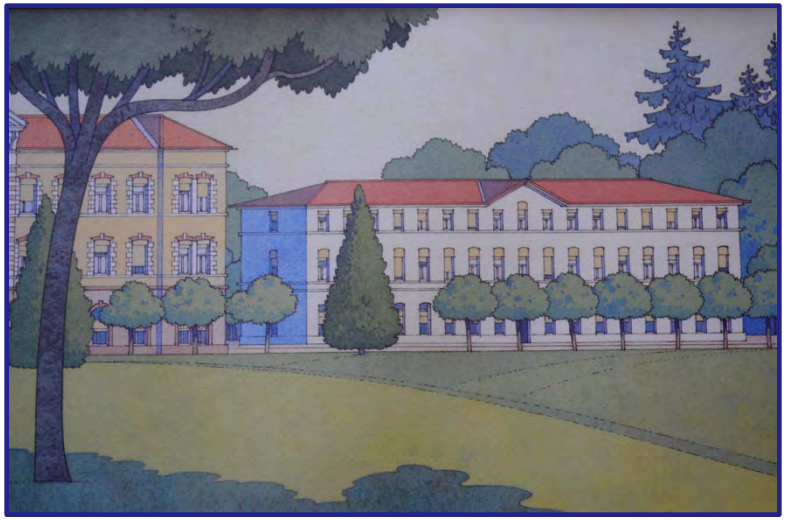

Dermoscopie en Médecine de Proximité

(Pourquoi ? Comment ? Et après ?)

Luc THOMAS

Service de Dermatologie
Centre Hospitalier Lyon Sud
Centre de recherche sur le cancer de Lyon (Pr Mehlen)
INSERM U1052 - CNRS UMR5286
Université Claude Bernard, Lyon 1
Lyon, France

Conflits d'intérêt

- Employé à temps plein du ministère de l'Enseignement Supérieur et de la Recherche. Pas d'activité libérale. Pas de lien financier personnels avec l'industrie pharmaceutique ou d'appareillage médical
- Investigateur Principal ou Associé bénévole dans des essais cliniques en onco-dermatologie exclusivement(VICAL, ROCHE, GSK, BMS, INTUISKIN, PIXIENCE, NOVARTIS, GENENTECH, GALDERMA, MERCK-SERONO, FLAMEL TECHNOLOGIES, TEACHSCREEN, FOTOFINDER, HEINE, ONCOMECA, SQUAREMIND) pas d'honoraires personnels.
- Auteur (avec droits) de :
  - « Atlas de Dermoscopie » RP Braun et L Thomas Elsevier Masson Paris 2007 (Français Portugais et Polonais)
  - « Précis de dermatologie et IST » JH Saurat, D Lipsker, L Thomas, L Borradori et JM Lachapelle 6eme édition, Elsevier, Masson, Paris 2017 (French & Italian)
  - «Diseases of the nail and their management, 4th edition» R Baran, D de Berker, M Holzberg, B Richert & L Thomas Willey-Blackwell, London 2019
  - «Dermatologie chirurgicale 2nd edition» JM Amici, D Egasse, M Beylot Barry et L Thomas Elsevier Masson Paris 2017
  - « Manuel de Dermoscopie » L Thomas Elsevier Masson Paris 2022 (Français)

Transparence santé

Base Transparence Santé

Accueil • Recherche par bénéficiaire • Résultats •

Résultats des déclarations par bénéficiaire

23/05/2022

Afficher les Avantages | Afficher les Conventions | Afficher les Rémunérations

15 Avantage(s) correspondant à votre sélection

Bénéficiaire	Type de bénéficiaires	Entreprise	Date	Nature	Montant	
THOMAS Luc	Médecin	ConsuMed Research	04/11/2015	Autre : Indemnite	120 €	Détail
THOMAS LUC	Médecin	NAOS	11/02/2016	REPAS	19 €	Détail
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THOMAS LUC	Médecin	BRISTOL-MYERS SQUIBB	11/03/2016	Transport	530 €	Détail
THOMAS LUC	Médecin	BRISTOL-MYERS SQUIBB	07/04/2016	Repas	47 €	Détail
THOMAS LUC	Médecin	NAOS	14/04/2016	REPAS	21 €	Détail
THOMAS LUC	Médecin	ICOMED	12/05/2016	Autre: [Enquête]	25 €	Détail
THOMAS LUC	Médecin	NAOS	07/04/2017	Repas	49 €	Détail
THOMAS LUC	Médecin	NAOS	13/04/2017	Repas	24 €	Détail
THOMAS LUC	Médecin	NAOS	14/06/2017	Repas	50 €	Détail
THOMAS LUC	Médecin	NAOS	07/09/2017	Repas	26 €	Détail
THOMAS LUC	Médecin	COSMETIQUE ACTIVE FRANCE	29/03/2018	REPAS	78 €	Détail
THOMAS LUC	Médecin	galderma international	01/03/2019	Déjeuner	35 €	Détail
THOMAS LUC	Médecin	galderma international	04/04/2019	Déjeuner	25 €	Détail
THOMAS LUC	Médecin	galderma international	04/04/2019	Acheminement	202 €	Détail

Financements

- Université Claude Bernard Lyon 1 et Hospices Civils de Lyon
- Ligue contre le cancer du Rhône and de l'Ain
- Association Vaincre le Mélanome
- Fonds gérés direction de la recherche clinique des Hospices Civils de Lyon (sous contrôle de la cour des comptes)


DREAM TEAM

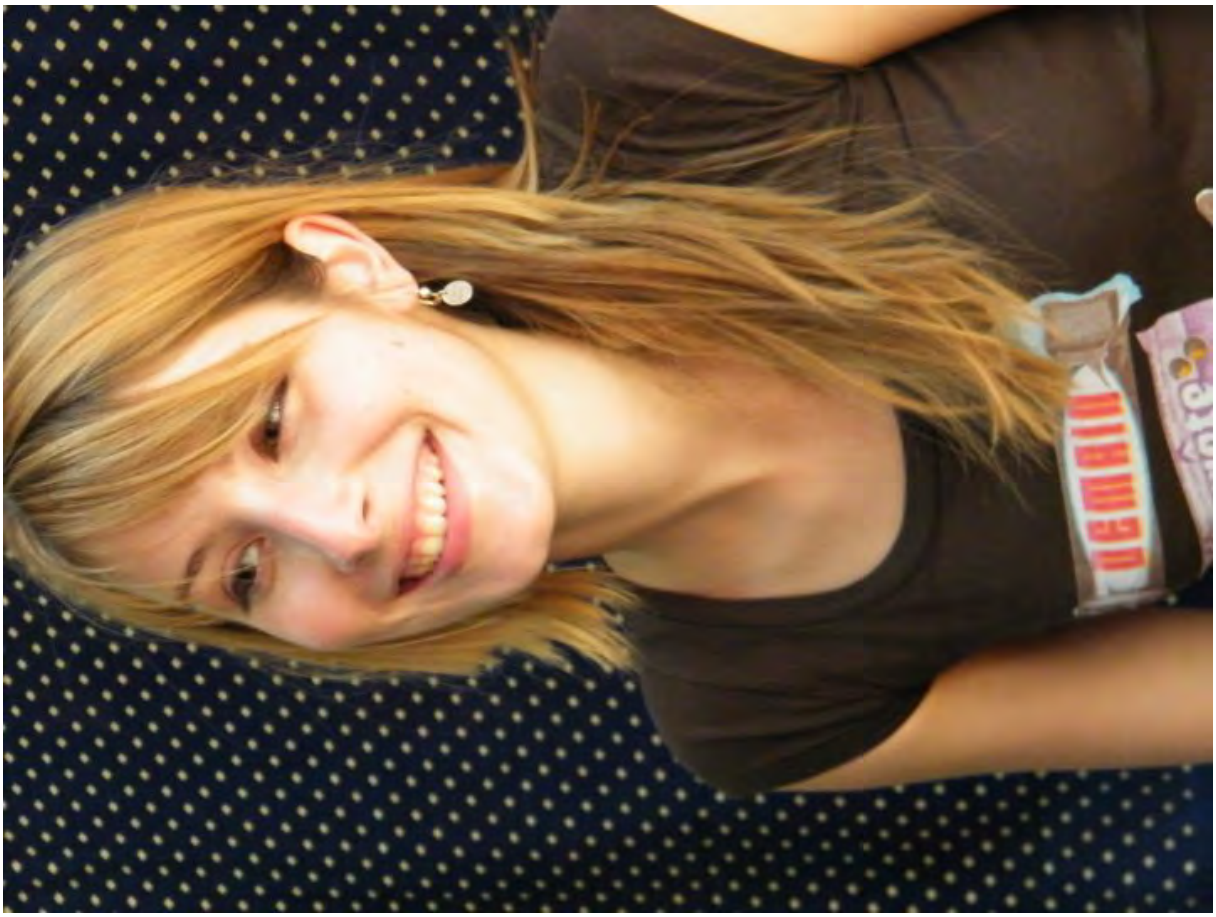
Stéphane Dalle

Alice Phan

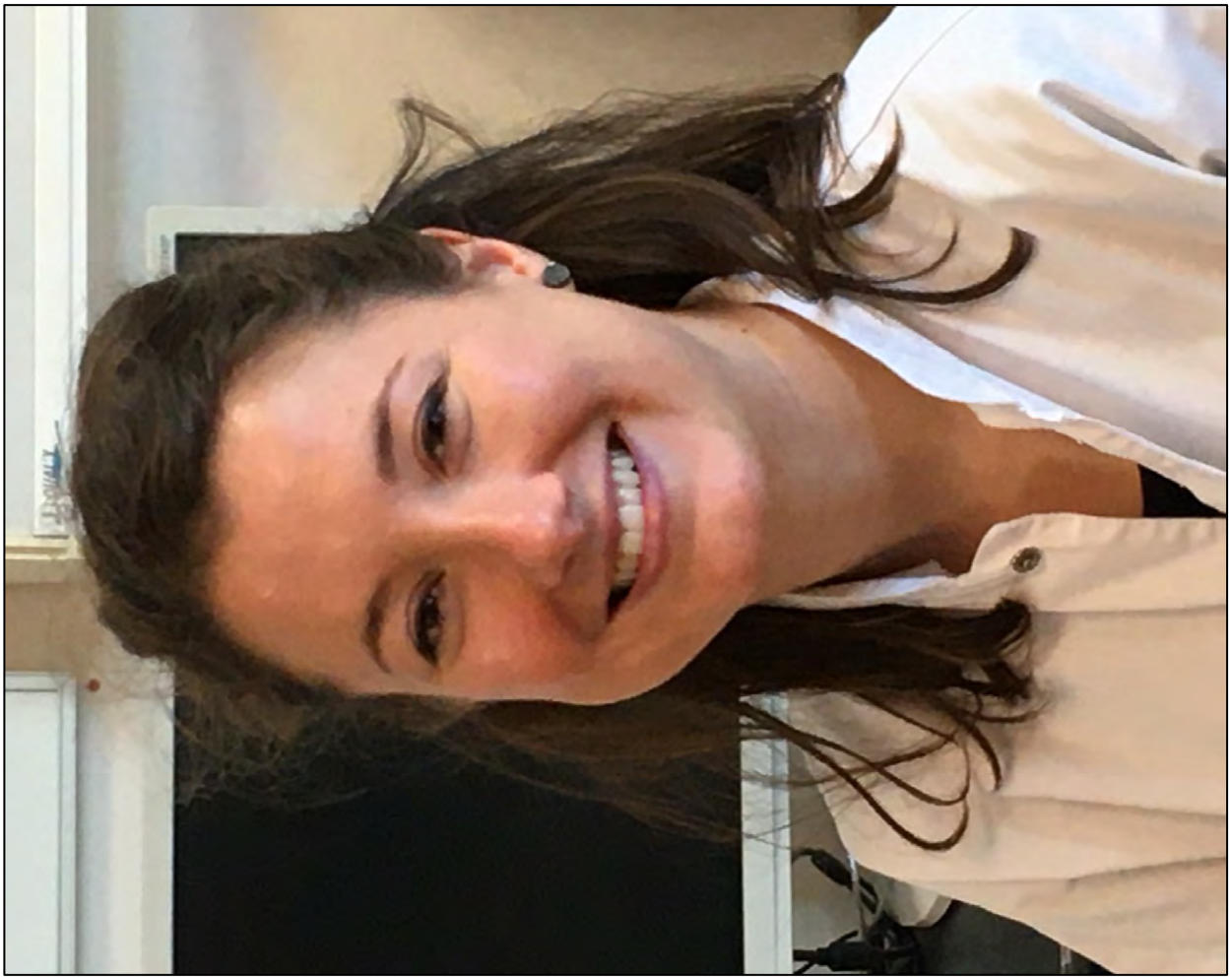
Sébastien Debarbieux

Nicolas Poulalhon

Marie Perrier-Muzet



Sarah Milley



Dermatopathology team

Toutes les images présentées appartiennent à la collection de l'Université Claude Bernard – Lyon 1
Les images empruntées, s'il y en a, font mention de leur auteur sur le diaporama
Tous les patients ont donné leur consentement pour l'usage des ces photos pour l'enseignement et la recherche
La reproduction, la diffusion de ces images, y compris sur l'internet, est formellement interdite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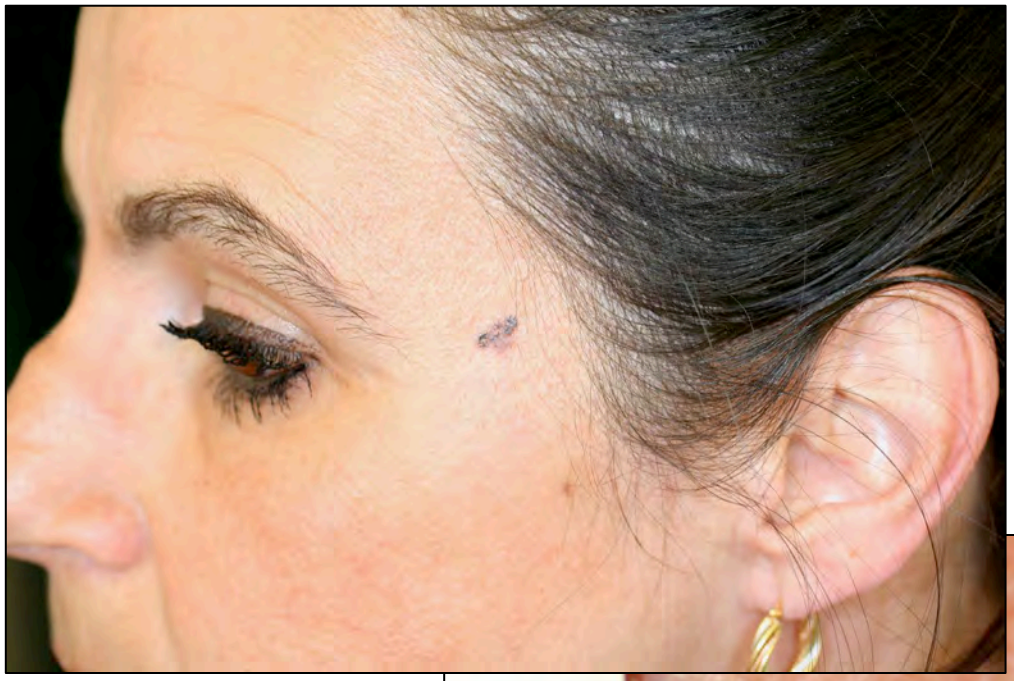

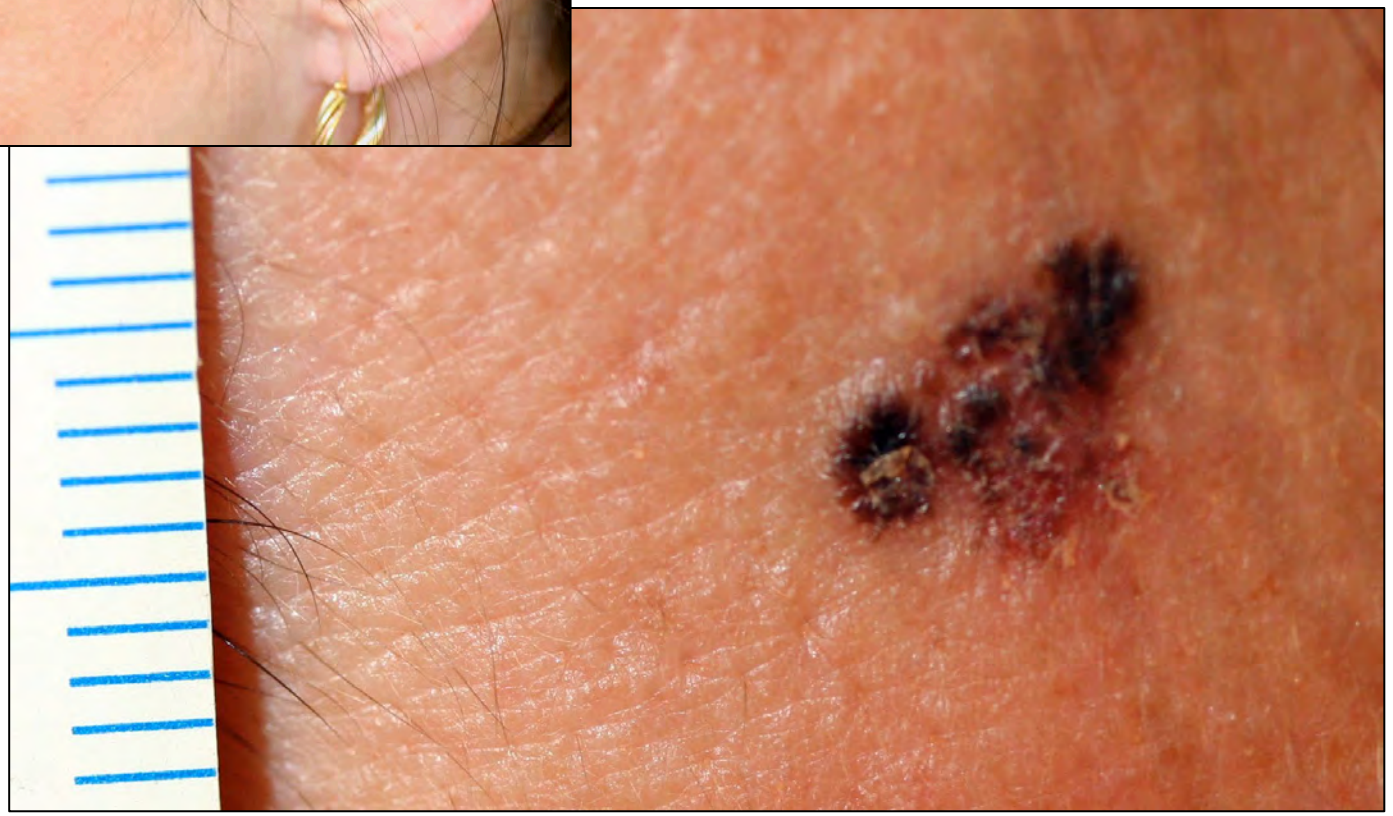

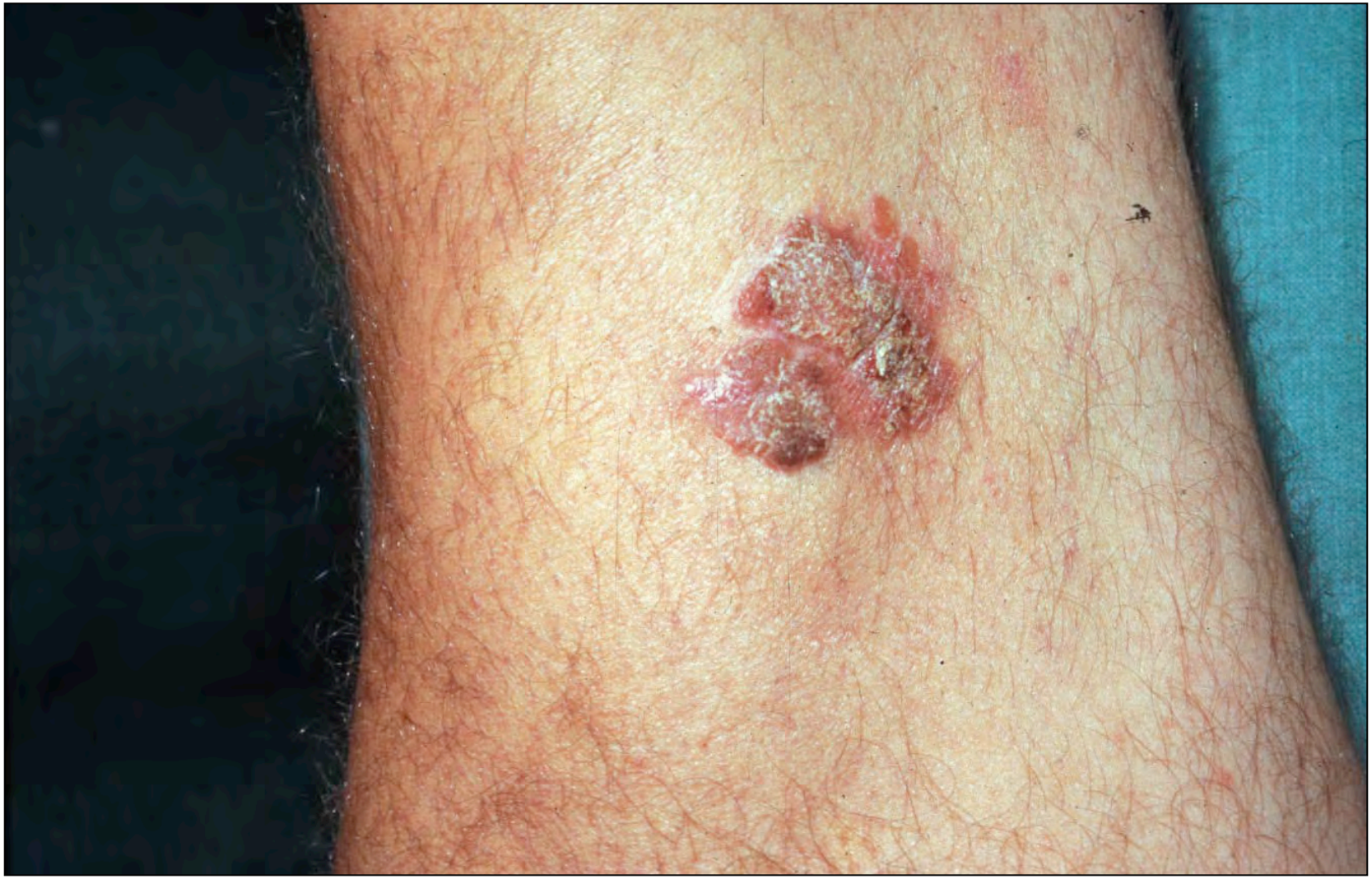

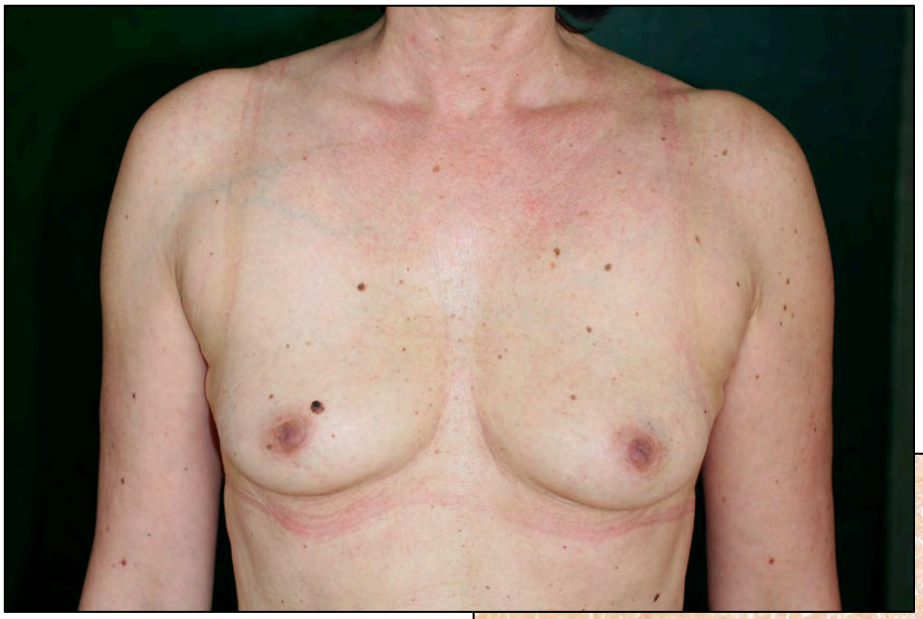

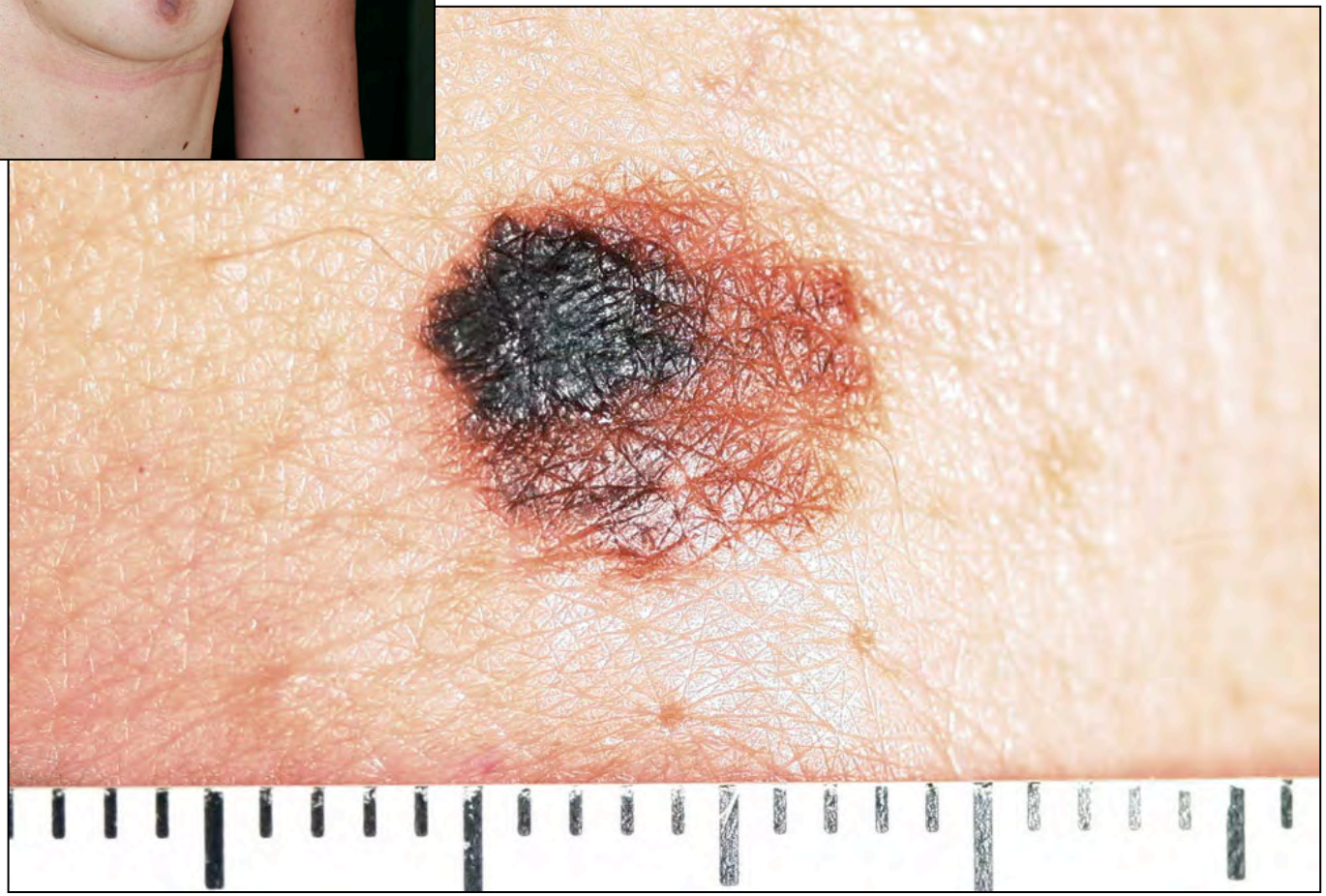


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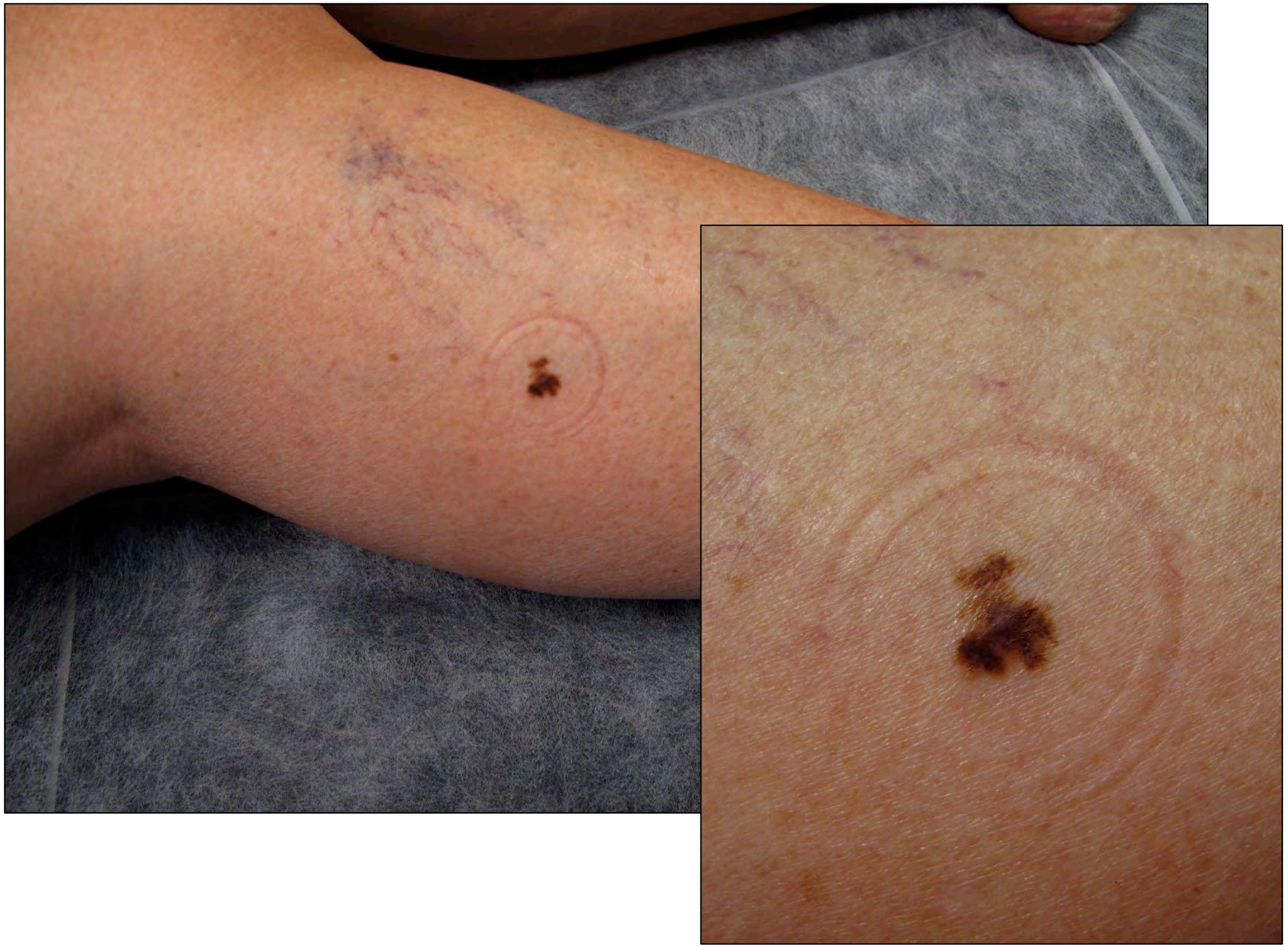

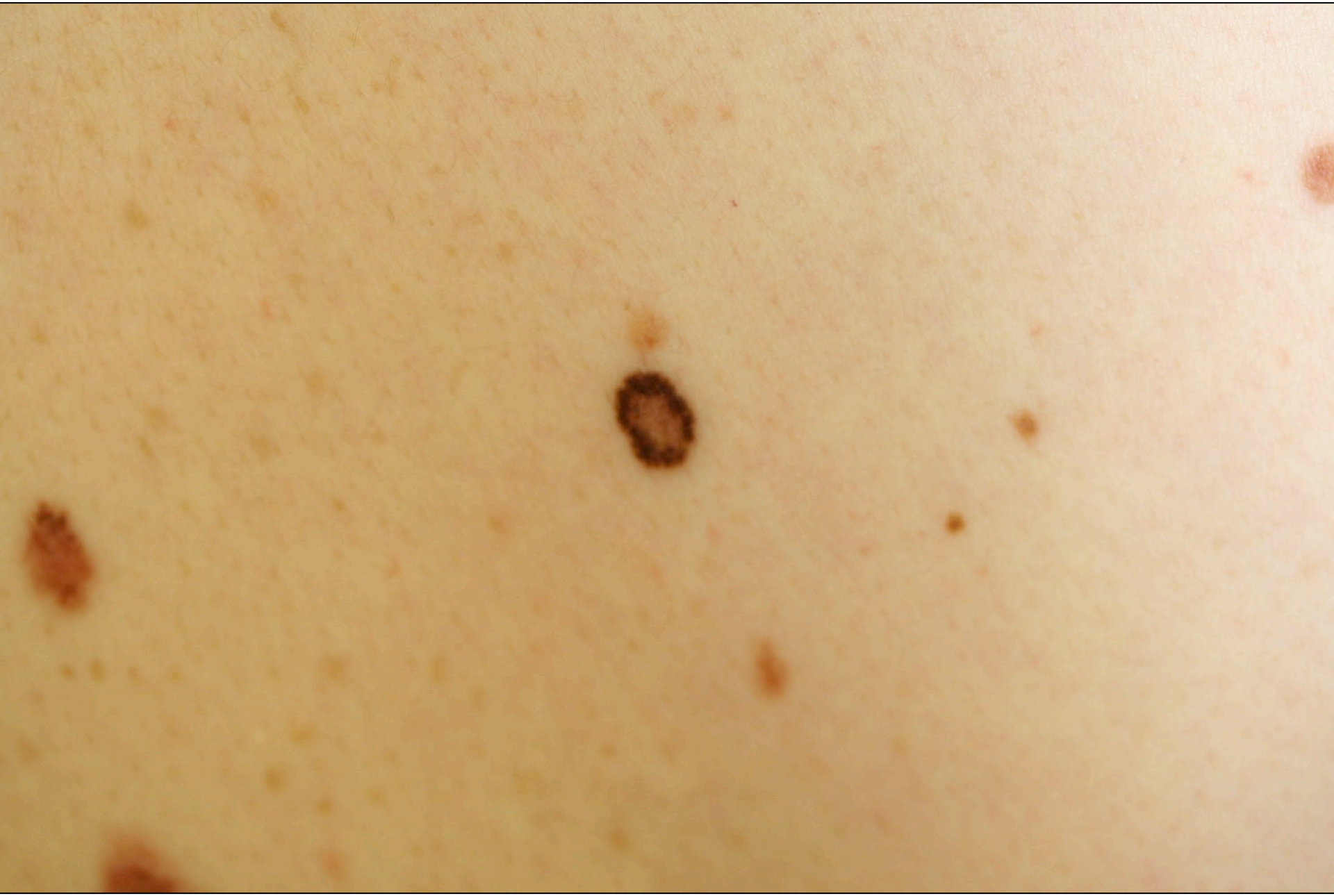


CONFOUNDING VARIABLES
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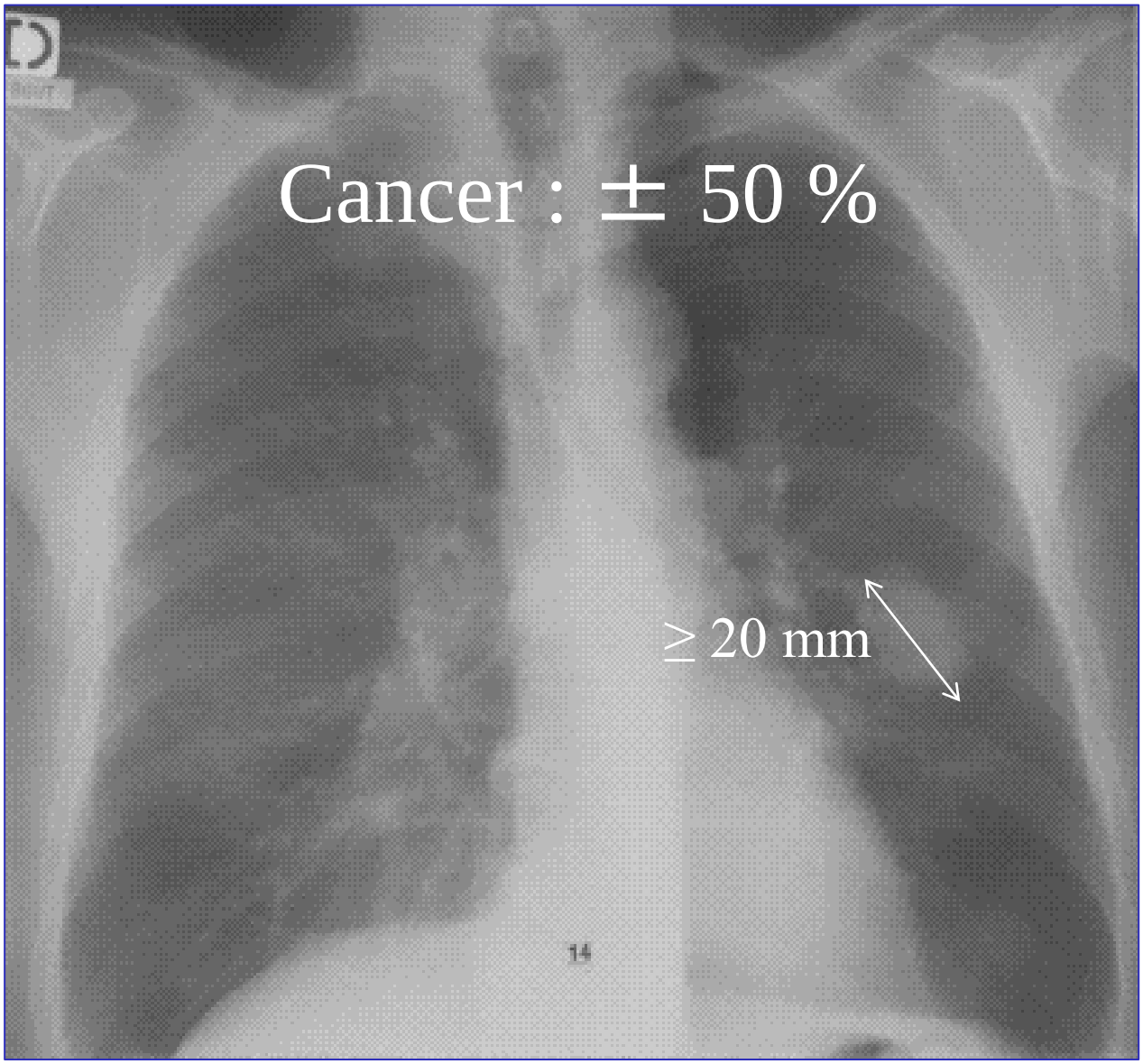
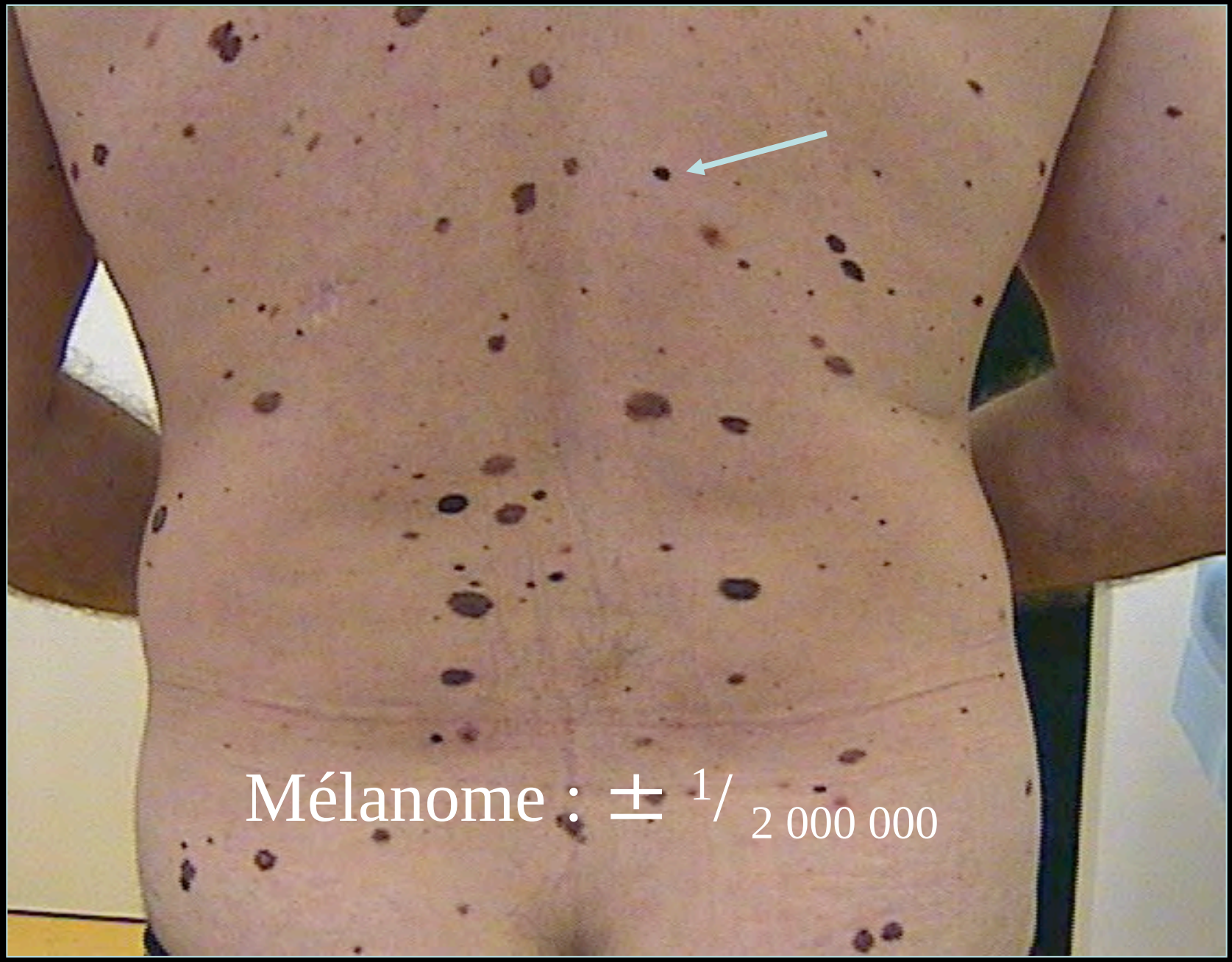
LUNG NERD

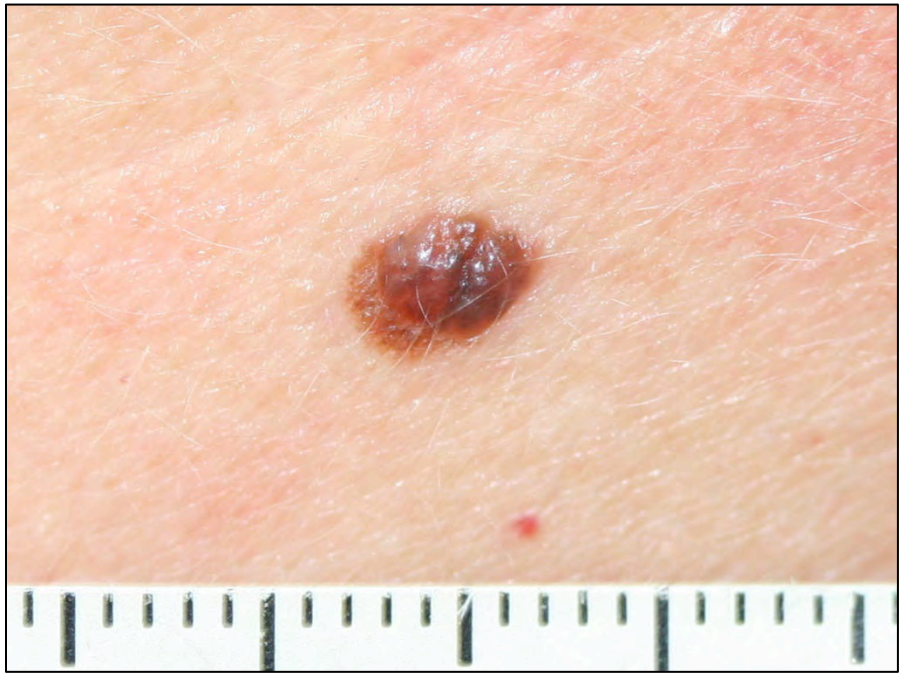

Cancer : ± 50 %
≥ 20 mm

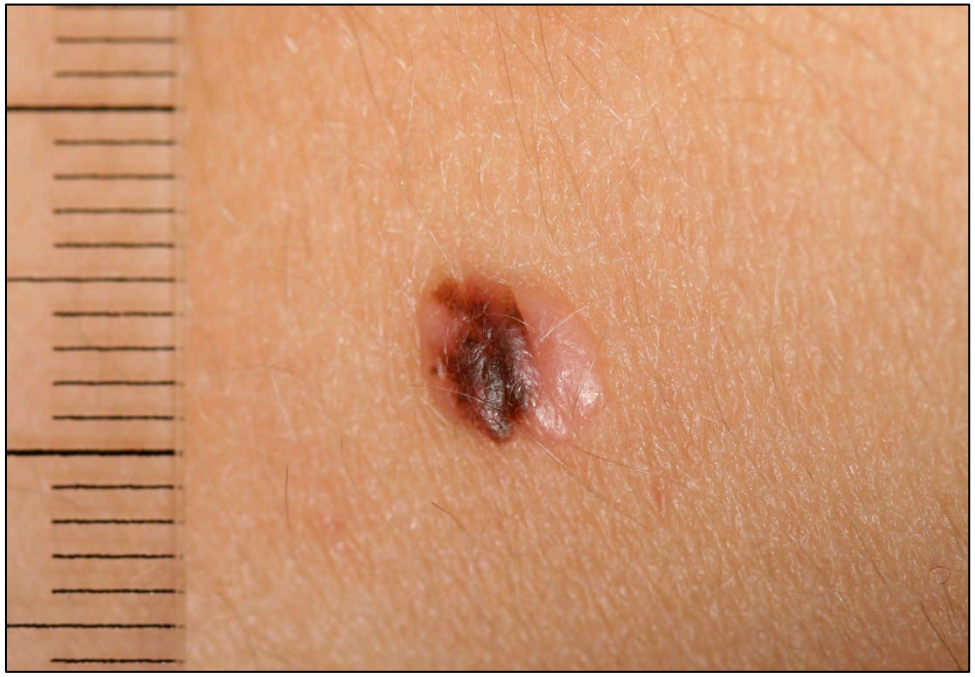

BEING A
DERMATOLOGIST
IS NOT A CAREER
IT'S A POST APOCALYPTIC
SURVIVAL SKILL

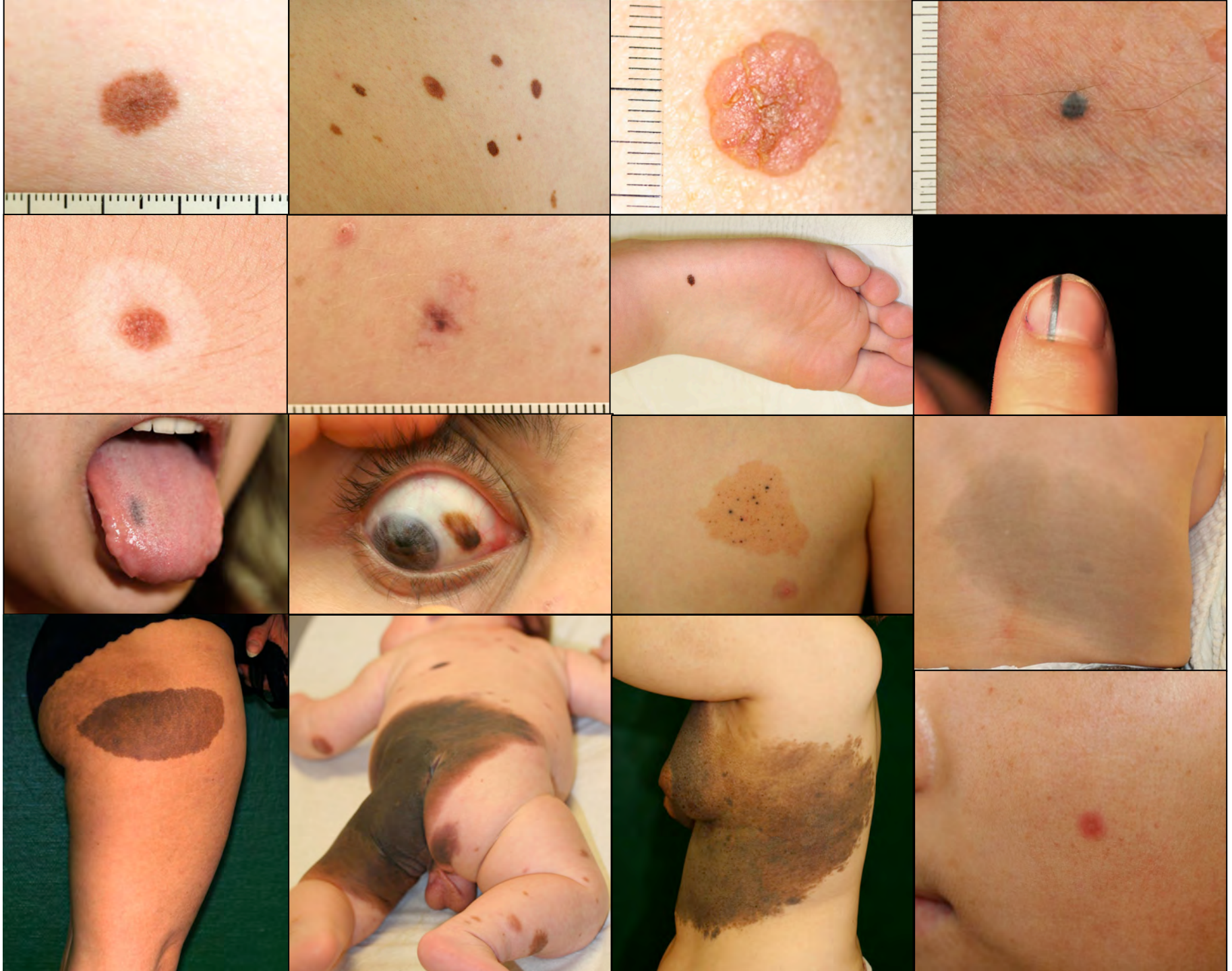

Mélanome : ± 1/ 2 000 000

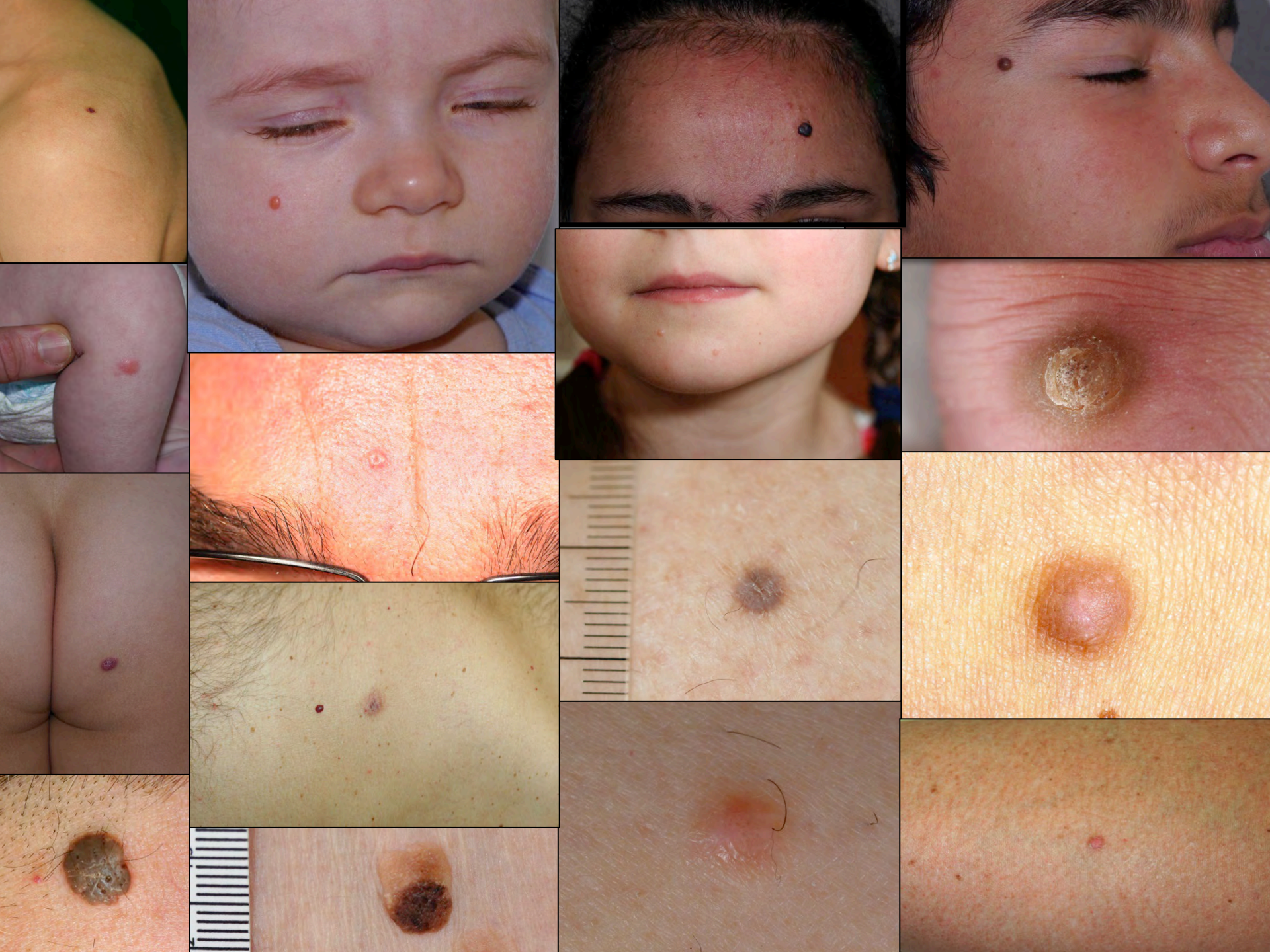
Naevus

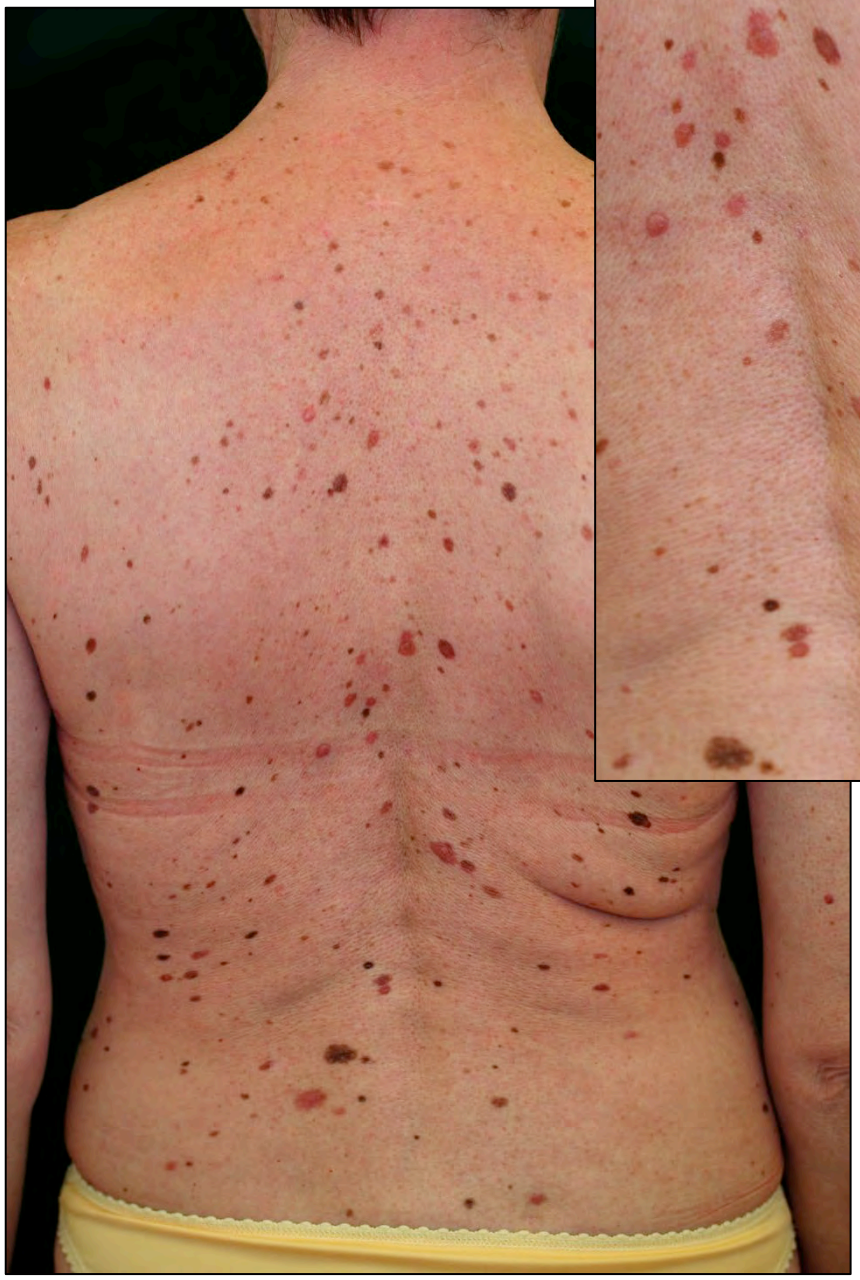
Mélanome

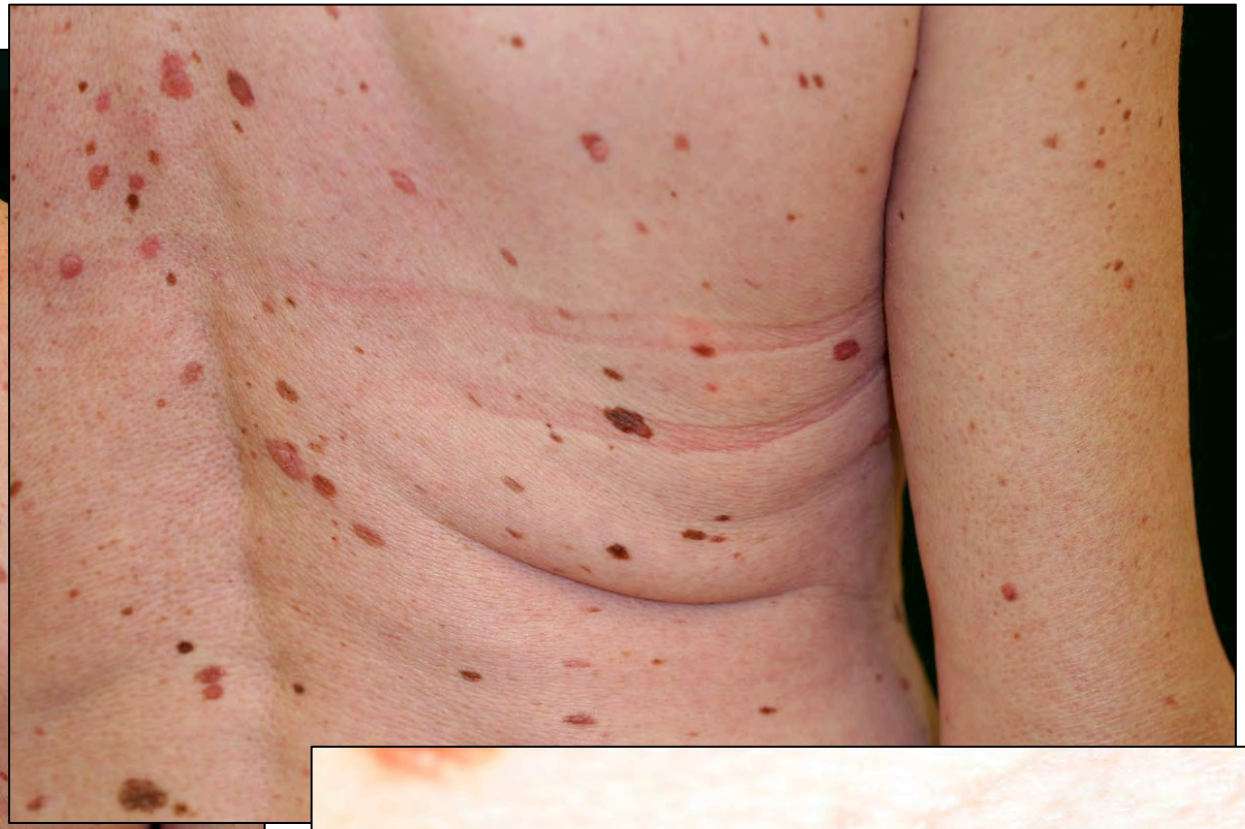












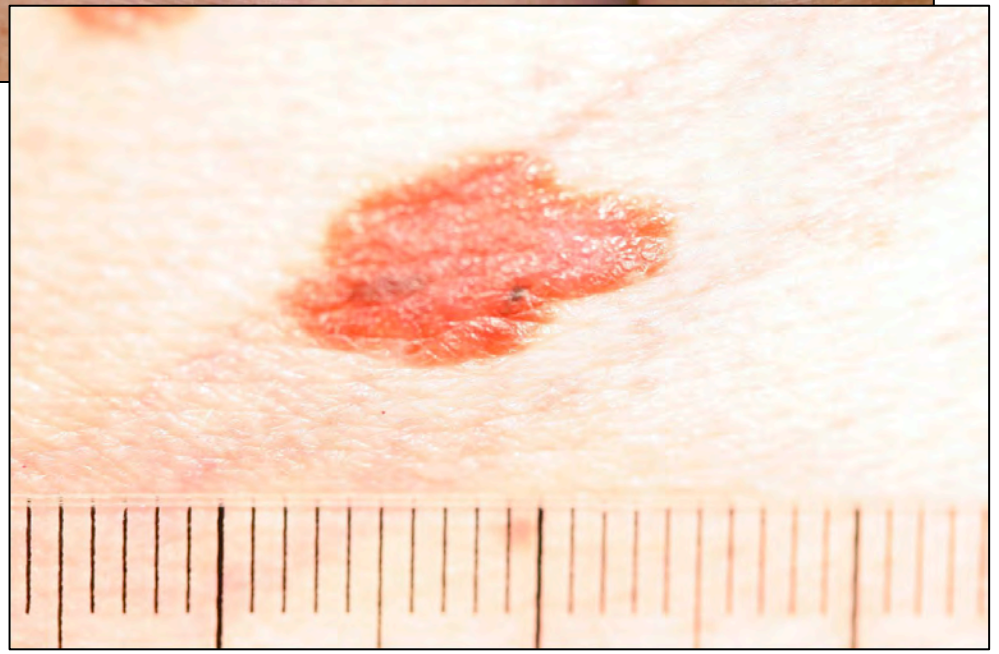


ILLUSTRATION BY ALBERTO RUGGIERI

EARLY DETECTION

Spotting the first signs

The sooner a cancer is found, the better. New technologies are pushing the limits of detection — towards the frontier of prevention.

BY NEIL SAVAGE

One day, a few years hence, a patient having a routine check-up might do little more than blow into a small machine at the doctor's office and, within a couple of minutes, be told whether there are any early signs of cancer. For another patient, a routine blood test to monitor cholesterol might present an opportunity to check for stray cells from tumours too small to spot. A dermatologist, instead of eying a mole and perhaps slicing it off to biopsy, could instead peer at it through a machine to instantly tell whether it is malignant or benign.

These, at least, are the visions of researchers developing technologies to detect the early signs of cancer. Better screening — looking for signs of cancer in people with no symptoms, as opposed to diagnosing suspected cancer — increases the odds that doctors will find cancer at its earliest stages when chances of a cure are higher. Screening has already reduced cancer deaths: the US National Cancer Institute (NCI) estimates that colonoscopies can lower mortality from colorectal cancer by at least 60%, and the National Lung Screening Trial recently found that computed tomography scans of heavy smokers could cut lung cancer deaths by as much as 20%. Researchers are exploring a new suite of potential screening methods that could one day join or even supplant today's colonoscopies, mammograms and pap smears. If some of these approaches can be shown to prevent cancer deaths and cut costs, they stand a good chance of becoming part of regular patient care.

LIGHT PROBES

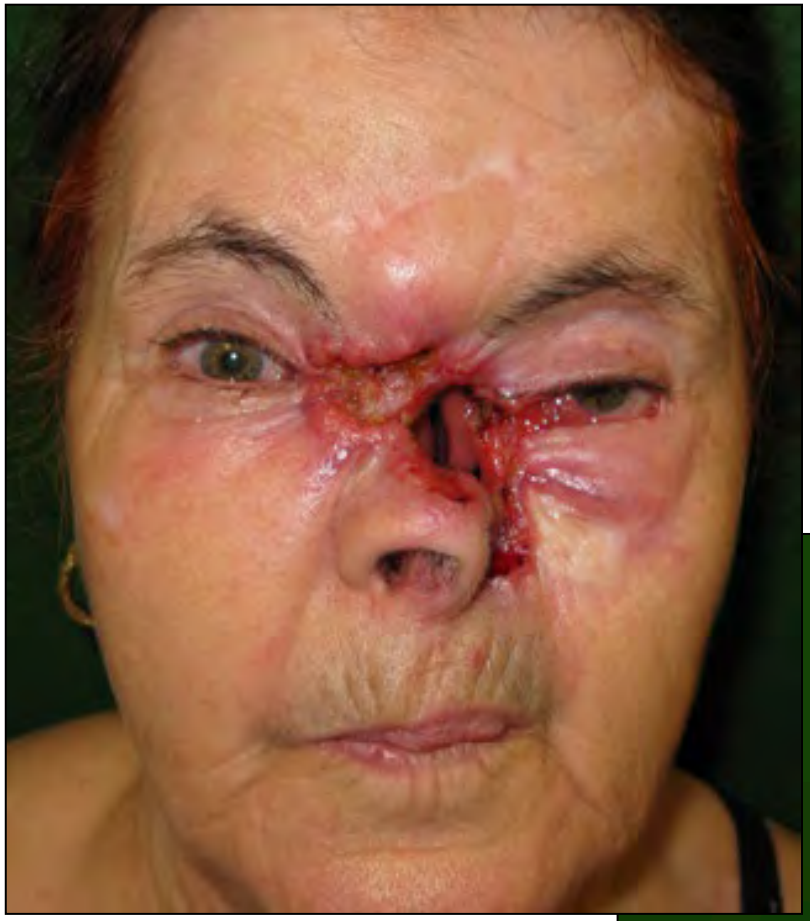
Many researchers are trying to improve on existing techniques such as endoscopy, delivering images from inside the body through fiber optics. Engineers at Duke University, North Carolina, for instance, have designed an optical system to search for premalignant changes in patients with Barrett's esophagus, in which stomach acid alters the cells lining the esophagus. The condition more than doubles the risk of esophageal cancer. Unlike conventional endoscopy, the Duke technique, called angle-resolved low-coherence interferometry, images structures beneath the surface of a cell for a sort of optical biopsy. Adam Wax, one of the Duke engineers, says looking at the basal layer of the epithelium, about 300 micrometers beneath the surface, seems most diagnostically useful. The system splits infrared light into two beams, and compares how far each travels to determine how deep it penetrates into the cell. Measuring the angle at which light bounces off cellular structures reveals the size of structures at increasing depth. The resolution is high enough to distinguish a normal-sized nucleus, about 10 micrometers in diameter, and a larger, precancerous one at least 13 micrometers.

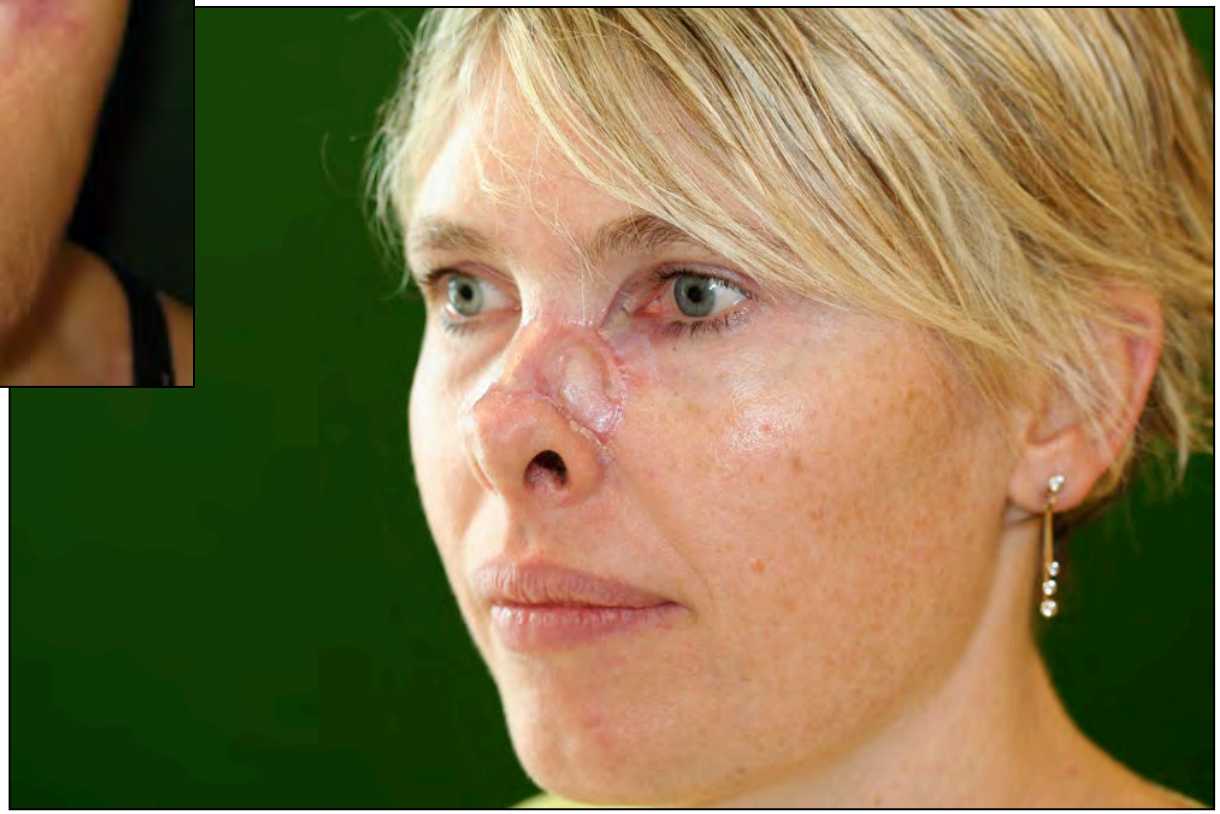
Wax says his enhanced endoscopy could provide better targets for biopsies — and, eventually replace biopsies altogether. According to the NCI, esophageal cancer causes nearly 15,000 deaths in the United States each year. "We hope that by contributing this tool we'll be able to shift that number downwards — the way it's gone with colonoscopy," says Wax, who has launched a company, Oncoscope, to raise funds for clinical trials.

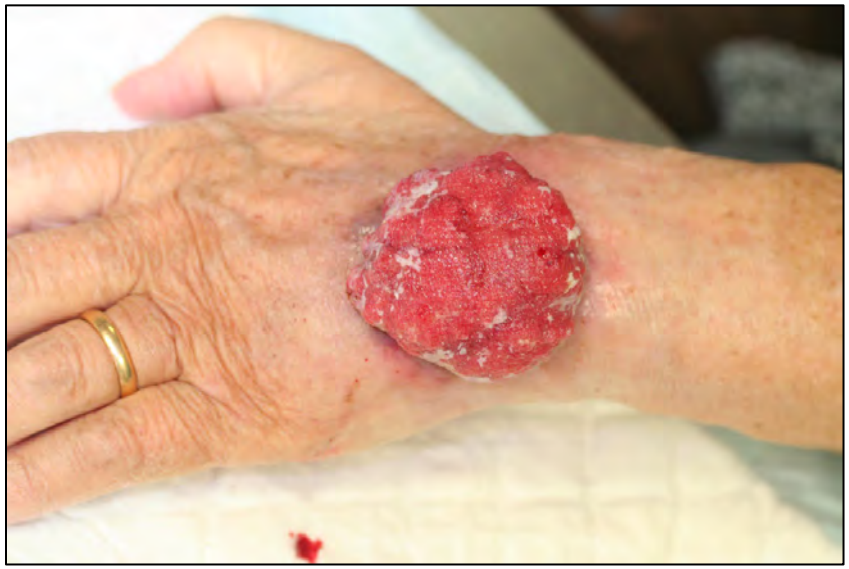
A similar light-based technique, optical coherence tomography (OCT) — could detect non-melanoma skin cancer below the surface of the skin, where standard visual exams can't see. Where Wax aims to get a precise measurement of cell structures, OCT provides images that doctors can examine. OCT — already used by ophthalmologists to examine the inside of the eye, also uses interferometry to image intracellular structures so doctors can see if they're abnormal. A British company, Michelson Diagnostics, is developing a handheld OCT scanner to detect non-melanoma skin cancer below the surface of the skin,

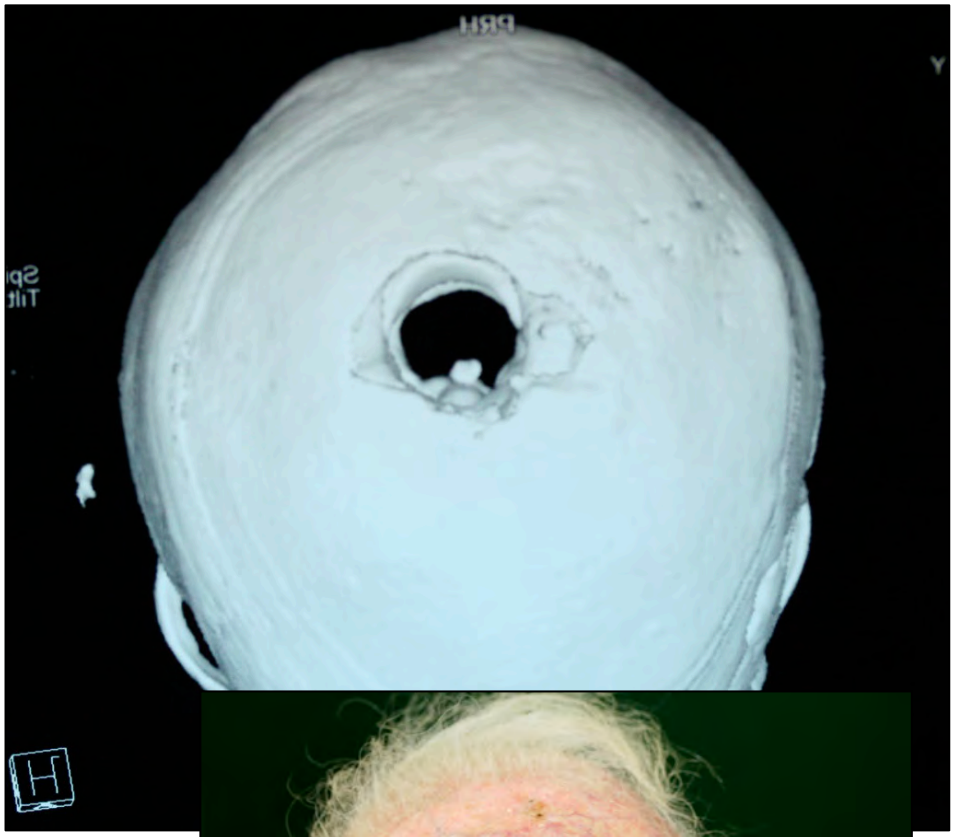
"We're very good at seeing where the lesion is," says biomedical engineer Gordon McKenzie, Michelson's medical applications director. "What we're doing now is gathering the evidence of whether we're seeing a cancer or a precancer." He says the machine, VivoSight, is comparable in both appearance and cost to the ultrasound machines found in obstetricians' offices. He hopes that the device, now

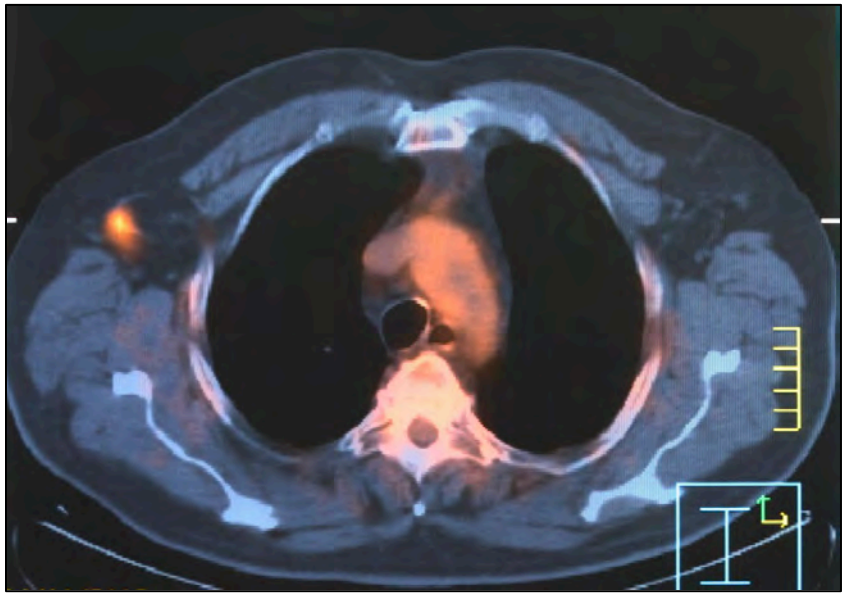
Nature 2011, 471, S14-5

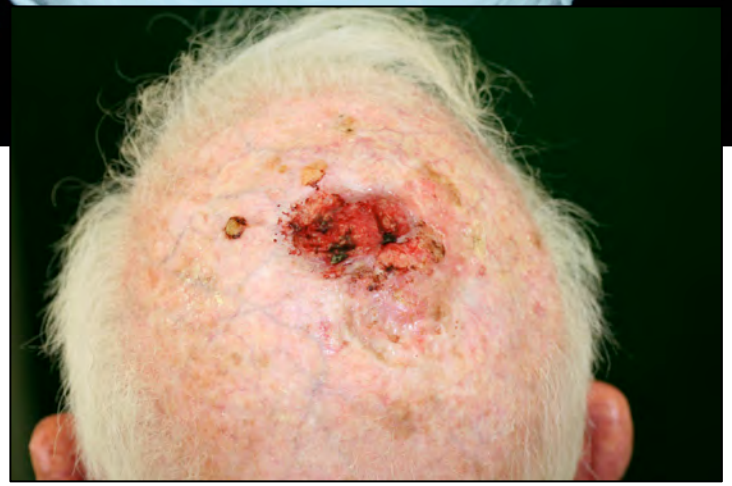


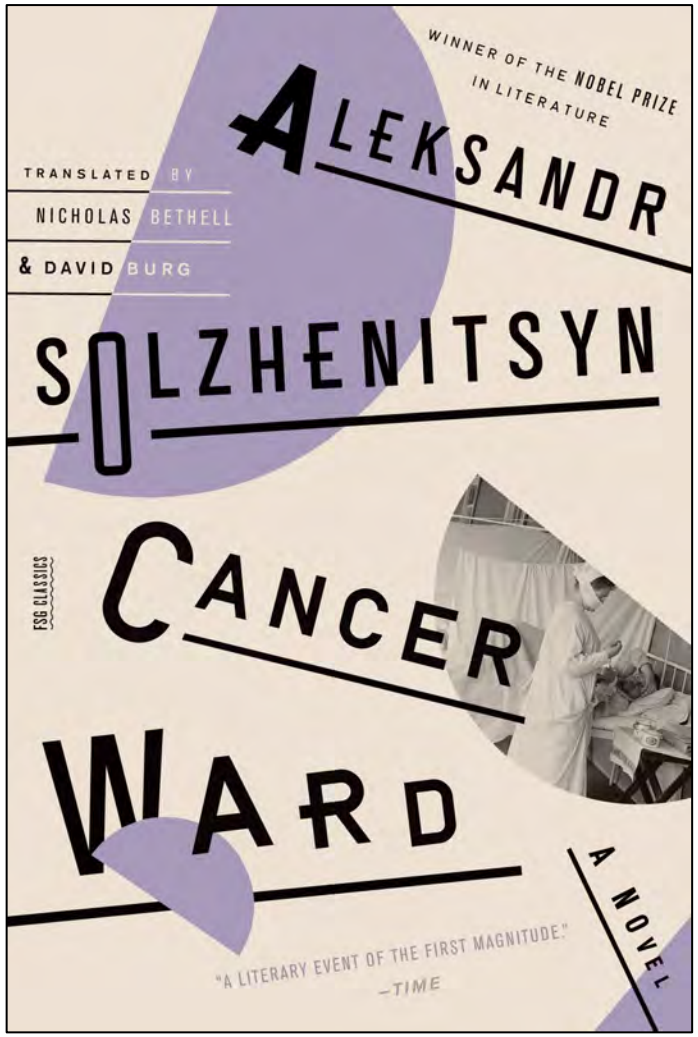




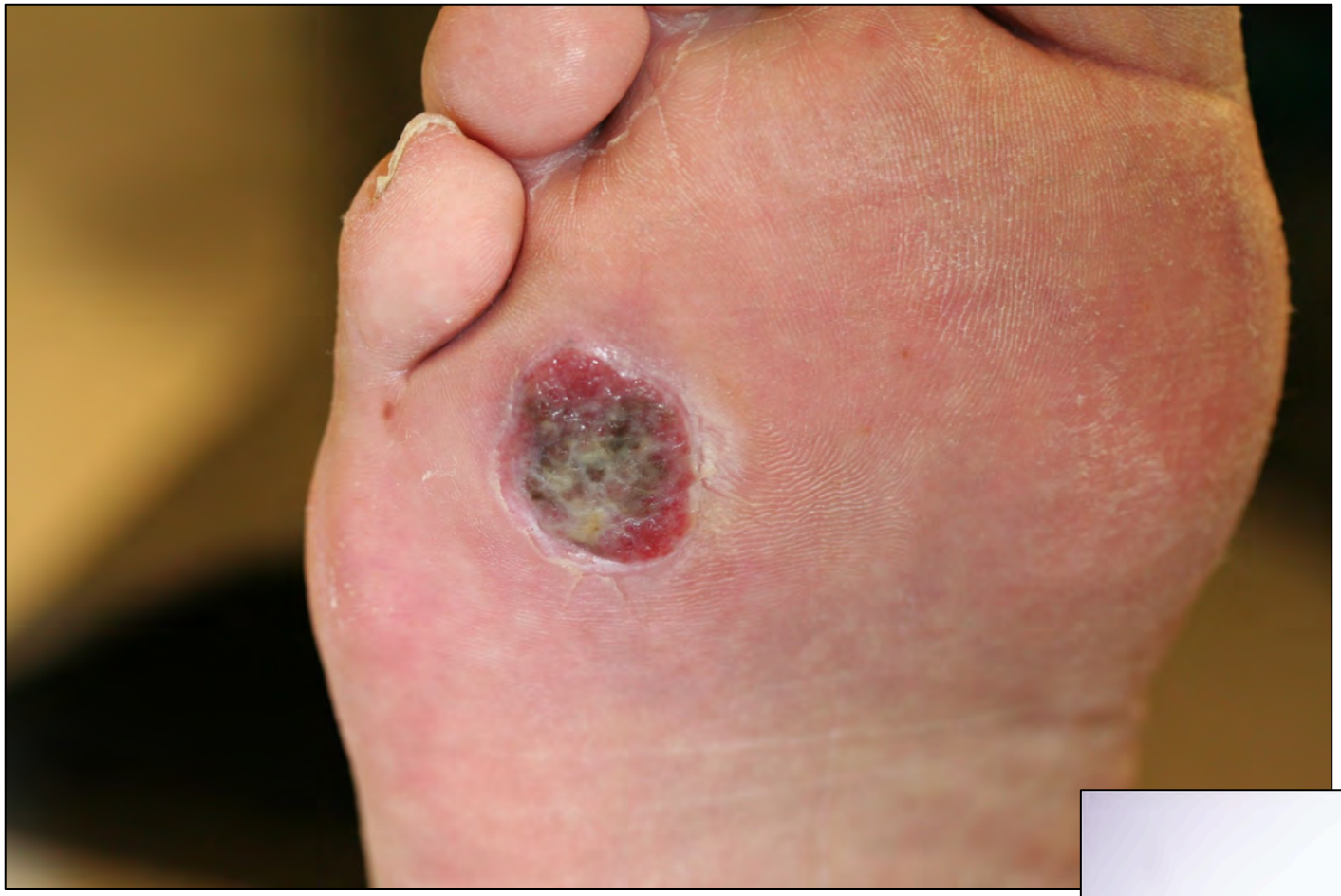


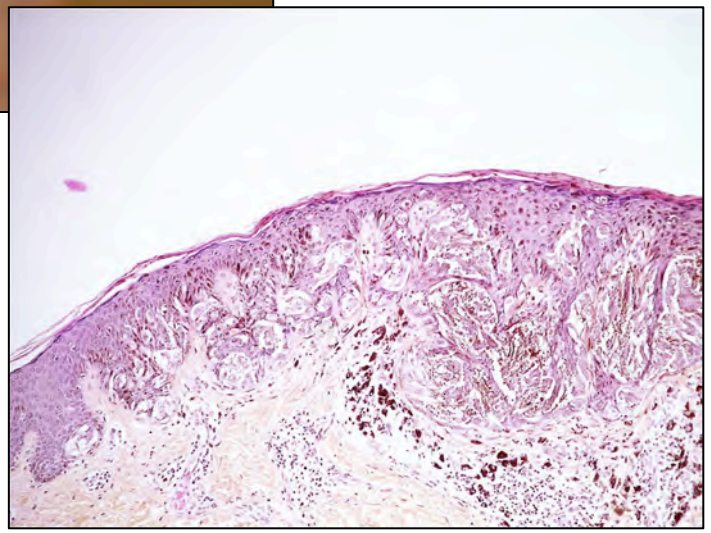






She was followed by a woman in-patient wearing a grey dressing-gown, with a little sherical pigmented tumour on the sole of her foot (… …), she was talking merrily away to the nurse, little realizing that this tiny ball, no more than a centimetre wide was the very queen of malignant tumours : a melanoma





2008-2018

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Shooting at ambulances in Israel: a cardiologist's viewpoint
S Vikkin

Registered as a newspaper. ISSN 0140-6736.

£5

Dementia pages 888, 909

The New England Journal of Medicine

VOLUME 361

Original Articles

Case Records of the Massachusetts General Hospital

Editorial

Sounding Board

Correspondence

Review Article

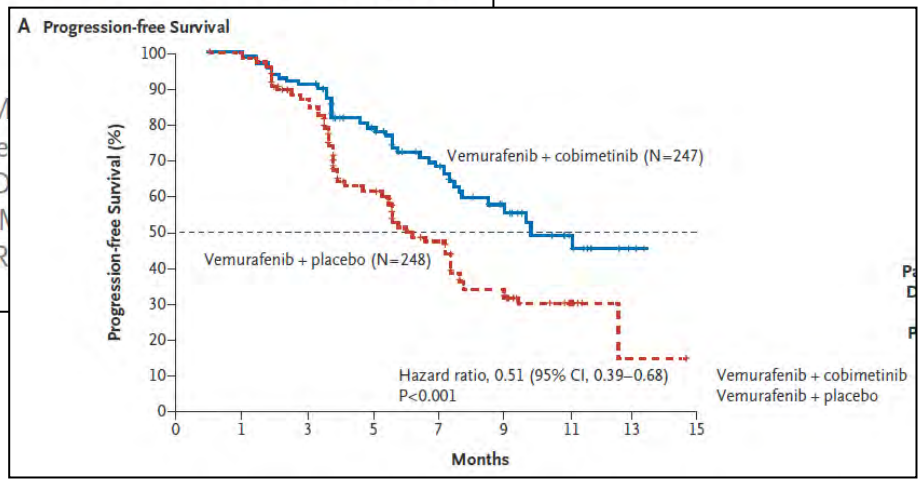
Clinical Problem-Solving

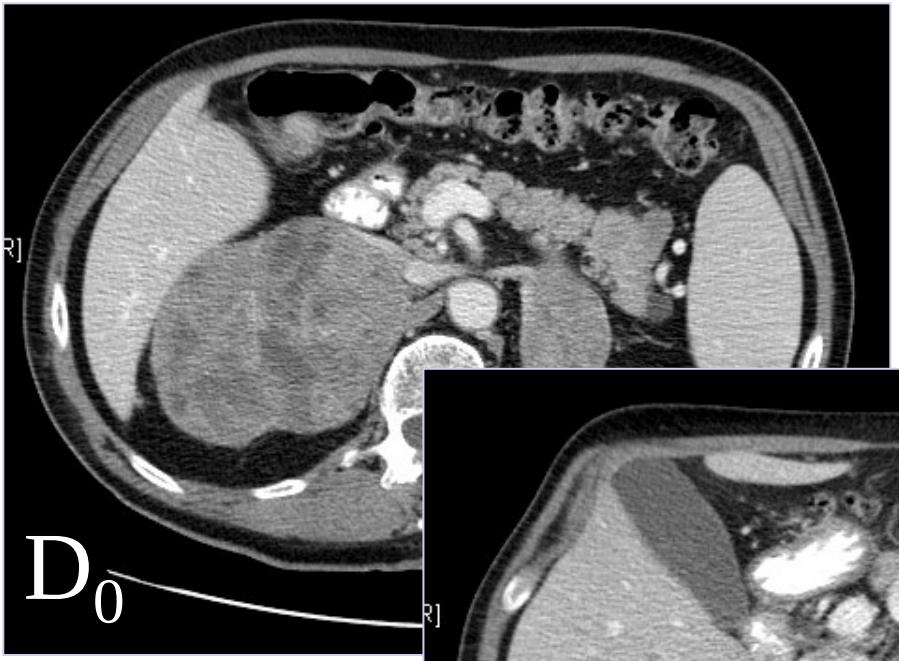
The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 NOVEMBER 13, 2014 VOL. 371 NO. 20

Combined Vemurafenib and Cobimetinib in *BRAF*-Mutated Melanoma

James Larkin, M.D., Ph.D., Paolo A. Ascierto, M.D., Brigitte Dréno, M
Gabriella Liszkay, M.D., Michele Maio, M.D., Mario Mandalà, M.D., Lev De
Luc Thomas, M.D., Ph.D., Luis de la Cruz-Merino, M.D., Caroline D
Mika A. Sovak, M.D., Ph.D., Ilsung Chang, Ph.D., Nicholas Choong, M
Grant A. McArthur, M.B., B.S., Ph.D., and Antoni R

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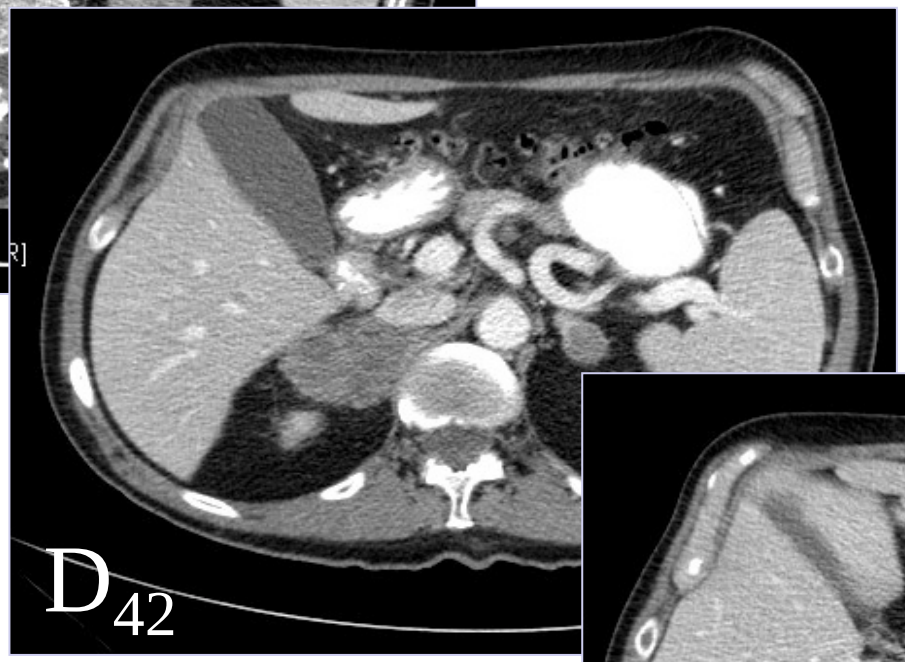
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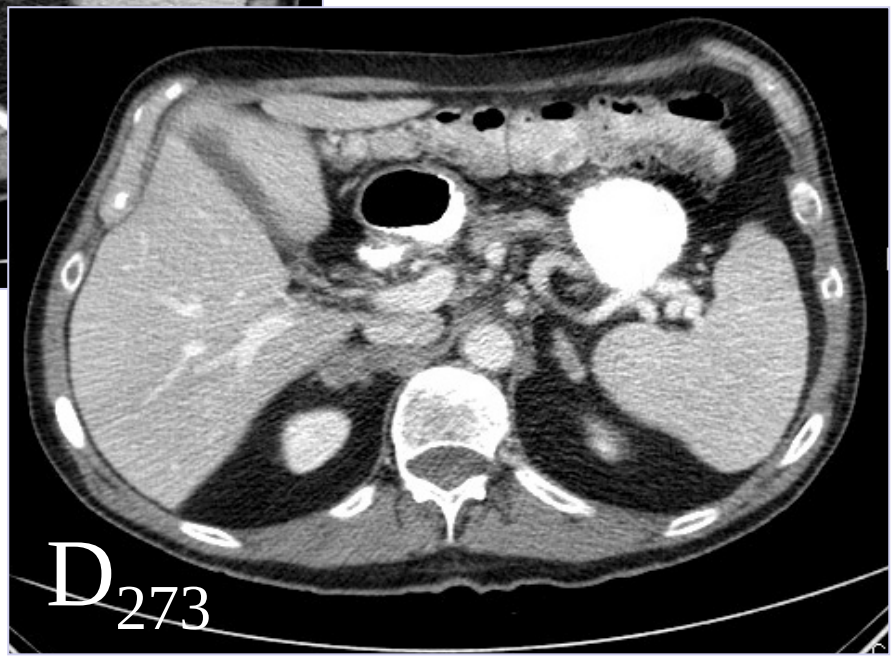
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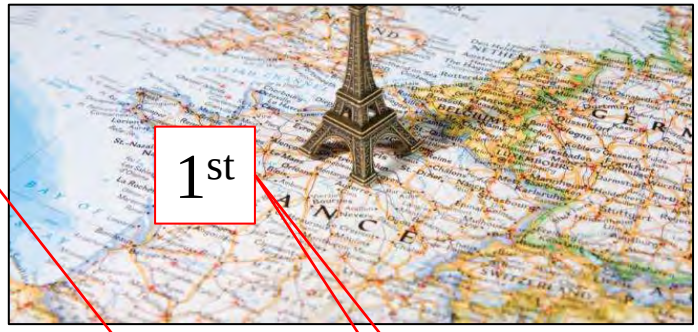
BUZZ
BUZZ
BUZZ
BUZZ
BUZZ
BUZZ

Cutaneous melanoma

- 1940 : 40% 5 year-survival
- 1971 : 68% 5 year-survival
- 2002 : 92% 10 year-survival

Hu S. et al Arch Dermatol 2009 145, 12 1369-1374



9th

1st

8th

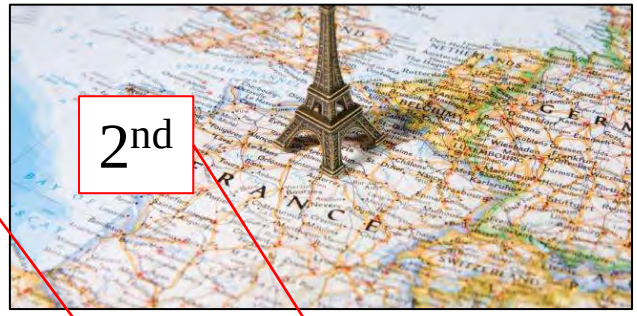
2nd

Tableau 1

Cas incidents/décès estimés et taux d'incidence/de mortalité standardisés Monde par localisation en 2012 et tendances évolutives (1980-2012 et 2005-2012), estimations chez l'homme

	Incidence				Mortalité			
	Situation en 2012		Taux annuel moyen d'évolution (%)		Situation en 2012		Taux annuel moyen d'évolution (%)	
Localisation	Nombre de nouveaux cas	Taux d'incidence (1)	1980-2012	2005-2012	Nombre de décès	Taux de mortalité (1)	1980-2012	2005-2012
Lèvre, cavité orale, pharynx	8 033	16,1	-2,8	-5,3	2 465	4,7	-3,7	-6,5
Œsophage	3 503	6,2	-3,0	-4,4	2 653	4,6	-3,4	-5,0
Estomac	4 308	7,0	-2,2	-2,2	2 834	4,4	-3,4	-2,8
Côlon-rectum	23 226	38,4	0,3	-0,3	9 275	13,3	-1,2	-1,5
Foie (2)	6 867	12,1	3,2	1,3				
Pancréas (2)	5 963	10,2	2,3	4,5				
Larynx	2 821	5,4	-2,9	-4,7	783	1,4	-6,4	-9,3
Poumon	28 211	51,7	0,1	-0,3	21 326	37,0	-0,5	-2,2
Mélanome de la peau	5 429	10,8	4,7	2,9	954	1,7	1,9	0,1
Prostate (3)	56 841 (3)	99,4 (3)			8 876	10,2	-1,5	-3,7
Testicule	2 317	7,2	2,4	1,6	85	0,2	-3,5	-2,6
Vessie	9 549	14,7	-0,4	-1,4	3 574	4,9	-1,1	-2,4
Rein	7 781	14,5	2,0	1,8	2 651	4,0	0	-1,2
Système nerveux central	2 814	6,3	1,1	0,4	1 761	3,6	0,4	-1,1
Thyroïde	2 324	5,5	5,2	5,4	145	0,2	-1,9	-2,7
Tous cancers (4)	200 350	362,6	0,8	-1,3	85 255	133,6	-1,5	-2,9

10th



2nd

5th

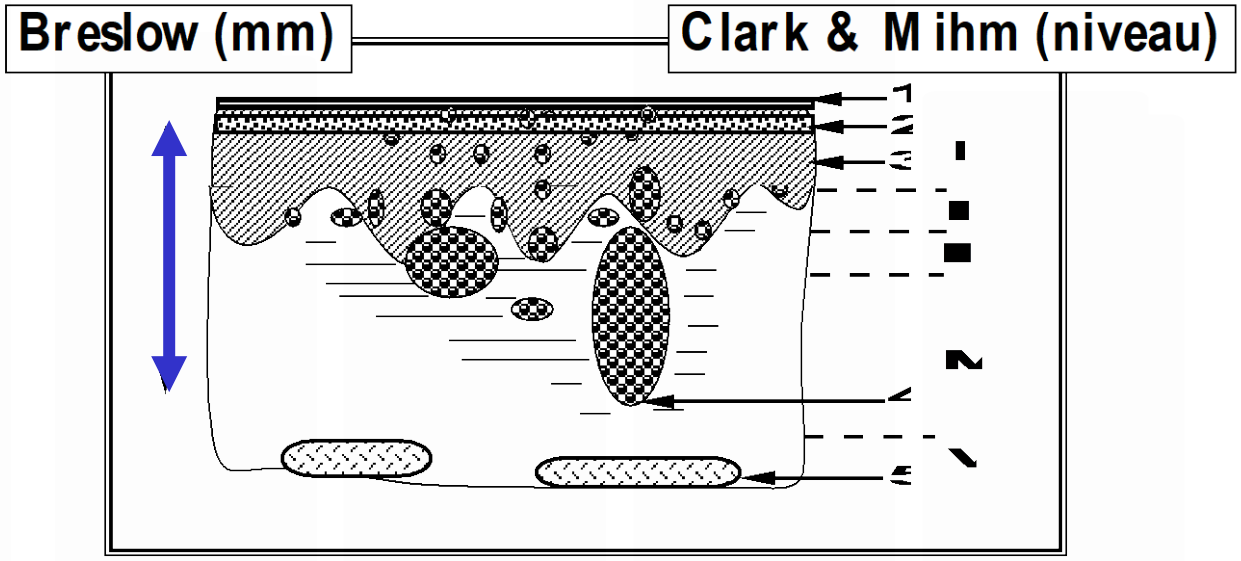
4th

I TABLEAU 2 I

Cas incidents/décès estimés et taux d'incidence/de mortalité standardisés Monde par localisation en 2012 et tendances évolutives (1980-2012 et 2005-2012), estimations chez la femme

	Incidence				Mortalité			
	Situation en 2012		Taux annuel moyen d'évolution (%)		Situation en 2012		Taux annuel moyen d'évolution (%)	
Localisation	Nombre de nouveaux cas	Taux d'incidence (1)	1980-2012	2005-2012	Nombre de décès	Taux de mortalité (1)	1980-2012	2005-2012
Lèvre, cavité orale, pharynx	3 283	5,6	1,5	1,1	727	1,0	-0,5	-2,2
Œsophage	1 129	1,5	1,1	1,1	791	0,9	-0,5	-1,1
Estomac	2 248	2,6	-2,6	-2,0	1 577	1,7	-3,8	-2,7
Côlon-rectum	18 926	23,7	0,1	-0,3	8 447	7,9	-1,4	-1,1
Foie (2)	1 856	2,4	3,5	3,0				
Pancréas (2)	5 699	6,9	3,9	5,4				
Larynx	501	0,9	1,1	0,5	123	0,2	-2,5	-4,5
Poumon	11 284	18,6	5,3	5,4	8 623	12,9	3,7	4,6
Mélanome de la peau	5 747	11,0	3,2	1,7	718	1,0	0,8	-1,8
Sein	48 763	88,0	1,4	-1,5	11 886	15,7	-0,6	-1,5
Col de l'utérus	3 028	6,7	-2,5	-1,2	1 102	1,8	-3,2	-2,0
Corps de l'utérus	7 275	10,8	0,1	0,3	2 025	2,2	-1,0	-0,6
Ovaire	4 615	7,6	-0,6	-1,2	3 140	3,8	-1,2	-3,3
Vessie	2 416	2,5	-0,4	0,9	1 198	1,0	-1,0	-0,9
Rein	3 792	5,8	1,7	1,4	1 306	1,4	-0,9	-2,1
Système nerveux central	2 185	4,2	0,9	0,2	1 291	2,2	0,4	-1,9
Thyroïde	5 887	13,8	5,1	2,7	230	0,2	-3,4	-4,2
Tous cancers (4)	155 004	252,0	1,1	0,2	63 123	73,2	-1,0	-1,4

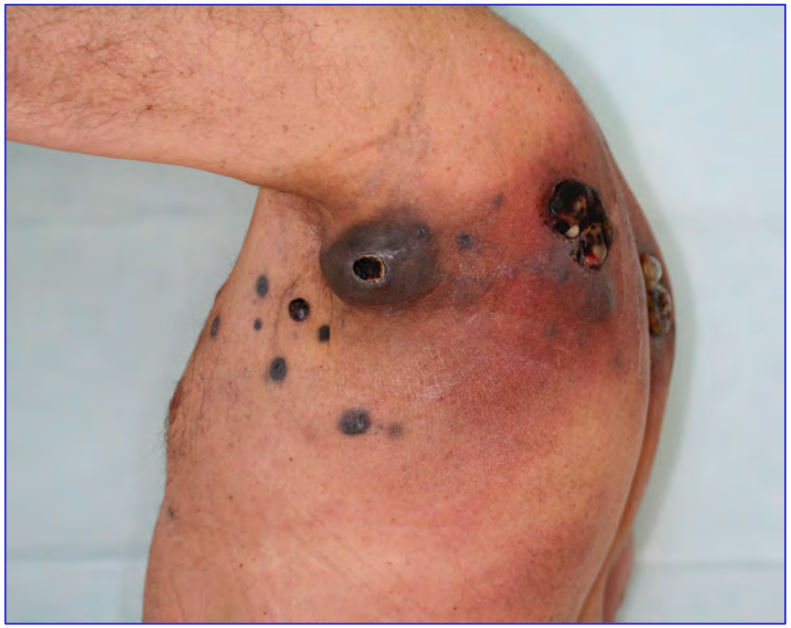
Epaisseur et niveaux d'invasion

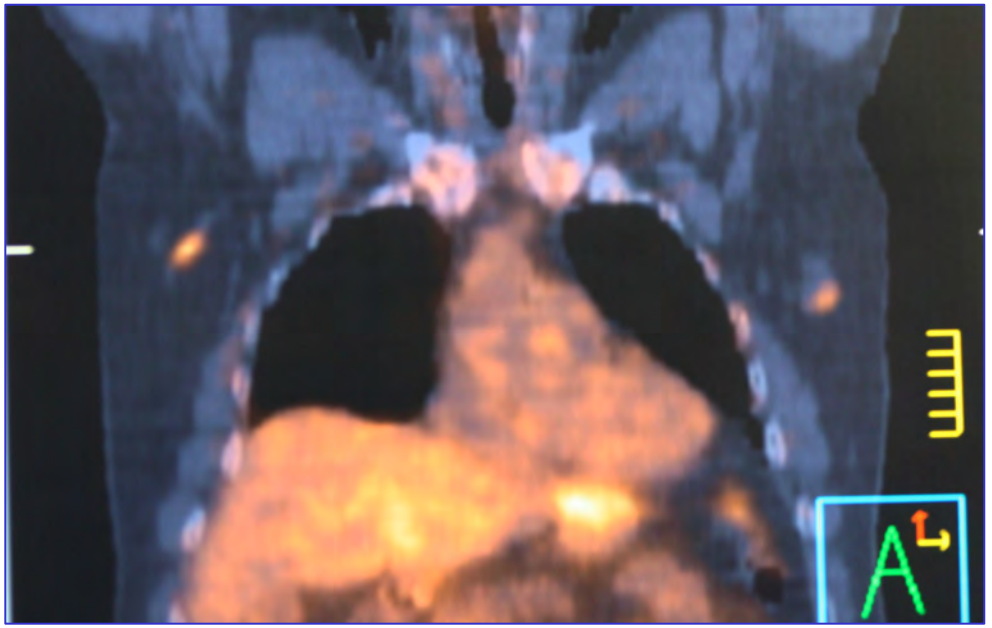


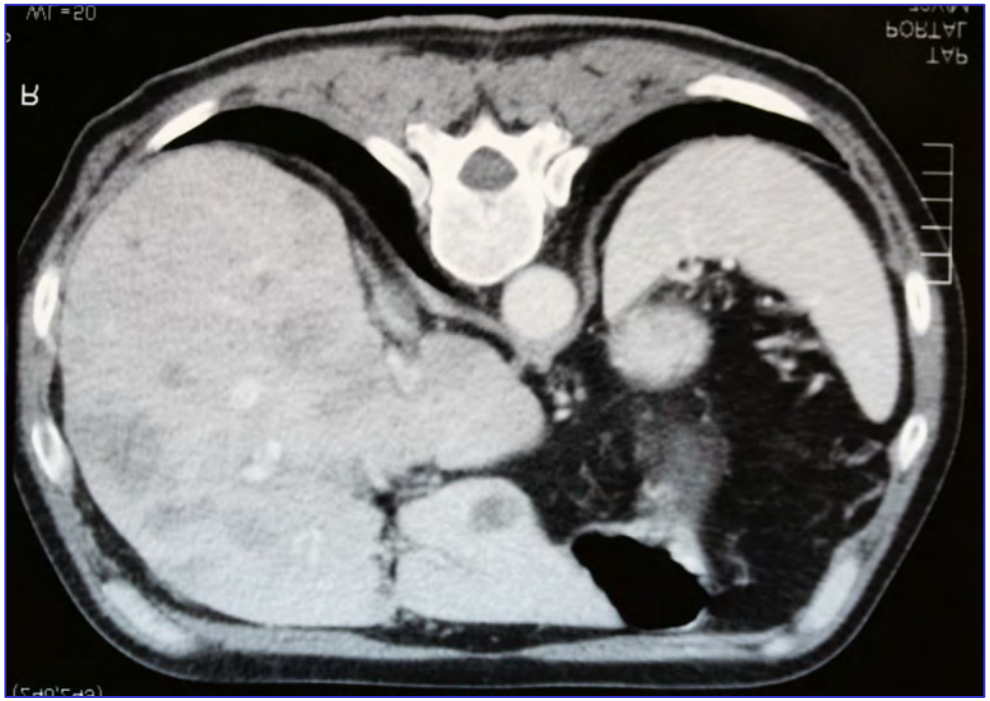
1: couche cornée
2: couche granuleuse
3: épiderme
4: plus profonde cellule tumorale
5: hypoderme

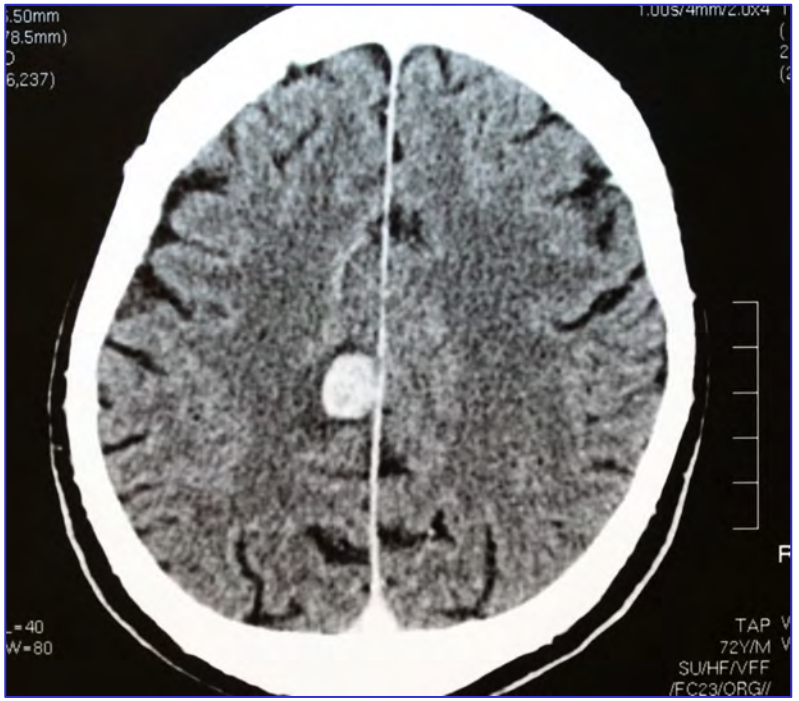
Pronostic

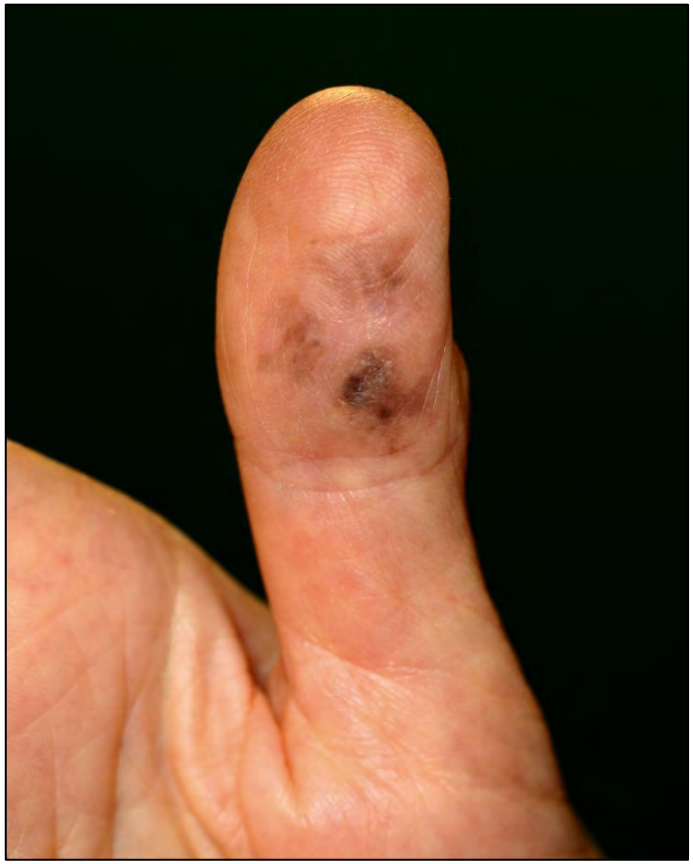
	Survie à 10 ans
Mélanome stade local (AJCC I et II)	
Toutes épaisseurs confondues :	**91 %**
in situ	**100%**
< 0,75 mm :	**96 %**
0,76 - 1,49 mm :	**87 %**
1,5 - 2,49 mm:	**75 %**
2,5 - 3,99 mm:	**66 %**
> 4 mm :	**47 %**
Mélanome Stade régional (AJCC III) :	**36 à 41 %**
Mélanome Stade métastatique (AJCC IV) :	**< 5 % (5 ans)**

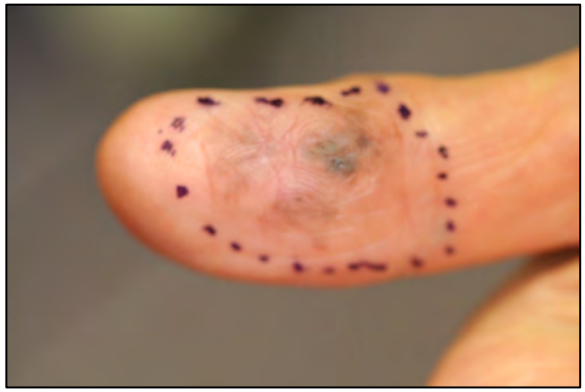




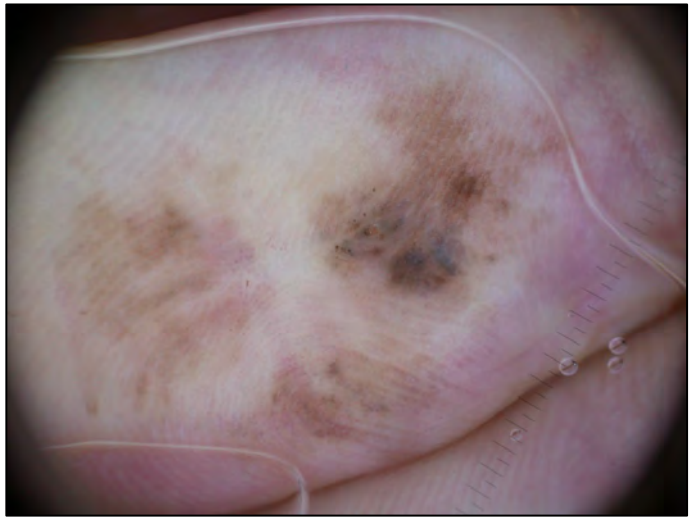


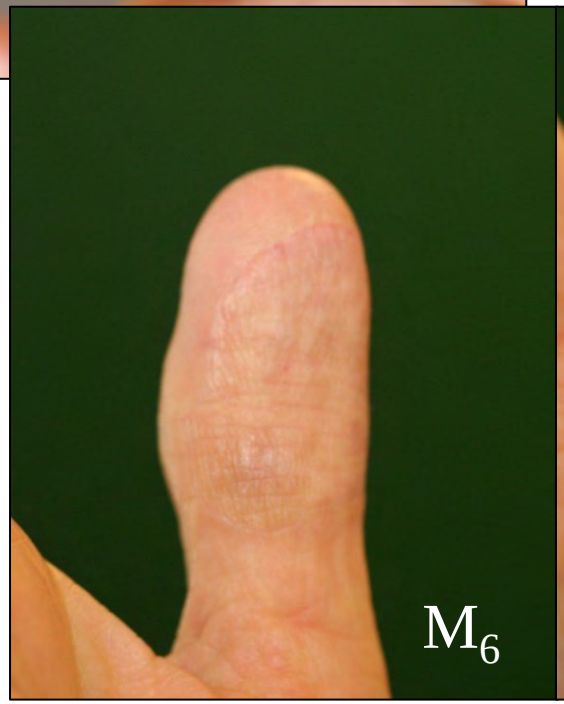


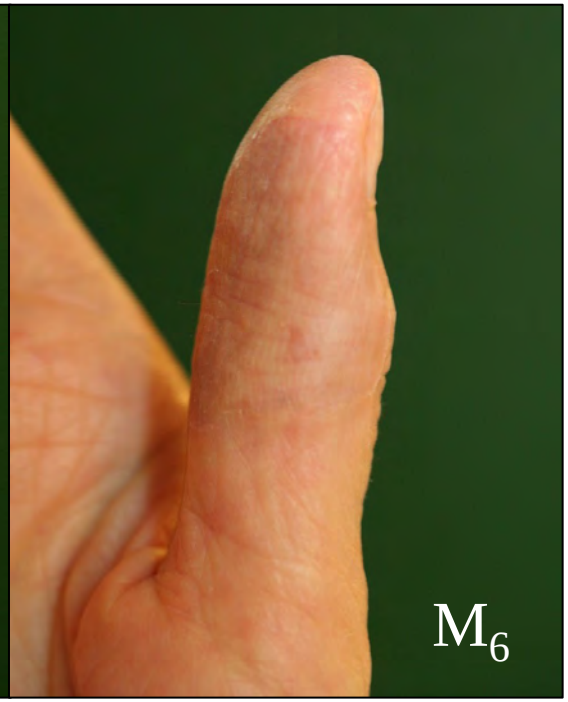





CONSERVATIVE

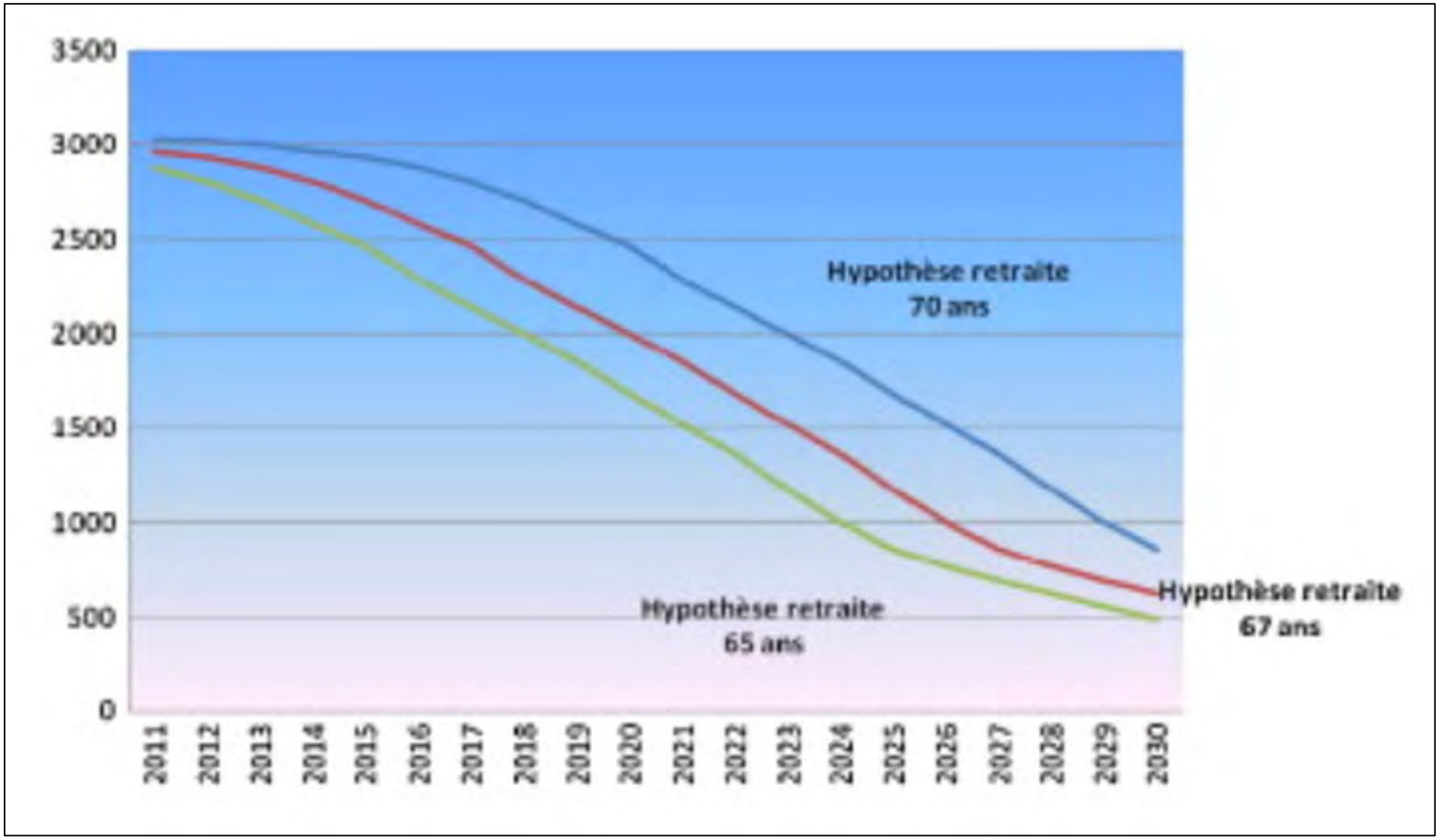



M6


M6


SO
WRONG

ARE YOU REALLY HERE



Ann dermatol venereol (2012) 139 833-11

Short wait times for patients seeking cosmetic botulinum toxin appointments with dermatologists

Jack S. Resneck, Jr, MD,[a] Shira Lipton, MD,[b] and Mark J. Pletcher, MD, MPH[c]
San Francisco and Los Angeles, California

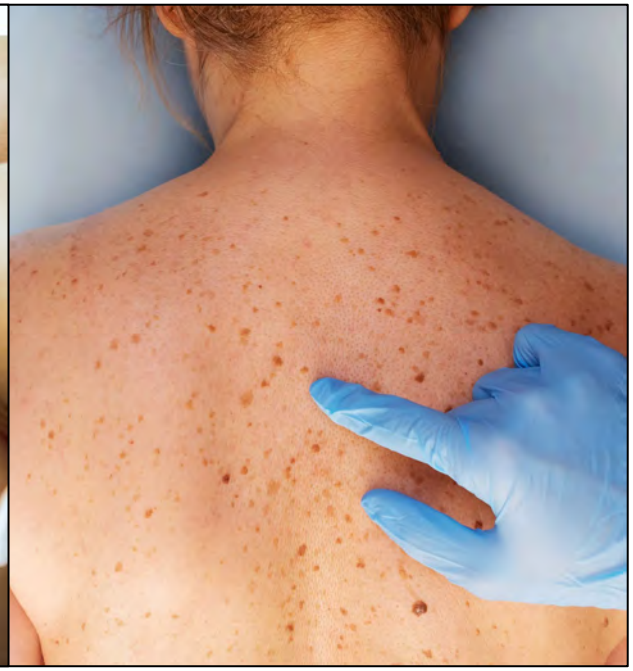
Background: Wait times for both routine and urgent dermatology appointments typically exceed 3 to 4 weeks. Many factors affecting physician workforce adequacy and patient access have been explored, but little is known about the impact of increasing numbers of doctors offering cosmetic services.

Objective: We sought to evaluate access to dermatologists for patients requesting cosmetic services.

Methods: Scripted patient telephone calls were made to 898 dermatologists in 12 metropolitan areas to assess wait times for an appointment to receive cosmetic botulinum toxin injections. The areas chosen were surveyed completely, and respondents represented about one tenth of practicing dermatologists in the United States. The methodology was identical to that used in a previous study of wait times for evaluation of a changing mole (a possible indicator of malignancy).

Results: Half of dermatologist respondents (455, 50.7%) offered appointments for botulinum toxin injections, and the median wait time was 8 days. Acceptance rates and wait times varied greatly by geographic area (range of median wait times 6.0-32.5 days), with dermatologists in Miami, Fla, and Orange County, California, most likely to provide a botulinum toxin appointment with a short wait time. Many dermatologists (241, 27%) employed physician extenders, and 39% of these extenders also offered appointments for botulinum toxin injections (median wait time 6 days). In comparison with a previous study showing median wait times of 26 days for evaluation of a changing mole in these communities, wait times for cosmetic injections were significantly shorter ($P < .001$).


DELAY



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Did you know?

Diagnosis and treatment of skin lesions are essential skills for primary care practitioners.

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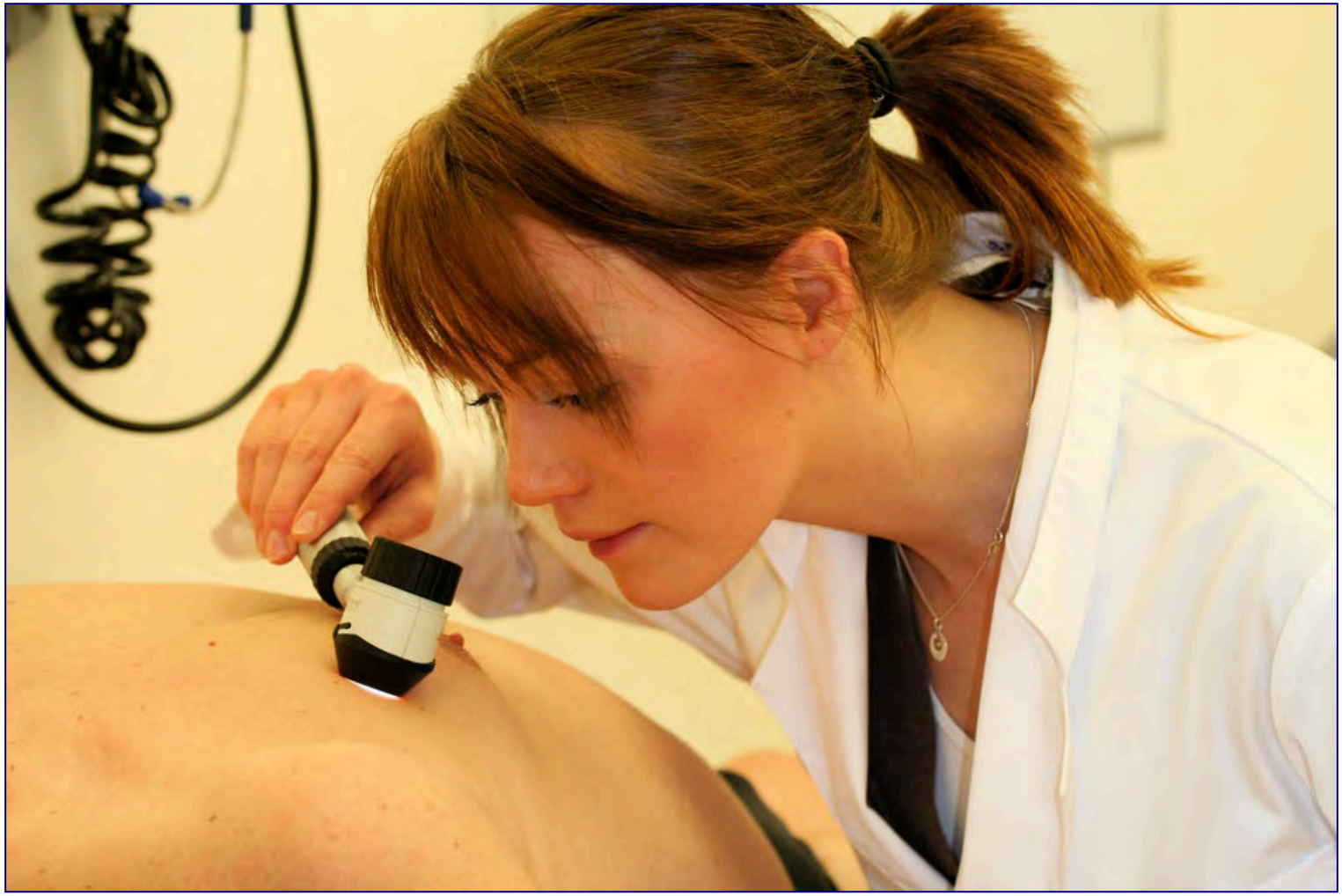
CASIO
HOW?

La dermoscopie c’est quoi ?



uestion N° 3 : Pr Luc Thomas

elle est (avec 4 exemples), ce qu'elle n'est pas (avec deux

Question N° 3 : Pr Luc Thomas

La lésion élémentaire en dermatologie, ce qu'elle est (avec 4 exemples), ce qu'elle n'est pas (avec deux exemples), et comment la rechercher.

- Ce qu'elle est : macule, papule, végétations, squames.

- Ce qu'elle n'est pas : - une lésion provoquée par grattage
  - une cicatrice

- On peut la rechercher à l'aide d'un dermatoscope, d'un mètre de couturière.

2052

Ce n’est pas …

Ce n’est pas …


BULLSHIT

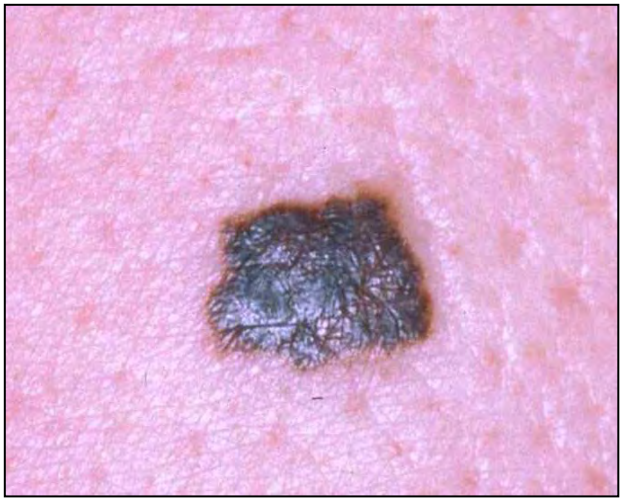
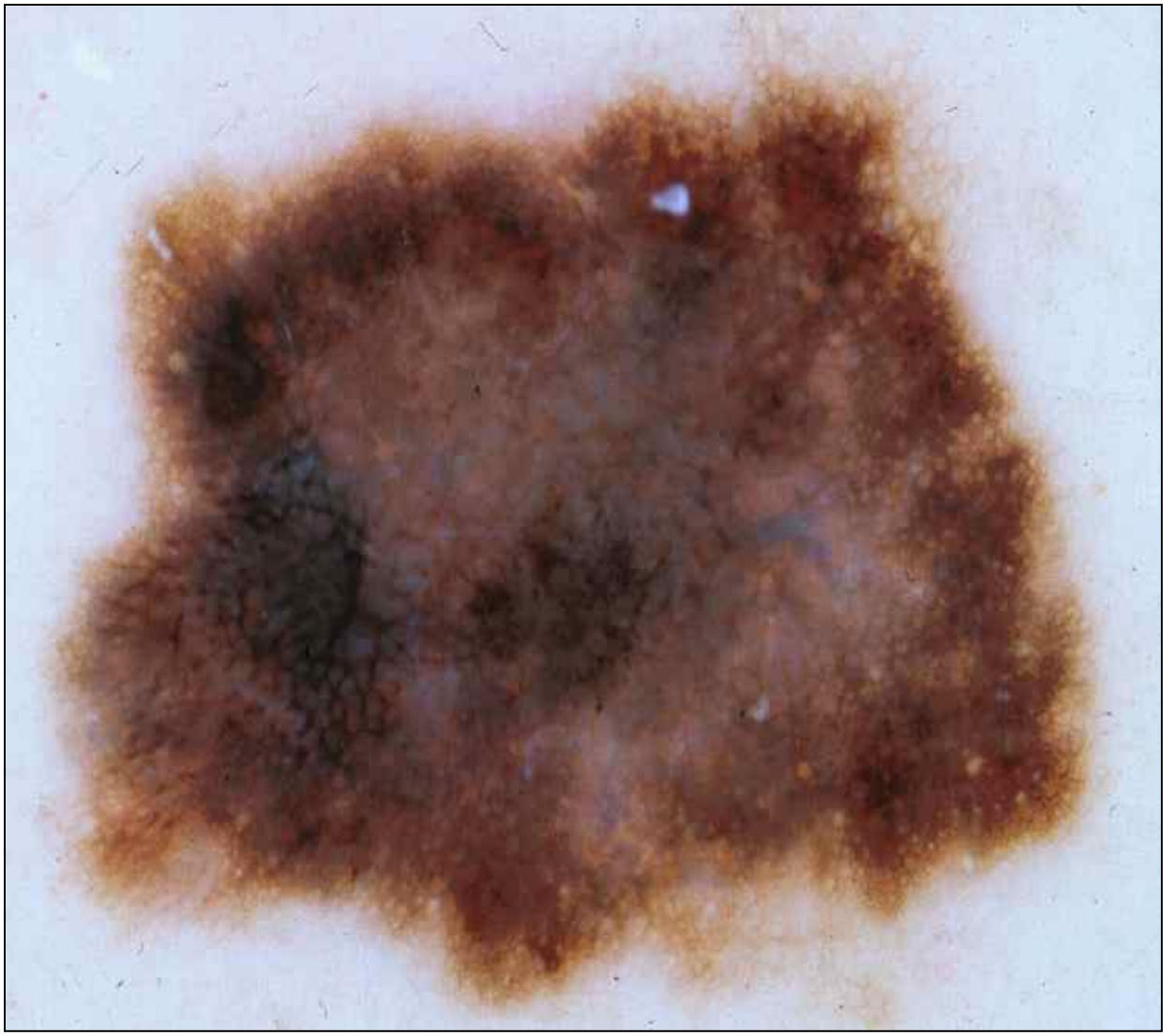
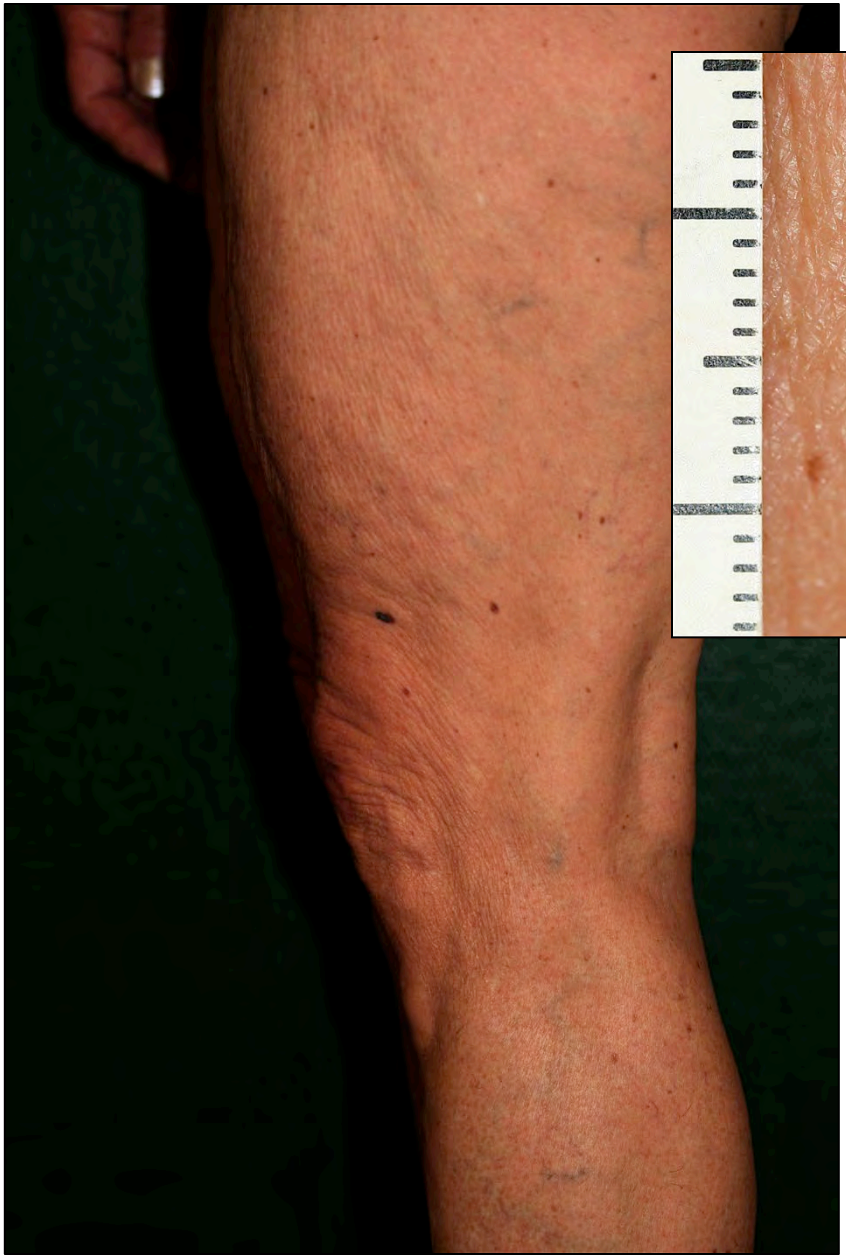
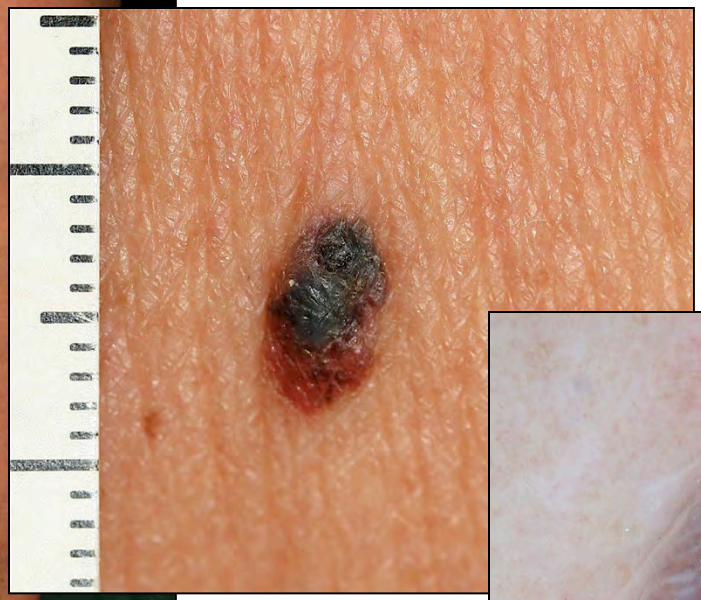


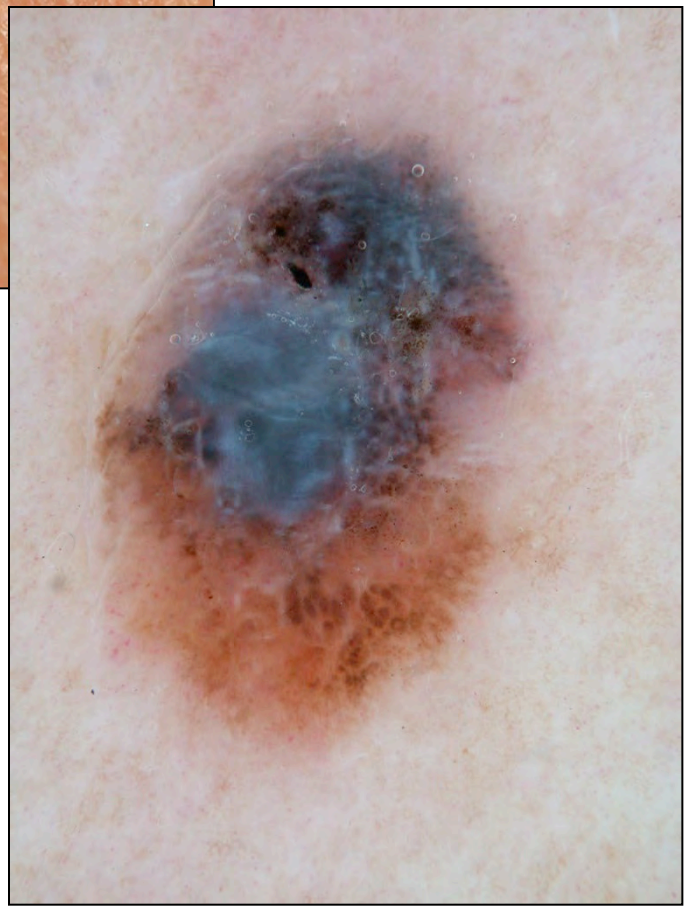
Image clinique

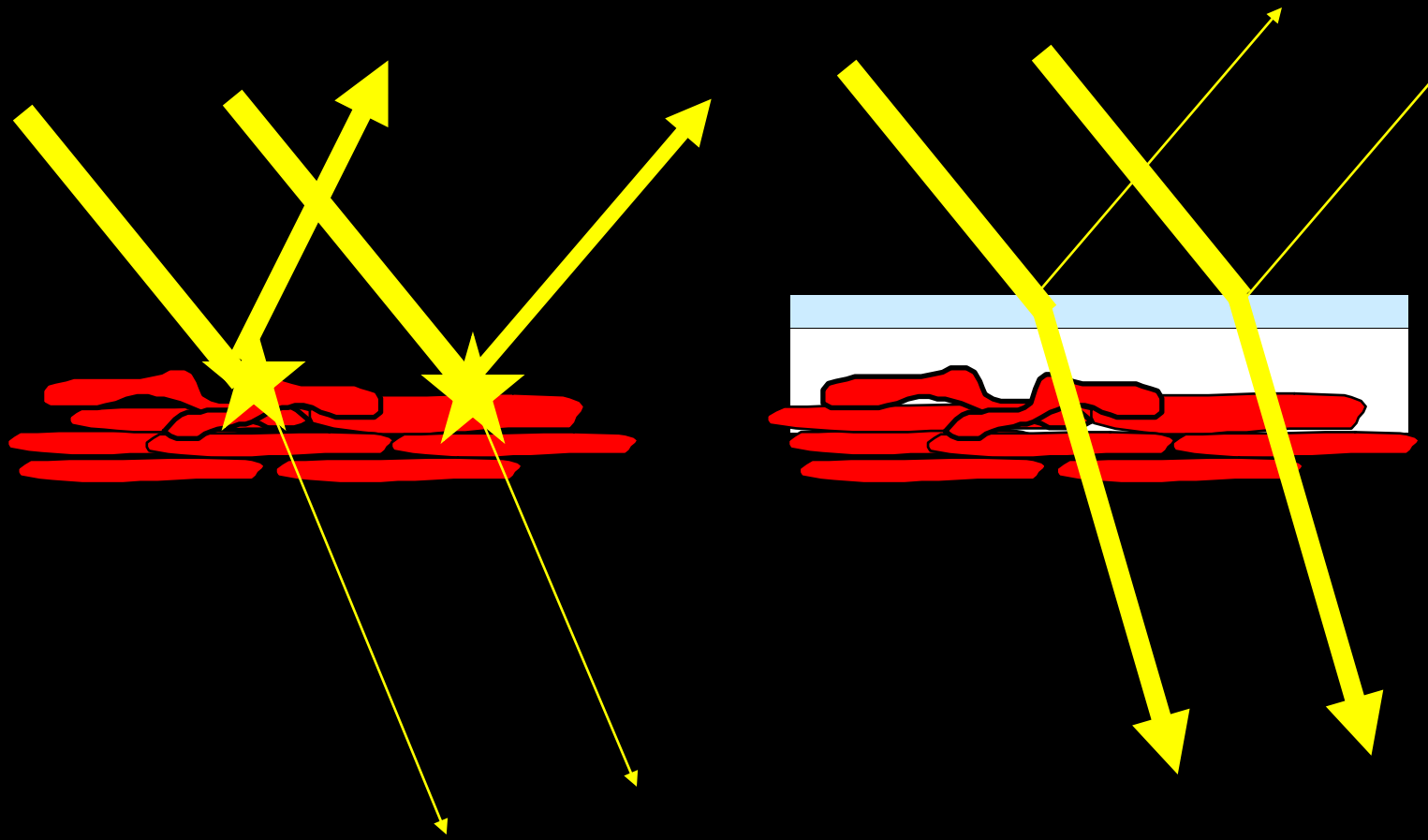


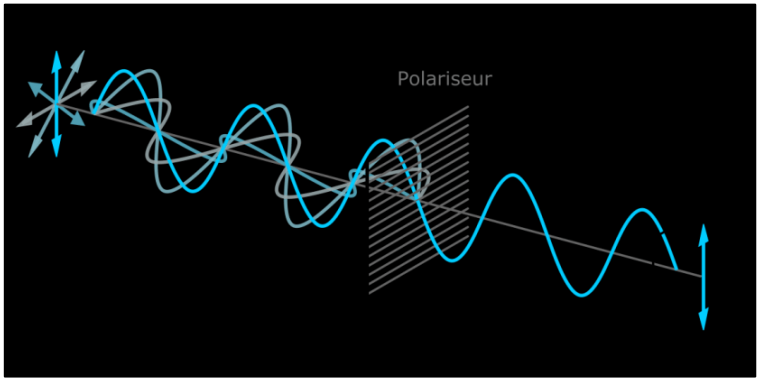
dermoscopie



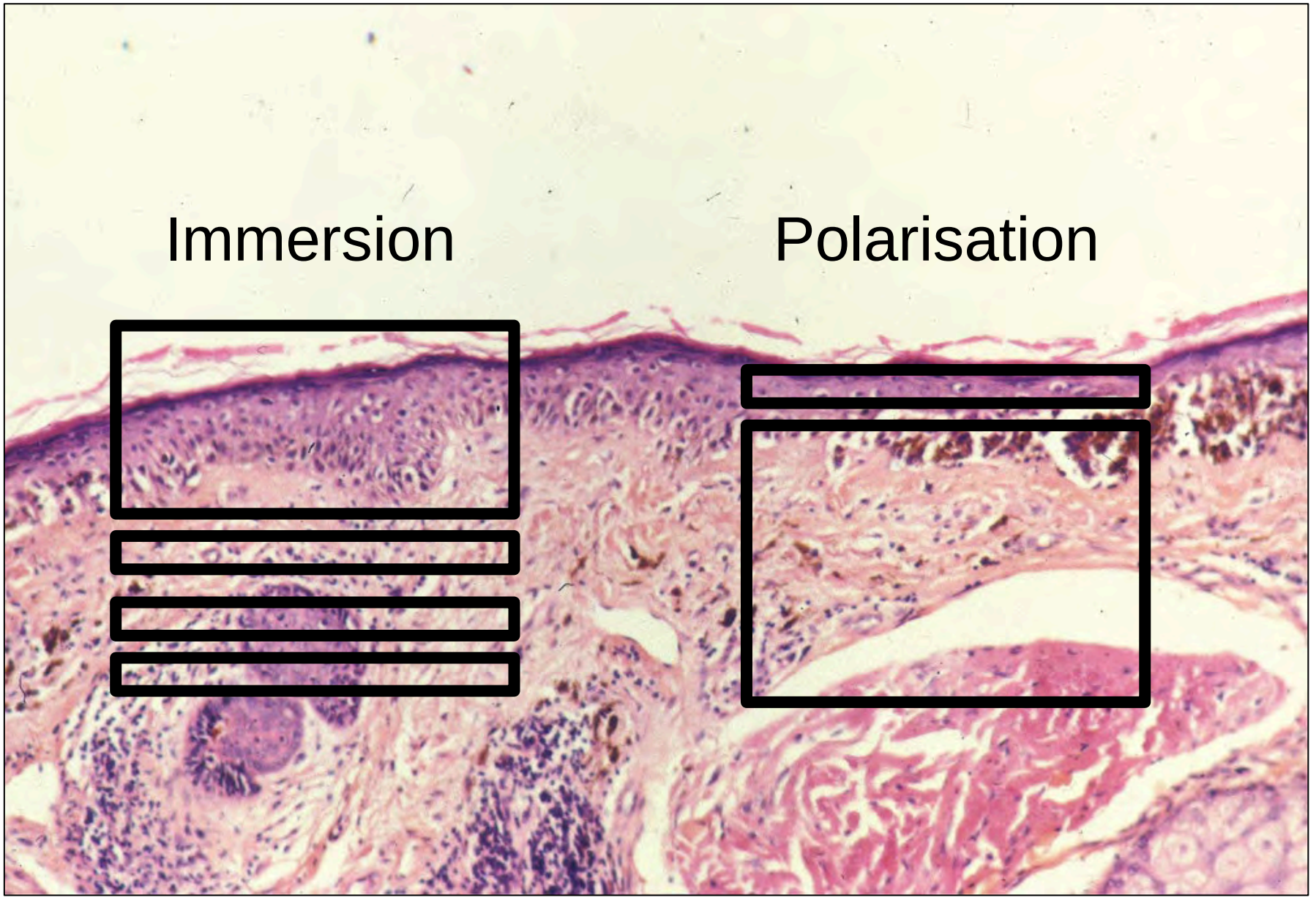


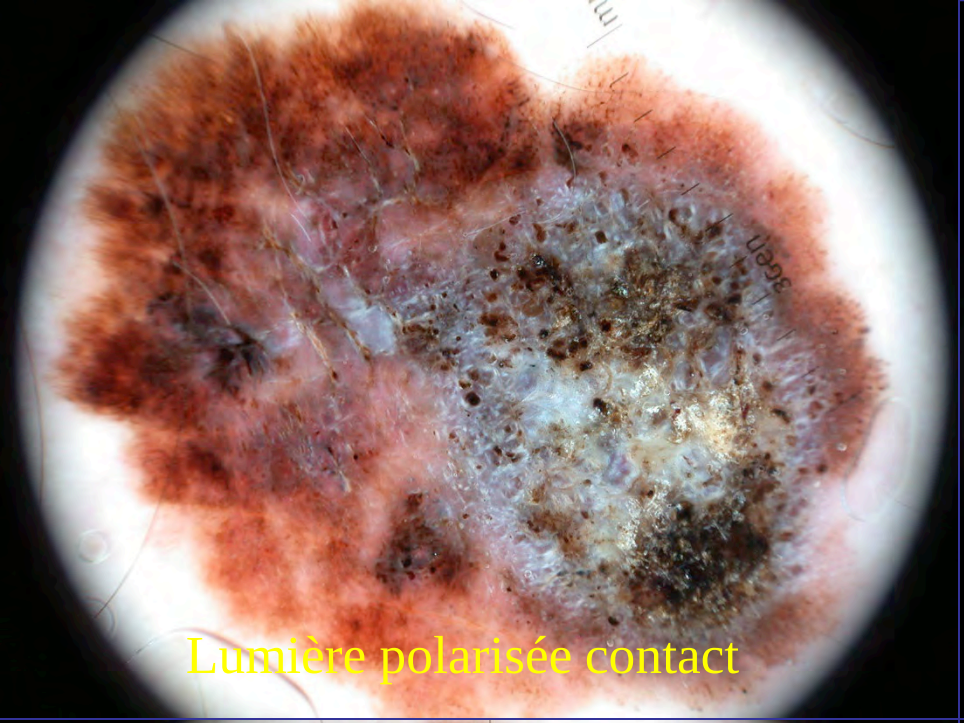




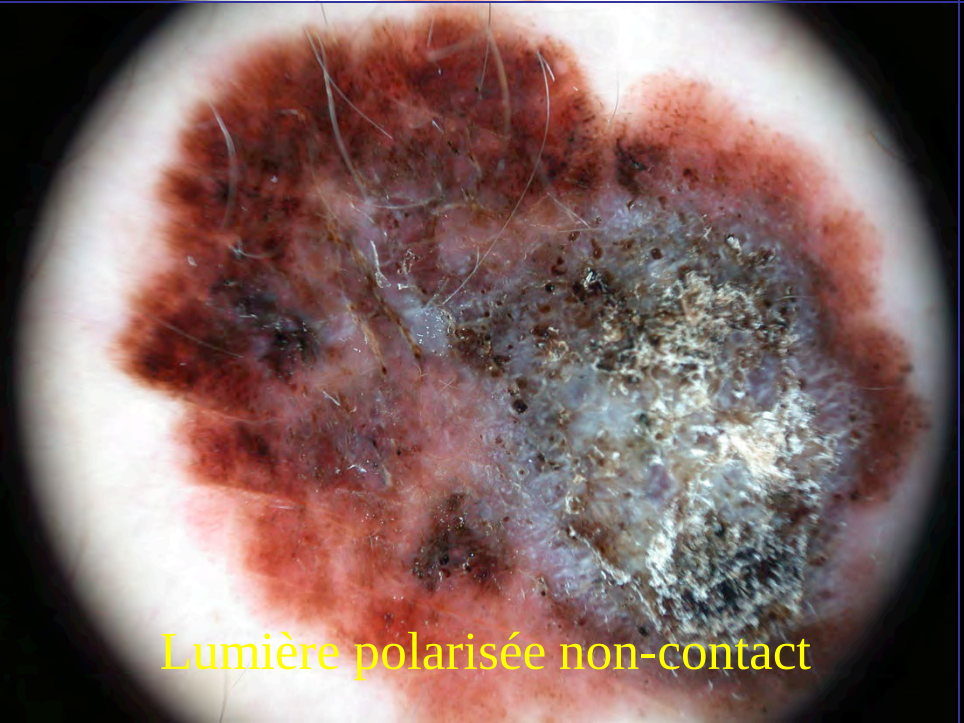

Polariseur

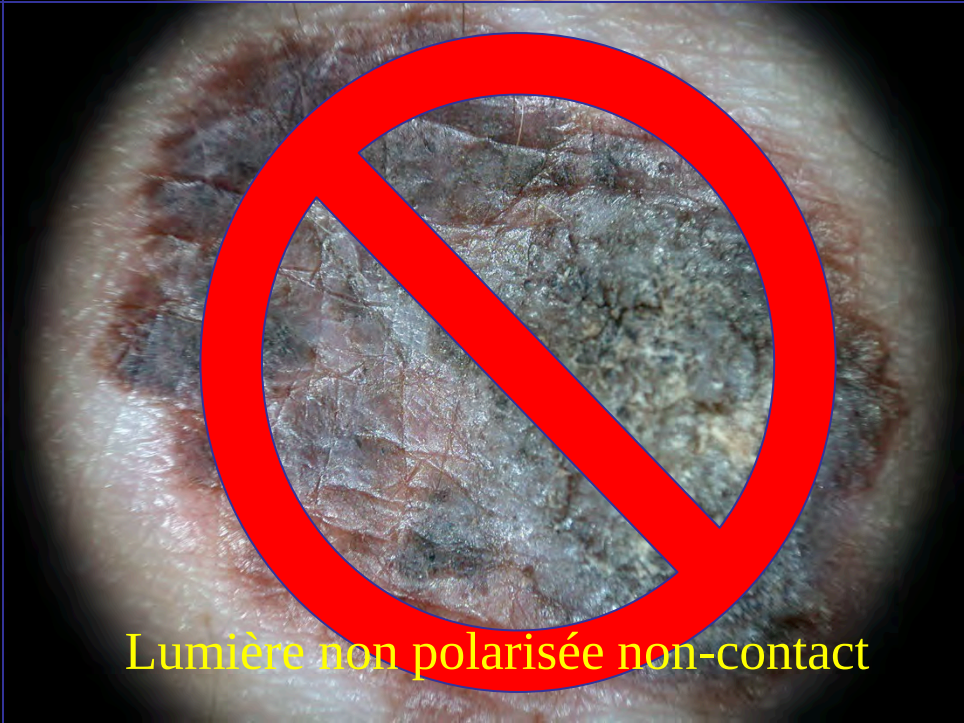
Dermoscopie double mode


Immersion
Polarisation


Lumière polarisée contact


Lumière non polarisée contact

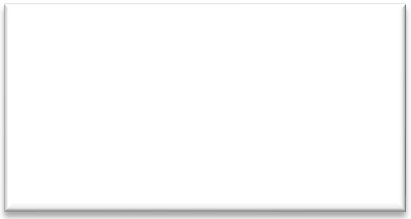

Lumière polarisée non-contact


Lumière non polarisée non-contact

Couleurs naturelles

Mélanine / hémoglobine (séchée)

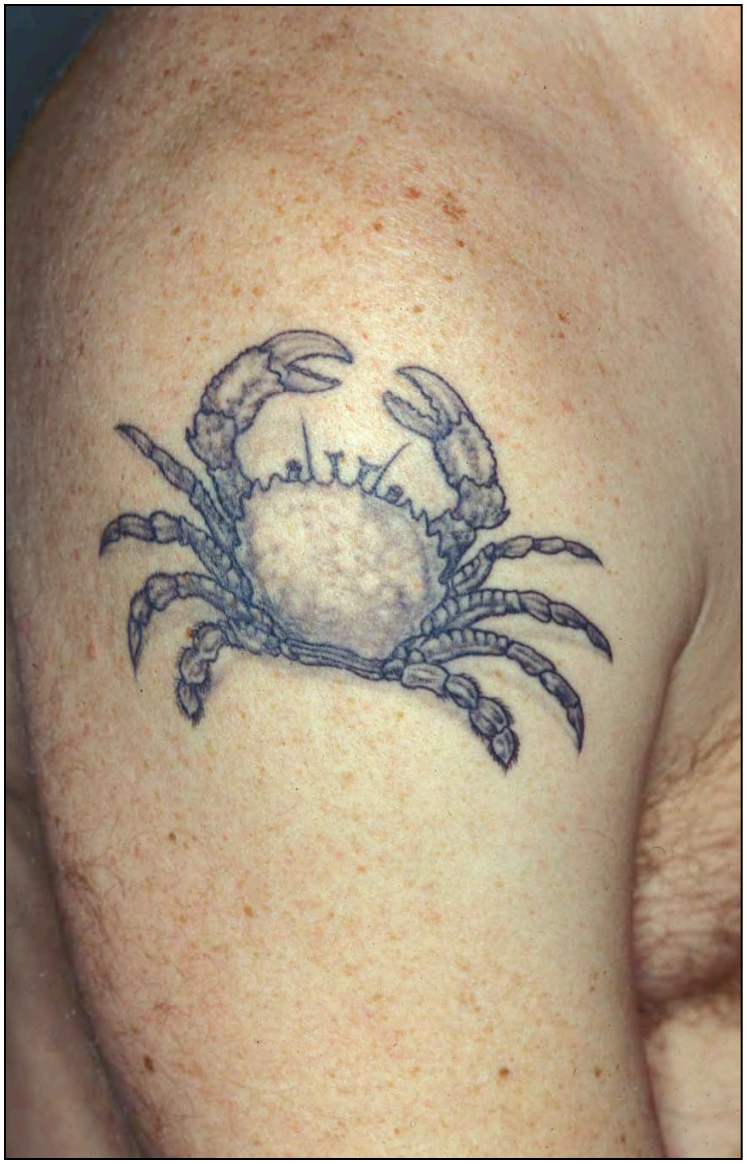
(Oxy)hémoglobine (intra-cellulaire)



Kératine (non oxydée)

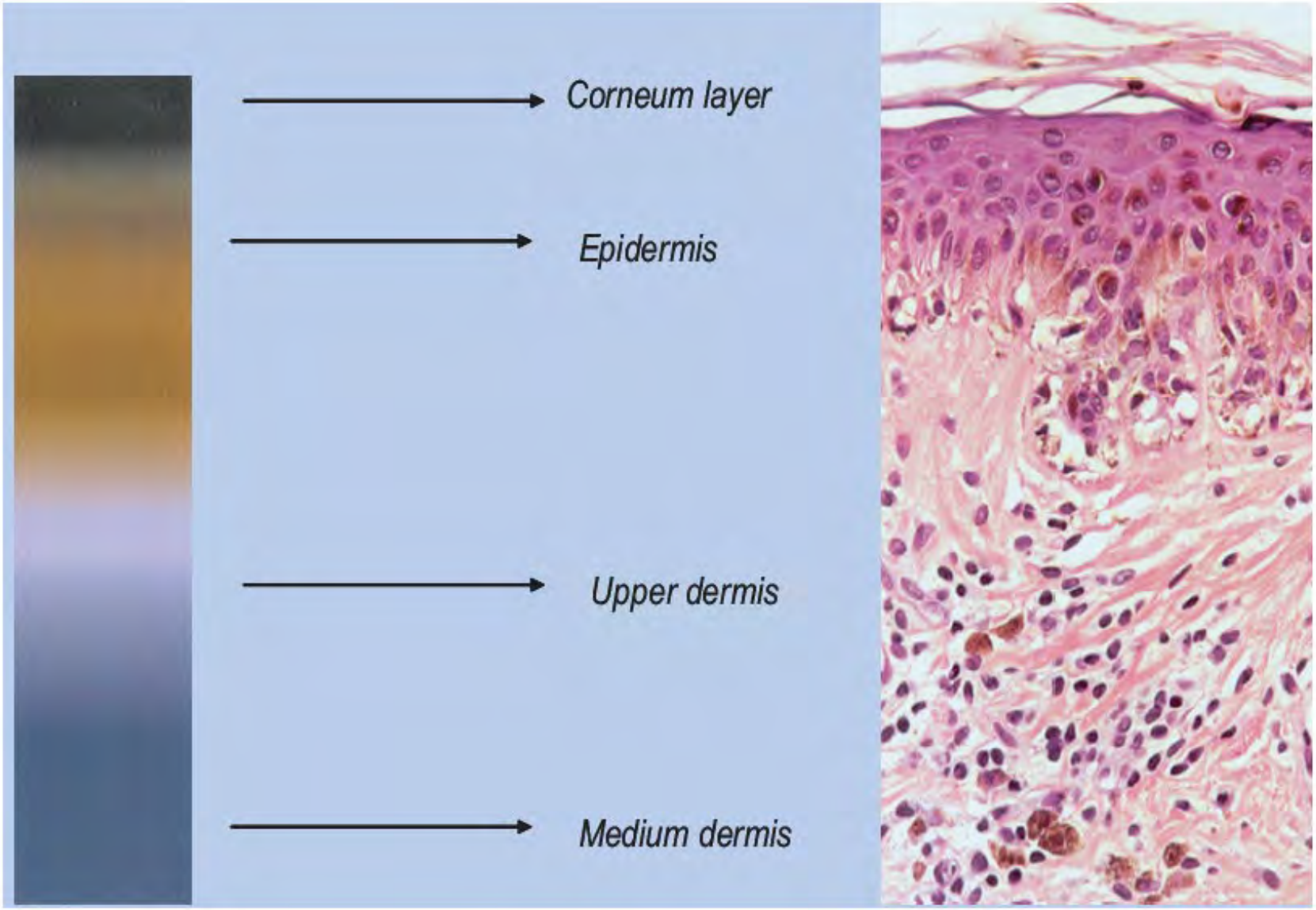
Kératine (oxydée) / sébum / sérum (séché)

Carboxyhémoglobine




NANKING


唐詩登鸛鵲樓
白日依山盡黃河
入海流欲
窮千
里目更上
一層樓



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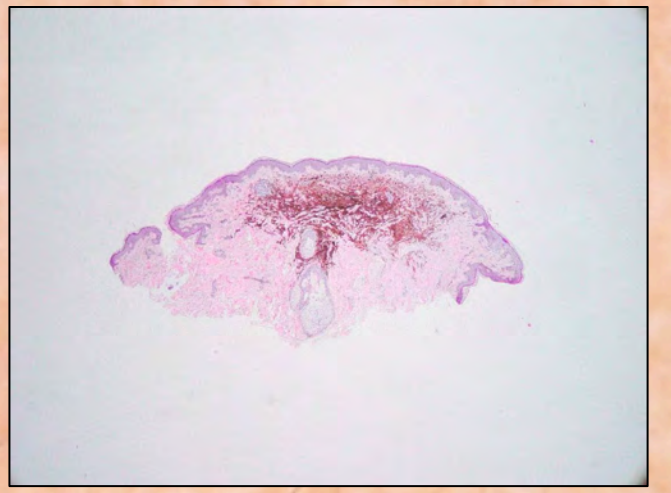
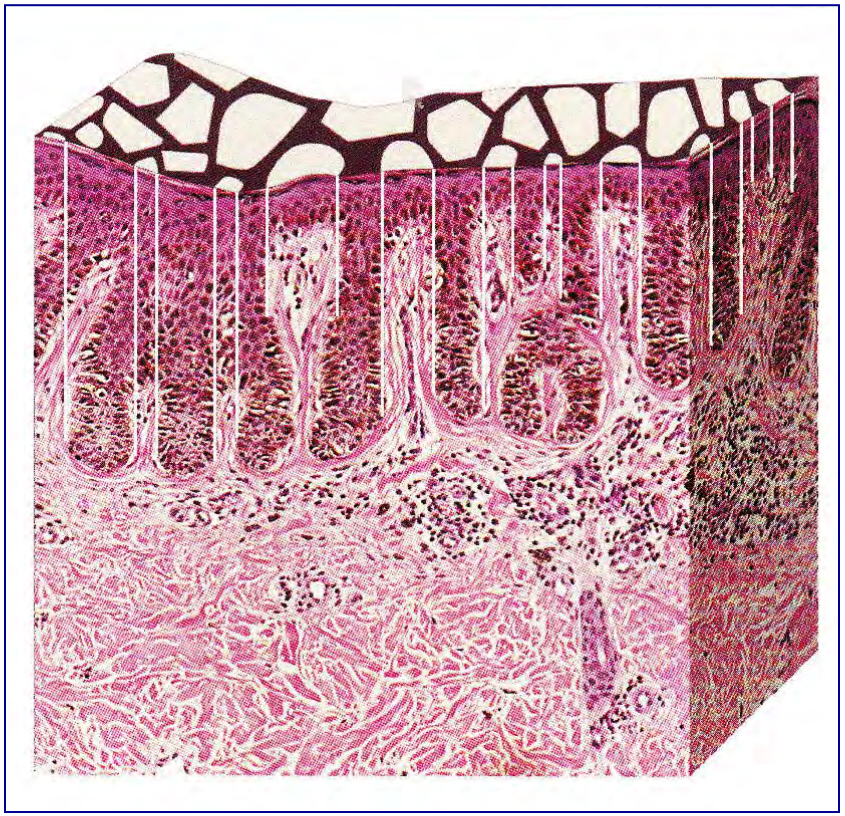


Structures

La dermoscopie reflète l'anatomie



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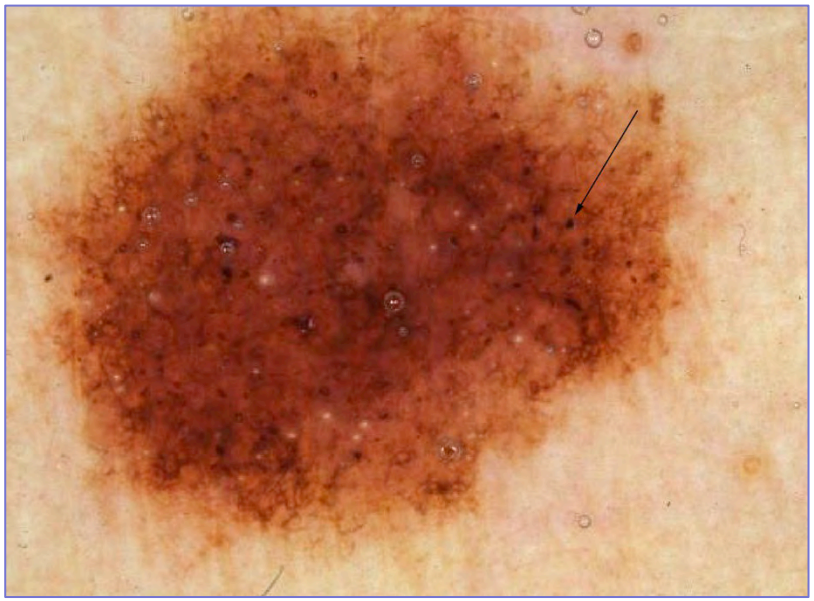
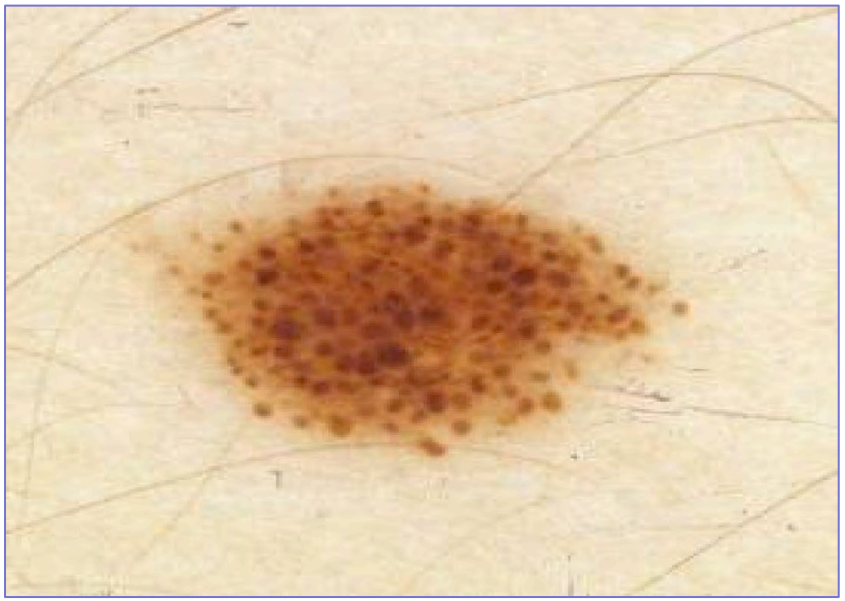
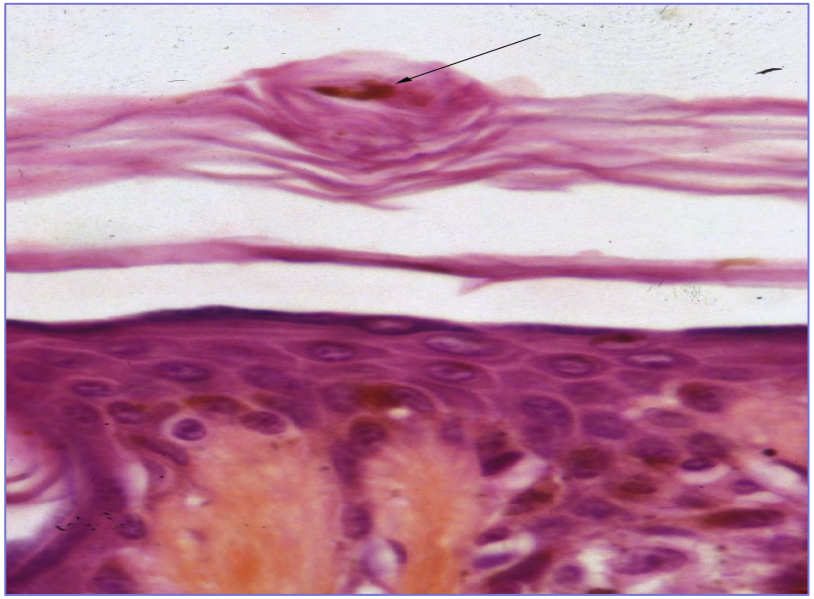
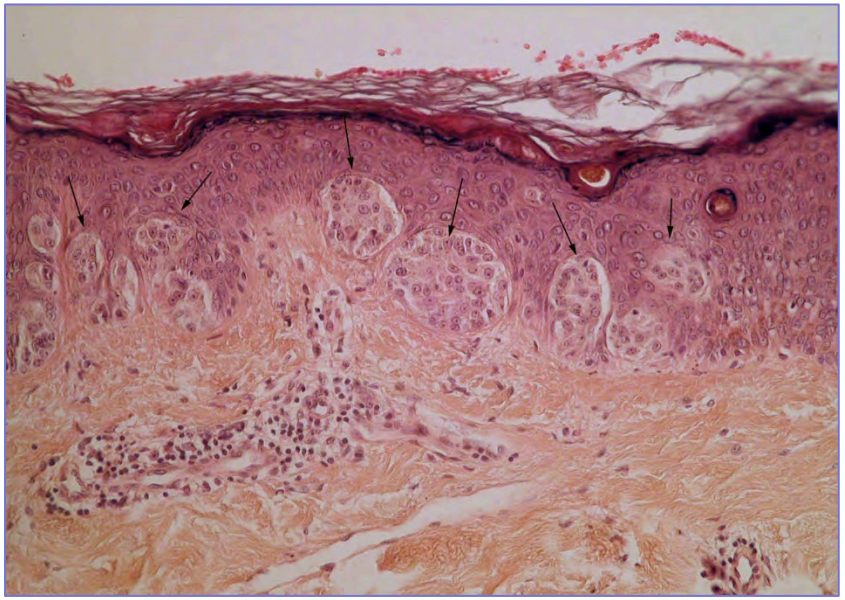
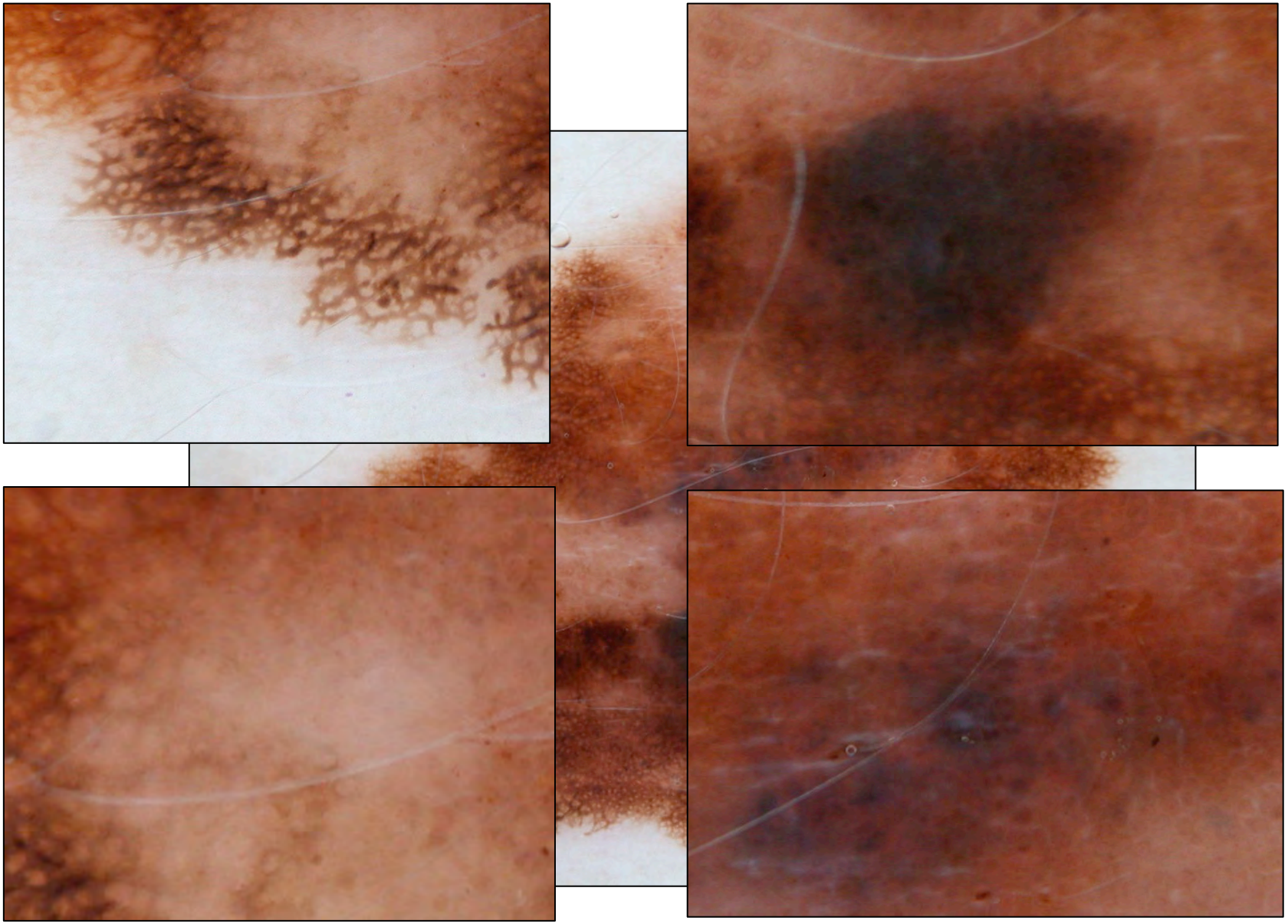


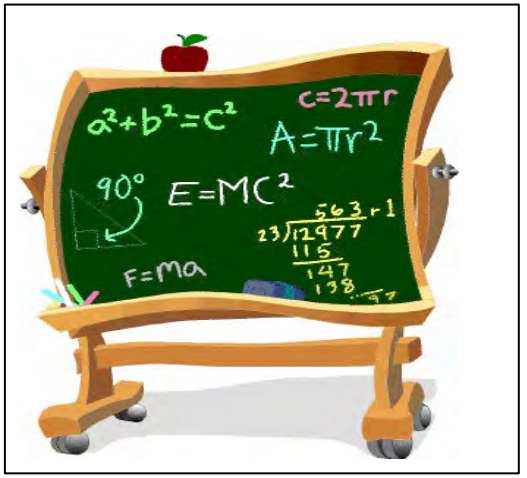


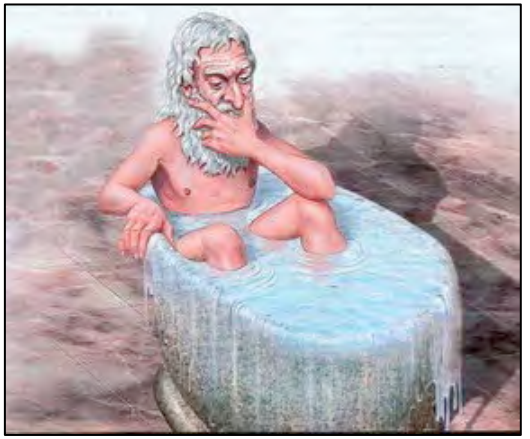


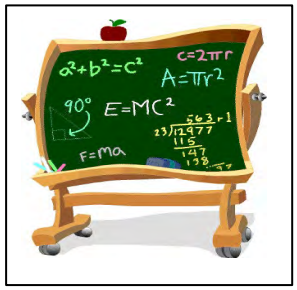




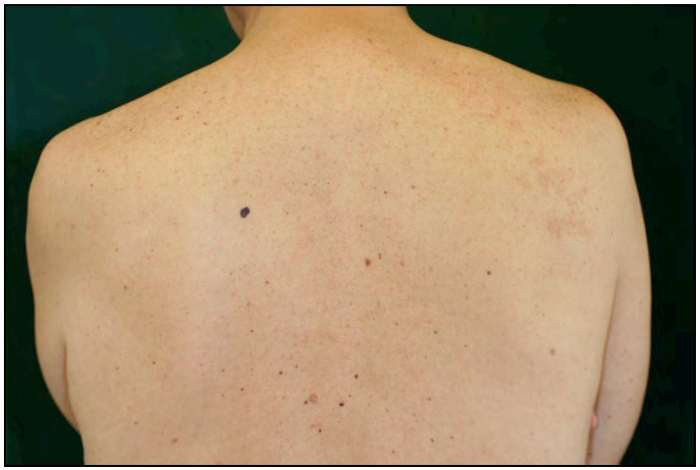
Méthodes







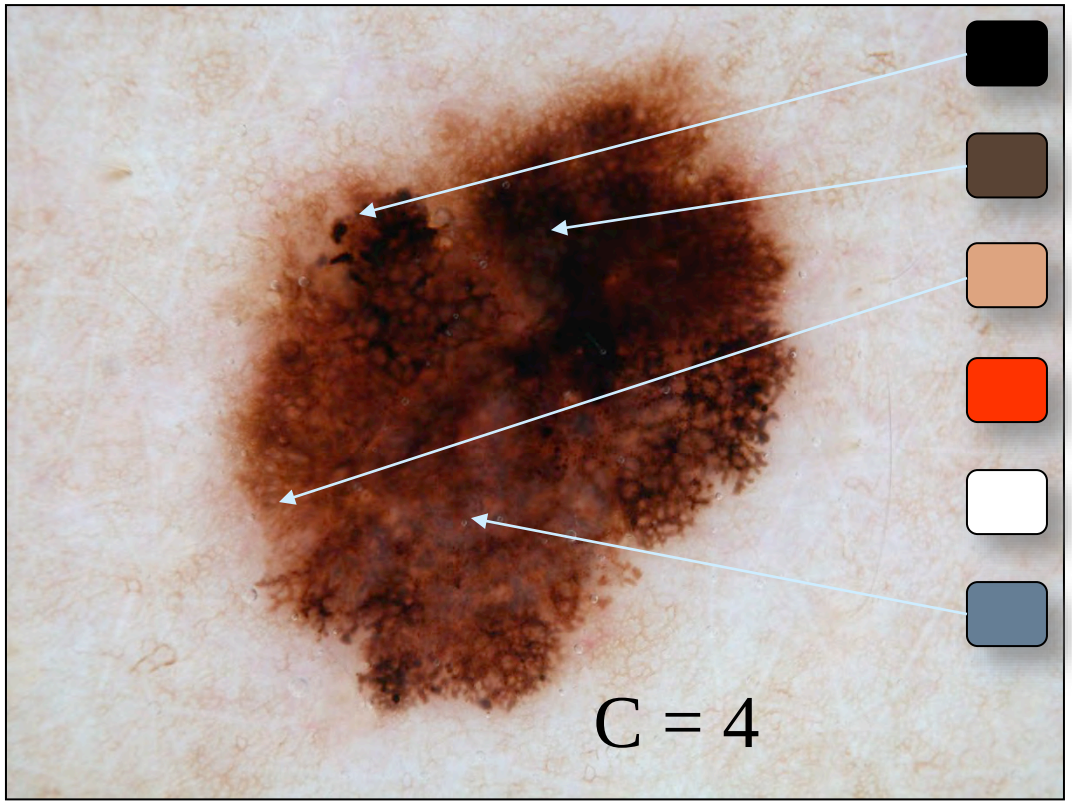
Algorithmes



A = 2

B = 3

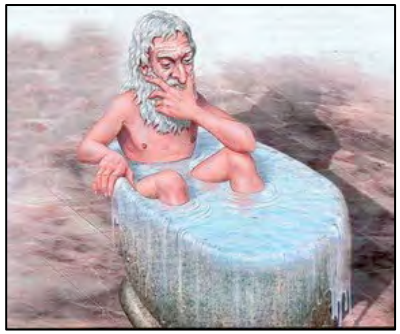
D = 4



TDS = (2 x 1,3) + (3 x 0,1) + (4 x 0,5) + (4 x 0,5) = 6,9

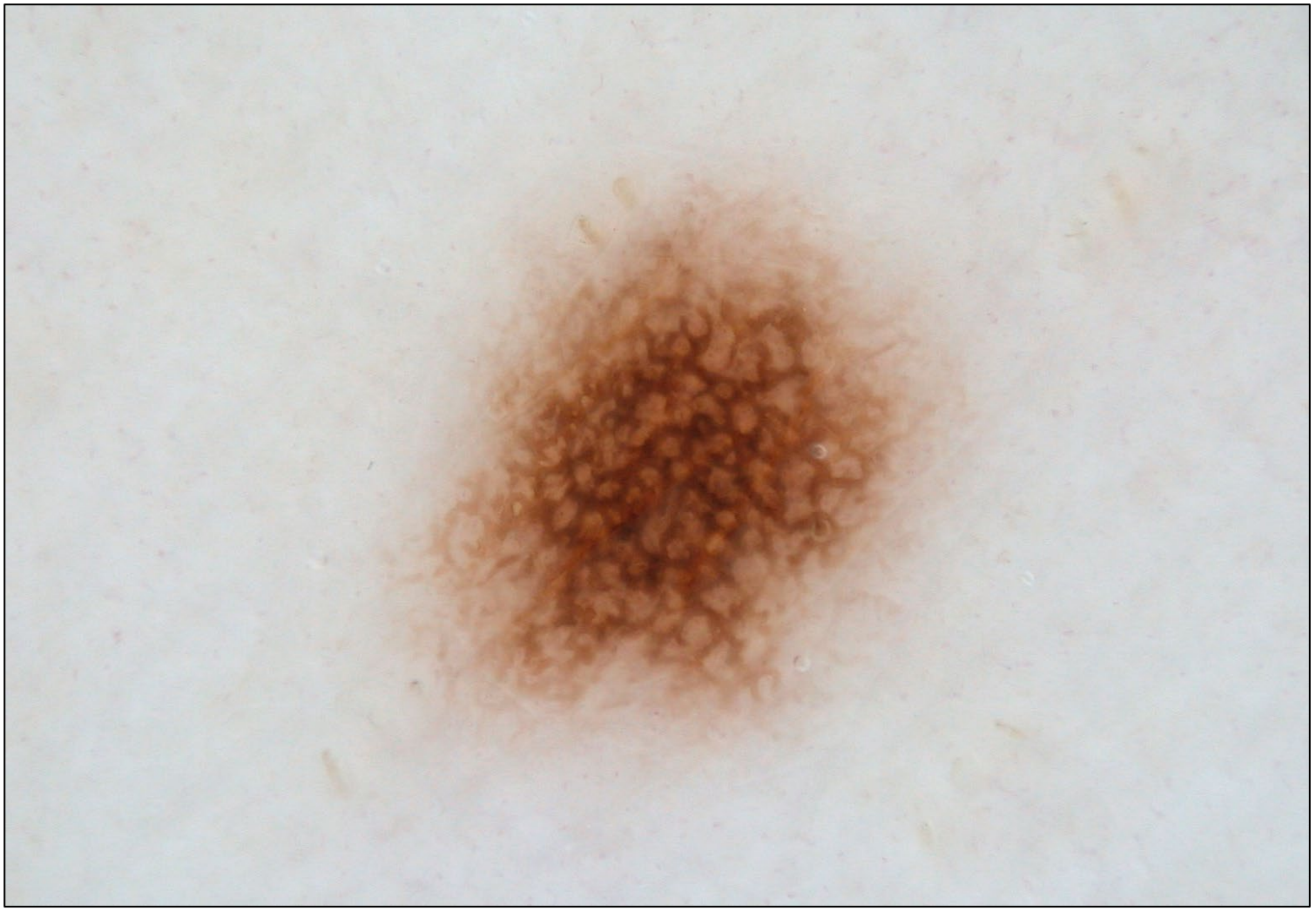
TDS > 5.45

Mélanome

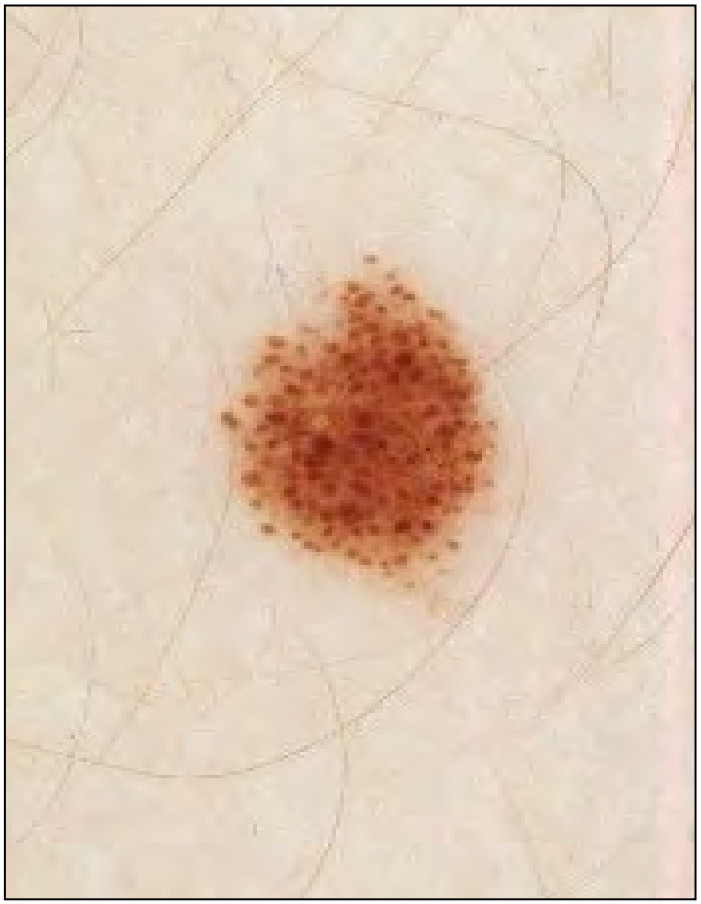


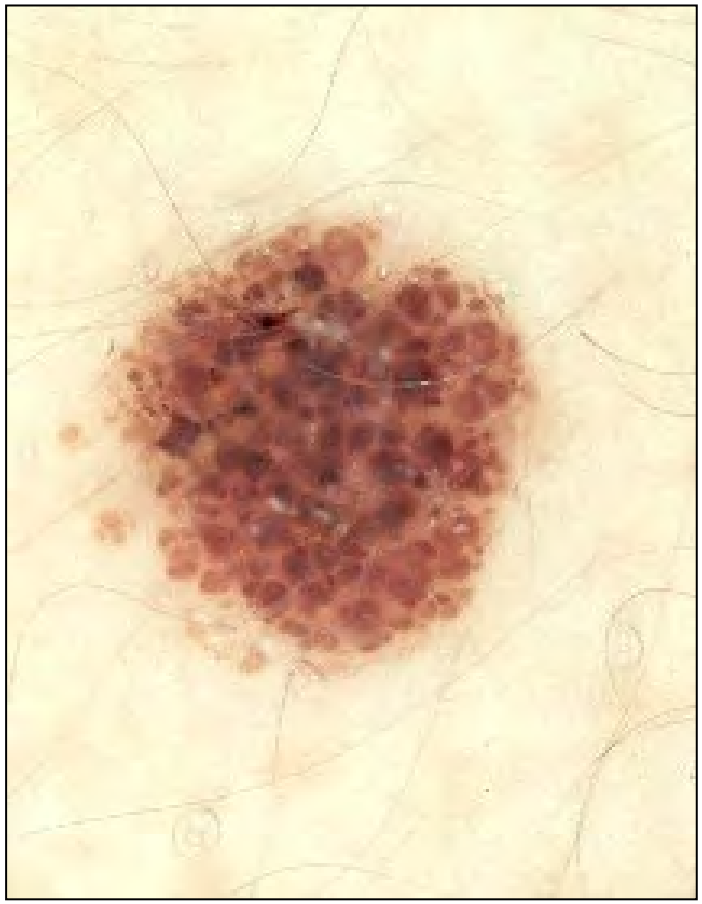
Patrons dermoscopiques

Patron réticulaire



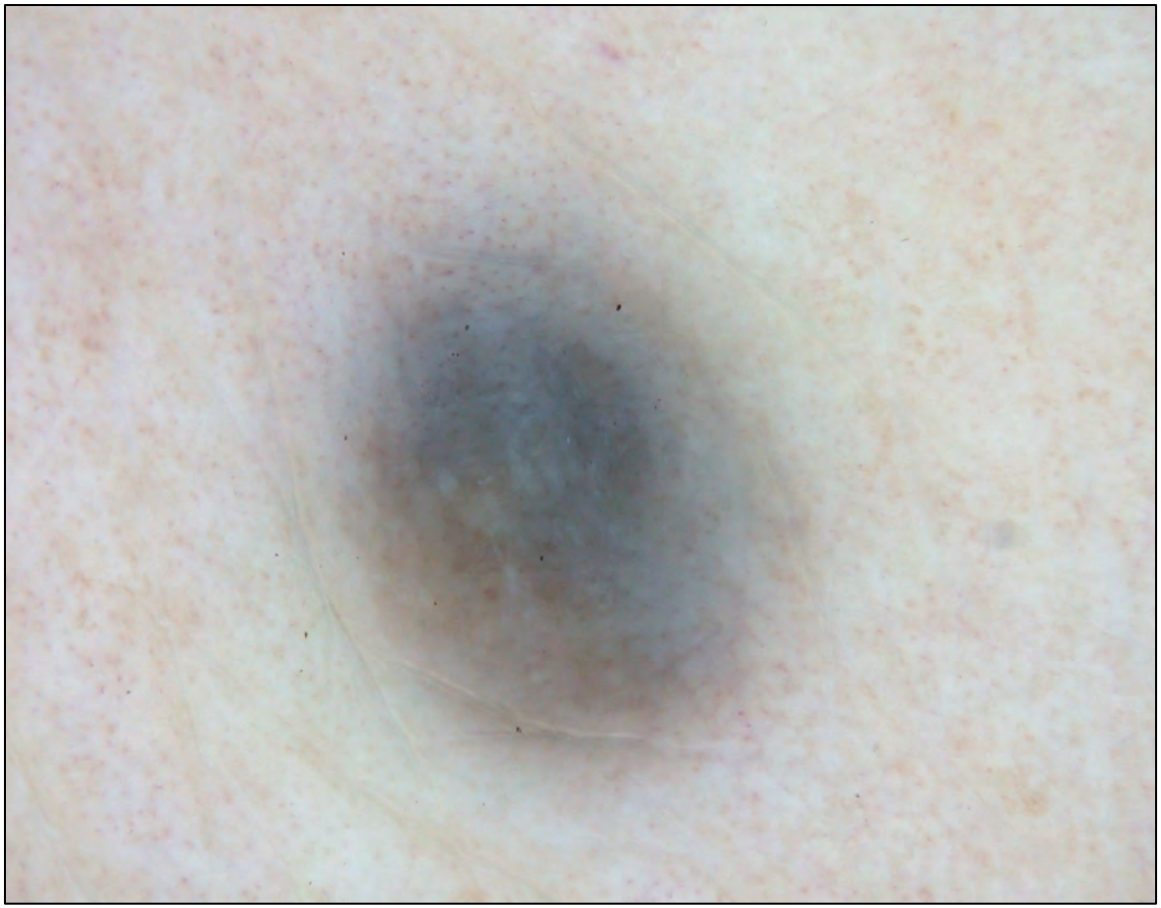
Patron globulaire
(et pavimenteux)



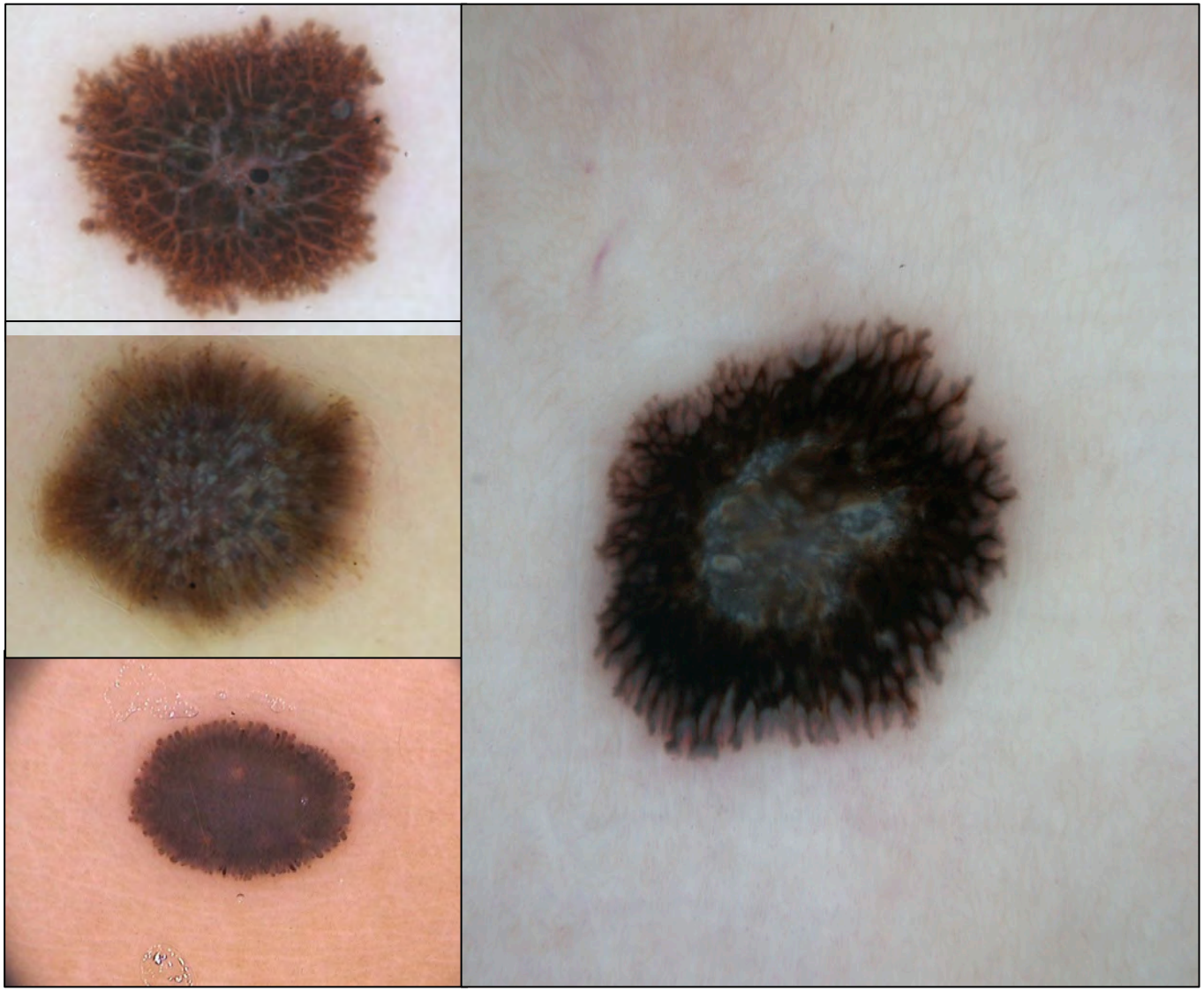


Patron sans structure

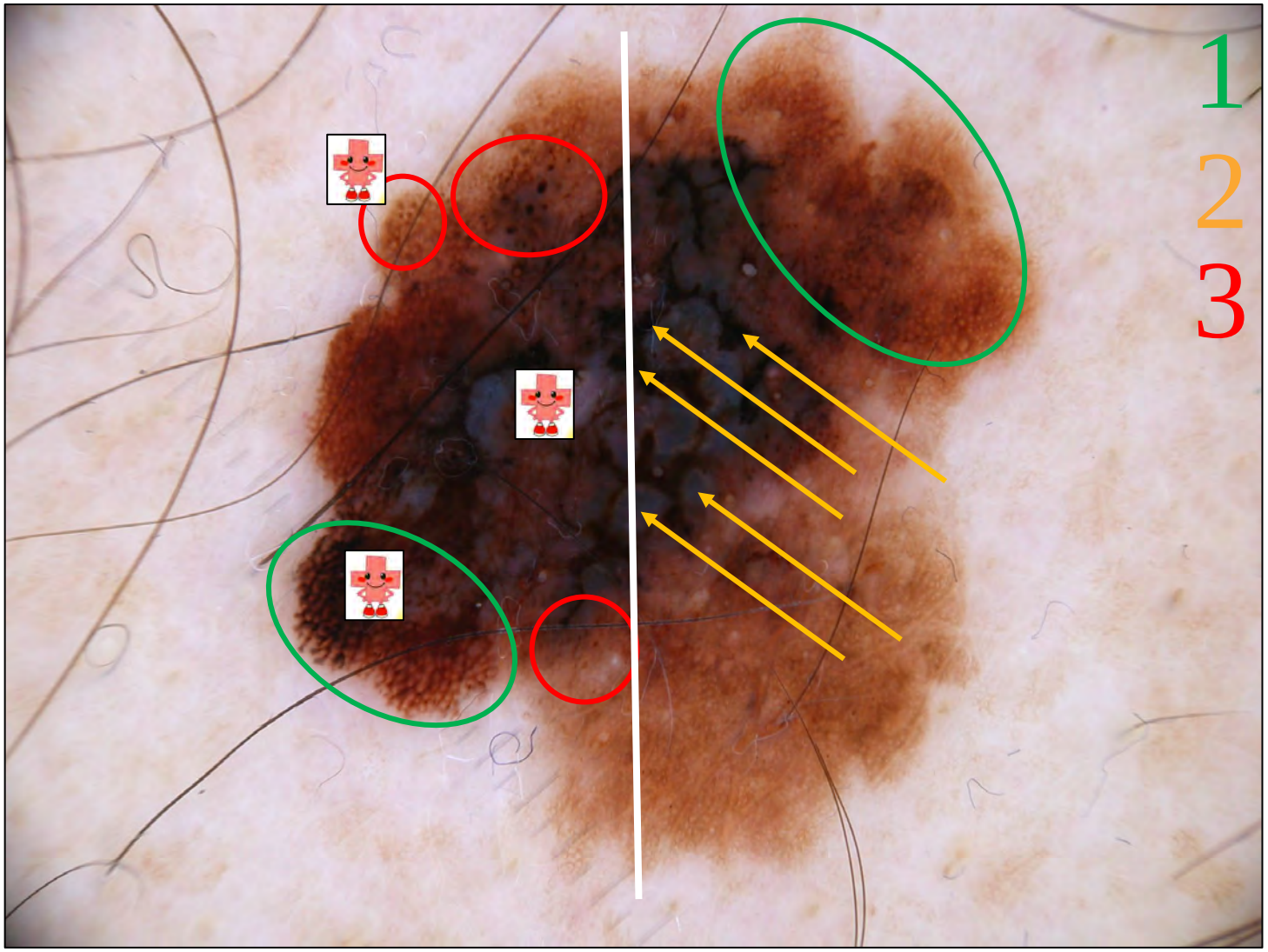
(ou homogène)

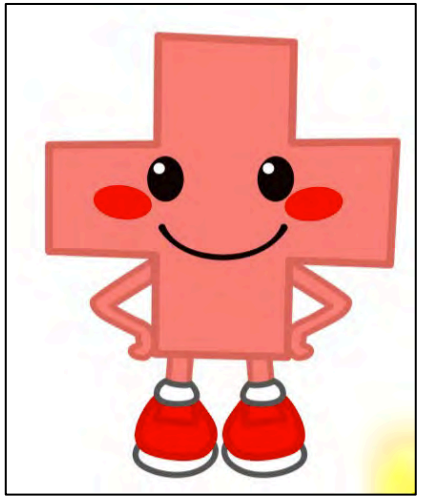


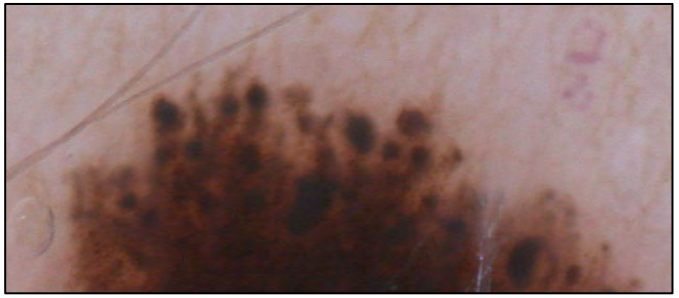
Patron étoilé

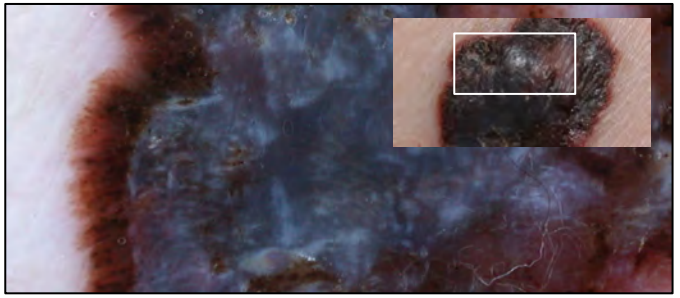


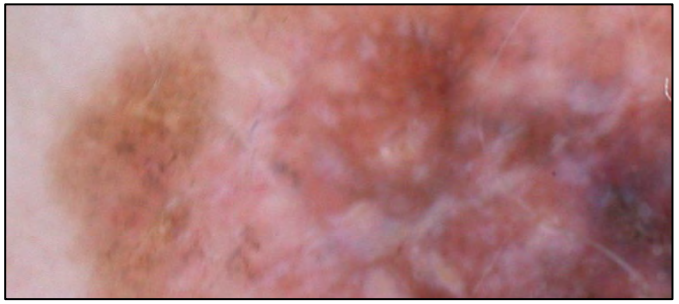
Patron multicomposé et asymétrique

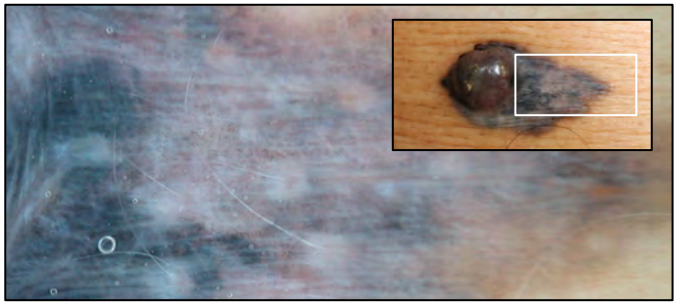


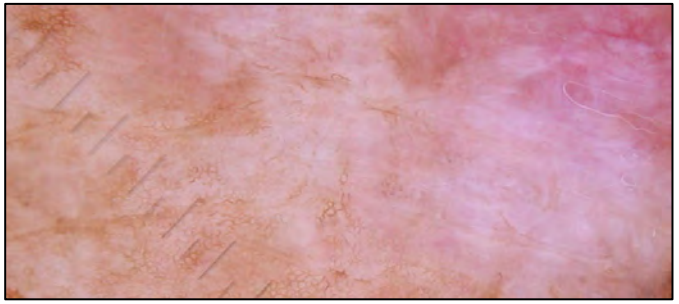


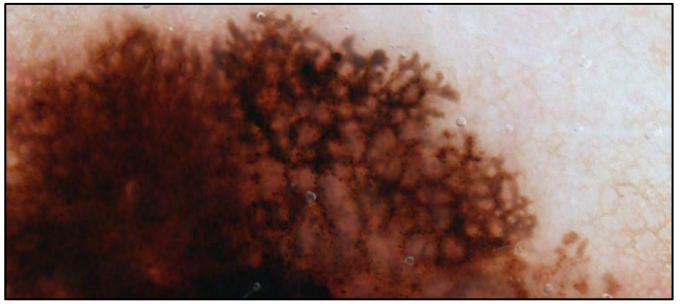


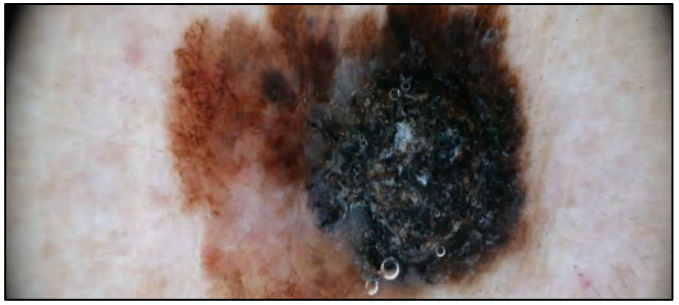


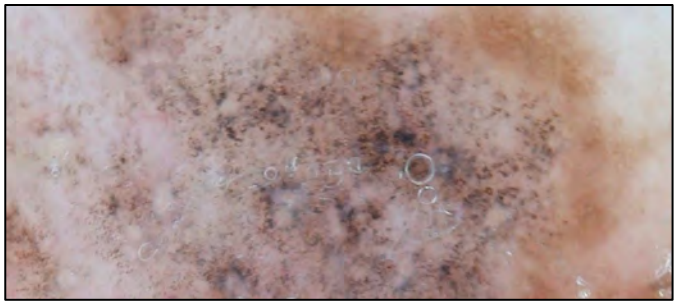




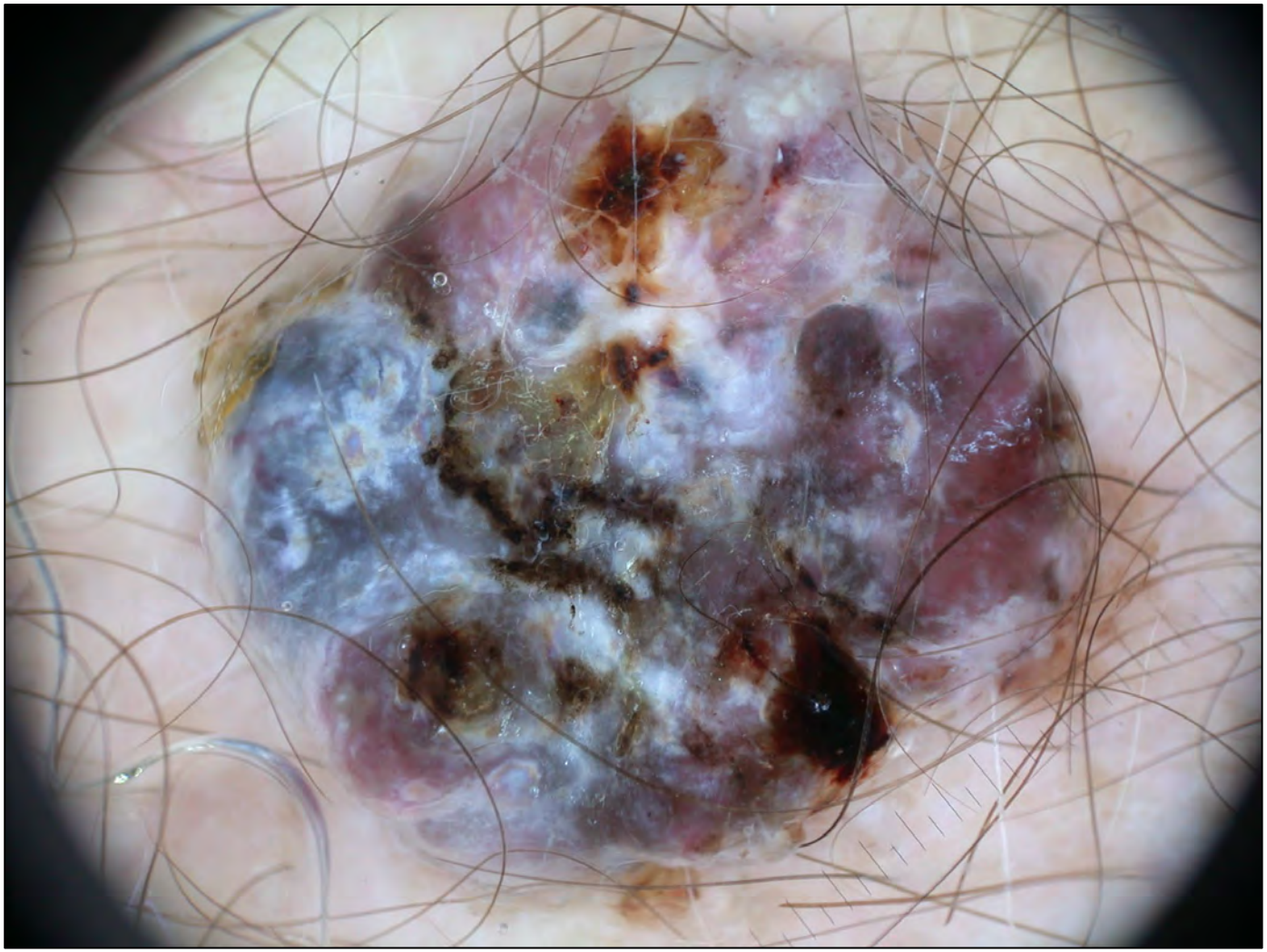




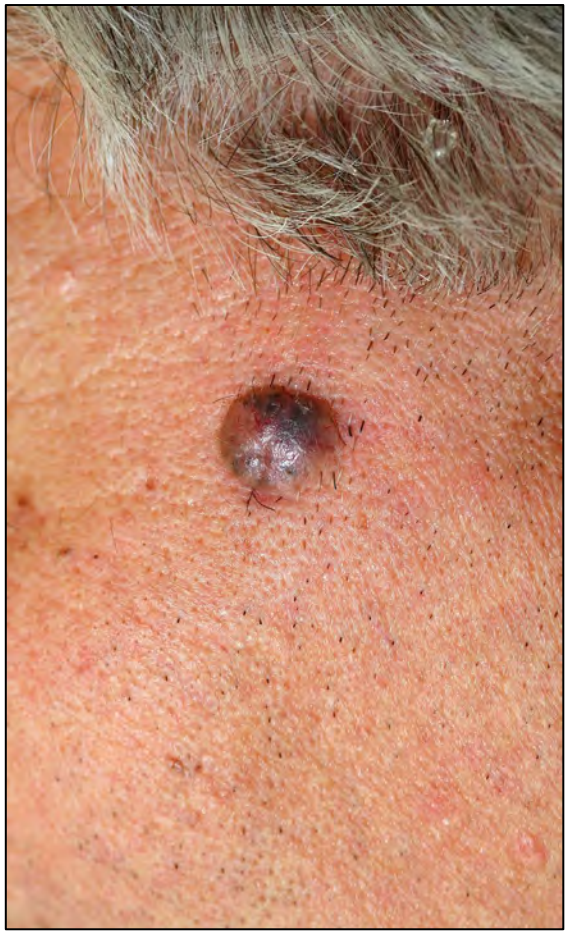


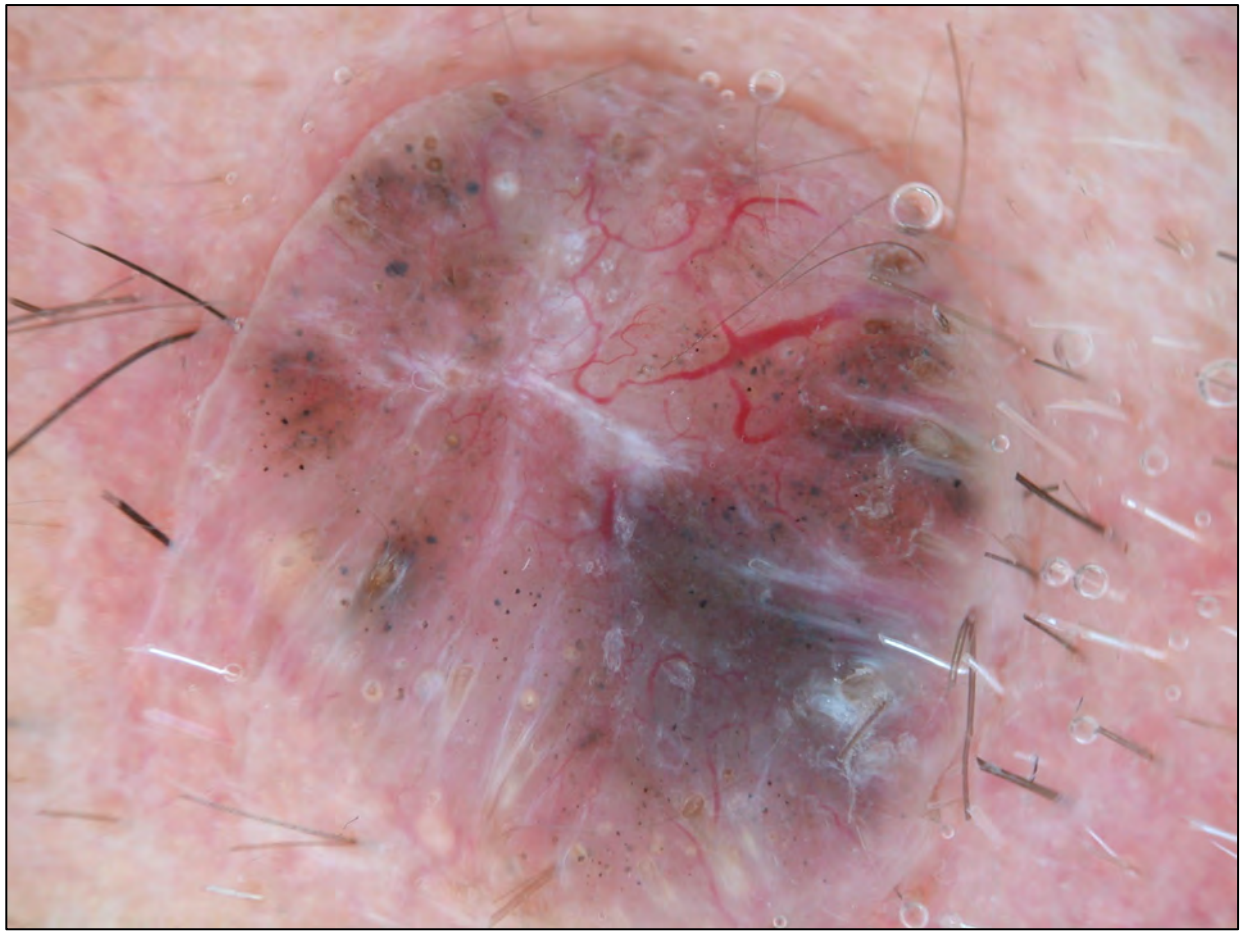


Patron nodulaire

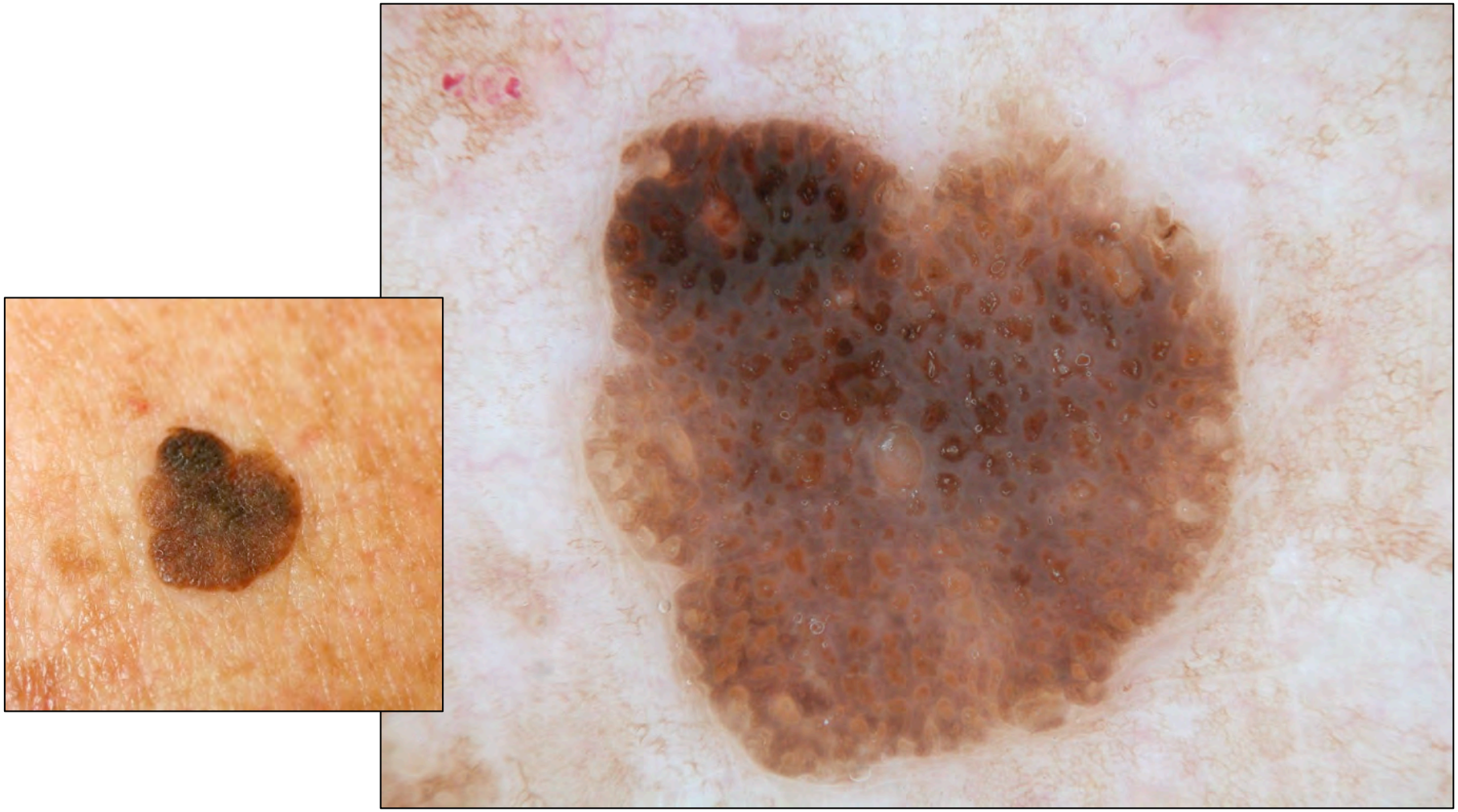


Carcinome basocellulaire

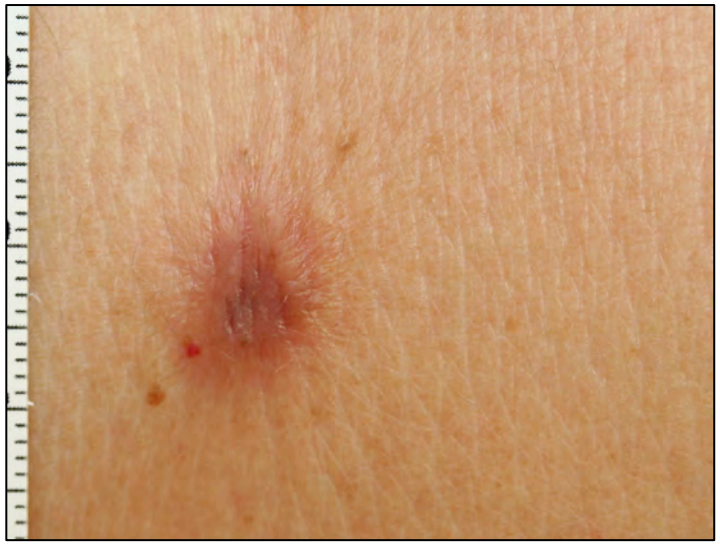


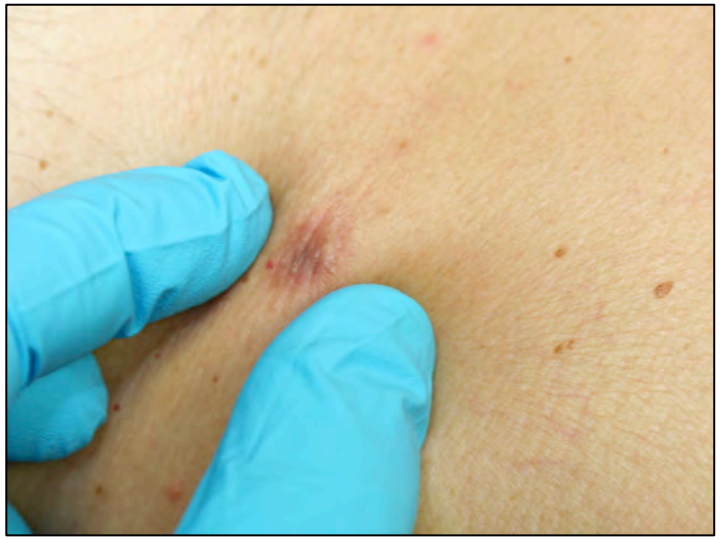


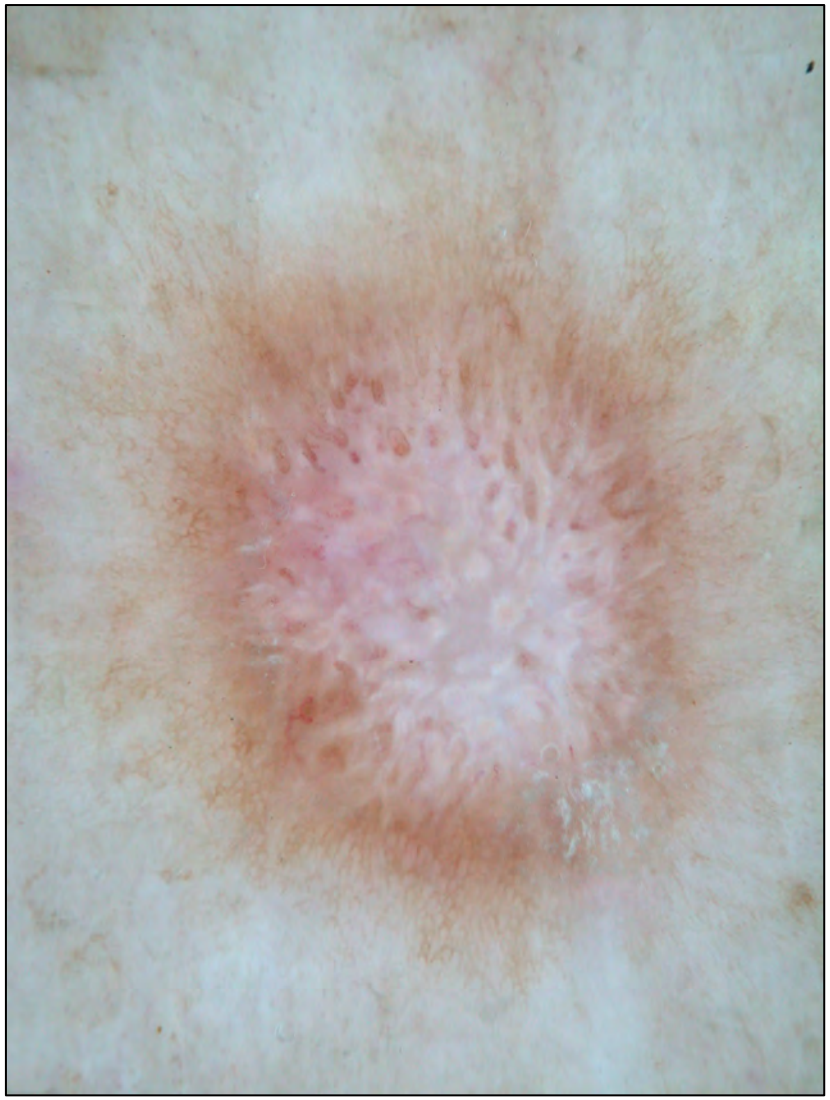
Kératose séborrhéique



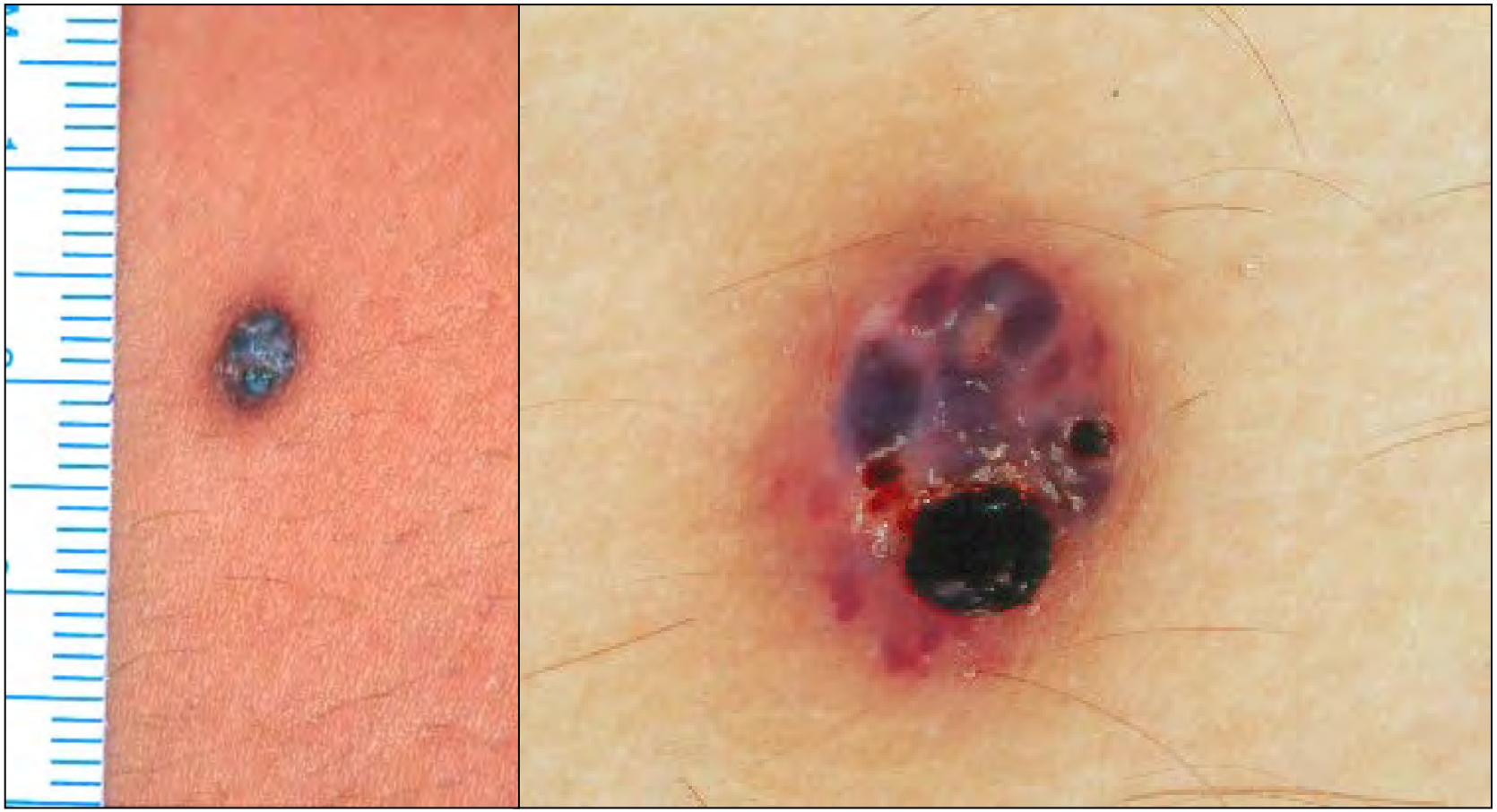
Dermatofibrome





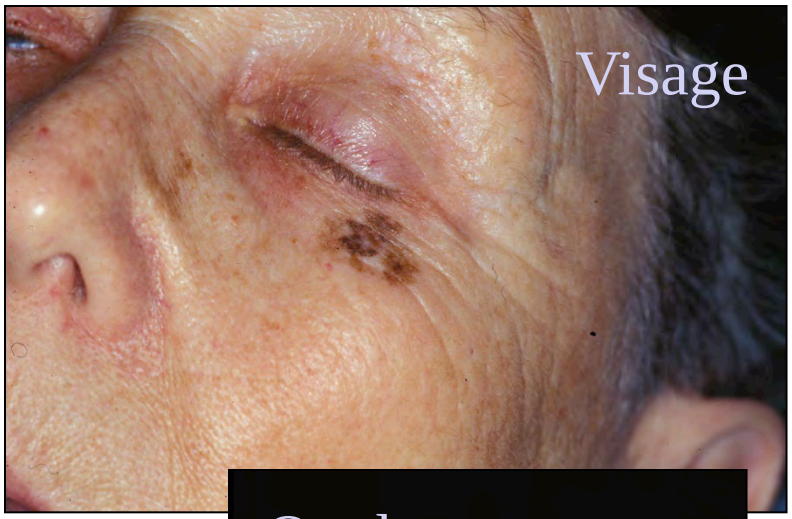


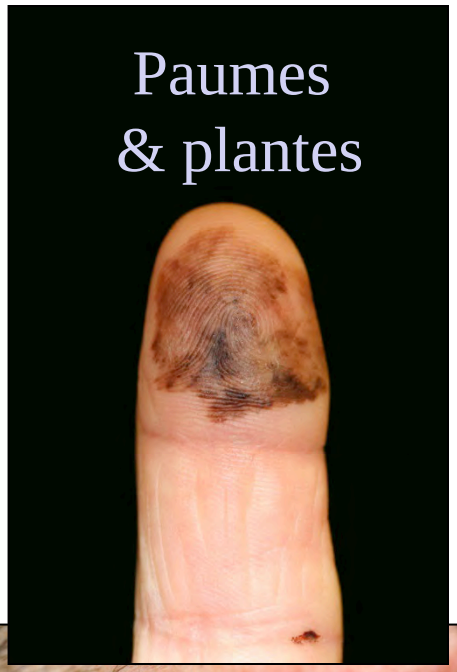
Hémangiome thrombosé

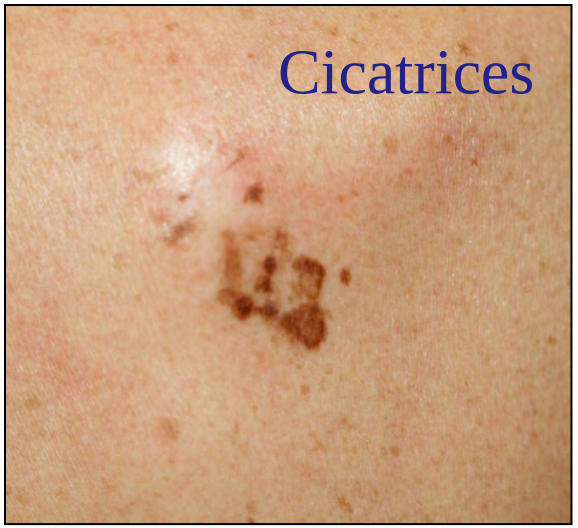


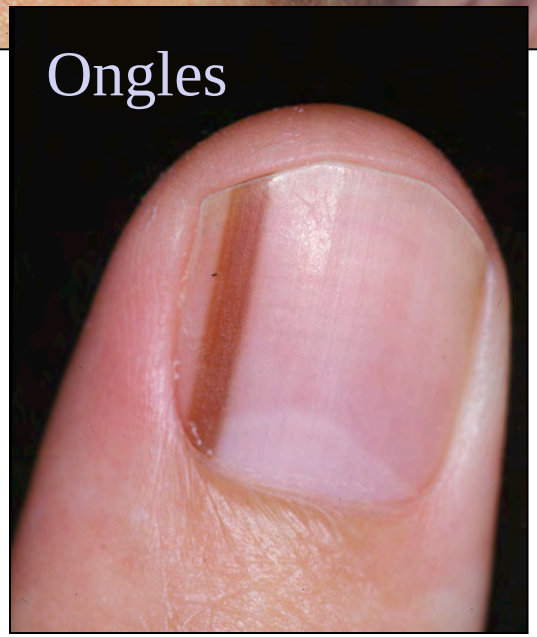
Complexité

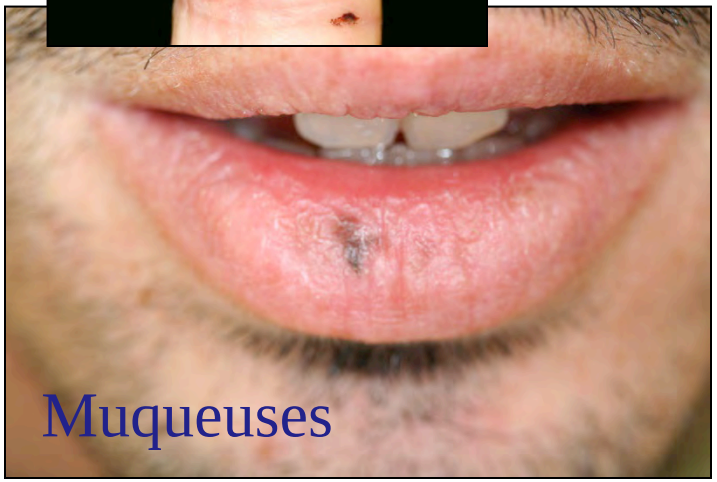
Exceptions topographiques



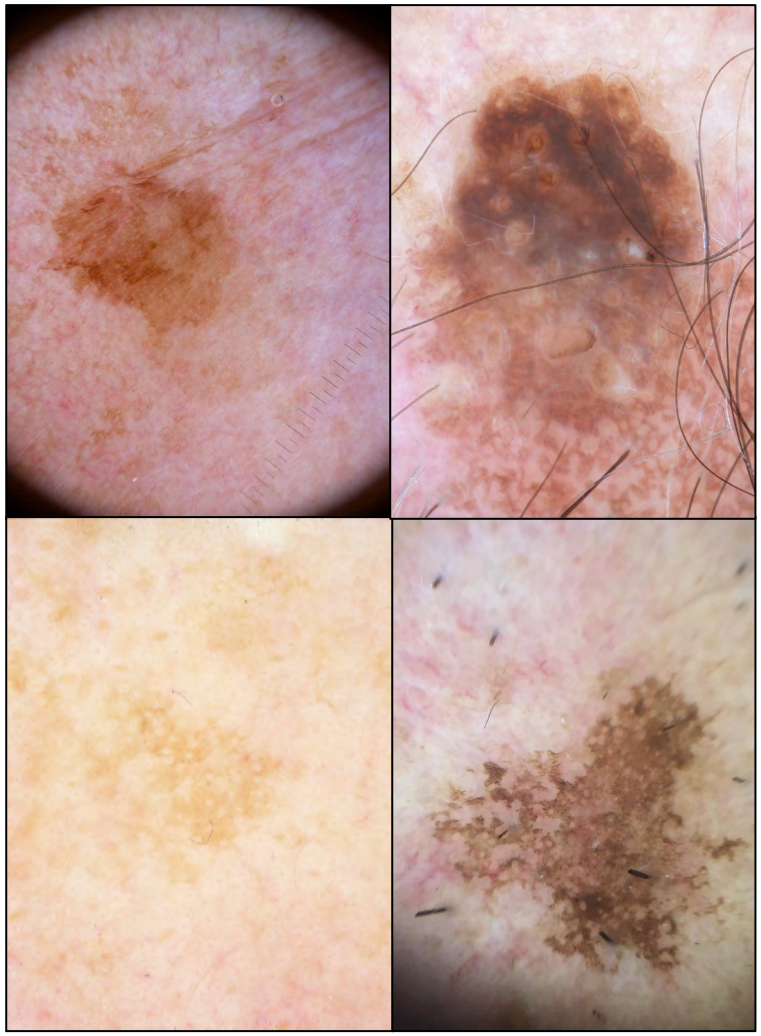


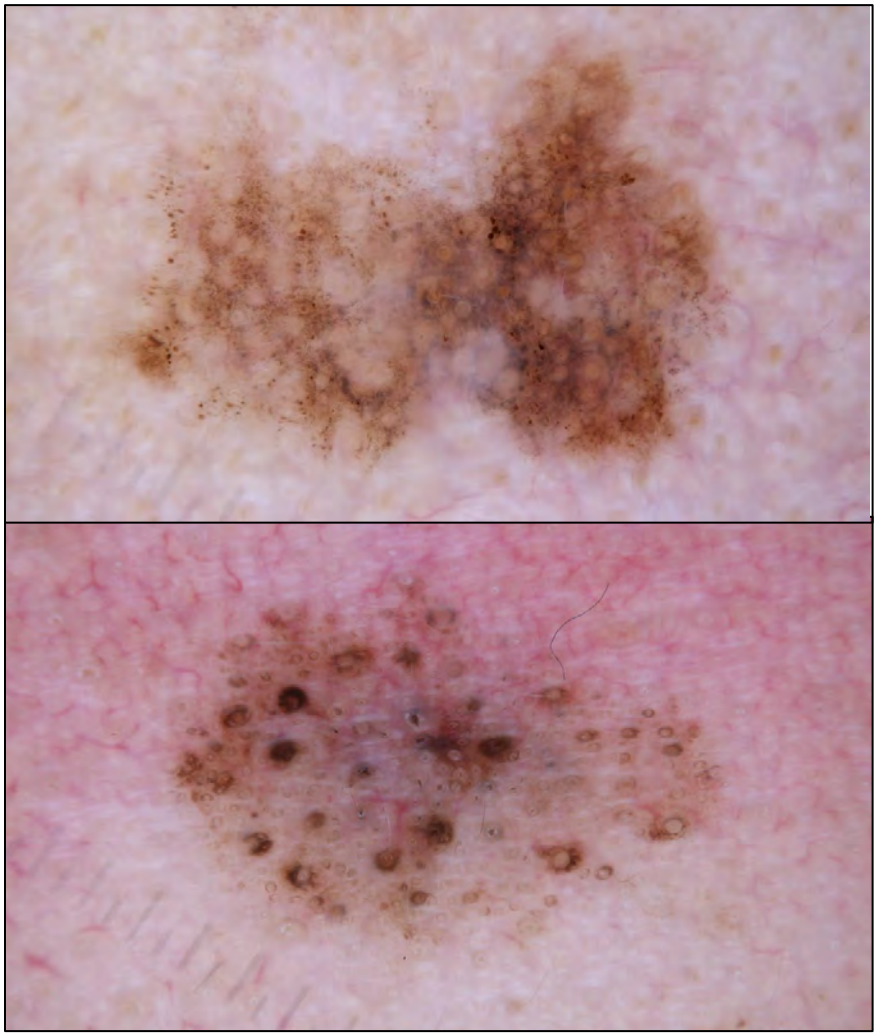




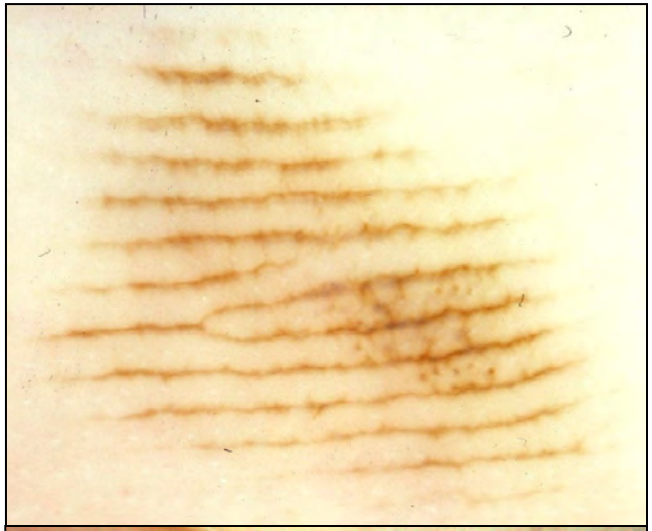


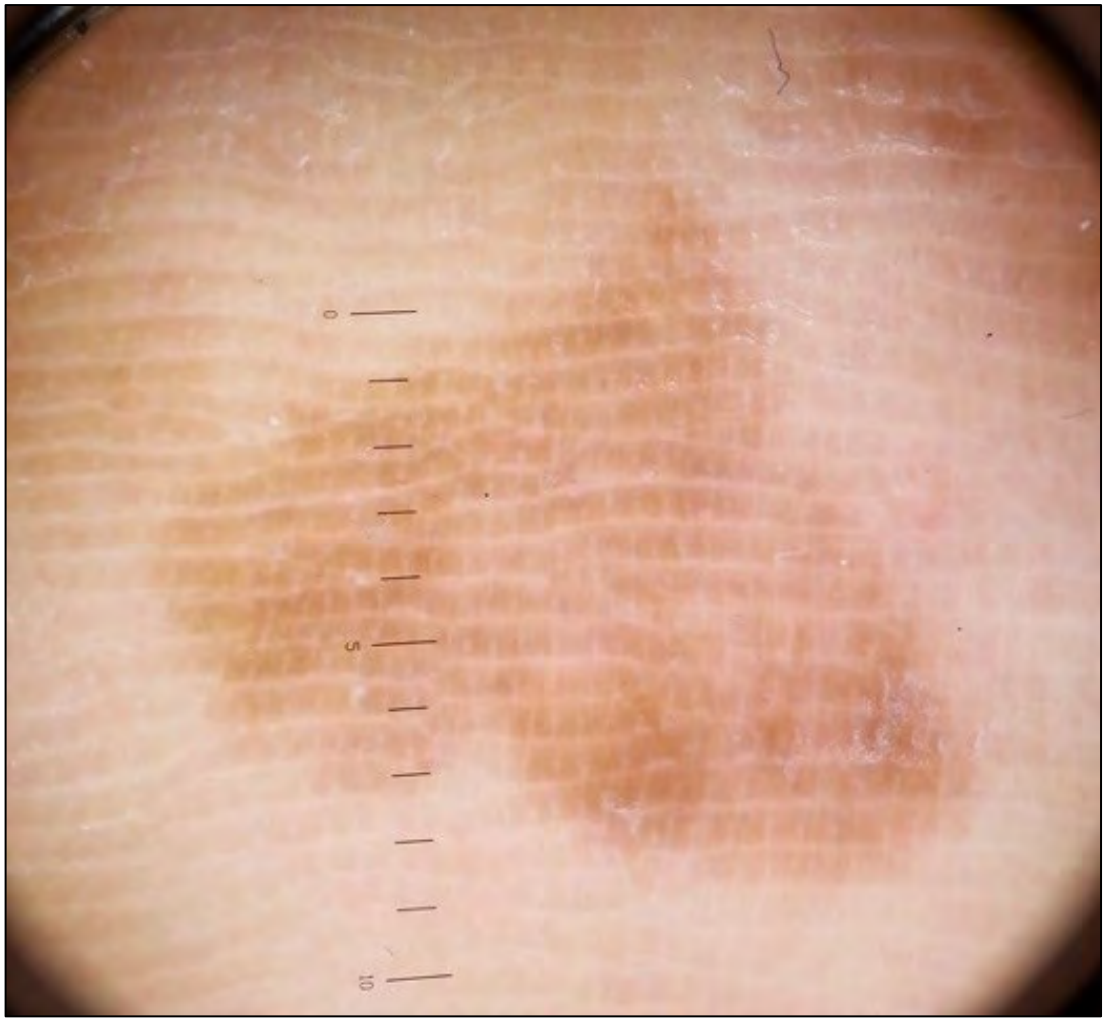
Visage



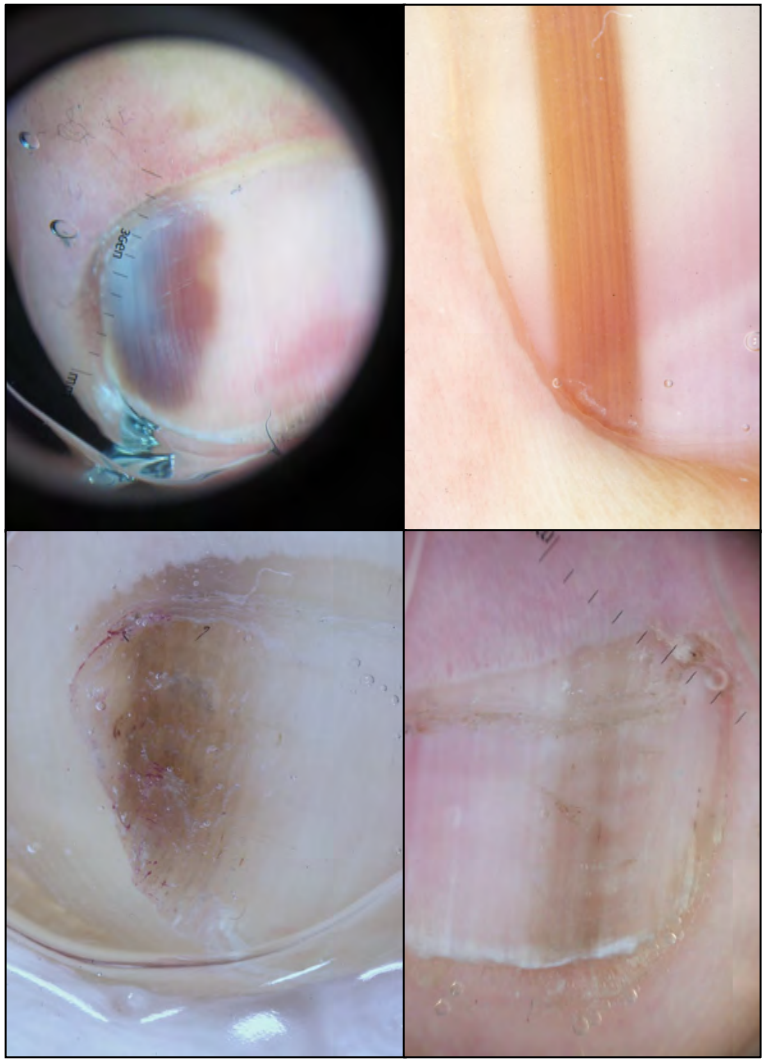


Paumes et plantes

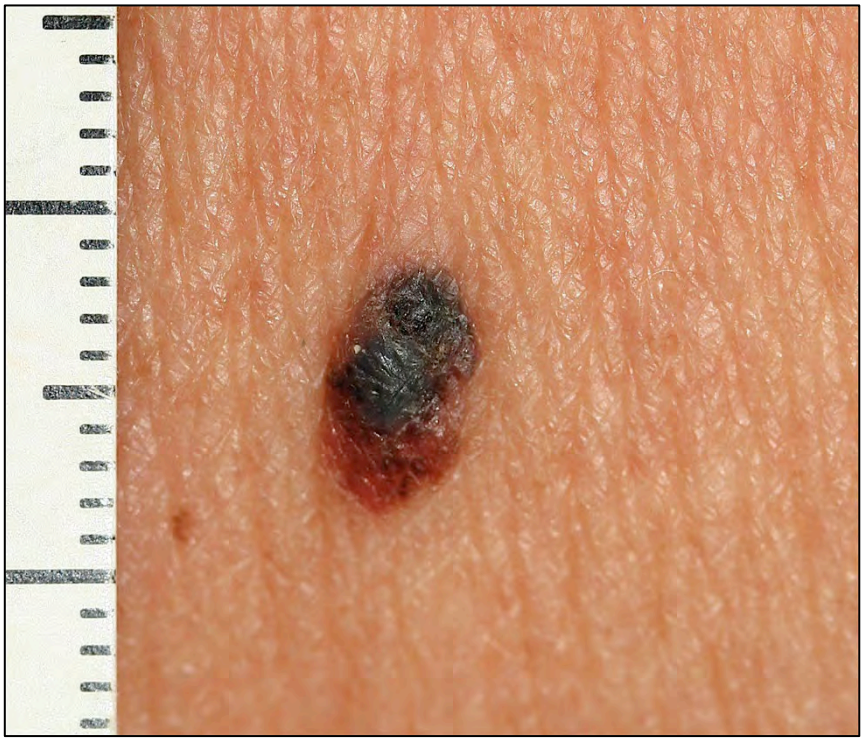


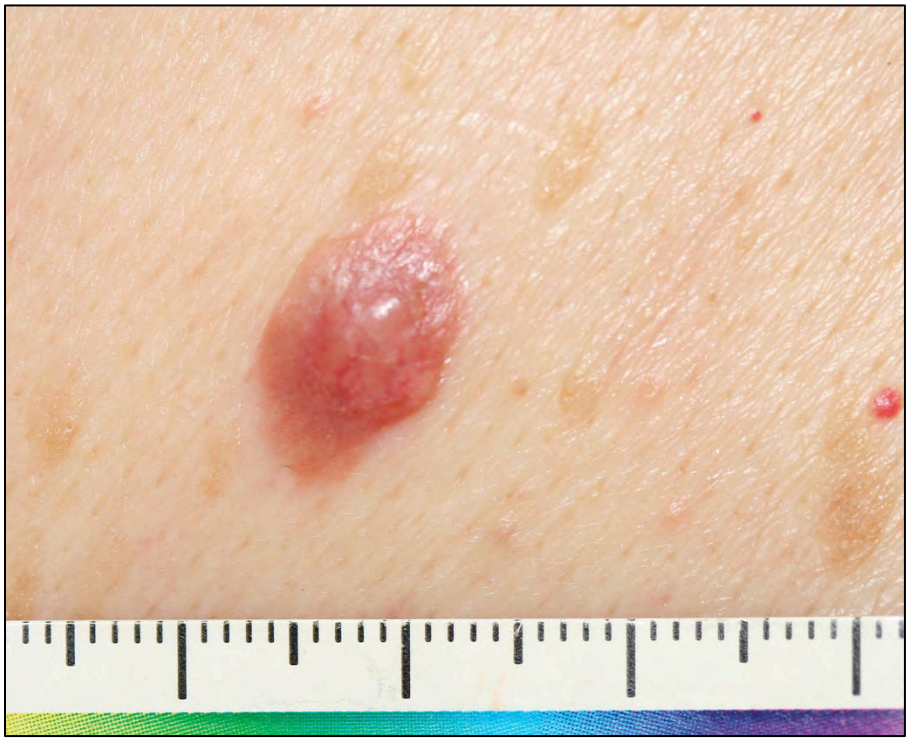


Ongles



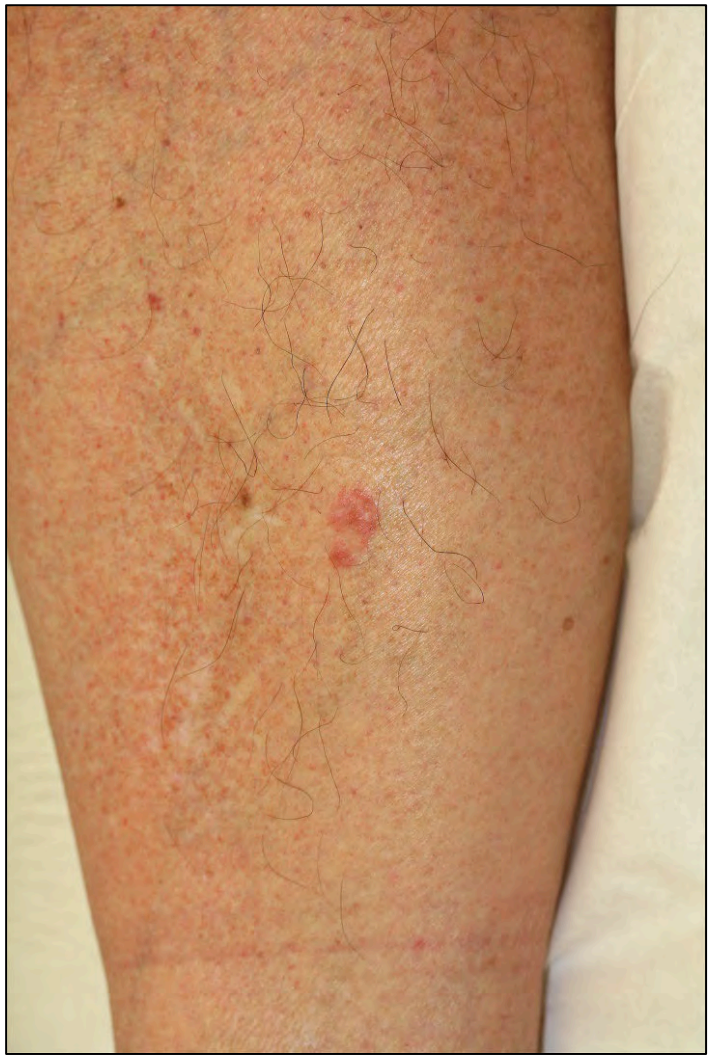
Exceptions sémiologiques

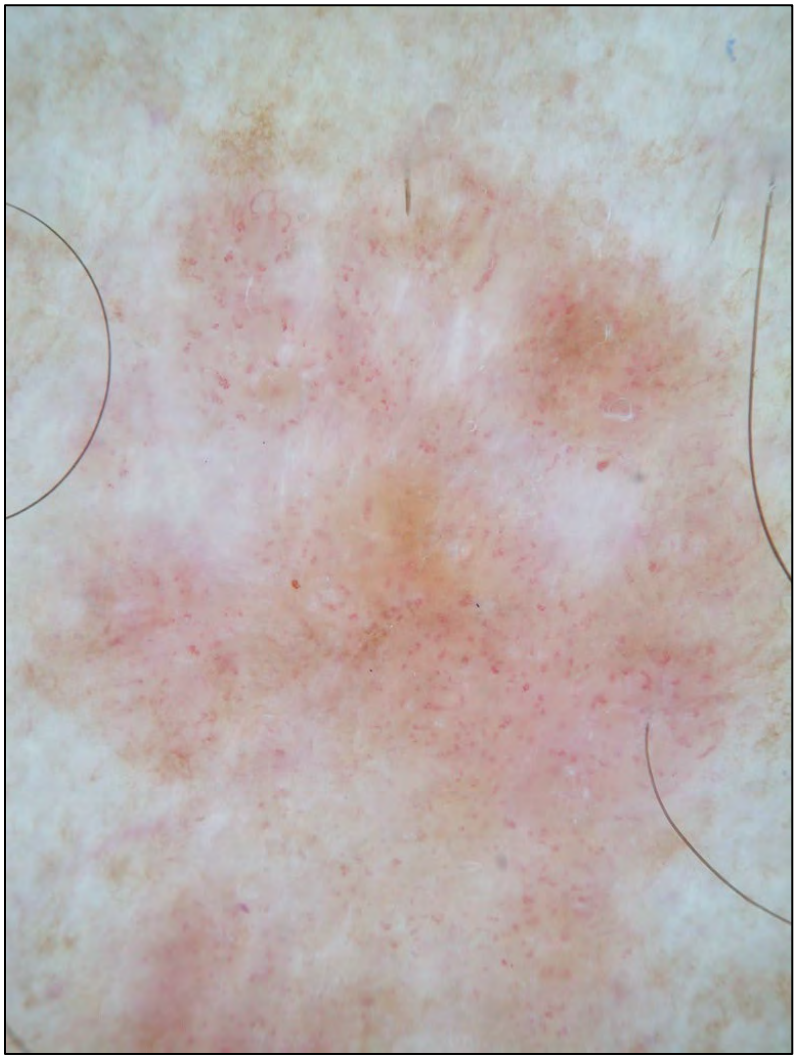




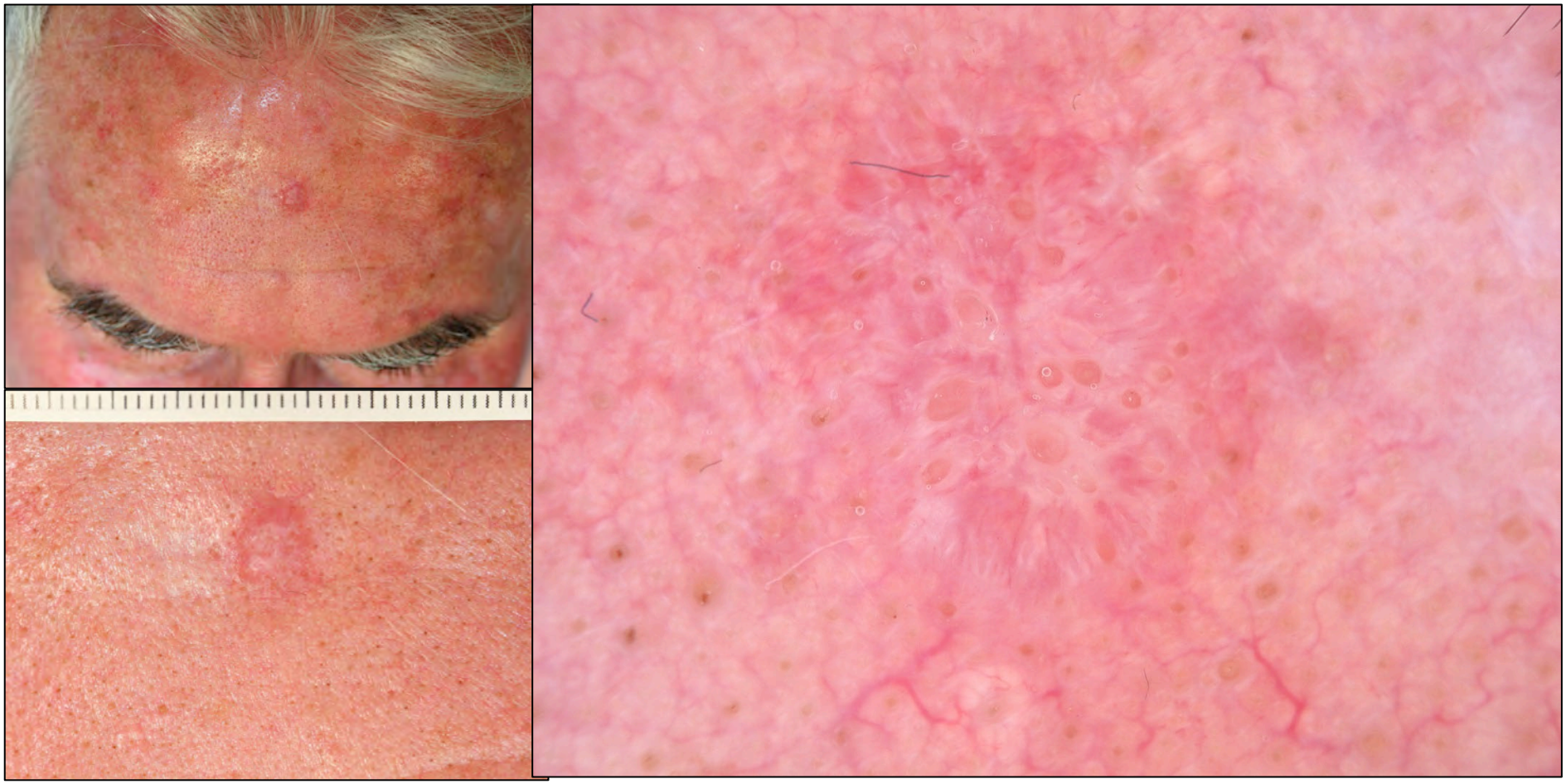
Bowen

(carcinome spinocellulaire *in situ*)

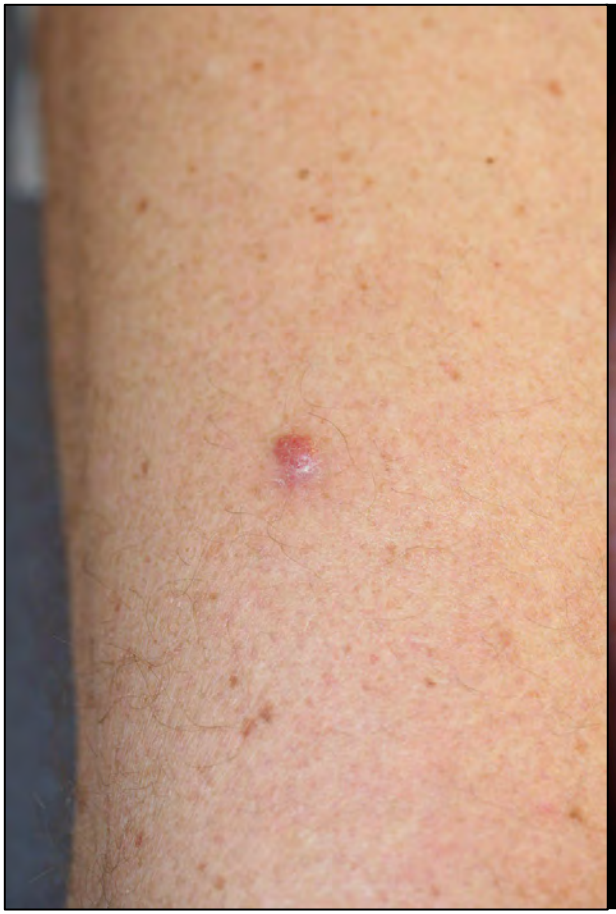


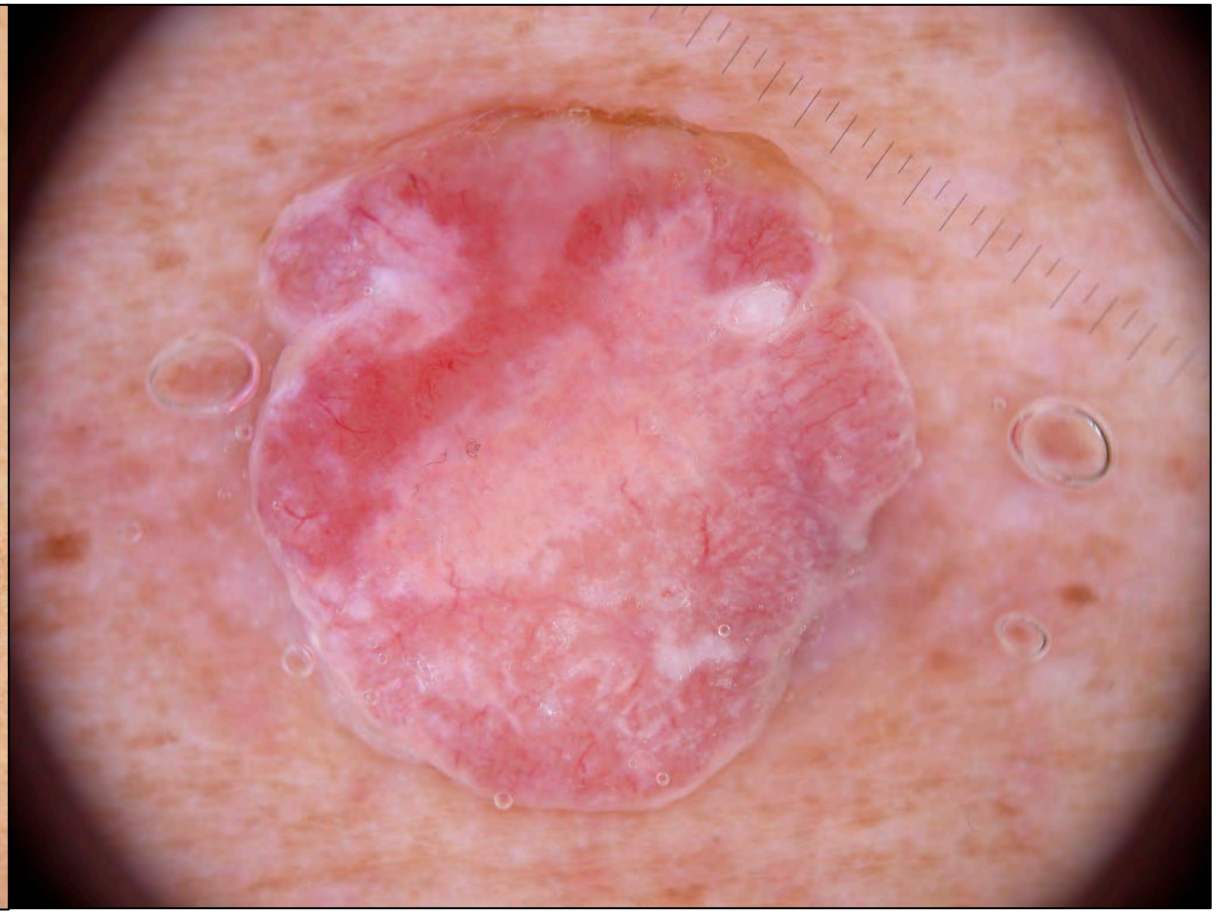


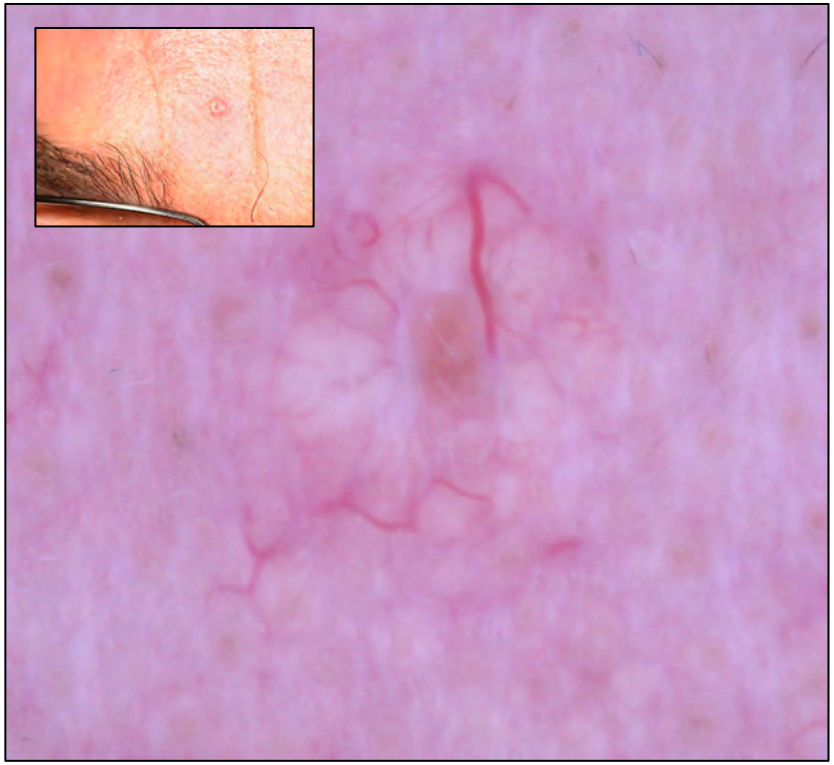
Carcinome spinocellulaire

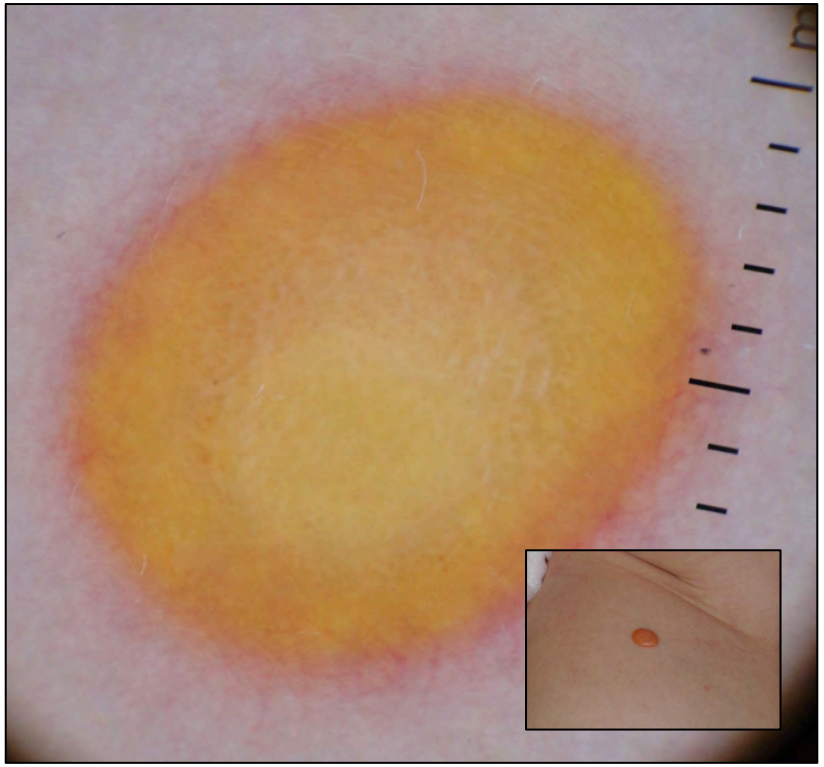


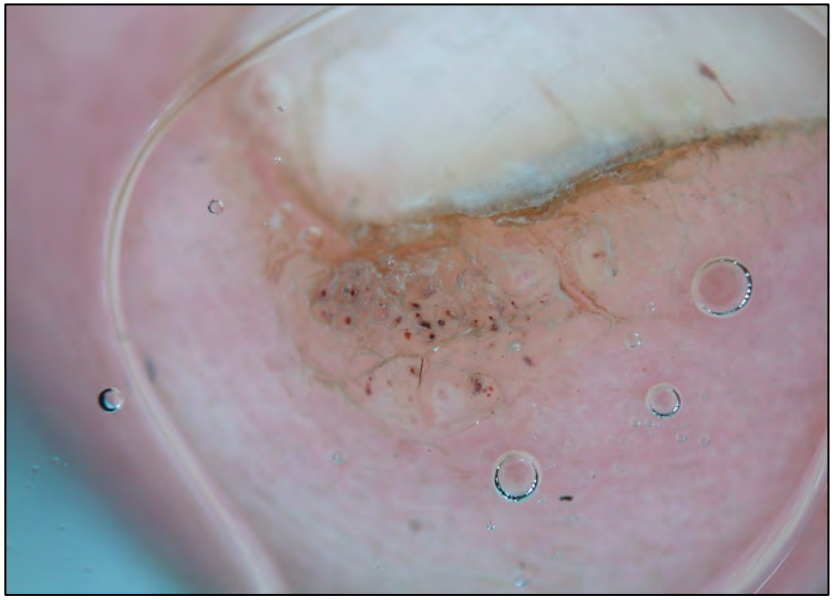
Mélanome

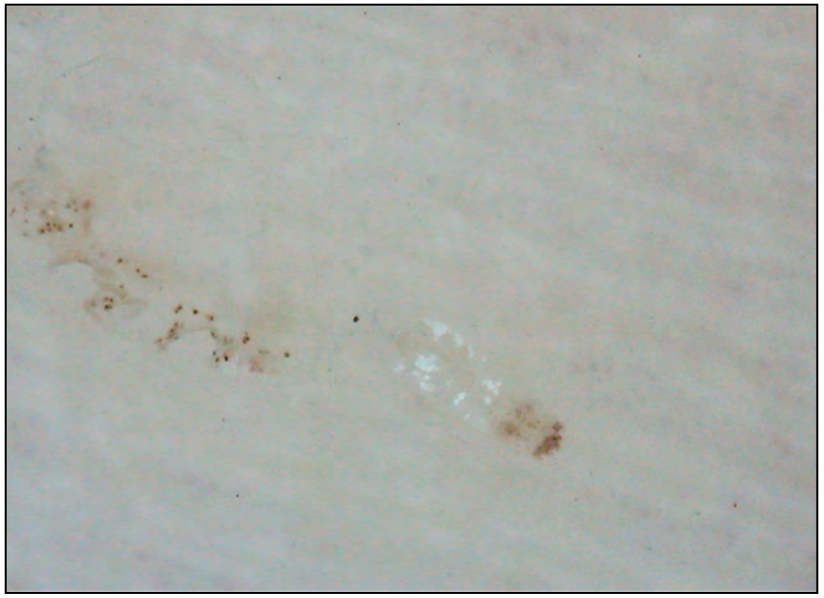




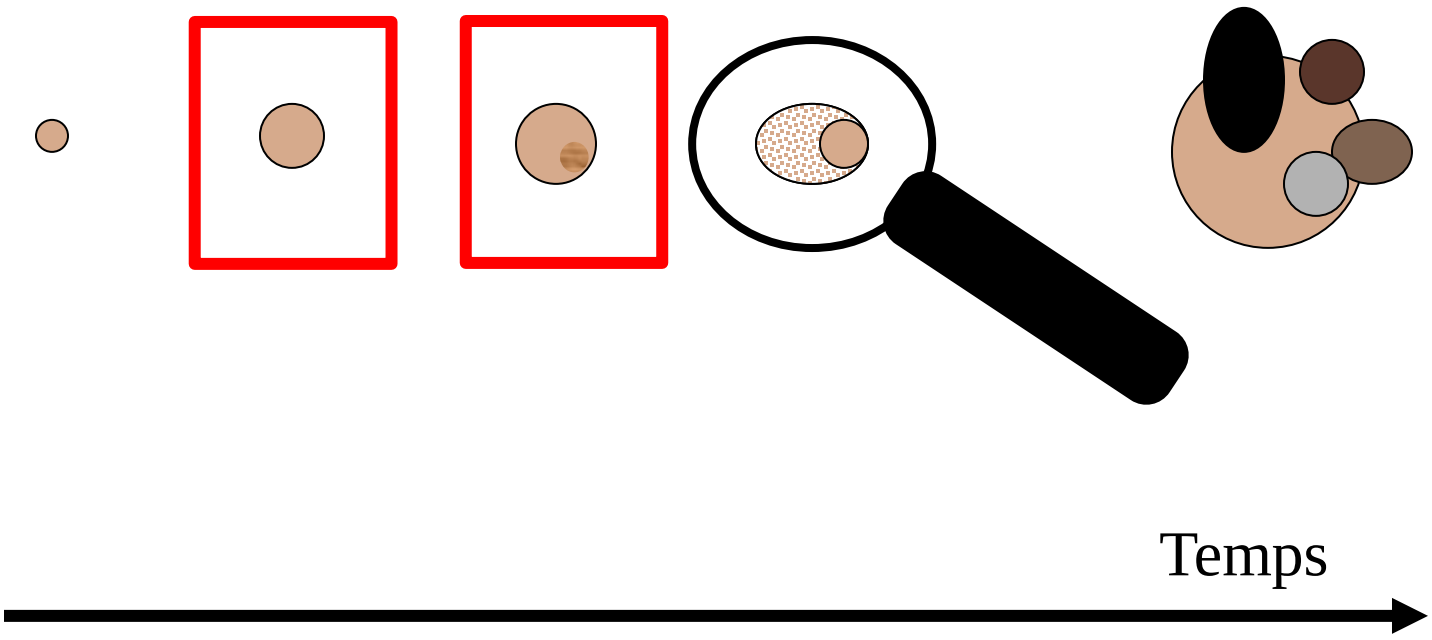


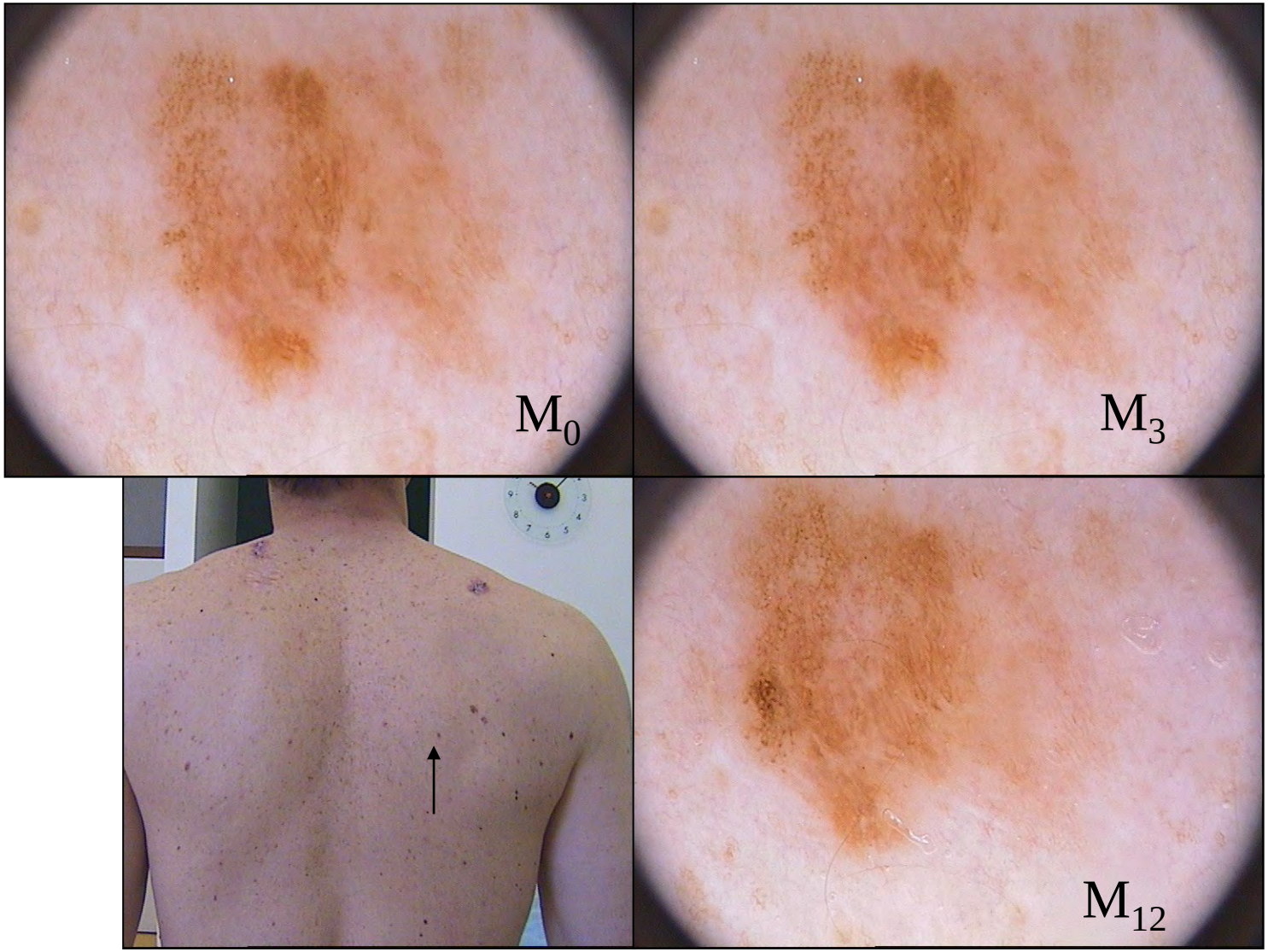






Dermoscopie dynamique





Mélanome, II, 0,2 mm $pT_1\ N_0\ M_0$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Dermoscopy, a useful tool for general practitioners in melanoma screening: a nationwide survey*

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[3]Lyon University, Institute Camille Jordan, UMR 5208, Université Jean Monnet, Lyon, France
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Conflicts of interest
None declared.

*Plain language summary available online

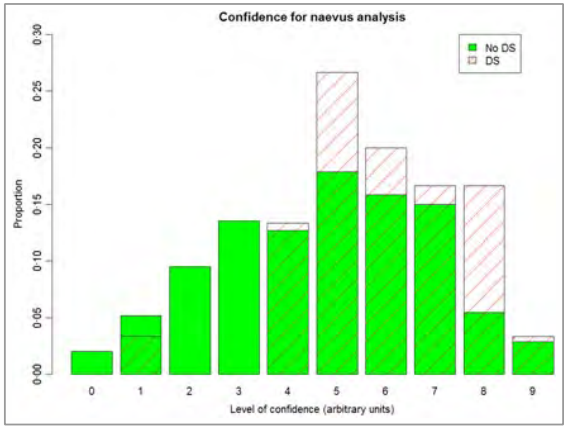
DOI 10.1111/bjd.14495

Summary

Background Dermoscopy improves diagnostic accuracy in melanoma, as shown by several meta-analyses. Although it is used by general practitioners (GPs) in Australia, Canada and Italy, no published data on this topic are available in France.
Objectives To review the opinions and use of dermoscopy by GPs in France and to understand their practice of skin examination.
Methods We designed a descriptive and cross-sectional survey and conducted it between 26 November and 26 December 2014. An anonymous, multiple-choice questionnaire about the demographic characteristics, skin examination modalities and use and training in dermoscopy was sent to 4057 GPs in four large regions of France. Pearson, χ^2, Student, Welch and Fisher tests were used for cross-tabulation statistical analysis.
Results Only 8% of respondents had access to a dermoscope; most were male practitioners and aged > 50 years. Dermoscopy increased self-confidence in analysing pigmented lesions (P = 0·004), and dermoscopy users referred fewer patients to dermatologists. The number of biopsies was reduced in the dermoscopy users group (P = 0·004). In total, 425 questionnaires were returned and analysed. Dermoscopy users took more time to evaluate a single pigmented lesion (P = 0·015). Only 16·9% of physicians declared having received some training on dermoscopy, yet this number reached 47% for those owning a dermoscope. Their training was mostly short and recent. Overall 29·2% of the respondents said the main advantage was to reduce the number of referrals to the dermatologists (P = 0·004), while its main disadvantage was the necessity of training (54·6%). Our responders declared they could spend seven working days on a dermoscopy training course.
Conclusions Our study demonstrates positive opinions regarding dermoscopy, despite a minority of French GPs using this technique in the areas surveyed. The need for formal training appears to be the main limitation to wider use. Appropriate and specifically designed training programmes should be offered.

What's already known about this topic?

- National surveys regarding the use of dermoscopy by general practitioners have been conducted mainly in Australia and Italy.
- The use by French general practitioners has never previously been described, despite dermoscopy being a useful tool for the diagnosis of melanoma.



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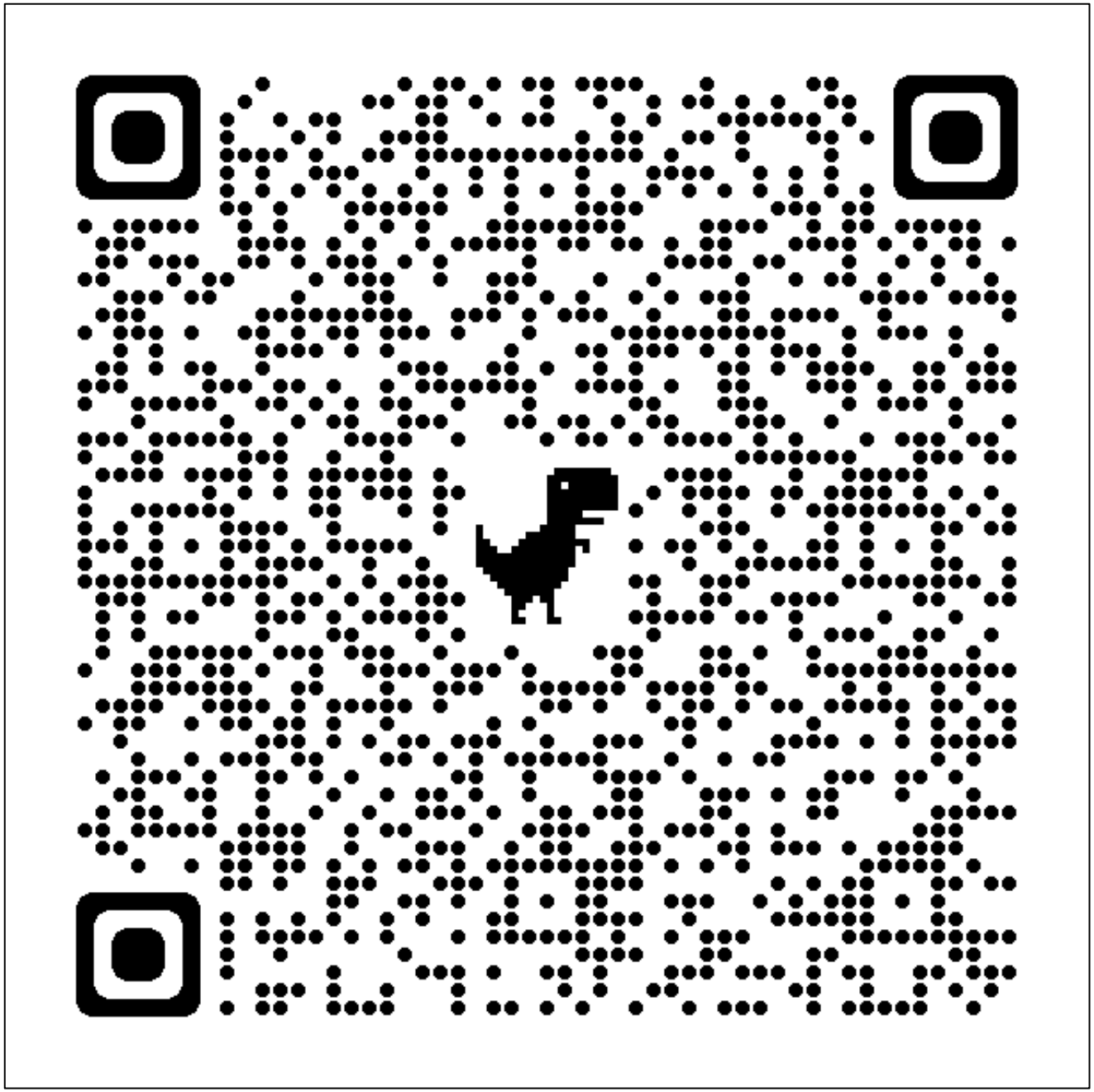
stephane.dalle@chu-lyon.fr



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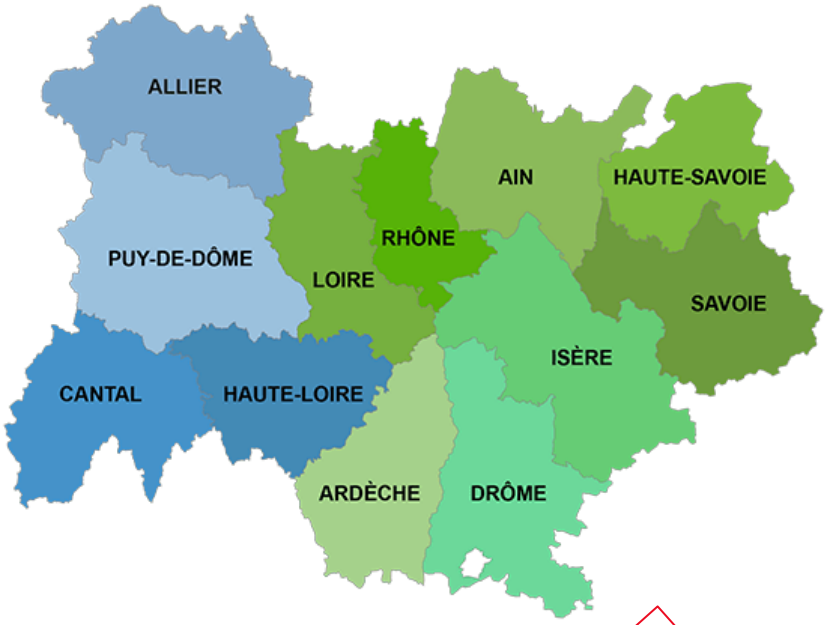
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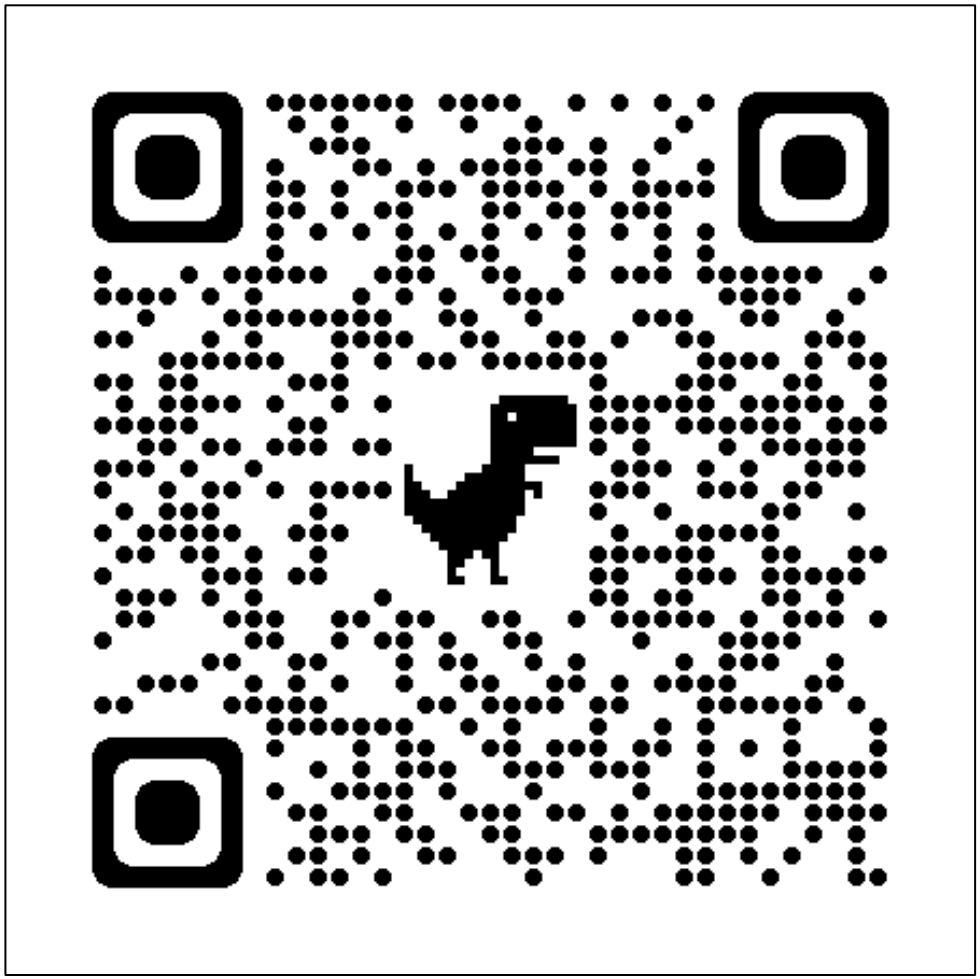


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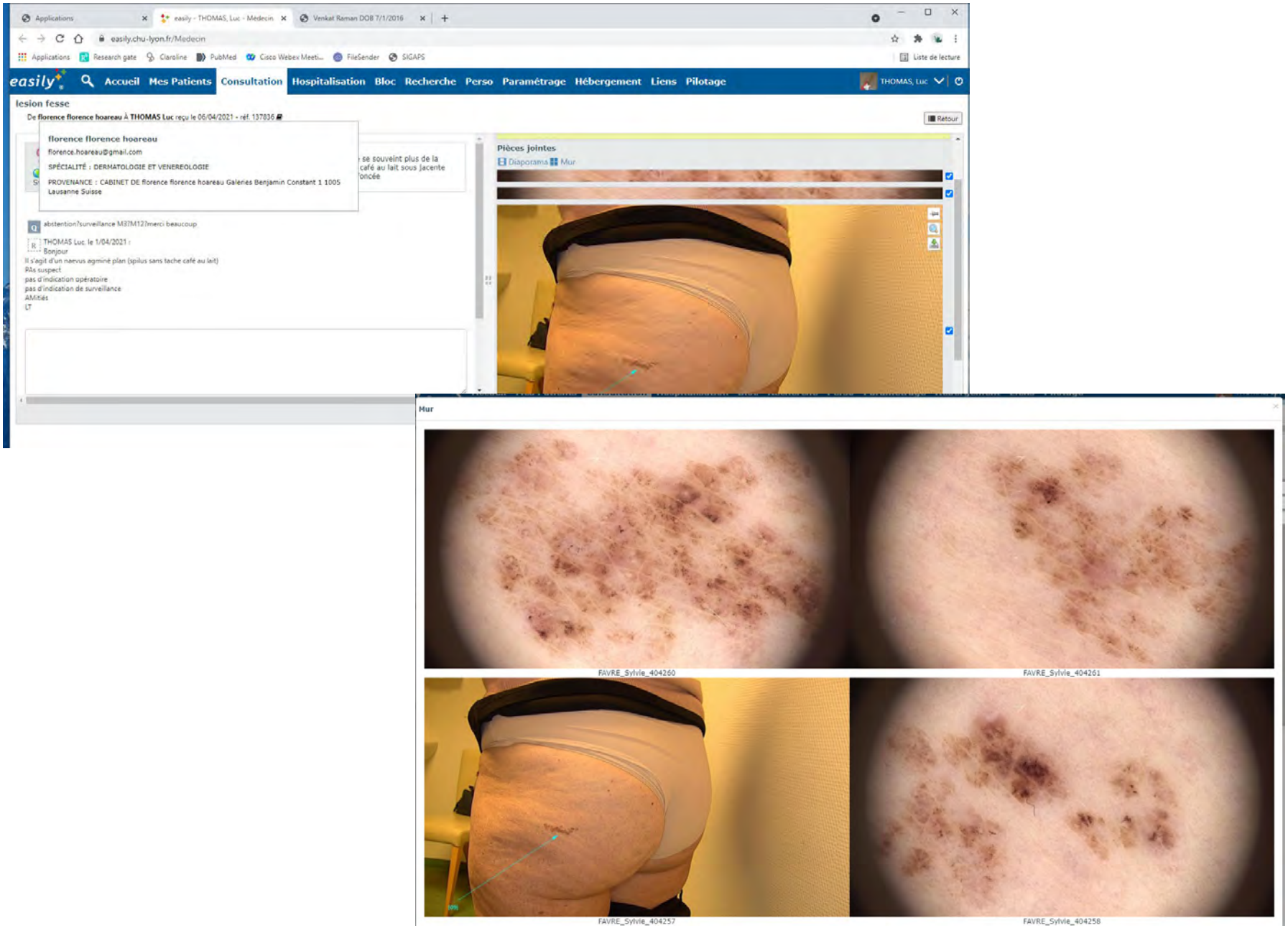
GEL HYDRO-ALCOOLIQUE
POUR LES MAINS
GEL ALCOHÓLICO PARA
DESINFECCIÓN HIGIÉNICA DE
MANOS ANTISÉPTICO PARA PIEL SANA
GEL ALCOÓLICO ANTISSÉPTICO
PARA MÃOS
ONTSMETTENDE HANDGEL
HYGIËNISCHES
HÄNDEDESINFEKTIONSMITTEL
GEL TIL HÅNDDESINFEKTION
HYGIENISKT GEL
GEL IDROALCOLICO PER LA
DISINFEZIONE DELLE MANI
100 mL e


Applications
easily - THOMAS, Luc - Médecin
Venkat Raman DOB 7/1/2016
easily.chu-lyon.fr/Medecin
Accueil
Mes Patients
Consultation
Hospitalisation
Bloc
Recherche
Perso
Paramétrage
Hébergement
Liens
Pilotage
THOMAS, Luc
lesion fesse
De florence florence hoareau À THOMAS Luc reçu le 06/04/2021 - réf. 137836
Retour
florence florence hoareau
florence.hoareau@gmail.com
SPÉCIALITÉ : DERMATOLOGIE ET VENEREOLOGIE
PROVENANCE : CABINET DE florence florence hoareau Galeries Benjamin Constant 1 1005 Lausanne Suisse
abstention?surveillance M37M12?merci beaucoup
THOMAS Luc, le 1/04/2021 :
Bonjour
Il s'agit d'un naevus agminé plan (spilus sans tache café au lait)
PAs suspect
pas d'indication opératoire
pas d'indication de surveillance
AMitiés
LT
Pièces jointes
Diaporama
Mur
Mur
FAVRE_Sylvie_404260
FAVRE_Sylvie_404261
FAVRE_Sylvie_404257
FAVRE_Sylvie_404258

Applications | easily - THOMAS, Luc - Médecin

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Applications | Research gate | Claroline | PubMed | Cisco Webex Meeti... | FileSender | SIGAPS | Liste de lecture

easily | Accueil | Mes Patients | Consultation | Hospitalisation | Bloc | Recherche | Perso | Paramétrage | Hébergement | Liens | Pilotage | THOMAS, Luc

Pigmented Nail Lesion Young Boy

De **Paul Fishburn** À **THOMAS Luc** reçu le 07/09/2021 - réf. 151888

Retour

5 ans
07/01/2016
Australia

Bonjour et salutations d'Australie Luc, merci beaucoup pour vos conseils. Slowly growing pigmented lesion distal index finger - please see attached PDF (I can send to you a PowerPoint via an email if you need to have larger images)

Clinical diagnosis

THOMAS Luc, le 7/09/2021 :
Hi Paul
Your French is impeccable !

This case is highly suggestive of a congenital nevus (or a congenital-type nevus) of the nail unit
IN such cases
- irregular lines
- change over time
- periungual pigmentation
are very commonly observed
Your case also exhibit a distal periungual pigmentation with a fibrillar pattern we consider now as a "signature feature" for this diagnosis (see joined image)
Our publication about that is uneder second revision in the JAAD and will hopefully be soon available

Envoyer

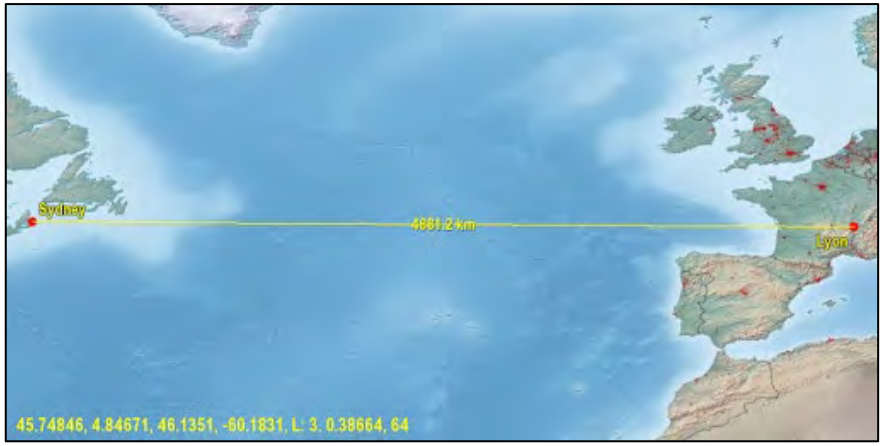
Actions

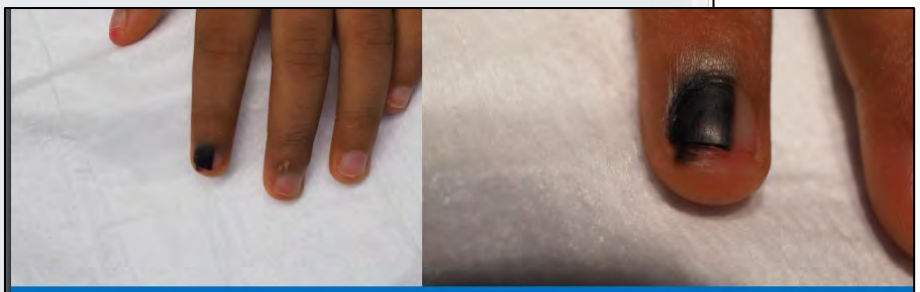
Archiver

Bloc-notes

Pièces jointes

Venkat_Raman_Nail_Presentation





March 2019
Clinical Images

March 2019
Dermatoscopy
NP Non-Polarised
P Polarised

Avez-vous eu des difficultés pour utiliser le service de télé-expertise ?

Très souvent	4 %
Souvent	18 %
Presque jamais	46 %
Jamais	33 %

Comment jugez-vous l'utilisation du service de télé-expertise ?

Inutilisable	2 %
Pas facile à utiliser	11 %
Facile à utiliser	69 %
Très facile à utiliser	18 %

L'utilisation du service de télé-expertise vous a-t-il permis de dégager du temps ?

Pas du tout	23 %
Un peu	25 %
Un temps appréciable	35 %
Considérablement	17 %

L'utilisation du service de télé-expertise a-t-il modifié dans un sens positif votre pratique ?

Aucune modification	9 %
Modifié un peu ma pratique	49 %
Modifié fortement ma pratique	41 %
Bouleversé ma pratique	2 %

Comment jugez-vous les délais de réponse du service de télé-expertise ?

Trop long	2 %
Long	2 %
Rapide	51 %
Très rapide	44 %

Continuerez-vous à utiliser le service de télé-expertise ?

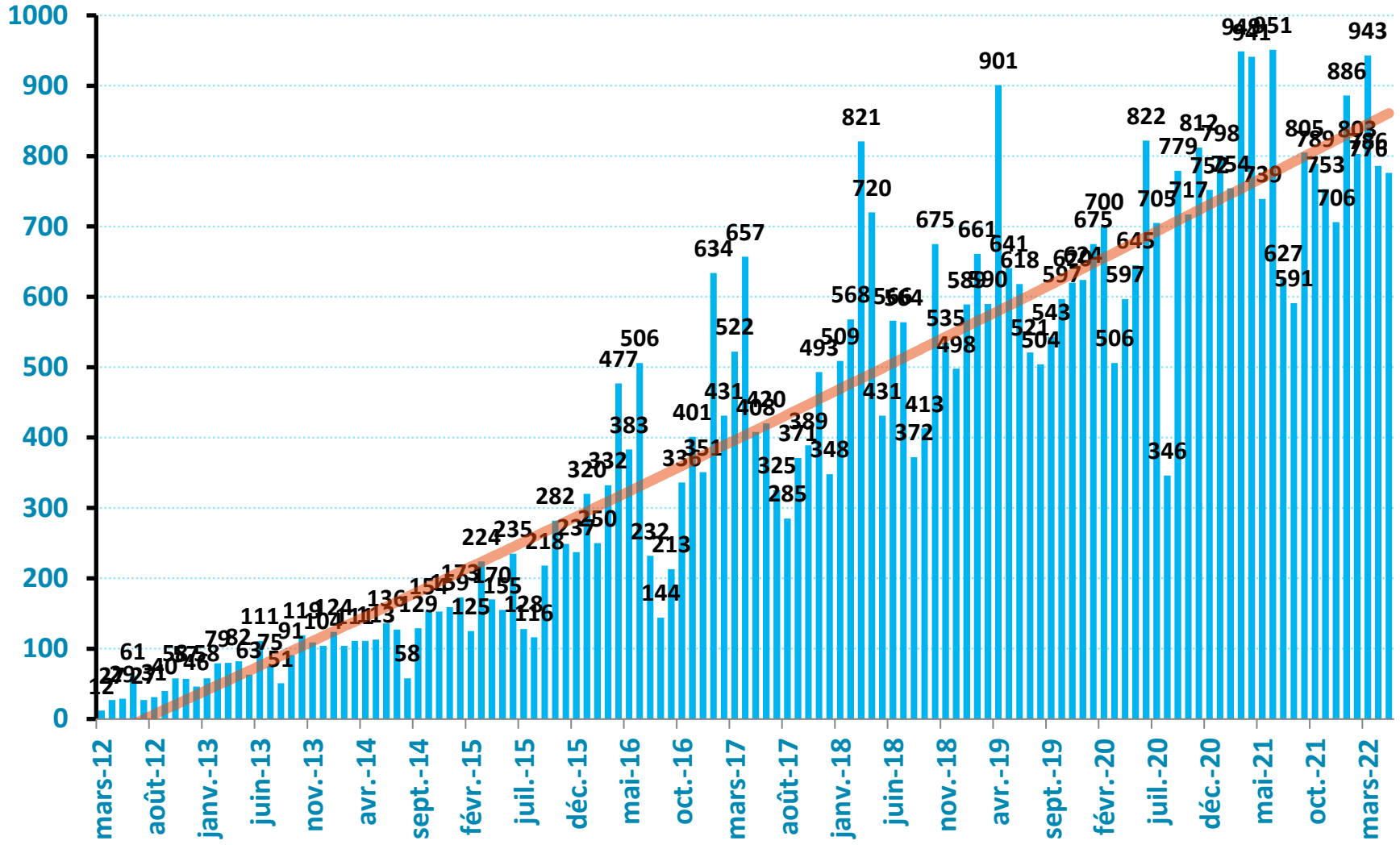
Certainement pas	2 %
Probablement non	0 %
Oui peut-être	8 %
Certainement	90 %

Quelle appréciation globale portez-vous sur le service de télé expertise ?

Très mauvaise	2 %
Mauvaise	2 %
Bonne	34 %
Très bonne	63 %

Recommanderiez-vous le service de télé expertise à vos confrères ?

Certainement pas	1 %
Probablement non	1 %
Oui peut-être	9 %
Certainement	89 %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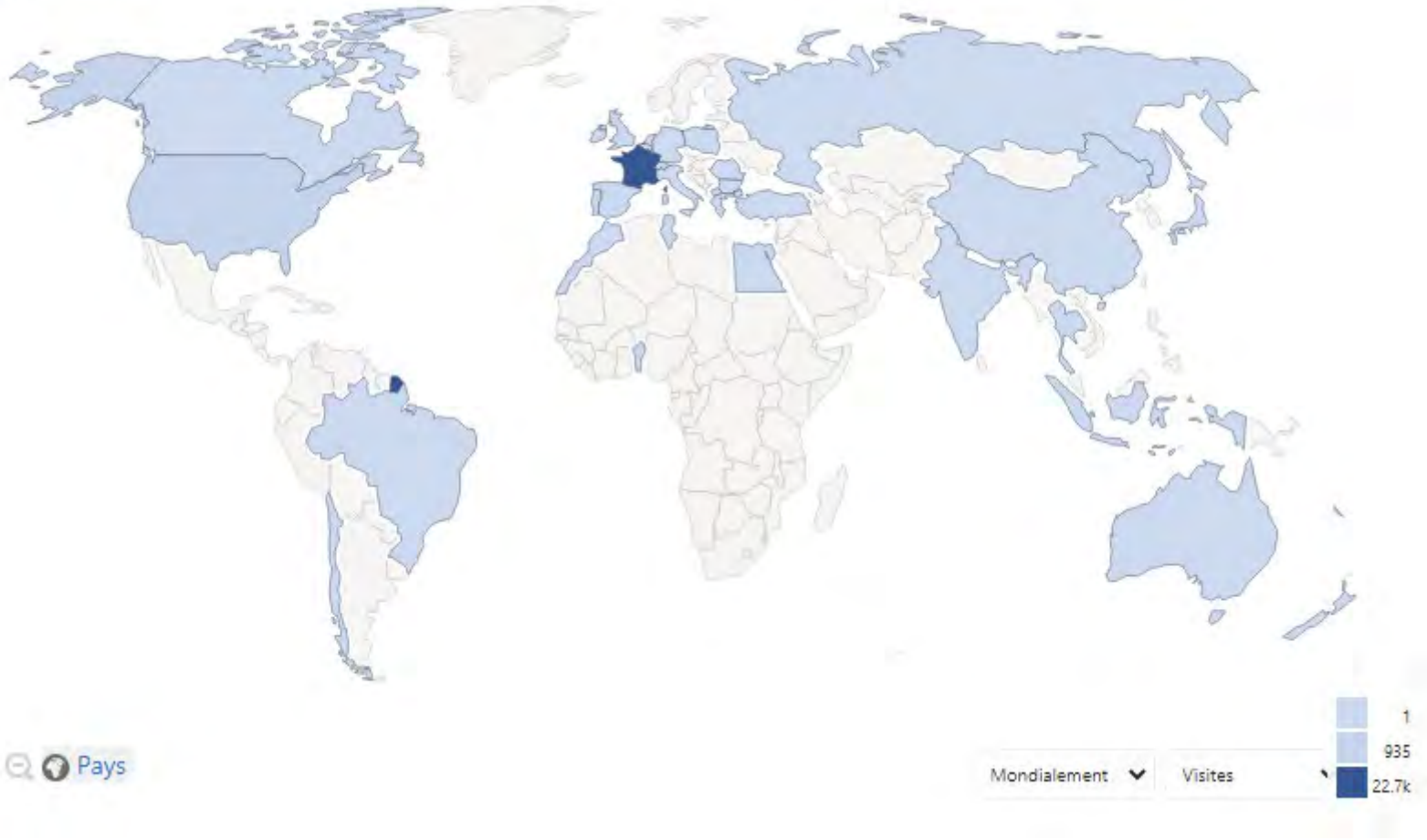
août-12
janv.-13
juin-13
nov.-13
avr.-14
sept.-14
févr.-15
juil.-15
déc.-15
mai-16
oct.-16
mars-17
août-17
janv.-18
juin-18
nov.-18
avr.-19
sept.-19
févr.-20
juil.-20
déc.-20
mai-21
oct.-21
mars-22

24 346 visites



EXPERT	N
THOMAS Luc	*19683*
PERIER-MUZET, Marie	11165
PHAN Alice	7643
DEBARBIEUX SEBASTIEN	4301
DALLE Stephane	3380
POULALHON NICOLAS	3371

2020	
France	14131
Belgium	610
Switzerland	390
Algeria	365
Luxembourg	174
Morocco	84
Senegal	23
Tunisia	89
Russian Federation	29
Portugal	152
Greece	62
Italy	187
Australia	147
United States	63
Israel	68
Spain	49
United Kingdom	37
Turkey	57

Celine LANGELLA	653
Carine DELALEU RAGUE	589
Genevieve CHOQUET	486
Marie Cecile LUAUTE MARCILLY	481
Fabienne LEGER POUSSET	454
Anne Laure RIVAL TRINGALI	446
Fabienne MARTIN	438
florence florence hoareau	426
Davide SALI	412
Celine GRAVERIAU	369
Elise ARBONA VIDAL	354
Nadia RUFFION	346
GERARD LESAGE	321
Carine FERRIERE	302
Philippe VIRARD	297
CELINA DUCHEMIN	288
Aude GOIRAND ODEON	286
Cecile BECUWE	269
AUDE ROUSSEL	255
Isabelle MIRONNEAU	232
Isabelle GUILLOT POUGET	230
Deborah Salik	225
Marie Charlotte DEROO BERGER	219
DUPIN Catherine	215
Francoise TRUCHOT	214
Patricia PERRET LIAUDET	199
Elsa THOMAS	197
Aimilios LALLAS	2

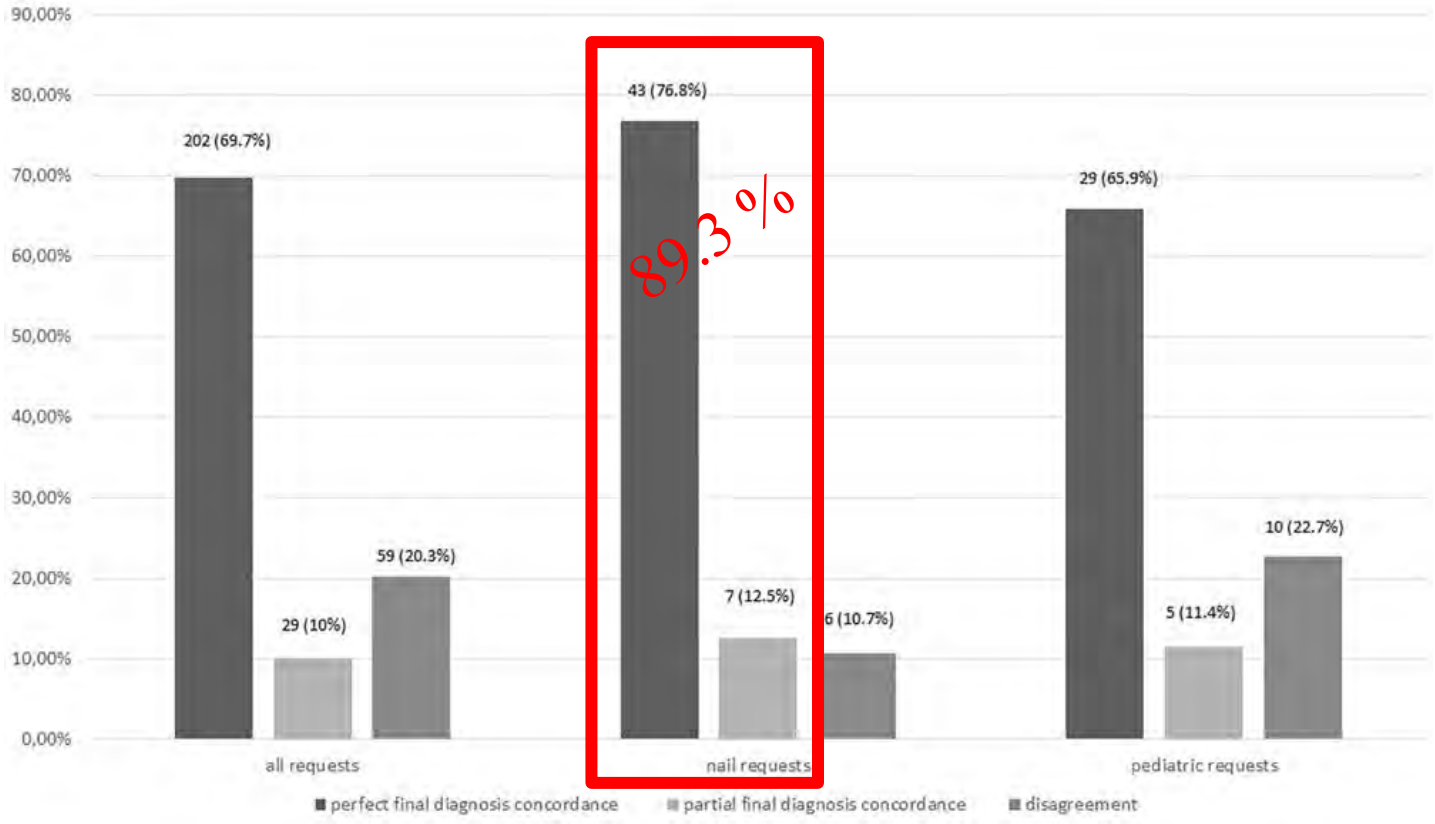


Figure 2. Perfect final diagnostic concordance between teledermoscopy expert and final diagnoses (histopathology or reasonable-delay benign follow-up).

Dermatology Practical & Conceptual

Table 3. Prediagnostic Concordance Between Teledermoscopy Expert and Referring Clinician

	All Requests (N = 290) (100%)	Nail Requests (n = 56) (19.3%)	Pediatric Requests (n = 44) (15.2%)
Perfect prediagnostic concordance	116 (40%)	16 (28.6%)	21 (47.7%)
Partial prediagnostic concordance	44 (15.2%)	12 (21.4%)	4 (9.1%)
Disagreement on prediagnosis	130 (44.8%)	28 (50%)	19 (43.2%)
No hypothesis from referring clinician	76 (26.2%)	21 (37.5%)	9 (20.5%)
No hypothesis from teledermoscopy expert	11 (3.8%)	0	3 (6.8%)

87.5 %

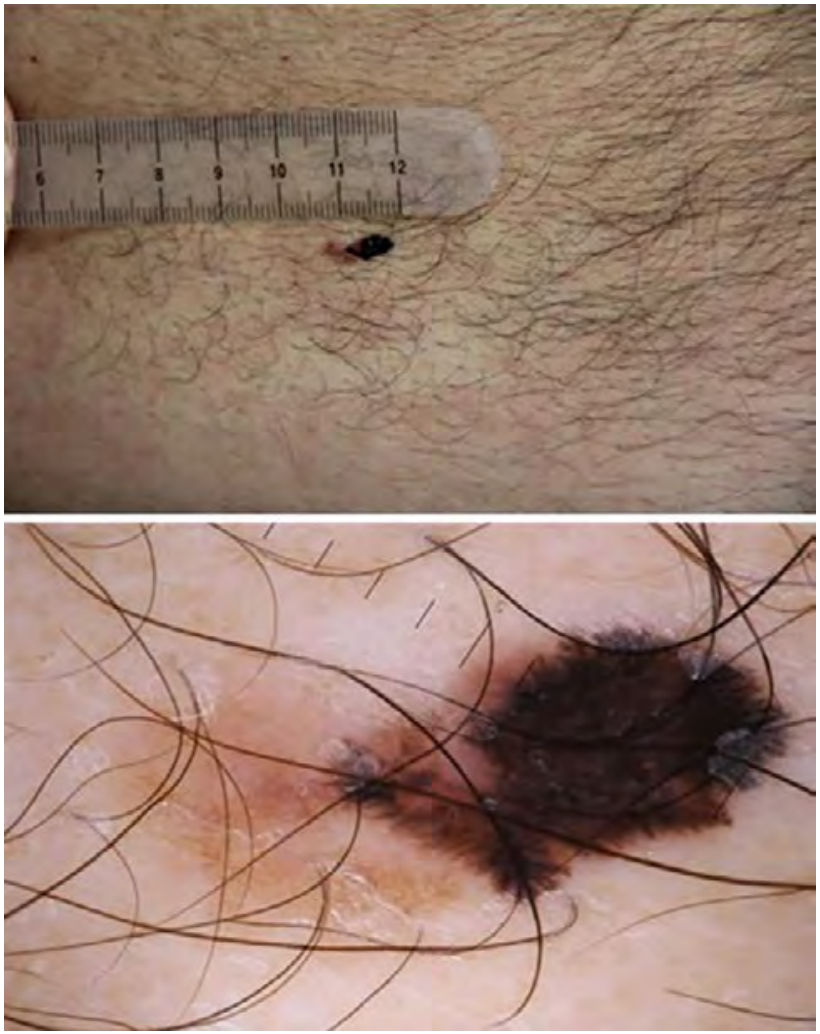


Figure 3. A 72-year-old man presented with a pigmented atypical lesion on the abdomen for 6 months. Expert and clinicians both diagnosed a melanoma and suggested excision of the lesion. Histology found a superficial spreading melanoma 0.35 mm thick.

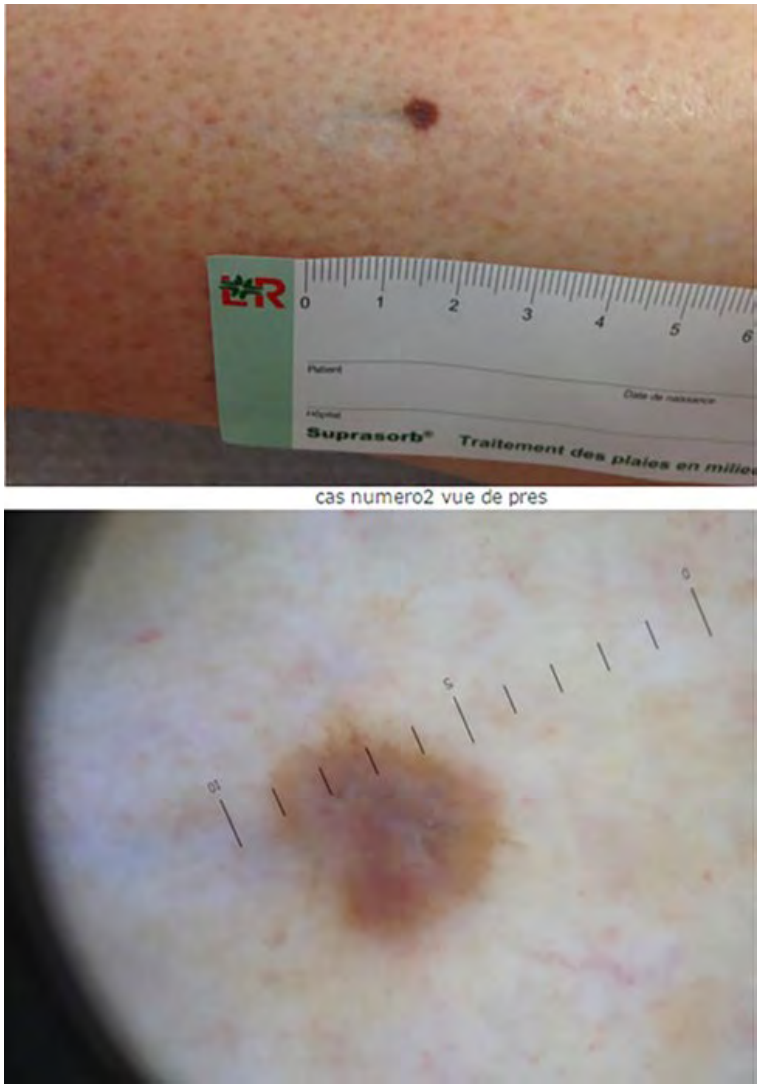


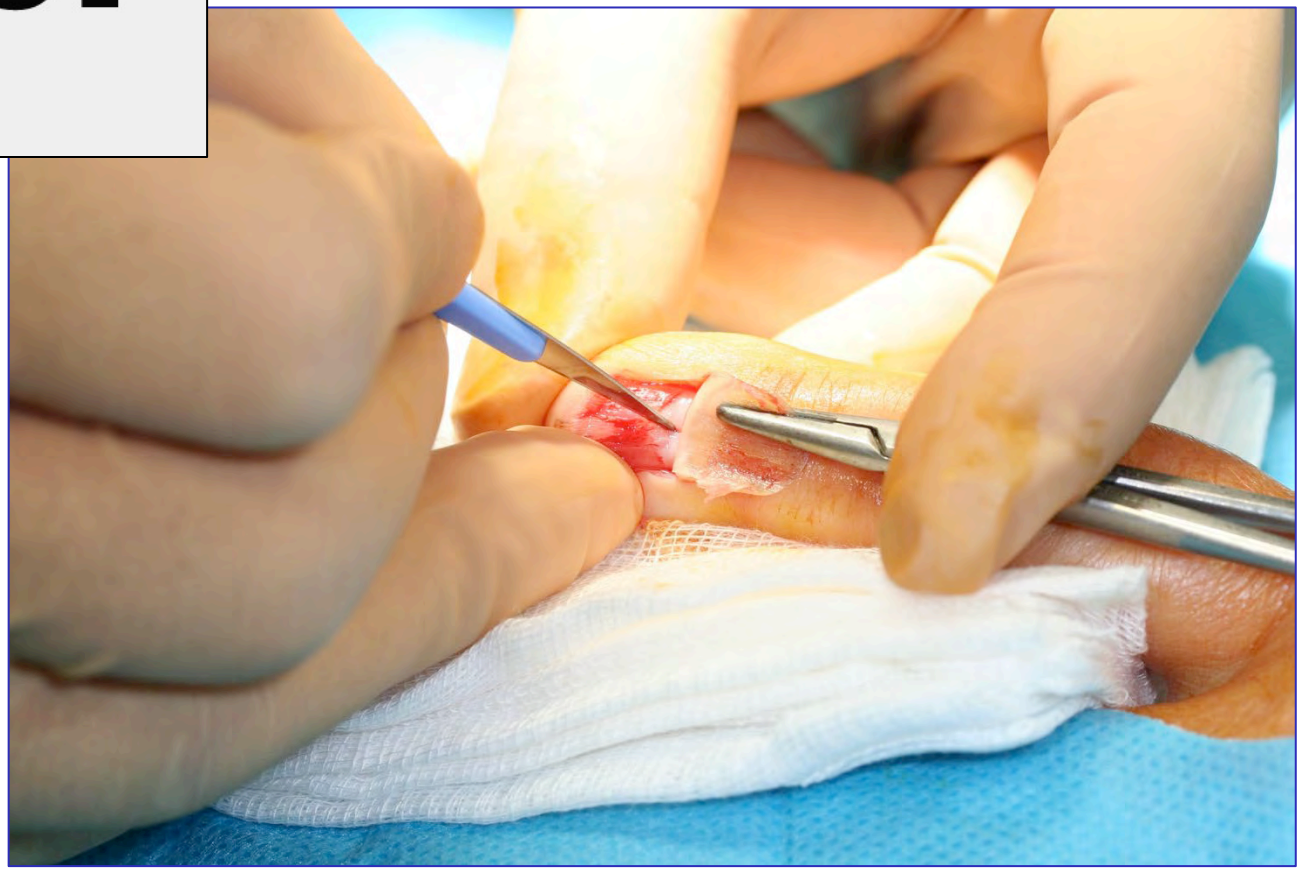
Figure 4. A 70-year-old woman presented with a pigmented atypical lesion on the leg. The referring clinician suggested excision for a possible melanoma. The diagnosis of dermatofibroma, suggested by the expert, was confirmed by histopathology.


ADDITIONAL
BENEFITS

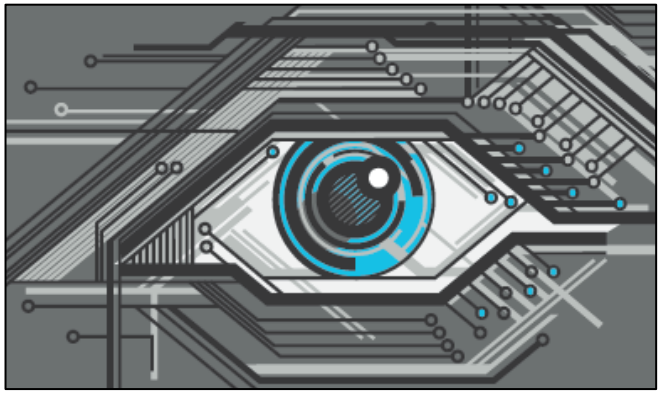

10:20
DELAYED
10:20
DELAYED
10:40
DELAYED
10:45
DELAYED
11:15
DELAYED
11:20
DELAYED


consultations

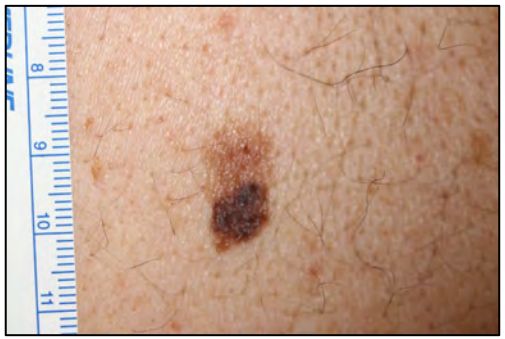

IMPACT

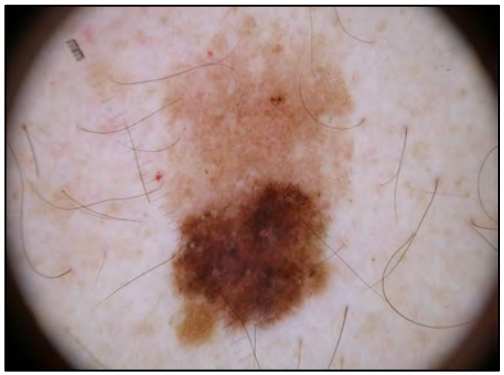


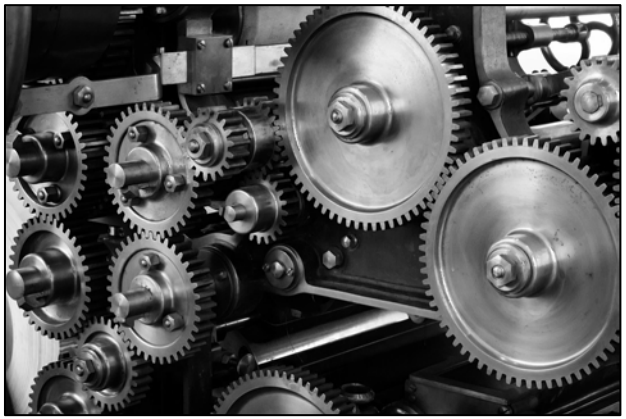
Time Consuming Tasks



Machine vision in melanoma







ESMO GOOD SCIENCE BETTER MEDICINE BEST PRACTICE

Annals of Oncology 0: 1–7, 2018
doi:10.1093/annonc/mdy166

ORIGINAL ARTICLE

Man against machine: diagnostic performance of a deep learning convolutional neural network for dermoscopic melanoma recognition in comparison to 58 dermatologists

H. A. Haenssle[1*,†], C. Fink[1†], R. Schneiderbauer[1], F. Toberer[1], T. Buhl[2], A. Blum[3], A. Kalloo[4], A. Ben Hadj Hassen[5], L. Thomas[6], A. Enk[1] & L. Uhlmann[7]

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†Both authors contributed equally as co-first authors.

Background: Deep learning convolutional neural networks (CNN) may facilitate melanoma detection, but data comparing a CNN's diagnostic performance to larger groups of dermatologists are lacking.

Methods: Google's Inception v4 CNN architecture was trained and validated using dermoscopic images and corresponding diagnoses. In a comparative cross-sectional reader study a 100-image test-set was used (level-I: dermoscopy only; level-II: dermoscopy plus clinical information and images). Main outcome measures were sensitivity, specificity and area under the curve (AUC) of receiver operating characteristics (ROC) for diagnostic classification (dichotomous) of lesions by the CNN versus an international group of 58 dermatologists during level-I or -II of the reader study. Secondary end points included the

ESMO GOOD SCIENCE BETTER MEDICINE BEST PRACTICE

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doi:10.1093/annonc/mdy166
Published online 28 May 2018

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Man against machine: diagnostic performance of a deep learning convolutional neural network for dermoscopic melanoma recognition in comparison to 58 dermatologists

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an international group of 58 dermatologists during level-I or -II of the reader study. Secondary end points include
dermatologists' diagnostic performance in their management decisions and differences in the diagnostic perform
dermatologists during level-I and -II of the reader study. Additionally, the CNN's performance was compared with
algorithms of the 2016 International Symposium on Biomedical Imaging (ISBI) challenge.

Results: In level-I dermatologists achieved a mean (±standard deviation) sensitivity and specificity for lesion
86.6% (±9.3%) and 71.3% (±11.2%), respectively. More clinical information (level-II) improved the sensitivity to 88
$P = 0.19$) and specificity to 75.7% (±11.7%, $P < 0.05$). The CNN ROC curve revealed a higher specificity of 82.5% wi
with dermatologists in level-I (71.3%, $P < 0.01$) and level-II (75.7%, $P < 0.01$) at their sensitivities of 86.6% and 88.9%
The CNN ROC AUC was greater than the mean ROC area of dermatologists (0.86 versus 0.79, $P < 0.01$). The CNN s
close to the top three algorithms of the ISBI 2016 challenge.

Conclusions: For the first time we compared a CNN's diagnostic performance with a large internationa
dermatologists, including 30 experts. Most dermatologists were outperformed by the CNN. Irrespective of any ph
experience, they may benefit from assistance by a CNN's image classification.

Clinical trial number: This study was registered at the German Clinical Trial Register (DRKS-Study-ID: DRKS000
www.drks.de/drks_web/).

Key words: melanoma, melanocytic nevi, dermoscopy, deep learning convolutional neural network, comp
automated melanoma detection

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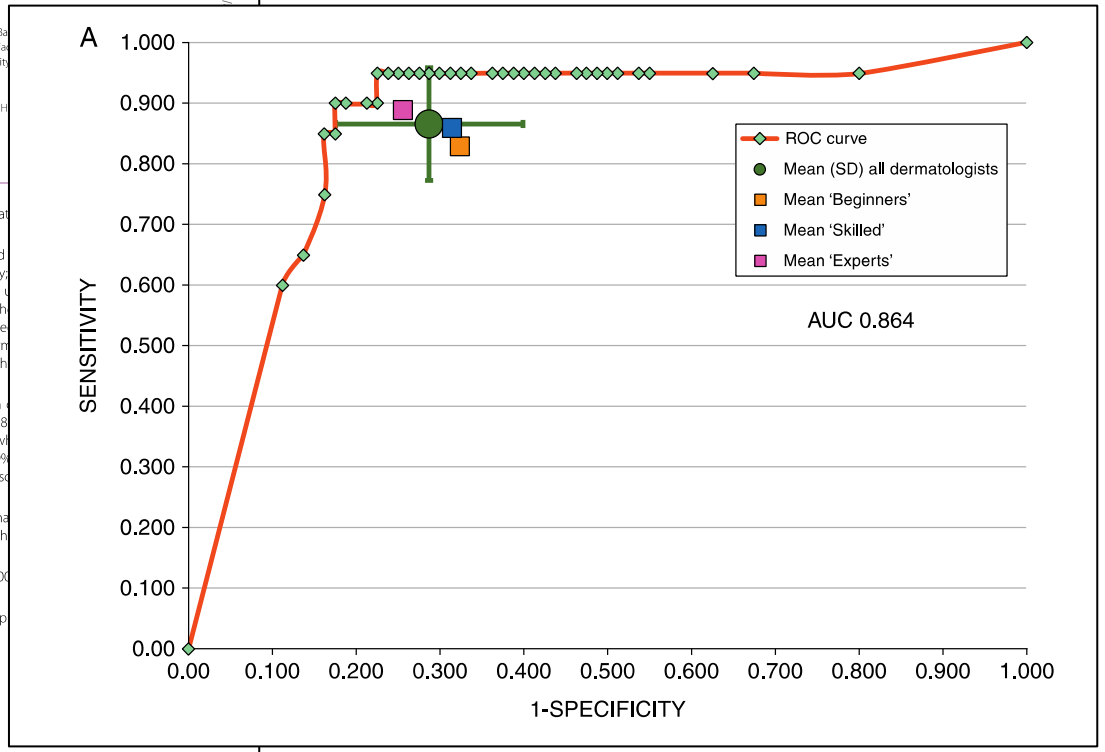

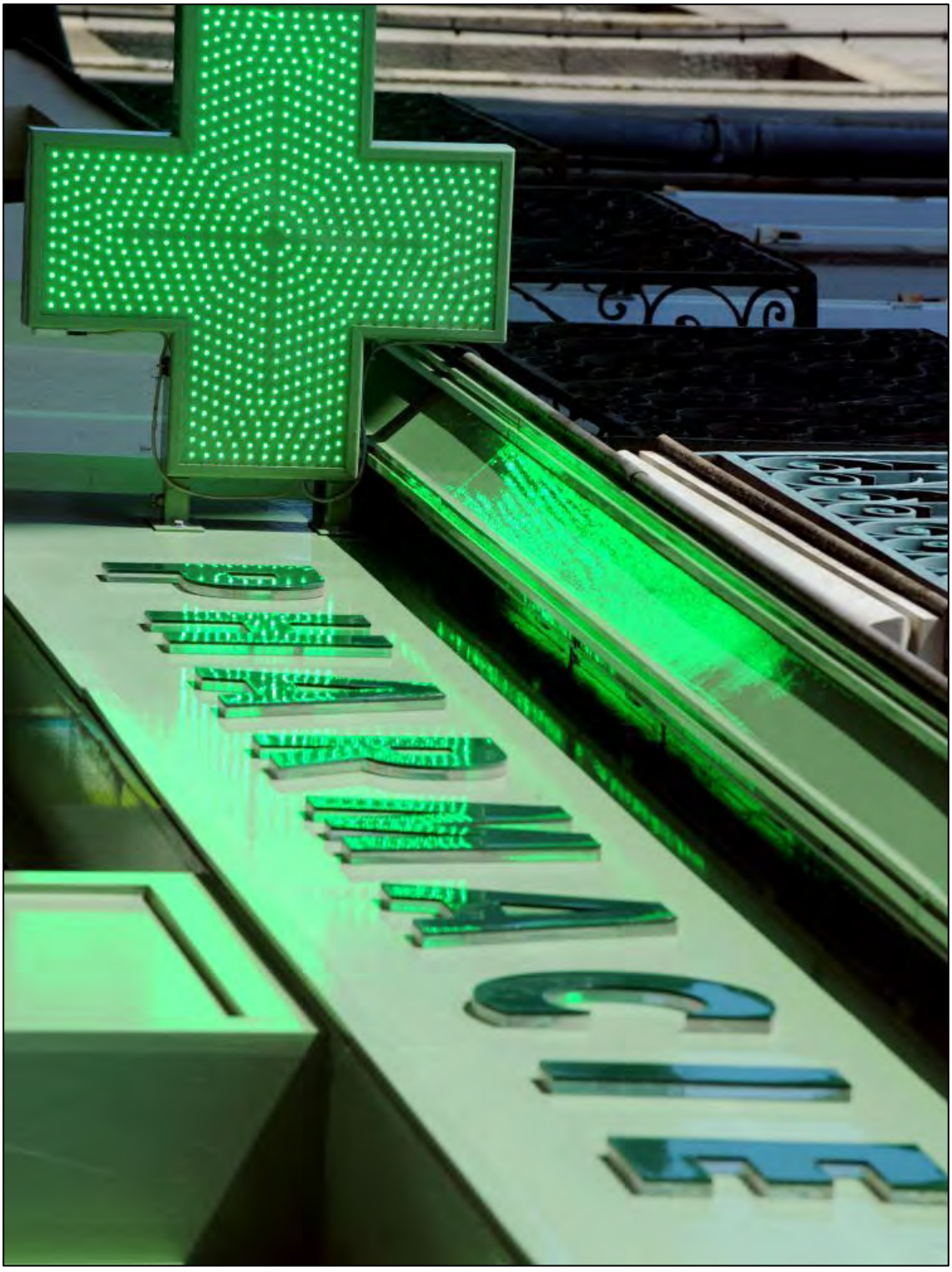
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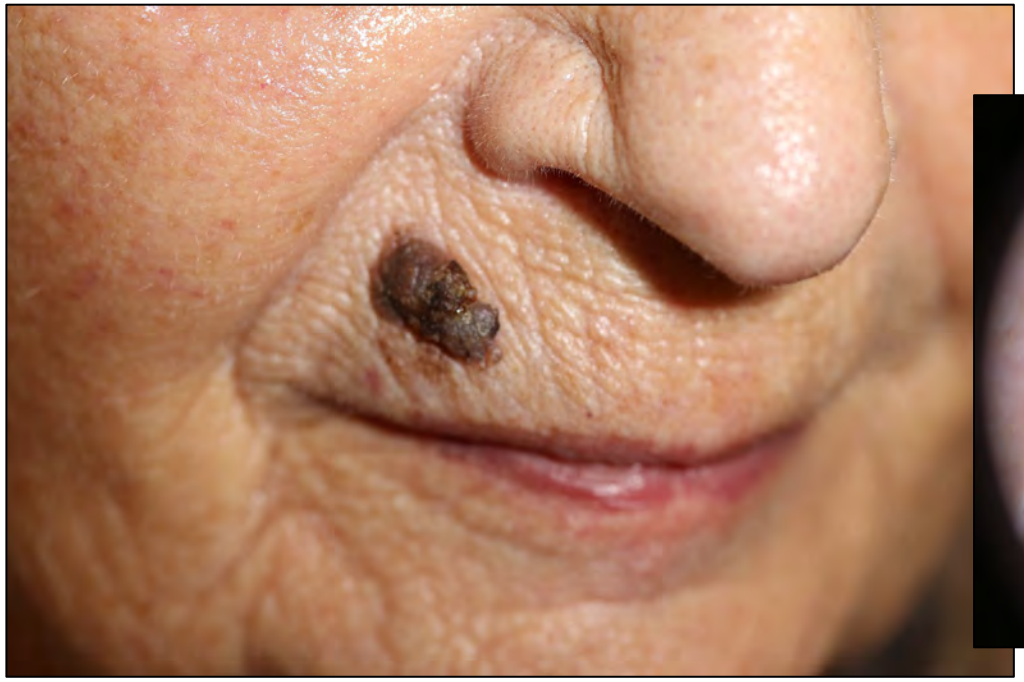

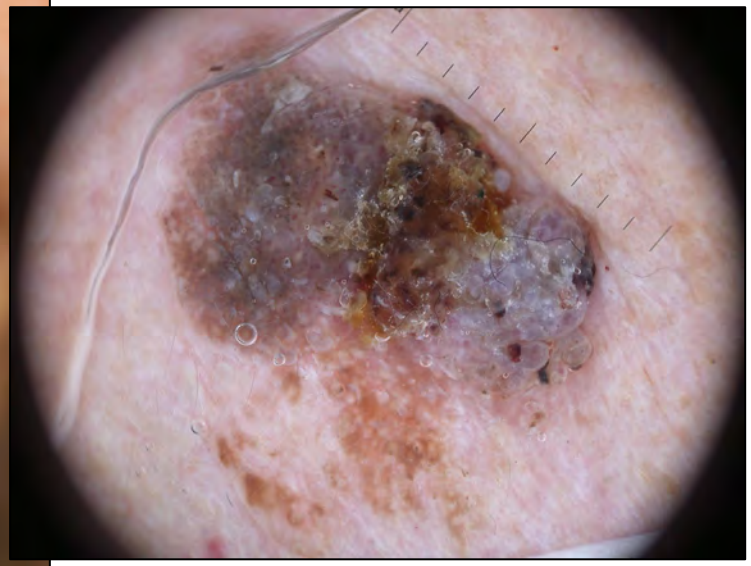

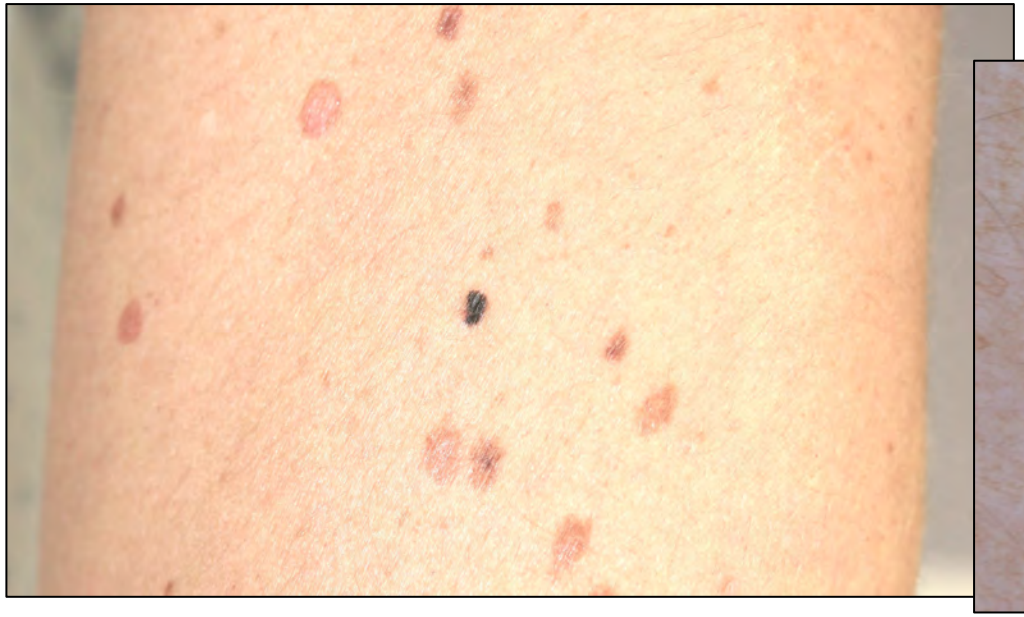

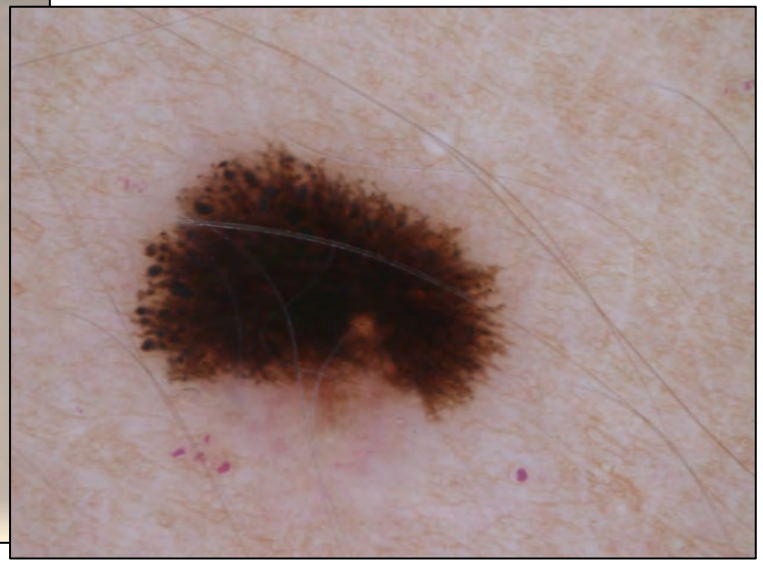

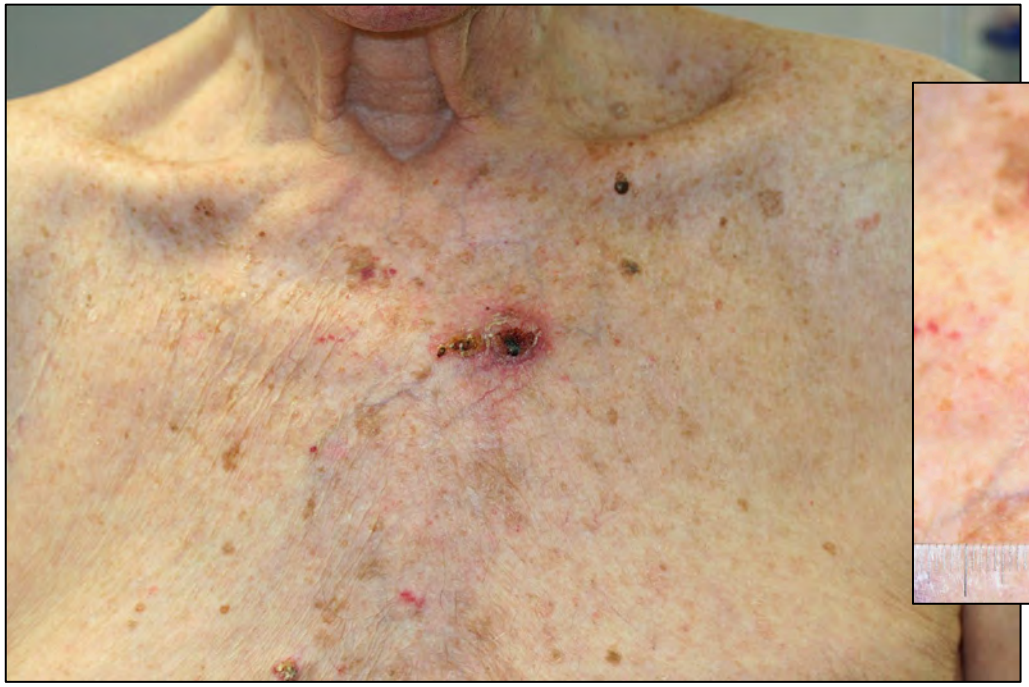

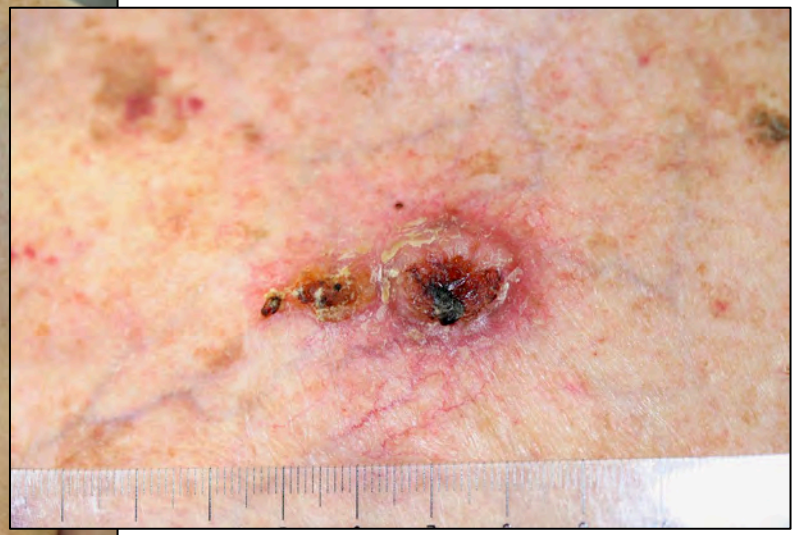

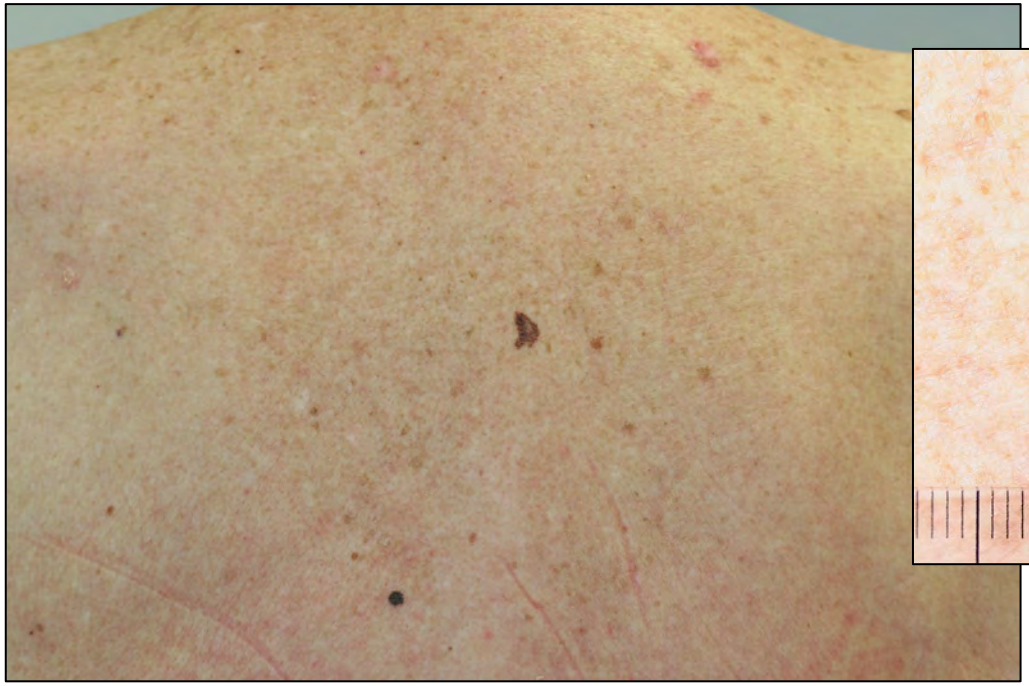

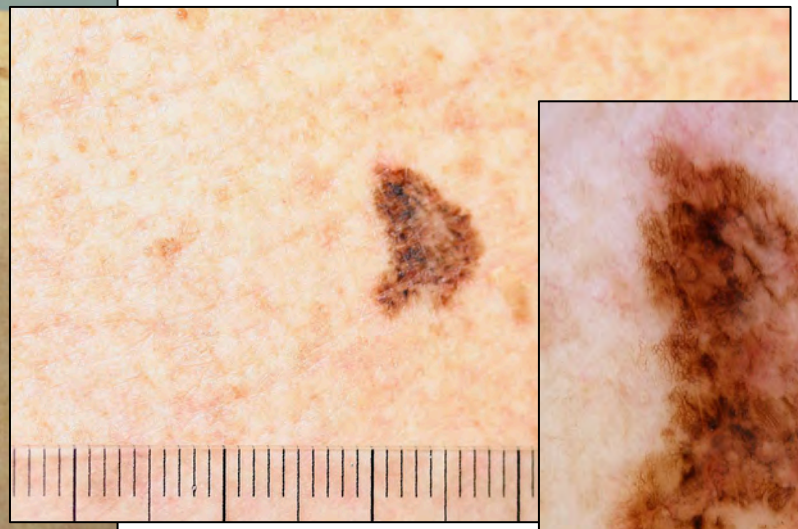

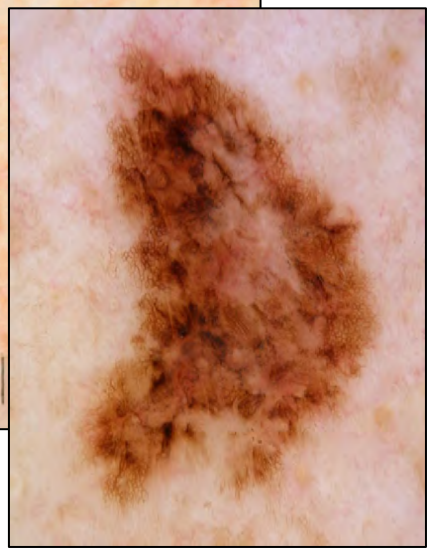

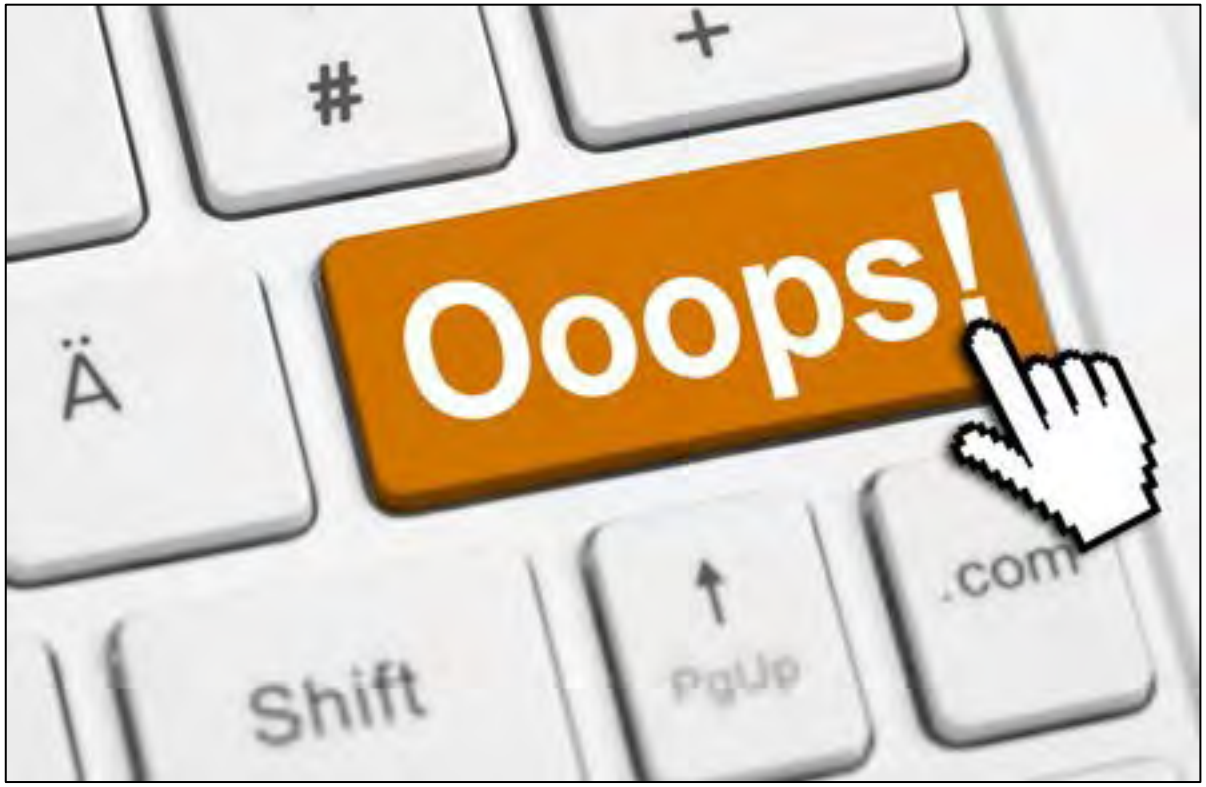
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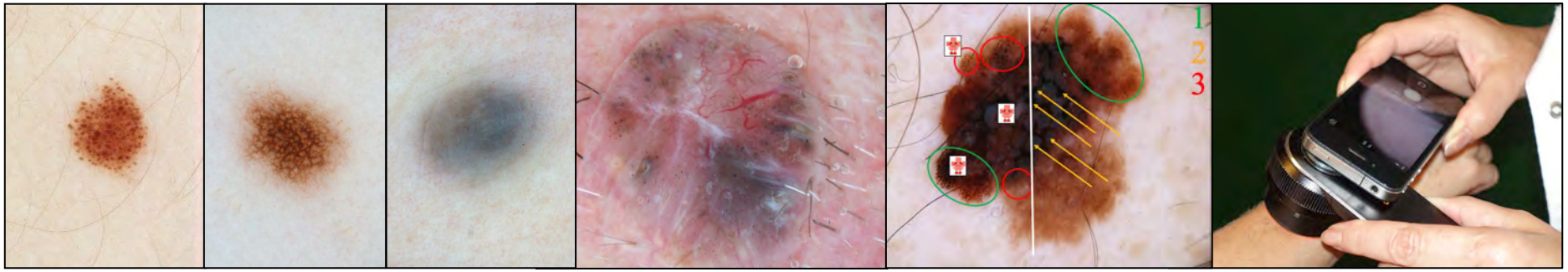
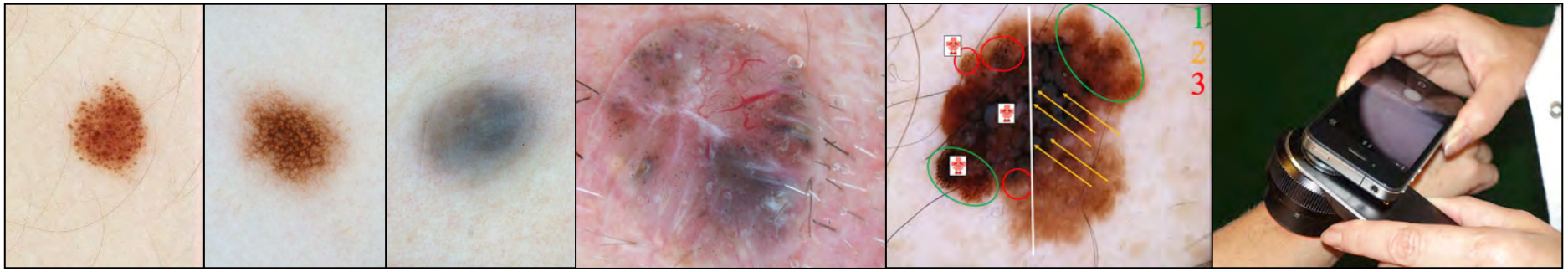
philosophie
magazine
Face à l'intelligence artificielle
COMMENT SAUVER L'INTELLIGENCE NATURELLE ?



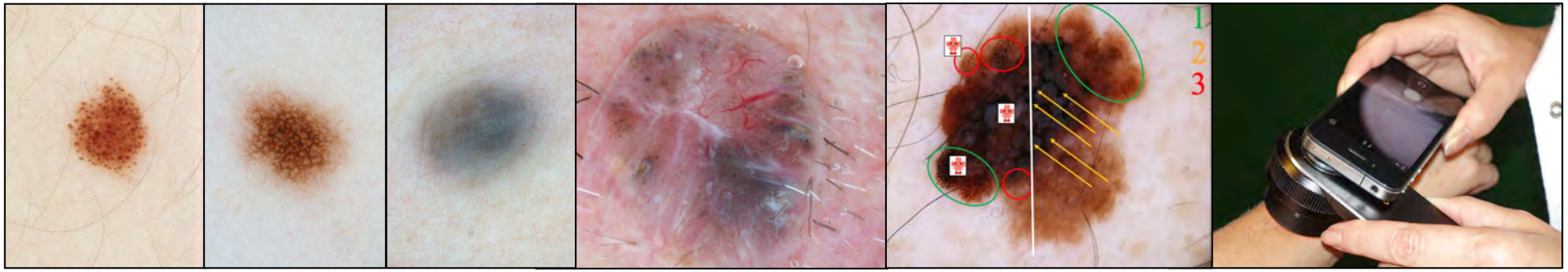
Conclusions 1

- La prise en charge du dépistage précoce des cancers de la peau est l'affaire de tous
- La dermoscopie renforce l'acuité diagnostique dans le difficile diagnostic différentiel des lésion pigmentées
- Sa pratique pourrait se développer en médecine de proximité
  - Médecine Générale
  - Médecine du travail
  - Pédiatrie …



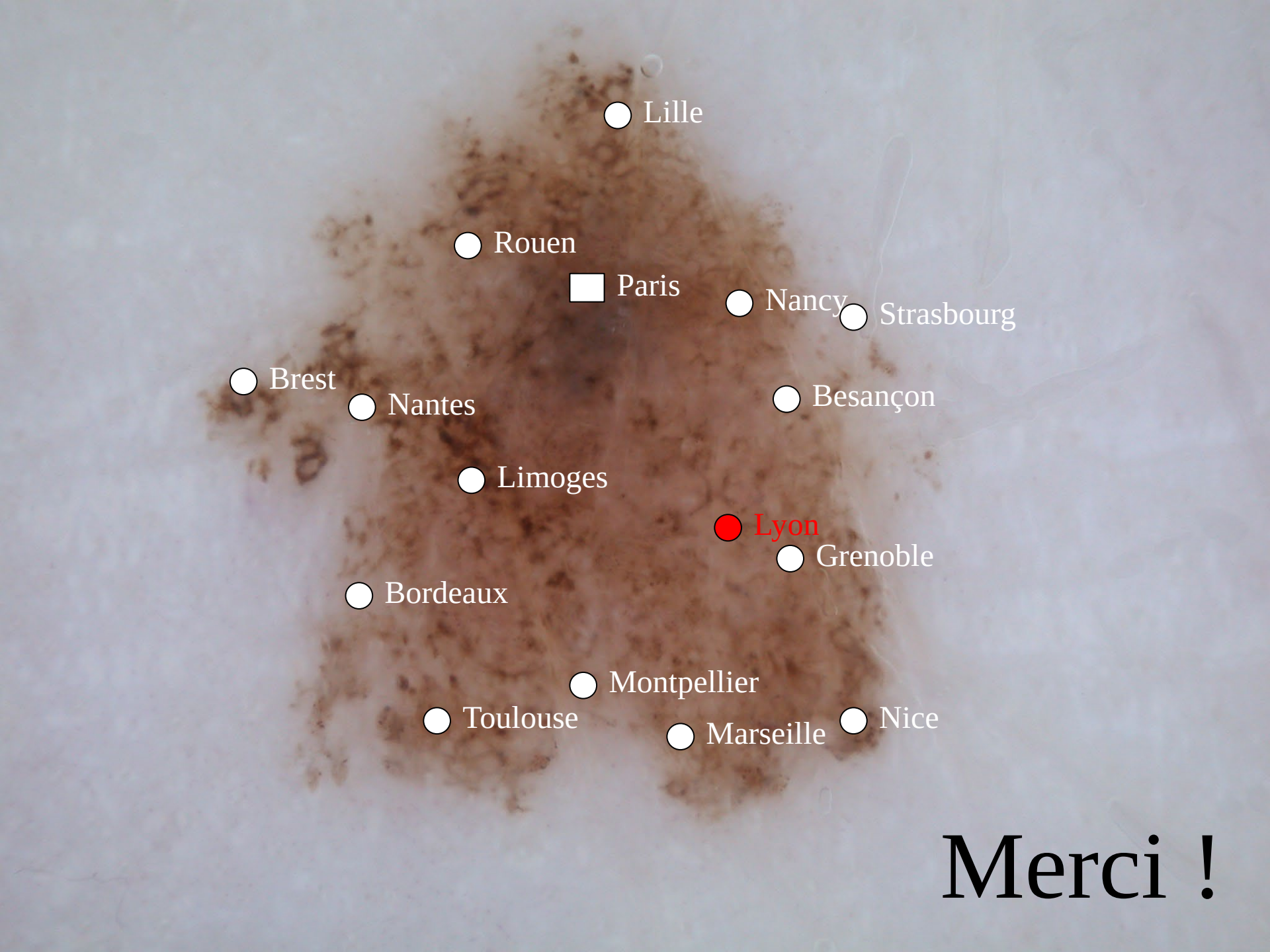
Conclusions 2

- La plupart des très nombreuses lésions bénignes de la peau sont faciles à reconnaitre en dermoscopie ce qui permet de rassurer immédiatement les patients
- La pratique de la dermoscopie dans certaines topographies (face, extrémités, muqueuses, cicatrices) et des lésions non pigmentées requiert une expertise supplémentaire
- La pratique de la dermoscopie dynamique requiert également une expertise supplémentaire



Conclusions 3

- Des formations de qualité en dermoscopie destinées à la médecine de proximité sont disponibles
- La pratique de la photodermoscopie est facile, ne requiert pas d'équipement supplémentaire et permet d'accéder à la téléexpertise
- Le développement des applications en I.A. permettra probablement un premier tri des lésions à considérer toutefois l'exhaustivité de l'examen cutané et la prise de décision nécessitera encore longtemps une « intelligence » naturelle…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Merci !