

# 5th World Congress of Dermoscopy

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(3) to achieve long-term disease control and (4) to prevent progression to invasive squamous cell carcinoma. Treatment considerations include patient-related factors, lesion-related factors, treatment-related factors.

## Overview of available treatment options for actinic keratosis

Speaker: Elena Sotiriou  
Department of Dermatology, Aristotle University of Thessaloniki, Greece

Actinic keratoses (AK) are graded as Grade 1, Grade 2 and Grade 3. AK lesions are classified as single when one to five lesions are present, and multiple when more than five are present. Field cancerisation refers to six or more AKs and contiguous areas of chronic sun damage and hyperkeratosis. In practice, lesions are treated according to the distribution: 1. isolated individual lesions scattered on separate body areas; 2. multiple lesions clustered into a single small field and 3. multiple lesions across a large field. For scattered lesions, lesion-directed therapies including cryotherapy, topical active drugs, laser or curettage are often employed. For clustered lesions in small field, cluster-directed therapies including topical 5% imiquimod, 0.5% 5-fluorouracil cream/10% salicylic acid or ingenol mebutate are used. For multiple lesions in a large field, large field-directed therapies including topical 5% imiquimod, topical 5-fluorouracil, topical 3% diclofenac or photodynamic therapy are used. The treatment goals are (1) to eradicate as many clinical and subclinical AKs as possible; (2) to reduce the extent of field cancerisation;

### **Learning points:**

Patient-related factors, lesion-related factors, treatment-related factors need to be taken into consideration in the management of actinic keratoses.

## Comparing guidelines on treatment for actinic keratosis

Speaker: Piergiacomo Calzavara-Pinton  
Department of Dermatology, University of Brescia, Brescia, Italy

Many guidelines exist to aid the management decision for actinic keratosis (AK). Across guidelines, similar themes emerge and these were discussed in the lecture. Overwhelmingly patient's treatment preferences are frequently mentioned in different guidelines. Some guidelines advocate to always treat AKs when they are diagnosed, and some advocate that treatments should only be considered if multiple AKs are present in the cancerisation field if the skin is severely photodamaged. The International League of Dermatological Societies in cooperation with the European Dermatology Forum advocates various treatment according to the following: whether single AK numbering one to five palpable or visible AK lesions per field or in affected body

regions are found, or whether multiple AK more than 5 lesions are found, or if field cancerisation has occurred. The British Association of Dermatologists advocate that individual treatment should be sub-divided into those that are lesion-directed, those which are field-directed and those that are both lesion and field-directed. Small field lesions are separated from large field lesions because of the cumulative cost of treatment, duration of treatment, and it varies according to the European Medicine Agency approval status of the drugs. Individual treatment factors to be considered include efficacy, degree of inflammation that the patient can tolerate, pain threshold, as well as the duration of treatment and a decision analysis approach is often undertaken.

### **Learning points:**

Individual treatment factors need to be considered when treating AKs: the number of lesions, whether field cancerisation has occurred, efficacy, degree of inflammation that the patient can tolerate, pain threshold, as well as the duration of treatment.

## **Management of Bowen's disease**

Speaker: George Gaitanis  
Department of Skin and Venereal Diseases,  
University of Ioannina Medical School, Ioannina,  
Greece

Squamous cell carcinoma in-situ, also known as Bowen's disease has invasive potential in 2 to 5% of non-genital cases. Photodynamic therapy is considered the treatment of choice in many cases. It can appear in patients with co-morbidities and involvement can be extensive. Therefore additional treatment approaches are needed. In transplant patients, it is a significant clinical problem. The British Association of Dermatology guidelines on management of Bowen's disease in 2014 were

reviewed. The recommendations take into account the size, number, affect site and expected healing potential when deciding on the modality of treatment (e.g. 5-fluorouracil, topical imiquimod, photodynamic therapy, cryotherapy, curettage, excision, radiotherapy, laser).

Combination therapy has recently been advocated. A 5-week regimen of immunocryosurgery in which a combination of imiquimod and cryosurgery is used in Bowen's disease. 5% imiquimod cream is applied locally for 5 weeks with cryotherapy administered on day 14. In a study observing 24 lesions, all 21 lesions with diameter <80 mm cleared after one immunocryosurgery cycle while the remaining three larger tumours cleared completely with two cycles. Overall 91.7% remained in complete remission at a median follow-up period of 24 months.

### **Learning points:**

The size, number, affect site and expected healing potential need to be taken into account when deciding on treatment for Bowen's disease. Combination therapy has also recently been advocated.

## **Acral naevi**

Speaker: Masaru Tanaka  
Keio University, Japan

The basic dermoscopy patterns of acral melanocytic lesions with reference to acral skin furrows, ridges and eccrine duct openings include:

- i) Parallel furrow pattern: Acral naevus.
  - Variants: single solid line, single dotted line, double solid line, double dotted line, crista dotted, crista reticulated, tram-like, fine parallel lines.
- ii) Lattice-like pattern: Acral naevus.

iii) Fibrillar pattern: Acral naevus.

- Exclusively seen on weight-bearing areas as a horizontal displacement of horny layer by body weight makes melanin column slanting.
- Each fibril corresponds to the melanin column in the horny layer and is similar in length.
- Beware that short fibrillary pattern often resembles a parallel ridge pattern and sequential oblique-view dermoscopy images will reveal the convergence of fibrillary pattern into a parallel furrow pattern, thus differentiating melanocytic naevus from acral melanoma.

iv) Parallel ridge pattern: Acral melanoma.

### **Learning points:**

The short fibrillary pattern often resembles the parallel ridge pattern and continuous oblique-view dermoscopy images enables the convergence of a fibrillary pattern into a parallel furrow pattern to be seen thus differentiating melanocytic naevus from acral melanoma.

## **Acral melanoma**

Speaker: Yaei Togawa  
Chiba University, Japan

The number of melanoma patients in Japan from 2005 to 2013 was 2,978 with 1237 (42%) cases of acral lentiginous melanoma. Advanced stage (III, IV) melanoma presenting at the first time visit was 33% in Japan, compared to 13% (stage III: 9%; IV: 4%) in the United States.

A revised two-step algorithm for dermoscopy examination was proposed to facilitate earlier diagnosis of melanoma. The first step was the criteria of melanocytic (L1, 6, 7) / non-melanocytic lesion (L2 to 5) and second step was to consist of pattern analysis, ABCD rules, Menzies methods, 7-point checklist, CASH methods or Kittler methods.

In pattern analysis, 'parallel ridge pattern' and 'irregular diffuse pigmentation' had a sensitivity of 86% and 85.4% for melanoma, as well as a specificity of 99% and 96.6%. According to an International Dermoscopy Society study in 2013, parallel furrow pattern, bizarre pattern, and diffuse pigmentation with variable shades of brown had the highest prevalence among 167 acral lesions (including 66 melanomas) in its Caucasian subjects, and lesions with a diameter >1 cm were more likely to be melanoma. As a benign pattern (e.g. parallel furrow pattern and its variant) is sometimes present in early acral melanoma, an acral lesion should be evaluated for the presence of malignant patterns. Dermoscopic features such as the characteristics of the ridge pattern, size of the lesion can help decide on subsequent management.

In Dr. Togawa's hospital, 214 melanoma patients accounted for 12% of skin cancers (N=2,300) in 10-year duration. Among them, 103 (48.1%) were acral melanoma including 33 cases of nail melanoma (32.0%). The prevalence of parallel ridge pattern was noted to be 66.7% in 93 patients with acral melanoma, while regression structures and irregular diffuse pigmentation were seen in 46.9% and 43.8% respectively. In the 33 cases of nail melanoma, specific findings were irregular lines and bands (62.5%), Hutchinson sign (56.3%), nail destruction (50%), micro-Hutchinson sign (50%) and triangular sign (18.8%).

### **Learning points:**

One should evaluate an acral lesion for the presence of malignant patterns first, as early acral melanoma may sometimes show the parallel furrow pattern or its variants.

## **Pitfalls in the diagnosis of melanocytic lesions**

Speaker: Eduardo Calonje

St John's Institute of Dermatology, London, United Kingdom

In the histological evaluation of melanocytic lesions, a single histological feature does not allow a diagnosis of malignancy, and those features include cytological atypia, upward migration, dermal mitoses, lack of maturation and perineural extension. Upward migration can be seen in variants of naevi including Spitz naevi, naevi at special sites and even after external trauma. Dermal mitotic activity can be present in benign naevi and a maximum of two or three mitoses may be permissible in one histological section provided there are no other features suspicious for melanoma.

Naevoid melanoma is more common in females and in middle-age (40-50 years) presenting with varied, non-specific clinical features. Its true incidence is not known and the diagnosis is often missed as appearances are not suggestive of malignancy. The trunk is more commonly involved than the limbs and the size is variable although often small. Moreover, it shares the same prognosis as a melanoma of the same thickness. The histological features of naevoid melanoma and verrucous melanoma are remarkably similar to a naevus with a tendency

to be symmetrical with minimal or absent junctional component. However, there is focal incomplete maturation, dermal mitoses with minimal or absent inflammation.

In pseudomelanoma (recurrent naevus), the histology can mimic very closely the changes seen in melanoma. A good clinical history is absolutely essential in particular a previous surgical procedure or trauma. If a biopsy has been performed before, this should be reviewed together with the current biopsy. In younger children with congenital naevi, the changes can mimic melanoma more closely and the histological diagnosis may be impossible unless the original biopsy is reviewed. The following changes are usually seen only in the epidermis overlying the scar and not beyond: (i) variable architectural disorder; (ii) single and nested junctional melanocytes; (iii) cytological atypia; (iv) minimal upward migration and (v) rare junctional mitotic figures.

### **Learning points:**

In the histological evaluation of melanocytic lesions, a single abnormal histological feature does not confirm a diagnosis of malignancy.