



Vulvovaginal Disorders: An algorithm for basic adult diagnosis and treatment

DESQUAMATIVE INFLAMMATORY VAGINITIS (DIV)

What is DIV?

Desquamative inflammatory vaginitis (DIV) is a cause of persistent vaginitis, sometimes accompanied by painful intercourse. DIV can occur at any age, before or after menopause. Women with DIV often complain of years of vaginal discharge, or may suddenly develop profuse discharge. The discharge may or may not be associated with irritation of the vulva and vagina. Occasionally, discharge is not a complaint, but pain with intercourse is.

In this condition, inflammation causes the vaginal wall to peel or shed, called desquamation. DIV is not a common cause of vaginitis, and women who have it are often treated for other kinds of vaginal infections before the diagnosis of DIV is made. DIV is similar to a kind of vaginitis seen in women with an inflammatory skin disease called lichen planus and may be related to lichen planus in some, but not all, cases. Because of this, DIV is sometimes also called “lichenoid vaginitis.”

What causes DIV?

The cause of DIV remains unknown. Since it may occur in women during the reproductive years, and since it does not respond to treatment with estrogen, hormone deficiency is an unlikely cause. Infection has been considered, but, to date, no bacterial agent has been identified, and most antibiotics will not clear it. It is not cancerous or contagious, and it is not sexually transmitted.

What are the signs and symptoms of DIV?

Women with DIV often complain of an excessive, pus-like, yellow-green discharge that may have been present for years. The discharge may be blood-stained. The discharge may be associated with vulvar burning, irritation, and itching. Intercourse is often uncomfortable or painful. Few women complain of odor. The Pap smear may be abnormal. Women are treated repeatedly with antibiotics, anti-fungals, and estrogen, without improvement.

How is a diagnosis made?

Diagnosis is made by the typical findings of a copious yellow-green vaginal discharge, and an elevated vaginal pH. The vagina is reddened and inflamed. The diagnosis cannot be made without a microscope. With it, the clinician sees many white blood cells and many cells shed from the vaginal wall called parabasal cells. The normal healthy vaginal bacteria, called lactobacilli, are absent. The condition is often mistakenly diagnosed as bacterial vaginosis, Trichomonas, or vaginal atrophy from low estrogen levels.

What is the treatment?

DIV often requires lengthy treatment. It is treated with either vaginal hydrocortisone suppositories (Anusol 25 mg rectal suppositories used **vaginally**, or stronger hydrocortisone suppositories that must be made up by a compounding pharmacy), or with vaginal Cleocin gel, inserted in the vagina nightly for at least two weeks, then decreasing in frequency. Sometimes a combination of these medications is used. Your clinician will tell you how long to use the medication. The treatment decisions are made by the examination and the microscopic findings, so that follow up visits are essential.



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How effective is the treatment?

Research suggests that about a third of women with DIV will get better after treatment; about a third of women will be better but may have a relapse of their symptoms, and about a third of women may need long-term maintenance to keep the symptoms under control.