Use of Systemic Therapies for Vulvar Lichen Sclerosus and Vulvovaginal Lichen Planus: A Survey Study of Dermatologists and Gynecologists

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Introduction

- Vulvar lichen sclerosus (VLS) and vulvovaginal lichen planus (VLP) are chronic autoimmune inflammatory processes that significantly affect quality of life.
- Topical high-potency corticosteroids or topical tacrolimus are commonly utilized[1,2]. However, for refractory disease, systemic agents may be appropriate.
- There are currently no guidelines for the use of systemic therapies in these vulvar conditions[3].

Objective

- We sought to understand how clinicians incorporate systemic agents into treatment for VLS and VLP.

Methods

- A 15-question, IRB-exempt, online REDCap survey was distributed worldwide using the International Society for the Study of Vulvovaginal Disease listserv.
- The survey was sent out twice, one month apart.
- Seventy-one participants completed the survey, with a 14% response rate.

Results

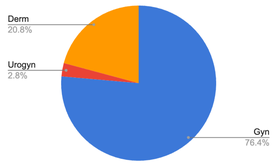


Figure 1: Specialties surveyed.

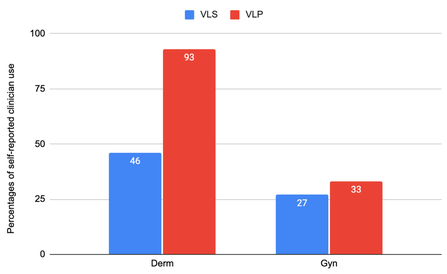
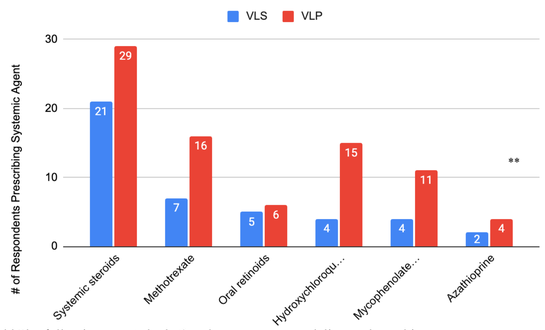


Figure 2: Percentages of dermatologists and gynecologists prescribing systemic agents for VLS and VLP.



**The following agents had <2 or less responses: Adalimumab, oral janus kinase inhibitors, dupilumab, and other.

Figure 3: Reported systemic agents used.

Response	VLS N(%)	VLP N(%)
Severe itch/pain (refractory to topicals)	(25, 40.3)	(25, 40.3)
Severity of ulceration, erosion	(22, 36.1)	(22, 36.1)
Extragenital involvement	(13, 20.6)	(13, 20.6)
Physical or psychosocial barriers preventing adequate topical application	(10, 17.2)	(10, 17.2)
Surface area of anogenital anatomic sites involved	(8, 13.6)	(6, 10.0)
Severity of lichenification or hyperkeratosis	(6, 9.8)	(6, 9.7)
Patient preference	(6, 9.7)	(4, 6.5)
Severity of white changes (hypopigmentation or depigmentation)	(2, 3.3)	(2, 3.3)

Figure 4: Responses to "Which of the following factors might influence your decision to use systemic therapies?".

Discussion

- More clinicians, both in dermatology and gynecology, chose to use systemic agents for VLP over VLS. All urogynecology respondents reported use of systemics for conditions other than VLP or VLS.
- Dermatologists reported more systemic agent usage for both VLP and VLS in comparison to gynecologists, (VLP: 93% derm, 33% gyn; VLS: 46% derm, 27% gyn).
- Systemic corticosteroids were the most used agents by dermatologists and gynecologists for both conditions, followed by methotrexate.
- Of the factors that may influence a decision to use systemic therapies, the most commonly selected as “most important” was severe itch or pain refractory to topicals for both VLS and VLP.
- Forty-seven percent reported reservations to using systemic agents for VLS or VLP, the most common reservation being potential side effects (55%).
- In additional comments from respondents, thirteen gynecologists reported that inadequate training was a factor (18%). Eleven respondents (28%) indicated they did not need to use systemics because patients responded well to topicals.

Conclusions

- Both disease severity and side effects of systemic agents were selected as the most important factors in deciding whether to use systemic therapies.
- Of note, some gynecologists reported inadequate training for use of systemic agents.

Future Studies

- Future studies on the use of systemic therapies for VLS and VLP are needed to establish treatment guidelines.
- Training courses and information on the use of systemic therapies for clinicians may also be helpful to optimize care for patients with VLP and VLS.

References

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