Vulvar Disease: Overview of Diagnosis and Management for College Aged Women

Lynette J. Margesson MD FRCPC
No Conflicts of interest

Lynette Margesson MD

Little evidence based treatment
Most information is from small open trials and clinical experience.

Most treatment discussed is “off-label”
Why Do Vulvar Disease?

Not taught    Not a priority
Takes Time
Still an area if taboo

VULVAR CARE IS COMMONLY UNAVAILABLE

For women this is devastating
Results of Poor Vulvar Care

Women:
- **suffer** with undiagnosed symptoms
- **waste** millions of dollars on anti-yeasts
- **hide** and scratch
- **endure** vulvar pain and dyspareunia
- **are desperate** for help
VULVA!

What is that?

Down there?
Vulvar Education

Lets eliminate the “Down there” generation

Use diagrams and handouts

See www.issvd.org - patient education
Recognize Normal Anatomy
Normal vulvar anatomy

Age
Race

Hormones determine structure
- Size & shape
- Pigmentation
- Hair growth
History

A good, detailed, accurate history

All previous treatment

Response to treatment

All medications, prescribed and over-the-counter

TAKE TIME TO LISTEN
Genital History in Women

Limited by:

- embarrassment
- lack of knowledge
- social taboos
Examination Tips

Proper visualization - light + magnification
Proper lighting - bright, but no glare

Erythema can be normal

Examine rest of skin, e.g. mouth, scalp and nails

Many vulvar diseases scar, not just lichen sclerosus
Special Anatomic Variations

Sebaceous hyperplasia
ectopic sebaceous glands

Vulvar papillomatosisis
**BIOPSY**

- punch
- shave
- or scissor biopsy

---

**Pre-anesthesia** -

- Use a topical anesthetic
  - 2.5% prilocaine / lidocaine cream
  - or 5% lidocaine ointment
- 15 -20 min for thin skin
- 60 to 90 min for keratinized skin

Inject 2% xylocaine with adrenalin
with a 30 gauge needle

---

**Stop bleeding:**

- Monsel’s, ferric chloride or silver nitrate and pressure, rarely need a suture

Use plain petrolatum daily until healed
BASIC FACTS

• Multifactorial processes are common
• Iatrogenic disease is common
• Vaginal disease is important
Herpes Simplex Virus (HSV)

Commonest cause of vulvar ulcers
Second most prevalent STD in USA

Pathophysiology:
- HSV I - 25-30% or HSV II - 70-75%
  - in college students 78% HSV I from oral contact
- HSV II, predominantly sexually transmitted
- Usually spread from contact with an asymptomatic partner
- Women are more susceptible
- Recurrence rate for HSV II 89%; HSV I 45%
Primary HSV
Fever, malaise, pain, dysuria
Groups of blisters, pustules
Extensive ulcers
Duration: 2 weeks

Recurrent HSV
Prodrome itch, tingling
Malaise - mild
Small blisters, fissures or ulcers
Duration 5 days
Genital Herpes Simplex (HSV) Tips

Primary HSV is uncommon
HSV I increasing - 50% first episode genital HSV is HSV I
History HSV unreliable
Women are asymptomatic carriers of HSV and may not recognize recurrent episodes
HSV can present as pain or irritation only

Women are unaware of their infection and most often present with recurrent HSV with no primary HSV history
Herpes Simplex Virus (HSV)

Think of HSV in a patient with a non-healing genital very painful ulcer, punched out ulcers or ulcerated nodules.

**Diagnosis**
- Tsank smear, **PCR**, culture, **Type-specific serology**, biopsy

Main cause of vulvar ulcers in immunosuppressed
Human Papilloma Virus
HPV
condylomata acuminate (genital warts)
most common sexually transmitted disease in the United States

Pathophysiology:
- most due to HPV, 6 and 11 (non-oncogenic)
- less common due to 16, 18 (31, 33, 35, etc.)
Can be oncogenic - associated with genital intra-epithelial neoplasia, squamous cell carcinoma.
HPV in Young Women

Infections are temporary

Most have little long-term significance:

Infections clear 70% 1 year and 90% in 2 years

Infections persists in 5% to 10%

High risk of developing precancerous lesions of the cervix

Progress to invasive cervical cancer 15-20 years
No definite “cure”
50% of patients with vulvar HPV have cervical HPV
Incubation period, 2 to 3 months
Varying degree of irritation, itching, soreness
Pinhead papules up to cauliflower-like clusters
30-40% of children with anogenital warts have been abused
Candidiasis is the commonest genital disease

Causes: Candida albicans 75%
       Candida tropicalis, etc. 25%

NO TELEPHONE DIAGNOSIS

Candida can complicate all vulvar problems
   e.g. LP, LSC, LS, Contact
Promoting factors for Candida

- antibiotics
- immunodeficiency
- diabetes
- chemotherapeutic agents
- hormones
- BCPs and pregnancy
- corticosteroids
- HIV
Up to 50% of women with “Yeast” are misdiagnosed.

All vulvar irritation and rashes are NOT “Yeast”

e.g. Contact dermatitis, HSV, lichen sclerosus
Candidiasis

Candidiasis is the commonest genital disease

Causes: Candida albicans 75%
Candida tropicalis, etc. 25%

NO TELEPHONE DIAGNOSIS

Candida can complicate all vulvar problems
  e.g. LP, LSC, LS, Contact
Treatment Candidiasis

**Topical** imidazole cream or vag tabs - 1, 3, 7d
nystatin cream or vag tabs

**Oral** imidazole - fluconazole 150 mg on day 1, 3, 7

**Suppression**
- clotrimazole  500g vag tab weekly or 200 mg twice a wk
- fluconazole 150 - 200 mg orally weekly
- ketoconazole 100 mg orally daily
- itraconazole  100 mg orally daily

**Resistant Candida**
- boric acid vaginal suppositories 600mg X 14 d
Vulvar Patients are desperate! with Itch, burn, pain

They try to:

“Wash it away” and “Clean up” the dirty area using Soaps, cleansers, Anesthetics, Yeast Rx
Vulvar Contact Dermatitis

Vulvar inflammation due to an exogenous agent acting as Primary Irritant or Allergen
Vulvar Contact Dermatitis

Primary irritant:

Prolonged or repeated exposure to caustic or physically irritating agent
This is a “chemical burn”

Very common with ALL vulvar problems

Causes:

Hygiene habits - soap, wipes, pads
Moisture - urine, feces, sweat
Topicals - lotions, antifungals
Contact Dermatitis

Primary irritant:

- Prolonged or repeated exposure to caustic or physically irritating agent
- Anyone will react
- Non-immunologic
  e.g. urine, feces, soap, sweat

COMMON
Contact Dermatitis

**Allergic:**

Type IV delayed hypersensitivity reaction

Only low dose of substance needed
e.g. Poison ivy, neomycin, benzocaine

**NOT COMMON**
# Common Vulvar Contactants

<table>
<thead>
<tr>
<th>ALLERGENS</th>
<th>IRRITANTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benzocaine (Vagisil)</td>
<td>Soaps/cleansers</td>
</tr>
<tr>
<td>Preservatives</td>
<td>Sweat, urine, feces</td>
</tr>
<tr>
<td>Neomycin</td>
<td>Creams (alcohol)</td>
</tr>
<tr>
<td>Latex condoms</td>
<td>Douches</td>
</tr>
<tr>
<td>Chlorhexadine (KY)</td>
<td>Medications - TCA, 5FU</td>
</tr>
<tr>
<td>Lanolin</td>
<td>Spermicides</td>
</tr>
<tr>
<td>Perfume</td>
<td>Panty liners</td>
</tr>
<tr>
<td>Nail Polish</td>
<td></td>
</tr>
</tbody>
</table>
Treatment Vulvar Contact Dermatitis

Stop Contact - Irritant or Allergen
- Stop irritants
- Educate patient
- Stop scratching
- Treat infection - yeast, bacteria
- Patch Test as indicated

Control inflammation
- triamcinolone 0.1% oint twice a day for 7-10 d
- If severe, use systemic corticosteroids
Vulvar Contact Dermatitis

Frequent

Complicates all vulvar conditions

Irritant contact most common

Skin barrier lost from soaps, urine, feces

BEWARE THE "DIRTY" VULVA
Tinea Cruris

Tinea cruris, ringworm - superficial dermatophyte infection

Clinical: annular, red, itchy rash with peripheral scaling

Dx: KOH, culture

Rx: imidazoles
Molluscum Contagiosum - pox virus
Scabies

Treat all contacts
5% permethrin cream 12-14 hours
Repeat 1 week

Oral ivermectin
3mg/30lbs repeat 1 week
Pediculosis

- Pubic lice or crabs are Phthirus pubis.
- Sexual history and screening for other sexually transmitted diseases is warranted.
Pediculosis Pubis

Treatment
• Permethrin 1% cream (Nix® Cream) or a pyrethrins with piperonyl butoxide (A-200®) or rinse applied to the affected areas and washed off after 10 minutes
• Ivermectin - same for scabies
  3mg/30lbs repeat 1 week
• Treat all contacts, clean clothes etc
Lichen Simplex Chronicus (LSC)

End stage of the cycle

Itch → Scratch → Itch

Worse with heat, humidity, stress and irritants

Associations: atopic dermatitis, psoriasis, contact dermatitis

Scratching feels so good
Itch \quad \rightarrow \quad Scratch

Thickened Skin
(lichenification)
Characteristics of Lichen Simplex Chronicus

- Relentless pruritus
- “nothing helps”
- “years of itch”
- uni or bilateral

- dyspigmentation
- excoriations, crusts
- lichenification
- hair loss

The diagnosis is clinical
Treatment LSC

Confirm diagnosis - biopsy?
Educate and support the patient

1) Improve the epithelial barrier layer function

2) Reduce inflammation whether or not it is visible clinically

3) Break the itch-scratch-itch cycle

Treatment in all three of these areas is essential

Look for more than one cause
Treatment LSC - Reduce inflammation

Stop all irritating factors - infection, trauma

Start - topical superpotent steroids -
clobetasol 0.05% oint bid x 2 wks, OD x2 wks, MWF x 2 wks

If severe or not better in 3 weeks, use systemic steroids:
1. Oral prednisone: 40 mg qAM X 5; then 20 mg qAM X 10 days
   or
2. IM Triamcinolone (Kenalog-40): 1mg/kg up to 80 mg/dose,
   repeat in 1-2 months if necessary

Treat infection - prevent Candida - fluconazole 150 mg/week
   - cefadroxil 500 mg bid for 1st week
Stop the itch-scratch-itch cycle:

For night time scratching use
**Hydroxyzine** or doxepin
starting with 10 (25) mg 2-3 hours before bedtime
increase by 10 (25) mg increments slowly

For daytime scratching treat as scratching is a form of OCD;
- use any **SSRI** - citalopram 20 to 40 mg q AM

Recognize and manage psychological factors

Follow - often relapse
Treatment Tips LSC

For recurrent infection:
Swab skin folds and nose for C&S - R/O MRSA, Candida

Bleach Baths - 3 times a week
½ cup bleach in 10” water for 5-7 min
1 ¼ teaspoons of bleach per gallon (4 liters) of water
Lichen Sclerosus

A chronic, autoimmune, mucocutaneous disease affecting the genital skin causing whiteness, tissue thinning and scarring.

Commonest cause of chronic vulvar disease
Prevalence 1:300 - 1:1000

15% cases children
15% have extragenital disease

3-5% SCC

Lichen Sclerosus

Age
- range 6 months to elderly
- Seen in teens and may not have been noted in childhood
- Perimenopausal 40 - 50 yrs

Etiology
- genetic - familial cases
- autoimmune link
  - thyroid disease - 30%
  - vitiligo
  - alopecia areata
Lichen Sclerosus
Symptoms

Itch - 90%  severe - 30-50%
Pain, burn, sore - 40%
Dyspareunia
Dysuria
Painful defecation, especially children
Rectal bleeding
Sexual dysfunction

Asymptomatic

Asymptomatic vulvar scarring - look for LS
Lichen Sclerosus
Clinical changes
Primary

Classic white or waxy papules and plaques
Diffuse erythema
Cellophane-like surface sheen, crinkled, atrophic
Figure of eight / hourglass pattern
Patterns variable (perianal 30% women)

NOT in VAGINA - rare in mouth (26 oral reports)
Lichen Sclerosus
Clinical changes
Secondary

- Excoriations
- Erosions
- Pustules
- Fissures

- Purpura
- Swelling
- Lichenification
- Hyperpigmentation

**Scarring** - Resorption with loss of normal architecture:
Scarring of clitoral hood and burying of clitoris,
Scarring and loss of Labia minora,
introital stenosis
Lichen Sclerosus Treatment

**Confirm diagnosis - biopsy**
- Stop irritants
- Stop scratching
- Educate patient
- Treat infection - yeast, bacteria

**Control inflammation**
- clobetasol or halobetasol 0.05% oint once or twice a day for 3 months then maintenance 1-3 times a week
  - If very thick, consider intralesional triamcinolone

**Not responding?**
Reassess, rebiopsy, R/O SCC, contact

**Follow forever**
Intralesional Triamcinolone

Sites of Injections of T/C 2.5-10mg/ml 27 gauge needle
4-5% Risk SCC With Vulvar LS

40% Vulvar SCC Have LS
Tips on Lichen Sclerosus

Look for LS in women with vulvar itching

Biopsy adults before starting topical steroids
Check thyroid function
Discuss and treat for sexual dysfunction

Always have patient report any change - lump, ulcer because of small risk of SCC

Be optimistic - most patients do very well
MANAGEMENT PRINCIPLES

Explain disease processes, treatments, and expectations

Use Handouts

Treat all factors
MANAGEMENT PRINCIPLES

Anticipate and minimize iatrogenic disease (yeast, irritant contact dermatitis)

Avoid cream vehicles on painful, or inflamed, vulvar skin

Avoid topical therapy in general and use oral medications, except for corticosteroids

The vulva is relative steroid resistant - use ultrapotents
Lichen Planus

An autoimmune, mucocutaneous, disorder of altered cell mediated immunity in older women - 50 - 60 years not usually college age patients

Affects - Skin, scalp, nails
Mucous membranes - oral, genital, anus esophageal, urinary tract
Pathophysiology of Lichen Planus

Unknown

Exogenous irritants or antigens target the epidermis

- Drugs/chemicals - thiazides, NSAIDS
- Infection - Hepatitis, super antigens

Responds to immunosuppressive therapy

2-5% SCC
Lichen Planus Vulvar Patterns

**Classic** - White, lacy, or fernlike papules

**Erosive** - Well-outlined red plaques with whitish to lacy edges
- Erosions, glazed erythema, ulcers, scarring

**Hypertrophic** - Thick, white like lichen sclerosus, scarred

LP also affects vagina, mouth and skin
Vaginal Lichen Planus

In the vagina:

LP causes **Desquamative Inflammatory Vaginitis** DIV with variable loss of the lining of the vagina so it is raw causing:

- Pain
- Synechiae
- Stenosis/ Scarring
- Erosions
- Dyspareunia
- Discharge
- Dysuria

- Mucopurulent vaginal discharge - yellow, green, bloody
Lichen Planus Treatment

Confirm diagnosis - biopsy
- Stop irritants
- Stop scratching
- Educate patient
- Control infection

Control inflammation
- clobetasol or halobetasol 0.05% oint daily
- intralesional, vaginal or systemic corticosteroids

As a steroid sparer -
- topical tacrolimus (Protopic) 0.03%, 0.1% oint - burns
Severe Lichen Planus Treatment

**Systemic corticosteroids** -
Triamcinolone 1mg/kg IM every 4 weeks for 3-4 shots
Prednisone 15-30 mg/d then taper

Mycophenolate mofetil 500mg -1.5 g bid
Acitretin (10 mg 5-7 d/wk)
Methotrexate 5-15 mg/week PO or SC + folate

Cyclosporine 4-5 mg/kg/d -3-4months
Hydroxychloroquine 200 mg bid
Etanercept 50 mg 1-2 doses / week ?
Adalimumab
The Lichens

Lichen Sclerosus
Lichen Planus
Lichen Simplex Chronicus
## The Lichens

<table>
<thead>
<tr>
<th>LS</th>
<th>LP</th>
<th>LSC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Itch or burn</td>
<td>Itch or burn</td>
<td>++++ Itch</td>
</tr>
<tr>
<td>Scars</td>
<td>Scars</td>
<td>No Scar</td>
</tr>
<tr>
<td>Not in Vagina</td>
<td>In Vagina And Mouth</td>
<td>Not in Vagina</td>
</tr>
</tbody>
</table>
Psoriasis

A hereditary, scaly rash

Silvery white adherent scale on red plaques on elbows, knees, and scalp

In groin - thin red patches
Vulvar Psoriasis

Clinical

Itchy vulvar rash involving hairy areas + gluteal cleft
Well demarcated papules and plaques
Diffuse redness esp. skin folds

Look elsewhere for typical lesions
e.g. elbows, knees, scalp, nails

Secondary changes with infection
- fissuring, pustules

Often missed or hidden
Psoriasis Treatment

Stop irritants

Treat infection - yeast and bacteria

Stop inflammation

- topical steroids - triamcinolone
  0.025%, 0.1% ointment am pm 5-7d then
- calcipotriene 0.005% cream or calcitriol oint
- tacrolimus 0.1% ointment or
  pimecrolimus 1% cream
- if severe, systemic medications
Drug Eruptions

Drugs can cause 100 different skin reactions
Many can be seen on the vulva
Erosive/ulcerative types -
- erythema multiforme
- aphthous ulcers
- Pemphigoid
- fixed eruptions,
- LP and LE eruptions,
Vulvar Squamous Cell Carcinoma

Commonest vulvar malignancy

85-90% of all vulvar cancers

Classification -
Intraepithelial - vulvar intraepithelial neoplasia (VIN III)
Invasive
Vulvar SSC

**Intraepithelial** - multifocal (HPV 16, 18)
- in younger women
- looks like condylomata (warts)
- solitary
  - in older women
  - asymptomatic growth

**Invasive**
- in women > 65 yr.
- up to 40% - lichen sclerosus
Vulvar SCC

30-40% vulvar SCC occur in lichen sclerosisus

Lichen sclerosisus and lichen planus can develop SCC in 3-4% cases

Biopsy any non-healing lesion
Commonest Causes of Vulva Ulcers in North America

- Trauma and Contact dermatitis
- Hidradenitis Suppurativa
- Tumors - Squamous cell carcinoma
- Aphthous ulcers
- Crohn’s Disease
- Sexually transmitted disease - HSV immunosuppressed, syphilis, chancroid
- Drug/medication
- Behcet’s Disease - rare
TRAUMA

Blunt / sharp
Factitial
Chemical
Mechanical
Physical heat

Factitial
Severe Irritant Contact Dermatitis
Trichloracetic acid
A caustic burn
Hidradenitis Suppurativa (HS)

Follicular occlusive, acneiform disease
Multiple lesions - misdiagnosed as “BOILS”
Distribution: axillae, submammary, groin, buttocks
Heterogeneous morphology: papules, pustules, nodules, ulcers, draining sinuses, rope-like scars
Multi-headed comedones
Family history of “boils”, acne
HS Clinical features

Onset - on or after puberty (age 21)
  rare before puberty
Peak incidence - 20-30 years of age
First lesions are “boils” - painful, deep, red nodules that last weeks/months, do not ‘point and drain’
Duration ~ 7 days  Average 2/month
Typical, chronic, recurrent, lesions in typical sites (axillae, groin)
Resume of HS management

Education, chronicity
No smoking, hygiene/pressure relief, diet
Hormones - anti-androgens as indicated
Anti-inflammatories - topical and systemic antibiotics, systemic cortisone, depending on severity
Early unroofing
Further surgery as indicated
Consider biologics for severe HS
  - for control before surgery
Squamous Cell Carcinoma
Vulvar Aphthous Ulcers

Canker sores on the vulva
Acute painful ulcer(s) of sudden onset
Common as acute reactive ulcers in younger patients - often missed

**Synonyms:**
- Complex Aphthosis
- Ulcus vulvae acutum
- Lipschütz ulcers
- Reactive nonsexually related acute genital ulcers*

Vulvar Aphthous Ulcers

“Canker Sores” on the Vulva

- Average age is 14 (9-19) yrs
- Sudden onset
- Usually multiple, painful, well demarcated punched-out ulcers
- Size: most <1cm; can be 1-3 cm
- Prodrome - flu-like with mild fever, headache, malaise
- Duration 1-3 weeks, can last months
- One episode, less common recurrent
- Past history of oral aphthae – canker sores
- Rarely Behcet’s in North America

VULVAR APHTHAE

**Acute** (more common)
- usually a prodrome - fever, headache, malaise, GI upset
- EBV, Mycoplasma pneumoniae, viral upper respiratory infection or gastroenteritis, influenza, Salmonella (typhoid, paratyphoid) Strep, CMV

**Recurrent / Complex** (recurrent oral and genital aphthae)
Inflammatory Bowel disease - Crohn’s, Ulcerative colitis, Celiac disease
Behcet’s disease
Medications - cytotoxic, NSAIDs
Myeloproliferative disease, cyclic neutropenia, lymphopenia
HIV
Evaluation Vulvar Aphthae

Thorough history and physical – eye, oral, genital

Lab tests to consider –
MAY NOT NEED TO TEST EXCEPT FOR HSV

- CBC, diff
- Serology for HSV, HIV, EBV, syphilis, CMV, *Mycoplasma pneumoniae*
- Influenza – swab PCR
- HSV - swab for PCR – always R/O HSV
- For Strep -throat swab and antistreptolysin O titer

GI investigations – For recurrent ulcers
for inflammatory bowel disease and celiac disease

Diagnosis of exclusion - etiology often not found
Vulvar Aphthae - Therapy

**Pain control** - topical, systemic

**Prednisone** 40 - 60 mg each morning until pain resolves (3-5 days, then ½ dose 3-5 days )
- ultrapotent corticosteroid

**Educate** - Most often a one-time event, can recur

If not controlled - recurrent:
- **Intralesional triamcinolone** 5-10 mg/ml
- **doxycycline** 50-100 mg daily to BID
- **colchicine** 0.6 mg bid-tid if tolerated
- **dapsone** 50-150 mg per day
- **dapsone + colchicine**
- **pentoxyfylline** 400 mg tid
- **cyclosporine** 100 mg 1-3/d
- **thalidomide** 100-150 mg per day
Epstein-Barr Virus (EBV)

Lymphotrophic herpes virus
Age - teens to early 20s
Clinical - acute onset
- fever, malaise
- sore throat - lasts 2 to 3 weeks
- punched out painful ulcer(s)
- recent hx of mono in family member

Serology - EBV IgM anti-VCA antibody
Vulvar Crohn’s Disease

Chronic inflammatory bowel disease that can have vulvar and vaginal ulcers
Rare on vulva - 2% women have vulvar lesion
Onset can be before GI disease

“Knife Cut” and aphthous ulcers

- **Contiguous**
  - direct fistulae from bowel to skin
- **Non-contiguous/metastatic**
  - painful labial edema +/- ulcers
  - “knife cut” ulcers
- **Non-specific**
  - aphthae - oral and vulvar
  - hidradenitis suppurativa type lesions and pyoderma gangrenosum
Syphilis

Painless ulcer - “chancre”
Sharp edge
Clean base
Seldom seen
Syphilis - Diagnosis

Non-treponemal tests - RPR and VDRL
Not as sensitive as the treponemal test for primary syphilis
If positive and ordered first do specific test
eg. Fluorescent Treponemal Antibody Absorption Test (FTA-ABS) or Treponema Enzyme Immunoassays (EIAs)

Treponemal tests
Specific anti-treponemal antibody tests -
- these test done first in European Union and USA
  EIA or CIA if positive do RPR +/- TP-PA
  Treponema Enzyme Immunoassays (EIAs)
  Treponema Chemiluminescence Immunoassays (CIAs)
  Treponema pallidum particle agglutination (TP-PA) test

Biopsy and stain - silver stain (Warthin-Starry)
  South and southeast Asia, Sub-Saharan Africa, Siberia

Treatment information go to http://www.cdc.gov/std/treatment/2010/toc.htm
Chancroid
Haemophilus ducreyi

Painful ulcers
Ulcers multiple and grouped
Ulcer base has purulent crust
Ulcer base soft and tender
Inguinal lymphadenopathy
(can be large tender suppurative lymph nodes)

Biopsy and smear may help for diagnosis - “school of fish”
Chancroid

Haemophilus ducreyi -

**Diagnosis** - no easy test - *diagnosis of exclusion*

Consider diagnosis if:
1. ulcers painful and tender
2. syphilis serology, 7 days after ulcer seen, is negative
3. clinical picture and lymphadenopathy fits.
4. HSV tests negative

PCR tests are available

Endemic - Africa
Asia and Latin America
50 cases /yr USA
Vulvar Behcet’s Disease

Commonest along “Silk Road” - Turkey, Middle East to Japan
Rare in women North America and Europe

Triad - oral and genital ulcers, uveitis
Specific criteria for diagnosis

Clinical -
  painful, punched-out, recurrent oral and vulvar ulcers
    - last 2-3 wks
    - heal with scars, sinuses on vulva
  - Skin rashes - erythema nodosum, superficial thrombophlebitis,
    pyoderma gangrenosum-type lesions,
    erythema multiforme-like lesions and purpura
    - variable systemic involvement lasting years

Prognosis - can be serious and debilitating
  - benign in western counties

RARE
Think of it last
Recurrent Vulvar Ulcers:

HSV
Contact Dermatitis
Aphthae
Trauma
Drug
Factitial
Multiple Vulvar Ulcers:

- HSV
- Aphthae and Crohn’s
- Contact Dermatitis
- SCC / Tumors
- Trauma
- Chancroid
- Factitial
Vulvar Pain

Prevalence - 16% of women have chronic vulvar pain
Constellation of disease processes and biological responses
Classification of Vulvar Pain I

Vulvar Pain Related to a Specific Disorder

1. Infectious  
   e.g. candidiasis
2. Inflammatory  
   e.g. erosive Lichen Planus
3. Neoplastic  
   e.g. squamous cell carcinoma
4. Neurologic  
   e.g. herpetic neuralgia
Classification of Vulvar Pain II

VULVODYNIA

Vulvar Pain Without Visible Lesions

1. Localized vulvodynia
   (formerly vestibulitis)
   vestibulodynia, clitorodynia, etc.

2. Generalized
   (formerly dysesthetic vulvodynia)

one of the most common causes of painful sexual intercourse
Vulvodynia = Sex Hurts

Ruins sexual activity and intimacy
Ruins relationships
Is a source of anxiety and frustration
Interferes with activities and even clothing
Results in poor self esteem
Vulvodynia

Prevalence

7% of women have vulvodynia
60 women per PCP practice
8,000,000 women in USA

Dr. B. Reed, Univ of Mich, ISSVD World Congress Sept 2009
Localized Vulvodynia
formerly
Vulvar Vestibulitis Syndrome

A chronic painful condition with pain on touching the vulva (vestibule area) or with any vaginal penetration.

Age - teens to 40 years
Only involves a localized area of vulva
Intercourse is always painful

**classic complaint of entry dyspareunia**

COMMON
Localized Vulvodynia

Pathophysiology:
A localized painful condition triggered by trauma
? yeast, contactant, mechanical irritation

The chronic pain sensitizes the local nerves,
the pelvic muscles tense, spasm and
a pain loop develops.
Localized Vulvodynia

Clinical: Looks normal with pain on Q tip testing around hymenal ring
Pelvic floor muscles often tense and sore

Rx: support
- topical anesthetics
- pain meds - tricyclics, gabapentin
- pelvic floor therapy and biofeedback
- surgery
Generalized Vulvodynia is mainly a Pain from Pudendal neuralgia and / or Regional Pain Syndrome
Generalized Vulvodynia

Involves the whole vulvar area with spontaneous pain and burning in older women

Pathophysiology: A Pudendal Neuralgia and / or A Complex Regional Pain Syndrome

With increased systemic pain perception - central nervous system sensitization (a centralized pain disorder)

- same processes in fibromyalgia, interstitial cystitis, etc
- may be associated with these conditions

UNCOMMON
Generalized Vulvodynia

Clinical:
diffuse, constant pain, burning, rawness, aching, lancinating pain with or without pain free periods

Treatment:
Support
Meds - tricyclics, gabapentin,
Pelvic floor Rx
Pain clinics eg. nerve blocks
Side Effects of Topical Steroids

- Epidermal atrophy
- Dermal atrophy and striae
- Bruising
- Telangiectasia
- Steroid rebound dermatitis
- Contact dermatitis - allergy to corticosteroid or base, or irritants in base
Topical Treatment Instructions

Give specific instructions for topicals

Amount to use
- show her, in the office, how much to use
- squeeze onto your finger, and demonstrate

Application site
- some women have never seen their vulva
- use a mirror, and show the exact place(s)
- give her a diagram with correct areas indicated

www.issvd.org Patient Education
How much to apply?

“1/4 of a Finger Tip Unit”

One fingertip unit = 0.5 g of cream or ointment
= two hand (palm) surfaces
Topical Steroid Use for the Vulva

The vulva is relatively steroid resistant

The labiocrural folds, perineum, and perianal areas are steroid sensitive

Patient education is very important

Limit amount prescribed

Remember complications - Candida and contact dermatitis
**IM Triamcinolone**

40 mg/ml

1mg/kg up to 80 mg/dose
3-4 doses/year

Site for IM injection

**Results of fat injection**

Poor absorption

Fat atrophy

**Do not inject into fat**

Gluteal Muscle

Anterior Thigh Muscle

If obese
IM TRIAMCINOLONE PRECAUTIONS

Allergy
Irregular menses
Hypopituitary Axis suppression
Blood Pressure
Diabetes
Infection - local, systemic
Eye - cataracts, glaucoma
Sterile abscess
Fat atrophy - must inject into muscle

Limit to 3-4 injections / year
Commonest Missed Concurrent Vulvar Diseases

- Candidiasis
- Contact Dermatitis
- HSV
- Atrophy
- Cancer

LOOK FOR MORE THAN ONE PROBLEM
Treat Vulvar Disease

Listen - review history
Biopsy and RE-BIOPSY
Look for
- infection - Candida, HSV, bacteria
- trauma from aggressive hygiene or other practices
- contact dermatitis
- squamous cell carcinoma

Educate
Support - counseling as needed
Assess compliance

LOOK FOR MORE THAN ONE PROBLEM
Vulvar Tips

Vulvar disorders are common
Too often hidden
Cause significant debility
Ask, look and recognize
Educate and demystify
You are VITAL for Vulvar Care

Hundreds of women will thank you!
Vulvar Disease Treatment Resource

Handout: Your Diagnosis Is?
Available at:
http://obgyn.med.umich.edu/patient-care/womens-health-library/vulvar-diseases/information
Under - Information Regarding Vulvar Diseases
Find Lectures then see
Your Diagnosis Is, June 2012 (pdf)

At issvd.org find
Patient education handouts
Vulvar Disease References


