# Diagnose Vaginitis by Exam, Not by Phone

***Symptoms are often misleading, and relatively few women can accurately self-diagnose candidiasis.***

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HOUSTON — Telephone consultations for vaginitis often result in misdiagnosis, Dale Brown Jr., M.D., warned at a conference on vulvovaginal diseases sponsored by Baylor College of Medicine.

"Patients think it is a drag to come in to be evaluated, and many health care professionals think it is a drag to have to treat vaginitis all the time," said Dr. Brown, chairman of clinical affairs in the obstetrics and gynecology department at Baylor.

Nonetheless, thorough office examinations are necessary, even for what appear to be repeated fungal infections, according to Dr. Brown. He maintained that symptoms are often misleading, and studies have found relatively few women can accurately self-diagnose vulvovaginal candidiasis.

"Patients are spending a lot of money over the counter and then they have to come in to be treated again. They don't know what they are treating," Dr. Brown said, contending that availability of over-the-counter antifungal treatments for candidiasis has not lived up to expectations of reduced health care costs. Instead, he said, many women are seeking a physician's help only after trying two or three different medications that did not relieve their symptoms.

*Candida albicans* was confirmed in only 33% of cases for which over-the-counter medications were purchased in one report cited by Dr. Brown (J. Fam. Pract. 1996;42:595-600).

He noted that women with a history of diagnosed fungal infections were even more likely to misdiagnose a repeat infection.

In another study at a vaginitis referral center, he said only 28% of cases of candidiasis were clinically confirmed (Obstet. Gynecol. 1997;90:50-3).

A third investigation cited by Dr. Brown involved the collection of vaginal swabs every 4 months from 1,248 women. He said the study, presented at a meeting of the Infectious Diseases Society for Obstetrics and Gynecology in 2002, found 24% of women who were never colonized by yeast used antifungal drugs at least once.

At least half the women who are diagnosed with candidiasis actually have another condition, according to Dr. Brown. Although frequently suspected, candidiasis accounts for only 20%-25% of vaginitis; bacteria are responsible for 40%-50% of cases and trichomoniasis for 15%-20%.

Dr. Brown urged consideration of other noninfectious causes and less common infections. He gave a long list of possible diagnoses that included atrophic vaginitis, a foreign body, allergic hypersensitivity and contact dermatitis, trauma, desquamative inflammatory vaginitis, erosive lichen planus, lactobacilli vaginosis, cytolytic vaginosis, streptococcal group A infection, ulcerative vaginitis with *Staphylococcus aureus*, and idiopathic ulceration associated with human immunodeficiency virus.

When examining women for vaginitis, physicians should have patients use a magnifying glass to identify the exact location of the itch.

He recommended collecting a specimen from the lateral midsection of the vagina and looking for systemic diseases that can present as a vulvovaginal symptom. He singled out erythrasma and tinea cruris as two conditions that can be mistaken for candidiasis.

"Most common vaginitis is not hard to treat, but too often we make a diagnosis that is not the correct diagnosis and we get failure of our treatment," he said. ■

# Lichen Planus and Beyond: A Review Of Erosive Noninfectious Skin Diseases

HOUSTON — Elizabeth "Libby" Edwards, M.D., gave an overview of erosive, noninfectious skin diseases at a conference on vulvovaginal diseases sponsored by Baylor College of Medicine.

According to Dr. Edwards, chief of dermatology at the Southeast Vulvar Clinic in Charlotte, N.C., and a faculty member at the University of North Carolina, Chapel Hill, gynecologists should consider the following skin conditions:.

► **Lichen planus.** This skin condition is well known to gynecologists, she said. An autoimmune disease, it also presents in the mouth and can cause scarring in the vagina and vulva. Its clinical appearance ranges from white reticulate papules to nonspecific erosions that often require biopsy to diagnose. Numerous therapeutic options include corticosteroids, an anti-inflammatory antibiotic given with fluconazole to prevent yeast development, and supportive care.

► **Desquamative inflammatory vaginitis spectrum.** Also known as sterile inflammatory vaginitis, this condition is often misdiagnosed, according to Dr. Edwards. It presents with a red or eroded vaginal epithelium and yellow/green secretions that contain a high number of white blood cells. Though the etiology is not known, she suspects it is "an autoimmune problem in the same family as lichen planus." If the patient initially was diagnosed with an infection but did not respond to penicillin, then Dr. Edwards considers desquamative inflammatory vaginitis spectrum as a possible diagnosis and gets a culture to tell for sure. If this diagnosis is confirmed, Dr. Edwards prescribes clindamycin cream intravaginally or hydrocortisone suppositories or both.

► **Posterior fourchette fissures.** This common erosive condition can occur every time a woman has intercourse, and it heals quickly. "If she does not come in within a day of intercourse, you won't see it," Dr. Edwards said. Some physicians treat this condition with topical estrogen, but she said the only therapy that has worked for her patients is perineoplasty.

► **Skin fold fissures.** These fissues are often compared with paper cuts, according to Dr. Edwards. They sometimes present as fine red lines. They can be caused by irritation from another condition, especially *Candida albicans*, but sometimes occur in patients who have nothing else wrong. Dr. Edwards recommends doing lots of cultures. If the cultures don't turn up anything, she uses a "shotgun" approach to eliminating the unknown cause by treating with an antifungal, clobetasol ointment, and cephalexin.

► **Fixed drug eruption.** This condition is a blistering/erosive reaction to a medication. Dr. Edwards said to make a diagnosis of the disease by history and clinical appearance. "Treatment is local care and avoidance of the medication," she said.

► **Blistering erythema multiforme.** Also known as Stevens-Johnson syndrome and toxic epidermal necrolysis, this condition can be a hypersensitive allergic reaction to an infection or recurring herpes simplex virus, according to Dr. Edwards. An acute condition, it presents with red nonscaling papules and plaques, blistering, and erosion that can cover 40% of skin. Dr. Edwards warned that it is a dangerous disease with a 40% mortality rate "that comes on like gangbusters. … Call a dermatologist; call an intensivist, and often send these patients to a burn center," she advised, urging gynecologists to do all they can to protect the vulva. "The guys in the ICU are not thinking about that," she said. "The guys in the ICU are trying to save this person's life."

► **Cicatricial pemphigoid.** This condition presents with erosion and scarring of mucous membranes. It can lead to blindness, tooth loss, obliteration of the vaginal space, labia minora agglutination, and narrowing of the introitus, according to Dr. Edwards. She said to diagnose by biopsy and immunofluorescence of adjacent skin, and treat in most cases with oral prednisone. Sometimes a topical medication or antimetabolite can be tried.

► **Pemphigus vulgaris.** Another autoimmune blistering disease of the skin and mucous membranes described by Dr. Edwards is pemphigus vulgaris. She said it does not scar except in vulvovaginal areas, where it can lead to disfigurements similar to cicatricial pemphigoid. Diagnosis and treatment are also similar.

► **Contact dermatitis.** This skin condition can be caused by poison ivy, scrubbing the skin with too much [pumice-containing] soap, or something else a woman is using, according to Dr. Edwards. "You have to ask specifically, 'What are you putting in the area?'" she said. ■

# *Skin Disorders Common Cause of Vulvovaginal Symptoms, Expert Says*

HOUSTON — Skin disorders are often overlooked as a cause of chronic vulvovaginal symptoms, Elizabeth "Libby" Edwards, M.D., said at a conference on vulvovaginal diseases sponsored by Baylor College of Medicine.

Gynecologists are not trained to look for skin disorders, and dermatologists don't want to diagnose vulvovaginal conditions, according to Dr. Edwards, chief of dermatology at the Southeast Vulvar Clinic in Charlotte, N.C. and also a faculty member at the University of North Carolina, Chapel Hill.

"Most physicians across all specialties are unaware of how unbelievably common chronic skin diseases of the vulva and the vagina are," said Dr. Edwards.

"Most physicians are taught that chronic vulvovaginal symptoms are due to yeast—maybe bacterial vaginitis and, if not that, maybe a sexually transmitted disease. And they keep looking for those same things over again," she said. "[But] there are hundreds of skin diagnoses that can be playing a role."

Some of these diseases will present as vulvovaginal, gingival, and even ocular conditions. Dr. Edwards told of one patient who was being followed by an ophthalmologist for dry eye syndrome, a dentist for gingivitis due to poor hygiene, and a gynecologist for lichen sclerosus. The common condition was cicatricial pemphigoid, which is a nonspecific skin disease that can affect mucous membranes in the eyes, mouth, vagina, and vulva.

Dr. Edwards urged physicians to get a culture and do biopsies when they can't identify the cause of a chronic vulvovaginal condition. She suggested sending samples with a differential diagnosis to a dermatologic pathologist who has experience with erosive skin diseases but warned that a biopsy may not provide the answer.

"A biopsy is not a lab test," she said. "It is just a different doctor in a different place giving an opinion on looking at the skin under a microscope."

Even after a diagnosis is made, she urged persistence if the patients still has symptoms.

"Often there is more than one factor in [a] chronic vulvovaginal symptom," Dr. Edwards said. "If you find one thing—i.e., a yeast infection—–don't stop looking, keep going." ■