LICHEN SCLEROSUS ET ATROPHICUS OF THE VULVA
(A case report with a brief review of literature)

CHETAN OBERAI,* D. J. A. REBELLO † AND V. D. PAREKH ‡

Summary

Lichen Sclerosus et Atrophicus (LSA) involving the Vulva of a 12 year old female is reported. The sites of involvement are the labia majora and minora only and an unusual feature of this case was the white spongy appearance of the lesions which simulated moniliasis.

Although LSA was first described by Hallopean in 1889 as a sclerosing type of lichen planus[1] Ormsby and Mitchell in 1922 were probably the first to use the name Lichen Sclerosus et Atrophicus[2]. It is now generally agreed that the various clinically similar conditions described in the past as 'Card like scleroderma of Unna', 'Dermatitis lichenoides chronica atrophicans of Csillag', 'white spot disease of Johnson & Sherwall & Meischer', and 'Lichen albus of Von Zumbusch' are all identical conditions which are now termed as lichen sclerosus et atrophicus.

The aetiology of this condition is unknown[3] and it probably has no racial predilection[4]. Although this entity is not usually familial, Barker and Gross[5] have reported this in a mother and daughter and also in two sisters. No area of the body is immune to this disease[6]. The male to female ratio is 1 : 6[5] and the disease is uncommon in children. Anogenital region is the most frequently affected[4,6]. This impression is corroborated by the following report in the world dermatological literature.

Wallace & Whimster	60%
Montgomery	60%
Clark & Muller	58.3%
Chernosky	35%
Dogtiotti	25%

In this entity there is no systemic involvement nor is the disease related to any internal disorder[5].

Case Report

A girl aged 12 years was referred to the skin outpatient's department of the J. J. Group of Hospitals by the department of Gynaecology for a lesion on the Vulva.

On interrogation the patient complained of itching in the genital region of six months' duration. On examination the inner aspects of the labia majora and the labia minora showed white spongy lesions. (Fig. 1 Page No. 289) There were no excoriations despite the history of pruritus. There were no changes in the perineum or the anal region. The rest of the skin surface was

* Reader
† Hon. Associate Professor
‡ Hon. Professor and Head
Dept. of Dermatology & Venereology
J. J. Group of Hospitals and
Grant Medical College, Bombay. - 400008.
Received for publication on 9—12—1976

normal. Physical examination did not reveal any abnormality. The patient was well nourished and in good health.

Blood VDRL was non-reactive and Urinalysis was normal. Scrapings for fungus studies revealed candida albicans. A biopsy of the lesion was taken which showed the histopathological features of LSA. (Fig. 2 Page No. 289)

Discussion

The vulval lesion appeared white and spongy, and gave the impression of either monilial vaginitis or white spongy nevus. The fungus studies revealed candida albicans and hence the patient was treated with Mycostatin ointment topically for about a fortnight. As there was no appreciable change in the appearance of the lesion a biopsy was done. The histopathological features showed typical changes of LSA. Hence this is an unusual case of LSA of the vulva where only the labia majora and labia minora were affected. Although the lesion is bilateral and symmetrical there is no extension of the lesion posteriorly involving the perineum and encircling the anal orifice in a characteristic hour glass pattern as reported by Barker and Gross[5] and Chernosky[6]. Moreover Wallace and Whimster report that in many cases of LSA of the vulva, the skin of the trunk and extremities is not involved. There was neither atrophy nor stenosis in our patient.

The patient was asked to apply Kenalog-s cream three times a day. Within four weeks there was considerable improvement. The spongy appearance cleared up but the depigmentation remained. At the present time corticosteroids used topically seem to be the most effective mode of therapy for this condition[2,6].

Regarding the prognosis of this condition the lesions invariably involute completely in children as opposed to adults in whom, parchment like atrophy is the usual sequela[7].

Acknowledgments

We are indebted to Dr. K. D. Sharma, the Dean of the Grant Medical College and J. J. Group of Hospitals for permission to publish this case report.

REFERENCES

1. Bedi BMS and Arunthathi S : Lichen Sclerosus et Atrophicus, Indian J Derm Ven 41 : 49, 1975.
2. Apisarnthanarax P, Osment LS and Montes LF : Extensive Lichen Sclerosus et Atrophicus in a 7 year old boy, Arch Derm. 106 : 94, 1972.
3. Rook A and Wilkinson DS : Text book of Dermatology, Blackwell Scientific Publications, Oxford 1972.
4. Clark JA and Muller SA : Lichen Sclerosus et Atrophicus in children, Arch Derm, 95 : 476, 1967.
5. Barker LP and Gross P : Lichen Sclerosus et Atrophicus of the female Genitalia, Arch Derm, 85 : 362, 1962.
6. Chernosky ME, Derbes VJ and Burks JW: Lichen Sclerosus et Atrophicus in children, Arch Derm, 75 : 647, 1957.
7. Fagan FJ : Discussion Scientific Articles, New York J Medical, 55 : 2914, 1955.
8. Dogliotti M, Bentley-Phillips LB and Schmaman A : Lichen Sclerosus et Atrophicus in the Bantu, Brit J Derm, 91 : 81, 1974.
9. Gade M : Lichen Sclerosus et Atrophicus of the Vulva. Acta Derm-Vener, 39 : 127, 1959.
10. Mulay DN, Mehta JS and Ahuja BB : Lichen Sclerosus et Atrophicus in a child, Indian J Derm Ven. 34 : 45, 1968.