ALSVH thanks a UK dermatologist and author of the BAD guidelines for lichen sclerosus for their comments, below, on VIN.

The article was requested after ALSVH received many emails from women over 50, diagnosed with lichen sclerosus and receiving a diagnosis of VIN, who are routinely told by uneducated medical professionals, across dermatology, gynaecology and sexual health, that they have a sexually transmitted disease. This has caused severe distress and needs to be addressed.

Differentiated VIN and lichen sclerosus

VIN stands for vulval intraepithelial neoplasia and occurs when the upper layers of the skin start to turnover in an abnormal way. The most common type of VIN is caused by human papilloma virus infection in a similar way to where there are abnormal cells on a cervical smear test.

A much less common type of VIN is differentiated VIN (dVIN) which occurs on a background of lichen sclerosus or less commonly lichen planus. This does not have a typical appearance but must always be considered in any area of lichen sclerosus that is eroded, ulcerated or thickened and which does not respond to increased application of a topical steroid. Your doctor should want to biopsy this but it is important that they work closely with the pathologist as the features of dVIN can be very subtle. In this type of VIN, the changes only occur at the base of the upper layer of the skin (epidermis) and above this the epidermis looks normal and the progression of cells through it is normal, hence the term differentiated. This is in contrast to the common type of VIN where the whole thickness of the epidermis is abnormal and so is called undifferentiated.

If dVIN is found, then the area should be removed surgically by excision as there is a higher risk of this developing into a vulval cancer. Patients with this problem should be seen in a specialist vulval clinic for management and follow-up.