PROPOSED CLASSIFICATION OF VULVAR DISORDERS OBSERVED MOST FREQUENTLY IN A VULVAR PATHOLOGY SURGERY UNIT

L. BECAGLI - L. CADORE - G. NARDELLI - D. DE SALVIA
Institute of Obstetrics and Gynecologic Clinic - University of Padua (Italy)
(Head: Prof. A. Onnis)

Summary: An adequate and unified classification of vulvar pathology has been difficult and continues to be a problem hard to solve, due to the difficulties in including different clinical aspects in various pathological classes.

The causes of this uncertainty, as rather a multiplicity of view points, may be ascribed in particular to the extreme polymorphic nature of vulvar pathology.

Our classification, in attempting to overcome arbitrary and absolute distinctions in such a polymorphic and variable field, adopts an etiological and anatomo-histological criterium which distinguishes vulvar pathology in: primary disorders, secondary disorders.

It is evidently important to know and distinguish possible vulvar infections, in order to be able to identify those disorders which assume an oncogenous risk, while trying to overcome the problems of differential diagnosis.

A great variety of pathologic pictures with different etiologies are frequently observed in an out-patient clinic for vulvar disease ([7, 15, 16]). In fact, due to its topographic location at the entrance to the urogenital tract, and its anatomo-histologic characteristics, the vulva is often the site of primary or secondary, specific or aspecific inflammations as well as bacterial, viral, mycotic and parasitic infections, dystrophic lesions, neoplastic processes, and not last, skin disorders which fit into a well-defined internal-general or psychosomatic pattern. However, if the clinical pictures are numerous and varied, the same is not true of symptoms which may be summed up in three key signs: pruritus, a burning sensation, and dyspareunia ([7, 15, 18]). Pruritus, in particular, in all its degrees of intensity, duration and spread is not an independent entity but a symptom common to many benign, malignant, local and general diseases and therefore cannot be considered a discriminating diagnostic factor for one condition rather than another ([3, 18]).

Clinical presentations also vary widely, and a dystrophic lesion for example may appear as a red or a white lesion, with a hyperplastic or hypoplastic and atrophic aspect. Moreover, in the overall context of vulvar disease, and specifically in terms of cancer prevention, great importance is attributed to conditions considered at risk, which according to most workers ([1, 4, 5, 6, 11, 14, 15]) are especially hyperplastic and mixed forms of vulvar dystrophy, acuminate condylomas, chronic vulvo-vaginal herpesvirus infections ([9, 10, 17]) and some sexually transmitted infections such as venereal lymphogranuloma and syphilis ([8, 13, 16]). Other workers ([12]) have also included radio-dermatitis, melanocytic nevus, atypical cheratoacanthoma, and squamous papilloma in this group as precancerous lesions, as well as all patients treated with radiotherapy for vulvar pruritus, immunodepressed patients, and patients with a previous history of genital tract cancer ([2, 6]).

Most attention therefore is given to vulvar pathology in order to identify

Lecture at International Meeting on Gynaecologic Oncology - Venice, April 21st-24th 1985.

among the patients attending the out-clinic those women with lesions at risk who must be treated medically and surgically, and then admitted to long term follow up.

The problem of a correct and adequate classification, which effectively helps the gynecologist confronted with such a multiform pathology, is pressing. Not many schemes have been thus far proposed; only Friedrich and Di Paola - Balina have reported their findings in this not easy branch of gynecology, which illustrates the marginal position of this pathology, so often misunderstood by gynecologists and neglected by dermatologists. For example, in Friedrich's scheme ([7]), vulval disease is divided into two classes, termed "white" lesions and "red" lesions; while this classification avoids useless distinctions, in our opinion, it has oversimplified the problem, since it neglects the most typical feature of vulvar disease, and that is the polymorphism in a single lesion.

Moreover, hyperplastic dystrophy, which Friedrich places in the group of white lesions, not only may appear as a red lesion, a more frequent finding in our opinion, but also as a mixed lesion, with features of both white and red lesions, and therefore cannot be placed only and exclusively in this group. That radio dermatitis and intertrigo are both classified as white lesions is also debatable; acute radio-dermatitis and intertrigo very often have the character and aspect of a red lesion, and this illustrates how a lesion may manifest at different times with different aspects which are not necessarily related in terms of development.

We agree instead with Janovski's scheme, which distinguishes and classifies vulval disease on the basis of the etiology and the antomo-pathologic features of the lesion.

Evidently, it is extremely difficult and complex to classify vulvar disease solely on the basis of morphologic and objective criteria without resorting to personal di-

Table 1. — *Primary cutaneous vulvar disorders.*

Inflammations:
- Intertrigo
- Contact dermatitis
- Psychosomatic traumatic abrasion
- Radio-dermatitis
- Edema traumatic
- Aspecific vulvitis

Infections:
- Bacterial infections:
  - Impetigo
  - Eritrasma
- Viral infections:
  - Herpes Simplex
  - Herpes Zoster
  - Condyloma acuminatum
  - Molluscum contagiosum
  - Venereal lymphogranuloma
- Mycotic infections:
  - Tinea cruris
- Parassitic infections:
  - Pediculosis
  - Scabies

Disorders of melanin pigmentation:
- Vitiligo
- Hypermelanosis

Vulvar dystrophy:
- Lichen sclerosus - atrophicus
- Hyperplastic forms
- Mixed forms

Tumors:
- *Benign tumors*:
- Epithelial:
  - Genital verruca
  - Kerato-acanthoma
  - Nevus
- Connectival:
  - Fibroma
  - Lipoma
- Vascular:
  - Hemangioma
  - Lymphangioma
  - Vulvar venous varicosity
- Cysts:
  - Epithelial cysts
  - Bartolin's cyst
- *Malignant tumors*

Table 2. — *Secondary cutaneous vulvar diseases.*

Skin disorders
- Inflammations:
  - Furunculosis
  - Psoriasis
  - Hydradenitis suppurativa
  - Seborrhoic dermatitis
  - Aphthosis
  - Pemphigoid
  - Bechet's syndrome
  - Lichen planus
- Infections:
  - Viral:
    Varicella
  - Mycotic:
    Phythiriasis versicolor

Systemic diseases
- Syphilis
- Generalized pruritus
- Acanthosis nigricans
- Diabetic vulvitis
- Crohn's disease.

stinctions in a field that is multiform and variable. To further illustrate the complexity of this problem, besides the polymorphism of a single lesion, it is worth noting how etiologically and clinically different lesions may manifest in various stages of their clinical course with similar or identical features. Briefly, pictures such as aspecific vulvitis, psychosomatic traumatic abrasion, contact dermatitis or diabetic vulvitis and pictures of local irritation that may be considered in a context of more generalized pruritus or systemic disease, may resemble localized and early hyperplastic dystrophy especially in the acute phases when edema, erythema and exudation are dominant features.

On the other hand, radio-dermatitis or severe widerspread vulvo-vaginal atrophy as well as long-term dermatosis may often be confused with forms of atrophic dystrophy. The various types of ulcerations, which are objectively similar, should also not be underrated since they may imply numerous phases and aspects of several situations; in the same way, che clinical picture sustained by herpes infection, especially in the very frequently encountered post-vescicular phase, may be confused with inflammatory-irritative vulvar lesions of various origin.

In an attempt to overcome these limits, we propose a classification based on antomo-pathologic and etiologic criteria, which we believe can make up for the deficiencies in the preceding schemes due to an overpersonal approach to the problem.

We first distinguish primary cutaneous vulvar disorders from secondary cutaneous disorders: the former have specific and pathognomic characteristics and do not involve other body sites; the latter are not only and necessarily vulvar but manifest within a contect of systemic or dermatologic disease. These two main pathologic pictures are then sub-classified into inflammatory, infective, dystrophic or neoplastic disorders, which include entirely all "possible and objective" patterns of vulvar pathology.

This approach, in our opinion, overcomes the problem of too rigid schemes which do not sufficiently express and represent this pathology in all its multifariousness. Moreover, dermatologic findings, often and unjustly considered strictly the concern of the dermatologist, are examined as well as internal aspects, in order to stress the multidisciplinary interest of this field.

Table 3. — *Vulvo-vaginal disorders.*

Inflammations:
- Aspecifiic vulvo-vaginitis

Infections:
- Candidiasis
- Trichomoniasis
- Aspecific flogosis

Vulvo-vaginal atrophy

This classification, therefore, permits a more accurate diagnosis of the various vulvar diseases, and distinguishes lesions more specifically at oncogenic risk from those with internal and dermatologic characteristics, in order to establish the most suitable medical or surgical therapy, as well as to identify situations requiring long-term follow-up.

BIBLIOGRAPHY

1) Ambrosini A. *et al.*: *Clin. Exp. Obst. Gyn.*, VII, *3*, 181, 1980.
2) Ambrosini A.: *Eur. J. Gyn. Oncol.*, III, *3*, 214, 1982.
3) Barker L. P.: "Pruritic dermatoses of female genitalia: guide to clinical diagnosis". N. Y. State J. M., 3111, 1967.
4) Becagli L.: *Clin. Exp. Obst. Gyn.*, XI, *3*, 96, 1984.
5) Becagli L.: *J. Gyn. Oncol.*, IV, *3*, 229, 1983.
6) Di Paola G. R.: *Eur. J. Gyn. Oncol.*, *1*, 20, 1980.
7) Friedrich E. G. *et al.*: *Am. J. Obst. Gyn.*, *135*, 8, 1036, 1979.
8) Friedrich E. G. *et al.*: "Vulvar disease Mayor problems in obstetrics and gynecology". Vol. 9, W. B. Saunders Co., Philadelphia, 1976.
9) Josey W. E., Nahmias A. J., Naib Z. M.: *Cancer*, *38*, 526, 1976.
10) Josey W. E.: *Clin. Obst. Gyn.*, *21*, 4, 1053, 1978.
11) Kaufman R. H. *et al.*: *Clin. Obst. Gyn.*, *21*, 1081, 1978.
12) Locatelli F. *et al.*: *Eur. J. Gyn. Oncol.*, IV, 2, 102, 1983.
13) Ridley C. M.: *Clin. Obst. Gyn.*, *21*, 963, 1978.
14) Ridley C. M.: *Br. J. Hosp. Med.*, *30*, 3, 158, 161, 164, 1983.
15) Tovell H. M., Young A. W.: *N. Y. State J. Med.*, *77*, 6, 938, 1977.
16) Woodruff D. J.: *Post. Grad. Med.*, *73*, 232, 1983.
17) Young A. W.: *Med. Clin. N. A.*, *56*, 1175, 1972.
18) Young A. W.: *Rev. Allerg.*, *22*, 648, 1968.