

JAAPA letters to the editor, March 2007

Effective topical treatments for atrophic vaginitis

To the Editor:

I appreciate the well-written article about atrophic vaginitis, published in the October 2006 issue of *JAAPA*, but I was disappointed to see that there was no discussion of other diseases that mimic atrophic vaginitis. Lichen sclerosis et atrophicus and squamous cell carcinoma should be considered along with atrophic vaginitis.

Lichen sclerosis et atrophicus (LS&A) is a disease that leads to scarring and atrophy of the anogenital skin in women. It can occur in both sexes but is 10 times more prevalent in women than in men. In females, it occurs in two age groups: young girls and post-menopausal women. It also can occur on non-genital skin.

Symptoms include pain, itching, bleeding, and interference with sexual function. Signs of LS&A are fragile, atrophic skin that is easily traumatized and slow to heal. Repeated cycles of skin breakdown and healing lead to stenosis of the introitus and atrophy, scarring, and shrinkage of the labia minora. Squamous cell carcinoma can occur in roughly 3% of the cases, thus a biopsy may be warranted.

Early diagnosis and treatment is necessary to prevent scarring and improve symptoms. High-potency topical steroids (clobetasol ointment .05%) and tacrolimus ointment 0.1% are helpful therapies. Estrogen replacement is not.

LS&A is an emotionally and physically debilitating disease to the women it affects. It is distinct from atrophic vaginitis and should be treated as such. Squamous cell carcinoma also is in the differential diagnosis and may need to be excluded by biopsy.

Leslie Werschkul, PA-C

Author's response:

Thank you for your insightful letter. LS&A is indeed distinct from atrophic vaginitis and should be considered separately. Although LS&A can cause atrophy of the vulvar tissues and narrowing of the vaginal introitus, the vagina itself is generally spared. This highlights the importance of a good physical examination as the symptoms may overlap. If the patient displays epithelial lesions, including the typical white papules or plaques of lichen sclerosis, a biopsy would be indicated. Similarly, if there is doubt regarding the diagnosis of atrophic vaginitis or the patient is not responding appropriately to treatment, lichen sclerosis could be considered.

Heidi E. Doyle, PA-C

Guttate psoriasis

To the Editor:

I'd like to comment on the Case of the Month published in the January 2007 issue which describes the case of a patient presenting with an acutely painful generalized skin eruption. The authors state that the patient's condition was diagnosed as *guttate psoriasis*.

Although the management of the patient's acute condition seemed appropriate, I think that the patient's presentation and clinical course were much more consistent with what is called *erythroderma*, or *generalized exfoliative dermatitis*.

Patients with preexisting psoriasis can indeed develop the guttate form following infection with beta-hemolytic streptococcus, in particular pharyngotonsillitis. However, in my experience this is usually an indolent or subacute condition and patients are not clinically ill. Itching and scaling without pain are the predominant symptoms. The appearance of droplet eruptions—hence the name—without inflammation of surrounding skin is characteristic.

The most effective treatment of guttate psoriasis consists of UVA therapy with or without sensitizing agents (psoralens).

Erythroderma, or generalized exfoliative dermatitis, can occur in individuals with preexisting psoriasis as with as other chronic dermatologic conditions; drug reactions (vancomycin, allopurinol, carbamazepine, sulfonamides); and malignancies. It is considered to be one of the few true dermatologic emergencies. Clinical findings include erythema and scaling on 80% to 90% of body surface area and can be associated with significant morbidity. Mortality has been reported in 20% to 40% of cases.

The patient with erythroderma may present much as Ms. Lundsten's patient did, with evidence of dysregulation of temperature and volume status as a result of heat and fluid losses. Treatment includes supportive therapy, systemic steroids, skin care, and identification and removal of the offending agent.

Susan Petry, PA-C

REFERENCES

1. Umar SH, Kelly AP. Erythroderma (generalized exfoliative dermatitis). Available at: <http://www.emedicine.com/DERM/topic142.htm>. Accessed February 22, 2007
2. Akhayani M, Ghodsi ZS, Toosi S, Dabbaghian H. Erythroderma: A clinical study of 97 cases. Available at: <http://www.biomedcentral.com/1471-5945/5/5>. Accessed February 22, 2007.
3. National Psoriasis Foundation. Resources for Health Professionals. Available at: www.psoriasis.org. Accessed February 22, 2007.
4. Baron ED, Taylor CR. Psoriasis, guttate. Available at: <http://www.emedicine.com/DERM/topic361.htm>. Accessed February 22, 2007

Race-based therapeutics: A discussion surrounding heart failure trials

To the Editor:

The discussion of beta-blocker trials in the article on the differences in therapeutic response to heart failure treatment between African Americans and European Americans, published in the February 2007 issue, describes metoprolol as a non-selective beta blocker. In fact, it is a selective beta-1 receptor antagonist in low to moderate doses. At near maximum or maximum doses, metoprolol does lose its beta-1 selectivity.

Dennis Silber, RPA-C

Author's response:

Thank you for the question and please allow me to clarify the statement. While it is true that at low doses metoprolol is a selective beta-1 antagonist, the MERIT-HF trial proposed using near maximum doses. Thus it would be more appropriately classified as a nonselective beta-blocker within the context of the study comparisons.

Natalie Schmitz, MMSc, PA-C