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A survey of management of vulvar disorders in the primary health care setting in an urban area of England

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Μελέτη του τρόπου διαχείρισης των περιστατικών γυναικών με παθήσεις αιδοίου στην πρωτοβάθμια φροντίδα υγείας σε μια αστική περιοχή στην Αγγλία

Περίληψη στο τέλος του άρθρου

OBJECTIVE **To determine the frequency of consultation for vulvar diseases in the primary health care setting, and their investigation and management patterns, and to identify the training needs of general practitioners (GPs) in vulvar disease.** METHOD **A survey was conducted using a 13-item questionnaire handed out to GPs during their regional post-graduate seminars in the area of Shropshire in the West Midlands in England.** RESULTS **Of 120 questionnaires distributed, a total of 107 responses were received (response rate: 89.1%). Of the participants, 67.3% reported that they see more than 5 patients per month with vulvar symptoms, and 24.6% that they see more than 5 patients per month with recurrent vulvar symptoms. The predominant symptom was pruritus vulvae (77.5%), with 94.5% of practitioners considering lichen sclerosus as the most likely diagnosis. For recurrent pruritus vulvae a gynecological referral was made in most cases (86%). In contrast, when there was vulvar pain, only few practitioners would refer the patient to a gynecologist (8.4%) or a dermatologist (17.3%). Only 41.1% of GPs had ever received any kind of training, with all (100%) agreeing that formal training in the diagnosis and management of vulvar diseases would benefit their care of their patients.** CONCLUSIONS **This survey showed that a substantial number of women consult their GP with vulvar symptoms. A variety of approaches were reported in the diagnosis and management of these cases. All the GPs agreed that there is a need for formal training in vulvar disease.**

Key words

Primary health care
Pruritus vulvae
Vulvar disease
Vulvar pain

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Community-based surveys show that about 20% of women suffer from significant vulvar symptoms, such as pruritus and pain, and may present changes in their vulvar skin color and texture.[1] In the UK, patients with vulvar disorders are initially diagnosed and managed in the primary health care setting, and may then be referred to a hospital-based clinic. Studies have been made of the frequency of vulvar disorders in women in both the general population and specialist dermatology or gynecology clinics. It is estimated that lichen sclerosus accounts for at least 25% of the women seen in vulvar clinics, with a reported incidence of from 1/300 to 1/1,000 of all patients referred to dermatology departments.[1] A large population-based study identified a prevalence of vulvodynia of 8.3%, with higher prevalence in younger women, and in those who were married.[2]

In 2011, the Royal College of Obstetricians and Gynecologists (RCOG) issued guidelines aimed at providing an evidence-based framework for the general gynecologist, with advice on when to refer patients with vulvar problems to a specialist multidisciplinary team.[1] In 2014, the British Association for Sexual Health and HIV issued guidelines with recommendations on the management of a range of vulvar disorders that may be managed by genitourinary physicians, with guidance about onward referral.[3] In spite of this interest, the curriculum of the Royal College of General Practitioners (RCGP) makes no mention of vulvar disorders beyond requiring knowledge of pruritus vulvae, and there is no formal requirement for GPs to learn about vulvar conditions.[4]

A survey was carried out in the primary health care setting to determine the frequency of vulvar disease encountered in general practice, and the investigation and management patterns practised by the GPs, and to identify training needs of the GPs in vulvar disease, as they are the first point of contact for these patients.

MATERIAL AND METHOD

A survey was made of the workload and management of vulvar disease by GPs in the wider area of Telford and Shrewsbury in Shropshire, in the West Midlands, UK. The survey was conducted by the use of a 13-item questionnaire that had been developed and used for data capture and analysis with regards to vulvar diseases in the community[5] (tab. S1). The questionnaire was distributed to all the GPs during their monthly regional post-graduate seminars, with no exclusions. The lead author (PK) at the start of these seminar sessions explained to the GPs the purposes of this survey.

The responses to the questionnaire were recorded in a participant non-identifiable way on an excel spreadsheet. Quantitative variables were presented as mean (±standard deviation, SD) and median values (+interquartile range, IQR). Qualitative variables were presented as absolute and relative frequencies.

This survey did not warrant ethics approval from the local institutional review board as it represented a data capture survey of the GPs' current practice, but it was conducted in line with the Declaration of Helsinki (1975). Each participant gave informed consent to participate in the survey by responding to and completing the questionnaire.

RESULTS

A total of 107 completed responses, of the 120 questionnaires that were handed out, were received (response rate: 89.1%). Of the respondents 49 (45.8%) were male and 58 (54.2%) female, with a mean duration in general practice of 11.8±8.9 years (range: 1–35 years) and a median of 12 years (IQR=16). Regarding consultations for vulvar prob-

Table S1. The 13-item questionnaire that was used for the survey on vulvar disease.

Item no	Item description
1	Please tell us how many years you have been in GP practice (you are: male/female)
2	The number of women complaining of vulvar symptoms you may see on an average per month are: less than 5, less than 10, between 10 and 20, more than 20
3	The number of women complaining of recurrent vulvar symptoms you may see on an average per month are: less than 5, less than 10, between 10 and 20, more than 20
4	Vulvar complaints are of various natures. Please rate 1–4 according to the predominant symptom you may come across during your practice: (a) Pruritus vulvae (itching), (b) vulvodynia (pain or burning sensation), (c) superficial dyspareunia (painful intercourse), (d) lump or thickening of skin
5	Do you carry out a genital examination in patients presenting with vulvar symptoms: (a) Always, (b) sometimes, (c) occasionally, (d) never
6	If you do not examine them always how could you best describe the reasons for not examining? [You can select more than one response]: (a) Satisfied with the patient's history as examination may not in result additional information (b) Examination of such nature is time consuming with no time to spare due to busy schedules (c) Unavailability of chaperones (d) Never had a formal training for examining vulvar conditions (e) Others; please specify
7	When a patient presents with vulvar symptoms how often do you plan baseline investigations before treating them: (a) Always, (b) sometimes, (c) occasionally, (d) never
8	Please indicate the type of investigations you may do in your practice with regard to vulvar diseases [You can select more than one response]: (a) High vaginal swab, (b) *Chlamydia* swab, (c) urine analysis, (d) vulvar biopsy, (e) others [please specify]
9	If a patient presents with recurrent episodes of pruritus vulvae despite initial treatment, what do you think the likely possibilities are [you can select more than one response]: (a) Eczema, (b) recurrent candidiasis, (c) secondary infection, (d) lichen sclerosus, (e) vulvar vestibulitis, (f) vulvar intraepithelial neoplasia [VIN]/vulvar cancer, (g) no diagnosis, (h) others [please specify]
10	When patients present with recurrent episodes of pruritus vulvae which do not respond to initial treatment, you may do: (a) Further microbiological tests, (b) further empirical treatment [different antibiotics, steroid creams], (c) a gynecological referral, (d) a dermatological referral, (e) others [please specify]
11	A patient complains of pain in the vulva and your examination is essentially normal other than tenderness in the vulvar region. What do you think the likely possibilities are? [You can select more than one response]: (a) Recurrent candidiasis, (b) neuropathic pain, (c) psychological cause, (d) lichen sclerosus, (e) no diagnosis, (f) others [please specify]
12	What further steps would you take in her case? [You can select more than one response]: (a) Reassure as there is no obvious cause for her pain, (b) local analgesic/anaesthetic creams, (c) tricyclic antidepressants, (d) topical steroid, (e) referral for counselling, (f) a gynecological referral, (g) a dermatological referral, (h) others [please specify]
13	During your training or career, have you had any kind of formal training with regard to management of vulvar diseases? Yes/no. If "yes", please enumerate the type of training you have had. Do you think that going through a formal training could benefit your patient care? (a) Strongly agree, (b) agree, (c) disagree, (d) strongly disagree

GP: General practitioner

lems, 58/103 GPs (67.3%) reported that they see more than 5 patients per month with vulvar symptoms, and 26/106 (24.6%) that they see more than 5 patients per month with recurrent vulvar symptoms (tab. 1).

The predominant symptom the participants reported in their patients was pruritus vulvae (77.5%) with other less frequent symptoms being vulvar skin changes, lumps (8.5%), superficial dyspareunia (7.5%) and vulvodynia (6.5%).

The majority of GPs (74.7%) always carried out a genital examination on patients presenting with vulvar symptoms. If examination was not performed, the most common reason was that the GP was satisfied with the patient's history and felt that the examination would contribute no additional information at that time. In 81.2% of cases baseline investigations were conducted, usually (>90%) a high vaginal swab and a chlamydia swab (tab. 2).

When a patient presented with recurrent episodes of pruritus vulvae despite treatment, the GPs considered the underlying cause to be lichen sclerosus (94.5%), recurrent candidiasis (84.6%), eczema (51.6%), vulvar vestibulitis (26.4%), vulvar intraepithelial neoplasia (VIN)/vulval cancer (25.3%), secondary infection (23.1%), no diagnosis suggested (9.9%) or other causes (4.4%) such as diabetes mellitus or postmenopausal changes. In the case of recurrence, the GPs would either make a gynecological referral (86%) or continue with further empirical treatment (73.4%) or further microbiological tests (67.1%) (tab. 3).

When a patient complained of vulvar pain with an essentially normal genital examination, the participants considered the underlying cause to be neuropathic pain (67.9%), of psychological origin (61.7%), lichen sclerosus (20.9%), or other causes such as recurrent candidiasis (1.2%).

Table 1. Workload of patients with vulvar problems seen at the general practice surgery (n=107).

Item of questionnaire	n (%)
Q2=The number of women complaining of vulvar symptoms you may see on an average per month are:	
Less than 5	45/103 (43.7)
Less than 10	40/103 (38.8)
Between 10 and 20	12/103 (13.6)
More than 20	6/103 (5.8)
Q3=The number of women complaining of recurrent vulvar symptoms you may see on an average per month are:	
Less than 5	80/106 (75.4)
Less than 10	16/106 (15.1)
Between 10 and 20	7/106 (6.6)
More than 20	3/106 (2.8)
Q4=Vulvar complaints are of various natures. Please rate the predominant symptom you may come across during your practice:	
(a) Pruritus vulvae (itching)	83/107 (77.5)
(b) Vulvodynia (pain or burning sensation)	7/107 (6.5)
(c) Superficial dyspareunia (painful intercourse)	8/107 (7.5)
(d) Lump or thickening of skin	9/107 (8.5)

Table 2. Examination and investigations performed by general practitioners on patients with vulvar problems.

Item of questionnaire	n (%)
Q5=Do you carry out a *genital examination* in patients presenting with vulvar symptoms:	
(a) Always	80/107 (74.7)
(b) Sometimes	23/107 (21.5)
(c) Occasionally	3/107 (2.8)
(d) Never	1/107 (0.9)
Q6=If you do not examine them always how could you best describe the *reasons for not examining*? [You can select more than one response]	
(a) Satisfied with the patient's history as examination may not result in additional information	77/107 (71.9)
(b) Examination of such nature is time consuming with no time to spare due to busy schedules	13/107 (12.1)
(c) Unavailability of chaperones	14/107 (13.1)
(d) Never had a formal training for examining vulvar conditions	3/107 (2.8)
(e) Others; please specify	4/107 (3.8)*
Q7=When a patient presents with vulvar symptoms how often do you plan *baseline investigations* before treating them:	
(a) Always	11/107 (10.2)
(b) Sometimes	76/107 (71.0)
(c) Occasionally	17/107 (15.9)
(d) Never	3/107 (2.8)
Q8=Please indicate *the type of investigations* you may do in your practice with regards to vulvar diseases [You can select more than one response]	
(a) High vaginal swab	89/90 (98.9)
(b) *Chlamydia* swab	83/90 (92.2)
(c) Urine analysis	39/90 (43.3)
(d) Vulvar biopsy	33/90 (36.7)
(e) Others [please specify]	6/90 (6.7)**

* Q6: Others specified were: Patient declined, only examine if patient returns with symptoms, refer to a female general practitioner (GP) rather than examining, someone already done an examination

** Q8: Others specified were: Blood glucose test, HbA_{1C}, testing for herpes, thyroid function tests, renal/liver function tests, thread worms testing, autoimmune tests, allergy tests, skin scrapings

Table 3. Management of pruritus vulvae and vulvar pain by general practitioners.

Item of questionnaire	n (%)
Q9=If a patient presents with *recurrent episodes of pruritus* vulvae despite initial treatment, what do you think the likely possibilities are? [You can select more than one response]	
(a) Eczema	47/91 (51.6)
(b) Recurrent candidiasis	77/91 (84.6)
(c) Secondary infection	21/91 (23.1)
(d) Lichen sclerosus	86/91 (94.5)
(e) Vulvar vestibulitis	24/91 (26.4)
(f) Vulvar intraepithelial neoplasia [VIN]/ vulvar cancer	23/91 (25.3)
(g) No diagnosis	9/91 (9.9)
(h) Others [please specify]	4/91 (4.4)*
Q10=When patients present with *recurrent episodes of pruritus* vulvae which do not respond to initial treatment, you may do:	
(a) Further microbiological tests	53/79 (67.1)
(b) Further empirical treatment (different antibiotics, steroid creams)	58/79 (73.4)
(c) A gynaecological referral	68/79 (86.0)
(d) A dermatological referral	12/79 (15.2)
(e) Others [please specify]	3/79 (3.8)
Q11=A patient complains of *pain in the vulva* and your examination is essentially normal other than tenderness in the vulvar region. What do you think the likely possibilities are? [You can select more than one response]	
(a) Recurrent candidiasis	1/81 (1.2)
(b) Neuropathic pain	55/81 (67.9)
(c) Psychological cause	50/81 (61.7)
(d) Lichen sclerosus	17/81 (20.9)
(e) No diagnosis	5/81 (6.1)
(f) Others [please specify]	3/81 (3.7)**
Q12= What *further steps* would you take in her case? [You can select more than one response].	
(a) Reassure as there is no obvious cause for her pain	8/81 (9.8)
(b) Local analgesic/anaesthetic creams	9/81 (11.1)
(c) Tricyclic antidepressants	47/81 (58.1)
(d) Topical steroid	37/81 (45.7)
(e) Referral for counselling	6/81 (7.4)
(f) A gynaecological referral	68/81 (8.4)
(g) A dermatological referral	14/81 (17.3)
(h) Others [please specify]	0/81 (0)

* Q9: Others specified were: Diabetes mellitus, postmenopausal changes, psychological cause, psoriasis, lichen planus

** Q11: Others specified were: Vaginismus, lack of oestrogen, vulvar cancer, cysts/abscess

In the case of these patients, depending on the suspected cause, the GPs would prescribe tricyclic antidepressants (58.1%), or topical steroids (45.7%), or make a dermatological referral (17.3%), with only 1 in 12 (8.4%) making a gynecological referral (tab. 3).

Only 41.1% of the GPs reported any kind of formal training in the diagnosis and management of vulvar diseases, and all participants agreed that formal training would benefit their care of their patients (tab. 4).

DISCUSSION

This survey revealed that 67.3% of GPs see more than 5 patients per month with vulvar symptoms, and 24.6% see more than 5 patients per month with recurrent vulvar disease. This finding is in line with other survey findings in England[5] and demonstrates the significant presentation of vulvar disease among women in the community, and therefore the importance of appropriate management at the primary health care level.

The predominant symptom of women consulting the GP in this survey was pruritus vulvae (77.5%), with the majority of GPs (94.5%) establishing the clinical diagnosis of lichen sclerosus. In contrast, there are reports that only 25% of women seen in specialist vulvar clinics and 1/300–1/1,000 of women seen in dermatology clinics suffer from lichen

Table 4. Training of general practitioners in vulvar disease diagnosis and management.

Item of questionnaire	n (%)
Q13=During your training or career, *have you had any kind of formal training* with regards to management of vulvar diseases?	
Yes	44/107 (41.1)
No	63/107 (58.9)
Do you think that going through a formal training could benefit your patient care?	
(a) Strongly agree	50/87 (57.4)
(b) Agree	37/87 (42.6)
(c) Disagree	0
(d) Strongly disagree	0

If "yes", please enumerate the type of training you have had:

DRCOG (Diploma of the Royal College of Obstetricians and Gynecologists) base teaching, diploma in dermatology, vulvar skin care updates, lectures, training during gynecology clinic appointments; GPVTS (*General Practice Vocational Training Scheme)* training, self-learning, dermatology updates

Other comments on training issues:
Some have suggested they are willing to sit in gynecology clinics
Some wanted brief not time consuming training
Some have suggested training for the general practice nurses

sclerosus.[1] This difference between the numbers of women with lichen sclerosus seen by GPs and those attending specialist clinics demonstrates the increased workload of vulvar disease seen in the community and highlights the role of the GP as the "gatekeeper" in the British health system.

This survey reported the frequency of vulvodynia, described as pain or burning sensation of the vulva, at 6.5%. This is much lower than the 14% reported in other community surveys in the past,[5] and the prevalence of 8.3% reported in large population-based studies.[2] This divergence could be attributed to the varying population characteristics among the different studies, and also to the fact that the questionnaire used did not give a standardized definition of vulvodynia. According to the most recent definition from the International Society of Vulvar Diseases in 2015, vulvodynia is a disorder characterized by ongoing pain on the vulva of at least 3 months duration that lacks a clear identifiable cause.[6] In the present survey, vulvodynia was defined as the general sense of pain or burning in the vulva (it was assumed that most GPs might not be aware of the strict criteria of the definition of vulvodynia).

The majority of the GPs (74.7%) reported that they always carried out a genital examination in women presenting with vulvar symptoms, and the vast majority of these (>90%) also took a high vaginal swab and a chlamydia swab as baseline investigations. These percentages are in accordance with other community-based studies reporting on the investigation patterns of GPs.[5]

In the case of women with recurrent episodes of pruritus vulvae despite initial treatment, only 25.3% of the GPs considered the possibility of VIN or vulvar cancer. Although most vulvar conditions can be detected on clinical examination alone, when symptoms persist, onward referrals to specialist clinics should be made to exclude malignancy. It has been reported that VIN usually presents with severe pruritus[1] and that 12–17% of women undergoing surgical treatment of VIN had clinically unrecognised vulvar cancer, diagnosed only on histology.[7,8]

The majority of GPs (67.9%) in the survey considered neuropathic pain mechanisms as the underlying cause of vulvar pain in women with an essentially normal genital examination. In this case, they would treat the women with neuropathic pain agents and in only a few cases would consider a dermatological referral (17.3%) or gynecological referral (8.4%). The etiology of vulvodynia is still basically unknown, reflected in the multiple treatment modalities available and the reports that no specific treatment method has been shown to have any greater benefit over another.[9,10] Multiple mechanisms of neurogenic inflammation have been considered as an explanation for this disorder but further research is required.[11–13] This survey revealed that the GP participants had a reasonably good understanding of vulvar pain disorder, as their diagnosis of neuropathic pain corresponded with literature reports.

In a retrospective review of women with vulvar cancer reported, it was suggested that suboptimal primary care and the failure of knowledge and appropriate examination by GPs may be a contributing factor to an increased rate of vulvar cancer.[14] In that review, the majority of women had had chronic vulvar irritation with abnormal vulvar skin for many years, with 31% having had more than three consultations relating to vulvar symptoms more than 6 months before the diagnosis of cancer was made.[14] Despite these reports, the RCGP has no formal accredited training process for vulvar disease at present, beyond requiring knowledge of pruritus vulvae.[4] In addition, there are no knowledge, skill or competence requirements for practice nurses on vulvar conditions. In contrast, other professional bodies, including the RCOG and the British Association for Sexual Health and HIV, have issued guidance on the management of women presenting with vulvar disease.[1,3] The present survey identified a significant training need amongst GPs, as only 41.1% of the participants in the survey reported having had any kind of training, and all participants agreed that a formal training in vulvar disease would benefit the care they provide for their patients.

There are certain limitations in this study to be considered. First, this was a data capture survey among GPs in the urban area of Shropshire in the West Midlands in England. The study population was GPs attending a monthly regional postgraduate seminar and therefore was a selected population that may not be representative of all GPs. This may have introduced a selection bias and the same survey in another community with different GPs and population characteristics might have yielded different results. It was impossible to compare characteristics of the participating GPs to assess the degree of potential bias. Second, the questionnaire used for the survey had already been referenced[5] in an attempt to document the practice of the diagnosis and management of vulvar disease in the community, and for this reason its psychometric properties were not retested. The strength of this survey is that it captured, in a way that was simple and easy to comprehend, the frequency of vulvar disease in the community, and the investigation and management patterns of the GPs, and most importantly, it highlighted their training needs on vulvar disease.

In conclusion, this survey confirmed that substantial

numbers of women present with vulvar symptoms in primary care. GPs employ a variety of approaches to the diagnosis and management of these vulvar skin conditions. There is a consensus among GPs that they have a need for formal training in vulvar disease.

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ΠΕΡΙΛΗΨΗ

Μελέτη του τρόπου διαχείρισης των περιστατικών γυναικών με παθήσεις αιδοίου στην πρωτοβάθμια φροντίδα υγείας σε μια αστική περιοχή στην Αγγλία

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ΣΚΟΠΟΣ Η μελέτη της συχνότητας των παθήσεων του αιδοίου, των σχετικών παρακλινικών εξετάσεων και του τρόπου διαχείρισης αυτών των περιστατικών στο πλαίσιο της πρωτοβάθμιας φροντίδας υγείας. Επίσης, η ανίχνευση τυχόν αναγκών εκπαίδευσης των γενικών ιατρών στις παθήσεις αιδοίου. **ΥΛΙΚΟ-ΜΕΘΟΔΟΣ** Πρόκειται για μελέτη η οποία διενεργήθηκε με τη χρήση ερωτηματολογίου, αποτελούμενου από 13 ερωτήσεις, το οποίο δόθηκε σε γενικούς ιατρούς κατά τη διάρκεια εκπαιδευτικής ημερίδας τους στην περιοχή Shropshire West Midlands. **ΑΠΟΤΕΛΕΣΜΑΤΑ** Έγινε συλλογή 107 ερωτηματολογίων από ένα σύνολο 120 ερωτηματολογίων που μοιράστηκαν (ανταπόκριση: 89,1%). Το 67,3% των συμμετεχόντων ανέφεραν ότι εξέταζαν >5 ασθενείς τον μήνα με παθήσεις αιδοίου, και ότι μόνο το 24,6% εξέταζε >5 ασθενείς τον μήνα με υποτροπιάζοντα συμπτώματα παθήσεων του αιδοίου. Το κυρίαρχο σύμπτωμα μεταξύ των γυναικών ήταν κνησμός αιδοίου (77,5%), με το 94,5% των γενικών ιατρών να θεωρεί ότι ο σκληρυντικός λειχήνας αποτελεί τη συχνότερη διάγνωση. Στην περίπτωση υποτροπιάζοντος κνησμού αιδοίου, η ασθενής παραπεμπόταν σε γυναικολόγο στην πλειοψηφία των περιπτώσεων (86%). Αντίθετα, σε περίπτωση αιδοιοδυνίας μόνο μικρός αριθμός γενικών ιατρών παρέπεμπε την ασθενή σε γυναικολόγο (8,4%) ή σε δερματολόγο (17,3%). Μόνο το 41,1% των γενικών ιατρών έλαβε κάποιας μορφής εκπαίδευση στις παθήσεις αιδοίου, με το σύνολο των γενικών ιατρών (100%) να συμφωνεί ότι κάποιο επίσημο πρόγραμμα εκπαίδευσης στη διάγνωση και στη θεραπεία των παθήσεων αιδοίου θα επέφερε όφελος στη φροντίδα των ασθενών τους. **ΣΥΜΠΕΡΑΣΜΑΤΑ** Η παρούσα μελέτη έδειξε ότι υπάρχει ολοένα αυξανόμενος αριθμός γυναικών με παθήσεις αιδοίου, οι οποίες προσέρχονται στην πρωτοβάθμια φροντίδα υγείας. Επίσης, φάνηκε ότι υπάρχει ποικιλομορφία τρόπων προσέγγισης ως προς τη διάγνωση και τη θεραπεία των παθήσεων αιδοίου από τους γενικούς ιατρούς. Όλοι οι γενικοί ιατροί συμφώνησαν ότι υπάρχει ανάγκη για επίσημη εκπαίδευση στις παθήσεις αιδοίου στο πλαίσιο της πρωτοβάθμιας φροντίδας υγείας.

Λέξεις ευρετηρίου: Αιδοιοδυνία, Κνησμός αιδοίου, Παθήσεις αιδοίου, Πρωτοβάθμια φροντίδα υγείας

References

1. ROYAL COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS. Vulval skin disorders, management. Green-top guideline no 58. RCOG, London, 2011
2. REED BD, HARLOW SD, SEN A, LEGOCKI LJ, EDWARDS RM, ARATO N ET AL. Prevalence and demographic characteristics of vulvodynia in a population-based sample. *Am J Obstet Gynecol* 2012, 206:170.e1–e9
3. BRITISH ASSOCIATION FOR SEXUAL HEALTH AND HIV. 2014 UK national guideline on the management of vulval conditions. BASSH, 2014
4. ROYAL COLLEGE OF GENERAL PRACTITIONERS. The RCGP curriculum: Professional and clinical modules – 2.01–3.21 curriculum modules. RCGP, London, 2016
5. NUNNS D, MANDAL D. The chronically symptomatic vulva: Prevalence in primary health care. *Genitourin Med* 1996, 72:343–344
6. BORNSTEIN J, GOLDSTEIN AT, STOCKDALE CK, BERGERON S, PUKALL C, ZOLNOUN D ET AL. 2015 ISSVD, ISSWSH and IPPS Consensus Terminology and Classification of Persistent Vulvar Pain and Vulvodynia. *Obstet Gynecol* 2016, 127:745–751

7. JONES RW, ROWAN DM, STEWART AW. Vulvar intraepithelial neoplasia: Aspects of the natural history and outcome in 405 women. *Obstet Gynecol* 2005, 106:1319–1326
8. POLTERAUER S, CATHARINA DRESSLER A, GRIMM C, SEEBACHER V, TEMPFER C, REINTHALLER A ET AL. Accuracy of preoperative vulva biopsy and the outcome of surgery in vulvar intraepithelial neoplasia 2 and 3. *Int J Gynecol Pathol* 2009, 28:559–562
9. STOCKDALE CK, LAWSON HW. 2013 vulvodynia guideline update. *J Low Genit Tract Dis* 2014, 18:93–100
10. ANDREWS JC. Vulvodynia interventions – systematic review and evidence grading. *Obstet Gynecol Surv* 2011, 66:299–315
11. PAPOUTSIS D, HAEFNER HK, CRUM CP, OPIPARI AW Jr, REED BD. Vestibular mast cell density in vulvodynia: A case-controlled study. *J Low Genit Tract Dis* 2016, 20:275–279
12. BORNSTEIN J, GOLDSCHMID N, SABO E. Hyperinnervation and mast cell activation may be used as histopathologic diagnostic criteria for vulvar vestibulitis. *Gynecol Obstet Invest* 2004, 58:171–178
13. CHATTERJEA D, MARTINOV T. Mast cells: versatile gatekeepers of pain. *Mol Immunol* 2015, 63:38–44
14. JONES RW, JOURA EA. Analyzing prior clinical events at presentation in 102 women with vulvar carcinoma: Evidence of diagnostic delays. *J Reprod Med* 1999, 44:766–768

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