THINGS THAT ITCH THAT AREN'T YEAST

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DISCLOSURES

- Jessica Pettigrew MSN CNM has no financial relationships with commercial interests to disclose
- Any unlabeled/unapproved uses of drugs or products referenced will be disclosed

OBJECTIVES

- Discuss how to differentiate vulvar dermatoses from vaginitis, and how to identify vulvar dermatoses
- Describe how to initiate treatment and assess response to treatment
- Explain how to perform vulvar biopsy or refer for biopsy when needed

VAGINITIS VS VULVAR DERMATOSES

Vaginitis: yeast, bacterial vaginosis, desquamative inflammatory vaginitis (DIV), STIs

Vulvar Dermatoses: The lichens – simplex, chronicus, contact dermatitis, atrophy, psoriasis, VIN, vulvar cancer

GETTING IT RIGHT THE FIRST TIME

- Vaginal symptoms are responsible for 5-10 million office visits annually
- Symptoms cause fear, anxiety, sexual dysfunction, physical discomfort
- Multiple over the counter products, many are not evidence based and may exacerbate symptoms

OBTAINING A GOOD HISTORY

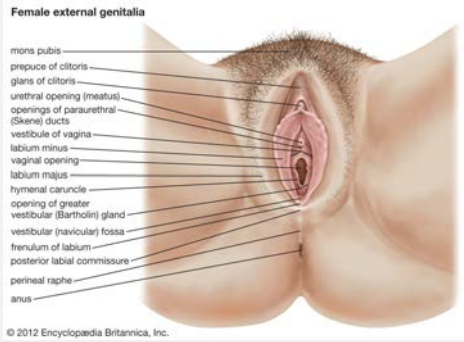
- Is itching internal, external, or both?
- Is it worse at night?
- Is there odor?
- What have you tried?
- Do you remove hair? If so, trim? Wax? Shave?
- Describe cleaning/care practices

PHYSICAL EXAMINATION

ALL PEOPLE WITH VULVAR COMPLAINTS MERIT A PHYSICAL EXAM

Use good light source, good positioning, and inspect top to bottom:

Examine clitoral hood	Look in interlabia l sulci	Look at discharge, introidus	Perineum	Separate skin to look at perianal skin folds



VULVAR DERMATITIS

VULVAR DERMATITIS

- COMMON cause of vulvar complaints
- Symptoms are usually external – labia majora, perineum, interlabial sulci
- Skin often appears normal, may have erythema
- Associated with removal of vulvar hair, chronic panty liner use
- Treatment: apply topical emollient such as A&D, Desitin, gentle vulvar care
  - Cleanse gently with water only
  - Allow hair to grow!
  - Consider low potency topical steroid
  - May try empiric antihistamine

COMMON IRRITANTS

Causes of vulvar contact dermatitis

Irritants	Allergens
Soaps, bubble bath, shampoo	Fragrances/balsam of Peru (*Myroxylon pereirae*) (eg, in soaps, feminine products)
Sanitary or incontinence pads, tampons	Preservatives – quaternium 15, paraben mix, ethylenediamine (eg, hydroxyzine), bronopol, propylene glycol, methylchloroisothiazolinone/methylisothiazolinone, methylisothiazolinone (eg, in moist flushable wipes)
Nylon underwear	
Sweat, urine	
Talcum powder	Medicaments – corticosteroids (hydrocortisone butyrate, clobetasol propionate, budesonide, tixocortol pivalate), anesthetics (benzocaine, dibucaine), antibiotics (neomycin, bacitracin, framycetin), antifungals (terconazole, clotrimazole)
Vaginal or vulvar medications	
Douches	
Vaginal hygiene products	Botanicals/tea tree oil
Vaginal contraceptive products	Lanolin
Methylated spirits	Rubber additives (natural rubber latex and synthetic rubber [nitrile]) (eg, condoms, diaphragms)
Tea tree oil	Nickel
Pinetarsol	Chlorhexidine and disinfectants (eg, in lubricants, antiseptic washes)
Alcohol	Dyes
Fragrances	Semen
Deodorants	
Hair conditioner	
Chemically treated clothing, toilet paper, or water	

UpToDate

scratch → itch → scratch → itch

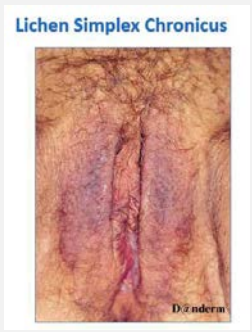
BREAK THE CYCLE!

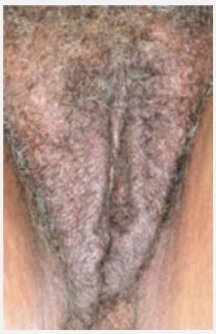
MEET THE LICHENS!

- Lichen simplex chronicus
- Lichen sclerosus
- Erosive lichen planus
- 90% OF VULVAR CANCERS ARISE IN A FIELD OF LICHEN

LICHEN SIMPLEX CHRONICUS

- Unresolved dermatitis may progress to lichen simplex chronicus
- Skin becomes thick and leathery from chronic irritation/inflammation
- Often thickened plaques develop, may be accompanied by fissures
- May develop secondary to chronic yeast





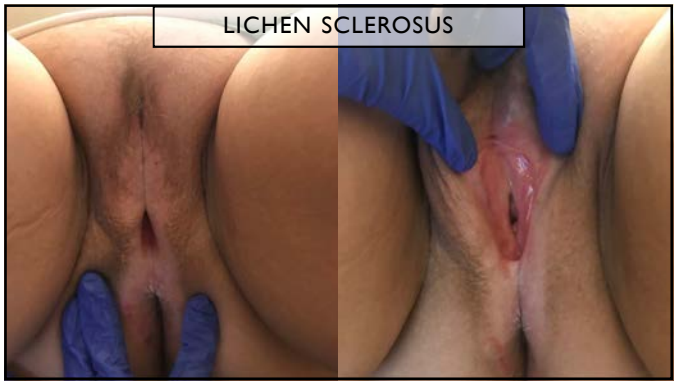
LICHEN SIMPLEX CHRONICUS TREATMENT:

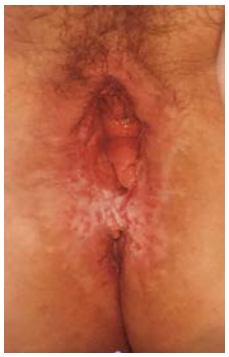
- May diagnose clinically
- Vulvar biopsy if unsure
- If suspicious for superimposed yeast, consider cutaneous microscopy
- For mild symptoms of lichen simplex chronicus consider low/medium potency steroid
  - OTC Hydrocortisone, desonide 0.05%, triamcinolone 0.1% 1-2 times daily for 2-4 weeks until symptoms resolve then at frequency needed to prevent recurrence
- For severe symptoms:
  - Hydroxyzine prn for puritis, topical clobetasol 0.05% daily x 30 days then re-evaluate
- Address atrophy (coming soon!)

LICHEN SCLEROSUS

- Chronic, progressive, inflammatory autoimmune cause of vulvar itching
- Often pts report itching that is worse at night
  - "Irritation"
  - "Discomfort"
- Occasionally patients are asymptomatic and will be incidental finding on exam
- On physical exam: thinning of skin, "cigarette-paper" like, loss of architecture as clitoris and labia minora may have disappeared, fissures may be seen

LICHEN SCLEROSUS





VULVAR LICHEN SCLEROSUS

LICHEN SCLEROSUS

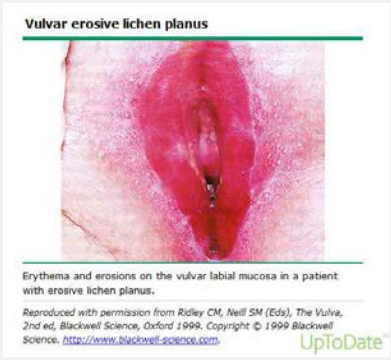
Diagnosis: biopsy is gold standard

Treatment: topical high potency steroid – clobetasol 0.05% applied daily x 2 weeks, then taper, reevaluate with exam in 4-6wks

Follow up: Annual vulvar exams, correct atrophy with topical estrogen PRN, many women do well with twice weekly clobetasol

LICHEN PLANUS

- Erosive skin process involving inner aspects of vulva and vaginal opening
- Bright red, painful glassy erosions, synechiae may be seen
- With extensive disease may develop vaginal adhesions, gentle speculum exam
- Affects mucous membranes, may have oral involvement
  - Ask about history of oral ulcers



TREATMENT OF LICHENS

Lichen Simplex Chronicus	• Mild symptoms: OTC Hydrocortisone, desonide 0.05%, triamcinolone 0.1% 1-2 times daily for 2-4 weeks until symptoms resolve then at frequency needed to prevent recurrence • Severe symptoms: Hydroxyzine prn for puritis, topical clobetasol 0.05% daily x 30 days then re-evaluate
Lichen Sclerosus	• Treatment: topical high potency steroid – clobetasol 0.05% applied daily x 2 weeks, then taper, reevaluate with exam in 4-6wks • Follow up: vulvar exam annually, treat atrophy if needed
Erosive Lichen Planus	• Treatment: topical high potency steroid – clobetasol 0.05% applied daily x 2 weeks, then taper, reevaluate with exam in 4-6wks • Follow up: vulvar/vaginal exam annually, treat atrophy if needed. Use of vaginal dilator

STUBBORN LICHEN

- Pts who do not respond completely may be referred to specialist to consider
  - Injection of local steroid, triamcinolone directly into the lesion
  - Oral steroid taper
  - Systemic immunosuppressant therapy
  - Excision of lesion

GSM: GENITOURINARY SYNDROME OF MENOPAUSE, AKA ATROPHY

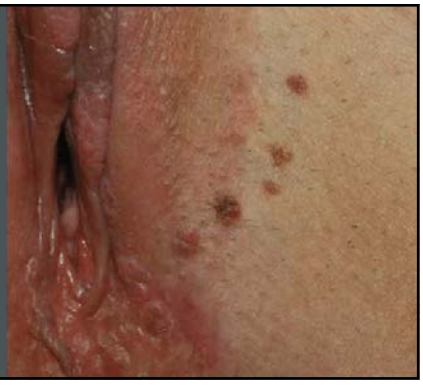
- Cessation of gonadal function→ atrophy
- Significant changes to vaginal microbiome
- Easily remedied with local replenishment with vaginal estrogens or DHEA
  - Creams
  - Tablets
  - Suppositories (DHEA)
  - Ring
- Vaginal estrogens have very few evidence-based contraindications

EDUCATION ON VULVAR CARE, AVOIDING IRRITANTS, AND CHRONIC NATURE OF DISEASE

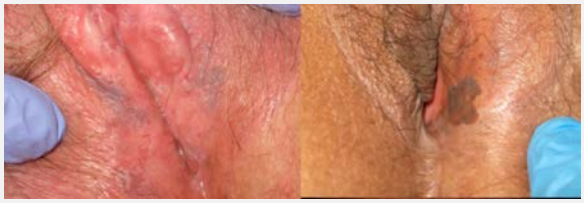
VULVAR INTRAEPITHELIAL NEOPLASIA (VIN) AND VULVAR CANCER

- VIN is HPV mediated and may present with itching and rough, raised irregular lesion, may have macular presentation
  - Precancerous squamous cell carcinoma in situ
- 90% of vulvar cancers arise in a field of lichen…look closely!
- Unifocal vulvar plaque, ulcer, or mass
  - May have symptoms of itching, pain, often asymptomatic

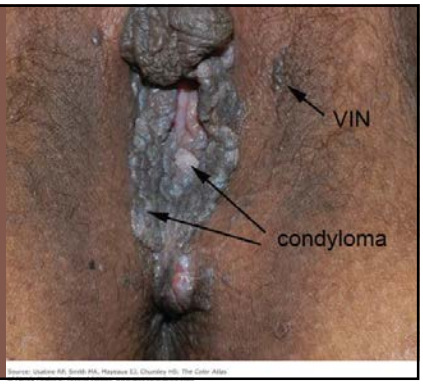
VIN AND VULVAR CANCER



VARIED APPEARANCE OF VIN



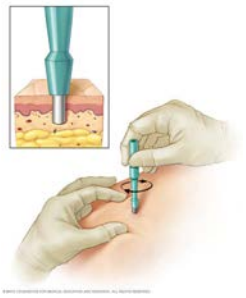
CLOSE INSPECTION REVEALS MULTIPLE AREAS OF CONCERN



PERFORMING A PUNCH BIOPSY

- Explain procedure an obtain consent
- Cleanse the skin with antiseptic
- Inject the skin with 1-2cc of lidocaine with epi
- Choose a 3mm or 4mm punch
- Apply direct pressure, can be challenging on vulvar skin with no firm bone behind
- Have a suture removal kit handy
- Be prepared to suture, but often hemostasis is achieved with silver nitrate

PUNCH BIOPSY



TREATMENT OF VIN

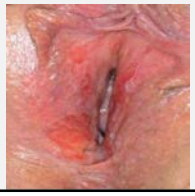
- Goal of treatment is to relieve symptoms, prevent progression to cancerous lesion while maintaining normal vulvar anatomy
- Surgical excision is required for most high-grade lesions
- Topical imiquimod for low grade lesions or multiple lesions
- Laser ablation
- Follow up genital exams at regular intervals due to recurrence risk
- PREVENTION: HPV VACCINE!

CASE STUDY 1

- 54 year old G3P3 presents for "sensitive skin down there". She reports a history of sensitive skin and eczema. "You know, I just cant wear certain fabrics, or, for example, pants with a seam. My skin is so sensitive." She reports burning with urination. Her PCP treated her presumptively for yeast and UTI, a genital exam was not performed.

PHYSICAL EXAM

- Exam is hindered by limited mobility due to a back injury. She is able to recline somewhat to allow you to gently separate the labia majora which reveals



CASE 1

- Exam is uncomfortable, you are unable to pass a single lubricated finger and are suspicious that vaginal adhesions may have formed.
- Diagnosis:
- Erosive Lichen Planus
- You treat with high potency steroid (clobetasol 0.05%) for 2 weeks and bring her back for examination with a colleague who is an expert in vulvar dermatoses.

CASE 1

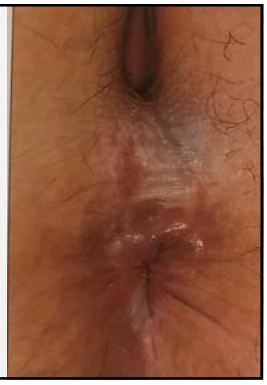
- On repeat exam, the ulcerations have improved but her skin remains tender and adhesions are still present
- Treatment for adhesions:
- Vaginal estrogen cream and dilator use
- If unresponsive to conservative therapy → surgical lysis of adhesions

CASE STUDY 2 (LICHEN SCLEROSUS)

- 26 year old G0P0 being seen for "yeast infections that don't go away". She states her "regular doctor" has called in Diflucan for her several times, she develops irritation with OTC yeast medication. She uses vagisil to manage her day to day itching it is worse at night. She reports that after sex, she feels as if she develops small cuts. Neg STI screens. "Can't you give me something else for this yeast? It won't go away!"
- BMI: 22
- PMH: noncontrib

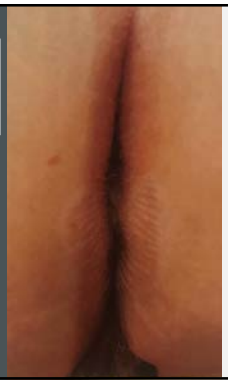
CASE 2

- On exam, you see thin pale skin with fissures noted on the perineal body



CASE 2

- Classic "figure of eight pattern noted perianally
- Wrinkled pale skin noted



CASE 2

- Your clinical diagnosis is:
- Lichen Sclerosus
- Biopsy?
- Treatment?
- In 6 weeks her symptoms have improved dramatically she thanks you profusely
- Education and follow up

REFERENCES

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