CORRESPONDENCE

Lichen Sclerosus in Boys

by Dr. med. Karl Becker in volume 4/2011

Lichen Sclerosus in Women

I read the article by Becker with great interest as it raises awareness for a widely unknown pathology.

Lichen sclerosus is still often regarded as a rare disease that affects mainly older women; the reason for this is that for a long time it was recognized only during the later stages. Now we suspect that up to 1% of women are affected, little girls and young women among them. Many patients have gone through many useless diagnostic tests and therapies (anti-infective drugs). My youngest patient was 3 years old.

In women and perhaps also in men, early diagnosis and treatment are crucial for the disease course since appropriate treatment helps to mostly avoid late sequelae such as uncontrollable pruritus, atrophy, synechiae, and degenerative changes. Histological analysis is not always required—a close look, preferably using a colposcope, and experience are usually sufficient. The symptoms of chronic pruritus, discrete white coloration, and skin injuries such as dermatorrhagia and rhagades subsequent to permanent scratching) and exclusion of fungal infections enable a clinical diagnosis more readily.

Treatment with corticosteroid ointment is standard treatment in women today and yields the best results during the early stages. However, fatty ointment without any water is equally as important. The skin loses its elasticity as a result of the sclerosis and is then more prone to injury and providing an entry point for micro-organisms in this densely colonized area.

The skin is relieved by consistent application of water free oil based care products, which reduce inflammatory reactions and damage to the epithelium; furthermore, it helps to limit the amount of corticosteroid that is required. Unfortunately this is a little known fact with regard to the anogenital region.

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Conflict of interest statement

Professor Petersen has received honoraria for speaking or continuing medical educational events from Bayer, Taurus, Essex Pharma, Kaymogyn, and Grünenthal.

Dermatologist Should Be Consulted

From a dermatologist's perspective—as the doctor who usually undertakes the diagnosis and therapy of lichen sclerosus (LS)—I wish to point out that genital LS occurs in adults more often than in children, and the even rarer extragenital LS affects primarily older women.

In case of not-retractable phimosis, it is too late for conservative treatment, but in the remaining cases this is still promising. If highly potent steroids are used at all they should be applied for a maximum of one week only because of atrophy and increased resorption in the genital region. After a week, patients should be switched to treatment with methylprednisolone aceponate, mometasone, hydrocortisone, or topical calcineurin inhibitors instead. In hypertrophic forms of LS, tretinoin-containing external medications and imiquimod have their uses. In sclerotic hardening with possible functional impairment of the prepuce, frenulum, glans, and perimeatal area, the situation can be rapidly improved by means of cryotherapy, best administered in spray form; surgical treatment can thus mostly be avoided.

In the conclusions section, the author recommended presenting suspect skin changes to a pediatric surgeon or urologist, but he forgot to mention the dermatologist, who is used to treating LS and is often able to prevent surgical treatment by administering appropriate topical treatment. In LS, complete circumcision is not always the treatment of choice because later, or even simultaneously, glans, meatus, and frenulum may be affected, and this cannot be eliminated by means of circumcision nor can it be prevented for the future.

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The author declares that no conflict of interest exists.

Adjuvant Topical Treatment With Inflammation: Suppressing Medications Should Be Given

The comprehensive article “Lichen sclerosus in boys” contributes to raising awareness for lichen sclerosus (LS) and to ensuring that it is appropriately rated in terms of its importance even in children. The author retrospectively reports of his enormous patient cohort; however, a 4-month follow-up period is under no circumstances enough to capture possible complications. Furthermore, the key messages suggest that LS can be cured by complete circumcision. Prospective data disproved this

statement as early as in 1994, since one third of the glandular lichenoid lesions that were observed in 70% of cases persisted after 5 years without aftercare (1).

In our pediatric urology patient collective we found in 45% of circumcised LS patients after they had healed that the glans and/or meatus were affected (2). The British Association of Dermatologists additionally deems adjuvant topical treatment with anti-inflammatory topical ointment after a histologically confirmed diagnosis of LS (3). Postoperative complications that are to be expected—in the present article these mainly included meatus stenosis in 10.7% and renewed phimosis in spite of circumcision in 50%—justify adjuvant and therapeutic application of anti-inflammatory topical substances, such as cortisone or tacrolimus, even in children because otherwise these small patients would have to endure repeated surgery under general anesthesia. We published our prospective data on adjuvant treatment with a topical tacrolimus ointment for a follow-up period of >1 year (2) and, even after a long-term follow-up of a median 2.8 years have not had to undertake a single secondary procedure in such topically treated LS.

In conclusion it does need to be pointed out that unfortunately the “buried penis”—with or without histologically confirmed LS—should never be treated by simple circumcision because this does not do justice to the complexity of the case in any way.

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The author declares that no conflict of interest exists.

In Reply:

Petersen assumes a prevalence of 1% in women; this underlines the importance of the disease. We have nothing to add to his additional remarks from a gynecologist's perspective. In all patients, early diagnosis means a wider therapeutic scope and improves the prognosis.

The treatment of LS in boys usually falls under the remit of a pediatric surgeon or pediatric urologist since phimosis—the lead symptom—is usually the reason for the referral, rather than the skin disease that would be referred to a dermatologist. Attempts have been made

to show that genital LS in children, masked by phimosis, is notably more common than is widely assumed. There is no reliable proof as to whether it is more common in boys or in adult men.

Kemmler qualifies the recommendation for surgery to apply to only cases with non-retractable phimosis. Among the 225 cases we examined, we found only one boy whose lichenoid changes had not yet resulted in irretractable phimosis. This patient represented one of the few cases that we managed to cure successfully by means of conservative treatment.

The question whether circumcision is curative in boys with LS has been the subject of discussion for a long time. Presumably it depends on the duration and dynamics of the process before treatment is started. Ebert cites the study reported by Meuli, who observed only 10 cases of lichen (1). Authors with larger patient cohorts have reported much higher cure rates. Kiss, for example, found in 471 circumcised LS patients 231 with glandular lesions, of which only two did not heal spontaneously (2). Depasquale similarly reported that 276 (92%) of 287 cases of glandular involvement were cured by means of circumcision alone (3).

Our experiences mirror those of Kiss and Depasquale and show that in a scenario of accurate diagnosis and early therapy lesions persisted in only few cases. We treat these topically, similarly to our colleagues in Regensburg, using a combination of highly potent corticoids and calcineurin inhibitors. On the basis of our own data we do not think that general topical aftercare is indicated and do not share the views of Neill et al in this respect (4). We explicitly pointed out that for the selection of protracted cases—in addition to the follow-up examination of boys four months after surgery mentioned earlier—long-term observation is required.

The “buried penis” represents a complex problem that requires a highly individualized therapeutic approach rather than a prescriptive therapeutic plan. The long term result in our patients was positive in every respect.

In sum, we wish to point out once again that an interdisciplinary German guideline for lichen sclerosus is overdue.

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The author declares that no conflict of interest exists.