Who Should Look After Genital Skin Disease in the 21st Century?

Joseph Pease, Norwich Medical School | Word count: 2273

Genital skin disease is arguably the most varied of all the categories of dermatoses. Firstly the patients may be any age, ranging from teenagers to the elderly. All genders are affected, however, the presentations between sexes may vary significantly, and could require completely different approaches. The range of underlying disease processes is also incredibly broad; e.g. inflammatory, infective, malignant, auto-immune. Multiple medical and surgical specialties are involved in the management of these conditions, including dermatologists, general practitioners, gynaecologists, genitourinary physicians and urologists. There is not always a clear choice as to which specialist is most suited for a given disease. Furthermore, we must not forget that there is a patient attached to this condition, and their individual thoughts may have a massive influence over whom they may consider as the most appropriate physician. As the National Health Service becomes increasingly centred on patient choice, then this could become a more prominent decider for referral than just the underlying cellular mechanism of the disease. I aim to discuss the various aspects of what may dictate who is most suited to treat genital skin disease.

The Physician:

As mentioned above, there are several health professionals who will come into contact with genital skin diseases. With most presenting complaints, the first port of call is the patient's GP. However, due to the sensitive nature of

genital dermatoses, some patients may seek an alternative professional. Walk-in GUM clinics may pose as a quicker and more confidential option for the patient, however, they are not for everyone. If not able to be treated by these first-line physicians, the patient may be referred on to another specialist, i.e. a dermatologist, gynaecologist or urologist. Therefore, there are at least five obvious contenders for taking on their genital skin condition, not to mention the input of plastic surgeons, oncologists, nurses and non-medical staff. Unsurprisingly, there are many parallels between dermatologists and GUM physicians in the treatment in genital skin disease. Both specialties can lead to a special interest or subspecialty in genital skin disease, so it begs the question – which profession is therefore the most appropriate? The General Medical Council states within the dermatology curriculum, that dermatologists should "*be able to detect sexually transmitted infection (STI) in patients presenting to dermatology, and refer appropriately to a Genitourinary Clinic*."[1] However, they are also expected to "*competently diagnose and manage common vulval disorders in patients presenting to dermatology*"[1], perhaps 'stealing' some of the gynaecologists' caseload? Finally, dermatologists should also "*be able to diagnose and manage common penile disorders*"[1], however, they should be able to explain when to make a referral to urology or GUM. Dermatologists may already be burdened with a vast array of an estimated 2,000 cutaneous diseases[2], so it is reasonable that they should share this with other specialists. However, the many different referral pathways to different specialists, is perhaps unnecessary if we had a clearer idea of exactly who should look after genital dermatoses. Whilst it may seem appropriate that dermatologists, the skin doctors, look after these conditions

as the genitals are covered by skin, much like the arms, or the face. Conversely, by this logic, *genito*-urinary physicians are arguably just as well-equipped, as these conditions invariably affect the genitals. The GMC states in the GUM specialty training curriculum 2010[3] that they should be able to "*progressively understand common vulval and penile dermatological conditions and to know when to refer to primary care or dermatology.*" The key, and perhaps ambiguous, word here is "*progressively*". Does this suggest that GUM physicians should be taking a more and more active role in the management of these conditions, suggesting a pre-empted shift by the GMC towards them becoming a bigger role in managing genital dermatoses? We should also recognize the role of the GP. Whilst it is unreasonable to expect them to treat all the genital dermatoses, they are able to manage a certain number, and direct the rest accordingly to the specialists. Whilst it is important that GPs refer the patients to the right clinician, not every person presenting with genital skin disease will access healthcare via primary care. Therefore the GP as the sole manager for orchestrating care for these patients is not foolproof. Additionally, the role of specialist nurses should be evaluated, as when surveyed for who they would prefer to see about sexual health problems, 54% of patients were happy to

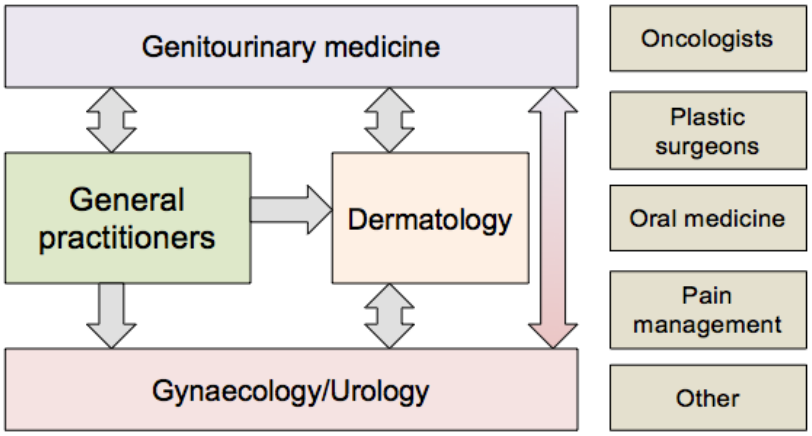

Figure 1. Typical referral pathways for management of a patient with genital dermatoses

see either a doctor or nurse.[4] This figure may not be directly applicable to genital skin disease, but it offers another option for who should treat these conditions.

The Disease:

Another way of considering who should manage these patients is to focus on the disease itself. I propose three ways of appraising this: the underlying pathogenesis; the patient's gender; and the definitive management. The GMC specialty curricula currently imply that dermatologists should deal with the non-infective causes of skin complaint, leaving STIs to the GUM physician. However, in the case of vulval conditions, gynaecologists are the key players. The Royal College of Obstetrics and Gynaecology offers guidelines[5] on the management of vulval conditions, be it infective, inflammatory or malignant. What would make the skin of the vulvae that different to anywhere else on the body such that it should warrant a non-dermatologist opinion? Perhaps the gynaecologist is more capable of dealing with any extra-cutaneous spread into the female genital tract; or can offer a more streamlined management endpoint, without interdisciplinary referral. We could compare this to the management of otitis externa by an ear-nose-throat doctor. The ear is lined by skin, but as this specialist's domain is the ear, it becomes their responsibility. For these reasons, I feel it is impractical to exclusively assign certain specialists for genital dermatoses based on the disease process, e.g. oncologists see all skin cancers; or GUM see all infective causes. An alternative could be to categorise conditions based on genders, i.e. females see gynaecologists and males see urologists. Whilst there may be skin

conditions that are universal to both sexes, e.g. from psoriasis to melanoma, it could work well such that the physician who deals exclusively with that portion of the body day-to-day, may be able to offer an optimal management pathway. However, it would be imperative that the curricula for management of genital dermatoses in both gynaecology and urology be extensive to ensure every specialist in these areas has adequate knowledge to treat these skin conditions. One significant advantage of this is that if surgical management is required for any of these conditions, then the patient would have likely been referred to gynaecology/urology, offering greater efficiency and continuity. Especially in the context of male genital health, where a specialist-led genital dermatology clinic found that circumcision was discussed with 27% of its male patients.[6] There are however caveats, for example, sexually transmitted infections would still require specialist services from GUM such as contact tracing; and widespread skin conditions not limited to the genitalia would still require dermatologist input.

The Setting:

Regardless of who is deemed as the most appropriate healthcare practitioner for the management of genital dermatoses, they are ultimately dealing with a human being. There is a huge spectrum of patients afflicted, and we need to consider their individuality. The teenager may approach a GUM clinic differently to a married octogenarian. There may be a certain stigma[7] attached to attending these clinics, acting as a barrier to seeking treatment. Alternatively, the stringent confidentiality and data protection measures within GUM clinics may be an advantage and encourage certain patients to attend.

Ideally, there should be no barriers for any patient attending for a genital skin complaint. Perhaps for this reason, it is preferable for them to be seen in the dermatology department, where there is a veil of secrecy by being a waiting room of various ailments. Furthermore, in the context of STIs, GUM clinics are already overstretched[8], so increasing their footfall could be damaging to all aspects of patient care.

The concept of interdisciplinary clinics is not new; it is used across Europe for many different presenting complaints. The British Society for the Study of Vulval Disease provided a model of care for women with vulval conditions[9]. Beyond the level 3 specialist care offered by GUM, gynaecology and dermatology; is the level 4 supraspecialist "Vulval Clinic." This clinic is helmed by a range of professionals, including gynaecologists, psychosexual therapists, plastic surgery, oral medicine, physiotherapy, pain management and continence advisors. This model was supported by a German study, published in 1999[11] whereby 71% of the interviewed physicians believed that an interdisciplinary vulval clinic is a

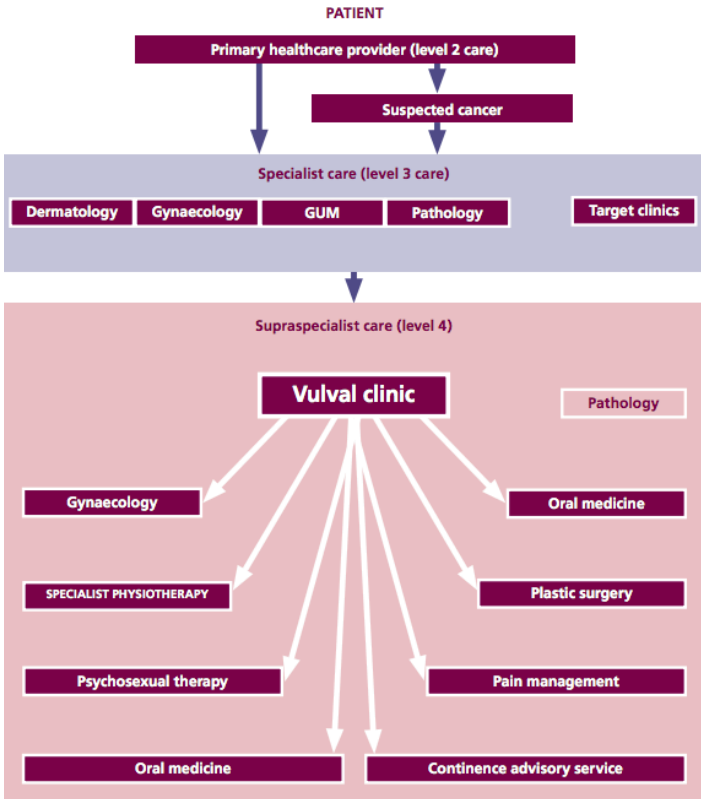

Figure 2. Suggested model of care for vulval disease *(taken from The British Society for the Study of Vulval Disease[9])*

necessity. 76% of gynaecologists and 75% of GPs were agreeable to the idea, compared to only 51% of dermatologists.

Currently, about 42% of UK sexual health clinics have dedicated genital dermatoses clinics, which are manned by GUM physicians, dermatologists, gynaecologists and urologists.[6] A male-only genital dermatoses clinic based in a Sexual Health Centre in Edinburgh reported a high discharge rate of 93%[10], implying it is an effective system. Another such service is being run at the Department of Genitourinary Medicine at Barts Health NHS Trust. They have highlighted certain problems with hosting the clinic in this way, notably the issue of coding the conditions. Only 19% of patients attending the specialist male-only clinic had their conditions coded in the notes, with 90% of these being classed as having 29D (genital dermatoses). Clearly genital skin conditions make up a significant proportion of their caseload, but there are no specialist codes for dedicated genital dermatoses clinics.[6] The problem here is that this affects the financial remuneration for the services provided, which discourages such clinics to be set up.

The value of "One Stop Shops" (OSSs), whereby patients are referred "under one roof" to the appropriate specialist the same day, has been evaluated in the scenario

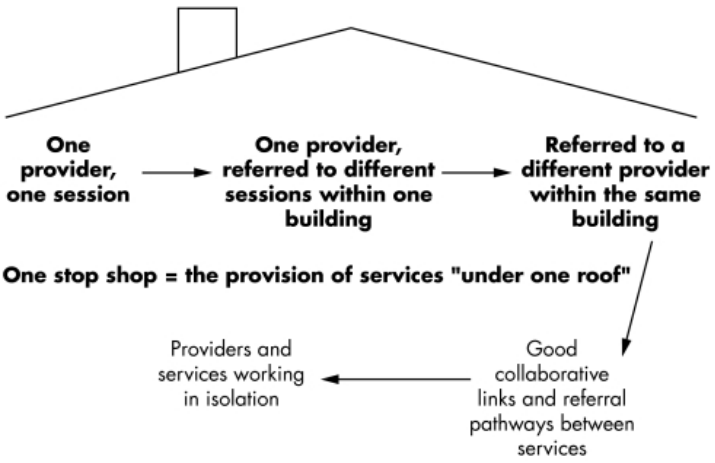

Figure 3. Example of integration within a one stop shop service *(taken from reference 12).*

of sexual health services[12]; considering the patient, staff and financial perspectives. Benefits for the patient include convenience, fewer contacts, better continuity and more holistic care.[12] Ultimately, cost is likely to be the major player in determining the viability of these clinics. The study argued that they would likely be more cost effective as it avoids "*duplication of service delivery functions*" and all the resources would be in the same place.[12] Of course, the financial approach to these clinics would need to be addressed and restructured, to optimise cost efficiency. However, there were some concerns over friction between staff members, as there has historically been a divide between specialties; however, it is thought that integrated care would improve staff motivation, flexibility and increase work opportunities, particularly for nurses. With this in mind, these clinics could operate under a nurse-led triage service, alongside better-defined expectations of which specialist is expected to manage what, I believe interdisciplinary, one-stop clinics could offer an high-quality service. Whether these clinics should be under the dermatology, GUM, gynaecology or urology departments is up for debate. Is it best to host them under the dermatology department to minimise any barriers to access associated with the GUM clinic? Or perhaps a new department entirely should be created, the GDD (Genital Dermatoses Department)?

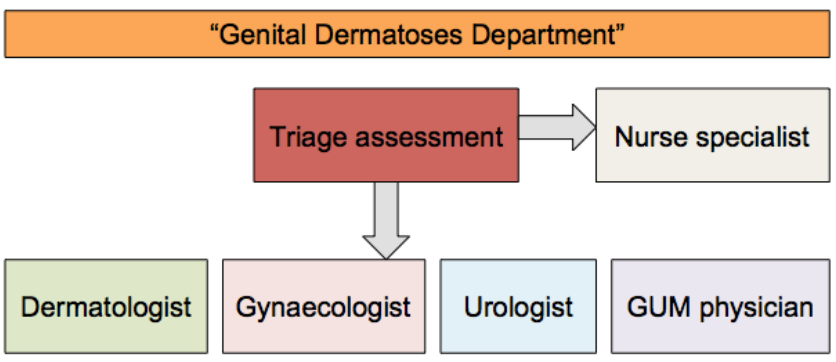

Figure 4. Schematic of interdisciplinary clinic

The Patient:

As this essay is addressing the management of genital conditions in the 21st century, then the overriding denominator of discussion should be the patient. Patient choice is becoming an ever-growing influence of how services are provided. With the introduction of NHS e-Referral Service in 2015, patient choice is very much at the forefront of care. All of the issues discussed above may steer a patient towards who or where manages their condition. 75% of respondents said that choice was either 'very important' or 'important' to them, particularly amongst older populations and non-white background individuals.[13] As it stands, patients broadly have the choice of GP or GUM clinic, with the potential of subsequent referral to secondary care specialists. The extent to how far this choice should extend is up for discussion. Should a lady with lichen sclerosus have the option of deciding to be sent to a gynaecologist or a dermatologist, when both are capable of managing her? Whilst patient autonomy is one of the fundamental principles in medical practice, when should we draw the line? Waiting times, confidentiality, resources, referral pathways, personal preferences – all of these features and more can influence the patient's decision, and are essential considerations for keeping the patient at the heart of the issue.

Conclusion:

There is not a simple answer to the question "Who should look after genital skin diseases in the 21st century". There are many genital dermatoses, and many different specialists, of whom have varying capabilities of treating the conditions. Whether it is the introduction of interdisciplinary clinics; or

allocating patients to a particular physician based on what disease is lurking amidst their undergarments; any of the options would require considerable planning and organisation to ensure that everybody is on the same page. Whilst I believe that an interdisciplinary approach, with utilisation of a dedicated genital dermatoses clinic, is the best option; it is clear that there remains great overlap across the specialists' curricula, confusing the issue of who should be the lead caregiver. However, each physician brings to the table valuable skills and knowledge, so if it were possible to unify this wisdom on common ground, then it could offer a comprehensive and effective genital dermatoses service. Maybe it is not a question of *who* should look after these patients, but *how* they should be looked after.

References:

1. Joint Royal Colleges of Physicians Training Board. *Specialty Training Curriculum for Dermatology*; 2010. http://www.gmc-uk.org/2010__AUC__Dermatology_curriculum__amendments_2012__AUC.pdf_56436726.pdf (accessed 15th January 2016)
2. Yusuf I, Turner R, Burge S. *A career in dermatology*. BMJ Careers. http://careers.bmj.com/careers/advice/A_career_in_dermatology (accessed 15th February 2016).
3. Joint Royal Colleges of Physicians Training Board. *Specialty Training Curriculum for Genitourinary Medicine*; 2010. http://www.gmc-uk.org/Genito_urinary_medicine_curriculum_2010.pdf_32485349.pdf_43566961.pdf (accessed 15th January 2016).

4. Ross JDC et al. Public involvement in modernising genitourinary medicine clinics: using general public and patient opinion to influence models of service delivery. *Sexually Transmitted Infections* 2006;82(6):484-488.
5. Royal College of Obstetrics and Gynaecology. *The Management of Vulval Skin Disorders*. Green-top Guideline No. 58. 2011. https://www.rcog.org.uk/globalassets/documents/guidelines/gtg_58.pdf (accessed 15th January 2016).
6. Hartley AJ et al. Are specialist-leg genital dermatology clinics a valuable and necessary part of sexual health service provision in the UK? *Sexually Transmitted Infections* 2013;89:379.
7. Scoular A, Duncan B, Hart G. "That sort of place…where filthy men go…." a qualitative study of women's perceptions of genitourinary medicine services. *Sexually Transmitted Infections* 2001;77:340-343.
8. White PJ. *Providing adequate treatment capacity for sexually-transmitted infections is cost-saving*. Imperial College Faculty of Medicine. https://www1.imperial.ac.uk/resources/60AF5D2A-2A7E-4E9A-B18D-E33C324382B4/ (accessed 16th January 2016).
9. British Society for the Study of Vulval Disease. *Standards of care for women with vulval conditions*; 2013.
10. Pearce J, Fernando I. The value of a multi-specialty service, including genitourinary medicine, dermatology and urology input, in the management of male genital dermatoses. *International Journal of STD & AIDS* 2015; 26(10):716-722.
11. Bauer A et al. Vulval Diseases Need an Interdisciplinary Approach. *Dermatology* 1999;199:223-226.

12. French RS et al. One stop shop versus collaborative integration: what is the best way of delivering sexual health services? *Sexually Transmitted Infections* 2006;82:202-206.
13. Dixon A et al. *Patient Choice: How patients choose and how providers respond*. The Kings Fund; 2010.