Dermoscopy report: Proposal for standardization

Results of a consensus meeting of the International Dermoscopy Society

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Background: Dermoscopy can assist clinicians in the evaluation and diagnosis of skin tumors. Since dermoscopy is becoming widely accepted and used in the medical community, there is now the need for a standardized method for documenting dermoscopic findings so as to be able to effectively communicate such information among colleagues.

Objectives: Toward this end, the International Dermoscopy Society embarked on creating a consensus document for the standardization and recommended criteria necessary to be able to effectively convey dermoscopic findings to consulting physicians and colleagues.

Methods: The Dermoscopy Report Steering Committee created an extensive list of dermoscopic criteria obtained from an exhaustive search of the literature. A preliminary document listing all the dermoscopic criteria that could potentially be included in a standardized dermoscopy report was elaborated and presented to the members of the International Dermoscopy Society Board in two meetings of the Society and subsequently discussed via Internet communications between members and the Steering Committee.

Results: A consensus document including 10 points categorized as either recommended or optional and a template of the dermoscopy report were obtained. The final items included in the document are as follows: (1) patient's age, relevant history pertaining to the lesion, pertinent personal and family history (recommended); (2) clinical description of the lesion (recommended); (3) the two-step method of dermoscopy differentiating melanocytic from nonmelanocytic tumors (recommended); (4) the use of standardized terms to describe structures as defined by the Dermoscopy Consensus Report published in 2003. For new terms it would be helpful to provide a working definition (recommended); (5) the dermoscopic algorithm used should be mentioned (optional); (6) information on the imaging equipment and magnification (recommended); (7) clinical and dermoscopic images of the tumor (recommended); (8) a diagnosis or differential diagnosis (recommended); (9) decision concerning the management (recommended); (10) specific comments for the pathologist when excision and histopathologic examination are recommended (optional).

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Limitations: The limitations of this study are those that are intrinsic of a consensus document obtained from critical review of the literature and discussion by opinion leaders in the field.

Conclusions: Although it may be acceptable for a consulting physician to only state the dermoscopic diagnosis, the proposed standardized reporting system, if accepted and utilized, will make it easier for consultants to communicate with each other more effectively. (J Am Acad Dermatol 2007;57:84-95.)

Dermoscopy is a noninvasive, in vivo technique that can assist the clinician in the diagnosis of skin tumors. The dermoscopic structures and colors together with their distribution can often help in differentiating between melanocytic and nonmelanocytic lesions and benign from malignant tumors. Furthermore, dermoscopy can aid in confirming the diagnosis of specific lesions, such as seborrheic keratosis, basal cell carcinoma, hemangiomas, and dermatofibromas. A list of dermoscopic structures, criteria for diagnosis, and diagnostic algorithms has been published by the participants of a dermoscopy consensus meeting.[1]

Since dermoscopy is becoming widely accepted and used in the medical community, there now exists the need for a standardized method for documenting dermoscopic findings so as to be able to effectively communicate such information among colleagues. Toward this end, the International Dermoscopy Society (IDS) embarked on creating a consensus document for standardization and minimal criteria necessary to be able to effectively convey dermoscopic findings to consulting physicians and colleagues.[2-16]

MATERIAL AND METHODS

The project for the dermoscopy report consensus document was proposed at the meeting of the IDS in February 2003 to the Board of the Society. A steering committee was chosen for this endeavor. The work began with an extensive search by the committee to identify publications on dermoscopy. This search included medical databases (MEDLINE, PubMed, and EMBASE) up to January 1987. In addition, the Dermoscopy Report Committee reviewed the reference lists from the retrieved articles, searched personal files, and contacted researchers in the field of dermoscopy to review their methodology for the reporting of dermoscopic examination findings. They reviewed all relevant publications and extracted an extended list of potential items to be considered in a dermoscopy report. Subsequently, the Dermoscopy Report Steering Committee created a preliminary document which was reviewed by all members of the IDS Board. This document was discussed at two meetings of the Society held in Washington, DC, in 2004 and in New Orleans in February 2005. Finally, the document was sent to all IDS members via the Internet for their review and comments. The review process lasted from April 1 to June 31, 2005 and culminated in the creation of the standardized dermoscopy reporting system presented in this article.

RESULTS

Information considered relevant by the majority of IDS Board members has been incorporated into the 10-point dermoscopy report outlined in the following paragraphs. The 10 points were subsequently classified into two categories: "recommended" and "optional." These criteria are summarized in Table I.

Patient's history (recommended)

Information concerning the patient, such as age, personal and family history of skin cancer including melanoma, personal and family history of dysplastic nevi, previous treatments or biopsies performed at the site of the lesion under investigation, number of melanocytic lesions present, Fitzpatrick skin type, and skin photodamage may all be helpful in interpreting the clinical and dermoscopic findings correctly. Furthermore, the patient's history regarding change in shape, size, color, contour, as well as a history of any symptoms within the lesion are important factors necessary for the consultant to render the appropriate management decisions.

The age of the patient may be an important factor. For example, age may affect the interpretation of some pigmented lesions, such as those possessing a globular starburst pattern (ie, melanocytic tumors with spitzoid features).[17] A patient's personal history of melanoma, its thickness, presentation (melanotic vs amelanotic), and subtype can prove important in the detection of subsequent melanomas. Furthermore, previous procedures performed at the site of the lesion under investigation may help correctly classify lesions as "recurrent nevi." In addition, the existence of acute or long-term sun damage is often a confounding factor when evaluating pigmented lesions.[18-20] The complete physical examination, including examination of the pigmented lesions surrounding the lesion under investigation, particularly in the setting of multiple dysplastic nevi, is important since most of the lesions in any