

COMMENTARY

Deepening the observation of mycosis fungoides through dermoscopy: definition of the dermoscopic profiles of its progression stages and variants

Dermoscopy is known to improve the accuracy in the diagnosis of many dermatological disorders.¹ Moreover, it has the prerogative of being a tool, which is very familiar to the dermatologist and of daily use in clinical practice. By virtue of the aforementioned features, its application in the dermatological field is constantly expanding, being currently used to support the diagnosis of pigmentary, inflammatory, infectious, adnexal and non-melanocytic tumour disorders.²

With reference to the latter area, Errichetti and Colleagues of the International Dermoscopy Society have recently published their work with the aim to define the main dermoscopic features of the various stages of classic mycosis fungoides (MF), as well as of some rarer MF subtypes, such as folliculotropic, poikilodermatous and erythrodermic subtypes.³ The authors retrospectively analysed 118 histologically proven MF lesions, which included 75 classic MF lesions (24 patches, 23 plaques and 28 tumour lesions), 26 folliculotropic, 9 erythrodermic and 8 poikilodermatous MF. Presence, morphology, arrangement and colour of five dermoscopic parameters were recorded and assessed. A dermoscopic-histopathological correlation was carried out in selected cases as well.

Following this methodological approach, the authors defined a dermoscopic profile for each stage and variant of MF. In a nutshell, dermoscopic observation should pay particular attention to the vascular pattern and the presence of scales in discriminating the different stages of progression from patches to tumour MF. Bright white structureless areas are found in more advanced stages. Follicular findings should be focused in the case of folliculotropic MF; it is worth noting that dilated follicles and lack of hairs are the most distinctive features of this variant. Linear/dotted vessels, patchy white scales and focal orange structureless areas may suggest the diagnosis of MF in the case of erythroderma, whereas a 'checkerboard' pattern together with white patchy scales and brown reticular lines are typical dermoscopic features of poikilodermatous MF.

The paper by Errichetti and Colleagues provides practical support for the diagnostic process of MF with particular regard to its different stages and rarest variants, which have been poorly addressed so far.^{4,5} By observing MF through the lens of

dermoscopy, the authors defined the most sensitive and specific dermoscopic clues for each MF subtype. The combination of dermoscopic, clinical and history features highly increases the probability of promptly undertaking the most appropriate diagnostic path which, in the case of suspected MF, must lead to a confirmatory skin biopsy.

My personal hope is that dermoscopy could be ever more applied to most of the various dermatological conditions and provide a robust semeiotic armamentarium, to be complemented and integrated with traditional clinical semeiotics, for the training of dermatologists of today and tomorrow.

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Conflicts of interest

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Data availability statement

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