IADVL

Special Interest Group (SIG) Female Genital Dermatoses

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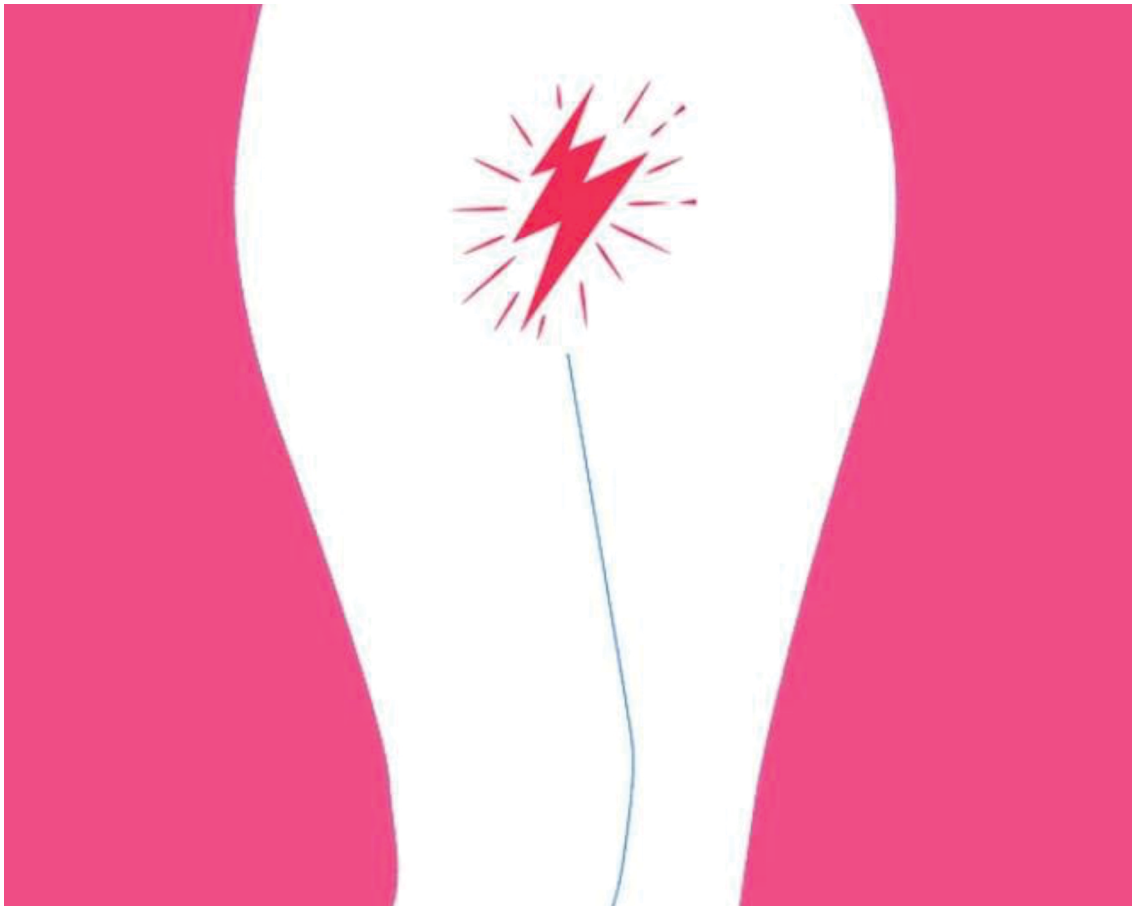

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FOREWORD

Dr. Nina Madnani **Dr. Smitha Prabhu**

The SIG FGD is happy to bring you our first newsletter, albeit during this pandemic of COVID-19 which has gripped the whole world. Vulvar dermatoses has become a much researched territory, from the barren field it was, till a couple of decades ago. Finally dermatologists across India are embracing vulvar disease as their own, and it gladdens us to see various aspects of vulvar disease as present and future thesis topics. We have included here the myriads of happenings and advancements in the field of vulvar dermatoses, both from India and abroad. Also an interview with leading vulvar specialists with respect to how Covid-19 has affected their practice. Happy reading!

MEDICAL PHOTOGRAPHY OF THE VULVA

Dr Smitha Prabhu

Reasons for photography

1. Documentation
2. Medical teaching
3. Patient education
4. Research, Paper presentation & publication
5. Monitor the progress of disease/treatment
6. Pre-operative planning and post-operative documentation

Positioning of the patient:

The area to be photographed should be devoid of clothing.

Excessive genital hair may require clipping or depilation for clear visualization.

The mons pubis should be either photographed in the standing position (figure 1) , or when lying down, with the camera positioned exactly above it . When taken standing, the patient should be approximately 3 feet in front of the background to avoid shadows.

Lesions on the labia, clitoris, introitus, perineum or fourchette are best photographed in the lithotomy position, with hips flexed 80 to 100° from the torso and thighs abducted approximately 30 to 40° from the midline. Stirrups may be used to support the legs at a position roughly parallel to the trunk. The frame should include the mid-thigh, entire genitalia and inferior border of buttocks. (figure 2)

Background: Should be uniform, with drapes positioned beneath and at sides of patient. 'Sky blue converted to 18% gray Kodak standard in grayscale' is the standard color recommended.

Lighting: Lights should ideally be positioned anterior, posterior, and superior to the patient. Cold light which is bluish gray is preferred to warm light that gives a yellow glow. The camera flash should be positioned parallel to the area of focus in order to minimize shadows. Where there is mixed lighting, the camera can be set to “automatic”to give the truest color.

The calibration of the camera should be at medium tone, to produce color closest to reality.

Camera positioning: The camera should always be kept at a constant level and distance. A tripod is often useful to attain this. Zoom can distort a picture, making it difficult to achieve consistency.

When photographing a small area, 8 cm or less, place a ruler to provide a referral frame for the size.

Photoediting: may be used only for side by side comparison, but is best avoided.

Medicolegal implications:

It is essential to obtain an Informed written consent by the patient allowing presentation, publication without compromising her identity

Single mobile phone to be used for photography, with adequate care not to misplace, sell or lend so as not to compromise patient photographs.

Ensure strict privacy setting on digital devices and store the photographs for minimal period

Do not share in social media or larger groups. Sharing within smaller special interest group should come with the explicit responsibility of each member as to maintain the privacy of the pictures.

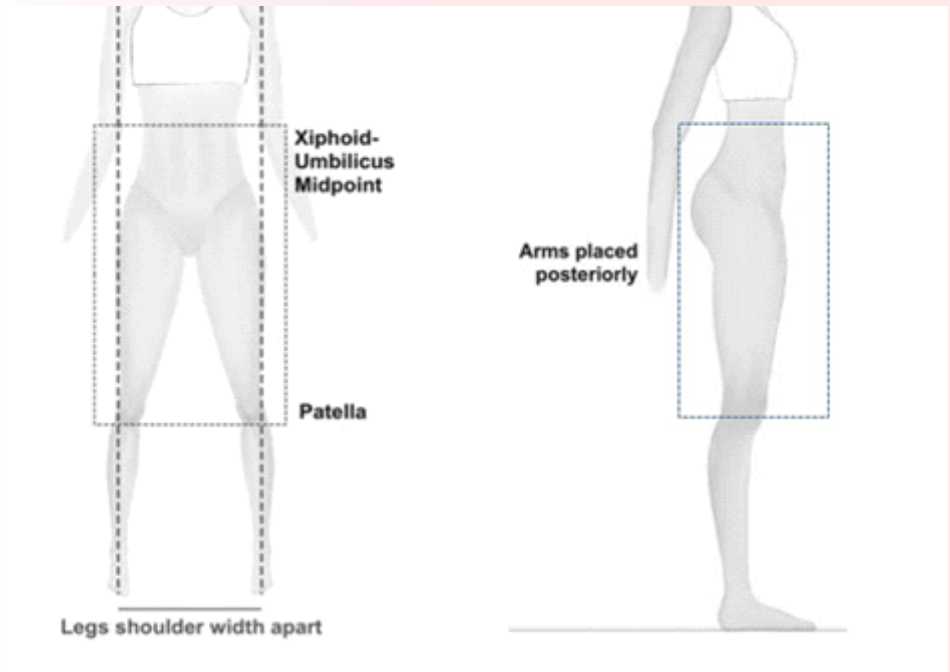

Figure 1: Vulvar photography in standing position[1] – front view and lateral. The box shows area that should be included in the photograph.

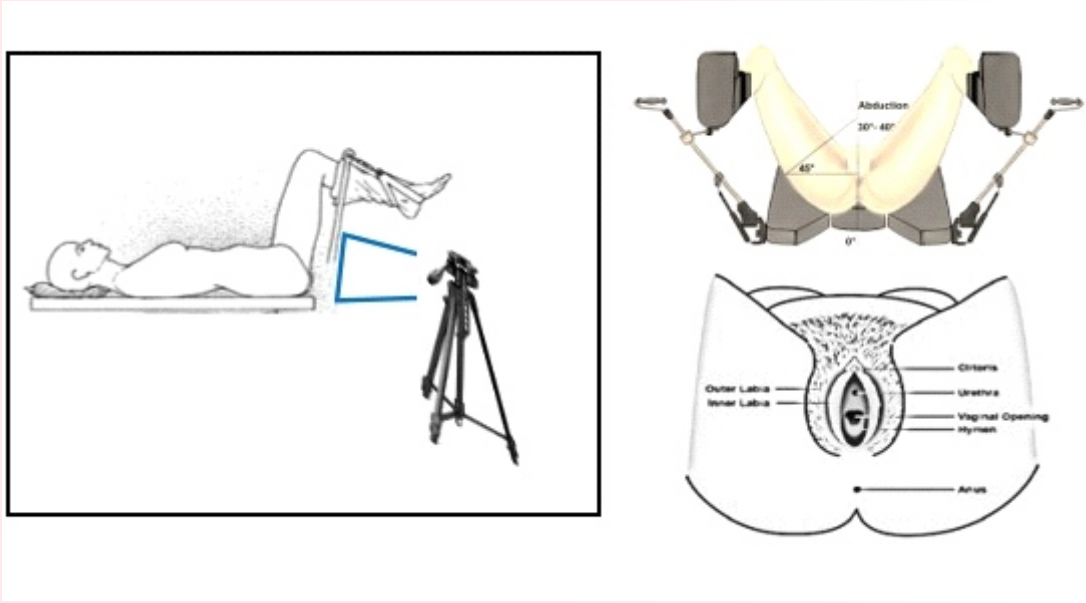

Figure 2: Vulvar photography in lithotomy position

References:

1. Natalie R Joumblat, BS, Jimmy Chim, MD, Priscila Gisselle Aguirre Sanchez, MD, Edgar Bedolla, MD, Christopher J Salgado, MD, Guidelines for the Standardization of Genital Photography, Aesthetic Surgery Journal, Volume 38, Issue 10, October 2018, Pages 1124– 1130,
2. Persichetti P, Simone P, Langella M, Marangi GF, Carusi C. Digital photography in plastic surgery: how to achieve reasonable standardization outside a photographic studio. Aesthetic Plast Surg. 2007;31(2):194-200.
3. Kunde, L., McMeniman, E. and Parker, M. (2013), Clinical photography in dermatology. Australasian Journal of Dermatology, 54: 192-197. doi: 10.1111/ajd.12063

RECENT RESEARCH SNIPPETS IN THE FIELD OF FEMALE GENITAL DERMATOSES

Dr. Eswari L

Vulvar lichen sclerosus

Gómez-Frieiro M, Laynez-Herrero E. Use of Er: YAG laser in the treatment of vulvar lichen sclerosus. International Journal of Women's Dermatology. 2019 Dec 1;5(5):340-4.

Three non-ablative, thermal-only Er:YAG laser treatment sessions (7 J/cm2, 2 Hz, 7 mm spot) were performed at 4-week intervals in 28 women with vulvar lichen sclerosus and was found safe, well tolerated, and effective method for the adjuvant treatment. There are many similar reports with small numbers, and we require more eveidence before this can be included as standard of care.

Vulvar erosive lichen planus

Rajkumar S, Lewis F, Nath R. The importance of topical steroids after adhesiolysis in erosive lichen planus and graft versus host disease.Journal of Obstetrics and Gynaecology. 2019 Jan 2;39(1):82-5.

Potent topical steroids used immediately after surgical adhesiolysis in patients with vulvo-vaginal lichen planus and graft-versus-host disease improves the outcomes and maintains function, which can give a prolonged benefit.

Vulvar psoriasis

Ryan C, Menter A, Guenther L, Blauvelt A, Bissonnette R, Meeuwis K, Sullivan J, Cather JC, Yosipovitch G, Gottlieb AB, Merola JF. Efficacy and safety of ixekizumab in a randomized, double-blinded, placebo-controlled phase III b study of patients with moderate-to-severe genital psoriasis.British Journal of Dermatology. 2018 Oct;179(4):844-52.

Ixekizumab, a monoclonal antibody targeting interleukin-17A, at the dose of 160 mg subcutaneously every 2 weeks for 12 weeks significantly improved the severity of genital psoriasis and associated disease characteristics in moderate -to - severe genital psoriasis.

Vulvar pain syndrome

Falsetta ML, Foster DC, Woeller CF, et al. : Identification of novel mechanisms involved in generating localized vulvodynia pain. Am J Obstet Gynecol. 2015;213(1):38.e1–12. 10.1016/j.ajog.2015.02.002

Recent studies have found that vestibular fibroblasts from vulvodynia patients express elevated levels of Dectin-1, a

surface receptor that binds *C. albicans*. They also showed that blocking the function or expression of Dectin-1 *in vitro* resulted in a significant decrease in IL-6 and PGE2 production, and targeting this may lead to newer therapies for vulvodynia.

Brown C, Bachmann G, Foster D, Rawlinson L, Wan J, Ling F. Milnacipran in provoked vestibulodynia: efficacy and predictors of treatment success. J Low Genit Tract Dis. 2015;19(2):140 -144.

Selective norepinephrine reuptake inhibitors, particularly duloxetine and milnacipran are more effective and have fewer adverse effects than tricyclic antidepressants (TCAs) in the treatment of vulvar pain syndrome.

Vaginal discharge

Woelber L, Prieske K, Mendling W, Schmalfeldt B, Tietz HJ, Jaeger A. Vulvar pruritus-Causes, Diagnosis and Therapeutic Approach. Dtsch Arztebl Int. 2020;116(8):126 -133. doi:10.3238/arztebl.2020.0126

The recommended treatment for C. glabrata-induced vulvovaginal candidiasis VVC is still an oral dose of 800 mg fluconazole for 2 to 3 weeks.

Patients with bacterial vaginosis, recurrent episodes VVC, are offered immunization with inactivated lactobacilli of various species to induce specific antibodies against aberrant strains in the Döderlein's flora (which do not contribute to the normal vaginal milieu), and to achieve regeneration of the affected vaginal flora, thereby enhancing local vaginal immunity. The recommended regimen consists of basic immunization with 3 doses at 2-week intervals and a booster dose after 6 to 12 months.

*Lev-Sagie, A., Goldman-Wohl, D., Cohen, Y. et al. Vaginal microbiome transplantation in women with intractable bacterial vaginosis. Nat Med **25,** 1500–1504 (2019).*

Vaginal microbiota transplantation (VMT), i.e., transplanting vaginal fluids from healthy women into the vaginas of those suffering from recurrent BV , a novel exploratory study in 5 women showed good results in 4.

HIV

Lajoie J, Birse K, Mwangi L, Chen Y, Cheruiyot J, Akolo M, Mungai J, Boily-Larouche G, Romas L, Mutch S, Kimani M. Using safe, affordable and accessible non-steroidal anti-inflammatory drugs to reduce the number of HIV target cells in the blood and at the female genital tract. Journal of the International AIDS Society. 2018 Jul;21(7):e25150.

Taking low-dose aminosalicylic acid ASA daily was associated with significant reduction in HIV target cells in the female genital tract.

Lipschutz genital ulcers

Chen W, Plewig G. Lipschütz genital ulcer revisited: is juvenile gangrenous vasculitis of the scrotum the male counterpart?.Journal of the European Academy of Dermatology and Venereology. 2019 Sep;33(9):1660-6.

Lipschutz genital ulcers, non-sexually related acute genital ulcers in females. A primary EBV infection is probably the most common aetiology. Young men can also be affected in the form of juvenile gangrenous vasculitis of the scrotum.

Vulvar Carcinoma

Regauer S, Reich O, Eberz B. 2014. Vulvar cancers in women with vulvar lichen planus: a clinicopathological study. Journal of the American Academy of Dermatology 71:698–707

Vulvar squamous cell carcinoma in patients with vulvar lichen planus is HPV 16 negative

Vaccari S, Barisani A, Preti EP, Dika E, Fanti PA, Patrizi A, Tosti G. Vulvar intraepithelial neoplasia and vulvar squamous cell carcinoma: differential dermoscopic features in a case series, and a progression model. Clinical and experimental dermatology. 2018 Jun;43(4):469-71.

Dermatoscopic findings of white colour and the presence of polymorphous vessels (in particular linear–irregular and hairpin vessels) should be interpreted as alarming features of microinvasive and invasive SCC

Lagerstedt M, Huotari-Orava R, Nyberg R, Mäenpää JU, Snellman E, Laasanen SL. Reduction in ERRα is associated with lichen sclerosus and vulvar squamous cell carcinoma. GynecolOncol. 2015;139(3):536-540. doi:10.1016/j.ygyno.2015.10.016

ERRs (estrogen-related receptors) ERRα, a key regulator of cell energy metabolism, may play a role in the pathogenesis of both LS and vulvar SCC

Horne ZD, Dohopolski MJ, Pradhan D, et al. Human papillomavirus infection mediates response and outcome of vulvar squamous cell carcinomas treated with radiation therapy. GynecolOncol. 2018;151(1):96-101. doi:10.1016/j.ygyno.2018.08.002

In vulvar SCC, P16-positivity, a surrogate for HPV, predicts better response rates to chemoradiation therapy and survival.

Gardner KM, Crawford RI.Distinction of CondylomataAcuminata From Vulvar Vestibular Papules or Pearly Penile Papules Using Ki-67 Immunostaining.Journal of cutaneous medicine and surgery. 2019 May;23(3):255-7.

Ki-67 negativity is a reliable marker to pathologically distinguish benign vulvar vestibular papules in women, or pearly penile papules in men, from HPV-induced condylomata acuminata.

BUSTING VULVO-VAGINAL MYTHS & MISCONCEPTIONS

Dr Mansi Kansal

1. All Vulvar ulcers are not STDs.

   Several non-STD causes include Behcet's, chronic apthosis, metastatic crohn's disease, to name a few.

2. All vaginal discharges are not pathological.

   Discharges which occur mid –cycle or during sexual stimulation are clear with a very mild odor. No pathogenic organism is involved.

3. Partners need not be treated in every case of genital infection.

   Recent reports do not recommend partner treatment for certain genital infections like candidiasis or bacterial vaginosis (BV).

4. Douching is not essential to cleanse the vagina

   In fact, douching is strongly discouraged as it changes the normal vaginal flora and pushes infections further up the vaginal canal.

5. Pubic hair removal is not an obligatory step in maintaining vulvar cleanliness.

   Pubic hair in fact acts like a cushion, protecting the delicate vulva. A hairless vulva is not a must to maintain hygiene.

6. Every patient of vaginal itch does not necessarily have a yeast infection.

   This is evident from various itchy vulvar disorders like lichen planus, lichen simplex chronicus, psoriasis which are misdiagnosed and treated with antifungals.

7. There is no anatomical basis of the hyped G-point.

   Researchers have failed to find any specific structure identifiable as the G-point in women.

8. Vaginal dimensions do not depend upon the stature of the patient.

   Usually the vaginal dimensions are genetically determined in every woman, but changes with hormonal status and sexual activity.

9. The vulvar parts should be symmetric.

   This is a misconception as the various parts are very often asymmetric. Social media, photo-shopping, and a “hairless vulva” have propagated this myth.

10. Many vulvar conditions are non-specific.

    Biggest myth, as all vulvar diseases have a specific diagnosis which needs to be identified.

NEWS FROM ABROAD: XXV WC ISSVD, TORINO, ITALY

Dr Nina Madnani

Torino, known for its breathtaking beauty, food and wine, gained an additional tag as the venue for the XXVth WC and Post-graduate course of the ISSVD! It was perfect weather and the venue Centro Congressi Unione Industriale Torino, was located in one of the amazing Renaissance areas of the city. September 2019, saw 450 delegates from across the world, arrive for an intensive five day event. The first 2 days dedicated to the teaching course, followed by 3 days of in - depth orations and lectures from top-notch vulvar specialists, who generously shared their expertise. Lunches were arranged in beautiful lawns under tents, with flowing wine and gourmet Italian fare. The PG lectures covered a vast array of subjects ranging from the normal vulva to principles of diagnosis, dermatoscopy, aging, surgery, difficult topics amongst many. I was happy to actively participate in the teaching course with 2 lectures viz, "Vulvar Dermatoscopy" and "Vulvar Hygiene, Does Age Matter"? Didactic lectures and orations kept all glued to their seats. My invited lecture "STIs in 2020-where are we going" was well received. Vulvar Cancer Day was celebrated, with all wearing specially designed t-shirts.

Every minute spent was a learning experience for vulvar disease enthusiasts. Every other minute was a visual and literal feast in this remarkable city! Kudos to the President Mario Preti, and Secretory General Debbie Roepe, and their team for this stupendous show

SIG CMES IN FEMALE GENITAL DERMATOSES: ACHIEVEMENT SO FAR

So far, we have been able to conduct a focused session in the national DERMACON in Pune, in January 2020, and 3 CMEs, the first one, February 16, 2020 Mumbai, second on March 1, 2020 Bangalore, the third was a webinar CME conducted by Gujarat IADVL with one accreditation point from the state medical council.

Focused session in Dermacon 2020, Pune

The topics discussed included HPV and the vulva(Speaker – Dr. Godha Venkata Ramana),

Sexual dysfunction in females(Speaker – Dr. Shrutakirthi D Shenoi) and panel discussion on female vulvar dermatoses moderated by Dr. Nina Madnani and panelists included SIG members Dr. Eswari L, Dr. G Venkata Ramana, Dr. Shrutakirthi D Shenoi , and Dr. Sanjeev Vaishampayan, the only non SIG member. Both the talks as well as the panel discussion were passionate, erudite, chockful of latest updates and well received by audience. The hall of moderate capacity was overflowing and audience had to stand at the back rows.

SIG- February 16, 2020

A half day programme on Vulvar Dermatoses was held at the Hinduja Hospital Auditorium on 16th February 2020.
We had 92 delegates attending with rapt attention.

Topics ranging from normal anatomy, to vulvodynia were ably presented by 3 SIG members viz Dr Deepti Desai, Dr Nisha Chaturvedi, Dr Nina Madnani, and 2 external speakers viz Dr Chitra Nayak and Dr Vidya Kharkar. This was followed by an exciting panel discussion with lots of audience participation.

The delegates were then treated to a delicious lunch, and had the remaining half of the day with their families.

SIG - March 1, 2020 was conducted in Bengaluru, under the aegis of IADVL Academy, SIG Female Genital Dermatoses and Community Dermatology Society Bengaluru.The SIG members who were actively involved included Dr. Eswari L, Dr. Kavitha Athota and Dr. Dipak Patel.

There were 145 registered members. The topics of the CME included: Normal vulva and its variations, Approach to, and management of vulvar pruritus, vulvar inflammatory disorders, vulvovaginal discharge, vulvar ulcers, sexual abuse and female genital mutilation, vulvodynia, vulvar intraepithelial neoplasia, vulvar and sexual hygiene. The lecture material contained within the slides were scrutinized by the SIG members beforehand. The most anticipated session was the panel discussion on interesting/challenging female genital dermatoses, which was actively discussed with good audience participation.

SIG Webinar, 17 May, 2020 was conducted as a part of the continuing ongoing CMEs of SIG- Female Genital Dermatoses . It was organized by IADVL Gujarat State Branch. There were 388 registered delegates. The guest lectures included Anatomy and variations of the vulva by Dr. Rashmi Mahajan, Vulvodynia by Dr. Smitha Prabhu (SIG convener), Vulvar and sexual hygiene by Dr. Dipak Patel (SIG member), stress incontinence and management by Dr. Dipti Patel, Vulvar ulcers and management by Dr. S Murugan (SIG member) , Vulvar discharge and management by Dr. Mansi Kansal (SIG member), with the finale of panel discussion on “Interesting cases of Female Genital Dermatoses” moderated by Dr. Nina Madnani (C0-ordinator, SIG). The lectures, and especially the panel discussion was much appreciated as good learning experience via online feedbacks.

TEST YOUR KNOWLEDGE OF VULVAR DERMATOSES

Dr Kavitha Athotta

I. MATCH THE FOLLOWING

1. Cigarette paper texture	a. Plasma cell vulvitis
2. Frog spawn appearance	b. Crohn's disease of vulva
3. Strawberry and cream appearance	c. Lichen scleroses
4. Cayenne pepper spots	d. Lymphangioma circumscriptum
5. Knife cut ulcers	e. Pagets disease of the vulva

II. MULTIPLE CHOICE QUESTIONS:

1.The following are recommended for vulvar skin care except

A. Wear loose cotton clothing B. Ointments are preferred over creams

C. Douching is acceptable D. Emollients like petrolatum can be used

2. According to ISSVD classification of vulvar dermatoses following diseases come under acantholytic pattern except

A. Darriers disease B. Hailey-Hailey disease C. Plasma cell vulvitis

D. Acantholytic pattern of vulvocrural area

3. The proposed etiology of vulvodynia includes

A. Neuropathic disorder B. Genetic C. Pelvic floor abnormalities

D. All the above

4. Which of the following is not a feature of differentiated vulvar intraepithelial neoplasia

A. Older women B. Associated with HPV C. Associated with LS

D. High risk of progression to squamous cell carcinoma

5. Hewitt-Pelisse syndrome is a variant of

A. LP B. LS C. LSC D. Psoriasis

ANSWERS

I. 1.c 2.d 3.e 4.a 5.b

II. 1. C 2. C 3.D 4.B 5.A

INTERVIEW

How the Covid-19 Pandemic has affected patients and physicians dealing with Vulvar disease

Dr Lynne Margesson, Assistant Professor of Ob-Gyn, Surgery, Dermatology, Geisel School of Medicine Dartmouth, Hanover, NH, USA

"Covid 19 has changed everything everywhere as you know. The big difference is we're seeing a lot less patients. Many still do not want to come out and get seen and potentially expose themselves to infection now. I am at home on FaceTime with Dr. Birenbaum. This is our second clinic like this and she is seeing the patients directly and then I join her on FaceTime and we see the patient together and I talk to the patient with her and we decide on a treatment plan altogether. Seeing the patient is working quite well although I can't see all the details of the vulva. Dr. Birenbaum does the vaginal examination's wet preps etc. It is slow doing it this way but the patients, I hope, are getting very good care".

Dr Ashwini Gandhi Bhalerao : Gynecologist, President of Mumbai Menopause Society, Co-pioneer of First Vulvar Clinic in India

"In India, women with vulvar problems visit Gynecologists quite late. With Covid-19 pandemic with lock down, they will postpone meeting a gynaecologist still later.Now the era of teleconsultation has started. This type of consultation is not useful for women with gynec/ genital problems as doctor cannot examine them physically".

Dr Susan Cooper Dermatologist, Vulvar and Contact Dermatitis Head, Oxford, UK

"This has had a major impact on vulval services, with departments in general stopping all face to face vulval clinics apart from suspected cancer cases. Telemedicine follow up appointments are being offered in some centres. These pose unique challenges for vulval clinics because of the difficulty some women have with self-examination and their inability to describe the vulval anatomy. There are particular difficulties in taking self photographs of the genital area and emailing sensitive genital images safely".

Dr Venkata Ramanna: Retd. Prof. & HOD Osmania Medical College. Practicing Dermatologist, HIV Medicine and Sexology.

"Due to travel restrictions in these Covid-19 times, only 60% of patients manage to reach the clinic. Once they come in, we follow the WHO Guidelines for in-patient safety, and patients are examined and then advised and given the best treatment".

Dr Nina Madnani, Dermatologist, Co-pioneer of First Vulvar clinic in India

"It's a bad time for patients with vulvar problems especially new patients, as good clinical examination and diagnosis is so essential. The bold ones are attempting clinical images taken by themselves or their husbands if married, many of poor quality, and sending via whatsap on a teleconsult. Swabs and other diagnostic procedures have to be kept on hold. Follow up patients are opting to wait till the face-to-face consults start. The suffering continues".

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