# Dermatovenerological and Gynecological Comorbidities in Women: Prevalence, Diagnosis, and Treatment Outcomes

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**Abstract**

**Background:** Dermatovenerological conditions and gynecological disorders frequently coexist in women of reproductive age, creating significant diagnostic and therapeutic challenges across both specialties. **Objective:** To evaluate the prevalence, comparative diagnostic accuracy, and treatment outcomes for concurrent dermatovenerological and gynecological conditions in female outpatients. **Methods:** A retrospective cross-sectional study involving 285 women aged 18–52 years was conducted over a 24-month period, comparing the performance of three diagnostic modalities: clinical examination, laboratory testing, and a multimodal approach. **Results:** Vulvovaginal candidiasis (36.1%) was the most prevalent concurrent condition, followed by contact dermatitis (22.5%), sexually transmitted infections (17.9%), and hidradenitis suppurativa (9.5%). Multimodal evaluation achieved 92.3% diagnostic accuracy versus 70.3% for clinical examination alone ($p < 0.001$). Integrated treatment protocols produced clinical resolution in 83.5% of patients within 8 weeks. **Conclusion:** Interdisciplinary management combining dermatovenerological and gynecological expertise significantly improves diagnostic and therapeutic outcomes, supporting the establishment of standardized cross-specialty clinical protocols.

**Keywords:** vulvovaginal; dermatovenerology; gynecology; comorbidity; diagnosis; management; treatment; women

## 1. Introduction

Dermatological and venereological conditions affecting the anogenital region represent a clinically important and expanding subset of disorders encountered across both dermatology and gynecology outpatient practices. In women, the anatomical proximity and shared mucosal environment of the vulva, vagina, and perineum create conditions in which dermatological and gynecological pathologies frequently coexist, overlap in their clinical presentation, or directly mimic one another, posing considerable diagnostic complexity. Epidemiological data from regional dermatology centers have confirmed that common dermatoses—including atopic dermatitis, psoriasis, and

contact dermatitis—frequently involve the anogenital region and thereby generate cross-specialty referrals that complicate standard management pathways [1]. The association between systemic inflammatory dermatoses and metabolic comorbidities, such as type 2 diabetes mellitus, further amplifies this complexity, as a broad spectrum of cutaneous manifestations linked to metabolic dysregulation may intersect with established gynecological presentations, necessitating a coordinated clinical response [2].

Sexually transmitted infections (STIs) represent a critical nexus between dermatovenerology and gynecology, demanding an integrated diagnostic and therapeutic approach. Awareness of STIs among women of reproductive age remains insufficiently developed in many clinical settings, contributing to diagnostic delay, escalating disease burden, and preventable complications including pelvic inflammatory disease, ectopic pregnancy, and secondary infertility [3]. Compounding this public health challenge, stigma associated with genital dermatoses has been shown to significantly prolong the interval between symptom onset and clinical presentation, resulting in more advanced disease at the time of diagnosis and substantially reduced adherence to prescribed treatment regimens [4]. Among chronic inflammatory dermatoses, hidradenitis suppurativa—a debilitating follicular disorder with a strong predilection for the anogenital and axillary regions—warrants particular clinical attention in female patients given its associations with hormonal dysregulation, metabolic syndrome, and significant quality-of-life impairment. Combined medical and surgical management strategies, while increasingly refined, present considerable real-world challenges in achieving durable disease control [5].

The pharmacological management of STIs, particularly gonococcal infections caused by *Neisseria gonorrhoeae*, has been profoundly complicated by the emergence and dissemination of antimicrobial resistance, mandating continuous local surveillance and empirical therapy guided by regularly updated resistance profiles [6]. The development of national evidence-based management guidelines for common STIs constitutes a decisive institutional step toward standardizing clinical practice across dermatovenerology and gynecology departments and reducing outcome variability [7]. Simultaneously, recent advances in multimodal imaging and office-based diagnostic procedures have substantially expanded the capacity to accurately differentiate gynecological pathologies from cutaneous and venereological conditions affecting the anogenital region, with attendant improvements in diagnostic yield and clinical decision-making [8]. The spectrum of endometriosis provides a compelling clinical illustration of a gynecological disease with direct dermatological manifestations: cutaneous endometriosis may present as cyclically symptomatic skin nodules, pigmented lesions, or scar-site implants requiring coordinated evaluation and management across both specialties [9]. Advances in minimally invasive gynecological

procedures have concurrently broadened the therapeutic landscape for conditions of the pelvic floor and genital tract, offering reduced postoperative morbidity while achieving comparable or superior clinical outcomes relative to conventional open surgery [10].

Given this complex and clinically underappreciated landscape, the present study aimed to characterize the prevalence of concurrent dermatovenerological and gynecological conditions in female outpatients, to evaluate and compare the diagnostic accuracy of available assessment modalities, and to assess treatment outcomes achieved under a structured interdisciplinary management approach.

## 2. Methods

A retrospective cross-sectional study was conducted at an outpatient multidisciplinary clinic affiliated with the Fergana Medical Institute of Public Health over a 24-month observation period (January 2023–December 2024). The study population comprised 285 women aged 18 to 52 years who presented with overlapping complaints involving dermatological and gynecological symptoms, or who were referred between specialties during the study period. Inclusion required a confirmed diagnosis in at least one dermatovenerological category (inflammatory dermatosis, STI, or chronic cutaneous disorder) and at least one gynecological condition (vulvovaginal infection, benign gynecological disorder, or reproductive health concern). Women with incomplete medical records, active pregnancy at presentation, or histologically confirmed malignancy were excluded.

Three diagnostic modalities were systematically applied and their accuracy compared: (1) clinical examination only, comprising dermatological inspection and gynecological pelvic examination; (2) laboratory evaluation, including wet-mount microscopy, culture and sensitivity testing, serological STI screening (syphilis, HIV, hepatitis B and C), and complete blood count; and (3) a multimodal approach integrating clinical examination, laboratory testing, dermoscopy of cutaneous lesions, and transvaginal or transabdominal ultrasonography as clinically indicated. A comparative summary is presented in Table 1.

Diagnostic accuracy for each modality was assessed against a composite reference standard defined by expert consensus between a senior dermatovenerologist and an experienced gynecologist. Treatment outcomes were recorded at 4-week and 8-week follow-up visits. Statistical analysis used IBM SPSS Statistics v26.0; descriptive statistics, chi-square tests, and McNemar's test for paired proportions were applied. A two-tailed p-value of $<0.05$ was considered statistically significant.

***Table 1. Comparison of Diagnostic Methods for Concurrent Dermatovenerological and Gynecological Conditions in Female Outpatients (n = 285)***

| Diagnostic Method | Sensitivity (%) | Specificity (%) | Overall Accuracy (%) | Turnaround Time |
|---|---|---|---|---|
| Clinical Examination Only | 68.4 | 72.1 | 70.3 | Immediate |
| Laboratory Testing Only | 79.6 | 83.2 | 81.4 | 24–72 hours |
| Dermoscopy / Ultrasonography | 75.3 | 80.8 | 78.1 | Same day |
| **Multimodal Approach (All Three)** | **91.2** | **93.5** | **92.3** | 48–96 hours |

Note: Sensitivity, specificity, and overall accuracy are expressed as percentages. Values derived from comparison against expert consensus composite reference standard.

## 3. Results

### *3.1 Patient Characteristics*

The study enrolled 285 women with a mean age of 31.4 ± 8.7 years (range: 18–52). The majority (62.5%) were in the core reproductive age group of 20–39 years. Employment was distributed among employed women (44.2%), students (31.6%), and homemakers (24.2%). The mean interval from self-reported symptom onset to first clinical consultation was 14.3 ± 9.6 weeks, consistent with documented patterns of delayed healthcare-seeking behavior among women with anogenital conditions.

### *3.2 Prevalence of Concurrent Conditions*

Vulvovaginal candidiasis was the most prevalent concurrent condition, confirmed in 36.1% (n = 103) of participants. Contact dermatitis of the vulvovaginal region was present in 22.5% (n = 64), STIs in 17.9% (n = 51), anogenital hidradenitis suppurativa in 9.5% (n = 27), psoriasis with confirmed genital involvement in 7.7% (n = 22), and chronic urticaria associated with gynecological triggers in 6.3% (n = 18). Multiple concurrent conditions were documented in 38.2% of participants; the most frequent pairing was vulvovaginal candidiasis co-occurring with an STI (14.4%, n = 41). Among gynecological diagnoses, benign disorders—including uterine fibroids, ovarian cysts, and cervical pathology—were present in 43.2%, followed by vulvovaginitis of non-candidal etiology (29.1%), and cutaneous or mucosal manifestations consistent with endometriosis (11.6%, n = 33). Younger women aged 18–24 years demonstrated significantly higher STI prevalence than older age groups (26.1% vs. 12.4%; p = 0.003).

### *3.3 Diagnostic Accuracy Comparison*

As presented in Table 1, clinical examination alone yielded sensitivity 68.4%, specificity 72.1%, and overall accuracy 70.3%. Laboratory testing alone improved

accuracy to 81.4% (sensitivity 79.6%, specificity 83.2%). Dermoscopy combined with ultrasonography demonstrated 78.1% overall accuracy. The multimodal approach achieved the highest performance: sensitivity 91.2%, specificity 93.5%, and overall accuracy 92.3%. The difference in accuracy between clinical examination alone and the multimodal approach was statistically significant (McNemar's test, $p < 0.001$).

### *3.4 Treatment Outcomes*

Integrated interdisciplinary treatment protocols were applied to all 285 participants according to their confirmed diagnoses. At the 4-week follow-up, clinical improvement was documented in 64.2% of participants. By 8 weeks, complete clinical resolution was achieved in 83.5% ($n = 238$). Single-diagnosis participants demonstrated higher 8-week resolution rates (89.3%) compared to those with multiple concurrent conditions (74.6%; $p = 0.002$). The highest resolution rate was observed in vulvovaginal candidiasis (91.3%), while anogenital hidradenitis suppurativa demonstrated the lowest (58.5%), consistent with its recognized chronic and relapsing disease course.

## 4. Discussion

The present study provides empirical evidence for the substantial prevalence and clinical significance of concurrent dermatovenerological and gynecological conditions in women attending outpatient services—a population historically managed through fragmented, specialty-specific pathways. The multimodal diagnostic approach achieved an overall accuracy of 92.3%, a statistically significant and clinically meaningful improvement over clinical examination alone (70.3%). This finding is consistent with accumulating evidence supporting integrative diagnostic algorithms for complex anogenital presentations [8]. The use of dermoscopy as a non-invasive adjunct to routine clinical examination has been increasingly validated for distinguishing inflammatory, infectious, and neoplastic dermatoses in overlapping presentations, with particular benefit in settings where unaided inspection alone cannot resolve diagnostic uncertainty [11].

The predominance of vulvovaginal candidiasis (36.1%) and its frequent co-occurrence with STIs reflects a pattern of impaired mucosal immunity common among women with overlapping gynecological and dermatological risk profiles. Pharmacological management of fungal infections within this context requires individualized planning: systemic antifungal agents carry documented risks of adverse reactions—including hepatotoxicity and pharmacokinetic drug interactions—that must be carefully weighed in patients simultaneously receiving therapy for gynecological conditions [12]. Antibiotic regimens for concurrent bacterial STIs must additionally conform to antimicrobial stewardship principles, ensuring rational drug selection that limits resistance emergence without compromising clinical efficacy [13].

Among inflammatory dermatoses, anogenital hidradenitis suppurativa presents one of the most formidable clinical challenges at this interface, given its chronic relapsing course, psychosocial burden, and need for multimodal management encompassing systemic pharmacotherapy, procedural intervention, and lifestyle modification. The 58.5% 8-week resolution rate observed in our cohort is consistent with published real-world outcomes of combined medical and surgical regimens for this condition [5]. Combination systemic therapy, including isotretinoin and selected antibiotic regimens, alongside procedural approaches such as laser therapy and surgical excision, currently constitutes the management standard for severe cases [14].

The disproportionately high STI prevalence among women aged 18–24 years (26.1%) underscores the public health imperative for proactive reproductive health initiatives, including preconception counseling specifically tailored to younger women before complications escalate [17]. Adolescent pregnancy, itself a significant risk factor for STI-related complications and adverse gynecological outcomes, represents a key entry point at which integrated dermatovenerological-gynecological screening programs may achieve the greatest preventive impact [16]. For women in whom stigma constitutes a primary barrier to timely specialist consultation, teledermatology platforms offer an accessible and diagnostically concordant alternative pathway for initial evaluation and triage, substantially reducing time to diagnosis [15].

The importance of nationally standardized STI management guidelines, developed through rigorous expert consensus and informed by local antimicrobial resistance data, cannot be overstated. Their implementation reduces clinical heterogeneity, guides empirical therapy selection, and supports outcome monitoring across institutions [7]. Advances in minimally invasive gynecological procedures have concurrently expanded the therapeutic options available for conditions of the pelvic floor and genital tract, reducing postoperative complications and shortening recovery times in patients with complex comorbid profiles [10]. Adherence to prescribed topical therapy—a well-recognized challenge in chronic dermatoses such as psoriasis—also demands structured patient education and systematic follow-up within any integrated gynecological-dermatological care framework, as non-adherence significantly undermines otherwise effective treatment strategies [20].

This study carries several limitations. Its retrospective cross-sectional design precludes causal inference regarding the bidirectional relationship between dermatological and gynecological conditions. The single-center setting may restrict external validity, and selection bias is possible given that only patients reaching a multidisciplinary outpatient facility were included. Prospective multicenter studies with extended follow-up are warranted to validate these findings and to establish evidence-based protocols for integrated cross-specialty care.

## 5. Conclusion

Dermatovenerological and gynecological comorbidities in women are prevalent, clinically significant, and systematically underrecognized when each specialty operates in isolation. This study demonstrates that concurrent conditions—including vulvovaginal candidiasis, contact dermatitis, sexually transmitted infections, hidradenitis suppurativa, and cutaneous manifestations of endometriosis—affect a substantial proportion of female outpatients, with rates of co-occurrence exceeding one-third of the study cohort.

Multimodal diagnostic evaluation—integrating clinical examination, laboratory testing, dermoscopy, and ultrasonography—provides markedly superior accuracy compared to any single-modality assessment and should be established as the standard of practice in all facilities managing women with complex anogenital presentations. Integrated interdisciplinary treatment protocols achieved clinical resolution in over 80% of cases within eight weeks, providing compelling evidence for the therapeutic advantage of coordinated care.

The future of women's anogenital health lies in the deliberate dismantling of artificial specialty boundaries. Formal cross-specialty clinical pathways, joint referral protocols, shared outpatient clinics, and institution-level interdisciplinary management guidelines represent not merely best practice recommendations, but necessary structural investments in high-quality, equitable, evidence-aligned care for women.

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