

# **A Guide to Dermatology in Primary Care**

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**Swansea NHS Trust**



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# Introduction

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The Guidelines have been adapted by the Department of Dermatology of the Swansea N.H.S Trust in conjunction with the Local Health Board.

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

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

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

# Dermatology Department

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# Referral

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## Urgent Referrals

All referrals will be assessed and graded by a Consultant. Urgent referrals may be faxed directly to the dermatology department on 01792 285330. Please include the patient's telephone number.

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

## Skin Cancer

Referrals for melanomas and squamous cell carcinomas should clearly indicate the provisional diagnosis and will be prioritised as "urgent". Referrals should be made by fax on 01792 285330. Referrals for other skin malignancies e.g. basal cell carcinoma, should be made in the usual manner.

## Benign Lesions

Benign lesions will not be treated in the Dermatology Department for cosmetic reasons. This includes skin tags, benign moles, seborrhoeic warts and viral warts. Such lesions should only be referred if there is concern about possible malignancy or for confirmation of diagnosis.

## Content of referral letter

The following information should be included in all referrals:

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

# Topical Steroid Ladder

Potent and very potent steroids should usually be avoided in flexures and on the face.

Steroid/Antibiotic combinations e.g. Fucibet, Fucidin H should be used for a maximum of 14 days at a time to prevent bacterial resistance developing.

Generally speaking start off with a stronger steroid to get the problem under control, then reduce down to the weakest steroid that keeps it under control.

<u><i>MILD</i></u>	<u><i>MODERATE</i></u>	<u><i>POTENT</i></u>	<u><i>VERY POTENT</i></u>
Hydrocortisone 1%	Eumovate	Betnovate	Dermovate
Fucidin H	Betnovate RD	Locoid	
Vioform HC	Stiedex LP	Elocon	
Canestan HC	Trimovate		

# General notes on prescribing emollients for patients

## Quantities

It is recommended that emollients be applied frequently during the day, particularly when the condition is florid. In these situations the following quantities for ADULTS for one week are suggested:

<b>EMOLLIENTS/EVERY 2 HOURS</b>	<b>Creams and Ointments</b>	<b>Lotions</b>
Face	50—100g	250ml
Both hands	100—200g	500ml
Scalp	100—200g	500ml
Both arms or both legs	300—500g	500ml
Trunk	1000g	1000ml
Groin and genitalia	50—100g	250ml

The BNF recommended quantities of EMOLLIENTS to be given to ADULTS for twice daily application for one week are:

<b>EMOLLIENTS/EVERY 2 HOURS</b>	<b>Creams and Ointments</b>	<b>Lotions</b>
Face	15—30g	100ml
Both hands	25—50g	200ml
Scalp	50—100g	200ml
Both arms or both legs	100—200g	200ml
Trunk	400g	500ml
Groin and genitalia	15—25g	100ml

# Section 1: Acne

## Treatment aims:

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

## clinical features

Mild to moderate acne should be managed in primary care. Several different agents may need to be tried alone or in combination. Do not use combinations of agents with similar properties or actions e.g. topical plus systemic antibiotics. Inform patient that response is usually slow and allow at least 12 weeks before review.

### Mild

#### Uninflamed lesions - open and closed comedones (blackheads).

Occasional papules and pustules

#### Topical therapy

- Benzoyl peroxide
- Benzamycin
- Adapalene - Differin
- Isotretinoin - Isotrex
- Tretinoin - Retin-A

Often cause irritation therefore start with alternate day application and build up to daily over 2-3 weeks. Advise additional moisturiser.

Starting at 2.5% increasing to 5 or 10% may reduce irritancy with benzoyl peroxide.

### Moderate

Greater number or more extensive inflamed lesions.

#### Systemic antibiotics

- Oxytetracycline 500mg bd
- Lymecycline 408mg od
- Doxycycline 100mg od
- Erythromycin 500mg bd
- Minocycline MR100mg od

Oxytetracycline must be taken on an empty stomach to be absorbed. Erythromycin can be started in a higher dose 1g bd. if tolerated Once daily treatments may aid compliance.

Treatment should continue for **6 months** minimum and continued for longer if necessary.

### Moderate – Severe

Papules/pustules with deeper inflammation and some scarring

Systemic treatment as above plus topical therapy eg Adapalene, or Isotretinoin gel.

Consider additional hormonal treatment in females - Dianette

If patient is referred for Isotretinoin therapy check fasting lipids, LFTs and in females of childbearing age give contraceptive advice and treatment (usually a combined oral contraceptive).

### Severe

Confluent or nodular lesions usually with significant scarring.

Commence systemic therapy and refer immediately for systemic Isotretinoin treatment.

## Referral Criteria for Acne

The main reason for referral is for Isotretinoin therapy. Females of child bearing age should be established on an oral contraceptive prior to treatment. The indications for Isotretinoin are as follows:

1. Severe nodulo-cystic acne
2. Moderate acne that has not responded to prolonged (i.e. more than six months) courses of systemic antibiotic treatment in addition to topical therapy
3. Mild to moderate acne in patients with an extreme psychological reaction to their acne and have failed to respond to prolonged (i.e. more than six months) courses of systemic antibiotic treatment in addition to topical therapy

## Mild acne



Mild

## Moderate Acne



Mild-Moderate

## Severe Acne



Moderate



Moderate Severe



Severe

Treatment aims:

- To achieve remission

## Section 2: Rosacea

### clinical features

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

### Ocular Rosacea

### treatment

#### Topical Treatment

- Metronidazole Gel/Cream bd

#### Systemic Treatment

- Oxytetracycline 500mg bd
- Doxycycline 100mg od
- Lymecycline 408mg od
- Erythromycin 500mg bd

- Oxytetracycline

#### Surgical Treatment

Vascular Laser

Dermabrasion  
Laser  
Surgery

### therapeutic tips

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

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

Mild to moderate cases or where systemic treatment is contra-indicated.

More widely used as an addition to systemic therapy.

Continue therapy for 6–12 months although response is normally more rapid.

NB. Tetracyclines are contra-indicated in pregnancy, lactation and renal disease.

NB. Both lymecycline and doxycycline can cause photosensitivity. Patients should be advised that they may need to avoid direct sunlight and to wear a suitable sun block when going outside.

Not contra-indicated in pregnancy  
NB. Prone to cause gastro-intestinal upset.

Advise patient on lid hygiene to manage blepharitis.

For telangectasia

For rhinophyma

## Section 2: Rosacea (cont)

### Criteria for referral

- Doubt over diagnosis.
- Severe disease .
- Severe Ocular Rosacea with keratitis or uveitis – refer to Ophthalmology Department
- Rhinophyma without rosacea – refer to Plastic Surgeons.



Rosacea



Rosacea



Rosacea (with Rhinophyma)

# Section 3: Hand eczema

## clinical features

### A Endogenous Eczema (eg. atopic)

### B Exogenous Eczema

#### (i) Irritant contact dermatitis

Due to substances coming into contact with the skin, usually repeatedly, causing damage and irritation.

Substances such as

- Detergents
- Shampoos
- Solvents, coolants etc
- Household cleaning products

#### (ii) Allergic contact dermatitis

Due to type IV allergic reaction to a substance the skin is in contact with.

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

Hand eczema is often multifactorial with endogenous and exogenous factors playing a role e.g. atopic eczema plus irritants, and contact allergy.

## treatment

### Avoidance of irritants

Soap substitutes such as Aqueous cream should be used. Gloves should be used for wet work such as dishwashing and food preparation. Gloves may also be required for dry work e.g. gardening.

### Emollients

These should be applied frequently. There are a variety of emollients on the market that vary in their degree of greasiness. Different patients will prefer different preparations.

### Topical Steroids

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

### Potassium permanganate

1:10000 soaks for fifteen minutes daily for acute wet eczema until blistering weeping has dried. This may stain nails brown.

### Antibiotics

Secondary infection often co-exists, if skin broken use a combined steroid/antibiotic e.g. Fucibet for 10 days only.

## therapeutic tips

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

**Patch testing** should be considered in all patients with persistent hand (or foot) eczema. History alone will only identify 50% of cases of allergic contact dermatitis

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

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

## Criteria for referral

- If allergic contact dermatitis is suspected and Patch Testing is therefore required.
- Severe chronic hand dermatitis, which is unresponsive to treatment described above.

# Section 4: Urticaria and Angioedema



## clinical features

### Establish the Diagnosis

In urticaria, wheals come and go. The duration of the wheal is a helpful diagnostic feature

Minimize aggravating factors

- Overheating.
- Stress.
- Alcohol.

Review the **drug history**.

Aspirin, codeine, opiates and ACE inhibitors are frequent culprits.

### Check:

C1 esterase level (if angioedema only)

FBC  
TFTs

## treatment

### Antihistamines

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

If attacks are frequent give continuous treatment with a non-sedating antihistamine. If no response, try another agent, and then consider adding in a sedating anti-histamine at night.

- Stop aspirin, NSAID, ACE inhibitors – consider alternatives (clopidogrel, Cox II inhibitors).

- A short course of prednisolone could be given in severe, acute urticaria, for example penicillin allergy.

Systemic steroids should never be given in chronic urticaria.

## therapeutic tips

In most cases urticaria and angioedema are benign and self-limiting and no underlying cause is found. Time taken to illicit a careful history is more rewarding than blind investigation.

Prick tests and RAST tests are not useful as screening tests in urticaria. Food allergy is usually obvious from the history.

Physical urticarias such as cold urticaria or dermatographism can usually be identified from the history.

Patch tests play no role in the investigation of urticaria.

Urticaria can follow viral, bacterial and parasitic infections. Rarely it can be a symptom of auto-immune thyroid disease or connective tissue disease.

Urticaria and Angioedema

## Criteria for referral

**Hereditary angioedema**

**No response to three different antihistamines given for at least 4 weeks each**

**Extremely severe urticaria and angioedema**

## Summary of non-sedating and low-sedating antihistamines

name	drug interactions	comments
Acrivastine	None	Short acting. Avoid in renal impairment and pregnancy.
Cetirizine	None	Minimally sedating. Half the dose in renal impairment. Avoid in pregnancy.
Fexofenadine	None	Avoid in pregnancy.
Loratadine/Desloratidine	None	Avoid in pregnancy.



Urticaria

# Section 5: Viral warts and Molluscum contagiosum

## management

### Viral Warts and Verrucae

These two viral induced lesions are common especially in children and are self-limiting.

There are no easy or guaranteed treatments or magic cures and they are best left to resolve spontaneously. Greater than 60% of hand and facial warts clear within two years, plantar warts tend to be most persistent.

### Molluscum Contagiosum

90% of mollusca clear within one year.

## treatment

Use a high concentration salicylic acid preparation such as

- Occlusal
- Verrugon

- Cryotherapy  
Pare down with a scalpel first.

Treat associated eczema or impetiginisation with:

- Emollients
- Mild topical steroids +/- antibiotic therapy

- Cryotherapy

## therapeutic tips

Instruct the patient that this should be applied daily after bathing and rubbing down the softened skin with pumice stone or sandpaper. This may need to be continued for many months.

Caution: Use of liquid nitrogen on pigmented skin may cause permanent loss of pigmentation.

Best performed at three weekly intervals with one freeze thaw cycle on the hands and two on the soles, (hands 70% cure rate after four treatments, plantar warts 40%). If there is no sign of improvement after four or five treatments then it is unlikely to be effective and should be discontinued.

Affected children should have their own towels to reduce the risk of transmission to siblings.

Caution: Use of liquid nitrogen on pigmented skin may cause permanent loss of pigmentation

Individual lesions will resolve if the central core is damaged by any modality including cryotherapy but this is not recommended in young children, as it is too painful.

Viral warts and molluscum contagiosum

## Criteria for referral

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

Patients may be referred if:

- There is any doubt about the diagnosis
- Severe disabling warts despite six months of topical salicylic acid treatment +/- cryotherapy.
- Significant warts or mollusca in immunocompromised patients i.e. transplant patients.
- Facial warts other than plane warts

# Viral warts and molluscum contagiosum

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Viral warts



Molluscum contagiosum

# Section 6: Scabies

## clinical features

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

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

There is usually

- Widespread inflammatory papular eruption
- Burrows on non hair bearing skin of the extremities (palms and soles)
- Pruritic papules around the axillae umbilical region and buttocks
- Inflammatory nodules on the penis and scrotum

The reactive rash to scabies can be eczematous or urticarial. **Several members of a family are usually affected.**

Impetiginisation may also occur i.e. secondary infection

## treatment

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

The first and essential step is to kill all the mites in the skin using a scabicide. Apply either:

**Permethrin 5%**  
(Lyclear Dermal Cream)  
**Malathion 0.5% aqueous solution**  
( Derbc M)

Apply it very thoroughly to all parts of the body from the chin down. Literally all the skin must be treated including the web spaces of the fingers and toes, under the nails and in all body folds.

Permethrin should be left on the skin for between 8–12 hours, Malathion for 24 hours.

One to two treatments are usually curative except in crusted (Norwegian) scabies.

Treat residual itchy areas with an emollient and topical anti-pruritic e.g.

**Crotamiton (+/- hydrocortisone)**  
Eurax (HC)

## therapeutic tips

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

Remind patients to re-apply the scabicide after washing their hands.

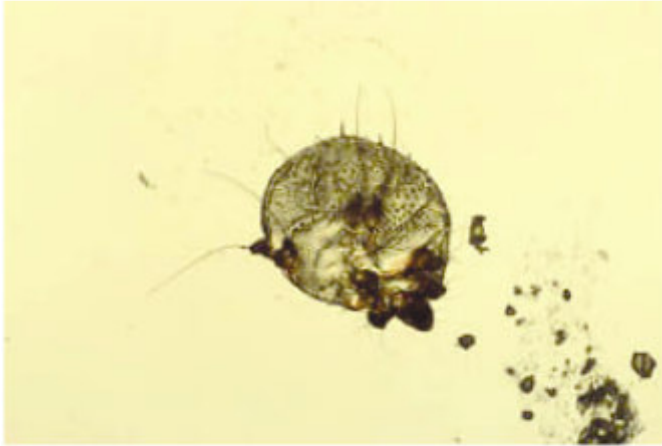
At the end of this period the patients can bathe, change their underclothes, nightclothes, sheets and pillowcases.

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

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

# Scabies

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Sarcoptes Scabies



Burrow

# Section 7: Solar Keratoses

## clinical features

### Solar Keratoses

Also known as actinic keratoses, usually are multiple, flat reddish brown lesions with a dry adherent scale. Commonly found on the face, bald scalps and backs of the hands.

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

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

Patients should be advised on sun protection and to use sunscreen.

## treatment

Cryotherapy  
Freeze for 5 to 10 seconds each.

- Diclofenac Sodium (Solaraze)  
Twice daily for 2–3 months.

- Topical 5-Fluorouracil (Efudix)  
Apply twice daily for 2 weeks.

## therapeutic tips

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

Useful for more widespread lesions. Optimum effect 1 month post treatment. May cause some irritation and contact dermatitis, moisturiser can help to reduce this.

This is the ideal treatment for widespread, multiple, ill-defined solar keratoses. It spares normal skin, allowing application to a wide skin surface. It is safe and effective, with little systemic absorption. Marked inflammation should occur prior to resolution and the patient must be warned to expect this. There is an excellent patient information leaflet on Efudix cream supplied by the manufacturers. Less frequent application may help if inflammation is brisk.

## Criteria for referral

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

# Solar Keratoses



## Section 8: Generalised pruritus

### clinical features

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

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

### treatment

Emollients and soap substitutes.

- Crotamiton or Crotamiton combined with hydrocortisone cream. (**Eurax / Eurax HC**)  
Apply twice daily to pruritic areas.

- 1% Menthol in Aqueous cream. Apply as often as felt necessary to pruritic areas.

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

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

or

- Doxepin nocte
- Amitriptyline nocte

- The use of potent topical steroids should be discouraged.

### therapeutic tips

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

- Anaemia  
Especially iron deficiency.
- Uraemia
- Obstructive jaundice
- Thyroid disease both hypo and hyperthyroidism
- Lymphoma, especially in young adults
- Carcinoma, especially in middle age and elderly
- Psychological

A full general examination must be performed at the outset.

Organise the following investigations, and follow up any abnormalities:

- FBC and differential
- ESR
- Urea and electrolytes
- LFT's
- Thyroid function tests
- Iron Studies
- CXR

NB. Pruritus may occasionally predate a lymphoma by several years.

# Section 9: Fungal infection of the nails

## clinical features

Thickened and dystrophic nails are common and a fungal infection is not the only cause.

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

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

## treatment

It is acceptable not to treat fungal nail infection.

**Do not treat unless mycology is positive.**

Oral antifungals:

- Terbinafine (Lamisil) 250mg od 12–16 weeks for toenails, 6–12 weeks for fingernails.

- Itraconazole (Sporanox)  
Pulse treatment, 3 pulses of Sporanox bd for 7 days repeated monthly (3 cycles for toenails, 2 for fingernails).

If systematic treatment is contra indicated, topical amorolfine (Loceryl nail lacquer) can be used for mild infection under the distal end of the nails or it can be used in combination with terbinafine to increase the success rate.

## therapeutic tips

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

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

If negative, repeat. If two scrapings are negative arrange for regular Chiropody to keep nails manageable.

# Fungal infection of the nails

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Non-matrix Onychomycosis



Non-matrix Onychomycosis  
(superficial white Onychomycosis)



Matrix involved Onychomycosis



Psoriatic nail

# Section 10: Skin Cancer

## clinical features

## treatment

## therapeutic tips

Skin cancer

### Basal Cell Carcinoma

These are common slow growing and locally invasive tumours. Most are easily recognised with a pearly rolled edge and later central ulceration. Pigmented and morphoeic (scar like, poorly defined). BCC's are less common variants.

They are best managed by complete excision but in some cases radiotherapy, cryotherapy, topical immunotherapy or photodynamic therapy (PDT) may be a preferred option. A tissue diagnosis (i.e. biopsy) is still required prior to treatment so initial referral to dermatology is advised. They do not need to be sent urgently through the skin cancer fax system. We will endeavour to comply with the Welsh Skin Cancer Standards to start definitive treatment for patients with BCC within 5 months of referral.

### Squamous Cell Carcinoma

These malignancies are much less common. They may be slow growing, well differentiated, keratinising or rapidly enlarging, poorly differentiated tumours. Occasionally they may metastasise to regional lymph nodes.

All patients with suspected SCC should be referred urgently via fax - 01792 255330. We will endeavour to comply with the Welsh Skin Cancer Standards to start definitive treatment for patients with SCC within 8 weeks of referral.

### Malignant Melanoma

This is the most dangerous skin malignancy. Early detection and excision is vital for good prognosis.

#### Melanoma subtypes

- Superficial spreading
- Nodular
- Amelanotic
- Lentigo Maligna
- Acral lentiginous and subungual

All suspicious moles should be referred urgently to the pigmented lesion clinic via fax number 01792 285330. General practitioners should not attempt to deal with suspected melanomas. We will endeavour to comply with the Welsh Skin Cancer Standards to start definitive treatment for patients with melanoma within 6 weeks of referral.

## Criteria for referral

The following seven point checklist may be useful in deciding whether to refer a changing pigmented lesion. Refer if at least one major or two minor criteria present.

#### Major features

- Change in size
- Change in colour (variability of pigmentation)
- Change in shape (irregularity of edge)

#### Minor features

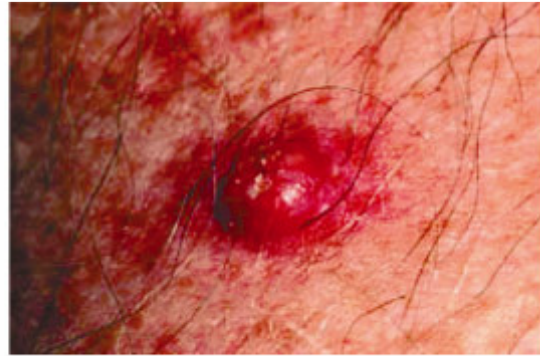
- Size >5mm diameter
- Inflammation
- Bleeding/crusting
- Itch

# Non melanoma skin cancer

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Basal cell carcinoma



Squamous cell carcinoma

# (Malignant melanomas)

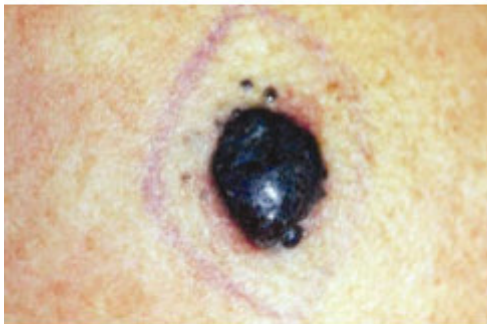
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Lentigo maligna



Superficial spreading



Nodular



Amelanotic

# Section 11: Psoriasis

## clinical features

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

## treatment

### Chronic Plaque Psoriasis

First line therapy:

#### 1 Emollients

Diprobase  
Cetraben  
Aqueous Cream

#### 2 Vitamin D analogues

- Calcitriol (Silkis)  
Apply twice daily (up to 210g weekly).
- Calcipotriol (Dovonex)  
Apply generously twice daily (up to 100g weekly).

Dovobet oint  
Apply once daily for up to 4 weeks (up to 100g weekly)

#### 3 Tar preparations

- Alphosyl cream
- Exorex lotion

#### 4 Topical Steroids

Useful in select areas:

Scalp- Betamethasone scalp application  
Face -1% Hydrocortisone  
Flexures – see below  
Palms and soles

#### 5 Dithranol

Dithrocream  
Micanol

## therapeutic tips

Ensure patients understand how and when to use their treatments.

Simple emollients are often underused in psoriasis but can reduce scaling dramatically  
They can be combined with other topical therapies.

Expect improvement to be gradual, achieving maximum effect over up to 12 weeks treatment. If useful can be continued long term or intermittently. They can cause irritancy and dryness, use emollient as well.

This is a combination of steroid and vitamin D analogue, and may give a quicker response than vit.D alone but is not suitable for long term treatment.

Refined tar products are less smelly or messy than old unrefined preparations. May stain clothes or irritate. Expect slow response over 6 – 12 weeks.

Do not use Dermovate or Diprosalic in chronic plaque psoriasis.

Can be used as short contact treatment but stains skin, clothing etc and may burn. Patients have to be very well motivated and require instruction on how to use it correctly. Used for day patient treatment.

# Section 11: Psoriasis

clinical features	treatment	therapeutic tips
<p><b>Guttate Psoriasis</b></p> <p>Numerous small lesions, mostly on trunk, generally affecting children/young adults acutely. Often self-limiting over 3 – 6 months.</p>	<p>Treat with emollients plus trials of tar preparations, Vitamin D analogues or moderate potency steroid e.g. Clobetasone Butyate 0.05%. If very inflamed use emollients alone.</p>	<p>If severe, early referral for phototherapy may be the best option.</p>
<p><b>Scalp Psoriasis</b></p>	<p>Generally requires combination of keratolytic and anti-inflammatory agents. Initially</p> <ul style="list-style-type: none"> <li>• <b>Calcipotriol</b> scalp application plus tar based shampoo <b>Polytar, Alphosyl</b> or <b>Capasal</b>.</li> </ul> <p>If very itchy a topical steroid could be substituted.</p> <p>In more severe cases use keratolytic e.g. <b>Cocois</b> massaged in and left in for up to an hour, washed out with tar shampoo plus topical potent steroid e.g.</p> <ul style="list-style-type: none"> <li>• Betamethasone 0.1%</li> <li>• Betamethasone 0.5% + Salicylic Acid 3%</li> </ul> <p>Apply once daily.</p>	
<p><b>Flexural Psoriasis</b></p> <p>Smooth well demarcated areas in axillae groins, inframammary folds and natal cleft. May occur alone or with chronic plaques elsewhere.</p>	<ul style="list-style-type: none"> <li>• Calcitriol</li> </ul> <p>Apply twice daily (up to 210g weekly)</p> <p>Use mild to moderate potency steroids combined with antibiotic/antifungals e.g.</p> <ul style="list-style-type: none"> <li>• Daktacort cream</li> <li>• Eumovate cream</li> <li>• Trimovate cream</li> </ul> <p>Apply once to twice daily.</p>	<p>Evidence suggests that calcitriol is effective and well tolerated in flexural/sensitive areas.</p> <p>Often partial response only is achieved.</p>

## Criteria for referral

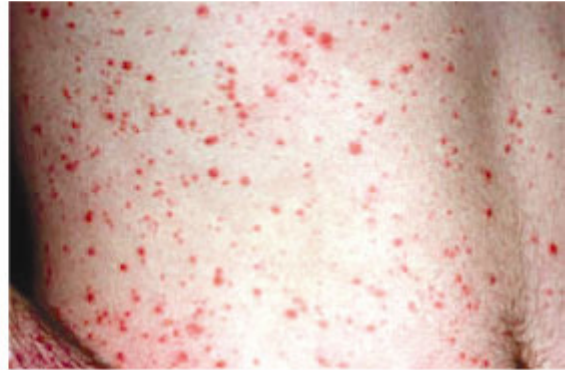
- 1 Extensive/severe or disabling psoriasis
- 2 Failure to respond to adequate treatment or rapid relapse post treatment
- 3 Extensive acute guttate psoriasis
- 4 Unstable and generalised pustular psoriasis

# Psoriasis

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Chronic Plaque Psoriasis



Guttate Psoriasis



Scalp Psoriasis



Flexural Psoriasis

# Section 12: Atopic eczema in children

## clinical features

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

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

Spontaneous improvement tends to occur throughout childhood.

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

## treatment

### General treatment measures

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

## therapeutic tips

### Emollients

Emollients should be prescribed in all cases.

Added to the bath e.g.

- Oilatum
- Balneum

Used directly on the skin during and after bathing

- Aqueous cream
- Diprobase
- Cetraben

Greasier preparations e.g.

- Emulsifying ointment
  - Epaderm
  - 50/50 liquid paraffin in white soft paraffin
- are better at hydrating skin

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

Always prescribe generous quantities of emollients to encourage frequent application.  
In severe eczema it is common to use at least 500 grams of emollient a week.

### Topical Corticosteroids

#### Mild

- Hydrocortisone

#### Moderate

- Clobetasone butyrate (Eumovate)

#### Potent

- Betamethasone 17-valerate (Betnovate)

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

Ointment preparations are usually more effective than creams but they are messier to use. Creams can be used if the eczema is weeping.

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

1–2 weeks of a potent strength product may be required, particularly for resistant, lichenified lesions in older children. Avoid repeat prescriptions for potent or very potent strength corticosteroids.

# Atopic eczema in children (cont.)

clinical features	treatment	therapeutic tips
	<p><b>Sedative antihistamines</b></p> <ul style="list-style-type: none"><li>• Chlorpheniramine</li><li>• Promethazine</li></ul> <p><b>Antibiotics</b></p> <p>Use steroid antibiotic combination:</p> <ul style="list-style-type: none"><li>• Fucidin H</li><li>• Fucibet</li></ul> <p>on bad areas for a short period (5-10 days)</p> <p>If the infection is severe treat with systemic antibiotics:</p> <ul style="list-style-type: none"><li>• Flucloxacillin</li><li>• Erythromycin ( if penicillin allergic)</li></ul>	<p>Suitable for short term use to control itch especially at night.</p> <p>Infection should be suspected whenever eczema worsens.</p> <p>Eczema that weeps is probably infected with staphylococcus aureus.</p>
	<p><b>Bandaging</b></p> <p>Wet wrap dressings may also be helpful, particularly at night in small children.</p> <p><b>Tacrolimus, Pimecrolimus</b></p>	<p>Initial training techniques will be required, given by a suitably trained nurse or health visitor.</p> <p>New class of topical immunosuppressives for the treatment of atopic eczema. Non-steroid so no thinning of the skin, helpful for areas such as face, eyelids etc. Avoid if infection is present. Not licensed for children under 2 years of age.</p>
<p><u><b>Allergies and allergy testing</b></u></p>	<p>Consider exclusion diets only in difficult cases and abandon if no improvement is apparent after 2 months.</p> <p>Keep dust down in child's bedroom, consider protective coverings to pillows and bedding.</p>	<p>No tests are available to confirm or refute food allergy as a cause of worsening eczema. RAST tests and skin prick tests are not helpful. Food allergies, especially to egg, wheat and dairy products only occasionally cause worsening of eczema. Dietetic advice is required if exclusion diets are used for more than 2 – 4 weeks.</p> <p>The role of the house dust mite can aggravate eczema in some children.</p>

# Atopic eczema in children (cont.)

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clinical features	treatment	therapeutic tips
	<p data-bbox="603 472 850 501"><b>Evening Primrose Oil</b></p> <p data-bbox="603 584 775 613"><b>Chinese Herbs</b></p>	<p data-bbox="1086 468 1453 517">There is no consistent evidence that it helps.</p> <p data-bbox="1086 566 1485 712">There are no product licenses and currently standardisation is poor. They do have a measurable effect in some children, but are not without potential serious adverse effects and cannot yet be recommended.</p> <p data-bbox="1086 736 1469 766"><u><b>Some contain potent topical steroids.</b></u></p>

## Criteria for referral

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

- For consideration of second line treatment such as photochemotherapy and cytotoxic drugs.
- Eczema herpeticum.
- For inpatient treatment.

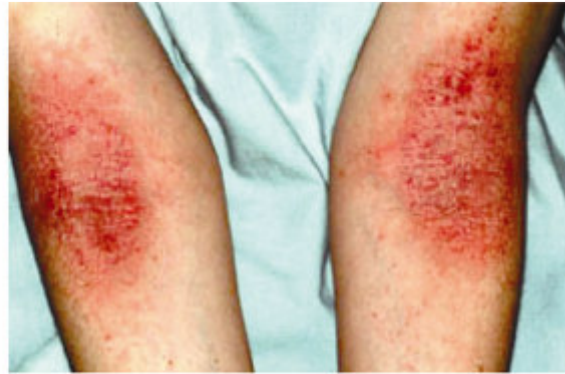
For advice on wet wrapping refer to Specialist Nurses.

# Atopic eczema in children

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Atopic eczema



Flexural distribution



Eczema Herpeticum

## Section 13: Patient support groups

<p>Acne Support Group Miss Alison Dudley PO Box 9 Newquay TR9 6WGUB4 OUT</p> <p>Tel: 0870 8840 2263 <a href="http://www.stopspots.org.uk">www.stopspots.org.uk</a></p>	<p>National Eczema Society Hill House Highgate Hill London N19 5NA</p> <p>Tel: 020 7281 3553 Fax: 020 7281 6395 Eczema Information Line: 0870 241 3604 (Mon–Fri 1–4pm) <a href="http://www.eczema.org">www.eczema.org</a></p>
<p>British Allergy Foundation Muriel A Simmons Deepdene House 30 Bellegrove Road Welling Kent DA16 3PY</p> <p>Tel: 020 8303 8525 Helpline: 020 8303 8583 (Mon–Fri 9am–5pm) <a href="http://www.allergy.baf.com">www.allergy.baf.com</a></p>	<p>The Psoriasis Association Milton House Milton Street Northampton NN2 7JG</p> <p>Tel: 01604 711129 Fax: 01604 792894 Email: <a href="mailto:mail@psoriasis.demon.co.uk">mail@psoriasis.demon.co.uk</a></p>
<p>Hairline International Ms Elizabeth Steel Lyons Court 1668 High Street Knowle, West Midlands B93 0LY</p> <p>Tel: 01564 775281 Fax: 01564 782270 <a href="http://www.hairlineinternational.co.uk">www.hairlineinternational.co.uk</a></p>	<p>Raynaud's &amp; Scleroderma Association Trust 112 Crewe Road Alsager Cheshire ST7 2JA</p> <p>Tel: 01270 872 776 Fax: 01270 883556 <a href="http://www.raynauds.demon.co.uk">www.raynauds.demon.co.uk</a></p>
<p>Herpes Viruses Association (SPHERE) and Shingles Support Society Miss Marion Nicholson, Director 41 North Road London N7 9DP</p> <p>Tel: 020 7607 9661 (office and Minicom V) Helpline: 020 7609 9061 (24 hours access) <a href="http://www.herpes.org.uk">www.herpes.org.uk</a></p>	<p>Changing Faces 1 &amp; 2 Junction Mews Paddington London W2 1PN</p> <p>Tel: 020 7706 4232 Fax: 020 7706 4234 <a href="http://www.changingfaces.co.uk">www.changingfaces.co.uk</a></p>
<p>Cancer BACUP 3 Bath Place Rivington Street London EC2A 3DR</p> <p>Tel: Freephone 0800 800 1234 (9am–7pm) Fax: 020 7696 9002 <a href="http://www.cancerbacup.org.uk">www.cancerbacup.org.uk</a></p>	<p>The Vitiligo Society 125 Kennington Road London SE11 6SF</p> <p>Tel: Freephone 0800 018 2631 Fax: 020 7840 0866 <a href="http://www.vitiligosociety.org.uk">www.vitiligosociety.org.uk</a></p>

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