Cutaneous Lesions of the External Genitalia

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KEYWORDS

• Cutaneous lesion • Dermatosis • Genitalia • Sexually transmitted infection
• Malignancy • Urology • Dermatology

KEY POINTS

- Widespread dermatoses may also affect the skin of the genitals, and these lesions may have distinct or atypical morphology compared with extragenital lesions.
- Malignant transformation may occur in background of benign conditions.
- Uncircumcised men are at increased risk for developing malignancy of the genitalia.
- Lesions that do not respond as expected to indicated treatment should be referred to a specialist because of concern for premalignant or malignant changes.

INITIAL EVALUATION

Individuals with cutaneous diseases of the external genitalia often initially present to their primary care provider. When present, these conditions may be associated with considerable physical symptoms and psychological distress. Initial evaluation of these patients requires obtaining a complete history with attention to associated symptoms, including sexual or urinary dysfunction, circumcision status, sexual history including contraceptive use, personal and family history, medications, and drug use. A thorough genital examination and a complete skin survey are necessary.

GENITAL INVOLVEMENT OF SYSTEMIC SKIN DISEASES

Many systemic dermatoses have genital manifestations that resemble their extragenital counterparts and thus are excluded from this review. However, some skin conditions have distinct or atypical genital lesions that differ from those located on extragenital sites. Occasionally, the genital lesion is the first or only manifestation of the systemic condition.

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Psoriasis

The characteristic lesion of psoriasis is a sharply demarcated, erythematous plaque with silvery-white scales, often affecting the extensor surfaces of the skin. Genital involvement in this condition is common affecting 30% to 40% of patients[1] and is typically in the context of extragenital lesions. Lesions on the genitals have variable appearance depending on their site. When located in intertrigonal regions (inguinal folds, intergluteal cleft, under preputial skin, on the labia), lesions tend to weep instead of scale.[2,3] When found on the glans or corona of circumcised men, plaques typically scale (**Fig. 1**); lesions may involve the entire penis and scrotum.[3]

Diagnosis of genital psoriasis can usually be made clinically; if associated with intertrigonal lesions, fungal infection should be ruled out. Mainstay of treatment is low-potency topical steroid for a short course (maximum of 2 weeks). Other approaches include topical vitamin D_3 analogues, topical calcineurin inhibitors, and low-potency retinoids.[4]

Lichen Planus

Lichen planus (LP) is an idiopathic inflammatory disease affecting the skin and mucous membranes with genital involvement in 25% of cases.[5,6] Lesions typical of LP are small, polygonal, violaceous flat-topped papules that commonly involve the flexor surfaces of the extremities, trunk, and lumbrosacral area. Oral mucosa may also be involved. When involving the genitalia, the appearance is variable and may include isolated or grouped papules, a white reticular pattern (known as Wickham striae; **Fig. 2**), or an annular arrangement of papules with or without ulceration.[7] Genital lesions may be associated with pruritus, pain, or burning, or may be asymptomatic. In men, the glans of the penis is most often involved and may have an erosive component; in women, lesions mainly involve the labia minora and the vaginal introitus and may erode, leading to pain, burning with urination, and dyspareunia. In long-standing LP, white plaques may develop around erosive lesions. Lesions often resolve spontaneously after a year; however, isolated cases of squamous cell carcinoma (SCC) arising in chronic genital lesions has been reported.[8]

Diagnosis of LP involving the genitals is clinical, but biopsy may be performed to establish the diagnosis, particularly if the lesions are noncharacteristic or isolated to the genitalia.[3] The mainstay of treatment of symptomatic genital LP is short course of high-potency topical corticosteroid (ie, clobetasol, 0.05% or halobetasol, 0.05%). Topical calcineurin inhibitors may also be used.[9] Systemic corticosteroid therapy

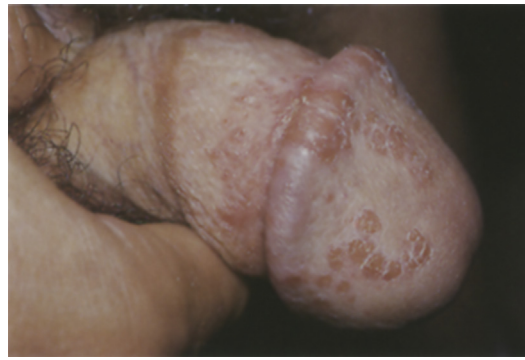

Fig. 1. Psoriasis on a circumcised phallus. (*From* English JC, Laws RA, Keough GC, et al. Dermatoses of the glans penis and prepuce. J Am Acad Dermatol 1997;37(1):14; with permission.)