Integrated skin service
Connected care for Skin

DERMATOLOGY GUIDELINES

INTRODUCTION

The Integrated Skin Service comprises the intermediate dermatology services in East Lancashire and Blackburn with Darwen CCGs, together with the dermatology department at East Lancashire Hospitals NHS Trust.

These guidelines have been produced to assist primary care colleagues in managing common dermatology conditions appropriately and knowing what can appropriately be referred into the intermediate and secondary care services.
The guidelines are an adjunct to the ongoing programme of dermatology education events organised by the Integrated Skin Service.

Feedback on the guidelines or suggestions of other conditions to cover is welcomed and can be emailed to office@abouthealthgroup.com as the guidelines will be kept under regular review.

SUPPORT AND ADVICE

The integrated skin service is happy to offer advice on the management of patients and on whether a referral is appropriate. Access to advice from one of the dermatology team can be arranged by contacting one of the following numbers:

Intermediate Dermatology Services

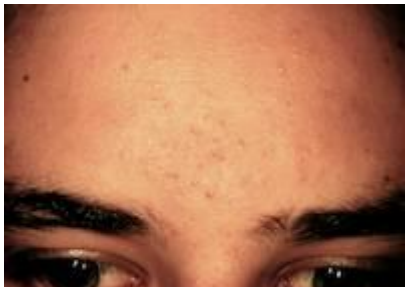
East Lancashire	01254 282930
Blackburn with Darwen	01254 617194

Secondary Care Services

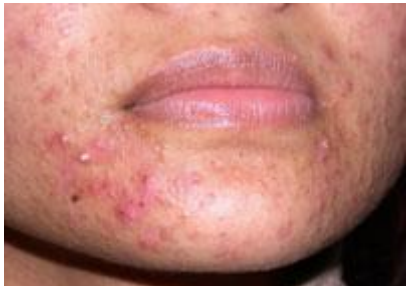
East Lancashire Hospitals NHS Trust	01254 733597

ACNE

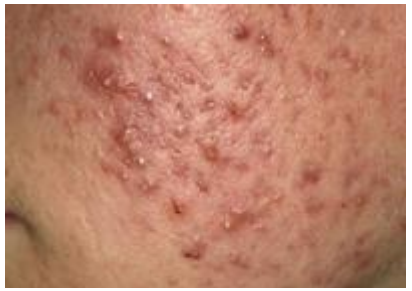
Mild Acne



Moderate Acne



Severe Acne



IMAGES - (June 2014, Dr Amanda Oakley)

PRIMARY CARE MANAGEMENT (ACTIONS BEFORE REFERRAL)

- All patients to have been on topical retinoids and or benzoyl peroxide e.g. Differin/Epiduo
- Female patients to have been tried on an antiandrogen/combined contraceptive pill if no contraindications e.g. Dianette, Yasmin,
- 2 trials of oral antibiotics of 3 months courses e.g. Lymcecycline 408mg daily (if over 12), Erythromycin 250mg bd.

APPROPRIATE REFERRALS TO INTERMEDIATE DERMATOLOGY SERVICE

- For clarification of the diagnosis if no response to treatment
- Moderate acne **(no scarring)** unresponsive to 2 trials of oral antibiotics of 3 month duration who does not want to go onto oral isotretinoin treatment.
- Patient has a history of severe depression and would not be suitable for oral isotretinoin treatment.

APPROPRIATE REFERRALS TO SECONDARY CARE DERMATOLOGY SERVICE

- at risk of, or are developing, scarring despite primary care therapies
- have moderate acne that has failed to respond to treatment which has included two courses of oral antibiotics, each lasting three months. Failure is probably best based upon a subjective assessment by the patient
- are suspected of having an underlying endocrinological cause for the acne (such as polycystic ovary syndrome) that needs assessment
- have a severe variant of acne such as acne fulminans or gram-negative folliculitis
- severe or nodulocystic acne and could benefit from oral isotretinoin
- severe social or psychological problems, including a morbid fear of deformity (dysmorphophobia)

Please note that if referring with a view to Roaccutane (Isotretinoin) therapy then pre-retinoid bloods should be done including FBC, LFT, Renal, fasting lipids and for female patients started on contraception where appropriate.

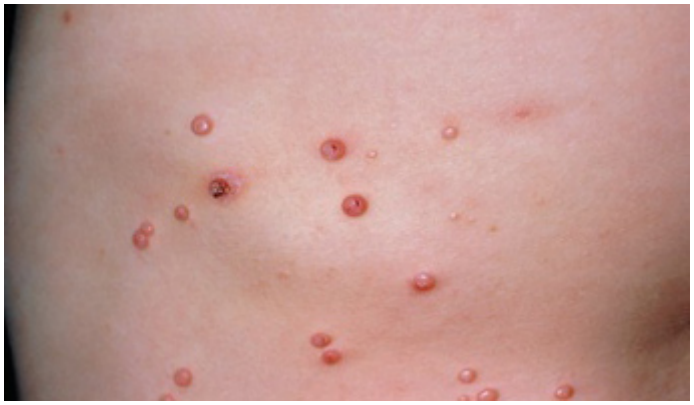
SUMMARY OF EVIDENCE / RATIONALE

Referral criteria for acne vulgaris are based on *Referral advice: A guide to appropriate referral from general to specialist services*, published by the National Institute for Health and Care Excellence (NICE). For patients requiring referral 'immediately' or 'soon', NICE specify that 'Health authorities, trusts, and primary care organizations should work to local definitions of maximum waiting times in each of these categories. The multidisciplinary advisory groups considered a maximum waiting time of 2 weeks to be appropriate for the urgent category' [NICE, 2001].

REFERENCES

Acne Vulgaris Clinical Knowledge Summary September 2014 http://cks.nice.org.uk/acne-vulgaris

MOLLUSCUM CONTAGIOSUM



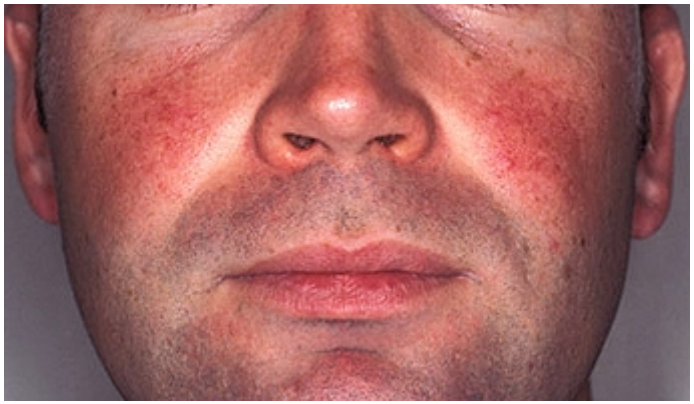
PRIMARY CARE MANAGEMENT (ACTIONS BEFORE REFERRAL)

- Most people do not require treatment. Lesions usually resolve spontaneously within 6-18 months
- The following link is a useful guide to go through with the patient explaining why the patient does not need a referral: http://www.bad.org.uk/shared/get-file.ashx?id=220&itemtype=document

APPROPRIATE REFERRALS TO SECONDARY CARE DERMATOLOGY SERVICE

- Immunosuppressed patients
- If it is causing significant problems in the management of atopic eczema

ROSACEA



PRIMARY CARE MANAGEMENT (ACTIONS BEFORE REFERRAL)

Exacerbating triggers may be:

- sunlight
- caffeine
- alcohol
- spicy food
- steroids

Lifestyle advice

- spf 50 to be worn daily.
  .

If Topical treatments can be used first line:

1. Soolantra Gel (topical ivermectin) – applied once daily for 3 months with sunscreen.
2. Azeliac Acid – 2nd line
3. Metronidazole Gel – Now 3rd line (only effective in 40% of cases).

Topical retinoids are unlicensed

If Severe - Oral antibiotics are first line:

4. Lymecycline 408mg od for 3 months
5. Doxycycline 50mg 1d for 3 months.
6. If allergic to tetracyclines then erythromycin 250mg bd for 3 months.

APPROPRIATE REFERRALS TO INTERMEDIATE DERMATOLOGY SERVICE

- If diagnosis is in doubt or GP is unfamiliar with medications and wishes a second opinion

APPROPRIATE REFERRALS TO SECONDARY CARE DERMATOLOGY SERVICE

- If no response to two courses of antibiotics, each with a 3 month duration

ECZEMA

Please refer to the comprehensive eczema guidelines which can be found here:

Eczema Guidelines.PDF

These provide treatment and referral guidelines for children and adults.

Emollient and Steroid Prescribing Guidelines

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** applications 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	100ml

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

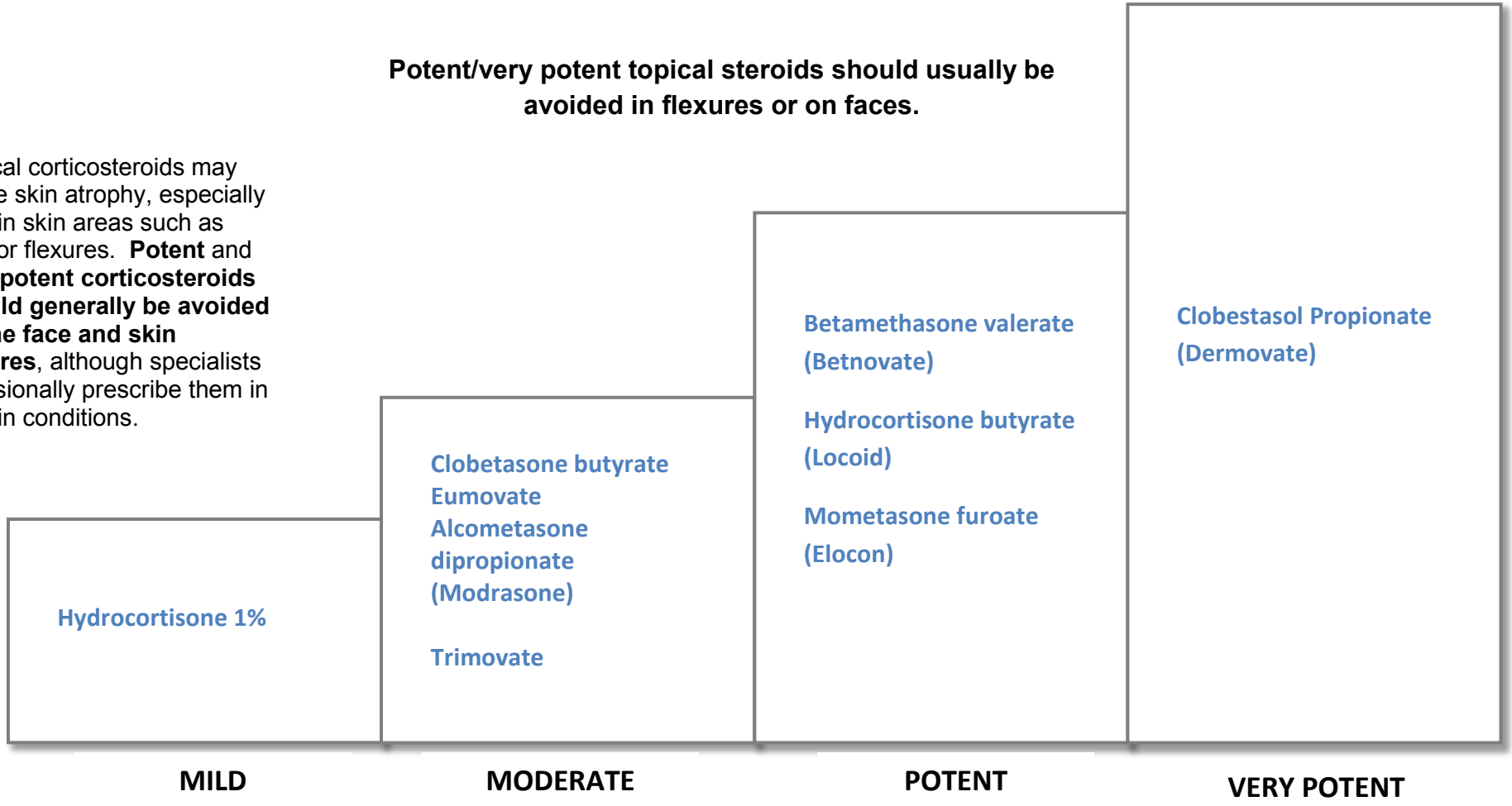
Number of fingertip units						
Age	**Face and neck**	**1 Arm (Including hand)**	**Trunk (One side)**	**Buttocks**	**1 leg (including foot)**	**Total body treatment**
3/12	1	1	1	0.5	1.25	8
6/12	1	1	1.5	0.5	1.5	9.5
12/12	1.5	1.25	1.75	0.5	2	12
18/12	1.5	1.5	2	0.75	2	13.25
2yrs	1.5	1.5	2	1	2	13.5
3yrs	1.5	1.75	2.5	1	2.5	16
4yrs	1.75	2	2.75	1	3.5	19.25
5yrs	2	2	3	1	3.5	20
7yrs	2	2.5	3.5	1.5	4.5	24.5
10yrs	2.5	3	4	1.5	6	30
12yrs	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
2yrs	13.5g	94.5g
3yrs	16g	112g
4yrs	19.25g	134.75g
5yrs	20g	140g
7yrs	24.5g	171.5g
10yrs	30g	210g
12yrs	36.5g	225.5g

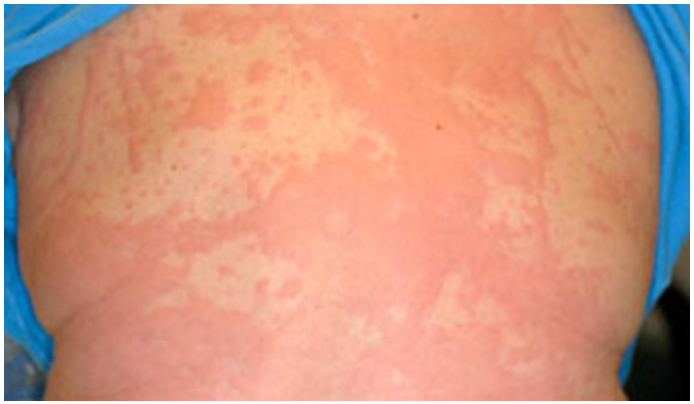
TOPICAL STEROID LADDER

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.



URTICARIA



PRIMARY CARE MANAGEMENT (ACTIONS BEFORE REFERRAL)

Patients with common urticaria should be assessed and managed in primary care in the first instance. There can be physical triggers e.g. heat, cold, sun, exercise or pressure. Certain medications can make urticaria worse;

- non steroid anti inflammatories,
- opiates,
- ACE inhibitors (Angiotensin 2 inhibitors),
- Penicillins

Please check the medication list prior to referral. Medications must be stopped 6 weeks before concluding they were not the cause.

Both acute and chronic urticaria should initially be managed by normal or supernormal doses of type 1 antihistamines

The course of urticaria is usually 12-18months.

The way to see if the urticaria has resolved is every 2 months to ask the patient to stop taking the antihistamine to see if the urticarial eruption recurs. If it does recur then restart the course and retest in another 2 months.

There are no deleterious side effects of taking antihistamine for this period of time.

If these measures are unsuccessful then please add a H2 antagonist (Ranitidine/Cimetidine unlicenced)

Add in montelukast 10mg at night.

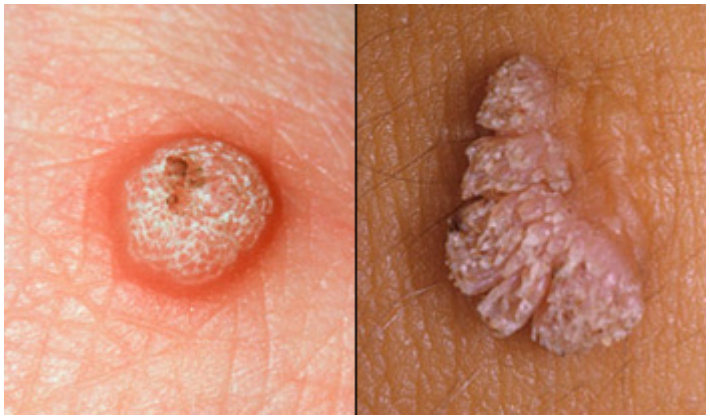
APPROPRIATE REFERRALS TO INTERMEDIATE DERMATOLOGY SERVICE

Common urticaria which has failed to respond to conservative management with high dose non-sedating antihistamines.
Referrals of common urticaria should only be made if the cause of the urticarial has been investigated (FBC, ESR, CRP, IgE and specific targeted RAST if appropriate) and rectified where possible by avoidance of causative agent or treatment with antihistamine.

APPROPRIATE REFERRALS TO SECONDARY CARE DERMATOLOGY SERVICE

Unusual or complicated urticaria e.g. suspected urticarial vasculitis or hereditary angio-oedema.

VIRAL WARTS



PRIMARY CARE MANAGEMENT (ACTIONS BEFORE REFERRAL)

GPs should treat hand warts and Plantar warts (verrucae) with wart paint / cryotherapy in surgery if available.

Treatment with wart paint should be used initially for 3 months and only continued for longer if it is helping, for instance, the discomfort of plantar warts. Cryotherapy should be given at intervals of up to 2-4 weeks for up to 3 months. Although a majority of viral warts will clear in 3 months a significant minority do not, so patients may have to wait for spontaneous resolution.

Salicylic acid or Glutaraldehyde are the recommended choice for both warts and verrucae as they can be self-administered and seems to be equally as effective as cryotherapy and less likely to cause adverse effects. Combination therapy with both topicals and cryotherapy has an enhanced cure rate.

APPROPRIATE REFERRALS TO INTERMEDIATE DERMATOLOGY SERVICE

Referral of patients with hand warts and plantar warts should **only** be made if patients have had initial failed treatment in primary

care (as described above) or the community (e.g. podiatrist) and have failed to respond to treatment **and** there is significant discomfort or diagnostic uncertainty.

APPROPRIATE REFERRALS TO SECONDARY CARE DERMATOLOGY SERVICE

Referral to dermatology department should only be made for:

- viral warts on face – any age
- viral warts in immunosuppressed patients
- if there is doubt about the diagnosis and concern about possible malignancy, e.g. a solitary lesion in a sun exposed site in a patient over the age of 40

Genital warts should be referred to Genito-Urinary Medicine.

DETAILED REFERRAL SUMMARY

A useful summary of where different conditions should be managed is set out over the next two pages.

Primary Care / Local Enhanced Service	Advice from Intermediate Dermatology /Step Up	Intermediate Dermatology Service	Advice from Secondary Care/Step Up	Secondary Care
• Mild acne and rosacea • Mild to moderate dermatitis or eczema • Small benign lesions and lumps, including skin tags in line with PLCV • Mild to moderate psoriasis • Basal cell papilloma/sebhorroeric warts in line with PLCV • Mollusca contagiosa in line with PLCV • Actinic /solar keratoses • Mild/moderate infections and infestations (e.g. tinea, impetigo, scabies) • Symptomatic seborrhoeic keratosis • Viral warts and verruca's (excluding genital) in line with PLCV • Uncertain mollusca contagiosa ➢ Minor surgical procedures – curettage/diagnostic biopsies ➢ Haemangioma in adults less than 1cm ➢ Sebaceous cysts ➢ Dermatofibromas	• Moderate infections and infestations (e.g. tinea, impetigo, scabies) where topical treatment is unsuccessful • Haemangioma in adults more than 1cm • Minor surgical procedures – curettage/diagnostic biopsies	• Chronic inflammatory dermatoses after trial of suitable treatment in primary care e.g. topical steroids /emollients (eczema/psoriasis etc.) NOT requiring phototherapy/day unit treatment/systemic treatment • Psoriasis after trial of treatment in primary care (involving more than 20% of body surface area) • Eczema; seborrhoeic, atopic (but not suspected allergic contact dermatitis) neurodermatitis • Undiagnosed rashes in otherwise well patients • Bowen's disease • Undiagnosed skin lesions where concern or uncertainty and not 2 week wait indicated • Chronic/debiting urticaria mild/moderate with failed primary care treatment • Chronic/debiting Pruritus not responding to primary care treatment • Nail disorders • Hair, scalp disorders, non-scarring alopecias • Female genital dermatology including vulval lichen sclerosus • Male genital rash (likely to respond to topical treatment) • Low risk BCCs as specified in NICE guidance (up to 10mm in diameter, below the clavicle) • Moderate acne not requiring systemic isotretinoin • Vitiligo • Moderate infections and infestations (e.g. tinea, impetigo, scabies) requiring systemic	• Female genital dermatology including vulval lichen sclerosus if intermediate treatment unresponsive • Male genital dermatology, including genital rash unresponsive to topical treatment • Occupational dermatoses and contact dermatoses where patch testing required • Hyperhidrosis only if iontophoresis required • Nail disorders - Consider advice from Secondary care or Podiatry prior to making a referral • Psoriasis possibility requiring phototherapy	• 2 week wait cancer referrals • High risk basal cell carcinoma (dermatology, maxillofacial) • Dermatological emergencies • Severe inflammatory skin disease requiring phototherapy, or systemic therapy (e.g. eczema, psoriasis, lichen planus, urticaria) • Life threatening skin disease • Severe paediatric skin disease • Photo-investigation and specialised photo-dermatology for photosensitive conditions • Specialised skin cancer e.g. CTCL/ rare tumours • Skin disease related to connective tissue disease • Cutaneous vasculitis • HIV related skin disease • Pathology requiring MDT discussion/management • Complex mycoses • Severe hair and nail disease – with scarring or significant psychological impact • Specialist intervention for patients having undergone organ transplant • Suspected allergic contact dermatitis • Severe axillary hyperhidrosis requiring botulinum toxin injections • Photodynamic therapy for patients requiring secondary care e.g. transplant recipients • Severe / scarring acne – Isotretinoin treatment • Severe rosacea, refractory to 1st line treatment

		management • hyperhidrosis – only consider referral if iontophoresis required • Inflammatory skin conditions e.g. Lichen planus, granuloma annulare • Benign moles and Pigmented lesions where 2 week wait is not indicated and where there is concern or uncertainty • Morphoea (localised) • Moderate to severe Folliculitis and not responding to primary care treatment • Keloid scarring • Dysmorphophobia • Patients stepped down from secondary care • Shared drug monitoring where appropriate For note: In delivering clinical management to all the above skin conditions, the community service will provide medical student teaching		• Severe hidradenitis suppurativa • Immune-suppressed patients with possible skin cancer • Auto-immune blistering disorders e.g. pemphigoid • Severe drug reactions e.g. Stevens-Johnson syndrome • Systemic illnesses related to skin disorders e.g. Lupus • Any patient requiring step-up from intermediate service

ACKNOWLEDGEMENTS

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REFERENCE(S)

Dr Amanda Oakley, Dermatologist. (June 2014). *Acne vulgaris.* Available: https://www.dermnetnz.org/topics/acne-vulgaris/. Last accessed 02 August 2017.