Author's response to reviews

Title: Accuracy of Siascopy for pigmented skin lesions encountered in primary care: development and validation of a new diagnostic algorithm.

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Dear Dr Shipley

**MS: 3308361023300530**

**Accuracy of Siascopy for pigmented skin lesions encountered in primary care: development and validation of a new diagnostic algorithm.**

**Jon D Emery, Judith Hunter, Antony J Watson, Per H Hall, Marc Moncrieff and Fiona M Walter**

Thank you for the further comments in relation to our revised manuscript. We were somewhat perturbed by the suggestion that our manuscript contains some errors and omissions. We list our responses and have highlighted additional changes made to the manuscript:

1. We would question the reviewer’s comments about lentigo maligna and refer to the 2008 Clinical Practice Guidelines for the Management of Melanoma in Australia and New Zealand which were endorsed by the Cancer Council of Australia, The Australian Cancer Network and the Ministry of Health of New Zealand. One of the authors of our paper (MM) contributed to this international evidence-based guideline and so we do not believe that our classification is ‘long passé’. We refer to the following quotation from Chapter 10 which is entirely devoted to the management of lentigo maligna:

‘Lentigo maligna  is a traditional term for atypical pigmented macular lesions on severely sun damaged skin, usually on the face of elderly patients. The histological diagnosis of lesions clinically suspicious of lentigo maligna may range from solar lentigo to in-situ melanoma (lentigo maligna pattern) or invasive melanoma (lentigo maligna melanoma). While some authors regard lentigo maligna as referring only to melanoma in situ, others distinguish between different phases of lentigo maligna as, respectively, a melanoma precursor and in situ melanoma.’

We have therefore deliberately reported lentigo maligna separately from melanoma in our data. We do not wish to enter a prolonged debate about the classification of lentigo maligna, but as regards our paper it does not actually alter any of the results for diagnostic accuracy as they were all treated as suspicious lesions.

2. As discussed previously, we deliberately obtained maximum clinical information about each lesion to inform the clinical expert reference standard diagnosis. This
included the 7-point checklist. We chose to do this so we could be as accurate as possible with our reference diagnosis where histology was not available. As such it would be methodologically inappropriate to retrospectively compare the accuracy of the 7-point checklist with siascopy because the 7-point checklist contributed to the reference diagnosis. We simply cannot conduct the analysis requested by the reviewer. We have added some sentences in the Discussion (para 1, p13) to clarify this.

3. The number of lesions that were excised was stated and underlined in our previous revisions on page 10, para 2. We apologise for not providing page numbers for each specific revision. We have highlighted this in our attached revised manuscript.

4. We have clarified that there was no long term follow-up of benign lesions and discuss this as a limitation on page 13, para 1.

I trust that we have now responded adequately to the issues raised by the peer reviews and look forward to hearing from you in due course.

Yours sincerely

Prof Jon Emery