Contact Dermatitis May Accompany Incontinence

Inadequate pads or liners may leave the vulva wet, chafing; some patients are overzealous in washing.

BY PATRICE WENDLING
Chicago Bureau

CHICAGO — Chronic use of sanitary pads and panty liners for urinary incontinence may put patients at risk for vulvar contact dermatitis, Dr. Lynette J. Margesson said at a conference on vulvovaginal diseases sponsored by the American Society for Colposcopy and Cervical Pathology.

Some women with urinary or fecal incontinence don't want to acknowledge they have the condition or are too embarrassed to wear incontinence pads, and instead opt to wear sanitary pads or panty liners to address their incontinence. The problem is that these are inadequate for urine volume, leaving the vulva wet throughout the day.

"Women don't use appropriate pads to stay dry, and we do have a real epidemic of incontinence," said Dr. Margesson of Dartmouth Medical School, Hanover, N.H. "These patients are desperate with itch, burn, and pain."

Elderly patients often have problems with contact dermatitis from incontinence that is complicated by obesity and reduced mobility.

Age-related loss of estrogen also increases susceptibility to irritant contact dermatitis by causing the epidermal barrier to be weakened and thinned, and less moist and viable.

The epidermal barrier also can be lost because of overzealous washing with a washcloth, sponge, or wipes. Dr. Margesson warned the audience to be wary of patients who are convinced the vulva is "dirty," and needs to be scrubbed.

"You can get a reaction including redness and swelling from the use of baby wipes," Dr. Margesson said.

"We're seeing a lot of patients using these." A strong show of hands confirmed a similar experience among the audience.

Other common vulvar allergens include benzocaine (Vagisil), neomycin (Neosporin), chlorhexidine (KY jelly), preservatives, latex condoms, lanolin, and nail polish. Common irritants include douches, spermicides, and medications such as trichloroacetic acid and 5-fluorouracil.

The clinical features of irritant and allergic contact dermatitis are similar and can be acute with blistering, subacute with redness and scaling, and chronic with redness and induration.

Contact dermatitis is frequently superimposed on preexisting, chronic vulvar conditions and complicates their management, Dr. Margesson said. Patients will self-treat with over-the-counter products or receive multiple medications from different providers. Dr. Margesson has observed patients who developed burns from using benzocaine 20% 10-15 times a day, or whose condition was worsened by their use of ice packs rather than cool gel packs to cool an itchy, burning vulva.

The first step in managing contact dermatitis in the anogenital area is to stop the irritant or allergen exposure and any irritating practices. A sitz bath, tub bath with lukewarm water only, or cool compress can be used one to three times a day for 5-10 minutes to improve barrier function and to soothe weeping, red, or hot irritated areas. Bland emollients such as petrolatum, mineral oil, or olive oil help seal in moisture.

Antibiotics should be used to treat secondary infections, and steroids to suppress inflammation. Patients should be given specific instructions for topical steroids and shown in the office the exact site to which to apply them.

To counter the commonly held belief that more must be better, Dr. Margesson suggests the use of "toothpick" dermatology, which limits the amount of ointment or cream needed to cover the vulva to the end of a toothpick.

Finally, it's essential to review and rereview hygiene habits with the patient. "It's amazing how many people will go back to what they were doing before," Dr. Margesson said. ■

Dorsal-Genital Nerve Stimulation Shows Efficacy for Bladder Control

BY MITCHEL L. ZOLER
Philadelphia Bureau

OTTAWA — Continuous dorsal-genital nerve stimulation was effective for controlling overactive bladder symptoms in a feasibility study with 19 evaluable patients.

The next step is to test this new approach to treating refractory urge incontinence with an implantable device in a controlled pilot study, Dr. Jeffrey M. Mangel said while presenting a poster at the annual clinical meeting of the Society of Obstetricians and Gynecologists of Canada.

The implantable device already on the U.S. market for controlling urge incontinence by continuous electrical stimulation, Medtronic Inc.'s InterStim, works by stimulating the sacral nerve.

The possibility of achieving similar results by stimulating the dorsal-genital nerve, part of the pudendal nerve, should be attractive to gynecologists, said Dr. Mangel, director of the division of urogynecology and reconstructive pelvic surgery at MetroHealth Medical Center in Cleveland.

That's because the device and leads are implanted by a ventral approach, a surgery that gynecologists are comfortable doing. In contrast, the sacral-nerve stimulator leads require placement over the sacrum, an approach with which gynecologists are less familiar, Dr. Mangel said in an interview.

Placing a dorsal-genital nerve stimulator "could potentially be an in-office procedure," he added.

Another possible advantage is that because the pudendal nerve is not a sensory nerve, patients may not experience the sensation of contraction that they feel with the InterStim device, he commented.

The dorsal-genital nerve stimulator that will be tested in future studies is made by NDI Medical, the company that sponsored the study presented by Dr. Mangel.

He disclosed that neither he nor his associates have any financial relationships with NDI beyond the company's funding of the study.

The study enrolled 21 women who had a primary diagnosis of urge incontinence and reflex-bladder contractions that had been confirmed by a cystometrogram, and who had not responded to medical therapies.

Seven patients each were enrolled at one of three centers: MetroHealth Medical Center, the Cleveland Clinic, and Duke University, Durham, N.C.

After a 5-day washout period and baseline measurements of incontinence, the women had electrodes placed on the dorsal-genital nerve using local anesthesia.

The electrodes were attached to an external generator that produced constant electrical stimulation of the nerve for 7 days.

The average age of the patients was 53 years, and the average duration of their incontinence was 6 years.

The impact of treatment was assessed based on patient diaries, the weight of pads used for incontinence, and reports of adverse events.

Outcome data were available for 19 patients.

Of the 19 patients, 13 had fewer urinary leak episodes per day, with 9 patients having improvements of 50% or more. The average number of leak events per day for all 19 patients fell from 4.7 at baseline to 2.6 after 7 days of treatment.

Also after 7 days, pad weight fell in 15 of 17 patients, by an average of 79%. Of these 17 patients, 8 had pads that were completely dry after a full day of use.

The electrical stimulation was well tolerated, and was described by patients as a thumping, tingling, or buzzing sensation.

Seven patients reported mild adverse effects that consisted of local erythema or a sensation of skin stimulation at the site of electrode implantation. ■

Viral Illness, Not STD, May Be Cause of Vulvar Ulcers

BY DIANA MAHONEY
New England Bureau

ATLANTA — Vulvar ulcers were associated with a viral illness rather than a sexually transmitted disease in 14 of 46 patients under age 22, based on the findings of a retrospective study.

"Many practitioners are quick to diagnose a genital ulcer as a sexually transmitted disease because STDs are the most common cause; but young women can present with vulvar ulcers that are secondary to a viral infection," Dr. Rebecca Kyle said in a poster presented at the annual meeting of the North American Society for Pediatric and Adolescent Gynecology.

"Although such cases may be rare, misdiagnosing this as an STD can be devastating to the patient and her family and can lead to the prescription of unnecessary medications," she noted.

The findings confirm the need for a thorough physical and history for all young women who present with vulvar or labial ulcers, said Dr. Kyle.

Dr. Kyle and her colleagues at the University of Missouri–Kansas City conducted a retrospective study of all patients aged 12-21 years who presented to Children's Mercy Hospital between 1999 and 2005 with a diagnosis of vulvar ulcer or lesion.

Of the 46 charts identified, "31 were excluded for diagnoses inconsistent with vulvar ulcer or for having positive lab results consistent with a sexually transmitted disease," said Dr. Kyle.

Of the remaining 15 patients, 14 reported an antecedent history of viral symptoms. "One of the 14 patients with a viral history was eventually diagnosed with Crohn's disease and another patient, who experienced recurrent ulcers, was referred to rheumatology for suspicion of Behçet's disease," she said.

All of the patients with non–sexually transmitted ulcers were treated symptomatically with complete resolution of the presenting ulcer, said Dr. Kyle.

Additionally, "although they are diagnoses of exclusion, Crohn's disease and Behçet's syndrome must be considered in patients with non–sexually transmitted genital ulcers, particularly when the ulcers are recurrent and occur in conjunction with or following other viral symptoms," Dr. Kyle stressed.

In particular, she noted, vulvar ulcers that occur in combination with oral ulcers and eye complaints should raise suspicion of Behçet's and those that occur in association with gastrointestinal symptoms potentially point to Crohn's, although genital ulcers as an extraintestinal manifestation of Crohn's can precede intestinal symptoms as well. ■