Symposium S003: Dermatology Grand Rounds: Case-based Dilemmas
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Mercury Ballroom

DISCLOSURE
• I have no relevant conflicts of interest to disclose.
• I will be discussing off-label medication uses for disease management.

Case: 67 year-old woman with “recalcitrant lichen planus”

History
• 68 year-old woman referred by OB-Gyn for “recalcitrant lichen planus” of the vulvovaginal region
• Onset 10 months ago, progressive
• Severely painful, difficult to walk, wipe, intercourse, etc
• Failing clobetasol BID, Hydrocortisone suppositories BID
• Associated with copious creamy vaginal discharge
• No history of previous vulvovaginal complaints
• No other topicals to area. Wears thick pads due to copious discharge

History
• Monogamous, rarely sexually active due to pain
• PMHx significant for NO STIs,
  - STI probes for gonorrhea, chlamydia, trichomonas, Gardnerella, candida negative
• No Inflammatory Bowel Dz history
  - Unremarkable colonoscopy within past year
  - Sometimes “blood coloring toilet water” after defecating
• Difficult-to-manage RA failing numerous DMARDs and anti-TNF therapy
  - Now taking pulsed Rituximab + Methotrexate (15mg q wk)+Hydroxychloroquine + low dose methylprednisolone (4mg qD) to manage symptoms

Work-up
• CRP = 7.6
• WBC elevated 15.4
• Urine >100 WBC, 21-50 RBC
• Urine and discharge cultures obtained
• SPEP: consistent with acute phase rxn
"Mild stomatitis has been reported to appear transiently or permanently as a side effect of correctly used, low-dose (2.5-35mg weekly) MTX treatment in up to 40% of patients."

Low-dose Methotrexate and vaginal ulcers

- Very uncommon, but rarely reported.
- Low dose MTX-induced ulcers most often in oral cavity, and most often the result of dosing errors.

Clinical Course

- Initial recommendation to Rheum: Hold Methotrexate just in case mucositis
- Treat with burst and taper of prednisone 1mg/kg (80mg initial)
- Pain management
- Monitor interim culture results
- Return in 2 weeks

Clinical Course: 2 weeks later

- Aerobic, anaerobic and fungal cultures all negative
- Slightly improved pain and discharge on higher doses of prednisone, but worsening again with taper
- Exam: Minimal change clinically

What is this?

Most striking and unusual feature to me: Suppurative Vulvovaginitis

Rituximab-induced suppurative vaginitis / pyoderma gangrenosum
Vulvovaginal Pyoderma Gangrenosum associated with Rituximab

- 6 cases, receiving rituximab for B-cell non Hodgkin’s lymphoma (NHL)
- Age range was 50–74
- Symptoms present for 2–24 months
- Severe pain
- Heavy discharge
- Large, deep purulent ulcers extending into the vagina


Vulvovaginal PG is rare

- 15 cases reported in last 25 years, 6 of these associated with rituximab therapy
- Glucocorticoids, azathioprine, minocycline and IVIg most common systemic therapies used to treat

What happened next?

- Discontinued Rituximab
- Struggled initially to get IVIg coverage by insurance, so began oral doxycycline and topical tacrolimus as a steroid-sparing bridge in interim, with some improvement
- Began IVIg 0.75g/kg q4 weeks as alternative steroid sparing agent

Limitations

- RA is a common PG-triggering condition

Might this be an emerging condition?

- Rituximab is becoming more and more commonly used in medicine, especially in dermatology (Autoimmune blistering disease and CTDs)
- Consider drug history looking for rituximab in patients with suppurative ulcerating vulvovaginitis
- IVIg appears to be an effective treatment