Discovered: Vulvar Subacute Atopic Dermatitis

BY NASEEM S. MILLER

Subacute atopic dermatitis of the vulva has been described for the first time by Dr. Albert Altchek, clinical professor of obstetrics and gynecology at Mount Sinai School of Medicine, New York, according to the physician.

Atopic dermatitis is a clinical diagnosis, according to Dr. Altchek. "There's no corresponding biopsy."

His findings are based on his observations of a large number of the same girls over a long period of time at three separate clinics as well as his continuing private office consultation, which he presented at the 15th Annual Postgraduate CME Course on Pediatric, Adolescent, and Young Adult Gynecology held at New York's Mount Sinai Hospital.

He also has written a chapter on the topic in "Pediatric, Adolescent, & Young Adult Gynecology" (Oxford: Wiley-Blackwell, 2009), edited by Dr. Altchek and Dr. Liane Deligdisch.

The symptoms include recurrent itching, redness, fissures, and vulvar dysuria. Diagnosis of vulvar atopic dermatitis includes gathering a family history of allergies, asthma, hay fever; looking at the past history of the patient; and conducting a physical examination starting from the head, he said.

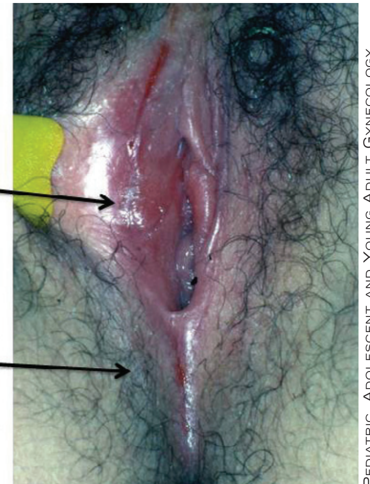
Atopic dermatitis fissures are symmetrical and narrow, and look as if they were "made by an artist with a scalpel," he said. The hymen is intact. In early stages, vulvar atopic dermatitis' most pronounced part is bilateral symmetrical fissures between labia minora and majora. Sometimes the fissures are deep and may cause bleeding. In addition, there is a midline sagittal perineal fourchette to the anterior anus at 12 o'clock, where there is usually a papule. The latter is the result of an anterior anal fissure with red inflamed edges. When red and present for a long time, there is severe permanent swelling simulating a hemorrhoid. In more severe cases there is a fissure anterior to clitoris.

In younger girls, the fissures may cause a sudden jump up from sitting because of pain, which is at times misdiagnosed as a neurologic condition.

The condition is sometimes confused with sexual molestation or lichen sclerosis. In sexual molestation cases there may be general signs of trauma and any vulvar fissures are irregular, with lacerations in addition to the history. "Lichen sclerosis of the vulva has coarse, wide irregular fissures in the same areas. With slight trauma the labia and vulva have transient dark blue subcutaneous blood boils," said Dr. Altchek, also an attending ob.gyn. at Lenox Hill Hospital. Lichen sclerosis has a specific biopsy finding, which vulvar atopic dermatitis does not. Patients with vulvar atopic dermatitis also have the condition on other parts of their body, including behind the ears, in axilla, elbows, or behind the knees, highlighting the importance of whole body exam.

The condition is managed by avoiding things that could irritate the vulva, including wet bathing suits, hot water, perfume, and certain clothing such as leotards and tights. Otherwise, treatment is individualized to reduce irritation and symptoms, Dr. Altchek said. The condition is most common among prepubertal and young pubertal girls, it may or may not disappear at puberty, and it is less common in adults.

Dr. Altchek said he had no relevant financial disclosures. ■



Pediatric, Adolescent and Young Adult Gynecology, Altchek et al. ©2009 Blackwell Publishing Ltd. Reproduced with permission of Blackwell

In this patient with atopic dermatitis of vulva, there is a right interlabial and midline perineal fissure.

Advanced Ovarian Cancer Often Treated Suboptimally

BY DAMIAN McNAMARA

FROM THE ANNUAL MEETING OF THE SOCIETY OF GYNECOLOGIC ONCOLOGISTS

ORLANDO – Only a minority of women in the Medicare population with advanced epithelial ovarian cancer receive optimal therapy with a combination of surgery and six cycles of chemotherapy, according to a large, retrospective study.

Of the 8,211 women diagnosed with stage III or IV epithelial ovarian cancer between 1995 and 2005, 3,241 or 39%, received full dual combination therapy as recommended by the National Institutes of Health consensus statement on Treatment of Advanced Ovarian Cancer.

Older age, nonwhite race, stage IV disease, and higher medical comorbidity were significantly associated with suboptimal care in the current study. In addition, unmarried women and women living in the Midwest were more likely not to complete treatment.

> **VITALS**
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> **Major Finding:** Thirty-nine percent of women with advanced ovarian cancer in the Medicare population receive recommended first-line combination of surgery and six cycles of chemotherapy.
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> **Data Source:** Retrospective study of 8,211 women diagnosed with stage III/IV epithelial ovarian cancer between 1995 and 2005.
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> **Disclosures:** Dr. Melissa Thrall and Dr. Michael Carney said they had no relevant financial disclosures.

Physicians could focus on improving quality of medical care for these women, including greater referral to gynecologic oncologists, Dr. Melissa Thrall said at the meeting.

"Among U.S. women with ovarian cancer over age 65, many do not receive multimodality therapy," Dr. Thrall said. "Some of this is likely due to medical infirmity, as evidenced by the association of older age, higher stage, and comorbidity scores with failure to complete treatment. However, the associations with marital status and geographic location suggest there are other modifiable factors in this failure to complete therapy, such as lack of social support or the unavailability of gynecologic oncologists."

"It is truly disappointing, shocking, and sad to hear that merely one out of three patients in this study received the standard-of-care treatment," said study discussant Dr. Michael Carney, who is on the gynecologic oncology faculty at the University of Hawaii in Honolulu.

Women were classified according to their initial treatment: Fifty-nine percent had primary debulking surgery, and 24% had primary chemotherapy. The remaining 17% had no evidence of either treatment in their Medicare claims within 1 year of their diagnosis.

"The survival for these [untreated] women is short, and reminds us we need to keep working on increasing the awareness of the symptoms of ovarian cancer, to work toward prompt diagnosis and referral so more of these women can be offered treatment," said Dr. Thrall, a fellow in the division of gynecologic oncology at the University of Washington in Seattle.

Dr. Thrall and her colleagues identified women older than 65 diagnosed with stage III/IV epithelial ovarian cancer from 1995 to 2005 using the Surveillance, Epidemiology, and End Results (SEER) database. Treatment was identified using linked data to Medicare hospital, provider, and outpatient center claims.

A total 75.8% of the primary surgery patients had subsequent chemotherapy, and 32.2% of the primary chemotherapy group had ovarian cancer–directed surgery.

A total of 4,307 women (52.4%) had surgery and at least one cycle of chemotherapy (in either order) in the first year following diagnosis. Dr. Carney said, "Sadly, this means about 50% receive no chemotherapy after initial surgery, no surgery after initial chemotherapy, or no surgery or chemotherapy at all."

Dr. Thrall reported that a large proportion of women in the primary chemotherapy group did not have any surgery (68% of the 2,017 women). Women were significantly more likely to receive primary chemotherapy based on increasing age, increasing stage, and comorbidity score in a multivariate analysis. In addition, African American women were more likely to receive primary chemotherapy, she said. Histology also made a difference – women with serous tumors were more likely to get primary chemotherapy, compared with those with endometrioid or clear cell histology.

Dr. Carney described the paper as "important and timely for several reasons." Medicine is now focusing more on quality as an outcome measure. In addition, "in ovarian cancer we have a pretty good idea what appropriate treatment should be – surgery, chemotherapy, and specialty care, all resulting in improved survival."

It makes sense in this paper, Dr. Carney said, that if a patient has more advanced cancer, is older, or has many medical comorbidities, that patient is more likely to receive a chemotherapy or neoadjuvant chemotherapy approach.

"Things that don't make sense: Why are patients more likely to receive chemotherapy initially based on race alone, particularly African American? Why is marriage a significant variable? Why does living in the Midwest lower the rate of receiving standard-of-care treatment?"

A reliance on billing claims for treatment data and no information on why a particular treatment sequence was selected and why treatment was incomplete are among the study limitations, Dr. Thrall said. In addition, treatment information came from billing data. Also, the study was limited to women aged older than 65 years. However, Dr. Thrall said, "median age of ovarian cancer diagnosis is 64 years, so these data represent about 50% of women with ovarian cancer in the U.S."

Identification of potential barriers to treatment should be explored in future trials, Dr. Thrall said. Also, variables not measured in this study, such as performance status, could further help to explain treatment decisions in these women with advanced epithelial ovarian cancer. ■