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Lichen Sclerosus Treatment & Management

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Approach Considerations

An evidence-based treatment guideline was published in the *British Journal of Dermatology* for lichen sclerosus (LS) in 2010 [26] and more recently, in 2015 from the European Academy of Dermatology and Venereology. [17] Of note, Table 1 of this 2015 consensus guideline summarizes treatment responses achieved with different therapies in women, men, girls, boys, extragenital, and long term in studies. The author's treatment practice is aligned with recommendations in these guidelines.

Genital lichen sclerosus

Multiple randomized controlled trials (RCTs) evaluating topical interventions, two RCTs evaluating acitretin, and one RCT evaluating para-aminobenzoate exist. [27, 28] The efficacy data for other agents include case reports and small studies. All genital lichen sclerosus cases should be treated, even if asymptomatic, with the goal of preventing scarring and its associated disfigurement, sexual and urinary dysfunction, and reduction in quality of life. Treatment success is typically evaluated every 3 months when actively modifying treatment. Efficacy is gaged by the patient's resolution of symptoms (pruritus and pain) and improved variables on physical examination (reduced ulceration, hyperkeratosis, erythema, ecchymosis, atrophy, and depigmentation). Clinical photography is helpful for monitoring from visit to visit, and scarring is permanent.

First-line therapy includes patient education and super-potent topical corticosteroids (eg, clobetasol propionate). It should be recognized that vulvar lichen sclerosus patients typically do not develop atrophy with prolonged use, owing to the resistant nature of modified mucous membranes of the labia and clitoris (in contrast to perianal and hair-bearing skin of the labia majora, which can atrophy within 2-3 wk of use). Although not used by the author, intralesional corticosteroid injections are also considered first-line therapy.

Second-line therapies include the calcineurin inhibitors, tacrolimus and pimecrolimus, which can be a helpful adjunct to topical corticosteroids for maintenance.

Third-line therapies that could be considered in treatment-resistant genital lichen sclerosus could include topical or oral retinoids, steroid injections, cyclosporin (topical shown not to work), methotrexate, or hydroxyurea. For extragenital lichen sclerosus, phototherapy or methotrexate could be considered (treatment regimens analogous to those used for morphea).

The author uses hydroxychloroquine with good results (< 6.5 mg/kg based on ideal body weight) as a systemic maintenance drug for both genital and extragenital lichen sclerosus. It is especially useful to help aid tapering of long-term immunosuppressant therapy.

Topical testosterone, topical estrogen, topical progesterone, and hormone replacement therapy should not be used. Although extensively used in the past, there is no evidence base for their use. Topical avocado and soybean extracts as alternative treatments for mild-to-moderate lichen sclerosus have been used in patients wishing to avoid corticosteroids. [29] The patients also received dietary supplements containing the same substances, along with vitamin E and para-aminobenzoic acid. In a small study of 23 patients, most reported improvement. Other anecdotal therapies include intralesional injection of adalimumab. [30]

Extragenital lichen sclerosus

There are no RCTs evaluating the efficacy of treatment for extragenital lichen sclerosus, and recommendations are based on case reports and small uncontrolled studies. [17] Treatment is often extrapolated from data from studies in genital lichen sclerosus and studies in the treatment of morphea. It is important to discuss with patients goals of care, and treat according to the patient's goals. If patients are asymptomatic, deferring treatment is reasonable. If localized lesion treatment (based on cosmesis or symptoms) is desired, topical treatment with potent or ultrapotent topical corticosteroids is first line. For those with extensive involvement, rapid progression, or a goal of preventing new lesions, phototherapy or systemic therapy should be offered.