Is it atrophic vaginitis or lichen sclerosus?

What is the difference between atrophic vaginitis and lichen sclerosus? What are the treatments?

Atrophic Vaginitis
Atrophic vaginitis is a thinning of the epithelium, usually secondary to a lack of estrogen. Patients are usually postmenopausal and present with symptoms of itching, burning, and soreness. On examination, both the vulvar and vaginal tissues are red, thin, friable, with a loss of rugae and loss of normal anatomy. Other infections should be ruled out using a wetmount preparation, especially if the symptoms are associated with a discharge. Treatment consists of oral estrogen, in regimens similar to hormone replacement therapy, or topical estrogen. Topical estrogen protocols include 0.01% estradiol vaginal cream, 2 g to 4 g daily, for one to two weeks, tapered to 1 g to 2 g for another one to two weeks, with a maintenance dose of 1 g up to three times weekly. There is also conjugated estrogen vaginal cream, 2 g to 4 g daily, three weeks of every month for three to six months. The use of progestins in patients with a uterus is not necessary with the short-term use of topical estrogen, but patients must be monitored for signs of endometrial proliferation, and any bleeding must be investigated. If the patient presents with postmenopausal pruritus, or the symptoms persist despite treatment, a punch biopsy is warranted.

Lichen sclerosus
Lichen sclerosus is a chronic condition of unknown etiology, associated with epithelial thinning and inflammation. Patients are usually perimenopausal or postmenopausal, but can be of any age, including infants. The chief complaint is usually intense pruritus with associated

Practice Pointer
With every vaginitis, always remember the basics: wearing loose cotton underwear, avoiding irritants, and proper drying after bathing are just a few of the simple things patients can do to both stop and prevent irritation.
You asked about...

scratching. As the disease progresses, patients may also complain of burning and dyspareunia. On examination, the vulvar tissue is usually thin and white but may be red and inflamed. The disease is localized to the labia, with sparing of the vagina. As with atrophic vaginitis, a loss of the vulvar architecture is seen with advancing disease. Diagnosis is made by a punch biopsy of the area (except in prepubertal patients); this is important to rule out malignant changes. The mainstay of treatment is the use of very high potency topical corticosteroids, including clobetasol propionate, 0.05%, or halobetasol propionate, 0.05%, creams applied two times a day for two to three weeks, and then tapering off. The maintenance dose is one to three applications per week. Ongoing monitoring of the condition should be performed. Persistence or worsening of symptoms may require another biopsy.

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Table 1

Atrophic Vaginitis Versus Lichen Sclerosus

<table>
<thead>
<tr>
<th>Atrophic Vaginitis</th>
<th>Lichen Sclerosus</th>
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<td><strong>What is it?</strong> A thinning of the epithelium, usually secondary to a lack of estrogen.</td>
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<td><strong>Patients:</strong> Postmenopausal</td>
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<td><strong>Symptoms:</strong> Itching, burning, and soreness.</td>
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<td><strong>Examination:</strong> The vulvar and vaginal tissues are red, thin, friable, with a loss of rugae and loss of the normal anatomy.</td>
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<td><strong>Diagnosis:</strong> Other infections should be ruled out using a wetmount preparation.</td>
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<td><strong>Treatment:</strong> Oral estrogen in regimens similar to hormone replacement therapy, or topical estrogen. Patients must be monitored for signs of endometrial proliferation, and any bleeding must be investigated.</td>
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In patients on warfarin for atrial fibrillation, is it necessary to monitor international normalized ratios (INRs) monthly in patients who are stable? Is this the accepted standard of care?

The answer to this question is yes, monitoring INRs monthly is the accepted standard of care.

The Stroke Prevention in Atrial Fibrillation (SPAF) III Study and the Coumadin Aspirin Reinfarction Study (CARS) used fixed doses of warfarin in their warfarin/aspirin arms—not INR adjusted—and failed to show benefit because the average INRs were below the therapeutic range. On the other hand, the Stroke Prevention in Nonrheumatic Atrial Fibrillation study (SPINAF), as well as the other studies, 4-9

Practice Pointer

My recommendation, which is in concordance with findings in well-conducted trials, is to start with warfarin in doses of 4 mg/day for patients younger than 70, and 3 mg/day for older patients.
used a rigorous monitoring regimen. The SPINAF study demonstrated a 79% reduction in stroke rate among the warfarin-randomized patients without an increase in bleeding complications. In this study, patients began taking 4 mg/day of warfarin, with a goal of maintaining the prothrombin time ratio (PTR) within 1.2 to 1.5 (INR, 1.4 to 2.8). Monitoring was performed weekly during a 12-week induction period and monthly thereafter during a maintenance period, for a total followup of 36 months. Patients whose PTR was > 1.5 had their warfarin reduced by 1 mg/day, while patients whose PTR was < 1.5 had their dosage increased by 1 mg/d if the low PTR persisted for two consecutive visits.

My recommendations, which are in concordance with findings in well-conducted trials, is to start with warfarin in doses of 4 mg/day for patients younger than 70, and 3 mg/day for older patients. Monitoring is essential. Considerable dose adjusting is required to keep patients within the therapeutic range, particularly during the initiation phase. Monthly, or once in three weeks, INR and adjustment of the dose in the stable phase is an appropriate and internationally accepted protocol.

References
How significant is the risk of a cerebrovascular accident (CVA) when using triptans in migraine sufferers with aura?

Triptans have not been incriminated in stroke among migraine sufferers with or without aura. There have been occasional rare cases of myocardial ischemia that have been reported in world literature (Medline).

This class of drugs work on the serotonin receptors within the extra cranial carotid and vertebral arteries, as well as in the coronary arteries. Luckily, however, nothing serious in terms of cerebrovascular accidents (CVAs) or transient ischemic attacks (TIAs), has been encountered. I have no concerns, therefore, in prescribing these drugs for patients with aura.

Due to small vascular risks, I ensure there is no underlying symptomatology of angina, previous coronary artery disease, uncontrolled hypertension, or even a history of Raynaud’s disease, before prescribing the drug. Most neurologists would also advise caution in prescribing triptans to patients who have multiple risk factors for vascular disease, such as diabetes or hypertension and high cholesterol in combination.

In spite of theoretical concerns, to my knowledge there have been no documented cases in the
literature concerning stroke and triptan utilization, both in migraine with and without aura (Medline).

Addendum: Two cases of cerebral hemorrhage—one due to an AV malformation and another due to subarachnoid hemorrhage—have been reported in the brief communication section of Neurology, May 2001, with further annotation in the December issue of the same journal. In my opinion, the use of sumatriptan in both these cases was, in all likelihood, an incidental occurrence in these instances of cerebral hemorrhage.

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