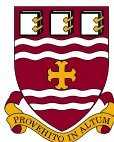

Vulvar Discomfort:

An Approach for the GP

Lesa Dawson, MD, FRCSC

Presented at Wednesday at Noon—Ask the Consultant

Most women will, at some time in their life, complain of vulvar pain, itching, irritation, or discomfort. These common symptoms can be caused by a multitude of diagnoses, making the topic a difficult one for family physicians. Diseases of the vulva represent a spectrum of benign and malignant conditions that can be broken down by etiology. The key point is that each problem can be diagnosed with careful examination and appropriate biopsy. Recurrent candiasis, although common in the premenopausal woman, is rarely seen in the older patient. It is important to consider other diagnoses once candida has been ruled out.

In all patients suffering from vulvar discomfort, the most important elements of care are:

- observation/examination of the vulva,
- generous use of biopsy, and
- strict attention to vulvar hygiene.

How do I do a biopsy?

Vulvar biopsy can be carried out in the office simply using lidocaine anesthetic as a spray, followed by an injection of a superficial bleb of 1% to 2% solution. Superficial biopsy using small diameter 3 mm to 4 mm Keyes "cookie cutter" punch can be done easily. Oozing from the site will rarely require suture, and can often be controlled with silver nitrate or Monsel's solution.

What can relieve the pain?

For most patients, regardless of the diagnosis, careful attention to vulvar hygiene with avoidance of perfumed or irritating products, and the use of cotton underwear and oatmeal-based bath powders are often helpful. Adding tea bags to sit-baths may be soothing. Careful drying of the vulva with a hair dryer on a cool setting is very effective, as it eases symptoms and speeds healing.

What problems are most common?

The first approach to vulvar disease begins with a division of local versus systemic problems.

Local problems most commonly encountered by the general practitioner will include:

- local skin sensitivities,
- vulvar dysplasia, and
- lichen sclerosis, as well as
- vulvar masses and nevi.

Local skin reactions will often occur after exposure to a new bath or feminine hygiene product, and will usually settle with simple hygiene

measures, antihistamines and avoidance of repeat exposure.

Vulvar masses: The most frequently seen vulvar mass is a Bartholin's gland abscess. This abscess typically will be acutely painful and will always be located at the posterior-lateral vulva. Treatment is via surgical marsupialization. Hidranitis suppuritiva, an inflammatory suppurative disorder of apocrine glands, will also present as a mass. Hidranitis suppuritiva, however, will present chronically, with recurrent subcutaneous nodules or draining abscesses on the superior-lateral vulvar extending towards the groin. This persistent disorder is best treated with antibiotics and excision, rather than with drainage alone.

Lichen sclerosis: Lichen sclerosis factors among the most commonly diagnosed vulvar dystrophy. It is usually seen in post-menopausal women. Pediatric cases are rarely reported. Theories about etiology include autoimmune triggers, or relative androgen deficiency. Clinically, the skin has a thin pale "cigarette paper" appearance, and there may be distortion of normal anatomy with loss of contour or fusion of the labia minora. Excoriations may be superimposed on the underlying weakened skin, as may cracks around the introitus. Classically, treatment was testosterone cream or progesterone cream. High-potency steroids, however, have been shown to be the most effective local treatment. Clobetasol, 0.05% twice daily for two to three months, is an effective approach, followed by tapered use. Exacerbations of this chronic disorder may require repeat intensive courses. Treatment is to be aimed at the prevention of progressive scarring and symptom relief.

Hyperpigmented lesions: Nevi or hyperpigmented areas on the vulva are common and must not be ignored, since vulvar melanoma represents a disproportionate percentage of all melanomas found on the body. Vulvar melanomas are often diagnosed later than similar lesions on other sites. Similar principles regarding evaluation of nevi elsewhere on the body apply to genital lesions.

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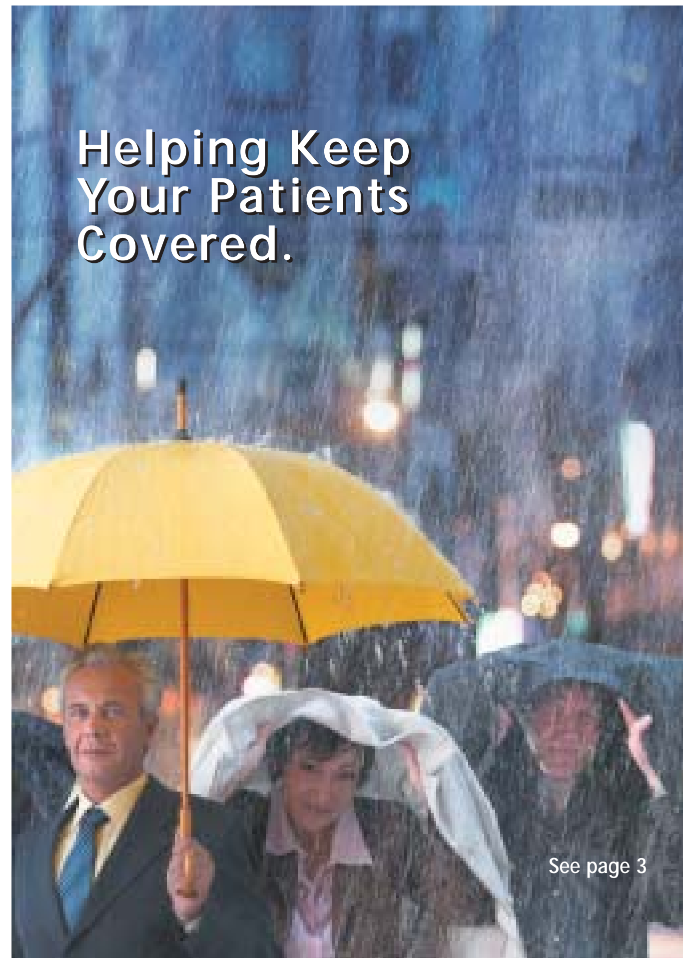

The principales are:
a) asymmetry,
b) borders,
c) colour,
d) diameter.

Given the difficulty that patients have in following vulvar lesions and the relative frequency of melanoma on the vulva, it is recommended that all hyperpigmented genital lesions be removed.

Vulvar dysplasia: The incidence of vulvar intraepithelial neoplasia (VIN) is increasing, especially in younger women and in those with a history of smoking or cervical dysplasia. Preinvasive disease on the vulva clearly represents one of several examples of viral carcinogensis linked with human papillomavirus. Significant VIN can be seen in women with subdued immune response (those with human immunodeficiency virus or organ transplantation). Most patients complain of persistent itching. Typically, vulvar preinvasive disease is white and well-demarcated in appearance. However, red or pigmented VIN are sometimes seen. The unpredictable examination of this disorder makes it clear that biopsy of any vulvar lesion is critical, as simple observation with the naked eye cannot rule out precancerous lesions. Options for treatment include local excision or ablation with carbon dioxide laser. Smoking cessation is unquestionably central in the treatment of this problem.

The key point is that each problem can be diagnosed with careful examination and appropriot biopsy

What else could it be?

Systemic diseases may also present at the vulva. Psoriasis on the vulva may not have the same "flaky" appearance compared to lesions elsewhere on the body. In the absence of a known diagnosis elsewhere, biopsy alone will distinguish psoriasis from other vulvar disease. Acute herpes simplex virus will usually be a straightforward diagnosis confirmed with viral culture. Crohn's disease may cause painful "knife-like" lesions on the vulva that abate with systemic treatment. The diagnosis of candiasis will be clear for most physicians, but it is important to remember that severe recurrent candiasis should prompt evaluation of glycemic control. CME

Take-home message

- Careful examination of the vulva at the time of pelvic exam or at the time of a patient complaint should be routine in general practice.
- The most important intervention in the management of vulvar disease is biopsy.
- The most important elements of care in all patients suffering from vulvar discomfort are observation/examination of the vulva and strict attention to vulvar hygiene, as well as generous use of biopsy.

Suggested Readings
1. Foster DC: Vulvar Disease. American College of Obstetricians and Gynecologists 2002; 100(1):145-63.
2. Kamarashev JA, Vassileva SG: Dermatologic diseases of the vulva: Clin Dermatol 1997; 15(1):53-65.
3. Larrabee R, Kylander DJ: Benign vulvar disorders: Identifying features, practical management of nonneoplastic conditions and tumors. Postgraduate Medicine 2001; 109(5):151-4, 157-9, 163-4.
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7. Irvin WP, Legallo RL, Stoler MH, et el: Vulvar melanoma: A retrospective analysis and literature review. Gynecologic Oncology 2001; 83(3):457-65.
8. Jones RW, Vulvar intraepithelial neoplasia: Current perspectives. Eur J Gynaecol Oncol 2001; 22(6):393-402.
9. ACOG educational bulletin: Vulvar nonneoplastic epithelial disorders. Number 221, October 1997 (Replaces no. 139, January 1990). American College of Obstetricians and Gynecologists.
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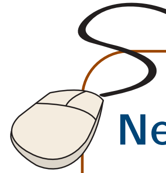
11. Cardosi RJ, Bomalaski JJ, Hoffman MS: Diagnosis and management of vulvar and vaginal intraepithelial neoplasia: Obstet Gynecology Clin North Am 2001; 28(4):685-702.
12. Edwards S, Handfield-Jones S, Gull S: National guideline on the management of vulvar conditions. Int J STD AIDS 2002; 13(6):411-5.

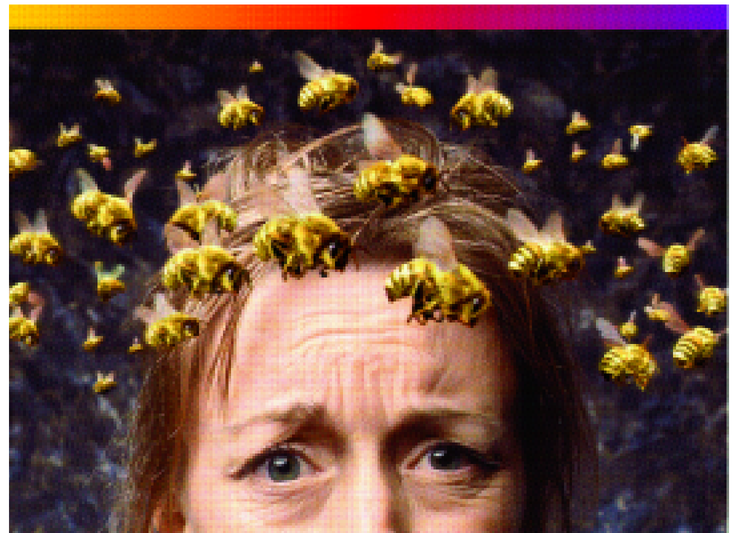


Net Reading

1. WomanHealth: *www.womanhealth.net*
2. The Colposcopy Unit, Sunnybrook Health Science Centre: *www.colposcopy.com*

www.stacommunications.com

For an electronic version of this article, visit: *The Canadian Journal of CME* online.



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