

LETTER TO EDITOR (VIEWERS CHOICE)

VULVAR ULCERS: UNEXPECTED AGENT AT PLAY

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The diagnosis of genital ulcers remains challenging, particularly in the pediatric population. Although vulvar ulcers are most commonly caused by infections, they may also result from autoimmune, inflammatory, neoplastic, traumatic, or drug-induced conditions.^{1,2}

Lipschütz ulcers, a rare and painful manifestation of genital ulcers predominantly found in non-sexually active adolescent females, were first identified by dermatologist Benjamin Lipschütz, in 1913. These ulcers have an acute onset and are commonly associated with viral illnesses, particularly Epstein-Barr virus, or bacterial infections like *Mycoplasma pneumoniae*. These ulcers are primarily identified clinically, requiring the exclusion of other potential causes.³

We report the case of an 11-year-old female who presented to the emergency department reporting vulvar pain and lesions that had developed over the previous 48 hours. Nonspecific discharge was noted. On day one of illness, she was treated with topical econazole without improvement. She was sexually inactive and no other topical or systemic medications had been used. No prior application of topical creams or other pharmacological substances were reported. There was no history of physical trauma or sexual abuse. The patient had no relevant medical history or a history of recurrent oral/genital ulcers. She denied gastrointestinal, genitourinary, neurological, ocular or articular symptoms.

Gynecological examination revealed vulvar erythema and four ulcers on the labia minora and vestibule, with red-violet borders covered by grayish exudate, with moderately symmetrical presentation resembling a "kissing pattern" (Fig.1). Exudate collection from the ulcers tested negative for *Mycoplasma pneumoniae*, *Trichomonas vaginalis*, *Ureaplasma*, *Haemophilus ducreyi*, Herpes simplex I and II, *Treponema pallidum*, *Neisseria gonorrhoeae* and *Chlamydia trachomatis*. Serologies for Cytomegalovirus, Epstein-Barr virus, Toxoplasmosis, Syphilis, Parvovirus, Herpes, influenza A and B and *Mycoplasma* were negative. The anti-paramyxovirus IgG and IgM antibodies were positive. Fecal calprotectin was 55 mg/Kg (reference value

Figure 1. Vulvar erythema and four ulcers on the labia minora and vestibule, with red-violet borders covered by grayish exudate, with moderately symmetrical presentation resembling a "kissing pattern"



50 mg/kg), ASCA and ANCA were negative. The remaining laboratory investigations were unremarkable. Considering the clinical presentation, the physical characteristics of the ulcers and the exclusion of other pertinent causes, the diagnosis of Lipschütz ulcers was established. The patient was discharged with lidocaine gel, benzydamine hydrochloride and clobetasol propionate. Complete healing was achieved after five weeks.

The pathogenesis of Lipschütz ulcers is not fully understood but is thought to involve an exaggerated immune response to an infectious trigger, leading to immune-complex deposition, dermal microthrombosis and painful vulvar ulceration.³ The disease is often preceded by influenza-like or mononucleosis-like symptoms, although these may be absent.⁴ It is characterized by an acute onset, often with bilateral symmetrical ("kissing") ulcers, and follows a self-limited course, with treatment focused on supportive care and pain relief.^{3,4}

Paramyxovirus has rarely been reported as a trigger of Lipschütz ulcers. Terrinoni et al.⁵ included it among the less frequent viral associations, and our case adds to the limited literature describing this finding. This case highlights the importance of considering Lipschütz

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ulcers in the differential diagnosis of acute genital ulcers in non-sexually active girls. Early recognition may prevent unnecessary investigations, inappropriate treatments and significant emotional distress for patients and their families.

Compliance with Ethical Standards

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