DERMATOLOGY
Guidelines for GPs in Bromley

Bromley Clinical Commissioning

February 2011
Bromley PBC Dermatology

Introduction

Welcome to the Bromley PBC Dermatology Project. We would like to introduce you to some easy to follow, evidence based and locally referenced care pathways that have been designed to help GPs deliver a first class service to their patients.

These guidelines follow on from the development of similar locally produced guidance for Gynaecology, ENT and Musculoskeletal Services and as such follow a similar format. Dermatology was chosen as the attendance rates in Bromley from GP referrals to dermatology outpatient services are well above the national average and there is a wide range between practices. Consequently, a recent peer review pilot (January to June 2010) was completed which confirmed that peer review and discussion of differential diagnoses could lead to a reduction in inappropriate referrals and improve our confidence levels and diagnostic skills with regards to skin conditions.

To make the most of these guidelines, please spend a few minutes looking through them to see what there is and how they work. Pages 4 & 5 summarise the key points in a dermatology history, include some useful dermatology terminology and a guide for 2 week wait referrals. Thereafter there is a common format of one page algorithm and one page notes. All the algorithms read from top to bottom (with the exception of leg ulcer management) with as few boxes as possible. You will also find key messages and resources, these will help you find the guidance on which these pathways are based, patient information and images to help you.

Please remember that these are only guidelines which have been developed for use by GPs with the necessary knowledge to interpret them and, unless otherwise indicated, are to assist you in the management of adult patients. They may be controversial in places and, whilst we hope accurate at the time of going to print, recognise that service guidelines may change. Your clinical instinct must always come first. Please also note that practices with Scriptswitch will need to consider alternative products recommended at the point of prescribing e.g. emollients and antihistamines. If you have any corrections, questions or ideas for improvement please let us know by emailing janet.edmonds@bromleypct.nhs.uk

Thank you
Drs Andrew Parson, Jon Doyle, Jackie Tavabie, Stephanie Munn, Sandy Flann, Chandima Sriwardhana, Geoffrey Barker, Abigail Barry & Janet Edmonds
Dermatology history and terminology

History
Sun exposure: episodes of blistering sunburn, sunbed use
Do you burn, burn then tan or just tan?
Sun protection used (health promotion)
Immunosuppression
Personal Hx skin Ca
Family Hx skin Ca
Change in size, shape, colour, sensation (See 7 point checklist)
Treatments (OTC, prescribed, complementary therapies)

Distribution
Acral Distal portions of limbs (hand, foot) and head (ears, nose)
Dermatomal Corresponding with nerve root distribution
Extensor vs Flexural (also known as intertriginous)
Follicular Individual lesions arise from hair follicles
Generalised, Symmetrical, Unilateral
Herpetiform Grouped umbilicated vesicles, as arise in Herpes simplex/zoster.
Koebnerised Arising in a wound or scar
Photosensitive Does not affect skin that is always covered by clothing.
Seborrhoeic Areas generally affected by seborrhoeic dermatitis: scalp, behind ears, eyebrows, nasolabial folds, sternum and interscapular
Truncal Favours trunk and rarely affects limbs

Morphology
Macule Smooth area of colour change less than 1.5cm diameter
Papule Small palpable lesion less than 0.5cm diameter
Nodule Larger solid papule greater than 0.5cm diameter
Plaque Palpable flat lesion greater than 0.5cm diameter
Vesicle Small fluid filled blister, less than 0.5cm diameter
Pustule Purulent vesicle
Bulla Large fluid-filled blister
Weal Oedematous papule/plaque caused by swelling in dermis, often indicates urticaria
2 and 4 Week Wait Criteria & Urgent

2 week Outpatient Appointment
Refer as 2 week wait (fax proforma) for:
- Lesion strongly suspicious of malignant melanoma
- Lesion strongly suspicious of SCC

Urgent Outpatient Appointment
Fax referral form or Choose & Book for:
- Widespread blistering disorder
- Severe cases of inflammatory skin disease e.g. Psoriasis involving widespread areas of body with systemic upset

4 week Outpatient Appointment
Letter to pigmented lesion clinic/Choose & book for:
- Changing atypical mole, not high suspicion of melanoma
- BCC of face
- Severe inflammatory disease

Routine (6-8 week) Outpatient Appointment
Letter to general dermatology clinic/Choose & book for:
- All other dermatological conditions including mole checks and BCC not involving face
- Nb: there is a separate paediatric dermatology clinic
Assessment of a pigmented lesion

Glasgow 7 point weighted checklist

Major features of lesions (2 points each):
- Change in size
- Irregular shape
- Irregular colour

Minor features of lesions (1 point each):
- Largest diameter 7mm or more
- Inflammation
- Oozing
- Change in sensation

1. Lesions scoring 3 points or more are suspicious
2. If you strongly suspect cancer any one feature is adequate to prompt urgent referral
3. For low suspicion lesions, undertake careful monitoring for change using the 7 point checklist for 8 weeks. NICE recommends photographing with marker scale/ruler and date (patient may take own photo)

The ABCDE system is a useful method of explaining to patients what to look out for:

Asymmetry shape of a melanoma is often uneven and asymmetrical;

Border or edges of a melanoma are often ragged, notched or blurred;

Colour of a melanoma is often not uniform. There may be 2-3 shades of brown or black;

Diameter of a melanoma is usually larger than 6 mm and it continues to grow. However, they can sometimes be smaller than this;

Evolving any change in size, shape, colour, elevation or any new symptom such as bleeding, itching or crusting may be due to a melanoma.

NB: Both the 7 point checklist and ABCDE criteria are useful, but it is vital to take account of the dermatology history (e.g. history of trauma to lesion).
Skin cancer: Malignant melanoma

Key messages

- Refer lesions strongly suspicious of MM under 2 week wait as per Glasgow 7 point list or ABCDE
- The major risk factor is sun exposure (including sun-beds), particularly in the first 20 years of life. Other risk factors include:
  - Fair skin that burns easily (Type I or II skin)
  - Blistering sunburn, especially when young
  - Previous melanoma
  - Previous non-melanoma skin cancer
  - Family history of melanoma
  - Large numbers of moles (especially if there are more than 100)
  - Abnormal moles (atypical or dysplastic naevi)
  - Immunosupression
- Biopsy of suspected MM should NOT be performed in primary care

Notes

1. Melanoma is caused by the uncontrolled growth of melanocytes. It occurs in adults of any age but is very rare in children.
2. Melanomas can arise from otherwise normal appearing skin (50% of melanomas) or from within a mole. Precursor lesions include: Congenital melanocytic naevi, atypical/dysplastic naevi and benign melanocytic naevi.
3. Melanomas can occur anywhere on the body, the commonest site in men is the back (around 40%), and the most common site in women is the leg (also around 40%).
4. Although melanoma usually starts as a skin lesion, it can also grow on mucous membranes such as the lips or genitals.

Resources
On-line pictures for GPs: [http://www.dermnetnz.org/lesions/melanoma.html](http://www.dermnetnz.org/lesions/melanoma.html)
Skin cancer: Squamous cell carcinoma

Key messages

Refer lesions strongly suspicious of SCC under 2 week wait:

- Non-healing keratinising or crusted tumour larger than 1cm with significant induration on palpation.
- Commonly found on face, scalp or back of hand (sun exposed sites).
- Expansion over 8 weeks.
- Those who have had an organ transplant and develop new/growing cutaneous lesions (SCC is common with immunosuppression but may be atypical and aggressive).
- Biopsy of suspected SCC should NOT be performed in primary care.

Notes

1. SCC is a malignant tumour of the keratinising cells of the epidermis.
2. Locally invasive and has potential to metastasise.
3. Invasive SCCs are usually slow growing, tender, scaly or crusted lumps.
4. High risk areas are lower lip (smoking is a risk factor), pinna, periauricular forehead and scalp.
5. May develop in areas of chronic inflammation e.g. leg ulcers (Marjolin’s ulcers).

Resources

On-line pictures for GPs:

Patient leaflets
http://www.patient.co.uk/doctor/Squamous-Cell-Carcinoma-of-Skin.htm
Skin cancer: Basal cell carcinoma

Key messages

- Refer lesions suspicious of BCC routinely.
- Early lesions are often small, translucent or pearly and have raised areas with telangiectasia. The classic rodent ulcer has an indurated edge and ulcerated centre. It is slow growing but can spread deeply to cause considerable destruction.

Notes

1. BCCs are slow growing, locally invasive malignant epidermal skin tumours, thought to arise from hair follicles. The commonest skin cancer in the UK (60%)
2. Sun-exposed areas of the head and neck (80%) are the most commonly involved sites, with the rest mainly on the trunk and lower limbs
3. Multiple BCCs are a feature of basal cell naevus (Gorlin’s) syndrome (BCNS)
4. Surgical excision is the preferred treatment but the choice of treatment depends on the site and size of the BCC, the condition of the surrounding skin and number of BCCs to be treated. Other treatments include:
   - Curettage and cautery
   - Cryotherapy
   - Topical fluorouracil 5% cream (Efudix) is useful in the management of multiple superficial BCCs on the trunk and limbs. The lesions must be proven by biopsy OR if treated empirically they must be closely followed-up and referred if not improved by treatment

Resources

NICE Skin Tumours (IOG) Improving Outcomes Guidance: Updated May 2010

Key messages

- Pre-cancerous lesions (e.g. Bowen’s, AKs) can be treated by GP or referred.
- Low risk BCCs may be managed in the community by:
  1. GPs performing skin surgery within LES/DES framework;
  2. GPwSI (None currently in Bromley, although this may change);
  3. Model 2 practitioners (Outreach community skin cancer services).
- Lesions suspicious of SCC/MM should be referred to dermatology.

- Low risk BCCs are:
  1. Nodulocystic
  2. No diagnostic uncertainty
  3. Less <1cm
  4. Below clavicle
  5. Not overlying important anatomical structures (e.g. major vessels)
  6. Patient >24 years, is not immunosuppressed, does not have Gorlin’s syndrome
- GP with DES/LES: Low risk BCC
- Model 1 care: Low risk BCC
- Model 2 care: Provides surgery only (GP or Nurse with appropriate skills)
- Model 3 care: Dermatology consultant in community
- Model 2 and 3 care is not yet available in Bromley, although this may change

Resources
Actinic/Solar Keratoses & Bowen’s

Initial assessment

**Treatment:**
Advise all patients on use of sun protection and emollients.

Diclofenac sodium (Solaraze) apply BD for 60-90 days.

Topical Fluorouracil 5% (Efudix) cream apply OD for 6 weeks OR BD for 4 weeks. Review after treatment to ensure healing has occurred.

Cryotherapy, freeze for 10-15 seconds each.

Diagnostic uncertainty

Suspicion of malignancy

Failure of response to one cycle of treatment (requires biopsy)

Refer dermatology
Actinic/Solar Keratoses

Key messages

- Actinic keratoses are usually multiple, flat, pale or reddish-brown lesions with a dry adherent scale.
- They are a reflection of abnormal skin cell development due to exposure to UV radiation and are considered pre-cancerous. A keratosis may also develop into a cutaneous horn.
- They appear as multiple flat or thickened, scaly or warty, skin coloured or reddened lesions.
- The vast majority do NOT progress to squamous cell carcinoma, evidence suggests the annual incidence of transformation is less than 0.1%. This risk is higher in the immunocompromised.
- It is not necessary to refer all patients with actinic keratosis. They should be managed in primary care.

Notes

1. Diclofenac sodium gel (Solaraze) produces much less inflammation than fluorouracil 5% cream (Efudix) and is better tolerated. It is less effective than Efudix for thicker lesions. Use with caution in those with GI/renal disease.
2. Fluorouracil 5% cream (Efudix) is ideal for multiple, ill-defined AKs. It spares normal skin. It is safe and efficacious with little systemic absorption. Marked inflammation should occur prior to resolution, warn the patient to expect this. Advise patient across the field of lesions (see patient advice leaflet).
3. Optimum effect is seen 1 month post fluorouracil (Efudix) treatment.

Resources

On-line pictures for GPs:  
http://www.patient.co.uk/doctor/Actinic-(Solar)-Keratosis.htm  

Patient leaflets:
Treatment with Fluorouracil 5% (Efudix) Cream Patient Advice Leaflet

You have been prescribed ‘Efudix’ or ‘5 fluorouracil’ cream, which is used to treat areas of sun-damaged skin. These may appear as scaly, pink or light brown patches on any part of the body that has had a lot of exposure to the sun over many years. Sometimes this damage may have occurred without producing any obvious mark on the skin and the cream will also treat this ‘invisible’ sun damage. The cream will not affect normal skin.

The dermatologist will tell you exactly which areas should be treated. How many times a day the cream should be applied and for how long varies for different degrees of sun damage and on different parts of the body.

You should apply a thin layer of the cream and rub it into the lesions and to a centimetre area of skin around the lesions as follows:

Once / Twice a day for ____ weeks to ______________________________

Wash your hands after use and avoid getting the cream in your eyes or mouth.

YOUR SKIN MAY SEEM TO GET WORSE BEFORE IT GETS BETTER

After a variable time the treated skin will become red and sore. This is an expected part of the treatment as the cream gets rid of the visible and invisible sun damage. You may bathe the area with water or a weak salt solution and cover with a dry dressing if necessary. If the reaction is uncomfortable this can be eased with paracetamol, aspirin or ibuprofen.

The reaction varies in different people and on different parts of the body. Sometimes the reaction is very mild and the skin only becomes a little red, but occasionally the reaction can be quite fierce and cause weeping, scabbing and rarely, bleeding or pain. If the reaction is this bad please stop the treatment for a few days to allow it to settle and then restart the treatment until you finish the course. The dermatologist or your GP may prescribe a mild steroid ointment to settle any reaction if necessary.

However severe the reaction it ALWAYS settles once the Efudix is stopped and this treatment is usually very successful at clearing the sun damage and leaving the skin smooth afterwards. The dermatologist may check that the treatment has worked a few weeks or months after the reaction has settled.

The face usually responds more quickly to treatment than the body, legs or arms. These areas may need more than one course of the cream although the reaction is usually less on subsequent courses. If any rough or scaly areas are left after the first course of treatment then the dermatologist may advise a second course, but you should only use the cream as instructed by the doctor. If you have any concerns during treatment you can phone the department for further advice on 01689 865260.
Acne

**Initial assessment**

- **Mild:** Open and closed comedones (non-inflammatory)
  - Papules and pustules (inflammatory)

- **Moderate:** More frequent lesions with mild scarring

- **Severe:** Cystic scarring acne
  - Severe psychological disorder as a result of acne
  - True treatment failure

**Topical therapy with keratolytic/comedolytic:**
- Salicylic acid 2% (Acnisal wash)
- Benzoyl peroxide start with 2.5% can increase to 5%
- Topical Retinoids
- Epiduo

**Continue topical therapy, in addition to:**
- Systemic antibiotic for 3 months:
  - Oxytetracycline 500mg BD
  - Doxycycline 50mg BD
  - Lymecycline (Tetralysal 300) 408mg OD

- Consider Co-cyprindiol (Dianette) in females particularly if needing contraception (exclude PCOS before starting). Licensed for 12 mths can consider acne friendly pill thereafter e.g. Yasmin or Cilest

**Continue antibiotics for at least 6 months, continue keratolytic**

**Trial alternative antibiotic for 3 months, consider concomitant Dianette in females**

**Consider trimethoprim 200mg BD for a further 3 months** NB point 4 overleaf

**Refer dermatology for consideration of oral isotretinoin**
Acne

Key messages

- Consider the psychological impact of the disease on the patient and their quality of life.
- Refer those with severe acne with nodules, cysts and scarring or those not responsive to at least 3 months of 2 different antibiotics.

Notes

1. Isotretinoin (Roaccutane) is a secondary care only drug for severe, scarring acne resistant to other therapies, it is teratogenic and females should be on oral contraceptive. Those with PCOS will not respond to treatment.
2. Discourage picking, squeezing and encourage application of oil free cosmetics.
3. Always use a topical keratolytic for comedones (salicylic acid/Acnisal 2%, benzoyl peroxide 5%, topical retinoids, Epiduo.)
4. Use antibiotics for moderate disease (oxytetracycline 500mg BD, doxycycline 50mg BD, lymecycline 408mg OD) combined with topical treatment. Trimethoprim 200mg BD is useful in resistant acne, but is unlicensed for this indication and tends to be initiated by dermatologists who may increase the dosage to 300mg BD.
5. Assess treatment at 2-3 months, continue for a total of 6 months.
6. Stress importance of compliance (aim for 50% improvement at 2 months).
7. Those with severe psychological overlay also require mental health referral.
8. Dermatology can reassure patient, review treatment and prescribe isotretinoin.

Resources

On-line pictures for GPs:
http://www.dermnetnz.org/acne  http://www.dermatologist.co.uk/acne_img.html

Patient leaflets

Eczema

Initial assessment

Baseline treatment:
1. Emollients
2. Avoidance of irritants (e.g. soap)
3. Topical steroids
4. Sedating antihistamine at night if sleep disturbed

Treatment of secondary infection: antibiotic as appropriate according to swab result

Severe eczema not responding to baseline treatment
Inability to return to work
Case of diagnostic difficulty
For contact allergy patch testing

Refer dermatology

Topical steroids in children
Face & flexures in all ages, mild to moderate eczema: **Mild potency** (Hydrocortisone 1%)
Moderate & severe eczema on trunk & limbs: **Moderate potency** (clobetasone - Eumovate)
Use wet wraps if infection is controlled (Refer if failure to respond to 2 weeks clobetasone treatment.)

Topical steroids in adults
Trunk & limbs: **Moderate potency** clobetasone (Eumovate, Betnovate RD) or **Potent** betamethasone (Betnovate), mometasone (Elocon), fluticasone (Cutivate)
Discoid or hand & foot eczema: **Potent** (Betnovate, Elocon, Diprosalic)
Eczema

Emollients

1. Bath oil and soap substitute (e.g. aqueous cream, Dermol 500 lotion), encourage daily baths.
2. Liberal and frequent moisturiser e.g. Diprobase cream, E45 cream, Epaderm, liquid paraffin 1:1 white soft paraffin (be careful as fire hazard with paraffin-based emollients). Prescribe large quantities, 500g/week if severe.
3. Leave 20 minutes between application of emollient and steroid.

Topical steroids

1. Use ointment (more effective) rather than cream if possible.
2. Prescribe appropriate strength for type/size of eczema and age of patient (see guidance on finger-tip units.)
3. Induce improvement with short course of stronger steroid then quickly move to weaker ones.

Secondary infection

1. The commonest cause for a flare of atopic eczema in children and the commonest cause of treatment failure.
2. Take swab in any acute eczema but particularly if crusting/weeping (take from most cracked area).
3. Prescribe antibiotic active against Staphylococci (e.g. flucloxacillin or erythromycin, and Co-amoxiclav should be reserved for severe infection and only following microbiology results).
4. Combined topical steroid/anti-infective preparations are useful for milder infections (e.g. Fucibet, Fucidin H, Betnovate N or C) for short-term use only.

Resources

Patient leaflets
Psoriasis

Initial assessment

Generalised erythrodermic or pustular psoriasis

Refer as dermatological emergency

Chronic plaque psoriasis
Assess lifestyle precipitants e.g. alcohol, medications
Emollient
Vitamin D analogue +/- topical steroid
Coal tar / topical steroid
Dithranol cream as short contact therapy
Topical retinoid

Guttate psoriasis
Throat swab and ASO titre
Emollient
Vitamin D analogue +/- moderate potency topical steroid
Coal tar / topical steroid

Scalp psoriasis
Combination of keratolytic and anti-inflammatory agents
Calcipotriol scalp application
Tar based shampoo
Potent topical steroid scalp application
Severe cases: keratolytic e.g. cononut, tar & salicylic ointment

Consider referral for phototherapy

Diagnostic uncertainty
Extensive disease
Occupational disability/excessive work/school absence
Involvement of difficult sites (face, palms, genitalia)
Failure of appropriate topical Tx after 2-3 months
Adverse reaction to topical Tx
Severe disease requiring systemic Tx

Refer dermatology

Flexural psoriasis
Mild to moderate potency steroids combined with anti-biotic/fungal

Facial psoriasis
Mild to moderate potency steroids used intermittently
Psoriasis

Key messages

- Instruct all patients in the use of emollients which make the skin more comfortable and reduce the quantity of active agents needed.
- Appropriate active treatment is dependent on type of psoriasis.
- Psoriasis is treatable but not curable.

Notes

1. Medications known to precipitate psoriasis: lithium, beta blockers, hydroxycholoroquine, NSAIDS, stopping corticosteroids.
2. Nail psoriasis responds poorly to topical Tx, consider podiatry for painful toenails, dermatology referral for severe disease.
3. Dermatology will follow-up those with very severe disease and those requiring systemic Tx.
4. **Topical vitamin D preparations**: Calcipotriol (**Dovonex**) licensed for long term use, apply liberally BD (not for use on face/flexures). Tacalcitol (**Curatoderm**) can be used on face, OD preparation. Calitriol (**Silkis**) can be used in flexures. **Dovobet** should be used intermittently and with caution maximum 4 weeks (can make psoriasis unstable and steroid over use side effects).
5. **Eumovate with 5% liquor picis carbonis** although useful for itchy inflamed psoriasis is a “Special” and as such the cost will vary dependent upon source.
6. For thick, scaling scalp psoriasis use **SebCo** ointment. Advise leave on overnight.
7. Psoriasis in children: use emollients and mild steroid/tar combinations such as **Alphosyl HC cream**. Dovonex can be used in over 12s.

Resources

On-line pictures for GPs:
http://www.dermnetnz.org/scaly/psoriasis-general.html

Patient leaflets
Urticaria/angioedema

Initial assessment: individual weals vanish after a few hours and are replaced by new weals

> 6 weeks Chronic

Trial of non-sedating antihistamine up to 6 weeks
Consider addition of H2 blocker

< 6 weeks Acute (May be allergic)
Take food and drug Hx

Diagnostic difficulty
Failure to respond to treatment with at least 6 weeks of continuous antihistamines of different types

Refer dermatology
Urticaria/angioedema

Key messages

- A careful history is key, lesions last for less than 24 hours and don’t leave bruises.
- Chronic urticaria often has a diurnal pattern, it is caused by an immunological malfunction.
- All patients should avoid strawberries, shellfish, aspirin, ACEIs, NSAIDs and codeine.
- Antihistamines are the mainstay of treatment.
- Steroids and adrenaline are NOT indicated for the management of simple urticaria.
- Check a full blood count in those with urticaria.

Notes

1. Weals are a central itchy white papule or plaque due to dermal oedema. This is surrounded by an erythematous flare. The lesions are variable in size and shape and may be associated with angioedema.
2. Angioedema is swelling of the soft tissues of the eyelids, lips and tongue, it is NOT itchy and lasts up to 72 hours. It is occasionally inherited.
3. Trial non sedating antihistamines first (e.g. loratadine 10mg OD, cetirizine 10mg OD).
4. Sedating antihistamines (e.g. chlorphenamine 4mg TDS, usual night time dose for hydroxyzine is 25mg at night increasing to TDS if required).
5. Addition of H2 blockers (e.g. cimetidine 400mg BD or ranitidine 150mg BD off licence use for both ) may be helpful in a small number of patients, consider referral.

Resources

On-line pictures for GPs:  
http://www.dermnetnz.org/reactions/urticaria.html

Patient leaflets:  
http://www.patient.co.uk/health/Urticaria.htm  
Rosacea

Mild: Topical treatment
Metronidazole 0.75 to 1% cream/gel BD
Azelaic acid 15% gel (Finacea) BD

Moderate: Systemic treatment
Oxytetracycline 500mg BD
Doxycycline (unlicensed use) 50-100mg OD
Lymecycline 408mg OD

Severe: rosacea not responding to systemic therapy
Diagnostic difficulty

Refer dermatology

Ocular rosacea

Refer ophthalmology

Initial assessment
Rosacea

Key messages

- Clinical features: papules on an erythematous background, pustules, telangiectasia, rhinophyma. No comedones.
- Flushing is made worse by alcohol, spicy foods, hot drinks, temperature changes or emotion.
- Early treatment is important as each exacerbation leads to further skin damage and increases the risk of more advanced disease.
- Consider intermittent therapy for those with very occasional flare-ups, continuous therapy needed for frequent recurrences.

Notes

1. Continue topical treatment for 6-8 weeks and re-assess.
2. Use cream for dry/sensitive skin, gel for normal/oily skin.
3. Continue systemic treatment for 8-12 weeks, response is usually rapid.
4. Advise those with ocular disease on lid hygiene and managing blepharitis.
5. Pulse dye laser can be used for moderate-severe telangiectasia however this may be regarded as a procedure of limited clinical effectiveness and therefore not available on the NHS.
6. Laser resurfacing may be offered for those with severe rhinophyma however this may be regarded as a procedure of limited clinical effectiveness and therefore not available on the NHS.

Resources

On-line pictures for GPs: http://dermnetnz.org/acne/rosacea.html
Patient leaflets
Skin infections

Viral warts

**Hand warts:** use high concentration of salicylic acid (keratolytic)
Adults: e.g. Occlusal (26%)
Children: e.g. Duofilm or Salactol (16.7%)

3 month treatment

**Cryotherapy:** Freeze times after wart has turned white
Face: 10 seconds
Hands: 10-20 seconds
Feet: 15 seconds, thaw 1-2 minutes then repeat 15 seconds

**Plantar warts:** Ver-rugon (50% salicylic acid)

**Plane warts (face/hands):**
Leave alone or trial of Tretinoin 0.025% (unlicensed use) cream for 4 weeks

**Filiform warts (face/eyelids):**
Cryotherapy

---

**Scabies**

Initial assessment: features suggestive of scabies

Impetignisation usually due to secondary *Staph* infection

Hydrocortisone 1% clinoquinol 3% (Vioform HC) cream +/- Flucloxacinil 7-10 days

Use scabicide to treat patient and contacts:
Malathion 0.5% aqueous solution (Derbac-M) OR
Permethrin 5% cream (Lyclear Dermal cream)

If residual rash/itch use Crotamiton/HCT (Eurax) and emollients
Viral warts

- Referral exclusion unless disabling (e.g. florid hand warts in a hairdresser) must have adequate treatment for 6 months prior to referral. Children are an absolute referral exclusion.
- There is no cure, more than 70% resolve spontaneously in 2 years. Plantar warts are more persistent.
- All wart treatments are locally destructive and some are painful and cause scarring. Choice of Tx depends on age of patient and site of warts (it is unkind to use cryotherapy for warts in children).
- Topical Tx is as effective as cryotherapy for hand warts. In children you may want to consider using a gel and cover with plaster to prevent spread.
- Keep warts pared down between treatments (insufficient filing of dead skin can reduce effectiveness of treatment. Treatment with duct tape may help.

Scabies

- Scabies is an infestation caused by the mite Sarcoptes scabiei. Mites are most readily transmitted from one person to another by close physical contact (e.g. sharing a bed, caring for children/elderly).
- An individual who has not had scabies previously, may not develop symptoms until 1 to 3 months after becoming infested.
- Clinical features: burrows on non hair bearing skin, often a widespread eczematous rash (sparing face in older children/adults). Possible inflammatory nodules on genitalia, periareolar areas, axilla/groin (especially if long standing).
- Malathion should be left on skin for 24 hours and repeated after 7 days. Permethrin for 8-12 hours and can be repeated after 7 days if necessary. One treatment usually curative except in crusted (Norwegian) scabies.
- It is essential that all household and other close social contacts receive treatment at the same time as patient.
- Mites are killed within 24 hours, but symptoms may take 3-6 weeks to settle.

Resources

On-line pictures for GPs:  
http://dermnetnz.org/scabies.html  
http://www.dermnetnz.org/viral/viral-warts.html

Patient leaflets  
http://www.patient.co.uk/health/Scabies.htm  
http://www.patient.co.uk/health/Warts-and-Verrucas.htm
**Tinea**

- **Initial assessment**
  - **Body (corporis)**
    - Skin scrapings for mycology
  - **Scalp (capitis)**
    - Skin scrapings for mycology, use disposable toothbrush in children
  - **Nails (unguium)**
    - Subungual nail scrapings for mycology

**Use topical treatment (ketoconazole shampoo) whilst awaiting microscopy**

**Treat unaffected family contacts with ketoconazole shampoo twice weekly for 4 weeks**

- **Topical treatment usually sufficient:**
  - Imidazole cream e.g. clotrimazole or miconazole BD for 1-2 weeks after skin healed, agents containing a steroid are usually not needed and should be used for 1 week only
  - Oral treatment rarely needed

- **Oral treatment is essential**
  - **Children:** only licensed treatment is Griseofulvin (15-20mg/kg) OD for 8-10 weeks
  - **Adults:** Griseofulvin or Terbinafine

**Single nail involvement:** Amorolfine 5% nail paint 1-2 x per week for 6/12 mths.
- **Multiple nails:** Terbinafine 250mg OD for 12 weeks. Check LFTs before starting treatment
- **2nd line is Itraconazole:** either 200mg OD for 3 months or pulsed 400mg OD one week/month for 2 courses for finger nails and 3 for toenails

Griseofulvin is only licensed treatment for children 10mg/kg/day for 6-12 months. Not recommended in adults

**If signs persist after treatment or diagnostic difficulty refer dermatology**

28
**Tinea**

**Key messages**
- Dermatophytosis (*tinea*) infections are fungal infections caused by dermatophytes (a group of fungi that invade and grow in dead keratin). They tend to grow outwards on skin producing a ring like pattern, hence the term “ringworm”.
- *Tinea* infections present with a variety of appearances e.g. annular plaques, diffuse scaling, grey patches, pustules, kerion, patchy hair loss, nail changes.

**Tinea capitis**
1. Usually a disease of children. A child can go back to school once treatment commenced. Schools should be informed and they should alert parents what to look for. Family contacts should avoid sharing combs/hair brushes.
2. Griseofulvin is available as 125mg tablets, which can be halved and crushed. Oral Terbinafine is being used increasingly. Although unlicensed in children, in practice it appears to be safe and very effective (at a daily dose of 250mg for child weighing 40kg, 125mg for 20-40kg, 62.5mg for <20kg for one month.)
3. Topical antifungal treatment alone is insufficient but probably reduces infectivity and the chance of relapse e.g. ketoconazole shampoo twice weekly or miconazole ointment twice daily for the first month. Washing the scalp daily with an antiseptic emollient helps remove scale e.g. Dermol 500.

**Tinea unguium**
1. Treatment should not be instituted on clinical grounds always consider other causes of nail dystrophy, psoriasis compression by shoes subungual melanoma. *Never prescribe systemic treatment without positive mycology culture*. Scrape subungual nail debris at most proximal part of infection, which may require clipping the nail back. If culture is negative repeat test. It can take 6 to 12 months for damaged nail to grow out.
2. Amorolfine 5% is the topical treatment 1st choice but is only recommended for limited infection (e.g. one nail or very distal disease in a few nails). May be used with systemic treatment to improve cure rates or if systemic treatment contraindicated.

**On-line pictures for GPs:** [http://dermnetnz.org/fungal/tinea.html](http://dermnetnz.org/fungal/tinea.html)

Pathway for the Management of Leg Ulceration

**Week 0**
- Patient presents with a wound to the lower leg

**Assessment 0-6 weeks**
- Complete Wound Assessment Form immediately
- Complete Leg Ulcer Assessment Form within 1 week
- Perform ABPI within 6 weeks for wounds that have not responded to standard treatment

**Diagnosis**
- Venous leg ulcer
- Arterial ulcer
- Mixed ABPI 0.6-0.8
- Mixed ABPI < 0.6
- ABPI > 1.3
- Disease specific management
- Oedema management
- Referral to TVN

**Treatment**
- Commence compression bandaging according to ankle circumference
- Refer to Tissue Viability for onward duplex and vascular referral
- Consider light compression
- Consider TV referral
- No compression
- Refer to TV for assessment and onward vascular referral
- Disease specific management
- Oedema management
- Referral to TVN

**Outcomes 0-6 months**
- Ulcer heals
  - Education
  - Prevention of recurrence
  - Hosiery
- Ulcer fails to heal
  - Education
  - Reassess
  - Advice from TV champion
  - TV referral if not healed in 6 months
- Other reasons for TV referral
  - Unable to tolerate compression
  - Allergy
  - Repeated infection
  - No response to treatment at 12 weeks

**RIO**
- Record activity as WOUNDCARE
- Record activity as MANAGEMENT OF LEG ULCER for venous leg ulcers

* In patients with a history of venous ulceration or with signs of venous disease, an ABPI should be performed at the earliest opportunity.
** Non venous leg ulcers should use activity ‘Skin Leg Ulcer Care’

LU Pathway GDunw TV 11/09
Adapted from The International Leg Ulcer Advisory Board Care Pathway (2002)
Leg ulcers

Key messages

• This algorithm is taken from the local comprehensive leg ulcer assessment and management guidelines (Bromley PCT, July 2010).

• **Identify risk factors**: smoking, peripheral vascular disease (history of claudication), history of varicose veins, deep vein thrombosis or rheumatoid arthritis (associated with inflammatory ulcers).

• **Examine patient** to identify vascular disease (venous or arterial).

• **Look for evidence of varicose eczema**: if present treat with moderate-potent topical steroids and compression hosiery.

• **Varicose ulcer**: refer to practice nurse for assessment including Dopplers, ulcer dressings and compression bandaging. If fails to respond refer to community tissue viability team. House-bound patients should be referred to District Nurses.

• **Arterial/mixed vascular disease**: refer to practice nurse for Dopplers, and vascular surgeons.

Notes

Dermatology referral criteria:

1. Diagnostic uncertainty, including concern about malignant change (Non healing ulcer with undermined edges).

2. Evidence of contact dermatitis.

3. Failure to respond to treatment after assessment by tissue viability team. Include info on previous dressings and Doppler assessment in referral letter.

Resources

On-line pictures for GPs: http://www.dermnetnz.org/site-age-specific/leg-ulcers.html

Patient leaflets
Management of Benign Skin Conditions

Key Messages:

Cosmetic removal is NOT possible on the NHS

- **Molluscum contagiosum**  No treatment necessary, can try Crystacide
- **Skin tags**  Treat only if problematic
- **Seborrhoeic warts**  Treat only if irritated/inflamed and there is no diagnostic uncertainty. Cryotherapy or curettage and cautery.
- **Pyogenic granuloma**  Curettage and cautery (histology essential), refer to dermatology if difficult size/site
- **Spider naevi/Campbell de Morgan spots / Vascular angiomata**  Do not treat
- **Bowen’s disease**  Cryotherapy or curettage and cautery, must be biopsied
- **Benign naevi**  Do not treat
- **Atypical naevi**  If genuine concern Re: melanoma refer 2 week wait
- **Sebaceous cysts**  If problematic can be excised under minor surgery DES
- **Keloid**  Cosmetic, treatment not possible on NHS
- **Lipoma**  Cosmetic removal not possible on NHS
- **Dermatofibroma**  Cosmetic removal not possible on NHS, take care as may leave ugly scar, refer if diagnostic uncertainty
- **Keratin horn**  Curettage and cautery (histology essential)
- **Solar/giant comedones**  Can be incised and contents expressed, lesions over 5mm need excision (cosmetic, treatment not possible on NHS)
- **Solar lentigines**  Cosmetic, treatment not possible on NHS
- **Congenital naevi**  Cosmetic, treatment not possible on NHS
Exceptional Treatments Policy

- Dermabrasion (chemical peel)
- Scar revision
- Tattoo removal
- Birthmark removal
- Excision of benign skin lesions
- Tunable dye laser

Referral Exclusions

- Viral warts and verrucae in children
- Molluscum contagiosum in children
- Skin tags
- Epidermoid (sebaceous) cysts
Useful Management Tips

Equipment
- Good light source
- Tape measure
- Surgical instruments
- Fungal scrapings kit
- Disposable toothbrush (fungal scrapings in children)

Topical Steroids: finger tip units
- One fingertip unit (FTU) is the amount of topical steroid that is squeezed out from a standard tube along an adult’s fingertip. 1 FTU = 0.5g, apply once daily
  - Face & neck (2.5 FTU, 15-30g/week)
  - Trunk (7 FTU, 100g/week)
  - Both arms (6 FTU, 30-60g/week)
  - Both legs (12 FTU, 100g/week)
  - Groin & genitalia (2.5 FTU, 15-30g/week)

Emollients
- BNF recommended quantities to be given to adults for twice daily application are:
  - Face (15-30g cream, 100ml lotion)
  - Both hands (25-50g cream, 200ml lotion)
  - Scalp (50-100g cream, 200ml lotion)
  - Both arms/legs (100-200g cream, 200ml lotion)
  - Trunk (400g cream, 500ml lotion)
  - Groin & genitalia (15-25g cream, 100ml lotion)
  - Scabies permethrin cream 30g generally sufficient although 60g for larger people. Maximum 60g per application. Lotion 100ml for whole body application (200ml bottle)
Sun Protection Tips

- Protect skin with clothing, including a hat, T shirt and UV protective sunglasses.
- Seek shade between 11am and 3pm when it's sunny.
- Use a sunscreen of at least SPF 30 which also has high UVA protection.
- Keep babies and young children out of direct sunlight.

Investigations in Primary Care

- **Skin scrapings**: Suspected fungal infection, use the blunt edge of a scalpel blade/disposable toothbrush in children to collect scale from leading edge of rash. Transport in a sterile container on black card.
- **Skin swabs**: Suspected bacterial infection, particularly in crusted/weeping eczema.
Patient information

www.patient.co.uk

Conditions

Acne
Atopic eczema
Psoriasis
Insect bites and stings
Headlice
Malignant skin ulcers
Solar keratosis
Epidermoid and pilar cysts
Pressure ulcers
Vitiligo
Acute, chronic and physical urticaria
Molluscum contagiosum
Lipoma
Contact dermatitis
Folliculitis
Erythema nodosum
Seborrhoeic dermatitis

Keloids
Keratoacanthoma
Lichen planus
Lichen sclerosus
Melanoma
Patch testing
Pemphigoid
Pityriasis rosea
Pityriasis versicolor
Psoriasis
Scabies
Seborrhoeic dermatitis
Seborrhoeic warts
Squamous cell carcinoma
Urticaria and angioedema
Venous eczema
Vitiligo

www.dermnetnz.org

Abscess
Acne
Acne in pregnancy
Actinic keratosis
Adverse reaction to drugs
Albinism
Allergic contact dermatitis
Alopecia areata
Angioedema
Atopic dermatitis/eczema
Bacterial skin infections
Basal cell carcinoma
B cell lymphoma
Behcet disease
Blue naevus
Bowen disease
Bullous pemphigoid
Campbell de Morgan spots
Candidiasis of skin folds
Chillblains
Chloasma
Congenital naevi
Contact allergic dermatitis
Dermitis
Dermatofibroma
Dermoid cyst

Disoid eczema
Eczema
Epidermal naevi
Epidermolysis bullosa
Erythema ab igne
Erythema multiforme
Erythema nodosum
Fifth disease
Folliculitis
Fungal infections
Genital skin problems
Granuloma annulare
Henoch Schoenlein purpura
Herpes simplex
Herpes zoster
Hidradenitis suppurativa
Hirsutism
Hypertrophic scars
Ichthyosis
Impetigo
Intervertebral
Kaposi sarcoma
Keloids
Keratoacanthoma
Leg ulcers
Leg vein therapies
Lichen planus
Lichen sclerosus
Malignant melanoma
Milium, milia
Papillomas, skin tags
Parasites & infestations
Pityriasis alba
Pityriasis rosea
Pityriasis versicolor
Pruritus
Psoriasis
Scabies
Scleroderma
Senile comedones
Solar keratoses
Solar urticaria
Tinea
Varicose eczema

Management

Acne treatments
Antihistamines
Topical steroids, fingertip units
Emollients (moisturisers)
Cancer of the skin – Prevention
Sun and health
Patch testing

www.bad.org.uk

Acne
Actinic keratosis
Basal cell carcinoma
Boils
Bowen’s Disease
Contact dermatitis
Dermatofibroma
Herpes simplex
Hirsutism
Ichthyosis
Impetigo

www.patient.co.uk

Conditions

Acne
Atopic eczema
Psoriasis
Insect bites and stings
Headlice
Malignant skin ulcers
Solar keratosis
Epidermoid and pilar cysts
Pressure ulcers
Vitiligo

Keloids
Keratoacanthoma
Lichen planus
Lichen sclerosus
Melanoma
Patch testing
Pemphigoid
Pityriasis rosea
Pityriasis versicolor
Psoriasis
Scabies
Seborrhoeic dermatitis
Seborrhoeic warts
Squamous cell carcinoma
Urticaria and angioedema
Venous eczema
Vitiligo

www.dermnetnz.org

Abscess
Acne
Acne in pregnancy
Actinic keratosis
Adverse reaction to drugs
Albinism
Allergic contact dermatitis
Alopecia areata
Angioedema
Atopic dermatitis/eczema
Bacterial skin infections
Basal cell carcinoma
B cell lymphoma
Behcet disease
Blue naevus
Bowen disease
Bullous pemphigoid
Campbell de Morgan spots
Candidiasis of skin folds
Chillblains
Chloasma
Congenital naevi
Contact allergic dermatitis
Dermitis
Dermatofibroma
Dermoid cyst

Disoid eczema
Eczema
Epidermal naevi
Epidermolysis bullosa
Erythema ab igne
Erythema multiforme
Erythema nodosum
Fifth disease
Folliculitis
Fungal infections
Genital skin problems
Granuloma annulare
Henoch Schoenlein purpura
Herpes simplex
Herpes zoster
Hidradenitis suppurativa
Hirsutism
Hypertrophic scars
Ichthyosis
Impetigo
Intervertebral
Kaposi sarcoma
Keloids
Keratoacanthoma
Leg ulcers
Leg vein therapies
Lichen planus
Lichen sclerosus
Malignant melanoma
Milium, milia
Papillomas, skin tags
Parasites & infestations
Pityriasis alba
Pityriasis rosea
Pityriasis versicolor
Pruritus
Psoriasis
Scabies
Scleroderma
Senile comedones
Solar keratoses
Solar urticaria
Tinea
Varicose eczema