OUR EXPERIENCE IN THE TREATMENT OF VULVAR SCLEROUS LICHEN

S. CONFORTI - C. DI SERIO - P. CARTOCCIO - M. TOTARO
P. MASTRANTONIO

University of Studies of Naples - Faculty of Medecine and Surgery
Institute of Gynecology and Obstetrics and Physiopathology of Human Reproduction
(Director: Prof. U. Montemagno)

Summary: The Authors refer to two cases of sclerous lichen treated with medical therapy (Vit. E, topic Betametasone and lavage with K-permanganato). They conclude that when there is no association with other dystrophies of the vulva defined precancerous, the medical therapy is the only one that supplies satisfactory results.

Included in the group of vulvar dystrophies sclerous lichen represents a specific morbid entity of unknown etiology. In fact both its microscopic and macroscopic aspects and its course are characteristic. Identical lesions may appear in any part of the body, therefore its development does not depend on any specific local ambient ([1, 2]). When it strikes the ano-genital area it can involve any part of the vulva, the cutis of the inguinal folds, the posterior perineum as far as the anus ([2, 3]). The percentage of the ano-genital area reported in Literature are: both sides of the vulva 81%; labia minor 68 %; clitoris 51 %; perineum 40 %; vestibular fossa 36 %. This lesion may also develop on the trunk, the shouldres, the forearm, beneath the breasts and the underarms ([2]).

Women are attacked more than men (10:1) and the highest incidence among women is observed in the perimenopausal age; young women of prepuberal age and children may also be attacked, besides post-menopausal women ([2, 5, 6]).

In the beginning the lesions appear like white papule-maculae, flat and irregularly outlined. Usually these dissolve later and form plaques. Occasionally the labia minor and the clitoris disappear completely as a result of the atrophy. The clitoris and periureteric regions can, besides, be sites of bleeding lesions. The lesions may delay synechia, with stenosis of the introitus and its consequences (pain and the impossibility of having sexual relations). Finally, at the cutaneous and mucous level, areas of telangectasia and small hematomas may be noted ([2, 6]).

From the microscopic point of view hypercheratosis is present; we have epithelial thinning with flattening of the papillae, vacuolation of the cytoplasm of the low-stratum cells, and attenuation of the follicles. Beneath the epidermis there is a tissue zone similar to collagen, red in colour, which is relatively deprived of cells and which may be the site of edema; in such a case the elastic fibres will be lacking. Beneath this homogeneous tissue, in the middle of the derma, lymphocytes and rare plasma cells are found ([2]).

The diagnosis of sclerous lichen is histological. The therapeutic approach to this dystrophy is prevalently medical and depends, above all on the eventual association with other vulvar dystrophies ([7]).

In the Gynecologic, Obstetric and Physiopathologic Institute of Human Reproduction of the II Faculty of Medecine and Surgery of Naples we observed two cases of sclerous lichen (fig. 1) treated with medical therapy for a year, making a first check at three months (fig. 2) a check at

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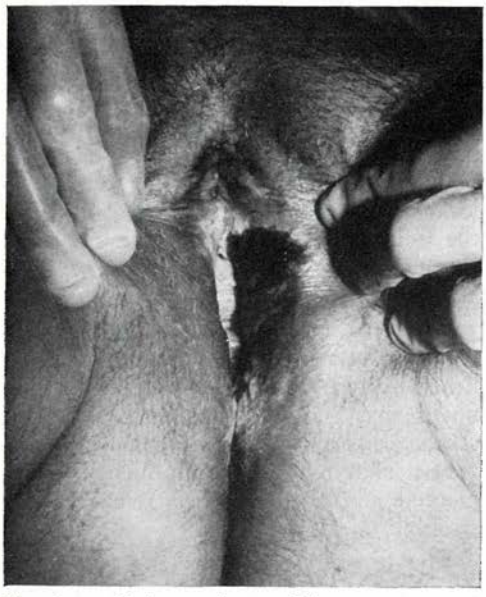

Fig. 1. — *Vulvavr sclerous lichen.*

6 months and another at a year from the first observation.

The therapeutic plan was: for the first six months oral administration of Vit. E * 800 mg/die in two administrations, and two topic administrations of betametason cream daily in cycles of twenty days, with ten-day intervals of rest. Only in the first cycle did we associate washing with permanganate of potassium. In the six following months we prescribed Vit. E, 800 mg/die administered twice daily by cycles of 15 days per month.

The subjective symptomology in both cases already showed regression after ten days of treatment, without reappearing up to the last check. Objectively the lesion regressed after three months, and a year after the first observation no vulvar lesion was machroscopically recognisable.

CASE REPORTS

Case No. 1. – Patient M. T.; 51 years old; profession, housewife; blood group A, Rh positive.

At the out-patients' examination the patient spoke of pruritis and a vulvo-perineal burning sensation of four month's duration.

From memory the patient referred to menarch at fifteen years and regular menstruation for all subsequent characteristics. She had had syphilis in 1959, which regressed under treatment. Three pregnancies were carried to full term and normally delivered, and there were three miscarriages.

Objective report: extensive leukoplakia in the vulvar and perineal region, with ulceration of the medial surface of the major and minor labia. Body of the uterus of normal volume, in axis, mobile. No appreciable annexes. Specular examination portio epithelialised.

Hematochemical examination was within the norm.

Colposcopy: slight eversion of the endocervical mucos. Glandular sequelae of open metaplasia were noted with acetic acid. The portio was dystrophic, iodine weak.

The patient underwent cavitary exploration and vulvar biopsy, which examinations revealed sclerous lichen.

Case No. 2. – Patient P.T.; 53 years old; profession: housewife; blood group 0, Rh positive.

At the out-patients' examination the patient spoke of pruritis and a burning sensation in the vulva of about eight month's duration.

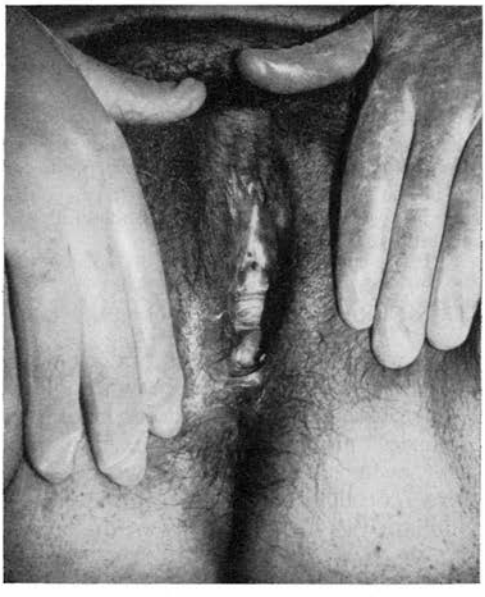

Fig. 2. — *Vulvar sclerous lichen.*

* Royal E - Eurofarma s.r.l.

Fig. 3. — *Vulvar sclerous lichen.*

From memory the patient referred to menarch at eleven years and regular menstruation for all subsequent characteristics. Three pregnancies were carried to full term and normally delivered, and one miscarriage.

Objective report: leukoplakia in the right labium majus with ulceration at that level. No appreciable annexes. Specular examination: portio epithelialised.

Hematochemical examination within the norm.

Colposcopy: slight eversion of the endocervical mucus. Dystrophic iodine-weak portio.

The patient was submitted to cavitary exploration and vulvar biopsy, which histological examination revealed sclerous lichen.

CONSIDERATIONS

As we have already referred, sclerous lichen is a pathology of unknown etiology. Numerous clinical observations, laboratory enquiries and histological examinations have been made which, however, have thrown no light on the problem. A certain familiarity in the appearance of the lesions has been noted ([2]). Inadequate estrogen production or even inadequate local reactivity to such hormones have been called in question ([6]); it has been noticed that sclerous lichen sometimes improves in pregnancy, although no success has been obtained with estrogenic therapy, either local or general ([7]). Partial resolution of the lesions by topic treatment with testosterone, a local enzymatic deficiency, has also been described ([3, 6]).

Attempts have also been made for transplanting healthy tissue onto a sclerous lichen surface and vice versa, and it was noted that the normal skin aquired the characteristics of sclerous lichen and vice versa; skin with sclerous lichen transplanted into other zones remained dystrophic ([8]).

The direction being taken today is to proceed to aimed multiple biopsy in colposcopy. In cases where there is no association of other dystrophies defined as pre-cancerous, medical therapy is the only one to give satisfactory results. Only when other lesions described as pre-cancerous are to be associated with vulvar sclerous lichen is surgical therapy advisable, which, not only does not prevent eventual relapses, but at times may worsen the course of the disease.

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CERVICAL INTRAEPITHELIAL NEOPLASIA. THERAPEUTICAL TRENDS

G. L. GRISMONDI - G. P. MASIN - L. SCIVOLI - A. MARINI
Division of Obstetrics and Gynecology - Hospital of Padua (Italy)

Summary: CIN is an intraepithelial alteration of unpredictable development. Its presence may require in the case of CIN 1 only periodical colposcopy and cytology, while in the presence of CIN 2 or CIN 3 a complete removal of the lesion is necessary. Surgery must be "personalized". Sometimes when the excision is large, it may be necessary to follow with hemostatic suture in order to reconstruct the portio.

Cervical Intraepithelial Neoplasia represents a group of uni-or multicentrically originated modifications of unpredictable development ([3, 7, 13]). Their presence, identified by colposcopy, cytology and single or multiple directed biopsy, requires careful evaluation. In presence of CIN 1 periodical colposcopic and cytological tests will be sufficient. In the presence of CIN 2 or CIN 3 it is necessary to excise the lesion completely ([2, 8, 9]).

Before dealing with the therapeutic problem it will be suitable to mention some distinctive characteristics of these lesions.

The zone of possible insurgence is limited inside the cervical channel by the histological os, and outside by the squamo-columnar zone.

In pre-menopausal women the histological os is below the anatomic internal os, and the squamo-columnar zone is very often located clearly on the esocervix. As years go by, such an area is susceptible of changes gradually shifting into the inner cervix, thus the histologic os in menopausal or older women may be located upon the anatomic os, and the squamo-columnar junction very often near the external os.

Therefore it happens that: a) in younger patients the more the lesion extends externally the less it will extend inwardly; b) in older patients a lesion generally located externally will more likely shift up inside the cervix ([10, 11, 15, 17]).

As to the therapeutic line it must be considered that the more the cylinder epithelium is externally evident and the younger the patient is, the less the CIN will extend up into the cervix towards the internal anatomical os.

Of the several physical methods available at present for the treatment of such lesions (cryosurgery, diathermocoaugulation, laser therapy) the best, now seems to be laser therapy, though it has some drawbacks such as the high initial cost (not entirely justified if compared with the results achieved by other methods) and a percentage of about 10% of relapses ([2, 16]).

Surgery must be also considered, which means the complete excision of the neoplastic tissue. In the presence of CIN 2 or CIN 3 we choose a variable-size conization. But in menopausal and older patients with lesions located mostly on the cervix, and with the internal genitalia showing a more or less involutive process, a cylinder excision (5 mm deep by scalpel) of the whole tissue around the cervix and the portio is considered more suitable: this will help indicate histologically the possible invasion of glandular crypts ([17]).

Conization and cylinder excision of the tissue around the cervix, if correctly performed, can be considered both diagnostic and therapeutic surgery.

Surgery must be " personalized ". The size and shape of the cone must be determined according to the size and location of the lesion, again indicated by enlarged colposcopy. So the cone will be superficial and affect only the lower part of the cervix when the lesion is entirely visible, while it will be deep, with the apex high into the endocervical canal, when part of the lesion extends upwards into it ([2]).

The section is followed by quick healing without further complication if surgery is followed by appropriate treatment. Sometimes when the excision is large an hemostatic suture, reconstructive of the portio, may be required. Various restorative systems have been devised, each proving more or less effective. We follow an original procedure, quick and simple, which allows a good hemostasis and leaves the regenerated squamo-columnar line accessible for the consequent follow-up.

Such therapeutic trends are supported by the experience acquired over the years, and the help given in the follow-up by enlarged colposcopy and colpo-cytology which, together, being complementary, provide a far more correct diagnosis in the screening of cervical lesions ([8]).

The surgical approach must be chosen every time we consider the link, prevention-prophylaxis-treatment of CIN, sustained also by the data provided by recent Literature. These data show how the percentage of relapses in CIN are fewer on regenerated epithelia after conization than on regenerated ones after different methods ([1, 4, 5, 6, 7, 12, 14]).

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