

Genital skin rash: Is it sexually transmitted? What else?

By Dr Rakesh Newaj

Not all skin manifestations in the genital region are due to sexually transmitted diseases or infections. In actual fact, most skin diseases that manifest on the rest of the body, can also affect the genitalia, causing lots of distress. Local factors, including warmth, moisture, friction as well as the effects of body fluids, are important in this area, rendering the diagnosis of skin diseases very difficult. The fact that only limited number of symptoms like pruritus and pain are the presenting features of a wide variety of diseases adds to the diagnostic dilemma.

Eczema and Psoriasis can both look similar in the genital region. They both have erythema, scaling and eczema can be more pruritic. The rash is commonly diagnosed as a sexually transmitted disease and treated accordingly, with no response. If the above diseases are suspected, a proper full body skin examination should be performed and lesions in other parts of the body can be very helpful in making a diagnosis. One should not forget to examine the scalp and nails. It is rare for these diseases to occur only in the genital region and a good history can also help. A skin biopsy can be performed if one is still in doubt.

The treatment is with topical corticosteroids, however due to the occlusive nature of the skin folds and moisture in the region, milder formulations are usually sufficient. Bacterial and fungal infections can complicate the therapy.

Lichen planus can commonly affect the genitals. There are four distinct forms of Genital lichen planus, with the classical violaceous papules and plaques typically affecting the labia minora and majora or mons pubis in women and the glans or shaft of the penis in men.

The erosive type of Lichen planus is characterised by erosions and scarring of the genitals as well as buccal mucosa can be affected. When examining a patient with genital Lichen planus, the skin in other areas, as well as the mouth are commonly involved. A lacy whitish reticulation may be very prominent in the genital and oral regions, and this can be the hallmark of the disease. The main symptom is that of severe pruritus and this should warrant a suspicion of Lichen planus.

The first line of treatment is superpotent corticosteroids with the use of emollients. Other treatments may include calcineurin inhibitors and circumcision in man can cure the disease, if it is restricted to the foreskin.

Lichen sclerosus is a chronic inflammatory disease with a predilection for the anogenital region. The aetiology is unknown. Around twenty percent of patients will also have manifestations in other parts of the body. This disease is ten times more common in females, with children and post-menopausal women being more prone to it. In men, the foreskin is most commonly involved. Both males and females may present with pruritus and soreness and dyspareunia is frequently reported. In women, the characteristic clinical findings are thin, wrinkled skin in a figure of eight, encircling the vulval and perianal region. The skin will be depigmented, often causing confusion with Vitiligo. Some purpura, blisters and scarring may be present raising suspicion of child abuse.

In men, the foreskin is prone to the disease with the perianal area, rarely involved. Severe pruritus and the inability to retract the foreskin can result in recurrent balanitis.

The diagnosis can be easily confirmed with a biopsy and treatment can then be started as early as possible.

In most instances, circumcision can cure the disease in men, however in women the treatment can be very difficult. Potent topical corticosteroids are the first line of treatment and can be continued for three to four months. Thereafter, the dose can gradually be reduced according to response. Topical calcineurin inhibitors can also help. In instances where there is distortion of the anatomy, only surgical correction can help.

Fixed drug eruptions can notoriously affect the genitals only. They can be caused by many different medications with Tetracyclines and Laxatives being the most commonly involved drugs. Usually they present as a round, erythematous to hyperpigmented rash, more noticeable on the penis. It can have a tingling or burning sensation. With repeated use of the medication, the rash tends to appear at the same spot, however new ones can also appear. These patients can become very distressed as it is usually confused with a sexually transmitted disease.

A good history and if in doubt a biopsy tends to help. Once the diagnosis is established, the offending drug should be stopped and patient advised not to use it in the future. Topical corticosteroids tend to bring relief slowly and the rash disappears with time.

Contact eczema is ever so common in the genital region. It is very common practice for patients to make use of all sorts of unimaginable substances in that area. Some use them as part of their tradition, others spice up the area to excite their partner, whilst still others make use of abrasive solutions to clean the region to achieve cleanliness of a surgical standard.

This can result in severe eczema, with erythema, pruritus, pains and burns to the skin. Patients can be very resistant to volunteer a thorough history, thus, when in doubt, direct questioning can catch them unaware and give the diagnosis. Needless to say that the first step is to stop the offending substance. Thereafter any superinfection must be treated accordingly, whilst slowly starting some oral or topical steroids.

Zoon's balanitis occurs predominantly in uncircumcised men. It is commoner in the third decade and has commonly been associated to poor penile hygiene or chronic irritation.

The disease can be asymptomatic or more commonly give rise to pruritus or dysuria.

The lesions are erythematous, discrete, moist plaques with an orange hue. 'Kissing' lesions are typical with involvement of adjacent areas.

The curative treatment is circumcision.

Even though the area is rarely exposed to the sun, all types of skin cancers can affect the genital region. Human papilloma viruses are commonly associated with Squamous cell carcinoma in the area, this being the most common tumour in the anogenital region. Tar, chimney soot, asbestos and petroleum products are other known carcinogens.

It occurs more commonly in elderly patients and the incidence is rising. The majority of cases arise on the glans penis or on the vulva. Of note, Squamous cell carcinoma is very rare in circumcised men.

The clinical feature is that of a small non-healing ulcer, a nodule or a plaque and usually a biopsy is needed to confirm the diagnosis.

The treatment of choice is surgical excision of the tumour.

Other skin cancers are anogenital Melanomas, Basal cell carcinoma and Extramammary Paget's disease.

These melanomas are not related to UV exposure and usually arise de novo. They are detected late and therefore the prognosis is poor. The treatment of choice is again surgical for early stages.

Basal cell carcinomas are rare in the area and the diagnosis can only be confirmed on histology. Surgical excision leads to cure.

Extramammary Paget's disease is an unusual intraepithelial adenocarcinoma of apocrine gland-bearing sites. It may be primary or secondary to an underlying malignancy.

The vulva in women and the perianal region in men are the most commonly affected sites, with a slowly expanding erythematous plaque which is sharply demarcated from the normal skin. The diagnosis can only be confirmed on histology.

Patients with extramammary Paget's disease need to be fully investigated as the disease is associated with an underlying visceral malignancy in up to 20% of cases.

There are many other diseases that affect the genital skin, one being more difficult than the other, to diagnose. If in doubt, specialist referral is important. Many of the diseases can only be labelled by performing a biopsy. It is of utmost importance to counsel patients that it is not an STD, as the psychological impact can be huge.