VULVAR DERMATOSES: Thinking Like a Dermatologist

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I have no conflicts of interest relating to my presentation or to this program.

VULVAR DERMATOSES

- Definition and Cases
- Vulvar Skin Care Basics
- Lichenoid dermatoses: the “Big Three”
- Clobetasol Complications & how to avoid them
- ICD-9 Coding: Beyond “Vulvitis”
- Systemic disorders: Recognition & Referral
- Managing “Itch”: Tips for Topical Therapy
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VULVAR DERMATOSES

- Visible changes on vulvar skin
- Lesions may be elsewhere on the body
- Distinctive histopathology
- Typically flare and remit
- Itching is not always a symptom

CASE #1

35-year-old woman with vulvar discharge and dyspareunia for three years.

The most likely diagnosis is:
1. Lichen sclerosus
2. Lichen planus
3. Chronic Candidiasis
CASE #2

25-year-old woman with vulvar itching for six months.

The most likely diagnosis is:
1. Lichen simplex chronicus
2. Lymphedema
3. Lichen planus
CASE #3

42-year-old woman with vulvar itching for seven years.

The most likely diagnosis is:
1. Vitiligo
2. Lichen simplex chronicus
3. Lichen sclerosus

CASE #4

27-year-old woman itching on her right labium for 6 months.

The most likely diagnosis is:
1. Bartholin’s cyst
2. Lichen simplex chronicus
3. Vulvar intraepithelial neoplasia
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SKIN FACTS

Healthy skin acts as a barrier to bacteria, fungi, irritants, minor trauma

_Natural lipids in the stratum corneum can be removed by detergents, solvents, scrubbing_

Skin turnover time is 28 days

_It takes at least 3 weeks for acute dermatitis to heal_

Healing is faster in a moist environment (ointment)
### IF IT’S WET, DRY IT

**Impetigo: child**

To decrease bacteria, Bleach (sitz) baths:
- One-half cup of Clorox in a tub of water
- (1/4 cup in half a tub)
- Repeat 3-5 x week

**Incontinence, adult patient**

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### IF IT’S DRY, WET IT

**Lichen simplex**

- Thick skin has more stratum corneum
- Dry layer contains less lipid
- Apply ointment after bathing while skin is moist
- Occlusion enhances the penetration of a medication

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### PROTECT and HEAL

- Gentle cleaning regimen
  - Baby soap, no washcloths, pat dry
- Sitz baths ("bleach bath")
  - Half-cup Clorox in tub of water
- Bland emollients
  - Aquaphor, Vaseline, Crisco
IRRITANTS and ALLERGENS

• IRRITANT: Skin irritation with immediate stinging
  Gels, alcohol, soaps: NON-SPECIFIC

• ALLERGEN: Delayed hypersensitivity
  1 exposure → 3 weeks of rash (e.g. poison ivy)
  SPECIFIC TO INDIVIDUAL
  Neosporin [Mycolog cream], Bacitracin

IRRITANT

ALLERGIC

Excoriated vulvitis

Allergy to Neosporin

CLC point: Cultural Beliefs

SKIN THERAPY

• Skin disorders tend to be CHRONIC
  Patients wrongly expect "overnight relief"

• Skin problems FLARE and REMIT
  It can be hard to tell what works

• It can take WEEKS or MONTHS to see results
  Schedule return visits for a month or two
CLC point: Physical Attributes/Qualities

**OBESITY, DIABETES, INFIRMITY**

- Examine the patient at each visit
  *She may be unaware of problems*
  *Talk to caregiver, but don’t assume they examine*
- Keep therapy simple (bleach bath, compress)
- Help patient obtain supplies
  *Cushions for wheelchair*
  *Absorbent diapers for incontinence*

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**WHAT IS THIS THING CALLED “LICHEN”?**
**LICHEN: [LIKE-in] “Change in texture”**

- **Lichenified**: thickened due to chronic rubbing or scratching
- **Lichenoid**: (pathology) band-like lymphocytic infiltrate, multiple causes

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**THE “BIG THREE” for GYN**

- **LICHEN SCLEROSUS et atrophicus (LS, LSA)**
  - Any age, pale skin, can itch, non-mucosal
  - Loss of vulvar architecture
- **LICHEN SIMPLEX CHRONICUS (LSC)**
  - Very common, itchy, thick from scratching
- **LICHEN PLANUS (LP)**
  - Rare, erosive oral/genital mucosa, adhesions

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**LICHEN SCLEROSUS: LS, LSA**

- 7-year-old child
- Classic hourglass
- Purpura
LICHEN SCLEROSUS

• Can begin in childhood
  Before puberty, Rx with hydrocortisone 2.5% cream
• Progression is variable
• Vulvar changes can be subtle, ask about other areas of involvement

LSA: Clobetasol 0.05% ointment,
2 x day for 2 months

LICHEN SCLEROSUS

• Elderly patients with lifelong LS may be at higher risk for VIN
• Biopsy persistent ulcers or thickened areas
“Increased skin markings,” thick, intensely itchy

LICHEN SIMPLEX CHRONICUS

- Thickening of the skin SECONDARY to chronic rubbing and scratching
- The initiating event is long gone
  - Candida vulvovaginitis
  - Contact dermatitis
  - Eczema
  - Ask patient why she thinks she has it

LSC: Clobetasol 0.05% ointment, 2 x day for 2 months
LICHEN PLANUS: LP

Violaceous papules
Oral striae, erosions
Mucosal only

• Autoimmune, cell-mediated disease
  Skin: wrists, shins

• Intense itching on non-genital skin
  Oral or vaginal mucosa
  Adhesions may obliterate vulvar architecture
  Erosive LP often spares non-mucosal skin

LP: Clobetasol 0.05% ointment,
2 x day for 2 months
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2. Lichen planus

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Compare and Contrast...
Clobetasol 0.05% ointment
2 x day for 2 months, THEN
Bedtime only for 2 months
OR
Daily for 2-3 weeks ONLY AS NEEDED

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CLOBETASOL PROPIONATE 0.05%

- Clobetasol 0.05% is a “superpotent” steroid
- Continuous application of 90gms per month will suppress the pituitary-adrenal axis
  *Patients are at risk for systemic problems (bone thinning, cataracts)*
- Don’t refill without seeing the patient at least twice so you know how reliable she is
TACHYPHYLAXIS

- Resistance to a medication that has been used for several months
- Not permanent – the medication can be used effectively again
- Use a high-potency topical steroid for flares and a medium-potency one for maintenance
  clobetasol 0.05% oint ➔ triamcinolone 0.1% cream

PATIENT INSTRUCTIONS

- Clobetasol is STRONG
  *It is only to be used as directed, for a limited time*
- Constant use will not only cause side effects, but it will make the skin resistant to it
- Use the least amount of ointment needed to control the problem

STEROID OVERUSE

- Easy bruising
- Skin atrophy and fragility
- Telangiectasias
- Permanent striae
STEROID REBOUND DERMATITIS
*Redness, burning, inflammation when steroid stopped*

CONTROL STEROID USE BY...
- **Amount prescribed:**
  One 45-gram tube of clobetasol ointment should last two months when treating the vulva twice daily
- **Frequency of application:**
  Twice daily for 2 mo, then once daily for 2 mo, then use for 2 weeks at a time as needed

RISK FACTORS for CANDIDA
- Diabetes
- Erosive vaginitis or lichen planus
- Chronic antibiotics
- Oral or inhaled steroids
  - **Using topical steroids on the vulva**
CANDIDA SUPERINFECTION

*Candida: satellite pustules*

- Nystatin powder comes in 15 gm (that’s not much)
- Ketoconazole 2% lotion or cream is better
- Diflucan 150mg per week or biweekly

CANDIDA SUPPRESSION REGIMEN

FLUCONAZOLE 150 mg, # 16 total

*One p.o. weekly for two months, (8 tabs)*

*Biweekly for two months, (4 tabs)*

*One p.o. monthly for 4 months (4 tabs)*

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BEYOND “VULVITIS” 616.10

Dermatitis, non-specific, inflammatory 692.9
Contact dermatitis: medications 692.3
Intertrigo: 695.89 (groin folds, under breasts)
Candida, skin: 112.3 (Candida vaginitis: 112.1)
Lichen planus: 697.0
Lichen sclerosus: 701.0
Psoriasis: 696.1
Dyschromia, abnormal pigmentation: 709.00

ICD-9 CODING: ITCH

698._ Pruritus (itching)
   .0 ani
   .1 vulvae (genital)
   .3 lichen simplex chronicus
   .4 neurotic excoriation
   .9 nonspecific

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Many different agents available, choice depends on:
- Severity and extent: body surface area, arthritis, limitation in activities of daily living
- Patient’s general health: Hx hepatitis, HIV limits use of antimetabolites (MTX) or biologics
- Send patient to Dermatology
SYSTEMIC DISORDERS

Behçet’s
Subacute cutaneous LE
Crohn’s

CONSULTATIONS & REFERRALS

• SYSTEMIC DISORDERS
  Rheumatology: Behçet’s disease, lupus
  Gastroenterology: Crohn’s disease
  Infectious Disease: HIV/AIDS complications
  Dermatology: differential diagnosis of...
    Recurrent ulcers and erosions
    Blistering disorders (pemphigus, pemphigoid)
    Pyoderma gangrenosum

HIDRADENITIS: Early & Late

• EARLY STAGE: Dermatology
  Folliculitis, boils on groin, axillae, breasts
  Doxycycline, TMP-SMX
  Bleach baths to decrease bacterial load

• LATE STAGE: Surgery (Gyn, General, Plastics)
  Abscesses, sinus tracts
  Excision of affected areas
WHICH ONE IS PAGET’S DISEASE?

1. 
2.

PAGET’S vs ECZEMA

- Nipple eczema is common (often on both breasts) and responds well to mid-potent topical steroids, e.g. triamcinolone 0.1%
- Patients typically have Paget’s lesions for months (or years) before a diagnosis is made
- Re-examine nipple eczema and perianal rashes after treatment to confirm clearing
- Biopsy if lesions look unusual
IMMUNE-COMPROMISED PTS

Granulomatous herpes, resistant to Rx in HIV

Common disorders or infections can appear unusual or be extensive

PIGMENTARY CHANGES

Vitiligo  Post-inflammatory  Vitiligo + LSC

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SYSTEMIC: “ITCHING ALL OVER”

- Diabetes
- Thyroid disease
- Anemia
- Renal failure
- HIV/AIDS
- Lymphoma/leukemia
- Psychiatric (OCD, delusional parasitosis)

PROTECT and HEAL

- GENTLE CLEANSING
  Baby soap, no washcloths, pat dry
- SITZ BATHS (“Bleach Bath”)
  Half-cup Clorox in tub of water
  (1/4 cup in half tub water)
- BLAND EMOLLIENTS
  Aquaphor, Vaseline, Crisco

SKIN THERAPY TIPS

- Manage patient expectations from the beginning – skin problems take weeks to resolve
- Choose the best topical for the job
- Know the most important question to ask a patient about her medication
WHY TOPICALS DON’T WORK

- PROBLEM PHYSICIAN
  - Wrong medication (or potency)
  - Inappropriate vehicle
  - Condition is resistant

- PROBLEM PATIENT
  - Med not used appropriately (or at all)
  - Patient dislikes medication
  - Patient dislikes caregiver

“Oh, I’ve had that and...”

- It makes it worse
- I’m allergic to it
- It doesn’t work any more
- It never works

“Oh, I’ve had that and...”

- It makes it worse
  - Candida superinfection? Needs steroid?
- I’m allergic to it
  - Immediate stinging is irritant, not allergic
- It doesn’t work any more
  - Tachyphylaxis – change drug to equivalent
- It never works
  - It comes back when you stop?
OINTMENTS, not CREAMS

- Ointments have fewer additives and preservatives (less likely to cause allergy)
- Occlusion helps medication penetrate skin
- Patients may not like them as well
  
  *Give a high-potency steroid ointment for flares*  
  *Give a steroid cream for maintenance*

TELL PATIENTS TO...

- Apply medication to lesions and rub in well
- Once it has been on for half an hour, don’t worry about wiping it off with toilet tissue (don’t reapply each time)
- Use med as directed
  
  *Whether skin improves or not, keep using med until next visit*  
  *Only stop if the problem gets worse after a week*  

The next time you see a vulvar rash, try to THINK LIKE A DERMATOLOGIST