



Dermoscopy in melanoma diagnosis

In his article on melanoma diagnosis in the June issue of *New Zealand Family Physician*, Christchurch GP, Dr Paul Corwin, concludes that “Clinical photographs, dermoscopy and digital imaging have not been shown to be superior to clinical examination of skin in detecting malignant melanomas”.

In respect of dermoscopy (dermoscopy), the conclusion is not correct. Dermoscopy has been shown to be superior to clinical examination in detecting malignant melanoma.

In his group's paper published in *The British Journal of Dermatology* last year, Dr Scott Menzies (Sydney Melanoma Unit) showed that the melanoma diagnosing skills of thirty-seven Sydney general practitioners improved from 54% to 76% following dermoscopy training (significant).¹ A control group of a further thirty-seven GPs showed no improvement. Dr Menzies concluded that all GPs in countries where melanoma leads to significant mortality should be formally trained in dermoscopy. Dr Menzies is highly respected interna-

tionally for his melanoma diagnosing skills, has written an excellent dermoscopy atlas, and is sought after as a speaker by dermatologists, both in this country, and internationally.²

As I work virtually full-time in dermoscopy, I recently undertook a self-audit at the Sydney Melanoma Unit using the same set of 100 cases used to test the Sydney GPs. I achieved a melanoma diagnosis sensitivity of 90% using dermoscopy, considerably better than I achieved using clinical examination alone. Leading international dermoscopists currently achieve similar levels of accuracy as demonstrated in the Consensus Net Meeting on Dermoscopy 2000.³

Dr Corwin's suggestion that “dermoscopy should be left in the hands of dermatologists with suitable training and expertise” is in direct conflict with Dr Menzies' published view that general practitioners should be trained in dermoscopy.

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References

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2. Menzies SA, Crotty KA, Invar C, McCarthy WH. An atlas of surface microscopy of pigmented skin lesions. Sydney: McGraw-Hill International Book Co., 1996.
3. Soyer H, Argenziano G, Chimenti S, Menzies S, Pehamberger H, Rabinovitz H, Stoltz W, Kopf A. Dermoscopy of pigmented skin lesions. An atlas based on the consensus net meeting on dermoscopy 2000. Edra 2001.

In Response

It should be noted that my colleague is a general practitioner with a Diploma in Dermatology who offers a dermoscopy service called ‘Mole Check’. Clearly he is a firm believer in the efficacy of dermoscopy.

Unfortunately the paper he cites sheds little light on whether dermoscopy can assist general practitioners in improving their diagnostic accuracy for pigmented skin lesions. It certainly did not show that dermoscopy was superior to clinical examination as no patients were clinically examined. Rather it compared the reading of photographs of pigmented skin lesions versus dermoscopic photographs (i.e. done at 10X magnification at skin level). Even then the improvement (from 58% to 76% correct diagnosis) in the sensitivity of dermoscopic diagnosis for melanomas reported by those GPs who received dermoscopy training has little clinical significance. If these GPs relied on dermoscopy alone they would still be missing 24% of melanomas. That is just not acceptable. As I stated in my article, a suspicious pigmented skin lesion should be excised.