

Is Dermoscopy Destroying Clinical Dermatology?

Claudio Conforti^{1,2}, Luca Ambrosio^{1,3}, Roberta Giuffrida⁴, Caterina Longo⁵,
Giovanni Pellacani³, Iris Zalaudek⁶

1 IDI-IRCCS, Dermatological Research Hospital, 00167 Rome, Italy

2 Link University of Rome, Department of Life Science, Health and Health Professions, Rome, Italy

3 Dermatology Unit, Department of Medical and Cardiovascular Sciences, “Sapienza” University of Rome, Rome, Italy

4 Department of Clinical and Experimental Medicine, Dermatology, University of Messina, Messina, Italy

5 Dermatology Department, University of Modena and Reggio Emilia, Modena, Italy

6 Department of Dermatology, Maggiore Hospital, University of Trieste, Trieste, Italy

Citation: Conforti C, Ambrosio L, Giuffrida R, Longo C, Pellacani G, Zalaudek I. Is Dermoscopy Destroying Clinical Dermatology? *Dermatol Pract Concept*. 2025;15(4):5823. DOI: <https://doi.org/10.5826/dpc.1504a5823>

Accepted: April 9, 2025; **Published:** October 2025

Copyright: ©2025 Conforti et al. This is an open-access article distributed under the terms of the Creative Commons Attribution-NonCommercial License (BY-NC-4.0), <https://creativecommons.org/licenses/by-nc/4.0/>, which permits unrestricted noncommercial use, distribution, and reproduction in any medium, provided the original authors and source are credited.

Funding: None.

Competing Interests: None.

Authorship: All authors have contributed significantly to this publication.

Corresponding Author: Luca Ambrosio, MD, Via dei Monti di Creta, 104, 00167, Rome, Italy. ORCID ID: 0000-0002-6312-7709. Email: luca.ambrosio@uniroma1.it

Dear Editor,

Dermoscopy represents a silent revolution in dermatology, profoundly transforming daily practice. Though its impact on early skin cancer detection and reduction of unnecessary excisions is well established, it has yet to gain consistent recognition in high-ranking medical journals. Nevertheless, this simple, cost-effective tool has become a global standard in skin cancer screening, with growing applications in general dermatology, including skin infections and inflammatory diseases, due to its accuracy and efficiency [1]. For these reasons, it is often referred to as the “dermatologist’s stethoscope” [2]. However, while the enthusiasm for dermoscopy has led to intense research resulting in the identification of numerous diagnostic criteria, the principle that it should complement clinical examination is being overlooked. Many published studies emphasize its use as a second-level tool, yet often neglect the description of clinical features, risking a loss of crucial educational and diagnostic context [3]. Clinical reasoning remains the cornerstone

of dermatology, especially for differentiating tumors from inflammatory diseases that may share overlapping dermoscopic features. For instance, the classification of keratinocyte tumors benefits more from contextual evaluation (photodamaged versus non-photodamaged skin) than from isolated dermoscopic findings [4]. Without such contextualization, dermoscopy risks fostering superficial interpretation. This trend is compounded by the increasing medicolegal weight of histopathology, leading to what has been termed “anatomopathological chaos,” with numerous subtypes of dysplastic lesions (e.g., SAMPUS, MEL-TUMP, THIMUMP) whose clinical significance remains debated [5,6]. The widespread use of dermoscopy from the early stages of residency has also encouraged a reversal of priorities: today, a dermatofibroma is often diagnosed dermoscopically before being confirmed by palpation, although tactile examination should remain fundamental. Similarly, conditions such as dermatitis, warts, and molluscum contagiosum, once diagnosed primarily through clinical evaluation, are increasingly approached dermoscopically. This prioritization of pattern

recognition over bedside reasoning extends to inflammatory diseases such as lichen planus, psoriasis, and mycosis fungoides [3]. A further shift has been observed in the evaluation of pigmented lesions, where the desperate search for features is giving way to the recognition of benign criteria first. Lallas et. al have shown how, instead of focusing on malignant features, clinicians must first assess the presence/absence of benign criteria typically associated with seborrheic keratoses, solar lentigo, or actinic keratoses [7]. Yet, modern teaching tools often promote rapid pattern recognition, sometimes in a gamified format, undermining deeper diagnostic reasoning. Coupled with a decreasing interest in research, this risks weakening the scientific rigor of the discipline. To address these challenges, a balanced approach is needed: dermoscopy should supplement, not replace, traditional clinical examination. Patient history, inspection, and palpation must remain central, supported by dermoscopy and by close collaboration with dermatopathologists. By maintaining this integration, dermatologists can provide holistic and effective care while ensuring that future generations remain grounded in essential clinical skills.

References

1. Ring C, Cox N, Lee JB. Dermatoscopy. *Clin Dermatol*. 2021;39(4):635-642. DOI:10.1016/j.clindermatol.2021.03.009. PMID: 34809768
2. Zalaudek I, Lallas A, Moscarella E, Longo C, Soyer HP, Argenziano G. The dermatologist's stethoscope-traditional and new applications of dermoscopy. *Dermatol Pract Concept*. 2013;3(2):67-71. DOI:10.5826/dpc.0302a11. PMID: 23785649
3. Errichetti E, Stinco G. Dermoscopy in General Dermatology: A Practical Overview. *Dermatol Ther (Heidelb)*. 2016; 6(4):471-507. DOI:10.1007/s13555-016-0141-6. PMID: 27613297
4. Conforti C, Giuffrida R, Pizzichetta MA, Di Meo N, Magaton-Rizzi G, Zalaudek I. Integrating the concept of field cancerization in the classification and risk assessment of cutaneous squamous cell carcinoma: proposal for a new classification and terminology of keratinocyte skin cancer. *J Eur Acad Dermatol Venereol*. 2019;33(9):e327-e330. DOI:10.1111/jdv.15624. PMID: 30980765
5. Titus LJ, Reisch LM, Tosteson ANA, et al. Malpractice Concerns, Defensive Medicine, and the Histopathology Diagnosis of Melanocytic Skin Lesions. *Am J Clin Pathol*. 2018;150(4):338-345. DOI:10.1093/ajcp/aqy057. PMID: 30007278
6. Ferrara G, Argenziano G. The WHO 2018 Classification of Cutaneous Melanocytic Neoplasms: Suggestions From Routine Practice. *Front Oncol*. 2021;11. DOI:10.3389/fonc.2021.675296. PMID: 34277420
7. Lallas A, Lallas K, Tschandl P, et al. The dermoscopic inverse approach significantly improves the accuracy of human readers for lentigo maligna diagnosis. *J Am Acad Dermatol*. 2021;84(2):381-389. DOI:10.1016/j.jaad.2020.06.085. PMID: 32592885