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Clinical Image
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Chronic Vulvitis in Diabetic Patient: A Description by Images

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Abstract

We described the case of an 84-year-old woman with type II diabetes mellitus and chronic vulvitis. At the first check-up, the woman presented a fairly severe form of chronic vulvitis with candida superinfection, associated with severe alteration of the external genitalia as well as extremely limiting symptoms.

The patient was treated with local therapy with vitamin E - based ointments and hyaluronic acid creams, cortisone and local antifungal therapy was then started and the boric acid tablets were interrupted, maintaining the evening sitz baths with boric water at 3%.

The woman returned to control after 3 and 6 weeks, presenting a significant improvement in the local state and in the symptomatic sequence she reported.

Clinical Reports

This brief paper we intend to describe the morphological features of a chronic vulvitis in an 84-year-old woman affected by type 2 diabetes mellitus, poorly controlled with diet and medical therapy - baseline blood sugar 132 mg/dl, HbA1c 6.3% [1]. The woman had certainly postponed her specialist visit for a long time and presented, at the gynecological examination, a case of vulvitis associated with burning, itching and pain. The vulva showed extensive edema and a highly erythematous area involving the labia majora bilaterally, the genitocrural folds, the perineum, the perianal and the intergluteal region (Figure 1). The presence of erythematous-squamous areas and the other morphological characteristics of the picture led to suppose, in the first hypothesis, a mycotic superinfection with candida [2,3].

The mucosa of the vulvar vestibule was dry and eroded. The vaginal introitus was strongly stenotic, to the point of not making it possible to see the labia minora and the clitoral button (Figure 2).

At the inguinal margin it was possible to observe ulcerated and easily bleeding scratch lesions, surrounded by areas of thickened epidermis as from hyperkeratosis (Figure 3).

At a general observation it was observed bilateral lesions, in both tibial areas, erythematous and ulcerated, similar to those founded in the vulva, characterized by reddish areas easily desquamating and small ulcers from alteration of the venous circulation (Figure 4), as often seen in patients with chronic diabetes [4]. The patient had vaginal swabs done which tested positive for *C. albicans*.

The patient was treated with fluconazole 50 mg tablets, one tablet per day for 28 days,

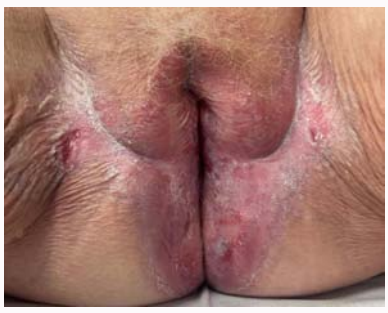

Figure 1: Chronic vulvitis with evidence of erythematous, ecchymotic, pruritic and ulcerated areas.

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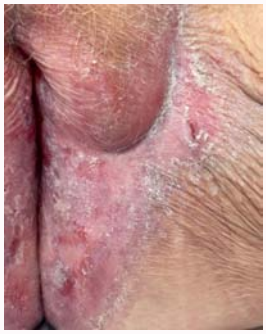

Figure 2: This image shows the severe stenosis of the vulvar introitus associated with disappearance of the labia minora and clitoral button.

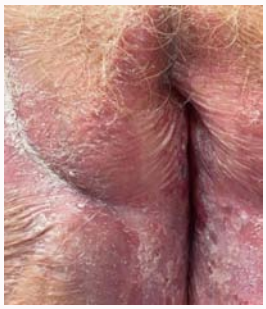

Figure 3: Area of hyperkeratosis associated with scratching lesions in the lateral area of the labium and at the level of the inguinal margin but with the presence of areas of altered tissue trophism due to vascular insufficiency.

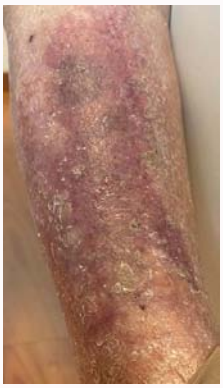

Figure 4: Diffuse erythematous lesions of the tibial area, reddish and squamous, similar to the same lesions are present on the vulva.

antihistamine Ebastine 10 mg, one tablet per day for 7 days, diflucortolone valerate + isoconazole nitrate cream, one application in the evening on the entire affected area, panthenol cream local applications in the morning, 3% boric acid for local compresses and sitz baths [5].

The woman returned to control after three weeks of therapy (Figure 5). The ulcerative lesions were on the mend, the edema and erythema also in the vestibule area were reducing and the patient reported a marked improvement in her clinical symptoms.

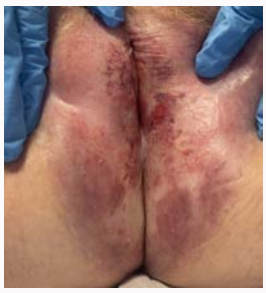

Figure 5: In this image it is possible to observe how the areas previously affected by Candida have undergone complete resolution after three weeks of therapy, with adequate re-epithelialization of the affected areas.

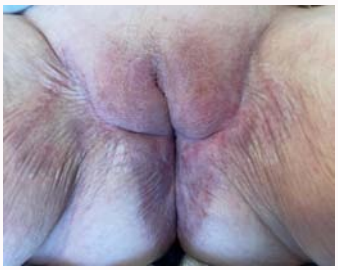

Figure 6: This image shows the vulva after six weeks of targeted therapy. The erythematous areas are strongly reduced in association with complete resolution of the ulcerative lesions.

Finally, 6 weeks after the beginning of the therapy, the two ulcerations at the root of the thighs had completely disappeared with a complete regression of the patient's symptoms. It was a residual erythema of purplish color, in inflammatory outcome, areas of scleroatrophy especially in the medial region of the root of the thighs (Figure 6). Local treatment with vitamin E-based ointment and hyaluronic acid creams was therefore started, treatment with cortisone and local antifungal was suspended and the compresses with boric acid were interrupted, maintaining the sitz baths in the evening with 3% boric water.

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