

Intergluteal Itching in Need of Relief

For almost a year, a 55-year-old African-American woman has experienced itchy skin changes in her perianal area. Treatment attempts with several topical creams—including clotrimazole, combination clotrimazole/betamethasone, and ketoconazole—have not helped.

The patient has seen several primary care providers for the problem. All have told her that it was yeast-related, except the last clinician, who suspected psoriasis. When the topical medication prescribed by that provider did not yield a resolution, the patient decided to consult dermatology. Due to her lack of insurance, she had to wait four months to see a derm clinician, since her only option was a once-a-month free clinic in her community.

Aside from mild hypertension, the patient claims to be in good health. Recent work-up indicated she does not have diabetes. She denies any family history of skin diseases, including psoriasis. She has had no previous complaints regarding her vaginal/perivaginal areas.

The patient's type V skin is free of notable changes except in the intergluteal and perianal areas. Specifically, no rash is noted on



her extensor elbows or knees or in her scalp, and there are no changes in her fingernails.

When the patient lies on her left side, extending her left leg and bringing her right knee toward her chest, the entire intergluteal and perianal areas can be visualized. Distinct loss of dark pigment is seen in the upper intergluteal/lower coccygeal areas. Closer inspection reveals that the pigment loss is complete, giving the affected skin a porcelain-like white appearance that also seems moderately atrophic. Palpation confirms this impression.

No such changes are noted in the perianal or perineal areas. However, there is diffuse hyperpigmentation, as well as signs of mild chronic excoriation.

Given the facts of the case as stated, the next logical step would be to

- Start the patient on a two-week course of oral fluconazole (200 mg bid)
- Perform a punch biopsy

- Scrape the affected area for a KOH prep
- Prescribe a two-week course of cephalexin (500 mg qid)
- None of the above

ANSWER

Admittedly, this is a bit of a trick question—but with a good teaching point to make. A course of oral fluconazole (choice “a”) is futile, since there’s no reason to think this problem is yeast-driven and since the patient has already demonstrated a lack of response to topical imidazoles.

Punch biopsy (choice “b”) would be a good choice, but not in this area, where it could quickly become a bigger problem than the one the patient presented with. Sutures would not likely hold the biopsy wound together, and resultant infection is all too likely.

A KOH test to detect fungal or yeast elements (choice “c”) is unlikely to shed any light on the problem, given the lack of re-



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sponse to antifungal creams. Finally, there's no reason to suspect a bacterial origin, so oral antibiotics such as cephalexin (choice "d") would be useless (and had already been tried unsuccessfully).

The correct answer is none of the above (choice "e").

DISCUSSION

This case illustrates why dermatology seems so maddeningly difficult to the uninitiated. Any experienced dermatologist would know the correct diagnosis, lichen sclerosus et atrophicus (LS&A), because it presents in such a distinctive way (in limited locations, predominantly in women) and because the differential is so limited. But if you've never *heard* of LS&A, you're unlikely to diagnose it, let alone know how to treat it.

LS&A is an inflammatory condition of unknown origin that affects the upper epidermis. It can present in extragenital locations

(particularly shoulders and legs) but is far more common in genital areas. As exhibited in this case, it presents with well-defined pigment loss, which is especially easy to see in patients with darker skin.

Although more commonly seen in women, LS&A can occur in men, usually manifesting on the penile glans and distal foreskin of uncircumcised patients. The dry atrophic changes seen on the glans can lead to stenosis of the urethral meatus and, proximally, to adhesions (phimosis) of the foreskin. (This condition was termed *balanitis xerotica obliterans* [BXO] long before its pathologic process was determined to be identical to LS&A's. Tissue specimens obtained during circumcisions performed for chronic phimosis often yield evidence of BXO.)

In women, untreated chronic LS&A can lead to sclerotic changes in and around the urethra and labia minora and can cause in-

troital stenosis. This case is a bit atypical; LS&A more often manifests in perivaginal and perirectal areas, where the intense hypopigmentation produces a classic "figure eight" appearance.

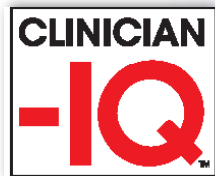
The differential includes lichen simplex chronicus, psoriasis, lichen planus, contact/irritant dermatitis, and seborrhea. Often, biopsy is necessary and appropriate to settle the issue, other factors being equal.

TREATMENT/PROGNOSIS

The patient was given a prescription for clobetasol 0.05% ointment for twice-daily application Monday through Friday (and no application for two consecutive days—in this case, the weekend—per week). Studies have established the efficacy and safety of this treatment regimen.

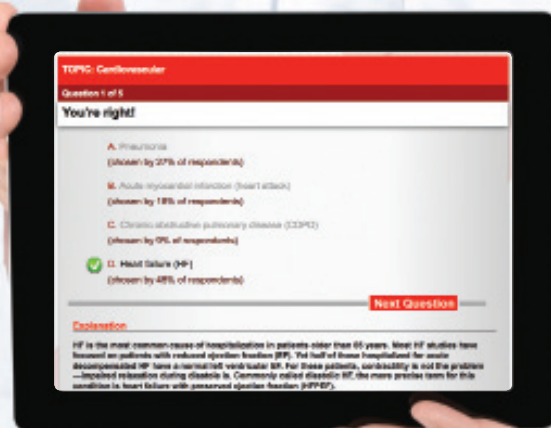
In a month or two, application can be reduced to once or twice a week to control the condition. **CR**

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