Treatment of Refractory Lichen Sclerosus

These recommendations are for patients who do not respond to standard therapy. No response is defined as continuing *itching* or persistent objective changes to the skin. Please note that patient's complaints of burning or pain with sexual intercourse may have other causes and thus will not necessarily respond to standard treatment. Standard therapy is defined as an adequate course of mid-high potency topical steroid.

- The reasons for the lack of response may be:

1. The diagnosis is wrong or there is a secondary diagnosis – consider treating empirically for secondary yeast and or bacterial infection. (eg. Diflucan 100 mg daily x 3 days). Consider VIN or ca in your differential diagnosis. Re-biopsy any unresponsive areas.

2. The treatment is inadequate

    a. Patient should be on a one-month course of high potency steroid Clobetasol (Dermovate) in an ointment preparation. Patient should apply a thin layer of Clobetasol and rub into affected tissue twice daily. Patient's should apply the medication on all of the external vulvar skin (labia majora, perineum and labia minora) and not just the "worst" areas. Avoid water or clothing for 15 minutes after medication applied. There should be little or no itching after 3 weeks of therapy. Ask the patient to bring in their medication each visit to review the amount of medication the patient has been using. A 30-gram tube applied twice a day should last approximately one month.

    b. Re-examine the patient after 4 weeks of potent steroid and switch to maintenance with a less potent steroid such as betamethasone 0.1% ointment or elocom 0.1% ointment. Apply this in the same fashion. Patient can begin to taper applications in the second month if she is asymptomatic.

    c. Consider an alternative treatment such as tacrolimus 0.1% applied BID for 6 weeks for patients who do not respond to topical steroid.

    d. Rarely intralesional injections are required.
    Indications for intralesional therpay include:
        - failure to respond to correctly and adequate amounts of topical steroids
        - physical inability to apply topical steroids
        - extensively keratinized areas

    Injections may be

- painful
- may induce atrophy or ulcers
- have systemic side effects more often than topical therapy

Intralesional injections

- dosages vary around 3 – 6 mg per cc of triamcinolone in each square centimetre of affected tissue. The medication may be diluted in xylocaine or marcaine.
- One should not exceed 10 mg per centimetre per week
- A single treatment should not exceed 20 –40 mg

There are patients who will objectively respond to topical steroid however continue to complain of vulvar burning. The burning may reflect neuropathic pain and may respond to an 8 week trial of oral amitriptyline 25 mg PO qhs.

Reference: Mazdisnian F. Degregorio F, Palmieri A. Intralesional injection of triamcinolone in the treatment of lichen sclerosus. J Repro Med 1999; 44:332-4