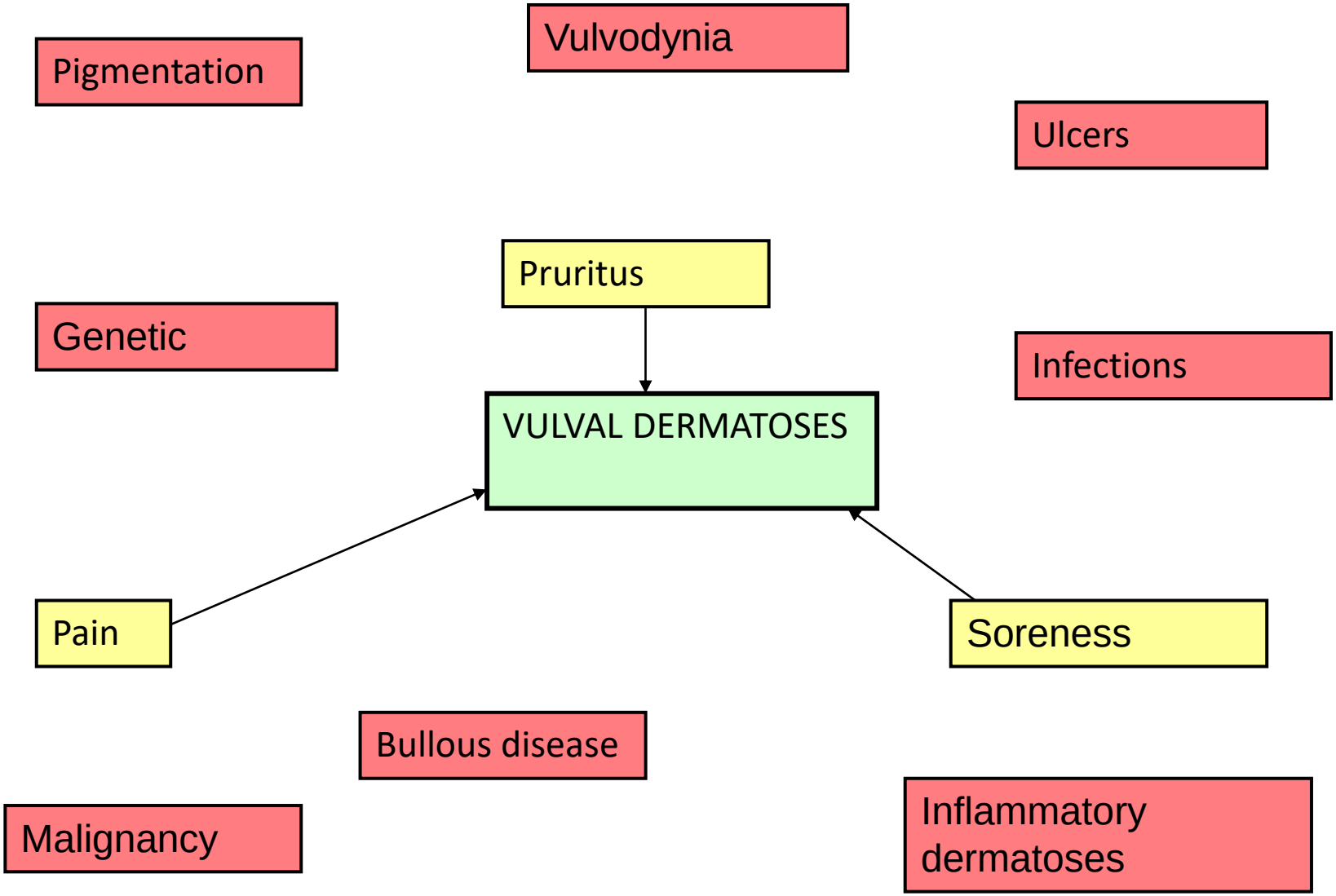
Vulval dermatoses

Dr Fiona Lewis,
St John's Institute of Dermatology,
Guy's & St Thomas' Hospital, London


Pigmentation
Vulvodynia
Ulcers
Pruritus
Genetic
Infections
VULVAL DERMATOSES
Pain
Soreness
Bullous disease
Malignancy
Inflammatory dermatoses

Common vulval dermatoses

- Eczema
- Psoriasis
- Lichen simplex

- *Lichen sclerosus*
- *Lichen planus*

Topical treatments and the vulva

- Soap substitute
- Emollients
- Barriers
- Topical steroids +/- antibiotic/anticandidal

Potassium permanganate soaks

- Useful for wet lesions
- Acute eczema
- Use for 10 minutes twice daily for 48 hours

Topical steroids - potency

I mild eg. 1% hydrocortisone

II moderate eg. clobetasol butyrate (Eumovate)

III potent eg. betamethasone valerate

IV super-potent (ultra-potent) eg. clobetasol propionate 0.05%

Tips for topical treatment

- Ointments are better than creams for vulval/anal skin
- Topical steroids – only ONCE a day
- Use as few preparations as possible

Eczema

- Seborrhoeic eczema
- Irritant eczema
- Allergic contact dermatitis/eczema

Contact reactions and the vulva

- Irritant contact dermatitis - COMMON
- Allergic contact dermatitis - RARE
- Contact urticaria – VERY RARE

Irritant dermatitis

- Ano-genital skin more susceptible to some irritants
- Moisture, friction, discharge can contribute
- Over-washing
- Urinary incontinence

Irritant eczema

- Often extends around peri-anal skin
- Symmetrical
- May have scaly rim

Allergic contact dermatitis

- Immune mediated reaction to allergen in sensitised individual
- Type IV (delayed) reaction
- Symptoms *may* be intermittent

Common allergens and the vulva

- Local anaesthetics eg. Benzocaine
- Preservatives
- Neomycin
- Fragrances
- Topical steroids
- Azo dyes

+ others!……

Patch testing

- BCDG standard series
- Preservatives
- Vulval/perianal
- Textiles

Management

- Avoid the cause!
- Bland emollients
- Topical steroids (II/III)
- Barriers

Contact urticaria

- Immediate swelling with intercourse
- Latex allergy most likely
- Semen allergy rare

Ano-genital psoriasis

- Common
- Can occur without psoriasis at other sites
- May occur with lichen sclerosus

- 43% have genital involvement

- Only 40% of these had been examined

GENIPSO study Larsabal M et al BJD 2019

Clinical features

- Well defined plaques
- Often not scaly
- May fissure
- Perianal involvement very common

Ano-genital psoriasis - treatment

- Emollients
- Mild/moderate topical steroids
- Barriers

Treatment

- Topical steroid – reducing regimen over 6 weeks
- Combination with an antibiotic or anticandidal helpful if fissuring disease
- Think about secondary candidiasis
- Avoid tar preparations

Other options

- Calcineurin inhibitors
- Systemic agents eg. methotrexate, retinoids (difficult in younger women because teratogenic)
- Biologics – anti-TNF, anti IL17 and 23 ?Ixekizumab
- >20% on systemics or biologics continue to have genital lesions

Lichen simplex

- May occur on a background of eczema or psoriasis
- Itch-scratch cycle
- Usually outer labia majora
- Peri-anal involvement common

Treatment of lichen simplex

- Emollients
- Topical steroids – potent on reducing regime over 3 months
- Sedating antihistamines at night

Hidradenitis suppurativa

- Abnormal follicular occlusion
- Painful nodules
- Purulent discharge, sinus formation
- Scarring
- Associated with smoking and obesity
- F>M

Sabat R, Jemec GBE, Matusiak Ł, Kimball AB, Prens E, Wolk K. Hidradenitis suppurativa. Nat Rev Dis Primers. 2020 Mar 12;6(1):18.

HS - treatment

- Topical antiseptics
- Antibiotics – tetracyclines, clindamycin and rifampicin (300mg/day for 12 weeks)
- Zinc
- Dapsone
- Retinoids (difficult in young women)
- Biologics - adalimumab
- Surgery

Auto-immune bullous disease

- Bullous pemphigoid
- Mucous membrane pemphigoid
- Pemphigus vulgaris

- Ano-genital involvement is common

Bullous pemphigoid

- Elderly
- Tense blisters
- Diagnosis: immunofluorescence shows linear IgG at basement membrane
- Rx: oral steroids +/- immune suppression

Mucous membrane pemphigoid

- Histology and IF similar to bullous pemphigoid but other mucous membranes involved
- Scarring is prominent
- Can affect mouth, eyes and larynx

Pemphigus vulgaris

- Rare
- IgG directed against keratinocytes
- Erosions and ulcers
- Rx: immuno-suppression

Signs of systemic disease

- Acrodermatitis enteropathica – zinc deficiency
- Necrolytic migratory erythema – glucagonoma
- Crohn’s disease

Genital pigmentation

- Accurate history unlikely (F>M)
- Is it blood? Is it melanin?

Genital pigmentation

- Papular pigmented lesions
- Diffuse pigmentation

ABCDE

A – asymmetry

B – irregular

C – colour

D – diameter 8mm

E – elevation

F – looks funny

Atypical genital naevi

- Subset in young people
  - enlarged junctional nests
  - variation in size, shape and position
- May be cytological atypia
- Expert pathology review

Christensen WN et al. Histological characteristics of vulvar naevocellular nevi. J. Cutan Pathol 1987:14(2):87-91

2. Diffuse pigmentation

- Is it blood? Is it melanin?
- History of preceding symptoms
- Clinico-pathological correlation

Genital melanosis

- Cause unknown
- Irregular pigmentation
- Increase in melanin – no increase in melanocytes
- Benign course

Melanosis - management

- Biopsy - mandatory
- Clinical photography
- Follow-up ?5 years

‘Failure’ of treatment

- Check the diagnosis - always biopsy unresponsive disease

‘Failure’ of treatment

- Check the diagnosis

- Check compliance – correct treatment in correct place

‘Failure’ of treatment

- Check the diagnosis
- Check compliance
- Is there an additional contact dermatitis or infection? Patch testing if appropriate, swabs

‘Failure’ of treatment

- Check the diagnosis
- Check compliance
- Is there an additional contact dermatitis or infection?
- Has the patient developed a dysaesthesia? Think about vulvodynia

Summary

- Careful clinical evaluation
- Look at other sites
- Specialised management is important, often different specialities are needed
- Clinico-pathological correlation is vital