Study Fellowship - Summer 2016
Richard Watchorn

For the past year I have been participating in the tertiary specialist male genital dermatology clinic at University College Hospital, London. The clinic is a unique resource in which dozens of patients with male genital dermatoses are seen weekly under the supervision of Professor Christopher Bunker, who has spent 25 years investigating male genital skin disease.

The caseload varies widely and is composed of systemic diseases such as Crohn's disease, sarcoidosis, also relatively common dermatoses with genital involvement, such as psoriasis, acne, immunobullous disease, as well as primary or predominantly genital dermatoses such as lichen sclerosus (MGLSc), chronic penile lymphedema and cellulitis, and lichen planus. Malignant and pre-malignant conditions including penile intraepithelial neoplasia, squamous cell carcinoma and extramammary Paget's disease also form an important component of the caseload and are managed in a multidisciplinary fashion with the andrology service. Other conditions seen include dysaesthesia, genital nevi and benign entities such as scrotal calcinosis, penile pearly papules and Fordyce spots. Rare cases are also seen, such as lymphangioma circumscriptum of the penis, porokeratosis of Mibelli and pseudoepitheliomatous, micaceous and keratotic balanitis.

Male genital dermatology is a subspecialty that is underserved nationally and internationally. This is in spite of the fact that the diseases have a disproportionate and devastating impact on the men who suffer from them. Literature indicates that only a minority of patients feel that their dermatologists pay sufficient attention to genital involvement of conditions such as psoriasis. Symptoms of itch, burning, bleeding or splitting of the penile skin result in a severe impact on quality of life. Additionally, there is a detrimental impact on social and sexual function and leads to a high burden of psychological morbidity. Some studies indicate that almost a half of patients do not discuss genital lesions with their dermatologists, possibly due to the perception of stigmatisation. Patients may also have an unexpressed fear regarding cancer or sexually transmitted infections, which can delay presentation. Complications may include further health problems; for example, MGLSc may spread into the urethra resulting in strictures, which can obstructive renal failure or urethral carcinoma. Certain male genital dermatoses (HPV and MGLSc) may lead to squamous cell carcinoma (SCC) of the penis, which has a high mortality rate.

In my time attending the clinic, I have gained invaluable experience in the management of recalcitrant genital dermatoses, diagnosis of obscure conditions, and solutions to a multitude of symptoms and concerns. In particular, I have refined my diagnostic skills, allowing me to appreciate subtle clinical signs of early lichen sclerosus and chronic penile lymphedema. Early recognition of these conditions may allow more effective intervention. I have participated in the weekly penile cancer multi-disciplinary meeting alongside andrologists and approached a multitude of complex genital conditions and clinical dilemmas in a multidisciplinary fashion.

My experience in the clinic under Professor Bunker's supervision allowed me to co-author a review article on the topic, which has been accepted for publication in *Clinics in Dermatology.*

While the clinic provides an essential service for patients suffering from male genital dermatological conditions, it also supports the many areas of research projects overseen by Professsor Bunker and his collaborators. Participation in the clinic opened the door to allow me become involved. I have recently commenced a project aiming to define the balanopreputial microbiome with next-generation sequencing technology and investigate the potential role of the balanopreputial microbiome in male genital lichen sclerosus. I have been awarded an EADV grant to take this project forward and hope that this will be the beginning of a career-long involvement in investigating genital dermatoses.

I have met a multitude of new and valued colleagues from around the world and have enjoyed the positive learning environment in University College Hospital. I have developed a subspecialty interest in male genital dermatoses which I hope to develop long-term, in order to deliver the expertise necessary to serve patients suffering the debilitating effects of multiple conditions. Importantly, I also aim to disseminate the skills and knowledge acquired to present and future dermatology colleagues.

I am very grateful for the support of the BAD and my former supervisors in the Royal Devon & Exeter Hospital in allowing me to take this important step towards my future career.

After clinic with Professor Bunker and team at University College Hospital