Vulval dermatoses

Fiona Lewis

Abstract

Dermatoses affecting the anogenital region are an important yet often overlooked group of conditions. When women present with vulval symptoms, it is important to exclude a dermatological condition as the cause. The vulva may be involved in generalized skin disease such as psoriasis, but certain dermatoses, for example, lichen sclerosus and lichen planus, affect the genital skin specifically. This article describes the clinical features and management of the commonly encountered vulval dermatoses.

Keywords Dermatoses; eczema; lichen planus; lichen sclerosus; psoriasis; vulva; vulval cancer

What's new?

- Lichen planus can affect many mucosal sites and requires a multidisciplinary approach to management
- Further study confirms that an ultra-potent topical corticosteroid is the most effective treatment for lichen sclerosus
- Calcineurin inhibitors should be used with care in genital dermatoses owing to uncertainty about their long-term safety.

The anogenital skin is vulnerable as it is an area subject to warmth, moisture and potential irritation from urine and faeces. The characteristic features of dermatoses that are easily recognized elsewhere on the skin may be absent or modified in this area, and many of the treatments used for skin disease at other sites are not suitable to use in the genital region. A thorough history and methodical clinical examination is vital in order to make an accurate diagnosis and choose the correct treatment. Examination of other mucosal and cutaneous sites can aid in diagnosis.

General principles of treatment of vulval dermatoses

The use of a bland emollient such as emulsifying ointment as a soap substitute is essential for all vulval dermatoses. Topical corticosteroids are quite safe to use on the vulva but it is important that they are applied in the correct area and this needs to be explained to the patient. In general, ointment preparations are preferable to creams or lotions and are better tolerated. Once-daily application is quite adequate for any topical corticosteroid.

The normal vulva varies in appearance, especially in the size of the labia minora.[1] The outer labia majora and mons pubis are covered by keratinized hair-bearing skin. The inner labia minora show prominent sebaceous glands, which are more evident if the skin is stretched. The vestibule is a non-keratinized mucosal surface and the transition between the two types of epithelia is marked by Hart's line, which is very prominent in some younger women.

Vestibular papillae are small projections seen at the vestibule, which are not related to human papilloma virus (HPV) and may be seen in 50% of pre-menopausal women. They are considered a normal variant and require no treatment. Epidermoid cysts and angiokeratomas are frequently seen on the labia majora.

Psoriasis

Psoriasis is one of the most common dermatoses seen in the general population and can affect the vulva as part of generalized disease or as an isolated problem.[2] The lesions are typically a 'salmon-pink' colour with a well-demarcated edge (Figure 1). The characteristic silvery scale seen elsewhere is absent except on the outer labia majora and mons pubis. Fissuring is a common finding, particularly over the perineum and in the natal cleft (Figure 2). Itching and soreness are the main symptoms but dyspareunia is an issue for some women.

The treatments used for psoriasis elsewhere, such as tar preparations, are too irritant on the vulva and a moderately potent topical corticosteroid applied in a reducing regimen over a few weeks will usually control the problem. It can recur and may need repeated treatment from time to time. Fissures are prone to secondary infection and should be treated with a topical corticosteroid/antibacterial combination. Topical calcitriol and calcineurin inhibitors, such as tacrolimus and pimecrolimus, are alternatives but often sting on application and are therefore not tolerated well.

Eczema

Irritant and seborrhoeic eczema are most commonly seen, as atopic eczema usually spares the vulva. The major symptom is pruritus and clinical signs may be subtle. In contrast to psoriasis, the erythema is ill-defined. Scaling with the build-up of keratin debris in the inter-labial sulci may be seen, and it is important to distinguish this from the thick discharge seen with candidiasis in

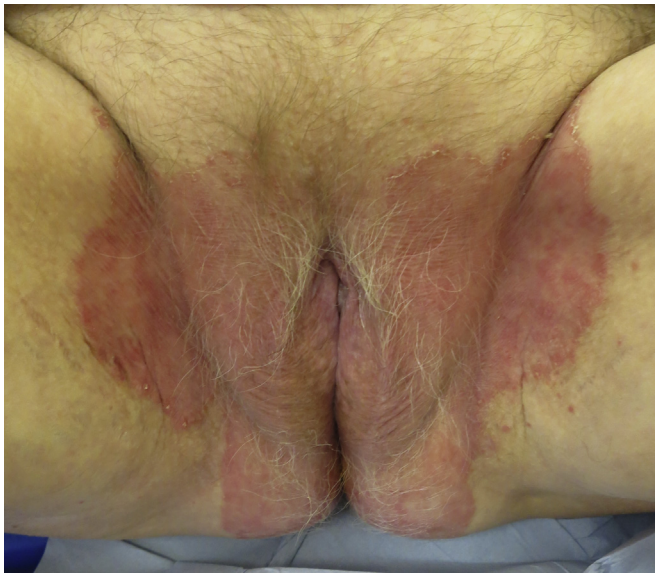

Figure 1 Anogenital psoriasis.

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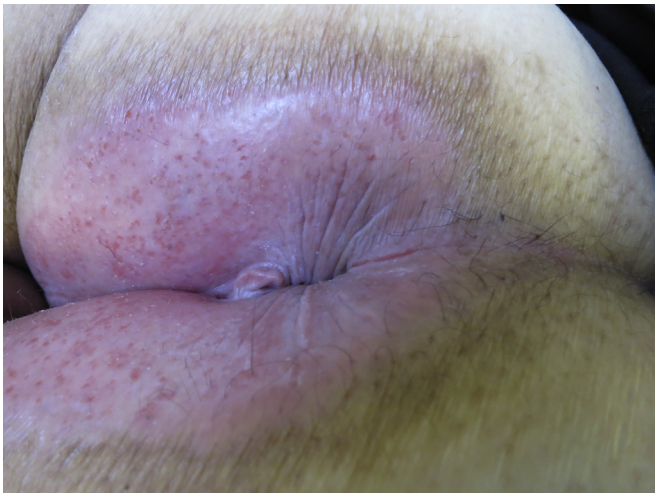

Figure 2 Perianal psoriasis with fissuring in the natal cleft.

the vagina and vestibule. An irritant eczema is often related to urinary incontinence and then the erythema may extend perianally. Full examination of the skin may often yield diagnostic clues such as scaling of the scalp, face and flexures in seborrhoeic eczema. Treatment is with a mild-to-moderate potent topical corticosteroid, such as hydrocortisone 1% or clobetasone butyrate 0.05% (Eumovate®) ointment, used daily initially and then as required.

Allergic contact dermatitis

An allergic contact dermatitis may occur as a secondary phenomenon to the application of topical treatments, but is rarely a primary problem. Extension to the thighs and perianal skin is common in a contact problem and, if acute, there may be erosions and blistering.[3,4] The most common causes of contact dermatitis are fragrances, preservatives and some topical antibiotics such as neomycin. If an allergic cause is suspected, comprehensive patch testing is required and must include preservatives and any 'over-the-counter' topical treatment used. Treatment is avoidance of the trigger allergen but a moderately potent topical corticosteroid is required to treat the eczematous response.

Lichen simplex

Lichenification is the term used to describe thickening of the skin as a result of scratching. An 'itch-scratch-itch' cycle is set up and the outer labia majora and perianal skin are the most common areas to be affected. It can occur in patients with a background of psoriasis or eczema, but occasionally the initial trigger to itch is difficult to find. Treatment is with a moderately potent or potent corticosteroid used in a reducing regimen over several weeks. Sedative antihistamines at night may be helpful.

Lichen sclerosus

Lichen sclerosus (LS) is a dermatosis with a predilection for the female genital skin. The aetiology is unknown but there is an association with other auto-immune disorders, most commonly thyroid disease. It can start at any age but peaks in pre-pubertal girls and post-menopausal women. The predominant symptom is severe itching, but women also describe soreness and dyspareunia. Constipation is a frequent finding in children.

The classic clinical features are white atrophic and sometimes sclerotic plaques on the inner aspects of the labia majora and labia minora. The clitoral hood, perineum and perianal area may also be affected. Ecchymosis is a pathognomonic feature. If untreated, scarring can result with resorption of the labia minora and fusion of the clitoral hood (Figure 3). Introital narrowing may result from anterior and posterior fusion of the labia. It is helpful to confirm the diagnosis on biopsy, although this is not generally preformed in children. However, a biopsy is vital if there are any atypical features or areas unresponsive to treatment.

Lichen sclerosus affects the vagina only if the vaginal mucosa becomes keratinized, which occurs in some women who have a significant prolapse. About 10% of women with genital disease have lesions on the trunk and limbs and these often occur at sites of friction. Interestingly, the extragenital lesions are usually asymptomatic.

First-line treatment is with an ultra-potent topical corticosteroid such as clobetasol propionate 0.05% (Dermovate®) ointment[5,6] applied in a reducing regimen over 3 months (once daily for the first month, alternate days for the second and then twice weekly for the third). After this, treatment is applied once daily as needed for any recurrent symptoms. This regimen is quite safe and 30 g of the topical corticosteroid should last 3 months in an adult and 6 months in a child. There is no role for the use of topical oestrogen or testosterone preparations. Surgery should not be used to excise benign disease as lichen sclerosus will often koebnerize in the scars. However, it does have a role in dividing

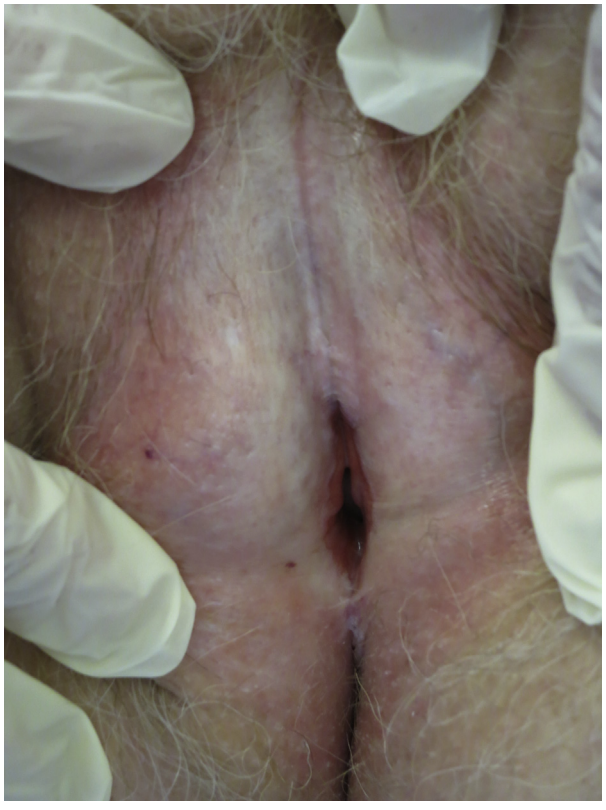

Figure 3 Lichen sclerosus.