The Normal Vulva: Overview of Basic Dermatology Treatment

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Lynette J. Margesson MD FRCPC
Assistant Professor of Obstetrics & Gynecology and Surgery(Dermatology)
Geisel School of Medicine at Dartmouth Lebanon, NH, USA

Disclosures Dr. Lynette Margesson

Dermtreat – consultant
Up To Date – author

Almost all treatment for vulvar diseases is off-label and there is little evidence based data
Objectives

- Describe normal vulvar care
- Correct barrier function
- Reduce and control inflammation

MANAGEMENT PRINCIPLES

- Education is Vital - overcome taboos
- Explain disease processes and treatment
- Discuss expectations
- Use Handouts - www.issvd.org
  - www.nva.org

Take Photographs for education and record

Treat all factors
Normal Vulvovaginal Care

To maintain barrier function for daily activities:

- movement and exercise
- menstruation
- sexual intercourse
- elimination
- parturition
Vulvar Skin Facts

Compared to other skin surfaces:
- Reacts more intensely to irritants
- Barrier function is weaker
- Surface must be kept moist and pliable

A Common Vulvar Myth

The vulva is a “dirty”

Patients attempt to
- “Wash it well” and “clean it up”
- Clean the “dirty” area

Using soaps, cleansers, face cloths, sponges, wipes
**Vulvar Cleansing**

Gentle and simple

Plain water - hands only - no scrubbing!
Lukewarm - not hot
Hypoallergenic soap substitute
Pat dry - no hair dryers
If no tub or shower - use a cup, basin or spray bottle

**Anal Cleansing**

Fecal soiling complicates vulvovaginal conditions

**Missed - Not Mentioned - PLEASE ASK**

Use - Plain water

Hypoallergenic soap substitute:

- Gentle Skin cleanser or unscented bar
- Mineral oil or Albolene Cleanser® on a tissue

Wipes - use Water Wipes®, No other cleansing “wipes”
Vaginal Cleansing - Never

No Douching

Without a normal protective coating, the ecological balance is changed resulting in increased - irritation - infection - local and PID

Lubricants and Humectants

Lubricants reduce friction
Humectants hold in the moisture

Best are patient’s own natural substances from vaginal transudate (lubricant) and sebaceous and cervical glands (humectant)
Lubricants and Humectants

For Vulva - best is an oil or petrolatum-based humectant
- plain petrolatum thin film

For Vagina - polycarbophil base humectant
- a water soluble, high moisture content base (Replens®)

For Intercourse -
- a water based lubricant and humectant -
  a methylcellulose base that holds water - KY®
- a water based lubricant - Astroglide®, Jo H2O®, Slippery Stuff®
- Dimethicone - Uber Lube®
- lard, butter, cooking fat
- No olive oil

Clothing

Choose ventilated, well fitted clothing
Avoid - thongs, girdles, tight clothes and hose
Use mild detergents and no fabric softeners
Menstrual Pads and Tampons

Disposable ($$) or Reusable cloth pads
Best
- cotton and hypoallergenic
- proper fit
- adequate absorbency

Change regularly

Menstrual Cup

[Images of menstrual cups]
Incontinence

“Moderate” urinary incontinence present in 10% of women over age 50

Thank God for all those years of doing my Kegels!

Urinary Incontinence

- Avoid use of panty liners
- Pads - designed for urinary incontinence
- Choose appropriate “diaper”
- Barrier cream (20% zinc oxide ointment)
- Pelvic floor rehabilitation as needed
- Request urological consultation
Correct barrier function

Stop scratching

Reduce inflammation

Correct Barrier Function I

- Stop all irritants
- Stop all offending practices
- Loose, ventilated clothing
- Gentle care
- Hydrate and protect
- Ointments are best/avoid creams
Correct Barrier Function II

- Hydrate, then restore barrier function
  - **SOAK** - Bath or Sitz bath or compress, 5-10 minutes bid to tid
  - Plain lukewarm to cool water
  - 1 tsp salt for 3 cups water = Normal saline

- To stop water loss and **SEAL** in moisture after the soak use -
  - Plain petrolatum
  - If ulcerated, 20% plain zinc oxide ointment

- Add Estrogen cream to help barrier function, when appropriate

Soak and Seal

Barrier Cream

20% Zinc Oxide
With a mineral oil and petrolatum base

Remove with plain mineral oil on soft tissue
Stop Scratching

Break the ITCH → SCRATCH → ITCH cycle

Stop Scratching - Nonspecific

- Cool water soaks or compresses
- Soft, freezer packs or moist cloths (Keep in sealed, reusable plastic bag in the fridge)
- 4 - 5% lidocaine ointment

No ice, ice packs or frozen vegetables
No benzocaine
These cause more injury
Stop Scratching

**HS sedation at 6-7 PM**
- Hydroxyzine or Amitriptyline 10 - 50 mg
- Doxepin 10 - 75 mg

**AM sedation - SSRI**
- Citalopram 20 - 40 mg
- Fluoxetine 20 - 40 mg
- Sertraline 50 - 100 mg

**Other**
Gabapentin 100 - 3600 mg/d

Reduce Inflammation

**Topical Corticosteroids I**
- Main treatment for all dermatoses
- Very safe if used properly
- Make sure of the diagnosis
- Know the potency to choose the best steroid
- Start strong and work down
- Monitor clinical response as your guide
Topical Corticosteroids II

- There are more available than you will ever need
- Get to know one well from each of the superpotent, midpotent and mild classes
- Use only a thin, invisible film

Vulvar trigone - moderately steroid resistant
Labiocrural fold, perianal area - steroid sensitive

Steroid Atrophy
Topical Corticosteroids III

- Patient education is very important
- Limit amount prescribed (15 gm tube)
- Treat infections (or risk spread)
- Avoid telephone refills
- Remember complications - Candida and contact dermatitis
- For very inflamed tissues use systemic treatment - avoid topicals

Topical Corticosteroid Classes

Class I: Superpotent
- Clobetasol propionate 0.05% $$
- Halobetasol 0.05%
- Betamethasone dipropionate 0.05%

Class II: High Potency
- Halcinonide 0.1%
- Amcinonide 0.1%

Class IV: Mid Potency
- Triamcinolone acetonide 0.1%
- Betamethasone 17 valerate 0.1%

Class VII: Mild
- Hydrocortisone 1 or 2.5%
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

“PEA SIZED” AMOUNT?
**Superpotent Steroids**

Use clobetasol or halobetasol propionate 0.05% oint
   e.g. for lichen sclerosus, or lichen planus

Start 1 to 2 X daily for 2 weeks then 1 X daily
   and reassess monthly for vulva
   (some severe cases even longer)
for perianal area decrease to 3 times a week after 2 weeks
   or
***Switch to mild corticosteroid***
1 - 2.5 % Hydrocortisone ointment 1 - 2 X daily

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**Clobetasol or Halobetasol propionate 0.05%**

- **Action** - anti-inflammatory
  - antiproliferative
- **Available** - ointment, cream, lotion, foam, gel
  15, 30, 45, 60 g tube
  use of 60 g in 2 weeks can cause adrenal suppression

- **Side Effects** - thin skin, infection, allergy

- **LIMIT to one 15 G tube and 1 refill**
Hydrocortisone acetate

low potency corticosteroid

Action
- anti-inflammatory
- antiproliferative

Available - ointment, cream, lotion
0.5%, 0.1%, 2.5% or 25 mg suppository
15 g tube to 1 lb jar

Side Effects - thin skin, infection, allergy
Can be compounded into
10% vaginal cream or 50 - 200 mg suppository

Side Effects of Topical Steroids I

Epidermal atrophy
Dermal atrophy and striae
Bruising
Telangiectasia
Steroid rebound dermatitis
Contact dermatitis - allergy to
corticosteroid or base,
or irritants in base
Side Effects of Topical Steroids II

Local immunosuppression

Increased risk of infection
- Candida
- Bacteria
- HSV
- HPV

Prednisone / Oral Corticosteroid Short Course

Short courses of Prednisone -
Tapered dose of 40 to 60 mg/d over 1 - 3 weeks
Cumulative dose of 600 - 625 mg

Indications - severe and / or chronic, recalcitrant dermatoses
Dose - am with food - 40 mg 4-5d, 30 mg 4-5d, 20 mg 5d,
10 mg 5d
- 60mg 2d, 50 mg 2d, 40 mg 4d,
30 mg 4d, 20 mg 4d, 10 mg 4d

Consider 1 to 2 repeat courses 4 - 6 weeks apart
Repeat courses can have a cumulative effect
Systemic Corticosteroids

Absolute Contraindication
- Systemic fungal infection
- Herpes simplex keratitis
- Hypersensitivity

Relative Contraindication
- Hypertension, congestive heart failure
- Psychosis, severe depression
- Active TB, positive TB test
- Diabetes mellitus
- Osteoporosis
- Glaucoma
- (Pregnancy)

Intralesional Triamcinolone (Kenalog 10 ®)

Advantage - For topical steroid resistant dermatosis or avoid use of systemic steroid

Dose - 10 mg/ml
- can be diluted with normal saline to 2.5, 3.3 or 5mg /ml
  (1 part triamcinolone acetonide + 2 parts normal saline = 3.3 mg/mL)
• A suspension - must shake well and inject with 27 gauge needle
• Inject tiny amount per site about 1 cm apart
• Limit to 6 ml every 4 weeks 2 to 3 times

Indications - resistant local area LSC, LP, LS, psoriasis, contact,

Intralesional Triamcinolone

Sites of Injections of T/C 2.5-10mg/ml 27 gauge needle

Topical Anesthesia
For - Biopsies, Injections, Pain or itch relief

- lidocaine 2.5% + prilocaine 2.5% cream (EMLA®)
- lidocaine 2%, 4%, 5% ointment
Apply - 5 - 10 minutes for mucous membranes
- 60 minutes for keratinized skin
reapply every 30 min for 60-120 min
Apply liberally, if possible, cover with plastic wrap
NO BENZOCAINE
For Raw Open Ulcers / Erosions

- Plain petrolatum
- Zinc Oxide ointment - 20% zinc oxide in petrolatum (Rugby® 1lb jar)
- Ihle’s paste - 25% zinc oxide, 25% anhydrous lanolin, 25% starch and 25% Petrolatum

Note: to remove these, use mineral oil liberally applied on a soft tissue. Dab off, do not rub

Support the Whole Patient

Treat depression

Use counselors, sex therapists

Prescribe pain medication
Avoid Inadequate Follow Up

“No symptoms”
“I’m OK”
“No problem”

Causes of Treatment Failure

1) Incorrect diagnosis

2) Missed concurrent conditions
   - LS, LP, contact, Candida, HSV, estrogen loss, SCC

3) Ineffective treatment plan

4) Noncompliance
   - poor education
   - fear of topical steroids
   - physical impairment
     - phobic about touching vulva
   - vulvar ignorance
   - miscommunication
   - secondary gain
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