These guidelines are provided by the Departments of Dermatology of County Durham and Darlington Acute Hospitals NHS Trust and South Tees NHS Foundation Trust, April 2010.

More detailed information and patient handouts on some of the conditions may be obtained from the British Association of Dermatologists’ website www.bad.org.uk
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Acne

Assess severity of acne by noting presence of comedones, papules, pustules, cysts and scars on face, back and chest.

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.

**Mild acne**

**Comedonal (Non-inflammatory blackheads or whiteheads)**
- Benzoyl peroxide 5-10% for mild cases
- Topical tretinoin (Retin-A) 0.01% - 0.025% or isotretinoin (Isotrex)
  Use o.d. but increase to b.d. if tolerated. Warn the patient that the creams will cause the skin to become dry and initially may cause irritation.
  **Stop if the patient becomes pregnant- although there is no evidence of harmful effects**
- Adapalene 0.1% or azelaic acid 20% may be useful alternatives

**Inflammatory (Papules and pustules)**
- Any of the above
- Topical antibiotics – Benzoyl peroxide + clindamycin (Duac), Erythromycin + zinc (Zineryt) Erythromycin + benzoyl peroxide (Benzamycin gel) Clindamycin (Dalacin T)
- Continue treatment for at least 6 months
- In patients with more ‘stubborn’ acne consider a combination of topical antibiotics o.d with adapalene, retinoic acid or isotretinoin od.
Moderate Acne

- Oral therapy in addition to topical
- First-line:
  
  Lymecycline 408 mg daily >12 years of age  
  OR
  Erythromycin 500 mg b.d. in woman at risk of pregnancy

- After 3 months if no improvement change to alternative antibiotic:
  
  Erythromycin 500 mg b.d.
  Lymecycline 408 mg o.d. No blood monitoring needed. May be taken with food. Avoid in renal impairment, caution with hepatic disease
  Doxycycline 100 mg o.d. Warn of photosensitivity

- Dianette may be added in women, if no contra-indication. Avoid progesterone based contraceptives including depot, implant and IUS; these are likely to exacerbate acne

Effective treatments should be continued if control has been achieved for at least 6 months before starting to reduce treatment.

Severe Acne

Patients should be referred to the dermatology department with:

- Nodular cystic acne
- Active scarring
- Unresponsive to adequate courses (>3 months) of 2 different systemic antibiotics in combination with topical therapy

Please document what they have had, and for how long

- Older patients with long-term acne
- Significant psychological upset

Female patients likely to need isotretinoin will be required to enter pregnancy prevention programme.
Alopecia

Correct management requires adequate examination and classification. Ascertain whether the alopecia is:

- Scarring
- Diffuse or localised

Scarring alopecia

Figure 3 – Discoid lupus causing scarring alopecia

- History of contact with animals to suggest a kerion
- Examine for evidence of lichen planus or discoid lupus elsewhere
- Refer early as scarring will be permanent

Non-scarring diffuse alopecia

- Exclude an effluvium from history:
  Telogen e.g. childbirth or acute illness about 4 months earlier
  Anagen e.g. recent chemotherapy
- Exclude metabolic disorder by blood tests:
  Ferritin (FBC alone inadequate) and thyroid function
Non-scarring localised alopecia

Figure 4 – Alopecia areata

- **Female pattern** (thinning of vertex & retention of hairline)
  Little evidence that treatment is helpful

- **Alopecia areata**
  Natural history is usually for spontaneous recovery
  Protracted course may warrant referral to dermatology department for intralesional steroid or diphencyprone as a contact sensitiser

- **Traction**
  Occasionally due to rolling hair excessively or using tight pony tails in women with thin hair. Patients often slow to accept they are responsible. Re-growth is often disappointingly incomplete

- **Trichotillomania**
  Patches are irregular in outline and hair loss is incomplete. The remaining hairs tend to be broken and of variable length.

- **Tinea capitis**
  Pluck hairs and scrape scale and send for mycology
  If positive treat with griseofulvin 10 mg/kg o.d. with food for minimum 6 weeks or oral terbinafine 250 mg o.d. for 4 weeks (unlicensed in children-refer BNF)

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

Before treating atopic eczema always exclude scabies, bacterial, viral (eczema herpeticum) and fungal infections with swabs and scrapings as clinically indicated.

Details below (adapted from NICE guidelines) refer to childhood atopic eczema, but the same principles apply to adult atopic eczema. Tailor the treatment step to the severity of the eczema. Emollients should form the basis of eczema management and should always be used, even when clear of eczema. Management can then be stepped up or down, according to the severity of symptoms.

Emollients

- Patients with eczema should be offered a choice of unperfumed emollients to use every day for moisturising and washing
- Leave-on emollients should be prescribed in large quantities (250–500 g weekly). Warn that moisturizers may sting for the first couple of days before soothing the skin

Topical corticosteroids

- Explain that the benefits of topical steroids outweigh the risks when applied correctly

They should only be applied once or twice daily to areas of active eczema, or where eczema that has been active in the previous 48 hrs
The potency of topical corticosteroids should be tailored to the severity of the eczema and the affected site

- Mild potency for mild eczema especially for the face and neck, except for short-term (3–5 days) use of moderate potency for severe flares
- Moderate potency for moderate eczema. Use moderate or potent preparations for short periods only (7–14 days) for flares in vulnerable sites such as axillae and groin
- Potent for severe eczema
- Potent or very potent for eczema palms & soles. If resistant consider cling film occlusion at night

**Do not use very potent preparations in children without specialist dermatological advice.**

- Consider treating problem areas of eczema with topical corticosteroids for 2 consecutive days per week to prevent flares in children with 2 or 3 flares per month
- Consider a different topical corticosteroid of the same potency as an alternative to stepping up treatment if you suspect tachyphylaxis
- **The base should be appropriate to the nature of the eczema – ointment for dry eczema and cream for moist eczema**

**Topical calcineurin inhibitors**

If eczema is not controlled by topical corticosteroids or if there is risk of important adverse effects from topical corticosteroid treatment, options for treatment with topical calcineurin inhibitors are:

- Tacrolimus for moderate to severe eczema in children aged 2 years and over
- Pimecrolimus for moderate eczema on the face and neck in children aged 2–16 years
- Topical twice weekly tacrolimus when eczema is in remission can significantly reduce the frequency and severity of subsequent flares
- **Do not use topical tacrolimus or pimecrolimus for:**
  - **Mild eczema**
  - **As first-line treatment for eczema of any severity**
  - **Under bandages or dressings**
Anti-infective agents

Bacterial

- Signs of bacterial infection include weeping, crust, pustules, failure to respond to therapy, rapidly worsening eczema, fever and malaise
- Take a swab to inform treatment
- Explain that topical treatments in open containers can be contaminated with micro-organisms and act as a source of infection. New supplies should be obtained at the end of treatment for infected atopic eczema

Localised infection

- Topical antibiotics including those combined with topical corticosteroids. Maximum 2 weeks
- Recurrent infected eczema. Consider antiseptics e.g. chlorhexidine as adjunct therapy for decreasing bacterial load. Beware too frequent use can cause skin irritation

Widespread bacterial infections

- Systemic antibiotics active against *S. aureus* and Streptococcus 1–2 weeks
- Flucloxacillin first-line treatment of *S. aureus* and streptococcal infection
- Erythromycin treatment of *S. aureus* and streptococcal infections in the case of allergy to flucloxacillin or flucloxacillin resistance
- Clarithromycin treatment of S. aureus and streptococcal infections in the case of allergy to flucloxacillin or flucloxacillin resistance and intolerance of erythromycin
Herpes simplex

Figure 7 – Eczema herpeticum

- Consider infection with herpes simplex virus in a child with atopic eczema if:
  - Areas of rapidly worsening, painful eczema
  - Fever, lethargy or distress
  - Clustered vesicles consistent with early-stage cold sore
  - Punched-out monomorphc punctate erosions which may coalesce
  - Resistant flare of atopic eczema
- If you suspect secondary bacterial infection, also start treatment with systemic antibiotic
- Treat suspected eczema herpeticum immediately with systemic aciclovir and refer for same-day specialist dermatological advice
- If eczema herpeticum involves the skin around the eyes, refer for same-day ophthalmological advice
Bandages and dressings

- Localised medicated dressings or dry bandages can be used on top of emollients and topical corticosteroids for short-term treatment of flares (7–14 days) or chronic lichenified eczema
- Use whole-body occlusive dressings on top of topical corticosteroids for 7–14 days only (or for longer with specialist dermatological advice). Use can be continued with emollients alone until the eczema is controlled
- **Do not use:**
  Occlusive medicated dressings or dry bandages to treat infected eczema
  Whole-body occlusive dressings or whole-body dry bandages as first-line treatment

Antihistamines

- Do not routinely use oral antihistamines
- Offer a 7–14 day trial of a sedative antihistamine to children over 6 months during acute flares, if sleep disturbance has a significant impact. This can be repeated for subsequent flares, if successful
- Offer a 1-month trial of a non-sedating antihistamine where there is urticaria

Hyperkeratotic

- For hyperkeratotic eczema e.g. palms & soles, 5% salicylic acid ointment b.d. +/-cling film occlusion

Acute exudative/pompholyx

- Normal saline or potassium permanganate soaks (Permatabs)
Hand Eczema

Figure 8 – Acute hand eczema

**Acute weeping eczema and pompholyx**
*(vesicular eczema of palms and soles)*

- Eliminate any obvious cause – perform swabs for bacteriology
- Rest
- Emollient wash, eg Aqueous cream, Diprobase cream
- Aspirate large bullae
- Soak in 1:8000 potassium permanganate solution x 2-4/day for 10 to 15 minutes (one Permitab in 4 litres warm water). Warn patient to apply vaseline to avoid staining fingernails brown
- Systemic antibiotic eg flucloxacillin/erythromycin for 10 days
- Potent/very potent topical steroid applied after potassium permanganate soaks, eg Betnovate C, Betnovate N, Fucibet & DermovateNN
- Non-adhesive dressings and light bandages
- Oral steroids may be needed if severe and non-infected
Chronic Hand Eczema

- Identify and remove possible causative factors at home or work. Take swabs and scrapings for mycology. Consider referring for patch testing.

- Avoid irritants, especially soap. Use soap substitutes eg Emulsifying ointment/Aqueous cream/Diprobase cream/E45 wash. Products in a pump dispenser decrease the risks of continuing infection. nb: Barrier creams are usually ineffective.

- Hand protection: Cotton lined gloves without holes should be worn for wet or dry work. nb: Acrylates and epoxy resins penetrate rubber and vinyl gloves.

- Emollients for frequent use; adequate amounts should readily be available at home and work. It may be necessary to try several to ensure optimum effect. Avoid irritants.

- Topical steroids should be used sparingly and at the lowest effective strength, BUT be prepared to use potent preparations if required. A combined steroid/antiseptic or antibacterial preparation or a 10-day course of oral antibiotics may be necessary.

- Other measures if eczema proves chronic or unresponsive – tar preparations eg 5% coal tar in emulsifying ointment, impregnated bandages, eg Ichthopaste.
Intertrigo

Figure 10 – Inframammary intertrigo

Differential diagnosis

- Seborrhoeic eczema
- Irritant secondary obesity
- Candidosis
- Psoriasis
- Erythrasma

Diagnose by full skin examination, especially other flexural sites.

- Swab for bacteria and yeast
- If dry or scaly, scrape for dermatophytes
- If wet, use potassium permanganate soaks and avoid talc
- Apply Daktacort b.d.
- If unresponsive, use potent steroid/anti-microbial preparation (e.g. Lotriderm/Locoid C cream) short-term (<4 weeks)
- Lose weight; Avoid tight clothing; Improve hygiene
- Apply barrier cream
- Consider incontinence & diabetes mellitus
Molluscum Contagiosum

Figure 11 – Molluscum contagiosum

- Discrete single or multiple (more often) shiny, flesh-coloured papules often with a central dimple/umbilication
- Often clustered or linear distribution (Köbner phenomenon after autoinoculation)
- Common in children with a background of atopic eczema where they may be disseminated
- Can get an area of halo dermatitis around lesions (known as Meyerson’s phenomenon)

The most common concerns are wanting to know the diagnosis and the appearance

- It will resolve spontaneously in children with minimal or no scarring
- The time to resolution is variable but settles within 12 months in the majority
- Treatment is unnecessary in most situations. It can be painful, poorly tolerated by children, risks scarring and is rarely indicated
- Avoid sharing towels
- A topical antiseptic may be used for secondarily infected lesions e.g. Betadine or Polyfax
- Treat any associated eczema on its own merit
Psoriasis

Figures 12 & 13 – Chronic plaque psoriasis

Explore precipitants/exacerbating factors

- Infection, particularly streptococcal. Treat if present
- Drugs – lithium, beta-blockers, NSAIDs, antimalarials
- Alcohol excess and binge drinking
- Stress

Plaque Psoriasis

- Simple emollients are essential
- 5 - 10% salicylic acid in emollient will help to reduce scale
- Vitamin D analogues - No need to check serum calcium levels
- Dovobet ointment o.d. for up to 3 months or until significant improvement and then maintenance treatment with emollients or Vitamin D analogues. Maximum 100g per week
- Tar preparations, e.g. Alphosyl HC cream or Exorex lotion. Clean tars – well tolerated
- Short contact dithranol regime (Dithrocrean/Micanol). More than one strength of Dithrocream can be prescribed on one FP10. Patient should increase strength weekly as tolerated. Cream to be rubbed in and washed off after 20-30 minutes. Stains skin, soft furnishings and bathrooms.
Flexural psoriasis
May present in isolation as ‘intertrigo’ or ‘groin candida’ – glazed non-scaly erythematous plaques. Usually symmetrical in groin, axillae, inframammary, umbilicus and in and around ears.

- Trimovate cream usually very helpful but stains clothing yellow
- Calcitriol (Silkis) well tolerated
- Calcipotriol too irritant.
- Avoid prolonged potent steroids – high risk sites for striae

Facial psoriasis
- Plenty of emollients
- Alphosyl HC cream
- Canesten HC may be useful in ‘sebo-psoriasis’ pattern
- Calcitriol (Silkis) may be tolerated but calcipotriol (Dovonex) is too irritant.
- Eumovate cream or ointment is useful for hairline psoriasis

Scalp psoriasis
If scale is slight
- Tar shampoo
- Massage into the wet scalp for 5 minutes to allow shampoo to penetrate the scale

If scale is moderate
- Xamiol gel or Dovonex scalp application combined with a tar shampoo
- 5-10% salicylic acid in Aqueous cream can be left overnight to soften scale.

If scale is heavy
- Apply a greasier preparation, e.g. Cocos or Sebco 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 (e.g. shower cap). 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. Betacap or Diprosalic, combined with a tar shampoo

For psoriasis of the hair margins

- 1% hydrocortisone ointment/Eumovate ointment – also suitable for ears

Palmoplantar pustular psoriasis

![Figure 14 – Plantar pustular psoriasis](image)

- Topical Diprosalic, Betnovate or Dermovate ointment
- Cling film occlusion may help
- May need referral to secondary care for phototherapy/second-line systemic treatment

Guttate psoriasis

Management

- In mild cases of guttate psoriasis, the use of an emollient regimen may be sufficient until spontaneous clearance occurs, usually after 2-3 months
- Acceptable coal tar preparations can be used e.g. Alphosyl HC & Exorex

Extensive guttate psoriasis or gutatte psoriasis without spontaneous clearance should be referred for phototherapy.
Generalised Pruritus

i.e itch without rash, other than secondary changes e.g. nodular prurigo, excoriations.

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

Investigations
- FBC and ESR
- Iron studies - irrespective of Hb and indices
- CXR
- Urea and electrolytes and creatinine
- Liver profile
- TFTs
- Protein electrophoresis
- Anti-basement membrane antibody (aged >50 years)

Management
- Treat primary dermatosis/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
- Consider wet wrap bandaging

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

n.b. 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-defecation, wipe clean, then re-apply
- Antifungal/steroid application, eg 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 commensal of perianal skin
- Strep pyogenes is an under-diagnosed infecting organism
- Avoid or stop potent sensitisers e.g. topical anaesthetics
Malassezia yeast infection can be cleared with:

- A topical imidazole e.g. clotimazole (Canesten) cream, miconazole (Daktarin) cream, ketoconazole (Nizoral) cream applied daily for 2-4 weeks
- Ketoconazole (Nizoral) shampoo used in the bath or shower
- 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
Paronychia - Chronic

Figure 16 – 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 are effective and should be continued until the cuticle reforms
- Systemic treatment is seldom required

Complications

- Acute paronychia needs swabs and appropriate systemic antistaphylococcal antibiotic orally
Rosacea

Avoid factors which aggravate rosacea:

- Tea and coffee, especially taken hot or strong
- Alcohol
- Mustard, pepper, vinegar, pickles or spicy foods
- Excessive heat
- Direct sunshine
- Topical steroids

Topical treatment

- Metronidazole gel or cream 0.75% b.d.
- Azealic acid 15% b.d.

Systemic treatment

- Oral tetracyclines – oxytetracycline 500 mg b.d. until control is achieved. Improvement will take up to two months to become apparent and treatment should continue for at least 6 months. The patient should be encouraged not to stop too soon

If rosacea fails to improve with either alone, a combination of topical preparation and oral tetracycline may be successful.

Erythema may be the predominant feature. This does not respond to antibiotics and requires camouflage e.g. “Green cream”. A more permanent solution is to remove the telangiectases with a vascular laser. This may also address flushing and the burning sensation.
Scabies

Figures 18 & 19 – Scabies

Adults

- Look for burrows on the borders of the hands and feet, wrists, sides of fingers and webs and male genitalia

Children

- Look for papules and pustules on the palms and soles, nodules and papules in the axillary folds. The head and neck may be affected in infancy.

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 7 days. Use Lyclear cream rinse to scalp if indicated.

Contacts

- All close contacts within the last month must be treated

Persistent rash or itch

- The rash or itch of scabies may not clear for at least a month after successful treatment. Emollients and mild/moderate steroid cream may be needed

- Re-infection is common: re-treat and check contacts
Skin Cancers

Refer urgently to secondary care using 2-week cancer referral proforma:

- Patients with a lesion suspected to be Melanoma
- Patients with lesions suspected to be Squamous Cell Carcinoma (SCC) i.e. non-healing keratinizing or crusted tumours with significant induration on palpation. They are commonly found on the face, scalp or back of hand with documented expansion over 8 weeks.
- Organ transplant patients who develop a new or growing skin lesion, as SCC is common in the immunosuppressed and may be atypical or aggressive.

Do NOT attempt to biopsy or excise any lesions suspicious of melanoma or SCC.

Melanoma

Change is a key element in diagnosing malignant melanoma

The 7 point checklist for assessment of pigmented skin lesions:

Major features (score 2 points each)

- Change in size
- Irregular shape
- Irregular colour

Minor features (score 1 point each)

- Largest diameter 7mm or more
- Inflammation
- Oozing
- Change in sensation

Lesions scoring 3 points or more are suspicious, but if you strongly suspect cancer any one feature is adequate to prompt referral.

n.b. Nodular melanomas, which are thicker and carry a worse prognosis, can present as symmetrical nodules of uniform brown, black or red colour!
Fig 20 – Squamous Cell Carcinoma

Fig 21 – Squamous Cell Carcinoma

Fig 22 – Lentigo Maligna

Fig 23 – Superficial spreading melanoma

Fig 24 – Nodular melanoma

Fig 25 – Subungual melanoma
Basal Cell Carcinoma (BCC)

Figure 26 – Nodulo-cystic BCC

Figure 27 – Superficial BCC

Figure 28 – Morphoeic BCC

**BCCs are slow growing and should be referred as routine non-urgent referrals**

According to the 2006 NICE Guidelines

- High risk BCCs on the head and neck should be referred to secondary care.
- Low risk BCCs on the trunk and neck can be managed in the community but *only* by specially accredited practitioners e.g. GPwSI
Pre-Malignant Conditions

Figure 29 – Bowen’s disease

Figure 30 – Actinic keratoses

If clinical diagnosis is confident or confirmed by biopsy, pre-malignant disease can be managed in primary care.

Bowen’s Disease

- This is intraepidermal in-situ SCC. It only rarely transforms to invasive SCC.
- It can be treated with cryotherapy, curettage and cautery, or 5-fluorouracil cream (Efudix)
- Caution: On oedematous legs any of these treatments could result in ulceration which may take several weeks to heal.

If referring to secondary care refer as routine non-urgent referral.
Actinic Keratoses

- Individual lesions have a very low malignant potential. They should be considered more as a marker of UV skin damage. Patients should be advised on safe sun practices and told that they are at risk of developing skin cancer on previously sun exposed skin.

- They can be treated with cryotherapy, diclofenac gel (Solaraze) (bd for 3 months) or 5-fluorouracil cream (Efudix).

Using Efudix Cream

- Patients must be warned that this treatment will cause skin irritation (redness and crusting) and the treated area will look worse during treatment but get better once treatment complete.

- Treated lesions should not be occluded.

- One regimen used is daily application for 4 weeks.

- If this causes too much irritation treatment may need to be stopped for a few days till irritation settles. Topical steroid may be used if irritation is severe.

- Once irritation settles one can restart treatment, using it less frequently but for longer e.g. alternate days for 8 weeks; twice a week for 14 weeks.

- It is safer to try treating one or a few lesions initially. Avoid the eye area.

If referring to secondary care, refer as routine non-urgent referral.
Tinea unguium

Figure 31 – Tinea unguium

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

Nail clippings must be sent for fungal culture before treatment preferably from proximal part of nail. Repeat if negative.

**Treatment is not always indicated.**

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

**Systemic**
- Terbinafine 250 mg o.d. for 6 weeks to 3 months

  **n.b. Contraindicated with astemizole**

  Nails take several months to become normal after adequate treatment

**Children**
- Griseofulvin 10 mg/kg up to a dose of 1000 mg daily, for a year or more, with food
- Terbinafine for 6-12 weeks (weight > 40 kg – 250 mg; weight 20-40 kg 125 mg; weight up to 20 kg 62.5 mg o.d.)

  **n.b. Terbinafine unlicensed for children <12 years**
Urticaria

Figure 32 - Urticaria

- 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.

n.b. Patch testing is inappropriate to investigate urticaria and allergy testing rarely indicated.

Treatment

- Start with a non-sedating antihistamine, eg cetirizine 10mg/day, fexofenadine 180mg/day, loratidine 10mg/day, acrivastine 8mg t.d.s., levocetirizine 5mg/day, desloratidine 5mg/day
- If there is no benefit after 14 days, add in a sedative antihistamine, e.g. brompheniramine 12 mg b.d. or 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

Chronic Urticaria

- Urticaria lasting more than 6 weeks

Physical Urticaria

- Urticaria caused by factors such as heat, cold water, pressure, sunlight and exercise. Dermographism is the most common form of this
Angio-oedema

- May occur as a part of ordinary urticaria
- May be induced by ACE inhibitor drugs.

Investigations

- Most chronic ordinary urticaria is non-allergenic and no investigation is required for majority of patients

- Acute or episodic urticaria take a thorough history to elucidate a cause

- This should include drug history, over the counter medications, herbal medicines, precipitating foods, latex etc.

- RAST tests (via immunology lab) and skin prick tests as suggested by history in selected patients
Venous Leg Ulcers

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 high pressure bandaging, such as Setopress and extra high compression for large oedematous legs such as Elastoweb

- Crepe bandages or Tubigrip are inappropriate. Patients should also be taught postural drainage and encouraged to have periods of rest with leg elevation during the day

- Treat surrounding venous eczema with a mild/moderate topical steroid/antimicrobial preparation e.g. 1% hydrocortisone or Eumovate ointment or Trimovate cream

- Treatment of the ulcer depends on its appearance. Slough should be removed by the use of Crystacide or with hydrocolloids and hydrogels which also encourage granulation and reduce pain

- Leg ulcers are colonised by bacteria (Staph aureus, Strep pyogenes, and Pseudomonas aeruginosa) However, unless the ulcer is clinically infected (red, swollen, warm, painful) oral antibiotics are not usually required

- If the ulcers or eczema are oozing, potassium permanganate soaks can help to dry this out before dressing. Daily dressings are recommended. Significant leg oedema, as the main cause of oozing or blister formation, requires aetiological assessment and management.

- 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.

- Some patients benefit from surgical investigation and treatment.
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.

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

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 pain and local damage, can cause alarming blistering in the first few days, but less scarring. The blisters should be punctured and the patients given analgesics – antibiotics are rarely needed

Refer to hospital
- Warty lesions in the elderly, as these are rarely viral
- In adults anogenital warts should be referred to the GUM clinic
- Anogenital warts in children should be referred to a paediatrician
- Warts in immunosuppressed patients to exclude malignancy
- Intra oral warts should be referred to Oral Medicine

Cryotherapy clinics in General Practice may well be useful for the treatment of warts in teenagers and adults, with suitable equipment and liquid nitrogen. Treatment with Histofreeze is ineffective.
Topical Treatments

The base

Ointments are greasy, and have little or no water and preservative and therefore do not evaporate and tend to be used for dry conditions.

Creams contain water and can be used in moist areas such as flexures or weeping/exudative surfaces. They contain preservatives to which some patients may be sensitive.

Lotions are used on hairy areas and as soap substitute.

Topical steroid

The ointment form is more effective than the cream form of the same formulation because of the above.

Increasing potency →

Mild steroid < Moderately potent steroid < Potent steroid < Very potent

e.g. hydrocortisone < Eumovate < Betnovate < Dermovate

Cream < Ointment

Occlusion increases absorption of topical steroid as does use on inflamed skin and also different treatment sites:
–

Back < Forehead < Axilla

→ increased absorption

Quantities

For topical treatments such as steroids, 15 g is enough to cover the whole body surface once and 100 g will allow daily treatment for one week. 1 finger tip unit, an amount covering the finger tip to the distal IP joint, will cover an area equivalent to 2 adult palms.

Emollients are an integral part of treatment of skin disease. Always try to prescribe appropriate amounts. A patient using moisturiser regularly and over the whole body will need 500 g a week.
Cryosurgery

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

What to treat

- Be certain of clinical diagnosis
- Keratotic lesions should be thoroughly pared with a scalpel before applying liquid nitrogen
- Most warts (not on the face) warrant keratolytic treatment 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 of delivery system and ice formation
- Ensure ice-ball extends to 2mm beyond margins of lesion
- Recommended treatment times are from ice-ball formation
- Thaw time should be at least 3x the 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 5 secs</td>
<td></td>
</tr>
<tr>
<td>filiform</td>
<td>1 x 5 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>2 x 20 secs</td>
<td>Local anaesthetic</td>
</tr>
<tr>
<td>Molluscum contagiosum</td>
<td>To ice formation only</td>
<td></td>
</tr>
<tr>
<td>Solar keratoses</td>
<td>1 x 5 secs</td>
<td></td>
</tr>
<tr>
<td>Seborrhoeic keratoses</td>
<td>1 x 5 secs</td>
<td>If large, use &quot;paint spray&quot; technique</td>
</tr>
</tbody>
</table>
Side-effects

- Erythema, oedema (especially near to the eye), blistering and crusting
- Pain
- Damage to adjacent structures e.g. nail matrix; naso-lacrimal duct
- Dyschromia- especially darker skin
- Infection

Aftercare

- Simple analgesia e.g. paracetamol 1g q.d.s.
- Burst tense blister with sterile needle
- Dermovate cream o.d. for <1 week ( not warts)
- Wash regularly
- Avoid occlusion as much as possible
- Possible infection-swab. Treat infection with fusidic acid/mupirocin topically or flucloxacillin/erythromycin orally