COMMON GENITAL DERMATOSES

Dr Tan Hiok Hee

INTRODUCTION

The external genitalia is a common site for rashes, itching, and minor infections. The various possible causes can be discussed under the following categories:

1. inflammatory plaques and patches,
2. white lesions,
3. erosive lesions / noninfectious ulcers, and
4. skin-coloured papules.

SFP2007; 33(2): 54-55

INFLAMMATORY PLAQUES AND PATCHES

Endogenous eczema

Patients may already have a history of endogenous eczema, or they could initially experience itch that may be caused by a yeast infection, heat, moisture, or any irritant. Scratching produces inflammation that heightens the sensation of itching.

Lichenification occurs eventually. This may be initially difficult to appreciate over the scrotum and labia majora, where the skin is normally thickened and rugated.

Linear and angular erosions caused by fingernails are common. Treatment consists of topical corticosteroids, antihistamines, and avoidance of irritants. Potent topical steroids should be avoided. Secondary infection of excoriated skin may require a course of antibiotics.

Contact dermatitis

Both irritant and allergic contact dermatitis can occur. The most common irritants are soaps, topical medicaments, urine, faeces, and infected or copious vaginal secretions. Irritant contact dermatitis of the genitalia presents with erythema and sometimes, scaling. In severe cases, edema and erosion can occur. An allergic contact dermatitis over the genitalia is morphologically indistinguishable from irritant contact dermatitis. The most common causes are the ingredients in topical medicaments, including preservatives and stabilisers. A patch test may be required to identify the specific allergen. Treatment includes the identification and removal of the offending agent, gentle cleansing with normal saline, and topical corticosteroids.

Lichen planus

Lichen planus of the genitalia can present as well-demarcated, erythematous flat-topped papules, or as an erosive disease. Reticulate striae can sometimes be discerned on the surface of the lesions. There may be associated itch. Topical corticosteroids are used.

Psoriasis

There are usually manifestations of psoriasis elsewhere on the body. Psoriasis affecting the genitalia often does not have the classical silvery scales seen in other areas because of the inherently moist nature of skin in this area. A mild topical corticosteroid is used. Patients should be told to minimise irritation over the area.

Fungal infection

Tinea cruris is caused by dermatophyte infections and occurs on the drier, keratinised skin. Candida can cause a balanitis as well as vulvitis, and generally spares the drier areas.

Plasma cell (Zoon's) Mucositis

This presents as a balanitis in males. It appears as a moist, shiny, erythematous, well-demarcated plaque on the glans penis. It is benign and can be treated with a topical corticosteroid. However, a biopsy is often required to differentiate it from erythroplasia of Queyrat. Nearly all cases occur in uncircumcised males.

WHITE LESIONS

Lichen sclerosus et atrophicus

Lichen sclerosus et atrophicus (LSA) (Figure 1) presents as ivory or porcelain-white, smooth, and atrophic areas on the genitalia. The etiology is unknown, and it may be present for years before detection. It is often asymptomatic, but can present with itch, pain, dysuria, dyspareunia, and phimosis and painful erections. Treatment is difficult and usually includes the use of potent topical or intralesional corticosteroids, as well as topical testosterone propionate ointment. Circumcision may relieve symptoms in males.

Postinflammatory hypopigmentation

This can follow any inflammatory disorder and does not require any specific treatment.

Vitiligo

These are sharply demarcated areas of depigmentation. Treatment consists of mild topical corticosteroids.

NON-INFECTIOUS ULCERS / EROSIVE DISEASES

Fixed drug eruption

The acute lesion is a well-demarcated erythematous plaque,

TAN HIOK HEE, Head, Department of STI Control, National Skin Centre

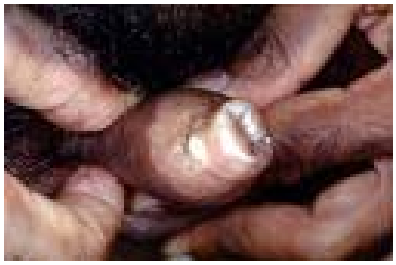

Figure 1. Lichen sclerosus et atrophicus with phimosis

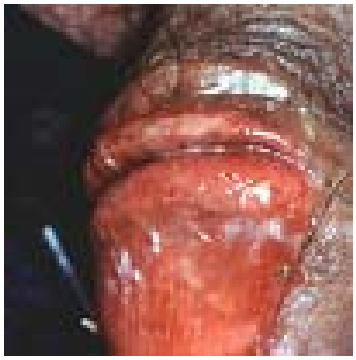

Figure 2. Fixed drug eruption

sometimes with blistering. A dark brownish or dusky pigmentation may be prominent as it resolves. Lesions are usually solitary, but may be multiple. Common causes include antibiotics, analgesics / NSAIDS, and anticonvulsant drugs.

Pemphigus vulgaris

This is usually associated with oral erosions and evidence of disease elsewhere, but occasionally may be localised. Diagnosis requires a biopsy for both histology as well as immunofluoresence.

Apthous ulcers

Patients with Behcet's disease classically present with both oral and genital ulcers. The disease can also affect many other organ systems. Genital aphthae are often multiple and painful. Infective causes of genital ulceration should be actively excluded if other features are absent.

SKIN COLOURED PAPULES

Genital warts

Condylomata acuminata is a sexually transmitted disease caused by the human papillomavirus (HPV). In women, genital warts may affect any part of the vulval or perineal skin, and may also occur within the introitus, in the vagina, and on the cervix. In men, scattered, flesh-coloured, smooth, or verrucous papules are seen on the glans penis, penile shaft, and scrotum and perianal area. Treatment options include cryotherapy, electrocautery, and chemical applications of podophyllin or podophyllotoxin and immune response modifiers, such as imiquimod.

Molluscum contagiosum

These can be sexually transmitted and present as discrete, shiny, skin-coloured papules with a central umbilication. They are usually treated with destructive methods, such as cryotherapy and trichloroacetic acid (TCA) application.

Scabies

Scabies can be sexually transmitted. Scabetic papules and nodules commonly occur on the genitalia and are often excoriated. Nocturnal itch is characteristic. After appropriate treatment, post-scabetic nodules may persist for weeks and are treated with topical corticosteroids.

Pearly penile papules

These present as two or three rows of uniform, flesh-coloured papules running circumferentially around the corona. Onset is typically noted in the 20s and 30s. The patient should be assured that the lesions are not infectious, and that no treatment is required.

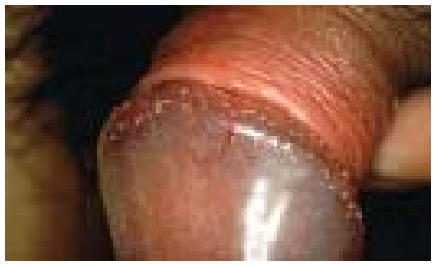

Figure 3. Pearly penile papules

Ectopic sebaceous glands (Fordyce spots)

These are uniformly distributed, 1-2 mm flesh-coloured or yellowish papules that occur on the penile shaft as well as the labial surfaces. No treatment is required.

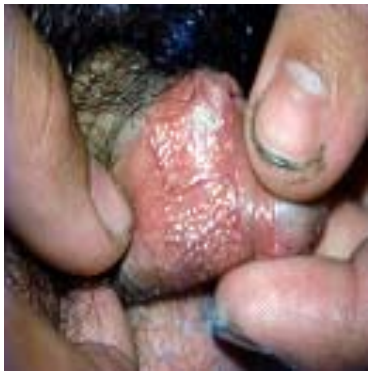

Figure 4. Fordyce spots