

The Older Woman with Vulvar Itching and Burning

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Disclosures

Mark Spitzer, MD

- Merck: Advisory Board, Speakers Bureau
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Old Adage

- If the only tool in your tool chest is a hammer, pretty soon everything begins to look like a nail.
- If the only diagnoses you are aware of that cause vulvar symptoms are Candida, Trichomonas, BV and atrophy those are the only diagnoses you will make.



Does this story sound familiar?

- A 62 year old woman complaining of vulvovaginal itching and without a discharge self treats with OTC miconazole.
- Two weeks later the itching has improved slightly but now she is burning.
 - She sees her doctor who records in the chart that she is complaining of itching/burning and tells her that she has a yeast infection and gives her teraconazole cream.
 - The cream is cooling while she is using it but the burning persists
- She calls her doctor but speaks only to the receptionist. She tells the receptionist that her yeast infection is not better yet.
 - The doctor (who is busy), never gets on the phone but instructs the receptionist to call in another prescription for teraconazole but also for three doses of oral fluconazole and to tell the patient that it is a tough infection.

- A month later the patient is still not feeling well. She is using cold compresses on her vulva to help her sleep at night.
 - She makes an appointment. The doctor tests for BV. The test comes back positive for Gardnerella and beta Strep. The doctor treats her with vaginal clindamycin cream for a "bacterial infection".
- After a few more phone calls to the doctor resulting in "telephone treatment for self diagnoses" she returns to the doctor.
 - The doctor sees nothing except atrophy that would be typical for a woman of this age, so he treats her with vaginal estrogen cream.
- The patient is now worse than ever. She Googles 'yeast infections' and finds all sorts of books, articles and chat rooms full of horror stories. She goes on a restrictive diet and begins to lose weight. She washes her vulva with antibacterial soap twice daily to keep it clean and uninfected. She begins to down acidophilus pills by the fist full. She now begins to experience a little itching and a slight cheesy discharge in addition to her burning (which is worse than ever).

- Desperate to get rid of an annoying and frustrating patient, her doctor refers her to me.

I see these patients every day

- When the patient comes into my office she lists as her chief complaint 'chronic yeast infection'
- The first thing I tell her is that in order to get to the bottom of her problem, we will first have to discard every diagnosis she has had in the past and that she may not have a yeast or bacterial infection at all.
- She asks me "If it is not a yeast infection, what else could it be?"

That is what this lecture will be about

Learning Objectives

At the conclusion of this lecture the participant should be able to:

- Describe the main differential diagnosis of vulvar burning irritation, rawness, stinging or pain in an older woman.
- Describe the main differential diagnosis of vulvar itching in an older woman
- Know the treatment of conditions that cause itching and burning of the vulva in an older woman

Vulvodynia

- Often a silent disease
 - 30% of women with these conditions will suffer without seeking medical care
 - Many doctors are unfamiliar with other causes vulvar itching, burning and pain so they treat what they know
 - Typically, these women are told they have:
 - Yeast infection
 - Bacterial vaginosis
 - Vaginal atrophy

Before We Start, Some Foundational Principles of Candida in the Older Woman

- Candida thrives in a well estrogenized, glycogenated vagina and absent certain risk factors, Candida is quite unusual in women with vaginal atrophy
 - Risk factors:
 - Hormone replacement (especially vaginal estrogen)
 - Immune suppression (steroids, immune suppressive medications, HIV)
 - DM (especially poorly controlled DM)
 - In older women, Candida is often not associated with a creamy or cheesy discharge and is much more likely to be non-albicans yeast that may be resistant to fluconazole.

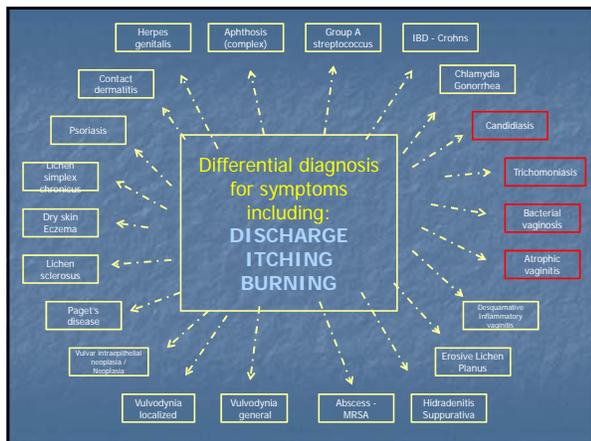
Before We Start, Some Foundational Principles of BV in the Older Woman

- BV is estrogen dependent. Postmenopausal women who are not on HRT or vaginal estrogen rarely get BV
- The symptoms are a vaginal discharge with a foul or fishy odor. Itching and/or irritation are less common.
- Because *G. vaginalis* is normally found in the vagina, a "detected" result using a nucleic acid probes for *G. Vaginalis* (Affirm VP11), although suggestive, is not definitive proof of BV. Results should be interpreted in conjunction with other test results and clinical findings. Amsel's criteria are useful tests to support a diagnosis of BV.

Differential diagnosis for symptoms including:
DISCHARGE
ITCHING
BURNING

Differential diagnosis for symptoms including:
DISCHARGE
ITCHING
BURNING





An Approach to the Evaluation of Vulvar Pain and Burning (and Itching)

- Causes
 - On the skin
 - Of the skin
 - Neither (diagnosis of exclusion)

On the Skin

- Candida
- Trichomoniasis (usually burning and irritation)
- HSV (usually pain, burning or irritation)
- ?Strep vulvovaginitis?
- Contact dermatitis (irritants or allergens)

Contact Dermatitis

- The **unestrogenized vulva is more susceptible to irritants** and allergens than the estrogenized vulva of someone who is of reproductive age
- No matter how the patient describes her symptoms, **irritative symptoms are almost always vulvar (not vaginal)** and treating the vagina will not be as effective as treating the vulva directly

Allergic Contact Dermatitis

- Much less common than irritant contact dermatitis
- Usually very itchy
 - May have previous exposure without an allergic reaction
 - May happen hours to days after the exposure
- Findings in acute allergic contact dermatitis
 - In keratinized skin
 - Well demarcated edema, papules, vesicles and crusts
 - In mucous membrane
 - Less well demarcated edema and erosion

Vulvar Eczema: Allergic or Irritant Dermatitis

- Thickened or red excoriated skin
- Skin changes may be minimal
 - **When no other cause of itching can be found, assume the cause is eczema**
 - Distinction between irritants and allergens is difficult and not necessary
- **Thin skin** is more easily irritated (diaper rash/post menopausal skin)
- **Irritated skin** is more easily irritated

Approach to 'On the Skin' Vulvar Care Measures

Avoid contact with potential irritants

- Soap
- Adult or baby wipes antiseptics
- Colored or scented toilet paper
- Condoms (lubricant or spermicide containing)
- Contraceptive creams, jellies, foams, nonoxynol-9, lubricants,
- Dyes
- Emollients (e.g. lanolin, jojoba oil, glycerin)
- Laundry detergents, fabric softeners, and dryer sheets
- Rubber products (including latex)
- Sanitary products, especially panty liners, incontinence pads
- Conditioners
- Tea tree oil
- Topical anesthetics (e.g. benzocaine, lidocaine, dibucaine)
- Topical antibacterials (e.g. neomycin, bacitracin, polymyxin)
- Topical antifungal preparations (e.g. imidazoles, nystatin)
- Topical corticosteroids
- Other topical medications, including trichloroacetic acid, 5-fluorouracil, Podofilox or podophyllin)
- Vaginal hygiene products (including perfumes and deodorants)

Vulvar Care Measures

- Use very mild soap for bathing the rest of the body. **No soap on the vulva.**
- Frequent baths with soaps may increase the irritation
- **You cannot wash away your symptoms**
- Vaginal odor and vulvar symptoms are rarely a hygiene problem and will not get better by washing more or washing more vigorously.
- Wear white 100% cotton underwear; No underwear at night; washed only in hypoallergenic detergent with no fabric softeners or dryer sheets.
 - No pantyhose or other tight-fitting clothes.
- Put underwear through an extra plain water rinse

Of the Skin

- Lichen simplex chronicus /squamous cell hyperplasia (end stage of vulvar eczema)
- Lichen sclerosus
- Lichen planus
- Psoriasis
- VIN
- Paget's disease
- Fissuring
 - Any acute or chronic condition that causes edema or thickening of the skin can cause fissuring

Lichen Simplex Chronicus (Hyperplastic Dystrophy, Squamous Hyperplasia)

- End stage of the itch-scratch-itch cycle of vulvar eczema
- Years of relentless chronic itching: "nothing helps"

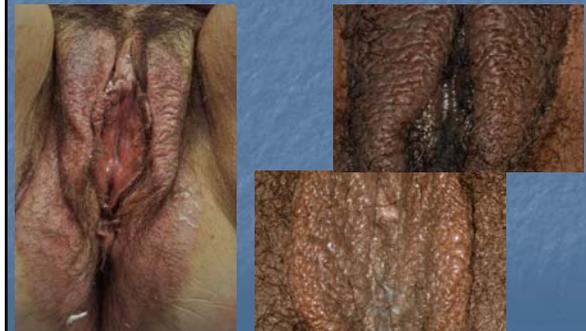


Lichen Simplex Chronicus

- Skin is thick (and often red)
 - Caused by intense repetitive rubbing and scratching
 - May exhibit erosions or fissuring



Lichen Simplex Chronicus





LSC and Squamous Cell Cancer

Treatment of LSC

- **Eliminate irritants**
- **Steroid creams** (ointments if the skin is broken)
 - Triamcinolone 0.1% BID for mild changes, fluocinonide 0.05% or clobetasol 0.05% for severe changes
 - Recheck in one month for signs of atrophy, super infection or steroid rebound dermatitis
- **Treat/suppress yeast** with weekly fluconazole
- **Nighttime sedation** with amitriptyline (produces deep sleep without scratching), diphenhydramine or hydroxyzine (produces REM sleep only and has no intrinsic anti-itch properties except for urticaria)

Lichen Sclerosus

- Chronic dermatologic condition.
 - Etiology - unknown (?autoimmune?)
 - Epithelial thinning, distinctive skin changes and inflammation.
- Very common condition.
 - Can occur at any age but primarily in postmenopausal women and pre-pubertal children (5-15%).
 - 3-5% lifetime risk of vulvar CA.



Lichen Sclerosus

- Symptoms include vulvar itching, burning, dyspareunia, pain with defecation.
- Biopsy may indicate only inflammation or minimal epithelial change early in disease.
- No vaginal involvement.



Clinical Findings in Lichen Sclerosus

- Pathognomonic sign is texture change. Thin, white, finely wrinkled, keratinized skin (figure-of-8 pattern).
- Loss of vulvar architecture
 - Loss of labia minora.
 - Clitoris buried by fusing overlying skin.
 - Keyhole opening
- Fissures
- Excoriations



Lichen Sclerosus: Presentation



Treatment of Lichen Sclerosus

- Clobetasol 0.05% cream or ointment BID x 6 weeks
 - Recheck after 6 weeks continue until the texture of the skin has normalized not just the color or the symptoms
 - Decrease gradually as symptoms demand but never to zero
 - 30 gm. tube should last approximately 3-6 months.
- Estrogen cream is useless
- Testosterone cream is useless and potentially harmful



Results of Treatment of LS

- 96% complete or partial relief.
 - 23% resolution to normal texture, color.
 - 68% partial resolution of hyperkeratosis, purpura, fissuring, erosions.
- Bornstein et al. Am J OG 1998;178:80.
Cooper et al. Arch Dermatol 2004;140:702
- Conflicting evidence on value of maintenance
 - Monitor 3 and 5 mos. following initial therapy.
 - Annual exams for women with well-controlled LS.
 - More frequent visits for those with poorly controlled disease.
 - **Conclusion: Advise patients to return if change in symptoms especially new growths or ulcers.**

ACOG Practice Bulletin, No. 93. Obstet Gynecol 2008;111:1243.

Results of Treatment of LS



Erosive Lichen Planus

- Unknown etiology (?autoimmune?)
- Age range: 29 - 68
- Symptoms: Itching, pain, burning, "raw" sensation, dyspareunia
- 2/3 of patients with vulvar disease develop mucous membrane disease
 - 20% of patients have only mucous membrane disease
- Vestibule may be red, eroded and tender and may be friable and have adherent exudate
- End stage disease - bands, resorption of labia minora, obliteration of clitoral hood and atrophy (similar to lichen sclerosis) introitus may be stenotic



Erosive Lichen Planus

- 1% of the general population has oral lichen planus. 25% of those have genital disease
- Physical Findings
 - Oral disease
 - Lacy linear papules with painful erosions in the posterior buccal mucosa (may bleed easily)
 - Vulvar disease
 - Mild - fine subtle white inter-lacy papules
 - Severe - erosive epithelium at the vestibule (sometimes surrounded by white "lacy" epithelium)



- Look for the presence of a narrow white border at the periphery of the eroded area.

Erosive Lichen Planus: Presentation

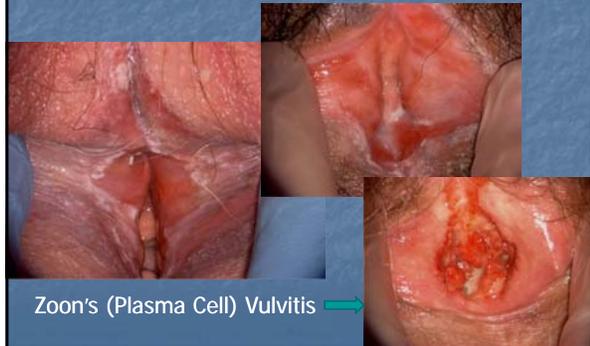


Image courtesy NVA

Classic Presentation

Subtle Presentation

Lichen Planus: Presentation



Zoon's (Plasma Cell) Vulvitis →

Desquamative Inflammatory Vaginitis

- May be a vaginal variant of erosive lichen planus
 - Etiology unknown (?autoimmune?)
- Clinical presentation:
 - Copious discharge that may have been present for years (often yellow-green, but may be bloody).
 - May be associated with vulvar burning, irritation and itching.
 - Intercourse is often uncomfortable or painful.
 - Looks like severe atrophic vaginitis

Desquamative Vaginitis (2)

- Physical examination:
 - Denuded vaginal epithelium
 - Purulent exudate
 - Most reliable finding is red patches in vagina that mimic postmenopausal atrophy with trauma
- Vaginal Microscopy: basal cells, lots of poly's, high pH, no lactobacilli
- Cultures – Candida (negative), bacterial (mixed flora)



Treatment of Lichen Planus/DIV

- Lichen planus
 - Mild disease - 1% hydrocortisone or 0.1% triamcinolone cream
 - Severe disease
 - 25 mg hydrocortisone suppositories t.i.d. for 1-2 months then once daily or 1/2 in the morning and 1/2 in the evening for 1-2 months
- or
- Bursts of oral prednisone 40-70 mg/day X 2-6 weeks
- Alternative treatment for vaginal lichen planus
 - Tacrolimus 0.1% suppositories for vaginal disease;
 - Tacrolimus 0.1% ointment for vulvar disease
- DIV
 - Hydrocortisone 100 mg/gram in clindamycin 2% emollient cream base
 - Insert 5 gram (applicator full) every other day x 14 doses

Vulvodynia

A Diagnosis of Exclusion:

- Exclude everything we have discussed so far
 - Physical exam including vulvar colposcopy
 - Vaginal wet prep and cultures
 - Therapeutic trial of avoiding irritants
- If the patient is not better, assume vulvodynia

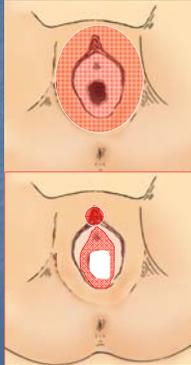
Epidemiology of Vulvodynia

- Vulvar pain may affect as many as 15% of women¹
- A 2003 study² found that:
 - Nearly 40% of women choose not to seek treatment,
 - Of those who did seek treatment, 60% saw 3 or more doctors, many of whom could not provide a diagnosis.

1. Jones and Lehr :Nurse Pract 1994;19:34,37-46
2. Harlow and Stewart: J Am Med Womens Assoc 2003;58:82-8.

Vulvodynia

- Generalized
 - Provoked (sexual, nonsexual, or both)
 - Unprovoked
 - Mixed (provoked and unprovoked)
- Localized (vestibulodynia, clitorodynia, vulvar vestibulitis, vestibular adenitis, hemivulvodynia, etc.)
 - Provoked (sexual, nonsexual, or both)
 - Unprovoked
 - Mixed (provoked and unprovoked)



Localized Vulvodynia (Vestibulodynia)

- Severe pain on vestibular touch or attempted vaginal penetration
- Tenderness to pressure localized within the vulvar vestibule
- Only physical findings may be varying degrees of erythema
- Colposcopy may be helpful (skip the acetic acid)



Localized Vulvodynia (Vestibulodynia)

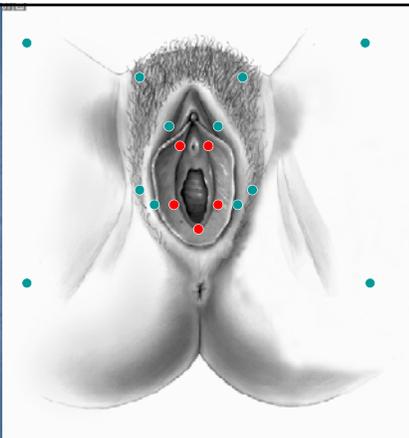
- May occur at any time in a woman's life **including before coitarche**.
- Pain, burning, stinging, irritation or rawness at the vaginal opening with attempts at intercourse, tampons, riding a bicycle, tight jeans, horseback-riding, jogging, etc.
- Symptoms often begin after experiencing some type of infection or trauma. Many women have been told they have a "chronic yeast infection"
- May be associated with interstitial cystitis or fibromyalgia



Cause of Vulvodynia and Vestibulodynia: Theories

- **Genetic predisposition** to having more inflammatory cells and fewer antiinflammatory cells in the skin.
- The inflammation causes **proliferation of nociceptive (pain) nerve fibers** in the skin and makes the skin more sensitive to pain.
- As a result, these women experience pain to a stimulus that is painless to everyone else.

- Cotton swab testing
- Diagram may be helpful in assessing the pain over time



Sequential Treatment of Vestibulodynia

1. Vulvar care measures
2. Topical anesthetics (e.g. 5% lidocaine ointment)
3. Tricyclic antidepressants (e.g. amitriptyline) or anti-convulsants (e.g. gabapentin) **(orally or compounded into a vulvar cream)**
4. Biofeedback and physical therapy
5. Surgery (vestibulectomy with vaginal advancement) (high success rates of 70%+). usually a last resort.



Reserve surgery for PURE vestibulodynia

Generalized Vulvodynia - Symptoms

- Burning, irritation, rawness, pain (not related to touch or pressure) without evidence of erythema, inflammation or other dermatopathology
 - May be intermittent or constant
 - May be similar to a UTI (e.g. frequency, urgency, dysuria) but with negative cultures
 - Periods of unexplained relief and/or flares
 - Older patients may also have rectal discomfort or chronic low back pain
- **May be related to fibromyalgia, interstitial cystitis, urethral syndrome or pudendal neuralgia**

Generalized Vulvodynia - Treatment

- Vulvar care measures
- Low dose tricyclic antidepressants
 - Start at 10 mg; increase every 7-21 days
 - **Side effects** include: drowsiness, dry mouth and eyes, constipation, urinary retention, loss of libido or the ability to have an orgasm, increase in appetite (weight gain) (side effects decrease with time)
- Anticonvulsant drugs (e.g. Gabapentin, Pregabalin)
 - Start at 300 mg (100 mg in older women); increase every 3-7 days
 - **Side effects** include: sleepiness and dizziness and less commonly GI symptoms and mild leg swelling. **May cause or increase balance problems and increase cognitive impairment in older women**
 - Discontinue medication GRADUALLY

Psychological Distress



Important Things to Remind Your Patients About Vulvar Pain

- It is rarely associated with cancer.
- It is rarely caused by an STD and is not contagious.
- Even if we can't prove what is causing the pain, we can treat it.
- It is not due to poor hygiene. In fact strong soaps and detergents can make the condition worse.

Important Things to Remind Your Patients About Vulvar Pain (2)

- It didn't develop overnight; it won't go away overnight.
- Treatment setbacks may occur.
- A setback may be due to the same condition or another condition with similar symptoms. **I can't tell over the phone. You have to come in.**
- We understand that chronic pain is exhausting and can be demoralizing.

Important Things to Remind Your Patients About Vulvar Pain (3)

- There is nothing wrong with you as a person; the problem is your pain.
- Don't feel that because this is genital pain that you can't talk to other people. People with chronic problems need others for support. Family and friends can help.
- If you are in a relationship, both of you are affected by this problem. Appropriate couple counseling may be needed.

Thank You