Vulvar Diseases: What Do You Know?

Hope K. Haefner, MD
Lynette J. Margesson, MD
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Disclosures

Hope K. Haefner, MD is on the advisory board of Merck Co. Inc.

Lynette J. Margesson, MD has nothing to disclose
Learning Objectives

At the end of this course, the participant should be able to:

- Identify the clinical features of various vulvovaginal conditions
- Recognize the gross features of non-neoplastic epithelial disorders of the vulva
- Become familiar with a variety of treatments for skin diseases
Colposcopy

Magnification

Bausch and Lomb
2 x magnification
Part 81-33-05

www.opticsplanet.net
Clinical Pitfalls of Vulvar Colposcopy

- Not all patients require magnification or acetic acid
- Acetowhitening is nonspecific
- Marked acetowhite changes in up to 65% of normal women
- Normal anatomic variants – like vestibular micropapillae – often confused with HPV colposcopically and histologically

Colposcopic Techniques

- 3% to 5% acetic acid
- Soak initially for 3-5 minutes
- Use copious amounts
- Reapply often
- Avoid using in presence of breaks in epithelium or inflammation
Anesthesia
- 1% lidocaine (with or without epinephrine)
- 27-30 gauge needle to inject 1-3 cc’s of anesthetic agent
- Inject subepidermally

Biopsy
- Keyes punch
  - 3-5 mm diameter dermatologic instruments (usually 4 mm)
- Fine suture (3.0 or 4.0 Vicryl Rapide) vs. Monsel’s or silver nitrate

Vulvar biopsy

Cervical biopsy instruments that can also be used for vulvar biopsy

Baby Tischler
Baby Kevorkian
Tips

Vulvar Excisional Biopsy

Courtesy Dr. E.J. Mayeaux
36 yr old lady presents with a very itchy vulvar rash for 4 years. The vulva flares intermittently with heat, friction.

- The rash does not respond to topical steroids. She is always scratching, even at work.
- She has hayfever and environmental allergies.
- She scratches at night and keeps her husband awake.
Your Diagnosis Is?

A. Lichen Sclerosus
B. Lichen Simplex Chronicus
C. Contact Dermatitis
D. Lichen Planus
What factor does not worsen lichen simplex chronicus?

A. Over washing  
B. Candidiasis  
C. Heat and Humidity  
D. Menopause

Lichen Simplex Chronicus (LSC)

End stage of the itch cycle

Itch ➔ Scratch ➔ Itch

Worse with heat, humidity, stress and irritants

Scratching feels so good
It is important to treat which associated conditions with lichen simplex chronicus?

A. Bacterial Infection  
B. Candidiasis  
C. Contact Dermatitis  
D. All of the Above

**Causes of LSC**

**Infection:** Candida and dermatophytosis  
**Dermatoses:** Atopic dermatitis, Psoriasis, Lichen Sclerosis, Contact Dermatitis, Lichen Planus

**Metabolic:** Diabetes  
**Neoplasia:** Vulvar intraepithelial neoplasia
Lichen Simplex Chronicus
Look for more than one problem

Contact +/-
Infection +/-
Dermatosis

**Treatment LSC**

Confirm diagnosis – biopsy?
Control infection (cefadroxil, fluconazole)
- Stop irritants - Educate patient
- Send for Patch Testing

**Stop Itch–Scratch–Itch cycle**

- Cool sitz baths/gel packs
- Sedate – doxepin or hydroxyzine PM, fluoxetine AM
- Topical superpotent steroids - clobetasol 0.05% oint bid x 2 wks, OD x2 wks, MWF x 2 wks
- Severe – prednisone taper or IM triamcinolone 1mg/kg up to 80 mg/dose

Look for more than one cause
For poorly responsive lichen simplex chronicus what should not be done?

A. Biopsy
B. Increase use of topical steroid
C. Reassess for compliance
D. Review Contactants and patch test

**Treatment Tips LSC**

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

**To prevent recurrent infections:**
Bleach Baths - 2-3 times a week for 5-7 min
- Tub -½ cup bleach in 10” water
- Sitz bath -1 ¼ teaspoons of bleach per gallon of water (4 liters)

**For recurrent Vulvar LSC**
Review treatment plan - make sure no irritants
Patch test
Use a daily topical - tacrolimus 0.03 or 0.1% to alternate with steroid
Stop scratching
A 21 y.o. G0 presents with a history of chronic immunosuppression secondary to autoimmune hepatitis. She has noted vulvar changes for one year. She complains of vulvar pain and occasional vulvar bleeding.
The images shown represent which vulvar conditions?

- HSIL of the vulva and molluscum contagiosum
- Condyloma
- Molluscum contagiosum
- Condyloma and HSIL of the vulva

<table>
<thead>
<tr>
<th>ISSVD 1986</th>
<th>ISSVD 2004</th>
<th>LAST 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>VIN 1</td>
<td>Flat condyloma or HPV effect</td>
<td></td>
</tr>
<tr>
<td>VIN 2</td>
<td>VIN, usual type</td>
<td>Low Grade</td>
</tr>
<tr>
<td></td>
<td>a. VIN, warty type</td>
<td></td>
</tr>
<tr>
<td>VIN 3</td>
<td>b. VIN, basaloid type</td>
<td>High Grade</td>
</tr>
<tr>
<td></td>
<td>c. VIN, mixed (warty/basaloid)</td>
<td></td>
</tr>
<tr>
<td>Differentiated VIN</td>
<td>VIN, differentiated type</td>
<td></td>
</tr>
</tbody>
</table>
Treatment for condyoma HSIL in this patient should be:

- Laser
- Wide local excision (WLE)
- A combination of laser and WLE
- No treatment. Observation only.
Other Preinvasive Conditions
A 19 year old lady presents with vulvar erosions and ulcers increasing for weeks. The itchy lesions started around the vulva and anal area. She is now consumed with itch and discomfort and nothing works.
• Biopsy - lichen simplex chronicus and secondary impetiginized excoriations. Rebiopsy - ulceration with mixed inflammation.

• symptoms are relieved with Sitz baths and a compounded cream - amitriptyline, baclofen, cyclobenzaprine, diclofenac, gabapentin, ketamine, and lidocaine.

• She is suicidal, depressed and co-dependent on mother

Your Diagnosis Is?

A. Contact Dermatitis
B. Herpes Simplex in Immunosuppressed
C. Crohn’s disease
D. Behcet’s Disease
Severe Primary Irritant Contact Dermatitis

Due to topical compound - 7 tubes a day
Contact Dermatitis can complicate which of the following conditions:

A. Candidiasis  
B. Lichen Sclerosus  
C. Squamous Cell Carcinoma  
D. All of the above

The following statement about contact dermatitis is incorrect:

A. The most common contact dermatitis is allergic contact dermatitis  
B. Primary irritant contact dermatitis can complicate all vulvar conditions  
C. Contact dermatitis can be acute or chronic  
D. Over cleansing and use of “Wipes” are a common cause of contact dermatitis
In a case of contact dermatitis that has failed topical and systemic corticosteroids what treatment should not be done:

A. Treat secondary infection
B. Use a different corticosteroid
C. Patch test
D. Biopsy

Patch Testing
North American Patch test series
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

7 year old with an irritant contact dermatitis from cleansing wipes with lichen sclerosus
20% Benzocaine Caustic Irritant Contact Dermatitis

Severe Itch and Burn 5 years

Witch Hazel

Severe Irritant Contact Dermatitis
Contact Dermatitis

Allergic:
Type IV delayed hypersensitivity reaction
Only low dose of substance needed e.g. Poison ivy, neomycin, benzocaine

NOT COMMON

Contact Dermatitis and HSV

Allergy Benzocaine
**Treatment of Vulvar Contact Dermatitis**

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

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

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**Vulvar Contact Dermatitis**

**Frequent**

Complicates all vulvar conditions

Irritant contact most common

Skin barrier lost from soaps, urine, feces

**BEWARE THE “DIRTY” VULVA**
Question 1

I see patients with chronic vaginitis

- [x] Yes
- [ ] No

Question 2

I like to see patients with chronic vaginitis

- [x] Yes
- [ ] No
**Vaginal discharge in lactating dairy cattle in New Zealand**

### pH and Wet Mount

<table>
<thead>
<tr>
<th></th>
<th>pH (3.0-4.5)</th>
<th>WBC</th>
<th>Parasbasals</th>
<th>Features</th>
<th>Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>3.0-4.5</td>
<td>Few or none</td>
<td>no</td>
<td>NI lactobacilli</td>
<td>Creamy, mucous, white</td>
</tr>
<tr>
<td>Yeast</td>
<td>3.0-4.5</td>
<td>no</td>
<td>no</td>
<td>Hyphae Spores (400x)</td>
<td>Curdy</td>
</tr>
<tr>
<td>Bacterial Vaginosis (Amsel Criteria)</td>
<td>&gt;5.0</td>
<td>No to small</td>
<td>no</td>
<td>Clue Cell</td>
<td>Yellow, grey w/ odor</td>
</tr>
<tr>
<td>Trichomoniasis</td>
<td>&gt;5.0</td>
<td>yes</td>
<td>maybe</td>
<td>Motile trich</td>
<td>Green, yellow, bubbly</td>
</tr>
<tr>
<td>DIV</td>
<td>&gt;5.0</td>
<td>yes</td>
<td>yes</td>
<td>Mixed bacteria, absent or reduced lacto</td>
<td>Yellow</td>
</tr>
<tr>
<td>Atrophic Vaginitis</td>
<td>&gt;5.0</td>
<td>likely</td>
<td>yes</td>
<td>Scant cells, few bacteria</td>
<td>Scant, dry</td>
</tr>
</tbody>
</table>
Causes for Elevated Vaginal pH

- Menses
- Heavy cervical mucus
- Semen
- Ruptured membranes
- Hypoestrogenism
- Desquamative vaginitis
- Trichomoniasis
- Bacterial vaginosis
- Foreign body with infection
- Streptococcal vaginitis (group A)
A 49y.o. G4P2 presents for consultation of chronic vulvar pruritus and irritation. Her vaginal pH is 4.0.
Her most likely diagnosis is:

- **Trichomonas**
- **Candida albicans**
- **Candida glabrata**
- **Bacterial vaginosis**
Candida albicans KOH

Candida glabrata on Cornmeal-Tween 80 agar:
Small, compacted blastoconidia
with no pseudohyphae formed

She is doing well for 6 months then returns with discomfort. A culture reveals Candida glabrata. This tends to respond to:
Candida glabrata tends to respond to:

- Oral fluconazole
- Boric acid per vagina
- Intravaginal metronidazole
- Terconazole (Terazole®)

Other Antifungals

Boric Acid

- Puratronic, 99.99995% (metals basic)
- Formula
  \[ \text{H}_3\text{BO}_3 \]
- Formula Weight
  61.83
- Form
  Crystalline Powder
- Melting Point
  170.9°
- Merck Number
  11,1336
Before Treatment
Candida glabrata

- Low vaginal virulence
- Rarely causes symptoms, even when identified by culture
- Exclude other co-existent causes of symptoms and only then treat for C. glabrata
Does she qualify for the diagnosis of having recurrent Candida infections?

- Yes
- No

The definition of recurrent Candida infections requires a minimum of how many infections per year

- 2
- 4
- 6
- 8
If this course were to occur again, new cases would be presented!
Summary

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.
- Evaluate for pre-cancer or cancer
If in Doubt, Cut it Out