Welcome to the University of Michigan Center for Vulvar Diseases clinic. We are happy to have you working with us. Here is an outline to help orient you during your time learning with us in this subspecialty clinic.

I. Clinic structure and providers
   a. Clinic occurs on Thursdays in the AM and PM and Fridays in the AM in B Hall
   b. There are 5 doctors that work in this clinic.
      i. Hope Haefner, MD (Thursdays/Fridays)
      ii. Natalie Saunders, MD – Co-directors (Thursday AM)
      iii. Samar Hassouneh, MD – Co-directors (Thursday PM)
      iv. Ebony Parker-Featherstone, MD (Friday AM)
      v. Rosalyn Maben-Feaster, MD (Friday AM)

   c. There are also 2 sexual health counselors that work with us as well.
      i. Lindsay Matthews (Thursday)
      ii. Casey O’Gara (Friday)

   d. Our nurse is Beth Hall.
      i. Occasionally other nurses will fill in for her.

   e. New patient encounter
      i. Starts with meeting with RN to review vulvar patient packet (binder with ring).
         Patient then meets with provider and finally, the visit completed with
         consultation with sexual health counselor.

II. Patient population
   a. Patients are referred from all over the state and also other areas of the United States.
   b. Gynecology evaluation is required for referral.
   c. Often these patients have seen multiple providers.
   d. Common complaints:
      i. Lichen sclerosus
      ii. Lichen planus
      iii. HPV: VIN, warts
      iv. Vulvodynia – initial referral to Chelsea Family Med, with select cases to our
         clinic
      v. Poor response to treatment of the above and more

III. Learning expectations
   a. History taking skills:
      i. Elicit a pertinent history regarding vulvar and vaginal complaints, and a focused
         review of systems regarding those symptoms.
      ii. Create a reasonable differential diagnosis based on the history.
      iii. Elicit sexual health concerns and history in a sensitive and objective manner.
b. Physical Exam skills:
   i. Inguinal lymph node assessment.
   ii. Cotton swab testing for vulvar pain/vulvodynia.
   iii. How to test for STDs, perform a wet prep with pH in accurate manner, obtain vaginal/anal pap smears, send yeast/ wound (aerobic cultures).
   iv. Learn to interpret a point of care wet prep.
   v. Recognize features of common vulvar conditions: HSIL of the vulva or vagina, lichen simplex chronicus, lichen sclerosus, lichen planus, yeast, atrophy, hidradenitis suppurativa, vulvar or vaginal agglutination/scarring, herpes, vulvar erosions/ulcers.
   vi. Pelvic exam to assess for vaginismus, pelvic muscle tenderness.
   vii. Learn to identify areas high yield to biopsy for abnormalities/information.
   viii. Proper anatomic description of the vulva and exam findings.

c. Office procedural skills:
   i. Vulvar biopsies: punch, excisional, suture elevation techniques.
   ii. Become familiar with vulvoscopy, anoscopy, and vaginoscopy.
   iii. Intraleisional injections.

d. Knowledge base: Goal is to become familiar with the presentation, etiology, physical exam, work-up and treatment options as well as follow-up for various vulvar conditions including:
   i. LSIL or HSIL of the lower genital tract (vulva, vagina or anus).
   ii. Vulvovaginal infections simple and complex/recurrent: bacterial vaginosis, STDs, desquamative inflammatory vaginitis, yeast vaginitis, herpes.
   iii. Vulvar ulcers.
   iv. Non-neoplastic epithelial conditions of the vulva: Lichen simplex chronicus (including the itch-scratch cycle), lichen sclerosus, lichen planus.
   v. Vulvodynia versus vulvar pain, vaginismus, dyspareunia.
   vi. Hidradenitis suppurativa- diagnosis, staging, and medical management.
   vii. Atypical junctional melanocytic hyperplasia (premelanoma).
   viii. Paget’s disease.
   ix. Condyloma acumminatum.

e. Counseling:
   i. Attend at least one or more sexual health therapy sessions.
   ii. Become familiar with sex therapy and its benefits.
   iii. Vulvar hygiene measures.
   iv. Lubricant and dilator options, and how to counsel patients on use.

f. Operative experience and skills- become familiar with as many of these procedures as possible:
   i. Surgical management of hidradenitis: localized vs widespread disease.
   ii. Wide local excision of vulvar lesion. Primary closure principles versus when to use a flap or skin graft.
iii. Vulvar, vaginal, anal laser for LSIL or HSIL.
iv. Lysis of vulvar and vaginal adhesions (lichen sclerosus or lichen planus).
v. Bartholin cyst marsupialization or excision of the cyst/gland.

IV. Resources
a. Residents
i. Website: Many helpful hints are available at: 
http://obgyn.med.umich.edu/patient-care/womens-health-library/vulvar-diseases/information
ii. International Society for the Study of Vulvovaginal Disease (ISSVD)
iii. Helpful Michart dotphrases
   1. .hsotcmeds (HS vitamin doses: Zinc, Copper, Vit C)
   2. .lichensclerosus
   3. .vulvabiopsypostop
   4. .vulvasteroiadtaper
   5. .remfvulvaboricacid
   6. .remfvulvabxconsent
   7. .remfvulvahs (Stages and treatments)
   8. .remfvulvalscdescription (itch-scratch regimen)
   9. .remfvulvanew (NP vulvar template)
  10. .remfvulvarbx (procedure note for biopsy)
  11. .hhphysical (physical exam template)

iv. Patient instructions
   1. Comfort measures
b. Patient information – in the drawer in Hall B
   i. Vulvar Patient Packet
   ii. Vulvodynia articles
   iii. Lichen sclerosus articles
   iv. Lichen planus articles
   v. Hidradenitis treatment
   vi. Itch Scratch regimen
      (If you happen to grab the last handout in that folder, please ask a medical assistant make copies before you give it to the patient)

V. Resident duties in clinic:
a. Sometimes new patients make for a better learning experience, but we feel there is plenty to be learned from returns as well. Pick whoever peeks your interest as long as clinic flow is not impacted.
b. Residents are expected to gather history but physical examination should be performed with attending present.
c. At the end of the visit resident is expected to review the problem list, add visit diagnoses, order in necessary labs, tests or medications and complete the wrap-up section as well.
They should consult with the attending for questions on billing. Please add GC modifier.

d. Residents are expected to discuss new patient’s information with sexual health counselor prior to the counselor meeting with the patient. End of the note should indicate that the patient was referred to the sexual counselor for x, y and z counseling.
   i. You are welcome and encouraged to attend at least one sexual health counselor session with a patient

e. Residents are expected to document the encounter within 72 hours. Please include whom the patient would like the letter sent to at the bottom of the note.
   i. When dictating new patients that are referrals, start the dictation as, “Dear _____, Thank you for referring _____ to the University of Michigan Center for Vulvar Diseases for consultation for...”
   ii. Dictations should not include sexual history information. This is considered confidential information in our patient population.
   iii. The intake survey for new patients should be placed on the rack on the left wall as you look out the windows of the Hallway B room.

f. Residents NOT expected to follow-up on test results.

VI.  Hope-ism’s:

   a. “Vagisil makes you ill”
   b. “Trim don’t shave”
   c. “Ointments not creams”
   d. Labia is pleural, labium is singular
   e. “HSV can look like anything”
   f. When in doubt cut it out. Cancer till proven otherwise.
   g. Sclerosus is spelled with sus at the end, not sis.

Healing the world, one vulva at a time. Come join us!