THE FREQUENCY OF SYMPTOMATIC VULVAL DISEASE: A GYNAECOLOGICAL'S PERSPECTIVE

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ABSTRACT
Vulval lesions are not always sexually transmitted. Those which are not sexually transmitted are referred to as non-venereal dermatoses of female external genitalia. In our society vulval and genital diseases are always thought to be sexually transmitted. Genital diseases may be associated with severe psychological trauma and fear in the mind of patients. Therefore, it is of immense importance to diagnose these non-venereal dermatoses to relieve the patient from the stigma of sexually-transmitted diseases.
The aim of this study was to determine the causes and relative frequency of non venereal vulval diseases seen in gynaecological practice over 19 months period from May 2008 till November 2009, all consenting female patients irrespective of their age and pregnancy status attending the outpatient of Obstetrics and Gynaecology in Basrah General Hospital who presented with a vulval problem or complain were included in the study.
A total of 66 female patients were included in this study. The age of the patients ranged from 3 years to 62 years. A total of 9 different types of disorders or dermatosis involving the vulva were noted. Common conditions observed in our study were vulval candidiasis (59%), this is in contrast with studies done in other countries were lichen sclerosis was the commonest cause of symptomatic vulval disease, while in our study the percentage of lichen sclerosis was only (3%).
In conclusion, this study highlights the importance of diagnosing non-venereal dermatoses and clinicians need to differentiate the various causes of non-venereal dermatoses. Specialist vulval clinics are a valuable source of clinical teaching and research.

INTRODUCTION
Vulval lesions are not always sexually transmitted. Those which are not sexually transmitted are referred to as non- venereal dermatoses of female external genitalia.[1] Recently vulval dermatoses have been classified by the International Society for the Study of Vulvovaginal Disease (ISSVD) inclusive of venereal and non-venereal vulval dermatoses.[2] Because venereal and non-venereal dermatoses tend to be confused, the occurrence of these dermatoses may be associated with mental distress and guilt feelings in affected patients. Patients presenting with a vulval problem complain of one or more of four symptoms: itch, pain, dyspareunia and vulvodynia a term which encompasses burning, rawness, stinging and discomfort. These symptoms are generally not specific to any particular vulvar pathology and all can be experienced with any condition.[3]
The aim of this study was to determine the causes and relative frequency of non venereal vulvar diseases seen in gynaecological practice over 19 months period.

MATERIAL AND METHODS
This is a cross sectional study done in a period of 19 months from May 2008 till November 2009. All consenting female patients irrespective of their age and pregnancy status attending the outpatient of Obstetrics and Gynecology in Basrah General Hospital who presented with a vulval problem or complain were included in the study. Some patients were referred to the outpatient clinic by the department of dermatology for thorough gynaecological assessment; some cases were referred from private clinics. In some cases the diagnoses was made with the help of a dermatologist. Informed consent was obtained. A detailed history including, chief complaints related to skin, presence of itching, skin lesions, onset, pregnancy status, menstrual status, and associated medical or skin disorders were elicited and recorded. Cases having venereal diseases was excluded from the study. The external genitalia were examined and findings were noted. A detailed physical examination was made to see any associated lesions elsewhere in the body. Investigations such as Gram stain and KOH mount were done when required to establish the diagnosis. Biopsy and histopathological examination of the specimen was done when required to confirm the diagnosis.

RESULTS
A total of 66 female patients with vulval symptoms were included in this study. A total of 9 different types of disorders or dermatoses

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involving the vulva were recorded in this study as shown in (Table-1).

Table 1. Distribution of patients according to the type of vulval disorders.

Vulval disorders	No. of patients	%
Lichen sclerosus	2	3
contact dermatitis	3	4.5
Psoriasis	1	1.5
Vitiligo	3	4.5
Candidiasis	39	59
Herpes zoster	2	3
Folliculitis	2	3
Bartholin cyst	7	10.6
labial adhesions	4	6
vulvodynia	3	4.5
Total	66	100

The age of the patients ranged from 3 years to 62 years. Most patients belonged to the age group of 20-29 years (42.4%), followed by the age group 40-49 years (19.6%), 10 patients were in the age group 30-39 years (15.5%) and only 6 (9.1%) were children. As in (Table-2).

Most of the women were in the reproductive age group (86%), 10 of them were pregnant, 6(9%) had not attained menarche. While women in the postmenopausal age group were only 3(4.5%). In the menstrual age group, 36 had vulval candidiasis (54.5%). Vulval candidiasis was the most commonly seen condition in pregnant women accounting for 8 cases out of the 10 pregnant patients. The other 2, one had Bartholin cyst and one had Folliculitis. The vulval disorders in prepubertal girls were 6 cases, monilila infection (2 cases), & non specific vulvovaginitis with labial fusion (4 cases). In postmenopausal age group only 3 cases were recorded one had lichen sclerosis, one candidiasis and one vulvodynia. The most common dermatosis was vulval candidiasis which constituted 39 (59%) cases followed by 7 cases of Bartholin cysts (10.6%) as in (Table-2). The common presenting feature was itchy genitalia (69%of cases) followed by swelling (28.1%) and white discoloration (8.4%). Other complaints were pain, burning sensation, mass, dyspareunia, redness, exfoliation of skin, raised lesions over skin, burning micturition, ulceration, thickening of skin and discharge. Some patients had more than one complaint.

Table 2. Distribution of patients according to age groups and diagnosis.

Age	No.	Diagnoses									
		Lichen sclerosis	Psoriasis	Contact dermatitis	Vitiligo	Candidiasis	Herpes zoster	Folliculitis	Bartholin cyst & abscess	Labial adhesion	Vulvodynia
Children	6					2				4	
14-19	6			1		3			2		
20-29	28			2	1	20		2	3		
30-39	10				1	8			1		
40-49	13	1	1		1	5	2		1		2
50 &above	3	1				1					1
Total	66	2(3%)	1(1.5%)	3(4.5%)	3(4.5%)	39(59%)	2(3%)	2(3%)	7(10.6%)	4(6%)	3(4.5%)

DISCUSSION

Disorders affecting the vulva are common and can cause considerable morbidity.[4] In our society vulval and genital diseases are always thought to be sexually transmitted. Genital diseases may be associated with severe psychological trauma and fear. Therefore, it is of immense importance to diagnose these non-venereal dermatoses to relieve the patient from the stigma of sexually-transmitted diseases. The commonest condition observed in our study was vulval candidiasis, this is in contrast with studies done in other countries where lichen sclerosis was the commonest cause of symptomatic vulval disease. Epidemiological surveys based on hospital referrals are likely to underestimate the prevalence of lichen sclerosus; estimates ranges from one in 300 to one in 1000 of all patients referred to dermatology departments.[3] The small number of cases of lichen sclerosus found during this study may be due to the fact that the disease is actually rare in our country. Another explanation is that no special vulval clinics are available with well trained personnel for proper diagnosis and recording of such conditions and many cases of chronic itching are not properly diagnosed. In our study candidiasis was diagnosed clinically and in some cases it was confirmed by scraping and direct examination under light microscopy and KOH mount. The increased frequency of candidiasis in this study my reflect the wrong medical practice and overuse of antibiotics to all patients complaining of dysuria and itch without investigations and the widely available antibiotics that can be found in the market even without medical prescription. Bartholin cysts are the most common cystic growths of the vulva.[7] Two percent of women develop Bartholin duct cyst or gland abscess at sometime in life. It may start as an asymptomatic unilateral nontender cystic swelling, but it can cause pain and limitation of activity with increase in size.[8,9] In this study 7 cases were recorded 2 of them were bartholin abscess. Vitiligo was observed in 3 cases. Vitiligo is an acquired Pigmentary disorder characterized by loss of melanocytes resulting in depigmentation.[10] Approximately 0.1 percent to 4 percent of people worldwide are affected by Vitiligo.[11] Labial fusion is a benign genital disorder in girls estimated to occur in 0.6%-5% of prepubertal girls.[12] It may be either congenital or acquired, sometimes due to poor hygiene.[13] In our study 4 cases were recorded. Labial fusion may be caused by inflammation and low prepubertal estrogen levels.[14] However, labial fusion has been noted in association with isolated premature thelarche, suggesting the existence of factors other than estrogen insufficiency.[14] Vulvodynia or vulval pain syndrome is a chronic syndrome of unexplained vulval pain, sexual dysfunction, and psychological disability.[15] The vulval pain syndromes are sensory disorders and are diagnosed when other causes of vulval pain have been excluded. The vulva looks normal, but there may be point tenderness on examination. The pain may be localized, or generalized.[16] In our study 3 cases were reported all 3 cases were diagnosed by exclusion of other vulvar conditions and in association with dermatologists. Psoriasis was an uncommon vulval dermatosis. In this study only one case was seen (1.5% of cases), the low number of psoriasis seen in this study is similar to that of other vulval clinics (1.8-5%).[17,18] Flexural psoriasis is well demarcated and presents as salmon pink patches. The scale that typifies psoriasis is rarely seen in the vulval area as it is a moist environment. Clues to the diagnosis may be found elsewhere on the body and it is important to examine the scalp and nails for evidence of the disease.[6] Folliculitis is defined histologically as the presence of inflammatory cells within the wall and ostia of the hair follicle, creating a follicular-based pustule.[20] Superficial folliculitis is common, but because it is often self-limited, patients rarely present to the doctor. Those who are seen more often have either recurrent/persistent superficial folliculitis or have deep folliculitis. Although the incidence is unknown, certain conditions make patients more susceptible. These include frequent shaving, immunosuppression, preexisting dermatoses, long-term antibiotic use, occlusive clothing and/or occlusive dressings, exposure to hot humid temperatures, diabetes mellitus, and obesity.[20] In our study 2 cases were seen, they suffered from recurrent folliculitis both had the habits of shaving the vulval hair and both were

overweight. Herpes Zoster is a common, predominantly dermal, and neurological disorder caused by the varicella-zoster virus, a virus morphologically and antigenically identical to the virus causing varicella (chickenpox). Varicella Zoster most commonly manifests in 1 or more posterior spinal ganglia or cranial sensory ganglia, presumably because viral particles have been preserved within these ganglia in a dormant state since the original episode of varicella. This results in pain and characteristic cutaneous findings Cutaneous findings classically appear unilaterally (for unknown reasons), stopping abruptly at the midline of the limit of sensory coverage of the involved dermatome. Vesicles initially are clear, but eventually, they cloud, rupture, crust, and involutes. This evolution often is accelerated greatly by treatment.[21] Only 2 cases were reported in the study.

In conclusion, this study highlights the importance of diagnosing non-venereal dermatoses and clinicians need to differentiate the various causes of non-venereal dermatoses. Specialist vulval clinics are a valuable source of clinical teaching and research. However, continued medical education should be tailored to the needs of the referring physicians and teaching of vulval dermatoses will allow general practitioners and other specialists to help manage these patients and to know when to refer the more complicated and rarer conditions to a specialist vulval clinic. Although most studies have comprised Caucasian patients, there are reports of lichen sclerosus in Africans and Asians. In our study lichen sclerosus frequency was only 3% compared to western studies which was 39%.

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