Follow-Up Is Key in Vulvovaginal Lichen Planus

BY PATRICE WENDLING
Chicago Bureau

CHICAGO — Lichen planus is a tough disorder to treat and requires a strong commitment to patient education and follow-up, Dr. Lynette J. Margesson said at a conference on vulvovaginal diseases.

Lichen planus is an inflammatory, lymphocyte-mediated mucocutaneous disorder of an unknown cause that is relatively uncommon in the vulvovaginal area, and is too often missed. It usually involves the skin and less commonly the oral mucosa, scalp, nails, eyes, esophagus, bladder, larynx, and anus.

About 1% of the population has oral lichen planus. Recent studies have shown that up to 70% of women with oral lichen planus have genital involvement. Up to 44% can be asymptomatic, said Dr. Margesson of Dartmouth Medical School, Hanover, N.H.

Complications include scarring, loss of any or all of the vulvar structures, narrowing of the introitus, psychosexual problems, and synechiae and scarring that can eventually obliterate the vaginal space. Vulvar lichen planus is often confused with lichen sclerosus and, like that disease, is associated with an increased risk (3%-4%) of squamous cell carcinoma.

Prognosis is notoriously unpredictable, with about 75% of patients having improvement in symptoms and 10% having resolution of clinical signs without scarring, Dr. Margesson said at the conference, which was sponsored by the American Society for Colposcopy and Cervical Pathology. Patient education needs to be optimistic, even though there is often no "cure." Some patients can go into remission permanently, but most have a tendency to relapse. Long-term follow-up is needed for compliance and cancer surveillance.

"Noncompliance is a big problem," Dr. Margesson said. "They come back and their vulva is dying."

Upon presentation, most patients complain of soreness, pain, and itching, which can be mild to moderate in the papular form and severe in the hypertrophic form.

On physical exam, the classic pattern on dry, keratinized skin includes raised, reddish brown to purple, well-defined, dry papules with fine lacy white streaks, referred to as Wickham's striae, on the surface.

Erosive lichen planus often shows deep red, glazed lesions around the posterior vestibule with associated loss of architecture and scarring. A whitish scalloped or reticulated edge to these lesions is a classic feature that is not present in lichen sclerosus and can help make the diagnosis of lichen planus, Dr. Margesson said. Oral involvement is seen in about 60% of these patients, with the same lacy reticulated pattern, plus varying degrees of ulceration and erosion present on the buccal or gingival mucosa and tongue. The hypertrophic form is the least common, and looks very much like thick lichen sclerosus on the vulva, with thickened, white, scarred skin and loss of normal architecture.

Regular histopathology biopsies are often unreliable, so Dr. Margesson recommends performing biopsies for both histopathology and direct immunofluorescence.

Nonspecific treatments include education and support, stopping all irritants, restoring the epidermal barrier, and offering psychosexual support, as these patients are usually sexually dysfunctional, she said.

Topical corticosteroids to suppress inflammation are the cornerstone of treatment. Dr. Margesson prefers clobetasol or halobetasol 0.05% ointment used very sparingly daily in a thin film for 8-12 weeks for the mucous membranes of the vulva, and 1-3 times a week for maintenance. Topical tacrolimus (Protopic) 0.1% ointment can be helpful, but this is an off-label use, and it should be applied sparingly as it may burn, she said.

Clobetasol or halobetasol ointment, or tacrolimus compounded in a 0.1% cream, can be used nightly intravaginally. Hydrocortisone acetate is available as a 25-mg suppository. A compounded hydrocortisone acetate suppository, 100-500 mg, used at bedtime for 2 weeks, can be given for severe vaginal disease, but adrenal suppression is possible. After 2 weeks, the dose is decreased, depending on the response.

For severe lichen planus, Dr. Margesson finds intramuscular triamcinolone acetonide 1 mg/kg every 4 weeks for 3-4 months is a better tolerated alternative to prednisone. Other effective drugs include methotrexate 5-10 mg per week or cyclosporine 4-5 mg/kg, but the latter should be limited to 2-3 months of treatment. Mycophenolate mofetil (CellCept) has been used up to 3 g per day, and recent studies suggest the use of etanercept (Enbrel) 50 mg subcutaneously twice weekly.

Surgery may be needed for significant scarring or vaginal adhesions, but these can recur. Dilators used nightly are important in these cases, and for vaginal stenosis, she said.

Many unanswered questions remain regarding lichen planus, Dr. Margesson said. They include the precise length of therapy, remission rate, best maintenance therapy, and long-term surveillance plan, whether treatment is needed in asymptomatic patients, which patients will go on to get squamous cell carcinoma, and what factors trigger lichen planus. ■

Sublingual More Effective Than Oral Misoprostol for Medical Abortion

BY NANCY WALSH
New York Bureau

MINNEAPOLIS — Sublingually administered misoprostol was significantly more effective than the drug given orally after mifepristone for medical abortion in a prospective randomized trial, Sheila Raghavan said at the annual meeting of the Association of Reproductive Health Professionals.

"Medical abortion is becoming more popular and is preferred by women because of the ease of administration and convenience," Ms. Raghavan said. Misoprostol typically has been administered orally or vaginally for abortion, although this use is off-label and, in fact, the labeling for misoprostol carries a boxed warning stating that its use by pregnant women can not only cause abortion but also birth defects and uterine rupture.

Pharmacokinetic studies have shown higher bioavailability and more rapid absorption when given sublingually. Initial investigations into this route of administration used high doses of sublingual misoprostol and found a high—98%—efficacy rate, but also showed a high rate of side effects. For example, in one study comparing sublingual and vaginal misoprostol given in a dose of 800 mcg, 54% of women receiving the sublingual drug experienced nausea, compared with 32% of those receiving the drug vaginally (Hum. Reprod. 2003;18:2315-8).

For investigation of whether a lower dose (400 mcg) of misoprostol given sublingually after 200 mg oral mifepristone would be effective, tolerable, and acceptable to women, 480 women who ranged in age from 18 to 46 years who were presenting for termination of intrauterine pregnancy were enrolled in the study. Gestational ages up to 63 days were permitted. Approximately 55% of the women had had previous abortions. The trial took place in Moldova, said Ms. Raghavan, who is program research coordinator at Gynuity Health Projects, a reproductive health research and technical assistance organization in New York City.

A total of 240 women were randomized to receive the oral drug, and 240 to receive the sublingual drug, at home 24 hours after receiving 200 mg oral mifepristone in the clinic. Two weeks later they were seen for follow-up assessment, at which time success rates of 98.7% and 94% were seen in the sublingual and oral groups respectively, a difference that statistically favored the sublingual route, Ms. Raghavan said. Four cases, all in the oral group, required surgical intervention.

Fever and chills occurred more frequently in the sublingual group, with 28% of patients reporting these side effects, compared with 18% in the oral group. The nausea lasted significantly longer in the oral group, however, and more than 80% of women in both groups reported that the side effects were acceptable or very acceptable. More than 91% of women in both groups reported being satisfied or very satisfied with the procedure, she said.

The study demonstrates that sublingual misoprostol in a dose of 400 mcg given after 200 mg mifepristone is more effective and as acceptable to women as the oral regimen in inducing abortion, she concluded. ■

Low-Dose Combination HT Aids Postmenopausal Health

BY HEIDI SPLETE
Senior Writer

WASHINGTON — Postmenopausal women who took a low-dose estrogen/progestin hormone therapy reported significant improvements in vasomotor symptoms and quality of life after 6 months, according to findings from an open-label efficacy study.

The therapy caused a significant increase in mean triglycerides, from 129 mg/dL at baseline to 168 mg/dL after 6 months. But the women had no other significant changes in their lipid profiles or in their body weight, body mass index, or blood glucose during the study period, Dr. Fernando Ayala Aguilera of the Hospital Universitario, Monterrey (Mexico) and colleagues reported in a poster presentation at the annual meeting of the American Society for Reproductive Medicine.

In the study, sponsored by Wyeth Pharmaceuticals, 68 postmenopausal women aged 45-55 years who reported at least four hot flashes per day received a combination of 1 mg 17β-estradiol and 0.125 mg trimegestone orally each day for 6 months. The study criteria excluded women without an intact uterus, with known or suspected breast cancer, or with abnormal bleeding.

Overall, patient scores on the MENQOL (a questionnaire designed specifically to evaluate the quality-of-life symptoms in menopausal women) dropped from an average of 78 at baseline to an average of 5 after 6 months of treatment.

The average total cholesterol remained stable between baseline and 6 months (201.3 vs. 200.2 mg/dL). Blood glucose, body weight, and body mass index were essentially unchanged from baseline to the 6-month follow-up: Average blood glucose was 92 at both baseline and 6 months, average body weight was 67 kg at baseline vs. 66 kg at 6 months, and average BMI was 27 kg/m^2 at baseline vs. 26.9 kg/m^2 at 6 months.

High triglycerides may be a cause for concern, but the triglycerides in this study did not reach unhealthy levels (above 200 mg/dL).

Although the findings were limited by a small number of patients and a short follow-up period, the preliminary results from this ongoing study suggest that a 17β-estradiol/trimegestone combination may provide enough relief from menopausal symptoms to outweigh the potential risks of increased triglycerides in the absence of other adverse effects on lipid profiles. ■