Dermatology PLT

Welcome to all!

Community Dermatology Southwark

Type in Q for Q & As at the end

Community Dermatology Southwark (CDS) close links with GSTT & KCH

- ICS wide, Community derm in all boroughs, linked in with 2*care.
- CDS: 7 GPwERs (2 trainees), 1 consultant, 1 GP trainee, 1Spr, Gp sit ins
- A fantastic admin team familiar with local transport networks
- GPwER triage/ A & G usually within 1 day *Right place first time
- Adults and children
- Clinics: @ Elm Lodge: 6pw, monthly consultant led clinic; GSTT: 7-8 pw, training Weekly Xsite meeting
- *Clinic letters emailed to GP & Pt ; *GPs do repeat Px Accurx for additional photos
- Direct access to Phototherapy, patch testing, vulval , hair, hot clinic

Where are we going?

- Managing patients in Primary care
- Resources:GL, PCDS top 30, PILS QR codes
- How using the form helps you and your patients
- Taking photos: Photosaf/ consultant connect, good news!
- Tips for 2 Week wait referrals…
- Whats Telederm and who gains?
- Inflammation in SOC
- How photos and a good history help
- Advice & guidance: Photos, Hair loss, Pruritus and Eczema
- A couple of cases Acne Keloides Nuchae, Pseudofolliculitis
- A guideline update : Spironolactone

South East London Dermatology Guidelines for Primary Care

June 2022

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 or other local pathway)

Your clinical instinct must always come first. Images of the conditions included are available in the A-Z guide and Lesions tables in http://www.pcds.org.uk/

We recommend that prescribing is in line with the South East London Joint Medicines Formulary and with the local borough antibiotic guidelines.

If you have any corrections, questions or ideas for improvement please let the authors know by emailing southwark.medicine-optimisation@selondonics.nhs.uk or alternatively email the SEL Integrated Medicines Optimisation Committee (IMOC) support team at: lambethmedicines@selondonics.nhs.uk.

Acknowledgements: This updated 2022 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)

Contents

https://www.pcds.org.uk

medical | Judaism 101: Who I... | Imported From Edge | Pan-London Tumou... | Disney | ESPN | bgs big smile .com | Contact Us | Dell UK | Community Service... | GPCPD - Handbooks

THE LEADING DERMATOLOGICAL SOCIETY FOR GPS | Website author - Dr Tim Cunliffe (read more) | ABOUT PCDS | CONTACT | SEARCH

PCDS

EDUCATIONAL EVENTS | GENERAL DERMATOLOGY DIAGNOSTIC TOOL | LESIONS DIAGNOSTIC TOOL & DERMOSCOPY | INVESTIGATIONS | CONCISE GUIDELINES | A-Z OF SKIN CONDITIONS | COMMISSIONING & SERVICE MODELS | LEARNING & OTHER RESOURCES | PATIENTS & CARERS

can't be found online. The Annual conference is a 2-day event with a Saturday night function, which is always fun and great for networking.

12 NOV **PCDS SCOTTISH FREE MEETING** GLASGOW

11 MAR **PCDS ANNUAL MEETING** CREWE

21 JUN **WHERE DERMATOLOGY MEETS...** LONDON

SEP **PCDS AUTUMN MEETING** MANCHESTER

21 JAN **INTERNATIONAL VIRTUAL DE...** ONLINE

01 MAR **ESSENTIAL DERMATOLOGY SER...** CAVENDISH CONFERENCE CENT...

11 MAR **PCDS ANNUAL MEETING** CREWE HALL HOTEL, CREWE,

19 MAY **SKIN SURGERY COURSE 2023** DARLINGTON MEMORIAL HOSPI...

GENERAL DERMATOLOGY EVENTS →

ESSENTIAL DERMATOLOGY EVENTS →

DERMOSCOPY EVENTS →

SURGICAL EVENTS →

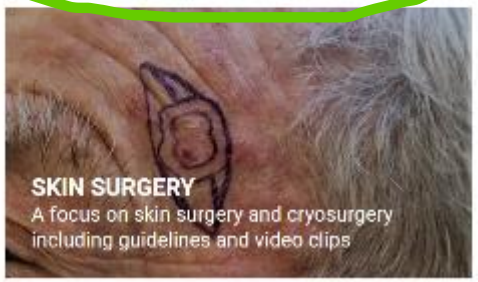
Extremely helpful to have memory stick with notes of talks given and further information. Thank you. Also, length of sessions about right and good speakers. Would recommend it to other GPs.
GP

Fast Facts: Dermoscopy
An interactive course designed to teach the basics of dermoscopy to healthcare professionals.
Independent Medical Education eLearning program has been sponsored by almirall
PCDS
Karger

CASE DISCUSSION AND OTHER LEARNING
Bite-sized learning and the opportunity to pos pre-diagnosed cases for discussion with PCDS members

DERMATOLOGY FROM SCRATCH - CONFIDENCE FOR ALL
Bite-sized learning for anyone with an interest in Dermatology. PCDS membership not required

COMMISSIONING, CARE MODELS, AND TELEDERMATOLOGY
Including GPwERs (GPs with Extended Roles) in Medical Dermatology and Skin Lesion Management



The Primary Care Dermatology Society
Making your Skin Better

Simply Scan the Relevant QR Code

A guide to skin cancer and self-examination

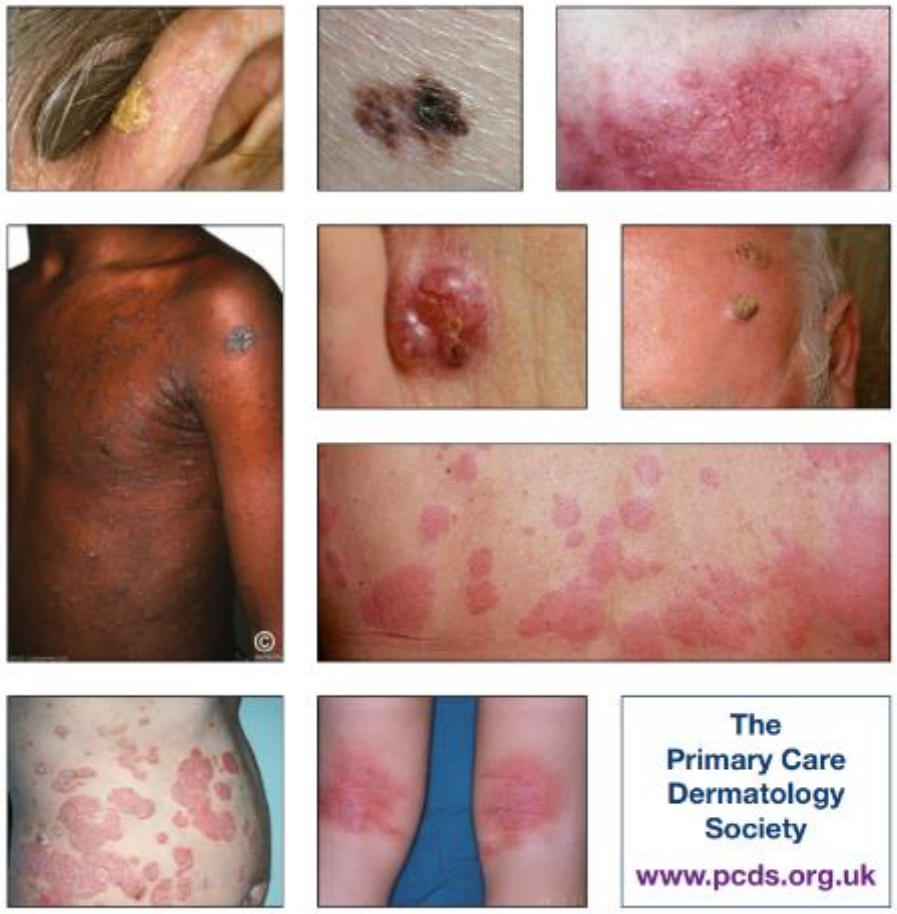
Diagnosing moles, skin lesions, lumps & bumps

Diagnosing skin rashes, other skin changes, hair & nails conditions

Patient information leaflets for common skin conditions

Treatment of common skin conditions

One of the world's leading websites in the management of skin conditions, the PCDS website is a free resource that can help with the diagnosis and treatment of a large range of skin conditions such as eczema, acne and psoriasis, as well as skin cancer and hair and nail disorders.



The Primary Care Dermatology Society
www.pcds.org.uk

The Primary Care Dermatology Society

PCDS
PRIMARY CARE DERMATOLOGY SOCIETY

QR-Code-Poster-A4.pdf (pcds.org.uk)

Southwark Community Dermatology Referral Form

FOR ALL Non 2WeekWait (non 2WW) DERMATOLOGY REFERRALS

Request Advice & Guidance via ERS or Consultant Connect or attach this form to an ERS referral to refer for triage

Use 2 Week Wait pathway for suspected MALIGNANCY (SQUAMOUS CELL CARCINOMA/ MALIGNANT MELANOMA)

Discuss ACUTELY UNWELL PATIENTS needing to be seen within 24-48 hours with the DERMATOLOGY SPR ON CALL
@ Guys & St Thomas' Hospital NHS Foundation Trust – 020 7188 7188 on call bleep 2010
Or @ King's College Hospital NHS Foundation Trust - 020 3299 9000 Bleep 214 or ask for on-call dermatologist
eg if any of the following are suspected

- Erythroderma (more than 90% of the skin is affected)
- Acne fulminans
- Eczema herpeticum

Any widespread Blistering disorder
Severe drug reactions including Erythema Multiforme, Stevens Johnsons Syndrome and Toxic epidermal necrolysis

Patient Details **Please double click on highlighted boxes as needed**

Please attach a good photo of the rash/lesion site(s), a close up and profile if palpable. PhotoSaf helpful

Title:		**NHS Number:**	
First Name:		**Date of Birth:**	
Surname:		**Gender:**	
Home Address:			
Telephone Number (confirmed)		**Specific needs**	☐ Transport (will be triaged to secondary care) ☐ Hoist (secondary care) or other needs
Mobile:		**Interpreter**	☐ Language requested:
Email :		**Ethnicity:**	

Does the patient have additional communication needs e.g. Braille, Audio?

Patient's preferred COMMUNITY CLINIC	**Patient's CHOICE OF HOSPITAL if triaged to SECONDARY CARE**
☐ Community at Guy's hospital ☐ ELM LODGE SURGERY SE24 9HJ	☐ GUY'S & ST THOMAS ☐ KING'S COLLEGE ☐ Other please state .....

Reason for referral	**(If insufficient information is included, you may be asked to rerefer with further Information)**		
☐ **URGENT REFERRAL**	☐ **ACNE/ROSACEA**	☐ **ECZEMA**	☐ **PSORIASIS**
☐ **Rash : diagnostic uncertainty**	☐ **Suspected Basal Cell Carcinoma (BCC)**	☐ **YES Skin lesion is suitable for triage to teledermatology** • 16-50 years old • 1 or 2 lesions (includes BCCs)	
☐ **Other skin condition**	☐ **Symptomatic benign skin lesion** ***(SEL TAP * APPLIES)***	☐ ***Lesion NOT suitable for triage to teledermatology if*** - *< 16years old or > 50 years old* - *Palmar/plantar/nail/genital lesions* - *Immunosuppressed patients (e.g. transplant)* - *Lesions suspected to be recurrent*	
Skin lesions will be managed in accordance with the SEL Treatment Access Policy ***Viral warts, seborrhoeic and other benign lesions are not usually treated***			

Please indicate your patient's Fitzpatrick skin type (I-VI) which influences their susceptibility to sun damage and other skin problems:

I ☐ II ☐ III ☐ IV ☐ V ☐ VI ☐

The Fitzpatrick Scale

Southwark Community Dermatology Referral Form

PLEASE REFER TO THE SEL Dermatology Guidelines for Primary Care BEFORE COMPLETING THE CLINICAL DETAILS BELOW

Referral details

ACNE PRE-REFERRAL CHECKLIST *PLEASE DOUBLE CLICK THE GREY BOX AND SELECT AS APPLICABLE:*	**YES**	**NO**
Acne with nodulo-cystic change, scarring or causing severe psychological distress? Patient has tolerated topical treatment with oral antibiotics at the right dose for 3 months (if moderate to severe), or 6 months (if mild-moderate?) *Please include details of treatment/ dosage/ frequency in eRS referral*	☐ ☐	☐ ☐
Do you think that the patient should be considered for Oral Isotretinoin? If yes, if your patient is female, please discuss need for very effective contraception? (Avoid POP as worsens acne)	☐	☐

if the answer is NO to any of the above please indicate in eRS letter why you are referring now

ECZEMA PRE-REFERRAL CHECKLIST *PLEASE DOUBLE CLICK THE GREY BOX AND SELECT AS APPLICABLE:*	**Yes**	**No**
The patient has excluded external irritants & used an emollient as soap	☐	☐
Have you prescribed plenty of emollients/ appropriate topical corticosteroids?	☐	☐

if you have answered No to any of the above please indicate in the eRS letter why you are referring e.g. Time off school, poor growth, repeated infective episodes, significant family distress and persistent disrupted sleep

PSORIASIS PRE-REFERRAL CHECKLIST *Patients fulfilling ONE of the following should be considered for specialist referral* *PLEASE DOUBLE CLICK THE GREY BOX AND SELECT AS APPLICABLE:*	**YES**	
There is diagnostic uncertainty	☐	
This is a new diagnosis in a young person aged < 18 years	☐	
The patient has **SEVERE** or **EXTENSIVE** of any type (>10% of body surface area is affected.)	☐	
The patient has any type of psoriasis not controlled with topical therapy	☐	
The patient has guttate psoriasis requiring phototherapy (consider early referral)	☐	
The patient's psoriasis is having a major impact on their person's physical psychological or social wellbeing (for example, DLQI 10+, distress or depression).	☐	DLQI
The patient has nail disease that is having a major functional or cosmetic impact.	☐	

Referral Date		**Reason for referral**	**What question/ concern is to be addressed ?**

Please include description of skin condition, duration, past history of skin disease, Family History of skin disease, past and present treatment with duration and outcomes (Please say where have they been seen previously)

.....

Please attach to ERS letter recent/ significant PMH, *letters concerning prior dermatology problems / medications*

Referrer Details			
Referrer Name:		Referrer Position: GP	
Practice Code:		Practice dorman email:	
Practice Address:			
Telephone:			

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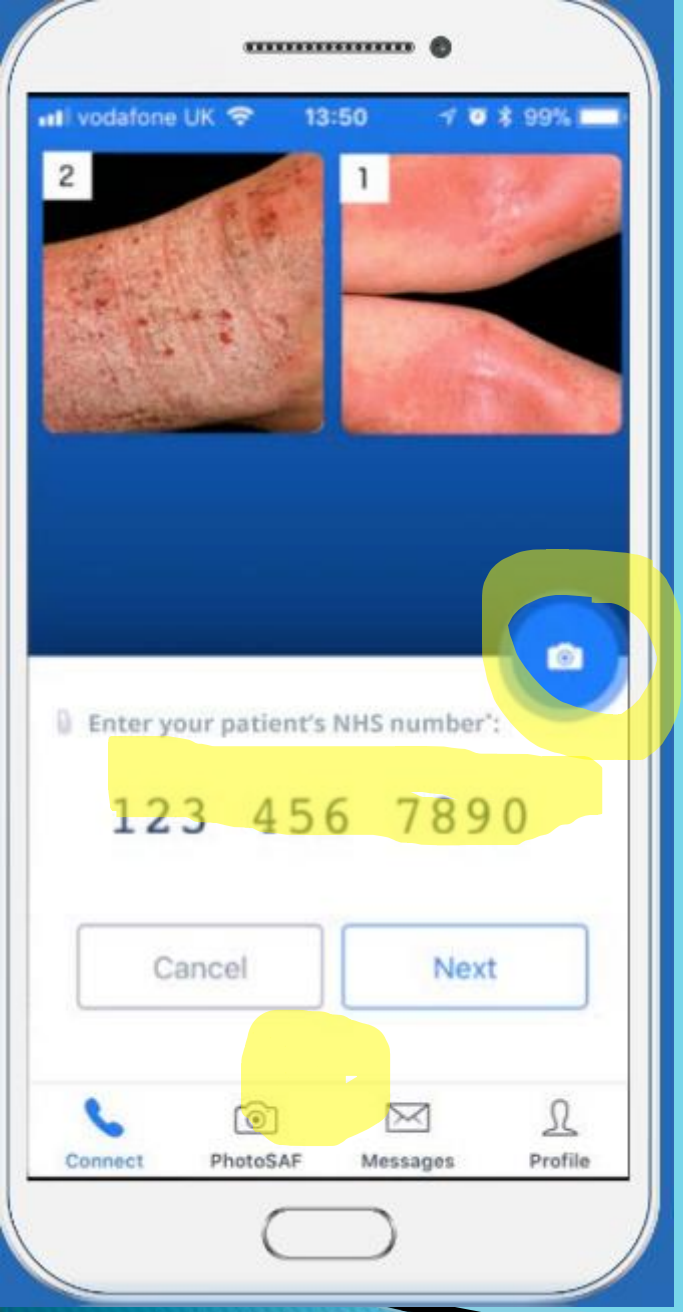

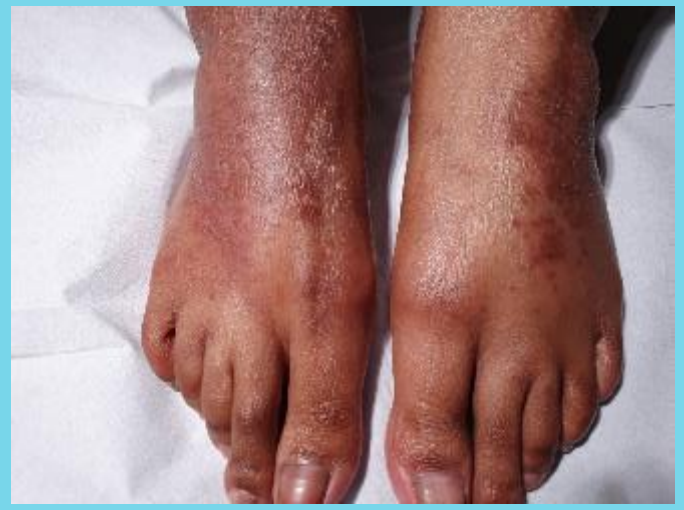

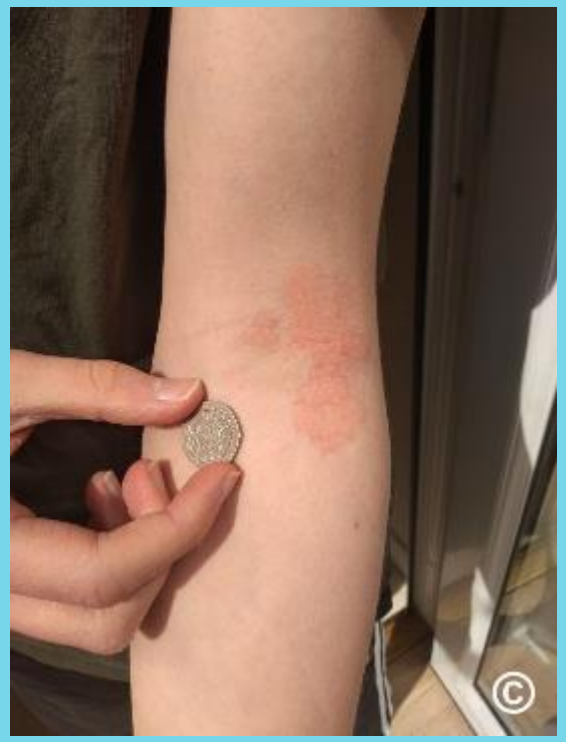

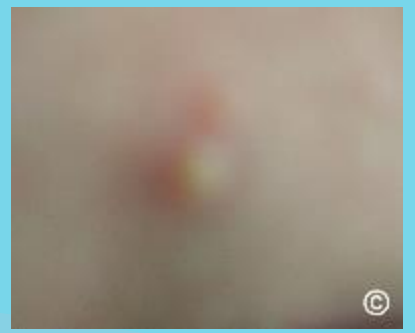

Taking a good photo using photosaf

- Sign up to Consultant Connect using your NHS email address
- Open app
- Select PhotoSaf (at bottom)

✓ Tick to confirm consent (chaperone?)

- Take photo (good light, no shadow, plain background, ruler or coin)

✓ **to accept photo**

- Add NHS number
- Take another photo if needed.. Next
- +/- add notes
- Save (to NHS cloud) +/- share (CC)

- You receive 2 emails
- From email, download PDF or images to folder on computer, attach to notes
- Can be attached to referral

Photos: Options:

- Share with Consultant Connect for immediate advice (T)

- Save (to NHS cloud) and upload to notes or send by Consultant Connect message

Quickest upload:

- Go to your email, download PDF or images to folder on computer
- In Emis, select Add document, add date and tag, save

- Or forward email with link to Admin who download, add to notes
- Attach to ERS referral

- AccurX photos can be attached to an ERS referral, or saved to computer, uploaded to consultant connect, and advice sought

- Coming very soon: Automatic Consultant Connect upload of photos, messages.. Like AccuRx

- Admin training available

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Referring Skin lesions

Top tips for 2WW

History and clinical features will help decide if a 2ww referral is needed

If referred for Triage to the Community Dermatology SPR, please give as much detail as possible and a photo

Dr Jane Cliffe, GP & GPwER

Key Qs: Context

Skin type?
Site?
Single or multiple
Age: older
Previous skin cancer
Immunosuppression
Family history is relevant
Sun exposure:
Lived/worked/ holidayed in hot countries, sunbeds
Severe sunburn (esp U26 F)
Outdoor occupation
Outdoor Hobbies

More likely to be benign

- Not changing
- Not sore

- Wobbly, compressible, blanching, crumbly
- One of many..

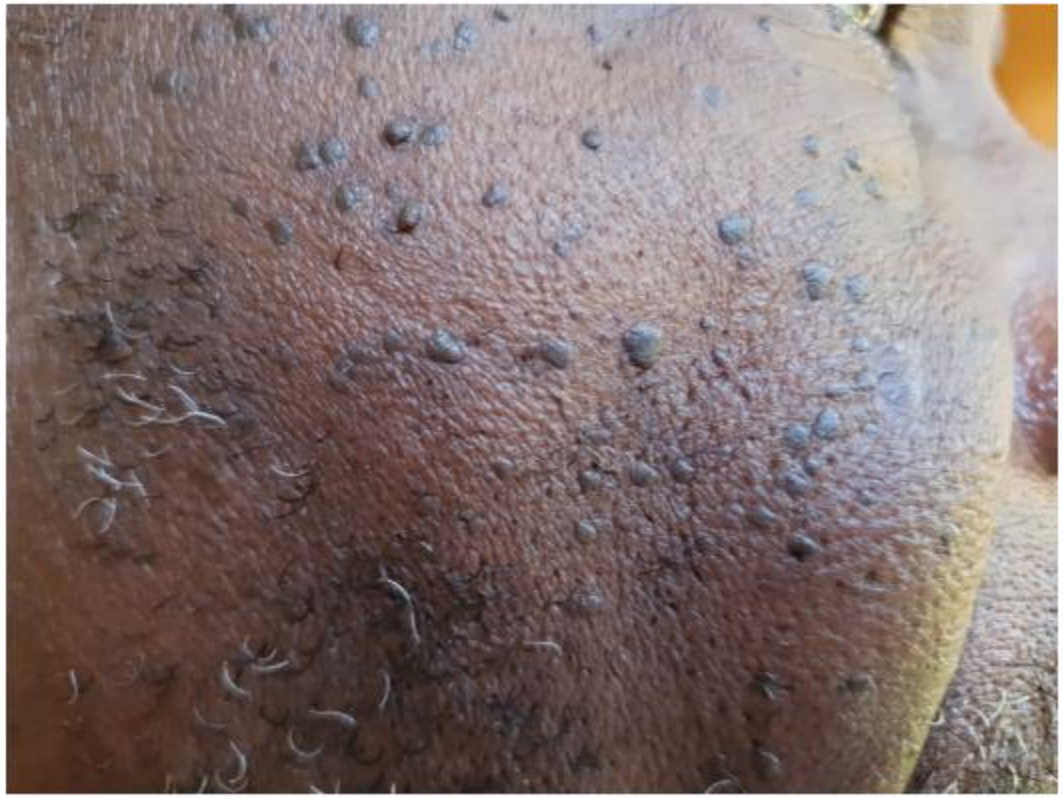
- Symmetry of colour/ structure
- < 3 colours

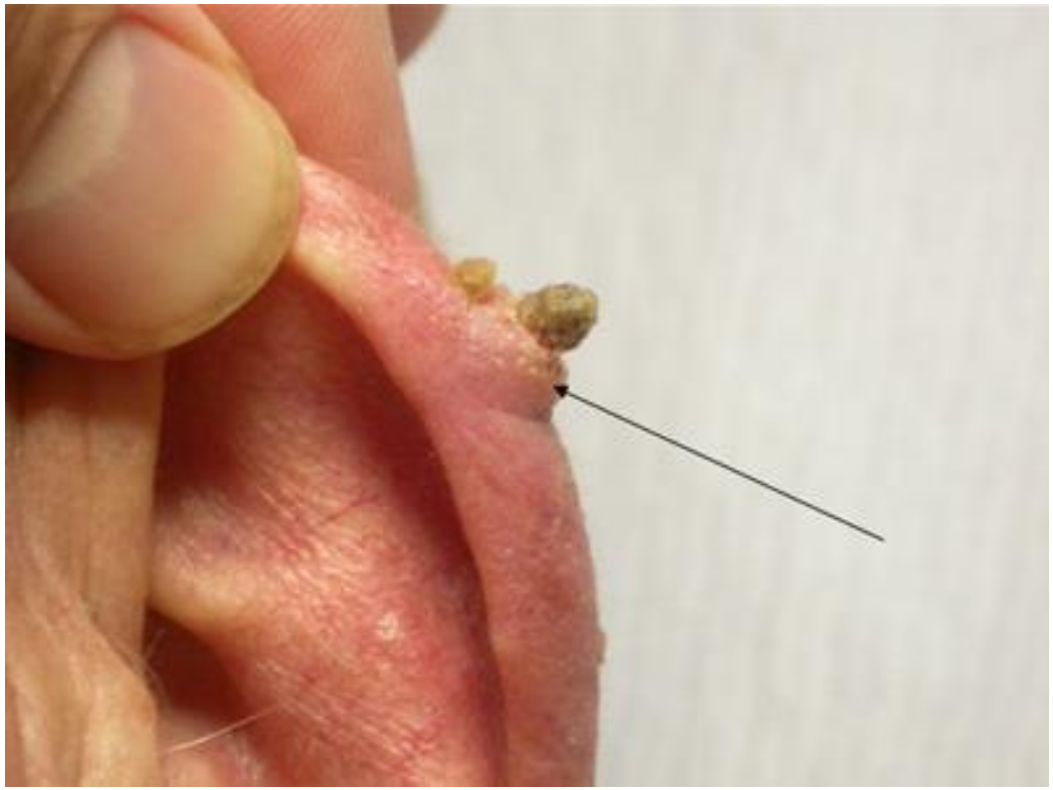
Dermoscopy helps

Suggestive of malignancy

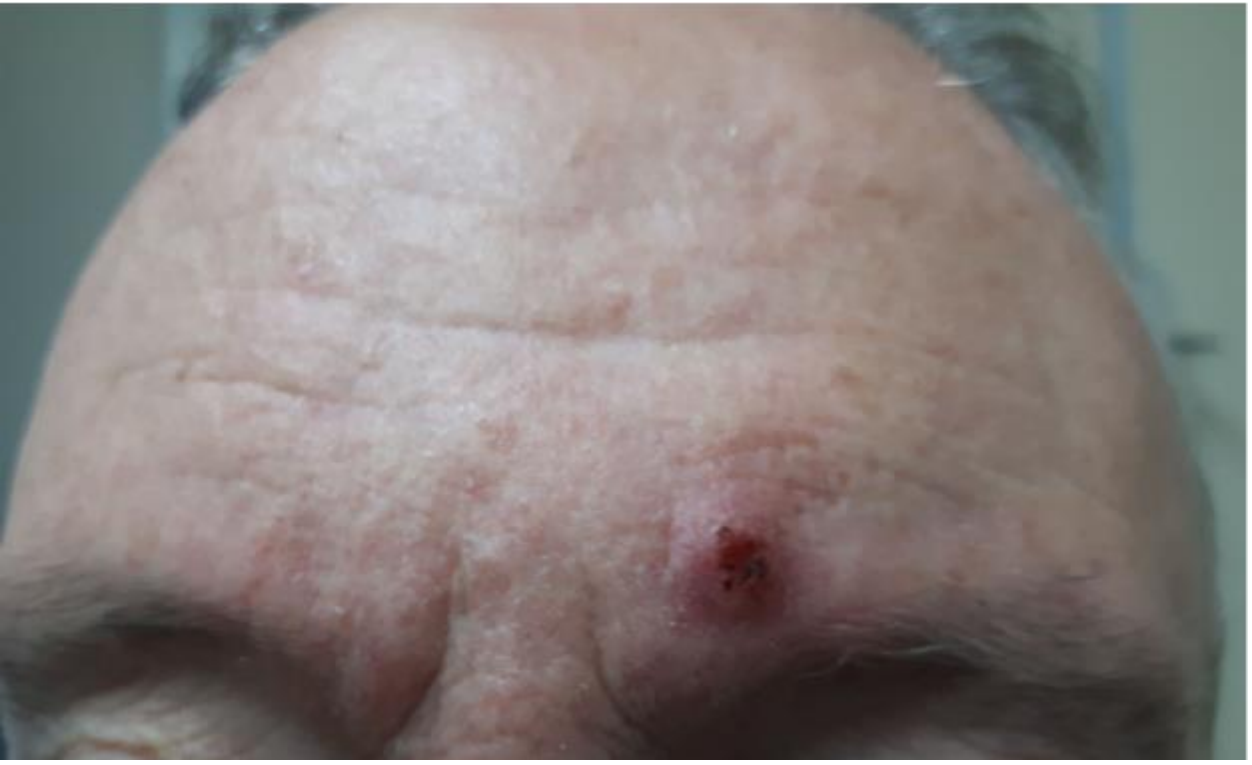
- Immunosuppression:↑SCC
- Rapid growth: ?SCC/ MM
- Soreness: ?SCC
- Bleeding: Melanoma ? SCC ? BCC
- Firm nodule (beware Pink, Growing)
- Nodule with a keratotic surface
- Beware the single dystrophic nail
- Beware the ugly duckling
- Asymmetry of colour/structure
- >3 colours suspicious (2 colours: check symmetry)
- Non healing or unexplained scar ? Bcc

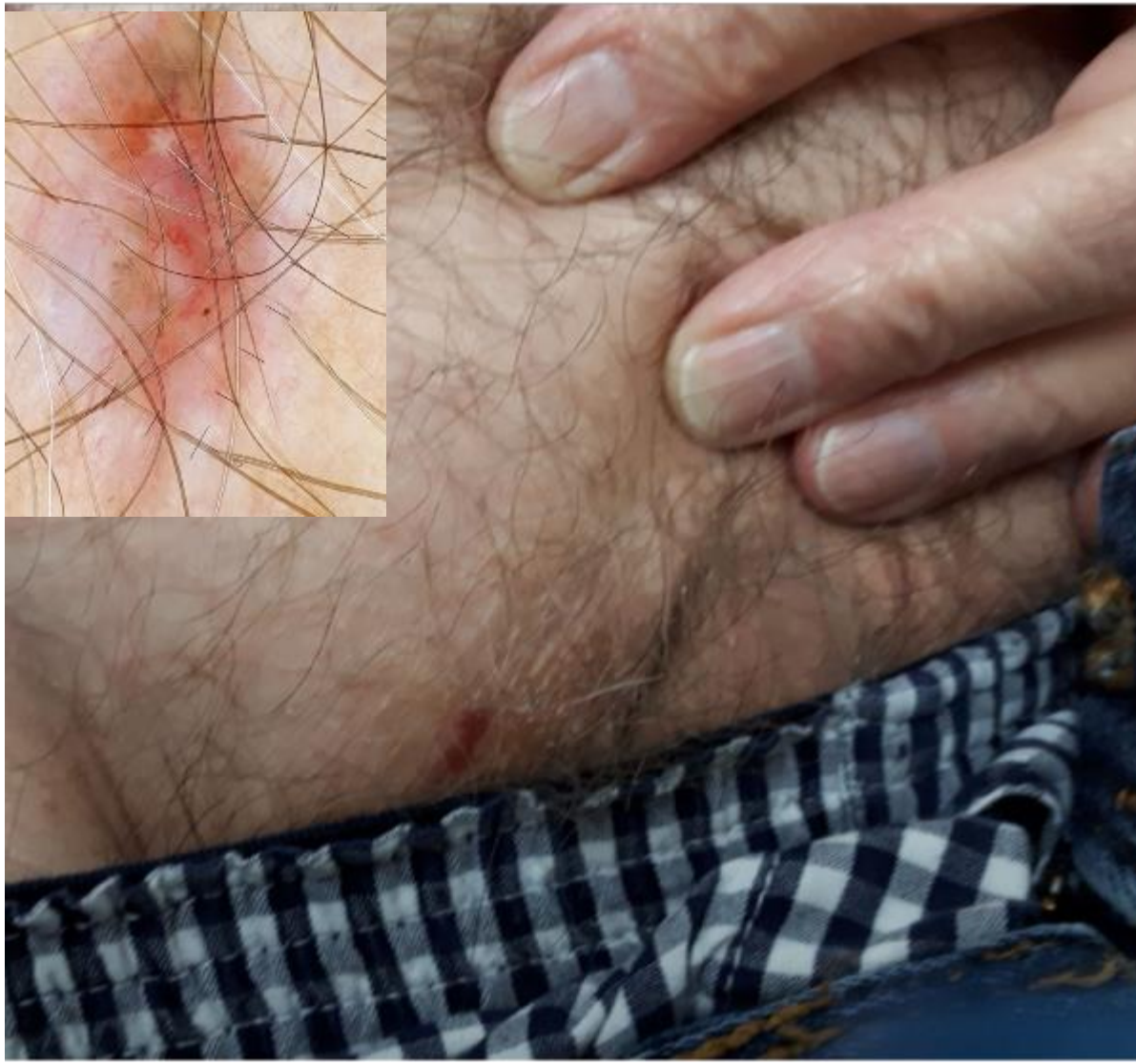
Helpful to know skin type & Pmh of BCC/ SCC





Immunosuppression increases the risk of having an Bcc/ scc eg Transplants pts, Azothiaprine, HIV





2ww referrals – Pan London form, send directly

SCC

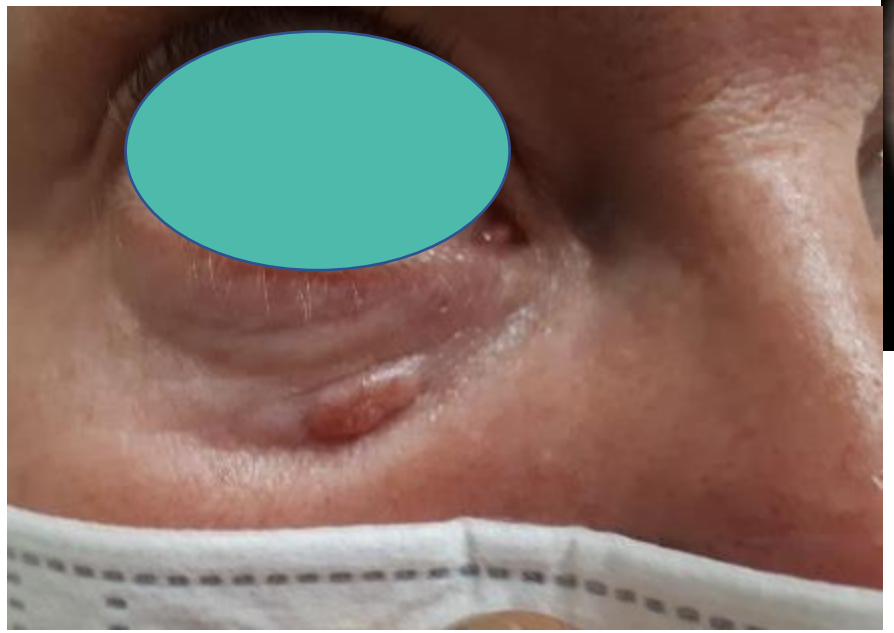
- On Face, backs of hands
- Growing quickly
- Tender, painful
- Crusting, non healing with induration
- May have risk factors

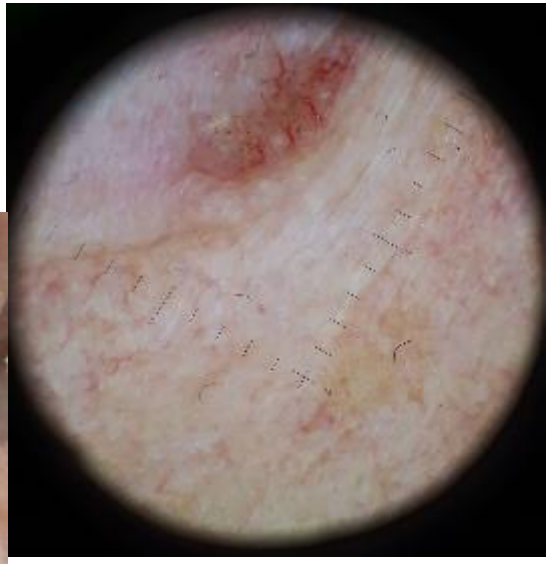
Melanoma

- ABCD EFG (Asymmetry, Border, Colour, Diameter + Elevated, Firm, Growing)
- 7 point check list

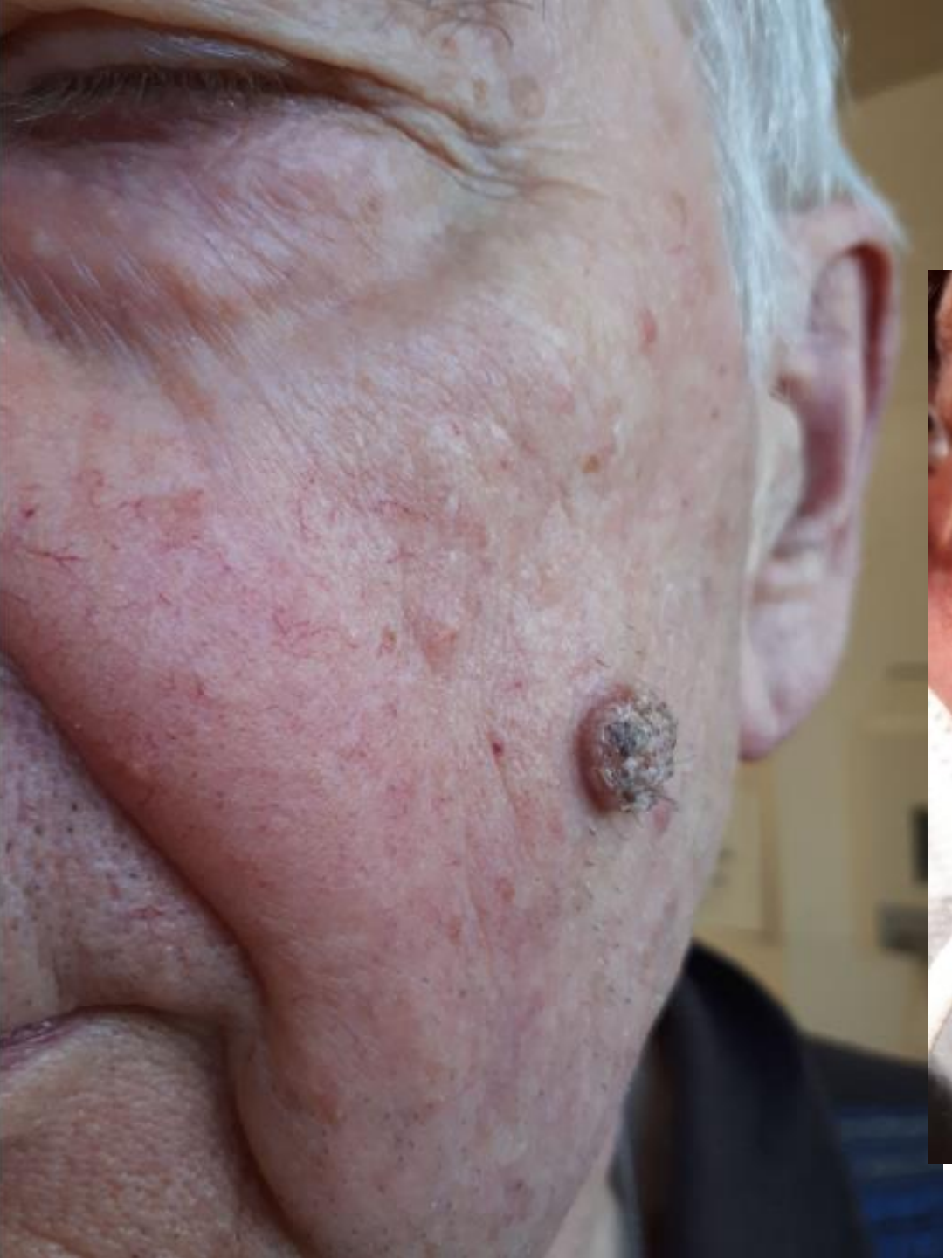
BCC

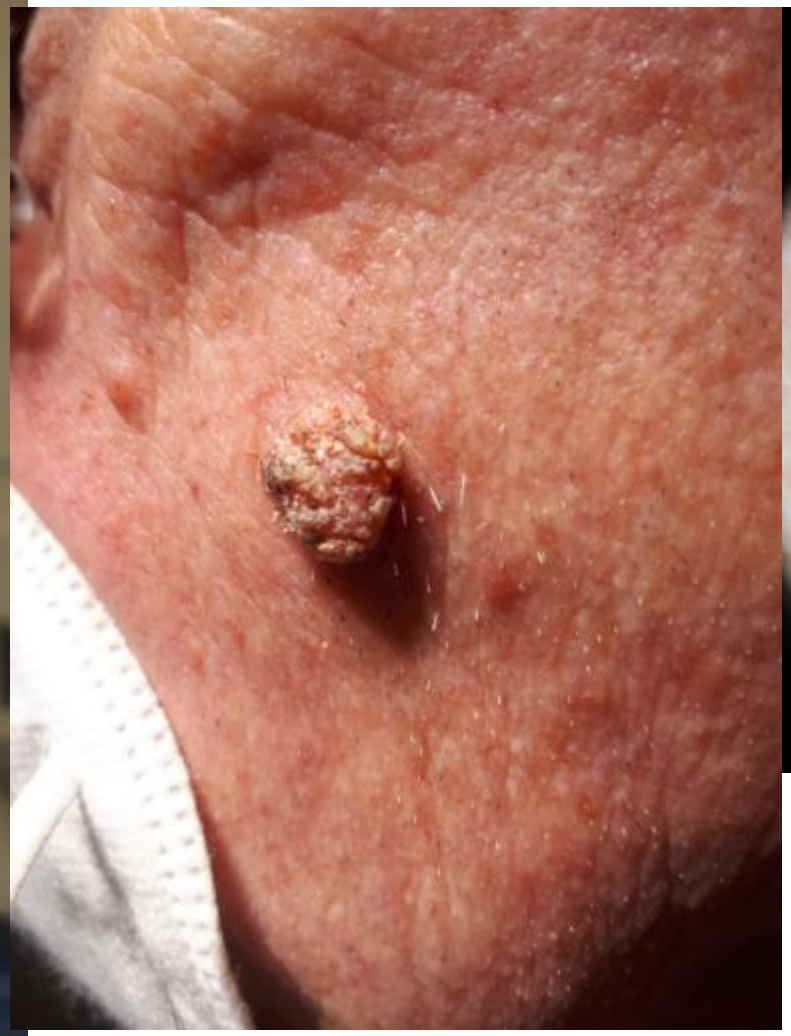
- Rapidly growing in high risk area (around eyes, nose or mouth).
- Doubt about diagnosis
- Pigmentation

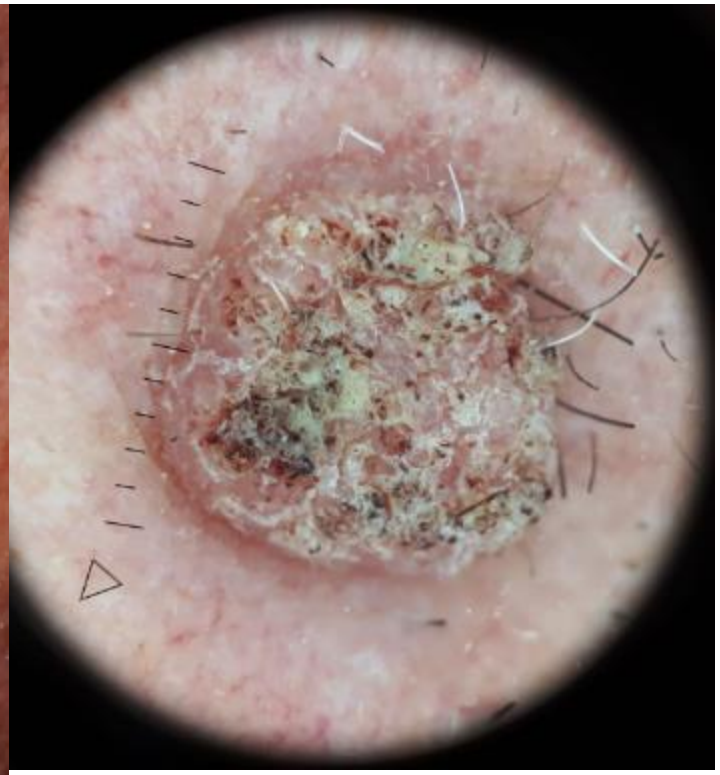




Growing over 9m



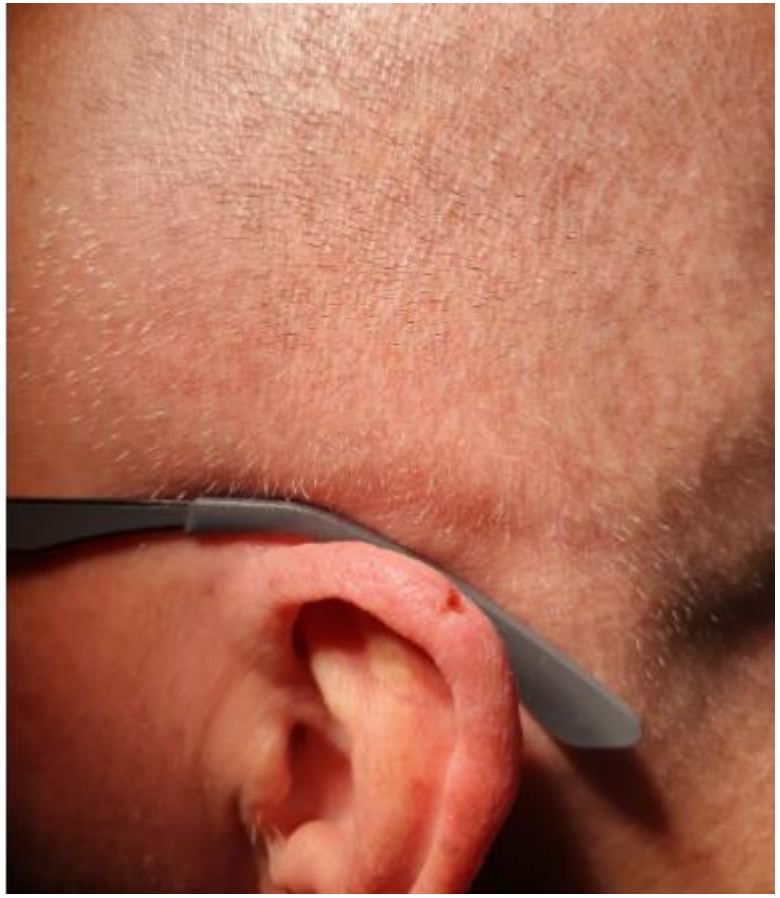


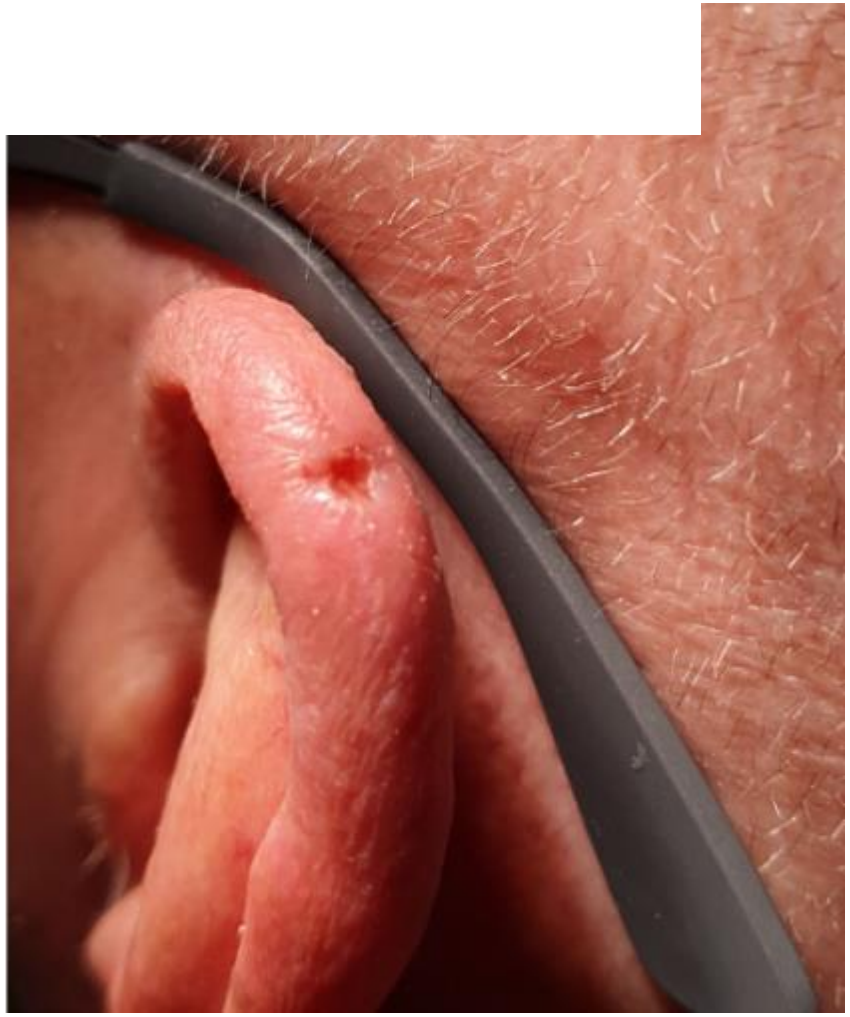


New, weeping, sore, bleeding

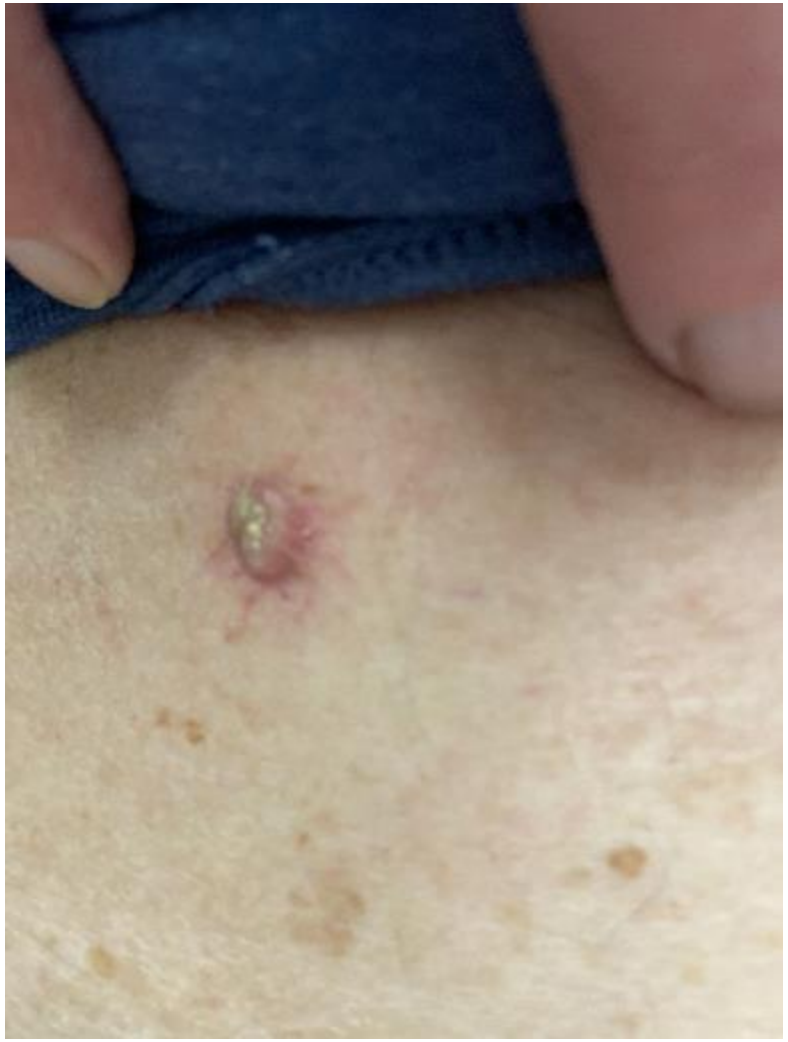
- 6/52 history Cabbie, tans, lots of sailing in Ibitha;
- More sore at night,
- wrong site for CND.

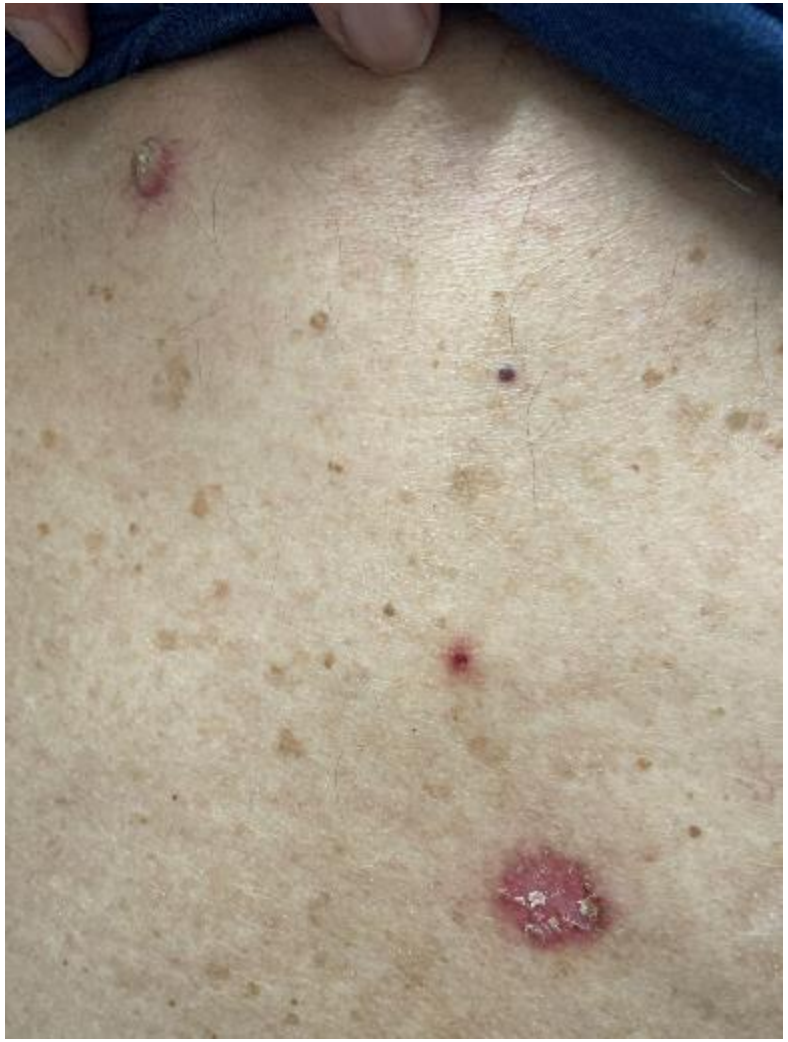
Fucibet + 2WW
Moderately well differentiated SCC on background of Bowenoid AK



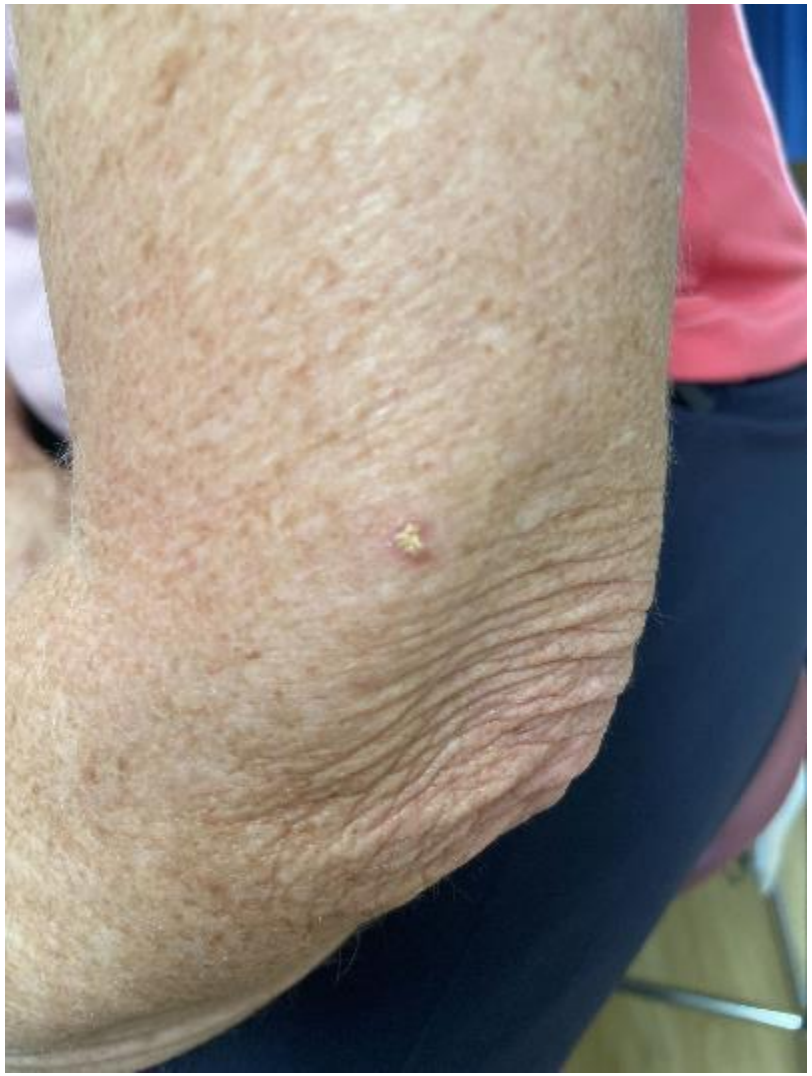


Lesions can occur together (same risk factors)





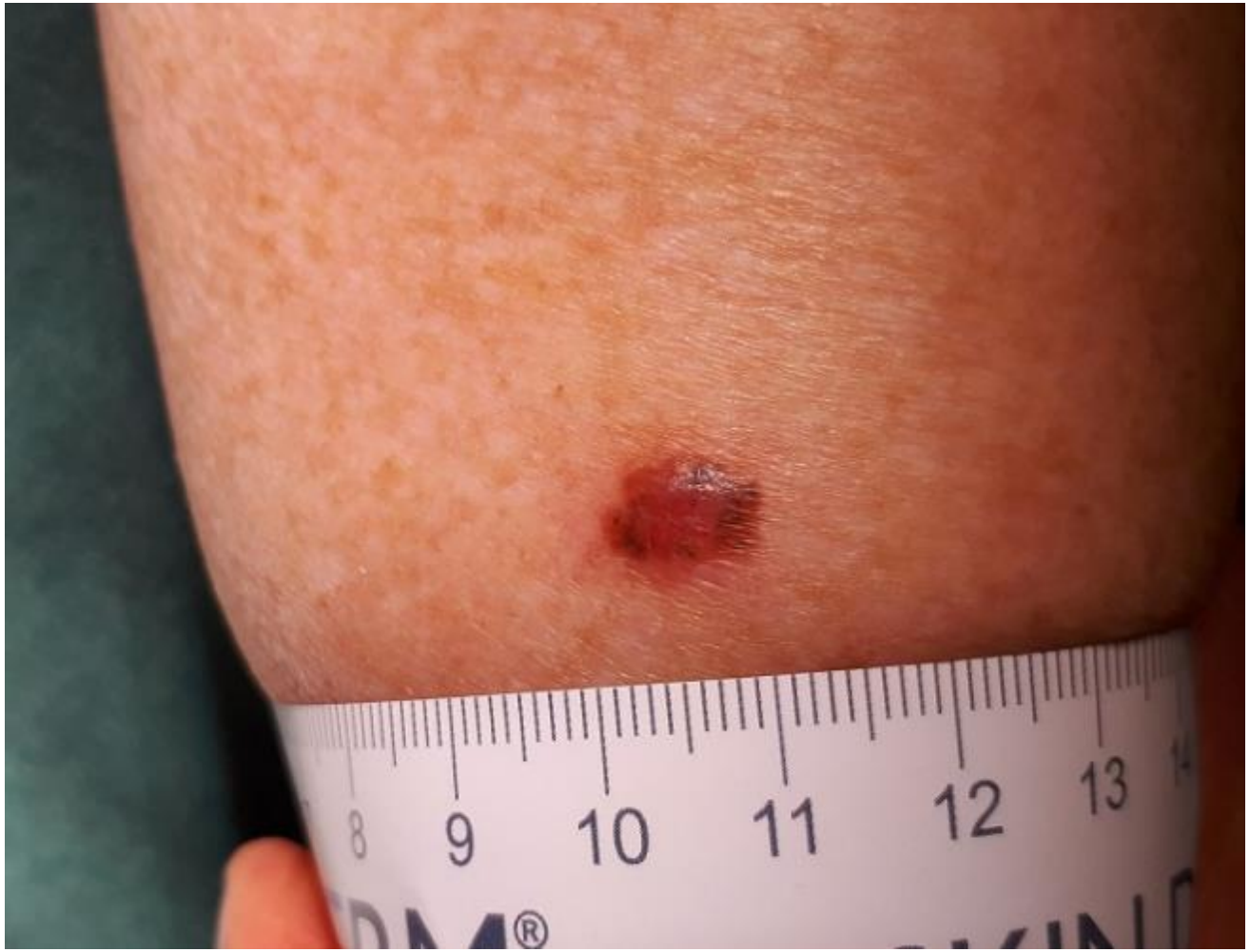
SCCs can be small and well differentiated

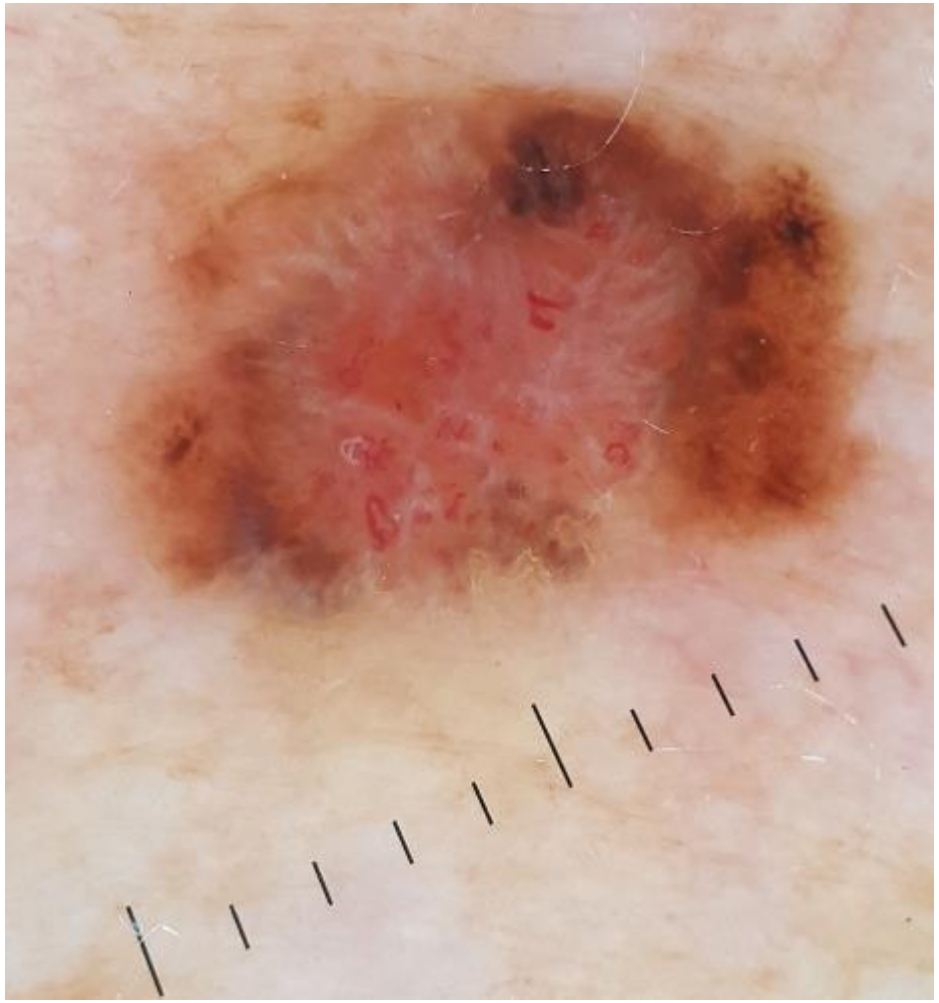


SCCs: Beware single nail dystrophy (this was referred as a 2WW & for CXR. It was an exostosis)

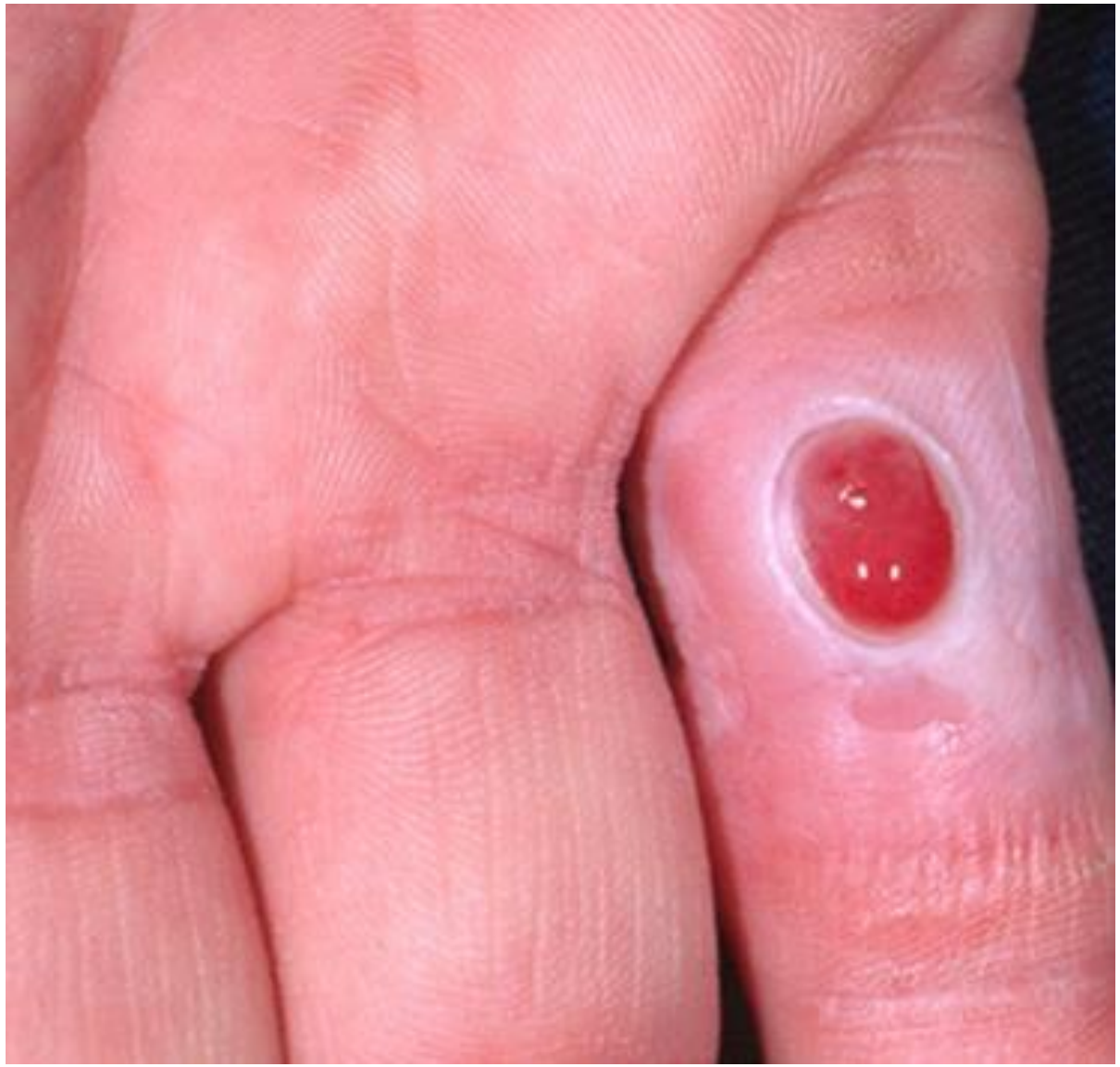
Ugly duckling

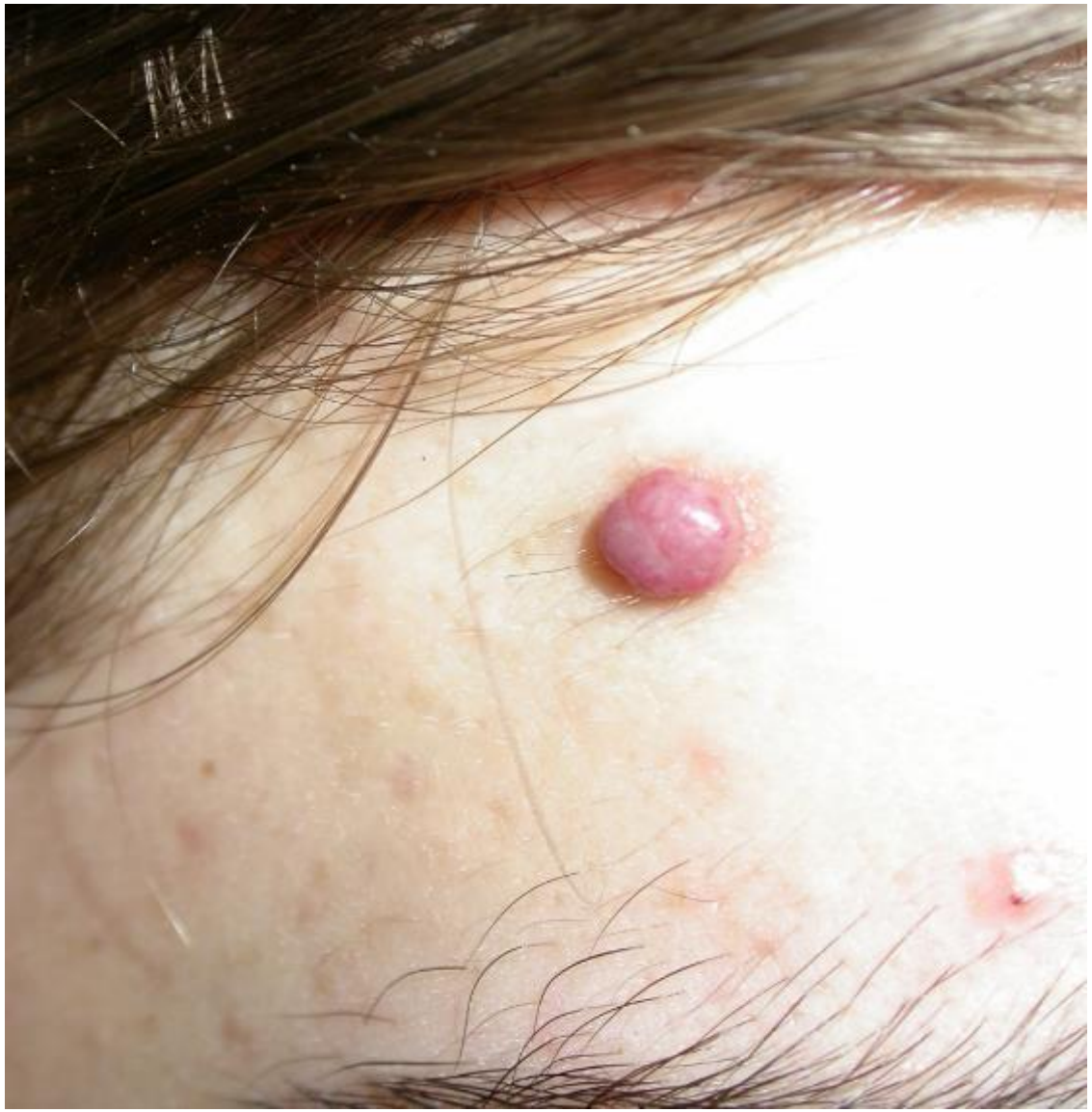
Type 1 skin, kenya as child, 3+ colours & asymmetry:





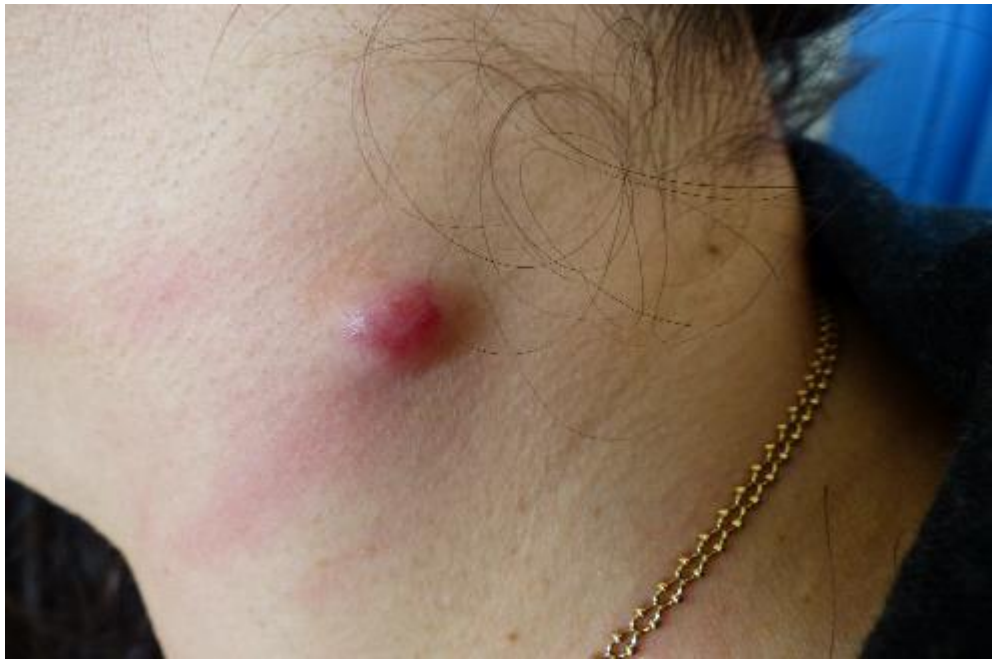
Pyogenic granuloma: History key



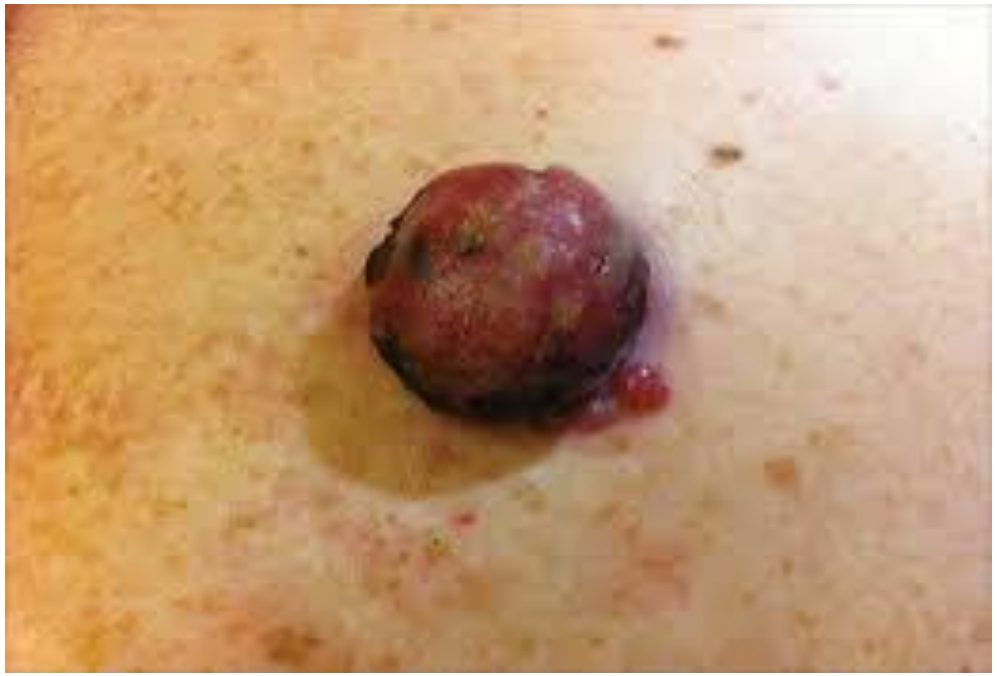


Beware pink growing or bleeding

Be suspicious and refer



Lymphoma



Merkel cell tumour

Referral of likely Benign skin lesions

If there is Diagnostic doubt:

- Consultant Connect for advice (photo taken with your phone in the App via Photo SAF and then shared with the SEL Dermatology Network- typical reply time 1 working day)
- Or A & G with option to convert referral: If 2WW needed we will return to YOU to action (LMC request)
- Or refer via ERS/ RAS with photo and good history: if we are concerned we will contact patient and upgrade to 2WW

→ if 18-50y not hands and feet, not recurrence and not immunosuppressed will be triaged to Telederm, otherwise will be triaged to appropriate clinic … *so please complete the form to help us!*

- Symptomatic Benign lesions : The **SEL TAP** must be considered- if in doubt consider **Advice and Guidance** from the CDS before referral

Treatment access Policy : SEL wide

- Removal of benign skin lesions cannot be offered for cosmetic reasons. It should only be offered in situations where the lesion is causing symptoms according to the criteria outlined below. Risks from the procedure can include bleeding, pain, infection, and scarring.

The list includes:

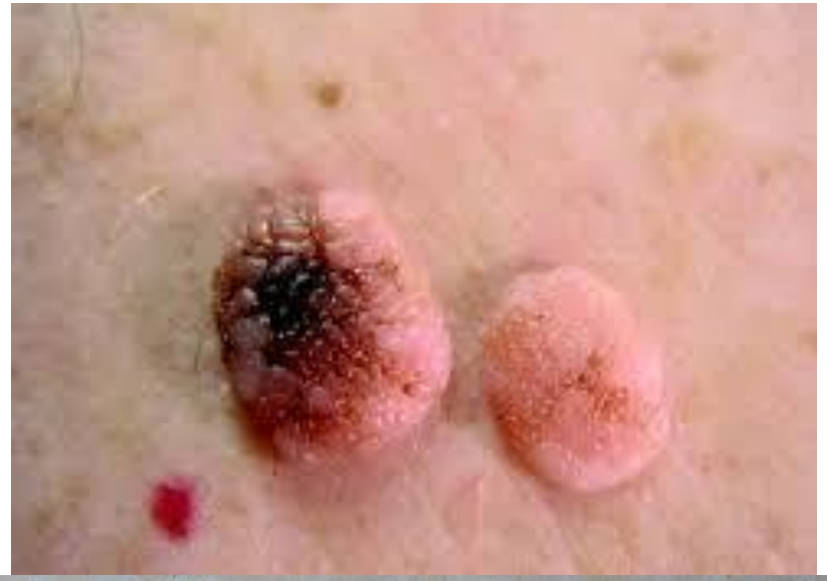
- benign moles,corn/callous,
- dermatofibroma,lipomas, milia,
- molluscum contagiosum (non-genital),
- epidermoid & pilar cysts (sometimes incorrectly called sebaceous cysts)
- seborrhoeic keratoses, skin tags (fibroepithelial polyps), spider naevi
- non-genital viral warts in immunocompetent patients
- xanthelasmata, neurofibromata

- ICS wide so we need to be doing the same as other Community derm/ 2* care sites

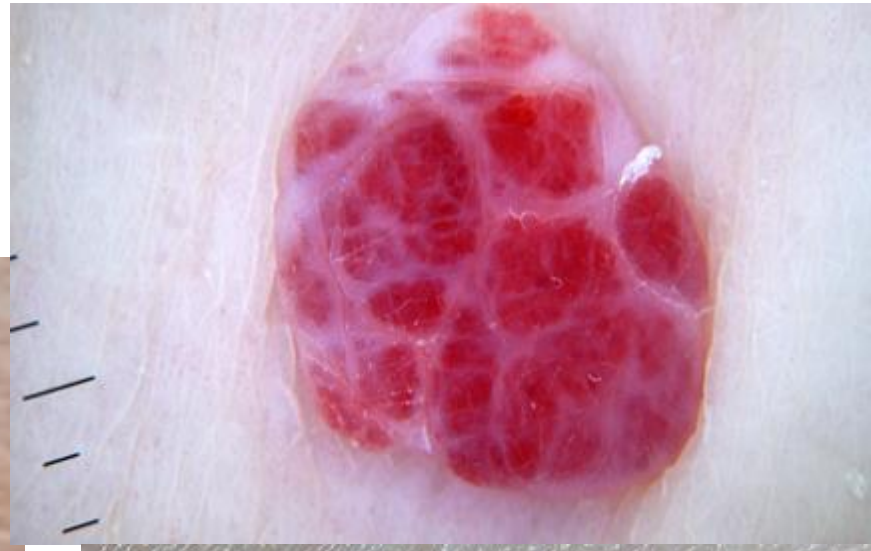
Exceptions:

- If the lesion is regularly traumatised
- Repeated infection X 2 per year and needed antibiotics
- Regularly bleeds
- Painful
- Causing an obstruction to an orifice or field of vision
- If left untreated, more invasive intervention would be required for removal
- Facial warts

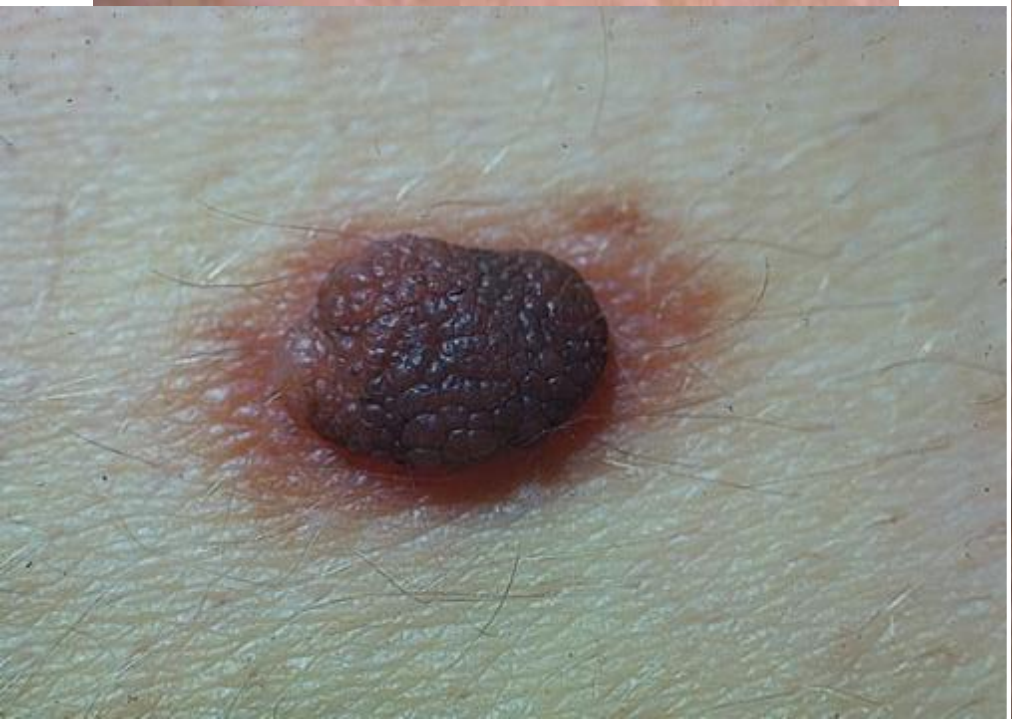
Reassuring Benign: Soft and compressible Non tap

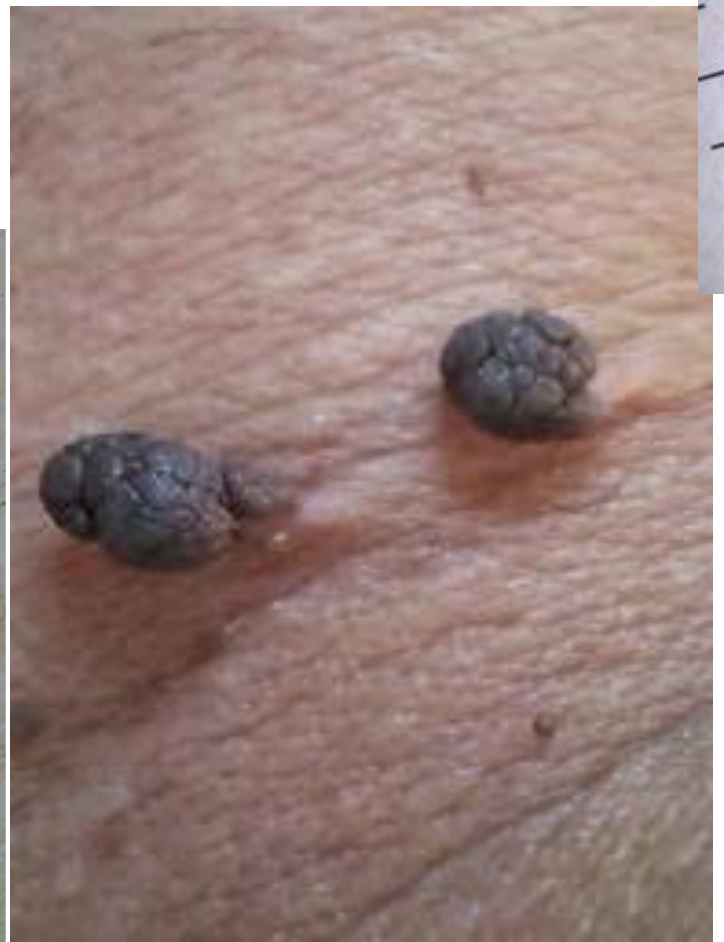


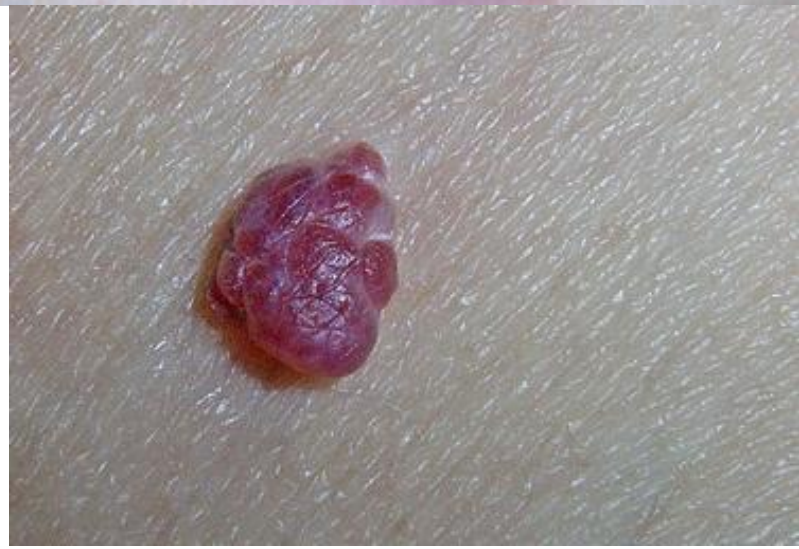
Compound naevi

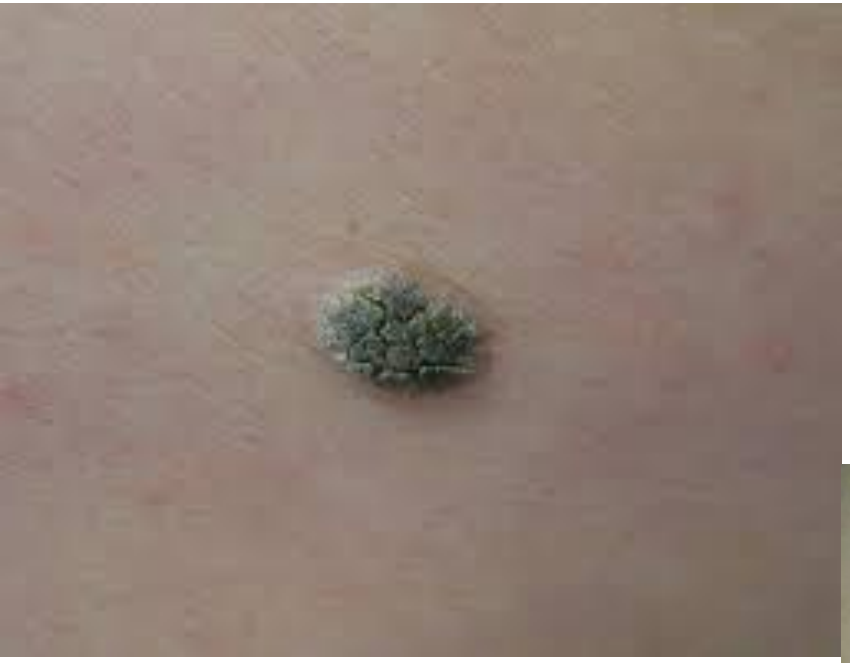


Skin tags

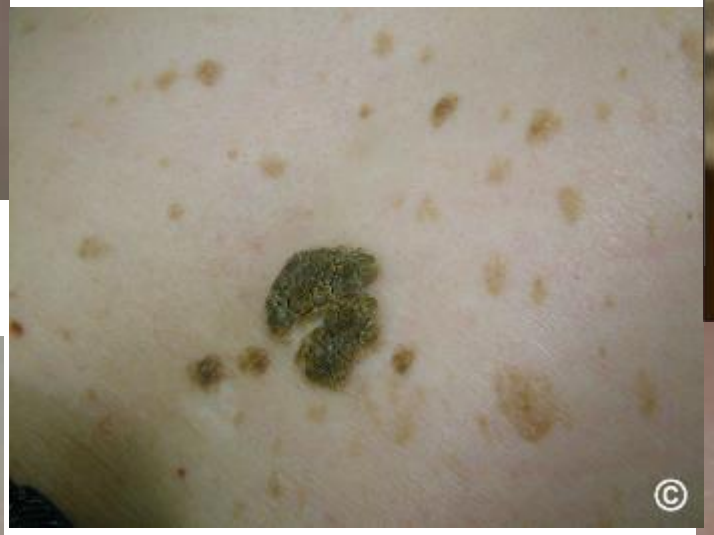


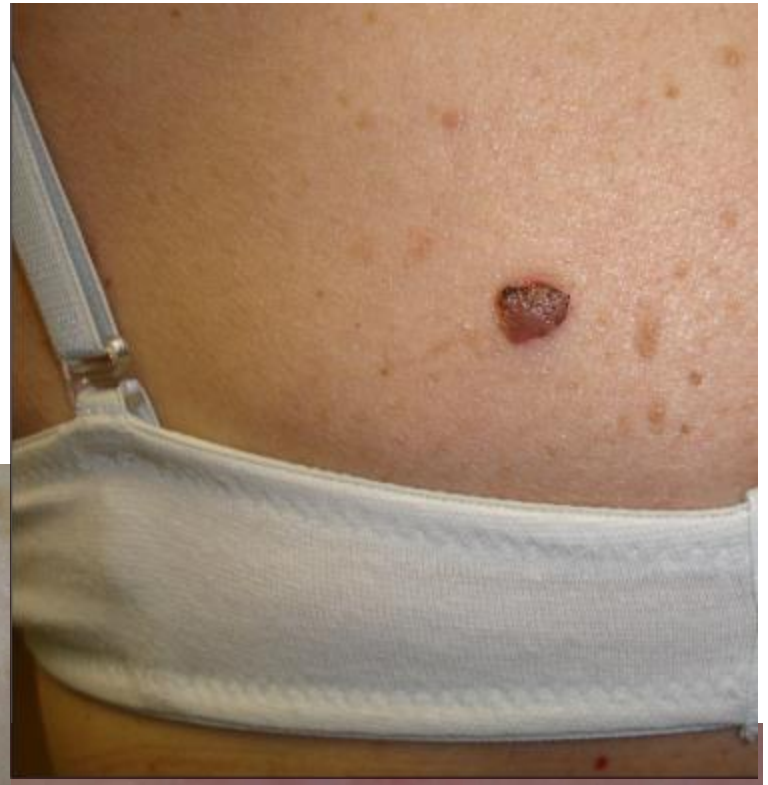


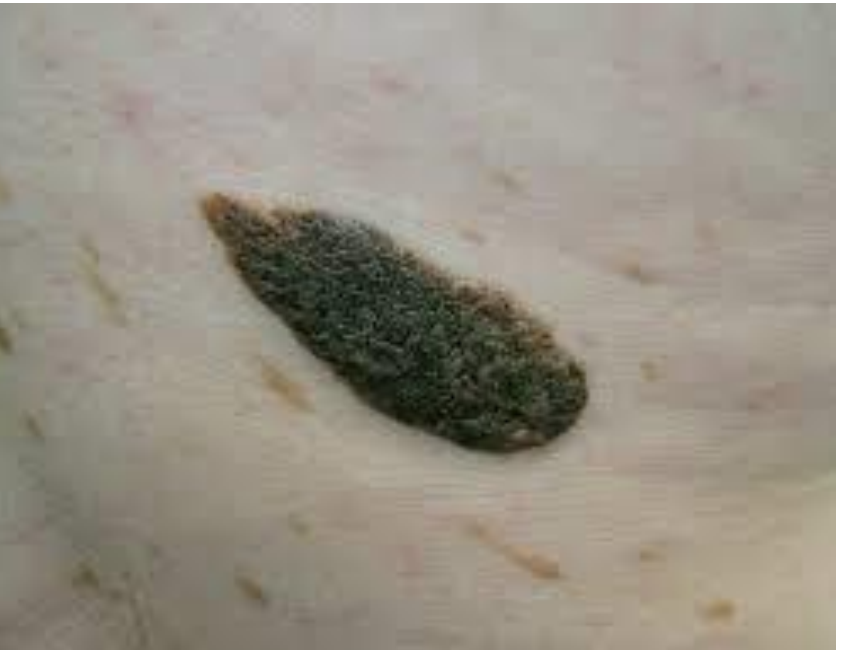




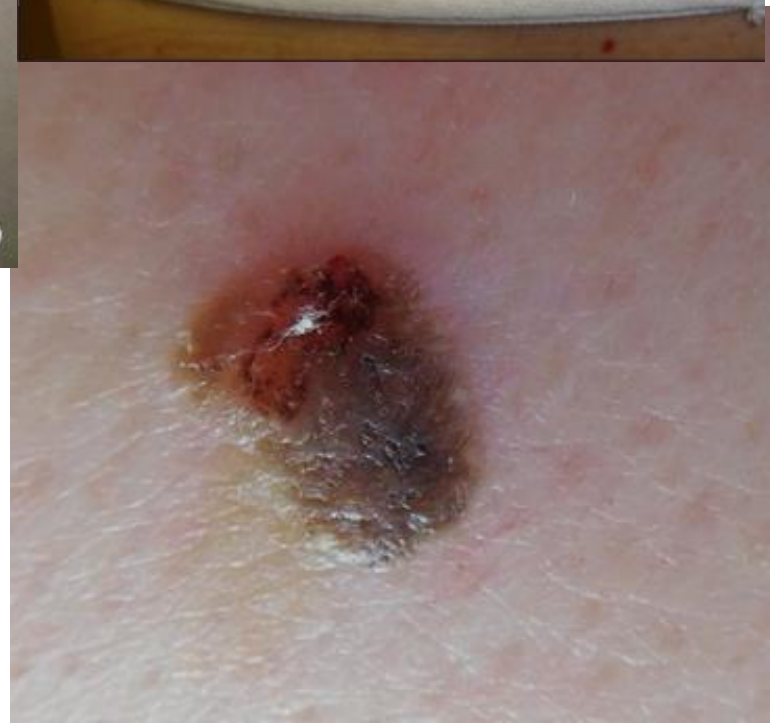
Crumbly



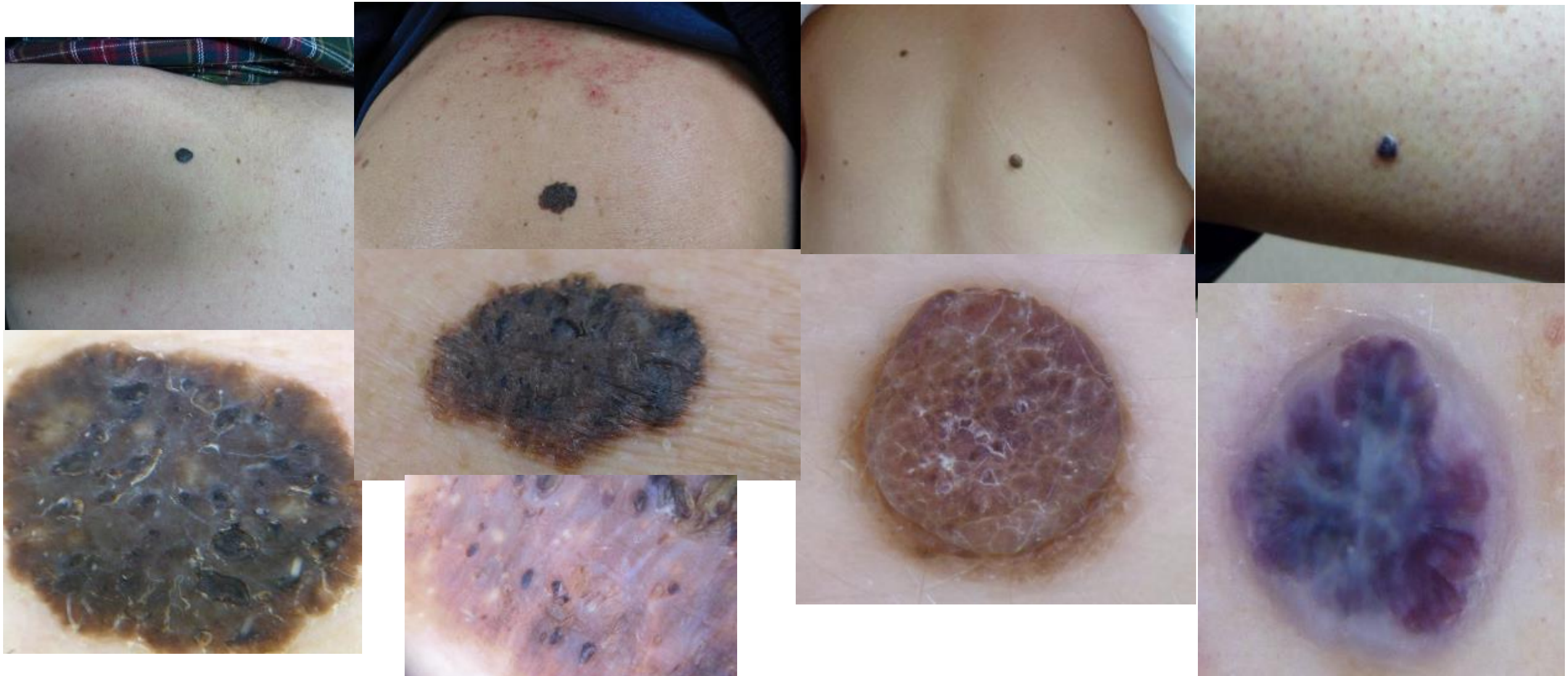




Seborrhoeic keratoses

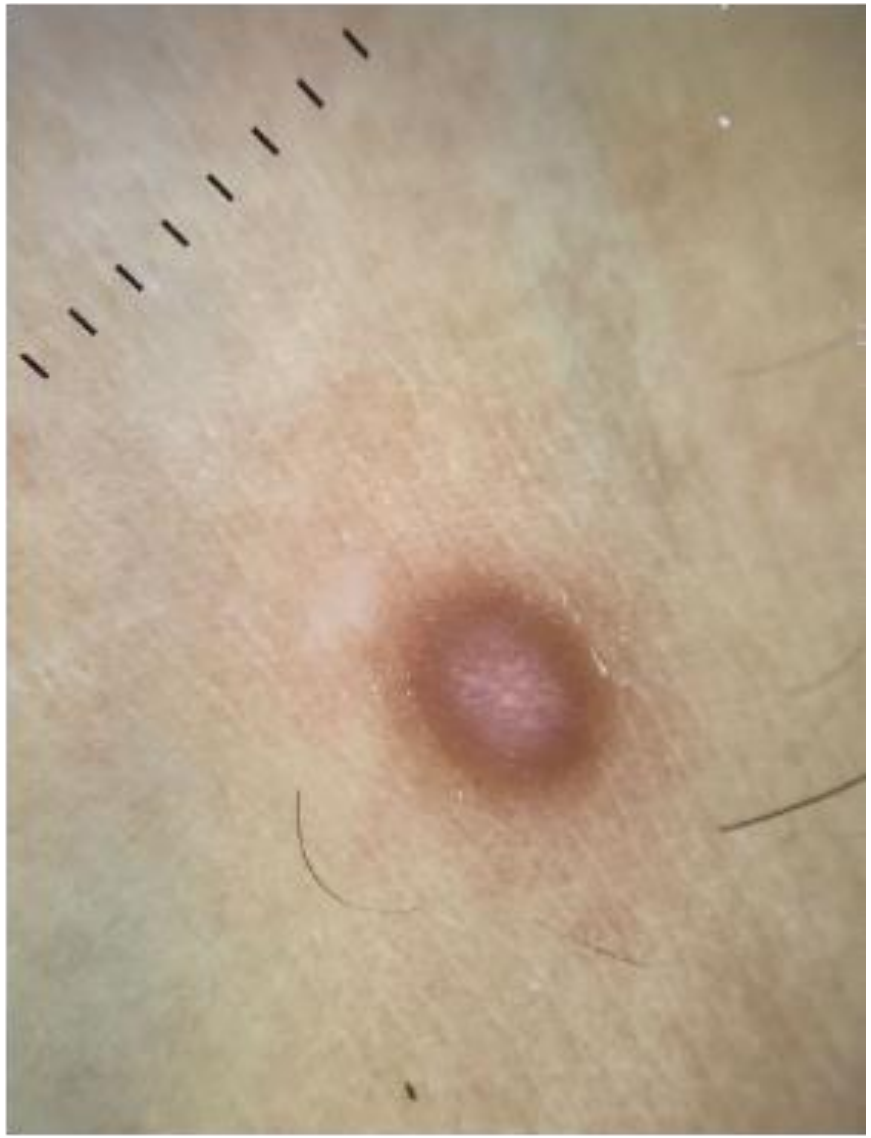


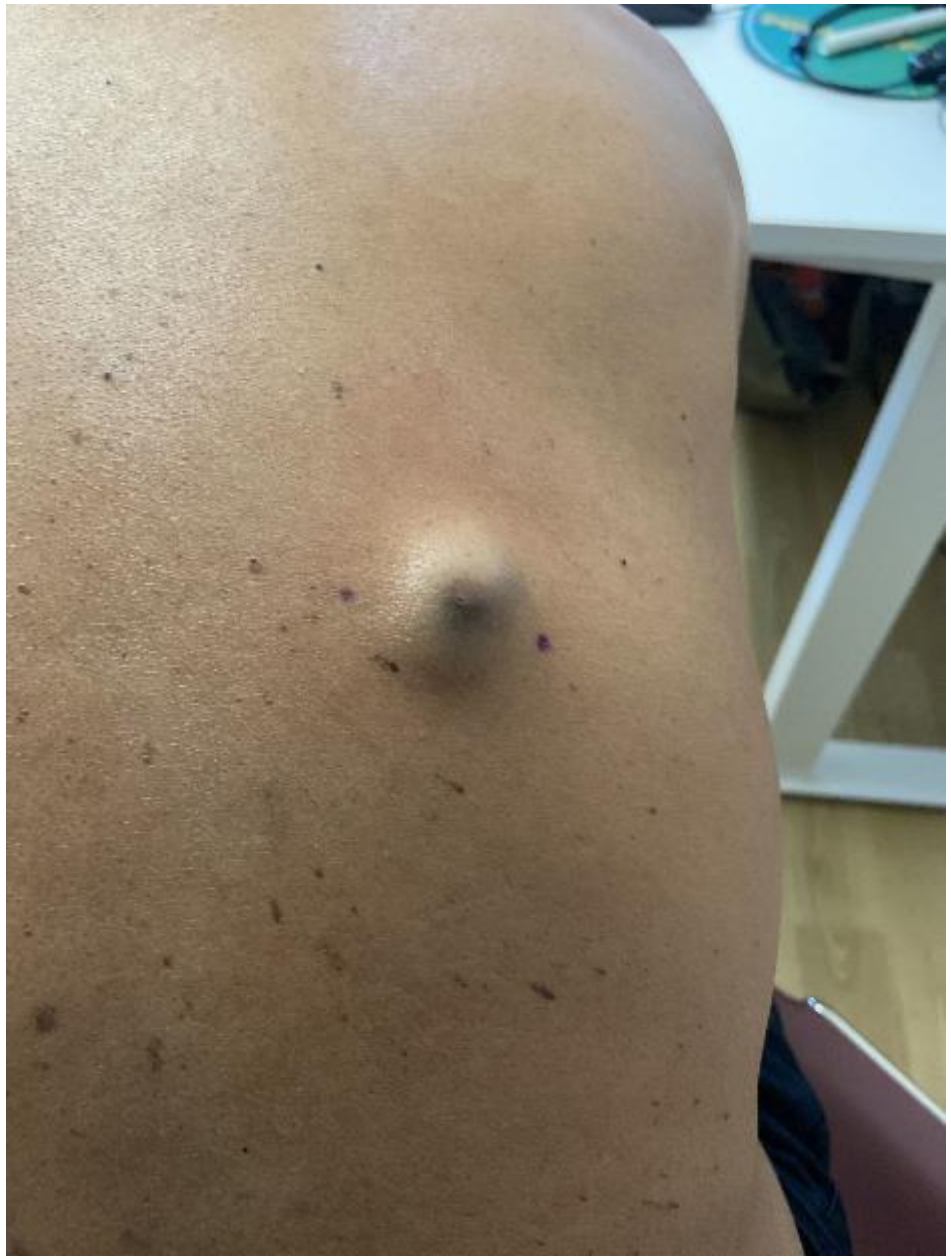
Beware ‘ugly ducklings’: benign dermoscopy



Offer or refer for dermoscopy

Within TAP? Lesions referred recently





References

- PCDS The Cunliffe (TP) Skin Lesion Diagnostic Tool (pcds.org.uk)
- Seborrhoeic keratosis (pcds.org.uk)
- BMJ learning, Common skin tumours http://learning.bmj.com/learning/module-intro/
- Suspected cancers Nice Guidelines http://www.nice.org.uk/guidance/ng12
- SEL Dermatology GuidelinesDermatology-Guidelines-for-Primary-Care-FINAL-January-2020-1.pdf (selondonccg.nhs.uk) latest version circulated
- Treatment Access Policy https://www.selondonics.org/wp-content/uploads/2022/07/SEL-Treatment-Access-Policy-Final-July-2022.pdf
- PCDS https://www.pcds.org.uk/clinical-a-z-list
- BAD leaflets A-Z Conditions & Treatments - BAD Patient Hub (skinhealthinfo.org.uk)

Lesions : summary

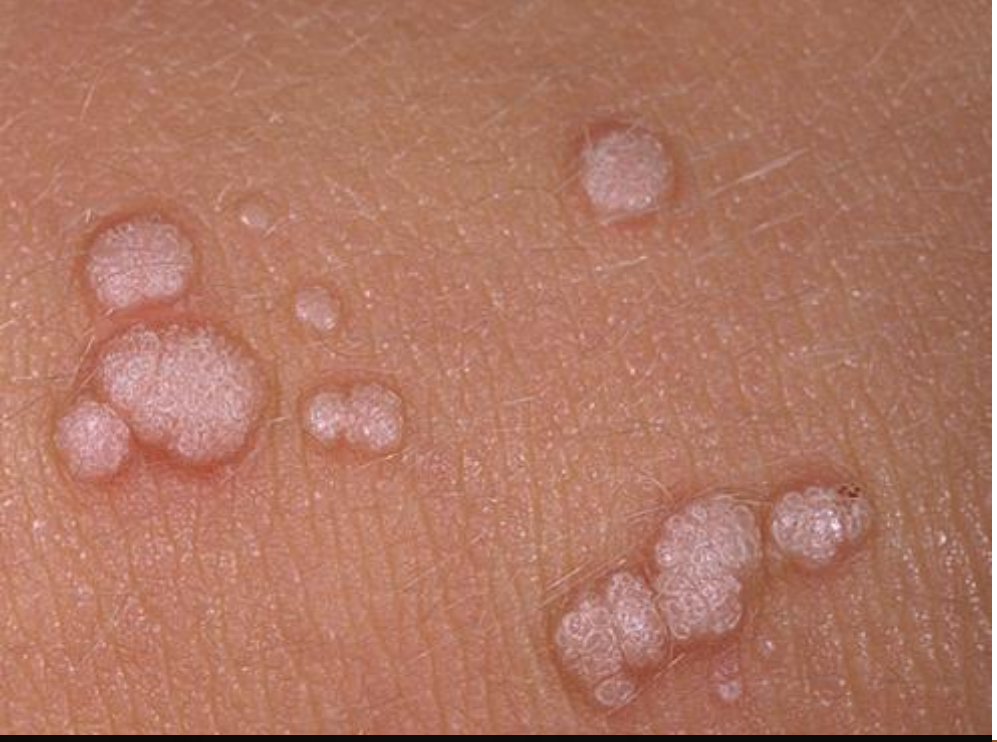
- 2 WW If high risk lesion/ history/ individual

- Not sure whether to use 2WW → Consultant connect with photo

- Unlikely 2WW, diagnostic uncertainty :

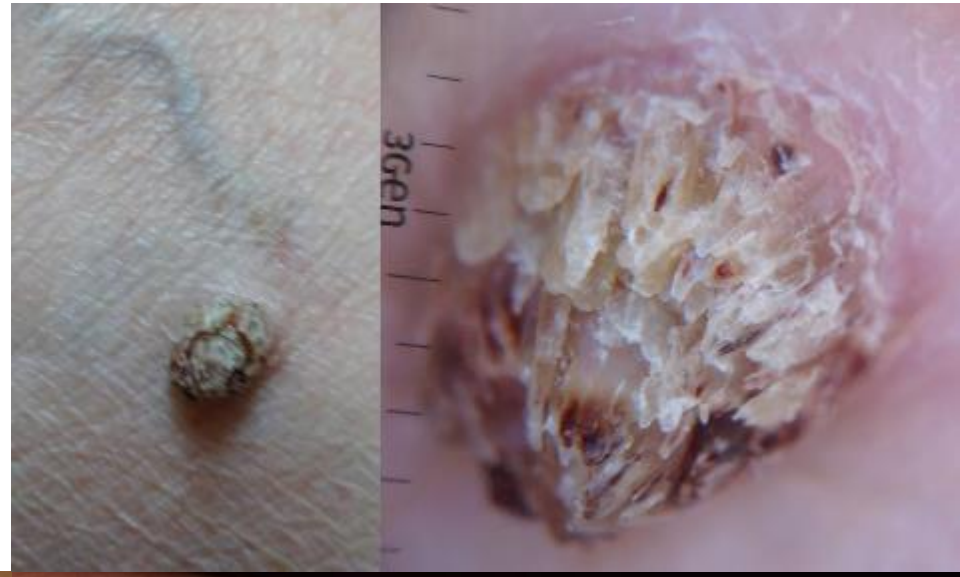
→ Refer RAS with photo, include relevant history, we will triage to Telederm or clinic, 2WW upgrade if nec (GPwER contacts pt)

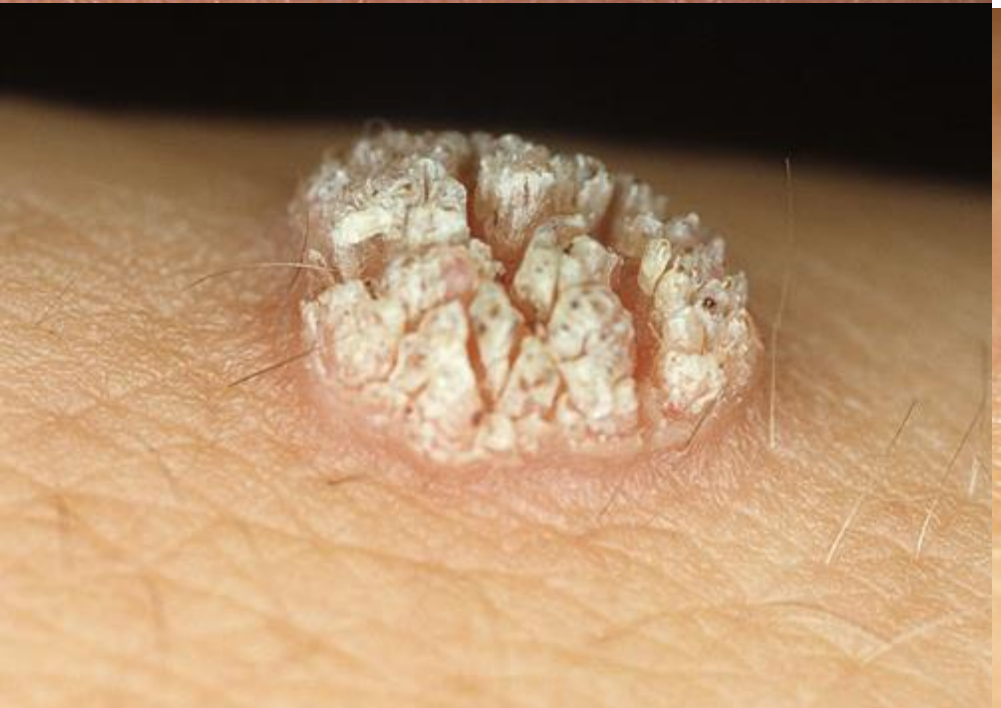
→ Advice and guidance +/- refer, we'll return if 2WW or arrange review if clinic or Telederm

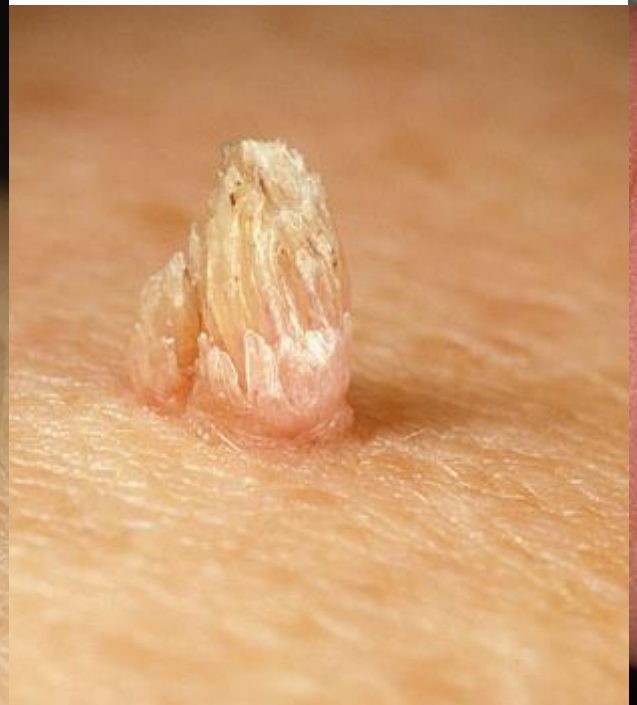


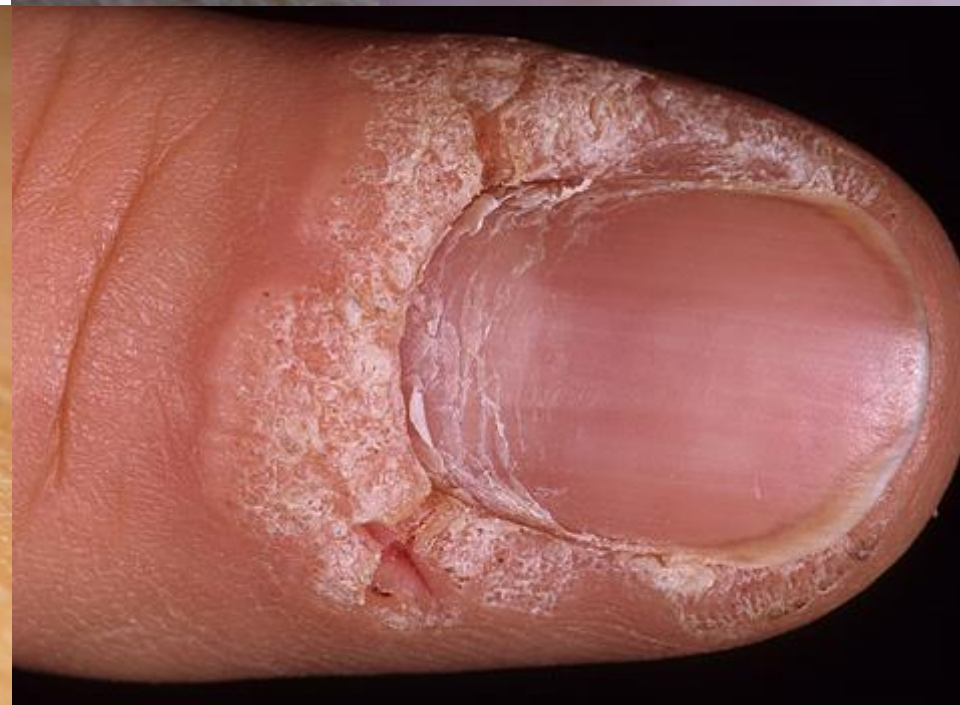
Warts

Non TAP unless
Immunocompromised









Warts:

- Zinc supplements 14029Pzinc.pdf (ouh.nhs.uk)
- Clear in 2-5 years
- Persistence, paring, duct tape (Many months)
- Salicylic acid 50% (or glutarol if bleeds ++)
- Coming up: ? Actikerall (Efudix and Salicylic acid)
- Verruca as pp : SWIFT

Keloids:

Primary care options: Dermovate under Duoderm/ Tegaderm
Betesil Plasters, Haelan tape applied overnight

If very symptomatic/ primary care options exhausted
Up to 3 injections to address symptoms
If > 3 cm, community derm direct to Plastics: Surgery and DXT

Southwark Practices	**Adults and Children**	**eRS: Community Dermatology Southwark - Dermatology - Guy's & St Thomas' - RJ1**

Advice and guidance

- **via Consultant connect (telephone) +/- Photosaf**
- **via ERS Dermatology Single point of referral** With option to convert to referral

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

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

Your referral will be reviewed by a local GPWER Dermatology with one of 3 outcomes:

- Advice about how to manage your patient returned to you via ERS
- The patient is offered an appointment within the community service (face to face or telephone)
- The patient is offered an appointment in secondary care.

Children are seen in the same clinic as adults for conditions appropriate for the community setting

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.

Community dermatology provider: **Community Dermatology Southwark**

Telephone Number (confirmed)		**Specific needs**	☐ Transport (will be triaged to secondary care) ☐ Hoist (secondary care) or other needs
Mobile:		**Interpreter**	☐ Language requested:
Email :		**Ethnicity:**	
Does the patient have additional communication needs e.g. Braille, Audio?			

Patient's preferred COMMUNITY CLINIC	**Patient's CHOICE OF HOSPITAL if triaged to SECONDARY CARE**
☐ Community at Guy's hospital ☐ ELM LODGE SURGERY SE24 9HJ	☐ GUY'S & ST THOMAS ☐ KING'S COLLEGE ☐ Other please state .....

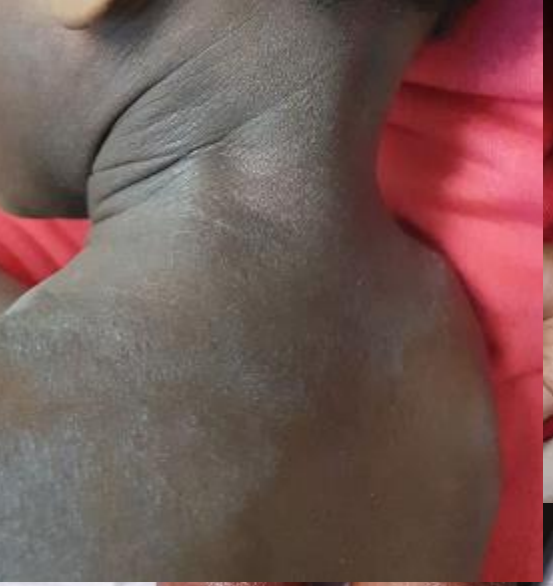
Reason for referral **(If insufficient information is included, you may be asked to rerefer with further information)**

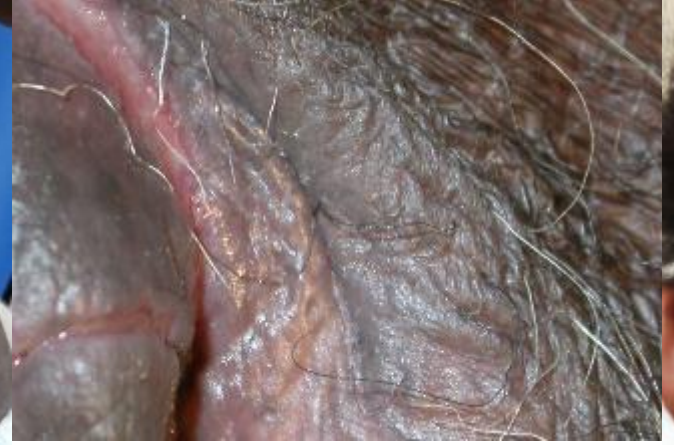
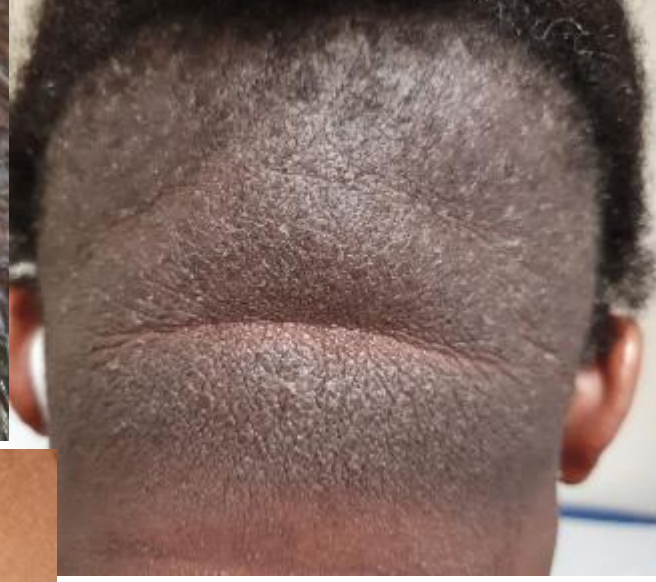
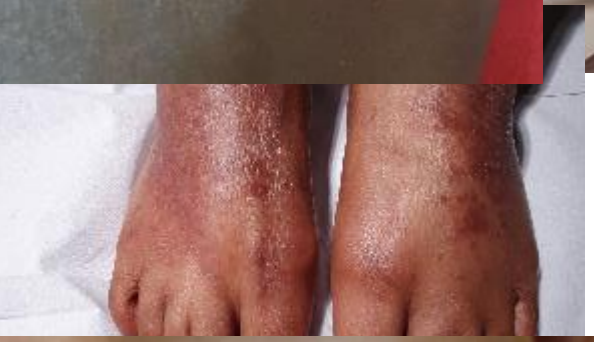
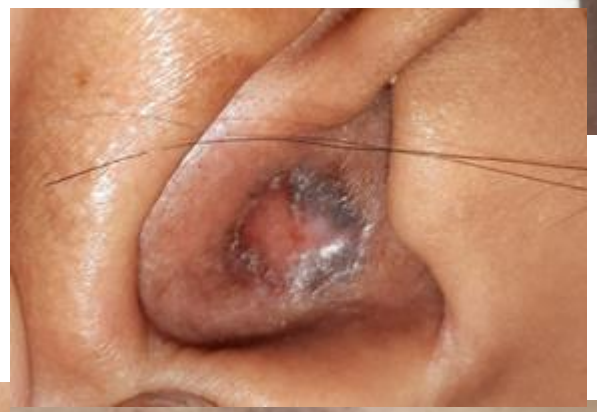
☐ **URGENT REFERRAL**	☐ **ACNE/ROSACEA**	☐ **ECZEMA**	☐ **PSORIASIS**
☐ **Rash : diagnostic uncertainty**	☐ **Suspected Basal Cell Carcinoma (BCC)**	☐ **YES Skin lesion is suitable for triage to teledermatology** • 16-50 years old • 1 or 2 lesions (includes BCCs)	
☐ **Other skin condition**	☐ **Symptomatic benign skin lesion *(SEL TAP * APPLIES)***	☐ ***Lesion NOT suitable for triage to teledermatology if*** - *< 16years old or > 50 years old* - *Palmar/plantar/nail/genital lesions* - *Immunosuppressed patients (e.g. transplant)* - *Lesions suspected to be recurrent*	
Skin lesions will be managed in accordance with the SEL Treatment Access Policy ***Viral warts, seborrhoeic and other benign lesions are not usually treated***			

Please indicate your patient's Fitzpatrick skin type (I-VI) which influences their susceptibility to sun damage and other skin problems:

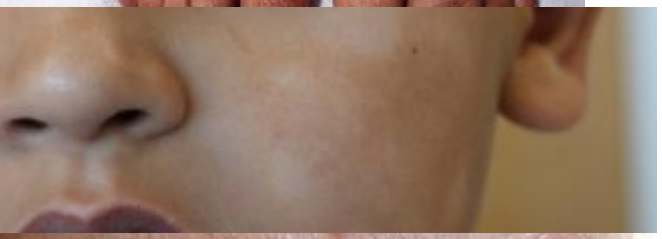
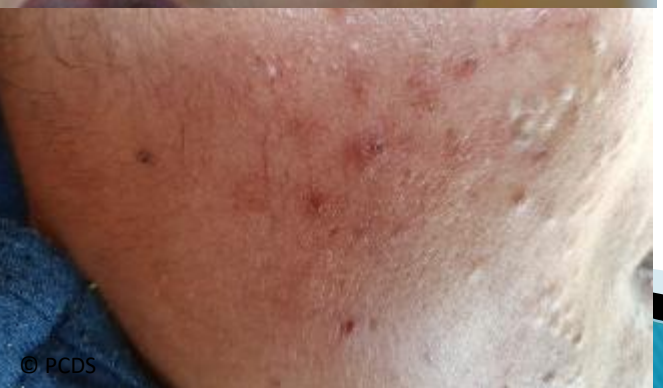
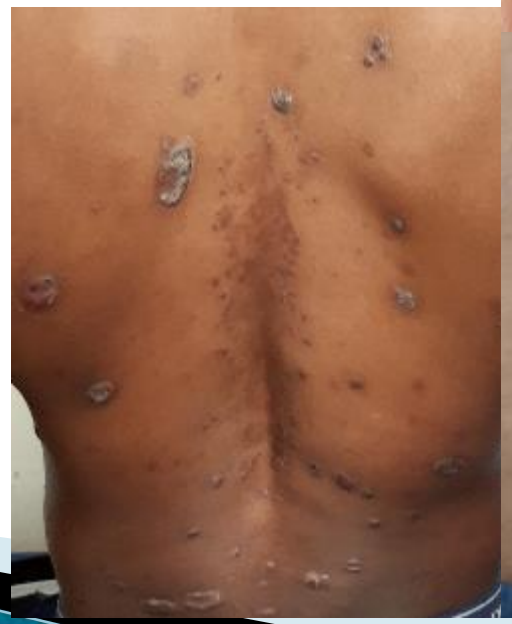
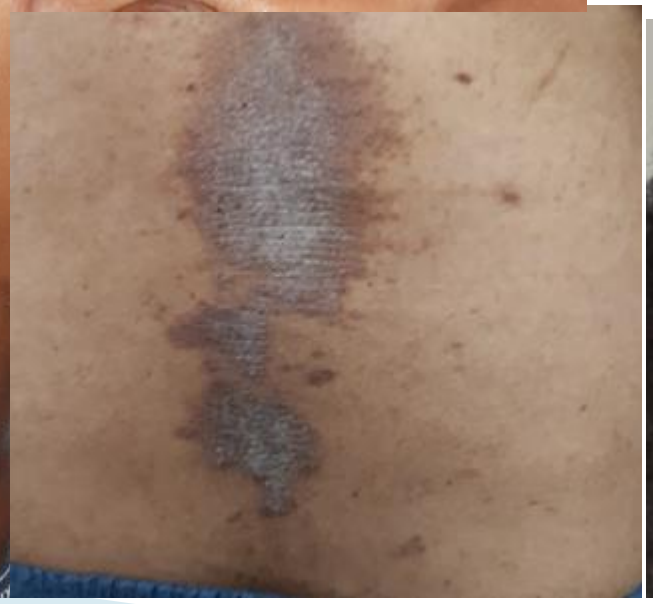
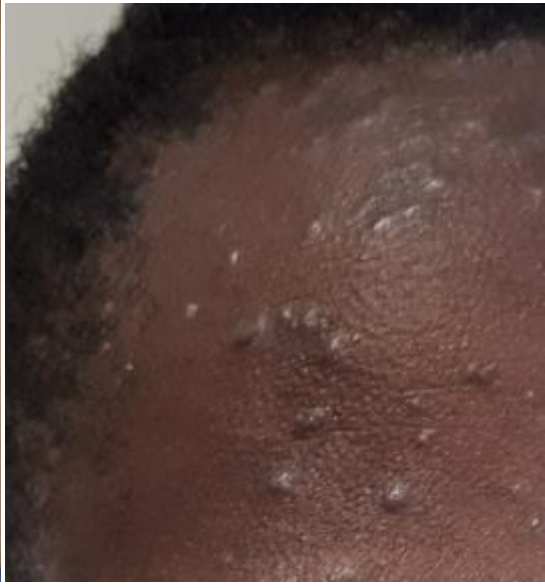
I ☐ II ☐ III ☐ IV ☐ V ☐ VI ☐

1: How does inflammation present in skin of colour?



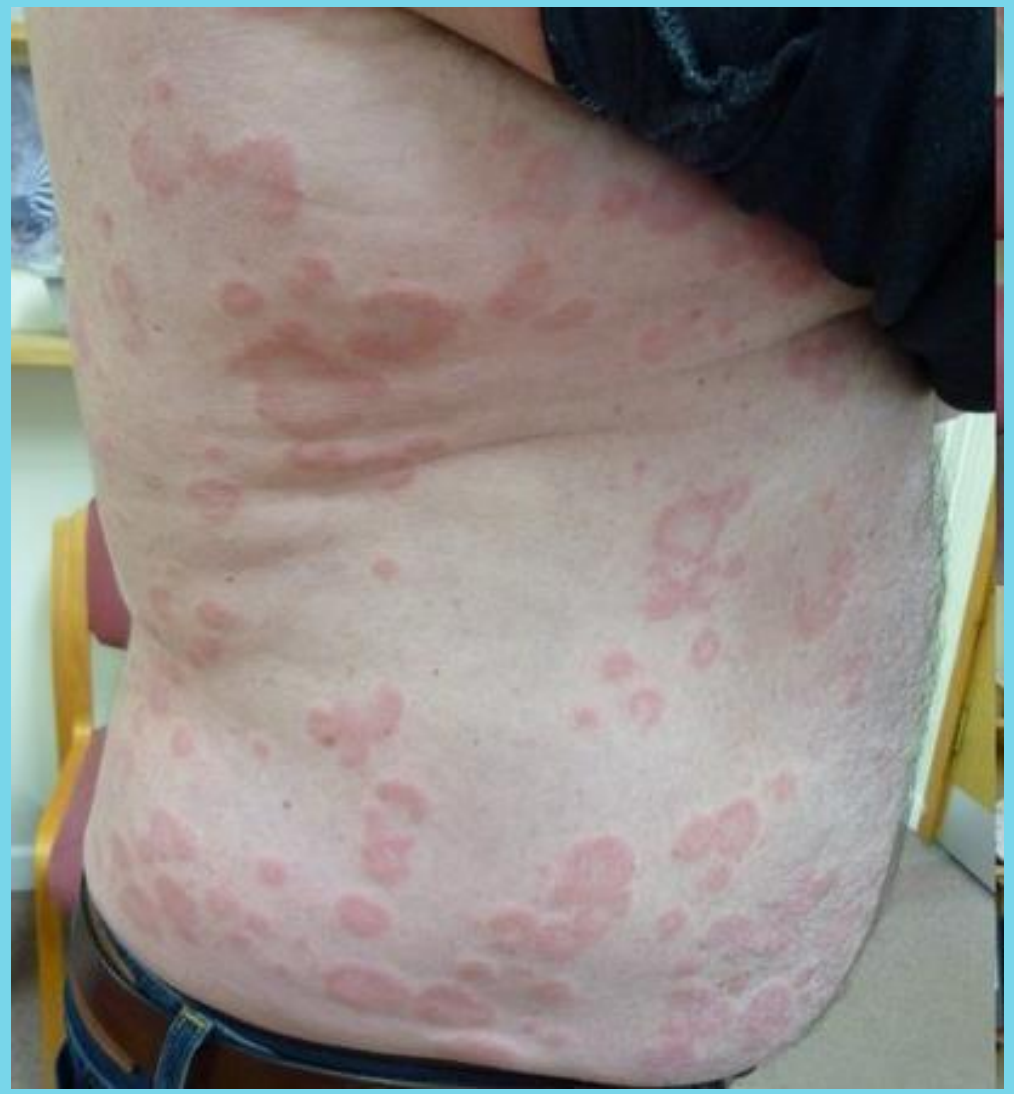





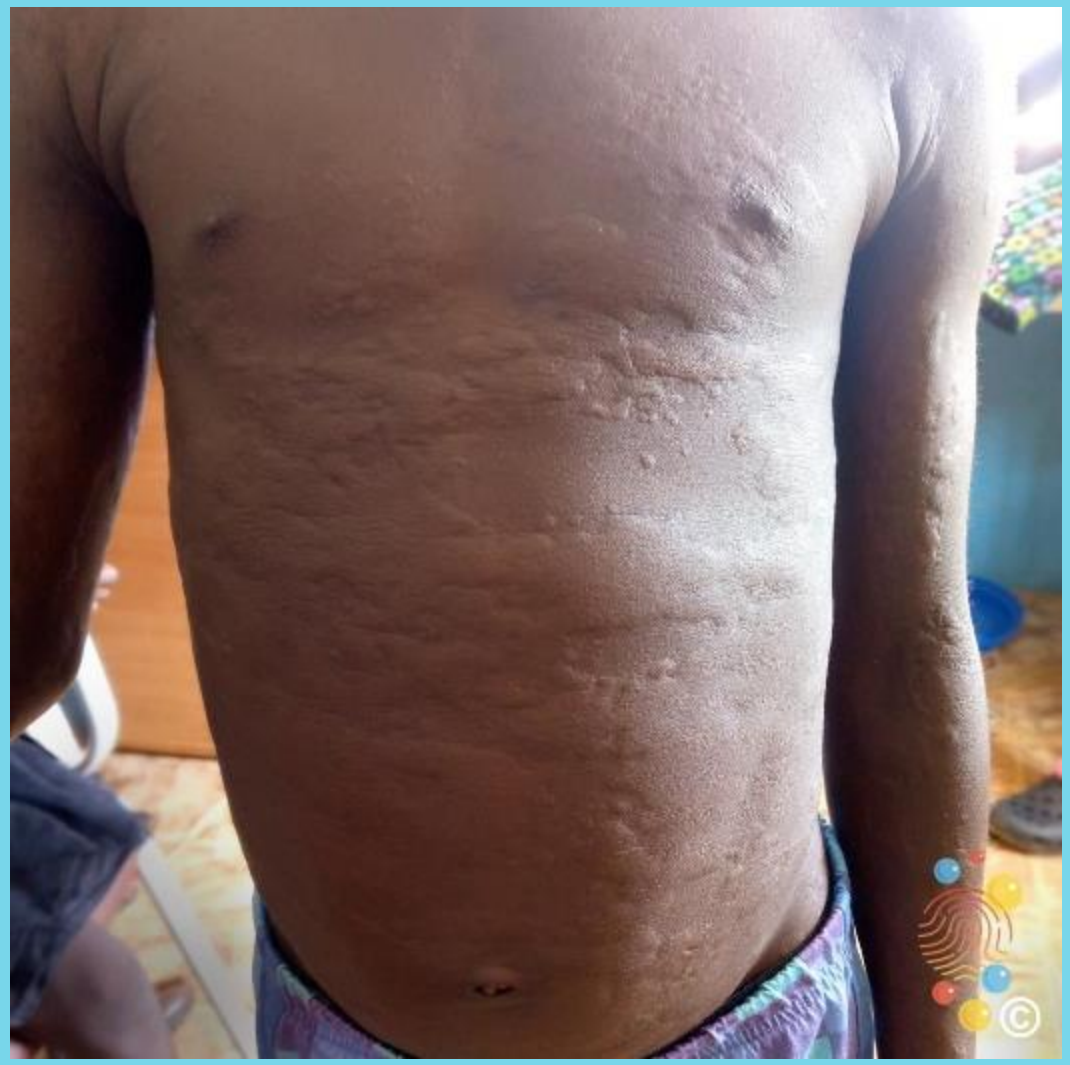
Inflammation in Soc

Inflammation in skin of colour: the skin will often look/ be

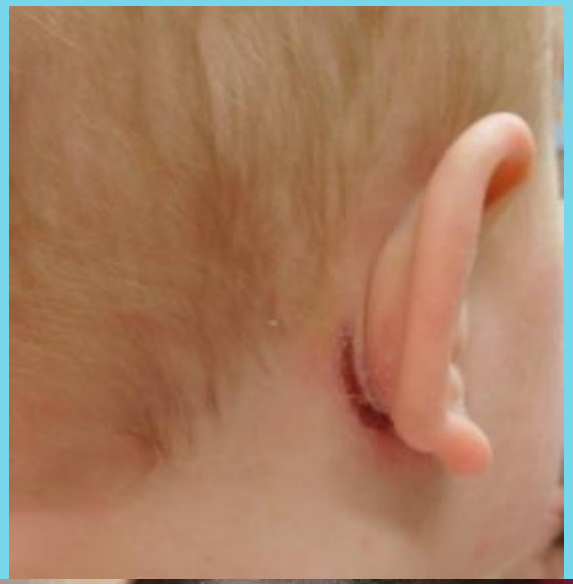
- Mauve
- Grey
- Darker than usual skin colour
- Paler than usual colour
- Dark brown
- Black
- Lichenified (thicker, rough, increased skin markings)
- Warm to touch
- It rarely looks Erythematous (red is difficult to see)

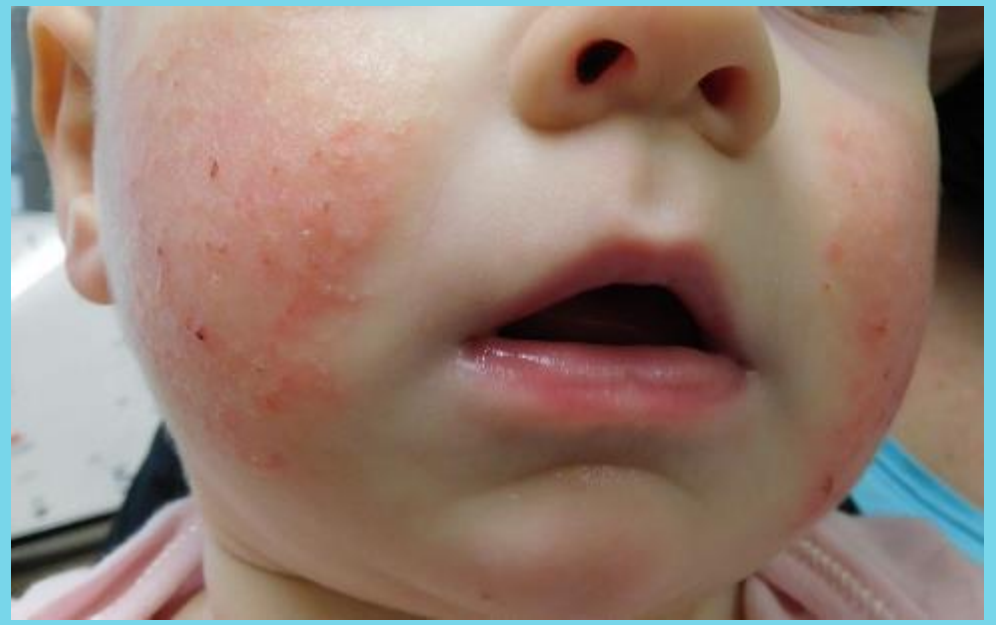


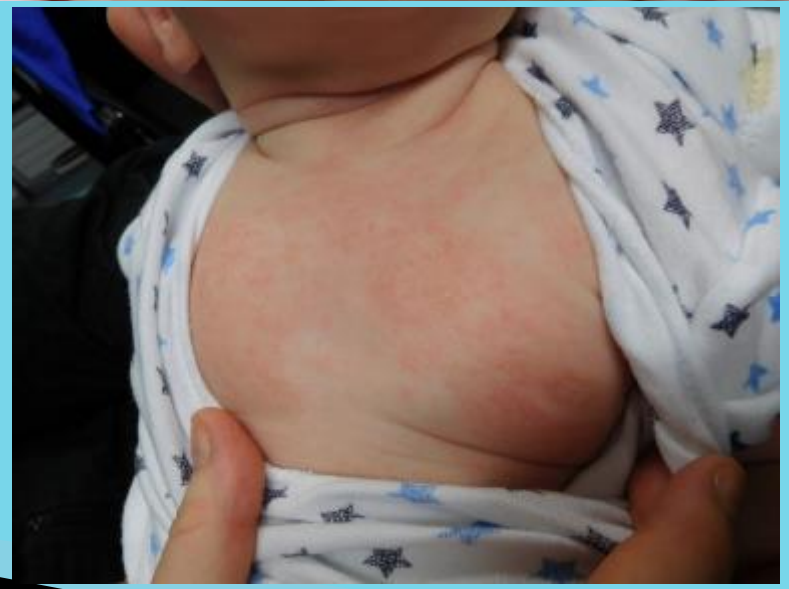


Urticaria : short-lived wheals

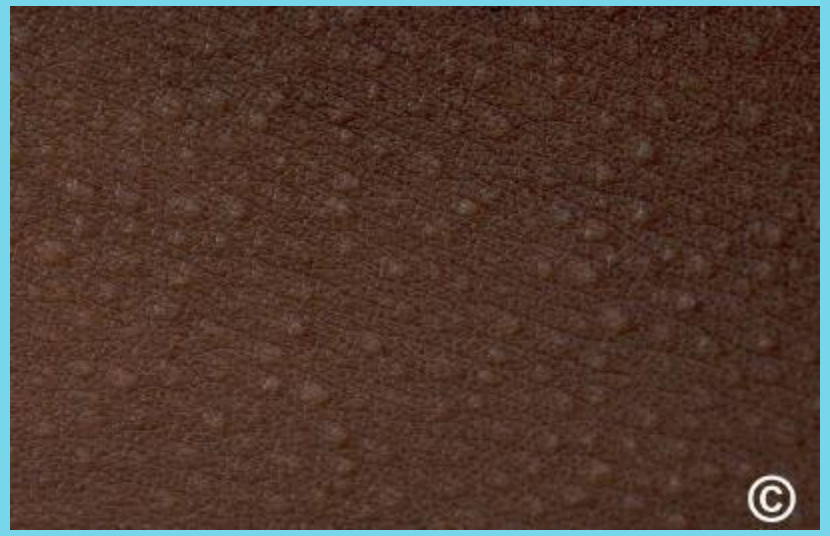
Atopic Eczema in Infants

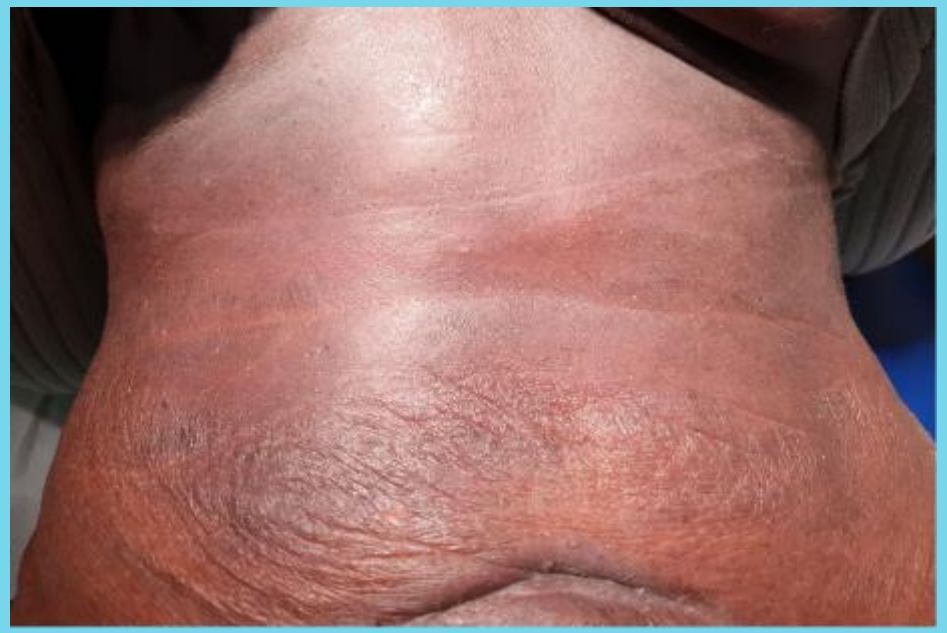


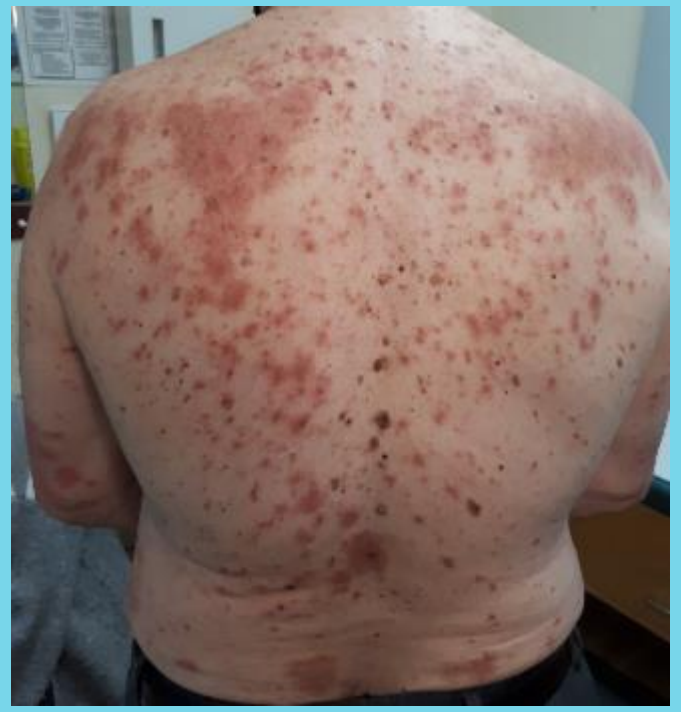


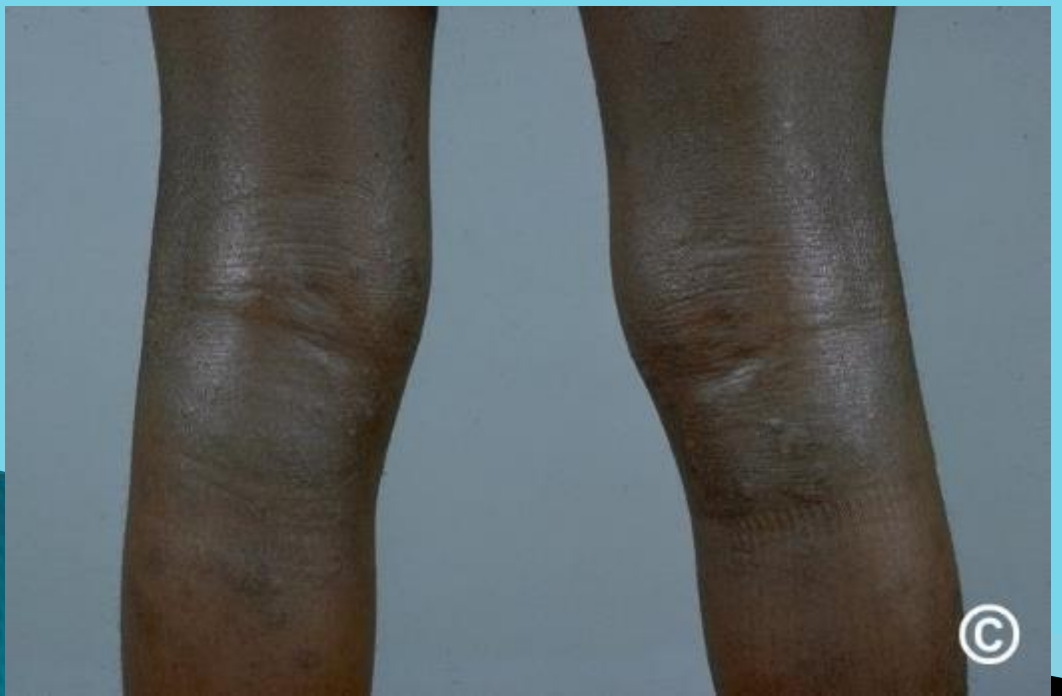


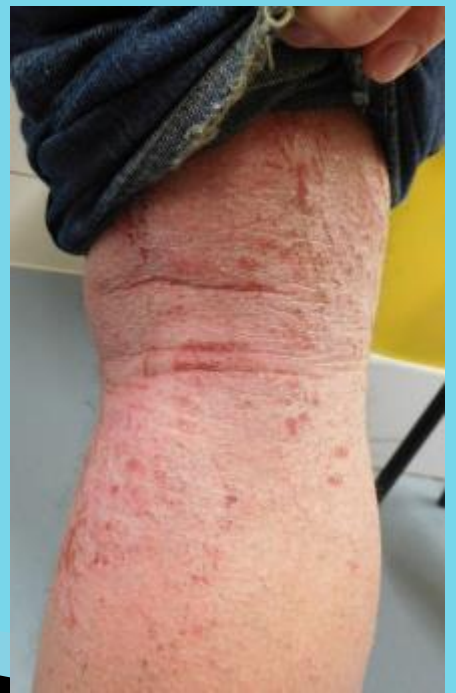
Eczema

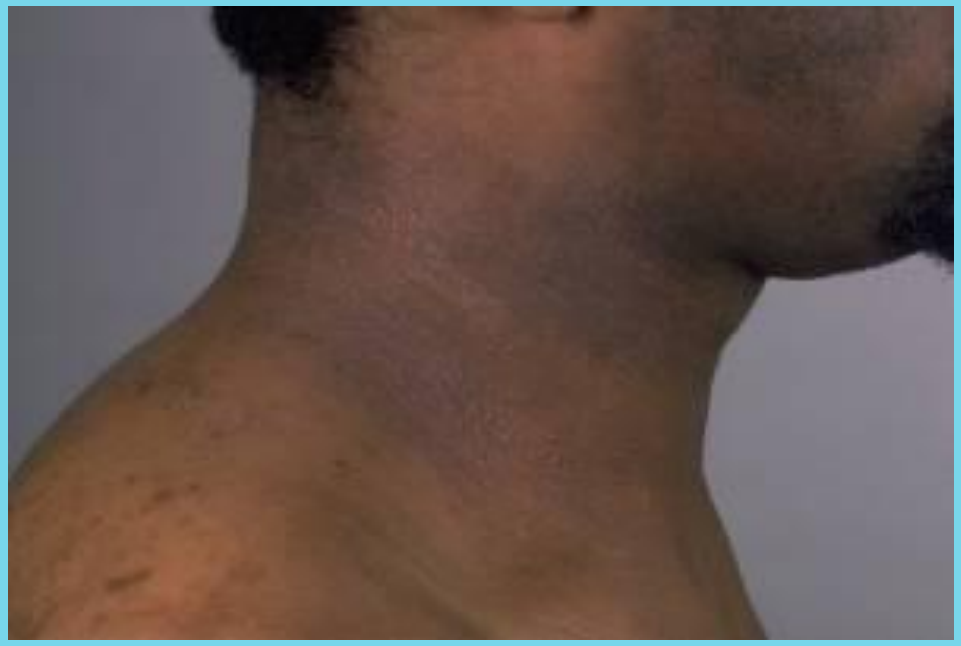




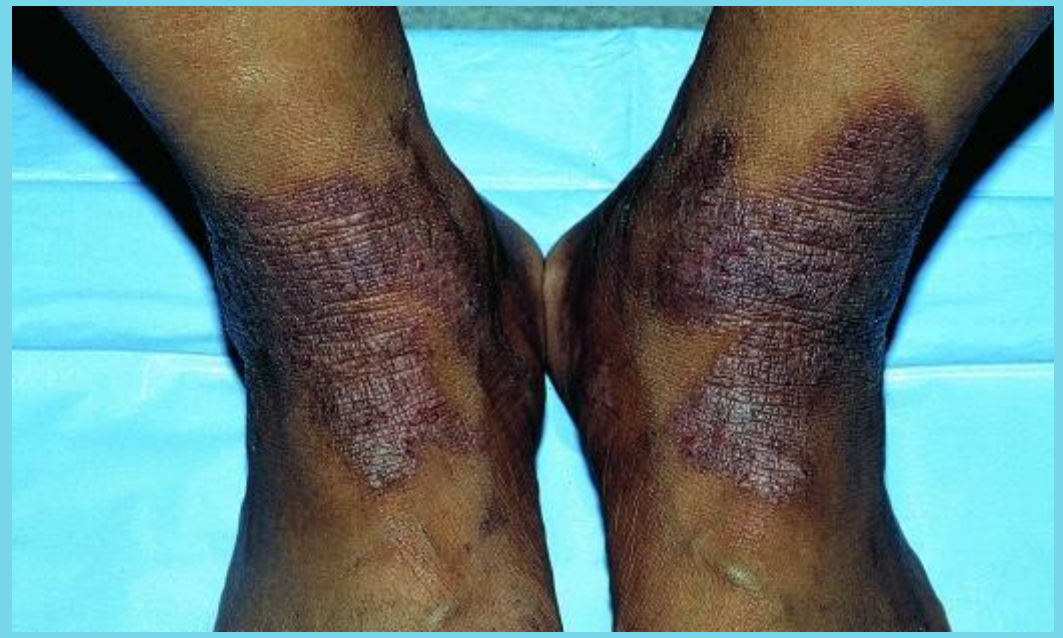


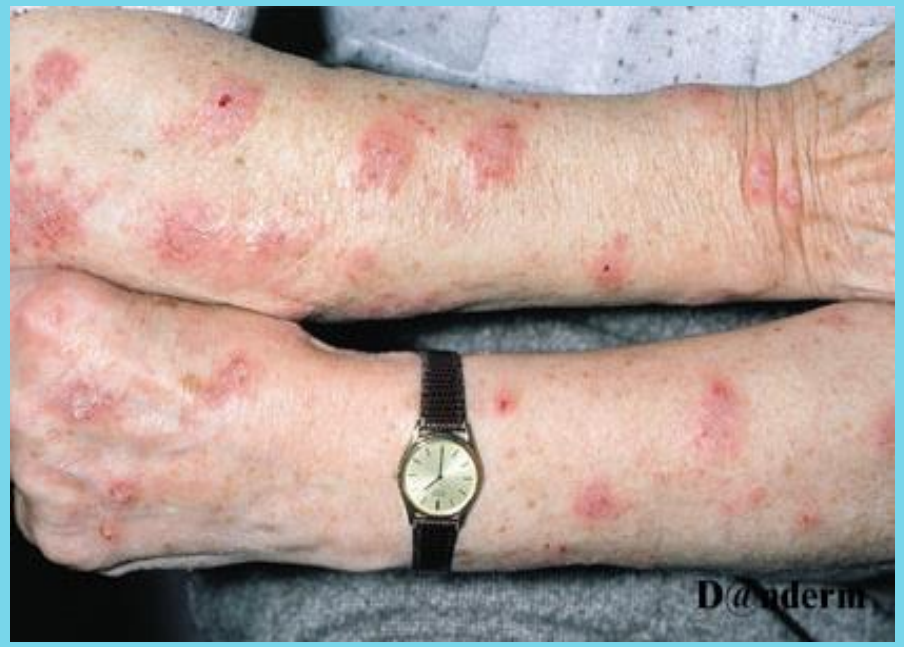


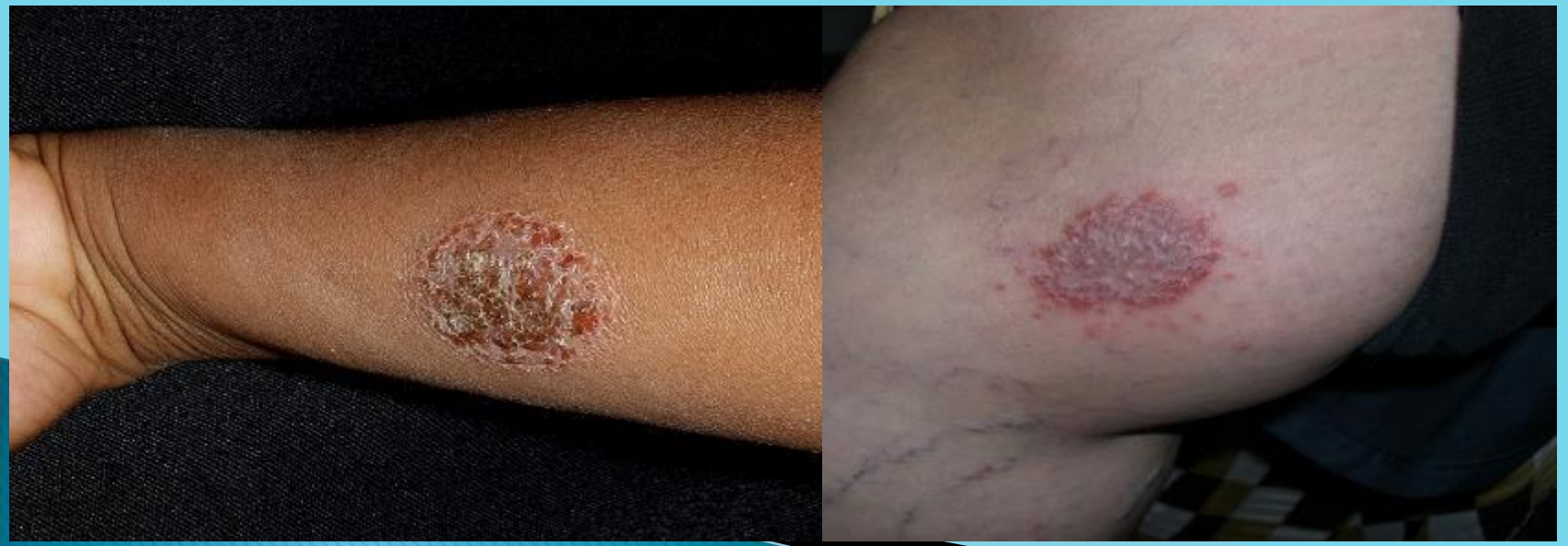




Lichen Simplex

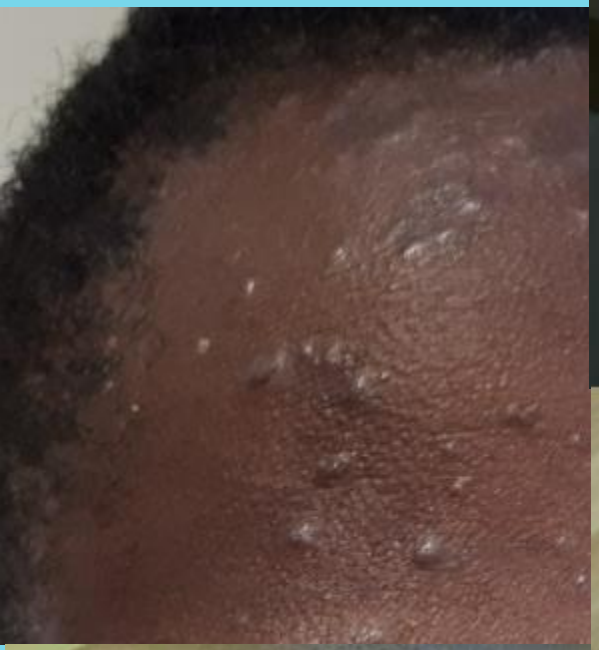


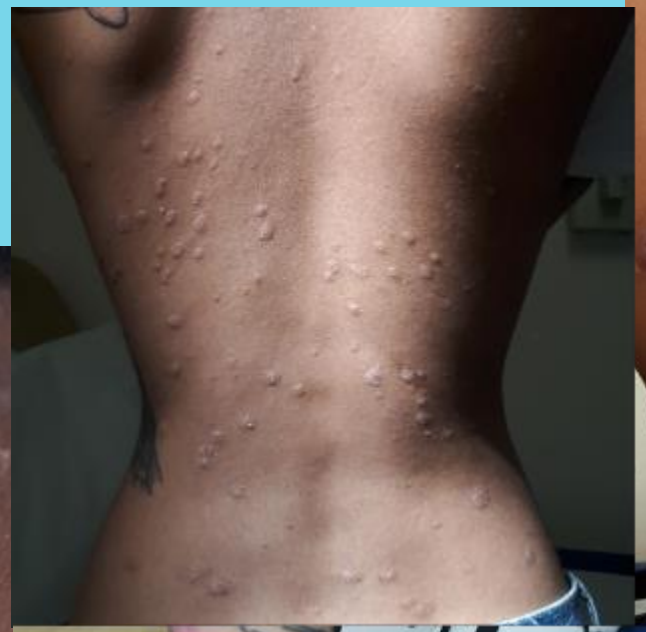


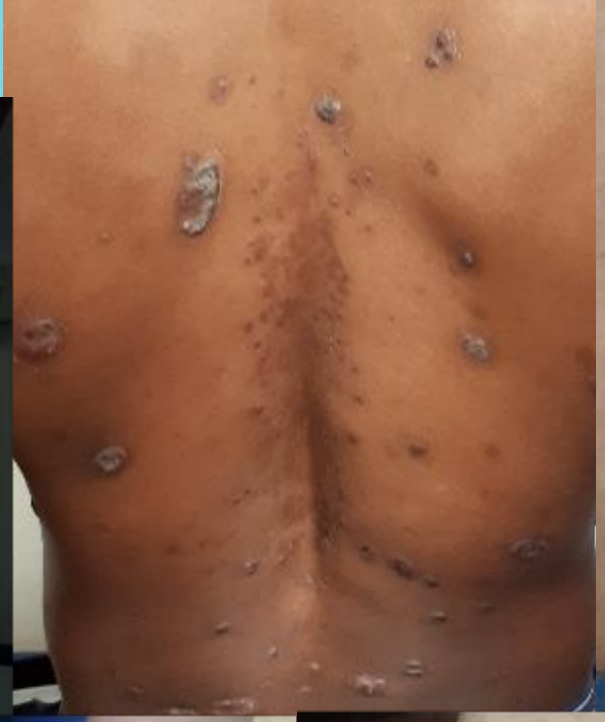


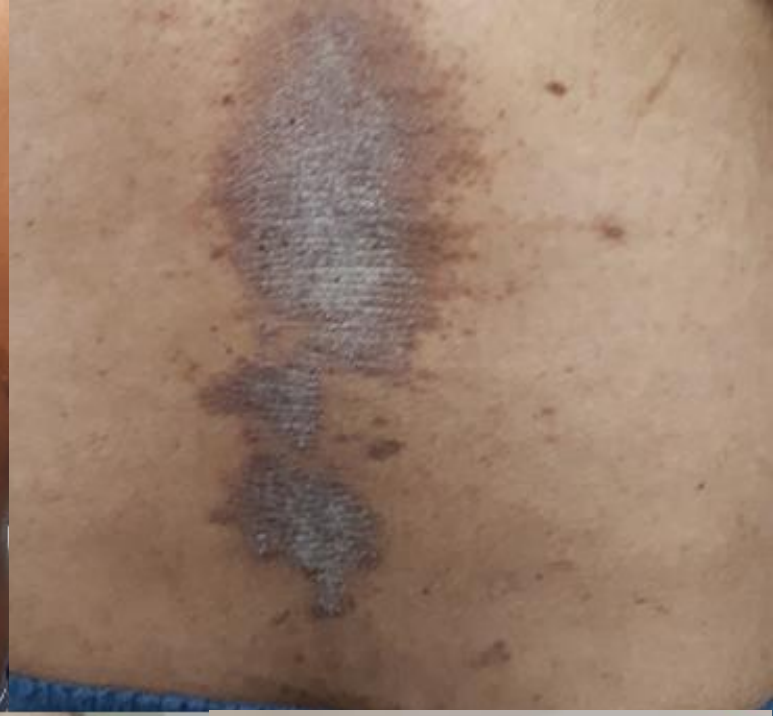
Discoid Eczema

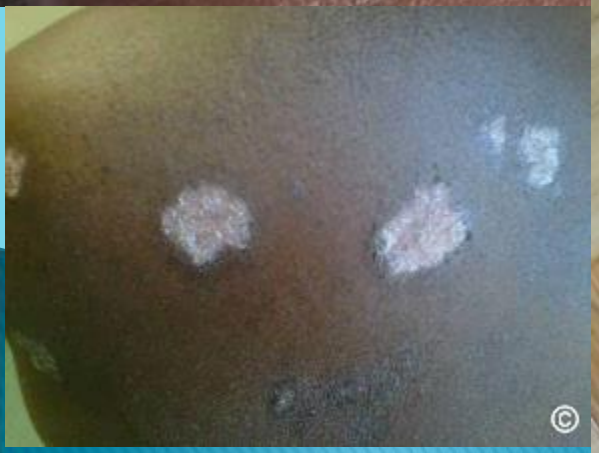
Psoriasis: Symmetrical Scaly,well demarcated

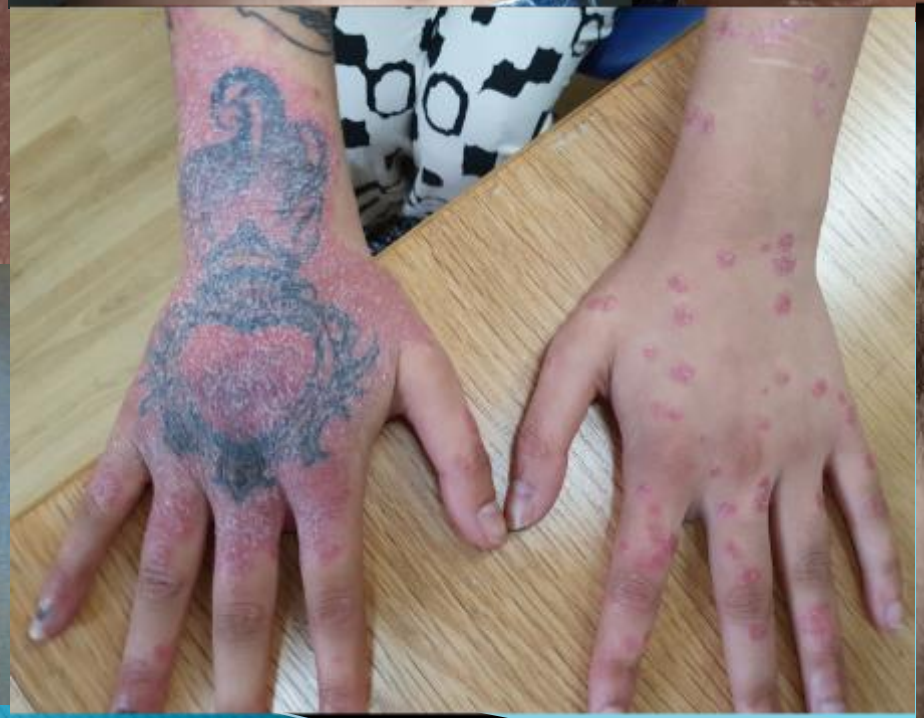


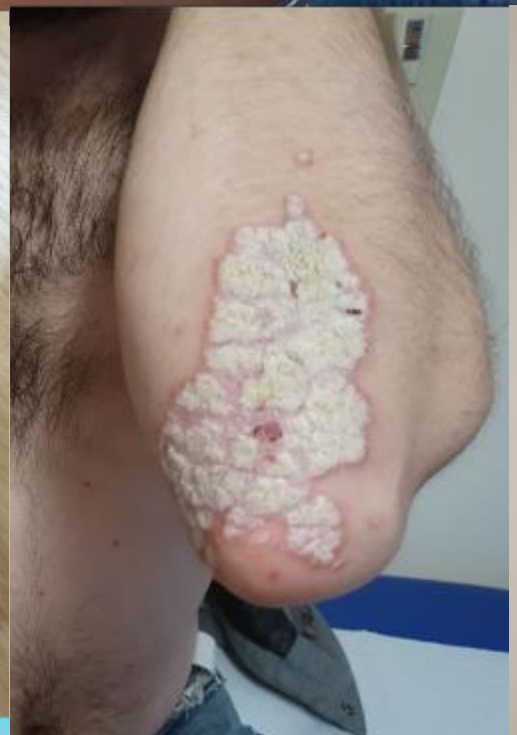


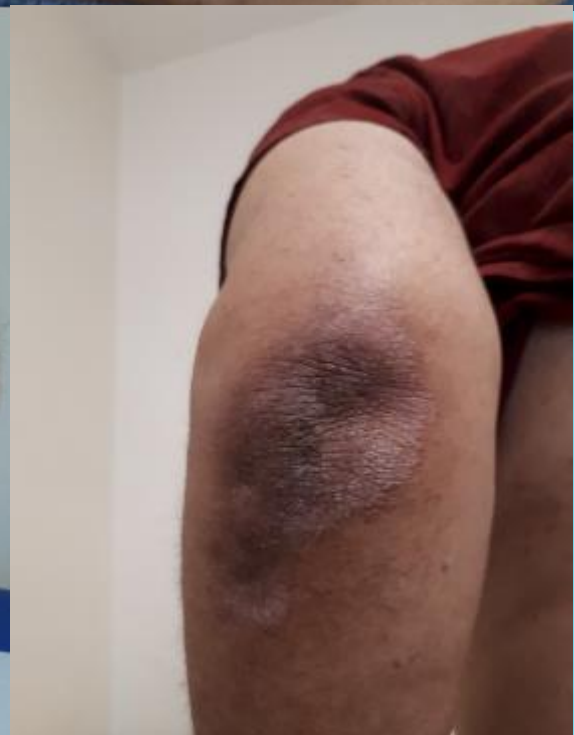


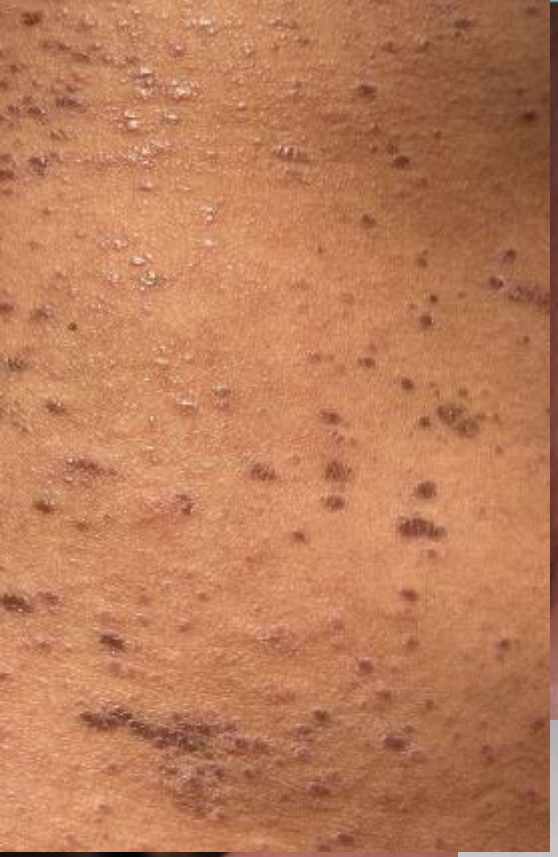


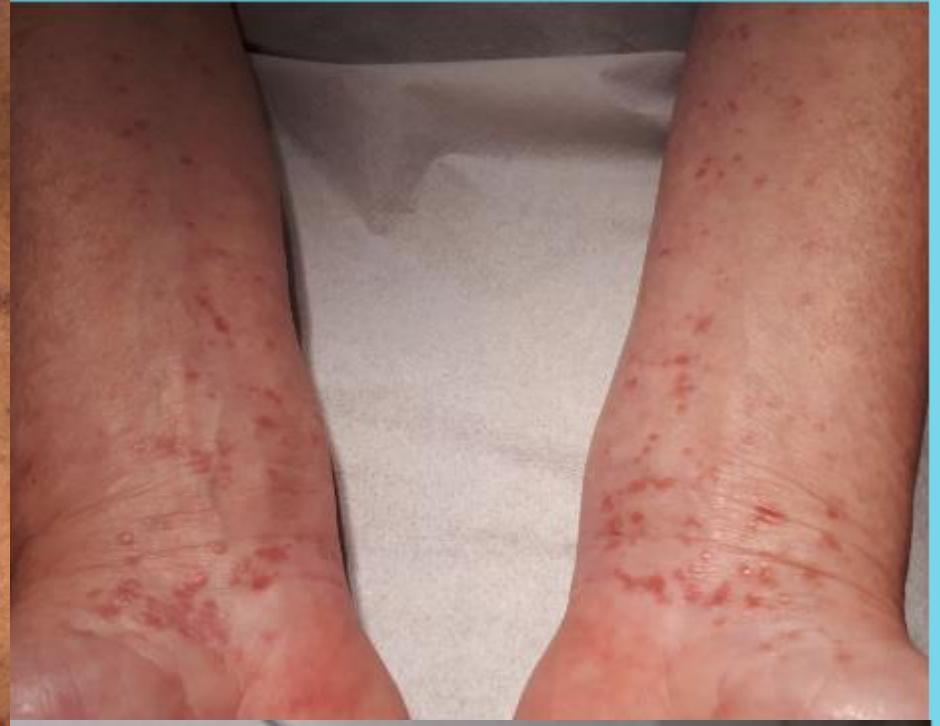


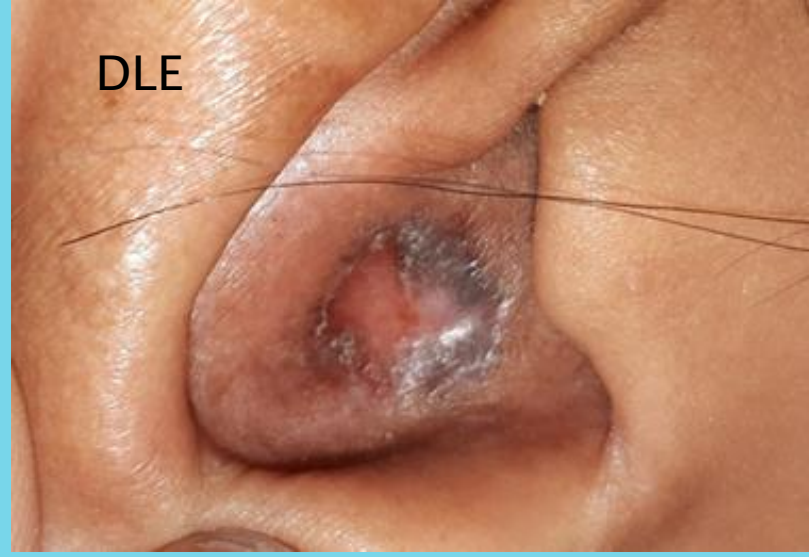


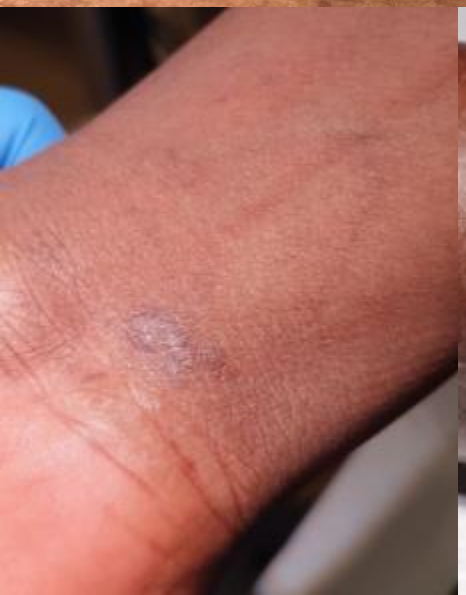


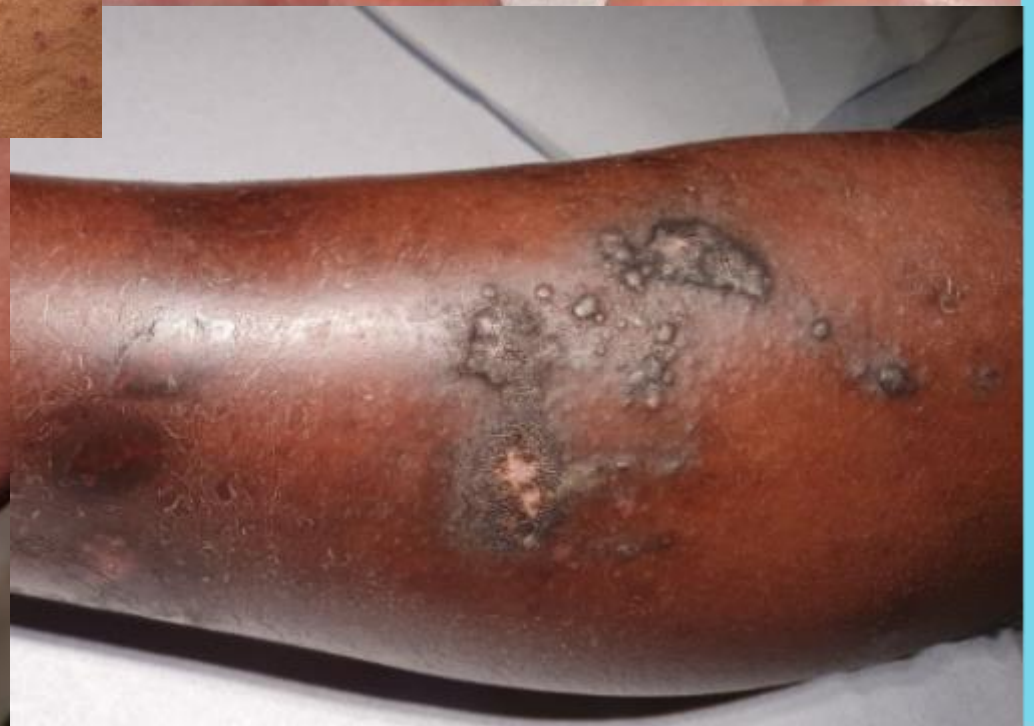






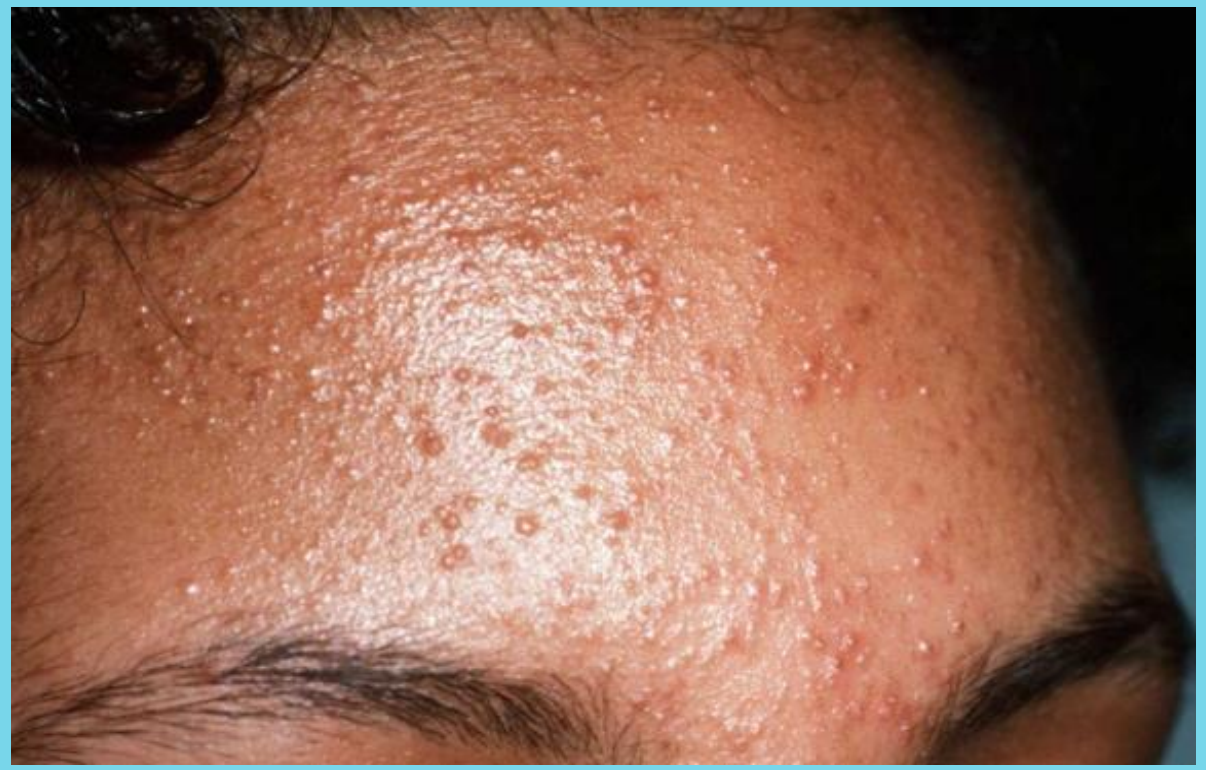


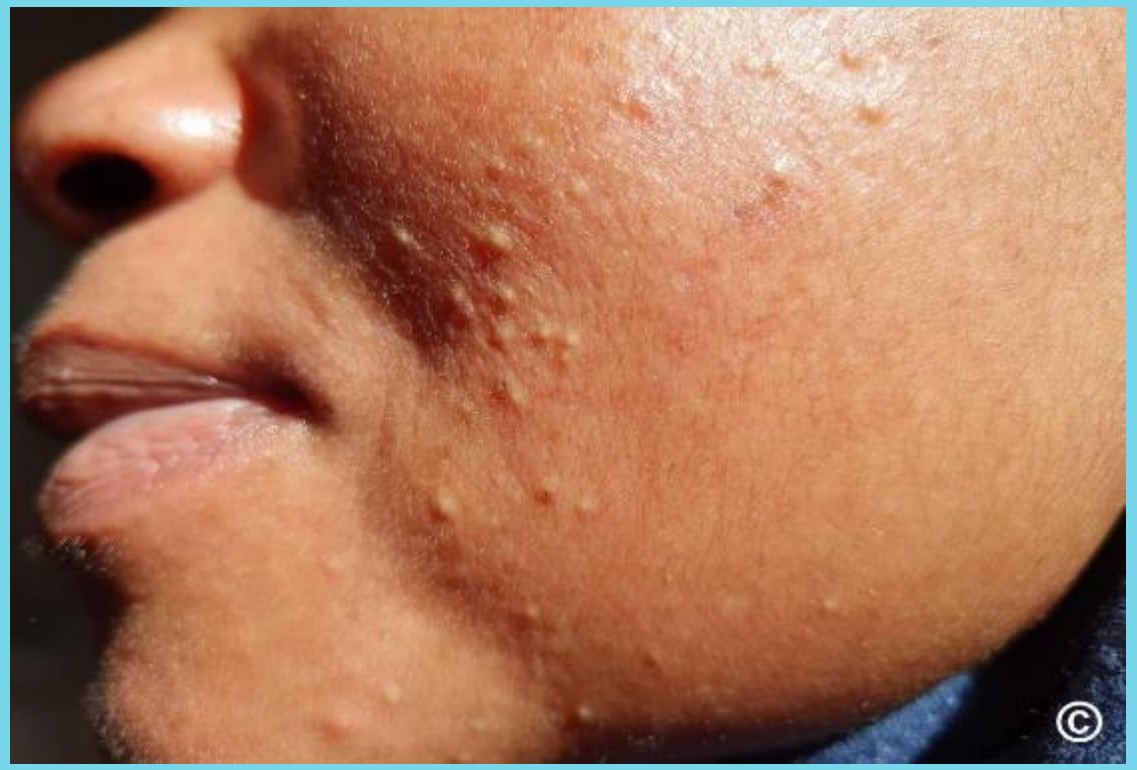


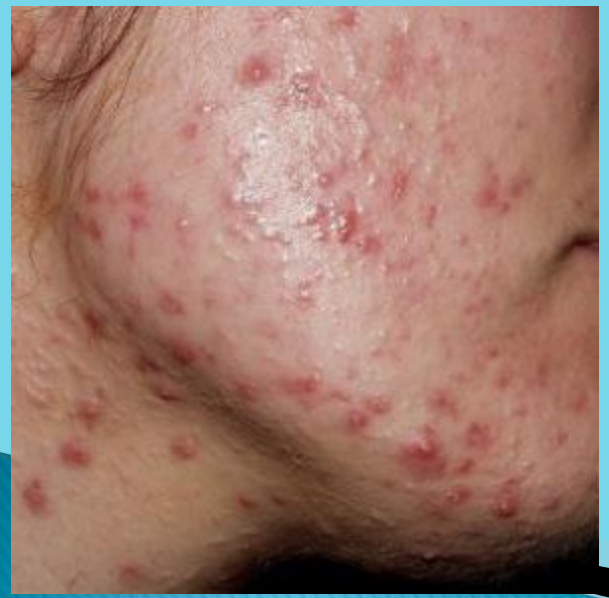


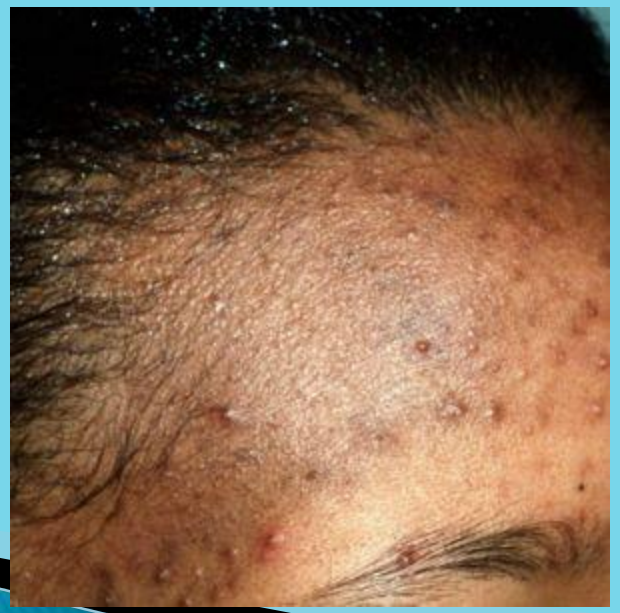
Lichen Planus

- Scalp,
- Mouth
- Wrists
- Ankles





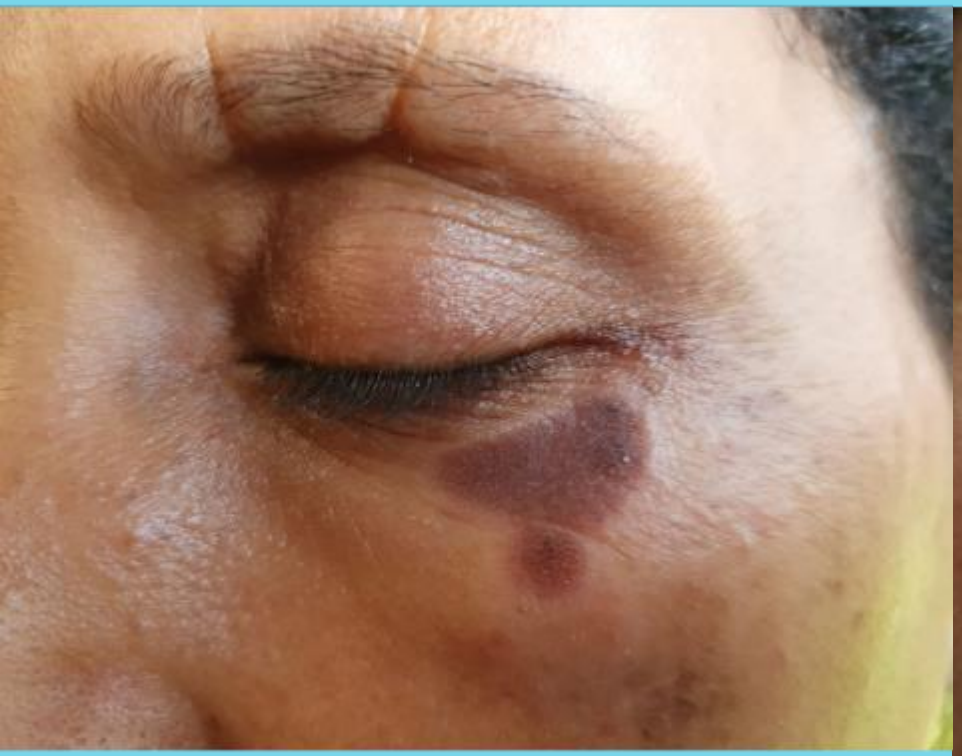


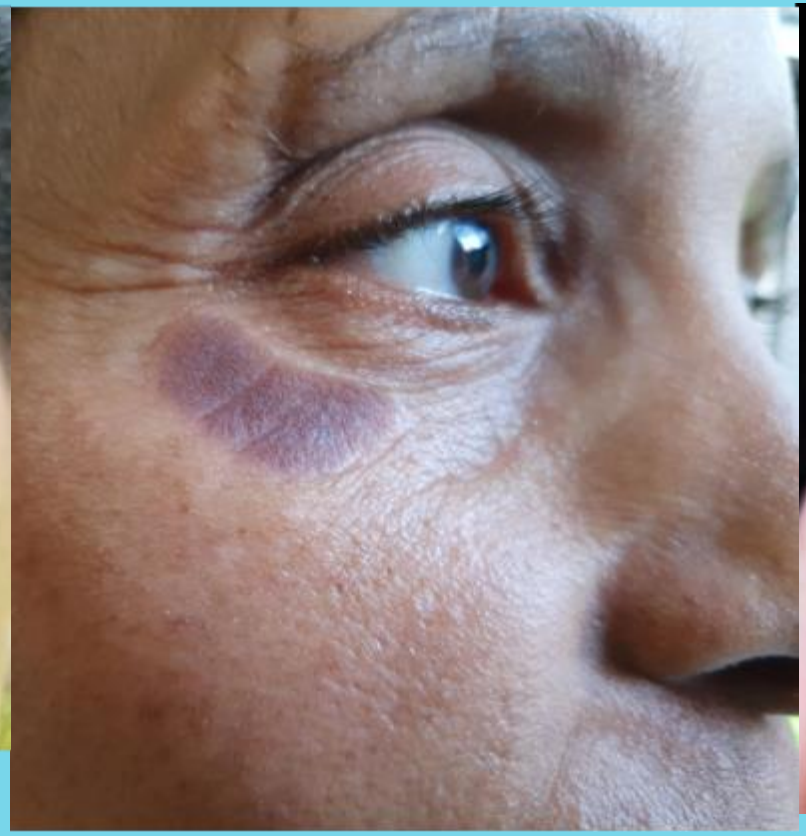


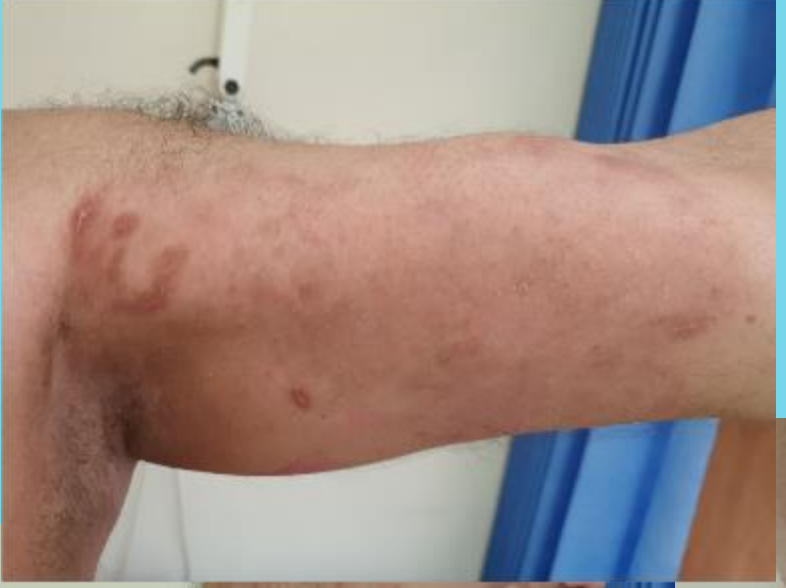
Acne

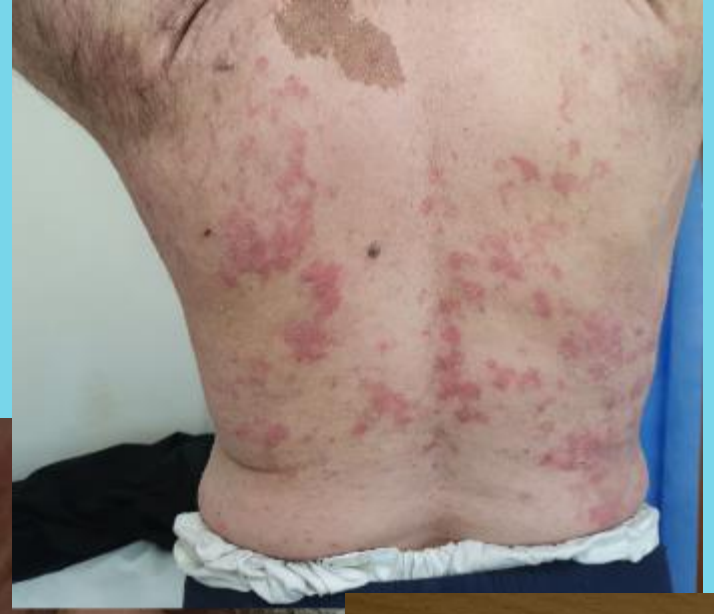
Comedonal acne
is inflammatory
in SOC
Tx Epiduo
Treclin, Duac

Why photos are useful





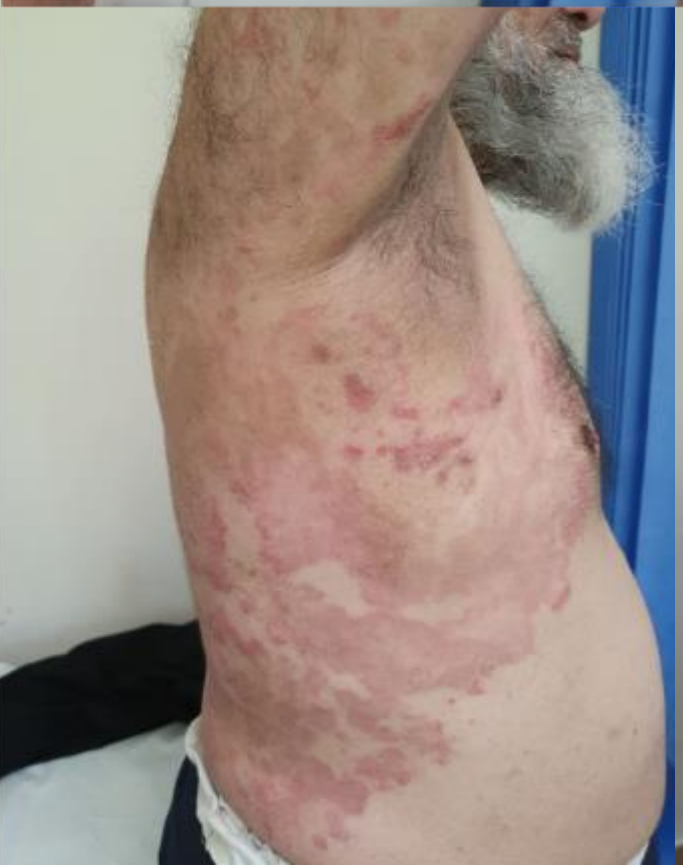


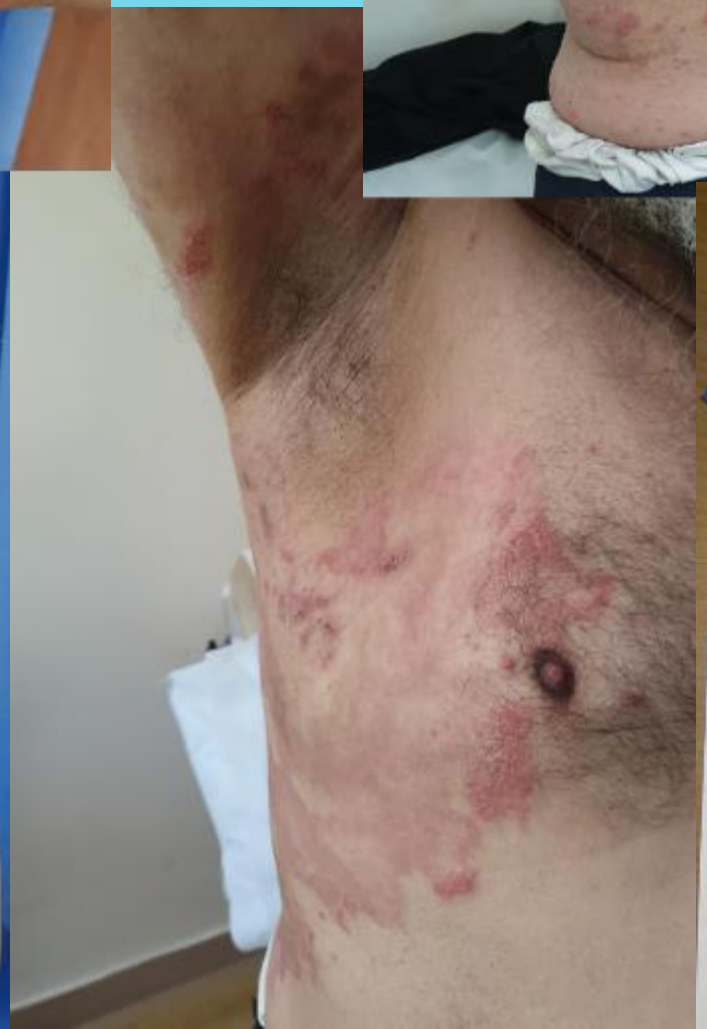


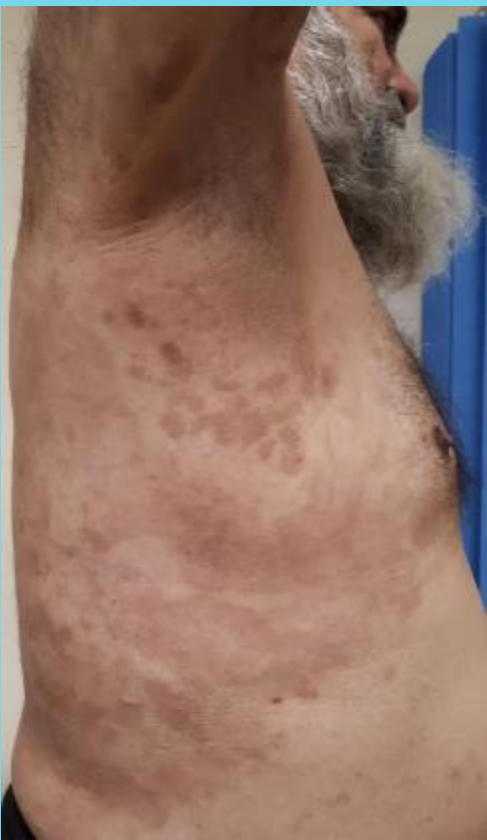
Why photos are useful

Asian, skin type V

→ Mycology (STH)







Rashes and other derm: advice or refer ?

- → Consultant connect with photo

- → Advice and guidance +convert to referral, with photo :

this allows us to give you advice AND to triage referral into a clinic (Community or sec care).. Include all details as below

- → Refer RAS with photo: include relevant current history, past derm history including where seen before; attach recent derm letters, meds.. + say what you need!

- Note referrals directly to Derm are rerouted to community RAS by KCH and GSTT

Rashes and other derm: need advice or refer

- → Refer RAS with photo: NB clinic wait will be 2-3 months

What about Urgent referrals ? Good news! ..

Outcomes:

→ Return more info needed (where seen, no photos, no letter..)

→ Return please do investigations eg swabs (? PVL) / Tx / Tx and rerefer asap

→ Advice, rerefer if needed once have implemented the advice

→ Advice + triage into Community .. FTF or telephone = Quickest way to phototherapy/ patch testing, iontophoresis

→ Advice + triage to General dermatology/ specialist clinic

→ Return: Non tap

What sort of advice might you be given?

Hair loss
Pruritus
Paediatric eczema

Dr Jo Cooper, Villa St GP, Trainee GPwER
Community Dermatology Southwark

Common screening tests in Dermatology

A quick eczema case

Dr Joanna Cooper

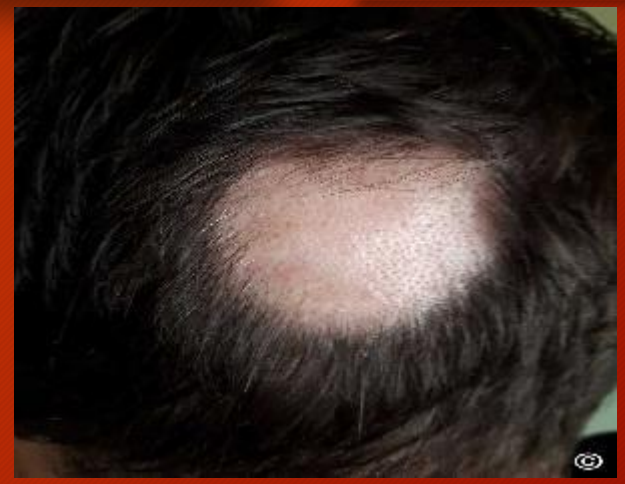
GP training to be a GPwER in dermatology

Common screens that we perform in the CDS

- Hair loss
- Pruritus

Hair loss

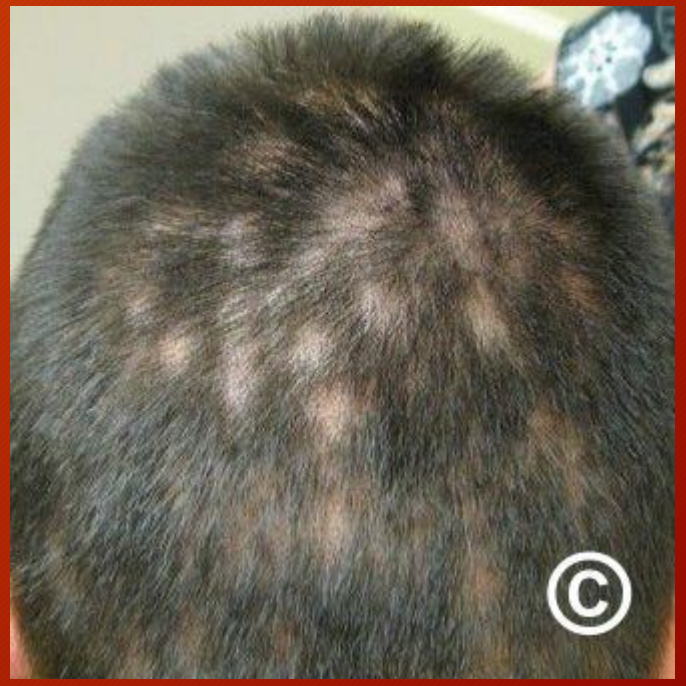
- Non-scarring – follicles intact – scalp may look normal
  - Alopecia areata
  - Female Pattern or Androgenetic
  - Telogen effluvium – acute or chronic
  - Trichotillosis
  - Traction
  - Tinea (kerion or scaling and erythema)
- Scarring – inflammatory process – follicles being destroyed
  - Symptoms - burning, itching
  - Signs – redness, scale (not exclusive), tufting, atrophy/shiny
  - Please highlight if you suspect this in referral so we can consider an urgent review



Both PCDS website

Hair loss bloods screen
For widespread generalised hair loss

- FBC + B12/folate/ferritin
- U&E
- LFT
- Hba1c
- Vitamin D
- Zinc
- TSH + antibodies
- ANA
- Hormone screen if signs of virilisation in FPHL – testosterone/SHBG/oestradiol/FSH/LH
- Consider syphilis for patchy hair loss



PCDS website

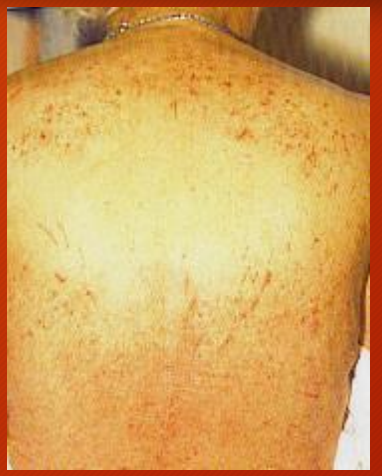
Hair loss – management

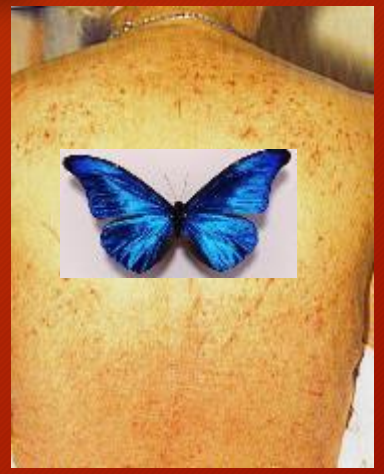
- Not all hair loss will require a referral
- The PCDS website has lots of useful guidance for management of the non-scarring alopecias

- Topical steroids are appropriate to use for scarring alopecias whilst the patient is waiting for their appointment

Primary Generalised Pruritus
Generalised itching without rash

- Dermatological/Systemic/Psychological causes
- Screen for symptoms of solid organ tumours and check for organomegaly/lymphadenopathy
- 50% idiopathic
- Dry skin is a common cause
- Check for burrows
- Can result in skin signs such as Lichen simplex or Nodular prurigo
- Consider urticaria as transient rash that may not be present at examination
- Common drug culprits: opiates, chloroquine, imatinib, ACE-I
- Test for dermographism





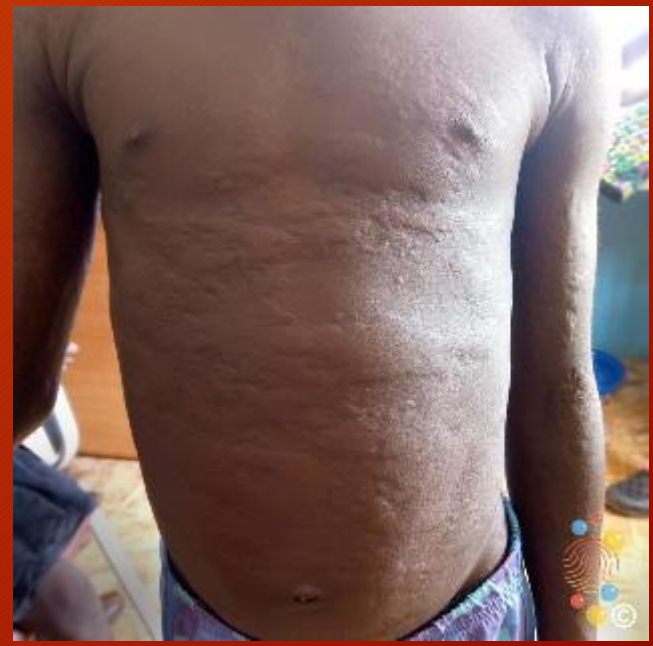
Both PCDS website

Pruritus screen – if generalised + >6/52

- FBC + B12 / folate / ferritin / iron +/- coeliacs
- CRP + ESR
- U&E
- LFT / bile acids
- Blood Bourne Viruses
- Autoantibodies inc Anti-mitochondrial antibody
- TFT
- Vitamin D
- Hba1c
- Bone
- LDH (1.5x upper limit)
- Myeloma screen
- CXR

Pruritus – management

- Advise to wash in luke warm water
- Cotton clothes
- Emollients +/- menthol, kept in the fridge & applied daily
- Anti-histamines if urticaria (up to 4x daily) or dermographic, sedating if affecting sleep
- Topical steroids can be helpful particularly in asteatotic eczema
- Always consider scabies and discuss the treatment protocol in detail including all household members/sexual contacts
- Switching from ACE-I to ARB can help and stopping any other culprit drugs where possible
- Refer if cause unclear or difficult to manage



A Case of Eczema

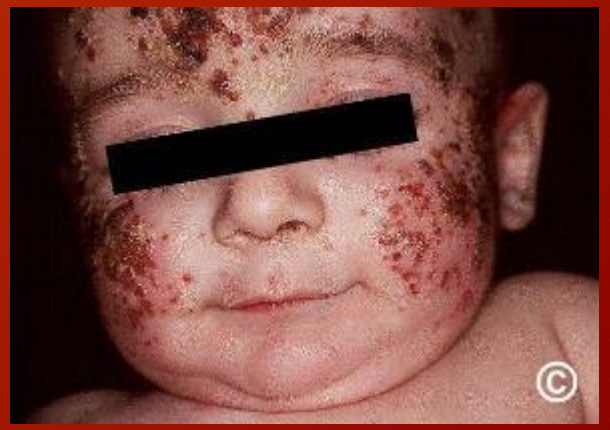
PCDS website

- 2 year boy seen in GP with widespread eczema
- Whole house is sleep deprived from unsettled child
- GP prescribes soap substitute, twice daily emollients and eumovate daily for 2 weeks
- Returns in 3-4 weeks – no real change to household wellbeing – demands referral
- GP agrees to referral and prescribes mometasone ointment whilst waiting
- Seen in SCDS 2 months later – skin is clear

A Case of Eczema – learning points

1. Go in strong with steroids and then peel back – builds confidence for the patient and for you!
2. Mometasone is fine on the body of children
3. Use steroids until the skin is looking and feeling near normal – this may take 6 weeks
4. Wean steroids down, either with strength or frequency, to reduce the risk of rebound
5. Discuss finger tip units – Pennines VTS / Patient UK
6. If the skin flares rapidly consider maintenance steroids twice a week
7. Topical tacrolimus is fine to use in the over 2s as a steroid sparing agent in localised sites

DermNZ website



PCDS website

Summary

- Consider the screens discussed today for pruritus and generalised hair loss before or at the point of referral
- Not all hair loss needs a referral
- Go strong with topical steroids and then review and wean down
- FTUs
- Consider steroid sparing agent
- Patient Resources | stjohnsdermacademy
- Alopecia (pcds.org.uk)
- https://selondonccg.nhs.uk/wp-content/uploads/dlm_uploads/2021/09/Dermatology-Guidelines-for-Primary-Care-FINAL-January-2020.pdf?UID=98623226520227723142 8

Thank you

PLEASE REFER TO THE SEL Dermatology Guidelines for Primary Care BEFORE COMPLETING THE CLINICAL DETAILS BELOW

Referral details

ACNE PRE-REFERRAL CHECKLIST *PLEASE DOUBLE CLICK THE GREY BOX AND SELECT AS APPLICABLE:*	YES	NO
Acne with nodulo-cystic change, scarring or causing severe psychological distress? Patient has tolerated topical treatment with oral antibiotics at the right dose for 3 months (if moderate to severe), or 6 months (if mild-moderate?) *Please include details of treatment/ dosage/ frequency in eRS referral*	☐ ☐	☐ ☐
Do you think that the patient should be considered for Oral Isotretinoin? If yes, if your patient is female, please discuss need for very effective contraception? (Avoid POP as worsens acne)	☐	☐

If the answer is NO to any of the above please indicate in eRS letter why you are referring now

ECZEMA PRE-REFERRAL CHECKLIST *PLEASE DOUBLE CLICK THE GREY BOX AND SELECT AS APPLICABLE:*	YES	NO
The patient has excluded external irritants & used an emollient as soap	☐	☐
Have you prescribed plenty of emollients/ appropriate topical corticosteroids?	☐	☐

If you have answered No to any of the above please indicate in the eRS letter why you are referring e.g. Time off school, poor growth, repeated infective episodes, significant family distress and persistent disrupted sleep

PSORIASIS PRE-REFERRAL CHECKLIST *Patients fulfilling **ONE** of the following should be considered for specialist referral* *PLEASE DOUBLE CLICK THE GREY BOX AND SELECT AS APPLICABLE:*	YES	
There is diagnostic uncertainty	☐	
This is a new diagnosis in a young person aged < 18 years	☐	
The patient has **SEVERE** or **EXTENSIVE** of any type (>10% of body surface area is affected.)	☐	
The patient has any type of psoriasis not controlled with topical therapy	☐	
The patient has guttate psoriasis requiring phototherapy (consider early referral)	☐	
The patient's psoriasis is having a major impact on their person's physical psychological or social wellbeing (for example, DLQI 10+, distress or depression).	☐	DLQI
The patient has nail disease that is having a major functional or cosmetic impact.	☐	

Clinical pearls

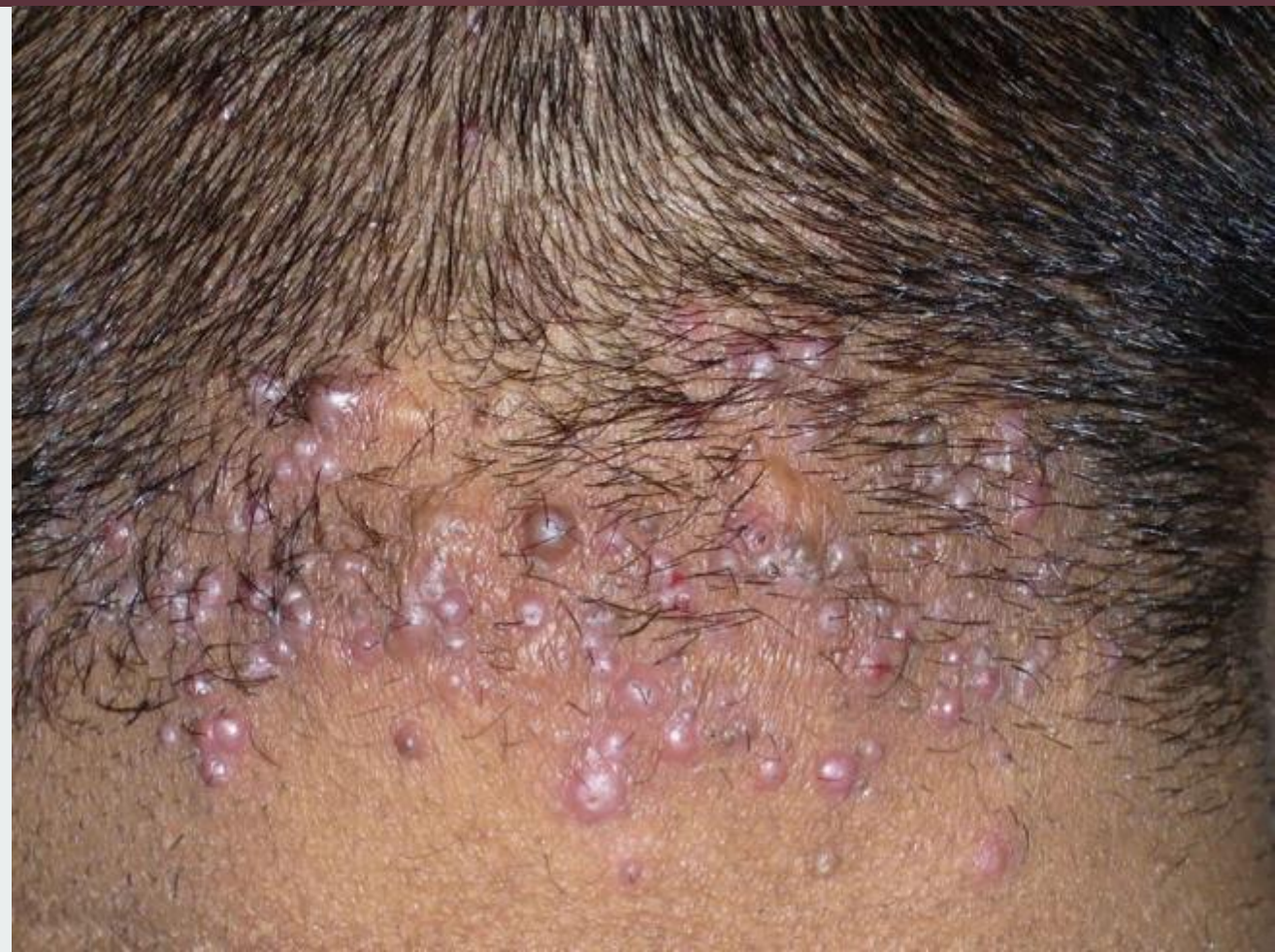
Dr Amr Salam

Consultant Dermatologist and Honorary Senior Lecturer

St John's Institute of Dermatology at Guy's and St Thomas' NHS Foundation Trust

Clinical case

- 28yo
- Type V skin
- 8 months, itchy, sore, weepy bumps on back of head
- Fit and well



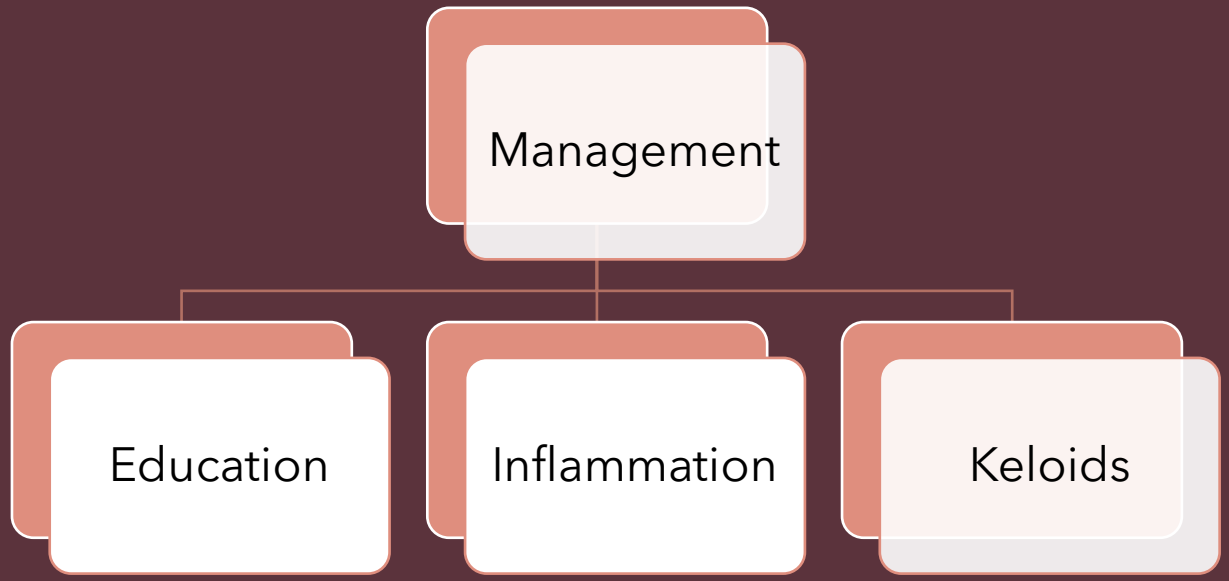
Approach

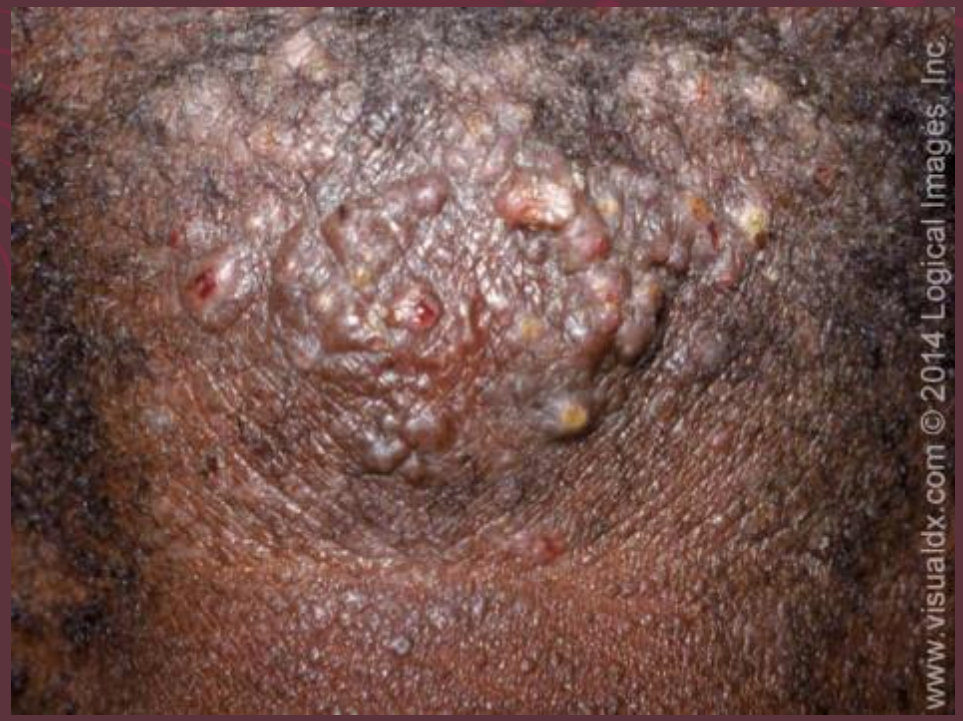
- History
  - Chronicity
  - Inflammatory activity
  - Hair grooming practices + antisepsis
  - Headgear
  - Smoking

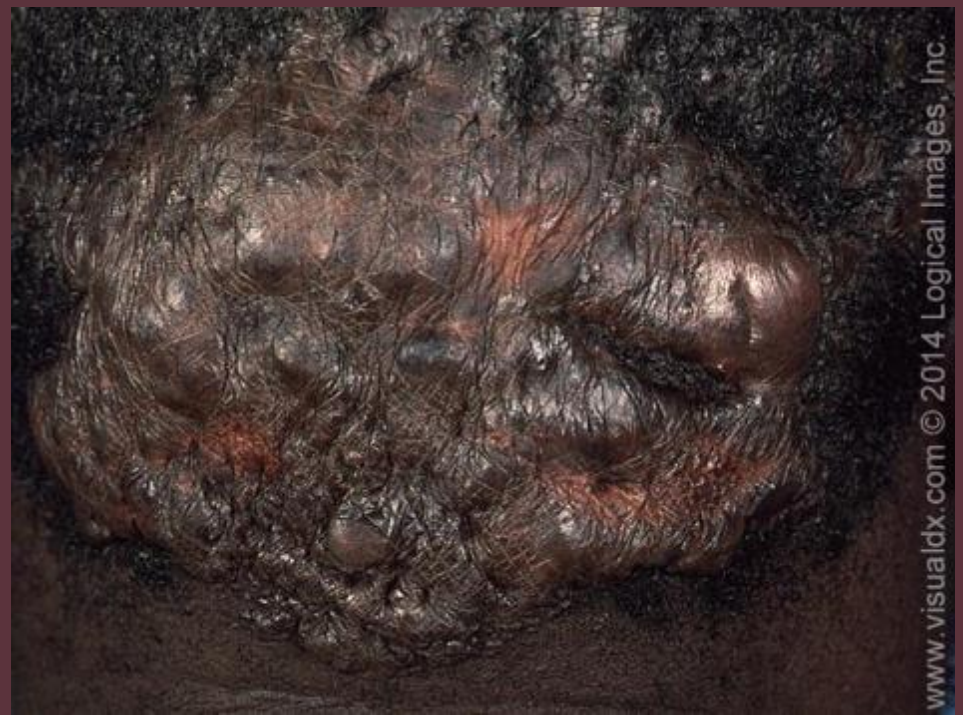
- Examination
  - Beyond scalp?
  - More keloidal or inflammatory?

Management

- General principles
  1. Avoid exacerbating factors
  2. Treat the inflammation
  3. Treat the scarring

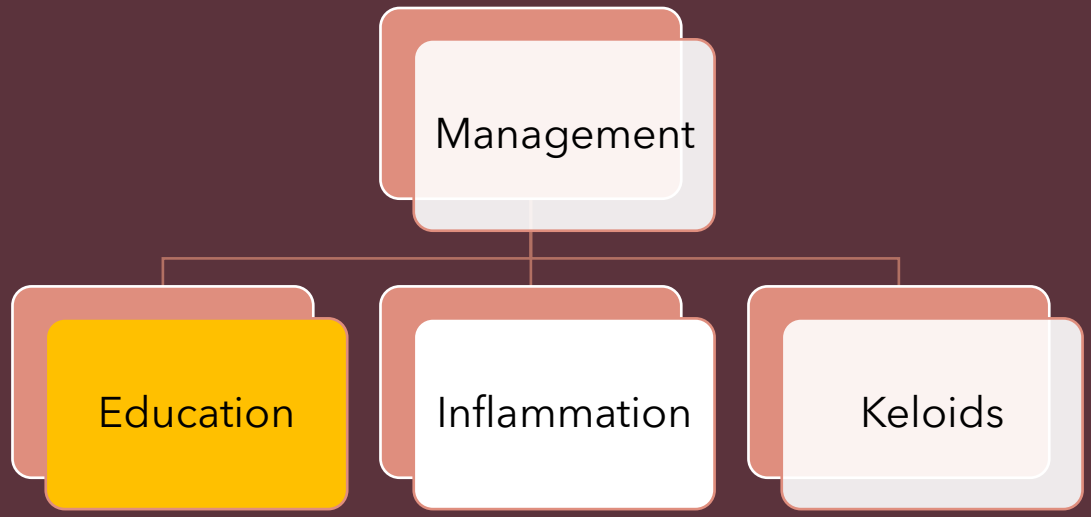






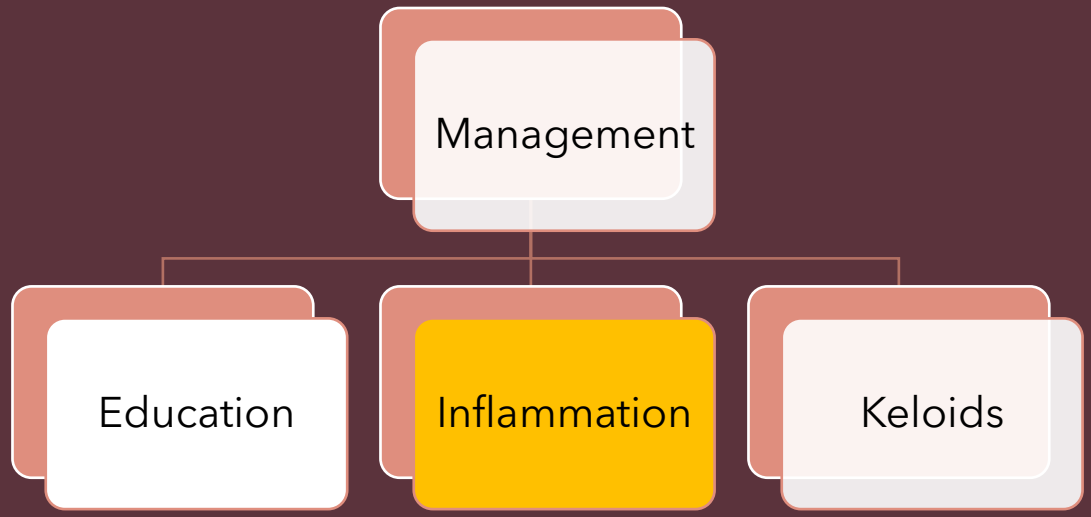
Management – 1) Education

- Avoid aggravating factors
  - Avoid razor/ close shave haircuts
  - Get own trimmers
  - Sterilise trimmers
  - Smoking cessation
  - Avoid friction: hats, helmets, tight collars



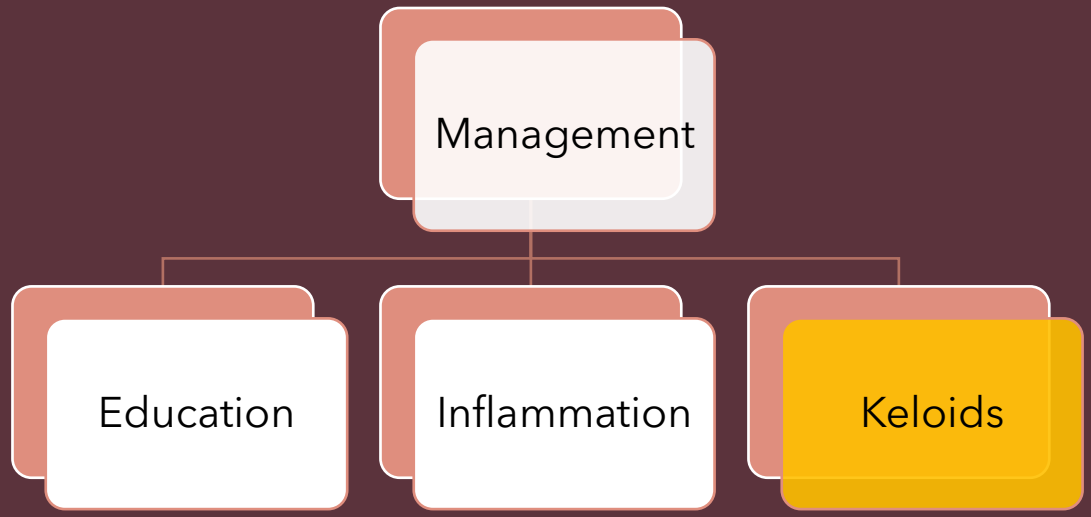
Management – 2) Inflammatory component

- Treat the inflammation
  - Steroids
    - **Topical**
    - Intralesional
  - Antimicrobials
    - **Mild? Antibiotic lotion**
    - **Mod/severe? Oral tetracycline**
    - **Antiseptic wash**
  - Retinoids
    - **Topical**
    - Oral isotretinoin
  - Surgery
  - Laser



Management – 3) Keloidal scarring

- **Topical corticosteroids**
- **Intralesional steroids**
- Surgery + intralesional steroids
- Surgery + radiotherapy



Spironolactone

Spironolactone - Principles

- Aldosterone antagonist
  - Diuretic + antiandrogen effect
  - New to the SEL Prescribing Guidelines
  - 30-50% reduction in sebum excretion

- Effective therapy for acne
- 2/3 have a >90% improvement
- **Isotretinoin still first line for mod/severe & scarring acne**

- Useful therapy for acne
  1. Patients who have failed, intolerant or relapsed after oral antibiotics
  2. Patients who are not candidates for isotretinoin
  3. Hormonal acne

Spironolactone - Prescribing

- Dosing
  - 25-50mg daily initially
  - Escalate as tolerated aiming for 50-100mg daily
  - Can go up to 200mg daily
- Monitoring
  - Bloods only if risk factors, I do baseline
- Response
  - By 3 months, max by 5 months
- Side effects
  - In 10% of patients
  - Menstrual irregularity – can add COCP
  - Dizziness + fatigue
    - Diuretic effect can benefit pre-menstrual water retention
  - No increased risk of breast, uterine or ovarian cancer in 2 big studies
  - Feminisation of the male fetus - only in animal studies, unlikely in <100mg daily, 100-200mg unclear, >200mg has been reported

Spironolactone – what is expected of GPs?

- Dosing
  - 25-50mg daily initially
  - Escalate as tolerated aiming for 50-100mg daily
  - Can go up to 200mg daily
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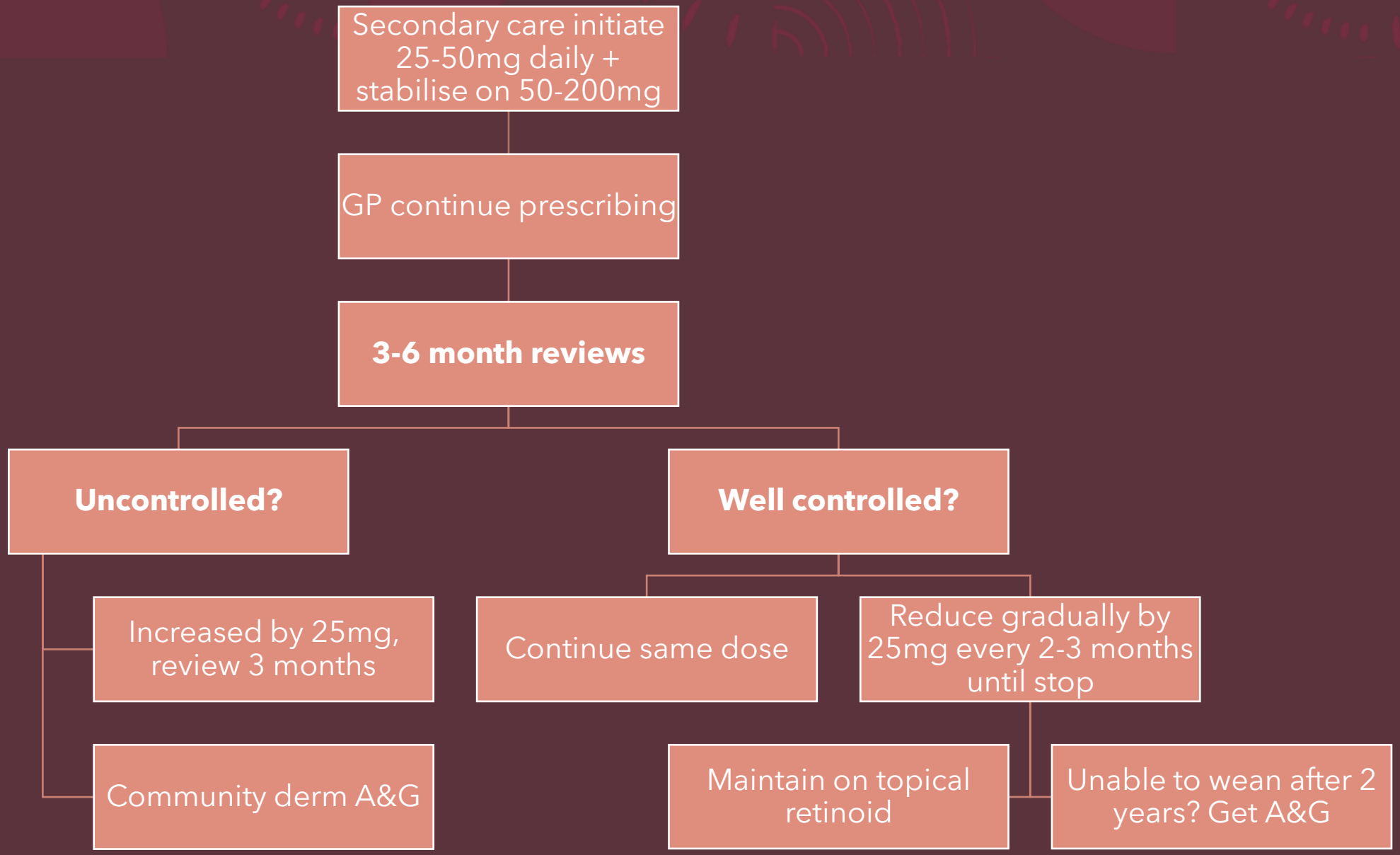
  - No increased risk of breast, uterine or ovarian cancer in 2 big studies
  - Feminisation of the male fetus - only in animal studies, unlikely in <100mg daily, 100-200mg unclear, >200mg has been reported

Spironolactone – practicalities flowchart



An Epilogue :Prescribe with care

- Botox.. No longer available in SEL for hyperhidrosis
- Miradry.. Not available in SEL for Hydrohidrosis
- But can refer for iontophoresis and for craniofacial hyperhidrosis can prescribe Glycopyrollate 2% in Cetamacrogol A cream (BAD special)

- For Hyperkeratosis of hands or feet we may ask you to prescribe: Salicylic acid 5% w/w / propylene glycol 47.5% w/w in clobetasol propionate 0.05% (Dermovate®) cream

If you vary the concentrations they become MUCH more expensive!

Coming up:

- International dermoscopy: Zoom Sat 21st January 2023 All Events (pcds.org.uk) This w/e!
- Hair Thurs 26th January 2023 Dr Syreeta Daw GPwER 1-1.45pm Zoom GPs/ ANP Next week!

Contact: Dermatology Teaching for South East London GPs Tickets, Multiple Dates | Eventbrite

- All PCP Skin club (Thurs 9th Feb PCDS, 7pm : Zoom (1.5hrs) Contact : pcds.org.uk
- All PCP: Dermatology from Scratch (PCDS): April 27th (Manchester), November (London)
- MedShr: Bite sized learning for HCP : PCDS Dermatology from Scratch – Clinical Confidence for All (medshr.net)
- Where Dermatology meets Rheumatology and Musculoskeletal medicine
  PCDS : Wednesday 21st June 2023: Central London All Events (pcds.org.uk)
- Comm Derm Southwark: Lunchtime recorded Zooms 22nd Feb, 24th March 1.30-2.30pm
  Look out for these in the ICS weekly bulletin: Management of actinic keratoses, genital dermatology, case discussions, Topical Calcineurin inhibitors & Eczema,/ Psoriasis, Lichen Planus, Vitiligo… Hyperhydrosis.

Dermatology from scratch (general dermatology for all HCP)

Join https://medshr.it/RpfVFZ6BvtbMedshr

Skin lesions, PCDS:A-Z Appendageal tumours (pcds.org.uk)

PCDS Dermoscopy Events (pcds.org.uk) :

Dfab for absolute beginners

DFI/Adv for Intermediates/ advanced

Lots of information on PCDS web site!

PCDS members can join the Dermoscopy Facebook group

www.pcds.org.uk

Resources that will be shared (If underlined: ctrl & click)

- SEL Primary care dermatology guidelines PDF
- PCDS Top 30, A-Z Concise guidance: National Primary Care Treatment and Referral Guidelines for Common Skin Conditions (pcds.org.uk)
- PCDS QR code PILS QR-Code-Poster-A4.pdf (pcds.org.uk)
- Patient Resources | stjohnsdermacademy videos & pdfs Topical steroids, emollients, scalp treatments
- Taking good photos: for patients : PDF and video Taking a good clinical image – YouTube
- A-Z Conditions & Treatments - BAD Patient Hub (skinhealthinfo.org.uk)
- Gst-tr.communitydermatologysouthwark@nhs.net
- ERS/ Photo-saf upload: training for administrative team PDF
- Telederm PIL

The Primary Care Dermatology Society

Making your Skin Better

Simply Scan the Relevant QR Code

A guide to skin cancer and self-examination

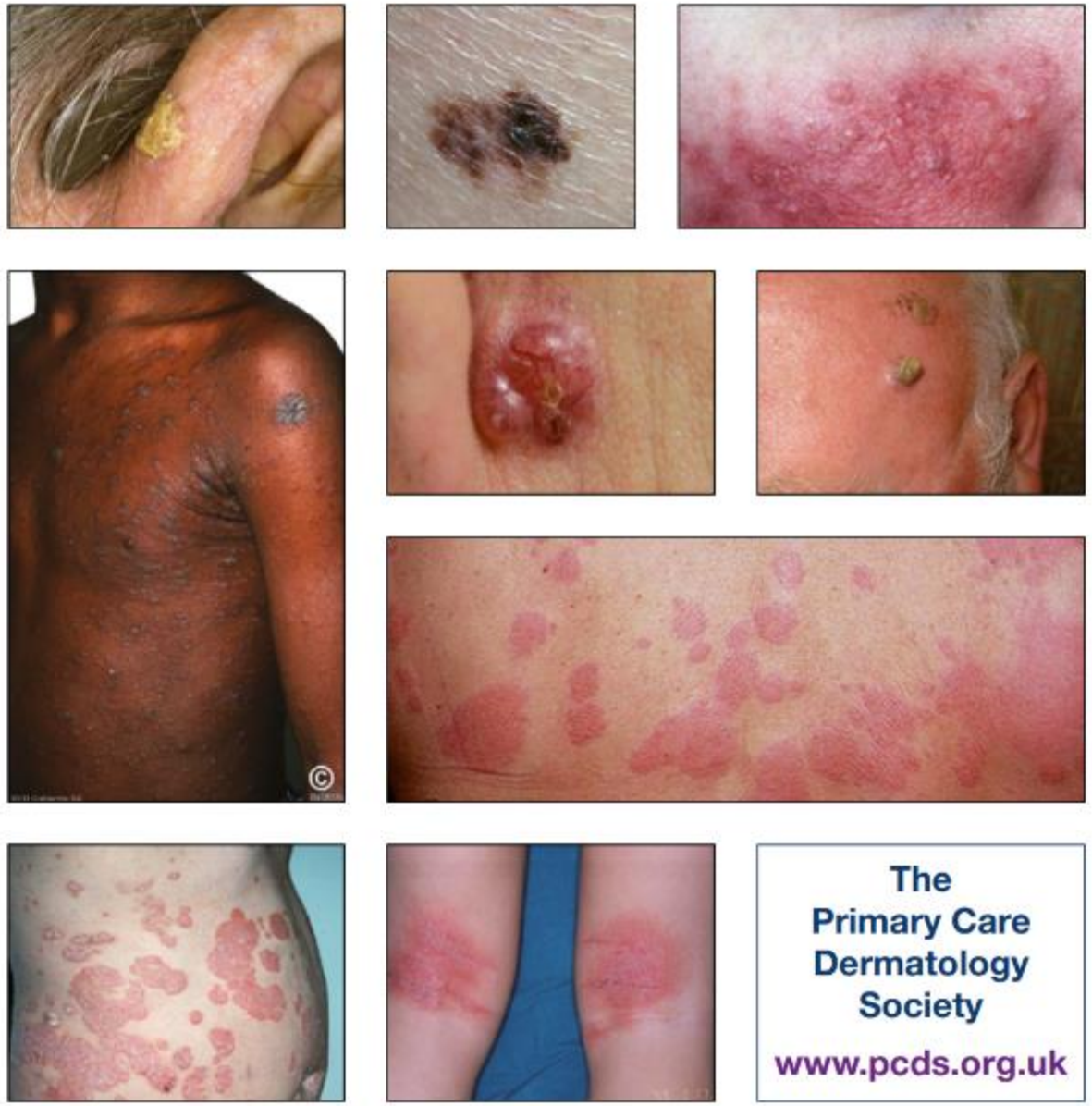
Diagnosing moles, skin lesions, lumps & bumps

Diagnosing skin rashes, other skin changes, hair & nails conditions

Patient information leaflets for common skin conditions

Treatment of common skin conditions

One of the world's leading websites in the management of skin conditions, the PCDS website is a free resource that can help with the diagnosis and treatment of a large range of skin conditions such as eczema, acne and psoriasis, as well as skin cancer and hair and nail disorders.



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www.pcds.org.uk