PRIMARY CARE DERMATOLOGY SOCIETY

Promoting Confident Dermatology Since 1994

Skin Lesion Assessment including Dermoscopy

PRIMARY CARE DERMATOLOGY SOCIETY

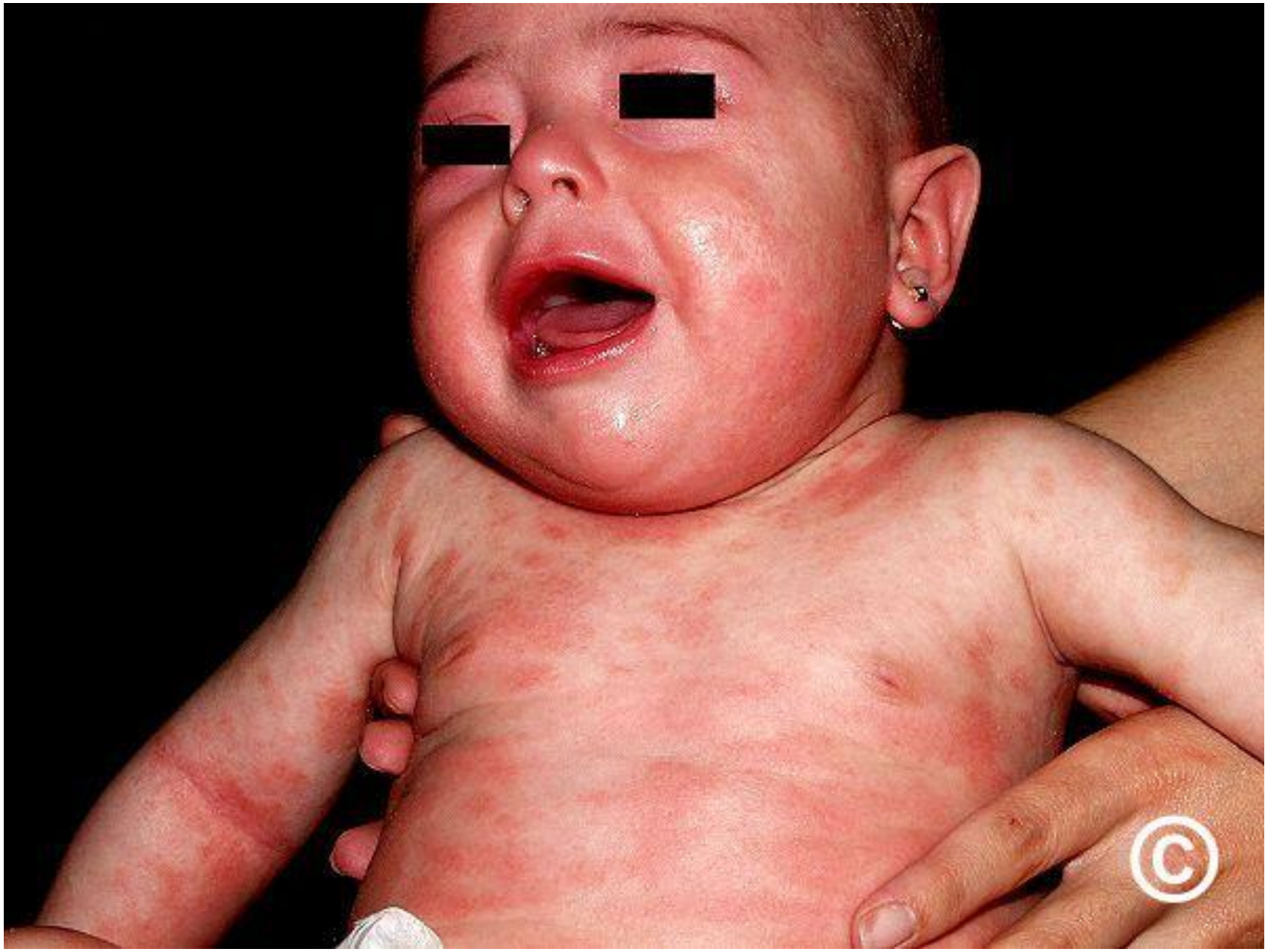
Dr Tim Cunliffe

- GPwER in Dermatology
- Joint Lead for Skin Cancer STHFT
- Author of www.pcds.org.uk
- Executive Chair of the PCDS
- Lead reporter nationally for the Mole Clinic

PCDS
PRIMARY CARE DERMATOLOGY SOCIETY

- I have worked across all NHS interfaces
- I have had skin cancer
- I am here to help, not hinder
- Even if you are not interested in teledermoscopy, please use www.pcds.org.uk (non-profit, no ads, made for Primary Care)
- The truth is …teledermoscopy is not difficult
- The PCDS has:
  - The Skin Lesion Diagnostic tool – comprehensive
  - The Clinicodermoscopic Skin Lesion Tool – concise
  - Best Practice Concise Guidelines

An avoidable skin lesion referral leads to:



Referral threshold

JRSM
JOURNAL OF THE ROYAL SOCIETY OF MEDICINE

J R Soc Med. 2002 Jun; 95(6): 287–289.
doi: 10.1258/jrsm.95.6.287

PMCID: PMC1279910
PMID: 12042375

Self-regulation in hospital waiting lists

D P Smethurst, MA MRCP and H C Williams, PhD FRCP

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Abstract

Go to: ▸

There is evidence that hospital waiting lists in the UK are resistant to shortening because reductions in length generate increases in referrals. We explored this concept by examining outpatient data for eight specialties in a large hospital centre over 17 months. Correlation coefficients were calculated by regressing waiting list density (numbers waiting more than 26 weeks) against referral rate.

THE PRIMARY CARE DERMATOLOGY SOCIETY (PCDS) is the leading UK society for all members of the primary healthcare team with an enthusiasm for dermatology, dermoscopy and skin surgery. **Read more** about the society, its subgroups and the committee...

TAKE A TOUR OF THE PCDS WEBSITE
Click here to see how to get the best out of the website.

GENERAL DERMATOLOGY DIAGNOSTIC TOOL
Diagnose inflammatory skin conditions and other rashes. Also hair, nail, oral and genital conditions

SKIN LESION DIAGNOSTIC TOOL
Diagnose benign lesions and skin cancer

THIS IS FOR YOU
Our education is for all **healthcare professionals. Click here** to see which of our education programs best suits your needs.

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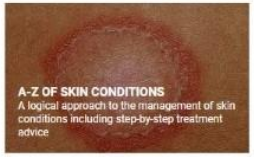
Benefits include reduced rates for educational events, the quarterly bulletin and journal watch, access to the PCDS Skin Club and Dermoscopy Group. **Read more** and find out how to join.

BEST PRACTICE CONCISE GUIDELINES
National guidelines on common and important skin conditions, including referral pathways



A-Z OF SKIN CONDITIONS
A logical approach to the management of skin conditions including step-by-step treatment advice

Annual Headline PCDS Conferences

The society's Annual Spring Conference and Scottish Conference provide a comprehensive educational package for all members of the Primary Care Health Professionals with talks from leading specialists, and hands-on workshops. The Spring conference is a 2-day event with an evening function, which is always fun and great for networking. The 'Where Dermatology Meets' conference provides cross speciality education with joined-up thinking.

- **20 JAN** — **2024 INTERNATIONAL DERMOSCOPY**
- **08 MAR** — **2024 ANNUAL MEETING** LONDON
- **27 JUN** — **WHERE DERMATOLOGY MEETS ORO-FACIAL**
- **14 SEP** — **2024 - SCOTLAND**

PCDS Events

Over 30 internationally recognised events a year for all members of the Primary Healthcare Team.

- **28 SEP** — **DERMATOLOGY & DERMOSCOPY ...** CAVENDISH CONFERENCE CENT...
- **04 OCT** — **DERMOSCOPY FOR ABSOLUTE B...** SWANSEA
- **12 OCT** — **ESSENTIAL DERMATOLOGY SER...** LEEDS, VENUE TBC
- **20 OCT** — **SKIN SURGERY COURSE 2023** ST GEORGE'S UNIVERSITY HO...

GENERAL DERMATOLOGY EVENTS → | DERMATOLOGY FROM SCRATCH →
ESSENTIAL DERMATOLOGY EVENTS → | DERMOSCOPY EVENTS →
SURGICAL EVENTS →

> *The most practical CPD course I have been on so far this year – easy practical applicable advice, thank you. Good coverage of main 4 common GP diagnoses*
> **GP**

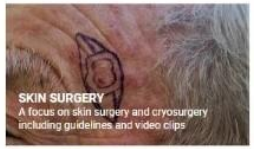
PCDS 30 YEARS ANNIVERSARY CELEBRATION 2024

CASE DISCUSSION AND OTHER LEARNING WITH MEDSHR
Bite-sized learning and the opportunity to post pre-diagnosed cases for discussion

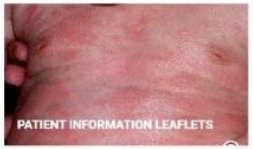
PCDS VIDEOS
Videos on how to take good clinical images, dermoscopy, skin surgery, how to apply creams, and the use of leg and other dressings

COMMISSIONING, CARE MODELS, AND TELEDERMATOLOGY
Including GPwERs (GPs with Extended Roles) in Medical Dermatology and Skin Lesion Management

DERMOSCOPY (AND PHOTOGRAPHY) - AN OVERVIEW
Improve your diagnostic skills

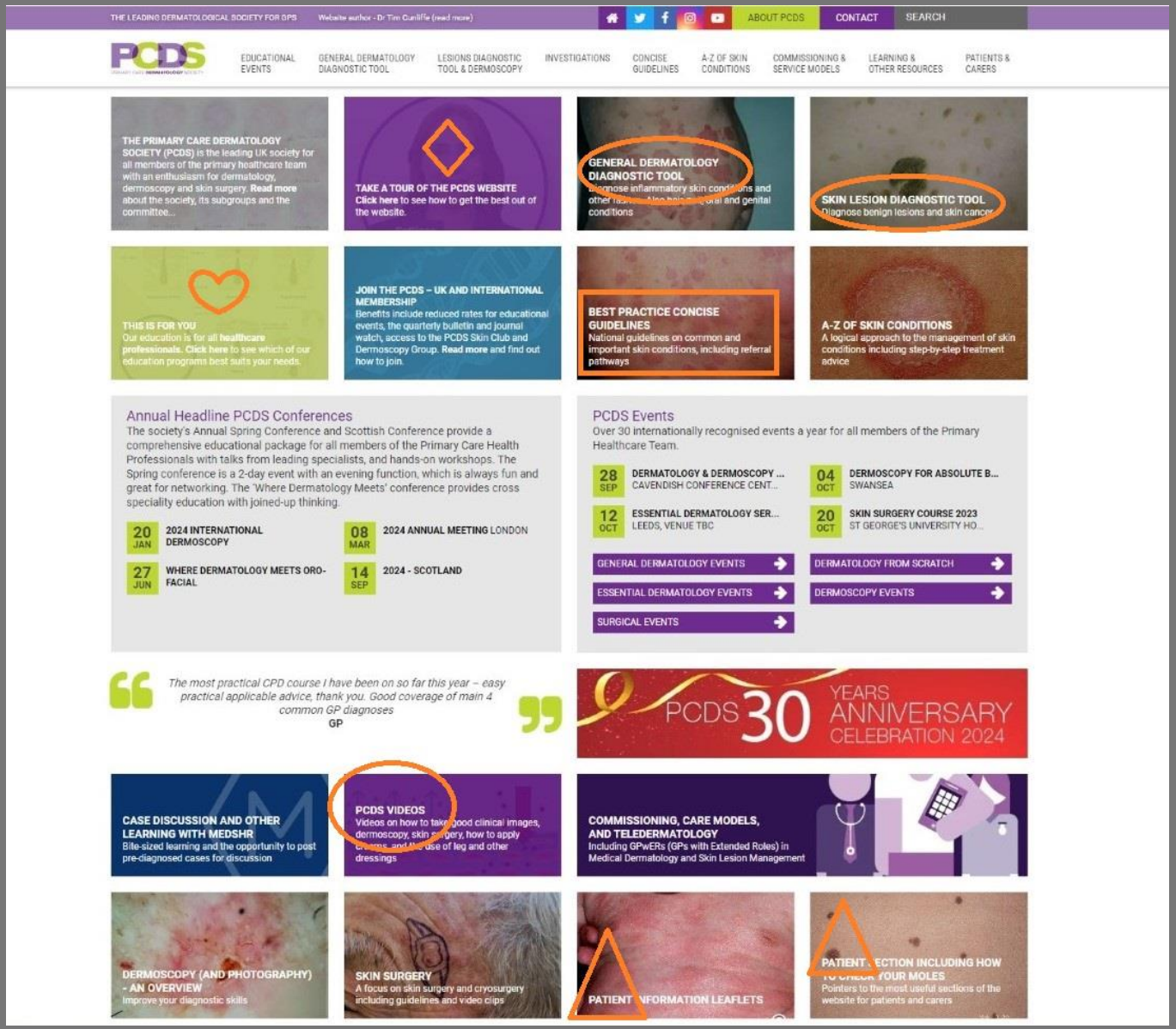


SKIN SURGERY
A focus on skin surgery and cryosurgery including guidelines and video clips



PATIENT INFORMATION LEAFLETS

PATIENT SECTION INCLUDING HOW TO CHECK YOUR MOLES
Pointers to the most useful sections of the website for patients and carers


THE LEADING DERMATOLOGICAL SOCIETY FOR GPS
Website author - Dr Tim Cunliffe (read more)
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LESIONS DIAGNOSTIC TOOL & DERMOSCOPY
INVESTIGATIONS
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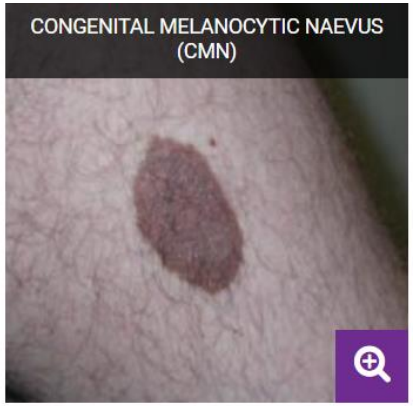
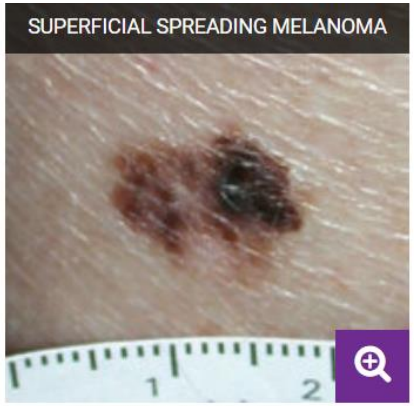
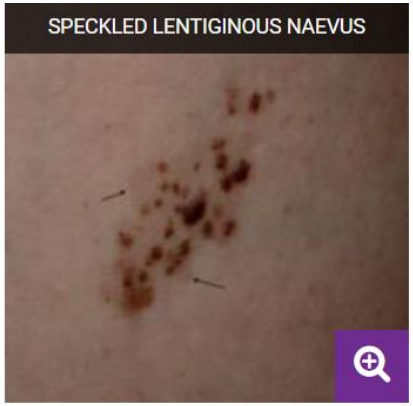
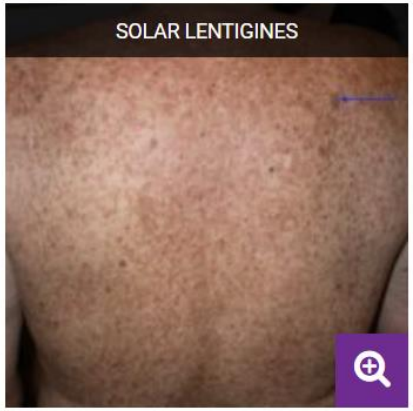
PCDS skin lesion (and medical dermatology) diagnostic tools – there is much you can do before you even pick up a dermatoscope.

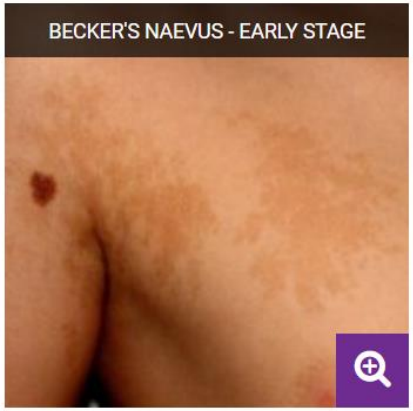
The Cunliffe (TP) Skin Lesion Diagnostic Tool

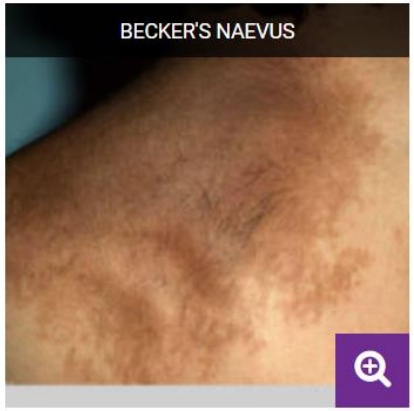


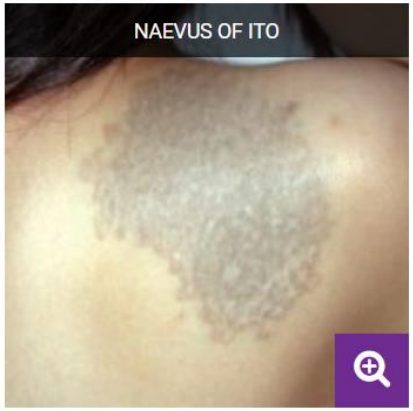












White-yellow / orange

Deep-seated (much of lesion under skin surface)

www.pcds.org.uk

The National Primary Care Treatment and Referral Guidelines provide concise advice on common and other important skin conditions. They have been developed by specialists with a wealth of experience working in both primary and secondary care, and draw information from numerous resources including NICE and other national guidelines.

For more thorough guidance on skin conditions refer to the **A-Z list of skin conditions**, or if you are uncertain about a diagnosis refer to the **General Dermatology Diagnostic Tool** (rashes, other skin conditions, hair and nails) or the **Skin Lesion Diagnostic Tool.**

Disclaimer: the author PCDS cannot accept responsibility for any misleading or incorrect statements, and the management of individual patients remains the direct responsibility of the individual doctor. We do however hope that visitors to this site can contact us regarding comments that are considered misleading or incorrect so that we can continue to improve the site.

1. Referral pathways +
2. Actinic (solar) keratosis +
3. Skin lesion algorithm - common benign lesions and skin cancer +
4. Acne vulgaris +
5. Alopecia (hair loss) - an overview +
6. Blistering (bullous) conditions +
7. Boils and folliculitis (including hidradenitis suppurativa): an overview +
8. Dermatological emergencies +
9. Drug rashes +
10. Eczema - discoid eczema +
11. Eczema - atopic (including facial eczema) +

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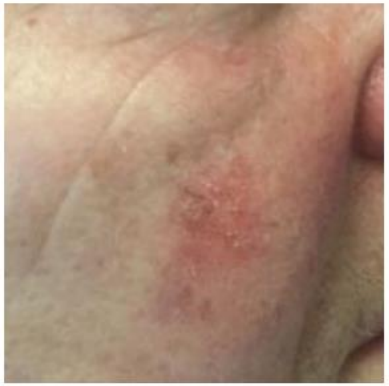
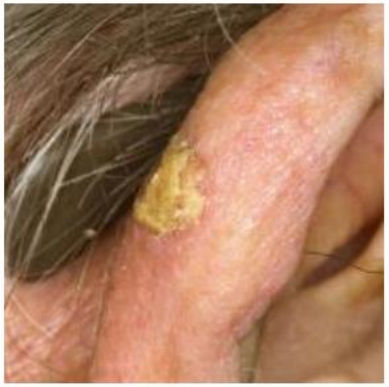


Treatment of grade 1 AKs - scale more palpable than visible, single or few lesions

- **Efudix ® cream** (5-FU) - OD for 4 weeks, washing off after 8 hours. Patients should be advised to expect erythema, crusting, and some discomfort during treatment; which is more effective than Solaraze ® gel
- **Klisyri ® (tirbanibulin)** - apply OD for 5 days. Patients should be advised to expect erythema, crusting, and some discomfort during treatment

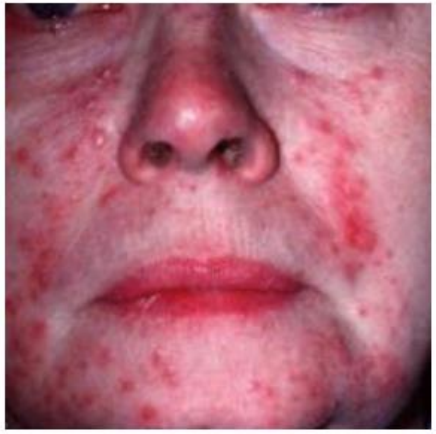


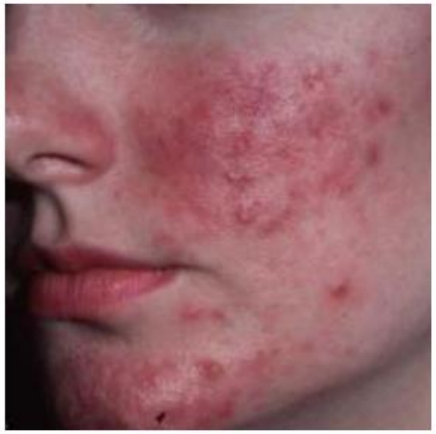
Grade 2 AKs - moderately thick scale, easily felt and seen, single or few lesions

- **Efudix ® cream (5-FU)** - OD for 4 weeks, washing off after 8 hours. Patients should be advised to expect erythema, crusting, and some discomfort during treatment
- **Actikerall ® solution** (0.5% 5-FU+10% salicylic acid) - OD for 6-12 weeks. Actikerall ® tends to leave a film on the skin, which should be washed/peeled off before the next application. At the thicker end of the grade 2 spectrum, Actikerall ® may be preferable to Efudix ® cream

- **Cryosurgery** - a singe 10-15 second freeze-thaw cycle with conventional liquid nitrogen. Other products, usually contained in a can, less likely to be effective. Cryosurgery can cause permanent hypopigmentation (eg on face), and avoid on gaiter area of legs

www.pcds.org.uk





Inflammatory rosacea

Topical treatments - mild symptoms:

- **First-line**: Soolantra ® (ivermectin 10mg/g) cream OD for 3 months
- **Second-line**: options include azelaic acid BD (15% gel as Finacea ® or 20% cream; cream may sting less), or Rozex ® gel or cream BD

Systemic antibiotics - if topical agents fail or presenting symptoms more severe:

- **First-line**: the tetracyclines (contraindicated in pregnancy). Consider doxycycline 40mg OD, this dose reduces the risk of antibiotic resistance. Alternatively, lymecycline 408mg OD or doxycycline 100mg OD. Unlike oxytetracycline, these drugs can be taken with (or without) food
- **Second-line**: clarithromycin or erythromycin 250-500mg BD
- **Duration**: initially 3 months. For infrequent recurrences, repeat the course. For frequent recurrences, take standard dose until symptoms settle, then reduce to a maintenance dose, eg once-twice a week

Who to refer: moderate-severe symptoms responding poorly to treatment - consider for isotretinoin

Vascular rosacea

Dermoscopy – a little bit on equipment

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Tees and N.Yorks

- DL4 scope
- I-phone …..
- An attachment
- (Accuryx / Pando App)
- PCDS videos from homepage
- And this is what you do …..

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Non-polarised vs polarised mode

- Use both as contact, with a liquid interface
- **Polarised – most lesions**
  - Multiple colours
  - Pink/red colours and white structures, the combination of which can be found in some hypomelanotic melanomas and superficial BCC
- **Non-polarised**
  - Good for some **seborrhoeic keratosis** (milia-like cysts and comdeo-like openings)
  - Blue-white colour, peppering (eg **lentigo maligna**)

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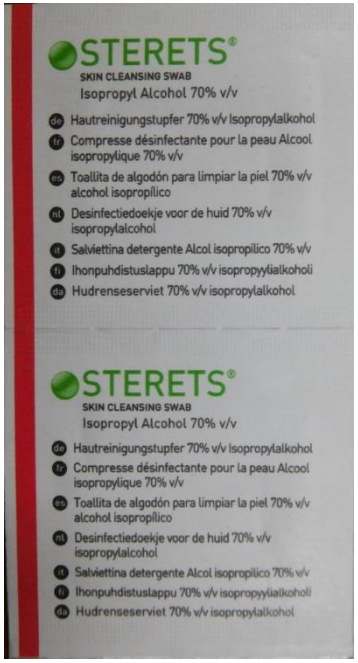
Other equipment



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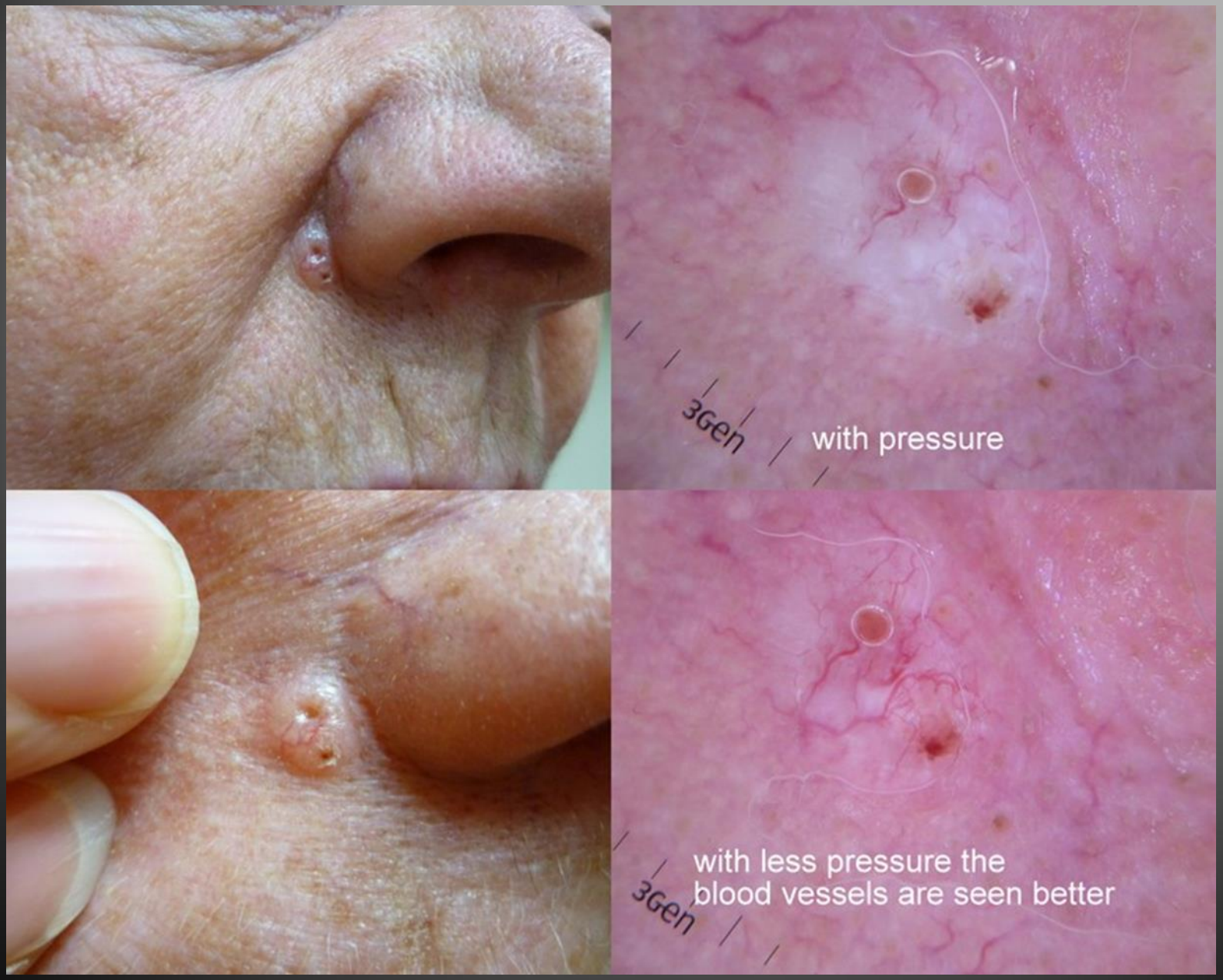
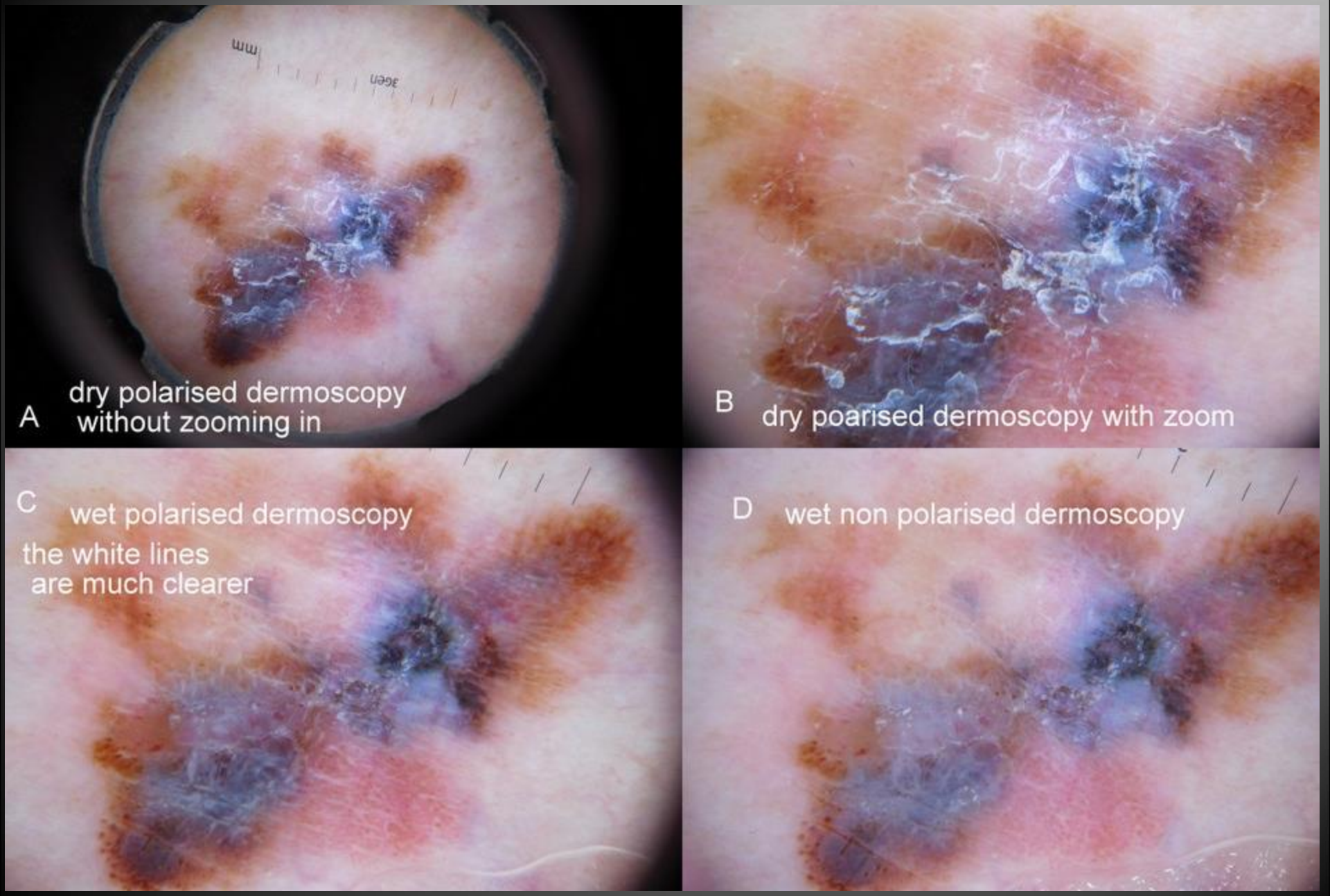
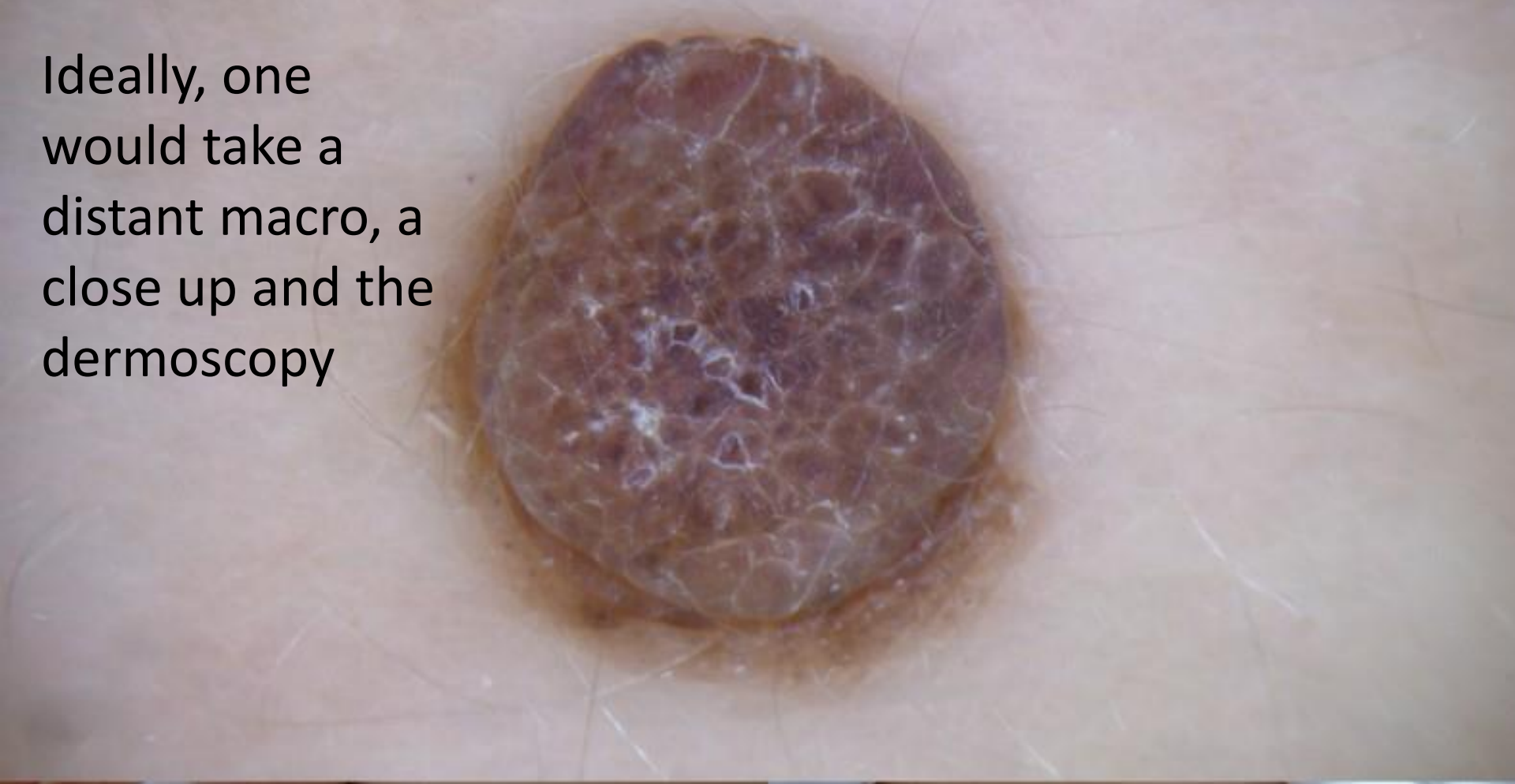
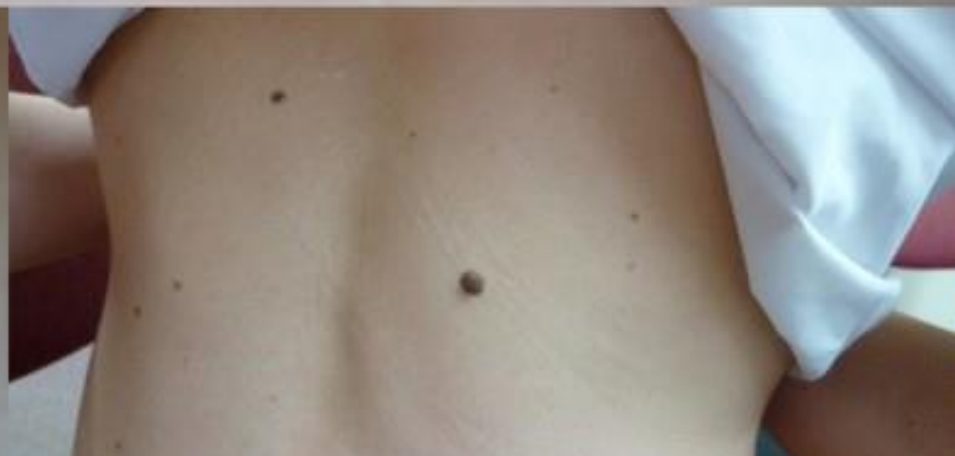
The effect of pressure



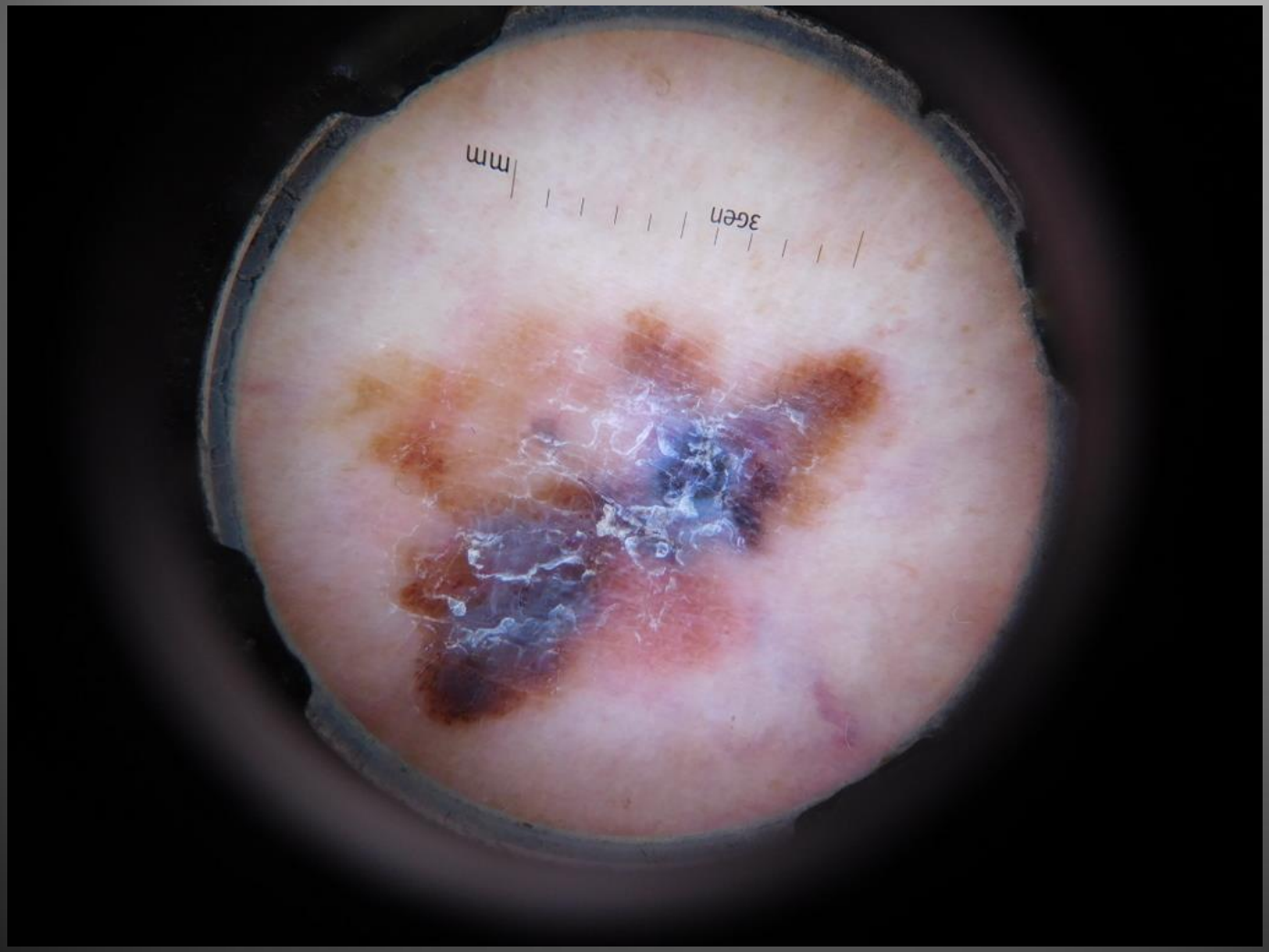

A
dry polarised dermoscopy
without zooming in
B
dry poarised dermoscopy with zoom
C
wet polarised dermoscopy
the white lines
are much clearer
D
wet non polarised dermoscopy

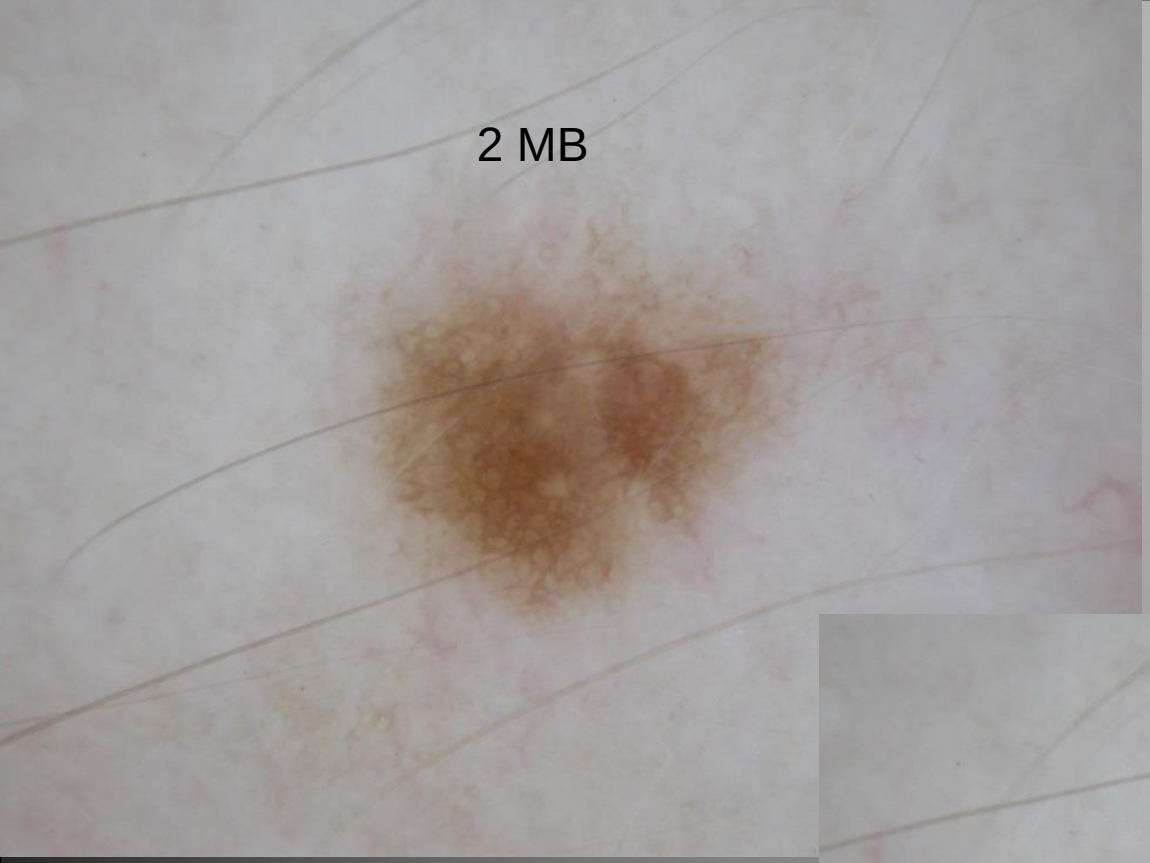
Ideally, one would take a distant macro, a close up and the dermoscopy





Zoom in with camera to avoid vignetting (tunnel vision)

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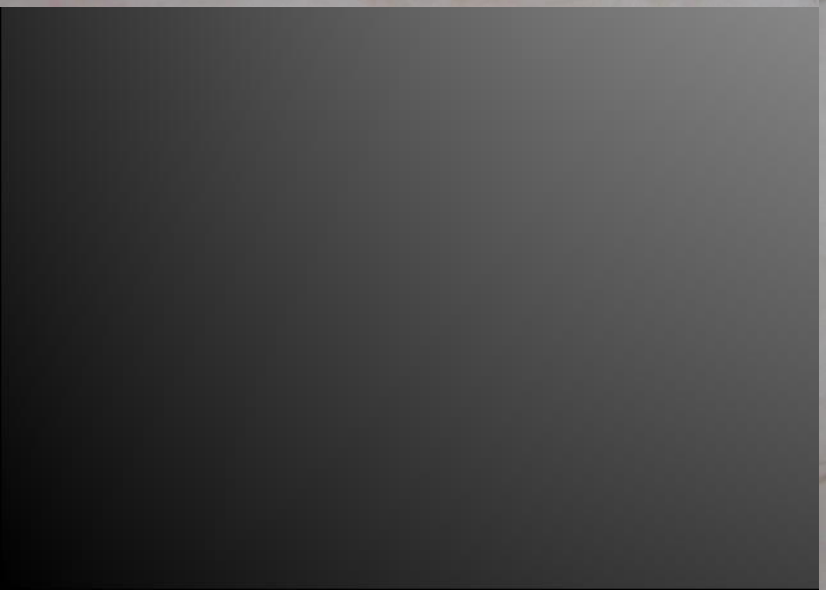

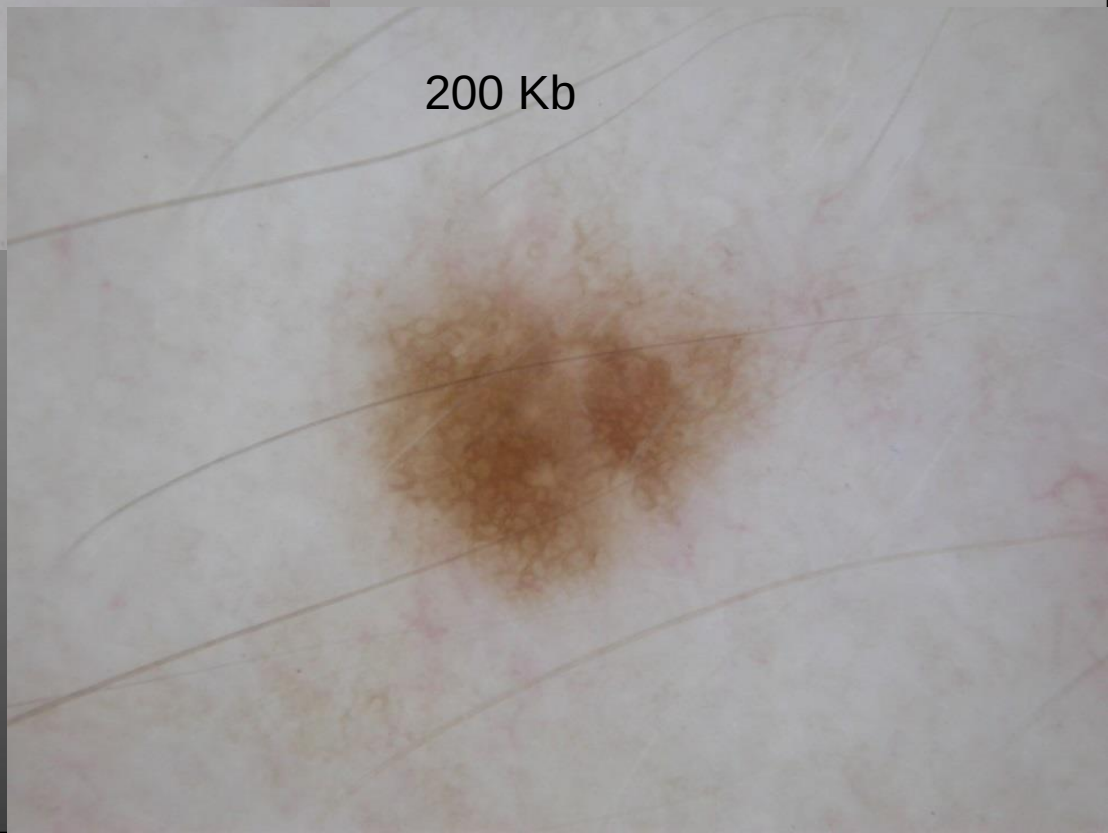
200 Kb

Practical tips – overview

- **Clinical images** – in focus. Good light and not too close
- **Dermoscopy** – polariased (softer light) vs non-polarised (harsher light …..sebK's)
- **Dermoscopic images (DL4 scope):**
  - Small amount of gel on the lesion
  - Extend scope so no shadow
  - Rest gently on the lesion
  - Use the phone screen to zoom in
  - Review images with patient present
  - Multiple lesions and labelling
  - Transfer of images (accuryx / Pando App)

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Practical advice – www.pcds.org.uk

- Homepage links:
  - Dermoscopy
  - Videos
- PCDS courses – DFAB, DFI

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The Clinicodermoscopic Skin Lesion Tool

- **Seborrhoeic keraotses and warts**
- Scaly lesions with variable amounts of surface scale but NO base
- Melanocytic naevi and thin melanomas
- Firm, palpable, benign lesions – small and large
- The EFG rule of skin cancer (solid BCC, SCC, nodular melanoma)
- Pink makes you think (including red and purple)
- Other lesions of concern requiring urgent referral
- If we still don't know what it is ….

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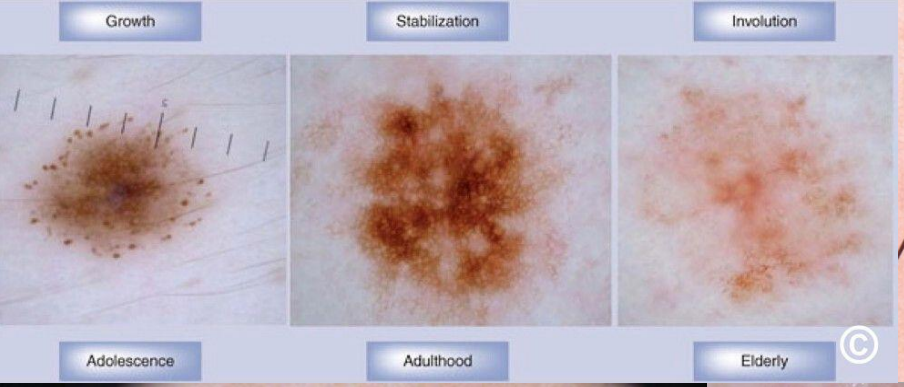
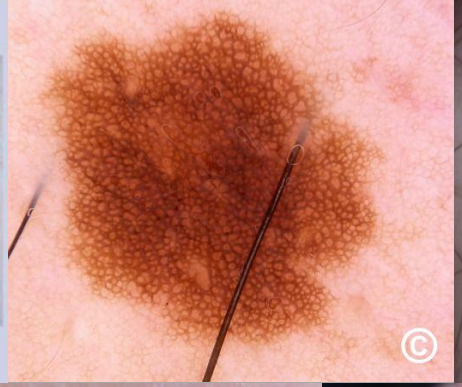
SEB K CLINICAL

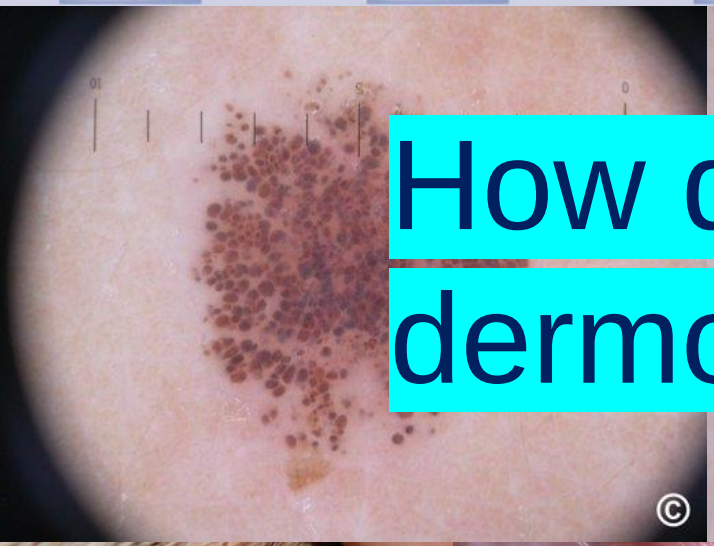
- Brown-black
- Thinner lesions paler
- Traumatised lesions appear inflamed
- ‘Greasy' or scaly
- ‘Stuck-on’
- Bits can drop off

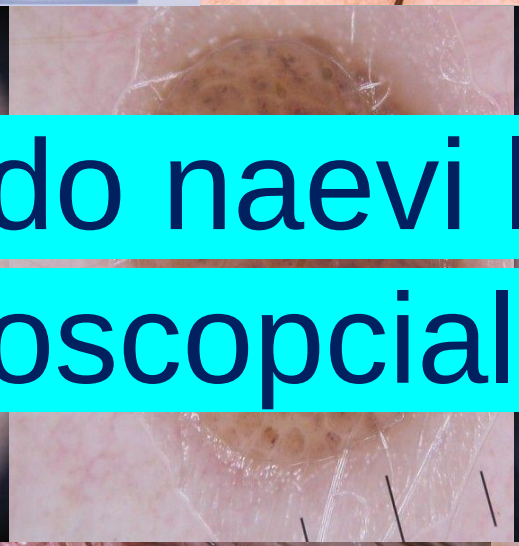
DERMOSCOPY

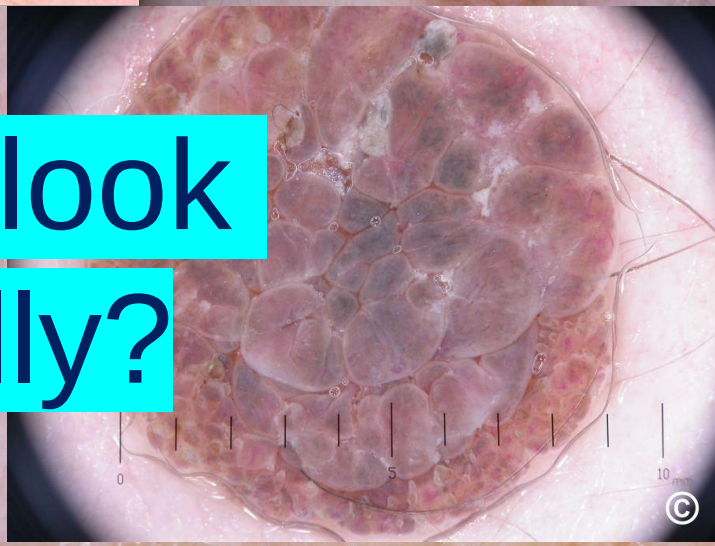
- Milia-like cysts and comedo-like openings
- Pigment bands, fissures and ridges, cerebriform
- ‘Frogspawn’ pattern
- Looped vessels



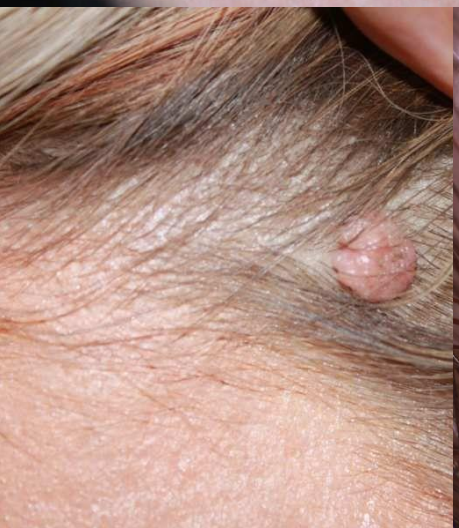


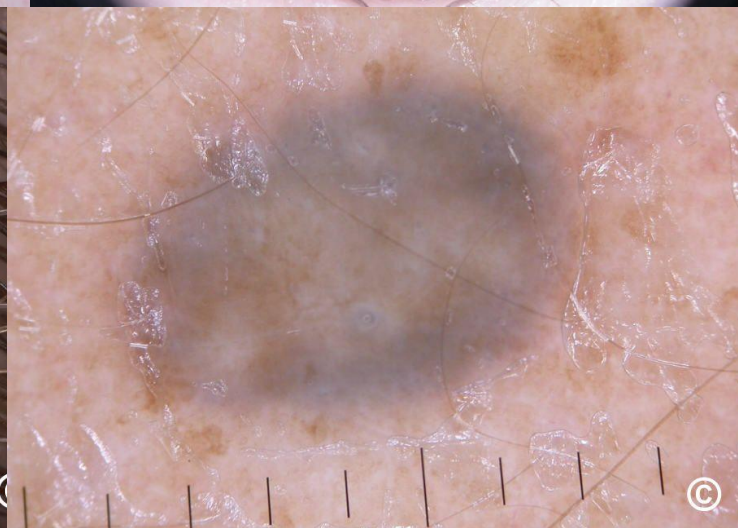


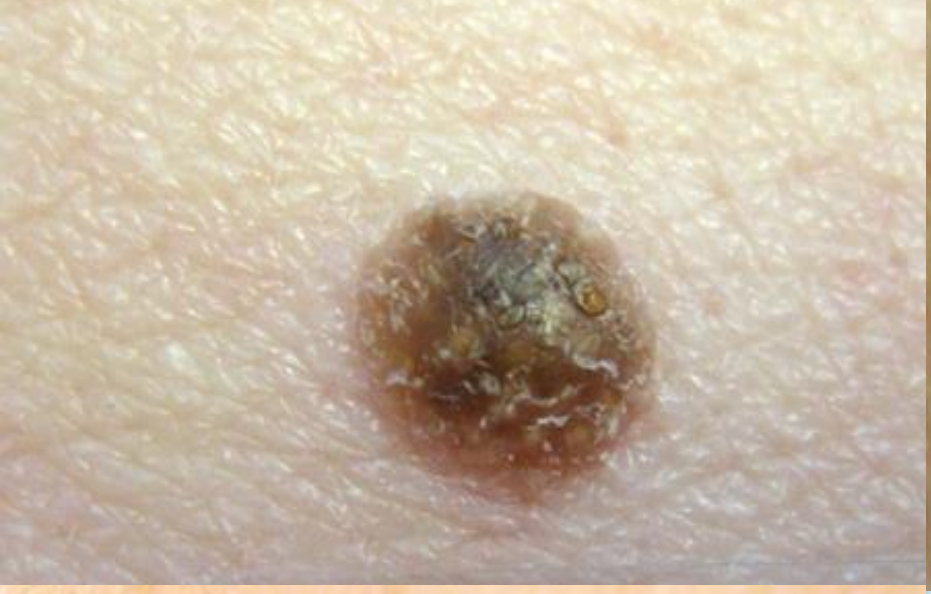
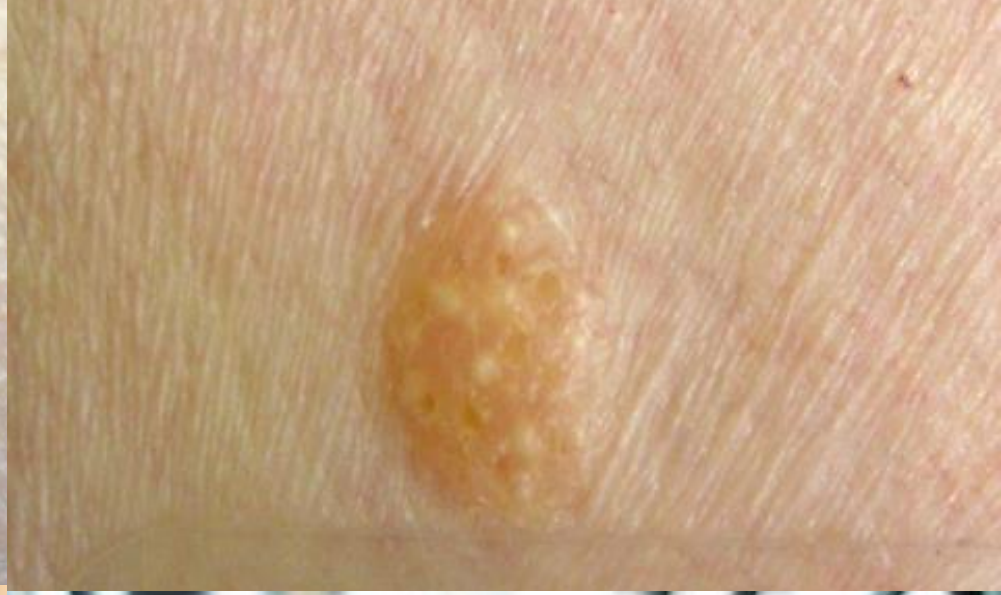
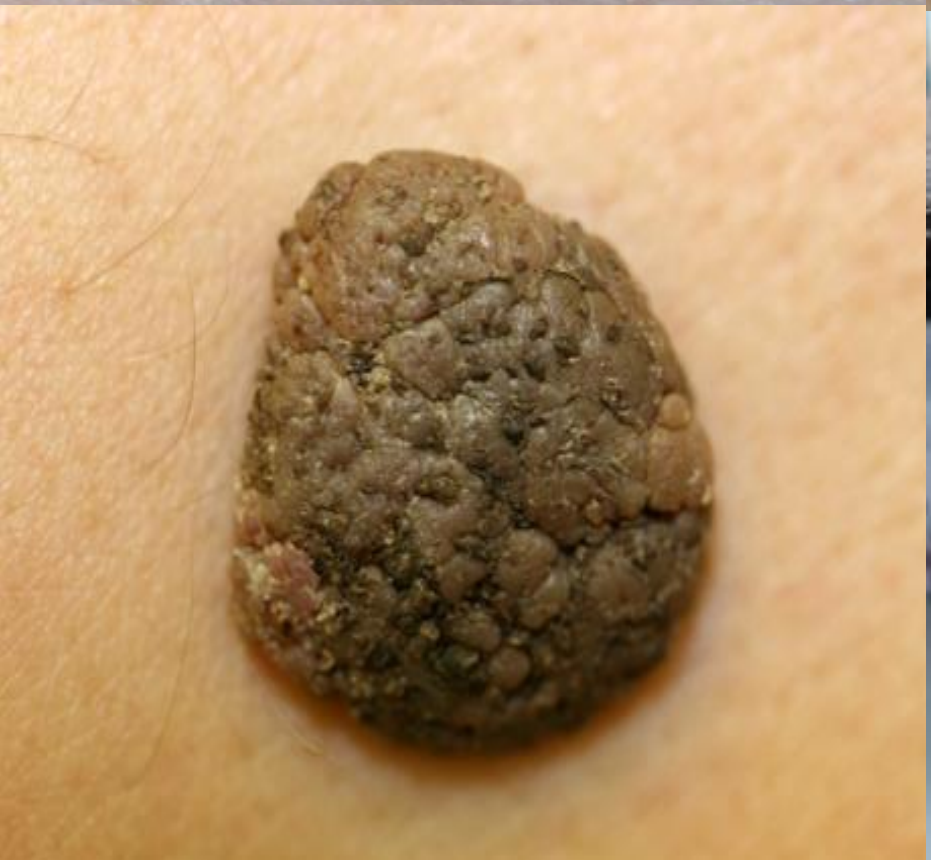




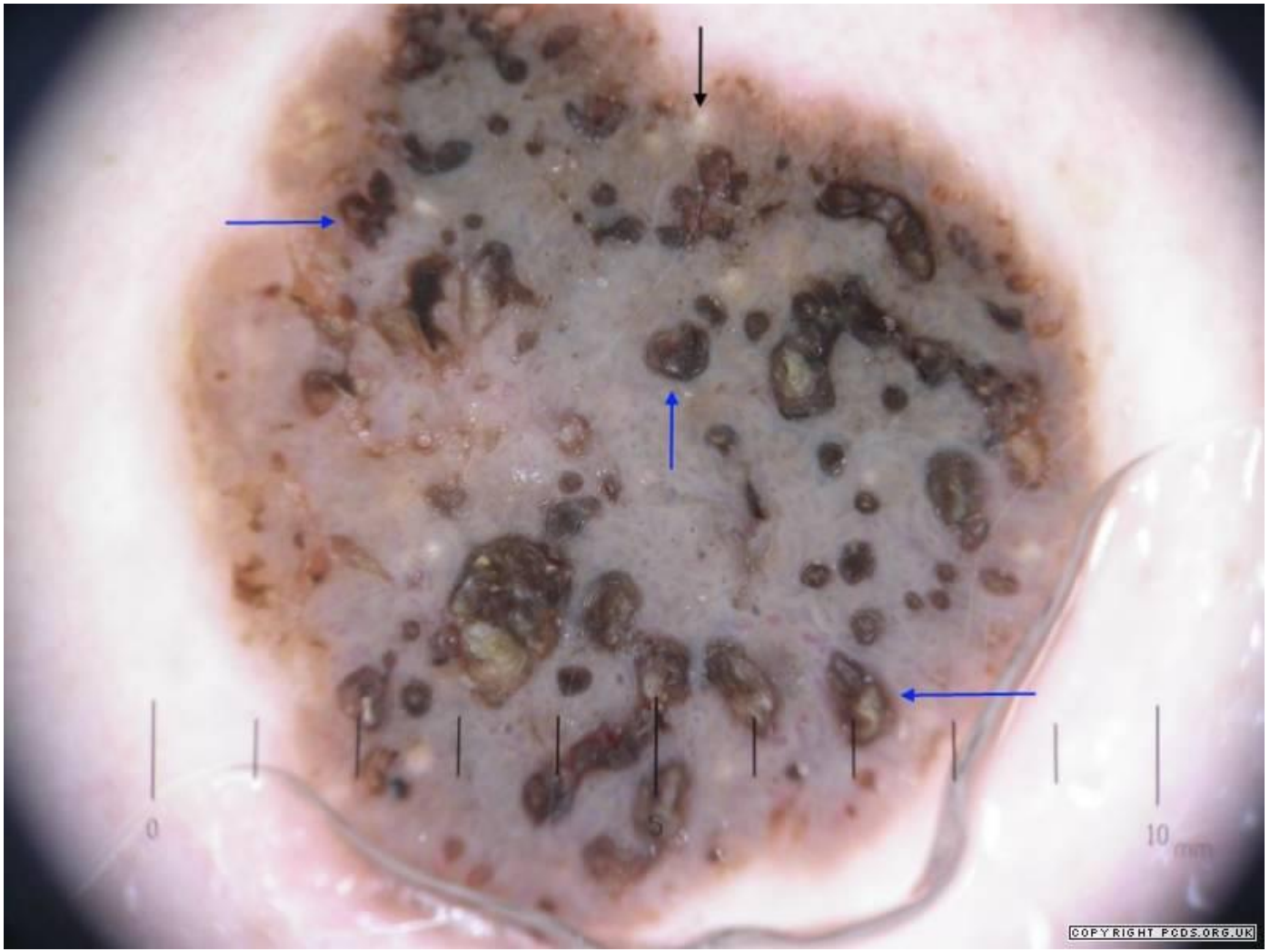
How do naevi look dermoscopcially?






Scattered comedo-like openings (grainy clods) and milia-like cysts (white clods)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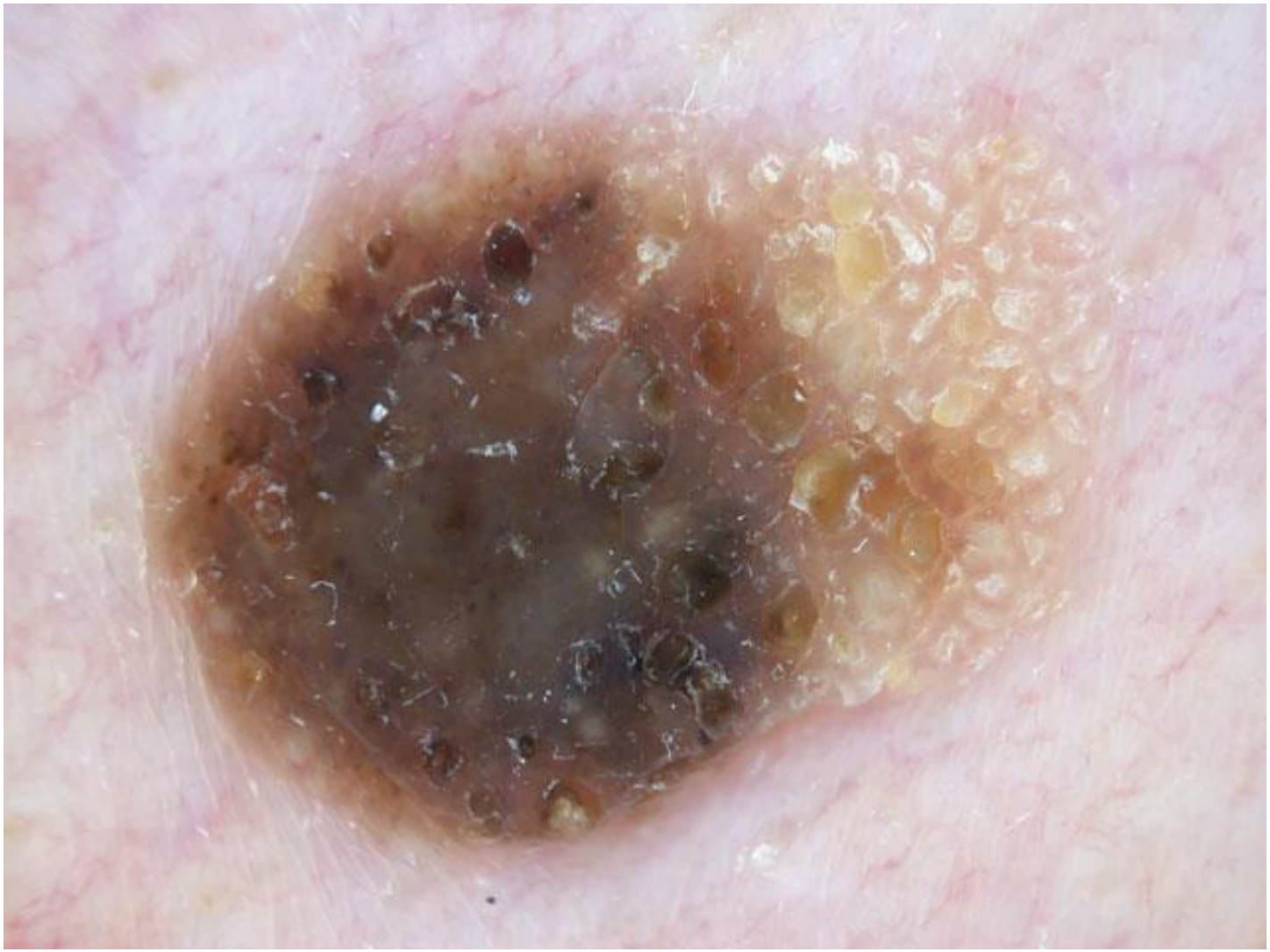
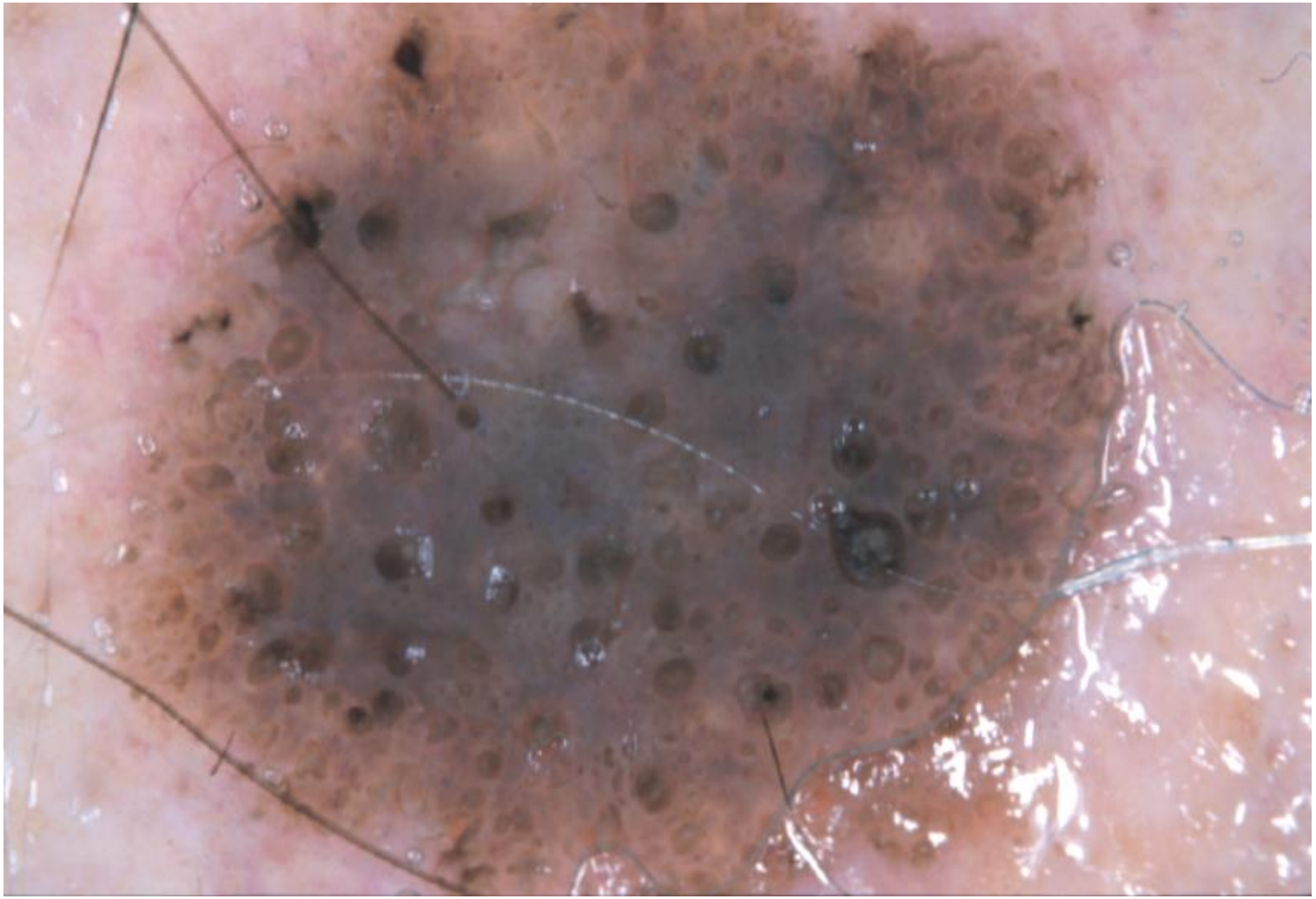
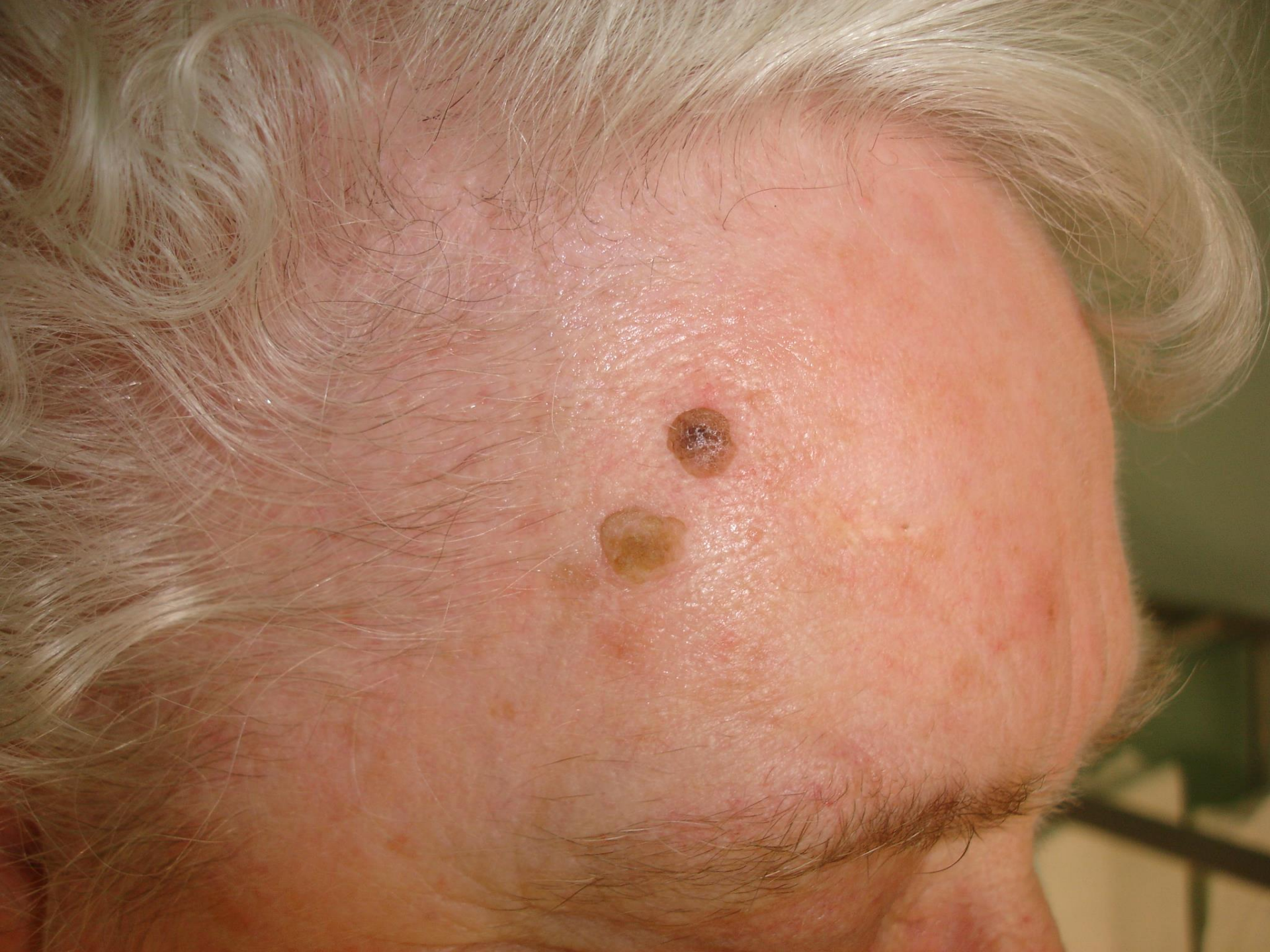


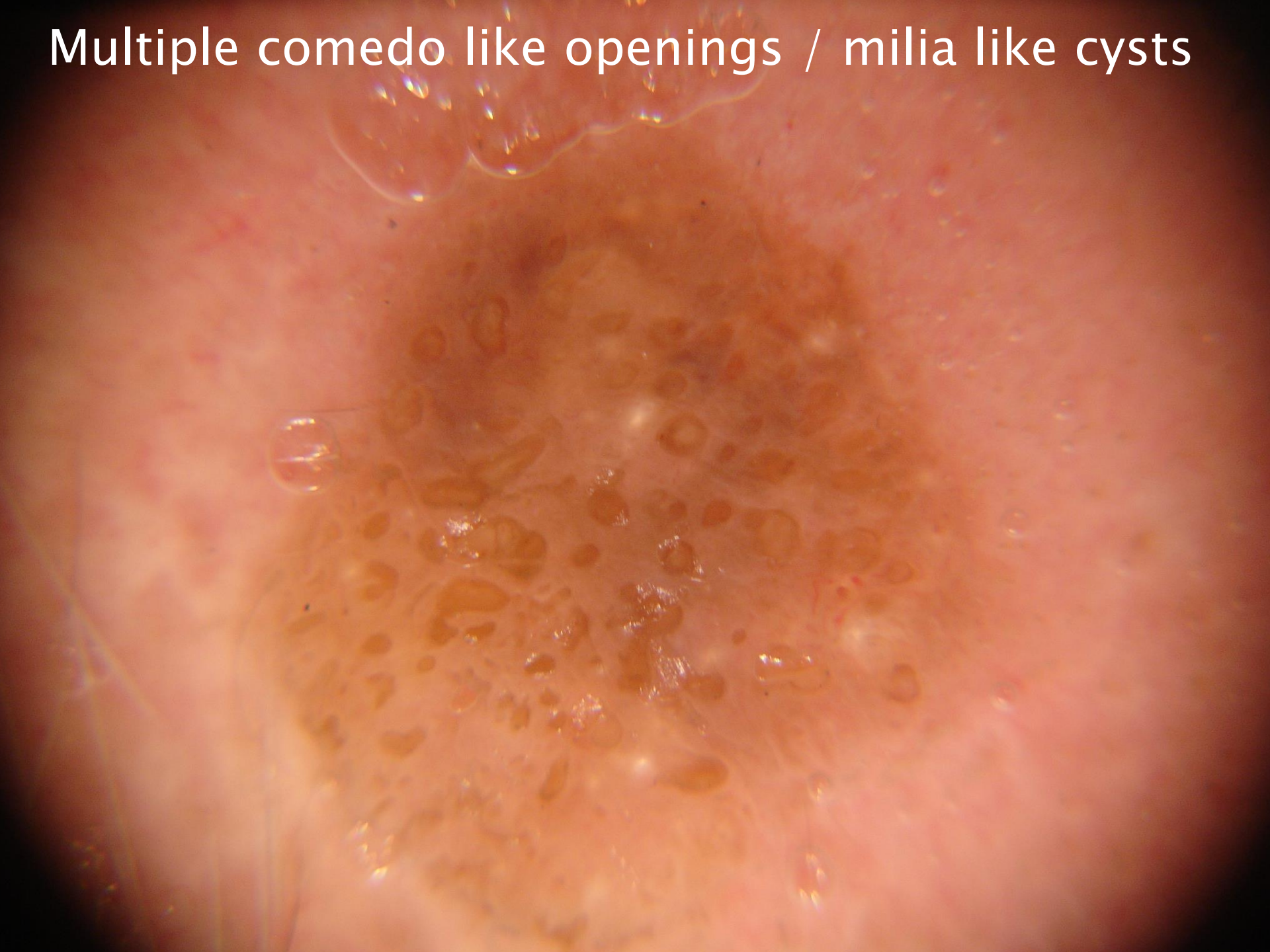


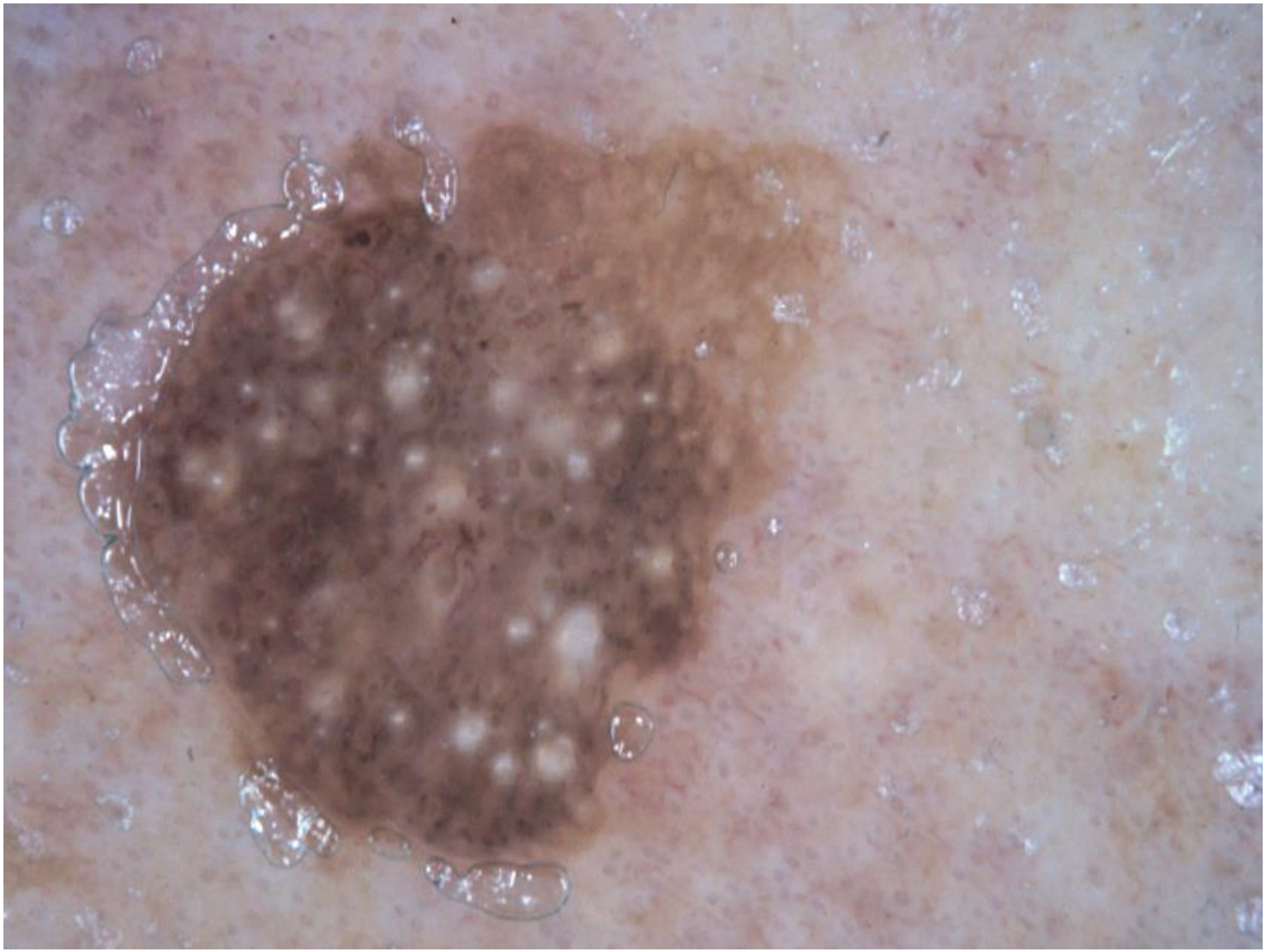


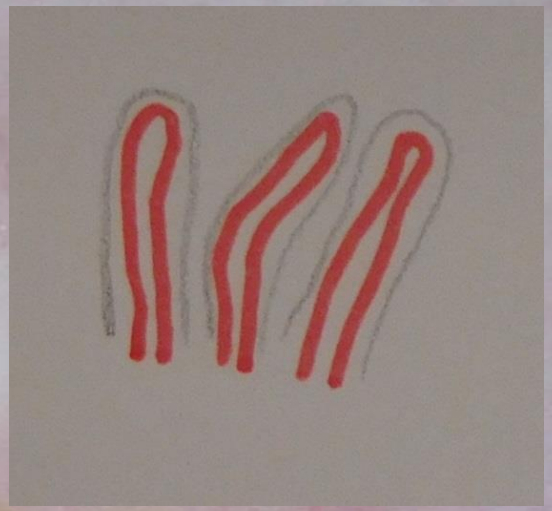
Comedo like openings and milia-like cysts

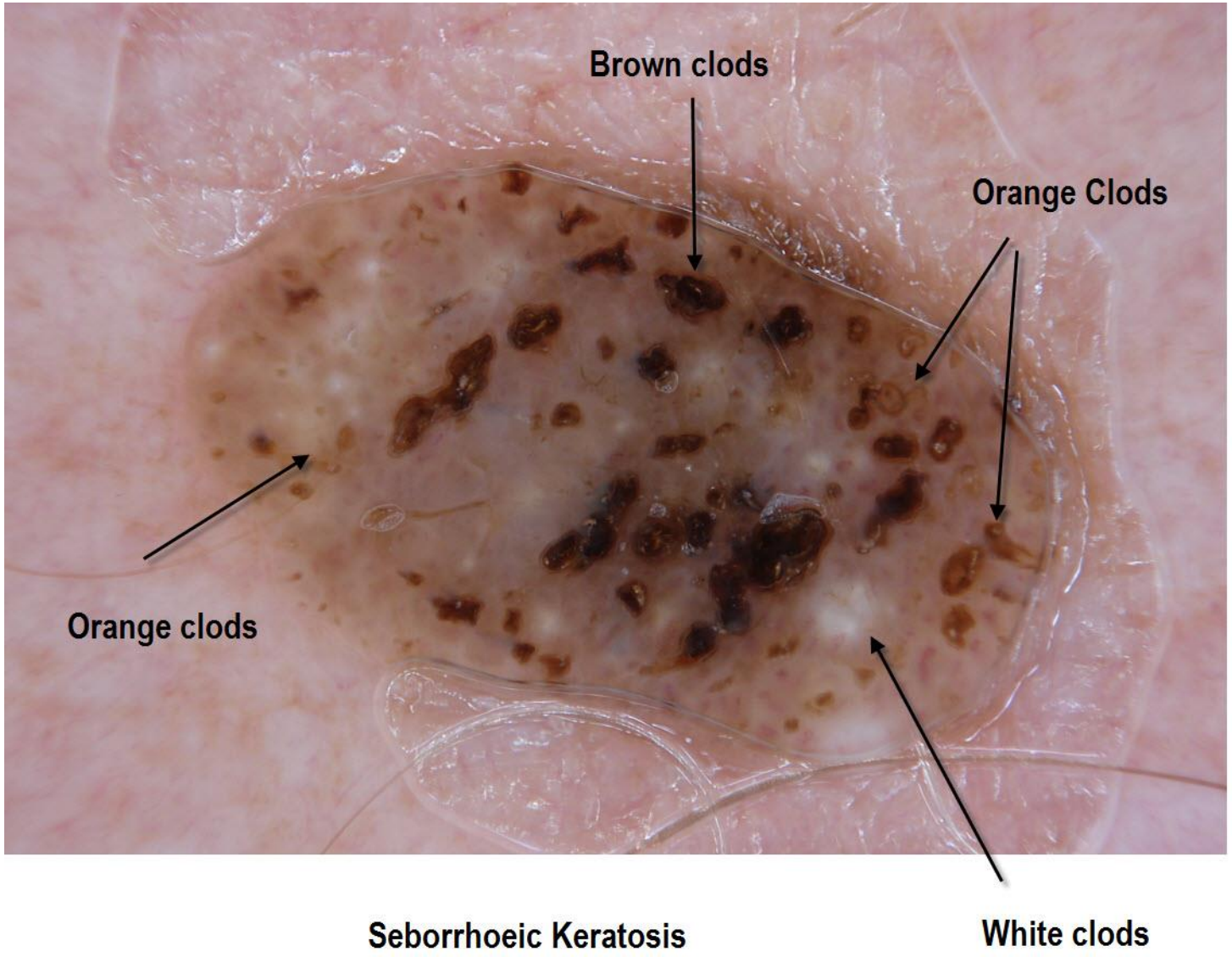
"Stuck on" border with meniscus of alcohol gel

Multiple comedo like openings / milia like cysts



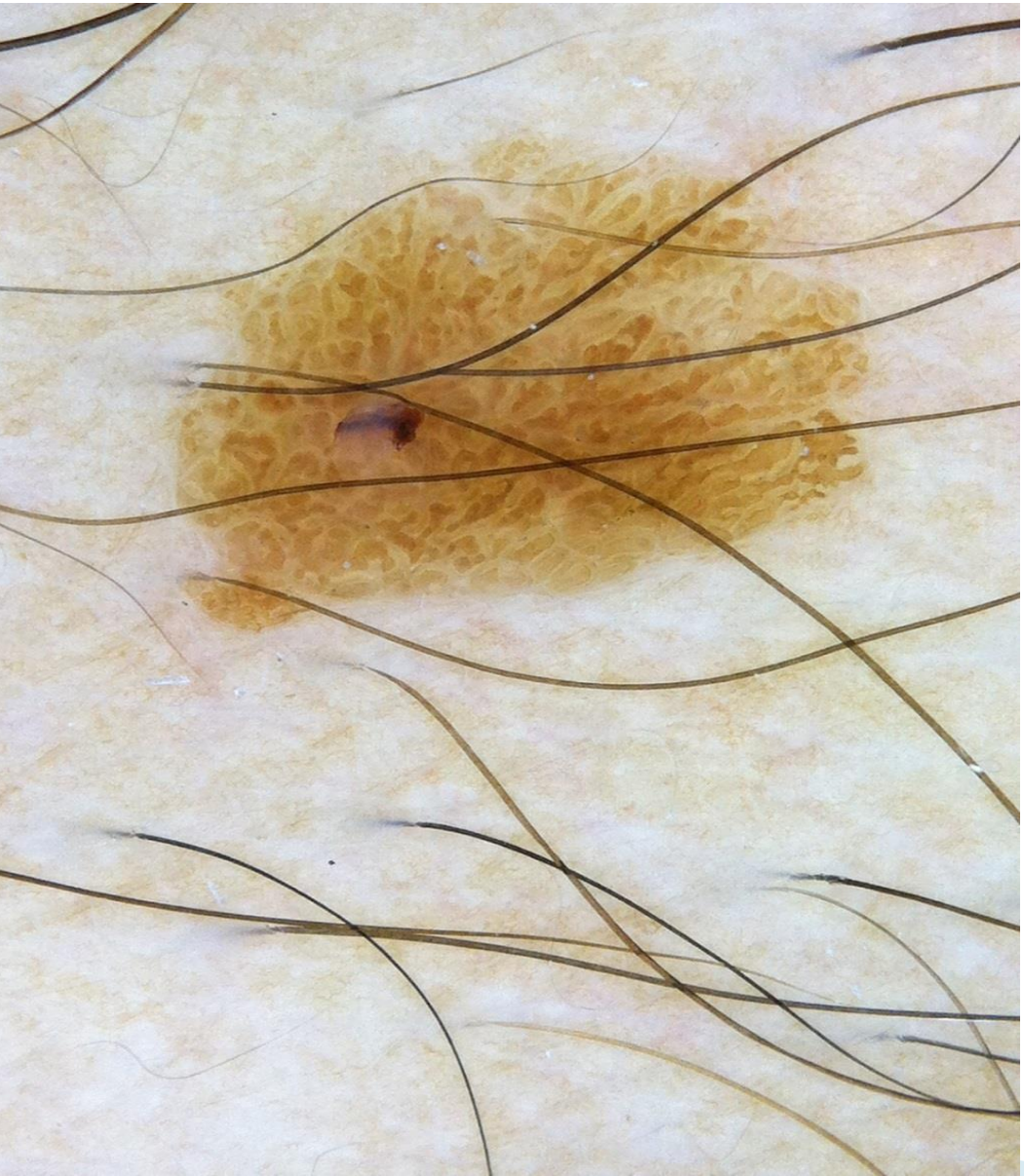





Brown clods
Orange Clods
Orange clods
Seborrhoeic Keratosis
White clods

Pigment bands / fissures and ridges

Pigment bands – coral-like



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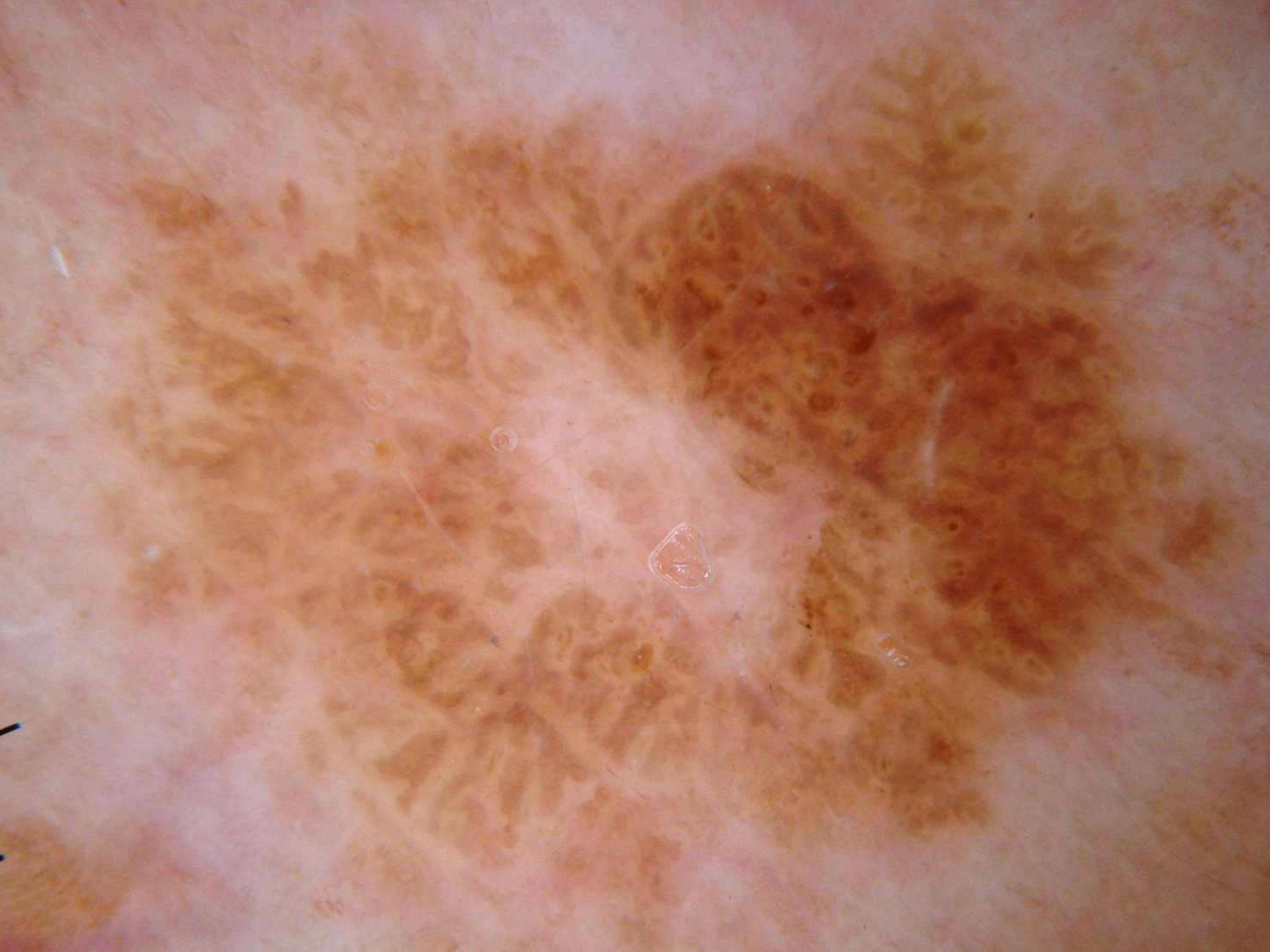

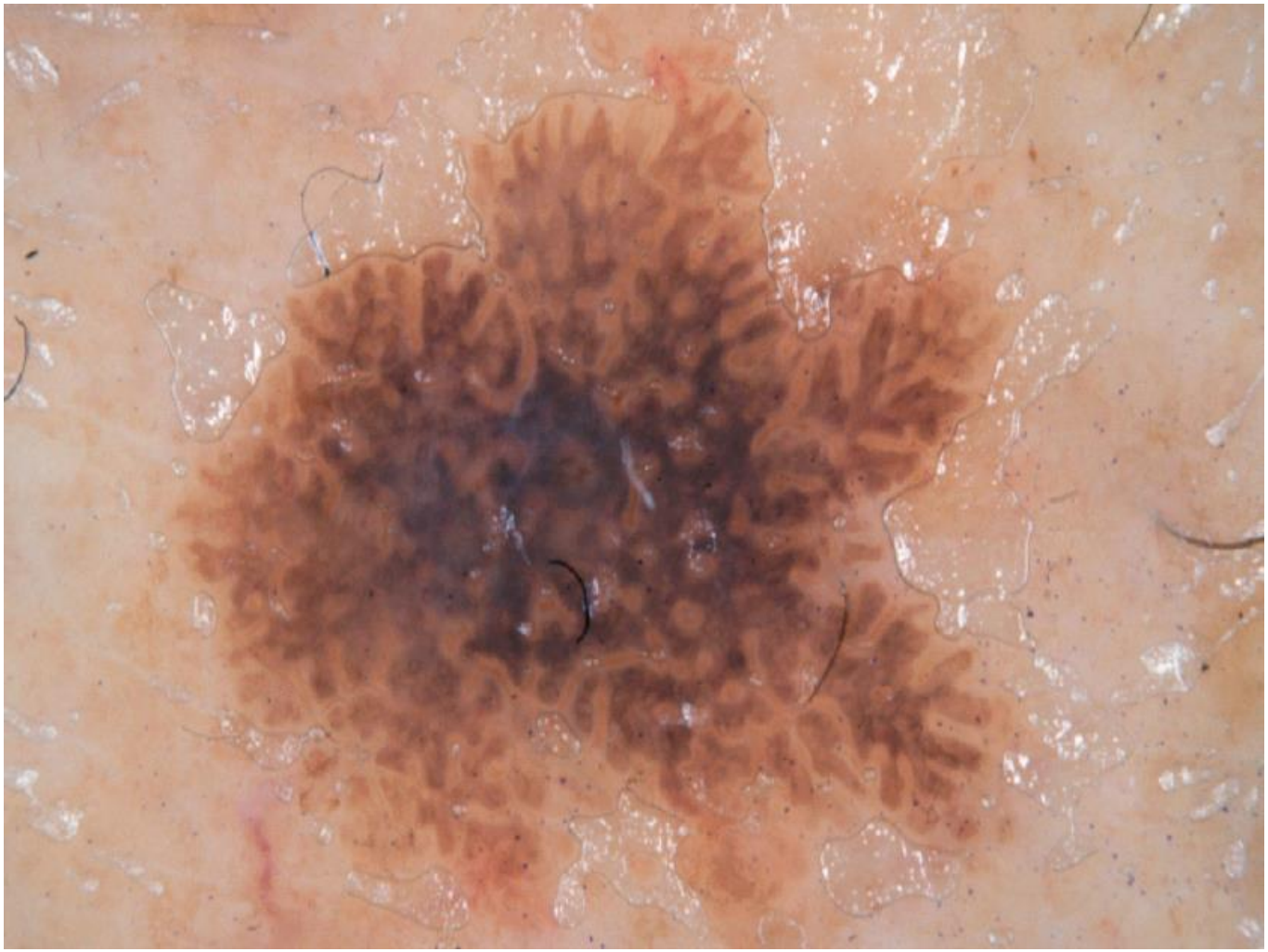

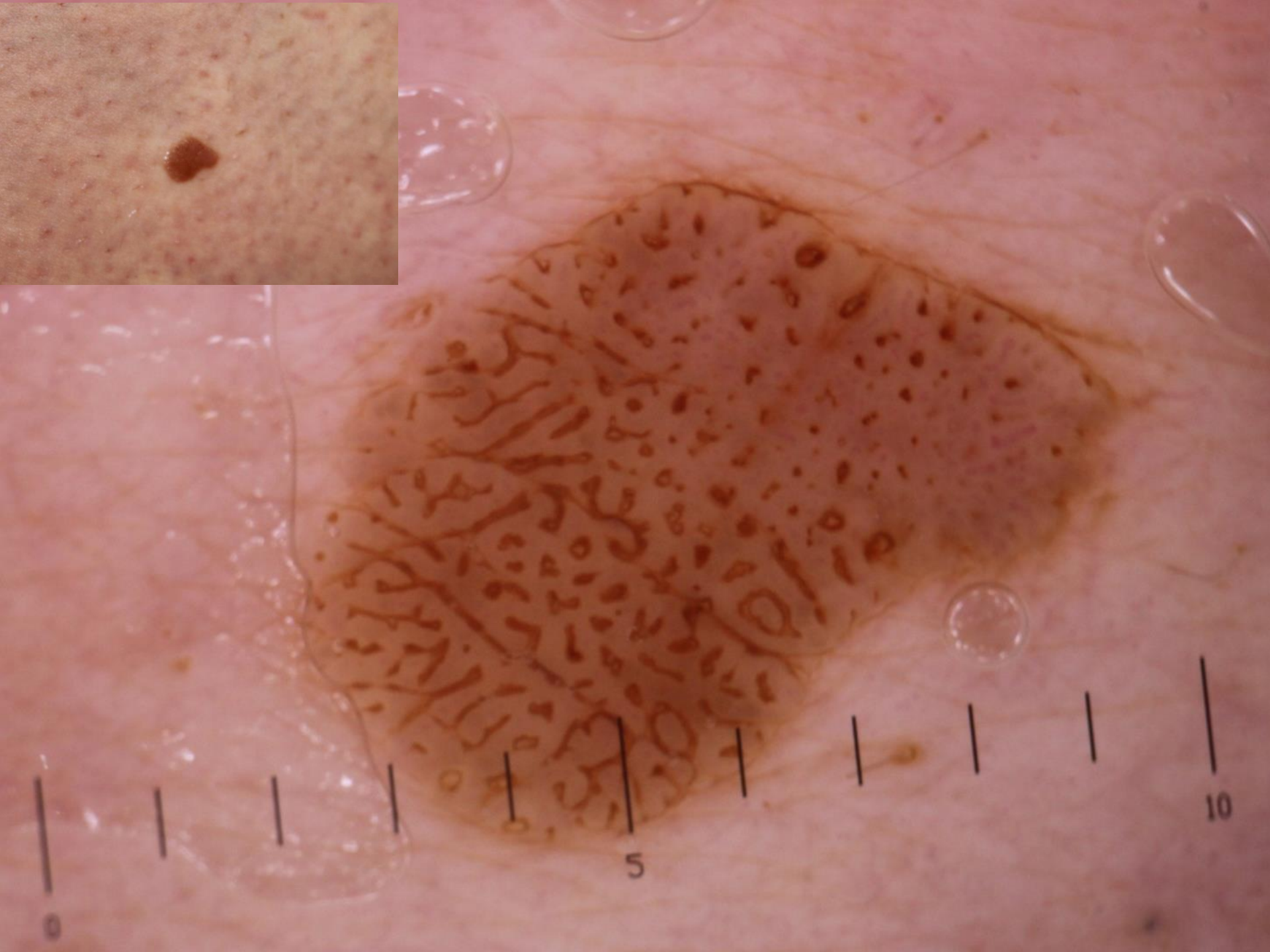
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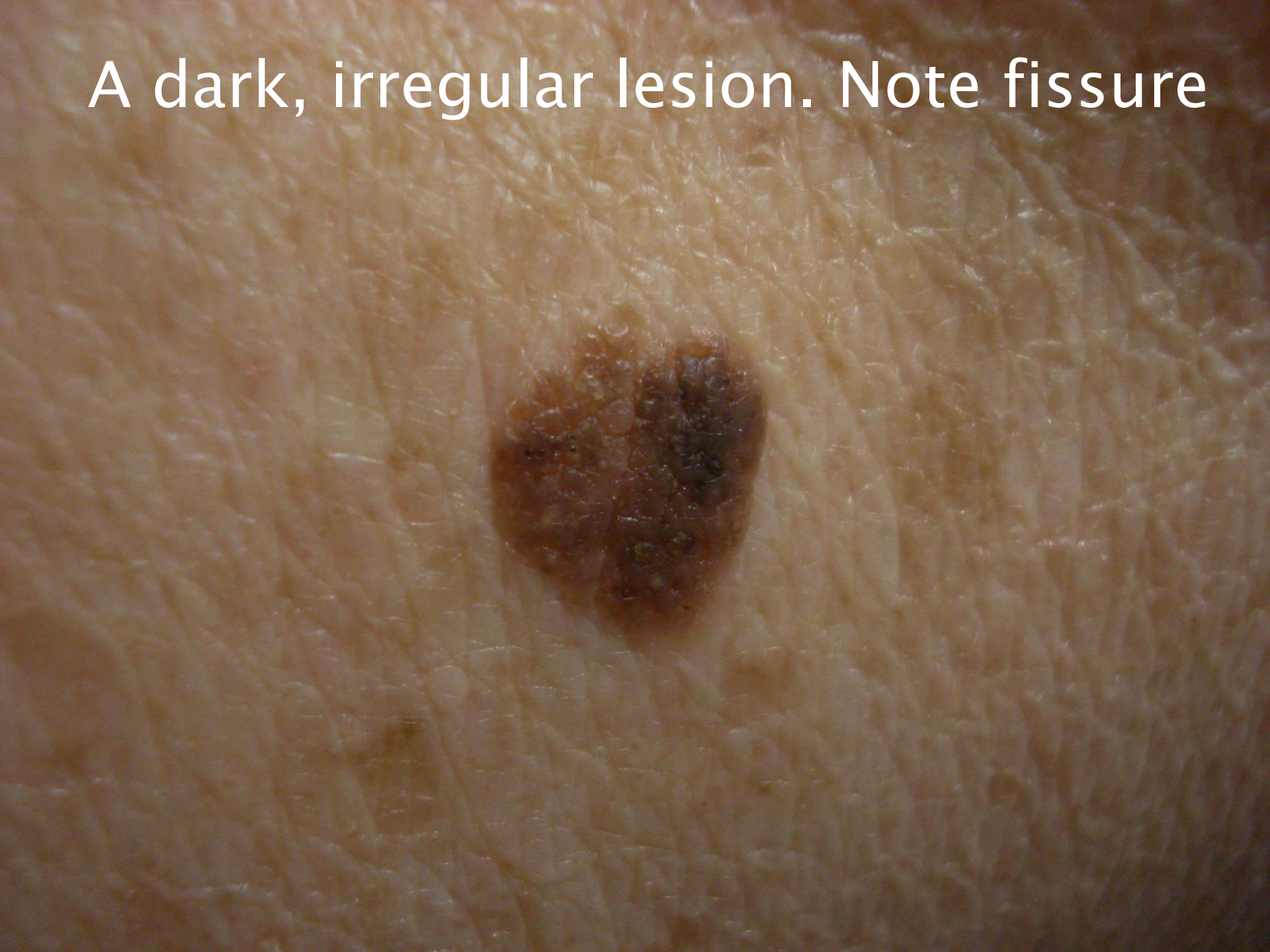
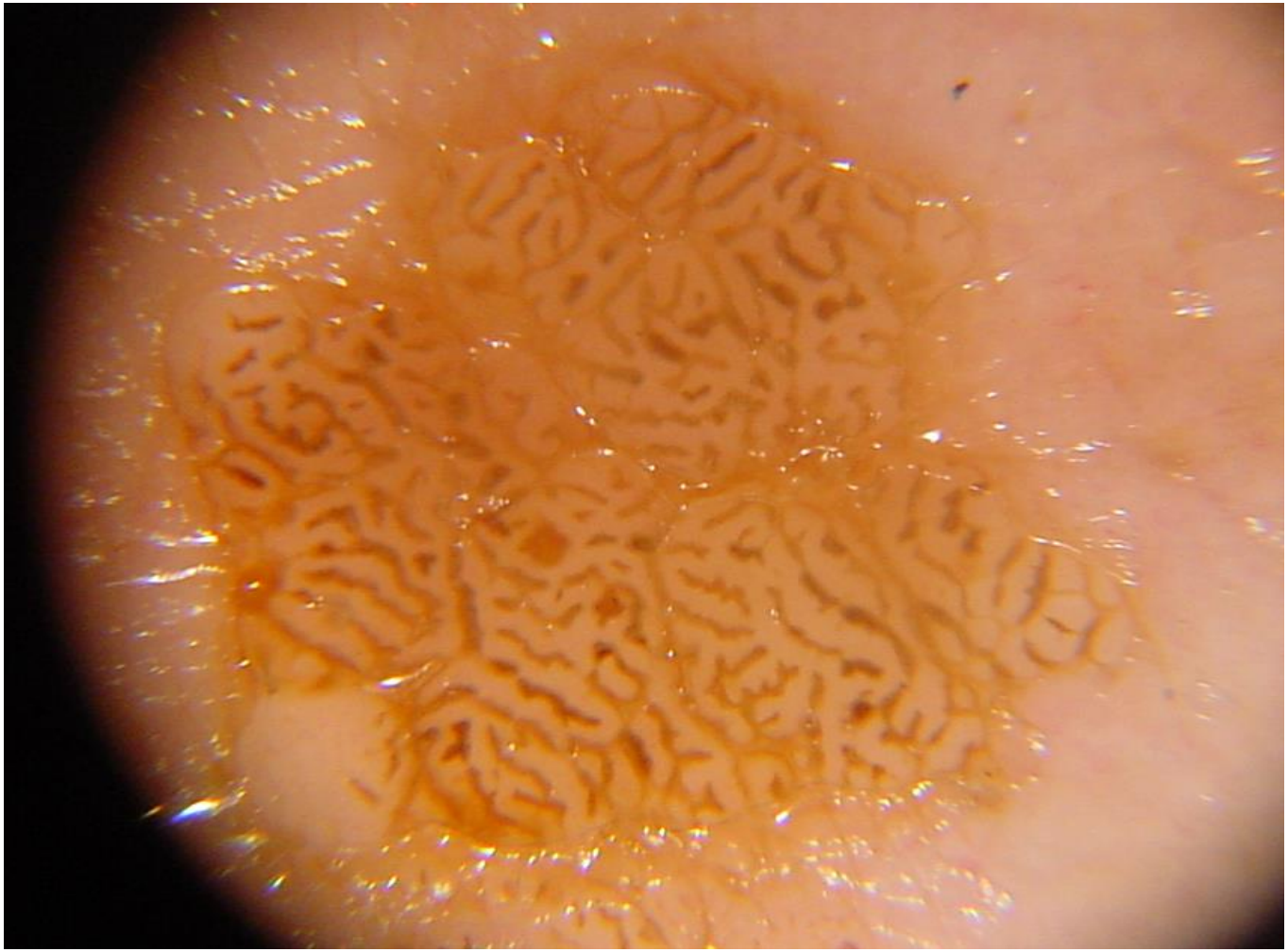

A dark, irregular lesion. Note fissure

San Tropez sign



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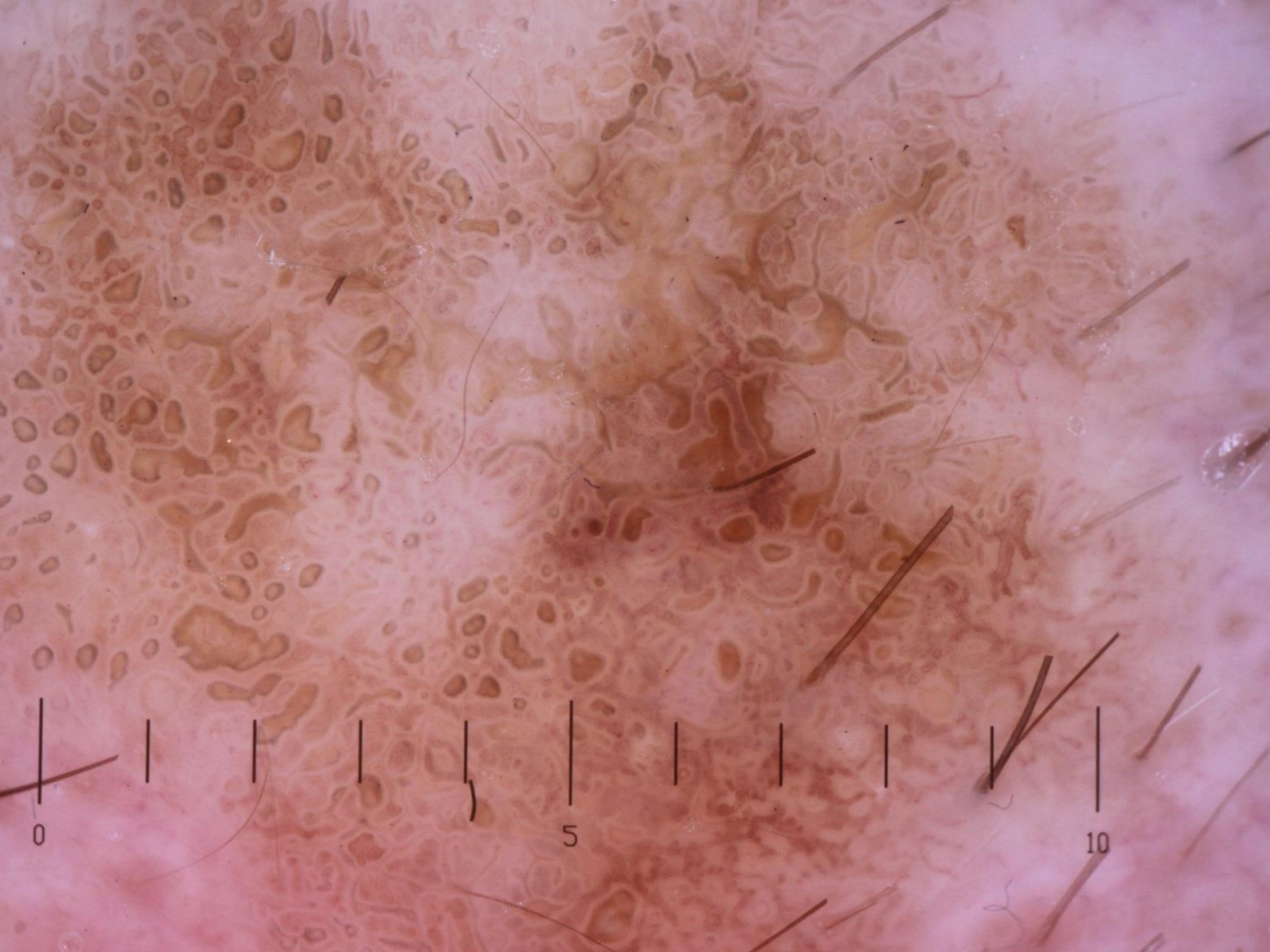
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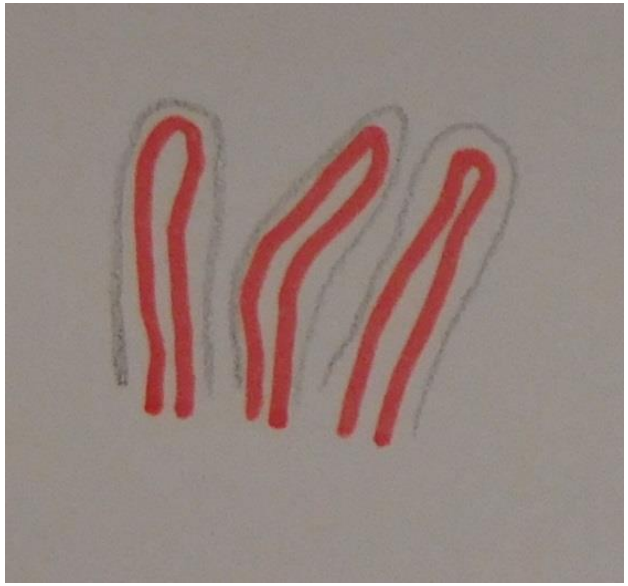
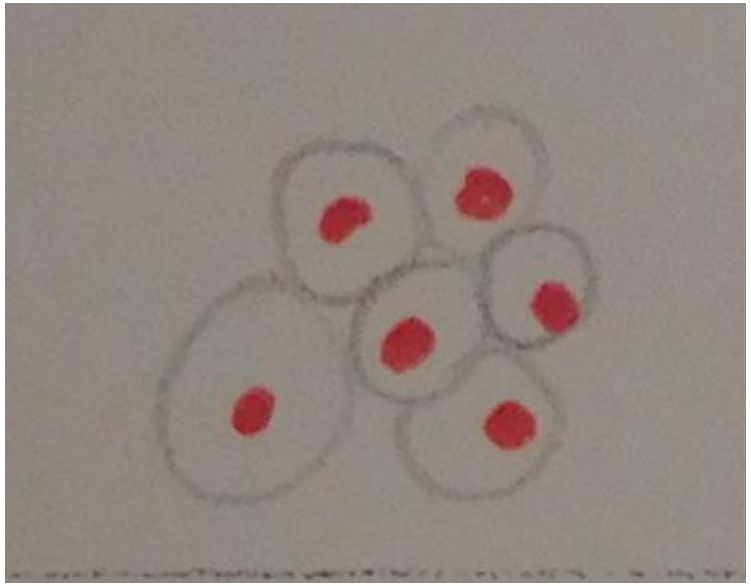
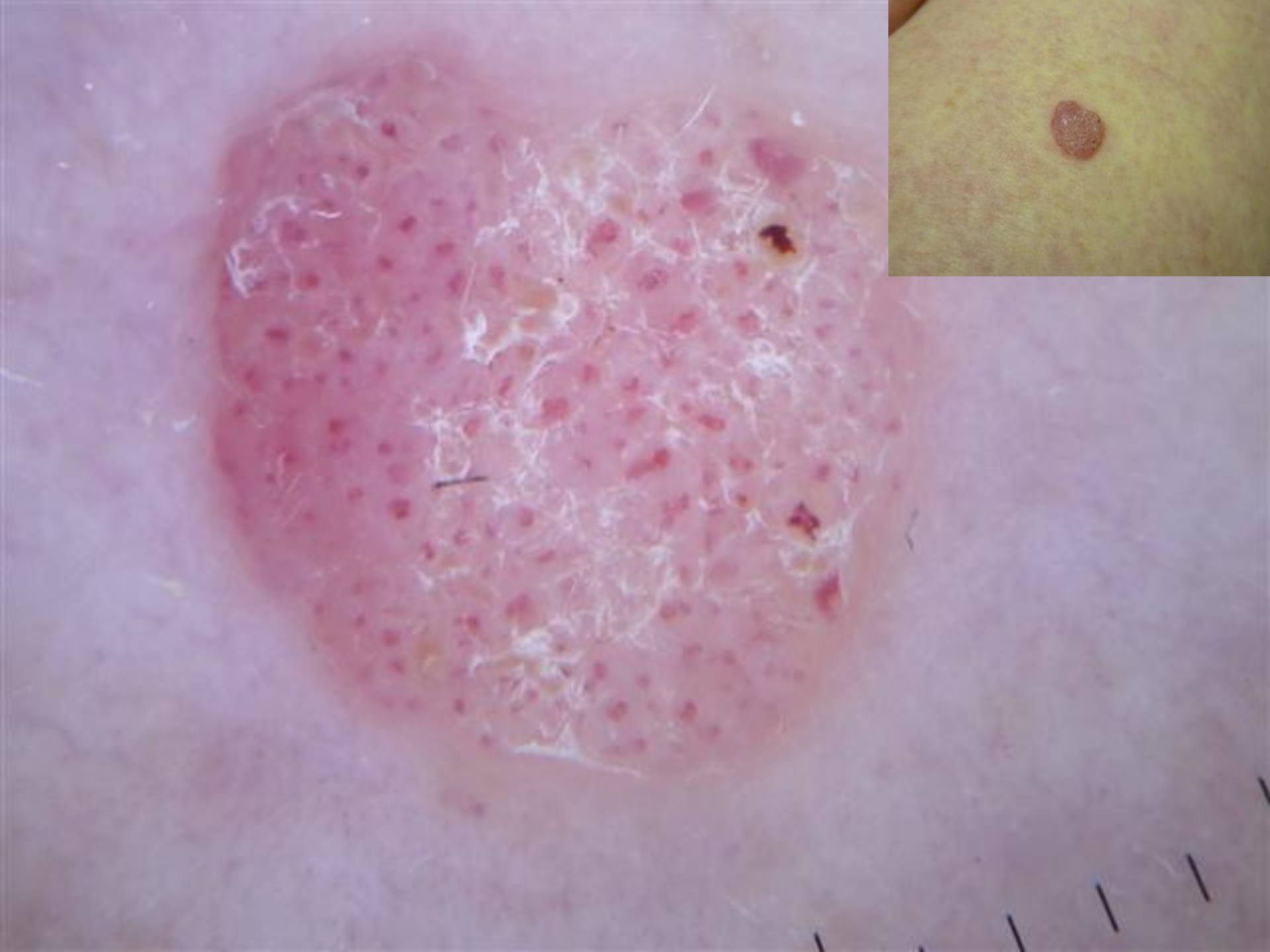
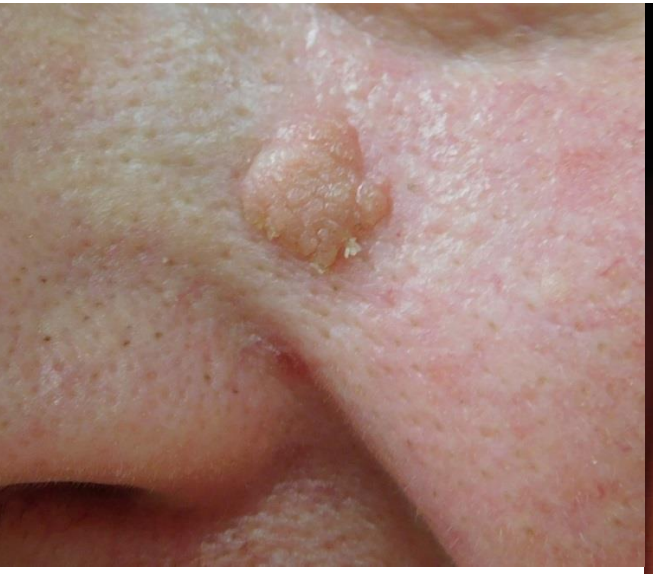
Grouped globules with central vessel ‘frogspawn’

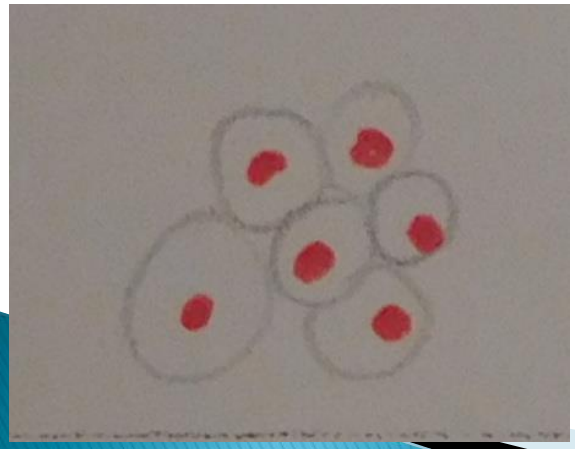


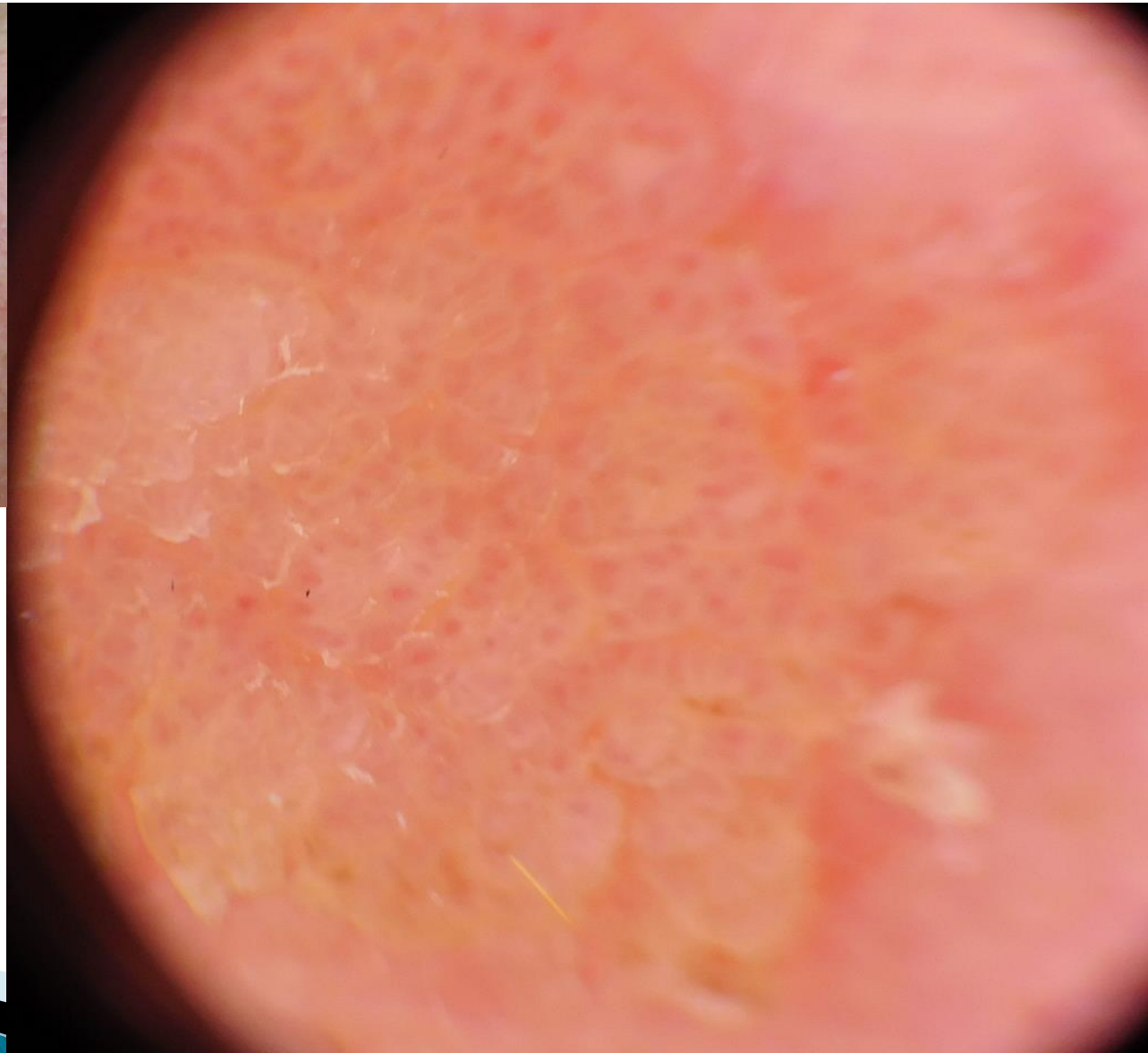




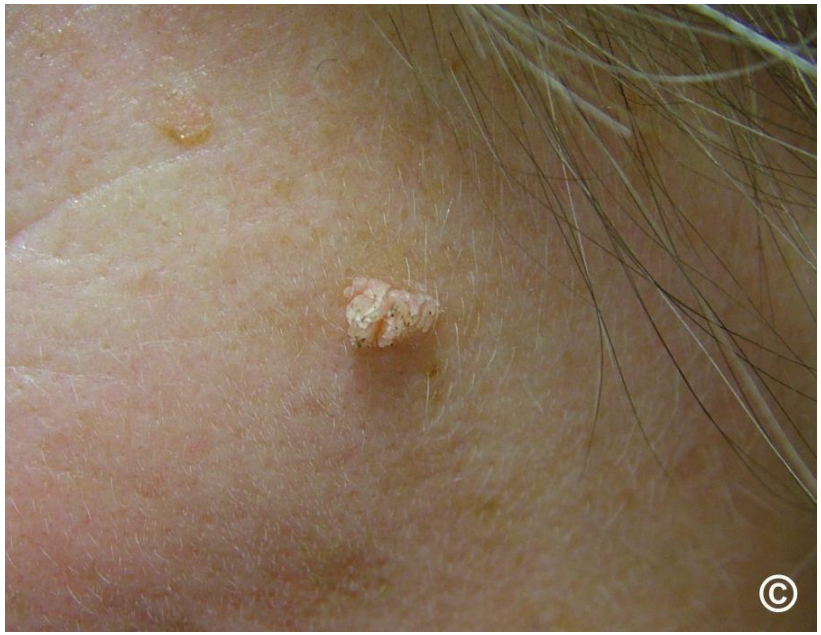
‘Frogspawn’ best seen in pale lesions

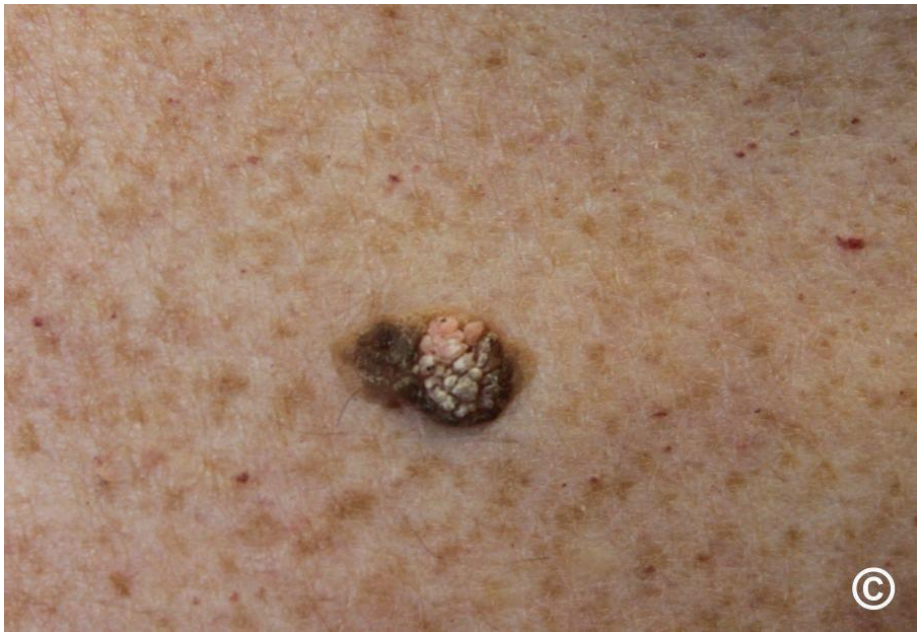






Warts (filiform) and verrucous keratosis





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- Seborrhoeic keraotses and warts
- **Scaly lesions with variable amounts of surface scale but NO base**
- Melanocytic naevi and thin melanomas
- Firm, palpable, benign lesions – small and large
- The EFG rule of skin cancer (solid BCC, SCC, nodular melanoma)
- Pink makes you think (including red and purple)
- Other lesions of concern requiring urgent referral
- If we still don't know what it is ….

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- **Actinic keratoses** – single to many. Small rough pink macules, often with white surface scale, usually on UV-exposed sites. Non-tender. Refer to the **Best Practice Guidelines** for management (Efudix cream and Dovobet ointment BD 4 days)

- **Bowen's disease** – single to few. Rough scaly plaque, usually on UV-exposed sites. Non-tender. Efudix OD 4 weeks and FU 3/12 after treatment finished

- For **other flat scaly lesions** refer to the **Skin Lesion Diagnostic Tool**

- **Cutaneous horns** – not a diagnosis, rather it tells us that something is going on in the epidermis:
  - No **palpable base/lump under the scale – viral wart** or **AK**
  - A **palpable lump under the horn suggests an SCC**, a diagnosis made more likely if the lesion is tender and growing

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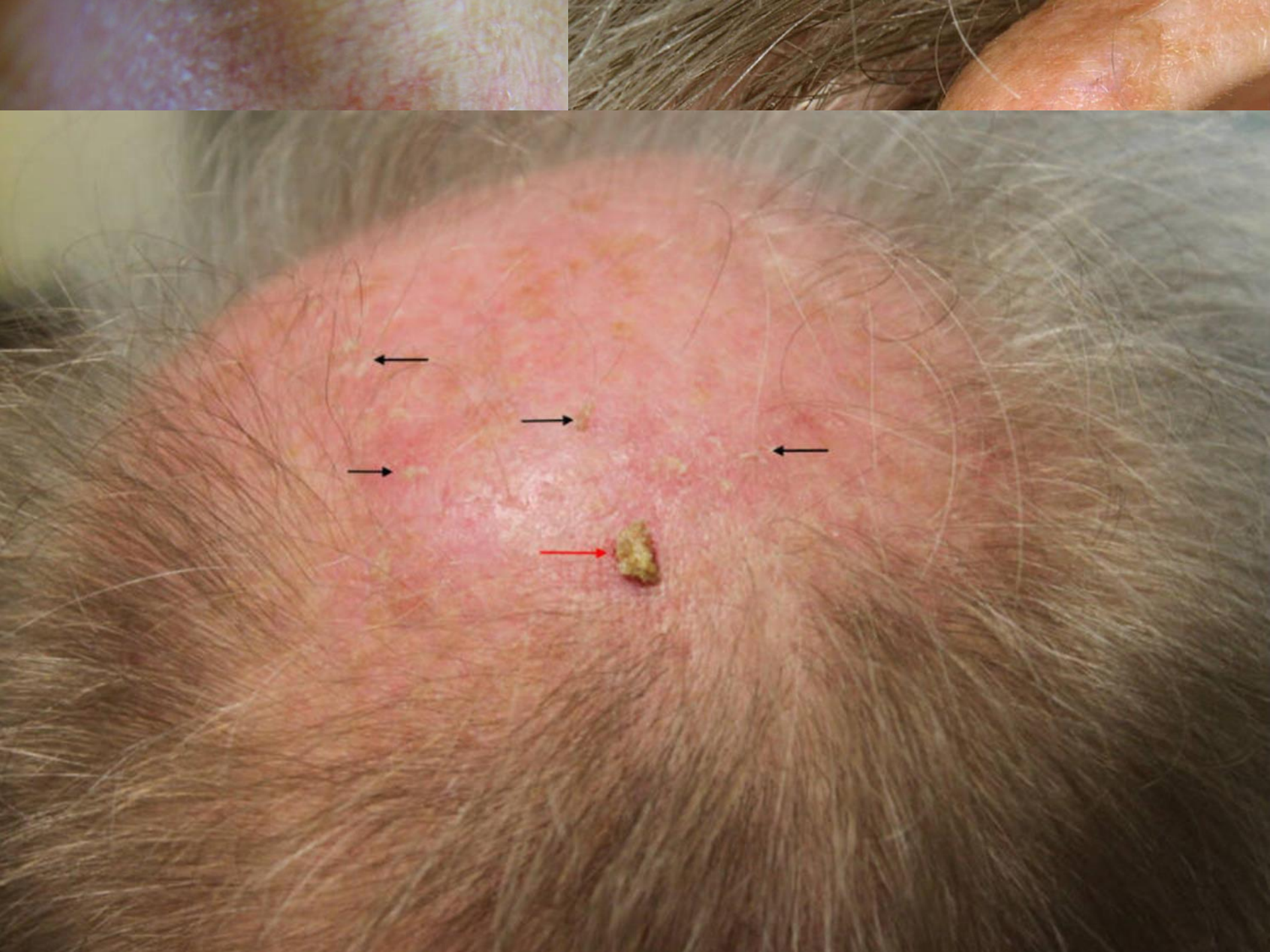

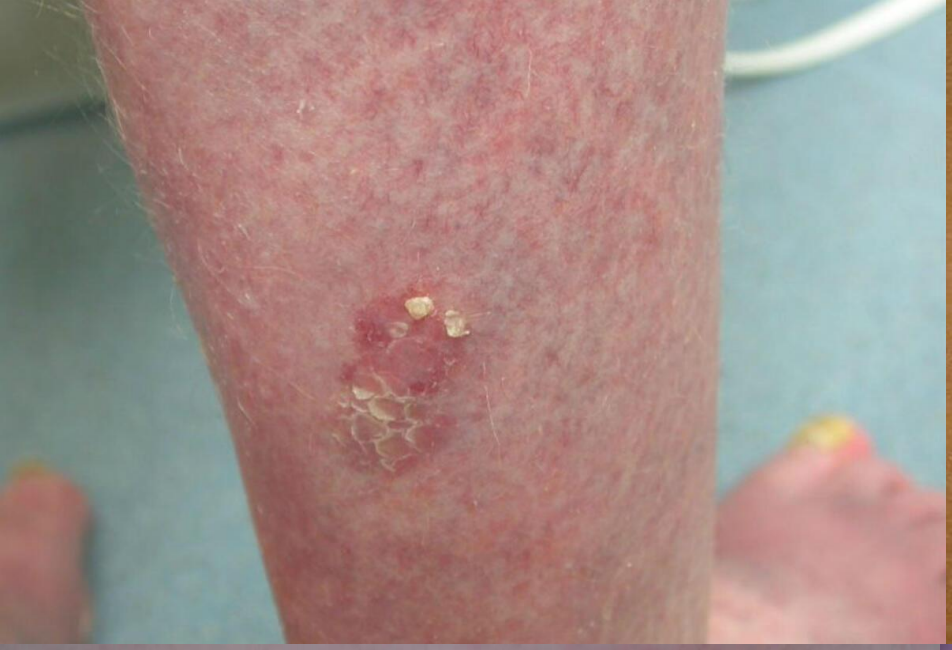

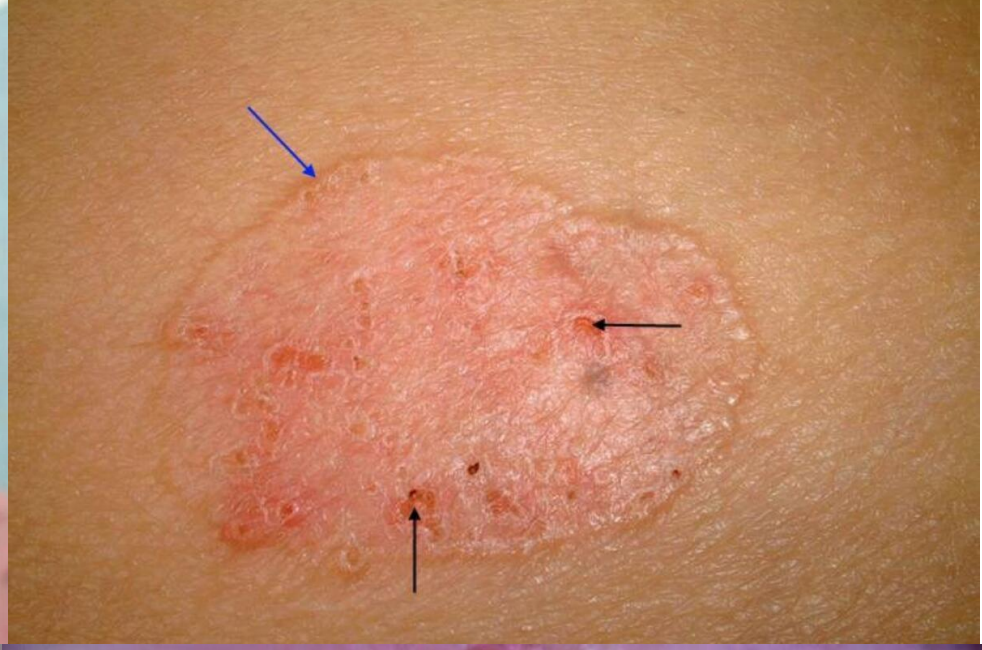

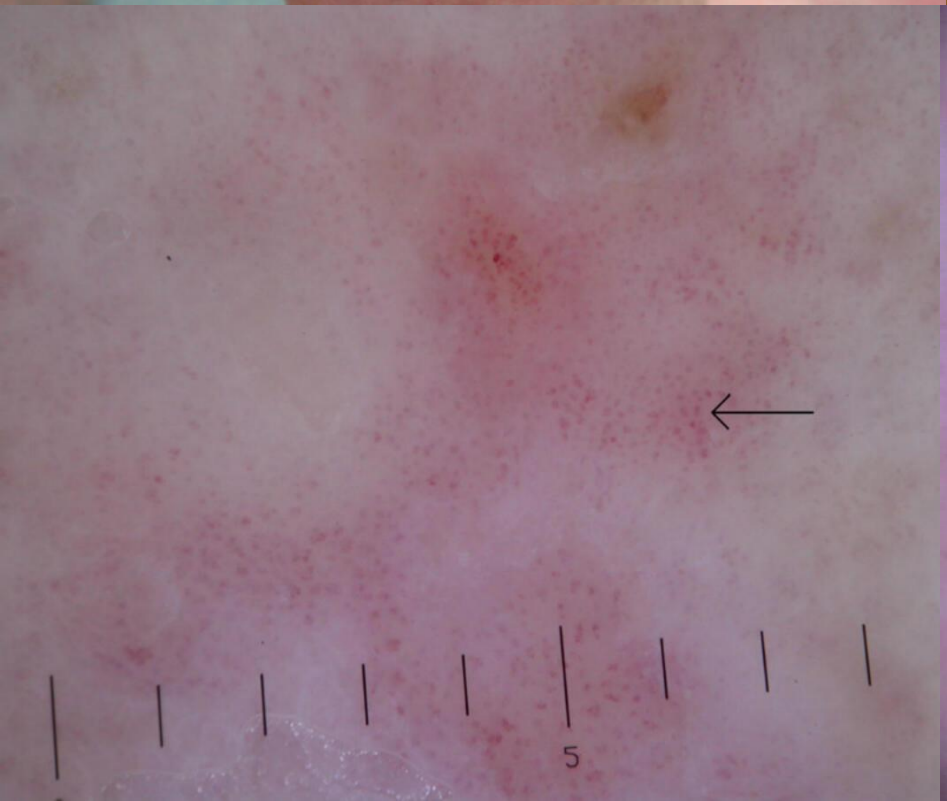
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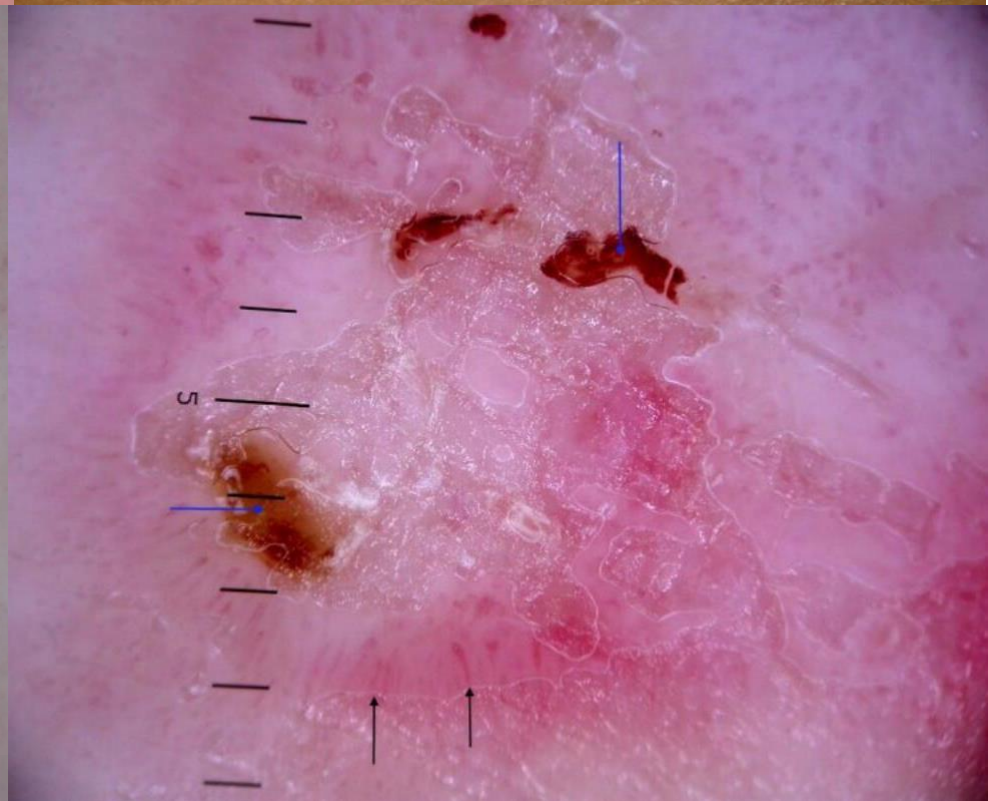
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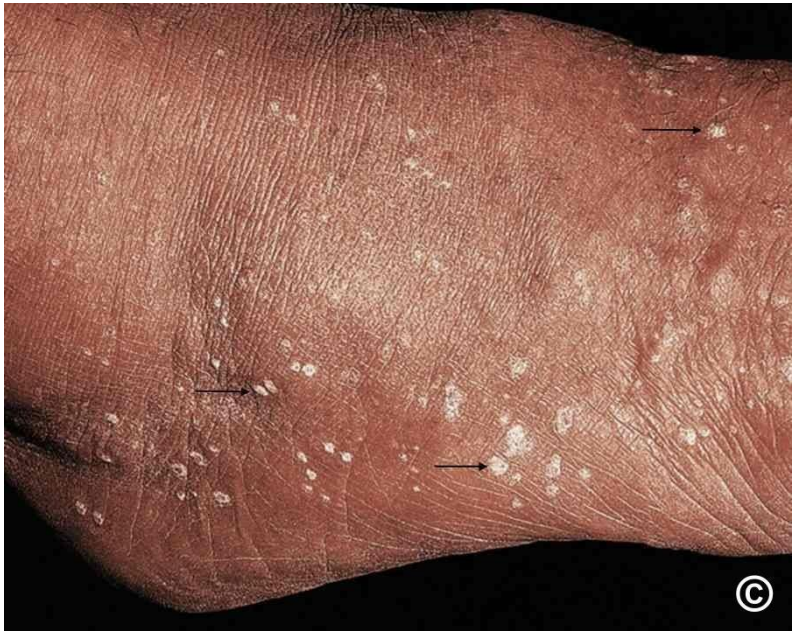
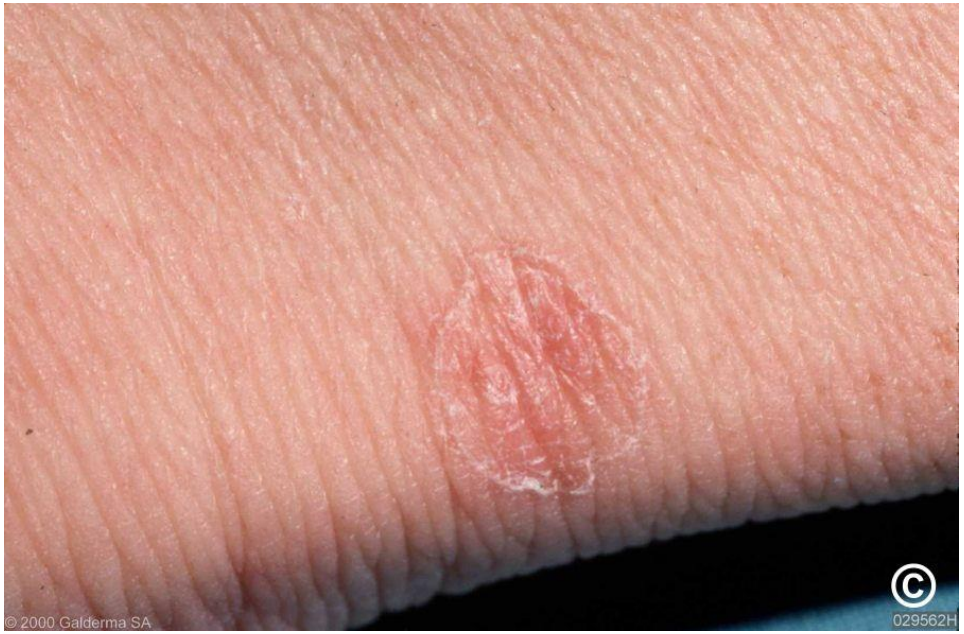
Many scaly lesions – Skin Lesion Diagnostic Tool





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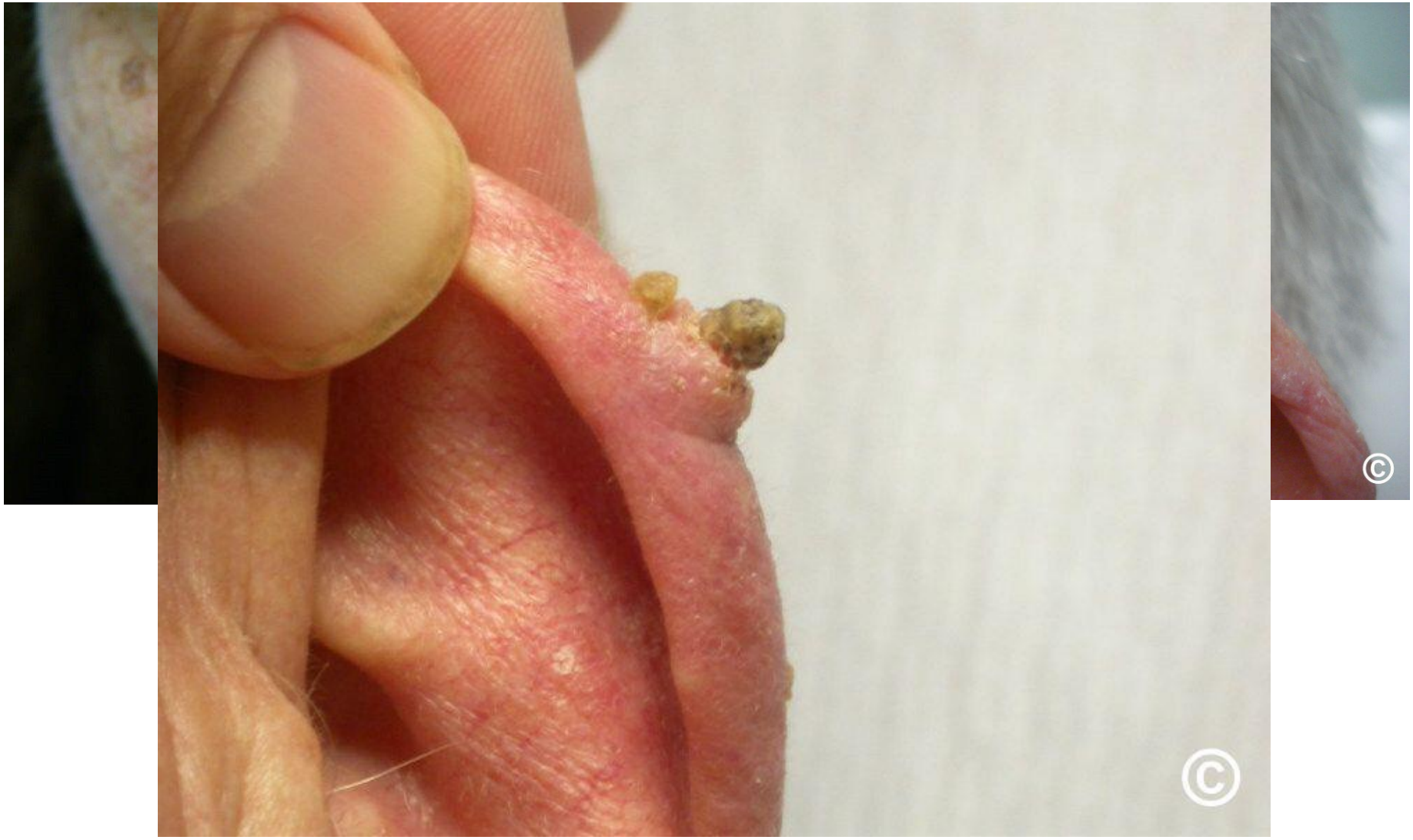
Cutaneous horns



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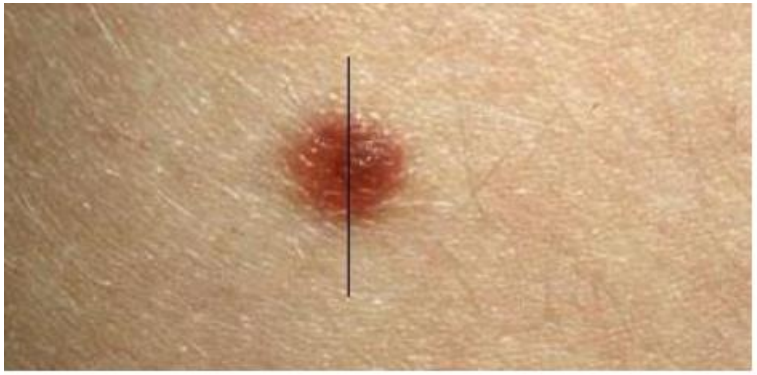
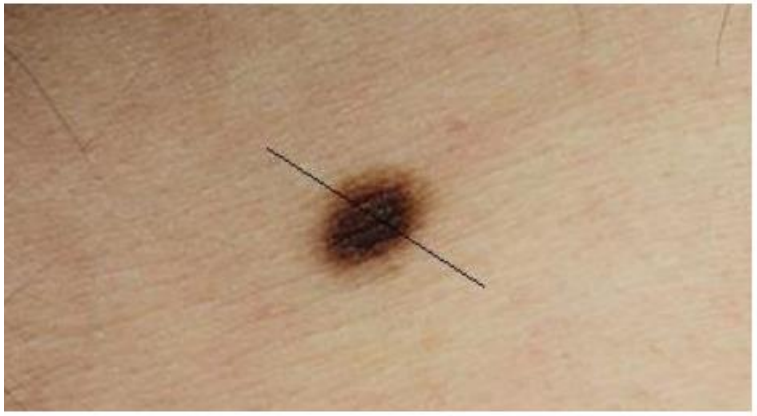
A few normal naevi



Symmetry - in shape and colour

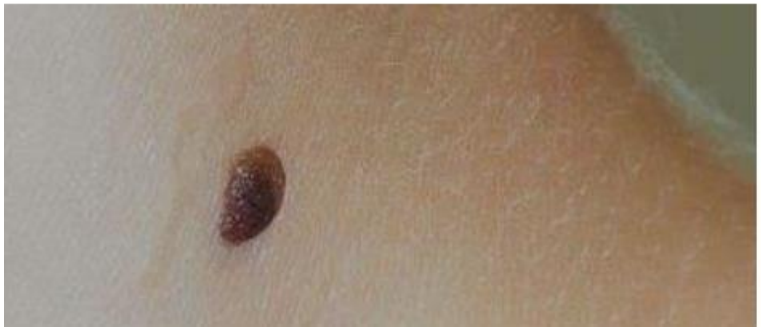
Border - smooth



Symmetry - in shape and colour

Even though there are two **colours** they are a similar shade of brown and the colour is evenly distributed in a symmetrical fashion

Border - smooth

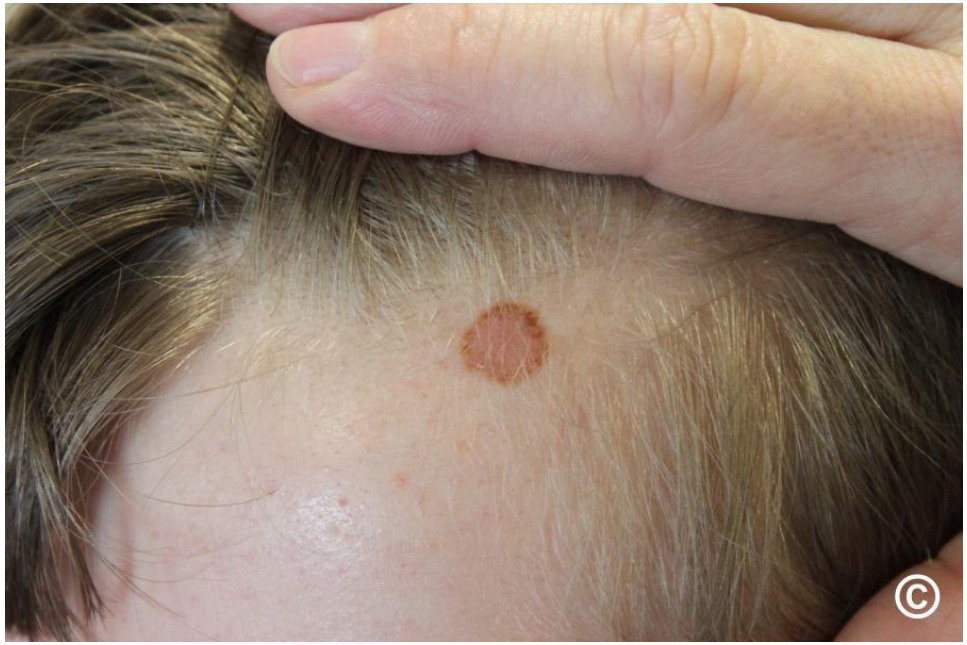


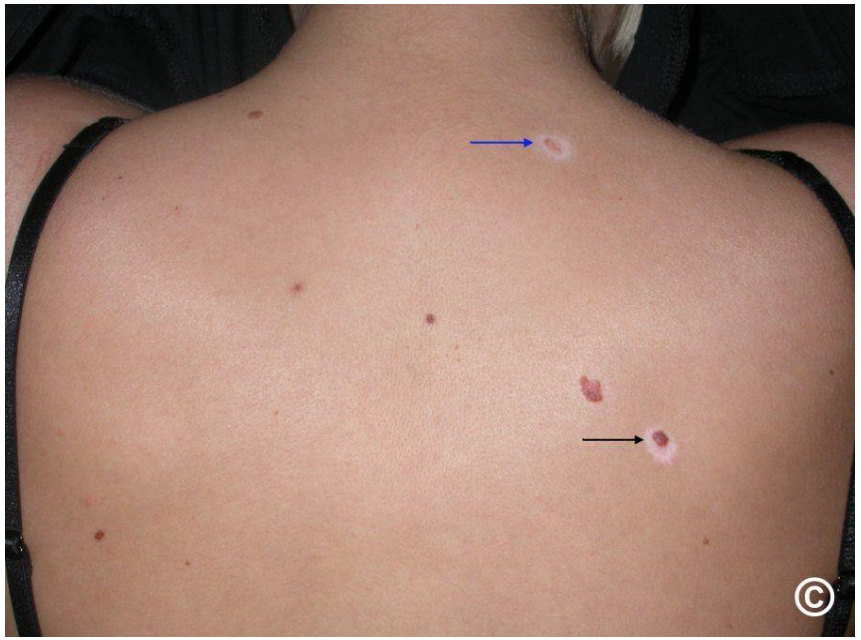
Soft and wobbly moles

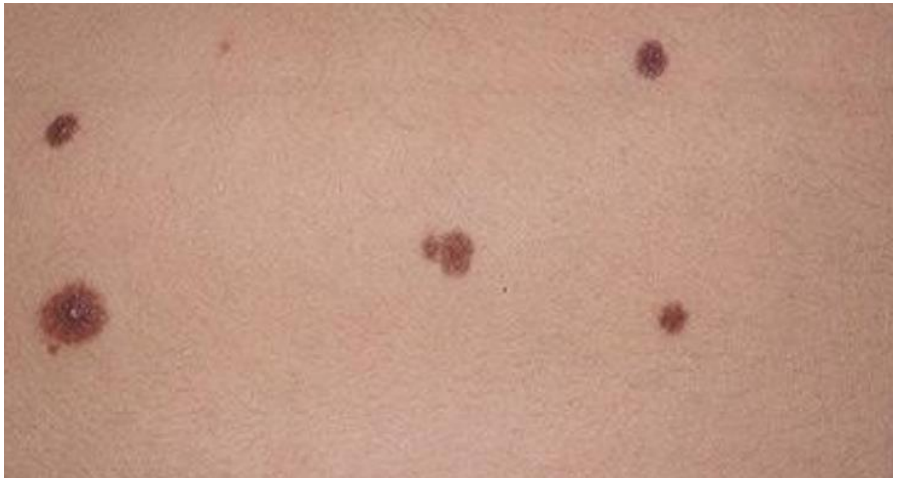
Symmetry - in shape and colour

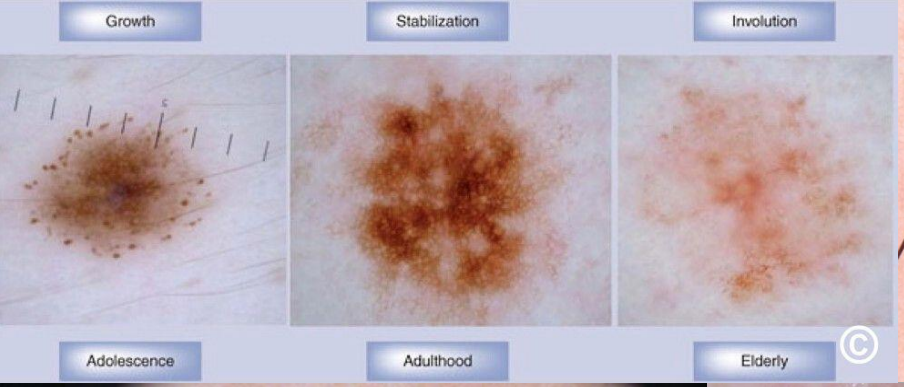
Borders - smooth

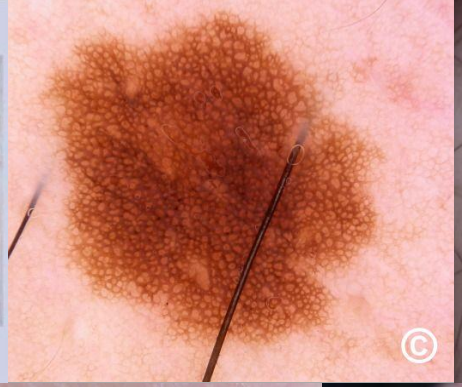
A few more normal naevi

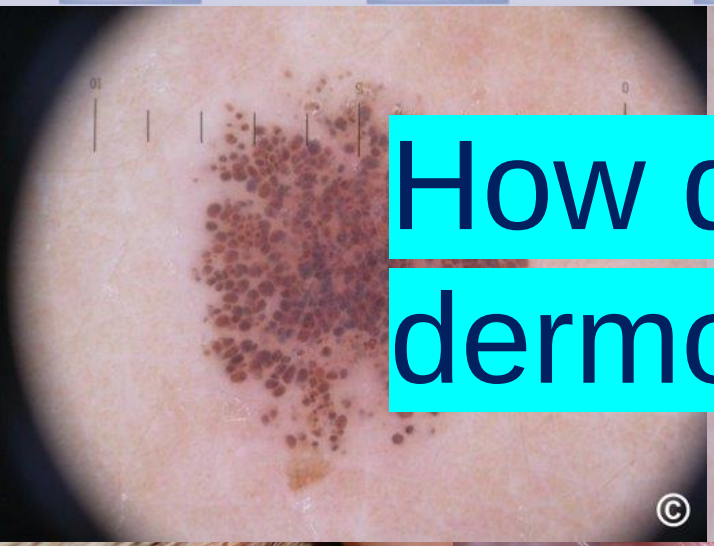


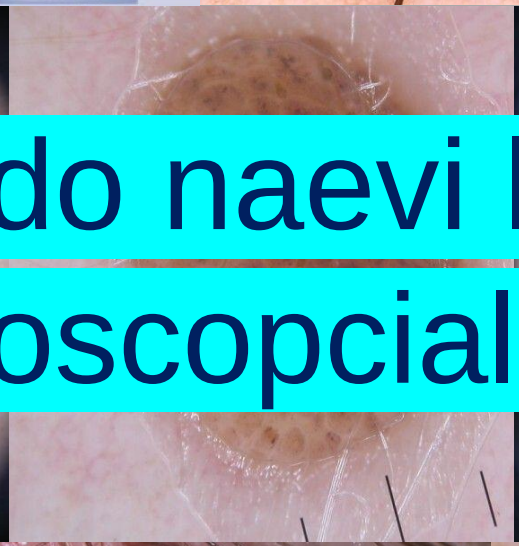


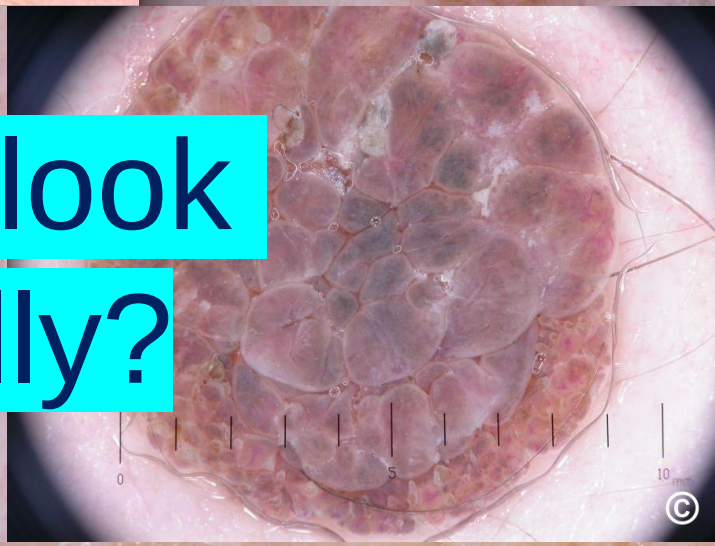




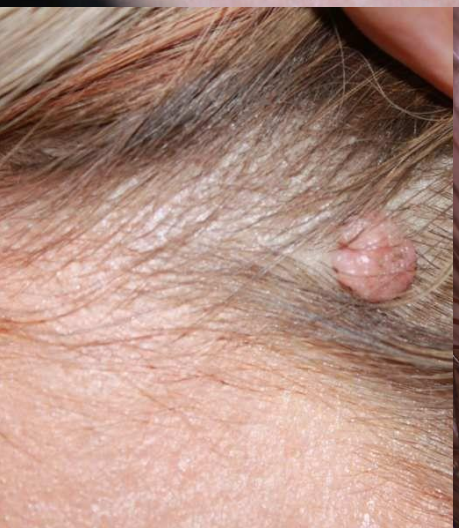


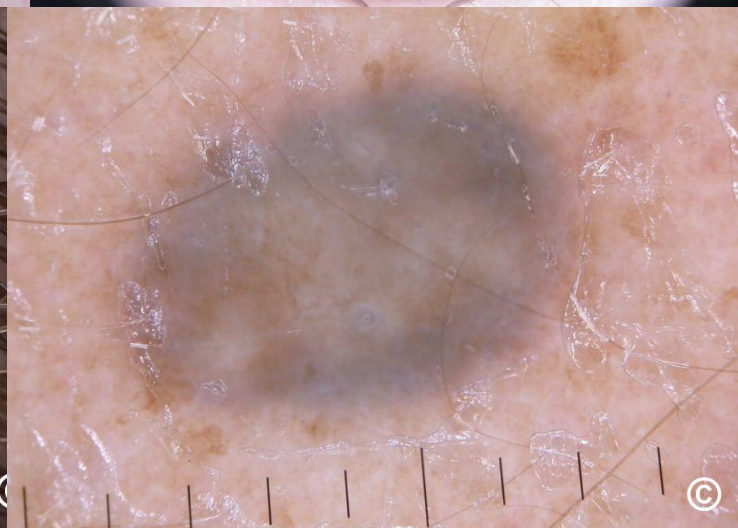






How do naevi look dermoscopcially?





The ABC rule - Superficial spreading melanoma and melanoma in situ (including lentigo maligna)

A	B	C
Asymmetry	Border irregular	Colour differs compared to other moles C also stands for comparison i.e the ugly-duckling that looks different to the patient's other lesions

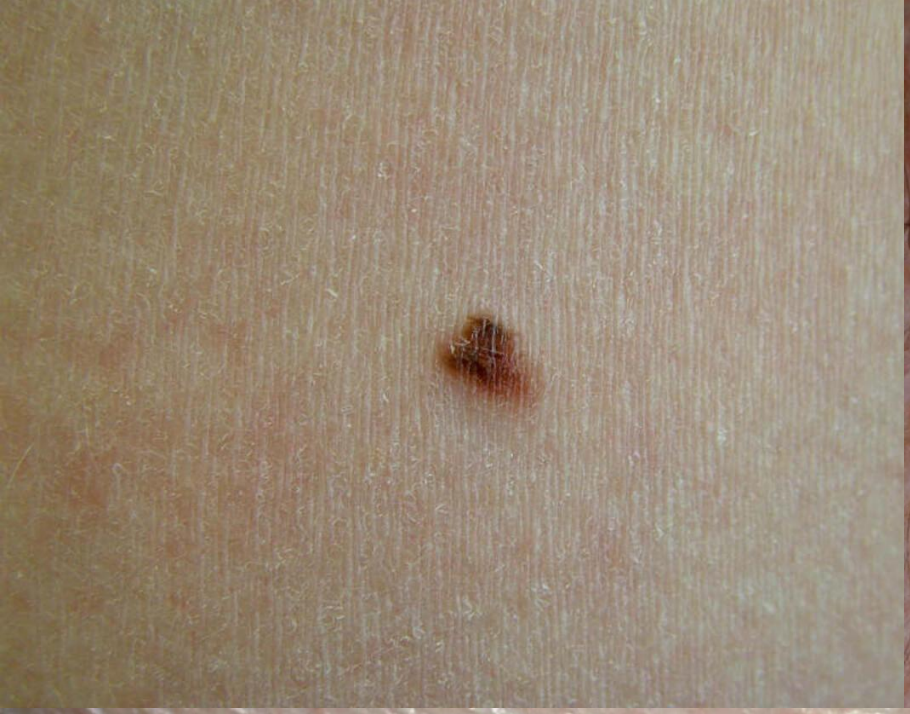
D

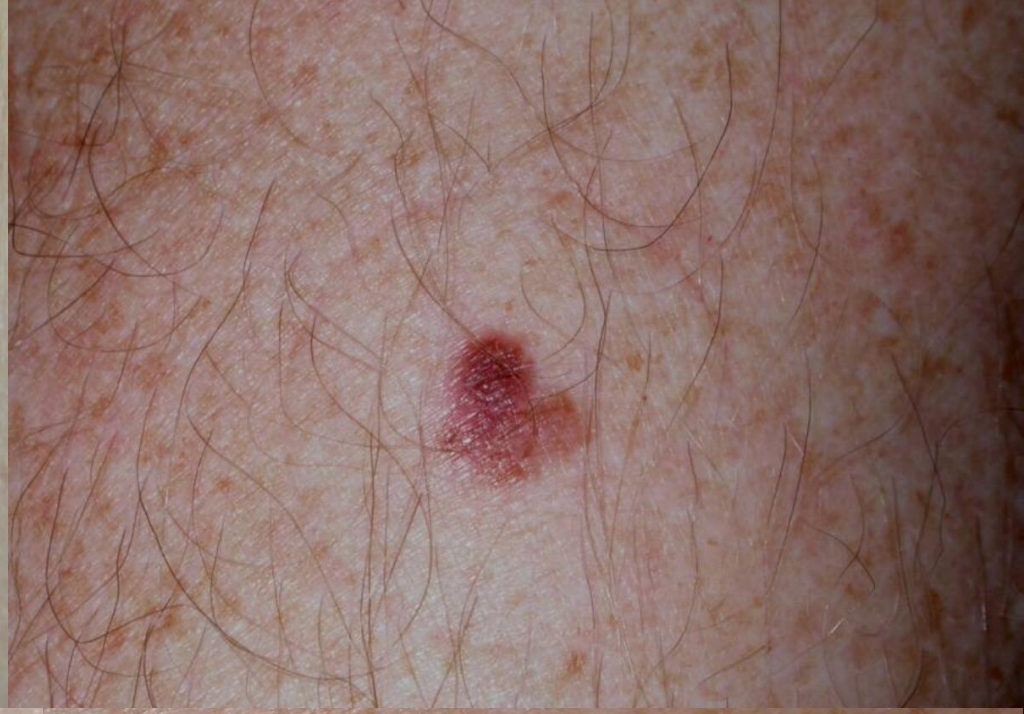
Changing Dimensions and/or Diameter > 6mm when first noticed

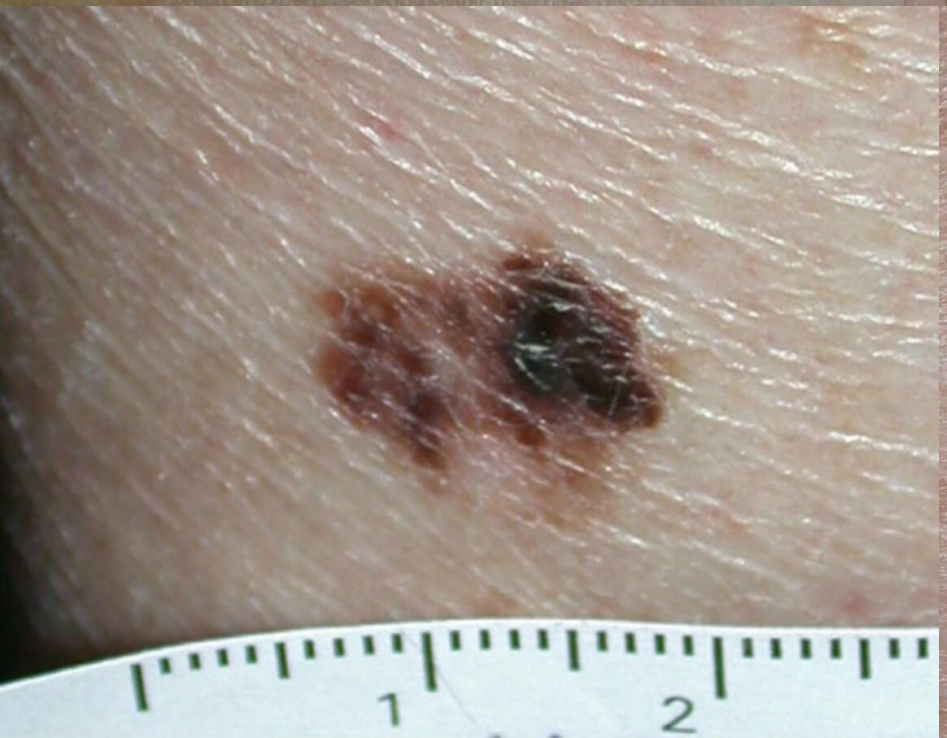
Superficial (and in situ) melanoma grow at different rates.

Even if the patient states that the lesion is not changing, if it looks suspicious still refer.

Melanoma usually has an irregular appearance, however, if a symmetrical lesions continues to grow out of proportion to the patient's other moles, especially if aged over 45, then melanoma must be considered.



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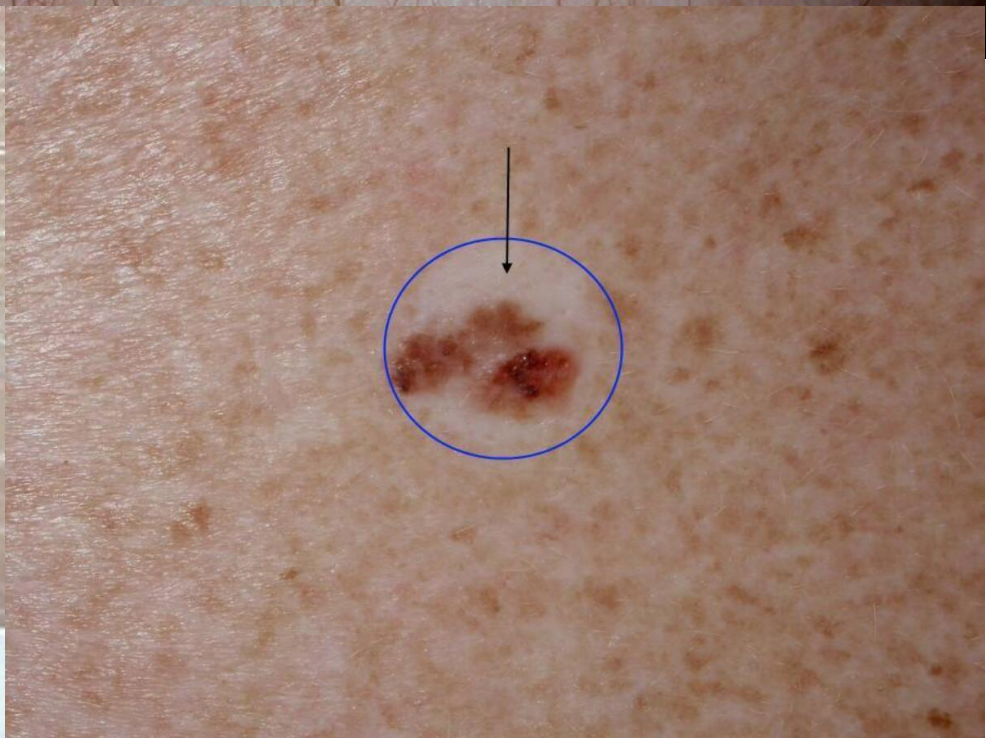

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- Many benign lesions < 5 mm diameter – Skin Lesion Diagnostic Tool
- Dermatofibroma …
- Keloid scars, cysts, and giant comedones ….
- Benign, traumatised lesions – review in 2-3/52

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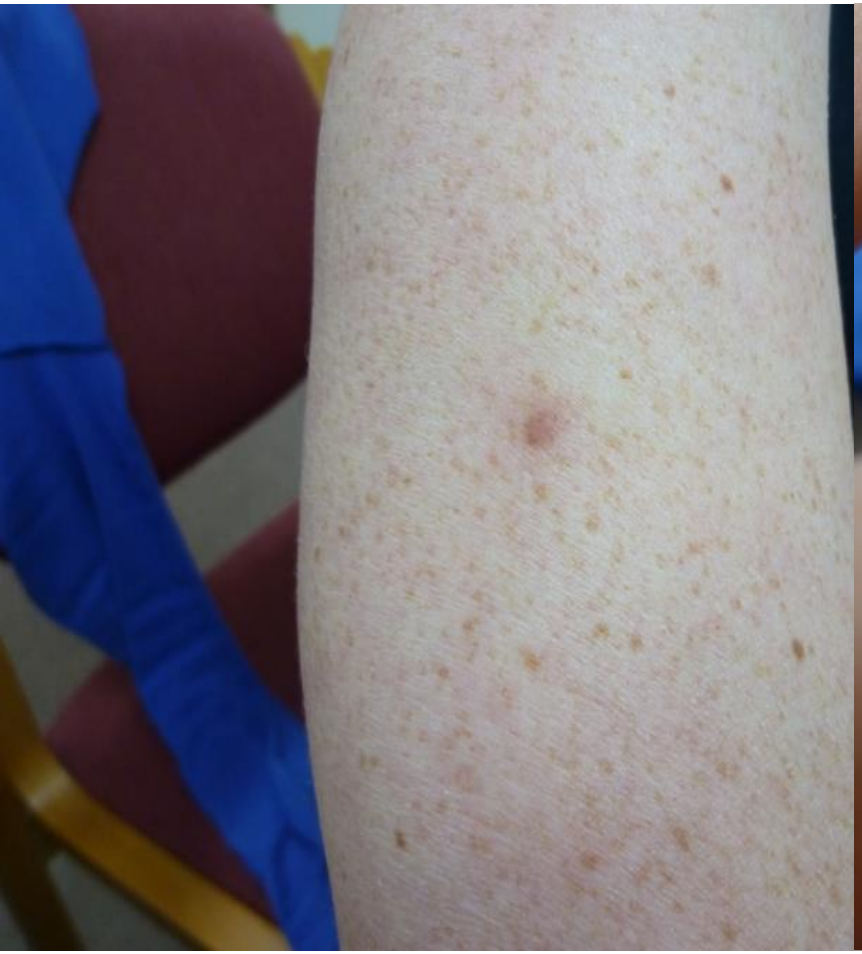
Dermatofibromas

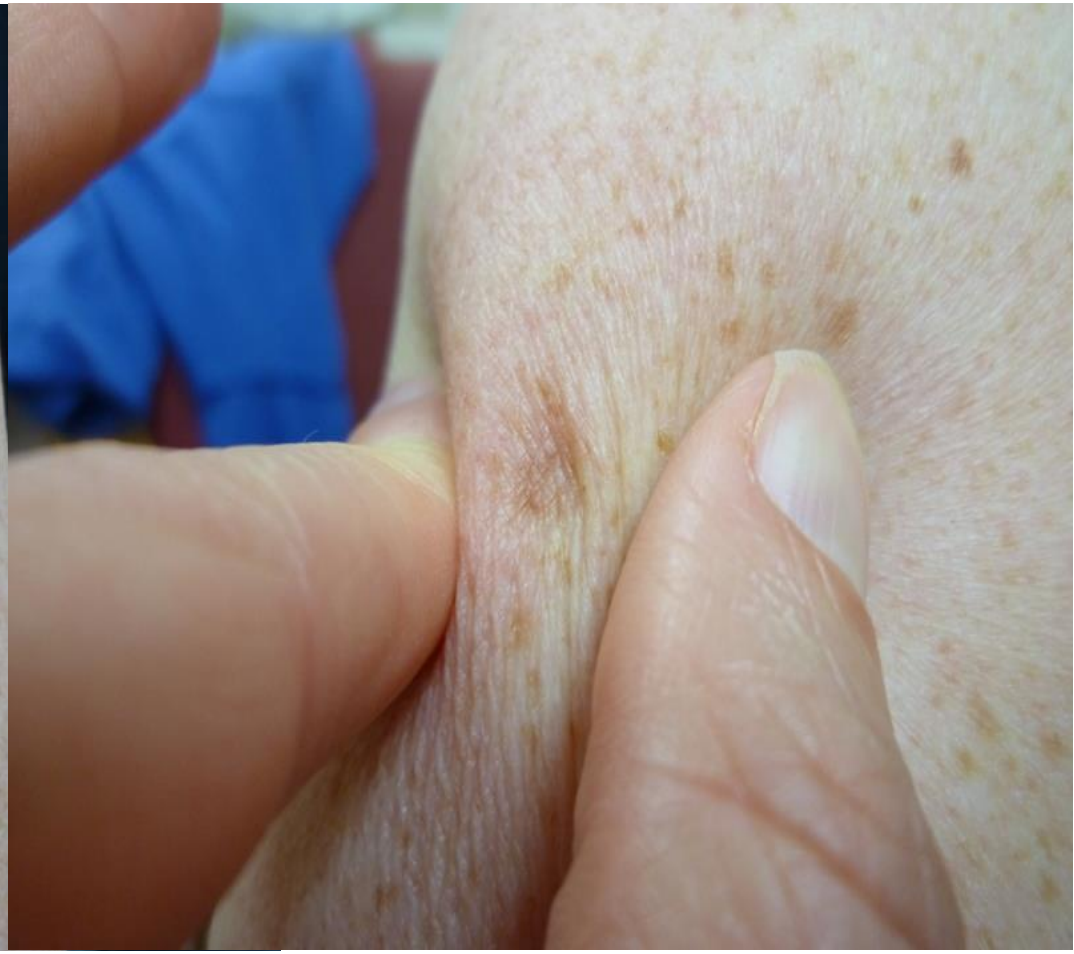
CLINICAL

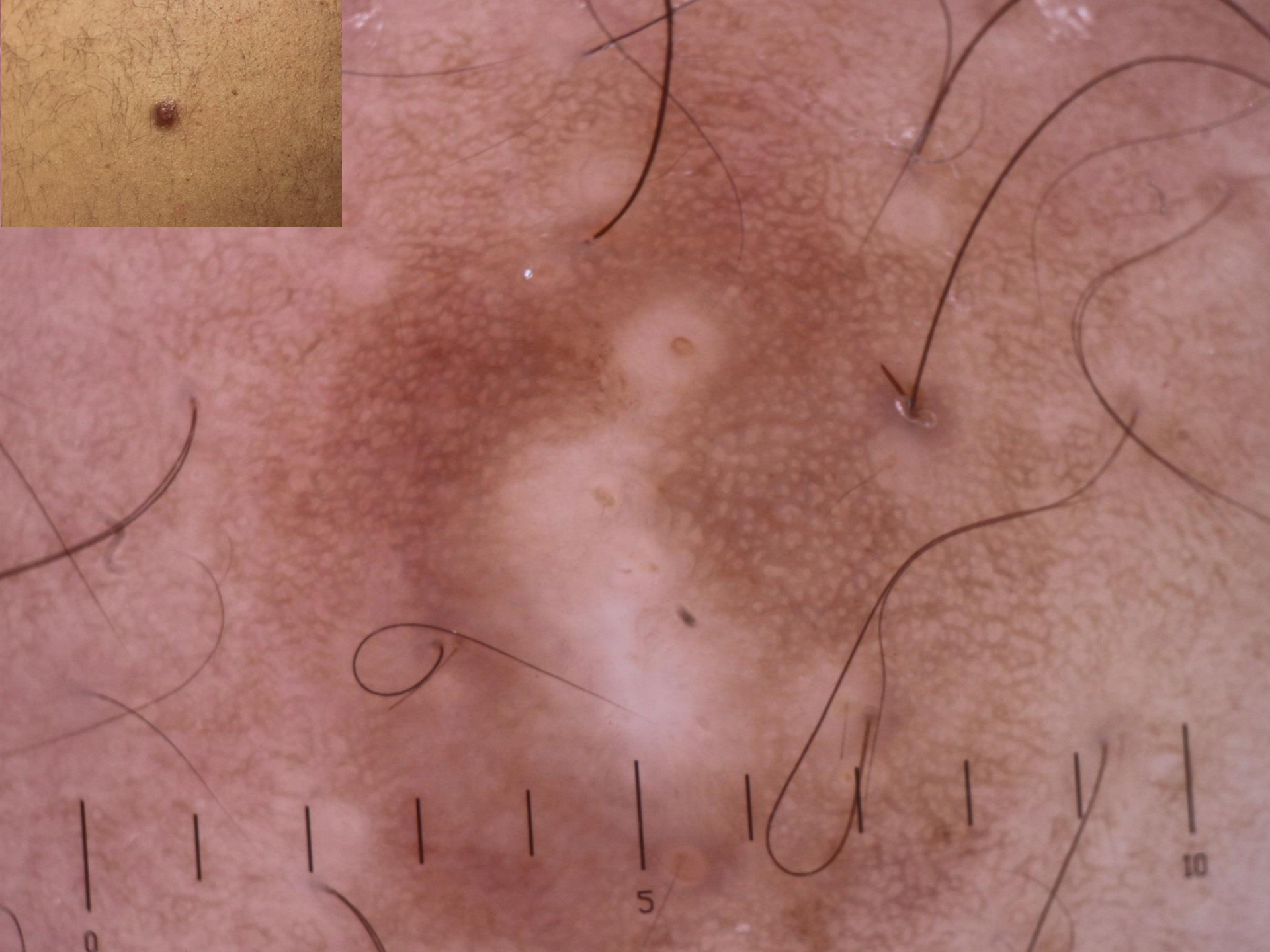
- One-several
- Commonly the limbs
- Pinkinsh with a subtle brown periphery
- Pinch (dimple) positive

DERMOSCOPY

- **Centre** – white scar-like, network, lines (not in flat lesions)
- **Periphery** – areas of subtle brown rounded network



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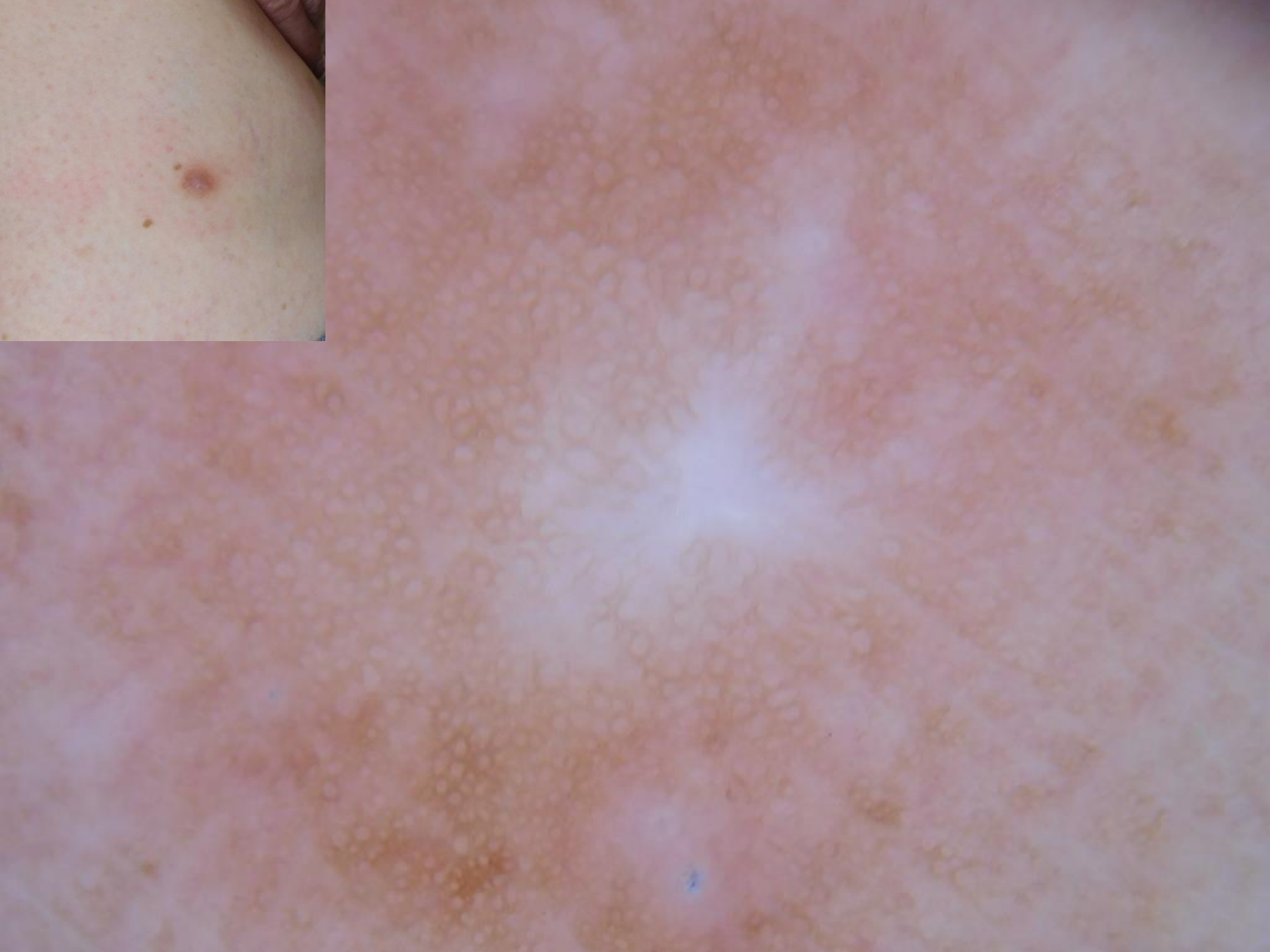

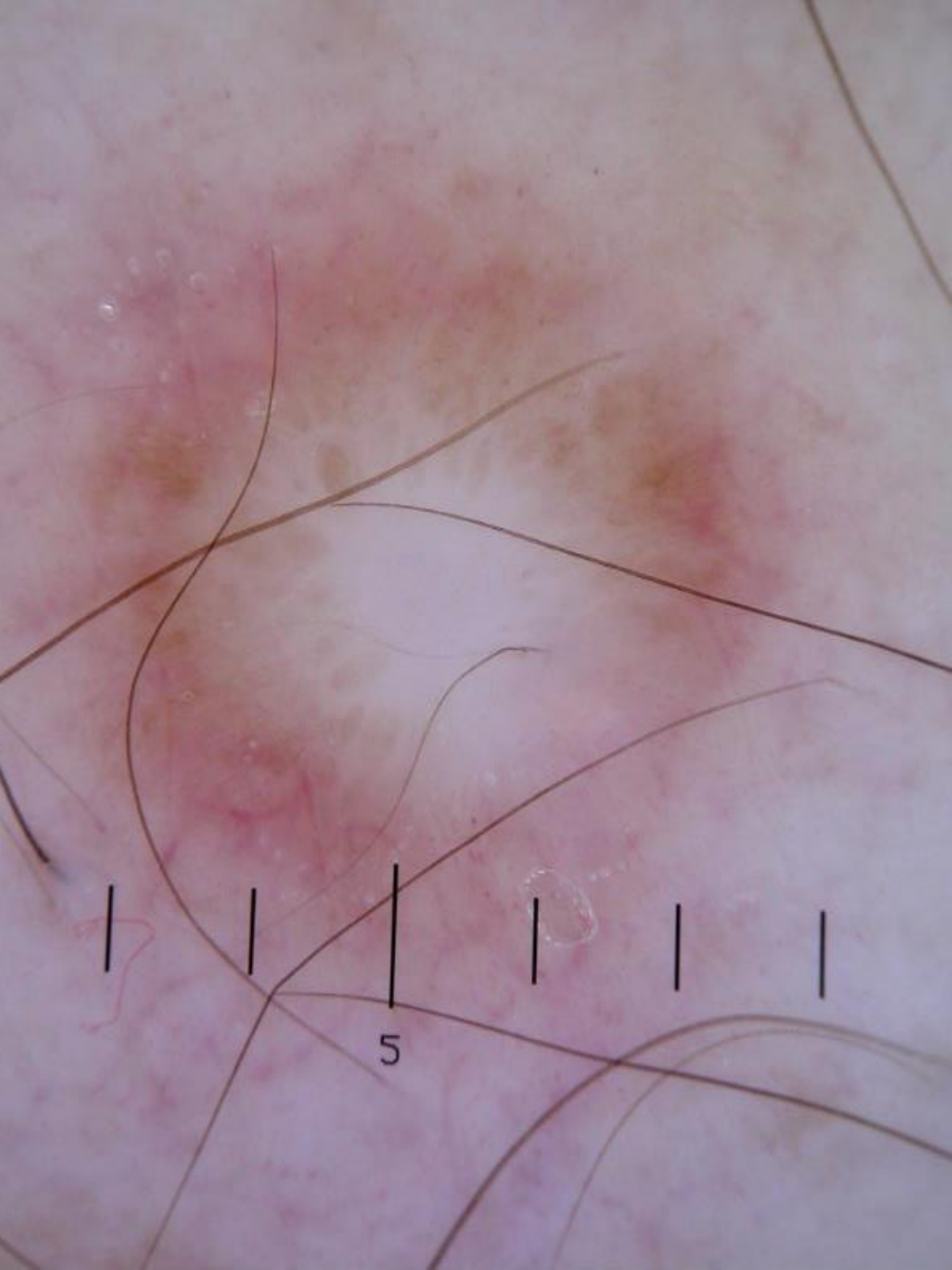
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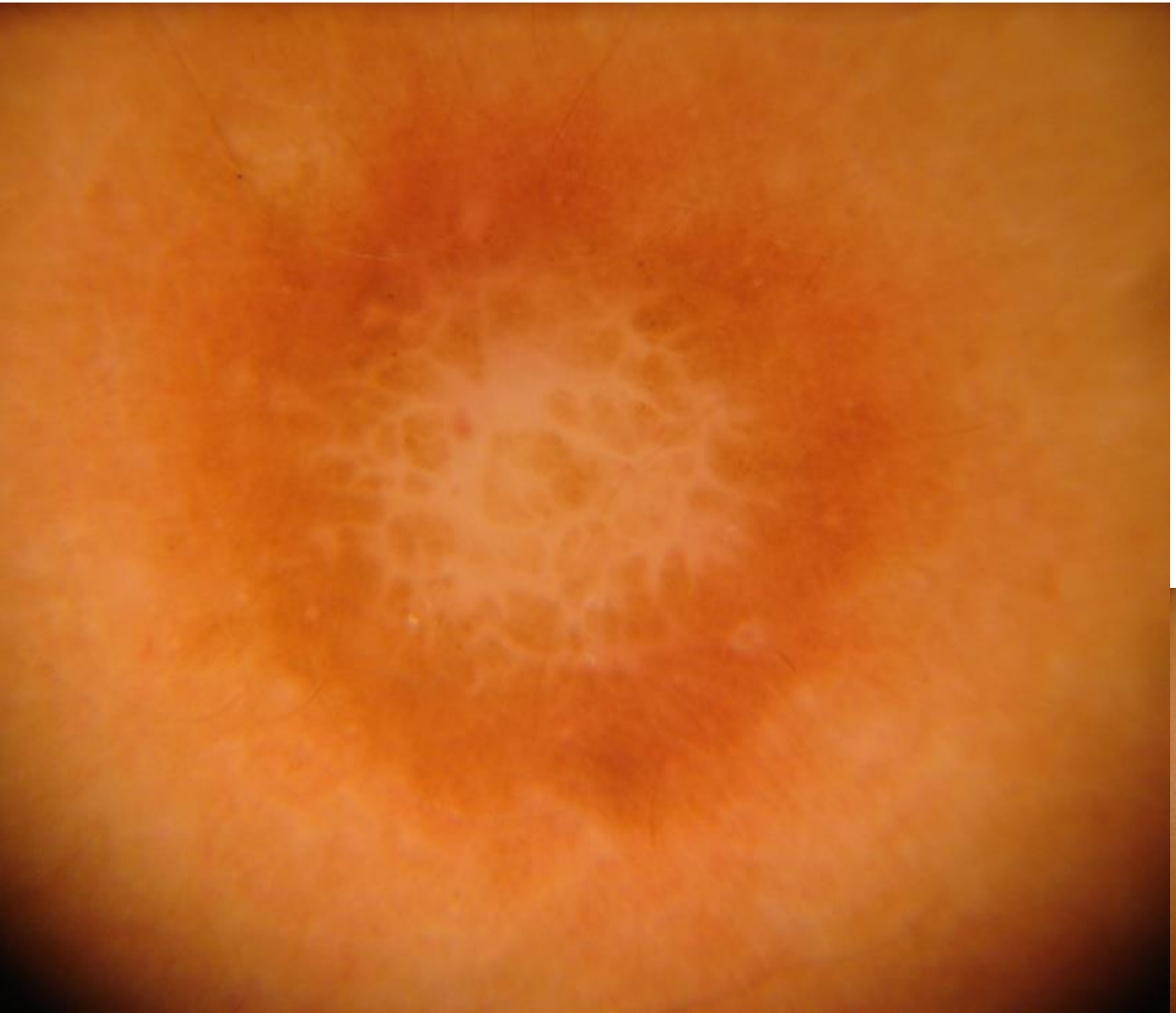
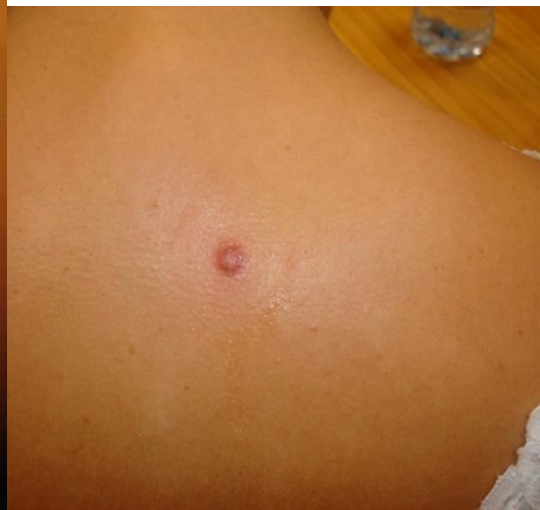
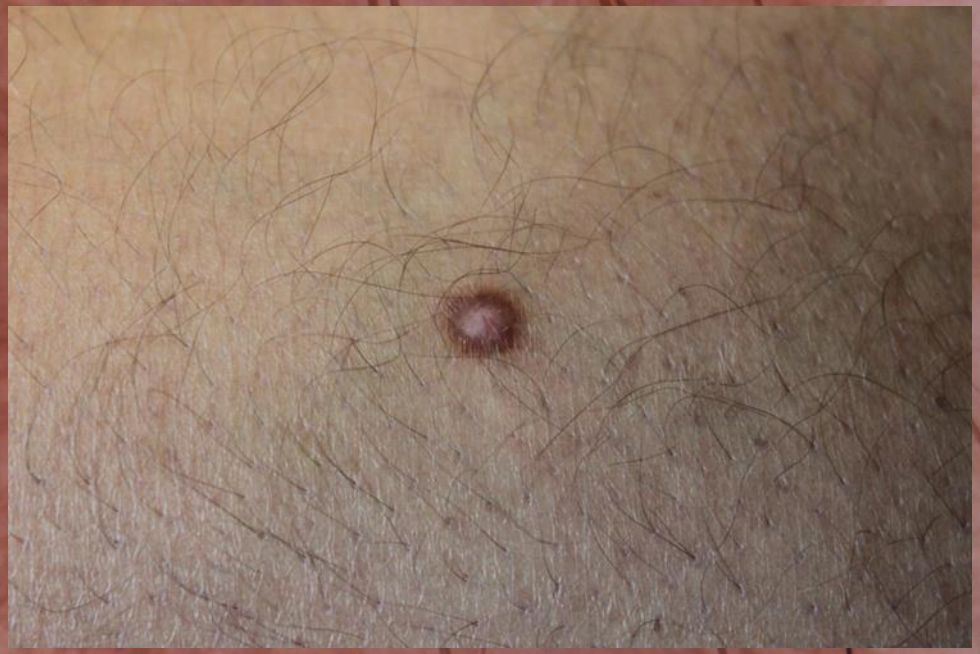
Central white network + peripheral rounded network



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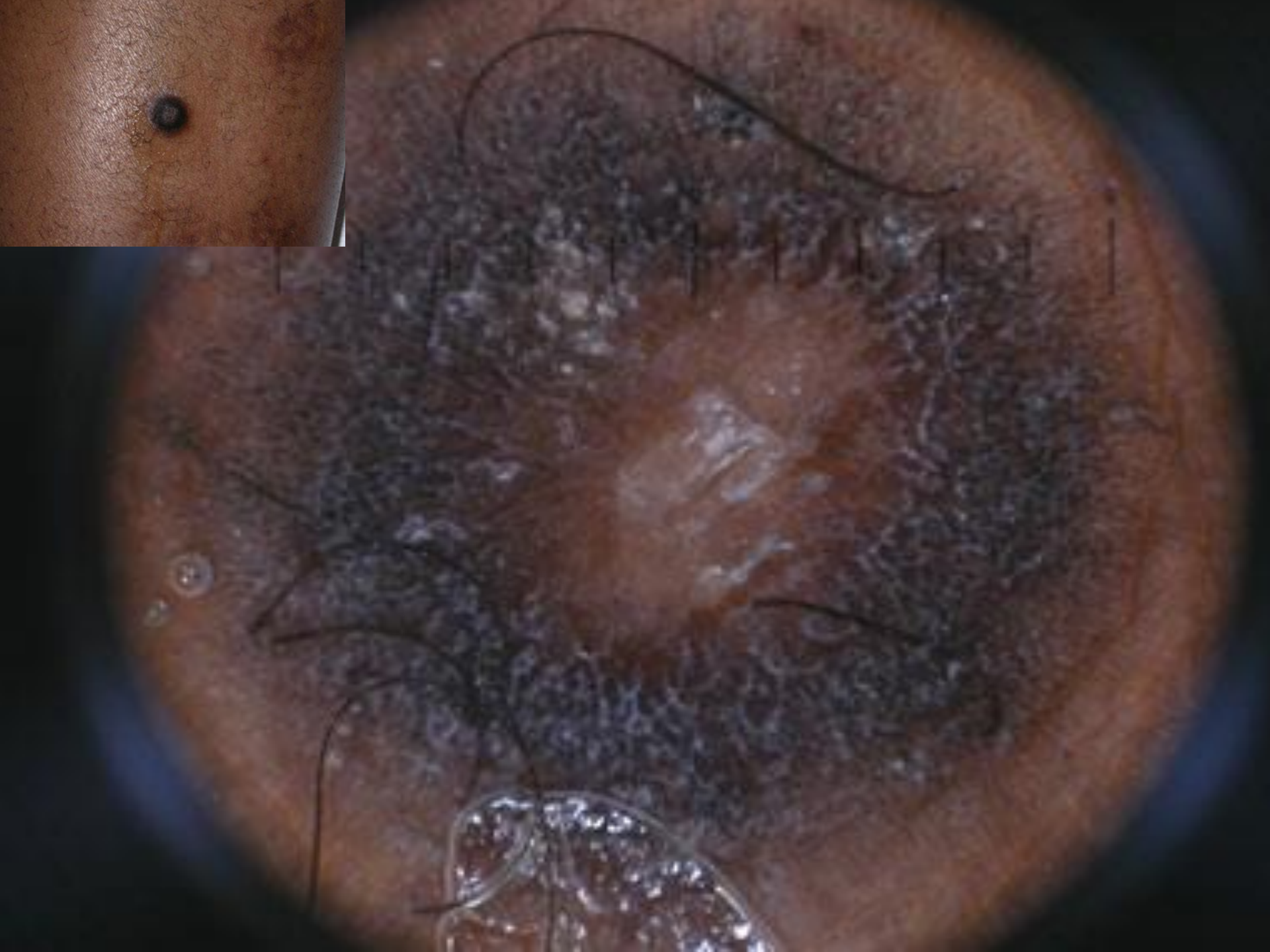
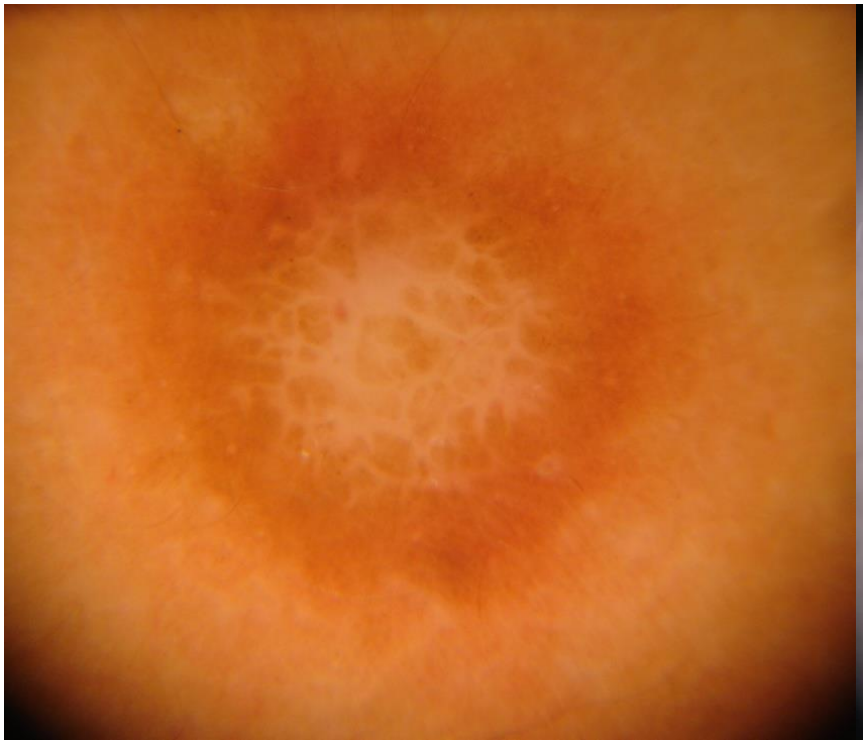
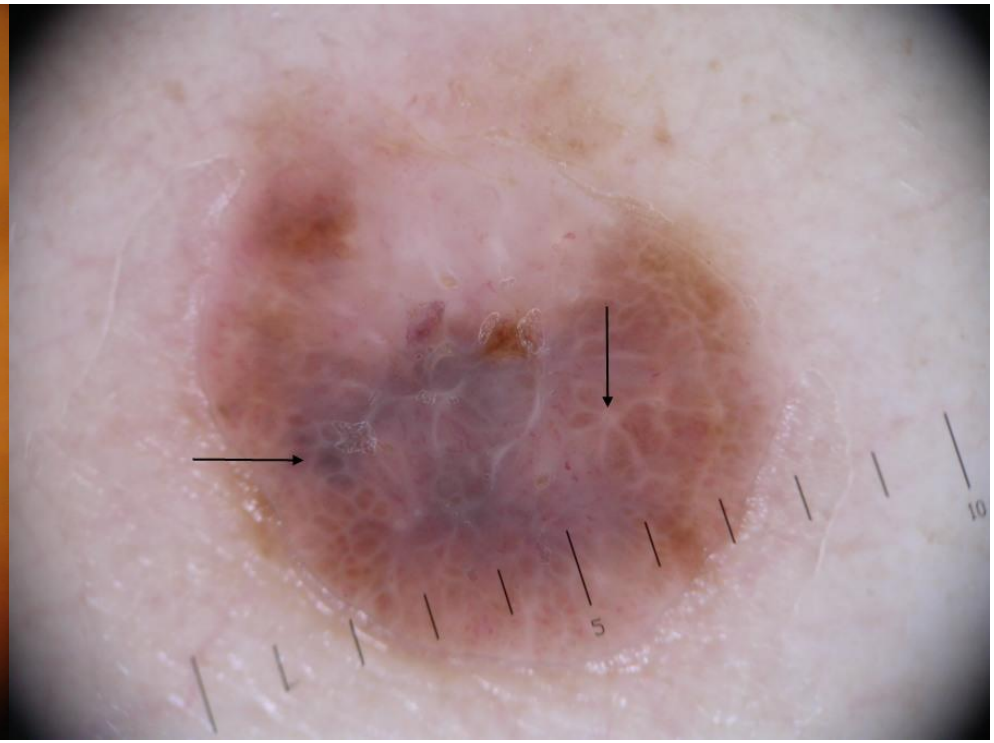


Symmetrical and feels like a DF



Asymmetrical and pinch/dimple negative



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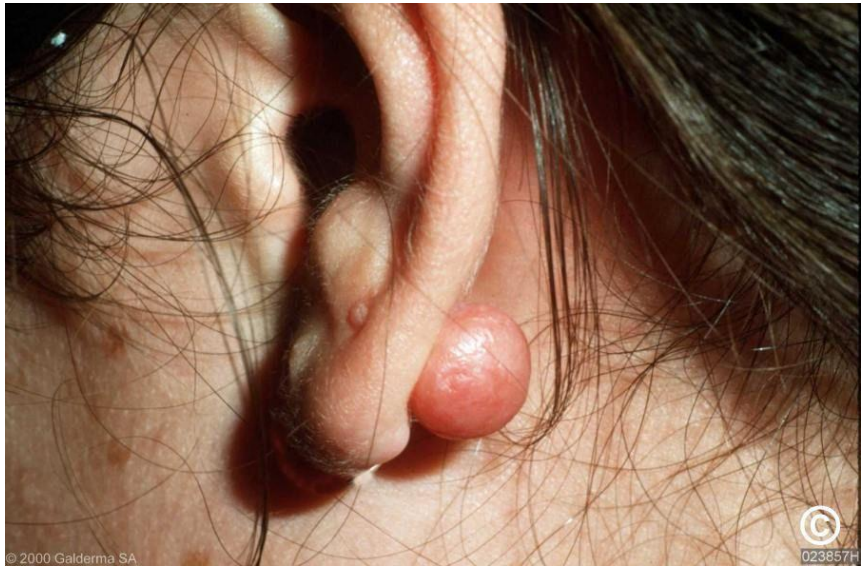
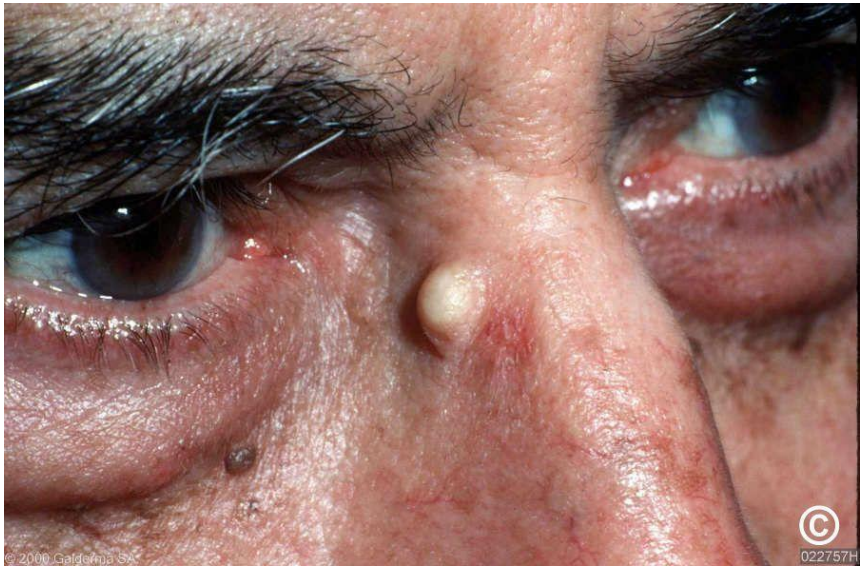
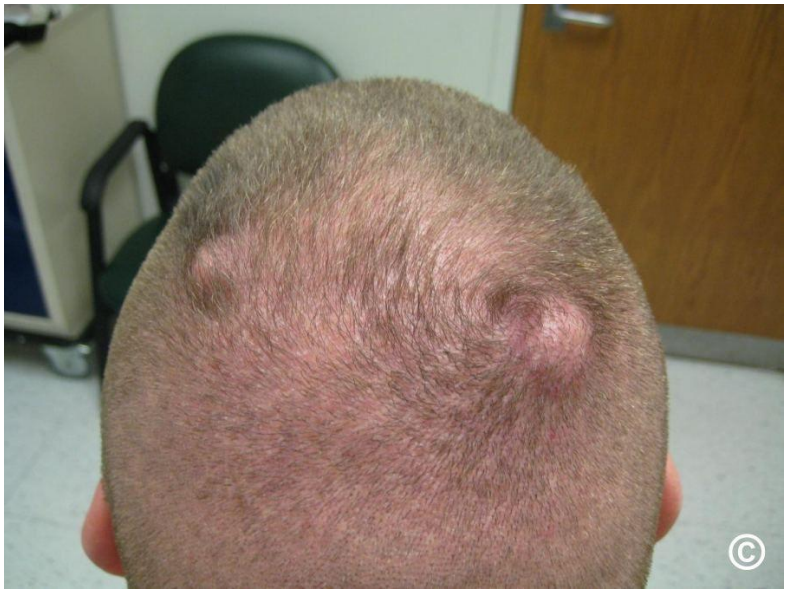
Keloid scars and cysts







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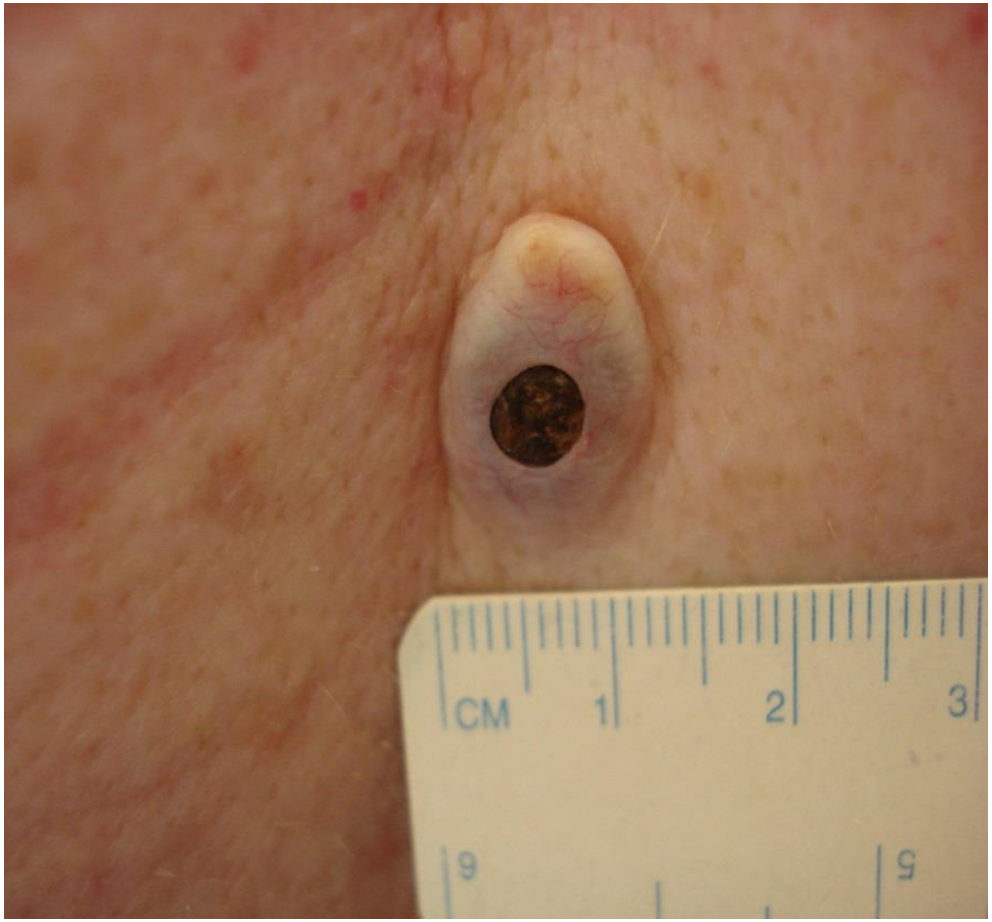
What is this?



A GIANT comedone

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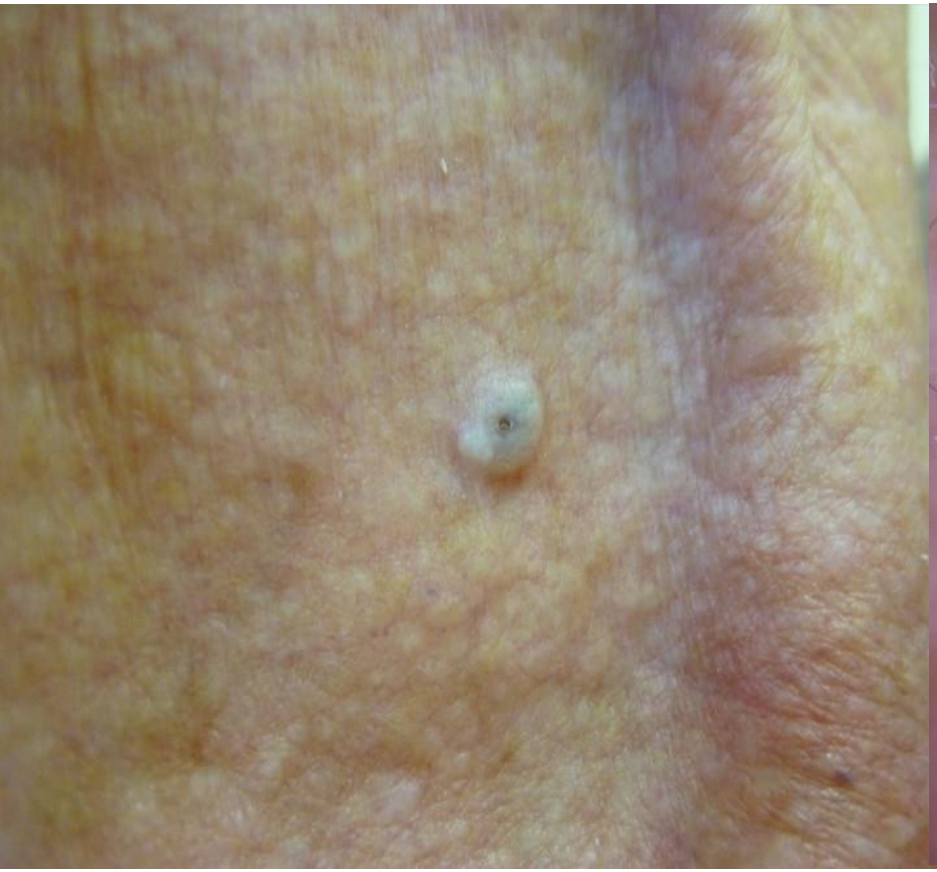
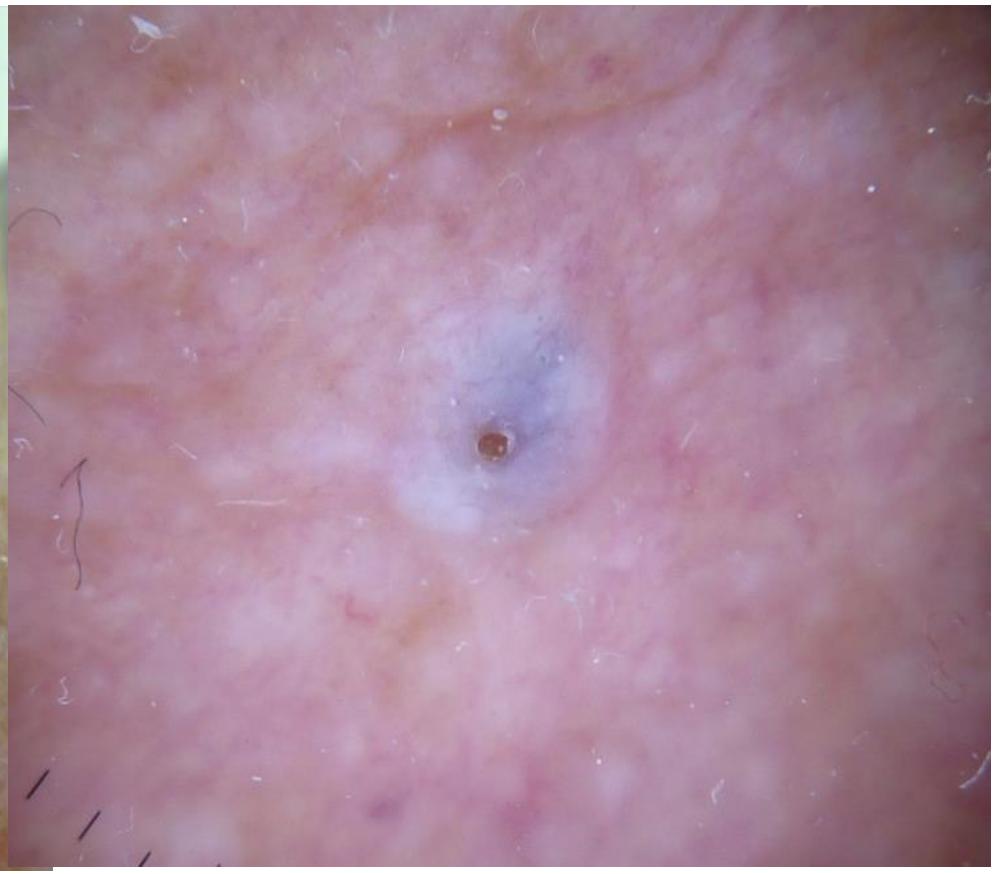
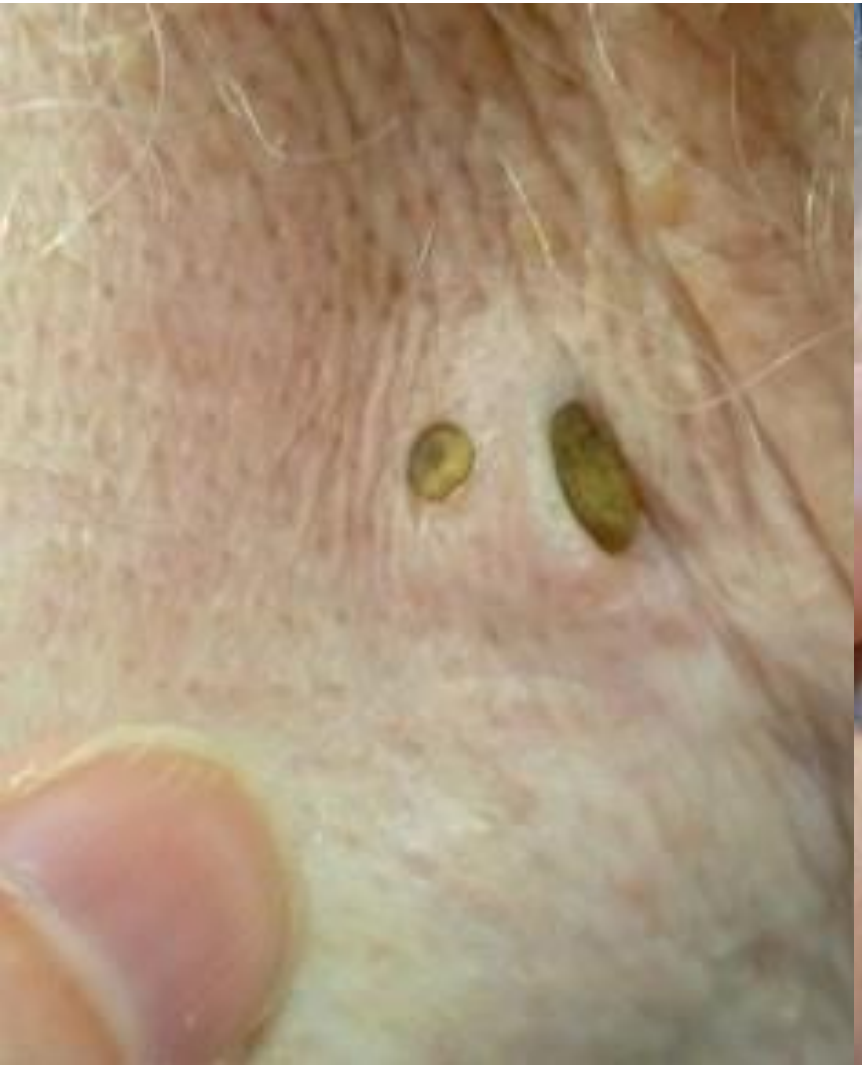
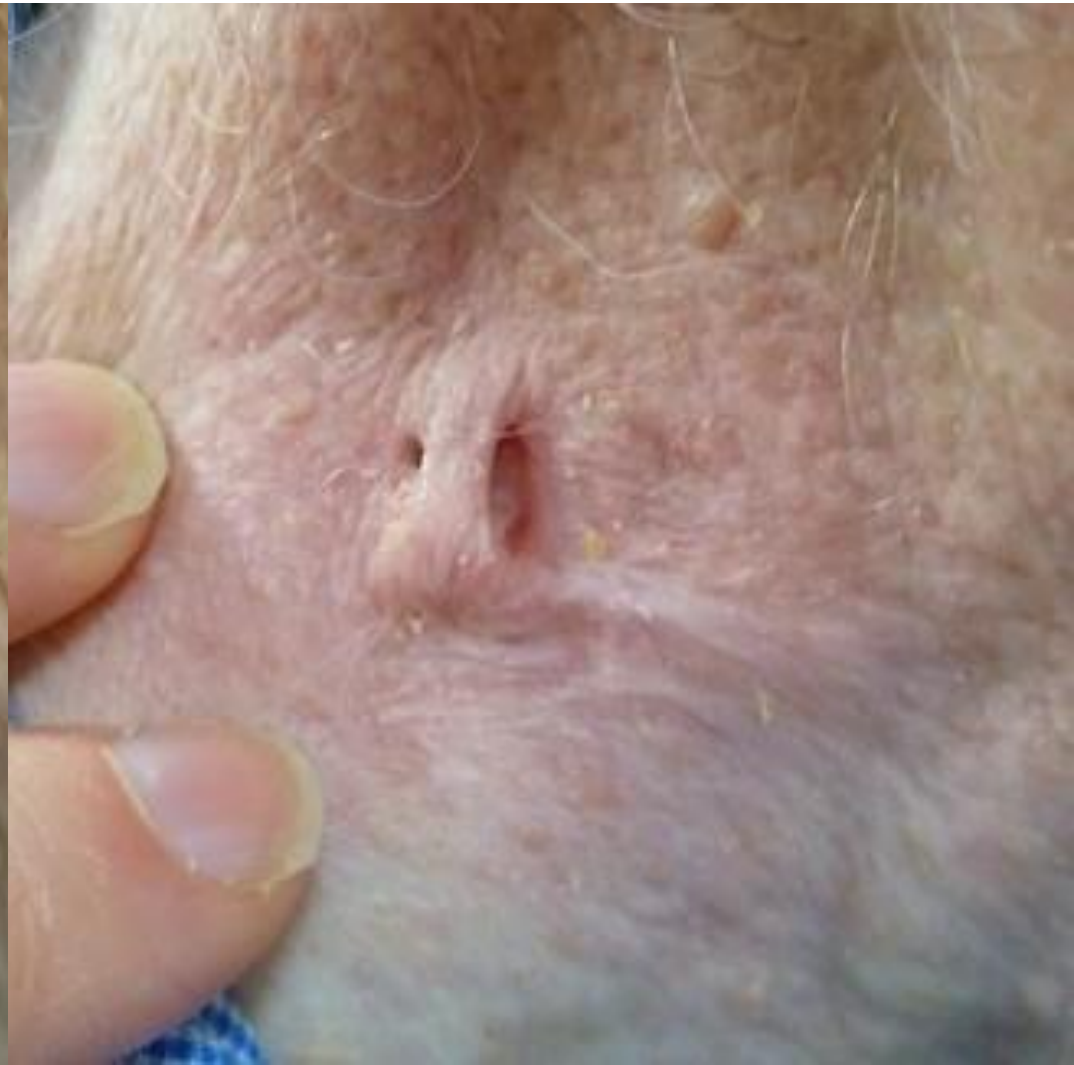




A giant comedone before…



and after, squeezing its contents out



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ALL OF E+F+G

E	F	G
Elevated (papule or nodule)	FIRM	Growth, persistent

A solid (nodular) BCC (basal cell carcinoma) is an EFG

If an EFG is not a BCC then refer urgently (2 week-wait) - nodular melanomas / SCC (squamous cell carcinoma) / other life-threatening tumours

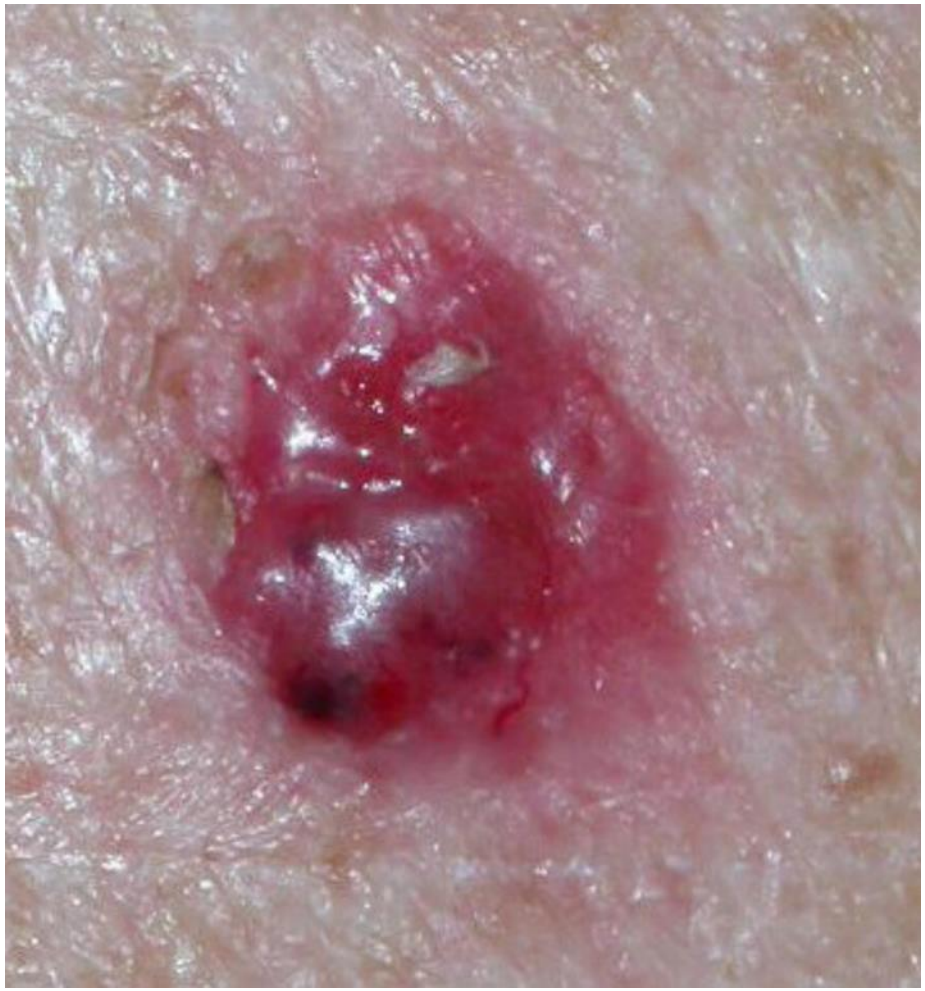
One of the exceptions - pyogenic granuloma

ALL OF E+F+G

A solid (nodular) BCC

Clinical features of solid BCC

- Grow 2-4 mm per year
- Non-tender
- Bleed/crust
- Shiny / pearly edge
- Telangiectasia
- Ulceration common



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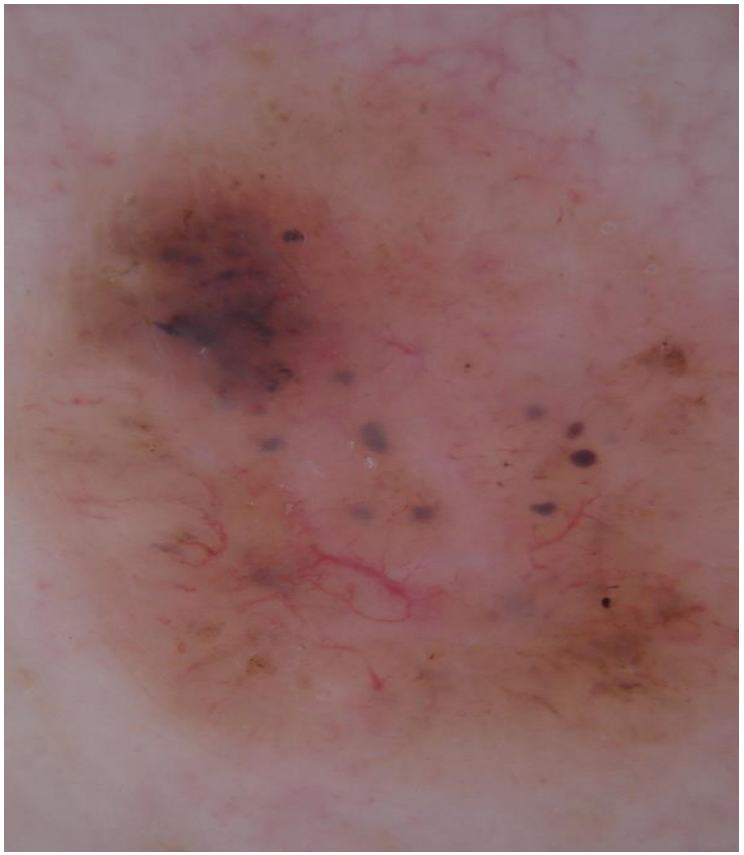
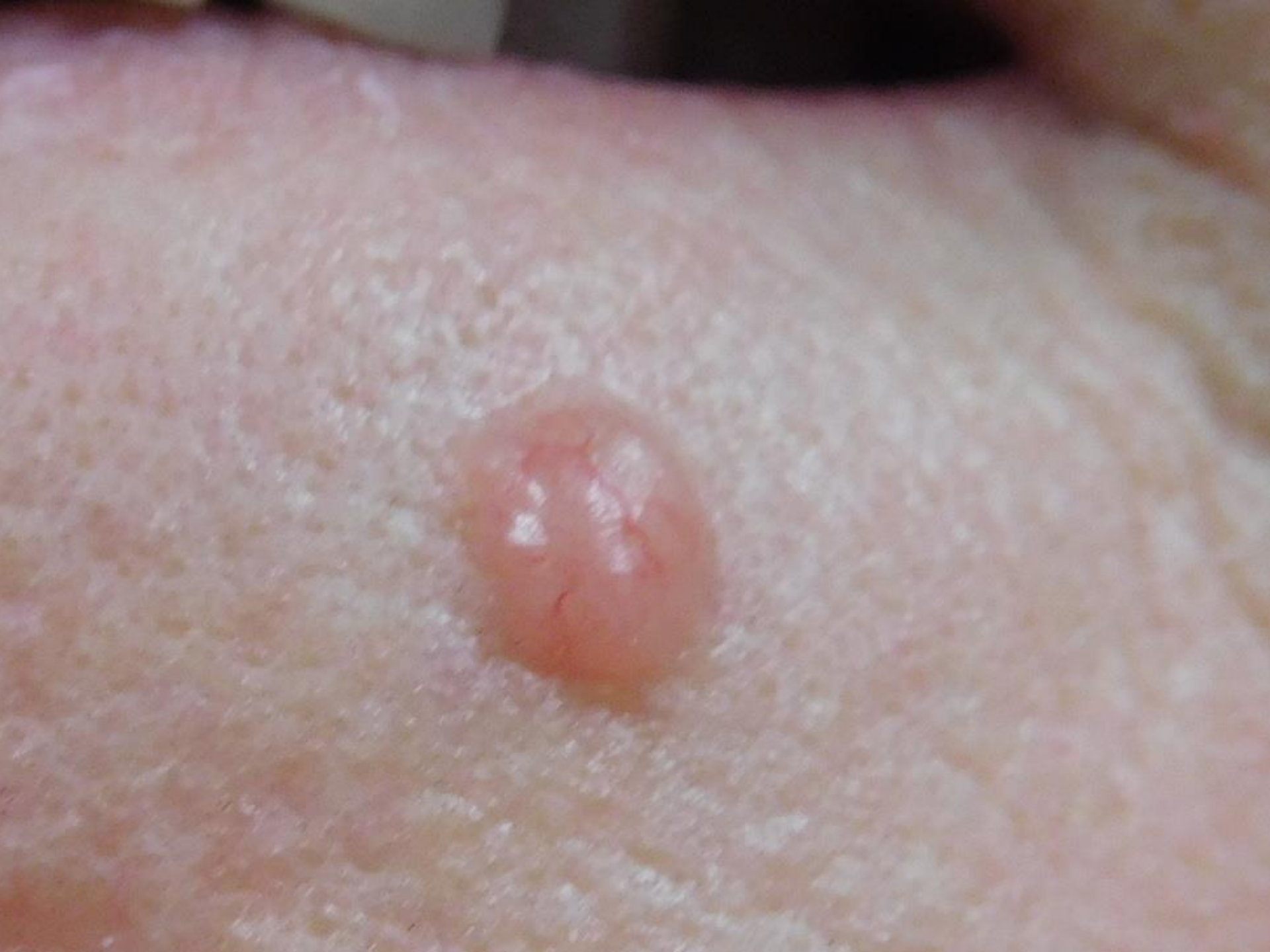
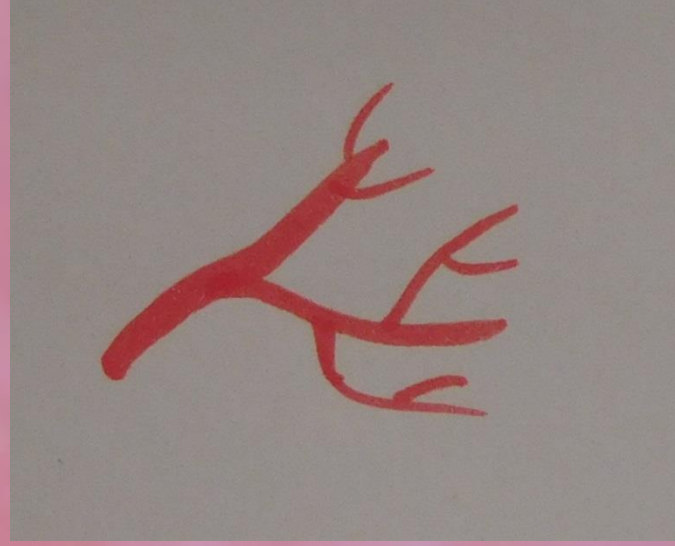
Dermoscopic features of solid BCC

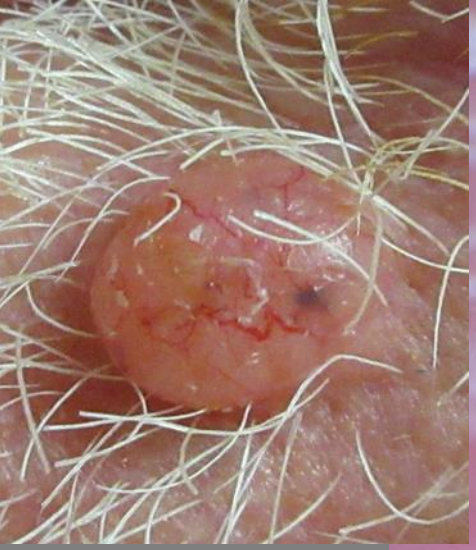
- Translucent pink background
- Sharply focussed arborising (branching) vessels
- Blue grey globules/ovoid structures (if a lot of blue structures think melanoma?)
- White structures (polarised light)
- ‘Leaf-like areas’

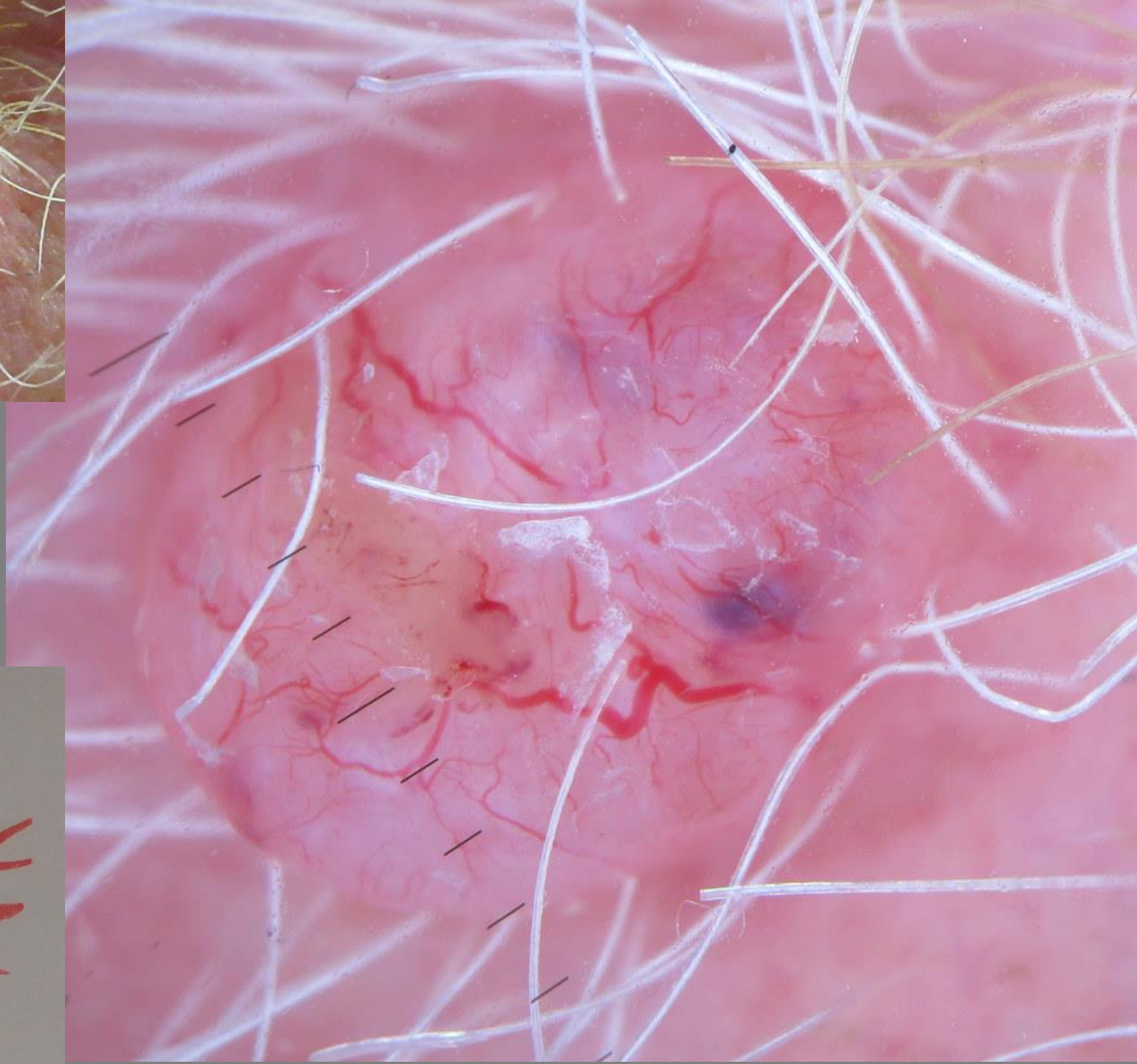


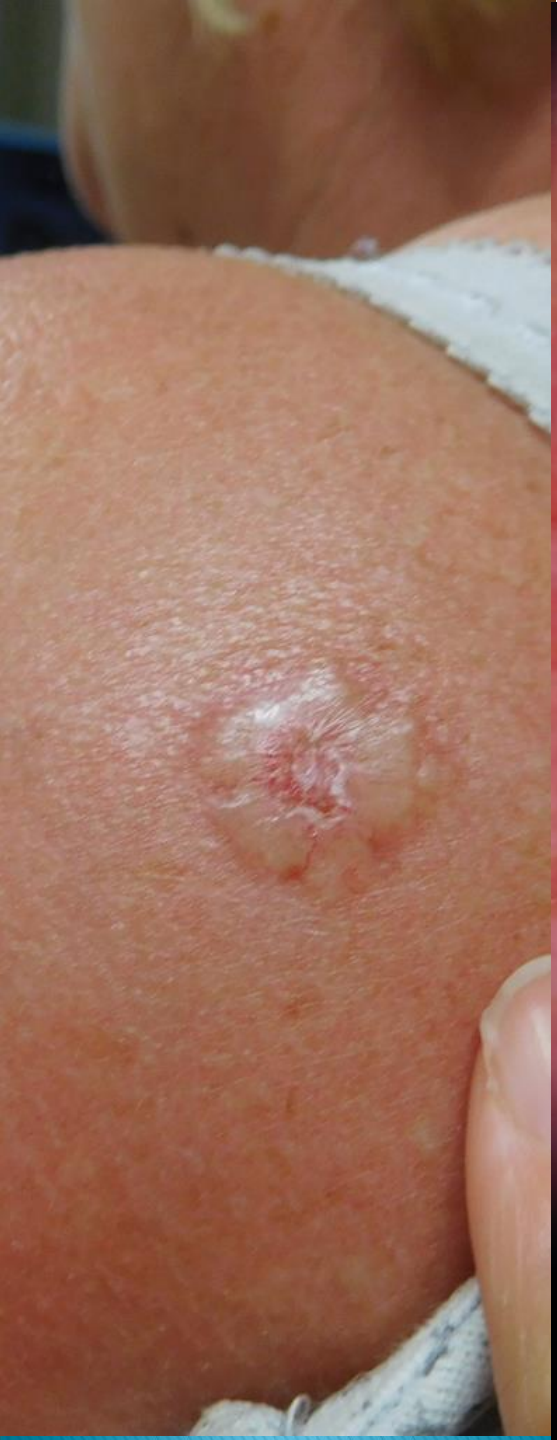
PCDS
PRIMARY CARE DERMATOLOGY SOCIETY

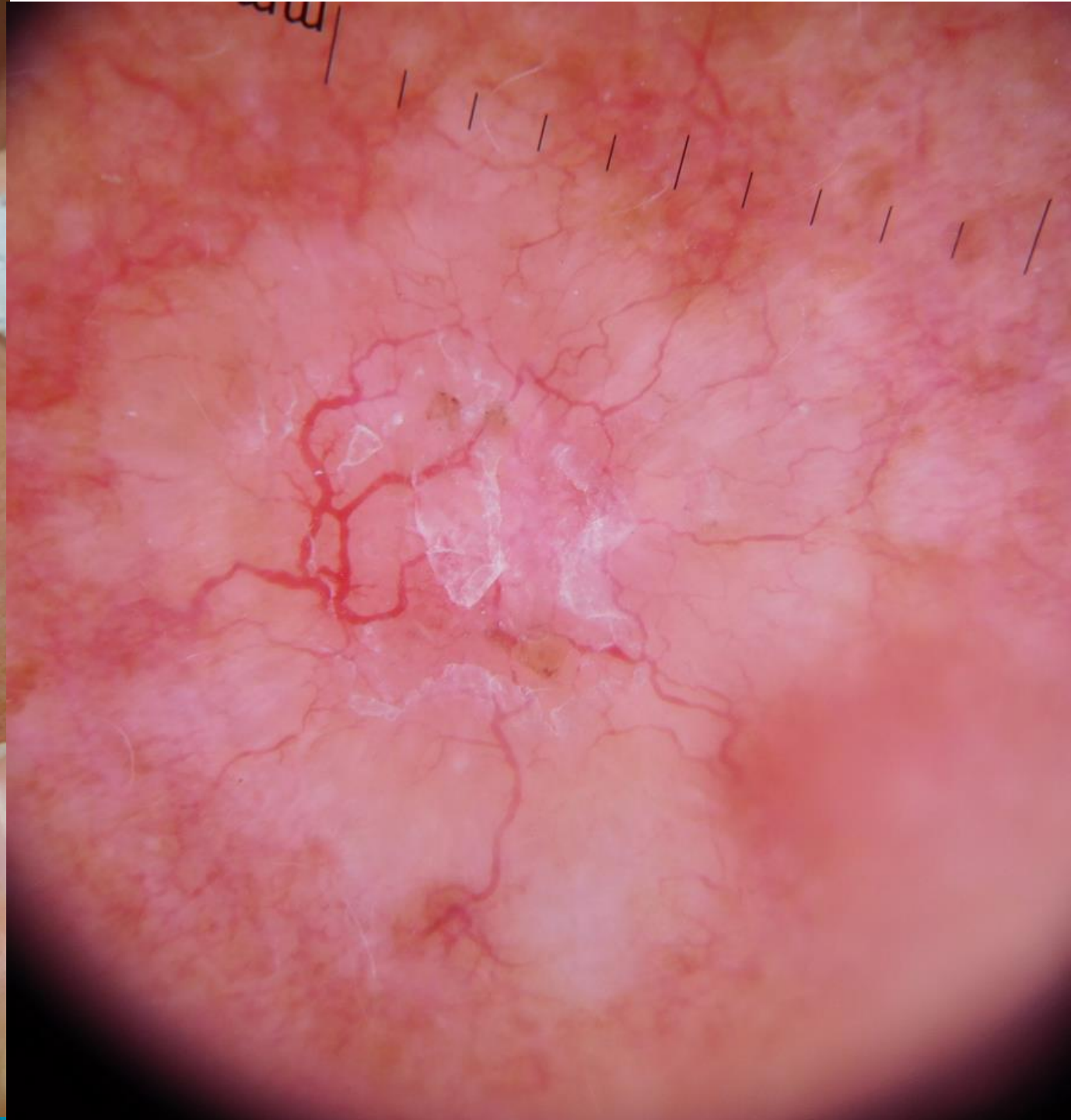


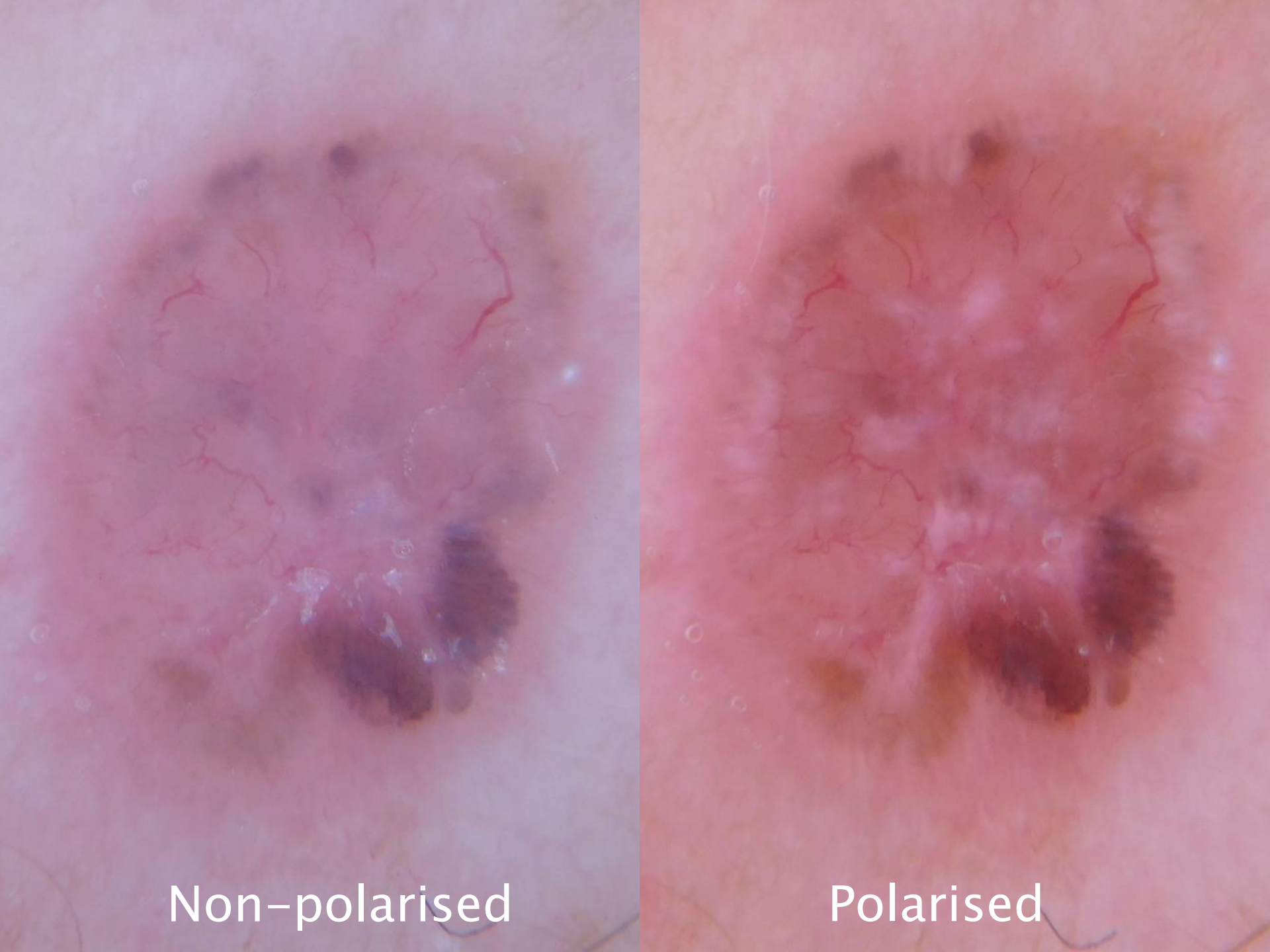




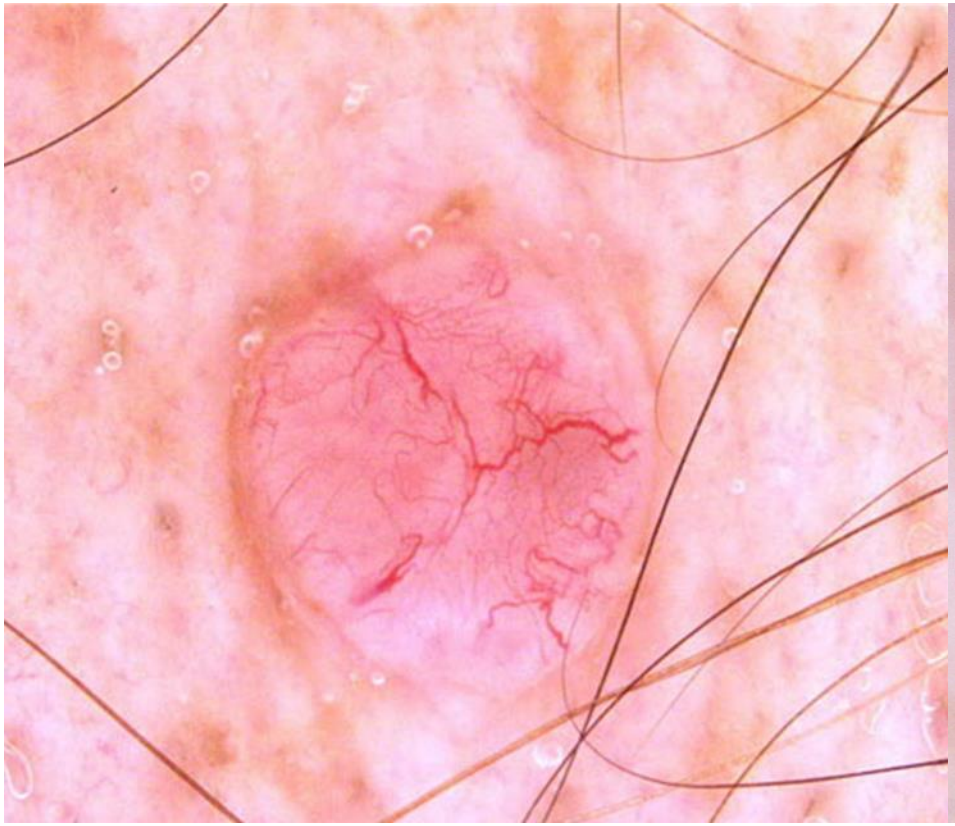


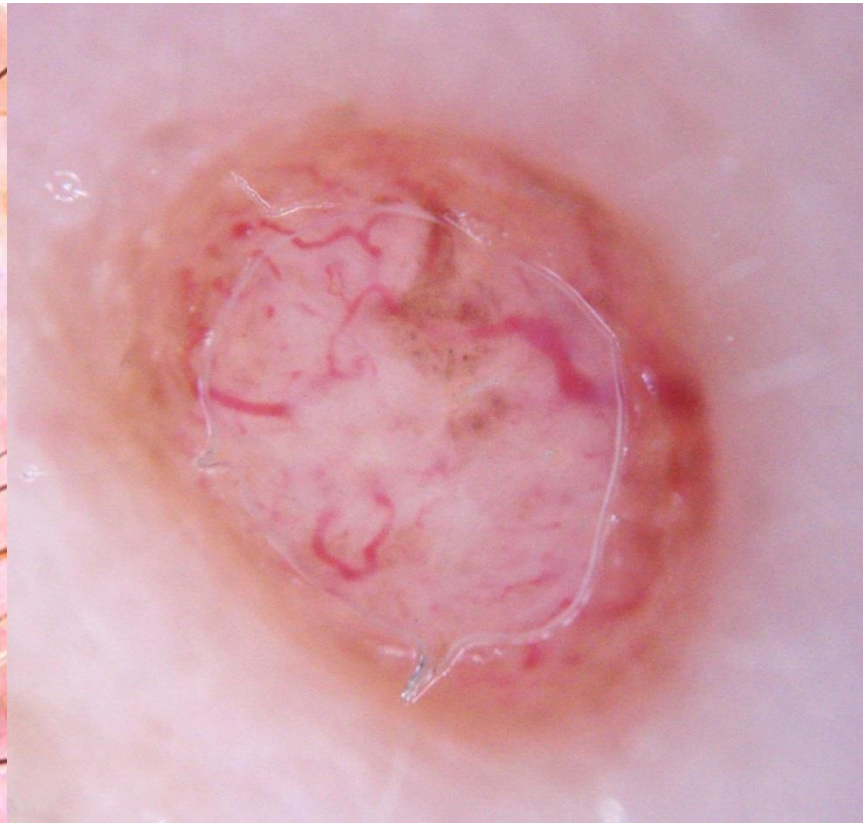





Non-polarised
Polarised

Clinical differential of BCC vs. benign intradermal naevus





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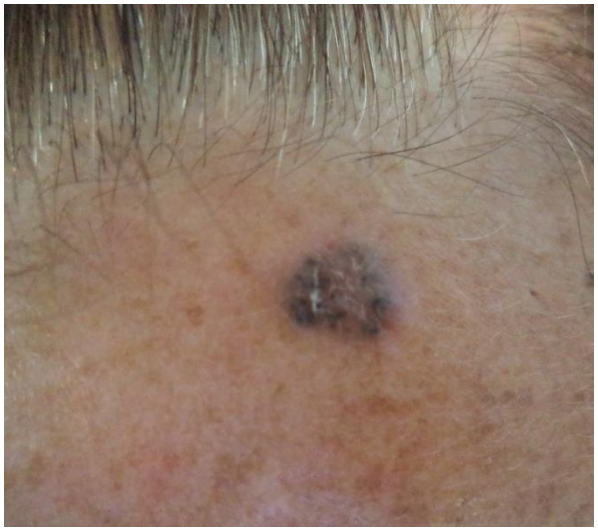
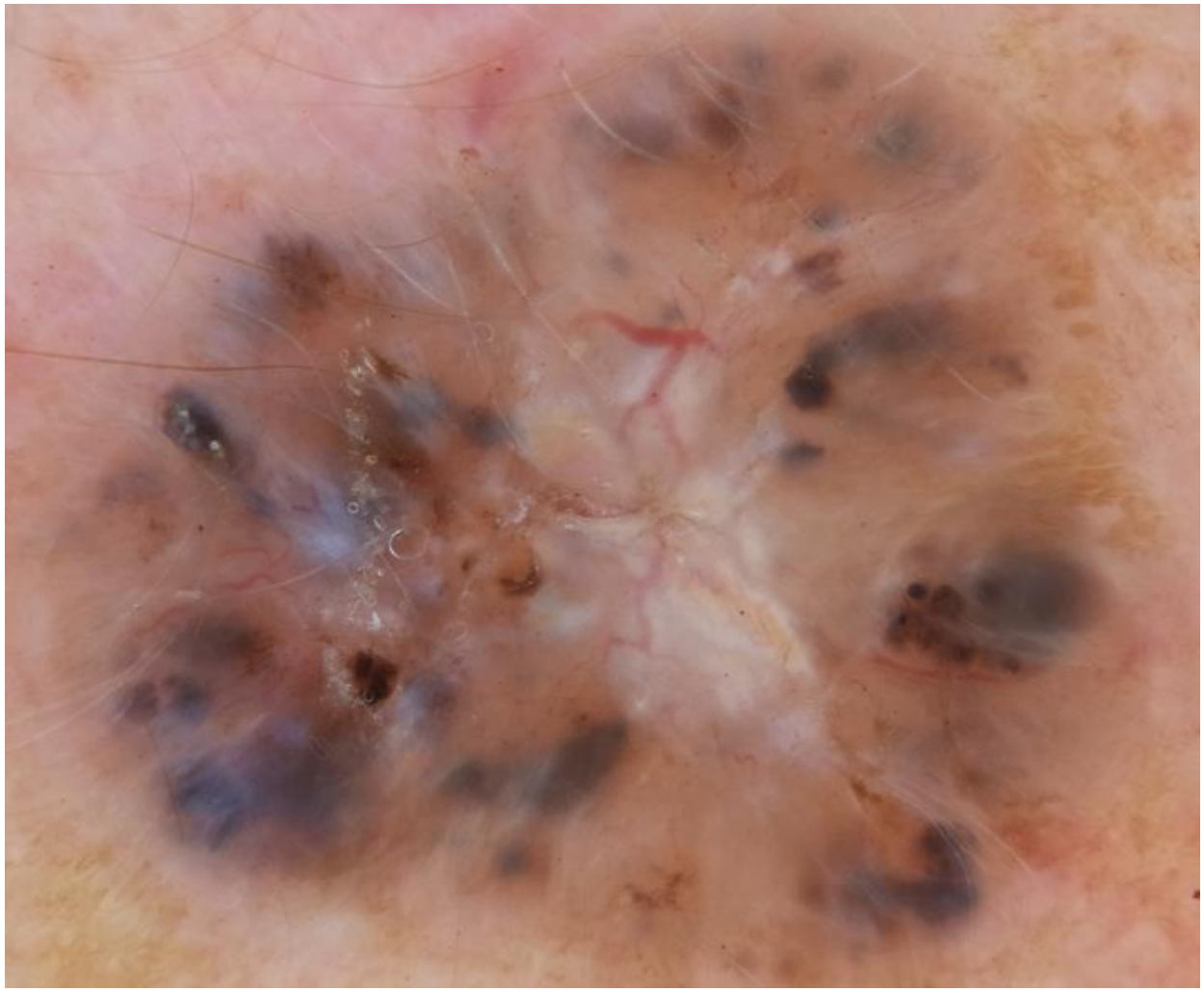
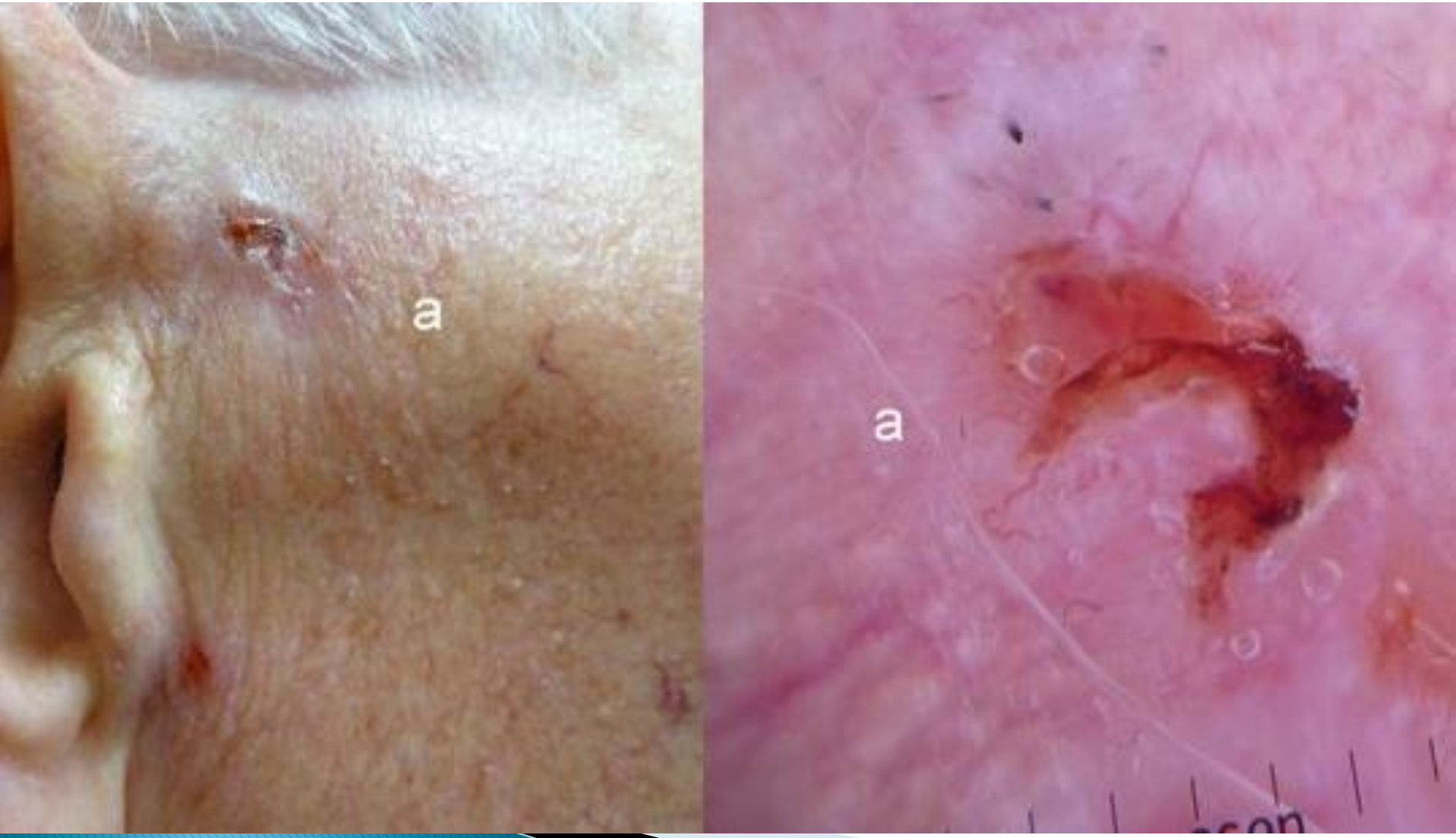
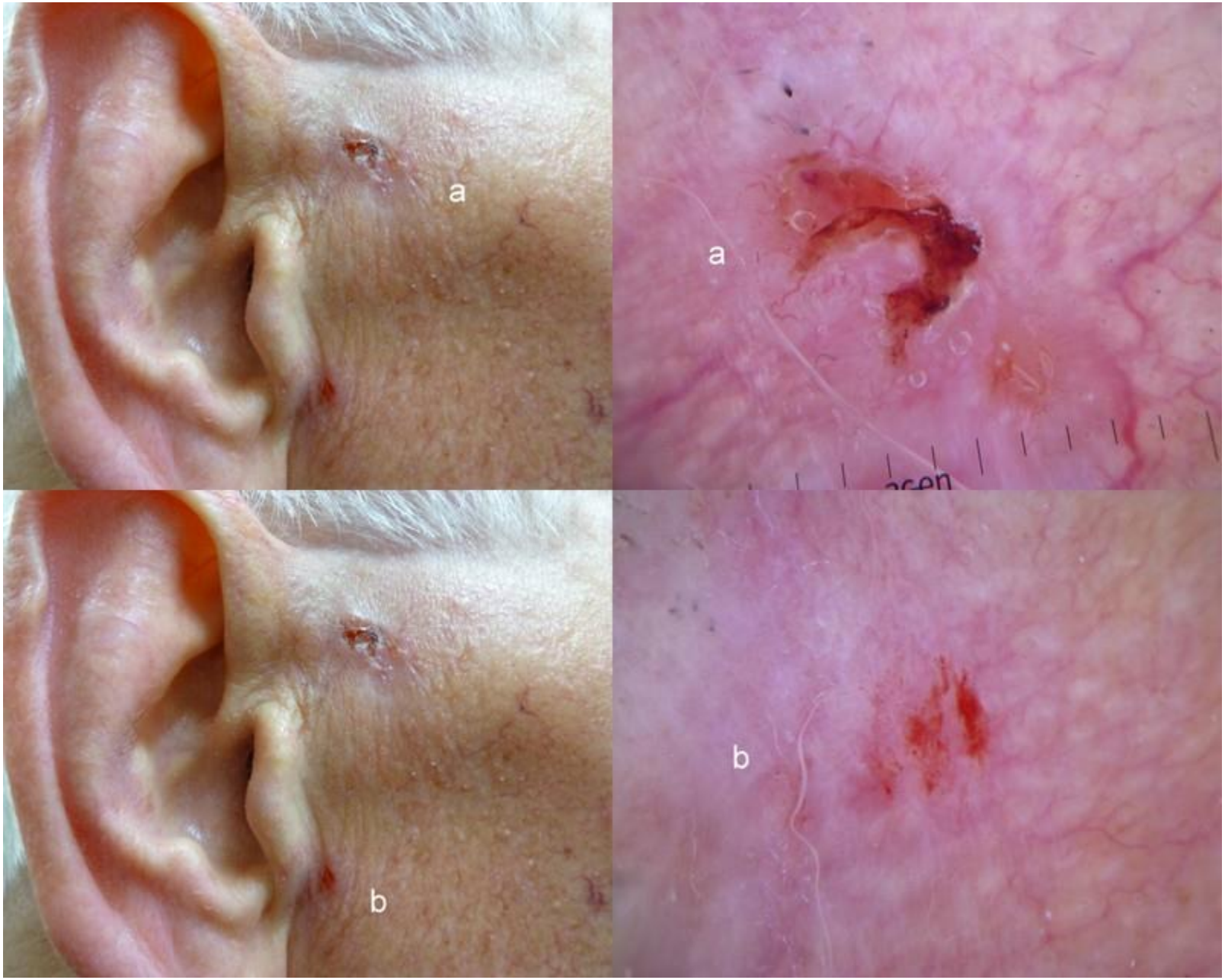
Heavily pigmented BCC (refer as 2WW)





If you find a BCC, always look for more…




a
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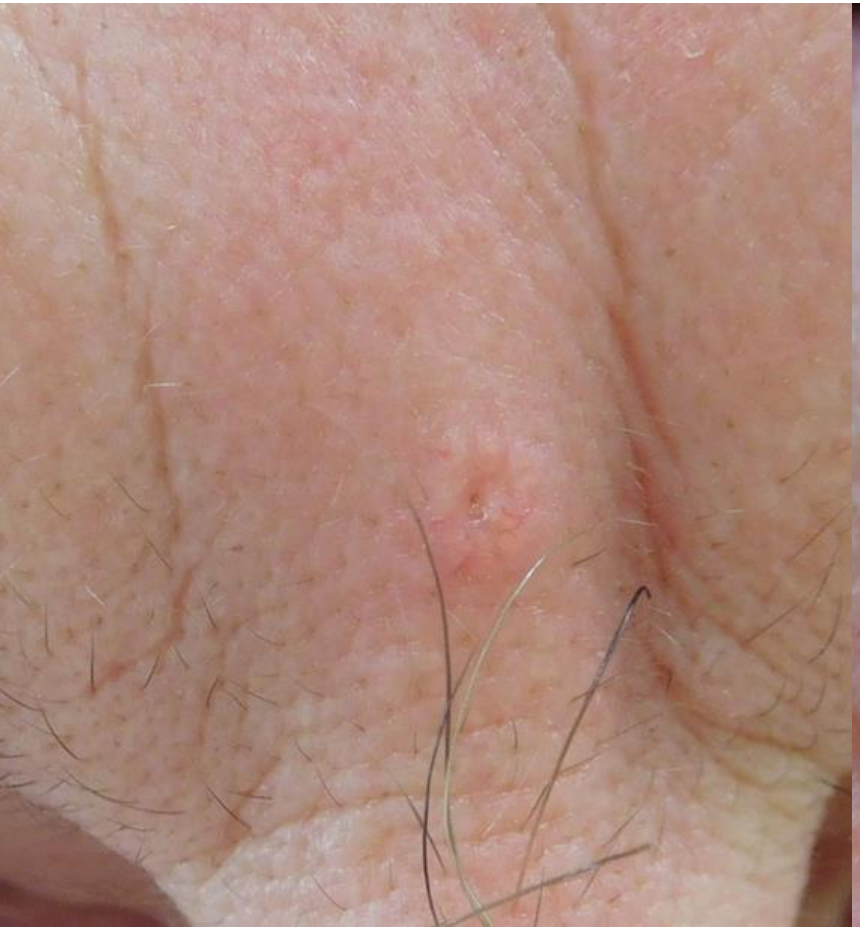
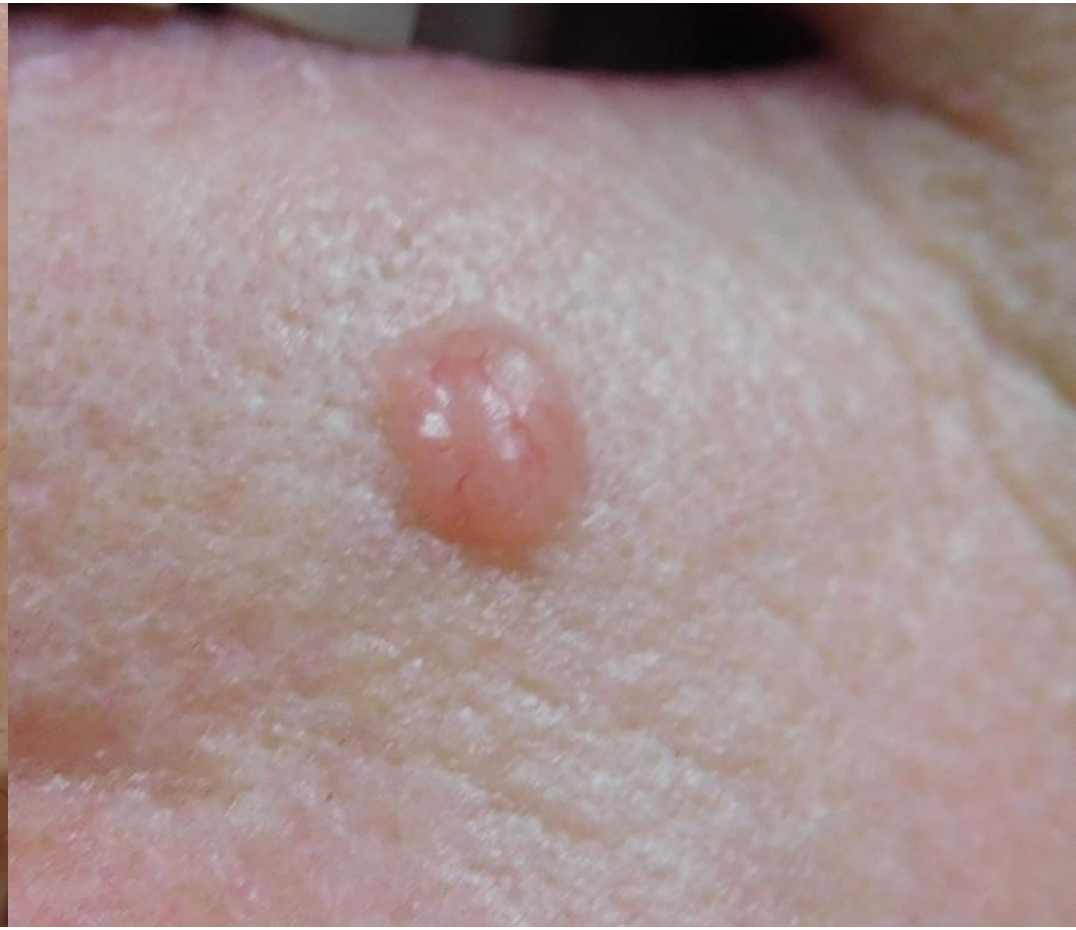
b
b

Differential of BCC– Sebaceous gland hyperplasia

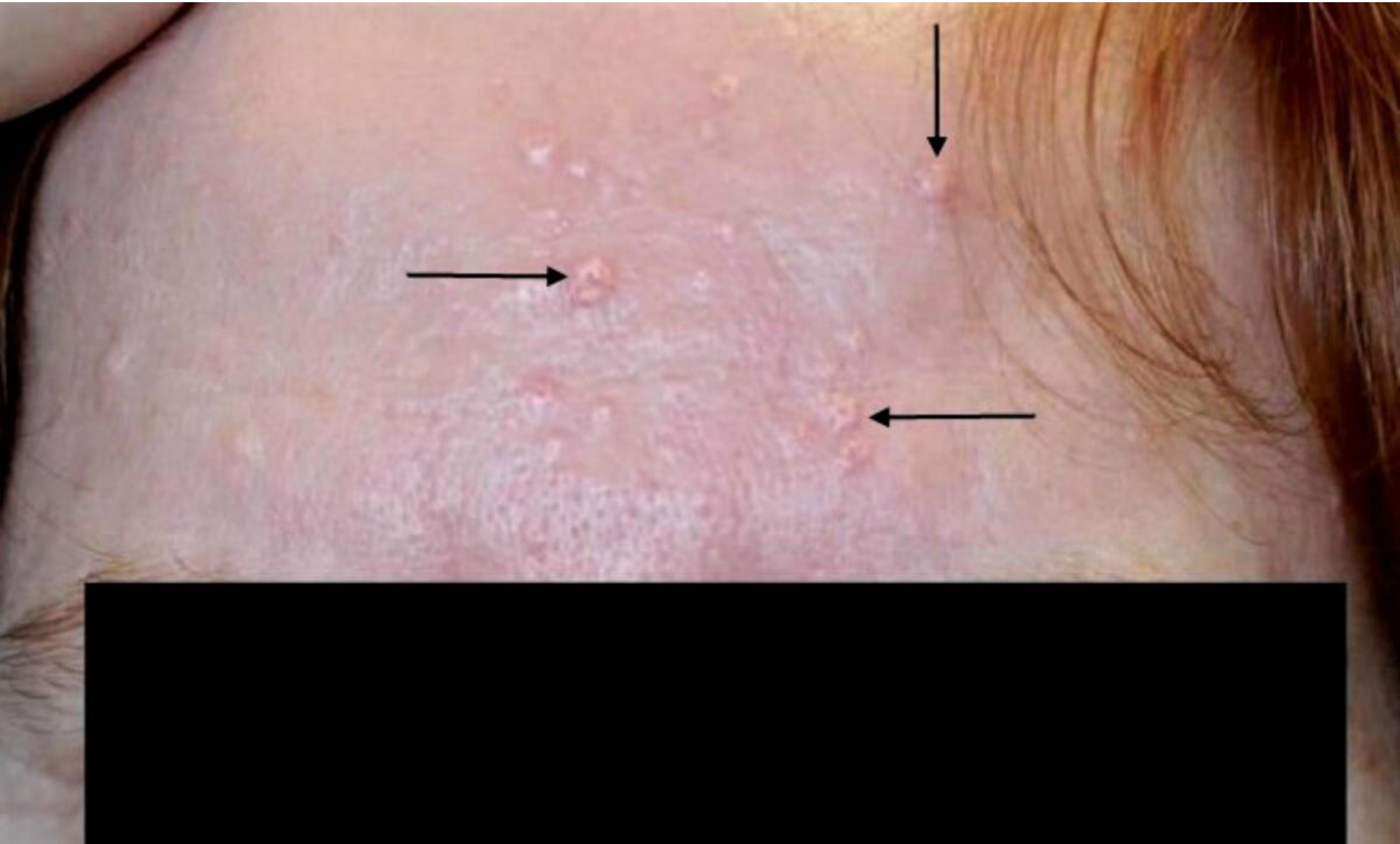


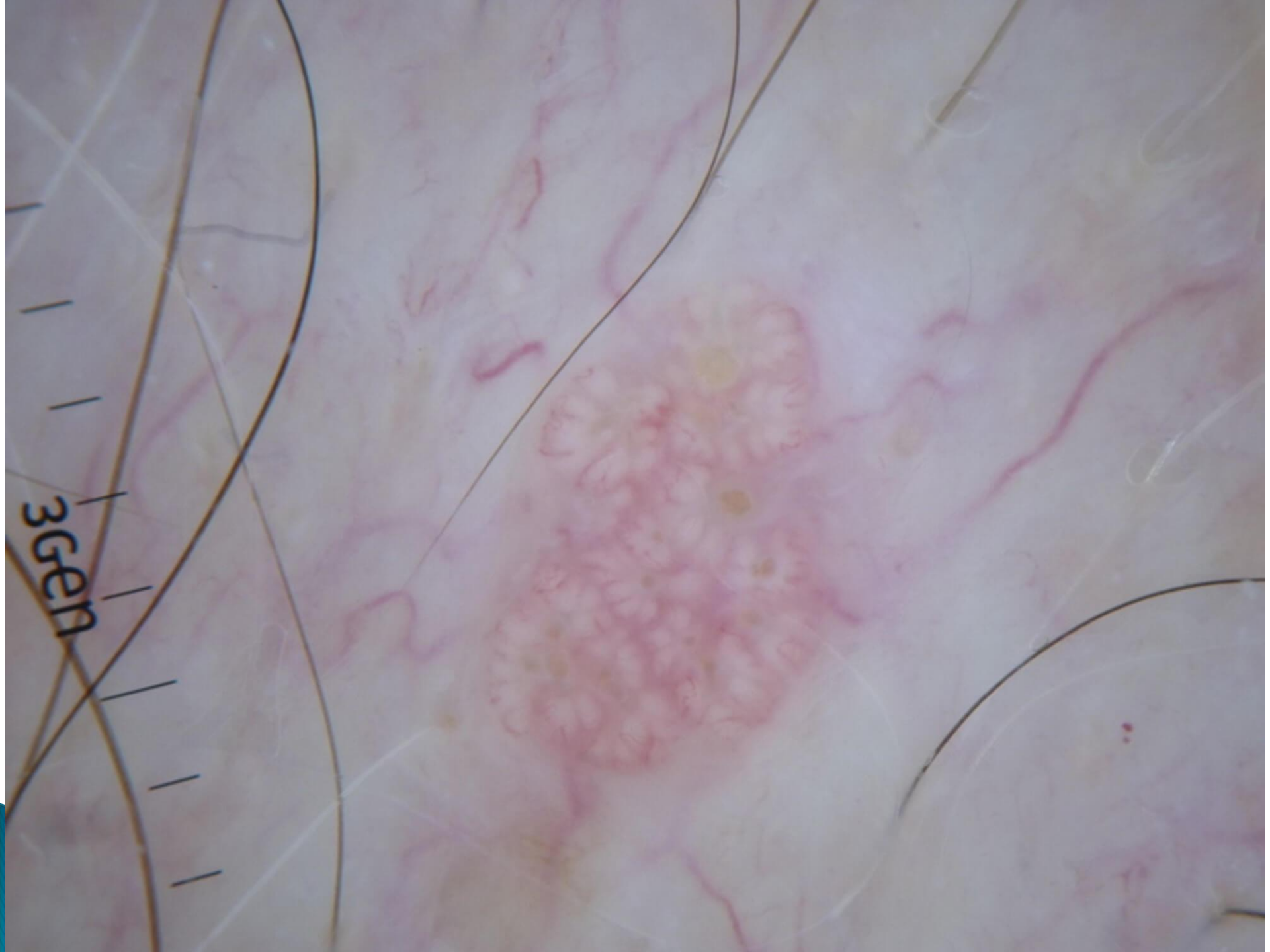


Sebaceous gland hyperplasia

CLINICAL	DERMOSCOPY
• Often multiple • Face • Small smooth white-yellow papules	• Grouped white globules (clods) • (crown vessels that do not cross the midline)

SGH

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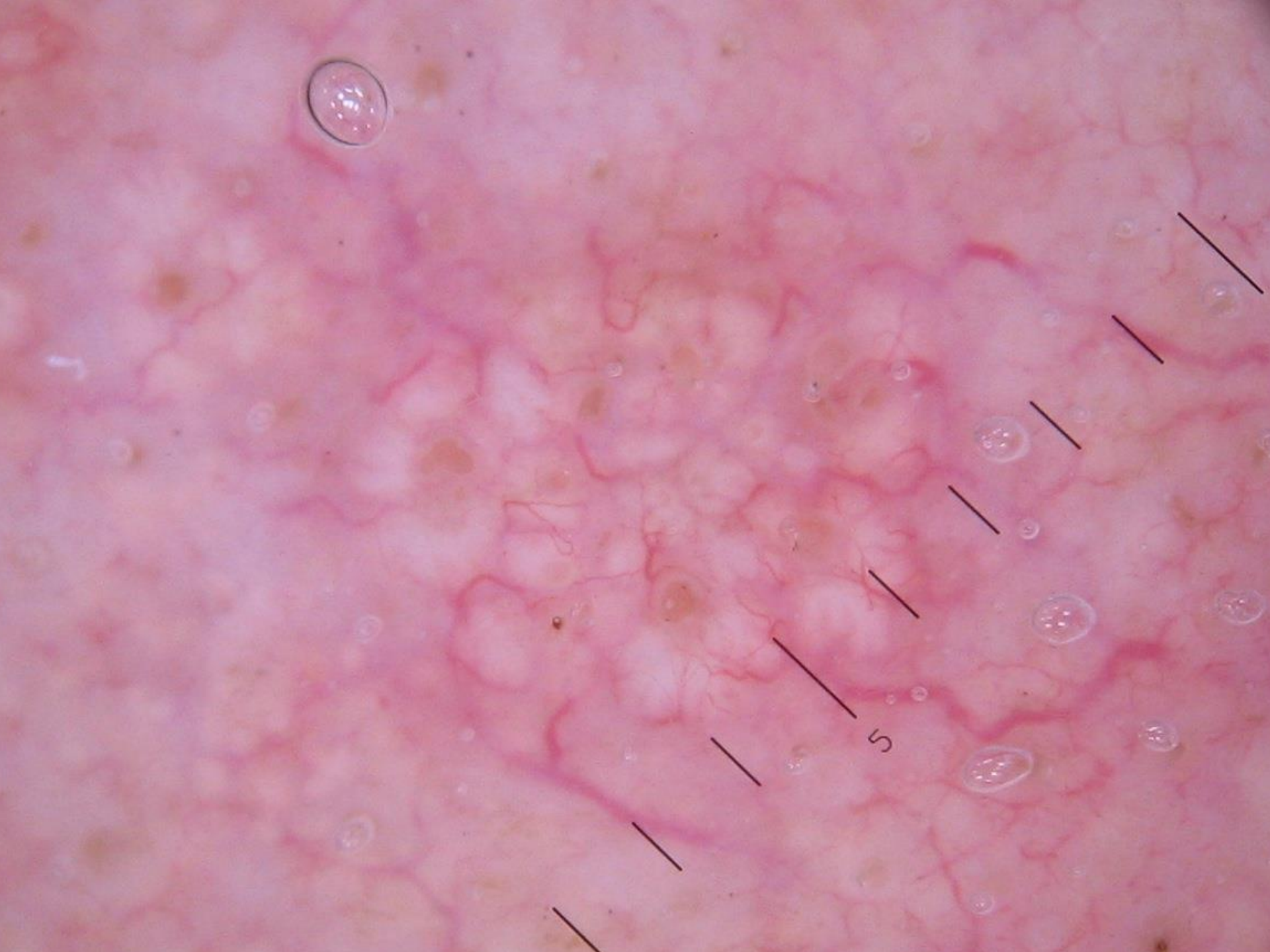
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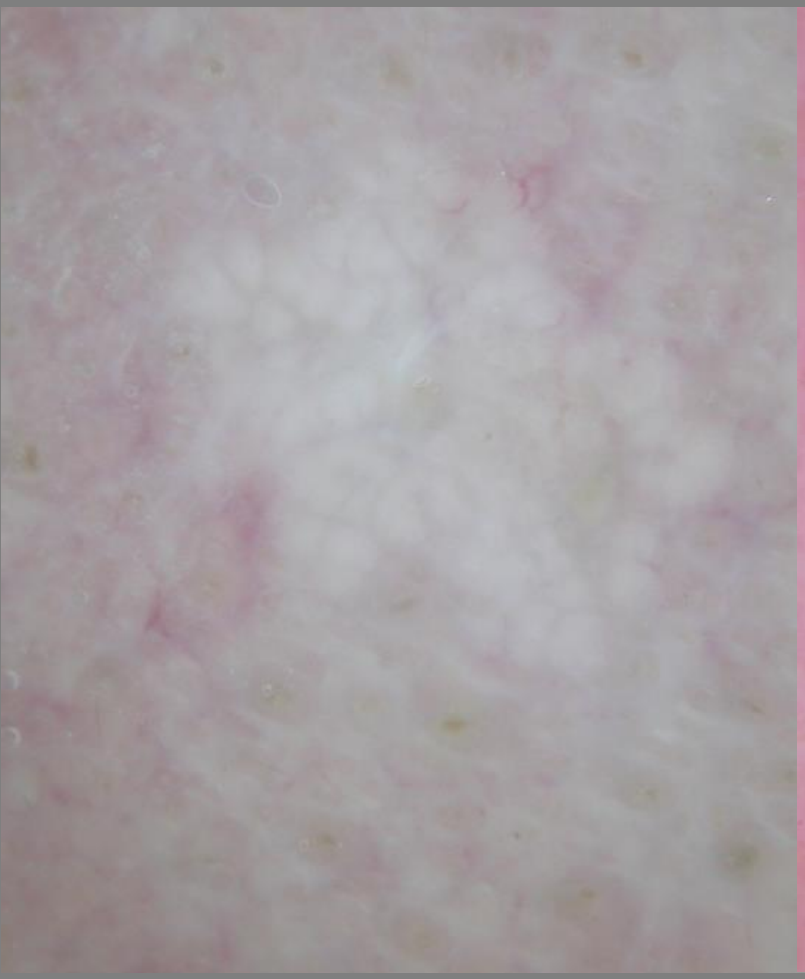
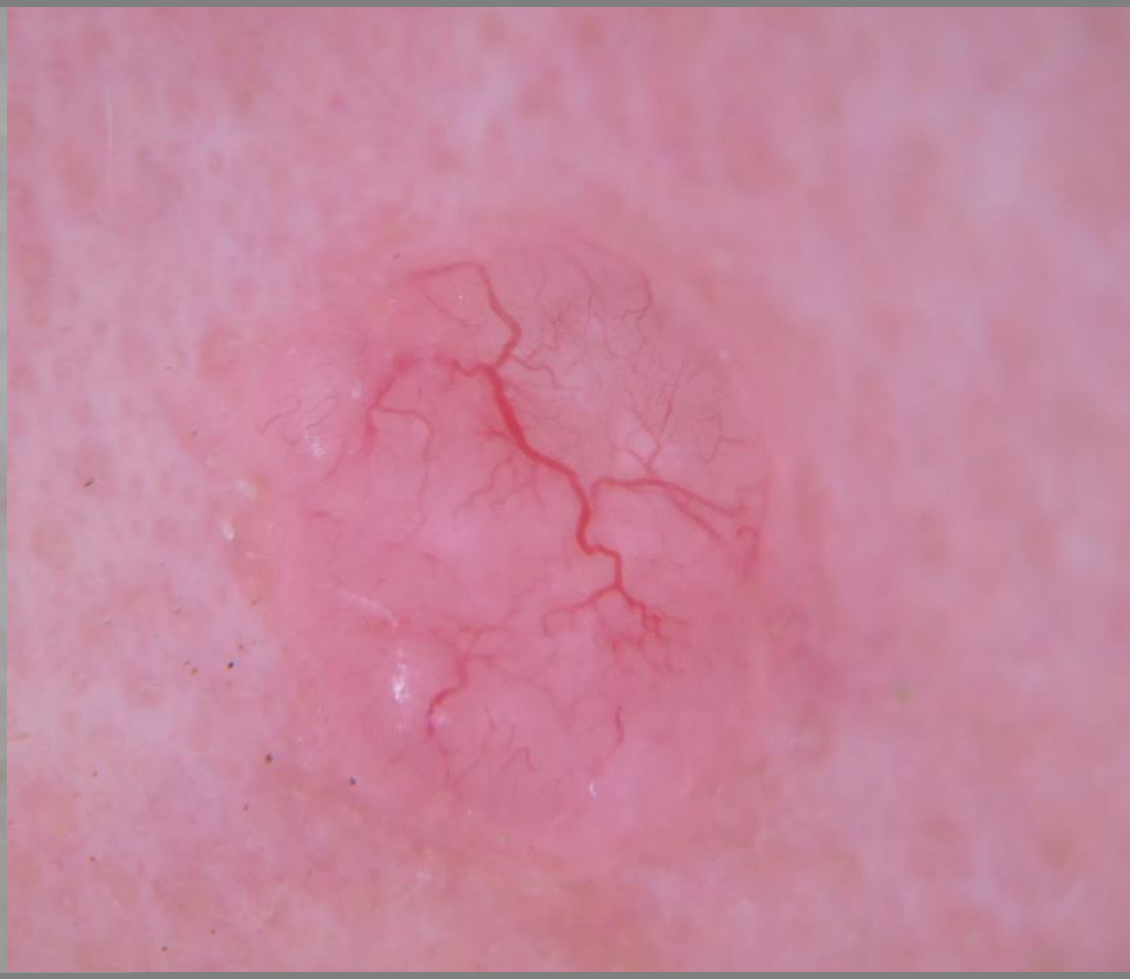
SGH

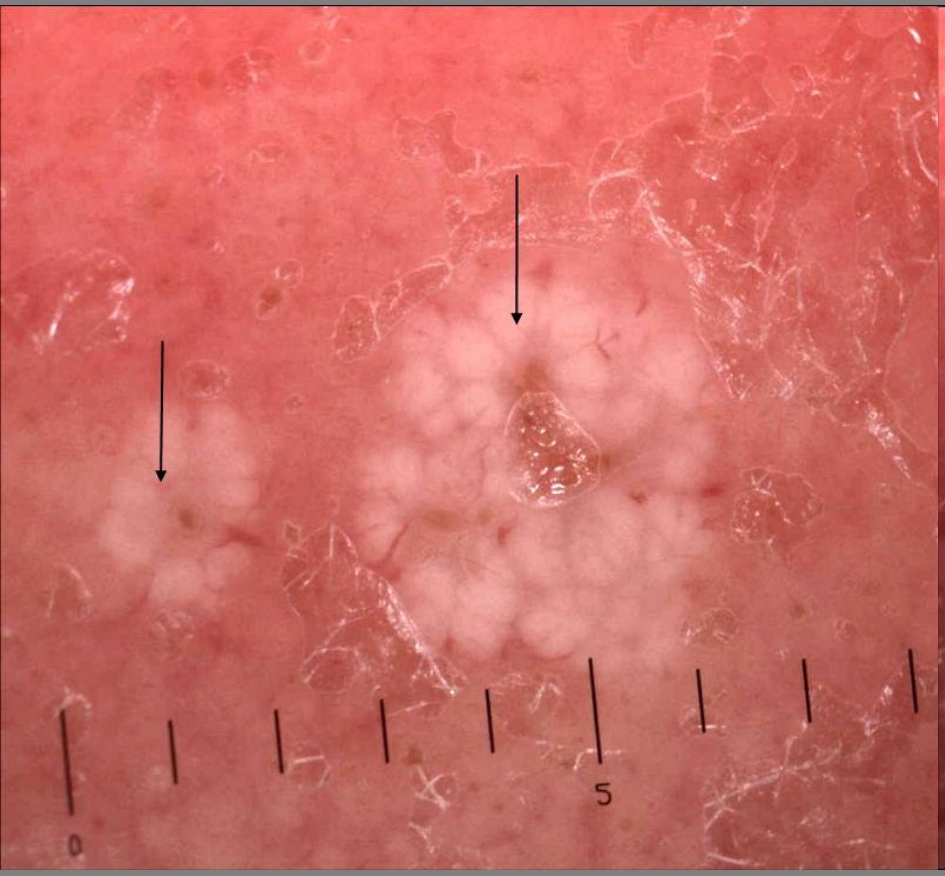
BCC

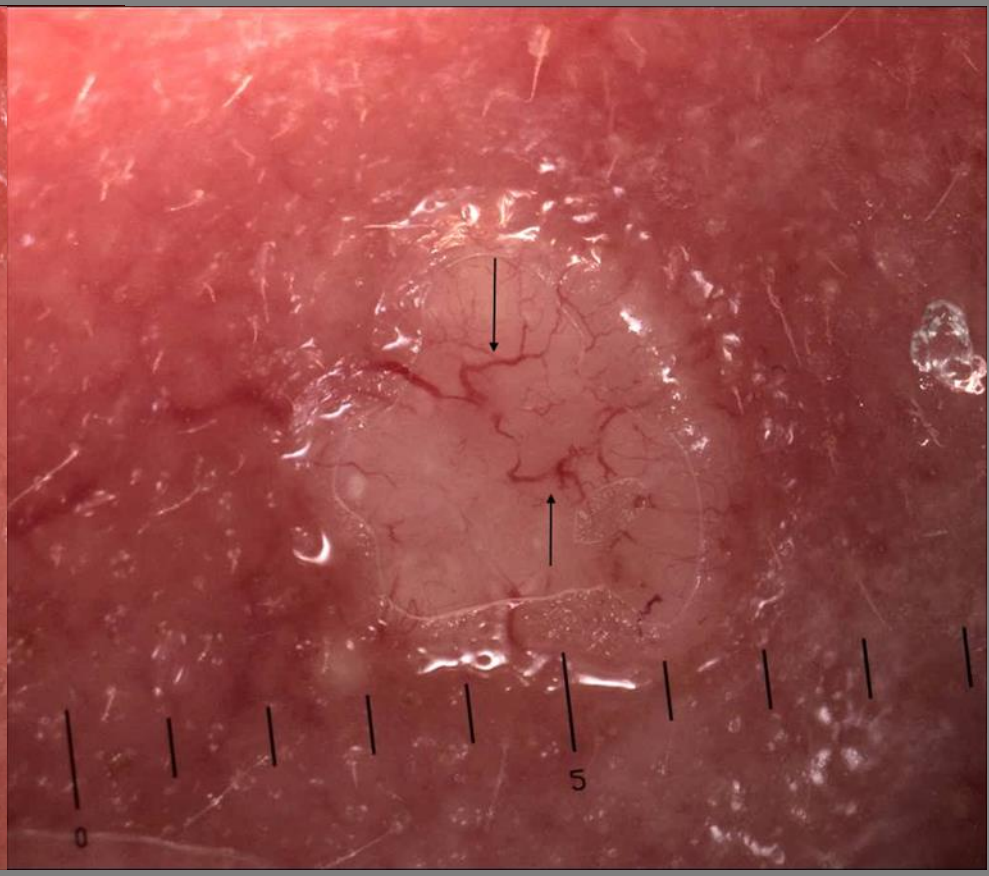




SGH

BCC





ALL OF E+F+G

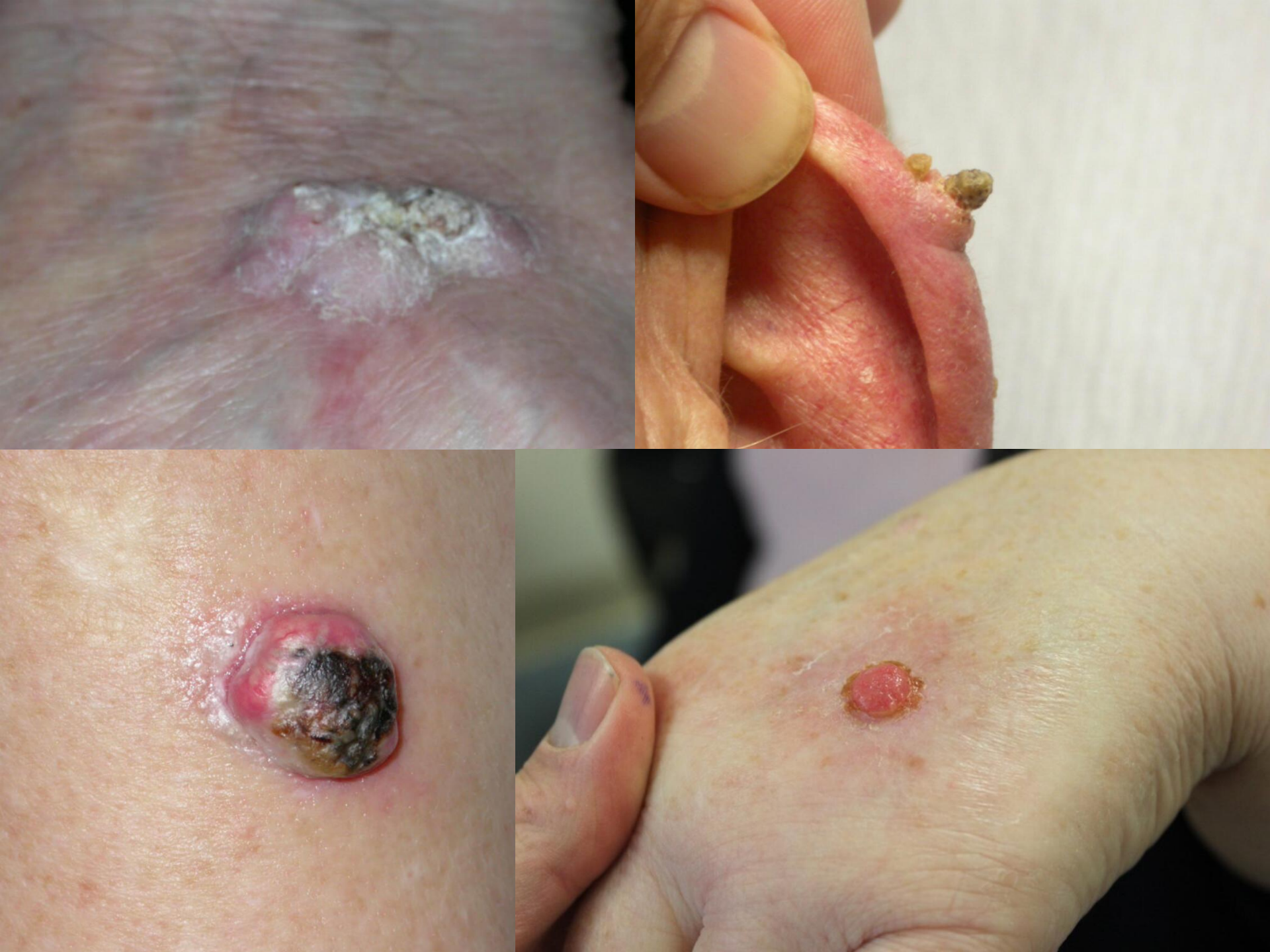
An SCC

BCC (SOLID)

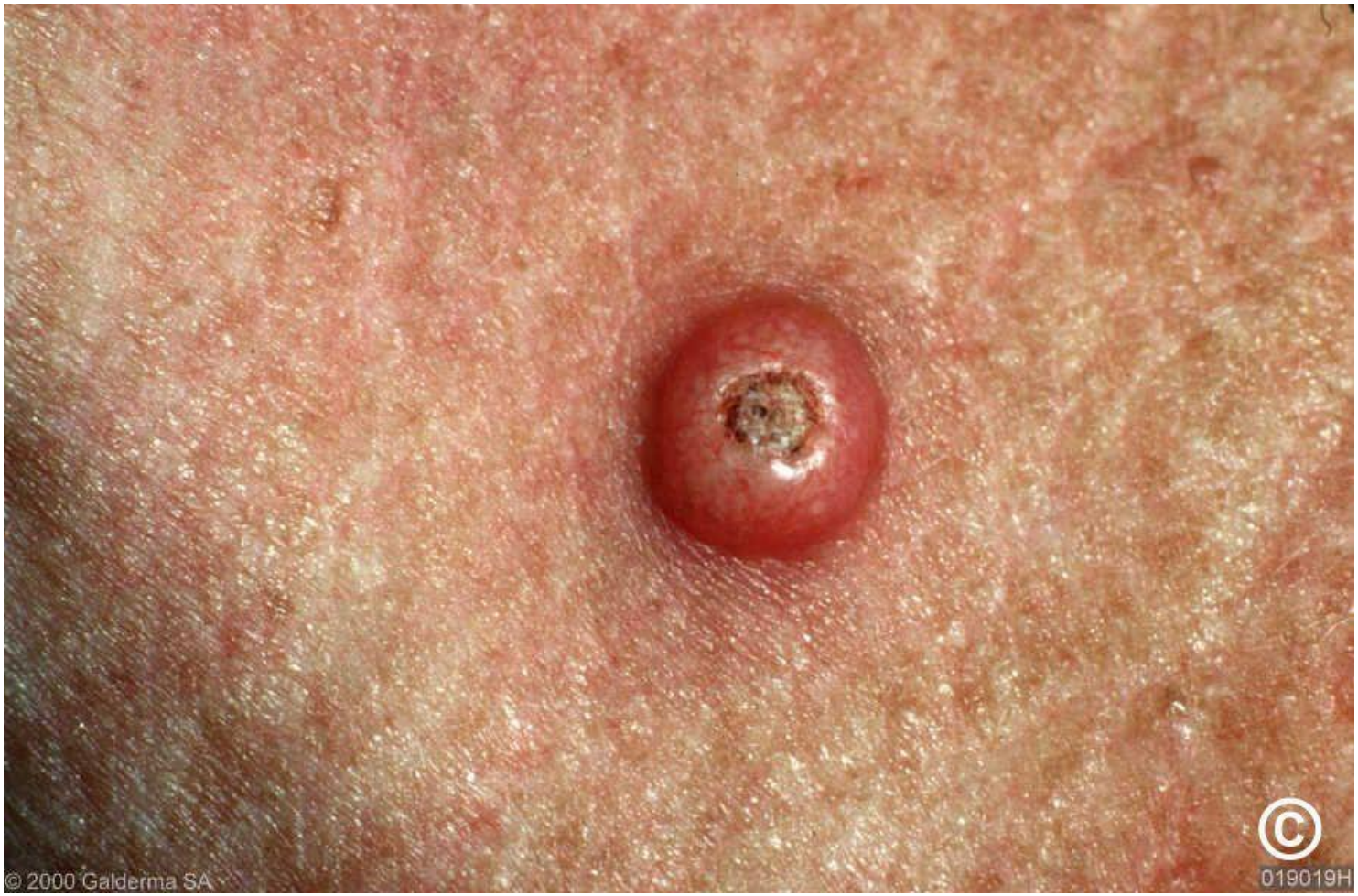
- Any site
- Grow slower
- Bleed/crust periodically
- Non-tender
- Pearly

SCC

- UV-exposed sites
- Grow more quickly
- Tender
- Many have white/yellow surface keratin (well-differentiated)



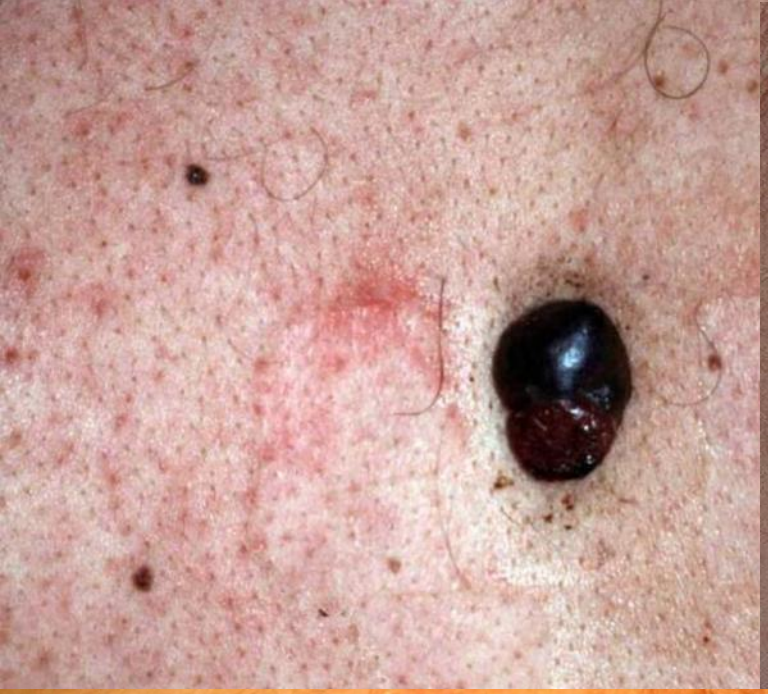
Keratoacanthoma

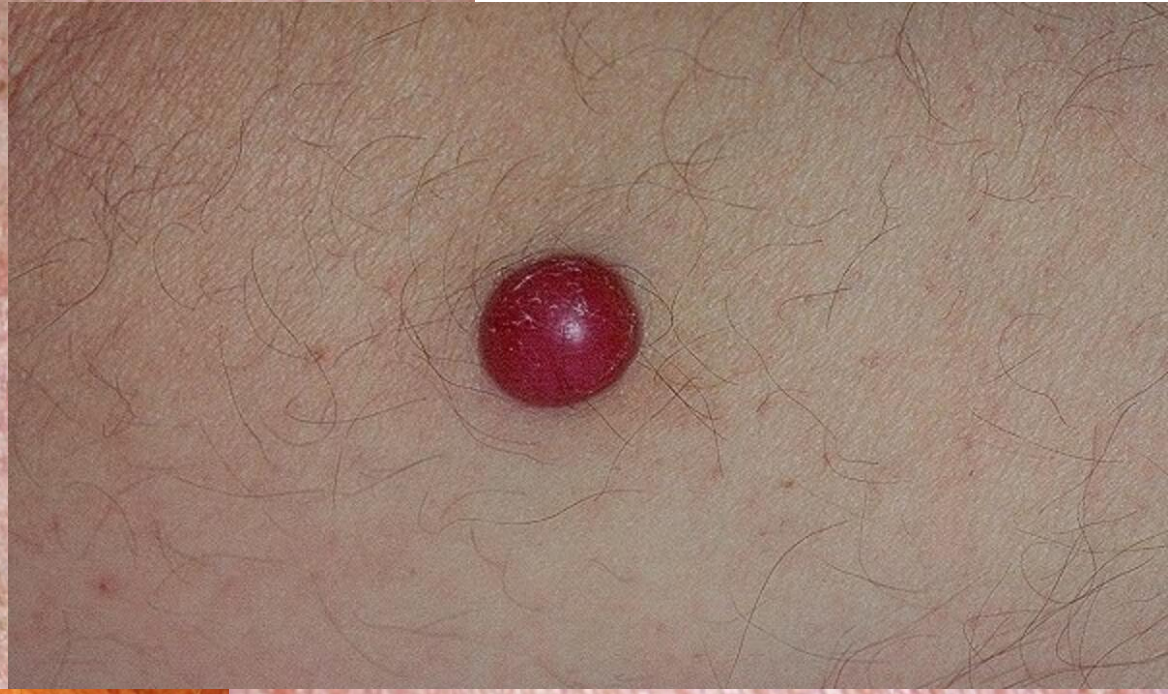


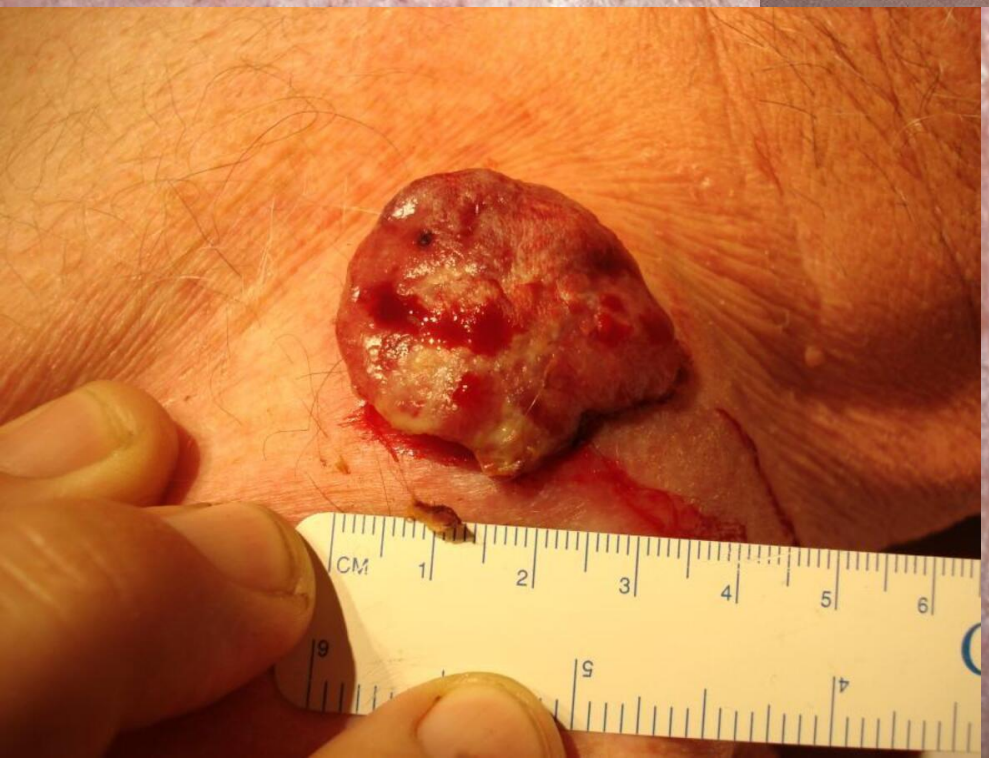
PRIMARY CARE DERMATOLOGY SOCIETY

ALL OF E+F+G

A nodular melanoma



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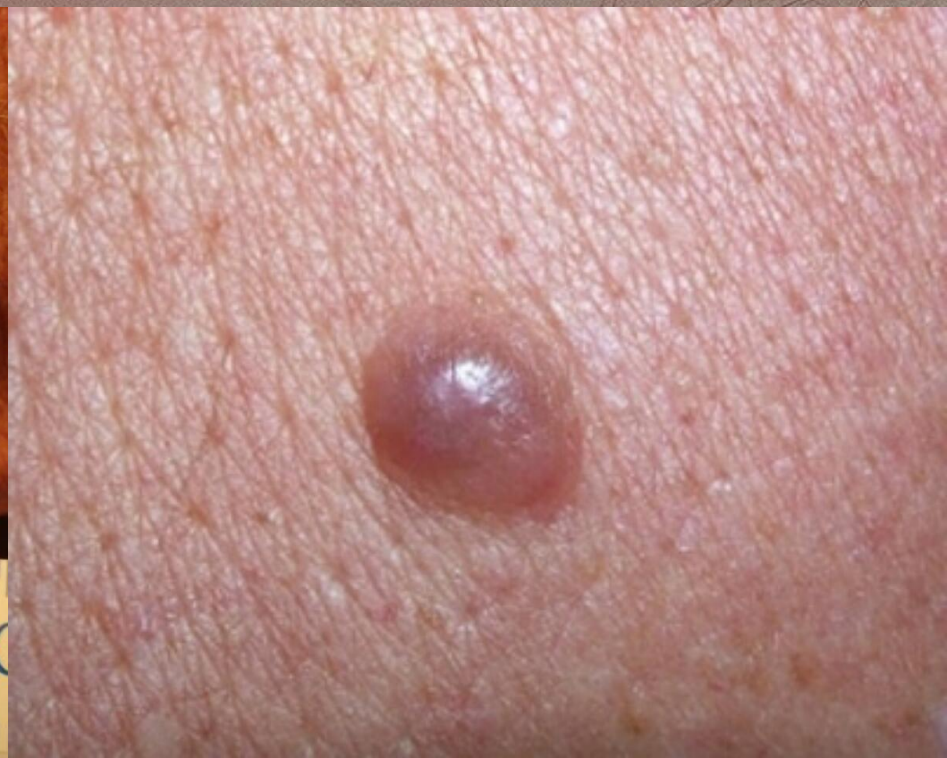
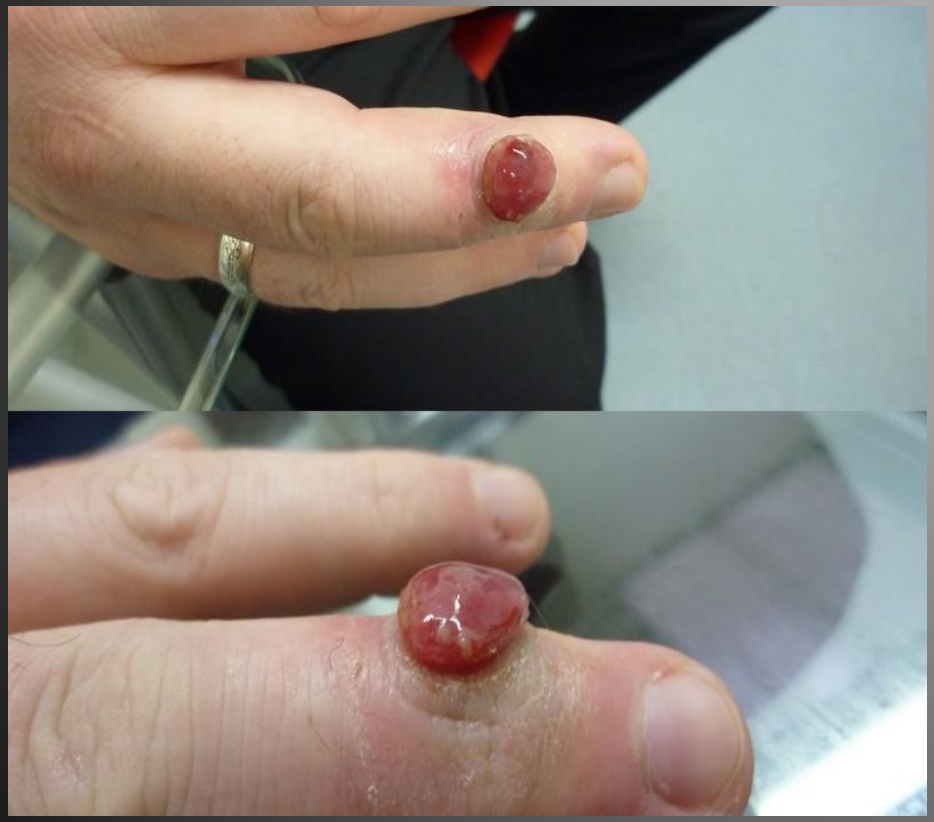


ALL OF E+F+G

A pyogenic granuloma (benign)

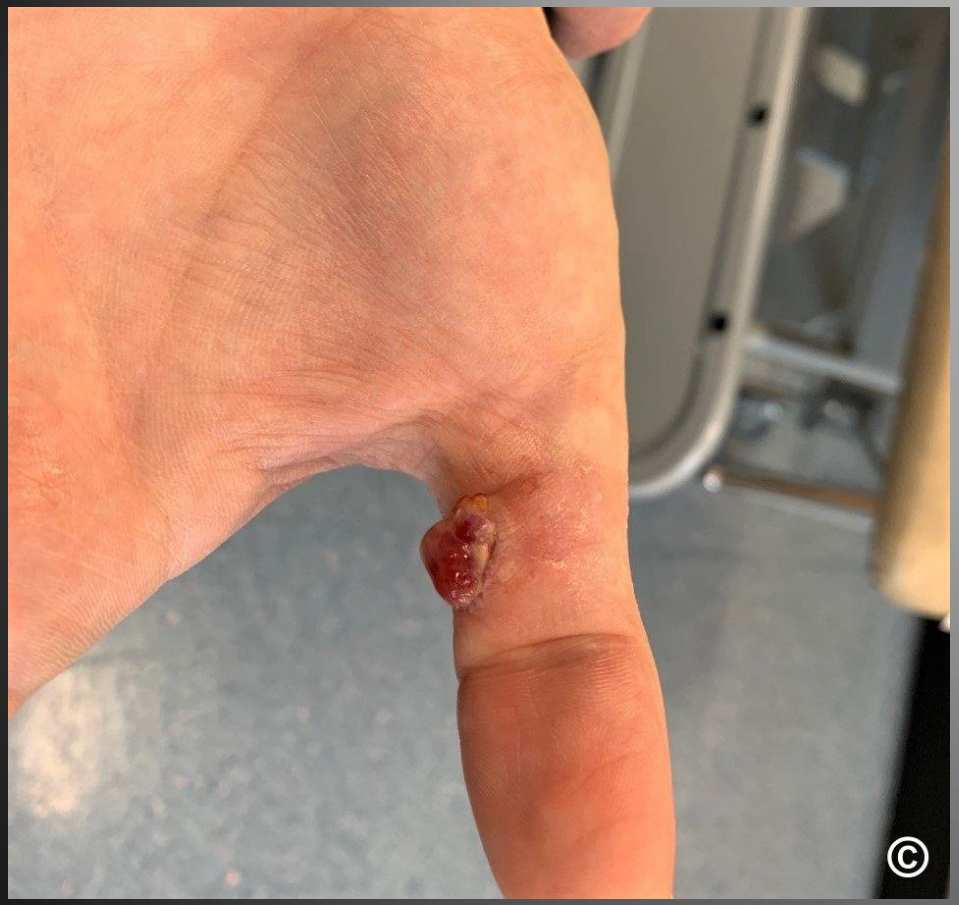
PYOGENIC GRANULOMA

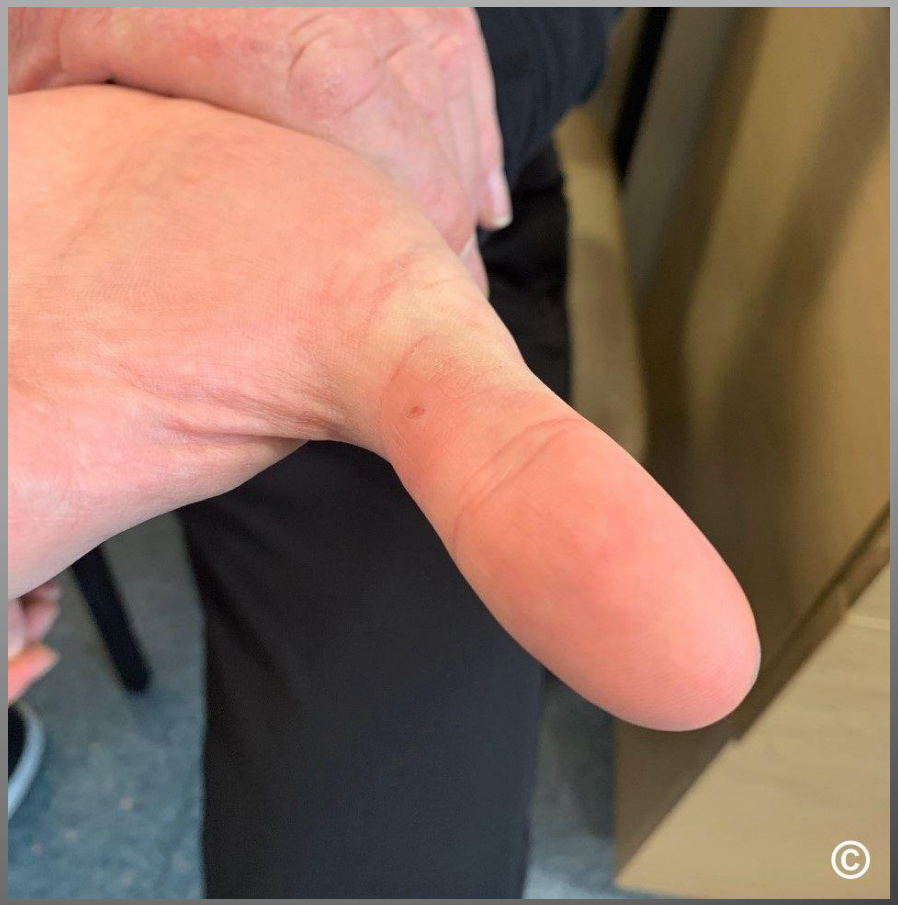


Some precipitated by trauma
Fast growing (weeks)
Bleed ++

Treatment

- Protect surrounding skin with Vaseline
- Table salt onto the PG
- Occlude
- Replace every 24 hours
- Review in two weeks … refer as a 2WW if not gone (almost gone)





- Seborrhoeic keraotses and warts
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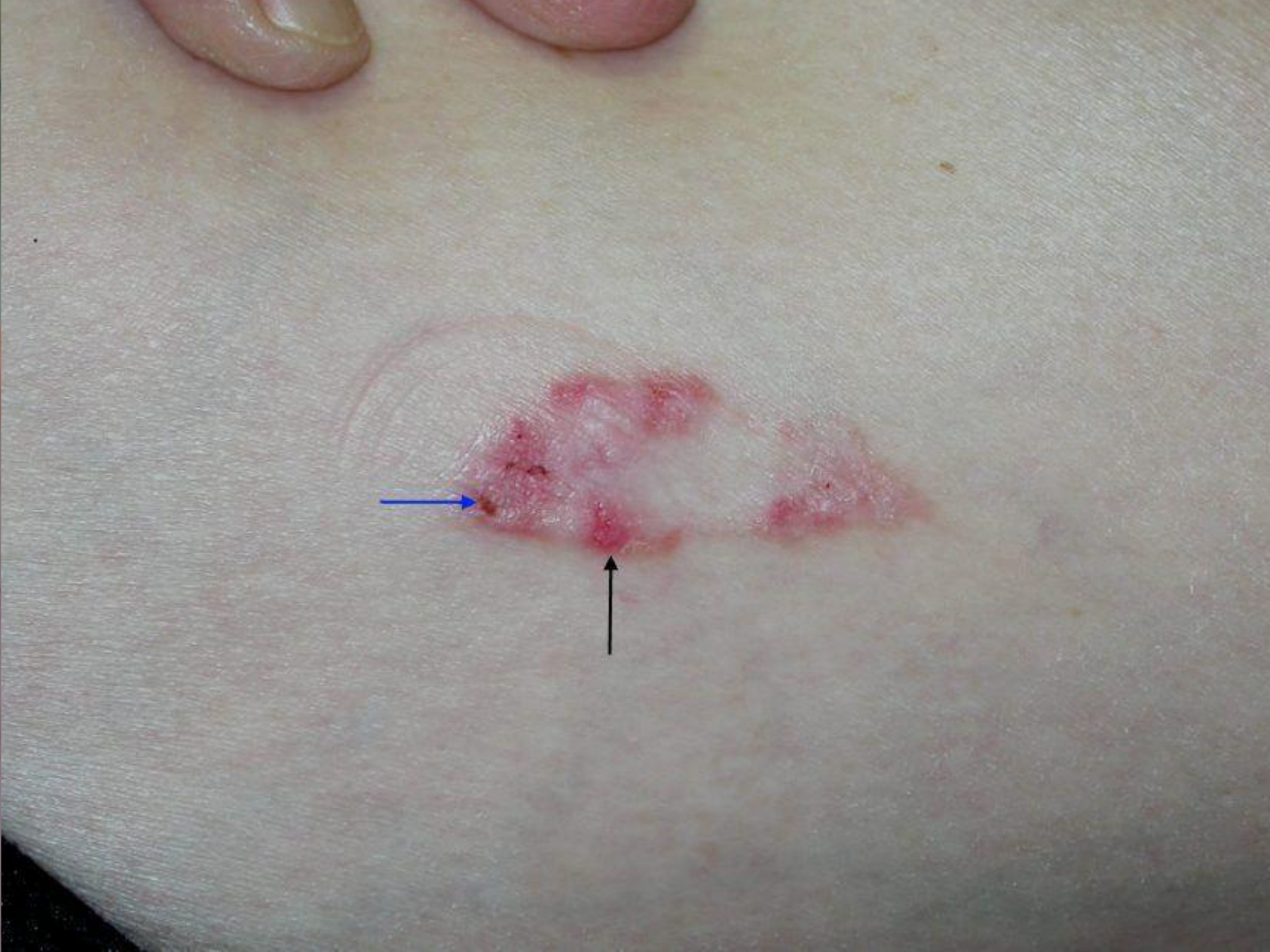
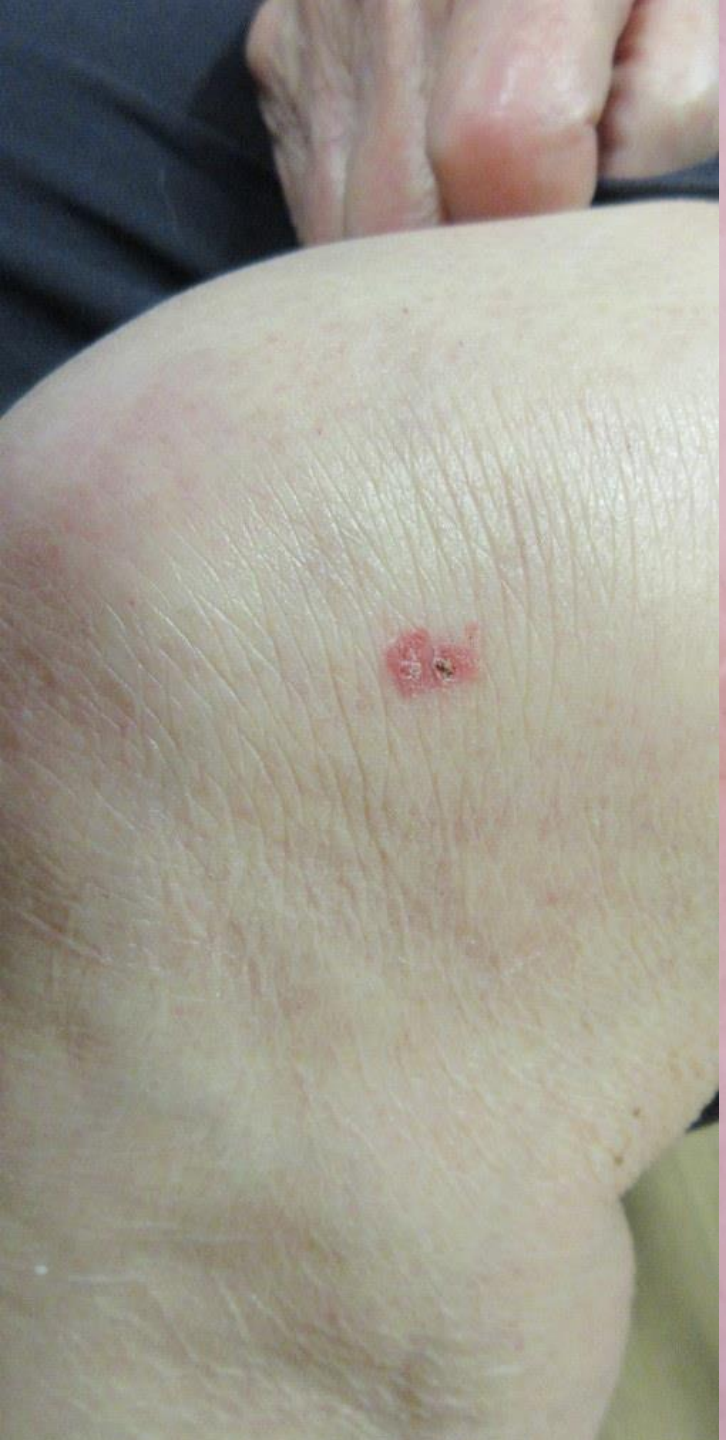
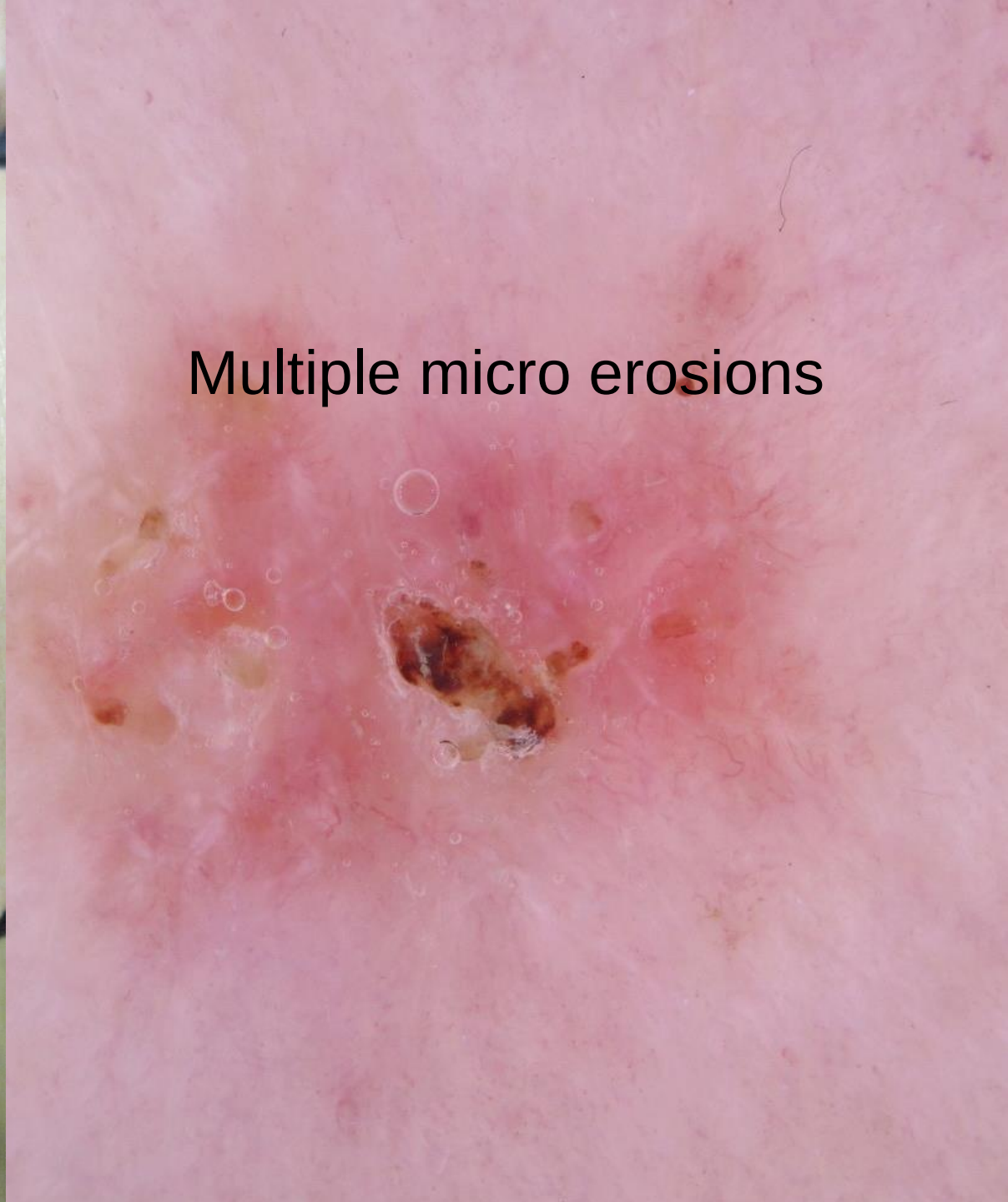
- Superficial BCC
- **Angioma**
- Multiple pink, benign melanocytic naevi
- Hypomelanotic melanoma or Spitz naevus

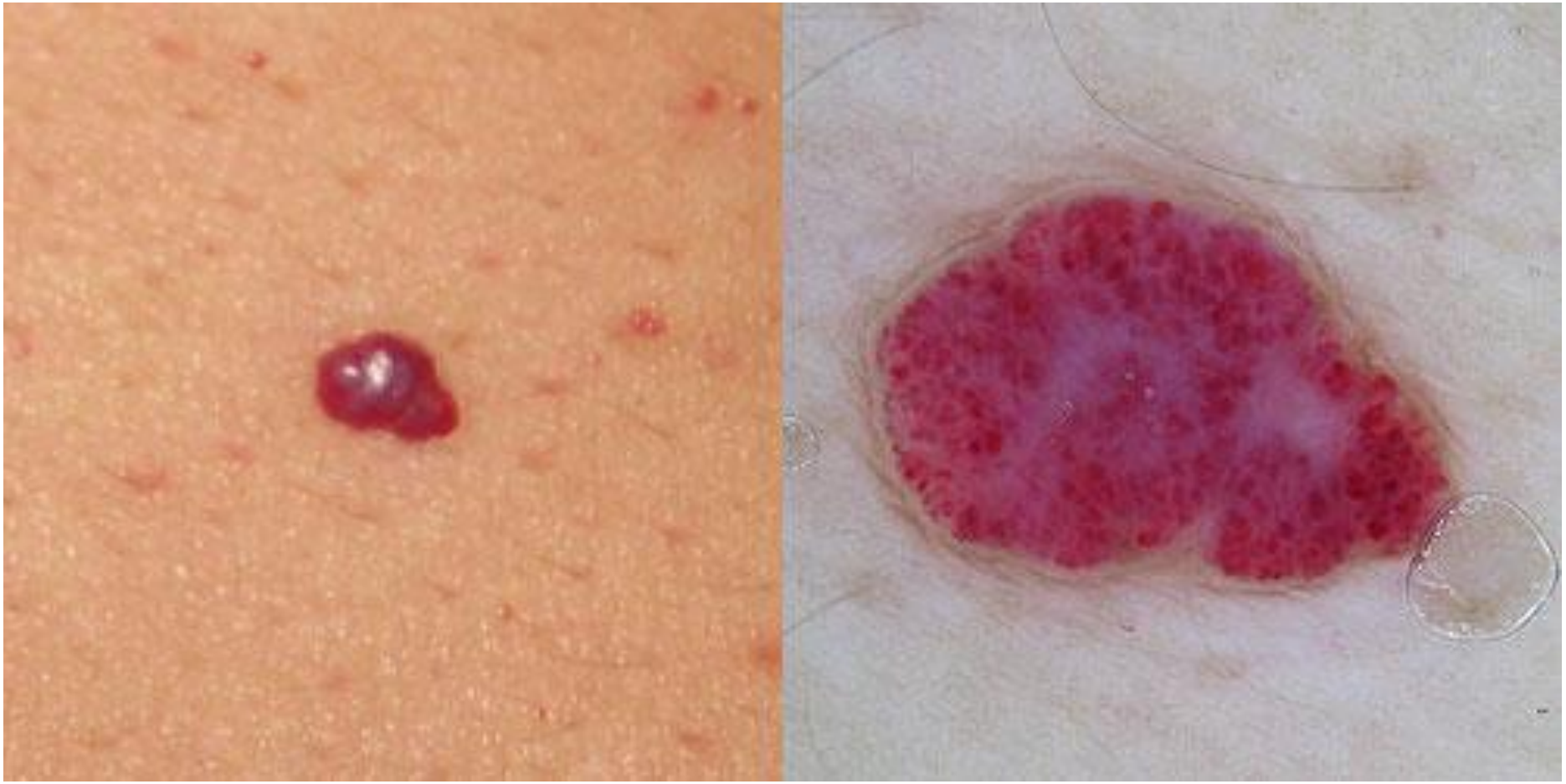


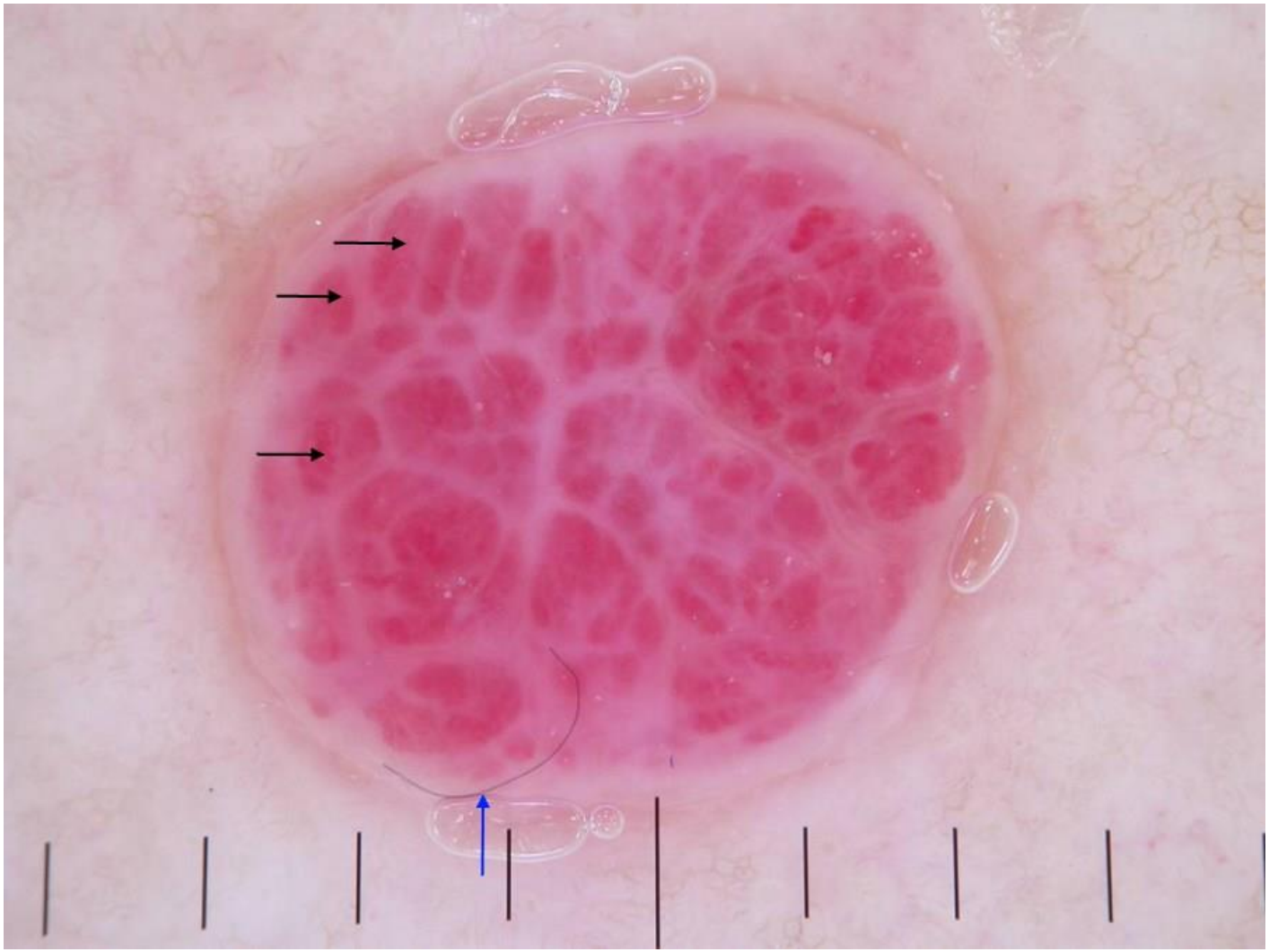


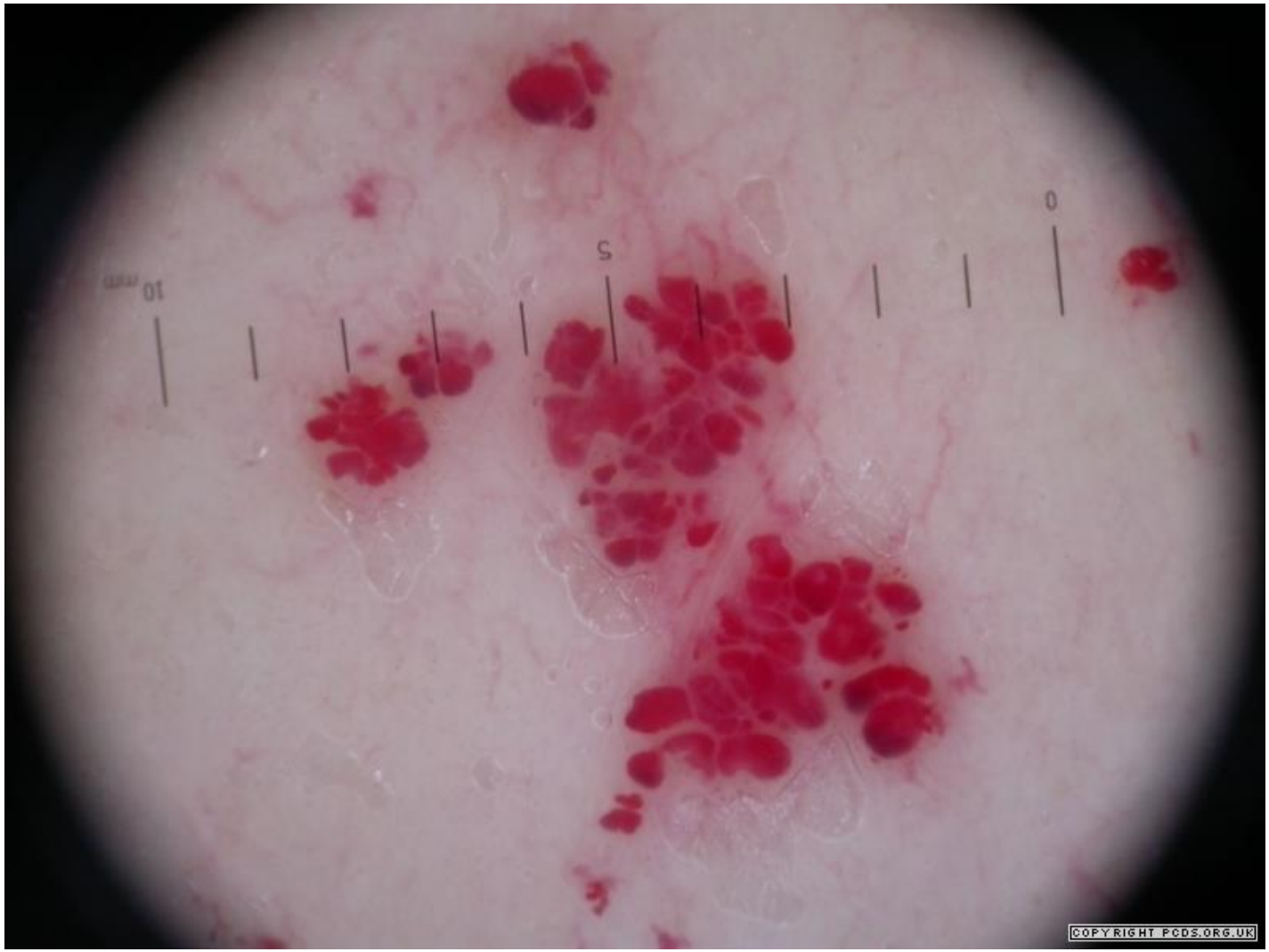

Multiple micro erosions

Angioma

CLINICAL	DERMOSCOPY
• One-many • Soft papules and nodules • Red / blue / purple / black	• Multiple well-defined lacunae • Same colours • White stroma • Individual blood vessels should not be seen



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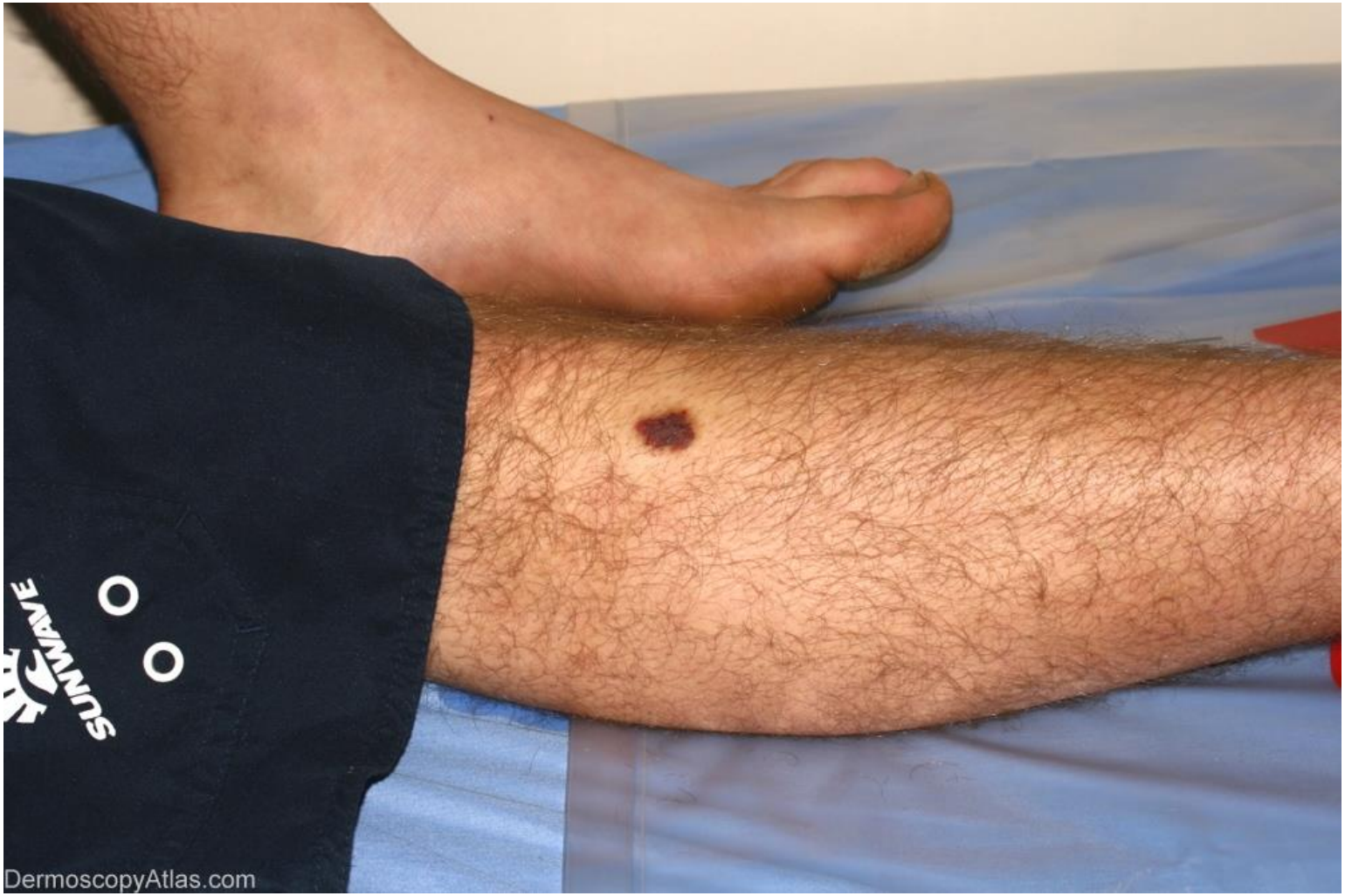
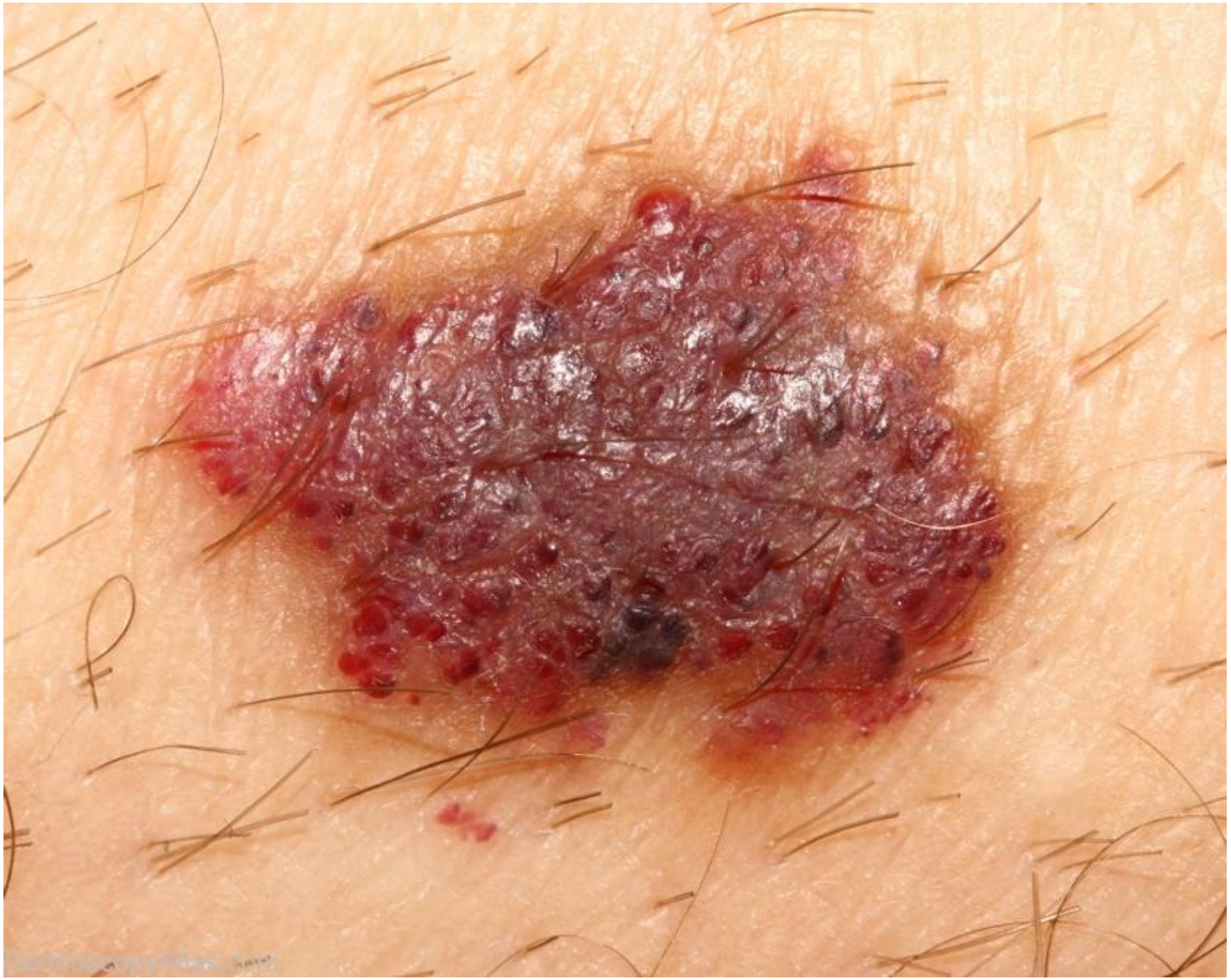
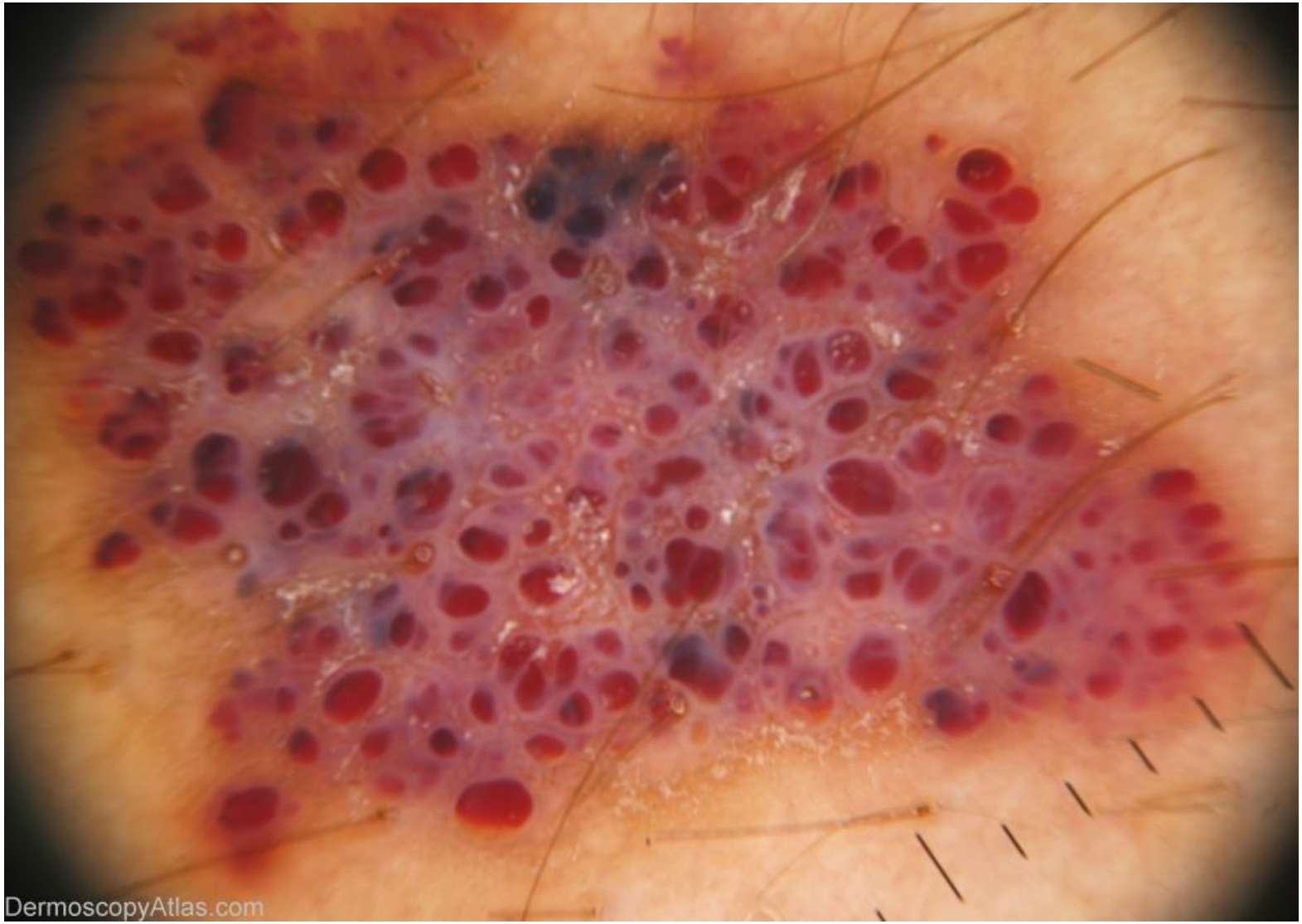

SUNWAVE
DermoscopyAtlas.com

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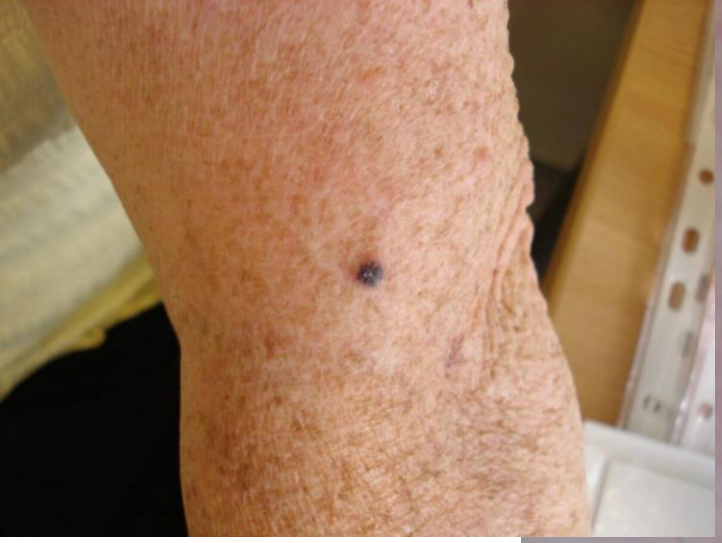

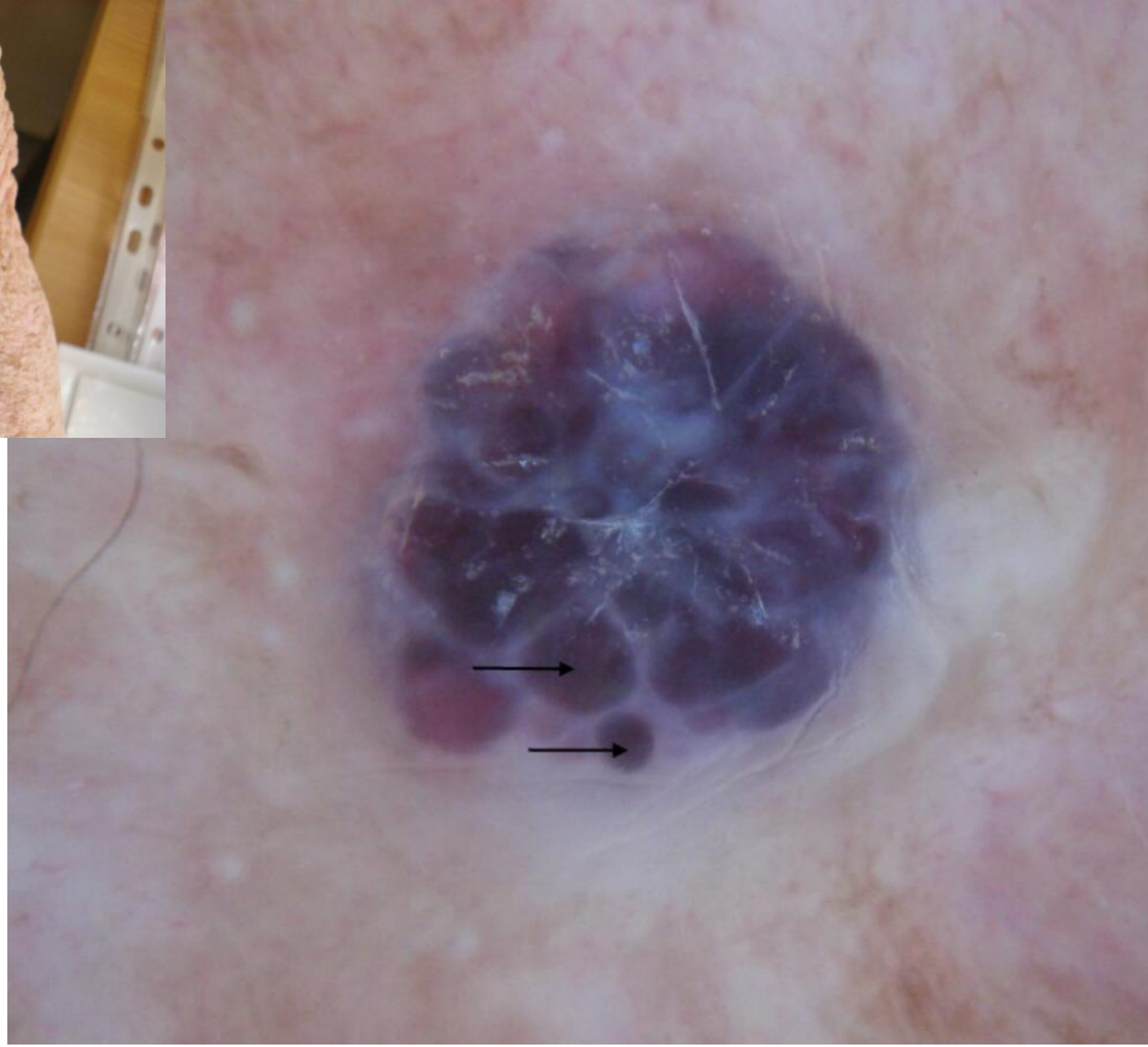

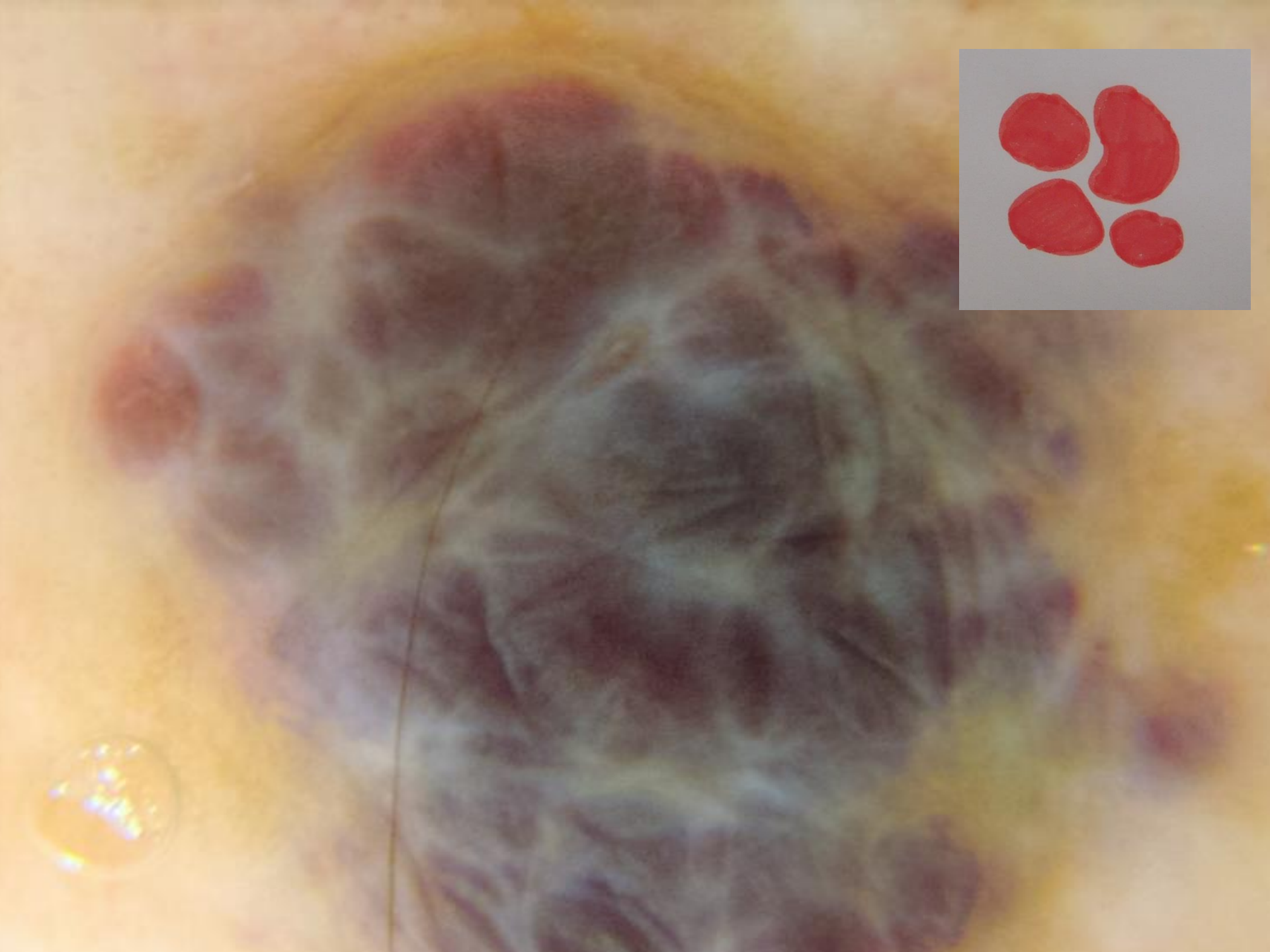

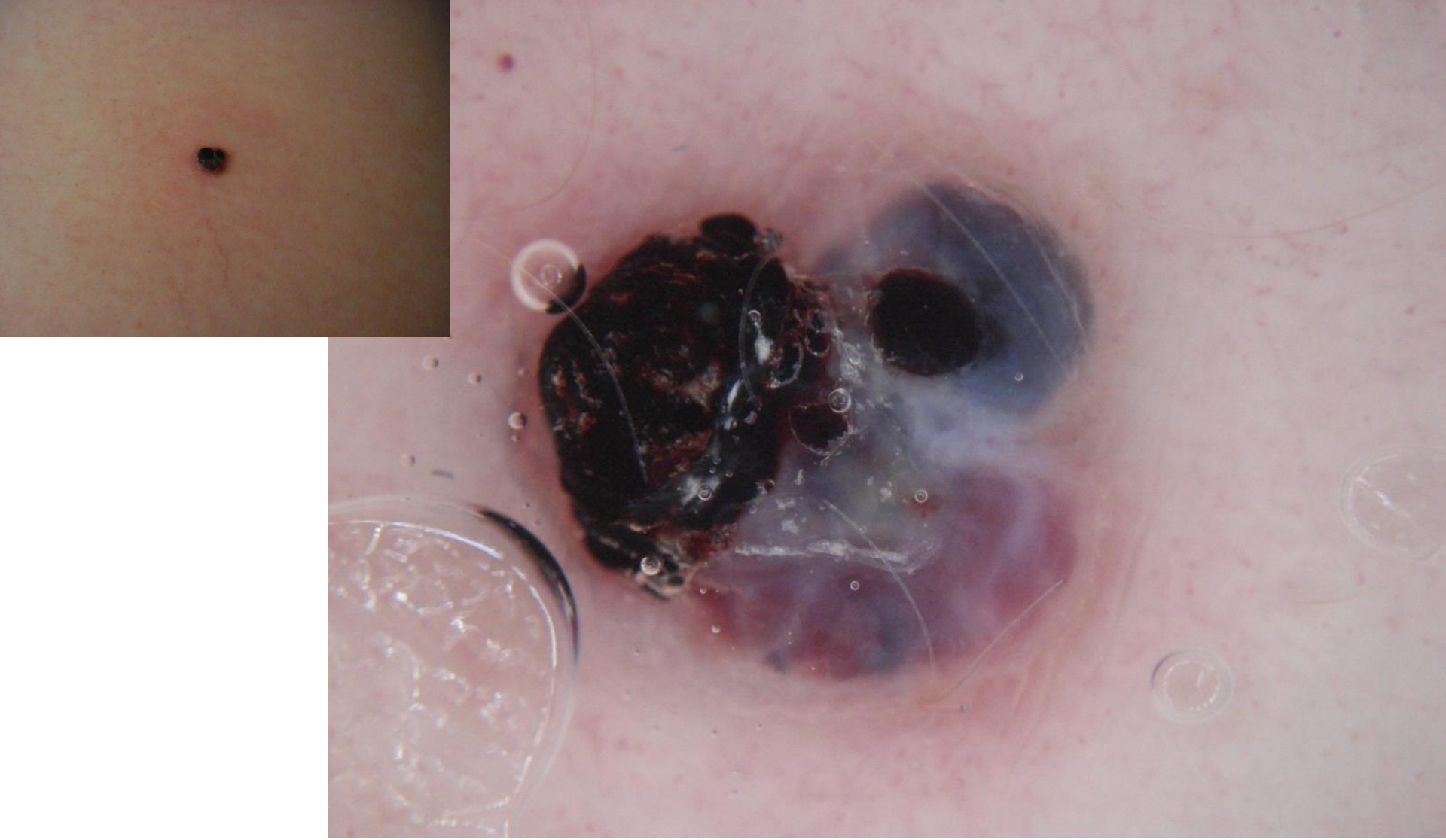

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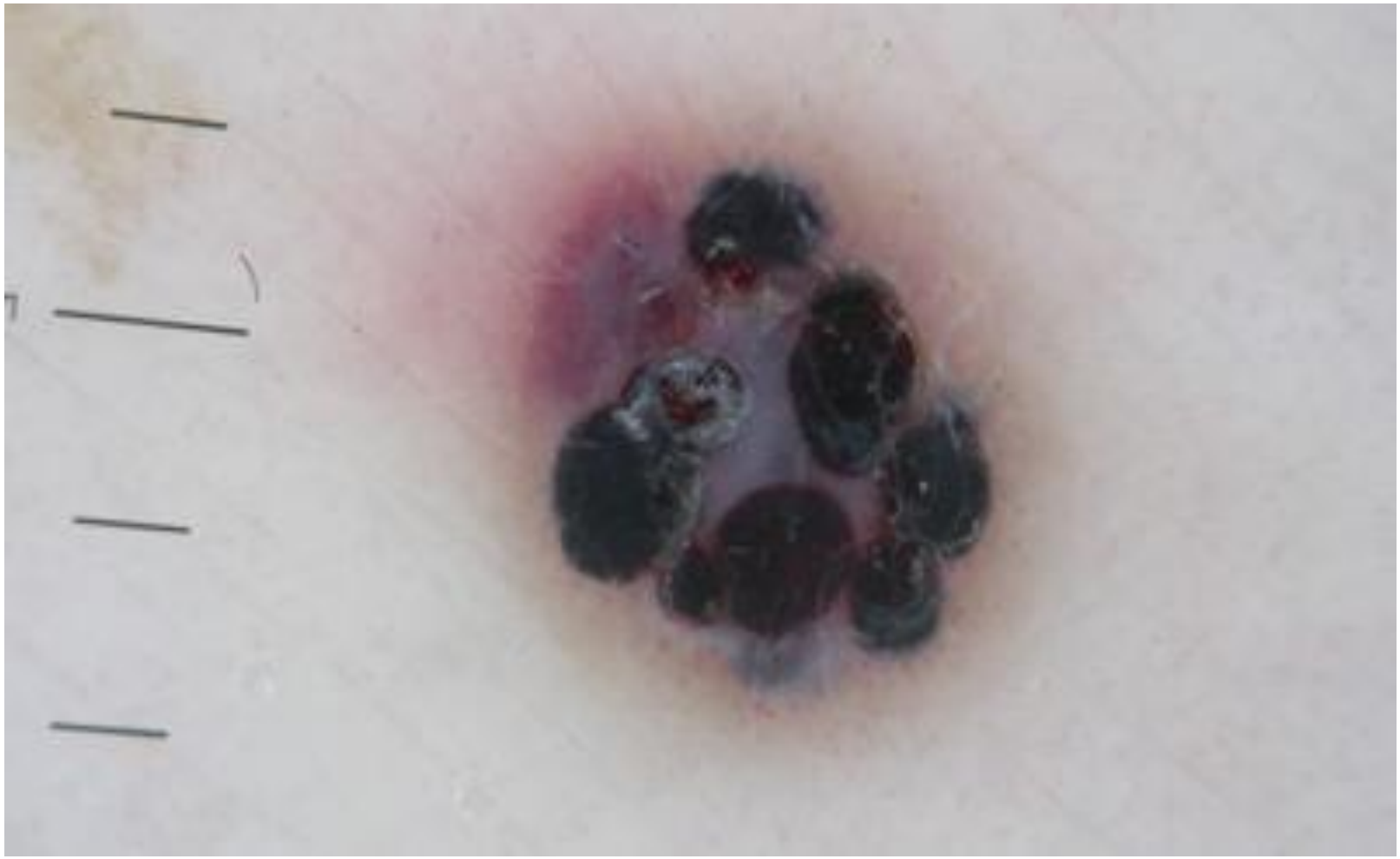
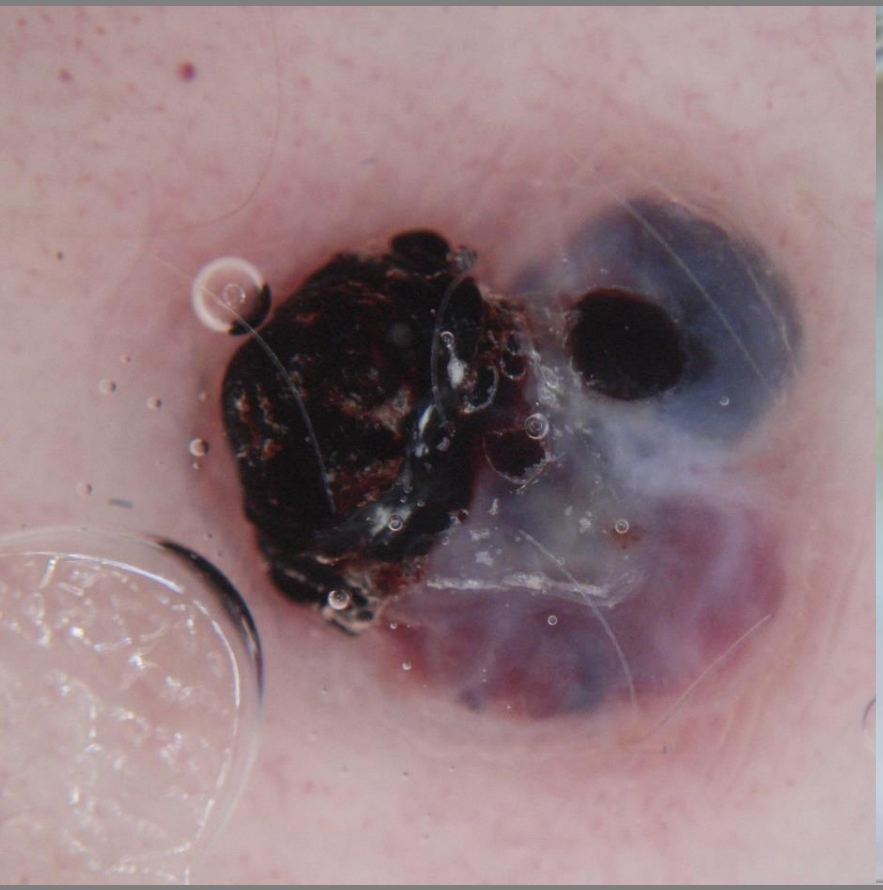
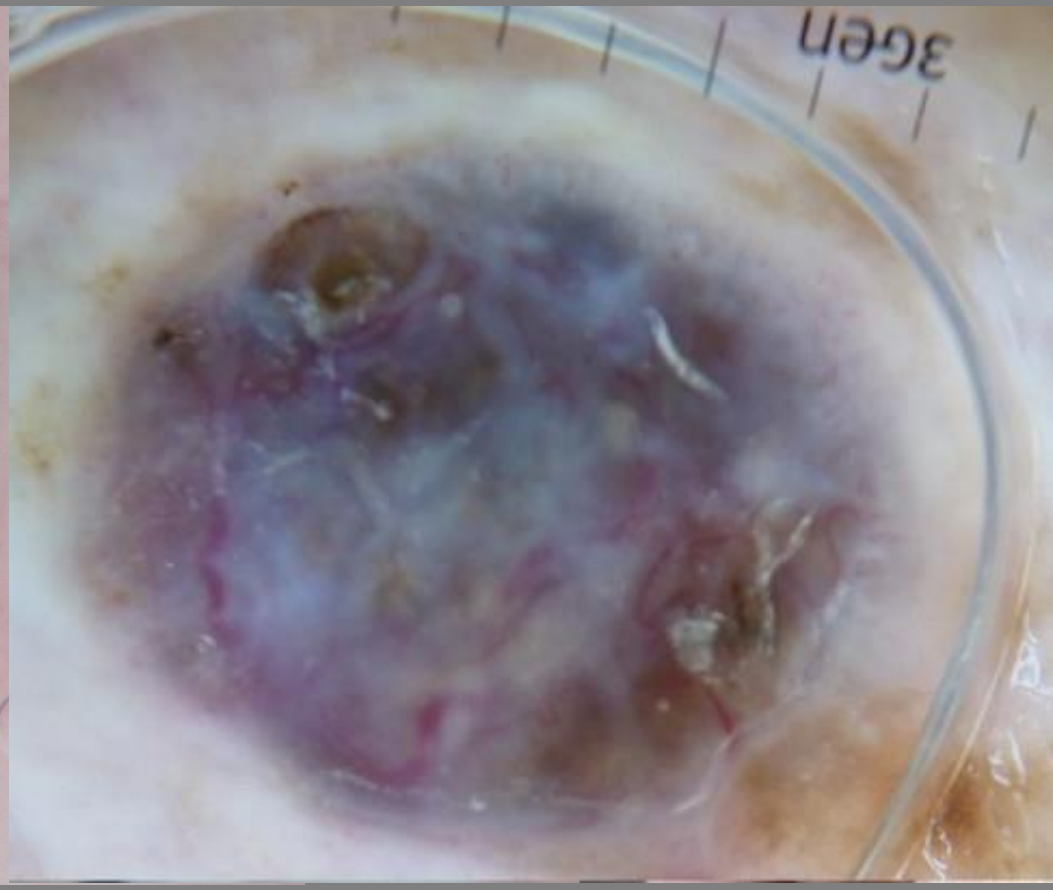


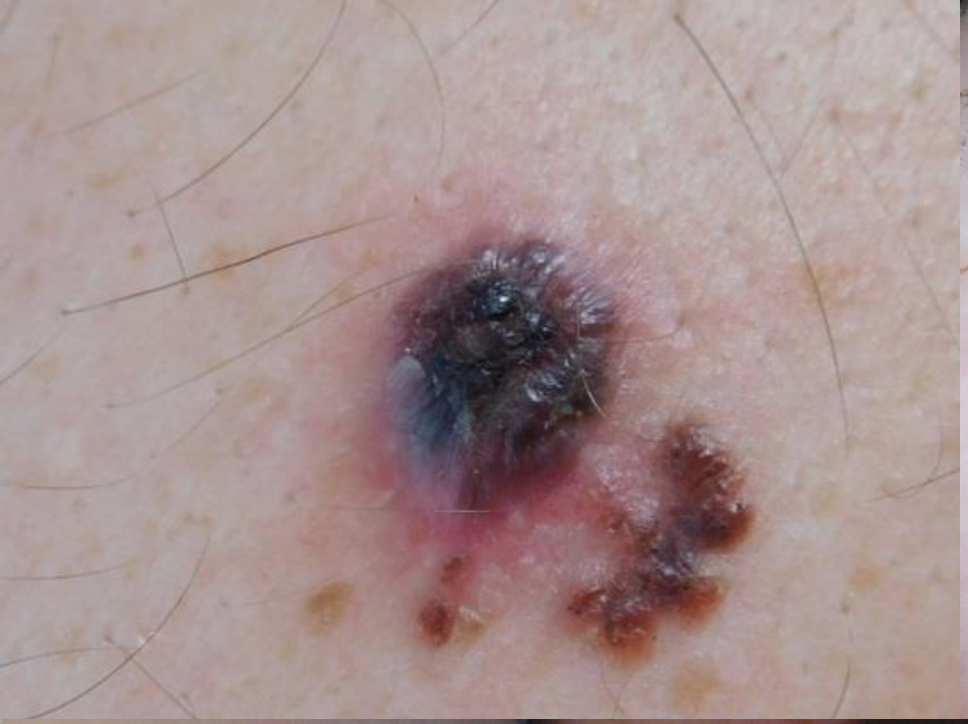
PRIMARY CARE DERMATOLOGY SOCIETY

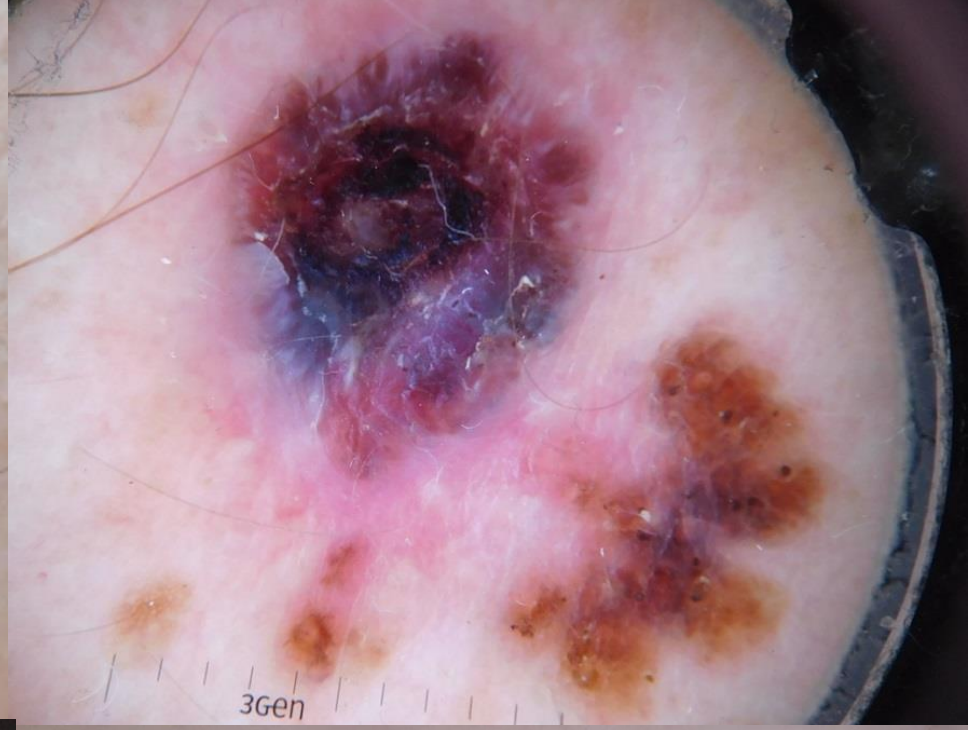
Good

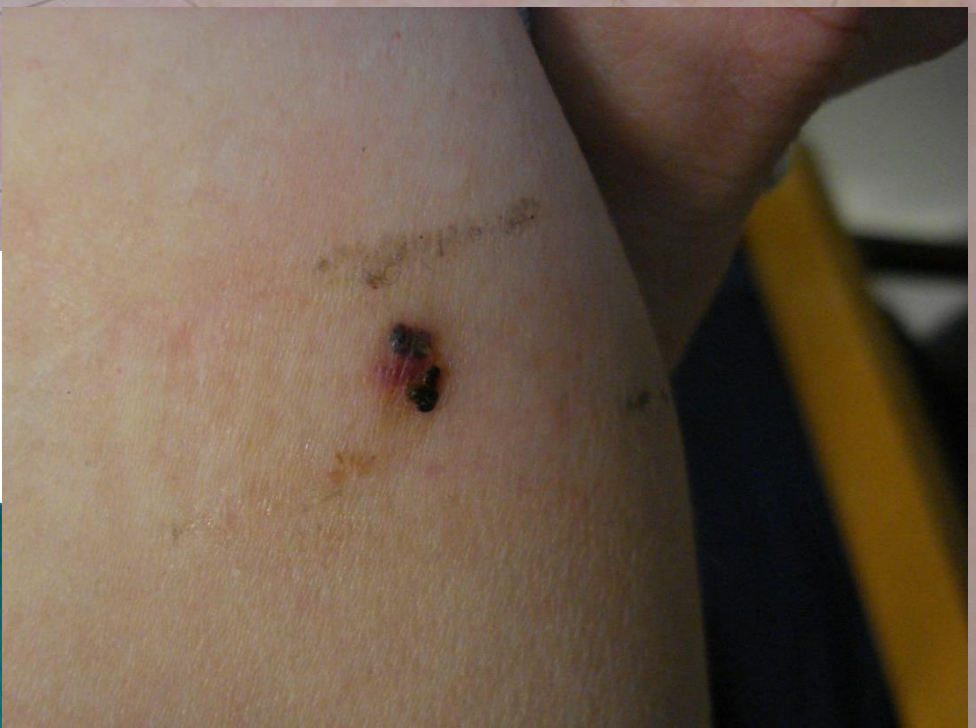


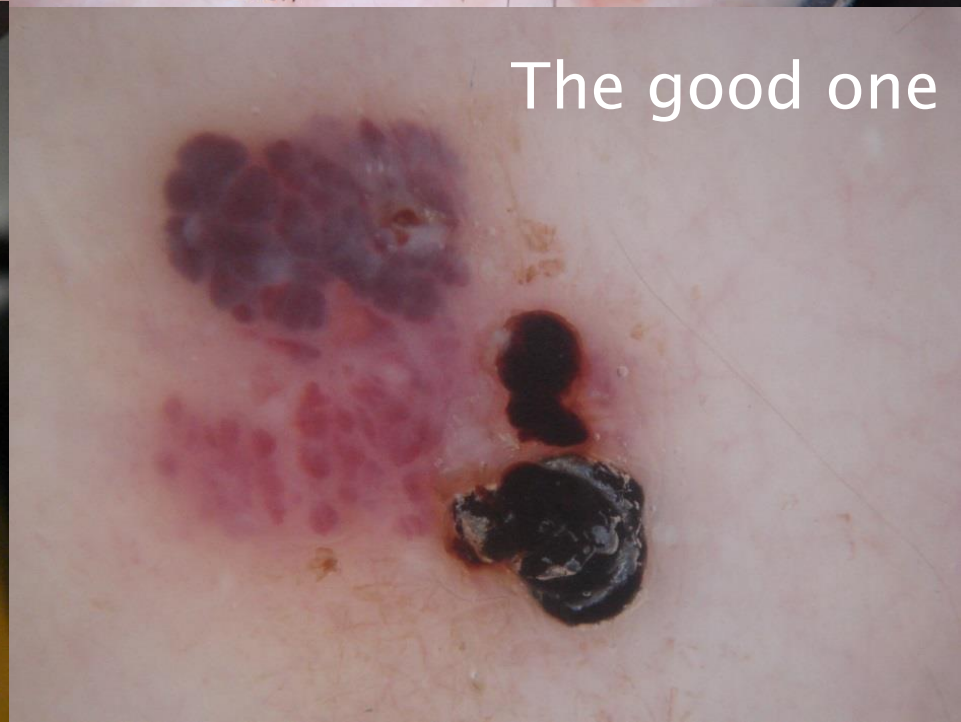
Bad





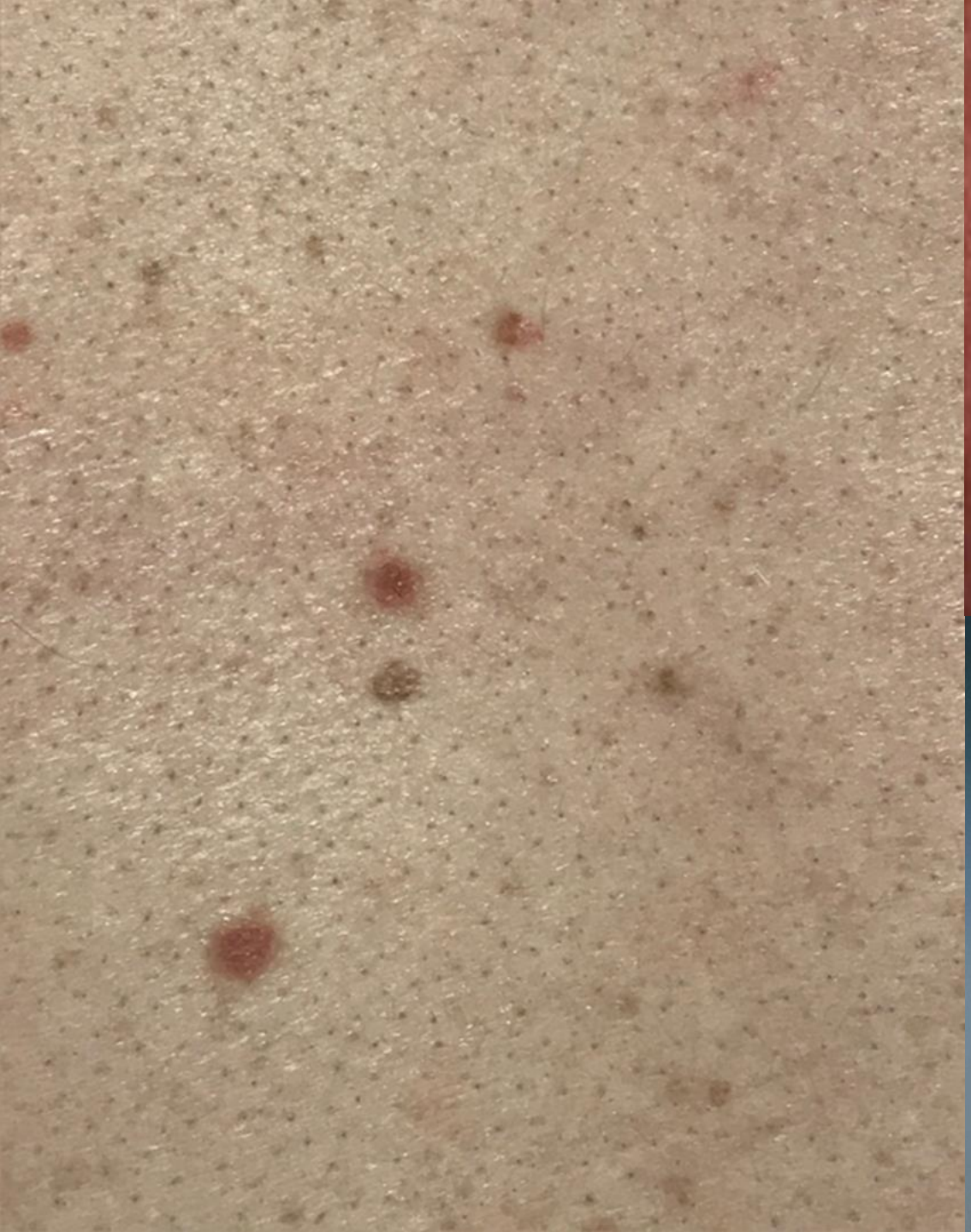


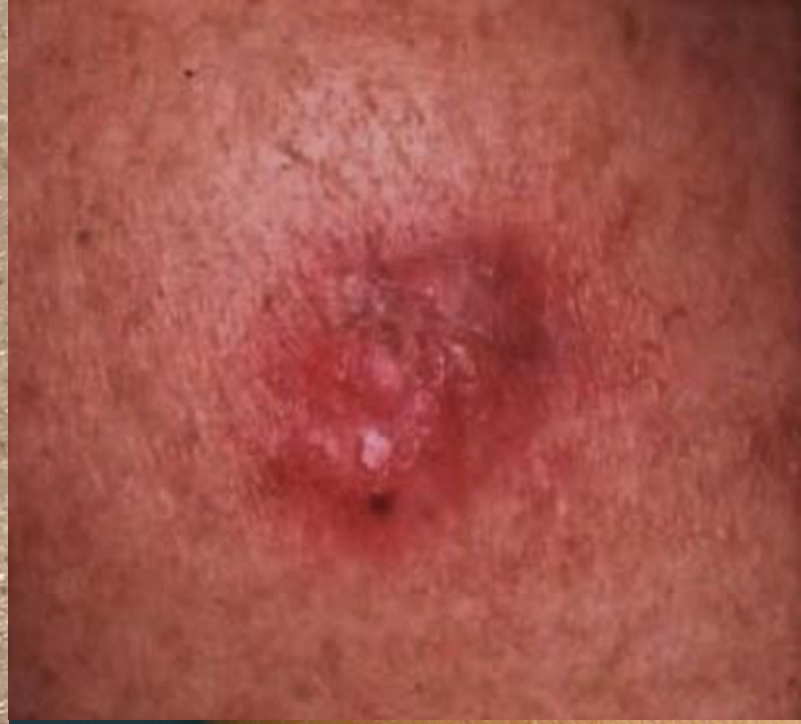


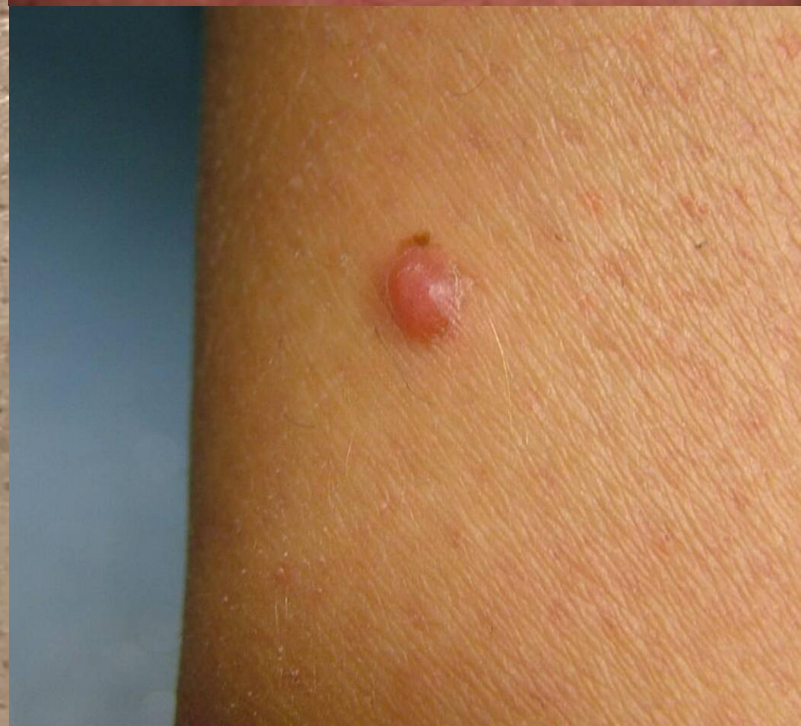


The good one

- Superficial BCC
- Angioma
- Multiple pink, benign melanocytic naevi
- **Hypomelanotic melanoma or Spitz naevus**







- Seborrhoeic keraotses and warts
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- Melanocytic naevi and thin melanomas
- Firm, palpable, benign lesions – small and large
- The EFG rule of skin cancer (solid BCC, SCC, nodular melanoma)
- Pink makes you think (including red and purple)
- **Other lesions of concern requiring urgent referral**
- If we still don't know what it is ….

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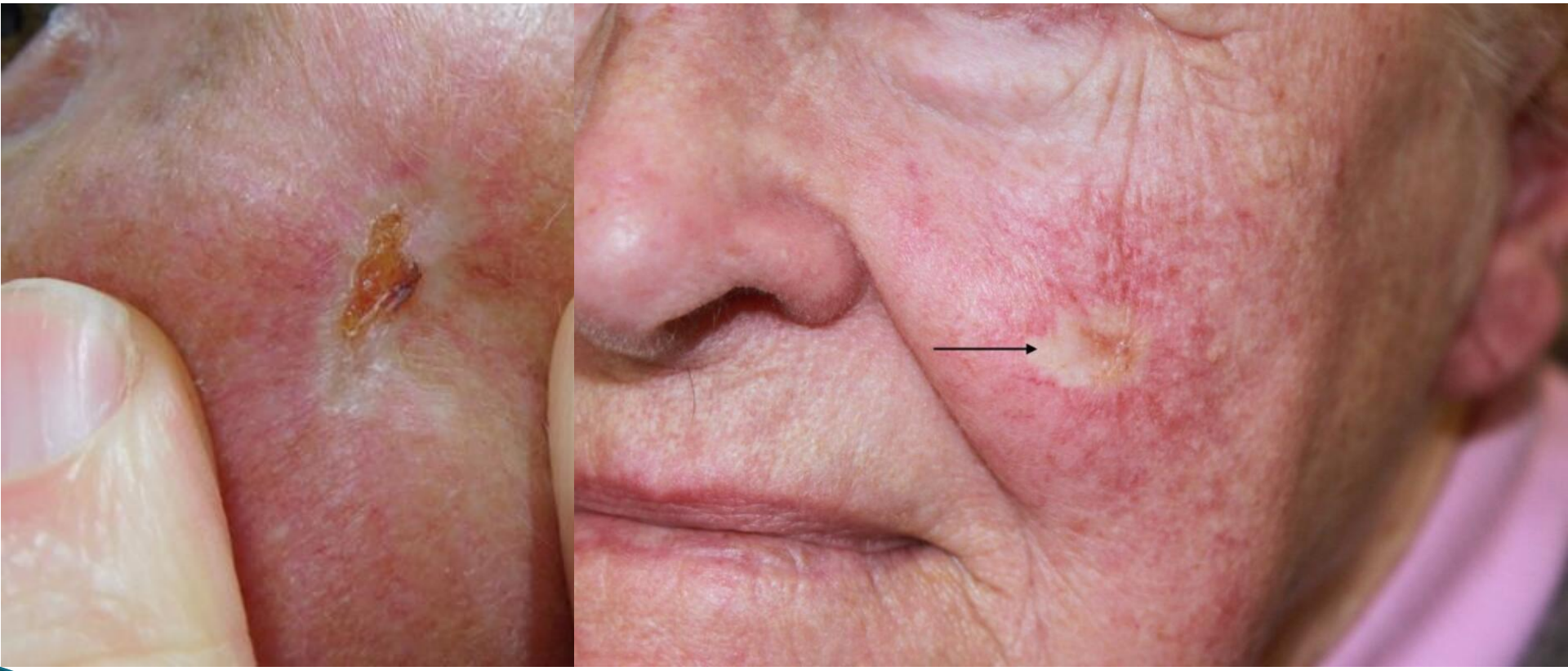
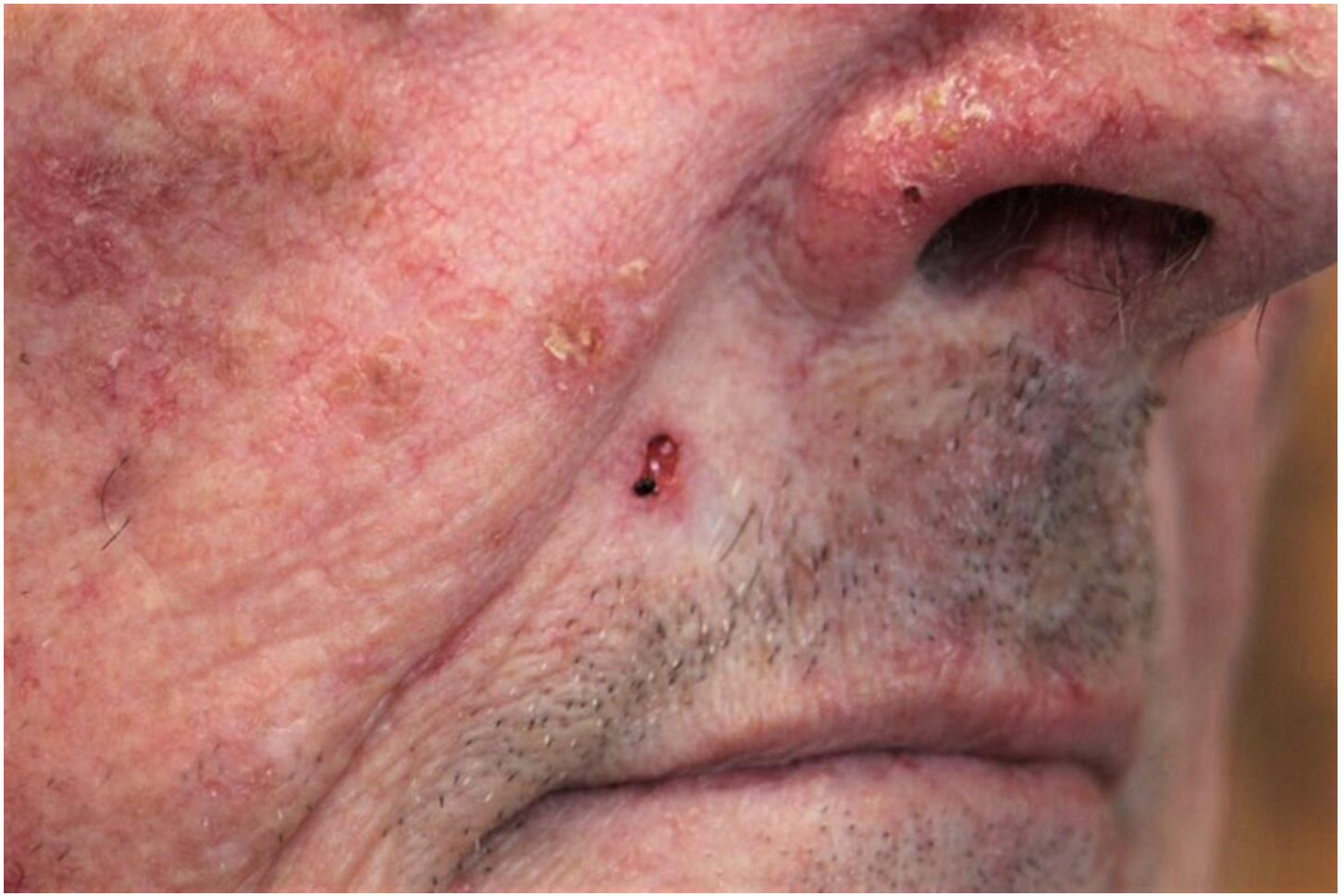
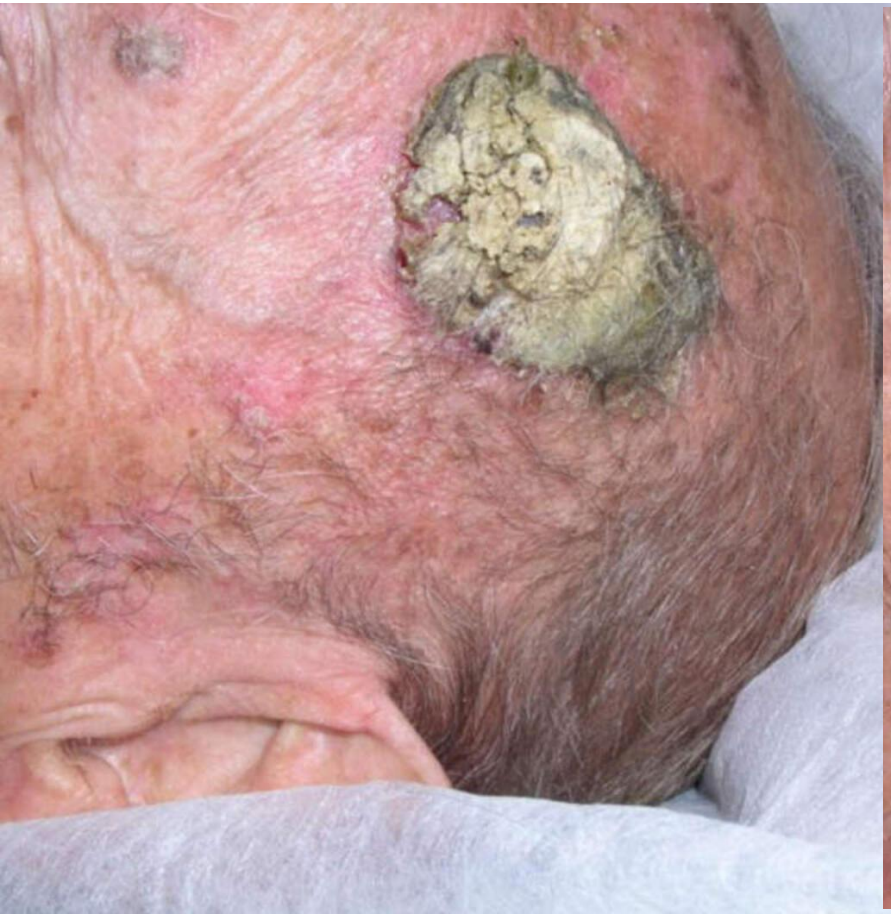
- Infiltrative BCC – a firm white/yellow plaque, often on the central face
- The punched-out ulcer of a poorly differentiated SCC
- What lies beneath a crust could be granulation tissue or malignancy
- Subungual melanoma
- Mucosal and genital lesions

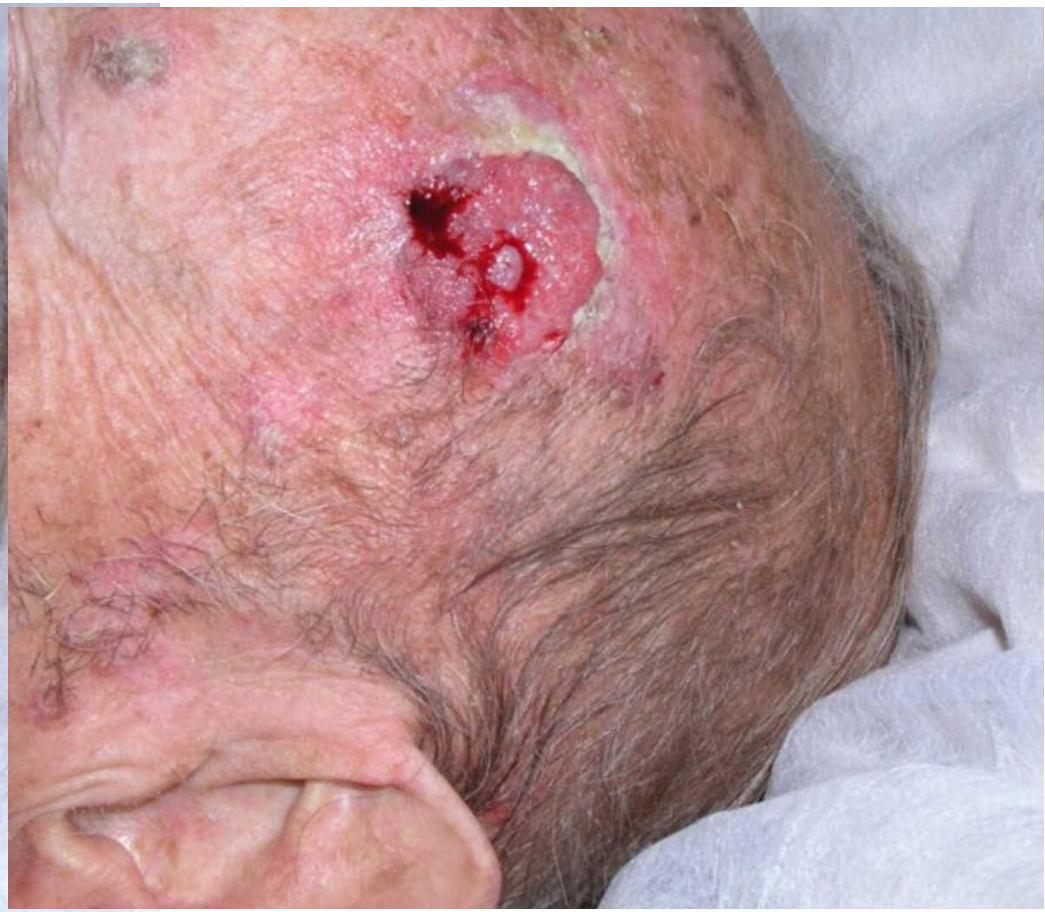
Infiltrative BCC may just look like a scar



Poorly-differentiated SCC







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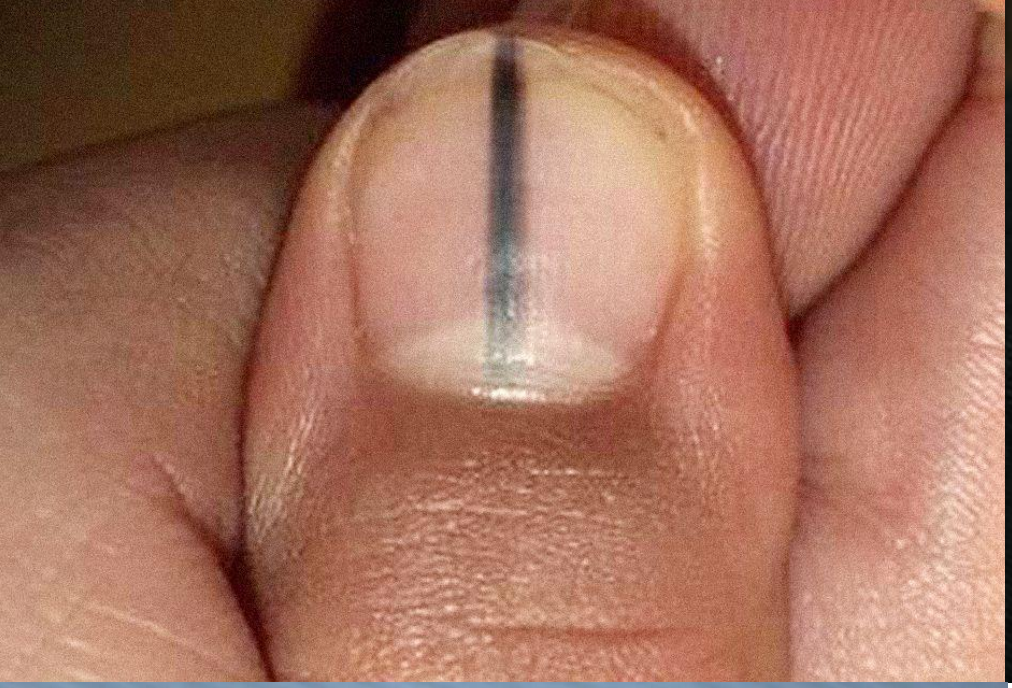
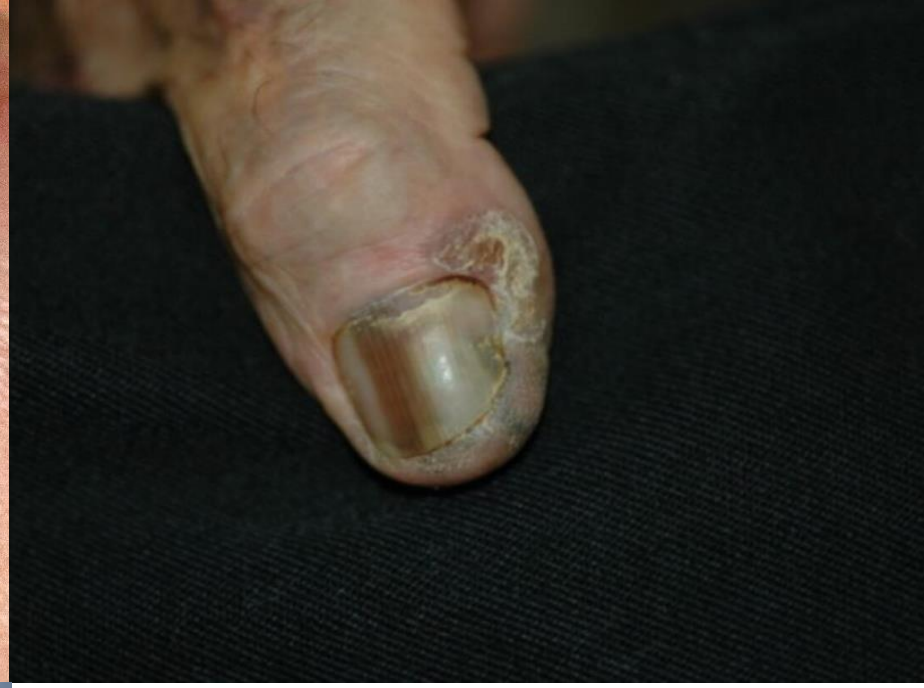
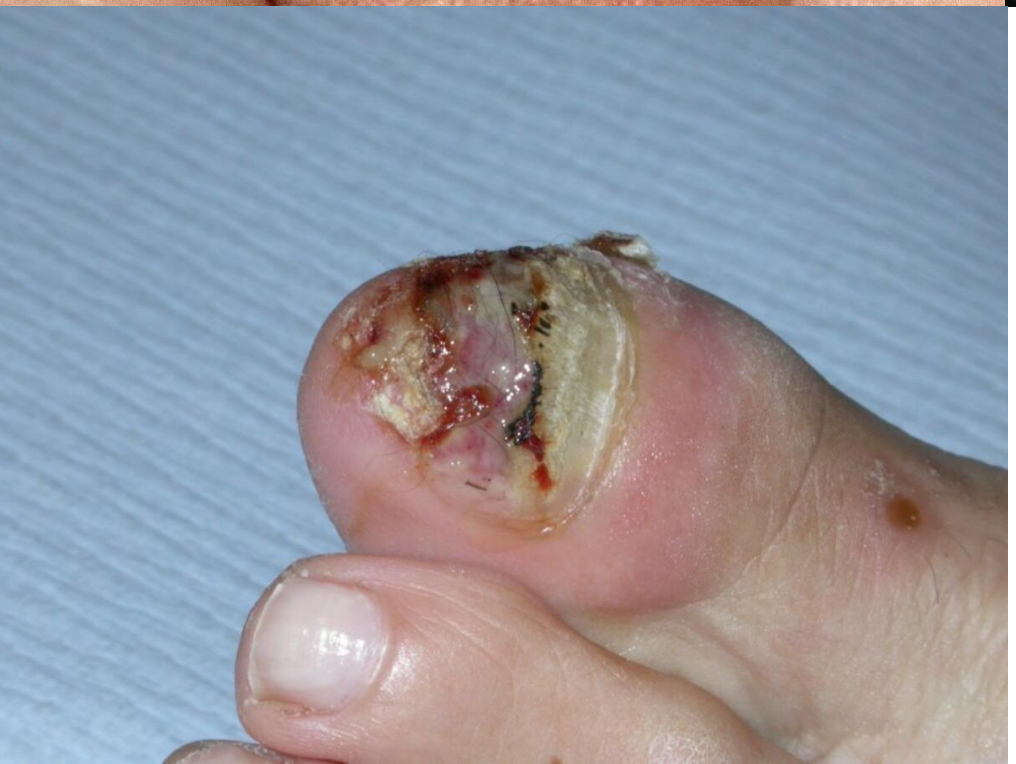
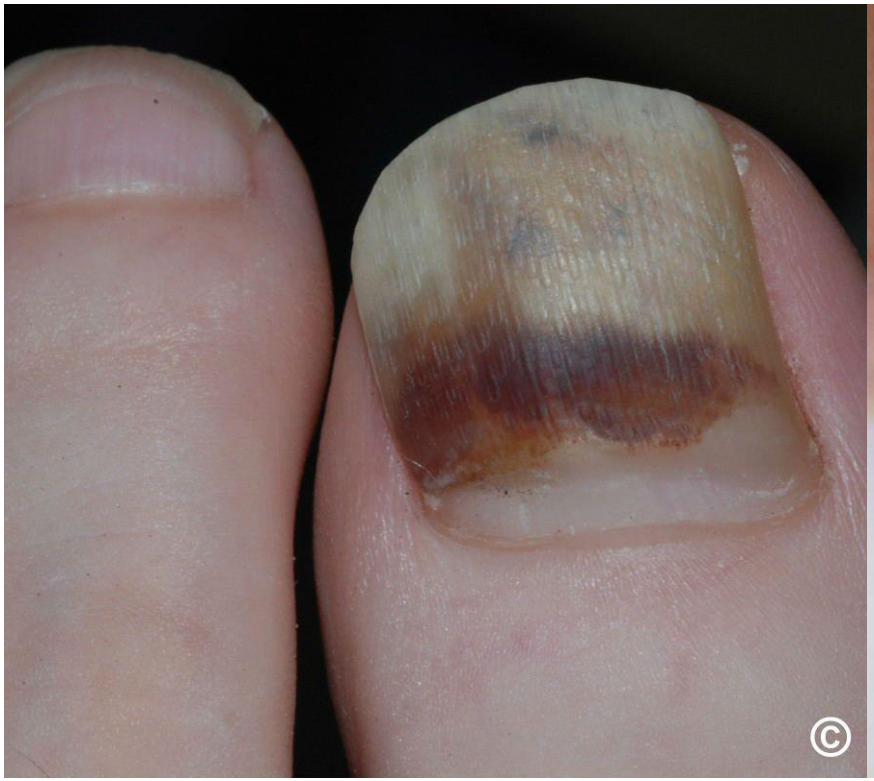




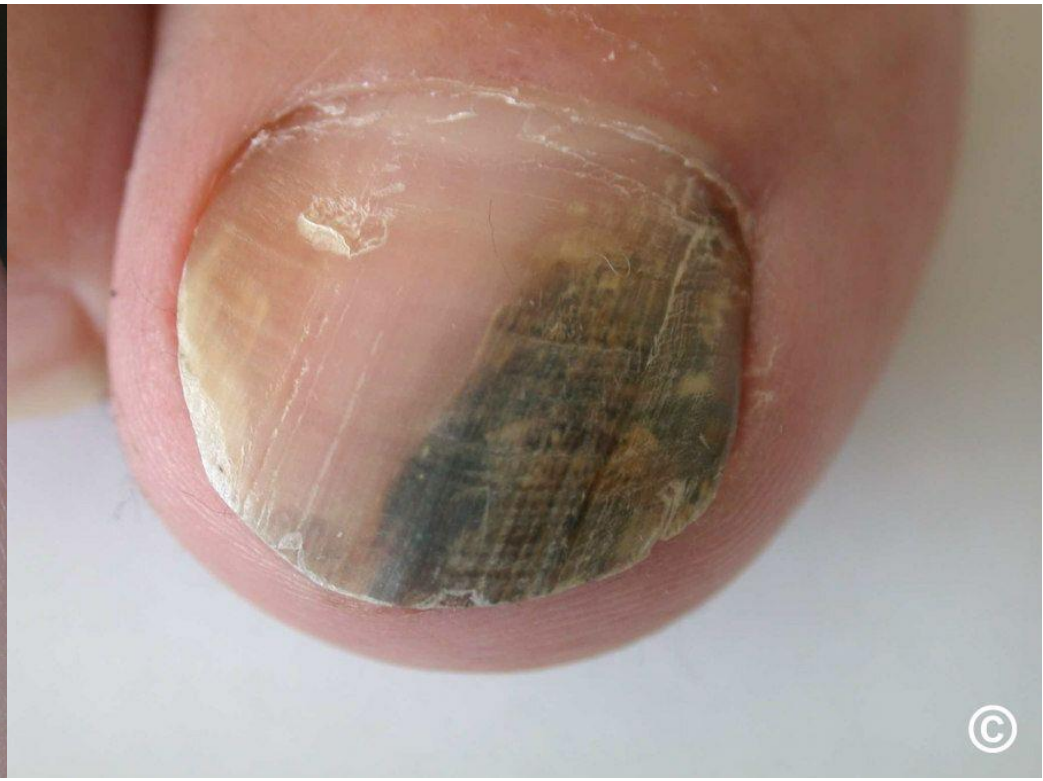


Melanoma

Sunbungual haematoma



Fungal infection – fusarium



Mucosal lesions

- Regular small brown macules – mucosal melanocytic macules
- New / changing lesions on the **lips** that are atypical in size, shape or colour should be referred as 2WW
- Have a low threshold for referring pigmented lesions on the **other mucosal surfaces** as a good history is hard to obtain (genital lesions to gynaecology, oral lesions to orofacial surgery)
- PIN/VIN/SCC – thickening, papule/nodule, ulcer

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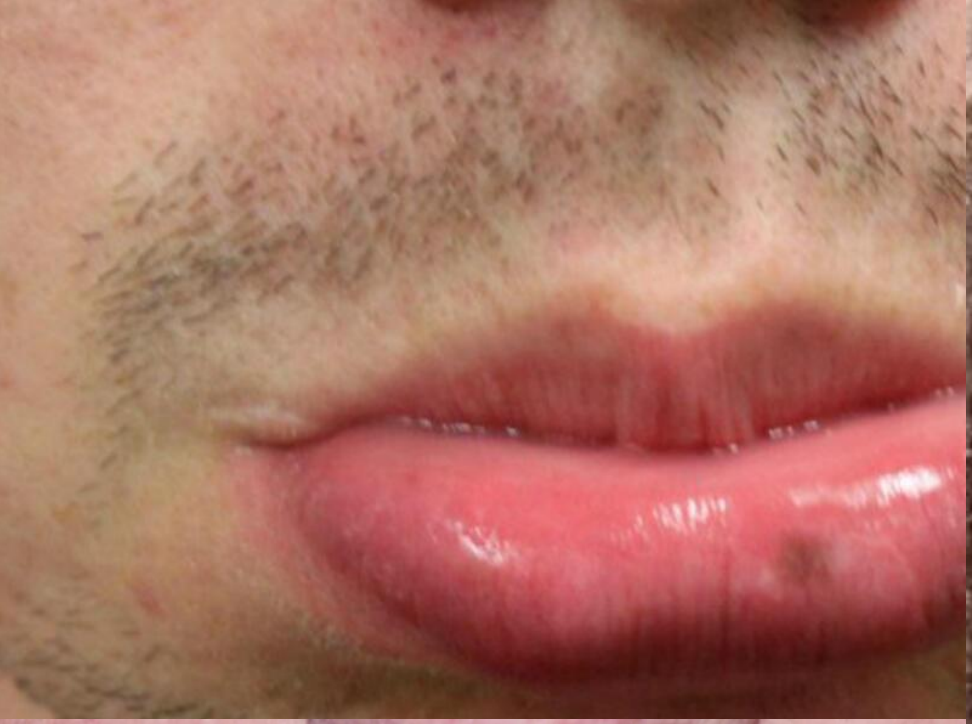

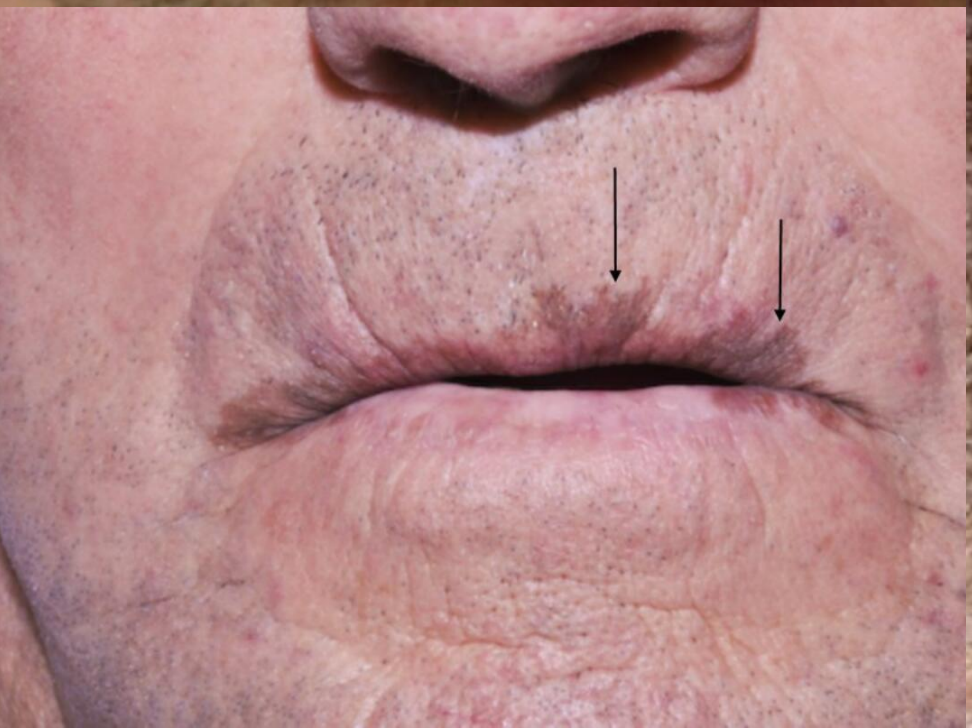

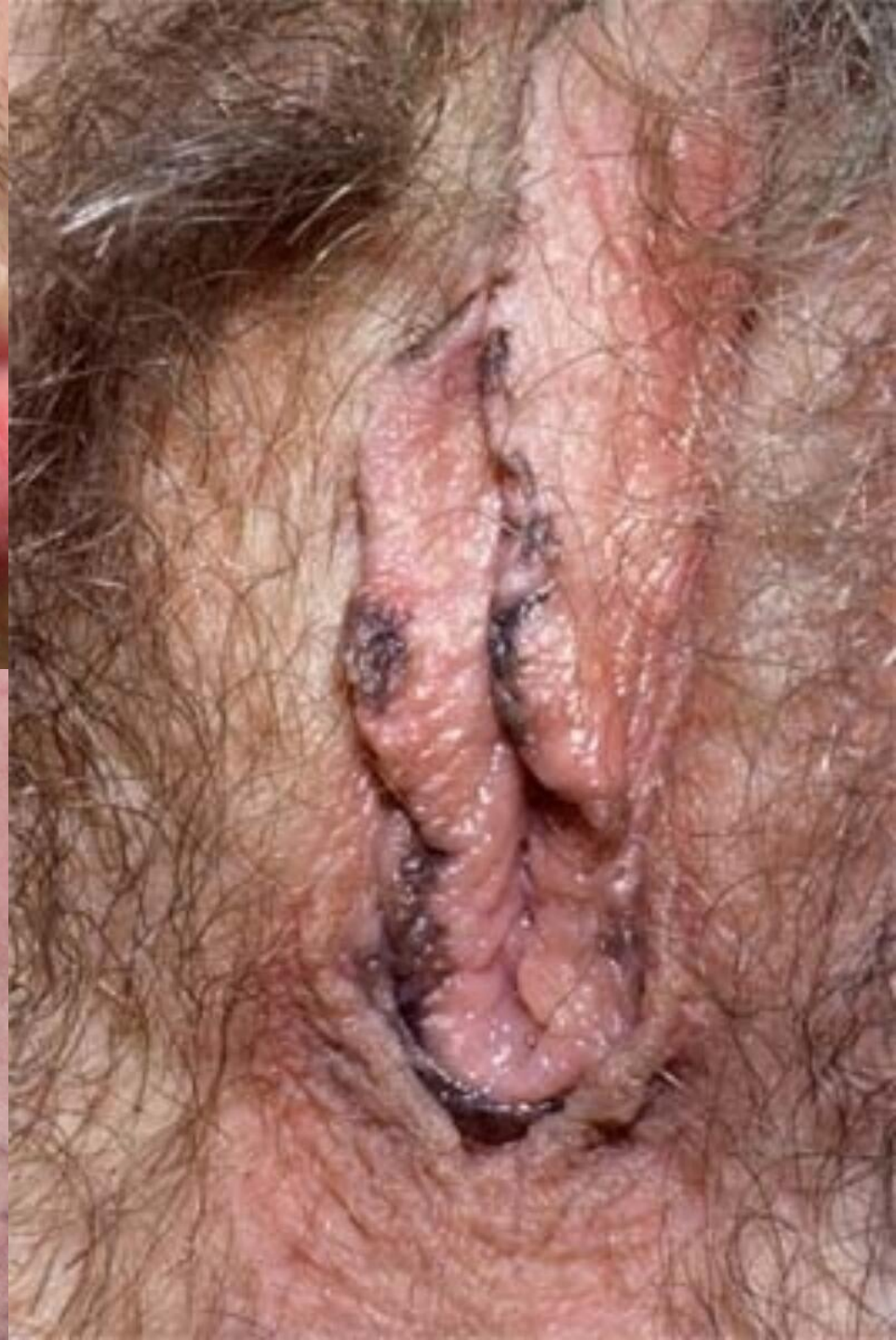

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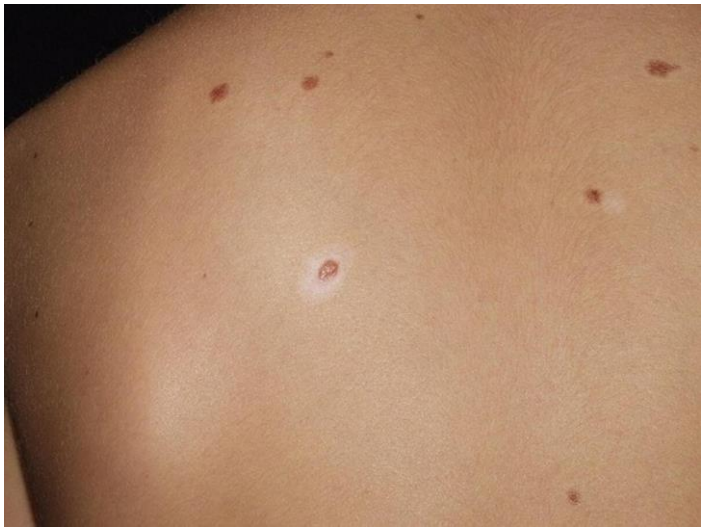
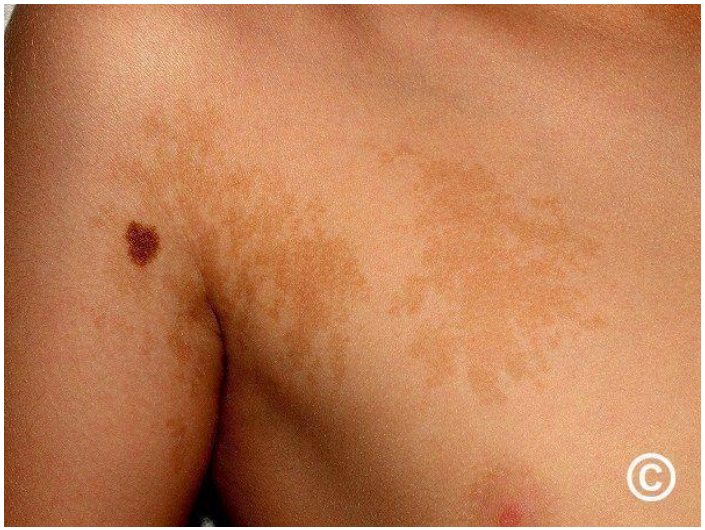
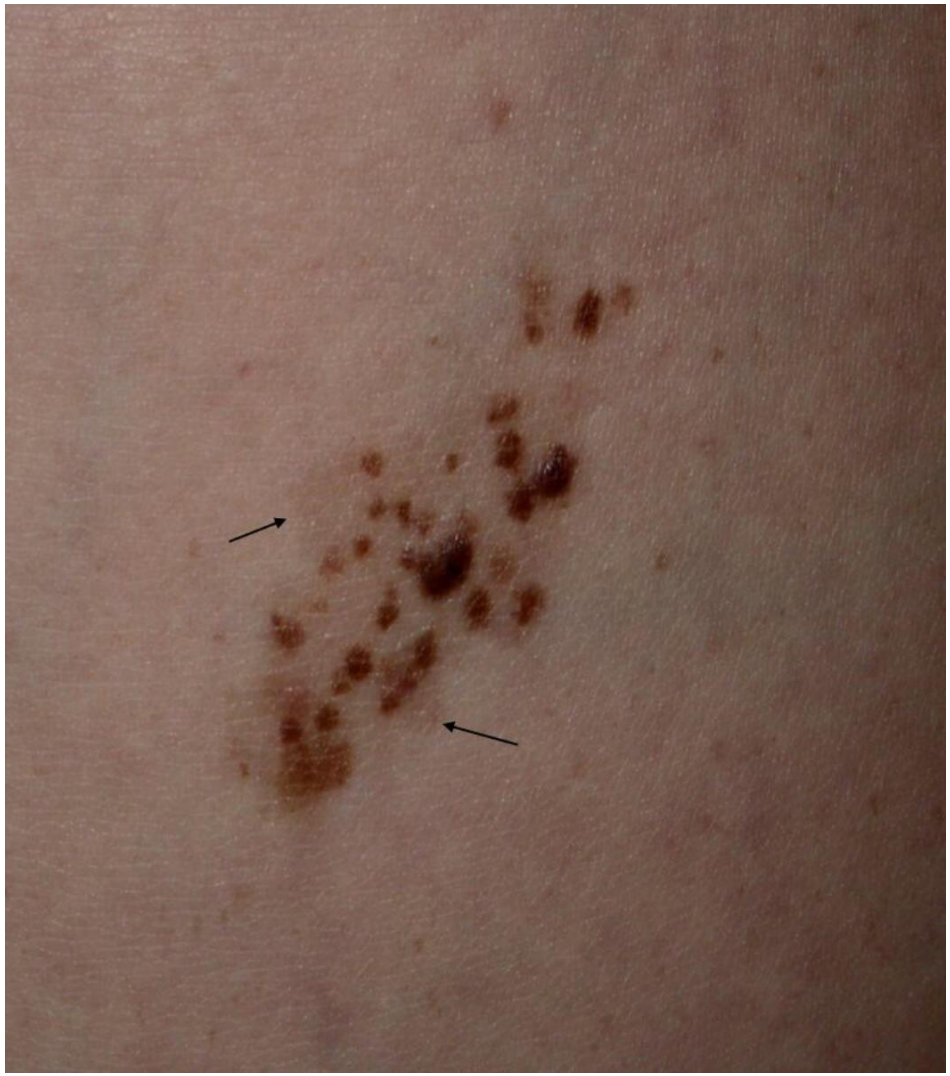
Skin Lesion Diagnostic Tool







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Putting this into practice

Screen out – clinicodermoscopically

Many sebK, angioma, DF, SGH

Clinical recognition of 2WW referrals

ABCD / EFG / Nails / Mucosal

BCC – clinicodermoscopic recognition

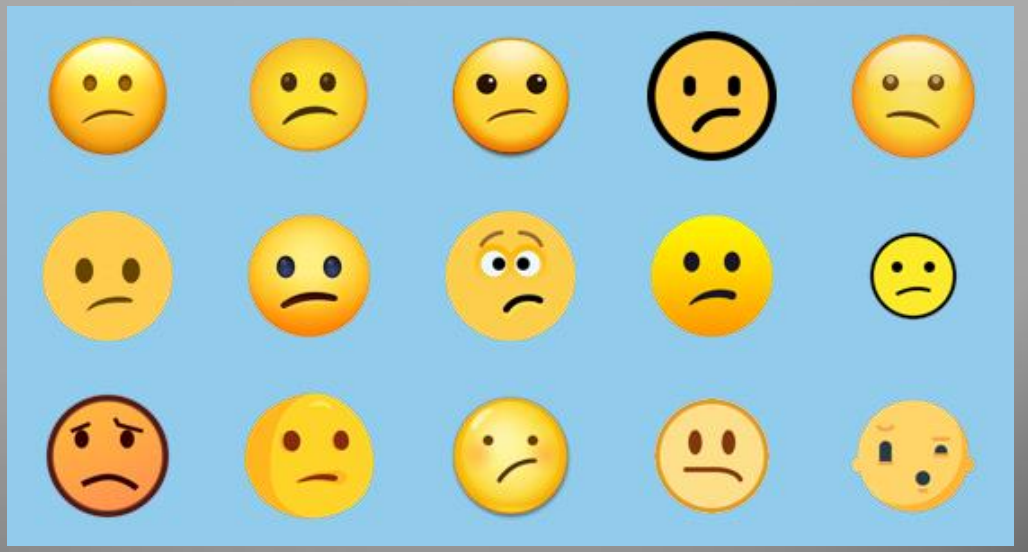
Manage accordingly

Aks / Bowen's

Majority in Primary Care – PCDS website

Teledermoscopy

Diagnostic uncertainty



2WW referral proforma

In Teesside / N.Yorks = Diagnostic confidence of melanoma or SCC

Teesside / N.Yorks non-2WW referral proforma

Group 1 – BCC

Low or high-risk

Group 2 – Diagnosis +/- lesion management

Teledermoscopy

- Relevant melanocytic naevi
- 'Odd seb K'
- ? AK vs BCC
- Unusual skin lesions

Face to Face

- Multiple lesions
- Widespread actinic damage
- Aks needing cryosurgery

Group 3 – Benign & problematic

PAT criteria & form

When/how to refer BCC more urgently – semi-urgent (6-8 weeks) vs 2WW

- Larger lesions especially if on or close to – eyes, nose, lips, ears
- Infiltrative pattern
- A pinkish lump that is not a BCC
- Refer to plastics (eyelids … oculoplastics) – clinical image (or 2WW)

BCC (SOLID)

- Any site
- Grow slower
- Bleed/crust periodically
- Non-tender
- Pearly

SCC

- UV-exposed sites
- Grow more quickly
- Tender
- Many have white/yellow surface keratin (well-differentiated)

Now for the practical session (again)

- **Clinical images** – in focus. Good light and not too close
- **Dermoscopy** – polariased vs non-polarised (sebK's)
- **Dermoscopic images (DL4):**
  - Small amount of gel on the lesion
  - Extend scope so no shadow
  - Rest gently on the lesion
  - Use the phone screen to zoom in
  - Transfer of images and file size
  - Multiple lesions

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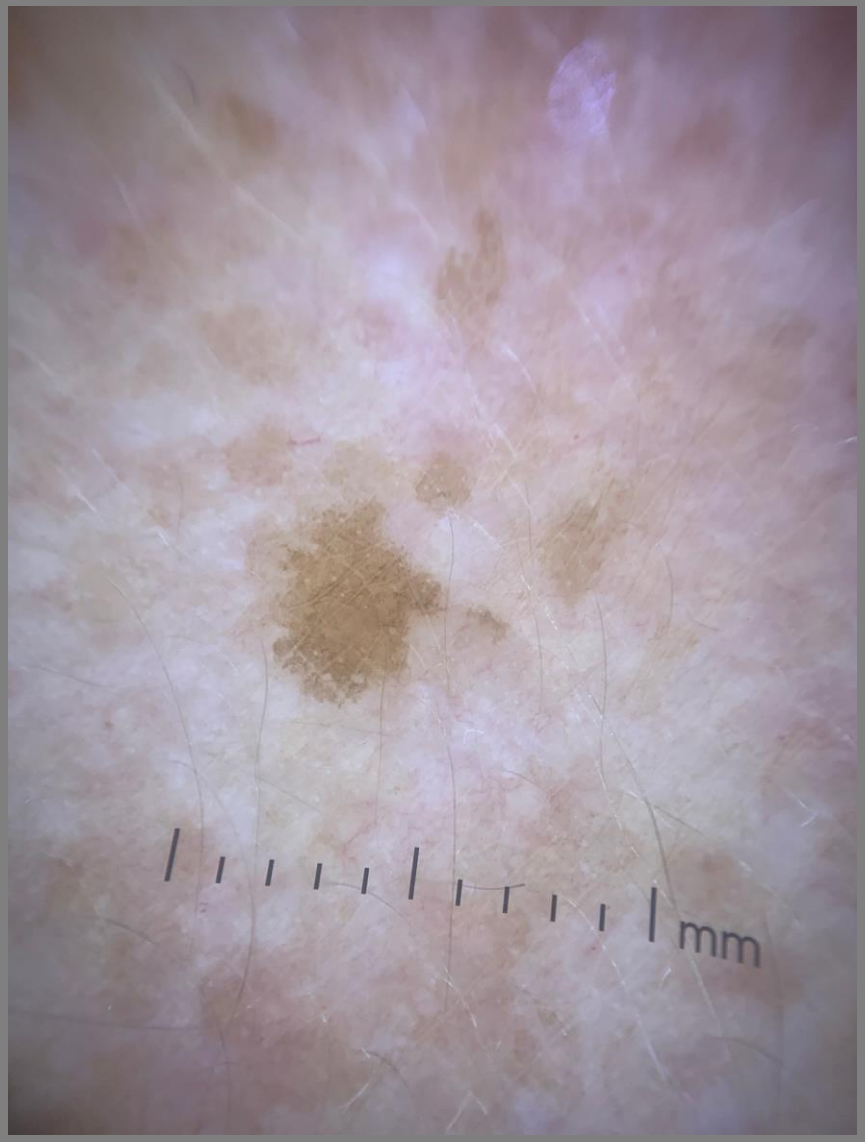
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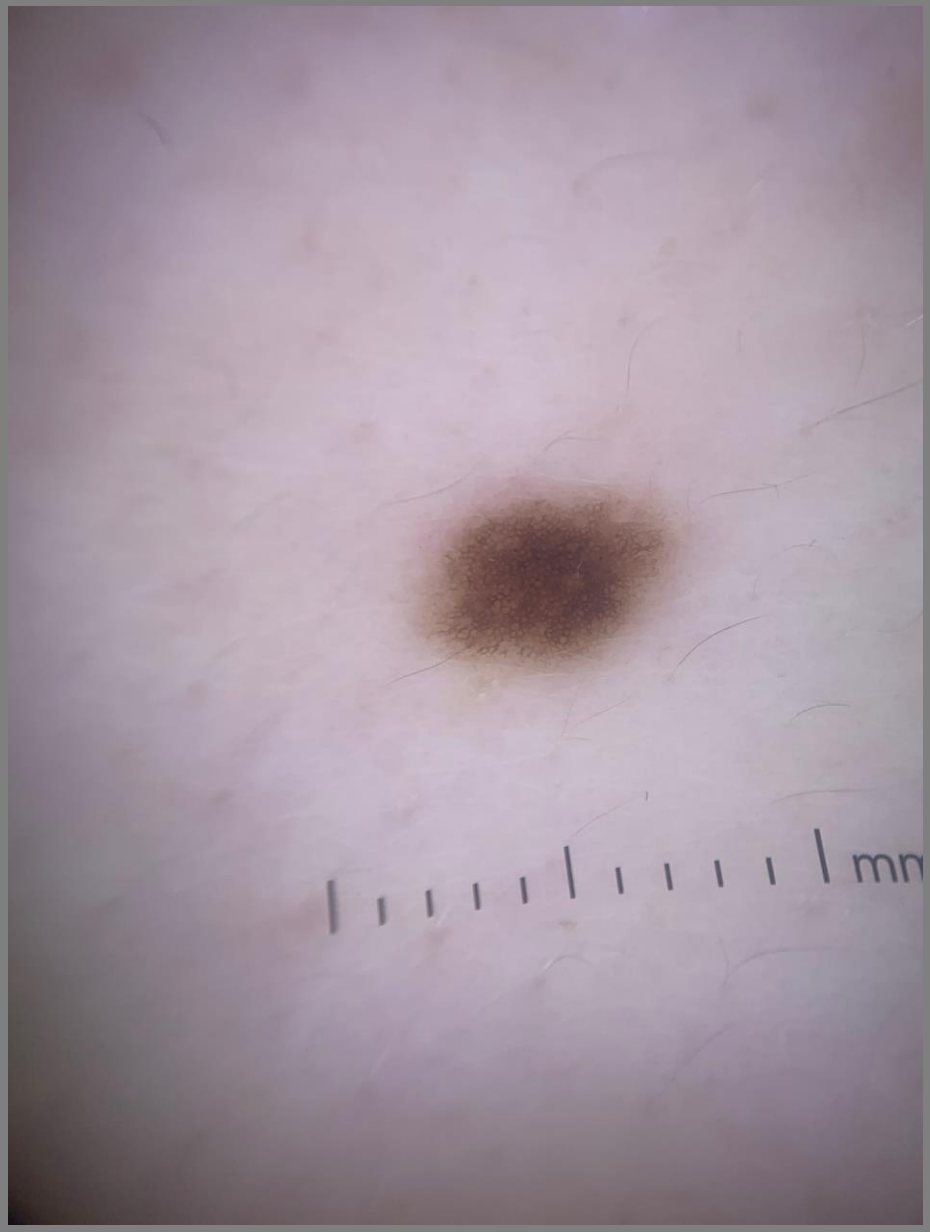
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Teesside Teledermoscopy Service

- Reviewed within 7 days
- We take over patient care where appropriate
- We recommend treatment where appropriate
- Letter back to GP with images – education
- Patient informed
- Reimage ☺
- Who else can take image – HCA and/or network
- Happy to support training
- Recorded session – please liaise with VTS
- Joined up working – in the best interest of the patient and health economy

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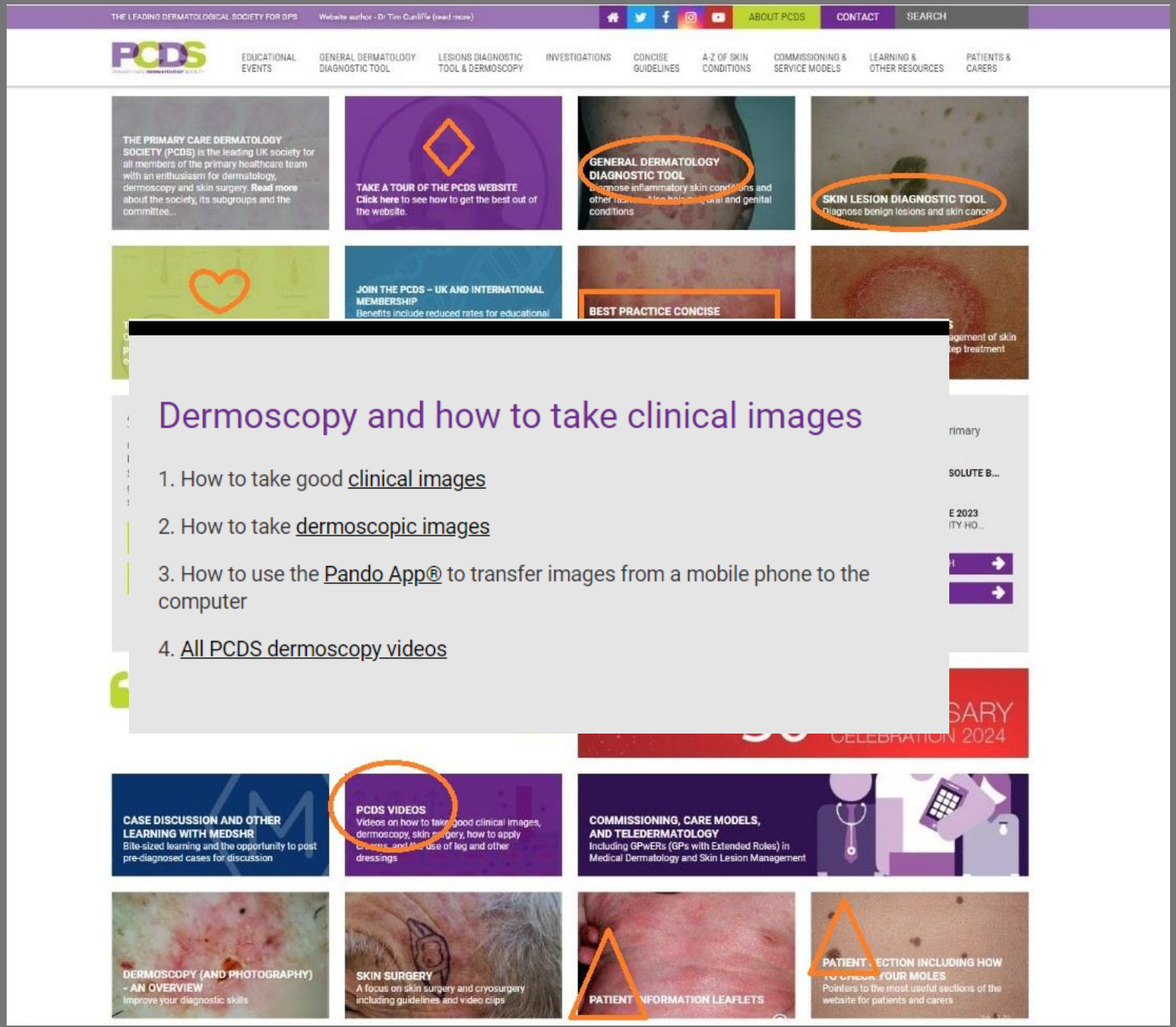
PRIMARY CARE DERMATOLOGY SOCIETY


THE LEADING DERMATOLOGICAL SOCIETY FOR GPS
Website author - Dr Tim Cunliffe (read more)
ABOUT PCDS
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PCDS
EDUCATIONAL EVENTS
GENERAL DERMATOLOGY DIAGNOSTIC TOOL
LESIONS DIAGNOSTIC TOOL & DERMOSCOPY
INVESTIGATIONS
CONCISE GUIDELINES
A-Z OF SKIN CONDITIONS
COMMISSIONING & SERVICE MODELS
LEARNING & OTHER RESOURCES
PATIENTS & CARERS
THE PRIMARY CARE DERMATOLOGY SOCIETY (PCDS) is the leading UK society for all members of the primary healthcare team with an enthusiasm for dermatology, dermoscopy and skin surgery. Read more about the society, its subgroups and the committee...
TAKE A TOUR OF THE PCDS WEBSITE
Click here to see how to get the best out of the website.
GENERAL DERMATOLOGY DIAGNOSTIC TOOL
SKIN LESION DIAGNOSTIC TOOL
Diagnose benign lesions and skin cancer
JOIN THE PCDS – UK AND INTERNATIONAL MEMBERSHIP
Benefits include reduced rates for educational
BEST PRACTICE CONCISE
Dermoscopy and how to take clinical images
1. How to take good clinical images
2. How to take dermoscopic images
3. How to use the Pando App® to transfer images from a mobile phone to the computer
4. All PCDS dermoscopy videos
CASE DISCUSSION AND OTHER LEARNING WITH MEDSHR
Bite-sized learning and the opportunity to post pre-diagnosed cases for discussion
PCDS VIDEOS
Videos on how to take good clinical images, dermoscopy, skin surgery, how to apply
COMMISSIONING, CARE MODELS, AND TELEDERMATOLOGY
Including GPwERs (GPs with Extended Roles) in Medical Dermatology and Skin Lesion Management
DERMOSCOPY (AND PHOTOGRAPHY) - AN OVERVIEW
Improve your diagnostic skills
SKIN SURGERY
A focus on skin surgery and cryosurgery including guidelines and video clips
PATIENT INFORMATION LEAFLETS
Pointers to the most useful sections of the website for patients and carers

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