

# Dermoscopy of Inflammatory Genital Diseases: Practical Insights



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## KEYWORDS

• Dermoscopy • Inflammatory genital diseases • Lichen sclerosus • Lichen planus • Psoriasis  
• Eczema • Plasma cell mucositis

## KEY POINTS

- Genital inflammatory diseases may have similar appearances and represent a diagnostic challenge for clinicians.
- Genital inflammatory diseases may be confused with infectious and malignant conditions as well.
- Practical guidance for the use of dermoscopy in the assessment of the main inflammatory genital diseases is provided within this article, namely for lichen sclerosus, lichen planus, psoriasis, lichen simplex chronicus, and plasma cell mucositis.
- Dermoscopy potentially improves the differential diagnosis of genital inflammatory diseases by defining specific patterns.

## INFLAMMATORY GENITAL DISORDERS: PRACTICAL PITFALLS

Dermoscopy was originally introduced as an integrative part in the clinical evaluation of pigmented lesions and skin tumors because it improves diagnostic accuracy.<sup>1</sup> Since then, the applicability of dermoscopy has been extended to numerous general dermatologic disorders, including non-pigmented tumors, inflammatory skin diseases,<sup>2–4</sup> hair and nail abnormalities,<sup>5,6</sup> skin infections, and infestations.<sup>7</sup>

Genital inflammatory disorders may represent a diagnostic challenge for both clinicians and pathologists.<sup>8,9</sup> In fact, an extraordinarily broad range of etiologies accounts for genital lesions, not only inflammatory in nature, but also cancerous and infectious conditions. The commonest inflammatory diseases that involve the genital sites are lichen sclerosus, lichen planus, lichen simplex chronicus,

eczema, including atopic dermatitis and contact dermatitis, and psoriasis. Other less common disorders include plasma cell mucositis of Zoon and fixed drug eruption.

In many cases, these disorders, which are extremely heterogeneous for etiopathogenesis, course, and prognosis, may have similar appearances. In addition, the genital area is exposed to friction, maceration, physiologic occlusion, and mechanical and chemical irritation. Consequently, the normal features of these common dermatoses may be lost or modified in this region.

Because of their location, these dermatoses may be confused with sexually transmitted diseases. On the other hand, genital inflammatory disorders may coexist with contagious conditions and this can further make their diagnosis tricky.<sup>10</sup>

Cancer may develop in the context of some inflammatory conditions, without pathognomonic

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clinical changes, especially in the early phases.<sup>11–13</sup> Furthermore, a number of physiologic genital variants or lesions should be recognized and differentiated from inflammatory disorders, such as cysts, syringomas, seborrheic keratosis, pearly papules, Fordyce spots, and hyperpigmentation. Another important aspect is that because of their anatomic location, genital lesions, mostly vulvar lesions, are often noted incidentally, especially in asymptomatic cases. Thus, their onset, duration, and behavior may be unknown.

Although a histopathological examination may be necessary to shed light on this wide variety of differential diagnoses, dermoscopy could be included as a part of the clinical inspection of genital diseases.<sup>14–16</sup> Specific dermoscopic patterns and features have been described for several inflammatory genital disorders. As a consequence, in this field, too, dermoscopy could become a noninvasive diagnostic aid to support diagnosis and avoid unnecessary invasive investigation. Furthermore, by recording dermoscopic photographs, the course of inflammatory conditions can be monitored. This is of particular value for those disorders that can evolve toward cancer or lead to anatomic changes, like lichen sclerosus. Response to treatment can be objectively assessed, too.<sup>17,18</sup>

## PRACTICAL TIPS FOR GENITAL DERMOSCOPY

During assessment of genital sites by dermoscopy, to prevent microbiological contamination of the probes and the subsequent potential transmission of infections between patients, previous studies have evaluated the possibility of covering the glass plate of the dermoscopic instrument with a disposable, polyvinyl chloride (PVC) food wrap (Domopak; Comital Cofresco SpA, Volpiano [Torino], Italy) with the interposition of mineral oil.<sup>19,20</sup> The use of PVC film during dermoscopic examination of mucosal surfaces was shown to act as a safe barrier for virologic contamination and to permit an unmodified view of the pigmented lesions.

## DERMOSCOPY OF INFLAMMATORY GENITAL DISEASES

The chief objective of this article was to provide practical guidance for the use of dermoscopy in the assessment of inflammatory genital diseases. The main dermoscopic clues described so far for this group of disorders are summarized as follows and in **Table 1**.

### *Lichen Sclerosus*

Genital lichen sclerosus (GLS) is a chronic inflammatory, immune-mediated disease that affects the

anogenital areas.<sup>21</sup> GLS primary lesions are flat, ivory-colored spots that may coalesce into thin crinkly patches. Ecchymosis and itching-related excoriations are common, especially in female patients,<sup>22</sup> and occasionally hyperkeratosis is a prominent feature. Postinflammatory scarring may cause destruction of anogenital architecture. In female patients, this may lead to progressive labial fusion, tearing of tissue, introital stenosis, and burying of the clitoris. Phimosis, adhesions of the foreskin to the glans, and meatal stenosis are typical sequelae in male patients. An increased risk of genital cancer is also recognized.<sup>23,24</sup> GLS is a very distressing disease, in fact most patients complain of the symptoms, mainly itching, burning, and sexual dysfunction.<sup>25–27</sup>

In the early stages of the disease the diagnosis can be difficult. The main differential diagnoses are lichen planus (LP), lichen simplex chronicus, vitiligo, immunobullous disorders such as mucous membrane pemphigoid, and vulvar or penile intra-epithelial neoplasia.<sup>21,28</sup>

To date, only a few studies have specifically addressed the dermoscopic features of GLS, with quite similar findings.<sup>29,30</sup> A whitish background together with patchy structureless areas, varying in color from white to white-yellowish to milky-pinkish, represent the prevalent dermoscopic feature of GLS (**Fig. 1**). These dermoscopic clues may be observable also in the case of absence of pallor at the clinical evaluation. They correspond to sclerosis and hyalinization, which are the main pathologic changes in lichen sclerosus (LS).<sup>29</sup> A marked decrease in vessel concentration in the context of GLS lesions when compared with unaffected surfaces is the other dermoscopic hallmark of this disease. Vessels are polymorphic in shape, without any specific arrangement. The correlation between dermoscopic vascular pattern and disease duration is controversial; Larre Borges and colleagues<sup>29</sup> did not find any association, whereas Borghi and colleagues<sup>30</sup> have observed that dotted vessels occur mostly in the early stage of GLS.

Gray-blue dots arranged in a typical peppering pattern can frequently be observed in GLS. Melanophages displaced in both the upper dermis and the perifollicular site are the histologic counterpart of this dermoscopic peppering, which is a consequence of the inflammatory process. Because of this, it is observed in other chronic, genital inflammatory diseases as well.<sup>31</sup> Postinflammatory hyperpigmentation may be so marked that in a few male patients it is reported to clinically and dermoscopically mimic melanoma.<sup>32,33</sup> In a case of pigmented postinflammatory penile LS, Sollena and colleagues<sup>33</sup> described a dermoscopic pattern

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