Knifelike Vulvar Ulcers Can Signal Crohn's Disease

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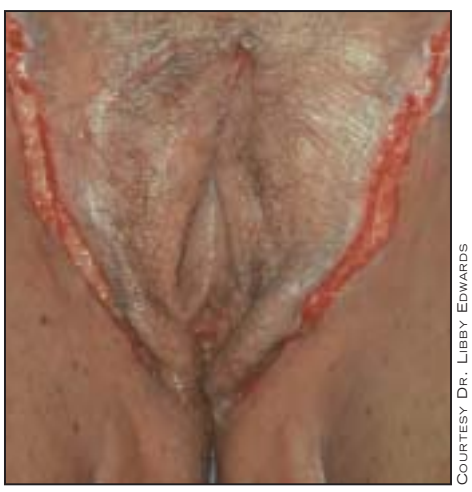
HOUSTON — Women with Crohn's disease can sometimes present with knifelike vulvar ulcers that are very specific to the disorder and may be its only manifestation, according to several experts who spoke at a conference on vulvovaginal diseases jointly sponsored by Baylor College of Medicine and the Methodist Hospital.

"There are three things in the vulvar or perianal area that might make you think of unrecognized Crohn's: knifelike ulcerations, vulvar edema that has no other cause, or fistula around the anus," said Dr. Libby Edwards, a dermatologist in private practice in Charlotte, N.C. "It has been said that vulvar Crohn's is rare, but it is not. It's uncommon but it's not rare. I see it several times a year, and most gynecologists will see it without necessarily recognizing what it is," she said in an interview.

Although vulvar signs may be the first presentation of Crohn's for some patients, this tends to be the exception, said Dr. Hope K. Haefner, professor of obstetrics and gynecology at the University of Michigan and director of the university's Center for Vulvar Diseases in Ann Arbor.

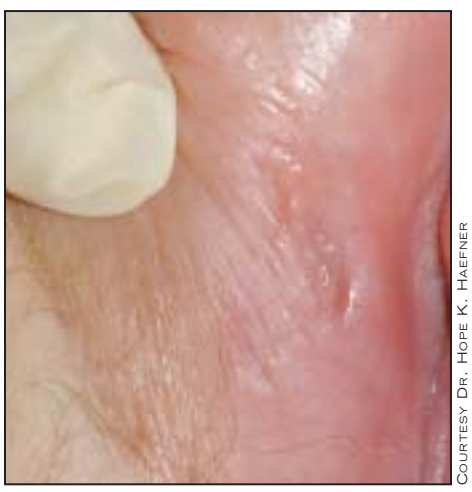
"There is the rare patient who doesn't have any gastrointestinal symptoms and might develop them later, but usually the majority already have a diagnosis of gastrointestinal Crohn's and are seeking gynecologic care for their vulvar symptoms," she said in an interview. In her opinion, perianal fistulae may be the most common of the three gynecologic manifestations of Crohn's. "I see them every couple of months, in children and in the elderly—there's a big age range," she said.

Vulvar and perianal Crohn's is a marker for severe disease that needs to be aggressively treated systemically, said Dr. Edwards, also of the department of dermatology at the University of North Carolina at Chapel Hill. "First of all, if [these patients] don't have an aggressive gastroenterologist, they really need one," she said, adding that aggressive systemic treatment for Crohn's might relieve some vulvar symptoms. But, she said, patients also need local vulvar care. "These patients get secondary infections, and when they do, they need oral antibiotics—maybe even on a long-term basis if they have open, draining sores." In addition, both oral antibiotics and immunosuppressive therapy for Crohn's can make patients susceptible to yeast infections, which may require weekly antifungal therapy, she said. ■



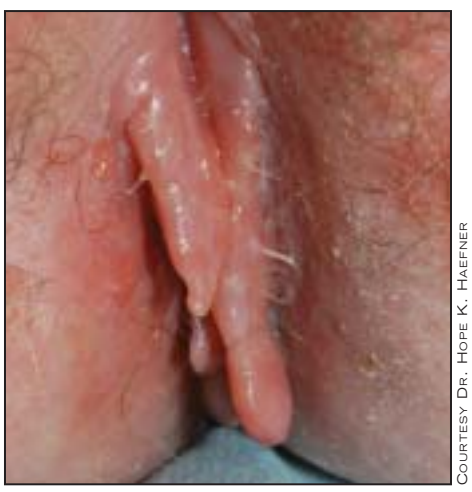
COURTESY DR. LIBBY EDWARDS

"Knife-cut" ulcerations in skin folds are pathognomonic for vulvar Crohn's.



COURTESY DR. HOPE K. HAEFNER

Fistulous tracts on the vulva are also a characteristic marker for Crohn's.



COURTESY DR. HOPE K. HAEFNER

Perianal Crohn's consists of large anal skin tags, perianal edema, and fistulae.

Classification of Vulvar Skin Disorders Joins Gynecology, Dermatology Terms

HOUSTON — A new classification of vulvar skin disorders from the International Society for the Study of Vulvovaginal Disease aims to establish a common language for gynecologists and dermatologists in their diagnosis and treatment of vulvar dermatoses, according to Dr. Peter J. Lynch, professor of dermatology at the University of California, Davis, and the document's senior author.

The new document (J. Reprod. Med. 2007;52:3-9) was outlined by Dr. Raymond H. Kaufman at a conference on vulvovaginal diseases jointly sponsored by Baylor College of Medicine and the Methodist Hospital.

"Dermatologic language can be far out for gynecologists and vice versa, and yet we're all seeing the same things on the vulva," said Dr. Kaufman, who is professor emeritus in obstetrics, gynecology, and pathology at Baylor College of Medicine, Houston.

"What has tended to happen in vulvar diseases is that tumors and neoplasms have been gynecologically handled, and skin rashes have been dermatologically handled," Dr. Lynch said in an interview. "What we are trying to do is to get rid of the notion of gynecologic disease or dermatologic disease to say that it is vulvar disease. We're trying to break down the barriers. We have to blend the language to get people to talk."

The new classification is also designed to pull pathologists more closely into the diagnostic discussion, Dr. Lynch added. "In the case of a simple lesion, most clinicians can either diagnose it immediately or the pathologist can make a specific diagnosis. But it's the situation where neither the clinician nor pathologist can be definitive that this new classification is designed for. The pathologist can designate the lesion to a general category and then put the ball back in the clinician's court to get more clinical data."

Whereas the older International Society for the Study of Vulvovaginal Disease (ISSVD) classification comprised just three categories, the new classification sorts vulvar dermatoses into eight: spongiotic pattern, acanthotic pattern, lichenoid pattern, dermal homogenization/sclerosis pattern, vesiculobullous pattern, acantholytic pattern, granulomatous pattern, or vasculopathic pattern (see box below).

Dr. Lynch says that although the terminology is designed to blend gynecology and dermatology, the document's aim is to help all clinicians. ■

ISSVD Classification of Vulvar Dermatoses

Spongiotic pattern
- atopic dermatitis
- allergic contact dermatitis
- irritant contact dermatitis

Acanthotic pattern
- psoriasis
- lichen simplex chronicus
- primary (idiopathic)
- secondary (to lichen sclerosus, lichen planus, or other vulvar disease)

Lichenoid pattern
- lichen sclerosus
- lichen planus

Dermal homogenization/ sclerosis pattern
- lichen sclerosus

Vesiculobullous pattern
- pemphigoid, cicatricial type linear IgA disease

Acantholytic pattern
- Hailey-Hailey disease
- Darier's disease
- Papular genitocrural acantholysis

Granulomatous pattern
- Crohn's disease
- Melkersson-Rosenthal syndrome

Vasculopathic pattern
- aphthous ulcers
- Behçet's disease
- Plasma cell vulvitis

More MRSA Diagnoses Turning Up in Persistent Vaginal Yeast Infections

HOUSTON — Pustules and excoriations in conjunction with vaginal yeast infections are increasingly testing positive for methicillin-resistant *Staphylococcus aureus* infection, Dr. Sebastian Faro said at a conference on vulvovaginal diseases jointly sponsored by Baylor College of Medicine and the Methodist Hospital.

"Those of us in this area are seeing a lot more MRSA. It is important to be aware of it," said Dr. Faro, clinical professor in obstetrics, gynecology, and reproductive sciences at the University of Texas, Houston.

He said the increasing number of vaginal infections with non-albicans strains of candidal yeast might play a role in this phenomenon, because they are resistant to regular antifungal treatments and can result in prolonged symptoms if not identified early.

Always culture because 'if the patient has a non-albicans species, she will likely fail standard therapy.'

DR. FARO

"I strongly recommend culturing the yeast in all cases because if the patient has a non-albicans species, she will likely fail standard therapy," he said in an interview. "Any of these patients can have excoriations, and so they are putting themselves at risk for secondary infection, such as MRSA."

Dr. Faro said because 20% of the general population has chronic nasal colonization with MRSA and up to 40% or more will be transiently colonized, he has a high index of suspicion when he sees excoriations.

"If any excoriation seems to have a halo of erythema or is raised, or if there is a purulent exudate, I routinely culture it [as well as] the patient's nose," he said. In patients with a positive MRSA culture, he recommends topical Bactroban cream or ointment, but if there are signs of cellulitis, he recommends oral minocycline 100 mg twice a day for 2 weeks. ■