ABC of Sexually Transmitted Diseases

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GENITAL SKIN AND OTHER CONDITIONS

Lichen sclerosis et atrophicus
Lichen planus
Psoriasis and dermatitis
Dermatitis
Trauma
Lymphocele
Peyronie's disease

Several skin and other conditions may affect the genital area but are not sexually transmitted. Because of their anatomical site patients with these conditions seek medical advice in the fear that they have acquired a sexually transmitted disease.

Lichen sclerosis et atrophicus

Lichen sclerosis et atrophicus is a rare disease that may occur in any age group but usually in those aged 30-60 years. The aetiology is unknown. The skin in the affected areas is atrophic, with white plaques and eventual contraction of tissues. When localised to the male genitals the condition is called balanitis xerotica obliterans. In men the major sites affected are the glans penis, urethral meatus, with extension into the terminal urethra, and the prepuce. In women the changes are found on the vulva, vaginal introitus, clitoris, perineum, and anus.

Clinical features—Men with this condition may present with penile pain and irritation, urethral discharge, and in the later stages of the disease phimosis and urinary obstruction. Women may notice itching of the vulva, sometimes associated with superficial dyspareunia. The dyspareunia may also be due to lesions on the vaginal introitus. The condition should not be forgotten as one of the causes of persistent pruritis vulvae.

On examination white plaques may be seen on the glans and prepuce, often encircling the end of the foreskin, which may be difficult to retract. The urethral meatus may also be surrounded with a small collar of white tissue extending a small distance up the urethra so that the first centimetre is pipe stem hard and the meatus very small in size. In women the same type of plaques may be found on the vulva, and the skin may often appear thin, with a parchment quality, and shiny. These skin changes may affect other areas of the body. In some cases erythema, purpura, excoriations, blister formation, and pigmentary changes may also be seen.

Diagnosis and treatment—The diagnosis should be confirmed by biopsy and histology. The aim of treatment is both to relieve the symptoms and to slow down the disease process. This may often be achieved by the application of a potent topical corticosteroid cream twice a day. In addition the skin may be moisturised and softened by the use of aqueous cream BP as a soap substitute and moisturising cream. Long term follow up is recommended since the lesions, particularly the phimosis and meatal narrowing, may progress and require dilatation, meatotomy, or circumcision. Neoplastic changes (squamous cell carcinoma) of the lesions may occur later.

Lichen planus

Lichen planus affects the genital area and other parts of the body and may present with mauvish papules or plaques. Usually the patient complains of itching at the site of the lesions, which occur on the glans penis, shaft, foreskin, scrotum, vulva, and perianal areas. The lesions may be papular or annular and often are white, particularly if situated in moist parts of the body. They may also be found in extragenital areas such as the arms, flexor aspects of the wrists, legs, and buccal epithelium. The disease is eventually self limiting but some relief can be obtained with a topical corticosteroid cream or ointment.

Psoriasis and dermatitis

Both psoriasis and dermatitis may affect the genital area either alone or in conjunction with widespread disease elsewhere. The lesions of psoriasis may be found on the penis, scrotum, vulva, groins, perineum, and perianal areas. These are often similar to the scaly red psoriasiform lesions found in other parts of the body. They may, however, lose their scales if present in moist parts of the genitalia and appear red and shiny. The condition has to be differentiated from tinea cruris, candidiasis, lichen planus, keratoderma blennorrhagica, erythroplasia, and seborrhoeic or contact dermatitis. In relation to the sexually transmitted diseases the most important condition that may look the same is the scaly papular rash of secondary syphilis. The presence of psoriasis in non-genital areas and the nails will help to exclude syphilis, however, though patients with psoriasis may also have syphilis. Psoriasis and dermatitis are not contagious but in patients presenting with skin conditions affecting the genital area it is essential to bear in mind that such conditions could be sexually acquired and to examine the entire surface of the skin. A full sexual and genitourinary history must be taken and microbiological and serological tests for syphilis performed.

The treatment of psoriasis affecting the genital region is the same as that for the condition in general—with coal tar preparations and corticosteroid ointments.

Dermatitis

There are two common types of dermatitis of the genitalia—seborrhoeic or contact. Seborrhoeic dermatitis is only rarely localised to the genital area, and other areas such as the scalp, ears, chest, axillae, and back may be affected. The lesions are red and scaly and not well circumscribed. Again all skin areas must be examined. The condition is not related to any known precipitating factors and in this way differs from contact dermatitis. On careful questioning patients with contact dermatitis may relate their symptoms to the use of particular soaps, deodorants, forms of clothing, medicaments, and occasionally the sheath or to friction and trauma. They may complain of irritation possibly associated with swelling. Unless the patient is examined during the acute phase there will be little to see apart from mild erythema. Should the contact dermatitis continue, however, thickening and scaling of the skin may occur. Patch testing is likely to be needed to confirm the diagnosis if there is a possibility of an allergic contact dermatitis.

The symptomatic treatment of dermatitis is usually with topical corticosteroid preparations. In contact dermatitis the causative agent should be removed.

Trauma

• Deliberate	Atypical lesions
	Bizarre appearance
	Accessible to patient's hand
	Psychiatric assessment
• Accidental	Atypical lesions
	Mechanical instruments
	Surgical repair (occasionally)

Several genital conditions, such as trauma, lymphocele, and Peyronie's disease, may be alarming both to the doctor and the patient. Trauma to the genitalia may be purposely or accidentally inflicted. Purposely self inflicted trauma (dermatitis artefacta) should be suspected when atypical lesions are present. They look bizarre, do not resemble any known condition, and are found in areas accessible to the patient's hand. The patient, who usually denies the aetiology, is often mentally unstable, and psychiatric assessment and help are needed.

The number of cases of accidental self inflicted genital trauma has risen in the last few years, because of the increased use of sexual aids and the more overt expression and possibilities for sadomasochistic sexual practices. These patients are not unstable. Trauma can follow anal intercourse using mechanical instruments, penile rings, or insertion of the whole forearm into the rectum. The reason for suspecting trauma is that the anal, rectal, and penile lesions tend to be atypical and unlike infective causes of ulceration, balanitis, etc. The lesions usually heal spontaneously but occasionally surgical repair is required.

Lymphocele

Lymphocele is a totally benign condition but very alarming to patients. The patient notices a cord like swelling around the coronal sulcus. It is sometimes accompanied by lymphangitis of the dorsum of the shaft. This may follow prolonged or particularly energetic sexual intercourse or masturbation, but this is by no means an essential prerequisite. The condition arises as a result of temporary obstruction of the lymphatics. No treatment is required, apart from reassurance and the explanation that it will resolve itself, which it does within a few days.

Peyronie's disease

Aetiology unknown
Pain and bending of penis
Spontaneous resolution
Surgery /steroids

Peyronie's disease is an alarming and distressing condition in which the patient first notices pain and permanent bending of the penis, particularly when erect. This is due to chronic fibrosis of the intercavernous septums of the penis. The condition may occur in association with Dupuytren's contracture. The aetiology is unknown. It usually occurs in middle aged men. On examination a hard ridge or lump of fibrous tissue may be felt on the dorsal aspect of the shaft of the penis and occasionally on the ventral and lateral aspect.

A few cases resolve spontaneously, which makes treatment claims difficult to assess. Surgical excision of the plaques is sometimes recommended, as are injections of the tissue with hydrocortisone.

Psychological effects

Genital conditions	?	Psychological sequelae ?
Lichen sclerosis et atrophicus		
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Doctors treating patients with disfiguring lesions of the genitals should not forget the profound psychological sequelae that may be associated with them. Patients often do not show their concern and practitioners may need to take the initiative in discussing these aspects and giving reassurance. If this is not possible or the condition is permanent psychiatric support may be needed.

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