Vulvar Diseases: What Do You Know?

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Disclosures

- Very little regarding the treatment of vulvar disorders is evidence based
- HKH Advisory Board Prestige, Inc.
- CKS no financial support beyond the University of Iowa
Objectives

- Recognize common vulvar skin lesions
- Review initial management strategies
  - Recognize that there is not always one answer to every problem
- Review indications for vulvar biopsy

Accurate diagnosis

- Traditionally considered “simple” for vulvovaginal complaints.
  - Thus, commonly managed by phone (office staff)
  - Patients often insist on this approach; decline office visit for a variety of reasons
- Diagnosis by telephone is only marginally better than random chance!!
- Women who self-treat with OTC (antifungal) are correct 1/3rd of the time (despite history i.e.-recurrent).
YES, Vaginitis

- Represents half of all outpatient female visits
- Is the most common self referral complaint
- Accounts for 40% of all vulvovaginal problems

However...

Common causes of Chronic Vaginitis
(referral population- Nyirjesy 2006)

- 200 new patients to vulvar specialty clinic

- **Contact dermatitis** 42 (21%)
- Recurrent candidiasis 41 (21%)
- **Atrophic vaginitis** 29 (15%)
- Vulvar vestibulitis 25 (13%)
- **Lichen simplex or sclerosus** 22 (11%)
- Bacterial vaginosis 13 (6.5%)
Thus, vaginitis is not the focus of our discussion today.

Complexities of care “Down There”

Among “top 10” as reasons for seeking care from general practitioners

- Most common complaint = “yeast infection”
  - Typically self medicate prior to seeking care
  - Hygiene routine often deeply ingrained (by mothers)
    - Douching
    - Washing frequency
    - Products used (detergent, soaps, feminine hygiene products)

Education key to compliance with plan  = TIME$$$

- Anatomy; rationale for treatment plan / products
### Evaluation

**History and Physical (of course) – NO PHONE DIAGNOSIS!!!**

- **pH testing**
  - 3.8 to 4.5 during reproductive years
  - $\geq 4.7$ pre-menarche and post-menopausal
- **“Whiff test” 10% KOH (fishy = positive)**
- **Microscopy (Wet prep)**
  - Saline
  - KOH
- **Consider**
  - Cultures (candida and trichomonas)
  - Point-of Care tests for pH and amines, trichomonas
  - Biopsy

### When to Biopsy

- Anytime you are unsure of the diagnosis!!
- The morphology of many dermatoses often appears different on genital skin
- R/O cancer or dysplasia
  - Presumed genital warts that fail to respond to 2-3 office treatments
  - Vulvar changes that do not respond to medical therapy (lichen sclerosus or lichen simplex)
  - Appearance is concerning for neoplasia
Disclaimer

- Limited “research” regarding vulvar vaginal disorders
  - Especially regarding treatment + outcomes

- Nothing “FDA” approved for treatment of specific disorders = “off label use”
  - Excluding infection and atrophy
The image shown represents which vulvar condition?

- A. Erosive lichen planus
- B. Paget disease
- C. Eczematous dermatitis
- D. None of the above
Beef Tongue

53 y.o. patient referred for lesion on right prepuce
History of biopsy proven LS dating back to 1991
Recent biopsy VIN differentiated
What to do now?

A. Wide local excision
B. Radical vulvectomy, clitoral resection
C. Laser
D. Imiquimod

VIN differentiated on biopsy
What to do now?

A. Wide local excision
B. Radical vulvectomy
C. Laser
Closure?

A. Leave open, pack and wait for final pathology, considering future split thickness skin graft
B. Close immediately after excision

Lichen Sclerosus and VIN Differentiated
Closure?

A. Primary
B. Flap

What type of flap?

A. V to Y
B. O to Z
V-to-Y Flaps

V-to-Y Flaps
V-to-Y Flaps
45 year old G0 presents with dyspareunia following lumpectomy for recurrent breast cancer. On adjuvant therapy including aromatase inhibitor. Recently attempted intercourse, but had to stop due to pain. Notes vaginal dryness.

- Recently menopausal
- No other PMH, PSH, meds, allergies

What is your preliminary diagnosis?

A. Vaginismus
B. Vaginal atrophy
C. Sicca syndrome
D. Doesn’t really like her husband much
EXAM: 45 year old on aromatase inhibitor following lumpectomy for recurrent breast cancer

Exam as pictured >

pH 5.5
Whiff negative
Microscopy >

What is the first line treatment?
A. Systemic estrogen
B. Local estrogen
C. Lubricant/moisturizer
D. Discontinue AI
Vaginal atrophy / GSM

- Half of postmenopausal women report symptoms.
  - Negative effect on quality of life is substantial.
  - 4-fold greater risk of sexual dysfunction if GSM symptoms present.
- Vasomotor symptoms tend to decrease over time.
  - GSM will not spontaneously resolve.

Interference of Activities

Percent of women reporting interference of activities

Atrophic Vaginitis
Genitourinary Syndrome of Menopause

- Diagnosis
  - Loss of vaginal rugae with smooth mucosa and variable inflammation.
  - Wet mount findings: immature oval and round epithelial cells with relatively large nuclei. *Lactobacilli* are usually lacking.
Atrophic Vaginitis

- **Differential Dx**
  - DIV (Desquamative Inflammatory Vaginitis)
  - Erosive Lichen Planus
    - look for: Coexisting skin and oral lesions
  - Pemphigoid / Pemphigus
- **Dx:**
  - H&P, microscopy, +/- biopsy
  - I typically biopsy when initial treatment fails or vaginal co-aptation is present

Atrophic Vaginitis
Genitourinary Syndrome of Menopause
Atrophy

What about women with a history of breast cancer?
ACOG March 2016
4 Recommendations & Conclusions

Committee Opinion
Number 659 • March 2016

Committee on Gynecologic Practice
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The Use of Vaginal Estrogen in Women With a History of Estrogen-Dependent Breast Cancer
ACOG Recommendation #1

“Non-hormonal approaches are the first-line choices for managing urogenital symptoms or atrophy-related urinary symptoms experienced by women during or after treatment for breast cancer.”

- Vaginal lubricants
- Vaginal Moisturizers
- Local Anesthetics

Nonhormonal options for dyspareunia and vulvovaginal atrophy

- **Lubricants (before sex)**
  - Water based
    - Astroglide Gel, Liquid
    - K-Y jelly
  - Silicone based
    - Astroglide S
    - K-Y Intrigue
    - ID Millennium
  - Oil based
  - Olive oil
  - Elegance

- **Moisturizers (2x week)**
  - Replens
  - Vagisil
  - KY Silk-E
  - Luvena
  - Silken Secret
  - Summer’s Eve

*Regular sexual activity (partner, device, solo)*
ACOG Recommendation #2

“Among women with a history of estrogen-dependent breast cancer who are experiencing urogenital symptoms, vaginal estrogen should be reserved for those patients who are unresponsive to non-hormonal remedies.”

ACOG Recommendation #3

“The decision to use vaginal estrogen may be made in coordination with a women’s oncologist. Additionally, it should be preceded by an informed decision-making and consent process in which the woman has the information and resources to consider the benefits and potential risks of low dose vaginal estrogen.”
The Gold Standard for GSM: Vaginal Estrogens

- **Estradiol ring (Estring) 2 mg**: lowest dose (7.5 mcg estradiol/day)
  - Wear in vagina and change Q 3 months
- **Estradiol vaginal inserts: 10/4 mcg tablet/gelcap**:
  - Nightly X 14, then 1-3 nights per week
- **Estradiol or CEE creams**:
  - 0.5-1 gm vaginally nightly X 7-14, then 0.5 gm 2-3 times per week
  - CEE cream FDA approved for 0.5 gm twice weekly or sequentially for 21 days followed by 7 day medication free interval

Risk Benefit Analysis

- Use of low dose vaginal estrogens does not result in sustained serum estrogen levels exceeding the normal menopausal range
- Lowest rates of systemic absorption found in the ring (5-10 pg/mL) and the vaginal tablet (3-11 pg/mL)
- Creams deliver a more variable dose, but dose can be kept low (80 pg/mL)
- No increase risk of VTE, no increased endometrial proliferation or hyperplasia with local estrogen therapy, additional progesterone not needed
ACOG Conclusion #4

“Data do not show an increased risk of cancer recurrence among women currently undergoing treatment for breast cancer who use vaginal estrogen to relieve urogenital symptoms.”

Sex Is Good For You!

- A short course of low dose vaginal estrogen therapy may allow resumption of sexual activity.
- Regular sexual activity or vaginal stimulation may prevent the recurrence of dyspareunia.
A 45 y.o. G2P1 presents with complaints of vulvar pruritus. It awakens her at night. A yeast culture was negative. She has been intermittently treated without success with Class 1 topical steroids for over a year.
Your Diagnosis Is?

A. HSIL of the vulva
B. Herpes
C. Lichen simplex chronicus
D. Lichen sclerosus

These Statements are True about LSC except:

A. It is often secondarily infected
B. It is associated with HIV
C. It commonly reoccurs
D. It is associated with atopy, psoriasis, and contact dermatitis
For Severe Itch-Scratch Cycle

Oral steroids (short term)
Cefadroxil 500 mg po bid x 7 days
Amitriptyline for a week or 2 (25 mg, increase to 50 mg if needed) vs.
Atarax (25 to 50 mg po qid prn) vs.
Gabapentin
White cotton gloves

Intramuscular Steroid Injections

IM triamcinolone 1 mg/kg (up to 80 mg total) can be used instead of oral or sq steroids for severe, itchy or extensive LSC. If repeat is necessary, it can be repeated monthly x 3 total doses.
Subcutaneous Steroid Injections (on occasion intramuscular)

STOP WIRE BRUSHES
62 year old female referred for 6 month history gluteal irritation and itching despite use of multiple over-the-counter and prescription medications and topical antifungals

No other concerns
What is your initial impression?

A. Paget's
B. Tinea
C. Lichen simplex chronicus
D. HSIL / vulvar dysplasia
What test do you want?
A. Biopsy
B. Yeast culture
C. KOH prep
D. HSV culture

KOH confirms hyphae elements

How will you treat?
A. No treatment needed
B. tolnaftate topical
C. fluconazole oral
D. Steroid topical
Tinea corporis

- Diagnosis suspected on clinical findings
- Confirmed with KOH prep
  - May also confirm with fungal culture (biopsy not necessary, but will confirm)

Tinea corporis - treatment

Topical or systemic antifungal drugs with antidermatophyte activity

- **Topical**
  - Azole
  - Allylamine
  - Ciclopirox
  - Butenafine
  - Tolnaftate

- **Oral**
  - Terbinafine
  - Itraconazole
  - Fluconazole
  - Griseofulvin

* Nystatin is not effective for dermatophyte infections

*Patients should not be treated with oral ketoconazole because of risk for severe liver injury
35 y.o. woman complains of severe burning on entire vulva

• She is unable to have intercourse

• She is unable to wear pants

Pain noted in red/pink area below
Using the Current Terminology
Your Diagnosis Is?

A. Localized vulvodynia
B. Generalized vulvodynia
C. Vulvar dysesthesia
D. Somatoparaphrenia

Using the Current Terminology
Your Diagnosis Is?

A. Localized vulvodynia
B. Generalized vulvodynia
C. Vulvar dysesthesia
D. Somatoparaphrenia-delusion
   where one suddenly denies ownership of a limb or an entire side of one’s body
Definition of Vulvodynia

Chronic discomfort
Burning
Stinging
Irritation
Rawness

2015 Consensus terminology and classification of persistent vulvar pain

Jacob Bornstein MD, MPA, Andrew Goldstein MD, and Deborah Coady MD
for the consensus vulvar pain terminology committee

From the International Society for the Study of Vulvovaginal Disease (ISSVD),
the International Society for the Study of Women's Sexual Health (ISSWSH),
and the International Pelvic Pain Society (IPPS)
2015 Consensus Terminology and Classification of Persistent Vulvar Pain and Vulvodynia

A. Vulvar pain caused by a specific disorder*
   • Infectious (eg, recurrent candidiasis, herpes)
   • Inflammatory (eg, lichen sclerosus, lichen planus, immunobullous disorders)
   • Neoplastic (eg, Paget disease, squamous cell carcinoma)
   • Neurologic (eg, postherpetic neuralgia, nerve compression or injury, neuroma)
   • Trauma (eg, female genital cutting, obstetric)
   • Iatrogenic (eg, postoperative, chemotherapy, radiation)
   • Hormonal deficiencies (eg, genitourinary syndrome of menopause [vulvovaginal atrophy], lactational amenorrhea)
B. Vulvodynia—Vulvar pain of at least 3 months’ duration, without clear identifiable cause, which may have potential associated factors

The following are the descriptors:
   • Localized (eg, vestibulodynia, clitorodynia) or Generalized or Mixed (Localized and Generalized)
   • Provoked (eg, insertional, contact) or Spontaneous or Mixed (Provoked and Spontaneous)
   • Onset (primary or secondary)
   • Temporal pattern (intermittent, persistent, constant, immediate, delayed)

* Women may have both

Appendix:
Potential Factors Associated with Vulvodynia*
   • Comorbidities and other pain syndromes (e.g., painful bladder syndrome, fibromyalgia, irritable bowel syndrome, temporomandibular disorder; level of evidence 2)
   • Genetics (level of evidence 2)
   • Hormonal factors (e.g., pharmacologically induced; level of evidence 2)
   • Inflammation (level of evidence 2)
   • Musculoskeletal (e.g., pelvic muscle overactivity, myofascial, biomechanical; level of evidence 2)
   • Neurologic mechanisms
      • Central (spine, brain; level of evidence 2)
      • Peripheral: neuroproliferation (level of evidence 2)
   • Psychosocial factors (e.g., mood, interpersonal, coping, role, sexual function; level of evidence 2)
   • Structural defects (e.g., perineal descent; level of evidence 3)

* The factors are ranked by alphabetical order.
Topical review

Vulvodynia: Current state of the biological science

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Etiologies

Sept. 2014

Not tender; no area of vulva described as area of burning

Alternative diagnosis
Key points: “Down There”

- Among “top 10” reasons for seeking care
- Underlying psycho-social concerns
  - Cancer, Sex, Monogamy, Normality
- Education and reassurance (aka time and $$$)
  - Need to establish realistic expectations
- May have more than 1 process present
  - Especially with recurrent / chronic complaints
- Biopsy; if in doubt – biopsy again!

Key Points (2)

When patients do not respond to therapy
- Reconsider the diagnosis
- Check for infection - fungal, bacterial, HSV
- Consider contact dermatitis to a medication, over washing, etc.
- Consider tracts/fistulae