Benign and Malignant Vulva Disease

- Background
- Most symptomatic vulvar disorders cause pain, burning or pruritus
- All give rise to great discomfort
- All poorly assessed: patient modesty
- Doctor needs proper classification framework to offer clever patient care
Classification

- Red lesions
- White lesions
- Dark lesions
- Ulcers
- Small tumours
- Large tumours
- Malignacies
Red lesions

- 1 Candidiasis
- 2 Contact dermatitis
- 3 Systemic skin disorders
- 4 Vulvodynia
- 5 Folliculitis
Red 1: Candidiasis

• Common, recurrent
• S: itch, white discharge, pain and swelling
• O: red lesion affecting labia majora and minora, also vagina, swelling, discharge
• Tests: not much needed. Trial of treatment: nitroimidazoles
  – Orally: fluconazole (Diflucan), itraconazole (Sporanox), ketoconazole (Nizoral)
  – Topically: clotrimazole etc.
Recurrent candidiasis

- Expect 95%+ success with first treatment
- Reasons for recurrence: antibiotics, steroids, DM, OCs, decreased immunity, other candida species
- Strategy: meticulous hygiene, long term use of anti-fungals, try to modify the causative factor
Red 2,3:

• Contact dermatitis:
  – Sudden onset of itch; often new soap/toiletries or clothes; red lesion on labia majora, demarcated, use saltwater sitz baths and discontinue the probable cause. Note: condom allergy does same!

• Systemic disease:
  – E.g. psoriasis, erythema of various causes. See lesions on rest of body as well
Red 4: Vulvodynia: painful vulva syndrome

• Uncommon, disastrous, very symptomatic
• Pain is relentless
• Major causes: Post HPV, dystrophies, vestibulitis, hypersensitivity post candidiasis
• Long term treatment: behaviour, saltwater, pain relief, topical steroid, sometimes surgery
Red 5: Folliculitis

- Staph infection around hair follicles
- Spreads to affect large parts of vulva
- Needs topical and sometimes systemic a/b as well as pain relief
- Meticulous hygiene
White lesions

- 1 Lichen sclerosus
- 2 Hyperplastic dystrophy
- 3 Pigment deficiencies
White 1: Lichen sclerosus

- Uncommon but destructive, probably autoimmune disorder
- S: itch, burn, narrowing of vagina
- O: white figure of 8 lesion, skin thin and leathery. Labia minora disappear, introitus narrows, clitoris gets buried. Sometimes ulceration, always scratch marks
- T: typical picture: offer treatment. Doubt: biopsy
LS 2

• Treatment
  – Meticulous hygiene (esp. in young persons)
  – Potent topical corticoid, antipruritics

• Risks
  – Vulvar destruction, 2% risk of Ca Vulva

• Prognosis
  – Good if life-long treatment
  – Surgery may from time to time be required
White 2: Vulvar hyperplasia

- Opposite of LS: skin is swollen, thickened, hangs in folds, hyperkeratotic thus grey-white in appearance, scratch marks
- Disease of irritation, obesity. May become atypical (histologically) -> VIN
- Biopsy -> hygiene -> topical corticoids
- Surgery often needed as thickened skin does not easily respond to medical treatment
White 3: Pigment deficiencies

- Vitiligo: common, white skin patches with residual hair pigmentation. No treatment.
- Albinism: congenital absence of melanin: skin and hairs depigmented. No treatment
- Intertrigo: Skin fold whiteness associated with obesity and irritation: emollient creams
Dark lesions

• 1 Nevi: regard as premalignant: remove surgically
• 2 neurofibromatosis dark skin patches: no treatment
Ulcers: STIs

- Herpes: small ulcers + vesicles + fever
- Syphilis: painless ulceration
- HIV: deep painless ulceration
- LGV: small genital ulcers with massive lymphadenopathy: chlamydial
- GI: bacterial, same as LGV but larger ulcers
- Rx: hygiene, saltwater, AB/AVs
Small tumours

- 1 Condylomata acuminata
- 2 Sebaceous cysts
- 3 Inclusion cysts
- 4 Fibro-epithelial polyps
- 5 Bartholin cysts and abscesses
- 6 Carcinoma (discussed later)
Small 1: C.a.

- Caused by HPV types 6/11, sexually active persons, causes irritation and secondary infection, may get quite large
- Recurrent in pregnancy, HIV, other immune suppression
- Typical picture: treat
  - Small: imiquimod (Aldara), podophyllin
  - Medium: electrocautery
  - Large: surgical excision
Small 2: Cysts

- Sebacious: yellow cysts in hair growing areas, if not leaking no symptoms otherwise itch. Remove if it is in the way
- Inclusion: central posterior, episiotomy repairs
- Bartholin: skin orgs, chlamydia, gonococ: swelling of gland and duct: abscess: red and sore: drain. Antibiotics play small role
- Cyst to be removed in >40s: fear of Ca!
Small 3: polyps

- Fibro-epithelial polyps common and benign; may have stalk and twist: painful. Excise if problem.
- Other small tumours include hemangiomas and postoperative skin tags. Best left alone.
Large tumours

• 1 Lipomas
• 2 Fibromas
• 3 Cancers (discussed later)
Lipomas and fibromas

• Lipomas grow in l majora, fatty tumours with few symptoms. Remove if in the way.
• Fibromas: grow in every part of vulva but esp. in labia minora. Remove if in the way.
Diverse conditions

• Vulvar oedema
• Vulvar varicocities
Vulvar malignancies and premalignancies

• 1 VIN
• 2 Paget’s disease of the vulva
• 3 Carcinoma
• 4 Melanoma
• 5 Others
VIN

- Common, esp. in HIV+ persons. Starts as HPV infection (young/immune deficient) or chronic irritation (older persons)
- Few symptoms: itch, burn, raised lesion
- O: pigment changes: red/white/dark lesions, multifocal
- Risk: associated HPV/Ca, may develop Ca
- Rx: excision
Paget’s disease

• Rare: Focal red itchy lesions. On biopsy looks like paget cells in breast lesions
• Risk: current or future malignancies
• Rx: excision and follow-up
Carcinoma

• Uncommon gynaecologic cancer
• Mostly squamous carcinoma
• Mostly caused by HPV 16/18, may follow on long standing dystrophies
• S: few to many: ulcer, exophytic growth, bleeding, pain
• O: same on view. Must confirm with biopsy!
Carcinoma 2:

• Staging: !: confined to vulva, lesion <2cm
  – II: Confined to vulva, >2cm. III: any size but involves the introitus, urethra, clitoris; IV: malignant groin nodes, vaginal or anal involvement

• Tests: For metastases and general condition

• Management: Predominantly surgery: Radical vulvectomy and groin node dissection; if + nodes also radiotherapy.

• Prognosis good: 75% 5ys. Recurrences treated surgically or radio/chemotherapy
Melanoma

• It exists, is rare and deadly
• Same appearance and symptoms as melanomas elsewhere
• Surgical approach in most cases
• Poor prognosis