DERMATOLOGICAL GUIDELINES

GUIDELINES FOR THE MANAGEMENT OF COMMON DERMATOLOGICAL DISORDERS IN PRIMARY CARE
(2nd Edition)

Main author:
Chris Harland
Consultant Dermatologist, Epsom & St. Helier Hospital

Supported and Sponsored by:
The Dermatology Primary Care Specialist Working Clinical Group, Merton & Sutton

Co-authors:
Sandeep Cliff
Consultant Dermatologist, Epsom & St. Helier Hospital
Steve Fuller
Interface Pharmacist, Epsom & St. Helier Hospital
Bob Bettridge
General Practitioner, Morden Hall Medical Centre
John Martin
General Practitioner, Wrythe Lane Medical Centre
Wendy Dudley
Dermatology Nurse Specialist, Epsom & St. Helier Hospital
Norman Evans
Pharmaceutical Adviser, Wandsworth PCT
Ian Wilson
General Practitioner (Revisions)
Fiona White
Nurse Practitioner (Revisions)
Philip Watkins
Community Nurse Specialist (Dermatology)
Pauline Beldon
Consultant Nurse (Revisions)

Main Editors:
Colin Holden
Consultant Dermatologist, Epsom & St. Helier Hospital
Peter Mortimer
Professor Dermatology, St. George’s Hospital
Allan Marsden
Consultant Dermatologist, St. George’s Hospital
Lucy Ostlere
Consultant Dermatologist, St. George’s Hospital
Robert Sarkany
Consultant Dermatologist, Queen Mary’s, Roehampton
Tamara Basarab
Consultant Dermatologist, Queen Mary’s, Roehampton
Sue Mayou
Consultant in Public Health Medicine,
Chair of MSW Dermatology Working Group (2000)
Annabel Ross (dec.)
Consultant in Public Health Medicine,
Chair of MSW Dermatology Working Group (2000)

Sutton PCG, East Merton & Furzedown PCG, Queen Mary’s University Hospital,
Epsom & St. Helier NHS Trust, Leo Pharmaceuticals,
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These guidelines have been endorsed by the Dermatology Primary Care Specialist Working Clinical Group, Merton & Sutton
The overall aim of this booklet is to help general practitioners and other health professionals in the management of dermatological conditions. Ten topics cover common skin disorders which give rise to difficulties and uncertainties in medical management. Specific objectives can be listed as follows:

- Increase confidence of general practitioners in treatment of dermatological conditions
- Educate health professionals and medical students about the management of skin disorders
- Aid to diagnosis (with selected illustrations)
- Improve quality of hospital referral to dermatology centres (currently swamped by a year-on-year rising referral rate)
- Enhance doctor-patient communication through the use of information leaflets and websites
- Improve cost-effectiveness of treatments within primary care
- To fulfil a demand for guidelines amongst general practitioners (a survey of SW London GPs showed 92% of respondents wanted guidelines for dermatology in primary care)

The guidelines are, wherever possible, evidence-based and are locally adapted for the needs of Merton, Sutton and Wandsworth, although other areas might benefit from them. Established criteria for the development of Medical Guidelines have been adhered to.

The authors are from both Primary and Secondary care. However, it is general practitioners who have had the most input into the design and content of this publication. Expert advice has also been sought from all quarters of the district.

Each topic is covered by a page of text with a facing flow-chart, incorporating illustrations. The text is intentionally brief. This second edition has incorporated important new therapies. There are four appendices. Appendix A gives advice on the use of emollients; appendix B contains some patient information leaflets, which can be reproduced without implications of copyright but others have been omitted in lieu of superior website addresses; appendix C relates to dermatological procedures and surgery, which might be carried out within the community; appendix D now contains Recognition of Skin Cancer by popular demand; appendix E provides the updated and mandatory skin cancer referral proforma for faxing (the previous sheet should be abandoned). The original Appendix A (drug cost comparisons) is obsolete. The ring-binder format should facilitate the future addition of supplements or updates. Appendix E also contains useful addresses/websites, and nurse specialist referral proforma.

Finally, it is hoped that these guidelines will be effectively implemented by the combination of postal dissemination and seminars, intranet launch, and provision of CD-ROMs.
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To all GP practices in Sutton and Merton PCT

Fax: 020 8715 2776

Email: annette.bunka@smpct.nhs.uk

Subject: Additional Dermatology Clinics

Sutton & Merton PCT has been working on a project to introduce primary care specialists into the PCT, with Dermatology being one of the six specialities prioritised.

It is proposed that specific Dermatological symptoms/conditions would be managed by an appropriately trained GP with a special interest (GPSI) in Dermatology. Examples include: advice on the management etc. for symptomatic benign lumps & bumps (skin lesions), highly symptomatic viral warts, molluscum contagiosum, acne (not requiring Roaccutane), moderate Psoriasis, moderate Eczema (not chronic contact), diffuse hair loss and common skin infections.

Two GPs are approved as GPSI, with clinics starting 2005. Two more GPs are being trained for 2006. In the first phase, it is intended that the service will be based at both Nelson and Sutton Hospitals.

In addition to this we have recently recruited a Specialist Nurse in Dermatology, Philip Watkins. Philip will be taking referrals patient advice, treatment maintenance and minor adjustments and backup with extended independent prescribing support and information relating to simple dermatoses, such as mild to moderate acne, adult and childhood and elderly (varicose) eczema, and psoriasis; as well as simple infections, such as impetigo, pityriasis, scabies, tinea and highly symptomatic warts.

The Dermatology Primary Care Specialist Group has drawn up a referral plan in order to support the selected GPs in referring appropriate conditions into the GPSI service. A copy of this is attached. In order to access the GPSI service, send your referrals to Epsom and St Helier NHS Trust and mark them as a GPSI in Dermatology referral. A referral proforma for specialist nurse can be photocopied from the last page (p78).

It is hoped that through these new services we will reduce the waiting times across Dermatology and provide more services to patients closer to where they live.

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**DERMATOLOGY REFERRAL PLAN (Merton and Sutton)**

**DIAGNOSIS UNKNOWN**

- 2 week rule
- Skin Cancer/Pre-Cancer
- Severe/Urgent Disease
- Other specified reason

**GP**

- Inappropriate referral letter should see GPwSI
- Advice/referral + management

**Consultant Service**

- Urgent or severe problems
- Needs community nursing referral e.g. childhood eczema

**DIAGNOSIS KNOWN**

- Treat & Discharge
- Nurse Led Support/Advice/Information: highly symptomatic viral warts, childhood eczema, Psoriasis and chronic dermatosis

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Referrals should only be made in line with Dermatology Guidelines

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The GP Specialist (GPSI) referral guidelines below have been agreed with Merton & Sutton PCT. For further information on Wandsworth PCT GPSI’s please contact Dr Allan Marsden, Consultant Dermatologist, on 020 8725 1996, or Wandsworth PCT Dermatology Clinic, 5 McMillan Way, Tooting Bec, London SW17 9SJ Tel: 0208 682 0521
Although this book is primarily directed at dermatological care within the community, the inevitable question often arises: ‘when, and when not, to refer’. Each topic addresses this problem in the form of a flow-chart. However, there are some general issues which are worth emphasising.

Table 1 provides basic guidance on referral. Also specific clinical scenarios are highlighted. Undertreatment is particularly common, due to misconceptions about safety of steroid creams, about quantities of creams needed per prescription, and because of poor patient compliance.

**TABLE 1**

Consider referral

- Diagnosis uncertain
- Hospital-based investigations needed
- Specialist treatment needed

The local dermatologists accept that reassurance and advice is sometimes needed, e.g. recurrent severe atopic eczema. Also it is appreciated that some patients and families place unreasonable demands on their GP to refer.

Referral debatable or of no value

**In general**

- Removal of benign lesions
- Undertreated patients

**Specifically**

- Urticaria for “allergy tests” (pp 26, 27, 52)
- Fungal infections (pp 16, 17)
- Suspected Scabies (pp 22, 23)
- Molluscum contagiosum (pp 21, 25)
- Itchy moles (pp 14, 15, 65, 66)
- One-off bleeding moles (pp 14, 15, 65)
- Acne, unless scarring or cystic, or true ‘treatment failure’ or psychological risk (pp 8, 9)
- Seborrhoeic keratoses (pp 14, 26, 71)
- **Viral Warts (pp 20, 21)**

Patients within the above categories should not be referred to hospital. Please contact your local GP specialists (GPSI’s) or dermatology specialist nurse for advice if necessary.

- Do not shave biopsy or curette moles unless absolutely certain of benign nature.
- Always send histology (except skin tags)
- Never punch biopsy pigmented lesions
- Never shave flat moles and avoid thin ‘slithers’ (see Appendix C)

Referral letters should include telephone numbers and patients’ NHS numbers. The drug history should contain details of topical therapy, indicating quantities prescribed, and of antibiotic dosage.
Undertreatment

In general, do not refer unless the optimum treatment has been provided, particularly with respect to emollients (500g/500 ml per prescription), and corticosteroids (see Table 2).

Steroid side effects

Potential side effects from topical steroids are widely publicised, resulting in misconceptions and apprehension about their correct, safe dosage (Table 2).

### TABLE 2

Safe average weekly doses (for adults) of topical steroids (not face)

<table>
<thead>
<tr>
<th>Treatment period (Months)</th>
<th>Potency (category)</th>
<th>Mild/Moderate ($\frac{1}{2}$)</th>
<th>Potent (3)</th>
<th>Very Potent (4)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>e.g. Eumovate 100 g</td>
<td>Betnovate 50 g</td>
<td>Dermovate 30 g</td>
</tr>
<tr>
<td>&lt; 2</td>
<td></td>
<td>50 g</td>
<td>30 g</td>
<td>15 g</td>
</tr>
<tr>
<td>2-6</td>
<td></td>
<td>25 g</td>
<td>15 g</td>
<td>7.5 g</td>
</tr>
<tr>
<td>6-12</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Suggested finger tip dosages for affected areas

References:
Coulson I. Topical Steroids for Skin Disease, *Dermatology in Practice* 1996; 5-8
Clement M, Du Vivier A. Topical Steroids for Skin Disorders (1987), Blackwell
Scientific Publications, Oxford
Also the National Eczema Society website (Appendix E)
The following sections cover a range of dermatological problems frequently encountered within the community. Written text on one side of A4 is supported by a flow-chart on the facing page. Future sections can be incorporated, or revised, according to popular demand.

**DISEASE INDEX**

Acne with Management Plan ................................. p8
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Leg ulcers with Management Plan .......................... p18
Warts (and Molluscum Contagiosum) with Management Plan ...................................................... p20
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Meningococcal septicaemia
Generalised itch, no rash
‘Male pattern’ hair loss
Other cause of hair loss
Urticaria
Patch tests
Eczema and diet
Hyperhidrosis
Cellulitis
Hirsuitism
Pigmentary Disorders
& Black Skin
Rosacea
Pityriasis rosea
Practitioners should be familiar with 2 main types of acne: comedonal and inflammatory (figures opposite). Comedones (whiteheads/blackheads) should be treated with comedolytics. Comedolytics also reduce the risk of antibacterial resistance. Inflammatory papules/pustules should be treated with antibiotics (topical or systemic) and a comedolytic. The worse type: nodulocystic, scarring acne (conglobata) requires hospital referral for isotretinoin (Roaccutane). Almost all other cases can be successfully managed in the community, according to the suggested guidelines. Inflammatory acne in pigmented skin may resolve leaving significant post-inflammatory hyperpigmentation. This may take several months to settle. Prompt and aggressive antibiotic treatment limits this risk. The use of pomade oils in certain cultural groups can cause acne of forehead. Treat in the conventional way whilst discouraging these greasy products.

**Topical Treatment**

Mild cases and comedonal acne can be managed with topical preparations only. Most patients should be tried on benzoyl peroxide (2.5 to 10%) on an ‘indefinite’ basis. All potential acne sites should be treated daily, regardless of disease activity. Benzoyl peroxide should be applied 1-2 times daily. It may irritate the skin but this usually settles with continued use, or with a weaker strength - warn the patient that it may bleach pillow cases, collars etc.

If benzoyl peroxide is ineffective or poorly tolerated, more specific comedolytics should be considered. Topical retinoids, e.g. adapeline cream (Differin) are contra-indicated during pregnancy.

Topical antibiotics are less useful for comedonal acne, except in combination with a comedolytic (e.g. Duac, gel Zineryt). Topical clindamycin (Dalacin T) comes in a lotion and is useful for dry skin/eczema and acne.

**Oral Therapy**

Start with (oxy)tetracycline 500 mgs bd one hour before meals or 4 hours after a meal or lymecycline 408 mg nocte for at least 3-6 months (sometimes for a year or more). It should not be given to children or to pregnant, or lactating, women. Women of childbearing age should be advised on adequate contraception. Stop if patient complains of persistent headaches (benign intracranial hypertension).

Second-line antibiotics include erythromycin 500 mg bd, doxycycline 100 mg od (photosensitiser) or minocycline 100 mgs daily. Publicised risks of minocycline have been exaggerated. However, should malaise or arthritic symptoms develop, stop the drug. LFTs and ANA should be monitored six-monthly with longterm minocycline. Drug-induced symptoms should resolve. There is a small risk of persistent pigmentation with long term use of minocycline.

**Acne and the Pill**

Female patients on a combined oral contraceptive pill who are prescribed antibiotics need additional contraceptive measures for the first six weeks. Progestosterone only pills are liable to aggravate acne. Female patients with acne can be prescribed Dianeette (ethinyloestadiol 35mg; cyproterone acetate 2mg which is an anti-androgen), although the small risk of thromboembolism should be explained and monitored. Some clinicians advise a break in treatment after 2 years. The above treatments can, of course, be used in combination. Check BNF for licence indications. References: www.prodigy.nhs.uk/guidance.asp?gt=acne
Assessment

Mild / Comedonal
- Topical therapy e.g. benzoyl peroxide 5% or retinoic acid

Moderate/Inflammatory
- Systemic antibiotic e.g. tetracycline 500mg bd or lymecycline 408mg nocte and comedolytic e.g. benzoyl peroxide 5%, or topical retinoids for three months. Consider Dianeett® in females.

Refer
- • Cystic scarring acne
- • Severe psychological disorder
- • True treatment failure

Failure to respond
- Try alternative antibiotic e.g. erythromycin 500mg bd for a further three months. Consider concomitant Dianeett in females.

Inadequate response
- Continue antibiotic for at least six months, then reassess (see text). Remember to continue a comedolytic e.g. benzoyl peroxide 5%, or topical retinoid.

Assess

Good response
- Low-energy pulsed dye laser is under evaluation. Contact 0208 296 4147, Sutton Laser Unit for update (private patients).

Inadequate response
- Minocycline 100mg or doxycycline 50mg bd for a further three months (see text).

Consider oral isotretinoin

Refer if true treatment failure
Eczema

Eczema and dermatitis are synonymous. Around 20% of the population develop eczema at some time in their lives. There are a number of clinical variants in adults (flow-chart). Childhood atopic eczema may persist into adulthood, or may return following a prolonged absence of symptoms. In some cases, childhood eczema may resolve and present in a different form (e.g. hand eczema in hairdressers). Adolescents with a history of eczema need advice about careers involving allergens and irritants.

Atopic Dermatitis

**UK diagnostic criteria:** must have an itchy skin condition and any three of:-
- Personal or family history of atopy
- Visible flexural involvement (or cheeks if under 10)
- Dry skin in last year
- History of flexural involvement (or cheeks if under 10)
- Onset under 2 (not used if child under 4)
- Exclude scabies

**Trigger factors:** heating, washing, pets, smoking, housedust mite, tree and grass pollens, infections (bacterial and herpes simplex), family interactions, stress. An acute flare-up of atopic eczema, and history of cold sore exposure, should prompt a careful examination for clustered punctate erosions of eczema herpeticum (urgent acyclovir etc).

**Investigations:** Height and weight monitoring in children. Swabs for bacterial and viral culture as appropriate.

**Therapy issues**

**Diet:** dietary manipulation has little value in the management of adult eczema, unless there is an obvious dietary trigger (rare). Diets for children should be supervised by a dietician and abandoned after 2 months if unhelpful.

**Emollients:** moisturisers should be applied liberally and frequently; the minimum prescription should be for 500g/500mls (Appendix A).

**Topical steroids:** a two-stage therapeutic approach is recommended. Use a mild/moderate potency corticosteroid for long-term maintenance, but a potent topical corticosteroid for short-term use (5-7 days) in an acute flare. In infants and young children, use milder preparations (e.g. 1% hydrocortisone ointment and Eumovate ointment respectively). Facial eczema can be safely treated with regular 1% hydrocortisone ointment. Palms and soles may require super-potent corticosteroid for maintenance treatment. Elocon and Cutivate are newer generation steroids which are unlikely to affect the adreno-pituitary axis and are applied once daily. Ointments are preferable to creams for non-weepy dry skin. The authors can find no good evidence that 1% hydrocortisone cream can precipitate glaucoma. However, potent preparations should be avoided on the face except for a severe, acute flare (eg. Elocon 5 days).

**Antihistamines:** Sedative antihistamines may be helpful for patients whose sleep is disturbed by itch.

**Chinese herbal remedies:** of little use in weepy eczema. Six monthly full blood counts and liver function tests recommended, as hepatitis is a known side effect. Unfortunately steroids have been identified in some preparations.

**Primrose oil (gamolenic acid):** ineffective

**Topical immunosuppressants:** See flow chart for Protopic and Elidel.
### Topical immunosuppressants

**Tacrolimus ointment (Protopic):** For moderate to severe atopic dermatitis not responding to conventional therapy (0.03% is equivalent to a weak corticosteroid, 0.1% to moderate potency); may irritate.

**Pimecrolimus cream 1% (Elidel):** for mild or moderate atopic dermatitis and is promoted for short term use (actively inflamed lesions), and long term intermittent use to prevent progression of ‘flares’. Protopic and Elidel may be particularly helpful for resistant cases of facial eczema (or risk of steroid complications), including children (NICE, 2004).

### Management Plan for Eczema

<table>
<thead>
<tr>
<th>Condition</th>
<th>Treatment Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderately to severe AD</td>
<td>Tacrolimus ointment (Protopic): 0.03% equivalent to weak corticosteroid, 0.1% to moderate potency; may irritate.</td>
</tr>
<tr>
<td>Hands and feet eczema - acute pompholyx</td>
<td>Large blisters may be punctured with sterile needle; potassium permanganate (1:10,000) soaks 10 mins b.d.; poten topical corticosteroid or oral corticosteroids may be required (e.g. prednisolone 30mg daily 2 weeks).</td>
</tr>
<tr>
<td>Hands and feet eczema - chronic</td>
<td>Potent or very potent topical corticosteroid and emollients; polythene occlusion (e.g. Clingfilm or PVC gloves night time); avoid trigger factors/irritants (e.g. white spirit).</td>
</tr>
<tr>
<td>Contact dermatitis</td>
<td>Tar or ketocnazole shampoo or cream; salicylic acid ointment or corticosteroid scalp preparation; imidazole/hydrocortisone combination; tar/hydrocortisone combination; Lotriderm cream (few days only for face).</td>
</tr>
<tr>
<td>Seborrhoeic dermatitis</td>
<td>Dull red, scaly patches on greasy areas e.g. scalp, face, chest, cheek, Nails, elbows, family history (psoriasis)?</td>
</tr>
<tr>
<td>Discoid eczema</td>
<td>Round or oval patches of red, scaly or weeping skin.</td>
</tr>
<tr>
<td>Atopic eczema</td>
<td>Itchy, red and dry skin often in childhood.</td>
</tr>
<tr>
<td>Stasis (varicose)</td>
<td>Elderly patients Varicose veins Oedema.</td>
</tr>
</tbody>
</table>

### Alert:
The rate of bacterial resistance to fucidic acid is increasing to unacceptable levels and so use of Fucidin should be restricted. Fucidin alone must be avoided in cases of infantile eczema, and if secondary infection is strongly suspected then consider topical corticosteroid in combination with flucloxacillin or erythromycin after swabs. Never use Fucidin-H or Fucibet beyond 2 weeks. Weepy and inflamed eczema of the cheeks in Protopic and Elidel may be particularly helpful for resistant cases of facial eczema (or risk of steroid complications), including children (NICE, 2004).

### Poor response

- Possibility of contact dermatitis
- Exclude scabies
- Regular severe episodes (?patch testing)
- For patch testing if recurrent
- Review after 1 week and reduce to moderately potent topical corticosteroids for 3-4 weeks; regular application of emollients
- Should respond within a few days although lesions usually recur; severe seborrhoeic dermatitis may indicate HIV infection

### Failure to respond

- Failure to control
- Failure of therapy; suspected contact allergy; suspected secondary infection with herpes simplex (start oral acyclovir)
- Consider referral if Doppler scanning confirms ischaemia. For patch testing where condition persists
Management Plan for Psoriasis Treatment

**Vitamin D analogues** are treatment of choice for mild to moderately severe cases. Calcipotriol is as effective daily as bd, but must be applied fairly liberally. Side effects: irritation, hypercalcaemia if > 100g / week used.

**Dithranol e.g. Dithrocream** 0.1-2.0%.

- Short contact for 30 minutes o.d.
- Rinse off thoroughly.

For **Body / Plaque Psoriasis** (Not Face or Flexures):
- Vitamin D analogues are treatment of choice for mild to moderately severe cases. Calcipotriol is as effective daily as bd, but must be applied fairly liberally. Side effects: irritation, hypercalcaemia if > 100g / week used.
- Dithranol e.g. Dithrocream 0.1-2.0%.
  - Short contact for 30 minutes o.d.
  - Rinse off thoroughly.

**Face, Flexures, Genitalia**
- Vitamin D analogues are treatment of choice for mild to moderately severe cases. Calcipotriol is as effective daily as bd, but must be applied fairly liberally. Side effects: irritation, hypercalcaemia if > 100g / week used.
- Dithranol e.g. Dithrocream 0.1-2.0%.
  - Short contact for 30 minutes o.d.
  - Rinse off thoroughly.

**Scalp**
- Shampoos: tar e.g. Polytar liquid, and salicylic acid e.g. Capasal (may be left 15 mins) Meted (3% salicylic acid, 5% sulphur).
- Pomade e.g. Cocos oint. (leave on scalp overnight).
  - Effective but messy.
  - ± Olive, Almond* and Arachis* oil soaked into scalp overnight
  - *avoid in nut-allergy

- ± Topical steroid e.g. Betnovate, Elocon, Betacap scalp applications, Synalar gel, Bettamousse
- ± Dovonex Scalp Solution b.d.

- Dermol 600 soaked into scalp 10-15 mins before shampoo

**Nails**
- **No Response**
- Consider clippings to exclude fungal infection
  - Keep nails short
  - No good treatment
  - Some evidence for Dovonex scalp application or a combination of betamethasone and salicylic acid,\(^1\) or Zorac gel daily for 3-6 months to nail fold

**Hands / Feet**
- **No Response**
- Consider Fungal Infection. Take scrapings for Mycology.
- +ve Mycology oral anti-fungal e.g. Lamisil 250mg daily 2-4 weeks

**References:**


**Life style**

Excess alcohol aggravates psoriasis and may hinder efficiency of treatment. Diet is not particularly helpful, except that weight reduction is recommended for flexural psoriasis, and oily fish is desirable. The Psoriasis Association details should be passed to patient.
2% of the population suffer from psoriasis. It is a genetic condition but only about 10% of the first degree relatives are affected. There are various types; the commonest varieties are listed (flow-chart). Treatment is tailored accordingly.

Patients should be aware that psoriasis is a treatable, non-infectious but incurable condition. Written information is useful (Appendix B). Successful treatment depends on regular application. One of the reasons for treatment failure is that insufficient quantities are applied. For example, for extensive psoriasis 100 gm per week is justified, despite obvious cost implications. There is no justification for “sparing” use of any of the creams listed whilst the condition is active. Regular emollients may be helpful if the skin is dry and cracking, andointments are usually better than creams.

**Precipitating factors:** streptococcal infection, alcohol, lithium, chloroquine, systemic steroids, Koebner phenomenon, e.g. sunburning can precipitate psoriasis in the burnt area; tattoos and surgical scars can be affected. Emotional stress and alcohol excess may play a role.

**Sunlight:** a sunny holiday is one of the best treatments for psoriasis (avoid burning). Commercial sunbeds are less effective, and patients should be advised that the cancer-risks following uncontrolled sun-bed usage are unknown, but probably significant.

**Corticosteroids:** useful for face, flexures (mild-moderate potency) and localised plaques (potent). However, large quantities of potent steroid should normally be avoided in view of risk of developing unstable or pustular psoriasis.

**Guttate psoriasis:** this disseminated micro-plaque variant of psoriasis is often preceded by a streptococcal sore throat. Continuous sunbathing, 120 g quantities of a vitamin D analogue (e.g. Dovonex) or tar/steroid, often settles the condition relatively quickly. Up to half of sufferers stay in remission. Those with resistant disease need referral for UVB light treatment, but try Dovobet 100g/week for 4 weeks before referral.

**Patient needs referral if:**
1. Diagnosis is in doubt
2. Not responding to regular use of appropriate quantities of topical treatment (including 4 weeks of Dovobet)
3. Generalised pustular/very inflamed or erythrodermic psoriasis (an emergency)
4. Extensive disease requiring UVB/PUVA or systemic treatment (>30-40% coverage)
5. Associated with severe psoriatic arthritis that may require systemic therapy (refer to Rheumatology)
6. Most patients with extensive psoriasis will need advice and reassurance of a skin department, and it may be appropriate to refer to specialist dermatology nurse or GPSI.

**Websites:**
- www.nice.org.uk
- www.bad.org.uk/doctors/guidelines/psoriasis/clinical.htm

**References:**
Psoriasis: Topical therapy remains first-line but systemic theory is indicated in severe forms. *Drugs & Therapy Prospectives* 1994; 4:10-13
Ton S, Trenaine R, Reardon PM. *Drugs and Therapeutics* 1996; 19: 7-5
Skin cancers are common and increasing in incidence. Of these, malignant melanoma, although still relatively rare, is the main killer, with 25% mortality rate. Prognosis is determined by depth of invasion. Therefore, it is especially important to detect melanoma early.

To avoid unnecessary anxiety and referral, benign pathology should be recognised. The seborrhoeic wart is the most commonly referred non-melanocytic lesion. It arises in older patients, and appears ‘stuck-on-to-the-skin-surface’. The lesions are usually multiple, warty, keratotic, verrucous or roughly textured; sometimes surface keratin pseudocysts are easily visible as pale or dark dots. Variations in size, shape and colour may give the unwary observer the impression of malignancy.

‘Itch’ and ‘bleeding’ are a second source of confusion. They are of no significance in normal looking moles. Review lesions 2 weeks after any sudden changes, e.g. bleeding, inflammation, swelling - they often reverse, obviating the need for referral.

Mackie’s checklist (adapted) is useful for alerting the clinician to the possibility of melanoma. In reality only one in thirty referred lesions turn out to be melanoma. Of these, most have alterations in size, shape and colour. Marked irregularity or notching of the border is typical of melanoma in association with variable pigmentation. Blackness is a particularly sinister sign.

**Mackie’s Checklist (adapted)**

<table>
<thead>
<tr>
<th>Major signs</th>
<th>Minor signs</th>
</tr>
</thead>
<tbody>
<tr>
<td>change in size</td>
<td>inflammation</td>
</tr>
<tr>
<td>change in shape</td>
<td>crusting or bleeding</td>
</tr>
<tr>
<td>change in colour</td>
<td>diameter &gt;7mm (altered sensation e.g. itch).</td>
</tr>
</tbody>
</table>

The presence of two or more major signs, with or without minor signs, should generate a high index of suspicion for melanoma. Minor signs (especially itch) on their own are unhelpful.

A tick-box referral sheet for the local pigmented lesion/skin cancer clinic is available for photocopying (Appendix E). It resembles the American ‘ABCD’ system (Asymmetry, Border, Colour, Diameter) which ‘ditches the itch’. Local skin cancer / pigmented lesion clinics will accommodate faxed referrals within 2 weeks. Patients with benign lesions will be reassured, but not treated.

Non-Melanoma Skin Cancer (NMSC) and Borderline Lesions

Most cases of NMSC comprise basal cell carcinoma (BCC) and squamous cell carcinoma (SCC). Bowen’s disease represents an intra-epidermal carcinoma (in situ) and has a low potential for malignant transformation. Solar keratoses are common on elderly, fair, exposed skins. If numerous, the individual should be checked carefully for the presence of NMSC. However, the risk of malignant transformation for an individual lesion is extremely low except for very thick lesions (curettage). Referral is therefore only necessary if there is a diagnostic doubt, or lesions are troublesome. Solar keratoses (SKs) and Bowen’s disease can be readily treated by cryotherapy, 5-fluorouracil (Efudix) or Solaraze gel (SKs) - see Appendix B for patient leaflet. NMSC should be referred, unless the GP has specific expertise in the treatment of skin cancer, and is familiar with up-to-date treatment guidelines. Imiquimod (Aldara cream) is now licensed for superficial BCCs.

Reference:

Harland C. Recognition of Skin Cancer 2005, see Appendix D. CD-roms will be available to all Merton, Sutton and Wandsworth Health Professionals (Tel: 020 8296 2843)
Referral Guidelines for Pigmented Lesions - Based on Risk

High Risk

Changes in colour, shape & size / diameter - assuming surface is not warty or keratotic (i.e. seborrhoeic wart)

Intermediate

One or two ‘major’ changes ± minor signs (see Mackie checklist)

Low Risk

Although variable in pigmentation the mole is symmetrical and small

Very Low Risk

A mole such as this on an asian black skin or on a child should not give rise to concern

No Risk

Reassure or refer to routine clinic unless the clinical signs are classical for melanoma

Uncertain - ‘could be melanoma’

Refer to Pigmented Lesion/Skin Cancer Clinic
See Appendix E 2 week proforma

Further changes or patient anxiety

‘Probably Benign’

Reassure, but record maximum diameter of lesion. Ask patient to monitor for further changes in colour, shape & size ± home photograph(s) of mole(s). CRC Mole Watcher leaflet* is recommended as hand-out (very cheap with bulk order)

Children, or patients with Asian / Afro-Caribbean skin, very rarely require referral to PLC/Skin Cancer clinic.

Reassure or refer to routine clinic unless the clinical signs are classical for melanoma

PIGMENTED LESION CLINIC (PLC) / SKIN CANCER REFERRALS

Indications: Possible/probable melanoma and squamous cell carcinoma only.
Please explain: (a) moles will only be removed if thought to be risky, (b) patients may be asked to strip-off for complete examination. The 2 week proforma (Appendix E) must be faxed. DO NOT refer basal cell carcinoma on proforma

References:
Free to M, S&W Health Professionals (0208-296 2843).

* CRC Mole Watcher Leaflet is available from Cancer Research Campaign, 6-10 Cambridge Terrace, Regent’s Park, London NW1 4HL Tel: 020 7224 1333
Management Plan for Fungal Infections of the Skin

**DERMATOPHYTE**

- **Pedis** ("athletes foot")
  - Tinea Cruris (groin, "Dhobi itch")
- **Corporis** (body)
  - Tinea Manuum (hand)
  - Pedis (moccasin type)
- **Tinea Capitis** (scalp)
  - usually children
- **Tinea Unguim** (nail)
  - Terbinafine 250mg od Toe nails 3/12 (TN)
  - Fingernails 6/52 (FN)
  - after clippings for mycology

**YEAST**

- **Pityriasis Versicolor**
  - No Response (3-6 months)

**Candidiasis**

- **Nystatin cream / suspension / pessaries as appropriate (per BNF)**
  - Itraconazole or fluconazole per BNF (N.B. griseofulvin ineffective)

**Topical Nizoral or Selsun** (per patient information sheet, appendix B) - and monthly for prevention

Itraconazole 200mg od 1 week (will not prevent recurrence)

No Response (2 months)

N.B. pigmentary changes may persist many months esp. after sun-tan

Repeat scrapings for mycology

Referral for diagnosis, e.g. oral lichen planus, dysplastic changes; eczema skin fold.

Classical "ringworm" with leading scaly edge

- **Imidazole creams e.g. miconazole 2/12.**
  - Terbinafine cream for resistant cases

**No Response (3 months)**

- Take scrapings (mycology) from leading scaly edge

- **Systemic Treatment**
  - terbinafine 250mg o.d. 2/52
  - Itraconazole 100mg o.d. 2/52

**No Response (4 weeks)**

- Check Compliance
  - Reconsider diagnosis (?)eczema)
  - Possibly repeat scrapings

**Either**

- **Trial of topical steroid 2/52**
  - (potent for palms / soles, weak/moderate for groins)

- **Negative mycology**
  - trial of potent topical steroid + salicylic acid preparations

**No Response (4 weeks)**

- **Positive mycology**
  - pulsed Itraconazole per BNF (N.B. some moulds are treatment resistant)

**No Response (3-6 months)**

- **Negative mycology**
  - probable abnormality of nail matrix (e.g. congenital, post-trauma, psoriasis, lichen planus). Asymmetry favours trauma or infection

**No Response**

- **Refer for diagnosis but no good treatment**
  - Removal of nail / matrix ablation if nail painful

- Trial of moderately potent topical steroid

- **No Response** after 2 months

- **Classical "ringworm" with leading scaly edge**

- **Systemic Treatment**
  - terbinafine (see text)
  - griseofulvin 4/52
  - Adults: 750mg - Ig
  - Children: 10mg / kg / day after plucklegs, scrapings, combing for mycology. Wait 6/12 for alopecia to recover.

**No Response (3-6 months)**

- **No response after 3-6 months** N.B. It takes 6/12 (FN) and 12/12 (TN) for new nail to grow through

- Repeat clippings if negative previously. Reconsider diagnosis e.g. psoriatic nails

- **Positive mycology:**
  - Systemic terbinafine (see text)

- **Negative mycology:**
  - trial of potent topical steroid + salicylic acid preparations

- **No Response (4 weeks)**
There are two main types of fungal infection of the skin: dermatophyte (e.g. *Trichophyton rubrum*) and yeast. Dermatophytes are normal commensals on human and animal skin, but commonly give rise to rashes (“ringworm”), and to nail and hair problems. Pityriasis versicolor (*Pityrosporum orbiculare*) and candidiasis (*Candida albicans*) are important examples of yeast infection; the latter produces skin and mucosal lesions.

**Diagnosis**

Preferably establish diagnosis before treatment. Harvesting specimens for mycological examination is simple. Scrape boldly the scaly border of the rash with a disposal blade placed perpendicularly to the skin. Collect abundant scales on dark paper (for ease of identification) which can be folded and secured with tape, or use commercially available self-seal packs (see below). The labelled specimen and form is sent to the local laboratory for “mycology”. Nail clippings (including the crumbly undersurface of nail plate) and hair pluckings can similarly be submitted. It takes 6 weeks for the final culture result. Green fluorescence of the scalp under Wood’s light in a darkened room supports the diagnosis of *Microsporum audouini* and *M. canis* infections. However, there has been an epidemic of tinea capitis in South Thames, mainly in schools. These fungi do not usually fluoresce (e.g. *T. tonsurans*) and can present with diffuse hair loss. Modified toothbrushes or combs can be used to sample skin and hairs (see below). Siblings, classmates and even parents can be asymptomatic carriers.

**Treatment**

See flow chart. Griseofulvin, except in the case of tinea capitis, has been superseded by modern drugs (e.g. terbinafine and itraconazole). The syrup for children is difficult to obtain. Terbinafine is a good treatment for tinea capitis but is not yet licensed for this indication. Consider terbinafine 62.5 mg daily in children weighing 10-20 kg, 125 mg daily in children weighing 10-20 kgs, 250 mg daily if > 40 kg (4 weeks).

**Commerically available skin/scalp sampling devices**

DERMAPAK® Type 4 (resealable plastic bag for enclosing skin, nail, hair samples sent to laboratory with request form) - Dermaco Ltd, P.O.Box 470, Teddington, Beds LU5 6BF Tel: 01525 876070 www.dermpak.com

Sampling of scalp in tinea capitis, particularly sibs/classmates:

**Toothbrush** available from - Brushaway Products Ltd., Croft House, Croft Road, Bromley, Kent BR1 4DR - £25 per 100 plus £9 handling charge; not reusable. One must request **unpasted** when ordering. They are small and easy to use even when the child has plaits.

**Comb** available from - Ogee Ltd., Unit 4, Area 10, Headley Park Estate, Woodley, Reading RG5 4SW. These are approximately £1.20 but are reusable (should be sterilised). Tel: 01189 443600. Free sample kits supplied by Galderma (UK) Ltd, Galderma House, Church Lane, Kings Langley, Herts WD4 8JP. Tel: 01923 291 033, Fax: 01923 291 060
Principle causes of leg ulcers:
- Chronic venous hypertension - 70%
- Arterial including diabetic and rheumatoid - 10%
- Combined venous and arterial - 10%-15%
- Other causes total less than 1%

Initial assessment
Identify the underlying cause as this has important implications for treatment therefore a holistic assessment is vital:
1. Medical/surgical history - vascular, diabetes, rheumatoid disease, heart failure etc. family history
2. Nutritional status/weight
3. Social/psychological status - smoking, occupation, depression, housing etc.
4. Clinical investigations - BP, Urinalysis and Doppler ABPI
5. General and ankle mobility
6. Pain - when it occurs and how it is relieved, e.g. arterial ulcer pain increases when leg elevated.
7. Allergies
8. Medication
9. Examination of legs and skin

Stigmata of venous disease:
- Varicose veins or staining (haemosiderin)
- Lipodermatosclerosis (brawny oedema)
- Varicose eczema
- Ankle flare
- Atrophie blanche
- Garter area (esp. medial malleolus)
- Oedema may be present in either type of ulcer, but is characteristic of venous disease.

Stigmata of arterial disease:
- Cold legs and feet (in a warm room)
- Dependent rubor, or bluish feet
- Poor capillary refill with leg elevation
- Absent or diminished foot pulses
- Hairless, shiny skin and trophic toenails
- Claudication or rest pain; gangrenous toes

Examination of the ulcer
Note the size, site, depth, appearance, ulcer base, surrounding skin and type of discharge

LOCAL ULCER MANAGEMENT
Colour coding is the simplest guide for identifying the stage of healing and thus the appropriate dressing choice.
BLACK = Necrotic - requires debridement. Options include: Surgical, Enzyme, Hydrocolloid, Hydrogel.
GREEN = Infected. If not responding to simple measures, then take a bacterial swab.
If heavily infected with virulent organism - systemic antibiotics for 2-3 weeks, avoid topical antibiotics if possible. Dressing options include: Alginates, Foams, Hydrogels, Cadexomer iodine, Flamazine, Low-adherent iodine dressing.
YELLOW = Slough - requires desloughing. Dressing options include: Alginates, Enzymes, Hydrocolloids, Hydrogels.
RED = Granulating - requires protection, encouragement and absorption of exudate. Dressing options include: Hydrocolloids, Hydrogels, Hydropolymers, Hydrocellular foam.
PINK = Epithelialising - requires encouragement and protection. Dressing options include: Foams, Hydrocolloids, Hydropolymer, Hydrogel, Silicone non-adherent dressing.

Reference:
Management Plan for Leg Ulcers

Rheumatoid* Arthritis
Venous Disease (See Stigmata)
Arterial Disease (See Stigmata)
Diabetic

Doppler assessment (ABPI) should be undertaken to exclude significant arterial disease. N.B. If limb is swollen or patient has significant arterial disease an artificially high reading may be obtained.

- ABPI 0.8-1 with tri/biphasic signals
- ABPI < 0.8 with monophasic signals

Therapeutic compression therapy via: Four-layer bandaging. Long Stretch bandage (i.e. Tensopress™/Surepress™) Short Stretch bandage (i.e. Actico™) Apply cotton layer (Actifast™ or Stockinette™) to skin and Wool padding bandage. Exercises: Ankle dorsiflexion & rotation, calf raise. High elevation of legs when sitting. Elevation of foot of mattress.

Response at 8 weeks
- yes
- no

Moderately ischaemic (0.6 - 0.8) legs may be treated cautiously with Short Stretch bandaging provided patient is asymptomatic of pain. Rheumatoid legs may be treated, excluding vasculitic ulceration. May need altered application of wool padding to protect bony deformity.

Persistent eczema despite Betnovate 1:4 or Elocon ointment under dressings (cream for weepy eczema)? patch tests

Continued until healed, then long-term Class II below knee stockings (FPIO, or specially fitted via specialist unit) (Class III if lymphoedema present)

ABPI = arterial brachial pressure index

NB: If arterial disease is suspected keep the leg dry to prevent secondary infection and refer to Vascular team
Management Plan for Warts

Topical Treatment Daily for Three Months e.g. Occlusal / Cuplex / Salatac. Pare Foot Warts

Clear?

NO

Compliance Good?

YES

Clear?

NO

Discharge

YES

Hand Warts

ADULTS

Liquid nitrogen (LN₂) 1x10 secs

Severe Reaction

LN₂ 1x5 secs

Moderate Reaction

LN₂ 1x10 secs

Mild Reaction

LN₂ 2x10 secs

4 Treatments of LN₂ Moderate Reaction at three-weekly intervals at same freeze cycle

No Response*

Topical Treatments indefinitely. Do not refer to hospital. GPSI for facial or highly symptomatic lesions. Try Duct tape occlusion. Surgery is rarely an option

Foot Warts

Mosaic Warts?

No Response*

Yes

3 - 10% Formalin soaks daily (soak for 5-10 mins then wash off) for 3 months

Salicylic acid 50% plasters for isolated warts for 3 months - plaster on for 2 days, repeat. Stop for a day if sore

Wrong diagnosis? e.g. corn

Pare down hard skin vigorously with scalpel blade. Punctate bleeding confirms wart

Chiropodist

Immunosuppression. Patients who are immunocompromised as a result of drugs (e.g. renal transplant) or HIV infection may develop a plethora of warts, which are often unresponsive to the above treatments. Realistic counselling is mandatory.
Patients should be counselled realistically. **Topical preparations** applied by patients are as effective as cryotherapy given in hospital. Indeed, spontaneous cure rates are as high as 93% at 5 years.

**Liquid Nitrogen (LN₂)**

LN₂ treatment is carried out by many GP surgeries. LN₂ is centralised strategically at some centres. Those interested in receiving training (including practice nurses) should contact Wendy Dudley, St. Helier Hospital 020 8296 2000 bleep 441. Training packages are available.

**Side effects** - pain, blistering, scars hypo- and hyperpigmentation (especially black, Asian skin). Avoid near eyes (periorbital oedema). Nail dystrophy may complicate periungual warts. Cryotherapy to side of finger can cause nerve damage and very rarely tendon rupture. **DO NOT TREAT YOUNG CHILDREN. REASSURANCE IS BEST**

**Other cryodelivery systems** (e.g. Dimethylether/propane) - **these might** be effective in the treatment of warts, but note that a recent study showed that they do not achieve tissue temperatures below 0°C.

**Surgery/electrocautery** - surgical treatments of multiple warts are of limited value. Side effects include pain, infection, scars and recurrences. Laser treatment is no better. Pulsed dye, CO₂ laser and intralesional bleomycin is available at Sutton Hospital, but only symptomatic unresponsive cases should be considered (private referral).

**Genital warts** - referral to GU clinic is suggested. In children, sexual abuse must be considered; however, hand warts can be transmitted to ano-genital areas through normal activities. Discuss with Consultant Community Paediatrician, SW London Community NHS Trust. Aldara cream is now available for treatment of genital units (FP1O).

**Seborrhoeic warts** - reassure; smaller warts - liquid nitrogen; giant warts - curettage.

**Foot warts** *(verruca; plantar warts)* - topical treatments only eg 50% salicylic acid ointment or plasters. Liquid nitrogen is relatively ineffective and poorly tolerated. Encourage patients to pare down regularly with sharp blade, pumicestone, emery etc. Paring is useful to distinguish between viral warts and corns. Warts have punctate bleeding points. Formalin soaks recommended, particularly for mosaic warts. Regular occlusive strapping with Duct tape is reportedly effective.

**Periungal warts** - very difficult to treat aggressively due to pain. Formalin soaks recommended or Duct tape.

**Corns** - refer to Chiropodist

**Molluscum Contagiosum**

Dermatologists are reluctant to treat molluscum in small children. Effective treatment is painful. Older children may tolerate LN₂. Application of liquid phenol or puncturing the lesion with needle or sharpened orange stick increases risks of scarring. Lesions can be squeezed at home. Inflamed, enlarged lesions often herald a remission. Molluscum also triggers eczema, so use moderately, potent steroid ointment (except face), if symptomatic. **Molluscum remits spontaneously, usually within one year and longer in atopics.** Although potentially contagious, there is no justification for keeping children off school. Molluscum is also a common manifestation of HIV infection in adults.
**Scabies** is caused by the *Sarcoptes* scabies mite. Infection is transmitted by close physical contact. Patient education is crucial to treatment success and to avoid possible development of resistance.

**Diagnosis**
- Itch, especially at night
- Contact cases in family (i.e. 2 or more people itching)
- Burrows and red papules on side of fingers, wrists, ankles, nipples, genitals (itchy penile papules diagnostic)
- Widespread ill-defined eczematous, excoriated skin (especially axillae, peri areolar, abdomen, buttocks, thighs)
- Babies - hands and feet involved
- Absolute diagnosis: mites or eggs demonstrated microscopically

**Treatment**

**Explanations**
- Mites killed by correct application (see below)
- Itch will persist 2-6 weeks (crotamiton, Eurax HC, potent topical steroid, may ease itch)

**Parasiticidals**
- Permethrin 5% (*Lyclear Dermal Cream*) 30g tubes; 30-60g per adult application) first-line treatment
- Malathion only 70% effective; Lindane discontinued; benzyl benzoate (Ascabiol) is highly irritant, but use as second-line treatment if compliance has been good and should be used on 3 occasions.

**Application**
- Hot bath not necessary
- All members of household should be treated
- Treat whole body, from neck downwards, including webs of fingers and toes under fingernails, soles of feet and genital area (bedtime)
- Under 2 years, immunocompromised or very old, or if treatment fails, extend application to scalp, neck, face and ears
- Proper application once only, for permethrin and malathione only, except in Nursing Homes (see opposite)
- Do not wash hands after treatment. Should be in contact at least 8 hours. Reapply if necessary.

**Bed Linen, etc.**
- See flowchart opposite (probably only important for nursing home residents).

**Pregnancy**
- Aqueous malathion first choice (and if breast-feeding).

**Children**
- Up to 1/8 tube Lyclear Dermol cream, aged 2 months to one year, 1/4 tube aged 1-5, 1/2 tube aged 6-12 years

**Crusted (Norwegian) Scabies**
- High scabies load in some elderly or demented patients.
- Very contagious (contact SWLHPU*)
- May need more prolonged treatment
- Ivermectin 200 mg/kg single dose is useful.
Strategy for Scabies Eradication in Nursing Homes

Contact South West London Health Protection Unit* to co-ordinate strategy for nursing homes Tel: 020 8682 6132 Fax: 020 8682 5936

- **Diagnosed Infected Persons**
  - **Severe skin problems**
  - **All others**
- **All close contacts**
  - **Symptomatic (itch +/- rash)**
  - **Asymptomatic**

**Week 1 (Day 1)**

- **Lyclear Dermal Cream two**
  - Two tubes (60g) should be applied to **whole** body including face, head and scalp for infected person; neck downwards for non infected persons. Particular attention should be paid to skin creases, folds between fingers, toes, under nails, genitals & soles. Leave cream for a minimum of 8 hours before washing. Each time hands are washed cream should be reapplied.

- **Clean bed linen and clothes after Lyclear washed off**

**Week 2 (Day 8)**

- **Lyclear Dermal Cream once**

**Week 1 (Day 1)**

- **Lyclear Dermal Cream One**
  - One tube (30mg) should be applied to **whole** body including face, head and scalp for infected person; neck downwards for non infected persons. Particular attention should be paid to skin creases, folds between fingers, toes, under nails, genitals & soles. Leave cream for a minimum of 8 hours before washing. Each time hands are washed cream should be reapplied.

**Week 2 (Day 8)**

- **Lyclear Dermal Cream once - same time as the 2nd treatment is applied to residents & symptomatic carriers**

Reference:
**Head Lice - Lotion Treatment Chart**

**Detection**: Comb wet, conditioned hair with detector comb, once a week. Check family/social contacts for head lice.

- If live lice are found treat with lotion (group A or B) to dry scalp. Leave on 12hrs. Allow to dry naturally (do not use hairdryer).

  - if no live lice are found do not treat.

- Repeat after 7 days. (1 treatment consists of 2 applications 7 days apart).

- Check hair after 3 days (using wet combing). Check family/social contacts for head lice.

- If live lice are found.

  - Treat with lotion from different insecticidal group. This may include a lotion from group C which is only available on prescription.

  - if no live lice are found do not treat.

  - Repeat after 7 days.

  - Check hair after 3 days (using wet combing). Check family/social contacts for head lice.

  - If live lice are found.

  - Seek advice

---

**Over the counter medication**

<table>
<thead>
<tr>
<th>Group A</th>
<th>Group B</th>
<th>Group C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malathion Aqueous</td>
<td>Permethrin Cream rinse Lyclear</td>
<td>Carbaryl Aqueous</td>
</tr>
<tr>
<td>Derbac M</td>
<td></td>
<td>Derbac C Alcohol</td>
</tr>
<tr>
<td>Quellada M</td>
<td></td>
<td>Alcohol Carlyderm</td>
</tr>
<tr>
<td>Alcohol</td>
<td></td>
<td>Suleo M</td>
</tr>
<tr>
<td>Suleo M</td>
<td></td>
<td>Suleo C</td>
</tr>
<tr>
<td>Prederm</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Do not use alcohol based lotions on babies, pregnant women, asthmatics or on people with dermatological (dry skin) conditions.

2. Ensure that any chlorine and conditioners are washed from hair, and that hair is allowed to dry, prior to the application of the lotions.

**Reference**: [http://www.besttreatments.org/headlice](http://www.besttreatments.org/headlice)

Contact South West London Health Protection Unit (on pg 23).
Viral Warts
These need not be referred to the dermatologist. Refer to GPSI if highly symptomatic.

None are appropriate to see urgently. If necessary, treat pain symptomatically by paring, or by the use of corn plasters.

Explain that treatment is aimed at wart, not virus destruction. Immunity occurs spontaneously. The GP specialists’ function is to reinforce the GP’s explanation of the natural history and will see patients once only.

Even so, before referral, all warts should have been treated topically for four months, or if they have been given cryotherapy, treated for at least four occasions at three weekly intervals. Paring plantar warts beforehand will enhance response time to treatment.

Basal Cell Carcinomas
These do not have to be seen urgently unless they are near the eye. Lesions may not be nodules or ulcers. The superficial spreading type can initially look like eczema/psoriasis.

Acne
Before referring treat for one year with combined a + b.

a) Oral antibiotics in full dosage (e.g. oxytetracycline, tetracycline, lymecycline, erythromycin, minocycline 100mg o.d.) plus

b) Topical keratolytics (benzoyl peroxide or retinoid nocte diffusely over areas)

Warn patients of initial skin irritancy and start cautiously, increasing gradually until nightly application is tolerated.

Expect only a 10% improvement per month of treatment. Do not stop antibiotics before six months even if the patient is better. After six months to a year consider stopping the systemic antibiotics but continue with topical keratolytic treatment.

In females, if contraception is needed or if there is associated hirutism, Dianette can be used with or without antibiotics.

Milder cases can be treated with a combination of topical antibiotics b.d. and topical keratolytics o.d.

In most cases dermatologists will not use isotretinoin (Roaccutane) unless high dose antibiotics have been used continuously for at least one year in conjunction with topical keratolytics. However, patients with scarring, cystic acne should be referred directly for Roaccutane, having commenced minocycline.

Molluscum Contagiosum
These need not be referred to the dermatologist. If necessary prick the umbilicated centre with a sterile pin and gently squeeze with tweezers at bath time. Apply an antiseptic cream afterwards. Associated eczema can be safely treated with emollients and topical steroids.
Eczema
Before referring, check that patients have stopped using soap/bubble bath/shower gels, and are using a substitute e.g. Aqueous cream.
Topical steroids should also be used appropriately. Ointments are preferable to creams. If clinically infected add a course of systemic antibiotics to topical steroids.
For hand eczema, gloves should be worn for all wet work including the handling of raw food.

Urticaria
Always stop histamine releasers such as aspirin, codeine, penicillin, and caffeine. Treat with non-sedating antihistamines. Patients should keep a food diary to bring to their first appointment with the dermatologist, if dietary factors suspected.

Psoriasis
Mild - moderate cases may be treated with calcipotriol (Dovonex), tar + steroid combination, or short contact dithranol for isolated lesions. Refer for diagnosis or severe cases (more than 30% skin surface). Dovobet 4 weeks before referral of less severe cases.

Scalp
Tar pomade or coconut oil compounds (Cocos) ointment nightly, short contact, is very useful to lift off scales of eczema or psoriasis, before using steroid lotion.

Scabies
Linear burrows in finger webs and excoriated papules in genital areas are usually seen. Treat all members within the household at the same time as the patient, even though they have no symptoms. There is no point in treating the patient alone first. Use Lyclear Dermal Cream (30g per adult application).

Pityriasis Rosea
Suspect if there is a history of a herald patch preceding the generalised rash. Do not refer patients until six weeks have passed.

Fungal
Obtain mycological proof before giving oral antifungals.

Seborrhoeic Warts
These are benign no matter the size and numbers and need not be referred.

Moles
Refer if suspicious. Excision of benign moles is unnecessary. Always submit for histology.

Adapted from Royal Surrey County Hospital guidelines, with permission by Dr Elizabeth Wong.

Reference:
Meningococcal septicaemia

The characteristic rash is petechial (i.e. spotty red rash which does not blanche on pressure - best demonstrated by pressing a glass slide onto rash). A stat injection of benzyl penicillin 1.2 g IV/IM should be considered prior to emergency referral of adults and children aged 10 years or more, 600 mg for children aged 1-9 and 300 mg for those aged less than 1 year. Penicillin should be withheld if there is a known history of anaphylaxis following previous penicillin administration.

Generalised itch, no rash

Screening investigations should include full blood count, iron status, renal, hepatic and thyroid function and possibly chest radiograph. Older patients may benefit from the copious use of moisturizers (‘senile pruritus’). Beware of scabies!

‘Male pattern’ hair loss

Men normally bald at fronto-parietal areas and over vertex of scalp. Women normally ‘thin on top’. Enquire about family history of hair loss (androgenetic). These patients may benefit from topical minoxidil (private prescription or O.T.C.). Treatment is expensive and relatively ineffective, and must be used long term to maintain benefit. If women have normal menses, endocrine investigations are not likely to be fruitful. However, long term antiandrogen therapy (Dianette ± cyproterone acetate) might be considered if patient is desperate. If excessive androgenisation is suspected, always submit testosterone and sex hormone binding globulin levels; any abnormalities should prompt a referral to an endocrinologist. Finasteride has been claimed to promote hair regrowth in men. It is licensed - only private prescription.

Other causes of hair loss

Examine for evidence of inflammation/scarring (?fungal, lichen planus, discoid lupus). Other types are localised (alopecia areata) or diffuse, without evidence of inflammation. Alopecia areata has an ominous prognosis if (a) associated with eczema (b) not responding to 4 months of potent topical steroid. Referral to hospital may then be justified, if only for counselling. If diffuse alopecia with sudden onset develops 2-3 months after an illness, or drug or pregnancy, there will be spontaneous recovery over one year and the patient will not go bald. Diffuse alopecia should be investigated with full blood count (serum ferritin) and thyroid function tests. Treat a lowish ferritin (<70ng/ml).

Urticaria

If present for 6 weeks, it is termed ‘chronic’ and is usually idiopathic. At least 25% of cases represent auto-immune disease. Itchy weals come and go and respond to non-sedative antihistamines (e.g. loratidine, cetirizine, fexofenadine). These should be continued on a daily, ‘indefinite’ basis, as the condition may grumble on for months or years. Avoid terfenadine in patients with hepatic and cardiac disease and patients on interacting drugs (see BNF). Always stop aspirin and codeine. Drug and food precipitants should be sought by careful history taking, but allergy tests (prick tests and patch tests) are of debatable value according to dermatologists. A full blood count with high eosinophilia may raise the suspicion of gut parasites, and thyroid function tests should be performed if thyrotoxicosis is suspected clinically. Some allergists employ serum RAST tests and pseudo-allergenic diets. For severe cases consider strict exclusion diet under supervision of dietician.
**PATCH TESTS**

Many children and adults are referred for “allergy testing”. In fact, rarely is there a need to patch test if there is a clear-cut history and pattern for atopic eczema. Prick testing is of little use in atopic eczema.

The following patterns of eczema should raise your suspicions of an allergic contact dermatitis, where patch testing may be useful, particularly if appropriate steroid therapy has failed.

1. Eyelid, face or perioral eczema as an isolated feature (these sites may, of course, be involved in atopic eczema or seborrhoeic eczema).
2. Otitis externa.
3. Either hand dermatitis or foot dermatitis. Allergic contact dermatitis tends to be worse on the dorsum of the hands or feet, whereas endogenous patterns tend to affect the palms and soles.
4. Eczema associated with venous ulcers.
5. Unusual patterns of eczema, particularly asymmetrical patterns.
7. Contact allergic dermatitis in occupationally exposed groups, e.g. dentists, hairdressers, printers etc.

**Eczema and diet**

The role of diet in eczema is controversial. In recent British Association of Dermatologists guidelines, it was stated that dietary manipulation in adult eczema was of little value. However, some children’s eczema improves on diets free from eggs, cow’s milk and other dairy products. Elimination is the most certain way of testing. If there has been no improvement after two months, then there is no point in continuing. Dietary manipulation is best carried out under the guidance of a dietician.

**Hyperhidrosis**

Increased sweating of palms and axillae should be treated with aluminium chloride hexahydrate (Anhyrol Forte or Driclor). Ensure that the area of skin is completely dry; do not shave armpits or use depilatory creams within 24 hours of application; do not apply to broken or irritated skin; apply at night, and wash off thoroughly in the morning. Use for two nights in succession, followed by a rest of two nights. Many patients manage on 1-2 treatments per week once controlled. Excessive irritation can be treated with mild-to-moderate topical steroid. Botulinum toxin intradermal injections to the axillae can be very effective, but requires long-term 6-monthly commitment.

**Cellulitis**

In cellulitis the skin is usually smooth and shiny, and at its mildest the infection is relatively minor with local tenderness and inflammation and affects only small area or a margin of a wound. All such cases can be managed in primary care with Penicillin V 500mg qds and flucloxacillin 500mg qds (or erythomycin 500mg qds), for at least seven days. If penicillin allergic consider a macrolide or cephradine 500mg 6 hourly with 24 hour review. More severe cases (acute pain, oedema, hotness, chills, rigors, listlessness and lymphangitis or tender lymphadeopathy) necessitates referral to MAU or A&E for assessment and possible joint community care with intravenous antibiotics.
‘Bilateral cellulitis’
This condition is unlikely to exist. Bilateral red, tender, hot swollen legs are associated with immobile elderly patients with dependent legs and stasis oedema. Elevation and compression therapy helps, but treat as cellulitis if the patient is unwell.

HIRSUTES
Excess facial hair in women may result from a virilising condition, such as polycystic ovary syndrome (PCOS), with possible associated features of acne, irregular periods or male pattern hair loss (see above). PCOS is the commonest endocrine cause. The problem can be dealt with by bleaching or depilatory cream. Women may find shaving unacceptable (there is no evidence for the myth that hair will grow back ‘stronger’ and ‘faster’). Electrolysis, in capable hands, is successful. Laser treatment is available (Sutton Laser Unit) and is helpful only for dark coarse hair; NHS treatment is restricted to those women with established endocrine abnormality who shave daily to prevent dark beard or moustache growth (extreme cases with psychological distress). Vaniqa (eflornithine 11.5%) cream on long term prescription may help reduce hair growth in 70% and is now available on NHS prescription.

PIGMENTARY DISORDERS

Post-inflammatory
Hypo- and hyper-pigmentation are common sequelae of inflammatory skin disorders, especially in pigmented skins. It is not treatable per se but the underlying disease should be treated more aggressively to allow recovery (weeks to months). A common mistake is to assume that topical steroids have caused hypopigmentation. In fact, this is rarely the case.

Vitiligo
This is probably an autoimmune disorder, which results in total loss of pigment at characteristic sites (e.g. knuckles, perioral) symmetrically, and without preceding clinical evidence of inflammation. Appropriate investigations to exclude associated disease (e.g. pernicious anaemia, thyroid disease) may be undertaken, although the yield for positive results is low. Treatment is disappointing. However, new areas of pigment loss can be treated by a very potent topical steroid daily for one month. Cosmetic camouflage for facial vitiligo should be offered; the Red Cross offer a free-advice clinic at St. Helier Hospital, and there is an ‘in-house’ camouflage clinic at St. George’s. Referrals should be made to the dermatologists and patients should be aware that charitable donations are gratefully received (Red Cross). Dermablend cosmetic products are available on prescription. Private advice can be sought from a qualified beautician. Advice about sunscreens and sun avoidance should be given. St Helier policy is not to treat vitiligo with PUVA, since controlled trials have failed to demonstrate clear-cut benefit. Troubled patients should join the Vitiligo Society (Appendix E). Excimer laser may help facial vitiligo, but currently it is unavailable in our region. Protopic 0.1% sometimes helps.

Chloasma (Melasma)
Pregnant women and women taking the oral contraceptive pill are at particular risk of developing facial pigmentation. This is aggravated by sun exposure. Judicious sun avoidance and sunscreens (at least SPF 15) are important. Use every day without fail during Spring and Summer. A weak hydroquinone
preparation is available on prescription (Eldoquin cream 2.4%), but its uncontrolled use can lead to permanent bleaching, contact dermatitis and, rarely, hyperpigmentation. Consider alternatives to oral contraception. Sometimes perfumed products with ultraviolet exposure leads to a photosensitising pigmentary reaction. Non-perfumed products should be used (e.g. Simple soap) with hypoallergenic make-up.

Black Skin

Black skin dermatoses may be difficult to diagnose. Erythema is difficult to detect, and pigmentation (usually post-inflammatory) is particularly pronounced and persistent (e.g. lichen planus); hypo- and hyperpigmentation are normal sequelae of eczema, psoriasis and acne. A more aggressive treatment approach is often appropriate (p. 27). Bleaching agents and superpotent steroids are sometimes used inapproprately and without prescription to overcome these unsightly complications. Excessive use of greasy pomades on scalp and forehead produces acne. Hair straightening methods, including Relaxers and hot-combing, induces scarring alopecia. There is a marked tendency toward keloid, especially over the sternum, and very characteristically, on the nape of men’s necks secondary to ingrowing hairs (acne keloidalis). Lupus perrnio is more prevalent in black skin (sarcoïd of nose). Vitiligo can have disastrous consequences in black skin. A bonus of natural pigmentation is protection against skin cancer, which is extremely rare in black skin.

Rosacea

Rosacea is an idiopathic, chronic relapsing, inflammatory condition which can permanently dilate the facial blood vessels. Fair-skinned, middle-aged to elderly individuals are affected. Redness, telangiectasia, pustules, inflammatory papules and induration occurs on central forehead, nose, cheeks and chin - although there are various permutations of the above features. Burnt-out rosacea leaves residual telangiectasia. Flushing is a common complaint. Precipitants, such as ultraviolet light, alcohol, hot drinks, spices etc., should be avoided if possible but the cause is unknown. Treatment is with anti-acne type oral agents, e.g. tetracycline 500 mgs bd, 6 weeks reducing to the lowest possible maintenance dose. Alternatively, full dose tetracycline or minocycline can be prescribed 3 months on, 3 months off. Maintenance treatment may need to be continued for years. Therefore, topical metronidazole, if effective, is usually preferred. Rozex cream is cosmetically superior to Metrogel, which tends to leave an unsightly ‘peel’. Sunscreens should be used in the spring and summer. Other causes of red face to be considered, and commonly confused with rosacea, are acne, seborrhoeic eczema and idiopathic telangiectasia. Systemic lupus is very rare; a negative antinuclear factor excludes it. Post-rosacea telangiectasia is unresponsive to drugs. Pulsed dye, and KTP 532 nm laser treatment is effective, but may not stop flushing (private referral).

Pityriasis rosea

A self-limiting rash which presents commonly to GPs. Typically a solitary scaly red patch on the trunk (‘Herald Patch’) precedes a generalised scaly rash. The textbook description of fir-tree distribution on the back may be subtle. Indeed the rash often masquerades as eczema. The cut-off at elbows and knees is a helpful diagnostic clue. Reassure, treat symptomatically, but review diagnosis if rash persists more than 6 weeks.

Reference:
Meningococcal infection: meningitis and septicaemia. Common Dis Rep CDR Review 1997; 7: R3-4
The Use Of Emollients In Dry Skin Conditions

The ABC of emollient use:
A. Avoid soap products1 - use an emollient bath substitute for washing
B. Benefit from regular use of emollients2 even when eczema is controlled
C. Control inflammation with steroids2 and dry skin with emollients

An estimated 15% of a practice population will consult their GP about skin problems.3
- Emollients are essential in the management of dry skin conditions but are underused in general practice. Regular use may reduce flare-ups of eczema and have a steroid sparing effect. Emollients do not control inflammation.
- Due to lack of good quality evidence comparing emollients, the choice depends on the patient and their acceptability of a given product.
- Select the cheapest emollient which is effective and likely to be used regularly.

A stepwise trial of the products prescribed in small quantities may enable a selection of the most suitable. Generic emollients like aqueous cream or hydrous ointment are often acceptable and should be used first.

- Generally ‘greasy’ products provide the best emollient effect2 but for daytime use or use on the face, patients may prefer a less oily preparation. In hot weather, the oily preparations may cause a sweat rash and other problems. Changing to a less oily preparation in the summer may be required.
- Compliance can be improved by explanation on how to use emollients and how much to use. Emollients should be applied liberally and frequently within 10 minutes of bathing and 3 to 4 times a day (prescribe a smaller size for use during the daytime).4
- Consider the use of up to 25g of emollient per application. Sufficient quantities should be prescribed once a suitable product has been found5 (see attached chart).
- Emollients should be used even when the skin condition has improved.
- There is no general consensus as to when to apply corticosteroids in relation to emollients. Locally, the patients are advised by the consultant dermatologist to apply the emollient to the whole skin and corticosteroid preparations to the eczema patches, preferably 15 to 20 minutes later.
- Bath additives may be beneficial for some patients. Choice is based on patient preference. Emulsifying ointment BP is acceptable to many patients and should be tried before a more expensive branded product. It should be dissolved in boiling water and added to bath water or used on a flannel. Note that these products solidify in the pipes during winter months and are known to ruin the rubber seals of washing machines.

The routine prophylactic use of an emollient/antiseptic combination (e.g. Dermol 500) is ONLY indicated when infection of the skin is significant or suspected.3

Patient information is available from the British Association of Dermatologists (www.bad.org.uk)

References:
3. MeRec Bulletin 1998;9; No 12

Prepared in consultation with:
Dr C Holden, Consultant Dermatologist, Epsom and St. Helier Hospitals
Anne Lowson, Formulary & Liaison Pharmacist, Epsom and St. Helier Hosp.
Brigitte van der Zanden, Pharmacy Team Leader, Sutton and Merton PCT
Kanta Patel, Practice Support Pharmacist, Sutton and Merton PCT
Neelam Sharma, Snr. Prescribing Adviser, E-Elmbridge and Mid-Surrey PCT
East Elmbridge and Mid-Surrey PCT Medicines Management Committee
Sutton and Merton PCT Medicines Management Committee
Sutton and Merton PCT Prescribing Sub-Groups
A Suggested Stepwise Approach To Emollient Choice
(based on the principles overleaf)

<table>
<thead>
<tr>
<th>Emollients</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 1</strong></td>
</tr>
<tr>
<td>Aqueous cream BP (L)(1)</td>
</tr>
<tr>
<td>Hydrous ointment BP (R)</td>
</tr>
<tr>
<td>Liquid Paraffin 50% : White Soft Paraffin 50% ointment (G)(2)</td>
</tr>
<tr>
<td><strong>Step 2</strong></td>
</tr>
<tr>
<td>E 45 cream (L)*</td>
</tr>
<tr>
<td>Oilatum / Ultrabase cream (L/R)*</td>
</tr>
<tr>
<td>White Soft Paraffin BP (G) or</td>
</tr>
<tr>
<td>Emulsifying ointment BP (G)(3)</td>
</tr>
<tr>
<td><strong>Step 3</strong></td>
</tr>
<tr>
<td>Diprobase cream (L)*</td>
</tr>
<tr>
<td>Unguentum Merck cream (R)*</td>
</tr>
<tr>
<td>Epaderm ointment (G)</td>
</tr>
</tbody>
</table>
*Available as pump dispenser

The potential sensitisers in these products are listed on the following page.

Key: (L) = ‘light’ or creamy emollients
(R) = ‘rich’ cream type emollients
(G) = ‘greasy’ emollients

(1) Aqueous cream can be used as a cleanser or a light moisturiser. Generic brands of aqueous cream may contain a potential irritant, sodium lauryl sulphate (SLS). Patients who seem to react to SLS should be warned to check the ingredients with the pharmacist, and change to a non-SLS containing aqueous cream preparation.

(2) Liquid Paraffin 50% : White Soft Paraffin 50% is the treatment of choice in babies due to its fluid consistency (does not require ‘rubbing in’); it does not contain preservatives, BUT can cause sweat rash and other problems in hot weather.

(3) Emulsifying ointment BP is more suitable as a soap substitute. It should be dissolved in hot water and added to bath water.

Folliculitis can occur in ‘hairy’ limbs of men as a result of use of greasy preparations. This may be limited by applying the preparation proximally to distally in smooth strokes.

Urea based preparations could be considered if the above products fail to provide relief.

Reference:

For further information contact Philip Watkins, Nurse Specialist (details p78)
Potential Sensitisers In Selected Emollients

<table>
<thead>
<tr>
<th>Emollient</th>
<th>Potential sensitisers</th>
<th>Emollient</th>
<th>Potential sensitisers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aqueous cream BP</td>
<td>Cetostearyl alcohol, Chlorocresol</td>
<td>Epaderm ointment</td>
<td>Cetostearyl alcohol</td>
</tr>
<tr>
<td>Hydrous ointment BP</td>
<td>Wool fat and related substances</td>
<td>Emulsifying ointment BP</td>
<td>Cetostearyl alcohol</td>
</tr>
<tr>
<td>Liquid Paraffin 50%; White Soft Paraffin 50% ointment</td>
<td>None stated</td>
<td>Diprobase cream</td>
<td>Cetostearyl alcohol, Chlorocresol</td>
</tr>
<tr>
<td>E45 cream</td>
<td>Cetyl alcohol, Lanolin derivatives, Cetostearyl alcohol, Hydroxybenzoates (parabens)</td>
<td>Ultrabase cream</td>
<td>Stearyl alcohol, Hydroxybenzoates, Fragrance</td>
</tr>
<tr>
<td>Unguentum M cream</td>
<td>Cetostearyl alcohol, Polysorbate 40, Propylene glycol, Sorbic acid</td>
<td>White Soft Paraffin BP</td>
<td>None stated</td>
</tr>
</tbody>
</table>

Suitable quantities of dermatological preparations to be prescribed for specific areas of the body (creams & ointments)

- **Face:** 15g - 30g
- **Scalp:** 50g - 100g
- **Both arms:** 100g - 200g
- **Both hands:** 25g - 50g
- **Trunk:** 400g
- **Groin and genitalia:** 15g - 25g
- **Both legs:** 100g - 200g

These amounts are usually suitable for an adult for twice daily application for one week. The patient should be asked to use handfuls of cream to emphasise the generous quantities used. Alternatively, finger tip quantities can be worked from the top of the limbs distally to leave a thin film on the surface (not rubbed in). The recommendations do not apply to corticosteroid preparations.

References:
1. BNF 45, March 2003
2. MIMS, August 2003

For further information contact Philip Watkins, Nurse Specialist (details p78).
Emollients

Drug Tariff August 2003 & Chemist and Druggist August 2003 (Prices are based on largest available container size and are subject to change). For further information contact Philip Watkins, Nurse Specialist (details p78). Oil baths are an expensive means of delivery temporary emollient, but some, for example Oilutum PLUS, are useful for infected eczema in childhood.

<table>
<thead>
<tr>
<th>Type</th>
<th>Emollient</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>Light or creamy</td>
<td>Aqueous cream BP</td>
<td>£1.06</td>
</tr>
<tr>
<td></td>
<td>E45® cream</td>
<td>£0.20</td>
</tr>
<tr>
<td></td>
<td>Diprobase® cream</td>
<td>£6.81</td>
</tr>
<tr>
<td>Rich cream type</td>
<td>Hydrous ointment BP</td>
<td>£1.99</td>
</tr>
<tr>
<td></td>
<td>Ultrabase® cream</td>
<td>£6.89</td>
</tr>
<tr>
<td></td>
<td>Unguentum M® cream</td>
<td>£8.55</td>
</tr>
<tr>
<td>Greasy</td>
<td>Emulsifying ointment BP</td>
<td>£1.52</td>
</tr>
<tr>
<td></td>
<td>White Soft Paraffine BP</td>
<td>£1.62</td>
</tr>
<tr>
<td></td>
<td>Liquid Paraffin 50%:</td>
<td>£3.78</td>
</tr>
<tr>
<td></td>
<td>White Soft Paraffin 50%:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Epaderm® ointment</td>
<td>£6.21</td>
</tr>
</tbody>
</table>
ACNE

Acne is a disease of the hair follicle and sebaceous grease gland. In acne there is increased sebum (grease) production, plugging of the follicles (pores) giving rise to whiteheads and blackheads and inflammation of the skin (spots, zits). Hormones affect acne, particularly during adolescence. If women have acne and irregular or absent periods, then investigations and hormonal treatment may be needed.

Late-onset acne is seen more and more in skin clinics, it seems. Frequently men and women over 30 are getting acne. Mostly there is no hormone problem. The grease glands are probably more sensitive, but no one knows why.

Treatment is needed for several months (at least six) or even years. Food and diet do not cause acne and probably have no place in treatment.

Local treatment with a cream such as benzoyl peroxide is applied daily. This can be expected to cause some irritation of the skin and bleach fabrics. It works by removing keratin and unblocking the ducts. It also reduces numbers of bacteria. Other local treatments are available.

General treatment with antibiotics given by mouth should be used for moderate and severe acne. The first choice is tetracycline given (outside mealtimes) for at least six months when there should be a gradual but continuous response. Treatment may be needed for up to two years. This drug should not be taken by pregnant or breast feeding women. The oral contraceptive called Dianette can be used for acne in women.

Response to treatment acne responds slowly to treatment. In six weeks it may improve by 10%, by three months 30% and by six months it will be 80-100% better. The condition comes back if treatment is stopped.

Hospital treatment is indicated for patients who fail to respond after two prolonged courses of different antibiotics (3-6 months of each), or for those who are developing disfiguring scars.

Laser treatment for inflamed acne is promoted commercially (N-lite). Data for its effectiveness are few. Limited experience at the Sutton Laser Unit suggests that a similar low-energy V-beam laser may help in the short-term, but good studies are needed. It is not available on the NHS (contact Sutton Lasercare Clinics 020 8296 4147 for further information).

Acne Support Group
1st Floor, Howard House
The Runway
South Ruislip
Middlesex HA4 6SE
020 8841 4747
www.stopspot.org


**ATOPIE ECZEMA (or dermatitis)**

Atopic eczema is the commonest form of eczema and tends to run in families, along with hayfever and asthma. It affects 5-10% of all children and will clear in 50% of them by the age of 2 years and 90% by the age of 15 years. However, eczema can come back in later life. Children with atopic eczema have skin which is both drier and more itchy than normal. Routine treatment should include the following.

**Moisturisers** (emollients) are applied to the skin in three ways. A daily bath with a bath oil such as *Balneum*, *Oilatum* or *Emulsiderm* is given. Secondly a soap substitute such as *Aqueous cream* is used. Soap and bubble baths irritate and must not be used. Thirdly after the bath a moisturiser such as *Aqueous cream*, *E45* or *Diprobase* is applied to the skin. Moisturiser must be applied frequently, at least twice daily, to help the dry skin and itch. This enables a lower dose steroid to be used.

**Topical steroids** are applied to affected areas of eczema only once or twice daily as directed by your doctor. If there is no active eczema only the bath oil and moisturiser are needed for routine treatment. 1% hydrocortisone can be safely used on the face.

Chinese herbs and other alternative treatments sometimes help but are sometimes fraudulent. Side effects and drug interactions can occur, and practitioners often have no medical qualifications. ‘Conventional’ treatments should be tried first.

**Acute exacerbation of eczema** means a flare up and this is often associated with infection which is treated with a course of antibiotic such as flucloxacillin or erythromycin. The frequency of application of moisturisers and the strength of topical steroids will also need to be increased.

**General measures** include keeping nails short, avoiding extremes of temperature and wearing cotton (not wool). Sedative antihistamines at night help sleep, but have limited effect on itch.

Other triggers are sometimes important. Babies are sometimes allergic to cow’s milk and other foods. A dietician’s advice is needed if this is suspected. Adults’ eczema is rarely affected by food. House dust and animal fur can make eczema more itchy. Advice is available from the Eczema Society.

**Self Help Group**
National Eczema Society
Hill House, Highgate Hill
London N19 5NA
Eczema Helpline 0870 241 3604
email: helpline@eczema.org
www.eczema.org
**HAND DERMATITIS**

*Hand dermatitis* can occur as localised patches or affect the whole hand. Initially it may be blistered, moist and oozing and later dry and cracked. It is caused by irritation from soaps, detergents, polishes and other chemicals in the home or at work.

**Protection** When working with irritants always protect your hands by wearing cotton lined rubber or PVC gloves.
- Dirty your gloves - not your hands
- Wash your gloves - not your hands

**Handwash** with a soap substitute (e.g. *Aqueous cream*). Wash as little as possible - all soaps irritate! Avoid shampoo if possible - get someone else to wash your hair or wear gloves.

**Emollients** (or moisturisers) help dry skin by providing a protective oily layer to the skin and preventing water loss. There are various kinds (e.g. *Doublebase gel for hands*, *Diprobase cream*, etc.). Find the moisturiser that suits you and use it frequently - at least three times daily and after washing.

**Steroids** are safe and effective used appropriately. Your doctor will advise on their strength and duration. Strong steroids are usually recommended by dermatologists. In some cases occlusion (e.g. polythene gloves worn at night) may be needed to enhance the action of the steroids.

**Remember** hand dermatitis may be stubborn and persistent. You may need to carry on hand care for life!
TREATMENT OF DERMATITIS

You have been given several medications which should be used regularly in the following manner.

1. ......................................... is a steroid cream/ointment to be applied sparingly to the inflamed area once/twice daily. More frequent application is unnecessary.

2. ......................................... is a moisturising cream which should be applied liberally and frequently to all dry or inflamed areas during the day and after washing.

3. Oilatum or other emollient is for the bath water. Do not shower. There is no need to bathe more than twice weekly.

4. Aqueous cream or Emulsifying ointment can be used instead of soap. Rub on the skin and wash off in the usual manner.

Steroid preparations should be used carefully and only under the supervision of a doctor.

Moisturising creams and Emulsifying ointment are always safe and should be used long after the dermatitis has gone. Take some to work or school with you. You do not need a prescription for these items - please get into the habit of using them.
PITYRIASIS (TINEA) VERSICOLOR

This is a yeast infection of the uppermost layers of the skin. It affects the chest, neck and back, being most apparent as finely scaling brown-coloured patches. The yeast temporarily affects normal tanning, and infection is often first noticed during the summer as pale patches contrasting against the normal tanned skin. After successful eradication of the yeast, normal tanning may not occur for some months, and recurrence of infection is common during the summer months.

Treatment with selenium sulphide (Selsun) or Nizoral shampoo:

1. Have a bath or shower.
2. Shampoo the hair as normal with the product.
3. Whilst still wet, apply the shampoo sparingly from the neck to the groins, and down the arms as far as the wrists.
4. Allow the shampoo to dry onto the skin, and leave overnight.
5. Bath or shower the shampoo off the next morning.
6. Repeat the procedure once more after three weeks.
7. These products may stain or irritate.

Note:
It may take several weeks for the marks to clear, even though the yeast has gone.
**PSORIASIS**

**Psoriasis** is a common inheritable skin disorder affecting about 2% of the population. Patches (called plaques) are red and scaly and occur commonly on the knees, elbows, trunk and scalp. In psoriasis the skin grows too quickly and too thickly. It can be triggered by stress, infection and after skin injury.

**Treatment** is usually with ointment or cream and varies according to body site.

**For Body or plaque psoriasis** treatments include:

**Vitamin D Products** (e.g. calcipotriol) usually applied twice daily. Irritation may occur with these products. Calcipotriol should not be used on the face or skin folds.

**Dithranol** (e.g. Miconal or Dithrocream) is applied for 30 minutes daily and is washed off thoroughly. It may irritate and stain and should not be used on the face or skin folds. Miconal must be washed off with lukewarm water only (no soap).

**Tar** (with or without steroid) is useful but may stain, irritate and can be smelly.

**Topical steroids** are good for small patches such as knees or elbows.

**For face, flexures and genitals** weak steroid creams are used. Body folds (e.g. groins and under breasts) may need steroid and antimicrobial combined creams.

**For the scalp** treatment with tar shampoos or applications containing salicylic acid is given. Dithranol, steroid and vitamin D preparations may also work.

**Hands and feet** need treatment with potent steroids (sometimes with occlusion) as advised by the doctor.

If there is no response after 2 months, you should be reviewed by your doctor. Patients who do not respond may benefit from referral to the Specialist Dermatology Nurse for supervision and advice, and patients with severe disease may need hospital treatment. Moisturisers should be applied regularly.

Psoriasis is not infectious or caused by what you eat.

**The Psoriasis Association**
Milton House
7 Milton Street
Northampton NN2 7JG
www.psoriasis-association.org.uk
SCABIES

Scabies is due to skin infestation by a mite. The mite must be killed by using an antiscabies cream. The rash and itch of scabies take a week or two to settle down after the mites are killed and a soothing lotion or cream (e.g. Calamine, Eurax or steroid) may be applied two or three times daily during this time.

Mites are killed by applying Lyclear Dermal cream. One application may be sufficient but a second application after 7 days is advisable. All the skin from neck downwards (including under fingernails, skin folds, genitalia) must be treated. Do not wash for at least 8 hours (reapply to hands if necessary).

Itch should be treated by regular applications of Calamine, Eurax or steroid creams for two or three weeks.

Contacts All members of the household and close contacts must be treated at the same time as the second application.

Treatment failure is usually the result of inadequate treatment, particularly of household members. Your doctor may need to review you.

Caution in pregnancy and in babies. The same product is probably safe, but an alternative is malathion. Babies’ heads and faces should also be treated.
HEAD LICE - The Facts

What are they? Head lice are tiny fast moving grey/brown insects and are about the size of a match head.

Where are head lice found? On the heads of children and adults in the general community. They keep close to the scalp to keep warm, feed and lay their eggs.

What is a nit? A nit is the egg of the headlouse which, when laid, is firmly glued to the hair close to the scalp. Nits are seen as light specks attached to the hair and are more noticeable when the lice have hatched leaving the empty shells. They cannot be brushed off the hair like dandruff.

How are head lice spread? They crawl from one head to another when in close contact with each other. Lice do not jump or fly. You don’t catch them from animals.

How do you know if you have got head lice? Strict regular observation is the best method by combing wet conditioned hair in sections with a head lice detection comb. Parents should regularly check their child’s head for lice. If live lice are found then treatment is necessary.

Head Lice some facts? 50% of all cases are found in children. Head lice can be passed on anywhere that people meet and very close head to head contact happens i.e. at a party, at school, in the park. The school nurse does not examine children for head lice because this has proved to be ineffective in school, without careful treatment/inspection at home. Encourage everyone, children and adults to check their head regularly.

How do I get rid of them?

Lotion treatment. If you find your child has live head lice treat their infested head with a preparation available from the chemist (some are only available on prescription). Carefully read and follow the instructions on the packet to ensure the treatment is effective. The treatments must not be used as a preventative measure.

• 1 treatment consists of 2 applications 7 days apart.
• Hair that has been in contact with chlorine or conditioners should be washed with shampoo only, rinsed and left to dry before applying the lotion.

Wet combing/Bug Busting. Condition wet hair to make it slippery and immobilise the lice, then comb through with a head lice detection comb to erase all live lice. It is important to comb all the head by using a systematic sectioning combing method so no area of the head is missed. Repeat every three days for a fortnight. This breaks the life cycle by catching new lice as they hatch out preventing them from laying eggs. Reusable bug busting kits are available from chemists.

Further advice is obtainable from your School Nurse; Health visitor; Pharmacist or “Bug Busters” Community Hygiene Concern, Helpline 020 8341 7167
SOLAR KERATOSES (ACTINIC)

What are Solar Keratoses?

Solar or actinic keratoses develop on the skin which has been damaged by long term sun exposure. Usually many are present and can appear as small hard scaly lumps. Some become unsightly as they slowly grow larger.

The skin underneath solar keratoses can vary in colour from normal fleshy shade to pink or red. Sometimes these skin lesions can become itchy. Common sites are the face, backs of hands, forearms, ears, scalp and neck.

The northern european skin type is at risk of developing solar keratoses, although those most at risk are outdoor workers, sailors and the very fair skinned. Solar keratoses are frequently seen in persons aged over 50 years of age.

Solar keratoses are not skin cancers. However a very small percentage can develop into a skin cancer in later life.

Early Warning Signs

- Solar keratoses appear as hard scaly lumps on the skin. They may crust but do not heal.
- Solar keratoses can be rough scaly irregular patches which can be easily felt, but not clearly seen. Often they are not troublesome in any way but do not heal.

Treatments available:

Solar keratoses can be treated by freezing using Liquid Nitrogen (Cryotherapy) or by applying a treatment cream. Treatment is usually carried out on an outpatient basis with a minimum disruption to your daily routine. Your G.P. or specialist doctor will be able to advise you on treatments available.

How can we prevent Solar Keratoses

Solar keratoses may recur following treatment and others may develop over the years.

- Examine your skin and feel for any scaly lumps or patches.
- Wear protective clothing and wide brimmed hats when outdoors. These will protect the areas of skin most at risk.
- Avoid sunshine during the midday hours if possible.
- Wear 100% U.V. protective sunglasses.
- High factor sunscreens are vital. SPF 15 is recommended. Apply to skin before going out into sunshine especially during summer months. Reapply every 2-3 hours.
- Advise others to protect themselves also, especially young children and those with a history of skin cancer.
EFUDIX CREAM FOR SOLAR KERATOSES & BOWEN’S DISEASE

Efudix cream has been prescribed for your particular skin condition. It should not be used for other skin conditions.

Apply the cream thinly twice weekly for 10 weeks. Only apply the cream to areas directed by the doctor. Be careful to keep the cream away from the eyes and always wash the hands after use. Apply daily if there is no red reaction for up to 3 weeks.

Reaction to cream. After a few days (usually 3-5 days) the keratoses will go red and may blister in some cases. Other adjacent areas of sun damaged skin may also react.

This reaction is inevitable and a necessary part of the treatment. Once the reaction has started and provided it is not too sore continue the application for a further two weeks. If at any time the reaction is too unpleasant then stop the treatment and apply a steroid cream such as 1% hydrocortisone twice daily. If a severe reaction has occurred, your doctor may need to prescribe a short course of strong steroid cream.

At the end of treatment (up to 3 weeks if daily; 10 weeks if twice weekly) any residual soreness may be treated with hydrocortisone. It may take 4 weeks from the end of treatment for all the lesions to heal.

Notes:
Do not use Efudix without supervision.
These instructions apply to the face. Lesions on arms, hands and legs may require more prolonged treatment and may need occlusion. The doctor will advise.
Avoid prolonged sun exposure during treatment (hats for bald scalps).
Do not use cosmetics while using Efudix.
CELLULITIS INFORMATION LEAFLET

What is Cellulitis

Cellulitis is a skin infection. Redness, hotness, swelling and sometimes pain spread along the skin. Often the leg is affected. If the face is affected the cellulitis is sometimes called “erysipelas”. Cellulitis is caused as a result of a break in the skin through which a streptococcus bacteria can spread (eg. Athlete’s foot between the toes). The patient often feels feverish or ill, or may feel “fluzy”. It is not infectious.

Treatment

If the cellulitis is bad, the patient requires hospital admission and antibiotic given directly into the vein. This ensures rapid treatment in the first 48 hours, then antibiotic tablets are given.

If the cellulitis is mild, the patient is given antibiotic tablets to take at home. The swelling in the affected leg/area may take several weeks to subside unless the following advice is taken.

Treatment of swelling (leg cellulitis only)

The treatment of your condition is Compression Therapy; there are several ways of achieving this depending on the severity of swelling.

- A single elasticated bandage
- A single non-elasticated bandage
- Several layers of bandage
- Compression stockings

Do’s and Don’ts (mainly for leg cellulitis)

Do take any painkillers regularly, they don’t work if you wait until the pain is bad
Do walk or exercise regularly to keep the muscles working properly
Do try to lose weight if you are overweight, this will take a lot of strain off your legs
Do take good care of your skin, keep it clean and apply a moisturising ointment
Do treat cracks in skin between toes with Daktarin or Canestan cream
Do rest with your legs raised, above the height of your hips if possible
Do raise the foot of your mattress by about 6 inches, old telephone directories are ideal!
Do wear your support stockings if these have been advised

Don’t remove your dressing or bandages, UNLESS YOU DEVELOP SEVERE PAIN IN YOUR CALF OR FOOT, OR YOUR TOES BECOME NUMB OR DISCOLOURED
Don’t stand or sit in one position for a long time, move around
Don’t scratch your legs - this can damage the skin and cause infection

Foot exercises

Even if you are unable to move around easily you can still do your foot exercises. These exercises mimic the action of walking and so can improve the flow of blood in your veins. They should be performed several times a day, the more often the better the effect!

- Rotate your foot in one direction then the other direction, do this 10 times
- Pull your toes up to point to your knees then point your foot down again, do this 10 times
- When ‘pottering’ around the house take a moment to stand, hold the nearest furniture, and come up onto tiptoe then down again, do this 10 times in a row
SUNBEDS AND SOLARIUMS

WARNING!

Ultra-violet radiation emitted from sunbeds and solariums is now known to have harmful effects on skin. Excessive use of sunbeds can cause rapid ageing of the skin, long term damage and increase the risk of developing skin cancer.

Fact 1: There is no such thing as a safe tan

Many people today use sunbeds to develop or maintain a tan. Some people believe that a sun tan from a sunbed is a safe tan. Skin specialists say there is no such thing as a safe tan and advise everyone to avoid the use of sunbeds and solariums. This is especially important for the very fair skinned and persons under the age of sixteen. Likewise, persons with skin cancer, or those with a family history of skin cancer, should never use sunbeds or solariums.

Fact 2: U.V.A. rays cause rapid ageing of the skin

Modern sunbeds and solariums emit U.V.A. rays which penetrate the deeper layers of the skin (dermis). These rays gradually destroy the elastin fibres and collagen contained in the dermis. Loss or destruction of these tissues will result in dry, wrinkled and aged looking skin. Artificial U.V. rays may also cause photosensitivity, fragile skin syndrome and severe blistering. Sunbeds should only be used under close medical supervision as certain medications, perfumes and cosmetics can cause severe photo-sensitive reactions. Frequently health clubs and solariums will review medical histories and request clients sign a disclaimer prior to commencing tanning sessions.

Fact 3: A sunbed tan will not protect you from strong natural sunlight and sunburn.

Great care should be taken when using a sunbed in preparation for a hot sunny holiday. U.V.A. rays do not cause the outer layer of the skin (epidermis) to thicken, which is another natural protection mechanism against ultraviolet radiation. Therefore persons who have artificial tans are at risk of being sunburnt due to U.V.B. rays in natural sunlight. Looking or being tanned from a sunbed can lead to a false sense of security. Always apply a high factor sunscreen when exposed to natural sunlight.

Fact 4: Excessive use of sunbeds is associated with skin cancer.

It is now recognised that excessive use of sunbeds causes the non-melanoma types of skin cancer (basal cell carcinoma and squamous cell carcinoma). Sunbeds may also play a part in increasing the risk of malignant melanoma as the use of sunbeds add to the total amount of sunshine to which we are exposed.
**SKIN CANCER**

Skin cancer is the second most common cancer in Britain today. Latest statistics state that over 40,000 new cases of skin cancer are reported each year. Fortunately, most are completely curable forms of skin cancer and very few skin cancers turn out to be a serious disease.

**Fact 1:** There are two main groups of skin cancer.
Skin cancer can be divided into two main types: 1) melanoma skin cancer and 2) non-melanoma skin cancer. Melanoma skin cancer is the rarest but most serious form. It affects the pigment producing cells (melanocytes) found in the skin and can appear as a new mole or arises from an existing mole on the skin. Melanoma skin cancer has the potential to spread to other sites or organs within the body. Melanoma skin cancer is CURABLE if treated early but more difficult to cure if spread has occurred.

Non-melanoma skin cancers are far more common, but less dangerous than the melanoma type and very rarely fatal. Basal cell carcinoma and squamous cell carcinoma frequently appear on sun exposed skin after many years of exposure. They are easily treated although others may appear. If left, non-melanoma skin cancers will grow and disfigure therefore early treatment is recommended.

**Fact 2:** Sunshine is the single most important causative factor for all skin cancers
Ultra-violet rays contained in sunshine are known to be harmful and can cause skin cancers. The increase in skin cancers in Britain has been linked with the desire to have a tan, repeated sunburn, fair skin types and genetic factors, such as number of moles.

Melanoma skin cancers are associated with frequent high intensity sun exposure. Whereas, non-melanoma skin cancers are caused by long term exposures to low intensity sunshine. The amount of sun exposure during childhood and frequency of sunburn are now believed to increase the risk of developing skin cancers in adult life. It is therefore most important to protect all children from intense sunshine. Hats, tee-shirts and sunscreens are recommended at home, at school and on holiday.

**Fact 3:** All white skinned people are at risk of developing skin cancer.
People with very fair skin are most at risk of developing skin cancer. Those who cannot develop a tan are most at risk of melanoma, but everyone is at risk of being sunburned, especially indoor employees, children and babies. Melanoma is twice as common in females as it is in males. Non-melanoma skin cancers are most frequently seen in the older age groups and outdoor workers who have a continuous all year tan. The incidence of skin cancer is rapidly rising in the young adult population.

**Fact 4:** All skin cancers are curable if treated in the early stages
Both melanoma skin cancers and non-melanoma skin cancers are curable if treated in the early stages. A minor surgical procedure is all that is usually required to remove cancers of the skin. Regular screening of skin and moles at home helps in recognising any abnormal skin lesions or changing moles. Changes in size, shape and colour of a mole are the early warning signs of melanoma. Always see your doctor for advice on any unhealing sore or changing/troublesome mole on the skin.

**IF IN DOUBT - CHECK IT OUT : SEEK MEDICAL ADVICE**
SUN PROTECTION

Ultra-violet rays contained in sunshine can be harmful to skin. Therefore we need to understand how to protect our skin from ultraviolet radiation when outside. It is important to enjoy the benefits of fine weather and all outdoor activities without being at risk.

Fact 1: Sun protection during childhood and early teenage years reduces the risk of skin damage and skin cancer in adult life.

Children and teenagers are exposed to greater amounts of sunshine compared to adult populations. This exposure is constant during summer months, at home, at school or college and during holidays. Sun protection is therefore most important during these early years to prevent potential health problems in adult life. It takes many years for the signs of sun damage to show in the skin, most of which is irreversible. The skin remembers every ounce of sunshine during our lives. The total amount of exposure, intensity of rays and frequency of burning add up to an increased risk of skin cancer in adult life.

Fact 2: ‘Covering up’ is the best and cheapest form of sun protection

Lightweight cool cotton clothing is an excellent form of sun protection. Fabrics should be tightly woven to avoid U.V. penetration through fibres. Polo shirt styles, and tee-shirts are preferable to vests and shoulder straps which do not provide enough protection for necks and shoulders. Hats with a brim of at least 6cm are recommended for young children, and 10cms for teenagers and adults. Wide brimmed cricket caps are excellent. Baseball caps only provide sufficient shade for the face. Ears and necks are still at risk of burning. Try to buy the legionnaire style of cap which protects ears and nape of neck. U.V. protective sunglasses are also recommended. When buying sunglasses ensure they meet British Safety Standards BS 2274:1987.

Fact 3: The sun’s rays are most harmful during the mid-day hours.

It is important to provide extra protection if outside during the mid-day hours. Skin specialists advise everyone to go indoors during these hours or find some shade. This can be shade from a tree, canopy, parasol and hats. This is especially important to remember during summer months or when on a sunny holiday.

Fact 4: Sunscreens help protect the skin from sunburn

Use a high SPF (15+), applied before going out and regularly (every 1-2 hours if fair skinned). Regular use throughout childhood years and adult life prevents premature ageing of the skin and reduces the risk of skin cancers in adult life.
ULTRA-VIOLET RADIATION

Fact 1: **Ultra-violet rays in sunshine are invisible**
Ultra-violet rays form part of the solar spectrum of invisible light. The heat we feel on a hot sunny day are infra-red rays which are also invisible. It is important to remember that on cooler days and cloudy days the ultra-violet rays may still be strong enough to produce sunburn.

Fact 2: **There are three wave bands in ultra-violet light:**
- **U.V.A. (A for ageing)**
  U.V.A. rays are the longest and all reach the earth’s surface. They penetrate skin to dermis and can damage collagen and elastin fibres. This causes premature ageing of the skin and shows as wrinkles, dryness and weathered skin. Scientists and doctors now believe that U.V.A. rays have a part to play in the cause of skin cancers, especially those of the non-melanoma type.

- **U.V.B. (B for burning)**
  U.V.B. rays are the middle length rays which are responsible for the sunburn we feel if exposed to strong sunshine. They are the most dangerous because often we do not feel sunburn until 8-10 hours after exposure. Ozone in the outer stratosphere screens out some U.V.B. rays. These rays are strongest during the midday hours which is when we are most at risk of burning. Always cover up, find some shade or go indoors during midday hours during sunny weather. Long term exposure to U.V.B. rays and frequency of sunburn are strongly associated with the melanoma type of skin cancer.

- **U.V.C. (C for cancer)**
  U.V.C. rays are the shortest waves within the ultra-violet spectrum. They are known to cause cancer, but fortunately none of these rays reach earth’s surface because the ozone layer acts as a barrier.

Fact 3: **Ultra-violet rays vary in intensity.**
The intensity of U.V. rays varies depending on the time of day, time of year, altitude and distance from equator. These rays are most intense during midday hours in the summer, although they are always present, even during winter months. Distance above sea level, and distance from the equator are also important to consider. The higher the altitude the greater the intensity of U.V. rays, so mountaineers and skiers are at increased risk of sunburn. The nearer one is to the equator the more intense the U.V. radiation. Therefore skin protection is vital in hot countries and whilst on sunshine holidays.
**VIRAL WARTS**

Common warts are easily recognised and affect most people at one time or other. They are not dangerous and do not lead to skin cancer. They are caused by wart virus and can occur on many parts of the body. The state of a person’s immunity to the wart virus can affect a wart’s development. Sometimes a whole ‘crop’ can appear and then as the body’s immunity to the virus increases they gradually go. They are particularly common in children (who have not yet developed immunity to the virus) but can occur at any age. Warts on the sole of the foot are called verrucas.

**Do they need treatment?**
Most simple warts do not need any treatment. They will go away on their own in time but this time may be quite long. 93% will have gone within 5 years.

**Are they infectious?**
The common wart virus is mildly infectious but as it may be present on normal looking skin and the development of warts depends more on the patient’s resistance than anything else. It is, in general, pointless to try and exclude people with warts from normal activities.

**Treatments**
Warts that need treating (most do not) can in general be easily treated at home. Sometimes it may be worth asking the opinion of your General Practitioner or practice nurse especially with warts on the face and around the nails where treatment can do more harm than good. Wart paints and creams work by gradually destroying the wart by chemical means.

Warts that are resistant to properly applied local treatments after 4 months may be treated by freezing with liquid nitrogen (cryotherapy). This treatment is not suitable for young children. It may be quite painful and lead to local swelling, blistering, discoloration and soreness temporarily. It usually needs to be repeated, normally at about 3 weekly intervals and is even then not always successful. Treatments that carry a danger of scarring are not indicated. When warts resolve on their own they do so without a scar. If you wish to try this treatment you need to see your G.P.

**MOLLUSCUM CONTAGIOSUM**

**MOLLUSCUM** is another harmless viral skin infection. It is quite common amongst school children, and is spread by contact. There is little one can do to prevent it. But it does clear on its own (usually within 1 year). Hospital referral is rarely helpful, except for reassurance. Young children do not tolerate the painful treatments which include pricking the lesions with orange sticks or needles and spraying with liquid nitrogen. If treated the spots may appear large and inflamed prior to disappearing. Molluscum will usually settle on its own within 6 months to one year.
TREATMENT OF SKIN CONDITIONS BY FREEZING

Freezing (or cryotherapy) as a method for treating some skin abnormalities has been in use for more than 150 years. Modern technology has allowed us to get higher success rates than with older methods. The machine used to treat your skin is a product of modern technology which carefully controls a very cold liquid (nitrogen) such that it can be sprayed or touched onto any area of skin that needs the treatment. This medical science is called cryosurgery. The particular advantage of the treatment is that it replaces the need for a surgical operation. In effect, the treatment is a carefully controlled cold burn.

Freezing treatment

The procedure may simply cause vague soreness or stinging pain - this depends on the length of the freeze and the area being treated. After treatment marked redness always occurs together with some swelling. These changes usually last for a few days. In some people, particularly where the skin is rather thin and sensitive, a water (or blood) blister may form and fluid may discharge.

After care

Once the fluid discharge or blistering stage is over a crust may form which will eventually drop off. The area will usually heal within a few weeks - whilst the area is healing you can wash the affected area. If you have been treated with a long freeze you may be prescribed a steroid cream to use, apply it twice daily on any clean dressing - unless otherwise instructed. Small areas can be covered with an elastoplast type dressing. If you have not received a prescription use any antiseptic cream, e.g. Savlon cream, twice daily to avoid the small chance of infection occurring. If undue discomfort or pain occurs after the treatment then a simple pain relief remedy such as paracetamol or aspirin may be taken for 3-5 days.

Risks

Occasionally scars develop. Pigmented or dark skins may lose pigment, resulting in persistent pink patches. Alternatively, darker patches may develop. Near the eye, swelling occurs for a few days - worse in the mornings.
URTICARIA

(Hives, nettlerash, welts) is a condition in which short-lived itchy swellings occur anywhere on the body. These weals may be pink or red with different shapes.

Angioedema is a deeper form of urticaria. Around the eyelids, lips and mouth the swelling can be frightening. Sometimes the eyes close due to the skin swelling.

Cause?

Urticaria is common and affects 20% of people at some stage of their lives. Histamine is released from the skin triggered by exercise, pressure on the skin and other physical factors as well as foods, drugs and infections. Antibiotics (especially Penicillins) and aspirin are commonly responsible. Sometimes nuts, fish, eggs, milk, tomatoes, vegetables and berries are the cause.

Chronic Urticaria

Bouts of weals occur daily or almost daily for longer than 6 weeks and a cause is even less likely to be found.

Tests

In the vast majority of people no cause can be found, though your doctor will ask questions to identify one. There is no special test. It is rare for an allergy to be a cause of chronic urticaria so routine allergy tests (skin prick tests) are not necessary. In a small percentage of people, foods, colouring agents and preservatives appear to worsen urticaria. A food diary can be kept, and these substances can be left out of the diet to see if the condition improves and then later deliberately reintroduced. As urticaria is a variable disease, interpretation of these tests is difficult.

Treatments

Avoid anything that may worsen urticaria such as heat, alcohol, aspirin. ANTIHISTAMINES reduce itching and rash in most people but may not relieve urticaria completely. If it occurs frequently, the antihistamines are best taken daily. Newer ones do not cause drowsiness, but are most likely to do so if taken with alcohol. Different antihistamines may need to be tried and sometimes prescribed for 6-12 months, or longer.

Severe Urticaria

Resistant cases may need steroid treatment. Tongue or throat swelling is rarely serious except in food allergies and the rare hereditary form of angioedema. Sprays or even injections of adrenaline (which can be self-administered) often provide rapid relief.

Allergy UK, 020 8303 8583, www.allergyuk.org
GUIDELINES FOR SURGICAL MANAGEMENT OF COMMON SKIN CONDITIONS IN GENERAL PRACTICE

Surgical treatment should not be attempted without a clinical diagnosis. If the diagnosis is not known, it is impossible to know whether surgical intervention is appropriate or necessary.

If surgery is desirable for cosmetic reasons it is essential that the optimal cosmetic result can be achieved. Unsightly scars are a common cause for complaint and levels of expectation are higher when treatment is performed solely for cosmetic reasons. Confident diagnosis and reassurance is often the treatment of choice for benign conditions.

Diagnostic Procedures

*Biopsy of a rash is often unhelpful unless:*

a) There is a good differential diagnosis
b) The correct biopsy site has been selected
c) The result can be discussed with a dermatopathologist

Biopsy of rashes or tumours prior to referral to a dermatologist is unnecessary.

Appropriate Surgical Procedures:

- Shave excision for non-pigmented or lightly pigmented benign moles
- Snip/cautery for skin tags and polyps
- Curettage and cautery for seborrhoeic keratoses, pyogenic granulomas and filiform warts on the lips and nose
- Cryosurgery for viral warts, actinic keratoses, molluscum contagiosum
- Excision of histiocytomas (if painful); epidermoid cysts, lipomas
- Recurrent ingrown toe nail - lateral phenolic matricectomy

*Viral warts: When treating viral warts remember:*

- Up to 80% respond to paints and gels in 100 treatment days
- Plain warts on the face are best left untreated
- Warts unresponsive to conservative treatment may be treated with cryosurgery
- Cryosurgery is very painful and not well tolerated by children
- Mosaic plantar warts are often resistant to cryosurgery
- Curettage of warts may result in scarring

CAUTION: Elliptical excision of benign moles often leaves a noticeable scar, especially on the upper trunk, shoulders and tops of arms. Beware of surgery in keloid-prone sites. Consider carefully whether a benign mole need be excised. Elliptical excision of seborrhoeic keratoses is inappropriate; curettage and cautery is the treatment of choice. Submit all specimens for histology.

Avoid using braided silk sutures which leave stitch marks unless removed early.
Avoid using alcohol based antiseptic solutions - they are a fire hazard with diathermy or cautery.
Avoid treating skin malignancies unless appropriately experienced. They require excision with adequate lateral and deep margins.
Avoid incisional biopsies of moles. Refer patients with suspicious moles. These lesions should always be excised with a defined margin along the correct anatomical axis.

BRITISH SOCIETY FOR DERMATOLOGICAL SURGERY December 1994
CRYOTHERAPY IN GENERAL PRACTICE

Cryotherapy (the application of a cold medium to treat lesions) is commonly used by dermatologists as a safe, simple, cheap and effective method of treating a variety of pre-malignant and non-malignant lesions with good cosmetic results. Several cryogens are available but liquid nitrogen is the most effective and widely used. Cryotherapy causes ischaemia and necrosis by direct cellular damage and microcirculatory failure; sloughing and healing follows. The best results are obtained by a rapid freeze and a slow thaw. Various systems have been devised, including using a cotton wool bud dipped into a flask of liquid nitrogen, spray guns, and skin/contact probes.

Air Product PLC are the main suppliers of liquid nitrogen delivery and storage systems for this country (previously Cryomedical); tel: 0845 6002381; fax: 01270 531665; email: megill@apci.com

Although we strongly support the appropriate use of liquid nitrogen in the community, with suitable training, we have some serious reservations about some recent promotional literature.

Agreed conditions where cryotherapy may be used -
Viral warts, skin tags, seborrhoeic warts, actinic (solar) keratoses. We strongly disagree with the use of cryotherapy in the community for the treatment of - invasive skin cancer, lentigo maligna, pigmented moles. Various other applications of liquid nitrogen have been described. Many of these have been superseded by other modalities, e.g. laser for post rosacea telangiectasia and acne vulgaris scarring. Surgical removal of moles should normally be followed by histological analysis. Modern laser treatment of moles, e.g. Q-switched ruby laser should only be reserved for highly disabling cosmetic lesions, where in fact histology will not be obtained. Liquid nitrogen should not be used for pigmented moles.

Training
St. Georges/St. Helier Dermatology Departments will attempt to accommodate GPs and nurses and trainees who wish to have training in cryotherapy. It is possible to arrange training, e.g. Wendy Dudley (St. Helier Hospital (Bleep 589)) or contact Dr. Lucy Ostlere, St. Georges Hospital Dermatology Department (020 8725 1996) and Dr. Chris Harland, St. Helier Hospital Dermatology Department (020 8296 2843) and Philip Watkins (philip.watkins@smpct.nhs.uk).

Availability of Liquid Nitrogen
One of the problems is storage of liquid nitrogen. Health and Safety regulations must be followed. Arrangements can be made with the local Trust (Dermatology and Immunology Departments) for pick-up of liquid nitrogen, The Nelson Hospital Outpatients, Kingston Road, Rayners Park SW19, Dr R Seyer, Robin Hood Lane Health Centre, Sutton, 020 8642 3848, and Dr I Grimble, Pepys Road, Rayners Park SW20, 020 8946 8249. However, it will ultimately be the responsibility of the PCTs to facilitate availability of cryotherapy clinics in the community. It is no longer accepted to refer patients to hospital for cryotherapy of warts.
INTRODUCTION
Skin biopsy is a useful investigation for the diagnosis of cutaneous lesions or unusual rashes. Correct technique is essential, both in providing adequate material for histological diagnosis and in leaving the best cosmetic result for the patient.

INDICATIONS
Skin biopsy supplements clinical skills required for the diagnosis of cutaneous manifestations of systemic disease. Diagnosis and treatment of skin neoplasms can be undertaken. Tissue can be provided for microbiology when unusual cutaneous infections are being considered, or for immunofluorescence when certain autoimmune disorders are suspected (Box A).

BOX A  INDICATIONS FOR SKIN BIOPSY
Histological diagnosis (incision biopsy)
- Cutaneous changes in systemic disease (e.g. sarcoidosis, vasculitis, metastatic carcinoma or HIV-related Kaposi’s sarcoma)
- Skin tumours prior to radiotherapy or definitive surgical treatment
Treatment (excision biopsy)
- Skin neoplasms (e.g. basal cell carcinoma or squamous cell carcinoma)
Diagnostic test
- direct immunofluorescence (autoimmune bullous disorders or systemic lupus erythematosus)
Fresh tissue for microbiology
- e.g. Cutaneous tuberculosis, opportunistic infections

However, biopsy of rashes often provides non-specific pathological changes, and should not be undertaken routinely. Referral to a dermatologist may circumvent the need to biopsy rashes or tumours. Surgical treatment of skin cancer should only be performed by those with specialist training.

TECHNIQUE
A step-by-step guide to skin biopsy is summarized in Box B and discussed below.

BOX B  STEP-BY-STEP GUIDE TO SKIN BIOPSY
- Explain the procedure fully to the patient and obtain signed consent form
- Check all equipment
  - sterile suture set
  - operating table and light
  - specimen pot with formalin
- Check the patient is not taking anticoagulant drugs or aspirin
- Lie the patient down
- Clean the area of skin, and mark the area to be excised with a skin-marker pen
- Inject local anaesthetic into the dermis
- Perform elliptical excision biopsy
- Close the defect with interrupted non-absorbable sutures
- Instruct the patient on wound care, and on date for suture removal

Explanation and preparation of the patient
Many patients are anxious about the procedure, and a few minutes of explanation can allay their fears.
It is important to warn all patients about the risk of scarring. This should be clearly documented in the patient’s notes. Certain body sites, such as joints or the back, tend to form stretched scars. Afro-Caribbean skin may produce keloids.

* Taken from “Essential Medical Procedures”, Toghill Arnold Publishers
The patient is asked to sign a consent form. The procedure which is to be performed must be clearly stated. Enquiries are made about medication, particularly warfarin or aspirin, which interfere with haemostasis.

A brief medical history should be elicited. Patients with valvular heart disease probably do not need antibiotic prophylaxis. Current recommendations are listed in the British National Formulary.

**Checking the equipment**

If possible, the skin biopsy should be performed in a purpose-built minor operations theatre with an adjustable-height operating table. Cautery or diathermy equipment should be available for facial and scalp surgery. Nearby resuscitation equipment is mandatory.

A complete suture set will be required (Fig. 1). This should include a scalpel with a No. 15 blade, skin hook, fine-toothed forceps, non-toothed forceps, stitch scissors, needle holder, swabs, syringe and needles. The specimen pot should contain 10% formal saline. Nylon suture (6 or 5/0 face, 4/0 body) is standard. Ideally, a trained nurse should be present.

**Preparation for the biopsy**

**Positioning of the patient**

The procedure is carried out with the patient lying down. The biopsy site should be stable and well illuminated.

**Preparation of the surgeon**

Hands should be washed twice in running water with 4% chlorhexidine (Hibiscrub) or 10% povidone-iodine (Betadine). Sterile disposable gloves should be worn. Masks and gowns are unnecessary, except when hepatitis C or HIV infection is suspected; goggles provide protection against splashing.

**Local anaesthetic**

Lignocaine or xylocaine (0.5 to 2%) with or without adrenaline (1/80 000 or 1/200 000) can be used for most procedures. Adrenaline provides a useful vasoconstrictor effect, but must not be used in areas supplied by end arteries, such as fingers, toes or penis, as intense vasospasm may lead to necrosis. EMLA cream (2.5% lignocaine, 2.5% prilocaine) applied to the biopsy site 1 h preoperatively induces variable anaesthesia; it is most effective on thin skin and in children. The maximum safe adult dose of lignocaine without adrenaline is 200 mg (3 mg/kg), for example 20 mL of 1% plain lignocaine. In children this dose is halved.
Performing an elliptical skin biopsy

The skin is cleaned with antiseptic solution or normal saline. The area to be removed is marked with a skin-marker pen; ball point or ink pens can lead to permanent tattooing of the scar. Alternatively, light scarification of the unanaesthetized skin with a No. 15 blade allows the incision lines to be planned without pain or risk of being washed off. The direction of the incision should fall within wrinkle lines, or relaxed tension lines. Skin is removed in an elliptical shape with a length to width ratio of 3:1 (Fig. 2). Circular defects can lead to ‘dog-ear’ formation.

![Fig 3](image)

**FIG 3** Schematic cross-section of biopsy site. (a) Correct and (b) incorrect angle of incision to achieve optimum apposition of wound edges.

The anaesthetic is injected with a small-gauge needle into the dermis. Successful technique results in the formation of a bleb around the injection site. If adrenaline is used, blanching of the overlying skin should also occur. Attempts to inject large amounts of lignocaine into the subcutis are futile since this layer is relatively anaesthetic. Discomfort can be minimized by injecting slowly, warming the anaesthetic and using plain weak solutions.

The skin should be supported between finger and thumb, and, using the scalpel with the blade vertical to the skin, the marked ellipse is resected, including the full thickness of the skin. Inward-slanting incisions result in wedge-shaped inadequate specimens with unsatisfactory apposition of the wound edges (Fig. 3). Holding the skin sample with skin hooks, or gently with forceps, the undersurface is freed with scalpel or scissors. The specimen is then placed in a correctly labelled formalin-containing pot. The accompanying request form must include the patient’s details, a clinical summary and differential diagnosis to aid the pathologist. Haemostasis is rarely a problem following firm pressure. The wound should be closed with interrupted non-absorbable sutures. However, not all defects require suturing; small wounds can be left to heal by secondary intention, with a hydrocolloid dressing. Large wounds require dissolvable subcutaneous sutures.

**POST BIOPSY CARE**

The patient should be warned to expect some local discomfort after a few hours. A dressing can be kept in place for 24 to 48 h; thereafter, the area can be gently cleaned. Dressings serve only to protect clothing from bloodstains. The date for suture removal will depend on the area biopsied (up to 1 week face; 2 weeks body). Certain sites, such as the lower leg, may result in tight wounds. Elevation or a knee-to-toe support bandage is recommended.
The patient should be advised not to put undue tension on the area for at least 2 weeks after suture removal to prevent wound dehiscence.

**SPECIALIZED BIOPSY TECHNIQUES**

**Punch biopsy**

Disposable instruments with cutting metal cylinders between 3 and 6 mm diameter can be used to provide samples of skin for histological assessment. The area is prepared as described previously. With the skin under traction between thumb and finger, the instrument is pressed perpendicular to the skin and gently rotated. The specimen is gently lifted with fine forceps and cut at its base with scissors or scalpel (Fig. 4). The remaining defect can be either left open, cauterized, or sutured. Although this method is quicker, and is sometimes useful in children, better histological interpretation is achieved with the elliptical incision.

**Shave biopsy**

Prominent and superficial lesions, such as intradermal naevi or skin tags, can be removed by shaving the lesion flush to the skin surface with a scalpel. Haemostasis of the base can be achieved with direct pressure, cautery, or by the application of 20% aluminium chloride solution.

**Curettage**

A sharp-edged Volkmann spoon, and now disposable ring curettes, can be used to remove viral warts, seborrhoeic keratoses and other superficial lesions. After anaesthetizing the area, the curette is held like a pen to scoop the lesion out of the skin. The fragmented sample must be sent for histological examination. The area is then cauterized. If removing malignant lesions, both steps are repeated at least twice, and only after expert tuition.

---

**FIG 4** Performing a punch biopsy. (a) The skin is supported between finger and thumb. (b) The instrument is pushed downwards and gently rotated. (c) The core of tissue is removed by cutting at its base with scalpel or scissors. (d) The remaining defect can be left open, cauterized or sutured.
Direct immunofluorescence

To aid the diagnosis of autoimmune skin disorders (e.g. pemphigoid, pemphigus, or systemic lupus erythematosus), a sample of skin can be studied for antibody and complement deposition. In the case of bullous disorders, a perilesional biopsy is necessary. The sample must NOT be put in formalin, but should be sent urgently to immunology, where it is usually stored in liquid nitrogen.

Kveim test
This was a useful confirmatory test for the diagnosis of sarcoidosis, and is no longer available.

COMPLICATIONS

Haemorrhage

Certain areas will bleed profusely, such as the face, scalp or fingers. Haemostasis is usually achieved after application of direct pressure, or wound closure. Small arteries may need to be ligated with absorbable suture.

Infection

The risk of infection is increased if poor aseptic technique is used, the wound is under tension or occlusive dressings are left unchanged. Good aftercare advice to the patient is essential. Local sepsis usually responds to topical antibiotics, but if there is evidence of cellulitis or lymphangitis, an oral antibiotic will be required.

Wound dehiscence

Wound breakdown can result from infection, excessive suture tension or poor technique. Resuturing is of no benefit following infection.

Keloid and poor scarring

The above factors, in addition to poor alignment of the wound, are also responsible for hypertrophic scars. Afro-Caribbean skin is prone to keloid formation. Poor scars are seen over sites of stretching, such as joints and the back.

DO NOT

- Shave or curette pigmented lesions (unless highly trained)
- Perform thin, slither specimens for histology (extremely difficult to interpret)
- Punch Biopsy (unless highly trained; rashes are rarely diagnosed by biopsy; pigmented lesions must be excised in toto)
- Treat skin cancer (unless highly trained and a member of Skin Cancer Network)

DO

Refer suspected melanoma and squamous cell carcinoma by 2-week faxed proforma (Appendix E)
**DO NOT**

- Shave or curette pigmented lesions (unless highly trained)
- Preform thin, slither specimens for histology (extremely difficult to interpret)
- Punch Biopsy (unless highly trained; rashes are rarely diagnosed by biopsy; pigmented lesions must be excised *in toto*)
- Treat skin cancer (unless highly trained and a member of Skin Cancer Network)

**DO**

Refer suspected melanoma and squamous cell carcinoma by 2-week rule faxed proforma (Appendix E of full guidelines)
Introduction

Skin cancer is the commonest human malignancy. Over 90% of cases comprise basal cell carcinoma (BCC), squamous cell carcinoma (SCC) and malignant melanoma. Skin cancer can be broadly classified as either melanoma (malignant melanoma) or non-melanoma (BCC, SCC and others).

![Skin Cancer Classification Diagram]

SKIN CANCER

MELANOMA (1)

NON-MELANOMA

Squamous Cell Carcinoma (8)

Basal Cell Carcinoma (30)

(Relative incidence shown in brackets)

General practitioners and medical students should be familiar with the clinical features of the following skin lesions:

SKIN CANCER

basal cell carcinoma (figs. 1-6)
squamous cell carcinoma (figs. 7-9)
malignant melanoma (figs. 15-30)

BENIGN PIGMENTED LESIONS

dermatofibroma/histiocytoma (figs. 31-32)
angioma/pyogenic granuloma (figs. 33-36)
seborrhoeic wart/keratosis (figs. 37-40)
mole (melanocytic naevus), lentigo (figs. 41-46)

BORDERLINE LESIONS

solar/actinic keratosis (figs. 10-12)
Bowen’s disease/squamous cell carcinoma in situ* (fig. 13)
keroatoacanthoma (fig. 14)
lentigo maligna (Hutchinson’s lentigo)* (figs. 26, 27)
dysplastic naevus/ atypical mole (figs. 47, 48)

*established malignant potential
Basal cell carcinoma (BCC)

Basal cell epithelioma is the commonest skin cancer

The main cause is cumulative sun-exposure, and therefore tends to occur on the face. BCC’s develop slowly – over years – and very rarely metastasise. Classically they have a cystic or whitish pearl-like appearance with overlying blood vessels (telangiectasia) (fig. 1-3)

Sometimes they are pigmented (fig. 3). Morphoeic BCC’s are associated with scar-like reaction and have an ill-defined edge (fig. 4); however, tautening the skin (fig. 5) may reveal a pearly rim (‘stretch test’). If neglected, BCC’s can ‘burrow’ deeply and ulcerate (hence ‘rodent ulcer’)

Figure 6 shows the ‘tip-of-the-iceberg’ effect; a BCC has infiltrated the orbit and nasolacrimal duct. Danger sites are the nasolabial groove, inner canthus of the eye, and external auditory canal.
Squamous cell carcinoma (SCC) is also a common cancer, occurring on sun exposed sites.

It evolves more rapidly than BCC (months or years). It originates from the keratinocytes, and therefore may have a keratotic brown, scaly, crumbly surface (figs. 7 & 8).

Solar keratoses, or actinic keratoses, are a marker of chronic sun damage.

Lesions do not necessarily warrant treatment but extensive keratoses should prompt a careful search for non-melanoma skin cancer.

Figure 10 and 11 show a typically sun damaged pate of an elderly man which has poorly defined scaly areas (sometimes with an erythematous base), and/or discrete yellow-brown keratotic lesions, representing solar keratoses; a BCC is also present. A close-up of keratoses is shown in figure 12. Histology reveals dysplasia. The malignant potential of individual lesions is very low.
Bowen’s disease is an intraepithelial SCC or SCC in situ.

Erythematous scaly plaques develop extremely slowly over years (fig. 13). Unlike psoriasis and eczema, the plaques are fixed or persistent. Legs of elderly women are often affected. Unless patients are old and frail, lesions may be worth treating since they rarely undergo malignant transformation. Multiple lesions are associated with past exposure to arsenic, which used to be taken as a ‘tonic’.

Keratoacanthoma can be thought of as a self-healing squamous cell carcinoma

It develops rapidly (weeks) on sun exposed sites. Initially, there is a dome-like nodule in the centre of which is a central keratin plug (fig. 14). Some months later the tumour involutes to form a scar. Surgical treatment is appropriate; the diagnosis of an aggressive SCC can then be excluded on histological examination.

Malignant melanoma

It is especially important to detect malignant melanoma of the skin during its earliest stage of development. Prognosis is directly related to tumour thickness on histology (Breslow thickness). Thin lesions (<1.5 mm) are associated with a good prognosis following surgical treatment. Thick lesions (>3.5 mm) often metastasise despite wide resection margins (fig. 15)

MacKie’s checklist is a useful guide for the recognition of melanoma. However, it does not distinguish between melanoma and seborrhoeic warts.

<table>
<thead>
<tr>
<th>Major signs</th>
<th>Minor signs</th>
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<tr>
<td>Change in size</td>
<td>Inflammation</td>
</tr>
<tr>
<td>Change in shape</td>
<td>Crusting or bleeding</td>
</tr>
<tr>
<td>Change in colour</td>
<td>Diameter &gt; 7 mm Altered sensation (e.g. itch)</td>
</tr>
</tbody>
</table>

The presence of two or more major signs, or one major with at least one minor sign, should generate a high index of suspicion for melanoma. Note that minor signs on their own are unhelpful.
All examples of melanoma in figures 16-19 have been characterised by the three major features (change in shape, size and colour) and are all over 7 mm in diameter (a minor feature). An irregular outline is a particularly sensitive indication of malignancy. Variable pigmentation is also important.

Figure 17 shows a melanoma undergoing regression; some pigmentation has disappeared, leaving a pink, scarred area. Pink areas can also indicate an inflammatory reaction (fig. 19).

The melanoma in figure 20 is uniformly black. Blackness can be regarded as a sinister pigmenatar change.

Itch is an unhelpful feature on its own. Benign pigmented lesions, including moles, frequently itch. Also, benign moles can rapidly enlarge and become inflamed after trauma or folliculitis. This normal reaction should settle within a couple of weeks.
Melanoma is more likely to develop in individuals with a **large number of moles** (at least 50), **fair skin** and **freckling** (fig. 21). The melanoma in figure 22 is on the freckled male back. Risk sites include the back in men, and legs in women. **The skin of children, Asians or Afro-Caribbeans rarely develop melanoma or other skin cancers.** Very thin melanomas (<0.5mm) are less readily recognised (figs. 23-25). Nevertheless, the public and GP’s have been detecting a greater proportion of thin lesions in recent years. This trend is heartening, as these tumours are cured by simple excision.
Lentigo maligna
(*Hutchinson’s lentigo*)

is a premalignant melanoma in situ which is usually found on elderly, sun damaged faces (Fig. 26). Lesions are flat, and often irregular in outline and pigmentation. They spread along the skin insidiously. Malignant transformation may take decades, so the need for treatment is controversial. The presence of the nodule indicates that the lesion has developed invasive foci, and must be treated (fig. 27).

In spite of the checklist and recent publicity, patients are still presenting with advanced, poor-prognosis tumours. *Amelanotic melanoma* (fig. 28) can be ignored by patient and doctor because they do not resemble a ‘textbook’ melanoma with pigmenary changes. However, they often contain a rim of pigment. Some patients will not declare the presence of suspected cancer.

The patient with the melanoma in fig. 29 was an alcoholic with a fear of hospitals. The melanoma in figure 30 has ‘satellite’ lesions with represent cutaneous metastases. Late tumours particularly affect the elderly, because of co-existent multiple seborrhoeic keratoses, living alone (melanomas are frequently detected by the partner), and partly because of poor eyesight. Perhaps this group should be specifically screened during health checks.
BENIGN PIGMENTED LESIONS

Dermatofibroma (histiocytoma)
is a benign fibrous tumour which is common on the upper torso and legs.

Note the overlying pigmentation (fig. 31 and 32). The hallmark of this tumour is its firm, smooth consistency. Its bulk is felt below the skin surface, but it is nevertheless tethered to the epidermis.

Sometimes the perilesional skin produce a central dimple when the lateral margins of the tumour are firmly palpated. Most lesions are less than 1 cm in diameter.

Benign vascular tumours
(haemangiomata or angiomata)

The Campbell de Morgan spot (a capillary haemangioma) is a cherry coloured papule (fig. 33). Vascular tumours may have a bluish black hue (fig. 34).
The *pyogenic granuloma* is a proliferation of blood vessels which is thought to be triggered by trauma (figs. 35 and 36). It may resemble amelanotic melanoma. Its diagnostic features are rapid growth (days or weeks) and profuse haemorrhage following slight trauma.

**Fig. 35** Pyogenic granuloma - a misnomer for an angioma which can develop rapidly de novo

**Fig. 36** Pyogenic granuloma. This lesion bled profusely on contact.

Seborrhoeic keratosis
*(seborrhoeic wart, basal cell papilloma)*

is a benign keratotic lesion which originates from the epidermis.

It is extremely common, especially with the elderly. Because it shares some of the features of melanoma on Mackie’s checklist, it causes diagnostic confusion. Over-referral suggests inexperience, but our GPs have improved.

**Fig. 37** Classical seborrhoeic keratoses; warty, ‘stuck-on’, superficial appearance. The significance of changing colour, size, shape etc., can be safely ignored under these circumstances.

**Fig. 38** Multiple seborrhoeic keratoses. The large dark lesion shares the characteristic, superficial appearance with other lesions, and does not merit referral to the pigment-ed lesion clinics. Pale or black dots within the surface signify keratin ‘pseudocysts’.

Characteristic features (fig. 37-40): crumbly, warty or scaly surface; yellowish brown, brown and black pigmentation; multiple lesions; and a ‘stuck on’ appearance – the bulk of the tumour is entirely above the skin surface. The occasional greasy semblance gives rise to the term ‘seborrhoeic’.
Some lesions are extremely flat; clinically it can be difficult to distinguish between seborrhoeic warts and lentigos. Indeed, so-called ‘liver spots’ on sun-exposed sites share features of both (fig. 13).

Moles (benign melanocytic naevi; naevi)  
*Benign moles are not always straightforward.*

**Halo naevus** or Sutton’s naevus (fig. 41) demonstrates an even rim of depigmentation which may herald the involution of the mole. If the mole appears benign (uniform pigmentation, smooth border), this phenomenon can be ignored. The patient can be warned that the mole may disappear, leaving a vitiligo-like patch.

A **blue naevus** is a benign mole in which abundant pigment is in the deeper dermis. It is blue, black or grey with a shiny round surface. Its appearance can be indistinguishable from a blue angioma (fig. 34), although the consistency of a blue naevus is firm as opposed to compressible. If there has been no recent changes in shape, size, colour etc., the patient can be reassured. An unusual reddish mole affecting children or young adults is the **Spitz naevus** (with the misleading synonym of ‘juvenile melanoma’). This somewhat resembles the mole in figure 41, but without the halo of depigmentation. If all other features are benign (shape etc), it is left untreated. Note that melanoma is exceedingly rare in children.
Moles are generally safe. There is no convincing evidence that trauma predisposes to melanoma. Indeed, only 50% of melanoma originate from moles. However, large congenital moles are reported to have an increased risk of malignant transformation. Extensive lesions require self-monitoring. A clinical photograph (fig. 42) is helpful for monitoring changes of shape, colour etc. Moles frequently have subtly different tones of brown (fig. 43). If these changes have a symmetrical pattern, and there are no other features of malignancy, these appearances are normal. Benign moles commonly have two discrete tones of brown. However, the rest of the skin should be examined for the presence of multiple atypical moles (see opposite).

Moles commonly mature and change during life. They start during early life as flat lesions, and later become raised and lose their colour (fig. 44). Moles, especially on the face, normally become raised and lose their pigmentation gradually (fig. 45), whilst those on the palms and soles tend to stay flat (fig.46).
The **atypical mole** or **dysplastic naevus** is a somewhat nebulous entity. However, it is clear that lots of ‘funny looking moles’ should alert the patient and doctor to an increased risk of melanoma. These atypical moles are often large, flat, with mild irregularities of outline and ‘spillage’ of pigmentation (fig. 47). If there is a family history or personal history of melanoma, then the risk is much higher (up to x400). The individual is then said to have **dysplastic naevus syndrome** or **atypical mole syndrome** (fig. 48). Such patients should be screened periodically for the presence of melanoma.

However, we believe that the onus should be on patients to self-monitor moles for changes in colour, shape, size, etc., albeit with the help of prior education, information leaflets and clinical photographs.
## APPENDIX E

<table>
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<tr>
<td>Acne Support Group</td>
<td>0870 870 2263</td>
<td><a href="http://www.stopspots.org">www.stopspots.org</a></td>
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<tr>
<td>Allergy UK</td>
<td>020 8303 8583(9am-5pm)</td>
<td><a href="http://www.allergyuk.org">www.allergyuk.org</a></td>
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<tr>
<td>Behcet’s Syndrome Society</td>
<td>01488 71116</td>
<td><a href="http://www.behcets.org.uk">www.behcets.org.uk</a></td>
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<td>CancerBACUP</td>
<td>0808 800 1234</td>
<td><a href="http://www.cancerbacup.org.uk">www.cancerbacup.org.uk</a></td>
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<td>012412 261332</td>
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<td>Changing Faces</td>
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<td>Darier’s Disease Support Group</td>
<td>01646 695 055</td>
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<td>DEBRA (Epidermolysis Bullosa)</td>
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<td>Hairline International</td>
<td>01564 775 281</td>
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<td>Herpes Viruses Association</td>
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<td>01708 731251</td>
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<td>Lymphoedema Support Network</td>
<td>020 7351 4480</td>
<td><a href="http://www.lymphoedema.org/lsn">www.lymphoedema.org/lsn</a></td>
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<td>01252 810 472</td>
<td><a href="http://www.marfan.org.uk">www.marfan.org.uk</a></td>
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<td>National Eczema Society</td>
<td>0870 241 3604</td>
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<td>National Rosacea Society</td>
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<td>Neurofibromatosis Association</td>
<td>020 8439 1234</td>
<td><a href="mailto:info@ichensclerous.org">info@ichensclerous.org</a></td>
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<td>Pemphigus Vulgaris Network</td>
<td>020 8690 6462</td>
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<td>Pseudoxanthoma Elasticum (PXE) Support Group</td>
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<td>Scleroderma Society</td>
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<td>Shingles Support Society</td>
<td>020 7609 9661</td>
<td><a href="http://www.herpes.org.uk/shingles">www.herpes.org.uk/shingles</a></td>
</tr>
<tr>
<td>Telangiectasia Self Help Group</td>
<td>01494 528 047</td>
<td><a href="http://www.telangiectasia.co.uk">www.telangiectasia.co.uk</a></td>
</tr>
<tr>
<td>Tissue Viability Society</td>
<td>01722 429057</td>
<td><a href="http://www.tus.org.uk">www.tus.org.uk</a></td>
</tr>
<tr>
<td>Tuberous Sclerosis Association</td>
<td>01527 871 898</td>
<td><a href="http://www.tuberos-sclerosis.org">www.tuberos-sclerosis.org</a></td>
</tr>
<tr>
<td>Vitiligo Society</td>
<td>0800 018 2631</td>
<td><a href="http://www.vitiligosociety.org">www.vitiligosociety.org</a></td>
</tr>
<tr>
<td>Wessex Cancer Trust Marc’s Line SCIN</td>
<td>01722 415 071</td>
<td><a href="http://www.k-web.co.uk/charity/">www.k-web.co.uk/charity/</a></td>
</tr>
<tr>
<td>WoundCare Society</td>
<td>01480 434 401</td>
<td><a href="http://www.woundcaresociety.org">www.woundcaresociety.org</a></td>
</tr>
<tr>
<td>Xeroderma Pigmentosum (XP) Support Group</td>
<td>01494 890 981</td>
<td><a href="http://www.xpsupportgroup.org.uk">www.xpsupportgroup.org.uk</a></td>
</tr>
</tbody>
</table>

Reference:
Skin Care Campaign Directory 2004-5. Tel: 020 7561 8249
Appendix E

Decision Support & Patient information available to EMIS users

Mentor
Type “ME” from the main menu or “?” in consultation mode. Mentor then prompts you to enter terms to search for, for example “RASH, ITCH, WHEAL”. You are then offered a list of possible matching diagnoses, divided into “common”, “uncommon” and “other”. Select a diagnosis and press return to read the Mentor text information about this diagnosis.

PILS
Type “PI” from the main menu or “/” in consultation mode. You can browse through the directories of patient information leaflets and select the relevant leaflet which then appears in a new window and can be printed. Both Mentor and PILS have been superseded by Mentor Plus, which is available if you are using LV3 or later versions.

Prodigy
Prodigy can be activated for users of the system. A user with high enough access rights needs to do this. Type “DT” then “M” to enter the Prodigy manager. Once active, Prodigy launches when certain Read codes are entered within consultation mode. This takes you through guidelines for the management of the condition and you can use it to generate prescriptions or patient information leaflets.

Mentor Plus
To enter Mentor Plus, use the mouse to click on the green cross icon near the top left hand corner of the LV window. Mentor Plus then opens in a new window. Mentor Plus presents a vast amount of information from various sources and the search facilities are intuitive. An added bonus is that it can keep a diary of your Mentor Plus usage which can be printed as support evidence for your appraisal (click on the PDP notes icon near the top right of the Mentor Plus window).

Patient information leaflets and contacts for self-help groups are available from Mentor Plus. There are links to the internet.

Dermis
Dermis is dermatological decision support program. EMIS have now incorporated it to within Mentor Plus and I find it actually harder to use than it used to be. In Mentor Plus, search for a type of skin lesion and from the list of suggested articles, choose “Refining the dermatology search.” You can then enter age and sex and various characteristics of the lesion and generate a report of possible diagnoses with links to relevant articles.

Internet
The world wide web offers a multitude of dermatological sites. Here is a selection of useful links:

- www.dermatology.co.uk - an independent site offering dermatology information to doctors, patients and students.
- www.dermnetnz.org - New Zealand dermatological society. The site offers information to GPs dermatologists and patients. A large selection of patient information leaflets are available. Unfortunately most pages carry the disclaimer “If you have any concerns with your skin or its treatment, see a dermatologist for advice,” which may be relevant in New Zealand, but for this country obviously the GP should be the first point of contact.
- www.ukdermatology.co.uk - Department of Dermatology, University Hospital of Wales, Cardiff. Offers information on training in dermatology and research. Also downloadable patient information leaflets.
- www.notn.ac.uk/dermatology - University of Nottingham. A good selection of dermatology links.
- www.skincarecampaign.org - provides details of support to suffers of skin conditions. There is an excellent Directory with leaflets for photocopying.
- www.had-online.org.uk - The Health Development agency has published a new reference to help health professionals to implement precautions aspects of MTS Cancer Plan.
### URGENT REFERRALS CRITERIA

**Referral information:**
(please tick boxes)

- [ ] Melanoma
- [ ] Squamous cell carcinoma

**Location/Site of lesion(s):**

#### Hospitals
N.B. please tick speciality if relevant. The large majority of suspected melanoma or suspected squamous cell cancers should be referred to dermatology for diagnosis. However those with obvious cancer may be referred directly to plastic surgery for treatment.

- St George’s  [ ] Skin Cancer Screening Clinic  [ ] Plastics
- Kingston  [ ] Dermatology  [ ] Plastics
- Epsom  [ ] Dermatology  [ ] Plastics
- Mayday  [ ] Dermatology  [ ] Plastics
- St Helier/Sutton  [ ] Skin Cancer Clinic/PLC (Sutton)  [ ] Plastics
- Queen Mary’s  [ ] Dermatology  [ ] Plastics

**Please note:**
- PLC = Pigmented Lesion Clinic
- Non-cancerous, benign or cosmetic moles/lesions will not be removed
- Patients may be asked to fully undress for total skin examination
- For written/illustrated guidelines please contact christopher.harland@epsom-sthelier.nhs.uk

### TO BE COMPLETED BY THE DATA TEAM:

Date received:  
Date 1st appointment booked:  
Date of 1st appointment  
Date 1st seen:  
Specify reasons if not seen at 1st appointment offered:  

**Final diagnosis (please circle):**
- Malignant
- Benign

### GP DETAILS

- **GP Name and Initials:**
- **GP Practice Code:**
- **Address (use practice stamp if available):**
- **Post Code:**
- **Telephone No.:**
- **Fax. No.:**

### PATIENT DETAILS

- **Last Name:**  
- **First Name:**  
- **Address:**
- **Post Code:**
- **Daytime Telephone No.:**  
- **Date of Birth:**  
- **Age:**  
- **Has the patient previously visited this hospital?**  
- **Gender:**  
- **Hospital No (if known):**  
- **NHS No.:**  
- **Interpreter required?**  
- **First Language:**

### COMMENTS/RELEVANT MEDICAL HISTORY (INCLUDING DRUG HISTORY)

### OTHER REASONS FOR URGENT REFERRAL

N.B. DO NOT REFER SUSPECTED BASAL CELL CARCINOMA ON THIS FORM
How to make urgent referrals for suspected skin cancers: melanoma and squamous cell carcinoma

Please FAX this form to the corresponding hospital. The telephone numbers are to enable you to confirm receipt of the fax. Please ensure that the referral reaches the hospital within 24 hours of the GP’s decision to refer. N.B. This form should not be used for basal cell carcinoma, which may be referred non-urgently.

Guidelines for urgent referral:

1 Melanoma

- Pigmented lesions on any part of the body which have one or more of the following features

<table>
<thead>
<tr>
<th>Growing in size</th>
<th>Changing shape</th>
</tr>
</thead>
<tbody>
<tr>
<td>Irregular outline</td>
<td>Change colour</td>
</tr>
<tr>
<td>Mixed colour</td>
<td>Ulceration</td>
</tr>
<tr>
<td>Inflammation</td>
<td></td>
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</tbody>
</table>

N.B. Itch alone is not a reason for referral. Sudden onset of inflammation is almost always a benign feature - allow 2 weeks before reassessing.

Note: Melanomas are usually 5mm or greater at the time of diagnosis, but small number of patients with very early melanoma may have lesions of smaller diameter.

2. Squamous Cell Carcinoma

- Slowly growing non-healing lesions with significant induration on palpation with documented expansion over a period of 1-2 months.
- Positive biopsy.
- Patients who are therapeutically immunosuppressed after organ transplant have a high incidence of skin cancers, especially squamous cell carcinomas which can be unusually aggressive and metastasize. Transplant patients who develope new or growing cutaneous lesions should be referred under the two week rule.

Note: Cancers tend to be larger (>1cm) than actinic keratoses and have a palpable component deep to the skin surface.

<table>
<thead>
<tr>
<th>EPSOM GENERAL HOSPITAL</th>
<th>ST HELIER HOSPITAL</th>
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<tbody>
<tr>
<td>DORKING ROAD, EPSOM, SURREY KT18 7EG</td>
<td>WRYTHE LANE, CARshalton, SURREY SM5 1AA</td>
</tr>
<tr>
<td>FAX: 01372 735402</td>
<td>FAX: 020 8296 3399</td>
</tr>
<tr>
<td>TEL: 01372 735346</td>
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<th>KINGSTON HOSPITAL</th>
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<tr>
<td>GALSworthy ROAD, KINGSTON, SURREY KT12 7QB</td>
<td>ROEHAMPTON LANE, PUTNEY SW15 5PN</td>
</tr>
<tr>
<td>FAX: 020 8934 3306</td>
<td>FAX: 020 8355 2502</td>
</tr>
<tr>
<td>TEL: 020 8934 3305</td>
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<tr>
<th>MAYDAY UNIVERSITY HOSPITAL</th>
<th>ST GEORGE’S HOSPITAL</th>
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<tbody>
<tr>
<td>LONDON ROAD, THORNTON HEATH, SURREY CR7 7YE</td>
<td>BLACKSHAW ROAD, TOOTING, LONDON SW17 0QT</td>
</tr>
<tr>
<td>FAX: 020 8401 3337</td>
<td>FAX: 020 8725 0778</td>
</tr>
<tr>
<td>TEL: 020 8401 3000</td>
<td>TEL: 020 8725 1111</td>
</tr>
<tr>
<td>Ext: 4855</td>
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### Name and Contact Numbers

<table>
<thead>
<tr>
<th>Name</th>
<th>Contact Numbers</th>
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<table>
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<table>
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<tr>
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</table>

<table>
<thead>
<tr>
<th>Date of Birth</th>
<th>Age</th>
<th>N.H.S. No</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>G.P. Practice and Contact Details</th>
<th>Referrer’s Name and Contact Details</th>
</tr>
</thead>
</table>

### Description of skin and symptoms

**Date Condition Began & Duration of Current Episode**

**Medications relevant to skin condition**

### Other Information (tick where appropriate)

- **Patient normally seen in Own Home**
- **Practice**
- **Health Centre**
- **Residential Home**
- **Other [please specify]**

- **Assessment and Joint Review of Skin Doctor**
- **Review and Explanation of Medications**
- **Patient Education and Advice**
- **Counselling and Support**
- **Other [please specify]**

**Other relevant information – [please keep brief]**