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Support@ceitraining.org

ECHO: NON-INFECTIOUS GENITAL DERMATOSES

Molly Plovanich, MD

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[video transcript]

00:09
I'll just hand it back over to Molly. Thank you. Perfect. Yeah. So I'm going to be talking about non infectious dermatosis, a genital dermatosis. Today, as, as we just heard, it's hopefully just to put some rashes and skin growths on the radar if things are not syphilis or HSV, or just otherwise aren't making sense clinically. So I have no disclosures. And this are these are just the learning objectives for today, we'll review how to recognize some common things that we see here in dermatology clinic, review, a differential and then the approach to treatment of these various dermatosis. And then talk about when it might be helpful to refer to dermatology and any questions that you may have, feel free to jump in and ask or put them in the chat and, and I'll address them as we go. We're happy to take questions after of course. So we'll start with rashes. First, I'm going to just show some photos, and I'll describe them and then we'll go over the diagnosis. So this is the first rash what we see here, and vulvar these, like adenomatous plaques, what I'll point out is that it's relatively sparing the skin folds here, and there's no pustules that we see obvious vaginal discharge, or clear kind of well defined or pigeon US borders. And this is another example now in in a male of the same diagnosis, and here we see just confluent, a Dimittis erythematous plaques involving the scrotum in the penis with some penile swelling as well. So this, these two cases are an example of contact dermatitis in the genital region, we see this not infrequently, I would say, and Dermatology Clinic really the differential here, what we would be thinking about is candidiasis. And candidiasis, I would say has a few distinguishing features. One is pustules, both within the rash itself, as I'm pointing out here with my arrow, but also what we call satellite pustules, as demonstrated here, and there's definitely a in terms of a distribution commonly involves the skin folds, whereas contact dermatitis in many cases, it's where either stool or urine or something the patient is using, often like wiping or applying like won't quite make it into the skin fold. So that's a distinguishing feature of contact contact dermatitis and the genitals. Generally, the skin folds are spared, but Canada involves them. And sometimes we see of course, discharge vaginal discharge. And then the other thing we're often thinking about is tinea cruris. And here's an example of that, where we have a rash that has some degree of clearing kind of within the center part and then the borders are more raised in what we call inflammatory meaning they're more red and prominent, and they're often kind of Sirpa Janus, which means snake like in terms of what we do if something isn't making sense to you for candidiasis or tinea, often we talk to the patient about what they might be using in terms of personal care products, this could be wipes, there's a lot of kind of preservatives and wipes. Perhaps lubricants they might be using are any new new soaps or over the counter ointments. The first photo actually that I showed was wipes that the patient was using. And the second one was a mention of some topical treatment that the patient had started for actually scabies so it's kind of separate, just itchy, a couple little bumps.

And then the treatment for this generally we give a low potency steroids such as hydrocortisone. 2.5, generally an ointment which is if there's a kind of more extensive rash, or even a little skin break out, break, break down, the ointment is a little bit more soothing to the skin than a lotion or cream. And we treat for one to two weeks generally not longer than that to prevent any adverse effects from topical steroids like skin thinning. And then I would say when you would want to think about referring to DERM say you're pretty certain it's contact dermatitis you give a little bit of hydrocortisone I would say if it doesn't really go away with the topical steroids definitely the patient can be seen in dermatology clinic. And at that point, we might consider a skin biopsy to confirm that indeed it is a contact dermatitis and a not another cause of rash or even a rare type of cancer. And then sometimes we do patch Testing for further evaluation. This is an example of patch testing where there are a number of chemicals that are put on the patient's back at day zero and then at day three and five, they come back and we look to see if they react to any chemicals. And if they do, then we try to have them avoid any personal care products that might have those chemicals in them. So I will now move on to our next case. This is a mild form of this particular diagnosis. Here you can just see some little relatively small, maybe one centimeter papule nodules, which are consistent with small abscesses in the skin. Kind of within the skin folds. It's a little tough to see but you might see a little bit of hyperpigmentation from prior rashes. And this is a more extreme example of this condition. And here you see extensive scarring, some recurrent abscesses and even sinus tracts under the surface of the skin. So this is a case of these two our case of Hydra adenitis super ativa or HS as we call it. Initially like when patients first present often it's thought maybe this is a folliculitis perhaps an abscess or even a cellulitis. But how to distinguish this would really be to do an exam and talk to the patient. Often folks have a recur a history of recurrent bumps or abscesses in what we call the inverse areas, which would be the armpits, the groin, sometimes the inframammary regions, and really to look out for these little teeny tiny little abscesses, larger abscesses, of course, sinus tracts and scarring. And I just put these up to kind of show the spectrum this is in the axilla. But similar things in the groin, these would be more early findings, which just looked like maybe a singular abscess. And then as the disease progresses, we see extensive scarring and sinus tracks how to identify a sinus track would be, sometimes you can almost see a little tunnel under the skin. But if you push on one place, sometimes pus or discharge can come out at a more distal location. For a more mild disease, often we talk about lifestyle changes, smoking cessation actually can have a huge impact on disease. So that's really important weight loss and avoiding hair removal, which is relatively irrelevant to the to the genitals. Oftentimes people do various types of removal, shaving, waxing, etc, we really ask them to minimize that either trim or pursue laser hair removal. It is helpful actually to have them use some deodorant to the groin that can help minimize sweating and inflammation of the sweat glands which in hair follicles, which we do think contributes to this condition. And then usually we have them do a wash either benzoyl peroxide or chlorhexidine daily and do your topical Klenda myosin. Beyond this, when it's more advanced, they had multiple recurrent

abscesses with some degree of scarring, or sinus tract formation. Really, we do want to see these patients in dermatology to initiate some sort of systemic treatment. The longer we go without treating the more extensive the scarring and tunneling can be in the more difficult it can be to control the disease. Generally, we start with systemic antibiotics, much like we do for acne with a tetracycline often doxycycline. And then we do think about spironolactone, which we use for acne and women. And then beyond that there's various biologics, often anti TNF agents that we that we use, I will say there are procedures we do where we open and remove some of the tracks too. So, but very common, often folks present with what they think might be an abscess, or they have a history of foils, and they're in those inverse areas, either the armpits or the groin are the most common. So definitely keep hydrated and itis super Theva on your radar to get them in early DERM and minimize disease progression.
09:30
This is the next rash that I have here. This really shows extensive example of a classic morphology, we call them knifelike ulcerations, often in the skin folds. You can see a little bit here at the superior aspect of the vulva. So knifelike ulcerations is one feature. And the second feature that we see in this condition is genital swelling that can be pretty pronounced It's either the penis or the vulva. Again, there's a few more subtle knifelike ulcerations here. And this is a case of cutaneous Crohn's disease. Often when this first presents, the patients are thought to have one of two conditions one is a cellulitis. Part perhaps of the genitals themselves or possibly a her Pedic infection, which I'll just go back here you can kind of see how it might be thought that either this little also here, this little, kind of more knife like ulceration could be a herpetic infection. Generally, if you see any of these features, like very prominent and pronounced genital swelling or knifelike, ulcerations, and you test for, for HSV, it's negative, sending them to dermatology would be wonderful. We can do a biopsy and confirm that there's a non kz ID and granulomas consistent with Crohn's disease. And then if the patient has any symptoms, GI symptoms concerning for IBD putting in a GI referral, makes sense to though we could also do that in dermatology, dermatology clinic. And then the treatment. Generally, it's prednisone to try to acutely control the swelling, topical steroids, sometimes injections. And then beyond that, there's a number of things we often give low dose on metronidazole, and then additional systemic immunosuppressive agents that are used for IBD. This is the next case. What I'll point out here are these little papules with a little bit of overlying scale, they have a bit of a purple discoloration and this kind of more or less reticulated white surface change. And kind of distributed here around the corona and then on the penile shaft as well. Here's another example of the condition where we have annular plaques that are kind of multifocal in nature. And then this is another example of a slightly different form and erosive form where there is just thin erythematous plaques or even patches, flat spots with little erosions here, and these photos show genital Lichen Planus and depending so there's more classic Lichen Planus that presents either with like these purple polygonal papules that are often itchy. Often on the genitals they have a more annular morphology. And then the vulva that I just showed actually is

a form of erosive Lichen Planus. And we see both in the genitals and I would say depending on what the morphology is that we're seeing the differential is different. So for those more papules, we would think of genital warts. For the annual or for we might even think about syphilis. And then for the erosive one, perhaps HSV infection, I would say definitely makes sense to do STD testing when you see something like this, but when it's not responding when the testing is negative, and any empiric treatment doesn't work, I would say definitely dermatology referral for evaluation consideration of biopsy and management. Sometimes if things look pretty classic, we'll just proceed with a trial of treatment. Other times we will perform a little a biopsy to confirm the diagnosis. And generally we start with topical steroids a bit stronger than we might otherwise in the genitals, usually class one, particularly for the erosive form. Sometimes we do injections and then beyond that, if it's more severe, we have systemic retinoids. We give her even immunosuppressants. This is the next case that we have. And here we have erythematous thin plaques that are involving the proximal thighs, the vulva and there's some overlying atrophy that we see some white discoloration and kind of a wrinkled appearance and when we see that wrinkled appearance, that tells us that the skin is atrophied there and this is another more severe form of this condition that's progressed and here we can see that the skin is definitely atrophied. There's some kind of tissue I modify kind of tissue architecture that's changed with like scarring and loss of part of the labia. And then there's also a good amount of PowerPro almost looks like it's hyper pigmented, but it's just more purpuric which is seen in this condition called Lycan sclerosis. So when we see like in sclerosis, often initially we might be thinking of, you know, an something infectious, maybe candidiasis, or even tinea, perhaps even another inflammatory dermatosis A contact dermatitis or Lichen Planus. The things that would really make this diagnosis I would say, is severe, more obvious or make us think about it as really severe itching when it comes up as well as pain, and then the atrophy that we see clinically, as well as early scarring, unfortunately. So we do try to catch this as early as possible. Think about this and someone who has that kind of early eight trophic patches and then just severe severe itching. Often there's extension in females involves the vulva as well as a very anal area. So it's kind of we call it a figured figure of eight distribution. So someone who just can't stop itching who has kind of these subtle pink to white plaques, definitely send them our way or send them to GYN. If you have a partnership with a GYN doctor. That that would be absolutely fine to. Generally what we do is we take a look, we do talk about biopsy to confirm the diagnosis. And then we give a very potent topical steroid, a class one like club beta cell ointment, and we have them use it one to two times a day, often just nightly for about three months. And then we reassess the patient, we want to see that the rash improves and also that they're itching and symptoms improve whether that's itching, pain, dyspareunia, etc. And then once their disease is controlled, we tapered off to maybe two to three times weekly at night. It's important for us to see these folks regularly because there is a risk for superimposed squamous cell carcinoma, anywhere between a one to two to 5% lifetime risk after diagnosis. All right. I'll just take a peek in the chat here to make sure. So next, I'm just

going to discuss a few examples of growths that we might see in clinic that are fairly common, I would say. So this is the first example and here we can kind of see these little shiny raised bumps, little papules around the around the corona have the penis sometimes they extend on the frenulum as well. And then kind of a similar thing I'm finding here these like very shiny, almost translucent little papules involving the labia, my Nora, as well as the vaginal introit. Us. I would say often, like sometimes we see them, of course, as providers, but often like the patient might come in and wonder about what these are, or whether they could be genital warts. And these are just honestly, a normal variant, a normal anatomical variant, we call them pearly penile papules. So the three P's and then in females, women we say vestibular papillomatosis. You know, and the main differential really, particularly in men who might be it might just come to their attention, wondering specifically whether they could be genital warts. If the patient is really bothered, or there's any question, certainly can see them in dermatology clinic to confirm that diagnosis. Some folks really do want them treated generally we just

19:15

recommend observation, no intervention. There are some folks who will do cosmetic treatment just by numbing up this skin with topical numbing cream and just use some electro desiccation, just a little Katari and Vaseline and other folks have used laser treatment if someone is bothered, but I think the important point here is just to recognize that in men but also in women, there's this like normal translucent little papules that are often present on folks to various variable degrees. This is the next case these are small, I would say pinpoint read per herbal papules, they don't blanch. And sometimes they're a little bit scaly these are. In men, they're often on the scrotum. And in women, they're often on the vulva. These are called angio, Cara Tomaz, which basically are just little proliferations of blood vessels benign with a little bit of scale on them. Sometimes folks think that they could be award or some other type of growth. And my main point is just to put this on your radar and recognize that they're a variant of normal, sometimes they're not as dense as the photos I show people sometimes can just have one or five or something like that, but totally benign. If the patient is worried or you're wondering, oh, it's fine to send the patient to dermatology clinic or if you have access to an EEG console, that would be perfectly fine to submit a photo. And then treatment, usually, we just recommend observation. If they're really extensive and bother the patient, they're amenable to treatment with a vascular laser, which is targets the blood vessel component of the growth, but nothing specifically needed. This is the next case, on the penis here, you can kind of see these papules that are grouped, that are a bit shiny, they actually look a little bit like vesicles. But the history here would be that they have been present for years, maybe even childhood and haven't really changed at all sometimes can be associated with the underlying swelling due to lymphatic overgrowth abnormalities. And this is the vulva same sort of thing is very shiny, almost translucent papules that are grouped. And these are lymphangiomas, which are due to little proliferations or even malformations of the lymphatic system. And really the main thing

that people might think about when they see them immediately as a herpetic, infection, even molluscum or some kind of other growth, but the history is telling here, usually they've been there for years haven't changed, and really just a benign growth. If there's ever a question, certainly you can refer to dermatology to confirm the diagnosis, but really just being aware of that, they look like vesicles and are grouped and you're thinking herpes, but they're a bit more firm and haven't changed to think about lymphangiomas. Really, we just recommend observation. There's an emerging therapy of topical rapa myosin in the mTOR pathway that might help them shrink that kind of targets the lymphatic vasculature. And then beyond that, some folks respond well to excision, electro desiccation or even laser therapy. And this, I believe, will be my last little set of images here. So this would be this is an ulcer on the penis, kind of, you know, erythematous. Well demarcated, I would say, almost looks like there's some vesicles here, but that's really just more so the granulation tissue at the base. This is another example of this particular condition that actually looks more like psoriasis well demarcated kind of that pink to salmon colored Well, plaques. And then this is a more progressed version of the diagnosis where there's a kind of ulcer that's more heaped up and starting to distort the anatomy of the penis. So, these are all examples of squamous cell carcinoma. The first two showed squamous cell carcinoma and site two, so not invasive, and the last one was an invasive sec. So the differential here would be syphilis, particularly for the first one which is our throat dysplasia, sometimes her paddock infection and even just a dermatitis like that more extensive multifocal SC photo that I showed that was actually thought initially to be psoriasis. So I would say anytime you have an ulcer on the genitals that is negative for STD screening, and that doesn't resolve within you know, a month or two definitely refer to dermatology for a biopsy and that way we can specifically evaluate for malignancy. If it's an invasive carcinoma, then we refer for excision and if it's in sight to like those other couple I showed there's a number of different options actually ranging from topical therapy like Ahmad to most surgery or even radiation. So that is the cases that I brought today I'm happy to take any questions about anything that I might have shown or if anyone has any other questions about genital dermatosis that are non infectious. Thanks very much.

[End Transcript]