Vulvar Diseases
What Do You Know?

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Course Objectives

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

• Identify the clinical features of various vulvovaginal conditions
• Advance your knowledge of common and puzzling vulvovaginal conditions
• Discuss a variety of treatments for skin diseases
Additional Information

https://medicine.umich.edu/dept/obgyn/patient-care-services/womens-health-library/center-vulvar-diseases/resources-providers

• or search Google for Resources for Providers Center for Vulvar Diseases
Gross and Histologic Images

Test Format
The image shown represents which vulvar condition?
Test Format

The image shown represents which vulvar condition?

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

Beef Tongue
81 y.o. G2P2 presents with vulvar itching and irritation. She had previously undergone a biopsy of the lesion, revealing verruca.

She says since the biopsy, the lesion has increased in size significantly.
Past Medical History

- Atypical chest pain (limited to approximately 1/2 block of ambulation and 1 flight of stairs secondary to shortness of breath)
- Vertigo
- Leg cramps
- Osteoarthritis
- Lichen sclerosus
- Bilateral cataracts
- Depression
- Osteoporosis
- Basal cell carcinoma (face)
- Spinal stenosis
- Peptic ulcer disease
- Hypertension
Biopsy 1 month prior to seeing you is verruca. What do you recommend as her treatment?

- Rub a potato on the wart and throw it over the fence
- Cryotherapy
- Trichloroacetic acid
- Wide local excision
What is the diagnosis?

- VIN 3
- Invasive squamous cell carcinoma
- Verrucous carcinoma
- Adenocarcinoma

35 y.o. woman complains of severe burning on entire vulva
- She is unable to have intercourse
- She is unable to wear pants
Using the Current Terminology, Your Diagnosis Is?

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

Pain noted in red/pink area below
Definition of Vulvodynia

Chronic discomfort
Burning
Stinging
Irritation
Rawness

2015 Consensus terminology and classification of persistent vulvar pain

Jacob Bornstein MD, MFA, 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, neroma)
   • 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)

a The factors are ranked by alphabetical order.
Etiologies

Vulvodynia: Current state of the biological science

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

Alternative diagnosis
Vaginal Lubricants

- Replens
- Astroglide
- KY Liquid
- Probe
- Slippery stuff
- Jo Premium

... etc.
Topical Anesthetics

- 5% Lidocaine (Xylocaine®) ointment safe, effective short-term symptom relief for vestibulodynia (pre-intercourse)
  - Benzocaine (Vagisil®) not recommended; it is a sensitizing agent, causing rebound vasodilation and pain
- Doxepin (Zonalon®)
- Topical amitriptyline 2% with baclofen 2% in WWB (water washable base)—squirt ½ cc from syringe onto finger and apply to affected area WWB. Apply qhs with increase not to exceed tid
- Topical ketamine 2%, topical gabapentin 6%, topical baclofen 2% in WWB. Apply qhs with increase not to exceed tid.

Oral Medications
She is 5 foot 4 inches and 300 pounds. She is concerned about the potential weight gain with tricyclics. She cannot remember to take anything more than twice a day. What would you consider for her pain?

A. Amitriptyline  
B. Gabapentin  
C. Topiramate  
D. Percocet
32 y.o. G0 with **painless** vulvar irritation and erythema (presented her at this meeting last year, now with new findings)
• Vulvar irritation began in fall 2015 when she experienced new watery odorless discharge and her PCP noted whitening of the left perineum
• She went on to develop a "growth" of the left perineal region
• Initially treated with topical steroids
• She also used an oral antibiotic regimen, which brought no significant improvement to her symptoms

• On January 12, 2016, patient underwent excision of the perineal lesion at an outside facility
  • Pathology demonstrated ulceration, pseudoepitheliomatous hyperplasia with rare squamous cells showing herpes virus cytopathic effect, an underlying polypoid granulation tissue
• On January 26, 2016, patient noted regrowth of the perineal lesion over the previous scar
• Diagnosed with pseudotumor herpes
What to do now?
Medication started July, 2016

Thalidomide

- Inhibits TNF-α, IL-6, IL-10 and IL-12 production
- Modulates the production of IFN-γ
- Enhances the production of IL-2, IL-4 and IL-5 by immune cells
- Inhibits NF-κB and COX-2 activity
- It increases lymphocyte count, costimulates T cells and modulates natural killer cell cytotoxicity
Additional Medications

• IUD prior to thalidomide
• Topical imiquimod
• Topical cidofovir

March, 2017
6 months after completing thalidomide, 3 small erosions noted on vulva

What workup would you recommend?
What treatment do you recommend?

Should she be on an antiviral during pregnancy?
A 62 y.o. with a long-standing history of lichen sclerosus diagnosed by biopsy in her 30s presents with worsening symptoms for the past year

- Rawness, tearing, pruritus, burning and increased pain despite using clobetasol
- She has been recently placed on lidocaine p.r.n. with minimal relief
Your most likely diagnosis is?

- a. Bartholin cyst
- b. Lipoma
- c. Sarcoma
- d. Hernia

Your next step? Part A

- a. Pelvic/vulvar CT
- b. Pelvic/vulvar MRI
- c. Pelvic/vulvar Ultrasound
- d. Go straight to the OR
Your diagnosis is? Part B

- a) Bartholin cyst
- b) Lipoma
- c) Sarcoma
- d) Hernia
The labium majus is homologous to the:

- **a** Scrotum
- **b** Urethra
- **c** Testicle
- **d** Seminal duct

47 y.o. G2P1spAb1 presents with a vagina that has a depth of 2 cm

- Intercourse is impossible
- She begs you to cure her
Your diagnosis is?

a. Paget disease  
b. HSIL of the vulva  
c. Plasma cell vulvitis  
d. Erosive lichen planus

She has been treated with various topical steroids in mouth, vagina, and on the vulva. You offer her topical steroids. Other things to consider include?

a. Offer more topical steroids, tell her to avoid intercourse  
b. Give her a vaginal dilator and tell her to come back when her vagina is normal in length for re-evaluation  
c. Lysis of adhesions in the OR  
d. There is nothing more to offer her
Can you cure her?

A. Yes
B. No
C. Maybe
Lichen planus (LP)

- Surgery for lichen planus (lysis of vulvovaginal adhesions) consists of opening the vagina under anesthesia, followed by long term vaginal dilation and intravaginal steroids.
Soft Type Backer Rods

- Ideal for irregular joints, particularly where free flowing and self leveling sealants are employed
- Google
22 y.o. with painful discolored clitoris
What do you recommend as her treatment for the pyogenic granuloma?

- Sharp excision of clitoris
- Cryotherapy
- Fine point electrocautery to remove lesion
- Trichloroacetic acid
Pyogenic granulomas are misnamed (neither infectious nor granulomatous)

- True
- False

Pyogenic granulomas are more common in males than in females

- True
- False
A 33 year old lady developed an chronic, rash on the edge of her left labium majus. Treatment with topical cortisone did not help. She was waking up at night scratching. A biopsy showed “a pattern compatible with lichen simplex chronicus”. Rash spreading!
Why didn’t her topical corticosteroid help?

A. Potency too low
B. Cream base used
C. Wrong medication
Your diagnosis is?

a. Lichen Simplex Chronicus
b. Contact Dermatitis
c. Tinea Cruris
d. Candidiasis

Tinea Cruris
Tinea Cruris
Rx clobetasol
Which one is not associated with Tinea cruris?

A. *Tinea nigra*
B. *Epidermophyton floccosum*
C. *Trichophyton rubrum*
D. *Trichophyton interdigitale*

What is the correct treatment for tinea cruris?

Topical antifungals (azoles, allylamines, butenafine, ciclopirox, and tolnaftate)

*Nystatin* is not effective

Tinea cruris that is extensive or fails to resolve with topical therapy can be treated with the oral antifungals
A 21 year old presents with chronic drainage from her right vulva since November 2005.

Underwent surgical resection of the draining area for possible Bartholin gland abscess in July 2006 with no significant improvement in her symptoms.
Your diagnosis is?

- a. Bartholin cyst
- b. Fistula in ano
- c. Granuloma inguinale
- d. Metastatic bowel cancer (Krukenberg tumor)

Studies you should order got fistula in ano include:

- a. Fistulography
- b. Endoanal/endorectal ultrasound
- c. MRI
- d. None of the above
Studies you should order include:

- Fistulography
  (referred with one- mother works in radiology)

Accuracy rate is 16–48%
Studies you should order include:

- Endoanal/endorectal ultrasound- 50% better than physical exam alone

Studies you should order include:

- MRI
  80 – 90% concordance with operative findings when observing a primary tract course and secondary extensions. Study of choice for complex fistulae.
The following images are from a MRI of a different patient with multiple tracks
Fistula in ano occur more often in females than males?

- Yes
- No
Fistula in ano occur more often in females than males?

- No  The male-to female ratio is 1.8:1

A 26 y.o. G1P0 presents with a recurrent vulvar cyst. On the right vulva, she has undergone two marsupializations, a cyst excision following her initial treatment with a Word Catheter.
What studies would you consider?

- I would not order any studies
- CT
- MRI
- IVP
88yo G4P2 who had cobalt therapy for endometrial cancer 50 years ago
• Complains of vulvar irritation
Would you take a biopsy?

a) Yes  
b) No
Your diagnosis is?

- [a] Squamous cell carcinoma
- [b] Adenocarcinoma
- [c] Paget disease
- [d] Prolapse (Bowel)
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 carcinoma
Great Job!

Questions and Answers