Referral pathways

Suspected malignant melanomas and squamous cell carcinomas

Patients in whom you suspect either of these two malignancies must be referred using the appropriate fax referral form. On receipt of the referral form the patient will be sent an appointment within two weeks. Slots are reserved in clinics for this purpose.

Severe inflammatory skin disease

If appropriate, contact the on-call medical team to request admission to the Medical Assessment Unit. Alternatively, contact a consultant dermatologist directly to discuss whether an urgent outpatient appointment can be arranged.

Indications include erythroderma caused by psoriasis, eczema, cutaneous lymphoma and Severe Cutaneous Adverse Reactions (SCAR) to drugs (e.g., Stevens–Johnson syndrome and toxic epidermal necrolysis), also extensive immunobullous diseases such as pemphigoid and pemphigus.

Routine dermatological conditions including basal cell carcinomas

All cases to be referred through CAB to the Dermatology Interface Service in Somerset (DERMISS), for triage to a local GPwSI clinic or to secondary care.

Basal cell carcinomas

Basal cell carcinomas will be triaged by DERMISS. High risk BCCs will be triaged to secondary care. Low risk BCCs will be triaged to a GPwSI who provides a community skin cancer service. Features of a high risk BCC are:

- Under 25 years of age
- Patient on immunosuppression treatment
- Lesion above the clavicle
- Greater than 1 cm in diameter
- Recurrent or previously incompletely excised
- An anatomically difficult or cosmetically important site
- Ill-defined at its margins

DERMISS – Dermatology Interface Service in Somerset

This is part of the new dermatology care pathway (see below) that has been agreed through
negotiation between the GP Commissioning Consortium, NHS Somerset, Somerset Community Health, Taunton and Somerset NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust.

All routine dermatology referrals to secondary care either at Yeovil District Hospital NHS Trust or Taunton and Somerset NHS Trust (excluding referrals under the two week wait system for suspected malignant melanomas and squamous cell carcinomas) are triaged/assessed by an experienced primary care dermatologist (GPwSI). This new pathway will significantly reduce the pressure on the secondary care service but more importantly ensure that, as far as possible, the patient is seen by the appropriate health care professional in their local community.

Teledermatology

The skin problem can be photographed with a high resolution digital camera and the image sent as an e-mail attachment to the consultant with your letter. A report will be faxed to you in three or four days (or less).

This report might contain

a) a suggested diagnosis and treatment together with an offer to see the patient in Out-patients if the problem does not resolve,

b) advice regarding suitable minor surgery at your own surgery,

c) direct referral to PUVA/patch test clinics at Musgrove Park Hospital,

d) direct entry on to skin surgery list at Musgrove Park Hospital.

Consultant clinics and location

<table>
<thead>
<tr>
<th>Consultant</th>
<th>Monday</th>
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<th>Wednesday</th>
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<th>Friday</th>
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<tr>
<td>Dr Pryce</td>
<td>Yeovil OPD am MPH 5pm</td>
<td>MPH OPD pm</td>
<td>MPH OPD am (wk. 1,2,3 &amp; 5)</td>
<td>Minehead OPD pm (wk. 2 &amp; 4)</td>
<td>MPH OPD am</td>
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<td>(Day Surgery Centre (DSC))</td>
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<td>Dr Boyle</td>
<td>MPH OPD pm</td>
<td>MPH OPD am (wk. 1,2,3 &amp; 5)</td>
<td>Yeovil OPD</td>
<td>Chard OPD pm (wk. 2 &amp; 4)</td>
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<tr>
<td>Dr Adams</td>
<td>MPH OPD am Bridgwater OPD</td>
<td>MPH OPD pm</td>
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<td>MDT meeting DSC pm</td>
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<tr>
<td>Dr Lewis</td>
<td>Bridgwater OPD</td>
<td>DSC am wk. 1, 3 &amp; 5</td>
<td>MPH OPD pm (wk. 1, 3 &amp; 5)</td>
<td>MPH OPD wk. 1 &amp; 3</td>
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<td>lesion clinic</td>
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<tr>
<td>Dr Wachsmuth</td>
<td>DSC am (wk. 1 &amp; 3)</td>
<td>Wellington OPD am (wk. 1 &amp; 3)</td>
<td>MPH OPD am (wk. 1,2,3 &amp; 5)</td>
<td>Yeovil (south petherton) pm wk. 4 &amp; 5</td>
<td>Yeovil OPD am &amp; pm</td>
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Treatment of dermatological conditions in primary care

Atopic eczema

- This is a common skin disorder and there is often a family history of asthma, eczema or hay fever. It is important to reassure the patient that the condition is not infectious.

- It is not unusual for the condition to fluctuate from time to time. This is the nature of the condition and not necessarily caused by an allergic reaction. Infection may be a factor.

- Environmental factors should be eliminated if possible e.g. animals, house dust mite, smoke, irritant clothing, excessive heat or cold.

- The mainstay of therapy is with emollients: for example, two tablespoons of emulsifying ointment dissolved in a jug of hot water and then poured into a warm bath. Emulsifying ointment may be applied directly to the patient prior to bathing. A daily bath is helpful but for severe exacerbation of eczema twice daily bathing may be necessary. Moisturising cream, for example E45 or Unguentum Merck should be applied regularly to reduce the dry component of atopic eczema.

- The eczematous component will require the use of topical steroids. Often a potent steroid is needed initially to gain control but thereafter the weakest strength steroid that maintains control should be used.

- From time to time more potent topical steroids may be necessary for short periods.

- Ointments, although more greasy than creams, are usually more effective.

- The amount of topical steroid prescribed is as important as the potency of steroid chosen. It takes 20 - 25 grams of a cream or ointment to completely cover the skin of a normal size adult on one occasion and therefore for widespread eczema larger quantities may be required.

- Antihistamines, particularly sedating ones may be helpful at night.

- If the diagnosis is in doubt a serum IgE level may be determined as this is usually raised in atopic individuals.

- If a sudden flare occurs consider:

  1. **Superadded staphylococcal infection.** This is often characterised by weeping eczema, folliculitis and pustules which needs to be treated with Flucloxacillin or Erythromycin 250mg qds for five days. Topical agents, such as Fucidin H cream, are helpful when the infection is less widespread.

  2. **Eczema Herpeticum.** Enquire about exposure to the herpes simplex virus. Clinically, small regular ulcerated lesions of the skin are seen. The patient is usually systemically unwell and may require admission and/or treatment with Acyclovir. For localised areas, topical Acyclovir is useful.

  3. **Development of an allergic contact dermatitis to a topical constituent (e.g. lanolin).** Consider alternative topical agent and referral for patch testing.
Psoriasis

- Dovobet ointment is probably now the treatment of choice in uncomplicated plaque psoriasis in addition to an effective emollient regime as for eczema.
- Coal tar and Dithranol products are now rarely prescribed.
- In general topical steroids should be avoided in psoriasis although they are useful in the treatment of psoriasis of specific body sites such as flexures, palms/soles and scalp.
- A mild topical steroid or topical steroid/antibiotic combination can be used to treat flexural psoriasis.
- Pustular psoriasis of palms and soles may require treatment with a potent topical steroid. Severe cases may require systemic treatment (retinoids, methotrexate or biologics) in secondary care.
- Mild scalp psoriasis may respond to a steroid scalp application or a combination preparation such as Dovobet Gel. Some cases may require prior ‘descaling’ with a coal tar and salicylic acid preparation (e.g. Ccois or Sebco) applied nightly for two or three weeks and shampooed in the morning.
- Phototherapy can be effective for patients with psoriasis that have not responded to routine topical therapy.
- UVB is administered three times a week and UVA twice a week for periods of up to 12 weeks. Patients receiving UVA take 8-methylpsoralens two hours before treatment (a combination known as PUVA).
- Ultraviolet light therapy thrice weekly for a period of four to six weeks is often very helpful in guttate psoriasis.
- As a rule of thumb, if psoriasis covers more than 5 – 10% of the total body surface area then topical treatment alone may not be effective. In this case consider referral for phototherapy or ‘third line’ treatment such as methotrexate, ciclosporin and ‘biologics’.
- Erythrodermic psoriasis, generalised pustular psoriasis and extensive plaque psoriasis are indications for referral to secondary care.

Infections

Impetigo

- Usually caused by staphylococcus aureus or Group A streptococcus. Blisters may occur.
- Treatment with topical or systemic antibiotic e.g. Bactroban or Flucloxacillin.
- Cellulitis or erysipelas requires prompt treatment with oral Penicillin (or Erythromycin if patient sensitive to Penicillin).
Herpes Simplex

- Topical Povidone-iodine or Acyclovir may reduce severity of recurrent lesions, particularly useful where patients develop associated **erythema multiforme**. - Topical Povidone-iodine or Acyclovir may reduce severity of recurrent lesions, particularly useful where patients develop associated **erythema multiforme**.

Note: Hospitalisation may be required for patients with atopic eczema or for immunosuppressed patients.

Herpes Zoster

- Can usually be treated effectively with analgesia, topical Povidone-iodine spray and systemic Acyclovir in severe cases. - Can usually be treated effectively with analgesia, topical Povidone-iodine spray and systemic Acyclovir in severe cases.
- Where ophthalmic division of trigeminal nerve is affected or Ramsay Hunt syndrome occurs, hospital referral is usually indicated.

Fungal Infections

- Fungal infection of finger nails requires mycological confirmation and treatment with Lamisil (Terbinafine) in a dose of 250 mgs once daily for six weeks to two months often eradicates fungal infection from finger nails. Liver function may need to be monitored during treatment with Lamisil therapy as hepatotoxicity has been reported occasionally.
- Toe nails rarely justify treatment with anti-fungal agents but if the patient is symptomatic then 3 months' therapy of Lamisil (Terbinafine) may be helpful.

Acne

- Patients with cystic acne generally warrant referral for treatment with Roaccutane and it is helpful if it is known that the patient has normal fasting lipids (triglycerides and cholesterol) and liver function tests.
- Milder cases of acne are often controlled with lymecyclie one tablet daily
- Oral treatment may need to be continued for six months. An alternative is Vibramycin 50 to 100mgs daily, or Minocin MR.

Pigmented Lesions

All suspected malignant melanomas must be referred using the fax proforma through the 2 week wait pathway.
- Don’t forget that melanomas can be ‘amelanotic’.
- Melanoma in prepubertal children is extremely rare.

It is sometimes difficult to decide between an melanocytic naevus and an early melanoma. The following parameters are associated with the development of malignant melanoma:

- A. Symmetry
- B. Borders (irregular or notched rather than smooth)
- C. Colour (varying shades of brown, blue, pink, white)
- D. Dimension (diameter greater than 4mm)
- E. Evolving (changing shape or colour over time)

**Lumps and Bumps**

- Many small cutaneous lesions can and are successfully excised in the GP's surgery. This is desirable as long as the specimens are submitted for histological examination. If problems arise, such as an unexpected histology result, then we are always happy to see the patient subsequently or give advice on the histology report.

- We do appreciate that GPs are often placed in an awkward situation when patients insist on a referral for treatment of benign lesions. If possible, we would prefer not to be referred patients for surgical procedures required for cosmetic purposes only.

- Given below is information on a number of common benign skin conditions with advice on treatment. Nevertheless, please do not be reluctant to refer such lesions if there is diagnostic doubt, where there is a significant cosmetic impairment, where the lesion is causing pain or if there is a suspicion of malignancy.

**Skin tags** are fibroepithelial polyps commonly seen around the neck, axillae and groin. They are soft pedunculated and may be either flesh coloured or pigmented. Treatment is not necessary. They can be removed by snipping off with a sharp pair of fine scissors.

**Milia** are miniature epidermoid cysts ranging in size from 0.5 to 2.0 mm. They may be seen around the eyes but also occur in other areas of skin following severe inflammation such as burns of a blistering disorder. They can be treated by lancing and then expressing the contents. Retin-A cream applied to surrounding skin may prevent further milia formation.

**Spider naevus**. These are dilated capillaries. They occur commonly on the upper trunk and face. No treatment is necessary but they can be removed by hyfrecation (there is a small risk of producing a scar) or by pulsed dye laser therapy.

**Dermatofibroma**. These are usually solitary firm dermal nodules which appear to be tethered to the overlying epidermis. The size ranges from a few millimetres to several centimetres. Some are dome-shaped, others depressed. Colours range from red to brown. They are commonly found on the lower legs of women. When pigmented, malignant melanoma is an important differential diagnosis. They can be excised but are probably best left untreated as scarring may be troublesome.

**Seborrhoeic keratoses** are warty lesions varying in colour from yellow to dark brown. Sizes range from 1 mm to several centimetres. They increase in size and number with age. They have no malignant potential. The differential diagnosis includes basal cell carcinoma, squamous cell carcinoma, atypical naevus and malignant melanoma. They usually cause no trouble but can be painful when inflamed. Mostly they are a cosmetic nuisance. The vast majority require no treatment but they can be removed by either cryotherapy or curettage.
**Epidermoid cysts** comprise the majority of cutaneous cysts. They occur on the face, neck, chest, periauricular areas and genitalia. Examination may reveal a small punctum. A wide differential diagnosis (depending on body site) needs to be considered before attempting any surgical treatment. Unless they become inflamed or infected they are rarely more than a cosmetic nuisance. It is advisable not to remove inflamed or infected cysts but when quiescent could be removed if they are subject to repeated bouts of inflammation or infection.

**Warts**

- Viral warts are caused by infection with human papilloma virus. Seventy-five per cent of viral warts clear spontaneously within two years.

- Genital warts should be referred to the GUM department.

- No treatment is one hundred per cent effective and no treatment has ever been shown to be significantly better than salicylic acid preparations.

- First file the wart with an emery board and then apply the salicylic acid preparation and repeat this process every twenty-four hours. It may be necessary to continue this treatment for up to three months.

- An alternative treatment for plantar warts is to use a 3 to 5% solution of formaldehyde in water. The surrounding skin is protected with Vaseline and the affected part soaked in a saucer containing the formaldehyde solution for ten to fifteen minutes, repeating every twenty-four hours.

- Cryotherapy repeated every three weeks for three months clear seventy per cent of hand warts. It is far less successful for plantar warts.

- 0.05% Retin-A cream is effective against plane warts in children.

- Molluscum contagiosum is a pox virus infection. It occurs mainly in childhood often in association with atopic eczema. Early umbilicated papules appear in crops. Individual lesions last about two months often resolving after becoming inflamed. The condition as a whole can last well over a year. There is no specific treatment. Antiseptics may be applied to inflamed lesions and only associated eczema must be treated.

**Useful addresses**

**British Association of Dermatologists** [http://www.bad.org.uk/site/1/default.aspx](http://www.bad.org.uk/site/1/default.aspx)

**St John’s Institute of Dermatology** [http://www.kcl.ac.uk/depsta/medicine/dermatology/index.html](http://www.kcl.ac.uk/depsta/medicine/dermatology/index.html)


**Acne Support Group**
PO Box 230
Hayes UB4 OUT
Middlesex
Tel: 0181 561 6868
Fax: 0181 561 6868

**Lupus UK**
James House
Eastern Road
Romford
Essex
RM1 3NH
Tel: 01708 731 251

**British Red Cross** (Cosmetic camouflage)
Sherald Manuel
Service Support & Development Department
British Red Cross
9 Grosvenor Crescent
London SW1X 7EJ
Tel: 0171 201 5490

**Changing Faces** (Facial disfigurement)
1 & 2 Junction Mews
Paddington
London W2 1PN
Tel: 0171 706 4232
Fax: 0171 706 4234
Email: info@faces.demon.co.uk

**Raynaud's & Scleroderma Association Trust**
112 Crewe Road
Alsagar
Cheshire ST7 2JA
Tel: 01270 872776
Fax: 01270 88355
Email: webmaster@raynauds.demon.co.uk

**Vitiligo Society**
125 Kennington Road
London SE11 6SF
Tel: 0171 840 0844
Fax: 0171 840 0855
Email: info@analysis.org.uk

**National Eczema Society** (http://www.eczema.org/)
Tavistock House North
Tavistock Square
LONDON WC2H 9SR
Tel: 0171 388 4097

**The Psoriasis Association**
Milton House
7 Milton Street
Northampton NN2 7JG
Tel: 01604 711129
Fax: 01604 792894

**Updated By:** Dr D.W. Pryce

**Job Title:** Consultant Dermatologist and Clinical services Lead

**Last Updated:** 28th November 2011
Patient presents to GP

GP consultation and assessment. Telemedicine to consultant if appropriate

MALIGNANT MELANOMA SQUAMOUS CELL CARCINOMA

SEVERE INFLAMMATORY SKIN CONDITIONS (e.g. BLISTERING DISEASES, ERYTHRODERMA etc ) AND HIGH RISK BCC’S

2 WW ‘Fast Track’ (Urgent referral to Secondary Care)

Refer to Secondary Care

ROUTINE SKIN CONDITIONS AND LOW RISK BCC’s

Dermatology Interface Service in Somerset ‘DERMISS’ (GPwSI triage/assessment)

SEVERE INFLAMMATORY SKIN CONDITIONS (e.g. BLISTERING DISEASES, ERYTHRODERMA etc ) AND HIGH RISK BCC’S

SECONDARY CARE DERMATOLOGY

Maxillofacial

Plastic Surgery

Radiotherapy

PLEASE NOTE:
These guidelines are suggested best practice. However the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or carer.

Referring back to referring GP with advice

Refer to local GPwSI

AUGUST 2011