NHS East Riding of Yorkshire
NHS Hull

Spot the Difference
A Guide to Dermatology In Primary Care

In Collaboration with Hull And East Yorkshire Hospitals NHS Trust

Great Staff - Great Care - Great Future

Contents

Introduction

The Guidelines have been produced by both the Department of Dermatology and Pharmacy at The Hull and East Yorkshire Hospitals Trust in collaboration with the PCTs.

This document offers recommendations of first line treatment for common skin conditions and useful guidelines, for the practice of Dermatology in Primary Care and defines the point at which Secondary Care may give additional benefit. This information is intended to be used as a source of reference by General Practitioners and other healthcare professionals working in primary care in order to become familiar with the most common skin diseases encountered in General Practice and to boost confidence in dealing with them.

It is impossible to define exactly the stage at which a secondary referral should be made and frequently the problems at the edge of our definitions are the most challenging.

These treatment recommendations should be followed prior to consideration of referral to the Consultant Dermatologists. **Criteria for referral are clearly stated at the end of each section.**

Additional information on doses, interactions, cautions etc may be found in the latest copy of the British National Formulary, or electronically at www.medicines.org.uk.

Dermatology Department

Hull Royal Infirmary

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Urgent Referrals Fax No		01482 608771
Freedom Centre	Dermatology Department	01482 344581
Appointments	New Appointments	01482 604444
Appointments	Follow-up / Queries	01482 816615

Referral

Urgent Referrals

All referrals will be assessed and graded by a Consultant. Urgent referrals may be faxed directly to the department on 01482 608771.

If you wish to discuss a case with a Consultant, please ring via the Secretary's direct line.

Skin Cancer

Referrals for melanomas and squamous cell carcinoma should clearly indicate the provisional diagnosis and should be made using the **two week wait referral process**, either via Choose and Book or via a faxed two week skin cancer referral form. These patients will be seen within two weeks. Basal cell carcinomas should **not** be referred via this route (two week wait). Recent NICE guidance for skin cancers has outlined that GPs should be fast tracking all these patients. There are some low grade skin cancers (low risk Basal Cell Carcinomas) that can be exised by GPs. Any GP knowingly excising low risk Basal Cell Carcinomas should be appropriately trained accredited and should be part of the local MDT, attending at least 2 meetings a year, including an audit-meetings so that they can maintain their knowledge base and follow up their patients' care.

Exceptional Treatments

Benign lesions, including skin tags, viral warts, molluscum contagiosum, benign moles and seborrhoeic warts, will not be treated for cosmetic reasons within the dermatology or Plastic Surgery Department. Surgical intervention for such conditions are not commissioned by local Primary Care Trusts and require individual funding approval via your local PCT Individual Funding Panel prior to referral. Such conditions should only be referred for exclusion of malignancy (if suspected) or if individual funding agreed.

Content of referral letter

The following information should be included in all referrals:

- Full demographics with contact telephone numbers.
- Nature of condition and duration.
- Relevant past medical history.
- All medication currently and previously used for this condition including dose, duration of treatment and response, plus all other concurrent medication.

General notes on prescribing dermatology products for patients

Quantities

It is recommended that emollients be applied at least twice a day, but can be as frequently as every two hours during the day, particularly when the condition is florid. In these situations the following quantities for ADULTS for one week are suggested:

Emollients (Every 2 hours)	Creams and Ointments	Lotions
Face	50-100g	250ml
Both hands	100-200g	500ml
Scalp	100-200g	500ml
Both arms or both legs	300-500g	500ml
Trunk	1000g	1000ml
Groin and genitalia	50-100g	250ml

The BNF recommended quantities of **emollients** to be given to **Adults** for **twice daily** application for one week are:

Emollients (Twice a day)	Creams and Ointments	Lotions
Face	15-30g	100ml
Both hands	25-50g	200ml
Scalp	50-100g	200ml
Both arms or both legs	100-200g	200ml
Trunk	400g	500ml
Groin and genitalia	15-25g	100,l

The recommended quantities of **Steroids** to be given to **Adults** for **twice daily** application for one week are:

Topical Steroids (Twice a day)	Creams and Ointments
Face and neck	15-30g
Both hands	15-30g
Scalp	15-30g
Both arms	30-60g
Both legs	100g
Trunk	100g
Groin and genitalia	15-30g

Prescribing of topical steroids for children

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

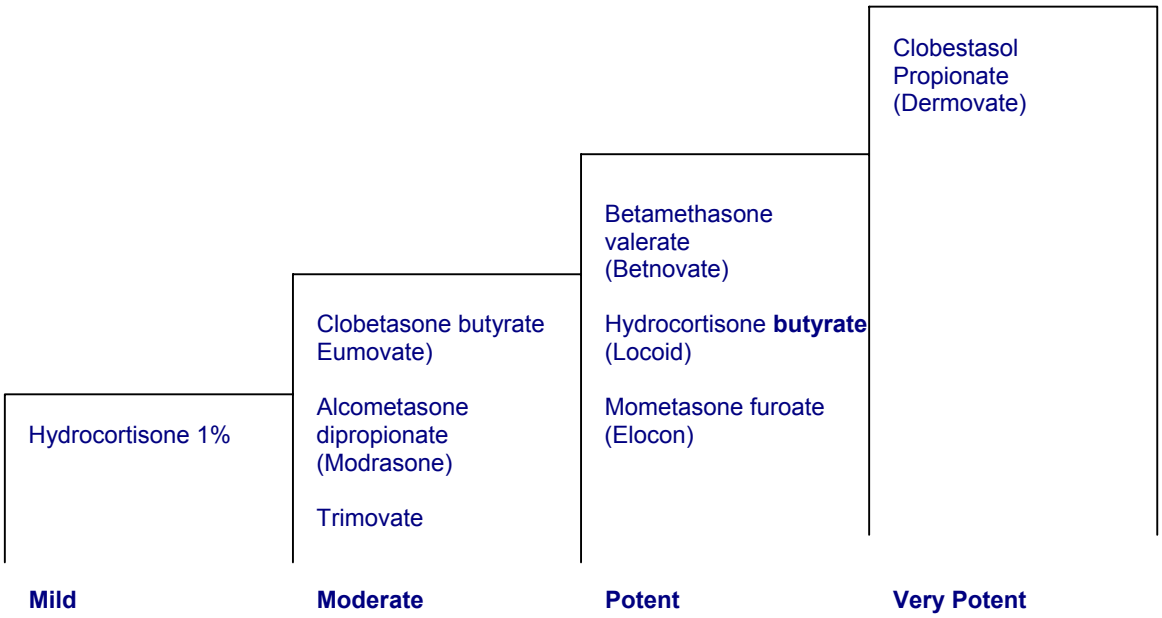
Finger Tip Units for Treating Children with Emollients

Number of finger tip units						
Age	Face and neck	1 Arm (including hand)	Trunk (One Side)	Buttocks	1 Leg (including foot)	Total body treatment
3/12	1	1	1	0.5	1.25	8
6/12	1	1	1.5	0.5	1.5	9.5
12/12	1.5	1.25	1.75	0.5	2	12
18/12	1.5	1.5	2	0.75	2	13.25
2 yrs	1.5	1.5	2	1	2	13.5
3 yrs	1.5	1.75	2.5	1	2.5	16
4 yrs	1.75	2	2.75	1	3.5	19.25
5 yrs	2	2	3	1	3.5	20
7 yrs	2	2.5	3.5	1.5	4.5	24.5
10 yrs	2.5	3	4	1.5	6	30
12 yrs	2.5	4	5	2	7	36.5

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

Topical Steroid Ladder

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



Topical corticosteroids may cause skin atrophy, especially on thin skin areas such as face or flexures**. Potent and very potent corticosteroids should generally be avoided on the face and skin flexures**, although specialists occasionally prescribe them in certain conditions.

For choice of emollients refer to Section 10 on page 29.

Topical Antibiotics

Resistance to topical antibacterial therapy is an ongoing problem. It is therefore recommended that topical antibacterial therapy is only initiated when specifically indicated. It should be prescribed at a therapeutic dose and used for a **maximum of two weeks**. Supplying patients with only the required quantity to cover the treatment period may prevent prolonged treatment. (See page 5&6 for guidance on quantities required).

Treatment aims:

- To reduce the severity and length of illness
- To reduce the psychological impact on the individual
- To prevent long-term sequalae such as scarring

Section 1: Acne

Clinical features	Treatment	Therapeutic tips
Mild to moderate acne should be managed in primary care. Several different agents may need to be tried alone or in combination. Avoid concomitant use of oral and topical therapy with chemically dissimilar antibiotics. (An example of a good combination is topical erythromycin plus oral erythromycin). Inform patient that response is usually slow and allow at least 12 weeks before review		Patients should be advised to avoid vigorous scrubbing as this may worsen acne Gels and solutions – oily skins Creams – sensitive and/or dry skin Lotions – useful for large and/or hairy areas Moisturisers and emollients should be avoided in particular problem areas, but may be used in areas of dry skin.
Mild Uninflamed lesions – open and closed comedones (blackheads). Sometimes with papules/pustules.	Topical Benzoyl/Peroxide preparations	Starting at 2.5% increasing to 5 or 10% may reduce irritancy with benzoyl peroxide.
	Topical retinoids (avoid pregnancy) ▪ Adapalene ▪ Isotretinoin ▪ Tretinoin ▪ EPIDUO Gel (Benzoyl Peroxide and Adapalene)	Often causes irritation therefore reduce frequency or duration of application and build up to daily over 2 –3 weeks. Advise mild antiseptic wash to prevent infection to wash with. Counselling points: • Redness and skin peeling may occur for several days, usually settling with time • Acne may worsen for first few weeks • Avoid excessive exposure to sunlight and avoid sun beds. • Advise contraception in women of child bearing age
	Topical antibiotic combination preparations e.g. ▪ Erythromycin combined with Zinc (Zineryt). ▪ Erythromycin combined with Isotretinoin – (Isotrexin) ▪ EPIDUO Gel (Benzoyl Peroxide and Adapalene)	May be more effective and aid compliance.
Moderate Greater number or more extensive inflamed lesions.	Systemic antibiotics ▪ Oxytetracycline 500mg bd (take 60 mins before food, avoid indigestion remedies at the same time) ▪ Lymecycline 408mg od ▪ Erythromycin 500mg bd 2nd Line – following specialist recommendation ▪ Minocycline 100mg od. Minocycline may rarely cause auto immune hepatotoxicity. LFT's should be checked every 3 months in patients who are on long term therapy.	Treatment should continue for 6 months minimum and repeat if necessary. Often most effective but has additional side effects and may therefore be preferred as second line. Topical benzoyl peroxide or retinoids may be used in combination.

Clinical features	Treatment	Therapeutic tips
Moderate – Severe Papules/pustules with deeper inflammation and some scarring.	Systemic treatment as above plus topical therapy. Consider additional hormone therapy. Ethinylestradiol combined with Cyproterone acetate (Co-cyprindiol) in women.	If a patient is referred in for Isotretinoin therapy check fasting lipids, full blood count and LFT's. In female patients of child-bearing age provide contraceptive advice and treatments (usually the combined oral contraceptive pill).
Severe Confluent or nodular lesions usually with significant scarring.	Commence systemic therapy and refer immediately for systemic isotretinoin treatment.	
Maintenance Persistent low-grade acne.	Topical retinoid therapy e.g. ▪ Adapalene 0.1% +/- benzoyl peroxide 2.5% EPIDUO Gel ▪ Isotretinoin 0.05% + erythromycin 2%	

Criteria for Referral

The main reason for referring a patient with acne is for Isotretinoin treatment.

The indications for Isotretinoin treatment are as follows:

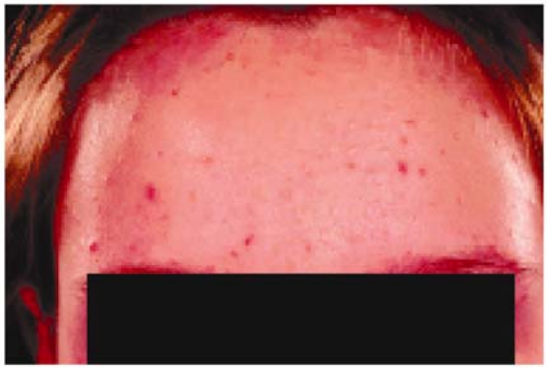
1. Severe nodulo-cystic acne or acne fulminans (refer immediately).
2. Moderate acne that has failed to respond to prolonged (i.e. more than six months) courses of systemic antibiotic treatment in addition to topical treatment.
3. Mild to moderate acne in patients who have an extreme psychological reaction to their acne and have failed to respond to prolonged courses of systemic antibiotic treatment and topical treatment.
4. Acne which is scarring – Most patients with acne can be managed in primary care. They should, however, be referred to service if they:
5. Are suspected of having an underlying endocrinological cause for the acne (such as polycystic ovary syndrome) that needs assessment.
6. Have, or develop, features that make the diagnosis uncertain

In addition, the following results should accompany the referral letter:

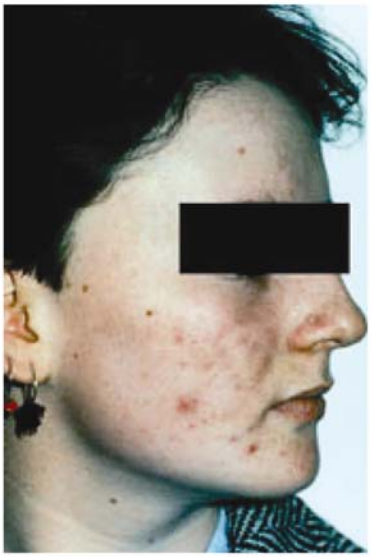
- Full blood count
- Biochemical profile
- Fasting lipids

Females of child bearing age should preferably be established on an oral contraceptive prior to treatment with Isotretinoin

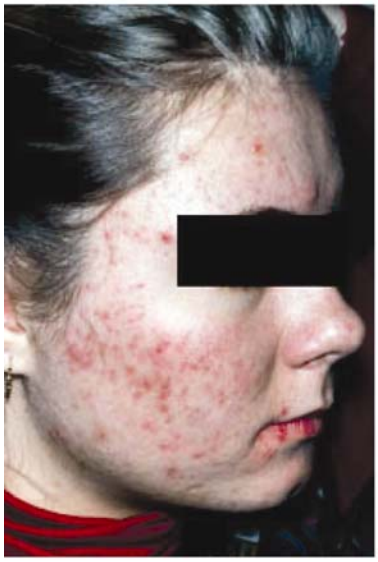
Acne



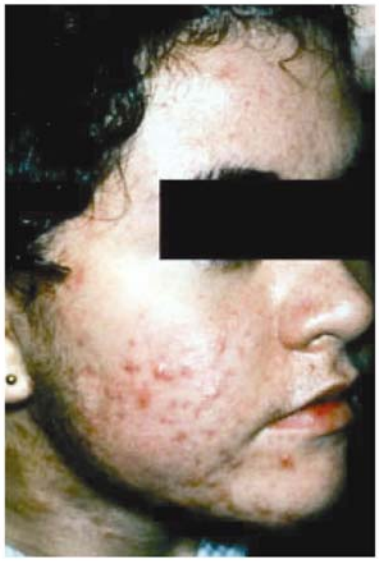
Mild



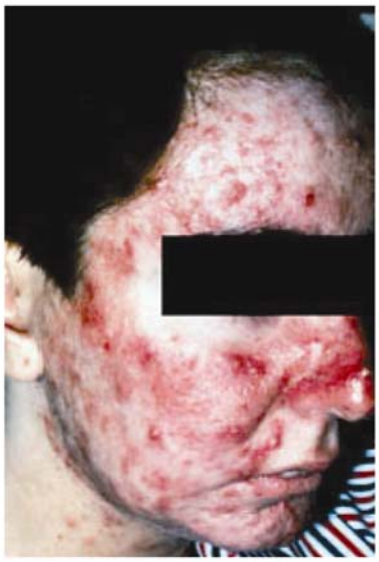
Mild–Moderate



Moderate



Moderate Severe



Severe

Treatment aims:
- To achieve remission

Section 2: Rosacea

Clinical features

- Flushing often made worse by alcohol, spicy foods, hot drinks, temperature changes or emotion
- Telangectasia
- Papules on erythematous background
- Pustules
- Facial disfigurement
- Intermittent or permanent
- Rhinophyma

Treatment

Therapy is aimed at treatment of inflammatory lesions (pustules or papules). The symptoms of flushing and erythema are not likely to be helped by topical or systemic antibiotics.

Topical Treatment

- Metronidazole Gel/Cream bd

Systemic Treatment

- Tetracyclines/Oxytetracycline 500mg bd
- Lymecycline 408mg od

2nd Line- following specialist advice

- Minocycline 100mg od. Minocycline may rarely cause auto immune hepatotoxicity. LFT's should be checked every 3 months in patients who are on long term therapy.

Therapeutic tips

Early treatment of rosacea is considered to be important as each exacerbation leads to further skin damage and increases the risk of more advanced disease.

Intermittent therapy can be considered for those with very occasional flare-ups but as detailed later frequency of recurrences can be reduced by maintenance therapy.

Mild to moderate cases or where systemic treatment is contraindicated. May be introduced at the end of a course of oral antibiotics to allow their tapering and withdrawal.

Preparations with a gel formulation tend to be less cosmetically acceptable to patients.

Avoid topical steroids.

Continue therapy for 6-12 weeks although response is normally more rapid.
NB. Tetracycline is contraindicated in pregnancy, lactation and renal disease.

Continue treatment for 6-12 weeks.
NB. Both drugs can cause photosensitivity.

Patients should be advised to avoid direct sunlight and to wear a suitable sun block when going outside.

Advise patient on lid hygiene to manage blepharitis.
Consider artificial tears

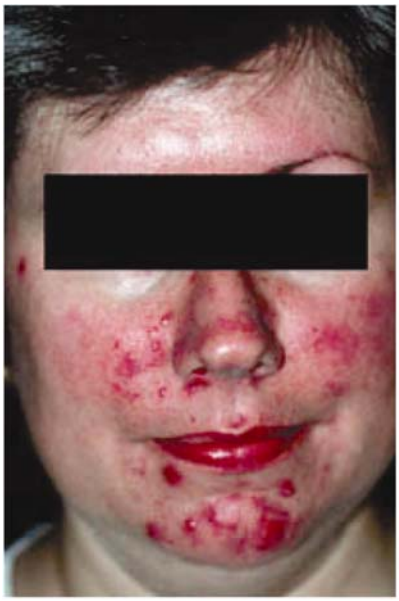
Cont/.

Clinical features	Treatment	Therapeutic tips
Surgical Treatment	Tuneable dye Laser Intense pulsed light Surgical shaving with diathermy and cryosurgery	Useful in the treatment of telangectasia. For the treatment of rhinophyma. Patient counselling Patients can be advised on a number of issues: heat and cold, alcohol and cosmetics all of which can provoke flushing. Stress management may also be considered.

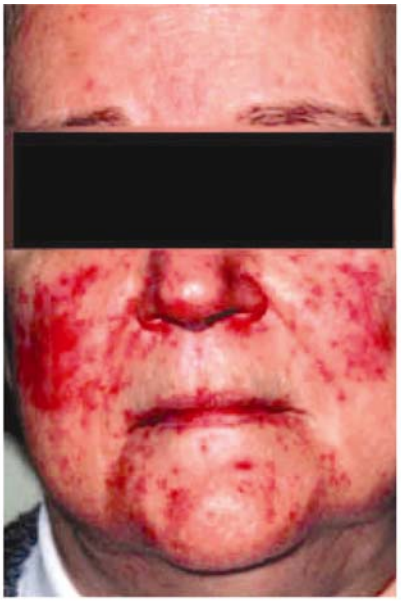
Criteria for Referral

- Doubt over diagnosis
- Severe disease associated with the development of pyoderma faciale.
- Severe Ocular Rosacea with keratitis or uveitis. (Refer to Opthalmologist)

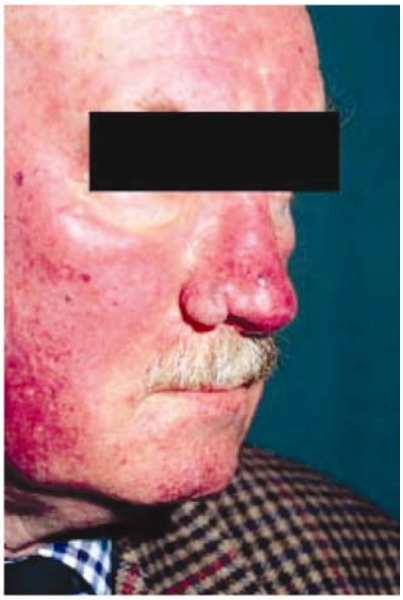
Rosacea



Rosacea



Rosacea



Rosacea (with Rhinophyma)

Section 3: Viral warts and molluscum contagiosum

Clinical features	Treatment	Therapeutic tips
Viral Warts and Verrucae These two viral induced lesions are common especially in children and are self-limiting. There are no easy or guaranteed treatments or magic cures and are best left to resolve spontaneously. Greater than 60% of hand and facial warts clear within two years, plantar warts tend to be most persistent.	Use a high concentration salicylic acid preparation such as: ▪ Salicylic acid 11% + lactic acid 4% in collodion (cuplex) ▪ Salicylic acid 26% in polyacrylic solution (Occlusal) ▪ Salicylic acid 50% in paraffin base (Verrugon)	Instruct the patient that this should be applied daily after bathing and rubbing down the softened skin with pumice stone or sandpaper. This may need to be continued for many months. Protect the area after application.
Molluscum Contagiosum 90% of mollusca clear within one year. However molluscum may be persistent in atopic children.	▪ Cryotherapy every 3 weeks Pare down with a scalpel first	Best performed at three weekly intervals with one freeze thaw cycle on the hands and two on the soles, (hands 70% cure rate after four treatments, plantar warts 40%). If there is no sign of improvement after four or five treatments then it is unlikely to be effective and should be discontinued. Affected children should have their own towels to reduce the risk of transmission to siblings. Individual lesions will resolve if the central core is damaged by any modality including cryotherapy but this is not recommended in young children, as it is too painful.
	Treat associate eczema or impetiginisation with: ▪ Emollients ▪ Mild topical steroids +/- antibiotic therapy ▪ Crystacide (hydrogen peroxide 1% cream)	Resistance to topical therapy is an increasing problem. It is therefore advised that they are used at therapeutic doses for a **maximum of two weeks**.

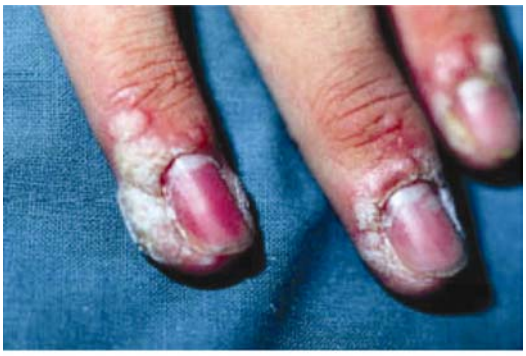
Criteria for Referral

In general patients with viral warts/verrucae and molluscum should not be referred.

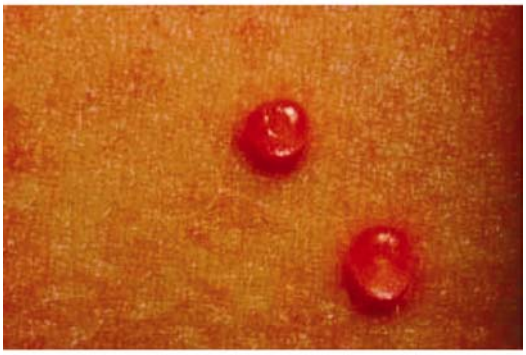
Patients may be referred if:

- Severe disabling warts despite six months of topical salicylic acid treatment +/- cryotherapy.
- Significant warts or Molluscum contagiosum in immunocompromised patients.

Viral warts and molluscum contagiosum



Viral warts



Molluscum contagiosum

Section 4: Scabies

Management

Human scabies is an infestation of the skin caused by the mite Sarcoptes scabiei.

The mites are most readily transmitted from one person to another by close physical contact in a warm atmosphere i.e. sharing a bed, adults tending to children, children playing with each other or young people holding hands. An individual who has never had scabies before may not develop itching or a rash until one month or even three months after becoming infested.

There is usually
- Widespread inflammatory papular eruption
- Burrows on non hair bearing skin of the extremities
- Pruritic papules around the axilla periareola regions, umbilical region and buttocks.
- Inflammatory nodules on the penis and scrotum.

The reactive rash to scabies can be eczematous or urticarial.

Impetiginisation may also occur. There is usually more than one family member afflicted.

Treatment

Treat patients when there is a strong clinical suspicion that they may be infested.

The first and essential step is to kill all the mites in the skin using a scabicide.
Apply either:
- Malathion 0.5% Aqueous solution
- Permethrin 5% Cream – not in pregnancy

Rub it in gently to all parts of the body or apply it using a 2" (5cm) paint brush.

Suitable quantities for body application:
Skin cream ~30-60g
Lotions ~100ml

Literally all the skin below the chin must be treated including the web spaces of the fingers and toes, under the nails and in all body folds.
2 applications - a week apart.

Malathion should be left on the skin for 24 hours and Permethrin for between 8-12 hours.
An extra application over night on the hands and arms would be advised.

Treat residual itchy areas with:
- Topical anti-pruritic Crotamiton cream
- Crotamiton combined with hydrocortisone.

Therapeutic tips

Counselling points:
Advise patients that itching may continue for at least a 6 weeks after successful treatment.

Use with caution in pregnancy.
Avoid unless clinically essential (Malathion 0.5% may be used in pregnancy if considered essential)

It is mandatory that all members of the household and any other close social contacts of an infested person should receive appropriate treatment at the same time as the patient **regardless of signs and symptoms.**

Remind patients to reapply the scabicide after washing their hands.

In children <5yrs and the elderly it is recommended to treat the face and scalp.

At the end of this period the patients can bath, change their underclothes, sheets and pillowcases.
Applications of longer duration than three weeks should be avoided.

If a second course is required a break between treatments of at least one week is recommended.

Disinfestation of clothing and bedding other than by ordinary laundering is not necessary.

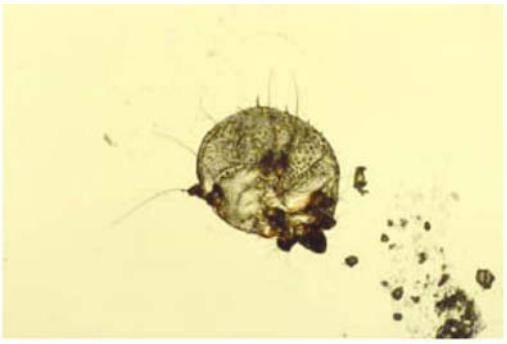
If these directions have been followed, all mites in the skin will have been killed but the pruritus takes 3-6 weeks to settle.

Do not allow the use of scabicides to these pruritic areas as repeated applications may irritate the skin.

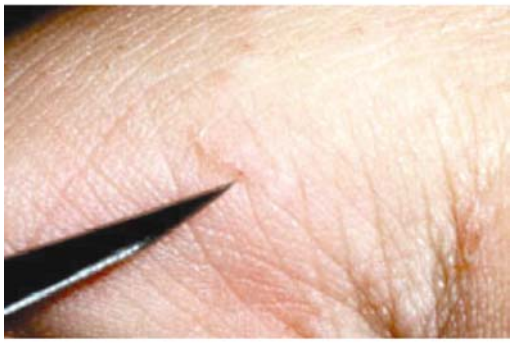
Criteria for referral

- ❑ Patients who have not responded to two courses of scabicides, and itching continues after six weeks despite topical anti-pruritic.

Scabies



Sarcoptes Scabies



Burrow

Section 5: Onychodystrophy (thickened and dystrophic nails)

Clinical features

The thickness of nail plates is normally 0.5mm; this consistently increases in manual workers and many disease states such as:

- Onychomycosis (Dermatophyte fungal infection)
- Psoriasis
- Chronic Eczema
- Lichen Planus
- Alopecia areata
- Norwegian scabies
- Darier's Disease
- Old age
- Trauma e.g. from footwear
- Congenital ichthyosis

Treatment

If mycology is positive use:

- Terbinafine 250mg od 12-16 weeks for toenails, 6-12 weeks for fingernails. If repeat treatment is necessary, leave a gap of three to four months before repeating. (Check Liver Function Tests first).
- Amorolfine nail lacquer 5% Apply once a week after filing and cleansing. Treatment should continue for 6 months for finger nails and 12 months for toe nails.
- Itraconazole 200mg Pulse treatment, 3 pulses of bd for 7 days repeated monthly (3 cycles for toenails, 2 for fingernails) - **only use if no response to two courses of terbinafine** (Check Liver Function Tests first).

Therapeutic tips

General cutaneous examination and examination of all the nails is necessary.

Avoid liquorice if taking terbinafine (diarrhoea)

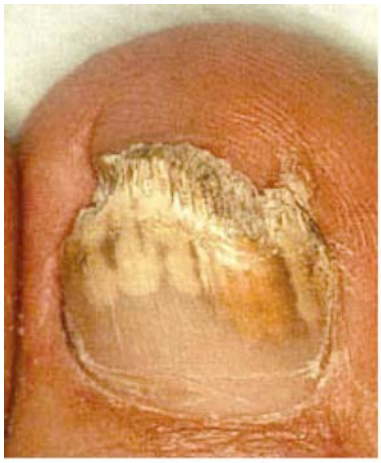
Send samples (**nail clippings including scrapings of thickened crumbly material on the underside of the nail if present**) for mycology.

Always obtain positive mycology before starting oral antifungal agents.

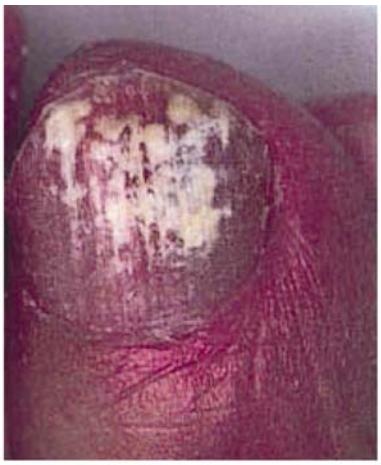
If negative, arrange for regular chiropody to keep nails short and thin.

Asymptomatic patients may be advised to 'leave well alone'.

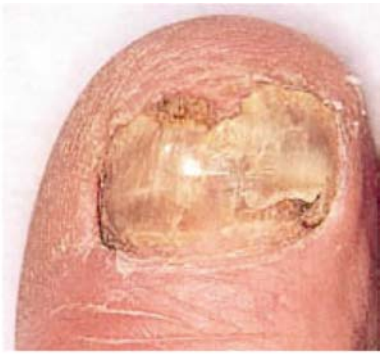
Onychodystrophy



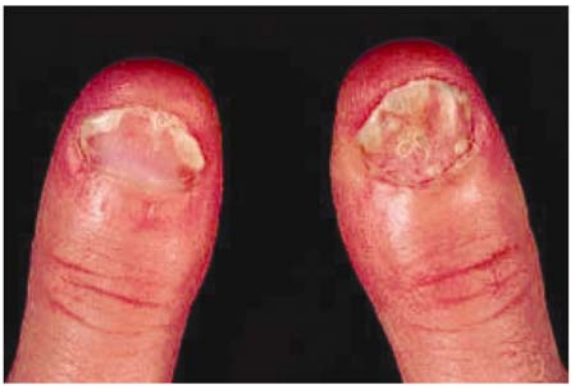
Non-matrix Onychomycosis



Non-matrix Onychomycosis
(superficial white Onychomycosis)



Matrix involved Onychomycosis



Psoriatic nail

Section 6: Impetigo

Clinical features

Characteristic yellow crusted lesions, most commonly found on the face, typically there are also scattered surrounding lesions (satellite lesions).

Lesions are rarely painful

Treatment

For small localised lesions topical antibacterials may be used for **up to two weeks.**

- Crystacide (hydrogen peroxide 1%) cream
- Mupirocin 2% Ointment tds

In patients who do not respond to topical therapy, or those who have spread to large areas, lymphoedema or systemic illness oral antibiotics may be used:

- Oral Flucloxacillin 500mg QDS for 7 days
- If penicillin allergic Erythromycin may be used

If there is no response to treatment:

- Take swabs to exclude resistant organisms
- Do not repeat courses of topical antibiotics
- Consider underlying cause

Therapeutic tips

Crusting lesions or exudates may be softened and removed if possible by soaking in warm water or povidone iodine solution.

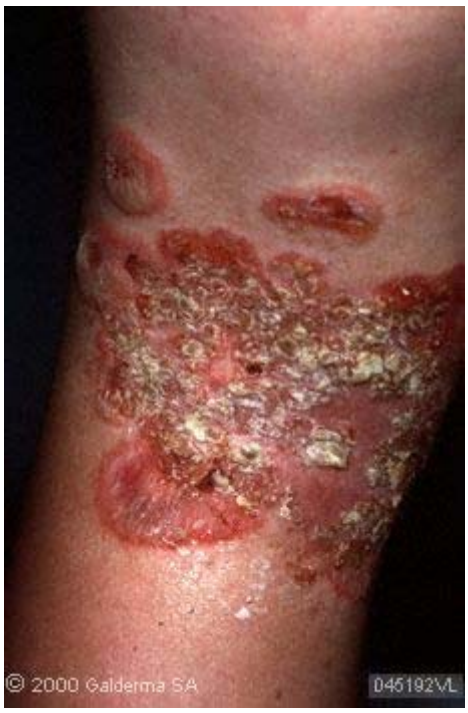
Mupirocin may sting on contact and should be used with caution in renal impairment. **(Mupirocin ointment is not interchangeable with the cream)**

Preventing transmission:
-Wash hands after touching patches of impetigo.
-Avoid sharing towels, flannels etc until the infection has gone.
-Children with impetigo should stay off school until there is no crusting.

Criteria for referral:

- Severe and / or unresponsive impetigo
- In cases of significant outbreak it may be advisable to contact the local consultant in communicable diseases.

Impetigo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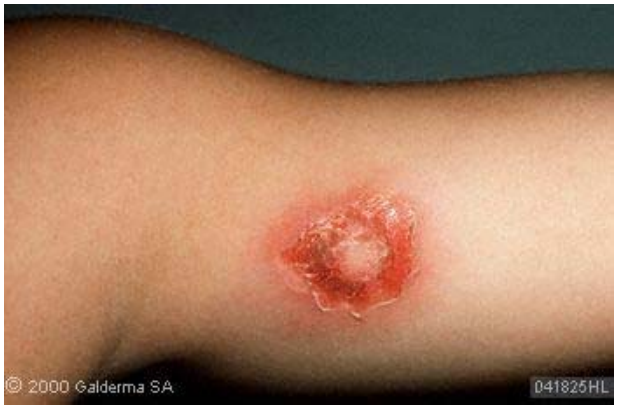
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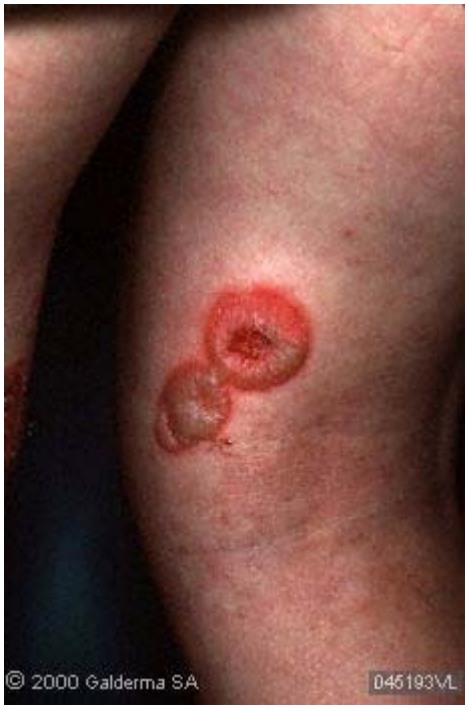
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Section 7: Urticaria and Angioedema

clinical features

Explain the condition to the patient and reassure that it is benign and usually self-limiting

Minimise:
- Overheating
- Stress
- Alcohol
- Caffeine

Review:
- Drug history

Both prescribed and non-prescribed as many drugs have been reported to cause Urticaria such as penicillins, statins and NSAID's. (Especially aspirin) Additionally opiates and NSAID's may exacerbate existing urticaria. ACE inhibitors can cause angioedema.

Exclude
- C1 Esterase Deficiency (if angioedema is the only sign)
- Insect bites

Check:
- FBC
- Thyroid function tests
- Complement levels C3C4 if clinically indicated

Treatment

Antihistamines

There is relatively little to choose between different antihistamines but individuals may vary in their response to different agents.

Sedative or non-sedative antihistamine choice depends on the need for sedation. Many antihistamines block histamine wheals and itching but do not suppress the rash completely. Use continuous medication if attacks occur regularly. Use fast acting antihistamines as required for sporadic attacks. If there is no response to one agent after six weeks, try a second and then a third agent.

In some cases of severe acute urticaria such as penicillin reaction, a short reducing course of Prednisolone starting at 30mg – 40mg od may be useful.

- Systemic steroids should never be used in chronic urticaria.

Therapeutic tips

In the majority of patients with urticaria no underlying trigger factor or associated disease is found and the condition is self-limiting.

Prick tests and RAST tests are not useful as a screening test of potential allergens in chronic ordinary urticaria.

Food allergy is usually obvious and trigger factors such as crustaceans, fish and nuts can be easily identified.

Contact urticaria is generally suggested by the history and can be confirmed by contact urticaria tests that are different to patch tests, which have no place in the investigation of urticaria.

Physical urticarias including:
- Dermagraphism
- Cholinergic urticaria
- Cold urticaria
- Solar urticaria
- Pressure urticaria

Can usually be identified on history.

Urticaria may follow non-specific infections, hepatitis, streptococcal infections, campylobacter and parasitic infestation. Rarely it may be a symptom of an underlying systemic disease such as thyroid disease or connective tissue disease.

Avoid drugs which may lower the threshold for urticarial reactions such as NSAIDs (salicyclates), ACE inhibitors and opiates.

Cont./

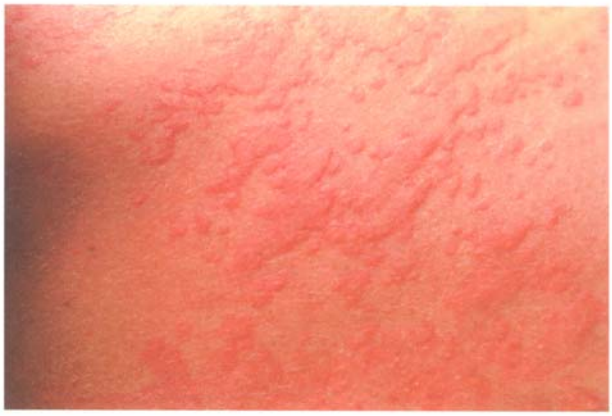
Summary of antihistamines

Name	Drug interactions	Comments
Non/low sedating		
Cetirizine	No significant interactions	Minimal sedating. Half the dose in renal impairment. Avoid in pregnancy. (Refer to BNF)
Fexofenadine	Avoid antacids containing aluminium or magnesium within 2 hours of fexofenadine (reduced absorption of fexofenadine).	Avoid in pregnancy.
Loratadine		Avoid in pregnancy. Reduce dose to alternate days in hepatic impairment. Avoid in pregnancy.
Rupatadine	No significant interactions	Avoid in pregnancy/ liver and renal impairment. Not for under 12 years. On specialist advice only.
Sedating	All sedative antihistamines should be avoided in the third trimester.	
Chlorphenamine	Increased sedative effects when given with alcohol.	
Alimemazine	Increased sedative effects when given with alcohol.	
Hydroxyzine	Increased sedative effects when given with alcohol.	

Criteria for referral

- Patients should be commenced on an effective antihistamine and referred.
- Urticaria is severe
- Does not respond to adequate trial (4-6 weeks) of an antihistamine if mild / moderate
- If urticaria lasts >6weeks
- Consider referral to immunologist

- Urticaria



Urticaria

Section 8: Generalised pruritis

Clinical features

Dry skin, eczema and scabies are the commonest cause of generalised pruritus.

If someone is itching all over, take a full history and examine the skin very carefully.

Treatment

- Standard emollients and soap substitutes.
- Crotamiton or Crotamiton combined with hydrocortisone cream. Apply daily/pm to pruritic areas.
- 1% Menthol in Aqueous cream. Apply as often as felt necessary to pruritic areas.
- Balneum Plus

If symptoms are still uncontrollable and/or there is a lot of anxiety consider

- Doxepin 50mg nocte on specialist advice
- Amitriptyline 30-150mg nocte

Sedating antihistamines

- Hydroxyzine 25mg nocte
- Chlorphenamine 4mg nocte/tds

The use of potent topical steroids should be discouraged.

Therapeutic tips

If NO RASH can be seen other than excoriations consider the following:

- Anaemia
  Especially iron deficiency. (If serum ferritin is less than 70 then patients should be prescribed iron supplements with vitamin C)
- Uraemia
- Obstructive jaundice
- Thyroid disease both hypo and hyperthyroidism
- Lymphoma, especially in young adults
- Carcinoma, especially in middle age and elderly
- Psychological

A full general examination may be helpful.

Organise the following investigations:

- FBC and differential
- ESR
- Urea and electrolytes
- LFT's
- Thyroid function tests
- Serum Ferritin
  (levels should be above 100)

NB. Pruritis may occasionally predate a lymphoma by several years. Close supervision is necessary.

Section 9: Psoriasis

Clinical features

Psoriasis is a chronic relapsing condition; mild to moderate involvement can usually be managed in primary care. Prior to referral, basic treatment should be tried as outlined.

Nursing input by an appropriately skilled nurse at this stage will decrease need for referral to secondary care. (Contact dermatology department for details of nurse training courses).

Treatment

Chronic Plaque Psoriasis

First line therapy:

1 Vitamin D analogues

- Calcipotriol/betamethasone dipropionate gel (Dovobet®Gel)

The recommended treatment period is 8 weeks for body and 4 weeks for scalp. After this period this repeated treatment can be initiated under specialist advice.
Apply once daily.
Maximum dose should not exceed 100gm per week.

- Calcipotriol Betamethasone Dipropionate Ointment (Dovobet®) The recommended treatment period is for 4 weeks. After this period repeated treatment can be initiated under specialist advice. Apply once daily.
Maximum dose should not exceed 100gm per week.

- Calcipotriol (Dovonex®) ointment
  Apply generously twice daily (up to 100g weekly)
- Calcitriol
  Apply twice daily (up to 200g weekly)

2 Tar preparations
Apply away from flexures twice daily

3 Dithranol preparations

Start with the lowest strength, applied daily to plaques for 15-30 minutes only, then wash off. Increase through strengths weekly unless irritancy occurs. Prescribe range:
Eg

- Dithranol 0.1%
- Dithranol 0.25%
- Dithranol 0.5%
- Dithranol 1.0%
- Dithranol 2.0%

As this counts as one prescription item. (Or Dithranol 1% and 3%).

Therapeutic tips

Some patients may prefer the cosmetic acceptability of a gel to an ointment. Dovobet®Gel can be used on body and scalp.
Some patients may find ointment more effective than gel.

Calcitriol is licensed for use on face and flextures in addition to psoriasis on trunk and limbs.Expect improvement to be gradual.
Achieving maximum effect over up to 12 weeks treatment. If useful can be continued long term or intermittently.
If used correctly many patients will achieve at least flattening and partial clearance of plaques.

Refer to agreed specials list on HEY formulary.
Refined tar products are less smelly or messy than old unrefined preparations.
May stain clothes or irritate. Expect slow response over 6-12 weeks.

Can be used as short contact therapy at home, away from face, flexures and genitals.

Often very effective if performend correctly with good remission time but time consuming to do therefore only useful if patient is well motivated.

Stains everything including skin and may cause irritation of the skin.

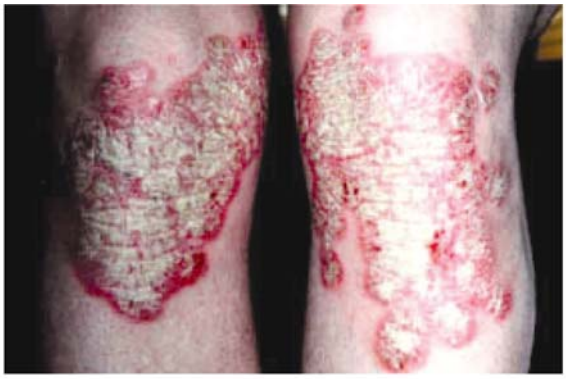
Refer to agreed specials list.

Clinical features	Treatment	Therapeutic tips
	4 Topical Retinoid ▪ Tazarotene Apply daily and pretreat plaque and surrounding skin for one hour with Vaseline/WSP to reduce risk of irritancy. Start with 0.05% increasing to 0.1% preparation.	Give adequate quantities of topical preparations appropriate to extent of disease. May be useful in fairly limited disease (<10%) with well defined plaques. May irritate the skin in which case it can be combined with a moderate potency topical cortiscosteroid such as clobetasone butyrate 0.05%.
Guttate Psoriasis Numerous small lesions, mostly on trunk, generally affecting children/young adults acutely. Often self-limiting over 3-6 months.	Treat with emollients plus trial of tar preparations, vitamin D analogues or moderate potency steroid e.g. clobetasone butyrate (Eumovate) 0.05%. If severe, early referral for phototherapy may be the best option.	
Scalp Psoriasis	Generally requires combination of keratolytic and anti-inflammatory agents.	
	▪ Calcipotriol/betamethasone gel (Dovobet® Gel) od Recommended treatment for 4 weeks. After this period repeated treatment can be initiated under specialist advice.	Arachis oil, massaged into the scalp overnight prior to shampooing, followed by combing with a fine tooth comb eg lice detector comb, may be beneficial. Calcipotriol/betamethasone dipropionate (Dovobet® Gel) can also be used for Chronic Plaque Psoriasis on the body. See previous page.
	▪ Calcipotriol 50 micrograms/ml scalp Application plus coal tar based shampoo.	
	If very itchy a topical steroid could be substituted. In more severe cases use keratolytic e.g. Cocois ointment massaged in and left overnight, washed out in the morning plus topical potent steroid e.g. ▪ Betamethasone 0.1% scalp application ▪ Betamethasone 0.1% combined with salicylic acid 3% ▪ Fluocinolone 0.025%gel Apply once to twice daily.	
Flexural Psoriasis Affects smooth well demarcated areas in axillae, groins, inframammary folds and natal cleft. May occur alone or with chronic plaques elsewhere.	Use mild to moderate potency steroids combined with antibiotic or antifungals e.g. ▪ Trimovate cream Apply once to twice daily.	Often partial response only is achieved.

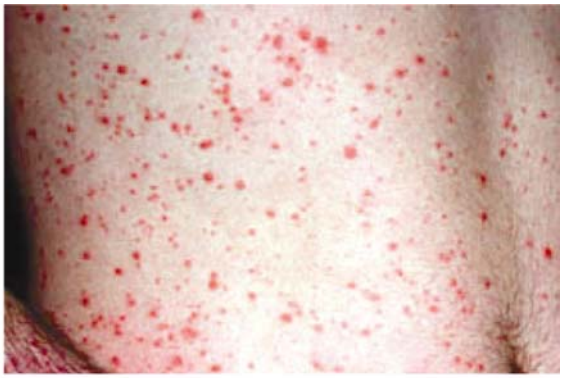
Criteria for referral

- Extensive/severe or disabling psoriasis
- Failure to respond to adequate treatment or rapid relapse post treatment
- Extensive acute guttate psoriasis
- Unstable and generalised pustular psoriasis

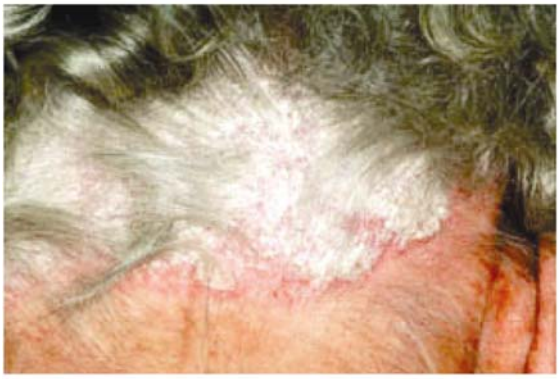
Psoriasis



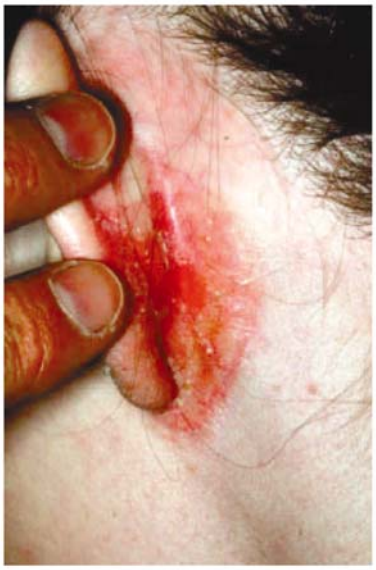
Chronic Plaque Psoriasis



Guttate Psoriasis



Scalp Psoriasis



Flexural Psoriasis

Section 10: Eczema in adults

Clinical features

A small number of adults have severe, generalised and lichenified atopic eczema.

Dry skin in the elderly can sometimes develop into asteatotic eczema.

Venous stasis (or varicose) eczema is associated with underlying venous disease. Signs of chronic venous hypertension in the lower legs are accompanied by eczema at this site.

Discoid eczema is a form of constitutional eczema characterised by circular, well-demarcated lesions on the trunk and limbs.

Seborrhoeic dermatitis is a form of chronic eczema involving hair-bearing skin. It typically involves the scalp and eyebrows, and naso-labial folds and is sometimes more extensive.

Treatment

General treatment measures
- Soaps and detergents including bubble bath and shower gels should be avoided.
- Cotton clothing should be used and avoid wool next to the skin.
- Fingernails should be kept short to reduce skin damaged from scratching.
- Bathing is not harmful but an emollient has to be used.

Emollients
Emollients should be prescribed in all cases. Added to the bath e.g.
- Oilatum – non-fragrance preparation
- Balneum

Used directly on the skin during and after bathing
- Epaderm cream
- Balneum cream
- Balneum Plus cream
- Diprobase
- Zerocream/Zerobase
- E45
- Nutraplus
- Hydromol

Greasier preparations e.g.
- Epaderm ointment
- Soft White Paraffin

are better at hydrating dry skin.

Topical Corticosteroids

Mild
- Hydrocortisone 1%

Moderate
- Clobetasone butyrate (Eumovate)

Potent
- Mometasone furoate 0.1%
- Fluticasone propionate 0.05%
- Etrivex shampoo (steroid based). (Clobetasol proprionate 0.05% shampoo).

Therapeutic tips

Potent topical steroids are often required to control discoid eczema.

Asteatotic eczema responds to emollients combined with mild to moderate topical steroids.

Venous stasis eczema usually requires long-term treatment with an emollient combined with a moderately potent topical steroid. Consider referral for patch testing if fails to respond to treatment +/- compression hosiery.

In patients with atopic eczema NICE recommend (TAG 81) topical corticosteroids should be applied once or twice daily. It is recommended that where more than one alternative corticosteroid is considered clinically appropriate the one with the lowest acquisition cost should be used, taking into account pack size and frequency of application. (full guidance available at www.nice.org.uk)

Seborrhoeic dermatitis may be managed with initially with a steroid combined with an imidazole (e.g. hydrocortisone1% combined with miconazole 2%, or clotrimazole 1% combined with Hydrocortisone 1% may be used initially , then switch to the single agent imidazole preparation.

Criteria for referral:

- For topical tacrolimus treatment
- Severe uncontrolled eczema not responding to current therapies

For examples see section 12 – Atopic Eczema in children

Section 11: Hand Eczema

clinical features

A Endogenous Eczema (e.g. atopic)

B Exogenous Eczema

(i) Contact Irritant Eczema
Due to substances coming into contact with the skin, usually repeatedly, causing damage and irritation.
Substances such as:
- Detergents
- Shampoos
- Household cleaning products
- Soaps
- Solvents or degreasing agents
- Dust and friction
- Metal-working fluids
- Wet working environment

(ii) Contact Allergic Dermatitis
Due to type IV allergic reaction to a substance when the skin is in contact with.
- Metals (Nickel, chromate)
- Perfumes
- Rubber and latex
- Preservatives

All types of endogenous and exogenous eczema can present with either 'wet' (blistering and weeping) or 'dry' (hyperkeratotic and fissured) eczema.

treatment

Avoidance of irritants
Soap substitutes such as Aqueous cream should be used. Gloves e.g. household PVC gloves should be used for wet work such as dishwashing. Gloves may also be required for dry work e.g. gardening.

Emollients
These should be applied frequently; ideally when the skin is moist (such as immediately following a bath)
There are a variety of emollients available, which vary in their degree of greasiness. Different patients will prefer different preparations.
Light/creamy
- Dermol cream
- Diprobase cream
- Epaderm cream
- Cetraben cream
- Hydromol cream
- Balneum and Balneum Plus cream

Greasy emollients
- Epaderm ointment
- Emulsifying ointment
- White Soft Paraffin/liquid paraffin 50/50
- Hydromol ointment

Topical Steroids
The strength of topical steroid required varies from case to case. However, it is often necessary to use a potent topical steroid short term. Prescribe a cream formulation if 'wet' and ointment if 'dry'.

Potassium permanganate (Permitabs) 1:10000 soaks for fifteen minutes daily for acute wet eczema until blistering weeping has dried.

Antibiotics (topical/systemic)
Exclude secondary infection and treat if appropriate.

therapeutic tips

Other skin conditions can mimic eczema and should be kept in mind. It is usually worth examining the patient's skin all over as this can provide clues to other diagnoses e.g. plaques in extensor distribution in psoriasis, scabetic nodules.

If contact dermatitis is suspected a careful occupational and social history should be taken and the patient will require Patch Testing.

Patch Testing is only of value in patients with eczema. It is of no use with type 1 reactions (e.g. food allergies causing anaphylaxis or urticaria). In practice the cause of eczema is often multifactorial with external factors precipitating eczema in a constitutionally predisposed individual.

If eczema is present on only one hand a fungal infection needs to be excluded by taking skin scrapings for mycology.

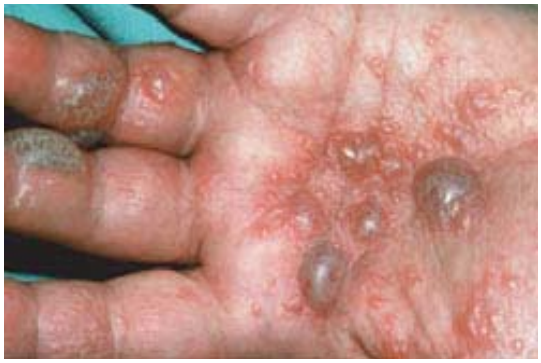
Limited evidence for combinations of steroid and antibiotic preparations. Topical antibiotics should be avoided or reserved for single small lesions, following microbiology testing for sensitivity

Resistance to topical antibiotics is an increasing problem. It is therefore advised that their use is limited to a maximum of **two weeks.**

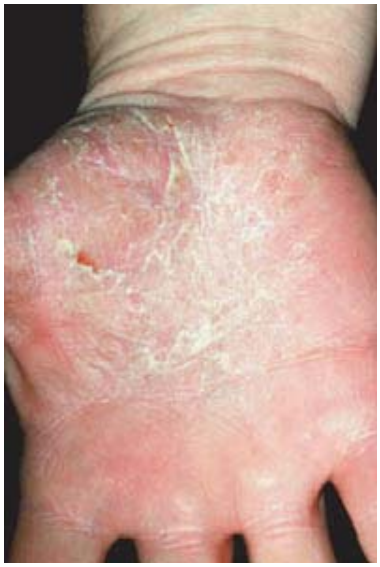
Criteria for Referral

- For patients unresponsive to topical steroids, refer to secondary care for consideration of alitretinoin therapy.
- If allergic contact dermatitis is suspected and Patch Testing is therefore required.
- Severe chronic hand dermatitis, which is unresponsive to treatment described above.

Hand Eczema



"Wet" (blistering and weeping)



"Dry" (hyperkeratotic and fissured eczema)

Section 12: Atopic eczema in children

Clinical features

Atopic eczema is a common disease affecting up to 15% of children.

Involvement of the face frequently occurs in infants with adoption of a characteristic flexural distribution by the age of 18 months.

Realistic treatment aims need to be discussed with the patient and parents.

The role of specialist nursing in this area is vital. Experienced dermatology nurses are available for advice, training, optimising, compliance (adherence, concordance) etc.

NICE recommend that topical steroids for atopic eczema are used once or twice a day. Where more than one alternative is available of the same potency the agent with the lowest acquisition cost taking into account pack size and frequency of application should be used.(NICE April 2004)

Treatment

General treatment measures
- Soaps and detergents including bubble bath and shower gels should be avoided
- Cotton clothing should be used and avoid wool next to the skin
- Fingernails should be kept short to reduce skin damage from scratching.
- Bathing is not harmful but an emollient has to be used

Emollients
Emollients should be prescribed in all cases.
Added to the bath e.g.
- Oilatum – non-fragrance preparation
- Balneum
- Aveeno bath oil

Used directly on the skin during and after bathing
- Epaderm cream
- Oilatum Junior cream
- Diprobase
- Nutraplus
- Hydromol cream
- Dermol cream

Greasier preparations are better at hydrating dry skin
- Epaderm ointment
- White Soft Paraffin

Topical Corticosteroids

Mild
- Hydrocortisone 1%

Moderate
- Clobetasone butyrate 0.05% (Eumovate)
- Alcometasone dipropionate 0.05% (Modrasone)

Potent
- Mometasone Furoate 0.1%
- Fluticasone propionate 0.05%

Therapeutic tips

Some patients have a preference and you may have to supply several until the patient finds something they like and will therefore use.

Some combination preparations have extra benefits e.g.
- Calmurid (but may irritate inflamed skin)
- Dermol 500 (agent of choice when there is secondary infection)
- Dermol cream
- Emulsiderm antiseptic
- Oilatum Plus

Although potent preparations can cause skin atrophy with long term use, topical corticosteroids are often underused because of concern about side effects.

There are many agents categorised into four groups of potency. Within each potency group there is no evidence for increased efficacy or safety of any one particular product. Ointment preparations are usually more effective than creams but they are messier to use. Creams can be used if eczema is weeping or on the face.

Mild or moderately potent preparations should control most cases of eczema when prescribed in appropriate amounts. It may be necessary to gain control with a moderately potent preparation and then reduce to a mild strength.

Cont/.

Clinical features	Treatment	Therapeutic tips
Atopic eczema in children (Cont'd)	Topical corticosteroids (Cont'd)	Short term (1-2 weeks) of a potent strength product may be required, particularly for resistant lichenified lesions in older children. Avoid repeat prescriptions for potent strength corticosteroids. In dry eczema use ointments and greasier emollients e.g. white soft paraffin, Epaderm ointment, try steroid/urea ± lactic acid e.g. Calmurid HC/Alphaderm.
	Antihistamines Sedative antihistamines ▪ Chlorphenamine ▪ Alimemazine	Suitable for short term use to control itch especially at night.
Infection The commonest infecting organism is Staph aureus which produces characteristic yellow crusting.	Antibiotics Consider antiseptic moisturiser combinations: In the bath ▪ Oilatum Plus ▪ Emulsiderm ▪ Balneum Plus	Infection should be suspected whenever eczema worsens. Eczema that weeps is probably infected with staphylococcus aureus. If in doubt take swabs for microbiology.
	Directly onto the skin ▪ Dermol 500 ▪ Dermol cream	
	Topical antibacterials may be used in conjunction with a steroid for short periods of time (**maximum of two weeks)** • Crystacide (hydrogen peroxide 1% cream) • Mupirocin 2% Ointment	Mupirocin may sting on contact and should be used with caution in renal impairment. **(Mupirocin ointment is not interchangeable with the cream)** Avoid contact with acute cold sore sufferers
	If the infection is widespread or severe treat with systemic antibiotics ▪ Flucloxacillin ▪ Erythromycin	
	If recurrent infections occur take nasal swabs from the family members and if positive use: ▪ Naseptin ▪ Mupirocin 2% nasal cream	
	Bandaging Zinc paste bandages used alone or over topical corticosteroids can result in rapid improvement of resistance, particularly lichenified, eczema. Wet wrap dressings or garments may also be helpful, particularly at night in small children.	Initial training techniques may be required given by a suitably trained nurse or nurse specialist.

Cont/.

Clinical features

Allergies and allergy testing

Treatment

Keep dust down and in severe cases try protective coverings to pillows and bedding.

Consider exclusion diets only in difficult cases and abandon if no improvement is apparent after 2-4 weeks.

Therapeutic tips

The role of the house dust mite can aggravate eczema in some children.

Food allergies, especially to egg, wheat and dairy products only occasionally cause worsening of eczema.

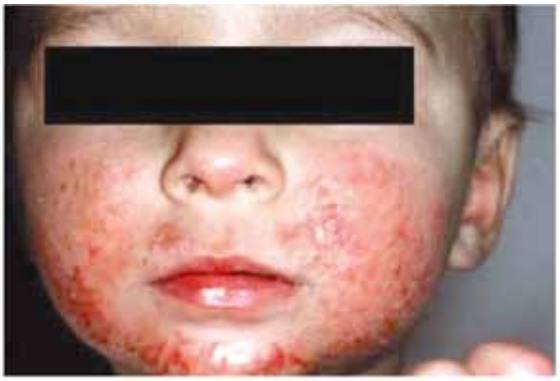
Food allergy or intolerance is often a temporary phenomenon. An attempt should therefore be made every few months to re-introduce the food in question. Dietetic advice is required if exclusion diets are used for more than 2-4 weeks.

Criteria for Referral

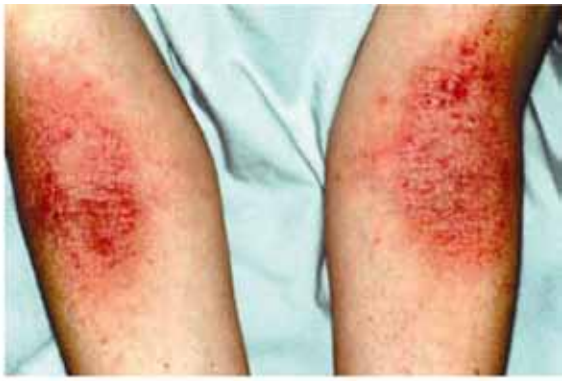
Only cases of severe or difficult eczema usually need to see a Dermatologist.

- For consideration of topical Tacrolimus treatment
- For consideration of second line treatment such as photochemotherapy and cytotoxic drugs
- Eczema herpeticum
- If allergic contact dermatitis is suspected
- For inpatient or daycase treatment
- For parent education by a Paediatric Dermatology Nurse

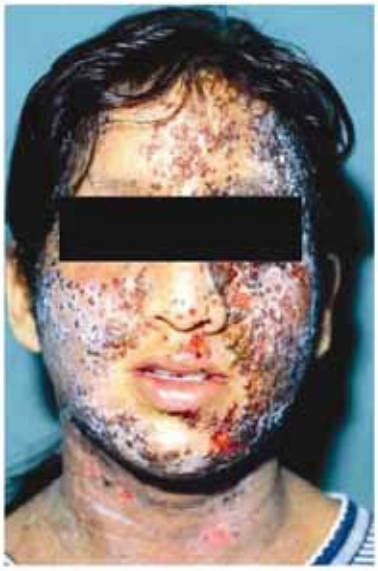
Atopic eczema in children



Atopic eczema



Flexural distribution



Eczema Herpeticum

Section 13: Solar Keratoses

Clinical features

Solar Keratoses

Also known as actinic keratoses, usually are multiple, flat reddish brown lesions with a dry adherent scale,

The vast majority of solar keratoses DO NOT progress to squamous cell carcinoma. Evidence suggests that the annual incidence of transformation from solar keratoses to SCC is less than 0.1%. This risk is higher in immunocompromised patients.

It is not necessary to refer all patients with solar keratoses.

Treatment

- Topical 5-Fluorouracil 5% Apply daily twice a week, occasionally three times a week
  If skin irritation occurs reduce application
- Topical Imiquimod cream 5% - used for 8 hours alternate nights from Monday to Friday for 6 weeks on advice from a Dermatologist.
- Diclofenac Sodium (3%) **Please note strength**. Twice daily for 2-3 months, with emollient barrier to normal skin
- Cryotherapy
  Freeze for 10-15 seconds each.

Therapeutic tips

Protect surrounding skin with emollients and use a gloved finger to apply.

Not to be handled by pregnant women.

This is the ideal treatment for widespread, multiple, ill-defined solar keratoses. It spares normal skin, allowing application to a wide skin surface. It is safe, efficacious, with little systemic absorption. Marked inflammation should occur prior to resolution and the patient must be warned to expect this. Refer to patient information leaflet supplied with product (also available at www.medicines.org.uk). Less frequent application may help if inflammation is brisk.

Optimum effect 1 month post treatment. May cause severe irritation and contact dermatitis.

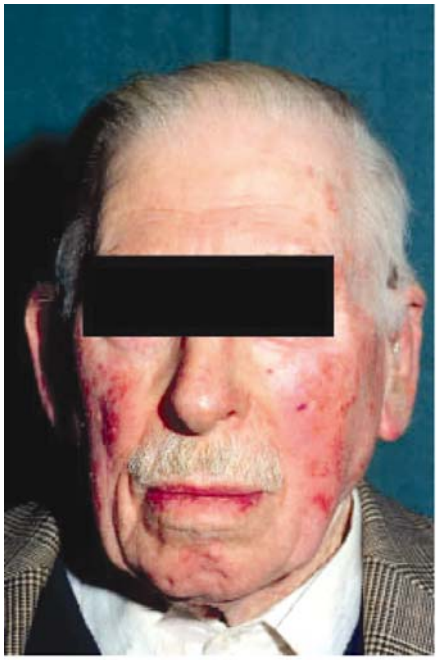
For isolated, well-defined lesions, this is the treatment of choice on specialist advice.

Criteria for Referral

- If there is a suspicion of malignancy
- If the lesions have not responded to treatment
- If the individual is on immunosuppressants (e.g. post-renal transplants).

Solar Keratoses

Solar Keratoses

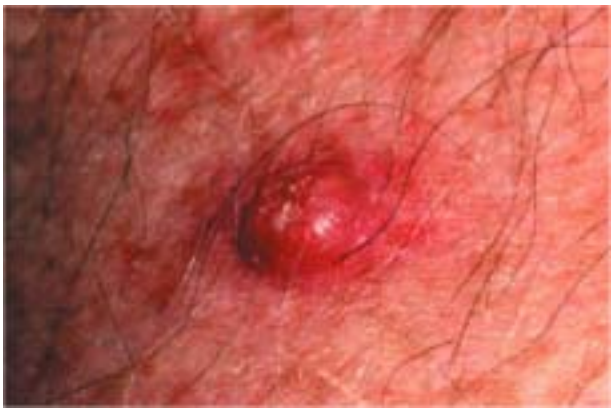


Solar keratoses

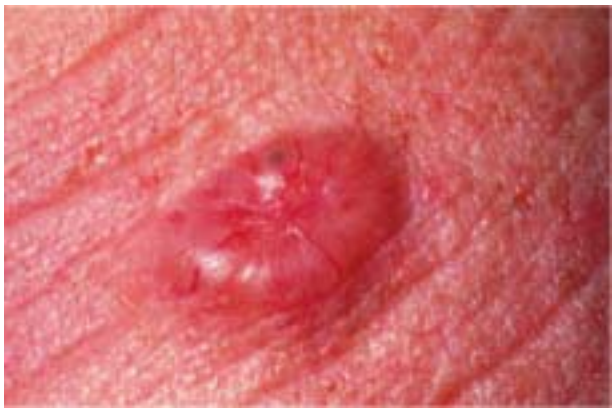
Section 14: Skin Cancer

Clinical features	Treatment	Therapeutic tips
Basal Cell Carcinoma These are common slow growing and locally invasive tumours. Most are easily recognised with a pearly rolled edge and later Central ulceration. Less common variants include pigmented or morphoeic (scar like, poorly defined) variants.	They are best managed by complete excision by the dermatology surgeons within the department and should be referred in the usual manner. In some cases radiotherapy may be a preferred option but a tissue diagnosis (i.e. biopsy) is still required prior to referral for radiotherapy and will be carried out in the Dermatology clinic. Other available options include Imiquimod cream and PDT (Photo Dynamic Therapy) on specialist advice.	Stretching the skin will often accentuate the pearly edge of lesion especially superficial BCC.
Squamous Cell Carcinoma These malignancies are much less common. They may be slow growing, well differentiated, keratinising or rapidly enlarging, poorly differentiated tumours. 5% may metastasise to regional lymph nodes.	Lesions with a high index of suspicion, especially if rapidly growing should be referred by fax within 24 hours. These patients will be subsequently assessed within the Government's two week cancer screening initiative.	Use 2 week cancer wait form
Malignant Melanoma This is the most dangerous skin malignancy. Early detection and excision is vital for good prognosis.	All suspicious moles must be referred on a 2 week pathway. Any lesion felt to be highly suspicious of melanoma will be excised on the day of clinic or within one week maximum.	Use 2 week cancer wait form, telephone dermatology secretaries or contact plastic surgery department.
Melanoma subtypes ▪ Superficial spreading ▪ Nodular ▪ Amelanotic ▪ Lentigo Maligna ▪ Acral lentiginous and subungal		

Non-Melanoma Skin Cancers

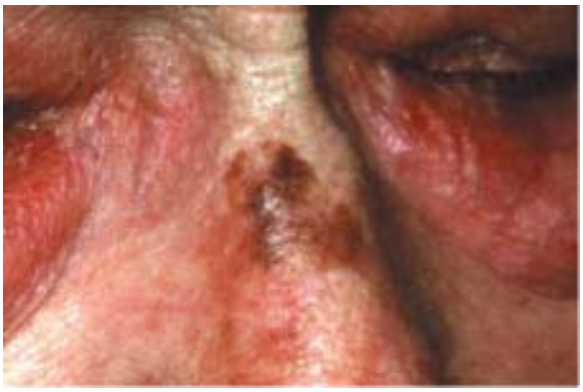


Basal cell carcinoma

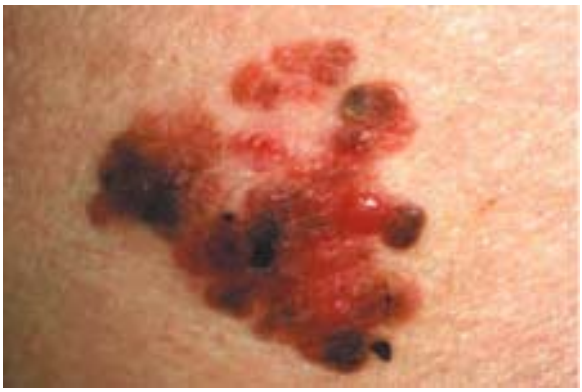


Squamous cell carcinoma

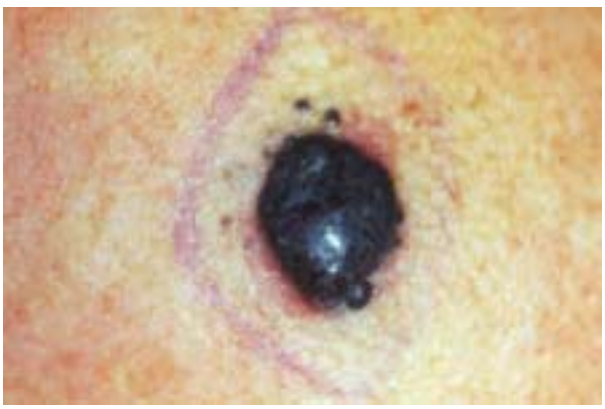
Malignant Melanomas



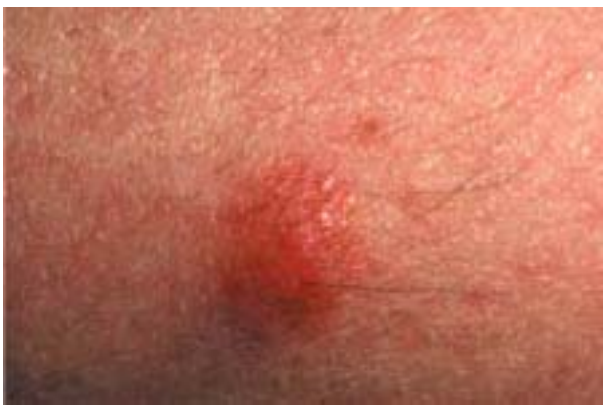
Lentigo maligna



Superficial spreading



Nodular



Amelanotic

COMMUNITY CANCER REFERRAL PATHWAY

Any General Practitioner in the community who unsuspectingly excises a skin cancer:

Basal Cell Carcinoma
Low risk if completely removed, no onward referral into secondary care required

High Risk

- **Clinical features of BCCs at high risk of recurrence (any of these):**
  Site ‘H’ zone of face (including inner canthus and alae margin), scalp, ears
  or
  Size 2cms or more or
  Circumstances;
  Immunocompromised patient
  Genetically predisposed patients (eg Gorlins Syndrome)
  Previously treated lesion
  Flat lesion, hard thickened skin (appearance of morphoeic BCC)
  Incompletely excised BCC

For the purpose of GP referral, ‘low risk BCC’ is considered to be any BCC, other than those above.

- If completely or incomplete excised, refer to the Skin Cancer MDT attaching the histology report for discussion.

Squamous Cell Carcinoma

- Refer to the Skin Cancer MDT attaching the histology report for discussion.

Malignant Melanoma

- Refer to Consultant Dermatologist under the 2 week wait guidelines if Breslow thickness is less than 1.0 mm, attaching the histology report for discussion at the Skin Cancer LSMDT for further management
- Refer to a Consultant Plastic Surgeon who is a core member of an SSMDT under the 2 week wait guidelines if
  - Breslow thickness is greater than 1.0 mm, Stage IB or higher. Attach the histology report for discussion at the Skin Cancer SSMDT for automatic consideration regarding wide excision and SNB.
  - Breslow thickness is less than 1.0 mm, Stage IB or higher with a high risk of
    - ulceration
    - high mitotic rate (or or above)
- If the report is inconclusive or requires review with the Dermatopathologist under local LSMDT, refer to the Consultant Dermatologist in the first instance. Melanoma with a breslow thickness of 1.0 mm or less without ulceration and with mitotic rate of zero (O) do not require mandatory discussion at SSMDT or referral to a consultant plastic surgeon who is a core member of an SSMDT but and MDT core member is free to decide for such a discussion/referral to be made to the SSMDT depending on individual circumstances (difficult anatomical site etc).

The local arrangement will be that patients with a new, single primary melanoma with a breslow thickness of 1.0 mm or less can have a wider excision by a dermatologist depending provided that adequate excision margins can be obtained without the need for complex reconstruction procedure. Those with breslow over 1.0 mm will be referred to plastic surgery for further management.

- Any patient with a suspicious mole or dysplastic naevus
  - < 1cm diameter refer under the 2 week wait guidelines to a Dermatologist.
  - > 1cm diameter refer under the 2 week wait guidelines to a Plastic Surgeon

Section 15: Patient Support Groups

Allergy UK Linday McManus Planwell House 35 Edgington Way Sidcup DA14 5BH Tel: 01322 619 898 Helpline: 01322 619 864 (Mon-Fri 9am-6pm) www.allergyuk.org	National Eczema Society Hill House Highgate Hill London N19 5NA Tel: 020 7281 3553 Fax: 020 7281 6395 Eczema information line: 0800 089 1122 (Mon-Fri 8am-8pm) www.eczema.org
Hairline International Ms Elizabeth Steel Lyons Court 1668 High Street Knowle West Midlands B93 0LY Tel: 01564 775281 / 01564 785980 Fax: 01564 782270 www.hairlineinternational.com	The Psoriasis Association Dick Coles House 2 Queensbridge Northampton NN4 7BF Tel: 0845 676 0076 Fax: 01604 251261 www.psoriasis-association.org.uk
Herpes Viruses Association (SPHERE) and Shingles Support Society Miss Marion Nicholson, Director 41 North Road London N7 9DP Tel: 0845 123 2305 Tel: 020 7607 9661 (office and Minicom V) Helpline: 020 609 9061 (24 hours access) www.astrabix.co.uk/sites/herpesviruses/defult.htm	Raynaud's & Scleroderma Association Trust 112 Crewe Road Alsager Cheshire ST7 2JA Tel: 01270 872776 / 0800 917 2494 Fax: 01270 883556 www.raynauds.org.uk
MacMillan Cancer Support 89 Albert Embankment London SE1 7UQ Tel: Freephone 0808 8080000 (9am-8pm Mon - Fri) www.macmillan.org.uk	Changing Faces The Squire Centre 33-37 Universiry Street London WC1E 6JN Tel: 0207 3919270 Fax: 0845 4500276 www.changingfaces.co.uk
The Vitiligo Society 125 Kennington Road London SE11 6SF Tel: Freephone 0800 018 2631 Fax: 020 7840 0866 www.vitiligosociety.org.uk	

Section 16 Dermatology Training Courses

***For General Practitioners**:*

Diploma in Practical Dermatology

Department of Dermatology, Box 27,
University of Wales College of Medicine,
Heath Park,
Cardiff,
CF14 4XM
Enquiries: Course Administrator – 02920 742885
Email: dermpostgrad@Cardiff.ac.uk
www.dermatology.org.uk

For Primary Care Nurses:

A variety of courses are available including a Diploma in Dermatology Nursing

Dermatology Nursing Education
Academic Dermatology Unit
Block C
St Woolos Hospital
Stowhill Hill
Newport, South Wales, NP20 4SZ
Enquiries: Course Administrator – 01633 238561

Dermatology Skin Club for GP's and Nurses in Hull and East Riding

A forum for GPs and nurses with an interest in Dermatology with emphasis on interface dermatology and treatment updates.
For details contact HYPERLINK "mailto:Shernaz.Walton@hey.nhs.uk" Shernaz.Walton@hey.nhs.uk.

Further information is also available on the British Association of Dermatologists website, (HYPERLINK "http://www.bad.ort.uk" www.bad.ort.uk) and the Prodigy website (HYPERLINK "http://www.prodigy.nhs.uk" www.prodigy.nhs.uk)

Reviews of dermatology conditions may also be found on the National Prescribing Centre (NPC) website (HYPERLINK "http://www.npc.co.uk" www.npc.co.uk)

Acknowledgements

Author: Dr S Walton for GP Education and Referral Advice.

Produced by the Pharmacy and Dermatology Department, Hull and East Yorkshire Hospitals NHS Trust in collaboration with the Hull and East Riding Prescribing Committee.

Grateful thanks to Dr J Mohungoo, Dr D Graham, Dr S Hakiman, Dr R Zaman, Mr C Parker, Karen Rhodes and Mrs L Elrick.

The printing of these guidelines is supported by an unconditional educational grant from LEO Pharma.