Vulvar Dermatoses: Pearls for Diagnosis and Management

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Disclosure of Relationships with Industry

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S007: Advice from Experts

Vulvar Dermatoses

Elorac, Galderma, Novan: Investigator, Fees to Institution
Novan: Advisory Board, Honoraria

Decision Support in Medicine, UpToDate®: Author, Honoraria

Off-label use of medication will be discussed.
We’re In This Together…Setting Expectations

- Most vulvar diseases are chronic

- Goal is often control, not cure
  - What is the patient’s primary concern, goal?

- Periods of relapse, flare will occur
  - May be unpredictable
  - Are manageable

- Quality of life can be better
We Must Be Realistic

This is Rome. It wasn’t built in a day.
Vulvar Biopsy Pearls

- Biopsy to support clinical diagnosis
- Multiple biopsies if needed (path, tissue cx)
- Utility and necessity of DIF
- Clinicopathologic correlation is key
- If no lesion = biopsy unlikely to be helpful
  – Consider microbial cultures (fungal, bacterial)
Vulvar Biopsy Tips and Tricks

• Buffered, warmed lidocaine, 30g needle
  – Inject slowly within the dermis/submucosa

• Wait 10 min before performing biopsy

• Get help – retraction, hemostasis, patient

• 4-8mm punch → suture closure vs AgNO₃

• Exceptions: clitoris, urethra, vagina
Evaluation of the Vagina
Vaginal Speculum

Welch Allyn Lighted Speculum System
Vaginal Exam with Speculum

- Introital narrowing, foreshortening
- Vaginal walls – erythema, erosion, ulcer
- Vaginal discharge
- Water as lubricant
- Defer exam if vaginal creams used within last 72hr
Pearl: Normal saline wet mount microscopy is the poor man’s speculum exam.
Vaginal Discharge Evaluation: Normal NaCl Wet Mount

• Epithelial cells: mature, immature
• WBCs: <1 per epithelial cell (or <10/HPF)
• Lactobacilli
• Clue cells
Normal Normal Saline Wet Mount
Abnormal Normal Saline Wet Mounts

Courtesy of Dr. Libby Edwards
## Abnormal NaCl Wet Mounts

<table>
<thead>
<tr>
<th>Finding</th>
<th>Candida albicans</th>
<th>Bacterial vaginosis</th>
<th>Atrophic vaginitis</th>
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<tbody>
<tr>
<td>Discharge amount &amp; color</td>
<td>↑↑, white</td>
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<td>scant, +/-purulent</td>
<td>↑↑, variable</td>
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<td>pH</td>
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DIV: Desquamative inflammatory vaginitis

Approach to Treatment

• Vulvar disease is often multifactorial

• Identify primary etiology

• Eliminate aggravating factors
  – Contact dermatitis
  – Infections (yeast, bacterial)
  – Estrogen deficiency
Therapeutic Pearls

• Utilize ointments (rather than creams)

• Topical anesthetics with caution

• Limit topical medications
  – Use systemic antibiotics, antifungals when available

• Vulvar disease can be relatively steroid-resistant
  – Use super-potent/potent corticosteroids
  – Monitor for atrophy at mons, inguinal creases, thighs, buttocks, perianal skin
Poor Response to Appropriate Therapy

• Secondary infection
  – Antibiotic-related candidiasis
  – Reactivation of herpes simplex virus

• Allergic or irritant contact dermatitis

• Additional disease process

• Incorrect initial diagnosis
Vulvovaginal Lichen Planus

- Chronic, idiopathic
- T-cell mediated, autoimmune disorder
- Prevalence: ~1 in 4000
  - Less common than LS
- Disease onset: peri/post-menopause
  - May present during reproductive years
  - Rare in children
Vulvovaginal Lichen Planus

- Pain, pruritus, dyspareunia, irritation\(^1\)
  - Can be asymptomatic (21%)

- 74% present with erosions\(^2\)
- 25% have purulent vaginal discharge\(^1\)
- >50% have significant scarring\(^1\)

- Vaginal involvement is common (≤70%)
  - Vaginal LP can occur isolation

\(^1\) Cooper SM, Wojnarowska F. Arch Dermatol. 2006; 142: 289-94.
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Vulvovaginal Lichen Planus Treatment

- **Topical corticosteroids**
  - Clobetasol ointment 0.05%
  - Intravaginal steroid suppositories
  - Intralesional triamcinolone (3-10mg/ml)

- **Topical calcineurin inhibitors** (tacrolimus oint 0.1%)

- **Systemic corticosteroids**
  - Acute flares, rapid recurrence upon d/c

- **Methotrexate, mycophenolate, azathioprine, tacrolimus, cyclosporine, antimalarials, acitretin**
Mucosal Lichen Planus

- Conjunctiva
- Nasal mucosa
- Auditory canal
- Esophagus
- Larynx
- Vulva and vagina
- Urethra
- Anus

Scarring
Obstruction
Loss of function
Vulvar Lichen Sclerosus

- Prevalence 0.1-1.7%¹,²
  - General population estimates: 1:300 to 1:1000
- “Bimodal” age distribution³,⁴
  - 9-23% premenarchal
  - 17-41% reproductive years
  - 50-60% postmenopausal
- Concomitant autoimmune disorders (28.4% LS vs 8.7%)
  - Thyroid disorder

Vulvar LS Treatment

• Super-potent topical corticosteroids**
  – Clobetasol oint 0.05% x 3 months → 66% symptom CR, 23% exam CR¹

• Topical calcineurin inhibitors (tacrolimus 0.1% oint)

• Intralesional TAC injection (≤10mg/ml)

• Systemic agents rarely required
  – Hydroxychloroquine
  – Systemic corticosteroids, retinoids, immunosuppressives

VULVAR SQUAMOUS CELL CARCINOMA
Vulvar LS and SCC

- Vulvar SCC incidence increases with age
  - 25/100,000 > 75yo
- Prospective risk in LS: 300X normal\(^1\)
- Interval between LS and SCC: 4-10yrs\(^1,2\)
- RFs for SCC in vulvar LS\(^3\)
  - Age at presentation (75yo vs 63yo)
  - Localized hyperkeratosis
  - Squamous dysplasia on histopathology

Does Treatment Impact Risk of Vulvar SCC?

- Prospective cohort, n=507, 55.4yr (18-86)
- Follow-up 4.7 yrs (range 2-6.8yrs)
- Induction → individualized maintenance

Does Treatment Impact Risk of Vulvar SCC?

<table>
<thead>
<tr>
<th></th>
<th>Compliant (n=357)</th>
<th>Partially Compliant (n=150)</th>
<th>P value</th>
</tr>
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<tr>
<td>SCC</td>
<td>0</td>
<td>7 (4.7%)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Progression of scarring</td>
<td>12 (3.4%)</td>
<td>60 (40%)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Symptom resolution</td>
<td>333 (93.3%)</td>
<td>87 (58%)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Corticosteroid dermatitis</td>
<td>8 (2.2%)</td>
<td>6 (4.4%)</td>
<td>.37</td>
</tr>
<tr>
<td>Atrophy</td>
<td>4 (1.1%)</td>
<td>3 (2.0%)</td>
<td>.43</td>
</tr>
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Vulvar LP and SCC

• Retrospective series of 95 women
  – Patient encounters occurred over 7 years
  – 2 developed vulvar SCC (2.1%)\textsuperscript{1}

• Prospective study of 114 women with VVLP
  – Mean follow-up = 72 months
  – 1 developed vulvar SCC (0.8%)\textsuperscript{2}

\textsuperscript{1} Santegoets LA et al. \textit{J Low Genit Tract Dis} 2010; 14: 323-8.
\textsuperscript{2} Cooper SM, Wojnarowska F. \textit{Arch Dermatol.} 2006; 142: 289-94.
Vulvar Dermatoses and SCC

- Educate your patients
- High index of suspicion
- Regular surveillance
- Biopsy
  - Multiple over time
  - Multiple with varied lesion morphology
THANK YOU

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www.issvd.org