

United Lincolnshire Hospitals NHS Trust

DERMATOLOGY

A guide to services and treatments available to General Practitioners and their patients for common dermatological disorders

Third Edition

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Dermatology Patient Information sheets:

- | | |
|--|---|
| www.dermnetnz.org | - excellent & comprehensive source of information sheets |
| www.patient.co.uk | - developing UK source of patient information |
| www.bad.org.uk/patients/ | - a new source of patient information sheets |
| www.omni.ac.uk/ | - UK searchable catalogue of internet sites for health & medicine |
| www.aad.org/pamphlets/index.html - American patient information sheets | |

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Introduction.

The Dermatology Service has developed considerably since I came to Lincoln in May 1997 and published the first edition of this booklet. Although a second edition was published in 2001, there have been a number of significant developments in both the service and available treatments that make a new edition necessary. Examples are:

- One stop service – most diagnostic and therapeutic procedures are performed at the first consultation in Lincoln, Grantham and Louth. This should shortly be possible at Pilgrim.
- Phototherapy clinics at Lincoln
- Allergy (Patch) Testing – a comprehensive service, based in Lincoln
- Paediatric clinics in Lincoln and Pilgrim. To be started in Grantham in 2004
- Dermatology specialist nursing service
- Teledermatology service, now up and running, but limited roll out - speak to your PCT.
- Two week wait referral service for suspected melanoma and Squamous cell carcinoma
- GPwSI service
- Triaging referrals by PCT
- Web-based patient information sources
- New treatments such as Tacrolimus, Pimecrolimus, Dovobet® and Solaraze®.

The most important developments have been to build new facilities to treat patients with skin disease in Lincoln, Pilgrim and Grantham and to integrate the services.

Our aim is to provide a comprehensive service across the county in a Hub and Spoke arrangement so that as many specialist services as possible are available in Lincolnshire. In tandem, the peripheral clinics in Louth, Spalding and Skegness have been developed, so that most care can be provided as locally as possible.

| Hub unit | Spoke Units | Peripheral clinics |
|--|---|---|
| <i>Lincoln County</i> | <i>Pilgrim Grantham</i> | <i>Louth, Skegness, Spalding</i> |
| Outpatient Consultations (Every day) | Outpatient Consultations (Most days) | Outpatient Consultations (Alternate weeks) |
| Dermatological Surgery | Skin Surgery | Simple skin surgery (Louth) |
| Phototherapy (UVB, PUVA, TL-01) | Phototherapy (UVB, PUVA) | |
| Patch Testing – comprehensive | Patch Testing – basic in Pilgrim | |
| Specialist clinics, Incl. Multidisciplinary clinics | | |
| Inpatient beds | | |

In addition there is an ever-expanding group of General Practitioners with a Special Interest (GpwsIs) in Dermatology who are providing care more locally in the community.

The objective of this booklet is:

- to explain what diagnostic and therapeutic facilities are available
- to offer some management guidance for:
 - some of the more common dermatological disorders
 - in monitoring treatment within General Practice.

Clinical Services.

Secretarial and Administrative Bases:

Lincoln County Hospital

Dermatology Suite
Greetwell Road
Lincoln
LN2 5QY

Telephone 01522 573412 (Secretary to Dr Hepburn)
01522 573680 (Secretary to Dr Bok & Dr Hussain)
Fax 01522 573680

e-mail: Neill.Hepburn@ulh.nhs.uk
Louis.Bok@ulh.nhs.uk
Khalid.Hussain@ulh.nhs.uk

Pilgrim Hospital

Sibsey Road
Boston
PE21 9QS

Telephone 01205 442016 (Dermatology Secretary)
Fax 01205 353392
e-mail: Anne.Cook@ulh.nhs.uk

Grantham Hospital

101 Manthorpe Road
Grantham
NG31 8DG

Telephone 01476 565232 ext 4525 (Dermatology Secretary)
Fax 01476 590441
e-mail: Gillian.Howard@ulh.nhs.uk

Telephone advice.

We are very happy to provide telephone advice about clinical problems at any time - please try to contact us through our secretaries.

Emergency Referrals to Clinics.

Please try to arrange these by telephone with us directly, or via our secretaries. Please fax a referral letter, or send it with the patient.

Teledermatology service - Now operational, but limited roll out to GPs - please speak to your PCT

Hospital Admissions (Lincoln only).

An inpatient facility is available on Alexandra Ward, Lincoln County Hospital, for difficult cases. If you would like to admit a patient acutely please try to contact us first to discuss the case.

Sister Kay Shepherd coordinates all admissions. Telephone: 01522 573712
Out of hours admissions should be via the acute medical admissions unit.

Domiciliary Visits

We prefer to see patients in clinic, as we are able to offer a better service. However, we appreciate this is not always practical. Please arrange visits through our secretaries.

Facilities

Lincoln County Hospital

Outpatient consultations – every day
Inpatient beds
Phototherapy (UVB, PUVA)
Patch Testing – comprehensive
Specialist clinics – acne, phototherapy, paediatric dermatology
Dermatology Surgery - comprehensive

Grantham Hospital -

Outpatient consultations – Mon, Tues, Weds
Dermatological Surgery
Phototherapy (UVB, PUVA)
Patch Testing – basic
Specialist clinics –paediatric dermatology

Pilgrim Hospital -

Outpatient consultations – every day
Inpatient beds
Phototherapy (only UVB, PUVA)
Patch Testing – basic
Simple skin surgery (to be improved)

Louth Hospital

Outpatient consultations (Tuesdays)
Simple skin surgery

Skegness Hospital

Outpatient consultations

Johnson Hospital Spalding

Outpatient consultations

Red Cross Camouflage Service. Volunteers trained by the Red Cross run camouflage clinics each month in Lincoln, Grantham, Pilgrim and Grimsby Hospitals. Appointments should be made through the hospital dermatology secretary.

The Dermatology Team

| | |
|--|---|
| Dr Neill Hepburn | Consultant Dermatologist & Clinical Director Special interests: Contact dermatitis (including Patch testing) Phototherapy (incl. Lasers) Acne Skin cancer & dermatological surgery Infectious skin diseases and tropical dermatology Innovative methods of delivering care to patients Education & training of medical and nursing staff Patient education |
| Dr Louis Bok | Locum Consultant Dermatologist Special interests: Paediatric dermatology |
| Dr Khalid Hussain | Consultant Dermatologist (International Fellowship) Special interests: Coordination of skin cancer services |
| Dr Charles Papafio | Associate Specialist in Dermatology Special interests: Charles is a general dermatologist |
| Dr Toni Watts | Staff Grade in Dermatology Special interests: Acne Paediatric dermatology |
| Sister Kay Shepherd Telephone: 01522 573712 | Dermatology Nursing Sister (Lincoln) Special interests: Topical treatments Paediatric dermatology Drug monitoring Patch testing |
| Sister Kathy Radley Telephone: 01205 3364801 ext 3111 | Dermatology Nursing Sister (Pilgrim, part time) Special interests: Topical treatments Paediatric dermatology Wound care |
| Sister Mary Morley Telephone 01522 512512 Ext 2308 | Dermatology Nursing Sister (Lincoln and Grantham) Special interests: Skin surgery and Wound dressings. |
| Stephanie Hocknell Telephone: 01205 3364801 ext 3112 | Dermatology Staff Nurse (Pilgrim, part time) |
| Sue MacFall Dermatology Telephone: 01205 3364801 ext 3111 | Dermatology Staff Nurse (Pilgrim, part time) |
| Tracy Fisher | Dermatology Nurse (Grantham, part time) |

Mrs Val Fox
Tel 01522 573299

Phototherapy Technician (Lincoln)
Val runs the phototherapy service in Lincoln.

Clinical Assistants and GPwSIs:

| | |
|-----------------------|---|
| Dr Paul Burns | - GPwSI and Clinical Assistant in Lincoln |
| Dr David Grant | - Clinical Assistant at Lincoln |
| Dr Damien Jackson | - GPwSI at Lincoln |
| Dr Ann Woollard | - GPwSI at Alford and Clinical Assistant at Louth |
| Dr Varah | - Clinical Assistant at Pilgrim |
| Dr Lawrence Taffinder | - GPwSI and Hospital Practitioner at Pilgrim |
| Dr George Campbell | - GPwSI and Clinical Assistant at Grantham |

Timetables

The departmental timetable is on page 8.

Timetable – Dr Hepburn, Consultant Dermatologist

| | | |
|-----------|----------|---|
| Monday | am pm | Clinic – County Hospital Ward Round / Admin – County Hospital |
| Tuesday | am & pm | Clinic - Louth Hospital or (Alternate weeks) Clinic - Grantham Hospital |
| Wednesday | am pm | Clinic - County Hospital (Skin cancer clinic) Private Patients |
| Thursday | am pm | Surgery List or Complex OP clinic County Hospital (Alternate weeks) Clinical Governance / Clinical meeting, Lincoln |
| Friday | am pm | Clinic - County Hospital Admin - County Hospital |

Departmental timetable

Timetables for dermatology clinics from 12 July 2004

| Dermatologist | Monday am | Monday pm | Tuesday am | Tuesday pm | Wednesday am | Wednesday pm | Thursday am | Thursday pm | Friday am | Friday pm | Clinical Sessions |
|---------------|--------------|---------------------------------|----------------------------|----------------------------------|----------------------|---|------------------------------|-----------------|-----------------|-----------------|----------------------|
| N C Hepburn | OPD CHL | | OPD Louth / Grantham | OPD Louth/ Grantham | OPD (2ww) CHL | | Skin Sx / OPD (FU) CHL | | OPD CHL | PT AltWeeks) | 6 ½ |
| L B Bok | | OPD CHL | | Skin Sx CHL | OPD PHB | OPD PHB | OPD CHL | | OPD Grantham | OPD Grantham | 7 |
| C Q Papafio | | OPD PHB/ Skeg (alt weeks) | OPD PHB | Skin Sx PHB | | OPDPHB (Wks2,4,5) OPD Spald (Wks1,3) | OPD CHL | | | OPD PHB | 6 |
| K Hussein | | OPD CHL | Skin Sx PHB | OPD PHB | OPD (2ww) CHL | | OPD / Skin Sx CHL | | OPD PHB | | 6 |
| T Watts | OPD CHL | OPD(acne) CHL | PhotoRx/ Skin Sx CHL | | | | OPD(paeds) CHL | | | | 4 |
| CA Lincoln | | | | | Dr Burns Dr Grant | | | | Dr Jackson | | |
| CA Pilgrim | | GpwSI Dr Taffinder | | | | | Dr Taffinder Dr Varah | Dr Taffinder | | | |
| CA Louth | | | | Dr Woollard (alt weeks) | | | | | | | |
| CA Grantham | | | Dr Campbell Alt week | Dr Campbell Alt week | | | GpwSI Dr Campbell | | | | |

CHL = County Hospital, Lincoln

PHB = Pilgrim Hospital, Boston

Referral letters

It would help us if the following information were included:

- Usual patient details and telephone contact number.
- Present problem/ reason for referral.
- Precise details of treatments tried for current problem.
- Summary of relevant past events.
- Previous drug history, including idiosyncrasies. Concurrent treatments.
- It is especially helpful to know especially about Aspirin, NSAIDs and Warfarin because diagnostic biopsies and surgical procedures are often performed at the first appointment.
- Please ask patients to bring all their creams & ointments to the clinic.

PCT Referral Triage

All referrals from West Lincolnshire PCT, except those via the 2-week cancer wait or marked urgent, are subjected to triage by the PCT before they are sent on the dermatology team.

PCT Low Priority Procedures

Treatment of the following conditions is defined as a low priority by the Lincolnshire PCTs. This means it is only available on the NHS after specific approval has been granted for that patient.

- Viral warts
- Benign skin lesions
- Cosmetic procedures
- Tattoo removal
- Laser treatments

Please explain this limitation to your patients and consider alternative management strategies.

ECZEMA / DERMATITIS

Eczema (= Dermatitis) is a pattern of disease rather than a definitive diagnosis. Before embarking on treatment, the type and the cause should be identified, if possible. 'Occupation' may be responsible not only for providing a contact allergen, but also for exacerbating a constitutional eczema.

Clinical patterns of eczema:

Asteatotic (dry)
Atopic
Contact allergic
Contact irritant
Discoid
Seborrhoeic
Varicose
Vesicular (pompholyx)

In addition the eczema may be:

acute
or
chronic

Treatment Scheme

Principles

- **Education**
- **Emollients + Topical Steroids**
Almost all patients with eczema will require emollients (to deal with the defective skin barrier and counteract the dryness) and a topical steroid (to stop the inflammatory process). Try to use ointments.
- **Infection / Bacterial colonisation**
A common aggravating factor, which may explain a sudden deterioration.
The presence of bacteria can also reduce the response to a topical steroid.
Treat it with topical and / or systemically if widespread.
- **Occlusive Dressings**
Are valuable techniques in intractable cases, but require motivation and training.
There are 3 techniques: impregnated bandaging, ointment dressings and wet wraps.
They should only be used during exacerbations.
- **Secondary / Systemic treatment**
Prednisolone, azathioprine, ciclosporin A & topical immunomodulators.

What's new?

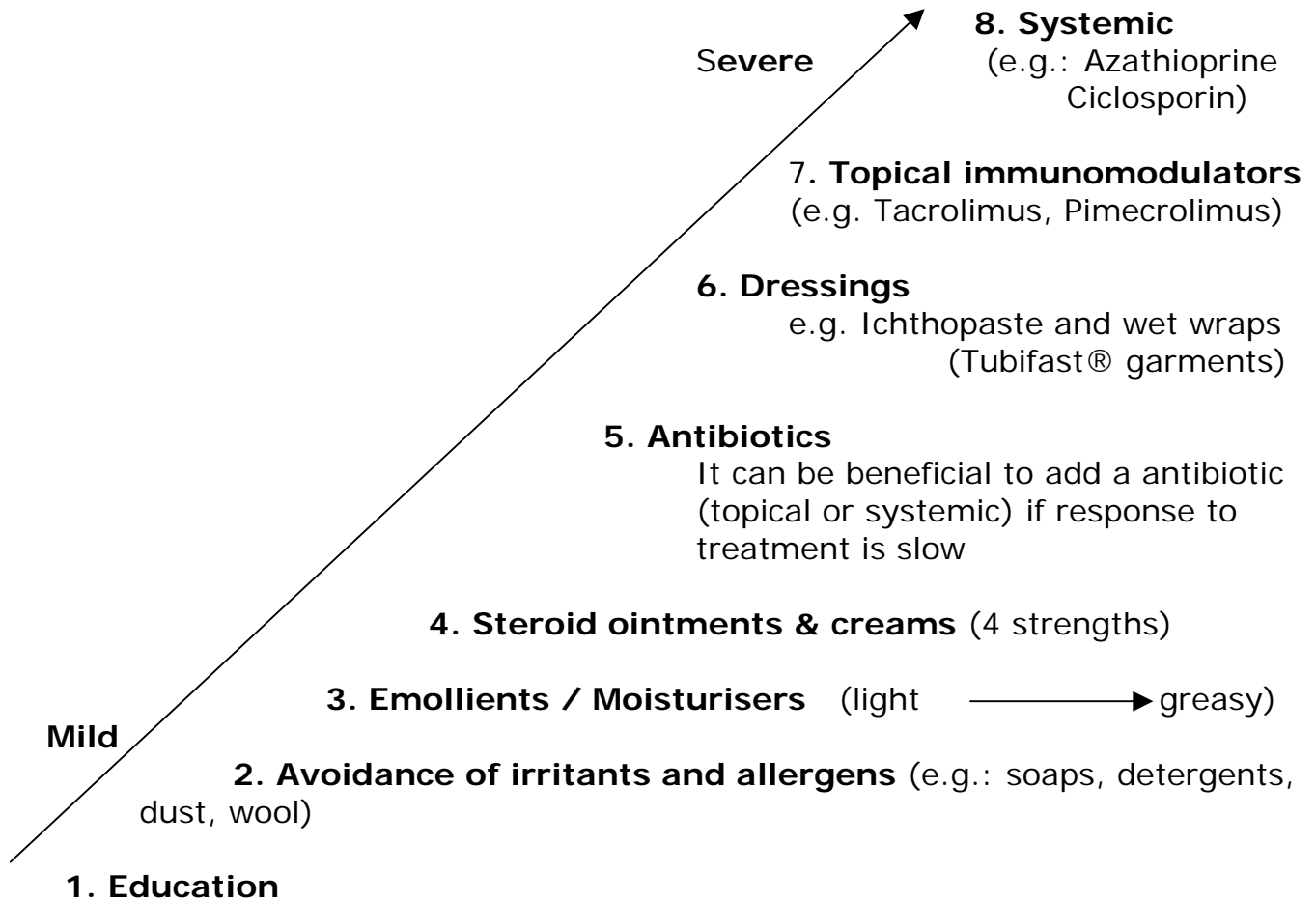
Topical immunomodulators: Tacrolimus and Pimecrolimus
Available since 2002,
Use in place of topical steroids, but a second line.
Avoids atrophy - so particularly useful for the face
Licensed for 2 years of age and over
Use twice daily

Avoid in acute weepy eczema
Avoid excess sun exposure
Preparations available:

- Tacrolimus (Protopic®)
0.03% for children
0.1% for adults
Equivalent to Betnovate®
- Pimecrolimus (Elidel®)
Equivalent to Eumovate®

NB Stings initially in 30%,
- but this wears off

Use a 'STEPLADDER' of care



Preparations and uses -
See tables listed at the end of this section

Impregnated bandages:

Useful for flexural atopic, gravitational, and lichenified eczemas.

Method

- Cut Impregnated bandage into 20cm strips
- Apply bandage as a series of strips round the limb
- Cover with crepe or cohesive (Coban®) bandage to hold in place
- Change daily

Ointment Dressings:

Useful for widespread eczema. The same dressing techniques can be used for other creams and ointments to contain the mess and improve penetration. It is best used overnight.

Method

- Oily bath
- Application of topical steroid ointment – (1% Hydrocortisone or Eumovate® for children, Betnovate RD® for adults)
- Application of 1% Ichthammol paste or White soft paraffin
- Application of Tubifast garment or cotton stockinette suit

Wet Wraps:

Useful for atotics where itching is a major problem.

Method

- Oily bath
- Copious application of a greasy emollient (eg Epaderm® or white soft paraffin), or 1% hydrocortisone ointment
- Application of a warm wet Tubifast® garment followed by a layer of dry Tubifast®.

Note:

1. Best used overnight.
2. Limit to a few days at a time
3. Remember - wet wraps can aggravate infection

Practice points

- Keep fingernails cut short to minimise the damage done by scratching, consider cotton gloves at night.
- Hydrocortisone preparations are safe in infants.
- Steroid creams & ointments are best used intermittently
 - use intensively followed by a break to prevent tolerance and skin thinning.
- If infected, avoid using occlusive dressings - clear infection first.
- Ensure you prescribe enough to allow patients to comply - see following pages.
- Give patients a ' **Skin Care Plan**' see following pages.

What can the dermatologist offer?

- Advice on diagnosis and management of difficult cases.
- Patient education about eczema and its management.
- Patch testing to detect cases of allergic contact dermatitis. (NB prick testing is for type 1 allergy and is only appropriate for asthma and hayfever - it is carried out in the allergy clinic run by the Immunologist).

In severe cases:

- Admission
- Day treatment
- Phototherapy - UVB & PUVA
- Systemic therapy including steroids, azathioprine, ciclosporin (see back pages)
- Topical immunomodulators.

Support Group:

The National Eczema Society
Hill House,
Highgate Hill
London
N19 5NA

Tel 0870 2413604

www.eczema.org

“Skin Care Plan for eczema”

MOISTURISER:

| | Name of Treatment | How often? | For how long? |
|-------------------------|-------------------|------------|---------------|
| Moisturiser | | | |
| Alternative Moisturiser | | | |
| In the Bath | | | |
| Soap Substitute | | | |

STEROIDS (inc combinations with antibiotic and/or antifungal):

| | | | |
|--------------|--|--|--|
| For the Body | | | |
| For the Face | | | |
| For | | | |

Prescribing Quantities

(NB it is easy to underestimate the amount of topical preparation to apply)

For twice-daily application for 1 week an adult requires:

| Site | Quantity |
|-------------------|-------------|
| Face & Neck | 30g |
| Hands | 30g |
| Scalp | 25g |
| Arms or Legs | 100g |
| Body | 100g |
| Groins & Perineum | 25g |
| Whole Body | 300g |

Name:

Appointment date:

Next appointment:






Nurse/doctor contact tel no:

Treatment:

The fingertip unit method

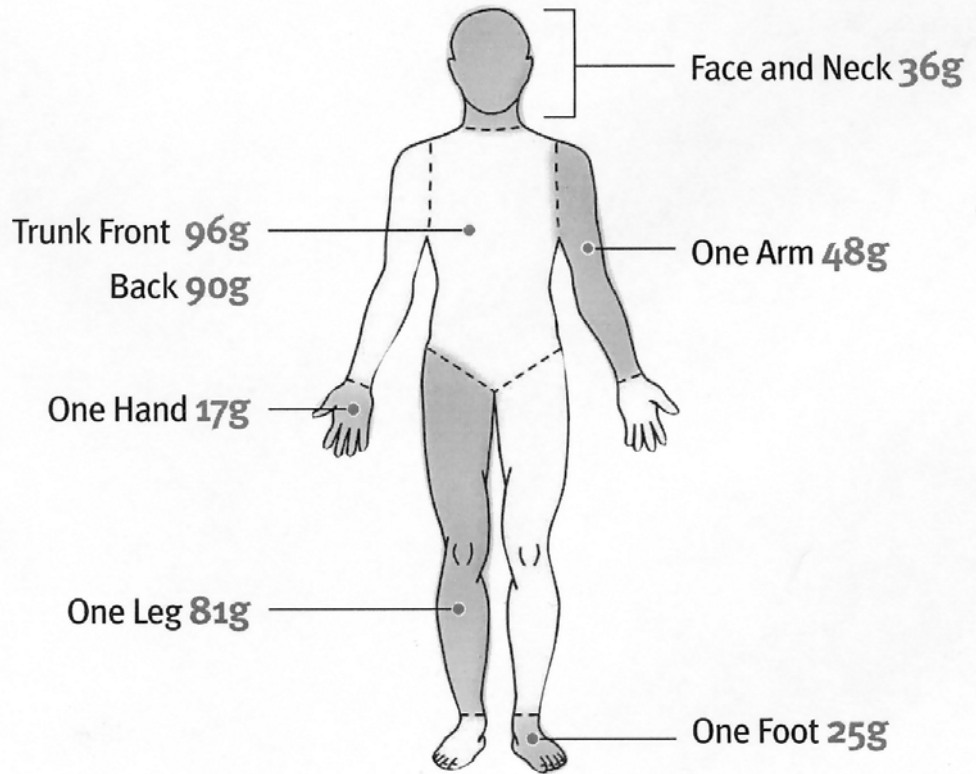
FTU = Fingertip unit (adult)
 1 FTU = 1/2 g of cream or ointment.
 Measurement based on 5mm nozzle.



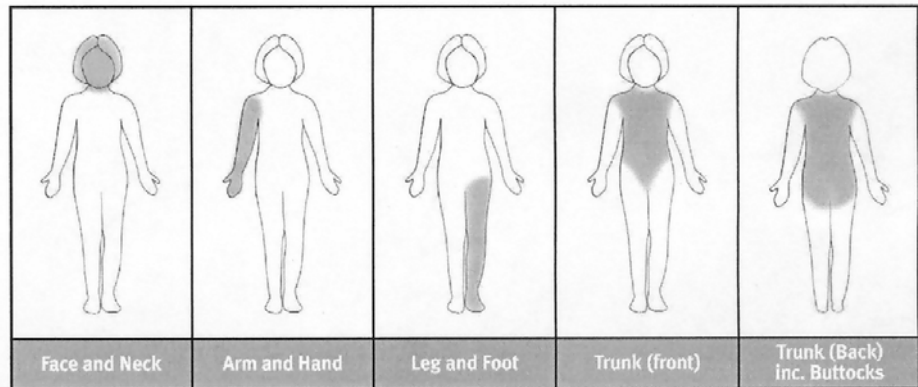
| FACE & NECK | ARM & HAND | LEG & FOOT | TRUNK (front) | TRUNK (inc buttocks) | | | |
|-------------|------------|------------|---------------|----------------------|--|--------------|---|
| 1 | 1 | 1 1/2 | 1 | 1 1/2 | 3-6 months  | | |
| 1 1/2 | 1 1/2 | 2 | 2 | 3 | 1-2 years  | | |
| 1 1/2 | 2 | 3 | 3 | 3 1/2 | 3-5 years  | | |
| 2 | 2 1/2 | 4 1/2 | 3 1/2 | 5 | 6-10 years  | | |
| FACE & NECK | ONE ARM | ONE HAND | ONE LEG | ONE FOOT | TRUNK (front) | TRUNK (back) | |
| 2 1/2 | 3 | 1 | 6 | 2 | 7 | 7 | Adult  |

The total amount to apply for *two weeks* treatment *twice daily*

Adults



Children



| AGE | Number of Grams | | | | |
|------------|-----------------|----|----|----|----|
| 3-6 months | 14 | 14 | 21 | 14 | 21 |
| 1-2 years | 21 | 21 | 28 | 28 | 42 |
| 3-5 years | 21 | 28 | 42 | 42 | 49 |
| 6-10 years | 28 | 35 | 63 | 49 | 70 |

Eczema- preparations and uses

Treatment

Preparations

Applications/notes

Emollients

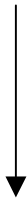
Bath

Aveeno
 Balneum
 Balneum Plus
 Bath E45
 Emulsiderm
 Hydromol
 Oilatum Oil & Gel
 Oilatum Plus

Balneum Plus contains antipruritic
 Emulsiderm contains antiseptic
 Oilatum Plus contains antiseptic

Topical

Light



Greasy

Aqueous Cream
 Dermol 500 Lotion
 Diprobase
 Aveeno Cream
 E45 Cream
 Emulsifying Ointment
 White Soft/Liquid Paraffin (50:50)
 Epaderm
 White Soft Paraffin

All patients
 Dermol 500 contains antiseptics
 As often as convenient (at least bd)

Topical Steroids

Potency

| | | |
|-------------|--|--|
| Mild | Hydrocortisone | Atopic children. Face in adults |
| Moderate | Betnovate RD Eumovate Modrasone Synalar 1 in 4 Synalar 1 in 10 | Moderate eczema |
| Potent | Betnovate Synalar Cutivate Elocon | Moderate/severe eczema Hands & feet Once daily Once daily |
| Very Potent | Dermovate Synalar Forte | Short term use Difficult cases Hands & feet Lichen simplex |

Topical Steroid/Antibiotic Combinations

| | | |
|-------------|------------------------|---|
| Mild | Fucidin H | Infected eczema, fissures, & Staph Aureus bacterial colonisation in acute flares |
| Potent | Betnovate C Fucibet | Infected eczema, discoid eczema, & Staph Aureus bacterial colonisation in acute flares |
| Very Potent | Dermovate NN | |

Topical Steroid/Antibacterial & Antifungal Combinations

Daktacort
Nystaform HC
Vioform HC

Seborrhoeic eczema
Napkin dermatitis

Potassium permanganate

Soaks/Baths

KMnO₄ Crystals
Permitabs

1 in 10,000
Wet oozy / infected eczema

Antibiotics

Topical

Fucidin / Polyfax
Mupirocin / Neomycin

Infection
Staph. Carriage in nose / ears

Systemic

Erythromycin & Clarithromycin
Flucloxacillin

Useful in eczema that suddenly deteriorates

Anti-virals

Zovirax

Eczema herpeticum

Antibiotics & Resistance

Topical antibiotics, such as fusidic acid (Fucidin) can be useful for treating Staphylococcal skin infections. However prolonged use may contribute to an increase in resistance. In order to prevent such an issue occurring we would like to emphasise that treatment with fusidic acid should;

- continue for up to a maximum of 2 weeks,
- patients should be prescribed the correct amount of ointment/cream for the area to be treated using the Finger Tip Unit method,
- unsupervised repeat prescriptions should be avoided.

Occlusive Dressings

| | | |
|----------------------|---|---|
| Stockinette | Cotton stockinette BP Ribbed cotton & viscose stockinette Tubegauze, Tubifast Sizes: Small limb- 5cm, Large limb- 7.5cm, Trunk 10cm (Tubifast: Green line for small legs (<5yr), Blue line for bigger legs (>5yr) and Yellow line for body) | Excellent for atopic infants / children Used in wet wraps |
| Tubifast garments | Ready to wear suits (full sleeved vest, leggings and socks) For ages 3 months to 5 years Wash 30 times before they need replacement | |
| Impregnated bandages | Ichthammol: Coal Tar Zinc bandages Use a crepe bandage over the top to hold in place May be left on for several days Useful for lichen simplex, flexural atopic eczema and gravitational eczema | Zinc & Ichthammol bandage BP, Ichthopaste Zinc & coal tar bandage BP, Coltapaste Zinc paste bandage BP, Viscopaste, PB7 |

Topical Immunomodulators

It is recommended that treatment with topical immunomodulators be initiated only by physicians (inc GPs) with a specialist interest and experience in the treatment of atopic eczema, and only after careful discussion with the patient of the potential risks and benefits of all appropriate second-line treatment.

[See the NICE website for further details www.nice.org.uk]

Before commencing treatment with topical immunomodulators clinical infections at treatment sites should be cleared.

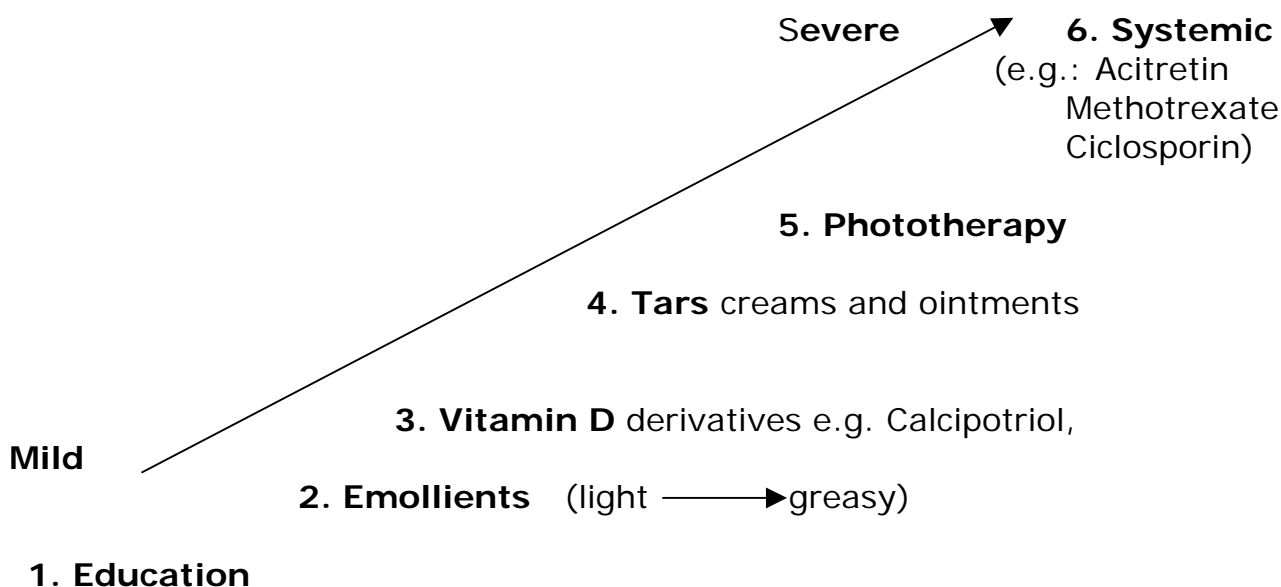
| | |
|------------------------|--|
| Tacrolimus (Protopic). | Tacrolimus is recommended as an option for the second-line treatment of moderate to severe atopic eczema in adults and children aged 2 years and older that has not been controlled by topical corticosteroids* and where there is a risk of adverse effects from further topical steroid use, particularly irreversible skin atrophy. |
| Pimecrolimus (Elidel). | Pimecrolimus is recommended as an option for the second-line treatment of moderate atopic eczema on the face and neck in children aged 2 – 16 years that has not been controlled by topical corticosteroids* and where there is a risk of adverse effects from further topical steroid use, particularly irreversible skin atrophy. |

(* This refers to disease that has not shown a satisfactory clinical response to adequate use of the maximum strength and potency that is appropriate for the patient's age and the area being treated).

PSORIASIS

Psoriasis is a chronic disease, which affects 2% of the UK population. Although there are strong genetic links, the cause is unknown. There is no single treatment that is satisfactory for every patient and different parts of the body require different preparations.

We use a 'STEPLADDER' of care



Treatment Scheme

| | |
|----------------------|--|
| Acute guttate | Potent topical steroid Topical coal tar Emollients |
| Stable Plaque | Emollients Vitamin D analogue e.g. Calcipotriol Topical coal tar Short contact Dithranol |
| Facial | Emollients Tar cream e.g. Alphosyl HC ® Mod. Potent topical steroid e.g. Modrasone® Topical immunomodulator e.g. Tacrolimus |
| Flexural | Mod. Potent Steroid + antifungal (e.g. Trimovate®) |
| Scalp | Tar shampoo Potent steroid scalp application or gel Cocis ointment® |

Palmar & Plantar Pustular Emollients
Potent topical steroids

Preparations and uses

Emollients

Often forgotten – improves flexibility

Vitamin D analogues

First choice in stable plaque psoriasis

Calcipotriol (Dovonex®)

Use twice daily until skin clear, patients must use *enough* - give up to 100g/ week.

Use ointment on trunk and limbs, cream on face, scalp application on scalp.

Clean, no staining or smell but may cause irritant dermatitis, especially on face.

Stop when plaques are flat

Calcitriol (Silkis®) and Talcalitol (Curatoderm®)

Alternatives to Calcipotriol.

Vitamin D analogue /Topical Steroid combination (Dovobet®)

Useful to get a rapid improvement e.g. before a holiday

Limit use to one month followed by a break

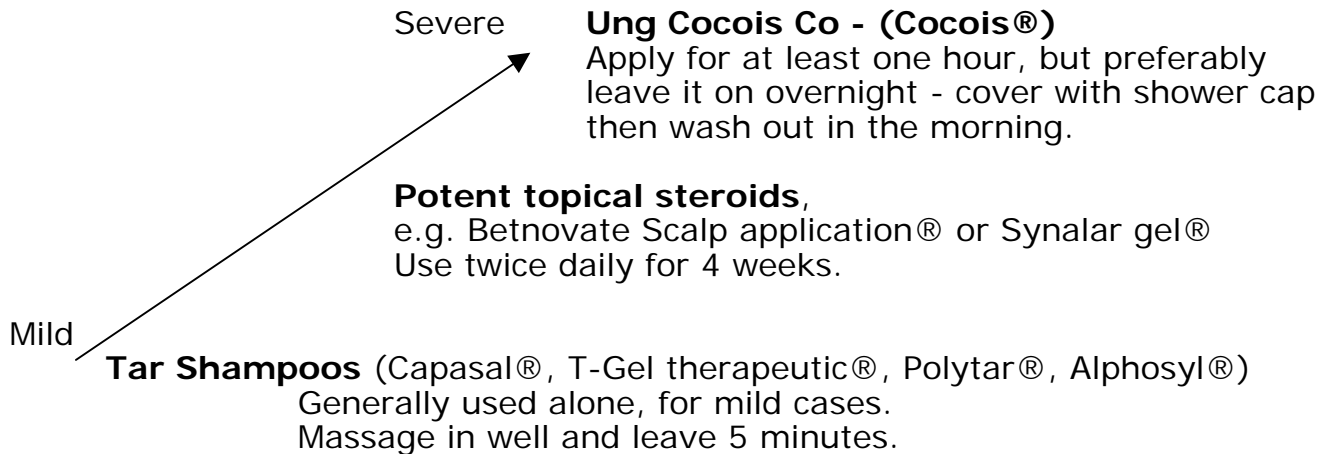
Use treatment guide on page

Coal Tar

Proprietary preparations are easier to use but they are generally less efficacious than the crude strong coal tars.

- Refined products include: Alphosyl®, Alphosyl HC®, Exorex lotion®, Carbo-Dome & Clinitar
- Intermediate preparations include: Gelcotar®, Pragmatar® (has salicylic acid which helps remove scales), & Psoriderm®.
- Cruder preparations include:
 - Coal tar ointment 2%, 5%, 10% and 15% using Strong Coal Tar Solution
 - Mixed in Ung M, Yellow soft paraffin or Emulsifying ointment.
 - Add 2% salicylic acid to lift scale and increase penetration (e.g. 10% SCT, 2% Salicylic acid in Ung M).
 - Start with a low concentration and work up the strengths. Titrate dosage against response. If irritation develops, reduce to a lower strength for a few days.
 - Progressively increase the strength enhances resolution.
 - Apply once daily. Overnight is often a good way.
 - Warn patients about temporary staining.

Scalp - Use a step wise approach:



Mod. Potent Topical Steroids

For face and flexures e.g. Eumovate®, Trimovate®.
Try to limit use to twice daily for maximum periods of 1 month.
Wean onto hydrocortisone if possible.
Supplement treatment with emollients.

Potent Topical Steroids

Widely used in USA, but not in UK. They may destabilise psoriasis leading to a flare.
Quick response but may be followed by a rapid relapse when the treatment is stopped.
Use for small recalcitrant plaques only (max 100g/month). Useful for scalp.
Use intermittently e.g. 2 weeks of treatment every 6 weeks.

Dithranol

For trunk and limbs, avoid flexures.
Highly effective when used properly, but requires *motivation*.
Use short contact method - apply just to plaques (cotton buds are useful), rub in well, leave on for 30 minutes, then wash off. Creams are easiest and two are available:

- Dithrocream, start at 0.1% and increase at 4 day intervals through 0.25%, 0.5%, 1% and finally 2% if tolerated.
- Micanol®, start at 1% and increase to 3% after one week if tolerated.

Give patients written instructions - e.g. Dermal treatment guide.

Problems: Staining - Purple discoloration of skin
- 'Pink rinse' in blond hair
- Bath & clothes stained

Burning - treat with mod. potent steroid for 3-4 days then try a lower strength.

Tazarotene

A retinoid Gel. Two strengths 0.05% and 0.1%.
For limited areas only (max 10% of body), and rather irritant.
It may be necessary to combine with a topical steroid e.g. Betnovate RD®.

Practice points

- Emollients - are very helpful as they increase skin flexibility and reduce the scaly appearance.
- If you can't feel it - don't treat it - psoriasis causes staining of the skin. So stop treating it when you can no longer feel the plaques. See treatment guide for DOVOBET on page 25.
- Treatment Holidays. Many treatments are inconvenient and messy - try periods of intense treatment with breaks or 'holidays' between e.g.: one month on, one month off.
- UVB - natural sunshine helps most patients. Hospital UVB is helpful but most beauty parlours have UVA sun beds, which are of little use (only 10% patients derive objective benefit although up to 40% report benefit). A new form of UVB (narrow band, TL-01) is very effective. But it involves attendance 2-3 times each week for 6-10 weeks.
- Many of the special tar preparations are available from Tayside Pharmaceuticals, Dundee.
- Drugs that make psoriasis worse include: Beta-blockers, ACE inhibitors, Lithium, anti-malarials and stopping steroids.
- Wear cotton pyjamas, socks and gloves to cover messy ointments. Alternatively Tubifast® garments can be prescribed.
- Support Group: The Psoriasis Association: www.psoriasis-association.org.uk

Which patients should you refer?

- Those who fail to respond.
- Those with unstable psoriasis.
- Erythrodermic patients and those with generalised pustular psoriasis.
- Pustular psoriasis of palms and soles.

What can the dermatologist offer'?

- Advice with respect to diagnosis and management of difficult cases.
- Patient education about their condition and its management.
- Day treatment
- In severe cases: - Admission
- Phototherapy - UVB & PUVA
- Systemic therapy including Acitretin, Methotrexate, Hydroxycarbamate, Azathioprine, Ciclosporin (see back pages for details)

Instructions for using Dovobet in patients with stable plaque psoriasis

- Apply Dovobet once a day for up to 4 weeks
- Progress Review with Doctor at **4 weeks** :-

➔ **CLEAR** Stop Dovobet and use emollients

➔ **IMPROVED
but
NOT CLEAR** Start a second course of Dovobet for up to 4 weeks and **REVIEW** again.
If not clear after 8 weeks of Dovobet – Use alternative or refer.

➔ **NO BETTER** Stop Dovobet and use an alternative treatment e.g. Dithrocream
Coal tar
Calcipotriol
Calcitriol

'**Clearance**' means the skin is flat to touch. Any red marks left will resolve without further treatment.

- Dovobet must not be used for more than 8 weeks at any one time.
- Dovobet can be used again after an interval of 4 weeks

URTICARIA

Urticaria is characterised by itchy, palpable weals, which may have a white centre due to oedema. Weals may occur on any part of the body and an individual lesion can last anything from a few minutes to several hours – but in uncomplicated urticaria always resolves within 24 hours.

It affects 20% of people at some stage in their lives.

It is due to histamine release.

Clinical patterns of urticaria:

- | | |
|-----------------|---|
| Acute - | Episodes, often widely separated in time, self-limiting, only lasting hours |
| Chronic - | Lesions come and go for months or years. Individual lesions last only a few hours, but recur at different sites |
| Angioedema - | Urticaria in soft tissues where gross oedema can develop. Usually face, oropharynx and larynx. |
| Dermographism - | Linear weals after scratching or local pressure. |
| Cholinergic - | Small papules often widely distributed. Precipitated by a hot bath or exercise. |

Aetiology of Urticaria

Histamine release can be triggered by exercise, pressure on the skin and other physical factors - as well as foods, drugs and infections. However, in the common forms of urticaria and angioedema, it is **uncommon** to identify an external cause and many are now thought to be **autoimmune**.

Identifiable external factors may include:

- Acute –
 - Drugs penicillin, aspirin
 - Foods - shellfish, strawberries
 - Topical e.g. Animal dander
 - Acute viral infections - often in children
- Chronic –
 - Drugs - aspirin, codeine, opiates
 - Chronic infections and infestations
 - Bacterial - dental, chest, gall bladder
 - Fungal - candida
 - Gut parasites
 - Food additives
 - Tartrazine: E 102, E 110, E 122, E 123, E124, E133, E151, E154
 - Benzoates: E210 - 219
 - Physical agents. Exercise, pressure, heat, cold, sunlight
 - Psychological factors i.e. stress

- General medical problems (rarely): thyroid, liver, SLE
- **Idiopathic - by far the majority**

Investigation: No specific tests are particularly useful. A Full blood count may show a raised eosinophil count in allergic cases and those due to helminths. If a specific allergic cause is suspected, e.g. peanuts, then a RAST test to peanut IgE may be useful. Skin prick testing is rarely helpful. For suspected cases of hereditary angioedema C3 & C4 should be measured and, if low the C1 esterase inhibitor measured.

Treatment Scheme

1. Remove the precipitating cause (if any).
2. Stop aspirin, salicylates, codeine and opiates.
3. Antihistamines - the corner stone of treatment.
 - Try non-sedative antihistamines first.
 - If the first drug you try does not work, consider increasing the dose, if appropriate, before switching to one of the others.
 - Patients often need higher doses of antihistamines than recommended by the manufacturer to control their urticaria.
 - Try combining two different antihistamines.
 - It is often a question of trial and error to find which drug suits a particular patient.

Non-sedating antihistamines

Cetirizine 10 mg/day, max. 20 mg/day
 Loratadine 10mg/day, max. 40mg/day
 Fexofenadine (Telfast®) 180mg/day
 Desloratadine (Neoclarityn®) 5mg/ day max 20mg/day (metabolite of Loratadine)
 Levocetirizine (Xyzal®) 5mg/day max 20mg/day (metabolite of Cetirizine)
 Acrivastine 8mg tds
 Mizolastine (Mistamine®) 10mg/day
 Terfenadine 120mg/day

NB: Terfenadine may cause ventricular arrhythmias - especially if given in larger than recommended doses. Arrhythmic potential increased by tricyclic antidepressants, erythromycin, and ketoconazole.

Sedating antihistamines - can often be used to give cover overnight, or for specific indications.

Chlorpheniramine malate (Piriton®), 4mg qds, max. 24mg/day
 Promethazine hydrochloride (Phenergan®), max. dose 25mg bd
 Hydroxyzine hydrochloride (Atarax®), max. dose 25mg qds
 Cyproheptadine (Periactin®), max dose 4mg qds.

Where anxiety or depression may be important factors, consider **Doxepin** (Sinequan®) initially 25mg nocte, increasing to a max dose of 75 mg/day.

Consider adding an H2 blocker e.g. cimetidine.

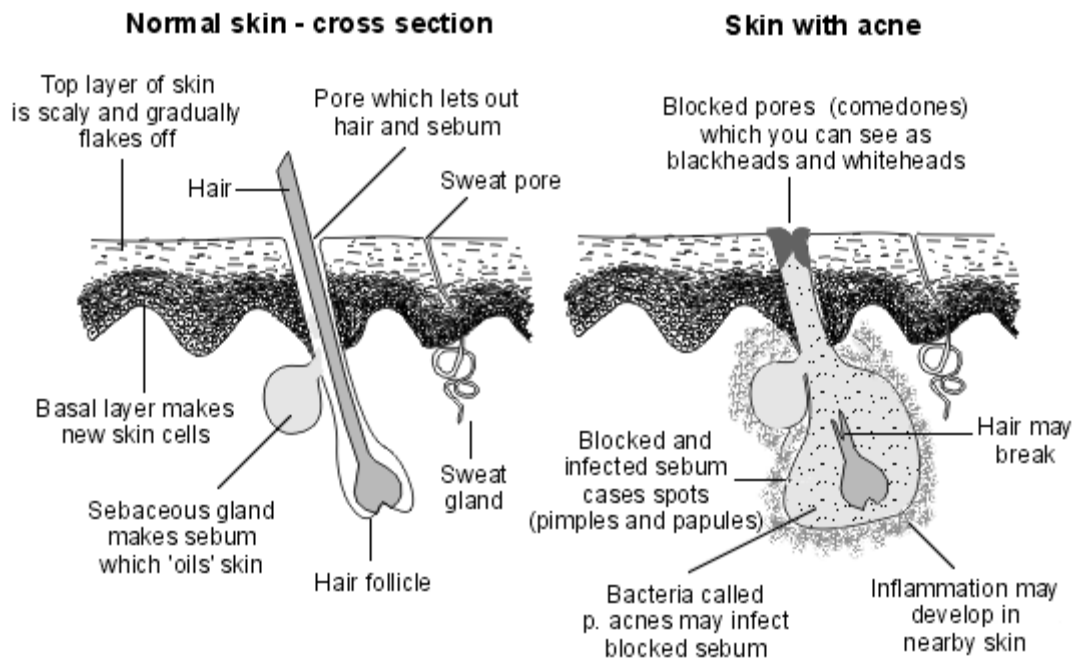
What can the dermatologist offer?

- Confirmation of diagnosis.
- Assessment of aetiology.
- Management plan & moral support.

ACNE

Acne is a chronic inflammatory condition involving the hair follicle and its associated sebaceous gland. Two abnormalities can occur which can induce both non-inflammatory and inflammatory lesions; these are:

- Increased sebum excretion
- Hypercornification of the follicle opening-causing blockage



Adapted from EMIS and PIP 2003
www.patient.co.uk

The microcomedone is the primary lesion of acne. This leads to non-inflammatory blackheads and whiteheads and then to inflammatory lesions (papules, pustules, nodules). The inflammatory lesions are caused by pooling of sebum in blocked follicles, proliferation of bacteria (*Propionibacterium acnes*) with breakdown of sebum to free fatty acids, cytokine production, neutrophil infiltration and pus formation.

Treatment Scheme

Mild acne

Comedones Predominate (black heads & whiteheads). Use Keratolytics

Retinoids: Retin A® 0.01% or 0.025% gel or cream is effective
(avoid in pregnancy)

Isotretin® Gel

- Apply OD initially, then increase to BD

Adapalene (Differin®) Gel

Azelaic acid: - Apply OD initially, then increase to BD
(Skinoren®) apply OD initially then BD.

Inflamed lesions predominate (papules, pustules)

Benzoyl peroxide: Panoxyl aquagel® (also cream and gel)
Start weak (0.25%) OD then increase in strength to 100% and BD.
May cause irritation and bleach clothing
Cream formulations such as Brevoxyl® and Quinoderm® cream (5 & 10%) are less irritant

Topical antibiotics: Benzamycin®, Zineryt®, Dalacin T®

Moderate acne +/- scarring

Combine topical keratolytics (as above) with oral antibiotics

e.g. Oxytetracycline 500mg bd, ½ hour before food, avoid milk
Minocycline 100mg od - check LFTs every 6 months
Erythromycin or Clarithromycin 500mg bd
Lymecycline 408mg od (Tetralysal 300)
Doxycycline 100mg od

Do not mix different topical and systemic antibiotics as it may lead to increased bacterial resistance.

Add

Anti-androgen + Oestrogen (Dianette®) - females only.

Severe acne

Nodulocystic acne and scarring.

Refer for a dermatological assessment for isotretinoin

- but start treatment immediately with oral antibiotics while awaiting appointment.

Isotretinoin (Roaccutane®)

Is a retinoid, which dries up the sebaceous glands and normalises keratinisation of the pilosebaceous follicle preventing comedone formation.

It is given as a four-month course. It will clear the majority (85%) of patients with acne, usually markedly improving the remainder and often prevents future recurrence. Only dermatologists can prescribe it.

It is **teratogenic**, therefore all women of child bearing age must take adequate precautions to avoid pregnancy during the course, and for one month afterwards. By late 2004, it is likely that all females will require a negative pregnancy test every month and to use 'double contraception'.

Side effects are common and include:

- particularly drying of the lips and nasal mucosa (cracked lips and bleeding nose), redness of the face, myalgia, arthralgia, and occasionally dry eczematous patches on the trunk and limbs.
- Triglycerides and LFTs may rise during treatment.
- Depression is an important, but probably uncommon, side effect.

Practice points

- The aim of treatment is to relieve distress and prevent scarring
- Give three months continuous treatment before assessing its efficacy. Patients respond slowly to topical and systemic antibiotics:
 - 30% of improvement seen at 3 months
 - 60% of improvement seen at 6 months
- Keratolytics - gradually increase frequency of application until tolerance is induced. Irritation is to be expected initially, especially with topical retinoids.
- Antibiotics & the oral contraceptive pill (OCP). The evidence that antibiotics used in acne inhibit OCP efficacy is slight. If an OCP containing at least 30µg of oestrogen is used and cycle control is good prior to starting the antibiotic, no further contraceptive measures are required.
- Keep patients on treatment while awaiting dermatology appointment.
- Scarring – the best treatment is prevention! At the first sign of scarring treatment should be maximised and, if appropriate, Roaccutane considered. Once scarring has occurred it is difficult to treat. Many scars improve spontaneously after the acne has settled - but it takes 2-5 years for the skin to remodel. Chemical peels and laser dermabrasion have a limited role and only after all acne activity has ceased.

Which patients should you refer?

- Patients unresponsive to conventional treatment.
- Patients who require isotretinoin. Suitable patients are those with:
 - Nodulo-cystic acne
 - Inflammatory acne that has failed to respond to a full course (6 months) of oral antibiotics combined with a topical preparation.
 - Dysmorphophobic patients, i.e. an inappropriate appreciation of body image - in this case a feeling that the acne is much worse than it appears clinically.

Please include in your referral letters:

Details of previous treatment, including dose and duration of therapy.

If female - details of contraception, if any. (Isotretinoin is very teratogenic and females of child bearing age must have contraceptive cover and be fully counselled about the drug).

If possible, result of a recent FBC, LFTs & fasting lipids.

SCABIES

Scabies is transmitted by prolonged physical contact (e.g. holding hands, lying in the same bed all night, cuddling children). The rash itself does not appear for up to 6 weeks after first infestation.

Diagnostic clues:

- Severe pruritus, worse at night, not usually affecting the head or neck except in infants.
- Always ask about partners
- Look in the finger web spaces, around the wrists, axillae, male genitalia (especially for nodules), around the nipples in females and soles of the feet.
- Check the palms and soles in infants and elderly.

Treatment Scheme

All close contacts must be treated despite an absence of symptoms. In practice, this means all individuals living in the same house and any sexual partner(s). If there are children in the family, grandparents, uncles and aunts, baby-sitters, neighbours and anyone else who have held the children will also need treating.

A bath is not necessary.

Treat all of the skin from the neck down – consider using a 2" paintbrush. Patients will need help to apply it. In infants - treat the face and scalp too.

Repeat treatment after 7 days to increase cure rate to 99%.

Re-infestation from clothing is only a remote risk, but clothing and bedding used in the 24 hours preceding treatment should be laundered, although no special procedures are needed.

Itching usually resolves within 4 to 6 weeks but itchy nodules may persist for 3 months. Retreat only if burrows are re-identified. Treat the residual itch with calamine, crotamiton cream (Eurax®) or 1% hydrocortisone cream b.d. for up to a week.

75ml of lotion or 30g of cream are needed to treat an adult once.

Scabeticides

There are 2 effective Scabeticides in common use:

0.5% malathion lotion (Derbac-M or Quellada M)

5% permethrin cream (Lyclear)

Benzyl benzoate is an irritant and stings the skin – try to avoid it.

Always use an aqueous emulsion or cream base (not alcohol-based products which are for crab lice).

Contact time 24 hours (8 hours for Permethrin), **repeat after one week to achieve 99% cure rate.**

No licence for use in infants or pregnant women, although probably OK.

Reasons for treatment failure

- Wrong use of scabeticide - particularly if only applied to itchy areas or washed off too early.
- Contacts not treated at same time leading to re-infestation.
- Diagnosis wrong - the patient has eczema and not scabies - anti- scabies treatment is likely to make the rash worse.
- Mite resistant to scabeticide – use a different scabeticide.

Institutional Scabies

Outbreaks in nursing homes and other institutions are common and require special care:

- Take care to establish the diagnosis (consider a domiciliary visit if in doubt)
- If an individual case – just treat that patient and warn staff to be alert.
- If 3 or more:
 - Consider treating all attendants and other residents
 - Look for a hidden case of **crusted scabies**
 - Inform Public Health at Lincolnshire Health

Consider oral **Ivermectin** for crusted scabies or for those who fail to respond despite adequate topical treatment. Give a single oral dose of 200micrograms/kg in combination with topical scabeticides.

What can the dermatologist offer?

Confirmation of the diagnosis.

Viral Warts

Viral warts are due to Human Papilloma Virus (HPV) infection and all eventually resolve spontaneously, most within 2 years, although a few may persist longer. There is currently no specific, effective, anti-HPV treatment and therefore treatments are not a cure but aim at:

- Local destruction of the warts
- Stimulation of an inflammatory reaction

Recurrence is not uncommon until an adequate cell-mediated immune response to the infecting virus is achieved which either eliminates or controls it.

Spontaneous cure rates:

- Common warts - 65% within 2 years
- Plantar warts - 50% within 6 months
- Slower in adults, atotics and immunosupressed patients.

Hence –if the warts are not causing problems leave them alone – time is the cure!

Criteria for Treatment

- Severe physical or psychological discomfort.
- Interferes with work.

Treatment Scheme

Essentially, simple occlusion, wart paints and cryotherapy are probably equally effective.

- Occlusion is most convenient, painless and cheap.
- Wart paints take patience - 12 weeks treatment is often needed,
- Cryotherapy is quicker (most go after 3-5 treatments at 2 week intervals) but it is painful.

References: Clin Evid Concise 2002; 8:338-340
Arch Pediatr Adolesc Med 2002; 156:971-974.

Common warts:

Occlusion - Waterproof tape e.g. Duck tape
Cut to cover wart,
Change every 6 days; pare down leave open for 12
hours
↓
Apply a new piece of tape

Failure after 12 weeks
↓
Keratolytic - salicylic acid e.g. Salactol, Salatac gel, Cuplex
↓

Failure after 3 months
↓
Liquid nitrogen cryotherapy
Double 10 second freeze
Repeat 2-3 weekly x 6 cycles, if needed

Plantar warts:

Pare down - Use # 15 scalpel. Patients should continue to pare twice weekly with emery board or pumice stone at home.

↓

Occlusion - Waterproof tape e.g. Duck tape
Cut to cover wart,
Change every 6 days, pare down leave open for 12 hours
↓
Apply a new piece of tape

Failure after 12 weeks

↓

Keratolytic - salicylic acid e.g. Salactol, Occlusal, or 3% Formaldehyde soaks

↓

Failure after 12 weeks

↓

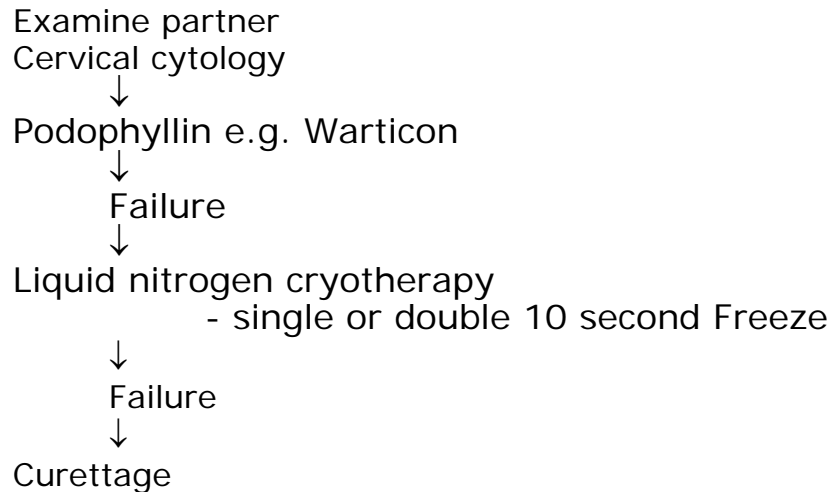
Liquid nitrogen cryotherapy
Double 10 second freeze with thaw between
Repeat 2-3 weekly x 6 cycles if needed

Note: Plantar Warts (Verrucae) are often painful due to heaped up keratin pressing into the sole of the foot while walking. The correct treatment for painful verrucae is to pare the excess keratin daily until the verruca is flat, it will then not be painful. Regular paring – at least twice weekly – must be encouraged. This simple step will avoid a great deal of unnecessary suffering. A variety of files and callus knives are available in Chemists.

Filiform Warts: Liquid nitrogen cryotherapy - single 10 second freeze
or
Curettage

Plane Warts: Placebo e.g. 2 % salicylic acid in oily cream or Retin A cream

Ano-Genital Warts: Investigate for other STDs – refer to Gentic-Urinary Medicine



Practice points:

- Give clear instructions to the patient - Go to either: www.dermnetz.org
 - Or www.patient.co.uk
- Topical treatments must be done daily.
- Treatment for 3 months is the norm and all known treatment methods have a 30% failure rate.
- Keratolytic effect is enhanced by Zinc oxide plaster occlusion.
- Facial warts are best treated by cryotherapy.
- Podophyllin should be applied by a skilled nurse and must not be used in pregnancy.
- Liquid nitrogen is "Painful" and generally unsuitable for young children.
- Although infectious - incubation period is often many months.
- Beware of implications of anal warts in young children.

What can the dermatologist offer?

Very little more than cannot be done in General practice.

Confirmation of the diagnosis and moral support

NB Warts are a low priority referral by Lincolnshire PCTs

VENOUS ULCERS

A chronic venous leg ulcer is an area of discontinuity of the epidermis persisting for 4 weeks or more, occurring as a result of venous hypertension and/or calf muscle pump insufficiency. It causes considerable morbidity and uses a significant proportion of available community nursing resources.

Exclusion of arterial disease is a prerequisite of appropriate management.

The vascular surgeons run venous ulcer clinics.

| Causes of leg ulcers | |
|-----------------------------|---|
| Vascular | <ul style="list-style-type: none">• Venous - 80% of all leg ulcers• Arterial - atherosclerosis, AV malformation• Vasculitis - SLE, Rheumatoid arthritis, scleroderma, polyarteritis nodosa, Wegener's• Lymphatic |
| Neuropathic | Diabetes, peripheral neuropathy- usually feet. |
| Haematological | Polycythaemia rubra vera, sickle cell anaemia |
| Traumatic | Burns, cold injury, pressure sores, radiation, factitious |
| Neoplastic | BCC or SCC, melanoma, Marjolin's ulcer, Bowen's disease |
| Others | Pyoderma gangrenosum, tropical ulcer, sarcoidosis |

Note: Aetiology may be multifactorial

Diagnosis by:
Clinical features
Biopsy
Doppler

Diagnosis

The most important criteria for the diagnosis of chronic venous leg ulceration are:

- Origin of the centre of the ulcer within the gaiter area of the lower leg.
- Pigmentation and thickening of the skin within the gaiter area (Lipodermatosclerosis).

- Exclusion of arterial disease by either:
 - The presence of a full and bounding dorsalis pedis and posterior tibial pulses.
 - Normal pressure gradient as measured by Doppler Ultrasound (the ratio of systolic BP at the ankle to that of the arm should be 0.8 - 1.2)

Notes-

Consider:

- FBC, Ferritin (anaemia will delay healing)
- ESR (vasculitis)
- U/Es, LFTs (hypoalbuminaemia may cause ankle oedema)

Other clinical features include venous flares, telangiectasia & atrophy blanche. Ulceration of the forefoot is unlikely to be of venous origin. Other criteria, such as the presence or absence of oedema, slough or granulation tissue, may determine finer points of management. Doppler ultrasound instruments are inexpensive (£300 - £400) and are easy to use.

Treatment

Elevation of the legs and compression bandaging are still the mainstays of treatment.

Effective treatment for venous leg ulcers

- Four layer compression bandaging
- Leg elevation
- Improve mobility
- Reduce obesity
- Improve nutrition
- Skin grafting in selected patients
- Venous surgery in selected patients.

Compression bandaging

Compression bandaging, properly applied, is the only treatment of proven efficacy. Venous ulcers worsen in the absence of such bandaging, and the failure to use it represents inadequate treatment.

Compression bandages provide active counter pressure, with graduated compression, maximal at the ankle, to enhance venous return.

Examples: Extensible bandages; Setopress, and Tensopress.
Elastic web bandages; Blue and red line webbing.
Multilayer compression using cohesive bandages ie 4 layer bandaging

NB always aim for 4 layer bandaging.

Compression hosiery

- Below knee is often all that is realistic.
- Graded I - III depending on compression (I = low, III = high).
- Remember that they are difficult to put on – disabled and elderly patients often require an application aid.
- Useful to prevent recurrence once healing has occurred.

Practice points

- If there is obvious oedema of the leg the ulcer is unlikely to heal.
- A weeping ulcer and/ or soaked dressings indicate venous insufficiency/hypertension and the leg must be elevated. Potassium permanganate soaks (1 in 10,000) are also useful.
- Crepe bandages do not apply adequate support or compression.
- 25% of patients with chronic venous ulcers will require some form of nursing help with the application of compression bandaging as a result of immobility or disability.

Infection

Colonisation of leg ulcers by potentially pathogenic organisms is universal. If clinical signs of infection are absent there is little evidence that they impair healing. However, the presence of B-haemolytic strep and Pseudomonas pyocyania may prejudice the outcome of skin grafting.

Routine swabbing of leg ulcers is unnecessary and intervention should only be considered in the presence of one of the following signs:

- Pyrexia
- Increase in pain
- Increasing erythema or surrounding skin
- Lymphangitis
- Rapid increase in ulcer size

Practice points

- Clean the leg regularly – use tap water and a bucket with a disposable bin liner.
- Remove adherent scale - bacteria grow beneath and cause inflammation
- Slough on the ulcer is not a sign of infection. It will delay healing by inhibiting granulation tissue – remove it mechanically with forceps and scissors.
- When infection is suspected - swabs must be sent in appropriate transport media.
- Treatment of infection with B-haemolytic strep should be with systemic penicillin.
- Cellulitis caused by other organisms should be treated according to culture sensitivities.
- Topical anti-microbial agents e.g. cetrimide, chlorhexidine, potassium permanganate, will reduce odour considerably with little risk.
- Topical antibiotics may sensitise patient and preclude future use.

Dressings

No dressings of any type have been proved to enhance the healing rate of ulcers.

There is evidence from clinical trials that occlusive dressings may relieve pain. Gel and hydrocolloid dressings absorb exudate. There is some evidence that *prolonged* use of antiseptics may be harmful.

Dressings and applications should be chosen on an individual basis as aids to:

Control or absorption of exudate.
Reduction of pain.
Control of odour.
Care of surrounding skin.
Optimum use of nursing time.
Debridement.
Promotion of re-epithelialisation.

Keep it simple:

Non-adherent dressings
Alginates
Hydrocolloids
Foam dressings

Treatment of Dermatitis

Uncomplicated venous dermatitis may require the application of barrier preparations such as zinc oxide paste, emollients and/or topical steroids.

Allergic contact dermatitis is a common complication and may be caused by: rubber, lanolin, parabens, topical antibiotics, cetosteryl alcohol, and colophony

Use short courses of a potent topical steroid (e.g. Betnovate cream bd for 7 days) applied to the skin around the ulcer.

Monitoring of Management

- Record of surface areas by planimetry
- Polaroid photography
- Record of pain
- Record of disability experienced
- Record of complications

Who to refer to:

- o Community clinic – for the vast majority.
- o Vascular surgeons' leg ulcer clinic – for those who fail to heal

What can the dermatologist offer?

Assessment of the difficult cases:

- Diagnostic uncertainty – particularly to exclude malignancy
- Cellulitis.
- Dermatitis.
- Adverse reactions to dressing or medicament.
- Investigation of dermatitis by patch testing.
- Assessment of underlying disease

Skin Lesions - Benign

Seborrhoeic Keratoses

These are very common tumours, but can occasionally mimic melanomas.

To distinguish look for the following features of seborrhoeic keratoses:

- Patient usually over 35y.
- Oval or round lesions >5mm.
- Appears stuck to skin, often plateau shaped in cross section.
- Keratin plugs on surface.
- No pigmentary incontinence - but may vary in colour from fawn to black.

What can the dermatologist offer?

- Help with confirmation of diagnosis.
- Curettage or cryotherapy.

Is a referral necessary?

Benign skin lesions are a low priority referral by Lincolnshire PCTs

Lumps and Bumps i.e. Naevi, sebaceous cysts etc..

What can the dermatologist offer?

- Confirmation of the diagnosis and reassurance.
- Immediate treatment by curettage, shave, excision etc., if necessary.

Is a referral necessary?

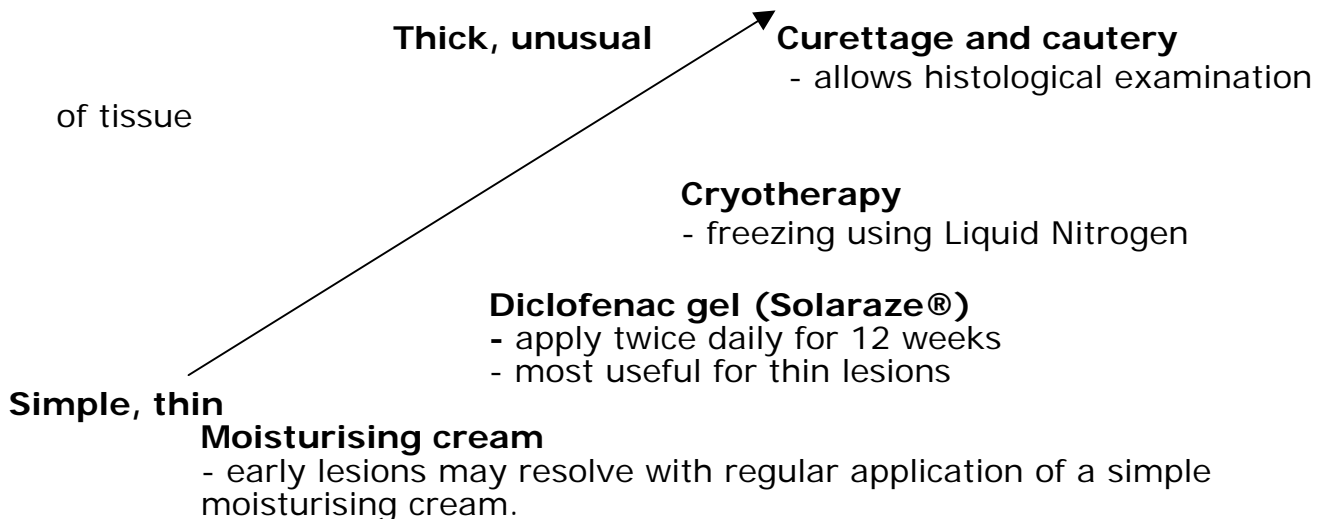
Benign skin lesions are a low priority referral by Lincolnshire PCTs

Skin Lesions - Pre-malignant

Actinic or Solar keratoses

Only 2% of actinic keratoses progress to skin cancer

Try a stepladder:



Efudix (5-FU) cream - is useful for patients who get many actinic keratoses. It destroys many early lesions, but, unfortunately, treatment is needed for 4 to 6 weeks and it causes a lot of inflammation. However, those who respond get far fewer lesions in the future.

Remember to check all over the patient for other sun-induced tumours - BCCs, and SCCs. Don't forget the back in men and the legs in women.

What can dermatologist offer?

- Cryotherapy.
- Efudix (including instruction in its use)

Is a referral necessary?

Benign skin lesions are a low priority referral by Lincolnshire PCTs

Bowen's disease

Only 10% progress to Squamous cell carcinoma, so in the frail elderly they may be best simply observed and only treated if they become troublesome or progress - this is especially relevant as more aggressive treatment is needed than for actinic keratoses, lesions most often occur on the lower legs where healing is poor and recurrences are relatively common.

- **Curettage**

- **Cryotherapy** - freezing using Liquid Nitrogen
- **Efudix®** (5-FU) cream - patients who get many actinic keratoses may find a course of 5-FU (Efudix®) cream helpful as it destroys many early lesions, but, unfortunately, treatment is need for 6 weeks and it causes a lot of inflammation. However, those who respond get far fewer lesions in the future.

Skin Lesions - malignant

Basal Cell Carcinomas

Diagnostic tips - BCCs

- Common types are nodulocystic, superficial and morphoeic.
- Nodulocystic may mimic a cellular naevus on face - telangiectasia and translucency of BCC may give a clue.
- Beware of odd scars, especially on the face. The patient may even claim previous injury - but it may be a morphoeic BCC. Irregularity may be a clue.
- Tend to bleed.
- Pigmentation may occur within a BCC making differentiation from melanoma difficult.
- Common sites:
 - Head and neck.
 - Back in men.
 - Legs in women - where ulcerated nature may mimic a SCC.

Treatment: - depends on site, type, facilities and experience of physician:

- Excision with a 3 mm margin.
- Cryotherapy for superficial BCCs, must be applied aggressively
- Radiotherapy

Follow up

If fully excised - one follow up visit at 3 to 6 month to:

- Check on healing
- Advise on sun protection
- Explain what to look out for - 50% get a second BCC.

What can the dermatologist offer?

- Surgical excision.
- Selection for radiotherapy.
- Long term supervision and follow up for those with extensive or multiple lesions.
- Discussion of treatment options within the multidisciplinary team.

nb: Basal Cell Carcinomas are NOT included in Two Week Cancer wait

Squamous Cell Carcinomas

Diagnostic tips - SCCs

- Papule or nodule, which may be scaly with central ulceration to give a crateriform effect or have a central horn.
- Surrounding erythema.
- Tend to bleed
- Occur mainly in the over 70's on sun exposed sites.
- Check for nodes.

Treatment: - depends on site, type, facilities and experience of physician:

- Excision with a 3 mm margin.
- Radiotherapy

Follow up

If small (<1cm), well differentiated and fully excised - one follow up visit at 3 to 6 months to:

- Check on healing
- Advise on sun protection
- Explain what to look out for - 50% get a second BCC or SCC.
-

If > 1cm and / or poorly differentiated then follow up for 3 years:

- 1st year 3 monthly
- 2nd yr 4 monthly
- 3rd yr 6 monthly

What can the dermatologist offer?

- Surgical excision.
- Selection for radiotherapy.
- Long term supervision and follow up for those with extensive or multiple lesions.
- Discussion of treatment options within the multidisciplinary team.

PLEASE REFER URGENTLY via TWO WEEK WAIT

Malignant Melanomas

The prime criteria for diagnosis are:

Major signs:

- Growth
- Irregular edge.
- Variation in pigmentation.

Minor signs:

- Itch.
- Inflammation.
- Crusting or bleeding
- Diameter >7mm.

Treatment: Immediate full surgical excision with a minimum 2 mm margin. Once the diagnosis is confirmed then further wider excision is needed, the margin depends on the depth (Breslow thickness).

Prognosis - depends mainly upon depth, or Breslow thickness:

| | | |
|-----------------------------------|--------------|-----|
| 10 yr survival figures in UK are: | <0.76mm | 98% |
| | 0.76 - 1.5mm | 91% |
| | 1.5-3.0mm | 82% |
| | >3.5mm | 47% |

Sex - females do better than males

Age - prognosis worse after age 50yr, especially males

Site - trunk, upper arms, neck and scalp have a poor prognosis

Ulceration - poorer prognosis

| | | |
|-----------------|---|------|
| Clinical stage: | I Primary only | 75% |
| | II Regional nodal disease | 25% |
| | III Distant disease (visceral or nodes) | 0-5% |

Follow up

If Breslow less than 1mm: 1st year 3 monthly
2nd yr 4 monthly
3rd yr 6 monthly then discharge

If Breslow less than over 1mm: 1st year 3 monthly
2nd yr 4 monthly
3, 4 & 5th yr 6 monthly then discharge

At follow up:

- Check wound - look and feel for local recurrence
- Feel nodes regional and other main areas
- Examine all of skin for new lesions and cutaneous metastases
- Advise on sun protection
- Explain what to look out for - 10% get a second melanoma

What can the dermatologist offer?

- Diagnosis with immediate, and often definitive surgery, in the majority of cases.
- Discussion of treatment options within the multidisciplinary team.
- Referral to appropriate specialist surgeons & oncologists, if required.
- Long-term supervision and care.

PLEASE REFER URGENTLY via TWO WEEK WAIT

Sun Protection Advice

- Avoid the mid day sun (between 11am and 3pm)
- Cover up -
 - Wear closely woven covering clothing. Long sleeves, long trousers, or a long skirt should be worn.
 - Put on a broad-brimmed hat.
- Seek Shade - Try to keep in the shade.
- Apply a sun block - to all uncovered skin before you go out. It should be SPF 15 or higher. Reapply it frequently.

DERMATOLOGICAL SURGERY

An increasing amount of dermatological practice revolves around the assessment and removal of benign and malignant tumours from the skin. This is a guide to what might be undertaken by general medical practitioners with an interest in skin surgery, and how the dermatologist may be able to help.

Practice points

- Always operate within your experience and knowledge
- Whatever you remove - send it for histology.
- Make sure the specimen labelling is correct.
- Give the pathologist details of the site and a brief clinical history.
- When removing a pigmented lesion, especially if the clinical diagnosis is uncertain, complete removal with a 2mm margin, is desirable. Try to avoid incisional biopsies.
- The pathologist cannot comment on the completeness of removal of curetted specimens.
- It is rarely helpful to biopsy a rash unless you are asking the pathologist to choose between specific diagnostic alternatives.
- Cryosurgery is destruction of a lesion by freezing, usually with liquid nitrogen. Stinging and burning starts during treatment and continues through thawing, it usually settles within a few minutes. Consider giving paracetamol. Redness and swelling occur and this may be followed by a water (or blood) blister, especially where the skin is thin. Prick the blister with a sterile needle to let the fluid out. Repeat this until the blister no longer fills. Apply an antiseptic cream.

What can the Dermatologist offer?

- Basic training, help and advice.
- Experience and expertise in doing those procedures in which you may not feel confident.
- Support when you get unexpected histology results, or something has gone wrong.

AZATHIOPRINE

Azathioprine is the most widely used immunosuppressive drug for dermatological and autoimmune diseases.

It is important to note that it is slow acting. Its full effect is not realised for 6-8 weeks and a therapeutic trial should not be considered a failure until a minimum of 12 weeks treatment has been given. The immunosuppressive effects may persist for several months after the drug has been discontinued.

Indications. Azathioprine has been found useful in several dermatoses including: bullous pemphigoid, pemphigus, severe eczema, severe psoriasis, vasculitis, connective tissue diseases and the photodermatoses.

Dosage Guidelines. Azathioprine is given orally at a dose of approximately 1 mg / kg 1 day. Subsequent increases in dosage of 0.5mg/kg/ day to a maximum of 2mg/kg/day can be given at intervals of 6-8 weeks, provided there has been no toxicity and no response at the lower dose.

In practice, because this drug is supplied in 50mg scored tablets, the starting dose is 50-100mg/day and it is increased by increments of 25mg/day until the maximum required dose is achieved

Monitoring.

Baseline FBC including differential & platelets
U / Es, Creatinine
LFTs
Urinalysis
TPMT level - can predict those at risk of bone marrow suppression

Weeks 1, 2, 3, FBC including differential and platelets

Week 4 FBC including differential and platelets
U /Es Creatinine
LFTs
Urinalysis

Week 6 FBC including differential and platelets

Week 8 then every 1-2 month
FBC including differential and platelets
U / Es Creatinine
LFTs
Urinalysis

NB Stop azathioprine if: WBC < 4 (or falls rapidly to 4)
Platelets < 100, 000
Transaminases > double baseline

Drug Interactions: Drugs, which cause problems include:

allopurinol
anti-cancer drugs
drugs used in anaesthesia

Allopurinol inhibits the metabolism of azathioprine, therefore the dose of azathioprine should be reduced to 25-50% of normal. Other concomitant immunosuppressive drugs may accentuate bone marrow depression, infection or subsequent neoplasm. Viral replication may be uninhibited when live vaccines are given. The neuromuscular blockade of succinyl choline is accentuated by azathioprine. In contrast the neuromuscular blockade induced by D-tubocurarine and pancuronium is antagonised by azathioprine.

Adverse Effects.

Haematological - Bone marrow suppression is dose related and may occur at any time in the therapeutic course. Leukopenia is most common, thrombocytopenia less common. NB macrocytic indices without anaemia are common and do not require action. TPMT level - can predict those at risk of bone marrow suppression

Gastrointestinal - Nausea and anorexia occur early in at least 10% of patients. Dividing the dose and taking the tablets after meals may decrease these symptoms. Less frequent problems are oral ulceration, hepatotoxicity (reversible), diarrhoea, steatorrhoea and pancreatitis.

Infections - Opportunistic infections should always be considered in the assessment of any immunocompromised patient. Overall, they are relatively uncommon at the doses used in dermatology.

Carcinogenicity - Azathioprine is associated with an increased risk of Non-Hodgkin's Lymphomas and cutaneous squamous cell carcinomas. The risk is, however, much less in dermatology compared to those requiring high doses following organ transplantation.

Miscellaneous - Uncommon (<1%) adverse effects include fever, arthralgia, morbilliform rashes, muscle wasting, and alopecia. Chronic high doses of azathioprine may reduce fertility in either sex. Teratogenicity has been reported primarily in patients receiving combined therapy with prednisolone and not azathioprine alone. However, azathioprine should be avoided in pregnancy.

METHOTREXATE

Methotrexate is an effective anti-psoriatic agent. It is useful in acute generalised psoriasis, psoriatic erythroderma, psoriatic arthritis and in extensive chronic plaque psoriasis which has not responded to first line therapy and /or which affects a patient's ability to maintain employment. It is particularly useful in elderly or infirm patients.

It can be used for a few months, to bring patients unstable psoriasis under control before returning to other modes of treatment. More often, it is used as a long-term maintenance treatment for patients who have extensive or severe psoriasis.

70-80% of patients respond, usually within 4-6 weeks. Complete response usually occurs by 2-3 months.

Dosage Regimens. The dose of methotrexate must be individually assessed for each patient. Most serious problems, and the rare deaths, arise because of a relative, or absolute, overdose.

Give methotrexate as a single weekly dose on the same day each week (e.g. Wednesday).

Give a test dose of 2.5mg initially to detect patients who are abnormally sensitive. If the laboratory monitoring remains satisfactory, regular maintenance treatment may then be started one week after the test dose.

Doses are increased gradually from the first dose according to response. The absolute maximum is 0.5mg/kg but most patients can be maintained on 10-15mg/week or less.

Folic acid 5mg daily (but omitting it on the day methotrexate is taken) may be given to improve patient tolerance and reduce toxicity.

Monitoring.

Baseline FBC including platelets, U/Es, Creatinine & LFTs
Procollagen peptide 3

Follow up FBC including platelets, U/Es, Creatinine & LFTs – on weeks 1, 3 and 6. Also 7 days after each dose increase.
Gradually reduce frequency to every 3 months once stable.
Procollagen peptide 3 every 3-6 months

NB Stop methotrexate if: WBC <3
Platelets <100,000
Transaminases > double baseline

It may be restarted at a lower dose after a 2-3 week rest period if the laboratory abnormality has resolved.

Liver monitoring.

Traditionally: Liver biopsy – after every 1.5 – 2g – this was recommended, in those under 65y, after discussion of risks and benefits with the patient.

Recently: Procollagen peptide 3 is measured prior as a baseline then every 6 months and, provided it is normal at the start and does not rise then a liver biopsy is not needed.

Drug interactions. The following drugs may interact with methotrexate and increase its activity:

Alcohol
Aspirin, salicylates, NSAIDs
Co-trimoxazole, trimethoprim, tetracyclines, chloramphenicol,

Frusemide, probenecid, pyrimethamine
Phenytoin, phenothiazides retinoids, dipyridamole

Adverse effects:

- Hepatotoxicity – Liver fibrosis is related to the cumulative dose and concomitant alcohol consumption. It can only be reliably detected by biopsy. If methotrexate is stopped it may regress.
- Haematological – Bone marrow toxicity. NB macrocytic indices without anaemia are common and do not require action.
- Gastrointestinal – Nausea and anorexia are common. Diarrhoea, vomiting and ulcerative stomatitis are less often observed but frequently require stopping treatment.
- Reproductive effects – Methotrexate is a potent teratogen and abortifacient. Women should not conceive during treatment and for one month afterwards. Men should not father children during treatment and for 3 months after therapy. Reversible oligospermia may occur.
- Pulmonary toxicity – Acute pneumonitis is idiosyncratic and rare.

Rare side effects include mild alopecia, headaches, fatigue, dizziness and photophobia.

CICLOSPORIN

Ciclosporin is an immunosuppressant, which acts on T lymphocytes. It has been used in transplantation since the early 1980's and it has since been licensed for psoriasis, eczema and rheumatoid arthritis.

Who should be treated? The inherent risks of Ciclosporin dictate that use is restricted to those patients with severe disease who have not responded to first line and second line therapy or in whom such therapy is inappropriate.

How is it used in dermatology? Ciclosporin is generally used as an intermittent therapy to control disease exacerbations. 70-80% of patients respond, usually within 1-4 weeks with the full effect apparent by 2-3 months. If no response has been observed by 3 months ciclosporin should be stopped.

Atopic eczema - short (8 week) courses only.

Psoriasis - Intermittent courses, of generally 3-6 months. to achieve control. In patients who relapse rapidly after stopping Ciclosporin maintenance may be needed. In these cases the objective is not to clear the skin but to maintain substantial clinical improvement with the lowest possible dose of Ciclosporin.

Pre-treatment assessment

- Thorough general and dermatological history and examination to check for underlying disease, especially malignancy.
- Creatinine- a minimum of 2 measurements to establish an accurate baseline.
- Blood Pressure - a minimum of 2 measurements to establish an accurate baseline.
- Standard laboratory screening - FBC, U/ Es. LFTS, Uric acid, Lipids, Urinalysis

Indications for particular caution in use.

- Previous or current malignancies (except BCCs)
- Pre-malignant conditions
- 1 – 2 immunodeficiency.
- Severe hepatic dysfunction
- Abnormal renal function
- Uncontrolled hypertension
- Serious Infection of any type
- Tendency to drug or alcohol abuse
- Possible or known pregnancy and lactation
- Inability or will to co-operate with regular monitoring

Dose regimens

Psoriasis

- Start at 2.5mg/kg/day in 2 divided doses. (If maximum speed of response required. start at 5mg/kg/day)
- If no improvement after one month, gradually increase daily dose to a maximum of 5mg/kg/day.
- Stop if no response after 3 months
- Maintenance - titrate dose to lowest effective level in steps of 0.5- 1mg/kg/day

Atopic eczema

- Start at 2.5mg/kg/day In 2 divided doses (if maximum speed of response required, start at 5mg/kg/day)

-If no improvement after 2 weeks, rapidly increase daily dose to a maximum of 5mg/kg/day

- Stop treatment after 8 weeks

Monitoring

Baseline

Creatinine- a minimum of 2 measurements to establish an accurate baseline
Blood pressure – a minimum of 2 measurements to establish an accurate baseline
Standard laboratory screening – FBC, U / .Es, LFT, Uric acid, Fasting Lipids
Urinalysis

Follow Up Every 2 weeks for 6 weeks then monthly

Creatinine
Blood Pressure.
U/Es, LFTs
Urinalysis

-If Creatinine rises >30% of baseline at more than one measurement reduce dose by 25%-50%, then measure weekly. If dosage reduction does not reduce creatinine within one month stop Ciclosporin.

-If hypertension occurs diastole >95mm Hg on 2 consecutive occasions reduce dose or treat with calcium antagonists e.g. nifedipine.

Drug Interactions. The following drugs may interact with Ciclosporin:

Nephrotoxic

Increase Concentration

Decrease Concentration

Aminoglycosides
Amphotericin
Ciprofloxacin
Melphalan
Trimethoprim

Ketoconazole
Erythromycin
Oral Contraceptives
Calcium Antagonists
Doxycycline
Fluconazole
Itraconazole
Propafenone
Lipid Solutions

Phenytoin
Carbamazepine
Barbiturates
Rifampicin

Aspirin
NSAIDs

Take care with concomitant NSAIDs . Diclofenac doses should be halved as, when given with Ciclosporin, the plasma level of diclofenac increases.

Ciclosporin should not be ingested with grapefruit as this may affect absorption.

Adverse effects:

Most are dose dependant and respond to dose reduction.

-Hypertension
-Renal dysfunction
-Gum hyperplasia - this can be reduced by careful dental hygiene.
-Hypertrichosis - this usually resolves when treatment stops.

-Common: Nausea, tremor, paraesthesia, headache, abdominal discomfort. Most Of these subside as treatment becomes established.

-Less common: Rashes, mild anaemia, pancreatitis, neuropathy, confusion, oedema, dysmenorrhoea / amenorrhoea, muscle weakness / cramps, hyperuricaemia, gout, hypercholesterolaemia. hypomagnesaemia, weight gain.

Rare: Thrombocytopenia, malignancies, lymphoproliferative disorders