Care of people with skin problems

Fairlands Medical Practice

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Introduction

- Around 24% of the population consult their GP with a skin problem each year
- 14% of GP consultations are for skin problems
- About 90% of all skin problems are managed exclusively in primary care

Some general pointers from the syllabus…..

- Identify symptoms which are within the normal ranges of normal
- Ensure that skin problems are not inappropriately dismissed as trivial and appreciate the psychosocial factors of skin disease
- Empower patients with chronic skin problems including managing the effects of disfigurement

Skin camouflage

- https://www.changingfaces.org.uk/Skin-Camouflage

- Locations include Aldershot health centre, Leatherhead hospital, Crawley hospital, St Peter's hospital, Ascot community clinic, Basingstoke hospital

- Patients can self refer. Waiting times 1-4 months.

- Be aware of the logistics of the creams that you are prescribing.
- Describe skin lesions accurately
- Undress the patient with dignity
- Don't forget genitalia, nails and mucous membranes
- Recognise the patterns and rashes of different skin diseases

The primary care dermatology society

- http://www.pcds.org.uk/p/diagnostic-tables-how-to-use

Diagnosis based on appearance		
Brown / black / blue	Skin-coloured / red / purple	White / yellow / orange
Flat, small-medium size	Flat and smooth	White
Larger patches	Scaly or crusty	Yellow and orange
Raised	Pedunculated	
	Smooth, skin-coloured papules or nodules	
	Smooth, red-purple papules or nodules	
	Subcutaneous / deep seated	

- Be aware of when further tests are appropriate
- Understand when to recommend incision/excision biopsy
- Take an adequate skin history eg past medical history, family history, chemical contacts, occupation and drug usage
- Be able to give advice re healthy skin
- Consider DLQI or PDI

DERMATOLOGY LIFE QUALITY INDEX (DLQI)

Hospital No: ..... **Date:** .....

Name: ..... **Score:** .....

Address: ..... **Diagnosis:** .....

.....

The aim of this questionnaire is to measure how much your skin problem has affected your life OVER THE LAST WEEK. Please tick (✓) one box for each question.

1.	Over the last week, how **itchy**, **sore**, **painful** or **stinging** has your skin been?	Very much ❒ A lot ❒ A little ❒ Not at all ❒		
2.	Over the last week, how **embarrassed** or **self conscious** have you been because of your skin?	Very much ❒ A lot ❒ A little ❒ Not at all ❒		
3.	Over the last week, how much has your skin interfered with you going **shopping** or looking after your **home** or **garden**?	Very much ❒ A lot ❒ A little ❒ Not at all ❒	Not relevant	❒
4.	Over the last week, how much has your skin influenced the **clothes** you wear?	Very much ❒ A lot ❒ A little ❒ Not at all ❒	Not relevant	❒
5.	Over the last week, how much has your skin affected any **social** or **leisure** activities?	Very much ❒ A lot ❒ A little ❒ Not at all ❒	Not relevant	❒
6.	Over the last week, how much has your skin made it difficult for you to do any **sport**?	Very much ❒ A lot ❒ A little ❒ Not at all ❒	Not relevant	❒
7.	Over the last week, has your skin prevented you from **working** or **studying**?	Yes ❒ No ❒	Not relevant	❒

- Know the indications for curettage, cryotherapy and cautery
- Recognise skin emergencies and act appropriately
- Be aware of major advances in therapy eg biological therapies
- Understand national guidance for skin problems.
- Refer appropriately to secondary care

Understand the alarm symptoms for skin cancers that need fast track referrals

7 point check list for melanoma. Any one feature qualifies for 2ww

1. Change in size
2. Change in shape/irregular shape
3. Change in colour/irregular colour
4. Diameter >7mm
5. Inflammation
6. Oozing
7. Change in sensation

Understand the alarm symptoms for skin cancers that need fast track referrals

SCCs can be 2ww referred if

1. Non-healing keratinizing or crusted lesion >1cm with significant induration on palpation
2. Documented expansion over 8 weeks
3. Subcutaneous component
4. Organ transplant recipient with new or growing lesion

Do not 2ww BCCs.

- Appreciate that skin diseases may result from other system pathologies
- Know the association between psoriasis and arteriosclerosis
- Be aware of inheritance of common skin disorders
- Be aware of logistical limitations of treatment
- Consider advising patients re pre-payment certificate for scripts

- Be aware of local alternative referrals eg GPwSIs or specialist nurses
- Be aware of shared care protocols with secondary care
- Consider the help of "expert patients"
- Involve other team members
- Consider referral meetings
- Be aware of primary care resources

Surrey Dermatology Service

NHS

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- About The Service
- How to Book
- GP Referral Guidelines
- GPwSI Training
- Clinical Team
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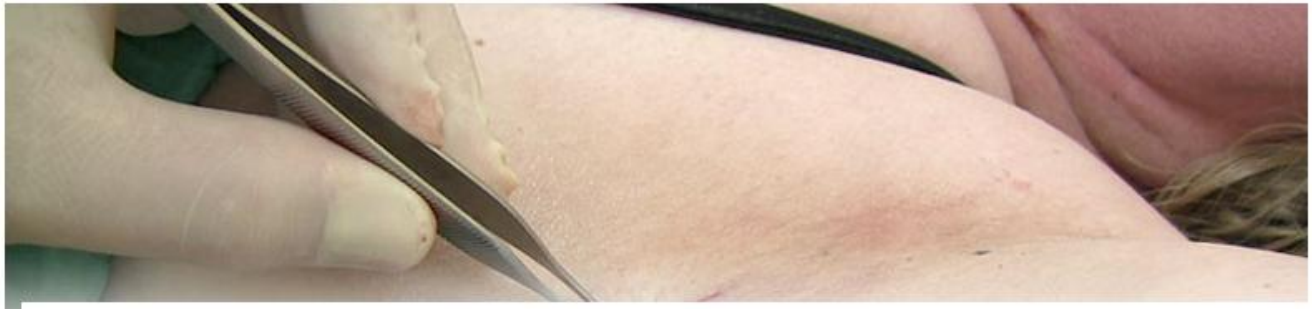
- Equality Impact Assessment
- Contact Us



About Surrey Dermatology Service

Welcome,

The Surrey Dermatology Service is a new specialist community NHS service for patients requiring treatment for skin problems in Guildford and Waverley. It has been commissioned by Guildford and Waverley Clinical Commissioning Group to improve local access to services and reduce waiting times for an appointment. Only patients living in this area can access treatment as it is a pilot scheme.

The service is provided by a team of expert Consultant Dermatologists, Consultant Plastic Surgeons, General Practitioners with a Specialist Interest in Dermatology, and specialist nurses. We have two locations for services located at the Villages Medical Centre in Send and Cranleigh Medical Centre. Both have good access to public parking and have excellent NHS facilities for seeing patients including minor procedures facilities.

If you work for a GP practice and would like to refer patients to us, please see our referral guidelines for more information about what we can see.

Excellent condition leaflets.

- http://www.bad.org.uk/for-the-public/patient-information-leaflets

CRYOTHERAPY

What are the aims of this leaflet?

This leaflet has been written to help you understand more about cryotherapy. It tells you what cryotherapy is, what is involved and what the potential side effects are.

What is cryotherapy?

The term 'cryotherapy' literally means 'treatment using low temperature', and refers to the removal of some skin lesions by freezing them. The most common product used by doctors is liquid nitrogen.

What is liquid nitrogen?

Liquid nitrogen is the liquid state of gaseous nitrogen, which occupies 78% of the air we breathe. Liquid nitrogen is extremely cold, boiling at minus 196°c. It is necessary to store and transport it in special flasks.

What conditions can be treated with cryotherapy?

A wide variety of superficial benign (non-cancerous) lesions can be treated

- Understand affect of environment on skin conditions
- Understand affect of ageing population on increase in skin cancers
- Recognise different cultures may have different incidences and different reactions to the same condition.
- Be aware of local restrictions on prescribing eg oral terbinafine, vaniqa, topical immunomodulators

ECZEMA & PSORIASIS

Chris Turner

GPST1

Aims

- Outline assessment and diagnosis of eczema and psoriasis
- Principles of management from Primary Care perspective
- When to refer to Secondary Care

- Based on NICE guidelines

Atopic Eczema / Dermatitis

Chronic, relapsing, itchy skin condition

Reduction in the lipid barrier of the skin leading to an increase in water loss and a tendency towards dry skin

The pathophysiology of atopic eczema is a complex interaction of susceptible genes, environmental triggers, defects in the skin barrier, and immunologic responses

30% of all dermatological consultations in GP Land

Around 80% of cases occur before 5 years of age

[Holden and Parish, 1998]

[Akdis et al, 2006; Peate, 2011].

[NICE, 2007; Peate, 2011; DermNet NZ, 2013].

Triggers

- Diet
- Irritants
- Inhalants
- Hormonal

Diagnosis

- **An itchy skin condition (or parental report of scratching) in the last 12 months, plus three or more of the following:**

1. A history of involvement of the skin creases (fronts of elbows, behind knees, fronts of ankles, around neck, or around eyes).

2. A personal history of asthma or hay fever (or history of atopic disease in a first degree relative if a child is less than 4 years of age).

3. A history of generally dry skin in the last year.

4. Onset under the age of 2 years (not used if a child is less than 4 years of age).

5. Visible flexural eczema (including eczema affecting cheeks or forehead and outer aspects of limbs in children less than 4 years of age).

Severity

CLEAR: normal skin, no evidence of active eczema.

MILD: areas of dry skin, infrequent itching (with or without small areas of redness).

MODERATE: areas of dry skin, frequent itching and redness (with or without excoriation and localized skin thickening).

SEVERE: widespread areas of dry skin, incessant itching and redness (with or without excoriation, extensive skin thickening, bleeding, oozing, cracking, and alteration of pigmentation).

Consider using validated tools to assess severity. For example, using visual analogue scales (0–10) of the individual's assessment of severity, itch, and sleep loss over the last 3 days and nights, or using the Patient-Oriented Eczema Measure

Psychological severity

Quality of life and psychosocial wellbeing:

NONE: no impact on quality of life.

MILD: little impact on everyday activities, sleep, and psychosocial well-being.

MODERATE: moderate impact on everyday activities and psychosocial well-being, and frequently disturbed sleep.

SEVERE: severe limitation of everyday activities and psychosocial functioning, and loss of sleep every night.

Consider objective questionnaires:
Children's Dermatology Life Quality Index (CDLQI) and Adult's Dermatology Life Quality Index (ADLQI), Infant's Dermatitis Quality of Life index (IDQOL), or Dermatitis Family Impact questionnaire (DFI)

Treatment

Stepwise approach tailored to severity of eczema

EMOLLIENTS EMOLLIENTS EMOLLIENTS! EVEN WHEN SKIN IS CLEAR!!!

Topical corticosteroids are recommended for areas of inflamed eczema, tailored to severity

Avoid triggers

MILD ECZEMA	MODERATE ECZEMA	SEVERE ECZEMA
Emollients	Emollients	Emollients
Mild potency topical corticosteriods	Moderate potency topical corticosteroids	Potent topical corticosteroids
	Non-sedating antihistamines	Sedating/Non-sedating anti-histamines
	Topical calcineurin inhibitors (tacrolimus or pimecrolimus)	Topical calcineurin inhibitors (tacrolimus or pimecrolimus)
	Bandages	Bandages
		Phototherapy
		Oral corticosteroids

“The correct emollient to use is the one that the patient will use”

How much to prescribe?

Area affected	Creams and ointments PER WEEK(g)	Lotions PER WEEK (ml)
Face	15-30	100
Both hands	25-50	200
Scalp	50-100	200
Both arms or both legs	100-200	200
Trunk	400	500
Groin and genitalia	15-25	100

How to apply? Isn't it obvious?

- Liberally and frequently
- Every 2-3 hours!
- Creams and lotions during the day
- Ointments at night
- MUST use during or after bathing
- Don't RUB in, SMOOTH in
- Creams and lotions best for inflamed skin
- Ointments best for non-inflamed

Topical corticosteroids

Choose the preparation containing the **least potent** drug at the lowest strength which is effective

Avoid repeat prescriptions for potent corticosteroids

Ointments more effective but messier

When to refer to secondary care?

- The diagnosis is, or has become uncertain
- 1-2 flares per month despite optimal treatment
- Facial eczema not responding to treatment
- Recurrent secondary infection
- Significant social or psychological

- Refer to clinical psychologist if well managed but QOL and psycho-social wellbeing affected

Eczema Herpeticum

Psoriasis

A ‘chronic, inflammatory, multisystem disease with predominantly skin and joint manifestations’.

It is characterized by scaly skin lesions, which can be in the form of patches, papules, or plaques. Itch is often a feature

Chronic plaque psoriasis affects 80-90% (includes flexural, scalp and facial)

Triggers

- Streptococcal infection
- Drugs – lithium, antimalarials, betablockers, NSAIDS, ACEI, penicillin, tetracycline
- Sunlight
- Trauma
- Post-partum hormonal
- Stress
- ETOH
- Smoking
- HIV
- Environment

Diagnosis

- Clinical
- Pink scaly plaques
- Clear delineation
- Fissures over joint line

Assessment

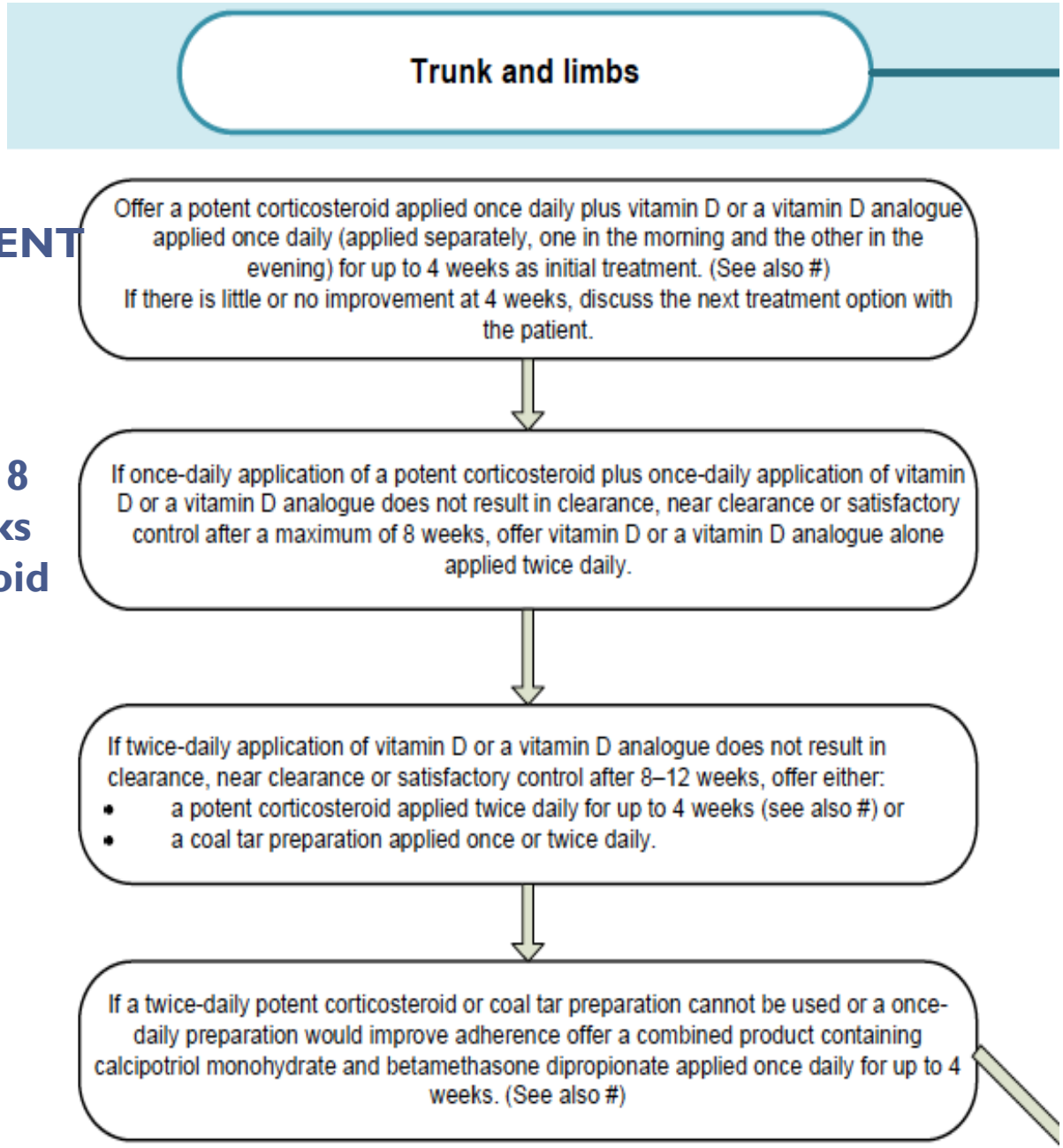
- Disease severity and body surface area
- 'Psoriasis Global Assessment'

Score 7	Severe: Very marked plaque elevation, scaling and/or erythema.
Score 6	Moderate to Severe: Marked plaque elevation, scaling and/or erythema.
Score 5	Moderate: Moderate plaque elevation, scaling and/or erythema.
Score 4	Mild to moderate: Intermediate between moderate and mild.
Score 3	Mild: Slight plaque elevation, scaling and/or erythema.
Score 2	Almost clear: Intermediate between mild and clear.
Score 1	Clear: No sign of psoriasis.

- Systemic symptoms
- Impact on physical, psychological and social wellbeing
- Psoriatic arthritis
- Co-morbidities

EMOLLIENT +

Max 8 weeks steroid



Dithranol

DITHROCREAM

Prescribed as a 'range' 0.1%-2%

Pretreat plaques with Vaseline for 1 hour

Apply lowest potency for 30 mins then wash off

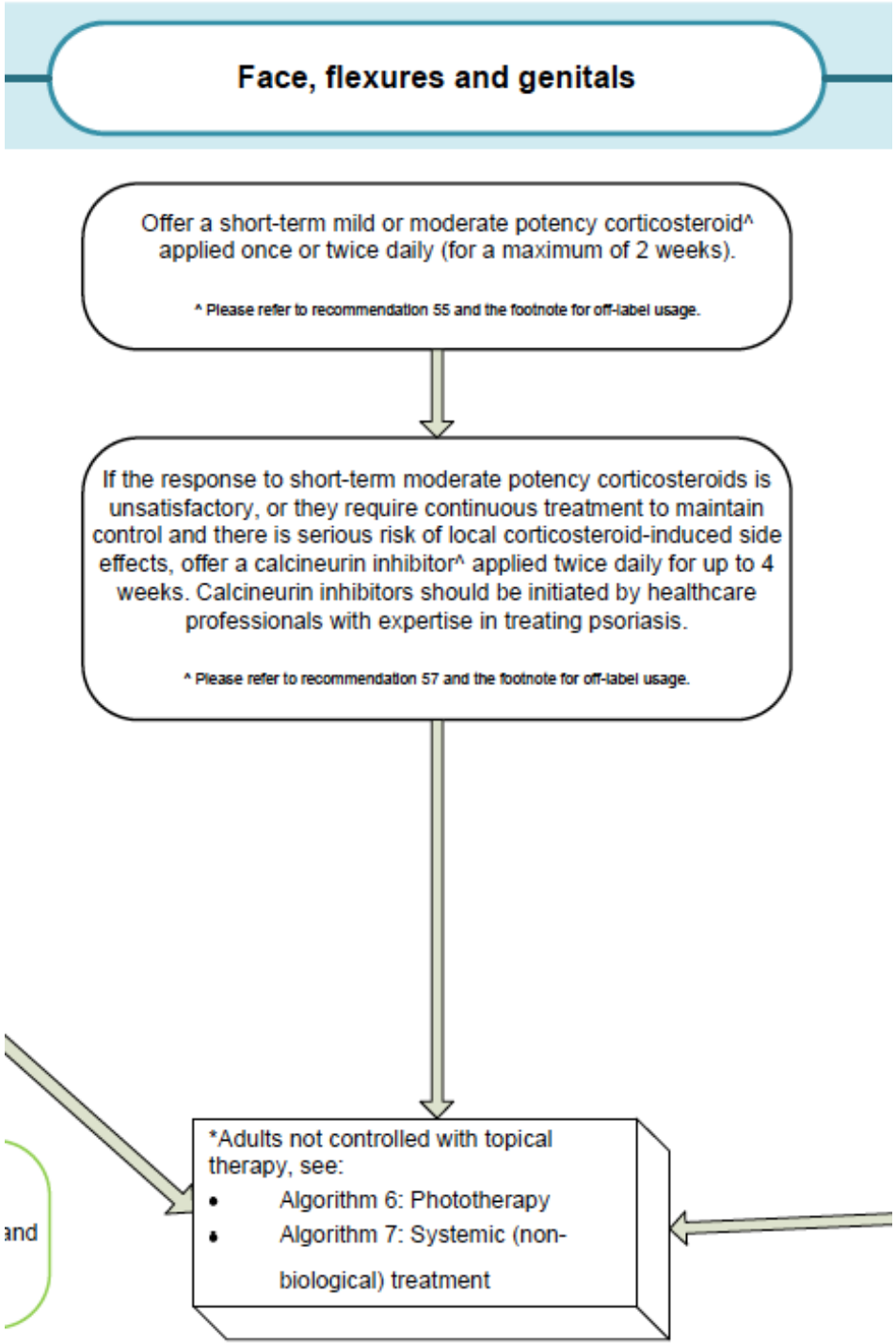
Increase weekly

MICANOL CREAM

1%, 3%

Other options

- "Offer phototherapy or systemic therapy" AT THE SAME TIME as topical therapy if thought unlikely to manage with topical therapy alone"
- >10% body surface area
- MODERATE on PSA scale
- Nail involvement


Face, flexures and genitals
Offer a short-term mild or moderate potency corticosteroid^ applied once or twice daily (for a maximum of 2 weeks).
^ Please refer to recommendation 55 and the footnote for off-label usage.
If the response to short-term moderate potency corticosteroids is unsatisfactory, or they require continuous treatment to maintain control and there is serious risk of local corticosteroid-induced side effects, offer a calcineurin inhibitor^ applied twice daily for up to 4 weeks. Calcineurin inhibitors should be initiated by healthcare professionals with expertise in treating psoriasis.
^ Please refer to recommendation 57 and the footnote for off-label usage.
*Adults not controlled with topical therapy, see:
Algorithm 6: Phototherapy
Algorithm 7: Systemic (non-biological) treatment

Scalp

Offer a potent corticosteroid applied once daily for up to 4 weeks as initial treatment. (See also #)

If treatment with a potent corticosteroid does not result in clearance, near clearance or satisfactory control after 4 weeks consider:

- a different formulation of the potent corticosteroid (eg a shampoo or mousse) and/or
- topical agents to remove adherent scale (eg agents containing salicylic acid, emollients and oils) before application of the potent corticosteroid. (See also #)

If the response to treatment with a potent corticosteroid remains unsatisfactory after a further 4 weeks of treatment offer:

- a combined product containing calcipotriol monohydrate and betamethasone dipropionate^ applied once daily for up to 4 weeks or
- vitamin D or a vitamin D analogue applied once daily (only in those who cannot use steroids and with mild to moderate scalp psoriasis).

^ Please refer to recommendation 51 and the footnote for off-label usage.

If continuous treatment with either a combined product containing calcipotriol monohydrate and betamethasone dipropionate applied once daily or vitamin D or a vitamin D analogue applied once daily for up to 8 weeks does not result in clearance, near clearance or satisfactory control offer:

- a very potent corticosteroid applied up to twice daily for 2 weeks (see also #) or
- coal tar applied once or twice daily or
- referral to a specialist for additional support with topical applications and/or advice on other treatment options.

When to refer?

- Same day referral for erythrodermic and generalised pustular psoriasis
- Diagnostic uncertainty
- >10% body surface area
- SEVERE on PSA scale
- Topical treatments have failed
- Patient not tolerating Primary Care intervention
- Impact on physical, psychological, social wellbeing
- Further education needed about topical treatments
- Arthropathy

Questions?

AKT Practice

Sukrti Nagpal GPST3

Question 1

- 26 year old female presents with 2 week history of rash.
- Started initially as a patch above her umbilicus. Over the course of following week developed satellite sites.
- Not pruritic, no hx allergy, systemically well.

What is the most likely cause

- A) Pityriasis Versicolor
- B) Pityriasis Rosea
- C) Drug Eruption
- D) Erythema multiforme
- E) Psoriasis

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Pityriasis Rosea

- Cause unknown, possibly herpes hominis virus 7 (HHV-7)
- Tends to affect young adults

Features

- Herald patch (usually on trunk)
- Followed by erythematous, oval, scaly patches. This may produce a 'fir-tree' appearance

Management

- Self-limiting, usually disappears after 4-6 weeks
- Reassurance

Question 2

Order the following steroid creams increasing potency (Least potent → Most potent)

- A) Betamethasone valerate 0.1% (Betnovate)
- B) Hydrocortisone 0.5-2.5%
- C) Clobetasol propionate 0.05% (Dermovate)
- D) Clobetasone butyrate 0.05% (Eumovate)

1) DCBA 2) ADCB 3) BDAC 4) BCAD

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1) DCBA 2) ADCB 3) BDAC 4) BCAD

Treatment of Eczema

Mild	Moderate	Potent	Very potent
Hydrocortisone 0.5-2.5%	Betamethasone valerate 0.025% (Betnovate RD)	Fluticasone propionate 0.05% (Cutivate)	Clobetasol propionate 0.05% (Dermovate)
	Clobetasone butyrate 0.05% (Eumovate)	Betamethasone valerate 0.1% (Betnovate)	

- Use weakest steroid cream which controls patients symptoms
- Treatment lengths……

The BNF makes recommendation on the quantity of topical steroids that should be prescribed for an adult for a single daily application for 2 weeks:

Area	Amount
Face and neck	15 to 30 g
Both hands	15 to 30 g
Scalp	15 to 30 g
Both arms	30 to 60 g
Both legs	100 g
Trunk	100 g
Groin and genitalia	15 to 30 g

Question 3

- 8 week old presents with on going erythema around genitals. Cries at nappy changes. Mum extremely upset as not improving with sudocrem.

Which is the least useful advice?

- A)Leave nappy off as much as possible
- B) Use Talcum powder
- C) Use water and cotton to wash and dry
- D) Continue to use a barrier cream
- E) Combination of antifungal and steroid can be useful

Which is the least useful advice?

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- E) Combination of antifungal and steroid can be useful

Nappy Rash

- Inflammation usually caused by local irritation (urine/faeces)
- Commonly infected with candida albicans
- Management is mostly conservative:
  - Leave Nappy off as much as possible
  - Use water only to wash as soap dries
  - Dry thoroughly (pat not rub) before replacing the nappy
  - AVOID talcum powder
  - Barrier cream
- Where infected, treat promptly

Question 4

What is the most likely diagnosis?

- A) BCC
- B) Seborrhoeic keratoses
- C) Melanoma
- D) SCC
- E)Actinic keratoses

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Question 5

Which of the following medications is most associated with these lesions?

- A) Prednisolone
- B) Amiodarone
- C) Aspirin
- D) COCP
- E) Statin

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References

- RCGP curriculum
- Oxford handbook of general practice
- http://www.bad.org.uk
- www.pcds.org.uk
- www.swshcn.neh.net

THANK YOU FOR LISTENING!!