DISCLOSURE OF RELATIONSHIPS WITH INDUSTRY

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S052 – Gender Dermatology: Diagnosis and Treatment of Genital Skin Disorders
Vulvar Dermatitis

DISCLOSURES
I do not have any relevant relationships with industry.
Vulvar Dermatitis

• Acute
  – Irritant Contact Dermatitis
  – Allergic Contact Dermatitis
  – Infectious

• Subacute/Chronic
  – 50% of chronic vulvovaginal pruritus is ACD or ICD\(^1\)
  – Eczema/Lichen Simplex Chronicus
  – Psoriasis

Acute Contact Dermatitis

• Morphology
  – Edema
  – Erythema
  – Vesicles with prompt erosions

• Irritant Contact Dermatitis
  – Burning
  – Irritation

• Allergic Contact Dermatitis
  – Itching
Irritant Contact Dermatitis

- Direct damage to keratinocytes
- No prior sensitization
- Irritation, rawness, burning
- Itching less than Allergic contact
- Vulvar ICD$^2$
  - Topical treatments for underlying disease
  - Skin care habits
  - Inflammation = facilitate passage of irritants

Common Vulvar Irritants

- Urine
- Feces
- Sweat
- Abnormal vaginal discharge
- Excessive hygiene
- Feminine hygiene products
  - Lubricants, pads, wipes
- Soaps and detergents
- Hair dryer
- Medications
  - Alcohol-based creams and gels, spermicides, propylene glycol

Irritant Contact Dermatitis

- Edema
- Erythema
- Erosions
Irritant contact dermatitis

From Trichloroacetic acid
Irritant contact dermatitis

From vaginal fluorouracil
Irritant Contact Dermatitis

From Lysol
Allergic Contact Dermatitis

• Incidence
  – Estimated between 15 and 30%\(^3,4\)
  – Relevant patch tests in 26%\(^4\)

• Anatomical Considerations
  – Occlusion, hydration, and friction
  – More permeable than exposed skin\(^5\)
  – Higher incidence of contact sensitivity
  – Study of vulval pruritus = 44% with 1 or more relevant contact allergens\(^6\)

Allergic Contact Dermatitis

• Differentiating factors
  – Persistence
  – Intense Itch
  – Relevant Exposure
• Persists at least 3 months after last exposure
• Not intermittent
  – Unless allergy to topical steroid
  – Short-term relief when applied, then flares

Common Vulvar Allergens

- **Topical anesthetics**
  - Lidocaine, Benzocaine, Tetracaine
- **Topical antibiotics**
  - Neomycin, Bacitracin, Polymyxin
- **Antifungals**
  - Imidazole, Nystatin
- **Fragrance**
- **Preservatives**
  - MI/MCI
- **Corticosteroids**
- **Lanolin**
- **Rubber-latex**
- **Spermicides**

Allergic Contact Dermatitis

Erythema and vesicles

Reaction can spread outside area of contact
Allergic contact dermatitis

Topical Diphenhydramine
Methylisothiazolinone
American Contact Dermatitis Society Allergen of the Year 2013

Iodopropynyl butylcarbamate
Preservative - also noted!
+ Patch Test

Methylisothiazolinone
Contact Dermatitis Treatment

• Patient education
  – Reassurance
  – Handouts/Written Instructions

• Stop Use of Potential Irritants

• Pharmacologic treatments
  – Treat inflammation
  – Treat itching
  – Prevent or treat infection

Contact Dermatitis Treatment

- **Potent Topical Steroids**
  - Corticosteroid ointment for 3-4 weeks
    - Betamethasone 0.05% ointment BID if severe
    - Triamcinolone 0.1% ointment BID if moderate
  - Prednisone 0.5 to 1 mg/kg tapered over 2-3 weeks if severe

- **Treat itching**
  - Anti-histamines
    - Hydroxyzine, doxepin, fexofenadine, cetirizine, loratadine

- **Prevent or treat infection**
  - Oral fluconazole 150 mg weekly while on topical steroids for *Candida* suppression
  - Oral antibiotics as needed for secondary impetiginization

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Topical Steroid Application

- Demonstrate application
- Use photos and mirrors
- Less than a pea-sized amount
Topical Steroid Application

- Small amount twice daily
  - Taper when fully responsive
  - Don’t stop until follow-up
  - Disease dependent
- Modified mucous membranes steroid resistant
  - Labia minora, medial labia majora, vestibule, clitoris, and clitoral hood
- Hair bearing skin more sensitive
  - Lateral labia majora, inguinal area, medial thighs, perianal
Steroid Dermatitis
Milia and steroid dermatitis

From years of triamcinolone
Striae
Topical Steroid Adverse Effects

- Mostly resolve with discontinuation
- Provide reassurance
- Exception is long-term steroid under diaper occlusion
Infectious Vulvar Dermatitis

• Vulvar itching
  – Most common mistake in chronic itching is over-diagnosis of yeast
  – Elicit history of contactants for allergic contact
  – History of pleasure with scratching = LSC

• Examine for infection or skin disease
  – Wet mount
  – Culture if wet mounts persistently positive or patient unresponsive to treatment
Infectious Vulvar Dermatitis

- **Candida Albicans**
  - Non-Albicans Candida produces irritation > itching
- **Folliculitis**
  - Bacterial or fungal
- **Trichomonas**
- **HSV**
- **Bacterial Vaginosis**
Candida

Antibiotic + Clobetasol + New Estrogen
Subacute/Chronic Vulvar Dermatitis

• Present with eczematous changes
  – Variable Erythema
  – Sometimes lichenification
  – Excoriations
  – Fissures
  – Weeping

• Causes
  – Irritant or Allergic Contact Dermatitis
    • Covered under Acute Dermatitis
  – Eczema/Lichen Simplex Chronicus
  – Psoriasis
Lichen Simplex Chronicus

• Itch-scratch cycle
  – Precipitated by an irritant/infection
• Manifested primarily by lichenification
• Excruciating itching and pleasure with scratching
• Usually, but not always, a history of atopy
LSC Morphology

• Exam Findings
  – Erythema
  – Swelling
  – Accentuation of skin markings
• Findings can be subtle, even with significant disease
• Morphology very variable according to skin type and location
Treatment for LSC

- Patient education
- High potency corticosteroid
  - BID for a month
- “Soak and seal”
  - Tub soaks and petroleum jelly
- Eliminate irritants
  - Give a handout on the avoidance of irritants
  - Over washing, panty liners, wipes, benzocaine, latex, spermicides, condoms/diaphragms, OTC medications, certain lubricants
Treatment for LSC

• Control nighttime scratching
  – Amitriptyline
  – Start with 10 mg 2 hours before bedtime

• Treat concomitant infection if present

• Xylocaine/lidocaine 2% jelly
  – As needed for itching on modified mucous membranes
Resistant LSC

- Psychological factors
- Neuropathic itch
  - Treat like vulvodynia
- Rule out secondary process
  - Vaginal infection
  - Contact dermatitis
- Non-compliance
Psoriasis

- Atypical or non-specific on vulva
- Any inflammatory process can cause resorption of normal architecture
- Morphology
  - Pink
  - Poorly demarcated
  - Subtle scale
  - Can look similar to lichen simplex chronicus
Psoriasis

- Check other areas of the skin for clues
- Consider biopsy if uncertain
- Treatment – same as non-genital psoriasis
Questions?

Thank you!