Your Diagnosis Is?
Test Your Knowledge of Various Vulvovaginal Conditions

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Professor
Michigan Medicine
Dallas, Texas
July 26, 2017
Disclosures
Hope K. Haefner, MD

• Previously on the advisory board of Merck Co., Inc.
Learning Objectives

At the conclusion of this activity, the participant should be able to:

• Identify problems common to general Ob/Gyn practice in relation to vulvovaginal diseases; order appropriate diagnostic tests when indicated; improve patient outcomes

• Identify conditions relevant to Ob/Gyn subspecialties (for example, vulvovaginal diseases) and evaluate these conditions within the scope of general practice; place appropriate referrals; improve patient outcomes

• Have a better understanding of the health care system and be able to function more efficiently within it
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 University of Michigan
Many women experience different forms of vulvar pain, including vulvodynia. Vulvodynia is pain on the lips of the vulva or upon intercourse with a normal appearing vulva. It is a burning, stinging irritation. Some patients are unable to accept sexual penetration due to muscle spasms and tenderness. Other conditions associated with vulvar pain include:

- Lichen sclerosus or lichen planus—chronic inflammatory skin disorders
- Vulvar intraepithelial neoplasia—a precancerous condition, often associated with a virus, the human papilloma virus (HPV)
- Hidradenitis suppurativa—a disease of the armpits and vulva, with pus filled pockets of fluid
- Bartholin cysts—fluid filled cysts at the base of the entranceway

During your first visit to the center, you will see a physician or nurse practitioner for diagnosis and development of a treatment plan. Throughout treatment, you will meet with experts from various disciplines to best meet your specific needs.

In addition to medical treatment, we also connect many patients to additional services, which may help with your condition, including sex therapy and physical therapy.

Health Library
- Vulvodynia
- Patient Education Booklet
- Resources for Providers

Contact Information:
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**Contact Information:**
15th World Congress on Menopause, Prague, September, 2016

- Vulvodynia Causes and Management (PPT PDF)

IPPS Meeting, Chicago, October, 2016

- Disorders Associated with Vulvar Pain (PPT PDF)

Vanderbilt, Nashville, February, 2017

- The Latest in Vulvar Dermatoses (PPT PDF)
- The Latest in Vulvar Dermatoses - Handout (PDF)
- Your Diagnosis Is (PPT PDF)
- Your Diagnosis Is - Handout (PDF)
- Current State of Vulvodynia (PPT PDF)
- Current State of Vulvodynia - Handout (PDF)

ASCCP/IFCCP, April, 2017

- Cases: Your Diagnosis Is (PPT PDF)
- Cases: Your Diagnosis Is - Handout (PDF)

ISSVD Houston, March, 2017

- Your Diagnosis Is (PPT PDF)
- Your Diagnosis Is - Handout (PDF)
Make Your Selection

A

B

C

D
Gross and histologic images
Test Format

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

A. HSIL
B. Melanoma
C. Molluscum contagiosum
D. None of the above
A 65 y.o. G4P3 complains of vulvar itching and burning. A biopsy is performed.
Your Diagnosis Is?

A. Psoriasis
B. Lichen sclerosus
C. Lichen simplex chronicus
D. Herpes
LICHEN SIMPLEX CHRONICUS (LSC) = SQUAMOUS CELL HYPERPLASIA

End stage of the itch-scratch cycle

Other names- neurodermatitis hyperplastic dystrophy
The common causes of postmenopausal vulvar itching include all except:

A. Atrophic vulvovaginitis
B. Lichen sclerosus
C. Candidiasis
D. Contact dermatitis
Diagnosing Lichen Simplex Chronicus

Clinical
Biopsy to R/O underlying condition
Culture for secondary infection
  - Yeast and bacteria
Consider patch testing
What treatment should not be used for vulvar itching?

A. Clobetasol 0.05% ointment  
B. Oral amitriptyline  
C. 20% benzocaine  
D. Tacrolimus ointment
Lichen Simplex Chronicus

Symptoms

- Relentless pruritus
- Long-term itch (months - years)
- Itch develops into burning pain
- Worse with heat, stress, periods and tight synthetic underwear
- Worsens during the night
Treatments for LSC

• Vulvar Care Measures to Stop the Itch-Scratch –Itch Cycle
• Rule out infection as precipitating or driving factor
• Steroids (prednisone 40 mg po q am x 5 days, then 20 mg po q am x 10 days)
• Oral cephalosporin as anti-inflammatory
• Sedation (hydroxyzine or amitriptyline)
• Patient education
STOP WIRE BRUSHES
Case Presentation

A 49y.o. G4P2 presents with chronic vulvar pruritus and irritation. Her vaginal pH is 4.0. She has had 4 other identical episodes this year (culture positive for Candida).
<table>
<thead>
<tr>
<th>Condition</th>
<th>pH (3.0-4.5)</th>
<th>WBC</th>
<th>Parabasals</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>
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<td>Yellow, grey w/ odor</td>
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<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>
Culture Positive for Candida Glabrata

• Low vaginal virulence
• Rarely causes symptoms, even when identified by culture
  – 50% of the time non-albicans yeast is an innocent bystander and is not causing the patient’s symptoms
    Nyirjesy 2016
• Exclude other co-existent causes of symptoms and only then treat for C. glabrata
Other Antifungals
Boric Acid

- Puratronic, 99.99995% (metals basic)
- Formula
  \[ H_3BO_3 \]
- Formula Weight
  61.83
- Form
  Crystalline Powder
- Melting Point
  170.9\(^\circ\)
- Merck Number
  11,1336
Boric Acid Capsule or Suppository
PER VAGINA

Fill 0-gel capsule halfway (600 mg)

For treatment of acute infection; insert *per vagina* qhs x 14 days
For prevention of recurrence; insert *per vagina* twice weekly

KEEP AWAY FROM CHILDREN
CONTRAINDICATED IN PREGNANCY
Before Treatment
After Treatment
Does she qualify for the diagnosis of recurrent Candida

A. Yes
B. No
Yeast/Candida iphone App

Contributors

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Vulvovaginal Candidiasis

CANDIDIASIS
- General Information
- Simple Candida
- Recurrent Infections
- Treatment by Type
- Pregnancy Considerations

INFORMATION
- Wet Mount Examples
- Clinical Images
- Patient Information
- About
There are limited data on some of the treatment regimens. The compounded medications generally are suggestions to consider when other agents are not working. The compounded medications are generally used for resistant strains of Candida.
Yeast Culture/Speciation Results

- Candida albicans
- Candida glabrata
- Candida parapsilosis
- Candida tropicalis
- Candida lusitaniae
- Trichosporon
- Saccharomyces cerevisiae
- Candida kefyr
- Candida dubliniensis

There are limited data on some of the treatment regimens. The compounded medications generally are suggestions to consider when other agents are not working. The compounded medications are generally used for resistant strains of Candida.
Candida lusitaniae

Topical creams can be irritating; vaginal tablets or suppositories may be less irritating. One-day products may be more irritating than longer-use products.

Ketoconazole is not included in this list due to the availability of more efficacious and less toxic medications.

Use as directed by package labeling. All pharmacies may not carry all products. The creams and suppositories are often oil-based and might weaken latex condoms and diaphragms.

**Oral**

Fluconazole

Additional information on drug interactions with fluconazole can be obtained in the CDC Guidelines [http://www.cdc.gov/std/tg2015/candidiasis.htm](http://www.cdc.gov/std/tg2015/candidiasis.htm)

In pregnancy, fluconazole is not to be used, instead use topical creams for treatment.

Recurrence:
150 mg oral tablet every 3 days for three times, then 150 mg orally weekly for up to six months

At times, other dosing may be required such as 100 mg oral tablet every 3 days for three times (day 1, 4, and 7), then 100 mg orally weekly for up to six months; or 200 mg oral tablet every 3 days for 3 times (day 1, 4, and 7) then 200 mg orally weekly for up to six months.

If fluconazole cannot be used, (liver disease, Steven's-Johnson syndrome, or side effects such as headaches or nausea) consider:
- Boric acid
- Maintenance creams for recurrent yeast

Itraconazole

In pregnancy, itraconazole is not to be used, instead use topical creams for treatment.

100mg oral tablet daily for 2 weeks, then twice weekly for up to 6 months.

**Topical**

Clotrimazole

Clotrimazole 1% vaginal cream: 1 applicatorful per vagina nightly for 7 nights

Clotrimazole 2% vaginal cream: 1 applicatorful per vagina nightly for 3 nights

Clotrimazole 7 day suppository/insert (100 mg per dose): One suppository/insert per vagina nightly for 7 nights
Miconazole
Miconazole 7 day cream 2% (100 mg per dose)
  • One applicatorful per vagina nightly for 7 nights

Miconazole 7 day cream 2% (100 mg per dose) plus miconazole nitrate cream 2%
  • One applicatorful per vagina nightly for 7 nights
  • Miconazole nitrate 2% cream to the vulva twice a day for up to 14 days

Miconazole 3 day cream, suppository, ovule 4% (200 mg per dose)
  • One applicatorful, suppository or ovule per vagina nightly for 3 nights

Miconazole 3 day cream, suppository, ovule 4% (200 mg per dose) plus miconazole nitrate cream 2%
  • One applicatorful, suppository or ovule per vagina nightly for 3 nights
  • Miconazole nitrate 2% cream to the vulva twice a day for up to 14 days

Miconazole 1 day insert (ovule) (1200 mg per dose) plus miconazole nitrate cream 2%
  • One insert (ovule) per vagina for one day or night
  • Miconazole nitrate cream 2% cream to the vulva twice a day for up to 14 days

Miconazole nitrate topical 2% cream to the vulva twice a day for up to 14 days

For some recurrent infections, consider using Miconazole 2% vaginal cream: 1 applicatorful per vagina nightly for 14 nights, followed by 1 applicatorful twice weekly for up to six months.

Compounded

Boric acid suppositories
In pregnancy, boric acid is not to be used, instead use maintenance creams for recurrent yeast.

Vaginal boric acid suppositories 600 mg per vagina for 14 nights; If recurrent, consider suppression after re-treatment with twice weekly boric acid 600 mg per vagina.

Boric acid capsules can be FATAL if swallowed/taken orally.
ERYTHEMA FROM CANDIDA INFECTION OF SKIN OVERLYING SACRUM
PATIENT INFORMATION

What are the symptoms of Candida (yeast) infection?
These are the symptoms of vaginal candida infection:
- genital itch - this is the most common symptom of thrush. Itching is especially worse before your period;
- soreness or burning inside (in the vagina) during or after sex;
- abnormal discharge – that can be thick and white or sometimes it can seem normal;
- a change in the smell of your vaginal secretions;
- redness and inflammation of the outside (vulva);
- soreness or discomfort on urination (peeing);
- pain - particularly if the infection occurs a number of times or hasn’t been treated properly; and
- small white spots on the vaginal wall or curds in the discharge.

How is it diagnosed?
A diagnosis of vaginal Candida infection is often made based on a number of things including your symptoms, physical examination, examination of vaginal secretions under the microscope and vaginal culture. However, there are many other conditions of the vagina and vulva that have symptoms in common and even associated with Candida, so if there is doubt about the diagnosis, or when it is recurrent, it is essential that your healthcare provider takes a vaginal swab for laboratory testing before treatment is started.
Case Presentation

38 y.o. G1P1, with clitoral mass increasing in size for the past 28 years

- Enlargement at clitoral location noted at her last delivery 3 years ago
- Past workup by an endocrinologist included a MRI of her adrenals/kidneys and a testosterone work up which were negative
Your Diagnosis Is?

A. Sarcoma
B. Lipoma
C. Plexiform schwannoma
D. Normal clitoral tissue
Video
22-year-old G0 with severe, generalized, erosive skin and mucosal eruption

She is diagnosed with Steven’s Johnson syndrome

Your service is consulted for suggestions on management recommendations (vulvovaginal)
Your management includes:

(3 main needs)
Your management includes:

Daily vaginal dilation

Intravaginal steroids if vagina involved

Topical steroids to vulva
17-year-old G0 with severe, generalized, erosive skin and mucosal eruption

- She had just started treatment for recent onset of seizures (phenytoin)
- Rapid onset of a diffuse maculopapular purple rash
- In 24 hours she had severe malaise, fever and blistering on skin (40% of BSA) and genital area with dysuria
Your Diagnosis Is?

A. Staph scalded skin syndrome
B. Steven’s Johnson syndrome
C. Graft vs. host disease
D. Toxic epidermal necrolysis
Toxic Epidermal Necrolysis (TEN)

A serious, life-threatening allergic skin rash

Clinical:

Severe pain
Diffuse sloughing of skin and mucous membranes
Severe conjunctivitis, stomatitis, esophagitis, bronchitis,
Definitions

• SJS is the less severe condition- <10 percent of the body surface
  – Mucous membranes are affected in over 90 percent of patients, usually at two or more distinct sites (ocular, oral, and genital)

• TEN involves detachment of >30 percent of the body surface area
  – Mucous membranes are also involved in over 90 percent of patients

• SJS/TEN overlap describes patients with skin detachment of 10 to 30 percent of body surface area.
Etiologies

Drugs (limited to first 8 weeks)

- Allopurinol
- Aromatic anticonvulsants (lamotrigine)
- Antibacterial sulfonamides
- Nevirapine
- Oxicam nonsteroidal anti-inflammatory drugs (NSAIDs)

In children

antimicrobials- sulfonamides
anticonvulsants- phenobarbital, carbamazepine and lamotrigine
Etiologies

• Infection
  – *Mycoplasma pneumoniae* infection is the next most common trigger

• Other

  Rarely reported and debatable causes of SJS/TEN include vaccinations, systemic diseases, contrast medium, external chemical exposure, herbal medicines, and foods
Differential Diagnosis
Steven’s Johnson/TEN

- Erythema multiforme
- Erythroderma and erythematous drug eruptions
- Acute generalized exanthematous pustulosis
- Generalized bullous fixed drug eruption
- Phototoxic eruptions
- Staphylococcal scalded skin syndrome
- Paraneoplastic pemphigus
- Linear IgA
## Drugs associated with Stevens-Johnson syndrome/toxic epidermal necrolysis (SJS/TEN)

<table>
<thead>
<tr>
<th>Strongly associated*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allopurinol</td>
</tr>
<tr>
<td>Amifostine</td>
</tr>
<tr>
<td>Carbamazepine</td>
</tr>
<tr>
<td>Etoricoxib</td>
</tr>
<tr>
<td>Lamotrigine</td>
</tr>
<tr>
<td>Meloxicam</td>
</tr>
<tr>
<td>Nevirapine</td>
</tr>
<tr>
<td>Oxcarbazepine</td>
</tr>
<tr>
<td>Phenobarbital, primidone</td>
</tr>
<tr>
<td>Phenytoin, fosphenytoin</td>
</tr>
<tr>
<td>Piroxicam, tenoxicam</td>
</tr>
<tr>
<td>Sulfadiazine, sulfadoxine, sulfamethoxazole, sulfasalazine</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Associated Δ</th>
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</thead>
<tbody>
<tr>
<td>Amoxicillin, ampicillin</td>
</tr>
<tr>
<td>Azithromycin, clarithromycin, erythromycin</td>
</tr>
<tr>
<td>Cefadroxil, cefixime, ceftriaxone, cefuroxime</td>
</tr>
<tr>
<td>Ciprofloxacin, levofloxacin, pefloxacin°</td>
</tr>
<tr>
<td>Diclofenac</td>
</tr>
<tr>
<td>Doxycycline</td>
</tr>
<tr>
<td>Dipyrone (metamizole)¶</td>
</tr>
<tr>
<td>Pipemidic acid°</td>
</tr>
<tr>
<td>Rifampin (rifampicin)</td>
</tr>
</tbody>
</table>
Mortality with TEN is:

A. 10%
B. 20%
C. 30%
D. 40%
Your management includes all of the following except:

A. Treatment in a burn unit
B. Sedation
C. IVIG
D. Pulse IV steroids
Summary
Stevens-Johnson Syndrome or Toxic Epidermal Necrolysis

• Examine the vulva and vagina (narrow speculum)
• If vagina involved, or disease close to vagina, start on daily vaginal dilation
  – The dilator does not need to be left in for an extended period of time with each dilation
• If the vulva is involved, start on clobetasol 0.05% ointment qhs
• If the vagina is involved, start patient on 50 mg hydrocortisone (ii 25 mg suppositories qhs (insert after dilation done)
• The patient should continue daily vaginal dilation for 2 months (or longer if the vagina is not healed by 2 months)

• Arrange follow up 2 weeks after patient is discharged
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 histologic images shown represent which vulvar condition(s)?

A. 1 HSIL of the vulva and 2 condyloma
B. 1 and 2 both condyloma
C. 1 and 2 both molluscum contagiosum
D. 1 condyloma and 2 HSIL of the vulva
Treatment for condyloma HSIL in this patient should be:

A. Laser
B. Wide local excision (WLE)
C. A combination of laser and WLE
D. No treatment. Observation only.
<table>
<thead>
<tr>
<th>ISSVD 1986</th>
<th>ISSVD 2004</th>
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</thead>
<tbody>
<tr>
<td>VIN 1</td>
<td>Flat condyloma or HPV effect</td>
</tr>
<tr>
<td>VIN 2</td>
<td>VIN, usual type</td>
</tr>
<tr>
<td></td>
<td>a. VIN, warty type</td>
</tr>
<tr>
<td></td>
<td>b. VIN, basaloid type</td>
</tr>
<tr>
<td></td>
<td>c. VIN, mixed (warty/basaloid) type</td>
</tr>
<tr>
<td>VIN 3</td>
<td></td>
</tr>
<tr>
<td>Differentiated VIN</td>
<td>VIN, differentiated type</td>
</tr>
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</table>

**LAST 2012**

**Low Grade**

**High Grade**

???
2015 ISSVD Terminology of Vulvar Squamous Intraepithelial Lesions

<table>
<thead>
<tr>
<th>Low grade squamous intraepithelial lesion (Flat condyloma or HPV effect)</th>
</tr>
</thead>
<tbody>
<tr>
<td>High grade squamous intraepithelial lesion (VIN usual type)</td>
</tr>
<tr>
<td>Intraepithelial neoplasia, differentiated-type</td>
</tr>
</tbody>
</table>
Lichen Sclerosus and VIN Differentiated V-to-Y Flaps
V-to-Y Flaps
V-to-Y Flaps
V-to-Y Flaps
Desquamative Inflammatory Vaginitis (DIV)

- Occurs in 8% of women presenting to a specialty clinic with chronic vaginitis symptoms
- More frequent in Caucasians
- Peak occurrence in perimenopause
- Diagnosis of exclusion

Desquamative Inflammmatory Vaginitis
PH and Wet Mount Findings

• Vaginal pH greater than 4.5
• Purulent vaginal discharge
  – (PMNs/epith > 1:1 in at least 4 hpfs on wet prep)
• Increase parabasal cells (>10% total)
• Loss of normal vaginal lactobacilli
<table>
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</table>
An important condition to rule out when considering DIV is:

1. Gonorrhea
2. Syphilis
3. Mobiluncus
4. Trichomonas
Desquamative Inflammatory Vaginitis

Rule out Trichomonas
What other conditions have a similar appearance to DIV?
Inflammatory Vulvovaginitis

- Atrophic vaginitis
- Erosive lichen planus
- Pemphigus vulgaris
- Behçet’s disease
- Collagen vascular diseases
- Traumatic
  - Foreign body, vesicovaginal fistulae
- Allergic vaginitis
- Chemical vaginitis
- Infection
  - Group A Streptococcus, Trichomonas, Cervicitis
- Degenerating leiomyoma or endometrial polyp
- Idiopathic
Proposed etiologies

- Immune mediated (autoimmune) (response to anti-inflammatory)
- Kallikrein-related peptidase
- Genetic link
- Bacterial infection
DIV Treatment


Up-to-date by Sobel J (slightly different regimen)
DIV

Therapy Options Clindamycin
(Adapted from Reichman and Sobel 2014)

Clindamycin 2% cream 5(g)
one applicator intravaginally qhs x 3 weeks
(consider 2 x per week x 2 months)
    Longer suppression time may be required

Clindamycin 200 mg vaginal suppository qhs x 3 weeks
(consider 2 x per week x 2 months)
    Longer suppression time may be required
DIV

Therapy Options Hydrocortisone
(Adapted from Reichman and Sobel 2014)

Intravaginal hydrocortisone suppositories 25 mg intravaginal bid for 3 weeks (consider 3 x per week x 2 months)

   Longer suppression may be required

Intravaginal hydrocortisone cream 300 to 500 mg intravaginal qhs for 3 weeks (consider 2 x per week x 2 months for maintenance therapy)

   Longer suppression may be required
Combine clindamycin cream and hydrocortisone suppositories.

1 applicatorful of 2% clindamycin cream and 25 mg hydrocortisone nightly x 14 or every other night x 14
DIV    Other Options

Compound a high dose intravaginal corticosteroid and 2% clindamycin* (variety of regimens)

Hydrocortisone 100 mg/gram in clindamycin in 2% emollient cream base. Insert 3 to 5 gram (applicator full) (300 to 500 mg active drug) per vagina every other night x 14 doses. Consider taper.

Hydrocortisone 100 mg/gram in clindamycin in 2% emollient cream base. Insert 3 to 5 gram (applicator full) (300 to 500 mg active drug) per vagina every night x 2 weeks, then 3 times per week and taper.

* This needs to be made at a compounding pharmacy.
If not working, reconsider the diagnosis!
(has estrogen been addressed?)

- May need to add estrogen

Erosive Lichen Planus
Lichen Planus (LP)

• Affects the genital skin and mucous membranes producing vaginal scarring
• Can result in complete closure of the vagina
• Can also result in esophageal strictures
Presentation, Diagnosis, and Management of Esophageal Lichen Planus: A Series of Six Cases

• Approximately 80 cases since first report in 1982
• Female to male ratios 5:1

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.
Other Treatments Lichen Planus (and Lichen Sclerosus)

- Hydrodissection with reverse V plasty technique
- Cryosurgery
- Ultrasound therapy
- Use of split thickness skin grafts or full thickness skin grafts
- Release of urethral strictures (oral mucosa grafts)
- Use of acellular human dermal allograft
- Role of adipose derived mesenchymal cells and platelet rich plasma in tissue regeneration
- Stem cell lift
Soft Type Backer Rods

• Ideal for irregular joints, particularly where free flowing and self leveling sealants are employed

• Google
Lysis of Vulvovaginal Adhesions in Lichen Planus

• Surgical lysis of adhesions
  – Goal
    • Improve urine flow, decrease risk of UTI
    • Allow intercourse, reduce dyspareunia
  – Best if disease controlled (koebnerization)
  – Results
    N=22, 11 patients who underwent surgery for vulvovaginal adhesions and 11 age matched controls
    • 6 months to 6 years post-lysis of adhesions
    • 91% satisfied with procedure
    • 75% of patients with decreased urinary difficulties
    • 55% able to have intercourse
    • 50% continued to fear pain
  – Post op dilator 48-72 hours, long term dilation and steroids

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Dosing</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intravaginal corticosteroids</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hydrocortisone 100 mg/g in</td>
<td>300 mg (3 g) per vagina QHS</td>
<td>First week postoperatively</td>
</tr>
<tr>
<td>emollient cream base</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>400 mg (4 g) per vagina QHS</td>
<td>Second week postoperatively</td>
</tr>
<tr>
<td></td>
<td>500 mg (5 g) per vagina QHS</td>
<td>Third week postoperatively</td>
</tr>
<tr>
<td></td>
<td>400 mg (4 g) per vagina QHS</td>
<td>Fourth week postoperatively</td>
</tr>
<tr>
<td></td>
<td>300 mg (3 g) per vagina QHS</td>
<td>Fifth week postoperatively</td>
</tr>
<tr>
<td></td>
<td>200 mg (2 g) per vagina QHS</td>
<td>Sixth week postoperatively</td>
</tr>
<tr>
<td></td>
<td>100 mg (1 g) per vagina QHS</td>
<td>Starting week 7, indefinitely&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Dilators&lt;sup&gt;b&lt;/sup&gt;</td>
<td>Largest size tolerated</td>
<td>QHS for 20–25 min for 6 mo (with silicone lubricant), then consider daily dilation with a water soluble lubricant in the shower (dilator placed into vagina and immediately removed to prevent adhesion formation)</td>
</tr>
</tbody>
</table>

<sup>a</sup> Depending on disease activity, patients may eventually decrease to 50 mg hydrocortisone suppositories nightly per vagina if tolerated and then 25 mg hydrocortisone suppositories nightly per vagina. The long-term goal is to utilize hydrocortisone suppositories 2–3 times per week; <sup>b</sup> Any medical-grade dilator set is acceptable.

Medical-Grade Vaginal Dilators
## Lubricants

### Water Based
- Astroglide
- Astroglide Gel Just Like Me
- Astroglide Silken Secret
- K-Y Liquid Personal
- K-Y SILK-E
- K-Y Ultra Gel
- Liquid Silk
- Me Again
- Pink Water
- Pjur Water Based
- Pre-Seed
- Probe
- Slippery Stuff Gel
- Sliquid H20
- Sweet seduction
- System Jo H20

### Silicone based
- Astroglide X
- Gun Oil
- ID Millennium
- Jo Premium
- K-Y Intrigue
- Lubrin (Suppository)
- Pink Silicone
- Pjur silicone
- Sliquid Silver
- Wet Platinum Premium Lubricant

### Hypoallergenic
- Good Clean Love
- Just like Me
<table>
<thead>
<tr>
<th>Moisturizers</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Extra Virgin Olive Oil</td>
<td>Luvena</td>
</tr>
<tr>
<td>Vitamin E oil</td>
<td>Replens</td>
</tr>
<tr>
<td>Coconut Oil</td>
<td>Moist Again</td>
</tr>
<tr>
<td></td>
<td>KY Silk-E</td>
</tr>
<tr>
<td></td>
<td>K-Y liquibeads</td>
</tr>
</tbody>
</table>
Case Presentation

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 dysethesia
D. Somatoparaphrenia
Pain noted in red/pink area below
Definition of Vulvodynia

International Society for the Study of Vulvovaginal Disease (ISSVD)

Chronic discomfort
Burning
Stinging
Irritation
Rawness
April 2015

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)

Support from the National Vulvodynia Association
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 [vullovaginal 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
2015 Consensus Terminology and Classification of Persistent Vulvar Pain and Vulvodynia

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.
Topical review

Vulvodynia: Current state of the biological science

Ursula Wesselmann

Adrienne Bonham

David Foster

Sept. 2014
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
Summary

• Assess your knowledge of vulvovaginal diseases
• Identify the clinical features of some difficult vulvovaginal conditions
• Familiarize yourself with a variety of treatments for skin diseases