PRACTICAL TIPS ON THE MANAGEMENT OF COMMON RASHES AND LESIONS

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WAITING TIMES FOR NEW APPOINTMENTS

URGENT: 18 WEEKS

ROUTINE: 39 WEEKS

ROUTINE DAY CASE: OCTOBER 2024

Guidelines on Referral of Benign Lesions to Secondary Care

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

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

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

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

Notes

1. People with viral warts rarely need hospital referral, except in immunosuppressed individuals. Three months treatment with a salicylic acid based wart paint will clear 50- 70% of warts in three months.

Cryotherapy is painful, and almost always cruel and unjustified in children. Chiropody is an appropriate treatment for persistent plantar warts (not available through dermatology). Genital warts should be referred to the GUM department.

2. Large Epidermal cysts and lipomata are more appropriatelyy referredd to the general surgeons.

"ALLERGY TESTING"

- We patch test patients in whom we suspect allergic contact dermatitis is contributing to their eczema/dermatitis. This is a specialised procedure, offered only by dermatology departments.
- We do not perform prick testing, except in patients with suspected type 1 allergy to latex, or in individuals in whom we suspect a contact irritant.
- Prick testing is of no value in chronic urticaria. If the patient's "allergy" symptoms relate to systems other than the skin, e.g. respirator y tract, it is appropriate to refer to the relevant discipline.
- We are fully aware that there are many reasons for referring patients with the above conditions, not least of which is patient pressure. If the referral falls outside these guidelines, it will be rejected
- Alternatively, you may wish to resubmit the referral clarifying the details of the exceptional circumstances surrounding the case.

Quantities

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

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

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

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

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

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

Prescribing of topical steroids for children

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

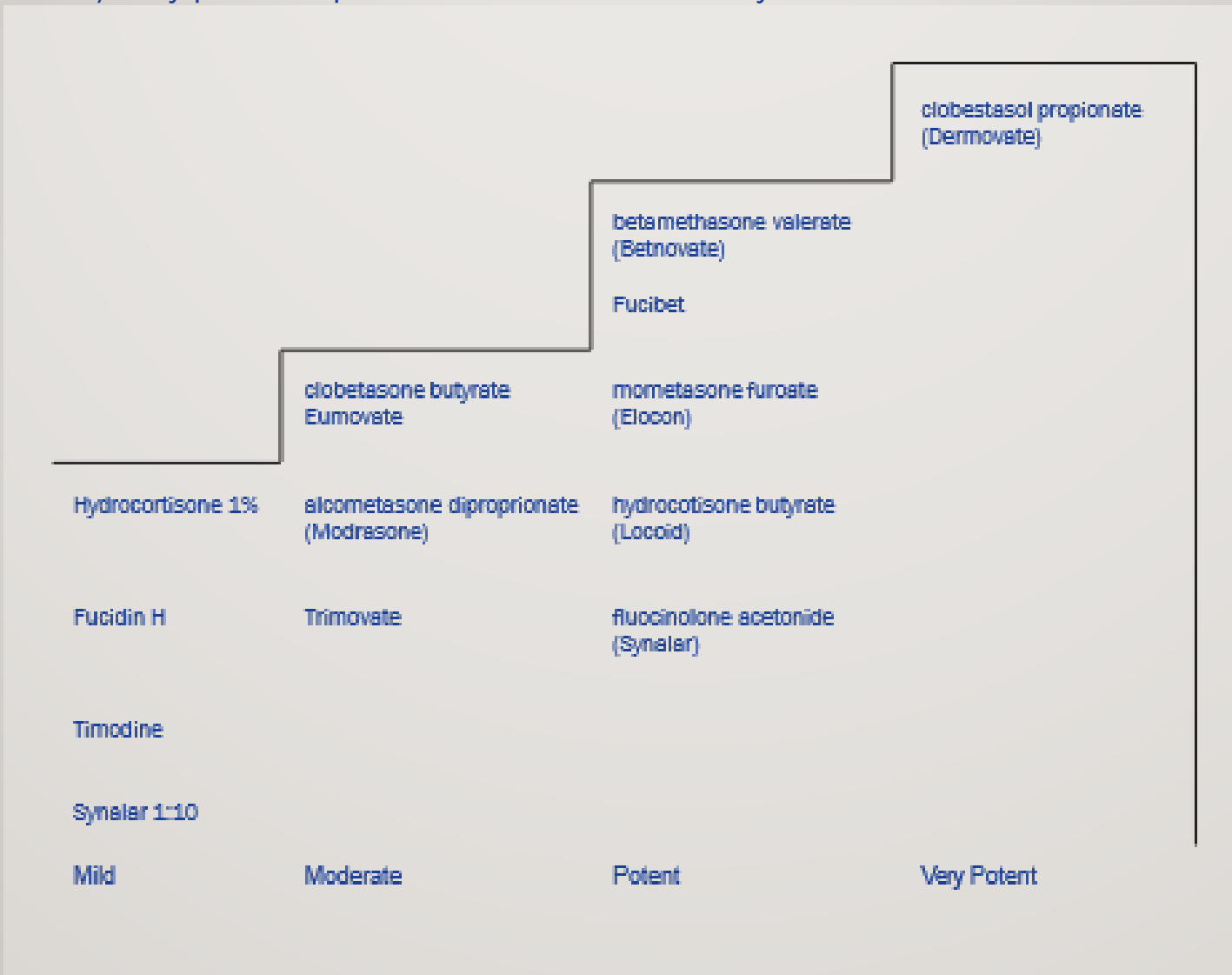
Finger Tip Units for Treating Children with Steroids

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

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

Topical Steroid Ladder

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



ATOPIC DERMATITIS IN CHILDREN

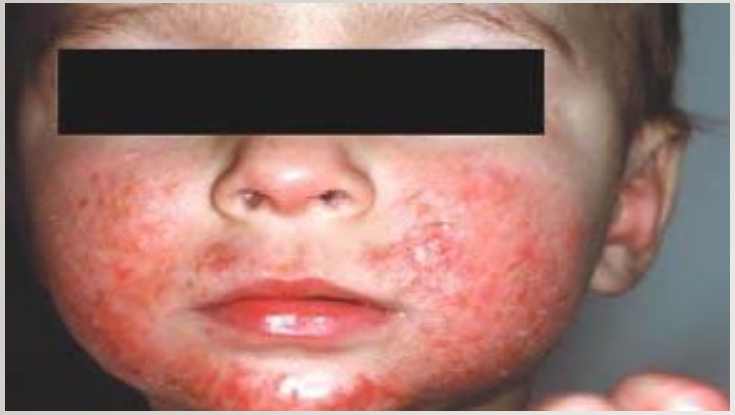
CLINICAL FEATURES

- Common disease affecting up to 15% of children
- Involvement of the face frequently occurs in infants with adoption of a characteristic flexural distribution by 18 months of age
- Realistic treatment aims need to be discussed with patient and parents
- The commonest infecting organism is Staph aureus producing yellow crusting

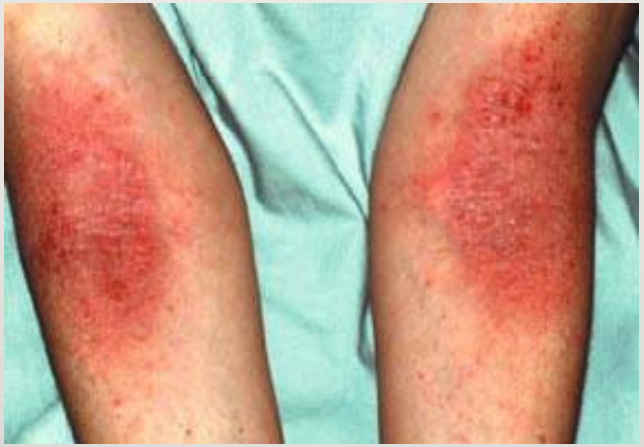
GENERAL MEASURES

- Soaps, detergents, bubble bath, shower gel should be avoided
- Cotton clothing should be used and avoid wool next to the skin
- Fingernails should be kept sort to reduce skin damage from scratching
- Bathing is not harmful but an emollient has to be used

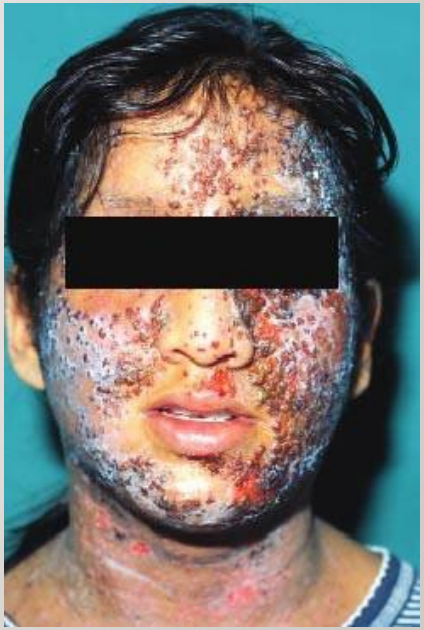
Atopic eczema in children



Atopic eczema



Flexural distribution



Eczema Herpeticum

ATOPIC DERMATITIS IN CHILDREN

EMOLLIENTS

- Emollients should be prescribed in all cases
- Added to the bath (Oilatum, Balneum, Bath E45)
- Used directly to the skin during bathing (Epaderm ointment, Aqueous cream, Diprobase cream, E45)
- Greasier preparations are better at hydrating the skin (Epaderm ointment, 50:50 WSP/LP)
- Some combination preparations have extra benefits (Calmurid cream, Dermol 500, Oilatum plus)
- Some patients have a preference and you may have to supply several until the patient finds something they like and therefore USE
- Advise patients that bath and shower base will be very slippery

ATOPIC DERMATITIS IN CHILDREN

TOPICAL CORTICOSTEROIDS

- Mild (1-2.5% Hydrocortisone acetate)
- Moderate (Clobetasone Butyrate, Betamethasone valerate 1:4 RD)
- Potent (Betamethasone Valerate 0.1%, Mometasone)

Although potent preparations can cause skin atrophy with LONG TERM USE, topical steroids are often underused because of concern about side effects

- Ointment preparations are usually more effective than creams but messier to use – better for dry/lichenified eczema
- Creams can be used if eczema is weeping or on the face
- Mild/moderate potent steroids should control most cases of eczema when prescribed in appropriate amounts
- Might be necessary in some cases to gain control with moderate/potent and then reduce to mild strength

ATOPIC DERMATITIS IN CHILDREN

ANTIBIOTICS

- Consider antiseptic moisturiser combination (Oilatum plus, Dermol 500)
- Use steroid/antibiotic combination (Fucidin H, Fucibet) on infected areas for a short period (no more than 2 weeks)
- If the infection is widespread or severe treat with systemic antibiotics (Flucloxacillin, Erythromycin)
- Nasal swabs from patient and family members in recurrent infections
- Infection should be suspected whenever eczema worsens
- Eczema that weeps is probably infected with Staph aureous
- Swabs for M&C if in doubt
- Treat with Naseptin, Bactroban nasal if positive nasal swabs

ATOPIC DERMATITIS IN CHILDREN

ANTIHISTAMINES BANDAGES

- Sedative antihistamines are suitable for short term use to control itching at night
- Bandaging – zinc paste bandages used alone or over topical steroids can result in rapid improvement of particularly lichenified eczema
- Wet wrap dressings at night can be helpful for small children

ALLERGIES/ALLERGY TESTING

- No tests are available to confirm or refute food allergy as a cause of worsening eczema
- RAST tests/skin prick tests are not helpful
- HDM can aggravate eczema in some children
- Food allergies (egg, wheat, or dairy) occasionally cause worsening eczema
- Food allergy/intolerance is often a temporary phenomenon. Re-introduce food in question every few months

ATOPIC DERMATITIS IN CHILDREN

MISCELLANEOUS

- Evening Primrose Oil: no consistent evidence that it helps
- Chinese herbs: no product licences and poor standardization, positive effects in some children but potential side effects, some contain potent steroids
- Topical Steroid Withdrawal: www.bad.org.uk for INFO

CRITERIA FOR REFERRAL

- Only cases of severe or difficult eczema
- Second line treatment/phototherapy
- Eczema herpeticum
- Suspicion of allergic contact dermatitis
- For inpatient treatment
- For parent education by a Dermatology nurse specialist

HAND ECZEMA

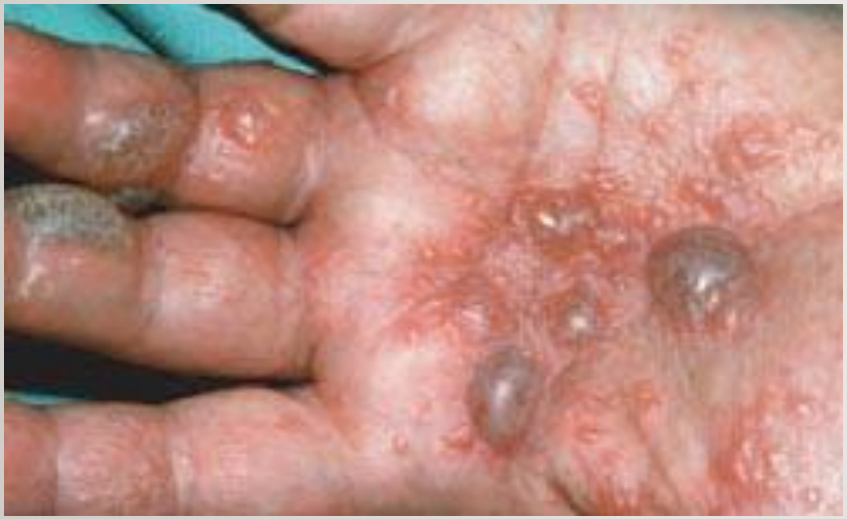
CLINICAL FEATURES

- Endogenous/atopic eczema
- Exogenous eczema

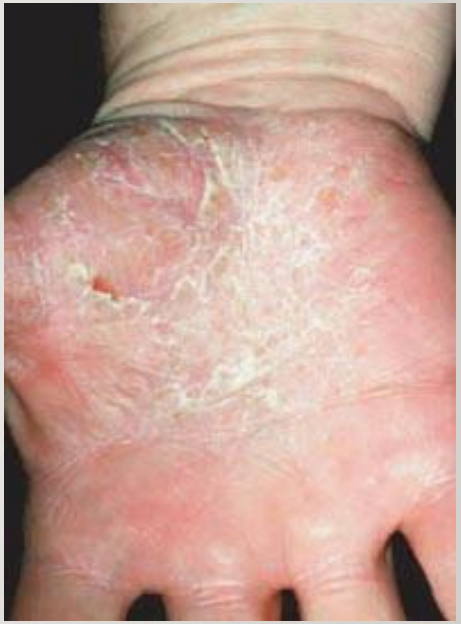
1. Contact irritant eczema: due to substances coming into contact with skin repeatedly(detergents, shampoos, household cleaning agents)
2. Contact allergic dermatitis: Type IV allergic reaction to a substance the skin is in contact with

TREATMENT

- Avoidance of irritants (soap substitutes, gloves)
- Emollients
- Potent topical steroids(cream formulation for "wet" and ointment for "dry"
- Antibiotics (topical/systemics)
- Potassium permanganate 1:10000 soaks 15min daily



"Wet" (blistering and weeping)



"Dry" (hyperkeratotic and fissured eczema)

HAND ECZEMA

HELPFUL TIPS

- Tinea (if "eczema" is present on only one hand), scabies can mimic hand eczema and should be kept in mind
- If contact dermatitis is suspected careful occupational and social history should be taken- patch testing will be required
- Patch testing is only of value in patients with eczema – it is no use with Type I reactions or urticaria

CRITERIA FOR REFERRAL

- If allergic contact dermatitis is suspected and patch testing is required
- Severe chronic hand dermatitis unresponsive to treatment described above

PSORIASIS

CHRONIC PLAQUE MILD/MODERATE

- Vitamin D analogues (Calcitriol 210g weekly, Calciprotriol 100gr weekly)
- Tar preparations (Alphosyl cream, Exorex lotion)
- Dipsosalic ointment
- Dovobet/Enstillar foam
- Emollients

GUTTATE

- Numerous small plaques mainly trunk, mainly children/young adults
- Often self –limiting
- Emollients
- Vitamin D analogues
- Moderaty potent steroids
- Early referral for phototherapy if severe

PSORIASIS

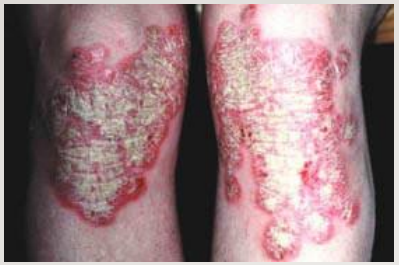
SCALP PSORIASIS

- Requires combination of keratolytic and anti-inflammatory agents
- Cocois/Capasal shampoo
- Polytar/Alphosyl shampoo
- Betamethasone scalp application
- Diprosalic scalp application
- Hairline: Synalar gel, Alphosyl HC
- Beyond hairline and into face: Calcitriol
- Treatment needs to be performed by a second person to be effective

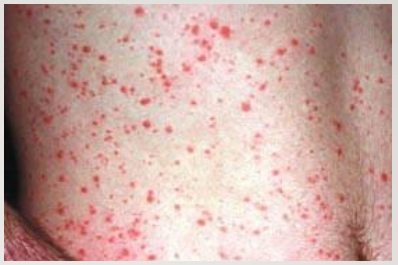
FLEXURAL PSORIASIS

- Calcitriol safe ,effective and well tolerated
- Mild/moderate potency steroids combined with antifungal/antibiotic : Timodine, Trimovate cream

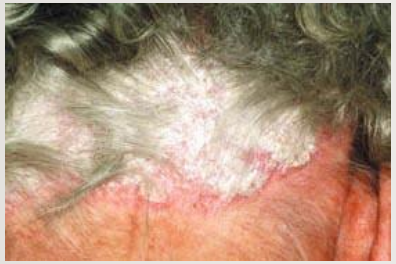
Psoriasis



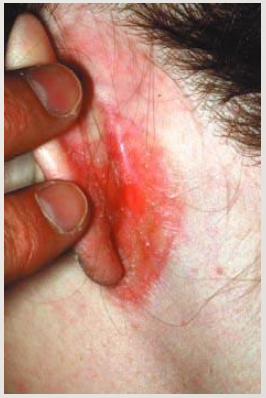
Chronic Plaque Psoriasis



Guttate Psoriasis



Scalp Psoriasis



Flexural Psoriasis

PSORIASIS

HELPFUL TIPS

- Calcitriol licensed for use on face, flexures, trunk, limbs
- Gradual improvement (12 weeks) with Vit D analogues
- Coal tar products may stain clothes or irritate, slow response(6-12 weeks)
- Diprosalic: for thick plaques on elbows, knees, sacrum , scalp

CRITERIA FOR REFERRAL

- Extensive/severe/ disabling disease
- Failure to respond to adequate Rx or rapid relapse post Rx
- Extensive guttate type
- Unstable or generalized pustular psoriasis

ACNE VULGARIS

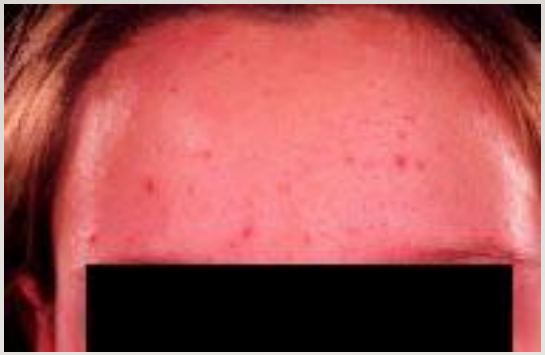
CLINICAL FEATURES

- Mild :uninflamed lesions- open/closed comedones
- Mild/Moderate: comedones and some papules/pustules
- Moderate :greater number or more extensive inflamed lesions
- Moderate/Severe: papules and pustules with deeper inflammation and some scarring

TREATMENT

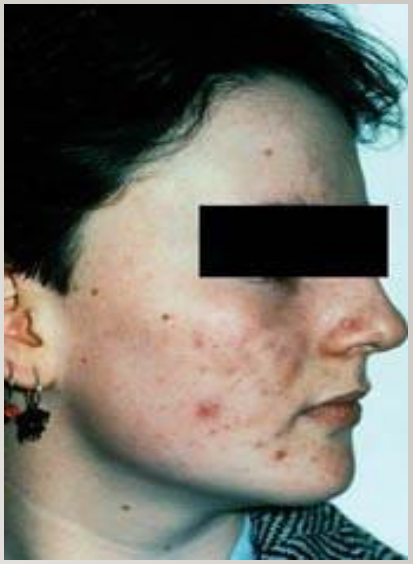
- Topical retinoids : Adapalene, Tretinoin, Isotrex
- Topical retinoid or topical BPO +/- topical antibiotic: Zineryt, Isotrexin, Duac, Treclin
- Systemic antibiotics: tetracyclines, erythromycin
- Systemic antibiotics plus topical therapy , consider Dianette in females

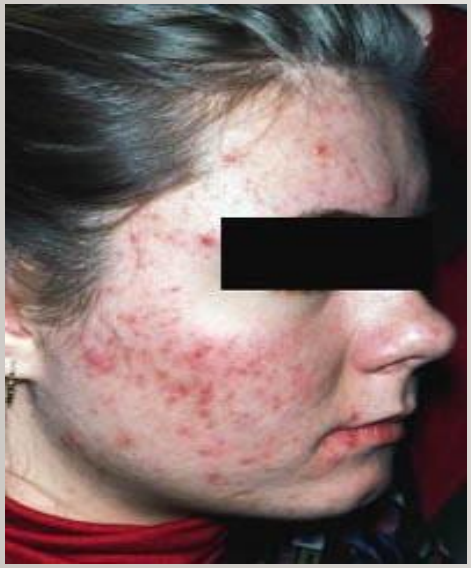
Acne



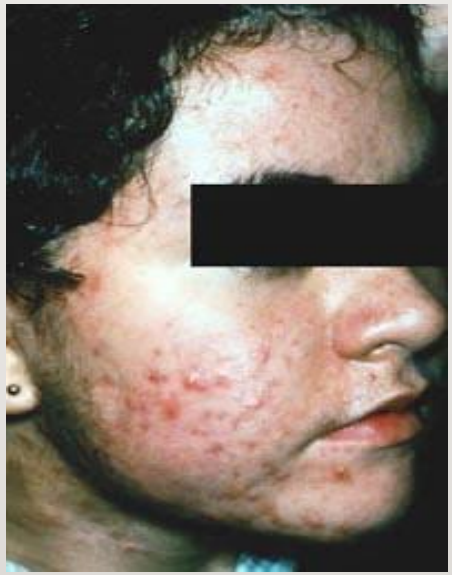
Mild

Mild—Moderate

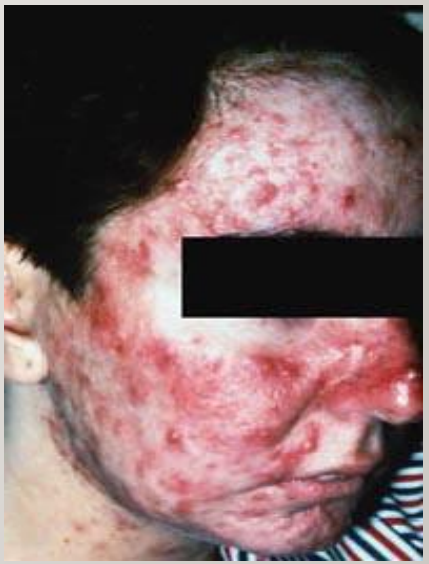




Moderate



Moderate Severe



Severe

ACNE VULGARIS

THERAPEUTIC TIPS

- Treatment lengthy minimum 6 months
- Slow response –allow 12 weeks at least before review
- Topical retinoids cause skin irritation
- Do not use combinations of agent with similar properties
- Confluent/ nodular lesions with significant scarring need to be referred immediately for systemic Isotretinoin

CRITERIA FOR REFERRAL

- Main reason for referral: systemic isotretinoin Rx
- Indications

1. Severe nodulocystic acne
2. Moderate acne that failed to respond to prolonged courses (>6 months) of systemic antibiotics plus topical Rx
3. Moderate acne in patients with extreme psychological reaction to their acne and have failed to respond to Rx

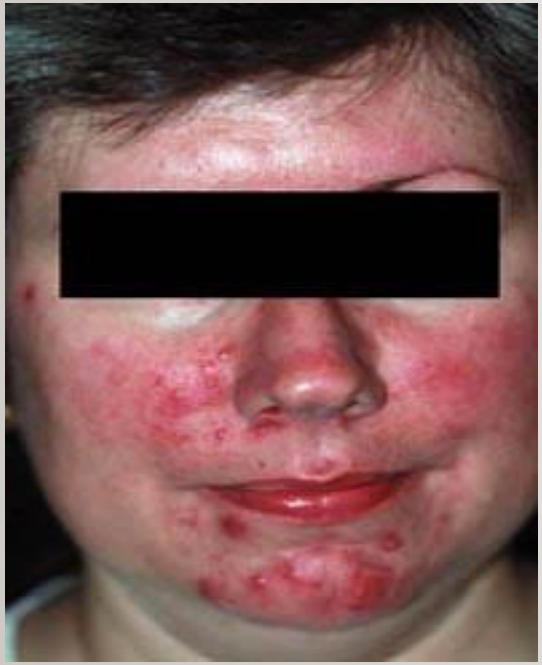
ROSACEA

CLINICAL FEATURES

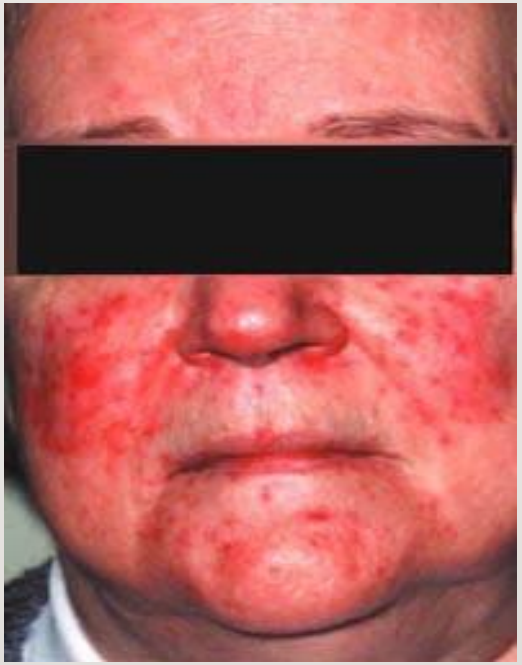
- Flushing
- Telangiectasias
- Papules on erythematous background
- Pustules
- Rhinophyma
- Ocular rosacea

TREATMENT

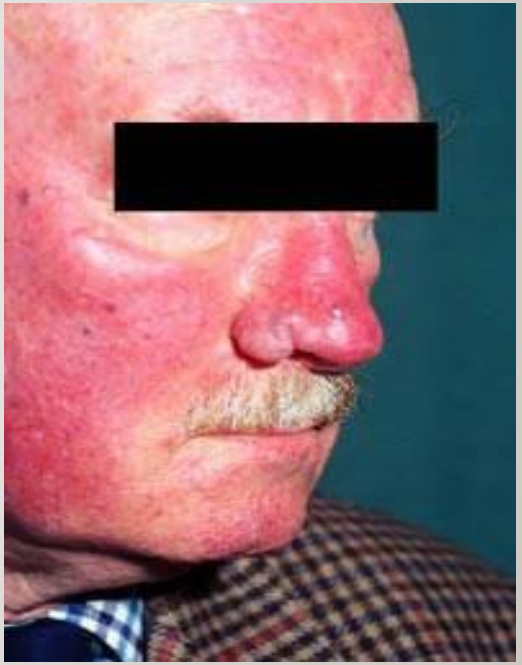
- Topical Rx: Metronidazole gel/cream, ivermectin cream
- Systemic Rx: Tetracyclines, Erythromycin
- Shave and cautery for rhinophyma
- Pulse dye laser/IPL for telangiectasias
- Cosmetic camouflage



Rosacea



Rosacea



Rosacea (with Rhinophyma)

ROSACEA

THERAPEUTIC TIPS

- Early treatment reduces skin damage and risk of more advanced disease
- Consider intermittent therapy for patients with occasional flare ups
- Topical Rx for maintenance after finishing systemic antibiotic course
- Avoid topical steroids
- Response within 4-6 weeks but treatment needs to be carried on for 8-12 weeks
- Sun avoidance /suitable sun block
- Erythromycin is NOT contraindicated in pregnancy
- Tetracyclines for ocular rosacea
- Secondary care referral if doubt over diagnosis, severe disease or severe ocular rosacea

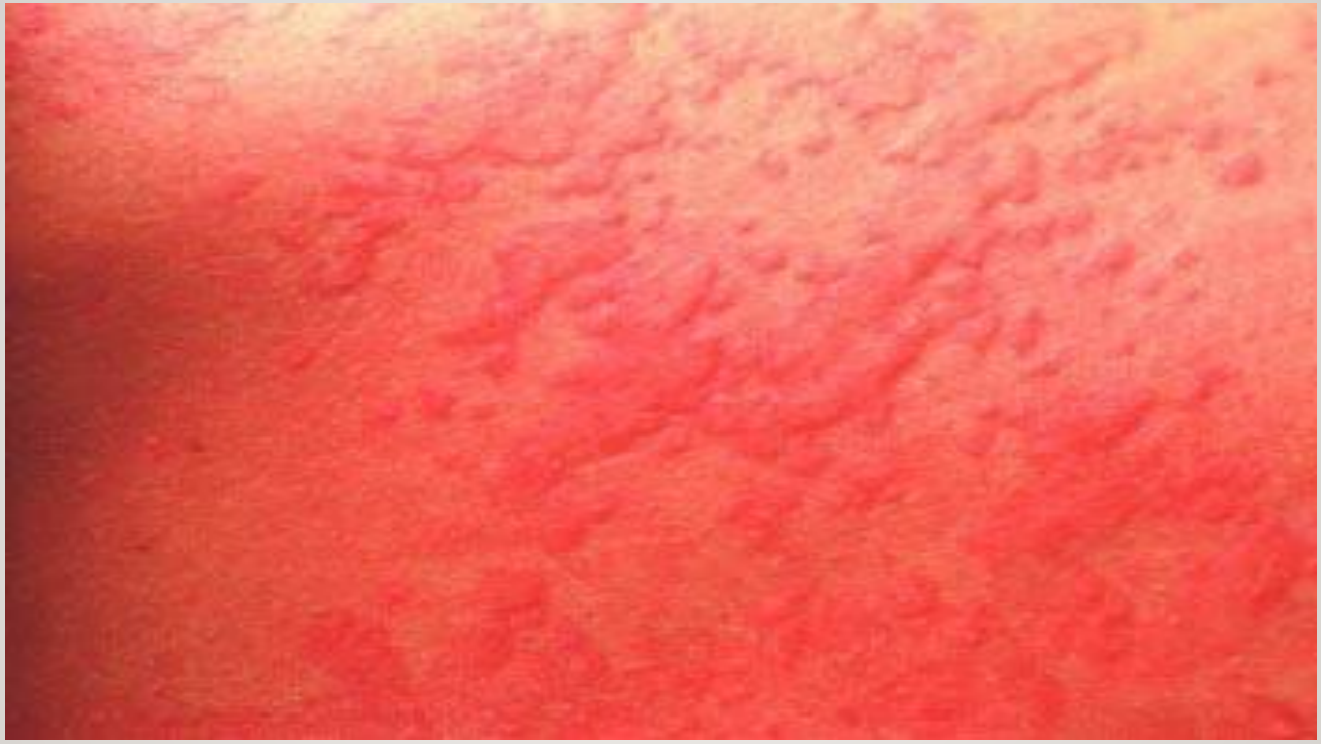
URTICARIA/ANGIOEDEMA

CLINICAL FEATURES

- Explain usually benign and self limiting
- Minimise: overheating, stress, alcohol
- Review prescribed and non-prescribed drugs
- Exclude insect bites and C1 esterase deficiency if angioedema only sign
- FBC, TFTs, c3, c4 if indicated clinically
- Recognize physical urticarias (dermographism, cholinergic, solar, pressure, cold urticaria)

TREATMENT

- High dose non sedative antihistamines up to QDS
- Consider addition of H2 antagonists (Famotidine 20mg bd)
- Consider addition of Montelukast
- Short reducing courses of Prednisolone for acute severe urticaria



Urticaria

URTICARIA/ ANGIOEDEMA

- No trigger factor identified in the majority of patients
- Prick /RAST tests not helpful in CIU
- Food allergy usually obvious as trigger
- Contact urticaria generally suggested by history
- May follow non specific viral/bacterial infections
- Avoid drugs that might exacerbate flares (NSAIDs, opiates, ACE inhibitors)
- Rarely a symptom of underlying systemic disease (thyroid or connective tissue disorder)
- REFER:

1. hereditary angioedema
2. non responsive urticaria after 6 weeks of treatment
3. extremely severe urticaria/angioedema

VIRAL WARTS AND MOLLUSCUM CONTAGIOSUM

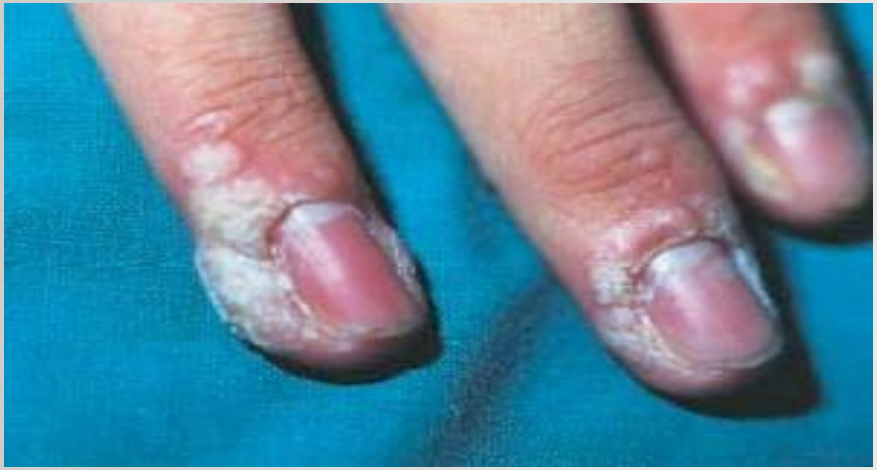
CLINICAL FEATURES

- Common and self limiting viral induced lesions
- No easy or guaranteed treatments
- Best left to resolve spontaneously
- Majority of facial warts clear within 2 years
- Plantar warts more persistent
- Molluscum clear within a year but persistent in atopic children

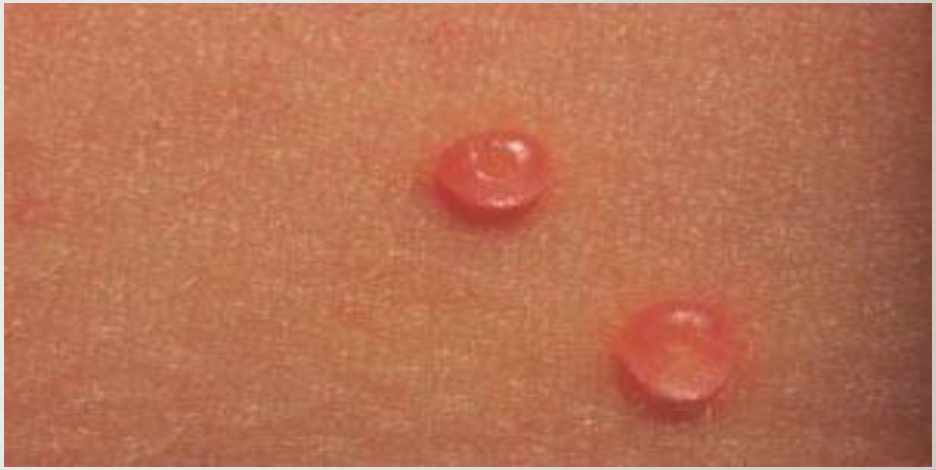
TREATMENT

- High concentration salicylic acid preparation
- Cryotherapy but pare down with scalpel first at 4 weekly intervals (not recommended in young children)
- Discontinue cryotherapy after 6 treatments if not effective
- Affected children should have own towels
- Treat impetiginized molluscum with emollients/topical steroids/antibiotics
- REFER: immunocompromised patient or functionally problematic lesions

Viral warts and molluscum contagiosum



Viral warts



Molluscum contagiosum

GENERALISED PRURITUS

- Dry skin , eczema and scabies commonest cause of generalized pruritus
- Detailed history and careful full body examination
- If NO RASH can be seen other than excoriations consider:

1. Iron deficiency anaemia
2. Uraemia
3. Jaundice
4. Thyroid disease
5. Lymphoma
6. Cancer
7. Psychogenc

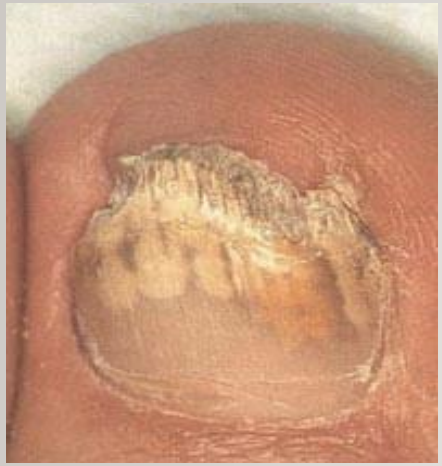
- Emollients/soap substitutes
- Crotamiton
- Menthol in Aqueous cream
- Consider Doxepin, Amitriprylline
- Sedating antihistamines
- Avoid chronic use of topical steroids
- Investigations: CXR, FBC, UEs, LFTs, TFTs, Iron studies, ESR
- PRURITUS CAN PREDATE LYMPHOMA BY SEVERAL YEARS

THICKENED AND DYSTROPHIC NAILS

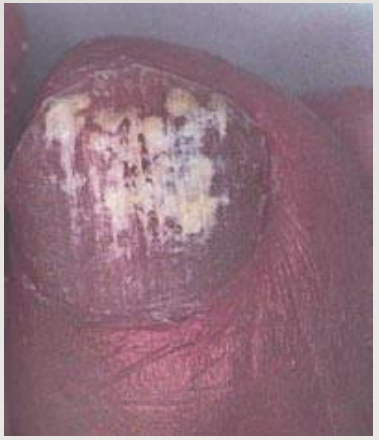
- Thickness of nail plates is normally 0.5mm
- Increased thickness in:

1. Manual workers
2. Onychomycosis
3. Psoriasis
4. Chronic eczema
5. Lichen Planus
6. Alopecia Areata
7. Darier's disease
8. Trauma
9. Old age
10. Congenital icthyosis

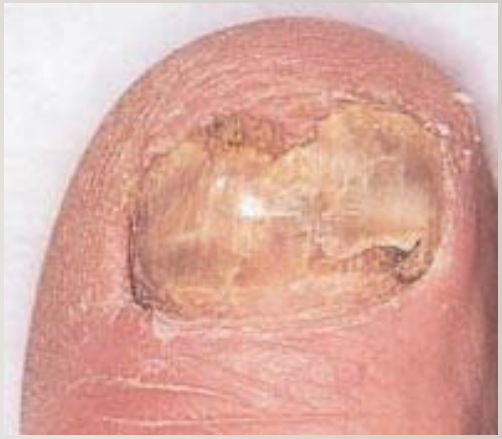
- Oral antifungals for distal onychomycosis (Terbinafine 250mg od for 12-16 weeks, Pulse Itraconazole 200mg bd for 7 days -3 cycles)
- Oral antifungals plus Amorolfine nail lacquer for Matrix involved onychomycosis (Baran et al. British Journal of Dermatology 2000)
- Nail clippings prior to oral therapy



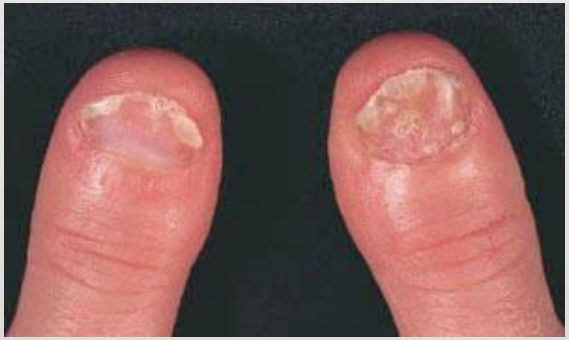
Non-matrix Onychomycosis



Non-matrix Onychomycosis
(superficial white Onychomycosis)



Matrix involved Onychomycosis



Psoriatic nail

SKIN CANCER

- BCC

1. Common
2. Slow growing
3. Pearly rolled edge (nodular/infiltrative)
4. (Later) Central ulceration
5. Pigmented BCC
6. Morphoeic (scar like) variant
7. Superficial variant

- Best managed with complete excision unless superficial variant
- Radiotherapy for large lesions or in cosmetically sensitive areas (tip of nose) but biopsy is required prior to referral
- 5% Imiquimod or double curettage and cautery for superficial variant
- Stretching skin will often make pearly edge of lesion more prominent

SKIN CANCER

- SCC

1. Less common
2. Slow growing (well differentiated) or rapidly enlarging (poorly differentiated)
3. 1-2% can metastasise to regional lymph nodes
4. Excision is gold standard
5. Double curettage and cautery acceptable for small well differentiated SCCs in patient with multiple comorbidities (advanced dementia)

- Malignant melanoma

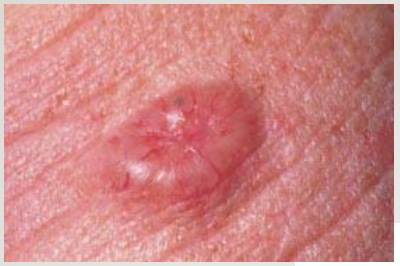
1. Superficial spreading
2. Nodular
3. Amelanotic (rare)
4. Lentigo malignant melanoma
5. Acral lentiginous
6. Subungual

- Any suspicious mole needs to be referred as 2ww

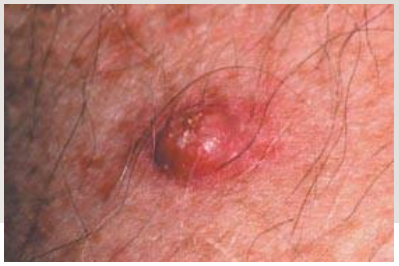
THANK YOU FOR YOUR ATTENTION

ANY QUESTIONS?

Non melanoma skin cancer

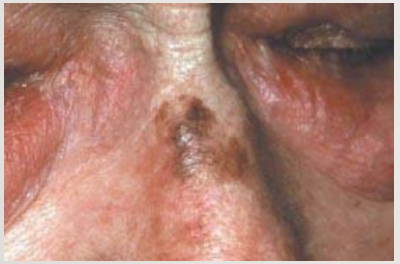


Basal cell carcinoma

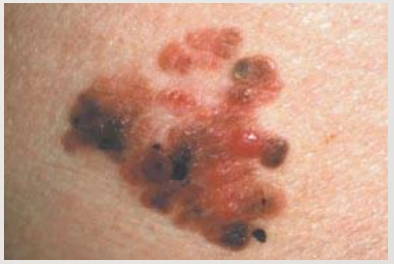


Squamous cell carcinoma

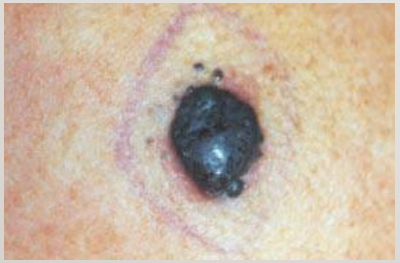
(Malignant melanomas)



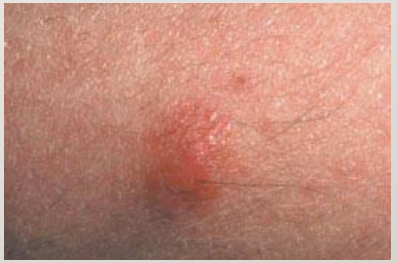
Lentigo maligna



Superficial spreading



Nodular



Amelanotic