South East London Dermatology Guidelines
for primary care

January 2020

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 ERS, consultant connect, 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 practitioner’s CCG’s antibiotic guidelines.

If you have any corrections, questions or ideas for improvement please let the authors know by emailing SOUCCG.Medicines-Optimisation@nhs.net or alternatively email the SEL Area Prescribing Committee (APC) support team at: LAMCCG.medicinesoptimisation@nhs.net.

Acknowledgements: This updated version of the Bromley CCG (2014) guidelines was developed by clinicians and pharmacists of Southwark, Bromley, Lambeth, Greenwich & Bexley, Lewisham CCGs and Guy’s and St Thomas’ and King’s College Hospital NHS Foundation Trusts with the SEL APC Dermatology Formulary subgroup.

The dermatology formulary subgroup will continue to update the clinical content of this document in line with national guidance. Referral pathways will be updated as needed by individual CCGs.

REMEMBER: These are guidelines, not rules and they are here to help you and your patients
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Approval date: January 2020

Review date: January 2022 [or sooner if evidence or practice changes]
Referral Overview for Dermatology Skin Conditions
**Offer primary care management with use of SEL APC dermatology guidelines and pre-referral checklists (eg acne, eczema and psoriasis) prior to referral **

<table>
<thead>
<tr>
<th>Community Dermatology Service (GPwER Level)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Acne (moderate and if patient unsuitable for oral Isotretinoin)</td>
</tr>
<tr>
<td>• Actinic Keratosis</td>
</tr>
<tr>
<td>• Alopecia/hair loss (moderate)</td>
</tr>
<tr>
<td>• BCCs below the clavicle (excision by level 3 accredited GPSI only)</td>
</tr>
<tr>
<td>• Bowen’s disease</td>
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<tr>
<td>• Congenital lesions – vascular or pigmented</td>
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<tr>
<td>• Eczema (moderate, not responding to treatment)</td>
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<tr>
<td>• Hair/nail/scalp disorders (moderate)</td>
</tr>
<tr>
<td>• Hidradenitis suppurativa (moderate)</td>
</tr>
<tr>
<td>• Hirsutism</td>
</tr>
<tr>
<td>• Hyperhidrosis Generalised, no underlying cause</td>
</tr>
<tr>
<td>• Infection + infestations, e.g. tinea</td>
</tr>
<tr>
<td>• Lesion of diagnostic uncertainty</td>
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<tr>
<td>• Lichen planus and other inflammatory disorders</td>
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<tr>
<td>• Pigment disorders e.g. vitiligo</td>
</tr>
<tr>
<td>• Pruritus</td>
</tr>
<tr>
<td>• Psoriasis (mild to moderate, not responding to treatment )</td>
</tr>
<tr>
<td>• Pyogenic granulomas</td>
</tr>
<tr>
<td>• Rash of diagnostic uncertainty</td>
</tr>
<tr>
<td>• Rosacea</td>
</tr>
<tr>
<td>• Urticaria</td>
</tr>
<tr>
<td>• Symptomatic, inflamed lesions on the face (needing diagnosis)</td>
</tr>
<tr>
<td>• Skin Check – mole review in high risk individuals</td>
</tr>
<tr>
<td>• Genital dermatosis</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MINOR SURGERY</th>
</tr>
</thead>
<tbody>
<tr>
<td>(PRIMARY CARE DES)</td>
</tr>
<tr>
<td>• Epidermoid cysts and similar benign skin lesions which are symptomatic and inflamed on more than one occasion</td>
</tr>
<tr>
<td>• Chronic/ recurrent in-growing toenails or nail deformities requiring surgical intervention or nail bed ablation where appropriate.</td>
</tr>
<tr>
<td>• Low risk Basal Cell Carcinomas (BCC) below clavicle (accredited GPs only)</td>
</tr>
<tr>
<td>Refer using local DES pathway</td>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th>SECONDARY CARE 2WW REFERRAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suspicion of Melanoma</td>
</tr>
<tr>
<td>Suspected squamous cell carcinoma (SCC) with definite history of change/ expansion</td>
</tr>
<tr>
<td>Keratoacanthoma (consider as SCC)</td>
</tr>
<tr>
<td>High risk BCC ('T zone’ ie eyes, nose, lips)</td>
</tr>
<tr>
<td>Pyogenic granuloma without a clear history of trauma</td>
</tr>
<tr>
<td>REFER via 2 WEEK WAIT PATHWAY</td>
</tr>
</tbody>
</table>
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, PRUH: Book an appointment via ERS whilst the patient is still with you:

Select 2WW then 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.

Urgent review: If patient is systemically unwell, bleep Dermatology SPR on call for review in <72 hrs e.g.

- Widespread blistering disorder
- Severe cases of inflammatory skin disease e.g. Psoriasis involving widespread areas of body with systemic upset (greater than 70% skin coverage)

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Phone Number</th>
<th>Bleep:</th>
</tr>
</thead>
<tbody>
<tr>
<td>King’s – Princess Royal Hospital</td>
<td>01689 866400</td>
<td>Dermatology SPR on call</td>
</tr>
<tr>
<td>King’s – Denmark Hill</td>
<td>020 3299 1998</td>
<td>Dermatology SPR on call</td>
</tr>
<tr>
<td>GSTT</td>
<td>020 7188 7188</td>
<td>Dermatology SPR on call</td>
</tr>
</tbody>
</table>

Routine Outpatient Appointments and Urgent review in >72 hrs (Not 2WW)

- Refer via local ERS pathways: Check contact details; Attach a photo if available.
- 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 eg 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, ideally attaching a photo

- via ERS Dermatology Single point of referral
- via Consultant Connect (telephone/ app) +/- Photosaf where available
### Bromley Practices

**Use E-referral (ERS)**

**Attach a photo and referral form**

<table>
<thead>
<tr>
<th>Adults:</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community dermatology: in line with above guidance</td>
<td>Children are not seen within the community service</td>
</tr>
<tr>
<td>PRUH via ERS for all other dermatological conditions other than 2WW</td>
<td>Refer children via ERS to the Evelina Dermatology department/ Kings college Hospital/ the PRUH</td>
</tr>
</tbody>
</table>

### Lambeth Practices

**E-referral (ERS)**

**Attach a photo**

<table>
<thead>
<tr>
<th>Adults and Children</th>
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<tbody>
<tr>
<td>Advice and guidance, ideally attaching a photo</td>
</tr>
<tr>
<td>- via ERS Dermatology Single point of referral</td>
</tr>
<tr>
<td>- via Consultant connect (telephone) +/- Photosaf to get an opinion</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Adults:</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>via ERS for all other dermatological conditions other than 2WW to secondary care dermatology e.g. KCH, GSTT</td>
<td>Refer children via ERS to the Evelina dermatology department, Kings college Hospital, the PRUH</td>
</tr>
</tbody>
</table>

### Southwark Practices

<table>
<thead>
<tr>
<th>Adults and Children</th>
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<tbody>
<tr>
<td>Advice and guidance, ideally attaching a photo</td>
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<tr>
<td>- via ERS Dermatology Single point of referral</td>
</tr>
<tr>
<td>- via Consultant connect (telephone) +/- Photosaf to get an opinion</td>
</tr>
</tbody>
</table>

**E-referral (ERS) via Dermatology single point of referral**

- For all dermatological conditions other than 2WW/ needing review in <72 hrs
- Indicate which community site/ secondary care site your patient would prefer to attend if offered an appointment

**Your referral will be reviewed by a local GPWERT 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.
- 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

### Lewisham Practices

<table>
<thead>
<tr>
<th>Adults and Children</th>
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<tbody>
<tr>
<td>Advice and guidance, ideally attaching a photo</td>
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<tr>
<td>- via ERS Dermatology Single point of referral</td>
</tr>
<tr>
<td>- via Consultant connect (telephone) +/- Photosaf to get an opinion</td>
</tr>
</tbody>
</table>

**E-referral (ERS) via Dermatology single point of referral**

- The patient is offered an appointment in secondary care.
- Urgent appointments are seen in 2 weeks and all other within 8 weeks
<table>
<thead>
<tr>
<th>Bexley Practices</th>
<th>Adults and Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral criteria with red flag symptoms and 2 WW applies</td>
<td></td>
</tr>
<tr>
<td>• Via E-referral (ERS) Dermatology Single point of referral</td>
<td></td>
</tr>
<tr>
<td>• Photos generally not required</td>
<td></td>
</tr>
<tr>
<td>Community dermatology provider: Communitas</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Greenwich Practices</th>
<th>Adults and Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral criteria with red flag symptoms and 2 WW applies</td>
<td></td>
</tr>
<tr>
<td>• Via E-referral (ERS) Dermatology Single point of referral</td>
<td></td>
</tr>
<tr>
<td>• GPs have access to teledermy by sending photos and to Consultant Connect (no photo availability)</td>
<td></td>
</tr>
<tr>
<td>Community dermatology provider: Communitas</td>
<td></td>
</tr>
</tbody>
</table>

**Children: all CCGs: Eczema Education Programme (from GSTT):**

Contact: for information and to refer: gst-tr.Eczemaeducation@nhs.net
## Dermatology History and Terminology

### History

<table>
<thead>
<tr>
<th>Key questions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>History of a rash</strong></td>
</tr>
<tr>
<td>Is there anything to see/feel?</td>
</tr>
<tr>
<td>Where and when did the rash first appear?</td>
</tr>
<tr>
<td>How has it spread (direction &amp; pace)?</td>
</tr>
<tr>
<td>Describe the course of the rash (progressive deterioration, constant but fluctuating in severity, intermittent, improving)</td>
</tr>
<tr>
<td>Are there associated features e.g. flushing</td>
</tr>
<tr>
<td>Can provoking factors be identified?</td>
</tr>
<tr>
<td>Can aggravating factors be identified?</td>
</tr>
<tr>
<td>Can relieving factors be identified?</td>
</tr>
<tr>
<td>What treatment has been tried (OverTheCounter and prescribed)?</td>
</tr>
<tr>
<td>What was the response to treatment?</td>
</tr>
<tr>
<td>Are you well or unwell?</td>
</tr>
<tr>
<td>Is it pruritic (itchy)?</td>
</tr>
</tbody>
</table>

| **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)? |

| **Past medical history** |
| History of atopy if eczema suspected |
| History of skin cancer |
| 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 or atopy |

| **Social history** |
| Smoking (particularly in hidradenitis suppurativa & palmoplantar pustulosis) |
| Alcohol intake |
| Occupation - 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)? |
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 morphology of lesions
- Palpate lesions & describe their consistency
- Describe the colour of the rash, noting the Fitzpatrick skin type as patients with Type V (Asian)/ Type VI (Afro-caribbean) skin are susceptible to more persistent hyperpigmentation & Type I/II (celtic/ blond/ redhead with blue eyes) to sunburn and solar damage.

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
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
Seborrhoelic Sites generally affected by seborrhoelic 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

Note:
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** - shape of a melanoma 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 2-3 shades of brown, red, white or black.
- **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 dermatology history (e.g. history of trauma to lesion).

Resources

*Self-exam of moles – Primary Care Dermatology Society*
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
  - 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; it is very rare in children.
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 VI (black) skin.
6. 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
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
   - 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 an advice and guidance photo via ERS/consultant connect or request urgent review in the community clinic; the patient will be seen within 6 weeks (Southwark).

Resources

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

- Nodulocystic
- No diagnostic uncertainty
- Small (<1cm)
- Below clavicle
- Not overlying important anatomical structures (e.g. major vessels)
- 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
Key Messages for Healthcare Professionals

- It is not necessary to refer all patients with actinic keratosis. They 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.

- 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 Bccs (Basal cell carcinomas). 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 text

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.

- Consider advising use of an OTC daily Vitamin D3 supplement as patients will be using sunscreen to avoid further 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 500cm² should be treated – 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 once daily 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 eg Monday Wednesday Friday for 4 weeks, wash off after 8 hours. In primary care to cover up to 25cm² of affected skin.
skin. Imiquimod 5% has more side-effects than Efudix® and patients may develop systemic (flu-like) symptoms. Discuss the risk of Herpes Simplex reactivation with assessing 4 weeks after treatment.

- **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 and is less effective than Efudix® for thicker lesions. Use for thin (grade 1 lesions only). 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) has been withdrawn from Jan/2020 (the EMA have suspended its licence and the MHRA have recalled Picato pending further review) because of a concern about a possible link between use of Picato and skin cancer. They advise “HCP should advise patients who have been 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 25cm² 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 reaplication
  - 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**

1) On-line pictures for GPs – Primary Care Dermatology Society
2) Clinical guidance – Primary Care Dermatology Society
3) Information for GPs: Patient leaflets – Patient.info
4) Patient information about AKs: Patient leaflets – British Association of Dermatology
7) Solaraze Gel leaflet: [https://www.medicines.org.uk/emc/product/6385/pil](https://www.medicines.org.uk/emc/product/6385/pil)
8) Actikerall leaflet: [Actikerall emc PIL](https://www.medicines.org.uk/emc/product/6385/pil)

Approval date: January 2020
Review date: January 2022 (or sooner if evidence or practice changes)

KEY

NHS = Community or Secondary care Dermatology
NHS = Specialist Dermatology (Secondary care)

**Actinic keratoses: Discrete lesions algorithm**

**Actinic keratoses: Field change algorithm**

See **Actinic Keratosis: Field change algorithm**

**Patient options**

- **Refer to Dermatology pathway**
- **Refer to dermatology medicolegal if not resolved**
- **Treat with topical in-office treatment**
- **Refer to specialist dermatology**
- **Refer to community or secondary care dermatology**
- **Self-manage**

**Multiple confluent lesions**

- **Refer for close skin to access**
- **Discuss treatment options**
- **Agree a management plan**

**Dermatomal solitary lesions**

- **Consider need for 2020 review**
- **7 SCC**

**Show images o response to treatment**

**Discuss treatment options**

**Agree a management plan**

**Superficial/Thin lesion**

- **Patient prefers self-management**
- **no further treatment**

- **Patient able to comply with topical treatment**
- **lesion not near the eye**

- **Eradicate** 5% 5-Fu cream (is not very effective) or 5-Fu/5-FU cream (is effective)

- **Refer to specialist dermatology for more effective treatment**

**Hyperplastic with this lesion**

- **Patient able to comply with topical treatment**
- **lesion not near the eye**

- **Acifel® gel 0.05% for 4-6 weeks**

- **Refer to specialist dermatology for more effective treatment**

**Hyperplastic (thick) lesion**

- **Patient able to comply with topical treatment**
- **lesion not near the eye**

- **Refer to specialist dermatology for more effective treatment**

**History of SCC**

- **Patient able to comply with topical treatment**
- **lesion not near the eye**

- **Refer to specialist dermatology for more effective treatment**

**Resistant (5 weeks if unresistant)**

- **Patient able to comply with topical treatment**
- **lesion not near the eye**

- **Refer to specialist dermatology for more effective treatment**

**KEY:** G.P. Community or secondary care

**KEY:** Specialist Dermatology (Secondary care)

**Notes:**

- **Non tender, growing slowly, may have a horn**
- **Refer to think dermatology pathway**
- **Non tender, not enlarging or growing slowly**
- **Sens, growing rapidly**
- **Tender, growing rapidly**

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

**Approval date:** January 2020
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Scaling dermatoses Atopic Dermatitis/Eczema

**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

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

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

**ADULTS** [FTU PIL]

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

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

- **Topical Calcineurin inhibitors (TCIs):** is used as **steroid sparing** (especially for face/flexures) once eczema is controlled x1-2 daily (maintenance twice weekly) and for **flares**; specialist initiation by experienced practitioners only.  
  **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]

**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 and have managed systemic infection

**Moderate to severe eczema**: child under 6 months to treatment: take an allergy focused history

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

 Seek advice/ Refer via ERS (electronic referral pathway) for

- **Severe eczema not responding to baseline treatment**
- **Diagnostic difficulty**
- **Contact allergy patch testing** (eg 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 immunosuppressant drugs or phototherapy AND children <12 years - moderate to severe or if primary care treatment is exhausted and carers in need of support)
Atopic Dermatitis/ Eczema

1. **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 APC emollients guideline (includes information about emollient greasiness) to find a SEL APC formulary product that the patient finds acceptable and effective for them. Prescribe enough to allow liberal application 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 dermatological diagnosis should be advised to purchase emollients if required.** Emollients are often used to help manage dry, itchy or scaly skin conditions. Patients with mild dry skin can be successfully managed using over the counter products on a long-term basis. **Prescription for treatment of dry skin should not routinely be offered in primary care** as the condition is appropriate for self-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 type/size of eczema and age of patient, OD (see guidance 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.

Secondary infection

1. Consider infection if eczema is 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 eg Flucloxacillin or Erythromycin (if penicillin allergic) orally as per BNF, while awaiting the swab result.

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 punched-out clustered erosions on the face and neck). If eczema herpeticum is suspected, take a viral swab before commencing empiric treatment and refer urgently (same day assessment) to secondary care.

3. Patients with recurrently infected eczema may benefit from very weak bleach baths

4. Dermol 500 lotion®/Dermol® cream has 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 (CMPA)

1. CMPA where severe eczema presents in breast fed babies under 3 months and is unresponsive to usual measures – refer to SEL APC CMPA guidance

2. A trial of an Extensively Hydrolysed Formula (EHF) for 4 weeks with a trial of re-introduction 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

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 (e.g. alcohol, medications, mood)
Offer an emollient (guidance) and Vitamin D analogue (Calcipotriol) OD in the morning and potent topical steroid OD (evening) for 4 weeks
If inadequate response, could use vitamin D analogue BD up to 12 weeks
If fails, offer potent topical steroid BD up to 4 weeks OR Coal tar lotion (Exorex®) OD or BD
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.

Guttate psoriasis
- Throat swab and 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)
- Change formulation or add descaling agent (e.g. SebCo®, Cocos®) up to 4 weeks
- Combination of calcipotriol and betamethasone (Dovobet®) 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 OD or BD
- Do not offer coal tar shampoos alone for the treatment of severe scalp psoriasis

Face, Flexures and Genital psoriasis
Regular use emollients to reduce scale and itch. Mild to moderate potency steroids OD- BD (max 1-2 weeks) in any month with 4 week break between courses.
Advise stop steroid when skin is (near) clear.
For inadequate response, check adherence; if poorly controlled or unable to take treatment break from Topical Corticosteroid (TCS) refer for trial of Topical Calcineurin Inhibitor (TCIs) (pimecrolimus/ tacrolimus) BD up to 4 weeks (Amber 2)

Consider early referral (NICE CG153) as well as initiating treatment when there is:
- Diagnostic uncertainty
- Extensive or Moderate to Severe disease requiring systemic treatment eg > 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

Complete pre-referral checklist and 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)

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

For fungal nail infections, take 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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• Refer early if systemic treatment may be required: Extensive (e.g. > 10% skin involvement) or moderate to severe disease; Major impact on physical, psychological or social wellbeing (e.g. occupational/school absence); Nail disease with a major functional/cosmetic impact; Involvement of difficult sites (face, palms, genitalia)
• 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. Explore the psychosocial impact of the disease (high risk of depression)
• Screen annually for psoriatic arthritis (particularly during the first ten years) using a validated tool PEST screening tool BAD and for cardiovascular comorbidities at diagnosis and every 5 years (NICE Clinical Guideline 153).

Notes
1. Medications known to precipitate psoriasis: lithium, anti-malarials, beta-blockers and stopping corticosteroids abruptly.
2. Do not use potent corticosteroids continuously for more than 8 weeks or very potent corticosteroids for more than 4 weeks. Aim for a 4-week break between courses.
   **Do not use very potent corticosteroids in children and young people.**
3. Nail psoriasis responds poorly to topical treatment; offer a trial of Dovobet® gel for three months or Dermovate® lotion rubbed into the nail fold and tricked under the free edge of the nail. Consider podiatry for painful toenails.
4. Dermatology service in secondary care follows up patients requiring systemic treatment.
5. Topical vitamin D preparations: calcipotriol (Dovonex®) licensed for long term use, apply liberally BD (not for face/flexures); tacalcitol (Curatoderm®) OD is licensed for use on face. NICE recommends topical calcineurin inhibitors; Calcipotriol and Betamethasone 0.1% (Enstilar® foam, Dovobet® gel/oointment) can be used intermittently for maximum 4 weeks (can make psoriasis unstable and cause steroid over use side effects).
   Creams are less likely to cause maceration in flexures.
6. For thick, scaling scalp psoriasis massage SebCo® (or Cocos®) 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 “How to Treat Scalp Psoriasis” video at [http://www.bad.org.uk/for-the-public/patient-information-videos](http://www.bad.org.uk/for-the-public/patient-information-videos). 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.
7. **Psoriasis in CHILDREN:** Offer emollients to all.
   For Trunk and limbs; > 1year potent corticosteroid ointments, or Dovonex® can be used in over 6-year olds. **NICE guidance - Trunk & limb psoriasis in children and young people** Refer all children to Paediatric dermatology at diagnosis.

<table>
<thead>
<tr>
<th>Potency</th>
<th>Drugs</th>
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<tbody>
<tr>
<td>Mild corticosteroid</td>
<td>Hydrocortisone 1%</td>
</tr>
<tr>
<td>Moderate corticosteroid</td>
<td>Clobetasone butyrate 0.05%; Betamethasone valerate 0.025%</td>
</tr>
<tr>
<td>Potent corticosteroid</td>
<td>Betamethasone valerate 0.1%; Betamethasone dipropionate 0.05%; Mometasone furoate 0.1%; Diprostone and Salicylic acid</td>
</tr>
<tr>
<td>Very Potent Corticosteroids (Adults)</td>
<td>Clobetasol propionate 0.05%</td>
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Resources
- On-line Psoriasis pictures for GPs – Primary Care Dermatology Society
- Dermatology Life Quality Index
- Psoriasis PIL – Patient.info
- Psoriasis patient leaflet – British Association of Dermatology


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Lichen Planus

- Highly pruritic (itchy), evolving symmetrical rash
- Well demarcated, shiny, violaceous, hyperpigmenting flat topped papules/plaques
- +/- Wickham’s striae
- It can be hypertrophic (typically shins) or annular (typically penis, palms and soles);
- Linear group lesions can develop in scars (Koebnerising)

Lichen planus may be linear, actinic, atrophic, guttate, bullous, pigmented flexural, blaschkoid (following Blaschko’s line); 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).
- In the mouth (50%) and on the vulva it presents as a fine white lacy network but can be erosive; on the penis it is more frequently annular.
- In type V (Asian) skin it can present as asymptomatic axillary macular hyperpigmentation.
- Scalp lichen planus can present with a burning sensation. There is often perifollicular scaling and violaceous erythema; it can be scarring. Refer scarring hair loss early

Differential:
Sarcoid (often not scaly), psoriasis; if annular 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:

- Emollients as soap and moisturiser helpful for pruritus.
- 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.
- Stop topical steroids when the papules are asymptomatic and macular (flat).
- Hypertrophic plaques may need potent or very potent topical steroids under Tegaderm occlusion, applied overnight and reviewed after 4 weeks.
- Do not treat asymptomatic post-inflammatory hyperpigmentation which will resolve spontaneously, over many months.
- Facial lichen planus may need intervention with Tacrolimus 0.1% ointment initiated by experienced practitioners.
- Refer Scarring or erosive Lichen planus early for rigorous intervention.

Resources
Lichen Planus for GPs – Primary Care Dermatology Society
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
Cystic or scarring acne; Severe psychological disorder as a result of acne
True treatment failure

Topical therapy with keratolytic/comedolytic:
- Topical Benzoyl peroxide - start with 2.5%, increase to 5% (available OTC – please encourage patients to buy)
- Topical Retinoids e.g. Adapalene 0.1%
  These are initially used in isolation, then in combination as Epiduo®
  If there are pustules, consider topical antibiotic with either of the above e.g. Duac® 3% or 5%
- Consider azelaic acid or topical erythromycin if intolerant of benzoyl peroxide or a retinoid
- Review at 6-8 weeks

Use topical keratolytic or comedolytic therapy, AND
Systemic antibiotic for 3 months (See point 7 below for further information):
- Doxycycline 100mg OD or
- Lymecycline 408mg OD NB: restricted use in some CCGs

For females who require contraception, consider adding Co-cyprindiol, Intra Uterine Device or condoms.
- Avoid Progesterone Only Pill.
- Never combine oral and topical antibiotics
- Review at 6 weeks

Review Response to treatment

Good response - stop antibiotics and advise maintenance keratolytic when required.

Partial response
- continue same antibiotics and topical for up to 4 months.
- consider adding COCP/co-cyprindiol for females (even if contraception is not required)

No response at 6 weeks or incomplete response in 3 months, refer to secondary care.
Whilst waiting an appointment offer a trial of Trimethoprim 200mg BD with a topical keratolytic.
- Consider earlier referral for those with type V/VI skin as they may develop persistent hyperpigmentation

Seek advice/Refer via local referral pathway for consideration of oral Isotretinoin or spironolactone (women with hormonal acne)
Complete & include pre-referral checklist where available.
Give patient a form to have bloods taken 4 weeks before clinic attendance: FBC, Renal, LFTs HbA1C, lipids (not fasting)
Ensure effective contraception in use at point of referral (Avoid POP)

Complete DLQI; Refer urgently
- offer a keratolytic and Trimethoprim 200mg BD until they are seen in clinic
- consider adding COCP/co-cyprindiol for females (even if contraception is not required)
Key messages

- Consider the psychological impact of the disease on the patient and their quality of life.
- 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 or poor response at least 3 months. There is no good evidence that switching antibiotics is effective.
- Avoid prolonged courses of antibiotics (greater than 3 months) to reduce antimicrobial resistance.

Notes

1. Discourage picking, squeezing and encourage application of oil free cosmetics.
2. Pomade acne only responds to stopping use of rich emollients on scalp and face.
3. 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 6-12 weeks, aiming for 50% improvement.
4. Benzoyl peroxide may cause bleaching of bedding, towels or clothing
5. Adapalene may cause increased sensitivity to sunlight.
6. 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.
7. Add antibiotics (doxycycline 100mg once daily OR lymecycline 408mg OD – Note: Some CCGs restrict the use of lymecycline therefore please follow local CCG antibiotic guidance* for preferred choice) 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.
8. 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 (Specialists may advise durations longer than 4 months).
9. Co-cyprindiol should be added after topical therapy or systemic antibiotic treatments in combination have failed. It 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.
10. 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.
11. Patients with severe psychological overlay also require psychological assessment.
12. 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 is needed.
13. 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.

Resources:

On-line pictures for GPs – Primary Care Dermatology Society

*Antibiotic Guidelines:

- Southwark & Lambeth antibiotic guidance
- Bexley, Lewisham and Greenwich antibiotic guidance
- Bromley antibiotic guidance

Patient leaflet – Patient.info
Patient leaflet – British Association of Dermatology
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)*

**Mild to Moderate** *(Limited number of papules and pustules, with no plaques)*

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

**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

---

**Flush & fixed erythema**

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

**Ocular Rosacea** *(+ Blepharitis/Keratitis)*

**Start oral antibiotics**
Doxycycline (unlicensed use) 100mg once daily
*OR*

**2nd Line alternative**
Lymecycline 408mg OD (unlicensed use)

---

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

**1st Line**
Ivermectin 1% cream once daily or azelaic acid 15% gel twice daily plus 6 - 12 weeks of either:
- Oral oxytetracycline 500mg twice daily (avoid taking with meals)
- Oral doxycycline 100mg daily (off-label, less expensive & well tolerated. May be used as an alternative in renal impairment)
- 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.)

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**Refractory**
- Rosacea not responding to systemic therapy
- Diagnostic difficulty
- Disease causing significant psychosocial problems

---

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

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.

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.

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

Impetigo

<table>
<thead>
<tr>
<th>Treatments: Adults and children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Localised Lesions</td>
</tr>
<tr>
<td>Topical antiseptic eg 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)</td>
</tr>
<tr>
<td>Localised Impetigo that is</td>
</tr>
<tr>
<td>• Spreading</td>
</tr>
<tr>
<td>• Persisting</td>
</tr>
<tr>
<td>Advise use of Octenisan® lotion as soap (available OTC)</td>
</tr>
<tr>
<td>Consider topical Mupirocin Ointment or cream TDS;</td>
</tr>
<tr>
<td>Note: Mupirocin Cream is not recommended for children &lt;1 year</td>
</tr>
<tr>
<td>If MRSA Positive: Follow local guideline</td>
</tr>
</tbody>
</table>

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**: Fucibet® cream BD is often needed as well as systemic treatment

<table>
<thead>
<tr>
<th>Systemic Treatment: ADULTS</th>
<th>Systemic Treatment: CHILDREN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Widespread/ Scattered lesions including:</td>
<td></td>
</tr>
<tr>
<td>• Severe</td>
<td></td>
</tr>
<tr>
<td>• Extensive and/or</td>
<td></td>
</tr>
<tr>
<td>• Bullous impetigo</td>
<td></td>
</tr>
<tr>
<td>• Flucloxacillin 250mg –500mg QDS for 7 days (Suitable if pregnant or breastfeeding)</td>
<td></td>
</tr>
<tr>
<td>If Penicillin allergic:</td>
<td></td>
</tr>
<tr>
<td>• Clarithromycin for 7 days</td>
<td></td>
</tr>
<tr>
<td>• Erythromycin for 7 days (Clarithromycin suspension has unpleasant taste) Refer to the BNFc for paediatric dose regime</td>
<td></td>
</tr>
<tr>
<td>If MRSA Positive: Follow local guidelines on appropriate treatment</td>
<td></td>
</tr>
</tbody>
</table>

- 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:**

<table>
<thead>
<tr>
<th>Nasal carriage</th>
<th>Treatment - ADULTS and CHILDREN</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>S.Aureus with:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Recurrent impetigo</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Persistent folliculitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Recurrent boils (not PVL/ not MRSA)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nasal Naseptin® cream applied inside each nostril x 3-4 per day for 7 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Encourage use of Octenisan® Wash lotion for bathing (or Dermol lotion in the context of eczema) both available OTC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PVL positive S.Aureus or MRSA with:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Recurrent impetigo</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Persistent folliculitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Recurrent boils</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Offer nasal Mupirocin ointment applied x 3 day inside each nostril for 5-7 day, (longer if bd)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Encourage use of Octenisan® wash lotion for bathing for 5 days including washing hair twice in the week or Dermol lotion (OTC) in the context of eczema</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Close contacts such as family/ household members may need swabs and decolonisation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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 such as the face (particularly around the nose and mouth) and limbs, or in flexures, especially the axillae.
**Impetigo** is usually diagnosed on clinical appearance. Poorly responsive or recurrent patients with impetigo should be swabbed 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. 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** is based on the extent and severity of the infection and whether it is recurrent. A systematic review indicates topical and oral treatment of Impetigo produces similar results. Meticulous hand washing/ hygiene is crucial.

**Recurrent Impetigo**: If not responding/ spreading check compliance and take skin/nasal swab for C & S. from patient and close family 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

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Treatment options ADULTS and CHILDREN</th>
</tr>
</thead>
</table>
| 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

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Treatment options: ADULTS</th>
<th>Treatment options: CHILDREN</th>
</tr>
</thead>
</table>
| 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 for paediatric dose regime* |

| Severe and/or recurrent infections | Systemic treatment: Treatment Choice (ADULTS)  
As above for longer duration  
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 Guidelines: 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 is diabetic.

Sterile Folliculitis
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 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:

<table>
<thead>
<tr>
<th>Confirmed PVL Staph aureus infection</th>
<th>General advice for all patients: Excellent hygiene, not sharing towels, change sheets and towels daily if possible. Offer patient information leaflet</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Infection severity</th>
<th>Treatment options (ADULTS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</td>
<td>May resolve without treatment.</td>
</tr>
<tr>
<td></td>
<td>Drainage of abscesses and sensitivity testing to find appropriate antibiotics.</td>
</tr>
<tr>
<td>Moderate</td>
<td>Requires systemic antibiotics:</td>
</tr>
<tr>
<td></td>
<td>Flucloxacillin 250mg – 500mg QDS for 7 days (suitable if pregnant or breastfeeding).</td>
</tr>
<tr>
<td></td>
<td>If Penicillin allergic:</td>
</tr>
<tr>
<td></td>
<td>Clarithromycin 250mg – 500mg BD for 7 days.</td>
</tr>
<tr>
<td></td>
<td>Clindamycin 450mg QDS for 7 days (may cause diarrhea).</td>
</tr>
<tr>
<td></td>
<td>Erythromycin 250mg - 500mg QDS for 7 days (if pregnant or breastfeeding).</td>
</tr>
<tr>
<td></td>
<td>(Longer courses may be needed).</td>
</tr>
<tr>
<td>Persistent, Recurrent or Severe Infection</td>
<td>Seek advice from local dermatologists and/or discuss with Microbiologist for local sensitivities.</td>
</tr>
<tr>
<td></td>
<td>Consider Referral to Specialist especially if patient is systemically unwell.</td>
</tr>
</tbody>
</table>

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 5 days and three times a week for hair.

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.
- 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

- 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

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

Resources

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  
Southwark and Lambeth Antimicrobial Guideline for Primary Care 2018  
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*
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 are key)

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

**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

As above;
* 50% salicylic acid can be applied under occlusion.

Cryotherapy should NOT be used (only improves clearance by 10%)

**Mosaic warts:**
- Formaldehyde soaks (refer to notes) used daily for 6 weeks.
- Offer Patient Information leaflet

**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

**Plantar warts (Verrucas):**
- As above; 50% salicylic acid can be applied under occlusion.

**Cryotherapy**

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Freeze times after wart has turned white:
- Face 10 seconds
- Hands 10-20 seconds (improves clearance by 40%)
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1-2 minutes then repeat 15 seconds

As above;
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Cryotherapy should NOT be used (only improves clearance by 10%)
Viral Warts

Warts (verrucae) 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.
- 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](https://www.england.nhs.uk/wp-content/uploads/2019/03/nhs-england-guidance-on-conditions-for-which-oct-items-should-not-be-routinely-prescribed-in-primary-care.pdf).
- 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](https://www.dermnetnz.org/conditions/warts.html).

**Resources:**

- On-line pictures for GPs (viral warts) – [DermNet NZ](https://www.dermnetnz.org/conditions/warts.html)
- Clinical Knowledge Summaries - Warts and verrucae
- Patient leaflet (warts and verrucae) – [Patient.info](https://www.patient.info/conditions/warts.html)
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 (sparring face in older children/adults); possible inflammatory nodules on genitalia, periareolar areas, axilla/groin (especially if long standing).

- Crusted (Norwegian)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 paying attention in between toes, fingers and under nails. Repeat after 7 days. Permethrin requires 8-12 hours contact with the skin, malathion 24 hours. At same time, wash personal clothing/linen ≥60°C. Seek advice for crusted (Norwegian) scabies and recurring scabies - 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.

- 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.

- Seek specialist advice from paediatric dermatologist for children under 2 months.

Resources

- On-line pictures for GPs (scabies) – Primary Care Dermatology Society
- Patient leaflet (scabies) – Patient.info
- NICE Clinical Knowledge Summary – Management of Scabies.

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Use scabicide to treat patient and all contacts:

- **First Line:** *permethrin 5% cream (Lyclear ® OTC)* – apply weekly for 2 treatments - left on overnight (8-12 hours)

- If contraindicated or not tolerated (e.g. allergy to chrysanthemum) – apply *malathion 0.5% liquid (Derbac-M ® OTC)* - apply weekly for 2 treatments - left on overnight (24 hours)

(Treatment available to be purchased over the counter)

Impetiginisation usually due to secondary *Staph aureus* infection

Treat post-scabietic itch: (residual itch)

- Crotamiton 10% cream/ Hydrocortisone 1% with emollients (available to be purchased over the counter)

CARE HOME (Norwegian scabies)

- contact Health Protection Agency and follow guidance

Recurring scabies

- Seek dermatology advice via local electronic pathway if unresponsive despite adequate treatment of index patient and contacts

Crusted (Norwegian)Scabies suspected

- Seek dermatology specialist advice

Highly infectious

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Non-crusted scabies

Initial assessment: features suggestive of scabies (images)

- Images of scabies: burrows, eczematous rash, nodules

- Images of impetiginisation: redness, pus, crusting

- Images of crusted scabies: thick, crusty, lichenified rash
Tinea

Initial assessment

Body (corporis)
- Skin scrapings for mycology

Scalp (capitis)
- Skin scrapings for mycology. Use disposable toothbrush in children. Pluck hairs in kerion

Nails (unguium) Usually adults
- Mycology: Subungual nail scrapings differentiates from psoriasis; most do not require treatment - simple self-care measures will suffice.
- Treat patients at risk of infection e.g. diabetics, history of cellulitis, lymphoedema

Use topical treatment at least twice weekly for 4 weeks (e.g. ketoconazole shampoo*) whilst awaiting microscopy and with oral treatment to prevent transmission.

Treat unaffected family contacts with ketoconazole shampoo* twice weekly for 4 weeks to reduce risk of transmission.

Self-care:
- Topical treatment (OTC) usually sufficient:
  - Topical terbinafine* BD for 2-6 weeks as per BNF or if not available
  - Imidazole cream e.g. clotrimazole*, miconazole* BD until 1-2 weeks after skin cleared.
  - Topical steroid should not be used.
- Oral treatment is rarely needed

Oral treatment is essential to cure scalp infection + screen other family members
- Adults: Terbinafine 250mg orally for 4 weeks (caution if prior abnormal LFTs)
- Children over 2 years: Weigh at presentation
  - Oral Terbinafine once daily (OD) for 4 weeks (see notes and BAD guidelines):
    - 10 - 19kg - 62.5mg = 1/4 tablet OD
    - 20 - 39kg – 125mg (1/2 tablet) OD
    - 40kg and above - 250mg (whole tablet) orally OD
- Children under 2 – Discuss with paediatric dermatology, usually liquid Itraconazole is given.

If signs persist after treatment or diagnostic difficulty seek advice/ refer via local electronic referral to Community dermatology service

*available to buy over the counter

Usually adults:
- Single nail involvement: Amorolfine 5% nail paint* 1-2 x per week for 6-12 months (OTC)
- Multiplae nails:
  - 1st line: Terbinafine 250mg OD for ONLY 12 weeks. Check LFTs before starting treatment if history of liver disease OR abnormal LFTs. Repeat only if abnormal
  - 2nd line: Itraconazole: either 100mg OD for 3 months or pulsed 200mg BD one week each month for 2 courses for fingernails and 3 courses for toenails
  - Expect to see c1mm of new toenail after 3 months of treatment
- Consult children’s BNF for paediatric treatment
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”.
- 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. 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. ketoconazole 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.
Never prescribe systemic treatment without positive mycology but note that 40% of affected nails will only have positive microscopy. Treat these as positive also.
2. Amorolfin 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.
3. Tinea Pedis Consider if there is unilateral sole/ foot scaling.

Resources
On-line pictures for GPs – Tinea capitis Primary Care Dermatology Society Nice CKS Fungal skin infection
Patient leaflet – Dermatophytosis Patient.info Patient leaflet – scalp ringworm British Association of Dermatology
Urticaria

For ALL types of urticaria

**STEP 1: ALL PATIENTS**

Non-sedating second-generation H1 antihistamines at licensed dose e.g. cetirizine, loratadine (available over the counter) fexofenadine 180mg OD* (prescription only)

- If inadequate control: after 2-4 weeks, or earlier if symptoms are intolerable

**STEP 2: IF NON-RESPONSER**

- 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 2-4 weeks, or earlier if symptoms are intolerable

**STEP 3: IF NON-RESPONSER**

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-RESPONSER**

- Consider adding H2 receptor antagonist e.g. ranitidine* up to 150mg BD/300mg daily.
- (Not essential for NICE criteria prior to omalizumab but useful to trial prior to referral to secondary care)
- Stop and refer if inadequate control after 2-4 weeks or earlier if symptoms are intolerable.

**IF NON-RESPONSER**

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

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*Denotes off-label use of the medicine

Please see the South East London Urticaria Treatment Pathway for further information

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Approval date: January 2020

Review date: January 2022 [or sooner if evidence or practice changes]
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** are where 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 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 after 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, check a full blood count, thyroid antibodies, TFTs, ANA, autoantibodies, ESR and helicobacter stool antigen in those with chronic spontaneous (idiopathic) urticaria.

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 up to 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 (loratadine) or renal function (cetirizine). All, especially Cetirizine, may be more sedating at higher doses.

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 12 years 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
Leg ulcers – Pathway Management

**Week 0**
- Patient presents with a wound to the lower leg

**Assessment 0-6 weeks**
- Complete Wound Assessment Form immediately
  - Venous leg ulcer
  - Arterial ulcer

**Diagnosis**
- Complete Leg Ulcer Assessment Form within 1 week
- Perform ABPI within 2-4 weeks for wounds that have not responded to standard treatment*

**Treatment**
- Treat varicose eczema
  - Commence compression bandaging according to ankle circumference and leg elevation
  - Consider light compression
  - Consider Tissue Viability (TV) referral
  - No compression
  - Refer to Tissue Viability for assessment and onward vascular referral
  - Disease specific management.
  - Oedema management
  - Referral to Tissue Viability nurse

**Outcomes 0-6 months**
- Ulcer heals
  - Education
  - Prevention of recurrence
  - Hosiery
- Ulcer fails to heal
  - Education
  - Reassess
  - Advice from TV champion
  - TV referral if not healed in 6 months
- Other reasons for TV referrals
  - Unable to tolerate compression
  - Allergy
  - Repeated infection
  - No response to treatment at 12 weeks

*In patients with history of venous ulceration or with signs of venous disease an ABPI should be performed at the earliest opportunity

**Treat varicose eczema around ulcers; Refer unusual ulcers in young people for biopsy

GSTT (Guys and St Thomas’) Referral Pathway and assessment forms available [here](#)
Lewisham and Greenwich Referral information to tissue viability available [here](#)
Bromley tissue viability information available [here](#)
Bexley Referral Pathway and assessment forms available [here](#)

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Approval date: January 2020
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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
# Management of Benign Skin Conditions

**Key Messages:**

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

<table>
<thead>
<tr>
<th>Condition</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Molluscum contagiosum</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Skin tags</strong></td>
<td>No treatment necessary. See NHS Choices for patient advice.</td>
</tr>
<tr>
<td><strong>Seborrhoeic warts</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Pyogenic granuloma</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Spider naevi/ Campbell de Morgan/Vascular angiomata</strong></td>
<td>Do not treat. Spider naevi arising in pregnancy may resolve spontaneously over time after delivery.</td>
</tr>
<tr>
<td><strong>Benign naevi</strong></td>
<td>Do not treat.</td>
</tr>
<tr>
<td><strong>Atypical naevi</strong></td>
<td>If genuine concern re melanoma refer as 2-week wait.</td>
</tr>
<tr>
<td><strong>Sebaceous cysts</strong></td>
<td>If symptomatic and inflamed can be excised under minor surgery DES.</td>
</tr>
<tr>
<td><strong>Keloid</strong></td>
<td>Cosmetic treatment not routine on NHS. Southwark GPs can refer to GPwER for up to 3 injections with steroid if very symptomatic.</td>
</tr>
<tr>
<td><strong>Lipoma</strong></td>
<td>Cosmetic removal not routine on NHS.</td>
</tr>
<tr>
<td><strong>Dermatofibroma</strong></td>
<td>Cosmetic removal not routine on NHS, take care as may leave ugly scar; refer if diagnostic uncertainty.</td>
</tr>
<tr>
<td><strong>Keratin horn</strong></td>
<td>Curettage and cautery (histology essential).</td>
</tr>
<tr>
<td><strong>Giant comedones</strong></td>
<td>Can be incised and contents expressed, lesions over 5mm need excision (cosmetic, treatment not routine on NHS).</td>
</tr>
<tr>
<td><strong>Solar lentigines</strong></td>
<td>Cosmetic treatment not routine on NHS.</td>
</tr>
<tr>
<td><strong>Congenital naevi</strong></td>
<td>Cosmetic treatment not routine on NHS.</td>
</tr>
</tbody>
</table>
South East London Treatment Access Policy (TAP)

South East London follows a Treatment Access Policy produced in collaboration between the six CCGs 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

- SEL treatment pathway for hyperhidrosis in primary care Hyperhidrosis
- 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: Bromley, Bexley, Greenwich, Lambeth, Southwark and Lewisham
Useful Management Tips

Equipment

- Good light source
- Tape measure
- Dermatoscope
- Fungal scrapings kit; Disposable toothbrush for fungal sampling from children’s scalps

Topical Steroids: Potency table

<table>
<thead>
<tr>
<th>Potency</th>
<th>Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild corticosteroid</td>
<td>Hydrocortisone 1%</td>
</tr>
<tr>
<td>Moderate corticosteroid</td>
<td>Clobetasone butyrate 0.05%; Betamethasone valerate 0.025%</td>
</tr>
<tr>
<td>Potent corticosteroid</td>
<td>Betamethasone valerate 0.1%; Betamethasone dipropionate 0.05%; Mometasone furoate 0.1%;</td>
</tr>
<tr>
<td>Very Potent Corticosteroids (Adults)</td>
<td>Clobetasol propionate 0.05%</td>
</tr>
</tbody>
</table>

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](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 likelyhood 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 (eg 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.
- **Skin swabs**: Suspected bacterial infection, particularly in crusted/weeping eczema.

Useful Blood tests

- **FBC**: Eosinophilia: consider adverse drug reactions
- **Pruritus**: FBC for anaemia and eosinophilia, TFT, Ferritin < 70ng/mL, Renal, LFTs
- **Hair loss**: Ferritin: Low < 100, consider zinc intake also
- **ESR**: raised: Erythema nodosum, sarcoid
- **ACE**: raised: Sarcoid
- **Ana (Antinuclear antibody) & dsDNA Ana**: consider SLE
- **ENA (Extractable nuclear antigen)**: anticientromere antibody & Raynauds: consider limited systemic sclerosis
- **HIV test**

**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 Area Prescribing Committee 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

References:

Acne:


Bowen’s disease:

Fungal Infection: Adults and children :
Onychomycosis: British Association of Dermatologists’ guidelines for the management of onychomycosis 2014 M. Ameen,1 J.T. Lear,2,3 V. Madan,2,3 M.F. Mohd Mustapa4 and M. Richardson2,5 http://www.bad.org.uk/shared/get-file.ashx?id=2125&itemtype=document

Psoriasis:
Rosacea:

Urticaria NICE : Chronic urticaria: off-label doses of cetirizine Evidence summary [ESUOM31] Published date: July 2014 (X4) , also the Omalizumab submission SEL APC submission sites x 4 usage of antihistamines. Management of CSU Not too complicated not too simple https://onlinelibrary.wiley.com/doi/full/10.1111/ceo.12465 Advances in Understanding and Managing Chronic Urticaria Yasmin Moolani,1 Charles Lynde,2,3 and Gordon Sussman1,4 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
- Headlce
- Hives
- Acute & chronic urticaria
- Insect bites/stings; Bed bugs
- Intertrigo
- Lipoma
- Molluscum contagiosum
- Psoriasis
- PVL Staph
- Seborrhoeic dermatitis
- Skin ulcers
- Solar keratoses
- Vitiligo

**Management**

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

**British Association of Dermatologists (BAD): patient-information-leaflets**

- 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
- Hyperhydrosis (& Iontophoresis)
- Ichthyosis
- Impetigo
- Kaposi’s sarcoma
- 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
- Sarcoïdosis
- 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

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