Vulvar Neoplasms: Benign and Malignant

Pooja R. Shah, MD, FAAD, interviewed by Carlos Garcia, MD, FAAD

CARLOS GARCIA, MD, FAAD: Hello, everyone. This is a new episode of *Dialogues in Dermatology*. This time, we are at the 2025 Annual AAD Meeting in Orlando. I'm your host, Dr. Carlos Garcia, from Oklahoma City. Today, I have the pleasure of talking with Dr. Pooja Shah, who is Assistant Professor and Director of Women's Skin Health and Wellness at Northwell Health University in New York.—

--We're going to be talking about some vulvar lesions and about how the dermatologist has to be aware of the importance of this type of diseases in our daily practice. Dr. Shah, thank you so much for taking time from your busy schedule at AAD 2025 to speak to us about this interesting topic.

POOJA R. SHAH, MD, FAAD: Thank you, Dr. Garcia, for having me here. I'm really excited to share my experience in this field and emphasize the importance of being an expert in vulvar dermatology, even as a general dermatologist.

CARLOS GARCIA, MD, FAAD: Why don't we start first with you telling us, how did you become involved in this particular area of dermatology? I practice general derm and it's not a common complaint. I know that sometimes we find very obvious things when the patients finally decide to tell us about it. But it is not something that I could rate as in the top 20 things that I do in my practice.

POOJA R. SHAH, MD, FAAD: I think that I am really lucky that I had very good training in vulvar dermatology as a resident at University of Rochester. Six years ago when I graduated and ended up at Northwell Health, which is my first job out of residency, I was practicing general dermatology, a mix of conditions. What I found was that the way that I had been trained, a full

body skin exam was not just looking at the face, the trunk, the arms, legs, but also looking at the genital region.—

--That to me was standard of care. So when I started practicing, a lot of patients who had been coming to this practice for years oftentimes were surprised that I would introduce myself and kind of give them a little heads up as to how I was going to do the exam. Patients were very surprised, “Why do you need to look at the genital region? It doesn’t see the sun.” That was the initial spark of, wow, there’s a lot of education and awareness lacking amongst the general public about the importance of doing genital exams.—

--That’s kind of how I started on the day to day doing vulvar exams in my full body skin check skin cancer screenings. What I found was that I have, over the years, accumulated a cohort of patients who have had lichen sclerosus. It’s just crazy to imagine that almost 50 percent of my patients with lichen sclerosus I have diagnosed on a full body skin cancer screening, where they did not even bring up a complaint about having irritation.—

--During my exams, when I would notice some changes and I would ask and prompt patients to dig a little more, then they would come forth about, “Oh, yeah, I’ve been itching for years. But, you know, the gynecologist is taking care of it.” Or, “Oh, I’ve been using antifungal creams.” “Oh, yeah, you know, I stopped engaging in sexual activity because I’ve been having pain with intercourse for years.” So I think hearing that, I saw a gap in practice.—

--Unlike where I had trained, where I saw these conversations happening a lot, when I was in Long Island I found that there was definitely an area where I feel like I could contribute to the field and really get involved in resident education and training the next set of dermatologists, so that this doesn’t become a hush-hush topic. That was my initial beginnings into vulvar dermatology.—

--And then patients started finding me through these secret Facebook groups. It's interesting, there's like a sisterhood about, I would ask patients, "How did you find me?" and they say, "Oh, I saw your name on a Facebook group." And I'm like, "What?" I just found that was very comical that that's how I'm being found. And also highlights such an important issue that we as dermatologists are at the frontline of diagnosing conditions like lichen sclerosus or even vulvar squamous cell carcinomas, especially when we are the ones doing full body skin cancer screenings.—

--The vulva is part of the skin exam. That's kind of where my interest in vulvar dermatology started. And then what kind of was that turning point for me was I had this patient in her late 30s come. She was very distraught and stressed out. I remember walking into the room and the energy, it was a stressful energy. I go in and she comes in with pain in the vulva.—

--She was kind of at her wit's end and had told me that she had seen a bunch of gynecologists and kept being told that she has herpes simplex virus. She's like, "I've been taking Valtrex on and on for episodes but it's not helping." Her and her husband started having marital issues because of this. So here I am thinking, wow, if this is truly recurrent herpes simplex, what am I going to do to stop them from happening if she's already on maintenance therapy or suppressive dosing of Valtrex and she's still getting breakthrough episodes?—

--Before the exam, I already have my mind turning and thinking, wow, I really hope, like what am I going to find? As I'm doing the exam, she has clear sclerotic macules. It wasn't the classic plaques but there were these distinct white, sclerotic macules. I said, "This is not herpes. This is lichen sclerosus, I know it." I did a biopsy and it was lichen sclerosus.—

--It was great, I hate to give this diagnosis to women, but having a true diagnosis to give a patient an explanation for why they've been suffering. When I saw her back, she was just so

happy to hear that there was a diagnosis that we can actually treat. Later on, kind of as I got to know her, she said that I essentially saved her from a divorce. So I just can't forget that.—

--Here I am thinking, oh, I'm just doing a routine exam and treating a woman with lichen sclerosus. But you don't really realize what's happening in their personal lives and how much this condition or vulvar conditions in general can affect someone's personal life, their sexual health. There's so many different impacts about when someone is suffering from things in the vulva. So that was my turning point and I decided, you know what, I really want to focus on this and help more women who are suffering and probably not as forthcoming about what they're going through, so that's how I started.

CARLOS GARCIA, MD, FAAD: Wow, what a case, interesting. For the regular dermatologist, sometimes it's hard to approach a patient and suggest that we want to do a genital exam when they're coming because they had a basal cell or the father had actinic keratosis. I think it would be very interesting for us to know how do you recommend that we approach this and suggest this, in particular, if you have had situations where culturally the women are shy?—

--In my clinic, I see a lot of Mexican women and it's a taboo type of thing sometimes, mostly with the elderly. So how do we train ourselves to start including the genital exam in our full skin exams? And if you have any tips or cautionary tales for biopsying in this area?

POOJA R. SHAH, MD, FAAD: I have the standard approach that I've been doing since day one of practice. I think a lot of us dermatologists are type A, we like to follow the checklist, and we all have certain ways of doing things. So the way that I like to approach these patients is, and I do a lot of full body skin checks and I see a lot of patients for skin cancer screenings, when I walk into the room if it's a new patient, I introduce myself and I say, I find out kind of why they are there, and if they say, "Well, I'm just here for a skin check."—

--Having said that, I usually ask, “Well, have you had a skin check before?” Sometimes they’ll say, “Yes, I’ve been to a dermatologist, I’ve been doing this for years.” I kind of start the conversation with, “I know you’ve had a skin check for years but I may be doing things a little differently, so I want to explain how I do it before we begin.” Then I say, “I usually start your exam head to toe, and I also check under the bra, and I check in the groin area to make sure that there is nothing there that we are concerned about.”—

--Oftentimes patients will say, “Well, no, you don’t really need to check there. It’s not like I go get sun exposure.” And then I emphasize it again, “You know, you’d be surprised but there are times when I have found things and it’s better to catch things early than to wait when things become far too advanced and then we’re going into deeper problems.” Usually that second statement is enough to get them to say, “Well, okay, I’m here, I might as well check.”—

--I say, “You know, it really takes a second to look but that second could really save you from trouble, if there is any.” Most of the time, patients are pretty okay with that. Now, sometimes there is the rare patient who is still very hesitant for a genital exam, then I don’t push it for that first exam. But once usually what I find is even in those instances, once I’ve done the full body skin check, a lot of times patients are, even though they’ve seen a dermatologist for years, they’re surprised when they’re like, “Wow, no one has ever looked at me with so much detail.”—

--So then I kind of give it that third chance of, “Hey, you’re here, do you want me to just check your genital exam?” A lot of times they just say, “Okay, yeah, sure, I’m here.” So I think prefacing while you’re introducing yourself in the room, kind of letting them know what you’re going to do before you even do it, that’s helped me. I know in my current practice I teach residents and I do find with my male residents sometimes patients are hesitant.—

--But they’re usually okay when I’m in the room with them. So for a male provider, I think having someone to chaperone with you, I think that would help in the exam. So I think if you set the

standard of, “Hey, this is what a dermatologist does. This is what a full body skin exam is,” most patients are okay with that. People don’t want to hear or ever be dealing with a word like cancer. So if we can save them from something that’s going to lead to cancer, I think most patients are okay with that.—

--The fact that they have come into our office for a skin cancer screening, they already are engaging in preventive care. So our job is to just educate them on that little piece and guide them in the right direction.

CARLOS GARCIA, MD, FAAD: Do we need to examine the vulva only or do you do we need a speculum to do the introitus? Where is going to be the money in this exam, where are we going to find most of our things? Do you have any tips about doing biopsies in the genital area?

POOJA R. SHAH, MD, FAAD: The one thing that actually helps when I’m giving my introduction to patients is I usually tell them, “I’m going to look in the genital region, in the vulva, but I’m not doing an internal speculum exam.” I feel like that takes a lot of the pressure off, because I’m not a gynecologist. I do not know what I’m looking for with a speculum exam. But I think that as a dermatologist, you don’t need a speculum to look at the vulva. You do need to spread the labia majora and look at the anatomy and make sure that the anatomy is intact.—

--Make sure you don’t see any inflammation or any lesions that are not responding to treatment. You don’t need a specific tool to necessarily do a vulvar skin exam. But then I do tell patients if they have HPV or they have warts, then I will make sure that they know to see a gynecologist as well, so they get their Pap smears and get screened for cervical cancer.—

--In terms of vulvar biopsies, actually what is really important is having the right help. I usually train my MAs, I like to do punch biopsies in the vulva because I think the vulva is very forgiving and it heals very quickly. Instead of using sutures, I actually put Gelfoam in. So after I do the

punch biopsy, I usually do Gelfoam. That way, it doesn't irritate them and within a week they're healed. I've never had a patient call me and say, "I'm uncomfortable down there."—

--Usually you need multiple sets of hands to hold the skin tight as you're doing the biopsy. It's just about setting expectations before doing such an invasive exam. I usually tell them, "I'm going to touch the vulva. I'm sorry that it's going to be a little uncomfortable but this is how we're going to do it."

CARLOS GARCIA, MD, FAAD: Not everything that we find in the vulva is going to be cancer, thank God. A lot of things are benign. Some of them have been surprising to me because I didn't even know that those things were there. In your practice, what are the most common things that you see?

POOJA R. SHAH, MD, FAAD: I agree, most of the time I'm finding benign things. The most common thing I see is angiokeratomas or angiomas in the vulva, which patients are so relieved because they sometimes look dark. They can be a little scary for a patient who doesn't know what certain skin lesions are. That's probably my most favorite diagnosis because most people think they're coming in with warts or they have an STD or they have cancer.—

--I take a look and I'm like, "Oh, these are nothing, these are just blood vessel growths." So angiokeratomas, skin tags, you see a lot of other benign lesions. Like in a pregnant female, you may see vulvar varicosities. You can see benign nevi in the vulva, so like dermal nevi. You have cysts, little milia, or steatocystomas in the vulva. So there's a lot of benign things in the female.—

--I wouldn't say they are that common but I do a lot of skin checks every day, most of my exams they have some benign findings and patients are just happy to know that they don't need to get anything removed in the vulva. Because no one wants to get a surgery down there. In my lichen

sclerosus patients, I make sure to educate them that even if their disease is controlled and they're on a good regimen, a lot of times patients feel like, "Well, I don't need to treat myself anymore because I'm better. My itch is gone."—

--It's so important to talk about maintenance therapy with these patients, because there is a slight risk of skin cancer. Less than 5 percent risk of getting a squamous cell carcinoma in chronic inflammatory vulvar disease, lichen sclerosus being the most common. So benign things are the most common but that being said, I've had three patients in the past six months with vulvar squamous cell carcinoma in situ. Caught early, they're treated early, and we're really saving a lot of lives.

CARLOS GARCIA, MD, FAAD: Unfortunately, our time is coming to an end. Why don't you please give us some take home messages to reflect on.

POOJA R. SHAH, MD, FAAD: I think that as a dermatologist who is training the next generation of dermatologists, I think that one thing I want to really get across is making the vulvar exam a standard of care in your fully body skin exam. I think that we are really the frontline of finding these conditions, treating them early, and really educating patients on the importance of looking down there.—

--Between benign and malignant, I think that it's really important to also emphasize the importance of HPV vaccination. So vulvar cancer, there's the HPV independent pathway and then there's the HPV dependent pathway. So very early on in HPV naïve patients, teaching parents the importance of HPV vaccination, like Gardasil 9 which is FDA approved, that really helps reduce risk of vulvar cancer, risk of cervical cancer.—

--I think it's just having an open conversation with your patients can really help you make this a standard of care. I would really like to see more dermatologists be less afraid of looking at the

vulvar and I hope that we can get that point across. One of the other key messages that I wanted to get across is that most of the malignancies that our GYN colleagues are seeing, only 5 percent of them are vulvar malignancies, whereas 100 percent of the malignancies that we as dermatologists find in the vulva, they're truly our domain.—

--So this is something that we as dermatologists should be treating, should be comfortable talking about, and educating our patients on, and really making sure that this becomes the standard of care.

CARLOS GARCIA, MD, FAAD: Thank you very much, Dr. Shah. Well, friends, we are at the end of this wonderful episode of *Dialogues in Dermatology*. I'm your host, Carlos Garcia from Oklahoma City. Today, we had the pleasure of speaking with Dr. Shah about vulvar exam and vulvar lesions. We'll see you next time.

POOJA R. SHAH, MD, FAAD: Thank you so much.

Commentary

Lauryn Reid, MD with Jules Lipoff, MD, FAAD (ed.)

In this Dialogues in Dermatology, Dr. Pooja Shah, Assistant Professor and Director of Women's Skin Health and Wellness at Northwell Health University in New York, discusses vulvar dermatologic conditions and management in her practice.

Total body skin exams (TBSEs) are a key component of dermatology. However, examination of the genitalia is often deferred. In fact, less than 5% of dermatologists report routinely examining the vulva, and Dr. Shah makes clear how her exam will be more comprehensive, which she feels is an important addition to the standard skin check that often excludes genital areas.

There are numerous barriers that discourage female genitalia exams during TBSEs including patient discomfort and preference. Additionally, some dermatologists may lack confidence in genital exams due to lack of exposure during training2. Dr. Shah argues that it is of high importance to educate patients that both benign and malignant cutaneous lesions occur on the vulva and foster an environment where patients are comfortable to express all concerns. Establishing a standardized protocol to incorporate vulvar exams into the TBSE can help ease the stigma for both patients and providers.

Dermatologists are well-equipped to diagnosis and treat the vast majority of cutaneous lesions, and Dr. Shah emphasizes that we should not shy away from examining seemingly difficult sites such as the vulva.

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