Research Letters

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Use of systemic therapies for vulvar lichen sclerosus and vulvovaginal lichen planus: a survey study of dermatologists and gynecologists

Keywords: lichen planus, lichen sclerosus, vulvovaginal

Vulvar lichen sclerosus (VLS) and vulvovaginal lichen planus (VLP) are chronic autoimmune inflammatory processes that significantly affect the quality of life. Topical immunosuppression with high-potency corticosteroids is the first-line treatment for both conditions.[1] However, for refractory disease, systemic agents may be appropriate. Various studies report that 30 to 50% of patients with VLP do not achieve symptomatic control with topicals alone,[2] and about 25% of patients who initially responded to topical steroids eventually require a second-line therapy.[3] Approximately 60 to 70% of VLS patients experience complete remission with first-line therapy, with 30 to 40% of patients remaining symptomatic.[4] There are currently no guidelines for the use of systemic therapies in these vulvar conditions.[5] We sought to understand how clinicians utilize systemic agents for VLS and VLP treatment.

A 15-question, institutional review board-exempt, online REDCap survey was distributed worldwide using the International Society for the Study of Vulvovaginal Disease listserv. The survey was sent out twice, 1 month apart. Seventy-one participants completed the survey (14% response rate). Seventy-six percent were gynecologists, 22% dermatologists, and 3% urogynecologists, with most practicing for >20 years in dedicated vulvar clinics (Table 1).

Systemic therapy use was reported by 31% of respondents for VLS and 47% for VLP (Table 2). Forty-seven percent of dermatologists and 27% of gynecologists reported prescribing systemic therapies for VLS, and 93% of dermatologists and 33% of gynecologists reported prescribing systemic therapies for VLP. The most common systemic agents were steroids, followed by methotrexate, for both VLP and VLS. Severe itch or pain refractory to topicals was the most selected factor in the decision to use systemic therapies for both VLS (47%) and VLP (41%). Forty-seven percent reported reservations about using systemic agents for both conditions, the most common reservation being potential side effects (55%). Eight gynecologists reported inadequate training was a factor (11%). Eleven respondents (28%) indicated they did not need to use systemics because patients responded well to topicals.

Overall, our survey found that over one-third of respondents prescribed systemic therapies for VLS (31%) and almost half for VLP (46%), with dermatologists being more frequent prescribers and over one-third of gynecologists utilizing systemic therapies for VLP. Disease severity and side effects of systemic agents were selected as the most important factors for systemic use. All specialties prescribed systemic steroids for VLS and VLP, with only dermatologists utilizing other systemic agents. Six of eight gynecologists who indicated lack of comfort with systemic agent use reported not prescribing systemics, while 2 prescribed systemic steroids.

Study limitations include a survey-based study with self-reported data. Several respondents had a dedicated vulvar clinic, and the results are likely not representative of general dermatologists and gynecologists. While systemic therapies may be considered in certain cases of VLS and VLP, it is important to recognize that their use is off-label and must be based on mutual decision-making between both clinician and patient. Prospective studies are necessary to understand the safety and efficacy of individual agents. Training courses and information on systemic therapies for clinicians may be helpful to optimize care for patients with VLP and VLS.

Conflicts of interest

None.

What is known about this subject in regard to women and their families?

- Topical corticosteroids are first-line agents in the medical management of vulvar lichen sclerosus and vulvar lichen planus.
- Lack of symptomatic control with topical agents contributes to decreased quality of life for those affected.
- Secondary systemic agents provide relief to some patients; however, there is a lack of current literature outlining guidelines for their use.

What is new from this article as messages for women and their families?

- About 30 to 40% of respondents indicated that they do prescribe systemic agents for vulvar lichen sclerosus and vulvar lichen planus. Mostly when the disease burden is severe and the quality of life is impacted.
- Systemic steroids are the most common systemic agent of choice for disease refractory to topical agents.
- About half of respondents indicated potential side effects of systemic agents as the main hindrance to their use.
- Education and guidelines on the safe use of systemic agents are necessary for prescribing clinicians.

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Table 1

Demographics of survey respondents

Demographics		n (%)
Type of practice	Gynecology	55 (76)
	Urogynecology	2 (2.8)
	Dermatology	15 (22)
Years of practice	<5 years	6 (9)
	5-10 years	13 (17)
	>10 years	18 (25)
	>20 years	35 (46)
Practice setting	Academic	33 (47)
	Group practice	11 (16)
	Solo practice	12 (17)
	Other	16 (23)
Respondents with a dedicated vulvar clinic:	Yes	42 (59)
	No	29 (41)
How many patients with vulvar lichen sclerosus (VLS) do you see per month?	<5	11 (16)
	5-10	22 (31)
	10-25	20 (28)
	>25	19 (24)
How many patients with vulvar lichen planus (VLP) do you see per month?	<5	46 (64)
	5-10	15 (21)
	10-25	8 (11)
	>25	3 (4)

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Study approval

N/A

Author contributions

All authors involved accept responsibility for the content of this manuscript and approve its submission.

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Disclaimer

Discussion of all systemic agents will be off-label, as there are currently no FDA-approved therapies for VLS or VLP.

References

1. Hargis A, Ngo M, Kraus CN, Mauskar M. Systemic therapy for lichen sclerosus: a systematic review. J Low Genit Tract Dis 2024;28:84–90. doi: 10.1097/LGT.0000000000000775.
2. Bradford J, Fischer G. Management of vulvovaginal lichen planus: a new approach. J Low Genit Tract Dis 2013;17:28–32. doi: 10.1097/LGT.0b013e318258bf5b.
3. Simpson RC, Littlewood SM, Cooper SM, et al. Real-life experience of managing vulval erosive lichen planus: a case-based review and U.K. multicentre case note audit. Br J Dermatol 2012;167:85–91. doi: 10.1111/j.1365-2133.2012.10919.x.
4. Singh N, Mishra N, Ghatage P. Treatment options in vulvar lichen sclerosus: a scoping review. Cureus. Published online February 24, 2021. doi: 10.7759/cureus.13527.
5. Latini A, Cota C, Orsini D, Cristaudo A, Tedesco M. Male and female genital lichen sclerosus. Clinical and functional classification criteria. Postepy Dermatol Alergol 2018;35:447–53. doi: 10.5114/ada.2018.77236.

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Table 2

Select survey questions and responses

Select survey questions		n (%)
Do you prescribe systemic therapies (ie, methotrexate, adalimumab) in general for any of the dermatologic conditions that you treat?	Yes	22 (31)
	No	45 (63)
	Gyn: Yes	7 (13)
	Gyn: No	43 (78)
	Derm: Yes	14 (93)
	Derm: No	1 (7)
	Urogyn: Yes	1 (50)
	Urogyn: No	1 (50)
Do you ever use systemic therapies for treatment of VLS?	Yes	22 (31)
	Derm	7 (47)
	Gyn	15 (27)
Which systemic treatments do you use for VLS?	Systemic steroids	21 (96)
	Methotrexate	7 (32)
	Oral retinoids	5 (23)
	Hydroxychloroquine	4 (18)
	Mycophenolate mofetil	4 (18)
	Adalimumab	3 (14)
	Azathioprine	3 (14)
	Oral janus kinase inhibitors (ie, tofacitinib)	1 (5)
	Other (specify) • Cyclosporine • Tricyclics, gabapentin, pregabalin	2 (9)
	Dupilumab	0 (0)
Do you ever use systemic therapies for treatment of VLP?	Yes	33 (46)
	Derm	14 (93)
	Gyn	18 (33)
Which systemic treatments do you use for VLP?	Systemic steroids	29 (85)
	Methotrexate	16 (47)
	Hydroxychloroquine	15 (44)
	Mycophenolate mofetil	11 (32)
	Oral retinoids	6 (18)
	Azathioprine	4 (12)
	Adalimumab	2 (6)
	Oral janus kinase inhibitors (ie, tofacitinib)	2 (6)
	Other (specify) • Cyclosporine • IL-23 inhibitors (Skyrizi, Ilumya)	2 (6)
	Dupilumab	0 (0)
Which of the following factors might influence your decision to use systemic therapies to treat VLS? Select more than one if applicable. Responses ranked in order of frequency of counts of "most important":	Severe itch/pain (refractory to topicals)	25 (40.3)
	Severity of ulceration, erosion	22 (36.1)
	Extragenital involvement	13 (20.6)
	Physical or psychosocial barriers preventing adequate topical application	10 (17.2)
	Surface area of anogenital anatomic sites involved	8 (13.6)
	Severity of lichenification or hyperkeratosis	6 (9.8)
	Patient preference	6 (9.7)
	Severity of white changes (hypopigmentation or depigmentation)	2 (3.3)
Which of the following factors might influence your decision to use systemic therapies to treat VLP? Select more than 1 if applicable.	Surface area of anogenital anatomic sites involved	6 (10.0)
	Severity of ulceration, erosion	22 (36.1)
	Severity of lichenification or hyperkeratosis	4 (6.5)
	Severity of white changes (hypopigmentation or depigmentation)	2 (3.3)
	Extragenital involvement	13 (20.6)
	Severe itch/pain (refractory to topicals)	25 (40.3)
	Patient preference	6 (9.7)
	Physical or psychosocial barriers preventing adequate topical application	10 (17.2)

Derm, dermatology; Gyn, gynecology, IL-23, interleukin-23; VLP, vulvar lichen planus; VLS, vulvar lichen sclerosus; Urogyn, urogynecology.