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Opinion

A Comprehensive and Holistic Approach to Vulvar Lichen Sclerosus: Looking Beyond Topical Corticosteroids

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Opinion

Lichen sclerosus (LS) remains one of the most under-recognized chronic inflammatory diseases affecting women's genital health. Although the disease is estimated to affect up to 1 in 70 women, delayed diagnosis remains common, particularly in perimenopausal and postmenopausal women, where symptoms are often mistakenly attributed to recurrent candidiasis, vulvovaginal atrophy, or nonspecific dermatitis. These delays may have profound consequences, including irreversible vulvar scarring, architectural distortion, dyspareunia, sexual dysfunction, psychological distress, and an increased risk of vulvar squamous cell carcinoma.

Current international guidelines appropriately recommend ultra-potent topical corticosteroids, particularly clobetasol propionate, as first-line therapy, with topical calcineurin inhibitors reserved for selected patients. These therapies have undoubtedly transformed the management of LS by reducing inflammation and lowering cancer risk. Nevertheless, in everyday clinical practice, many women continue to experience persistent symptoms despite guideline-directed care. Others struggle with lifelong steroid dependence, concerns regarding skin fragility, or progressive anatomical changes despite treatment.

These observations suggest that symptom suppression alone may not be sufficient for every patient and that a broader, individualized management strategy deserves consideration.

LS is increasingly recognized as an immune-mediated disease. Numerous studies have demonstrated significant associations with autoimmune disorders, including autoimmune thyroid disease, vitiligo, alopecia areata, pernicious anemia, and type 1 diabetes. Approximately one-third to one-half of affected women demonstrate autoimmune serological abnormalities, further supporting an immunological basis for disease development. Hormonal influences, particularly declining androgen and estrogen levels, may contribute to disease susceptibility, while local trauma and the Koebner phenomenon are recognized precipitating factors.

In my clinical practice, I have observed that disease onset or exacerbation frequently follows periods of physiological stress, hormonal transition, infection, or significant life stressors. Although these observations are consistent with known mechanisms of immune dysregulation, they remain clinical observations and warrant prospective investigation before firm conclusions can be drawn. Likewise, anecdotal reports of disease onset following COVID-19 infection require further study before any causal relationship can be established.

These clinical experiences have encouraged me to adopt a comprehensive evaluation that extends beyond treating the vulvar skin alone. Every patient undergoes assessment for associated autoimmune disease, hormonal deficiency, nutrient deficiencies, chronic vulvovaginal infections, bladder dysfunction, psychosocial stressors, and contributing lifestyle factors. Correction of estrogen or androgen deficiency when clinically indicated, treatment of coexisting infections such as recurrent candidiasis or bacterial vaginosis, optimization of nutritional deficiencies,

and individualized dietary counselling form part of an integrated management strategy designed to reduce inflammatory burden and optimize tissue health.

Over recent years, regenerative medicine has emerged as a promising adjunct in vulvar disease. Platelet-rich plasma (PRP) has demonstrated anti-inflammatory and regenerative properties through the delivery of concentrated growth factors that stimulate angiogenesis, collagen remodeling, and tissue repair. Early clinical studies suggest improvements in symptoms, tissue quality, and sexual function among women with vulvar LS.

Similarly, fractional CO_2 laser therapy has demonstrated improvements in vulvar tissue elasticity, collagen synthesis, vascularization, and symptom relief in selected patients. While existing studies are limited by small sample sizes and heterogeneous methodology, the accumulating evidence suggests that energy-based therapies may provide meaningful benefit when used as an adjunct to established medical treatment or when the standard of care fails.

Recognizing the potential synergy between regenerative biologics and energy-based devices, I developed an integrative treatment protocol combining monopolar radiofrequency, fractional radiofrequency microneedling, and biologic therapy using either platelet-rich plasma or exosomes. In our recently published prospective case series, patients experienced marked reductions in itching, burning, fissuring, dyspareunia, and overall disease burden. Many reported restoration of normal sexual function, improved vulvar tissue quality, healing of chronic fissures, and significantly improved quality of life. Although preliminary and limited by the absence of a control group, these encouraging findings support further investigations into these treatments as patients reported a significant improvement of many of their symptoms and improvement of their sexual health.

Perhaps the most compelling aspect of LS management is not simply disease control but restoration of quality of life. Women frequently describe LS as affecting every aspect of daily living. Chronic itch, pain, anxiety regarding progressive anatomical loss, and avoidance of intimacy contribute substantially to emotional distress. Sexual dysfunction often extends beyond the patient herself, affecting intimate relationships and family wellbeing. As gynecologists, preserving vulvar anatomy and restoring sexual health should be regarded as essential components of comprehensive care rather than secondary treatment goals.

One patient in our study summarized this transformation particularly well. After years of persistent symptoms despite conventional management, she described complete resolution of tearing, marked improvement in vulvar appearance, restoration of sexual function, and for the first time since diagnosis, a renewed sense of hope. While individual patient experiences should never substitute for scientific evidence, they remind us that quality-of-life outcomes remain critically important in chronic vulvar disease.

The future of LS management should not be viewed as a choice between corticosteroids and regenerative medicine, but rather as an opportunity to develop individualized, multimodal treatment strategies grounded in evidence while remaining open to innovation. Topical corticosteroids remain the cornerstone of treatment. However, patients with persistent symptoms or progressive disease despite optimal medical therapy deserve investigation into complementary approaches that address immune regulation, tissue regeneration, hormonal health, sexual function, and overall wellbeing.

As clinicians, we have an obligation to continue exploring therapies that not only control disease but restore function, preserve anatomy, and improve quality of life. Larger prospective randomized studies evaluating integrative regenerative protocols are now warranted to determine their place within evidence-based management of vulvar lichen sclerosus [1-10].

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Conflict of Interest

No Conflict of Interest.

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