GENITAL DERMATOSES

Practice Points For All Genital Skin Conditions

Clinical

- Note: timing, drugs, allergies, personal / family history of dermatoses / atopy
- Examine entire skin surface, mucosal surfaces, joints, mouth
- Full sexual health screen
- Consider HSV swab, urinalysis for glucose, skin swab if secondary infection suspected
- Refer for biopsy of any atypical lesions (wide differential and risk of malignancy) via internal referral to GUM or SRH complex
- Refer for patch testing if secondary medicament allergy suspected (e.g. Dermatological referral via SCI Gateway).

General Advice To Patients

There is a general patient information leaflet 'Genital Skin Care' which can be texted to client via Sandyford team site leaflets

- Avoid contact with soap, shampoo or bubble bath. Aqueous cream BP can be used as a soap substitute. Suggest the use of an emollient eg. Hydromol
- Avoid tight fitting garments which may irritate the area. Wear loose fitting cotton underwear
- Avoid night time scratching – consider use of anti-histamines and night cotton gloves.
- Avoid coloured underwear or toilet paper
- Avoid antiseptics in the bath

Non-Specific Balanitis

Most balanitis will settle with conservative measures and reassurance

- Do not diagnose definite asymptomatic NGU on Gram stain alone in presence of significant balanitis
- **Always** check urinalysis to exclude diabetes
- Advise salt water bathing (using syringe to irrigate beneath prepuce if this is difficult to retract)
- Consider metronidazole 400mg BD for one week if **anaerobic balanitis** suspected
- Reserve topical clotrimazole for proven yeast infection (subprep slide or culture) and topical hydrocortisone where simple measures fail. See also male candida
- Refer patients with troublesome non-retractile prepuce for consideration of circumcision. Think about lichen sclerosus.

Vulval Dermatitis

Irritant, allergic, atopic or seborrheic
Secondary – e.g. to iron deficiency, Lichen simplex, or after candidal infection

Further Investigations to be considered

- Screening for infection (especially candida)
- Ferritin *(NB can be iron deficient with normal FBC)*
- Biopsy *via referral to SRH Complex*
- Dermatological referral

Management

- Avoidance of precipitating factor
- Salt water bathing
- Topical corticosteroid – the choice of preparation will depend on severity, 1% Hydrocortisone in milder cases, or betamethasone or clobetasol for limited periods if severe or lichenified. A combined preparation containing antifungal and/or antibiotic may be required if superinfection likely. Apply once or twice daily.

Vulval Intraepithelial Neoplasia (VIN)

VIN must be considered in all atypical wart lesions, especially those which fail to improve after 6 weeks of topical therapy.

- The commonest aetiological agent is Human papillomavirus (HPV). It is also associated with dermatological conditions such as lichen sclerosis.
- Clinical appearance is very variable
- Raised white, erythematous or pigmented lesions occur and these may be warty, moist or eroded
- Multifocal lesions are common

Management

Biopsy refer urgently via internal referral to SRH complex

Penile Intraepithelial Neoplasia (Bowen`s Disease, Erythroplasia Of Queyrat)

This condition is considered a pre-malignant change in penile tissue. The appearance is variable, and can be easily confused with plasma cell balanitis (Zoon`s) or other skin conditions. It may arise in pre-existing warty lesions or in Lichen Sclerosus. It is more prevalent in older men. Clinical suspicion should arise when areas of skin change fail to settle or respond to standard therapies.

Management: Biopsy – refer internally to GUM complex

References

UK national guideline on the management of vulval conditions
https://www.bashhguidelines.org/current-guidelines/skin-conditions/vulval-conditions-2014/ [Accessed March 2022]

UK National Guideline on the Management of Balanoposthitis
https://www.bashh.org/guidelines [Accessed March 2022]

Appendix for Sandyford Staff

Sandyford Local Protocol for Aqueous Cream

Sandyford nursing staff can supply one tube Aqueous Cream to be used as a soap substitute.
Patient to wet the skin first, then wash with cream and rinse off.

Exclusion criteria:

Known sensitivity to aqueous cream or any of its excipients