key points

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Dermoscopy as a clinical tool was developed primarily to evaluate pigmented lesions, particularly suspected melanoma. It is also useful in many other clinical situations, including the evaluation of a variety of benign and malignant skin tumours, inflammatory conditions, hair disorders, connective tissue diseases, and common infections and infestations.

Melanomas can vary considerably in clinical and dermoscopic appearance, but there is almost always asymmetric pigmentation together with other characteristic features. Benign lesions that can be confused with melanoma include seborrhoeic keratoses, melanocytic naevi, angiomas and dermatofibromas. Basal cell carcinoma is the most common malignant tumour of the skin. It can usually be diagnosed on dermoscopy by a characteristic pattern of arborising vessels.

Subtle pustulation seen on dermoscopy may confirm palmoplantar pustulosis. Visualisation of micropustules on the face on a background of telangiectasia enables a diagnosis of rosacea. Follicular plugging may contribute to a diagnosis of discoid lupus erythematosus.

Dermoscopy also has a role in the evaluation of certain hair disorders. Exclamation mark hairs in alopecia areata are readily visualised, as is the miniaturisation of hairs that typifies androgenetic alopecia and the perifollicular inflammation that is characteristic of frontal fibrosing alopecia.

The dermatoscope can be attached directly to a digital camera or a dedicated dermatoscopic lens can be obtained for a camera. Adequate images can also be captured extremely easily and quickly by a smartphone encased in a connection kit, which locks onto the dermatoscope. Images can be archived or exported for a second opinion and can also be shown to, and discussed with, the patient.