Consultant360 Multidisciplinary Medical Information Network

PHOTO QUIZ

PEER REVIEWED

What Is This Woman's Genital Lesion?

Volume 60 - Issue 2 - February 2020

AUTHORS:

Nguyet-Cam V. Lam, MD, and Richa Sharma, MD

Family Medicine Residency, St. Luke's University Hospital, Bethlehem, Pennsylvania

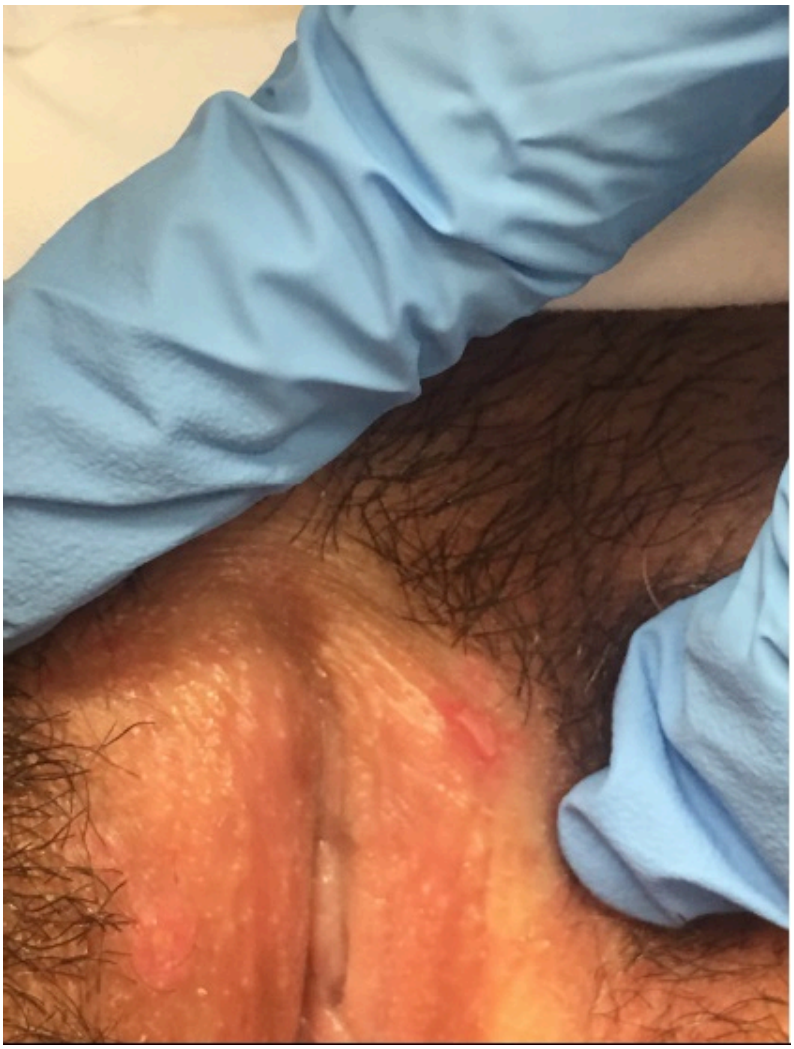
CITATION:

Lam N-CV, Sharma R. What is this woman's genital lesion? *Consultant*. 2020;60(2):51-52. doi:10.25270/con.2020.02.00004

A 34-year-old woman with a medical history significant for allergic rhinitis, seasonal allergies, and childhood eczema presented with concern for a genital lesion of 2 days' duration. The patient stated that she had felt a bumplike lesion in her perineum 2 days prior, which then had flattened. The lesion was painless and nonpruritic; however; she stated that urination caused irritation.

The woman had history of unprotected sex 2 months prior. She denied use of any new cosmetics, laundry detergent, or medication, but she had been swimming in community pool recently. She denied any vaginal discharge, pruritus, lower abdominal pain, recent fever, cough, cold, and rash elsewhere on her body. She had an intrauterine device (IUD) and had had a period 2 weeks ago.

On examination, the abdomen was soft and nontender, and no inguinal lymphadenopathy was noted. Two nontender, 2-mm ulcerative lesions with clear edges and a pale base were noted on the vulva. No induration of the lesions' margins was present. One lesion was on the superior aspect inside the labia majora and the other on inside of the left labia inferiorly (**Figure**).



Speculum examination showed a multiparous cervix. Threads of IUD were visualized on examination. Bimanual examination demonstrated no cervical motion tenderness. The uterus was firm and nontender with no adnexal tenderness.

Two days later, the patient called reporting that she had developed multiple such lesions all over her vulva. The lesions were still painless but caused burning and irritation with urination.

Based on the patient's history and physical examination findings, which one of the following is the most likely diagnosis?

A. Syphilis

B. Herpes

C. Chancroid

D. Granuloma inguinale

E. Spongiotic dermatitis

Consultant360 Multidisciplinary Medical Information Network

PHOTO QUIZ

PEER REVIEWED

What Is This Woman's Genital Lesion?

Volume 60 - Issue 2 - February 2020

Answer: Spongiotic Dermatitis

Given the patient's history and examination findings, the lesions were suspicious for spongiotic dermatitis, especially with development of multiple erosive lesions over the course of time without systemic symptoms. Swimming in a community pool most likely acted as an irritant, and the features were consistent with contact vulvitis or an eczematous process.

DISCUSSION

Spongiotic dermatitis is a histological diagnosis and may be seen in eczematous dermatitis, allergic contact dermatitis, or irritant contact dermatitis. Pruritus is a common presenting symptom. Burning may be present if the mucosa is involved. Clinical signs may be subtle and can include poorly defined erythema, scales, fissure, and excoriation.[1] Involvement of mucosa presents as erosions.

The clinical approach to patients presenting with vulvar dermatoses requires a detailed history and physical examination, as well as laboratory studies. Biopsy is often needed in order to identify the cause and allow for the initiation of directed treatment.

Treatment principles include restoring the skin barrier, reducing inflammation, offering symptomatic relief, and preventing and treating secondary infection.[2]

DIFFERENTIAL DIAGNOSIS

Primary syphilis manifests as a solitary, painless chancre that develops at the site of infection an average of 3 weeks after exposure to *Treponema pallidum*. Without treatment, bloodborne spread of *T pallidum* occurs over the next several weeks to months. This results in secondary syphilis, which has numerous clinical manifestations, the most common of which are fever, lymphadenopathy, diffuse rash, and genital or perineal condylomata lata.[3]

Genital herpes simplex virus (HSV) infection begins as multiple vesicular lesions that sometimes are painless. Vesicles may rupture spontaneously, then become painful, shallow ulcers. Prodromal

painless. Vesicles may rupture spontaneously, then become painful, shallow ulcers. Prodromal symptoms may occur in 20% of HSV cases before ulceration and may include mild tingling up to 48 hours before ulceration, or shooting pain in the buttocks, legs, or hips up to 5 days prior.[4] Primary infections may cause malaise, fever, or localized adenopathy. Subsequent outbreaks are usually milder and are caused by reactivation of latent virus.[5]

Chancroid ulcers are usually nonindurated painful lesions with a serpiginous border and friable base. Painful, unilateral, inguinal adenitis occurs in approximately half of patients with chancroid and may develop into buboes. Fluctuant buboes may rupture spontaneously if not aspirated or incised and drained.[4]

Granuloma inguinale is characterized by persistent, painless, beefy-red papules or ulcers, which may be hypertrophic, necrotic, or sclerotic and with an incubation period of 8 to 12 weeks.[4]

OUTCOME OF THE CASE

In this patient, a biopsy was taken and cultures were sent, given her history of unprotected sexual intercourse. Results of rapid plasma reagin testing, viral cultures, and chlamydia cultures were negative.

Punch biopsy results revealed mild spongiosis with lymphocytic exocytosis and perivascular and periadnexal lymphohistiocytic inflammatory reaction, consistent with a diagnosis of spongiotic dermatitis.

The patient was recommended to use petroleum jelly on the lesions as skin barrier, and the lesions resolved spontaneously within a week.

REFERENCES:

1. Welsh BM, Berzins KN, Cook KA, Fairley CK. Management of common vulval conditions. *Med J Aust.* 2003;178(8):391-395.
2. Stewart KMA. Vulvar dermatoses: a practical approach to evaluation and management. *J Clin Outcome Manag.* 2012;19(5):205-220.
3. Brown DL, Frank JE. Diagnosis and management of syphilis. *Am Fam Physician.* 2003;68(2):283-290.
4. Roett MA, Mayor MT, Uduhiri KA. Diagnosis and management of genital ulcers. *Am Fam Physician.* 2012;85(3):254-262.
5. Groves MJ. Genital herpes: a review. *Am Fam Physician.* 2016;93(11):928-934.