

DISORDERS OF THE VULVA, VAGINA, CERVIX AND UTERUS

VULVAR VESTIBULITIS

These patients usually present in her third or fourth decade of life, complaining of the sudden onset of severe posterior vulvar burning and /or pain, which is significantly exacerbated during and immediately after intercourse. Eventually the pain becomes constant. There is usually erythema around the vestibular gland openings, which are located from about the 4 o'clock to the 8 o'clock position just outside the hymeneal ring. To date, no etiology has been found. Some investigators consider the disorder to be a combination of etiologies, including chronic yeast infection, chronic vaginitis, and atrophic vulvitis.

In many patients, the condition will regress in 6 months to 1 year. Many therapies have been tried to help patients with this condition. Some authors recommend surgical removal of the area. No treatment has been totally successful with this condition. Below is a list of medical therapies attempted.

VULVAR DYSTROPHY

Vulvar dystrophy has been used to describe two conditions: lichen sclerosis and hyperplastic epithelium. The classic presentation of vulvar dystrophy is the onset of vulvar pruritis and/or burning in the perimenopausal and postmenopausal period. It is likely that this condition begins with thinning of the vulvar epithelium, which may go on and become symptomatic. This is called lichen sclerosis. The other end of the spectrum is hyperplastic epithelium.

The standard treatment at this time is a high-potency steroid cream or ointment applied twice a day for a minimum of 4 to 6 weeks. Other therapies include testosterone cream, subepithelial injections of hydrocortisone or, rarely, surgical removal. Surgical removal is associated with a high rate of removal. These changes are not premalignant.

VULVODYNIA

Chronic vulvar irritation, previous vulvar surgery, and long term effects of vulvar viral infections can lead to a diffuse vulvar burning or pain without any visible evidence of change in the epithelium. These patients usually respond well to 3 months of treatment with a low dose anti-depressant.

HYDRADENITIS

Hydradenitis occurs most commonly in the fourth and fifth decades of life. Initially presenting as small abscesses on the vulva, it eventually becomes a deep-seated inflammation of the apocrine glands. They often have lesions of the vulva and in the axillary regions. Early lesions can be treated with hot soaks and regular washing with antibiotic soaps. Deep-seated lesions should be aggressively opened and cleaned with curettage, allowing secondary healing. Removal of the glands and skin grafts work best in the axillary region. Conservative therapy is recommended on the vulva. Rarely do

these patients respond to antibiotics. There is some evidence that placing patients on birth control pills may be helpful.

CONDYLOMATA ACCUMINATA

Condylomata accuminata occurs most commonly on the female vulva, and can also be seen on the vagina, cervix, or in the peri-rectal area. They are the result of exposure to human papilloma virus types 6 and 11. The risk of underlying carcinoma is always there. Women older than 45 should have removal of large condyloma. This is secondary to a high risk of underlying carcinoma. For women younger than 45, conservative therapy is recommended. Initially, painting the external warts with 80% bichloroacetic acid may result in a response rate up to 80%. Weekly applications for 4 weeks should provide the best response. Resistant cases can be treated with freezing or laser removal. Surgical excision is also possible. They appear to be equally effective. In the case of very resistant warts, AIDS should be considered.

NABOTHIAN CYST OF THE CERVIX

In an attempt for the squamous cells to cover the columnar cells of the endocervix, some endocervical glands and crypts are trapped. This results in a cyst like structure called a Nabothian cyst. It is a small, yellow, fluid-filled cyst on the exocervix. It is a completely benign condition without any short or long-term risk. No treatment is necessary.

ENDOCERVICAL POLYPS

Endocervical polyps can sometimes be difficult to distinguish from pedunculated leiomyomata. The vast majority of endocervical polyps are benign. It should, however, be removed and sent to pathologist for evaluation.

LEIOMYOMATA UTERI

Lieomyomata uteri (fibroids) are the most common pathologic condition of the female genital tract. Fibroids can occur anywhere along the tract, including the vulva, vagina, and cervix. The majority are in the uterine fundus. They are classically described by their location as being submucosal (protruding into the endometrial cavity), intramural (within the myometrium), subserosal (on the external surface), or pedunculated (either intraperitoneally or within the endometrial cavity). The vast majority regress after menopause. They may appear with calcifications on x-ray. It is difficult to differentiate fibroids from ovarian cancer. Ultrasound and laparoscopy have significantly decreased this problem. Treatment of fibroids is individualized, on the basis of symptoms and physical findings. The most common finding is abnormal bleeding, most often menorrhagia, and/or metrorrhagia. Endometrial evaluation to rule out endometrial hyperplasia or endometrial cancer should be the first step. This is done by an endometrial biopsy.

Pedunculated fibroids should be removed. They can be removed through the vagina by tying a suture around the base. Bleeding secondary to submucosal or intramural fibroids will often respond to birth control pills. Depo-provera administered every 3 months appears to be a conservative treatment. Gn-RH agonist treatment is a good mechanism for stopping the bleeding in order to increase the hematocrit prior to a more definitive

therapy. Although most fibroids will shrink during treatment with Gn-RH agonist, they rapidly return to their original size when the medication is stopped.

Pain with fibroids is most likely secondary to hypovascular necrosis, sometimes related to torsion of an external pedunculated fibroid, but more commonly a subserosal fibroid at the top of the fundus.

Massive fibroids in a very young patient may require myomectomy to preserve future childbearing ability. Growth of fibroids postmenopausally is extremely un-common and should warrant immediate evaluation, first ruling out ovarian cancer and then considering hysterectomy, as there is no good mechanism to diagnose leiomyosarcoma except with pathologic evaluation of the entire uterus.

ADENOMYOSIS UTERI

This is a condition in which the normal endometrial glands and stroma have invaded or somehow become trapped in the myometrium. During the menstrual cycle these cells respond to hormonal stimulation similar to the normal endometrium; however, at the time of the period they have no place to go, and thus necrosis and bleeding occur. This patient will complain of heavy painful periods that have gotten worse with each month that goes by. On examination during a menstrual period the patient will usually have an enlarged, boggy, tender uterus. This condition is rare in the nulligravid patient. There are not known risk of long-term sequela secondary to adenomyosis: thus, conservative therapy using oral contraceptives or Gn-RH agonist is first line therapy. Hysterectomy is only considered in refractory cases. Perimenopausally, this condition will regress.