VULVAR DISORDERS

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SUMS

Anogenital Wart

- infection with HPV occurs most commonly by intimate contact, while infection of non-genital skin may occur via direct skin to skin contact or indirectly through contaminated surfaces and objects (e.g. swimming pool, gymnasium)

- PCR based detection, normal-appearing skin surrounding HPV-associated lesions and even skin of healthy volunteers may contain HPV DNA
- These observations help to explain the high recurrence rate of warts (e.g. ۲۰–۵۰% for genital condylomata) and the observation that treatment may not prevent further transmission of the virus

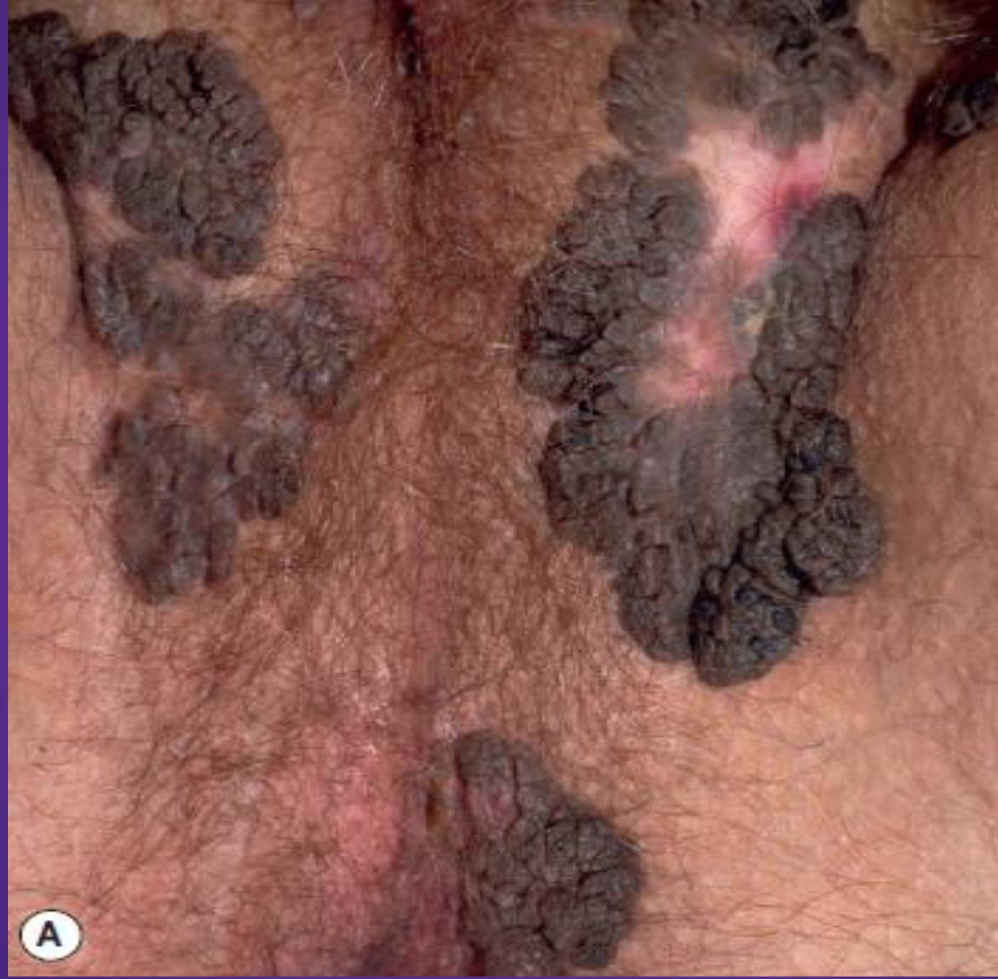
- More than ۴۰ HPV types preferentially infect the mucosa of the anogenital and upper aerodigestive tracts
- Subclinical infections are much more common than visible warts. Application of ۵% acetic acid (acetowhitening) may aid in the identification of subclinical lesions as white areas

Clinical Manifestation

- Condylomata acuminata
- Condylomata plana
- Bowenoid papulosis
- Erythroplasia of Queyrat

BX

- Is indicated for pigmented, erosive, bleeding and therapy resistant genital lesions to exclude malignancy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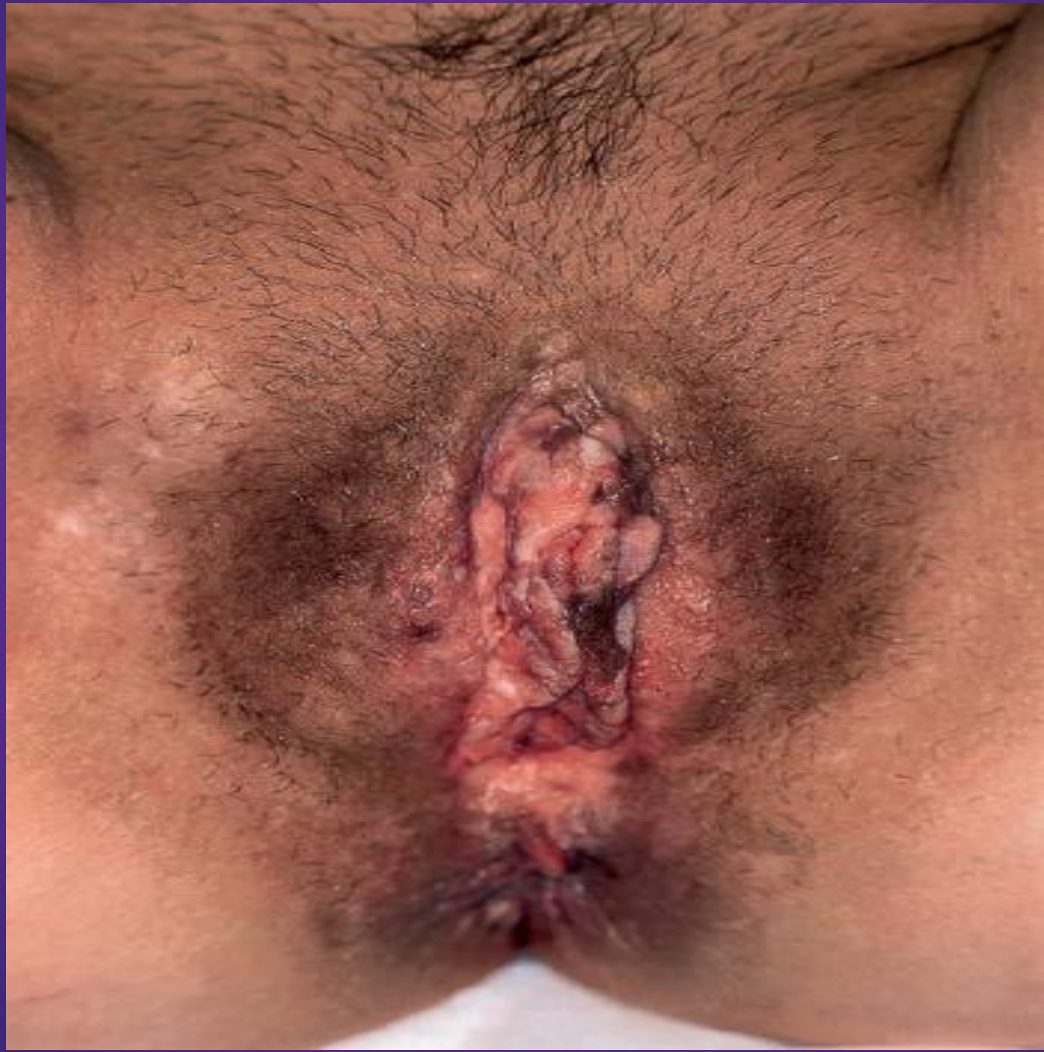
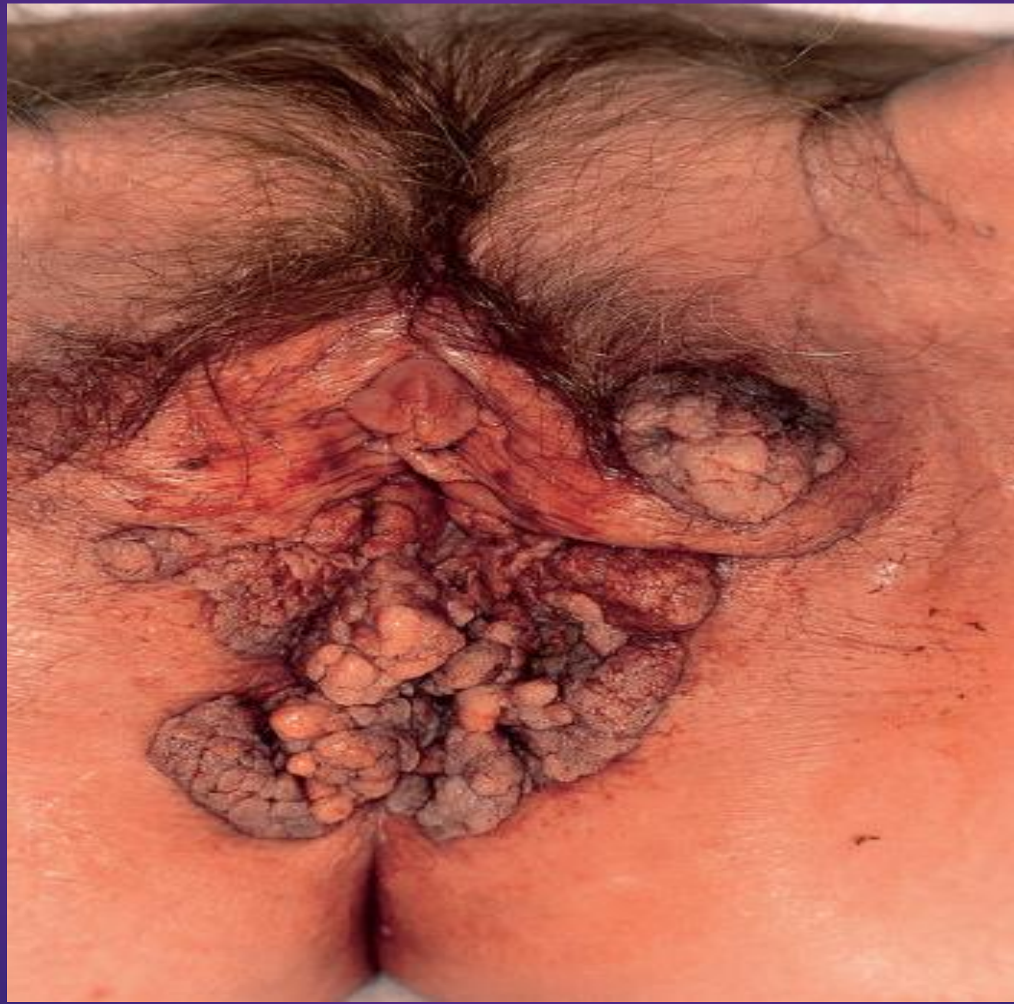




Mucosal lesions		
• Condylomata acuminata	6, 11	40, 42–44, 54, 61, 70, 72, 81
• High-grade intraepithelial neoplasias (including cervical condylomata plana, bowenoid papulosis, erythroplasia of Queyrat) and invasive cancer	16	18, 26*, 31, 33, 35, 39, 45, 51, 52, 53*, 56, 58, 59, 62, 66*, 68, 73, 82
• Buschke–Löwenstein tumor	6, 11	
• Recurrent respiratory papillomatosis, conjunctival papillomas	6, 11	
• Heck disease (focal epithelial hyperplasia)	13, 32	

*Probably carcinogenic[33].

MANAGEMENT OF ANOGENITAL WARTS WITH GRADING OF RECOMMENDATIONS

Patient-applied therapy

- Podophyllotoxin 0.5% solution, 0.15% cream (1)
- Imiquimod 5% cream (1)
- Sinecatechins 10% or 15% ointment (1)

In-office therapies

- Cryotherapy (liquid nitrogen spray, cryoprobe) (1)
- Trichloroacetic acid (TCA) or bichloroacetic acid (BCA) 80–90% solution (1)
- Electrosurgery (1)
- Scissor or shave excision, curettage (1)
- Laser vaporization (CO_2, PDL, Nd:YAG) (2)
- Surgical excision (3)

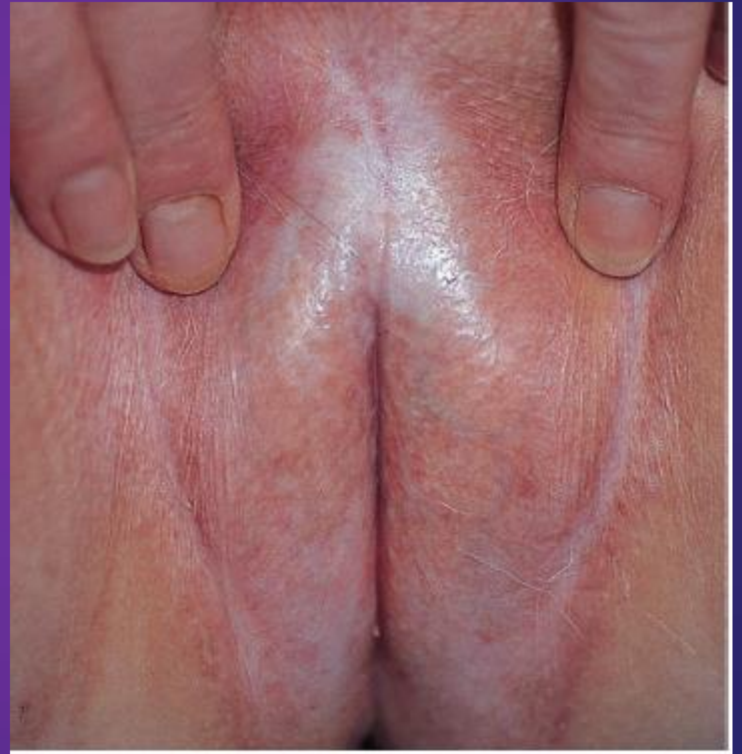
LICHEN SCLEROSUS

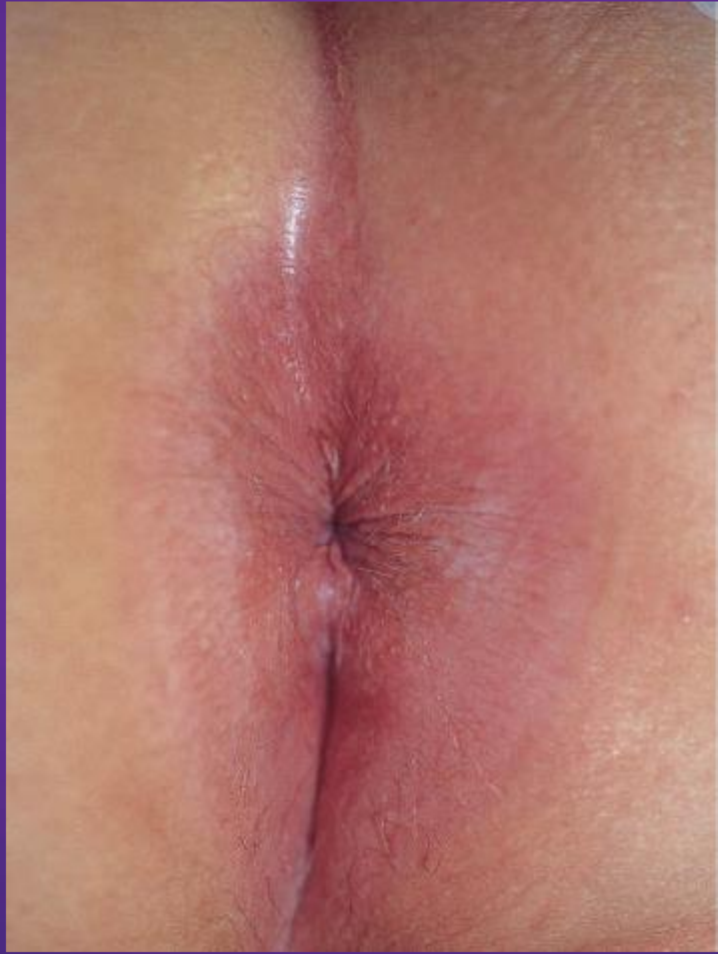
Key features

- Chronic inflammatory disease with a predilection for the anogenital region
- Pruritus is the most frequent symptom
- Major clinical signs are pallor, atrophy, fissures, and foci of hyperkeratosis
- Scarring may cause loss of the normal architecture of the vulva in women and phimosis in men

- Lichen sclerosus is ۶–۱۰ times more prevalent in women than in men. The disorder may occur at any age, but the two peaks of onset are childhood and after menopause
- In women, the characteristic clinical findings are vulvar hypopigmentation and thin, wrinkled, atrophic skin in a figure-of-eight distribution encircling the vulvar and perianal region

- Dyspareunia is frequently reported
- Lichen sclerosus is a scarring disease and therefore architectural change is common
- The disease usually presents with pruritus, pain, and dyspareunia





THERAPIES FOR ANOGENITAL LICHEN SCLEROSUS
First-line
Soap substitutes and emollients (3) Superpotent topical corticosteroids (3-month course) (1) Circumcision in men, if phimosis (2)
Second-line
In some patients, longer-term maintenance with potent topical corticosteroids (2) Surgery to correct narrowing of introitus and reverse clitoral burying (3) Tacrolimus ointment (2) Pimecrolimus cream (1) Circumcision in men, if unresponsive to medical treatment (3) Methotrexate (3)

LICHEN PLANUS

■ Four distinct forms of genital lichen planus are observed:
(۱ papules or plaques (۲) erosive disease;
(۳) hypertrophic disease (۴) lichenplanopilaris

■ Although cutaneous disease is often self-limiting, mucous membrane disease is more persistent

■ The classic findings in cutaneous disease are violaceous, flattopped papules and plaques; lacy white streaks typically occur on the genitalia as well as the oral mucosa

■ Erosive lichen planus often involves multiple mucous membrane sites – in particular, the vulva, vagina, and oral mucosa

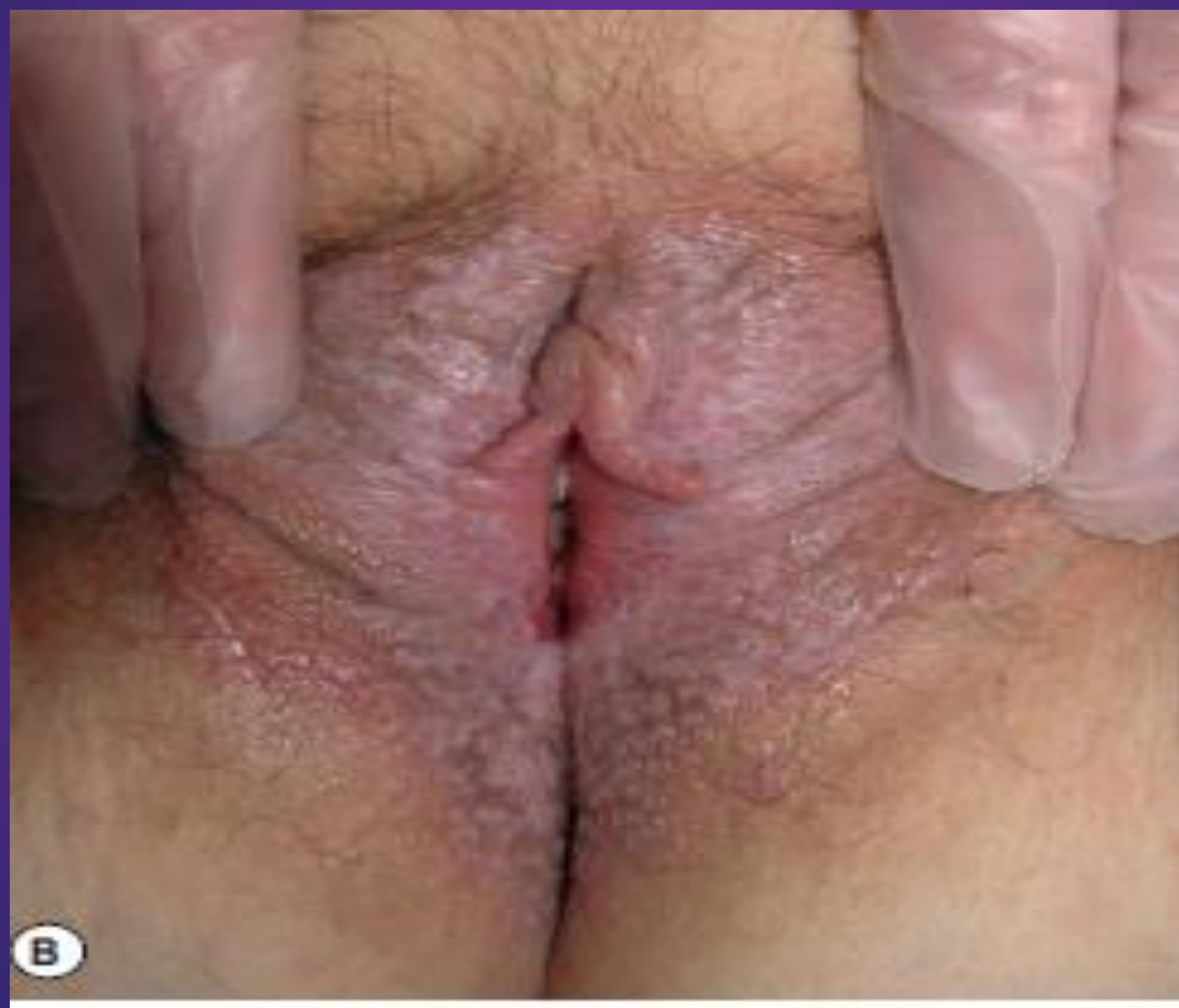
- Lichen planus is more common in women, generally presenting in the sixth decade. The exact prevalence is unknown, but it is likely that some cases of genital involvement in cutaneous lichen planus may be missed

LICHEN PLANUS

- Approximately ۵۰% of women with cutaneous lichen planus have genital involvement
- The classic violaceous papules and plaques typically affect the labia minora and majora or the mons pubis
- Erosive lichen planus is a distinct subtype of the disease, characterized by severe, scarring erosive disease of the vestibule, introitus, vagina, and ora cavity
- Hypertrophic genital lichen planus and lichen planopilaris are the least frequent forms.

Erosive LP

- Erosive lichen planus occurs much more frequently in women than in men
- Pain and dyspareunia are the most common complaints
- Extensive erosions occur around the vaginal orifice
- Frequently leads to scarring, resulting in distortion of the vulvar architecture
- Long-term evaluation of these patients is advised because of the risk of malignant transformation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THERAPIES FOR ANOGENITAL LICHEN PLANUS

First-line

Soap substitutes and emollients (3)
Superpotent topical corticosteroids (2)
For vaginal disease, corticosteroid foams*, enemas*, suppositories* or ointments (± dilators) (3)

Second-line

Longer-term maintenance with superpotent topical corticosteroids or combined moderately potent corticosteroid/antifungal/antibacterial preparations (3)
Surgery to correct narrowing of introitus and reverse clitoral burying in women or circumcision in men (3)
Topical calcineurin inhibitors (3)
Intralesional corticosteroid (hypertrophic disease) (3)
Systemic immunosuppressants (3)
Systemic antibiotics (minocycline ± nicotinamide) (3)

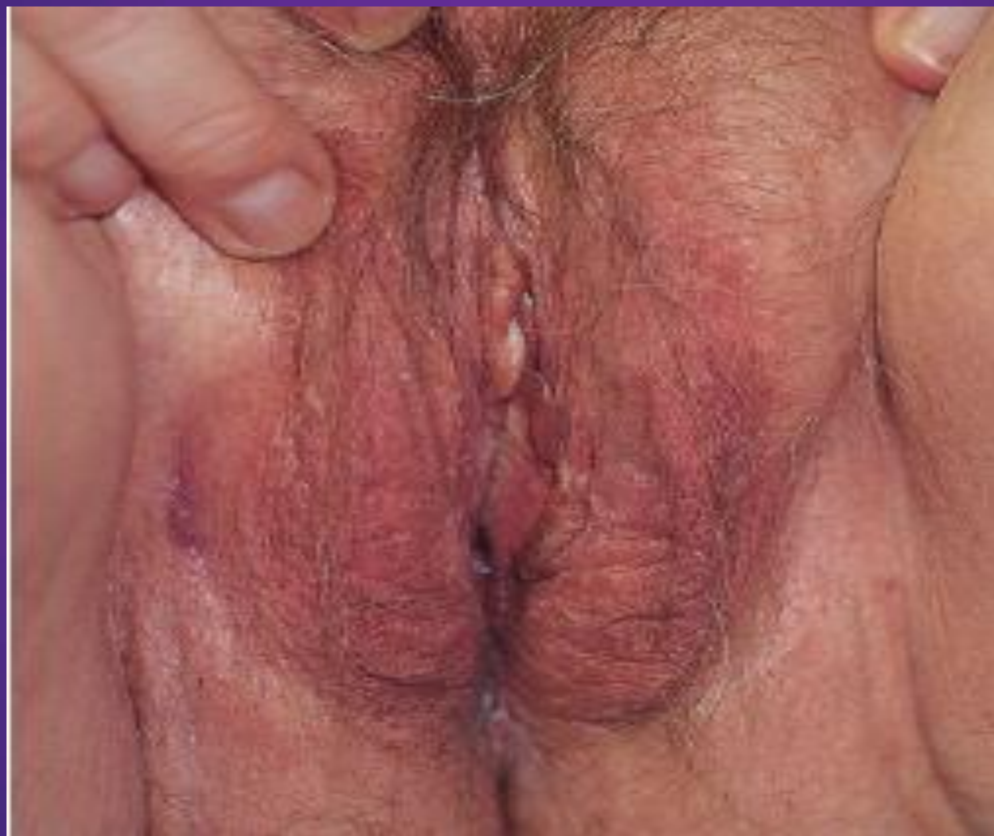
*Available for the treatment of inflammatory bowel disease.

Vulvar Dermatitis

- Appearance ranges from mild erythema to marked lichenification
- Pruritus and soreness are the main complaints
- A mixed etiology is common
- Exogenous irritants and allergens must be sought

Vulvar Dermatitis

- The anogenital area is susceptible to irritants, and allergic contact dermatitis is very prevalent in this site is usually due to topical medications or personal hygiene products (e.g. “wet wipes” that contain methylisothiazolinone)
- Psychological issues and local environmental problems such as heat, sweating, and over-cleansing may be contributing factors



- RX: regular use of bland emollients and the substitution of an emollient for soap is recommended.
- Exacerbating factors, including stress, heat, excessive washing should be identified
- Topical corticosteroids, often in combination with topical antifungal agents, topical antibacterial agents and/or topical immunomodulators

Psoriasis

Key features

- Erythematous well-defined plaques
- Evidence of psoriasis elsewhere on total body skin examination
- Intergluteal cleft frequently affected
- Poor response to treatment

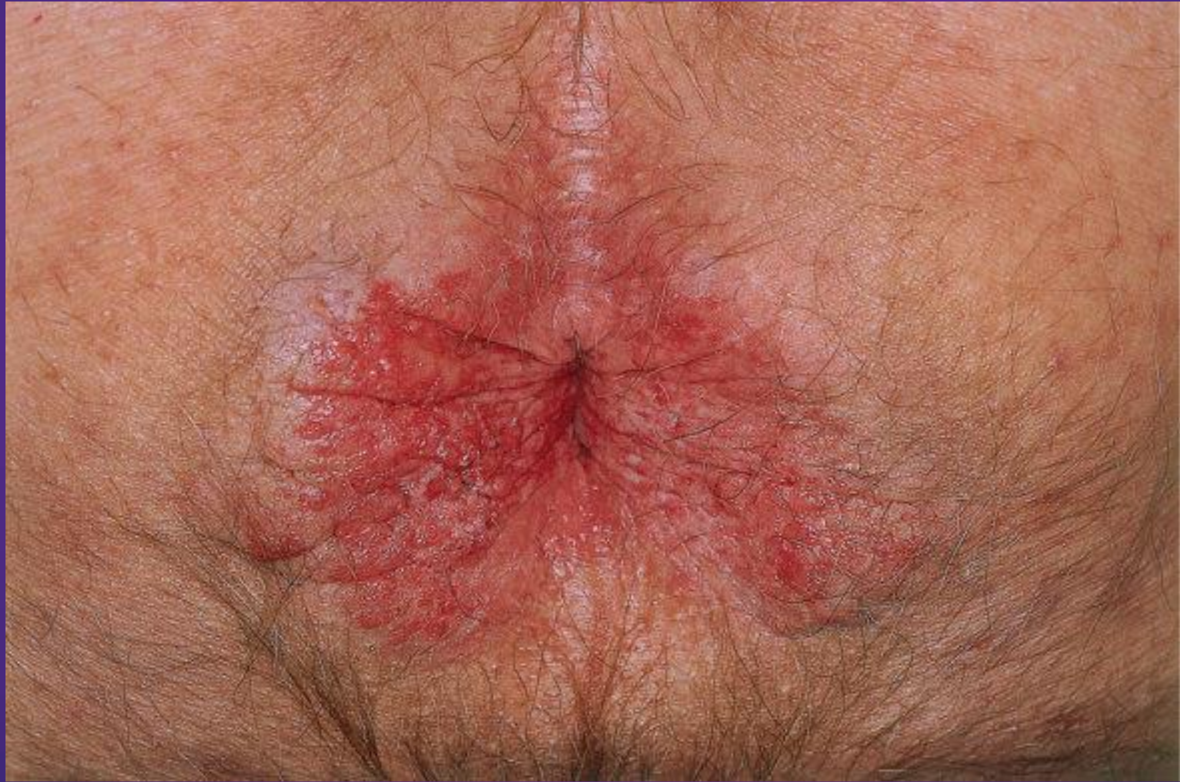
- In women, erythematous, smooth, clearly demarcated plaques typically affect the labia majora and the mons pubis
- Psoriasis is usually confined to the hair-bearing areas, so the labia minora are unaffected
- RX: topical steroids and calcineurins inhibitors

Extramammary Paget Disease

- Rare intraepithelial adenocarcinoma
- May be primary or secondary to an underlying malignancy
- Associated with an underlying visceral malignancy in ١٠–٢٠% of patients

Extramammary Paget Disease

- The vulva is common site in women
- There may be associated pruritus or burning or the lesions may be asymptomatic
- A slowly expanding erythematous plaque is typical, with a sharp demarcation between normal and involved skin



- RX: A thorough search for interna malignancies associated
- In the anogenital region, wide local excision or Mohs micrographic surgery is recommended
- Long-term follow-up is recommended for these patients

Localized Vulvodynia

- Superficial dyspareunia
- Tenderness on localized pressure within the vulvar vestibule
- Occurs in young, sexually active women

- This particular localized pain syndrome occurs in the young, premenopausal, sexually active woman whose main complaint is one of dyspareunia on penetration
- The vulva looks entirely normal but there is pain when the vestibular area is pressed by a cotton-tipped applicator

- RX: Regular application of bland emollients and avoidance of irritants such as detergents and fragranced products
- Topical local anesthetic agents
- Tricyclic antidepressants

Generalized Vulvodynia

- Persistent burning pain is characteristic and patients have often consulted many doctors before the correct diagnosis is made
- Depression may be a feature of any chronic pain syndrome
- There is an association with fibromyalgia and the irritable bowel syndrome

- Pain, often accompanied by a burning sensation over the entire vulva
- The genital area may hurt even when nothing is touching it
- Symptoms are worse on sitting or walking up stairs. Wearing of underwear may be impossible
- On inspection vulva looks entirely normal
- RX: such as localized vulvuodynia

Thank You..