THE ITCHY VULVA

2021

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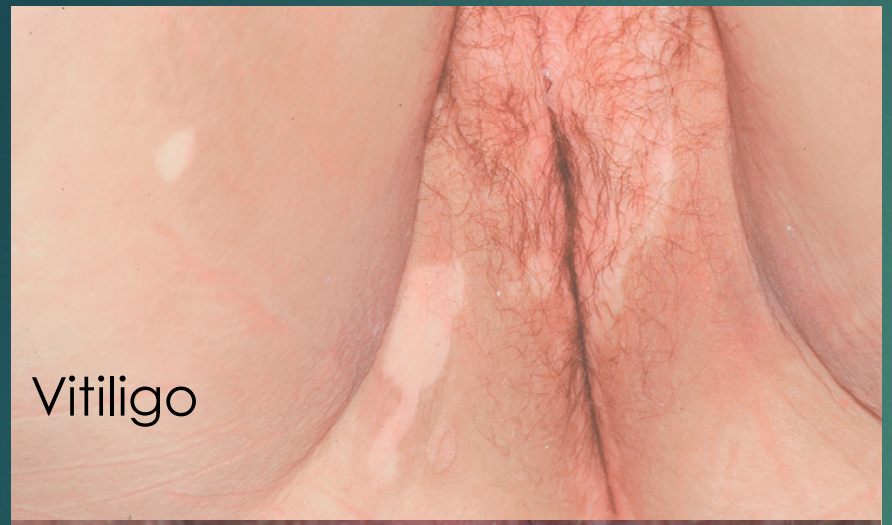
OBJECTIVES

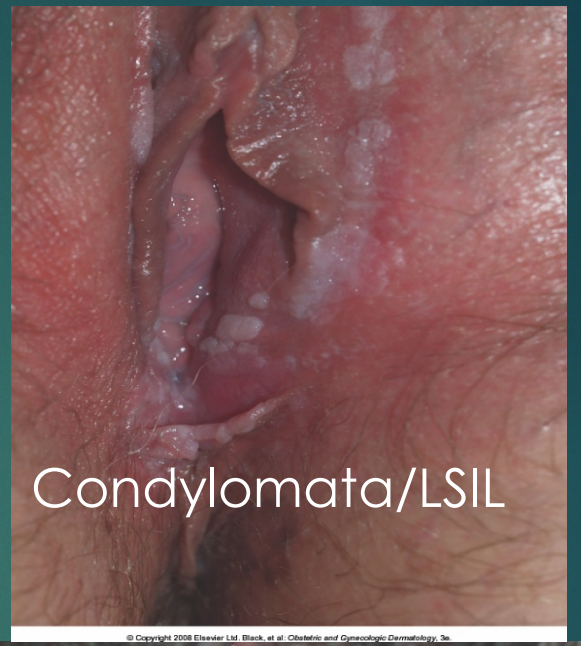
- To recognize diagnostic clinical features of the most common inflammatory vulvar disorders
- To gain an understanding of the current recommendations for safe and effective management of these disorders
- DISCLOSURES: None
- Most treatments are “off-label”

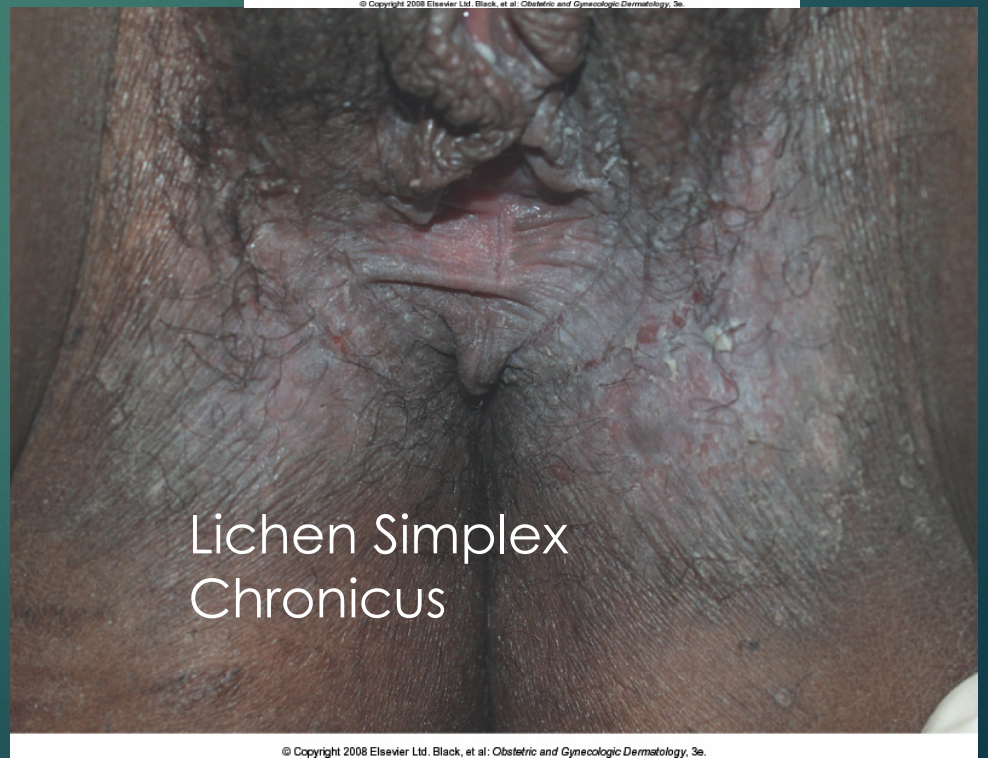
WHY is this important?

- 1 in 6 women experience undiagnosed and untreated vulvovaginal discomfort at some point in their lives
- May present late due to anxiety/embarrassment/home remedies
- Treatment of vulvar disorders → improves quality of life
- ALWAYS EXAMINE THE VULVA

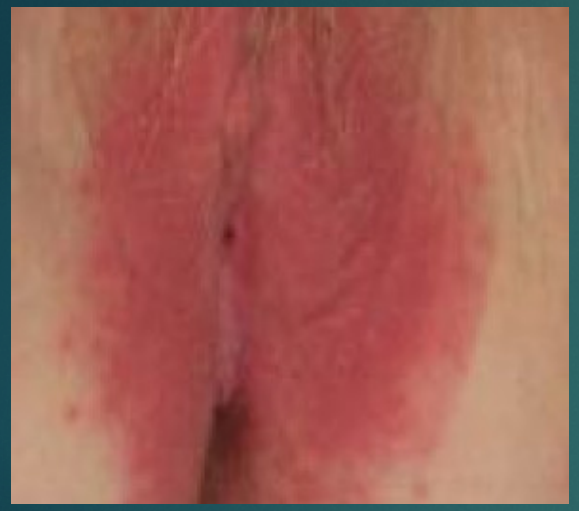
All that is white is *not* Lichen Sclerosus



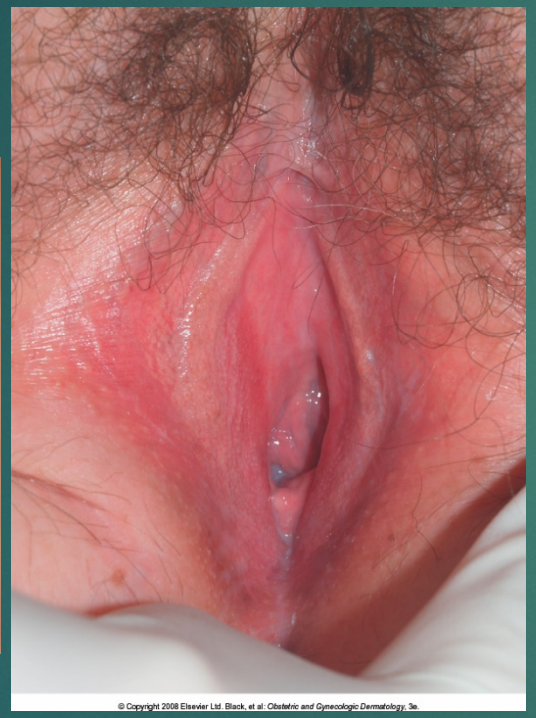




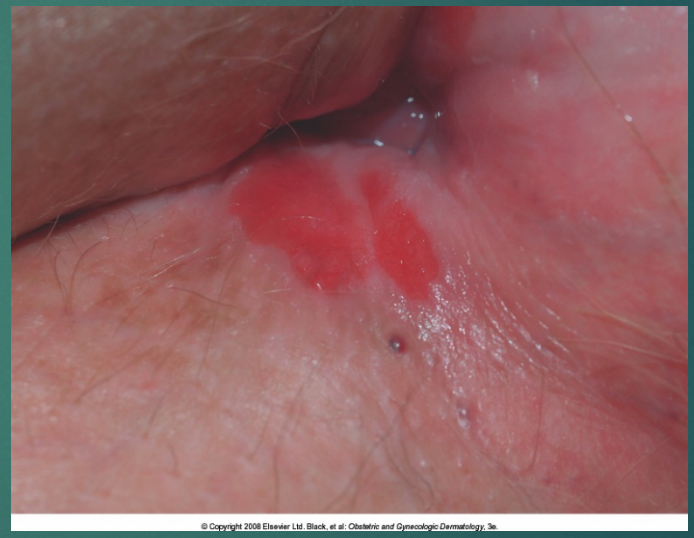
All that is red is *not* Candida



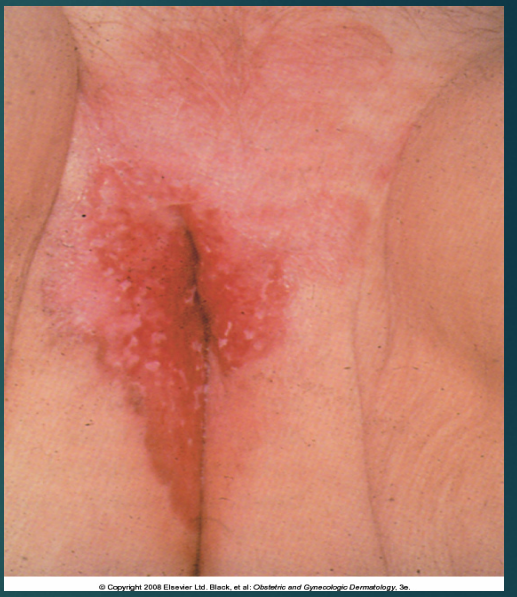
Vulvar candidiasis



Irritant contact vulvitis



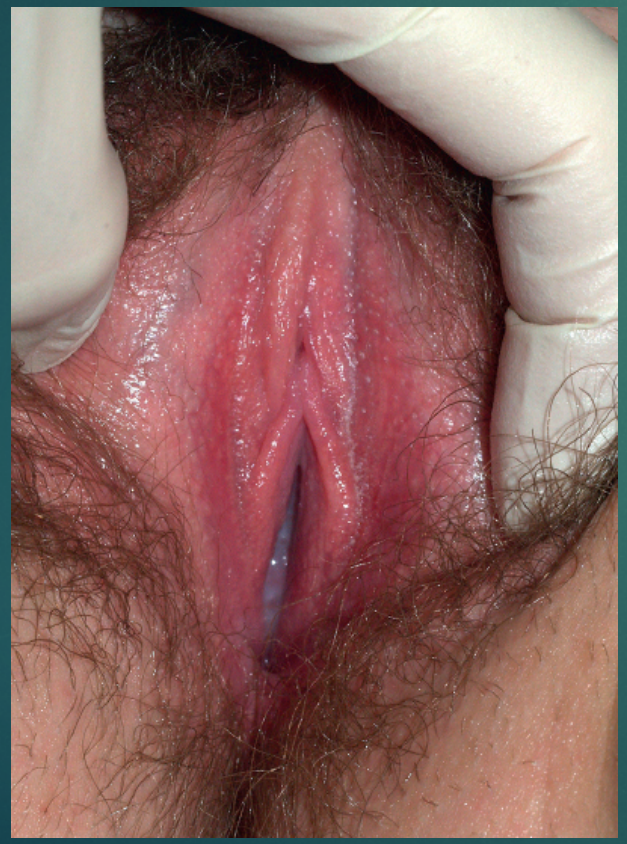
VIN (LSIL/HSIL)



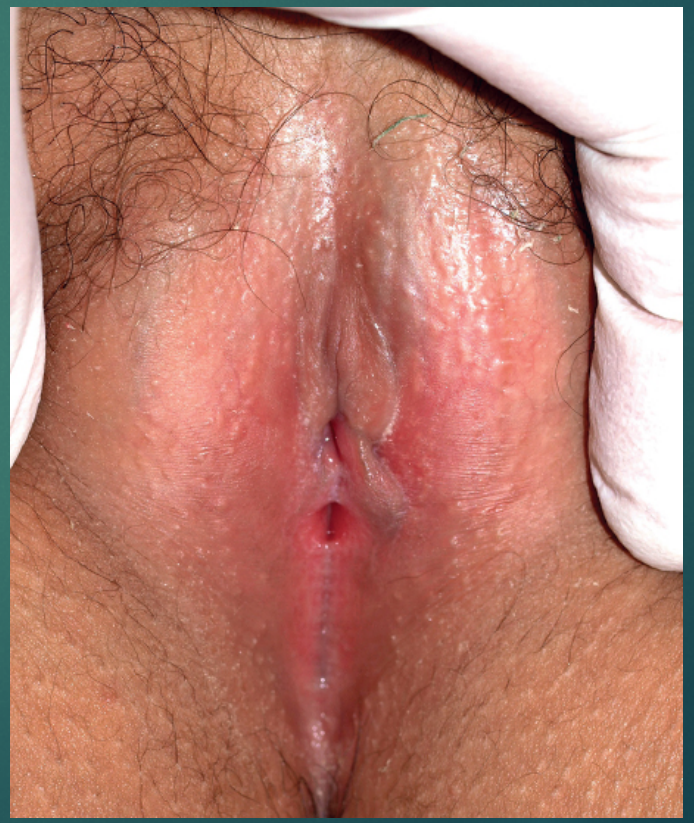
Paget's Disease

LOOK FOR ABNORMAL VULVAR ANATOMY

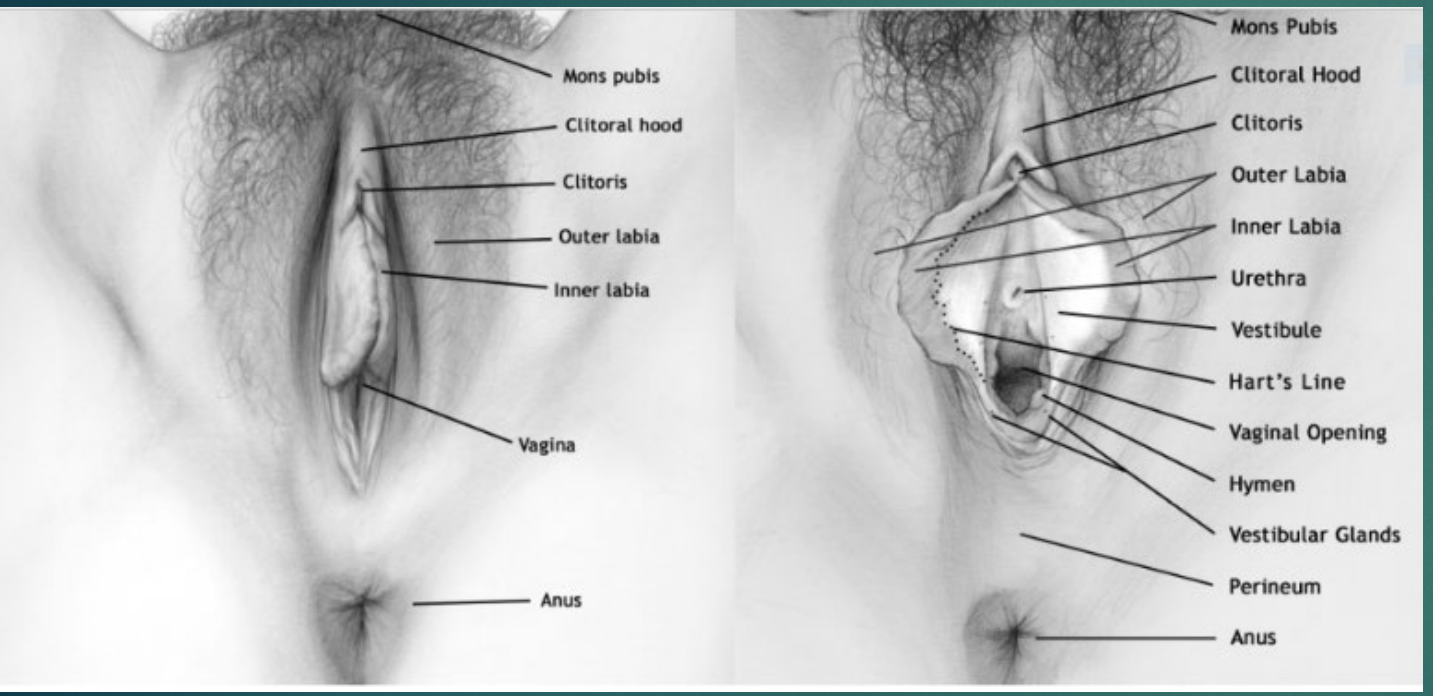
- NORMAL VULVA



- ALTERED VULVAR ARCHITECTURE



Vulvar Epithelia



- Keratinized (hair-bearing) skin (mons, inguinal, lab majora)
  → *dermatitis, psoriasis*

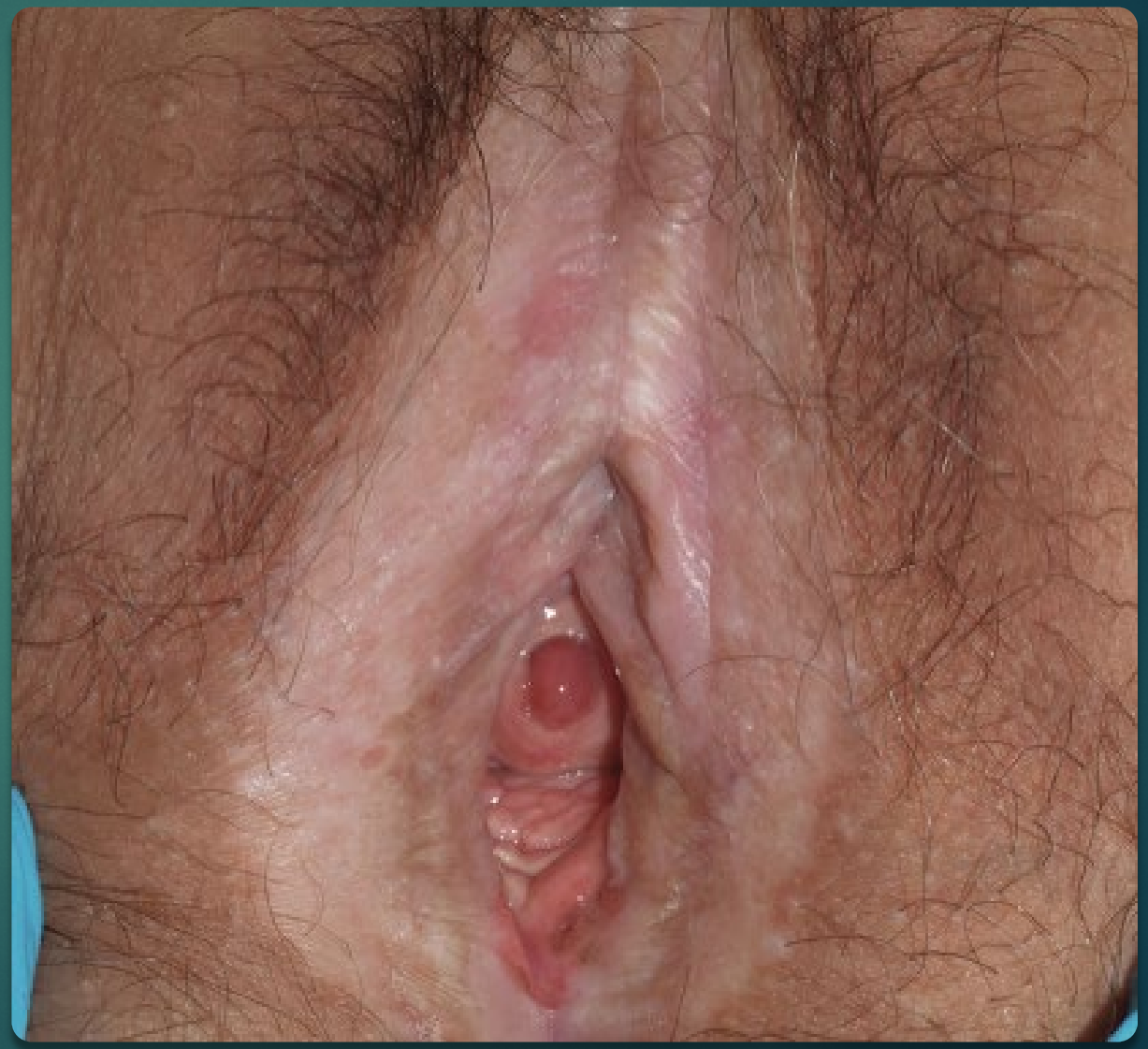
- Partially keratinized, modified mucous membrane (interlabial sulci, outer lab min to Hart's Line, clitoral hood, post fourchette)
  → *LS*

- Mucous membrane(inner lab min)
  → *LP*

Causes of Vulvar itch

- Lichen Sclerosus
- Lichen Planus
- Vulvar Dermatitis: contact, atopic, seborrheic, atrophic
- Lichen Simplex Chronicus
- Infection: candidiasis >staph, strep
- Psoriasis
- Plasma Cell Vulvitis

LICHEN SCLEROSUS



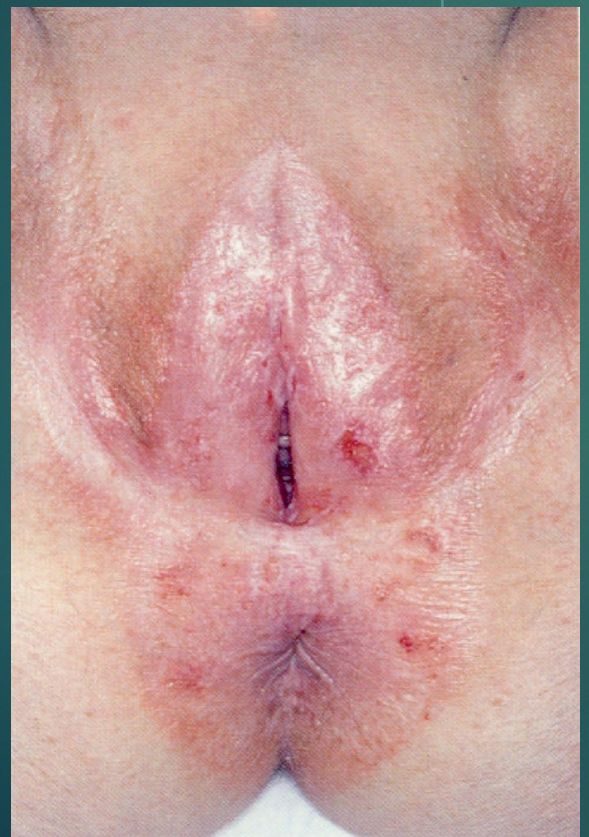
LICHEN SCLEROSUS

- chronic inflammatory, autoimmune* disease of vulva, perineum, perianal area (almost never vagina**)
- presents most frequently in caucasian postmenopausal women
- 10-15% of cases occur in children (itch, constipation)
- 15-20% have extragenital lesions (less symptomatic)
- increased incidence autoimmune thyroid disease, vitiligo, lichen planus, +/- psoriasis, morphea

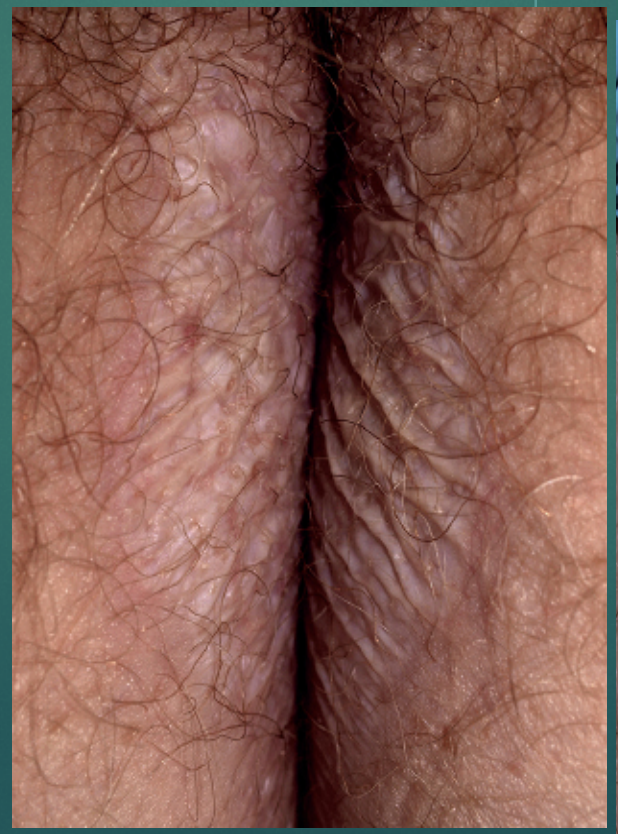
*Not a contraindication for Covid Vaccine!

LICHEN SCLEROSUS

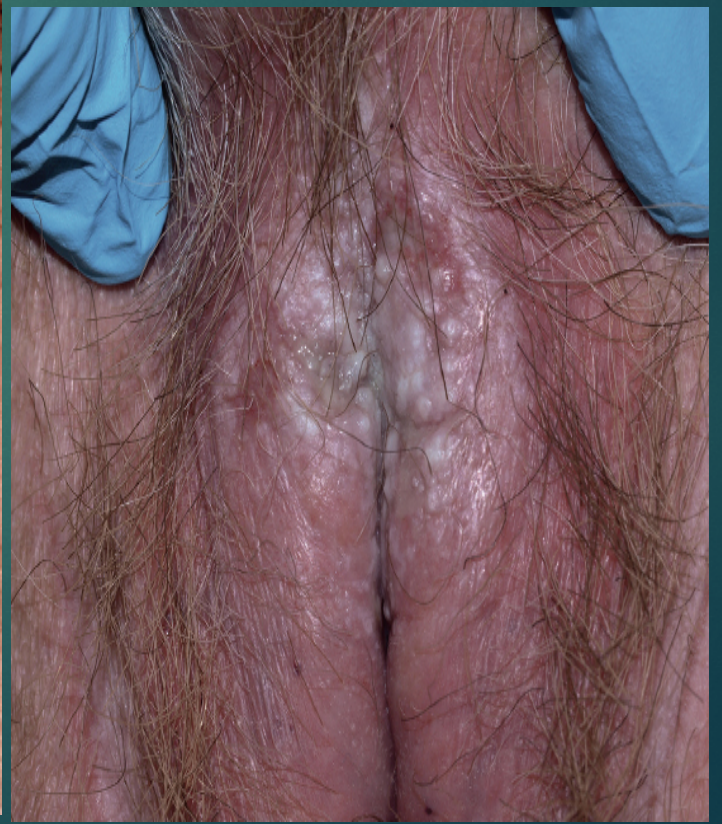
Figure of 8



Atrophic LS

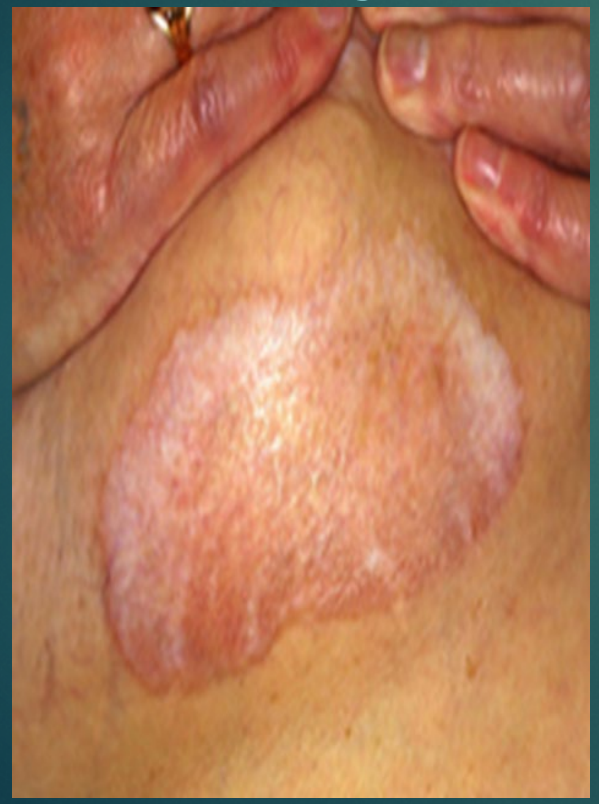


Hypertrophic LS

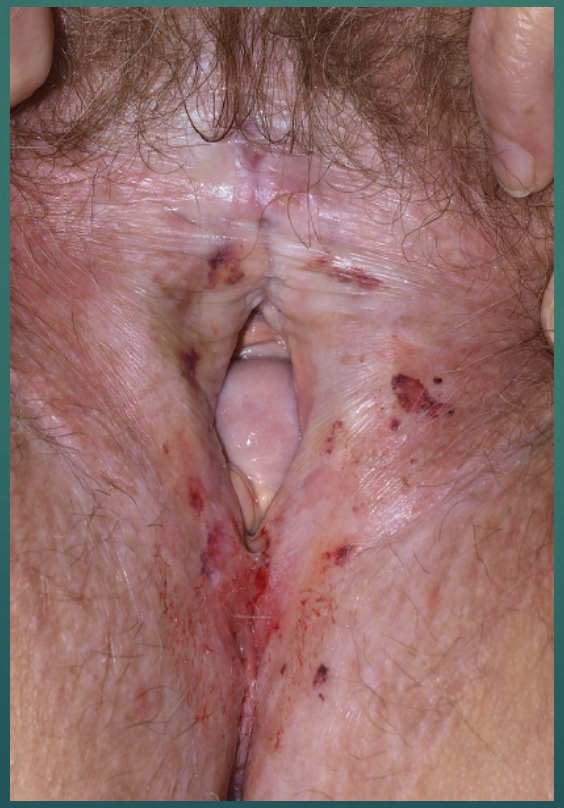


LICHEN SCLEROSUS

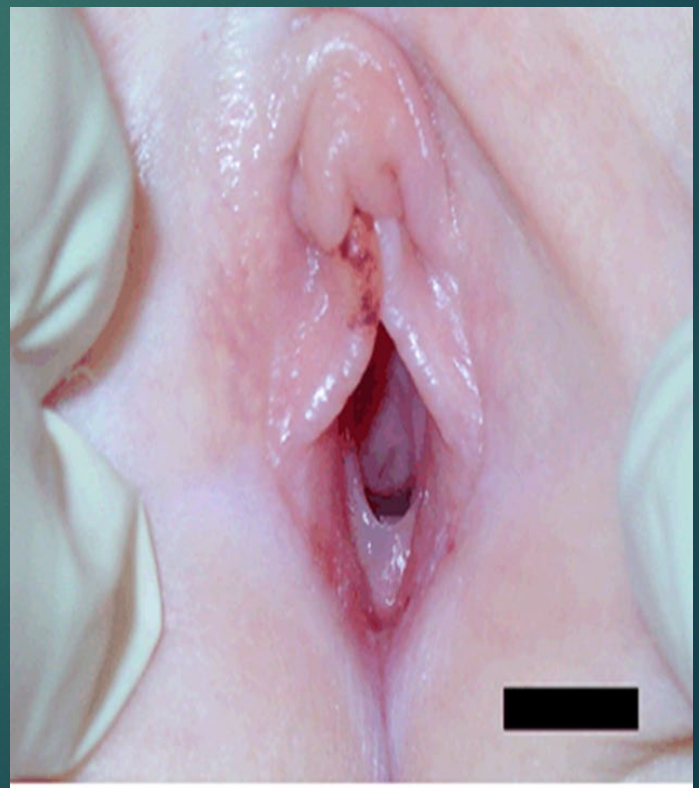
Extragenital LS



LS with purpura



Pediatric LS



Lichen sclerosus in a four year old Note the

LICHEN SCLEROSUS - TREATMENT

- *Objectives:*

  1] control symptoms

  2] prevent further loss of vulvar structures

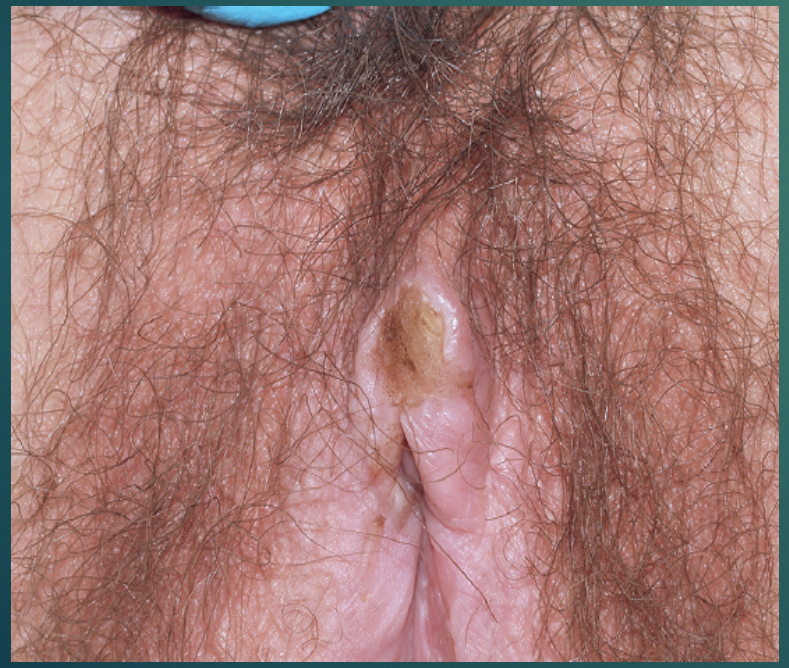
  3] reduce long-term risk of SCCa *

- **Evidence*: JAMA Dermatol.2015:151(10):1061-1067 Lee et al

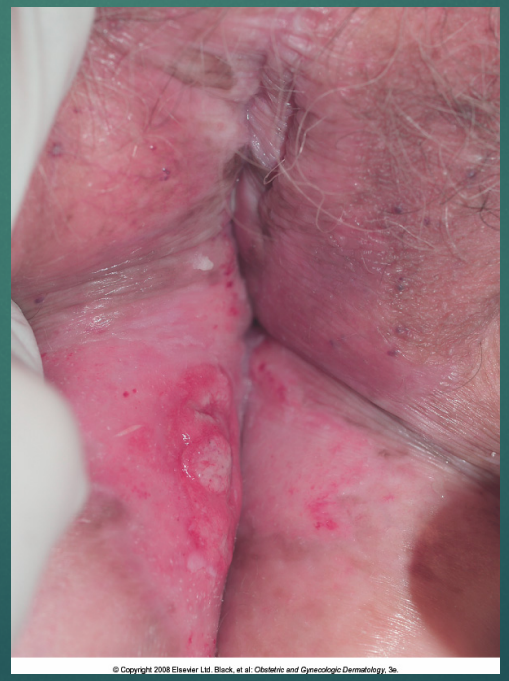
SCCa in LS

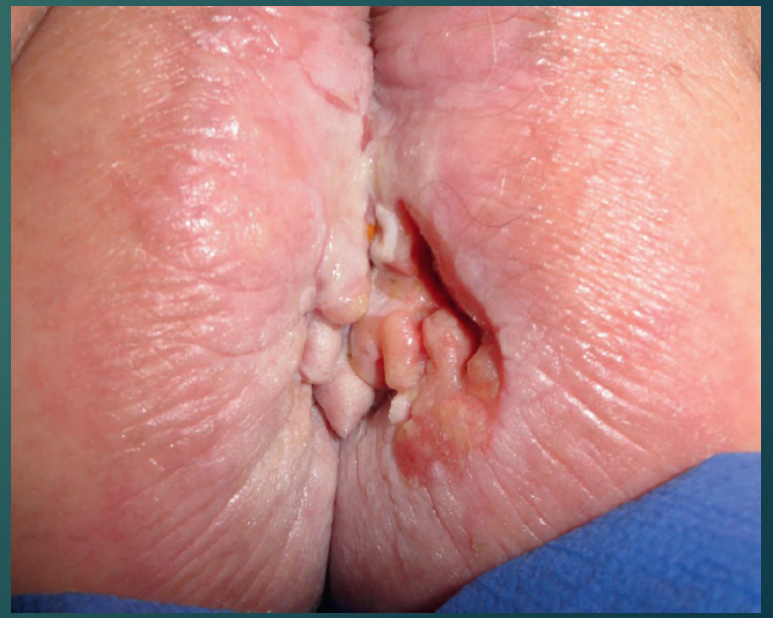
3-5%, high risk: severe, longstanding LS

dVIN in LS



SCCa in LS





LICHEN SCLEROSUS - Treatment

Initial:

Clobetasol 0.05% **ointment**

- ½ pea-size
- BID x 2-4 months, then OD x 1-2 months, reassess
- +/- local estrogen replacement

Maintenance:

- Clobetasol 0.05% **ointment** 2-3 x per week, reassess 4-6 mos. **OR** taper to less potent steroid (eg Betamethasone valerate) od
- Alternate: tacrolimus 0.1% ung od

LICHEN SCLEROSUS – Treatment

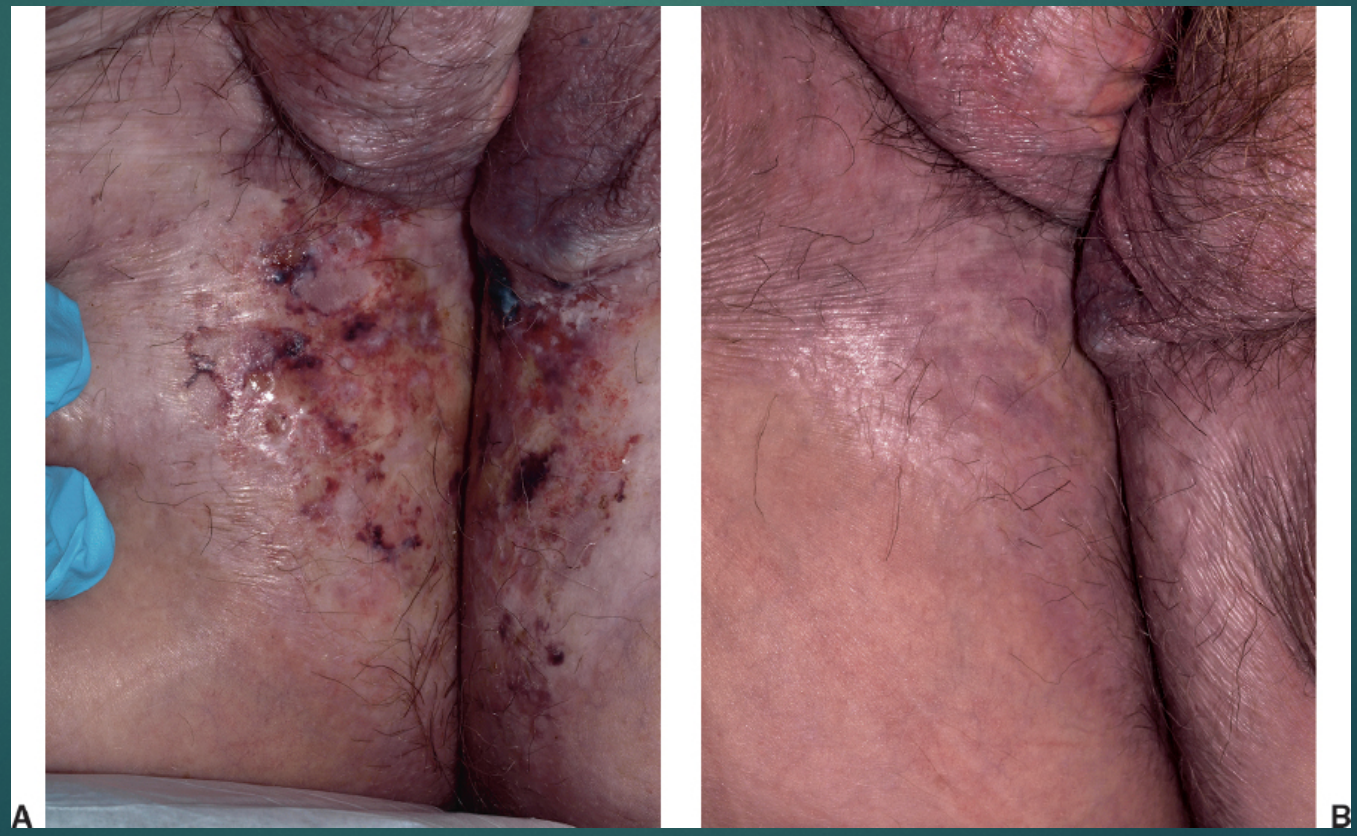
*******Must continue treatment indefinitely******

- Followup q 6-12 mos
- Biopsy ulcerated or indurated lesions to r/o SCCa
- Resistant or severe: systemic steroids, retinoids, methotrexate, cyclosporin
- Unproven: CO2 laser, Platelet-rich plasma, adipose-derived stem cells

LICHEN SCLEROSUS - Treatment

Before

After 6 mos



LS NONRESPONDERS

- Consider:
  - not using prescribed treatment
  - applying ointment incorrectly
  - secondary infection
  - poor vulvar skin care
  - more than one diagnosis
  - incorrect diagnosis
  - dVIN, SCCa

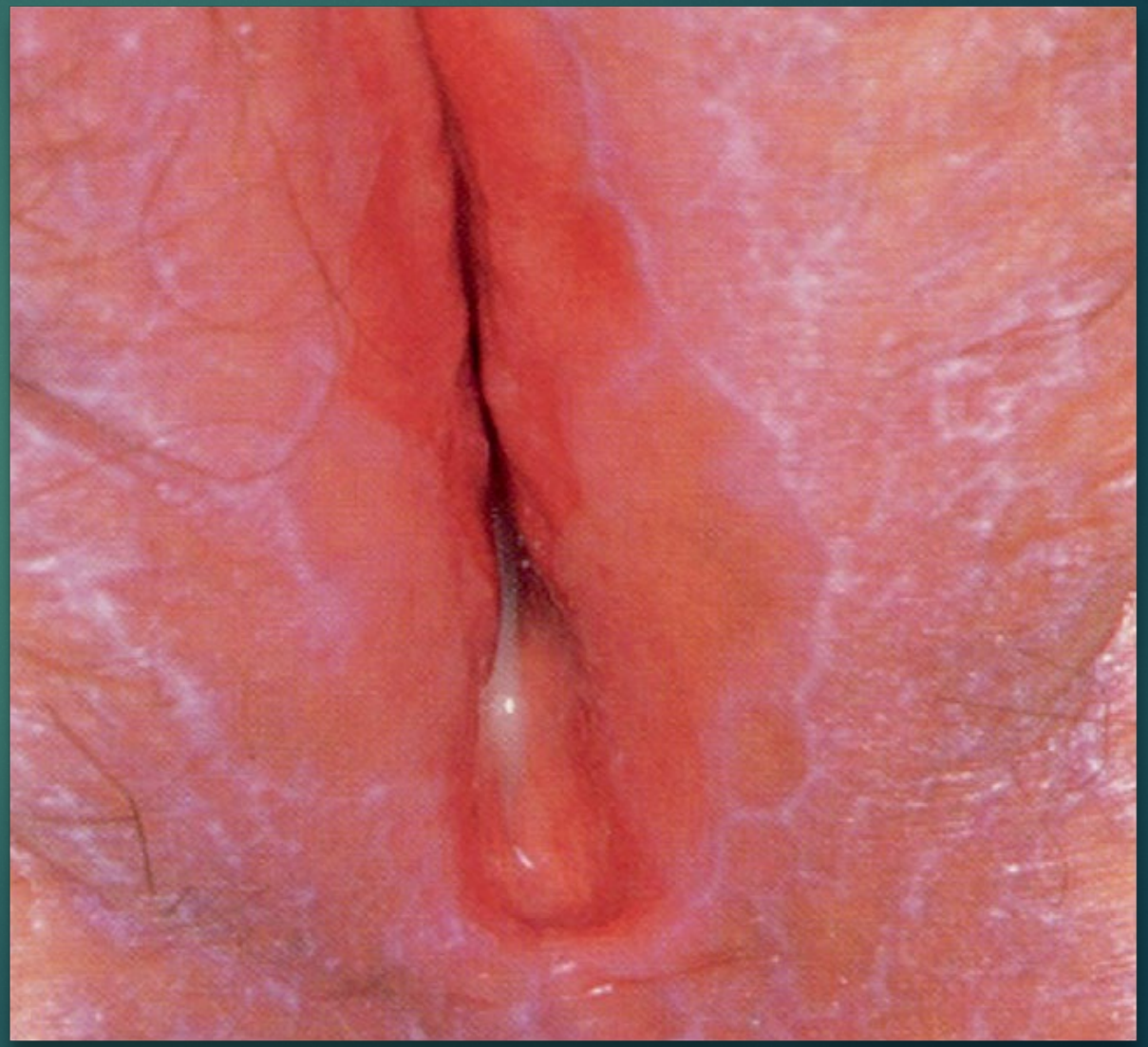
LICHEN PLANUS

Bright red patches
May be eroded
Symmetrical

Border: white lacy patches

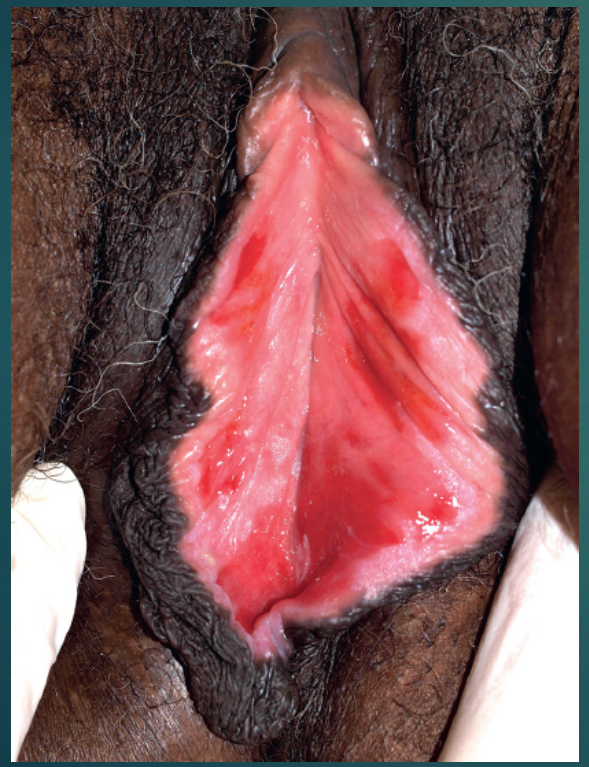
itchy and/or painful

Frequent oral involvement

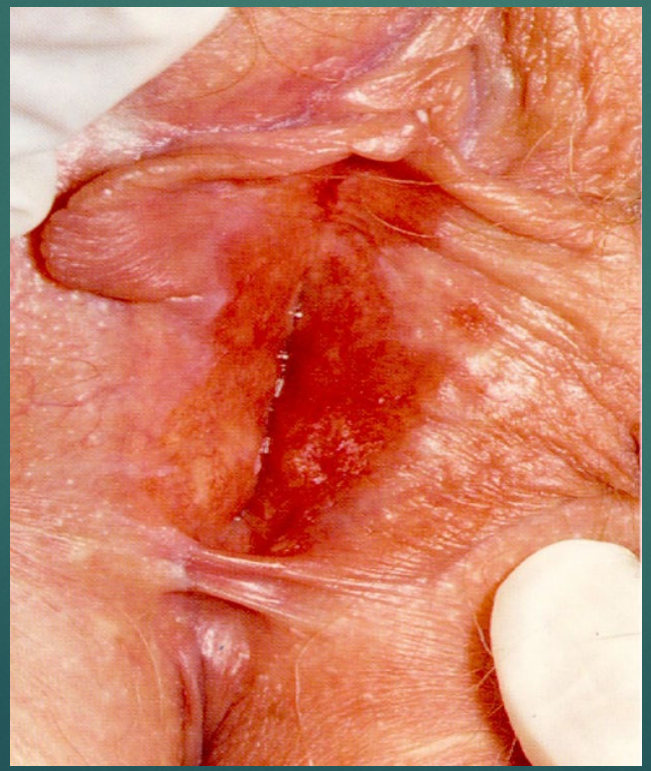


LICHEN PLANUS

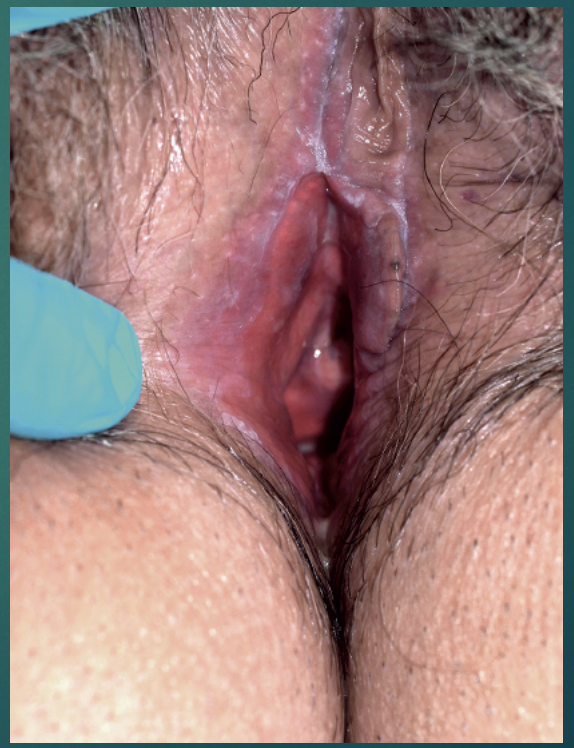
EROSIVE LP



EROSIVE LP

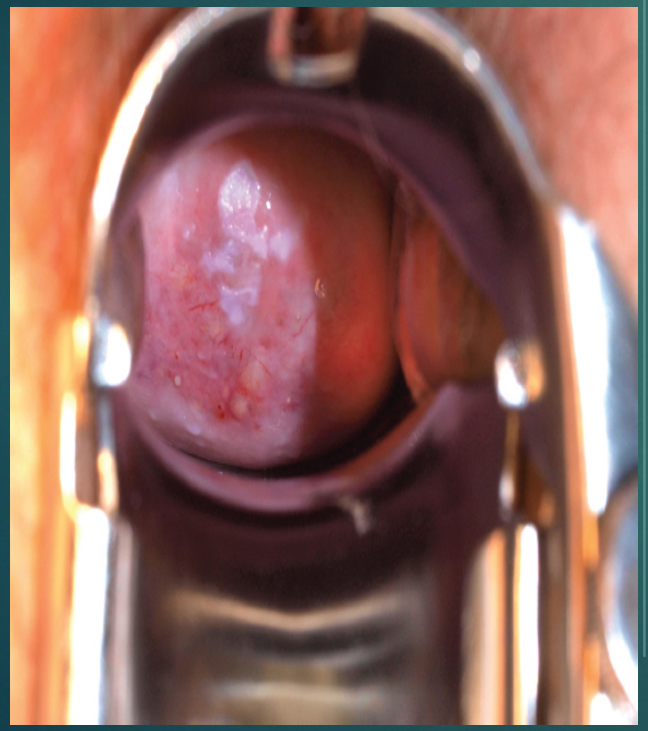


VULVAR LP

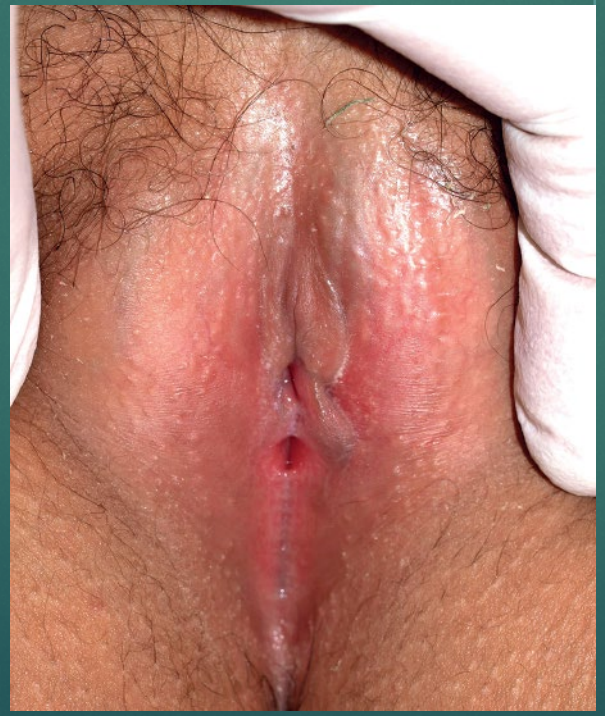


LICHEN PLANUS

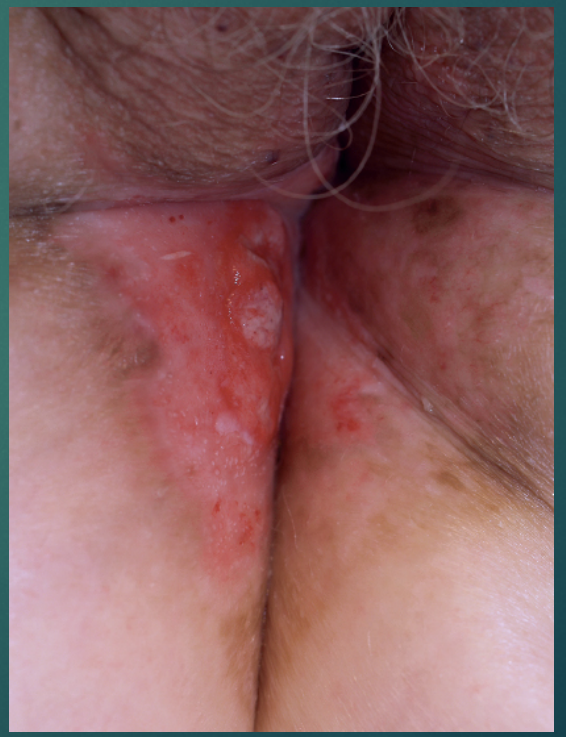
VAGINAL LP [70% / DIV]



SCARRING

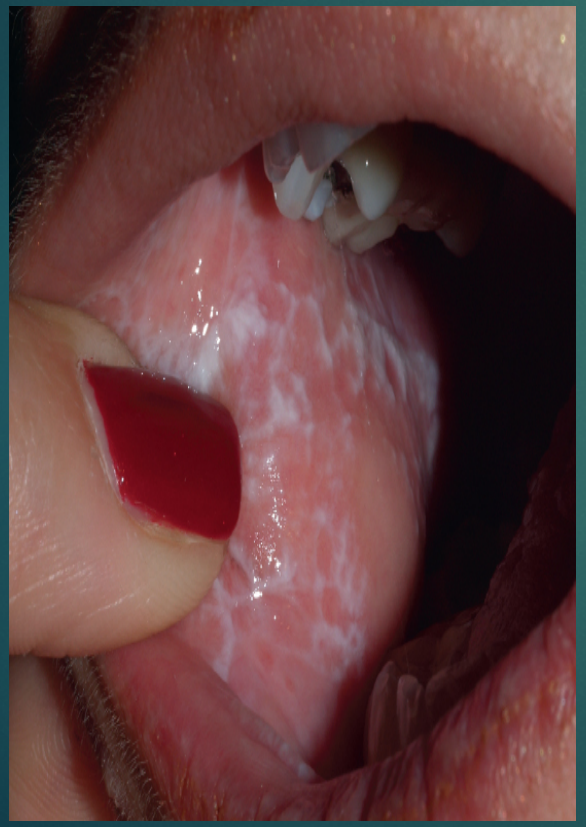


SCCa [3-5%]

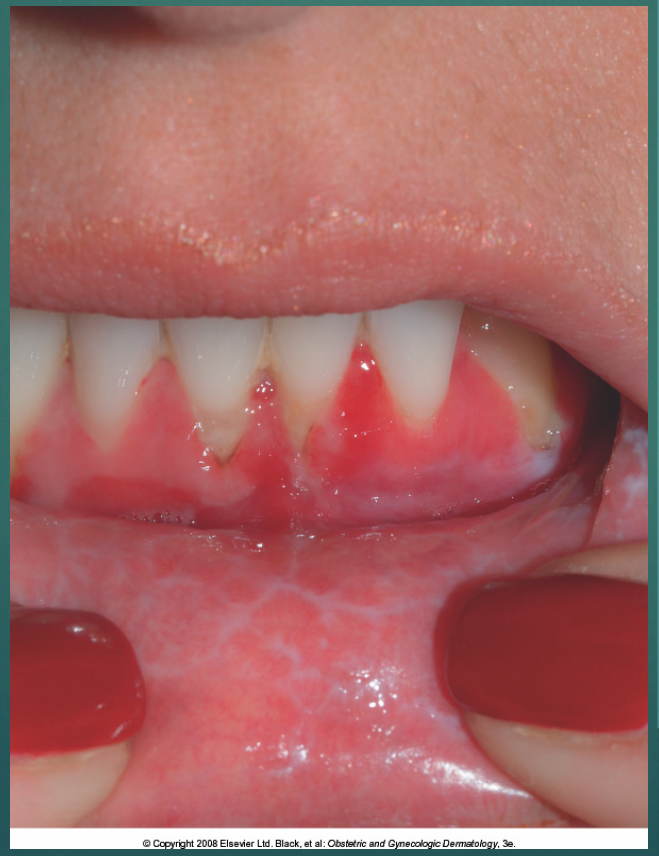


LICHEN PLANUS

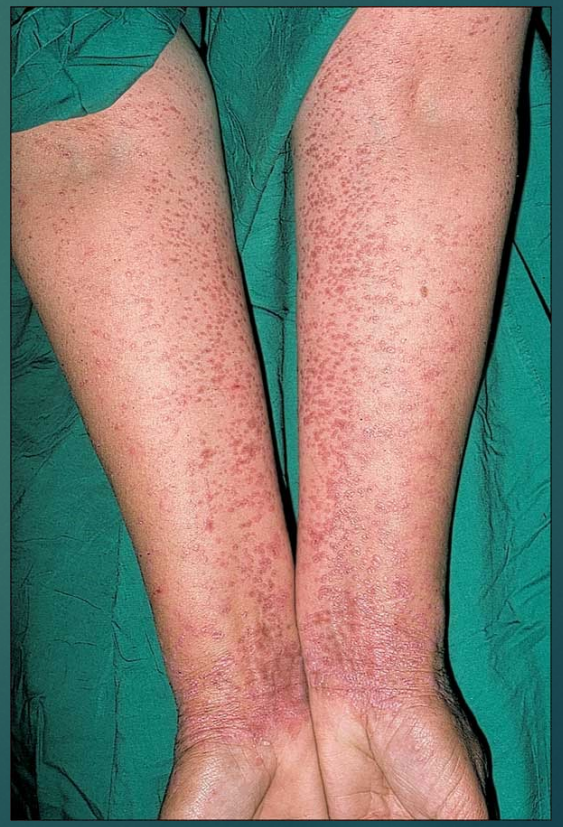
BUCCAL LP



GINGIVAL LP



CUTANEOUS LP



LICHEN PLANUS - Treatment

Vulvar

- *Initial:* clobetasol 0.05% ointment bid x 1 - 3 months
- Maintenance: medium-potency topical steroid bid **prn** OR tacrolimus 0.1% ointment bid **prn**

- +/- intralesional triamcinolone 3 mg/ml q 6-8 wks
- *+/- topical estrogen*

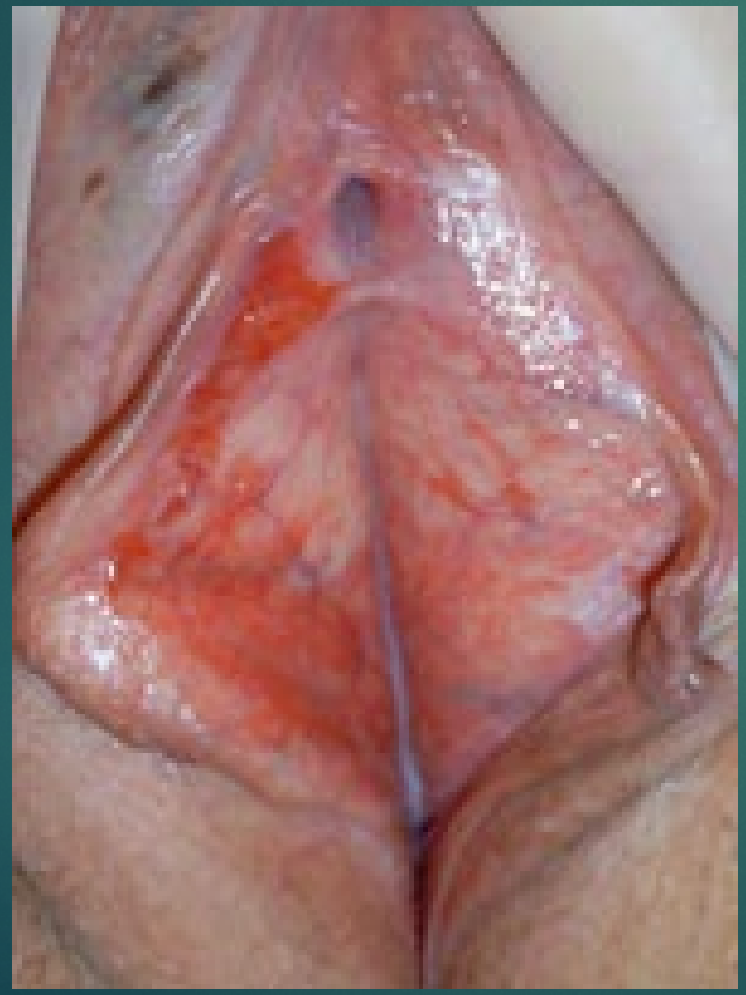
Vaginal

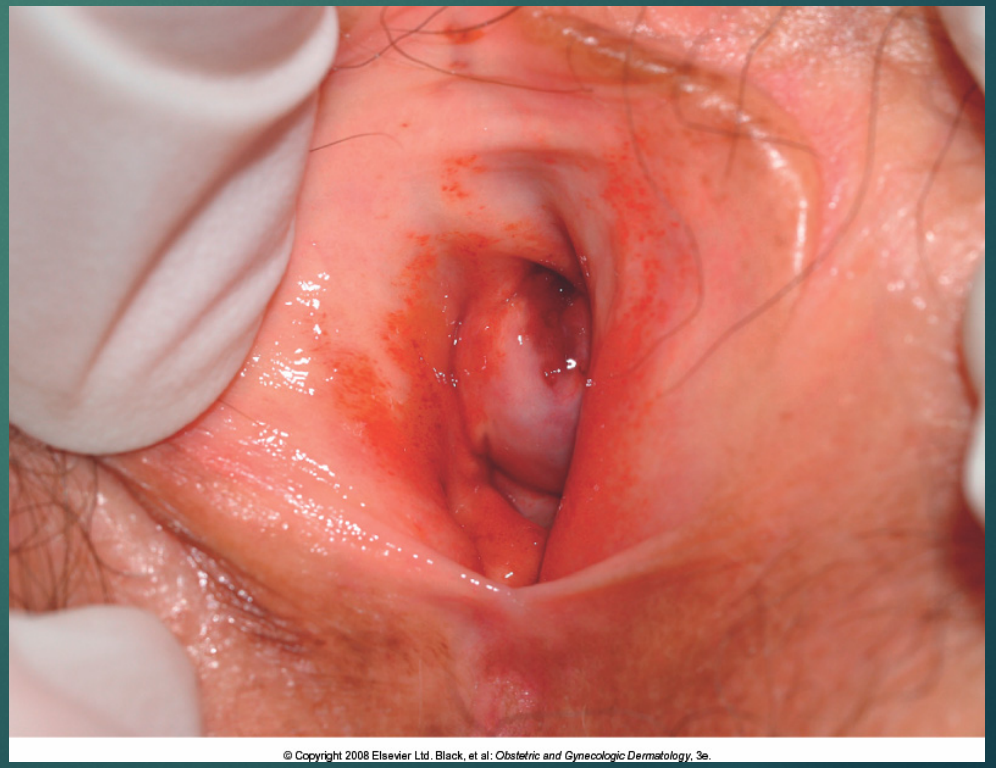
- Clobetasol or fluocinonide cream 0.5-1 gm pv hs (applicator/tampon)
- Corticosteroid rectal suppositories/foam pv
- *+ vaginal estrogen*
- *Dilators 3x/wk*

LICHEN PLANUS - Treatment

- **Systemic treatment: rarely needed**
  - prednisone 40 mg daily orally; taper
  - triamcinolone IM 1mg/kg q 4-6 weeks
  - antimalarials, methotrexate, oral retinoids, cyclosporin, mycophenolate mofetil, etanercept, adalimumab

ZOON'S PLASMA CELL VULVITIS





ZOON'S PLASMA CELL VULVITIS

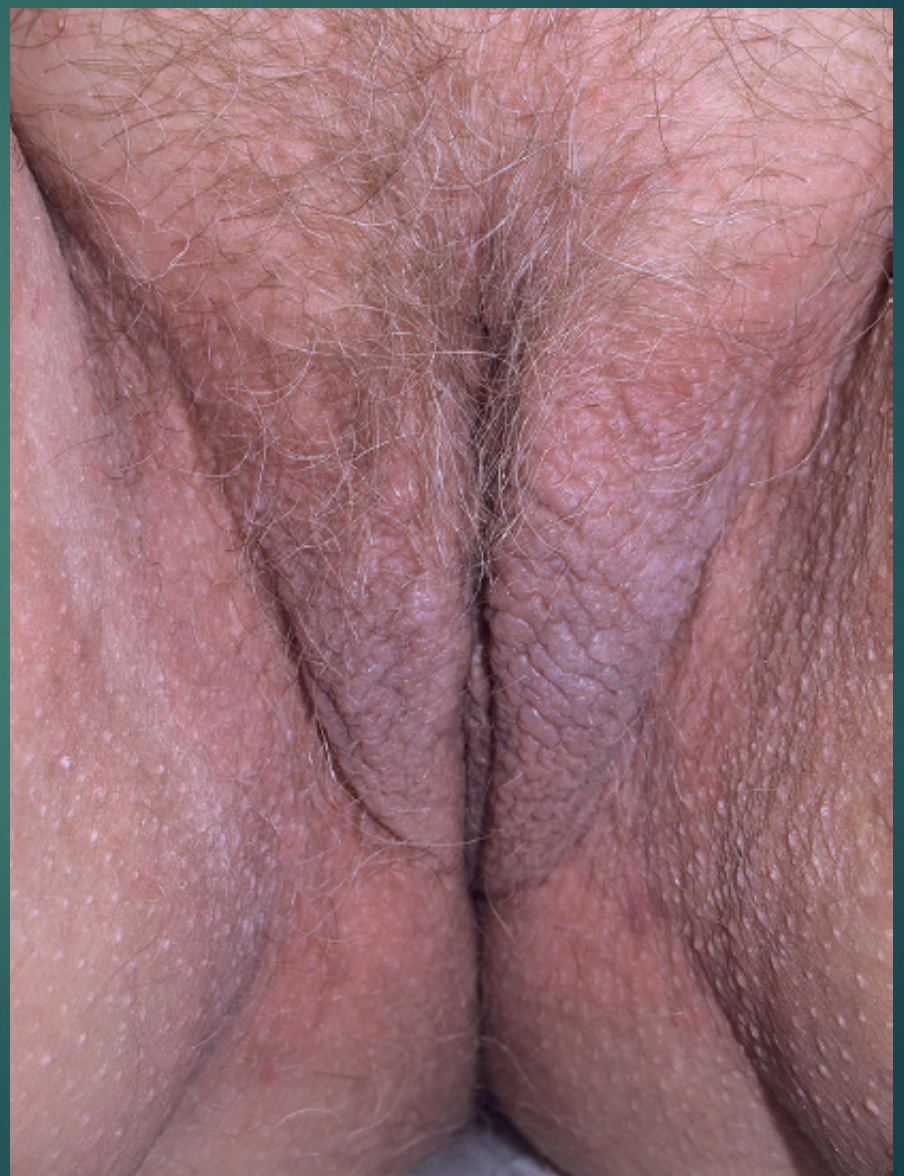
- Deep red-brown +/- petechial glistening patches
- Vestibule, periurethral, labia minora "kissing" lesions
- Burning/tenderness/dyspareunia
- Occasionally itchy

- DDx: LP/VIN /fixed drug eruption

- Path: dense band-like infiltrate/ >50% plasma cells

- Tx: potent topical +/intralesional corticosteroids

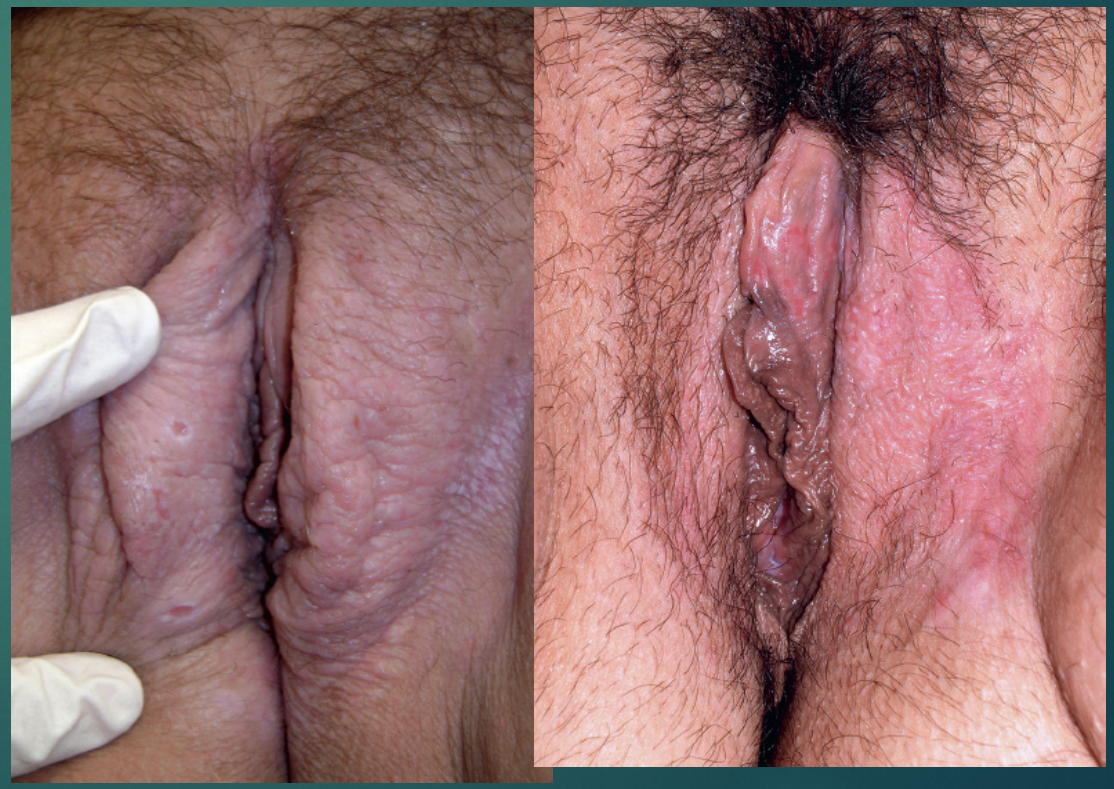
LICHEN SIMPLEX CHRONICUS



LICHEN SIMPLEX CHRONICUS

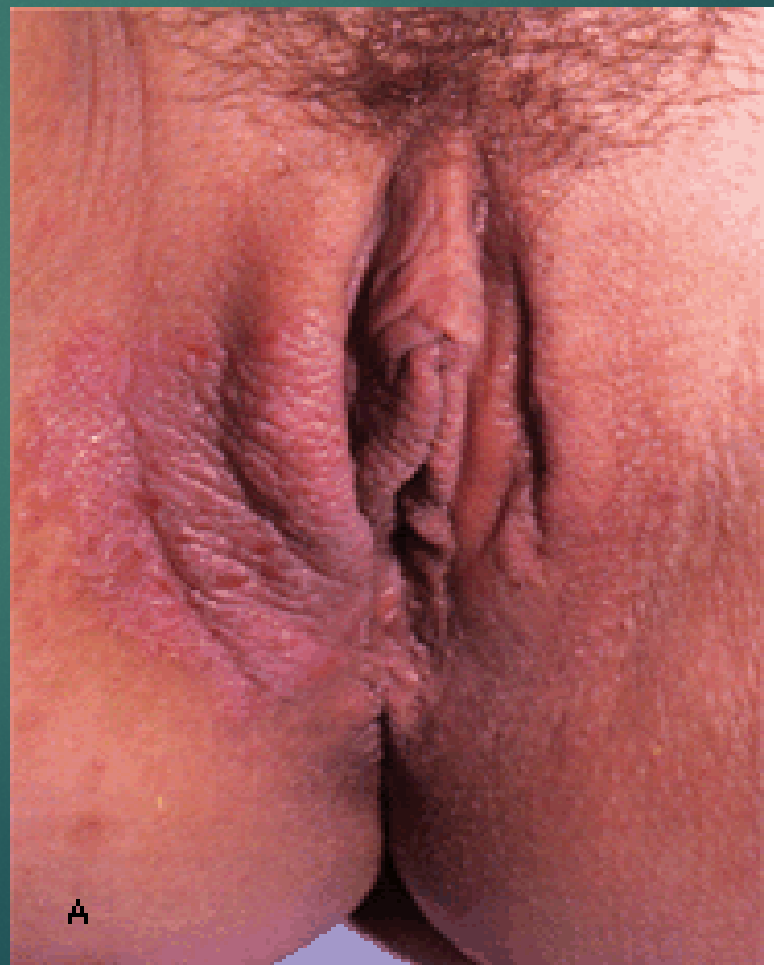
- ++itchy red/pink patches and plaques
- Lichenification
- Not typically symmetrical
- +/- hyper or hypopigmentation
- +/-erosions, crusts, fissures
- Non-scarring →

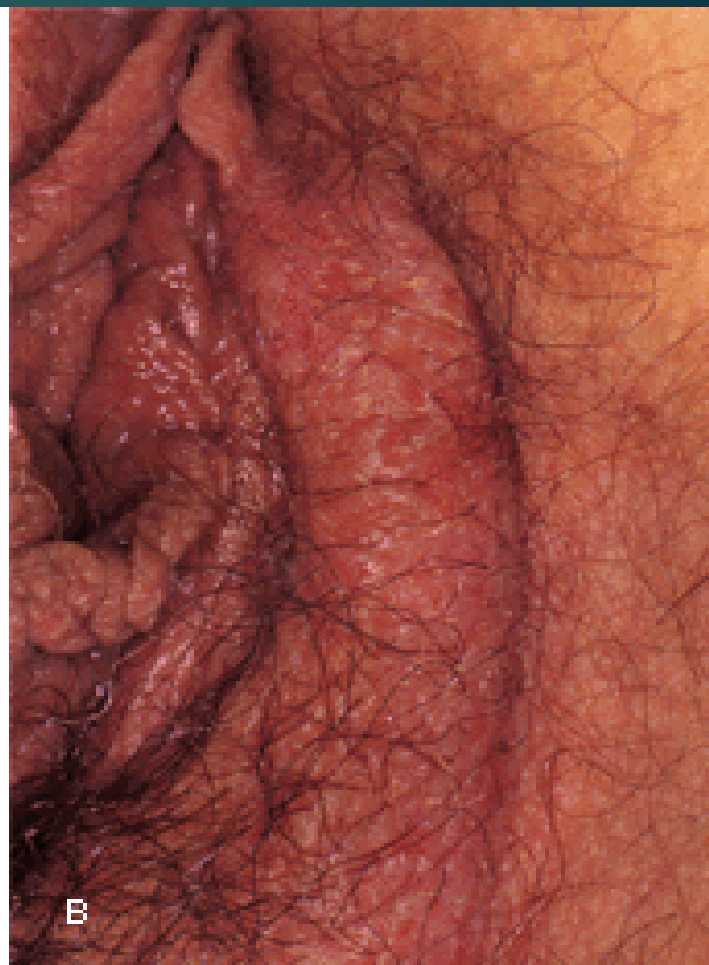
  vulvar architecture maintained



LICHEN SIMPLEX CHRONICUS

- Also called squamous hyperplasia, hyperplastic dystrophy
- ?trigger factors + increased cutaneous sensory nerve activity→ itch → scratch → itch→ repetitive trauma, altered skin barrier and **benign** epidermal hyperplasia
- May be primary OR the end result of chronic dermatitis or any other pruritic vulvar disease

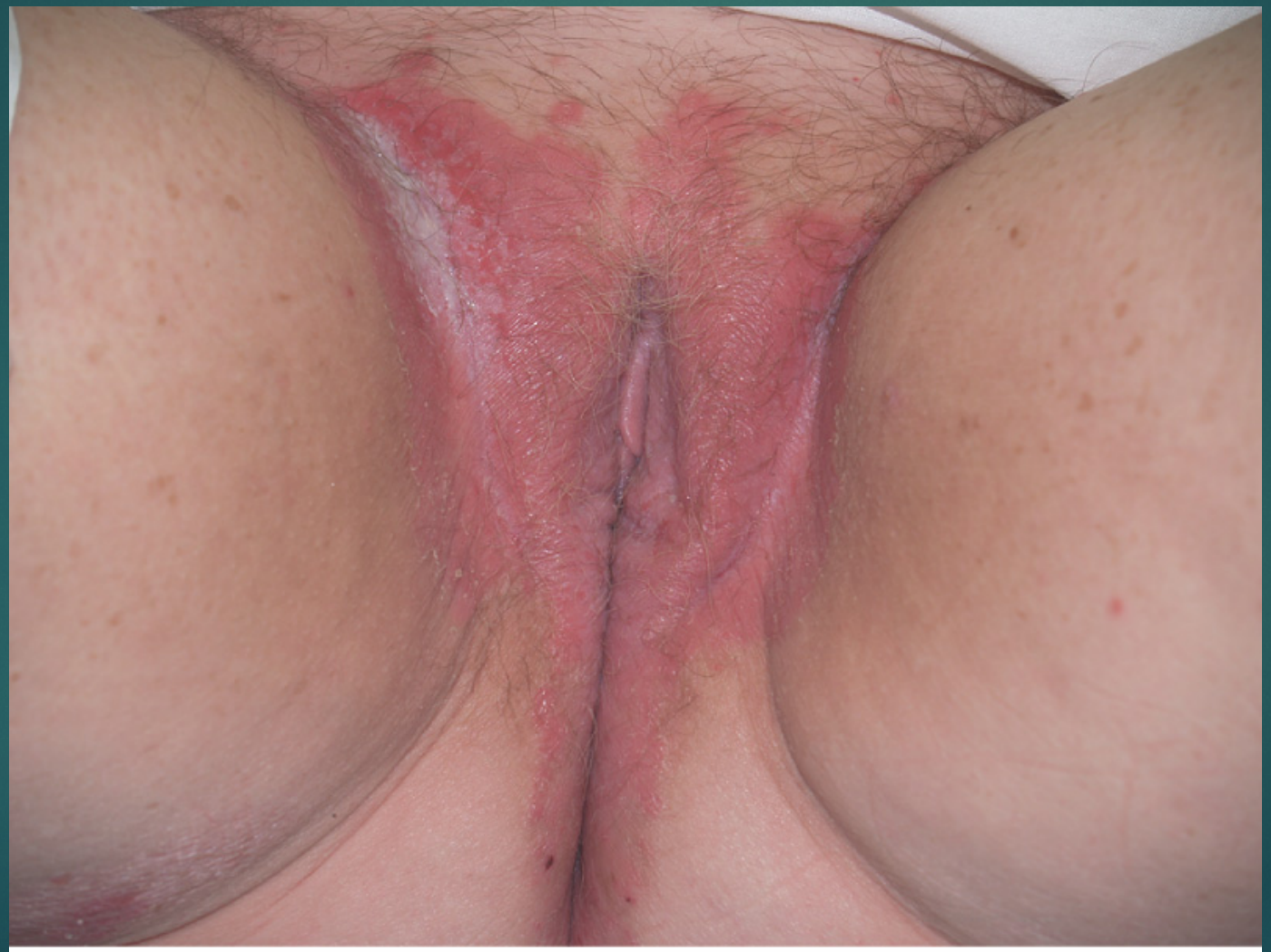




LSC - Treatment

- Rule out other conditions*
- Identify irritants / **vulvar skin care**
- Topical corticosteroid ***ointment***: medium potency (eg betamethasone valerate) tapered to low potency (hydrocortisone valerate 0.2%) bid prn
- ***Control itch:*** **oral antihistamines**, cold, ¼% menthol added to topical corticosteroid, xylocaine 5% ointment; *avoid benzocaine-containing agents*

ANOGENITAL PSORIASIS

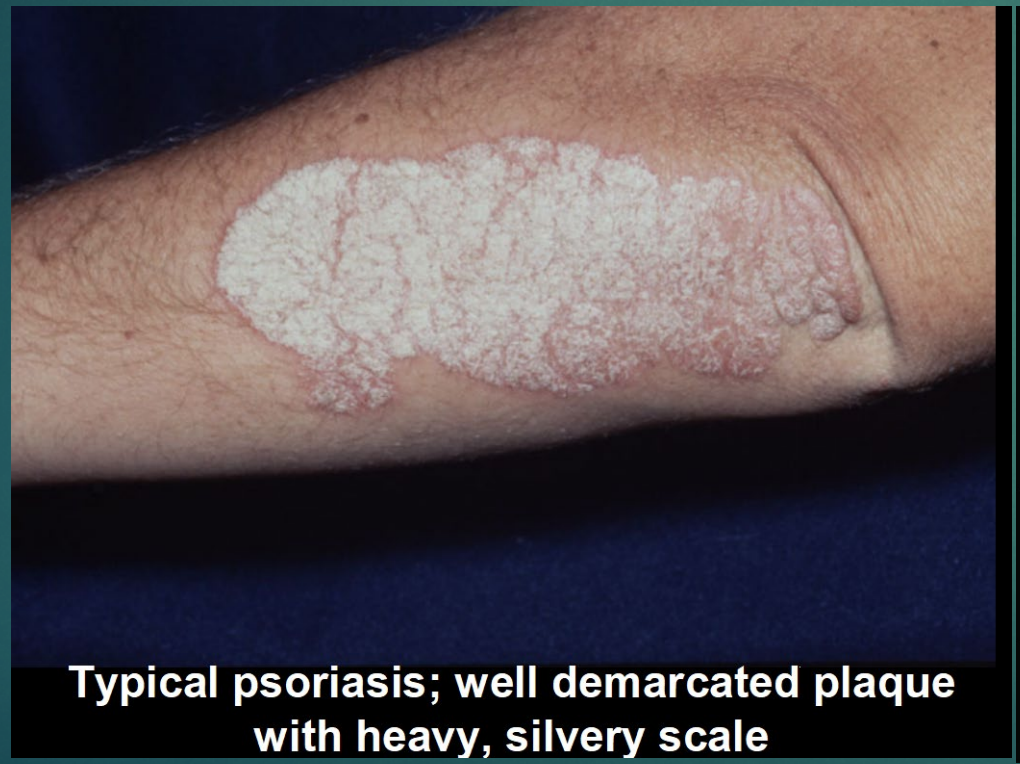


ANOGENITAL PSORIASIS

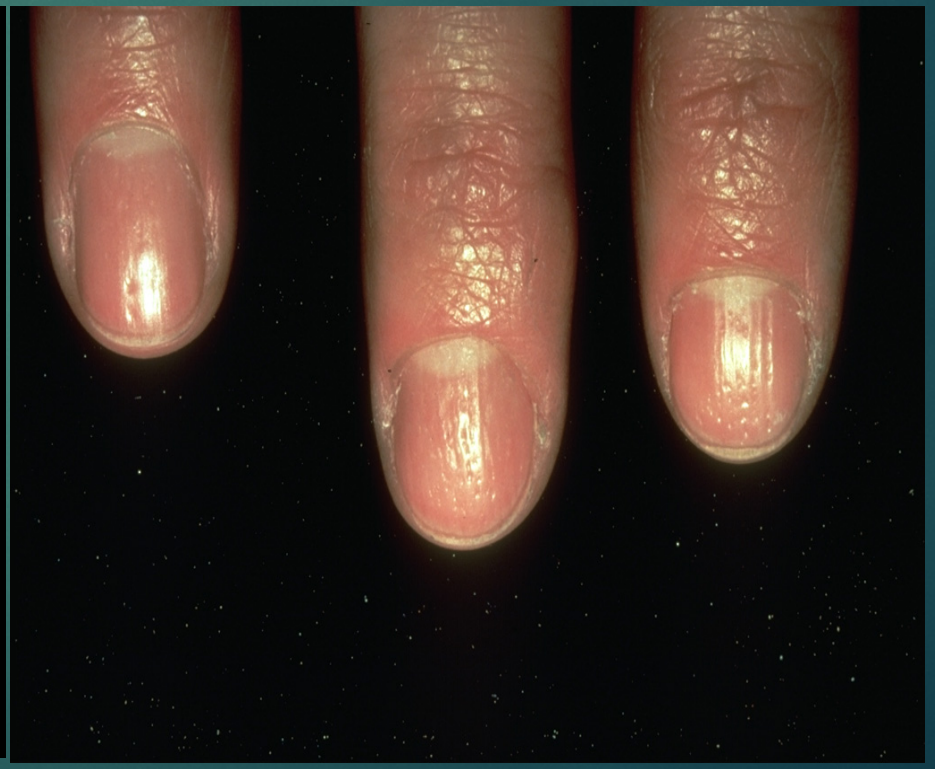
- pruritus main symptom
- symmetrical, well-demarcated smooth red plaques labia majora, mons
- ***fissured, red patches in intergluteal fold
- look for psoriasis in other sites: scalp, nails, extremities
- + family history, co-morbidities

- Under-diagnosed

PSORIASIS



Typical psoriasis; well demarcated plaque with heavy, silvery scale



ANOGENITAL PSORIASIS - Treatment

- Low-medium potency topical steroid ointment*
- +/- tar (3% LCD), ¼% menthol prn itch*
- Calcipotriol (Dovonex) or Calcitriol (Silkis) ointment*

- Tacrolimus (Protopic 0.1%) ointment

- Intralesional triamcinolone 3 mg/ml

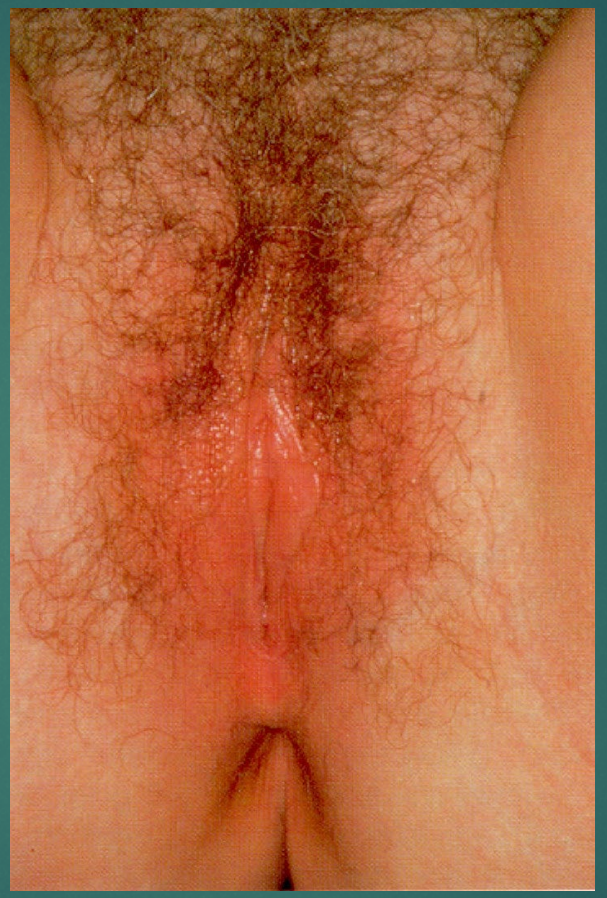
- Oral antihistamines prn itch

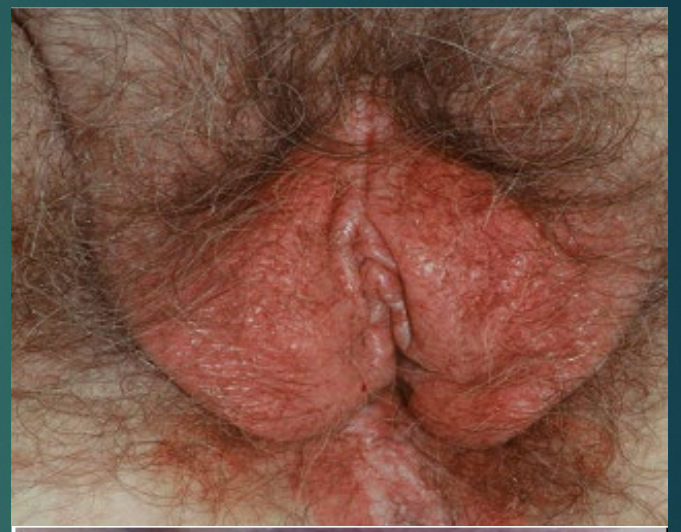
- Responds to systemic antipsoriatic therapy if indicated (mtx, retinoids, biologics)

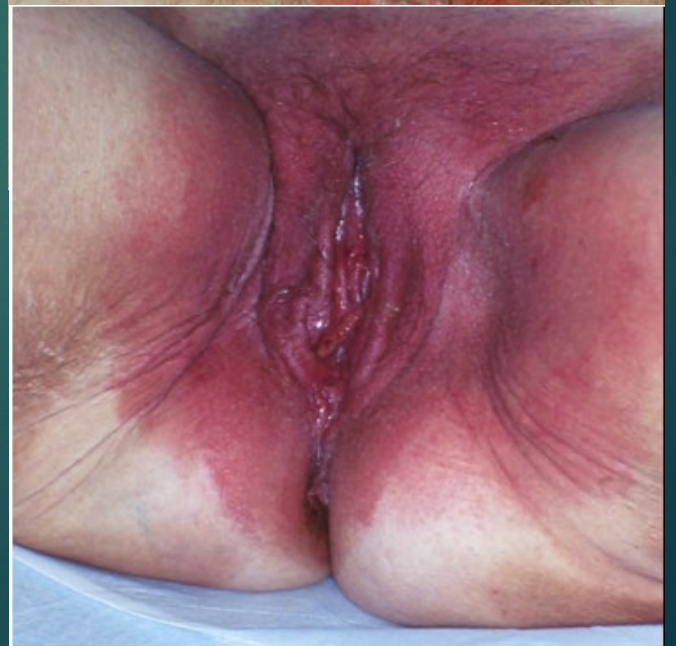
- Minimize trauma, vulvar skin care

Vulvar Dermatitis

- Atopic
- Seborrheic
- *Contact* : irritant / allergic
- *Atrophic*







Anogenital Contact Dermatitis

Irritant Contact Dermatitis

moisture (urine, vaginal discharge, sweat)

friction (pads & liners, scrubbing, biking, riding)

soaps, detergents

Allergic Contact Dermatitis

benzocaine (Lanacane, Vagisil)

diphenhydramine (Benadryl) cream

fragrances (Balsam of Peru)

sanitary pads (acrylates, methyldibromoglutarylnitrile)

baby wipes (preservative MCI/MI, fragrance)

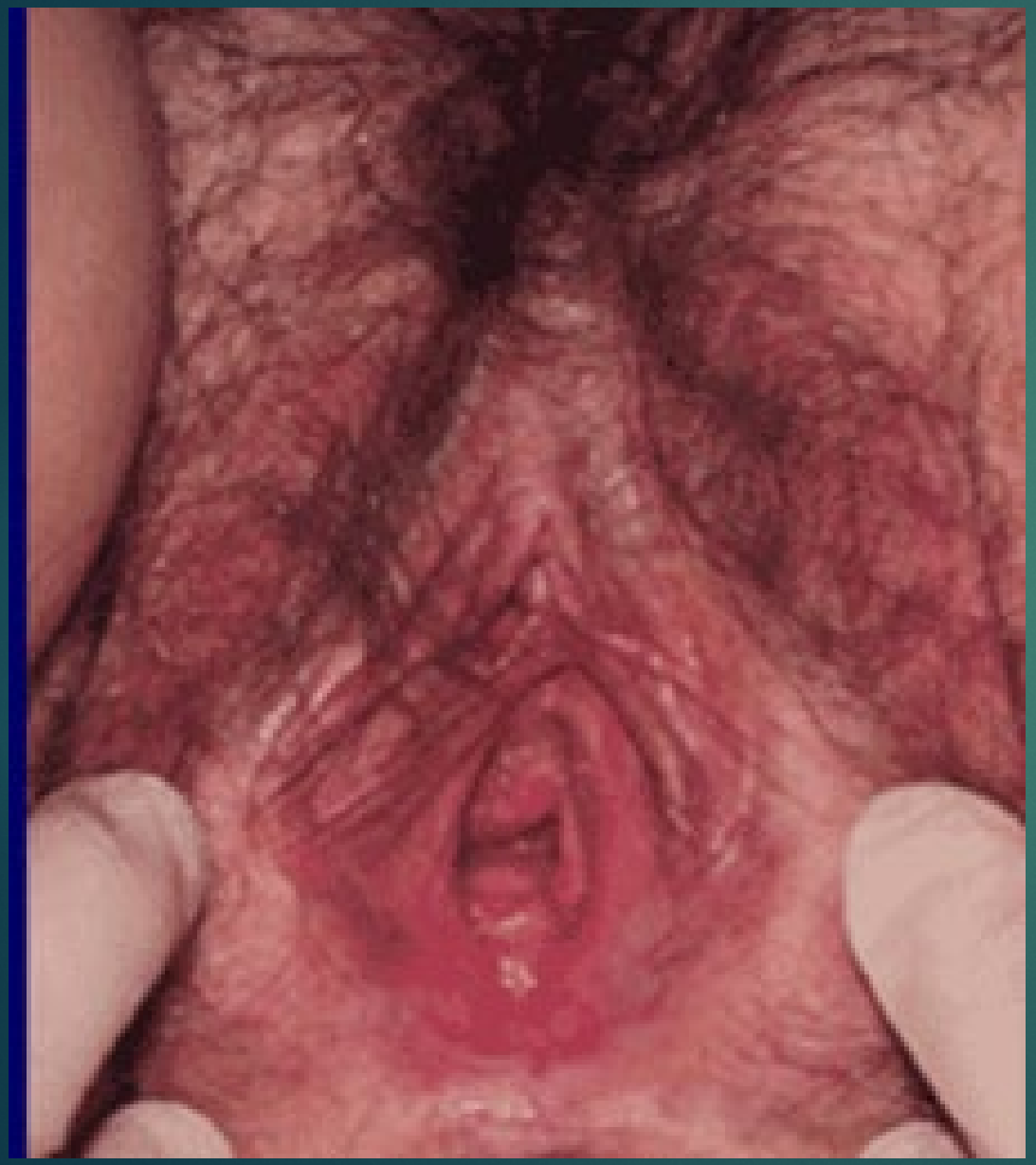
Anogenital Contact Dermatitis

Treatment: remove etiologic factor(s)

- low-medium potency topical steroid ointment bid prn
- barrier (petroleum jelly, zinc oxide ointment, silicone ointments)
- oral antihistamines
- vulvar skin care

***may need short course of systemic steroid for severe allergic contact dermatitis

***may require patch testing by a Dermatologist



Atrophic Vulvovaginitis/ Genitourinary Syndrome of Menopause

- 2 yrs since natural menopause (also breastfeeding, surgical/medical menopause, androgenic meds)
- Vulvovaginal dryness, pallor, decreased elasticity & volume, itching, burning, dyspareunia
- Urgency, frequency, dysuria, recurrent UTIs
- Urethral caruncle

GSM TREATMENT

Estrogen Replacement:

systemic

local: estrone (Estragyn) cream 0.5 gm pv 2x/week & topically od

estradiol (Vagifem) tabs pv 2x/week or Estring

Estrace 0.01% in Glaxal Base topically od

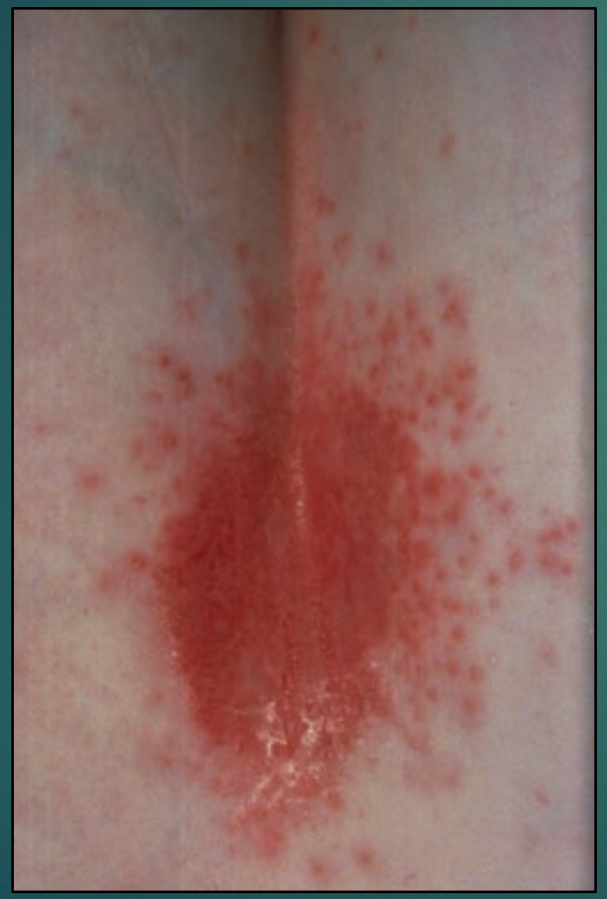
*** ***avoid Premarin (highly scented)***

Non-hormonal

polycarbophil (Replens), hyaluronic acid (Repagyn, Gynatrof)

Vaseline, vulvar skin care

Candidiasis

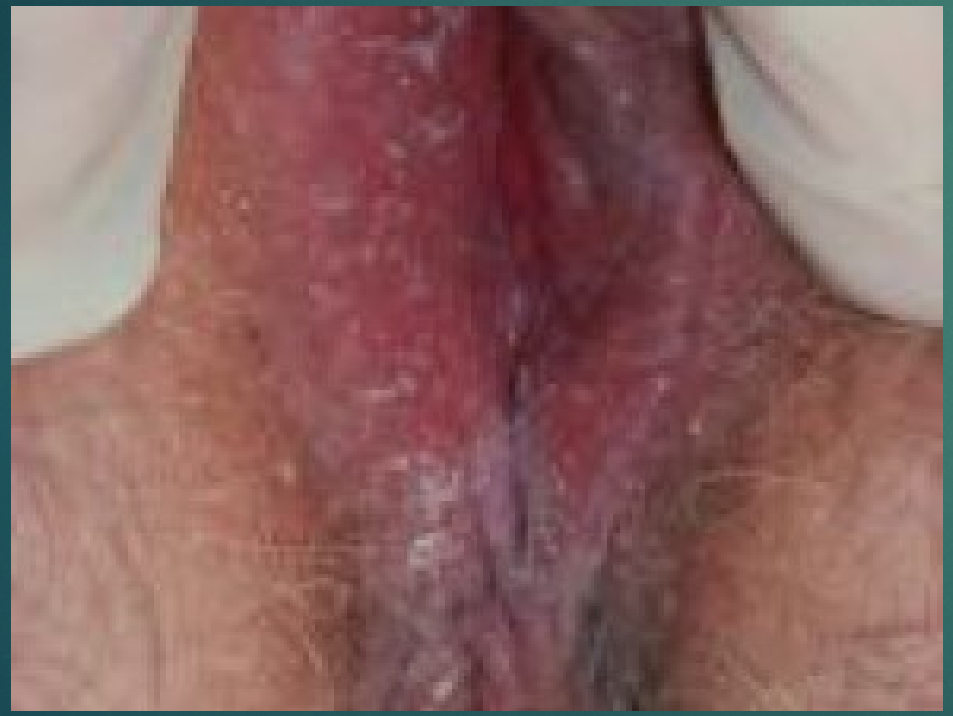


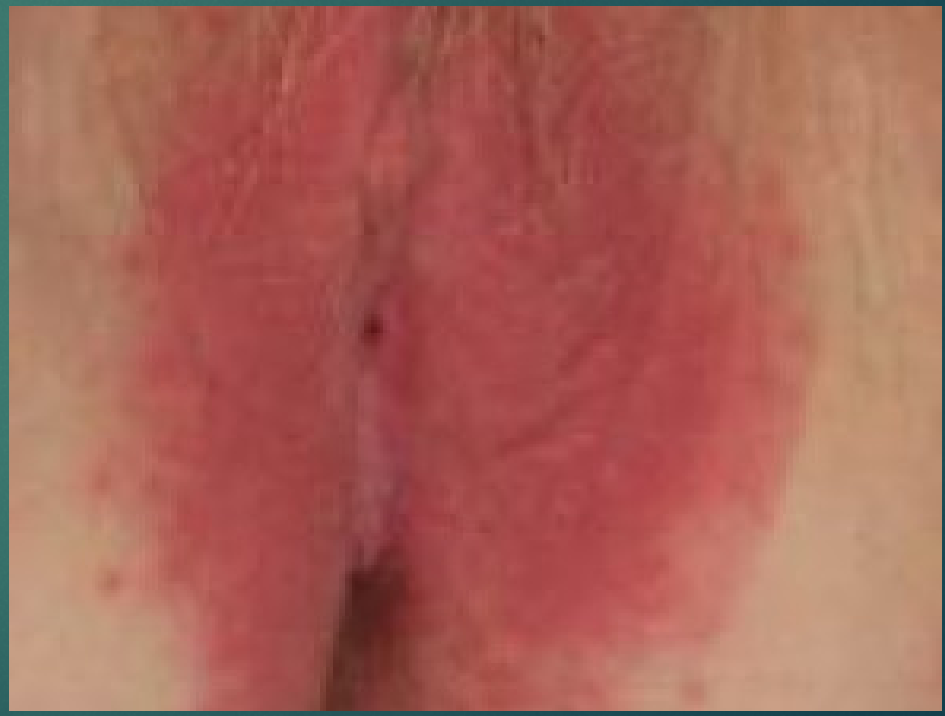
- Bright red patches with satellite papules and/or pustules
- +/- white debris
- +/- vaginal candidiasis

- Vulva, perianal, gluteal, inguinal & other skin folds
- May be superimposed on another primary disorder (eg psoriasis, LS)

- May be recurrent in high-risk individuals: diabetes (poorly controlled and/or on glycosuric meds (SGT2 inhibitors), incontinence,heat/sweating, immunocompromised(intrinsic/iatrogenic), estrogen therapy

VULVAR CANDIDASIS





Candidiasis – Treatment

- Acute, mild-moderate: oral fluconazole* 150 mg single dose
- Acute, severe: Oral fluconazole 150 mg q 72 h x 3
- Recurrent/ high-risk patient: oral fluconazole 150 mg q week + q 72 hrs x 3 prn flares

  +/-topical: Hydrocortisone 1% powder in clotrimazole cream (hair-bearing skin, folds)

  HC 2%/Nystatin/ZnO2 (mucosa, modified mucosa)

*fluconazole potential drug interactions: not of concern with intermittent dosing

Topical Steroid Potency

Classification by steroid molecule (cream base)

Weak – e.g. hydrocortisone 0.05%, 1% , hydrocortisone valerate 0.2% (Hydroval)

Moderately potent - e.g. betamethasone valerate (Betaderm, Celestoderm), mometasone (Elocom), triamcinolone(Aristocort-R)

Potent – e.g. desoximetasone 0.25% (Topicort*), fluocinonide (Lyderm), betamethasone diproprionate(Diprolene, Lotriderm)

Very potent - e.g. clobetasol (Dermovate), halobetasol proprionate (Ultravate)

Topical corticosteroids

Choice of vehicle affects potency and tolerability

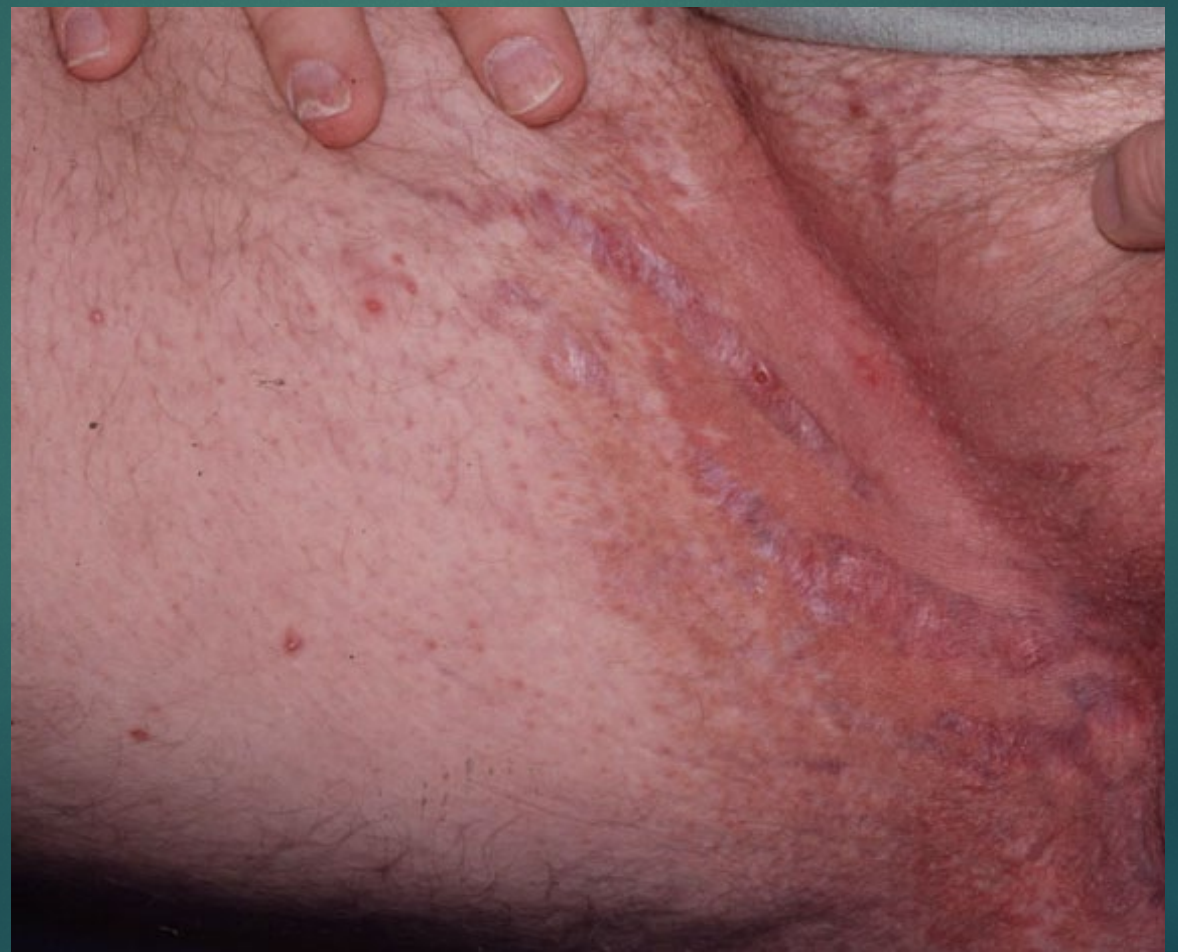
Ointments: less likely to cause irritant or allergic contact dermatitis

- more potent relative to same steroid in cream, lotion or gel base

Limit amount and strength for long term use

Educate patient re: correct application

Striae from topical corticosteroid



TAKE-HOME MESSAGES

- Always examine the vulva!
- Make the correct diagnosis
- Consider co-existing primary or secondary diagnoses
- Biopsy tips: multiple sites, appropriate depth, rebiopsy if path inconsistent with clinical
- Eliminate irritant and/or allergenic contributors
- Optimize barrier, estrogenization
- Choose the lowest potency effective topical corticosteroid
- Prescribe ointments vs creams whenever possible