Buckinghamshire Dermatology Referral Guidance
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Dermatology

This is intended as a guide only. It is not exhaustive and appropriate clinical judgement should be used for individual cases.

When referring to Dermatology (either community or Acute) please provide information in accordance with the core required information fields of the referral letter with particular attention to the following sections:

Past history:
Relevant family history, H/O any co-morbidity, presence of risk factors

Investigations:
State whether the patient has had any relevant investigations (and attach results if available): e.g. Renal function tests, FBC, X-ray, USG reports and specific tests like PSA.

Please note, if you are concerned about your patient's condition and require urgent assessment it is not necessary to undertake routine tests unless this will significantly alter your referral decision.

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<thead>
<tr>
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<th>Emergency admission likely to be appropriate</th>
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<tbody>
<tr>
<td></td>
<td>Suggested referral to Secondary Care or GPSI</td>
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<tr>
<td></td>
<td>Continue to manage in Primary Care if appropriate</td>
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</table>

Note: All follow up appointments following inpatient stays in hospitals, for the same condition, should be arranged via secondary care and NOT booked by GPs.
1) ATOPI C ECZEMA IN CHILDREN AND ADULTS


What to consider in Primary Care before referring:

General
- Atopic eczema is a common disease affecting up to 15% of children. It may also affect adults.
- Involvement of the face frequently occurs in infants with adoption of characteristic flexural distribution by the age of 18 months.
- Realistic treatment aims to be discussed with the patient and parent.
General treatment measures:
- Soaps and detergents including bubble bath and shower gels should be avoided.
- Cotton clothing should be used and avoid wool next to the skin.
- Fingernails should be kept short to reduce skin damage from scratching.
- Bathing is not harmful but an emollient must be used.

Emollients
- Emulsifying Ointment, 500g,
- Hydrous (oily cream) Ointment, 500g,
- Diprobath Cream or Ointment, 500g, ointment or cream
- E45, 500g,
- Cetraben, 500g,
- Doublebase, 500g,
- Unguentum M Cream, 500g.

Greasier preparations are better at hydrating the skin e.g:
- Liquid Paraffin / White Soft Paraffin Ointment 50:50, 500g,
- White or Yellow Soft Paraffin, 500g.

Soap Substitutes
- Emulsifying ointment
- Aqueous Cream

Bath Emollients
Bath emollients are of particular value for children less than 5 years.
Adults do not routinely need prescribed bath emollients unless they have areas that they cannot reach to apply creams.
- Diprobath additive
- Oilatum – non-fragrance preparation, 250ml and 500ml
- Oilatum junior 500ml
Some combination preparations have niche uses:

Those containing antiseptics can be useful for infective episodes.

- Dermo® 500 (contains antiseptic)
- Emulsiderm (contains antiseptic)
- Olatum Plus (contains antiseptic)

Urea acts as a Keratin softener and so can be useful for areas of hard skin which also require hydration:

- Calmurid (contains Urea)

Barrier Creams

- Drapolene, or Metanium

Treatment in Primary Care

Emollients should be prescribed in all cases & in adequate quantities.

Some patients react to one and may need an alternative, therefore you need several options. Persist until the patient finds something they like and will therefore use. Use directly on the skin during and after bathing.

- Emulsifying Ointment, 500g,
- Hydrous (oily cream) Ointment, 500g,
- E45, 500g,
- Diprobase Cream or Ointment, 500g ointment or cream
- Cetraben, 500g
- Doublebase, 500g
- Unguentum M Cream, 500g

Greasier preparations are better at hydrating the skin e.g:

- Liquid Paraffin / White Soft Paraffin Ointment 50:50, 500g
- White or Yellow Soft Paraffin, 500g
Topical Corticosteroids

Although potent preparations can cause skin atrophy, mild corticosteroids such as 1% hydrocortisone do not and are safe to use in the long term. Hydrocortisone 1% is the strength of choice for the face and flexures. Topical Corticosteroids are often underused because of concern about the side effects.

Ointment preparations are more effective than creams and contain fewer additives. Creams can be used if the eczema is weeping or on the face.

There are four groups of potency. Within each potency group there is no evidence for increased efficacy or safety of any one particular product.

Mild
- Hydrocortisone 1% cream or ointment.

Moderate
- Clobetasone Butyrate (Eumovate).
  - OR
- Betamethasone Valerate 0.025% cream or ointment (Betnovate RD).

Potent
- Betamethasone Valerate 0.1% cream ointment and scalp appln. OR lotion (Betnovate).
  - Mometasone (Elocon) reserved as 2nd line if Betnovate does not suit.
  - Beclomethasone Diproprionate cream and ointment (0.025%) (Propaderm).

Very Potent
- Clobetasol Propionate (Dermovate) 0.05% cream, ointment and scalp application.

Try to avoid the use of very potent steroids due to the increased risk of skin atrophy and the fact that these super potent steroids can affect the appearance of the rash so that diagnosis is much more difficult.

Mild or moderately potent preparations should control most cases of eczema when prescribed in appropriate amounts. It may be necessary to gain control with moderately potent preparation and then reduce to a mild strength.

1 to 2 weeks of a potent strength product may be required, particularly for resistant, lichenified lesions in older children.

Avoid repeat prescriptions for potent strength corticosteroids.

In dry eczema try steroid / urea Alphaderm cream (moderate potency as urea increase the penetration of the hydrocortisone).

Assessment of severity of disease and progress on treatment

The Nottingham patient eczema questionnaires are an excellent way of assessing severity. They are available for adults and children.

http://www.nottingham.ac.uk/scs/divisions/evidencebaseddermatology/resources/nottinghameczemaseverityscale(ness).aspx

It is very difficult to give guidance on amounts of topical steroids for the treatment of eczema. If the right strengths for the site and severity of eczema are being used repeatedly without any steroid free gaps, then patients should probably be considered for alternative treatments or investigation.
Infection Control

Antihistamines
Suitable for short-term use to control itch especially at night.

Sedative antihistamines
- Chlorphenamine
- Hydroxyzine

Infective Eczema
*Infection should be suspected whenever eczema worsens. Eczema that weeps or crusts is probably infected with staphylococcus aureus - if in doubt take swabs for microbiology.*

The commonest infecting organism is Staph. aureus which produces characteristic yellow crusting.

Consider antiseptic moisturiser combination in the bath:
- Oilatum Plus bath oil
  OR
  Directly onto the skin: Dermol® 500

If the infection is widespread or severe treat with systemic antibiotics (for 7 to 10 days):
- Flucloxacillin 500mg QDS OR Erythromycin 2 x 250mg QDS (if penicillin allergic)

*Widespread infected eczema should be treated with a systemic antibiotic and plain topical steroid ointment.*

If recurrent infections occur take nasal swabs from the family members and if positive:
- Consider MSSA eradication according to the local BHT policy. Link to be added when available

Bandaging

Recommended products

Cheapest Standard conforming bandage range is currently Easyfix K (K band is more expensive)

Elasticated Viscose Stockinette Bandage.
- E.g. Tubifast
  - 3.5 cm, red line (small limb)
  - 5 cm, green line (medium limb)
  - 7.5 cm, blue line (large limb)
  - 10.75 cm, yellow line (child trunk)
  - 20 cm, purple line (adult trunk)

Vests, leggings, gloves and socks provide no advantages over old clothes and prescribing these are low priority.

Zinc paste bandages alone or Zinc paste and ichthammol (e.g. Ichtopaste), may be useful in chronic lichenified eczema, Ichthammol is believed to reduce pruritus. Apply creams such as
steroids and emollients 1st before applying Ichopaste, a final bandage over the Ichopaste is also required.

- Initial training techniques may be required which can be given by a suitably trained nurse or nurse specialist.
- Zinc paste bandages used over emollients or over topical corticosteroids can result in rapid improvement of resistant, particularly lichenified eczema.
- Wet wrap using tap water to dampen a standard bandage over emollients or steroids or both – may also be helpful, particularly at night in small children.

*Wet wrap garments are both cost effective and acceptable to patients.*

**Allergies**

The house dust mite can aggravate eczema in some patients.

- Vacuum mattress and keep dust level down.
- In severe cases try protective coverings to pillows and bedding (e.g. INTERVENT) – not prescribable on FP10
- No tests are available to confirm or refute food allergy as a cause of worsening of eczema. RAST tests and skin prick tests are not helpful. Patch testing is used to investigate specific contact allergic eczema if from an occupational cause.

Food allergies, especially to egg, wheat and dairy products rarely cause worsening of eczema.

- Consider exclusion diets only in difficult cases.
- Seek advice of dietician for young children and abandon if no improvement is apparent after 2 – 4 weeks.

Food intolerance is often a temporary phenomenon. An attempt should therefore be made every few months to re-introduce the food in question. Dietetic advice is required if exclusion diets are used for more than 2 – 4 weeks.

**Evening Primrose Oil**

- There is no consistent evidence that it helps, therefore *NOT RECOMMENDED*

**Chinese herbs**

- There are no product licenses and currently standardisation is poor.
- Serious adverse effects have been recorded and they cannot be recommended. Some contain potent topical steroids.
<table>
<thead>
<tr>
<th>Referral Threshold - Community Dermatology Service</th>
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<tbody>
<tr>
<td>Only cases of severe or difficult eczema need to see a Dermatologist:</td>
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<tr>
<td>• Diagnostic difficulty</td>
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<tr>
<td>• For second line treatment such as photochemotherapy and cytotoxic drugs. Eczema herpeticum.</td>
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<tr>
<td>If allergic contact dermatitis is suspected – consider patch testing in secondary care</td>
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| Referral Threshold 999 for emergency Urgent referral to Dermatology |
VIRAL WARTS AND MOLLUSCUM CONTAGIOSUM

All treatment is low priority

What to consider in Primary Care before referring:

General Comments

Viral Warts and Verrucae all treatments are LOW PRIORITY

- These two viral induced lesions are common, especially in children and are self-limiting
- There are no easy or guaranteed treatments or magic cures and lesions are best left to resolve spontaneously. Greater than 60% of hand and facial warts clear within two years.
- Plantar warts tends to be most persistent.

Molluscum Contagiosum

90% of mollusca clear spontaneously within one year. All treatments are LOW PRIORITY

Treatment in primary care

Viral Warts and Verrucae all treatments are LOW PRIORITY

- Use a high concentration salicylic acid preparation such as:
  - Occlusal = Salicylic acid 26%
    Many products also available over the counter.
    Instruct the patient that this should be applied daily after bathing and rubbing down the softened skin with pumice stone or sandpaper. This may need to be continued for many months.

Cryotherapy is available in many but not all GP practices:
Best performed at one to three weekly intervals with two freeze thaw cycles, (hands 70% cure rate after four treatments, plantar warts less than 40%). If there is no sign of improvement after six treatments then it is unlikely to be effective and should be discontinued. Higher cure rates with combined cryotherapy and topical agents.

- Molluscum Contagiosum all treatments of the condition are LOW PRIORITY except eczema and infections

- Observation only is the usual option.
- Treatment associated eczema or impetigisation with:
  - Emollients
  - Mild topical steroids +/- antibiotic therapy
- Affected children should have their own towels to reduce the risk of transmission to siblings
- Individual lesions will resolve if the central core is damaged by any modality including cryotherapy but this is not recommended in young children, as it is too painful.
**Referral Threshold – Community dermatology**

In general patients with viral warts/verrucae and molluscum should not be referred.

Patients may be referred if:

- Severe disabling warts despite six months of topical salicylic acid treatment +/- cryotherapy.
- Significant warts or mollusca in immunocompromised patients

**Community Dermatology Service**

**Referral – 999 for emergency admission**

Urgent referral to **Dermatology**
3) HAND ECZEMA

What to consider in Primary Care before referring:

Clinical Features
A Endogenous Eczema (e.g. atopic)
B Exogenous Eczema

(i) Irritant Contact Eczema (ICD)
Due to substances coming into contact with the skin, usually repeatedly causing damage and irritation. Substances such as:
- Water
- Detergents
- Shampoos
- Household cleaning products

(ii) Allergic Contact Dermatitis (ACD)
Due to type IV allergic reaction to a substance the skin is in contact with.
All types of endogenous and exogenous eczema can present with either ‘wet’ (blistering and weeping) or ‘dry’ (hyperkeratotic and fissured) eczema

General Comments
- Other skin conditions can mimic eczema and should be kept in mind.
- It is usually worth examining the patient’s skin all over as this can provide clues to other diagnoses e.g. plaques in extensor distribution in psoriasis, scabetic nodules in scabies.
- If an eczematous looking rash is present on only one hand, a fungal infection needs to be excluded by taking skin scrapings for mycology.
- If contact dermatitis is suspected a careful occupational and social history should be taken and the patient may benefit from Patch Testing
- Patch Testing is only of value in patients with eczema - It is of no use with type 1 reactions (e.g. food allergies causing anaphylaxis or urticaria).
- In practice the cause of eczema is often multi-factorial with external factors precipitating eczema in a constitutionally predisposed individual, in which case patch tests are usually unhelpful. Resistant hand eczema does however, merit consideration of these to exclude type 4 reactions.

Treatment in Primary Care
Avoidance of irritants
- Soap substitutes such as Emulsifying Ointment should be used.
- Gloves e.g. Household rubber or PVC gloves should be used for wet work such as dishwashing. Gloves may also be required for dry work e.g. gardening.
Recommended emollients
- Emulsifying Ointment, 500g,
- Hydrous (oily cream) ointment, 500g,
- Diprobase cream or ointment, 500g, ointment or cream
- E45 cream, 500g,
- Cetabrun cream, 500g,
- Doublebase gel, 500g,
- Unguentum M cream, 500g.

Greasier preparations are better at hydrating the skin e.g. –
- Liquid paraffin / White soft paraffin Ointment 50:50, 500g,
- White or Yellow Soft Paraffin, 500g,

Topical Steroids
- The strength of topical steroids required varies from case to case
- It may be necessary to use a potent steroid in the short term
- Use cream formulation if wet – use ointment if dry

Potassium permanganate – Permitab 400mg. Can be purchased OTC

Dilute 1 tab in 4L of water to pale pink (rose wine colour) and soak for fifteen minutes 2 to 3 times daily for acute wet eczema until blistering weeping has dried.

Make up a pale pink/rose colour using warm water

Antibiotics (topical/systemic)  Exclude secondary infection and treat if appropriate

Referral – Community Dermatology
- Severe chronic hand dermatitis, which is unresponsive to treatment described above.
- Occupational difficulty after standard therapy in primary care falls.
- If allergic contact dermatitis is suspected, Patch Testing may be

Referral - 999 for emergency admission
Urgent referral to Dermatology
4) ACNE

See guideline 820FM [Treatment of Acne vulgaris Algorithm] and [GP referral form for Dermatology at BHT].
5) Psoriasis

What to consider in Primary Care before referring:

General Comments

Psoriasis is a chronic relapsing condition: mild & moderate involvement can usually be managed in primary care. Prior to referral, basic treatment should be tried as outlined.

Nursing input by an appropriately skilled nurse at this stage will decrease need for referral to dermatology service. **Ensure patients understand how and when to use their treatments.**

Treatment in primary care

Chronic Plaque Psoriasis – see [guideline 61FM Psoriasis Topical Treatment Algorithm - Adults](#)

*If used correctly many patients will achieve at least flattening and partial clearance of plaques*

Guttate Psoriasis

Numerous small lesions, mostly on trunk, generally affecting children/young adults acutely. Often follows sore throat and is self-limiting over 3 – 6 months.

Treat with emollients plus trials of tar preparations.

Calcipotriol or moderate potency steroids e.g. clobetasone butyrate 0.05%.

If severe consider referral for phototherapy.

Facial Psoriasis

See [guideline 61FM Psoriasis Topical Treatment Algorithm - Adults](#)

Scalp Psoriasis

See [guideline 61FM Psoriasis Topical Treatment Algorithm - Adults](#)
### Referral Criteria – Community Dermatology Service

- Extensive / severe or disabling psoriasis – covering 20% body surface area or more.
- Failure to respond to adequate treatment or rapid relapse post treatment.
- Extensive acute guttate psoriasis.
- Unstable and generalised pustular psoriasis – URGENT REFERRAL.
- Diagnostic uncertainty.
- Use of dithranol

### Referral Threshold – 999 for emergency admission Urgent referral to Dermatology
6) Skin Cancer

What to consider in Primary Care before referring:

General Comments

**Basal Cell Carcinoma (BCC)**
These are common slow growing and locally invasive tumours. Most are easily recognised with a pearly rolled edge and later central ulceration. Pigmented and morphoeic (scar like, poorly defined) BCCs are less common variants.

The following malignancies are much less common:

**Squamous Cell Carcinoma (SCC)**
They may be slow growing, well differentiated, keratinising or rapidly enlarging, poorly differentiated tumours. 5% may metastasise to regional lymph nodes.

**Malignant Melanoma (MM)**
This is the most dangerous skin malignancy. Early detection and excision is vital for good prognosis. Melanoma subtypes

- Superficial spreading
- Nodular
- Amelanotic
- Lentigo Maligna
- Acral lentigious and subungual

**Criteria for diagnosis**

The six following point checklist may be useful in deciding whether to refer a changing pigmented lesion:

**Major features:**
- Change in size
- Change in colour (variation of pigmentation)
- Change in shape (irregular of edge)

**Minor features:**
- Size ≥ 7mm diameter
- Inflammation
- Bleeding / crusting

Itch is not a good indicator of malignancy or otherwise, but may draw attention to a mole.
Treatment in primary care is by referral:

**Basal Cell Carcinoma (BCC)**
- They are best managed by complete excision by the dermatology surgeons within the department and should be referred in the usual manner.
- In some cases radiotherapy may be a preferred option but tissue diagnosis (e.g. biopsy) is still required prior to referral for radiotherapy and will be carried out in the Dermatology clinic.

**BCC’s (low risk, not on face) can only be removed in primary care by GP in the intermediate service.**

**Squamous Cell Carcinoma (SCC)**
Lesions with a high index of suspicion, especially if rapidly growing, should be referred by fax within 24 hours.

USE 2 week wait SKIN CANCER REFERRAL PROFORMA

**Malignant Melanoma (MM)**
All referrals for suspicious moles should be faxed to the dermatology service to be seen within 2 weeks.

Any lesion felt to be highly suspicious of melanoma will be excised on the day of clinic or as soon as possible afterwards.

Use 2 week wait skin cancer referral proforma available on CCG website

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<tr>
<th>Referral – Community Dermatology Service</th>
<th>Community Dermatology Service</th>
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<tbody>
<tr>
<td>All skin cancer should be referred to dermatologists for confirmation of diagnosis and treatment plan.</td>
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<tr>
<td>Suspicious lesions, SCC and MM refer under 2/52 rule via faxed proforma</td>
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</table>

**Referral Threshold – 999 for emergency admission Urgent referral to Dermatology**
7) Scabies

What to consider in Primary care before referring:

General Comments
Human scabies is an infestation of the skin caused by the mite *Sarcoptes scabiei*.
The mites are most readily transmitted from one person to another by close physical contact in a warm atmosphere e.g. sharing a bed, holding hands, adults tending to children, children playing with each other.
An individual who has never had scabies before may not develop itching or a rash until one month to three months after becoming infested.
There is usually:
- Widespread inflammatory papular eruption.
- Burrows on non-hair bearing skin of the extremities.
- Pruritic papules around the axilla, nipples, umbilical region and buttocks.
- Inflammatory nodules on the penis and scrotum.
The reactive rash to scabies can be eczematous or urticarial – Impetigo may also occur.
Usually more than one family member is affected.
It is mandatory that all members of the household and any other close social contacts of an infested person should receive treatment at the same time as the patient.

Treatment in primary care
Treat patients when there is a strong clinical suspicion that they may be infested. If unsure whether eczema or scabies, treat eczema first and review.
If diagnosis of scabies – the essential step is to kill all the mites in the skin using a scabicide.

Scabicide
Apply either:
- Malathion 0.5%, Aqueous solution (Derbac M) Rub it in to all parts of the body, 200ml
- Permethrin 5% (Lyclear Dermal Cream), 60g
Treat all the skin other than the face.
- Remove rings and use a nail brush to apply under the nails.
- Remind patients to re-apply the scabicide after washing their hands.
  Malathion should be left on the skin for 24 hours and Permethrin for between 8 and 12 hours.
  At the end of this period the patients can bath, they must also change their underclothes, nightclothes, sheets and pillowcases.
- Disinfection of clothing and bedding other than by ordinary laundering is not necessary.
- One treatment is probably curative but a second application after 1 week is recommended.

If these directions have been followed, all mite in the skin will have been killed but the pruritus may take 3 to 6 weeks to settle.
Do not keep using scabicides as repeated applications may irritate the skin.
Treat residual itchy areas with:

- Topical anti-pruritic e.g. Crotamiton cream (Eurax)
- Crotamiton / hydrocortisone (Eurax HC or constituent parts)
A higher potency of steroid may be needed to treat areas of secondary eczema.

Referral Threshold – Community Dermatology Service
Diagnostic Uncertainty
Failure of response to treatment

Community Dermatology Service

Referral Threshold – 999 for emergency admission Urgent referral to Dermatology

Treat residual itchy areas with:

- Topical anti-pruritic e.g. Crotamiton cream (Eurax)
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A higher potency of steroid may be needed to treat areas of secondary eczema.

Do not keep using scabicides as repeated applications may irritate the skin.
Treat residual itchy areas with:

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- Crotamiton / hydrocortisone (Eurax HC or constituent parts)
A higher potency of steroid may be needed to treat areas of secondary eczema.
8) Actinic Keratoses

See guideline 365FM [Treatment of Actinic Keratoses](#)
9) Rosacea

See guideline 724FM Rosacea Treatment Pathway
10) Urticaria and Angioedema

What to consider in Primary Care before referring:

General Comments

- Urticaria / Angioedema is believed to be an autoimmune process.
- In the vast majority of patients with urticaria no underlying trigger factor associated disease is found and the condition is self-limiting. Prick test and RAST tests are not useful as a screening test of potential allergens in chronic ordinary urticaria.
- Food allergy is usually obvious and trigger factors such as crustaceans, fish and nuts can be easily identified.
- Contact urticaria is generally suggested by the history and can be confirmed by contact urticaria tests that are different to patch tests, which have no place in the investigation of urticaria.

Physical urticaria including:

- Dermagraphism
- Cholinergic urticaria
- Cold urticaria
- Solar urticaria
- Pressure urticaria

Can usually be identified on history.

Urticaria may follow non-specific infections, hepatitis, streptococcal infections, campylobacter and parasitic infestation. Rarely, it may be a symptom of an underlying systemic disease such as thyroid disease or connective tissue disease.

Management in Primary Care / Advice for self-care

Explain the condition to the patient and reassure that it is benign and usually self-limiting.

Minimise:

- Overheating
- Alcohol
- Caffeine
- Stress

Review Drug history – Both prescribed and non-prescribed, many drugs have been reported to cause urticaria such as penicillins, ACE inhibitors, statins, NSAID’s, in particular aspirin.

Additionally opiates and NSAID’s may exacerbate existing urticaria.

Exclude: C1 Esterase Deficiency (If angioedema is the only sign)
Insect bites

**Treatment in Primary Care: Antihistamines**

- There is little to choose between different antihistamines but individuals may vary in their response to different agents.
- Sedative or non-sedative antihistamine choice depends on the need for sedation.
- Many antihistamines block histamine wheals and itching but do not suppress the rash completely.
- Use continuous medication if attacks occur regularly.
- Use fast acting antihistamines as required for sporadic attacks.
- If there is no response to one agent after four weeks, try an alternative second and even then a third agent.
- In some cases of severe acute urticaria, such as a penicillin reaction, a short reducing course of prednisolone starting at 30mgs – 40mgs daily may be useful.
- **Systemic steroids should not be used in chronic urticaria.**

**Summary of low-sedating antihistamines.**

<table>
<thead>
<tr>
<th>1st Choice</th>
<th>Name</th>
<th>Drug Interactions</th>
<th>Comments</th>
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<tbody>
<tr>
<td></td>
<td>Loratadine</td>
<td>None</td>
<td>Avoid in pregnancy</td>
</tr>
<tr>
<td>Equal 1st choice</td>
<td>Cetirizine</td>
<td>None</td>
<td>Minimally sedating. Half the dose in renal impairment. Avoid in pregnancy.</td>
</tr>
<tr>
<td>3rd choice</td>
<td>Fexofenadine 180</td>
<td>None</td>
<td>Avoid in pregnancy</td>
</tr>
<tr>
<td></td>
<td>If ineffective consider also more sedating antihistamines e.g. chlorphenamine, hydroxyzine.</td>
<td>None</td>
<td>Hydroxyzine not usually 1st choice in pregnancy.</td>
</tr>
</tbody>
</table>

**Note:** In pregnancy it is suggested that the long established antihistamines be used e.g. chlorphenamine

Double doses of antihistamines are used *off license* locally – the local experts believe they are more effective in urticaria at higher doses.
11) Generalised Pruritus

What to consider in Primary Care before referring:

General Comments
- Dry skin, eczema and scabies are the commonest cause of generalised pruritus.
- If someone is itching all over, take a full history and examine the skin very carefully. Check lymph nodes and blood tests as below.

Management in Primary Care
If NO RASH can be seen other than excoriations consider the following:
- Anaemia – Especially iron deficiency.
- Uraemia.
- Obstructive jaundice.
- Thyroid disease both hypo and hyperthyroidism.
- Lymphoma, especially in young adults.
- Carcinoma, especially in middle aged and elderly.
- Psychological

A full general examination may be helpful.
Organise the following investigations:
- FBC and differential
- ESR
- Urea and electrolytes
- LFT’s
- Thyroid function tests
- Iron Studies
- Abdominal USS (Consider if clinically indicated)
- Chest X-ray (Consider if clinically indicated)

NB: Be aware that pruritus may occasionally predate a malignancy by several years.
Treatment: Emollients, sedative anti-histamines, anti-pruritic bath oils.

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<td>Refer to Dermatology if treatment fails.</td>
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<td>-</td>
<td>Referral Threshold – 999 for emergency admission Urgent referral to Dermatology</td>
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12) Onychodystrophy
(thickened and dystrophic nails)

What to consider in Primary Care before referring: for onychodystrophy

General Comments
In Bucks we have a **LOW PRIORITY statement around fungal nail infections.**

The priorities committee considers the treatment of onychomycosis (fungal nail infection) with terbinafine to be a low priority and not normally prescribed, with the exception of infection in the frail elderly, diabetic or other immunocompromised patients. In these patients, take nail clippings: start therapy only if infection is confirmed by laboratory. Terbinafine is more effective than azoles. Liver reactions are rare with oral antifungals.

In the unusual situation where treatment is indicated on the NHS:
- **1st** line – terbinafine, 250mg, daily 6 – 12 weeks (fingers) 3 – 6 months (toes)
  (intermittent regimens are not as effective as daily treatment with terbinafine)
- **2nd** line – Itraconazole, 200 mg, orally twice a day for 7 days a month
  -2 courses (for fingers)
  -3 courses (for toes)

General cutaneous examination and examination of all the nails is necessary.

Send samples (nail clippings including scrapings of thickened crumbly material on the underside of the nail if present) for microbiology. If repeatedly negative, advise regular filing of nails to keep nails short and thin.

Asymptomatic patients should be advised to ‘leave well alone’.

Treatment in Primary Care

If mycology is positive and dystrophy does not extend to nail matrix (distal onychomycosis) consider no treatment. If treatment is required consider:

Oral antifungals: Always obtain +ve mycology before starting oral antifungal agents.
- Terbinafine (Lamisil), 250mg od 3 – 6 months for toenails, 6 – 12 weeks for fingernails
- Itraconazole (Sporanox) Pulse treatment, each pulse of itraconazole 200mg twice a day for 7 days repeated monthly (3 cycles for toenails, 2 for fingernails).

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**Referral Threshold** – Community Dermatology Service
Do not refer patients with this condition

**Community Dermatology Service**

**Referral Threshold – 999** for emergency admission Urgent referral to **Dermatology**
13) Referral Criteria for Secondary Care Dermatology

Primary Care Treatment

All mild and some moderate disease should be treated initially in primary care before considering referral to a dermatologist.

Criteria for referral to Community Dermatology

Mild to moderate acute or chronic rash where unsure of diagnosis

Moderate inflammatory conditions where treatments in primary care have been unsuccessful e.g.
- Moderate acne (where treatments in primary care have been unsuccessful)
- Moderate Eczema (where suggested primary care treatments have failed)

Urticaria (where suggested primary care treatments have failed)

Tinea/Bacterial Infections

Pruritus (where suggested primary care treatments have failed)

Criteria for referral to Acute Service

Severe acne

Severe psoriasis

Severe eczema

Blistering disorders e.g. bullous pemphigoid

Severe rash where unsure of diagnosis

Any condition requiring hospital treatment (e.g. phototherapy, patch testing, day treatments, prescription of hospital only drugs)

Criteria for referral directly to A&E

Steven Johnson syndrome/toxic epidermal necrolysis or acute rash e.g. blistering erythrodera

Referral forms are available on CCG intranet sites.

Please feedback any comments on this guideline to s.crotty@nhs.net

The authors value your input and will make revisions if needed.