EROSIVE AND ULCERATIVE DISEASES OF THE VULVA
Libby Edwards

DISCLOSURES
None
ULCERS vs EROSIONS

Erosions = loss of epithelium. Shallow, red base; often appears as a red patch only

Ulcer = loss of epithelium and at least some dermis. Deeper, often with white base
LICHEN PLANUS
VULVAR LICHEN PLANUS

- Autoimmune, cell mediated disease of older women
- On keratinized skin, dusky, shiny, flattopped papules, often itchy
- Vulva, vagina and mouth most often exhibits erosive disease
Nonspecific erosions
White epithelium
LICHEN PLANUS

- Scarring is prominent on vulva and in vagina
- Usually, only mouth and vulvovaginal skin affected
**LICHEN PLANUS**

**Diagnosis**

- Morphology
- Location
- Confirmed by biopsy (if you are lucky. Nonspecific lichenoid histology is a common reaction pattern)
- Differential diagnosis to follow
LICHEN PLANUS

Therapy – first line is same as for LS and LSC

- Stop irritants, control infection
- Estrogen in post menopausal women
- Corticosteroids. If prominent erosions, consider prednisone 40-60 mg po and re-evaluate each week. Otherwise, ultra potent steroid OINTMENT (clobetasol, halobetasol, etc) bid – follow for AE’s
LICHEN PLANUS

Therapy –

• Tacrolimus/pimecrolimus ointment twice daily can be added (stings)
• Black boxed for skin cancer and lymphoma
• I believe the risk of SCC with these meds is far less than the risk for women with untreated LP; but inform patients and document

LICHEN PLANUS

Remember vagina, mouth and esophagus

• If trouble swallowing, send to GI
• Vagina – (systemic absorption possible)
  - Hydrocortisone acetate 25 mg rectal suppositories hs
  - Hydrocortisone 100 mg compounded suppositories
  - Clobetasol/halobetasol oint via applicator – careful of absorption
  - Tacrolimus ointment or compounded suppositories
LICHEN PLANUS

Remember vagina, mouth, esophagus

- **Vagina** –
  Insert dilator daily (or frequent intercourse) to prevent adhesions
  Follow symptoms, exam, wet mounts

- **Mouth** –
  Clobetasol gel/dexamethasone elixir qid
  Tacrolimus/pimecrolimus qid

- **Esophagus**
  Refer to GI for endoscopy for dysphagia

- **Watch for yeast of mouth and vagina**

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LICHEN PLANUS

**Systemic**

- Hydroxychloroquine (Plaquenil) 200 mg*
- Methotrexate up to 25 mg q wk*
- Tumor necrosis factor alpha antagonists (etanercept/Enbrel; adalimumab/Humira)*
- Mycophenolate mofetil (CellCept) up to 3 g/d
- Azathioprine/cyclophosphamide
- Retinoids (isotretinoin/Accutane, acitretin/Soriatane)
- Cyclosporine, topical or oral

* These are my first three choices
Acute Contact Dermatitis
ACUTE CONTACT DERMATITIS (podophyllum resin, TCA/BCA, poison ivy/oak)

- Vesicular with prompt erosions
- Vesicles become erosions almost as soon as they form
- Allergic contact – itchy
- Irritant contact – burn/irritation

Allergic contact dermatitis

Topical diphenhydramine (Benadryl®)
Irritant contact dermatitis

from trichloroacetic acid

Irritant contact dermatitis

from vaginal fluorouracil
Fixed Drug Eruption

**FIXED DRUG ERUPTION**

- Peculiar same-site erosive reaction to medication, or same-site blister on dry, keratinized skin that leaves hyperpigmented round patch
- Confused historically with HSV
Fixed drug reaction to a tetracycline
## MORE COMMON OFFENDING MEDICATIONS

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## MANAGEMENT

- Stop the medication and avoid in future
- Local care; soaks (water) and bland emollients (petroleum jelly)
STEVEN'S-JOHNSON JOHNSON, TOXIC EPIDERMAL NECROLYSIS

BLISTERING ERYTHEMA MULTIFORME – Toxic epidermal necrosis, Steven’s Johnson Syndrome

- Hypersensitivity reactions to medications, or, with SJS, HSV
- SJS – mild blistering EM (<40% BSA)
  - discrete red spots with central blisters
  - mucous membrane erosions
- TEN – severe EM (>40% BSA)
  - skin turns red, generalized sloughing
SJS – discrete blisters

TEN – generalized bubbling
Redness and sloughing of epithelium. As for the eyes scarring can be severe and debilitating.
MOST COMMON OFFENDING MEDICATIONS

• Usually, caused by a first time medication begun from 2 weeks to 3 months before onset of rash
• Or, immediately after restarting a medication
• The most allergenic medications are
  sulfas  barbiturates
  penicillins  NSAIDS
  phenytoin  HCTZ
  carbemzaepine  furosemide

BLISTERING ERYTHEMA MULTIFORME

• Diagnosis is by explosive onset in a patient with exposure in expected timeframe
• Confirmed by biopsy (can do frozen section very quickly)
BLISTERING ERYTHEMA MULTIFORME
Care for vulva and vagina

• Care for overall disease is not your job
• Manage infection. Yeast is common
• Dilator daily; scarring can occur
• Petroleum jelly on vulva

BENIGN MUCOUS MEMBRANE PEMPHIGOID (CICATRICIAL PEMPHIGOID)
(CICATRICIAL) BENIGN MUCOUS MEMBRANE PEMPHIGOID

- Autoimmune blistering disease of older individuals; characterized by erosions and scarring of mucous membranes; VV, eyes, mouth
- 20% with intact blisters of keratinized skin

Because blisters slough immediately, the appearance can be indistinguishable from lichen planus, TEN/SJS, pemphigus vulgaris
BMMP

• Diagnosis by morphology, setting, confirmatory routine and direct immunofluorescent biopsy
• Treatment – call a dermatologist and ophthalmologist (systemic corticosteroids, antimetabolites, immunosuppressives)

BMMP
Your Job

• Look after the vulva and vagina
• Local care
  – Infection surveillance
  – Dilators to prevent scarring
  – Cancer surveillance
  – Intralesional corticosteroids
  – Advocate for your patient
PEMPHIGUS VULGARIS

(for your purposes, same as BMMP)

- Autoimmune blistering disease seen most often in about 4th decade; characterized by erosions mucous membranes, flaccid bullae and erosions of keratinized skin
- Classically nonscarring, but vulva and vagina definitely scar
PEMPHIGUS VULGARIS

- Diagnosis by relative gradual onset, mucous membrane erosion, flaccid blisters and confirmed by routine bx and bx for direct immunofluorescence
- Treatment is supportive care and oral corticosteroids
- Rituximab and other immunosuppressives as steroid sparing agents

Thank you!