any abnormality.

A finding of mucosal papillation, known as vaginal papillomatosis (Figure 12), and similar to that seen on the surface of the tongue, is a normal variant, and should not be confused with wart infection.

Investigation

Which investigations are appropriate and which patients need them?

Vaginal swab

All patients with a vulval condition should have a low vaginal swab performed at the initial visit; however, there must be no use of antifungal agents in the week prior to the swab being taken. Vaginal swabs must be repeated if the clinical situation changes abruptly, particularly if there is a sudden relapse in a previously well-controlled patient.

Vaginal swabs are needed to confirm or rule out a diagnosis of subclinical vulval candidiasis or streptococcal vaginitis. A Gram-stained smear is useful when diagnosing desquamative vaginitis.

Vulval biopsy

Vulval biopsy should be performed immediately if:

- malignancy is suspected
- when a rare or premalignant condition (such as lichen planus or

lichen sclerosus) is suspected
- there is inadequate clinical response to initial treatment.

Pap smear

A Pap smear is not an essential part of the work up of most vulval problems but should nevertheless be offered as part of a general gynaecological assessment.

Patch testing

Patch testing is appropriate in cases where there is evidence of allergy to applied substances. Patch testing is also appropriate in longstanding, recalcitrant dermatitis.

Differential diagnosis

The history and symptoms, aided by investigation, give a guide to the diagnosis. The flowchart on page 36 presents a guide to the differential diagnosis of chronic vulval conditions. Even though the range of conditions is wide, as listed in Table 1, the commonest conditions responsible for most presentations are dermatitis, chronic vulvovaginal candidiasis, lichen sclerosus and psoriasis. These (and the more uncommon conditions) will be described further in Parts 2 and 3 of this series.

Management

There are a number of general management principles that are common to all patients with a vulval condition.

Modalities

Environmental

Environmental modification is always the first step in management of any vulval problem. Vulval skin, rather like the skin of the hand, is particularly prone to a number of adverse environmental influences (Table 3). In addition to maceration caused by sweat, secretions, sanitary pads and tight occlusive clothing, there is exposure to perfumes (toilet paper, pads, sprays), medications, cosmetics, bubble bath and soap. Patients with vulval problems often feel 'unclean' and have a tendency to overuse detergent-based substances, which exacerbate their problem.

We advise patients to use a soap substitute or alternatively only water, eliminate all perfumed products and wear loose fitting clothes including loose cotton underwear. We also ask them to use tampons in preference to sanitary pads and to avoid using panty liners between periods. Vigorous exercise should be suspended in the acute phase. We ask patients to cease using over-the-counter medications and prescribed ones that have been unhelpful.

It is important to give patients permission to suspend sexual intercourse until they have recovered. This may involve several weeks of abstinence, but in our experience, it is rare for our patients in a long term relationship to see this as a problem. If they do choose to continue sexual intercourse, we recommend they use a bland lubricant such as vegetable oil or petroleum jelly (unless using condoms).

Dermatological

All patients with a vulval skin condition require a bland moisturiser for regular use as they experience dryness invariably and superficial fissuring often. Petroleum jelly or aqueous cream BP is a good choice but sorbolene cream is best avoided as it often causes stinging on the vulva. For patients with faecal or urinary incontinence, zinc and castor oil is often helpful.

Secondary infection should be ruled out by low vaginal and vulval swabs and treated, as appropriate, with oral or topical antibiotics and antifungal agents.

Dermatological conditions will require specific treatment (see Part 2 of this article); however, it has to be emphasised to all patients that dermatological conditions are often chronic and need ongoing maintenance treatment, including ongoing environmental modification. This may mean the abandonment of cherished but inappropriate personal hygiene routines. Continued positive reinforcement is necessary to encourage compliance. As with other skin conditions, emotional upsets may make control intermittently more difficult.

If response is poor or exacerbations occur, always consider superinfection, allergy or emotional crisis.

Practice points

- Dermatitis, not thrush, is the commonest cause of vulval symptoms, and most of these patients are atopic.
- Routine low vaginal swabs prevent missing infection that may not be apparent clinically.
- Only use antifungal creams if there is documented bacteriological evidence of a fungal infection. They can be irritating if over-used.
- Oestrogen creams are only useful where there is oestrogen deficiency.
- White, thickened or hyperpigmented areas should be biopsied.
- Environmental modification is always important in managing patients with a vulval rash.
- If a patient with dermatitis responds poorly to treatment, or deteriorates while on treatment, consider allergy, infection or adverse conditions such as heat and stress.
- When using topical steroids on the vulva, always try to use the lowest potency that will control the rash, but you may use the more potent ones for short periods if necessary.
- Enquire about possible fears of cancer and sexually transmitted disease.

Manipulative

The physiotherapy and chiropractic literature has long recognised that lower back dysfunction may cause referred pain in the lower abdomen, pelvis and even the vulva. Therefore, if vulval pain has a 'musculoskeletal' pattern and examination and swabs are normal, it is worth referring the patient to a manipulative therapist for assessment and a trial of treatment. Vulval pain with a 'musculoskeletal' pattern is exacerbated by activity, relieved by rest and more severe when sitting than when standing or lying. One must keep an open mind in these cases and always remain willing to reassess the original diagnosis if one form of treatment fails. Details of these conditions will be described in Part 3 of this article.

Surgical

We are of the opinion that there is virtually no place for operative solutions to the vulval dermatological conditions described in this article. Of course, neoplasms should be excised and there is sometimes an indication for surgical division of adhesions due to, for example, advanced lichen sclerosus. However, excision of vulval skin as a treatment for diseases that are nonsurgical is not logical and, given that reflex pelvic floor muscle spasm and neuropathic conditions are not uncommonly encountered as a result of painful procedures, runs the risk of creating an ongoing pain problem.

Psychological

Our combined clinical experience has led us to reject the notion that psychological problems are more important in the causation of vulval disorders than in any other branch of medicine. Many of our patients are extremely anxious regarding their problems but they tend to be the patients who have gone the longest without effective management. Although most skin problems exacerbate at times of stress, either psychological or physical, we do not feel that patients with vulval conditions are in any way different to our other patients with nonvulval conditions.

It is true, however, that there is often a greater psychological overlay to any vulval condition than an equivalent rash on any other part of the skin. Several factors may cause this: firstly, embarrassment often prevents patients seeking help for long periods so diagnosis and treatment may be delayed; secondly, interference with sexual function and primary relationship adds another dimension to the patient's distress.

There is still a great deal to be learnt about the way in which psychological factors affect pain sensation in the pelvic area and it would be dangerous to make unproven statements. However, it is our impression that longstanding, distre-ssing vulval conditions can lead to intractable vulval pain that persists after the condition has been adequately treated. We have also observed that depressed or anxious patients take longer to recover from painful vulval conditions. We also believe that patients with vaginal hypersensitivity (also known as 'vulvar vestibular syndrome') may have developed the condition as an anxiety response to a noxious event, be it physical or psychological, in the past.

Patients with complex vulval conditions benefit greatly from a stable therapeutic relationship. Simple supportive discussion is all that is required for most; in the patients who shows signs of depression or in whom pain continues despite what seems adequate therapy, consider referral.

Related issues

Hormone replacement therapy

We see many postmenopausal patients whose vulval symptoms are in large part related to the use of hormone replacement therapy.

Because management of these women includes temporarily ceasing such therapy we discuss with the patient the whole question of whether she really needs to be on hormone replacement therapy at all. (We do not regard the menopause as a 'hormonal deficiency disease' but rather as a natural stage in a woman's life.) There are many women who will want to take hormone replacement therapy, either in the short term for control of unpleasant symptoms or in the much longer term for prophylaxis of degenerative conditions for which they may be at risk such as osteoporosis or cardiovascular disease. However, we regard pharmaceutical hormone replacement therapy like any other class of drugs – it should be used only when the potential benefits outweigh the risks.

After thinking through such issues, many of our patients choose not to restart hormone replacement therapy. Of those who do restart it, we find that a lower dose of oestrogen is usually satisfactory for menopausal symptom control – this may however involve individualising therapy as only 'standard' doses of oestrogen are available in convenient combination packs (with progesterone).

The 'pill'

The oral contraceptive pill is hardly ever primarily responsible for vulval symptoms and therefore should be stopped only as a last resort and only after carefully discussing the patient's priorities. However, we have observed that cyclical symptoms are sometimes improved by switching from a tricyclic to a monocyclic oral contraceptive pill. Additionally the use of itraconazole (Sporanox), which is used for long term treatment of candidiasis, makes highly effective contraception imperative.

A woman using itraconazole who has achieved maintenance status of her vulval condition and who wants to conceive should be changed to a 'three day' topical antifungal course every week and advised to stay on this until her confinement.

Incontinence

Every effort must be made to improve any chronic urinary or faecal incontinence as the resulting skin irritation will make management of any vulval problem all the more difficult. Although discussion of these issues is beyond the scope of this article there are some tips which may prove helpful:

- if pads cannot be dispensed with, a brand with a 'breathable' backing will be less irritating
- pads should be changed as soon as they are soiled
- gentle washing, with water only, after a bowel motion will reduce inadvertent faecal soiling of the perineum
- efforts to improve urinary function must be made – for example, urinary tract infections should be treated and the use of alcohol, caffeine and cigarettes should be minimised; most common bladder problems will improve if the patient is prepared to persevere with pelvic floor exercises.

Obesity

Being overweight or obese makes any vulval condition more severe and effective management more difficult because of increased friction and heat. The ideal solution is adequate weight loss, a usually impossible task. Failing that, attention should be directed to reducing friction and heat. Drying after a shower by using a hair-dryer on a 'cool' setting will reduce skin maceration. The patient must pay particular attention to skin folds.

Many obese women wear underwear that is too small and therefore too irritating. Buying a larger size often improves the clinical situation.

Conclusion

The diagnosis and management of vulval disease is challenging but rewarding. We have had to keep an open mind, think laterally, and challenge accepted teaching in order to help our patients.

An understanding that the majority of patients with a vulval complaint have a dermatological disease is basic to this field. The above aspects of investigation and management are common to all vulval disorders. An understanding of the impact of vulval disease on a patient's life and a supportive clinical relationship are essential for these patients. MT

Further reading

1. Sobel JD. Vaginitis. N Engl J Med 1995; 337: 1896-1903.
2. Fischer G, Spurrett B, Fischer A. The chronically symptomatic vulva: aetiology and management. Br J Obstet Gynaecol 1995; 1102: 773-779.
3. Bohl TG. Vulvodynia and its differential diagnoses. Sem Cut Med Surg 1998; 17: 189-195.

Next month, Part 2 of this series describes conditions that present with a rash and symptoms. Part 3, to be published the following month, will outline conditions that present either with a rash alone or with symptoms but no (significant) rash.