BASHH

British Association for Sexual Health and HIV

CLINICAL GUIDELINE

BASHH Guideline on the Management of Balanoposthitis (and related penile skin conditions) 2026

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British Association for Sexual Health and HIV (BASHH)

Short Title: BASHH Balanoposthitis guideline
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What is new in the 2026 guideline

- Guideline reviewed to cover the diagnosis and management of infective causes of balanoposthitis and the recognition of other presentations, with initial treatment advice and reference to other relevant guidelines for management.

Introduction and Methodology

Objectives: The main objective is to aid recognition of the signs and symptoms and complications of penile skin conditions which may present in Sexual Health clinic attendees. This guideline concentrates on a selected group of conditions, which may present to sexual health services, either alone or in conjunction with other specialists. It is not intended as a comprehensive review of the treatment of all balanitis. The guideline is aimed primarily at people aged 16 years or older presenting to health care professionals working in sexual health services. The recommendations are primarily aimed at services offering level 3 care in sexually transmitted infections (STIs) management within the United Kingdom. However, the principles will apply to those presenting to level 1 and 2 services, and appropriate local referral pathways will need to be developed. This guideline offers recommendations on the diagnostic tests and treatment regimens needed for the effective management of infective balanoposthitis and includes the following conditions:

- Candidal balanoposthitis
- Anaerobic infection
- Aerobic infection
- Balanoposthitis relating to STIs

It also provides guidance on the recognition of the following causes of balanoposthitis and gives general management advice only but provides references to the appropriate guidelines for specialist referral and care:

- Lichen sclerosus
- Lichen planus
- Zoon's (plasma cell) balanitis
- Psoriasis and circinate balanitis
- Fixed drug eruptions
- Penile intraepithelial neoplasia (PeIN)
- Eczema
  - Seborrheic
  - Irritant / Allergic
- Balanitis associated with systemic disease
  - Sarcoid
  - Tuberculosis (TB)
  - Crohn's disease
  - Bechet's syndrome

Search strategy:

This guideline was produced according to specifications set out in the CEG 21 document 'Framework for guideline development and assessment' (2015, 22 updated 2020) accessed at https://www.bashh.org/_userfiles/pages/files/resources/2020_guidelines_framework.pdf . It has been updated by reviewing the previous balanoposthitis guideline (2008) and medical literature since its publication using abstracts and articles in the English language up to August 2020. The following sources were reviewed: Medline/Pubmed and Embase, the Cochrane Library (including the Cochrane Database of Systematic Reviews, Database of Abstracts and Reviews of Effects and Cochrane Central Register of Controlled Trials), British Association for Sexual Health and HIV (BASHH) and British Association of Dermatologists (BAD) guidelines (including the previous European guideline for the management of balanitis 2014 and the UK National guideline for the management of balanitis 2008), and the National Institute for Health and Care Excellence (NICE) guidelines. Other relevant guidelines were identified on Google or produced by the US Centres for Disease Control. The evidence reviewed included randomised controlled trials, cohort studies and in the absence of these, case series, case reports and consensus of the writing group. Where there was a paucity of randomised control trials and high-quality evidence for the management of genital manifestations of skin conditions, evidence from other sites was also reviewed by the writing group.

Search terms: Balanitis, Balanoposthitis, Penile dermatoses, and specific terms in respect of each condition.

Sources: OVID, Medline, PubMed, National Institute for Health, and Care Excellence (NICE), Cochrane Library, Guidelines produced by: IUSTI, BASHH, CDC.

Equality impact assessment: An assessment of the guideline and its recommendations was undertaken to ensure the principles of equality and diversity were adhered to.

Stakeholder involvement, piloting, and feedback:

The document was reviewed by the Clinical Effectiveness Group of BASHH, and their comments incorporated. The draft guideline was placed on the BASHH website, and any comments received during the consultation period were reviewed by the authors and acted on appropriately. The document was also piloted by target users and the public panel of BASHH, and their feedback considered by the authors.

The guideline was circulated to Fabia Brackenbury (Vulval Health Awareness Campaign and Worldwide Lichen Sclerosus Support) and lay representative on the BASHH Dermatology special interest group, and her comments incorporated.

After publication on the BASHH website the CEG will keep it under review. The guideline will be formally reviewed and updated every 5 years.

Aetiologies

Balanitis is the term for inflammation of the glans penis, and posthitis describes inflammation of the prepuce. In practice both areas are often affected and the term balanoposthitis is then used. It is a common condition affecting up to 20% of uncircumcised men[1] but is uncommon after circumcision. In many cases preputial dysfunction is a causal or contributing factor. It is a collection of disparate conditions with similar clinical presentation and varying aetiologies affecting a particular anatomical site (see table 1).

Table 1. Range of factors causing balanitis [2,3]

Infectious	**Dermatoses**	**Miscellaneous**
Candida spp	Lichen sclerosus	Trauma
Staphylococcus aureus	Lichen planus	Poor hygiene
Streptococci (Group A and B)	Psoriasis	Penile intraepithelial neoplasia (PeIN)
Anaerobes	Circinate balanitis	Systemic disease • Behçet's • Crohn's • Sarcoid • Tuberculosis
Gardnerella vaginalis	Zoon's balanitis	
Bacterial STIs • Chlamydia • Lymphogranuloma venereum • Gonorrhoea • *Mycoplasma genitalium* • Syphilis • Chancroid • Granuloma inguinale	Eczema • Irritant • Seborrhoeic • Contact allergy	
Viral STIs • Herpes simplex • Human papillomavirus	Fixed drug eruption	
Protozoal STIs • *Trichomonas vaginalis* • *Entamoeba histolytica*	Stevens-Johnson syndrome	
Parasitic • Scabies	Immuno-bullous disorders	

Other, rarer dermatoses are not included in this chart.
Infections may be secondary to primary inflammatory dermatoses.

General Management [2, 3]

Clinical Features

The clinical features of balanoposthitis can be divided into local and systemic and primarily include a rash affecting the glans penis and prepuce, which can cause itch. There may be associated changes in colour or texture and sometimes oedema of the skin. If fissuring or ulceration is present, this can be associated with discomfort and dyspareunia. There may also be difficulty retracting the foreskin and a sub-preputial discharge (which can be malodorous). The typical appearances of different conditions are covered in more detail in the individual management sections. Systemic symptoms include rash elsewhere on the body (including mucosal surfaces), joint pains and swelling, lymphadenopathy, and general malaise.

Diagnosis

Balanoposthitis is only a descriptive term, and a more specific diagnosis can often be made from the clinical appearances. However, the appearances should not be considered pathognomonic, particularly as complication by superinfection is common. Biopsy may be required for diagnostic uncertainty or to exclude Penile intraepithelial neoplasia (PeIN)[4].

The following investigations aid diagnosis in cases of uncertainty, and onward referral may be required.

- Sub-preputial swab for *Candida spp* and bacterial culture - to exclude an infective cause or superinfection of a skin lesion or dermatosis.
- Urinalysis for glucose - appropriate in most cases but especially if candidal infection is suspected.
- *Herpes simplex* virus nucleic acid amplification test (NAAT) - if ulceration present.
- *Treponemal pallidum* NAAT and /or dark ground examination for spirochaetes if an ulcer is present, with syphilis serology followed up to 3 months.
- Microscopy or NAAT for *Trichomonas vaginalis* - particularly if a female partner has an undiagnosed vaginal discharge.
- Screening for other sexually transmitted infections (STIs) - particularly screening for *Chlamydia trachomatis* infection / Non-specific urethritis if a circinate-type balanitis is present.
- Dermatology opinion for dermatoses and suspected allergy.
- Urological referral for circumcision or assessment of PeIN or possible malignancy.
- Biopsy - if the diagnosis is uncertain and the condition persists[4].

General Management

The aims of diagnosis and treatment are to identify and manage patient symptoms, to diagnose and treat any related sexually transmitted disease, to minimise sexual dysfunction, to minimise urinary dysfunction, to treat pre-malignant disease and exclude penile cancer. The

identification of any underlying diagnosis is also important in providing the patient with detailed information about the natural history and long-term health implications or their condition (such as risk of malignancy) and any risk to their partner if an STI is identified.

As predisposing factors for balanoposthitis include both poor hygiene and overwashing[5], advice should be given on good genital skin care, personal hygiene, and avoidance of soaps. The use of emollients as soap substitutes should be encouraged. Patients should be warned of effects on condoms if creams are applied. Management of other predisposing factors such as a non-retractile foreskin and systemic conditions such as diabetes should be optimised and the role of circumcision[6] should be discussed.

INFECTIVE CAUSES

Balanoposthitis may be caused by infectious agents [7, 8], both sexually and non-sexually transmitted (although some of the latter may be sexually transmissible) as shown in Table 1. If an STI is suspected as a cause, a full screen for common STIs should be done. There is also an association between carriage of organisms and increased risk of Human Immunodeficiency virus (HIV) infection[9]. However, the presence of an infective agent on swabbing does not confirm causality as superinfection of other skin conditions is common. Follow up is not generally needed.

Candidal balanoposthitis

Clinical Features

Patients generally present with an erythematous rash which may be associated with itch and/or soreness. The typical appearance is of blotchy erythema with small papules, which can be eroded, or of dull red areas with a glazed appearance. In severe cases the whole of the glans and prepuce may be involved. It is commoner with increasing age[10] and can be the presenting sign of diabetes mellitus.

Diagnosis

The presence of *Candida spp* can be confirmed by sub-preputial culture, but other dermatoses should be excluded as the presence of *Candida spp* is most commonly an opportunistic infection. Similar appearances can be seen with irritant and non-specific balanoposthitis.

Urinalysis for glucose should be considered, as should investigation for causes of immunosuppression, if the balanitis is severe or persistent.

Management

Although there has been an increase in reports of drug resistance in serious candidal infection, there is no new evidence pertaining to treatment of candidal balanitis. Hygiene measures should be recommended as above. As there is a high rate of candidal infection in sexual partners, treatment of symptomatic partners can be considered (2, D).

Recommended regimens[11]

- Clotrimazole cream 1%[12](I, A)
- Miconazole cream 2%[13](2, B)

Apply twice daily for 7-14 days.

Alternative regimens

- Fluconazole 150mg stat orally[12](I, A)- if symptoms severe
- Nystatin cream[13] 100,000 units/gm - if resistance suspected, or allergy to imidazoles (2, B)
- Topical imidazole with 1% hydrocortisone - if marked inflammation is present[11](2, D)

Anaerobic infection [14]

Clinical features

Characteristic features include the presence of foul-smelling odour and sub-preputial discharge, which may be associated with superficial erosions, oedema, and tender lymphadenopathy in severe cases. There is an association with phimosis.

Diagnosis

The diagnosis may be made clinically, but gram stain may show fusiform bacteria or a mixed bacterial picture. Culture may not be helpful, although *Gardnerella vaginalis* (a facultative anaerobe) may be isolated. Sub-preputial NAAT should be taken to exclude other causes such as *Trichomonas vaginalis* or *Herpes simplex* (if ulcerated).

Management

If phimosis is present, circumcision may be required to prevent recurrence, and advice should be given about genital hygiene.

Recommended regimen

- Metronidazole 400 - 500mg twice daily x 1 week (1, D). The optimum dosage schedule for treatment is unknown.
- Milder cases may respond to topical metronidazole.

Alternative regimen

- Co-amoxiclav 375mg three times daily x 1 week.
- Clindamycin cream applied twice daily until resolved.

These treatments have not been assessed in clinical trials (2, D).

Aerobic infection

Clinical Features

The presence of erythema +/- oedema and purulent discharge may suggest an infective aetiology.

Diagnosis

This is dependent on the isolation of a potential causative organism on sub-preputial culture. *Streptococcus spp and Staphylococcus aureus* have been reported as causing balanitis [7, 8, 15] although other organisms may also be involved. Superinfection of an underlying dermatosis rather than a primary infective balanitis should also be considered.

Management

Hygiene measures and topical treatment may be sufficient for milder cases, but more severe cases (i.e. if oedematous or if Group A Streptococci isolated) warrant systemic treatment and would depend on the sensitivities of the isolate.

Recommended regimens (2, D)

- Mupirocin ointment 2-3 times per day for 7-10 days[16]
- Trimovate cream once or twice daily for 7-10 days
- Severe cases may require systemic antibiotics while awaiting culture results[16,18.]
    - Consider prescribing oral phenoxymethylpenicillin 500 mg four times a day for 10 days while awaiting swab results.
    - Oral clarithromycin 250 mg twice daily for seven days

BALANOPOSTHITIS RELATING TO STIs

Balanoposthitis can be a feature of many STIs (see table 1). The following section describes the presentation of balanoposthitis relating to specific STIs. For further diagnostic and management information please refer to BASHH guidelines for each condition.

Chlamydia (D-K serovars)

Clinical Features

Chlamydial infection is associated with circinate balanitis, which is a feature in 40% of cases of reactive arthritis[17]. It presents as erythematous annular shallow erosions with raised borders and surface covered with yellowish white scaly areas. There may also be a serpiginous annular lesion that often has a greyish white granular appearance that may form geographical patterns[17,18].

Diagnosis

The diagnosis of chlamydial circinate balanitis is based on the clinical appearance with an associated positive NAAT for chlamydia. Histology should not be undertaken routinely but shows spongiform pustules seen in the upper epidermis and resembles that of pustular psoriasis. The diagnosis may be supported by HLA B27 positivity.

Management
Chlamydial infection should be managed as per BASHH guidelines[19]. Skin lesions should be managed as for Psoriasis (see subsequent section).

Lymphogranuloma Venereum (LGV)

Clinical Features
The genital form of LGV causes transient superficial herpetiform ulcers on coronal sulcus, prepuce, glans & scrotum in men. Penile oedema may result in varying degrees of phimosis[20] although balanitis is a recognised but uncommon type of primary lesion in LGV [21].

Diagnosis and Management [22, 23]
Refer to guidelines[22, 23.]

Gonorrhoea

Clinical Features

Gonococcal balanoposthitis can rarely be the primary manifestation and is characterized by tender ulcers, pustules, or furuncles on the prepuce or shaft of the penis[24]. Abscesses of the prepuce and ulceration of glans penis have also been reported, but are rare [25, 26]. It can also cause preputial oedema and erythema in men with urethritis[27]. Recurrent gonococcal balanoposthitis may result in secondary hypopigmentation of the glans [28].

Diagnosis and Management
Refer to BASHH guidelines [29.]

Mycoplasma

Clinical Features
There is a significant correlation of *Mycoplasma genitalium* with development of balanitis/posthitis, usually in association with urethritis[30]. *Mycoplasma genitalium* can present as a non-specific balanitis and/or posthitis, and erythematous or circinate lesions with a tendency for haemorrhage may be seen [31]. Balanitis may also occur in the absence of urethral discharge[30].

Diagnosis and management
Refer to BASHH guidelines[32.]

Syphilis

Clinical Features

Syphilitic Balanitis of Follman is an uncommon presentation of primary syphilis and is.
described as erosive balanitis with a bright red glans and foreskin, with multiple oozing superficial erosions and associated with palpable non-tender lymph nodes [33].

Features may be variable and can also include oedema and dark red erythema over the glans penis [34, 35], diffuse induration of the glans penis [34, 35, 36, 37]. Erosions, crusted or scaly lesions and coalescent white / pink papules and circinate lesions have also been described [35, 36, 38, 39, 40].

Syphilitic balanoposthitis has been reported at all stages of infectious syphilis and may not always present with a concomitant chancre. [33, 35, 36, 37, 41, 42]

Diagnosis and Management

Balanitis can be the sole clinical feature of primary syphilis. Syphilis should be suspected in cases of balanoposthitis, particularly when there is induration of the glans penis and lymphadenopathy. Dark field microscopy or NAAT should be undertaken where possible and syphilis serology should be performed. Diagnosis of syphilitic balanoposthitis requires the exclusion of other infections.

For further details of diagnosis and management refer to BASHH guidelines[43].

Chancroid

Clinical Features
Lesions begin as tender erythematous papules on prepuce and frenulum in men which then ulcerate. Balanoposthitis develops from the irritant effects of by purulent discharge from untreated lesions in uncircumcised men [44].

Diagnosis and Management
Refer to BASHH guidelines [45].

Granuloma Inguinale

Clinical Features
Balanoposthitis may be caused by the purulent exudate from fleshy granulomatous ulcers affecting the foreskin or glans. The lesions themselves are painless, non-indurated and covered with friable granulation tissue.

Diagnosis and Management
Refer to BASHH guidelines [46].

Genital Herpes simplex virus infection

Clinical Features
Typical lesions of herpes may rarely develop into a necrotising balanitis [47, 48]. This is characterised by eschars, pustules and purulent discharge on the glans and erythema and oedema of the glans, prepuce, and shaft. Immunosuppressed patients may develop chronic ulceration, crusted and verrucous lesions.

Diagnosis and Management
Refer to BASHH guidelines [49].

Human Papillomavirus (HPV) infection

Clinical Features
Balanoposthitis has been associated with subclinical HPV infection of the glans and prepuce. This is commoner in uncircumcised men with a history of prior treatment for warts, and can present with redness, itching, burning, tenderness, and dyspareunia. It may cause macular lesions, fissuring and rarely, penile oedema and adenopathy[50, 51].

Diagnosis
HPV should be considered in the pathogenesis of chronic and/or recurrent balanoposthitis. Usually a clinical diagnosis is made from recognition of characteristic lesions although dermatoscopy/penoscopy may be helpful (if available). Rarely, biopsy may be required to confirm the diagnosis in atypical lesions. HPV detection or typing does not influence management and is not recommended [52].
Management
Refer to BASHH guidelines [53].

Human Immunodeficiency Virus (HIV) infection

HIV may be associated with balanoposthitis, particularly circinate balanitis, which may be in a more severe form. Other forms of balanitis have also presented in HIV infection but no specific HIV related balanoposthitis is reported. There is also an association between carriage of organisms and increased risk of Human Immunodeficiency virus (HIV) infection[9].

Trichomoniasis

Clinical Features
Balanoposthitis may occur in approximately one third of male carriers of *Trichomonas vaginalis (TV),* and a long prepuce has been found to be a predisposing factor[54]. It typically causes an erosive balanitis, but ulcerative forms can also occur. Patients may also have an associated urethritis, and inguinal adenopathy[54, 55].

Diagnosis
Diagnosis can be confirmed by identification of TV from the sub-preputial space in a wet preparation or by NAAT.

Management
Refer to BASHH guidelines [56].

Scabies

Clinical Features
Scabetic balanitis can present with erythematous, excoriated papules and nodules with pustules secondary to bacterial infection [57]. Bullous lesions have also been described [58,59].

Diagnosis and Management
Diagnosis is dependent on identification of pathognomonic lesions in association with balanitis.
Refer to BASHH guidelines [60].

DERMATOLOGICAL PRESENTATIONS (see Figure 1)

PALLOR

Lichen sclerosus typically reveals pale or white patches on the glans, often with involvement of the prepuce. Architectural changes such as blunting of the coronal sulcus, phimosis or 'wasting' of the prepuce, and meatal narrowing.

Differential diagnosis of pallor: vitiligo – this presents without any inflammation or structural change.

Initial management: Ultra-potent topical steroids (e.g. clobetasol propionate 0.05% ointment) applied once daily for up to 3 months (reducing course) until remission, then gradually reduce to a maintenance dose.[64, 65, 72]

Complications: superinfection, penile cancer.
Further management and guidelines: ref 61-76

WELL DEMARCATED ERYTHEMA

Lichen planus[77-89.]
Characteristic clinical appearance on keratinised skin is of polygonal violaceous papules, which may be itchy and associated with white reticulate surface (Wickham's striae), with linear lesions exhibiting Koebner's phenomenon. Annular white patches and erosive lesions can occur on mucosal surfaces.

Initial management:
Moderate to ultrapotent topical steroids depending on severity[84,85 (]1, B)
E.g. Clobetasol propionate ointment or cream applied daily for 4 weeks then reducing in frequency over the next 8 weeks depending on response.
Complications: phimosis, dysplasia / squamous ca
Further management and guidance: ref 77-89

Zoon's[90-101]
Appearance includes well circumscribed orange–red glazed areas with multiple pinpoint redder spots - "cayenne pepper spots" on the glans and contiguous inner aspect of the prepuce in a symmetrical pattern.
Initial management[93,94]: consider topical steroid preparations with or without added antibacterial agents e.g. Clobetasol proprionate or Trimovate cream, applied once or twice daily (1, D) and refer for circumcision[93].
Complications: missing diagnosis of PeIN / SCC
Further management and guidance: ref 90-101

Psoriasis and circinate balanitis[102-107]
The lesions are characteristically well demarcated, and in the circumcised male, psoriasis on the glans is similar in appearance to the condition elsewhere, presenting with red scaly plaques. However, in uncircumcised men, scaling is lost, and the patches appear red and glazed. The clinical features of circinate balanitis are described under chlamydial infection.

Initial management: Moderate potency topical steroids[104,105] (+/- antibiotic and antifungal) (1, C)
Further management and guidance: ref 102-107

Fixed drug eruptions[108-110]
The lesions are usually well demarcated and erythematous but can be bullous with subsequent ulceration. As the inflammation settles there may be post-inflammatory hyperpigmentation.
Initial management: Lesions will settle without treatment when the precipitant is discontinued, but mild to moderate strength topical steroids may be required for symptomatic relief[115](1, C).

Penile intraepithelial neoplasia[111-137]
These are an important differential diagnosis and should be considered for any non-resolving lesion. They are now classified as differentiated and undifferentiated PeIN – the latter more commonly affecting the glans and having a greater risk of malignant transformation.
Lesions vary in clinical appearance:

- small warty/papillomatous papules, usually appearing on the lower shaft or base of the glans penis and surrounding pubic region. Lesions are usually multiple. (Previously known as Bowenoid papulosis)
- warty, scaly, and eczematous or psoriatic appearance erythematous patch. (Previously known as Bowen's disease)
- A 'glazed' or 'velvety' red patch. (Previously known as Erythroplasia of Queyrat). Risk of progression to invasive cancer appears relatively high if untreated; almost a third of patients.[129]

Management: Patients should be referred to Uro-Oncology multidisciplinary pathways (1, A).
Further management and guidance: ref 111-137

POORLY DEMARCATED ERYTHEMA

Eczema

Seborrhoeic dermatitis[138-140]
Seborrhoeic dermatitis can cause non-specific redness and itch, without the scale seen at non genital sites. Seborrhoeic dermatitis classically affects other sites such as nasolabial folds, scalp, ears, and eyebrows.

Initial management: Antifungal cream with a mild to moderate steroid (1, D).
Further management and guidance: There is a paucity of evidence specifically for balanitis, and low-quality evidence for other sites[138-140.]

Irritant /Allergic Eczema[141-144]
Irritant balanoposthitis is commonly associated with frequent washing of the genital area with soap and is associated with fragrances and preservatives. There may be a history of atopy. Patients usually present with itch and redness, and the appearances can vary in severity from mild erythema to widespread oedema of the penis.

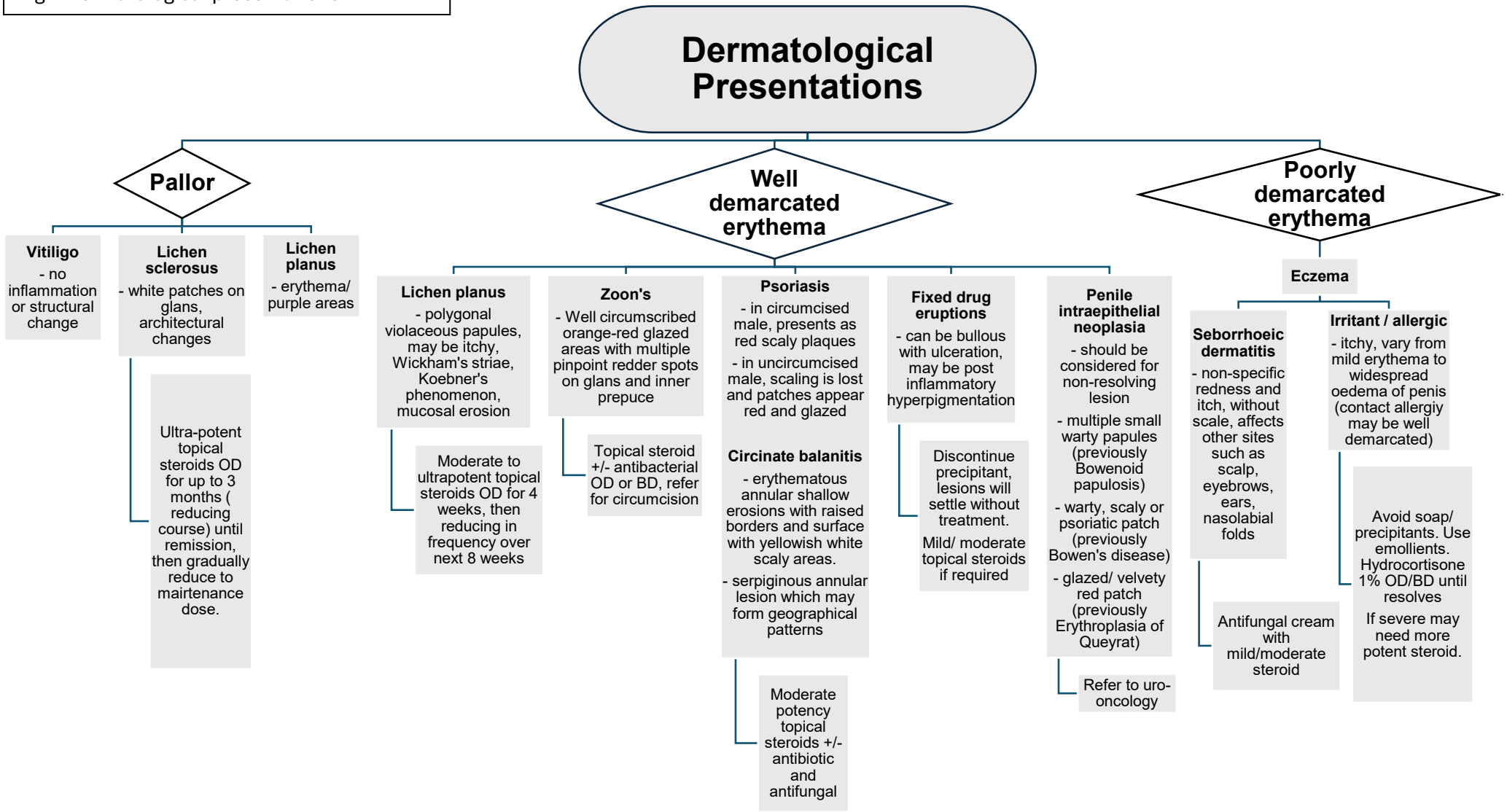
Initial management: Patients should be advised to avoid soaps and other precipitants, and to use emollients as soap substitutes and as required. Recurrent problems are common, and the patients need to be informed of this.

Recommended Regimen

- Hydrocortisone 1% applied once or twice daily until resolution of symptoms. (1C,)
- In more florid cases more potent topical steroids may be required and may need to be combined with antifungals and/or antibiotics
- Calcineurin inhibitors may be useful (II, b) [114], but onward referral is recommended

Further management: refs 138-144

Fig 1 Dermatological presentations



BALANITIS ASSOCIATED WITH SYSTEMIC DISEASE [145-166]

Whilst the majority of genital skin presentations are likely to be sexually transmitted or specific dermatoses, it is important to consider other systemic causes in the differential diagnoses, especially in lesions refractory to treatment or those at low risk of STIs.
Below is a list of alternative causes of genital lesions that should be considered so that they can be appropriately identified and referred on to the appropriate specialty (1, D).

Sarcoid

Sarcoid has been reported to cause ulcerative lesions of the penis,[145] as well as pink/purple annular eczema-like plaques and papules associated with pruritus and oedema [146-148].

Tuberculosis (TB)

TB tends to present as small, shallow genital ulceration with either singular or multiple lesions, sometimes with sinus tract formation. Very rarely, it can result in elephantiasis of the genitals[149-151].

Crohn's Disease

Crohn's of the genital region can present as genital ulceration, balanitis and phimosis or genital oedema [152-154].

Behçet's Syndrome

BS-related genital aphthous ulcers typically start as a tender nodule, becoming a round, deep and painful ulcer (0.5cm to over 3cm), interfering with sitting, walking, and causing sexual dysfunction[155-166].

CONSIDERATION OF RESOURCE IMPLICATIONS

It is acknowledged that some tests and treatments may not be available in all settings. Where biopsy is not available these patients should be referred to Dermatology. We recommend if malignancy is considered to refer on 2WW cancer pathway.

Some treatment preparations, e.g. Topical vit D preparations, may not be available on local formularies. It is advised that such preparations are discussed with MDT before prescribing.

QUALIFYING STATEMENT

The recommendations in this guideline may not be appropriate for use in all clinical situations. Decisions to follow these recommendations must be based on the professional judgement of the clinician and consideration of individual patient circumstances and available resources. It is acknowledged that not all departments will have specific genital dermatology provision.

All possible care has been taken to ensure the publication of the correct dosage of medication and route of administration. However, it remains the responsibility of the prescribing physician to ensure the accuracy and appropriateness of the medication they prescribe.

AUDITABLE OUTCOME MEASURES

- Patients should be given a full explanation of their condition with written or web-based information. Target 97%
- An assessment should be made of the impact of the condition on the person's quality of life and/or sexual health should be assessed and documented. Target 97%

RECOMMENDATIONS FOR FURTHER RESEARCH

Further research is recommended on the optimum regimes for treatment of skin conditions in genital skin.

ACKNOWLEDGMENTS

The guideline was circulated to Fabia Brackenbury (Vulval Health Awareness Campaign and Worldwide Lichen Sclerosus Support) and lay representative on the BASHH Dermatology special interest group, and her comments incorporated.

REVIEW ARRANGEMENTS

An author group will be invited by the BASHH CEG to review and revise the guideline in 2031 using the BASHH framework for guideline development. However, addenda may be issued sooner than 2031, particularly if relevant new data are available relating to testing or treatment options.

DISCLOSURES

Editorial independence

This guideline was commissioned, edited, and endorsed by the BASHH CEG without funding being sought or obtained.

Conflict of interest

All members of the guideline writing committee completed the BASHH conflict of interest declaration form at the time the guideline's final draft was submitted to the CEG. No authors have any conflicts of interest to declare.

Membership of the Clinical Effectiveness Group

- Current membership of the BASHH Clinical effectiveness group is available at https://www.bashh.org/guidelines

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