

# South East London Dermatology Guidelines for Primary Care

March 2025

These guidelines are easy to follow, evidence-based and locally referenced for use by GPs, nurses, and other healthcare professionals in primary care with the necessary knowledge to interpret them.

***Underlined items are hyperlinked, press Ctrl and click on the item to access them.***

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

For guidance on Acute Trust details and Local Referral Pathways please follow the link to [appendix 1](#).

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](#), [Evelina Paediatric Formulary](#) and with the local borough antibiotic guidelines. Prescribing recommendations follow the Red, Amber, Green, Grey (RAGG) guidance to promote safe, effective prescribing within the most appropriate setting by the most appropriate person.

If you have any corrections, questions or ideas for improvement please let the authors know by emailing [southwark.medicine-optimisation@selondonics.nhs.uk](mailto:southwark.medicine-optimisation@selondonics.nhs.uk)

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

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# Referral Overview for Dermatology Skin Conditions

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

Please direct all Non 2WW dermatology referrals to the local RAS as detailed in the appendices; In broad terms you can expect patients to be seen in the community services unless the dermatology problems are severe/ very extensive or requiring 2<sup>nd</sup> Line systemic treatments as detailed below, or unless the surgery is outside the community service's remit.

Community Dermatology Service (GPwER Level)	Minor Surgery (GPwER level)
<ul style="list-style-type: none"> <li>• Acne (moderate to severe)</li> <li>• Actinic Keratosis (if beyond the scope/ confidence of general practice)</li> <li>• Alopecia/hair loss (non-scarring)</li> <li>• BCCs (unless meets secondary care or 2WW)</li> <li>• Bowen's disease (or primary care)</li> <li>• Congenital lesions – vascular or pigmented</li> <li>• Eczema (not responding to treatment as per SEL guideline)</li> <li>• Nail or scalp disorders (moderate severity)</li> <li>• Hidradenitis suppurativa (in accordance with local GPwER remit)</li> <li>• Hyperhidrosis generalised (not responding to treatment as per SEL guideline)</li> <li>• Infection + infestations, e.g. tinea (not responding to standard therapy)</li> <li>• Lesion of diagnostic uncertainty (not 2WW)</li> <li>• Lichen planus and other inflammatory disorders</li> <li>• Pigment disorders e.g. vitiligo</li> <li>• Pruritus</li> <li>• Psoriasis (not responding to treatment as per SEL guideline)</li> <li>• Pyogenic granulomas</li> <li>• Rash of diagnostic uncertainty</li> <li>• Rosacea</li> <li>• Urticaria</li> <li>• Skin Check – mole review in high-risk individuals</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Lumps and bumps/ benign skin lesions</b> as per <a href="#">SEL TAP</a> (≥5cm refer to general surgery, Maxillo facial or plastics as appropriate)</li> <li>• <b>Low risk Basal Cell Carcinoma (BCC)</b> (2cm below the clavicle, 1cm above the clavicle )</li> <li>• <b>Refer to local foot health services</b> for management of chronic/ recurrent in-growing toenails or nail deformities requiring surgical intervention or nail bed ablation where appropriate</li> </ul>

Secondary Care Dermatology Service	Secondary Care 2WW Skin
<ul style="list-style-type: none"> <li>• Acne (severe and for prescription of oral isotretinoin which cannot be initiated by Community Dermatology Services)</li> <li>• Allergic contact dermatitis</li> <li>• Alopecia (unresolving)</li> <li>• BCC (high risk not covered by 2WW)</li> <li>• Congenital lesions – vascular or pigmented</li> <li>• Connective tissue disorders (suspected)</li> <li>• (Cutaneous) vasculitis</li> <li>• Eczema (inadequate response to topical therapy)</li> <li>• Genital dermatosis (severe)</li> <li>• Genodermatoses (suspected)</li> <li>• Hidradenitis suppurativa (not responding to GPwER intervention)</li> <li>• Hyperhidrosis (as per SEL guideline)</li> <li>• Nail tumours</li> <li>• Photodermatoses</li> <li>• Psoriasis (inadequate response to topical therapy)</li> <li>• Rash (with systemic disturbance in any age group)</li> <li>• Rash in pregnancy</li> <li>• Urticaria (not responding to treatment as per SEL guideline)</li> </ul>	<ul style="list-style-type: none"> <li>• Suspicion of Melanoma</li> <li>• Any other suspicious lesion</li> <li>• Suspected squamous cell carcinoma (SCC) with definite history of change/expansion</li> <li>• Keratoacanthoma (consider as SCC)</li> <li>• High risk BCC (rapidly growing skin lesion on the eyelid, lip margin or nose or where a delay may have a significant impact (this is not the same as the T-zone) or diagnostic doubt - possible SCC or basisquamous lesion)</li> <li>• Pyogenic granuloma without a clear history of trauma</li> </ul>

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## 2 Week Wait Suspected Cancer Criteria

### Refer as '2WW → 2WW Skin'

- Suspicion of Melanoma
- Any other suspicious lesion especially if sore, or changing over weeks-months
- Suspected squamous cell carcinoma (SCC) with definite history of change/expansion
- Keratoacanthoma (consider as SCC)
- High risk BCC (rapidly growing skin lesion on the eyelid, lip margin or nose or where a delay may have a significant impact (this is not the same as the T-zone) or diagnostic doubt - possible SCC or basisquamous lesion)
- Pyogenic granuloma without a clear history of trauma

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

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

Select '2WW' as the speciality then clinic type '2WW Skin': select a location and appointment, print appointment details for your patient; attach a completed Pan London 2WW referral form to your ERS booking. Note that in several trusts in SEL 2WW patients 16-50 years old with 1 or 2 lesions (not genital and patient not immunosuppressed) are offered an initial 2WW teledermatology appointment, unless certain exclusion factors are met; they attend for photography and dermoscopy. They are contacted with the outcome and offered a face to face appointment in clinic for further assessment where needed. Follow local advice about the relevant age range.

**Children:** Skin cancer in young people is uncommon. Where there is a significant concern a 2WW appointment can be booked by selecting '2WW' then clinic type '2WW Skin' and selecting either Guy's and St Thomas' or LGT Queen Elizabeth Hospital for South East London.

Please print appointment details for your patient.

## Routine Referral and Urgent Review Criteria

### Routine referral and urgent review (Not 2WW, no red flags needing review <72 hrs)

- Refer via eRS Referral Assessment Service (RAS) pathways: Check contact details and attach a photo(s). Please see [appendix 1](#) for local referral pathways.
- Provide as much detail as possible on the SEL dermatology referral form to explain why an appointment is required.
- Complete and attach a referral form and pre-referral checklist if available.
- Attach DLQi/ relevant past dermatology letters.
- Arrange relevant blood tests e.g. pre-Isotretinoin bloods and contraception.

#### Advice and guidance

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

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

- **Advice about taking good photos for HCP and for patients, and attaching photos to referrals:**
  - Video: <https://vimeo.com/591539694>
  - [Photography for the patient - how to take a good photograph of a skin condition / skin lesion \(pcds.org.uk\)](http://pcds.org.uk)
  - [Photography for the clinician - how to take a good dermoscopic photograph \(pcds.org.uk\)](http://pcds.org.uk) [Clinical photography in skin of colour: tips and best practices \(pcds.org.uk\)](http://pcds.org.uk)

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# Dermatology History and Terminology

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

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## Examination

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

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

## Distribution

**Acral** Distal portions of limbs (hand, foot) and head (ears, nose)

**Dermatomal** Corresponding with nerve root distribution

**Extensor vs Flexural** (also known as intertriginous in body flexures)

**Follicular** Individual lesions arise from hair follicles

**Clustered**

**Generalised, Symmetrical, Unilateral**

**Herpetiform** Grouped umbilicated vesicles, as arise in *Herpes simplex/zoster*

**Koebnerised** Arising in a wound or scar

**Photosensitive** Does not affect skin that is always covered by clothing

**Seborrhoeic** Sites of increased sebaceous gland activity. Seborrhoeic dermatitis: scalp, behind ears, eyebrows, nasolabial folds, sternum and interscapular

**Truncal** Favours trunk and rarely affects limbs

## Morphology

**Macule** Flat non-palpable area of colour change of less than 0.5cm diameter (< 5 mm)

**Patch** Flat non-palpable skin lesion greater than 0.5cm diameter (> 5 mm)

**Papule** Small palpable lesion less than 0.5cm diameter

**Nodule** Larger solid papule greater than 0.5cm diameter

**Plaque** Palpable flat lesion greater than 0.5cm diameter

**Vesicle** Small fluid filled blister, less than 0.5cm diameter

**Pustule** Purulent (pus filled) vesicle

**Bulla** Large fluid-filled blister greater than 0.5cm diameter

**Weal** Oedematous papule/plaque caused by swelling in dermis, often indicates urticaria

**Dermal** Dermal lesions do not have surface change/ scaling

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

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

**Note: Pre-payment certificates (PPC) are helpful where a patient will need 4+ prescriptions (in 3 months) or 12+ (12 months). Patients buy them online or by telephone. Please set the expectation that the purchase of a pre-payment certificate does not remove the requirement for purchasing OTC medication in line with the SEL self-care policy.**

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# Skin cancer: Malignant Melanoma (MM)

## Key messages

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

### The ABCDE checklist:

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

### 7-point checklist

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

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

- **Resources** [Self-exam of moles – Primary Care Dermatology Society](#)

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### Consider attending a dermoscopy course:

Eg: DFAB: Dermoscopy for Absolute beginners, then Dermoscopy for Intermediates [Dermoscopy Events](#)  
 PCDS Advanced Dermoscopy, PCDS International dermoscopy course.

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## Risk factors for malignant melanoma (MM)

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

## Biopsy of suspected MM should NOT be performed in primary care

### Notes

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

### Resources

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

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# Skin Cancer: Squamous Cell Carcinoma (SCC) and Keratoacanthoma

## Key messages

Refer suspected SCCs under 2-week wait pathway:

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

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

## Notes

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

## Resources

[On-line pictures for GPs – Primary Care Dermatology Society](#)

[Patient leaflet – Patient.info](#)

[Patient leaflet – British Association of Dermatology](#)

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# Skin Cancer: Basal Cell Carcinoma (BCC)

## Key messages

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

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

## Notes

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

## Resources

[On-line pictures for GPs – Primary Care Dermatology Society](#)

[Patient leaflet – Patient.info](#)

[Patient leaflet – British Association of Dermatology](#)

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

## Key messages

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

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

### Low risk BCCs are:

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

### Resources

[NICE Guidance](#)

## Immunosuppression/ HIV

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

### Resources

[Clinical Guidelines – Primary Care Dermatology Society](#)

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## Actinic/Solar Keratoses (AKs) [\[Images\]](#)

### Key Messages for Healthcare Professionals

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

### Treatment notes:

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

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

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

For patients who may not be able to apply the topical treatments as above but in whom treatment of field change is appropriate – consider referring to secondary care for photodynamic therapy.

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

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

- Cryotherapy by someone trained in its use; freeze for 5-10 seconds each.
  - Avoid below the knee
  - Caution in pigmented skin as risk of depigmentation
  - Caution around nails and eyes
  
- **5-FU 0.5% and salicylic acid 10% (Actikerall®)**
  - For palpable and moderately thick hyperkeratotic actinic keratosis (grade I/II)
  - Maximum area of 25cm<sup>2</sup> and maximum duration 12 weeks
  - Apply to the lesion with brush applicator OD for up to 12 weeks, reduce frequency to x3 per week if response is too inflammatory; peel off existing coating before reapplication
  - Consider if cryotherapy not available or tolerated, site below the knee,
- When superficial with a thin base Efudix® 5% cream can also be considered

### Resources

[On-line pictures for GPs – Primary Care Dermatology Society](#)

[Clinical guidance – Primary Care Dermatology Society](#)

[Information for GPs: Patient leaflets – Patient.info](#)

[Patient information about AKs: Patient leaflets – British Association of Dermatology 5-fluorouracil cream - BAD Patient Hub \(skinhealthinfo.org.uk\) Efudix® \(5-FU\) cream \(pcds.org.uk\)](#)

Aldara PIL <https://www.medicines.org.uk/emc/files/pil.823.pdf>

Solaraze Gel leaflet: <https://www.medicines.org.uk/emc/product/6385/pil>

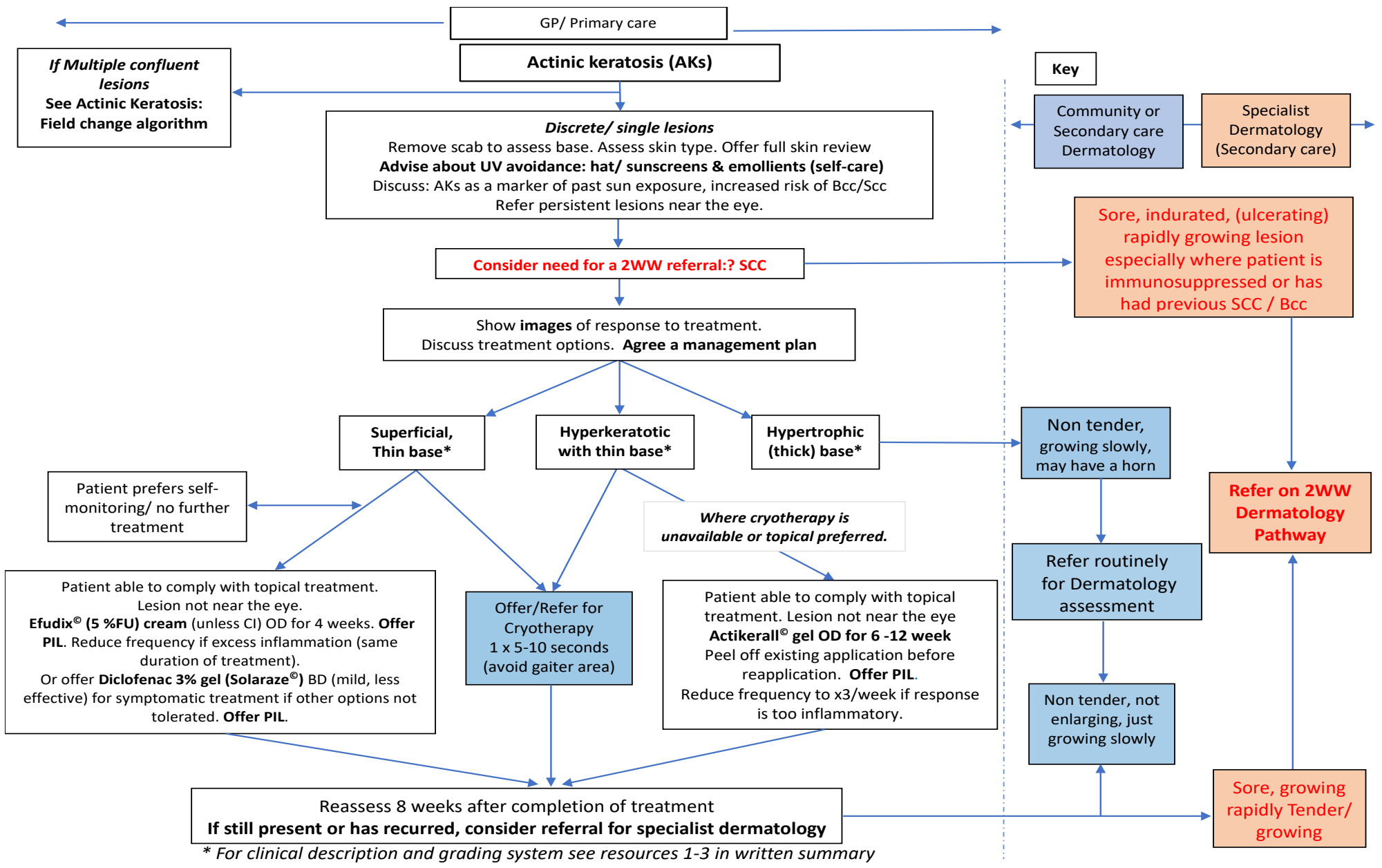
Actikerall leaflet: [Actikerall emc PIL](#)

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# Actinic Keratosis Field change algorithm

**Actinic keratoses: Field change**  
 Remove scabs to assess base. Assess skin type. Offer full skin review  
*Consider via 2WW referral if lesions are sore, growing rapidly*  
**Discuss treatment options. Advise use of sunscreens & emollients for all**  
 Discuss AKs as marker of sun exposure, recurrent problem, and increased risk Bcc/ScCs.  
**Referral to dermatology can be made at any stage if diagnosis is uncertain**

Key

GP / Community or  
Secondary care

Specialist Dermatology  
(Secondary care)

**Refer sore, rapidly changing lesions  
on 2WW Dermatology pathway**

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

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

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

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

**1<sup>st</sup> line**  
Offer **5%FU (Efudix®)** cream Once daily for 4 weeks, or 3-4/week for longer if poorly  
tolerated. Advise re small risk of systemic reaction (change treatment if this occurs).  
Can be used for whole scalps and whole face, including lips.  
**Offer review 8 weeks after completion of treatment or SOS**

**2<sup>nd</sup> line**  
Offer **Imiquimod 5% (Aldara®)** applied od for 4 weeks. Wash  
off after 8 hours e.g. use overnight. **Review 4 weeks after  
completion of treatment, and repeat if required**

*Or If  
intolerant of  
Efudix*

**Reassess after completion of treatment to ensure healing.**

**Residual discrete  
lesions: Follow  
Discrete lesion  
algorithm**

**Refer sore, rapidly  
changing lesions on  
2WW Dermatology  
pathway**

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

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

Refer non tender static hypertrophic  
lesions to Dermatology routinely.



# Scaling dermatoses - Atopic Dermatitis/Eczema

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

### Baseline treatment: 1-3

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

### ADULTS [FTU PIL](#)

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

**Face and flexures:** *Mild to moderate eczema*

**Mild potency TCS**- e.g. hydrocortisone 1% **for 1- 2 weeks**

**Severe Eczema:** **Moderate potency** TCS and review at 2 weeks

#### Trunk and limbs:

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

#### Discoid or hand & foot eczema:

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

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

### CHILDREN

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

**Face and flexures:** Mild to moderate eczema

**Mild potency** - e.g. hydrocortisone 1% **for 1- 2 weeks**

#### Trunk and limbs:

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

#### Severe eczema:

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

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

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

**Topical Calcineurin inhibitors (TCIs) (Amber 1):** *steroid sparing* (especially for face/flexures) once eczema is controlled x1-2 daily (maintenance twice weekly) and *for flares*. Licensed for initiation by practitioners experienced in managing eczema.

**Infants over 3 months:** Pimecrolimus 1% Cream

**Children over 2yrs:** Tacrolimus (0.03%) Ointment

**>16 years and adults:** Pimecrolimus 1% cream or Tacrolimus (0.03%, 0.1%) ointment [TCI PIL](#)

### Seek advice via Consultant Connect/photoSAF or eRS A&G/refer where there is:

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

**Community Dermatology Service:** Adults - moderate-severe; children <12 years (if available): moderate-severe

**Secondary Care Dermatology:** Adults - severe or who may need phototherapy or immunosuppressant drugs. Children <12 years - moderate to severe eczema or if primary care treatment is exhausted and carers in need of support

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## Atopic Dermatitis/Eczema

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

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

### Topical steroids

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

### Secondary infection

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

### Topical calcineurin inhibitors (TCIs) RAGG rating of Amber 1 Offer [TCI PIL](#);

1. Introduce slowly, with test on unaffected skin for a few days first; tingling is not an allergy
2. Advise patients to stop TCIs when the skin nearby is infected e.g., active cold sore
3. Can cause sun sensitivity. Advice once daily use at night and use of sunscreens when it is very sunny
4. Can cause flushing after alcohol; stop use if this occurs

Please refer to appendix 2 for further [advice to support use of topical calcineurin inhibitors TCIs](#)

### Cow's Mil Protein Allergy (CMA)

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

**Resources:** [NHSE guidance for over the counter items that should not routinely be prescribed in primary care.](#)

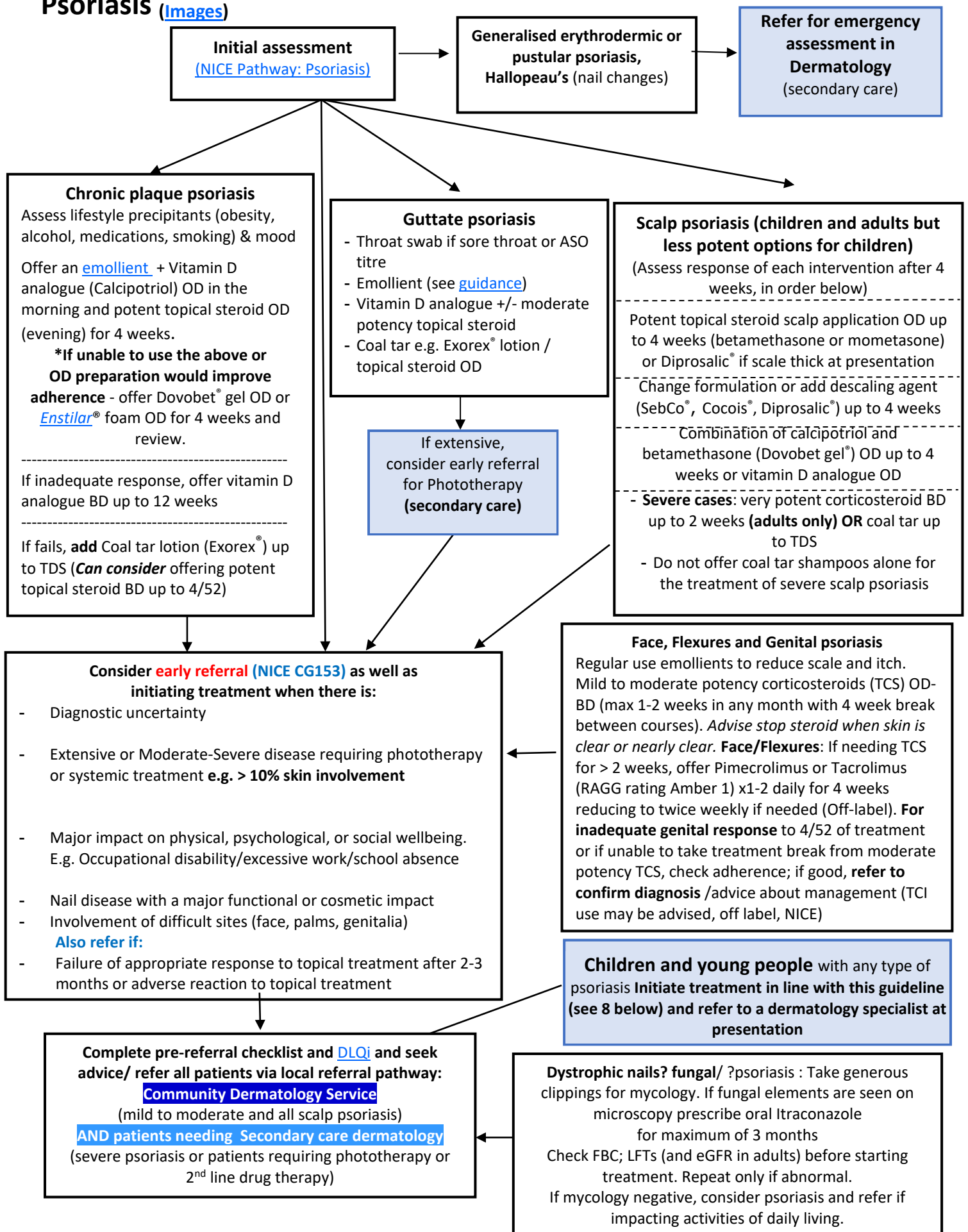
[On-line pictures for GPs – Primary Care Dermatology Society](#) [Patient.info \(Fingertip Unit Guide\)](#) [Prescribing guidance \(topical Steroids\) - PrescQIPP](#) [Patient leaflets \(eczema herpeticum\) – British Association of Dermatology](#) [TCI PIL](#)  
[The use of Milton® baths in dermatology](#) [GSTT – St John's Institute of Dermatology patient advice videos](#)

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# Psoriasis (Images)



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## Psoriasis: Key messages

- Refer early if systemic treatment may be required: Extensive (e.g. > 10% skin involvement, *strong association of obesity with metabolic syndrome so offer intervention*) or moderate to severe disease/ Major impact on physical, psychological or social wellbeing (e.g. occupational/ school absence)/ Nail disease with a major functional or cosmetic impact/ Involvement of difficult sites (face, palms, genitalia)  
Refer all children to Paediatric dermatology at diagnosis but initiate treatment as well (see 8 below)
- Instruct all patients about the use of emollients as a soap and moisturiser, which will make the skin more comfortable and reduce the quantity of active agents needed.
- Appropriate active treatment is dependent on the **type** of psoriasis
- Discuss buying a prepayment certificate to reduce the burden of treatment costs.
- Psoriasis is treatable but not curable, complete DLQI to assess impact. High risk of depression explore psychosocial impact.
- Screen annually for psoriatic arthritis (particularly during the first ten years) using [Pest screening tool \(pcds.org.uk\)](#). Screen for cardiovascular comorbidities at diagnosis and every 5 years ([NICE Clinical Guideline 153](#)).
- Severe/atypical psoriasis is an HIV indicator condition. For information, please see the [CKS topic on HIV infection](#)
- Caution about use of Topical Calcineurin Inhibitor for genital psoriasis in uncircumcised men: refer to dermatologist if unresponsive to moderate potency Topical Corticosteroid/ cannot take treatment breaks from topical corticosteroid

### Notes

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

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

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

**Resources:** [On-line Psoriasis pictures for GPs – Primary Care Dermatology Society](#) [PsoTeen, Psoriasis Association](#) [Dermatology Life Quality Index](#) [Psoriasis PIL– Patient.info](#)

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## Lichen Planus

### Background:

- Fairly common, usually (but not always) highly pruritic (itchy), non-infectious, evolving symmetrical rash
- Usually occurs in adults between the ages of 40-60 (rare in children and very old)
- Hepatitis and Varicella Zoster virus implicated as triggers

### Examination:

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

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

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

### Differential:

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

### Management of Lichen Planus:

- Prognosis: 50% patients clear in 9 months/85% by 18 months; most resolve within 2 years. 20% relapse
- Emollients as soap and moisturiser are helpful for pruritus with cool compresses instead of scratching. Short-term, sedating antihistamines available OTC may help with sleep.
- Limit stress and avoid triggers (smoking, alcohol, irritating food in oral lichen planus)
- Potent (Betamethasone Valerate 0.1% Ointment or Mometasone Furoate Ointment) or supra-potent (Clobetasol propionate = Dermovate®) OD using Finger Tip Units (FTUs) for a month or more. Warn that this may cause hypopigmentation in Type V/VI skin.
- Stop topical steroid when the papules are asymptomatic and macular (flat)
- Tacrolimus 0.1% (Protopic®) ointment or Pimecrolimus Cream may be used steroid sparing topicals on sensitive sites (e.g., face/flexures) or if it itching continues after the lesions are macular (flat) (RAGG Amber 1)
- Oral symptoms may be treated with betamethasone 500mcg or fluticasone 400mcg which are to be dissolved in 10mL water and gargled for 2-4 minutes in accordance with [SEL Oral Medicine Guidance](#).
  - Both treatments are off-label, RAGG rating of Amber 2, so required specialist initiation from secondary care clinicians or GPwERs, after which prescribing may be transferred to primary care
  - Please advise patients **NOT TO swallow the contents** when using a mouthwash (*Spit out*)
  - Please see the betamethasone 500mcg [Patient Information Leaflet](#) or Fluticasone 400mcg [Patient Information Leaflet](#) for further information
- Hypertrophic plaques may need potent or very potent topical steroids under Tegaderm occlusion, applied overnight and reviewed after 4 weeks or applied under Duoderm Extrathin and left for 5 days at a time.
- Do not treat asymptomatic post-inflammatory hyperpigmentation which improves spontaneously (usually but not always), over many months
- **Refer Scarring or erosive Lichen planus early** for rigorous intervention.

### Resources

[Lichen Planus for GPs - Primary Care Dermatology Society](#)

[British Association of Dermatologists - Patient Information Leaflets \(PILs\) \(bad.org.uk\)](#)

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# Acne

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

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

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

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

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

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

**Mild-Moderate Acne**  
**Topical therapy** with keratolytic/ comedolytic: These are initially used in isolation, then in combination as Epiduo® to improve adherence  
 Mild -Moderate Acne: consider

- If there are pustules, consider topical antibiotic with e.g. Duac® 3% or 5% or Treclin®
- Consider **azelaic acid** or topical erythromycin if intolerant of benzoyl peroxide or a retinoid

**Moderate – Severe Acne**

- Do not combine oral and topical antibiotics
- **Add Systemic antibiotic to Epiduo for 3 months** (See point 7)
  - Doxycycline 100mg OD or
  - Lymecycline 408mg OD

Consider Erythromycin 500mg BD or Trimethoprim 200mg BD (see p22:10) if tetracyclines are contraindicated or not tolerated  
 Consider **azelaic acid bd** or topical erythromycin if intolerant of benzoyl peroxide or a retinoid. If need contraception, **avoid** Progesterone Only Pill; consider adding Co-cyprindiol, Intra Uterine Device or condoms

Review treatment compliance/response at 12 weeks

Review treatment compliance/response at 12 weeks

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

**Partial response**  
 Continue same antibiotics and topical for up to 4 months (up to 6 months if relapse quickly after stopping treatment Rarely longer\*\*) If PCOS consider COCP/ co-cyprindiol for females (even if contraception is not required) Consider early referral for type V/VI skin with risk of persistent hyperpigmentation

**Incomplete response at 3 months**  
 Ensure that they have topical keratolytic and taking oral antibiotics; if not, add this. **Seek A&G and refer for consideration of double dose antibiotics, Isotretinoin, Photo Dynamic Therapy.** Whilst waiting for an appointment and in line with advice and guidance consider a trial of spironolactone (females) -RAGG Amber 1 or if contraindicated Trimethoprim 200mg BD (see p22:10) with a topical keratolytic e.g. Epiduo

**Seek advice/ Refer via** local referral pathway, attaching photos, for consideration of spironolactone RAGG Amber 1 (women with hormonal acne) see pg 23/ oral Isotretinoin RAGG Red) and [BAD isotretinoin PIL](#) and [spironolactone PIL](#):

- Mild-moderate acne unresponsive to 2 complete courses of treatment
- Moderate-severe acne unresponsive to a single course of oral antibiotics
- Acne with persistent pigmentary changes
- Acne of any severity cause persistent psychological distress or a mental health disorder (Consider referral to CMHT/ IAPTS also)
- Consider referral if secondary to medical disorder or anabolic steroids

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

**Complete DLQI Refer urgently**

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

HS only.

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## Acne: Key messages

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

## Notes

1. Encourage use of non-alkaline synthetic detergent (syndet) cleansing product twice daily.
2. Avoid oil-based and comedogenic products and remove cosmetics at the end of the day.
3. Discourage picking, squeezing of acne lesions which may promote scarring.
4. Pomade acne only responds to stopping use of rich emollients on scalp and face.
5. Always use a topical keratolytic to prevent comedone formation (e.g. **salicylic acid 2% (Acnisa<sup>®</sup>)**, **benzoyl peroxide 2.5% - 5% (BPO)**, **topical retinoids eg Treclin<sup>®</sup>, Epiduo<sup>®</sup>**). Initial treatment with Acnisa / BPO available **OTC – encourage patients to buy**. Assess treatment at 12 weeks, aiming for 50% improvement. The higher strength of Epiduo<sup>®</sup> 0.3% Adapalene /2.5% BPO can be used for moderate acne if comedones persist despite use of Epiduo<sup>®</sup> 0.1%/2.5% but causes more skin dryness and irritation. In this group it can be helpful in the prevention and reduction of scarring.
6. Benzoyl peroxide may cause bleaching of bedding, towels, or clothing
7. Adapalene may cause increased sensitivity to sunlight, use OTC sunscreen and protective clothing.
8. Advise patients to test new products on the inside of their arm for the first few days then *apply to the whole of the affected area* 3-4 days per week. Increase use gradually. **ROAT**: (Repeat Open Application Trial)
9. **Add** antibiotics (doxycycline 100mg once daily OR lymecycline 408mg OD for moderate disease. **Do not prescribe topical or oral antibiotic monotherapy** without a keratolytic. Never combine topical and oral antibiotics. Continue for a total of 3 months; if there is good response, stop the antibiotic and prescribe a keratolytic alone. If a partial response continue for 6 months; Dermatologists may increase the dose to twice daily. **Avoid minocycline** due to risk of lupus, skin pigmentation and hepatitis.
10. Trimethoprim 200mg BD is useful in resistant acne but is unlicensed for this indication and tends to be initiated by dermatologists (who may increase the dosage to 300mg BD and may advise durations longer than 4 months). NICE advises its use for mood – severe acne at the point of referral however locally use of spironolactone is preferred. Trimethoprim should be discontinued early if the patient becomes systemically unwell. *Be aware of risk of [SJS/TEN and DRESS](#) with trimethoprim, discontinue treatment if rash develops.*
11. Co-cyprindiol or any other COCP can be added after topical therapy or systemic antibiotic treatments. Co-cyprindiol can be especially useful in women who have **PCOS and acne**. It should be discontinued 3 to 4 menstrual cycles after the woman's acne has resolved due to the increased risk of venous thromboembolism. *Progesterone-only* contraception exacerbates acne.
12. Oral isotretinoin is prescribed by secondary care for severe, scarring acne and acne resistant to other therapies. It is teratogenic and females should be using an effective contraceptive *when referred*. Patients with Polycystic Ovarian Syndrome (PCOS) may not respond to treatment so well, but many still derive benefit.
13. Refer patients (or encourage IAPT self-referral) with severe psychological overlay for psychological assessment.
14. Topical Benzoyl peroxide or topical erythromycin are safe to use in pregnancy and breastfeeding. Avoid topical retinoids and oral Tetracyclines. Seek advice if systemic treatment required.
15. Topical erythromycin and Clindamycin lotion solution can safely be used in children. Seek advice if systemic treatment is needed for children and for all infantile acne.
16. Treat acne that relapses in the same way or with a different antibiotic; Epiduo or if one component is contraindicated; adapalene, azelaic acid or benzoyl peroxide can all be used as maintenance treatments.

[British Association of Dermatologists \(bad.org.uk\)](http://britishassociationofdermatologists.org.uk) [Oral-isotretinoin-guide-for-young-people.pdf](#)  
([medicinesforchildren.org.uk](http://medicinesforchildren.org.uk))

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## Spironolactone in Acne

Spironolactone may be initiated for females with moderate – severe hormonally mediated acne who are not pregnant and also when it is not hormonally mediated (see SAFA study below) It can be taken alongside antibiotics and use of topicals

The use of spironolactone in acne has a RAGG rating of Amber 1, so prescribing can be initiated by primary care practitioners, where they are confident to do so, following the advice of a dermatology specialist clinician .

**The Spironolactone for acne in Females (SAFA)** study confirmed that spironolactone can be useful for all women with resistant acne. As such it may be recommended for non-pregnant women

- i) whose acne is unresponsive to systemic antibiotics and topicals, at the point of referral for isotretinoin when it can be alternative to offering Trimethoprim. It can be taken alongside use of topicals
- ii) with moderate-severe acne who prefer to avoid taking systemic antibiotics (taken with use of a topical)
- iii) with moderate acne alongside systemic antibiotics and use of a topical keratolytic to optimise outcome
- iv) who do not wish to consider taking isotretinoin or have been advised that they should not do so.

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

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

### Initiation of spironolactone

Being RAGG Amber 1 spironolactone can be initiated for female patients in primary care following the advice of a dermatology specialist clinician, provided effective contraception is in place.

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

Consider a starting dose of 50mg once daily for 1 month, increased to 100mg if well tolerated (as is usual) after 4 (or 8) weeks . Review at 3-4 months and if necessary increase to 125 mg or 150 mg depending on response i.e. if still having new spots.

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

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

### Resources:

[On-line pictures for GPs – Primary Care Dermatology Society](#)

<https://www.acnesupport.org.uk/>

[Patient leaflet – British Association of Dermatology SJS/TEN Patient Leaflet – British Association of Dermatology](#)

### \*Antibiotic Guidelines:

[Bexley, Lewisham, Oxleas, and Greenwich antimicrobial guidance](#)

[Bromley antibiotic guidance](#)

[Lambeth antibiotic guideline](#) [Southwark antimicrobial guidance](#)

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# 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.  
 Patients with richly pigmented skin may present with a burning sensation of their skin.

**Papulopustular Rosacea**

**Mild to Moderate**  
 (Limited papules, pustules, no plaques):  
**Advise OTC SPF30 & UVA 4-5 star rated Sunscreen +**  
 \*Ivermectin 1% cream, OD for up to 4 months. Treatment can be repeated as necessary. *Discontinue after 3 months if no improvement or*  
 \*Azelaic acid 15% applied BD for 6-9 weeks. *Discontinue after 2 months if no improvement or*  
 \*For those who have responded to previous courses of metronidazole 0.75% gel a repeat course for 8 weeks may be a suitable alternative to the above treatments.

**Flushing & fixed erythema**

**Avoid triggers.**  
**Advise daily OTC SPF30 & UVA 4-5 star rated sunscreen +**  
 Consider **beta blocker** e.g., propranolol 10-20mg BD especially if triggered by anxiety.  
 Consider **Clonidine** 25-50mcg BD (starting as 25 mcg OD and titrate up if tolerated (off label))

Refer if inadequate response.

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

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

Refer to Ophthalmology via local referral pathway.

**Severe (Extensive papules, pustules, or plaques) or persistent moderate rosacea unresponsive to topicals alone**  
**Advise daily use of OTC SPF 30 and UVA 4-5 star rated sunscreen and a hat.**

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

- Oral doxycycline 100mg daily (off-label, less expensive & well tolerated and can be used with renal impairment)
- Consider Erythromycin 500mg BD for pregnant/breast feeding or it tetracycline is contra indicated.

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

- Lymecycline 408mg once daily for up to 12 weeks (off-label, shorter courses are usually required) **OR**
- Doxycycline 40mg MR capsules once daily **for up to 16 weeks** (Licensed for rosacea without ocular involvement. Fewer side effects and equivalent efficacy to 100mg but more expensive)
- If tetracycline contraindicated, or for pregnant women, consider oral clarithromycin 250-500mg BD or erythromycin 500mg BD for 6-12 weeks.

Rosacea fulminans/very severe symptoms: refer immediately to specialist dermatology services (via on call SPR)  
**Seek advice/Refer to Community Dermatology via eRS/RAS, attaching a photo for**

- Diagnostic difficulty
- **Refractory rosacea** not responding to systemic therapy after 12 weeks of optimal treatment (Encourage use of alternative topical if not trialed, or patients' preferred topical whilst await review)
- Disease causing significant **psychological problems** eg anxiety and depression
- Low dose isotretinoin may be considered by specialist

Refer to ophthalmology if ocular rosacea not improving, refer urgently if decrease in vision or pain.  
 Pulse dye laser for moderate-severe telangiectasia and laser resurfacing of a rhinophyma is not usually offered as nhs procedures

- **Rhinophyma:** Refer to local dermatology services to discuss low dose isotretinoin to prevent progression, or laser resurfacing
- **Telangiectatic Rosacea:** May respond well to treatment with (pulse dye) laser but this intervention is not available within the NHS in SEL. These treatments may be available through local private providers.

## 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). Seborrheic dermatitis often co-exists and needs to be managed appropriately. Encourage patient to take a photo at baseline and at each review.

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 when a course of treatment can be repeated. Treatment should be based on Rosacea symptoms and level of severity.
- Patients responding to treatment can be stepped down from combined oral and topical treatment to topical treatment alone, intermittent use eg topical treatment x2-3 per week, or treatment cessation (patient preference)
- GP review (with updated photo) after 3 - 4 months to assess whether maintenance treatment is needed. If next step is unclear, seek advice & guidance using local RAS.
- Advise patients to test new topical products on the inside of their arm for the first few days then apply treatment to the affected areas of the face 3 to 4 times per week gradually increase frequency of application.
- For ocular disease advise about lid hygiene/ managing blepharitis e.g. warm eye pad, eyelid massage, ocular lubricants (OTC)

### Self-care advice for all patients with Rosacea

Recommend frequent application of high factor sunscreen (minimum SPF30 and with 5\*UVA protection) and encourage use of hats in direct sunlight. UV glasses required, especially in ocular rosacea.

Avoid aggravating factors in ocular rosacea, air conditioning, smoky atmosphere, medications that cause dry eyes.

Advise warm compresses with a heatable eye pad e.g. The Eye Doctor Mask (OTC). Advise use of UV sunglasses.

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](#).

Advise that people may self-refer to the charity [Changing Faces](#), which provides education from skin camouflage practitioners on the use and application of cosmetic camouflage creams and powders (To be bought OTC).

### Additional Information

- For persistent or fixed background erythema:  
Brimonidine (Mirvaso<sup>®</sup>) is licensed for the management of facial erythema of rosacea, but it is a grey listed drug in the SEL Joint Medicines Formulary hence should not be prescribed by GPs. It can cause persistent rebound erythema.

**Resources:** [On-line pictures for GPs- Primary Care Dermatology Society](#) [Patient Leaflet-British Association of Dermatology Rosacea](#)

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## Skin Infections

### Impetigo

	Treatments: Adults and children
<b>Localised Lesions</b> <i>Non bullous</i>	Topical antiseptic e.g. Hydrogen peroxide cream Crystacide® (OTC) TDS for 5 days or if unavailable/ inappropriate Fusidic Acid 2% cream/ointment TDS for 5 days (up to 10 days if recurrent)
<b>Localised Impetigo</b> that is <ul style="list-style-type: none"> <li>• Spreading</li> <li>• Persisting</li> </ul>	Advise use of Octenisan® lotion as soap (available OTC) Consider topical Mupirocin Ointment or cream TDS <i>Note: Mupirocin Cream is not recommended for children &lt;1 year</i> If <b>MRSA Positive</b> : Follow local guideline

### Widespread/ Scattered lesions: (Adults and Children)

<ul style="list-style-type: none"> <li>• 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.</li> <li>• <b>Bullous impetigo</b>: systemic treatment (Fucibet® cream BD may be needed)</li> </ul>		
	Systemic Treatment: ADULTS	Systemic Treatment: CHILDREN
<b>Widespread/ Scattered lesions</b> including: <ul style="list-style-type: none"> <li>• Severe</li> <li>• Extensive and/or</li> <li>• Bullous impetigo</li> </ul>	<ul style="list-style-type: none"> <li>• Flucloxacillin 250mg –500mg QDS for 5-7 days <i>(Suitable if pregnant or breastfeeding)</i></li> <li><b>If Penicillin allergic:</b></li> <li>• Clarithromycin 250mg -500mg BD for 5-7 days</li> <li>• Erythromycin 250mg – 500mg QDS for 5-7 days <i>(if pregnant or breastfeeding)</i></li> </ul>	<ul style="list-style-type: none"> <li>• Flucloxacillin for 5-7 days</li> <li><b>If Penicillin allergic:</b></li> <li>• Clarithromycin for 5-7 days</li> <li>• Erythromycin for 5-7 days <i>(Clarithromycin suspension tastes unpleasant)</i></li> </ul> <p><b>Refer to the <a href="#">BNFc</a> or <a href="#">SEL Paediatric formulary</a> for paediatric dose regime</b></p>

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

### Treat nasal carriage of *Staphylococcus aureus*:

Nasal carriage	Treatment - ADULTS and CHILDREN	Comments
<i>Place a 'match head' of ointment/cream inside nostrils and squeeze alar together</i>		
<b>S.Aureus with:</b> <ul style="list-style-type: none"> <li>• Recurrent impetigo</li> <li>• Persistent folliculitis</li> <li>• Recurrent boils</li> </ul> <b>(not PVL/ not MRSA)</b>	Nasal Naseptin® cream <i>applied inside each nostril x 3-4 per day for 7 days</i> Encourage use of Octenisan® Wash lotion for bathing (or Dermol lotion in the context of eczema) both available OTC	Consider nasal Mupirocin ointment if: peanut, soya, or neomycin allergic (Naseptin® is peanut oil based and contains neomycin), failed Naseptin® usage, Fusidic Acid resistance or MRSA
<b>PVL positive S.Aureus or MRSA with</b> <ul style="list-style-type: none"> <li>• Recurrent impetigo</li> <li>• Persistent folliculitis</li> <li>• Recurrent boils</li> </ul>	Offer <i>nasal</i> Mupirocin ointment <i>applied x 3 day inside each nostril for 5-7 day, (longer if bd)</i> Encourage use of Octenisan® wash lotion for bathing, lathered on for 1 minutes for 5 days including washing hair twice in the week or Dermol lotion (OTC) in the context of eczema	Close contacts such as family/ household members may need swabs and decolonization:  Wash sheets / towels everyday Vacuum and dust. Use liquid soap.

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

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

**Treatment** of Impetigo is based on the extent and severity of the infection and whether it is recurrent. A systematic review indicates topical and oral treatment produce similar results. Meticulous hand washing/ hygiene is crucial, using separate towels (wash at 60°C). Provide BAD patient information leaflet on [impetigo](#) for more information.

**Poorly responsive or Recurrent Impetigo:** If not responding/ spreading check compliance and *take skin/nasal swab for C & S* from patient and close family to identify possible methicillin-resistant Staphylococcus aureus (MRSA). Swabs are best taken from a moist lesion, or, in cases of bullous impetigo from a de-roofed blister. Request **C+S + PVL (Panton Valentin Leukocidin)**

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

## Folliculitis/ Boils

Characteristics	Treatment options ADULTS and CHILDREN
Mild: Persistent/ Recurrent Folliculitis or boils	<ul style="list-style-type: none"> <li>May resolve without treatment</li> <li>Consider topical antiseptic, e.g. Octenisan® wash lotion for short-term use (available OTC)</li> <li>Application of moist heat to aid drainage</li> </ul>

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

Characteristics	Treatment options: ADULTS	Treatment options: CHILDREN
Deep-seated and/or persistent lesions	<ul style="list-style-type: none"> <li>Flucloxacillin 250mg – 500mg QDS for 7 days <i>(Suitable if pregnant or breastfeeding)</i></li> </ul> <p><b>If Penicillin allergic:</b></p> <ul style="list-style-type: none"> <li>Clarithromycin 250mg – 500mg BD for 7 days</li> <li>Erythromycin 250mg - 500mg QDS for 7 days (if pregnant or breastfeeding)</li> </ul>	<ul style="list-style-type: none"> <li>Flucloxacillin for 7 days</li> </ul> <p><b>If Penicillin allergic:</b></p> <ul style="list-style-type: none"> <li>Clarithromycin for 7 days <i>Clarithromycin suspension has unpleasant taste)</i></li> <li>Erythromycin for 7 days</li> </ul> <p><b>Refer to the <a href="#">BNFc</a> or <a href="#">SEL Paediatric formulary</a> for paediatric dose regime</b></p>
Severe and/or recurrent infections	<p><b>Systemic treatment: Treatment Choice (ADULTS)</b> As above for longer duration or consider Doxycycline 100mg once daily orally 6-12 weeks Swab nose for <b>nasal carriage</b> (if reoccurs or no improvement), if positive treat with mupirocin nasal ointment</p>	
<b>Consider discussing the management of children with local dermatologist/ microbiologist</b>		

[Treat nasal carriage of Staphylococcus aureus](#) (refer to table on page 26)

## Folliculitis

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

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

See the [Primary Care Dermatology Society: Folliculitis](#) for further information.

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### **Persistent/ Recurrent Folliculitis/ boils:**

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

### **Sterile Folliculitis**

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

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

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

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

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

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

<b>Confirmed PVL Staph aureus infection</b>	<b>General advice for all patients:</b> Excellent hygiene, not sharing towels, change sheets and towels daily if possible. <a href="#">Offer patient information leaflet</a>
<b>Infection severity</b>	<b>Treatment options (ADULTS)</b>
Mild	<ul style="list-style-type: none"> <li>• May resolve without treatment</li> <li>• Drainage of abscesses and sensitivity testing to find appropriate antibiotics</li> </ul>
Moderate	<p><b>Requires systemic antibiotics:</b></p> <ul style="list-style-type: none"> <li>• Flucloxacillin 250mg – 500mg QDS for 7 days (Suitable if pregnant or breastfeeding)</li> </ul> <p><b>If Penicillin allergic:</b></p> <ul style="list-style-type: none"> <li>• Clarithromycin 250mg – 500mg BD for 7 days</li> <li>• Clindamycin 450mg QDS for 7 days (may cause diarrhea)</li> <li>• Erythromycin 250mg - 500mg QDS for 7 days (if pregnant or breastfeeding)</li> </ul> <p>(Longer courses may be needed)</p>
Persistent, Recurrent or Severe Infection	<p><b>Seek advice from local dermatologists and/ or discuss with Microbiologist for local sensitivities</b></p> <p><i>Consider Referral to Specialist especially if patient is systemically unwell</i></p>
<p><b>HPA advise: all cases of PVL-SA should receive decolonisation treatment after antibiotic treatment once the infection has resolved and wound have healed.</b> (Note that local dermatologists find early decontamination more effective)</p> <p><b>Skin/nasal decolonization:</b> Nasal Mupirocin to nostrils TDS and wash with Octenisan® wash lotion daily for 5days and three times a week for hair (decolonisation normally carried out at the end of antibiotic treatment however may be initiated early)</p> <p><a href="#">Decolonisation of nasal carriage of <i>Staphylococcus aureus</i></a> (refer to table on page 26)</p>	

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## PVL (Panton Valentine Leukocidin) Staph Aureus Infection:

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

### Risk factors for PVL Clinical infection:

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

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

### Resources:

[Patient leaflet – Impetigo](#)

[Clinical Knowledge Summaries - Impetigo](#)

[Primary Care Dermatology Society – Images Impetigo](#)

[Primary Care Dermatology Society – Clinical Guidance on Folliculitis and boils \(furuncles / carbuncles\)](#)

[Clinical Knowledge Summaries - Boils, carbuncles, and staphylococcal carriage](#)

[Infection prevention control - Guidance on the diagnosis and management of PVL-associated Staphylococcus aureus infections \(PVL-SA\) in England](#)

British Association of Dermatologists PIL [BAD Panton Valentine Staphylococcus Aureus \(PVL-SA\) skin infection](#)

\*Antibiotic Guidelines:

[Bexley, Lewisham, Oxleas, and Greenwich antimicrobial guidance](#)

[Bromley antibiotic guidance](#)

[Lambeth antibiotic guideline](#)

[Southwark antimicrobial guidance](#)

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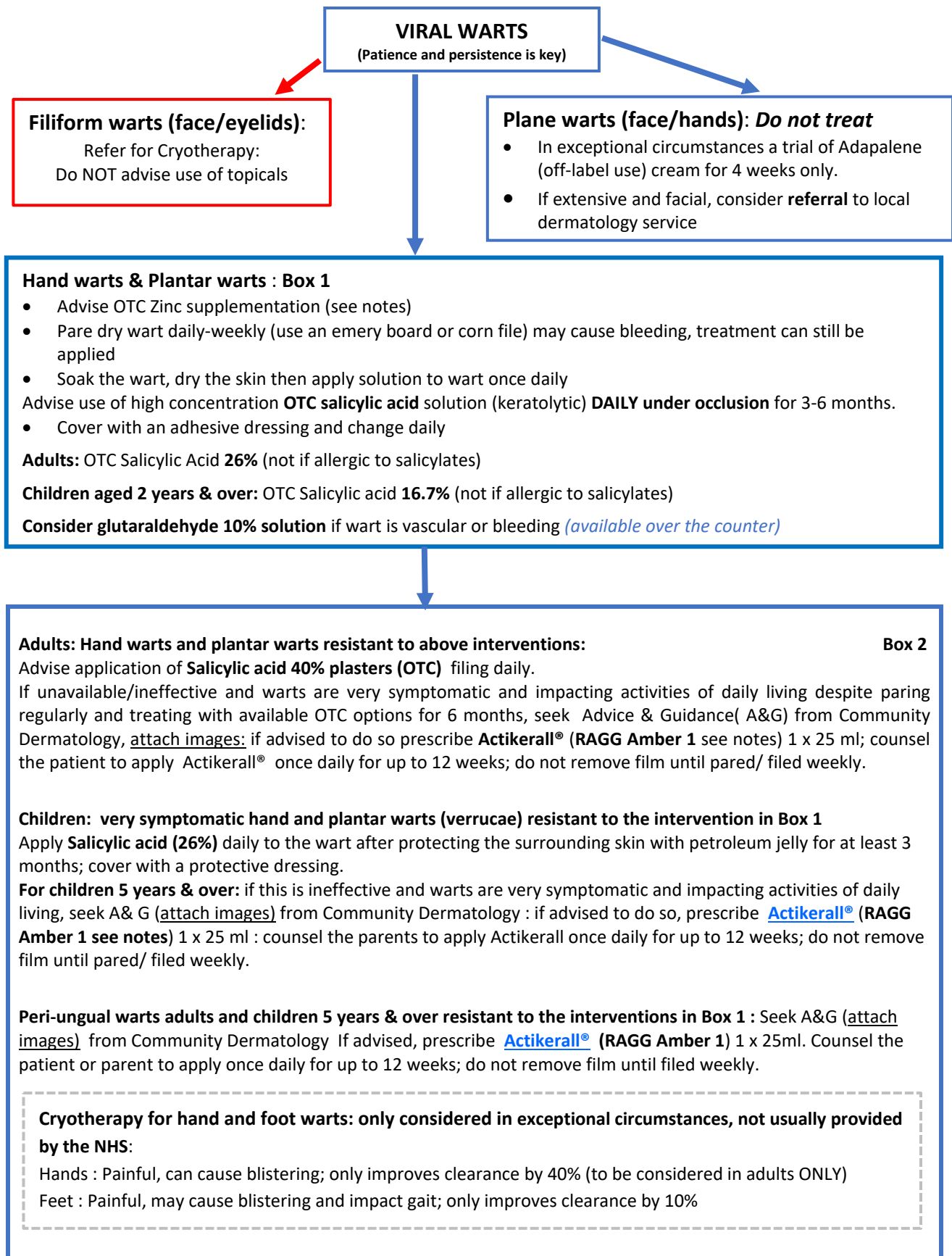
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# Viral Warts

Self-care with over-the-counter treatments is appropriate. Treatments not routinely prescribed in primary care



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## Viral Warts

Warts (verrucae) are caused by a human papillomavirus, most frequently affecting the hands, feet (plantar warts), and the anogenital region. Warts may regress on their own and treatment is required only if the warts are painful, unsightly, persistent, or cause distress. Treatment usually relies on local tissue destruction. Seek advice from podiatry for people who have diabetes.

- Refer to “Treatment Access Policy” section for referral exclusions. Referral of children for viral warts is usually outside the TAP.
- Patients with **genital warts** should self-refer to a local sexual health service for management.
- Oral zinc taken by adults and children may speed the resolution of warts. (Oral zinc supplement 15mgx1-2daily OTC) See Oxford Hospitals PIL <https://www.ouh.nhs.uk/patient-guide/leaflets/files/103608zinc.pdf> (Oral zinc for warts).
- 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. If very extensive consider immunosuppression.
- Persistent facial (filiform) warts respond well to cryotherapy if needed. Do not apply topical treatments to facial warts.
- All wart treatments are locally destructive, can be painful and can cause scarring. Choice of treatment depends on the age of the patient and site of warts (cryotherapy should not be used for warts in children). Cryotherapy can cause permanent pigmentary change (hypopigmentation) in people with skin type V & VI.
- Topical treatment is as effective as cryotherapy for hand warts. Persistence and patience with treatment is key. Each topical treatment should be used for at least 3 months, daily until no sign of the wart remains. When available, salicylic acid up to 50% strength can be applied daily for adults and children under occlusion. Gluteraldehyde solution application can be useful if the wart is especially fleshy.
- Keep warts pared down between treatments, daily if needed; this is more easily done when the wart is dry. Insufficient filing of dead skin can reduce effectiveness of treatment. Weekly paring with an emery board, pumice stone or corn file is often sufficient, however effective paring will make verrucas more comfortable to walk on .
- Topical treatments need to be applied once daily covering the wart with a plaster after treatment to improve penetration and prevent spread.
- 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](#). Topical treatments for adults and children are available without a prescription from a community pharmacy. Pharmacists are well placed to advise on the management of viral warts.
- **Recalcitrant Warts**  
Very symptomatic warts impacting ADL (activities of daily living ) despite prior steps, or where these steps are inappropriate e.g. peri-ungual warts/cryotherapy in children/ cryotherapy in richly pigmented skin/ or when patients are immunosuppressed, seek A & G from community dermatology RAS in ERS: if advised to do so, prescribe Actikerall 1x 25 ml cutaneous solution (RAGG Amber 1 off Licence) and offer Great Ormond Street [Actikerall PIL](#). Actikerall is applied once daily to warts for up to 12 weeks. A \*2021 study suggests that applying for 7 consecutive days before removing the Actikerall film is more effective than daily removal.
- Swift (microwave) treatment for recalcitrant viral warts is a treatment available from podiatrists, outside the NHS. It can be very effective.

**Resources:** [On-line pictures for GPs \(viral warts\) – DermNet NZ](#) [Clinical Knowledge Summaries - Warts and verrucae](#)  
[Warts and Verrucas | Causes and Treatment | Are warts contagious? | Patient](#)

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# Scabies

Initial assessment: History and examination suggestive of scabies  
([images](#))

Non-crusted scabies

Crusted Scabies suspected  
(Seek dermatology specialist advice)

**Give printed PIL with instructions for treatment**

[Scabies - BAD Patient Hub \(skinhealthinfo.org.uk\)](#) and prescribe scabicide.

**Advise topical scabicide patient & all contacts (see p 33); treat all of skin + wash personal clothing/ linen/ towels or place in plastic bag for 72 hrs see PIL**

- First Line: permethrin 5% cream (Lyclear<sup>®</sup>) – apply and leave on overnight, reapply after 12 hrs if hands washed (consider reapplying to all sites) leave on for a full 24 hours then wash off. Retreat once for 24 hours one week later (30g per application for an adult, ie 3 x 30 g)
- If permethrin cream is contraindicated or not tolerated (e.g. allergy to **chrysanthemum**) – Apply malathion 0.5% liquid (Derbac-M<sup>®</sup>) - apply 2 treatments 1 week apart- each left on for 24 hours.

Advise washing with **Dermol<sup>®</sup> lotion, or Octenisan wash** left on for 1 minute, each day for 1 week (*Treatment available to be purchased over the counter*)

**Treat post-scabietic itch:** (can last for 6 weeks) with Emollients + Hydrocortisone cream or Eumovate Cream (*both available to be purchased over the counter*) Or can prescribe betamethasone 0.025% (Betnovate RD) once/day

**CARE HOME (Crusted scabies)**  
contact [Health Protection Agency](#) and follow guidance

**Impetiginisation** is usually due to secondary *Staph aureus* infection  
If not responding to use of Dermol<sup>®</sup> lotion or Octenisan as wash,  
  
consider oral flucloxacillin qds 5-7 days as per local/ CKS guidance. This may be extended in accordance with infection severity/ clinical judgement eg if there is an associated folliculitis.

**2nd presentation: Assume incomplete treatment/ reinfestation:**  
Review with patient checklist of measures needed/ who has been treated (as detailed in PIL)  
**If > 2-4 weeks and burrows are seen, repeat above treatment, reapply after 12 hrs, leave on 24 hrs** reiterating importance of following advice closely.  
Advise use of emollients, treat itch and secondary infection if present.

Impetiginisation/ infection is usually due to secondary staphylococcal aureus infection; advise washing with Dermol lotion or Octenisan wash, consider adding oral flucloxacillin according to extent, severity & duration (see box)

**3rd presentation: Review diagnosis, check for burrows, exclude differentials** (Consider dermatology A & G with photos)  
**If ongoing suspicion of scabies:**  
Weigh patient: Prescribe **oral ivermectin 2<sup>nd</sup> line (licensed generic) x2 doses (off label\*) (200 mcg/kg) 7 days apart (not if < 15 kg) + repeat all other measures.** Re-treat contacts also and follow all other measures

**Indications for Oral ivermectin 2<sup>nd</sup> Line (licensed generic)**

- Crusted scabies
- Treatment failure 6 weeks after use of topicals as intended
- Topicals are unavailable
- Patients unable to comply with topical treatments

**4th presentation: Refer to dermatology. Consider A & G** if patients are very symptomatic or request early appointment (general derm, fast access to community or hot clinic)

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## Scabies

- Scabies is a mite infestation. *Sarcoptes scabiei* mites are easily passed from one person to another with skin to skin contact (e.g. sharing a bed, caring for children/elderly). They are not seen with the naked eye.
- An individual who has not had scabies before may not develop symptoms for 1 to 3 months after contact with someone with scabies; they may not be aware that they have scabies.
- Only a few mites are needed to cause symptoms of widespread itch and a rash with burrows on non-hair bearing skin. The rash likely to be most active in between fingers and around skin creases like axilla/groin with inflammatory nodules on genitalia and peri-areolar areas. Papules and pustules on the palms and soles are characteristic of scabies in infancy.
- Scabies can be successfully treated with a 5% permethrin cream (2-3 x 30g tubes per adult) or malathion lotion applied to the skin. These are both available over the counter, from online pharmacies or can be prescribed.
- **Crusted Scabies** is more common in patients who are immunosuppressed or frail or elderly; carers will need treatment (and may transmit scabies to others). Seek advice about management from the HPA (Health Protection Agency)

**The best chance of treating scabies and avoiding recurrence of scabies is to ensure all people with symptoms and any possible contacts are treated correctly at the same time.**

- **All people with symptoms need treatment** Give printed PIL [Scabies - BAD Patient Hub \(skinhealthinfo.org.uk\)](https://www.skinhealthinfo.org.uk)
- Any household and skin-to-skin contacts need treatment even if no symptoms or rash (this will likely include all household members, sexual partners, members of sports teams and other close contacts).
- All people need two treatments one week apart.
- **Treatment is best applied at night** - see below for **tips on how to use to best effect**:
  - Remove all clothes
  - Wash before treatment with cool (not hot) shower ensuring skin creases and areas under nails are cleaned thoroughly. Would advise cutting nails short.
  - Apply to clean, cool, dry skin.
  - Apply to **all of skin** including **all of** body, neck, scalp and face (only avoid areas around eyes). The product advice may suggest not treating scalp and face but in fact would advise all these areas are treated to manage infestation.
  - Certain areas of skin need particular attention for treatment to be successful: **Ensure product is applied generously to:**
    - areas between fingers and toes
    - genital areas
    - areas behind ears
    - nipples
    - under nails (use of a soft toothbrush can help with this)
    - ideally remove all jewellery. If this is not possible make sure to apply under any jewellery
    - Apply product to soles of feet last
    - Once applied leave 10-15 minutes for product to dry before putting any clothes on.
- If any areas are washed during this time (especially hands) product should be reapplied. Given current concerns about effective treatment, consider reapplication to all sites after 12 hours, leave on for full 24 hours
- The product should be washed off without soap initially. Once completely showered soap and/ or moisturisers or emollients can be used.
- At same time as treatment, wash personal clothing/linen/ towels  $\geq 60^{\circ}\text{C}$  and drying by hot dryer, dry cleaning or sealing in a plastic bag for 72 hours.
- Once treatment has been used you can return to all normal activities.
- Treatments can cause irritation of this skin which can be one cause of ongoing rash and itch. Moisturisers (emollients), treatment of dermatitis/ eczema such as topical corticosteroids and anti-histamine tablets may be used if needed.
- **Repeat treatment after 7 days:** Treatments should be repeated as above one week later to ensure effective eradication of both the scabies mite and the scabies eggs.

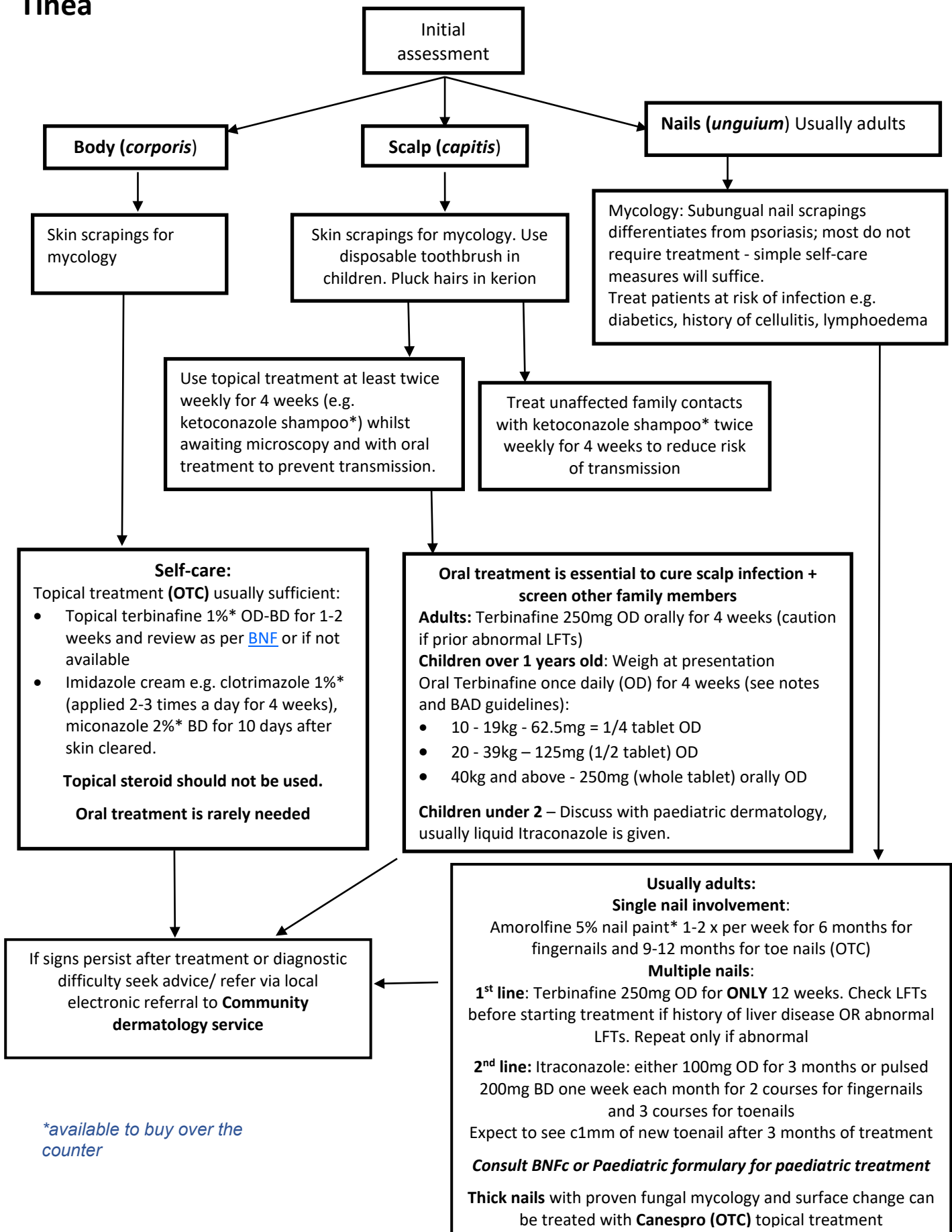
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- **Most treatment failures relate to incomplete treatment of the patient and their contacts or where treatment has not been completed at the same time allowing reinfestation.**
- For recurring scabies 6 weeks after 2 complete treatment cycles follow algorithm (weigh the patient); patients may benefit from oral Ivermectin 2 doses 7 days apart (Off label see p3 \*BAD/BSPAD consensus statement October 2023) or from dermatology A & G/ referral if there is diagnostic doubt.
- Neither topical is licensed for use during pregnancy or breastfeeding - refer to the BNF and SmPC regarding risks. Offer patient leaflet on scabies treatment in pregnancy. [Scabies \(medicinesinpregnancy.org\)](https://www.medicinesinpregnancy.org) Treatment should be removed from breasts before breastfeeding and reapplied afterwards.
- All household/ other close social contacts need treatment at the same time as patient.
  - Mites are killed within 24 hours, but symptoms may take 3-6 weeks to settle.
- If skin problems do not settle following 6 weeks after treatment or any ongoing concerns, then a review of skin by a health worker should be arranged.
- Genital nodules can be treated with potent topical Betamethasone 0.1% Cream applied once daily just to the nodule
- Seek specialist advice from paediatric dermatologist for children under 2 months.
- **Resources**
- [Scabies images \(pcds.org.uk\)](https://pcds.org.uk)
- PILs [Scabies - BAD Patient Hub \(skinhealthinfo.org.uk\)](https://skinhealthinfo.org.uk)
- \* [Scabies-guidance-consensus statement BAD PSPAD OCT-2023.pdf \(bad.org.uk\)](https://bad.org.uk)
- [Scenario: Management of scabies | Management | Scabies | CKS | NICE](#)

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# Tinea



\*available to buy over the counter

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## Tinea: Key messages

- Dermatophytosis (tinea) infections are fungal infections caused by dermatophytes (a group of fungi that invade and grow in dead keratin). They tend to grow in an expanding circular pattern on the skin producing a ring, hence the term “ringworm”.
- Treat with an antifungal e.g. Terbinafine cream or Miconazole cream rather than a combination cream with a topical corticosteroid.
- If extensive/ atypical/ not responding take mycology or send patient with a written request for sampling to **St Thomas’ Mycology dept, 1<sup>st</sup> Floor, Staircase C, South Wing M-F 9.30-4pm**
- Tinea infections present with a variety of appearances, e.g. annular plaques, diffuse scaling, grey patches, pustules, kerion, patchy hair loss, nail changes.
- **Id response:** when fungal infections are treated orally, a very itchy fine usually localised papular rash can develop at another site; this is not an allergic reaction. It may last 2-3 weeks. Provided the fungal infection is being adequately treated, emollients and moderate strength topical corticosteroids e.g. clobetasone (OTC) can be applied once daily whilst it settles. If the rash is extensive and progressive discontinue and seek advice.
- **Tinea capitis**
  1. Usually a disease of children; it presents with an itchy scalp, scaling/ crusting, or hair loss. Advise families to avoid sharing towels, pillows, combs/brushes, and hats. A child can go back to school once treatment has commenced. Schools should be informed and should alert parents what to look for. Take brushings from household members at presentation if they are in the surgery. If there is a boggy swelling (? Kerion) take a scraping and include plucked hairs.
  2. The Mycology dept at St Thomas Hospital will take samples from patient and family. Give a completed form or letter and ask the patient to contact the department on 0207 188 6400.
  3. **Oral terbinafine** being fungicidal is being used increasingly in urban populations instead of Griseofulvin (which is just fungistatic). It is considered superior against the majority of species causing infections in South East England, as noted in the Children’s BNF and current [BAD guidelines](#). Although unlicensed in children, in practice it appears to be safe and very effective. For children aged 1-17 years ONCE daily doses should be: 250mg for child weighing 40kg and above; 125mg for 20-39kg and 62.5mg for 10-19kg. Four weeks treatment. **LFTs are not usually needed for children.**
  4. Topical antifungal treatment alone is insufficient but probably reduces infectivity and the chance of relapse, e.g. 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. **Obtain positive mycology before prescribing systemic treatment** but note that 40% of affected nails will only have positive microscopy. Treat these as positive also.
2. Amorolfine 5% is the topical treatment 1<sup>st</sup> choice but is only recommended for limited infection (e.g. one nail or very distal disease in a few nails). May be used with systemic treatment to improve cure rates or if systemic treatment contraindicated. Apply twice weekly for 6-12 months until nail grows out.

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

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

### Resources

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

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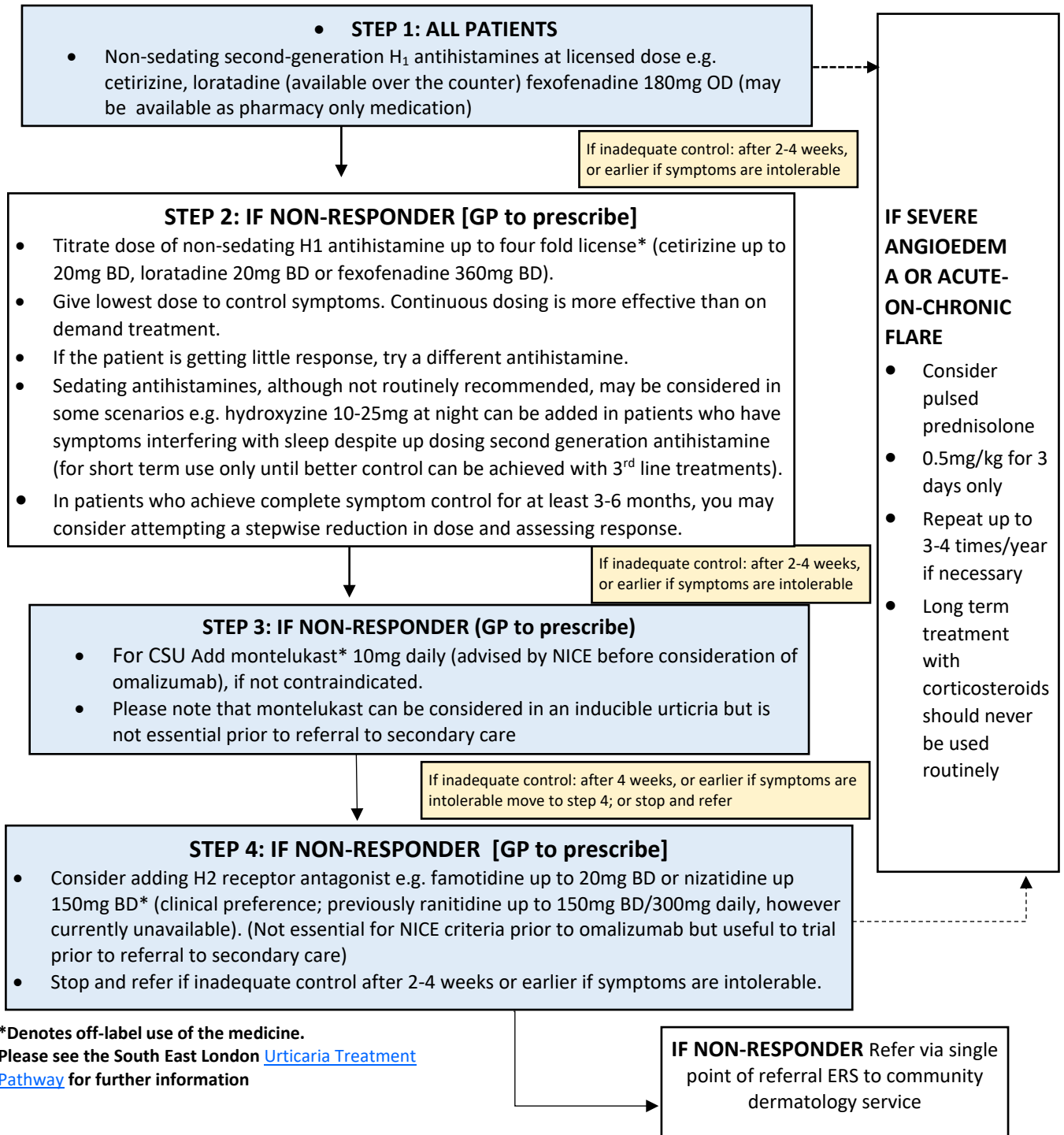
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# Urticaria For ALL types of urticaria

Primary care



\*Denotes off-label use of the medicine.  
Please see the South East London [Urticaria Treatment Pathway](#) for further information

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## Urticaria/Angioedema Key messages

- **Urticaria** is characterised by pruritic weals, angioedema, or both. The history is key. Individual weals last less than 24 hours and don't leave bruises. Consider urticarial vasculitis where weals persists for more than 24 hrs or leave persistent bruising.
- **Acute Spontaneous Urticaria:** symptoms persist less than 6 weeks. It may be exacerbated by food or medication. Where possible identify and avoid trigger factors e.g. stress, alcohol, caffeine. Diagnostic tests are not recommended.
- **Chronic urticaria:** symptoms continue for longer than 6 weeks. It can be classed as inducible (physical) or spontaneous. Chronic spontaneous urticaria can present as urticaria alone or as urticaria with angioedema. It often has a diurnal pattern. It is caused by immunological dysfunction.
- Inducible urticarias may be triggered by **heat, cold, pressure, vibration, water, ultraviolet light (UV)**, etc. [PCDS Inducible Urticaria Diagnosis & Images](#). These urticarias are induced reproducibly when a specific physical stimulus is applied, however there can be a certain degree of overlap between spontaneous and inducible urticarias. If not responding to trigger avoidance (including use of sunscreens/hat for UV urticaria) and antihistamines, referral is appropriate.
- Impact on patient can be assessed using this validated scoring tool: **7-day Urticaria Activity Score (UAS7)** = In depth review of urticaria control on weekly basis or the DLQI [Dermatology-Life-Quality-Index-DLQI.pdf](#)
- All patients with Urticaria should avoid aspirin, NSAIDs and codeine. Patients with *angioedema without weals* should avoid ACE inhibitors.
- Antihistamines are the mainstay of treatment. Continuous dosing is more effective than intermittent dosing.
- Steroids and adrenaline are NOT indicated for the management of simple urticaria, but short courses of prednisolone (3 days) may be valuable as 'rescue' treatment for facial angioedema or very severe urticaria exacerbations.
- Before referral for patients with chronic spontaneous (idiopathic) urticaria, check a full blood count (FBC), hepatic (LFTs) and renal function (eGFR), thyroid antibodies (TFTs), autoantibodies and ESR. **Attach results with photos.**

## Notes

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

## Resources

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

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## South East London

### Adult Hyperhidrosis- treatment pathway for Primary Care

#### History and diagnosis.

[Establish Primary<sup>1</sup> or Secondary](#)

#### Secondary hyperhidrosis:

1. Treat [underlying cause](#)
2. Refer to appropriate speciality
3. Manage symptoms with topical treatments

#### Primary hyperhidrosis:

1. Characterise<sup>1</sup>
  - Focal → craniofacial, axillary, palmoplantar
  - Generalised (more than one site but no underlying cause)
2. Calculate baseline HDSS<sup>2</sup>
3. Management:
  - a) **Self-care:**
    - High-strength antiperspirants e.g. aluminium salts (Driclor<sup>®</sup> or Anhydrol Forte<sup>®</sup>)- Buy OTC, apply to dry skin, build up duration from 30 mins x3 /week to daily (overnight) as tolerated; trial for at least 6 weeks.
    - b) General advice<sup>3</sup> & support group (The [Hyperhidrosis Support Group](#), and [International Hyperhidrosis Society](#)).
    - c) **Prescribing options:**
      - Craniofacial hyperhidrosis – Consider a referral for a trial of **glycopyrrolate 2% w/w in cetomacrogol A cream (BAD approved special)**. Apply to affected area once or twice daily,
      - Oral anticholinergics<sup>4</sup> (primary generalised hyperhidrosis but can be used in focal)
        1. **First line: Oxybutynin immediate release 2.5mg daily, build up to 5mg three times a day (off label)**
        1. **Second line: where there are intolerable adverse effects or inefficacy of oxybutynin IR – consider either:**
          - (i) Oxybutynin modified release 5-10mg daily (Off label) or
          - (ii) Propantheline 15mg three times a day and 30mg at night (maximum total daily dose 120mg)
4. Recalculate HDSS post 1 month of each treatment trial - aim for reduction of HDSS to 1 or 2. If successful continue, review regularly. Also see SEL IMOC [Recommendation 077](#) for further information
5. If HDSS 3 or 4 despite above measures refer to **Community Dermatology Service**. NB: for focal hyperhidrosis - earlier consideration may be given for referral to Dermatology for a trial of tap water iontophoresis

<sup>4</sup> See NICE hyperhidrosis [evidence summary](#)

Monitor for anti-muscarinic adverse effects and consider anticholinergic burden: Many medicines have anticholinergic activity as a secondary pharmacological effect (e.g. some psychotics, antidepressants, furosemide, some antiepileptics); the additive cholinergic burden should be considered if intending to use

#### <sup>1</sup>Disgnosis of primary hyperhidrosis

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

#### <sup>2</sup> Hyperhidrosis Severity Scale (HDSS)

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

#### <sup>3</sup> Advice for primary focal hyperhidrosis:

**Recommend the following lifestyle measures: Modify behaviour to avoid triggers (crowded rooms, caffeine, or spicy foods)**

**Primary craniofacial hyperhidrosis: Avoid food and drink triggers (caffeine, chocolate, spicy or sour foods, hot foods, alcohol, citric acid or sweets)**

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# South East London

## Adult Hyperhidrosis - treatment pathway for Secondary Care (Referrals from SEL Community Dermatology Services via e-RS only)

### Generalised hyperhidrosis:

- Optimise systemics
- Combined approach

### General Clinic:

1. Verify steps within Primary Care pathway have been taken and confirm diagnosis
2. Calculate baseline HDSS

### Focal hyperhidrosis

Axillary

Craniofacial

Palmoplantar

Botulinum toxin (Botox™), miraDry® treatment, and iontophoresis for axillary hyperhidrosis are **not commissioned** by the SEL Integrated Care Board

These treatments may be available through local private providers

\*Note a trial of axillary pads for iontophoresis may be suitable for some patients (not offered by SEL NHS services)

**Glycopyrrolate 2% w/w in cetamacrogol A cream RAGG Amber 1 (BAD approved special).**

Apply to affected area up to a maximum of twice daily.

Prescribe in Emis as **Glycopyrronium Bromide cream 2% in cetamacrogol (formula A)**

**Iontophoresis (treatment delivered in all secondary care sites except Queen Elizabeth Hospital Woolwich):**

1. Trial tap water iontophoresis x 7
2. Assess treatment efficacy (recalculate HDSS<sup>2</sup>). If stable and can purchase own machine provide information and training for home iontophoresis (\*note can also buy axillary pads)

**If symptoms remain uncontrolled:**

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

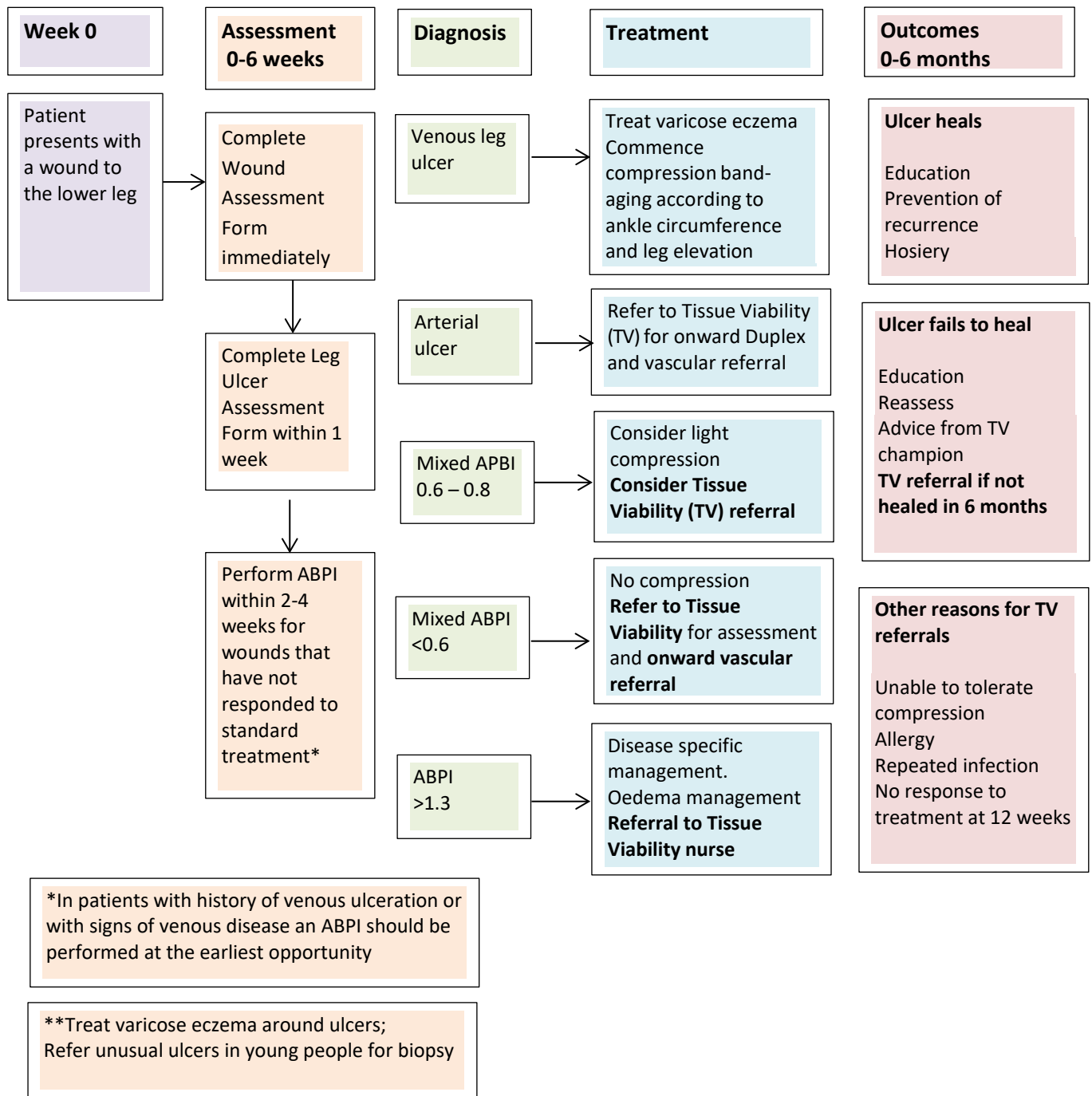
\*\* Note the 0.1% solution may be used as full strength or diluted with tap water to half strength 0.05% or quarter strength 0.025%. Patients will be stabilised on a strength, dose and frequency and be fully trained/counselled before moving to home treatment.

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# Leg ulcers – Pathway Management



Bexley: Provided by Oxleas, information available [here](#)  
 Bromley: Provided by Bromley Health Care, information available [here](#)  
 Greenwich: Provided by Oxleas, information available [here](#)  
 Lambeth: Provided by Guy's and St Thomas', information available [here](#)  
 Lewisham: Provided by Lewisham and Greenwich, information available [here](#)  
 Southwark: Provided by Guy's and St Thomas', information available [here](#)

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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](#)

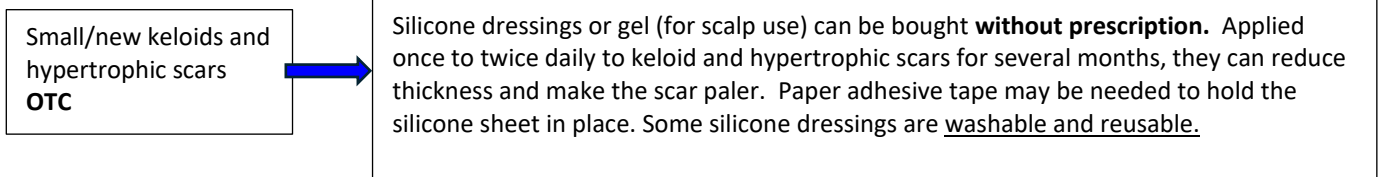
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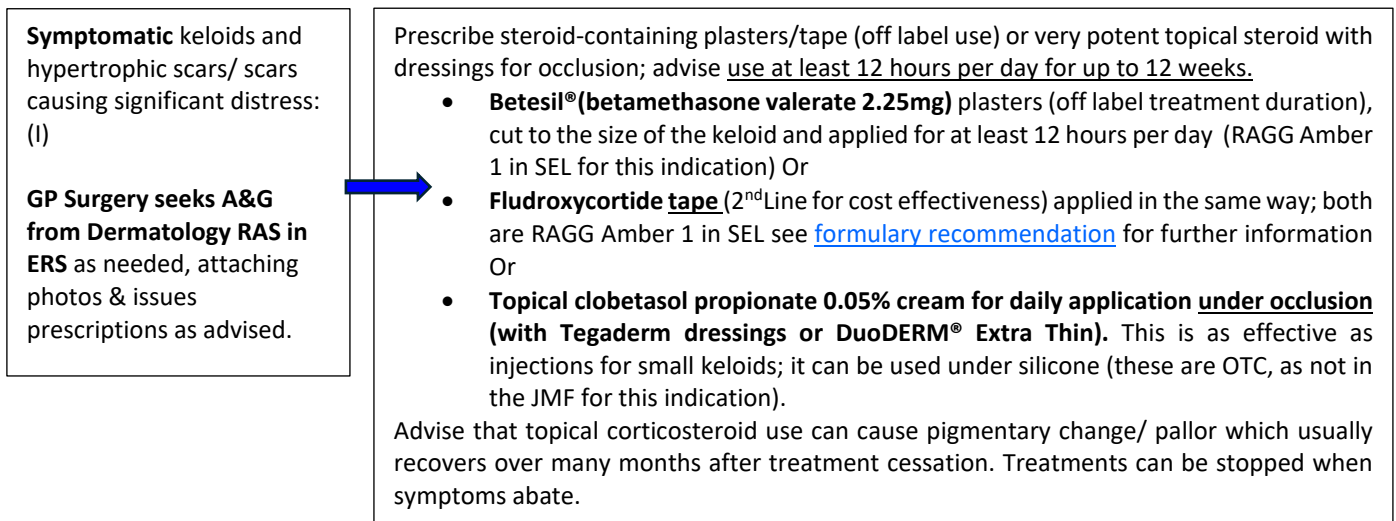
# Management Pathway for keloid and hypertrophic scar referrals in adults

A **keloid scar** is a firm, smooth, hard growth due to excessive scar formation; the upper chest, shoulders and ear piercings are especially prone to them. They may be painful or itchy and extend well beyond the original injury. Those with more richly pigmented skin form keloids more easily than Caucasians. **Keloids** may cause disfigurement and considerable distress/ embarrassment. As wounds heal, scar tissue forms, which at first is often red and somewhat prominent. Over several months, a scar usually becomes flat and pale. Sometimes however, the healed scar becomes thicker than usual. This is known as a **hypertrophic scar**. A hypertrophic scar is limited to the damaged skin. If a keloid has formed, advise future avoidance of unnecessary surgery/ piercings and early treatment of acne as a keloid may also develop at future sites of trauma/ inflammation. Early use of silicone sheets (OTC) after necessary surgery may prevent keloid formation.

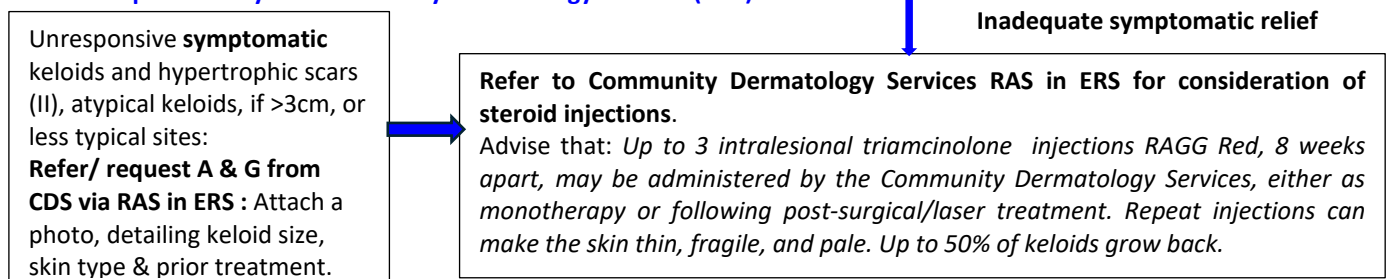
## Initial treatment for keloids and hypertrophic scars is OTC



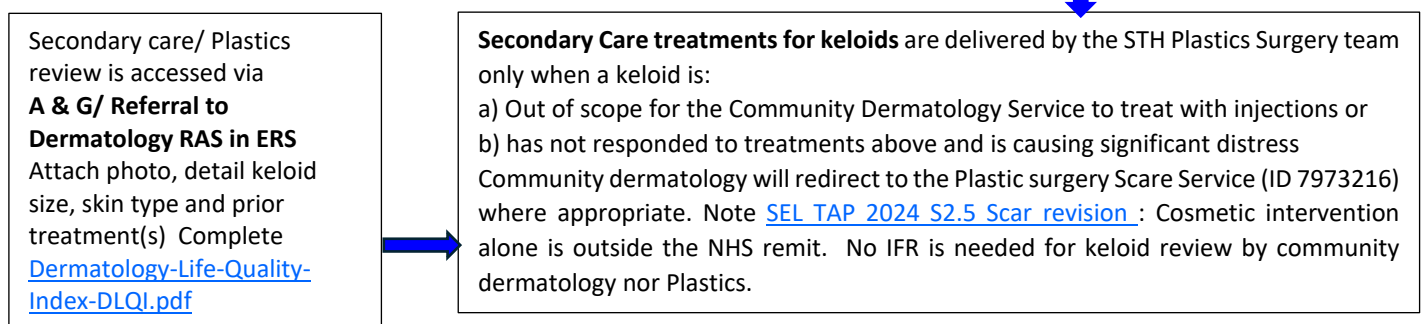
## Treatments for symptomatic keloid and hypertrophic scars from general practice :



## Treatment provided by SEL Community Dermatology services (CDS):



## Surgical review is provided by Plastic Surgery (Scar service) in SEL secondary care:



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[British Association of Dermatologists Keloid PIL](#)

[PCDS Scars - hypertrophic and keloid](#)

[Keloid scars - NHS](#)

The Latest Strategy for Keloid and Hypertrophic Scar Prevention and Treatment: The Nippon Medical School (NMS) Protocol [Journal of Nippon Medical School Vol.88 No.1](#)

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# Management of Benign Skin Conditions

## Key Messages:

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

<b>Atypical naevi</b>	If genuine concern re melanoma refer as 2-week wait.
<b>Benign Naevi</b>	Cosmetic treatment not available on NHS
<b>Congenital naevi</b>	Cosmetic treatment not available on NHS
<b>Dermatofibroma</b>	Cosmetic removal not available on NHS, take care as may leave ugly scar; refer if diagnostic uncertainty.
<b>Giant comedones</b>	Can be incised and contents expressed, (cosmetic treatment not available on NHS).
<b>Keloid</b>	Cosmetic treatment not available on NHS. If very symptomatic (itch/burning) may respond to treatment, Betesil plasters or Fludroxycortide tape cut to size and applied overnight (see the <a href="#">keloid and hypertrophic scar section</a> for further information), or supra potent topical steroid (eg Dermovate) under occlusion (e.g. DuoDerm extra thin™ or TegaDerm film dressing™) applied nightly for 12 weeks before referral (not face). Warn that this can cause hypopigmentation (as can steroid injection). GPs in all boroughs can refer keloids to their local Community Dermatology Service for consideration of 3 steroid injections.
<b>Keratin horn</b>	Curettage and cautery (histology essential if the base is hypertrophic).
<b>Lipoma</b>	Cosmetic treatment not available on NHS
<b>Molluscum contagiosum</b>	No treatment necessary; can try Potassium Hydroxide (Molludab) applied once daily for 14 days (OTC only) or Crystacide (off licence but marketed for this); note that these cause an inflammatory response before resolution.
<b>Pyogenic granuloma</b>	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. A trial of salt application for daily for 14 days under occlusion is acceptable but should NOT delay referral. <a href="http://pcds.org.uk">Pyogenic granuloma (pcds.org.uk)</a> <a href="http://bad.org.uk">British Association of Dermatologists (bad.org.uk)</a>
<b>Sebaceous cysts</b>	If symptomatic and inflamed, may fall within the TAP.
<b>Seborrhoeic warts</b>	Treat only if symptomatic and inflamed and there is no diagnostic uncertainty. A 10-day application of Fucibet cream bd will often settle inflammation and itching, review if concerned.
<b>Skin tags</b>	No treatment necessary. See NHS Choices for patient advice.
<b>Solar lentigines</b>	Cosmetic treatment not available on NHS
<b>Spider naevi/ Campbell de Morgan/ Vascular angiomas</b>	No treatment necessary. Spider naevi arising in pregnancy may resolve spontaneously over time after delivery.
<b>Vascular birthmarks/ genetic facial disfiguring growths. Severe Rhinophyma</b>	Pulse Dye Laser is available for vascular birthmarks genetic facial disfiguring growths, resurfacing laser for severe rhinophyma, and trials of laser assisted drug delivery.

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## South East London Treatment Access Policy (TAP)

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

## Other South East London Dermatology Guidelines

- [Shared care guideline for the prescribing and monitoring of non-biological Immunomodulatory drug monitoring in dermatology](#)

## Individual Funding Requests (IFR) Policy

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

An up-to-date copy of the SEL TAP policies can be found [here](#).

Further information with regards to IFR Policies can be found [here](#).

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# Useful Management Tips

## Equipment

- Good light source, tape measure
- [Dermatoscope](#), came or phone to access Consultant Connect/PhotoSAF. **Obtain consent.**
- Fungal scrapings kit; Disposable toothbrush for fungal scalp sampling

## Topical steroids: Potency table

Potency	Drugs examples
<b>Mild Corticosteroid</b>	Hydrocortisone 1%
<b>Moderate corticosteroid</b>	Clobetasone butyrate 0.05%; Betamethasone valerate 0.025%
<b>Potent corticosteroid</b>	Betamethasone valerate 0.1%; Betamethasone dipropionate 0.05%
<b>Very Potent Corticosteroid (Adults)</b>	Mometasone furoate 0.1%. Clobetasol propionate 0.05%

Topical steroids are usually applied **once daily**, after the application of emollients.

When used on 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.

[Enstilar®](#) for psoriasis also has a license for twice weekly maintenance use.

## Topical steroids: Finger Tip Units (FTU)

One finger tip unit (FTU) is the amount of topical steroid that is squeezed out from a standard tube along an adult's fingertip ie from the distal crease to the end of the finger. 1 FTU = 0.5g This covers 2 adult 'handprints' (including fingers)

- Face & neck (2.5 FTU = 15-30g/week for adults)
- Trunk (7 FTU, 100g/week for adults)
- Both arms (6 FTU, 30-60g/weeks per adults)
- Both legs (12 FTU, 100g/week for adults)
- Groin and genitalia (2.5 FTU, 15-30g/week for adults)

**Adult finger tip units apply for use in children** but fewer are needed, see: <https://patient.info/treatment-medication/steroids/fingertip-units-for-topical-steroids>

## Emollients

- Adults 600g/week as emollient and soap. For kids 250g/week. Refer to the [SEL emollient guideline](#).

## Topical Calcineurin inhibitors (TCIs): [TCI PIL](#)

Topical calcineurin inhibitors are immunomodulators that act in the immune system to reduce inflammation. They reduce itching and redness. They may be used alongside topical corticosteroids (TCS) OR instead of them to reduce the likelihood of adverse effects from TCS e.g., [Eczema](#) and [psoriasis](#) in adults and children, seborrheic dermatitis in adults (RAGG rating Amber 1) and Lichen [planus](#), vitiligo, facial inflammatory disorders and when there is a need to limit the long term effects of topical corticosteroids (RAGG rating Amber 1).

They are used once or 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; they can be applied daily to normal skin for a few days TCIs should not be applied to infected skin (e.g., impetigo or herpes/cold sore). They can cause sun sensitivity and should be applied once daily at night when it is very sunny.

**Scabies** Permethrin cream 30g generally sufficient for 1 application although 60g for larger people. Maximum 60g per application. Lotion 100mL for whole body application (200 mL bottle)

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## Sun Protection Tips

- Melasma, post inflammatory hyperpigmentation/hyperpigmenting disorders are exacerbated by sun exposure.
- 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 in Europe.
- Use a sunscreen of at least SPF 30 UVB protection, which also has high (4-5\*) UVA protection; Tinted sunscreens (OTC) reduce exposure to visible light which can exacerbate melasma (men and women)
- 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 to collect scale from leading edge of rash. A disposable toothbrush can be used in children for scalp infection. Transport in a sterile container or black card. The Mycology department at St Thomas' Hospital will take scrapings for individuals and family groupings if referred with a completed form or letter of request.

**Mycology Dept, 1<sup>st</sup> Floor, Staircase C, South Wing, St Thomas' Hospital, Lambeth Palace Road, SE1 7EH.**  
**Tel: 0207 188 6400**

- **Skin swabs:** suspected bacterial infection, especially if recurrent (nasal swab) **Type in request for PVL** if needed
- **Virology swabs (Coban red or green tubes):** swab ulcers or blisters. Request HSV 1 & 2/VZV

## Useful Blood Tests

HIV test

FBC: Eosinophilia: consider adverse drug reactions.

**Pruritus:** FBC for anaemia and eosinophilia, TFT, Ferritin <70 ng/mL (check iron/TIBC as Ferritin if raised >150 likely to be reactive), Renal function, LFTs, LDH, Vitamin D, Autoantibodies for Primary Biliary Cirrhosis, HIV

**Hair loss:** check Hb, Ferritin: Low < 100, can mislead as if raised may be reactive); if so, check Iron and TIBC, Vitamin B12, Vitamin D, check zinc/zinc intake and supplement if low, aim for mid-range.

ESR: raised: Erythema nodosum, sarcoid.

ACE: raised: Sarcoid

Ana (Antinuclear antibody) & dsDNA Ana: Consider SLE

ENA (Extractable nuclear antigen): Late onset Raynaud's, check ENA: if anticentromere antibody consider limited systemic sclerosis with risk of pulmonary hypertension

## UV (Woods) 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 specialist list found [BAD-Specials-Booklet-2018-FINAL.pdf](#).

The following are in the joint formulary:

*Glycopyrrolate 2% w/w in cetomacrogol cream* for difficult Facial Hyperhidrosis (Amber 1)

*Salicylic acid 5% w/w/propylene glycol 47.5% w/w in Dermovate® cream* hand and foot hypertrophic scaling eg psoriasis/eczema (Amber 2)

*Dermovate 60% in propylene glycol 40%* for hand and foot hypertrophic scaling (Amber 2)

Accurate prescribing is important as costs in the community can vary by £100s per prescription.

**Speak to prescribing advisors at the ICB for advice.** Refer to the [South East London Joint Medicines Formulary](#) to determine the RAGG status for a particular drug.

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## Useful resources for Health Care Professionals:

[Images and Differential diagnosis PCDS Primary Care Dermatology Society](#) Open Access

2024: Download the PCDS app for use on your phone

[Images of less common conditions DermnetNZ](#)

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## References:

Acne:

PCDS pathway [http://www.pcds.org.uk/ee/images/uploads/general/Acne\\_Treatment\\_2015-web.pdf](http://www.pcds.org.uk/ee/images/uploads/general/Acne_Treatment_2015-web.pdf)

European Guideline 2016 [european acne guideline 2016](http://www.eurodermatology.com/2016/06/european-acne-guideline-2016/).

British Association of Dermatologists' guidelines for the care of patients with actinic keratosis Br J Dermatol 2017 176:20-43 D. de Berker,<sup>1</sup> J.M. McGregor,<sup>2</sup> M.F. Mohd Mustapa,<sup>3</sup> L.S. Exton<sup>3</sup> and B.R. Hughes<sup>4</sup>

[https://www.bad.org.uk/guidelines\\_standards/actinic-keratoses/](https://www.bad.org.uk/guidelines_standards/actinic-keratoses/)

S3 European Guideline 2017 Evidence- and consensus-based (S3) Guidelines for the Treatment of Actinic Keratosis - International League of Dermatological Societies in cooperation with the European Dermatology Forum - Short version

<https://www.ncbi.nlm.nih.gov/pubmed/26370093>

*J Eur Acad Dermatol Venereol.* 2015 Nov;29(11):2069-79. doi: 10.1111/jdv.13180. Epub 2015 Sep 14

Bowen's disease:

British Association of Dermatologists' guidelines for the management of squamous cell carcinoma in situ (Bowen's disease) Br J Dermatol 2014; 170: 245-260 C.A. Morton,<sup>1</sup> A.J. Birnie<sup>2</sup> and D.J. Eedy<sup>3</sup>

<https://www.bad.org.uk/pils/squamous-cell-carcinoma-in-situ/>

Fungal Infection: Adults and children :

Onychomycosis: British Association of Dermatologists' guidelines for the management of onychomycosis 2014 M. Ameen,<sup>1</sup> J.T. Lear,<sup>2,3</sup> V. Madan,<sup>2,3</sup> M.F. Mohd Mustapa<sup>4</sup> and M. Richardson<sup>2,5</sup>

<https://www.bad.org.uk/pils/fungal-nail-infections/>

Tinea Capitis: British Association of Dermatologists' guidelines for the management of tinea capitis 2014 L.C. Fuller,<sup>1</sup> R.C. Barton,<sup>2</sup> M.F. Mohd Mustapa,<sup>3</sup> L.E. Proudfoot,<sup>4</sup> S.P. Punjabi<sup>5</sup> and E.M. Higgins<sup>6</sup>

*Br J Dermatol* 2014 171:454-463

[https://www.bad.org.uk/guidelines\\_standards/tinea-capitis/](https://www.bad.org.uk/guidelines_standards/tinea-capitis/)

Pruritus : British Association of Dermatologists' guidelines for the investigation and management of generalized pruritus in adults without an underlying dermatosis 2018 G.W.M. Millington, A. Collins, C.R. Lovell, T.A. Leslie, A.S.W. Yong, J.D. Morgan, T. Ajithkumar, M.J. Andrews, S.M. Rushbook, R.R. Coelho, S.J. Catten, K.Y.C. Lee, A.M. Skellett, A.G. Affleck, L.S. Exton, M.F. Mohd Mustapa and N.J. Levell. *Br J Dermatol* 2018; **178**: 34–60

*Br J Dermatol* 2018; **178**: 34–60

Psoriasis:

Rosacea:

Rosacea treatment update: recommendations from the global ROSacea Consensus (ROSCO) panel. ROSCO guideline 2017 : *Br J Dermatol.* 2017 Feb;176(2):465-471. doi: 10.1111/bjd.15173. Epub 2017 Feb 5. Schaller M<sup>1</sup>, Almeida LM<sup>2</sup>, Bewley A<sup>3,4</sup>, Cribier B<sup>5</sup>, Dlova NC<sup>6</sup>, Kautz G<sup>7</sup>, Mannis M<sup>8</sup>, Oon HH<sup>9</sup>, Rajagopalan M<sup>10</sup>, Steinhoff M<sup>11</sup>, Thiboutot D<sup>12</sup>, Troielli P<sup>13</sup>, Webster G<sup>14</sup>, Wu Y<sup>15</sup>, van Zuuren E<sup>16</sup>, Tan J<sup>1</sup>

PCDS Rosacea guideline 2017 : [https://www.pcds.org.uk/files/general/Rosacea\\_Treatment\\_2019-web.pdf](https://www.pcds.org.uk/files/general/Rosacea_Treatment_2019-web.pdf)

SEL JMF 2018: [SEL IMOC Papulopustular Rosacea pathway](https://www.selimoc.org.uk/papulopustular-rosacea-pathway)

Urticaria NICE : Chronic urticaria: off-label doses of cetirizine Evidence summary [ESUOM31] Published date: July 2014 (X4) , also the Omalizumab submission SEL IMOC submission sites x 4 usage of antihistamines.

Management of CSU Not too complicated not too simple <https://onlinelibrary.wiley.com/doi/full/10.1111/cea.12465>

Advances in Understanding and Managing Chronic Urticaria Yasmin Moolani,<sup>1</sup> Charles Lynde,<sup>2,3</sup> and Gordon Sussman<sup>a,1,4</sup>

[Understanding and managing chronic urticaria](https://onlinelibrary.wiley.com/doi/full/10.1111/cea.12465)

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# Patient Information

[Patient Information Leaflets \(pcds.org.uk\)](#)

## Conditions

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

## Management

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

[A-Z Conditions & Treatments - BAD Patient Hub \(skinhealthinfo.org.uk\)](#)

Acne  
 Actinic (solar) keratosis  
 Alopecia areata  
 Atopic eczema  
 Basal cell carcinoma  
 Boils/Abscess  
 Bowen's Disease  
 Calcineurin inhibitors  
 Care of vulval skin  
 Cellulitis and Erysipelas

Contact dermatitis  
 Dermatofibroma  
 Dermatitis Herpetiformis  
 Digital Myxoid cyst  
 Discoid eczema  
 Eczema herpeticum  
 Epidermolysis bullosa  
 Erythema multiforme  
 Erythema Nodosum  
[Efidix treatment \(bad.org.uk\)](#)  
 Folliculitis barbae  
 Frontal fibrosing alopecia  
 Fungal infection of nails  
 Granuloma Annulare  
 Hair loss Female  
 Hair loss Male pattern  
 Head Lice  
 Herpes simplex  
 Herpes Zoster (Shingles)  
 Hidradenitis suppurativa  
 Hirsutism  
 Hyperhidrosis (& Iontophoresis)  
 Ichthyosis  
 Impetigo  
 Kaposi's sarcoma  
 Keloids  
 Keloids  
 Keratoacanthoma  
 Keratosis Pilaris  
 Latex allergy  
 Lentigo Maligna  
 Lichen Planopilaris  
 Lichen planus  
 Lichen sclerosis (Female)  
 Lichen Sclerosus (Male)  
 Lichen Simplex  
 Melanoma  
 Melanoma in situ  
 Melasma (Chloasma)  
 Molluscum contagiosum  
 Morphoea  
 Mycosis fungoides  
 Nodular Prurigo  
 Omalizumab  
 Oral lichen Planus  
 Oral treatment with corticosteroids  
 Palmoplantar pustulosis  
 Patch testing  
 PDT Photodynamic therapy  
 Pemphigoid  
 Peri-oral dermatitis  
 Phototherapy  
 Pityriasis alba  
 Pityriasis rosea  
 Pityriasis versicolor  
 Plantar warts

Polymorphic eruption of pregnancy  
 Pruritus  
 Pruritus ani  
 Psoriasis  
 PVL staph aureus  
 Pyoderma gangrenosum  
 Pyogenic granuloma  
 Polymorphic light eruption  
 Rhinophyma  
 Rosacea  
 Scabies  
 Seborrhoeic dermatitis  
 Seborrhoeic warts/ keratosis  
 Sarcoidosis  
 Skin camouflage  
 Solar urticaria  
 Subacute lupus erythematosus  
 Squamous cell carcinoma  
 Telogen Effluvium  
 Tinea Capitis  
 Topical corticosteroids  
 Traction alopecia  
 Urticaria and angioedema  
 Vascular birthmarks  
 Venous eczema (Varicose)  
 Venous Leg Ulcers  
 Vitiligo  
 Vulvodynia

[www.dermnetnz.org](http://www.dermnetnz.org)

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South East London Integrated Medicines Optimisation Committee (SEL IMOC). A partnership between NHS organisations in South East London Integrated Care System:

NHS South East London (covering the boroughs of Bexley/Bromley/Greenwich/ Lambeth/Lewisham and Southwark) and GSTFT/KCH/SLaM/ Oxleas NHS Foundation Trusts and Lewisham & Greenwich NHS Trust

## Appendix 1: Acute Trust details and Local Referral Pathways

<b>Urgent review/patient unwell, for review in &lt;72 hrs bleep Dermatology SpR on-call</b> <ul style="list-style-type: none"> <li>Widespread blistering disorder</li> <li>Severe inflammatory skin disease e.g. Psoriasis involving &gt; 70% skin with systemic upset</li> </ul>		
Beckenham Beacon (KCH)	01689 863000	<b>Bleep</b> on-call medical registrar
Denmark Hill (KCH)	020 3299 1998	<b>Bleep 214</b> or on-call doctor for Dermatology
Guy's and St Thomas' (GSTT)	020 7188 7188	<b>Bleep 2010</b> or on-call doctor for Dermatology
University Hospital Lewisham (LGT)	020 8333 3000	<b>Bleep 540</b> or on-call doctor for Dermatology
Queen Elizabeth Hospital (LGT)	020 8333 3000	<b>Bleep 1962</b> or on-call doctor for Dermatology

### Community Dermatology Services

#### Advice and guidance

- via Consultant Connect/PhotoSAF
- via eRS Dermatology Single Point of Referral

#### Electronic Referral Service (eRS) via Dermatology single point of referral. \*Use new SEL form

- For **all** dermatological conditions other than 2WW or patients needing review in <72 hrs
- Indicate which secondary care site your patient would prefer to attend if offered a secondary care face to face appointment

#### Attach photo(s)

- Use PhotoSAF to take high quality photo(s) and attach to the referral on eRS
- Photos of genitals are unsuitable
- 'How to guides' (written and video) on how to take and attach photos: <https://vimeo.com/591539694>

#### Your referral will be reviewed by a local Dermatology GPwER with one of 4 outcomes:

- Advice about how to manage your patient returned to you via eRS
- Your patient is offered a teledermatology appointment (16-50yo, 1-2 lesions, exclusions: genital or nail lesions, patients who are immunosuppressed)
- The patient is offered an appointment within the community dermatology service
- The patient is offered a dermatology appointment in secondary care

For both adults and paediatrics services select 'Dermatology' as the speciality. If you select "Search Primary Care" and no service appears, please "Search All", services will appear as:

**<<borough name>> Community Dermatology**

In services that see children, children are seen in the same clinic as adults for conditions appropriate for the community setting

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

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**Community Services Contact Details : Bexley, Bromley, Greenwich, Lambeth, Lewisham, Southwark**

<a href="#">Bexley</a>	020 8683 6734	<a href="mailto:intermediate.services@nhs.net">intermediate.services@nhs.net</a>
<a href="#">Bromley</a>	020 3930 0245	<a href="mailto:bgpa.admin@nhs.net">bgpa.admin@nhs.net</a>
<a href="#">Greenwich</a>	020 8683 6734	<a href="mailto:intermediate.services@nhs.net">intermediate.services@nhs.net</a>
<a href="#">Lambeth</a>	020 7188 7188 Ext 53813	<a href="mailto:gst-tr.communitydermatologylambeth@nhs.net">gst-tr.communitydermatologylambeth@nhs.net</a>
<a href="#">Lewisham</a>	020 3640 2113	<a href="mailto:ohl.derm@nhs.net">ohl.derm@nhs.net</a>
<a href="#">Southwark</a>	020 7188 7188 Ext 56420 07776 512 899 (Elm Lodge)	<a href="mailto:gst-tr.communitydermatologysouthwark@nhs.net">gst-tr.communitydermatologysouthwark@nhs.net</a>

You can review the service details, requirements, and exclusions by clicking on the service name on the Service Selection screen in e-Referrals.

If you are unsure which service is appropriate you can search by using “Clinical Term” instead of specialty and clinic type. The search will be performed on the exact string of characters that you enter so extra spaces or incorrect spellings may mean that no results are returned.

Click on the small blue box, to the right of the “Clinical Term” box to perform the search and, when you have found what you require, click “Done”. You can then “Search Primary Care” or “Search All” and only those services that are suitable for the clinical term chosen will be displayed.

For EMIS Web users, once the referral has been completed or you have abandoned the process always click on “Service Selection” and choose the correct option (service selected or abandoned the process). If this step is not performed the “partial” referral will appear in the work flow section as incomplete.

All practices can request advice and guidance with the option to convert the A&G request into a referral if selected by the GP.

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