Comment on: "Vulval dermatoses (venereal and nonvenereal) among female patients presenting to a tertiary care hospital in North India"

Sir,

Kaur *et al*. in their article on "Vulval dermatoses (venereal and nonvenereal) among female patients presenting to a tertiary care hospital in North India" (Indian Journal of Sexually Transmitted Disease and AIDS, 2022) have exhaustively listed the different dermatosis that may afflict the female genitalia. They have subdivided their patients into age groups and listed the conditions by frequency in each.[1]

The disturbing issue in their study is the observed presence of sexually transmitted infections (STIs) in 24.4% of all the women attending the gynecology and dermatology outpatient clinics. We feel that this should not be labeled as prevalence of venereal infections in the area as it does not represent the general population; the authors have screened only patients with vulvar dermatoses so it can be mentioned that 24.4% of the cases with vulval dermatoses had venereal etiology. The figures obtained for vulval dermatoses from general outpatient clinic in the present study have been compared with those from Sexually transmitted diseases (STD) clinics which further adds to the confusion. High prevalence of venereal diseases in sexually active group (21–40) is possible or expected, but it is very difficult to distinguish whether these are acquired by sexual route/abuse or innocently by fomites in the younger age group <20 years where the authors have observed high prevalence of warts and mollucum contagiosum.[2] The authors could have been more careful

in deciding this. Other equally disturbing figure is the observed prevalence of STIs in 43.18% of pregnant women, which appears frightening. If we consider some percentage of seropositivity for syphilis and HIV in the patients and their partners, it is a real disaster in the real life, which in reality, it is not. The authors should have mentioned the frequency of different STIs observed in the pregnant females.

The authors of the study have excluded patients without any visible skin lesion; however, some patients with complaints of pruritus and burning sensation of the vulva in the absence of skin lesions may have vaginal discharge or cervicitis. Although the authors have mentioned about candidal vulvovaginitis, other causes of vaginal discharge like bacterial vaginosis or trichomoniasis have not been mentioned in this subset. In a study among women attending the gynecological outpatient department, in a tertiary center in North India, it was seen that mixed infection was the most common (34.5%) followed by bacterial vaginosis (15.5%).[3] Thus, history of discharge must be sought from patients presenting with vulvar dermatosis, which should have been adequately investigated.[4]

Although the authors have conducted examination of vulva and other parts of the body, a per speculum examination is a must; as it aids in diagnosis of cervicitis as vulval dermatoses may be an extension of vaginal or cervical (introitus) pathology which may sometimes manifest; secondary changes on the vulva due to discharge or itching.

It would be interesting to know the final diagnosis in patients who had feeling of dryness (18.65% of patients) and thickened and rough skin in another 11.73% of patients (about one third of total patients).

The most common non venereal vulvar dermatosis reported by the authors was tinea cruris, it usually affects the groins; genitalia are mostly affected by the extension of tinea cruris and in many cases it is postulated to have a sexual mode of transmission.[5] This distinction should have been clearly made out. Were the spouses of these patients also examined for evidence of tinea cruris?

Lesser number of cases of candidal vulvo-vaginitis in the study have been ascribed to the outbreak of chronic and recalcitrant tinea infections without giving any plausible reason/explanation as to how an increase in tinea infection will lead to decrease in cases of candidal vulvo-vaginitis.

In this cross-sectional study, proper attention has not been given to selection/detection of patients as speculum examination was not done. More serious issue is the identification of STIs in a very large subset of patients and more so in pregnant females, which appears more than the reported figures from large studies on antenatal surveys and community-based studies. Moreover, diagnostic criteria for labeling a patient with a STI have not been specified. Serology for herpes is unhelpful in confirming the diagnosis and cut off value for syphilis serology in the absence of skin lesions has not been specified. Hence, the reader should consider these high figures for STIs in patients attending general gynecology and dermatology outpatients with a degree of caution.

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Conflicts of interest
There are no conflicts of interest.

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