DERMATOLOGY GUIDELINES

These guidelines have been produced in collaboration with the Directorate of Dermatology at The James Cook University Hospital.

Their aim is to help GPs and other Primary Care health professionals in the management of common skin disorders.

The guidelines will be updated annually and are presented in a form that can be downloaded.

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Disclaimer – The author of this site cannot accept responsibility for any misleading or incorrect statements, and the management of individual patients remains the direct responsibility of the individual doctor. We do however hope that visitors to this site can contact us regarding comments that are considered misleading or incorrect so that we can continue to improve the site.

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ACNE

Figures 1 & 2 – Acne vulgaris

Emphasise to patient that acne may continue for several years from teens and treatment may need to be prolonged. Treatment depends on the severity and morphology of the acne lesions.

I. Mild Acne

Comedonal
- Non-inflammatory blackheads, whiteheads. Topical retinoic acid (Retin-A), isotretinoin (Isotrex), or less irritant adapalene (Differin).
- Use od, but increase to bd if tolerated.
- Safety in pregnancy not established.
- Benzoyl peroxide.

Inflammatory
- Topical antibiotics – erythromycin (Stiemycin), erythromycin + zinc (Zineryt), clindamycin (Dalacin T).

II. Moderate to Severe Acne
- Oral therapy in addition too topical.
- Oxytetracycline 500 mg bd on an empty stomach over 12 years of age.
- After 3-6 months, if no improvement, Erythromycin 500 mg bd, Lymecycline 408mg od, Doxycycline 100mg od, or Minocycline 100 mg od
- Dianette in women with premenstrual flare if no contra-indication.

III. Severe Acne
- Cystic/scarring/unresponsive to adequate antibiotics.
- Refer to Dermatology Department for consideration of oral isotretinoin. Enclose results of recent LFTs and fasting lipids (triglycerides & cholesterol).
Correct management requires adequate examination and classification. Ascertain whether the alopecia is:

- Scarring?
- Diffuse or localised?

I. Scarring Alopecia
- Examine for evidence of lichen planus or discoid lupus elsewhere.

II. Non-Scarring Diffuse Alopecia
- Exclude an effluvium from history:
  - Telogen – childbirth or acute illness about 4 months earlier
  - Anagen – e.g. recent chemotherapy
- Exclude metabolic disorder by blood tests:
  - Ferritin (FBC alone inadequate)
  - Thyroid function
III. Non-Scarring Localised Alopecia

- Female pattern
- Little evidence that treatment is helpful
- Alopecia areata:
  - Natural history is usually for spontaneous recovery.
  - Protracted course may warrant referral for intrallesional steroid or diphencyprone as a contact sensitiser.
- Traction
- Trichotillomania
- Tinea capitis:
  - Pluck hairs and scrape scale and send for mycology. If positive treat with griseofulvin 10 mg/kg od with food for 6 weeks or oral terbinafine for 2 weeks.
  - If patient requires a wig, emphasise that it won’t inhibit hair growth. The regulations for free provision of wigs or help with the cost can be found in leaflet WF11.
ATOPIC ECZEMA

Figures 5 & 6 - Atopic eczema

Figure 7 - Eczema herpeticum

Figure 8 – Acute allergic contact dermatitis
I) General treatment principles for eczema:

**Written explanation**
- This is central to efficient and effective management.

**Emollients**
- **Moisturisers** –
  - Prescribe something the patient will use
  - Copiously amounts needed. Never prescribe less than 500 grams
  - If the patient presents back with dry skin then they are probably not using enough
- **Soap substitutes** – These can be prescribed in addition to the above, E45 is one example.
  - If the patient has financial concerns moisturisers can also be used as soap substitutes
- **Bath emollients** –
  - Take care with the elderly!
  - Plain oilatum or balneum are often adequate for non-infected eczema
  - Oilatum plus useful for infected eczema
  - Balneum plus useful for very itchy eczema.

**Topical steroids**
Use in addition to moisturisers when inflammation present –
- **Patient education essential**
- **Bases**- Liquid applications or creams best for acute weeping eczema. For dry eczema ointments are more effective but creams better tolerated.
- **Apply** as the first layer. Ideally wait one hour before applying moisturisers on top to avoid dilution.
- **When the eczema is marked or flares badly use the following**:
  - Fucibet for 3-5 days on any body site, including in children. Elocon or cutivate are other options for children.
  - Once settled try to control patients on the lowest strength steroid. Skin thickness is important when deciding what to use in the long term. Thinner skin is more susceptible to the side effects of steroids. Thickness decreases in descending order as follows:
    - Palms and soles
    - **Trunk and limbs**
    - Face and flexures
    - Scrotum.
- **Avoid using combined steroid/antibiotic preparations in the long-term as it will promote bacterial resistance.**

As a guide an average sized adult should not be using more than 60 grams of betnovate for the body/month. Long-term steroid use should be avoided on the face where possible (see later – Facial eczema)

An alternative way of treating patients with moderate eczema who have frequent relapses is to use fluticasone cream/ointment once a day until control is achieved (up to 4 weeks) and then to use as a maintenance dose twice a week.
Antibiotics –
• For an acute flare of eczema an appropriate dose of flucloxacillin or erythromycin if allergic to flucloxacillin, should be given for 1 week.

Anti-histamines –
• If itch is troublesome a sedating anti-histamine can be particularly helpful at night.
• Hydroxyzine can be used from 6 months of age or consider promethazine 5-15mg nocte.
• Use with caution in drivers.

Affordability –
• Pre-payment exemption certificate.

Support -
• The National Eczema society

II) Treatment for specific types of eczema -

Scalp -
• For scale use shampoos such as capasal or polytar shampoo.
• For inflammation use steroid scalp lotion i.e. betnovate (BD) or elocon (daily) scalp lotion.

Facial eczema –
• Regular moisturisers.
• Minimum steroid usage, no stronger than eumovate in the long term for adults.
• For eczema of the eyelids you must take particular care. Principally rely on moisturisers with occasional use of an appropriate steroid. Patients needing long term-term application of steroids to the eyelids, including weak preparations such as hydrocortisone, should be reviewed by the ophthalmologists to look out for glaucoma.
• For mild to moderate facial eczema, especially around the eyes consider pimecrolimus cream as opposed to topical steroids.

Contact dermatitis -
• This may be irritant or allergic.
• Time from contact to development of symptoms is rarely helpful in differentiating between irritant and contact dermatitis. As an example a strong irritant can cause acute symptoms, whereas an allergen such as chrome causes symptoms only after years of contact.
• A more helpful way of differentiating is being aware of the substances that commonly cause allergic reactions.
• Ointments are less likely to cause problems than creams. With regards steroids eumovate, betnovate (full and ¼ strength) ointment are unlikely to cause problems. See later
• The site of the rash can also help. Simultaneous involvement of the hands and face is very suggestive of an allergic reaction. Other common areas for allergy include feet, skin around stasis ulcers and peri-anal skin. Problematic eczema around the eyes may also be an area worth patch testing.
• Constitutional pomphlyx principally starts in late teens. If blisters are seen for the first time in patients older than this one cannot rule out contact dermatitis.
• Patch testing is very useful for allergic contact dermatitis but not irritant dermatitis. But beware of occasional false negatives that can occasionally occur with hydrocortisone.
• The most important part of treatment is avoidance of known precipitating/irritant factors. A patient information leaflet is essential.
• Plentiful emollients and appropriate steroid use is also needed.

Other hand/foot eczema –
• If exudative use potassium permanganate soaks. Soak in 1:8000 potassium permanganate solution x 2-4/day for 10-15 minutes (one Permitab in 4 litres warm water). Warn patient to apply vaseline to avoid staining fingernails brown.
• If resistant for dermovate that can be applied under cling film at night.
• If hyperkeratoses for 5% salicylic acid ointment BD, if also inflamed used betnovate instead

Varicose eczema -
• Plentiful moisturisers such as 50:50 emulsifying ointment in WSP.
• Minimize steroid usage.
• Avoid agents most likely to sensitise such as hydrocortisone and neomycin.
• Class II below knee stockings for oedema as long as peripheral circulation good.
• If using layers for treatment if ABPI is 0.6-0.8 reduce compression, so for example consider 3 layers as opposed to 4 layers. Such a reading is not likely to be ischaemic but nevertheless stringent compression is likely to delay healing.

III) The management of difficult eczema:

Check compliance

Skin infections -
• Recurrent S.Aureus infection could be due to nasal carriage so swabs may be useful. If positive use systemic antibiotics for 7-10 days and nasal bactroban BD.
• Be aware of secondary herpetic infections in atopic children.

Allergy to topical preparations –
• Topical medications are estimated to account for between 20-30% of all cases of allergic contact dermatitis.
• We must be alert to this possibility if:
  - An eczematous eruption occurs at the site of application.
  - A condition simply fails to respond to treatment.
  - Eczema develops distant to the site of application.
• Certain factors relate to development of contact dermatitis:
  Position - More common around leg ulcers, eyes, ears and peri-anal skin.
  Emollients – Ointments contain fewer preservatives than creams so are less likely to cause problems. Lanolin has been widely replaced as a vehicle although the newer refined lanolins do not often cause problems.
  Active agents – Hydrocortisone is the steroid most commonly associated with contact allergy and should be avoided at sensitive sites such as around leg ulcers. Betnovate ointments are less likely to cause problems than drugs with budesonide in.
  Topical antibiotics – Neomycin in particular.
Wet and dry wraps -

- **Wet wraps** – 0.025% beclomethasone dipropionate ointment diluted further to one part ointment in 10 parts of white soft paraffin BP is very effective. Wraps should be used initially once to twice daily, but then decreased as the condition improves. However due to a number of reasons wet wraps are probably mainly useful in the first week of an exacerbation. The introduction of tubifast garments may make wet wrapping more acceptable.
- **Dry wraps** – Not as effective but sometimes the patient/family will not tolerate wet wraps.
- Wraps can be prescribed in General practice as 10 metres of tubifast. It is supplied in the following colours – Red for a small limb / Green for a medium limb (e.g. 3 year old) / Blue for a large limb / Yellow for an extra large limb and a small trunk (child) / Beige for a medium or large trunk.
- **Viscopaste** - Useful for severe localised areas of eczema/lichen simplex. It is well tolerated.
- **Icthapaste** - Used as above and better for reducing itch but it has a strong smell, and some patients will not like it as much.

Either viscopaste or icthapaste can be used with betnovate or Dermovate, the dressing can be left on for 2-7 days and should be supported with tubifast bandages on top.

**Tacrolimus** –

- Should be prescribed by a specialist
- Use on patients with moderate-severe eczema.
- Use initially as 0.03% face and 0.1% body BD for ‘3 weeks’.
- Advise re sun protection as evidence of acceleration of carcinogenesis in mouse skin.
- Once settled use moisturisers only.
- For flares use the minimum strength of tacrolimus that settles it down, but don’t forget about the possibility of associated skin infections in particular herpes simplex.

**Second line treatments** –

- Immunosuppressants such as cyclosporin.
- Light therapy.
- Acetretin useful for hand eczema particularly if associated with marked hyperkeratoses. Marked teratogen even 2 years after stopping therapy.

**Diet** –

- Dietary restriction is of little or no benefit in adults, and in children it is only worth trying if the child has poorly responding eczema Any dieting should be done with professional supervision.

**Other** –

- Evidence for House dust mite eradication is worthy of a trial but in practice not easy.
- The use of Evening primrose oil is inconclusive.
Figure 10 – Seborrhoeic eczema

Advise patient that seborrhoeic eczema is often recurrent. It can be cleared by appropriate treatment, but it is likely to relapse and repeat courses of treatment may be needed. Reassure the patient that it is not infectious and does not cause ill-health.

Scalp:
- Polytar AF.
- Ketoconazole shampoo twice weekly initially, then every 1-2 weeks for maintenance. Leave on scalp for 15 mins before rinsing off.
- Steroid scalp application if necessary, e.g. Betnovate SA. If scalp is heavily excoriated, use aqueous preparation, e.g. Betnovate lotion.

Face and chest:
- Ketoconazole cream bd.
- Antifungal – hydrocortisone combination cream e.g. Daktacort.

Intertriginous areas:
- Antifungal-hydrocortisone combination cream e.g. Daktacort.

Secondary bacterial infection:
- As indicated by swab.
- If not responding, or if very extensive, prescribe Itraconazole 200 mg daily for two weeks. If no improvement, consider the possibility of an immunocompromised state.
NAPKIN DERMATITIS

Figure 11 – Napkin dermatitis

This is a term that is applied to eczema in the napkin area. It is usually due to the irritant effects of the contents of the nappy.

There may be an underlying skin disorder such as seborrhoeic eczema or atopic eczema. Examination of other sites will help in the diagnosis.

The skin is frequently colonised or infected by bacteria or candida. It is helpful to take skin swabs.

Erosive changes may indicate ammoniacal dermatitis, which is due to prolonged wearing of wet or soiled nappies. This is less common now that disposable nappies are widely used.

Treatment

- More frequent changes of nappies or even leaving the child out of nappies for short periods of time may be required.
- Avoid soap. Use a soap substitute e.g. aqueous cream, Diprobase at every nappy change and bath oil.
- Apply a moisturiser to the skin before applying each nappy.
- If the skin is very inflamed, an antifungal/hydrocortisone combination such as Daktacort cream or Canesten HC cream applied twice daily in addition to the above steps, can be useful. Stronger topical steroids are usually not required.
- If an underlying skin condition is found, this should also be treated.
INTERTRIGO

Possible diagnosis:
- Seborrhoeic eczema
- Psoriasis
- Candida
- Tinea
- Secondary to obesity
- Erythrasma
Management

- Take swabs for bacteria and yeasts.
- If dry or scaly, take scrapings for fungi.
- If area is wet, use astringent soak, e.g. potassium permanganate and avoid talc.
- Apply Daktacort/Canesten HC cream bd.
- If no benefit, short term use (4 weeks) of a potent steroid/anti-bacterial preparation (e.g. Locoid C / Lotriderm cream).
- Lose weight, improve hygiene.
- Apply barrier cream.
MOLLUSCUM CONTAGIOSUM

Figure 15 – Molluscum contagiosum

Common complaints relate to not knowing what it is and concerns about appearance.
- The viral infection will resolve spontaneously in children, with minimal scarring.
- The time to resolution is variable, but settles within 12 months in the majority.
- Treatment is usually unnecessary.
- Avoid sharing towels.
- A topical antibacterial may be useful for secondarily infected lesions e.g. Betadine, Aureomycin ointment.
- Aggressive treatment may risk scarring, is unpleasant, poorly tolerated by children and rarely indicated.
PLAQUE PSORIASIS

Figures 16 & 17 – Plaque Psoriasis

Figures 18 – Psoriasis

Figure 19 – Palmar-plantar pustular psoriasis
Treatment

I. Flat but scaly plaques
- Simple emollients may be sufficient.
- 5% salicylic acid in white soft paraffin.
- Tar preparations, e.g. Carbo-Dome cream, Alphosyl cream,
- Vitamin D analogues – calcipotriol (Dovonex) ointment, tacalcitol (Curatoderm) ointment.
- Combination Vitamin D analogue and potent steroid - Dovobet.

II. Thicker Plaques
- Dithranol is still the most effective topical therapy, e.g., Dithrocream as short contact therapy. After removal an emollient should be applied.
- Vitamin D analogues.
- Combination Vitamin D analogue and potent steroid - Dovobet.
- Moderate potency steroids can help relieve pruritus and reduce inflammation but have little effect on the plaques themselves and should ideally not be used in isolation.

SCALP PSORIASIS

If scale is slight:
- Tar shampoo only, e.g. Polytar (plus)/Capasal.
- Massage into the scalp for 5 minutes to allow shampoo to penetrate the scale.

If scale is moderate:
- Dovonex scalp application combined with a tar shampoo.

If scale is heavy:
- Apply a greasier preparation, e.g. Cocois ointment 2-3 times weekly, thickly to the affected areas. Massage in for 5 minutes. Leave on for at least 2 hours, or overnight under occlusion. Wash out with tar shampoo.
- Significant hair loss may occur, but usually recovers.

If the scalp is inflamed or itchy:
- Use a steroid scalp application, e.g. Betnovate, Diprosalic, Betacap daily, combined with a tar shampoo.

For psoriasis of the hair margins:
- 1% hydrocortisone ointment/Eumovate ointment twice daily – also suitable for face and ears.
GUTTATE PSORIASIS

Figures 21 & 22 - Guttate psoriasis

Management
- In mild cases of guttate psoriasis, the use of an emollient regimen may be sufficient until spontaneous clearance occurs.
- Acceptable coal tar preparations:
  - Alphosyl cream or lotion (5% coal tar extract) twice daily on all affected areas.
  - Alphosyl HC cream (5% coal tar extract with 0.5% hydrocortisone) may be more helpful for itchy or inflamed eruptions and facial involvement.
- Alternatives:
  - Carbo-Dome cream (10% coal tar).
  - Tarcortin cream (5% coal tar with 0.5% HC).
  - Dovonex cream/ointment (Calcipotriol).
    May be used on trunk and limbs once or twice daily, avoiding the face. (Maximum weekly amount not to exceed 100 gm).
  - Combination vitamin D analogue and potent topical steroid (Dovobet).
  - Natural sunlight in moderation can improve or clear guttate psoriasis. The use of UV sun-beds without medical supervision is discouraged.
  - A course of narrow band UVB may be provided as a hospital outpatient for severe or unresponsive cases.
PRURITUS GENERALISED

Itch without rash, other than secondary changes e.g. prurigo, excoriations.

Diagnose aetiology
- Primary dermatosis – eczema, urticaria, etc.
- Systemic disease – iron deficiency, polycythaemia, lymphoma, chronic renal failure, cholestasis, hypo/hyperthyroidism, paraneoplastic.
- Drugs.
- Psychogenic.
- Idiopathic.

Investigations
- FBC and ESR.
- Iron studies – irrespective of Hb and indices.
- CXR.
- Urea and electrolytes and creatinine.
- LFTs.
- TFTs.
- Protein electrophoresis.

Management
- Treat primary dermatoses/system disease/psychiatric state.
- Emollient regimen: avoid soap/use bath oil and emollient/cooling agents, e.g. 1% menthol in aqueous cream.
- Avoid rough fabrics against the skin.
- Cautious use of sedative antihistamines, e.g. hydroxyzine 10 mg bd and 25 mg nocte.
- **NB** Non-sedative antihistamines should only be used in urticaria and have no role in other itchy conditions.
- Calamine lotion provides short-term relief, but also long-term drying and caking of the skin and should not be used.
PRURITUS ANI

Exclude treatable causes:
- Fissure in ano
- Haemorrhoids
- Eczema
- Psoriasis
- Threadworms
- Medicament dermatitis

NB  The management of the above may include some of these steps:
- Take swabs for bacteria and yeasts.
- Ensure good hygiene.
- Avoid soap as a cleanser – use emollient for washing.
- Apply emulsifying ointment to the anal margin post-defaecation, wipe clean, and then re-apply.
- An antifungal/steroid application, e.g. Daktacort / Canesten HC cream.
- If there is no response, or if lichenification is present, increase the potency of the topical steroid ointment e.g. Lotriderm.
- Candida is a frequent contaminant of perianal skin.
- Strep pyogenes is an under-diagnosed infecting organism.
- Avoid or stop potent sensitisers, e.g. topical anaesthetics and Tri-Adcortyl cream (contains ethylenediamine and neomycin).
PITYRIASIS VERSICOLOR

Figure 23 - Pityriasis vesicolor

Pityrosporal yeast infection can be cleared with:
- A topical imidazole, e.g.
- Canesten cream ( clotrimazole).
- Daktarin cream (miconazole).
- Nizoral cream (ketoconazole) applied daily for 2-4 weeks.
- Nizoral shampoo used in the bath or shower.
- Selsun shampoo (half strength selenium sulphide 2.5% in a detergent base) applied to affected areas and washed off after 15 minutes, weekly for 4 weeks. This may be irritant and less acceptable than topical imidazoles.
- In widespread or resistant cases, Itraconazole 200 mg daily for 7 days.
- After treatment, the skin may still show patchy depigmentation, which will usually repigment after sun exposure.
- Terbinafine is active against dermatophytes and not indicated in yeast infections.

TREATMENT OF PITYRIASIS VERSICOLOR WITH SELSUN

- Pityriasis versicolor is a yeast infection of the top layers of the skin. It is not serious and can be cleared by following these instructions:
  - Dilute Selsun shampoo to half strength using tap water. (Empty the contents of the bottle into a small jam jar, refill the bottle with water and add it to the shampoo to form paint).
  - Using cotton wool or tissues, apply the lotion to cover all the affected areas and allow to dry on the skin.
  - Wash the paint off after 15 minutes by bathing or showering.
  - The treatment should be carried out on 4 occasions at weekly intervals.
  - Because scale contains the infection, it is possible to be infected again from your own bedding. Therefore on the days of treatment, the sheets and pillowcases from your bed should be washed in the usual fashion, so that you go into a clean bed that night.
  - The infection leaves areas of pale skin in the same pattern as the rash. This will usually disappear in several weeks.
PARONYCHIA CHRONIC

Figure 24 – Chronic paronychia

Candida may be the sole pathogen, or be found with pseudomonas or proteus.

Predisposing Factors
- Wet work.
- Poor circulation.
- Candidiasis.

Clinical Features
- Proximal and sometimes lateral nail folds of one or more nails become red and swollen.
- Cuticles are lost and pus may be expressed.
- Adjacent nails become ridged and discoloured.

Treatment
- Hands should be kept dry and warm.
- Imidazole antifungal solutions or creams applied to the nail folds 2 or 3 times per day until the cuticle reforms.
- Systemic treatment is seldom required.

Complications
- Acute paronychia needs swabs and appropriate systemic antistaphylococcal antibiotic orally.
Figures 25 & 26 - Acne rosacea

Avoid factors that aggravate rosacea:
- Tea and coffee, especially taken hot or strong.
- Alcohol.
- Mustard, pepper, vinegar, pickles or spicy foods.
- Excessive heat.

Topical treatment
- Metronidazole gel 0.75% (Rozex) applied twice daily.

Systemic treatment:
- Oxytetracycline or erythromycin 500 mg bd until control is achieved, then 500 mg daily. Improvement will take up to two months to become apparent and treatment should continue for at least 6 months to a year, so the patient should be encouraged not to stop too soon.
- If rosacea fails to improve with either alone, a combination of topical metronidazole and oral tetracycline may be successful.
- Erythema may be the predominant feature and does not respond to antibiotics. It can be disguised with green cream or improved with laser therapy.
SCABIES

Figure 27 - Scabies

Figure 28 – Scabetic burrows

Figure 29 – Scabies in an infant
Adults
Look for burrows on the borders of the hands and feet, wrists, sides and webs of fingers and male genitalia.

Children
Look for papules and pustules on the palms and soles, papules on the axillary borders. May affect the head and neck.

Treatment
- 5% permethrin cream (Lyclear) is the treatment of choice; other scabicides are more irritant and less effective.
- Use a single application: 1 x 30 g tube should cover an average adult.
- Pay special attention to skin creases, genital area and underneath the nails.
- Wash off after 8-24 hours.
- Re-apply to the hands after washing within the first 8 hours.
- Thereafter, launder all bed linen and clothing.
- Repeat treatment after 4 days.
- Use Lyclear cream rinse to scalp if indicated.

Contacts

NB ALL CLOSE CONTACTS within the last month must be treated. Re-infection is common.

Persistent rash or itch
- The rash or itch of scabies may not begin to clear for at least a month after successful treatment.
- Emollients and mild/moderate steroid cream may be needed.
- Re-infection: re-treat and check contacts.
- Resistance to scabicide less likely with permethrin.
SKIN CANCERS

I. Malignant melanoma

Figure 30 – Superficial spreading malignant melanoma

Figure 31 – Lentigo maligna melanoma

Figure 32 – Nodular melanoma

Figure 33 – Subungual melanoma
Prognosis depends on thickness and site of lesion.

7-Point Checklist:

Change in size
Change in shape
Change in colour
Diameter > 7 mm

Inflammation
Oozing or bleeding
Spontaneously itching

major features

minor features

DO NOT ATTEMPT BIOPSY OR EXCISION OF SUSPICIOUS LESIONS

Refer for urgent consultation as via proforma
II. Basal Cell Carcinoma

Figure 34 – Nodulo-cystic BCC.

Figure 35 – Superficial BCC

Figure 36 - Morphoeic BCC

Figure 37 – Pigmented BCC

Slow growing, pearly lesion, very low potential for metastasis.

Refer for consultation within 8-12 weeks.
III. Squamous Cell Carcinoma

May grow rapidly; metastasise to lymph nodes via blood and lymphatics.

Refer for urgent consultation as via proforma

Plastic Surgery Referral

It is more appropriate to refer patients directly to Plastic Surgery in the following circumstances:

- The lesion is 1 cm or greater in diameter
- In locations where there is skin shortage that prevents primary wound close.
- The lesion is located in a difficult functional or aesthetic area such as the muzzle region (middle third of the face including eyelids, nasal, para-nasal and peri-oral skin) and ears.
- All recurrent cancers.
Pre-malignant lesions
Bowen’s Disease

Figure 41 – Bowen’s diseases

Management

In situ carcinoma, only rarely transforms to SCC. Consider use of topical 5-fluorouracil (Efudix) before referral (see below).

Actinic Keratoses

Figure 42 – Actinic keratoses

Management

Very low malignant potential. Consider use of topical 5-fluorouracil (Efudix)/topical diclofenac (Solaraze).

Regimen for 5-fluorouracil (Efudix):

For the first month:

- Apply the topical Efudix (5-fluorouracil) to scaly lesions (solar keratoses/Bowen's disease) with a gloved finger before going to bed.
- Don't cover the treated area with a plaster.
- In the morning, apply Eumovate cream to scaly lesions.
- Repeat this treatment each day for a month and then stop.
The scaly patches may become angry and inflamed. If this reaction is severe, see your General Practitioner.

- Discard the remaining contents of the tube of Efudix in the toilet before putting the tube in the bin.

For the second month:

- Apply mupirocin (Bactroban) cream morning and evening to any raw oozy area of skin for up to a month to minimise risk of infection.
- Review 3 months after starting treatment to assess the response.
TINEA UNGUIUM

Figure 43 – Tinea unguium

Exclude skin diseases that may cause similar nail changes, e.g. psoriasis, lichen planus, alopecia areata, dermatitis by examining whole of skin.

NB Nail clippings must be sent for fungal culture before treatment.

Treatment:
Not always indicated.

Topical
- Cure rate low
- Tioconazole nail solution bd for 6-12 months.
- Amorolfine nail lacquer 1-2 times per week after filing the nails.
- 3-6 months for fingernails, 6-12 months for toenails.

Systemic
- Terbinafine 250 mg od for 6 weeks to 3 months.
- Itraconazole 200 mg od for 6 weeks to 3 months.
- Pulse therapy -200 mg bd for one week, then 3 weeks off the drug
  3 x pulses for toenail infections
  2 x pulses for finger nail infections.
- NB Contraindicated with astemizole.

Children
- griseofulvin 10 mg/kg up to a dose of 1000 mg daily, for a year or more, with food.

NB Nails take several months to become normal after adequate treatment
**CHRONIC URTICARIA**

![Figure 44 - Urticaria](Image)

**Management**
- Take a thorough drug history.
- Avoid aspirin, NSAIDs and ACE inhibitors.
- Exclude physical factors e.g. heat, cold, water and sunlight.

Most urticaria of a chronic nature is non-allergenic. In these cases, avoidance of a precipitating event is not usually possible.

**NB** Patch testing is inappropriate to investigate urticaria and allergy testing rarely indicated?

**Treatment**
- Start with a non-sedating antihistamine, e.g. Fexofenadine 180 mg daily or Cetirizine 10 mg daily.
- If there is no benefit after 14 days, add in a sedative antihistamine, e.g. Hydroxyzine 25-50 mg nocte.
- Once control is established, slowly withdraw the sedative drug. Chronic urticaria often lasts for more than a year.
- Children are less likely to develop prolonged urticaria, but can be treated similarly, with appropriate doses for their age.
VENOUS LEG ULCERS

Figure 45 – Venous ulcer

The following advice is for the management of venous leg ulcers and assumes that you have excluded the presence of other diseases such as vasculitis:

- Assess the patient’s general condition and treat any co-existing medical conditions that might impair ulcer healing, such as diabetes, cardiac failure or anaemia.
- Doppler reading and ensure ankle:brachial systolic BP ratio > 0.75.
- Treat venous hypertension: this can only be done with adequate support bandaging, such as Elastoweb, Elset or Blue line bandages. These actually treat the pathogenesis of venous leg ulcers. Crepe bandages or tubigrip are inadequate to deal with this. Patients should also be encouraged to have periods of rest with legs elevated during the day.
- Treat the surrounding venous eczema with a mild/moderate topical steroid cream e.g. 1% hydrocortisone.
- Treatment of the ulcer depends on its appearance.
- Slough to be removed by the use of Hioxyl cream or Varidase. Hioxyl is also a useful antiseptic. If granulation tissue is slow to form, a colloid dressing such as Granuflex can be useful; it also has the benefit that it can be left in place for several days before changing.
- Leg ulcers contain excellent culture medium and many organisms will thrive in this environment. However, unless the ulcer is infected to the naked eye, oral antibiotics are not usually required.
- Two organisms, however, are probably best treated – Staph aureus and Strep pyogenes.
- If the ulcers or eczema are very wet, potassium permanganate soaks can help to dry this out before application of topical therapies. However, if the legs are very oedematous, the skin will continue to weep until the oedema is controlled. Medical causes of oedema should be excluded. Such leg ulcers are usually best dressed daily.
- Once the ulcer has healed, below-knee Class I-II support stockings should be worn to discourage recurrence. Any further venous eczema should be treated promptly, as this has potential to progress to a new ulcer.
WARTS

No specific anti-wart viral therapy exists. All wart treatments are locally destructive and some are extremely painful and cause scarring. Treatment of choice depends on the age of the patient and the site of the warts.

Treatment for Children

The vast majority of childhood warts resolve spontaneously after an interval of 1-4 years, without scarring and confer long-lasting immunity. Painful/scarring treatment is therefore rarely justified under the age of 10. Uncomfortable warts may be treated with wart paints combined with abrasion with emery board, which gives the patient/parent a sense of activity while awaiting resolution. Plane warts on the face or hands are resistant to all destructive methods.

Treatment for Adults

Rarely develop immunity to their warts and destructive methods may be needed, after a trial of keratolytics for 3 months. Electrocautery requires local anaesthetic injections and results in scarring; Cryotherapy with liquid nitrogen causes severe pain and local damage, with alarming blistering in the first few days, but less scarring. The blisters should be punctured and the patient given analgesics – antibiotics is rarely needed.

Cryotherapy clinics in General Practice may well be useful for the treatment of warts in teenagers and adults, with suitable equipment and liquid nitrogen. Histofreezers are ineffective on hands and feet, so are a waste of money for this purpose.

Anogenital warts

Refer to Department of Genito-Urinary Medicine & Sexual Health.
CRYOSURGERY

Liquid nitrogen (-196°C) is far colder than Histofreeze (-50°C) and more effective.

What to treat:
- Be certain of the clinical diagnosis.
- Keratotic lesions should be thoroughly pared with a scalpel before applying liquid nitrogen.
- **Most warts (not on the face) warrant keratolytic therapy for at least 3 months before liquid nitrogen treatment.**
- Resist use in children – demonstrate on parents first!

How to treat:
- Hold tip 1 cm from lesion to be treated.
- Keep canister perpendicular to the ground to avoid cooling the delivery system and ice formation.
- Ensure iceball extends 2 mm beyond margins of the lesion.
- Recommended times are from iceball information.
- Thaw time should be at least x 3 freeze time.

Treatment of benign lesions:

<table>
<thead>
<tr>
<th>Lesion</th>
<th>Spray Time</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wart: plane</td>
<td>1 x 10 secs</td>
<td></td>
</tr>
<tr>
<td>filiform</td>
<td>1 x 10 secs</td>
<td></td>
</tr>
<tr>
<td>common</td>
<td>1 x 10 secs</td>
<td>Repeat every 2 weeks</td>
</tr>
<tr>
<td>plantar</td>
<td>1 x 10 secs</td>
<td></td>
</tr>
<tr>
<td>mosaic</td>
<td>Local anaesthetic</td>
<td>2 x 20 secs</td>
</tr>
<tr>
<td>Solar keratoses</td>
<td>1 x 10 secs</td>
<td></td>
</tr>
<tr>
<td>Seborrhoeic keratoses</td>
<td>1 x 10 secs</td>
<td></td>
</tr>
</tbody>
</table>

Side-effects:
- Erythema, oedema (especially near the eye), blistering and crusting.
- Pain.
- Damage to adjacent structures: e.g. nail matrix, naso-lacrimal duct.
- Dyschromia – especially in darker skins.
- Infection.

Aftercare:
- Simple analgesia, e.g. paracetamol 1 g qds.
- Burst blister with sterile needle.
- Dermovate cream od for up to a week (not warts).
- Wash regularly.
- Avoid occlusion as much as possible.
- Possible infection: swab, Fucidin/Bactroban topically; Flucloxacillin/Erythromycin systemically.