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An overview of vulval lesions in a tertiary care centre of western Rajasthan

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Abstract
Objectives: A wide spectrum of benign, premalignant and malignant lesions may involve the vulva. Our study is taken to overview the different types of Vulval disorder among patients presented in a tertiary care institute.
Methods: It is a retrospective study of patients having different type of Vulval lesions, who were admitted in the department of Obstetrics and Gynecology, over a period of 24 months.
Results: In our study 40 patients were having Vulval lesion amongst total 2248 admitted patients with genital organs lesion comprising incidence of 1.78%. Almost all the patients were diagnosed by histopathological examination. The mean age was 47.7 years. The most of the patients were from 40-60 years age group. Lichen sclerosis was the commonest finding, incidence being 15(37.5%) and pruritus vulva was the commonest presenting symptom followed by soreness and pain in the vulva.
Conclusions: General care of Vulval skin is a fundamental component of treatment. The mainstay of the management of lichen sclerosis is topical ultra-potent steroids. Women with VIN require a mandatory biopsy to confirm disease.

Keywords: Vulva, lichen sclerosis, pruritus vulva, vulval intraepithelial neoplasia (VIN), vulval cancer

Introduction
A wide spectrum of benign, premalignant and malignant lesions may involve the vulva. The challenge to the clinician is to differentiate between normal variants, benign findings and potentially serious disease and this is not always easy. The most useful means of generating a differential diagnosis of vulval lesions is by morphologic findings rather than by symptomatology which is often nonspecific [1, 2]. The general approach to evaluate vulval lesions includes the history, physical examination and diagnostic studies. If a diagnosis cannot be made clinically, biopsy should be strongly considered. Vulval biopsies should also be performed if the lesion is clinically suspicious for malignancy. The aim of the study is to overview the different types of vulval disorder among all gynecological admissions in our O & G department including their presenting features, response to the treatments and follow up.

Methods
It was a retrospective study over a period of 24 month (August 2017 to July 2019) of patients having suspected vulval lesion, admitted in the department of Obstetrics and Gynecology, Bangur Hospital, GMC Pali. Data were collected from bed history tickets, OT register and from department of Pathology of our hospital. A total 40 patients were found having vulval lesions amongst total 2248 patients, admitted for gynecological disorders. Age distribution, spectrum of vulva' lesions, presenting symptoms, treatment given and type of surgeries performed were noted and analysed.

Results
In our study 40 patients were having vulval lesions amongst 2248 admitted patients with suspected genital organs lesion comprising incidence of 1.78%. The mean average age was 47.66 years. As shown in Table 1,11 (27.5%) women were between 40 - 50 years of age group, 9 (22.5%) were between the age of 50 - 60 years, 7 (17.5%) women each were in <30 years & 30-40 years age group and 5(12.5%) of them were between 60-70 years of age. Only 1 (2.5%) women were more than 70 years of age. The maximum age of a patient was 75 years, who came with cauliflower growth over the clitoris and diagnosed to have vulval carcinoma.

Table 1: Age distribution of vulva] lesion (study population) [n=40]

Age (years)	Number of cases	Incidence (%)
< 30	7	17.5
30 - 40	7	17.5
40-50	11	27.5
50 – 60	9	22.5
60-70	5	12.5
> 70	1	2.5

Table no. 2 depicts pruritus vulva is the commonest presenting symptoms (50% cases). Out of the 20 patients of pruritus vulva, 15 were suffering from lichen sclerosis, 4 were suffering from squamous cell hyperplasia and 1 from psoriasis vulva. 15 patients presented to us as soreness of vulva and amongst them 4 were suffering from squamous cell hyperplasia, 3 were suffering from infected Bartholin cyst and rest of the 8 were found to have lichen sclerosis. Among the 15 cases, presented with vulval pain, 4 had vulval carcinoma, 3 were having infected Bartholin cyst and rest 8 had lichen sclerosis. 8 cases of lichen sclerosis also complained of dyspareunia. All the 8 cases of cystic swelling were suffering from Bartholin cyst swelling. Four patients of watery discharge from vulva suffered from vulval squamous cell hyperplasia. Five patients presented with discolouration of vulval skin, ultimatel diagnosed having vulval intraepithelial neoplasia (4 cases), fix dysplasia (1 case) and from psoriasis vulvae (1 case). There we 3 cases of vulval ulcer that suffered from ulcerative dermatosis and presented with Mucopurulent discharge from vulva. All 4 cases of cauliflower growth in the vulva (3 cases - growth over labia majora, another 1 case - growth over clitoris) were diagnosed as vulval carcinoma.

Table 2: Symptomatology of vulval lesions (study population)

Symptoms	Cases
Pruritus vulva	20
Soreness of vulva	15
Vulval pain	15
Dyspareunia	8
Cystic swelling	8
Vulval Discharge	7
Discolouration of skin	5
Cauliflower growth	4
Vulval ulcer	3

Table 3 shows Lichen sclerosis was the commonest finding 15 (37.5%) amongst 40 patients who presented with pruritus vulvae, soreness of vulva, dyspareunia and all of them were treated medically. The second most common presentation was Bartholin cyst, 8 such cases (20%) presented as acystic swelling in the vulva and treated surgically. The third common presentation were squamous cell hyperplasia, Vulval intraepithelial neoplasia (VIN), Vulval carcinoma each having 4 cases, comprising incidence of 10% in each group. All the cases of squamous cell hyperplasia presented with pruritis vulva along with soreness, watery discharge. They were treated medically whereas all cases of VIN presented as discolouration of skin, treated surgically. Cases of vulval carcinoma treated surgically by Vulvectomy. All 3 cases (8.33%) of ulcerative dermatosis, presented as vulval ulcer were treated medically. Amongst the others, 1 patients were having focal dysplasia, presented as dark plaque and they are on follow-up and another 1 were suffering from psoriasis vulvae, managed conservatively.

Table 3: Spectrum of vulval lesions (n=40)

Disorders	Cases	Incidence (%)	Management
Lichen Sclerosis	15	37.5	Medical
Bartholin cyst	8	20	Surgery
Squamous cell hyperplasia	4	10	Medical
Ulcerative dermatosis	3	7.5	Medical
VIN*	4	10	Surgery
Vulval carcinoma	4	10	Surgery
Others: Focal Dysplasia	1	2.5	Medical
Psoriasis Vulva	1	2.5	Medical

*Vulval intraepithelial neoplasia

Discussion

In our study lichen sclerosis was the commonest finding (37.5%), all of them presented with severe pruritus which was worse at night. We have seen Uncontrollable scratching causing trauma with bleeding and skin splitting and symptoms of discomfort, pain, soreness and dyspareunia in 8 cases (53.33%) among total 15 cases. Careful hygiene, avoidance of irritants and allergens, use of cotton underwear and avoidance of connecting and heat-inducing clothing are sensible adjuncts of local care. These types of local care also helped the patients to alleviate the symptoms. Clobetasol propionate 0.05% ointment, applied twice daily for 1-3 months (with the dose gradually tapered) provides short-term relief and long-term control in most patients. Lorenz and colleagues found very high success rates in 81 symptomatic patients with biopsy-proven disease who had failed previous therapy 4. We instructed the parents to use Clobetasol 0.05% ointment on a continuously. After three months of therapy 22 patients (90.91%) recovered from symptoms well. Only two

patients did not recover well. They were prescribed tretinoin cream. Encouraging results have been obtained with tretinoin cream 0.025% and systemic acitretin'.

We have found total 8 cases of Bartholin cyst. Problems with the Bartholin glands include cysts, which are relatively painless enlargements of the gland, and abscesses, which are infections of the gland. Bartholin cysts are most likely to occur in women of child-bearing age, as in our study four cases each from below 30 and between 30-40 age group were found. We have done excision of the cyst in four cases and by marsupialisation in the remainder including four Bartholin abscess cases who presented with painful cystic swelling with soreness of vulva also.

There were four cases of squamous cell hyperplasia diagnosed after histopathological study. This also helps to identify cases of squamous cell hyperplasia with Atypic that may have a propensity to develop carcinoma. Three cases were between 30-40yrs age group & one was below 30yrs age group. They presented with pruritus, soreness and watery discharge from vulva. Treatment of squamous cell hyperplasia is the same as that for lichen sclerosis and is aimed at halting the itch-scratch-itch cycle.

Joura *et al.* strongly suggested that the incidence of VIN is increasing, esp) ecially in women prior to the 7th decade of life" Our study also showed three cases (VIN-1) were between 50-60yrs age group and one case (VIN-2) were between 40-50 yrs age group. The treatment of VIN is local to wide excision, in case of very extensive involvement or recurrence, even a simple Vulvectomy may require. We have done wide local excision for all six cases. Vulva! cancer, a malignant invasive growth in the vulva, accounts for about 4% of all gynecological cancers and typically affects women in later life & squamous cell carcinoma accounts for about 90% of vulval cancers'. In our study, total four cases of vulval cancer were found. Three cases were between 60-70yrs age & they presented with vulval pain and cauliflower growth over labia major a over middle third area in one side (>2cm). No lymph node was palpable. Biopsy was taken and the diagnosis was squamous cell carcinoma of vulva. They were diagnosed to have stage IB vulval carcinoma & they underwent radical Vulvectomy with bilateral inguino-femoral lymph node dissection. The margin of the operated specimen was malignancy free and no lymphatic metastasis was found on histopathology. The patients are doing well on regular follow up & even they don't receive any chemo-radiation therapy. But they developed lymphedema of the lower extremities as observed in different studies 8. Another one patient was above 70yrs of age and she presented with vulval pain and growth over clitoris (>2cm) with non palpable inguinal nodes. We have done anterior hemivulvectomy in that case with inguinal selective lymphadenectomy. Operated specimen on histopathology showed tumour free margins and no lymphatic metastasis seen. She was diagnosed as stage IB and also didn't receive any chemo-radiation. They are doing well in her six months of post-Operanve period and also do not develop lymphedema**.**

Conclusion

Most disorders of the vulva are readily identified by general diagnostic principles and by looking for similar lesions located elsewhere on the body. General care of vulval skin is a fundamental component of treatment. Avoidance of potential irritants will benefit most conditions. The mainstay of the management of lichen sclerosis is topical ultra-potent steroids. Biopsy followed by histopathological evaluations may be required in any chronic dermatoses not responding to medical therapy in order to exclude VIN and frank carcinoma. Women with VIN require a biopsy to confirm disease. Long-term surveillance is necessary, particularly when a medical or conservative approach to management is advocated. All Gynaecologists require experience in the management of common vulval disorders, but a specialist service improves care for women by improving the accuracy of diagnosis and the implementation of adequate and appropriate treatment**.**

References

1. Fischer GO. The commonest causes of symptomatic vulval disease. a dermatologist's perspective. Australias J Dermato1. 1996; 37:12.
2. Foster DC. Vulval disease. Obstet Gynecol. 2002; 100:145.
3. Smith YR, Haefner HK. Vulval lichen sclerosis. Am J Clin Dermatol. 2004; 5(2):105-25.
4. Lorenz B, Kaufman RH, Kutzner SK. Lichen sclerosis - Therapy with Clobetasol propionate. 3 Reprod Med. 1998; 43(9):790-4.
5. Virgili A, Corazza M, Bianchi A *et al*. Open study of topical 0.025% tretinoin in the treatment of vulval lichen sclerosis. One year of therapy. 3 Reprod Med. 1995; 40(9):614-8.
6. Joura EA, Lbsch A, Haider Angeler MG, Breitenecker G, Leodolter S. Trends in vulval neoplasia. J Reprod Med. 2000; 45:613-615.
7. Sideri M, Jones RW, Wilkinson El, Preti M, Heller DS, Scurry J *et al*. Squamous vulval intraepithelial neoplasia '04 modified terminology. J Reprod Med. 2005; 50:807-10.
8. Novackova M, Halaska MJ, Robova H, Mala, Pluta M, Chmcl R Rob L. A prospective study in detection of lower-limb lymphederm and evaluation of quality of life after vulval cancer surgeryint Gynecol Cancer. 2012; 22(6):1081-88.