Vulval Psoriasis

BSSVD Presidential Essay Prize

500 words

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Psoriasis is a chronic inflammatory skin condition which affects 2% of the population. Vulval involvement can be part of widespread disease but in 2-5%, it is the only area affected[1,2]. It is one of the commonest dermatological conditions to affect genital skin, is often overlooked and can have a devastating impact on women's physical and mental health.

The clinical presentation of vulval psoriasis differs from generalised disease. Lesions are typically symmetrical. In skin folds, well-demarcated, thin plaques form which are erythematous and shiny or greyish. Scaling does not tend to appear due to friction. Labial lesions appear silvery and can be scaly although far less so than elsewhere[2,3]. The combination of moisture, warmth and friction causes fissuring of lesions which become sore and pruritic. Disease can be worsened by clothing and friction due to the Koebner phenomenon as well as specific irritants such as urine and faeces[4].

Vulval psoriasis tends to be a clinical diagnosis however, due to similarly presenting conditions, this can be difficult. Candidiasis, tinea cruris, lichen simplex chronicus and various forms of dermatitis should all be considered as differentials and these tend to present with their own typical characteristics[4]. It can be that psoriasis is co-existing with another disease, in particular contact dermatitis. Skin biopsies can be used and may show spongiosis, with intercellular oedema within the epidermis, changes which can be present in both psoriasis and dermatitis[5]. A personal or family history of psoriasis, lesions elsewhere on the body and other manifestations of psoriasis, such as joint pain, would point towards a diagnosis of psoriasis.

Treatment is based upon expert opinion and case reports. Irritant elimination and treatment of concurrent disease is an important first step. Topical corticosteroid therapy may be used first line[2,4]. Topical coal-tar derivatives, eg: 5% coal tar solution, initially diluted 50% with water, before applying full strength, if tolerated, either in combination with steroid or alone may be effective longterm[2,4]. Vitamin D analogues (Tacalcitol and Calcitriol are less irritant than Calcipotriol) are useful and safe. The topical immunomodulators, tacrolimus and pimecrolimus (licenced for eczema but less irritant in flexural psoriasis) are effective, with the advice that their use may lead to reactivation of viral skin disease and again cause local irritation and stinging[4]. If purely genital involvement, oral agents are rarely needed but for refractory and severe eroded /split vulval and perianal psoriasis systemic treatment, particularly Methotrexate, is useful.

Vulval psoriasis is a condition that causes significant emotional and physical distress to women. Once correctly diagnosed, it is relatively easy to treat but needs careful monitoring of therapy to ensure significant side-effects do not develop.

References

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