VULVAR DISEASE PROTOCOLS

WHITE LESIONS OF THE VULVA

Summary from E. G. Friedrich, M.D.

The vast majority of these problems represent dystrophy - a benign condition that is often reversible with correct diagnosis and therapy. Biopsy is necessary to establish the diagnosis, and essential if symptoms are not resolving with treatment.

Hyperplastic dystrophy is a nonspecific response of the vulvar skin to a variety of irritants and is characterized by a whitened thickened skin that histologically demonstrates hyperkeratosis, acanthosis and inflammation. Topical Valisone with Eurax added for its antipruritic effect usually brings about resolution once the inciting factor has been identified and removed. 6 to 12 weeks of treatment may be required. Also discuss gentle perineal hygiene to prevent re-irritation of sensitive skin.

Lichen sclerosus is a disease of unknown etiology that may affect all age groups. The vulva is the most common site of occurrence and a thin, wrinkled, white skin results. Biopsy shows a thin epithelium with loss of the rete ridges and a subepithelial homogeneous zone of dermis. The epithelial cells are capable of growth but are prevented from doing so due to some unidentified agent.

1. Start with 1% hydrocortisone dream or desonide 0.06% ointment or cream, BID.
2. Advance to medium potency steroids, such as Triamcinolone 0.1% cream for more severe disease, but monitor closely for thinning in areas that already are atrophic
3. For severe, symptomatic disease, consider temovate 0.05% ointment BID X 4 weeks, then re-evaluate for signs of skin atrophy. May maintain with daily application instead of BID, and then weekly application as needed.
4. Testosterone 2% cream may be useful only if disease is resistant to topical steroids.

Topical 2% testosterone propionate has resulted in symptom relief, arrest of the dissolution process and histologic improvement. B.I.D. application for about 6 weeks is usually necessary followed by 6 more weeks at a reduced dosage.

It is not uncommon for treatment to be life long.

Mixed dystrophies exist wherein patches of hyperplasia are noted in areas of lichen sclerosus. Treatment schedules for this entity combine Valisone and Testosterone applications in an alternate manner.

Atypias may exist in any hyperplastic lesion. Mild degrees of atypia are treated conservatively but severe atypias should probably be regarded in a manner similar to that for carcinoma in situation.

RED LESIONS OF VULVA

Summary from Peter J.Lynch, M.D.

The red lesions of the vulva are inflammatory in nature and as such, are usually pruritic or painful or both. These lesions may be subdivided into three morphologically characteristic groups. The first, the papulosquamous lesions, are less acute and have marginated borders. Scale is generally present though it may be unapparent because of moisture. The second, the dermatitis-eczema lesions, are more acute and have poorly marginated borders. Weeping and crusting is usually present in addition to varying amounts of scale. The third has, in addition to redness, small-superimposed pustules. Although these are usually quite visible, scratching sometimes breaks the pustules leaving small erosions.

The major diseases in the papulosquamous group include psoriasis, tinea cruris and tinea versicolor. Psoriasis is recognized primarily by the presence of typical psoriatic lesions elsewhere on the body especially the scalp, elbows and knees. In addition, the Koebner phenomenon and nail pitting may be present. Halogenated topical steroids are the treatment of choice. Tinea cruris is characterized by the presence of bilateral plaques on the inner thighs with relative sparing of the genitalia. "Athletes foot" may be present and, of course, if the KOH and culture are positive, Tinactin, Lotrimin, or Micatin are the treatment of choice. Tinea versicolor is characterized by the presence of typical lesions elsewhere, a brown-red color, and a positive KOH.

The major diseases in the dermatitis-eczema group include contact dermatitis and seborrheic dermatitis. Contact dermatitis is characterized by the history of new medication or cosmetic use and is treated by the removal of the suspected agents, soaks and Hydrocortisone. Seborrheic dermatitis is characterized by location in skin folds with little extension onto nonintertriginous skin. The treatment is removal of maceration and the application of Hydrocortisone. The itch-scratch cycle is characterized by the presence of excoriations and the history of subconscious scratching. The cycle may occur de nova or may be superimposed on some other vulvar disease. Treatment includes nail care, the use of steroid ointments and often short-term sedation.

The major diseases in the pustular group include candidiasis and folliculitis. Candidiasis is characterized by a vaginal, vulvar and (if extensive), intertriginous distribution. The major areas of disease may be free of pustules, but almost always where there is extension onto nonmucosal surfaces, small pustules can be found on the advancing border. Vaginal Monistat and Lotrimin solution applied to the vulvar area are the treatment of choice. Topical steroids may be necessary if itching is severe. Folliculitis is characterized by isolated pustules with an erythematous base. There is no associated vaginitis. Reduction in skin irritation and topical antibiotics are appropriate treatment.
For severe yeast infections, especially if recurrent: R/O diabetes. Fissures and dyspareunia are common findings in recurrent yeast infections.

DARK LESIONS OF THE VULVA

Biopsy is necessary to establish the diagnosis. These lesions include carcinoma, melanoma, lentigo, nevi, trauma and seborrheic keratoses.

Ulcerative Lesions of the Vulva

Herpes Genitalis	Syphilis	Basal Cell Tumors
Behçet's Disease	Granuloma Inguinale	Tuberculosis
Crohn's Disease	Pemphigus Vulgaris	Carcinoma
Traumatic Ulcers	Undetermined Etiology	

Herpes is most common. Carcinoma and syphilis are less common. Others are rare. Herpes is characteristically painful ulcerated lesions with an erythematous edge. Herpes can also present similar to a severe yeast infection. If yeast does not respond to treatment, think about herpes as a cause.
Syphilis lesions are not painful.