



Dermatology Referral Advice

SWANSEA BAY SECONDARY CARE PRACTICE

INTRODUCTION

PRIMARY CARE GUIDELINES ALSO EXIST FOR YOUR PERUSAL

The purpose of this document is to allow a more collaborative working between our dermatology department and other secondary care specialties. Within it are contact details, advice for referrals and management plans for when dermatologists are not available. Clinics and theatre lists run in every weekday session in Singleton Hospital and Neath Port Talbot Hospital including Friday afternoon. It can take 45 minutes to an hour to get to Morriston in afternoon traffic and we do not do on call. If this document helps to reduce referrals, it will reduce the impact on the day to day service when seeing referrals.

We do not wish to stop people making referrals. We would simply like to make use of our service more efficient. This is not a fixed document and suggestions for change or cases to include would be welcome.

Advice on emergency cases can be found here and more general advice on common dermatology conditions and treatments can be found on the **PRIMARY CARE GUIDELINES**.

CONTENTS

	Page
Contact Details	2
Making Referrals	3
Urgent Cases	5
• Erythroderma	5
• Blistering Disorders	6
• Toxic Epidermal Necrolysis	7
• Drug Reactions	8
Topical remedies	9
Non urgent cases	10
Paediatric cases	10
ITU Cases	10

CONTACT DETAILS

SINGLETON HOSPITAL

Covers patients in and from Swansea

CONSULTANTS

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

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

SECRETARIES

SINGLE NUMBER TO CONTACT

01639 875714

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

REGISTRARS

SpR 2
SpR 3

[REDACTED]
[REDACTED]

NEATH AND PORT TALBOT HOSPITAL

Covers patients in and from Neath, Port Talbot

CONSULTANTS

Dr. Avad Mughal

[REDACTED]
[REDACTED]

SECRETARIES

SINGLE NUMBER TO CONTACT

[REDACTED]

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

REGISTRARS

SpR 1

46011

DON'T FORGET THAT ADVICE IS ALSO AVAILABLE ON THE PRIMARY CARE GUIDELINES. FEEL FREE TO USE THEM ALSO.

MAKING REFERRALS

All referrals need to be made at **consultant level**. If when a consultant has seen the patient they wish to ask one of their junior team to actually make the referral, that is fine but the decision need to be made by the consultant. Ideally, the consultant should make contact with the receiving consultant. All referrals must state the named consultant.

1. DOES THIS NEED TO BE SEEN AS INPATIENT?

YES	NO
Erythroderma Toxic Epidermal Necrolysis New onset rash not resolving Widespread Blistering Uncertain diagnosis and unwell Clinical concern (gut feeling)	Stable, chronic conditions Mild complaint, stable patient Patients being discharged Skin lesions (lumps and bumps)

If yes to the above question, go to 2.

2. DOES THIS NEED TO BE SEEN URGENTLY?

- If the patient is **unwell**
- Condition **worsening**
- Standard treatments **not working**
- Clinical **concern** – Your experience as a **consultant** is a valuable tool in deciding if this patient needs to be seen urgently or not. We would trust that judgement.

All **URGENT** referrals need to be supporting by a telephone discussion with the **receiving consultant** for patient safety. This is in line with **Health Board Policy (since 2002)**.

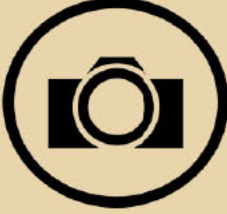
3. WHO SHOULD I CONTACT?

Identify the area the patient comes from. If they are a patient under the care of a dermatology team already with a chronic condition, it is best to call the team already looking after them.

4. HOW SHOULD I MAKE THE REFERRAL?

- **Call** the registrar first and provide the patient details, nature of condition, urgency of referral, name of referring consultant and name of referrer with bleep/phone number.
- If an urgent referral, after giving details, ask to be put through to the receiving consultant
- **Email** referral letters are acceptable for **non-urgent** cases.
- If handing over to another team, inform the next team a dermatology referral has been made and inform us of the new contact details
- **The referral is the responsibility of the doctor making the referral until seen by the receiving team**
- **IF A PATIENT WAITING TO BE SEEN IS DISCHARGED – ALWAYS INFORM US IMMEDIATELY**

Photography



In all cases, medical photography can be used to support a referral. This can be done by the medical photography department and sent to the email address of the receiving consultant. The medical photography department have our email addresses and can support this.

REMEMBER TO ENSURE PERMISSIONS ARE GRANTED FOR US TO SEE THE IMAGES

URGENT CASES

ERYTHRODERMA

PRESENTATION

- Red, inflamed skin covering most of body
- Can be dry, flaky
- Can be weepy
- Itchy and painful

CAUSES

- Chronic skin conditions – worsened
- Eczema
- Psoriasis
- Pityriasis rubra pilaris
- Staphylococcal scalded skin syndrome

INVESTIGATIONS

- Skin swab for infection

MANAGEMENT

- General supportive measures
 - Fluid balance, pain management, temperature
- Greasy topical moisturisers
 - Liquid paraffin 50% in white soft paraffin QDS or more all over
 - **NEVER USE AQUEOUS CREAM BP** ❌
 - **NEVER USE CALAMINE LOTION** ❌
- Topical steroids (potent or above)
 - Betamethasone valerate ointment OD on red areas
- Antibiotics as needed
- Chlorphenamine (Piriton) will not work

WHEN TO REFER

All erythrodermic patients should be referred urgently. However, if the above management is implemented then after 2 days, there may be such a significant improvement that they no longer need to be seen as an inpatient

CAUTION

Make sure the topical remedies are applied. Treatment failure is most often due to lack of compliance by staff.

BLISTERING DISORDERS

PRESENTATION

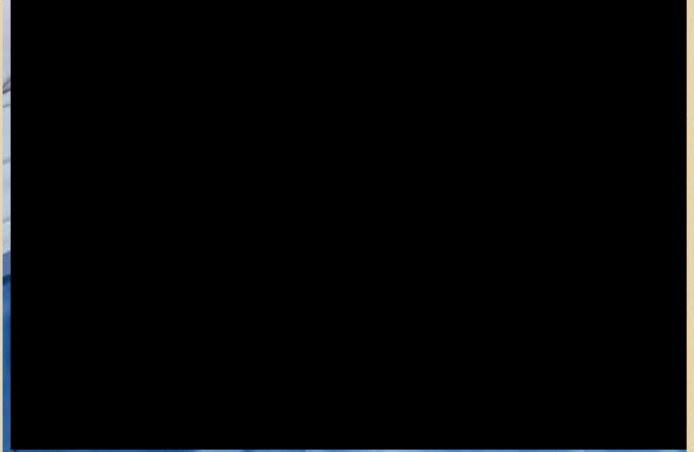
- Fluid filled lesions on skin
- De-roofed, raw areas of skin with loose skin around
- Associated blisters inside mouth
- Can be localised (lower limbs/extensor)
- Can have red background

CAUSES

- Bullous pemphigoid
- Pemphigus vulgaris (very rare)
- Secondary to oedema (lower limbs)

NON-URGENT

- Infection (bullous impetigo – especially in children)
- Linear IgA bullous disease (can be secondary to vancomycin)
- Dermatitis herpetiformis (extensor surfaces)



INVESTIGATIONS

- Pemphigus and pemphigoid antibodies
- Skin swabs
- Anti TTG (if suspecting dermatitis herpetiformis)

MANAGEMENT

- Always pop blisters – prevents increase in plane of dissection
- Dress with inadine
- If oedema associated, elevate and compress
- Topical clobetasol **propionate** (Dermovate oint) if autoimmune
- Systemic steroids (after discussion with dermatology)

WHEN TO REFER

- If not caused by oedema, needs urgent referral
- Discuss with dermatology, best to be seen in urgent outpatient appointment
- If caused by oedema, may be managed conservatively

CAUTION

- Left untreated these can spread and be a site for infection such as cellulitis.

TOXIC EPIDERMATL NECROLYSIS

PRESENTATION

- Sores in mucosal surfaces
- Skin peeling and shedding over large areas
- History of new drug started within 28 days
 - Antiepileptics, allopurinol, antibiotics, NSAIDS (could be any)
- Generally unwell
- Thankfully, rare

CAUSES

- Drug hypersensitivity reaction

INVESTIGATONS

- As for acutely unwell patients (include bicarbonate)
- Skin biopsy

MANAGEMENT

- **Immediate transfer to burns unit**
- **Withdraw offending drug (if known)**
- Peripheral IV lines over central
- Minimal manipulation
- Fluid balance
- Analgaesia
- Ophthalmology and anaesthetic review

WHEN TO REFER

- **Always**

CAUTION

- **High risk of death**
- **Act quickly**

ECZEMA HERPETICUM

PRESENTATION

- Widespread facial (sometimes other) vesicles, painful
- Patient has atopic eczema and contact or has cold sores
- Rapid spread
- Secondary impetigenisation (yellow pus/crusting)
- Can have ocular involvement

CAUSES

- Herpes simplex virus on background of atopic eczema

INVESTIGATION

- Dry swab for HSV PCR
- Send red swab or just tip of black one in universal container

MANAGEMENT

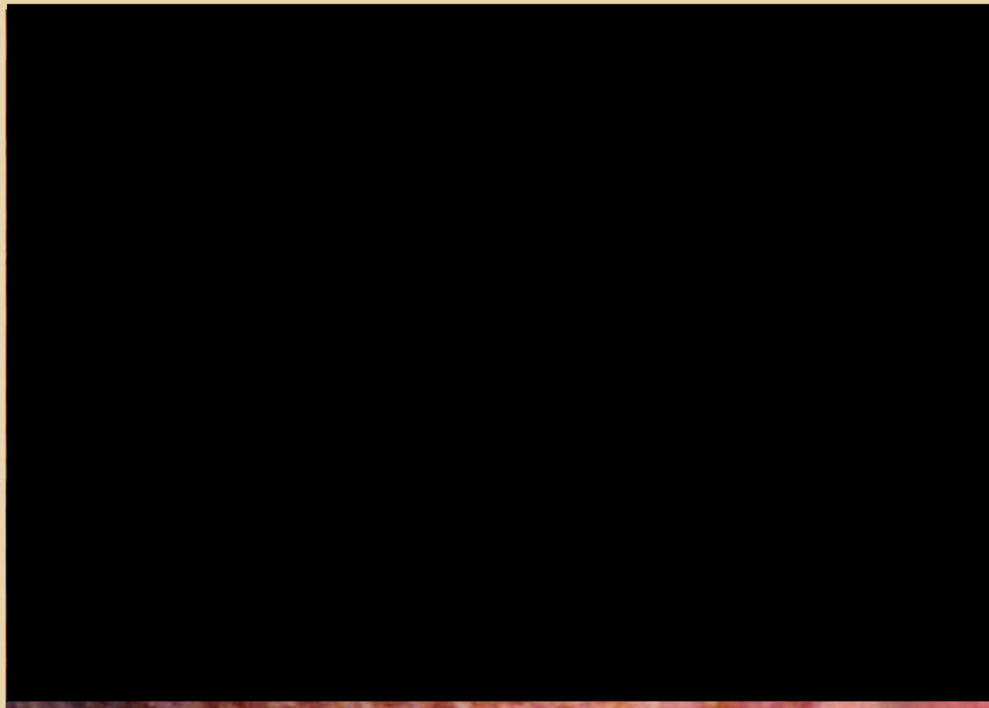
- Aciclovir 400mg TDS for 5 days

WHEN TO REFER

- If severe
- Consider ophthalmology if eyes involved

CAUTION

- Corneal ulceration



DRUG REACTIONS

PRESENTATION

- **Varies widely**
-
- Widespread, red, bumpy rash that is itchy with associated eosinophilia (Type IVb)
- Immediate urticarial weals over body (Type I)
- Toxic epidermal necrolysis (Type IVc)
- Widespread pustules all over body (Type IVd)
- Idiosyncratic reactions

CAUSES

- Could be any drug in the last 28 days (Type IV reactions)
- Drug given in last 60 minutes (Type I reactions)
- Drug identification based on history

INVESTIGATIONS

- Eosinophil count
- General investigations

MANAGEMENT

- **Stop offending drug (if known)**
- General supportive measures
- Type IVb
 - Topical clobetasol proprionate on red areas OD
 - Liquid paraffin 50% in White Soft Paraffin QDS all over
 - Make sure it is done
- Type I
 - Oral cetirizine 10mg up to QDS as needed
 - Or IV chlorphenamine if PO not available
 - IM Adrenaline if anaphylaxis

WHEN TO REFER

- Rash not improving
- Systemically unwell (check for DRESS syndrome)

CAUTION

- Topical treatments not being applied (check this)
- Worsening liver function and rising eosinophils (DRESS syndrome)

TOPICAL REMEDIES

PRINCIPLES

Topical drugs get to where they are needed faster than systemic ones. The biggest problem is that they are time consuming and often not applied. Sometimes patients refuse application but this is too easily recorded as an excuse.

TOPICAL STEROIDS

Use the minimum strength steroid that achieves effect. In the acute setting, potent and super-potent steroids are most often needed:

Potency	Name	Brand name
Super-potent	Clobetasol proprionate	Dermovate/Clobaderm
Potent	Betamethasone valerate Mometasone furoate	Betnovate Elocon
Moderate	Clobetasone butyrate	Eumovate
Mild	Hydrocortisone acetate	Hydrocortisone 1%

Apply once daily to red areas

EMOLLIENTS

Greasiest moisturisers are the best. In hospital, this is what should be needed. Upon discharge, less greasy cream moisturisers can be used.

Liquid paraffin 50% in white soft paraffin (50:50) should be in stock on all wards.

Class	Common brands
Ointment	50:50 Hydromol ointment Cetraben ointment
Cream	Diprobase Cream Doublebase cream Cetraben cream

Apply all over skin several times a day. If skin is appearing dry, they need to be applied more frequently.

NEVER PRESCRIBE AQUEOUS CREAM BP – IT IS HARMFUL  TO SKIN

SOAP SUBSTITUTES

- Dermal 500 lotion
- Hydromol Ointment
- Cetraben Ointment

Chlorphenamine (Piriton) only works as a sedative or for urticaria

NON-URGENT CASES

These usually do not need to be seen as an inpatient

CHRONIC CONDITIONS

- Make sure usual management is being used (applied)
- Contact team looking after patient (check area) if needed
- Call if condition exacerbates and not being discharged soon

SKIN CANCERS

- Best seen in outpatients
- If melanoma or squamous cell carcinoma, will need to have surgery
- Basal cell carcinomas can wait

PATIENTS ABOUT TO BE DISCHARGED

- It can wait for outpatients

PAEDIATRIC CASES

- Many spontaneously resolve (infective exanthema)
- If the child is well – it can wait in many cases
- Atopic eczema (see above)
- **We have a low threshold to see if required**
- **Please use this wisely (call us)**

ITU CASES

- Lack of continuity a problem
- Patients move from one area to another but progress not documented
- 50:50 ointment is a good treatment initially for all inflammatory cases
- Caution about oxygen friction
-
- **We have a low threshold to see if required**
- **Please use this wisely (call us)**

HAND ECZEMA ADVICE BOX

- No soap
- Dermal 500 as soap substitute (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



LOOK AFTER YOUR HANDS
Rinse hands after taking off gloves and apply moisturiser.