An important ulcer

Dr Fiona Lewis
Consultant Dermatologist
St John’s institute of Dermatology,
Guy’s & St Thomas’ NHS Trust
History

• 26y female admitted via A&E to gynae ward
• Acute vulval pain with pain on micturition
• Associated vomiting and fever
• 4 days background malaise 2 days following travel to Philippines & South Korea
• Sepsis
  • 40.7 deg C - persisted 48h
  • Hypotensive 94/59
Past Medical History

1. Surgical termination of pregnancy 2016
2. Chlamydia - last tested 2016 neg
3. UTI - 2016
Day 2 hospital admission
Treatment during admission

• Empiric co-amoxiclav & gentamicin
  • Switched to: Cefuroxime 1.5g TDS, Metronidazole 500mg TDS, Aciclovir 400mg TDS

• Topical lidocaine/ prilocaine (EMLA®)
Investigations

**INFECTION**
- Blood: Cultures sterile
- MSU: no growth
- Bacterial swab: no growth
- HSV/ VZV swab, PCR not detected (HSV done twice!)
- HSV-1, HSV-2 DNA: negative
- HSV 1 IgG detected; HSV 2 IgG not detected
- HIV antigen/ ab: not detected
- T. pallidum DNA/ T pallidum ab: negative
- Paul Bunnell: negative
- Influenza A& B RNA / parainfluenza RNA / human metapneumo RNA/ RSV RNA / Entero RNA / Adeno RNA: negative

**IMMUNOLOGY**
- Ig A 4.51 (high), IgM 0.97, IgG 0.97
- Anti MPO & PR3: negative
- ANCA: negative
- ANA: negative
- C3 0.95 (0.9-1.8), C4 0.23 (0.1-.04)

**Imaging**
- CXR: normal
- CT TAP: no evidence of infection
Course

• Discharged home but continued symptoms.

• Re-presented to GP

• Seen in dermatology 2 days later
Day 13 Dermatology OPD
LIPSCHUTZ ULCER (acute genital ulcer)

Rx: Prednisolone 10mg od 5 days
Topical Lotriderm cream od
10 days later (day 24)
Differential Diagnosis

VULVAL ULCER

Acute
- Infective
  - HSV
  - Syphilis
  - HIV
  - Lipschutz
- Trauma
- Inflammatory
  - Contact dermatitis
  - Aphthae
  - TEN/SJS

Chronic
- Malignancy
  - SCC
  - BCC
  - Melanoma
  - others
- Inflammatory
  - Crohns
  - HS
  - Behcets
  - Langerhans cell histiocytosis
  - Pyoderma gangrenosum

### Lipschutz ulcer (acute genital ulcer)


- Reactive phenomenon in setting of infection

- Clinical features
  - Acute pain
  - Young women; no male correlate
  - “Kissing ulcers” – often bilateral but can be unilateral
  - Self-limiting, non-scarring
Take home messages

• Often a missed diagnosis
  • Seen by GUM / ID / Gynaecology
  • Usually assumed to be herpetic even though bilateral and swabs negative

• Management
  • Role for short course oral steroid
  • Avoid using EMLA on the vulva because of irritancy
  • Avoid surgical debridement