MedCrave
Step into the World of Research

MOJ Clinical & Medical Case Reports

Case Report

Open Access

CrossMark

Vulvar adhesion in lichen sclerosus and atrophic, about a case

Summary

This is a 58-year-old patient who came to the clinic due to droplet urine and pruritus of 2 weeks of evolution, was evaluated by urology who presented total closure of the urethral and vaginal meatus due to adherence synechiae, paraclinical indications and evidence of an infection of the upper urinary tract, indicating intravenous antibiotic therapy, and later suggesting surgical resolution of the ureterovaginal fistula. She decides to consult another specialist in regenerative gynecology or therefore decides to treat vulvar adherenciolysis with Diode laser associated with Exosomes with complete resolution of symptoms and satisfactory evolution.

Keywords: vulvar atrophic lichen sclerosus, vulvar dermatosis, diode laser, exosome

Volume 12 Issue 4 - 2022

Renaud Ajakaida
Especialista en Ginecologia y Obstetricia, Ginecologia Regenerativa Funcional y Estética,Venezula

Correspondence: Renaud Ajakaida, Especialista en Ginecologia y Obstetricia, Ginecologia Regenerativa Funcional y Estética, Barquisimeto, Estado Lara, Email ajakaidarenau.tv@gmail.com

Received: December 04, 2022 | **Published:** December 15, 2022

Introduction

Lichen sclerosus and atrophic vulvar is a dermatosis, whose onset is silent and progressive, its diagnosis is generally late, it takes at least 10 years and 3 or 4 specialists to reach it. Its clinical manifestations are varied, from hypo or hyperpigmented lesions that start in the vulva, include the labia minora, perineum, and compromise the perianal region in its greatest percentage. Its clinic is manifested by vulvar pruritus that improves with steroids in most cases, however, in a large percentage its use exacerbates the symptoms associated with urogenital atrophy.

In 30 percent of cases, it can have extragenital manifestations in the lower limbs, trunk, and buccal mucosa. Its evolution is chronic and silent, reaching the labia minora, causing adherence of the labia minora, with phimosis of the clitoris, and closure of the entrance to the vaginal canal and/or urethral meatus. Its diagnosis is not only clinical, it must be associated with histology, since we know that 3% can become malignant. The literature coincides in a proportion of 1 in 30 women, however, these underdiagnosed risk factors are related to local estrogen deficiency, so their incidence is found in two groups of prepubertal age and menopause, however, today it is found in all age groups.

Although the term atrophy has been applied to these lesions, some studies have indicated that the thinned epithelium is not metabolically inactive. The use of ultrapotent topical steroids for VLS has now been accepted for first-line treatment of VLS in both children and adults. The treatment of choice in these pathologies when it does not respond to local steroids is surgical vulvectomy, however with the advent of new non-invasive techniques associated with EBD, such as lasers that allow cutting, dissecting, coagulating and photo vaporizing, allowing dissection of tissues better than with a scalpel, likewise the use of stem cells today in regenerative gynecology provides angiogenic effects in the case of pathologies associated with dystrophy with very good aesthetic, regenerative and functional results.

Presentation of the case

Female patient, years old, Caucasian, with no history of interest, menopause at 46, hysterectomized, complained of vulvar itching and progressive vaginal dryness, recurrent urinary tract infections, and decreased urinary flow that worsened in the last two weeks to the point of dribbling (Figure 1). She went to her gynecologist on several occasions with symptomatic treatment without improvement.[1-7]

Physical exam

Hypopigmented lesion that covers the inner edge of the labia majora, introitus and median raphe, with loss of anatomical configuration, and fusion of the labia majora and minora with total closure of the vaginal canal and urethral entrance, it was classified as absent vulvar architectural change (without scars), mild (minor labial fusion, adhesion and/or reduction), moderate (loss of the labia and/or partial concealment of the clitoris), or severe (complete loss of the labia, concealment of the clitoris and narrowing of the introitus) (Figure 2).

A biopsy is taken in the vulvar region in 2 points whose histological report is lichen sclerosus (figure 3) and atrophic vulvar, in the office after infiltrative local anesthesia with 2% lidocaine, infiltration of the area to be treated is performed and at the same time placement of Exosomes (cells mother of the umbilical cord) are maintained for 3 hours and 6 hours, said area to proceed to vulvar adherenciolysis with a 980nm diode laser with a 600 micron fiber at 2 w of power, in continuous mode. in controls every 72 hours with massage with ozonated oil and placement of Exosomes on two subsequent occasions, surveillance and follow-up for 45 days until complete healing. During her postoperative period, vaginal leds were indicated in the external zone of the vulva and then introitus.

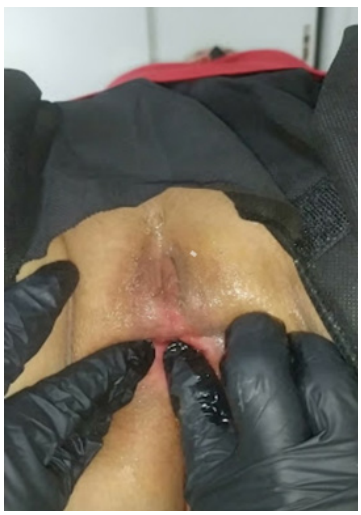

Figure 1

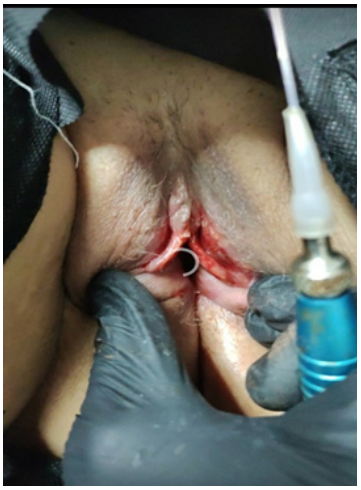

Figure 2

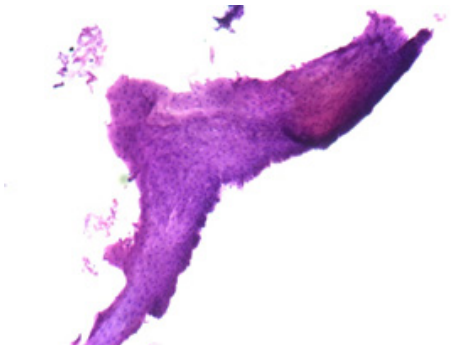

Figure 3

Complementary exams

Profile 20 (complete hematology, glycemia, urea, creatinine, urine test, cholesterol, triglycerides within normal limits. Positive urine culture for *E. coli*. Treatment: antibiotic therapy for urinary tract infection.

Discussion

Vulvar dermatoses tend to be underdiagnosed, and the skin of the vulva can be the seat of at least a dozen of them, exacerbated by chemical agents, trauma, and local estrogen deficiency. Atrophic lichen sclerosus usually appears in the 4th decade of life, and must be diagnosed in its early stages so that its progression is not torpid and impairs quality of life and sexual function. Although the procedure for severe cases is surgical, we believe that the use of tools such as lasers allows the formation of collagen that does not heal and treatment and management at the office level with minor risks, associated with platelet growth factors or Exosomes, in such a way that all the clinical symptoms that lead to sexual dysfunction are improved.

We conclude that the advance in regenerative gynecology allows the adaptation of techniques and technologies to various pathologies, achieving the restoration of the regenerative and functional point of view at the level of the consultation.

Acknowledgments

None.

Conflicts of interest

Authors declare that there is no conflict of interest.

References

1. Kunstfeld R, Kirnbauer R, Stingl G, et al. Successful treatment of vulvar lichen sclerosus with topical tacrolimus. *Arch Dermatol*. 2003;139(7):850–852.
2. Lorenz B, Kaufman RH, Kutzner SK. Lichen sclerosus. Therapy with clobetasol propionate. *J Reprod Med*. 1998;43(9):790–794.
3. Fischer G, Spurrett B, Fischer A. The chronically symptomatic vulva: aetiology and management. *Br J Obstet Gynaecol*. 1995;102(10):773–779.
4. Oberfield RF. Lichen sclerosus et atrophicus and kraurosis. Arch Drem. 2000;83:806.
5. Lorenz B, Kaufman RH, Kutzner SK. Lichen sclerosus: therapy with clobetasol propionate. *J Reprod Med*. 1998;43(9):790–794
6. Dalziel KL, Wojnarowska F. Long-term control of vulvar lichen sclerosus after treatment with a potent topical steroid cream. *J Reprod Med*. 1993;38(1):25–27.
7. Kurman R. *Blaustein's Pathology of the female genital trac*. 4th ed. New York: Springer-Verlag; 1994.
8. López LP, Ruíz A. *Hombre con Liquen escleroso perianal tratado con Láser CO2 y Plasma rico en plaquetas*. Dermitek; 2019.

Citation: Ajakaida R.Vulvar adhesion in lichen sclerosus and atrophic, about a case. *MOJ Clin Med Case Rep.* 2022;12(4):65–66.
DOI: 10.15406/mojcr.2022.12.00423