Incontinence-Induced Dermatitis Is on the Rise

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CHICAGO — Chronic use of sanitary pads and panty liners for urinary incontinence may put patients at risk for vulvar contact dermatitis, Dr. Lynette J. Margesson said at a conference on vulvovaginal diseases sponsored by the American Society for Colposcopy and Cervical Pathology.

Some women with urinary or fecal incontinence don't want to acknowledge they have the condition or are too embarrassed to wear incontinence pads, and instead opt to wear sanitary pads or panty liners to address their incontinence. The problem is that these are inadequate for urine volume, leaving the vulva wet throughout the day.

"Women don't use appropriate pads to stay dry, and we do have a real epidemic of incontinence," said Dr. Margesson of Dartmouth Medical School, Hanover, N.H. "These patients are desperate with itch, burn, and pain."

Elderly patients often have problems with contact dermatitis from incontinence that is complicated by obesity and reduced mobility.

Age-related loss of estrogen also increases susceptibility to irritant contact dermatitis by causing the epidermal barrier to be weakened and thinned, and less moist and viable.

The epidermal barrier also can be lost because of overzealous washing with a washcloth, sponge, or wipes.

Dr. Margesson warned the audience to be wary of patients who are convinced the vulva is "dirty," and needs to be scrubbed.

"You can get a reaction including redness and swelling from the use of baby wipes," Dr. Margesson said. "We're seeing a lot of patients using these." A strong show of hands confirmed a similar experience among the audience.

Other common vulvar allergens include benzocaine (Vagisil), neomycin (Neosporin), chlorhexidine (KY jelly), preservatives, latex condoms, lanolin, and nail polish. Common vulvar irritants include douches, spermicides, and medications such as trichloroacetic acid and 5-fluorouracil.

The clinical features of irritant and allergic contact dermatitis are similar; they can be acute with blistering, subacute with scaling and redness, and chronic with redness and induration.

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Contact dermatitis is frequently superimposed on preexisting, chronic vulvar conditions and complicates their management, said Dr. Margesson. Patients will self-treat with over-the-counter products or receive multiple medications from different providers.

Dr. Margesson has observed patients who developed burns from using benzocaine 20% 10-15 times a day, or whose condition was worsened by their use of ice packs rather than cool gel packs to cool an itchy, burning vulva.

The first step in managing contact dermatitis in the anogenital area is to stop the irritant or allergen exposure and any irritating practices.

A sitz bath, tub bath with lukewarm water only, or cool compress can be used one to three times a day for 5-10 minutes to improve barrier function and to soothe weeping, red, or hot irritated areas. Bland emollients such as petrolatum, mineral oil, or olive oil help seal in moisture.

Antibiotics should be used to treat secondary infections, and steroids to suppress inflammation.

Patients should be given specific instructions for topical steroids and shown in the office the exact site to which to apply them.

To counter the commonly held belief that more must be better, Dr. Margesson suggests the use of "toothpick" dermatology, which limits the amount of ointment or cream needed to cover the vulva to the end of a toothpick.

Finally, it's essential to review and rereview hygiene habits with the patient. "It's amazing how many people will go back to what they were doing before," Dr. Margesson said. ■