Northern Ireland
mdta
Medical & Dental Training Agency

Northern Ireland

Version: 2018

General Practice

Dermatology Treatment Guidelines

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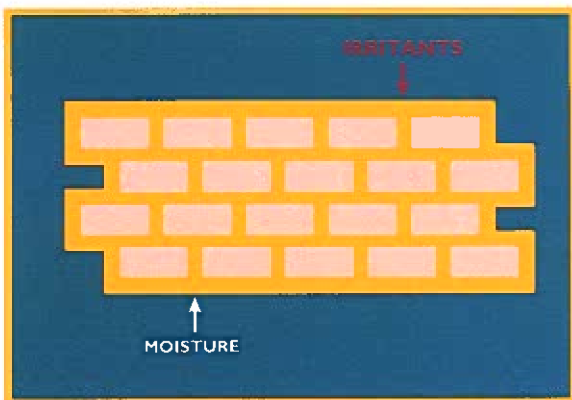
NORMAL SKIN



In normal skin, natural oils fill spaces between plump skin cells to form a good skin barrier – keeping moisture in and irritants out.

Skin cells and the surrounding natural oils are often shown as a brick wall. The skin cells are the 'bricks' and the natural oils the 'mortar'.

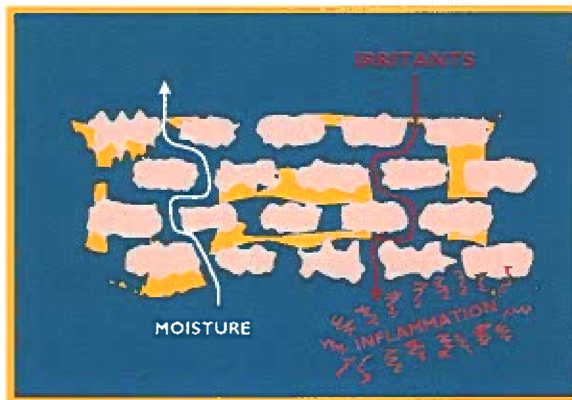
What causes inflammation?

If irritants cross the skin barrier the skin reacts causing inflammation. This is the body's natural defence system to protect against its enemies (irritants and bacteria).

In atopic eczema, the body can over react and 'flare up' in response to chemicals and bacteria which would usually be harmless.

Presented with the compliments of Dermal
www.dermal.co.uk

ECZEMA – A DAMAGED SKIN BARRIER



In eczema there is a shortage of natural oils in the skin which allows moisture to escape too quickly. Also, the skin cells shrink, opening cracks which allow irritants to enter.

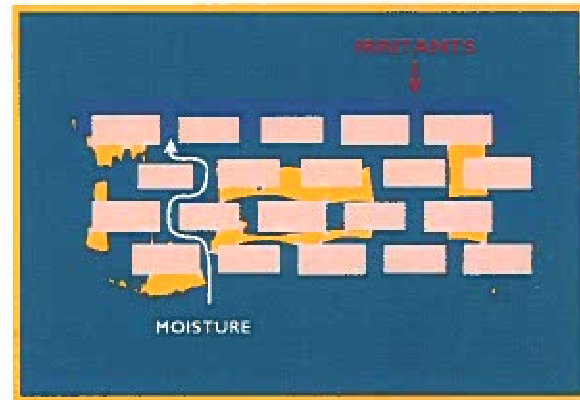
The skin reacts causing redness, inflammation and is very itchy. Scratching damages the skin further. This leads to more irritation, itching and further scratching.

Reducing inflammation

When the skin 'flares up' steroid creams will reduce the inflammation and redness. Continue using emollients as they help the steroids.

If the skin is red and itchy it may be due to the reaction of the skin to bacteria e.g. *Staph. aureus* which is more common on atopic skin. The doctor may prescribe a treatment to reduce the number of these bacteria and help remove the cause of irritation.

RESTORING THE SKIN BARRIER USING A MOISTURISER/EMOLLIENT



Emollients rehydrate dry skin by forming a layer of oil which traps moisture in the skin allowing cells to swell and close the cracks.

Emollients should be applied regularly in large amounts to moisturise and soften the skin, making it supple and less itchy. It is important to continue using emollients even when the skin appears to be better.

Avoiding irritants

There are a number of factors in the environment that can make eczema worse such as heat, dust and contact with irritants such as soap or detergent.

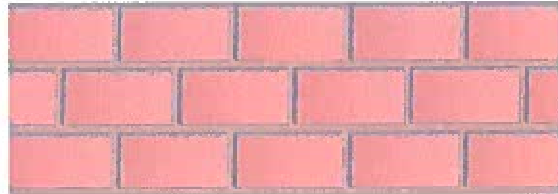
More information about eczema is given overleaf with some helpful suggestions about avoiding irritants or 'trigger factors' that can make eczema worse.

What does my emollient do?

Healthy skin is like a brick wall

- The skin cells are the bricks
- The natural lipids are the mortar

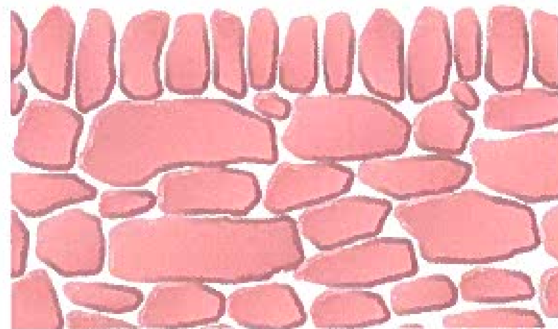
It is waterproof and protective



In eczema, skin is like an old dry stone wall

- The cells are shrunken and oddly shaped like rough stones
- The lipids (mortar) are reduced

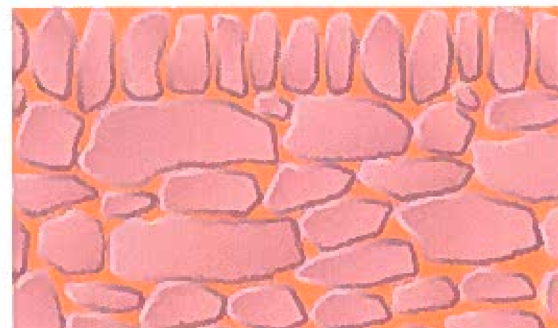
It lets water out and dirt, irritants and bacteria in



Using emollients is like repointing the wall

- The missing lipids (mortar) are replaced with emollient
- A protective barrier is created

It stops water escaping and dirt, irritants and bacteria from entering



Produced by

MSD

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EMOLLIENT LADDER

To use on conjunction with BNF, Joint Medicines Formulary and Tier Two Eczema and Psoriasis Guidelines (Available from the intranet)

VERY GREASY

50% Liquid soft paraffin / 50% White soft paraffin

GREASY

Hydromol ointment
Epaderm ointment
Emulsifying ointment

RICH CREAM

Unguentum cream
Doublebase Gel
Dermamist Spray
Neutrogena Dermatological Cream

CREAMY

Diprobase cream
Cetraben cream
Oilatum cream
E45 cream
Dermol 500 cream (antimicrobial)
Aveeno cream

Urea containing
Aquadrate cream
Calmurid cream
Eucerin cream
Balneum plus cream
E45 itch relief

LIGHT

E45 Lotion
Aveeno lotion
Keri lotion
Dermol 500 lotion (antimicrobial)
* Aqueous Cream

Urea containing
Eucerin lotion

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Primary Care Trust

Items in Green are recommended as these are on the ALWPCT Dermatology Formulary.
* We do not recommend this as a leave on emollient.

STEROID LADDER

To use on conjunction with BNF, Joint Medicines Formulary and Tier Two Eczema and Psoriasis Guidelines (Available from the Intranet)

VERY POTENT

Dermovate (clobetasol propionate 0.05%)
Nerisone Forte (diflucortolone valerate 0.3%)
Halciderm Topical (halcinonide 0.1%)

POTENT

Betamethasone valerate 0.1%
Betnovate (betamethasone (as valerate) 0.1% in a water miscible basis
Betacap (betamethasone (as valerate) 0.1% in a water-miscible basis containing coconut oil derivative)
Bettamousse (betamethasone valerate 0.012%)
Cutivate (fluticasone propionate 0.05%)
Diprosone (betamethasone (as dipropionate) 0.05%
Elocon (mometasone furoate 0.1%)
Locoid (hydrocortisone butyrate 0.1%)
Metosyn (fluocinonide 0.05%)
Nerisone (diflucortolone valerate 0.1%)
Propaderm (beclometasone dipropionate 0.025%)

*With antimicrobials

Betnovate-N (betamethasone (as valerate) 0.1%, neomycin sulphate 0.5%)
Betnovate-C (betamethasone (as valerate) 0.1%, clioquinol 3%)
Fucibet (betamethasone (as valerate) 0.1%, fusidic acid
Locoid C (hydrocortisone butyrate 0.1%, chlorquinaldol)
Locoid crelo (hydrocortisone butyrate 0.1%, chlorquinaldol 3%)
Lotriderm (betamethasone dipropionate 0.064%, clotrimazole 1%)
Synalar C (fluocinolone acetonide 0.025%, clioquinol 3%)
Synalar N (flucinolone acetonide 0.025%, neomycin sulphate 0.5%)

With salicylic acid

Diprosalic (betamethasone (as dipropionate) 0.05%, salicylic acid 3%)

MODERATE

Eumovate (clobetasone butyrate 0.05%)
Modrasone (alclometasone dipropionate 0.05%)
Betnovate RD (betamethasone (as valerate) 0.025%
Haelan (fludroxycortide 0.0125%)
Synalar 1 in 4 Dilution (flucinolone acetonide 0.00625%)

*With antimicrobials

Trimovate (clobetasone butyrate 0.05%, oxytetracycline 3%, nystatin 100 000units/g)

With urea

Alphaderm (hydrocortisone 1%, urea 10%)

MILD

Hydrocortisone 0.5%
Hydrocortisone 1%
Hydrocortisone 2.5%
Dioderm (Hydrocortisone 0.1%)
Efcortelan (Hydrocortisone 0.5%)
Mildison (Hydrocortisone 1%)

*With antimicrobials

Canesten HC (hydrocortisone 1%, clotrimazole 1%)
Daktacort (hydrocortisone 1%, miconazole nitrate 2%)
Econacort (hydrocortisone 1%, econazole nitrate 1%)
Fucidin H (hydrocortisone acetate 1%, fusidic acid 2%)
Vioform-Hydrocortisone (hydrocortisone 1%, clioquinol 3%)
Nystaform-HC (hydrocortisone 0.5%, nystatin 100 000 units/g, chlorhexidine 1%)

With crotamiton

Eurax-Hydrocortisone (hydrocortisone 0.25%, crotamiton 10%)

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* To be used for no more than 14 days continually at any one time. Avoid intermittant use.

Only Steroids that you will need!

Please note these are suggestions only

Strength	Plain	Antibiotic	Antifungal	Other
Mild	1% HC	Fucidin H	Daktacort	Timodine
Moderate	Eumovate			Trimovate
Potent	Betnovate	Fucibet		Diprosalic
Very Potent	Dermovate	Dermovate NN	Dermovate NN	

ATOPIC ECZEMA

About 1 in 5 children in the UK has atopic eczema and it commonly starts in babies aged 3-6 months.

For many children eczema largely resolves as they get older, and there are many ways to help in the meantime.

In atopic eczema there is a deficiency of the normally protective skin barrier, with fewer of the natural oils that help to retain moisture.

WHAT ARE THE SYMPTOMS?

The skin can become dry, cracked, red and sore. Eczema can be confined to small patches or affect the whole body. It may come and go or be relatively persistent.

The skin is also very itchy – the main symptom of eczema – which leads to scratching further damaging the skin.

When skin becomes dry, it has less protection against irritant factors. These include detergents, chemicals and bacteria such as *Staph. aureus*, which can make the itchy eczema worse. Also, the skin can become infected more easily, particularly when damaged by scratching.

Young children find it difficult to resist the urge to scratch. Keeping nails short will help to minimise damage to the skin and anti-scratch mittens are useful for babies.

Pinching or pressing the skin is less damaging than scratching and distracting your child can help.

Symptoms can be seasonal, either improving during the summer months and getting worse in the winter, or vice versa.

SKIN FRIENDLY HELPFUL HINTS

- ✓ Avoid having the central heating too high.
- ✓ A simple humidifier can make the air less dry.
- ✓ Air the rooms daily.
- ✓ Use a damp cloth when dusting.
- ✓ Vacuum carpets regularly.
- ✓ Use a cover on mattress, pillows and duvet – avoid feathers – where possible air bed linen in sunshine.
- ✓ Wear cotton or silk clothing rather than wool next to the skin.
- ✓ Use non-biological washing powder. NB. Washing temperatures over 58°C kill house dust mites.
- ✓ Wash and wipe toys regularly. NB. Soft toys in a plastic bag and kept in the freezer overnight kills house dust mites.
- ✓ Try to avoid contact with anything that may cause allergic reaction e.g. furry pets, detergents, chemicals or house dust.
- ✓ Do not mow the lawn while your child is nearby.

INFORMATION ABOUT ECZEMA ACCREDITED BY THE

Hill House, Highgate Hill, London N19 5NA
www.eczema.org Helpline: 0800 089 1122
(8am - 8pm Mon - Fri)

The National Eczema Society is registered with the Charity Commission for England and Wales under No 1009671. The Society does not recommend or endorse any specific product or treatment.

GOOD SKIN CARE

ESTABLISH AN EMOLLIENT REGIME

Moisturise as often as possible – this is the most important part of skin care.

Emollients, or moisturisers help to rehydrate and soften the skin making it smooth and supple.

Improving the condition of the skin by regular emollient use reduces itching and the need for more potent steroids.

Even when the skin looks and feels 'normal' emollients should be continued and used regularly.

Emollients are available as lotions, creams, ointments and gels. Lotions are lighter than creams and ointments are greasier.

It is important to find the most suitable emollient(s) for the skin.

AVOID SOAP AND FOAMING BATH/SHOWER PRODUCTS

Don't use soaps, bubble baths or foaming shower gels, which tend to dry and irritate the skin. If it bubbles or foams it dries the skin.

Use an emollient soap substitute for washing in the bath, under the shower or at the sink – it does not need to lather.

Bathing keeps the skin clean and free from scales and crusts. Add an emollient bath additive that is designed to disperse efficiently in water.

Wash with lukewarm water rather than hot water.

Make a note of where, how often and how much emollient to apply.

Ask your doctor, nurse or health visitor for advice.

Atopic Eczema

Diagnostic Criteria:

Itchy skin in the past 12 months plus 3 or more of the following (NICE):

1. Visible flexural dermatitis involving the skin creases (children less than four, cheeks/extensor areas).
2. A personal hx of asthma or hay fever.
3. A hx of generally dry skin.
4. Onset under the age of 2 years old.

Emollient Combo:

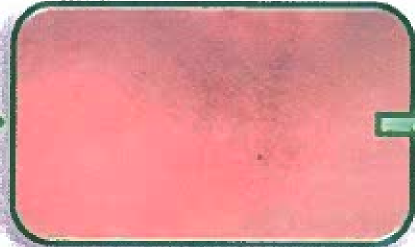
- Cream for during the day.
- Ointment for night time.
- Shower gel or bath addition.
- The best emollient to use is the one the patient likes!)

Steroid Strengths:

- Mild – Hydrocortisone 1%
- Moderate – Eumovate
- Potent – Betnovate
- Very Potent - Dermovate

MILD

C/O: Little impact on everyday activity, sleep and psychological wellbeing.



O/E: Areas of dry skin. Infrequent itching (with/without) small areas of redness.

Mx: 1% Hydrocortisone cream/ointment. Daktacort (Anti-Fungal) Fucidin H (Bacterial)

Apply once daily for 14 days then use at weekends for maintenance.

MODERATE

C/O: Moderate impact on everyday activities and psychological wellbeing. Frequently disturbed sleep.

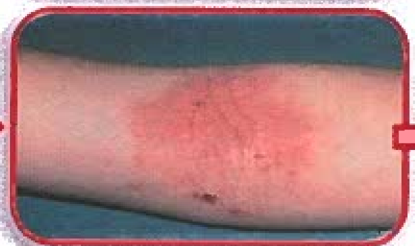
O/E: Areas of dry skin. Frequent itching. Redness (with/without) excoriation and localised thickening.

MX: Eumovate cream/ointment or Trimovate. Consider Antihistamine.

Apply once daily for 14 days then use at weekends for maintenance.

SEVERE

C/O: Severe limitation of everyday activities and psychological functioning. Nightly loss of sleep.



O/E: Widespread areas of dry skin. Incessant itching. Redness +/- excoriation, lichenification, bleeding, ooze, cracking, altered pigment.

Mx: Elocon or Betnovate cream/ointment daily poss with sedative antihistamine. Consider calcineurin inhibitors, zinc bandages or wet wraps.

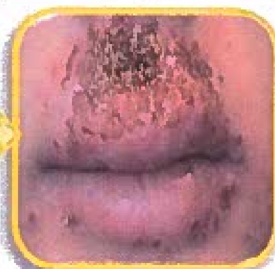
Apply once daily for 14 days then use at weekends for maintenance. Consider referral for Systemic treatment or phototherapy.

INFECTION:

Think infection if : pustules, crusts, temperature, rapidly worsening skin, malaise or atopic eczema not responding to treatment.

Appropriate Antibiotics:

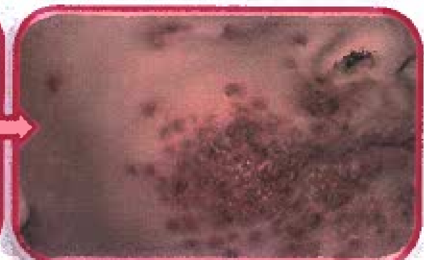
- Flucloxacillin
- Erythromycin
- Clarithromycin
- Azithromycin



ECZEMA HERPETICUM:

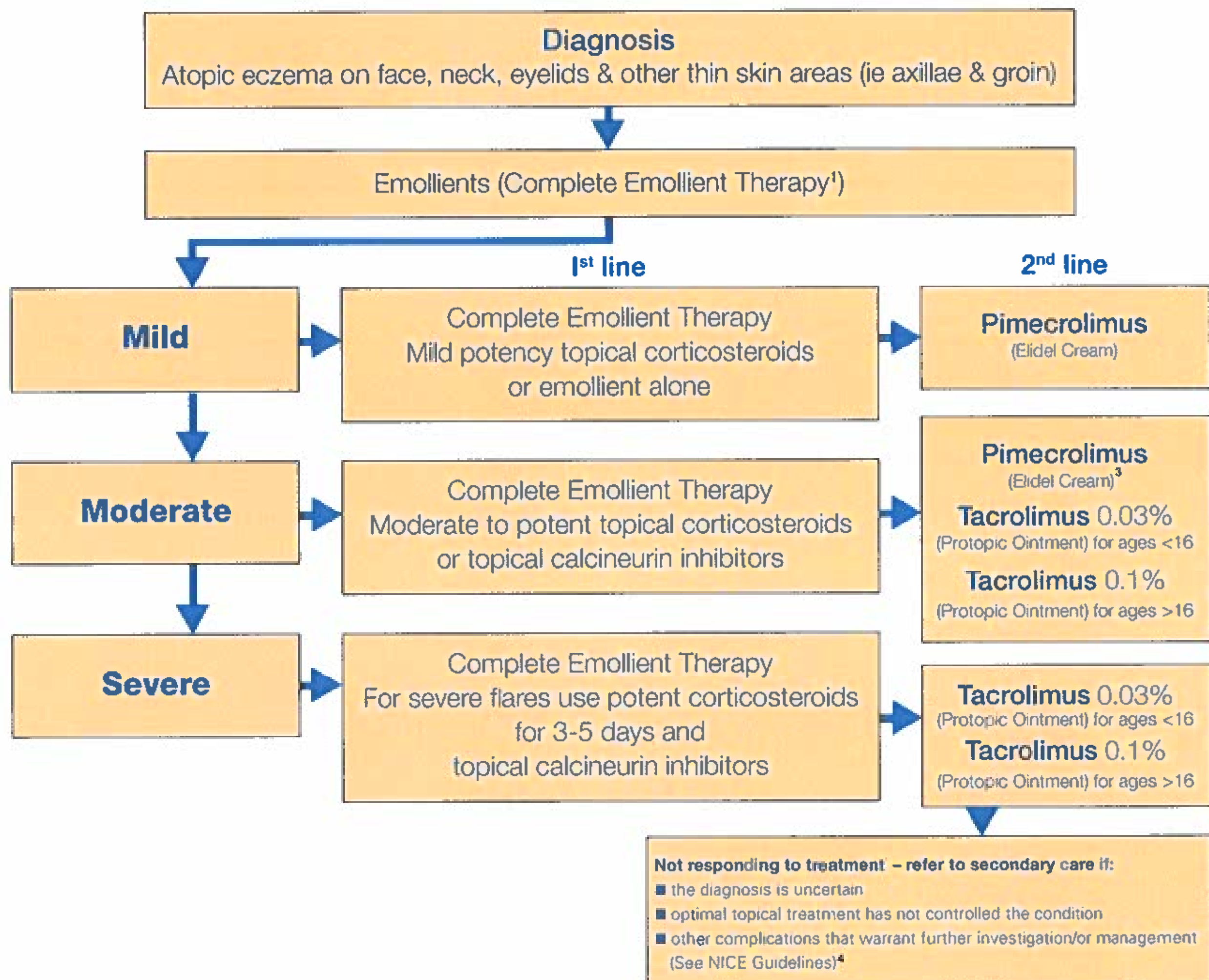
Always be aware of eczema herpeticum as it is one of the few dermatology emergencies.

REFER



Simplifying Topical Calcineurin Inhibitors for Primary Care – Reducing the Referral Burden to Secondary Care

Chairman: Dr Stephen Kownacki
Contributors: Professor Malcolm Rustin, Dr Chris Bower, Dr Sue Lewis-Jones, Dr George Moncrieff, Dr Stuart Wolfman, Dr Tom Poyner, Dr Christine Clark, Julie Van Onselen



Notes:

1. **Complete Emollient Therapy:** Healthcare professionals should offer children with atopic eczema the choice of unperfumed emollients to use every day for moisturising, washing and bathing. This should be suited to the child's needs and preferences, and may include a combination of products or one product for all purposes. Leave-on emollients should be prescribed in large quantities (250-500g/weekly) and easily available to use at nursery, pre-school and school.

* Short term license for TCIs is for use until the condition improves, with re-assessment if no improvement after 6 weeks with pimecrolimus, or 3 weeks with 0.03% tacrolimus. Tacrolimus ointment is licensed for the prevention of flares with twice weekly application for up to one year.

References

3. Kempers S et al. A randomized investigator-blinded study comparing pimecrolimus cream 1% with tacrolimus ointment 0.03% in the treatment of pediatric patients with moderate atopic dermatitis. JAAD 2004; 51: 515-525

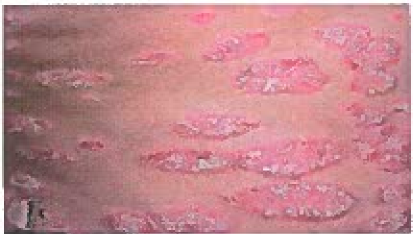
4. Atopic eczema in children – management of atopic eczema in children from birth up to the age of 12 years. NICE Clinical Guideline, December 2007

Patient Resources

National Eczema Society, Talk Eczema and Eczema Scotland
www.eczema.org www.talkeczema.com www.eczemascotland.org

Meda Pharmaceuticals in conjunction with Signature Healthcare Communications brought together a panel of dermatology experts for an advisory board meeting. Although funded by Meda Pharmaceuticals the opinions, views and content contained herein was independent and Meda Pharmaceuticals had no editorial control other than copy checking for medical accuracy and balance.

UK/ELI/12/0041 September 2012



Psoriasis Management Guideline

Patient Infromation Leaflet http://www.bad.org.uk/shared/get-file.ashx?id=178&itemtype=document

Assess patients for

- Disease Severity
- Arthropathy
- Co-Morbidities
- ADVISE RE CHRONICITY

Emollient Combo Supersize!

Prescribe 500-1000g **Softens Plaques, decreasing itching and koebnerisation.**

Combination of

Bath Oil / Shower Gel

+

Cream / Ointment

Examples:

- Doublebase
- Doublebase Dayleve
- Balneum
- Oilatum
- Diprobase
- Cetraben

Maintenance

Use emollients liberally.

Frequent flares?

Try:

Vit D Analogue* Mon – Fri

+

Betnovate for weekend Rx on Sat + Sun

Refer if:

- Diagnostic Uncertainty
- Severe/Extensive Disease >10% BSA
- Not controlled with topical treatment
- Acute guttate requiring UVB
- Nail Disease with major functional/cosmetic impact
- Any type of psoriasis having a major impact on personal, psychological and/or physical wellbeing

Active Treatments **http://www.pcds.org.uk/clinical-guidance/psoriasis-an-overview**

Enstilar Foam: **Daily for 4 weeks;** Then twice weekly as maintenance (*off license*). Can use Exorex / Vit D Analogue* for maintenance.

→ **Eumovate Ointment Mane + Vitamin D Analogue* Nocte for 4 weeks. (Maximum 8 weeks)** For young children and adults use one or the other.

→ **Vitamin D Analogue* BD for 8 weeks. (Maximum 12 weeks)**

→ **Eumovate Ointment BD for 1 week. (Maximum 4 weeks) Or Exorex Lotion OD/BD**

Vitamin D Analogues:
Silkis - Calcitriol
Dovonex - Calcipotriol
Curatoderm – Tacalcitol
Combination products
DOVOBET / ENSTILAR-
(Calcipotriol and

Flexural Psoriasis

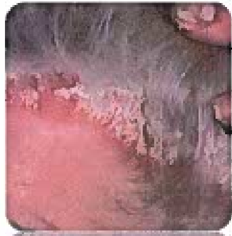
Use in combination with Emollient Combo and avoidance of irritants.

Daktacort Bd** → **Timodine bd** → **Trimovate bd** → **Silkis bd** → **Betnovate For short periods only – 48 hours**

SMcE 2017

Facial Psoriasis : Daktacort BD/Silkis BD / Hydrocortisone bd

Scalp Psoriasis



Betnovate Scalp application for 4 weeks
(In children >1 for 7 days only)
+
Shampoo:
Polytar/T-Gel/Capasal/Dermax

Polytar: Massageinto scalp for 5 mins.

T-Gel: Prescrible as Neutrogena T-Gel. Popular with patients.

Capasal: Massage into scalp for 5 mins.

Dermax: No odour.

If no response in 4 weeks

SEBCO/COCOIS:
Massage into affected areas for 5 mins and then leave for at least 1 hour before washing off.
USE DAILY FOR 3-7 DAYS THEN PRN.
(>6 yrs old as for adult

Bettamouse:
APPLY APPROX GOLF BALL SIZED AMOUNT TO SCALP BD.
If no improvement after 7 days – discontinue OR Maintenance once daily PM
Licensed >6yr old for 5-7 days

Etrivex Shampoo:
(Clobetasol Proprionate)
Apply to affected area once daily for max of 4 weeks, leave on for 15 mins before rinsing.

If no response in 4 weeks

DOVOBET GEL:
APPLY TO SCALP DAILY FOR 4 WEEKS
Massage into dry scalp and then shampoo off in am.
(Put shampoo directly onto dry hair for first wash before rinsing).
Not licensed <18 years old

If no response in 8 weeks

Dermovate Scalp Application:
Apply sparingly to affected areas bd until improvement occurs.

OR

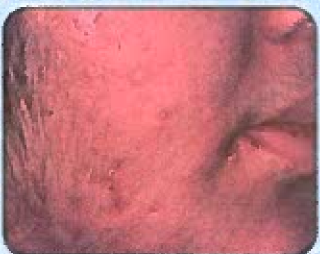
Diprosalic Scalp Application:
Useful for heavy scale.
Apply few drops to scalp twice daily and rub in.

If no response in 2 weeks

Refer for Further Care!

ACNE TREATMENT GUIDELINES

Woman of child bearing age.
Irregular periods?
Hirsutism?
Acne?
Think Pcos!



Ix
Serum total+ free testosterone
Gynae hormone profile
Early am cortisol
PCOS p

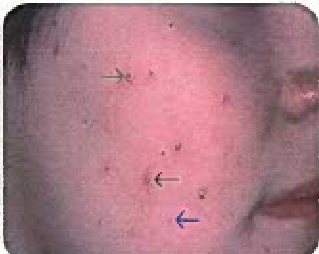
PCOS
Dianette
Decreases Free Testosterone
Anti Androgen
Cyproterone Acetate may be used.
Spironolactone also helpful
Needs BP+K+Monitoring

Comedonal Acne

Differin - Adapalene
BPO -2.5%
Epiduo - Adapalene&BPO
Isotrex**
Retin-a**
All once daily

Cleanse skin and remove make up with mild soap & water or Dermol wash.

Mild Acne
<20 Comedones
<15 Inflammatory Lesions
Total Count <30

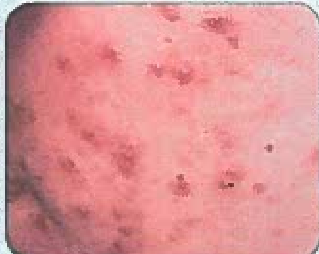


Topical Retinoids** & Anti-microbial
Epiduo (Adapalene & 2.5% BPO)
Treclin (clindamycin 1% & 0.025% tretinoin)**
Duac gel (clindamycin & 5% BPO)

Restores normal follicular kerantinisation.
Prevents new comedones from forming.
Advise to start gently every 3rd night and build up as tolerance develops.

**Not in pregnant or those planning a pregnancy.

Moderate Acne
20-100 Comedones
15-50 Inflammatory Lesions
Total Count: 30-125



Combine systemic and topical rx.
Tetralysal 408mg daily.
Oxytetracycline 500mg bd.
Doxycycline 100mg daily. Not in pregnancy or those aged < 12.

Treat until clear for 3 months then continue with topical Rx.
Review in 2 months after starting Rx.
If working continue for 6 months.

Severe Acne
>100 Comedones
>50 Inflammatory Lesions
Total Count >125

Referral for Roaccutane (oral Isotretinol)
0.5-1mg/kg/day
A/E's: Dry skin, sore lips, epistaxis, muscle pains, raised lipids.
Pre-treatment: FBP, U&E, Lipids, LFTs
Girls need adequate contraception.

Referral criteria:
Poor response to 6m of oral antibiotics.
Severe acne.
Severe psychological upset.

Acne Rosacea Guidelines

Clinical Features

- Background Erythema
- Red Spots (Papules)
- No Blackheads or Whiteheads and Rarely Nodules
- Frequent Blushing or Flushing
- Telangectasia
- Dry and Flaky Skin
- Distributed Mainly on Nose, Forehead, Cheeks and Chin.

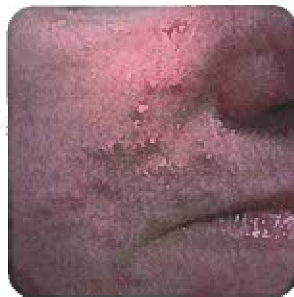
Other Clinical Signs

- Up to 50% of patients have eye symptoms (dry, gritty eyes)
- Worsening symptoms with sun exposure
- Hot, spicy goods exacerbate
- Alcohol worsens
- Sensitive skin (burning with makeup, sunscreens and facial creams)
- Enlarged, un-shapely nose (rhinophyma)
- Persistent redness and swelling of upper face.

General Measures

- Avoid iritants such as:
  - Alcohol/Spicy Foods/Oil-Based Creams/Soaps (use pH neutral cleansers)
  - Regular use of sun-screen (SPF > 30)

Papsules & Pustules

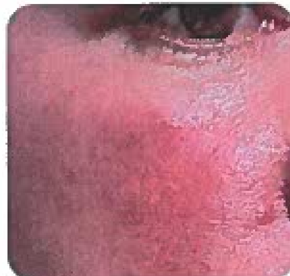


Ivermectin 1% Gel (Soolantra) od +++

Azelaic Acid (Finacea) cream bd ++

Metronidazole gel or cream bd +
Doxycycline 40mg daily
Lymecycline 408mg daily
Erythromycin/Clarithromycin 250-500mg bd
Usually for 3 months but can reduce earlier if improvement.

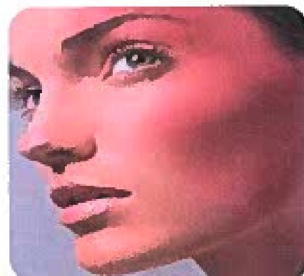
Erythema & Telangectasia



Consider camouflage creams.
Consider referral for IPL +++

Pulsed Dye Laser ++.

Flushing



Brimonadine (Mirvaso) 3mg/g gel ++ - apply 5 pea-sized amounts to forehead, nose, chin and cheek once daily.

Clonidine 50-75mcg bd ++

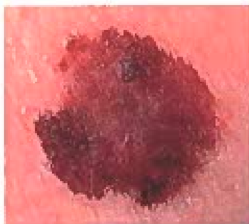
Propranolol 40-80mg tds +

Carvedilol 3.125-6.25mg tds +

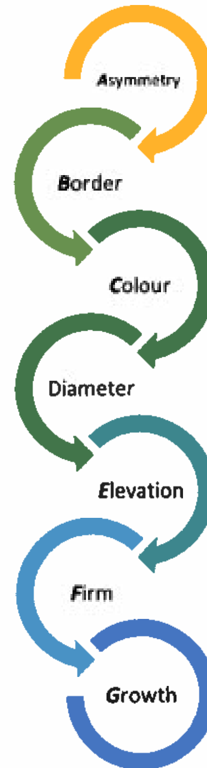
Assessment of a Pigmented Lesion

History

MAJOR SIGNS	- Change in Size (30%) - Change in Colour (25%) - Change in Elevation (15%)
MINOR SIGNS	- Inflammation - Ooze/Bleeding (9%) - Diameter > 6mm - Itching (4%)



On Examination:



NORMAL		CANCEROUS
	"A" IS FOR ASYMMETRY • If you draw a line through the middle of the mole, the halves of a melanoma won't match in size.	
	"B" IS FOR BORDER • The edges of an early melanoma tend to be uneven, crusty or notched.	
	"C" IS FOR COLOR • Healthy moles are uniform in color. A variety of colors, especially white and/or blue, is bad.	
	"D" IS FOR DIAMETER • Melanomas are usually larger in diameter than a pencil eraser, although they can be smaller.	
	"E" IS FOR EVOLVING • When a mole changes in size, shape or color, or begins to bleed or scab, this points to danger.	

Refer Urgently If There Is:

- A new mole appearing after the onset of puberty which is changing in shape, colour or size.
- A long standing mole which is changing in shape, colour or size.
- Any mole which has three or more colours or has lost its symmetry.
- A mole which is itching or bleeding.
- Any new, persistent skin lesion, especially if growing, pigmented or vascular in appearance and if the diagnosis is 'not clear'.
- A new pigmented line in a nail especially where there is associated damage to the nail.
- A lesion growing under a nail.

Information for Referral:

- Is this a new pigmented skin lesion?
- Is this a change within a pre-existing pigmented lesion?
- Site
- Measurement
- Increasing in size?
- Irregular shape?
- Irregular colour/pigmentation?
- Change in sensation?
- Inflammation or oozing?

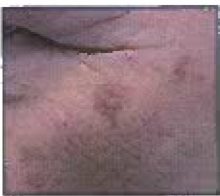
AK
Actinic Keratosis

Actinic (Solar) Keratosis

PCDS

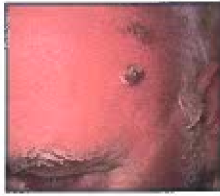
General Measures	
Applicable to all patients and may be all that is needed for management: 1. **AKs are a marker of UV damage: examine other areas of the skin** 2. Encourage prevention: sun screen and protection	3. Advise patients to report change 4. Consider use of emollients for symptom control

Clinical Grading (according to Olsen 1991)

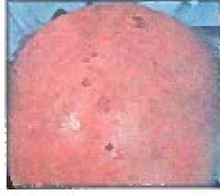


Grade I: Flat, pink maculae without signs of hyperkeratosis and erythema often easier felt than seen. Scale and possible pigmentation may be present

Grade II: Moderately thick hyperkeratosis on background of erythema that are easily felt and seen



Grade III: Very thick hyperkeratosis, or obvious AK, differential diagnosis includes thick IEC (intra-epidermal carcinoma or SCC)



Field damage: Large areas of multiple AKs on a background of erythema and sun damage

Suggested Treatment Regimes

Brand Name	Protocol	Notes
Solaraze	Twice daily for 60-90 days	Because of the length of treatment needed, compliance may be an issue
Efudix	Once or twice daily for 3-4 weeks	Early & severe inflammatory reaction is normal, typically peaking in the second week
Actikerall	Once daily for 6-12 weeks	Apply with brush applicator & peel off existing coating before reapplication
Aldara	Apply three times a week for 4 weeks Assess after 4 week interval. Repeat if required	Flu like symptoms are occasionally reported
Zyclara	Two treatment cycles of two weeks, separated by 2 treatment free weeks	Flu like symptoms are occasionally reported
Picato 150µg/g gel – face & scalp	Once daily for 3 consecutive days	Skin reaction may occur from day one and usually resolves within 2 weeks
Picato 500µg/g gel – trunk & extremities	Once daily for 2 consecutive days	Skin reaction may occur from day one and usually resolves within 4 weeks

AK
Actinic Keratosis

Actinic (Solar) Keratosis – Primary Care Treatment Pathway

PCDS Primary Care Dermatology Society

What is an AK

An actinic keratosis is a common, UV induced, scaly or hyper-keratotic lesion which has a very small potential to become malignant. There is a high spontaneous regression rate and low rate of transformation – less than 1 in 1000 per annum, but with an average of 7.7 AKs the risk of one transforming in 10 years is 10%* (See over)

Contributors
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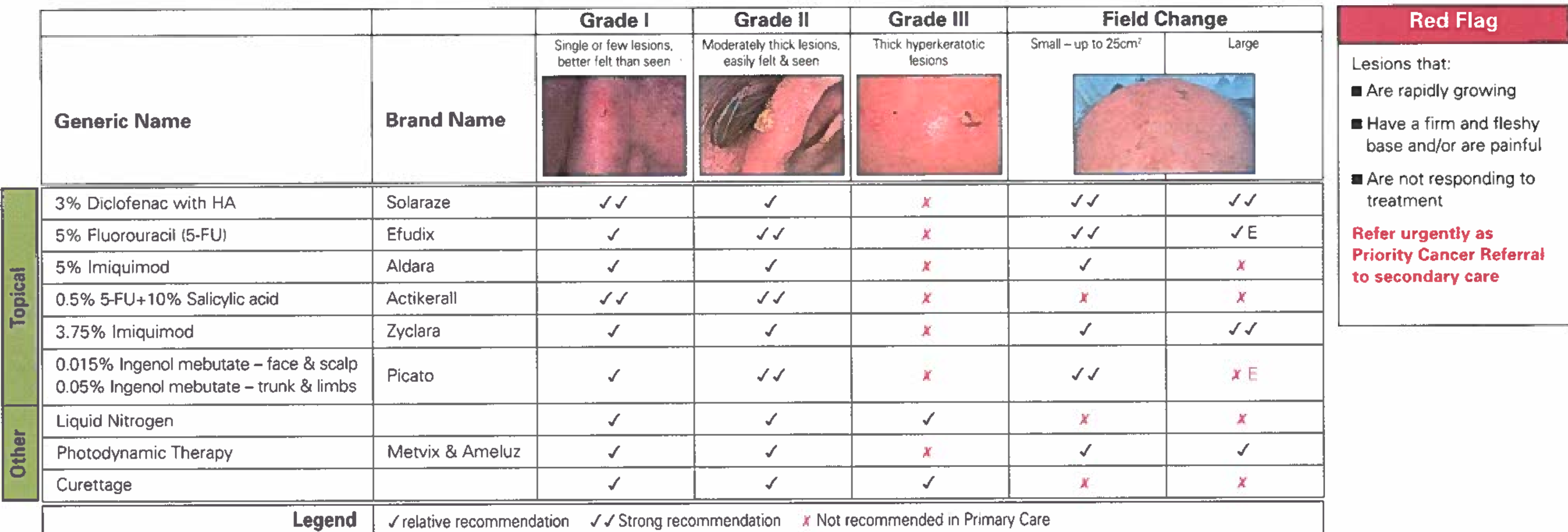
Important Information about Treatments

A. Expect local skin reactions which can be severe with several of these treatments. This can be very severe especially if large areas are being treated. These should be regarded as an effect of the treatment. Patients should be warned to expect this effect rather than regarding it as an unwanted side effect
B. Complete clearance of lesions can be delayed several weeks beyond completion of topical therapies
C. Please refer to SPCs for further information regarding these products
D. Local formularies and regional guidance may exist for individual products
E. It may be preferable to divide larger areas into smaller ones and treat them sequentially

Identify High Risk Patient

Past history of skin cancer, those with extensive UV damage, immunosuppressed patients or the very young, consider referral to secondary care or accredited GPwSI. If not high risk then consider treatment as below



	Generic Name	Brand Name	Grade I Single or few lesions, better felt than seen	Grade II Moderately thick lesions, easily felt & seen	Grade III Thick hyperkeratotic lesions	Field Change Small – up to 25cm²	Field Change Large
Topical	3% Diclofenac with HA	Solaraze	✓✓	✓	✗	✓✓	✓✓
Topical	5% Fluorouracil (5-FU)	Efudix	✓	✓✓	✗	✓✓	✓E
Topical	5% Imiquimod	Aldara	✓	✓	✗	✓	✗
Topical	0.5% 5-FU+10% Salicylic acid	Actikerall	✓✓	✓✓	✗	✗	✗
Topical	3.75% Imiquimod	Zyclara	✓	✓	✗	✓	✓✓
Topical	0.015% Ingenol mebutate – face & scalp 0.05% Ingenol mebutate – trunk & limbs	Picato	✓	✓✓	✗	✓✓	✗E
Other	Liquid Nitrogen		✓	✓	✓	✗	✗
Other	Photodynamic Therapy	Metvix & Ameluz	✓	✓	✗	✓	✓
Other	Curettage		✓	✓	✓	✗	✗

Legend ✓ relative recommendation ✓✓ Strong recommendation ✗ Not recommended in Primary Care

Please note these recommendations do not take into consideration the cost of treatment and are based on the clinical expertise of the guideline contributors with the products

Red Flag

Lesions that:
- Are rapidly growing
- Have a firm and fleshy base and/or are painful
- Are not responding to treatment

Refer urgently as Priority Cancer Referral to secondary care

Reference: * De Berker D et al. British Journal of Dermatology 2007;156: 222-230

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Hand eczema

To speed healing and prevent relapse of your eczema you should remember:

- HANDWASHING. U se lukewarm water and soap substitute or baby soap without any perfume tar or sulphur. The soap should be used sparingly and the hands thoroughly rinsed. Dr carefully with a clean towel, not forgetting to dry carefully between the fingers.
- DETERGENTS: As far as possible avoid direct contact with detergents and other strong cleansing agents. Measure the quantity according to the manufacturers' instructions; otherwise they may well be too strong. Keep the packages clean to avoid irritations from detergents on the outside.
- SHAMPOO: Avoid direct contact with shampoo, allow someone else to wash your hair or wear plastic gloves.
- POLISH: Avoid direct contact with metal, wax, shoe, floor, car, furniture and window polish.
- DIY: Be careful not to get SOLVENTS and STAIN REMOVERS e.g. white spirit, petrol, trichloroethylene, turpentine and thinners on the skin.
- FOOD: Don't peel or squeeze oranges, lemons or grapefruit with bare hands.
- HAIR: Don't apply hair lotion, hair cream or hair dye with bare hands.
- Wear gloves in cold weather
- RINGS should not be worn during housework or other work even when the eczema has healed. Rings should be cleaned frequently on the inside with a brush and rinsed thoroughly. NEVER wash your hands with soap when wearing a ring.
- WASHING UP: use running water if possible.
- GLOVES should be used for washing dishes and clothes; they should be plastic and not rubber as the latter often causes eczema. If the water happens to enter a glove it must be immediately taken off. Turn the gloves inside out and rinse under the hot tap several times per week. Sprinkle with talc before they are used again as they must be completely dry. Cotton gloves can be used under the plastic ones. They should only be worn a few times before they are washed. Buy several pairs of plastic and rubber gloves at a time.
- REMEMBER The resistance of the skin is lowered for at least 4-5months after the eczema appears to be completely healed; so continue to follow the instructions
- Washing machines and dishwashers are the ideal way of preventing further attacks.

PSORIASIS EPIDEMIOLOGY SCREENING TOOL (PEST)

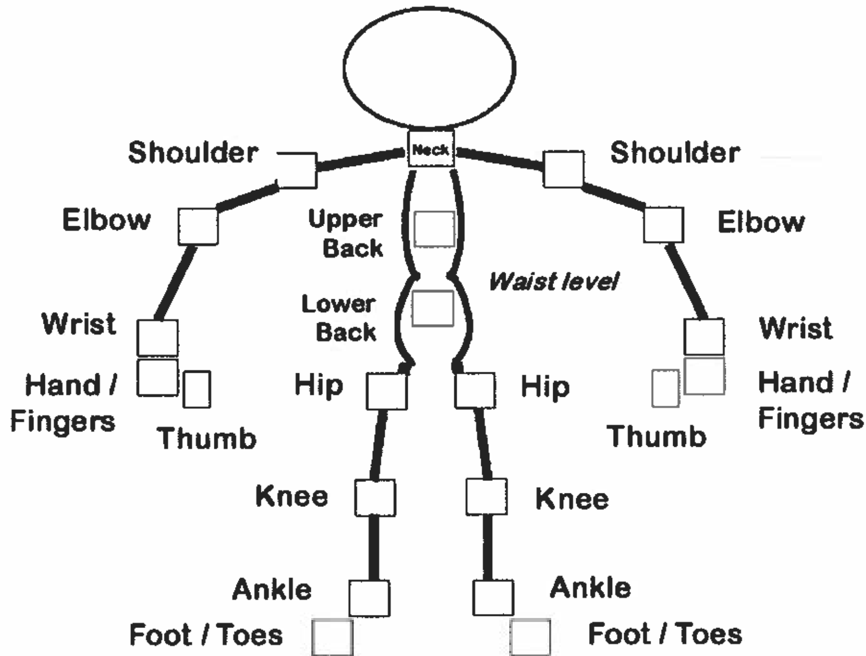
HOSPITAL NO. ....

PATIENT NAME ....

DATE OF VISIT ....

PEST is a validated screening tool for psoriatic arthritis (PsA) and it is recommended that patients with psoriasis who do not have a diagnosis of PsA complete an annual PEST questionnaire (NICE psoriasis guidelines 2012). A score of 3 or more indicates referral to rheumatology should be considered.

In the drawing below, please tick the joints that have caused you discomfort (i.e. stiff, swollen or painful joints).



Reproduced with kind permission of Professor Philip Helliwell (University of Leeds)

Please answer the questions below and score 1 point for each question answered 'Yes'

		Yes	No
1.	Have you ever had a swollen joint (or joints)?		
2.	Has a doctor ever told you that you have arthritis?		
3.	Do your finger nails or toenails have holes or pits?		
4.	Have you had pain in your heel?		
5.	Have you had a finger or toe that was completely swollen and painful for no apparent reason?		

Total /5

A total score of 3 or more out of 5 is positive and indicates a referral to rheumatology should be considered

Lesion	FTs	No of FT's	Margin mm	No of treatments	Interval weeks
Actinic Keratoses	5	1	1	1	
Warts	10	1	2	3	4
Cutaneous horn	10-15	1	2	1	
Dermatofibroma	20-30	1	2	2	8
Myxoid cyst	20	1	<1	1	
Pyogenic granuloma	15	1	<1	1	
Sebaceous hyperplasia	10	1	<1	3	4
Skin tags	5	1	2	1	4
Solar lentigos	5	1	<1	1	
Bowens disease	10s	2	3	1	

MANAGEMENT OF URTICARIA

Step 1:

Cetirizine, 10mg once daily ***most rapid onset, can use up to 30mg**

Levocetirizine, 5mg once daily

Fexofenadine, 180mg once daily

Loratadine, 10mg once daily

Desloratadine, 5mg once daily ***longest T 1/2**

Offer at least 2

Step2:

Fexofenadine 180mg AM + Cetirizine, 10mg PM

Levocetirizine, 5mg / Desloratadine, 5mg

Week 2: 5mg bd

Week 3: 10mg bd

Week 4: Change to 20mg other drug

Step 3:

Cetirizine, 10mg mane

Add

Chlorpheniramine 4-12mg

or

Hydroxyzine 10-50mg

as night time dose.

Step 4:

H1 BLOCKER as step 2&3

+

H2 BLOCKER - off licence

Ranitidine 150mg BD

Step 5:

H1 BLOCKER as step 2&3

+

ANTILEUKOTRIENE?

Montelukast 10mg

REFER

General Measures:

Calamine/1% Menthol in aq. Cream

Cool affected area - fan, flannel

Avoidance of ppt factors

Overheating/Stress/Alcohol

Drugs - Minimise aspirin & codeine use & NSaids - in aspirin sens. patients

ACE Inhibs - with angioedema without weals

Dietary Changes

Salicylates in fruits

Amines/Tartarazine/Benzoates

Investigations not always useful - should be based on individual history.

E.g.

FBP, ESR

TFTS & AUTOBODS

IgE

RAST

Complement Levels

Skin Biopsy

Weals>24 Hours

Urticarial Vasculitis

Refer for Complement Levels and Skin Biopsy

Exceptional Circumstances

ORAL STEROIDS

50MG X 3DAYS / Tapering Course

SM^cE 2014