

Dermatology

Disclaimer: The recommendations contained in this guideline do not indicate an exclusive course of action, or serve as a standard of medical care. Variations, taking individual circumstances into account, may be appropriate. The authors of these guidelines have made considerable efforts to ensure the information on which they are based is accurate and up to date. The authors accept no responsibility for any inaccuracies, information perceived as misleading, or the success of any treatment regimen detailed in the guidelines.

Atopic Dermatitis

Atopic dermatitis affects 20% of children and in the majority resolves with age. It is genetically determined but many environmental factors, such as drying of the skin by detergents and sweating, play a key role in disease exacerbation.

Diagnostic Criteria

The child must have an itchy skin rash plus 3 or more of the following:

1. A history of generally dry skin
2. Personal or family history of asthma or hay fever
3. History of involvement of skin creases
4. Visible flexural eczema (or cheeks or extensor limbs if under 4 years)
5. Onset under the age of 2 years (only used if over 4 years old)

Treatment

1. **Avoid aggravating factors**
e.g. irritants (soap and shampoo), heat, woollen/nylon clothing and animal hair
2. **Moisturisation**
 - Daily bath with bath oil and/or a soap substitute helps to prevent infection and improve hydration of the skin by trapping moisture in the skin once emollient has been applied
 - Moisturise 3 times daily with as greasy a moisturiser as tolerated by the patient e.g. liquid paraffin 50% in white soft paraffin
3. **Topical Corticosteroids**
 - Applied twice daily to all active areas until redness and itching have cleared (usually 3 days)
 - Scaling and hyperpigmentation take longer to clear but do not require active treatment. Treatment needs to be repeated for relapses which may be weekly.
 - 1% hydrocortisone ointment should be used on the face
 - Eumovate strength steroid ointment to the trunk and limbs

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Common Complications

- | | |
|---------------------|---|
| 1. Impetiginisation | Recognised by weeping or crusting of the skin
Treat with topical crystacide or a steroid and antimicrobial/antibiotic combination
Treat with an oral antibiotic after swabbing if generalized |
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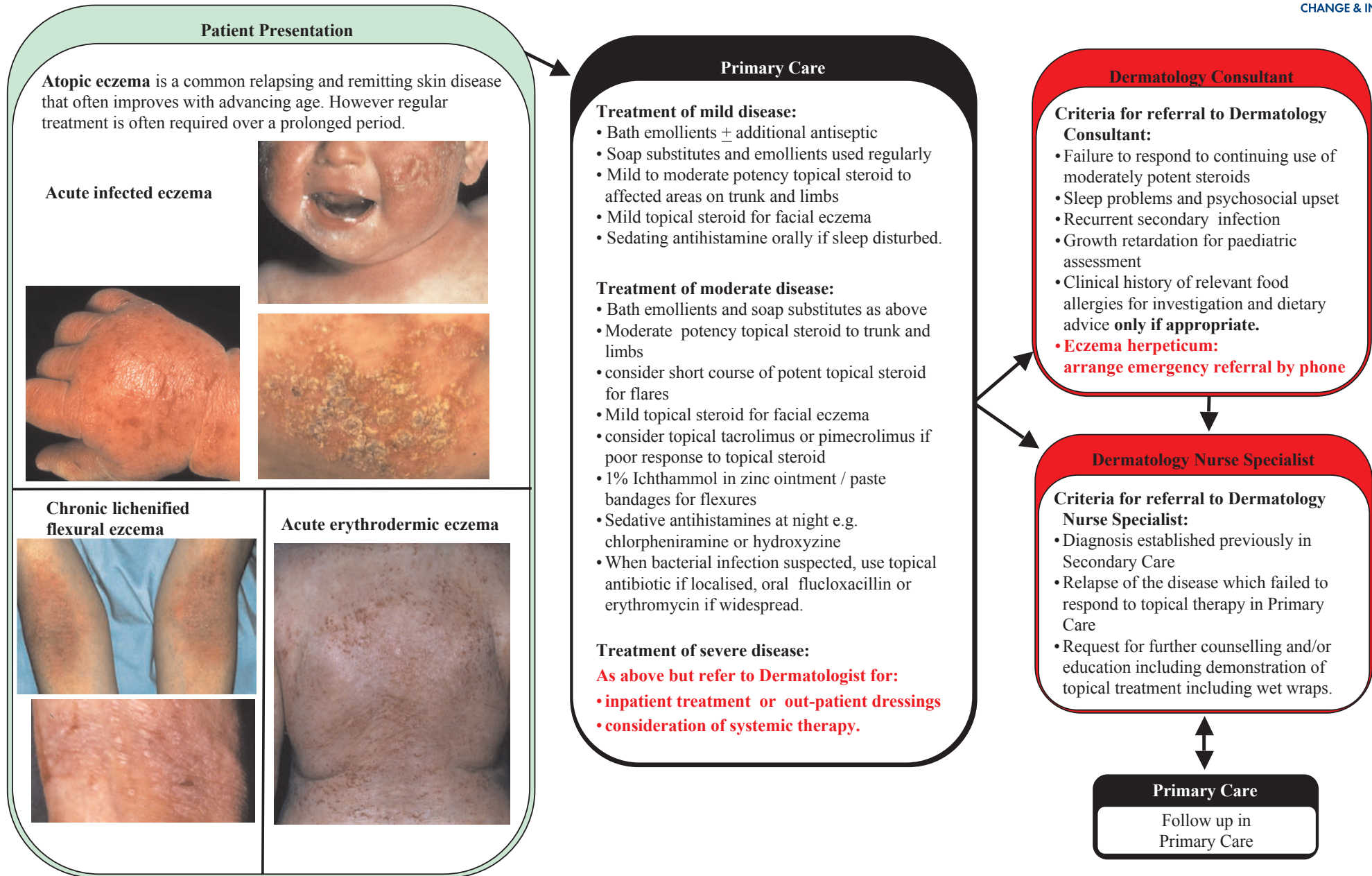
NB Continuous use of Topical fucidic acid may give rise to resistant Staph. Aureus

- | | |
|----------------------------|--|
| 2. Herpetic superinfection | Recognised by widespread monomorphic round vesicles or erosions
Treat with oral aciclovir if mild
Refer urgently if severe or send to A&E out of hours |
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Indications for Referral

1. Failure of eczema to respond to the above approach, in particular to the regular use of a greasy moisturiser and a eumovate strength steroid
2. Suspected herpetic superinfection

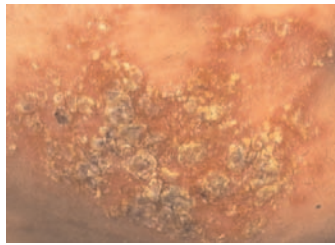
Dermatology - Atopic Eczema Patient Pathway April 2005



Patient Presentation

Atopic eczema is a common relapsing and remitting skin disease that often improves with advancing age. However regular treatment is often required over a prolonged period.

Acute infected eczema



Chronic lichenified flexural eczema



Acute erythrodermic eczema



Primary Care

Treatment of mild disease:

- Bath emollients + additional antiseptic
- Soap substitutes and emollients used regularly
- Mild to moderate potency topical steroid to affected areas on trunk and limbs
- Mild topical steroid for facial eczema
- Sedating antihistamine orally if sleep disturbed.

Treatment of moderate disease:

- Bath emollients and soap substitutes as above
- Moderate potency topical steroid to trunk and limbs
- consider short course of potent topical steroid for flares
- Mild topical steroid for facial eczema
- consider topical tacrolimus or pimecrolimus if poor response to topical steroid
- 1% Ichthammol in zinc ointment / paste bandages for flexures
- Sedative antihistamines at night e.g. chlorpheniramine or hydroxyzine
- When bacterial infection suspected, use topical antibiotic if localised, oral flucloxacillin or erythromycin if widespread.

Treatment of severe disease:

- As above but refer to Dermatologist for:**
- **inpatient treatment or out-patient dressings**
 - **consideration of systemic therapy.**

Dermatology Consultant

Criteria for referral to Dermatology Consultant:

- Failure to respond to continuing use of moderately potent steroids
- Sleep problems and psychosocial upset
- Recurrent secondary infection
- Growth retardation for paediatric assessment
- Clinical history of relevant food allergies for investigation and dietary advice **only if appropriate.**
- **Eczema herpeticum: arrange emergency referral by phone**

Dermatology Nurse Specialist

Criteria for referral to Dermatology Nurse Specialist:

- Diagnosis established previously in Secondary Care
- Relapse of the disease which failed to respond to topical therapy in Primary Care
- Request for further counselling and/or education including demonstration of topical treatment including wet wraps.

Primary Care

Follow up in Primary Care

Patient

Primary Care

Secondary Care

Dermatology - Atopic Eczema Patient Pathway April 2005

Therapeutic tips:

- Advise patient to continue normal diet unless clear history of reacting to specific foods.
- Prescribe **adequate quantities** of emollients, soap substitutes (+/- antiseptics) and bath additives.
- Reassure patient that weak or moderate topical corticosteroids are safe and effective when applied to active areas of eczema only
- Give advice on lifestyle factors (avoid biological washing powders and fabric conditioners, cigarette smoke or hairy pets).
- Advise patient to use cotton clothing.
- In adults and adolescents give advice on suitable career options.
- History of adverse reaction to topical treatment may be an indication for patch testing.
- Consider secondary bacterial infection if eczema weeping or crusted.

Useful Information for Patients

www.skincarecampaign.org
www.eczema.org
www.bad.org.uk



Information about the development and future updating of these Patient Pathways is available on the CCI website: www.cci.scot.nhs.uk
Photographs have been kindly provided by clinicians on the group.

Protocol for the Treatment of Warts

- Many warts resolve spontaneously and therefore a policy of 'wait & see' is reasonable

Facial warts

- Wart paints cannot be used on the face
- If the child wants active treatment then cryotherapy with liquid nitrogen is the only real option

Hand and plantar warts

- None - wait for natural resolution
- **Topical treatment**
 - As a first option children should have a three month trial of wart paint applied nightly after filing
 - Covering with an adhesive plaster may improve efficacy
 - If this fails consider cryotherapy
- **Cryotherapy with liquid nitrogen**
 - Freeze wart until an ice ball covers the whole wart and there is a collarette for 10 seconds
 - Allow to thaw
 - Repeat freeze for at further 10 seconds
 - Repeat freezing every three weeks for 6-10 cycles

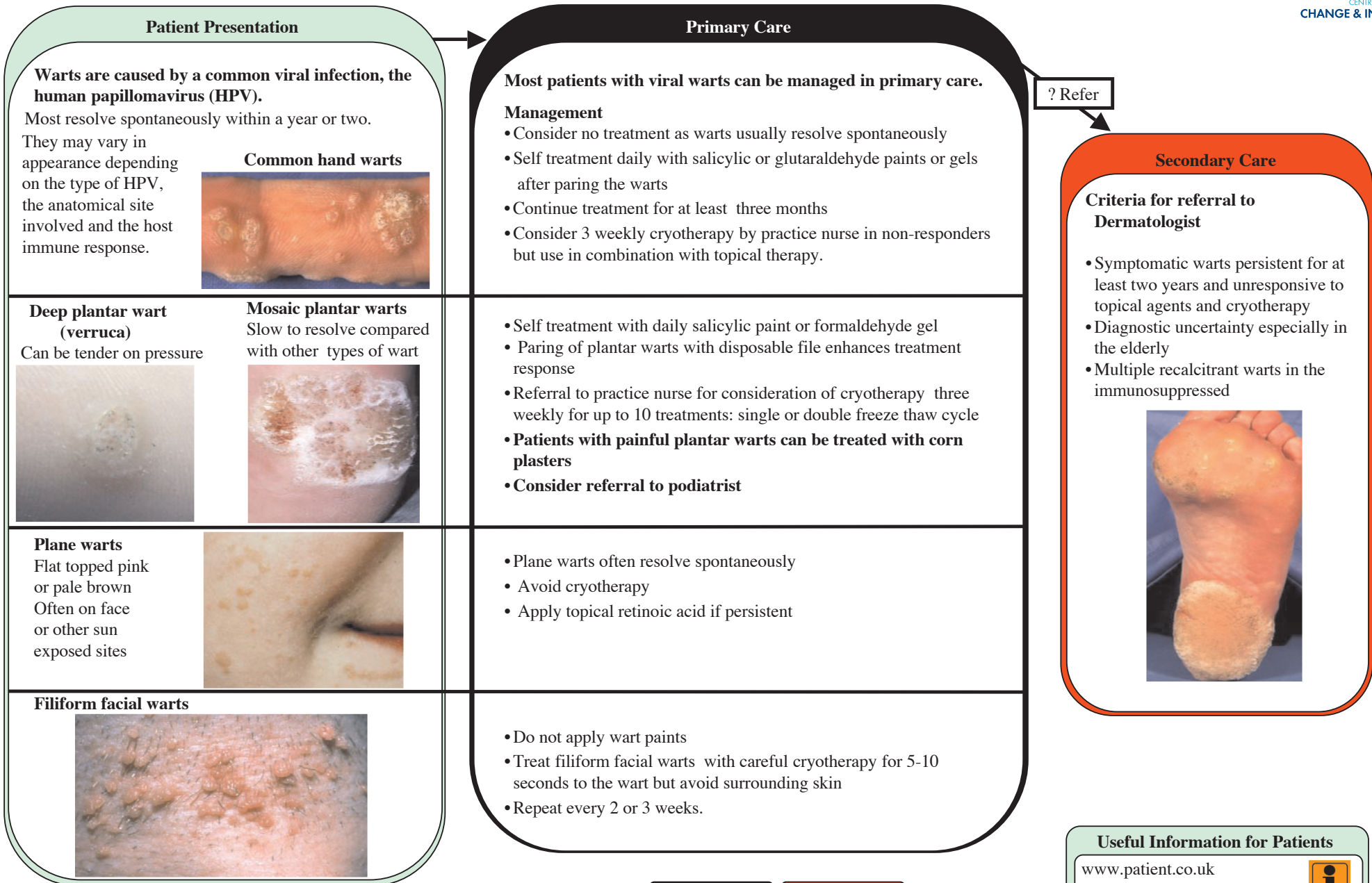
Referrals to secondary care

RHSC Yorkhill has implemented the patient pathways developed by the centre for change and Innovation for NHS Scotland. These can be found at <http://www.pathways.scot.nhs.uk/index.htm>.

The majority of warts require no treatment. For this reason, we can only accept referrals for facial and genital warts, and painful warts which have been present for more than 2 years.

Please note: **Cryotherapy is painful** and is rarely tolerated by children < 7 years or for multiple warts.

Dermatology - Viral Warts Patient Pathway April 2005



Dermatology - Viral Warts Patient Pathway April 2005

Therapeutic tips:

- Do not use salicylic acid on the face.
- Cryotherapy should be administered by appropriately trained staff to minimise the risk of excessive tissue damage.
- Cryotherapy may cause hyper- or hypopigmentation
- Diagnostic doubt over solitary wart: remove by curettage for histopathology.
- Children with verrucae should not be barred from swimming but can wear verruca socks.
- Anogenital warts: refer patients to genito-urinary medicine for infection screening and cervical cytology

Patient Presentation

Molluscum Contagiosum is a common pox virus infection of the skin. Most infections resolve spontaneously within a few months.

Clinical appearance

Flesh coloured or pink papules with umbilicated centre.



Eczema around molluscum contagiosum



Resolving molluscum contagiosum



Primary Care

MANAGEMENT

- In the majority of the cases no treatment is required as spontaneous resolution occurs.
- Squeeze lesions with tweezers after bathing then apply antiseptic cream.
- Topical antiseptic may minimise secondary infection
- Consider topical salicylic acid gel or topical imiquimod
- Cryotherapy by practice nurse (avoid in young children).
- Curettage with use of topical anaesthetic cream: send specimen for histopathology if there is diagnostic doubt.

Therapeutic tips:

- Avoid sharing towels and sponges.
- Eczema around molluscum: treat with emollients, 1% ichthammol paste or mild topical steroid.
- Ano-genital molluscum contagiosum: treat with podophyllotoxin paint once weekly
 - adults: consider referral of patient to genito-urinary medicine for infection screen
 - children: infection commonly acquired from swimming pools.

? Refer

Secondary Care

Criteria for referral to Dermatologist

- Diagnostic uncertainty
- Extensive, painful, inflamed lesions
- Immunosuppressed patients



Picture shows extensive molluscum in immunosuppressed patient

If associated conjunctivitis is present:
refer to Ophthalmologist

Useful Information for Patients

www.bad.org.uk
www.patient.co.uk
www.doctoronline.nhs.uk
www.nhs.uk



Patient

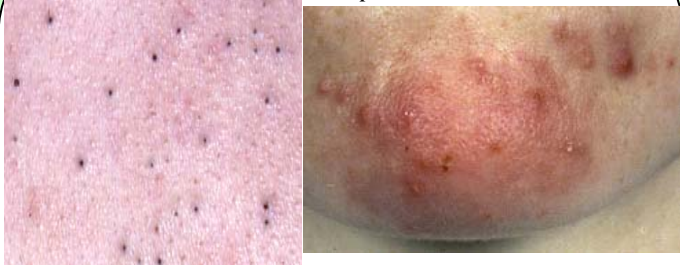
Primary Care

Secondary Care

www.cci.scot.nhs.uk

Patient Presentation

Non inflamed comedones *Inflamed papules and pustules*



More extensive inflamed lesions on face and trunk



Deep inflamed cysts and scarring



Primary Care

Mild to moderate acne

Patients with mild to moderate acne can usually be managed in Primary Care. Prolonged treatment may be required with regular review to encourage patient compliance.

Topical treatment:

- Keratolytics
- Benzoyl peroxide
- Retinoids: Adapalene
Isotretinoin
Tretinoin

Advice from **pharmacist** on over the counter preparations

- Topical clindamycin, erythromycin or tetracycline alone or combined with benzoyl peroxide, retinoids or zinc.

Systemic therapy

Oral antibiotics for at least 6 months.

Under 12 years old:

Erythromycin 500mg bd

12 years and over:

Oxytetracycline 500mg bd	Doxycycline 100mg od
Lymecycline 425mg od	Minocycline 100mg od
Erythromycin 500mg bd	

In women consider additional anti-androgen treatment e.g. cyproterone and ethinylloestradiol combination

Treatment failures: referral for consideration of oral isotretinoin therapy, but advise patients about potential side effects including teratogenicity in women.

Therapeutic tips:

- Benzoyl peroxide starting at 2.5% increasing to 5% or 10% may help reduce irritant effects.
- Topical retinoids can cause irritation therefore build up frequency and duration of application over 2-3 weeks.
- Assess response to oral antibiotics at 2 to 3 months. If poor response, change to alternative oral antibiotic but continue for 6 months minimum.
- Minocycline may have additional side effects therefore preferred as second line.
- **Regular follow up in Primary Care** to encourage patient compliance and to ensure that response to treatment is satisfactory.
- Patients referred to Dermatology should continue prescribed treatment until seen in the out-patient clinic.

Primary Care

Severe cystic acne with scarring

Commence systemic antibiotic therapy and refer immediately for consideration of systemic isotretinoin, indicating the reasons justifying an urgent referral.

Dermatology Consultant

Criteria for referral

Primarily for consideration of oral isotretinoin in patients with:

- Poor response to at least six months of one or two different oral antibiotics plus topical therapy
- Severe Acne (extensive disease or nodules or scars)
- Severe psychological upset.

Useful Information for Patients

www.stopspots.org
www.m2w3.com/acne
www.bad.org.uk



Patient

Primary Care

Secondary Care

www.cci.scot.nhs.uk

Patient Presentation

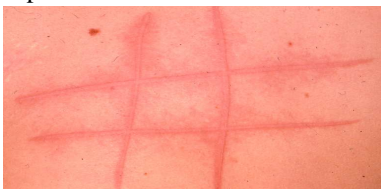
Acute urticaria

Patients present with sudden onset of very itchy, transient wheals which resolve within hours. May be accompanied by angioedema.



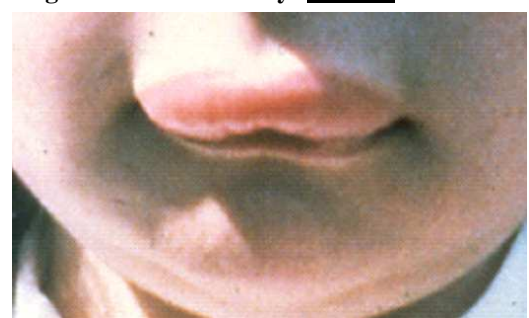
Chronic urticaria:

Regular episodes persisting for more than 3 months, fluctuating in intensity. Associated dermographism. Spontaneous resolution is the usual outcome.



Dermographism induced by application of firm pressure to skin

Angio-oedema of airways without urticaria



Primary Care

Most patients with urticaria can be managed in Primary Care.

Causes of acute urticaria: detailed history may identify possible triggers e.g. medication. Laboratory tests (RAST or CAP) are rarely necessary and only to confirm suspected specific triggers.

SKIN PATCH TESTING IS INAPPROPRIATE

Treatment of acute urticaria:

Non sedating antihistamines: fexofenadine, loratidine, mizolastine, cetirizine.
 Sedative antihistamines: use in addition at night if sleep is disrupted e.g. chlorpheniramine, hydroxyzine.
 Continue regular treatment until symptoms subside.
 Oral corticosteroids: Short course only for severe acute urticaria.

Causes of chronic urticaria:

- Physical e.g. cold, pressure, dermographism
- Auto-immune aetiology.

Treatment of chronic urticaria:

Non-sedating antihistamines: fexofenadine, loratidine, desloratidine, mizolastine, cetirizine, levocetirizine.
 Sedating antihistamines: additionally at night if sleep disturbed.
 Topical antipruritic: 1% menthol in aqueous cream.

Secondary Care

Causes:

- Idiopathic angioedema
- C1 esterase inhibitor deficiency is rare and specific treatment is required.

Investigation of angioedema without urticaria:

Check complement and C1 esterase inhibitor levels

Treatment: non sedating antihistamines as above

Patient

Self administration of adrenaline by Epi-pen injector

- Patient must understand the indications for and how to self-administer.
- Two devices must be carried
- Patient must seek urgent medical advice immediately after use of the Epi-pen.

Dermatology Consultant

Criteria for referral

- Persistent urticaria unresponsive to 3 different anti-antihistamines each for 4-6 weeks
- Urticarial vasculitis with associated joint pains, persistent wheals and bruising

Immunologist

Consider referral to an immunologist for patients with angioedema of unknown aetiology.

Useful Information for Patients

www.patient.co.uk
 www.bad.org.uk
 NHS24: 08454 24 24 24



Dermatology - Urticaria Patient Pathway April 05



Diagnostic tips

- Itchy red wheals occurring or recurring in crops
- Transient nature usually resolving in hours
- No residual scarring or bruising
- Elicitation of dermographism
- Possible coexistence of angioedema

Therapeutic tips

- Advise patient to avoid suspected triggers: stress, heat, tight clothing, alcohol, caffeine.
- Stop any histamine releasing drugs eg: aspirin, codeine, ACE inhibitors, penicillin, non-steroidal anti-inflammatory drugs
- Change to alternative anti-histamine after 4-6 weeks if one agent has not helped.
- Consider combination of two drugs.
- Antihistamine administration should be related to the time pattern of symptoms.
- Avoid long term oral steroids in chronic urticaria.

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