Dear readers,

we are now back from Brisbane, after a very exiting meeting of our Society.

More than 700 participants attended the event, that was hosted by our colleges from the Queensland Institute of Dermatology, with prof Peter Soyer as president of the Congress.

The meeting had a very dense and interesting agenda, with a number of outstanding lectures about dermoscopy news and in the field of skin cancer care in general.

You will find the abstracts of the WDC in the current issue of Dermatology Practical and Conceptual, the official journal of the IDS.

In this issue of the Newsletter you find a letter from the president of our Society, dr Argenziano.

During the congress, the board assigned the research grant of the IDS for 2011 to Dr Zaballos, from Spain.

The grant has the intention of funding young (<40 years old) members of the society for research projects in the field of dermoscopy.

Next grants will be assigned every 3 years during each IDS conference.

In the next sections of the Newsletter you will find a brief CV of the winner, with a highlight on his work.

Continuing with the educational purposes of the Newsletter, in this edition we will focus on the dermoscopy features of dermatofibroma, that also represented one of research fields of dr Zaballos.

Finally, the board also announced the next meeting of the Society, that will take place in Vienna in 2015, president of the congress will be dr Harald Kittler.

Looking forward to seeing you soon in one of the next meeting

With all my best regards

Elvira Moscarella

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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 friends,

I really like to send you a big thank you for participating to the World Congress of Dermoscopy held in Brisbane last week. Without your enthusiastic participation in the many sessions, workshops and courses the event would not have been so successful.

More than 700 colleagues joined the congress, in which more than 70 international experts in the field of dermoscopy brought their experiences and knowledge.

But the congress was not only outstanding in terms of scientific contents but also it was wonderful for the warm and friendly atmosphere that everybody contributed to create.

At the bottom line, dermoscopy is a kind of big family composed by physicians interested in improving the quality of their care of patients with skin cancer. And in this spirit I hope to see you numerous at the next World Congress of Dermoscopy that will take place in Vienna in 2015!

All the best

Geppi Argenziano
President of the International Dermoscopy Society
DERMOSCOPY OF DERMATOFIBROMA

Dermatofibromas are very common cutaneous lesions that clinically appear as firm, single or multiple hard papules, plaques, or nodules, with a smooth surface, usually characterized by a color variable from light brown to dark brown, purple-red, or yellow.

Histologically it can be defined as a fibrosing cutaneous lesion characterized by an increased number of fibrocytes in the dermis and occasionally subcutis, a variable admixture of macrophages and other inflammatory cells, with coarse collagen bundles and hyperplasia of adjacent structures (epidermis and hair follicles) or cells (melanocytes).

Dermatofibromas can develop anywhere on the body surface, with a predilection for the lower extremities.

Although the clinical diagnosis of dermatofibroma is rather easy, in some instances the differentiation from other tumors, such as melanoma, is difficult.

The most frequent presentation, that we can describe as classical dermatofibroma, include the presence of peripheral delicate pigment network and central white scarlike patch.

However, several patterns were identified and recently described.

These patterns can be grouped into two main groups:

1. dermatofibromas with peripheral delicate pigment network, and

2. those without the peripheral pigment network.

In summary we can recognize 10 different dermoscopic pattern.

Fig1. Dermoscopy of classical dermatofibroma, presenting a peripheral delicate pigment network and central white scar-like patch.
First group:
Pattern 1: pigment network located throughout the lesion.
Pattern 2: delicate pigment network at the periphery and central white scarlike patch.
(Fig 1)
Pattern 3: delicate pigment network at the periphery and central white network
Pattern 4: delicate pigment network at the periphery and central homogeneous pigmentation.

Second group:
Pattern 5: white network throughout the lesion.
Pattern 6: homogeneous pigmentation throughout the lesion.
Pattern 7: total scarlike patch and a variant with multiple white scarlike patches regularly distributed.
Pattern 8: peripheral homogeneous pigmentation and central white scarlike patch. (Fig 2a)
Pattern 9: peripheral homogeneous pigmentation and central white network.
Pattern 10: atypical pattern that consists of the presence of atypical pigment network,

atypical scarlike patch or white network, atypical homogeneous pigmentation, or irregular distribution of these structures. (Fig 2c)

Vascular structures in dermatofibromas can be frequently observed, and may represent a confounding feature. They include: dotted and hairpin vessels in the center of the lesion or throughout the entire lesion. Telangiectasia in the center of the lesion (Fig 2d), and polymorphous, atypical vessels.

Additional dermoscopic patterns include: globular-like structures (Fig 2b), and rainbow pattern.
Zalaudek Iris:
Looks like pyogenic granuloma, but because no single criterion allows ruling out melanoma with 100% accuracy, you should try to achieve histopathologic confirmation by performing a shaving biopsy. No problem with local anesthesia in pregnancy. Other ddx could be also irritated molluscum.

Warn her re risk of satellitosis after i.e. multiple lesions developing around the surgical site.

Muir James:
I never leave these. I did a report years ago on a woman who presented in pregnancy with a pyogenic granuloma on the back.

It was observed and not excised till 4 months post partum i.e. 11 months after first noticed. Histology reported as 10 mm thick melanoma with palpable mets in axillae and groin.

The reason given for failure to act at initial presentation was concern for the foetus and the possibility of spontaneous resolution. The first is a non-concern and the second a big risk and these are annoying.

If you shave, cauterise the base to make it treatment as well. Alternatively excise.

Minas Stelios:
Prof Soyer on International Dermoscopy Diploma said us more than 20 time what pyogenic granuloma very very often clinically simulating melanoma!

PG=HSTP REPORT

Drljevic Irdina:
I am going to posting you one p.granuloma.

Chamberlain Alex:
agree with Iris and Jim - 'PG in pregnancy' but warrants diagnostic and therapeutic shave bx
IDS research grant 2011

Brief CV of the winner

Dr Pedro Zaballos, MD, graduated in 1997 at the Faculty of Medicine of “Universitat Rovira I Virgili” with the Extraordinary End-Of-Study Award and obtained his specialization diploma in Dermatology and Venereology in 2002 (Universidad de Zaragoza). He is currently the head of the Department of Dermatology at Hospital de Sant Pau I Santa Tecla and Associate Professor at Universitat Rovira I Virgili, in Tarragona, Spain. He obtained a Master of Medical Education at the “Universitat Autonoma de Barcelona” in 2011. His Special Research Area is Dermoscopy with the publication of 30 scientific publications (21 as first author) and 10 book chapters about dermoscopy. Have been working in teaching with special interest in the area of dermoscopy in Spanish and International Courses and Congresses

Requirements of the candidate:

- 37 years-old, a member of the IDS and have not obtained an IDS award in the past.
- First author of the 3 publications presented that are:

   Impact factor: 4.76
   Impact factor: 2.74
   Impact factor: 4.26

Short Description of the studies

The first work is the dermoscopic study that has included the highest number of dermatofibromas (412). The authors describe the dermoscopic features, including vascular structures, and patterns associated with dermatofibromas and show the wide range of presentations of these lesions.

In the second study, authors evaluated the natural evolution of a series of 22 cases showing the intermediate stage of the regression of seborrheic keratosis in lichenoid keratosis using sequential dermoscopy imaging over time. The results of this study confirm the proposal that lichenoid keratosis represents a regressive response to a pre-existent epidermal lesion. Another important message to be gleaned from this study is that dermoscopy could also be a useful tool in the study of the evolution of dynamic lesions, like lichenoid keratoses, helping to understand its pathogenesis.

In the third multicenter study, authors determined the diagnostic significance of dermoscopic structures and patterns associated with pyogenic granulomas in a large series of cases (122 pyogenic granulomas and 140 other tumours, including 28 amelanotic melanomas and 7 melanoma metastases). In this work, dermoscopy has shown to be a very useful tool to evaluate pyogenic granulomas. However, the authors that signed this study are still in favour of removing all pyogenic granulomas to study them histopathologically because this tumour is a simulator of amelanotic/hypomelanotic melanoma by clinical and dermoscopic examination.