Female Genital Itch

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KEYWORDS

• Vulvar pruritus • Vulvar itch • Anogenital pruritus • Vulvar dermatoses • Lichen simplex chronicus • Atopic dermatitis • Lichen sclerosus • Lichen planus

KEY POINTS

- Female genital itch is a common presenting symptom of numerous conditions and thus requires a systematic approach to establish the correct diagnosis.
- Therapy should be initiated in a timely manner to avoid the prolongation of suffering and to prevent complications that may result in disfigurement and/or dysfunction.
- Long-term follow-up and a multidisciplinary approach are often required in this patient population.

INTRODUCTION

Vulvar pruritus is a common complaint among young girls and women presenting to primary care physicians, gynecologists, and dermatologists. Although the true prevalence of vulvar dermatoses is largely unknown, in one vulvar specialty clinic, pruritus of the anogenital region, was found to be the most common presenting symptom, reported by 70% of all male and female patients seen.[1,2] The potential causes of vulvar itch are vast and, more often than not, multifactorial. Although the etiopathogenesis of itch remains poorly understood, the mechanisms underlying vulvar itch are even less so. Vulvar pruritus is often complicated by several factors that are unique to the female anogenital anatomy. Among these factors, the complex innervation of genital skin, the presence of both stratified squamous and modified mucosal epithelia, as well as the introduction of various irritants via a direct connection to the urinary, reproductive, and digestive tracts feature most prominently.

Although pruritus in general has a profoundly negative impact on quality of life because of disruption in work and sleep, female genital itch further interferes with intimacy and sexual function, making it exceptionally distressing. Moreover, the great psychosocial stress caused by vulvar pruritus secondary to the sensitive nature of vulvar disease as well as the pervasive desire to scratch (a socially unacceptable public behavior) cannot be overstated.

Although vulvar pathologic condition may be broadly classified into inflammatory, environmental, neoplastic, and infectious causes, the primary focus of this article centers on the diagnosis and management of inflammatory vulvar dermatoses presenting with pruritus. The authors comment briefly on the more common infectious and neoplastic dermatoses as they pertain to potential differential diagnoses and also speak to their ability to coexist with or develop as a consequence of other primary inflammatory dermatoses.

General Vulvar History

The initial encounter with a patient presenting with a primary complaint of genital itch should include a detailed history guided by the intent of differentiating primary and secondary causes of pruritus. Symptom duration, severity, and aggravating and alleviating factors should be addressed first. Acute

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onset of pruritus is often indicative of an infectious disease, although irritant or allergic contact dermatitis (ACD) may present acutely as well. Chronic pruritus, or itch lasting more than 6 weeks, is suggestive of an inflammatory, neoplastic, or hormone-mediated process.

Inquiry into secondary hygiene practices, including those that may have been implemented to alleviate the pruritus, associated odors, or presumed infection, is imperative. This will often reveal sources of external irritation, such as excessive washing, douching, and the application of feminine hygiene products that may be exacerbating or perpetuating the underlying process. Information regarding bowel and bladder control is also critical to obtain as incontinence of urine or feces as well as products used to manage these conditions, such as panty liners, Depends, and premoistened or premedicated wipes, are additional sources of irritants and allergens.

A thorough past dermatologic history should be gathered because this may reveal a known history of a relevant primary dermatosis affecting other cutaneous or mucosal sites, such as psoriasis, eczema, or lichen planus (LP). A reproductive history, including a history of urogenital malignancies, should be obtained. Clarification of menstrual or menopausal status is often helpful because many women may come with a diagnosis of atrophic vaginitis and may or may not be on estrogen therapy. Last, inquiry into whether sexual partners or other members of the household are experiencing similar symptoms may be useful because this may suggest infection or infestation.

Developing a questionnaire may be the most efficient way to collect all of the pertinent historical data. Patients can complete this before their evaluation so it can be referenced during the initial patient visit.

INFLAMMATORY

Atopic Dermatitis

Atopic dermatitis (AD) is a chronic, common noninfectious cause of vulvar itch that is often underdiagnosed by nondermatologists.[3]

Skin barrier dysfunction in vulvar skin is compounded by numerous other local factors, such as sweat, urine and/or feces, the use of irritating and/or allergenic products, hygiene practices, and certain lifestyle choices, such as repetitive friction from exercise and the use of tight-fitting clothing.

Diagnosis

Severe pruritus is the most common symptom of eczema and may be most pronounced at night. On physical examination, there is a broad spectrum of clinical presentation from poorly demarcated erythematous edematous plaques with vesicles (acute AD), erythematous patches, and plaques (subacute AD), to hyperpigmented lichenified plaques (chronic AD/lichen simplex chronicus [LSC]).

Lichen Simplex Chronicus

LSC is a descriptive term used in the setting of primary, localized, chronic scratching and rubbing of the vulva with no implication toward a specific cause.[4]

Although the actual cause of primary vulvar pruritus and the subsequent development of LSC remain unknown, several patients are ultimately identified as atopic, with either a personal or a family history of allergic rhinitis, hayfever, and/or asthma. It is important to note that LSC can and often will develop as a consequence of other pruritic inflammatory dermatoses of the vulva, namely irritant or ACD and lichen sclerosus (LS).

Regardless of the inciting incident, when itching prompts scratching or rubbing behavior, cutaneous nerve endings are further stimulated, triggering a stronger sensation of itch and thus leading to the "itch-scratch cycle" that is invariably identified in all cases of LSC.

Patients presenting with LSC will often report intermittent or incessant itch that is relieved, albeit temporarily, by scratching or rubbing behaviors. Identifying the presence of nighttime scratching is imperative when approaching treatment.

Environmental factors, such as excessive sweating or friction related to body habitus, exercise or tight-fitting clothing, the use of menstrual or incontinence pads, and the application of over-the-counter medications or other home remedies, may also contribute to perpetuating the itch-scratch cycle and should be addressed.

The importance of psychological factors cannot be overemphasized. Although many patients will not voluntarily offer that they are depressed or anxious, many can identify that their itching and subsequent scratching is exacerbated by stress.

On physical examination, LSC is characterized by ill-defined, erythematous, xerotic plaques with increased skin markings, or lichenification, and a variable degree of overlying scale. The most common site of involvement is the labia majora with occasional extension to the labia minora, mons pubis, or upper medial thighs (**Fig. 1**). The vagina is always spared.[5–8] Secondary excoriations are commonly encountered and can be differentiated from erosions or ulcers by their angulated appearance. Overlying serous and heme-crusting may be present and, depending on the degree, may indicate