Postmenopausal Vulvar Pruritus - Colposcopic Diagnosis and Treatment

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A Bilge Sener, Neslihan C. Seckin, Oya Gokmen (Departments of Menopause, Dr. Z.T.B. Women's Hospital, Ankara, Turkey.)
Esra Kuscu, Omer Cobanoglu, Gurkan Zorlu (Departments of Oncology, Dr. Z.T.B. Women's Hospital, Ankara, Turkey.)
Dilara Taner (Departments of Pathology, Dr. Z.T.B. Women's Hospital, Ankara, Turkey.)

Abstract

Vulvar pruritus is a common symptom in post-menopausal women and treatment is easy if the diagnosis is duly recognized. The purpose of this study is to show the importance of colposcopic examination and directed biopsies in 27 post-menopausal women with pruritus. Biopsy sites were selected by colposcopy. The prevalence of vulvar pruritus, vulvar pathologies, vulvar dystrophies and vulvar intraepithelial lesions (VIN) were 2.18%, 1.49%, 0.94% and 0.07% respectively. Vulvardystrophies were treated by topical steroids and success rate was 100%. All patients with vulvar pruritus need examination under colposcopy to define optimal therapy and to exclude atypia or malignancy (JPMA 45:315,1995).

Introduction

Pruritus vulva is a relatively frequent gynecologic problem in post-menopausal women and in this age group, the main reason is vulvar dystrophies[1,2]. The differentiation of vulvar dystrophies from infectious lesions and from precancerous conditions by clinical examination is extremely difficult, because in many cases, they are similar in gross appearance[3-5]. Colposcope, an instrument, which was used for detection of cervical pathologies after introduction by Hinselmann in 1925 has in recent years become more popular in the evaluation of vulvar lesions[6]. The purpose of this study is to show the importance of colposcopy guided biopsies in post-menopausal women with chronic vulvar pruritus and the successful results of medical therapy in vulvar dystrophies.

Patients and Methods

Between January 1992 and March 1993, 1275 women who had menopause for at least one year were admitted to Dr. Zekai Tahir Burak Women's Hospital Menopause Center. Of these, 27 women who had chronic vulvar pruritus besides climacteric complaints were included in this study. After erradication of metabolic (diabetic), haematological and 'infectious disorders, patients were referred to colposcopy clinic. A careful inspection of vulva was done initially. Preceding step, was the application of 3-5% acetic acid solution. The whole vulva, including personal areas, were saturated with acetic acid soaked guaze swabs. Under colposcopy, we systematically examined the vaginal introitus, labia minora, labia majora and perineum, finally the clitoris and personal area. Biopsies were obtained from all suspicious areas by a Kevorkian forceps. In each case, the defect was about 0.5 to 1.0 cm large and 2 to 5 mm depth which was left granulating or closed with a single stich of absorbable 3.0 non-chromic suture. Biopsy specimens were evaluated by a co-author pathologist. Patients with squamous cell hyperplasia (SCH) received 0.02% flumethasone 3%, iodochlor hydroxyquinolone, twice daily and 2% testosterone propionate in petrolatum were given to patients with lichen sclerosus twice a day. Topical fluorinated corticosteroids followed by testosterone propionate was prescribed to patients with mixed dystrophy. In

vulvar dystrophies topical therapy continued intermittently for 2-4 months until all symptoms were resolved. Each patient was re- evaluated and control biopsies taken after completing therapy. Patient with VIN II undenvent skinning vulvectomy. Flat condyloma accuminata, hemangioma, compound nevus were treated by excisional biopsies. Acyclovir 1 gram per os daily for five days was used for herpetic vulvitis. Topical hydrocortisone 1% was applied twice daily for 6 weeks for chronic dermatitis.

Results

Out of 1275 post-menopausal women, 27 (2.18%) had chronic vulvar pruritus. Clinical data is summarized in the Table.

Table. Clinical data in patients with vulvar pruritus (n=27).

Age	52.8±0.6 (42-66)*
Menopausal age (Year)	5.2±0.2 (1-10)*
Type of menopause	
Natural	17 (62.9)#
Surgical	10 (37.1)#
Year with pruritus	3±1 (1-14)*
Initial symptom	
Pruritus	(70.4%)#
Pruritus+Leukoplakia	(29.6%)#
Gross appearance	
Normal	6 (22.2%)#
White	11 (40.8%)#
Red	9 (33.3%)#
Vesicle	1 (3.7%)#
Ethnic group	White

*Mean±SD (Range)
Number (%)

Age of patients ranged between42 and 66 years with the mean being 52.8±0.6 (Mean±SD). All patients had pruritus at least for one year. Clinical examination showed the presence of white, red, normal and vesiculated areas. Eight women (29.6%) with normal colposcopic finding, had a history of using irritative agents. After the elimination of all possible irritants, patients were found to be free of symptoms. One herpetic vulvitis, one flat condyloma accuminata, one hemangioma, one compound

nevus and two chronic dermatitis, seven SCH, four lichen scierosus (LS), one mixed dystrophy and one VIN II were detected via colposcopy guided biopsy specimens. In compound nevus, hemangionia and condyloma accuminata biopsy sites were clinically evident. They were macroscopically visible, hyperkeratotic and red areas. In patients with SCH, one patient with LS and one patient with VIN II were macroscopically normal and sites of biopsy were selected by colposcopy. Pathologic distribution of cases are shown in Figure.

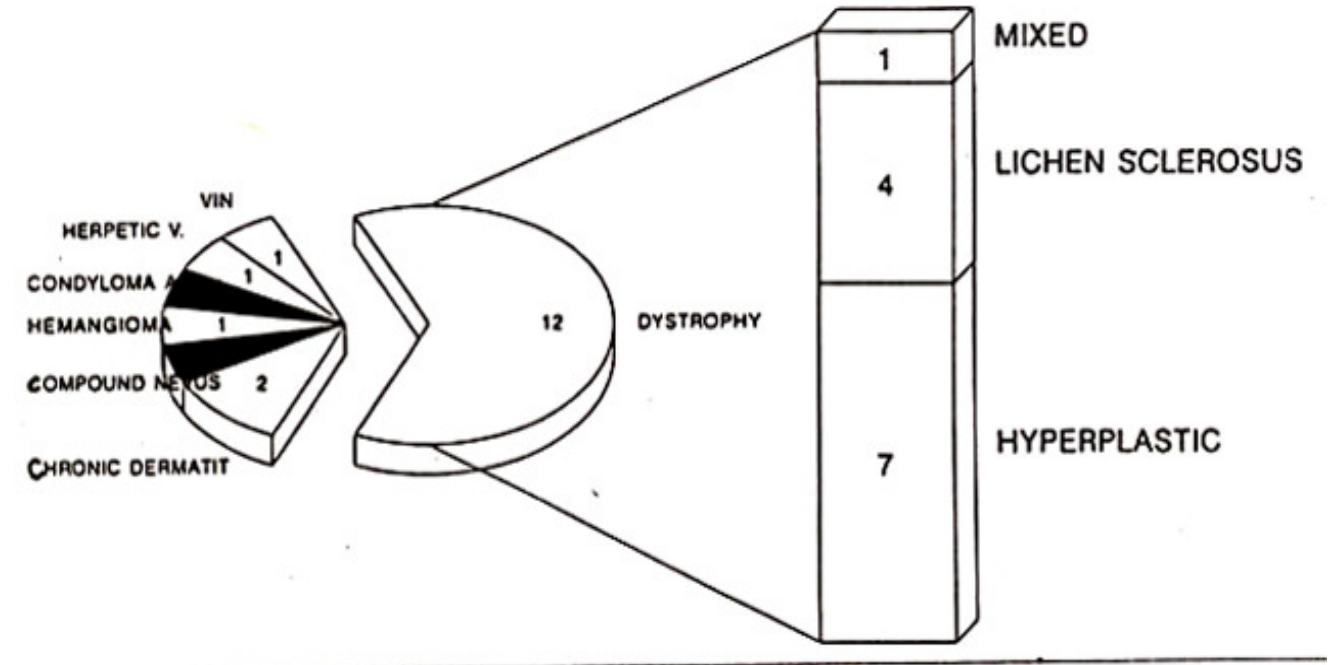

Figure. Histopathologic distribution of vulvar lesions.

Immunoglobulins (Ig) M and G were found to be positive in the patient with heipetic vulvitis and serum IgM value was negative when she was re-evaluated 6 weeks later. In post-menopausal women, the prevalence of vulvar pathologies, vulvar dystrophies and yIN were 1.49%, 0.94% and 0.07% respectively. Dystrophies were 63% (12/19) of vulvar pathologies, consisting of 58.3% SCH, 33.3% lichen sclerosus and 8.4% mixed dystrophy. The therapeutic effect of fluorinated steroids and testosterone on the subjective and objective symptoms of the disease was excellent. In 8 patients, the pruritus diminished within two weeks of treatment and after six weeks symptomatology improved in 100% of cases. In the histopathologic follow-up, the tissue normalised after four months of treatment. The remission rate was 100% (12/12). Two patients with chronic dermatitis and patients with VIN H were free of disease after six months.

Discussion

Vulvar pruntus is a common symptom and may be associated with generalized itching in endocrine, metabolic and haematological disorders and skin diseases. However, it usually occurs as an isolated phenomenon, either primarily due to a vulvar lesion or secondary for a genitourinary condition[7]. Vulvar epithelium hyperplasia with or without atypia and vulvar neoplasm may also presentwithpruntus and this is the most diagnostic feature[8]. In the differential diagnosis of patient with chronic vulvar pruritus, colposcopy guided biopsy is an important diagnostic procedure which supplement local inspection and palpation. Sites of biopsy are selected either from macroscopically visible hyperkeratotic, eroded or raised areas, or in the case of non- këratotic lesions by colposcopy[9]. The greatest value of the

colposcope is in directing the biopsy to the area that is most likely to yield the most significant histologic pattern. It is also useful in identifying extension beyond the macroscopic limits of the lesion and permitting adequately wide excision, especially in Paget's disease. Dargent et al, advocated vulvoscopy and guided biopsy for screening VIN in 1988[10]. In our study, out of 27 women with chronic vulvar pruritus, we found one VIN II via colposcopy guided biopsy. Occasionally, the colposcope is of value in identifying vulvar dystrophies, small sub-clinical condylomas, small herpetic ulcers and the presence of molluscum contagiosum[11]. Condyloma accuminata and herpetic vulvitis were clinically evident in our patients. Four patients with SCH and one patient with LS were macroscopically normal and biopsy sites were selected by colposcopy. Pepe et al. reported 2.72% vulvar pathologies in post-menopausal women[12]. in our menopause clinic the prevalence of vulvar pathologies was 1.49% Vulvar dystrophies are the main cause of vulvar pruntus in post-menopause[13]. In our experience vulvar dystrophies were 44.4% of vulvar pruntus consisting of 58.3% SCH and 33.3% LS. The relative frequency of SCH varies from clinic to clinic. In Houston, 48% of patients with vulvar dystrophy were determined to suffer from this variety and in New York experience, 54% of the dystrophies were hyperplastic[14]. A good clinical and histologic correlation was noted following local steroid application in patients with histologically proven vulvar dystrophies. Other workers reported their high success rates in the medical treatment of vulvar dystrophies[15-17]. Some gave fluorinated steroids to patients with SCH with a response rate of 90.1% and testosterone propionate to patients with LS and the response rate was 87.7%' . Our success rate was 100% and this probably due to the small number of patients. All patients with vulvar pruritus who have normal or abnormal macroscopic appearance must be referred to colposcopy clinic and the final diagnosis made by the colposcopy guided biopsies to define optimal therapy and to exclude atypia or malignancy.

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