Desquamative Vaginitis: Not an Infectious Entity

Condition may be a range of blistering disorders; as such, no one treatment is always appropriate.

BY ELIZABETH MECHCATIE  
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BETHESDA, MD. — Most experts now believe that desquamative inflammatory vaginitis (DIV) is not a diagnosis of one condition, but may represent a range of blistering disorders, such as lichen planus, mucous membrane pemphigoid, and pemphigus vulgaris. Hope K. Haefner, M.D., said at a conference on vulvovaginal diseases. With descriptions in the medical literature dating to the 1950s, the signs and symptoms of desquamative inflammatory vaginitis (DIV) include dyspareunia and exudative, chronic vaginitis, with yellow- watery, purulent discharge that is occasionally blood-tined, said Dr. Haefner, director of the University of Michigan Center for Vulvar Diseases, Ann Arbor. Patients with DIV also may have a spotted rash on the vagina and cervix, massive vaginal cell exfoliation, and an increased vaginal pH, she said. Previous terms used to describe this condition include exudative or membranous vaginitis, and hydrothorax vaginæ. DIV can occur at any age, and although it has been considered rare, it is being seen more frequently than in the past. “Although we don’t know what it is ... we don’t think it is an infectious process,” Dr. Haefner said, noting that in studies describing DIV in the 1950s and 1960s infectious organisms were detected in association with DIV but have since been ruled out. Other forms of vaginulitis caused by chlamydomas and other infections can be confused with DIV, as can noninfectious causes of erosive vaginulitis, such as lichen planus and graft-versus-host disease, she said. Other noninfectious causes of erosive vaginulitis include collagen vascular diseases and a local toxic effect of a drug. The cause also may be idiopathic. Distinguishing DIV from atopy can be difficult, since lab findings are similar to those found with atopic vaginitis, with a nonspecific histology and parabasal cells and many polymorphonuclear leukocytes (PMNs) on cytology. Atrophic vaginitis has serosanguinous or watery discharge similar to that seen with DIV, as well as an elevated vaginal pH, with a thin vagina and red petechiae, Dr. Haefner said at the conference, sponsored by the American Society for Colposcopy and Cervical Pathology. Atrophic vaginitis and erosive lichen planus are among the noninfectious conditions that are high on Dr. Haefner’s list of differential diagnoses in a patient she suspects may have DIV. Lower on the list are other noninfectious causes of these symptoms, including lichen sclerosus, lichen planus, erosive vaginitis, and atrophic vaginitis of the esophagus, and anus. In lichen planus, erosions may be found in the conjunctivae, external ear canal, esophagus, and anus. In some cases, histology can help in diagnosing lichen planus, but in Dr. Haefner’s experience, this has not been very helpful because lab and cytologic changes are nonspecific and may be similar to those found with atrophic vaginitis. In diagnosing patients with DIV, she recommended considering what is happening with the whole patient, and whether the condition is acute or chronic and focal or diffuse. Also consider whether it involves the vestibule and/or the vagina and whether the patient has a local estradiol deficiency, oral mucosal or ocular disease, or any atrophic topical etiology. As for the use of dilators, Dr. Haefner said that for patients with chronic lichen planus, prophylactic dilation is important, because those patients often present with “shut” vaginas. However, prophylactic dilation is not necessary and would be considered overtreatment if used for all patients with DIV. To distinguish whether a patient has DIV or lichen planus, consider performing a biopsy and immunofluorescent studies to rule in or out some of the conditions in the differential diagnosis. Because DIV is not a single disease, no one treatment will be effective in all cases. Treatment with 2% clindamycin cream for 2 weeks is a first-line therapy for most patients. Although DIV is not considered an infection, clindamycin is still useful because it has an anti-inflammatory effect. Patients with DIV usually are treated by the couple, with each partner treated. Those who are being treated may respond to treatment with hydrocortisone at a dose of 100 mg/g in a clindamycin 2% emollient cream base. A 5-g applicator should be inserted every other day for a total of 14 doses. This treatment regimen is expensive, however, and is not recommended for a first episode, said Dr. Haefner, who stated that she has no relevant financial relationships with any commercial interest relative to the subject of this presentation.

Consider Patient Age, Lesion Location When Diagnosing VAIN

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BETHESDA, MD. — An older age, a history of cervical intraepithelial neoplasia, and the presence of multifocal lesions in the upper third of the vagina are among the features associated with vaginal intraepithelial neoplasia (VAIN), Thomas C. Wright Jr. said at a conference on vulvovaginal diseases. Vaginal intraepithelial neoplasia (VAIN) is not common, accounting for only 0.4% of intraepithelial lesions of the lower genit tract, according to Dr. Wright, director of obstetrics, gynecology, and pathology at Columbia University College of Physicians and Surgeons, New York. Women at higher risk include those with vulvar intraepithelial neoplasia (VIN), cigarette smokers, and those who have had radiation therapy. A woman who has had radiation therapy for endometri- al cancer and presents with an abnormal Pap smear exemplifies one clinical sce- nario in which the index of suspicion for VAIN should be high, he noted. Another typical VAIN case is a postmenopausal patient who has been treated for cervical intraepithelial neoplasia (CIN), even 10 years earlier, often with a hys- terectomy, and has been considered cured. She then develops a high-grade squamous lesion on cytology, with no lesion on the vagina that is visible to the naked eye. Some of these risk factors were associ- ated with VAIN in a 2001 study of 121 women with biopsy-confirmed VAIN, which found that 41% smoked, 39% had a history of human papilloma virus (HPV), 22% underwent surgery for CIN, and 23% had undergone a total abdominal hys- terectomy. The mean age of the patients was 35 years, and the majority had VAIN-1, a diagnosis Dr. Wright said he is “very leery about classi- fying” as true VAIN lesions. Most of the pa- tients he sees with VAIN are in their 40s to late 60s. VAIN is rare among women in their 20s and 30s, but when it does occur among younger women, there usually is a history of immunosuppression or CIN, Dr. Wright said. The sensitivity of cytology in diagnos- ing VAIN remains uncertain. Most VAIN patients are postmenopausal, raising the question of whether a patient has high- grade VAIN or “severe atrophy, which is causing the cytology to mimic high grade VAIN,” he said at the conference, spon- sored by the American Society for Colposcopy and Cervical Pathology. On cytology, squamous intraepithelial neoplasia and VAIN “look exactly the same,” he added. And on histopathology, VAIN looks “exactly the same” as CIN, VIN, or anal intraepithelial neoplasia. He advised caution about the diagnosis of VAIN-1. “A lot of us are trying not to make low-grade diagnoses of VIN or VAIN,” and instead, “classify the majority of these lesions as flat condylomas, because the natural history of these low-grade lesions is not really well characterized.” It is unclear whether a flat, low- grade–appearing lesion in a 60-year-old has any premalignant potential, he added. Low-grade VAIN has many fea- tures of a flat condyloma, com- pared with VAIN-3, which is more clearly a high-grade lesion. Whether the location of VAIN-3 morcellations are found in the upper third of the vagina, usually contiguous with CIN, if a cervix is present. Most cases are multifocal, often with lesions found in the “dog-ears of the vaginectomy,” which changes colposcopy very difficult. Colposcopy is required to diagnose VAIN, but is difficult, especially in postmenopausal women who have been treated for a hysterectomy. It becomes nec- essary to look inside the folds and “dog- ears,” he said. VIN may be present as well, so the vulva needs to be examined, he added, saying that “a fair number of patients” will have VIN, CIN, and VAIN at the same time. On colposcopy, VAIN “frequently appears as slightly raised, acetowhite lesions,” which can be subtle, especially in postmenopausal patients with low estrogen levels, he said. In the vagina, with high-grade lesions, vascular patterns such as mosaicic in the vagina usually are not present as they are with cervical lesions. These lesions usually are not acetowhite and are identified only after the application of Lugol’s solution. On colposcopy, conditions that mimic VIN or VAIN include congenital transforma- tion zones that extend into the vagina and leukoplakia, which can appear on the vagina, not just the cervix, he said. Vaginal ulcers or trauma and granula- tion tissue also can look like VIN lesions on colposcopy. Inflammation caused by tri- chomonas, candida, atrophic vaginitis, or radiation atrophy can obscure VIN les- ions, he added. Treatments for VAIN include excisional biopsy in the office, intravaginal 5-fluo- rouracil, laser ablation or electrofulguration, and partial vaginectomy. Cryosurgery is not used very much now, he added. VAIN-1 usually is not treated aggressively, but fol- lowed, except in women suspected of hav- ing a higher-grade lesion, or those who have had a hysterectomy for CIN 2 or 3 or cancer, or a conization for CIN 2 or 3, Dr. Wright said. Dr. Wright said.