Ashford and St. Peter's Hospitals
NHS Foundation Trust

Pre-pubertal Gynaecological problems

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Guideline History		
Date	**Comments**	**Approved By**
17/01/2022	First ratified	Paediatric Guideline Committee

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Contents

1.

Vulvovaginitis/ Vulval dermatitis

Background:
Prepubertal anatomy plays a major aetiological role –close anatomical proximity of the rectum; lack of labial fat pads and pubic hair; small labia minora; thin and delicate vulvar skin; thin, atrophic, anoestrogenic vaginal mucosa; and children's tendency to have poor local hygiene and to explore their bodies. All these factors make the vagina and vulva more susceptible to inflammation and infection. Especially when young girls take on more responsibility of own hygiene.

Vulvovaginitis is the most common cause of prepubertal vaginal discharge. Most new-born girls have small amounts of mucoid white vaginal discharge. After 3 months of age until puberty, physiological vaginal discharge is minimal.

Symptoms are itching (50%), discharge (60-90%) redness and soreness (74-82%), and dysuria (19%). Occasionally itching, soreness and discharge can be severe and persistent.

Causes :
Infective

- Non-specific with mixed bacterial flora (most common cause – 75%)
- Group A beta-haemolytic streptococcus, Haemophilus influenzae,
- Candida (unusual – Diabetes/antibiotics use/sexual abuse)
- Systemic infections : Varicella, Measles, Rubella, Diphtheria, Shigella

Chemical
Vulval dermatitis: Soap, Bubble baths, Playing in a sandpit, prolonged contact of urine and faeces, skin Irritants, e.g., perfume, clothing dye

What should I do?
In mild cases, no investigations are necessary. Explanation / reassurance

- If discharge is profuse / offensive – take a swab from the introitus
  - If positive for organisms (group A Streptococcus, Haemophilus, Gardnerella) treat with appropriate antibiotics.
- If discharge is bloody, or offensive and persistent, consider a foreign body.
- If perianal or vulval itch/irritation is a major symptom, consider threadworms and treat accordingly.
- If there is skin disease elsewhere, consider eczema and psoriasis as possible causes.

Refer if severe and /or persistent symptoms

Treatment of vulvovaginitis

- Careful vulval hygiene to relieve symptoms and help to prevent recurrence:
- Ensure that the bottom is completely clean after defaecation
- Avoid constipation
- Wipe from front to back
- Avoid soaps and bubble baths
- Sitz baths
- Ensure that the vulval area is properly dry after bathing.
- Ensure legs are wide apart when passing urine.
- Avoid tight clothing, especially jeans
- Wear cotton underwear
- Do not wear underwear in bed
- Use gentle emollients and barrier creams

Refer to

1. Gynae ASPH *(Dr Raji)*
2. UCLH (https://www.uclh.nhs.uk/our-services/find-service/womens-health-1/gynaecology/paedatric-gynaecology)

References

Parent Leaflet :
https://ruh.nhs.uk/patients/services/clinical_depts/paediatrics/documents/patient_info/PAE044_Vulvovaginitis_in_young_girls.pdf

Caveat : Always consider NAI where appropriate

Lichen sclerosis (Hypotrophic dystrophy of the vulva)

Background:
A chronic skin disorder of presumed auto immune origin. Commonly seen in postmenopausal women, but also seen in prepubertal girls. Prevalence between 1 in 900 girls, although it may be under-reported and under-recognized.

It usually presents with severe vulval pain and itching. Secondary constipation is also a common complication due to pain and withholding.

Appearance - white, flat-topped papules, thin plaques, or commonly atrophic patches. Purpura is a hallmark feature of vulvar LS. Hyperpigmentation, erosions, and ulceration can result. Figure-of-eight pattern encircling the vagina and anus.

Note - Ecchymosis may be very striking and potentially mistaken as evidence of **sexual abuse**. However, the two are not mutually exclusive as some cases of LS may possibly be caused or aggravated by sexual abuse. Suspicious features include LS arising in older prepubertal girls, poor response to treatment, the presence of associated STI or symptoms/signs of abuse.

What should I do?

If symptoms are mild, no treatment other than an emollient/soap substitute is needed.

In more severe cases, use of a topical corticosteroid such as Clobetasol propionate 0.05%, twice daily for 3 months. Will require Maintenance therapy (lower potency topical steroids/ Low-concentration topical tacrolimus) long term and may flare up again once off treatment (requiring restarting clobetasol again).

Girls with LS should be seen at 3 months after the initial consultation and then 6 months later, Follow-up should continue until at least puberty in all cases. Although childhood LS often improve at puberty, there may be cases that persist into adulthood and the patient should be made aware of this. Long-term follow-up may be needed for those patients with ongoing disease activity. Malignancy has been very rarely reported in girls but scarring/atrophy can occur.

Refer female children and young people with LS to specialized gynaecology services (vulval clinic, dermatologist, gynaecology clinic)

References

Parent Leaflet
https://www.ouh.nhs.uk/patient-guide/leaflets/files/14028Plichensclerosus.pdf

Vaginal bleeding

Background
Age is important:
New-born:

- Common to have slight vaginal bleeding in the first week of life (Physiological Menstruation) due to withdrawal of maternal oestrogens. Requires no investigation or treatment.

Older girls:
Blood-stained discharge in an older girl, consider:

- Onset of first menstruation
    - Consider precocious puberty if before 8 years of age. Refer to Endocrine Services
- Vaginal foreign body
    - Toilet paper, a small plastic toy, a cap, or other small objects. Bleeding in such a situation might be accompanied by pelvic pain and a foul-smelling discharge.
- Trauma (including straddle injury and sexual abuse)
    - Most common injury is a straddle injury following a fall on the edge of some object. It rarely results in deep lacerations and usually spares the hymen and the vagina; ecchymosis and swelling are typical.
    - A nonaccidental trauma with vaginal bleeding may be the result of **sexual abuse**. When attempting to assess whether the injury was accidental or not, it is essential to consider if the harm matches the story provided by the parents or caregivers
- Excoriation associated with threadworms
- Topical dermatitis (eczema, psoriasis),severe vulvovaginitis, Lichen Sclerosis.
    - Trauma from rubbing or scratching pruritic areas can lead to prepubertal vaginal bleeding as the presenting symptom of a vulvar dermatologic condition
- Haematuria
- Urethral prolapse (inflamed “doughnut” of tissue is visible at the urethral meatus)
- Malignancy (rare)
    - Most common malignant tumor in young girls (usually 2-5yrs) is rhabdomyosarcoma, specifically, sarcoma botryoides (intralabial grape-like, vesicular mass).
    - Under 2 years may present with an Endodermal sinus tumors with vaginal bleeding and discharge, and a polypoid or sessile tumor originating from the posterior fornix.

Labial Adhesions

Background

Adherence of the medial edges of the labia minora, due to a combination of thin vaginal mucosa and minor irritation (wet nappies, soaps). Most frequently between 13 and 23 months of age when the oestrogen level is physiologically low. This is a normal variant and will resolve spontaneously in late childhood. In 8 out of 10 cases a fusion corrects itself within a year. There is a risk of it coming back, but this usually stops after puberty begins with higher oestrogen levels. Labial fusion is not linked to any medical condition and has no long-term effects – it will not affect fertility or future sexual life.

35% asymptomatic. Infrequently it can cause urinary dribbling, vulval irritation and soreness.

What Should I Do?

Provided the child is able to void easily, no treatment is needed other than reassurance. The condition may be left alone for the labia to separate on its own, over time.

For moderate cases, where the lower part of the vagina may be covered, treatment may involve several weeks of applying a mild emollient ointment and gentle separation.

For more severe cases, with coverage of vaginal/urethral opening, may prescribe an estrogen-based cream (Estriol 0.01% - twice a day for 6-8 weeks). Side effects can include irritation around the genital area, temporary pigmentation, vaginal spotting after the cream discontinued).

Rarely, Referral for surgical separation of the labia is required.

References:

Parent Leaflet

https://www.ouh.nhs.uk/patient-guide/leaflets/files/30426Plabial.pdf

Tips for Gynaecological examination of the prepubertal girl

This must be done with sensitivity and gentleness. If the girl is very small the examination can be done with her on her mother's lap. However, if older she should lie on the couch with her legs in the frog-leg position.

Gentle separation and retraction of the labia should allow visualisation of the external genitalia, introitus and hymen.

Discharge can pool in the posterior fourchette and a swab can be taken from this area. Standard swabs used in adults for high vaginal swabs may be too large, in which case, a small, wire, cotton-tipped swab should be used.

If visualisation is difficult, placing the child in the knee–chest position can sometimes allow a better view. Instrumentation of the vagina in an awake, prepubertal girl can be painful, unpleasant and distressing for her and should be avoided

ASPH Chaperone Policy

https://www.ashfordstpeters.info/images/policies/PAT149.pdf

2. Supporting References

1. Birmingham Outpatient Guidelines https://bwc.nhs.uk/download.cfm?doc=docm93jijm4n3110.pdf&ver=4641)
2. Stricker, T. (2003). Vulvovaginitis in prepubertal girls. *Archives Of Disease In Childhood*, *88*(4), 324-326. doi: 10.1136/adc.88.4.324
3. Garden, A. (2010). Vulvovaginitis and other common childhood gynaecological conditions. *Archives Of Disease In Childhood - Education And Practice*, *96*(2), 73-78. doi: 10.1136/adc.2009.181883
4. Lewis FM, Tatnall FM, Velangi SS, et al. British Association of Dermatologists guidelines for the management of lichen sclerosus, 2018. *Br J Dermatol*. 2018;178(4):839-853. doi:10.1111/bjd.16241
5. Holliday, K., & Agwu, J. (2018). Vaginal bleeding in the pre-pubertal child. Paediatrics And Child Health, 28(3), 144-148. doi: 10.1016/j.paed.2018.01.002
6. Collins, J., Maney, J., & Livingstone, A. (2020). Fifteen-minute consultation: Apparent vaginal bleeding in the pre-pubertal girl. *Archives Of Disease In Childhood - Education & Practice Edition*, *106*(3), 142-148. doi: 10.1136/archdischild-2018-316218

3. Supporting relevant trust guidelines

N/A

2. Guideline Governance

a. Scope

This guideline is relevant to all staff caring for all children from 0-18 years old across the emergency department, inpatient ward and outpatient department.

b. Purpose

i. This guidelines aims to facilitate a common approach to the management of children. At times deviation from the guideline may be necessary, this should be documented and is the responsibility of the attending consultant.

ii. This guideline is subject to regular review to ensure ongoing evidence based practice.

c. Duties and Responsibilities

All healthcare professionals responsible for the care of all children 0-18years should be aware of practice according to this guideline.

d. Approval and Ratification

This guideline will be approved and ratified by the Paediatric Guidelines Group.

e. Dissemination and Implementation

i. This guideline will be uploaded to the trust intranet 'Paediatric Guidelines' page and thus available for common use.
ii. This guideline will be shared as part of ongoing education within the Paediatric Department for both medical and nursing staff.
iii. All members of staff are invited to attend and give comments on the guideline as part of the ratification process.

f. Review and Revision Arrangements

a. This policy will be reviewed on a 3 yearly basis by the appropriate persons.
b. If new information comes to light prior to the review date, an earlier review will be prompted.
c. Amendments to the document shall be clearly marked on the document control sheet and the updated version uploaded to the intranet. Minor amendments will be ratified through the Paediatric Guidelines Group. A minor amendment would consist of no major change in process, and includes but is not limited to, amendments to documents within the appendices.

g. Equality Impact Assessment

Background • Who was involved in the Equality Impact Assessment
Author and the supervising consultants.
Methodology • A brief account of how the likely effects of the policy was assessed (to include race and ethnic origin, disability, gender, culture, religion or belief, sexual orientation, age) • The data sources and any other information used • The consultation that was carried out (who, why and how?)
All groups of staff and patients were taken into consideration and there is no bias towards or against any particular group.
Key Findings • Describe the results of the assessment • Identify if there is adverse or a potentially adverse impacts for any equalities groups
There is no evidence of discrimination.
Conclusion • Provide a summary of the overall conclusions
There is no evidence of discrimination.
Recommendations • State recommended changes to the proposed policy as a result of the impact assessment • Where it has not been possible to amend the policy, provide the detail of any actions that have been identified • Describe the plans for reviewing the assessment
This guideline is appropriate for use.

h. Document Checklist

To be completed (electronically) and attached to any document which guides practice when submitted to the appropriate committee for approval or ratification.

Title of the document: Pre-pubertal gynaecological problems

Policy (document) Author: Asma Azmatullah

Executive Director: N/A

		Yes/No/ Unsure/NA	Comments
1.	**Title**		
	Is the title clear and unambiguous?	**Y**	
	Is it clear whether the document is a guideline, policy, protocol or standard?	**Y**	
2.	**Scope/Purpose**		
	Is the target population clear and unambiguous?	**Y**	
	Is the purpose of the document clear?	**Y**	
	Are the intended outcomes described?	**Y**	
	Are the statements clear and unambiguous?	**Y**	
3.	**Development Process**		
	Is there evidence of engagement with stakeholders and users?	**NA**	
	Who was engaged in a review of the document (list committees/ individuals)?		**Dr Alison Groves, Dr James Thomas**
	Has the policy template been followed (i.e. is the format correct)?	**Y**	
4.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	**Y**	

		Yes/No/ Unsure/NA	Comments
	Are local/organisational supporting documents referenced?	**n/a**	
5.	**Approval**		
	Does the document identify which committee/group will approve/ratify it?	**Y**	
	If appropriate, have the joint human resources/staff side committee (or equivalent) approved the document?	**N/A**	
6.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	**Y**	
	Does the plan include the necessary training/support to ensure compliance?	**N/A**	
7.	**Process for Monitoring Compliance**		
	Are there measurable standards or KPIs to support monitoring compliance of the document?	**N/A**	
8.	**Review Date**		
	Is the review date identified and is this acceptable?	**Y**	
9.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for coordinating the dissemination, implementation and review of the documentation?	**Y**	
10.	**Equality Impact Assessment (EIA)**		
	Has a suitable EIA been completed?	Y	

Committee Approval (Paediatric Guidelines Group)			
If the committee is happy to approve this document, please complete the section below, date it and return it to the Policy (document) Owner			
Name of Chair	**Dr Claire Mitchell**	**Date**	**31/03/2022**
Ratification by Management Executive (if appropriate)			
If the Management Executive is happy to ratify this document, please complete the date of ratification below and advise the Policy (document) Owner			
Date: n/a			