MANAGING COMMON GENITAL DERMATOSES

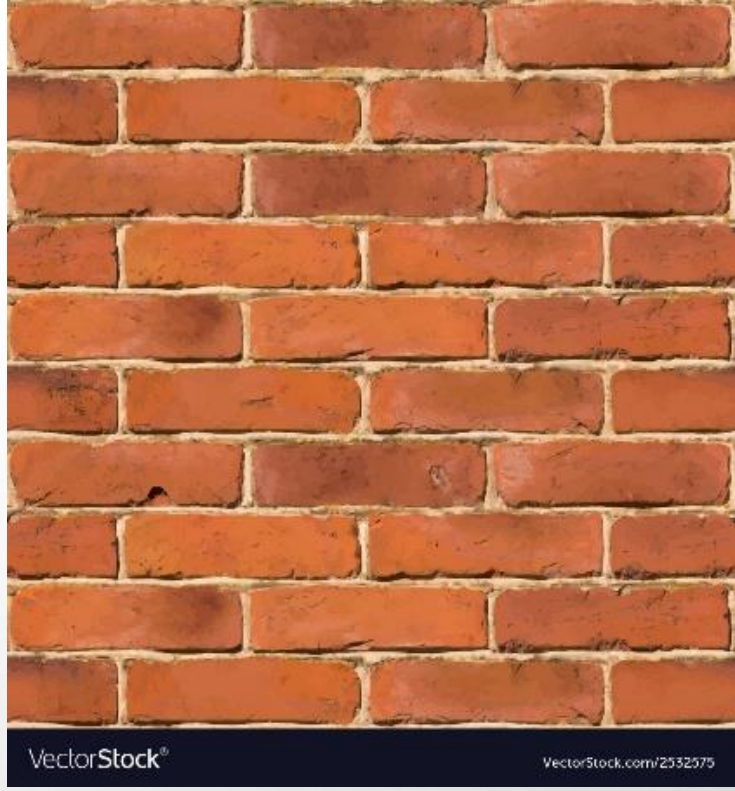
ALISON STEWART-PIERE

NP

CLINICAL LEAD SOUTHERN SEXUAL HEALTH SERVICE

SKIN STRUCTURE

- LIKE A BRICK WALL – HAS BRICKS/CELLS, KEPT IN PLACE AND HEALTHY BY THE MORTAR/INTERSTITIAL FLUID AND OILS.
- A HEALTHY BRICK WALL PROVIDES A VERY EFFECTIVE BARRIER TO INVASION/INFECTION
- WHEN THE WALL IS NOT WELL MAINTAINED, OR OTHER FACTORS ERODE IT, THE MORTAR COMES OUT, THE BRICKS GET DAMAGED, THE WALL BECOMES WEAK AND INEFFECTIVE
- SKIN GETS DAMAGED, LOSES MOISTURE, GETS DRY AND CRACKED, BREAKS DOWN AND IS PRONE TO INFECTION AND IRRITATION



GENITAL SKIN CARE

- GENITAL SKIN IS MORE SENSITIVE THAN OTHER AREAS
    - **DON'T SCRUB!**
- WASH ONLY WITH WATER OR MOISTURISING SOAP SUBSTITUTE
- AVOID PRODUCTS AND ACTIVITIES THAT IRRITATE:
    - SCENTED MOISTURISERS
    - SCENTED HYGIENE PRODUCTS
    - FLAVOURED OR COLOURED LUBES OR CONDOMS
    - UNCOMFORTABLE CLOTHING
    - HAIR REMOVAL TECHNIQUES
- CONSIDER ADDING MOISTURISER TO MAINTAIN SKIN HEALTH

WHAT MOISTURISERS??

- MUST BE NEUTRAL
- **NOT** ANTIBACTERIAL
- NOT FRAGRANCED
- THE BEST EMOLLIENT IS THE ONE A PERSON WILL USE
  - SO GIVE OPTIONS: LOTION, CREAM AND OINTMENT
  - OINTMENT IS GENERALLY BEST TOLERATED IF USED AT NIGHT
- ESSENTIAL TO USE AT LEAST DAILY WITH ANY ONGOING SKIN CONDITION

COMMON GENITAL IRRITANTS

- NAIL POLISH
- FRAGRANCES
- SOAPS
- TOPICAL TREATMENTS
- WET WIPES
- PANTY LINERS
- URINE
- FAECES

NOT LAUNDRY POWDER

PRURITIS – GENITAL OR ANAL

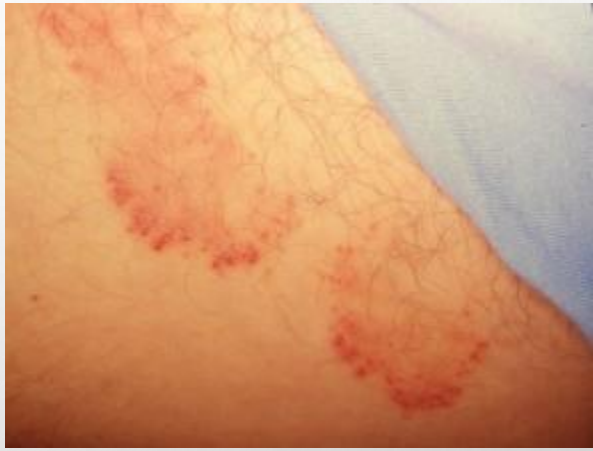
- IS IT ACUTE OR CHRONIC?
- POSSIBLE CAUSES: LOCAL & SYSTEMIC?
- LOCAL CAUSES:
  - FUNGAL
  - DERMATITIS – IRRITANT OR ALLERGIC
  - DERMATOSES – ECZEMA, PSORIASIS, LICHEN SCLEROSIS, LICHEN PLANUS
  - INFECTIVE – SCABIES, PUBIC LICE, WORMS
- SYSTEMIC CAUSES:
  - IRON DEFICIENCY, RENAL FAILURE, LIVER DISEASE, ENDOCRINE DISORDERS, DRUG REACTION, MALIGNANCY, PSYCHOGENIC CAUSES

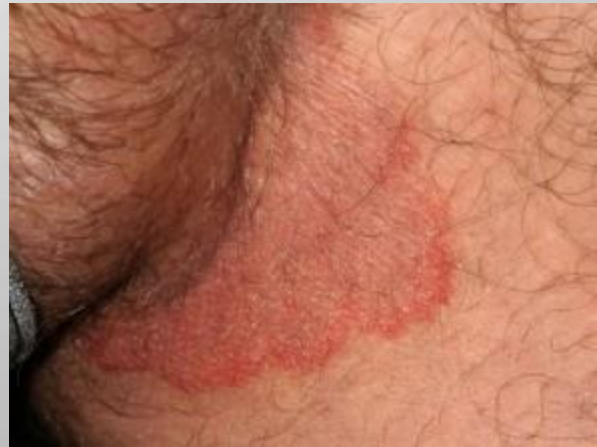
FUNGAL PRURITIS – THRUSH?

- FEMALE IN MENSTRUATING AGE RANGE – EXCLUDE THRUSH (CANDIDA)
- MALE AND PREPUBESCENT OR POST MENOPAUSAL FEMALE – THRUSH IS UNLIKELY –
  - POSSIBLE IN DIABETES, IMMUNE SUPPRESSION OR OTHER GENITAL DERMATOSES AND IN BREASTFED BABIES
- IF CANDIDA PRESENT ON SWAB – TREAT
- CHECK 1 WEEK LATER TO BE SURE ITCH HAS RESOLVED
- USING CONSISTENT EMOLLIENTS HELPS PROTECT SKIN LONG TERM

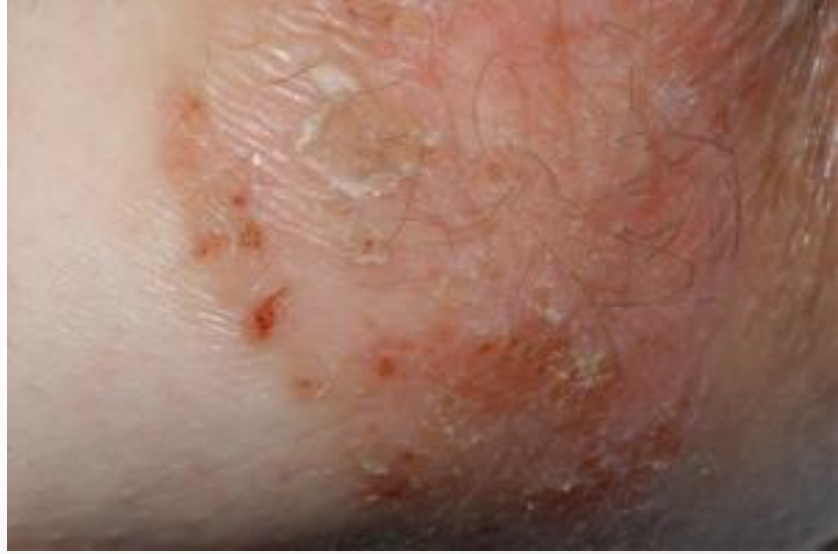
TINEA CRURIS – "JOCK ITCH"

- COMMON BETWEEN THIGHS AND SCROTUM OR IN SKIN FOLDS OF OVERWEIGHT PEOPLE
- VERY ITCHY
- USUALLY A RAISED, SCALY RED BORDER
- NOT OFTEN SEEN ON GENITAL OR PERIANAL AREA
- CHECK FEET FOR TINEA PEDIS AND TREAT BOTH IF PRESENT.
  - ADVISE PUT ON SOCKS BEFORE JOCKS TO REDUCE REINFECTION.
- TREAT WITH TOPICAL ANTIFUNGALS FOR AT LEAST 6 WEEKS
- CAN USE HYDROCORTISONE 0.5% INITIALLY TO RELIEVE ITCH

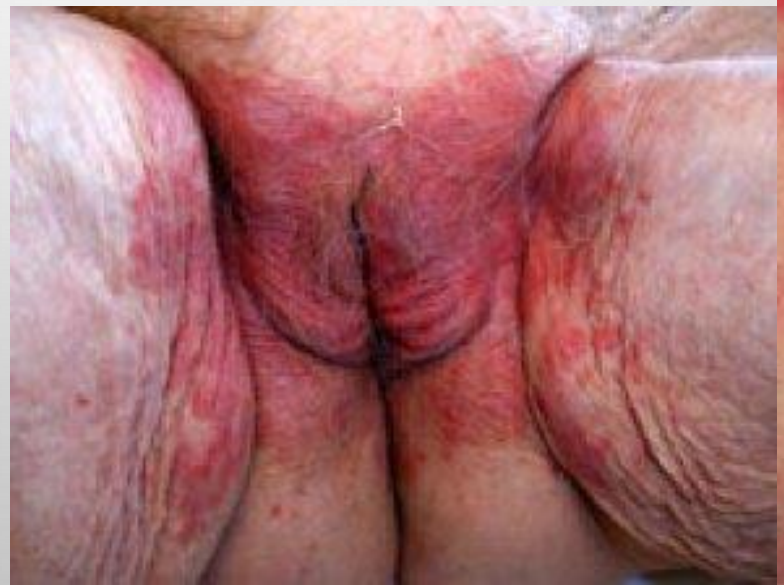




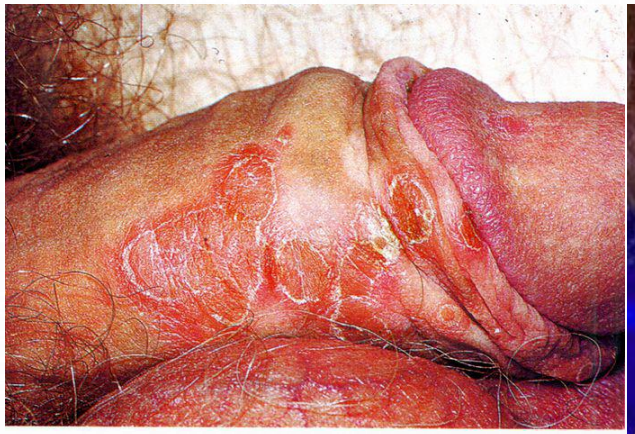
GENITAL DERMATITIS: IRRITANT OR ATOPIC DERMATITIS

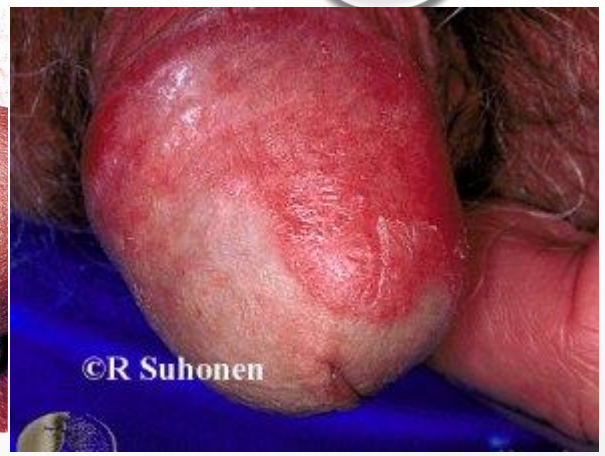


- Atopic Dermatitis = Eczema
  - Treat same as elsewhere on body
  - Itchy ears, Itchy scalp can indicate eczema
- Persistent vulval/perineal/perianal splits -
  - Frequent presentation of both irritant and atopic dermatitis
  - Treat with anti fungal <u>if</u> positive fungus on swab
  - **<u>ALWAYS</u>** treat as dermatitis – potent topical steroids and consistent, long term emollients

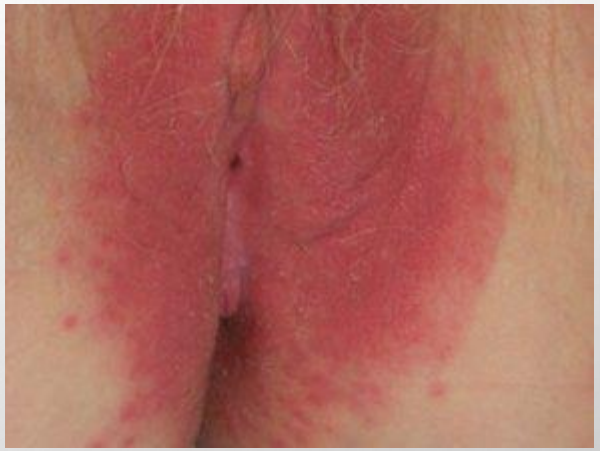


PSORIASIS

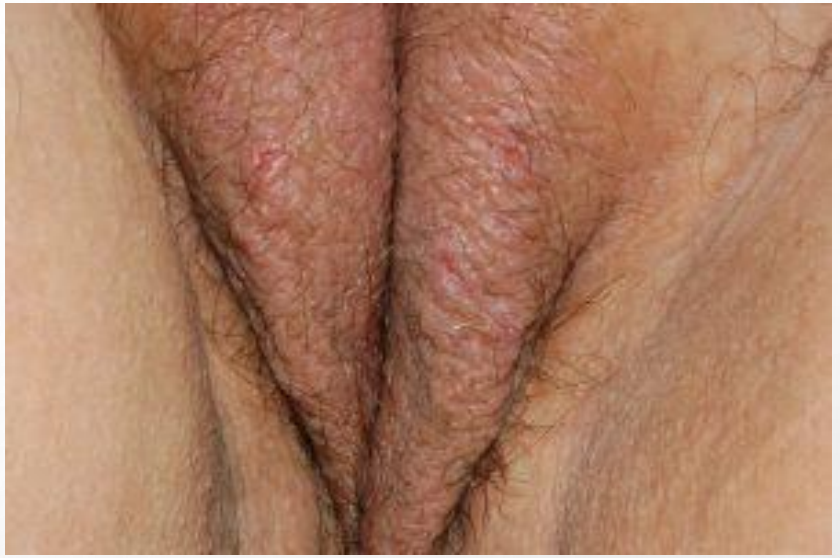




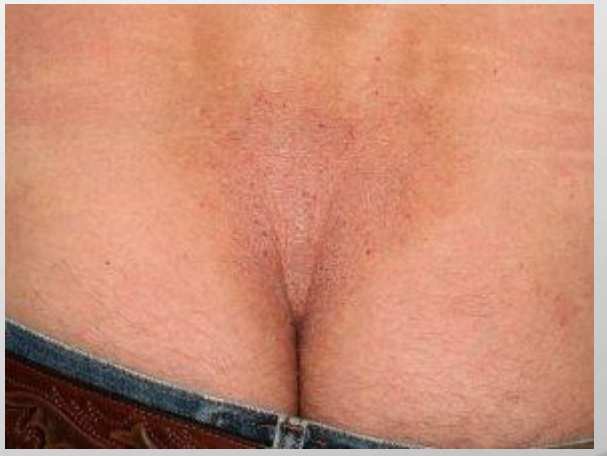
- Difficult to differentiate from eczema and dermatitis.
- Characteristic scaling not usual in genital area so doesn't need urea or salicylic acid creams, **very** irritant in genital area.
- Is usually fairly symmetrical (both sides of the body)
- Clue is always in the rest of the skin and the personal & family history.
- Strong indicators of psoriasis:
  - Irritation and skin splitting in the natal cleft,
  - Pitting of nails or oncholysis
  - Persistent splits behind ears; now or as a child
- Treat with moderate to potent steroids topically, and emollient



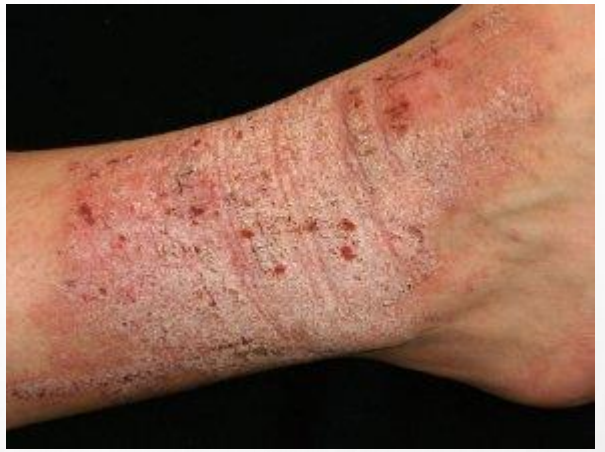
LICHEN SIMPLEX CHRONICUS



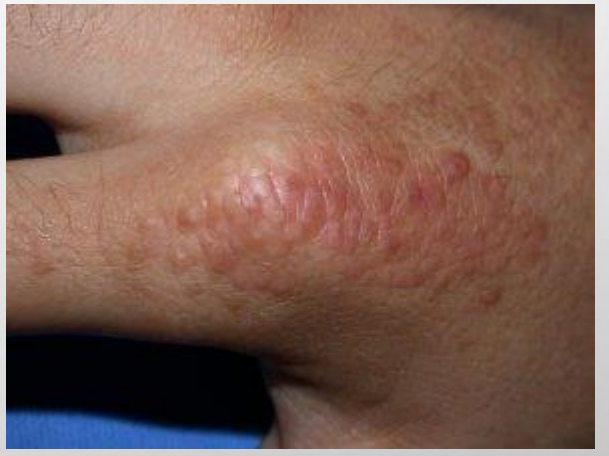
- Intense and persistent itch
- Thickening of skin and leathery appearance with NO architectural change.
- Needs potent steroid (not ultra potent) to stop itch/scratch cycle, e.g. Betamethasone
- Once itch has settled step down to medium potency steroid e.g. Eumovate, patient to have on hand if Sx recur.
- Long term use of emollient is best prevention for skin irritation, which can precipitate recurrence of Sx



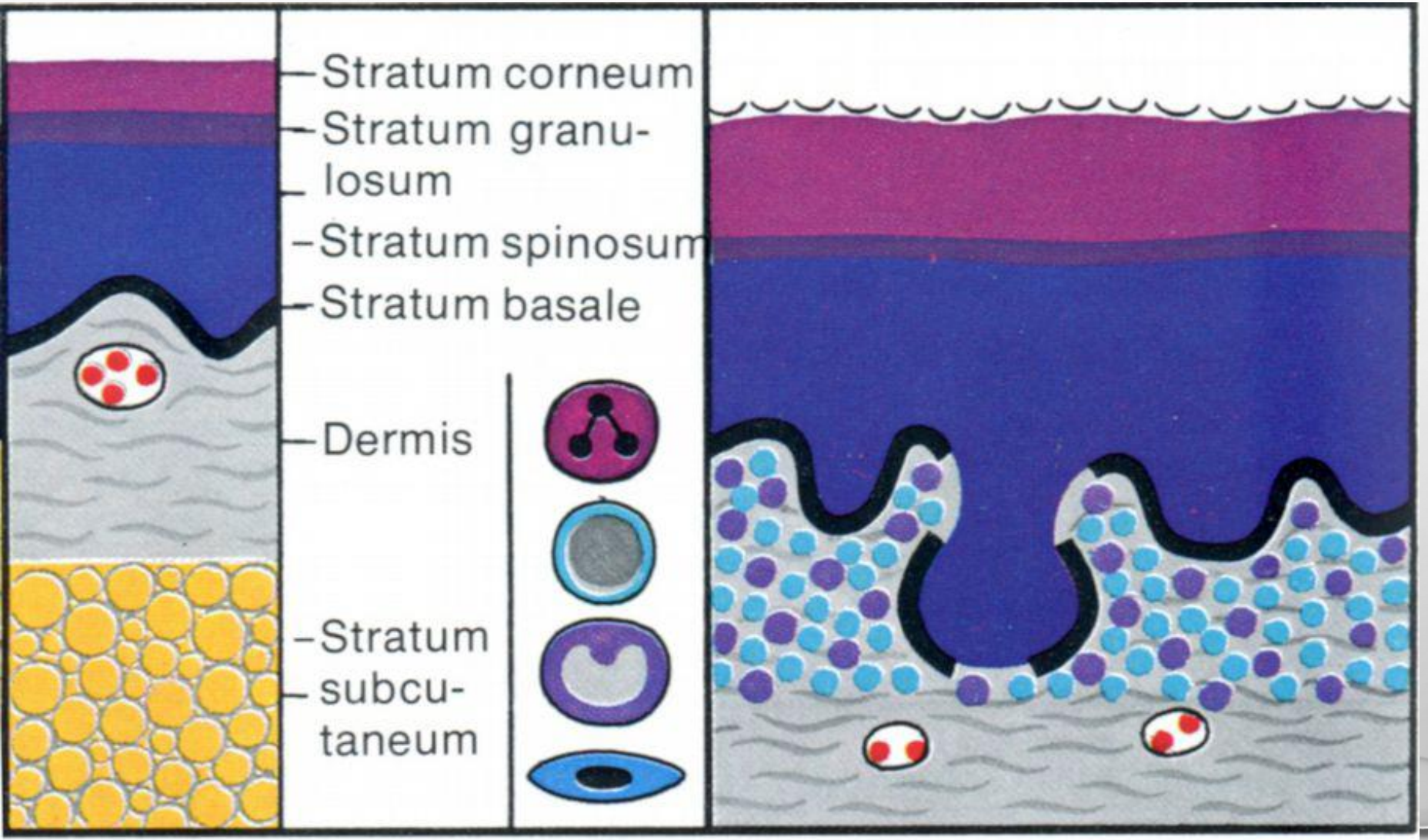
GENERALISED HISTAMINE REACTION



- COMMON IN ATOPY.
- LICHENIFICATION MUST BE TREATED EVERYWHERE TO GAIN ITCH CONTROL IN ANY PARTICULAR ANATOMICAL AREA
- IF THERE IS ECZEMA AND LICHENIFICATION ANYWHERE ELSE, TREATMENT OF ONLY THE GENITAL AREA WILL NOT PROVIDE LASTING RELIEF



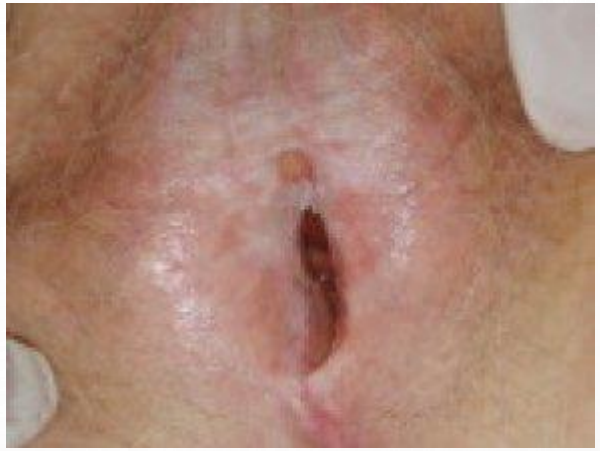
LICHEN SCLEROSIS

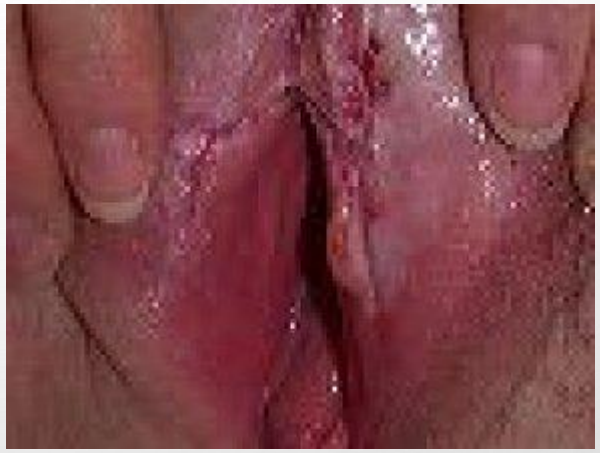


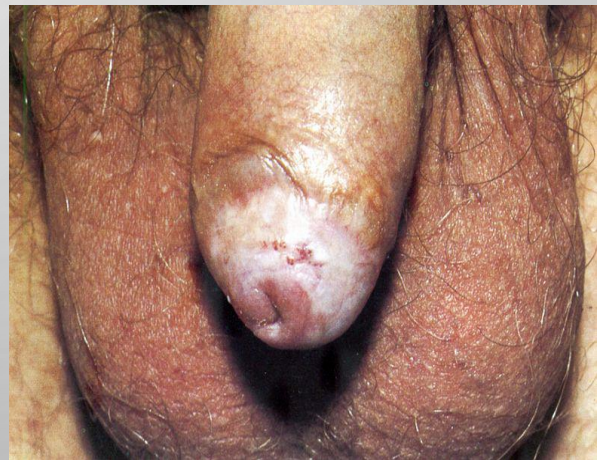
Inflammation of basement membrane causing scarring, thickening of skin and destruction of melanocytes

LICHEN SCLEROSIS

- Usual presentation is intense itch
- Scarring present at diagnosis will not reduce but will stop progressing with proper treatment
- Expect to be a life long condition, but can burn itself out
- Symptoms very hard to control in presence urinary leakage
- Penile symptoms -frequently cured by circumcision; women need urogynae input.
- Needs ultra potent steroids and emollients, most likely life-long.



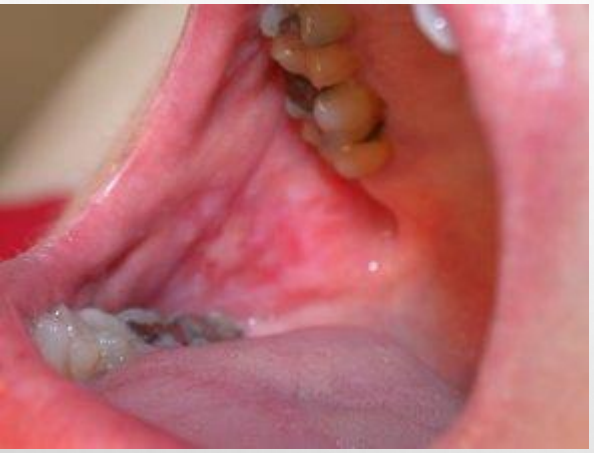


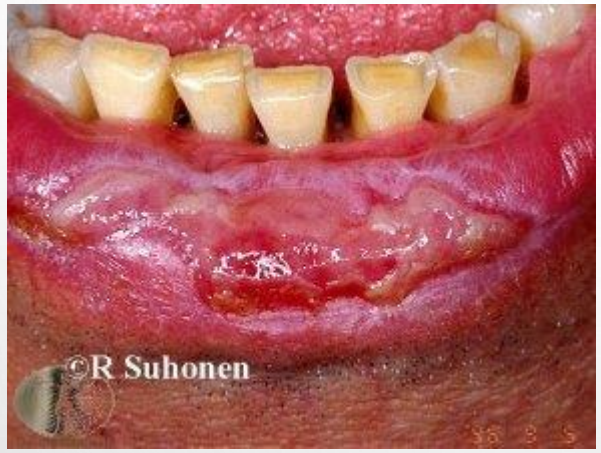


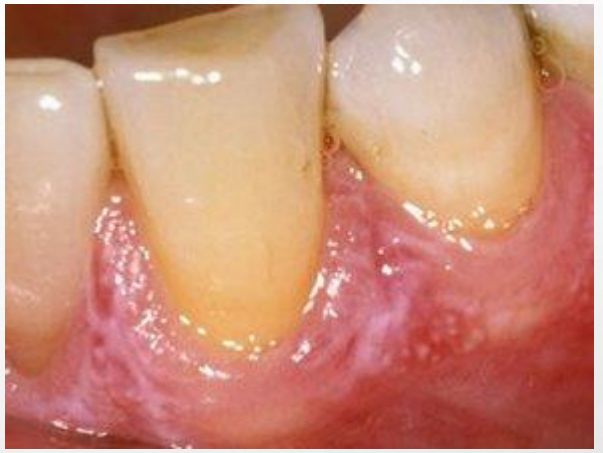
LICHEN PLANUS

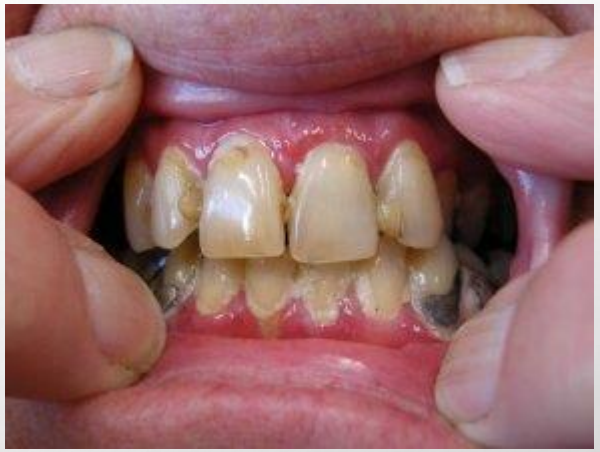
- A T CELL MEDIATED AUTO IMMUNE DISEASE, AFFECTING SKIN AND MUCOSAL SURFACES
- SLIGHTLY MORE COMMON IN WOMEN THAN MEN, USUALLY PRESENTING OVER AGE 40,
- CAN BE ASSOCIATED WITH SKIN INJURY OR INFECTION, STRESS, CONTACT ALLERGY, OR DRUG REACTION
- CAN BE ASSOCIATED WITH OTHER AUTOIMMUNE DISEASES: THYROID DISEASE, PERNICIOUS ANAEMIA, VITILIGO, ALOPECIA AREATA.
- CUTANEOUS DISEASE OFTEN SELF RESOLVES AFTER 2 YEARS, MUCOSAL DISEASE IS LESS LIKELY TO BUT CAN RESOLVE OVER A DECADE
- BIOPSY IS BEST PRACTICE FOR DIAGNOSIS

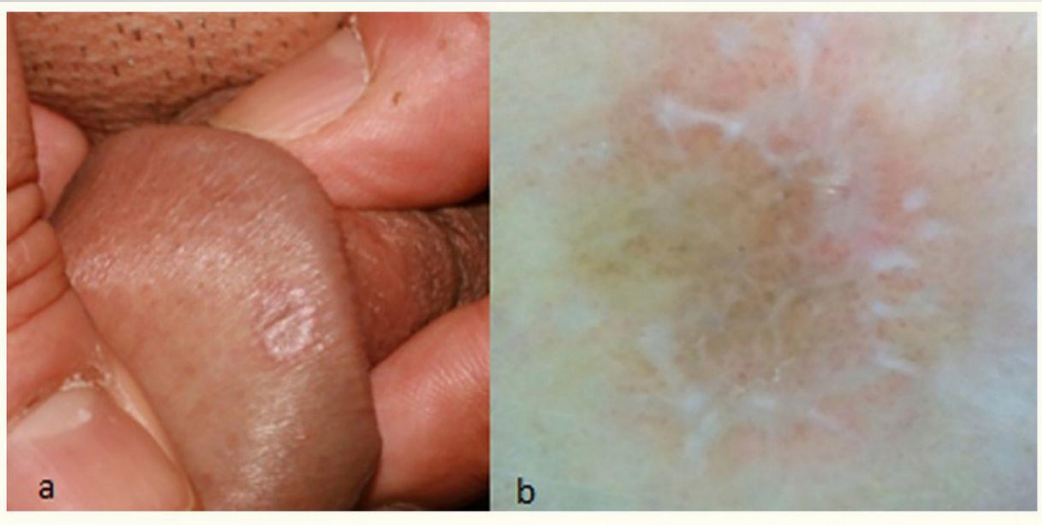
ORAL LICHEN PLANUS







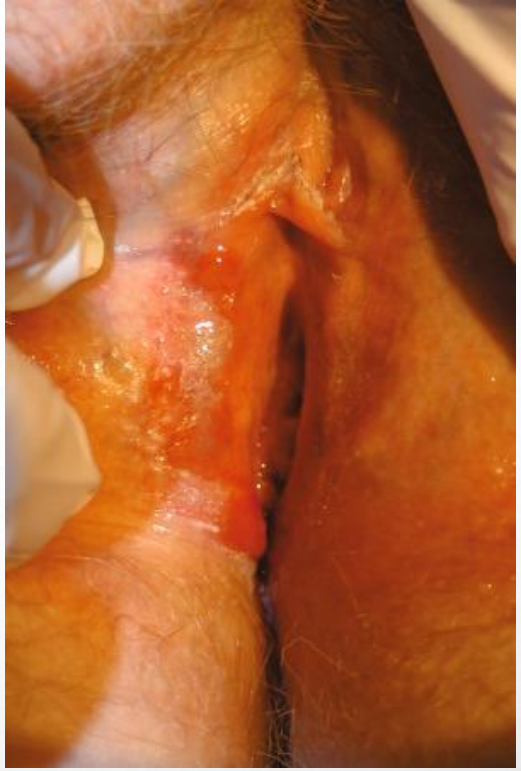


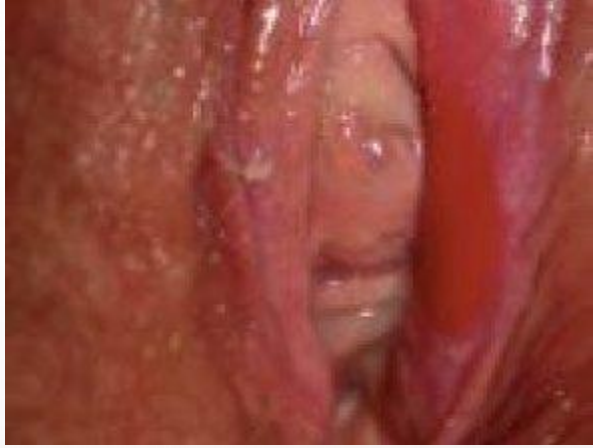


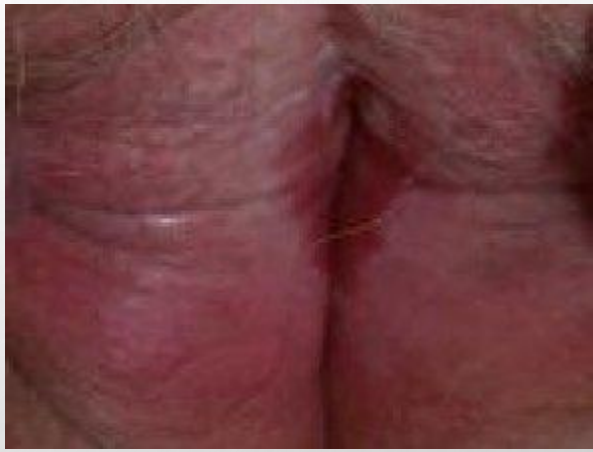
Violaceous papules with a white network on the surface
Often described as having a scalloped or lacy edge.
White markings known as Wickham's striae

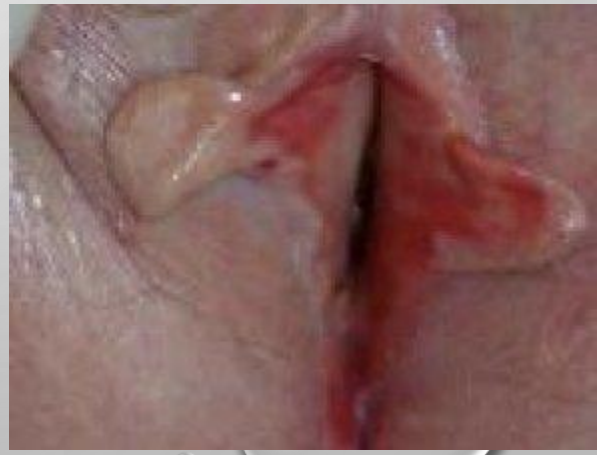
VULVAL LICHEN PLANUS

- USUALLY PRESENTS WITH:
  - PAINFUL, PERSISTENT EROSIONS OR ULCERS,
  - SCARRING, LOSS OF LABIA MINORA
  - DYSPAREUNIA,
  - *POSSIBLY* DESQUAMATIVE VAGINITIS
- ASSESS FOR VAGINAL DISEASE – CAN CAUSE STENOSIS AND FUSION OF VAGINAL WALLS
- 3-4% RISK OF DEVELOPING SQUAMOUS CELL CARCINOMA
- NEEDS ULTRA POTENT TOPICAL STEROID TO TREAT, (CLOBETASOL PROPIONATE. 0.05% OINTMENT) DAILY FOR 1 MONTH, ALTERNATE DAYS FOR 1 MONTH THEN TWICE WEEKLY ONGOING, REDUCING FURTHER IF SX CONTROLLED.
- NEEDS ONGOING MONITORING BY EXPERIENCED CLINICIAN

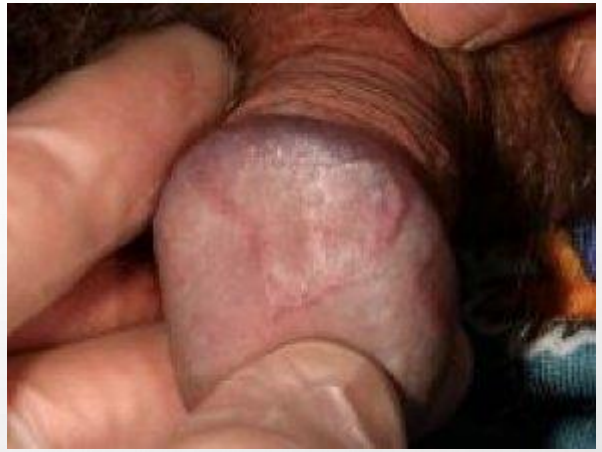




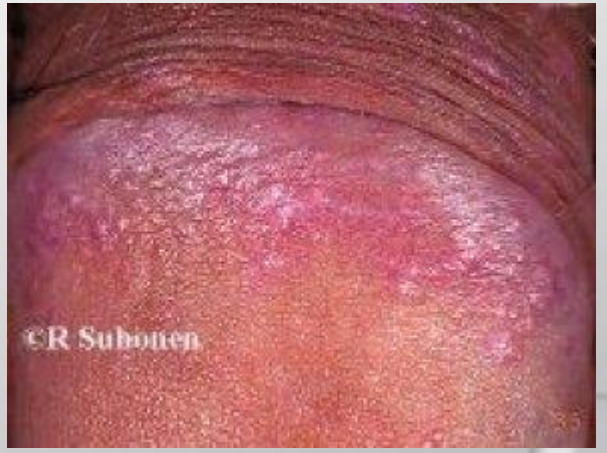




PENILE LICHEN PLANUS

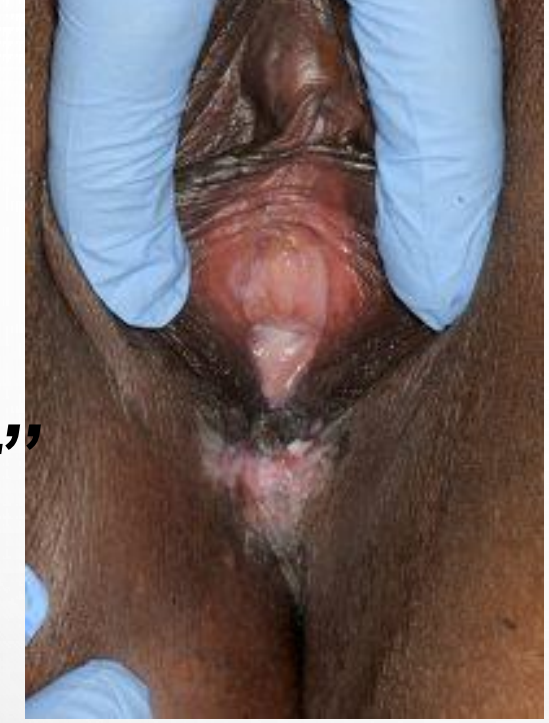


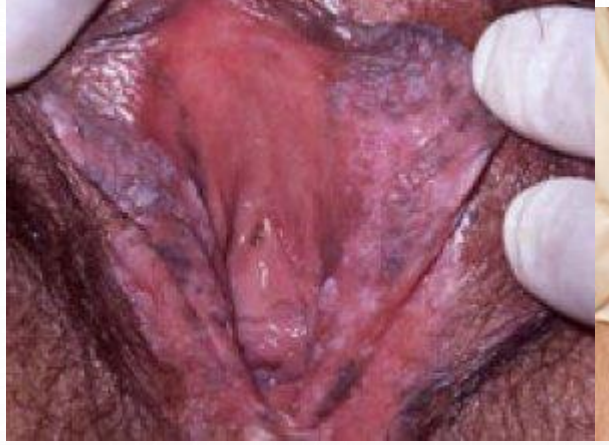
- MALE GENITAL DISEASE IS VERY DIFFERENT FROM FEMALE
- PENILE LP MELTS AWAY WITHIN A FEW WEEKS WITH CLOBETASOL PROPIONATE. 0.05% OINTMENT (DERMOL)
- IF DERMOL DOESN'T RESOLVE PENILE SYMPTOMS THEN IT ISN'T LP

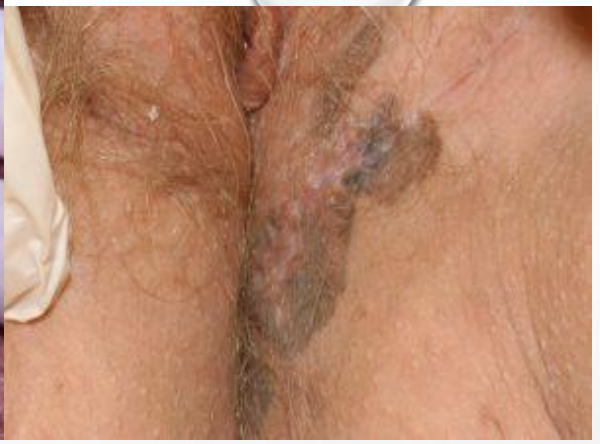


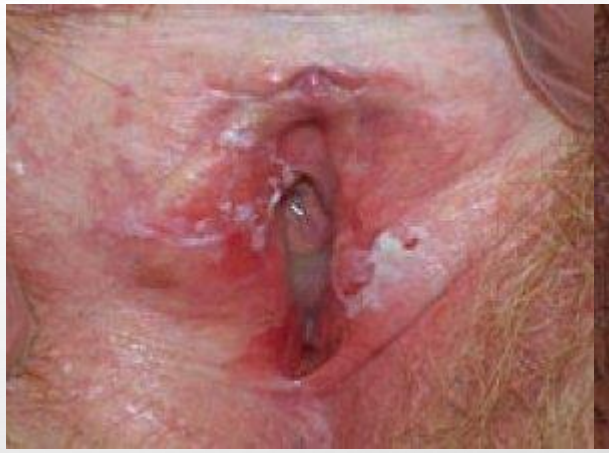
VIN

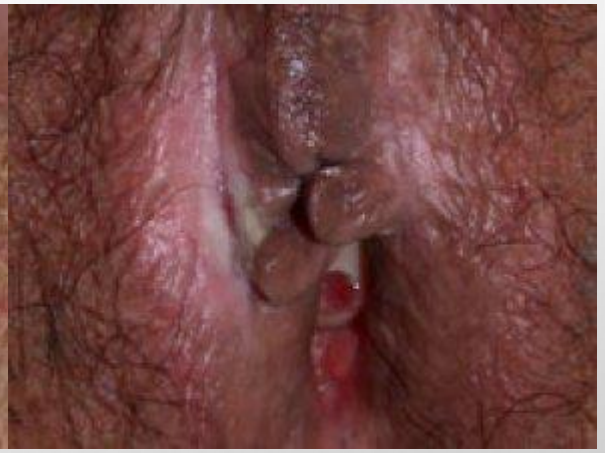
- ***"It just looks different"***
- Usually symptomatic
  - itchy,
  - irritating
  - painful
- Appearance 'usually' monomorphic
- Get a second opinion when odd
- Biopsy when unsure
- If any VIN, VAIN, CIN or AIN present, look for all the others!

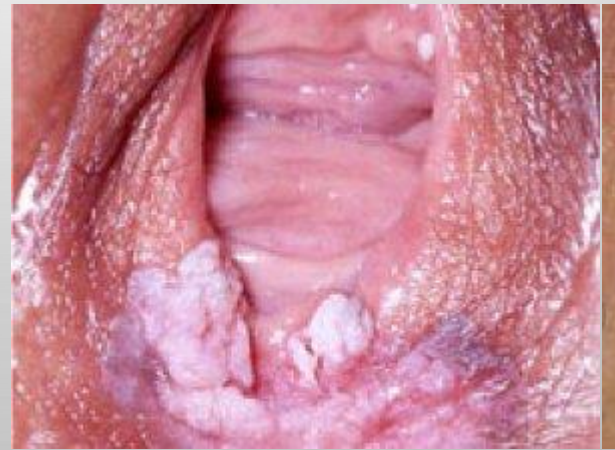


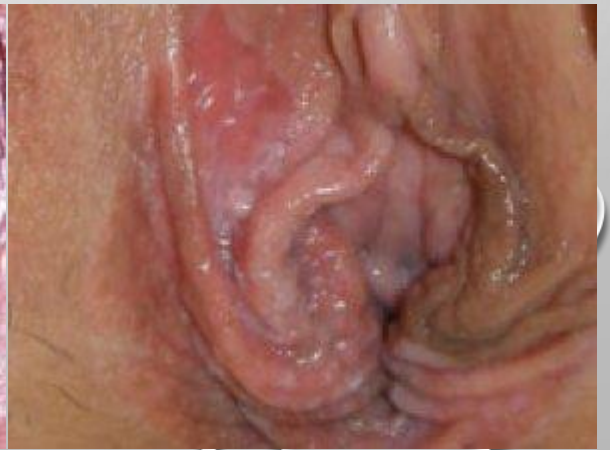


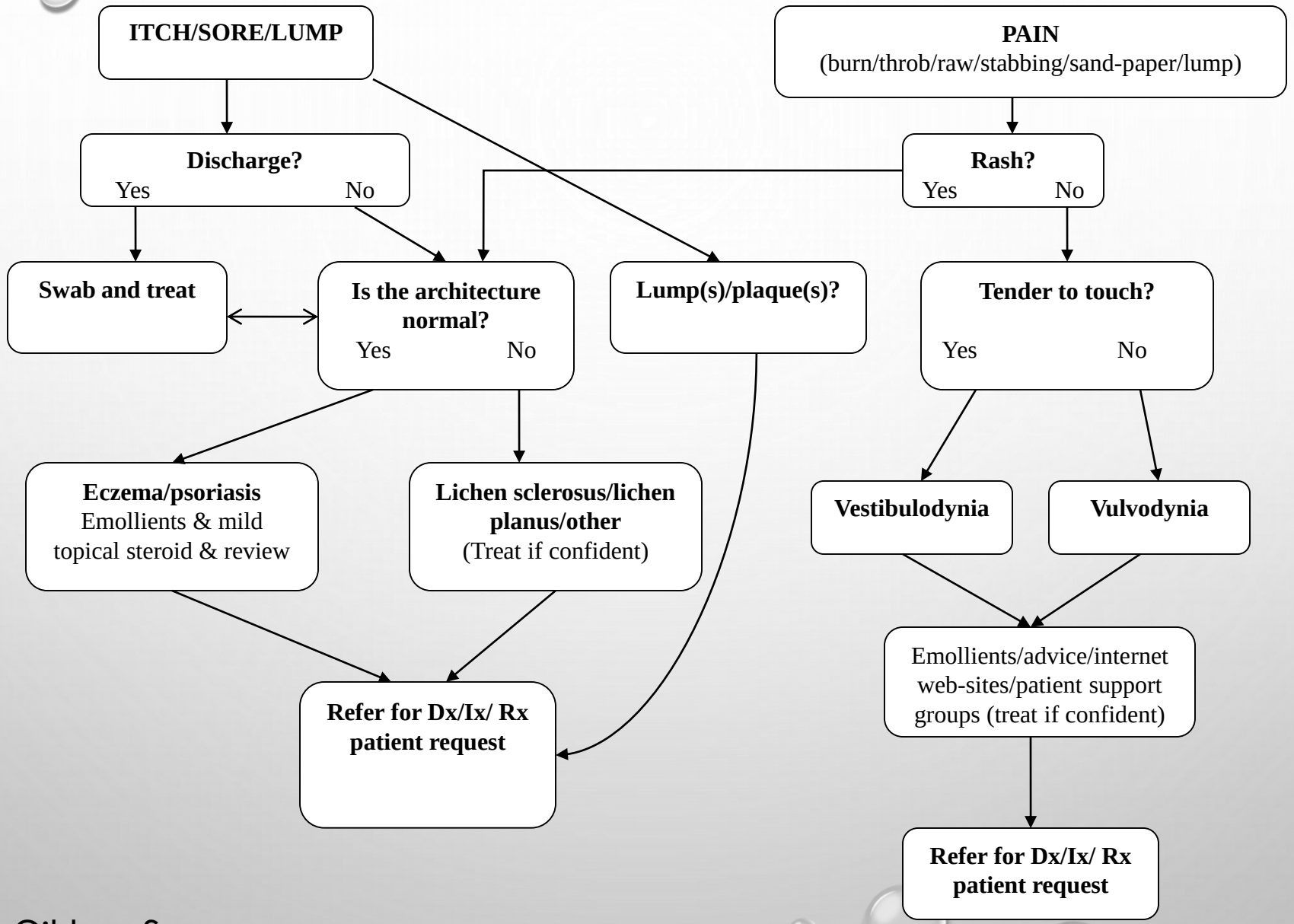












Thanks to Dr Karen Gibbon, St Bartholomew's NHS Trust UK

IMAGES COURTESY OF DERMNET NZ & BSSVD

THANKS TO STAFF IN DERMATOLOGY SERVICES AT EAST LANCASHIRE NHS TRUST, ST BARTHOLOMEW'S NHS TRUST AND GUY'S AND ST THOMAS'S NHS TRUST

RECOMMENDED RESOURSES:

- A PRACTICAL GUIDE TO VULVAL DISEASE DIAGNOSIS AND MANAGEMENT, BY FIONA LEWIS, FABRIZIO BOGLIATTO & MARC VAN BEURDEN
- GENITAL DERMATOLOGY ATLAS, BY LIBBY EDWARDS AND PETER LYNCH