The Genital Skin During Menopause in Health and Disease

2nd PANHELLANIC CONGRESS on Lower Genital Tract Disorders
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Almost all treatment for vulvar diseases is off-label and there is little evidence based data
50 year old perimenopausal lady -

“My vulva is shrinking”.

Is she just getting “old” or is there something wrong?

Recognize Normal Anatomy

Note the “missing bits”

White, scarred

Flat, scarred

Lichen Sclerosus age 50 yrs
Aging Vulva

Recognize Normal

30 35 yrs

65-70 yrs

45 yrs

Anatomy can be confusing

Look Carefully
Light - Extra Hands - Magnification - Time
Vulvar Education

Help the older women
Understand the Taboos
Demystify the vulva
Use diagrams, pictures and handouts
See www.issvd.org - patient education
Vulvar Conditions in Menopausal Women

- Genitourinary Syndrome of Menopause GSM (Atrophic Vulvovaginitis)
- Candidiasis in Diabetics or with HRT
- Dermatitis - Contact irritant
- Intertrigo
- Lichen Sclerosus
- Lichen Planus
- Squamous Cell Carcinoma
- Malignant Melanoma
- Extramammary Paget’s Disease


Women living longer 30 or more years in menopause

Estrogen is “Female Fuel”
Without it there is - LOSS OF VULVOVAGINAL BARRIER FUNCTION
Causing - Increased GU infections, incontinence, contact dermatitis and sexual dysfunction
Genitourinary Syndrome of Menopause (GSM)
Without adequate estrogen, vulvovaginal tissues are more easily irritated.

- Estrogen deficiency causes a decrease in barrier function with an increase in irritation from soap, creams, urine, feces, friction.
- Atrophy confuses and complicates all vulvar conditions.

50% of women have atrophic vaginitis and less than 25% are treated.

GS Menopause

**Clinical Presentation:**
- Thin, pale, dry, less sensitive skin
- Hair loss
- Tissue loss - flabby L. majora, shrunken L. minora
  - introital narrowing
  - loss of prepuce
  - loss of vaginal rugae with narrowing and shortening of vagina
- Cliteromegaly
- Fissures, watery discharge with itch, burn, dysuria, dyspareunia
On systemic estrogens

- Vagina may improve
- Vestibule can still be atrophic - needs topical estrogen

Atrophy / Estrogen Deficiency compared to
Thickened rugated vaginal surface with estrogen

Atrophy

Estrogenized mucosa
GSM - Atrophic Vulvovaginitis

Despite systemic estrogen 25% still need local Rx

Treatment
• Avoid irritants especially soaps and “wipes”
• Local or systemic estrogen
• Topical conjugated estrogens (Premarin®) cream or estrone 0.1% or estradiol tab or ring (Estring®)
  - use for vulva and vagina

1. Use estrogen cream on vulva for lichen sclerosus and lichen planus to improve barrier function
2. Consider compounded cream in bland base if sensitive

Candidiasis

The most common genital disease
Caused by:  85% - Candida albicans
            15% - Non-albicans Candida tropicalis, krusei, parapsilosis

Candida needs an estroganized environment
• Postmenopausal women seldom have “yeast” unless -
  - On estrogen - topical and systemic
  - Immunosuppressed and / or diabetic
  - On topical cortisone

Can complicate all vulvar problems:
• Atrophy, contact dermatitis, lichen sclerosus, lichen planus even genital cancer

NOT A TELEPHONE DIAGNOSIS
Spectrum of Vulvar Candidiasis

62 Year old with Candidiasis

Lichen Sclerosis, Clobetasol and Candidiasis
Treatment Candidiasis

Do culture and speciate

**Topical:**
- Clotrimazole 1 % or 2 % cream, vaginally
- Miconazole 2 %, 4 % cream vaginally
- Miconazole 100 mg, 200 mg, 1200 mg suppositories
- Terconazole 0.4 %, 0.8 % cream

**Oral:**
- Fluconazole 150, 200 mg orally on days 1,3,7

**Suppression:**
- Clotrimazole 500 mg vaginal tab weekly or 200 mg 2 X week
- Fluconazole 150 mg or 200 mg, PO, weekly
- Itraconazole 100 mg orally, daily 2 weeks then twice a week 6 months

**Resistant Candida spp:**
- Boric acid vaginal suppositories compounded: 600 mg daily x 14d
- Consider nystatin 100,000 unit suppository daily for 14 days

Vulvar Contact Dermatitis

**Primary Irritant**
Common in menopause due to loss of barrier function
Prolonged or repeated exposure to caustic or physically irritating agent - a “chemical burn”

Very common with ALL vulvar problems

Causes:
- Hygiene habits - soap, wipes, pads
- Moisture - urine, feces, sweat
- Topicals - lotions, antifungals

**Allergic: uncommon**
- Usually Itchy
- Allergy to perfumes, preservatives or chemicals
Incontinence

A hidden epidemic

Urinary incontinence is moderate in 10% > 50 years old
Results in:
  Contact Irritant Dermatitis from wipes, pads, over washing

Irritant Contact Dermatitis

From Urine and Sanitary Pads

From “wipes for diarrhea”
Irritant Contact

Contact from “wipes” and atrophy

Lichen Sclerosus and Contact from fecal soiling

Severe Irritant Contact Dermatitis

From 20% Benzocaine itch cream - “a chemical burn”
Allergic Contact Dermatitis

Type IV delayed hypersensitivity reaction

e.g. neomycin, fragrance, benzocaine, Poison ivy

Not common in Menopause

Benzocaine

Allergic Contact Dermatitis

To a preservative in a cortisone cream - Ethylenediamine

To a topical anaesthetic cream for recurrent HSV - Benzocaine
### Treatment Vulvar Contact Dermatitis

**Stop Contact - find Irritant or Allergen**
- Stop irritants - Educate patient
- Stop scratching - Treat infection - yeast, bacteria
- Patch Test as indicated for allergic contact dermatitis

**Control inflammation**
- triamcinolone 0.1% oint twice a day for 7-10 days
- If severe, systemic corticosteroids

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### Perianal Dermatitis

- **Contact Dermatitis** from
  - feces
  - hygiene
- **Trauma**
  - straining
  - cleaning
- **Secondary infection**
  - Staph
  - Strep

**Constipation in older ladies is common**

**Worse due to diet and inactivity, medications**

**Perianal fissures producing and worsened by constipation**
Anal / Perianal / Fecal Dermatitis

**Treatment**
- Control diet, diarrhea, “wipes” use Water Wipes® only
- No facecloths, sponges etc - use bare hands only
- Rinse with hand held shower or squirt bottle
- If very raw - tub or sitz bath 5-7 min AM and PM then pat dry and coat with plain petrolatum
- For very sticky feces or fecal soiling: Use plain mineral oil on a tissue
- If irritated use 2.5% HC ointment +/- 25 mg HC suppository HS

63 year old lady with severe vulvar and perianal itching for 3 weeks from a fragrance in moisture cream

For all itchy vulvas look for contact dermatitis
How to find the cause of contact dermatitis

Take a very thorough history
Note -
- all hygiene habits and possible contactants
- all personal care products
- occupation
- partners products like perfumes

• patients may forget or hide hygiene or destructive behavior

Review and Re review

Recognize Contact Dermatitis

Complicates all vulvar conditions

Frequent

Irritant contact most common

Skin barrier lost from soaps, urine, feces

BEWARE THE “DIRTY” VULVA
**Intertrigo**

- Rash in folds of skin
- From maceration, friction, heat and/or occlusion with secondary infection
  - Staph/Strep, Candida
- Worse with:
  - obesity
  - tight synthetic clothes
  - incontinence
  - Psoriasis

**Intertrigo**
Intertrigo

LP Inactive
Incontinence
Intertrigo
Bacterial infection with lack of estrogen
Intertrigo Treatment

- Stop hot, tight clothing
- Gentle cleanse (hypoallergenic unscented bar) and pat dry
- 1 to 2 1/2 % hydrocortisone cream bid with an imidazole cream bid
  or
- 1% iodoquinol with 1% hydrocortisone in a cream base bid for 1-2 weeks
- Treat infection - yeast, bacteria
- **Keep folds dry** with a powder or a thin strip of cotton placed into skin fold
Lichen Sclerosus

Commonest cause of chronic vulvar disease and asymptomatic vulvar scarring

- 1 in 300 to 1000
- Age - perimenopausal and menopausal

Etiology:
- genetic
- autoimmune (vitiligo, thyroid disease)

15% have extragenital disease

4-5%  **vulvar SCC**

LS Spectrum
Lichen Sclerosus

Symptoms

Itch - 90%
Pain, burn, sore - 40%
Dysuria
Dyspareunia, sexual dysfunction
Asymptomatic

Lichen Sclerosus Clinical Changes

Primary
- Classic white, papules and plaques
- Cellophane-like surface sheen, crinkled, atrophic
- Figure of eight
- Patterns variable (perianal 30% women)

Secondary
- Scratches
- Erosions
- Pustules
- Fissures
- Purpura
- Swelling
- Lichenification
- Hyperpigmentation

Scarring - can be introital stenosis
Incontinent and lack of estrogen

- Sits all day
- Poor hygiene
- Urinary incontinence
- In a diaper

Neglected Lichen Sclerosus
Squamous Cell Carcinoma (in LS)
May be asymptomatic

Diagnosis Lichen Sclerosus

- Can be made clinically
- Biopsy recommended for adults - “passport stamp” to care
- Photo document if possible

LS has 4-5% Risk SCC
60% Vulvar SCC have LS
Lichen Sclerosus

- Precancerous if not treated
- Chronic - no cure yet
- **Treatment with corticosteroids decreases risk of scarring and cancer**

Lichen Sclerosus Treatment

Confirm diagnosis - biopsy

- Stop irritants
- Stop scratching
- Educate patient
- Treat infection - yeast, bacteria

Control inflammation

- clobetasol or halobetasol 0.05% oint, daily for L.minora, clitoris, vulvar trigone until tissue is as normal as possible (**not just symptom control**)
- For perianal LS Rx 2-4 weeks daily - then taper
- Severity will indicate strength of topical steroid
  - If very thick, consider intralesional triamcinolone
Lichen Sclerosus: Treatment

- Taper to every other day or daily with milder steroid
- **LIFELONG** therapy: 1 - 7 d a week
  LS can be symptom free with ongoing scarring
- **Treat even if asymptomatic**
- Follow forever
- **Pearl:** Use estrogen (topical or vaginal) for postmenopausal women

JAMA Dermatol. 2015 Oct;151(10):1061-7

50 year old Controlled LS for 10 years, sexual dysfunction, vulvar burning

6 weeks topical Estrogen cream

Symptoms - better
Lichen Sclerosus Before Rx  After 12 wks of clobetasol

Lichen Planus

An autoimmune, cutaneous hypersensitivity reaction in older women - 50 - 60 years

Affects - Skin, scalp, nails

Mucous membranes - oral, genital, anus, esophageal, urinary tract

2-5% SCC

Always Examine the Vulva & Vagina & Mouth
Lichen Planus

- On vulva typically non descript
- erosions with itching, burning, irritation and sexual dysfunction
- 10 times less common than LS

Lichen Planus Symptoms

- Sore, burn, - 70%, severe - 35%
- Itch - 60%
- Dyspareunia - 60-70%
- Apareunia - 30%
- Dysuria
- Asymptomatic

Causes asymptomatic vulvar scarring
Lichen Planus Vulvar Patterns

Variable mixed morphology

**Eroptive - 75%**
- Red plaques with whitish to lacy edges
- Glazed erythema, erosions, ulcers, scarring

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

**Hypertrophic - rare**
- Extensive white, thick scarring, destruction
- Very itchy
- Looks like LS

Can have normal vulva and active vaginal LP
30% oral LP have vulvovaginal LP
60% vulvar LP have oral LP

Vaginal Lichen Planus

In the vagina: may be asymptomatic

LP causes **Inflammatory Vaginitis** with:

- Pain  - Synechiae  - Stenosis/ Scarring
- Erosions - Dyspareunia - Discharge
- Mucopurulent vaginal discharge - yellow, green, bloody

Always examine vagina

LP can present only in vagina
For Diagnosis:
Biopsy -
  Site  ●
  Number 1-2
  Size 3-4 mm
  H&E

Pathology may be non specific

Lichen Planus Treatment

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

Control inflammation
- clobetasol or halobetasol 0.05% oint
- intralesional, vaginal or systemic corticosteroids
- topical tacrolimus
  (Protopic®) 0.03%, 0.1% oint - burns
Difficult Lichen Planus

**Systemic Corticosteroids:**
- Triamcinolone 1 mg/kg (Kenalog 40®) IM q4wks x 3
- Use for severe LP
- Prednisone 40 - 60 mg PO OD, tapered dose

**Intravaginal** - corticosteroids and dilators may be needed

**Severe LP** - Mycophenolate mofetil, Methotrexate, Acitretin or Cyclosporine

Get Help

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**IM Triamcinolone 40 mg/ml**

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

Results of fat injection
- Poor absorption
- Fat Atrophy

Site for IM injection

Vulvar Squamous Cell Carcinoma SCC HSIL, VIN

- Intraepithelial
  1. High Grade Intraepithelial Lesion / HSIL
     - multifocal, HPV related, in younger women

  2. VIN III differentiated / dVIN -
     differentiated vulvar intraepidermal neoplasia
     - solitary, is seen in LS and LP in older women

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

LS + dVIN III

Re-biopsy

Vulvar SCC

30 - 40% vulvar SCC occur in lichen sclerosus

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

Look for vulvar cancer in cases of excessive vulvar itch or pain
Differentiated Vulvar Intraepithelial Neoplasia (dVIN) with Squamous Cell Carcinoma

80 year old chronic itch 5 years and no Rx helps
74 year old with burning and itching on clitoris for 10-12 months - no response to topical steroids

Vulvar Malignant Melanoma (MM)

- 5% vulvar cancer are MM
- Found in older women > 65 years
- Site - 75% on vulvar mucosa
- Amelanotic 25%, multifocal 20%
- Atypical color - with variably red, white, or blue color: amelanotic MM pink or red
- A late diagnosis
Malignant Melanoma

Extramammary Paget’s Disease

- Rare - 1% vulvar malignancy   age - 70 yrs
- **Primary EMP** - carcinoma from epidermis or from an epidermal appendage - usually no underlying carcinoma
- **Secondary EMP** - a visceral carcinoma (anorectal, bladder, urethra, breast) epidermotrophic to the skin
- Underlying local carcinoma - in 20% - 25% of vulvar EMP

Itching, soreness, erosions, multifocal
Commonly mistaken for a dermatitis that does not respond to cortisone
Take home messages:

- Don’t forget to listen to your patients
- Touch the skin
- Do not hesitate to re-biopsy if the results are not consistent with the whole picture
Commonest Missed Concurrent Vulvar Diseases

- Candidiasis
- Contact Dermatitis
- HSV
- Atrophy
- Cancer

LOOK FOR MORE THAN ONE PROBLEM

Missed Concurrent Conditions

- Very Itchy Lichen Sclerosus 25 years
- Squamous Cell Carcinoma
Vulvar problems can make them all miserable

You can help them!

You are VITAL for Vulvar Care

Hundreds of women will thank you!