The Ulster Medical Journal, Volume 64, No. 1, pp. 92 - 94, April 1995.

Case Report:

Crohn's disease of the labia minora

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Accepted 24 January 1995

Cutaneous involvement of the vulva is a rare complication of Crohn's disease. It most commonly presents as erythema and oedema leading to ulcer formation.[1] However, between 1966 and 1993 only 25 cases have been reported in the English literature. We describe a further case of Crohn's disease with involvement of the vulva presenting with enlargement of the labia minora and recurrent ulceration of the mons pubis.

CASE REPORT: A 34 year old woman was referred to the gynaecological outpatient clinic with repeated episodes of painful blistering of the skin over the mons pubis, and a six week history of bilateral, progressive swelling of the labia minora. In 1981 she had developed inflammatory bowel disease which was diagnosed as Crohn's disease in 1987. Subsequently, she developed anal strictures and proctitis. In 1991 the terminal ileum, caecum and proximal ascending colon were resected because of the condition.

In 1991 she developed, for the first time, a genital rash diagnosed as hidradenitis suppurativa of the mons pubis. She was prescribed metronidazole 400 mg three times daily and cefuroxime 500 mg twice daily with success. In 1993 vesicular lesions again developed on the mons pubis. On examination both labia minora were found to be hypertrophied with lesions resembling large condylomata arising from their free edges. On the right these measured approximately 2 x 1 cm and on the left 4 x 1.5 cm. The labia majora were unaffected, and anal skin tags were also noted, but otherwise pelvic examination was normal. The vesicular lesions were initially considered to be herpetic and, were treated with acyclovir 200 mg five times daily for five days without response. Four weeks later, under general anaesthetic, biopsies were taken from the mons pubis and the hypertrophied left labium minus was excised. Histopathological examination of the skin lesions showed a non specific inflammatory response. The hypertrophied labium minus contained numerous granulomata composed mostly of multinucleated giant cells and lymphocytes with scanty epitheloid cells. The granulomata were discrete and showed no central necrosis. (Figure) These findings are in keeping with a diagnosis of Crohn's disease of the labia minora. It was not possible absolutely to confirm the presence of Crohn's disease of the mons pubis, and these lesions subsequently resolved without treatment.

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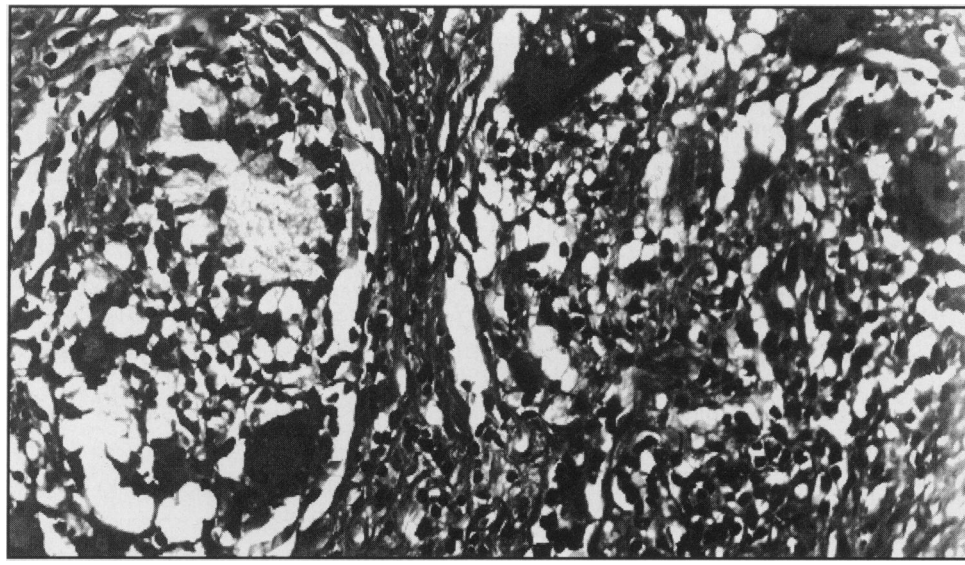

Fig. Two discrete giant cell granulomata. Haematoxylin and Eosin.

DISCUSSION

Two other cases of Crohn's disease of the vulva have been reported from Northern Ireland.[2] Dermatological manifestations of this condition are, by contrast, relatively common with a reported incidence of 22-44%.[3,4] They are more common with colonic involvement,[5] and include cutaneous ulceration, skin abscesses, erythema nodosum and pyoderma gangrenosum.[6] Crohn's disease of the genital region may occur either in continuity with, or in isolation from the gastrointestinal system. Of the two previously reported cases from Northern Ireland, one presented with vulval ulcerations whilst the other presented with extensive granulomatous involvement of the vulva and buttocks.[2]

This case was initially misdiagnosed and treated as hidradenitis suppurativa. It is likely that the associated blistering and ulceration of the mons pubis were in fact due to Crohn's disease. However, it was only when the labial biopsies were examined histologically that the diagnosis became clear. The macroscopic differential diagnoses of vulval Crohn's disease include condylomata acuminata or lata,[7] and sarcoidosis.[8] Microscopically, granulomatous inflammation may be due to tuberculosis, lymphogranuloma venerum, sarcoidosis and fungal or pyogenic organisms.

In considering the diagnosis of vulval lesions, especially with concurrent inflammatory bowel disease, gynaecologists should be aware of the possibility of extraintestinal manifestations of Crohn's disease. In this case, the diagnosis was facilitated by the long history of the disease, ano-rectal involvement, and the histological finding of multiple non-caseating granulomata. Extraintestinal manifestations may precede the onset of intestinal disease by as much as 18 years.[9]

We acknowledge the help of Dr Neil McClure, Department of Obstetrics and Gynaecology, the Queen's University of Belfast, in the preparation of this manuscript.

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