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Dermatoscopy in general practice

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Linked Article: Chappuis et al. *Br J Dermatol* 2016; **175**:744–750.

'Melanoma writes its message on the skin with its own ink and it is there for all to see. Unfortunately some see but do not comprehend.' Since Neville Davis made this statement in the *Annals of Plastic Surgery* in 1978,¹ the advent of dermatoscopy has facilitated earlier diagnosis of melanoma, as well as enhancing diagnostic accuracy for many dermatological conditions, both benign and malignant. Such is the level of evidence for the diagnosis of melanoma that dermatoscopy is now the standard of care in Australasia for clinicians treating pigmented skin lesions.² With skin conditions accounting for up to 14·8% of all consultations in general practice³ it has been suggested that dermatoscopy is now as applicable in that discipline as is use of the stethoscope.⁴

In their study in this edition of the *BJD*, Chappuis et al. deliver detailed findings of the first assessment of dermatoscopy use by French general practitioners (GPs),⁵ reporting that 8% of respondents possessed a dermatoscope and 16·9% had received training in dermatoscopy.

This low level of usage of dermatoscopy is not unique to GPs or to France. Studies on dermatoscopy use, cited in the study by Chappuis et al.,⁵ suggest that while use appears to be high by dermatologists in Europe and Australia (94·6% in France⁶ and 98% in Australia⁷), less than half of the dermatologists surveyed in a cross-sectional survey in the U.S.A. in 2010 had used a dermatoscope,⁸ although a more recent survey suggests use may have increased to around 79%.⁹ The only other study that attempted to quantify dermatoscopy use by GPs reported that one-third of respondents, in Australia in 2007, used dermatoscopy.¹⁰

In the twenty-first century, debate about the merits of dermatoscopy is as inappropriate as debate about the merits of using an otoscope. Cited drawbacks such as cost and time constraints are no longer tenable and any perceived lack of efficacy of dermatoscopy is likely to be related to lack of training and experience rather than to science.

It is time for a paradigm shift in attitude and practice and such changes start not at workshops for graduate doctors, no matter how appropriate these are, but in medical school. The kit of stethoscope, patella hammer, ophthalmoscope and otoscope, which adorned the twentieth-century medical student's white coat, should have the dermatoscope added to it. Instruction in the use of this relatively low-cost hand-held device should be an integral part of teaching in medical school as well as in advanced training programmes for GPs.

The study by Chappuis et al. found that GPs in France were receptive to training in dermatoscopy.⁵ The time is ripe to respond to this, not only for GPs in France, but for medical students globally. This will bring us one step closer to the dream of the late Bernie Ackerman: that no person should die of melanoma.¹¹

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Conflicts of interest

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Dermoscopy for basal cell carcinoma subtype prediction

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In the current issue of the *BJD*, Ahnlide et al. assessed the value of dermoscopy in predicting the histopathological subtype of basal cell carcinoma (BCC).¹ The value of dermoscopy for the diagnosis of BCC has been documented extensively in the literature.^{2,3} Both pigmented and nonpigmented BCC is known to display characteristic dermoscopic criteria that significantly enhance its clinical recognition.^{4,5} The diagnostic accuracy of dermoscopy for BCC has been reported to range between 95% and 99%, depending on BCC type and on the set of diseases included in the control group.^{2,3,6}

In addition to its unquestionable value for BCC diagnosis, dermoscopy has recently been shown to be beneficial also for the management of the tumour, by providing information relevant for the selection of the optimal treatment, as well as the evaluation of the treatment outcome.^{7–9} The study by Ahnlide et al. confirms the previously suggested usefulness of dermoscopy for subtype prediction and provides novel information on the most potent dermoscopic predictors of superficial BCC (sBCC) in a fair-skinned population. The investigators performed a prospective study in two

periods, one with optional and one with obligatory use of dermoscopy, after a short educational intervention. The analysis highlighted that BCC subtype prediction was significantly more accurate when naked-eye examination was coupled with dermoscopy. A flat surface and the dermoscopic presence of multiple small erosions represented the most robust criteria suggestive of sBCC.¹

The introduction of effective nonsurgical treatment modalities in skin oncology questioned the traditional notion that the management of skin cancer should always be surgical. Undoubtedly, surgery remains the therapeutic mainstay for skin cancer, being considered to be the only reasonable choice for melanoma and the treatment of choice for the majority of nonmelanoma skin cancers.⁵ However, nonsurgical modalities continuously gain appreciation especially for the treatment of in situ epithelial cancer, including sBCC and in situ squamous cell carcinoma.⁵ For a few years now, guidelines on BCC management have suggested imiquimod and photodynamic therapy (PDT) as first options for the management of low-risk sBCC, with surgery remaining the first-line treatment for high-risk sBCC and, of course, for all invasive subtypes.¹⁰ This suggestion is based on the documented very high response rates of sBCC to imiquimod and PDT, which have been reported as high as 99%. In contrast, surgery of sBCC is known to be associated with a high recurrence rate, because of the biological tendency of the tumour to grow peripherally beyond clinically visible margins. In nodular BCC, instead, the efficacy of nonsurgical modalities has been reported much lower, while surgery usually results in complete tumour eradication.¹⁰

Effectively, having an accurate estimation of BCC subtype would allow clinicians to individualize BCC management, choosing the most appropriate treatment for each patient, and therefore reducing treatment failures.

In the study by Ahnlide et al., the addition of dermoscopy to the naked-eye clinical examination improved all measures of diagnostic accuracy for sBCC.¹ From a clinical point of view, the most relevant measure would be the specificity for sBCC diagnosis, as it reflects the possibility of misdiagnosing and undertreating a nonsuperficial tumour as an sBCC. The study showed a significant increase of the specificity of sBCC diagnosis when dermoscopy was added. The latter finding is in line with a previous study introducing the value of dermoscopy in subtype prediction, while other studies showed that it may also provide other information that might influence the treatment selection.^{7,11} Added to all these data, the study by Ahnlide et al. elevates the level of evidence supporting that the dermatoscope is a useful and reliable clinical tool for the diagnosis and management of BCC.

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Conflicts of interest

None to declare.