Sublingual More Effective Than Oral Misoprostol for Medical Abortion

BY PATRICE WENDLING Chicago Bureau

MINNEAPOLIS — Sublingually administered misoprostol was significantly more effective than the drug given orally after mifepristone for medical abortion in a prospective randomized trial, Sheila Raghavan said at the annual meeting of the Association of Reproductive Health Professionals.

“Medical abortion is becoming more popular and is preferred by women because of the ease of administration and convenience,” Ms. Raghavan said. Misoprostol typically has been administered orally or vaginally for abortion, although this use is off label and, in fact, the labeling for misoprostol carries a boxed warning stating that it use by pregnant women can not be acceptable to women as the oral regimen in in unacceptable to women. More than 91% of women in both groups reported being satisfied or very satisfied with the procedure, she said.

Many unanswered questions remain regarding lichen planus, Dr. Margesson said. They include the precise length of therapy, remission rate, best maintenance therapy and long-term surveillance plan, whether treatment is needed in asymptomatic patients, which patients will go on to get squamous cell carcinoma, and what factors trigger lichen planus.

Follow-Up Is Key in Vulvovaginal Lichen Planus

BY PATRICE WENDLING Chicago Bureau

CHICAGO — Lichen planus is a tough disorder to treat and requires a strong commitment to patient education and follow-up, Dr. Lynette J. Margesson said at a conference on vulvovaginal diseases.

Lichen planus is an inflammatory, lichenified, maculocutaneous disorder of an unknown cause that is relatively uncommon in the vulvovaginal area, and is therefore often missed. It usually involves the skin and less commonly the oral mucosa, scalp, nails, eyes, esophagus, bladder, larynx, and anus.

About 1% of the population has oral lichen planus. Recent studies have shown that up to 70% of women with oral lichen planus have genital involvement. Up to 44% can be asymptomatic, said Dr. Margesson of Dartmouth Medical School, Hanover, N.H.

Complications include scarring, loss of any or all of the vulvar structures, narrowing of the introitus, psychosocial problems, and synchiea and scarring that can eventually obliterate the vaginal space. Vulvar lichen planus is often confused with lichen sclerosus and, like that disease, is associated with an increased risk (3%-4%) of squamous cell carcinoma.

Prognosis is notoriously unpredictable, with about 75% of patients having improvement in symptoms and 10% having resolution of clinical signs without scarring, Dr. Margesson said at the conference, which was sponsored by the American Society for Colposcopy and Cervical Pathology. Patient education needs to be optimistic, even though there is often no cure. Some patients can go into remission permanently, but most have a tendency to relapse. Long-term follow-up is needed for complete and cancer surveillance.

“Noncompliance is a big problem,” Dr. Margesson said. “They come back and their vulva is dying.”

Upon presentation, most patients complain of soreness, pain, and itching, which can be mild to moderate in the papular form and severe in the hypertrophic form.

On physical exam, the classic pattern on dry, keratinized skin includes raised, reddish brown to purple, well-defined, dry papules with fine lacy white streaks, referred to as Wickham’s striae, on the surface.

Erosive lichen planus often shows deep red, glazed lesions around the posterior vestibule with associated loss of architecture and scarring. A whitish scalloped or reticulated edge to these lesions is a classic feature that is not present in lichen sclerosus and can help make the diagnosis of lichen planus, Dr. Margesson said. Oral involvement is seen in about 60% of these patients, with the same lacy reticulated pattern, plus varying degrees of ulceration and erosion present on the buccal or gingival mucosa and tongue.

The hypertrophic form is the least common and looks very much like thickened mucosa on the vulva, with thickened, white, scaped skin and loss of normal architecture.

Regular histopathology biopsies are often unreliable, so Dr. Margesson prefers confirming the diagnosis by performing biopsies for both histopathology and direct immunofluorescence.

Non-specific treatments include education and support, stopping all irritants, restoring the epidermal barrier, and offering psychosexual support, as these patients are usually sexually dysfunctional, she said.

Topical corticosteroids to suppress inflammation are the cornerstone of treatment. Dr. Margesson prefers clobetasol or halobetasol ointment, or tacrolimus (Protopic) 0.1% ointment daily in a thin film for 8-12 weeks for the mucous membranes of the vulva, and 1-3 times a week for maintenance. Topical tacrolimus (Protopic) 0.1% ointment can be helpful, but this is an off label use, and it should be applied sparingly as it may burn, she said.

Clobetasol or halobetasol ointment, or tacrolimus compounded in a 0.1% cream, can be used nightly intravaginally. Hydrocortisone acetate is available as a 2.5 mg suppository. A compounded hydrocortisone acetate suppository, 100-500 mg, used at bedtime for 2 weeks, can be given for severe vaginal disease, but adrenal suppression is possible. After 2 weeks, the dose is decreased, depending on the response.

For severe lichen planus, Dr. Margesson finds intra-muscular triamcinolone acetonide 1 mg/kg every 4 weeks for 3-4 months is a better tolerated alternative to prednisone. Other effective drugs include methotrexate, 5-10 mg per week or cyclosporine 4-5 mg/kg, but the latter should be limited to 2-3 months of treatment. Mycophenolate mofetil (CellCept) has been used up to 3 g daily, but recent studies suggest an alternative is enbrel (Embrel) 50 mg subcutaneously twice weekly.

Surgery may be needed for significant scarring or vaginal adhesions, but these can recur. Dilators used nightly are important for these patients, and they may be needed even if the woman is asymptomatic, she said.

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Low-Dose Combination HT Aids Postmenopausal Health

BY HEIDI SPLETE Senior Writer

WASHINGTON Postmenopausal women who took a low-dose estrogen/progestin hormone therapy reported significant improvements in vasomotor symptoms and quality of life after 6 months, according to findings from an open-label efficacy study.

The therapy caused a significant increase in mean triglycerides, from 129 mg/dl at baseline to 168 mg/dl after 6 months. But the women had no other significant changes in their lipid profiles or in their body weight, body mass index, or blood glucose during the study period, Dr. Fernando Ayala Aguilera of the Hospital Universitario, Monterrey (Mexico) and colleagues reported in a poster presentation at the annual meeting of the American Society for Reproductive Medicine.

In the study, sponsored by Wyeth Pharmaceuticals, 68 postmenopausal women aged 45-55 years who reported at least four hot flashes per day received a combination of 1 mg 17β-estradiol and 0.125 mg trimegestone orally each day for 6 months. For women aged 64 and older, the dose was 0.2 mg 17β-estradiol and 0.375 mg trimegestone.

Overall, patient scores on the MENSOL (a questionnaire designed specifically to evaluate the quality-of-life symptoms in menopausal women) dropped from an average of 78 at baseline to an average of 5 after 6 months of treatment.

The average total cholesterol remained stable between baseline and 6 months (203± vs. 200± mg/dl). Blood glucose, body weight, and body mass index were essentially unchanged from baseline to the 6-month follow-up. Average blood glucose was 92 at both baseline and 6 months, average body weight was 67 kg at baseline vs. 66 kg at 6 months, and average BMI was 27 kg/m² at baseline vs. 26.9 kg/m² at 6 months.

High triglycerides may be a cause for concern, but the triglycerides in this study did not reach unhealthy levels (above 200 mg/dl).

Although the findings were limited by a small number of patients and a short follow-up period, the preliminary results from this ongoing study suggest that a 17β-estradiol/trimegestone combination may provide enough relief from menopausal symptoms to outweigh the potential risks of increased triglycerides in the absence of other adverse effects on lipid profiles.

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