South East London Dermatology Guidelines for Primary Care

June 2022

These guidelines are easy to follow, evidence-based and locally referenced for use by GPs, nurses, and other healthcare professionals in primary care with the necessary knowledge to interpret them.
Underlined items are hyperlinked, press Ctrl and click on the item to access them

Unless otherwise stated, they are for the management of adults & children. If your patient is pregnant or breastfeeding, please contact your local dermatology service for advice (via Consultant Connect/PhotoSAF, eRS or other local pathway)

Your clinical instinct must always come first. Images of the conditions included are available in the A-Z guide and Lesions tables in http://www.pcds.org.uk/

We recommend that prescribing is in line with the South East London Joint Medicines Formulary and with the local borough antibiotic guidelines.

If you have any corrections, questions or ideas for improvement please let the authors know by emailing southwark.medicine-optimisation@selondonics.nhs.uk or alternatively email the SEL Integrated Medicines Optimisation Committee (IMOC) support team at: lambethmedicines@selondonics.nhs.uk.

Acknowledgements: This updated 2022 guideline is a revision 2020 guidance developed and updated through the SEL Dermatology Pathway sub-group, a sub-group of the SEL Integrated Medicines Optimisation Committee (SEL IMOC)

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Original Approval date: January 2020 Last reviewed and updated: October 2022 Review date: October 2024
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Contents

Referral Overview for Dermatology Skin Conditions

**Offer primary care management with use of SEL IMOC dermatology guidelines and pre-referral checklists (e.g. acne, eczema, and psoriasis) prior to referral **

Community Dermatology Service (GPwER Level)

- Acne (moderate and if patient unsuitable for oral Isotretinoin)
- Actinic Keratosis
- Alopecia/hair loss (moderate)
- BCCs below the clavicle (group 2 or 3 Accredited GPwERs)
- Bowen's disease (or GP management)
- Congenital lesions – vascular or pigmented
- Eczema (moderate, not responding to treatment)
- Hair/nail/scalp disorders (moderate severity)
- Hidradenitis suppurativa (moderate)
- Hirsutism
- Hyperhidrosis Generalised, no underlying cause
- Infection + infestations, e.g. tinea
- Lesion of diagnostic uncertainty
- Lichen planus and other inflammatory disorders
- Pigment disorders e.g. vitiligo
- Pruritus
- Psoriasis (mild to moderate, not responding to treatment)
- Pyogenic granulomas
- Rash of diagnostic uncertainty
- Rosacea
- Urticaria
- Symptomatic, inflamed lesions on the face (needing diagnosis)
- Skin Check – mole review in high-risk individuals
- Genital dermatosis

MINOR SURGERY (PRIMARY CARE DES)

- Epidermoid **cysts and similar benign skin lesions** which are symptomatic and inflamed on more than one occasion (≥5cm refer to general surgery, max fax or plastics as appropriate)
- Chronic/ recurrent in-growing **toenails** or **nail deformities** requiring surgical intervention or nail bed ablation where appropriate.
- **Low risk Basal Cell Carcinomas (BCC)** below clavicle **(accredited GPs only)**

Refer using local DES pathway

SECONDARY CARE DERMATOLOGY SERVICE

- Acne (severe and for prescription of oral isotretinoin)
- Allergic contact dermatitis
- Alopecia with: scarring, unresolving alopecia areata, or significant psychological upset
- BCC above the clavicle (including suspected)
- Congenital lesions – vascular or pigmented
- Connective tissue disorders (suspected)
- (Cutaneous) vasculitis
- Eczema (severe, for immunosuppressant drugs or phototherapy)
- Genital dermatosis, severe
- Genodermatoses (suspected)
- Hidradenitis suppurativa (resistant cases)
- Hyperhidrosis (as per SEL pathway)
- Nail tumours
- Photodermatoses
- Psoriasis (New diagnosis in under 18 year olds, severe or extensive psoriasis, tricky sites, patients requiring phototherapy or 2nd line drug therapy)
- Rash (with systemic disturbance in any age group)
- Rash in pregnancy
- Second opinion for any rash /lesion for diagnosis or management
- Urticaria not responding to standard therapies

SECONDARY CARE 2WW REFERRAL

Suspicion of Melanoma

Suspected squamous cell carcinoma (SCC) with definite history of change/ expansion

Keratoacanthoma (consider as SCC)

High risk BCC ('T zone' i.e. eyes, nose, lips)

Pyogenic granuloma without a clear history of trauma

REFER via 2 WEEK WAIT PATHWAY

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Urgent and Routine Referral Criteria

2 Week Wait suspected cancer: Refer as '2 Week Wait'

- Suspected melanoma or SCC (Squamous Cell carcinoma) or Keratoacanthoma
- High risk BCC (eyes, nose, lips); Pyogenic granuloma without a clear history of trauma

Check contact details; Ensure that patient can attend a hospital appointment in the next 10 working days (If not, review to generate the appointment when they will be available)

KCH, GSTT, LGT: Book an appointment via ERS **whilst the patient is still with you**:

Select **2WW t**hen **2WW Skin/ Dermatology:** select a location and appointment, print appointment details for your patient; attach a completed Pan London 2WW referral form to your ERS booking.

Children: Skin cancer in young people is uncommon. Where there is a significant concern a 2WW appointment can be booked by selecting **2WW/2WW skin/Dermatology** and selecting the Evelina Children's Hospital option. Please print appointment details for your patient.

Routine referral and urgent review (Not 2WW, not Red flags needing review <72 hrs)

- Refer via eRS Referral Assessment Service (RAS) pathways: Check contact details; Attach a photo (in focus) if available. Please see appendix 1 for local referral pathways.
- Provide as much detail as possible on the referral form to explain why an urgent appointment is required.
- Complete and attach a referral form and pre-referral checklist if available.
- Attach DLQi/ relevant past dermatology letters.
- Arrange relevant blood tests e.g. pre-Isotretinoin bloods and contraception.
- Check referral complies with TAP. Symptomatic benign lesions on face need IFR (individual funding request) and referral to plastics or minor surgery unless there is diagnostic doubt.

Advice and guidance

- via Consultant Connect +/- Photosaf
- via eRS Dermatology Single Point of Referral and ideally attaching a photo

All services will be offering advice and guidance where actions need to be taken before a patient can be considered for clinic review

Consultant Connect / photosaf Guidance

Advice about taking good photos for HCP and for patients:

Photography for the patient - how to take a good photograph of a skin condition / skin lesion (pcds.org.uk)

Clinical photography in skin of colour: tips and best practices (pcds.org.uk)

Photography - how to take a good dermoscopic photograph (pcds.org.uk)

Dermatology History and Terminology

History	Key questions
History of a rash	Is there anything to see/ feel? Where and when did the rash first appear? How has it spread (direction & pace)? Describe the course of the rash (progressive deterioration, constant but fluctuating in severity, intermittent, improving) Are there associated features e.g. flushing Can provoking factors be identified? Can aggravating factors be identified? Can relieving factors be identified? What treatment has been tried (OTC Over The Counter/prescribed)? What was the response to treatment? Is the patient well or unwell? Is it pruritic (itchy)?
History of a lesion	How long has the lesion been present? Has it changed since first noticed (colour, shape, size)? Has it bled or crusted? Is it symptomatic (painful or itchy)?
Skin type	Likelihood of burning on sun exposure (Fitzpatrick skin type I-VI
Sun Exposure	Lifetime sun exposure? Early sunburn episodes, use of sunscreens
Past medical history	History of atopy if eczema suspected History of skin cancer such as melanoma History of joint disease if psoriasis suspected
Medication	Regular, recent including over-the-counter medication & herbal remedies
Allergies	Drug allergy (outline nature of reaction reported) Food allergy (most relevant in paediatric atopic eczema) Allergic rhinoconjunctivitis (relevant in atopic eczema)
Family history	Family history of skin disease, atopy or skin cancer such as melanoma
Social history	Smoking (particularly in hidradenitis suppurativa & palmoplantar pustulosis) Alcohol intake Occupation – Indoors/outdoors. Is the severity of the eruption influenced by work? What is the impact of the problem on the patient's quality of life (use the Dermatology Life Quality Index)?

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Examination

Where possible, perform a full skin check (including mucous membranes, hair & nails). Use the most appropriate descriptive term(s) for primary lesions and any secondary changes

- Define the **distribution** of lesions
- Describe the **shape, demarcation, surface** and **colour** of lesions
- Noting the **skin colour/ Fitzpatrick skin type (I-VI).** Inflammation in patients with Type V (Asian)/ Type VI (Afro-caribbean) skin can look grey/ mauve; such patients are susceptible to more persistent hyperpigmentation. Patients with Type I/II (celtic/ blond/ redhead with blue eyes) are more susceptible to sunburn and solar damage.
- Describe the **colour of any** rash
- **Palpate** lesions & describe their c**onsistency**
- Is **hair loss** focal (frontal/ crown/ parting) or diffuse, is there **scarring** or **scaling,** is there peri-follicular scale or colour , how many hairs per follicle?

Distribution

Acral Distal portions of limbs (hand, foot) and head (ears, nose)
Dermatomal Corresponding with nerve root distribution
Extensor vs Flexural (also known as intertriginous in body flexures)
Follicular Individual lesions arise from hair follicles
Clustered
Generalised, Symmetrical, Unilateral
Herpetiform Grouped umbilicated vesicles, as arise in *Herpes simplex/zoster*
Koebnerised Arising in a wound or scar
Photosensitive Does not affect skin that is always covered by clothing
Seborrhoeic Sites of increased sebaceous gland activity. Seborrhoeic dermatitis: scalp, behind ears, eyebrows, nasolabial folds, sternum and interscapular
Truncal Favours trunk and rarely affects limbs

Morphology

Macule	Flat non-palpable area of colour change of less than 0.5cm diameter (< 5 mm)
Patch	Flat non-palpable skin lesion greater than 0.5cm diameter (> 5 mm)
Papule	Small palpable lesion less than 0.5cm diameter
Nodule	Larger solid papule greater than 0.5cm diameter
Plaque	Palpable flat lesion greater than 0.5cm diameter
Vesicle	Small fluid filled blister, less than 0.5cm diameter
Pustule	Purulent (pus filled) vesicle
Bulla	Large fluid-filled blister greater than 0.5cm diameter
Weal	Oedematous papule/plaque caused by swelling in dermis, often indicates urticaria
Dermal	Dermal lesions do not have surface change/ scaling

Aim to have a differential diagnosis. Consider immunosuppression in anyone whose skin presentation is more extensive/ florid than expected

Acronyms OD = Once daily **BD** = Twice daily **OTC** = Over the Counter **PIL** = Patient information leaflet

Note: Pre-payment certificates (PPC) are helpful where a patient will need 4+ prescriptions (in 3 months) or 12+ (12 months). Patients buy them online or by telephone

Skin cancer: Malignant Melanoma (MM)
Key messages

- Refer lesions strongly suspicious of MM on the 2-week wait pathway
- The ABCDE and Glasgow 7-point checklist are useful for assessing pigmented lesions

The **ABCDE** checklist:

- **Asymmetry -** melanoma shape is often uneven and asymmetrical
- **Border** or edges of a melanoma are often ragged, notched or blurred.
- **Colour** of a melanoma is often not uniform. There may be shades of brown, red, white, or black. (can also be applied to **Comparison** with other moles, and dermoscopic **Chaos)**
- **Diameter** of a melanoma is usually larger than 6 mm and it continues to grow. However, they start smaller than this and may be identified dermoscopically.
- **Evolving** - any change in size, shape, colour, elevation, or any new symptom such as bleeding, itching, or crusting may be due to a melanoma.

7-point checklist

- Major features of the lesion (2 points each):
  - Change in size
  - Irregular shape or border
  - Irregular colour
- Minor features of the lesion (1 point each):
  - Largest diameter 7 mm or more
  - Inflammation
  - Oozing or crusting of the lesion
  - Change in sensation (including itch, pain, and soreness)
- Suspicion is greater for lesions scoring 3 points or more. However, if there are strong concerns about cancer, any one feature is adequate to prompt urgent referral under the 2-week wait

- **NB:** Both the 7-point checklist and ABCDE criteria are useful, but it is vital to take account of the skin type and dermatology history (e.g. history of trauma to lesion). The dermoscopic pattern is also useful with a chaotic pattern and pigmentary assymetry being especially of concern.
- **Resources** Self-exam of moles – Primary Care Dermatology Society

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Consider attending a dermoscopy course:
Eg: DFAB: Dermoscopy for Absolute beginners, then Dermoscopy for Intermediates Dermoscopy Events
PCDS Advanced Dermoscopy, PCDS International dermoscopy course.

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Risk factors for malignant melanoma (MM)

- The major risk factor is sun exposure (including sunbeds), particularly in the first 20 years of life.
- Other risk factors include:
    - Fair skin that burns easily (Type I or II skin)
    - Blistering sunburn, especially when young (especially women Under 26)
    - Previous melanoma
    - Previous non-melanoma skin cancer
    - Family history of melanoma
    - Large numbers of moles (especially if there are more than 100)
    - Abnormal moles (atypical or dysplastic naevi)
    - Immunosuppression (for example azathioprine and methotrexate), transplant patients and patients with Haematological disorders e.g. lymphoma

Biopsy of suspected MM should NOT be performed in primary care

Notes

1. Melanoma is caused by the uncontrolled growth of melanocytes. It occurs in adults of any age. Melanoma is very rare in children; refer neonates with > 1 naevus at birth or a single naevus > 5 cm.
2. Melanomas can arise from otherwise normal appearing skin (50% of melanomas) or from within a mole. Precursor lesions include:
    a. Congenital melanocytic naevi
    b. Atypical/dysplastic naevi
3. Melanomas can occur anywhere on the body. The most common site in men is the back (around 40%), and the most common site in women is the lower leg.
4. Melanoma can also grow on mucous membranes such as the lips or genitals.
5. Remember acral melanoma (hands and feet, nails) in individuals with type IV-VI (black) skin.
6. Consider amelanotic melanoma if a pyogenic granuloma does not have a history of preceding trauma.
7. Remind patients who have had a melanoma about long term avoidance of further sun exposure: Use of a broad brimmed hat and application of a broad spectrum sunscreen (SPF 30+ (UVB) and 4-5* (UVA) and consider advising use of an OTC vitamin D3 supplement.

Resources

Melanoma images for GPs – Primary Care Dermatology Society
Self-examination of moles – Primary Care Dermatology Society
Patient leaflet – Patient.info
Patient leaflets on melanoma stages 1-4 – British Association of Dermatology

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Skin Cancer: Squamous Cell Carcinoma (SCC) and Keratoacanthoma

Key messages

Refer suspected SCCs under 2-week wait pathway:

- Non-healing, scaly or crusted nodule, often tender. Commonly found on face, scalp or back of hand (sun exposed sites)
- Rapid expansion/ growth over weeks
- Patients who have had an organ transplant and develop new/growing cutaneous lesions (SCC is common with immunosuppression but may be atypical and aggressive)
- Keratoacanthoma are considered to be and managed as SCCs

Biopsy of suspected SCC should NOT be performed in primary care.

Notes

1. High risk areas are ear, vermilion of lip, central face, hands, feet and genitalia.
2. SCCs may rarely develop in areas of chronic inflammation, e.g. leg ulcers (Marjolin's ulcers). Refer for assessment if there is a sudden change, a heaped-up edge or failure to heal.
3. There is an increased risk of SCC in:
    - Immunocompromised patients, for example, those who are taking or have taken DMARDs e.g. azathioprine and other immunosuppressive therapy, transplant patients, patients with some haematological disorders
    - People who have had significant cumulative UV light exposure especially people with Fitzpatrick skin type 1 or type 2 whose skin is more likely to burn with sun exposure
    - For people with skin colour of Fitzpatrick IV-VI, SCC is the most common skin cancer and often develops on non-sun exposed sites
    - People who have had previous SCC, BCC or > 8 actinic keratoses
    - People with skin conditions such as albinism, xeroderma pigmentosum
4. 20% increase in risk of SCC where people have rheumatoid arthritis irrespective of immunosuppressants.
5. **Where a pre-existing warty lesion has become inflamed/ bled consider measuring it and advising application of Fucibet cream twice daily for 10 days;** review at 4 weeks to see whether it's clearly a traumatised seborrheic keratosis that has settled or needs 2-week wait referral. If you are unsure send a high-quality photo for advice and guidance photo via ERS/ consultant connect *or request urgent review in the community clinic.*
6. Consider an SCC where there is **unexplained single nail deformity** without prior trauma :

Resources

On-line pictures for GPs – Primary Care Dermatology Society
Patient leaflet – Patient.info
Patient leaflet – British Association of Dermatology

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Skin Cancer: Basal Cell Carcinoma (BCC)

Key messages

Refer lesions suspicious of BCC routinely, unless in high risk areas (eyes, nose, lips). If BCCs are nodular or recurrent they behave more aggressively.

- See NICE updated 2010 guidance 'Improving outcomes for people with skin tumours including melanoma (update): the management of low-risk basal cell carcinomas in the community'. All remaining recommendations in the original 2006 guidance are still valid.
- Early lesions are often small, translucent or pearly and have raised areas with telangiectasia. The classic rodent ulcer has an indurated edge and ulcerated centre. It is slow growing but can spread deeply to cause considerable destruction.

Notes

1. BCCs are slow growing, locally invasive malignant epidermal skin tumours, thought to arise from hair follicles. They are the commonest type of skin cancer in the UK (60%).
2. Sun-exposed areas of the head and neck (80%) are the most commonly involved sites, with the rest mainly on the trunk and lower limbs.
3. **Surgical excision** is the preferred treatment, but the choice of treatment depends on the site and size of the BCC, the condition of the surrounding skin and number of BCCs to be treated. Mohs Micrographic Surgery is considered for BCCs where tissue conservation is important (e.g. nose, eyes, lips, ears). Other treatments include:
    - Curettage and cautery
    - Cryotherapy
    - Topical fluorouracil 5% cream (Efudix) (specialist initiation and continuation only) or Imiquimod 5% (Aldara) (specialist initiation and continuation only) is useful in the management of superficial BCCs on the trunk and limbs. The lesions must be proven by biopsy OR if treated empirically they must be closely followed-up and referred if not improved by treatment
4. Radiotherapy can be a useful option for some patients, depending on the site of the lesion. Patients referred to secondary care may be discussed in the multidisciplinary meeting (MDM) with the clinical oncologists to plan treatment.
5. Photodynamic Therapy may be offered by some secondary care providers for superficial BCCs.

Resources

On-line pictures for GPs – Primary Care Dermatology Society
Patient leaflet – Patient.info
Patient leaflet – British Association of Dermatology

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NICE Skin Tumours Improving Outcomes Guidance (IOG): Updated May 2010

Key messages

- Pre-cancerous lesions (e.g. Bowen's, Actinic Keratosis (AK)) can be treated by GP or referred. Bowen's needs to be biopsied before treatment.
- Low risk BCCs may be managed in the community by:
    1. GPs performing skin surgery within DES framework
    2. GPwERs at community clinics (Group 2 and 3 GPwER) (Model 1 care)

Lesions suspicious of high risk BCCs/SCC/MM must be referred to the Skin cancer Local skin MDT for review by a core member or discussion at the MDT

Low risk BCCs are:

1. Nodulocystic
2. No diagnostic uncertainty
3. Small (<1cm)
4. Below clavicle
5. Not overlying important anatomical structures (e.g. major vessels)
6. Patient >24 years, is not immunosuppressed, does not have Gorlin's syndrome (which is associated with BCCs at multiple sites)

Resources

NICE Guidance

Immunosuppression/ HIV

Suspect immunosuppression or HIV whenever a skin condition is much more extensive or florid than expected. Cutaneous manifestations of human immunodeficiency (HIV) disease may result from HIV infection, from opportunistic disorders secondary to immunosuppression or as drug reactions resulting from treatment of HIV.

Resources

Clinical Guidelines – Primary Care Dermatology Society

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Actinic/Solar Keratoses (AKs) [Images]

Key Messages for Healthcare Professionals

- Patients with actinic keratosis can be managed in primary care *unless they are not responding*, or there is *uncertainty regarding the diagnosis* (e.g., palpable lesions when crust/ horn has been removed [use emollient in advance to facilitate removal]) or there is a concern that they may have transformed into a SCC. Pain or tenderness on palpation suggest a need for further evaluation before treatment.
- Actinic keratoses (AKs) are usually multiple, flat, pale or reddish-brown lesions with a dry adherent scale which feels rough/ like sandpaper. They reflect abnormal skin cell development due to exposure to UV radiation and are considered pre-cancerous. A keratosis may also develop into a cutaneous horn. Multiple actinic keratoses are a marker of lifetime sun exposure damage; diagnosis is an opportunity to discuss vigilance for new/ rapidly changing and sore lesions which may be squamous cell carcinoma (SCCs) or persistent scaling, ulcerating lesions which may be Basal cell carcinomas (BCCs). Offer PIL to patients.
- The vast majority of actinic keratoses do NOT progress to SCCs - evidence suggests the annual incidence of transformation is < 0.1%. This risk is higher in people who are immunocompromised (this includes patients who are taking or have taken DMARDS e.g., azathioprine).
- Advise about avoiding further sun exposure: use of wide- brimmed hat, emollients, (SPF 30+ UVA) sunscreens (self-care) which may induce regression of actinic keratoses.

Treatment notes:

Please see the accompanying algorithm for this section on pages 17-18

Field change refers to areas of skin that have multiple confluent AKs associated with a background of erythema, telangiectasia and other changes seen in sun-damaged skin. These areas may be more at risk of developing SCC, especially if left untreated more active treatment should be considered. The treatments should be applied to the whole area of field change and not just the individual lesions. Management involves a *dialogue with patients* about treatment options of this long-term problem with recurrent episodes. Usually only one topical treatment is prescribed at a time. Reassess 8 weeks after treatment for residual isolated lesions needing Actikerall® or cryotherapy

- Consider advising a Vitamin D3 supplement OTC as patients will be using sunscreen to avoid sun exposure.
- **Fluorouracil 5% cream (Efudix©)** is ideal for multiple, ill-defined AKs. It spares normal skin. Efudix© can be used for whole scalps and whole face, including lips. A maximum area of 500cm^2 should be treated – this translates to about a dinner plate size area of skin. *Marked inflammation should occur prior to resolution, warn the patient to expect this, usually 2-3 weeks into treatment.* Advise patient to apply Efudix© once daily at night and to wash it off the next morning x5-7 days per week for 4-6 weeks (or x 3-4 days per week for longer if poorly tolerated). Apply across the field of lesions (see PIL) and wash hands. Optimum effect is seen 4-6 weeks post-treatment. Plentiful emollients or a moderate to potent topical steroid ointment may help settle down any inflammation – which can be severe. Used appropriately it is safe and efficacious with little systemic absorption. Warn patients however that occasionally systemic symptoms occur reflecting an enzyme deficiency; Efudix© **must** then be stopped and **never** used again.
- **Imiquimod 5% (Aldara©)** is used 2nd line for field change (multiple actinic keratoses). Snip the corner of the sachet and apply Aldara© with a finger to beyond the field change; fold over the edge of the sachet and close with a paper clip; use the remainder over subsequent treatments. Apply 3 times per week e.g., Monday Wednesday Friday for 4 weeks, wash off after 8 hours. In primary care sufficient cream should be applied to cover the treatment area, one sachet will cover up to 25cm^2 of affected skin. Imiquimod 5% has more side-effects than Efudix© and patients may develop systemic (flu-like) symptoms. Discuss the risk of **Herpes Simplex reactivation.**
- **Diclofenac sodium gel 3%** (**Solaraze©**) produces much less inflammation than fluorouracil 5% cream (Efudix©) and is better tolerated but needs to be used bd for 90-180 days. Use for thin (grade 1 lesions only as it is less effective than Efudix© for thicker lesions. Use with caution in those with GI/renal disease. It may be useful for prevention of further actinic keratoses in someone who is immunosuppressed or where there have been many recurrences of actinic keratoses.

For patients who may not be able to apply the topical treatments as above but in whom treatment of field change is

appropriate – consider referring to secondary care for photodynamic therapy.

Picato (Ingenol) licence was suspended EMA Jan 2020 and it was recalled by MHRA because of a concern about a possible link between use of Picato and skin cancer. They advise 'HCP should advise patients prescribed Picato to be vigilant for any skin lesions developing and to seek medical advice promptly should any occur'.

For localised lesions: see the accompanying algorithm for this text and resources 1-3 below for grading

- Cryotherapy by someone trained in its use; freeze for 5-10 seconds each.
  - Avoid below the knee
  - Caution in pigmented skin as risk of depigmentation
  - Caution around nails and eyes

- **5-FU 0.5% and salicylic acid 10%** (**Actikerall©**)
  - For palpable and moderately thick hyperkeratotic actinic keratosis (grade I/II)
  - Maximum area of 25cm^2 and maximum duration 12 weeks
  - Apply to the lesion with brush applicator OD for up to 12 weeks, reduce frequency to x3 per week if response is too inflammatory; peel off existing coating before reapplication
  - Consider if cryotherapy not available or tolerated, site below the knee,
- When superficial with a thin base Efudix© 5% cream can also be considered

Resources

On-line pictures for GPs – Primary Care Dermatology Society
Clinical guidance – Primary Care Dermatology Society
Information for GPs: Patient leaflets – Patient.info
Patient information about AKs: Patient leaflets – British Association of Dermatology
Efudix leaflet: https://www.medicines.org.uk/emc/files/pil.9260.pdf
Meda Aldara PIL https://www.medicines.org.uk/emc/files/pil.823.pdf
Solaraze Gel leaflet: https://www.medicines.org.uk/emc/product/6385/pil
Actikerall leaflet: Actikerall emc PIL

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GP/ Primary care

Actinic keratosis (AKs) [Images]

If Multiple confluent lesions
See Actinic Keratosis: Field change algorithm

Discrete/ single lesions
Remove scab to assess base. Assess skin type. Offer full skin review
Advise about UV avoidance: hat/ sunscreens & emollients (self-care)
Discuss: AKs as a marker of past sun exposure, increased risk of Bcc/Scc
Refer persistent lesions near the eye.

Consider need for a 2WW referral:? SCC

Sore, indurated, (ulcerating) rapidly growing lesion especially where patient is immunosuppressed or has had previous SCC / Bcc

Show **images** of response to treatment.
Discuss treatment options. **Agree a management plan**

Superficial, Thin base*

Hyperkeratotic with thin base*

Hypertrophic (thick) base*

Non tender, growing slowly, may have a horn

Patient prefers self-monitoring/ no further treatment

Where cryotherapy is unavailable or topical preferred.

Patient able to comply with topical treatment.
Lesion not near the eye.
Efudix© (5 %FU) cream (unless CI) OD for 4 weeks. Offer PIL. Reduce frequency if excess inflammation (same duration of treatment).
Or offer **Diclofenac 3% gel (Solaraze©)** BD (mild, less effective) for symptomatic treatment if other options not tolerated. Offer PIL.

Offer/Refer for Cryotherapy
1 x 5-10 seconds
(avoid gaiter area)

Patient able to comply with topical treatment. Lesion not near the eye
Actikerall© gel OD for 6 -12 week
Peel off existing application before reapplication. Offer PIL.
Reduce frequency to x3/week if response is too inflammatory.

Refer routinely for Dermatology assessment

Refer on 2WW Dermatology Pathway

Non tender, not enlarging, just growing slowly

Sore, growing rapidly Tender/ growing

Reassess 8 weeks after completion of treatment
If still present or has recurred, consider referral for specialist dermatology

** For clinical description and grading system see resources 1-3 in written summary*

Key

Community or Secondary care Dermatology

Specialist Dermatology (Secondary care)

Actinic Keratosis Field change algorithm

GP/ Primary care

Actinic keratoses: Field change

Remove scabs to assess base. Assess skin type. Offer full skin review

Consider via 2WW referral if lesions are sore, growing rapidly

Discuss treatment options. Advise use of sunscreens & emollients for all

Discuss AKs as marker of sun exposure, recurrent problem, and increased risk Bcc/Sccs.

Referral to dermatology can be made at any stage if diagnosis is uncertain

Refer sore, rapidly changing lesions on 2WW Dermatology pathway

Refer to Dermatology routinely in context of higher risk e.g. PMH of multiple SCCs/ Bccs Immunosuppression: post-transplant, HIV, haematological disorder, past or current immunosuppressive therapy

Consider referral to dermatology routinely if PDT a better option E.g. lower limb/ Unable to apply or intolerant of other treatments

Patient chooses to self-monitor (no additional treatment) or to use **Diclofenac 3% (Solaraze©) BD** (mild, less effective) for symptomatic treatment if other options not tolerated

Patient able to comply with topical treatment, show images of response to treatment; **Agree treatment plan,** give PIL

Offer **5%FU (Efudix©)** cream Once daily for 4 weeks, or 3-4/week for longer if poorly tolerated. Advise re small risk of systemic reaction (change treatment if this occurs). Can be used for whole scalps and whole face, including lips.

Offer review 8 weeks after completion of treatment or SOS

1st line

Or If intolerant of Efudix

2nd line

Offer **Imiquimod 5% (Aldara©) applied od for 4 weeks**. Wash off after 8 hours e.g. use overnight. **Review 4 weeks after completion of treatment, and repeat if required**

Reassess after completion of treatment to ensure healing.

Residual discrete lesions: Follow Discrete lesion algorithm

Refer sore, rapidly changing lesions on 2WW Dermatology pathway

Refer non tender static hypertrophic lesions to Dermatology routinely.

Intolerance/Residual typical field change: Repeat Efudix© 5% Cream or offer Imiquimod 5% cream as above

Full Resolution: Remind about vigilance for new AKs/ SCC/ BCCs, need for sun avoidance; Discuss likely need for further treatments in future with range of treatment options (as above)

Key

GP / Community or Secondary care

Specialist Dermatology (Secondary care)

Scaling dermatoses - Atopic Dermatitis/Eczema

Initial assessment *(refer to pre-referral checklist)*

Baseline treatment: 1-3

1. **Emollients** as moisturiser x 2-4 daily and as soap
2. **Avoidance of irritants** (e.g. soap, bubble baths, shower gel)
3. **Add topical corticosteroids**, preferably ointments, for inflamed patches OD (use finger-tip units (FTU) guide)
4. **Short term use** only of **sedating antihistamine** at night if sleep disturbed
5. **Manage Infected Eczema** initially with **topical corticosteroids** (NOT antibiotics) unless systemically unwell

ADULTS FTU PIL

Topical steroids (TCS): apply ONCE daily, after emollients, ointments other than in flexures. Give **PIL**

Face and flexures: *Mild to moderate eczema* **Mild potency TCS**- e.g. hydrocortisone 1% **for 1- 2 weeks**
Severe Eczema: **Moderate potency** TCS
and review at 2 weeks

Trunk and limbs:

- *Moderate Eczema:* **Moderate potency** - Clobetasone butyrate 0.05% (Eumovate®), Betamethasone 0.025% (Betnovate RD®) **OR**
- **Potent** - betamethasone 0.1% (Betnovate®), mometasone 0.1% (Elocon®)
- Daily use for 2-4 weeks to control flare reducing to *twice weekly on* sites of flare to maintain clear skin

Discoid or hand & foot eczema:

- **Potent** (Betnovate®, Elocon®, Diprosalic®)
- **Very Potent** - clobetasol propionate 0.05% (Dermovate®)

For **hands and feet:** Consider using under clingfilm occlusion in difficult cases

CHILDREN

Topical steroids (TCS): once daily, ointments preferred other than in flexures. Give FTU PIL

Face and flexures: Mild to moderate eczema
Mild potency - e.g. hydrocortisone 1% **for 1- 2 weeks**

Trunk and limbs:

- *Moderate eczema:* **Moderate potency** - clobetasone butyrate 0.05% (Eumovate®) ointment
- Advise daily use for 2-4 weeks to control flare, reducing to *twice weekly* to sites of flare to maintain clear skin

Severe eczema:

- **potent steroid** e.g. Betamethasone 0.1% Ointment or mometasone 0.1% (Elocon®) ointment
- Review at 2 weeks; seek advice if failure to respond to treatment. Treat infection with antibiotics only if systemically unwell.

Moderate to severe eczema: child <6 months not responding to treatment: take an allergy focused history

Use wet wraps only if previously advised by GPwER or secondary care AND if infection is controlled

Topical Calcineurin inhibitors (TCIs) (Amber 2)**:** *steroid sparing* (especially for face/flexures) once eczema is controlled x1-2 daily (maintenance twice weekly) and *for flares*. Licensed for initiation by practitioners experienced in managing eczema.
Children over 2yrs: Pimecrolimus 1% Cream or Tacrolimus (0.03%) Ointment
>16 years and adults: Pimecrolimus 1% cream or Tacrolimus (0.03%, 0.1%) ointment TCI PIL

Seek advice/ Refer via ERS A & G or Consultant Connect where there is:

- Severe eczema not responding to baseline treatment (Call on-call reg is systemically unwell/erythrodermic)
- Diagnostic difficulty
- Contact allergy patch testing (e.g. difficult hand eczema unresponsive to treatment and avoidance of irritants
- Eczema with significant social or psychological problems, e.g. Inability to return to work or sleep disturbance

Community dermatology service (if available) – adults: moderate-severe; children <12 years: moderate-severe
Secondary care dermatology: Adults - severe or who may need phototherapy or immunosuppressant drugs. Children <12 years - moderate to severe eczema or if primary care treatment is exhausted and carers in need of support)

Atopic Dermatitis/ Eczema

Inflammation in brown or black 'skin of colour' may present as darker than usual or grey/ mauve rather than red. It may feel hot, there may also be fine papular/ follicular change. In all skin types, skin will be lichenified when eczema has been active for some time. In skin of colour it may also be hyperpigmented. The pigmentary changes fade over months once the eczema responds to treatment,

1. **Emollients: All patients who have eczema** benefit from application of emollients x2-4 daily to restore their skin barrier. No evidence supports one emollient over another– refer to the SEL IMOC emollients guideline (*includes information about emollient greasiness*) to find a SEL JMF formulary product that the patient finds acceptable and effective for them. **Prescribe** enough to allow liberal application (downwards, in line with hairs) as frequently as required e.g. 600+g/week for an adult, 300g for a younger child. Encourage use even when eczema has subsided. All emollients except 50:50 can be used as a soap substitute for washing as conventional soaps strip the skin of natural oils/cause shedding. GSTT videos offer advice about application
2. Warn about fire hazard with paraffin-based emollients.
3. Ideally, leave 20 mins between application of emollient and steroid but 5-10 mins is pragmatic.
4. Additional guidance - Running a 60-degree wash once a month will protect washing machines from the impact of greasy emollients that can damage the machine seals.
5. For adults, discuss the purchase of a **prepayment certificate**
6. Patients without a diagnosis of eczema must be advised to purchase emollients over the counter as prescriptions for the treatment of dry skin should not routinely be offered in primary care

Topical steroids

1. Use ointment rather than cream (more effective, if acceptable to the patient) other than for flexures.
2. Prescribe appropriate strength for site & severity of eczema and age of patient. Advise ONCE DAILY use following finger tip unit guide (see PIL on finger-tip units and videos produced by St John's Institute of Dermatology).
3. Induce improvement with short course of stronger steroid. Consider weaning to twice weekly maintenance or step down to less potent steroid if necessary.
4. Consider steroid card for those on long term topical therapy.

Secondary infection

1. Eczema may be infected when crusted or weeping. **Initial treatment of infection is with appropriate strength topical steroids NOT antibiotics.** If the patient is systemically unwell take a skin swab (from the most crusted area) and start empiric treatment e.g. Flucloxacillin or Erythromycin (if penicillin allergic) orally as per BNF.
2. Teach patients or their carers to recognise **eczema herpeticum** especially where other family members are known to have cold sores and in teenagers (Typically presents with small punched-out monomorphic clustered erosions on the face and neck). If eczema herpeticum is suspected, take a viral swab before prescribing empiric treatment. Refer urgently (same day assessment) to on call SPR in secondary care.
3. Patients with recurrently infected eczema may benefit from very weak bleach baths (See St John's PIL)
4. Dermol 500 lotion®/Dermol® cream have antimicrobial properties which can be useful for infected eczema.
5. Octenisan® wash is a useful antibacterial for recurrently infected eczema but can cause irritation.

Cow's Milk Protein Allergy (CMA)

1. Consider CMA when severe eczema in breast fed babies under 3 months is unresponsive to usual measures – refer to SEL IMOC CMA guidance. A trial of an Extensively Hydrolysed Formula (EHF) for 4 weeks **with a trial of CMP re-introduction at 4 weeks** may be appropriate.

Resources: NHSE guidance for over the counter items that should not routinely be prescribed in primary care.
On-line pictures for GPs – Primary Care Dermatology Society
Patient.info (Fingertip Unit Guide) Prescribing guidance (topical Steroids) - PrescQIPP
Patient leaflets (eczema herpeticum) – British Association of Dermatology TCI PIL
The use of Milton® baths in dermatology GSTT – St John's Institute of Dermatology patient advice videos

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Psoriasis (Images)

Initial assessment
(NICE Pathway: Psoriasis)

Generalised erythrodermic or **pustular psoriasis, Hallopeau's** (nail changes)

Refer for emergency assessment in Dermatology
(secondary care)

Chronic plaque psoriasis
Assess lifestyle precipitants (obesity, alcohol, medications, smoking) & mood

Offer an emollient + Vitamin D analogue (Calcipotriol) OD in the morning and potent topical steroid OD (evening) for 4 weeks

***If unable to use the above or OD preparation would improve adherence** - offer Dovobet® gel OD or Enstilar® foam OD for 4 weeks and review.*

If inadequate response, offer vitamin D analogue BD up to 12 weeks

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trilf fails, **add** Coal tar lotion (Exorex®) up to TDS (***Can consider*** offering potent topical steroid BD up to 4/52)

Guttate psoriasis
- Throat swab if sore throat or ASO titre
- Emollient (see guidance)
- Vitamin D analogue +/- moderate potency topical steroid
- Coal tar e.g. Exorex® lotion / topical steroid OD

If extensive, consider early referral for Phototherapy **(secondary care)**

Scalp psoriasis (children and adults but less potent options for children)
(Assess response of each intervention after 4 weeks, in order below)

Potent topical steroid scalp application OD up to 4 weeks (betamethasone or mometasone) or Diprosalic® if scale thick at presentation

Change formulation or add descaling agent (SebCo®, Cocois®, Diprosalic®) up to 4 weeks

Combination of calcipotriol and betamethasone (Dovobet gel®) OD up to 4 weeks or vitamin D analogue OD

- **Severe cases**: very potent corticosteroid BD up to 2 weeks **(adults only) OR** coal tar up to TDS
- Do not offer coal tar shampoos alone for the treatment of severe scalp psoriasis

Consider early referral (NICE CG153) as well as initiating treatment when there is:
- Diagnostic uncertainty
- Extensive or Moderate-Severe disease requiring phototherapy or systemic treatment **e.g. > 10% skin involvement**
- Major impact on physical, psychological, or social wellbeing. E.g. Occupational disability/excessive work/school absence
- Nail disease with a major functional or cosmetic impact
- Involvement of difficult sites (face, palms, genitalia)

Also refer if:
- Failure of appropriate response to topical treatment after 2-3 months or adverse reaction to topical treatment

Face, Flexures and Genital psoriasis
Regular use emollients to reduce scale and itch. Mild to moderate potency corticosteroids (TCS) OD-BD (max 1-2 weeks in any month with 4 week break between courses). *Advise stop steroid when skin is clear or nearly clear*
For inadequate genital response to 4/52 of treatment check adherence or unable to take treatment break from moderate potency TCS **REFER to confirm diagnosis/ consideration of Topical Calcineurin Inhibitor** (TCIs) (Amber 2) (pimecrolimus/ tacrolimus) BD up to 4 weeks

Children and young people with any type of psoriasis should be referred to a **secondary care specialist at presentation**

Complete pre-referral checklist and DLQi and seek advice/ refer via local referral pathway:

Community dermatology service
(mild to moderate and all scalp psoriasis)
Secondary care dermatology
(severe or patients requiring phototherapy or 2nd line drug therapy)

Dystrophic nails? fungal/ ? psoriasis : Take generous clippings for mycology. If fungal elements are seen on microscopy prescribe oral Terbinafine 250mg OD for maximum of 3 months
Check FBC; LFTs (and eGFR in adults) before starting treatment. Repeat only if abnormal.
If mycology negative, consider psoriasis and refer if impacting activities of daily living.

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Psoriasis: Key messages

- Refer early if systemic treatment may be required: Extensive (e.g. > 10% skin involvement, *strong association of obesity with metabolic syndrome so offer intervention*) or moderate to severe disease/ Major impact on physical, psychological or social wellbeing (e.g. occupational/ school absence)/ Nail disease with a major functional or cosmetic impact/ Involvement of difficult sites (face, palms, genitalia)

Refer all children to Paediatric dermatology at diagnosis

- Instruct all patients about the use of emollients as a soap and moisturiser, which will make the skin more comfortable and reduce the quantity of active agents needed.
- Appropriate active treatment is dependent on the **type** of psoriasis
- Discuss buying a prepayment certificate to reduce the burden of treatment costs.
- Psoriasis is treatable but not curable, complete DLQi to assess impact. High risk of depression explore psychosocial impact.
- Screen annually for psoriatic arthritis (particularly during the first ten years) using PEST screening tool BAD . Screen for cardiovascular comorbidities at diagnosis and every 5 years (NICE Clinical Guideline 153).
- Severe/atypical psoriasis is an HIV indicator condition. For information, please see the CKS topic on HIV infection
- Caution about use of Topical Calcineurin Inhibitor for genital psoriasis in uncircumcised men: refer to dermatologist if unresponsive to moderate potency Topical Corticosteroid/ cannot take treatment breaks from topical corticosteroid

Notes

1. Medications that trigger psoriasis: lithium, anti-malarials, beta-blockers, stopping oral corticosteroids abruptly.
2. Do not use potent corticosteroids continuously *for > 8 weeks* or very potent corticosteroids *for > 4 weeks*. Aim for a 4-week break between courses. **Do not use very potent corticosteroids in children and young people.**
   It is important to ensure safe volumes of potent/very potent topical corticosteroids on repeat prescription. Patients on long term treatment require annual F2F review to check for excessive use/skin atrophy.

Potency	Topical Corticosteroid
Mild corticosteroid	hydrocortisone 1%
Moderate corticosteroid	clobetasone butyrate 0.05% or betamethasone valerate 0.025% ointment
Potent corticosteroid	betamethasone valerate 0.1%; betamethasone dipropionate 0.05% mometasone furoate 0.1%; diprosone and salicylic acid each in ointment form
Very Potent Corticosteroids (Adults)	clobetasol propionate 0.05%

3. Nail psoriasis responds poorly to topical treatment but can offer a trial of Dovobet® gel for three months or Dermovate® lotion rubbed into the nail fold and trickled under the free edge of the nail. Advise cut finger nails with clippers in small segments. Consider podiatry for painful toenails. Refer if painful finger nails impacting activities of daily living as changes do respond to systemic treatment (on referral to secondary care).
4. Recurrent guttate psoriasis: evidence for benefit of antibiotic treatment is weak but in practice antibiotics are sometimes helpful for people with recurrent proven sore throats proven to be due to streptococcus.
5. Patients taking systemic treatments are followed up by secondary care dermatology (Contact CNS for queries)
6. Topical vitamin D preparations: calcipotriol (**Dovonex®**) licensed for long term use, apply liberally BD (not for face/flexures); tacalcitol **(Curatoderm®) OD** licensed for facial use. Creams are less likely to cause maceration in flexures. NICE recommends topical calcineurin inhibitors for face/flexures; calcipotriol and betamethasone 0.1% (**Enstilar®** foam**, Dovobet®** gel/ ointment) can be used intermittently for maximum 4 weeks (can make psoriasis unstable and cause steroid over use side effects).
   - Some patients benefit from Enstilar® twice weekly maintenance therapy until the next flare, when the frequency of application should be increased to once a day.
7. For thick, scaling scalp psoriasis massage **SebCo© (or Cocois©)** ointment into dry scalp; wash out after one hour or leave on overnight under a shower cap and wash out in the morning with any shampoo. Direct the patient to the British Association of Dermatologists Treating scalp psoriasis BAD video. **Dovobet gel©** applied to the scalp is left on until chosen hair wash; before washing hair, *apply shampoo to dry hair,* then wash out to avoid a gloopy mess.
8. **Psoriasis in CHILDREN**:
   Offer emollients. For Trunk and limbs; > 1year potent corticosteroid ointments, or **Dovonex®** for over 6-year olds. NICE Trunk & limb psoriasis in children and young people ***Refer to Paediatric dermatology at diagnosis.***

Resources:
On-line Psoriasis pictures for GPs – Primary Care Dermatology Society
Dermatology Life Quality Index Psoriasis PIL– Patient.info
Psoriais patient leaflet – British Association of Dermatology

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Lichen Planus

Background

- Fairly common, highly pruritic (itchy), non-infectious, evolving symmetrical rash
- Usually occurs in adults between the ages of 40-60 (rare in children and very old)
- Hepatitis and Varicella Zoster virus implicated as triggers

Examination :

- Well demarcated, shiny, violaceous, hyperpigmenting flat topped papules/ plaques
- +/- Wickham's striae (fine lacy white lines)
- Lichen planus may be linear, actinic, atrophic, guttate, bullous, pigmented flexural, blaschkoid (following Blaschko's line).
- It can be hypertrophic (typically shins)) or annular (typically penis, palms and soles);
- Linear group lesions can develop in scars (Koebnerising).
- A mixed lichen planus/ discoid lupus erythematosus has been described.

Check other sites to confirm clinical suspicion: it can develop anywhere but typically:

- Flexor aspect of wrists, ankles, low back, mouth (typically cheeks, less often tongue/ gingiva), scalp, nails, genitalia; on the penis it is more frequently annular.
- In the mouth (50%) and on the vulva it presents as a fine white lacy network but can be erosive; oral disease affecting lips and inside mouth more common in patients from the Indian subcontinent originally.
- In type V (Asian) skin it can present as asymptomatic axillary macular hyperpigmention.
- Scalp lichen planus can present with a burning sensation. There is often perifollicular scaling and perifollicular violaceous erythema; it can be scarring. **Refer scarring hair loss early**

Differential:

Sarcoid (often not scaly), psoriasis; if annular and no surface change consider granuloma annulare
Lichenoid drug eruptions: commonly on torso and can look more psoriasiform e.g. after taking Amlodipine (check FBC for eosinophilia)

Management of Lichen Planus:

- Prognosis: 50% patients clear in 9 months/85% by 18 months. In most cases, will go away with 2 years. Relapse in 20% of cases
- Emollients as soap and moisturiser helpful for pruritus with cool compresses instead of scratching. Short-term, sedating antihistamines available OTC may help with sleep.
- Limit stress and avoid triggers (smoking, alcohol, irritating food in oral lichen planus)
- Potent (Betamethasone Valerate 0.1% Ointment or Mometasone Furoate Ointment) or supra-potent (Clobetasol propionate = Dermovate©) OD using Finger Tip Units (FTUs) for a month or more. Warn that this may cause hypopigmentation in Type V/VI skin.
- *Stop* topical steroids when the papules are asymptomatic and macular (flat).
- Oral symptoms may be treated with betamethasone 500mcg or Flixonase® 400mcg which are to be dissolved in 10ml water and gargled for 2-4 minutes in accordance with SEL Oral Medicine Guidance.
    - Both treatments are off- label, and have a RAG rating of Amber 2 therefore requires specialist initiation from secondary care clinicians or GPWeRs, after which prescribing may be transferred to primary care
    - Please ensure patients **DO NOT** swallow the contents when using as a mouthwash
    - Please see the betamethasone 500mcg Patient Information Leaflet or Flixonase® 400mcg Patient Information Leaflet for further information
- Hypertrophic plaques may need potent or very potent topical steroids under Tegaderm occlusion, applied overnight and reviewed after 4 weeks or applied under Duoderm Extrathin and left for 5 days at a time.
- Do not treat asymptomatic post-inflammatory hyperpigmentation which will resolve spontaneously, over many months.
- **Refer Scarring or erosive Lichen planus early** for rigorous intervention.

Resources

Lichen Planus for GPs – Primary Care Dermatology Society
British Association of Dermatologists - Patient Information Leaflets (PILs) (bad.org.uk)

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Acne

Initial assessment – key aim is to prevent scarring
(Consider using the Dermatology Life Quality Index).
Guidelines and on-line pictures – Primary Care Dermatology Society

MILD
Open and closed comedones (non-inflammatory)*+/- some papules & pustules (inflammatory)*

MODERATE
More lesions that are mostly inflamed/ pustular lesions, nodules

SEVERE
Nodulo-cystic or Scarring acne; acne conglobata; Severe psychological disorder as a result of acne.
True treatment failure
Refer same day: Acne fulminans

Topical therapy with keratolytic/ comedolytic **e.g. Benzoyl peroxide BPO** - start with 2.5%, increase to 5% **(Encourage patients to buy OTC)**

All acne severities: Topical adapalene + benzoyl Peroxide (BPO) i.e. Epiduo® can be short contact or alternate day initially

Mild-Moderate Acne
Topical therapy with keratolytic/ comedolytic:
These are initially used in isolation, then in combination as Epiduo® to improve adherence
Mild -Moderate Acne: consider
- If there are pustules, consider topical antibiotic with e.g. Duac® 3% or 5%
- Consider **azelaic acid** or topical erythromycin if intolerant of benzoyl peroxide or a retinoid

Moderate – Severe Acne
- Do not combine oral and topical antibiotics
- **Add Systemic antibiotic to Epiduo for 3 months** (*See point 7)*
  - Doxycycline 100mg OD or
  - Lymecycline 408mg OD
  - Consider Trimethoprim 200mg BD or Erythromycin 500mg BD if tetracyclines are contraindicated or not tolerated

Consider **azelaic acid bd** or topical erythromycin if intolerant of benzoyl peroxide or a retinoid. If need contraception, **avoid** Progesterone Only Pill; consider adding Co-cyprindiol, Intra Uterine Device or condoms

Review Response to treatment at 12 weeks, check treatment compliance

Good response - stop antibiotics and advise maintenance keratolytic when required. Treat recurrence with same treatment or equivalent.

Partial response
Continue same antibiotics and topical for up to 3 months (up to 6 months if relapse quickly after stopping treatment Rarely longer**)
If PCOS consider COCP/ co-cyprindiol for females (even if contraception is not required)
Consider early referral for type V/VI skin with risk of persistent hyperpigmentation

Incomplete response at 3 months
Ensure that they have topical keratolytic and taking oral antibiotics; if not, add this. **Refer for consideration of double dose antibiotics, Isotretinoin, Photo Dynamic Therapy**
Whilst waiting an appointment offer a trial of Trimethoprim 200mg BD with a topical keratolytic e.g. Epiduo

Seek advice/ Refer via local referral pathway for consideration of oral Isotretinoin or spironolactone (women with hormonal acne):
- Mild-moderate acne unresponsive to 2 complete courses of treatment
- Moderate-severe acne unresponsive to a single course of oral antibiotics
- Acne with persistent pigmentary changes
- Acne of any severity cause persistent psychological distress or a mental health disorder (Consider referral to CMHT/ IAPTS also)
- Consider referral if secondary to medical disorder or anabolic steroids

Complete & include pre-referral checklist where available.
Ensure **effective contraception** in use at point of referral (Avoid POP); Advise patients to remove make-up for clinic visit. Give patient a form to have bloods taken **4 weeks** before clinic attendance: **FBC, Renal, LFTs HbA1C, lipids (not fasting)**

Complete DLQi **Refer urgently**
- Offer keratolytic and Trimethoprim 200mg BD until they are seen in clinic
- consider adding COCP/ co-cyprindiol for females (even if contraception is not required)

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Acne: Key messages

- Consider the psychological impact of the disease on the patient and their quality of life.
- Use **topical keratolytic** and/or **comedolytic** therapy (reduced bacterial resistance in combination) e.g. Epiduo
- Advise that treatment is effective but can take 6-8 weeks to work. Stress the importance of compliance, especially with keratolytics.
- Refer patients with severe acne with nodules, cysts and scarring urgently.
- Refer for consideration of Isotretinoin those with no response to antibiotics and a keratolytic at 6 weeks (severe) or poor response at least 3 months. There is no good evidence that switching antibiotics is effective.
- Where possible avoid prolonged courses of antibiotics (> 3months) to reduce antimicrobial resistance.
- NICE advise referral to a consultant led team experienced in managing scarring for severe scarring persisting > 1 year after acne has responded fully to treatment

Notes

1. Encourage use of non-alkaline synthetic detergent (syndet) cleansing product twice daily.
2. Avoid oil-based and comedogenic products and remove cosmetics at the end of the day.
3. Discourage picking, squeezing of acne lesions which may promote scarring.
4. Pomade acne only responds to stopping use of rich emollients on scalp and face.
5. Always use a topical keratolytic to prevent comedone formation (e.g. **salicylic acid 2% (Acnisal®), benzoyl peroxide 2.5% - 5% (BPO), topical retinoids, Epiduo®**). Initial treatment with Acnisal / BPO available **OTC – encourage patients to buy.** Assess treatment at 12 weeks, aiming for 50% improvement.
6. Benzoyl peroxide may cause bleaching of bedding, towels, or clothing
7. Adapalene may cause increased sensitivity to sunlight, use OTC sunscreen and protective clothing.
8. Advise patients to test new products on the inside of their arm for the first few days then *apply to the whole of the affected area* 3-4 days per week. Increase use gradually. **ROAT:** (Repeat Open Application Trial)
9. **Add** antibiotics (doxycycline 100mg once daily OR lymecycline 408mg OD for moderate disease. **Do not prescribe topical or oral antibiotic monotherapy** without a keratolytic**.** Never combine topical and oral antibiotics. Continue for a total of 3 months; if there is good response, stop the antibiotic and prescribe a keratolytic alone. If a partial response continue for 6 months; Dermatologists may increase the dose to twice daily. **Avoid minocycline** due to risk of lupus, skin pigmentation and hepatitis.
10. Trimethoprim 200mg BD is useful in resistant acne but is unlicensed for this indication and tends to be initiated by dermatologists (who may increase the dosage to 300mg BD and may advise durations longer than 4 months). NICE advises its use for mood – severe acne at the point of referral. *It should be discontinued early if the patient becomes systemically unwell.*
    Be aware of risk of SJS/TEN and DRESS with trimethoprim, discontinue treatment if rash develops.
11. Co-cyprindiol or any other COCP can be added after topical therapy or systemic antibiotic treatments. Co-cyprindiol can be especially useful in women who have **PCOS and acne.** It should be discontinued 3 to 4 menstrual cycles after the woman's acne has resolved due to the increased risk of venous thromboembolism. *Progesterone-only* contraception exacerbates acne**.**
12. Oral isotretinoin is prescribed by secondary care for severe, scarring acne and acne resistant to other therapies. It is teratogenic and females should be using an effective contraceptive *when referred.* Patients with Polycystic Ovarian Syndrome (PCOS) may not respond to treatment so well, but many still derive benefit.
13. Refer patients (or encourage IAPT self-referral) with severe psychological overlay for psychological assessment.
14. Topical Benzoyl peroxide or topical erythromycin are safe to use in pregnancy and breastfeeding. Avoid topical retinoids and oral Tetracyclines. Seek advice if systemic treatment required.
15. Topical erythromycin and Clindamycin lotion solution can safely be used in children. Seek advice if systemic treatment is needed for children and for all infantile acne.
16. Treat acne that relapses in the same way or with a different antibiotic; Epiduo or if one component is contraindicated; adapalene, azelaic acid or benzoyl peroxide can all be used as maintenance treatments.

Spironolactone in Acne

Spironolactone may be initiated for women with moderate – severe hormonally mediated acne by a specialist dermatology clinician. It may be continued for several years at doses of 50-100mg (occasionally up to 200mg) once daily (Spironolactone BAD PIL) with dose up-titration by GPs (if willing) as advised by the initiating clinician. Some women are able to reduce the dose or frequency over time without deterioration of their acne.

Clinicians must ensure the ongoing use of highly effective contraception (COCP, LARC or non-hormonal method) by all women of child-bearing potential taking spironolactone as it can cause testicular feminisation of a male fetus. The COCP (unless contraindicated) can be useful for managing menstrual irregularity associated with taking spironolactone.

The use of spironolactone in acne has a RAG rating of Amber 2, therefore prescribing must be caried out by a specialist ensuring female patients have effective contraception.

Baseline blood tests will include U&Es and blood pressure. This does not need repeating unless the patient is over 45 years old, has a history of renal or cardiac problems or is taking diuretics, aspirin/ indomethacin, trimethoprim or LMW heparin. In such circumstances or if there is baseline abnormality a repeat potassium level (K+) & eGFR 2 weeks after each dose change is desirable.

A 3-6 monthly review of efficacy, dosage and compliance with contraception by the GP (or GPwER/ dermatologist/ CNS if preferred) is desirable. Trial of dose reduction as appropriate when acne has been well controlled for 3-4 months: eg By 25mg/ day every 1- 2 months, consider maintenance topical therapy eg Adapalene or Epiduo etc. Advice and guidance from the community service can be sought if needed . If unable to reduce dose after 2 years* or skin flares despite maximum tolerated dose, refer back to discuss alternative intervention.

An eGFR < 60ml/min/1.73m^2, Cushings syndrome, Congenital adrenal hyperplasia and use of potassium sparing diuretics, potassium supplements, ACE Inhibitors, digoxin will usually preclude use of Spironolactone for acne. Potassium supplements, a diet rich in potassium or salt substitutes containing potassium can all lead to hyperkalaemia.

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Resources:

On-line pictures for GPs – Primary Care Dermatology Society
www.acnesupport.org
Patient leaflet – British Association of Dermatology
SJS/TEN Patient Leaflet – British Association of Dermatology
*Antibiotic Guidelines:
Bexley, Lewisham, Oxleas, and Greenwich antimicrobial guidance
Bromley antibiotic guidance
Lambeth antibiotic guideline
Southwark antimicrobial guidance

Original Approval date: January 2020 Last reviewed and updated: October 2022 Review date: October 2024
South East London Integrated Medicines Optimisation Committee (SEL IMOC). A partnership between NHS organisations in South East London Integrated Care System: NHS South East London (covering the boroughs of Bexley/Bromley/Greenwich/ Lambeth/Lewisham and Southwark) and GSTFT/KCH /SLaM/ Oxleas NHS Foundation Trusts and Lewisham & Greenwich NHS Trust

Rosacea **(adults)**

Initial assessment
Is there Flushing with clear triggers, are there telangiectasia?
Are there monomorphic inflamed papules, pustules?
Ask about ocular signs. Men may have rhinophyma and infra-orbital oedema

Papulopustular Rosacea
(SEL Rosacea pathway)

Flushing & fixed erythema

Ocular Rosacea
(+ Blepharitis/Keratitis)

Mild to Moderate
(Limited papules, pustules, with no plaques):

OTC Sunscreen + 1st Line
Ivermectin 1% cream, OD for up to 4 months. Treatment can be repeated as necessary. *Discontinue after 3 months if no improvement*

OTC Sunscreen + 2nd Line alternative
Azelaic acid 15% applied BD for 6-9 weeks. *Discontinue after 2 months if no improvement*
For those who have responded to previous courses of metronidazole 0.75% gel, a repeat course may be a suitable alternative to the above treatments; it is no longer a preferred option in new patients

Avoid triggers

Consider **beta blocker** e.g. propranolol 10-20mg BD especially if triggered by anxiety
Consider **Clonidine**
25 - 50mcg BD, starting as 25mcg OD and titrate up if tolerated

Refer if inadequate response

Lid hygiene/ warm compresses, eyelid massage/ OTC ocular lubricants/ avoid trigger meds
Oral antibiotics: 1st line
Doxycycline (unlicensed use) 100mg once daily
Or **2nd Line alternative:**
Lymecycline 408mg OD (unlicensed use)

Refer to Ophthalmology via local referral pathway

Severe: Systemic treatment *(Extensive papules, pustules, or plaques)*

1st Line Topical : Ivermectin 1% cream once daily *or* azelaic acid 15% gel twice daily **plus 6 - 12 weeks of either:**

- Oral doxycycline 100mg daily (off-label, less expensive & well tolerated; and an alternative in renal impairment)
- Oral oxytetracycline 500mg twice daily (avoid taking with meals)
- Consider Erythromycin 500mg BD for pregnant/ breast feeding or if tetracycline is contra indicated

2nd Line alternative oral antibiotic choices
If intolerance/inefficacy/adverse reactions (e.g. photosensitivity, abdominal pain, nausea) switch to:
Ivermectin 1% cream once daily *or* azelaic acid 15% gel twice daily plus **either:**

- Lymecycline 408mg once daily for up to 12 weeks (off-label, shorter courses are usually required) **OR**
- Doxycycline 40mg MR capsules once daily **for up to 16 weeks** (Licensed for rosacea without ocular involvement. Fewer side effects and equivalent efficacy to 100mg but more expensive)

- Diagnostic difficulty
- **Refractory:** Rosacea not responding to systemic therapy
- Disease causing significant psychosocial problems
  Low dose isotretinoin may be considered by specialist

Seek advice/ Refer to Community dermatology service via ERS where available

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Rosacea

Key messages

Clinical features: monomorphic papules on an erythematous background, pustules, telangiectasia, rhinophyma in association with flushing; with no comedones (distinguishing rosacea from acne).

Early treatment is important as each exacerbation leads to further skin damage and increases the risk of more advanced disease for example rhinophyma or infraorbital oedema in men

If flushing is problematic, advise avoidance of trigger factors, such as, extremes of temperature, sunlight, strenuous exercise, stressful situations, spicy food, alcohol, hot drinks. Avoid exacerbating medication (e.g. Calcium channel blockers) and topical steroids.

There is currently no known cure for rosacea, treatments help keep the symptoms under control.

Follow up & Monitoring

Follow up the patient after 6 - 9 weeks *(topical treatment)* or **12 weeks** *(oral antibiotics)*, to assess the effectiveness of treatment. If maintenance treatment is required:

- This may be continuous, followed by a 'drug holiday' until symptoms recur
- Patients responding to treatment can be stepped down from combined oral and topical treatment to topical only treatment alone, and then treatment cessation.
- Treatment should be based on Rosacea symptoms and level of severity. Patient review in 3 - 4 months by GP regarding maintenance treatment, if needed.
- Advise patients to test new topical products on the inside of their arm for the first few days then apply treatment to the affected areas of the face 3 to 4 times per week gradually increase frequency of application.
- For ocular disease advise about lid hygiene/ managing blepharitis e.g. warm eye pad, eyelid massage, ocular lubricants (OTC)

Self-care advice for all patients with Rosacea

Recommend frequent application of high factor sunscreen (minimum SPF30 and with 5*UVA protection) and encourage use of hats in direct sunlight. UV glasses required, especially in ocular rosacea.
Avoid aggravating factors in ocular rosacea, air con, smoky atmosphere, medication that cause dry eyes. Advise warm compresses with a heatable eye pad e.g. The eye doctor.
If the skin is dry, advise the use of non-comedogenic, hypoallergenic emollients. Apply cream to dry/sensitive skin or gel to normal/oily skin.
Provide sources of information and support, such as the British Association of Dermatologists (BAD) Patient Information Leaflet (PIL) for *Rosacea*.

Additional Information

- Pulsed dye laser for moderate-severe telangiectasia and Laser resurfacing for those with rhinophyma are not routinely available on the NHS (classified as procedures of limited clinical effectiveness).
- For persistent or fixed background erythema:
    - Brimonidine (Mirvaso®) is licensed for the management of facial erythema of rosacea, but it is a grey listed drug in the SEL Joint Medicines Formulary hence should not be prescribed by GPs

Resources:
On-line pictures for GPs – Primary Care Dermatology Society Patient leaflet – Patient.info
Patient leaflet – British Association of Dermatology
SEL IMOC Formulary Recommendation for Lymecycline in rosacea

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Skin Infections

Impetigo

	Treatments: Adults and children
Localised Lesions *Non bullous*	Topical antiseptic e.g. Hydrogen peroxide cream Crystacide® (OTC) TDS for 5 days or if unavailable/ inappropriate Fusidic Acid 2% cream/ointment TDS for 5 days (up to 10 days if recurrent)
Localised Impetigo that is • Spreading • Persisting	Advise use of Octenisan® lotion as soap (available OTC) Consider topical Mupirocin Ointment or cream TDS *Note: Mupirocin Cream is not recommended for children <1 year)* If **MRSA Positive:** Follow local guideline

Widespread/ Scattered lesions: (Adults and Children)

- Advise use of Octenisan® wash lotion as soap or Dermol Lotion in context of eczema (both available OTC) for bathing /or showering until lesions clear.
- **Bullous impetigo**: systemic treatment (Fucibet® cream BD may be needed)

	Systemic Treatment: ADULTS	Systemic Treatment: CHILDREN
Widespread/ Scattered lesions including: • Severe • Extensive and/or • Bullous impetigo	• Flucloxacillin 250mg –500mg QDS for 5-7 days *(Suitable if pregnant or breastfeeding)* ***If Penicillin allergic:*** • Clarithromycin 250mg -500mg BD for 5-7 days • Erythromycin 250mg – 500mg QDS for 5-7 days *(if pregnant or breastfeeding)*	• Flucloxacillin for 5-7 days ***If Penicillin allergic:*** • Clarithromycin for 5-7 days • Erythromycin for 5-7 days *(Clarithromycin suspension tastes unpleasant)* ***Refer to the BNFc or SEL Paediatric formulary for paediatric dose regime***

- **Keep children off school until lesions have resolved or 48 hours after antibiotics are started**
- **Treat nasal carriage** with a topical antibiotic as per table below
- If infection is confirmed to be due to MRSA follow local guidelines on appropriate treatment

Treat nasal carriage of Staphylococcus aureus:

Nasal carriage	Treatment - ADULTS and CHILDREN	Comments
	Place a 'match head' of ointment/cream inside nostrils and squeeze alar together	
S.Aureus with: • Recurrent impetigo • Persistent folliculitis • Recurrent boils **(not PVL/ not MRSA)**	Nasal Naseptin® cream *applied inside each nostril x 3-4 per day for 7 days* Encourage use of Octenisan® Wash lotion for bathing (or Dermol lotion in the context of eczema) both available OTC	Consider nasal Mupirocin ointment if: peanut, soya, or neomycin allergic (Naseptin ® is peanut oil based and contains neomycin), failed Naseptin® usage, Fusidic Acid resistance or MRSA
PVL positive S.Aureus or MRSA with • Recurrent impetigo • Persistent folliculitis • Recurrent boils	Offer *nasal* Mupirocin ointment *applied x 3 day inside each nostril for 5-7 day, (longer if bd)* Encourage use of Octenisan® wash lotion for bathing, lathered on for 1 minutes for 5 days including washing hair twice in the week or Dermol lotion (OTC) in the context of eczema	Close contacts such as family/ household members may need swabs and decolonization: Wash sheets / towels everyday Vacuum and dust. Use liquid soap.

Impetigo is a contagious bacterial infection of the superficial skin, predominantly occurring in children. It can be caused by Staphylococcus aureus *(S.Aureus)* or, less commonly, by Streptococcus. There are two clinical forms: the more common non-bullous impetigo known as **'Impetigo'** and **Bullous impetigo**. Multiple lesions arise, most commonly on exposed sites e.g. the face (around the nose /mouth) and limbs, or in flexures, especially the axillae.

Impetigo is usually diagnosed clinically. Due to the infectious nature of Impetigo, children must be kept off nursery and school until the impetigo has healed or crusted over, or 48 hours after antibiotics are started.

Treatment of Impetigo is based on the extent and severity of the infection and whether it is recurrent. A systematic review indicates topical and oral treatment produce similar results. Meticulous hand washing/ hygiene is crucial, using separate towels (wash at 60°C). Provide BAD patient information leaflet on impetigo for more information.
Poorly responsive or Recurrent Impetigo: If not responding/ spreading check compliance and *take skin/nasal swab for C & S* from patient and close family to identify possible methicillin-resistant Staphylococcus aureus (MRSA). Swabs are best taken from a moist lesion, or, in cases of bullous impetigo from a de-roofed blister. Request **C+S + PVL (Panton Valentin Leukocidin**)

Impetigo and Eczema: Where a child has eczema and impetigo it is important *to treat the eczema as usual with topical steroids*. If their eczema is recurrently infected, treating proven nasal carriage of *S.aureus* and treatment with weak bleach baths is helpful.

Folliculitis/ Boils

Characteristics	Treatment options ADULTS and CHILDREN
Mild: **Persistent/ Recurrent Folliculitis or boils**	• May resolve without treatment • Consider topical antiseptic, e.g. Octenisan® wash lotion for short-term use (available OTC) • Application of moist heat to aid drainage

More severe/persistent/ recurrent infections: Systemic antibiotics, use of antiseptic wash and treatment of nasal carriage

Characteristics	Treatment options: ADULTS	Treatment options: CHILDREN
Deep-seated and/or persistent lesions	• Flucloxacillin 250mg – 500mg QDS for 7 days *(Suitable if pregnant or breastfeeding)* ***If Penicillin allergic:*** • Clarithromycin 250mg – 500mg BD for 7 days • Erythromycin 250mg - 500mg QDS for 7 days (if pregnant or breastfeeding)	• Flucloxacillin for 7 days ***If Penicillin allergic:*** • Clarithromycin for 7 days *Clarithromycin suspension has unpleasant taste)* • Erythromycin for 7 days ***Refer to the BNFc or SEL Paediatric formulary for paediatric dose regime***
Severe and/or recurrent infections	**Systemic treatment: Treatment Choice (ADULTS)** As above for longer duration or consider Doxycycline 100mg once daily orally 6-12 weeks Swab nose for **nasal carriage** (if reoccurs or no improvement), if positive treat with mupirocin nasal ointment	
Consider discussing the management of children with local dermatologist/ microbiologist		

Treat nasal carriage of *Staphylococcus aureus* *(refer to table on page 27)*

Folliculitis

In Folliculitis, clusters of follicles are inflamed; this inflammation can be superficial or deep, infective, or non-infective.

- Send a microbiology swab take from a punctured pustule, exclude nasal carriage of staph aureus and exacerbating factors. If the swab is positive manage as for recurrent impetigo; **refer** if folliculitis is persistent.
- If a jacuzzi has been used a swab may confirm a pseudomonas folliculitis, needing treatment with systemic antibiotics.

See the Primary Care Dermatology Society: Folliculitis for further information.

Persistent/ Recurrent Folliculitis/ boils:

- Consider PVL (Paton Valentine Leukocidin) staph aureus especially if there are recurrent boils.
- Swab patient's nose, axilla, groin and nose of siblings, parents, partner. **Request PVL (Panton Valentine Leukocidin**).
- **Treat nasal carriage** as detailed below.
- Consider whether the patient has diabetes, consider FBC alongside HbA1c.

Sterile Folliculitis

Review aggravating factors; pseudofolliculitis, occlusion folliculitis or medications such as corticosteroids, androgens, and lithium. When a swab taken from a pustule is sterile the differential diagnosis includes:

Acneiform folliculitis: This may respond to oral tetracycline (> 12 years and if not pregnant/breastfeeding)

Pityrosporum folliculitis: Take a **mycology** scraping when the pustules are monomorphic and associated with fine scaling or where a sterile folliculitis is not responding to treatment: Malassezia is found on microscopy only.

- Treat with topical ketoconazole cream/ shampoo lathered on and left on for 1 minute, daily, until it settles (discuss with dermatologist/microbiologist if no improvement)
- Occasionally Itraconazole (off-label) orally 100mg OD for 10 days is prescribed for yeast infections. *(consider interactions)*
- If the folliculitis is florid or extensive and not responding to treatment, consider immunosuppression/ HIV

Eosinophilic folliculitis: Mycology negative, unresponsive to oral tetracycline; consider Immunosuppression/ HIV and refer for a biopsy.

Management of (Panton Valentine Leukocidin) PVL Staph aureus infection:

Confirmed PVL Staph aureus infection	**General advice for all patients:** Excellent hygiene, not sharing towels, change sheets and towels daily if possible. Offer patient information leaflet

Infection severity	**Treatment options (ADULTS)**
Mild	• May resolve without treatment • Drainage of abscesses and sensitivity testing to find appropriate antibiotics
Moderate	**Requires systemic antibiotics:** • Flucloxacillin 250mg – 500mg QDS for 7 days (Suitable if pregnant or breastfeeding) ***If Penicillin allergic:*** • Clarithromycin 250mg – 500mg BD for 7 days • Clindamycin 450mg QDS for 7 days (may cause diarrhea) • Erythromycin 250mg - 500mg QDS for 7 days (if pregnant or breastfeeding) (Longer courses may be needed)
Persistent, Recurrent or Severe Infection	***Seek advice from local dermatologists and/ or discuss with Microbiologist for local sensitivities*** *Consider Referral to Specialist especially if patient is systemically unwell*
HPA advise: all cases of PVL-SA should receive decolonisation treatment after antibiotic treatment once the infection has resolved and wound have healed. (Note that local dermatologists find early decontamination more effective) **Skin/nasal decolonization:** Nasal Mupirocin to nostrils TDS and wash with Octenisan® wash lotion daily for 5days and three times a week for hair (decolonisation normally carried out at the end of antibiotic treatment however may be initiated early) Decolonisation of nasal carriage of *Staphylococcus aureus* *(refer to table on page 27)*	

PVL (Panton Valentine Leukocidin) Staph Aureus Infection:

- PVL-positive *Staphylococcus aureus* (PVL-SA) causes recurrent skin and soft tissue infections (SSTIs)presenting as painful boils/red areas on the skin, often in more than one place, which don't get better despite antibiotic treatment when microbiological sensitivities suggest that response would be expected.
- The affected area is often more painful than the size of the lesion would suggest. It can cause invasive infections **in otherwise healthy young people in the community.**
- PVL is a cytotoxin that can destroy white blood cells. The toxin was first described by Panton and Valentine in 1932.
- Consider screening *anyone* with recurrent abscesses/furunculosis/ boils.
- Take Swabs (axilla/perineum/nasal) and **specify** '**?PVL'** if reason to suspect PVL-positive *S. aureus* (e.g. unresponsive to treatment/ recurrence, recent contact.)
- PVL *S. aureus* prevalence in the community is rapidly increasing (10-fold in 10 years). Infection control measures include screening of household contacts etc. for *S. aureus* carriage, requesting PVL detection and treating/ decolonising accordingly.

Risk factors for PVL Clinical infection:

(Remember the 5C's 'Close contact, Contamination, Crowding, Cleanliness, Cuts and grazes)

- Overcrowding (ask whether other household members have had recurrent boils or skin infections)
- Engagement in close contact sports (causing skin abrasions) e.g. rugby, wrestling.
- Being in military, residential home and school settings.
- Using contaminated articles: sharing towels, razors, baths
- Poor hand hygiene.
- Damaged skin, e.g. eczema.
- Recent overseas (exotic) travel
- Illicit drug use
- Immunosuppression

Resources:

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Patient leaflet – Impetigo
Clinical Knowledge Summaries - Impetigo
Primary Care Dermatology Society – Images_ Impetigo
Primary Care Dermatology Society – Clinical Guidance on Folliculitis and boils (furuncles / carbuncles)
Clinical Knowledge Summaries - Boils, carbuncles, and staphylococcal carriage
Infection prevention control - Guidance on the diagnosis and management of PVL-associated Staphylococcus aureus infections (PVL-SA) in England
British Association of Dermatologists PIL BAD Panton Valentine Staphylococcus Aureus (PVL-SA) skin infection
*Antibiotic Guidelines:
Bexley, Lewisham, Oxleas, and Greenwich antimicrobial guidance
Bromley antibiotic guidance
Lambeth antibiotic guideline
Southwark antimicrobial guidance

Viral Warts

Treatment of viral warts should not be routinely prescribed in primary care, as the condition is appropriate for self-care with over-the-counter treatment

VIRAL WARTS
(Patience and persistence is key)

Filiform warts (face/eyelids):
Refer for Cryotherapy:
do NOT advise use of topicals

Mosaic warts:
Formaldehyde soaks (refer to notes) used daily for 6 weeks.

Offer Patient Information leaflet

Hand warts:

- Use high concentration of **OTC salicylic acid** solution (keratolytic) **DAILY under occlusion** for 3-6 months.

Patience and persistence are key

- Pare dry wart weekly (use an emery board or corn file) may cause bleed but treatment can still be applied
- Soak the wart, dry the skin then apply solution to wart once daily
- Cover with an adhesive dressing and change daily

Adults: OTC Salicylic Acid **26%**

Children aged 2 years & over: OTC Salicylic acid **16.7%**

Consider glutaraldehyde 10% solution if wart is vascular or bleeding *(available over the counter)*

Resistant warts (Adults): Apply **Salicylic acid (50%)** to the wart after protecting the surrounding skin with petroleum jelly; cover with a protective dressing

Resistant warts (Children): Apply **Salicylic acid (26%)** to the wart after protecting the surrounding skin with petroleum jelly; cover with a protective dressing

Cryotherapy
(For exceptional circumstances, not usually available on the NHS) To be used in adults ONLY:
Freeze times after wart has turned white:
- Face 10 seconds
- Hands 10-20 seconds (improves clearance by 40%)
- Feet 15 seconds, thaw

1-2 minutes then repeat 15 seconds

Plantar warts (Verrucas):
As above;
* **50% salicylic acid** can be applied under occlusion.
Cryotherapy should NOT be used (only improves clearance by 10%)

Plane warts (face/hands): ***Do not treat***

- In exceptional circumstances a trial of Adapalene (off-label use) cream for 4 weeks only.
- If extensive and facial, consider **referral** to local dermatology service

Original Approval date: January 2020 Last reviewed and updated: October 2022 Review date: October 2024
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Viral Warts

Warts (verrucas) are caused by a human papillomavirus, which most frequently affects the hands, feet (plantar warts), and the anogenital region; treatment usually relies on local tissue destruction. Warts may regress on their own and treatment is required only if the warts are painful, unsightly, persistent, or cause distress.

- Refer to "Treatment Access Policy" section for referral exclusion
- **Children are an absolute referral exclusion**.
- For most, there is a strong case for **not treating warts**: there is no cure, more than 70% resolve spontaneously in 2 years. Plantar warts (Verrucae) are more persistent.
- All wart treatments are locally destructive, can be painful and cause scarring. Choice of treatment depends on age of patient and site of warts (cryotherapy should not be used for warts in children).
- Topical treatment is as effective as cryotherapy for hand warts. cover the wart with a plaster after treatment to improve penetration and prevent spread.
- Keep warts pared down between treatments; this is more easily done when the wart is dry. Insufficient filing of dead skin can reduce effectiveness of treatment.
- Treatment with duct tape may help.
- OTC low dose Zinc supplementation may improve or clear warts, Oxford University Hospitals have a helpful PIL.
- Viral warts are included in the NHS England guidance on conditions for which over the counter items should not be routinely prescribed in primary care.
- For **mosaic warts** (multiple, coalescing warts of feet), formaldehyde soaks are useful. Prescribe Formaldehyde 4% solution, to be used daily. Solution can be reused for 4-6 weeks; online pictures and guidance

Resources:
On-line pictures for GPs (viral warts) – DermNet NZ
Clinical Knowledge Summaries - Warts and verrucae
Patient leaflet (warts and verrucas) – Patient.info

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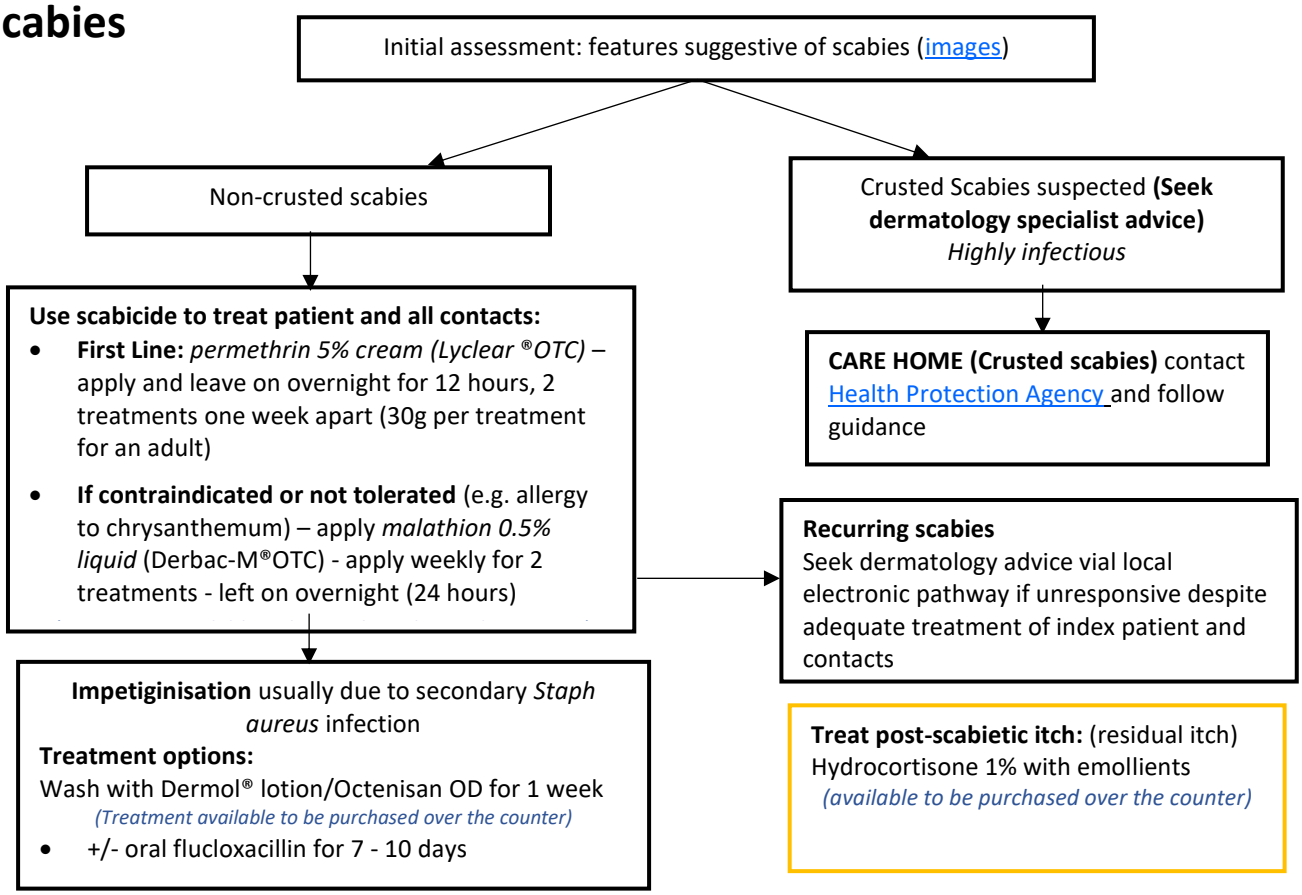
Scabies



- Scabies is an infestation caused by the mite *Sarcoptes scabiei.* Mites are most readily transmitted from one person to another by close physical contact (e.g. sharing a bed, caring for children/elderly).
- An individual who has not had scabies previously may not develop symptoms until 1 to 3 months after becoming infested.
- **Clinical features:** burrows on non-hair bearing skin; often a widespread eczematous rash (sparing face in older children/adults); possible inflammatory nodules on genitalia, periareolar areas, axilla/groin (especially if long standing). Papules and pustules on the palms and soles are characteristic of scabies in infancy.
    - ***Crusted Scabies*** is more common in patients who are immunosuppressed or frail or elderly; carers will also need treatment (and may transmit scabies to others).
- Apply scabicide to the whole-body (from chin/ears down) paying attention in between toes, fingers and under nails. Apply to the face and scalp in the immunosuppressed, elderly and very young. Repeat after 7 days. Permethrin requires 12 hours contact with the skin, malathion 24 hours. At same time, wash personal clothing/linen ≥60°C and drying by hot dryer, dry cleaning or sealing in a plastic bag for 72 hours. Seek advice for crusted scabies and recurring scabies as patients may require oral Ivermectin (weigh the patient, named patient only).
- Neither is licensed for use during pregnancy or breastfeeding - refer to the BNF and SmPC regarding risks. Offer patient leaflet on scabies treatment in pregnancy. Treatment should be removed from breasts before breastfeeding and reapplied afterwards.
- All household/ other close social contacts need treatment **at the same time** as patient.
- Mites are killed within 24 hours, but symptoms may take 3-6 weeks to settle. Genital nodules can be treated with localised potent topical Betamethasone Cream.
- Seek specialist advice from paediatric dermatologist for children under 2 months.

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Resources

On-line pictures for GPs (scabies) – Primary Care Dermatology Society NICE Clinical Knowledge Summary – Management of Scabies.
British Association of Dermatologists - Patient Information Leaflets (PILs) (bad.org.uk) Patient leaflet (scabies) – Patient.info

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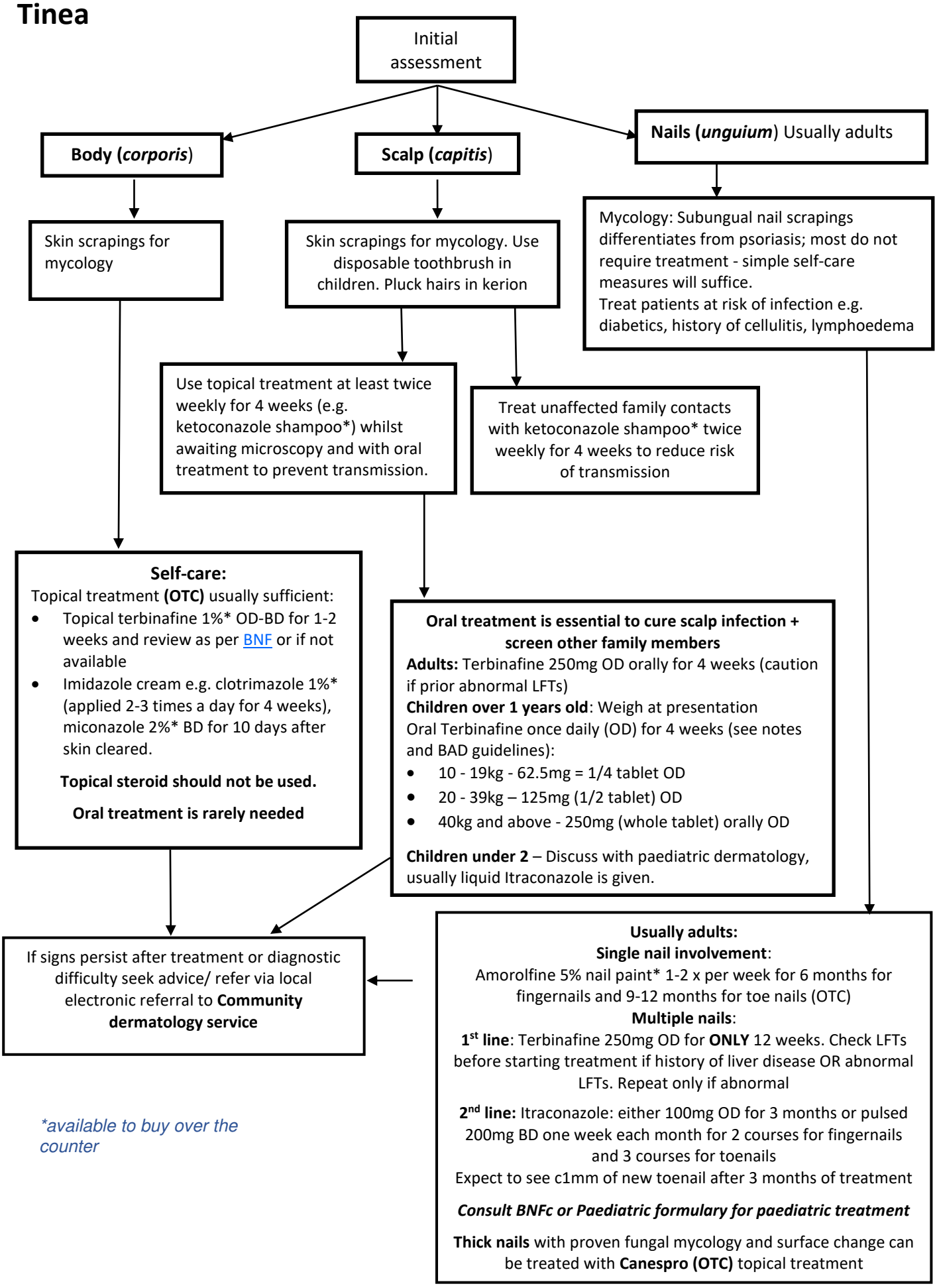
Tinea



available to buy over the counter

Original Approval date: January 2020 Last reviewed and updated: October 2022 Review date: October 2024

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Tinea: Key messages

- Dermatophytosis (tinea) infections are fungal infections caused by dermatophytes (a group of fungi that invade and grow in dead keratin). They tend to grow in an expanding circular pattern on the skin producing a ring, hence the term "ringworm".
- Treat with an antifungal e.g. Terbinafine cream or Miconazole cream rather than a combination cream with a topical corticosteroid.
- If extensive/ atypical/ not responding take mycology or send patient with a written request for sampling to **St Thomas' Mycology dept, 1st Floor, Staircase C, South Wing M-F 9.30-4pm**
- Tinea infections present with a variety of appearances, e.g. annular plaques, diffuse scaling, grey patches, pustules, kerion, patchy hair loss, nail changes.
- **Id response:** when fungal infections are treated orally, a very itchy fine usually localised papular rash can develop at another site; this is not an allergic reaction. It may last 2-3 weeks. Provided the fungal infection is being adequately treated, emollients and moderate strength topical corticosteroids e.g. clobetasone (OTC) can be applied once daily whilst it settles. If the rash is extensive and progressive discontinue and seek advice.

• Tinea capitis

1. Usually a disease of children; it presents with an itchy scalp, scaling/ crusting, or hair loss. Advise families to avoid sharing towels, pillows, combs/brushes, and hats. A child can go back to school once treatment has commenced. Schools should be informed and should alert parents what to look for. Take brushings from household members at presentation if they are in the surgery. If there is a boggy swelling (? Kerion) take a scraping and include plucked hairs.
2. The Mycology dept at St Thomas Hospital will take samples from patient and family. Give a completed form or letter and ask the patient to contact the department on 0207 188 6400.
3. **Oral terbinafine** being fungicidal is being used increasingly in urban populations instead of Griseofulvin (which is just fungistatic). It is considered superior against the majority of species causing infections in South East England, as noted in the Children's BNF and current BAD guidelines. Although unlicensed in children, in practice it appears to be safe and very effective. For children aged 1-17 years ONCE daily doses should be: 250mg for child weighing 40kg and above; 125mg for 20-39kg and 62.5mg for 10-19kg. Four weeks treatment. LFTs are not usually needed for children.
4. Topical antifungal treatment alone is insufficient but probably reduces infectivity and the chance of relapse, e.g. ketaconazole shampoo twice weekly or miconazole ointment twice daily for the first month. Washing the scalp daily with an antiseptic emollient helps remove scale e.g. Dermol® 500.

Tinea unguium

1. Treatment should not be instituted on clinical grounds - always consider other causes of nail dystrophy, psoriasis, compression by shoes, subungual melanoma. **Take mycology.** Scrape subungual nail debris at most proximal part of infection, which may require clipping the nail back, and include clippings. It can take 6 to 12 months for damaged nail to grow out. **Obtain positive mycology before prescribing systemic treatment** but note that 40% of affected nails will only have positive microscopy. Treat these as positive also.
2. Amorolfine 5% is the topical treatment 1st choice but is only recommended for limited infection (e.g. one nail or very distal disease in a few nails). May be used with systemic treatment to improve cure rates or if systemic treatment contraindicated. Apply twice weekly for 6-12 months until nail grows out.

Tinea Pedis **Consider if there is unilateral sole/ foot scaling.**

1. Systemic treatment should be used if there is co-existent nail involvement, treat as per tinea unguium.

Resources

On-line pictures for GPs – Tinea capitis Primary Care Dermatology Society NICE CKS Fungal Infections
Patient leaflet – Dermatophytosis Patient.info Patient leaflet – scalp ringworm British Association of Dermatology
Patient leaflet - fungal infections of the nails British Association of Dermatology

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Urticaria

For ALL types of urticaria

Primary care

STEP 1: ALL PATIENTS

Non-sedating second-generation H_1 antihistamines at licensed dose e.g. cetirizine, loratadine (available over the counter) fexofenadine 180mg OD*

If inadequate control: after 1-4 weeks, or earlier if symptoms are intolerable

STEP 2: IF NON-RESPONDER Complete DLQi

- Titrate dose of non-sedating H1 antihistamine up to four-fold off-licence* (cetirizine up to 20mg BD, fexofenadine 360mg BD, loratadine 20mg BD)
- Give lowest dose to control symptoms
- Continuous dosing is more effective than on demand treatment
- If the patient is getting little response, try a different antihistamine
- Sedating antihistamine e.g. hydroxyzine 10-25mg at night can be added in patients who have symptoms interfering with sleep despite up dosing second generation antihistamine (for short term use only until better control can be achieved with 3rd line treatments)

If inadequate control: after 1-4 weeks, or earlier if symptoms are intolerable

STEP 3: IF NON-RESPONDER

Add montelukast* 10mg daily (advised by NICE before consideration of omalizumab)

If inadequate control: after 4 weeks, or earlier if symptoms are intolerable move to step 4; or stop and refer

STEP 4: NON-RESPONDER

- Consider adding H2 receptor antagonist e.g. famotidine up to 20mg BD or nizatidine up 150mg BD (clinical preference previously ranitidine up to 150mg BD/300mg daily, however currently unavailable, addition of trial of H2 antagonist still recommended prior to referral)
  (not essential for NICE criteria prior to omalizumab but useful to)
- Stop and refer if inadequate control after 2-4 weeks or earlier if symptoms are intolerable.

IF NON-RESPONDER

Request advice and guidance or refer via single point of referral ERS to community dermatology service

IF SEVERE ANGIOEDEMA OR ACUTE-ON-CHRONIC FLARE

- Consider pulsed prednisolone
- 0.5mg/kg for 3 days only
- Repeat up to 3-4 times/year if necessary
- Long term treatment with corticosteroids should never be used routinely

***Denotes off-label use of the medicine**
Please see the South East London Urticaria Treatment Pathway **for further information**

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Urticaria/Angioedema

Key messages

- **Urticaria** is characterised by pruritic weals, angioedema, or both. The history is key. Individual weals last less than 24 hours and don't leave bruises. Consider urticarial vasculitis where weals persists for more than 24 hrs or leave persistent bruising.
- **Acute Spontaneous Urticaria:** symptoms persist less than 6 weeks. It may be exacerbated by food or medication. Where possible identify and avoid trigger factors e.g. stress, alcohol, caffeine. Diagnostic tests are not recommended.
- **Chronic urticaria**: symptoms continue for longer than 6 weeks. It can be classed as inducible (physical) or spontaneous. Chronic spontaneous urticaria can present as urticaria alone or as urticaria with angioedema. It often has a diurnal pattern. It is caused by immunological dysfunction.
- Inducible urticarias may be triggered by **heat, cold, pressure, vibration, water, ultraviolet light (UV**), etc. PCDS Inducible Urticaria Diagnosis & Images These urticarias are induced reproducibly when a specific physical stimulus is applied, however there can be a certain degree of overlap between spontaneous and inducible urticarias. If not responding to trigger avoidance (including use of sunscreens/hat for UV urticaria) and antihistamines, referral is appropriate.
- All patients with Urticaria should avoid aspirin, NSAIDs and codeine. Patients with *angioedema without weals* should avoid ACE inhibitors.
- Antihistamines are the mainstay of treatment. Continuous dosing is more effective than intermittent dosing.
- Steroids and adrenaline are NOT indicated for the management of simple urticaria, but short courses of prednisolone (3 days) may be valuable as 'rescue' treatment for facial angioedema or very severe urticaria exacerbations.
- Before referral for patients with chronic spontaneous (idiopathic) urticaria, check a full blood count (FBC), hepatic (LFTs) and renal function (eGFR) , thyroid antibodies (TFTs), autoantibodies and ESR **.**

Notes

1. Weals are itchy centrally white papules or plaques (due to dermal oedema) surrounded by an erythematous flare. The lesions vary in size and shape.
2. Angioedema is swelling of the soft tissues e.g. eyelids, lips, and tongue; it is NOT itchy and lasts 12-72 hours. It is occasionally inherited.
3. Patients with **Cold Urticaria** develop symptoms after exposure to the cold as in a cold wind, drinking a cold drink. Due to massive histamine release patients can develop life-threatening reactions if they are exposed to sudden temperature drops. Aquatic activities should always be done under supervision. *Refer such patients to Dermatology for a discussion about carrying EpiPens.*
4. Trial non-sedating antihistamines first as in the algorithm. The dose can be increased up to 4-fold standard dose daily (NICE) if needed, excluding patients with impaired hepatic function (loratadine) or renal function (cetirizine). All, especially Cetirizine, may be more sedating at higher doses.
    a. Where there is renal impairment, cetirizine should be dose adjusted or avoided (see BNF). Any additional anticholinergic medications prescribed may increase the risk of dementia – to help calculate the risk refer to the Anticholinergic Burden Scale.
5. Sedating antihistamines at night, e.g. hydroxyzine 25mg. Cautious use for patients over 75 years or if there is evidence of prolonged QT interval on their ECG.
6. Adults and children over 12years with severe, persistent urticaria may be offered Omalizumab in Secondary care.

Resources

On-line pictures for GPs – Primary Care Dermatology Society
Clinical Knowledge Summaries: Urticaria
Patient leaflet – Patient.info
Patient leaflet – British Association of Dermatology

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South East London Adult Hyperhidrosis Pathway - treatment pathway for Primary Care

History and diagnosis
Establish Primary or Secondary

Secondary hyperhidrosis:
1. Treat underlying cause
2. Refer to appropriate speciality
3. Manage symptoms with topical treatments

1. Characterise[1] primary hyperhidrosis
   - Generalised
   - Focal → palmoplantar, axillary, craniofacial
2. Calculate baseline HDSS[2]
3. **Management:**
   - Self-care:
     - High-strength antiperspirants e.g. aluminium salts (Driclor® or Anhydrol Forte®)
     - General advice[3] and support group (The Hyperhidrosis Support Group at and The International Hyperhidrosis Society)
   - **Prescribing options:**
     - Craniofacial hyperhidrosis- Trial glycopyrrolate 2% w/w in cetomacrogol A cream (BAD approved special). Apply to affected area twice daily.
     - Oral anticholinergics (generalised but can be used in focal[4])
       1. **First line:** Oxybutynin immediate release 2.5mg daily up to 5mg three times a day
       2. Second line options, where there are intolerable adverse effects or inefficacy of oxybutynin IR – consider either:
          (i) Oxybutynin modified release 5-10mg daily or
          (ii) Propantheline 15mg three times a day and 30mg at night (maximum total daily dose 120mg)

Also see SEL integrated Medicines Optimisation Committee **Recommendation 077** for further information.

4. Recalculate HDSS post **1 month** of each treatment trial - aim for reduction of HDSS to 1 or 2
   - Refer to secondary care (**dermatology**) if HDSS 3 or 4 despite above measures. **NOTE for focal hyperhidrosis- earlier consideration may be given for referral to dermatology for a trial of tap water iontophoresis.**

[4] See NICE hyperhidrosis evidence summary
Anti-muscarinic adverse effects: constipation, dry mouth, nausea, confusion, dizziness, headache, somnolence, blurred vision, urinary retention, flushing and dry skin
Anticholinergic burden: Many medicines have anticholinergic activity as a secondary pharmacological effect (e.g. some any psychotics, antidepressants, furosemide, some antiepileptics), and the additive cholinergic burden should be considered if intending to use oxybutynin or propanthaline in patients taking other agents with anticholinergic activity.

[1] Diagnosis of primary hyperhidrosis
- Focal visible excess sweating; present for at least 6 months; no apparent secondary causes
- At least 2 of the following: Bilateral and symmetric; impairs activities of daily life; at least one episode/week; age of onset <25 years; Positive family history (in 60-80% of cases); Stops during sleep

[2] Hyperhidrosis Severity Scale (HDSS)

Subjective Score	Clinical Interpretation
My sweating is never noticeable and never interferes with my daily activities	1 Mild
My sweating is tolerable but sometimes interferes with my daily activities	2 Moderate
My sweating is barely tolerable and frequently interferes with my daily activities	3 Severe
My sweating is intolerable and always interferes with my daily activities	4 Severe

[3] Advice for primary focal hyperhidrosis:
Recommend the following lifestyle measures: Modify behaviour to avoid triggers (crowded rooms, caffeine, or spicy foods)
Primary axillary hyperhidrosis: Use a commercial antiperspirant frequently; avoid tight clothing and manmade fabrics; wear white shirts or black clothing to minimise the signs of sweating; consider using dress shields to absorb sweat and protect clothing.
Primary plantar hyperhidrosis: Wear moisture-wicking socks, changed twice daily; use absorbent soles and use foot powder twice daily; avoid occlusive footwear. Alternate pairs of shoes on a daily basis.
Primary craniofacial hyperhidrosis: Avoid food and drink triggers (caffeine, chocolate, spicy or sour foods, hot foods, alcohol, citric acid or sweets)

South East London Adult Hyperhidrosis Pathway - treatment pathway for Secondary Care

General Clinic:
1. Verify above steps taken and confirm diagnosis
2. Calculate baseline HDSS

Generalised hyperhidrosis:
- Optimise systemics
- Combined approach

Focal hyperhidrosis:

Axillary

Day Surgery Laser Unit (DSLU) referral (via EPR)
- Funding for treatment of axillary hyperhidrosis with botulinum toxin (Botox™ licensed, 50 units in each axillae) as per SEL Treatment Access Policy criteria if:
  - Severe (HDSS 3 or 4)
  - Failed 6-month trial of conservative management including topical aluminium chloride or extra strength antiperspirant, general measures[3]
- Further treatments, at intervals of no less than 16 weeks, will only be commissioned provided at least a 2-point reduction on HDSS score can be shown during the 4 months following initial treatment.
- This pathway will be subject to audit and monitoring requirements.
- NOTE: Indications for botulinum toxin other than axillary hyperhidrosis require IFR funding approval

Palmoplantar

Iontophoresis pathway on Dermatology Day Centre (via EPR):
1. Trial tap water iontophoresis x 7
2. Assess treatment efficacy. If stable and has purchased own machine provide information and training for home iontophoresis.

If symptoms remain uncontrolled:
3. Consider combined prescription with systemic anticholinergic
4. Offer glycopyrronium iontophoresis x 2
5. Recalculate HDSS to demonstrate efficacy
6. If efficacy demonstrated, to continue glycopyrronium iontophoresis
7. If patient is stable and has purchased own machine, prescribe glycopyrronium 0.1% aqueous solution via outpatient prescription (submission of B* notification form to commissioners required) to enable continuation of glycopyrronium supply from the hospital for use at home.

Craniofacial

Glycopyrrolate 2% w/w in cetomacrogol A cream (BAD approved special). Apply to affected area up to a maximum of twice daily

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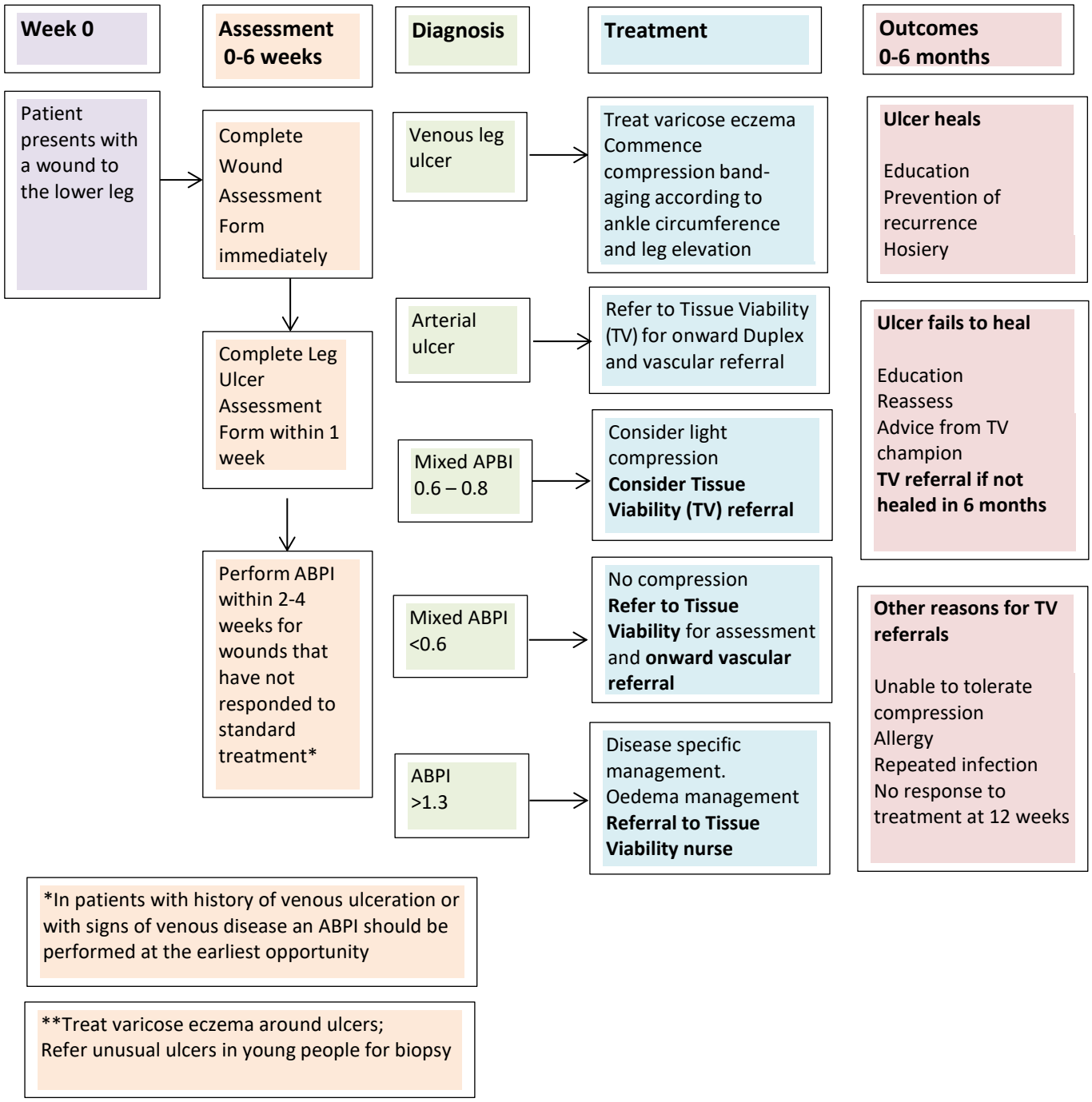
Leg ulcers – Pathway Management



GSTT (Guys and St Thomas') Referral Pathway and assessment forms available here
Lewisham and Greenwich Referral to Integrated Wound Care services Integrated Wound Care Service - Oxleas NHS Foundation Trust
Bromley tissue viability nursing information available here
Bexley Referral Pathway and assessment forms available here

Leg Ulcers

Key messages

- This algorithm is taken from the local comprehensive leg ulcer assessment and management guidelines (July 2010).
- **Identify risk factors:** smoking, peripheral vascular disease (history of claudication), history of varicose veins, deep vein thrombosis or rheumatoid arthritis (associated with inflammatory ulcers).
- **Examine patient** to identify vascular disease (venous or arterial).
- **Look for evidence of varicose eczema:** if present, treat with daily moderate-potent topical steroids and compression hosiery. Think about dressing contact dermatitis
- **Varicose ulcer:** refer to practice nurse for assessment including Dopplers, ulcer dressings and compression bandaging. If fails to respond refer to community tissue viability team. Housebound patients should be referred to District Nurses.
- **Arterial/mixed vascular disease:** refer to practice nurse for Dopplers, and vascular surgeons.

Notes

Dermatology referral criteria (secondary care):

1. Diagnostic uncertainty, including concern about malignant change (refer on 2WW only if suspected melanoma or SCC)
2. Ulcer with a heaped-up edge, pain or increasing size (non-healing ulcer with undermined edges).
3. Evidence of contact dermatitis.
4. Failure to respond to treatment after assessment by tissue viability team. Include info on previous dressings and Doppler assessment in referral letter.

Resources

On-line pictures for GPs – Primary Care Dermatology Society

Patient leaflet – Patient.info

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Management of Benign Skin Conditions

Key Messages:

Cosmetic removal is NOT available on the NHS (see Treatment Access Policy on next page)

Molluscum contagiosum	No treatment necessary; can try Potassium Hydroxide (Molludab) for 14 days OTC only; Crystacide (off licence but marketed for this) note that these cause an inflammatory response before resolution.
Skin tags	No treatment necessary. See NHS Choices for patient advice.
Seborrhoeic warts	Treat only if symptomatic and inflamed and there is no diagnostic uncertainty. A 10-day application of Fucibet cream bd will often settle inflammation and itching, review if concerned.
Pyogenic granuloma	Curettage and cautery (histology essential), refer to dermatology if difficult size/site or no clear history of trauma as the differential would include amelanotic melanoma.
Spider naevi/ Campbell de Morgan/ Vascular angiomata	Do not treat. Spider naevi arising in pregnancy may resolve spontaneously over time after delivery.
Benign naevi	Do not treat.
Atypical naevi	If genuine concern re melanoma refer as 2-week wait.
Sebaceous cysts	If symptomatic and inflamed can be excised under minor surgery DES.
Keloid	Cosmetic treatment not routine on NHS. GPs in all boroughs can refer keloids to their local Community Dermatology Service for steroid injections if very symptomatic.
Lipoma	Cosmetic removal not routine on NHS.
Dermatofibroma	Cosmetic removal not routine on NHS, take care as may leave ugly scar; refer if diagnostic uncertainty.
Keratin horn	Curettage and cautery (histology essential).
Giant comedones	Can be incised and contents expressed, lesions over 5mm need excision (cosmetic, treatment not routine on NHS).
Solar lentigines	Cosmetic treatment not routine on NHS.
Congenital naevi	Cosmetic treatment not routine on NHS.

South East London Treatment Access Policy (TAP)

South East London follows a Treatment Access Policy produced in collaboration between the six boroughs in South East London. It is reviewed and updated annually and divided into two sections.

SECTION 1

The Treatment Access Policy states that the following are **NOT ROUTINELY AVAILABLE OR FUNDED ON COSMETIC GROUNDS**. If the **TAP** criteria are met, i.e. the patient is over 21 and has severe physical disfigurement with professionally diagnosed reactive psychological disorder, **funding can be sought through the 'Individual Funding Request' (IFR) process** as below. See TAP for details on specific condition criteria.

- Dermabrasion (chemical peel)
- Scar revision (N.B. An exception may be made for scars that interfere with function (e.g. following burns) or for treatment of keloid and post-surgical scarring
- Tattoo removal
- Removal of birthmarks (note TAP criteria for removal if 18 or under)
- Removal of other benign skin lesions (inc. skin tags) N.B. epidermoid (sebaceous) cysts are NOT removed in the hospital dermatology department.
- Viral warts and molluscum contagiosum in children under 16 years of age
- Viral warts in adults
- Note that hirsutism despite having an underlying medical cause is not funded.

SECTION 2

Procedures that **do not require prior approval** if the restricted access criteria outlined in the TAP are met. An audit of these procedures will be undertaken routinely.

- Pigmented lesions
- Tunable dye laser

Other South East London Dermatology Guidelines

- Shared care guideline for the prescribing and monitoring of non-biological Immunomodulatory drug monitoring in dermatology

Individual Funding Requests (IFR) Policy

An IFR is made when a GP or consultant considers that their patient has a need for an un-commissioned treatment and wishes to request funding on their patient's behalf. NB. The TAP should be referred to in the first instance.

An up-to-date copy of the SEL TAP policies can be found here**.**
Further information with regards to IFR Policies can be found here.

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Useful Management Tips

Equipment

- Good light source
- Tape measure
- Dermatoscope
- Fungal scrapings kit; Disposable toothbrush for fungal scalp sampling)

Topical Steroids: Potency table

Potency	Drugs
Mild corticosteroid	Hydrocortisone 1%
Moderate corticosteroid	Clobetasone butyrate 0.05%; Betamethasone valerate 0.025%
Potent corticosteroid	Betamethasone valerate 0.1%; Betamethasone dipropionate 0.05% Mometasone furoate 0.1%;
Very Potent Corticosteroids (Adults)	Clobetasol propionate 0.05%

Topical steroids are usually applied **once daily,** after the application of emollients.
When used in the treatment of eczema, once the eczema has cleared the frequency may be reduced to twice weekly applied to normal skin at the site of flares to maintain remission whilst minimising the risk of adverse effects.

Topical Steroid: finger tip units (adults only)

- One fingertip unit (FTU) is the amount of topical steroid that is squeezed out from a standard tube along an adult's fingertip. 1 FTU = 0.5g
- Face & neck (2.5 FTU, 15-30g/week)
- Trunk (7 FTU, 100g/week)
- Both arms (6 FTU, 30-60g/week)
- Both legs (12 FTU, 100g/week)
- Groin & genitalia (2.5 FTU, 15-30g/week)

For **FTUs for children** see: http://patient.info/health/fingertip-units-for-topical-steroids

Emollients

- Adults 600g/week as emollient and soap. For kids 250g/week. Refer to the SEL emollient guideline.
- Scabies permethrin cream 30g generally sufficient for 1 application although 60g for larger people. Maximum 60g per application. Lotion 100ml for whole body application (200ml bottle)

Topical Calcineurin inhibitors (TCIs):

Topical calcineurin inhibitors are immunomodulators that act in the immune system to reduce inflammation. They reduce itching and redness. They may be used alongside topical corticosteroids (TCS) or instead of them to reduce the likelihood of adverse effects from TCS. They are use twice daily for flares or twice weekly to maintain skin clearance. They can cause tingling and irritation when first applied; this happens less if the skin condition is well controlled before a TCI is started. TCIs should not be applied to infected skin (e.g. impetigo or herpes/ cold sore. TCI PIL

Sun Protection Tips

- Protect skin with clothing, including a hat, t-shirt, and UV protective sunglasses.
- Seek shade between 11am and 3pm when it's sunny in the UK or 10 am to 4pm abroad.
- Use a sunscreen of at least SPF 30 UVB protection, which also has high (4-5*) UVA protection.
- Reapply sunscreen across the day, especially after swimming.
- Keep babies and young children out of direct sunlight.

Investigations in Primary Care

- **Skin scrapings:** Suspected fungal infection, use the blunt edge of a scalpel blade (or a Swann Morton blade)/ or disposable toothbrush in children to collect scale from leading edge of rash. Transport in a sterile container on black card. The Mycology department at St Thomas' Hospital will take scrapings for individuals and family

groupings if referred with a completed form or letter of request.
Mycology Dept, 1st Floor, Staircase C, South Wing, St Thomas Hospital 0207 188 6400

- **Skin swabs:** Suspected bacterial infection, particularly in crusted/weeping eczema Type in request for PVL if needed

Useful Blood tests

HIV test
FBC: Eosinophilia: consider adverse drug reactions
Pruritus: FBC for anaemia and eosinophilia, TFT, Ferritin < 70ng/mL (check iron/ TIBC as Ferritin if raised > 150 likely to be reactive), Renal, LFTs, LDH, HIV
Hair loss: check Hb, check Iron and TIBC, (Ferritin: Low < 100, can mislead as if raised may be reactive), Vitamin B12, Vitamin D, check zinc/ zinc intake also
ESR: raised: Erythema nodosum, sarcoid
ACE: raised: Sarcoid
Ana (Antinuclear antibody) & dsDNA Ana: consider SLE
ENA (Extractable nuclear antigen):
Late onset Raynaud's, check ANA: if anticentromere antibody consider limited systemic sclerosis

UV light:

Can be obtained inexpensively and is useful for confirming:

- Vitiligo - Depigmentation is white
- Microsporum canis - Glows Green
- Corynebacterium (Erythrasma) - Glows pink

Prescribing "Specials"

Most specially manufactured products recommended by specialists are included within the BAD specials list found here. Dermovate 60% in propylene glycol 40% is an additional special (for hand and foot hypertrophic scaling) in the joint formulary.
Please note, costs in the community can vary by £100s per prescription. **Speak to prescribing advisors at the CCG for advice.** Refer to the South East London Joint Medicines Formulary website for the South East London Red, Amber, Grey (RAG) list.

Useful resources for Health Care Professionals:

Images and Differential diagnosis PCDS Primary Care Dermatology Society Open Access
Images of less common conditions DermnetNZ

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References:

Acne:
PCDS pathway *http://www.pcds.org.uk/ee/images/uploads/general/Acne_Treatment_2015-web.pdf*
European Guideline 2016*european acne guideline 2016.*

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S3 European Guideline 2017 Evidence- and consensus-based (S3) Guidelines for the Treatment of Actinic Keratosis - International League of Dermatological Societies in cooperation with the European Dermatology Forum - Short version
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SEL JMF 2018: SEL IMOC Papulopustular Rosacea pathway

Urticaria NICE : Chronic urticaria: off-label doses of cetirizine Evidence summary [ESUOM31] Published date: July 2014 (X4) , also the Omalizumab submission SEL IMOC submission sites x 4 usage of antihistamines.
Management of CSU Not too complicated not too simple *https://onlinelibrary.wiley.com/doi/full/10.1111/cea.12465*
Advances in Understanding and Managing Chronic Urticaria Yasmin Moolani,[1] Charles Lynde,[2,3] and Gordon Sussman[a,1,4]
Understanding and managing chronic urticaria

Patient Information

PCDS

www.patient.co.uk

Conditions

- Acne (including pregnancy)
- Adverse reaction to drugs
- Atopic eczema
- Chilblains
- Contact dermatitis
- Epidermoid and pilar cysts
- Erythema nodosum
- Folliculitis
- Headlice
- Hives Acute & chronic urticaria
- Insect bites/stings; Bed bugs
- Intertrigo
- Lipoma
- Molluscum contagiosum
- Psoriasis
- PVL Staph
- Seborrhoeic dermatitis
- Skin ulcers
- Solar keratosis
- Vitiligo

Management

- Acne treatments
- Antihistamines
- Cancer of the skin – Prevention
- Emollients (moisturisers)
- Patch testing
- Sun and health
- Topical steroids, fingertip units

A-Z Conditions & Treatments - BAD Patient Hub (skinhealthinfo.org.uk)

Acne
Actinic (solar) keratosis
Alopecia areata
Atopic eczema
Basal cell carcinoma
Boils/Abscess
Bowen's Disease
Calcineurin inhibitors
Care of vulval skin
Cellulitis and Erysipelas
Contact dermatitis
Dermatofibroma
Dermatitis Herpetiformis
Digital Myxoid cyst
Discoid eczema
Eczema herpeticum
Epidermolysis bullosa
Erythema multiforme
Erythema Nodosum
Efudix treatment PIL
Folliculitis barbae
Frontal fibrosing alopecia
Fungal infection of nails
Granuloma Annulare
Hair loss Female
Hair loss Male pattern
Head Lice
Herpes simplex
Herpes Zoster (Shingles)
Hidradenitis suppurativa
Hirsutism
Hyperhidrosis (& Iontophoresis)
Ichthyosis
Impetigo
Kaposi's sarcoma Keloids
Keloids
Keratoacanthoma
Keratosis Pilaris
Latex allergy
Lentigo Maligna
Lichen Planopilaris
Lichen planus
Lichen sclerosus (Female)
Lichen Sclerosus (Male)
Lichen Simplex
Melanoma
Melanoma in situ
Melasma (Chloasma)
Molluscum contagiosum
Morphoea
Mycosis fungoides
Nodular Prurigo
Omalizumab
Oral lichen Planus
Oral treatment with corticosteroids
Palmoplantar pustulosis
Patch testing
PDT Photodynamic therapy
Pemphigoid
Peri-oral dermatitis
Phototherapy
Pityriasis alba
Pityriasis rosea
Pityriasis versicolor
Plantar warts
Polymorphic eruption of pregnancy
Pruritus
Pruritus ani
Psoriasis
PVL staph aureus
Pyoderma gangrenosum
Pyogenic granuloma
Polymorphic light eruption
Rhinophyma
Rosacea
Scabies
Seborrhoeic dermatitis
Seborrhoeic warts/ keratosis
Sarcoidosis
Skin camouflage
Solar urticaria
Subacute lupus erythematosus
Squamous cell carcinoma
Telogen Effluvium
Tinea Capitis
Topical corticosteroids
Traction alopecia
Urticaria and angioedema
Vascular birthmarks
Venous eczema (Varicose)
Venous Leg Ulcers
Vitiligo
Vulvodynia

www.dermnetnz.org

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Appendix 1 – Acute Trust details and Local Referral Pathways

<table>
<tr><td colspan="4">Urgent review/patient unwell, for review in <72 hrs Bleep Dermatology SpR on call
• Widespread blistering disorder
• Severe inflammatory skin disease e.g. Psoriasis involving > 70% skin with systemic upset</td></tr>
<tr><td colspan="2">KCH – Beckenham Beacon</td><td>01689 866400</td><td>Bleep: Medical Registrar on call
(Out of hours: Dermatology SpR on call at Denmark Hill)</td></tr>
<tr><td colspan="2">KCH – Denmark Hill</td><td>020 3299 1998</td><td>Bleep: Dermatology SpR on call</td></tr>
<tr><td colspan="2">GSTT</td><td>020 7188 7188</td><td>Bleep: Dermatology SpR on call</td></tr>
<tr><td colspan="2">LGT – University Hospital Lewisham</td><td>020 8333 3000</td><td>Bleep: Dermatology SpR on call
(Out of hours: Medical Registrar on call)</td></tr>
<tr><td colspan="2">LGT – Queen Elizabeth Hospital</td><td>020 8333 3000</td><td>Bleep: Dermatology Clinical Fellow on call
(Out of hours: Medical Registrar on call)</td></tr>
<tr><td rowspan="2">Bexley Practices
Use eRS
Attach a photo and referral form</td><td>Adults and Children</td><td colspan="2">eRS: Dermatology RAS - Bexley CCG</td></tr>
<tr><td colspan="3">Advice and guidance
• via Consultant Connect/PhotoSAF
• via ERS Dermatology Single Point of Referral

Community dermatology provider: Communitas</td></tr>
<tr><td rowspan="2">Bromley Practices
Use eRS
Attach a photo and referral form</td><td>Adults</td><td colspan="2">eRS: Bromley Dermatology Referral Assessment Service (RAS)</td></tr>
<tr><td colspan="3">Advice and guidance
• via Consultant Connect/PhotoSAF
• via ERS Dermatology Single Point of Referral

Children are not seen within the community service. Refer children via eRS to secondary care dermatology.

Community dermatology provider: Bromley GP Alliance</td></tr>
<tr><td rowspan="2">Greenwich Practices
Use eRS
Attach a photo and referral form</td><td>Adults and Children</td><td colspan="2">eRS: Dermatology RAS (Previously RMBS) - Greenwich CCG - 08A</td></tr>
<tr><td colspan="3">Advice and guidance
• via Consultant Connect/PhotoSAF
• via ERS Dermatology Single Point of Referral

Community dermatology provider: Communitas</td></tr>
<tr><td>Lambeth Practices</td><td>Adults and Children</td><td colspan="2">eRS: Lambeth Community Dermatology - Dermatology – Guy's & St Thomas' - RJ1</td></tr>
</table>

<table>
<tr><td>Use eRS
Attach a photo and referral form</td><td colspan="2">Advice and guidance
• via Consultant Connect/PhotoSAF
• via ERS Dermatology Single Point of Referral

Community dermatology provider: GSTT</td></tr>
<tr><td rowspan="2">Lewisham Practices
Use eRS
Attach a photo and referral form</td><td>Adults and Children</td><td>eRS: Lewisham Community Dermatology</td></tr>
<tr><td colspan="2">Advice and guidance
• via Consultant Connect/PhotoSAF
• via ERS Dermatology Single Point of Referral

Community dermatology provider: One Health Lewisham</td></tr>
<tr><td rowspan="2">Southwark Practices</td><td>Adults and Children</td><td>eRS: Community Dermatology Southwark - Dermatology - Guy's & St Thomas' - RJ1</td></tr>
<tr><td colspan="2">Advice and guidance
• via Consultant connect (telephone) +/- Photosaf
• via ERS Dermatology Single point of referral

E-referral (ERS) via Dermatology single point of referral
• For all dermatological conditions other than 2WW/ patients needing review in <72 hrs
• Indicate which community site/ secondary care site your patient would prefer to attend if offered a face to face appointment
Your referral will be reviewed by a local GPWER Dermatology with one of 3 outcomes:
• Advice about how to manage your patient returned to you via ERS
• The patient is offered an appointment within the community service (face to face or telephone)
• The patient is offered an appointment in secondary care.
Children are seen in the same clinic as adults for conditions appropriate for the community setting

Within the community service patients will be seen for investigation, a management plan and initial prescription as appropriate. In exceptional circumstances practices may be asked to initiate a new prescription. Repeat prescribing remains in general practice.

Community dermatology provider: Community Dermatology Southwark</td></tr>
</table>

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