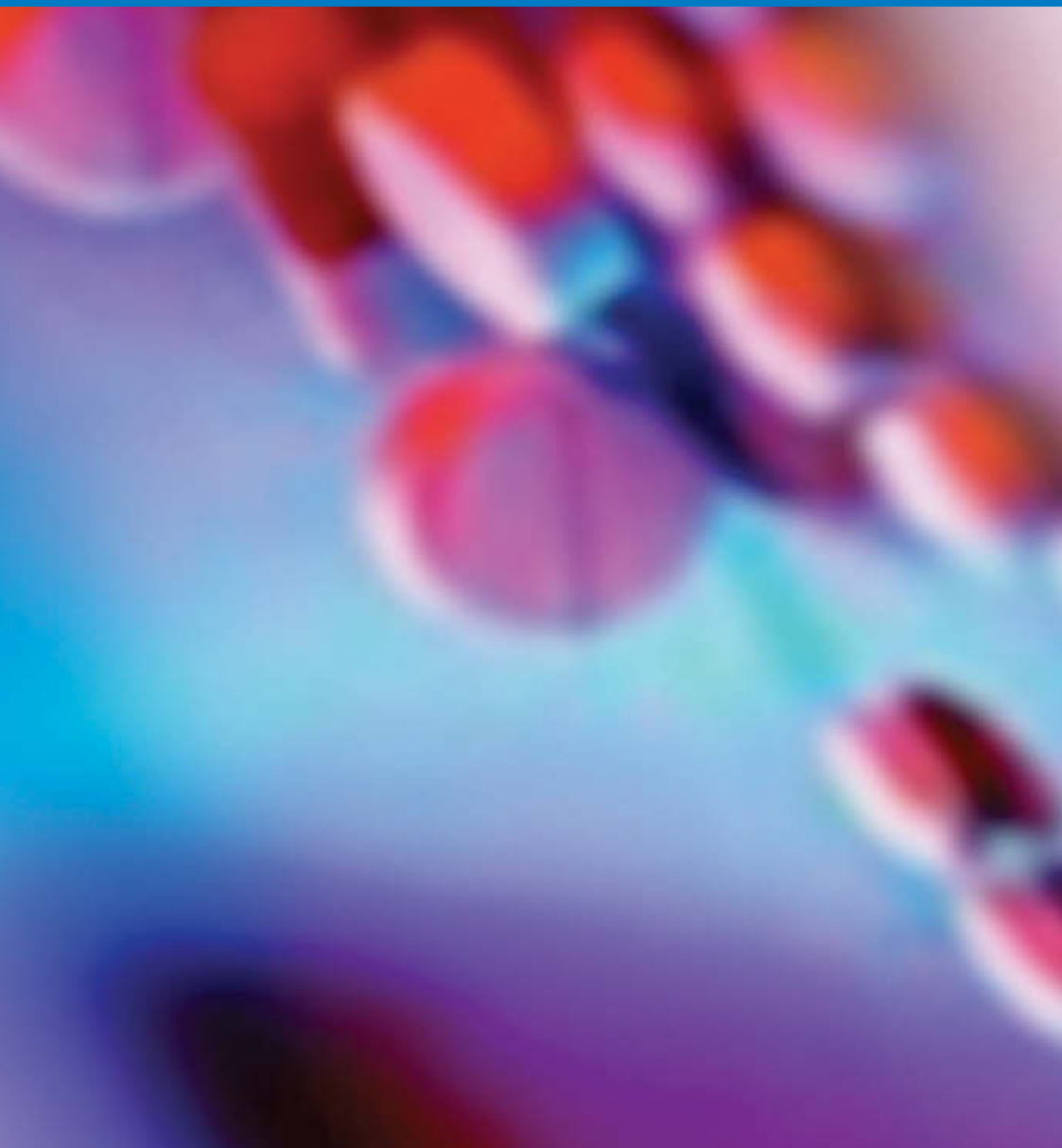
NHS Eastern Cheshire Clinical Commissioning Group
NHS South Cheshire Clinical Commissioning Group
NHS Vale Royal Clinical Commissioning Group
Mid Cheshire Hospitals NHS Foundation Trust
East Cheshire NHS Trust

Local Health Economy Dermatology Guidelines

1st Edition - October 2015
For Review - October 2017



Contents

Introduction

These guidelines have been developed by The Department of Dermatology at Leighton Hospital, in partnership with the East Cheshire Dermatology Department, NHS Eastern Cheshire CCG, NHS South Cheshire CCG and NHS Vale Royal CCG. They are based upon a document provided by Dr. Farzana Nayeemuddin, a Consultant Dermatologist at Trafford Hospitals, which was originally adapted from Medway NHS Trust guidelines.

Galderma (UK) Ltd has supported the production of these guidelines by means of an educational grant.

The guidelines are a first point of reference for local Primary Care clinicians. They do not absolutely define the stage at which referral to dermatology specialists should always occur, however they provide a stepped management approach for various dermatological conditions to guide treatment and referral decisions.

The British Association of Dermatologists' website has patient information leaflets available to download on many of these conditions and their treatments: http://www.bad.org.uk

Useful information on diagnosis and management in dermatology is also available at DermNetNZ: http://www.dermnetnz.org/

Treatment options are listed in order of preference unless otherwise stated.
Criteria for referral are clearly stated at the end of each section.

Referrals

Urgent Referrals to Secondary Care

All referrals will be assessed and prioritised by a Consultant / member of the Dermatology team.
Urgent referrals may be faxed directly to your chosen hospital or via Choose and Book.
If you wish to discuss a case with a Leighton or Macclesfield Hospital Consultant, please telephone via the relevant secretarial direct line.

Skin cancer

Referrals for suspected malignant melanomas and squamous cell carcinomas must be made using the HSC 205 (2 week wait) referral pathway. These patients will be assessed within two weeks of receipt of referral. Referrals for other skin lesions e.g. basal cell carcinoma should be made via the non-urgent pathway.

Content of referral letter

The following information should be included:

- Nature of condition and duration
- Relevant past medical history
- All medication currently and previously used for this condition including dose, duration of treatment and response, plus all other concurrent medication and their starting dates if these may be connected with onset of rash.
- Photographs (optional)

Prescribing of Unlicensed Products

The Dermatology Departments at both Mid and East Cheshire have agreed to take responsibility for the initiation and on-going prescribing of all unlicensed extemporaneous preparations (specials).

Acne

Treatment algorithm at end of section

Treatment aims:

- To reduce the severity of the disease
- To reduce the psychological impact on the individual

Mild to moderate acne should be managed in primary care. Several different agents may need to be tried alone or in combination e.g. **topical benzoyl peroxide** (BPO) plus systemic antibiotics. Inform patient that response is usually slow and allow 12 weeks before review.

Benzoyl Peroxide or topical retinoids are also the preferred agent for maintenance therapy in place of antibiotics, reducing the likelihood of bacterial resistance.

First line topical treatments (benzoyl peroxide, adapalene and azelaic acid) can be provided by local community pharmacies offering the Think Pharmacy Minor Ailments Service. Exclusion criteria may apply.

The goal is to minimise the use of topical antibiotics and not to use topical or oral antibiotics as monotherapy.

Acne

CLINICAL FEATURES	TREATMENT	THERAPEUTIC TIPS
MILD ACNE Uninflamed lesions Open and closed comedones (Blackheads / Whiteheads)	• **Topical Retinoids** **Note: AVOID IN PREGNANCY Counsel/provide contraception to all patients of child-bearing age** Adapalene 0.1% (Differin) cream Isotretinoin 0.05% (Isotrex) gel • **Azelaic Acid 20% (Skinoren) cream** • **Consider adding in Benzoyl Peroxide separately if available** This can be in combination with Adapalene as Epiduo (Adapalene 0.1% + BPO 2.5%)	Use topical retinoids at **all stages** of acne to help minimise formation of comedones. They should be applied to entire acne prone area. Build very slowly (twice per week) over 2-3 weeks. Then up to every other day or once daily (depending upon patient). Use in the evening as a thin film, using only one pea shaped amount for the whole face. If dryness occurs, stop for 1-2 weeks and then restart at less frequent intervals. Build slowly to daily BPO use over 2-3 weeks. If irritation occurs, reduce frequency of application and possibly build up again. If skin becomes excessively dry, may add a moisturiser. Lotion or cream preparations may reduce irritation. **NB: BPO can bleach sheets and towels**
If papules / pustules	• **Consider adding topical antimicrobial separately or in combination** Benzoyl peroxide + Potassium hydroxyquinoline sulphate (Quinoderm) cream Clindamycin + Benzoyl peroxide 5% (Duac) gel Clindamycin 1% lotion Clindamycin 1% topical solution Erythromycin + Zinc acetate (Zineryt) topical solution	**Avoid antibiotic monotherapy topically or systemically.** Ideally not as monotherapy, can alternate with retinoids or BPO.

Acne

CLINICAL FEATURES	TREATMENT	THERAPEUTIC TIPS
MODERATE ACNE More extensive inflamed lesions	• **Systemic antibiotics Continue topical retinoid/BPO and add in oral antibiotics as needed.** Lymecycline 408mg once daily Doxycycline 100mg once daily Oxytetracycline 500mg twice daily Erythromycin 500mg twice daily (2 x 250mg e/c tablets) Minocycline 100mg once daily **Minocycline - Hospital only initiation and shared care after review of effectiveness (NB. Minocycline should only be considered as 3rd line option due to side effect profile)** • **Consider hormone therapy** (females only) alone or systemic antibiotics can be added if response is suboptimal - Co-cyprindiol - Ethinyloestradiol / Cyproterone acetate (e.g. Dianette) or - Desogestrel / Ethinyloestradiol (e.g. Marvelon, Gedarel) - unlicensed or - Ethinylestradiol / Drospirenone (e.g. Yasmin, Lucette) - unlicensed Avoid Norethisterone / Levonorgestrel containing contraceptives.	Treat for 3 months and reassess Should be >70% improved Stop at 6 months & continue with topical. Repeat if relapses. Use alternative antibiotic if poor response. Lymecycline should be considered 1st line due to compliance (once daily) for patients >12 years old ANA/LFTs required pre Minocycline and at 6 months. ANA/LFTs every 3 months thereafter. Minocycline can induce Lupus. Treat for 4-6 months and reassess (slow onset of response).
SEVERE ACNE	Commence systemic therapy and refer for assessment for treatment with oral Isotretinoin (Roaccutane).	Ensure women are using effective contraception prior to referral for Roaccutane therapy, preferably avoiding progestogen-dominant options. Please do fasting lipids, LFT's, FBC and glucose and include results in the referral.
MAINTENANCE	Topical retinoid therapy or topical benzoyl peroxide preparations	For 3-6 months after systemic treatment is completed.

Acne

CRITERIA FOR REFERRAL

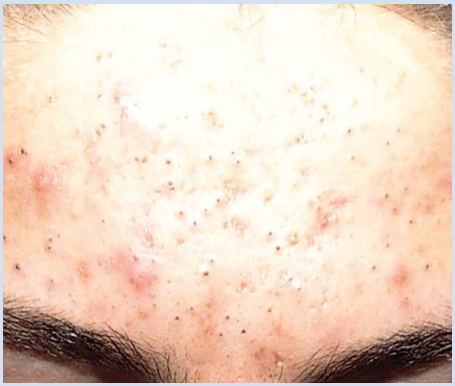
The main reason for referring a patient with acne is for oral Isotretinoin treatment.
The indications for Isotretinoin treatment are as follows:

- Severe nodulocystic acne (refer immediately)
- Moderate acne that has failed to respond to 2 or more courses of the above treatments or is causing scarring
- Mild to moderate acne in patients who have extreme psychological distress despite prolonged courses of systemic antibiotics and topical therapy
- Persistent acne in over 30s

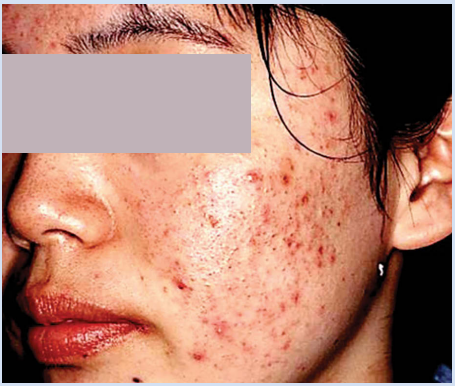
Do not refer female patients planning a pregnancy. Caution patients re: sun exposure / photosensitivity / avoiding in pregnancy as per BNF with all retinoids (topical and oral) and Doxycycline.

BAD Acne Patient Leaflet Link
http://www.bad.org.uk/for-the-public/patient-information-leaflets/acne?q=Acne

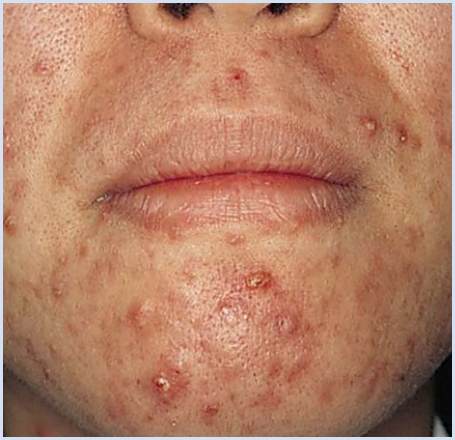
Mild



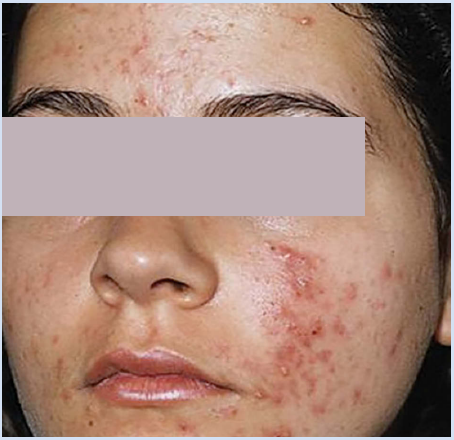
Mild / Moderate



Moderate

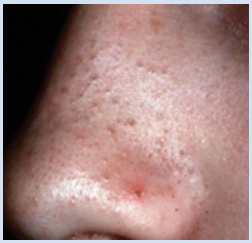
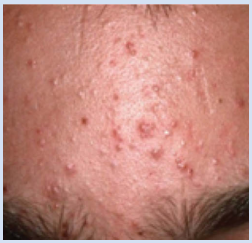
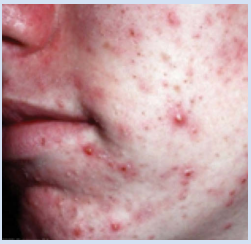
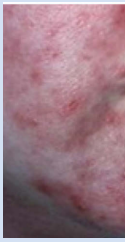


Moderate / Severe



Acne Treatment Algorithm

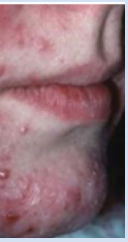
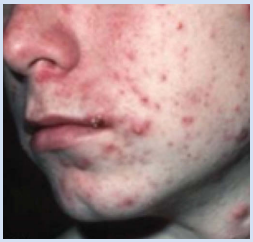
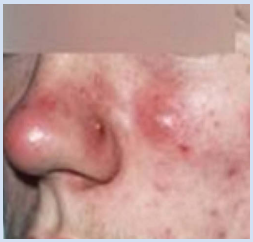
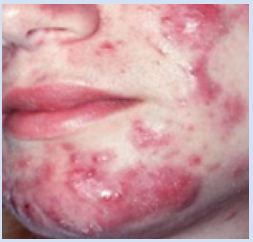
• To prevent scarring • To prevent disease progression • To reduce psychological impact
• To treat as many pathogenic factors of acne as possible

	Mild Comedonal	Mild Papular/Pustular
1st LINE	**Topical Retinoid*** • Adapalene 0.1% (Differin) cream • Isotretinoin 0.05% (Isotrex) gel	**Topical Retinoid* and Benzoyl Peroxide (BPO)** • Adapalene 0.1% (Differin) cream + BPO • Isotretinoin 0.05% (Isotrex) gel + BPO • Adapalene 0.1% + BPO 2.5% (Epiduo) gel
2nd LINE	• Azelaic acid 20% (Skinoren) cream • Benzoyl peroxide (BPO) • Adapalene 0.1% + BPO 2.5% (Epiduo) gel	**Combination Topical Antimicrobial** • Clindamycin 1% + BPO 5% (Duac) gel • BPO + Potassium hydroxyquinoline sulphate (Quinoderm) • Erythromycin topical solution (Zineryt) only in conjunction with BPO or topical retinoids

Mild

- Use topical retinoids at all stages to minimise comedone formation
- Apply to all acne prone areas in the evening, use pea sized amount
- Build up slowly, start 2 x week for 2-3 weeks then increase to alternate days/daily as tolerated
- Can use a moisturiser if extensive drying
- **Review after 12 weeks**
- Do not use topical and oral antibiotics simultaneously
- ***Do not use topical retinoids in pregnancy**

Moderate Inflammatory

Topical Retinoid* and Benzoyl Peroxide and Oral Antibiotics

- Adapalene 0.1% (Differin) cream or BPO or Adapalene 0.1% + BPO 2.5% (Epiduo) gel
  1) Lymecycline 408mg once daily
  2) Doxycycline 100mg once daily
  3) Oxytetracycline 500mg twice daily
  4) Erythromycin 500mg twice daily
  (consider in pregnancy and under 12s)

Females - Consider Hormone therapy

- Co-cyprindiol (Dianette) – wait 4-6m before assessing response as slow onset
- 2nd line consider (off licence)
  Ethinyloestradiol / Desogestrel (Marvelon, Gedarel)
  Ethinyloestradiol / Drospirenone (Yasmin, Lucette)
- +/- oral antibiotics

Severe

Oral Isotretinoin - Referral Criteria

- Severe nodulocystic acne or new scarring
- Inadequate response to ≥2 systemic antibiotics + topical treatment, each given for ≥3 months
- Patients with associated and severe psychological symptoms, regardless of physical signs

Consider

- Commencing oral antibiotics whilst waiting for referral
- Fasting lipids / LFTs / FBC + glucose prior to referral
- Start oral contraceptive pill for females of child-bearing age prior to referral

Moderate

- Use oral antibiotics for 3 months then reassess, should be >70% improved
- Stop antibiotics at 6 months and continue with topical treatments
- Caution patients regarding sun exposure with retinoids / doxycycline

Severe

- Continue maintenance topical retinoids or BPO for 3-6 months after systemic treatment is completed to reduce relapse rate

Rosacea

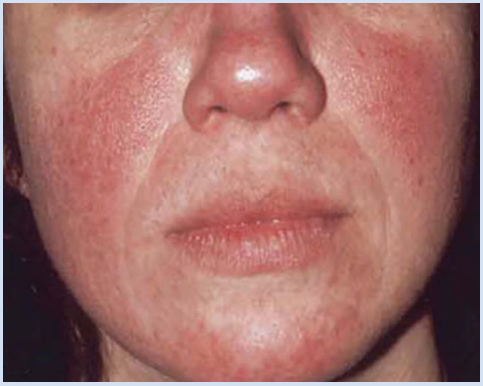
CLINICAL FEATURES	TREATMENT	THERAPEUTIC TIPS
Papules on an erythematous background, pustules,telangiectasia. Flushing often made worse by alcohol, spicy foods, hot drinks, temperature changes or emotion. Rhinophyma - Please see severe section for advice.	Early treatment of rosacea is considered to be important as each exacerbation leads to further skin damage and increases the risk of more advanced disease. Intermittent oral therapy e.g. 3 month courses dropped down to topical therapy for maintenance can be considered for those with occasional flare-ups. Continuous therapy will be needed if there are frequent recurrences.	**Sun protection** Sunshine may exacerbate Rosacea. SPF50 worn daily April-September. Higher factors if abroad. Reapply 1-2 hourly.
Mild to moderate cases or where systemic treatment is contraindicated	• **Topical Treatment** Metronidazole 0.75% cream / gel twice daily Azelaic Acid 15% gel (Finacea) twice daily	Continue for 6-8 weeks and re-assess Creams for dry / sensitive skin Gels for normal / oily skin.
Moderate - Severe	• **Systemic Treatments** Oxytetracycline 500mg twice daily Lymecycline 408mg (Tetralysal) once daily (unlicensed) Doxycycline 50-100mg once daily **(unlicensed)** Erythromycin 500mg twice daily (2 x 250mg e/c tablets) NB: not contraindicated in pregnancy Doxycycline 40mg* modified-release (Efracea) once daily Minocycline 100mg once daily (unlicensed in Rosacea) **Minocycline - Hospital only initiation and shared care after review of effectiveness**	**NB Tetracyclines are contraindicated in pregnancy, lactation and renal disease.** **Intermittent therapy 3 month courses, step down to topical therapy** *Anti-inflammatory dose. Will not kill bacteria or cause resistance. **ANA/LFTs required pre Minocycline and at 6 months.** **ANA/LFTs every 3 months thereafter.** **Minocycline can induce Lupus.**
Ocular Rosacea Mild eyelid redness and dry irritable eyes in 50% of patients	If severe, start oral tetracycline and refer to Ophthalmologist - can lead to keratitis and blindness.	Advise patient on lid hygiene to manage blepharitis. NB: Cleansing wipes on prescription (such as Blephaclean) are not supported by local Ophthalmologists.
Telangiectasia with / without rhinophyma	Laser treatments	**Subject to funding approval**
Erythema	Brimonidine 5mg/g (Mirvaso) gel is licensed for the treatment of facial erythema in rosacea.	Brimonidine has a limited role in therapy. **Assessment and initiation should be by a Dermatologist and shared care after review of effectiveness.**

Rosacea

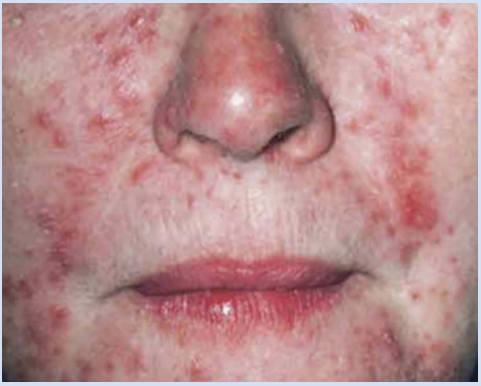
CRITERIA FOR REFERRAL

- Doubt over diagnosis
- Poor response to systemic therapy
- Consideration of oral retinoids
- Severe disease associated with the development of pyoderma faciale
- Severe ocular rosacea with keratitis or uveitis (refer to ophthalmologist)

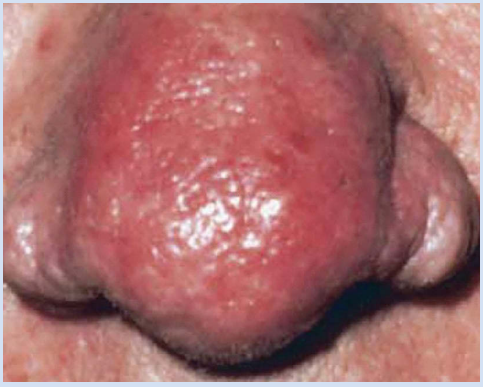
BAD Rosacea Patient Leaflet Link
http://www.bad.org.uk/for-the-public/patient-information-leaflets/rosacea?q=Rosacea



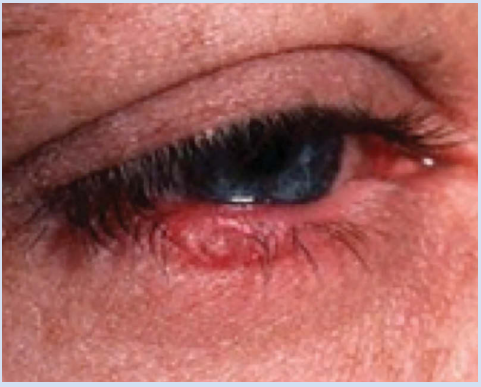
Subtype I:
Erythematotelangiectatic (ETR)



Subtype II:
Papulopustular rosacea (PPR)



Subtype III: Phymatous rosacea



Subtype IV: Ocular rosacea

Atopic Eczema - General Information

CLINICAL FEATURES

Atopic eczema is a common disease affecting up to 15% of children and 2-10% of adults.

If it does not itch, it is unlikely to be eczema. There may also be personal / immediate family history of asthma / hayfever.

Involvement of the face frequently occurs in infants.

The characteristic flexural distribution is usually present by the age of 18 months.

Realistic treatment aims need to be discussed with the patient and parents / carers.

Consider referral to nurse led education clinic if eczema is resistant to standard treatment (may benefit from wet wrapping at night).

Allergies and allergy testing

TREATMENT

Avoid irritants

- **Emollients** – see formulary emollients on pages 14/15

Emollients should be prescribed in all cases. Insufficient prescribing is frequent and can be the cause of poor response to treatment. Consider initially prescribing 2 x 500g tubs of different products for those with widespread eczema and review in 2 weeks to assess patient preference and effectiveness. See list of emollients on pages 14/15.

Emphasise to patient that this volume of emollients is the cornerstone to effective eczema management.

- **Bath Additives**

- **Shower preparations**

Keep dust down and in severe cases try protective coverings to pillows and bedding.

Consider exclusion diets only in difficult cases and abandon if no improvement apparent after 2 weeks.

THERAPEUTIC TIPS

Commercial soaps and detergents including bubble bath and shower gels should be avoided.

Water on its own can be drying and irritant.

Choose cotton clothing
Avoid wool next to the skin.

Fingernails should be kept short to reduce skin damage from scratching.

Skin should be moisturised at least 4 times per day. Emollients are best applied when skin is moist but can be applied at other times.

NB Paraffin products are flammable - Advise patients to avoid smoking when using paraffin products.

Aqueous Cream is **NOT** recommended as a soap substitute or emollient as it contains sodium lauryl sulfate which can act as an irritant.

House dust mites can aggravate eczema in some children.

No tests are available to confirm or refute food allergy as a cause of worsening eczema. RAST and skin prick tests may be considered if there is a good history of immediate reaction to food. False positive and false negative results are common (interpretation of results is complex). Testing may be considered in secondary care in resistant cases.

Patch testing is useful if patients report irritation with topical preparations or in facial, hand/fingertip and perioral eczema.

Food allergies; products only occasionally cause worsening of eczema, however dietetic advice is required if exclusion diets are used for more than 2-4 weeks.

The commonest manifestation of food allergy is urticaria not eczema.

NPSA Safety Alert
Fire Hazard with Paraffin Based Skin Products on Dressings and Clothing

http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59876

In November 2007 the National Patient Safety Agency (NPSA) issued an alert to all healthcare staff involved in the prescribing, dispensing or administration of paraffin based skin products. The NPSA highlighted that the topical administration of paraffin based skin-products, for example, emulsifying ointment or 50% liquid paraffin + 50% white soft paraffin (WSP) ointment carry a potential fire risk as bandages, dressings and clothing that come in to contact with them are easily ignited with a naked flame or cigarette. The risk is greater when these preparations are applied to large areas of the body and clothing or dressings become soaked with the ointment.

All patients and their families should be warned regarding the following risks:

- The risk of fire should be considered when using large quantities of any paraffin-based emollient (e.g. application of 100g or more at once or over a short period of time).
- Bedding and clothing should be washed regularly to minimise the build-up of impregnated paraffin.
- Patients should be advised to keep away from open or gas fires or hobs and naked flames, including candles etc. and not to smoke when using these paraffin containing preparations.
- A patient leaflet is available using the link above.

The following commonly prescribed products contain WSP at concentrations of 50% or more representing a higher level of risk:

Product	Concentration of WSP
White Soft Paraffin	100%
Zinc ointment BP	72.25%
Diprobase ointment	95%
Emulsifying ointment	50%
Liquid paraffin 50%/WSP 50% ointment	50%
Emollient aerosol spray	50%
Zinc and salicylic acid paste BP	50%

(PrescQIPP Bulletin 49 I May 2013 I v2.0)

Patients who require large quantities of emollient (100g or more per application) should use a water-based product (cream or lotion) rather than a paraffin based product (ointment) to reduce the fire risk.

Patients using medical oxygen should not use any paraffin based emollient.

List of Emollients on Local Formulary

Since the choice of emollient should be guided primarily by patient response and preference all emollients are available within the formulary. However, both Primary and Secondary Care clinicians should prescribe the lower cost formulations at the start of therapy.

Pump packs are preferred to reduce the risk of microbial contamination.
Fragranced preparations are not usually prescribed due to the risk of skin sensitization.

Lighter Emollients	
Lower Cost Formulations	**Higher Cost Formulations**
Aquamax cream	Aveeno Cream (pump pack preferable due to cost)
Cetraben cream (pump)	Hydromol cream (pump)
Diprobase cream (pump)	
Doublebase gel (pump)	
E45 cream (pump)	
Oilatum cream (pump)	
Unguentum M cream (pump)	

Heavier Emollients (effective, but not as cosmetically acceptable)	
Lower Cost Formulations	**Higher Cost Formulations**
Emulsifying ointment	Diprobase ointment
Hydromol ointment	Emollin spray
Liquid paraffin 50% / White Soft Paraffin 50% ointment	Epaderm cream (pump)
	Epaderm ointment
White Soft Paraffin	

Containing Urea (aids absorption, not for use on broken skin)	
Lower Cost Formulations	**Higher Cost Formulations**
Balneum cream (pump)	Calmurid cream (pump)
Balneum Plus cream (pump)	Hydromol Intensive cream
E45 Itch Relief cream	

Emollient Bath and Shower Preps – add bath emollients prior to getting into water	
Lower Cost Formulations	**Higher Cost Formulations**
Balneum bath oil	Aveeno bath oil
Balneum plus bath oil	
Cetraben bath oil	
Diprobath	
Doublebase bath additive	
Doublebase shower gel	
E45 emollient bath oil	
E45 wash cream	
Hydromol emollient bath additive	
Oilatum emollient bath additive	
Oilatum shower emollient gel	

List of Emollients on Local Formulary

With antimicrobial (appropriate for use if there are recurrent problems with infection)	
Lower Cost Formulations	**Higher Cost Formulations**
Dermol cream (pump)	Dermol 600 bath emollient
Dermol 200 shower emollient	Eczmol cream
Dermol 500 lotion (pump)	

Soap substitutes
All emollients with the exceptions of Doublebase and Liquid paraffin may be used as soap substitutes.

Aqueous cream is not recommended as an emollient or soap substitute as it contains sodium lauryl sulphate which can act as an irritant and cause stinging in a high number of patients.
Soap substitutes can replace shower / bath additives.
Commercial shower gels and soaps must be avoided.

Emollient Quantities

The BNF recommended quantities of emollients to be given to **ADULTS** for **twice daily** application for **ONE WEEK** have been used to calculate these monthly recommendations.

It is recommended that **CHILDREN** aged 12-18 years are prescribed the same quantity of emollients as adults.

Smaller quantities will be required for children under 12 years of age.
These recommendations do not apply to corticosteroid preparations.

Emollient Quantities for 12-18 years & Adults	Emollient Weekly Amounts	Monthly Amounts	Lotion Weekly	Lotion Monthly
Face	15 - 30g	60 - 120g	100ml	400 ml
Both hands	25 - 50g	100 - 200g	200ml	800ml
Scalp	50 - 100g	200g - 400g	200ml	800ml
Both arms or both legs	100 - 200g	400g - 800g	200ml	800ml
Trunk	400g	1600g	500ml	2000ml
Groin and genitalia	15 - 25g	60 - 100g	100ml	400ml

NB: In some cases emollients will be required 4-6 times daily and quantities should be increased accordingly.

Patients with widespread eczema should be prescribed 500–1000g of emollient per week.

Appropriate soap substitute should be prescribed unless the patient is also using their emollient as a soap substitute.

Topical Corticosteroids

For steroid therapy it is generally better to use higher potency steroids short term to gain control and then slowly step down therapy to minimum strength to maintain control. Sudden withdrawal of potent steroids will lead to rebound.

Topical Steroid Ladder

Mild	e.g. Hydrocortisone 0.5%,1% and 2.5%
Moderate	e.g. Betamethasone valerate 0.025% (Betnovate RD) Clobetasone butyrate 0.05% (Eumovate) Clobetasone butyrate 0.05% & Oxytetracycline & Nystatin (Trimovate)
Potent	e.g. Betamethasone valerate 0.1% (Betnovate) Fluocinolone acetonide 0.025% (Synalar) Hydrocortisone butyrate 0.1% (Locoid) Mometasone furoate 0.1% (Elocon)
Ultra Potent	e.g. Clobetasol propionate 0.05% (Dermovate) Diflucortone valerate 0.3% (Nerisone Forte)

Children - Quantities of Topical Corticosteroids

The recommended quantities of **STEROIDS** to be given to **CHILDREN** need to be in proportion to their size. The use of the fingertip unit helps in prescribing for limited areas of the body (see table). In order to minimise the side effects of a topical corticosteroid in children it is important to apply it thinly to affected areas only, no more frequently than twice daily and to use the least potent formulation which is fully effective. Children, especially babies, are particularly susceptible to side effects. The more potent steroids are contra-indicated in infants less than one year, and in general should be avoided or used with great care for short periods.

Age	3-6 mths	1-2 yrs	3-5 yrs	6-10 yrs
Face & Neck	1	1½	1½	2
Arm & Hand	1	1½	2	2½
Leg & Foot	1½	2	3	4½
Trunk (front)	1	2	3	3½
Trunk (back)	1½	3	3 ½	5

F.T.U. = Finger Tip Unit

Ref 1

1 F.T.U. = 0.5g

For an extensive body rash, quantities are more easily calculated depending on proportional surface area:

	% Adult dose	Daily (BD use)	Weekly (BD use)
Adult	100%	35.0g	245g
12yrs	75%	26.5g	183g
3 - 4yrs	50%	17.5g	122g
Infant	25%	8.7g	61g

Atopic Eczema in Children

CLINICAL FEATURES	TREATMENT	THERAPEUTIC TIPS
	• **Topical Steroids**	
Mild - Any site	Hydrocortisone 1% ointment twice daily for 1 week	Use body surface area charts to calculate correct quantities.
Mild/Moderate - Flexural/Face	Hydrocortisone 1% ointment twice daily for 1-2 weeks	Hydrocortisone 1% containing preparations are safe for long-term use. This is the only mild potency steroid.
Moderate - Trunk / Limbs	Clobetasone butyrate 0.05% (Eumovate) ointment twice daily for 1-2 weeks then reduce to hydrocortisone 1% ointment for 2-4 weeks	Tubifast garments can be very useful as single or double layer use (as in wet wraps)
Severe	Start treatment as for moderate and refer. **If potent or very potent steroids are being used on children, these patients should be referred.**	**Silk garments are very expensive and are not currently commissioned.**
For moderate or severe eczema with a poor response to standard treatment	• **Topical Immunomodulators Should only be initiated by physicians with experience in dermatology** Pimecrolimus 1% cream twice daily Tacrolimus 0.03% ointment twice daily for 6 weeks (can use as maintenance treatment twice a week)	Burning and irritation may occur and wears off within 7–10 days. Avoid in presence of infection, including HSV. Tacrolimus is very useful on the face, neck and flexures where potent steroids are contraindicated.

Adults - Quantities of Topical Corticosteroids

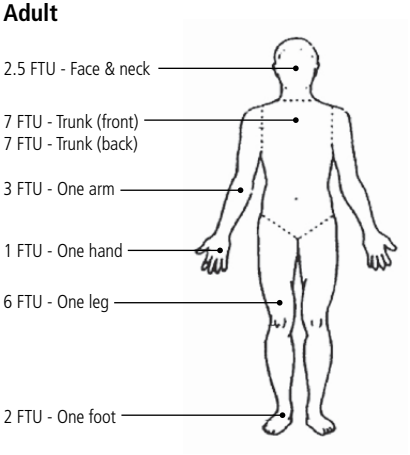
The recommended quantities of **STEROIDS** to be given to **ADULTS** if using twice daily applications for **ONE WEEK** have been used to calculate these monthly recommendations.
If these are potent or very potent steroids they have potentially serious side effects and their prescription must be reviewed regularly.

Affected Area	Quantity of Creams / Ointments per week	Quantity per month
Face	15 - 30g	60 - 120g
Both hands	15 - 30g	60 - 120g
Scalp	15 - 30g	60 - 120g
Both arms	30 - 60g	60 - 120g
Both legs	100g	400g
Trunk	100g	400g
Groin and genitalia	15 - 30g	60 - 120g

F.T.U. = Finger Tip Unit
Ref 1

1 F.T.U. = 0.5g

Adult



Atopic Eczema in Adults

CLINICAL FEATURES	TREATMENT	THERAPEUTIC TIPS
	• **Topical Steroids**	
Mild - any site	Hydrocortisone 1% ointment twice daily for 1 week	Creams are preferable in flexural sites
Moderate - Trunk / limbs	Betamethasone valerate 0.1% (Betnovate) ointment – use for 2 weeks, review and reduce to Clobetasone butyrate 0.05% (Eumovate) ointment	Ointments are preferable elsewhere
Moderate - Face / Flexures	Clobetasone butyrate 0.05% (Eumovate) ointment – use for 2 weeks, review and reduce to Hydrocortisone 1% ointment	
Severe - Trunk / limbs	Clobetasol propionate 0.05% ointment (Dermovate) twice daily for 2-4 weeks, review and reduce to Clobetasone butyrate 0.05% (Eumovate) ointment	An ultra-potent topical steroid
Severe - Face	As for moderate. Where topical treatments are not suitable, severe eczema may require a tapering course of oral Prednisolone 30mg once daily for 1 week, reducing by 5mg a day every 3 days and then stop.	**Consider referral if needing more than one course of oral steroid per year. Please see Steroid Patient Leaflet link below ***
For eczema of any severity with a poor response to standard treatment	• **Topical Immunomodulators should only be initiated by clinicians with experience in dermatology**	
Mild to moderate	Tacrolimus 0.03% ointment twice daily until clearance Pimecrolimus 1% cream twice daily until clearance	If eczema flares when using topical immunomodulators, STOP, change back to topical steroid and consider infection as a cause.
Moderate to severe	Tacrolimus 0.1% ointment twice daily for 3 weeks then twice weekly to maintain control. Can be interspersed with topical steroids to help control.	Once acute flare or infection is treated restart topical immunomodulators twice per week as maintenance treatment.

* BAD Oral Steriod Leaflet Link

http://www.bad.org.uk/for-the-public/patient-information-leaflets/oral-treatment-with-corticosteroids

Infected Eczema

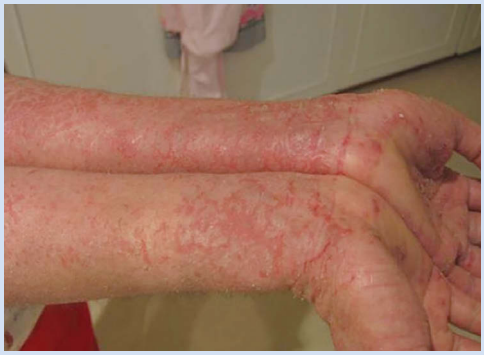
CLINICAL FEATURES	TREATMENT	THERAPEUTIC TIPS
Infected Eczema Suspect infection if localised, poor response to topical steroid treatment, weepy, crusting, bleeding or sudden flare.	**Use topical steroid with added antimicrobials of strength appropriate to site and severity of eczema.** • **Hydrocortisone 1% containing preparations** - Oxytetracycline 3% + Hydrocortisone 1% ointment (Terra-Cortril) - Clotrimazole 1% + Hydrocortisone (Canesten HC) for flexures - Miconazole 2% + Hydrocortisone 1% (Daktacort) for flexures - Fusidic acid 1% + Hydrocortisone 1% (Fucidin H) • **Clobetasone butyrate 0.05% containing preparations** - Clobetasone butyrate 0.05% w/w, Oxytetracycline 3.0% + Nystatin 100,000 units (Trimovate cream) • **Betamethasone valerate 0.1% containing preparations** - Betamethasone valerate 0.1% + Clioquinol 3% (Betnovate C) - Betamethasone valerate 0.1% + Neomycin sulphate 0.5% (Betnovate N) - Fusidic acid 1% + Betamethasone valerate 0.1% (Fucibet) - Chlortetracycline 3.09% + Triamcinolone Acetonide 0.1% (Aureocort) • **If extensive or severe infection - ADD oral antibiotics to plain topical steroids** - Flucloxacillin 500mg four times daily for 7-14 days or for children over 2yrs 250mg four times daily for 7-14 days - Clarithromycin 500mg twice daily for 7-14 days - Erythromycin 500mg four times daily for 7-14 days (2 x 250mg e/c tablets)	**Take nasal swabs from patient and family, if recurrent infected eczema.** **Most common pathogens:** Staphylococcus aureus Streptococcus pyogenes Candida albicans Antibiotic-containing topical treatments should not be used for more than 2 weeks (to reduce antibiotic resistance). **Avoid adding Fucidin H or Fucibet to repeat prescriptions due to the increasing importance of appropriate targetted use of antibiotics and the increasing resistance to fusidic acid.** Creams containing tetracycline + nystatin mix are good for flexures. Products containing tetracyclines are yellow and stain clothing. **NB: Avoid oral and topical antibiotics in combination** Take skin swabs to ensure correct antibiotic prescribed.

Infected Eczema

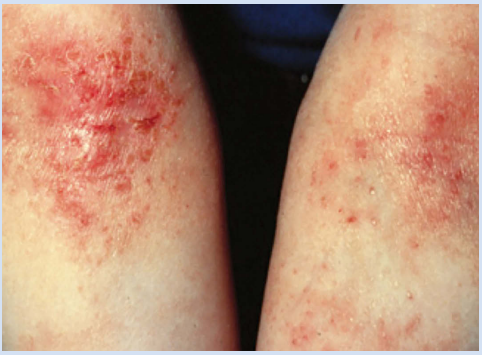
CLINICAL FEATURES	TREATMENT	THERAPEUTIC TIPS
	If recurrent infections, take nasal swabs from family members and if positive, eradicate nasal carriage of Staphylococcus aureus: - Naseptin twice daily for 10 days - Bactroban nasal ointment three times a day for 5 days	
Lichenified Chronic Eczema Of Limbs	• **Bandaging (adults and children)** Zinc paste bandages (Zipzoc) on the limbs used alone or over topical corticosteroids can result in rapid improvement of lichenified eczema.	Bandaging techniques may be demonstrated by a suitably trained nurse or nurse specialist. Ideally initiated by secondary care or GPSI.

BAD Eczema Patient Leaflet Link
http://www.bad.org.uk/for-the-public/patient-information-leaflets/atopic-eczema

National Eczema society Link http://www.eczema.org/



Eczema



Infected Eczema

CRITERIA FOR REFERRAL – SPECIALIST NURSE CLINICS

Known cases of eczema for:

- Patient education / advice
- Review of treatment
- To learn techniques e.g. Zinc based paste bandages / Wet Wraps etc.

CRITERIA FOR REFERRAL – DERMATOLOGY

- Only cases of severe or difficult eczema usually need to see a Dermatologist
- For consideration of second line treatment e.g. phototherapy or cytotoxic drugs
- Eczema herpeticum – **Emergency Referral**
- If allergic contact dermatitis is suspected, refer for consideration of patch testing
- For in-patient treatment

Hand Eczema

CLINICAL FEATURES	TREATMENT	THERAPEUTIC TIPS
Dry Hand Eczema **Blistering Hand Eczema (Pompholyx)** **Both conditions may also affect feet**	**Avoidance of irritants** e.g. commercial soaps, shampoos, detergents. Use cotton / PVC gloves to avoid contact with allergens and irritants. **All patients should be given emollients and soap substitutes** • Emollients (see emollient appendix) • Soap substitutes (see emollient appendix) • Topical Steroids Moderate to potent strength • **Dry and scaly eczema** Betamethasone valerate 0.1% (Betnovate) ointment twice daily for 4-6 weeks, review. • **Wet, weeping or blisters/ burst blisters** Potassium permanganate soaks 1:10,000 solution for 10-15 minutes twice daily for 5-7 days. Flucloxacillin 250 mg four times daily for 7 days. Clobetasol propionate 0.05% cream, (Dermovate) twice daily for 2 to 3 weeks. When dry switch to Betamethasone valerate 0.1% (Betnovate) ointment as per dry eczema • **For severe cases consider Prednisolone 30 mg once daily for 7 days if patient is unable to complete topical treatments**	Other skin conditions can mimic eczema and should be kept in mind. Examine the skin all over as this can provide clues to other diagnoses e.g. plaques in extensor distribution in psoriasis, scabetic nodules. An occupational and social history should be taken. The patient may need Patch Tests. If eczema is present on only one hand fungal infection needs to be excluded by taking skin scrapings for mycology. Dissolve one Permitab tablet in 4 litre bucket of water until colour is a light pink. Potassium permanganate can cause nails to be stained brown, and also stains porcelain sinks/baths.
Occlusion / cracks or splits on digits/heels	• **Fludroxycortide (Haelan) Tape** leave on for at least 12 hours daily Review at 4-6 weeks Regular review to ensure treatment is effective.	

Note: Risk of death or serious harm from accidental ingestion of potassium permanganate preparations. Patient Safety Alert:

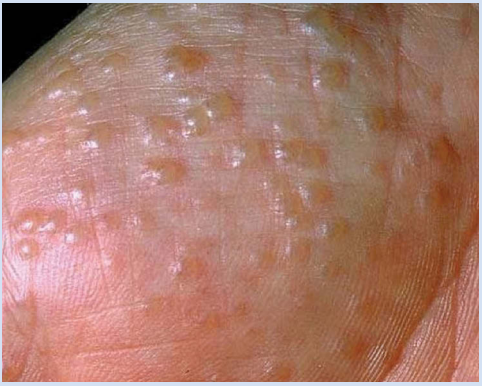
http://www.england.nhs.uk/wp-content/uploads/2014/12/psa-potass-prmangant.pdf

Hand Eczema

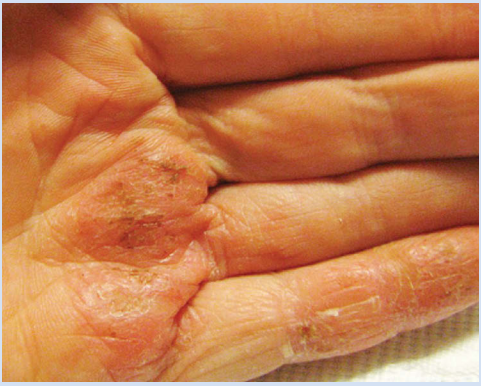
CRITERIA FOR REFERRAL

- If allergic contact dermatitis is suspected patients may benefit from Patch Testing
- Patch Tests are of no value in type 1 reactions (e.g. food allergies, anaphylaxis or urticaria).
- Severe chronic hand dermatitis which is unresponsive to standard treatment i.e. not significantly improved after 2 weeks

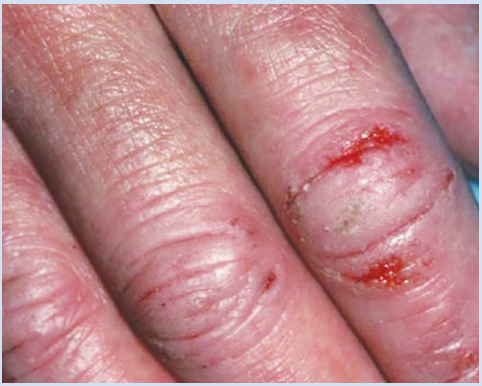
BAD Hand Eczema Patient Leaflet Link
http://www.bad.org.uk/for-the-public/patient-information-leaflets/contact-dermatitis



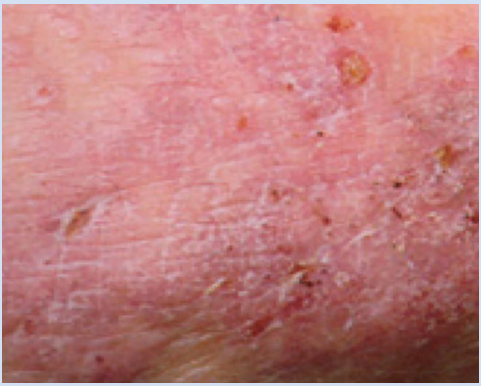
"Wet" (Blistering and Weeping) eczema



"Dry" (Hyperkeratotic and fissured)



Splits and cracks "Dry" eczema



Lichenified eczema

Varicose Eczema

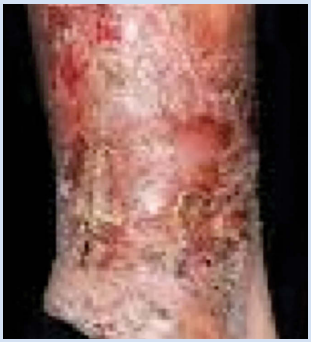
CLINICAL FEATURES	TREATMENT	THERAPEUTIC TIPS
Varicose eczema commonly co-exists with varicose ulcers	**All patients need:** • **Emollients** - see formulary emollients on pages 14/15. • **Soap substitutes** - see emollient appendix • **Topical steroids** - see below • **Calcineurin inhibitors** can be used as steroid sparing agent. **Below knee compression stockings worn only during the day time.** **Doppler studies are required to confirm arterial sufficiency before prescribing compression hosiery.**	Use creams if wet / weeping Use ointment if dry / scaly. Stockings are available in Class I, II and III dependent upon severity - usually start with Class I stockings. Typically they should be replaced after 3 months of use. If prescribing two pairs, one to wear and one to wash, both pairs will usually need replacing after 6 months.
Mild	Clobetasone butyrate 0.05% (Eumovate) twice daily	
Moderate - Severe or 'Discoid' eczema	Betamethasone valerate 0.1% (Betnovate) twice daily, use for 2-4 weeks then reduce to lowest effective strength ↓ Betamethasone valerate 0.025% (Betnovate RD) twice daily ↓ Hydrocortisone 1% ointment twice daily	
Infection **Wet, Weeping or Blisters**	**Burst blisters** Potassium permanganate soaks 1:10,000 for 10-15 minutes twice a day **Substitute - steroid-antibiotic preparations** - as for infected eczema	Dissolve one Permitab tablet in 4 litre bucket of water until colour is a light pink. Potassium permanganate can cause nails to be stained brown, and also stains porcelain sinks/baths.

Note: Risk of death or serious harm from accidental ingestion of potassium permanganate preparations. Patient Safety Alert:

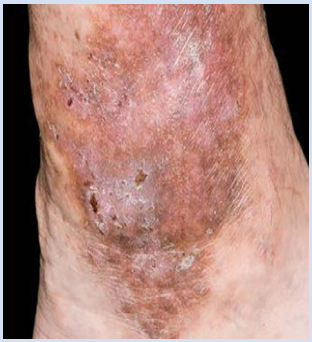
http://www.england.nhs.uk/wp-content/uploads/2014/12/psa-potass-prmangant.pdf

Varicose Eczema

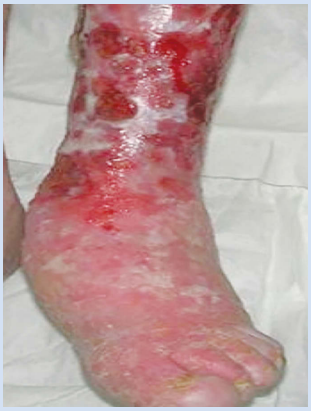
CLINICAL FEATURES	TREATMENT	THERAPEUTIC TIPS
Severe Infection	Treatment as for infected eczema	Take skin swabs for culture and sensitivity
Cellulitis	**Oral Antibiotics** - Flucloxacillin 500mg four times daily for 7 days - Clarithromycin 500mg twice daily for 7 days - Doxycycline 100mg twice daily for 7 days	**If patient is febrile and ill consider assessment for IV treatment** If patient is afebrile and otherwise healthy, use oral flucloxacillin alone. Repeat the course if slow response after 7 days.



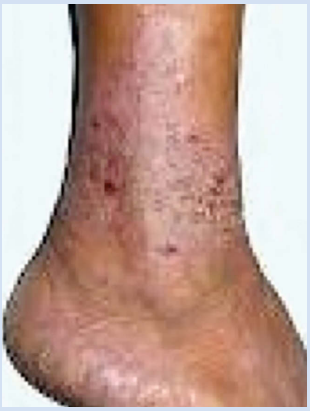
Wet / weepy infected eczema and ulcers



Dry / scaly eczema and ulcers



Blisters / weeping eczema



Dry / scaly eczema and ulcers

BAD Varicose Eczema Patient Leaflet Link
http://www.bad.org.uk/for-the-public/patient-information-leaflets/venous-eczema

Seborrhoeic Dermatitis

CLINICAL FEATURES	TREATMENT	THERAPEUTIC TIPS
Very common chronic dermatosis, characterised by redness and scaling, affecting areas where sebaceous glands are most active i.e. scalp, face, presternal area + body flexures. Newborns can present with cradle cap. Usually improves with sunlight. Consider HIV status in young patients presenting with severe rapid onset of symptoms.		
Infants with cradle cap	Olive oil / emulsifying ointment under cap to soften scales and wash off with baby shampoo. Then apply Hydrocortisone 1% cream / ointment.	Occlude with cap for 2-3 hours.
Infants – face and body	Options for treatment are: • Hydrocortisone 1% cream twice daily for 5-7 days • Hydrocortisone 1% + Miconazole nitrate 2% (Daktacort) cream twice daily for 5-7 days • Hydrocortisone 1% + Clotrimazole 1% (Canesten HC) cream twice daily for 5-7 days.	
Older children and adults – face	• Hydrocortisone 1% cream twice daily • Hydrocortisone 1% with Miconazole nitrate 2% (Daktacort) cream twice daily for 5-7 days • Hydrocortisone 1% with Clotrimazole 1% (Canesten HC) cream twice daily for 5-7 days • Ketoconazole 2% (Nizoral) cream twice daily for 7-10 days • Clobetasone butyrate 0.05% (Eumovate) cream twice daily	Hydrocortisone 1% products can be used longer term if needed.
Eyelids	Wash with diluted baby shampoo and wipe with a warm flannel	
Scalp	Tar based or antifungal shampoo e.g. Ketoconazole / Capasal shampoo / TGel / Etrivex once or twice a week	Rotation with different shampoos can be helpful as resistance can build. Ensure shampoo is left on for 5-10 minutes before washing out.

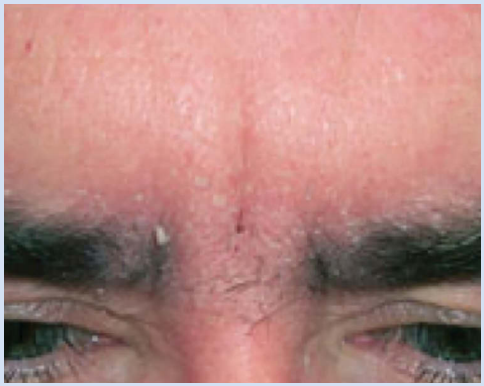
Seborrhoeic Dermatitis

CLINICAL FEATURES	TREATMENT	THERAPEUTIC TIPS
Pre-sternal area / flexures	Ketoconazole 2% (Nizoral) cream twice daily Clobetasone butyrate 0.05% (Eumovate) cream twice daily Steroid sparing treatments: 1) Pimecrolimus 1% cream twice daily 2) Tacrolimus 0.03% or 0.1% ointment twice daily 3) Itraconazole 200mg orally once daily for 7 days	Consider these if using topical steroids frequently **NB: 1) & 2) Unlicensed indication and should only be initiated by clinicians with experience in dermatology**

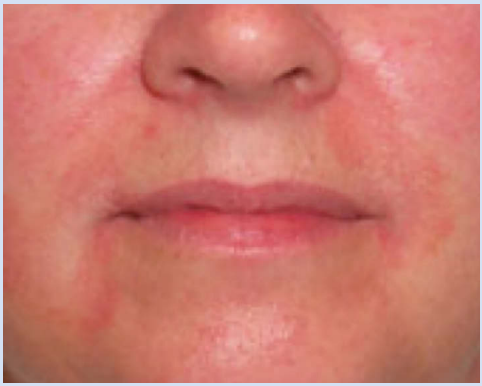
CRITERIA FOR REFERRAL

- Failed suggested treatments
- Persistent or frequent episodes
- Uncertainty in diagnosis

BAD Seborrhoeic Dermatitis Patient Leaflet Link
http://www.bad.org.uk/for-the-public/patient-information-leaflets/seborrhoeic-dermatitis



Seborrhoeic Dermatitis



Seborrhoeic Dermatitis

Psoriasis

The following guidelines, which may differ from current NICE guidelines, have been agreed by local Primary and Secondary care clinicians to enhance compliance and cost effective prescribing.
Acknowledgement to Salford Royal NHS Foundation Trust.

Treatment algorithm at end of section

CLINICAL FEATURES	TREATMENT	THERAPEUTIC TIPS
TRUNK & LIMBS **Mild to moderate** Pink plaques with silvery white scales, commonest sites are elbows and knees. Aggravated by stress and infections. Improves with sunlight	• **Emollients and soap substitutes for all patients at all stages in sufficient quantities as per guidance page** *plus* • **Vitamin D analogues** Calcitriol 3mcg/g (Silkis) twice daily Calcipotriol 50mcg/g once or twice daily Tacalcitol 4mcg/g once daily *or* For minimal localised plaques **Potent Steroids** can be used, with emollients, as sole treatment e.g. Betamethasone valerate 0.1% (Betnovate) • **Combination (may improve compliance / be more effective)** Calcipotriol 50mcg/g + betamethasone dipropionate 0.05% (Dovobet) gel / ointment once daily • **Coal Tar Preparations** Exorex Lotion twice daily Alphosyl HC twice daily Carbo-Dome 10% CT cream	Vitamin D analogues should be used for 2-3 months to assess response. Calcitriol is licensed for 12yrs and over can be used in flexures. Calcipotriol is licensed for 6yrs and over, please check BNF for dosing. Tacalcitol is licensed for 12yrs and over. Vit D preparations can cause skin irritation. Vit D Analogues should be avoided in those with calcium metabolism disorders as they can cause hypercalcaemia. Use of potent steroids should be continued until the plaques are no longer raised or scaly then continue with emollient alone. For particularly scaly plaques, potent steroids with salicylic acid may be preferred e.g. Diprosalic. **Dovobet is useful for smaller areas whereas Vitamin D analogues alone can be used for more extensive areas.** Coal tar products are not to be used on broken / highly inflamed skin, sore / acute pustular psoriasis or infected skin.
TRUNK & LIMBS **Severe**	Start Calcipotriol 50mcg/g & betamethasone dipropionate 0.05% (Dovobet) gel once daily and **REFER** to secondary care	Licensed for 18yrs and over.

Psoriasis

CLINICAL FEATURES	TREATMENT	THERAPEUTIC TIPS
FLEXURES & GENITALIA	• Clobetasone butyrate 0.05% + Oxytetracycline 3.0% + Nystatin 100,000 units (Trimovate) cream twice daily for 1 - 2 weeks to control a flare moving on to the following milder preparations for control.	Try one preparation for two weeks Step down from moderately potent steroid once controlled to either mild steroid or vitamin D analogue
	• Clotrimazole 1% + Hydrocortisone 1% (Canesten HC) cream twice daily *or* Miconazole 2% + Hydrocortisone 1% (Daktacort) cream twice daily *or* Hydrocortisone 1% twice daily	
	• Calcitriol 3mcg/g (Silkis) twice daily *or* Tacalcitol 4mcg/g (Curatoderm) once daily (unlicensed indication)	See above therapeutic tips regarding Vitamin D analogues
	If no improvement with milder preparations:	
	• Clobetasone butyrate 0.05% w/w, Oxytetracycline 3.0% + Nystatin 100,000 units (Trimovate) cream twice daily for 1-2 weeks *or*	
	• Tacrolimus 0.1% ointment for 2-4 weeks (unlicensed indication)	Tacrolimus on specialist initiation with ongoing review

Psoriasis

CLINICAL FEATURES	TREATMENT	THERAPEUTIC TIPS
FACE & HAIRLINE	• **Emollients for all patients** *plus*	
	Clobetasone butyrate 0.05% (Eumovate) twice daily. **Max 2 weeks at a time.**	Step down from moderately potent steroid once controlled to either mild steroid or vitamin D analogue.
	• Hydrocortisone 1% twice daily • Miconazole 2% + Hydrocortisone 1% (Daktacort) twice daily • Clotrimazole 1% + Hydrocortisone 1% (Canesten HC) cream twice daily	Try one preparation for up to 2 weeks
	or	
	• Calcitriol 3mcg/g (Silkis) twice daily • Tacalcitol 4 mcg/g (Curatoderm) once daily	Silkis is licensed for eyelids with caution
	• Tacrolimus 0.03% or 0.1% (unlicensed indication) • Pimecrolimus 1% cream can be very effective for facial psoriasis (unlicensed indication)	Tacrolimus / pimecrolimus on specialist initiation with ongoing review
PALMAR PLANTAR	• **Emollients for all patients** *plus*	Try one treatment for 2-4 weeks then review
	Betamethasone valerate 0.1% (Betnovate) ointment once or twice daily	
	or	
	Betamethasone dipropionate 0.05% + Salicylic acid 2% (Diprosalic) ointment once or twice daily	If no improvement, include plastic occlusion overnight i.e. plastic gloves / cling film
	or	
	Calcipotriol 50mcg/g + betamethasone dipropionate 0.05% (Dovobet) once daily	

Psoriasis

CLINICAL FEATURES	TREATMENT	THERAPEUTIC TIPS
SCALP PSORIASIS		
Mild	• **Shampoos** Polytar Alphosyl 2 in 1 Ceanel Capasal Nizoral T-Gel	Always check patient preference to smell, colour and application to ensure maximum compliance. Leave on scalp for up to 5 minutes before washing out.
Moderate	Betamethasone valerate 0.1% (Betnovate) scalp application once or twice daily Betamethasone dipropionate 0.05% + Salicylic acid 2% (Diprosalic) scalp application once or twice daily Fluocinolone acetonide 0.025% (Synalar) gel once daily if other lotions sting Calcipotriol 50mcg/g + Betamethasone dipropionate 0.05% (Dovobet) gel once daily for 2-4 weeks Clobetasol propionate 0.05% (Etrivex) shampoo. Apply for 15 minutes once daily for 2 weeks. As control is gained reduce frequency. Courses of 4 weeks can be repeated intermittently.	Apply steroid or Dovobet gel to affected areas daily for 2-4 weeks to gain control then reduce to once or twice a week for maintenance. Apply to dry hair leave in overnight. To remove; apply medicated shampoo (see above) to dry hair, then wait a few minutes before washing as normal. Repeat shampoo as needed. After 15 minutes contact add warm water to wash hair then rinse out as a normal shampoo. Use if plaques are thin and widespread throughout scalp.
Severe (Thick scale)	Coconut oil compound (Sebco) to be applied every night for 7 days to descale and then treat as for moderate. Plus a shampoo of choice from the list above.	Either apply for one hour in the evening and wash out before bed time or, for greater efficacy consider use overnight underneath a shower cap as occlusion (unlicensed)

Management of Psoriasis in Primary Care - Quick Reference Guide

Treatment

- Discuss treatment options
- Assess practicalities of treatment
- Explain method of applicatiom
- Explain need for compliance
- Prescribe appropriate quantities
- Please consider cost of treatment relative to patient compliance

Education

- Educate the patient about psoriasis and counsel on use of treatments
- Provide information leaflets as required e.g. http://www.bad.org.uk/site/865/default.aspx (good for multilingual leaflets) http://www.papaa.org/ (good for self help / psychological support)

Assessment

- Include details of CV assessment i.e. BP, BMI, fasting lipids and smoking **as psoriasis is an independent risk factor for CV disease**
- Consider exacerbators - alcohol, stress, smoking, co-existing mental health problems, streptococcal infection, medications e.g. B-blockers, Lithium, Antimalarials, ACE inhibitors

EMOLLIENTS AND SOAP SUBSTITUTES FOR ALL PATIENTS

Palmar Plantar

- Betnovate ointment bd
- Diprosalic ointment bd
- Dovobet ointment od
- If no improvement add plastic occlusion overnight eg. Plastic gloves / clingfilm

Scalp

Mild (fine scaling only)

Shampoo - Polytar, Alphosyl 2 in 1, Ceanel, Capasal, Nizoral, T/Gel

Moderate

1. Betnovate scalp solution bd
2. Diprosalic scalp bd
3. Synalar gel od
4. Dovobet gel (consider 1st line if also using for plaque psoriasis), od 2-4 weeks then reduce for maintenance
5. Clobetasol (Etrivex) shampoo 15 minutes application max 4 weeks

Trunk and limbs

Mild / Moderate

- Vitamin D analogues e.g Calcipotriol bd (>6s). Calcitriol bd (>12s), Tacalcitol od (>12s) - all useful for more extensive thin areas but note limited amount / week
- Potent Steroids for minimal localised plaques
- Dovobet gel / ointment od (>18s) (useful for smaller thick plaques)
- Coal Tar preparations (not on inflamed/infected skin) e.g. Exorex lotion bd, Alphosyl hc bd, Carbodome 10% CT

Flexures and Genitalias

1. Trimovate bd 2w to control flare
2. Canesten HC / Daktacort bd / HC cream
3. Calcitriol bd or Tacalcitol od (unlicensed)
4. Tacrolimus 0.1% 2-4 weeks

Face and Hairline

- Eumovate bd for 2 weeks then step down to HC 1% bd, Daktacort bd or Canesten HC bd
- Calcitriol (Silkis) bd (licensed for eyelids with caution)
- Tacalcitol 4 mcg/g (Curatoderm) once daily
- Tacrolimus 0.03%/0.1% or Pimecrolimus 1% (unlicensed indication)

Severe
Sebco scalp ointment 1 hour or overnight under occlusion (shower cap) for 7 nights. Use mild and moderate treatments also as needed.

- Dithrocream - max. 30 minutes with higher strengths (give clear instructions on use)

Severe

- Start dovobet od and refer

Patient Review

- Initial treatment period 4 weeks then review as required
- Check compliance / amount of treatment used

Improvement

- If clear tail off treatment, if improved go to maintenance therapy i.e. initial treatment for mild / moderate disease
- Review every 8 weeks or as and when needed

No Improvement

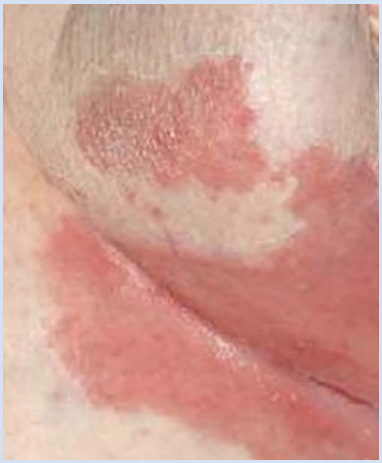
- Change to topical treatments as per protocol
- Review after 4 weeks
- Consider referral

Criteria for referral

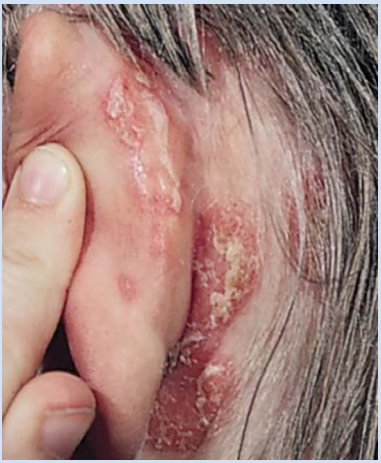
- Erythroderma
- Extensive >20% body surface area with disabling psoriasis
- Failure to respond to topical treatment
- Unstable / rapidly extending psoriasis

Acknowledgements to Salford Royal NHS Foundation Trust

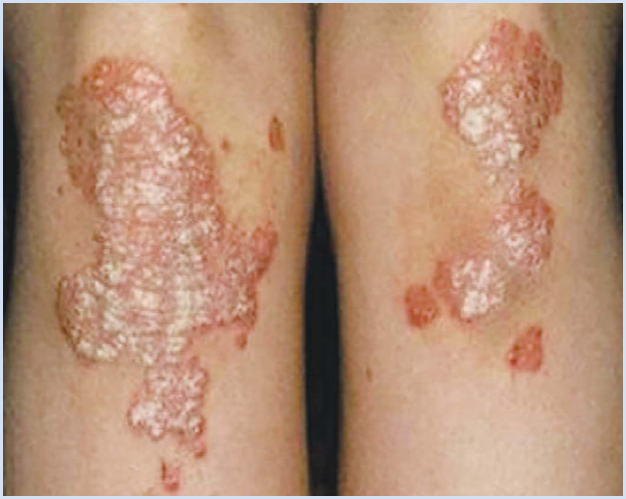
Psoriasis



Flexural Psoriasis (Breast fold)



Psoriasis hairline



Plaque Psoriasis (limbs)

BAD Psoriasis Patient Leaflet Link
http://www.bad.org.uk/for-the-public/patient-information-leaflets/psoriasis---an-overview

CRITERIA FOR REFERRAL

- Erythroderma
- Extensive >20% body surface area with disabling psoriasis
- Failure to respond to topical treatment
- Unstable / rapidly extending psoriasis

Generalised Pruritus

CLINICAL FEATURES	TREATMENT	THERAPEUTIC TIPS
Dry skin, low grade eczema and scabies are the commonest cause of generalised pruritus. **A full history and skin examination are required.**	**Standard emollients and soap substitutes –** see pages 14 / 15 Crotamiton 10% cream or Crotamiton 10% + Hydrocortisone 1% (Eurax HC) cream twice daily / as needed to pruritic areas. Menthol 1% in aqueous cream as often as necessary to pruritic areas. If symptoms are still uncontrolled consider sedating antihistamines at night Hydroxyzine 25 - 75mg at night or 10 - 30mg at night (elderly) Chlorphenamine Maleate 2 - 4mg at night	If **NO RASH** can be seen other than excoriations consider the following: Iron deficiency Uraemia Obstructive jaundice Thyroid disease Lymphoma, especially in young adults Carcinoma, especially in middle age and elderly Psychological **Investigations:** FBC ESR Urea and electrolytes LFTs Thyroid function tests Iron / TIBC / Ferritin Chest X-ray Immunoglobulins / Electrophoresis **NB: Pruritus may occasionally predate a lymphoma by several years. Regular follow-up is indicated for patients whose itching is unexplained.**

Note: MHRA safety alert: Hydroxyzine (Atarax, Ucerax): risk of QT interval prolongation and Torsade de Pointes.

https://www.gov.uk/drug-safety-update/hydroxyzine-atarax-ucerax-risk-of-qt-interval-prolongation-and-torsade-de-pointes

When using hydroxyzine:

- do not prescribe hydroxyzine to people with a prolonged QT interval or who have risk factors for QT interval prolongation
- avoid use in the elderly - they are more susceptible than younger patients to the side effects of hydroxyzine
- consider the risks of QT interval prolongation and Torsade de Pointes before prescribing to patients taking medicines that lower heart rate or potassium levels

The maximum daily dose is now:

- 100mg for adults
- 50mg for the elderly (if use cannot be avoided)
- 2mg per kg body weight for children up to 40 kg in weight

Prescribe the lowest effective dose for as short a time as possible

CRITERIA FOR REFERRAL

Patients may be referred if:

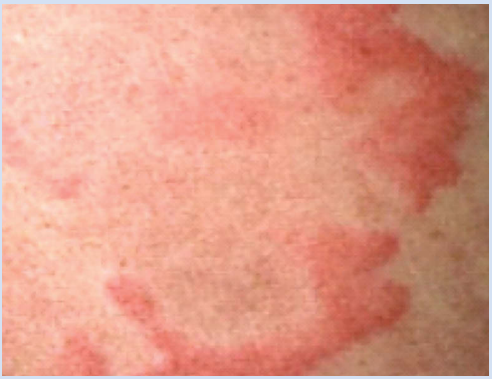
- Diagnosis uncertain
- Persistent symptoms not responding to topical treatments.

Urticaria and Angioedema

CLINICAL FEATURES	TREATMENT	THERAPEUTIC TIPS
Rash of recurrent itchy wheals in which individual wheals resolve within 24 hours **Reassure the patient that it is benign and usually self-limiting.** ***Minimise:*** **Overheating** **Stress** **Alcohol** **The following drugs are associated with urticaria - aspirin, codeine, morphine, NSAIDs, ACE inhibitors and penicillin.** **If angioedema is the only sign, exclude C1esterase inhibitor deficiency by blood test for C3, C4 and C1 esterase inhibitor.**	• **Antihistamines** Non-sedating - start with once daily dose and can increase to twice daily if required (unlicensed dose). Should be used as required for sporadic attacks or if more persistent as prophylaxis. If there is no response after six weeks, double the dose or try a second and then a third agent. If sleep is disturbed, add a sedative antihistamine at night. Can try H_2 antagonists e.g. Ranitidine to add to antihistamine effect. For acute and severe attacks, can use short course of oral steroid. Not for long term use.	Prick tests, RAST tests and Patch tests are of no value in urticaria. The cause of food allergy is usually obvious from the history. Contact urticaria is rare and the cause is obvious from the history. Urticaria may follow non-specific infections, hepatitis, streptococcal infections, campylobacter and parasitic infestations. Rarely it may be a symptom of an underlying systemic disease such as thyroid disease or connective tissue disease e.g. Lupus. Do FBC, TFT and autoimmune screen (including thyroid peroxidase antibody) in urticaria of more than 3 months duration.

Urticaria and Angioedema

Recommended Antihistamines	
Non / Low Sedating	
1st Line	Cetirizine
	Desloratadine
	Fexofenadine (180mg)
	Loratadine
2nd Line	Acrivastine
	Levocetirizine
3rd Line	Mizolastine
More Sedating	
Hydroxyzine* (see safety information on page 35)	
Chlorphenamine maleate (OK in pregnancy)	



Urticaria

BAD Urticaria and Angioedema Patient Leaflet Link
http://www.bad.org.uk/for-the-public/patient-information-leaflets/urticaria-and-angioedema

CRITERIA FOR REFERRAL

- Individual urticarial wheals lasting more than 24 hrs, leaving skin changes resembling bruising (sign of urticarial vasculitis)
- Failure to respond to above maximum treatment

Ask patients to bring photos of rash to appointment

Viral Warts

CLINICAL FEATURES	TREATMENT	THERAPEUTIC TIPS
Viral Warts / Verrucae **> 70% resolve spontaneously in 2 years.** **Topical treatment is as effective as cryotherapy for hand warts.**	• **Topical keratolytics** **Hand warts** Use high concentrations of Salicylic acid once daily for up to 3 months - **Adults** e.g. Occlusal (25% Salicylic acid) - **Children** e.g. Duofilm (16.7% Salicylic acid) Salactol (16.7% Salicylic acid)	File warts daily before applying a fresh coat of paint solution
Plantar warts are more persistent.	**Plantar warts** Verrugon (50% Salicylic acid) • **Duct Tape** • **Cryotherapy** **For warts resistant to above topical treatments** **Experienced practitioners only** Freeze times: - Face 5 – 7 seconds - Hands 10 – 15 seconds Feet: - 1st freeze 15 seconds - Thaw 1 – 2 minutes - 2nd freeze 10 – 15 seconds	Occlude warts Smaller lesions need shorter freeze times Up to 6 treatments 3-4 weeks apart. Combine with topical treatment between cryotherapy sessions once inflammation from cryotherapy has settled as this may improve response. It is unkind to treat very young children (< 10yrs) with cryotherapy for warts.
Plane warts (face/ hands)	No treatment *or* Trial of Tretinoin 0.025% cream / gel for 4 weeks (unlicensed indication) Imiquimod 5% (Aldara) cream 3 days per week (Mon, Wed, Fri) for 4 weeks - GP's with dermatology experience (unlicensed indication)	Plane warts are notoriously resistant to treatment and usually get worse with cryotherapy / destructive treatments as a result of the Koebner Phenomenon
Filiform warts (face/eyelids)	Cryotherapy Curettage & cautery	Avoid topical keratolytics which are too irritant for use on the face

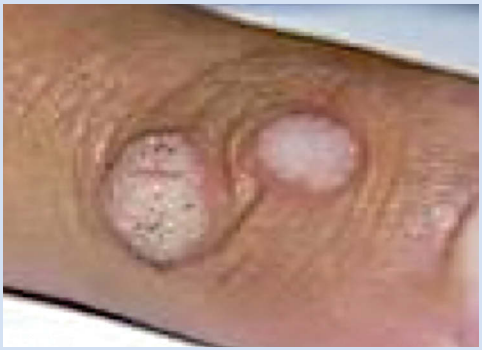
CRITERIA FOR REFERRAL

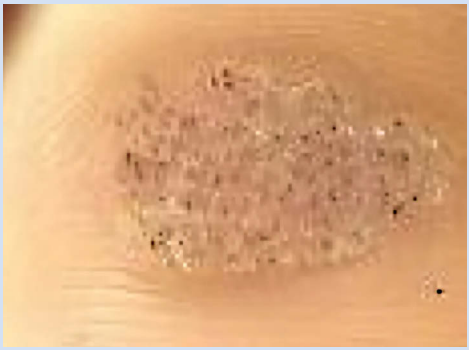
In general patients with viral warts / verrucae should not be referred.

Patients may be referred if:

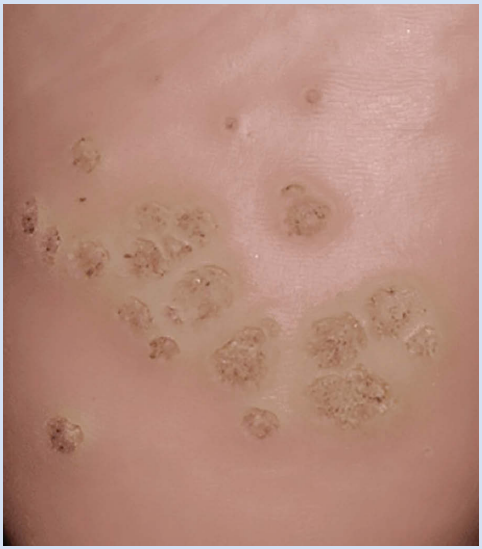
- Severe disabling warts despite six months of topical salicylic acid treatment + cryotherapy
- Significant warts or mollusca in immunocompromised patients
- Atypical appearance, difficult anatomical sites

Viral Warts

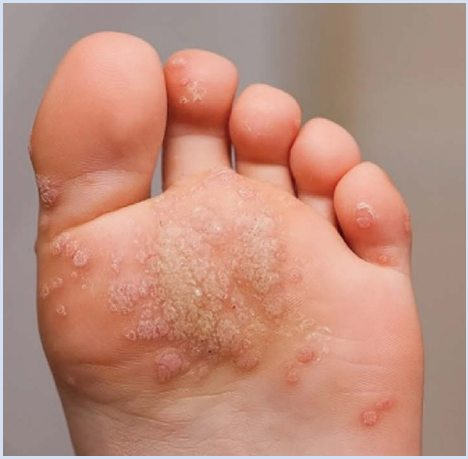


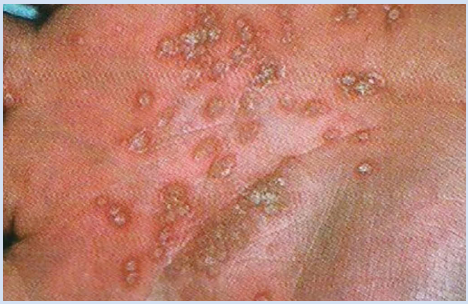


Viral Warts



Mosaic Warts on heel





BAD Plantar Warts Patient Leaflet Link
http://www.bad.org.uk/for-the-public/patient-information-leaflets/plantar-warts

Molluscum Contagiosum

CLINICAL FEATURES	TREATMENT	THERAPEUTIC TIPS
Most lesions spontaneously resolve in 6-12 months. Resolution is often preceded by inflammation, swelling and crusting. Patchy dry skin surrounding molluscum contagiosum is common	• **No Treatment** *or* • **Trial of hydrogen peroxide 1% cream** (Crystacide) twice daily for 3 weeks (unlicensed use) • **Cryotherapy** Treat complications: • **Infection** Topical Fusidic acid 2% cream • **Eczema** Treat dry skin (if necessary) with emollients (see appendix) Mild topical steroids e.g. Hydrocortisone 1% Avoid potent or moderately potent steroids as molluscum may spread	NB: Molludab (Potassium Hydroxide 5% Solution) is NOT a formulary medicine. It is available for self-purchase over the counter. Cryotherapy is very poorly tolerated by very young children <10 years. Risk of permanent scar/pigmentation changes with cryotherapy.

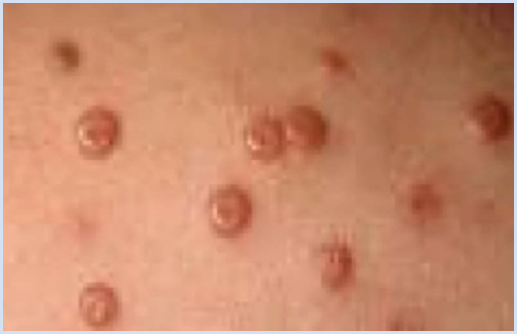
CRITERIA FOR REFERRAL

In general patients with Molluscum contagiosum should not be referred.

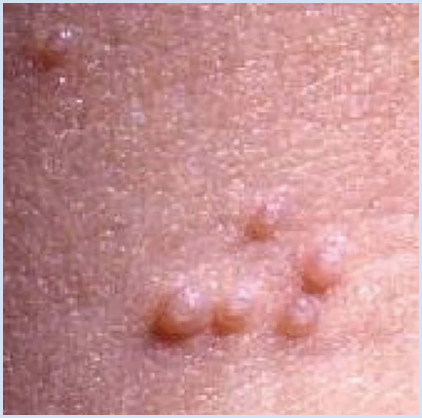
Patients may be referred if:
- Age >10 with persistent lesions >2 years
- Facial lesions causing concern
- Giant molluscum
- Immunocompromised

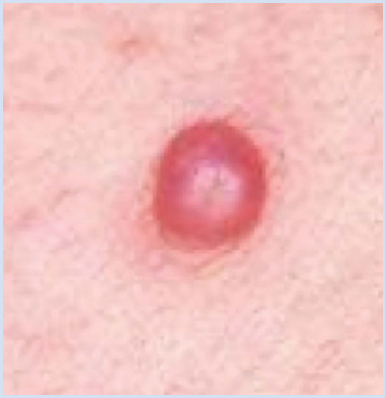
BAD Molluscum Contagiosum Patient Leaflet Link
http://www.bad.org.uk/for-the-public/patient-information-leaflets/molluscum-contagiosum

Molluscum Contagiosum

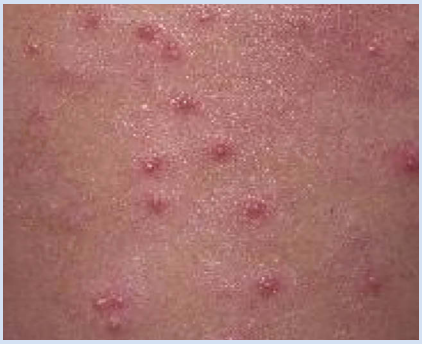


Molluscum contagiosum

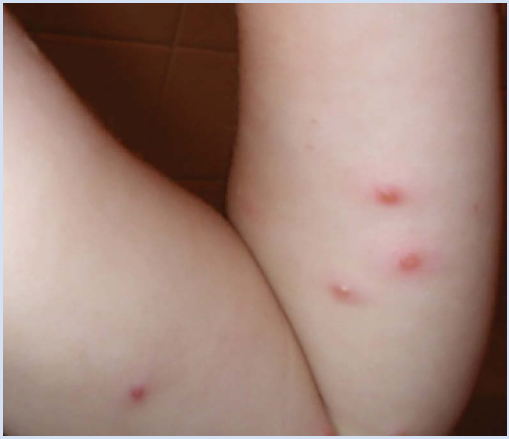


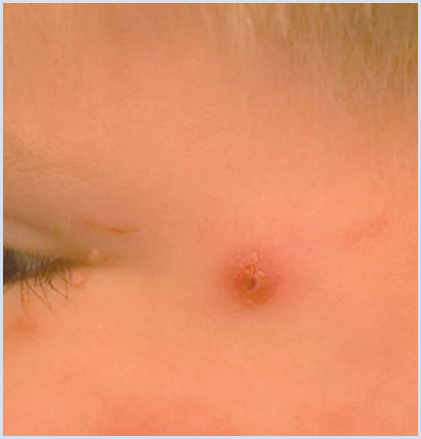


Giant molluscum



Molluscum with dry skin





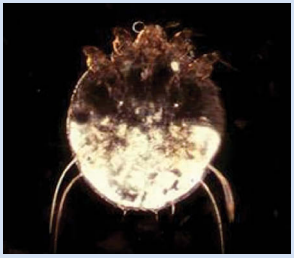
Scabies

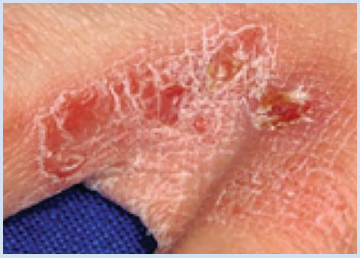
NB: Treatments can be provided by Community Pharmacies offering the Think Pharmacy Minor Ailments Service

CLINICAL FEATURES	TREATMENT	THERAPEUTIC TIPS
Human scabies is an infestation caused by the mite Sarcoptes scabiei. Mites are transmitted from one person to another by close physical contact (in a warm atmosphere) e.g. sharing a bed, children playing with each other or young people holding hands. An individual who has never had scabies before may not develop itching or a rash until 1 - 3 months after becoming infested. There are burrows on non-hair bearing skin e.g. palms / soles / wrists / ankles / sides of feet and often a widespread eczematous rash (sparing face in older children and adults). Consider scabies as diagnosis if inflammatory nodules on male genitalia, peri-areolar areas and axilla/groin, especially in long standing cases or impetiginisation due to secondary infection with Staph Aureus.	Treat when there is a strong clinical suspicion of infestation. Apply either: Permethrin 5% (Lyclear Dermal cream) Malathion 0.5% Aqueous solution (Derbac-M) – apply with a paintbrush Permethrin should be left on the skin for 24 hours and Malathion for 8-12 hours Repeat treatment in 7 days Treat residual rash / itch with: Crotamiton 10% + Hydrocortisone 1% (Eurax HC) cream For impetiginised rash: Flucloxacillin 250-500mg 4 times daily for 7-10 days +/- Betamethasone 0.025% (Betnovate-RD) ointment twice daily *or* Clobetasone 0.05% (Eumovate) ointment twice daily +/- Inflammatory nodules settle spontaneously though this can take months.	It is essential 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. All skin below the chin must be treated including the web spaces of the fingers / toes, under the nails, genitals and all body folds. Children under 12 months must have treatment applied to head as well. **Remind patients to re-apply the scabicide after washing their hands.** Disinfestation of clothing and bedding other than by ordinary laundering is not necessary. Mites are killed within 24 hrs but the pruritus and rash may take 3-6 weeks to settle. Do not allow repeated use of scabicides to pruritic areas as this may irritate the skin.

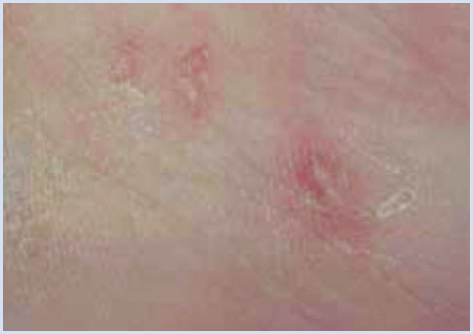
BAD Scabies Patient Leaflet Link
http://www.bad.org.uk/for-the-public/patient-information-leaflets/scabies

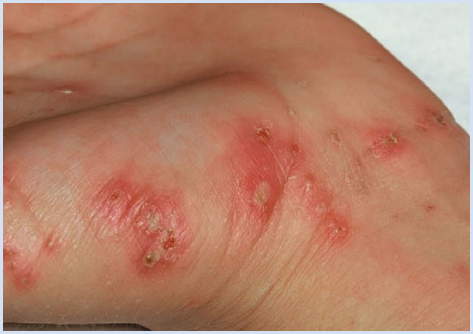
Scabies

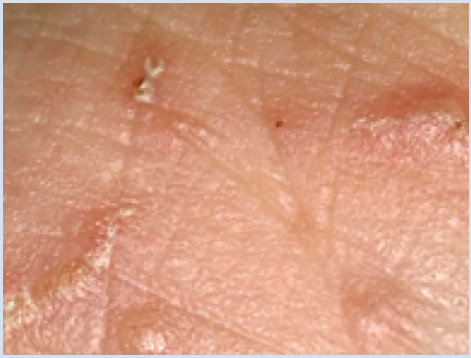


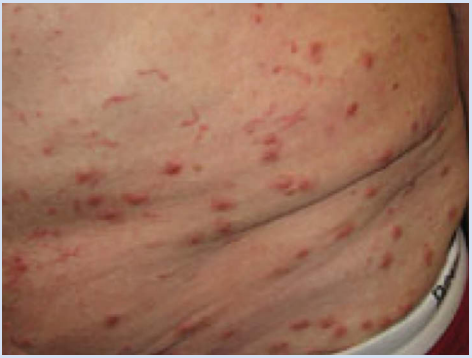


Scabies





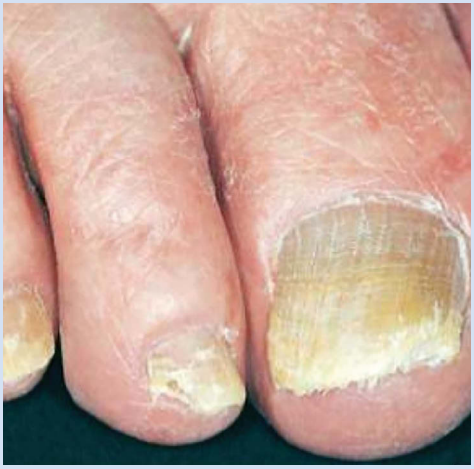


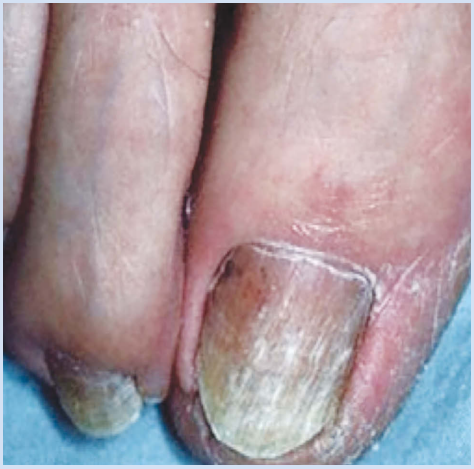


Onychodystrophy - (thickened and dystrophic nails)

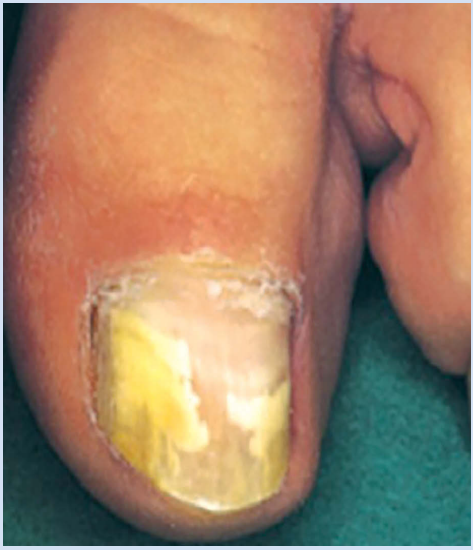
CLINICAL FEATURES	TREATMENT	THERAPEUTIC TIPS
The thickness of nail plates is normally 0.5mm; this increases in manual workers and in certain disease states including: • **Onychomycosis (fungal / yeast infection)** • **Psoriasis** • **Chronic Eczema** • **Lichen Planus** • **Alopecia areata** • **Norwegian scabies** • **Darier's Disease** • **Old age** • **Trauma e.g. from footwear** • **Congenital Ichthyosis**	**Onychomycosis** **Asymptomatic patients may be advised to 'leave well alone'. The usual source of nail fungus is inter-digital tinea pedis which should be treated at the same time.** If nail is thickened and dystrophic use oral treatment • Terbinafine 250mg once daily - 6-12 weeks for fingernails - 3-6 months for toenails • Itraconazole 200mg twice daily for 7 days repeated monthly - 3 cycles for toenails - 2 cycles for fingernails *or* 200mg once daily for 8-12 weeks For yeast infections Itraconazole (regime as above) If dystrophy does not extend to nail matrix i.e. (superficial onychomycosis) then use topical treatments: • Amorolfine (Loceryl) lacquer once weekly continued for 6-12 months. (trim and file down nails prior to application)	Examine all nails and all of the skin. Ask patient to grow nails to provide viable samples (large nail clippings including scrapings of thickened crumbly material from the underside of the nail if present) for mycology. (NB: Poor samples = false negatives) **For children, seek specialist advice.** Cultures take up to 6 weeks. If repeated negative mycology, consider alternative diagnosis. If treatment considered despite negative mycology always discuss risks and benefits. Review after 3 months of treatment and consider treatment success if proximal nail is clear of disease. 3 monthly LFTs required for longer-term use of Terbinafine. Follow BNF advice. Terbinafine is not effective for yeast infections. **Caution: Itraconazole drug interactions see BNF** Monitor LFTs if treatment is continuous for more than 1 month.

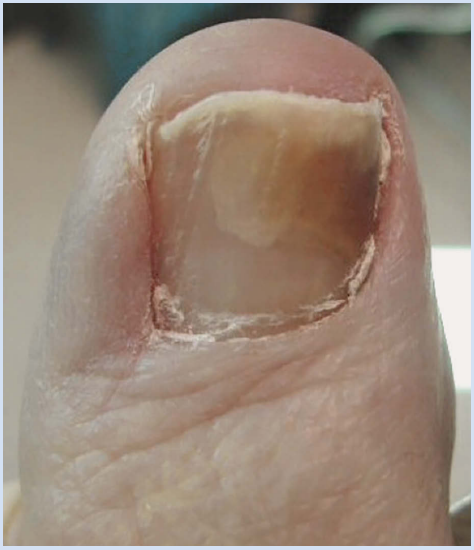
Onychodystrophy - (thickened and dystrophic nails)





Thickened Nails





Dystrophic Nails

BAD Fungal Nails Patient Leaflet Link
http://www.bad.org.uk/for-the-public/patient-information-leaflets/fungal-infections-of-the-nails

Actinic (Solar) Keratosis

Usually multiple, flat, pale or reddish-brown lesions with a dry adherent scale.
Evidence suggests that the annual incidence of transformation from solar keratoses to SCC is less than 0.1%.
The risk is higher in immunocompromised patients.

Preventative measures:

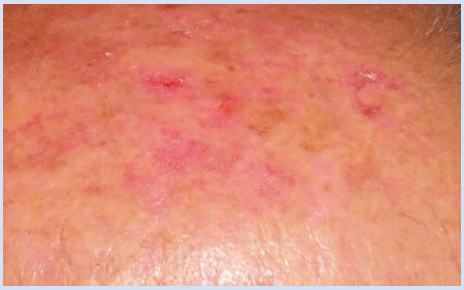
SPF50 (Sunblock) April - September
Apply to exposed areas (face, neck, hands)
Cover up / use hat for sunny days

CRITERIA FOR REFERRAL

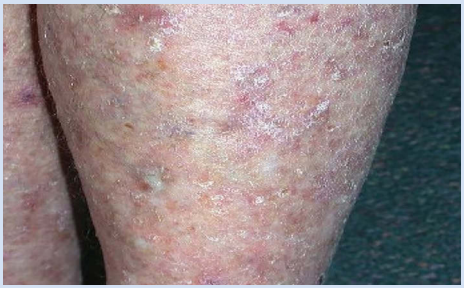
Patients may be referred if:

- If there is suspicion of malignancy (e.g. if lesion has significant induration of underlying skin, is particularly painful or if on removal of keratotic crust the base looks thickened or slightly ulcerated (the crust should not detach easily).
- If the lesions have not responded to treatment
- Diagnostic uncertainty
- If the individual is on immunosuppressants (e.g. post renal transplant)

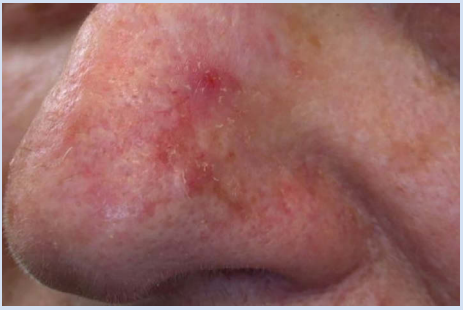
BAD Actinic Keratosis Patient Leaflet Link
http://www.bad.org.uk/for-the-public/patient-information-leaflets/actinic-keratoses



AK Scalp



AK Leg



AK Nose

Suggested Approach to Treatment of Actinic (Solar) Keratosis

Please be aware of the inflammatory side-effects of these treatments and counsel patients accordingly.

Isolated Hyperkeratotic Lesions

Remove crust before treatment if possible

Actikerall - Fluorouracil 0.5% + Salicylic acid 10% solution
- **Apply daily to maximum of 10 lesions for 12 weeks**

Cryotherapy
- **Freeze for 10-15 seconds each**

Multiple Lesions - Thin, mild AKs

Solaraze - Diclofenac Sodium 3% gel
If patient concerned about inflammatory side-effects of other agents and happy to comply with 3 month treatment
- **Apply twice daily to maximum of 10 lesions for 12 weeks.**

Solaraze will produce much less inflammation than Efudix. Solaraze is less effective than Efudix for thicker lesions.

Multiple Lesions - More extensive/thicker AKs

Efudix - Fluorouracil 5% cream
Can also choose if problems with immune response as does not rely on immune system for action
- **Apply sparingly once or twice daily for 2-4 weeks**

Stop treatment once marked inflammation occurs. The patient must be warned to expect this. Inflammation will settle in a few weeks.

Efudix is a treatment for multiple, ill-defined solar keratosis. It is safe, efficacious, with little systemic absorption. Can be used less frequently long term for field control.

Hydrocortisone 1% cream can be used to treat inflammation. Optimum effect 1 month post treatment.

Aldara - Imiquimod 5% cream
Choose if failure with Efudix in past or quick recurrence after Efudix
- **Apply 3 times a week for 4 weeks**

Patients must be warned to expect inflammation but lower recurrence than other treatments, if tolerated.

Zyclara - Imiquimod 3.75% cream
- **Apply once daily.**

Two x 2-week treatment cycles, separated by 2 weeks without treatment.

Less inflammatory response than 5% so compliance may be improved. More helpful and cost effective for field change and larger areas up to 200cm^2, not for smaller areas.

Picato - Ingenol mebutate gel
For trunk and limbs - ingenol mebutate **0.05%** gel
- **Apply once daily for 2 consecutive days**

For face and scalp - ingenol mebutate **0.0015%** gel
- **Apply once daily for 3 consecutive days**

For areas under 25cm^2
May improve compliance due to short treatment course. Likely to have less side-effects than fluorouracil / imiquimod, though side-effects may appear up to 2-4 weeks post treatment.

Local agreement for the prescribing of medicines for Actinic (Solar) Keratosis
All products may be initiated by a GP if they are confident of the diagnosis and how to use the medicine.
If a patient is referred to dermatology for diagnosis then the hospital clinician is responsible for initiating treatment.

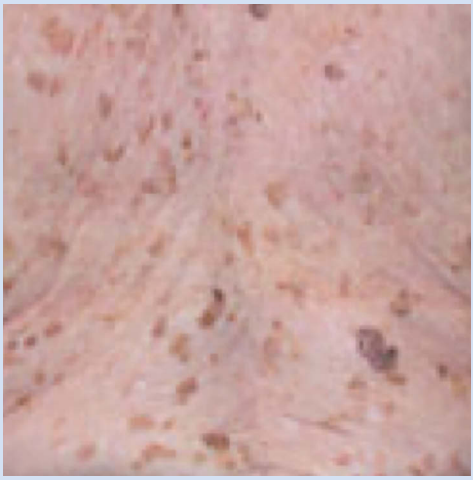
Seborrhoeic Keratosis / Warts (Basal Cell Papilloma)

CLINICAL FEATURES	TREATMENT	THERAPEUTIC TIPS
Common benign warty lesions of variable size and pigmentation with a characteristic 'stuck on' appearance. Usually appear after age 30. Can be hereditary. They have no malignant potential.	**1) No treatment** - the majority of lesions do not require treatment. **2) Cryotherapy** - suitable for small troublesome lesions **3) Curettage & cautery** - only for large troublesome lesions	**Dermatoscopic features** Under the Dermatoscope look for milia-like cysts and comedo-like openings with a distinct border to the lesion.

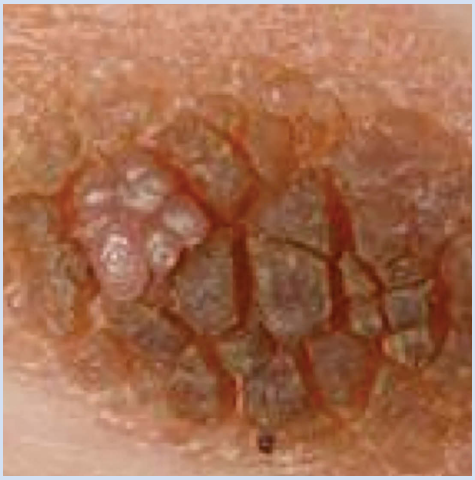
CRITERIA FOR REFERRAL

- Large troublesome lesions on difficult anatomical sites
- Diagnostic uncertainty

BAD Seborrhoeic Warts Patient Leaflet Link
http://www.bad.org.uk/for-the-public/patient-information-leaflets/seborrhoeic-keratosis



Seborrhoeic Keratosis



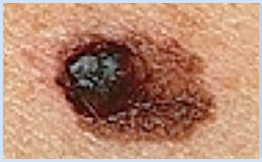
Seborrhoeic Keratosis

Skin Cancer

CLINICAL FEATURES	TREATMENT	THERAPEUTIC TIPS
Basal cell carcinoma 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.	They are best managed by: **1) Excision** *or* **2) Radiotherapy** **3) Curettage** - for superficial BCCs. Can be used for nodular BCCs by specialists. **4) Superficial BCC** on trunk can be treated with Imiquimod, PDT (Photodynamic Therapy), or curettage.	Radiotherapy may be the preferred option in frail, elderly patients. Mohs Micrographic surgery is the best option for removing BCCs from difficult facial sites e.g. nose, lips and for morphoeic BCCs. **NB: BCC does not require a HSC 205 (two week wait) referral**
Squamous cell carcinoma Much less common. Often rapidly enlarging keratinising tumours. May be slow growing or ulcerated. Up to 5% may metastasise to regional lymph nodes (10% from lips and ears)	Lesions with a high index of suspicion, especially if rapidly growing, should be referred using the Skin Cancer HSC 205 proforma (two week wait). **Referrals of facial and scalp lesions should be directed to Facial Plastics ENT Clinic and should also have dermatology referral for full skin surveillance.** Referrals through fax or Choose and Book should be within 24 hours and patients will be seen within two weeks.	
Malignant melanoma This is the most dangerous skin malignancy. Early detection and treatment is vital for optimising outcome. Melanoma subtypes • Superficial spreading • Nodular • Amelanotic • Lentigo Maligna • Acral lentiginous and Subungual	**All suspicious moles must be referred using the Skin Cancer HSC 205 proforma (two week wait)** and will be seen within two weeks. Any lesion felt to be highly suspicious of melanoma will be excised within 2 weeks where possible.	

ABCDE of Malignant Melanoma Identification

A

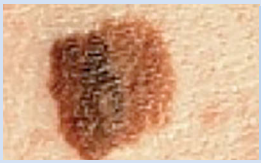


Asymmetry
if you draw a line through this mole, the two halves will not match, meaning it is asymmetrical, a warning sign for melanoma.

B

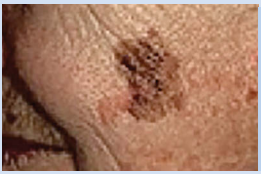
Border
The borders of an early melanoma tend to be uneven. The edges may be scalloped or notched.

C



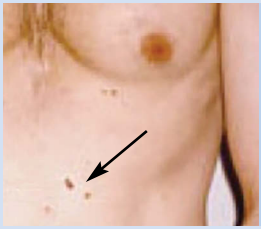
Colour
Having a variety of colours is another warning signal. A number of different shades of brown, tan or black could appear. A melanoma may also become red, white or blue.

D



Diameter
Melanomas usually are larger in diameter than the eraser on your pencil (1/4" or 6mm) but they may sometimes be smaller when first detected.

E



Evolving
When a mole is evolving, see a doctor. Any change in size, shape, colour, elevation or another trial, or any new symptom such as bleeding, itching or crusting - points to danger.

CRITERIA FOR PIGMENTED LESION REFERRAL

The following seven point checklist may be useful in deciding whether to refer a changing pigmented lesion. Refer if at least one major or two minor criteria present.

Major features
- Change in size
- Change in colour (variability of pigmentation)
- Change in shape (irregularity of edge)

Minor features
- Size >6mm diameter
- Inflammation
- Bleeding / crusting
- Itch

BAD Melanoma Patient Leaflets Link
http://www.bad.org.uk/for-the-public/skin-cancer/melanoma-leaflets

Patient Support Groups

The Acne Academy
Dermatology Department,
Harrogate & District Foundation Trust
Lancaster Park Road, Harrogate
North Yorkshire HG2 7SX

Tel. 01707 226023

www.acneacademy.org

British Allergy Foundation
Muriel A Simmons
Deepdene House, 30 Bellegrove Road
Welling, Kent DA16 3PY

Tel: 020 8303 8525
Helpline: 020 8303 8583 (Mon-Fri 9-5pm)

www.allergy.baf.com

The Psoriasis Association
Milton House
Milton Street
Northampton NN2 7JG

Tel: 01604 711129
Fax: 01604 792894

www.psoriasis-association.org.uk

Herpes Viruses Association (SPHERE) And Shingles Support Society
Miss Marion Nicholson, Director
41 North Road, London N7 9DP

Tel: 020 7607 9661 (office and Minicom)
Helpline: 020 7609 9061

http://www.herpes.org.uk/index.html

http://www.shinglessupport.org/

Cancer BACUP
3 Bath Place, Rivington Street,
London EC2A 3DR

Tel: Freephone 0808 800 1234 (9am - 7pm)
Fax: 020 7696 9002

www.cancerbacup.org.uk

Lupus UK
St James House, Eastern Road
Romford
Essex RM1 3NH

Tel: 01708 731251

www.lupusuk.org.uk

National Eczema Society
Hill House, Highgate Hill
London N9 5NA

Tel: 020 7281 3553

Eczema Information Line: 0870 241 3604
(Mon - Fri 9-5pm)

www.eczema.org

Hairline International
Ms Elizabeth Steel
Lyons Court, 1668 High Street
Knowle, West Midlands B93 0LY

Tel: 01564 775281
Fax: 01564 782270

www.hairlineinternational.com

Raynaud's & Scleroderma Association Trust
112 Crewe Road
Alsager, Cheshire
ST7 2JA

Tel: 01270 872776
Fax: 01270 883556

www.raynauds.demon.co.uk

Changing Faces -
Now running Camouflage Service
1 & 2 Junction Mews
Paddington, London
W2 1PN

Tel: 020 7706 4232
Fax: 020 7706 4234

www.changingfaces.co.uk

The Vitiligo Society
125 Kennington Road
London SE11 6SF

Tel: Freephone 0800 018 2631
Fax: 020 7840 0866

www.vitiligosociety.org.uk

Patient Information

A range of NHS resources and advice are available on the NHS Choice Website: www.nhs.uk/livewell

Patient Information leaflets can be found at the following website: www.bad.org.uk

Mid Cheshire Contact Information

Leighton Hospital
Middlewich Road, Crewe CW1 4QJ

Telephone: **01270 255141**
Fax: **01270 587696** (for 2 week waits)

Fax for urgent appointments: **01270 612575**

Dermatology Consultant / Clinical Lead - Dr Harris (Secretary 01270 612106)

Dermatology Consultant / Skin Cancer Lead - Dr Wong (Secretary – 01270 612384)

Associate Specialist - Dr Black (Secretary 01270 612106)

Nurse Practitioner - Sister Lawson (Secretary 01270 612358)

Nurse Specialist - Sister Dye (Secretary 01270 612358)

Cancer Pathway Co-ordinator - Allane Nugent (01270 278088)

East Cheshire Contact Information

Macclesfield District General Hospital
Victoria Road, Macclesfield SK10 3BL

Telephone: **01625 421000**
Fax: **01625 661027** (for 2 week waits)

Fax for urgent appointments: **01625 661027**

Dermatology Consultant / Skin Cancer / Clinical Lead - Dr T Kingston (Secretary 01625 661051)

Locum Consultant - Dr T Razzaq (Secretary 01625 663675)

Associate Specialist - Dr L Black (Secretary 01625 663675)

Macmillan Skin Clinical Nurse Specialist - Sister Kate Howlen (01625 663016)

Specialist Nurse - Jan McIntyre

Specialist Doctors - Dr W Maxwell, Dr R Edwards, Dr R N Stones (Secretary 01625 661051)
Dr V Ramsden, Dr R Calver (Secretary 01625 661051)

Dermatological Surgeon - Mr N J Gathercole (Secretary 01625 663675)

Cancer Pathway Co-ordinator - Julie Elkin (01625 663664)

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