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Editorial

Recognition and diagnosis of vulvar dermatoses

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Diagnosing late-stage vulvar lichen sclerosus (VLS) is rarely difficult. If patients present with hallmark white depigmentation, texture change, and vulvar scarring we can focus the clinical visit on education and treatment options. However, patients should not have to wait for architectural obliteration to receive a diagnosis. Treating patients with early, undifferentiated disease can be a humbling experience.

Patients report a significant delay from the start of symptoms to diagnosis as they are reluctant to disclose sensitive issues to physicians if not directly prompted [1,2]. In fact, up to 61% of women may approach their genitalia with feelings of shame and embarrassment [3]. However, patients also note that physicians overlook or dismiss vulvar complaints. In a recent publication focused on genital eczema, only 11% of patients felt their dermatologists paid attention to their genital concerns [4].

It is not uncommon for patients to peruse websites for home remedies or to visit their local pharmacy to self-treat before reaching out to their healthcare provider [5]. Therefore, when they finally present to a doctor they often have more than one condition. Lichen sclerosus with superimposed irritant contact dermatitis from wet wipes, erosions from benzocaine used to numb itch, and intertrigo from summer heat will look much different from any of these diagnoses alone.

Having a consistent, stepwise approach to diagnosing patients with vulvar disorders is helpful. This should begin with training office staff to triage patients with vulvar disorders appropriately. Asking questions such as "Why are you coming to our office? If it is for itch or pain, is it in the genital area or do you have a vulvovaginal concern?" will enable your office to send patients a detailed questionnaire to fill out at home. This will give patients privacy to write down what they are applying, what medications they have used before, and how they are cleaning, which can be very cathartic. You can also use this form to ask sensitive questions about intimate partner violence or if their condition is causing them to feel like hurting themselves.

We often underestimate the role that "keeping clean" contributes to our patient's underlying condition. Patients often think their vulvas are "dirty" or that they can "wash their symptoms away." It is only by asking targeted questions that I discovered one of my patients was applying lidocaine 30 minutes before she showered so she could really "get in there" and scrub her vulva with antimicrobial soap. She told me that white specks kept coming off on the washcloth, so she would tearfully scrub until it stopped. This helped explained the horrific erosions and lichenified plaques of lichen sclerosus on her vulva. She was literally scrubbing her skin off! Her referring physician gave her the right diagnosis and the right medication, but aggressive cleaning was contributing to her recalcitrant disease.

When examining patients with vulvar conditions it is important to take the same approach every time. Are there any parts missing? Can you retract the clitoral hood? Do they have hairline fissures? Is there texture change or sheen to the interlabial sulcus? Are there depigmented macules around hair follicles? Each of these findings should prompt you to think about VLS.

You may need to look at other parts of the body. If the patient presents with well-demarcated pink plaques on the labia majora, you should check under the breasts, the umbilicus and gluteal cleft for similar findings. Are there plaques on the scalp? Pits on the nails? These nuanced differences can aid in distinguishing vulvar psoriasis from intertrigo or contact dermatitis.

Some of the most difficult patients to treat are those with nonspecific erythema and pruritus. Taking the steps above to figure out what they are cleaning with, addressing underlying urinary or fecal incontinence, and reviewing gentle skin care can help diagnose irritant contact dermatitis as a contributing factor. These patients are often treated empirically for candidiasis even when cultures are negative. Sometimes they have central sensitization or anxiety contributing to their symptoms and disease flares.

These patients can also have prodromal symptoms of another condition, such as early inflammatory VLS. In this case, take photographs and have them return to your office every 6 months to appreciate any subtle interval changes. Try to resist the urge to give them a final diagnosis - not all of our patients read the textbook. Treating underlying irritation, co-morbid anxiety or depression, or genitourinary syndrome of menopause can help. In 6 months, you may notice small texture

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changes, tightening of the clitoral hood, or fine Wickham striae develop around the introitus that provides insight to the underlying condition.

When in doubt, take a biopsy. However, do not biopsy an area only if a patient has symptoms and you do not detect a primary lesion or texture change. Have a differential diagnosis before you do the procedure and share this with your pathologist on the requisition form. Are you concerned the patient has VLS? Take the sample from an area with hypopigmentation or texture change; the biopsy should capture both the epidermis and the upper reticular dermis to assess the density of collagen. Are you concerned about erosive lichen planus? If so, the biopsy should capture the transition zone between erosion and intact vulvar skin; take a superficial biopsy at the white tread-like border to see the lichenoid inflammation at the dermoepidermal junction.

I have found being honest with patients when that they do not fit in a specific box, but reassuring them that we will work together until they feel better, to be the most helpful. Encourage your patients to talk about their conditions with family members and friends, so we can diagnose these conditions earlier, before scarring causes irreversible changes. If you need help, refer patients to a vulvovaginal specialist.

Diagnosing and treating patients with vulvar disorders has become one of the most fulfilling and satisfying aspects of my career. Embrace caring for these patients; you can make a difference in the lives of countless women.

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References

[1] E.J. Yang, K.M. Beck, I.M. Sanchez, J. Koo, W. Liao, The impact of genital psoriasis on quality of life: a systematic review, Psoriasis: Targets and Therapy 8 (2018) 41.
[2] L.A. Sadownik, E. Koert, C. Maher, K.B. Smith, A qualitative exploration of women's experiences of living with chronic vulvar dermatoses, J. Sex. Med. 17 (9) (2020 Sep) 1740–1750.
[3] M. Preti, A. Selk, C. Stockdale, F. Bevilacqua, P. Vieira-Baptista, F. Borella, C. Benedetto, Knowledge of vulvar anatomy and self-examination in a sample of italian women, Journal of Lower Genital Tract Disease 25 (2) (2021) 166–171.
[4] Y.R. Woo, Y. Han, J.H. Lee, Y.B. Lee, J.E. Kim, M. Kim, S.H. Cho, Real-world prevalence and burden of genital eczema in atopic dermatitis: a multicenter questionnaire-based study, J. Dermatol. 48 (5) (2021) 625–632.
[5] M.M. Mauskar, K. Marathe, A. Venkatesan, B.J. Schlosser, L. Edwards, Vulvar diseases: approach to the patient, J. Am. Acad. Dermatol. 82 (6) (2020 Jun) 1277–1284.

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