International Dermoscopy Society

IN THIS ISSUE

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Interested in submitting a quiz case for the IDS Newsletter ?

Just send an email to:
elvira.moscarella@gmail.com

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Dear readers,

Waiting for the upcoming meeting in Brisbane, I'd like to share with you some news from the dermoscopy world.

During the last congress of the American Academy of Dermatology, the executive board of the society discussed about the guidelines to be followed for the election of the next sites of the world congresses. The board agreed on organizing the meeting once in Europe and once abroad, every three years. The **proposals for conference hosting** should be evaluated by the EB in the meetings following the last conference. The next conference in 2015 will be officially announced in Brisbane.

The board also renovated the intention to assign **research grants** funding research projects in the field of dermoscopy. The grants will be assigned every 3 years during each IDS conference.

See here for Minutes of the executive board meeting.

I'd also like to highlight the ongoing **Collsion Tumors study,** a study proposed by dr Blum, with the intent to describe the dermoscopic features of collision tumors. If interested in providing cases, just contact dr Blum.

Continuing with the educational purposes of the newsletter, in this edition we will focus on the **dermoscopy features of non melanoma skin cancer**, particularly on actinic keratoses and squamous cell carcinoma in situ.

Finally, I would like to give you a Report of **first CME on Dermoscopy held in Mumbai** on 8th Jan 2012, that revealed the growing interest and awareness about dermoscopy among indian dermatologists.

Looking forward to seeing you soon in Brisbane

With all my best regards

Elvira Moscarella

DERMOSCOPY OF ACTINIC KERATOSIS AND SQUAMOUS CELL CARCINOMA

In times of spreading use of non surgical treatment, such as Imiquimod or PDT, a reliable preoperative diagnosis is important for the management on non-melanoma skin cancer.

Here we examine dermoscopic pattern of intra-epidermal carcinoma in situ (IEC) and actinic keratosis (AK).

Diagnosis of these tumors mainly relies on the analysis of the vascular pattern plus additional dermoscopic features.

ACTINIC KERATOSIS

Actinic keratosis (AK) present clinically as scaly, reddish macules or papules on sun-exposed sites and are usually multiple. Once developed, AK may follow different pathways: regression, persistence, or progression to in situ or invasive SCC.

Classical, non-pigmented AK, when developing on the face, are characterized by a ill defined red pseudonetwork and surface scales.

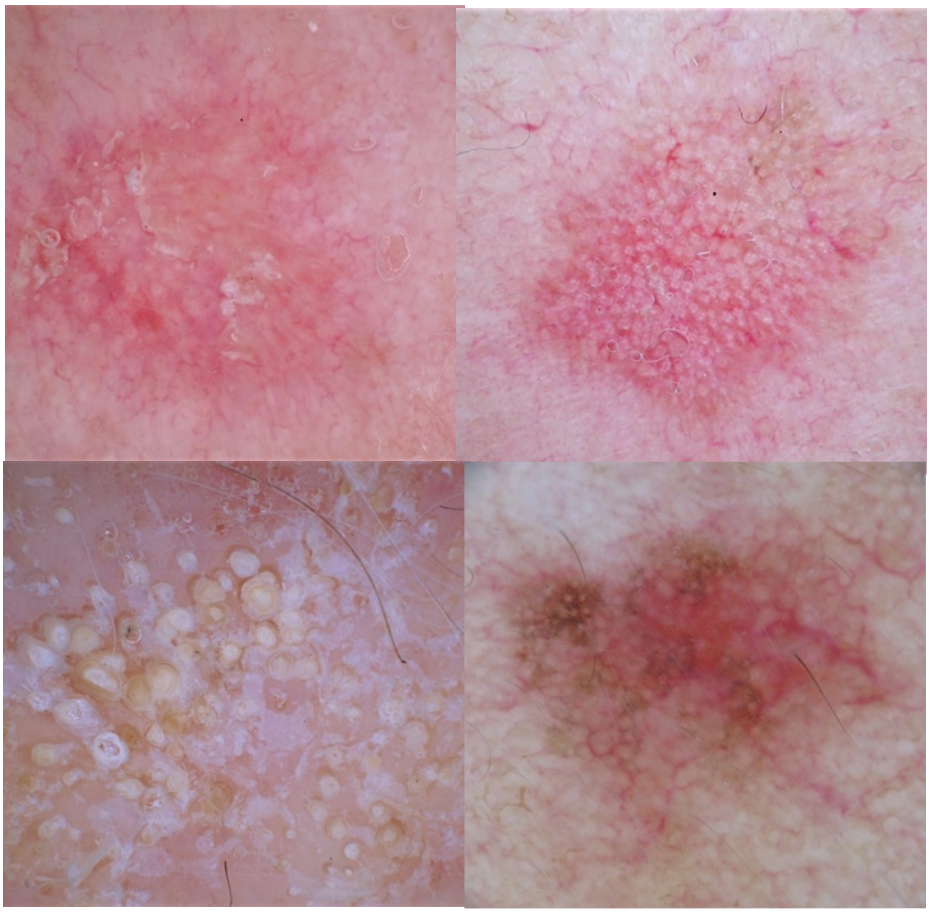


Fig1. Dermoscopy of classical non pigmented AKs (up) presence of a red pseudonetwork and scaly surface.

Hyperkeratotic AK (down left) showing yellow-white keratotic hair follicles.

Pigmented AK (down right) with asymmetrically pigmented follicles and small, gray to brown dots around hair follicles.

When using polarized dermoscopy, it is possible, at times, to visualize the so called "rosettes", they are defined as four closely aggregated white, small dots in correspondence to follicular opening resembling 4-leaf clover. If one imagines connecting 4 dots with line, geometric figure of rhombus can be formed.

In *hyperkeratotic AK,* hair follicles can be filled by hiperkeratotic material, determining the presence of yellow-white keratotic hair follicles.

Pigmented AK present asymmetrically pigmented follicles and small, gray to brown dots around hair follicles. These lesions are usually a pitfall in the differential diagnosis with early

lentigo maligna. The case of the newsletter highlights the common questions raised in the daily practice by these difficult to diagnose lesions. A feature that can help raising confidence in diagnosis can be the presence of a scaly surface, usually found in AK and rarely in lentigo maligna. In doubtful cases however, a punch biopsy or a short term follow up are recommended. (fig 1)

BOWEN'S DISEASE
(intraepidermal carcinoma in situ- IEC)

Also called in situ SCC, IEC typically presents as a slowly growing, scaly plaque, differentiation of early lesions from AK clinically alone can be difficult. On dermoscopy, specific dermoscopic patterns have been described for IEC.

Classical, non pigmented IEC presents the very typical vascular pattern of glomerular and/or dotted vessels. The vessels are typically grouped in clusters within the lesions. On the surface, multiple scales and micro-erosions are found.

Recently, patterns of the *pigmented variant of IEC* have been described, including the presence of brown dots/globules in a linear arrangement, usually at the periphery of the lesions. Clusters of dotted/glomerular vessels can also be found. The center of the lesions id usually represented by a red/white structureless area. (fig 2)

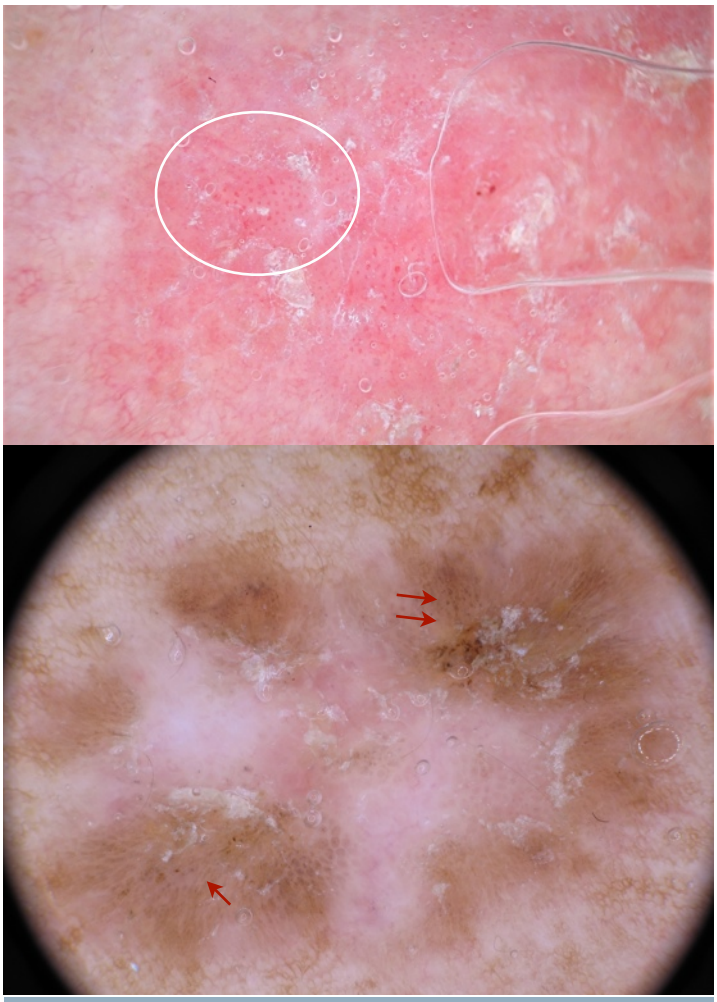


Fig 2. Classical non pigmented IEC showing clusterd dotted vessels (white circle) and a superficial scaling.

Pigmented IEC showing brown dots in linear arrangement at the periphery of the lesions (red arrows). A central white/red structureless area is also detected.

CASE OF THE NEWSLETTER

request #3513 by Colic Sladjana

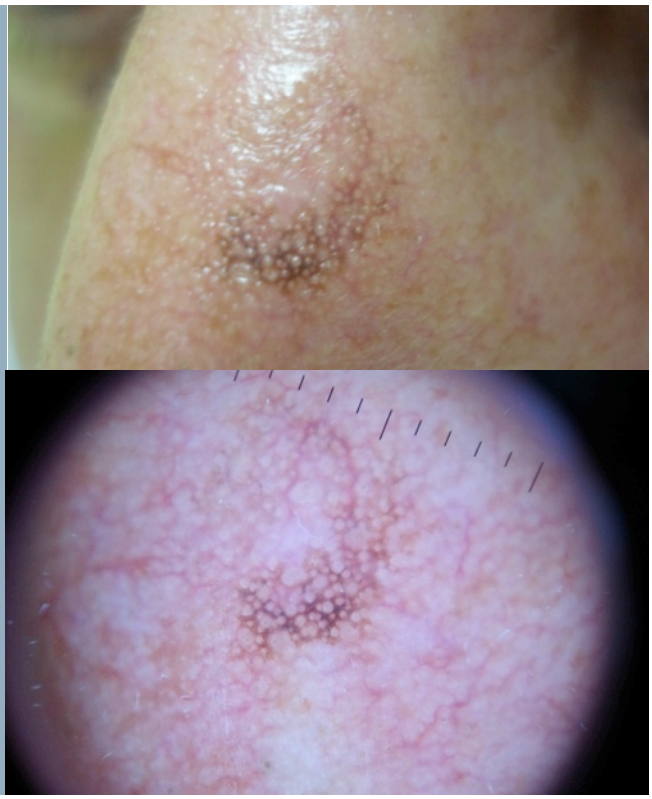
title of request: excision or follow up?

age: 58 years sex: m location: nose

clinical history:

This patient came to me first time today, worried about this pigment lesion on the dorsum of his nose. Seven days ago he had an excision of the BCC on the lower eyelid of the right eye, done by his ophtalmologist. He told me this pigment lesion was bigger in diameter, but he rubbed it with cotton soaked in alcohol, and some of it disappeared. I thought, it might be pigmented actinic keratosis, but when I looked it with dermoscopy, there are same annular granular structures, maybe initial rhomboids around folicular ostia. Could it be lentigo maligna?

question: Lentigo maligna in collision with actinic keratosis?



Comments

Giuseppe Argenziano:
to my eye this looks more in line with a pigmented actinic keratosis but I would definitely keep an eye on it!

Bergamo Antonella:
Really I don't see any structures that make me think to LM. I'm agree with Geppi: pigmented AK..but check in 3 months!

Pyne John:
My vote goes to solar lentigo but not with 100% certainty. Could also be pigmented AK or less likely LM.

Small lesion = confocal or excision. Because I don't trust unequivocal central face pigmented macules on sun damaged skin of patients this age - as the IDS site has shown before.

Baker Ron:
I find PAK and LM can be very hard on the face. The patient is worried, the signs are not diagnostic, why not a small punch biopsy which would heal easily? A 3mm punch would remove most of the lesion, enough for a pretty good path report.

Rubegni pietro:
Good evening to all of you. Obviously my opinion is different. I vote for... seborroheic keratosis but ... I agree with Gepy keep an eye on it

Fox Gary:
Isolated, nonscaly central facial lentigo like lesion. Nuff said for me for include LM in ddx.

SALI Davide:
agree with small punch biopsy, full South; without a hurry, of the patient prefers to wait.

DEPARTMENT OF DERMATOLOGY
SETH G.S. MEDICAL COLLEGE &
K.E.M HOSPITAL, PAREL, MUMBAI.

Organizes

DERMATOSCOPY- A NEW LOOK AT THE SKIN

National CME on Dermoscopy
8th January 2012

CME Venue
Jivraj Mehta Lecture Theatre (MLT),
Seth GS Medical College, KEM Hospital, Parel, Mumbai.

Dr. Uday Khopkar, Convener | Dr. Vidya Kharkar, Organizing secretary | Dr. Siddhi Chikhalkar & Dr. Atul Dongre, Joint organizing secretaries

Program Schedule

Time	Topic	Speaker
8.00 am	Registration	
8.30 am	Inauguration	Dr. Sanjay Oak (Dean & Director, GS Med Mumbai)
9.00 am	Principles & Technique	Dr. KC Nischal
9.15 am	Looking through a dermoscope	Dr. Uday Khopkar
9.25 am	Dermoscopy of Nevi, Keratoses & Melanoma	Dr. Laxmisha Chandrashekar
9.40-10.00 am	Tea and snacks	
Dermoscopy of Hyperpigmentation Disorders		
10.00 am	Melasma	Dr. Sunanda Mahajan
10.10 am	Pseudo-ochronosis	Dr. Sunil Mishra
10.15 am	Schamberg's Disease	Dr. Siddhi Chikhalkar
10. 25 am	Becker's Nevus	Dr. Mary Thomas
10.35-11.00 am	Panel Discussion & Videodermoscope Demonstrations	
Trichoscopy		
11.00 am	Trichoscopy overview	Dr. Vidya Kharkar
11.15 am	Trichoscopy for AA and Tinea capitis	Dr. Nishant Ghodake
11.25 am	Cicatricial Alopecia	Dr. Laxmisha Chandrashekar
11.35 am	Hair analysis	Dr. Shehnaz Arsiwala
10. 45 am	Trichoscan and phototrichogram	Dr. Puneet Saraogi
11.55 am	Folliscope	Dr. Vaishali Gode
12.05 am-12.25	Panel Discussion & Videodermoscope Demonstrations	

Time	Topic	Speaker
Vitiligo (Session Sponsored by Galderma)		
12.25 pm	Assessing stability of Vitiligo with dermoscopy	Dr. Laxmisha Chandrashekhar
12.35 pm	Vitiligo vs Hansen's patch	Dr. Rameshwar Gutte
12.40 pm	Vitiligo vs Idiopathic guttate hypomelanosis	Dr. Monika Bambroo
12.50 pm	Choosing Dermascopy Instrument for your Practice	Dr. Uday Khopkar
1.00 – 1.20 pm	Panel Discussion & Videodermoscope Demonstrations	
1.20-2.00 pm	Lunch	
Inflammatory Diseases		
2.00 pm	Lichen Planus & its differential diagnosis	Dr. Sunanda Mahajan
2.15 pm	Lichen Planus Pigmentosus Vs Ashy Dermatoses	Dr. Shekhar Haldar
2.25 pm	Psoriasis vs Eczema (Talk sponsored by MSD)	Dr. Sushil Pande
2.35 pm	Inflammatory Skin Diseases	Dr. Hita Shah
2.45 pm	Capillaroscopy in connective tissue disorders	Dr. Pinanky Jadhav
2.55-3.15 pm	Panel Discussion & Videodermoscopy Demonstrations	
3.15-3.30 pm	Tea Break	
Miscellaneous		
3.30 pm	Dermoscopy in clinical practice: using your iphone as dermoscope	Dr. Nina Madnani
3.40 pm	Keratosis pilaris dermoscopy: implications for treatment	Dr. Mary Thomas
3.50 pm	Dermoscopy without a dermoscope	Dr. Usha Khemani
4.00 -4.10 pm	Panel Discussion & Videodermoscope Demonstrations	
4.10-4.20 pm	Vote of thanks	

FIRST CME on Dermoscopy held in Mumbai on Jan 2012

Written by Uday Khopkar, Shekhar Haldar

Dermoscopy as a field is relatively nascent in India. Melanoma being rare in India, most dermatology clinics lack a dermoscope. GS Medical College and KEM Hospital is one of the premier medical institutes in India and one of the very few centers in India where multiple types and versions of dermoscopes are being used on a routine basis.

Hence, it was with the intent of stimulating interest and generating awareness about this unexplored field that the **Dept. of Dermatology, Seth GS Medical College and KEM Hospital organized the First National CME on Dermoscopy** in the month of January 2012.

This first ever CME received enthusiastic response from the dermatology community from all over India. Three hundred dermatologists attended the CME, most of them connected with medical colleges across India. A concise compilation of the various dermoscopic findings in the form of a Short Text and Atlas edited by Dr. Uday Khopkar and titled "Dermoscopy and Trichoscopy in Diseases of the Brown Skin" was also released at the inauguration ceremony of the CME. The book is being published by Jaypee Publishers, New Delhi.

The CME started with a talk by Dr. K.C. Nischal on the **basic principles of dermoscopy.** This was followed by a talk by Dr. Uday Khopkar mentioning in brief the basic patterns of dermoscopy that are seen in various **inflammatory and pigmentary conditions**. This was followed by a brief talk by Dr. Laxmisha Chandrashekar on the various dermoscopic patterns seen in benign **melanocytic nevi,** seborrheic keratosis and melanomas that help in differentiating these conditions.

Dr. Sunanda Mahajan delivered a talk on dermoscopic findings in **melasma** showing accentuation of the pseudo-network over the face along with reticulo-globular pattern of pigment distribution sparing the perifollicular areas.

Dr. Sunil Mishra showed how dermoscopy can be used to identify cases of early **exogenous ochronosis** and differentiate them from mixed (dermal and epidermal) melasma

Dr. Mary Thomas talked about the dermoscopic findings of **Becker's nevus** showing blotchy areas of hyperpigmentation in the center of the lesion and focal areas of parafollicular hyperpigmentation at the periphery of the lesion. These findings were different from the dermoscopic features of clinically similar lesion like café au lait macules which show accentuation of snail track like normal pigmentary patterns of hyperpigmentation.

This was followed by a session on dermoscopic findings in **hypopigmented disorders** like vitiligo and idiopathic guttate hypomelanosis (IGH). Value of dermoscopy in assessing the stability of vitiligo was highlighted by Dr. Laxmisha Chandrashekar.

Dr. Monica Bambroo highlighted the similarity of dermoscopic features of IGH and **guttate vitiligo.** A nebular and feathery pattern of hypopigmentation was associated more with evolving guttate vitiligo whereas petaloid and amoeboid patterns of hypopigmentation were more common in IGH and stable guttate vitiligo.

This was succeeded by a session on dermoscopic findings in inflammatory conditions of the skin such as lichen planus, psoriasis and eczema. Dr. Sunanda Mahajan demonstrated the various patterns of Wickham striae (WS), the radiating capillaries found in an active lesion of **lichen planus** and the pigment pattern along the borders of the WS in a subsiding lesion of lichen planus. Dr. Shekhar Haldar demonstrated that the dermoscopic pattern in **lichen planus pigmentosus** (perifollicular and perieccrine granular pigment distribution) differ from those of ashy dermatosis (granular pigmentation sparing the perifollicular and peri-eccrine areas.

Dr. Sushil Pande elaborated that dermoscopic findings of red globules seen in a scaly plaque of **psoriasis** can help in differentiating plaques of psoriasis from plaques of chronic eczema.

The session on trichoscopy was the most keenly followed by a packed auditorium. It introduced the audience to dermoscopic features of alopecia areata, tinea capitis, scarring alopecias, and various techniques of hair analysis like; trichoscan, phototrichogram and folliscopy.

Dr. Mary Thomas delivered a talk on dermoscopic findings in **keratosis pilari**s (KP) and based on the findings of twisted and coiled hair shafts proposed that the primary defect in KP is a twisted and coiled hair shaft which ruptures the follicular epithelium leading to inflammation, and at times, abnormal follicular keratinization.

Another highlight of the CME was the role of dermoscopy of the **nail fold capillaries** in assessing the disease activity in patients of scleroderma, demonstrated by Dr. Pinanky Jadhav. The architectural disorganization of the nail fold capillaries can help in assessing and monitoring disease activity.