Our Dermatology Online

Case Letter

Vestibular papillomatosis: A differential diagnosis of vulvar condylomas

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Sir,

For a considerable time, vestibular papillomatosis (VP) has been conceived of as a secondary pathology to HPV (human papilloma virus). Nowadays, several authors are reconsidering it as an anatomical variant of the vestibular mucosa. We report a case of VP initially mistaken for vulvar condyloma.

A 25-year-old female without any particular medical history presented herself to the gynecologist for genital papules, without functional signs of genital discharge or dyspareunia. A cervicovaginal smear and viral serologies for HIV and hepatitis B and C were negative, and a diagnosis of vulvar condyloma was reached. The patient was referred to the dermatology department for eventual treatment. A clinical examination revealed filiform, flexible, flesh-colored papillae 1–2 mm in diameter located on both edges of the vulva (Fig. 1). A dermoscopic examination found linear, symmetrical papillae in the vulval vestibule with abundant vessels along them (Fig. 2). There was no whitening of the lesions under the acetic acid test. The diagnosis of vestibular papillomatosis was reached, the patient was reassured, and no treatment was prescribed.

At the beginning of the eighties, authors linked the occurrence of VP to an HPV infection based on histological and/or molecular evidence of the presence of the virus and considered VP to be responsible for many cases of pruritus and/or vulvodynia. Based on these findings, a number of clinicians have treated this condition with laser ablation or topical application of podophyllin or trichloroacetic acid [1]. Currently, several studies have shown the rare relationship between HPV infection and VP. VP is thus considered an anatomical variant of the vestibular mucosa [2]. Papillae are generally distinguishable from condyloma acuminata by clinical and dermoscopic examination, without the need for biopsies or HPV testing [1]. Clinical criteria have been proposed to assist in the differential diagnosis between VP and condyloma acuminata. In VP, the papillae are symmetrical or linear, soft and pinkish. Their bases are separated, unlike acuminate condylomata, which are hard and irregular and whose projections may cluster around the same base. In addition, most acuminate condylomata bleach under the acetic acid test [3]. Dermoscopy of VP shows abundant and irregular vessels along the center of cylindrical papillae. In addition, in acuminate condyloma, irregular projections with tapered ends are found, which are clearer and wider than in VP. Hemorrhages in the form of red dots or streaks may also be present [4]. No ablative treatment is usually necessary in the case of VP even in the presence of concomitant symptomatology or molecular HPV infection [1].

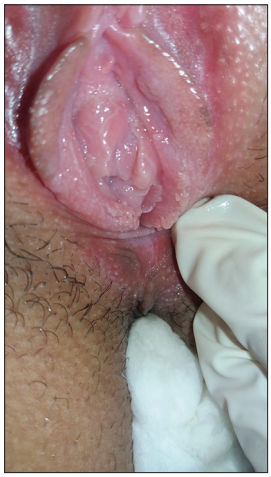

Figure 1: Filiform, flesh-colored papillae on the lateral edges of the vulva.

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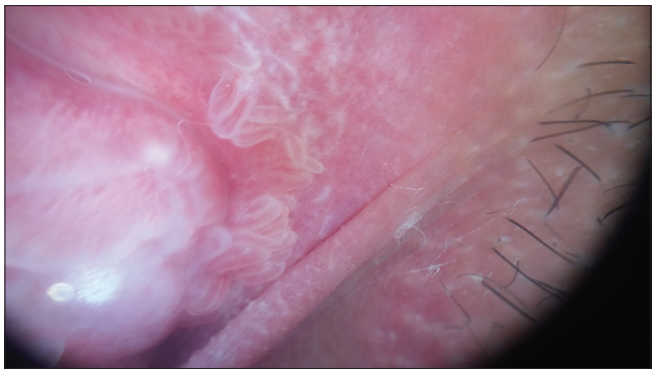

Figure 2: Profuse and irregular vascular channels in the transparent core of multiple, cylindrical filiform projections, with the bases of the individual projections remaining separate.

Vestibular papillomatosis is an entity that dermatologists should be aware of. Correct diagnosis helps to reassure patients and avoid unnecessary laboratory tests, biopsies, and invasive treatments.

Consent

The examination of the patient was conducted according to the principles of the Declaration of Helsinki.

The authors certify that they have obtained all appropriate patient consent forms, in which the patients gave their consent for images and other clinical information to be included in the journal. The patients understand that their names and initials will not be published and due effort will be made to conceal their identity, but that anonymity cannot be guaranteed.

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