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MAGAZINE

THE VULVA

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Obituary

RANZCOG acknowledges and pays respect to the Traditional Custodians of the lands, waters and communities across Australia, on which our members live and work, and to their Elders, past, and present. RANZCOG recognises the special status of Māori as tangata whenua in Aotearoa New Zealand and is committed to meeting its obligations as Te Tiriti o Waitangi partners.

Vol. 27 No. 2 Winter 2025

From the President

Dr Gillian Gibson
FRANZCOG, RANZCOG President

The College's advocacy efforts across our two countries have continued without pause. In March, the Australian federal budget was released. It contained significant funding for women's health in Australia. How this investment is put into practice to benefit Australian women, now that the results of the election are known and the re-elected Labor Government begins its term, is yet to be seen. The College's report on advocacy developments is highlighted in this issue of *O&G Magazine*.

It is a difficult health system environment for Fellows and trainees in Aotearoa New Zealand. With a new Minister of Health, ongoing focus on financial savings, restructures and delivery of health targets, alongside huge workforce pressures, especially in our regional hospitals, there are challenges ahead. There have been some wins with Pharmac agreeing to fund both Estradot and Estradiol menopause patches, and to fund the desogestrel (Cerazette) progestogen-only oral contraceptive pill. Te Kāhui Oranga ō Nuku is continuing to advocate for structured clinical leadership for women's health at a government level, and to highlight lack of access to gynaecological care, particularly for the management of endometriosis and urogynaecological conditions. RANZCOG provided written and oral feedback on the Pae Ora (Healthy Futures) (3 Day Postnatal Stay) Amendment Bill, noting lack of evidence that longer postnatal stays would improve outcomes and raising concern about funding and capacity to implement longer stays.

I acknowledge with sadness the recent death of Emeritus Professor Ronald William Jones CNZM (1939-2025) who leaves a substantial legacy in New Zealand medical history. He established the first dedicated vulva clinic in New Zealand, just one of his many achievements. He bravely spoke out against unethical treatment of women with cervical abnormalities at National Women's Hospital in the 1980s, resulting in the Cartwright Inquiry, which led to changes to medical ethics and the rights of health consumers. I benefited enormously from Ron's teaching, mentorship and friendship. More recently, he rang me to say how honoured he was to receive a prestigious award from the American Association for the Advancement of Science, the only New Zealander to have ever received this distinction. Ron's significant contribution to women's health in New Zealand is acknowledged in an obituary in this edition of *O&G Magazine.*

Reflecting on my term as RANZCOG President as I approach the end of my time in this role in October, I want to thank every one of our members and trainees for the support you provide the College. I am so grateful for the dedication of the Board, Councillors, our many committee members and RANZCOG staff. I extend my heartfelt congratulations to President-Elect Dr Nisha Khot, who will take over stewardship of the College later this year.

Advocacy Update

Budget

The Australian federal budget was a win for women, through the pledge of a $793 million women's health package. The package featured investments in many areas of women's health that the College has been calling for over time. This investment should make medications cheaper, accessing care easier and provide more choice.

The new listing of contraceptives and menopause therapies on the Pharmaceutical Benefits Scheme (PBS), while reducing the maximum cap on out-of-pocket costs to fill prescriptions will significantly improve women's ability to choose the medications that are best suited to them without additional undue financial stress—no small feat in this era of accelerating cost of living. From a health perspective, this expansion of available medications has been a long time coming, and it is something the College has been advocating for through many avenues, such as the 2024 roundtable on medicines and devices shortages. Shortages of key medicines and devices will remain an issue – this budget does not address that persistent problem – and The College will continue making the case that a complete rethink is needed on how to best secure adequate supplies of essential medicines and devices.

Women will further benefit by increases in Medicare Benefits Scheme (MBS) rebates for insertion and removal of long-acting reversible contraceptives (LARC). This makes the choice of a LARC more financially viable for women who may wish to choose that option; again allowing women to have greater autonomy over their own health and power over their reproductive freedom. The College has been heavily involved in consultations with the Australian Department of Health and Aged Care throughout 2024 and into 2025 about how better access to LARC care can be supported, and financial barriers is one area that has been consistently raised.

RANZCOG™
Excellence in Women's Health

Election of President for the Fourteenth RANZCOG Council

Following the conduct of the election for President of the Fourteenth RANZCOG Council, and the announcement at the March 2025 Council Meeting, Dr Nisha Khot is declared the President-Elect for the Fourteenth RANZCOG Council, to take office from October 2025 to October 2027.

Dr Khot shall assume the office of President at the conclusion of the 2025 Annual General Meeting and until then, shall be known as the President-Elect.

The RANZCOG Board and Council congratulates Dr Nisha Khot on her election.

Furthermore, the expansion of funding for pelvic pain-related MBS items also makes it easier to seek care for such pain and conditions like endometriosis, as does dedicated funding to expand the footprint of endometriosis and pelvic pain-specific clinics. This is also something the College has supported, for example in through participation in the South Australian Select Committee on Endometriosis in 2024.

The budget did not contain specifics to support the specialist health professional workforce. The College was relieved to see money for hospitals, and specifically money to support the maternity wards in Hobart and Gosford in light of the challenges both those communities face. But in the long-term, much more needs to be done to support the range of health professionals – including specialist O&Gs – who staff these hospitals and make it attractive and sustainable to work in currently underserved areas. This is particularly true in rural, regional and remote communities. It is critical that the government tackle the systemic issues fueling workforce shortages and make consistent ongoing investments in upskilling and training for *all* healthcare professionals, so that women can continue to receive the care they need and deserve, close to home.

Election

The College congratulates re-elected Labor Government and Prime Minister Albanese, as well as all newly elected and returned Members of Parliament and Senators. During the lead-up to the election season and during the campaign, the College was reassured to see support for women's health across the aisle. Women's health should not be the territory of any one political point of view, and the College remains committed – as always – to working with any government to advance the health of women and girls.

The College used the opportunity presented by the federal election to socialise a number of key priorities that are important to progress in the next term of government. These priorities were: a movement towards a national free contraceptive plan; a comprehensive approach to tackling systemic gender bias in health care; more support for a sustainable health workforce, eliminating the persistent shortages of medicines and devices, and finally reform of how private maternity and gynaecology services are supported by government.

Prior to Christmas 2024, with the expectation of an Autumn campaign, the College wrote to the leaders of the parties with seats in Parliament as well as the crossbench Independent MPs calling for the consideration of a national free contraception program modeled on the one recently adopted in Canada. While the federal budget includes welcome investments in contraception, true reproductive freedom for women in Australia can only be achieved by removing financial barriers entirely. Both Labor and the Coalition put their policy to the electorate through matching the initiatives in the budget funding package, primarily the additional listing of contraceptives on the PBS as mentioned. The Australian Greens went further in supporting the concept of free contraception, and the College heard from a number of the Independent MPs in the last Parliament with interest in being involved in developing this policy as well.

The College's advocacy for gender equity predates the election, and continues to push the parties to commit to a true review of our health institutions – be that the MBS and PBS, medical research, or in the legislative framework governing private health insurance – to identify and eliminate policy settings that bake in gender bias. There is openness to this across the political spectrum; the next steps are to push for this to actually happen.

With access to reproductive freedom under threat domestically and overseas, and access not always what it should be here in Australia, the College has also been vocal about the need to expand training and education in sexual and reproductive health care to a wider range of health professionals. This expands access for women seeking reproductive support, and when needed, abortion care, by ensuring that there are skilled and experienced health professionals available to them.

Finally, RANZCOG continued to highlight the urgent need to resolve the crisis in private health care, with much more needing to be done, and urgently, as the new term of government begins. Closures of private maternity wards in several communities put the challenges in stark relief. This isn't a theoretical problem; it is affecting women now. Our government needs to meet the moment and shore up this vital side of our health care system. The College has called for a serious effort to reform the risk equalisation framework to allow obstetrics and gynaecology services to be provided in a wider range of private insurance products.

Looking ahead

With the campaign behind us and the new term of government getting started, the political environment for the next few years is relatively clear. Significant policy challenges that will affect obstetrics and gynaecology remain. The pressure on private health care remains acute, and there is no clear long-term program from elected leaders to put private practice on a sustainable footing. The College will continue to push for this with the federal government, working with stakeholders to advance the recommendations of our private practice roundtable.

LEADERS IN FOCUS

Dr Talat Uppal
FRANZCOG, FAAQHC, FACHSM, DDU

This feature sees Dr Talat Uppal in conversation with women's health leaders in a broad range of leadership positions. We hope you find this an interesting and inspiring read.

Join the conversation on Instagram
#Celebratingleadership
@RANZCOG

Dr Rebecca Saunderson
Chief Executive Officer, Consentic
BMedSci (hon1), MBBS (hon), MPhil (cantab) FACD

Introducing Dr Rebecca Saunderson

Dr Rebecca Saunderson is a consultant dermatologist and the Chief Executive Officer of Consentic, a digital health platform that is reshaping the way clinicians engage with patients around medical consent. Dr Saunderson has expertise in managing both adult and paediatric skin conditions, with additional experience in female genital dermatology and complex medical conditions that occur in the skin. Dr Saunderson brings both clinical insight and academic excellence to her work, having earned First-Class Honours in Medicine and Medical Science and completed a Master of Philosophy in Infectious Diseases at the University of Cambridge as a Gates Cambridge Scholar. Drawing on years of experience treating patients and navigating the intricate world of medical consent, Dr Saunderson co-founded Consentic to bridge a crucial gap in patient understanding. Her dual lens as a dermatologist and a digital health leader offers valuable insight into the evolving landscape of women's health, consent, and care.

What drew you to focus on vulval dermatology and women's health?

Working in dermatology, I became increasingly aware of how under-recognised and under-treated vulval skin conditions were, not just by patients, but often by clinicians too. Vulval dermatology sits at the intersection of dermatology, gynaecology, sexual health, and often psychology. I was drawn to the complexity and the opportunity to make a meaningful difference for women whose symptoms had often been minimised or dismissed. Vulval conditions are invisible diseases, and women can suffer in silence for years due to stigma, lack of access to expertise, or misdiagnosis. I wanted to be part of changing that.

What are the most common misconceptions about vulval conditions you encounter?

One of the most damaging misconceptions is that symptoms like pain, itching, burning, or irritation are "just in the patient's head". Many women are told their distress is psychological or related to anxiety, particularly when no obvious signs are visible on examination. This minimisation can delay diagnosis and erode trust in the medical system.

Is there one vulval condition you feel deserves more awareness or research focus?

Lichen planus, particularly erosive vulval lichen planus, is significantly under-recognised and often misdiagnosed. It can cause severe discomfort, scarring, and sexual dysfunction, yet there are no approved treatments and limited high-quality data to guide management.

We are currently running a clinical trial investigating Deucravacitinib, a selective TYK2 inhibitor, compared to methotrexate, for erosive lichen planus.

How do you see digital tools like Consentic improving patient experience, particularly in procedures such as vulval biopsies? Would you be able to share a screenshot or example of a digital consent template that might be used in this context?

Digital tools like Consentic are transforming how we engage with patients, not only at the point of consent but throughout their entire journey.

In vulval care, many patients have had difficult, fragmented healthcare experiences. Consentic helps streamline and humanise that process. When integrated with practice management systems like Gentu, patients can complete their patient registration, medical history, and relevant surveys, such as the Vulval Quality of Life Index (VQLI), online, at their convenience. This means clinicians have the information they need before the consultation, stored securely and accessibly in the patient file.

Practitioner speaking to patient

When it comes to procedures, patients can watch short, clear animated videos that explain what to expect, the risks and the alternatives. This helps reduce anxiety and ensures patients are genuinely informed. The completed consent is then linked directly to the clinical file, ensuring transparency and continuity of care.

By digitising and integrating these steps, we're not only improving the quality and consistency of information, but also reducing administrative burden, minimising errors, and empowering patients to take a more active role in their care.

What are you most excited about in the future of women's health regarding vulval care? Do you feel AI will make diagnosis easier in future?

I'm particularly excited about the emerging role of biologics, especially Janus kinases (JAK) inhibitors, in the treatment of vulval diseases like lichen planus and lichen sclerosus. These therapies, which target specific pathways involved in inflammation, have shown great promise in other areas of dermatology, and I believe they could dramatically improve the quality of life for women with chronic vulval conditions. These will be game changers.

I'm not sure about AI in terms of clinical examination diagnostics, but certainly, it can be helpful for history taking and reducing administrative tasks in clinics.

What advice would you give to younger doctors interested in caring for women in this context?

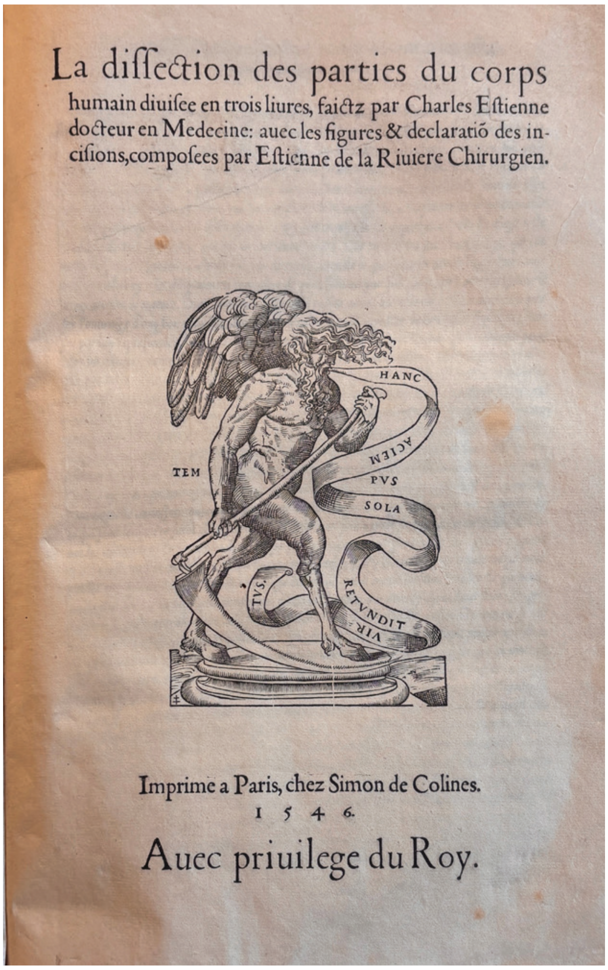
You'll have many grateful patients and the sisterhood needs you! Caring for women's vulval health is incredibly rewarding. Many women have suffered in silence for years, and by specialising in this area, you can make a profound difference in their lives.

RANZCOG Historical Collection:

Charles Estienne's La dissection des parties du corps humain diuisee en trois liures, 1546

Greg Hunter
RANZCOG, Archivist and Historical Collections Administrator

The year is 1546. King Henry VIII is on the throne of England. In Rome, a 71-year-old Michelangelo is appointed the chief architect of the still unfinished St Peter's Basilica. In Paris, the vellum covered French edition of *Charles Estienne's La dissectione partium corporis humani libri tres* (1545) is published. This book, now close to 500 years old, is the oldest object held in RANZCOG's Historical Collection.



La diſſection des parties du corps
humain diuiſee en trois liures, faictz par Charles Eſtienne
docteur en Medecine: auec les figures & declaratiõ des in-
ciſions,compoſees par Eſtienne de la Riuiere Chirurgien.

Imprime a Paris, chez Simon de Colines.
1 5 4 6.
Auec priuilege du Roy.

Figure 1. Title page of Charles Estienne's La dissection des parties du corps humain diuisee en trois liures, 1546. (RANZCOG Frank Forster Library collection)

Charles Estienne (1504-1564), born in Paris, was the son of the notable printer, Henri Estienne. Between 1530 and 1534, Estienne studied in Padua, "learning Greek, botany, and natural science."[1] He later returned to Paris, undertaking medical study under the tutelage of Jaques Dubois (Sylvius) and obtaining his doctor's degree from the University of Paris in 1542.

With his printing connections, and medical knowledge, Estienne was ideally placed to add to the literature of medicine, with a particular interest in anatomy. Prior to the 1540s, only one fully illustrated anatomical text existed – Jacopo Berengario de Capri's *Isagoge breves*, published in 1522. During the 1530s, while studying under Sylvius, Estienne began the compilation of what would eventually become his own anatomical atlas.

To this end, Estienne hired a former classmate from the University of Paris, Etienne de la Rivière, to provide anatomical drawings for his atlas.[2] By the late 1530s, work on the manuscript was complete, and Estienne was set to publish. However publication was halted when a lawsuit was brought against Charles Estienne by de la Rivière, who accused him of plagiarism and demanded credit for performing "the dissections on which the illustrations were based."[1] The suit was successful, and Estienne "was required to credit de la Rivière in his text for anatomical preparations and figures."[3] This process delayed publication of Estienne's atlas until 1545, by which time another classmate of Estienne, Andreas Vesalius, had published his own illustrated anatomical atlas, *De Humani Corporis Fabrica* (1543). Vesalius's encyclopaedic text was revolutionary. Stretching to seven volumes, and complete with exquisite illustrations, it has since become one of the most famous and highly regarded texts in the history of medicine and anatomy.

Despite being overshadowed by the work of Vesalius, Estienne's publication was nonetheless very significant. It was "the first text to illustrate step by step dissections,"[3] with illustrations in the atlas being derived from real dissections undertaken by Estienne and de la Rivière. The construction of many of these images is fascinating. To complete his work, "Estienne took some of his illustrations from non-anatomical books, replacing a section of the woodblock with an insert that depicted the body's interior."[1] Some have suggested this was a cost saving measure, while others have suggested this was a deliberate choice on behalf of Estienne to evoke "the antiquity of dissection".[3]

300 DE LANATOMIE,ET DISSEC. DES PARTIES

A La maniere comment chaſcun des deux enfans/qui ſont dens le corps/eſt garny de ſon enuelope particuliere.
B Les neudz autour du petit boyau qui entre au nõbril de l'enfant/ entourans le col & les bras d'iceluy.

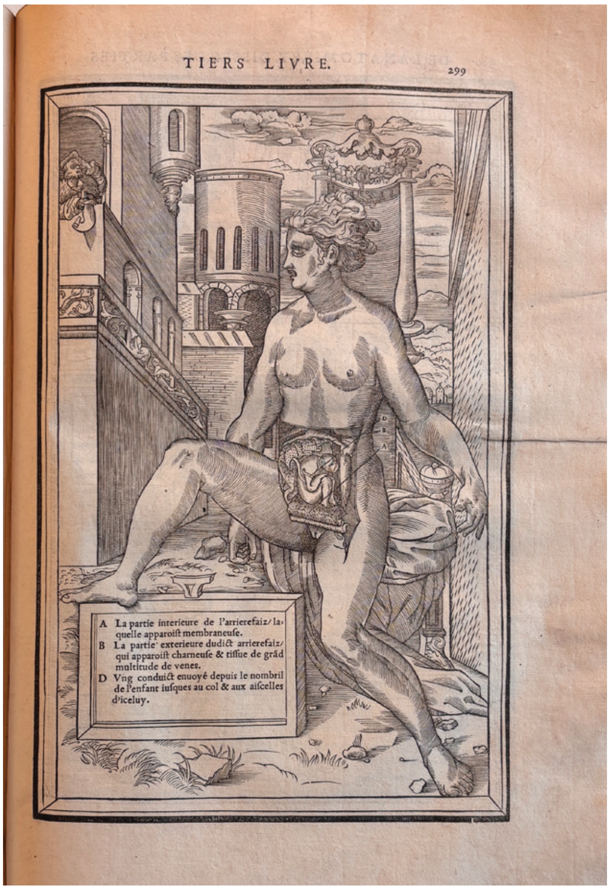
Figure 2. An illustration from Estienne's atlas. Note the very clear rectangle around the illustration of the uterus, indicating that a smaller woodcut has been inserted into a pre-existing illustration to create this image. (RANZCOG Frank Forster Library collection)

Whatever the intention, the result of this decision is a series of fantastic illustrations where anatomy illustrations have been inserted into the bodies of nude figures "in heroic poses in a variety of classical landscapes, exposed on marble seats or propped up against trees."[3]

For illustrations of the female reproductive system, and the uterus, Estienne utilised poses "from a series of erotic prints by Jacopo Caraglio,"[1] and it has been suggested that the atlas was "popular beyond the academics of the day due to the often-erotic positions used in the illustrations." It is possible that this may even have been used "as a marketing ploy to sell copies outside of the local universities."[3]

History has arguably been unkind to Charles Estienne. Partly by virtue of being a contemporary of the famed Andreas Vesalius, Estienne's own contributions to reshaping medical orthodoxy have often been overlooked. Gernot Rath writes that "far more than any of his contemporaries Estienne ventured to doubt tradition… in his work," and was one of the first to cast doubt upon the teachings of Galen, a Roman and Green physician whose ideas had dominated medicine for more than a millennia.[4] Markatos and others agree, claiming that Estienne "was a real man of the Renaissance in his attempt to trust his own dissection and to criticize the traditional anatomic knowledge of his era."[2]

Estienne was also a medical innovator. He was the first person to demonstrate the existence of a canal through the spinal cord, as well "the first to trace blood-feeding microvessels into the substance of bone."[2] He recognised that "the esophagus and trachea were different organs with an entirely different function and purpose," and was also "a pioneer in the description and importance of the lymphatic system."[2]



TIERS LIVRE. 299

A La partie interieure de l'arrierefaiz/ laquelle apparoiſt membraneuſe.
B La partie exterieure dudict arrierefaiz/ qui apparoiſt charneuſe & tiſſue de grãd multitude de venes.
D Vng conduict enuoyé depuis le nombril de l'enfant iuſques au col & aux aiſcelles d'iceluy.

Figure 3. Another image from Estienne's atlas. Deliberately provocative, or a cost saving measure? You be the judge. (RANZCOG Frank Forster Library collection)

It would be an understatement to say medicine has changed a lot in 500 years. Estienne's *La dissection des parties du corps humain diuisee en trois liures* is a tangible reminder of where we have come from, having been published at a time when long-accepted ideas about anatomy and the human body were on the cusp of being completely reconceptualised. Who knows where medical knowledge will take us in another 500 years?

Charles Estienne's La dissection des parties du corps humain diuisee en trois liures (1546) was gifted to the Australian Regional Council of RCOG by its parent body in 1954. It was one of the very first objects acquired into the College's Historical Collection.

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Updates from our Research and Policy Team

Professor Cindy Farquhar
RANZCOG Dean of Policy & Research
MB ChB, MD, FRCOG, FRANZCOG, CREI,
MPH, MNZM, PMMRC

Acknowledging the theme of this issue, current RANZCOG clinical guidance statements and guidelines that help inform the topic of the vulva include:

- C-Gyn 1 Female Genital Mutilation/ Cutting (FGM/C) (2023)

The first half of 2025 has seen the publication of two significant pieces of work for the Research and Policy Team; the *Australian Living Evidence Guideline: Endometriosis*, and the *Miscarriage, Recurrent Miscarriage and Ectopic Pregnancy Clinical Guideline (C-Gyn 38).*

The *Australian Living Evidence Guideline: Endometriosis* updates the 2021 RANZCOG Endometriosis clinical practice guideline (the Foundation Guideline). In 2022, the Australian Government invited RANZCOG to update the Foundation Guideline and transition it into a living evidence format (Living Guideline). The Living Guideline builds on the Foundation Guideline and integrates the latest research. The use of living evidence enables clinical guidelines to respond to emerging evidence relevant to the Australian context and highlight areas where there is either low certainty or absent evidence to signal where further research is needed. A dissemination and implementation plan, for both primary and secondary care, has also been developed to support this important work.

The *Miscarriage, Recurrent Miscarriage, and Ectopic Pregnancy Clinical Guideline (C-Gyn 38)* is RANZCOG's first clinical guideline focused on early pregnancy loss. Developed by a multidisciplinary Guideline Development Group chaired by Dr Kasia Siwicki, this comprehensive guideline offers evidence-based recommendations and clinical guidance to registered health professionals in Australia and Aotearoa New Zealand providing care to women with suspected or confirmed early pregnancy loss.

Topics addressed include:

- Treatment options for incomplete and missed miscarriage
- Progesterone treatment for bleeding in early pregnancy, and for recurrent miscarriage
- Recurrent miscarriage, including screening tests
- Diagnosis and management of tubal ectopic pregnancy
- Management of non-tubal ectopic pregnancy (including interstitial, cervical, and caesarean scar ectopic pregnancies)
- Rh(D) Immunoglobulin (Anti-D)

In the remainder of 2025, the Research and Policy Team will continue or commence work covering other important areas, including:

- Intrapartum fetal surveillance (C-Obs 1) (anticipated 2025)
- Birth after caesarean (C-Obs 38) (anticipated 2025)
- Vasa praevia (C-Obs 47) (anticipated 2025)
- Menopause (C-Gyn 9) (anticipated 2026)
- Robotic Assisted Surgery in Gynaecology (C-Gyn 29) (anticipated 2026)

The Research and Policy Team and Women's Health Committee would like to thank all Guideline Development Group Chairs and members for their valued work. Opportunities to contribute to guideline development and provide feedback on draft work are advertised in *Connect*. Visit the RANZCOG website and select the Women's Health tab to access our clinical guidance documents.

RANZCOG's Endometriosis Research and Development Group

RANZCOG's Endometriosis Research and Development team. Left to right: Kate Smith, Magda Bofill, Professor Cindy Farquhar, Marian Showell

An Adventurous Soul – A Midwife's Experience Working in Yemen

Amy Carter
RM, MMid,
Fetal Medicine Specialist
Midwife

Mel Yean
RANZCOG, States and
Territories Support
Coordinator

Originally published in Midwife Aotearoa New Zealand, this article by Violet Clapham has been adapted for our readers in this edition of O&G Magazine."

My journey to this point in my career has been one of adventure and exploration, beginning with my move from Ireland to Aotearoa New Zealand in 2011. I spent over seven years in Hawke's Bay providing complex midwifery care and serving as a flight midwife. With plans for a one-year sabbatical, I travelled to Qatar. One year quickly turned into three as I found myself enjoying the experience, despite the culture shock. When I returned to Aotearoa New Zealand in 2020, I worked for a year on Auckland's North Shore before joining the Maternal Fetal Medicine team, where I focused on providing abortion care and contraceptive services. Driven by a desire to contribute to global health, in June 2023, I applied to Médecins Sans Frontières (MSF). The recruitment process was rigorous, involving a three-hour interview and comprehensive preparations, including securing visas, permits, and necessary vaccinations, but finally, after months of anticipation, I was deployed to Yemen.

Yemen's Complex Crisis

Since 2014, Yemen has been engulfed in civil war, leading to what the United Nations (UN) describes as the world's worst humanitarian crisis. The UN estimates that 60% of the estimated 377,000 deaths in Yemen between 2015 and the beginning of 2022 were the result of indirect causes like food insecurity and lack of accessible health services. Two-thirds of the population, or 21.6 million Yemenis, remain in dire need of aid, including 11 million children. An estimated 4.5 million people have been displaced. Another 5 million are at risk of famine, and a cholera outbreak has affected over one million people. All sides of the conflict are reported to have violated human rights and international humanitarian law.[1]

Political tensions are evident daily. Anti-American and anti-Semitic broadcasts contribute to the general mistrust of foreigners. In June 2024, more than 30 humanitarian workers were detained on espionage accusations, further increasing tension and uncertainty.[2]

Adjusting to My New Environment

I was stationed in a very remote village as a midwifery manager within a multidisciplinary MSF team. Communication was a major challenge for me due to my limited Arabic ability meaning I must rely on translators and bilingual colleagues to communicate with patients. Our location, an eight-hour drive from the capital, Sana'a, significantly isolates us. While we can leave at any time, the reality of the journey is complicated.

> *"Communication and basic services like internet, hot water and electricity are unreliable and at times, completely unavailable."*

Every six weeks, we briefly return to Sana'a amidst the threat of missile attacks. These breaks offer rare opportunities to reconnect with family.

Living conditions are strictly controlled, with mandatory curfews and enforced safety protocols. Our diverse MSF team shares a communal living space and meals prepared locally, offering companionship and mutual support amid challenging conditions.

Facing the Realities of Birth and Death

The frequency of maternal deaths is a harsh reality here with many women receiving no antenatal care at all and are typically only seen for the first time during or after their labour.

The hospital, rebuilt by MSF in 2015 after being destroyed by bombing, offers limited but essential healthcare services. The women's health department, responsible for both women's health and paediatric cases, operates with minimal resources - two birthing beds, basic fetal monitoring equipment, and no pain relief or specialised neonatal care. Emergency care options are limited, and access to specialist referrals is restricted, as the nearest specialist service is one and a half hours away.

Caesarean sections are rare and preserved for life saving cases only due to requiring approval from the women's husband, the ministry of health, and the hospital director, and when allowed, performed by general surgeons rather than obstetricians.

> *"The ongoing cholera crisis means that infected women must deliver in an isolated tent outside the main building."*

Women often arrive to the hospital too late, suffering severe postpartum haemorrhages after home births without prenatal care. One particularly distressing case I can recall involved a woman who, after her tenth childbirth, arrived with dangerously low haemoglobin and no signs of life. Despite our best efforts, we could not save her.
Infant mortality is also alarmingly high.

Babies who do not survive birth are wrapped in a towel and taken home by the family.

To date the families do not get a birth or death certificate for newborns unless requested from the ministry of health. This often results in women not knowing their own date of birth or the age of the older children.

The lack of autonomy and restrictions on women's movement and reproductive choices have been particularly unsettling for me. Women must always be accompanied by a female caretaker and contraception and abortion services are forbidden. It is in this context of a highly charged political environment that I must balance the needs of women with the realities of my situation. Women sometimes come to me requesting contraception or abortion care, but I must be extremely careful. I cannot always trust the other hospital staff to keep it confidential and worry they would report it to the hospital director.

Amy Carter with two newborns

Amy Carter with a young girl

The MSF Experience

Working with MSF provides practical support, including flights, accommodation, a modest stipend, and necessary legal and psychological assistance. Regular breaks and counselling services help manage the intense emotional and physical demands.

Despite the challenges, working with MSF has been one of the most profound experiences of my career and I have been deeply impressed by my Yemeni colleagues. Their clinical skills and resilience in such resource-limited settings are extraordinary.

To midwives considering humanitarian work, I strongly recommend careful preparation for the emotional, ethical, and professional demands involved. Engage with experienced humanitarian midwives, strengthen your clinical skills, ensure robust personal support, and consider language training, particularly in Arabic or French.

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Insights from He Hono Wāhine and Allen + Clarke Māori Trainee Recruitment and Retention Research

Bailey Parata Thomas
Te Ātiawa ki Whakarongotai, Ngāi Tahu,
RANZCOG Kaitohutohu Hauora Wāhine Māori | Māori Women's Health Senior Advisor

As the medical profession increasingly recognises the need for greater diversity in the workforce to address health inequities, particular effort is being made by RANZCOG to encourage and attract Māori to pursue obstetrics and gynaecology (O&G) as their chosen specialty. Medical registration data shows that only 4.7% of practising doctors in Aotearoa New Zealand identify as Māori, despite Māori comprising 17.8% of the national population. Whilst progress has been made over recent years, Māori only comprise 4.4% of O&G specialists.[1]

Recent research, completed for RANZCOG by Allen+Clarke, offers invaluable insights into the educational journeys of Māori completing medical studies and moving into specialist training, shedding light on the factors that influence their decisions to pursue (or not pursue) a career in O&G, and revealing the good and not so good aspects of their FRANZCOG training experience. The research and recommendations developed provide a guide for RANZCOG to foster a more inclusive and supportive pathway for Māori into and through the FRANZCOG training program, and ultimately to increase the number of Māori in O&G.

Phase One

Goals of RANZCOG's Te Rautaki Māori me Te Ara Whakamua 2021-2026 include that *'Māori trainees are supported throughout the training period to be culturally safe, valued, and respected'* and that *'The Māori O&G workforce grows to reflect the population'*. He Hono Wāhine commissioned this research to better understand how Māori experience recruitment and training for the FRANZCOG program. The study aimed to explore Māori doctors' experiences in applying for FRANZCOG training, as well as the strengths and weaknesses of the program from their perspective. The findings will inform changes to increase Māori participation and improve their training experience.

The research was conducted through in-depth qualitative interviews using a hīkoi (journey) based narrative approach. The study examined individual experiences, medical system structures, and broader societal impacts on Māori trainees.

Findings indicate that Māori are drawn to obstetrics and gynaecology to make a difference for pēpi (baby), wāhine (women), and whānau Māori (family).

Positive role models and informal mentors played a significant role in encouraging their entry into the profession. However, workplace culture significantly influenced their decisions, with experiences of bullying, sexism, and racism deterring some, while supportive environments encouraged others.

> *"I was lucky enough that when I was there the Senior Registrar was Māori, so she kind of took me under her wing."*

> *"I have been quite traumatised by that experience, and I do not have the energy now. I got into this to help Māori women and whānau, but I feel like I have failed."*

"I just wanted to do the speciality so bad. At the end of the day, I want to be an O&G specialist helping Māori women throughout the motu (island), so I just put my head down."

The application process for FRANZCOG training was found to be clear and transparent. However, the interview process lacked alignment with te ao Māori values, particularly in fostering whanaungatanga (relationship, connection). Participants suggested creating more opportunities to emphasise personal values and motivations in interviews.

While trainees found the clinical and academic demands challenging, they were willing to commit the necessary effort. However, they also faced additional pressures, such as cultural loading, being expected to represent Māori perspectives, engaging with Māori patients, and participating in committees. The College's appointment of a Kaitohutohu Wāhine Māori (Māori Women's Health Advisor) was seen as a positive step in supporting Māori members of RANZCOG and was also seen as a display of RANZCOG's commitment to Māori.

Training placements significantly impacted trainees' experiences. Proximity to whānau and support networks was beneficial, as were placements in smaller hospitals, where supervisors sometimes have more time to engage in training, and the environment was more adaptable to Māori needs. Many reported culturally unsafe environments in larger hospitals, where Western models dominated and te ao Māori practices were undervalued. Some trainees faced racism and bias, including negative attitudes toward cultural birthing practices and resistance to Te Tiriti o Waitangi training. These experiences led to stress, leave-taking, and, in some cases, a change in career path.

"When I first started working, I looked around and there were no Māori doctors... I realised there was only one Māori O&G doctor in my area and from then I was like 'I have to do this'."

"A consultant made me seriously consider O&G. He was really passionate about women's health. And he also was not trying to force me down this route. He was very frank and said, 'if you really want to help the Māori community there's a few specialties you should really consider'."

Hospital hierarchies made it difficult for trainees to challenge problematic behaviours, given their dependence on senior doctors for assessments. Despite these challenges, many trainees remained committed to the profession, motivated by their ability to make obstetrics and gynaecology more culturally safe for Māori.

Support networks played a crucial role in trainees' resilience. Connections with senior registrars, Te Ohu Rata o Aotearoa (Te ORA), and RANZCOG's He Hono Wāhine were valuable. Participants suggested establishing a formal Kaiāwhina (support) role to provide cultural support to Māori trainees.

"I think what's important is support networks outside of the hospital which make things a lot easier."

"The opportunity to tutaki (meet), whanaungatanga (connect) and be guided by tuakana (consultants, registrars, prevocational doctors and medical students) who look and sound like me, would have been an asset and I believe this would have helped me navigate medical school and speciality training more confidently. This is important, this is how we decolonise the whakaaro of "imposter syndrome", we as Māori, are exactly who is needed and what is needed to look after iwi Māori".

Phase Two

While phase one focused on the lived experiences of Māori already connected to RANZCOG, phase two of the research provided valuable insights into the earlier stages of the medical journey. This research aimed to better understand the factors influencing Māori doctors' decisions around medical specialisation. The study explored what encourages or deters Māori medical students from considering obstetrics and gynaecology as a career and identified opportunities to increase Māori interest and ultimately participation in FRANZCOG training.

The research was conducted through an online survey targeting Māori medical students, prevocational doctors, current trainees, and recently qualified specialists. It focused on key decision points — early interest in medicine at school, and career decision-making during medical education and in the post graduate years. The survey, distributed through Te ORA (Māori Medical Practitioners Association), received 95 responses (54% response rate) from doctors with various medical specialisations.

Many respondents had already developed an interest in medicine during their school years, often due to a strong aptitude for science subjects, the challenge and prestige of the profession, and the desire to improve Māori health outcomes. Personal experiences with the healthcare system, both positive and negative, were also significant motivators.

"I was often in hospital myself as a child and I loved seeing and interacting with doctors who appeared friendly and clever. I also observed from a young age that such people were well respected by the adults in my life".

"I had the experience of my whānau being unwell and little being done to help them and I knew I wanted to bring about positive change for them".

"I hadn't considered doing medical school until a teacher suggested it to me when I said I wanted to be a psychologist, and they suggested psychiatry".

Support from whānau and exposure to Māori doctors played a key role in career aspirations. However, discouragement from teachers and career advisors was a common experience, with some students being steered toward other fields like nursing.

Interest in specific medical specialisations developed through clinical experiences, personal interests, and lifestyle considerations. Factors such as work-life balance, the ability to work in community settings, and the opportunity to contribute to Māori health outcomes influenced decision-making.

Mentorship from Māori doctors and positive clinical placements played a crucial role in guiding career choices. Conversely, negative experiences, including instances of bullying, racism, and inadequate supervision, discouraged some from pursuing particular specialities, including obstetrics and gynaecology.

About one-third of respondents expressed some interest in obstetrics and gynaecology during their medical education. Clinical placements significantly influenced their decisions — both positively and negatively. Positive experiences included hands-on learning and the ability to integrate hauora Māori (Māori health) into practice, while negative experiences, such as workplace bullying and cultural insensitivity, deterred interest.

"I had an attachment in a rural hospital for my O&G placement in which the population was 80% Māori. The care and hands on experience with Māori whānau showed how hauora Māori for wāhine and whānau can be integrated in our Eurocentric health system".

"If anything, the toxic workplace in O&G pushed me further away from even considering O&G. It was not an enjoyable rotation".

To encourage Māori participation in the field of medicine, survey respondents highlighted the need for greater exposure to Māori role models, improved mentorship, and culturally safe training environments. Engagement with RANZCOG and O&Gs at conferences and through He Hono Wāhine provided valuable support but would benefit from further expansion.

"All it takes is one inspirational SMO at a stand to get you hooked!"

By addressing barriers and leveraging existing support structures, the RANZCOG can help ensure more Māori doctors enter and thrive within the field.

The findings from both phase one and phase two of this research provide RANZCOG with recommendations for supporting Māori students and encouraging greater diversity within the specialty of obstetrics and gynaecology. By addressing key issues such as clinical experiences, training placements, visibility of Māori role models, support systems and systemic change, RANZCOG can help build a more inclusive and supportive pathway for Māori.

There are currently more Māori medical students graduating from medical schools, and more Māori FRANZCOG trainees than ever before, meaning we have the opportunity to make significant progress towards a workforce that reflects the population it serves. Through Te Rautaki Māori me te Ara Whakamua, RANZCOG's He Hono Wāhine will continue supporting growth of Māori O&Gs. The overriding message from the research is that we can all play a key role in fostering Māori representation in obstetrics and gynaecology by fostering culturally safe learning environments, strengthening mentorship networks, and engaging early and positively with Māori medical students and post-graduate doctors. The research powerfully showed that it can be the support or role-modelling of one individual, Māori or non-Māori, that makes the difference and inspires a future Māori O&G.

"I was encouraged at [hospital] when I went there. I was well mentored and looked after by that department. I loved the work, the emergency, and the birthing moment is a real privilege as well."

On behalf of RANZCOG and He Hono Wāhine, we thank the Fellows, trainees and other Māori doctors who generously and bravely shared their experiences, to allow us to learn and improve for future trainees, and ultimately wāhine and whanau Māori.

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Healthy Investing

Dr Michelle Van
BMed (Hons), RANZCOG Trainee

The RANZCOG Environment and Sustainability Working Group (ESWG) formed in late 2024. The group has two main focus areas. The first is to advise on practices and strategies for environmental sustainability within the College and the O&G profession. The second is to highlight the connections between environmental issues and women's health and to develop relevant resources for clinicians and the community.

ESWG members will be contributing a short sustainability-themed article to each edition of the O&G Magazine. In this, our first article, Dr Michelle Van gives an overview of the connections between climate change and women's health and goes on to discuss an effective action that any of us can take: healthy investing.

Introduction

It is abundantly clear that climate change is having a destructive impact on human health and that its effects will continue to be borne, and amplified, in future generations. Extreme heat and weather events, increased transmission of vector-borne diseases, and food and energy insecurity are caused by climate change and are major threats to human health.[1] The implications for global women's health are particularly grave – this is a population group more vulnerable to the direct effects of climate change and less able to mitigate its effects due to unequal economic access, higher rates of illiteracy, and cultural hierarchies.[2] As the effects of climate change continue to escalate, we are witnessing the pathological effects of extreme weather events on rates of preterm birth, low birth weight and stillbirth; reduced access to reproductive healthcare (often the first service to be withdrawn at times of crisis); and increased gender-based violence.[3,4] Beyond the direct and indirect impacts of climate change, our ongoing reliance on fossil fuels has health consequences which disproportionately affect women. These include the greater exposure of women to air pollution associated with gas and fire stoves due to the division of domestic labour, and the increasingly documented health effects of microplastics and endocrine-disrupting chemicals on obstetric outcomes and fetal development.[5,6,7]

This crisis is entirely preventable; while governments and corporations have not been adequately held to account, we must also recognise the role we play as individuals within a system that prioritises growth and profit over the health and wellbeing of others. The annual Lancet Countdown and Intergovernmental Panel on Climate Change (IPCC) reports are a sobering read but to combat a problem, we need to honestly acknowledge its true extent and our contribution to the issue.

The issue is extremely complex, and no single action can fully address it – significant, ongoing, and sustained change within the broader community is required.

The RANZCOG ESWG wants the issue of environmental sustainability and climate change to always be front of mind. We want to illustrate that many ways you can positively impact your community, and advocate that we, as privileged professionals, dedicated to enhancing health and wellbeing, have a responsibility to act.

Healthy Investing

Adjusting our investment practices is a straight-forward action with potentially significant effects. This article does not constitute financial advice, but our money is one aspect over which we as consumers have direct control. We can change our banking institutions, superannuation investment choices, and energy providers if their practices do not align with our values.

As reported in the Lancet's 2024 Countdown report, global energy related CO_2 emissions reached an all-time high in 2023 and the 114 largest oil and gas companies are projected to produce emissions that exceed 1.5°C of heating by 189%.[1] Unfortunately, knowingly or unknowingly, our money may be contributing to climate change when invested in these industries. Many Australians have accounts with the "big four" banks, which have lent AUD $3.6 billion to the fossil fuel industry in 2023, of which $2.5 billion was used to fund the expansion of coal, oil and gas projects.[8] Meanwhile, the top 30 Australian superannuation funds have more than $39 billion invested in companies involved in fossil fuel expansion and the average investment option has nearly 9% of its members' share investments in these companies.[9] Three quarters of Australian energy usage is derived from fossil fuels and the "big three" Australian energy providers responsible for 63.2% of our electricity supply have been found to be the most obstructive with regards to provision of renewable energy, commitment to ending coal use by 2030 and halting fossil fuel expansion.[10, 11]

Divestment works by revoking the social licence for an industry to operate.[12] It also creates consumer demand, pressuring institutional investors to adopt climate transition plans and offer divested investment products. Tobacco divestment, now well established and vocally supported by the medical profession has resulted in states and multiple superannuation funds no longer investing in tobacco companies.[13, 14] Whilst there is limited evidence for the impact of individual shareholder divestment in fossil fuels, we have a moral imperative to demand banks and superannuation funds stop financing existing and new fossil fuel projects. Medical organisations including RANZCOG, the Royal Australasian College of Physicians (RACP) and the British Medical Association have already divested.[15]

How to make the switch

Assess your bank's position on fossil fuel investment and evaluate how much of your superannuation investment is exposed to fossil fuels. Market Forces is an organisation that provides clear, informative ratings for most major banks and superannuation funds. If your bank's stance or investment options do not align with your values, contact them to advocate divestment or consider choosing a 'socially responsible' investment option if available. If their response is inadequate, move your business and inform them of your rationale for the change.

Similarly, review your energy provider's progress in transitioning to renewable energy, engage with them directly if their performance is lacking and consider switching if their response remains unsatisfactory.

An alternative to divestment is shareholder activism which requires active participation at Annual General Meetings and engaging with companies directly to drive the change. Individual shareholders can increase their power by joining shareholder activist organisations which consolidate votes to propose shareholder resolutions.

As consumers, our financial choices do hold power, and we encourage readers to put their money where their mouth is and demand change from industries which are threatening human health.

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In Conversation with Artist Jamie McCartney: The Great Wall of Vulva

Jamie McCartney
Artist

Rebecca Young
RANZCOG, Podcast and Communications Specialist

The cover of this special 'Vulva' edition of O&G Magazine features a section from British artist Jamie McCartney's internationally acclaimed work, The Great Wall of Vulva. Spanning eight metres and featuring over 400 plaster casts, the installation challenges narrow ideals of beauty and celebrates the natural diversity of the vulva. In this interview, McCartney reflects on the inspiration behind the project and the impact it has had on participants and viewers alike.

Can you share a bit about your journey as an artist? What first drew you into art, and how did those early experiences shape your practice?

My mother is a painter, and I grew up in London with all its rich international history and culture. I always knew I would be an artist – making things was my happy place. I remember seeing Salvador Dali's "Lobster Telephone" as a child; it spoke to me, it was unconventional and absurd, and it showed me that anything can be art. Much of my work now defies convention, using real objects to make statements or tell stories, so that artwork remains a big influence.

I went on to complete a bachelor's degree in Experimental Art and I chose to study in the USA, as it offered me the progressive education I was craving. My education was steeped in social politics, and it still greatly informs my practice today. I have no interest in making stuff that looks like something you've seen before so experimenting is critical to keep punching the envelope.

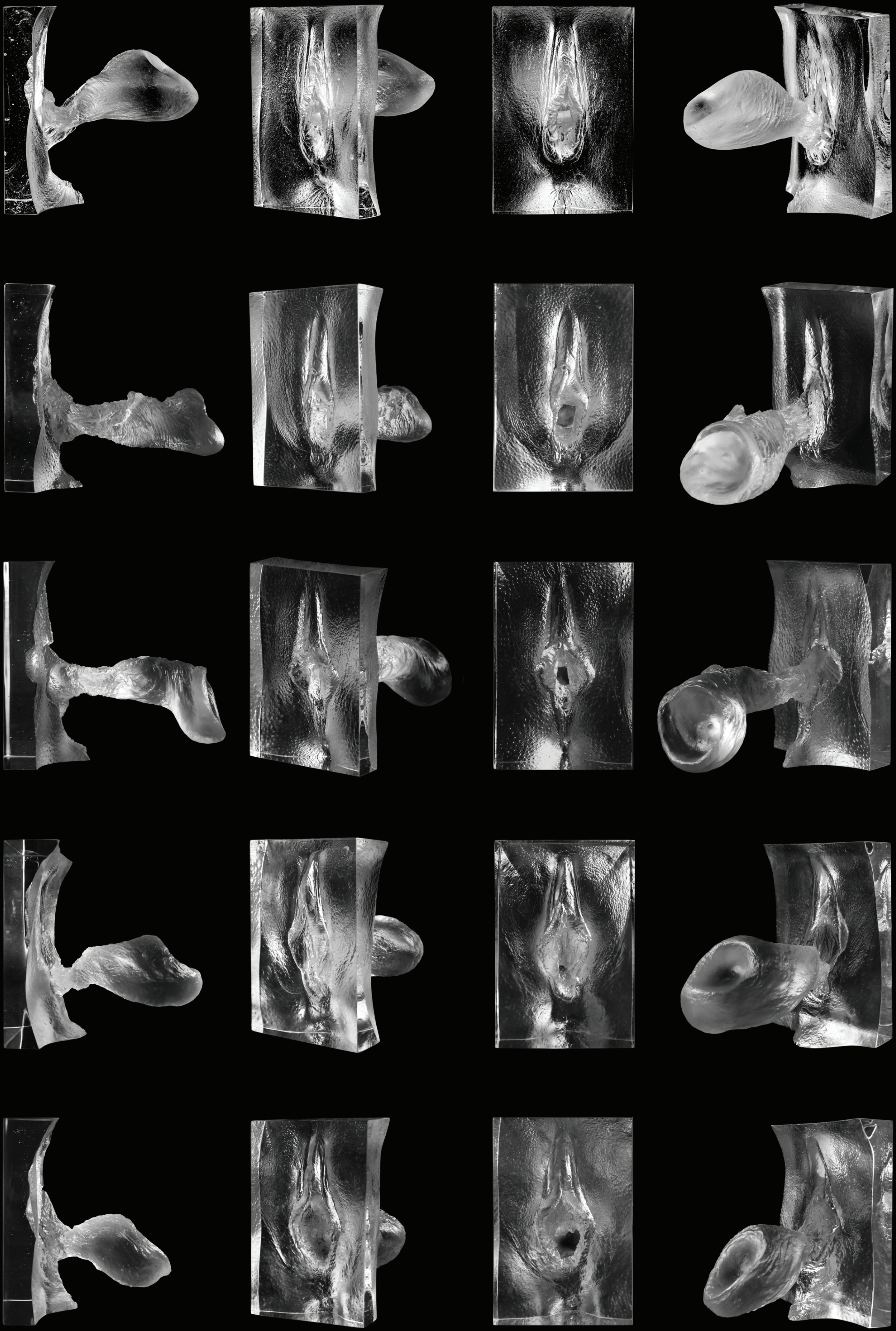
What inspired you to create *The Great Wall of Vulva*?

In 2006, I was commissioned to create a piece for a sex museum and made *The Spice of Life* – a wall of genital and breast casts from 18 men and 18 women. Including my own cast allowed me, for the first time, to compare myself to others without the distortion of pornography. It was surprisingly affirming. Conversely, many women expressed dissatisfaction with their labia, pointing out previous casts with smaller labia as more desirable. Other women were reassured by seeing larger labia that mirrored their own.

At the time, labiaplasty was the fastest growing surgery in the UK, and I thought "No! Not in my name." I don't stand for the idea that smaller labia are 'better', and I don't believe women are defective or in need of fixing. Since this was a psychological issue, not a physical one, surgery seemed an excessive response. I'm not opposed to surgery when it's an informed, autonomous choice, but too often, women make decisions without ever seeing what vulva diversity looks like. That's what *The Wall* offers, representation and reassurance.

Why did you choose plaster casting as your medium?

Plaster casting was at the heart of the project from the very beginning. I did consider using photography early on, but I felt it would never escape the similarity with porn. Casts of a modular size would be an honest, almost scientific survey. I chose plaster partly because the uniformity of the white casts would neatly sidestep any indication of skin colour. But mainly I used plaster because it was cheap, and this project was completely self-funded.



'Internal Affairs' poster © Jamie McCartney. All Rights Reserved, DACS/Copyright Agency, 2025

Were there particular ethical responsibilities you felt when working with participants?

Yes, it was a terrifying prospect when I started. I didn't want to get anything wrong or risk devaluing the project by any sense of it being erotic art. I'd had no training in how to do this so I developed a protocol that was there to provide safety to all concerned and to ensure everyone's safety and to make sure participants clearly understood what they were sighing up for and what to expect on the day. It was important to me that they were volunteers as that clearly indicates their endorsement and belief in the project. A man paying women to take their clothes off would have conveyed a totally different message.

I honoured their trust by designing the piece to be deliberately architectural, sterile and unerotic. The repetitive tiling of hundreds of casts meant you don't focus on and fetishise any one vulva. The eight-metre-long linear array means you have to be in motion to see the whole piece. It's a very active viewing experience and I think it really prevents it from being in any way a sexual experience.

Can you share a memorable story from a participant or viewer?

There are hundreds, which is why I created a book alongside the artwork to share them. Many participants spoke of the healing experience, of reclaiming their bodies after trauma, overcoming anxiety, or simply doing it in solidarity to help other women or to get over their own genital anxiety.

During the private show I did for the participants, they all were trying to find their own cast, enlisting partners to participate in the search. Some went to the loo to take photos of their vulvas on their phones to use as a guide and even swapped phones with other women to help the search. It was hilarious theatre.

Viewers similarly express a huge range of feelings. I have seen several women leave the exhibition crying.

Do you feel society's understanding of vulva diversity has improved since you began the project?

It's hard for me to be objective about what has changed and what impact my work may have had. Anecdotally, I believe the conversation has moved on. I receive a lot of positive feedback from both the public and professionals. The comments page on my website alone tells me this work has been a game-changer.

Looking at social media, there is now far more open discussion about labia, vulvas, and menstruation, and I do think society is less shy about these topics. By creating *The Great Wall of Vulva* website, I provided a free online resource for women and men around the world to find the answers they are looking for, it still amazes me that it took an artist to do that.

However, challenges remain. Misogyny and body shaming persist, especially among disaffected youth drawn into harmful online cultures. Education remains critical. We need to meet young people where they are – on social media platforms – and fight disinformation with real information.

Have you received feedback from healthcare professionals, and what role do you think they can play in normalising genital diversity?

Yes, I receive continual positive feedback from healthcare professionals. Images of the work are widely used to reassure women and girls, where photos of actual vulvas may be inappropriate. The plaster casts have a more clinical feeling. It is also used by surgeons performing gender affirming surgery on trans patients, to manage expectations around outcomes. Its value cannot be underestimated.

I think doctors are critical to shifting attitudes. They're in a position of immense trust. I often say: there should be a panel from *The Great Wall of Vulva* in every doctor's surgery! Visual education could make a profound difference in tackling genital insecurity early.

Finally, what's next for your work?

I'm currently exploring internal vaginal casting, an equally fascinating and diverse area. I have also had interest within the scientific community and amongst healthcare product developers.

I have even been asked to collaborate on a scientific paper by an evolutionary biologist. Artists and scientists have a lot more in common that many people imagine. These disciplines should never have divorced and working together we can achieve brilliant results. As an artist I can bypass a lot of the strictures that bind scientific research on live subjects but the data I gather is to some extent wasted on me. I know it has value and I'm willing to share for the good of the world. That is what my work is all about.

See the Work, Meet the Artist

Jamie McCartney will give a public talk about his work at the University of Sydney in September 2025. *Internal Affairs* (featured opposite) and other works by McCartney form part of the permanent collection of The Museum of Desire in Melbourne, where he will also make a personal appearance in September 2025.

The Great Wall of Vulva is currently on show at the Wilzig Museum in Miami until December 2025. Institutions and organisations interested in connecting during his Australian visit may enquire via the website: www.jamiemccartney.com

Editorial

Dr Helena Qian
BMed, DipLANG, CHIA, AICGG, ARANZCOG (Cert)

> *"My vulva, the horn, The Boat of Heaven...Rejoicing at her wondrous vulva, the young woman applauded herself."*
>
> *The Courtship of Inanna and Dumuzi*
> *(D Wolkenstein, Inanna, Harper and Row 1983)*

As advocates for women's health, and the dignity and care for those with reproductive anatomy, it is a curious paradox within our field that one of the most fundamental structures remains cloaked in discomfort, stigma and misunderstanding.

The vulva is one of the oldest motifs in prehistoric art. The ancient Sumerians (6000 BCE – 1750 BCE) revered Inanna, goddess of love, war, and fertility, whose very essence embodied the vulva's powerful symbolism: sensuality, pleasure, and "the promise of new life." Similarly, Pre-Vedic India (3300 BCE – 1500 BCE) named the vulva 'yoni', positioning it as a profound cultural symbol of feminine principle and creation. Yet, despite public efforts to reclaim and destigmatise the vulva, public discourse has centred largely on vulvoplasty and cosmesis, as opposed to gynaecological health and sexual wellbeing.

"Fanny," "lady bits," "vajayjay," "minge," "down there," "lady parts," "coochie" – a cursory online search reveals countless vulval euphemisms, with one article listing 70!
We speak freely of the uterus, placenta and ovaries—but how often do we name the vulva, clinically and confidently, as the essential physiological and anatomical site it is?

For most, the vulva exists at the margins of our attention. In this edition of *O&G Magazine,* we open a conversation long overdue. This is not simply a thematic choice; it is a call to action.

We examine how clinical knowledge gaps, research under-representation and barriers to accurate, affirming care leads to delayed diagnoses and management of conditions like lichen sclerosus, under-reporting of vulvodynia and widespread misinformation about what is "normal". We are fortunate to feature contributions from specialists and advocates who explore diagnostic nuances, comprehensively outline vulval disorders (including in under-represented cohorts like children and postmenopausal women), discuss the rise of labiaplasty and share Kath Mazzella's inspiring survivor's journey. These insights underscore the importance of nuanced diagnosis over blanket prescribing and the need for dermatological literacy alongside empathy.

To reclaim the vulva is to prioritise visibility over vagueness, science over stigma and patient-centred care over cultural discomfort. Whether you are a trainee in vulval clinic, a midwife conducting a perineal exam, a specialist navigating rare dermatological diagnoses or a public health advocate striving to improve menstrual and sexual health education—there is something here for you.

The vulva deserves our clinical attention, our research curiosity, and, above all, our voice. To talk about the vulva is to talk about power, pain, pleasure, pathology, and personhood. We hope this edition of the *O&G Magazine* can help you gain confidence in raising your voice, deepen your knowledge, and continue the work of destigmatising, diagnosing, and delivering the care that every patient deserves.

Advocating for Vulvar Health: A Survivor's Journey

Kath Mazzella
OAM

Dare to be Vulva Aware

At the age of 39, I faced the diagnosis of vulvar cancer, an uncommon cancer usually described as affecting postmenopausal women. Surviving a radical vulvectomy 30 years ago was just the beginning of my journey. This surgery involved removal of my clitoris, vulva, and groin lymph glands due to vulvar cancer, an experience that profoundly altered my life. The subsequent six weeks of pelvic radiation therapy induced menopause at the age of 42. I cannot begin to describe those first two years and discovering the taboos and stigmas associated with the word ‘vulva’.

Coincidentally, I met with a woman who experienced the same diagnosis and journey eight months previously. I remember this meeting so well, she lifted her dress, and I lifted mine and there we realised, we were on the same page. We had both requested our medical professionals to connect us with others battling vulvar cancer, but we had both been advised against doing so because ‘it would be too depressing’. There were no support groups for women navigating the post-operative journey after radical vulvectomy. This was my turning point. Feeling all alone and ostracised by society I placed an advertisement in a women’s magazine seeking others with whom I could talk. I received 38 responses, from women all over Australia, facing the same sense of isolation and embarrassment that I was experiencing. This compelled me to try to understand what made women fearful of speaking out about their symptoms and diagnosis. At the time, most women did not know the difference between ‘vagina’ and ‘vulva’. How could they, when even gynaecological cancer brochures did not include a diagram or picture of a vulva. In 2005, I presented my story to the New South Wales Cancer Council questioning the absence of a diagram of a vulva in their brochures. They took my feedback on board and have since updated their brochure to include a vulva that is appropriately represented. Other states followed suit. Sadly though, even today, reproductive health brochures, aimed at women, often have diagrams of the ovary, uterus, cervix and vagina but they do not include a vulva. I have made it my mission to increase awareness of vulvar cancer, among both women as well as health professionals, by destigmatising the use of correct terminology.

Alone we sit, together we make a mighty roar

I have been told that vulvar cancer is rare and often diagnosed late because of its 'intimate' nature. However, around 400 Australian women are diagnosed with vulvar cancer each year.[1] Of these, many are young, like I was when I received my diagnosis, and many die of this devastating cancer because of the late diagnosis. And it is not just vulvar cancer. It is also other vulvar conditions like lichen sclerosus, another condition that gets overlooked despite one in 80 women suffering from it. Women themselves feel embarrassed to ask for help for vulvar issues. Medical professionals can also be reluctant to examine the vulva. When they do, they often lack the knowledge and experience to accurately diagnose vulvar conditions. I often hear from women how they were misdiagnosed as having thrush instead of lichen sclerosus or cancer of the vulva.

My entire life, since my diagnosis, has been focused on empowering women to embrace their bodies, especially their vulvas, and have open conversations about vulval symptoms like itching, discharge, skin discolouration, and lumps and bumps, and to seek help early. I want health professionals to take women's symptoms seriously, to expand their knowledge of vulval diseases and educate women on vulval health. I feel we can only do this if we use accurate terminology, hence my insistence on using the word 'vulva'. Not vagina, vulva. When I first started to talk about the vulva, I was told it was an offensive word, and that it would be better to say 'vagina'. That made no sense to me. The vagina and vulva are two different parts of the body. One is internal, the other is external. We do not call a man's penis his testicles! How can women talk about their body accurately if they do not know the correct words to use? Hence, I started my 'Red Knickers' campaign with the tagline 'Viva la Vulva' and advocated for 10 September to be celebrated as International Gynaecological Awareness Day (IGAD). King Edward Memorial Hospital in Western Australia has celebrated IGAD for the past nine years. My advocacy has been recognised with many awards, but awards are superfluous in the absence of action. In 2018, I was selected as Western Australia Senior Australian of the Year. This only spurred me to continue my advocacy.

Viva la Vulva

Despite the challenges, and being a multiple award recipient, I remain steadfast in my mission to ensure that women with vulvar health issues receive the attention and care they deserve and that research into vulvar cancer receives the same funding as breast cancer or ovarian cancers. My journey is a testament to the resilience and determination necessary to effect change in this critical area of women's health. This is a new world with women demanding old stigmas and taboos be broken. It is time to shine a light on this silent suffering and I will continue to be the voice of women who are afraid to speak out about vulvar issues.To learn more about the author, visit: https://www.kathmazzella.com

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Vulval Disorders Post Menopause

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The most common causes[1] for any form of vulval discomfort and dyspareunia across all age groups are contact dermatitis, chronic vulvovaginal candidiasis, psoriasis, and lichen sclerosus. However, there are certain conditions that occur more frequently in older women than in younger age groups.

Lichen Sclerosus

Vulval and peri-anal lichen sclerosus (LS) is common, impacting around 1 in 300 women. Two thirds of patients are over the age of 50 at presentation. Although association with thyroid disease and vitiligo may be more prevalent than in age-matched controls, LS itself is not thought to have an exclusively autoimmune aetiology.

In addition to the management of symptoms and prevention of scarring, adequate treatment of lichen sclerosus is essential to mitigate the five percent lifetime risk of squamous malignancy[2].

Lichen sclerosus typically presents with symptoms such as itch, discomfort, dysuria, and dyspareunia. However, it may also be asymptomatic and identified during routine examination.

The classic examination findings are of thickened white vulval skin with alteration of vulval architecture. Because there are other skin conditions that may present with white thickened vulval skin (especially lichenified dermatitis or vulval intraepithelial neoplasia (VIN) biopsy is essential to confirm the diagnosis.

Topical corticosteroids (TCS), used continuously to maintain objective control of skin changes are the gold standard[3]. The potency is titrated against the thickness of initial skin changes. LS is very unlikely to remit, but the careful long-term use of appropriate TCS is very safe and effective.

Oestrogen Deficiency

Although all women, if their lifespan allows, will reach menopause, not all women will become symptomatic of menopausal oestrogen deficiency. Despite this observation, topical oestrogen therapy is frequently prescribed as a blanket tool for vulval discomfort without considering alternative diagnoses.

Atrophic vaginitis caused by oestrogen deficiency can cause the same symptoms as many other vulval dermatoses and older women who experience atrophic vaginitis are also more likely to suffer from neuropathic vulval pain[4]. Additionally, many women experience menopausal symptoms alongside other vulval skin disorders.

There can be a great deal of overlap in examination findings between oestrogen deficiency and other vulvo-vaginal skin disorders. While some shrinkage of vulval structures can be due to menopause, adhesions, fusion, distortion, or significant resorption of structures are always caused by another skin disorder.

The specifics of topical oestrogen therapy will not be discussed here. The essential point however is that symptoms solely due to oestrogen deficiency will be promptly improved after an adequate trial of topical oestrogen. If the symptoms persist, another diagnosis should be considered.

Lichen Planus

This is a rare condition, with a varied and sometimes changeable presentation making diagnosis challenging. Genital lichen planus can involve both the vaginal mucosa and vulval skin. Although uncommon, its higher prevalence in older women makes it an important consideration. Common presenting symptoms include pain, dyspareunia, and vaginal discharge. Women who do not practice vaginal penetration may be completely asymptomatic. There is an association between lichen planus and VIN[5]. Similar to lichen sclerosus, complete suppression of the disease effectively mitigates the risk of progression to squamous cell carcinoma.

The examination findings are highly variable. Skin changes include vaginal erosions, erythema, and adhesions, but thick white skin may be seen on the vulva. More rarely, ecchymoses can cause post-menopausal bleeding. While histopathological diagnosis is specific, it is not always sensitive; thus, clinical diagnosis is often necessary. Biopsy should be done if LS or VIN is suspected.

Lichen planus requires ultra potent corticosteroids to control symptoms and skin changes. One in five patients require oral immunosuppressants as well as topical therapy. This disease is often best managed in conjunction with dermatology or immunology colleagues.

Psoriasis

Psoriasis is common and affects women of all ages. Although psoriasis is neither unique to nor overrepresented amongst women following menopause, its variable presentation[6] warrants consideration in any patient presenting with vulval discomfort. Psoriasis is usually intensely itchy and, in the vulva, does not always have the characteristic findings seen on skin elsewhere. A red rash extending into the natal cleft is common as are fissures across the vulval skin. Psoriasis does not cause vaginitis, but can coexist with candidiasis and in oestrogen deficiency, both of which may present similarly. Topical corticosteroids are usually effective for initial improvement and inducing remission. However, as a chronic, relapsing condition, maintenance therapy is usually required with steroid sparing agents and emollients. Optimising skin triggers like urinary incontinence, friction, heat, sweat and coexistent vulval dermatoses is essential to minimise flare-ups.

Neuropathic Vulval Pain

Vulvo-vaginal pain in the absence of a skin condition has long been a cause of confusion for clinicians. However, an approach which considers the close relations of the vulva and vagina to the bowel, spine and hips makes it easier to understand vulvo-vaginal pain and potentially help our patients. We think that most vulval discomfort in the presence of normal vulval skin is caused by neuromuscular dysfunction.

Lower limb pain referred from the spine is well known, as is bladder dysfunction referred from the spine and/or bowel. It is therefore plausible that vulvo-vaginal pain could similarly be associated with bowel and musculoskeletal diseases or dysfunction. Harris et al clearly established the role of neuromuscular contributions to vulval pain in the absence of a skin problem[7]. Commonly, the pain will be in a horseshoe shaped ring involving the inferior vulval structures and perineum. This has led to the concept of "pudendal nerve entrapment" as a cause for this type of pain. We think however, that relying on pudendal nerve dysfunction alone to explain vulval neuropathic pain is too narrow a concept and does not always help our patients.

Bowel dysfunction should be improved where possible, and dual-skilled musculoskeletal and pelvic physiotherapy and/or neuromodulating drugs may significantly improve this type of pain. Younger women in this category tend to improve with physiotherapy, while older women may benefit more from neuromodulating drugs. A detailed description of the safe use of such medications as amitriptyline, gabapentin, pregabalin or duloxetine is beyond the scope of this article.

Adjunctive therapies, such as psychology, can also be beneficial, along with encouraging a realistic approach to balancing exercise and rest appropriate to age and pathology.

Vulval discomfort in the post-menopausal state can occur due to several conditions, whether independently or in conjunction with each other. While often well intentioned, prescribing topical oestrogen as a universal remedy for vulval issues in older women can be harmful and should only be used when the treatment of oestrogen deficiency is likely to be of clinical benefit. Familiarity with age-appropriate vulval anatomy and function, as well as an understanding of vulval dermatoses across all ages is essential before then narrowing the focus of assessment to that of the post-menopausal woman.

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Topical Oestrogen for Vulvovaginal and Urological Health: The Low-Hanging Fruit for Women's Wellbeing

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Case study

An 80-year-old woman presented to the gynaecologist with red, tender urethral caruncles (see Figure 1). Her recent history included a urinary tract infection (UTI) and genital rash, treated with antibiotics and topical steroid treatment along with a recent hip replacement following an osteoporotic fracture. Initiation of topical oestriol therapy led to notable improvement of her symptoms within just three days. She was advised to continue the topical oestrogen therapy, highlighting its potential to address her presenting symptoms effectively. Low oestrogen levels postmenopause can contribute to all the symptoms that this patient experienced. Urethral caruncles can develop due to the lower elasticity and strength of the urethral tissues leading to discomfort.[1] Low oestrogen levels changes the vaginal flora and weakens the bladder muscle which leads to increased postvoid residual volume that can lead to the development of UTIs and/or urinary incontinence.[2] Recurrent UTIs can also be a major source of morbidity through its effect on quality of life and the increased incidence of delirium, indication for antibiotics which can have gastrointestinal and microbiome side effects as well as the increase in vaginal thrush, and possibility for complications that can lead to hospitalisation such as pyelonephritis and sepsis.[3]

***Figure 1.** Vulva with urethral caruncles. Photo shared with patient permission*

Introduction: The Overlooked Solution

For many postmenopausal women, symptoms associated with genitourinary syndrome of menopause (GSM) – such as vulvo-vaginal dryness, dyspareunia, bleeding, recurrent UTIs and urological urgency, while common, are often underdiagnosed or dismissed as an inevitable part of aging. However, they can significantly impact quality of life. A simple, evidence-based intervention exists: topical oestrogen such as Ovestin cream or pessary, and Vagifem pessary, as seen in Table 1 below.[4] Despite proven efficacy and safety, barriers including prescription requirements and societal stigma continue to limit treatment access.

Product	Presentation	Composition
Ovestin	Cream	0.5mg oestriol = 1 application; daily for first 14 days, then twice weekly ongoing
	Pessary	0.5mg oestriol = daily for first 14 days, then twice weekly ongoing
Vagifem Low	Pessary	10mcg oestradiol hemihydrate; daily for first 14 days, then twice weekly ongoing
Intrarosa	Pessary	6.5mg dehydroepaindrosterone (DHEA) daily (prasterone)

***Table 1.** Vaginal Therapy options from the Australian Menopause Society[4]*

The Importance of Oestrogen

Oestrogen plays a crucial role in maintaining the health of vulvovaginal and lower urinary tract tissues. As women approach and reach menopause, oestrogen production from the ovaries decreases and eventually ceases. Some levels of circulating oestrogen remain through the aromatisation of androgens from the ovaries, adrenal glands, and adipose tissue however the levels will never be as high as they previously were before menopause.[5]

This decline in oestrogen levels leads to thinning of the vaginal epithelium, decreased blood flow, and loss of elasticity. This contributes to symptoms such as dryness, irritation, and dyspareunia. Additionally, the urethra and bladder, which also have oestrogen receptors, become more susceptible to infections and urgency issues due to the increased bacterial colonisation from an increased vaginal pH resulting from decreased oestrogen.[5]
Topical oestriol directly replenishes local oestrogen levels with minimal systemic absorption, distinguishing it from systemic hormone replacement therapy (HRT), which circulates throughout the body. Topical formulations deliver the hormone directly to the affected tissues leading to a lower risk profile. While the vaginal lining is atrophic, there may be a tiny increase in serum estrogen levels however this quickly subsides.[5] Literature reviews that inform clinical guidelines have demonstrated that regular use of topical vaginal oestrogen significantly reduces recurrent UTIs, improves vaginal moisture and elasticity by thickening and maturing the vaginal wall, alleviates dyspareunia, and decreases urgency-related urinary symptoms.[5,6,7]

The Case for Accessibility: Over-the-Counter Availability

Currently in Australia, topical oestrogen remains prescription-only, unlike the UK where low-dose vaginal oestrogen (Gina vaginal tablets) and Ovesse (vaginal cream) can be accessed following pharmacist consultation, reflecting a growing recognition of its safety and necessity. This is a similar idea to the distribution of fluconazole which is available with a pharmacist consultation for the treatment of vaginal thrush in many countries including Australia. Like postmenopausal syndrome, vaginal thrush is a common condition with a high safety treatment profile with pharmacist guidance to ensure proper usage. These secondary prevention strategies are also more efficient for how resources are used in the healthcare system, freeing up time and cost for general practitioners and specialists.

Several compelling arguments support improving accessibility. The safety profile of topical oestrogen is well-documented, with negligible systemic absorption and minimal risk compared to systemic HRT. The Australian Menopause Society reports that 27% of women using systemic hormone therapy still experience symptoms of GSM and so it should not be overlooked in these patients.[8] While certain groups of women may be less ideal candidates, such as those with histories of gynaecological cancers, this can be screened for by a pharmacist. However, a systematic review showed that patients who have had breast cancer in the past and used vaginal oestrogen did not have an increased rate of breast cancer recurrence, breast cancer mortality, or overall mortality.[9] Moreover, many women avoid healthcare consultation due to embarrassment, lack of awareness, or difficulty accessing healthcare providers. Approximately 50% of post-menopausal women experience symptoms associated with GSM resulting from decreased oestrogen; however less than seven percent are given safe oestrogen therapy.[10] Allowing over-the-counter access could significantly increase awareness of available treatmentsand empower women to take control of their health and quality of life.

A Call to Action: Increasing access to topical oestrogen

Advocating for regulatory changes to allow over the counter access to topical oestrogen in Australia is a step towards addressing the unmet needs of many women. Research suggests only 4.5-7.8% of peri and postmenopausal Australian women are using vaginal oestrogen, despite the substantial proportion who would likely benefit.[8] Creating awareness around vulvovaginal and urological health is crucial for women to access and benefit from safe treatments. Enhanced accessibility would represent a significant stride in recognising the unnecessary suffering many women are experiencing and advancing women's health and wellbeing.

Conclusion

Topical oestrogen is a safe, effective, and underutilised treatment for managing postmenopausal vulvovaginal and urological symptoms. Given its minimal risks and substantial benefits, there is a strong case for making it available over the counter with pharmacist guidance, as seen in the UK. By prioritising accessibility and awareness, we can empower women to take control of their health and improve their quality of life with a simple, evidence-based solution.

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Advocacy against Female Genital Cutting: History of the Practice, Progress, and Future Directions

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Nobel Peace Prize recipient (2018), and Congolese gynaecologist Dr Denis Mukwege once said, "Silence is the greatest ally of sexual violence". Advocacy is crucial for promoting human rights and women's rights and remains essential in addressing Female Genital Mutilation (FGM), or rather, what this article defends as alternative terminology, Female Genital Cutting (FGC).

Despite ongoing human rights campaigns, FGC/FGM continues to prevail worldwide. The World Health Organisation reports over 230 million girls and women have experienced FGC/FGM in up to 30 different countries[1, 2]. Girls can be subject to this cruel and painful act as early as infancy to the age of 15[1]. Although progress has been made, FGC/FGM continues with significant physical and psychological consequences to the girls and women affected. Furthermore, the World Health Organisation (WHO) reports up to USD $1.4 billion per year in terms of cost to health systems in providing treatment for the subsequent health complications to victims of this practice[1].

Language matters, and there is an ongoing shift from using the term FGM to FGC depending on your audience.

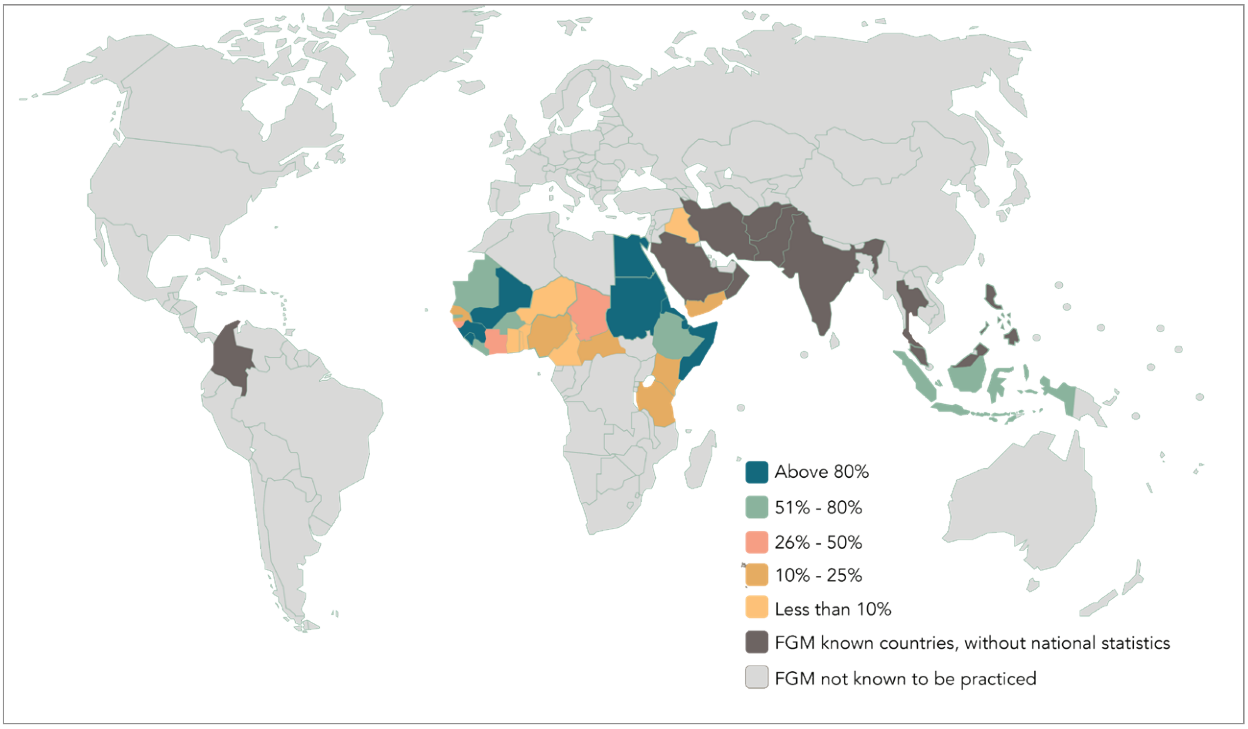


Figure 1. *Percentage prevalence of FGC/FGM Worldwide for girls and women ages 15-49 (WHO FGM Calculator, 2020)*[3]

The United Nations recently rebuked the term "female genital circumcision" as it often draws parallels to cis-male circumcision and negates the far more serious and harmful psychological and physical implications of this practice[4]. "Mutilation" reinforces the severity of the practice; yet communities that practice FGC may find this word offensive in that it implies their intent was malicious when that may not be the case. Another reason is that using FGM in reference to individuals and their bodies, may result in decreased engagement from affected communities and individuals. As a result, many organisations utilise both terms simultaneously – FGC/FGM, with FGC being used when speaking to patients, whilst FGM is often used in literature[4].

There are four types of FGC/FGM categorised according to the anatomical structure that has been affected (Figure 2)[5]. There are no supported health benefits to FGC/FGM, only significant physical harm to girls and women both short- and long-term.

These include[1]:

- Pain
- Swelling
- Bleeding
- Acute and recurrent vaginal and urinary tract infections
- Death
- Difficultly with urination
- Dysmenorrhea
- Keloid scarring
- Dyspareunia
- Childbirth complications including the need for caesarean section
- Excessive tearing/bleeding
- Perinatal mortality

Women frequently require multiple surgeries both before and after childbirth or for deinfibulation. The mental health impacts can result in lifelong post-traumatic stress disorder, depression, and anxiety[1].

It is important to recognise that FGC/FGM is an illegal practice in Australia and individuals will be prosecuted if they intend to take their daughters overseas to facilitate these practices[6]. Nevertheless, there is hope for victims of FGC/FGM to receive deinfibulation treatment for women experiencing physical symptoms pre-conception or in the antenatal period, along with psychological support and counselling.

In some countries, medicalisation of FGC/FGM occurs due to a belief that performing the procedure with a medical practitioner under sterile conditions may reduce risks, and complications, although there is no evidence for this. Those who offer medicalised FGC/FGM attempt to legitimise the practice either for financial incentives or to support existing social beliefs/norms[7].

Why does this practice persist and where did it originate? These are questions I recently explored. As I dove further into my reading, I discovered its history stems beyond ideologies of fertility, preservation of virginity, and patriarchal control over women's bodies[8]. Its roots were explored by Professor Sada Mire, an archaeologist, and professor of Heritage Studies at University College London in her book entitled, *"Divine Fertility."* Her research exposes cultural traditions predating sexual control of girls and women, rooted instead in practices reflecting divine sacrifice. She argues that societies deeply linked the practice of FGC/FGM to the many rituals females experienced as they progressed through the stages of life (just as males did in their own stages), citing carved archaeological evidence of images and symbols to support this theory. She explains that the practice is deeply rooted in Indigenous cultural beliefs if not adhered to, resulted in communities shaming individuals for abandoning their culture and angering the ancestors resulting in curses manifesting as drought, lost crops, and livestock and medical illness[9]. The intent to control girls and women's bodies and sexuality appears to be a secondary rationale that developed over time. To demystify this practice, and advocate against it, it is important to understand this background. Professor Mire argues that introducing alternative practices to FGC/FGM which allow for the cultural blessings of the ancestors whilst denouncing the practice of cutting, can engage more communities and change outcomes for girls/women[9].

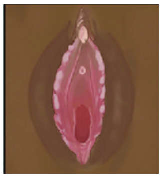
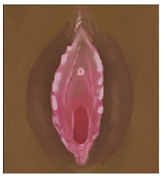
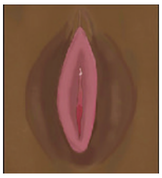
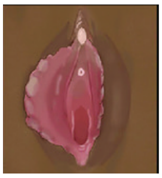
Unaltered	Type 1 Clitoridectomy	Type 2 Excision	Type 3 Infibulation	Type 4 Other
				
Unaltered external female genitalia.	Complete or partial removal of the clitoris, and/or the prepuce.	Partial or total removal of the clitoris and the labia minor, with or without excision of labia majora.	Narrowing of the vaginal orifice with a covering seal, with or without removal of the clitoris.	All other harmful procedures to the female genitalia for non-medical purposes (e.g. stretching, piercing, pricking, scraping, incising, and cauterisation).

Figure 2. *Types of FGC/FGM*[5]

An alternative rite of passage (ARP) was initially championed in Kenya by a Women's Development Organisation, *Maendeleo Ya Wanawake* (MYWO) and Programme for Alternative Technology in Health (PATH). Interestingly, they commenced with educational programs for parents and girls alike which faced resistance as parents still feared shame if they did not participate in FGC/FGM practices[10]. Their program developed into an alternative rite of passage, allowing families to support their daughters to transition from girls to womanhood, while including the public religious rites, and courses covering content such as reproductive anatomy, dating and marriage, pregnancy and contraception, sexually transmitted infection prevention, empowering young women to feel more informed and families to abandon FGC/FGM through seeing its lack of benefits[10]. The key is to honour and respect cultural practices while effectively campaigning against FGC/FGM. There are multiple studies currently exploring the effectiveness of ARPs, and collating data which have been adopted by many NGOs. One major challenge in Kenya is even within specific communities there are obvious nuances. There was reduced uptake amongst Maasai Peoples as the rituals tend to be less public in nature and involve the immediate and extended family. Consequently, ARPs must be thoroughly researched and tailored specifically to individual community needs to ensure effectiveness[10]. In addition to ARPs, ensuring local legislation is in place and is enforced can also assist in reducing rates of FGC/FGM.

Currently, numerous organisations and NGOs strongly advocate and lobby for legislative reform.

From writing to political leaders to implementing ARPs within communities, conducting research and collecting data on outcomes for girls, women and neonatal and obstetric outcomes.

The United Nations recently celebrated "International Day of Zero Tolerance for Female Genital Mutilation" on 6 February 2025. The United Nations announced its commitment to ending FGC/FGM by 2030, noting the ongoing decline of the practice in the last 30 years, and that today a girl is one third less likely to experience FGC/FGM. They released a 2023 annual report on joint initiatives by organisations, both global and grassroots, to reduce the rates of FGC/FGM[11].

Like many aspects of clinical practice, continued professional development can assist in providing care to women and girls affected by FGC/FGM. The most recent update of the *RANZCOG Female Genital Mutilation/Cutting (C-Gyn 1)* provides clinicians with a comprehensive, evidence-based resource outlining obstetric considerations for women affected by FGC/FGM. The College also provides a learning module on FGC/FGM in its education platform, Acquire[12]. True Relationships and Reproductive Health, a profit-for-purpose organisation provides a publicly accessible online course which enables capacity building for healthcare professionals around treating women with FGC/FGM in their clinical practises, including approach, cultural sensitivity, and support[12].

Further research into alternative rites of passage and their effectiveness will be essential to determine their potential impact on reducing FGC/FGM rates. Ongoing education, understanding and advocacy are crucial. As healthcare professionals, providing culturally sensitive healthcare can significantly assist women and girls affected by this FGC/FGM, and help break the cycle of this practice, empowering the future generation of young women.

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Labiaplasty: A GP’s Journey from Patient Request to Research and Advocacy

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Around fifteen years ago, a mother and her teenage daughter presented to my rooms requesting a referral to a plastic surgeon to ‘fix the daughter’s prolapsed vagina’. Aside from being an unusual request, what took me by surprise was that an appointment had already been made, and they expected me to simply comply with their wishes. Further questioning revealed that the daughter had had her pubic hair removed for the first time and she was disgusted by the appearance of her newly exposed labia. The mother also considered her daughter’s appearance to be quite different to her own, reinforcing the notion that her daughter’s genital appearance was ‘abnormal’. They went home and googled for information only to find that the ‘outie’, where the labia minora protrudes beyond the margin of the labia majora, could be corrected surgically with a ‘Barbiplasty’ procedure which was described online as merely trimming the labia minora to achieve an aesthetic ideal that matched their expectations. It sounded easy enough, and a bit like getting a haircut. On the day they presented to my rooms with the request for the referral, the girl permitted me to examine her but refused to look at herself to point out what it was that disgusted her so much. Despite reassuring them that everything appeared normal and there was no vaginal prolapse, they insisted on keeping their appointment with the plastic surgeon. The girl was not yet sexually active and had been seeing a psychiatrist for a generalised anxiety disorder. My referral included the history, details of our conversation, the lack of need for the surgery and that this was a reaction based mainly upon ignorance regarding genital anatomy. Weeks later, I received a postoperative discharge letter outlining that the labiaplasty procedure was a success. The surgeon’s letter infuriated me, as in my opinion, this was an unnecessary cosmetic procedure driven by the girl’s and mother’s lack of knowledge and skewed expectations.

This consultation highlighted several concerns: both mother and daughter had preconceived notions about ‘normal’ external female genitalia, believing the labia minora should not extend beyond the margin of the labia majora. Anything outside of this was considered abnormal and caused emotional distress. They lacked knowledge of the female genital anatomy and viewed irreversible surgery, discovered online, as an appropriate solution to achieve a genital aesthetic ideal without consideration of possible consequences. Furthermore, the surgeon’s normalisation of their request demonstrated a vast difference in management approaches and heralded a new, opportunistic industry where the internet now shaped views around normal and therefore desirable female genitalia. At that time, my knowledge and experience around labiaplasty and the suite of services under the bracket of ‘female genital cosmetic surgery’ (FGCS), was lacking.

My next steps involved my own Google and literature search which initially led to the discovery of airbrushed images of models with prepubescent looking genitals and media commentary using terms such as “camel toe” and “meat flaps,” among other derogatory descriptors. There was a lack of research around this group of procedures referred to as FGCS, and I learned that it aimed to change aesthetic (or functional) aspects of a woman’s genitalia for non-medically indicated conditions. This comprised of a mostly unregulated set of procedures which can be performed by plastic surgeons, aesthetic doctors (GPs with a special interest), dermatologists, urogynaecologists, gynaecologists and urologists, without any standardised training requirements. Labiaplasty comprises around fifty percent of all FGCS procedures being performed, often for medicalised functional discomfort in tight leisure wear or G-strings, which can include excision of the clitoral hood, tightening of the vagina, plumping or liposuction of the mons pubis and G-spot injections[1].

The publications at the time were mostly out of the United Kingdom, United States, Western Europe, and other developed nations where the cohorts were larger and where statistics were similar or higher to those reported in Australia. This prompted me to undertake my own research through the Department of General Practice at the University of Melbourne, as an honorary researcher, and I chose to explore what young women thought was ‘normal’ or desirable looking female genitalia[2] and what the role of the general practitioner was in managing requests for FGCS[3]. Two penultimate medical students were recruited to undertake the research, and the preliminary findings were shared at the 2014 Royal Australian College of General Practitioners (RACGP) Women in General Practice conference, where many GPs shared similar experiences to mine. They felt that there was a need for more information to help them guide their patients. This was “a new dilemma for GPs,”[4] which prompted the development of a guide called, *Female genital cosmetic surgery – A resource for general practitioners and other health professionals,*[5] published by the RACGP, in 2015. Alongside this, I instigated a cross-sectional survey exploring knowledge, attitude and practice of general practitioners around FGCS[6].

Of the 443 Australian GPs who took part in the study, 97% had been asked by women of all ages about genital normality, 54% had encountered patients requesting FGCS, 35% reported they had requests from girls under the age of 18 years, for female genital cosmetic surgery. More than half the GPs suspected psychological disturbances in their patients requesting FGCS, such as depression, anxiety, relationship difficulties and body dysmorphic disorder, yet most of the girls cited concerns about the size of their labia as the reason for wanting cosmetic surgery. Requests for surgery for 15-24 year olds were the same for 25-45 year olds. The climb in requests highlights the power of socio-cultural factors that medicalise functional discomfort such as chafing, combined with emotive online marketing promising a youthful, desirable 'vagina', has fuelled an epidemic of genital anxiety. The three-fold increase in requests for nationally funded labiaplasty procedures, for the period from 2001-2011, reflected this and prompted a review of Medicare claims[7] which resulted in new restrictions to medically indicated diseases with specific item numbers for repair of congenital anomalies, female genital mutilation and another for vulval hypertrophy. The Medicare item number for labiaplasty or vulvoplasty (35534) is now restricted to patients aged 18 years or more who present with structural abnormalities causing significant functional impairment or extends more than eight centimetres below the vaginal introitus when standing. Girls under 18 years of age, must undergo mandatory psychological assessment and observe a 3-month cooling off period which is in contrast with the British Society for Paediatric and Adolescent Gynaecologists, which states that genital cosmetic surgery be delayed until after 18 years of age, which is when full genital maturity is achieved[8]. Following the Medicare review in 2014, a significant reduction of measurable rates of labiaplasty in Australia ensued, however the number of procedures performed in the private sector remain unmeasured.

In 2013, Women's Health Victoria (WHV) addressed misinformation online by developing the interactive *Labia Library*[9]. Now in its tenth year, the updated *Labia Library* depicts genital diversity across various ages, races and from different angles. Despite more than 11 million people accessing the site, rates of FGCS continue to climb [10]. Celebrities and influencers publicly endorsing procedures to attain a 'designer vagina' reinforce prepubertal aesthetic ideals, which inevitably mean we will continue to see women and adolescents who present for all types of FGCS and to which I warn the public around cultural drivers that have potential to cause long term disfigurement or harm, through mainstream media[11].

Body enhancement through female genital cosmetic surgery creates ethical and rights dilemmas[12] for the clinician and it is our responsibility to educate our patients around genital anatomy and function. The RACGP guide recommends using diagrams to determine what she wishes to have altered, explore her reasons for this request and exclude intimate partner or parental coercion. It is equally important to conduct a psychosexual and gynaecological history and provide her with information around the diversity of genital appearance. Where mental health conditions such as depression, anxiety, or body dysmorphic disorder are suspected, refer for psychological support, regardless of age. Address all the woman's concerns around functional discomfort and offer to perform a sensitive examination. Provide reassurance where medical indications for surgery do not exist, discuss physiological changes over the lifespan as there are growth spurts in adolescents which can result in asymmetry which self corrects, changes during and after pregnancy and genital atrophy and shrinkage post menopause. Discuss potential risks of surgery and the lack of evidence regarding outcomes. Explain how marketing terms such as 'vaginal rejuvenation', 'clitoral resurfacing', 'G-spot enhancement' are non-medical terms and lack the rigour of scientific evaluation.

Agency in decision making is a woman's right however women having little knowledge about their own anatomy and succumbing to social forces that influence the way women feel about their bodies, in the absence of knowing something as fundamental as that the labia minora are second to the clitoris in sensitivity, means that implications of such surgery down that track may well have consequences for those who benefit financially from these procedures.

Conflict of Interest

Women's Health Victoria (WHV) Board Member 2013-2022
RACGP Expert Committee for Quality Care 2015-2024

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Understanding the Vulva: Beyond Anatomy to Pleasure and Empowerment

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The vulva is an extraordinary, complex, yet often misunderstood part of the human body. Central to identity, pleasure, and health, the vulva remains undervalued in both cultural narratives and medical discussions. As a sexologist, I aim to elevate our understanding of the vulva and encourage open conversations about its anatomy, its role in pleasure, its changes during arousal, and the medical conditions that can affect it.

The Current Climate: How We Talk About the Vulva

The word 'vulva' is rarely used in everyday conversations, with many incorrectly using 'vagina' - which only describes the internal canal) - to describe the entire genital region. This linguistic oversight reflects broader societal discomfort in discussing genitalia, leading to misinformation and shame.

Research shows that inadequate education about vulval anatomy and function often leaves people with misconceptions about their bodies. Many vulva owners feel embarrassed or hesitant to raise questions with their healthcare providers, which can lead to delays in seeking help for medical or sexual concerns (Herbenick et al., 2010).

As healthcare providers, we play a vital role in creating a safe, inclusive environment where patients feel comfortable discussing their vulva without stigma or judgment.

Vulva Anatomy: What Every Patient Should Know

A thorough understanding of vulval anatomy is essential for recognising normal variations, diagnosing conditions accurately, and facilitating discussion around sexual function. The vulva consists of the following structures:

1. Mons pubis: The fatty mound of tissue located above the pubic bone. After puberty, this area is typically covered in pubic hair.
2. Labia majora: The outer 'lips' of the vulva that protect the internal structures. These folds of skin contain sebaceous (oil) and sweat glands.
3. Labia minora: The inner 'lips' located between the labia majora. They are typically hairless and rich in nerve endings.
4. Clitoris: A highly sensitive organ with internal components, including crura and bulbs, extending along the vaginal canal (O'Connell et al., 2005).
5. Vestibule: The area enclosed by the labia minora, containing the urethral opening, vaginal opening, and Bartholin's glands.
6. Bartholin's glands: Located at the base of the labia minora, these glands secrete mucus to lubricate the vulva during arousal.
7. Perineum: The area between the vaginal opening and the anus, also sensitive to touch.

The Vulva and Pleasure: A Sensory Powerhouse

The vulva is not just functional — it is designed for pleasure. The clitoris alone contains thousands of nerve endings in its glans, with the internal components extending the scope of sensation throughout the vulva. While the exact number of nerve endings varies, the clitoris is one of the most sensitive structures in the human body (O'Connell et al., 2005).

Pleasure extends beyond the clitoris; The labia, mons pubis, vestibule, and perineum all significantly contribute to sexual arousal and responsiveness. Many vulva owners achieve orgasm through external stimulation, with research showing that fewer than 20% experience orgasm through penetration alone, making our conversations about the importance of understanding and being familiar with the vulva even more important! (Herbenick et al., 2010).

If we are all able to discuss the importance of the vulva when talking with patients, we will be able to empower them to embrace their unique experiences of pleasure and to make this a fun topic in sexual relationships. Knowledge is power, and power leads to autonomy and confidence in setting boundaries and guided erotic experiences.

Let's explore what happens to the vulva when sexual arousal is experienced? Fun facts that you can share with your patients to help them understand and appreciate their bodies!

The vulva undergoes dynamic changes during sexual arousal, reflecting its adaptability and responsiveness:

1. Clitoral engorgement: Increased blood flow causes the clitoris to swell and become more sensitive.
2. Labial changes: The labia majora and minora swell and darken due to increased vascularisation.
3. Lubrication: Bartholin's glands and the vaginal walls produce fluid, enhancing comfort during sexual activity.
4. Pelvic floor activation: Muscular contractions in the pelvic region can enhance arousal and orgasm.

These physical responses occur alongside psychological arousal (remember the biggest sexual organ is the brain), highlighting the importance of addressing both mental and physical aspects of sexual health (Basson, 2001).

Common Vulval Conditions

While the vulva can be a source of immense pleasure, for many it may also be impacted by various medical conditions that can significantly impact quality of life:

1. Vulvodynia: Chronic vulval pain affects 8–10% of vulva owners, presenting as burning, stinging, or irritation without an identifiable cause (Harlow et al., 2008).
2. Lichen sclerosus: An autoimmune condition characterised by thinning, whitening, and itching of the vulval skin. Topical corticosteroids remain the first line of treatment (Cooper et al., 2015).
3. Post-menopausal atrophy: Oestrogen depletion during menopause often leads to vulvovaginal atrophy, causing dryness, irritation, and discomfort during intercourse (Kingsberg et al., 2017).
4. Dermatoses and infections: Conditions such as eczema, psoriasis, and recurrent fungal infections frequently manifest on the vulva.

Combatting Stigma

One of the most significant barriers to vulval health is the stigma surrounding its discussion. Many patients are concerned about the 'normalcy' of their vulva, often comparing themselves to unrealistic media representations.

Normalising the diversity of vulval anatomy is crucial. Patients should understand that variations in labial size, asymmetry, pigmentation, and texture are completely natural. Initiatives such as The Vulva Gallery, and Comfortable in My Skin website, alongside educational resources, can help foster a sense of pride and acceptance in vulva owners.

Empowering Patients

As healthcare providers, you play a critical role in empowering your patients through education and confidence. Here is how:

1. Educate patients: Share accurate information about vulval anatomy, function, and pleasure.
2. Encourage exploration: Encourage practices such as mirror observation and self-exploration to assist patients in becoming familiar with their vulval anatomy.
3. Validate pleasure: Normalise conversations about sexual pleasure as part of holistic health.
4. Address concerns: Provide evidence-based treatments for conditions like vulvodynia and dryness.

Conclusion

The vulva is a remarkable part of the human body, deserving of greater attention and care. By normalising discussions around vulval health and pleasure, we can empower patients to better understand and celebrate their bodies. With accurate education, compassionate care, and a commitment to reducing stigma, we can help vulva owners feel confident, informed, and connected to their bodies and sexual health.

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Benign Vulval Lesions

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Vulval disease remains a neglected area of gynaecology and vulval examinations are often rushed past during the bimanual or speculum examination. Conditions that affect the vulva can appear dermatological in nature, making generalists hesitant in their diagnosis and management. However, it is not uncommon for vulval lumps and bumps to present in emergency departments or to general gynaecology clinic. This article aims to provide guidance for diagnosing and managing discrete benign vulval lesions. Dermatoses such as lichen sclerosus, lichen planus and desquamative inflammatory vaginitis (DIV) are not included, neither is discussion of premalignant lesions such as vulval intraepithelial neoplasia (VIN).

Normal Variations

One of the key components of vulval medicine is being confident in your knowledge of normal anatomy so patients who have normal variations can be appropriately reassured without the need to biopsy. Incorporating a brief vulval examination at the beginning of all speculum examinations can build confidence in assessing normal anatomy and reassurance to women in an area that is difficult to self-inspect. Some normal variants noticed by women, their partners or their general practitioners (GPs) can be cause for concern and referral to gynaecology clinic include:

Vulval papillomatosis: multiple small papillae (raised lesions) on the inner aspect of the labia minora. Flesh coloured, with a smooth surface and symmetrical distribution across the labia they can be mistaken for warts but do not have a rough thickened top.

Prominent sebaceous glands: the inner aspect of the labia minora is rich in sebaceous glands which are generally imperceptible. In some people they may be more prominent appearing as multiple yellow flat or slightly raised lesions 1-2 mm in diameter.

Prominent or uneven hymenal remnants can present as a finger like projection of mucosa out with the vaginal orifice. Removal is only necessary if the patient is experiencing distress.

Lumps

Sebaceous cysts: a common cause of white or flesh coloured vulval lumps that range from a few millimetres to a couple of centimetres in diameter. They may be itchy, and patients can present with multiple lesions across the labia majora. They are uncommon in younger women and adolescents and are more frequent in women with a raised BMI. They can become infected and then may release their contents. They can generally be managed conservatively but some women request surgical excision due to irritation however, there is a significant risk of recurrence following excision.

Vulval angiokeratomas: small, dark red or purple lesions found across the labia majora that are usually asymptomatic. They are common and seen from middle age onwards. Occasionally they will bleed if knocked or scratched and they can be treated with diathermy if this is an issue.

Hidradenitis suppurativa: a relatively common chronic inflammatory condition of the apocrine sweat glands and so is found in the axillae, groin, vulva and under the breasts. It is not seen before puberty and is more common in overweight people and smokers. It presents as recurrent tender painful lumps that may drain pus with associated sinuses, abscesses and comedones. It is thought to be due to blocked apocrine glands rupturing within the skin and causing inflammation. The main differential diagnosis is recurrent boils associated with Staphylococcus aureus infection but in hidradenitis skin swabs are usually normal.

The condition is thought to result from hypersensitivity of the apocrine glands to normal testosterone levels and so if contraception is being used an anti-androgenic progesterone can be useful in a combined or progesterone only pill. Management is coordinated by dermatologists and involves prolonged courses of antibiotics, intra-lesional steroid injections, newer biological agents and once the disease is under control excisional surgery can be considered.

Ulcers

Herpes: the most common infective cause of genital ulcers, caused by both Herpes Simplex Virus (HSV) 1 and 2. These begin as vesicular lesions that erode to become ulcers ranging from 3-10 mm in size and can also have a serpiginous shape. They can be found across the vulva, extending onto the thighs and buttocks and cause cervicitis and urethritis. The primary episode is usually the worst and associated with regional lymphadenopathy and feeling unwell. Viral swabs are useful to confirm the diagnosis and differentiate between HSV 1 and 2. Genital herpes is more frequently due to HSV 2 and although both are associated with recurrent flares, they are more frequent in HSV 2 – on average four times a year, rather than once a year in HSV 1.

Starting treatment at the time of diagnosis reduces the length of the flare by days to weeks but does not prevent recurrences. Treatment includes anti-virals such as valaciclovir or acyclovir, alongside symptomatic treatment including analgesia, topical lignocaine gel, cool baths, and urinary catheterisation if in retention. Recurrent episodes are less severe and usually easier to diagnose due to patient awareness.

Herpes ulcers can also complicate other vulval skin conditions such as lichen sclerosus or lichen planus if the patient is on immunosuppressants or high dose topical corticosteroids.

Aphthous ulcers: An uncommon finding of acute painful vulval ulcers usually in patients under 20, also known as Lipschütz ulcers or non-sexually acquired acute genital ulceration (NSAGU). They present as sudden onset acutely painful ulcers that may prevent mobilisation or urination and vary in size from 3-20mm often bilateral or kissing ulcers. They can be associated with Epstein–Barr Virus (EBV) and if so, the patient will have general malaise symptoms. The ulcers resemble oral aphthous ulcers, often with a sloughy based and a slightly raised erythematous rim often oval in shape.

The most important part of management is an early accurate diagnosis and reassurance to relieve the distress of the usually adolescent girl and her parents. The ulcers will heal without leaving scars in most cases. It is important to enquire after symptoms that might suggest Crohn's disease or Behçet's which are the part of the differential diagnosis. Viral swabs are usually taken to rule out HSV.

The treatment is then symptomatic with analgesia, catheterisation if necessary, topical lignocaine and ultra-potent steroids topically for small ulcers or systemically for severe disease.

Vulval Crohn's: In patients with Crohn's disease who present with genital ulcers the possibility of vulval Crohn's should be considered. Similar to aphthous ulcers in appearance but more like a knife cut in shape and associated with significant vulval swelling and fissuring. Vulval Crohn's may precede gastrointestinal Crohn's diagnosis by several years. The diagnosis is made on biopsy showing typical granuloma if there is not a pre-existing history of Crohn's. They respond well to steroids and need referral for ongoing management to a gastroenterologist.

Behçet's disease: This is a chronic vasculitis most common in those whose heritage can be traced back to the Silk Road that stretched from China, across North Asia to the Middle East and particularly Türkiye. The most common manifestation is oral aphthous ulcers and 75% of sufferers also have genital aphthous ulcers that are painful. Cutaneous ulcers are also common as is uveitis.

Consider this diagnosis in patients presenting with painful genital aphthous ulcers and have signs of disease elsewhere – oral ulcers, eye symptoms or less commonly central nervous system or pulmonary disease. In such cases, biopsy of the ulcer edge to confirm vasculitis is valuable, and referral to a rheumatologist is recommended. For aphthous ulcers with no signs of systemic disease biopsy is not necessary.

Hopefully, this article has encouraged you to integrate routine vulval examination into your clinical practice and it improves your confidence in identifying and managing some of the common benign vulval lesions.

Vulval Dermatology: A Dermatologist's Journey

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Vulval dermatology is a niche but essential subspecialty that sits at the intersection of dermatology, gynaecology, urology and sexual health[1]. As a dermatologist with a special interest in vulval skin conditions, I have witnessed firsthand the profound effects that vulval dermatological disorders can have on women's quality of life. For many patients, these conditions not only cause physical discomfort but can also lead to emotional distress, making early diagnosis and proper management vital. This article outlines my journey into vulval dermatology, highlights treatment challenges, and reviews common vulval skin conditions that require expert care.

My Journey into Vulval Dermatology

My journey into vulval dermatology began during my first year of dermatology training, where I had the privilege of working under the mentorship of Associate Professor Amanda Oakley who is a leading expert in the field of vulval dermatology. I was fortunate enough to attend her weekly vulval clinics. The sense of validation women experienced upon finally receiving a diagnosis-and the immense impact on their quality of life once adequately treated-was inspiring. This experience solidified my interest in the field long after completion of my dermatology training.

Vulva as Skin of Special Site

The vulva consists of three distinct types of skin: mucosal, intertriginous, and cutaneous. The mucosal skin — including the inner labia minora and the vestibule — is non-hair bearing and more delicate than other skin types. The labia majora and surrounding areas, on the other hand, have cutaneous skin, which is similar to the skin found on other parts of the body. Additionally, the inguinal regions where the skin touches skin (e.g., the folds between the labia majora) are classified as intertriginous skin which is more susceptible to the effects of occlusion, friction and sweat. When assessing vulval skin conditions, it is crucial to identify which type of skin is involved, as this can greatly influence both the diagnosis and the treatment plan.

The vulva is also unique in that it has a limited way in which rashes can appear – with a cursory look every condition can look similar! For example, psoriasis on the elbow typically presents as a well-demarcated erythematous plaque with silvery scales, but psoriasis on the vulva appears erythematous without the characteristic scales. Despite these diagnostic limitations, some general guidelines can assist clinicians. Erythematous rashes are often seen in conditions like eczema, psoriasis, tinea, or candida. White patches or pallor may suggest lichen sclerosis, lichen simplex, vitiligo, or even malignancy. Ulcers and erosions are typically indicative of lichen planus, autoimmune blistering diseases, or aphthous ulceration. A thorough assessment of other areas of the body, including the scalp, face, flexures, extensors, and nails, can offer valuable clues to help differentiate these conditions.

The Importance of Vulval Skin Care

When managing vulval dermatological conditions, skin care plays a critical role. It is essential to take a detailed history to understand what products are being used on the vulva. Over-the-counter products, such as perfumes, soaps, and hygiene wipes, can often exacerbate existing skin conditions and contribute to irritant or allergic contact dermatitis. For example, patients with urinary incontinence may use pads that can irritate the vulval skin, while those with faecal incontinence may rely on wet wipes, which can cause similar issues.

In my practice, I often advise patients to use plain water or non-soap cleansers to cleanse the vulval area, as they are less likely to cause irritation. I also emphasise the importance of not over-washing, as excessive washing can disrupt the skin's natural barrier and exacerbate inflammation. I recommend loose-fitting underwear made from breathable materials such as cotton or silk to reduce friction and moisture accumulation, both of which can contribute to vulval skin irritation.

When prescribing treatments, I generally prefer ointment formulations for delicate mucosal areas, as they have no water content and do not contain preservatives, making them less likely to irritate. In contrast, creams and lotions can cause a burning or stinging sensation due to their higher water content and added preservatives. However, care must be taken when applying ointments to hair-bearing areas, as they can cause occlusion and folliculitis. Additionally, while topical steroids are often used to treat inflammatory vulval skin conditions, they can lead to side effects such as steroid-induced rosacea, periorificial dermatitis, infections like herpes or candidiasis and if not used properly can result in early and late changes of steroid-induced atrophy.

Common Vulval Skin Conditions

The most common skin conditions referred to a vulval dermatology clinic are lichen sclerosus, eczema and psoriasis[2]. Other conditions often seen are lichen planus, hidradenitis suppurativa, peri-orificial dermatitis, granular parakeratosis, vitiligo and Zoon's vulvitis.

Lichen Sclerosus

Lichen sclerosus is a chronic inflammatory skin disorder that typically manifests as white, thickened patches on the vulva. This condition is often intensely pruritic, causing severe itching, which can lead to discomfort and pain, particularly during sexual intercourse. The active inflammation in lichen sclerosus may present as erythema, hyperkeratosis, erosions, and fissures. Over time, chronic lichen sclerosus can lead to scarring, labial fusion, and narrowing of the vaginal opening. Lifelong surveillance is necessary to monitor for potential development of vulvar squamous cell carcinoma, as there is an increased risk of malignancy associated with the condition.

Vulval Eczema

Vulval eczema encompasses a range of conditions, including atopic dermatitis, irritant contact dermatitis, allergic contact dermatitis, seborrheic dermatitis, and lichen simplex[3]. Atopic dermatitis is often associated with a personal or family history of asthma, hay fever, or eczema elsewhere on the body. Irritant contact dermatitis occurs when a substance, such as soap or water, repeatedly encounters the vulval skin, causing irritation. Contact allergic dermatitis requires a high degree of suspicion and keeping up to date with the common and emerging contact allergens. If unable to be elicited on history, formal patch testing is necessary to evaluate contact allergic dermatitis. Lichen simplex is a neurogenic type of eczema where there is a perpetual itch scratch cycle that leads to thickened and leathery skin with accentuated skin markings. Underlying causes of the initial pruritus/trigger can be varied.

Vulval Psoriasis

Psoriasis on the vulva often presents as erythematous plaques on the labia majora, which may extend into the inguinal, perianal, or gluteal cleft areas. Unlike psoriasis on other parts of the body, vulval psoriasis may not present with the characteristic silvery scale. However, a careful history and examination of other parts of the body (e.g., the scalp, nails, and elbows) can provide important diagnostic clues. Vulval psoriasis that does not respond to intermittent use of mild to moderate potency topical steroids may require systemic treatments, especially if symptomatic. Adjuvant topical treatments commonly used in cutaneous psoriasis-such as tar, calcipotriol, salicylic acid-are typically too irritating for the vulval area and treatments such as phototherapy are not possible.

Granular Parakeratosis

Granular parakeratosis is a condition that affects the intertriginous areas of the vulva, often in middle-aged women. It is thought to be triggered by friction, occlusion, and sweating, which alters the skin's microbiome. This leads to red-brown patches and desquamation of the skin. Although previously uncommon granular parakeratosis has increased in incidence in recent years especially during the Covid pandemic due to widespread use of antiseptic laundry products containing benzalkonium chloride. Treatment typically involves the use of mild to moderate topical steroids to reduce inflammation, along with oral antibiotics to restore the skin's natural microbiome and keratolytic agents to manage desquamation.

The Role of Multidisciplinary Care and Resources

Given the complexity of vulval dermatology, a multidisciplinary approach is often required, particularly for patients with complex or treatment-resistant conditions. In many cases, gynaecologists, sexual health physicians, physiotherapists, sex therapists, and psychologists may be involved in the care of these patients. Vulval clinics, often found in tertiary centres, are invaluable for providing comprehensive care to women with complex vulval dermatological issues. These clinics offer coordinated care that addresses the physical, emotional, and psychological aspects of vulval health.

Several resources are available to both healthcare professionals and patients. The Australian and New Zealand Vulvovaginal Society (ANZVS) is an excellent resource for those involved in the care of women with vulval conditions[4]. Additionally, websites like caredownthere.com.au and dermnetnz.org provide up-to-date information on vulval dermatology, and they serve as educational tools for both patients and health professionals[5,6].

Conclusion

Vulval dermatology is a vital field that significantly impacts the lives of women. As dermatologists, gynaecologists, and other healthcare providers, we can make a profound difference in the lives of women affected by vulval skin conditions. Through early diagnosis, proper treatment, and a multidisciplinary approach, we can help patients regain comfort, confidence, and quality of life.

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Flip Through My Flaps: A Conversation with a Vulva Photographer

Ellie Sedgwick
Author, Photographer

Dr Nisha Khot
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Ellie Sedgwick is a body image advocate, photographer, and founder of Comfortable in My Skin—a movement dedicated to dismantling shame and empowering people to embrace their bodies, starting with their vulvas. Known to many as "The Vulva Photographer," Ellie uses her lens and voice to challenge narrow beauty ideals and foster conversations around self-worth, pleasure, and body acceptance. Her journey began with her own struggles around vulval self-esteem, leading her to create a platform that celebrates anatomical diversity and encourages connection through shared stories. Her latest project, *Flip Through My Flaps,* features photographs of over 500 vulvas, each one a powerful testament to individuality and empowerment. Through her work, Ellie is helping people see themselves more clearly—and more kindly.

How did you come to be a vulva photographer?

My journey began with my own struggles with body image, specifically around vulva anxiety. For years, I struggled with shame and self-doubt. When I started photographing women's bodies, I realised how many others shared these same insecurities. This journey, along with my own healing process, drove me to create Comfortable in My Skin, a platform and movement dedicated to empowering women to accept and love their bodies fully.

Most people would ask, 'Why?' Why photograph vulvas?

Because we need to! Our lack of exposure to diverse vulvas starts with the shortcomings in sex education, especially in schools. For too long, the only vulvas we've seen are in outdated textbooks, which give a ridiculously narrow idea of what's 'normal.' I wanted to challenge the stigma, open conversations, and showcase the true beauty and diversity of vulvas.

What has the experience of being a vulva photographer been like?

Emotional, beautiful, moving… I've heard everything from "I had no idea what mine looked like" to "This is the first time I've ever felt proud of my vulva." The impact is huge. Watching women go from anxious to empowered in front of my lens is something I'll never get tired of. Through these group workshops, I saw women reveal secrets they had never told anyone in their lives, from being diagnosed with herpes to insecurities they had about their labia. Often, when they shared these experiences, someone else in the group had a similar experience, instantly shattering the shame as they realised they were not alone.

What is 'vulva anxiety'?

Vulva anxiety is the belief that something is 'wrong' with your vulva because it doesn't match a limited, unrealistic standard. It's the fear that yours isn't normal, that it should be smaller, neater, more 'perfect.' It's the reason labiaplasty rates are skyrocketing. But here's the truth - vulvas are as unique as faces, and there is no one 'perfect' shape.

What do women who get photographed do with their photos?

Some frame them. Some tuck them away as a private reminder of their self-love journey. Some share them with partners as an act of confidence. But most importantly, they keep them as proof that they are worthy, beautiful, and completely normal.

What prompted you to publish your book 'Flip Through My Flaps'?

When I started the photography for *Flip Through My Flaps,* I was driven largely by my personal experience. Today it's no longer just a personal issue; it's become a public health crisis. One in six Australians are anxious or embarrassed about the way their labia look, and almost a third of Gen Z associates their labia with negative words such as 'weird', 'disgusting' or 'ugly.' This underscores the need for greater education and acceptance, which is why *Flip Through My Flaps* is needed now more than ever.

Tell our readers about Comfortable in My Skin

Comfortable in My Skin is a movement and community aimed at celebrating body diversity and tackling the stigmas around women's health. We want our audience to feel empowered, seen, and encouraged to embrace their bodies as they are. By sharing real stories and images, we hope to normalise the diverse beauty of all bodies and break down taboos around women's health that are often shamed into silence.

What has your experience taught you about sexual pleasure?

That confidence and pleasure are deeply connected. When you're consumed by insecurity, it's hard to let go and enjoy intimacy. But when you learn to love your body—really love it—pleasure becomes so much more fulfilling. I've learnt that the labia I spent so much of my life worrying about is completely normal. And it's not just a pointless piece of skin; it has thousands of nerve endings that can be used as a tool for my pleasure.

You are involved in so much more than vulva photography. Could you tell our readers about the education and awareness work that you are involved with?

Comfortable in My Skin has evolved into a platform for education, activism, and empowerment. We tackle everything from body image to sexual health, providing resources, expert opinions, events and workshops. I'm also working to get *Flip Through My Flaps* into schools and libraries, so young people grow up knowing that their bodies are normal and nothing to be ashamed of. By creating a culture of openness and acceptance, we can rewrite the shameful narratives we've been handed and truly embrace our bodies, just as they are.

Ellie Sedgwick holding a copy of her book 'Flip Through My Flaps'

Vulval Disorders in Children

Dr Angela Dunford
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Overview

Vulval conditions make up the bulk of paediatric gynaecology referrals. Whilst children can be affected by many of the same disorders as adults, they can manifest different symptoms and clinical appearances. Always remember that vulval presentations may be the most symptomatic element of a generalised disorder.

The fundamental goal of the vulval examination is to determine whether the skin appears abnormal. Children differ from adults in their engagement during examinations and your capacity to biopsy abnormalities. A full clinical examination should include inspection of extragenital skin, hair, ears and nails.

Baseline photography of the anogenital area to aid treatment review remains underutilised by gynaecologists compared to our dermatology colleagues. Developing a secure system and consent process for taking and storing clinical photographs can make a huge difference to our capacity to monitor treatment response.

A vulval swab has limited utility in premenarchal children, often yielding polymicrobial results. A swab can be considered if inflammation extends to the vagina and discharge is severe, offensive and persistent. Candida species are rarely present prior to oestrogenisation, except in cases of diabetes or significant immune compromise[1]. Likewise, vulval biopsy is rarely used. Malignancy is exceedingly rare in children and most benign diagnoses can be made on clinical features and response to treatment[2].

Lichen sclerosus

Lichen sclerosus (LS) occurs across all age groups with diagnostic peaks in premenarchal girls and postmenopausal women. There has been considerable debate about clinical monitoring beyond adolescence when LS is diagnosed in childhood. Evidence now supports regular review to prevent architectural and functional consequences[4].

Children present with pain and erythema but may also wake from sleep crying or experience pain when voiding or opening bowels[5]. In severe cases of irritation, there can be bleeding and bruising. Examination findings can be similar to those in adults with pallor and architectural loss. More than 30% can have subepithelial haemorrhage. Purpuric blotches and melanocytic lesions are also associated and can be mistaken for alternative diagnoses[5].

See table 1.

Treatment aims to manage symptoms, normalise colour and texture while also limiting architectural disruption. General vulval care advice should always be given. The Royal Children's Hospital in Melbourne have excellent handouts for parents[6].

Psoriasis

Psoriasis is a chronic inflammatory skin condition. It appears as red plaques, often well demarcated and symmetric, with overlying scale on hair bearing skin (note that scale is not seen in inverse psoriasis). Fissures and maceration can occur within skin folds and the condition favours the perineum and natal cleft, but the vagina is not involved[7].

The recognition extragenital involvement (most commonly the scalp) helps to make the diagnosis[8]. Eye lesions are well demarcated and favour the medial aspect. On the other hand, contact dermatitis extends over the whole of the upper eyelid. Nail changes are common[9]. Children with psoriasis are at an increased risk of developing diabetes, metabolic syndrome and obesity beginning in adolescence[10]. Recognising psoriasis provides an opportunity for prevention.

As for LS, psoriasis treatment aims to reduce triggers, calm flares and keep the disease under control. Good vulval care advice should always be given.

See table 2.

Vulvovaginitis

Vulvovaginitis is an umbrella term that when applied to prepubertal girls refers to contact dermatitis. The most common symptoms are pruritus, pain, dysuria and discharge. The vulva and vagina appear erythematous and often have excoriations demonstrated by linear erosions and traumatic vesicles. Severe excoriation can be associated with discharge and bleeding.

The lack of oestrogen in prepubertal girls is the primary contributor to vulvovaginitis. It is also helped along by underdeveloped vulval fat pads, the absence of protective pubic hair, anatomical proximity of vulva and anus and the haphazard techniques employed by children when they first start independent toileting.

Management is often surprisingly straightforward. Parents should be informed that symptoms may flare but are better managed if treatment is commenced early and vulval care continued regardless of symptoms.

Aim of Treatment	Treatment	Australian Examples
Initial Management	Super potent or potent topical corticosteroid ointment daily until remission	• Betamethasone dipropionate 0.05%
Maintenance Therapy	Same treatment with decreased frequency (e.g. twice weekly) Or Low to medium potency steroid daily	As above • Methylprednisolone aceponate 0.1% • Hydrocortisone 0.5–1%

Note: Treatment frequency and steroid potency needs to be individualised. Only treating during a flare rarely results in adequate control[5].

Table 1. Lichen sclerosus management suggestions with Australian examples

Aim of Treatment	Treatment	Australian Examples
Flare Management	Topical MODERATE potency topical corticosteroid ointment PLUS 2% liquor picis carbonis (LPC) in zinc cream	• Methylprednisolone aceponate • Betamethasone valerate 0.02–0.05% • Compounding chemists only
Severe Flare	Topical HIGH potency corticosteroid ointment	• Betamethasone dipropionate (Diprosone)
Severe & Systemic	Immunosuppressive agents and biologics	• Managed under the care of dermatology
Flare Prevention	BD barrier ointment Or Low potency steroid	• Sudocrem, Bepanthen, Amolin • Hydrocortisone acetate 0.5–1%

Table 2. Psoriasis management suggestions with Australian examples

Treatment	Examples
Vulval care	• No underwear at night • Loose clothing with natural fibre underwear • Barriers and emollients • Avoid contact with irritants (scented soaps, fabric softeners, bath bubbles) • Front to back wiping when toileting
Barrier protection	• Unscented products with minimal ingredients (e.g. white soft paraffin, Amolin, Bepanthen or Sudocrem
pH alteration	• ½ cup white vinegar added to shallow bath nightly until symptoms settle

Table 3. Supportive vulval skin care strategies, including barrier protection and pH modification

What to do When Simple Measures Fail	
Nocturnal distress	Treat the whole family for pinworms. Repeat for the affected child at weekly intervals for the following two weeks (Mebendazole 100mg)
Severe excoriation	This can prevent vinegar baths and comfortable toileting: a short course of moderately potent topical steroid ointment can settle the itch scratch cycle rapidly (e.g., Methylprednisolone aceponate BD for 7 days)
Blood stained offensive and persisting discharge not responding to standard therapy	Consider foreign bodies including small bits of toilet paper. A vaginoscopy and examination under anesthetic may be required if saline flush has failed[11]
Treatment	Reassess the diagnosis - symptoms may evolve and examination findings may give clues to an alternative differential

Table 4. Management considerations when first-line vulval care strategies are insufficient

Labial adhesions / fusion

Labial fusion is a variation of normal. Adhesions result from the low oestrogen prepubertal environment and will resolve once pubertal development commences[12]. There is rarely an indication to treat with oestrogen even when no opening is visible unless the patient is diagnosed with recurrent urinary tract infection or is unable to void. Manual separation in the office is traumatic, poorly tolerated and should never be done. Separation under anesthetic should only be considered in the rare instances adhesions remain after puberty or cause acute urinary retention. Most parents are easily reassured and can be directed to resources such as the Royal Children's Hospital in Melbourne fact sheets[13]. Similarly, generalised mild erythema at the vestibule is a normal finding in healthy patients without vulvitis and does not require treatment.

Labial adhesions are often mistaken for the cause of vulval pain and referrals seeking treatment to remedy the pain are common. More often, the discomfort is secondary to concurrent vulvovaginitis resulting from the low oestrogenised environment that is common to both conditions. Reassurance, vulval care and simple vulvovaginitis treatments are often sufficient to alleviate symptoms.

Conclusion

Vulval conditions in children are common. Most are easy to treat with simple measures. Recognising normal variations and confidently reassuring parents is a key component of the paediatric vulval consultation. When an abnormality is identified, it is important to generate a differential diagnosis to direct treatment and measure treatment response. Seek a second opinion from a paediatric or adolescent gynaecologist or dermatologist before proceeding with anaesthetic or biopsy.

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A Rare Case of a Nephrogenic Adenoma in a Urethral Diverticulum

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A 57-year-old female presented with bothersome and progressively worsening lower urinary tract symptoms. Symptoms included continuous dribbling, leakage, and mild stress urinary incontinence. The patient required continuous use of incontinence pads which were consistently saturated by the end of the day.

The patient's medical history is of smoking one pack a day for 30 years, obesity, depression, hypertension and hypercholesterolemia, diabetes mellitus and recent intentional weight loss of 13 kg. Her medications are venlafaxine, amlodipine, rosuvastatin, metoprolol and gabapentin. Her obstetric history includes one baby delivered via lower segment caesarean section; she has no other surgical history. She has been post-menopausal for seven years.

Prior to specialist referral a pelvic ultrasound was performed. It revealed a multiloculated cystic mass in the vagina. The smallest lesion was nearly collapsed, the two larger individual cysts measure 2cm on the right and 1.8cm on the left.

Vaginal examination revealed a midline mass approximately 2-3cm in diameter and appeared to be abutting the urethra. The mass was soft and did not discharge with gentle pressure. It was thought to be suspicious for diverticulum. Magnetic resonance imaging (MRI) was performed for diagnosis confirmation and surgical planning.

MRI confirmed a multilocular cystic lesion 2.3 x 2.4 x 1.9cm posterior lateral to the mid to distal urethra. There was no solid component and no obvious urethral connection, most consistent with urethral diverticulum.

The patient was counselled on management options and scheduled for a diverticulectomy. A cystoscopy was performed prior to the surgery. Cystoscopy confirmed a normal bladder and a small area likely to be the communication within the urethra. The surgery was performed with an inverted U incision and a combination of sharp and blunt dissection to excise the diverticulum. Care was taken to avoid breaching the diverticulum during dissection. The urethra was entered during the surgery and closed over with 3.0 Vicryl. After excision of the diverticulum the vagina was closed with 2.0 Vicryl suture. A catheter was left in situ postoperatively. The patient was discharged home with a catheter for four weeks post-surgery. Her post operative recovery was uneventful.

Interestingly the histopathology revealed a urethral diverticulum with chronic inflammation, mucosal ulceration, and an incidental finding of nephrogenic adenoma.

The patient reports no recurrence of symptoms at 12 months follow up. We report this unique case of a nephrogenic adenoma occurring in a urethral diverticulum of a female patient.

Discussion

This case represents a unique instance of a patient presenting with urinary symptoms and a vaginal mass. This case leads to the discussion of an uncommon diagnosis of a urethral diverticulum, coupled with a rare histopathology finding of a nephrogenic adenoma in a female.

Urethral diverticulum (UD) is an outpouching of the urethral mucosa into the peri urethral tissue. They are uncommon, occurring at a rate of 0.6-6%[1]. The first case of UD was reported in the early nineteenth century, the frequency of diagnosis has been increasing with more sensitive imaging modalities[2].

UD are most likely to be secondary to an infection of the peri urethral gland leading to gland obstruction, local abscess formation with eventual rupture into the urethral lumen[2]. Some theories support a congenital aetiology, including faulty union of primordial folds, genesis from cell rests or Gartner's duct remnants, and Mullerian remnants causing vaginal cysts[2].

Urethral diverticulum can be challenging to diagnose. They can present with a range of symptoms including urinary incontinence, pelvic and urethral pain, urinary tract infections, a vaginal or pelvic mass, vaginal or urethral discharge, urinary urgency, frequency, or hesitancy. There is a classic triad known as the '3Ds' dysuria, dyspareunia and dribbling however, this is not necessary for diagnosis[1, 2].

Diverticula typically appear on the middle to distal urethra in varied size, shape and location (1). Patients with UD may present with vaginal wall tenderness with or without a palpable mass. Digital pressure may express purulent or bloody discharge(2). The gold standard for diagnosis of a urethral diverticulum is MRI (1). MRI has advantages over ultrasound or urethroscopy as it allows better visualisation of diverticular that may be small or non-communicating. The multiplanar resolution of an MRI allows for improved differentiation between normal anatomical variants, soft tissue masses and urethral pathology, which improves detection rates of diverticula (3).

While the majority of UDs are benign, malignant change has been reported in 6-9% of cases (3). The most common neoplasm reported is adenocarcinoma, however transitional cell carcinoma and squamous cell carcinomas have been identified(2). Rare cases are reported of Nephrogenic adenoma.

Nephrogenic adenoma (NA) is a rare, benign lesion of urothelial proliferation. It can involve any segment to the urothelial tract (4 - 7). Nephrogenic adenoma usually arise in the urinary bladder (80%), typically confined to the lamina propria, and occasionally focally involve superficial muscular propria (6). They can involve the urethra (15%), the ureter (5%), and rarely the renal pelvis. Case reports exist of NA in urethral diverticulum (6). Nephrogenic adenoma occurs more commonly in men than women (8). Our case is interesting as only rare reports of NA in urethral diverticulum of women exist (8, 9).

Symptoms of NA are often non-specific and varied in the literature. Prestation is similar to urethral diverticulum including, a palpable mass, recurrent urinary tract infections (UTIs), obstructive urinary symptoms, haematuria, dyspareunia, or suprapubic pain (5, 7).

It is theorised that nephrogenic adenoma result from exfoliated renal epithelial cells that implant into the urinary tract at the site of prior injury (6). Or as described in our case within a diverticulum. Historically, nephrogenic adenoma was described in 1949 by Davis, who named the pathology hamartoma of the bladder (7, 10). Friedman and Kuhlenbeck in 1950 re-described the lesion and named it Nephrogenic Adenoma due to its histological similarities to the renal tubules (7, 11).

Nephrogenic adenoma is characterized by a circumscribed proliferation of tubules, cysts, and papillae lined by cuboidal to columnar epithelium interspersed in oedematous and inflamed stroma. This is surrounded by a thickened, hyalinised basement membrane (4 -8, 12). Immunohistochemically, Nephrogenic adenoma stains positive for cytokeratin 7, alpha-methylacylCoA racemase (AMACR) and PAX2, a renal transcription factor (8).

Histologically Nephrogenic adenoma can resemble a skene's gland of a female. Of more significance however is that NA can mimic variants of clear cell adenocarcinoma and prostate adenocarcinoma. Therefore, the combined histological examination and immunohistochemistry is necessary for correct diagnosis (1, 8).

The recurrence rate is reported to range from 0.5% to 80% therefore adequate follow up, even after surgical excision is recommended (7).

This case of nephrogenic adenoma within a urethral diverticulum presents a rare finding. We highlight the importance of maintaining a high index of suspicion for urethral diverticulum in women presenting with urinary symptoms and, or a vaginal mass. This case demonstrates the importance of appropriate investigations for UD and the benefit of MRI in women with urinary symptoms and a vaginal mass prior to surgical excision.

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Lichen Sclerosus – An All-in-One Resource

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OK, full disclosure: reviewing a textbook on Lichen Sclerosus (LS) is something neither of us had done before. Having independently come across this publication (MH via the International Society for the Study of Vulvovaginal Disease (ISSVD) when it was published in mid-2024; MD two weeks ago via Tania), we were both impressed by its delivery and purpose. We hope that we can convey just how fabulous a book on vulval dermatitis can be.

Backstory: we met Dr Tania Day, co-editor of the book, at a recent RANZCOG Council meeting over a discussion about the next issue of the O&G Magazine. By way of introduction, Dr Tania Day MD PhD, is a Newcastle-based RANZCOG and an American College of Obstetricians and Gynecologists Fellow with clinical and research special interest in vulval disease. You may have previously come across some of Tania's work if you've read and used any patient information on the Australia & New Zealand Vulvovaginal Society website (Australia New Zealand Vulvovaginal Society: anzvs.org/patient-information). During our conversation, we discussed Tania's recently published book on LS and realised that many were unaware of this untapped resource. We then decided that we would read the 211 pages in a week to provide you with some advice about why you need to download this book.

This book is a free, online resource via ISSVD (issvd.org/resources). It is divided into 16 chapters with sub-headings and yes, you can search for specific terms/ pathologies easily. It is contemporary and evidence-based, with appendices brimming with references and discussions of their limitations. The editors have harnessed and skilfully curated specialist opinion on a spectrum of relevant topics on lichen sclerosus. For those with a research interest, the book generously highlights future directions and gaps in the literature. Although contents have been provided by a wide range of experts from across the world, it is skilfully edited and reads seamlessly.

Lichen sclerosus is common. Even if you don't see much vulval dermatology in your practice, you will inadvertently come across this condition in your daily work. It is often ignored by primary and secondary care and/or misdiagnosed. Early diagnosis and appropriate management can often prevent its many commonplace sequelae (dyspareunia, architectural changes, and dysuria) and improve quality of life for affected individuals. Starting a steroid cream and/or referring appropriately can make a world of difference.

Here are some of our thoughts and impressions after reading and using the advice from this book.

MD: I loved the layout - designed in the way we approach clinical care - so many helpful chapters, great sections about what is not known/limitations of the literature - so different from any textbook I have read in the past decade Highlights for me included the glossary of terms at the back! The biopsy table of techniques! And new terminology and concepts -vaginitides, steroid phobia (notably highest among pharmacists), the difference between moisturisers, emollients and ointments. Great photos of steroid doses on a fingertip to demonstrate doses, helpful algorithm for steroid non responders.

The language is directive and helpful ('Use of a mirror is associated with an increased sense of control, knowledge, and a desire to use it again during future examinations'. I also liked their often wry tone 'Reading the whole pathology report builds familiarity with pathologic vocabulary and diagnostic approach.'

This book taught me how great and full of care a bio psychosocial consult for LS could be and I am so grateful it has been written. Kudos to the editors, authors and ISSVD who have made it free and downloadable.

MH: As someone who sees patients with vulval dermatoses on a regular basis, I'd like to congratulate Dr Day and her co-editors Drs Mauskar and Selk, for this sterling resource. It is 211 pages of pure gold. In addition to providing a comprehensive overview of vulval dermatology fundamentals such as terminology, anatomy and basic pathology, it also delves deeply but succinctly into all the practical aspects of care (how do you know when someone uses too much ointment? What's the best method of pubic hair removal and menstrual care with women with dermatoses, amongst others). Particular mention must be made to an important inclusion of a separate chapter on LS during the peripartum period and considerations regarding mode of birth – a highly useful and unique resource in our practice.

I admit to having several dermatology and vulval health books on my shelf but these (or certainly the chapters on LS) are beginning to gather dust as I repeatedly reach for this book. Page 77 (how much steroid to use) proudly resides on a wall in my private rooms (a picture is worth a thousand words) and serves as a visual reminder/ reinforcer of the counselling patients receive. This book's systematic approach has provoked thoughtful reassessment and reframing of some of the presentations I have seen recently.

I have also found this book to be an excellent resource for teaching, and I frequently share it with my trainees. Looking wider, I would love to see an abridged 2-page summary, including the differential diagnosis and treatment algorithms, specifically aimed at general practice. As a minor quibble, both MD and I noted some confusion in terminology particularly in the fast-changing world of species nomenclature (e.g. is it a Candida glabrata or Nakaseomyces glabrata?). A frequently updated living appendix would be an excellent accompaniment to this book and would assist clinicians navigating microbiology reports (without the need to 'Google' the species name).

In summary, we highly recommend *Lichen Sclerosus. ISSVD Practical Guide to Diagnosis and Management* - this valuable, comprehensive and up-to-date e-book is a go-to resource in this field.

We cannot wait for a hardcopy version, and we are proud as punch of our colleague Dr Tania Day for putting this together.

Molar Pregnancies

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What is Gestational Trophoblastic Disease?

Gestational Trophoblastic Disease (GTD) is a spectrum of pregnancy-related conditions characterised by abnormal proliferation of trophoblastic tissue[1].

GTD includes both benign and malignant conditions. The most common benign entities are Complete Hydatidiform Mole (CHM) and Partial Hydatidiform Mole (PHM). Other benign entities are Exaggerated Placental Site, Placental Site Nodule and Atypical Placental Site Nodule (APSN). APSN is considered a non-malignant condition but may be a precursor to or co-exist with Placental Site Trophoblast Tumour (PSTT) or Epithelioid Trophoblast Tumour (ETT) (in 10-15% of cases[2]). The malignant versions are Persistent Disease or Invasive Mole, Choriocarcinoma (CC), PSTT, and ETT. Collectively they form Gestational Trophoblastic Neoplasia (GTN). GTN can occur following any pregnancy but is most commonly seen following a molar pregnancy.

Incidence and Risk Factors

Molar pregnancy rates vary worldwide; in Australia it affects approximately 1 in 1,000 pregnancies. Established risk factors include extremes of reproductive age and previous molar pregnancy. Molar pregnancies are also more common in women of Asian descent[2]. The majority of GTN cases arise following a molar pregnancy, the rest can occur following a term pregnancy, miscarriage or ectopic pregnancy.

Features of Molar Pregnancy

CHM are androgenetic diploid conceptions, characterised by hydropic villi, trophoblast proliferation and negative p57 expression. Ultrasound findings show no fetus, heterogenous material with anechoic spaces and ovarian theca lutein cysts. Human chorionic gonadotropin (hCG) levels are often >100,000 and hyperthyroidism may occur.

PHM are diandric triploid conceptions, characterised by occasional hydropic villi, minimal trophoblast proliferation and positive p57 expression. Ultrasound will show a fetus is present and the placenta may contain cystic spaces. hCG levels are usually lower.

Diagnosis

CHM is often suspected based on ultrasound findings showing cystic spaces within the endometrial cavity with no fetal pole or parts identified. In PHM, a fetus is present on ultrasound and the diagnosis is usually made during a curettage for a miscarriage or termination. Histological diagnosis is confirmed via suction curettage, which should be performed under ultrasound guidance - especially for suspected CHM - to ensure complete evacuation[3].

As ultrasound scans become more sensitive, curettage is occurring at earlier gestations, making histological diagnosis more challenging as the classic histologic features of molar pregnancies are not always present. Expert pathology review and molecular genotyping may be required for ambiguous cases. After review, the initial diagnosis can be changed in up to 26% of cases[4]. Molecular genotyping helps distinguish between diandric triploids (PHM) and digynic triploids (non-molar triploids) as well as to diagnose other causes of abnormal villous morphology (e.g. trisomy).

Post molar GTN is usually diagnosed during hCG monitoring and does not require histological diagnosis. Performing a hCG level should be considered if a woman presents with abnormal vaginal bleeding following any pregnancy.

Monitoring and Follow Up

Once a molar pregnancy has been diagnosed, hCG levels are monitored until they return a negative result. Monitoring is typically weekly until negative but should occur at least every two weeks. Confirmatory negative testing includes weekly hCG checks for three consecutive weeks or a repeat test one month after hCG normalisation.

For CHM, patients undergo monthly hCG testing for six months (after normalisation). Patients should be advised not fall pregnant during that time. Emerging evidence suggests hCG monitoring may be discontinued once negative if it occurs within 56 days of evacuation[5]. Patients diagnosed with a PHM do not require any further hCG testing (after normalisation) and can pursue pregnancy when desired.

The relapse risk after achieving negative hCG is less than 1%. Factors that increase relapse risk include advanced maternal age and delayed hCG normalisation (beyond 56 days).

FIGO Score	0	1	2	4
Age	<40	>40	–	–
Antecedent pregnancy	Mole	Abortion	Term	
Interval from index pregnancy, months	<4	4–6	7–12	>12
Pretreatment hCG MIU/ml	$<10^3$	$>10^3$–10^4	$>10^4$–10^5	$>10^5$
Largest tumor size including uterus[2] cm	–	3-4	≥5	–
Site of metastases including uterus	Lung	Spleen, kidney	Gastrointestinal tract	Brain, liver
Number of metastases identified	–	1-4	5-8	>8
Previous failed chemotherapy	–	–	Single drug	Two or more drugs

Table 1. WHO scoring system based on prognostic factors modified as FIGO score

Persistent Disease and GTN

Persistent disease occurs in 15% -20% of CHM and after 0.5 - 5% of PHM cases [2]. Persistence is defined as a hCG fall of less than 10% over 3 weeks or a hCG rise by more than 10% over two weeks.

If persistence occurs, imaging is required to exclude metastatic disease. This can include Chest X-Ray (CXR) and Pelvic ultrasound or a computed tomography (CT) scan of the head/neck/chest/abdomen and pelvis.

The World Health Organization (WHO)/International Federation of Gynecology and Obstetrics (FIGO) Prognostic Score is then calculated (see Table 1). A score of six or less is considered Low Risk disease and a score of 7 or more is considered High Risk disease. A score of 13 or higher indicates Ultra High-Risk disease. Whether the patient has low, high or ultra high-risk disease determines the chemotherapy agents used for treatment.

Chemotherapy

Patients with Low-Risk disease requires single agent chemotherapy. This can include Actinomycin D or Methotrexate. The 2016 Cochrane Review and a 2021 meta-analysis report superior efficacy with Actinomycin D, with a higher primary remission rate (80.2% vs 65.1% for Methotrexate), with increased (although acceptable) dermatological and GIT toxicity [6,7]. Actinomycin D is administered every two weeks via an intravenous route. Alternatively, Methotrexate can be given as an intramuscular injection every second day on Days 1,3,5,7 (with folinic acid rescue orally on Days 2,4,6,8) or as an intravenous infusion over 12 hours. Queensland uses Actinomycin D as the preferred first line agent. The bi-weekly administration is more convenient for patients, particularly those living remotely where travel to a chemotherapy facility every second day is not practical.

Patients with high-risk disease require multi-agent chemotherapy. Etoposide, Methotrexate, Dactinomycin, Cyclophosphamide, Vincristine (EMA-CO) is the most used regimen. If patients are extremely unwell low dose induction etoposide-cisplatin (EP) may be commenced first and then changed to EMA-CO when the patient is able to tolerate it [3]. Patients with ultra high-risk disease are commenced on EP/EMA. Immunotherapy agents (ie. Pembrolizumab) are being used in GTD, particularly in cases of resistance or relapse.

Chemotherapy is given in fortnightly cycles until the hCG has reached negative. Once the hCG has fallen to negative, a further three consolidation cycles of chemotherapy are given. hCG testing is performed monthly for 12 months and the patient is advised not to fall pregnant during that time. Any form of reliable contraception is acceptable.

Role of Surgery

Repeat curettage may be required for patients who experience ongoing bleeding with evidence of retained product (as detected on a pelvic ultrasound scan) or if hCG rises with no evidence of metastatic disease. In 60% of cases chemotherapy may be avoided[8]. Repeat curettage (with hysteroscopic or ultrasound guidance) should be performed by an experienced clinician to avoid perforation of the uterus or Asherman's Syndrome. Very rarely, even in the event of metastatic disease, curettage may be performed to decrease the burden of disease and the number of cycles of chemotherapy required.

In patients who have completed childbearing, hysterectomy may be performed at the time of diagnosis of a molar pregnancy or once persistence develops. Hysterectomy is the procedure of choice for PSTT and ETT as these entities are less sensitive to chemotherapy.

Resistance and Relapse

Resistance occurs in approximately 30% of patients with low-risk disease and 20% of patients with high-risk disease [1,9]. Resistance is defined as a hCG fall by less than 10% over three weeks or a hCG rise by more than 10% over two weeks whilst undergoing chemotherapy. Patients may need to be re-scanned to assess for progression of metastatic disease. Alternative chemotherapy agents are utilised based on the beta-human chorionic gonadotropin (BhCG) level at the time of resistance. The cut-off value for changing to an alternative agent is constantly being updated.

Treatment adjustments depend on BhCG levels:

- **For low-risk disease:** if BhCG levels are below 1000 IU/L, a different single chemotherapy drug may be used. If BhCG levels are above 1000 IU/L, multiple chemotherapy drugs is recommended.
- **For high-risk disease:** different combinations of multiple chemotherapy drugs, such as EMA/EP or TE/TP, are used.

There is emerging evidence for the use of immunotherapy agents (i.e. Pembrolizumab) in treating resistant disease. Other treatments such as surgical intervention or radiation therapy may be utilised in cases that are refractory to chemotherapy to achieve remission. Patients with resistant or refractory disease have a poorer prognosis with a five-year survival of only 43% when compared with patients who relapse [10].

Relapse is defined as a rise in hCG after initial normalisation. Relapse can occur at any time following a GTN event. Despite relapse, salvage chemotherapy resulted in a 100% cure rate for low-risk disease and 84% for high-risk disease [10].

Common Pitfalls in the management of GTD and GTN

Histological Diagnosis: Early curettage can obscure classic molar features, necessitating expert pathology review and ancillary testing. After expert pathology review, the initial diagnosis can be changed in up to 26% of cases [4].

hCG monitoring: monitoring should be performed at least every two-weeks, but routinely weekly, to assess the trend of the hCG level. Performing the test more frequently than this leads to confusion in interpretation of the results. It is important to use the same hCG assay each week and patients are encouraged to attend the same laboratory for testing.

WHO Prognostic Score: errors are commonly made in calculating the Prognostic score which can lead to incorrect chemotherapy treatment.

- hCG level at the time of diagnosis of GTN should be used and not the patients initial hCG.
- Confusion with how the hCG is displayed (10^{-3}, 10^{-4}, 10^{-5}) leads to an incorrect score.
- Lung metastases should be scored from a CXR. A CT scan may be used for scoring, but lung metastases should only be counted if they are 1cm or more in size.
- Largest tumour size includes the size of any uterine lesion. However, a uterine lesion is not included in the number of metastases.

PSTT and ETT – a Prognostic Score should not be calculated for these diagnoses. They are only assigned a FIGO Score. The mainstay of treatment for PSTT and ETT is hysterectomy as these are typically non metastatic and resistant to chemotherapy [2]. In the presence of metastatic disease or an interval >48 months from the index pregnancy, platinum-based chemotherapy is required.

Centralisation of care

Best practice is to register a molar pregnancy with a specialist GTD centre. Centralisation allows for a multi-disciplinary team approach to improve patient outcomes and develop consensus-based guidelines [1]. The type of GTD centre will depend on resources available. Queensland, Victoria, and Western Australia have established centralised care, and New South Wales is progressing towards this model. The International Society for the Study of Trophoblastic Disease (ISSTD) and the European Organisation for the Treatment of Trophoblastic Diseases (EOTTD) are organisations aimed at improving care of women diagnosed with GTD. These organisations can provide expert review of complex cases and allow for collaboration of research projects.

Conclusion

GTD is a diverse group of rare, but highly curable conditions. When possible, cases should be managed in specialised centres. Updated guidelines from FIGO and EOTTD for GTD management are expected in 2025.

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RANZCOG Miscarriage, Recurrent Miscarriage and Ectopic Pregnancy Clinical Guideline

Dr Kasia Siwicki
FRANZCOG

As health professionals, we are responsible for providing women and their support people with clear, relevant evidence-based and individualised information to guide their discussions about their choices and decisions.

In April, as part of an ongoing review and update of College statements and guidelines, RANZCOG published *the Miscarriage, Recurrent Miscarriage and Ectopic Pregnancy Clinical Guideline (C-Gyn 38).* This important guideline has been prepared using the same evidence-based approach to developing and updating Clinical Guidance Statements that RANZCOG has adopted since 2020, in a collaborative process overseen by the RANZCOG Women's Health Committee (WHC) and internally funded by RANZCOG. The work was spearheaded by the outstanding RANZCOG Research and Policy Team (RAPT) alongside the multi-disciplinary Guideline Development Group (GDG), with public consultation and input sought from RANZCOG members, key stakeholders, and consumers to ensure the guideline is reflective of current knowledge, practices, and perspectives.

The scope and clinical questions (formulated by the RAPT and GDG, with review by the WHC) address specific clinical, diagnostic and therapeutic challenges that clinicians encounter commonly in early pregnancy care, and less familiar conditions that are, nonetheless, associated with a significant clinical or personal implications. In line with other updated RANZCOG guidelines, this guideline was developed following accepted international processes according to the National Health and Medical Research Council (NHMRC) and Grading of Recommendations Assessment, Development and Evaluation (GRADE) processes and meets the criteria of the Appraisal of Guidelines for Research & Evaluation (AGREE) II framework. Because this is a guideline intended for practitioners in Australia and Aotearoa New Zealand, the clinical practice advice it provides has also been shaped by the views of the GDG and stakeholder feedback, with consideration for the varied settings and situations in which the RANZCOG members and the women they care for reside across the two countries.

The application of these guidelines can inform the clinical foundation of a trusting therapeutic relationship and patient-centred care, but the practice of that care also draws on experience, beliefs and empathy with the individual's situation. The importance of these aspects of care were emphasised repeatedly during discussions within the GDG and in the feedback received during the consultation process.

There is consistent messaging from consumers that clear and empathetic communication, appropriate language, culturally safe practices and an individualised approach are vital in the management of early pregnancy loss, due to the recognised impact of negative health-care interactions on patient experience and recovery.

Specific mental health interventions and comprehensive mental health management were deemed to be outside of scope for this guideline. And it is acknowledged that they may be outside the scope of practice of many members who nonetheless care for women and their support people experiencing pregnancy loss. Being familiar with resources and support networks, local grief counselling and mental health services and liaising with GPs can be part of every practitioner and organisation's remit. The guideline includes a list of resources identified during the guideline development process.

How, where and who provides care during the deeply personal and emotional experience of pregnancy loss, and the management of conditions that contribute to it, has evolved. In reviewing the evidence, the GDG has identified areas for future research, aimed at helping to ensure that the evolution of our approach to care continues to meet the needs of our patients.

Recommendations for future research

- Where care is provided and by who, e.g. Early Pregnancy Assessment Service
- Women's experiences using ED services rather than maternity services for acute early pregnancy complications
- Medical management of miscarriage – preparation for, best analgesia to treat pain, women's experiences
- Early pregnancy outcomes (including miscarriage and ectopic pregnancy) associated with women who have endometriosis

Source	Name of resource and hyperlink
National Blood Authority Australia	Guideline for the prophylactic use of Rh D immunoglobulin in pregnancy care
New Zealand Blood Service	Use of Rh D Immunoglobulin (Anti-D Immunoglobulin) During Pregnancy and the Post Partum Period (111G130)
Tommy's National Centre for Maternity Improvement UK	Tommy's Miscarriage Support Tool
Pink Elephants Support Network	The Pink Elephants Support Network - Home
Red Nose Foundation	Home | Miscarriage Australia
Miscarriage Australia	Miscarriage Australia - Navigating miscarriage together
Sands New Zealand	Sands New Zealand - Pregnancy, Baby and Infant Loss Support, New Zealand
Whetūrangitia – online service supporting bereaved parents and whānau in Aotearoa New Zealand	Information for bereaved family and whānau experiencing the death of a baby or child

Table 1. The above table is an excerpt from Miscarriage, Recurrent Miscarriage and Ectopic Pregnancy (C-Gyn 38) pg 74

Further research priorities include:

- Intrauterine adhesions (IUAs) – incidence following uterine instrumentation, impact and treatment options
- Late miscarriage (pregnancy loss between 13–20 weeks) studies to test the effectiveness, safety, and acceptability of medical and surgical management, and options for pain management
- The role of screening for ANA, sperm DNA fragmentation and B2GP1 antibodies in recurrent miscarriage patients
- Evaluating the best thresholds for diagnosing subclinical hypothyroidism

Recommendations and further research points are excerpted from Miscarriage, Recurrent Miscarriage and Ectopic Pregnancy (C-Gyn 38) pg 73

We all hold out for the gold-standard of early pregnancy care in well-resourced, dedicated early pregnancy units with specially trained multi-disciplinary staff but acknowledge that this is difficult to realise, universally, across all of Australia and New Zealand. There are the grinding practicalities of funding, staffing and training. And the challenges of creating a level playing field for all consumers regardless of rurality, remoteness, orientation, background, beliefs or language. RANZCOG invests time and effort in producing up to date guidance for its members so that best outcomes can be achieved in the hands of compassionate clinicians working collaboratively with colleagues in providing care for well-informed women and their support people.

Name	Position on GDG
Dr Kasia Siwicki	Chair
Dr Ashleigh Smith	Member
Prof Thierry Vancaillie	Member
Dr Lisa Bedson	Member
Dr Nicole Liesis	Member, Diplomat (DRANZCOG)
Dr Letitia McGinness	Member
Dr Julia Coffey	Member
Dr Sam Holford	Member
Dr Shelley Reilly	Member
Dr Joanne Ludlow	Member
Ms Nicole Freeman	Member, Midwifery Representative, Australia
Ms Alison Weatherstone	Member, Midwifery Representative, Australia
Ms Tessa Kowaliw	Member, Consumer Representative
Research & Policy Team	
Professor Cindy Farquhar, University of Auckland	Dean of Research and Policy, RANZCOG
Ms Katie Coulthard, RANZCOG	Research and Policy Lead
Ms Angela Hunter, RANZCOG	Research and Policy Senior Coordinator
Research Evidence Team (University of Auckland)	
Professor Cindy Farquhar, University of Auckland	Dean of Research and Policy, RANZCOG and University of Auckland
Dr Karyn Anderson	Research Fellow
Dr Magdalena Bofill	Research Fellow
Dr Angela Beros	Research Fellow
Ms Solène Bertrand	Research Assistant

Table 2. Guideline Development Group Membership

Professor Ronald W Jones
CNZM, MB ChB, MD (Otago), FRCS(Ed),
FRCOG, FRANZCOG

1939-2025

Professor Ronald (Ron) Jones died in Te Toka Tumai, Auckland on 31 March 2025 aged 85; two nights earlier he had been out at an orchestral performance. Two years ago, he gave me his CV in order to get the facts right in his obituary.

Ron will be remembered as a man who changed the course of women's health and put Aotearoa New Zealand on the map in the world of cervical and vulval disease. Born in Christchurch, he entered the University of Otago to study medicine in 1960 and played both cricket and rugby. Following resident positions in Canterbury, he travelled by boat to the UK to complete his training initially in surgery, and then obstetrics and gynaecology at The Hammersmith, Poole and Southampton, obtaining FRCS in 1969 and FRCOG in 1970.

Ron returned to Aotearoa New Zealand in 1973 as a tutor specialist at National Women's Hospital and established a private obstetrics and gynaecology practice.

He was appointed Professor of Gynaecological Oncology in 2002, after establishing the first multidisciplinary vulval clinic in Aotearoa New Zealand and training New Zealand's first nurse colposcopist 25 years ago. Ron championed the introduction of gender-neutral HPV vaccination and continued his passionate advocacy for women's health until his retirement in 2010, by which stage he had accumulated over 7kg of “letters to the hospital administrators”.

In 1984, he co-authored the publication that would spark the 1987 Cartwright Inquiry and change the path of medicine in New Zealand. These events led to the establishment of the National Cervical Screening Programme, the Health and Disability Commission and robust ethical processes for research. He was made a Companion of the New Zealand Order of Merit in 2009 for services to women's health and subsequently in 2022 became the only New Zealander to be awarded the Scientific Freedom and Responsibility Award by the American Association for the Advancement of Science.

In 2017, he published *Doctors in Denial: The Forgotten Women in the ‘Unfortunate Experiment’,* a book about the events that had a profound impact on his career and ultimately fulfilled his long-held wish, for the wāhine involved to to receive an apology from the District Health Board and RANZCOG. Ron never stopped learning and authored 80 peer reviewed publications, along with many letters to the editor. He completed his research MD in 2010 as he retired.

In retirement Ron continued to teach and was an honorary lecturer in ethics at the University of Auckland and sat on ethics committees and the Health Practitioners Disciplinary Tribunal. In 2015, he gave the Doris Gordon Memorial Lecture for RANZCOG and was trustee for her Memorial Trust. His book about Doris Gordon was sent to the editor the week before his death.

An internationally regarded expert in vulval disease, Ron was President of the International Society of the Study of Vulval Disease (ISSVD) from 2003-2006 and brought their World Congress to Queenstown, where he took the international faculty jet boating and sheep shearing. He also brought the International Federation for Cancer Prevention and Colposcopy (IFCPC) Triennial Meeting to Auckland in 2008 whilst serving as Chair of their Scientific Committee, and he was President of the Australia and New Zealand Vulvovaginal Society (ANZVS) and was on the faculty of EUROGIN for 10 years.

Ron was a mentor to many, with professional "children" around the world who had spent time working with him in Auckland. He regarded them as part of his extended whānau. Family and colleagues were essential sources of support, and he fostered this community by establishing “Gynae Club” (now the New Zealand Society of Obstetrics and Gynaecology), an annual scientific meeting where participants are encouraged to bring their partners and children. This tradition has helped build strong collegial support across the motu. In 1999, he also convened the inaugural meeting of New Zealand Gynae Oncologists, which later evolved into the multidisciplinary New Zealand Gynae Cancer Group, bringing together scientists and clinicians dedicated to treating gynaecological cancers across Aotearoa.

Ron is survived by his partner, his four children, his grandchildren and many grateful colleagues, trainees and patients who were touched by his life and in whom his legacy will continue.

Kua hinga te tōtara o Te Waionui a Tāne.
A mighty tōtara has fallen.

By Dr Lois Eva
Department of Gynaecological Oncology, MB BS,
MRCOG, MD, CCT (Gyn Onc), FRANZCOG