safe practical clinical answers - *fast*

How should I assess a woman with pruritus vulvae?

There is an identifiable cause for pruritus vulvae in most women.

▪ **Confirm that the woman is experiencing vulval itch,** not vulval pain (which is outside the scope of this topic).

▪ **Take a careful history** — this may find an underlying cause for the vulval itch. Ask about:

o **Duration and timing of symptoms**

o How long have symptoms been present? — Acute itch is generally due to infection or acute contact dermatitis.

o Is the itch worse at night? — Nocturnal vulval itching may indicate lichen sclerosus, lichen simplex, or threadworm infestation (particularly if combined with peri-anal itch).

o **Associated symptoms**

o Is the itch confined to the vulval area? — Itch elsewhere may indicate a more generalized problem, including scabies.

o Is there vaginal discharge? — Discharge may indicate infection, such as candidiasis, bacterial vaginosis, or trichomoniasis.

o **Hygiene practices**

o Could hygiene practices be causing symptoms? — The use of creams, perfumes, deodorants; sanitary wear containing bleach; douches; soaps; wipes (baby or hygiene); moist toilet tissues; or simply excessive washing may result in vulval irritation or even contact dermatitis.

o **Use of topical vulval preparations**

o Could self-administered treatments be causing or aggravating symptoms? — Some women may develop irritation secondary to use of

antifungal creams for presumed candidiasis, hormone replacement therapy creams, or pessaries.

o What contraception is being used? — Some women are allergic to spermicides, or the latex in condoms and diaphragms.

o **Other conditions**

o Is the woman known to have a generalized skin disorder that can affect the vulval area, such as dermatitis or psoriasis?

o Does the woman have a personal or family history of atopic conditions (for example hay fever, asthma, eczema)?

o Does the woman have diabetes mellitus? — Diabetes increases the risk of candidal infection.

o Does the woman have a systemic illness that could cause itch, such as renal or hepatic impairment, or anaemia?

o Is the woman menopausal? — Atrophic vaginitis may be the cause of the symptoms.

o Is the woman breastfeeding? — Breastfeeding can result in lowered oestrogen levels and consequent vulval symptoms.

o Does the woman have faecal or urinary incontinence? — These can damage the vulval skin either directly or indirectly by the use of sanitary products or over washing.

▪ **Assess the severity of symptoms and the impact this is having on the woman** — in particular enquire into psychosexual problems, low mood, loss of sleep pattern, and feelings of anxiety.

▪ **Examine:**

o **The anogenital region** — examination findings may indicate an underlying cause, such as signs of candidiasis, dermatitis, psoriasis, atrophic vaginitis, lichen sclerosus, or lichen planus.

o **The mouth** — examination may find signs of lichen planus.

- **The skin** — examine for signs of psoriasis (for example on scalp, elbows, knees, and nails), and eczema (which may be seen on any area of the skin).

- For a discussion of the possible causes of pruritus vulvae, and their differentiating features, see Causes.

Basis for recommendation

- Recommendations for the assessment of pruritus vulvae are based on expert opinion [Nunns, 2002; Welsh et al, 2003; Doxanakis et al, 2004; Weichert, 2004; Bohl, 2005; BASHH, 2007; RCOG, 2010].

- **Identifiable cause**

- The statement that there is an identifiable cause for pruritus vulvae in most women is based on published expert opinion [Doxanakis et al, 2004].

What are the possible causes of pruritus vulvae?

- **Most women who present with pruritus vulvae have an identifiable cause [Doxanakis et al, 2004; Bohl, 2005]:**

- Dermatological conditions — contact dermatitis is thought to be the most frequently encountered and avoidable condition seen in clinics that specialize in vulval disorders.

- Infection and infestations.

- Neoplastic conditions.

- Hormonal changes.

- Gastrointestinal and urinary incontinence.

- Systemic conditions.

- **Idiopathic pruritus vulvae is thought to be uncommon.**

Which dermatological conditions can cause pruritus vulvae?

- **Contact dermatitis** (most common cause of pruritus vulvae) — reaction to proprietary creams (especially those containing local anaesthetics); topical antibiotic preparations (neomycin); barrier contraceptives; perfumes; soaps; bubble baths, wet wipes; textile dyes; detergents; fabric conditioners (can cause contact allergy or aggravate vulval symptoms); and bleaches, dyes, and perfumes in sanitary wear, such as panty liners, tampons, and sanitary towels.

- **Psoriasis** — well-demarcated border, absence of scale when affecting the vulval area, often with typical psoriasis lesions elsewhere on the body.

  - For more information, see the CKS topic on Psoriasis.

- **Seborrhoeic dermatitis** — ill-defined border, some scaling, with or without involvement of other sites, such as the axillae, face (eyebrows or nasolabial folds), anterior chest, or scalp.

  - For more information, see the CKS topic on Seborrhoeic dermatitis.

- **Lichen simplex** — thickened plaques with exaggerated skin markings over the hair-bearing labia majora and sparing the mucosal vulval skin and labia minora (the end result of an itch-scratch-cycle, regardless of the initial underlying cause of the itch).

- **Lichen planus** — erythema and or erosive pattern, ulceration with intense pruritus, destruction of vulval architecture (possibly with other sites involved such as the nails and buccal mucosa). Lesions are bluish-purple, shiny, flat-topped papules with small white dots or lines (Wickham's striae). There is a small risk of squamous cell carcinoma developing in women with lichen planus (less than 3%).

- **Lichen sclerosus** — lesions are white papules and or plaques, often associated with areas of bruising and usually found on the interlabial sulci, labia minora, clitoral hood, clitoris, perineal body, and perineum. Affected skin appears somewhat crinkly, like cigarette paper. Bleeding into the affected areas produces red or purple purpuric lesions. Scarring and loss of tissue can lead to burying of the clitoris, loss of the labia minora, and narrowing of the vulval introitus. There is a small risk of squamous cell carcinoma developing in women with lichen sclerosus (less than 5%).

- **Fox–Fordyce disease** (very rare) — small dome-shaped papules, with or without involvement of the axillae; intensely itchy and often presenting as lichenification (grossly thickened skin with accentuated skin markings).

- **Hailey–Hailey disease** (very rare) — vesicles erupt causing pruritus, with or without involvement of the axillae and sides of the neck. It is also known as 'familial benign chronic

pemphigus', and is an inherited autosomal dominant condition. It is easily mistaken for intertrigo or dermatitis.

- **Darier's disease** (very rare) — warty plaques, which may be macerated and malodorous, possibly with the involvement of seborrhoeic areas of the trunk, flank, and face. An autosomal dominant condition, which may be confused with Hailey–Hailey disease.

- **Symptomatic dermatographism** — a form of localized urticaria triggered by a direct firm touch, scratching, or rubbing.

- Images of the different conditions listed above that can cause pruritus vulvae can be found at www.dermnet.com.

Basis for recommendation

The information and descriptions of the underlying causes of pruritus vulvae is based on published expert opinion [Nunns, 2002; Doxanakis et al, 2004; Margesson, 2004; Bohl, 2005].

Contact dermatitis

- The information that contact dermatitis is the most frequently encountered and avoidable condition seen in clinics that specialize in vulval disorders is based on published expert opinion [ACOG, 2008] and is supported by one small observational study. In the study, of 141 women with chronic vulval symptoms who were referred to a dermatologist, dermatitis was identified as the commonest cause (54%). Other commonly seen conditions were lichen sclerosus (13%), chronic vulvovaginal candidiasis (10%), dysaesthetic vulvodynia (9%), and psoriasis (5%) [Fischer, 1996].

Lichen simplex and lichen planus

- The descriptions of lichen simplex and lichen planus are published expert opinion [Nunns, 2002; Farage et al, 2008].

Lichen sclerosus

- The description of lichen sclerosus is published expert opinion [BAD, 2010].

Which infections and infestations can cause pruritus vulvae?

- **Infections and infestations that can cause pruritus vulvae**

  - **Candidiasis** — pruritus, discharge, erythema, oedema, white plaques, and satellite erythematous lesions. The typical discharge and swelling associated with acute candidiasis are generally absent in recurrent vulvovaginal candidiasis, whereas skin fissuring and irritation after intercourse are more common.

  - For more information, see the CKS topic on Candida - female genital.

  - **Trichomoniasis** — often severe pruritus, with thin, frothy, malodorous vaginal discharge.

  - For more information, see the CKS topic on Trichomoniasis.

  - **Bacterial vaginosis** — mild pruritus (not always present) with thin vaginal discharge.

  - For more information, see the CKS topic on **Bacterial vaginosis**.

  - **Herpes simplex of the genitalia** — can present as pruritus, but may present with vesicles, ulcers, cutaneous hyperaesthesia, perineal burning with or without severe dysuria, and systemic symptoms.

  - For more information, see the CKS topic on Herpes simplex - genital.

  - **Pubic lice *(Pediculus pubis)*** — intense vulval pruritus, possibly with sky-blue spots on trunk and thighs. Lice may be seen on hair, pubis, trunk, legs, axillae, scalp, eyelashes, and eyebrows.

  - For more information, see the CKS topic on Pubic lice.

Basis for recommendation

The information and descriptions of the underlying causes of pruritus vulvae is based on published expert opinion [Nunns, 2002; Doxanakis et al, 2004; Margesson, 2004; Bohl, 2005].

Which malignant and pre-malignant conditions may cause pruritus vulvae?

- **Malignant neoplasms of the vulva** (uncommon).

- Squamous cell carcinomas account for 90% of malignant disease of the vulva. Other less common neoplastic conditions include peri-anal intraepithelial neoplasia, basal cell carcinoma, melanoma, and carcinoma of Bartholin's gland.

- **Squamous cell carcinomas** often arise from pre-existing background disease. Unlike vulval intraepithelial neoplasia (VIN) and Paget's disease, squamous cell carcinomas are rarely itchy; they usually present as a lump or ulcer and are usually tender:

- In elderly women, the background disease is most likely to be lichen sclerosus or lichen planus.

- Vulval intraepithelial neoplasia — is a pre-malignant skin lesion of the vulva and is the most likely background disease in young women. This is usually linked to the wart virus.

  - **Vulval intraepithelial neoplasia (VIN) is a pre-malignant skin lesion of the vulva.**

- If left untreated, VIN may go away by itself (especially the type of VIN known as 'Bowenoid papulosis'), or it may turn into an invasive cancer in later years. On average, it takes well over 10 years for VIN to progress to cancer.

- Vulval intraepithelial neoplasia may occur in women of all ages; the average age of women with VIN is 45–50 years of age, although currently an increasing number of younger women (even teenagers) are presenting with the condition.

- Vulval intraepithelial neoplasia may be completely symptom-free, however most women present with:

- Mild to severe vulval itching.

- Mild to severe vulvar burning.

- One or more slightly raised, well-defined skin lesions that may be pink, red, brown, or white.

- **There are two types** of VIN:

- **Usual-type VIN —** caused by persistent infection with high-risk human papillomavirus. Risk factors for developing usual type VIN include smoking and immunosuppression.

- **Differentiated-type VIN** — associated with lichen sclerosus. This is less common than usual-type VIN (accounts for less than 2–5% of all VIN lesions).

▪ **Extra mammary Paget's disease** (very rare) — a cutaneous neoplasm with a chronic eczema-like rash of the skin around the anogenital regions of males and females. A common symptom is a mild to intense itching of a lesion found around the groin, genitalia, perineum, or peri-anal area. Pain and bleeding may occur from scratching lesions that have been around for a long time. Thickened plaques may form that can become red, scaly, and crusty. Plaques are fixed (unchanging over a few weeks), with sharply demarcated margins and are usually asymmetric, often only affecting one side of the vulva (or peri-anal skin) Although they may appear similar to eczema, they fail to clear up with topical steroid creams.

Basis for recommendation

The information and descriptions of neoplastic conditions that may cause pruritus vulvae, including vulval intraepithelial neoplasia, is based on published expert opinion [Canavan and Cohen, 2002; DermNet NZ, 2007].

What hormonal changes can cause pruritus vulvae?

▪ **Atrophic vulvovaginitis**

- In peri- and postmenopausal women, declining oestrogen levels may contribute to vaginal and vulval changes that result in vulvovaginal itching, dryness, and sometimes burning, although the natural aging process may be a key factor in this change. The vulva will look atrophic, pale, and dry, and if irritated may show erythema, petechiae, telangiectasia, or fissuring (these signs and symptoms are similar to the features of lichen sclerosus). The vaginal epithelium will be dry, pale, thin, and smooth owing to the loss of rugae. Cessation of menstruation and other symptoms, such as hot flushes, may indicate that the cause is the menopause.

- In breastfeeding women, elevated prolactin levels can have an antagonistic effect on oestrogen production, and may result in low oestrogen levels. This can lead to vaginal dryness, itching, burning, and irritation.

- **Pregnancy**

- Pregnancy can cause perineal pruritus through vulval engorgement. Pregnancy is also associated with increased vaginal discharge as a result of increased hormone levels, and an increased incidence of candidal vulvovaginitis.

Basis for recommendation

The information that hormonal changes may cause pruritus vulvae is based on published expert opinion [Bohl, 2005].

What gastrointestinal conditions can cause pruritus vulvae?

- **Gastrointestinal disease** — from prolonged contact of stool with the vulval skin due to faecal incontinence or poor peri-anal hygiene.

- **Urinary incontinence** — which makes the vulval skin moist and macerated.

Basis for recommendation

The information that gastrointestinal disease and urinary incontinence are possible underlying causes of pruritus vulvae is taken from published expert opinion [Bohl, 2005].

What systemic conditions may cause pruritus vulvae?

- **Any cause of generalized pruritus** — including drug reactions and systemic diseases, such as renal or hepatic disease, diabetes, iron deficiency anaemia, lymphoma, other haematological abnormalities, and thyroid dysfunction.

- For more information on managing generalized pruritus, see the CKS topic on Itch - widespread.

- **Psychological problems** — may occasionally present as pruritus vulvae.

- **Stress** — may be a cause of itch, or if not an initial cause, an exacerbating factor causing prolongation of symptoms or a flare-up.

Basis for recommendation

The information and descriptions of the underlying causes of pruritus vulvae is based on published expert opinion [Nunns, 2002; Doxanakis et al, 2004; Margesson, 2004; Bohl, 2005].

What investigations should I consider?

- **Investigations that might be helpful**

  - Fasting blood glucose level, if diabetes mellitus is suspected — diabetes may cause general pruritus.

  - Routine screen, including full blood count, serum ferritin, and thyroid function tests.

  - Iron deficiency anaemia, lymphoma, other haematological abnormalities, and thyroid dysfunction may cause general pruritus. For more information on the investigation of general pruritus, see the CKS topic on Itch - widespread.

  - Vaginal swabs for *Candida sp.* — swabs can be considered in all women, as there may be little or no discharge with chronic vulvovaginal candidiasis.

  - Vaginal swabs for other infections, if suspected, such as bacterial vaginosis or trichomoniasis.

- If a sexually transmitted infection is suspected, ideally, refer the woman to a service specializing in sexual health or a general practice providing an enhanced sexual health service to confirm the diagnosis.

Basis for recommendation

These recommendations are based on expert opinion [Nunns, 2002; Welsh et al, 2003; Doxanakis et al, 2004; Weichert, 2004; Bohl, 2005; BASHH, 2007; RCOG, 2010].

What self-care advice should I give to women with pruritus vulvae?

- **Advise the woman:**

o To shower rather than bath, and to clean the vulval area only once a day with a soap substitute (for example Epaderm® or Diprobase® cream) — over cleaning may aggravate vulval symptoms. Once the vulval area is clean, gently dab the vulval area dry with a soft towel or use a hairdryer on a cool setting held well away from the skin.

- **Advise women with pruritus vulvae to avoid:**

o Washing with water only or with soap as these cause dry skin and make itching worse.

o Contact of the vulval skin with:

o Shampoo.

o Bubble bath.

o Over-the-counter preparations used on the vulva, such as Vagasil® or vaginal washes.

o Wet wipes (feminine or baby).

o Perfumed sanitary towels and panty liners.

o Sponges or flannels — these may irritate the skin.

o Antiseptics such as Dettol®.

o Tight-fitting garments or synthetic clothes, for example nylon underwear, as these may irritate the vulval area.

o Fabric conditioner or biological washing powder when washing underwear.

o Use of spermicidally-lubricated condoms.

- Coloured toilet paper.
- Wearing nail varnish on fingernails if they are scratching.
- Wearing dark-coloured underwear — dark textile dyes (black, navy) may cause an allergy, however it is thought that if they are washed a few times before wearing, this is less likely to be a problem.

▪ **Encourage all women with vulval symptoms to perform a self examination to monitor the skin condition and any suspicious areas.**

- The following organizations provide patient information leaflets on how to perform a self examination:
- British Society for the Study of Vulval Disease.
- National Lichen Sclerosus Support Group.
- Vulval Pain Society.
- The International Society for the Study of Vulvovaginal Disease.

Basis for recommendation

These recommendations are based on published expert opinion [BASHH, 2007; ACOG, 2008; Burrows et al, 2008; RCOG, 2010].

Self examination

▪ The recommendation regarding self examination is based on published expert opinion from the Royal College of Obstetricians and Gynaecologists [RCOG, 2010]. Although there is no trial evidence to support the use of self examination, many patient support groups and specialist societies recommend self examination to detect any suspicious areas.

What symptomatic treatment can I offer?

▪ For all women with pruritus vulvae, consider prescribing:

- **An emollient** — advise the woman to apply the emollient directly to the vulval area throughout the day (as well as using it as a soap substitute).

- When used every day (even when there are no symptoms), an emollient protects the skin and may help to prevent flare-ups.

- For more information on prescribing emollients, see the section on Emollients in the CKS topic on Eczema - atopic.

- **A sedating antihistamine** at night, such as hydroxyzine (which is licensed for pruritus) or chlorphenamine (off-label indication) to reduce nocturnal itch and scratching.

Basis for recommendation

Emollients

- The recommendation to use emollients as a soap substitute is based on published expert opinion [Doxanakis et al, 2004; Bohl, 2005; BASHH, 2007; Wray, 2009; RCOG, 2010].

Sedating antihistamines

- The recommendation to use a sedating oral antihistamine at night is based on published expert opinion, as some women may be helped by oral antihistamines [Doxanakis et al, 2004; Bohl, 2005; DermNet NZ, 2010]. CKS identified no controlled trials that investigated the use of antihistamines for pruritus vulvae.

- If an antihistamine is considered appropriate, first-generation antihistamines (for example chlorphenamine and hydroxyzine) are more sedating than second-generation antihistamines, and may therefore be useful for night-time use [O'Donoghue and Tharp, 2005].

- Experts postulate that sedating oral antihistamines probably provide a reprieve from nocturnal scratching by inducing sedation, helping to break the itch-scratch-cycle [Weichert, 2004].

How should I manage pruritus vulvae with a known cause?

- A comprehensive discussion of the management of specific causes of pruritus vulvae is beyond the scope of this topic. A brief discussion follows, with links to other relevant CKS topics.

- Most women who present with pruritus vulvae have an identifiable cause which can be managed, including:

- Dermatological conditions.
- Infections and infestations.
- Possible neoplasm.
- Hormonal changes.
- Gastrointestinal disease and urinary incontinence.
- Systemic causes.

How should I manage dermatological conditions?

Dermatologists or gynaecologists with the necessary expertise will be able to give comprehensive advice for the treatment of individuals, but in general the following management is suitable.

- **Manage the underlying dermatological cause.**

- **Contact dermatitis**
  - Identify and remove exposure to irritants (for example soaps and deodorants).
  - For mild itching, consider prescribing a mild potency topical corticosteroid ointment, such as hydrocortisone 1% for 2–4 weeks, and then review.
  - Seek specialist advice if stronger corticosteroids are being considered. Stronger potency corticosteroids (such as betamethasone or clobetasol) may be considered if, symptoms are severe, if the skin is lichenified, or to break the itch-scratch-cycle.
  - Consider referral to dermatology for skin patch testing if avoidance of irritants has not helped.
  - For more information, see the CKS topic on Dermatitis - contact.
- **Seborrhoeic dermatitis**
  - Ketoconazole shampoo can be used as body wash for seborrhoeic dermatitis.

- For more information, see the CKS topic on Seborrhoeic dermatitis.

- **Psoriasis**

- For management information, see the section on Treatment in the CKS topic on Psoriasis.

- **Lichen simplex**

- Consider prescribing a potent topical corticosteroid ointment (such as betamethasone), for 1–2 weeks to break the itch-scratch cycle and bring the condition under control.

- **Lichen sclerosus and lichen planus**

- Refer to secondary care for confirmation the diagnosis.

- Once the diagnosis is confirmed in secondary care, very potent corticosteroids are usually initiated by a specialist, repeated intermittent courses of topical steroids may be required for longer term management.

- **For more information on prescribing:**

- **Topical corticosteroids:** see the CKS topic on Corticosteroids - topical (skin), nose, and eyes.

- **Emollients:** see the section on Emollients in the CKS topic on Eczema - atopic.

Basis for recommendation

CKS identified no trial evidence to support these recommendations. They are based on guidelines published by the British Association for Sexual Health and HIV [BASHH, 2007] and published expert opinion [Salim and Wojnarowska, 2005; RCOG, 2010].

Lichen simplex

- The recommendation to use potent topical corticosteroids in women with lichen simplex (for a short period) to bring the condition under control in the early stages is based on published expert opinion [Salim and Wojnarowska, 2005]. It is thought that weaker-potency topical corticosteroids are not effective for breaking the itch-scratch-cycle in women with lichen simplex.

Lichen sclerosus and lichen planus

▪ Referral is recommended to confirm the diagnosis because women with lichen sclerosus and lichen planus have a small risk (3–5%) of developing cancer.

Skin patch testing

▪ The recommendation to refer a woman with dermatitis to dermatology for skin patch testing is based on published expert opinion from the Royal College of Obstetricians and Gynaecologists (RCOG) [RCOG, 2010].

o The RCOG state that specific allergic reactions are often identified in women with pruritus vulvae and that most studies suggest that 26–80% of women referred with vulval symptoms have at least one positive result on patch testing. The most common allergens identified have been cosmetics, medicaments. and preservatives. Other allergens identified include fragrances, preservatives in topical treatments, rubber, and textile dyes.

How should I manage infections or infestations?

▪ **For information on the manage the underlying infection or infestation,** see the CKS topics on:

o Bacterial vaginosis.

o Candida - female genital.

o Herpes simplex - genital.

o Pubic lice.

o Scabies.

o Threadworm.

o Trichomoniasis.

Basis for recommendation

The evidence to support the management of infections and infestations is discussed within the relevant CKS topic.

How should I manage pruritus vulvae caused by a possible neoplasm?

- **Refer urgently (within 2 weeks) all women with an unexplained vulval lump or ulcer.**

o If the woman presents with vulval pruritus or pain, but no other specific features, it is reasonable to use a period of 'treat, watch, and wait' as initial management. The woman should be followed up until symptoms resolve or a diagnosis is confirmed. If symptoms persist, refer with urgency depending on the symptoms and degree of concern about cancer.

o Vulval intraepithelial neoplasia — a skin biopsy is required to confirm the diagnosis and pick up any early cancers. As 50% of women have associated abnormalities including cervical intraepithelial neoplasia or cancer, it is very important to have annual cervical smears.

o Usually all vulval intraepithelial neoplasia lesions are treated to reduce the risk of cancer (in secondary care). Treatments which may be offered include removal of affected tissue, topical imiquimod, or 5-fluorouracil.

Basis for recommendation

These recommendation to refer urgently all women with an unexplained vulval lump or ulcer are based on guidance issued by the National Institute for Health and Clinical Excellence; *Referral guidelines for suspected cancer* [NICE, 2005].

Vulval intraepithelial neoplasia

- The information on which treatments may be given for vulval intraepithelial neoplasia is based on published expert opinion [Canavan and Cohen, 2002; DermNet NZ, 2007].

How should I manage hormonal changes which cause pruritus vulvae?

- **Manage the underlying cause:**

o **Atrophic vaginitis** — see the CKS topic on Menopause.

- **Pregnancy** — see the CKS topic on Itch in pregnancy.

Basis for recommendation

The evidence to support the management of hormonal changes is discussed within the relevant CKS topic.

How should I manage gastrointestinal disease or urinary incontinence which is causing pruritus vulvae?

- **Manage the underlying cause:**

- **Faecal incontinence or poor peri-anal hygiene** — advise on appropriate hygiene and manage faecal incontinence (for example regular toileting, use of barrier creams).

- **Urinary incontinence** — manage appropriately. See guidance from the National Institute for Health and Clinical Excellence (NICE) (pdf) on the management of urinary incontinence in women.

Basis for recommendation

The advice regarding faecal incontinence and good personal hygiene is based on what CKS considers to be good practice.

How should I manage a systemic cause of pruritus vulvae?

- **Manage the underlying cause:**

- **Anaemia (iron deficiency)** — see the CKS topic on Anaemia - iron deficiency.

- **Anaemia (vitamin B_{12} and folate deficiency)** — see the CKS topic on Anaemia - B12 and folate deficiency.

- **Diabetes type 2** — see the CKS topic on Diabetes - type 2.

- **Hyperthyroidism** — see the CKS topic on Hyperthyroidism.

- **Hypothyroidism** — see the CKS topic on Hypothyroidism.

Basis for recommendation

The evidence to support the management of systemic causes is discussed within the relevant CKS topic.

How do I manage pruritus vulvae with an unknown cause?

The aim of treatment is to reduce irritation of the vulval area, relieve itch, reduce scratching, and break the itch-scratch-cycle.

- Offer symptomatic treatment with an emollient and a sedating antihistamine.
- Consider prescribing a short trial (1-2 weeks) of low potency topical corticosteroids (hydrocortisone 1% ointment).
- If symptoms persist despite treatment with an emollient, a sedating oral antihistamine, and a trial of low potency topical corticosteroids, refer for further investigation to a dermatologist, gynaecologist, or vulval clinic.
- While the woman is waiting to be seen by a specialist advise her to continue using an emollient and a sedating antihistamine.

Basis for recommendation

These recommendations are based on expert opinion, because CKS found no trial evidence on how pruritus vulvae is best managed in primary care when there is no obvious underlying cause [Doxanakis et al, 2004; Bohl, 2005; Wray, 2009].

- **Low potency topical corticosteroids**

- CKS identified evidence from one small trial which showed that moderately potent topical corticosteroids are no more effective than placebo for treating pruritus vulvae with an unknown cause [Lagro-Janssen and Sluis, 2009].

- Opinion from CKS expert reviewers was divided regarding the use of low potency topical corticosteroids in women who have pruritus vulvae that has an unknown cause. However, CKS recommends that treatment may be

considered on the basis that some women may benefit, and a short trial of low potency corticosteroids is unlikely to cause harm.

When should I refer a woman with pruritus vulvae?

- **Referral to a dermatologist or gynaecologist with expertise in managing vulval disease** is indicated if:

  - The cause of the pruritus vulvae is unclear and symptoms persist:

  - In most women an identifiable cause can be found.

  - The urgency of the referral will depend on the nature of the symptoms and degree of concern (if any) about cancer.

  - The cause is known, but symptoms persist despite primary care management:

  - For example, some women with contact dermatitis may require referral to try and identify the irritant or allergen. If allergic contact dermatitis is suspected, then patch test investigations may be initiated.

  - A premalignant condition, such as vulval intraepithelial neoplasia, lichen sclerosus, or lichen planus, is suspected:

  - Accurate diagnosis is important because the woman may require long-term follow up. Women who require long-term follow up include those with troublesome ongoing symptoms, localized skin thickening, previous cancer, or vulval intraepithelial neoplasia.

  - Specialist advice on management is often necessary.

- **Urgent referral (within 2 weeks)** is indicated if:

  - Vulval carcinoma is suspected (for example if the woman has an unexplained vulval lump or ulcer).

Basis for recommendation

These recommendations are based on expert opinion [Ridley et al, 2000; Edwards et al, 2002; Nunns, 2002; Doxanakis et al, 2004], and referral guidelines for suspected cancer published by the National Institute for Health and Clinical Excellence [NICE, 2005].

Prescriptions

For information on contraindications, cautions, drug interactions, and adverse effects, see the electronic Medicines Compendium (eMC) (http://emc.medicines.org.uk), or the British National Formulary (BNF) (www.bnf.org).

Non-drug management

Age from 16 years onwards

Advice only: avoidance of vulval irritants

Age: from 16 years onwards
Licensed use: no

Patient information: Vulval skin is sensitive, and may react to irritants such as soaps. You should avoid all contact of the vulva skin with soap, shampoo, bath salts, bubble bath, perfumes and personal deodorants, wet wipes, textile dyes, sanitary wear, detergents and fabric softeners. Wash the vulva every day, but avoid washing excessively. Aqueous cream BP or emulsifying ointment BP are examples of bland emollients that can be used both as a soap substitute and moisturiser. Either formulation can also be used when bathing. Avoid tight-fitting clothes and materials that irritate, for example, nylon. Wear cotton underwear. Avoid the use of spermicidally-lubricated condoms. Try not to scratch, keep fingernails short, and consider wearing cotton gloves at night to stop scratching in your sleep.

Bland emollients

Age from 16 years onwards

Advice only: over-the-counter purchase

Age: from 16 years onwards
Licensed use: no

Patient information: Emollient cream and ointment preparations are available to buy from pharmacies and many are cheaper than the NHS prescription charge. The emollient can be applied liberally as a moisturiser 3 or 4 times a day to the vulva and after bathing. If the condition is inflammatory, the preparation can also be used as a soap substitute. Very occasionally people are sensitive to an ingredient in an emollient preparation. If you experience an allergic reaction then STOP applying the cream or ointment and see your doctor or pharmacist. It is best to sample a few emollients and choose the one that suits you best.

Aqueous cream: Apply to vulva 3 to 4 times a day

Aqueous cream
Apply to the vulva liberally as a moisturiser 3 to 4 times a day, and after bathing. If the condition is inflammatory, also use as a soap substitute.
Supply 100 grams.

Age: from 16 years onwards
NHS cost: £1.41

OTC cost: £2.50
Licensed use: yes

Patient information: Aqueous cream contains a preservative that very occasionally people are sensitive to. If you experience an allergic reaction then STOP applying the cream and see your doctor or pharmacist.

Aqueous cream: Apply to the vulva 3 to 4 times a day

Aqueous cream
Apply to the vulva liberally as a moisturiser 3 to 4 times a day, and after bathing. If the condition is inflammatory, also use as a soap substitute.
Supply 500 grams.

Age: from 16 years onwards
NHS cost: £1.84
OTC cost: £3.24
Licensed use: yes

Patient information: Aqueous cream contains a preservative that very occasionally people are sensitive to. If you experience an allergic reaction then STOP applying the cream and see your doctor or pharmacist.

Emulsifying Oint: Apply to the vulva 3 to 4 times a day

Emulsifying ointment
Apply to the vulva liberally as a moisturiser 3 to 4 times a day, and after bathing. If the condition is inflammatory, also use as a soap substitute.
Supply 100 grams.

Age: from 16 years onwards
NHS cost: £0.44
OTC cost: £0.78
Licensed use: yes

Patient information: Very occasionally people are sensitive to an ingredient in emulsifying ointment. If you experience an allergic reaction then STOP applying the ointment and see your doctor or pharmacist.

Emulsifying ointment: Apply to the vulva 3 to 4 times a day

Emulsifying ointment
Apply to the vulva liberally as a moisturiser 3 to 4 times a day, and after bathing. If the condition is inflammatory, also use as a soap substitute.
Supply 500 grams.

Age: from 16 years onwards
NHS cost: £2.22
OTC cost: £3.92
Licensed use: yes

Patient information: Very occasionally people are sensitive to an ingredient in emulsifying ointment. If you experience an allergic reaction then STOP applying the ointment and see your doctor or pharmacist.

Sedating antihistamines (for sleep disturbance)

Age from 16 years onwards

Chlorphenamine tablets: 4mg at night when required

Chlorphenamine 4mg tablets
Take one tablet at night when required for relief of itching.
Supply 14 tablets.

Age: from 16 years onwards
NHS cost: £0.52
OTC cost: £0.92
Licensed use: no - off-label indication

Patient information: You may buy chlorphenamine (chlorpheniramine) syrup or tablets from a pharmacy.

Hydroxyzine tablets: 25mg at night when required

Hydroxyzine 25mg tablets
Take one tablet at night when required for relief of itching.
Supply 14 tablets.

Age: from 16 years onwards
NHS cost: £0.56
Licensed use: yes

Topical corticosteroid - short trial

Age from 16 years onwards

Hydrocortisone 0.5% ointment: Apply once or twice a day

Hydrocortisone 0.5% ointment
Apply thinly to the vulva once or twice a day when required for relief of itching. Use for 7 to 14 days.
Supply 15 grams.

Age: from 16 years onwards
NHS cost: £1.95
Licensed use: yes

Hydrocortisone 1% ointment: Apply once or twice a day

Hydrocortisone 1% ointment
Apply thinly to the vulva once or twice a day when required for relief of itching. Use for 7 to 14 days.
Supply 15 grams.

Age: from 16 years onwards
NHS cost: £1.43
Licensed use: yes

Potent corticosteroids (lichen simplex) Age from 16 years onwards

Betamethasone valerate 0.1% ointment: apply once or twice a day

Betamethasone valerate 0.1% ointment
Apply thinly to the affected area(s) once or twice a day.
Supply 100 grams.

Age: from 16 years onwards
NHS cost: £4.77
Licensed use: yes