Evaluation and Treatment of Vulvar Itch

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I have no actual or potential conflict of interest in relation to this presentation
Objectives

- Be aware of the most common pruritic vulvar conditions
- Develop a routine practice of targeted vulvar exam as part of every gynecologic exam
- Develop a logical and evidence-based treatment for lichen sclerosus

Take a careful history!

What are the symptoms? Itch, pain?
Duration of symptoms, what the triggers are, and whether condition flares, is intermittent
Previous treatments and responses
List of all topicals applied to vulva: Herbal, antibiotic, hormonal, etc.
How often do they use pads or liners?
Are they using Vagasil or other over the counter anesthetics?
Any urinary incontinence? Stool?
Does the condition interfere with sex, and if so, how?
Do symptoms interfere with sleep? Itch/scratch often worse at night
Are they scratching? Specifically ask this.
Any history of genital HSV?
Any dermatologic conditions on non-genital skin or scalp?
Personal medical history (Diabetes? Autoimmune disease? Menopausal symptoms?)
Any history of oral lichen planus?

(for vulvodynia, ask about jeans, bike seat, tampons to assess triggers, limitations)
DO NOT SAY VAGINA WHEN YOU MEAN VULVA

Patients may say “vaginal” itch or pain. If the history clarifies that it’s vulvar, then we should not use “vaginal” in coding, in the assessment/plan, in the problem list, or in communications with other providers. This is a frequent problem and leads to missed diagnoses, mis-diagnosis and over treatment and wrong treatment. We must do better!

Vulvar itch/irritation: What’s most likely?

★ Irritant/allergic contact dermatitis
★ Lichen sclerosus
★ Yeast vulvovaginitis (this can present with minimal change or can look extremely abnormal)
  • Lichen simplex chronicus (in some practices, this will be in the top 3)
  • Psoriasis
  • Eczema, other dermatitis
  • Vulvodynia (can present with itch or a combination of itch and pain)
  • Lichen planus (might burn rather than itch)
  • Crohn’s related dermatitis (non-specific, often fissuring, erythema, sometimes edema, some features of LS/LP)
  • VIN, cancer
  • Paget’s disease
  • Warts (usually the chief complaint is bumps/warts/tags, not itch)
  • Scabies, Lice
Photos

Bright red: yeast vs contact dermatitis

- Erythema, usually bilateral. In darker skin, look for alteration in color rather than erythema. Pay attention to distribution of changes.

- May itch or may burn. These tend to itch at baseline and often burn when creams are applied.

- Scaling can be present

- Fissures in creases are common with yeast but can happen with any dermatitis

- Look for satellite lesions with yeast

- Quick test = KOH slide from vagina. Even if the itch is external, your yield will be higher with a vaginal swab. If there is an isolated patch that looks fungal and it is away from the vagina, I will also do a KOH swab of the skin and evaluate with microscopy. A soft pap brush works nicely for collection onto a glass slide.

- If KOH is negative, send a test to the lab, for example vaginal culture or PCR test.

- Psoriasis can also look red and or/scaly but tends to be a bit more patchy and dry (ask about other sites of psoriasis, family history of psoriasis)
Vulvar contact dermatitis

- About 1/2 of patients presenting to vulvar clinics may have irritant or allergic contact dermatitis (ACD)

- Rates of relevant positive patch testing is higher in patients with anogenital dermatitis than in those without dermatitis

- Irritant contact dermatitis is more common than ACD; some products can be both irritants and cause sensitization.

- Risk factors for irritant dermatitis include urinary/fecal incontinence, obesity, limited mobility

- ACD can occur as a primary process or as a complication of treatment of a vulvar condition (for example in LS patients with long term application of a topical medication)

- If ACD suspected, refer to dermatology for patch testing

Woodruff et al Vulvar Allergic Contact Dermatitis

Agents causing allergic contact dermatitis in a gynecology practice

- Topical antibiotics
- Antifungals
- Topical steroids
- Lidocaine, benzocaine
- Plant compounds (calendula, tea tree oil, jojoba oil, etc)
- Absorbant materials in menstrual/incontinence pads
- Emollients/vehicles of topicals (propylene glycol, lanolin, glycerin, example: estradiol cream and Premarin cream have propylene glycol)
- Fragrances
- Antiseptics
- Preservatives (in almost everything)
- Nail polish
Treatment of Vulvar Contact Dermatitis

• Try to identify the irritant with your history
• Remove the offending agent
• Topical steroids may be helpful (low to mid-potency steroid ointment for 2-4 weeks should help). If you suspect the steroid they are using is the allergen, refer for patch testing and in the meantime, try desoximetasone, which is less frequently implicated in ACD
• Bland barrier emollient such as pure petrolatum
• Patch testing if allergy suspected and treatment isn’t working

Yeast vulvovaginitis

• Yeast vulvitis can look very abnormal on exam with dramatic color changes, fissures, peeling.
• Yeast vulvitis can mask the presence of other things that have more subtle findings. It is often helpful to treat and then re-examine.
• If you can’t rule out cancer, and you can’t be sure they will come back soon for close follow up, then biopsy. However, if you’re able to wait until after treatment, you will be able to better target your biopsy (for cancer, LS, etc) once the yeast is treated - this will improve your yield with your biopsy.
• I have many patients who have intermittent yeast as well as chronic lichen sclerosus (some have intermittent HSV as well). Making one diagnosis does not exclude another.
• In patients with recurrent yeast (and/or recurrent HSV) who also suffer from lichen sclerosus, consider suppression of the yeast/HSV. More on this later.
Yeast tips (see CDC site for detailed treatment guidelines)

- Recurrent vulvovaginal yeast: fluconazole 200mg Q 72 hours x 3 doses or use extended (14 day) vaginal therapy

- Alternative to oral/topical therapy: Boric acid 600mg vaginal capsules, insert one nightly in the vagina for 14 days

- Avoid 1 day topical over the counter preparations as they often burn (use 3 or 7 day treatment instead)

- For severe vulvovaginal candidiasis with fissuring, anti-fungal creams can burn when applied to skin. Consider oral therapy, +/- vaginal therapy, consider hydrocortisone ointment 2.5% or triamcinolone ointment 0.1% on the skin for 7-14 days for the inflammation. Use emollients for the fissures.

- Consider suppression where indicated (weekly fluconazole for 6 months or boric acid vaginally 2-3 days per week)

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A Little-Known Skin Disease That Can Disrupt People’s Sex Lives

Patients deal with pain and itching and often encounter medical ignorance and mistreatment until affected tissues become irreparably scarred.

Jane Brody 5/12/2019, NYT
Lichen Sclerosus

- Chronic, inflammatory dermatosis that can cause itch, pain, scarring, functional impairment

- Diagnosed at any age, under-recognized in premenopausal patients. Have a high suspicion in patients with vulvar itch who give a history of “yeast” (often without discharge). Patients may note symptoms for the first time when postpartum.

- Etiology unknown, thought to be immune-related based on increased prevalence of auto-immune disorders in patients with LS. In addition, reports of patients on PD1 inhibitors developing lichen sclerosus lend support to an immune mechanism. No LS-specific autoantibody has been identified.

- Association with autoimmune conditions such as alopecia, vitiligo, Hashimoto’s

- Risk of SCCA in patients with LS in is between 0 and 5%. Other risk factors for SCCA are VIN, smoking, age, immunosuppression.

Lichen sclerosus case: 29 yo for routine gyn exam

- 29 year old presents for routine gyn exam, no vulvar complaints. Healthy. Family h/o hypothyroidism, no personal or family dermatologic history.

- On exam, there is a chaffed appearance to inner labia majora. The labia minora are very small and don’t come away from the majora as expected. Clitoral hood doesn’t retract much.

- Gives a h/o “yeast issues” in past.

- On follow up few months later, patient had the same findings. Declined biopsy.

- Next routine gyn exam (age 30) just reports intermittent irritation. Exam: minimal labia minora, interlabial creases are very prominent, perineal body a little pale. Discussed biopsy vs treatment and they wanted to have biopsy for confirmation. Biopsy showed lichen sclerosus.

- Lessons: Look at the vulva when you do a pap. Ask specifically about symptoms if you suspect LS. Yeast (and herpes) can co-exist with LS, don’t let that history throw you off and make sure to treat those if they occur. Don’t let young age lower your suspicion.
Screening tips - 2 things to look for on the vulva that should make you want to know more

1. Prominent lines in the inter-labial sulci
2. Limited or non-retraction of the clitoral hood

Practice checking this on every patient.
Teach your learners.
It takes about 5 seconds.
You can do it while retracting skin for the speculum without spending extra time.

Physical exam for LS

• Get telescoping hand held mirrors for your exam rooms

• Do your exam and then hand the patient the mirror and point out the areas that you identify as LS. The goal should be for the patient to be able to apply the ointment by touch. They should not need a mirror while applying. They generally need one hand to retract the labia major (“where the hair is”). Otherwise, most of the steroid will land more laterally than where it’s needed.

• DO NOT RELY ON COLOR, especially in darker skinned patients

• In every vulvar exam, look at the inter-labial sulci and look at the clitoral hood. Normally the sulci will be smooth. If you see a permanent crease/line, with or without a fissure, it’s a sign of a dermatosis (dermatitis or LS or LP for example). Visually check that the clitoral hood is not attached to the underlying glans. If you can’t see an opening under the hood or if it is a very small opening, then have a high suspicion for LS
Lichen Sclerosus

- Altered pigmentation
- Common sites for LS = clitoral hood, interlabial folds, perineal body, perianal
- Classic is figure of 8 pattern of white (or of altered coloration) but may be more limited
- Mimics: hypoestrogenic state, vitiligo, other vulvar dystrophies, VIN
- Loss of architecture
- Fissures (but not specific to LS)
- Prominent creases in the interlabial folds
- Thinning
- Wrinkled (parchment paper) appearance
- Sub-epithelial hemorrhages (especially after menopause)
- Post inflammatory hyperpigmentation

Where is the racial diversity in our LS population?

- Provider education on LS is an issue - trainees and providers are taught to look for white change and text books use pictures of light-skinned patients. Providers including gynecologists are likely missing this on exams.
  - From UptoDate: “women with genital LS have thin, white, wrinkled skin on the labia”
  - From ACOG Practice Bulletin: “On examination, typical lichen sclerosus lesions appear as porcelain-white papules and plaques, often with areas of ecchymosis (or purpura)”
- Providers might more readily attribute some patients’ symptoms to use of body care products and suggest they change their hygiene practices rather than doing a careful exam.
- In my experience, there is a provider focus on vaginitis and ruling out STI even when symptoms are vulvar, and this may be even more so in pre-menopausal Black and Brown patients.
- There may be bias in how we respond to phone calls/messages. Are we asking more follow up questions with some patients and not others (for example, getting at the vaginitis vs vulvar symptoms issue)? Are some messages replied to more quickly or with more detail?
- "A study using health care utilization data on 132,423 US patients showed that racial and ethnic minority groups are underrepresented in referrals to medical and surgical subspecialty offices - especially Black patients in dermatology. The authors give several factors that may account for this implicating systemic issues that are best characterized as structural racism"

*Cai, C et al. Racial and Ethnic Disparities in Outpatient Visit Rates Across 29 Specialties*
Vulvar biopsy

Tips:

• I generally don’t biopsy right on a fissure if a fissure is present (Note, fissure is not the same as ulcer. Fissure is linear and follows natural skin lines or occurs at common points of tension).
• If there is color change, biopsy color change.
• In darker skinned patients, pay more attention to structure and texture and skin lines than color.
• If no color change, and there is obvious agglutination of labia minor to major, then just alongside/lateral to the inter-labial line is often fruitful if a line is present here.
• If you find yeast, bring them back after yeast treatment before doing biopsy. The subtle texture and color changes of LS can be obscured by yeast vulvitis.
• 3mm punch biopsy rarely needs a stitch, just pressure and silver nitrate.
• If biopsy is to r/o CA or VIN, then use your judgement and biopsy the most abnormal area or areas. If you suspect cancer, you don’t need to wait to treat yeast first. Consider taking more than one biopsy. If patient consents, consider a photo for the chart to aid in oncology or dysplasia provider assessment.

Lichen Sclerosus Treatment

• Topical clobetasol propionate 0.05% ointment daily or BID for 1-3 months then taper if responding. They just need a small pea-sized amount.

• Liberal bland emollients daily (Aquaphor, Vaseline, Emuaid, coconut oil, diaper rash ointments, etc)

• Then maintenance steroid vs steroid for flares, depending on extent of disease, presence of ongoing symptoms, patient preference. Maintenance can be with triamcinolone 0.1% ointment or clobetasol ointment, generally 2-3 times per week (no good data to guide frequency).

• No evidence to support topical testosterone rather than steroid

• Based on eczema data, tacrolimus ointment for steroid failures, steroid intolerance.

• Surgery for symptomatic adhesions

• Examine regularly (6-12 months depending on age) for cancer (SCCA), VIN
Clobetasol (standard) vs Mometasone for LS

- Randomized trial on clobetasol propionate vs mometasone furoate for vulvar LS, done in 2014
- 54 patients with LS
- 12 week treatment
- 89% responders in the clobetasol group
- 89% responders in the mometasone group
- Both drugs had decrease in mean symptoms and sign scores over the study
- No significant difference between the 2 drugs and they were similarly tolerated
- My take home from this - mometasone is a good alternative if patients don’t tolerate clobetasol or if clobetasol is not covered for them. Mometasone is a bit less potent than clobetasol.

Tacrolimus/pimecrolimus - 2nd line therapy

- These are topical calcineurin inhibitors (not steroids)
- FDA approval is for eczema, not for LS, but these are used for LS and LP
- Standard of care is to use as second line therapy when steroid is not working or when steroid causes adverse effect
- Why not use first line? Clobetasol is more effective than tacrolimus and pimecrolimus in head to head studies, and there’s a concern that long term use of the calcineurin inhibitors might increase cancer risk (there’s a black box warning regarding this).
- Recent data in about 8000 children with atopic dermatitis who used tacrolimus ointment for greater than or equal to 6 weeks did not show an increase in cancer over baseline and there were no non-melanoma skin cancers or incident lymphomas.
- Side effect is burning. These medications do not cause thinning of the skin. Risk of HSV, yeast. Cost/coverage can be an issue.
Clobetasol (standard) vs tacrolimus for LS

- 2014 study of clobetasol 0.05% vs tacrolimus 0.1% (Protopic)
- Randomized, double blind study of 58 patients with new diagnosis of LS who had not been treated for a month prior to the study.
- 28 were treated with tacrolimus, 27 with clobetasol
- Both groups had significant decrease in symptoms and signs of LS over 3 months
- There were patients in both groups who still had signs of LS after 3 months (which would be expected)
- More patients in the clobetasol group had absence of signs and symptoms of LS
- Authors’ conclusion is that clobetasol is superior to tacrolimus
- They state the long term safety of tacrolimus is unknown
- My takeaway: tacrolimus is effective (in patients who can't tolerate steroids or don't respond to steroid)

Q: Do topical steroids reduce cancer risk?
A: We don’t know

A Cochrane review in 2011 on vulvar LS noted that a RCT of at least 984 patients of adequate duration would be required to determine whether treatment can reduce the risk of cancer.

Authors' conclusions: The current limited evidence demonstrates the efficacy of clobetasol propionate, mometasone furoate, and pimecrolimus in treating genital LS. Further RCTs are needed to determine the optimal potency and regimen of topical corticosteroids, examine other topical interventions, assess the duration of remission or prevention of flares, evaluate the reduction in the risk of genital squamous cell carcinoma or genital intraepithelial neoplasia, and examine the efficacy in improving the quality of the sex lives of people with this condition.
Lichen sclerosus - example of instructions for the After Visit Summary in EMR

**LICHEN SCLEROSUS INSTRUCTIONS**

1. Choose one of the following emollients and use it once or twice daily to the entire vulvar area (this helps moisturize the skin and prevent tearing). These are very important!

- Vaseline
- Emuaid
- Vitamin A and D ointment (this is in the baby/diaper aisle of the drugstore or grocery store. Generic has less odor)
- Aquaphor (in the dry skin aisle near Eucerin)
- CeraVe Soothing Eczema Creamy Oil
- Desitin (in the baby/diaper aisle. This is a little tacky/sticky, so some people don't like it)
- Coconut oil (pure oil, NOT cocoa butter. This is in the food section with the other cooking oils)

2. Use your ointment (***) *** times per (day/wk/mo). You should only use a small amount (about the size of a pea).

3. Things to avoid:

- Soaps (wash with water)
- Fragrances (in bath products, laundry soap, etc)
- Fabric softeners, dryer sheets
- Vagisil
- Frequent pad or panty liner use
- Baby or feminine wipes
- Scratching
What is lichen sclerosus?

Lichen sclerosus is a skin disease that occurs most often on the vulva and sometimes on the skin around the anal area. The cause is unknown. However, many believe that it occurs when the immune system, that part of your body that fights off infection, becomes overactive and attacks the skin.

Lichen sclerosus usually causes itching, and sometimes easy skin bruising, tearing, and even pain. Some people have no symptoms at all. Skin affected by lichen sclerosus is usually lighter in color than other skin, sometimes there is a fine, crinkled texture, and often the skin is dry. If untreated, lichen sclerosus can cause scarring, and the opening of the vagina can narrow. Usually, lichen sclerosus does not affect non-genital skin, but about one person in ten has a few scattered spots in other areas.

Fortunately, there is excellent treatment of this disease. A high potency cortisone (steroid) ointment usually returns the skin close to its original color and texture, although it does not reverse scarring. The usual medication is clobetasol propionate ointment, a small amount used once or twice a day. The medication can irritate some people’s skin. This irritation usually resolves, but if it doesn’t, let your provider know. Brief setbacks are common during the first month or two, but don’t get discouraged. Ultimately, people with lichen sclerosus do well. Lichen sclerosus can cause the vulvar skin to be dry and to develop cuts (fissures) easily. A daily emollient such as Vaseline, Aquaphor or coconut oil can be helpful in preventing dryness and fissures. If you have a history of genital herpes, it’s possible to get an outbreak while using steroid ointments (please let your provider know if you have a history of genital herpes and they might adjust the frequency or duration of steroid use).

Most people need up to three months or more of daily ultrapotent steroid treatment. Patients are examined about every 3 months while using this medicine daily. After the initial treatment period, the steroid is either used on a maintenance regimen, for example 2-3 days every week, or is used for short courses as needed to prevent return of lichen sclerosus symptoms. After the first check-up, you should follow-up with a provider about every 6 months. This is to watch for progression of lichen sclerosus (worsening of color or change in structures or worsening symptoms) or signs of side effects from the steroid. Too much steroid can cause thinning of the skin. Another reason for follow up exams is that people with lichen sclerosus have an slightly increased risk of skin cancer in the vulvar area. Other risk factors for vulvar skin cancer include older age and cigarette smoking.

Please advise your provider if you have any change in symptoms including new itching or pain or if you notice any new skin changes such as erosion or thickening.

What about PRP, laser, borax baths, and everything else I read about on (insert social media here)?

Given the limited number of randomized, placebo-controlled studies, platelet rich plasma is not an evidenced based treatment for lichen sclerosus at this time.

There is not compelling evidence to use fractional CO2 laser for LS at this time but there are ongoing studies.

Surgery has always been an option for some patients, but is a treatment for structural changes and functional issues, not a treatment for itch. Surgery does not obviate the need for steroids.
Case: 70 yo with oral, esophageal, vulvar lichen planus

- 70 yo with long h/o vulvar symptoms and with diagnosis of lichen planus over 10 years ago
- Recalls an Estring getting stuck and needing to be “cut out”
- Pathology report (years ago) states “lichenoid interface reaction” with comment “while not diagnostic, there are findings … suggestive of lichen planus”
- LP managed by dermatologist with hydroxychloroquine and she applies clobetasol into introitus
- No current vulvar symptoms except now can’t have intercourse. Hadn’t tried in several months due to partner’s health.
- Exam significant for vagina only about 2cm in length, then agglutinated/obliterated beyond that
- Plan: 1/2 of 25mg hydrocortisone rectal suppository placed vaginally daily, then every other day after the first month. Alternating days topical steroid ointment with estrogen cream to skin around vaginal opening. Use a dilator regularly.
- F/U 2 months later: She has adhered to regular steroid and dilator use. Vagina with good length (full finger length)
- F/U 6 weeks later: able to have intercourse without pain. Using dilator 2 days per week. Using 1/2 of 25mg hydrocortisone suppository vaginally 2 days per week.
Lichen Planus (LP)

Autoimmune, muco-cutaneous disorder that tends to occur more commonly in peri and post menopausal patients. Can also occur as a drug reaction.

Can occur on the skin and in the mouth (often asymptomatic in the mouth) and in the esophagus as well as other sites. Oral LP may be asymptomatic and noticed by their dentist. About 1/2 of people with oral LP have signs of vulvar LP.

In a review of 100 patients with vulvar LP at Mayo, 91% reported dyspareunia and 69% reported pain/burning/pruritus

Can have vulvar itch and loss of vulvar structures and mimic or co-exist with LS

May be preceded (by years) or may co-exist with desquamative inflammatory vaginitis

Association with other autoimmune conditions (thyroid, vitiligo, RA, celiac) but majority of patients do not report another autoimmune disease

Biopsy specimens rarely give a definitive diagnosis of LP - often result is lichenoid dermatitis. Clinical impression is very important with LP (with LS, definitive diagnosis is common if location of biopsy is well chosen)

Mimics - lichen sclerosus (vaginal or oral involvement is a clue that it’s LP rather than LS), GVHD (clue is history of bone marrow transplant and often an existing diagnosis of GVHD)

Lichen planus treatment

- Treat vulvar skin as you would treat lichen sclerosus, with clobetasol ointment as first line.

- Introital burning (erosive type) LP can be treated with alternating days clobetasol ointment and estrogen cream applied digitally, in peri and post menopausal patients. Younger patients may not benefit from topical estrogen. Treating this area helps with dyspareunia.

- Have a mirror in the office and show patients where to put meds (vulvar or introital). Many are older with limited flexibility, so show them with a mirror but teach them how to do it by touch. They do not need mirrors to do this at home.

- Make sure to check the vagina (digital exam is best) for narrowing, strictures, that can occur with erosive vaginal LP. If the patient wants to have vaginal intercourse, needs access to cervix or is at risk of urinary stream blockage, they will need vaginal dilators and vaginal steroid. If they are not bothered by vaginal closure and no longer need pap, you don’t have to treat the vagina.

- University of Michigan vulvar clinic uses hydrocortisone 25mg suppositories (Anusol HC) 1/2 BID for 2 months then taper. I find that 1/2 once daily is adequate, even in people with almost complete vaginal obliteration. I have patients start a dilator at the same time. If there is progress, they can reduce steroid to 3 days per week after the first 1 or 2 months. These suppositories are often not covered by insurance. Make sure to be clear on medication label about vaginal rather than rectal use. They may be cheaper from a compounding pharmacy.

- If the patient has multi-site LP, co-manage with a dermatologist who can manage systemic drugs and monitor other sites.
Lichen Simplex Chronicus

- End stage disorder caused by rubbing or scratching.
- History is important: ask what they are washing with (get specific), how much they rub or scratch when wiping, whether they have risk factors for yeast, whether they are exposed to irritants (urine, wipes, stool)
- On exam there is lichenification (thickening, white to grey color, fissures, accentuated skin lines) and often excoriations. Check for yeast. It's such a mimic and it can also co-occur.
- Itch-scratch cycle. Itch-scratch cycle. Itch-scratch cycle. I tell patients “whatever caused your itch in the first place might be gone now. I’ll look for a cause, but I might not see it anymore. When the skin is rubbed or scratched, it can thicken over time and that becomes the cause of the itch. So now the important thing is to stop the scratching and to take care of the skin while it’s healing.”
- May feel good to scratch. They often scratch at night. If so, consider night time measures like applying steroid at HS, consider antihistamine at night.
- Remove irritants, use emollient barrier, mid to high potency steroid cintment (I’ll often start with triamcinolone 0.1% cintment), antipruritic measures, treat yeast if present and suppress yeast if recurrent.
- They should continue emollients daily even when they taper/stop the steroid. Especially use emollients when fissures are present. I say “your skin is usually a really good barrier, but when it has cuts or breaks in it, it loses its barrier function. So it can’t hold onto water and it can’t protect you as well from things you come in contact with. Your emollient is like a protective layer of skin”.
- Past treatment failures are often due to non-adherence, lack of understanding of itch-scratch cycle, fear of steroids on the part of provider/patient, stopping steroid too soon, ongoing exposure to irritant or infection. Please acknowledge how hard this condition is for patients to live with.
- Often need to biopsy to clarify diagnosis as this can mimic VIN, LS, cancer.
Treatments for itch

- **Emollients** - helpful for most vulvar itch (Aquaphor, Vaseline, Emuaid, Vitamin A and D ointment, Zinc diaper rash ointment/paste, coconut oil although it is less of a barrier)

- **Doxepin 5% cream** (only one study)

- **Lidocaine** (better for pain than itch, can cause contact dermatitis)

- **Calcineurin inhibitors** (pimecrolimus, tacrolimus)

- **Oral antihistamine** (diphenhydramine, hydroxyzine) at night

- **Oral gabapentin**, start with low dose at night (300mg or 100mg)

- **Oral amitriptyline** at night (10 or 25mg)

- **Oral SSRI**

- Be careful with creams as they have preservatives and some patients’ itch is related to contact dermatitis. If you suspect allergy, you can refer for patch testing.

References


Questions?