A Guide to Dermatology in Primary Care

Royal United Hospital Bath NHS Trust

Contents

Introduction

The Guidelines have been produced by the Department of Dermatology of the Royal United Hospital Bath NHS Trust with the backing of local Primary Care Trusts.

This document offers recommendations of first line treatment for common skin conditions and useful guidelines, for the practice of Dermatology in Primary Care and defines the point at which Secondary Care may give additional benefit. This information is intended to be used as a source of reference by General Practitioners in order to become familiar with the most common skin diseases encountered in General Practice and to boost confidence in dealing with them.

We would expect these treatment recommendations to be followed prior to consideration of referral to the department. Criteria for referral are clearly stated at the end of each section. It would be helpful if referrals were to the department rather than named Consultants as this enables us to pool and distribute referrals evenly.

Dermatology Department

Consultants:

Dr Chris Lovell	01225 824524
Dr Bill Phillips	01225 824525
Dr Amrit Darvay	01225 821577
Dr Cari Aplin	01225 821577
Specialist Registrar	01225 428331 Bleep 7844

Nurse Specialist:

Kay Dawkes	01225 824312 Bleep 7648
Day Treatment Unit:	01225 825660
Dermatology Outpatients Reception:	01225 825658
Urgent Referrals Fax No.	01225 824935

Referral

Urgent Referrals

All referrals will be assessed daily by a Consultant. Please Fax 01225 824935 with the details or use the electronic referral system. Those marked with possible melanoma or squamous cell carcinoma will be seen within two weeks. Other urgent cases will be prioritised by a consultant.

If you wish to discuss a case with a Consultant, please ring via the Secretary's direct line.

Skin Cancer

Referrals for possible melanomas and squamous cell carcinomas should clearly indicate the provisional diagnosis and will be prioritised as "urgent". These referrals should be faxed on 01225 824935. Referrals for other skin malignancies e.g., basal cell carcinoma should be made in the usual manner.

Content of referral letter

The following information should be included in all referrals:

- Full demographics with contact telephone numbers.
- Nature of condition and duration.
- Relevant past medical history.
- All medication currently and previously used for this condition including dose, duration of treatment and response, plus all other concurrent medication.

Guidelines on Referral of Benign Lesions to Secondary Care

In order to make the best use of resources, and to keep waiting times to a minimum, we propose not to offer treatment for the following conditions except in exceptional circumstances. These guidelines are in accordance with national recommendations, and have been agreed in consultation with GP representatives on the PCTs.

Referral is appropriate if there is diagnostic doubt, although the lesion will not normally be removed if it is felt to be benign.

We are normally unable to provide treatment for the following conditions:

1. Viral warts
2. Seborrhoeic warts/keratoses
3. Skin tags
4. Benign moles/naevi
5. Dermatofibromas
6. Histiocytomas
7. Epidermal (sebaceous) cysts
8. Lipomata
9. Spider naevi

Notes

1. People with viral warts rarely need hospital referral, except in immunosuppressed individuals. Three months treatment with a salicylic acid based wart paint will clear 50-70% of warts in three months. Cryotherapy is painful, and almost always cruel and unjustified in children. Chiropody is an appropriate treatment for persistent plantar warts (not available through dermatology). Genital warts should be referred to the GUM department.

2. Epidermal cysts and lipomata are more appropriately referred to the general surgeons.

"Allergy testing"

We patch test patients in whom we suspect allergic contact dermatitis is contributing to their eczema/dermatitis. This is a specialised procedure, offered only by dermatology departments. We do not perform prick testing, except in patients with suspected type 1 allergy to latex, or in individuals in whom we suspect a contact urticant. Prick testing is of no value in chronic urticaria. If the patient's "allergy" symptoms relate to systems other than the skin, e.g. respiratory tract, it is appropriate to refer to the relevant discipline.

We are fully aware that there are many reasons for referring patients with the above conditions, not least of which is patient pressure. If the referral falls outside these guidelines, it will be returned with an enclosed letter that you may wish to send on to the patient. Alternatively, you may wish to resubmit the referral clarifying the details of the exceptional circumstances surrounding the case.

General notes on prescribing dermatology products for patients

Quantities

It is recommended that emollients be applied frequently particularly when the condition is florid. In these situations the following quantities for ADULTS for one week are suggested:

EMOLLIENTS	Creams and Ointments	Lotions
Face	50—100g	250ml
Both hands	100—200g	500ml
Scalp	100—200g	500ml
Both arms or both legs	300—500g	500ml
Trunk	1000g	1000ml
Groin and genitalia	50—100g	250ml

The BNF recommended quantities of EMOLLIENTS to be given to ADULTS for twice daily application for one week are:

EMOLLIENTS	Creams and Ointments	Lotions
Face	15—30g	100ml
Both hands	25—50g	200ml
Scalp	50—100g	200ml
Both arms or both legs	100—200g	200ml
Trunk	400g	500ml
Groin and genitalia	15—25g	100ml

The recommended quantities of STEROIDS to be given to ADULTS for twice daily application for one week are:

STEROIDS/TWICE DAILY	Creams and Ointments
Face	15—30g
Both hands	15—30g
Scalp	15 –30g
Both arms	30—60g
Both legs	100g
Trunk	100g
Groin and genitalia	15—30g

Prescribing of topical steroids for children

Children, especially babies, are particularly susceptible to side effects. The more potent steroids are contraindicated in infants less than 1 year, and in general should be avoided in paediatric treatment, or if necessary used with great care for short periods.

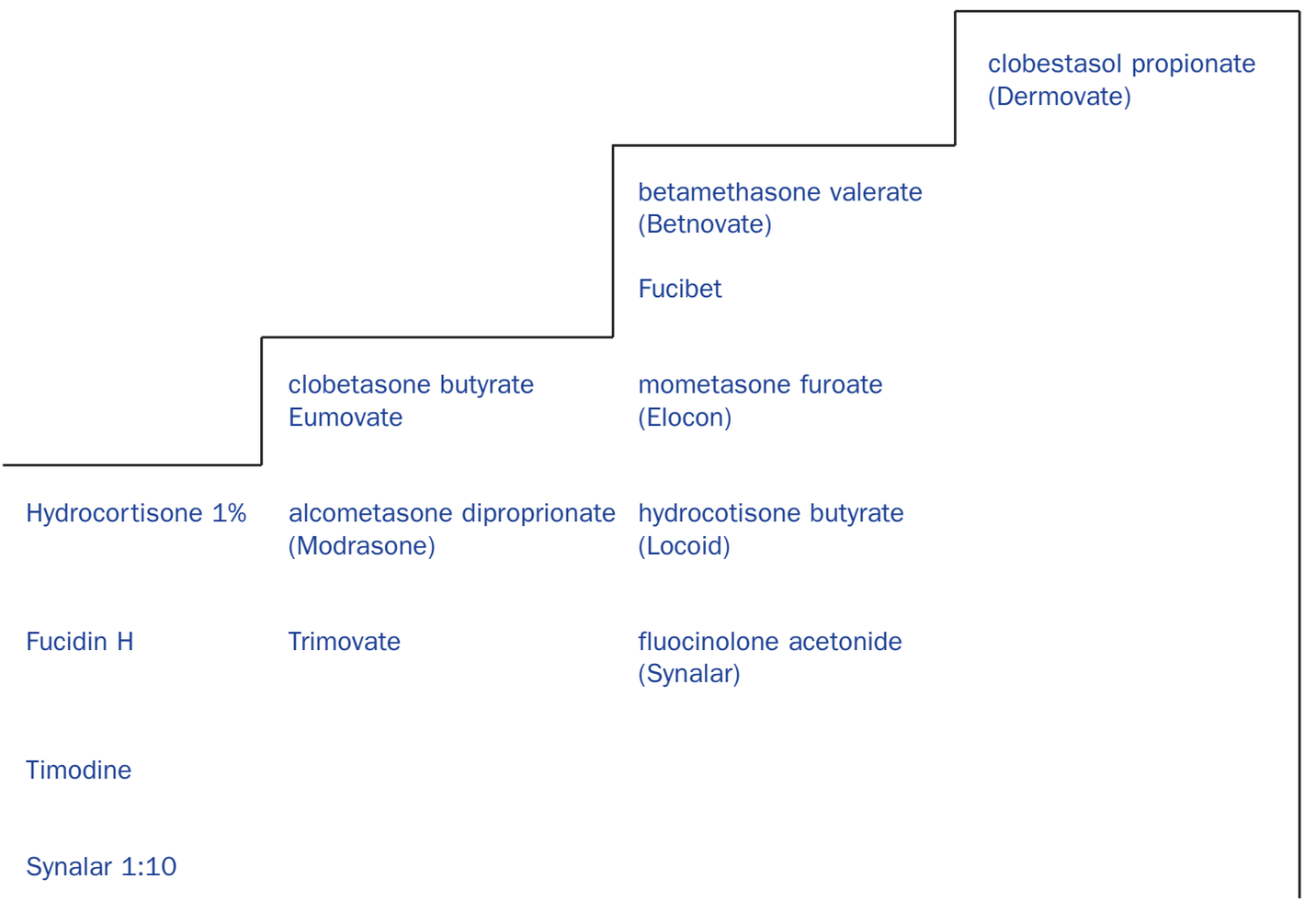
Finger Tip Units for Treating Children with Steroids

Number of finger tip units						
Age	**Face and Neck**	**Hand and Arm**	**One Side of Trunk**	**Buttocks**	**Foot and Leg**	**Total Body**
3/12	1	1	1	0.5	1.25	8
6/12	1	1	1.5	0.5	1.5	9.5
12/12	1.5	1.25	1.75	0.5	2	12
18/12	1.5	1.5	2	0.75	2	13.25
2 yrs	1.5	1.5	2	1	2	13.5
3 yrs	1.5	1.75	2.5	1	2.5	16
4 yrs	1.75	2	2.75	1	3.5	19.25
5 yrs	2	2	3	1	3.5	20
7 yrs	2	2.5	3.5	1.5	4.5	24.5
10 yrs	2.5	3	4	1.5	6	30
12 yrs	2.5	4	5	2	7	36.5

Twice daily all over steroid application		
Age	Daily	Weekly
3/12	8g	56g
6/12	9.5g	66.5g
12/12	12g	84g
18/12	13.25g	92.75g
2 yrs	13.5g	94.5g
3 yrs	16g	112g
4 yrs	19.25g	134.75g
5 yrs	20g	140g
7 yrs	24.5g	171.5g
10 yrs	30g	210g
12 yrs	36.5g	225.5g

Topical Steroid Ladder

Potent/very potent topical steroids should usually be avoided in flexures or on faces



Treatment aims:

- To reduce the severity and length of illness.
- To reduce the psychological impact on the individual.
- To prevent long-term sequelae such as scarring.

Section 1: Acne

clinical features

Mild to moderate acne should be managed in primary care. Several different agents may need to be tried alone or in combination. Do not use combinations of agents with similar properties or actions e.g. topical plus systemic antibiotics. Inform patient that response is usually slow and allow at least 12 weeks before review.

Mild

Uninflamed lesions - open and closed comedones (blackheads).

Mild - Moderate

Comedones and some papules/pustules.

Moderate

Greater number or more extensive inflamed lesions.

treatment

Topical retinoids (avoid pregnancy)
- Adapalene - Differin
- Isotretinoin - Isotrex
- Tretinoin - Retin-A

Topical retinoid or topical benzoyl peroxide preparations
+/- topical antibiotic
Combination preparations e.g.
- *Erythromycin/Zinc - Zineryt.*
- *Benzoyl peroxide/Erythromycin - Benzamycin*
- *Erythromycin/Isotretinoin - Isotrexin*
- *Erythromycin 2%, 4% gel –* Eryacne

Systemic antibiotics
- Oxytetracycline 500mg bd
- Doxycycline 50mg od
- Lymecycline 408mg od
- Erythromycin 500mg bd
- Minocycline 100mg od

therapeutic tips

Often cause irritation therefore reduce frequency or duration of application and build up to daily over 2-3 weeks. Advise additional noncomedogenic moisturiser.

Starting at 2.5% increasing to 5 or 10% may reduce irritancy with benzoyl peroxide.

May be more effective and aid compliance.

Treatment should continue for 6 months minimum and repeat if necessary.

Often most effective but has additional side effects and may therefore be preferred as second line.

Topical benzoyl peroxide or retinoids may be used in combination.

cont/.

clinical features	treatment	therapeutic tips
Moderate – Severe Papules/pustules with deeper inflammation and some scarring.	Systemic treatment as above plus topical therapy. Consider additional hormone therapy. Ethinyloestradiol/Cyproterone acetate (Dianette) in women.	
Severe Confluent or nodular lesions usually with significant scarring.	Commence systemic therapy and refer immediately for systemic isotretinoin treatment.	
Maintenance	Topical retinoid therapy e.g. Adapalene	

Criteria for Referral

The main reason for referring a patient with acne is for Isotretinoin treatment. Females of childbearing age should preferably be established on an oral contraceptive prior to treatment with Isotretinoin.

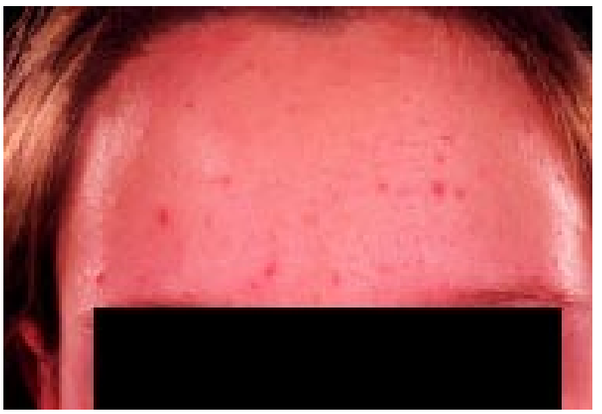
The indications for Isotretinoin treatment are as follows:

1. Severe nodulo-cystic acne (refer immediately).

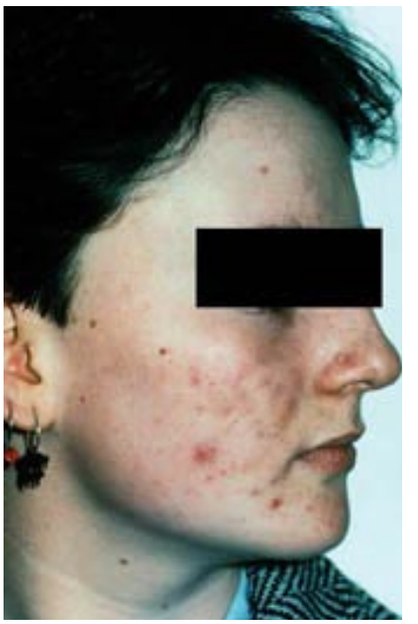
2. Moderate acne that has failed to respond to prolonged (i.e. more than six months) courses of systemic antibiotic treatment in addition to topical treatment.

3. Mild to moderate acne in patients who have an extreme psychological reaction to their acne and have failed to respond to prolonged courses of systemic antibiotic treatment and topical treatment.

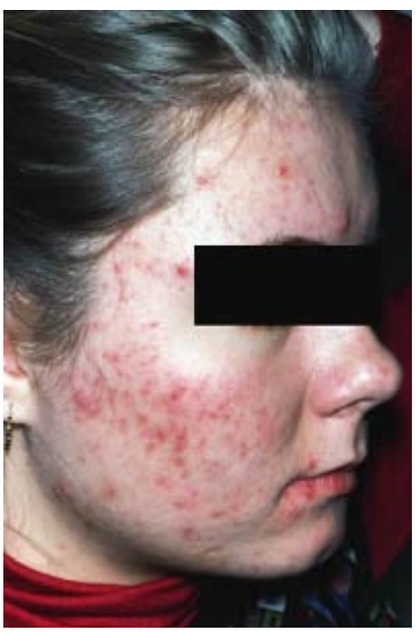
Acne



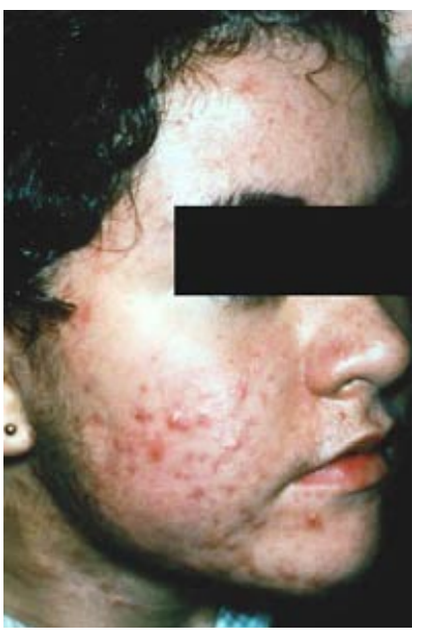
Mild



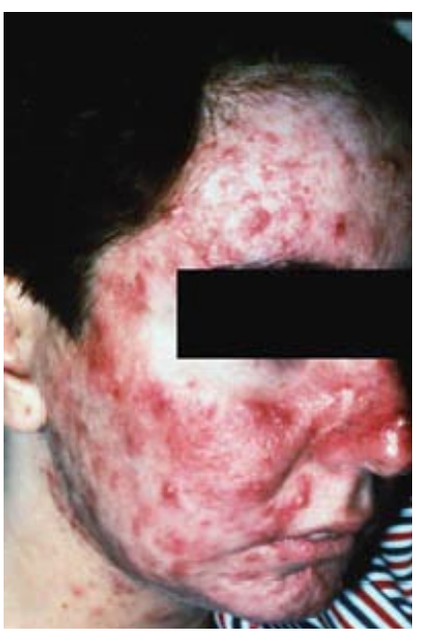
Mild—Moderate



Moderate



Moderate Severe



Severe

Treatment aims:

- **To achieve remission**

Section 2: Rosacea

clinical features

- Flushing often made worse by alcohol, spicy foods, hot drinks, temperature changes or emotion
- Telangiectasia
- Papules on erythematous background
- Pustules
- Facial disfigurement
- Intermittent or permanent
- Rhinophyma

Ocular Rosacea

treatment

Topical Treatment

- Metronidazole Gel/Cream bd

Systemic Treatment

Tetracyclines

- Oxytetracycline 1g od

- Doxycycline 50mg od
- Minocycline 100mg od

- Lymecycline 408mg od

- Erythromycin 500mg bd

- Tetracycline

therapeutic tips

Early treatment of rosacea is considered to be important as each exacerbation leads to further skin damage and increases the risk of more advanced disease.

Intermittent therapy can be considered for those with very occasional flare-ups but as detailed later frequency of recurrences can be reduced by maintenance therapy.

Mild to moderate cases or where systemic treatment is contraindicated. May be introduced at the end of a course of oral antibiotics to allow their tapering and withdrawal.

Preparations with a cellulose base (e.g. Metrogel) tend to be less cosmetically acceptable to patients.

Avoid topical steroids.

Continue therapy for 6-12 weeks although response is normally more rapid.
NB. Tetracycline is contraindicated in pregnancy, lactation and renal disease.
Continue treatment for 6-12 weeks.
NB. Both drugs can cause photosensitivity.

Patients should be advised to avoid direct sunlight and to wear a suitable sun block when going outside.

Not contraindicated in pregnancy

Advise patient on lid hygiene to manage blepharitis.

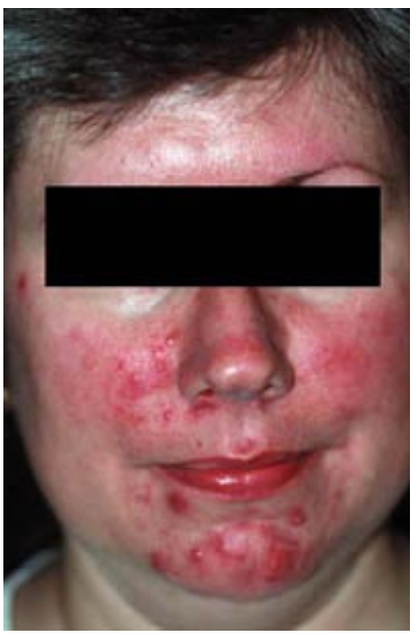
Cont/.

clinical features	treatment	therapeutic tips
Surgical Treatment	Tuneable dye Laser Intense pulsed light Surgical shaving with diathermy	Useful in the treatment of telangiectasia. For the treatment of rhinophyma.
Patient Counselling		Patient counselling. Patients can be advised on a number of issues: heat and cold, alcohol and cosmetics all of which can provoke flushing. Stress management may also be considered.

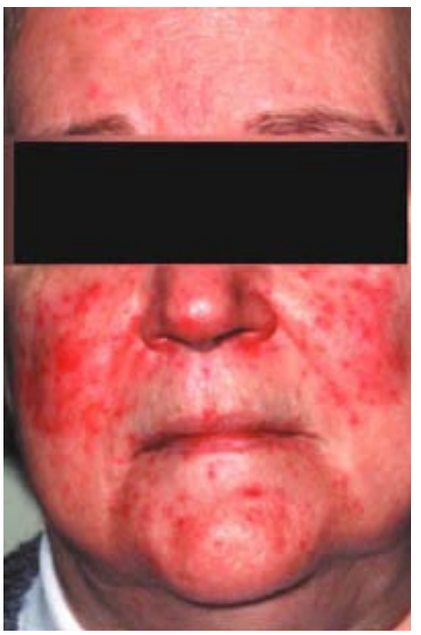
Criteria for Referral

- Doubt over diagnosis
- Severe disease.
- Severe Ocular Rosacea with keratitis or uveitis.

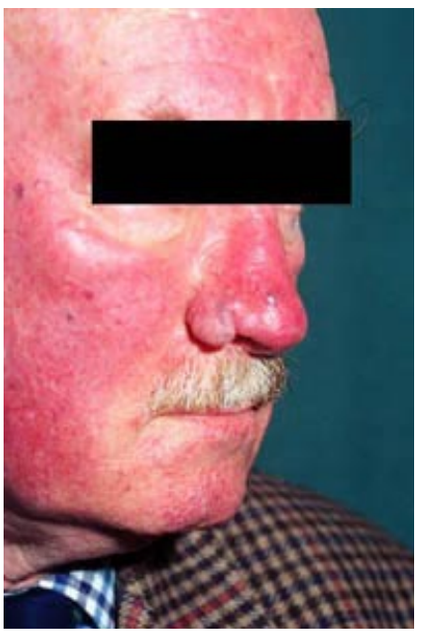
Rosacea



Rosacea



Rosacea



Rosacea (with Rhinophyma)

Section 3: Hand Eczema

clinical features

A Endogenous Eczema (e.g. atopic)

B Exogenous Eczema

(i) Contact Irritant Eczema
Due to substances coming into contact with the skin, usually repeatedly, causing damage and irritation.
Substances such as:

- Detergents
- Shampoos
- Household cleaning products

(ii) Contact Allergic Dermatitis
Due to type IV allergic reaction to a substance with the skin is in contact with.

All types of endogenous and exogenous eczema can present with either 'wet' (blistering and weeping) or 'dry' (hyperkeratotic and fissured) eczema.

treatment

Avoidance of irritants
Soap substitutes such as Aqueous cream should be used. Gloves e.g. household PVC gloves should be used for wet work such as dishwashing. Gloves may also be required for dry work e.g. gardening.

Emollients
These should be applied frequently. There are a variety of emollients available that vary in their degree of greasiness. Different patients will prefer different preparations.

Topical Steroids
The strength of topical steroid required varies from case to case. However, it is often necessary to use a potent topical steroid short term. Prescribe a cream formulation if 'wet' and ointment if 'dry'.

Potassium permanganate
1:10000 soaks for fifteen minutes daily for acute wet eczema until blistering weeping has dried.

Antibiotics (topical/systemic)
Exclude secondary infection and treat if appropriate.

therapeutic tips

Other skin conditions can mimic eczema and should be kept in mind. It is usually worth examining the patient's skin all over as this can provide clues to other diagnoses e.g. plaques in extensor distribution in psoriasis, scabetic nodules.

If contact dermatitis is suspected a careful occupational and social history should be taken and the patient will require Patch Testing.

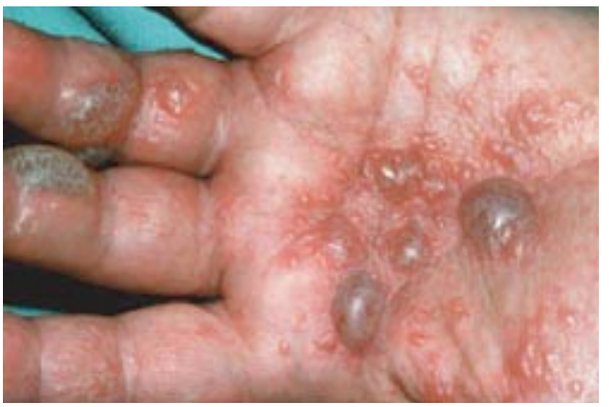
Patch Testing is only of value in patients with eczema. It is of no use with type 1 reactions (e.g. food allergies causing anaphylaxis or urticaria). In practice the cause of eczema is often multifactorial with external factors precipitating eczema in a constitutionally predisposed individual.

If eczema is present on only one hand a fungal infection needs to be excluded by taking skin scrapings for mycology.

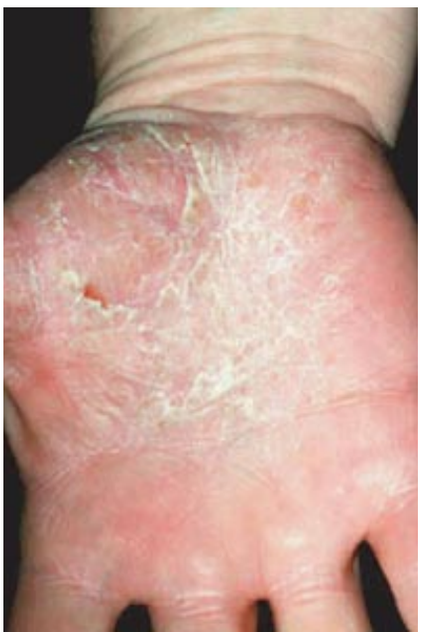
Criteria for Referral

- If allergic contact dermatitis is suspected and Patch Testing is therefore required.
- Severe chronic hand dermatitis, which is unresponsive to treatment described above.

Hand Eczema



"Wet" (blistering and weeping)



"Dry" (hyperkeratotic and fissured eczema)

Section 4: Urticaria and Angioedema

clinical features

Explain the condition to the patient and reassure that it is benign and usually self-limiting

Minimise:
- Overheating
- Stress
- Alcohol
- Caffeine

Review:
- Drug history

Both prescribed and non-prescribed as many drugs have been reported to cause Urticaria such as penicillins, statins and NSAIDs. Additionally opiates and NSAIDs may exacerbate existing urticaria. ACE inhibitors can cause angioedema.

Exclude
- C1 Esterase Deficiency (if angioedema is the only sign)
- Insect bites

Check:
- FBC
- Thyroid function tests
- Complement levels C3C4 if clinically indicated

treatment

Antihistamines

There is relatively little to choose between different antihistamines but individuals may vary in their response to different agents.

Sedative or non-sedative antihistamine choice depends on the need for sedation. Many antihistamines block histamine wheals and itching but do not suppress the rash completely. Use continuous medication if attacks occur regularly. Use fast acting antihistamines as required for sporadic attacks. If there is no response to one agent after six weeks, try a second and then a third agent.

In some cases of severe acute urticaria such as penicillin reaction, a short reducing course of Prednisolone starting at 30mgs – 40mgs od may be useful.

- Systemic steroids should never be used in chronic urticaria.

therapeutic tips

In the majority of patients with urticaria no underlying trigger factor or associated disease is found and the condition is self-limiting.

Prick tests and RAST tests are not useful as a screening test of potential allergens in chronic ordinary urticaria.

Food allergy is usually obvious and trigger factors such as crustaceans, fish and nuts can be easily identified.

Contact urticaria is generally suggested by the history and can be confirmed by contact urticaria tests that are different to patch tests, which have no place in the investigation of urticaria.

Physical urticarias including:
- Dermagraphism
- Cholinergic urticaria
- Cold urticaria
- Solar urticaria
- Pressure urticaria

can usually be identified on history.

Urticaria may follow non-specific infections, hepatitis, streptococcal infections, campylobacter and parasitic infestation. Rarely it may be a symptom of an underlying systemic disease such as thyroid disease or connective tissue disease.

Avoid drugs which may lower the threshold for urticarial reactions such as NSAIDs, ACE inhibitors and opiates.

Cont./

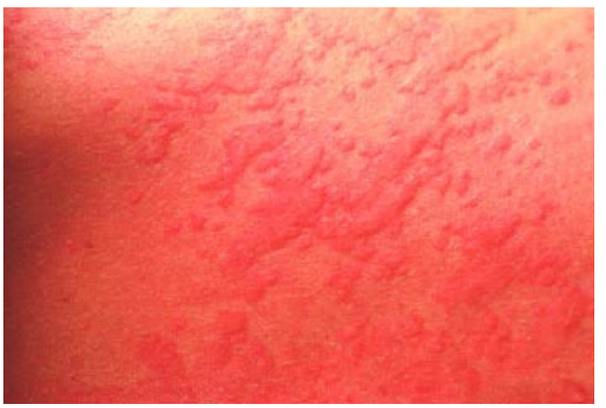
Summary of non-sedating and low-sedating antihistamines

name	drug interactions	comments
Acrivastine	None	Short acting. Avoid in renal impairment and pregnancy.
Cetirizine	None	Minimal sedating. Half the dose in renal impairment. Avoid in pregnancy.
Fexofenadine	None	Avoid in pregnancy.
Mizolastine	Imidazoles. Macrolide antibiotics.	Avoid in cardiac disease, pregnancy and severe hepatic impairment.
Loratidine / Desloratidine (Xyzal) Levocetirizine	None	Avoid in pregnancy.

Criteria for Referral

- Hereditary Angioedema
- No response to three different antihistamines used for a period of six weeks each
- Extremely severe urticaria and angioedema

Urticaria



Urticaria

Section 5: Viral warts and molluscum contagiosum

clinical features

Viral Warts and Verrucae

These two viral induced lesions are common especially in children and are self-limiting.

There are no easy or guaranteed treatments or magic cures and are best left to resolve spontaneously. Greater than 60% of hand and facial warts clear within two years, plantar warts tend to be most persistent.

Molluscum Contagiosum

90% of mollusca clear within one year. However molluscum may be persistent in atopic children.

treatment

Use a high concentration salicylic acid preparation such as:

- **Occlusal**
- **Verrugon**

- **Cryotherapy**
  Pare down with a scalpel first

Treat associated eczema or impetiginization with:

- **Emollients**
- **Mild topical steroids +/- antibiotic therapy**
- **Cryotherapy**

therapeutic tips

Instruct the patient that this should be applied daily after bathing and rubbing down the softened skin with pumice stone or sandpaper. This may need to be continued for many months.

Best performed at three weekly intervals with one freeze thaw cycle on the hands and two on the soles, (hands 70% cure rate after four treatments, plantar warts 40%). If there is no sign of improvement after four or five treatments then it is unlikely to be effective and should be discontinued.

Affected children should have their own towels to reduce the risk of transmission to siblings.

Individual lesions will resolve if the central core is damaged by any modality including cryotherapy but this is not recommended in young children, as it is too painful.

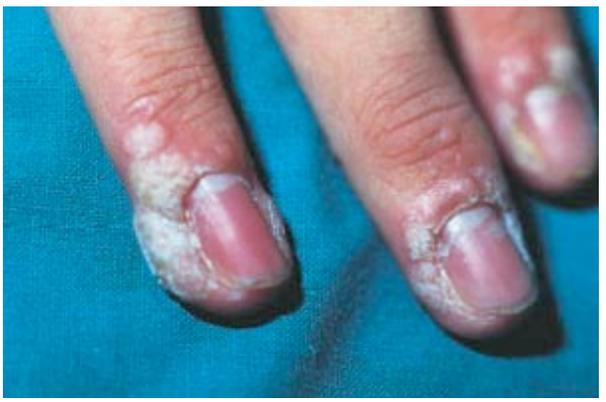
Criteria for Referral

In general patients with viral warts/verrucae and molluscum should not be referred.

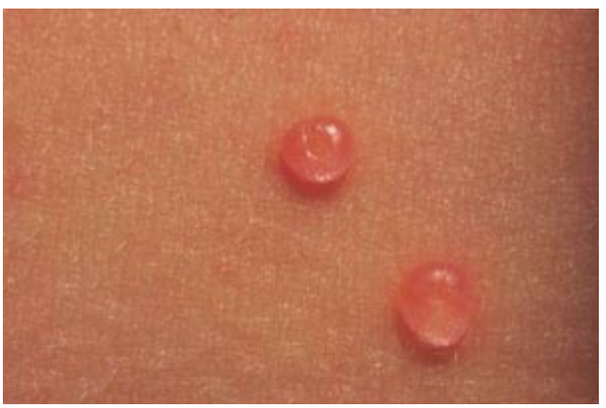
Patients may be referred if:

- Severe disabling warts despite six months of topical salicylic acid treatment +/- cryotherapy.
- Significant warts or mollusca in immunocompromised patients.

Viral warts and molluscum contagiosum



Viral warts



Molluscum contagiosum

Section 6: Scabies

management

Human scabies is an infestation of the skin caused by the mite Sarcoptes scabiei.

The mites are most readily transmitted from one person to another by close physical contact in a warm atmosphere i.e. sharing a bed, adults tending to children, children playing with each other or young people holding hands. An individual who has never had scabies before may not develop itching or a rash until one month or even three months after becoming infested.

There is usually
- Widespread inflammatory papular eruption
- Burrows on non hair bearing skin of the extremities
- Pruritic papules around the axilla periareola regions, umbilical region and buttocks.
- Inflammatory nodules on the penis and scrotum.

The reactive rash to scabies can be eczematous or urticarial.

Impetiginization may also occur. There is usually more than one family member afflicted.

treatment

Treat patients when there is a strong clinical suspicion that they may be infested.

The first and essential step is to kill all the mites in the skin using a scabicide.
Apply either:
- Malathion 0.5% Aqueous solution (Derbac M)
- Permethrin 5% (Lyclear Dermal Cream)

Rub it in gently to all parts of the body or apply it using a 2" (5cm) paintbrush.

Literally all the skin below the chin must be treated including the web spaces of the fingers and toes, under the nails and in all body folds.

Malathion should be left on the skin for 24 hours and Permethrin for between 8-12 hours.

One treatment only is usually curative except in crusted (Norwegian) scabies.

Treat residual itchy areas with:
- Topical anti-pruritic Crotamiton cream (Eurax)
- Crotamiton/hydrocortisone (Eurax HC).

therapeutic tips

It is mandatory that all members of the household and any other close social contacts of an infested person should receive appropriate treatment at the same time as the patient.

Remind patients to reapply the scabicide after washing their hands.

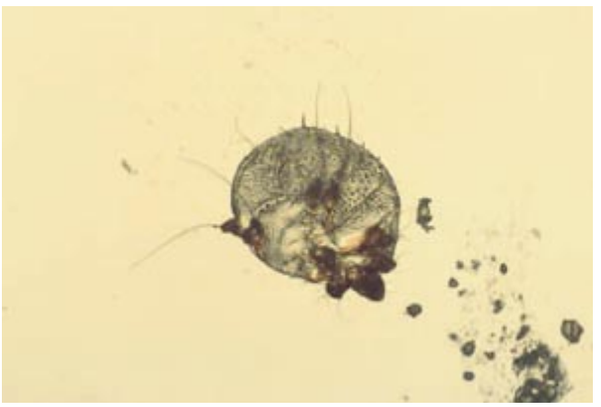
At the end of this period the patients can bath, change their underclothes, sheets and pillowcases.

Disinfestation of clothing and bedding other than by ordinary laundering is not necessary.

If these directions have been followed, all mites in the skin will have been killed but the pruritus takes 3-6 weeks to settle.

Do not allow the use of scabicides to these pruritic areas as repeated applications may irritate the skin.

Scabies



Sarcoptes Scabies

Burrow

Section 7: Solar Keratoses

clinical features

Solar Keratoses

Also known as actinic keratoses, usually are multiple, flat reddish brown lesions with a dry adherent scale,

The vast majority of solar keratoses DO NOT progress to squamous cell carcinoma. Evidence suggests that the annual incidence of transformation from solar keratoses to SCC is less than 0.1%. This risk is higher in immunocompromised patients.

It is not necessary to refer all patients with solar keratoses.

treatment

- **Topical 5-Fluorouracil (Efudix)**
  Apply twice daily for 3 weeks.

- **Diclofenac Sodium (Solaraze)**
  Twice daily for 2-3 months.

- **Cryotherapy**
  Freeze for 10-15 seconds each.

therapeutic tips

This is the ideal treatment for widespread, multiple, ill-defined solar keratoses. It spares normal skin, allowing application to a wide skin surface. It is safe, efficacious, with little systemic absorption. Marked inflammation should occur prior to resolution and the patient must be warned to expect this. There is an excellent patient information leaflet on Efudix cream supplied by the manufacturers. Less frequent application may help if inflammation is brisk.

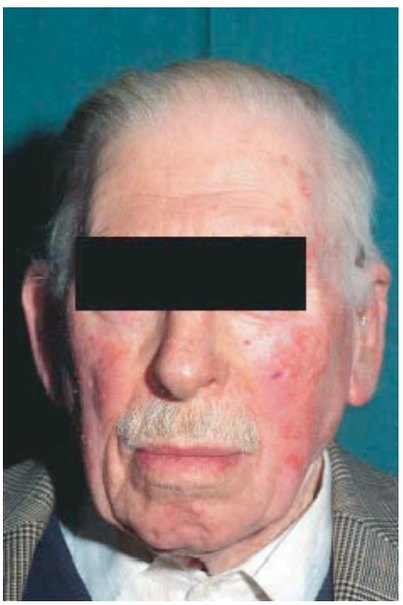
Optimum effect 1 month post treatment. May cause severe irritation and contact dermatitis.

For isolated, well-defined lesions, this is the treatment of choice.

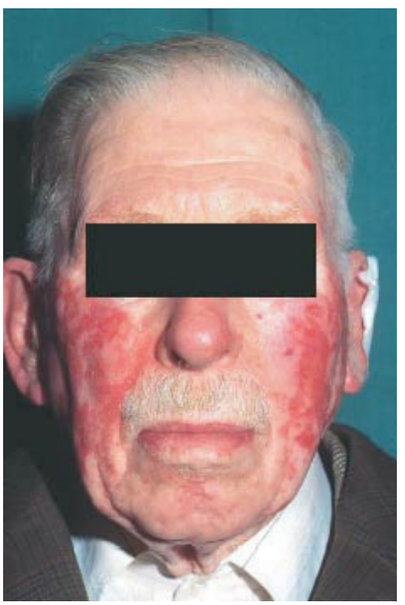
Criteria for Referral

- If there is a suspicion of malignancy
- If the lesions have not responded to treatment
- If the individual is on immunosuppressants (e.g. post-renal transplants).

Solar Keratoses



Solar keratoses



Reaction to 5 Fluorouracil after 3 weeks treatment

Section 8: Generalised pruritus

clinical features

Dry skin, eczema and scabies are the commonest cause of generalised pruritus.

If someone is itching all over, take a full history and examine the skin very carefully.

treatment

- **Standard emollients and soap substitutes.**
- **Crotamiton or Crotamiton combined with hydrocortisone cream. Apply twice daily/pm to pruritic areas.**
- **1% Menthol in Aqueous cream. Apply as often as felt necessary to pruritic areas.**

If symptoms are still uncontrollable and/or there is a lot of anxiety consider

- **Doxepin 50mg nocte**
- **Amitriptyline 30-150mg nocte**

Sedating antihistamines

- **Hydroxyzine 25mg nocte**
- **Chlorpheniramine 4mg nocte/tds**

The use of potent topical steroids should be discouraged.

therapeutic tips

If NO RASH can be seen other than excoriations consider the following:

- Anaemia
  Especially iron deficiency.
- Uraemia
- Obstructive jaundice
- Thyroid disease both hypo and hyperthyroidism
- Lymphoma, especially in young adults
- Carcinoma, especially in middle age and elderly
- Psychological

A full general examination may be helpful.

Organise the following investigations:

- FBC and differential
- ESR
- Urea and electrolytes
- LFT's
- Thyroid function tests
- Iron studies

NB. Pruritus may occasionally predate a lymphoma by several years. Close supervision is necessary.

Section 9: Onychodystrophy (thickened and dystrophic nails)

clinical features

The thickness of nail plates is normally 0.5mm; this consistently increases in manual workers and many disease states such as:

- Onychomycosis (Dermatophyte fungal infection)
- Psoriasis
- Chronic Eczema
- Lichen Planus
- Alopecia areata
- Norwegian scabies
- Darier's Disease
- Old age
- Trauma e.g. from footwear
- Congenital ichthyosis

treatment

If mycology is positive and dystrophy does not extend to nail matrix (distal onychomycosis) use: Oral antifungals:

- Terbinafine (Lamisil) 250mg od 12-16 weeks for toenails, 6-12 weeks for fingernails

- Itraconazole (Sporanox) Pulse treatment, 3 pulses of Sporanox bd for 7 days repeated monthly (3 cycles for toenails, 2 for fingernails)

Alternatively, consider adding

- Amorolfine (Loceryl nail lacquer) Weekly continued for 6-12 months.

Matrix involved Onychomycosis.
Where matrix involvement is encountered, a combination of oral terfinabine and Amorolfine Lacquer has been shown to provide more effective cure rates than terbinafine alone*. A dose of 250mg of terbinafine should be given daily for up to 12 weeks and amorolfine Lacquer applied once a week for up to 15 months.

* Baran et al, British Journal of Dermatology, 2000; 142: 1177-1183.

therapeutic tips

General cutaneous examination and examination of all the nails is necessary.

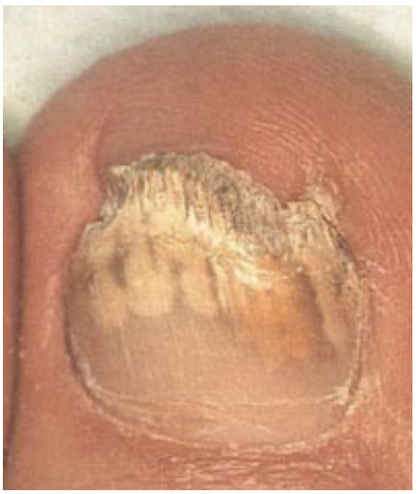
Always obtain +ve mycology before starting oral antifungal agents.

Send samples (nail clippings including scrapings of thickened crumbly material on the underside of the nail if present) for mycology.

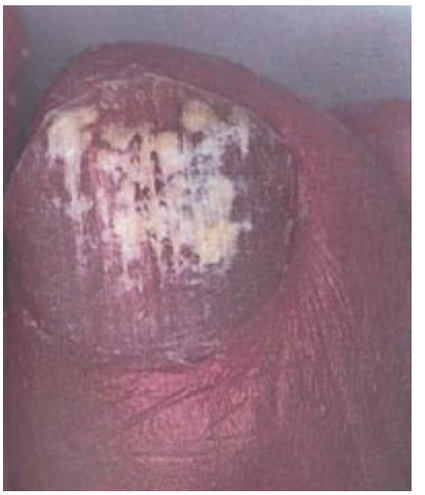
If negative, arrange for regular chiropody to keep nails short and thin.

Asymptomatic patients may be advised to 'leave well alone'.

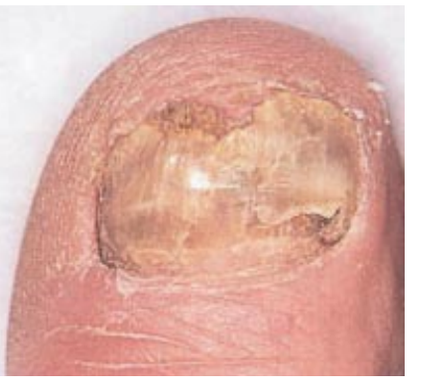
Onychodystrophy



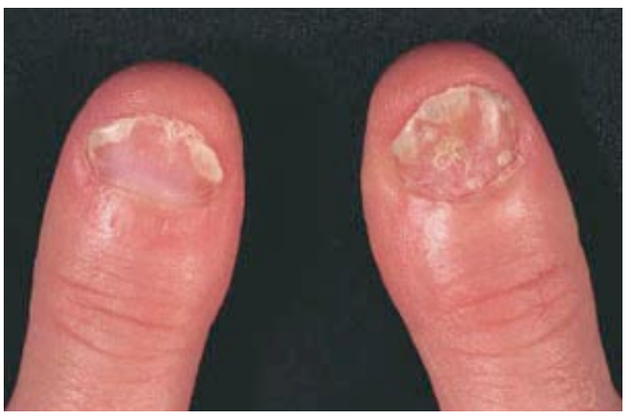
Non-matrix Onychomycosis



Non-matrix Onychomycosis
(superficial white Onychomycosis)



Matrix involved Onychomycosis



Psoriatic nail

Section 10: Skin Cancer

clinical features	treatment	therapeutic tips
Basal Cell Carcinoma These are common slow growing and locally invasive tumours. Most are easily recognised with a pearly rolled edge and later central ulceration. Pigmented and morphoeic (scar like, poorly defined) BCC's are less common variants.	They are best managed by complete excision and should be referred in the usual manner where they will be categorised as 'soon', In some cases radiotherapy may be a preferred option but a tissue diagnosis (i.e. biopsy) is still required prior to referral for radiotherapy and will be carried out in the Dermatology clinic.	Stretching the skin will often accentuate the pearly edge of lesion especially superficial BCC.
Squamous Cell Carcinoma These malignancies are much less common. They may be slow growing, well differentiated, keratinising or rapidly enlarging, poorly differentiated tumours. 5% may metastasise to regional lymph nodes.	Lesions with a high index of suspicion, especially if rapidly growing should be referred by fax within 24 hours. These patients will be subsequently assessed within the Government's two week cancer screening initiative.	Fax No for urgent skin cancer appointments: 01225 824935
Malignant Melanoma This is the most dangerous skin malignancy. Early detection and excision is vital for good prognosis.	All suspicious moles must be referred requesting an urgent appointment. Patients will be seen within 10 days of receipt of letter. Any lesion felt to be highly suspicious of melanoma will be excised on the day of clinic or within one week maximum.	Fax No for urgent skin cancer appointments for suspicious pigmented lesions: 01225 824935
Melanoma subtypes • Superficial spreading • Nodular • Amelanotic • Lentigo Maligna • Acral lentiginous and subungual		

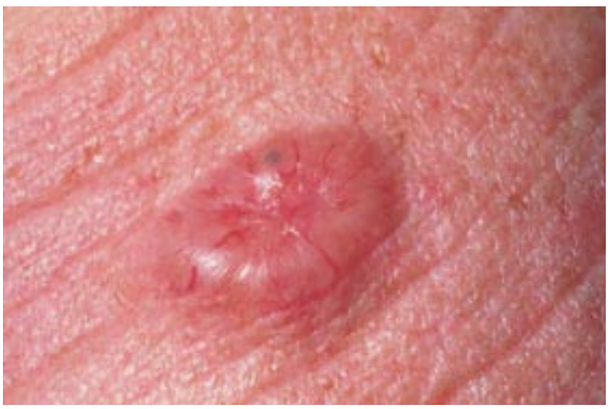
Criteria for Referral

The following seven point checklist may be useful in deciding whether to refer a changing pigmented lesion.
Refer if at least one major or two minor criteria present.

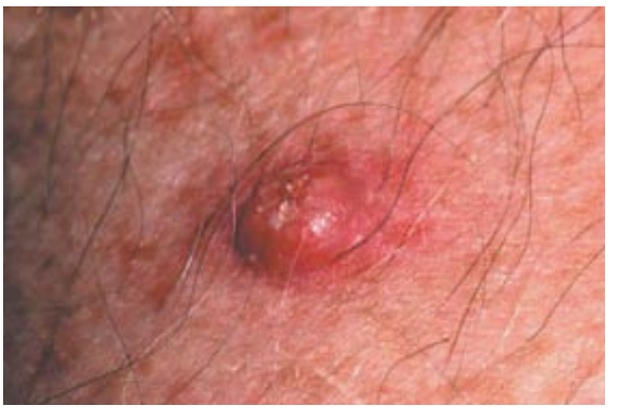
Major Features
- _ Change in size
- _ Change in colour (variability of pigmentation)
- _ Change in shape (irregularity of edge)

Minor Features
- _ Size >6mm diameter
- _ Inflammation
- _ Bleeding/crusting
- _ Itch

Non melanoma skin cancer

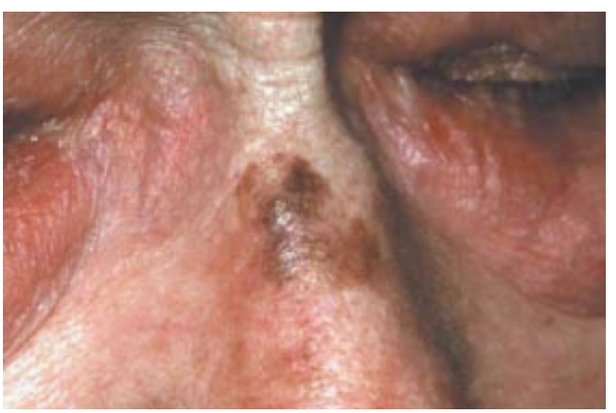


Basal cell carcinoma

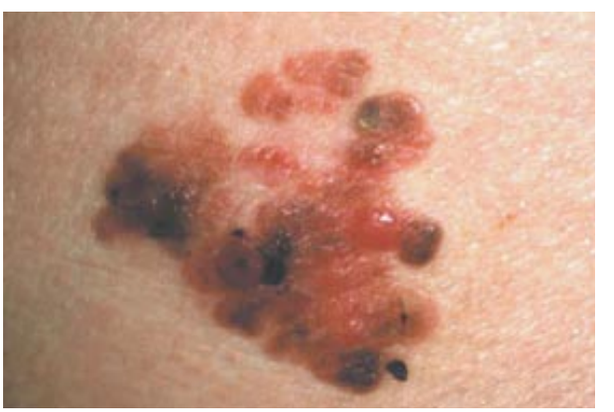


Squamous cell carcinoma

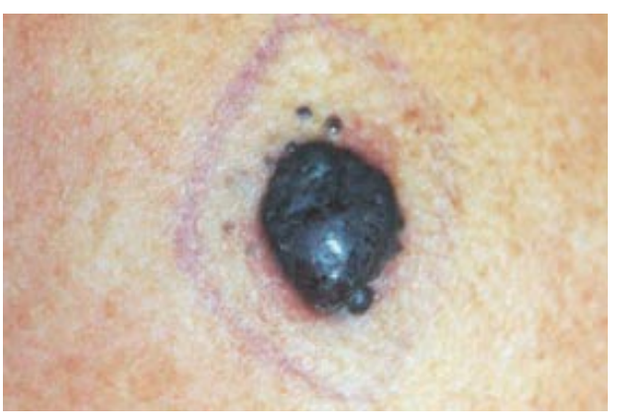
(Malignant melanomas)



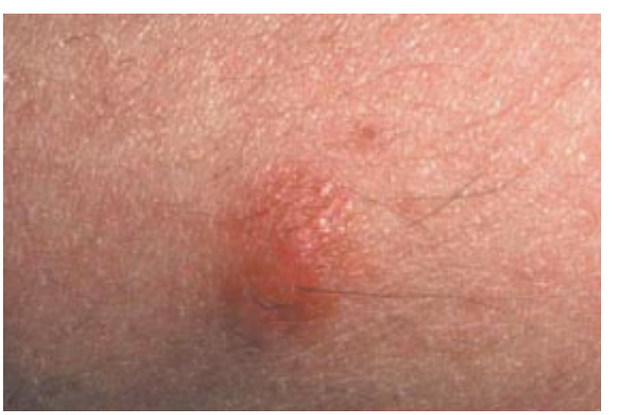
Lentigo maligna



Superficial spreading



Nodular



Amelanotic

Section 11: Psoriasis

clinical features

Psoriasis is a chronic relapsing condition; mild to moderate involvement can usually be managed in primary care. Prior to referral, basic treatment should be tried as outlined.

Nursing input by an appropriately skilled nurse at this stage will decrease need for referral to secondary care. (Contact department for details of nurse training courses).

treatment

Chronic Plaque Psoriasis

Emollients should be prescribed in all cases. See Section 12- Emollient Therapies.

First line therapy:

1 Vitamin D analogues
- Calcitriol

Apply twice daily (up to 210g weekly)
- Calcipotriol

Apply generously twice daily (up to 100g weekly)
- Tacalcitol od

2 Tar preparations
- Alphosyl cream
- Exorex lotion

Apply away from flexures twice daily.

3 Dithranol preparations
- Dithrocream
- Micanol

Start with the lowest strength, applied daily to plaques for 15-30 minutes only, then wash off. Increase through strengths weekly unless irritancy occurs. Prescribe range:
E.g.
- Dithrocream 0.1%
- Dithrocream 0.25%
- Dithrocream 0.5%
- Dithrocream 1.0%
- Dithrocream 2.0%

as this counts as one prescription item. Or Micanol 1% and 3%.

4 Other Treatments
- Diprosalic ointment
- Dovobet

therapeutic tips

Ensure patients understand how and when to use their treatments.

Calcitriol is licensed for use on face and flexures in addition to psoriasis on trunk and limbs.
Expect improvement to be gradual, achieving maximum effect over up to 12 weeks treatment. If useful can be continued long term or intermittently. If used correctly many patients will achieve at least flattening and partial clearance of plaques.

Refined tar products are less smelly or messy than old unrefined preparations. May stain clothes or irritate. Expect slow response over 6-12 weeks.

Can be used as ‘short contact therapy’ at home, away from face flexures and genitals.

Often very effective if performed correctly with good remission time but time consuming to do therefore only useful if patient is well motivated.

Stains everything including skin and may cause irritation of the skin.

Give adequate quantities of topical preparations appropriate for extent of disease.

Particularly for persistent thick plaques on the elbows, knees and sacrum.

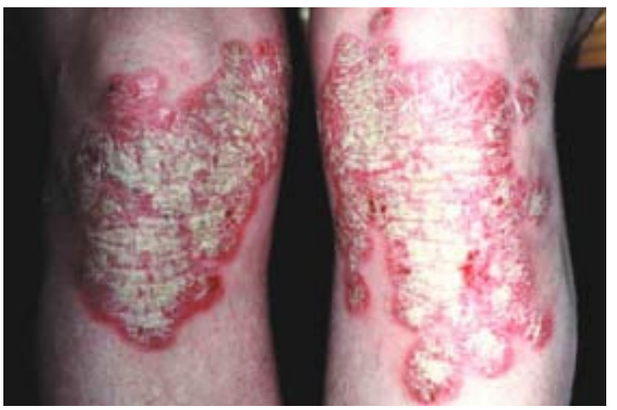
Cont/.

clinical features	treatment	therapeutic tips
Guttate Psoriasis Numerous small lesions, mostly on trunk, generally affecting children/young adults acutely. Often self-limiting over 3-6 months.	Treat with emollients plus trials of tar preparations, vitamin D analogues or moderate potency steroid e.g. Clobetasone Butyrate 0.05%	If severe, early referral for phototherapy may be the best option.
Scalp Psoriasis	Generally requires combination of keratolytic and anti-inflammatory agents. If very itchy a topical steroid could be substituted. In more severe cases use keratolytic e.g. Cocois ointment massaged in and left overnight, washed out in the morning plus topical potent steroid e.g. • Betamethasone • Betacap • Diprosalic scalp application Could consider Calcipotriol scalp application plus tar based shampoo e.g. Polytar, Alphosyl or Capasal	If condition intrudes beyond the hairline or onto the face, Calcitriol is a well tolerated and effective treatment. For the hairline use courses synalar gel and alphosyl HC. Treatment needs to be performed by a second person to be effective.
Flexural Psoriasis	• Calcitriol Apply twice daily (up to 210g weekly) Use mild to moderate potency steroids combined with antibiotic/ antifungals e.g. • Timodine • Trimovate creams Apply once to twice daily.	Evidence suggests that Calcitriol is effective and well tolerated in flexural/sensitive areas. Often partial response only is achieved.

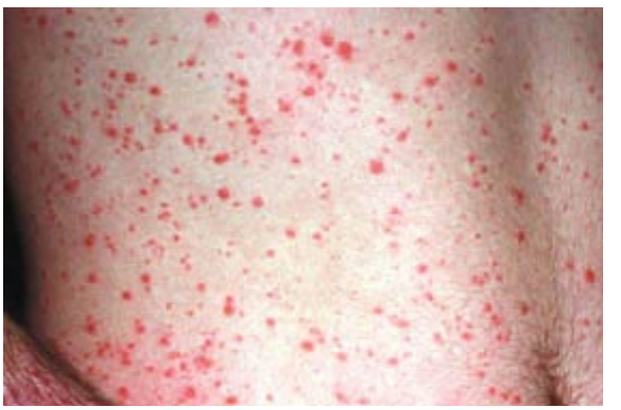
Criteria for Referral

1. Extensive/severe or disabling psoriasis
2. Failure to respond to adequate treatment or rapid relapse post treatment
3. Extensive acute guttate psoriasis
4. Unstable and generalised pustular psoriasis
5. For patient education by nurse practitioner on how to apply topical treatment

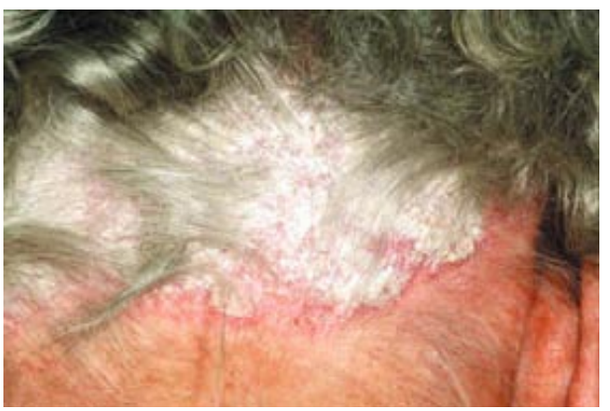
Psoriasis



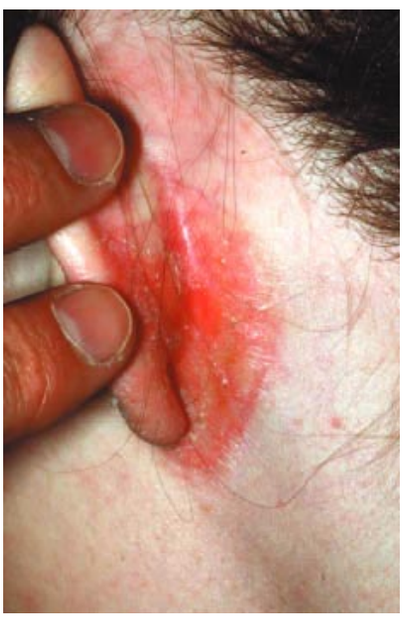
Chronic Plaque Psoriasis



Guttate Psoriasis



Scalp Psoriasis



Flexural Psoriasis

Section 12: Atopic eczema in children

clinical features

Atopic eczema is a common disease affecting up to 15% of children.

Involvement of the face frequently occurs in infants with adoption of a characteristic flexural distribution by the age of 18 months.

Realistic treatment aims need to be discussed with the patient and parents.

The role of specialist nursing in this area is vital.

treatment

General treatment measures
- Soaps and detergents including bubble bath and shower gels should be avoided
- Cotton clothing should be used and avoid wool next to the skin
- Fingernails should be kept short to reduce skin damage from scratching.
- Bathing is not harmful but an emollient has to be used

Emollient Therapies

Emollients should be prescribed in all cases.
Added to the bath e.g.
- Oilatum – fragrance free
- Balneum
- Bath E45

Used directly on the skin during bathing
- Epaderm ointment
- Aqueous cream
- Diprobase cream
- E45
- Emulsifying ointment
  For showering
- Oilatum Shower Gel

Greasier preparations e.g.
- Epaderm ointment
- 50% Liquid Paraffin in 50% White Soft Paraffin
  are better at hydrating dry skin

Topical Corticosteroids

Mild
- Hydrocortisone acetate 1%-2.5%

Moderate
- Clobetasone butyrate (Eumovate)
- Alclometasone dipropionate (Modrasone)

Potent
- Mometasone (Elocon)
- Fluticasone (Cutivate)

therapeutic tips

Some patients have a preference and you may have to supply several until the patient finds something they like and will therefore use.

Some combination preparations have extra benefits e.g.
- Calmurid
- Dermol 500
- Emulsiderm
- Oilatum Plus

} antiseptic

CAUTION: Advise patients that bath and shower base will be very slippery.

Although potent preparations can cause skin atrophy with long term use, topical corticosteroids are often underused because of concern about side effects.

There are many agents categorised into four groups of potency. Within each potency group there is no evidence for increased efficacy or safety of any one particular product. Ointment preparations are usually more effective than creams but they are messier to use. Creams can be used if eczema is weeping or on the face.

Mild or moderately potent preparations should control most cases of eczema when prescribed in appropriate amounts. It may be necessary to gain control with a moderately potent preparation and then reduce to a mild strength.

Cont/.

clinical features	treatment	therapeutic tips
		Short term (1-2 weeks) of a potent strength product may be required, particularly for resistant, lichenified lesions in older children. Avoid repeat prescriptions for potent strength corticosteroids. In dry eczema use ointments and greasier emollients e.g. white soft paraffin, Epaderm ointment, try steroid/urea ± lactic acid e.g. Calmurid HC/Alphaderm.
	Antihistamines Sedative antihistamines • Chlorpheniramine • Trimeprazine	Suitable for short term use to control itch especially at night.
Infection The commonest infecting organism is Staph aureus which produces characteristic yellow crusting.	**Antibiotics** Consider antiseptic moisturiser combinations: In the bath • Oilatum Plus • Emulsiderm Directly onto the skin • Dermol 500 Use steroid antibiotic/antiseptic combination: • Fucidin H • Fucibet on infected areas for a short period (not more than 2 weeks). If the infection is widespread or severe treat with systemic antibiotics • Flucloxacillin • Erythromycin If recurrent infections occur take nasal swabs from the family members and if positive use: • Naseptin • Bactroban nasal	Infection should be suspected whenever eczema worsens. Eczema that weeps is probably infected with staphylococcus aureus. If in doubt take swabs for microbiology.
	Bandaging Zinc paste bandages used alone or over topical corticosteroids can result in rapid improvement of resistance, particularly lichenified, eczema. Wet wrap dressings may also be helpful, particularly at night in small children.	The role of specialist nursing in this area is vital.

Cont/.

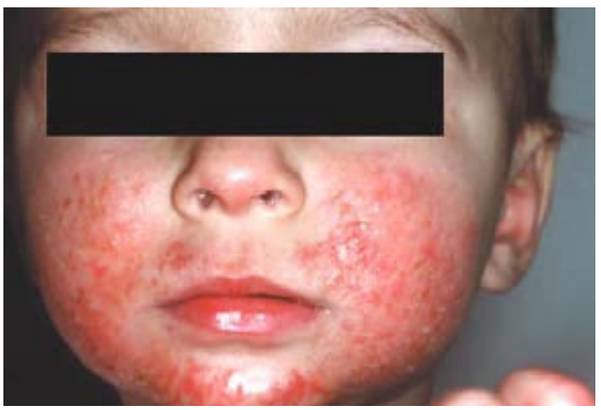
clinical features	treatment	therapeutic tips
Allergies and allergy testing		No tests are available to confirm or refute food allergy as a cause of worsening eczema. RAST tests and skin prick tests are not helpful. Patch testing is used to investigate specific contact allergic eczema.
	Keep dust down and in severe cases try protective coverings to pillows and bedding.	The role of the house dust mite can aggravate eczema in some children.
		Food allergies, especially to egg, wheat and dairy products only occasionally cause worsening of eczema.
	Consider exclusion diets only in difficult cases and abandon if no improvement is apparent after 2-4 weeks.	Food allergy or intolerance is often a temporary phenomenon. An attempt should therefore be made every few months to re-introduce the food in question. Dietetic advice is required if exclusion diets are used for more than 2-4 weeks.
	Evening Primrose Oil	There is no consistent evidence that it helps.
	Chinese Herbs	There are no product licences and currently standardisation is poor. They do have a measurable effect in some children, but are not without potential serious adverse effects and cannot yet be recommended.
		Some contain potent steroids.
	Second Line Treatment • **Tacrolimus** • **Pimecrolimus**	

Criteria for Referral

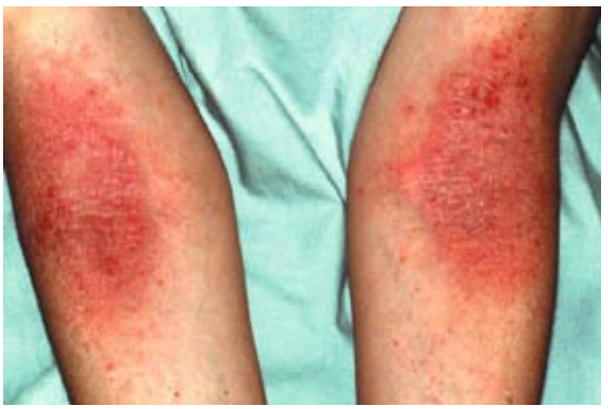
Only cases of severe or difficult eczema usually need to see a Dermatologist.

- For consideration of second line treatment such as photochemotherapy and cytotoxic drugs
- Eczema herpeticum
- If allergic contact dermatitis is suspected
- For inpatient treatment
- For parent education by a Dermatology nurse specialist

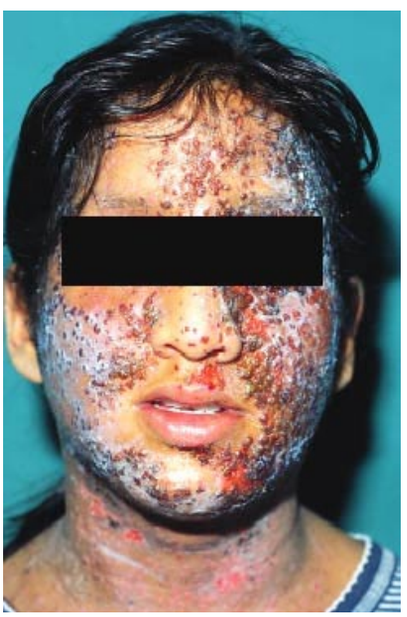
Atopic eczema in children



Atopic eczema



Flexural distribution



Eczema Herpeticum

Section 13: Eczema in adults

clinical features

A small number of adults have severe, generalised and lichenified atopic eczema.

Dry skin in the elderly can sometimes develop into asteatotic eczema.

Venous stasis (or varicose) eczema is associated with underlying venous disease. Signs of chronic venous hypertension in the lower legs are accompanied by eczema at this site.

Discoid eczema is a form of constitutional eczema characterised by circular, well-demarcated lesions on the trunk and limbs.

Seborrhoeic dermatitis is a form of chronic eczema involving hair-bearing skin. It typically involves the scalp and eyebrows, and nasolabial folds and is sometimes more extensive.

treatment

General treatment measures

- Soaps and detergents including bubble bath and shower gels should be avoided.
- Cotton clothing should be used and avoid wool next to the skin.
- Fingernails should be kept short to reduce skin damaged from scratching.
- Bathing is not harmful but an emollient has to be used.

Emollient Therapies

Emollients should be prescribed in all cases.
Added to the bath e.g.

- Oilatum – fragrance free
- Balneum
- Bath E45

Used directly on the skin during bathing

- Epaderm ointment
- Aqueous cream
- Diprobase cream
- E45 Wash
- Emulsifying ointment

For showering

- Oilatum Shower Gel

Greasier preparations e.g.

- Epaderm ointment
- 50% Liquid Paraffin in 50% White Soft Paraffin
  are better at hydrating dry skin.

Topical Corticosteroids

Mild

- Hydrocortisone acetate 1%-2.5%

Moderate

- Clobetasone butyrate (Eumovate)
- Alclometasone dipropionate (Modrasone)

Potent

- Mometasone (Elocon)
- Fluticasone (Cutivate)

therapeutic tips

Potent topical steroids are often required to control discoid eczema.

Asteatotic eczema responds to emollients combined with mild to moderate topical steroids.

CAUTION: Advise patients that bath and shower base will be very slippery.

Venous stasis eczema usually requires long-term treatment with an emollient combined with a moderately potent topical steroid. Consider referral for patch testing if fails to respond to treatment +/- compression hosiery.

Cont/.

clinical features	treatment	therapeutic tips
	Topical Tacrolimus	Topical tacrolimus and pimecrolimus are licensed for moderate to severe atopic dermatitis in adults who are not adequately responsive to or are intolerant of conventional therapies. There is a weaker preparation of tacrolimus (0.03%) and pimecrolimus are licensed for children over the age of two These drugs should be used as second line treatments for eczema by clinicians experienced in the treatment of atopic eczema.
	Ketoconazole shampoo	Seborrhoeic dermatitis requires a mild steroid combined with an imidazole, such as Canesten HC cream or Daktacort ointment.

Section 14: Patient Support Groups

Acne Support Group
Miss Alison Dudley
P O Box 230
Hayes
Middlesex
UB4 0UT

Tel: 020 8841 4747
www.stopspots.org.uk

British Allergy Foundation
Muriel A Simmons
Deepdene House
30 Bellegrove Road
Welling
Kent
DA16 3PY

Tel: 020 8303 8525
Helpline: 020 8303 8583 (Mon-Fri 9am-5pm)
www.allergy.baf.com

Hairline International
Ms Elizabeth Steel
Lyons Court
1668 High Street
Knowle
West Midlands
B93 0LY

Tel: 01564 775281
Fax: 01564 782270
www.hairlineinternational.com

Herpes Viruses Association (SPHERE)
and Shingles Support Society
Miss Marion Nicholson, Director
41 North Road
London
N7 9DP

Tel: 020 7607 9661 (office and Minicom V)
Helpline: 020 609 9061 (24 hours access)
www.astrabix.co.uk/sites/herpesviruses/defult.htm

Cancer BACUP
3 Bath Place
Rivington Street
London
EC2A 3DR

Tel: Freephone 0808 800 1234 (9am-7pm)
Fax: 020 7696 9002
www.cancerbacup.org.uk

National Eczema Society
Hill House
Highgate Hill
London
N19 5NA

Tel: 020 7281 3553
Fax: 020 7281 6395
Eczema information line: 0870 241 3604 (Mon-Fri 1-4pm)
www.eczema.org

The Psoriasis Association
Milton House
Milton Street
Northampton
NN2 7JG

Tel: 01604 711129
Fax: 01604 792894

Psoriatic Arthropathy Alliance
PO Box 111
St Albans
AL2 3JQ

Tel: 0870 770 3212
Fax: 0870 770 3213
Web: http://www.paalliance.org

Raynaud's & Scleroderma Association Trust
112 Crewe Road
Alsager
Cheshire
ST7 2JA

Tel: 01270 872776
Fax: 01270 883556
www.rayauds.demon.co.uk

Changing Faces
1 & 2 Junction Mews
Paddington
London
W2 1PN

Tel: 020 7706 4232
Fax: 020 7706 4234
www.changingfaces.co.uk

The Vitiligo Society
125 Kennington Road
London
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Section 15: Dermatology Training Courses

For General Practitioners:

Diploma in Practical Dermatology

Department of Dermatology, Box 27,
University of Wales College of Medicine
Heath Park
Cardiff CF14 4XM
Enquiries: Course Administrator: 02920 742885

For Primary Care Nurses:

A variety of courses are available including a Diploma in Dermatology Nursing

University of Wales College of Medicine
Gwent Healthcare NHS trust
St. Woolos Hospital
Newport
NP20 4SZ
Enquiries: Course Administrator: 01633 238561