

# A Clinical Approach to Vulvar Ulcers



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## KEYWORDS

• Vulvar • Ulcer • Differential diagnosis • Treatment

## KEY POINTS

- Vulvar ulcers are nonspecific skin findings.
- The differential diagnosis of vulvar ulcers is broad.
- Vulvar ulcers are frequently misdiagnosed on clinical examination.
- Laboratory testing is usually required for accurate diagnosis.

## VULVAR ULCERS

### *Background*

Most vulvar ulcers are painful and trigger considerable anxiety and emotional distress for the patient. Any form of vulvar irritation or discomfort affects all aspects of a patient's life, including simple activities of daily living, exercise, and sexual encounters. In addition to physical pain and discomfort, however, there are also often underlying fears that the symptoms are due to a sexually transmitted infection, undiagnosed cancer, poor hygiene, or that there will never be relief,<sup>1</sup> leading to psychological effects on the well-being of relationships and the patient's feelings of self-worth.

Providers are often challenged to determine the cause of this nonspecific clinical sign and institute appropriate therapy. Ulcerative vulvar conditions include a spectrum of primary examination findings, including ulcers, erosions, and other ulcerated lesions, such as sinus tracts and draining nodules. This article seeks to provide a practical clinical approach to the evaluation of ulcerative vulvar disease.

Ulcers of the vulva are diagnostically challenging due to variation in clinical morphology. Accurately identifying the primary morphology is clinically relevant because most disease states produce either erosions or ulcerations, and correctly identifying the primary lesion can significantly narrow the differential diagnosis.<sup>2</sup> Determining the primary morphology of a vulvar ulcer, however, is often complicated by secondary changes and that more than a single condition is often present.

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Vulvar ulcers are a symptom, and an underlying cause must not be assumed but rather must be sought. Diagnosis based solely on clinical findings is often inaccurate. Identifying the cause of a vulvar ulcer is best accomplished by obtaining a careful history, performing a detailed physical examination, and considering a broad differential diagnosis. Although the most common causes of vulvar ulcers are sexually transmitted infections, it is imperative to maintain a broad approach by considering the range of nonsexually transmitted causes.<sup>3</sup> A study of 53 women presenting for evaluation of genital ulcers at a clinic in Brazil, for example, showed that 54.7% of cases were associated with sexually transmitted infections and that the remaining 45.3% of cases resulted from other causes.<sup>4</sup> The differential diagnosis includes sexually and nonsexually transmitted infections, dermatoses, trauma, neoplasms, hormonally induced ulcers, and drug reactions (**Box 1**).

### ***Patient History***

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Using a patient questionnaire tailored to your practice can facilitate and expedite the patient encounter (**Box 2**). The interview should start with the patient's defining her symptoms. This definition may be facilitated by offering a variety of descriptors, such as burn, rawness, pain, tingling, irritation, and itch. Next, define the location (unifocal, multiple areas, or generalized) and onset (chronicity, recurrence) of the symptoms, as well as any potentially relevant circumstances.

Review in detail the signs and symptoms at onset and their evolution over time. Ask the patient to identify potential triggers, anything that makes the symptoms better or worse, and previous similar eruptions. Clarify management before presentation, including over-the-counter (OTC) treatments, home remedies, and prescriptions; determine the length of use and the results of such treatments. Inquire about personal hygiene routines and products, including cleansers, douches, use of washcloths and wet wipes, sanitary pads, and tampons. Determine how the products are used and how frequently. Review the patient's sexual experience and travel history, including gender of sexual contacts; new, anonymous, or high-risk partners; number of sexual contacts in last month and last 6 months; geographic locations of sexual contacts; anatomical sites of sexual contacts; history of previous sexually transmitted infections; and use of barrier protection.

Gather pertinent past medical history, including allergies; OTC and prescription medications, with emphasis on any changes in the 6 months before symptom onset; immune status; systemic disease; relevant surgeries; age of menarche; and last menstrual period. Conduct a directed review of systems, including fever, fatigue, headache, muscle pain, nausea, vomiting, anorexia, abdominal pain, skin eruption or rash, oral lesions, pain with swallowing, vaginal discharge, pain with intercourse, pain with urination, cold or flu-like symptoms, eye irritation, blurred vision, depression, and anxiety. Identify any pertinent family history of genital ulcers, Behçet disease, Crohn disease, and lupus or other autoimmune disease.

### ***Physical Examination***

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The physical examination should include a whole-body mucocutaneous examination, focusing on the skin, eyes, oropharynx, anogenital areas, lymph nodes, and joints. Because vaginal disease can have great effect on the vulva, the vaginal mucosa should be included in the examination. A sample of the vaginal secretions should be studied microscopically for the presence of clue cells, lactobacilli, hyphae, pseudohyphae, or budding yeast. Inspect the entire vulva for ulcers, erosions, fissures, subtle erythema, friability, induration, edema, lichenification, crusting, atrophy, and hyperpigmentation or hypopigmentation, as well as the presence of scarring and

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