Authors' reply

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Dear Sir,

I thank De Giorgi et al for their comment on our paper.[1,2] I agree that in the light of strong clinical evidence and the numerous indexed papers of the past few years, dermatoscopy should have been at least mentioned. Dermatoscopy features of vulvar basal cell carcinomas (BCCs) are well recognised, such as linear and arborising telangiectasia, pinkish background, blue ovoid nests, white shiny structures and brown dots.[3,4] However, in our clinic setting, the role of dermatoscopy is limited.

In our hospital, vulvars clinic are situated in the colposcopy suites under a gynaecology cancer centre, which is a tertiary referral centre. All cases of vulvar BCC are managed by gynaecologists trained in gynaecological oncology. In our current clinic setting, colposcopy is used to examine lesions under magnification. Dermatoscopy is currently limited to the dermatology clinic and is not yet available in vulvar clinics. Hence, gynaecologists will need special training in performing vulvar dermatoscopy procedures.

Women with vulvar conditions often present late because of shyness or seek medical attention only when the symptoms do not improve. These reasons account for their presentation with nodular, infiltrative or ulcerated lesions. The threshold for vulvar biopsy is low for these women and the role of dermatoscopy is limited in majority of these cases.

I believe that dermoscopy is a very helpful tool for surveillance of lichen sclerosus, vulvar intraepithelial neoplasia, pigmented lesions of the vulva and much more.[5] We appreciate the comment by De Giorgi et al and plan to bring dermatoscopy to our multidisciplinary vulvar clinics in future.

Yours sincerely,

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