Desquamative Vaginitis: Not an Infectious Entity

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

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BETHESDA, MD. — Most experts now believe that desquamative inflammatory vaginitis 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 1930s, the signs and symptoms of desquamative inflammatory vaginitis (DIV) include dyspareunia and exudative vaginitis (DIV) include dyspareunia and vaginal symptoms of desquamative inflammatory vaginal diseases.

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 iatrogenic topical etiology.

As for the use of dilators, Dr. Haefner said that for patients with chronic lichen planus, prophylactic dilatation is important, because those patients present with “shut” vaginas. However, prophylactic dilatation 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 should be warned that treatment may respond to treatment with hydrocortisone at a dose of 100 mg/g in a clindamycin 2% emollient cream base. A 5 mg 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.