A Guide to Dermatology in Primary Care

Swansea Bay University Health Board

Introduction

SECONDARY CARE GUIDELINES ALSO EXIST FOR YOUR PERUSAL

This document offers recommendations of first line treatment for the most common skin conditions 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.

It is impossible to define exactly the stage at which a secondary referral should be made and frequently the problems at the edge of our definitions are the most challenging.

Although each case should be considered individually, these treatment recommendations should be helpful prior to consideration of referral to the Consultant Dermatologists. **Criteria for referral are clearly stated at the end of each section.**

Although some information regarding doses, contra-indications etc are mentioned in this document, this is not exhaustive. Therefore check the British National Formulary (BNF) and/or ABMU HB Primary Care Antimicrobial Guidelines before prescribing. Additional information on doses, contraindications, cautions, drug interactions and adverse effects etc may be found in the latest copy of the BNF or electronic Medicines Compendium (EMC).

REFERRALS AND QUERIES

All formal referrals need to be made via the Welsh Clinical Portal system on WCCG with an attached photograph. The better the quality of the history and photograph, the better the advice we can give and triage appropriately. All referrals should be made from GP to consultant. It is entirely appropriate for a junior member of the team to make the referral if the case has been assessed by the GP as well. This should be stated with the responsible GP's name for audit trail.
For existing patients, it is best to contact the department directly (or the patient to contact the department) rather than using Welsh Clinical Portal. Patients who have worsening of existing under follow conditions can contact us directly also rather than going through yourself.

PHOTOGRAPHY (HIGH RESOLUTION)

LESIONS

- Close up (of lesion) and distant shots (of whole body segment)
- Ensure in well-lit area
- Dermoscopy shot also if available but clinical more useful
-

RASHES

- Whole body to assess extent and distribution
- Close up of body segments affected
- Closer shot of individual lesions

CONTACT DETAILS

SINGLETON HOSPITAL

Covers patients in and from Swansea

CONSULTANTS

Dr. Sairan Whittaker [redacted]
Dr. Deana Al-Ismail [redacted]
Dr. Ashima Lowe [redacted]
Dr. Rami Hamadeh [redacted]

SECRETARIES

SINGLE NUMBER TO CONTACT **01639 875714**

[redacted]

REGISTRARS

SpR 2 [redacted]
SpR 3 [redacted]

NEATH AND PORT TALBOT HOSPITAL

Covers patients in and from Neath, Port Talbot

CONSULTANTS

Dr. Avad Mughal [redacted]

SECRETARIES

SINGLE NUMBER TO CONTACT [redacted]

[redacted]

REGISTRARS

SpR 1 [redacted]

CONTENTS

1. SKIN LESIONS

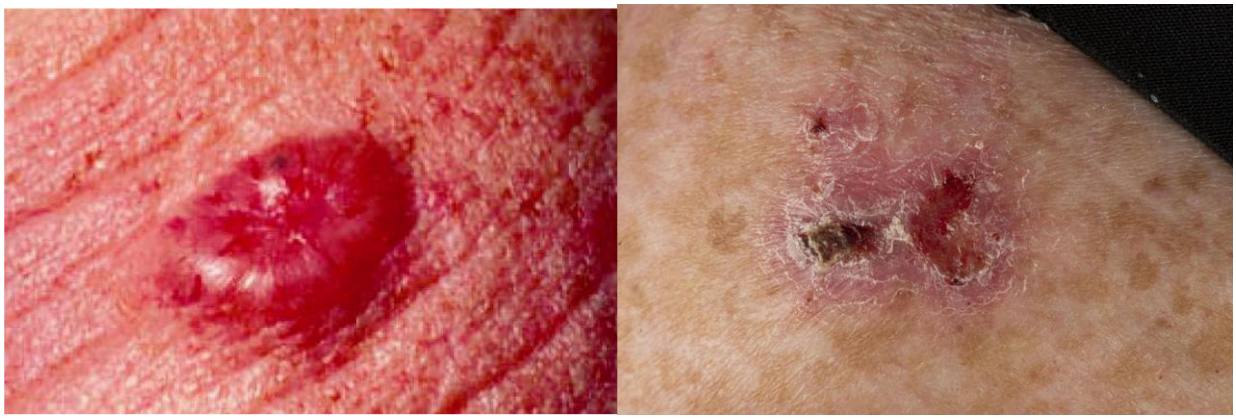
a. BASAL CELL CARCINOMA

HISTORY

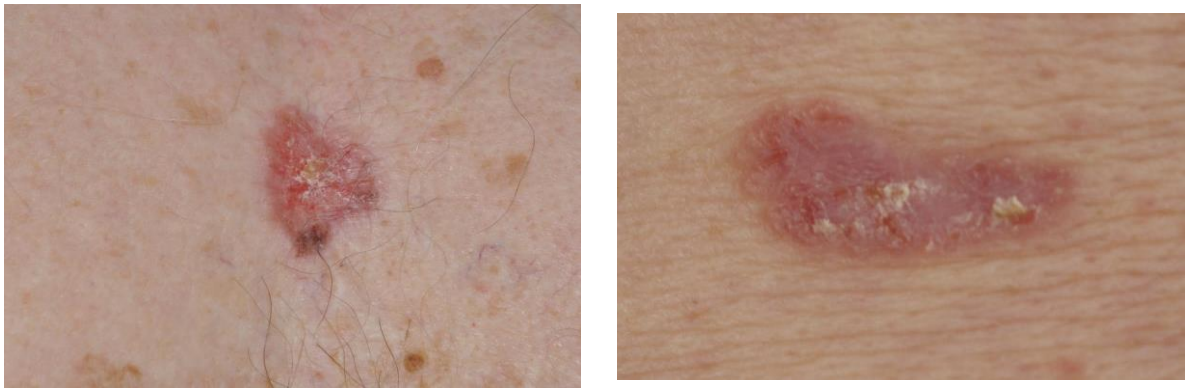
- Slow growing, painless lesion (~0.5cm per year)
- Sun exposed areas
- May bleed
- Paler skin more common but not exclusive

EXAMINATION

- Pink, pearly edged lesion
- May have rolled edge
- May be a lump
- Could be flat and scaly



Nodular Basal Cell Carcinoma



Superficial Basal Cell Carcinoma

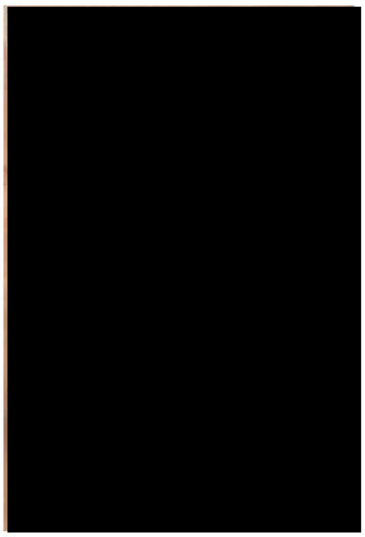
MANAGEMENT

- Excision or Topical Therapy

WHEN TO REFER

- Always refer on an **URGENT** (**Non-USC**) manner
    - Nodular BCCs will need excision
    - Superficial BCCs can be treated topically when histology confirmed

b. ACTINIC KERATOSIS



HISTORY

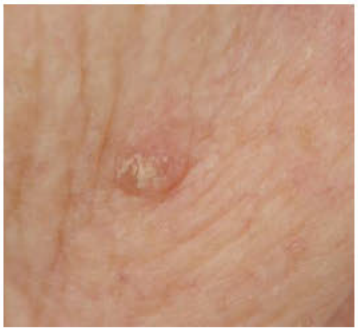
- Scaly, rough structure on sun exposed areas
- More common in pale skin
- History of chronic sun exposure
- Not growing, not bleeding
- Scale may intermittently peel off and regrow

EXAMINATION

- Rough, stuck on structure, millimetres in size
- May have erythematous background
- Can feel like a grain of sand stuck to the skin

MANAGEMENT

- Nothing – it is reasonable to leave alone if not causing bother
- Moisturiser and sunblock
- Topical chemotherapy (see below)
- Cryotherapy
- Curettage



WHEN TO REFER

- Diagnostic uncertainty
- Fails to respond to standard treatment
- Thick actinic keratosis requiring surgery
- Refer as **routine**

Topical Therapy	Regime
5' Flourouracil (Efudix®)	Apply to area daily for 4 weeks then stop. Advise about burning during treatment
5% Imiquimod (Aldara®)	Apply three days a week (Monday, Wednesday, Friday) for 4 weeks then stop. Advise about burning during treatment.
Ingenol mebutate (Picato®)	**WARNING: DO NOT USE – POTENTIAL CARCINOGEN**
3% Imiquimod (Zyclara®)	Apply once daily for 2 weeks. 2 weeks off then again for 2 weeks. Particularly good for large areas needing treatment
5' Flourouracil with salicylic acid(Actikerall®)	Apply daily for 3 months. Good for hyperkeratotic actinic keratoses

Topical diclofenac (Solaraze®) does not work any better than moisturisers.

PATHOLOGY OF ACTINIC KERATOSES

- Non basal cells (stratum spinosum or granulosum) get DNA damage from sunlight
- Most are corrected by checkpoint factors in the cell cycle
- If checkpoint factors are damaged, cells continue to divide
- Sunlight usually causes some minor DNA damage to all sun exposed cells
- This causes repair mechanisms to engage and slow cell cycle
- Check point damaged cells are not slowed and continue to grow
- They differentiate as well as divide, just faster due to increased rate of division
- This causes a cone of cells that have slightly thicker dead stratum corneum at the top
- This manifests as the typical scaly, gritty surface of an actinic keratosis
- The dead layer often falls off like all skin cells do and regrows again

c. SEBORRHOEIC KERATOSIS (SEBORRHOEIC WART)

HISTORY

- Solitary or multiple
- Brown, knobbly raised lesions on skin
- Often on back (can be anywhere)
- Not itchy or painful
- More common in elderly

EXAMINATION

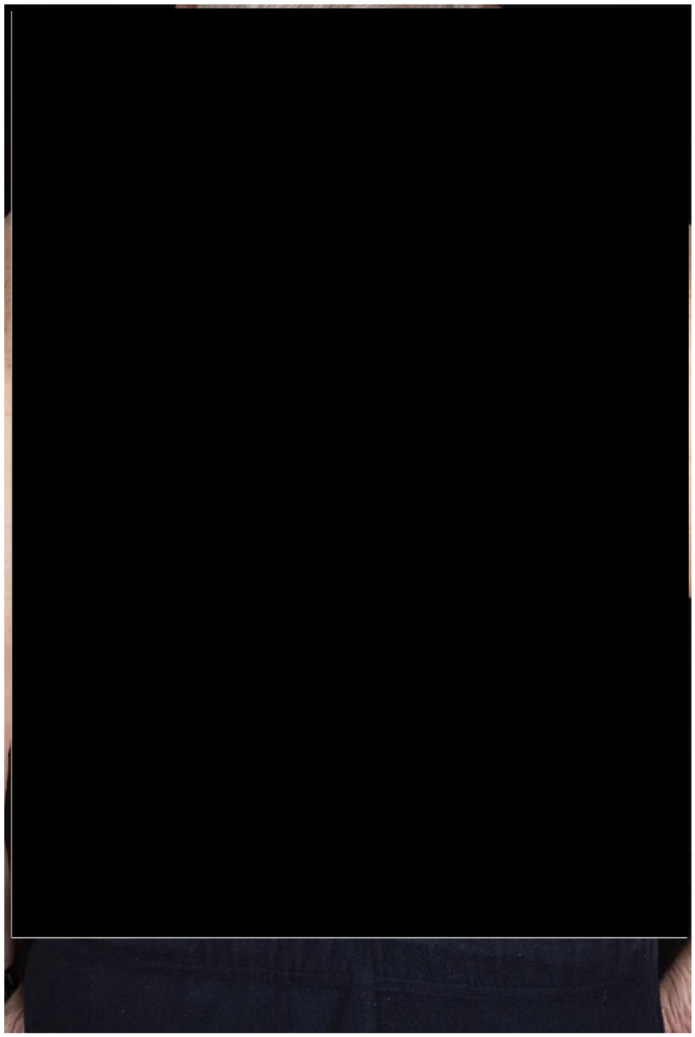
- Solitary or multiple, papillomatous lesions
- Can have stuck on appearance
- Pale cysts visible on dermoscopy
- Not bleeding or itching

MANAGEMENT

- Nothing
- If catching on clothing and a bother, cryotherapy or shave

WHEN TO REFER

- Causing **significant** symptoms
- Refer as **routine**



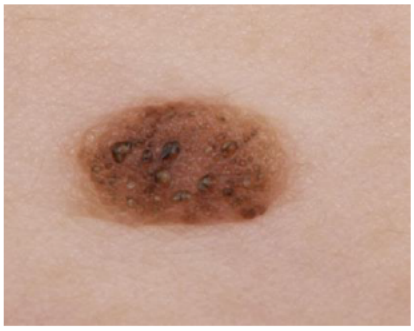


Figure above:
Single seborrheic keratosis zoomed in. Note the bumpy surface, sharp edge and keratin cysts within it.

Figure left:
Multiple seborrhoeic keratosis on the back in a typical “Christmas Tree” distribution

d. BOWEN'S DISEASE (SQUAMOUS CELL CARCINOMA IN SITU)

When on the penis, it is called *erythrodysplasia of Queyrat*

HISTORY

- Pink, scaly patch on sun exposed area
- Commonly lower leg in elderly female
- Slow growing
- Can bleed
- More common in pale skin

EXAMINATION

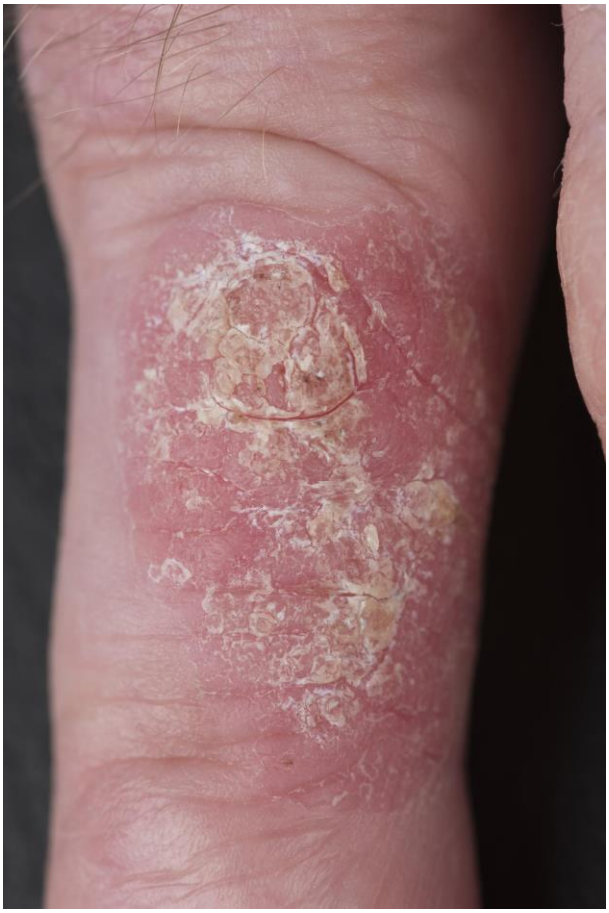
- Pink, scaly, flat area
- Red, streaks may be visible

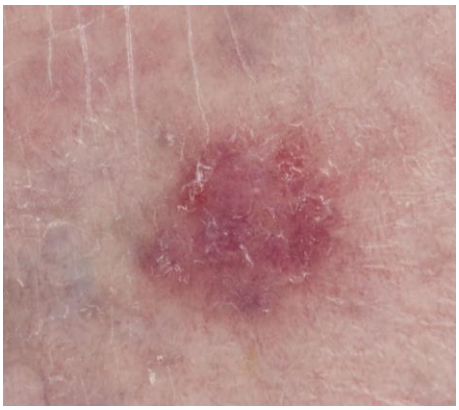
MANAGEMENT

- Topical therapy (after histological confirmation)
- Curettage and cautery

WHEN TO REFER

- Always (unless facilities exist for minor surgery)
- Topical therapies similar to actinic keratosis but longer courses
- Photodynamic therapy also available





In Bowen's disease, the scaly appearance is due to the rapid cell turnover and differentiation from dysplastic, growing cells. Psoriasis also has a scaly appearance due to rapidly growing and differentiating cells but that is due to an increase in inflammatory cytokines. However, they look similar for this reason.

e. SQUAMOUS CELL CARCINOMA

HISTORY

- Rapidly growing lesion (1cm in 6 to 12 weeks)
- Painful
- Partly keratinised
- Often bleeding
- History of chronic sun exposure

EXAMINATION

- Fleshy base
- Partially keratinised horny section
- May be a central horn poking out
- Can be bloody
- Often on sun exposed sites, back of calf.

MANAGEMENT

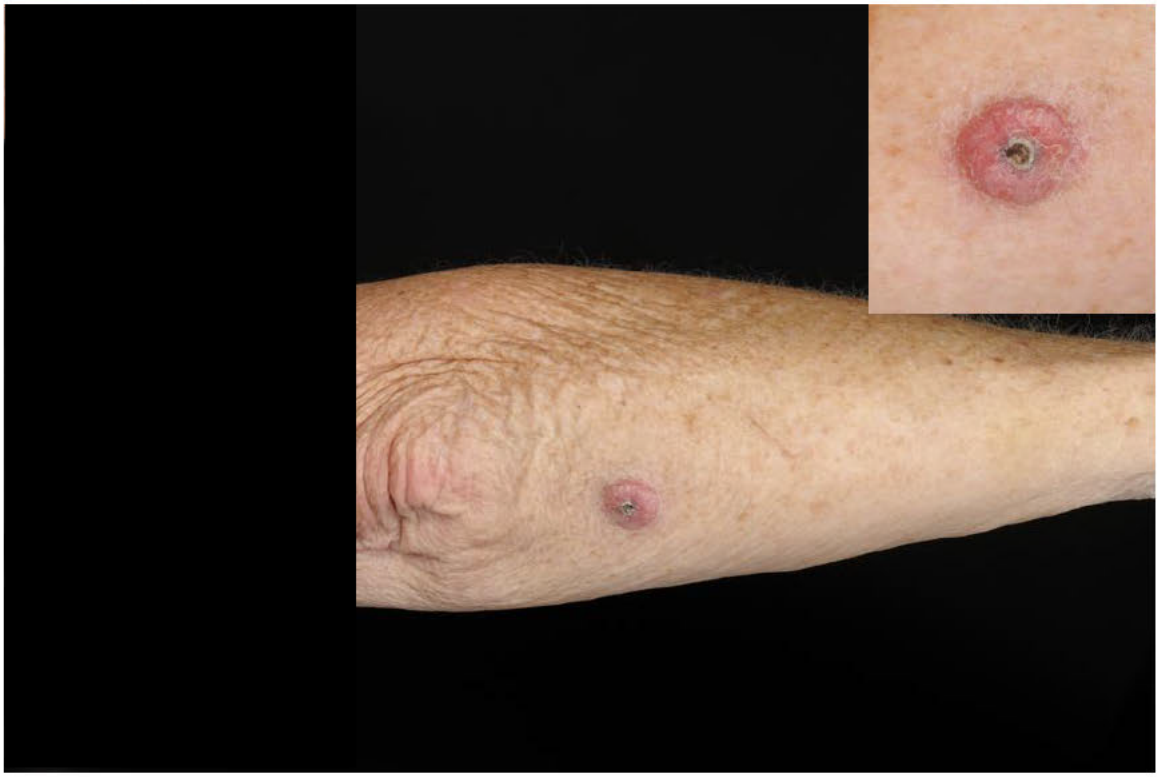
- **USC** referral for excision
- **This cancer metastasises**

WHEN TO REFER

- Always

CAUTION

- Well differentiated SCCs may look like BCCs (rolled edge)
- Speed of growth and pain can differentiate
- Be wary of patients on immunosuppressants as this can alter the appearance of skin cancers



f. MALIGNANT MELANOMA

HISTORY

- New mole in elderly
- Change in existing mole in younger patients
  - Size, shape, colour, itching
- Bleeding is a worrying sign
- Can be anywhere
- Top of back is a common site
- Sun exposure and pale skin

EXAMINATION

- Pigmented brown, black or blue lesion
- **Asymmetry** of colour, shape or border
- Can be ulcerated
- Dermoscopy can show interrupted pigment network and blue/white veil
- May stand out from other moles **(Ugly Duckling Sign)**

MANAGEMENT

- **USC** referral for excision
- **DO NOT BIOPSY FOR DIAGNOSIS**

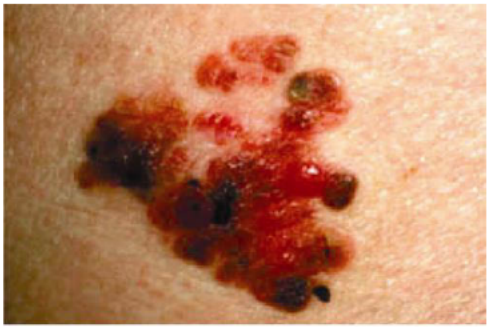
WHEN TO REFER

- Always
- **Do not refer for mole mapping or to have a look at all moles**

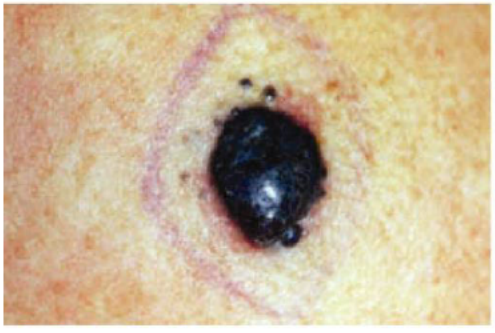
CAUTION

- Moles can darken in pregnancy and on hormone therapy – be wary of one that stands out
- Normal moles undergo regression and can disappear as one ages
- Patients on immunosuppressants may have altered features in skin cancers

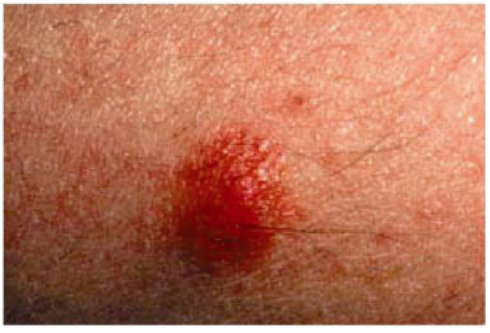
Lentigo maligna



Superficial spreading

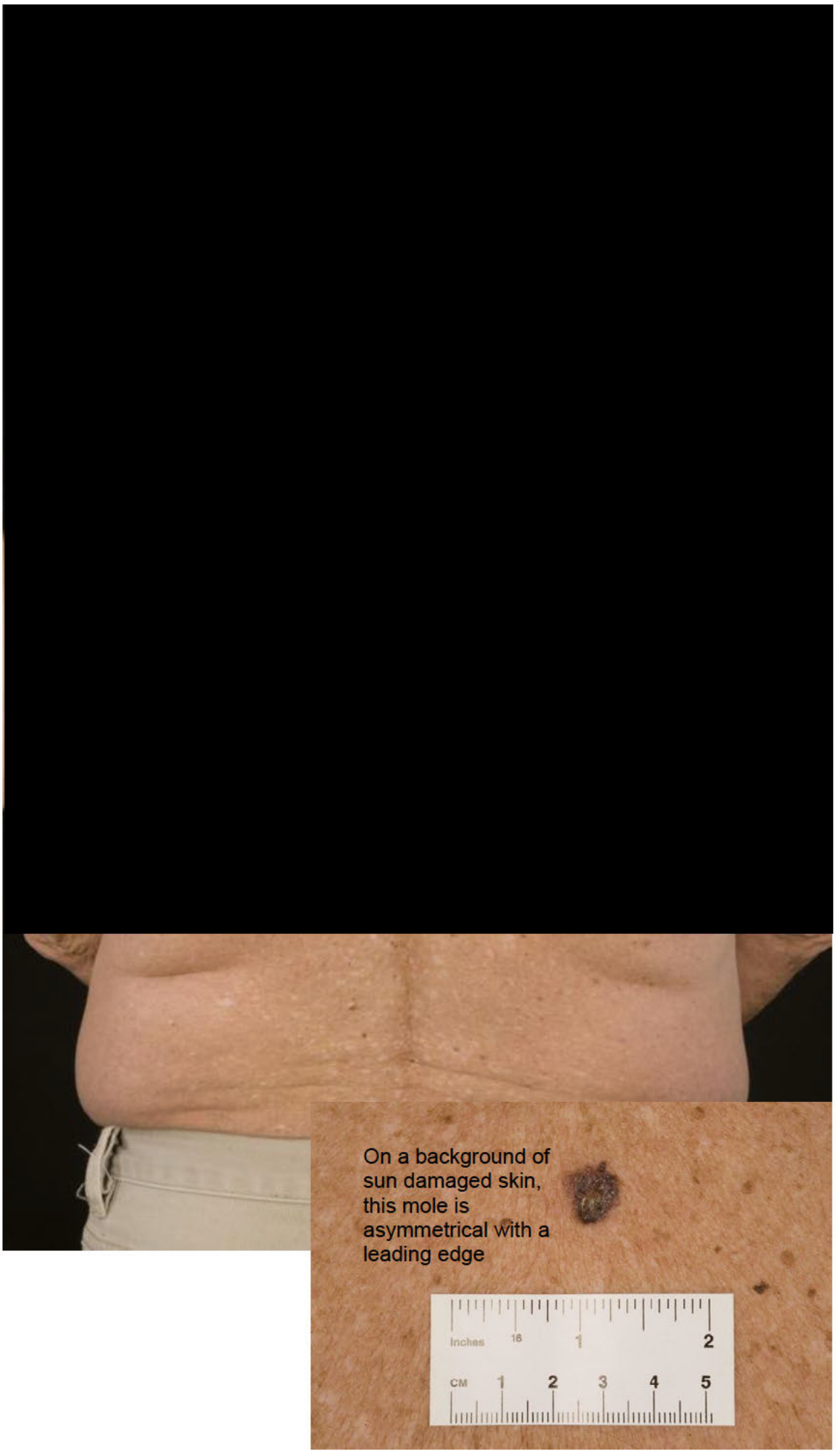


Nodular



Amelanotic

Whilst these are example images, they are not absolute and clinical judgement should be used in all cases. Use your experience.


On a background of sun damaged skin, this mole is asymmetrical with a leading edge
Inches
16
1
2
CM
1
2
3
4
5

2. ECZEMA

HISTORY

- Itchy, red skin
- Scaly and thickened in places
- Atopy in family

EXAMINATION

- Weepy, broken, diffuse, excoriated
- Flexures of adults, all over in babies (not napkin area), extensors in toddlers

MANAGEMENT (see box below)

- Emollients frequent enough so skin is not dry
- Soap substitutes
- High liquid paraffin bath oils if using them
- Topical steroids (long term at appropriate strength)
- Topical calcineurin inhibitors
- Topical vitamin D analogues

WHEN TO REFER

- Treatment failure
- Erythroderma (>70% of body affected)

CAUTION

- By the time they see you, steroids will be needed
- **Fear of topical steroids has led to prolonged disease and worse prognoses**
- Make sure treatment regimes are adhered to. Repeat appointments may be necessary to improve compliance.
- If failing to improve, consider contact dermatitis
- Antibiotic overuse is leading to resistance – they need steroids
- Early aggressive treatment leads to better prognosis
- **AQUEOUS CREAM BP IS HARMFUL TO SKIN – DO NOT USE**

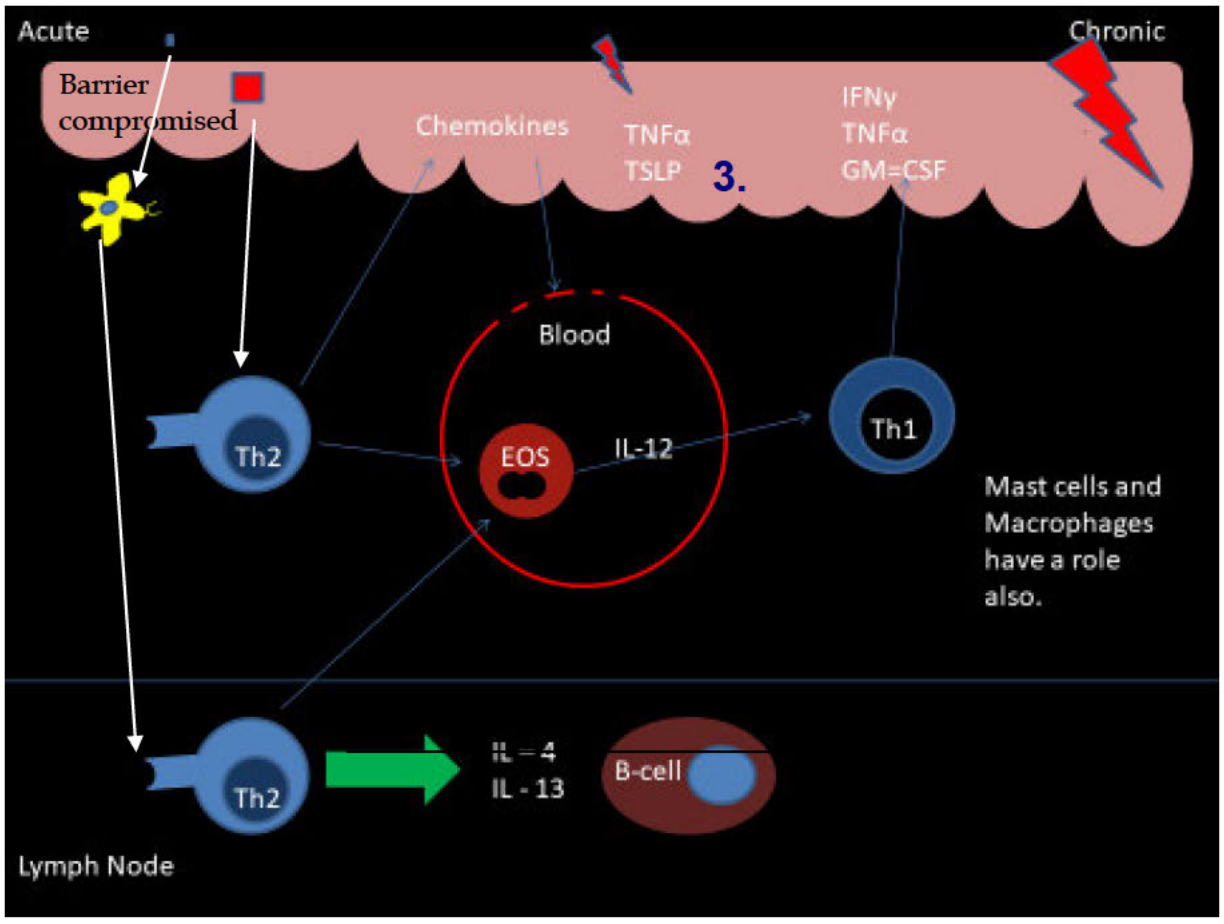
Treatments	How to use
Topical steroids a. Mild Eczema = Hydrocortisone 1% ointment b. Moderate Eczema = Eumovate® ointment c. Severe Eczema = Betnovate® ointment or Elocon® ointment d. Very severe, thickened or Hand Eczema = Dermovate® ointment	Apply to red areas OD for 4 weeks Then every other day for 4 weeks Then maintain at two days a week only Increase to daily during flare ups and wean down to 2 days a week when better **The biggest side effect of topical steroids is lack of use**
Soap substitutes a. Dermol® 500 lotion b. Hydromol® ointment c. Epimax® ointment d. Cetraben® ointment e. Doublebase® wash	Use in shower like soap. It will not lather. Advise patients it still cleans to an adequate level even if it does not give that raw feeling soap does
Emollients a. Diprobase® cream b. Epimax® cream c. Cetraben® cream® d. Doublebase® gel e. Hydromol® ointment f. Liquid paraffin 50% in WSP	Apply frequently, at least twice a day. After bathing/washing is a good time If skin is still dry, apply more frequently and/or go from cream to ointment base. The best moisturiser is the one the patient uses
Bath oil a. Dermol® 600	Low liquid paraffin bath emollients have shown to have little moisturising effect but do reduce irritation from water. Dermol® is also antimicrobial

Topical Calcineurin Inhibitors a. Protopic® ointment 0.1 or 0.03% b. Elidel® cream	Apply BD to red areas continuously for 6 months then can be reduced to three days a week if effective. Alternatively, use as maintenance once topical steroids have induced remission Warn patients about the burning and itching that comes with starting the treatment and to persist as it should improve with time in most people. Good for eyelid eczema after patch testing

There is no place for Fucidin® cream

PATHOLOGY OF ECZEMA (ILC-2 PATHWAY)

- Barrier dysfunction of skin
- Filaggrin is a structural protein in stratum corneum
- Filaggrin and other protein anomalies lead to eczema
- Barrier dysfunction leads to inflammatory response and excess IgE production
- Inflammation causes itch and worsens barrier function
- Leads on to asthma, hay fever and sometimes food allergies
- **Eczema is not an allergy**
- Other sources of barrier dysfunction causing eczema exist
- Emollients restore barrier function
- Soap substitutes prevent further barrier weakness
- Steroids reduce inflammation



More information on emollients in section 11

3. PSORIASIS

HISTORY

- Adults in 20s and 50s (commonly)
- Scaly patches on scalp, elbows and knees
- Often itchy
- Better in the sun
- Brittle nails
- Joint pains can be associated (asymmetrical)
- Risk factor for obesity, type II diabetes, cardiovascular disease and depression

EXAMINATION

- Discreet, scaly, well demarcated red patches over body
- Localised to areas of tendon insertion (eg extensors)

MANAGEMENT

- Emollients frequent enough so skin is not dry
- Soap substitutes
- High liquid paraffin bath oils if using them
- Topical steroids (long term at appropriate strength)
- Topical vitamin D analogues
- Topical calcineurin inhibitors
- Management of metabolic/cardiovascular association

WHEN TO REFER

- Treatment failure
- Erythroderma (>70% of body affected)
- Psoriatic arthritis (to rheumatology)

CAUTION

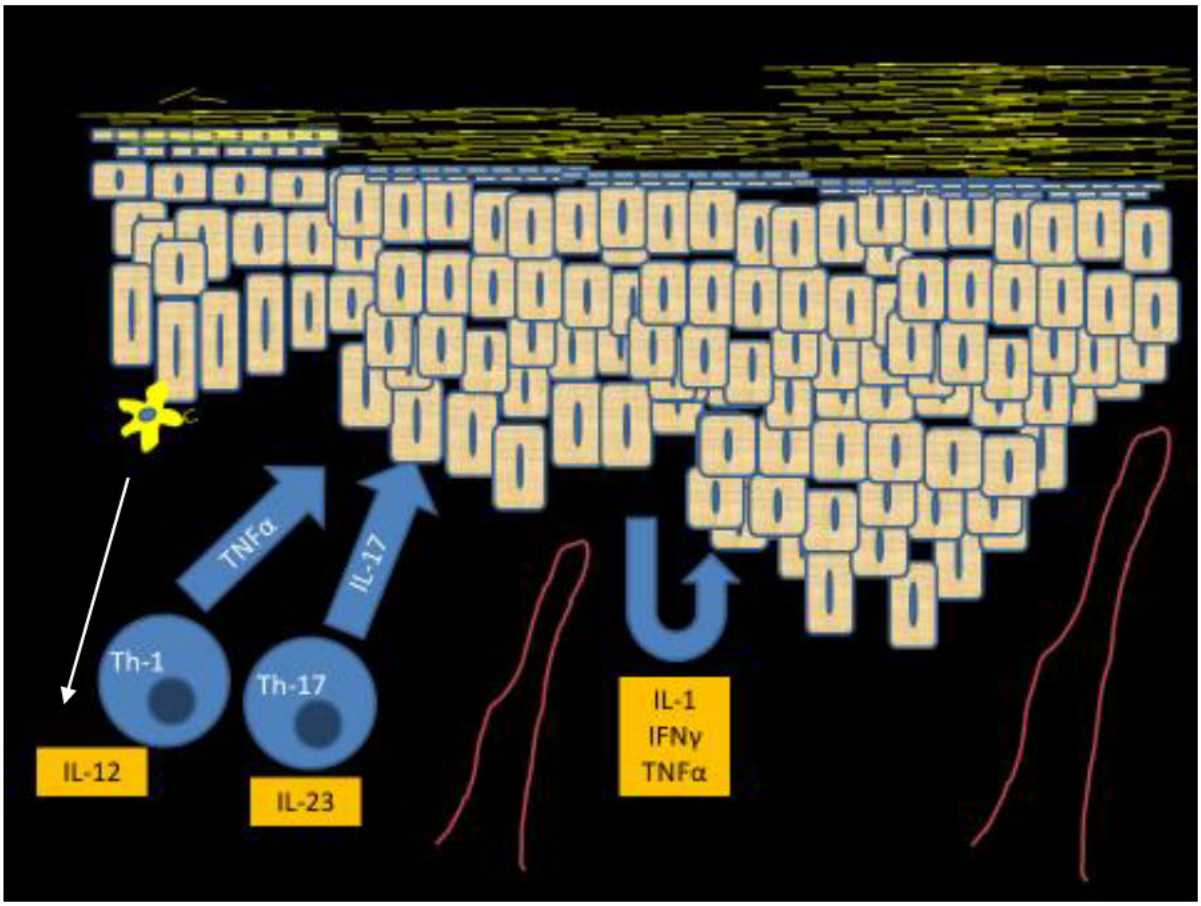
- Make sure treatment regimes are adhered to. Repeat appointments may be necessary to improve compliance.
- Psoriatic arthritis can be mutilating and destructive – refer early
- Stopping topical steroids suddenly causes a rebound flare

Treatments	How to use
Vitamin D analogue/Steroid combination a. Enstillar (Dovobet) ® Foam b. Dovobet® Gel c. Dovobet® Ointment d. Wynzora® cream	Apply to plaques OD for 4-6 weeks to control psoriasis then switch to vitamin D analogue alone as maintenance. Switch back to this during flare ups Not to be used >30% body surface area. In this case use topical steroids alone.
Vitamin D analogue alone a. Dovonex® b. Silkis® c. Curatoderm®	Apply OD to plaques when not using steroid combination. Can be used also with separate topical steroid to make own combinations
Topical steroids a. Facial/Eyelid = Hydrocortisone 1% ointment b. Guttate/widespread = Eumovate® ointment c. Severe widespread = Betnovate® ointment or Elocon® ointment d. Hand/Foot Psoriasis = Dermovate® ointment e. Thick, scaly plaques – Diprosalic® ointment	Use in combination with Vitamin D analogue or on own in wide areas. **CAUTION** in stopping steroids to quickly as it causes a rebound. Always wean down. Diprosalic® can be used in short bursts to reduce thickness before more standard treatments
Topical Calcineurin Inhibitors c. Protopic® ointment 0.1 or 0.03%	Good for facial psoriasis

d. Elidel® cream	
Topical salicylates a. Cocois® b. Sebco®	Breaks down thick areas of scalp for Dovobet® gel to get in to areas. Apply overnight and shampoo out in morning
Soap substitutes f. Dermol® 500 lotion g. Hydromol® ointment h. Cetraben® ointment i. Epimax® ointment j. Doublebase® wash	Use in shower like soap. It will not lather. Advise patients it still cleans to an adequate level even if it does not give that raw feeling soap does
Emollients g. Diprobase® cream h. Cetraben® cream® i. Doublebase® gel j. Epimax® Cream k. Hydromol® ointment l. Liquid paraffin 50% in WSP	Apply frequently, at least twice a day. After bathing/washing is a good time If skin is still dry, apply more frequently and/or go from cream to ointment base. The best moisturiser is the one the patient uses

PATHOLOGY OF PSORIASIS (ILC-1 PATHWAY)

- Immune activation of T cells (likely from Langerhans cells)
- Causes stimulus to excessive healing in skin
- Skin grows rapidly (hyperkeratosis)
- Recruits white cells to fight perceived infection (inflammation)
- Increase blood supply for healing (redness)
- Barrier function is compromised
- Much of what we treat is secondary eczema



4. LEG ULCERS

HISTORY

- Full thickness loss of epidermis on lower limb
- Venous ulcer
  - Chronic, indolent course
  - Painless (mostly)
  - Chronic oedema
- Arterial ulcer
  - Painful
  - Peripheral vascular disease
  - Numb
- Diabetic ulcer
- Pyoderma gangrenosum
  - History of trauma
  - Blister that has burst
  - Can be associated with IBD

EXAMINATION

- Venous ulcer (figure 4a)
  - Shallow ulcerated area
  - Often in gaiter and other venous areas
  - Feet warm and oedematous
- Arterial ulcer (figure 4b)
  - Deep, punched out ulcer
  - Can be black
  - Feet cold, reduced pulses
- Pyoderma gangrenosum (figure 4c)
  - Purple (violaceous) edge
  - Undermined

MANAGEMENT (see flow chart)

- Seek help from community tissue viability nurses
- Venous ulcer
  - Non adherent dressings
  - Treat associated eczema
  - Compression (after ankle brachial pressure index)
  - If oedematous, consider changing anti-hypertensives if on calcium channel blockers to diuretics
- Arterial ulcer
  - Referral to vascular service
- Diabetic ulcer
  - Podiatry services
  - Could require combination of above treatments
- Pyoderma gangrenosum
  - Superpotent topical steroids at edges daily
  - AVOID ANY SURGICAL INTERVENTION

WHEN TO REFER (see flow chart)

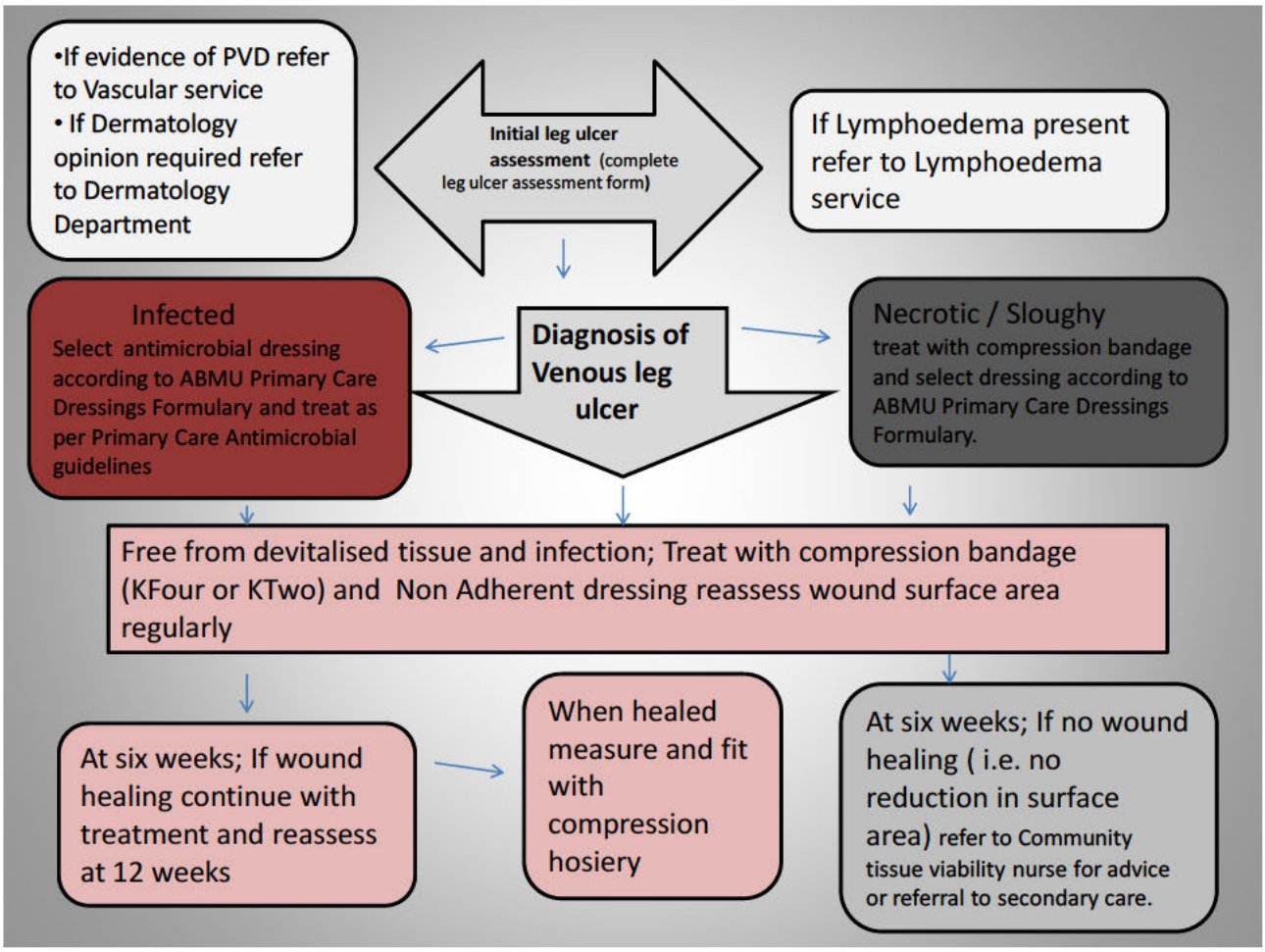
- Treatment failure
- Community tissue viability nurses can help here
- Refer to lymphoedema if present
- Refer to vascular if evidence of peripheral vascular disease
- Refer to podiatry in cases of diabetic ulcers
- Refer to dermatology if pyoderma gangrenosum

CAUTION

- Cellulitis (temperature and infective symptoms)
- Necrotising fasciitis (hard, woody texture)
- Surgical debridement in pyoderma gangrenosum

- Compression in presence of peripheral vascular disease

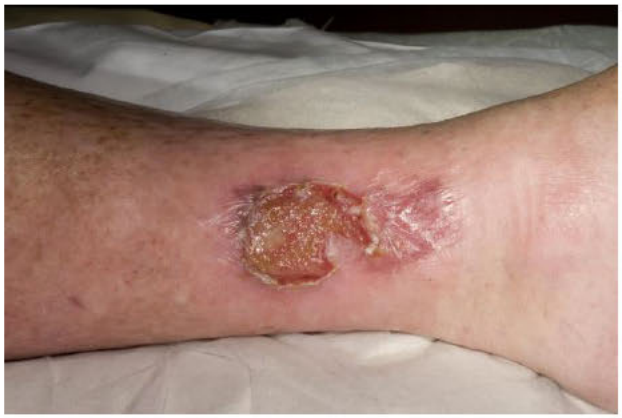
LEG ULCER FLOW CHART



Further information is available from the tissue viability section of COIN

Further information about diabetic ulcers can be found here:

http://howis.wales.nhs.uk/sites3/Documents/926/CID70%20Diabetic%20Foot%20Guideline%20-%20April%202018.pdf



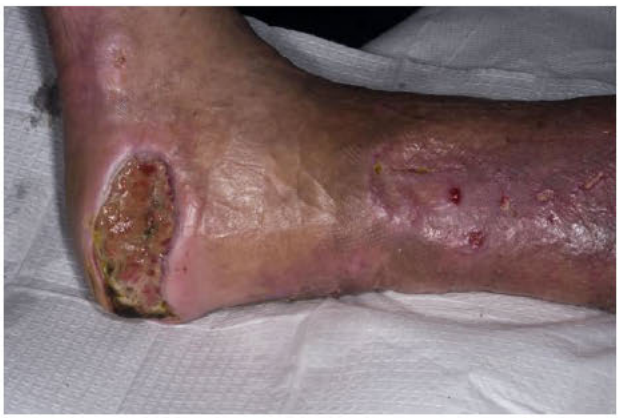
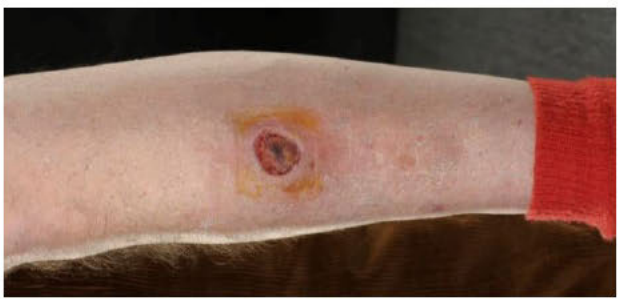


Figure 4a (top left) – Venous ulcer

Figure 4b (top right) – Arterial ulcer

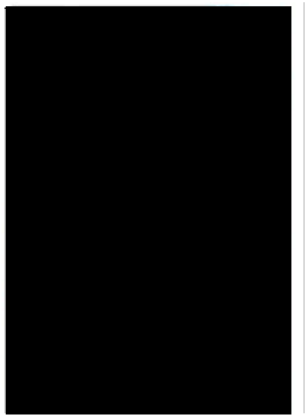
Figure 4c (bottom) – Pyoderma gangrenosum



5. ACNE

HISTORY

- Red spots over cheeks, jawline, forehead and sometimes trunk
- Often in teenage years
- May have scarring
- May have body image issues



EXAMINATION

- Whiteheads (closed comedones)
- Blackheads (closed comedones)
- Scarring (where old spots have been)
- Cysts and nodules (very severe cases)

MANAGEMENT

- Topical therapy - can be used long term (see table)
  - Benzoyl peroxide BD – slowly increase concentration to avoid irritation
  - Topical retinoids BD (adapalene, isotretinoin)
  - Azaleic acid BD
  - Antibiotics – Clindamicin, Erythromicin
  - Combination therapies also available
- Systemic antibiotics – typically 6 month courses. Change if no effect > 3 months
  - Should be combined with topical, non-antibiotic treatments
  - Tetracyclines (not minocycline)
    - Lymecycline 408mg OD, Doxycycline 50-100mg OD
  - Erythromicin (if tetracyclines contraindicated)
    - 500mg BD
    - 1000mg BD in severe cases
- Oral contraceptive – in addition to above or in combination with above
  - Dianette® - discontinue 3-4 cycles after acne resolves
  - Useful in jawline acne

WHEN TO REFER

- Treatment failure
- Isotretinoin is needed
  - Please give British Association of Dermatologists leaflet
  - Please check FBC, U&E, LFT and Fasting lipids
  - For female patients, start oral contraceptive
  - Referral proforma data:
  - https://cdn.bad.org.uk/uploads/2023/10/Acne-primary-care-referral-proforma.pdf

CAUTION

- Do not use topical retinoids in pregnancy
- Do not use tetracyclines in pregnancy
- Feverish, severe acne and joint pain – consider acne fulminans (urgent case)
- Despite our best efforts, MHRA guidelines are still in place – please include proforma data

PATHOLOGY OF ACNE

- Excess skin growth in apocrine areas (facial convexities, axillae, groins)
- Increased activity of apocrine glands
- Causes blockage of skin appendages
- Leads to inflammatory reaction
- Management is to
  - Reduce inflammation (ribosomal antibiotics)
  - Reduce cellular turnover (retinoids)
  - Reduce apocrine activity (combined oral contraceptives)

6. ROSACEA

HISTORY

- Red areas on convex surfaces of face
- Easy flushing
- Thread veins
- Yellow spots
- Altered texture of skin
- Made worse by heat, sunlight, alcohol and spicy foods

EXAMINATION

- Erythematotelangectatic rosacea (no pustules)
- Papulopustular rosacea (yellow spots come and go)
- Phymatous rosacea (dimpled, bulbous skin changes)
- Occular rosacea (sore, gritty red eyes)

MANAGEMENT

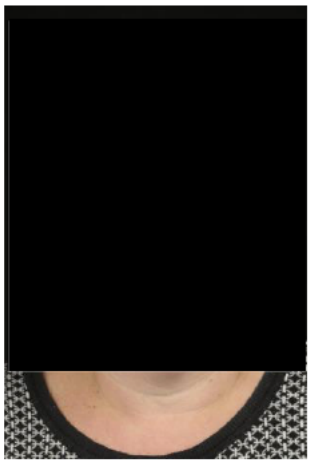
- Erythematotelangectatic rosacea
  - Sunblock and avoid triggers of flushing
  - Topical metronidazole BD (Rozex®
  - Topical brimonidine PRN (Mirvasso®)
  - Topical ivermectin OD for 4 months (Soolantra®)
  - Topical azaleic acid BD (Finacea®)
  - Doxycycline 50mg OD
  - Erythromicin 500mg BD
- Papulopustular rosacea
  - As above
- Phymatous rosacea
  - As above but refer for surgical intervention when needed
- Occular rosacea
  - Ophthalmology opinion needed

WHEN TO REFER

- Treatment failure
- If isotretinoin needed (very rarely)
- Occular rosacea (to ophthalmology)
- Severe phymatous rosacea (to plastic surgery)

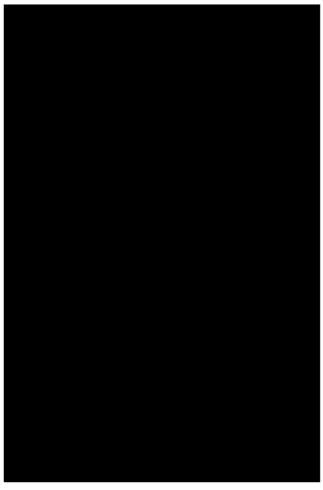
CAUTION

- Advise about rebound flushing when using Mirvasso®
- Painful red eye is an emergency (possible acute closed angle glaucoma)



Left: Papulopostular rosacea

Right: phymatous rosacea affecting the nose (also called rhinophyma)



7. CONTACT DERMATITIS

HISTORY

- Localised dermatitis (eczema)
- Occurs 1-2 days after exposure
- Possible trigger identified
- Worse when at work (healthcare)
- Worse when away from work (fragrances)
- Worse on holiday
- Dermatosis not resolving with standard treatment
- **Not anaphylaxis or hives**

HAND ECZEMA ADVICE BOX

- No soap
- Dermol 500 as soap subsitiue (has anti-COVID action)
- Prescribe cream moisturiser as well (eg Cetraben®, Diprobase®)
- Moisturise after every wash
- Frequent moisturising between
- Dermovate® cream at **NIGHT**
  - Every night 4 weeks
  - Every other night 4 weeks
  - Then 3 nights a week
- Refer for patch testing

EXAMINATION

- Localised dermatitis
- Red, itchy skin in defined areas
- Hands, face, legs
- Eyelid eczema
- Anogenital eczema

MANAGEMENT

- Refer for patch testing
- If hands affected
  - Dermol 500 to wash, Dermovate® oint at night, regular moisturiser

WHEN TO REFER

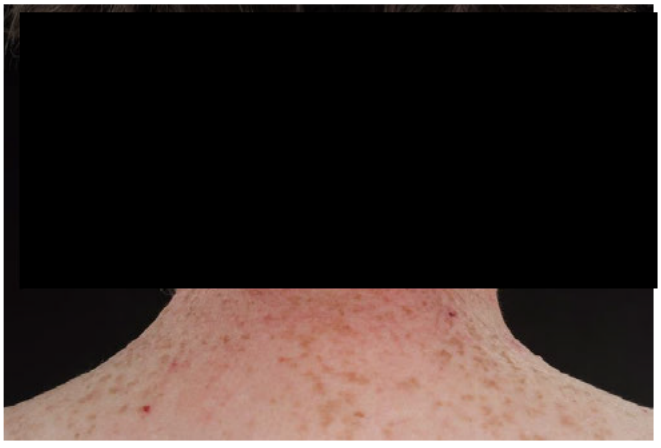
- Localised dermatitis
- Eyelid dermatitis
- Dermatitis not resolving with usual therapies

CAUTION

- Patch testing for contact dermatitis is contraindicated in pregnancy
- Several studies have identified patch testing is **underutilised**
- A separate clinic exists for food allergy

PATHOLOGY OF CONTACT DERMATITIS

- External agent (e.g. metals, fragrances or preservatives) touches skin
- Part of the agent diffuses through the skin
- Agent is phagocytosed by a professional antigen presenting cell (e.g. Langerhans cell)
- Agent is digested and presented on MHC class II molecule
- Langerhans cell migrates to lymph node where it presents to T-cells
- If T-cell recognises the substance it multiplies and migrates to the skin
- An immune response is mounted at site of agent in skin
- Results in a localised dermatitis



8. VIRAL WARTS

HISTORY

- Painless growth on any body site
- More soft on mucosal surfaces
- Can be sore to walk on, on feet (verrucae)
- Sexual transmission possible

EXAMINATION

- Bumpy, hard, thickened skin
- Discrete papules or nodules
- Can have black dots within them

MANAGEMENT

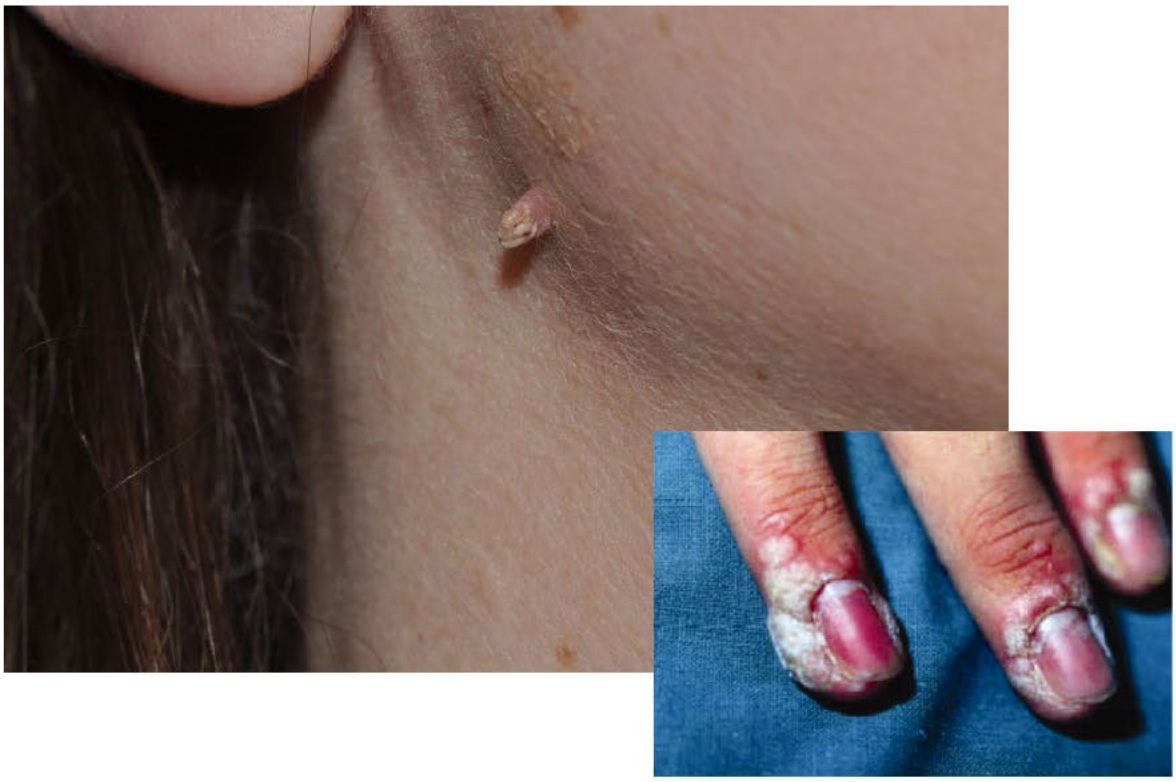
- **NO GOOD TREATMENTS EXIST FOR WARTS**
- **>200 TREATMENTS HAVE BEEN DOCUMENTED**
- Wait – they eventually go with time (years)
- Filing down hard surfaces will help (especially on feet). This has the best evidence
- Any other treatment is as good as another

WHEN TO REFER

- **Never** – we do not have any other treatment options

CAUTION

- Over the counter freezing products are a waste of money
- Rapid, painful change could indicate squamous cell carcinoma
- Advise immunosuppressed patients to watch for changes



Viral warts

9. MOLLUSCUM CONTAGIOSUM

HISTORY

- Pearly spots appearing on body
- Spreading over many areas
- May be atopic history
- Often young children

EXAMINATION

- Small, pearly white papules
- Central dimple (umbilicated)
- Scattered distribution
- Mildly itchy
- Patient often well otherwise

MANAGEMENT

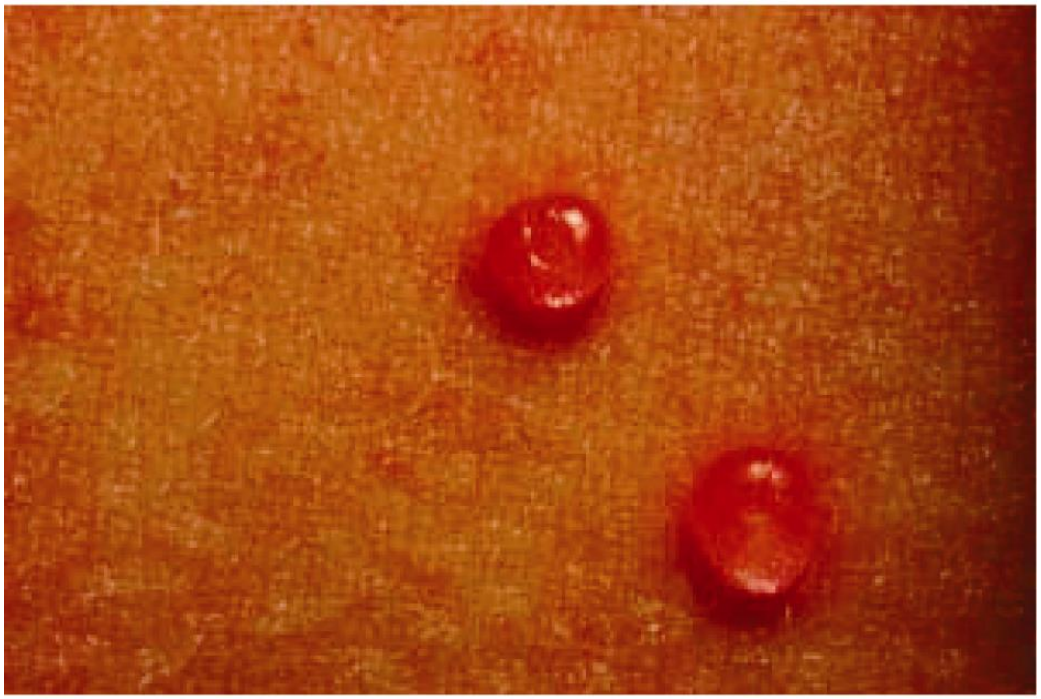
- Wait – self limiting pox virus infection
- Often spontaneously resolves after 24 months
- Scratching may spread further but may also increase immune response
- Emollients can help with itch

WHEN TO REFER

- Never

CAUTION

- Molludab® is licensed for lesions but is potassium hydroxide – will worsen eczema. We do not recommend this.
- Cryotherapy is very painful to children (and adults) and can leave permanent marks



Molluscum contagiosum

10. URTICARIA

HISTORY

- Itchy rash
- Raised, nettle rash like
- Comes and goes, moving to different areas
- Individual lesions do not last >24 hours
- Leaves no mark when faded
- Made worse by alcohol, sudden temperature change, spicy foods, opioids and NSAIDS

EXAMINATION

- Raised, red/white bumpy areas over body
- Sites of pressure/scratching may show signs
- Can be transient
- Scratching induces rash (dermographism)

MANAGEMENT

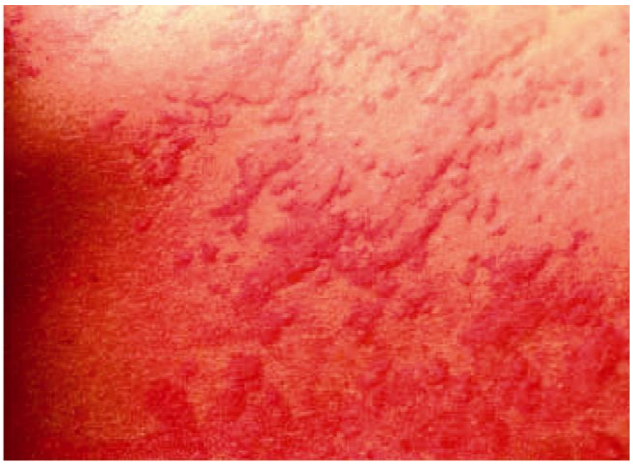
- Stepwise increase in management
- If very infrequent – cetirizine 10mg PRN
- Otherwise:
- Step 1
    - Avoidance of exacerbating factors (alcohol, benzoate spices, NSAIDS, Opiods)
    - H1 antihistamine OD (**Loratadine 10mg, Cetirizine 10mg, Fexofenadine 180mg**)
- Step 2
    - Increase H1 antihistamine to BD, TDS or QDS as needed to control symptoms
- Step 3
    - Add **montelukast 10mg OD**
- Treatment aim is to control **symptoms**
- Once symptoms controlled, maintain therapy for 6 months at a time
- If symptoms controlled, **20-30mg prednisolone OD for 3 days** can be given as breakthrough therapy

WHEN TO REFER

- Treatment failure at maximum therapy
- Frequent breakthrough doses required

CAUTION

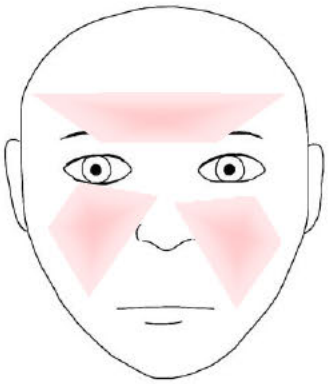
- Mistaking for allergy – most urticaria is not allergic in origin but is idiopathic
- Check for symptoms/signs of anaphylaxis (throat swelling, dizziness, dyspnoea)



Urticaria

11. SEBORRHOEIC DERMATITIS

HISTORY



- Facial scaly rash
- Associated dandruff
- Worse in sunlight
- Infant to 12/12, adolescent or 30-60
- Can be itchy
- 3% population (more in immunosuppressed)
- Associated with Parkinson's Disease

EXAMINATION

- Scaly red rash in forehead, eyebrows, cheeks
- Correspond to apocrine (sebaceous) gland areas
- Affects nasolabial folds (very few rashes do this)
- Can be shiny – dandruff visible often

AETIOPATHOLOGY

- Multifactorial and not conclusive
- Decreased saturated fatty acids on skin increasing concentration of unsaturated fatty acids
- Unsaturated fatty acids diffuse into epidermis separating layers due to bend in hydrocarbon tail causing barrier dysfunction (eczema)
- Yeast may be consuming saturated fatty acids disproportionately
- Host sebaceous gland secretion may favour unsaturated fatty acid secretion

MANAGEMENT

- Antifungal treatment
  - Ketoconazole shampoo 2 days a week – rub into wet scalp for 5 minutes then wash out
- Anti-inflammatory treatment
  - Tar based shampoos (Capasal®, Alphosyl®)
  - Hydrocortisone cream OD for 4 weeks
  - Hydrocortisone/(miconazole or clotrimazole) combination BD for 4 weeks
  - Elidel cream BD continuous

WHEN TO REFER

- Treatment failure at maximum therapy
- Diagnostic uncertainty

CAUTION

- Differentials – contact dermatitis, discoid lupus, dermatomyositis
- Consider HIV status in treatment resistant cases
- Take scrapings to confirm diagnosis if needed – should grow *Malasezzia furfur*

12. EMOLLIENT SUMMARY

THE BEST MOISTURISER IS THE ONE THE PATIENT LIKES USING

Large amounts of moisturiser need to be prescribed in order to restore the barrier function of the skin. They work by preventing water leaking out of damaged skin. Hence, greasiest moisturisers are best but not always best tolerated.

BATH ADDITIVES

- Effectiveness doubted in recent studies
- High light liquid paraffin (LLP) content ones may be beneficial

Examples:

Dermol® 600 bath oil (25% LLP)	£7.55/600ml
QV® (85.09% LLP)	£4.79/500ml

LOTIONS

- Useful for washing
- Too watery for moisturising dry skin

Examples:

Dermol® 500 lotion (antibacterial)	£6.04/500ml
Aveeno® lotion	£6.66/500ml
Cetraben® lotion	£5.64/500ml

GELS

- Greasier than creams, not as greasy as ointments. Do not contain as many preservatives

Examples:

Doublebase® Gel	£5.83/500g
AproDerm® Gel	£3.99/500g

CREAMS

- Paraffin based

Examples:

Epimax® cream	£2.49/500g
Cetraben® cream (LP 105mg/g WSP 132mg/g)	£5.99/500g
Diprobase® cream	£6.35/500g
Oilatum® cream (LP 60mg/g WSP 150mg/g)	£5.28/500g
Zerocream® (LP 126mg/g WSP 145mg/g)	£4.08/500g

- Glycerin based

Examples:

Aveeno® cream	£7.19/500g

- Urea containing (for keratolysis and pruritus)

Examples:

Balneum® cream	£9.97/500g
Calmurid® cream	£33.40/500g

OINTMENTS

- Greasiest of moisturisers.

Examples:

Fifty:50 (WSP 950mg/g)	£3.65/500g
Hydromol® ointment (YSP 300mg/g)	£4.89/500g
Can also be used as a wash	
Epimax® ointment	£4.99/500g
Can also be used as a wash	

13. PATIENT SUPPORT GROUPS

British Association of Dermatologists: Dermatology Patient Support Groups Poster

This contains an alphabetical listing of national, regional and local patient support groups for those suffering from skin disease. These groups are often run by volunteers who suffer from the disease themselves, and many patients find it enormously valuable to have such contact with others both for support and for practical help. They also often support research efforts.

Additional Support Groups not contained within this listing:

Macmillan Cancer Support
Tel: 0808 808 0000 (Monday–Friday, 9am-8pm)
Website address: www.macmillan.org.uk

Skin Care Cymru
Website address: www.skincarecymru.wales

Skin Care Swansea Bay
This is a patient support group affiliated with Swansea Bay University Health Board