Guy's and St Thomas'

NHS Foundation Trust

An important ulcer

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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

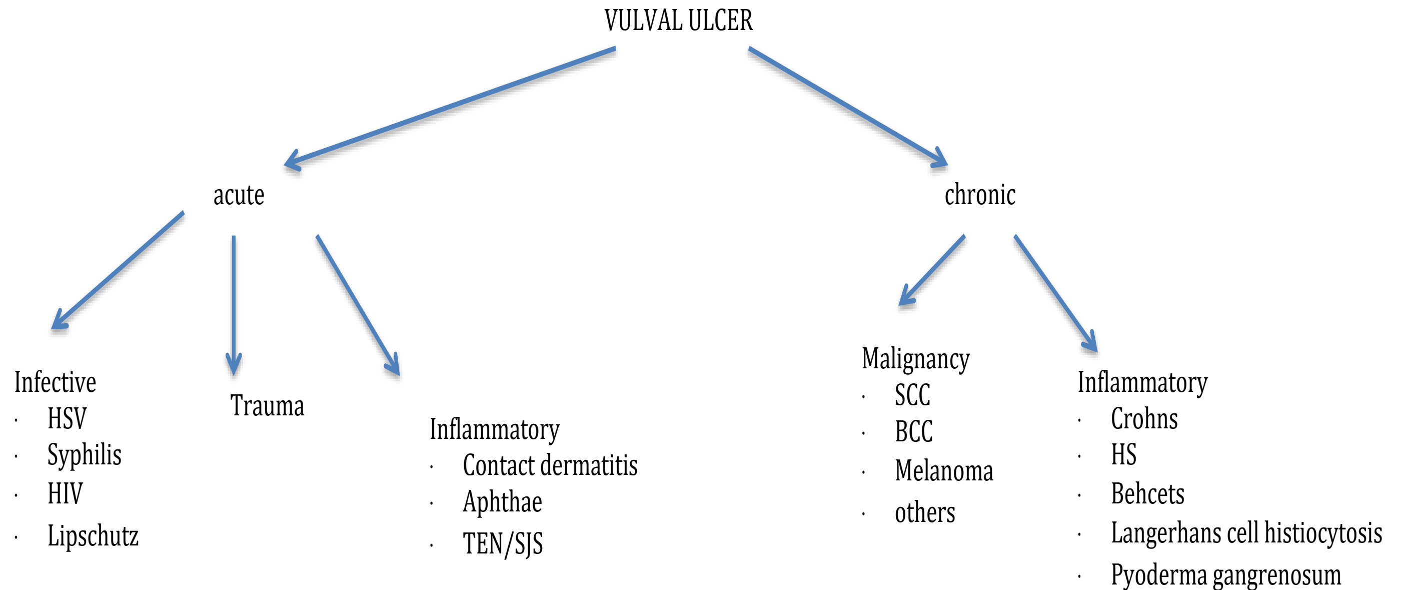
LIPSCHUTZ ULCER (acute genital ulcer)

Rx: Prednisolone 10mg od 5 days

Topical Lotriderm cream od

10 days later (day 24)

Differential Diagnosis



Taken from: A practical Textbook of Vulval Disease. Eds. Lewis, Bogliatto, Van Beurden. Wiley-Blackwell 2017

Lipschutz ulcer (acute genital ulcer)

- Lipschütz B. Über eine eigenartige Geschwürsform des weiblichen Genitales (ulcus vulvae acutum). Arch Dermatol Syph (Berlin) 1913; 114: 363–395. In dermatological but not gynaecological literature
- Reactive phenomenon in setting of infection
- Clinical features
  - Acute pain
  - Young women; no male correlate
  - “Kissing ulcers” – often bilateral but can be uniliateral
  - 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