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Case Report

Invasive extramammary Paget's disease of the vulva: a multimodality organ-preserving approach

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ABSTRACT

Extramammary Paget's disease (EMPD) of the vulva is an uncommon intraepidermal adenocarcinoma of apocrine gland- bearing skin, typically affecting elderly women. It frequently presents as a chronic pruritic eczematous lesion and is often misdiagnosed as benign dermatoses, leading to delay in diagnosis. While many cases remain intraepidermal, a subset progresses to invasive disease with stromal and visceral involvement, associated with nodal and distant metastasis and worse prognosis. There is no universally accepted standard for locally advanced invasive EMPD; surgery, radiotherapy, and systemic therapy are all used in various combinations. A 70-year-old postmenopausal woman presented with invasive vulvar EMPD with bladder base infiltration, staged as T2N1M0 (stage IIIA). She received neoadjuvant paclitaxel- carboplatin chemotherapy followed by definitive external beam radiotherapy to the pelvis with a vulvar boost after declining radical vulvectomy. She achieved a partial response to chemotherapy and remains disease-free on follow-up after completion of radiotherapy, illustrating the role of individualized multimodal, organ-preserving treatment in invasive vulvar EMPD.

Keywords: Extramammary Paget's disease, Vulva, Invasive Paget's disease of vulva

INTRODUCTION

Extramammary Paget's disease (EMPD) is a rare cutaneous adenocarcinoma arising in apocrine gland-bearing skin, most often involving the vulva in women, and the scrotum, perineum, or perianal region in men. It accounts for only a small fraction of vulvar malignancies-approximately 1-2% of vulvar neoplasms in large series-yet poses disproportionate diagnostic and therapeutic challenges because of its chronic, indolent, and often deceptively benign clinical appearance. EMPD typically affects elderly, postmenopausal women, with median age at diagnosis between 60 and 80 years, and frequently presents as a long-standing erythematous, eczematous, or plaque-like lesion accompanied by pruritus, burning, or soreness. These non-specific features closely mimic common inflammatory dermatoses such as eczema, lichen sclerosus, psoriasis, and chronic vulvovaginitis, leading to repeated topical treatment and significant delay before biopsy and definitive diagnosis.[1]

Pathologically, primary vulvar EMPD is characterized by large pale Paget cells with abundant mucin-rich cytoplasm scattered within the epidermis and adnexal structures; immunohistochemically, these cells typically express CK7, EMA, and CEA, and are negative for CK20 and CDX2, which helps distinguish primary disease from secondary involvement by colorectal or urothelial adenocarcinoma. Although EMPD is classically regarded as an intraepidermal neoplasm, stromal invasion is seen in

13-40% of cases, and this invasive subset is associated with a substantially higher risk of regional lymph-node metastasis and distant spread. The clinical behavior of invasive EMPD of the vulva varies widely: patients with disease confined to the epidermis often have excellent long-term survival, whereas those with nodal or visceral metastases have 5-year survival rates below 10% despite treatment.[2]

Standard management of vulvar EMPD has historically centered on surgery, including wide local excision, radical excision, or vulvectomy, with attempts to secure negative margins through mapping biopsies, intraoperative frozen section, or Mohs micrographic surgery. However, due to the multifocal and "'skip' nature of Paget cell spread, positive or close margins remain common even after radical procedures, and reported local recurrence rates range from 20% to 70% across series. Extensive surgery in elderly women can also be associated with considerable morbidity, including wound complications, sexual dysfunction, and urinary or fecal incontinence, raising important quality-of-life and autonomy concerns. Radiotherapy has therefore been explored as both a primary and adjuvant modality, and small retrospective studies and case series suggest that external beam radiotherapy to doses of 45-66 Gy can achieve durable local control with acceptable toxicity in selected patients with in situ or invasive EMPD.[3]

Systemic therapy for EMPD has traditionally been reserved for unresectable, recurrent, or metastatic disease, and evidence comes primarily from small retrospective cohorts and case reports. Conventional regimens using 5-fluorouracil, platinum agents-taxanes, or anthracycline-based combinations produce objective response rates around 40-60% but are associated with frequent grade 3-4 myelosuppression and have not clearly improved overall survival in metastatic cohorts. In contrast, recent molecular profiling has identified recurrent ERBB2 (HER2) amplifications and mutations in a substantial subset of EMPD, particularly in vulvar and scrotal primaries, providing a rationale for HER2-targeted therapy. Phase II data on docetaxel plus trastuzumab in HER2-positive advanced EMPD demonstrate objective response rates of approximately 77% with manageable toxicity, and case series of trastuzumab-based regimens and HER2-directed antibody-drug conjugates further support targeted therapy as an emerging standard for advanced disease.[4]

Against this background of limited high-level evidence and evolving systemic options, management of invasive vulvar EMPD remains highly individualized and often requires integration of surgery, radiotherapy, and systemic therapy tailored to patient comorbidities, tumor extent, biomarker status, and preferences. The present case describes an elderly woman with HER2-positive invasive vulvar EMPD with bladder base involvement who declined radical vulvectomy, and was successfully managed with neoadjuvant paclitaxel-carboplatin followed by definitive external beam radiotherapy, highlighting a multimodal, organ-preserving approach for locally advanced disease in a real-world setting.

CASE REPORT

A 70-year-old postmenopausal woman presented to the dermatology outpatient clinic with complaints of vulvar itching and swelling for two years. The symptoms were insidious in onset and gradually progressive, with increasing discomfort during walking and sitting, and intermittent serous discharge but no frank bleeding or dysuria. She had received multiple empirical courses of topical corticosteroid and antifungal preparations at peripheral facilities with only temporary relief. There was no history of hematuria, abnormal vaginal discharge, or altered bowel habits.

Her past medical history revealed systemic hypertension for 10 years, controlled with oral medication. She was not diabetic and had no history of tuberculosis, prior pelvic irradiation, or major abdominal surgery. She denied smoking, alcohol consumption, or use of smokeless tobacco. There was no family history of gynecologic, breast, colorectal, or urothelial malignancy. Obstetric history included three term vaginal deliveries. Menopause had occurred at 50 years of age.

On general examination, she was of average build and nourishment with stable vital signs. Systemic examination was unremarkable. Her body surface area was approximately 1.6 m², and Eastern Cooperative Oncology Group (ECOG) performance status was 1.

Local vulvar examination revealed an irregular fungating erythematous lesion involving both labia majora, more prominent on the right side, measuring roughly 5×3 cm. The surface was moist with areas of superficial ulceration, and the surrounding skin showed eczematous changes and depigmentation extending to the perineum. The margins were ill-defined with palpable induration extending anteriorly towards the clitoral hood. The lesion was tender on palpation but non-bleeding. There were no obvious satellite lesions. Per speculum examination revealed an atrophic vagina and cervix with no visible intravaginal lesion. Bimanual and rectovaginal examination suggested anterior vaginal wall thickening adjacent to the lesion but no parametrial fixation. Bilateral inguinal examination revealed small, firm, mobile, subcentimetric lymph nodes without overlying skin changes.

Routine laboratory investigations, including complete blood count, liver and renal function tests, and coagulation profile, were within normal limits. Screening for viral infections (HBV, HCV, HIV) was negative. A punch biopsy of the vulvar lesion showed large pale cells with abundant vacuolated cytoplasm and prominent nuclei distributed singly and in clusters throughout the epidermis and involving adnexal epithelium. Foci of invasion into the superficial dermis were evident. IHC demonstrated

positivity for cytokeratin 7, EMA, and CEA, with negativity for cytokeratin 20 and p63, confirming the diagnosis of primary invasive extramammary Paget's disease of the vulva. HER2 immunostaining was 3+ by IHC, indicating HER2 overexpression.

Contrast-enhanced CT scan of the abdomen and pelvis demonstrated an enhancing vulvar mass involving the labia majora with anterior extension abutting the bladder base and lower anterior vaginal wall, associated with a few subcentimetric bilateral inguinal lymph nodes but no pelvic or para-aortic nodal enlargement or distant metastases. No synchronous colorectal, urothelial, or gynecologic adenocarcinoma was identified on imaging or clinical evaluation. Based on clinical and radiologic findings, the disease was staged as T2N1M0, corresponding to Stage IIIA invasive vulvar EMPD.

Multidisciplinary tumor board discussion concluded that the optimal strategy would be neoadjuvant chemotherapy with paclitaxel and carboplatin to reduce tumor burden and potentially downstage the lesion, followed by radical vulvectomy with bilateral inguinofemoral lymphadenectomy if feasible. Paclitaxel 175 mg/m² (260 mg) and carboplatin AUC 5 (approximately 450 mg) were administered intravenously on day 1 of a 21-day cycle, with standard premedication for paclitaxel, including dexamethasone, H1 and H2 blockers, and triple-drug antiemetic prophylaxis with a 5-HT3 receptor antagonist, dexamethasone, and an NK1 antagonist. A total of six cycles were planned, with interim assessment after the third cycle.

The patient completed six cycles of neoadjuvant paclitaxel carboplatin between 14 October 2024 and 20 January 2025. Hematologic toxicity included grade 2-3 neutropenia during cycles three and four, which was managed with short-course granulocyte colony-stimulating factor and temporary dose delay, without febrile episodes. She developed grade 2 mucositis during early cycles, controlled with saline and bicarbonate mouth rinses and topical anesthetic gels, and grade 1 neuropathy manifesting as mild distal paresthesia, which did not require dose modification. Non-hematologic events such as nausea and fatigue were grade 1-2 and managed symptomatically.

Clinical evaluation after three cycles revealed substantial reduction in lesion size with flattening of the fungating component and residual plaque measuring approximately 2.5 × 1.5 cm. Post-chemotherapy CT evaluation after six cycles confirmed partial response as per RECIST 1.1 criteria, with decreased thickness of the vulvar mass, reduced contact with the bladder base, and no new lesions or distant metastases. Inguinal lymph nodes remained subcentimetric and non-necrotic.

Radical vulvectomy with bilateral inguinofemoral lymphadenectomy was recommended again as the preferred modality for durable local control; however, after extensive counseling regarding benefits and risks, the patient declined surgical intervention due to concerns about extensive tissue loss, urinary and sexual dysfunction, and prolonged postoperative morbidity. In view of her refusal of surgery but reasonable performance status and good response to chemotherapy, the tumor board elected to proceed with definitive external beam radiotherapy with curative intent.

Radiotherapy was delivered using an anterior-posterior parallel opposed field technique to encompass the vulva, perineum, and bilateral inguinofemoral and pelvic nodal regions. A total dose of 50 Gy in 25 fractions (2 Gy per fraction, five fractions per week) was prescribed to the pelvis, followed by a vulvar boost of 10 Gy in 5 fractions using a direct field (6×6 cm at 1 cm depth), resulting in a cumulative dose of 60 Gy in 30 fractions over six weeks, from 12 February 2025 to 1 April 2025. Concomitant systemic therapy was omitted because of preceding full-dose chemotherapy and age-related concerns regarding tolerance. During radiotherapy, the patient experienced grade 2 nausea and diarrhea, managed successfully with antiemetics, loperamide, and pre/probiotics. She developed grade 2 moist desquamation over the vulvar and perineal region towards the end of treatment, which responded to non-adherent dressings, topical barrier creams, and adequate analgesia. There were no treatment breaks, and hematologic parameters remained within acceptable limits.

At one-month post-treatment evaluation, the vulvar lesion had largely re-epithelialized with residual erythema and mild fibrosis but no ulceration or nodularity. Subsequent follow-up at 2-3-monthly intervals showed sustained clinical remission. At the most recent visit on 5 December 2025, approximately nine months after completion of radiotherapy, she remained disease-free clinically, with dry depigmented skin, mild vulvar fibrosis, and small superficial ulcerations over the irradiated area, which were being managed conservatively. There was no evidence of inguinal lymphadenopathy, bladder or rectal toxicity, or distant metastasis.

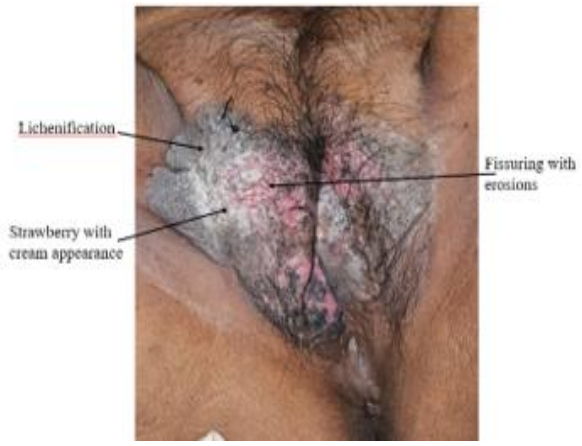

Figure 1: Clinical examination findings at the time of initial presentation.

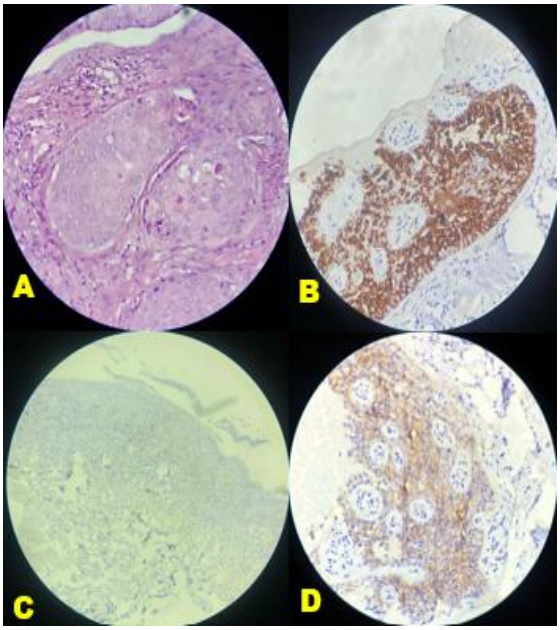

Figure 2: (A) Paget's cells- EMPD; (B) Cytokeratin 7 positive; (C) Cytokeratin 20 negative; and D) HER2 positive.

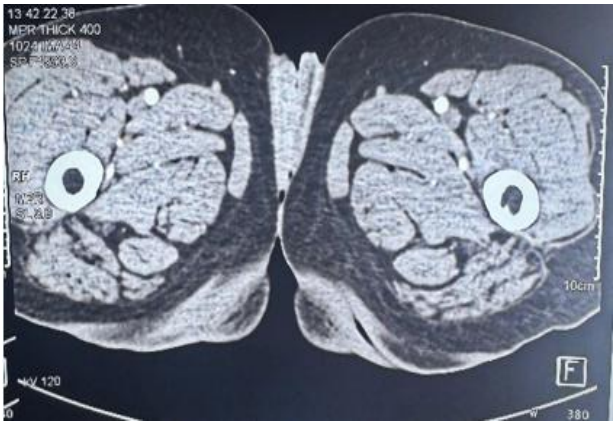

Figure 3: CECT pelvis showing enhancing vulvar mass lesion.

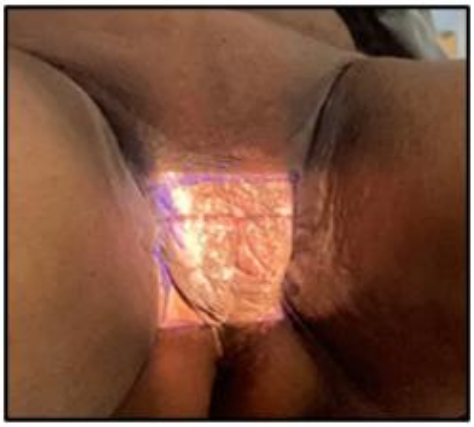

Figure 4: Vulvar boost radiotherapy in frog-leg position.

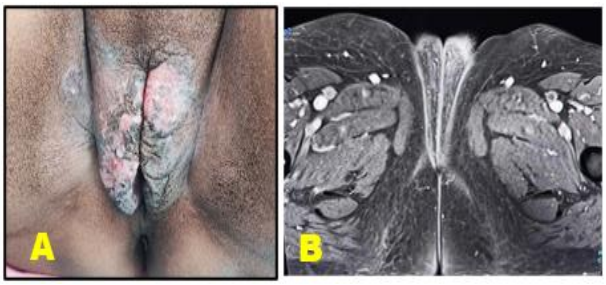

Figure 5: (A) Late skin toxicity changes- disease free status during last follow-up; and (B) CEMRI pelvis- no mass lesion.

DISCUSSION

This case illustrates several key aspects of the biology and management of vulvar EMPD that are increasingly recognized in contemporary series. First, the patient's protracted history of pruritic vulvar symptoms treated with topical agents before biopsy underscores the well-documented propensity for diagnostic delay in EMPD, which arises from its eczematous appearance and overlap with benign dermatoses. Multiple cohort studies have shown that women with vulvar EMPD often experience symptoms for months to years before histologic confirmation, and that delayed diagnosis contributes to higher rates of invasive disease and nodal metastasis at presentation. Early biopsy of any chronic, treatment-refractory vulvar lesion in postmenopausal women therefore remains a critical first step to improving outcomes.[5]

Second, the histopathologic and immunophenotypic features in this patient-Paget cells confined to the vulvar epidermis with foci of stromal invasion, CK7/EMA/CEA positivity, and CK20 negativity-are typical of primary invasive EMPD of the vulva and help differentiate it from secondary EMPD due to spread from colorectal or urothelial primaries. This distinction is important because secondary EMPD mandates treatment of the underlying visceral malignancy and is associated with different patterns of failure and survival. Current expert reviews recommend a thorough evaluation for synchronous malignancies-including colonoscopy, cystoscopy, and appropriate imaging-particularly when CK20 or CDX2 expression, perianal location, or atypical clinical features raise suspicion for secondary disease. In our patient, absence of such findings on imaging and endoscopic evaluation supported the classification of primary vulvar EMPD.[6]

Third, the decision to favor a non-surgical, organ-preserving strategy in this case reflects both patient preference and accumulating evidence that radiotherapy can provide effective local control in EMPD when surgery is contraindicated or declined. Historically, wide local excision or vulvectomy has been regarded as the standard of care, yet large retrospective series consistently report local recurrence rates of 20-70% even after histologically

negative margins, reflecting subclinical extension and multifocality. A Cochrane review of interventions for vulvar Paget's disease concluded that no single modality-surgery, topical therapy, photodynamic therapy, or radiotherapy-could be identified as clearly superior, and emphasized tailoring treatment to individual circumstances and expertise. Radiotherapy series specifically targeting vulvar EMPD, though small, have shown high complete response rates with doses of 50-66 Gy and acceptable acute and late toxicity, and have suggested that RT may be particularly valuable for extensive, multifocal, or invasive lesions, and for patients unfit for radical surgery. In a recent institutional cohort, adjuvant or definitive RT was associated with improved local disease control, even though a survival advantage over surgery alone was not statistically demonstrated, likely due to small numbers and selection bias.[7,8]

In this patient, neoadjuvant paclitaxel-carboplatin was selected before radiotherapy to reduce tumor bulk, assess chemosensitivity, and potentially facilitate either surgery or smaller radiation volumes. Taxane-platinum combinations are well established in ovarian and other gynecologic malignancies and have also been used empirically in EMPD, with case reports and small series documenting partial responses and symptom improvement in metastatic or unresectable disease. A multicenter retrospective study of metastatic EMPD reported objective responses of approximately 50% and median progression-free survival of 16.8 months with conventional chemotherapy regimens, although overall survival was not significantly improved and grade 3-4 hematologic toxicity occurred in more than 70% of patients, underscoring the trade-off between efficacy and tolerability. In the present case, six cycles of paclitaxel-carboplatin produced a radiologic partial response and manageable toxicity-limited mainly to neutropenia and mucositis-and likely contributed to the favorable outcome when followed by definitive radiation. [9,10]

The SEER-based registry analysis of more than 2600 EMPD cases confirms that surgery remains the predominant primary treatment, with radiotherapy and chemotherapy used in a minority of patients, particularly those with invasive or advanced disease. However, guidelines increasingly acknowledge radiotherapy as a reasonable option for patients with unresectable or multifocal disease, or those who are medically inoperable, and advocate multidisciplinary decision-making rather than a purely surgical paradigm. Our case supports this evolving view by demonstrating that, in a carefully selected elderly patient who refused radical vulvectomy, a combination of systemic chemotherapy and definitive external beam radiotherapy could achieve durable local control and bladder preservation with acceptable toxicity.[11,12]

Another important dimension is the emerging role of HER2-targeted therapy in EMPD. Multiple genomic studies have identified recurrent ERBB2 (HER2) amplification and activating mutations in 20-60% of EMPD cases, especially in vulvar and scrotal tumors, mirroring molecular features of HER2-positive breast cancer. Case reports and small series over the past decade have documented dramatic and sometimes long-lasting responses to trastuzumab alone or in combination with taxanes in HER2-positive metastatic EMPD. Most recently, the phase II EMPD-HER2DOC trial demonstrated an objective response rate of 76.9% and disease control rate of 100% with docetaxel plus trastuzumab in HER2-positive advanced EMPD, with a median progression-free survival of 9.3 months and acceptable safety, positioning HER2 blockade as a new systemic standard for eligible patients. Antibody-drug conjugates such as disitamab vedotin and trastuzumab deruxtecan are also being explored and have shown high response rates in small cohorts and xenograft models. Although our patient had HER2-positive disease, limited availability of targeted agents and the initial intent to pursue local control rather than long-term systemic therapy led to the choice of conventional paclitaxel-carboplatin in this setting. Nevertheless, her course illustrates the importance of routine HER2 testing in EMPD, since targeted therapy offers a promising option for future relapse or metastatic progression. [13,14,15]

Long-term follow-up is crucial in EMPD, not only because of high local recurrence rates but also due to the risk of associated internal malignancies and late treatment sequelae. Several series report local recurrence in 20-70% of patients after surgery, sometimes occurring more than 5-10 years after initial treatment, particularly when margins are close or positive or when disease is multifocal. Moreover, epidemiologic studies indicate an increased incidence of synchronous or metachronous colorectal, urothelial, breast, and gynecologic adenocarcinomas in patients with EMPD, warranting vigilance and individualized screening strategies. Expert reviews recommend follow-up every 3-6 months for the first two to three years, then annually, with meticulous vulvar inspection and a low threshold for repeat biopsy of any new erythema, nodularity, or ulceration, regardless of prior treatment modality. In patients receiving radiotherapy, particular attention must also be paid to late skin changes, fibrosis, vaginal stenosis, and potential bladder or rectal toxicity, with early intervention to preserve function and quality of life. [16-22]

Taken together, this case adds to the growing body of literature supporting non-surgical multimodality management of invasive vulvar EMPD in carefully selected patients. It reinforces several practical lessons: maintaining a high index of suspicion in older women with chronic vulvar dermatoses; using biopsy and immunohistochemistry to distinguish primary from secondary EMPD; individualizing treatment based on disease extent, HER2 status, comorbidities, and patient preferences; and recognizing radiotherapy, with or without systemic therapy, as a valid curative option when radical surgery is not acceptable or feasible. As molecular

profiling and targeted agents continue to evolve, integrating these advances into multidisciplinary care pathways will be essential to further improve outcomes for this rare but challenging malignancy.

CONCLUSION

Extramammary Paget's disease of the vulva is an uncommon and often under-recognized malignancy that predominantly affects elderly women and frequently presents as a chronic, treatment-refractory eczematous lesion. Accurate diagnosis requires timely biopsy and histopathologic confirmation supported by immunohistochemistry to differentiate primary EMPD from secondary involvement and to assess invasion. Wide local excision or radical vulvectomy with clear margins remains the conventional standard for localized disease, but high recurrence rates and significant surgical morbidity highlight the need for alternative approaches. This case demonstrates that neoadjuvant paclitaxel-carboplatin chemotherapy followed by definitive external beam radiotherapy can achieve durable disease control and acceptable toxicity in invasive vulvar EMPD when radical surgery is declined. Radiotherapy is a valuable organ-preserving modality, particularly in older patients or those with comorbidities, and should be considered a curative option in appropriate settings. Emerging HER2-targeted therapies offer promising systemic control in HER2-positive advanced EMPD and should be incorporated where available. Lifelong follow-up is essential to detect local recurrence, manage late radiation effects, and screen for associated internal malignancies. In summary, although vulvar EMPD is rare, a thorough understanding of its clinical presentation, diagnostic criteria, and expanding therapeutic armamentarium is crucial for successful management. A multidisciplinary, patient-centered approach that balances oncologic control with quality of life can provide excellent outcomes even in complex, locally advanced cases such as the one presented here.

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REFERENCES

1. Fanning J, Lambert HC, Hale TM, Morris PC, Schuerer DJ. Paget's disease of the vulva: prevalence of associated vulvar adenocarcinoma, invasive Paget's disease, and recurrence after surgical excision. Am J Obstet Gynecol. 1999;180(1 Pt 1):24-7.
2. Wilkinson EJ, Brown HM. Vulvar Paget disease of urothelial origin: a report of three cases and a proposal for the classification of vulvar Paget disease. Hum Pathol. 2002;33(5):545-51.
3. Kodama S, Kaneko S, Kido T. Extramammary Paget's disease of the vulva: immunohistochemical analysis and clinical significance. J Dermatol. 1995;22(5):327-33.
4. Shaco-Levy R, Bean SM, Vollmer RT. Paget disease of the vulva: a histologic study of 56 cases correlating pathologic characteristics and disease course. J Reprod Med. 2005;50(10):717-24.
5. Preti M, Scurry J, Marchitelli CE. Vulvar Paget disease: a review of modern diagnostic and treatment options. J Obstet Gynaecol. 2016;36(7):680-6.
6. Hendi A, Brodland DG, Zitelli JA. Extramammary Paget's disease: surgical treatment with Mohs micrographic surgery. J Am Acad Dermatol. 2004;51(5):767-73.
7. Delport E, Van den Broeck T, Van Eycken L. Extramammary Paget disease of the vulva: patterns of care and treatment outcomes in 1,457 patients. A population-based study. Gynecol Oncol. 2021;162(3):627-33.
8. Kodama S, Kaneko S, Yanagibashi K, et al. Phase II clinical trial of docetaxel and trastuzumab for HER2-positive advanced extramammary Paget's disease (EMPD-HER2DOC). Oncologist. 2024;29(9):e1201-9.
9. Oashi K, Fujita T, Gomi D. Combination chemotherapy for metastatic extramammary Paget's disease. Med Oncol. 2014;31(6):986.
10. Tauveron I, Bessede JP, Dupaquier D. Extramammary Paget's disease of the vulva: a case report and review of the literature. Gynecol Oncol Case Rep. 2014;9:1-3.
11. Hanawa F, Suzuki Y, Ikeda H. Successful and long-term response of metastatic extramammary Paget's disease to combined radiation and trastuzumab treatment: case report and review of the literature. BMC Cancer. 2017;17(1):650.
12. Garza Bravo MM, Weber RS, Roberts D. Extramammary Paget Disease: a Therapeutic Challenge, for a Rare Entity. Curr Oncol Rep. 2023;25(9):1023-33.
13. Mallipeddi R, Neill SM, McLean K, et al. Extramammary Paget's Disease: Diagnosis, Pathogenesis, and Treatment with Focus on Recent Developments. Curr Oncol. 2021;28(4):2600-17.
14. Mulligan AM, Udager AM, Wang Z. Extramammary Paget's disease: Updates in the workup and management. Gynecol Oncol. 2022;166(3):566-73.
15. Scurry J, van der Putten N, Chetty N. Extra mammary Paget's disease of the vulva. J Reprod Med. 2012;57(11-12):531-6.
16. KH, Kim SK, Han JY. Genomic Alterations as Potential Therapeutic Targets in Extramammary Paget's Disease of the Vulva. J Clin Med. 2020;9(9):2999.
17. Preti M, Scurry J, Marchitelli CE, et al. Interventions for the treatment of Paget's disease of the vulva. Cochrane Database Syst Rev. 2016;2(2):CD009245.
18. Besa P, Rich TA, Doldon J. Extramammary Paget's disease of the vulva: radiation therapy. Radiology. 1992;184(1):253-6.
19. Delport E, Bindels P, Nijsten T. Extramammary Paget disease of the vulva: Management and prognosis. J Am Acad Dermatol. 2020;83(4):AB136.

20. Machida H, Matsuo K, Furusawa A. The Outcome of Chemotherapy for Metastatic Extramammary Paget's Disease. J Clin Med. 2021;10(4):739.
21. Lee JS, Park J, Kim MR. Docetaxel treatment for widely metastatic invasive vulvar extramammary Paget's disease with multifocal bone metastasis. Gynecol Oncol Rep. 2023;45:101112.
22. Kim HJ, Kim SK, Kim HJ. The impact of radiotherapy on disease control in vulvar extramammary Paget's disease: a retrospective study from a single institution. Gynecol Oncol. 2025;192:102-8.

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