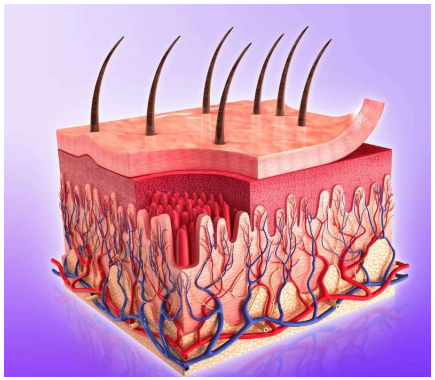
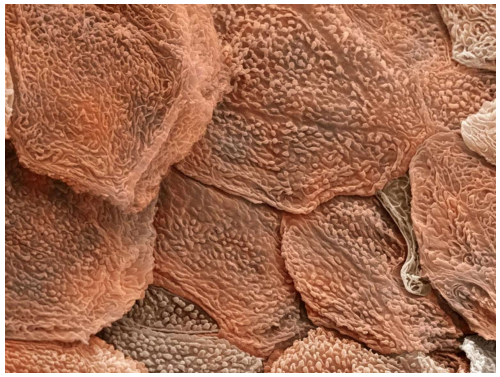
Some skin things





Dr Chin Whybrew

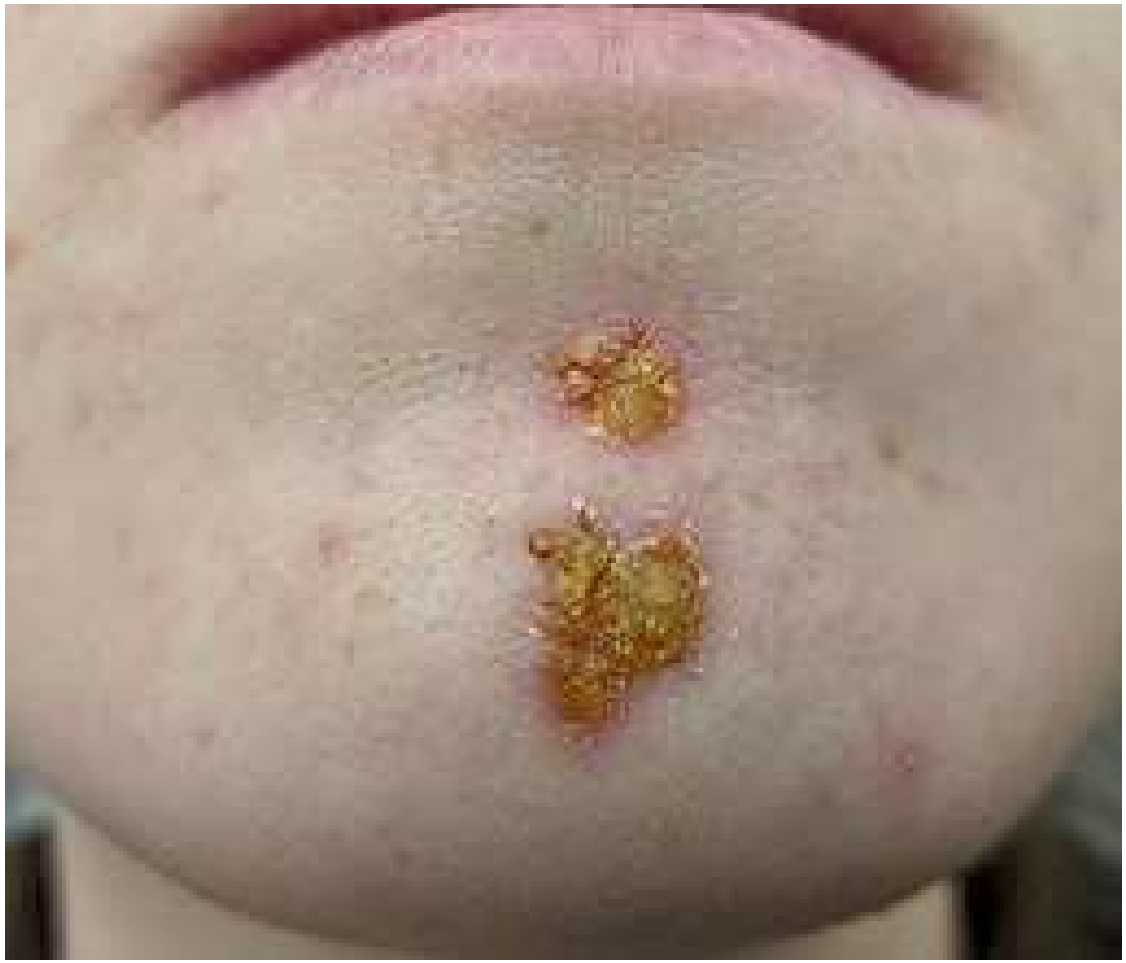
GP, Cheltenham, UK

PCDS exec committee member and dermoscopy lead

Jobbing GP working exclusively in NHS primary care

Impetigo

- Topical hydrogen peroxide
- Oral flucloxacillin / clarithromycin
- Topical hydrocortisone
- Topical Eumovate
- Topical aciclovir
- Refer to a prescriber for something else

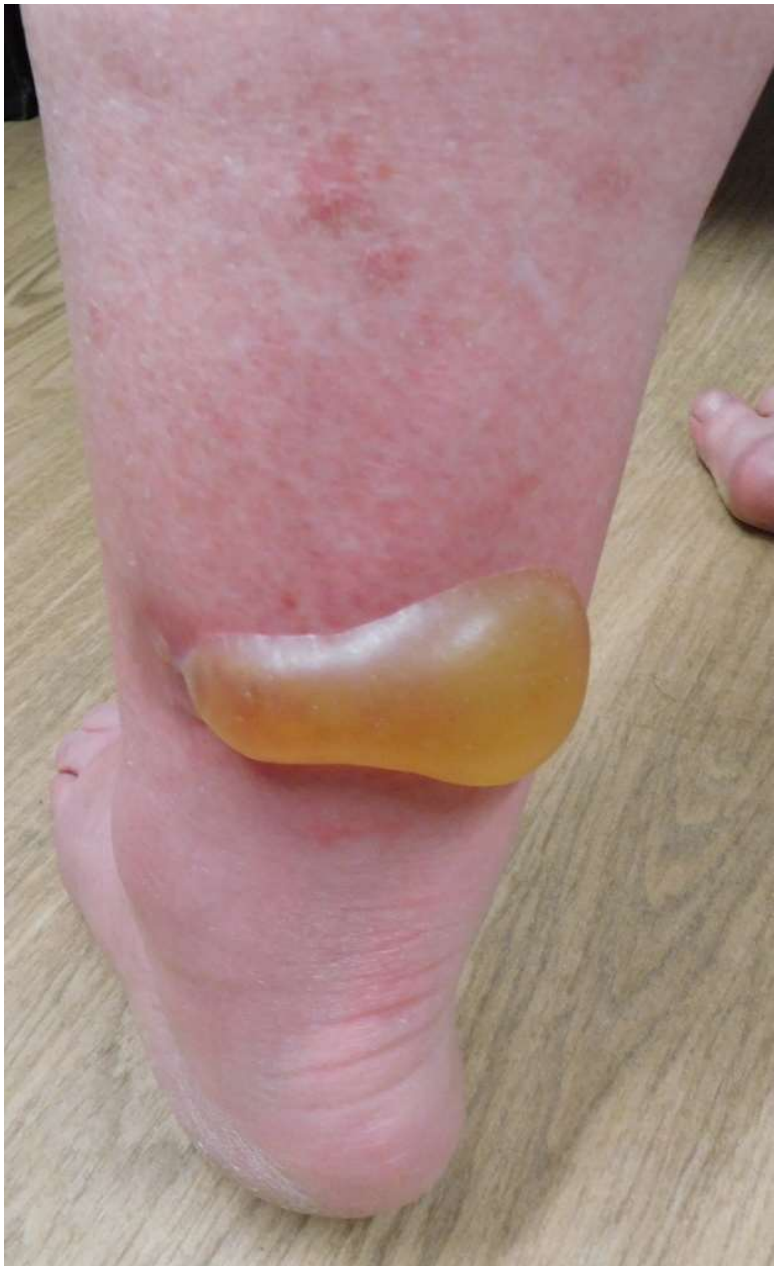


Impetigo treatments

- Hydrogen peroxide cream – localised, non bullous
- Fucidic acid cream – only if HP can’t be used (eg near the eye)
- Flucloxacillin, clarithromycin, erythromycin – if widespread

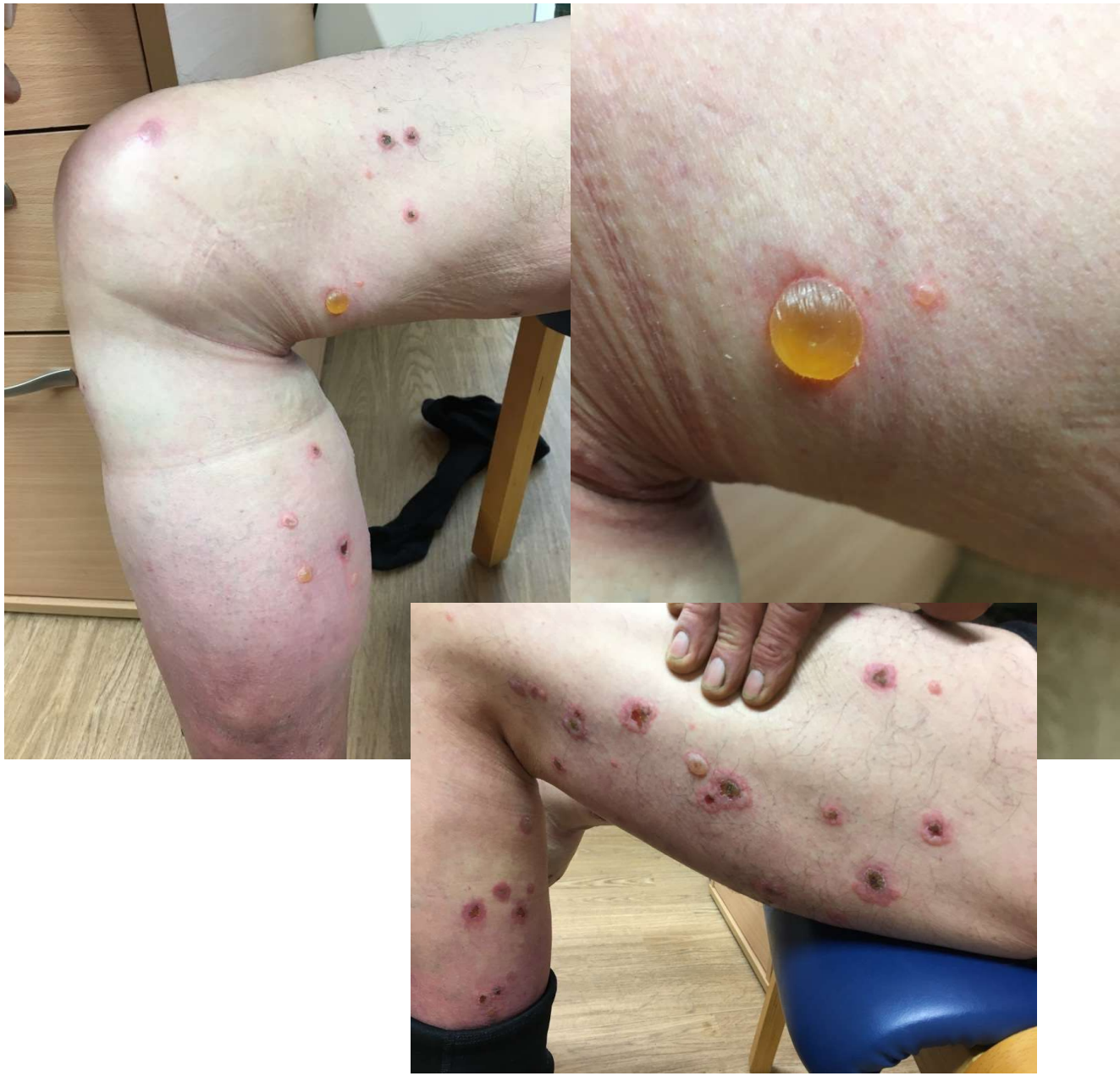
Impetigo - bullous

- Bulla means a large, tense, blister
- The infection is a bit deeper than ordinary impetigo
- Needs oral treatment and is excluded from the PGD

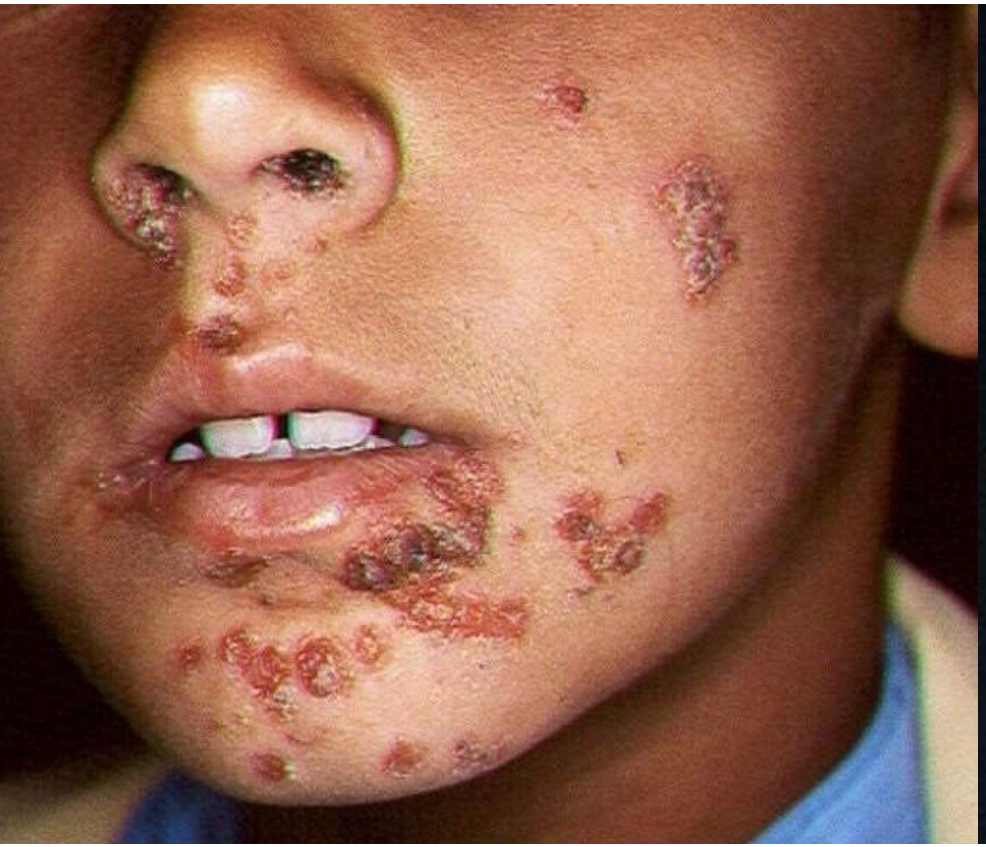


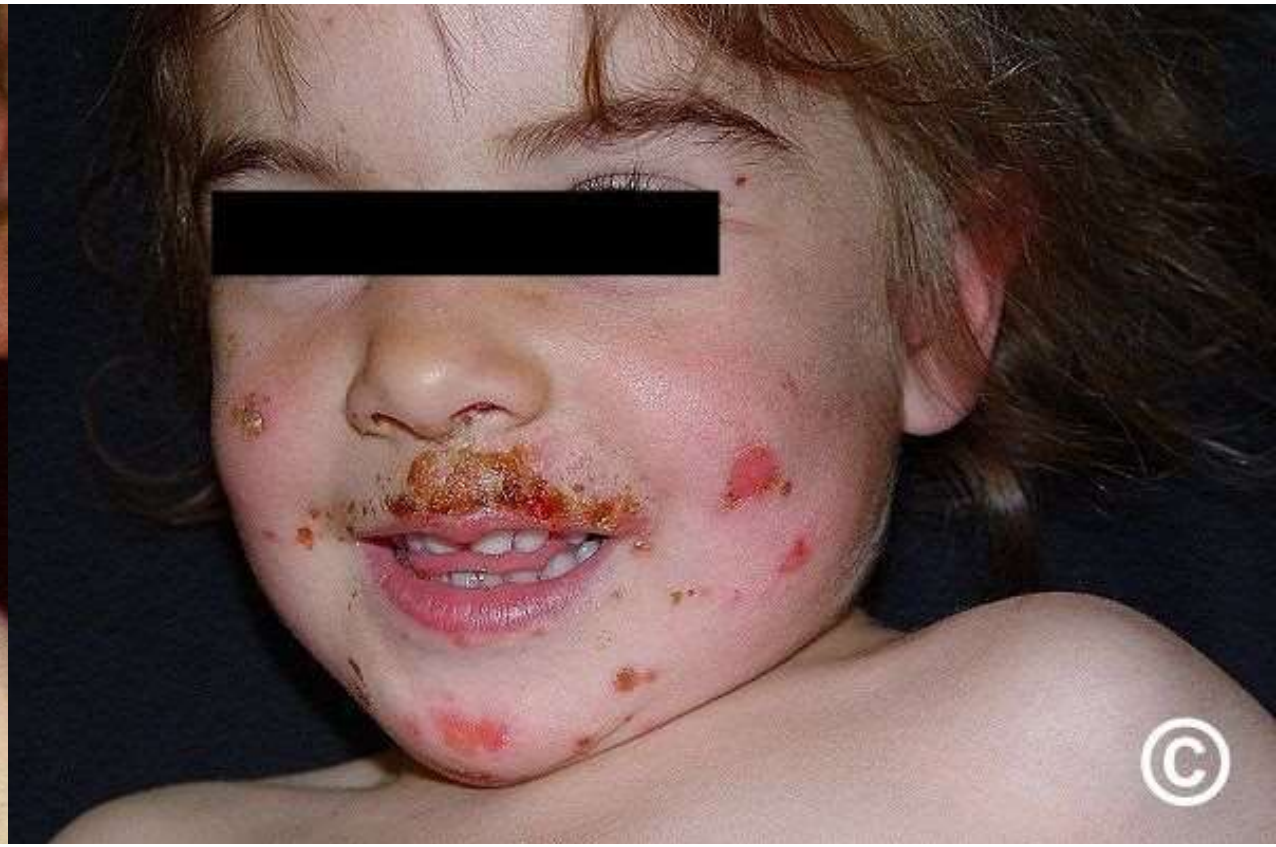
Bullous pemphigoid

- Needs treatment with steroids
- Can get quite unwell
- Initially may look similar to bullous impetigo



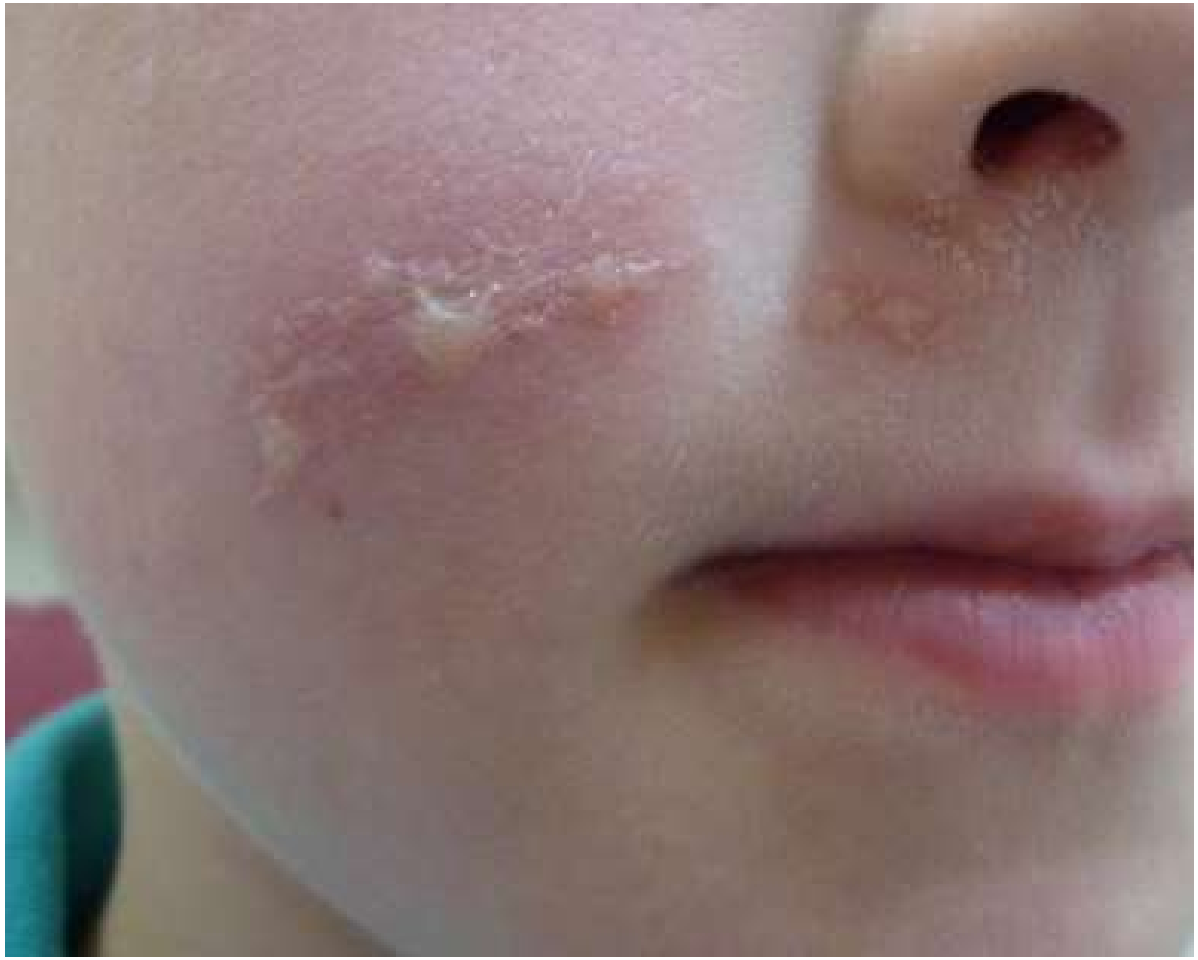
Impetigo - widespread

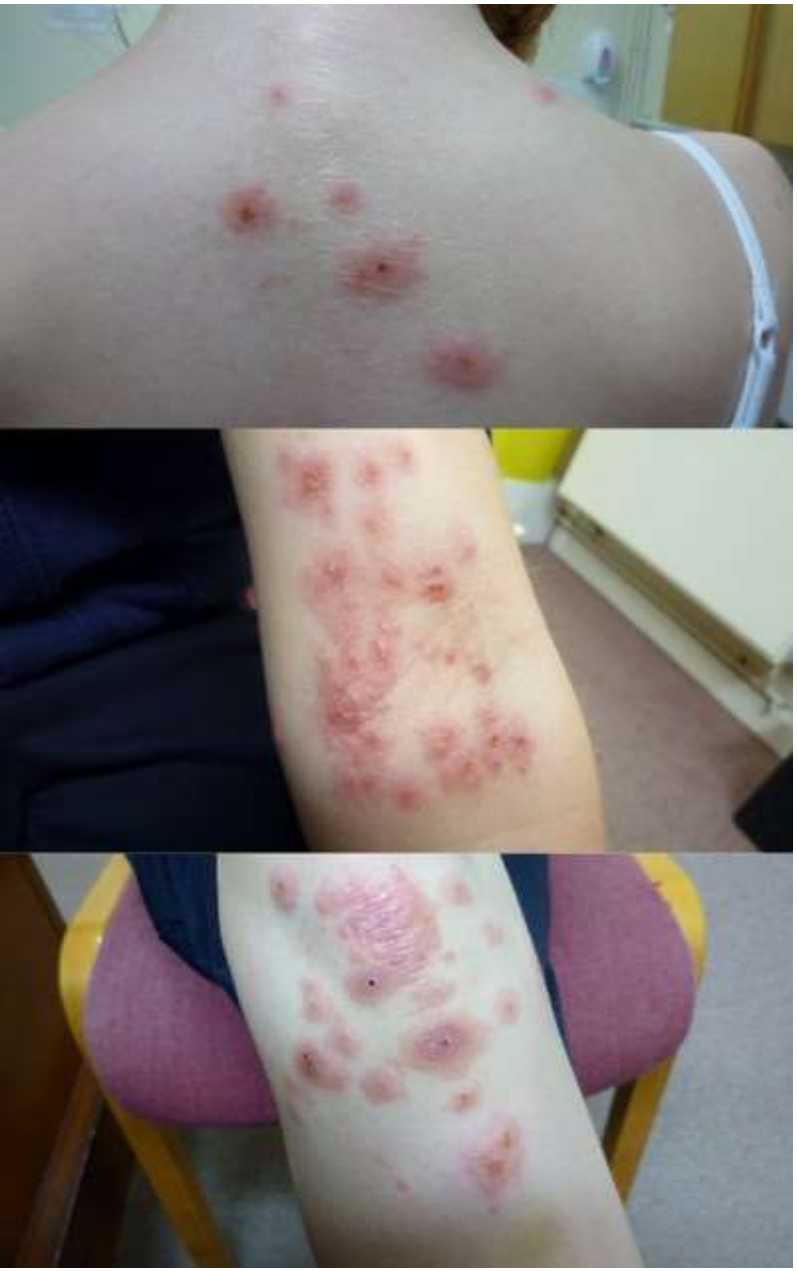




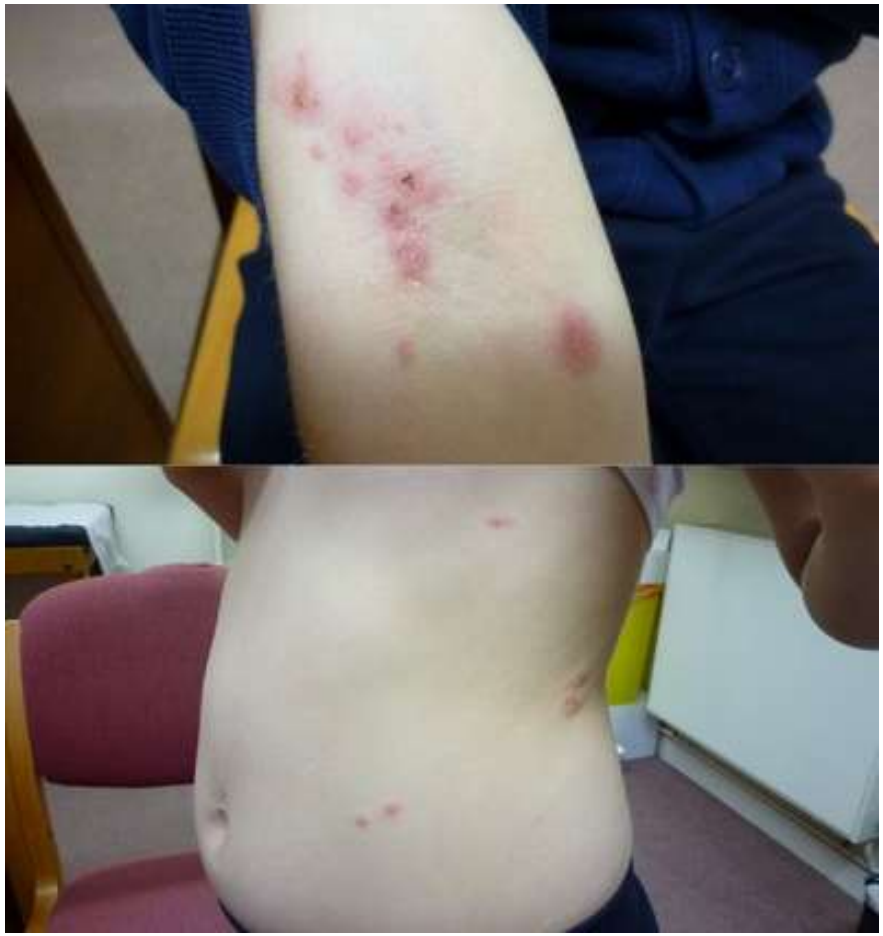
Impetigo - bullous

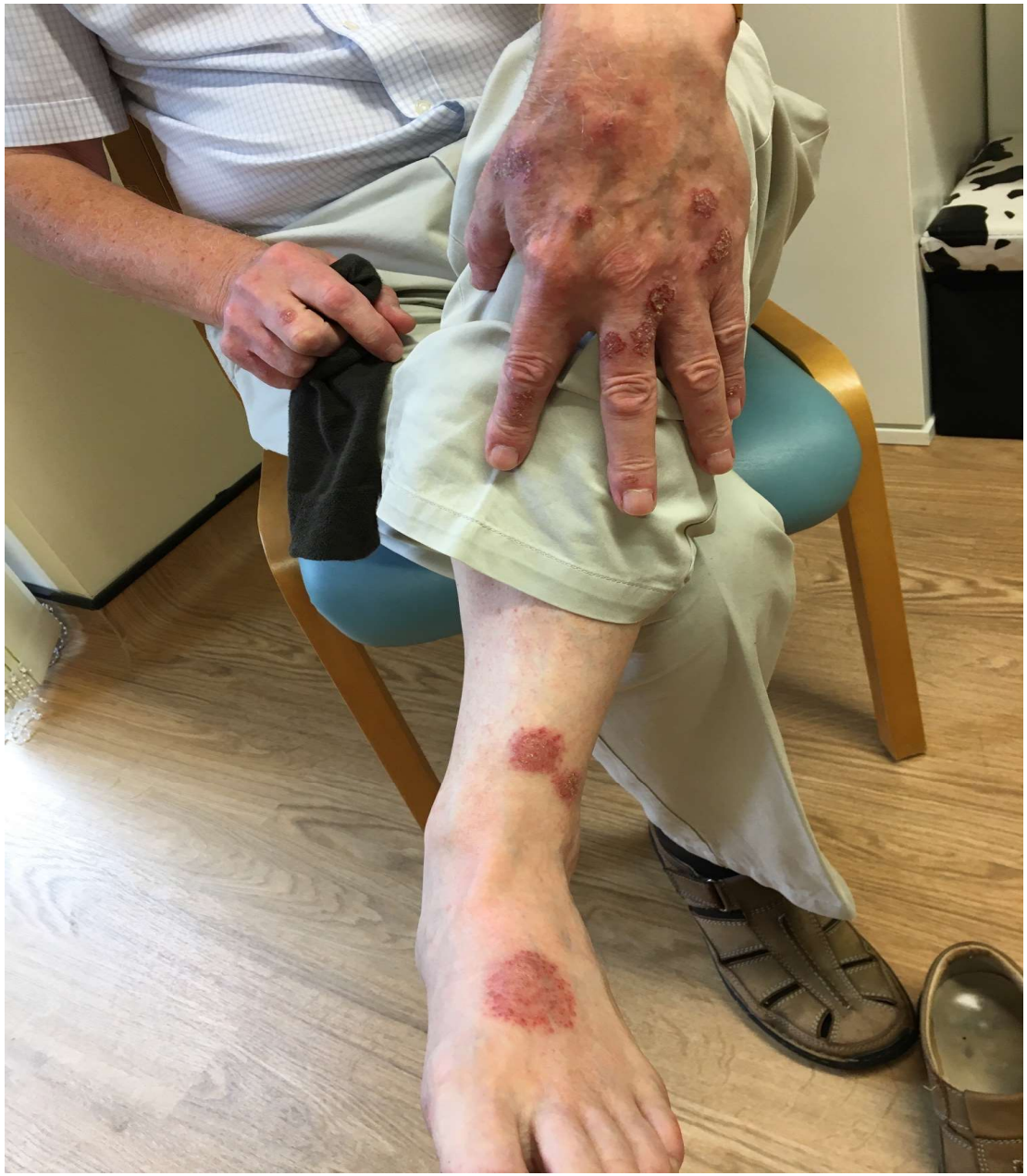
- **Oral flucloxacillin / clarithromycin**
- **Refer to a prescriber** (outside the PGD)

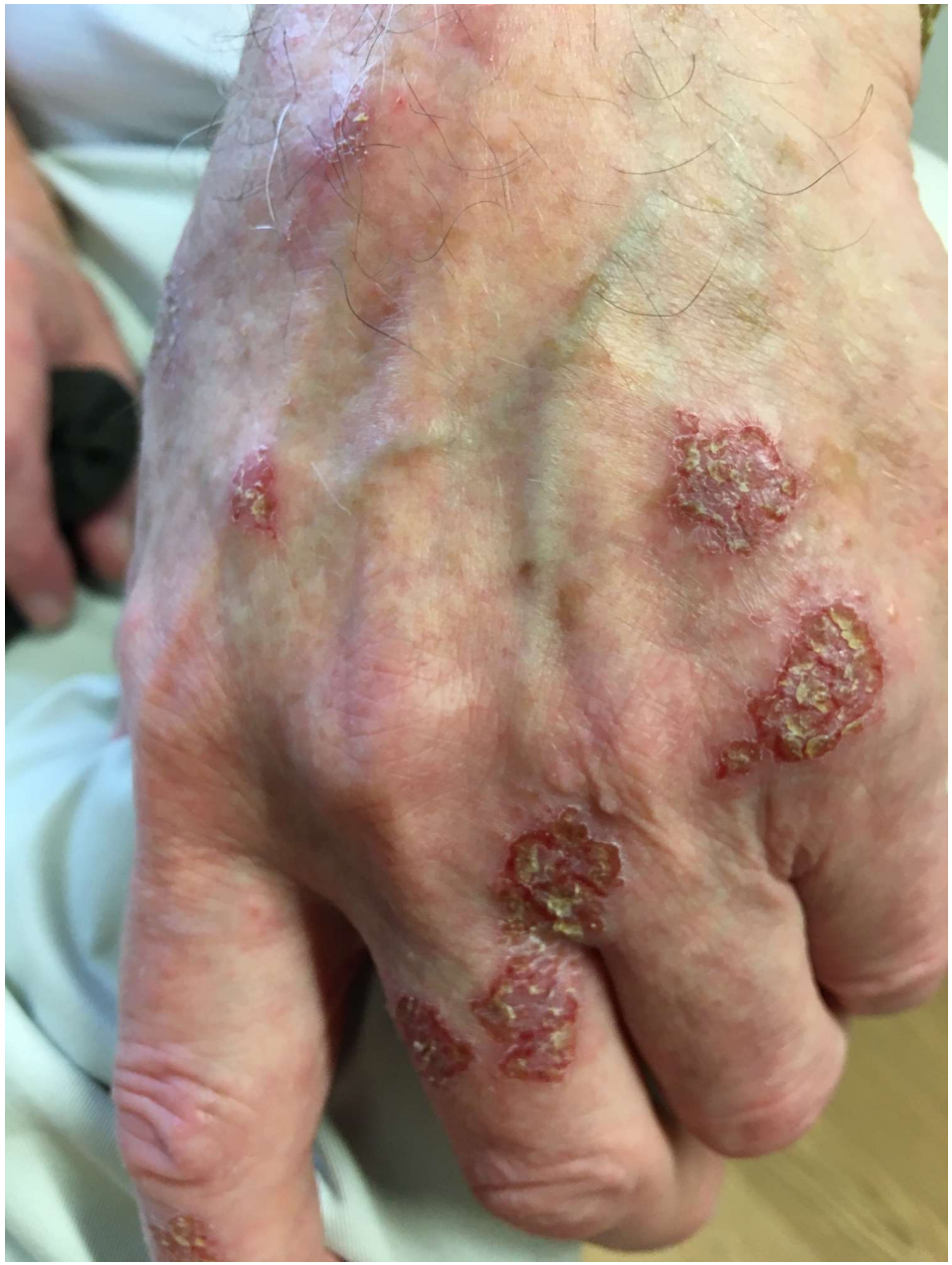


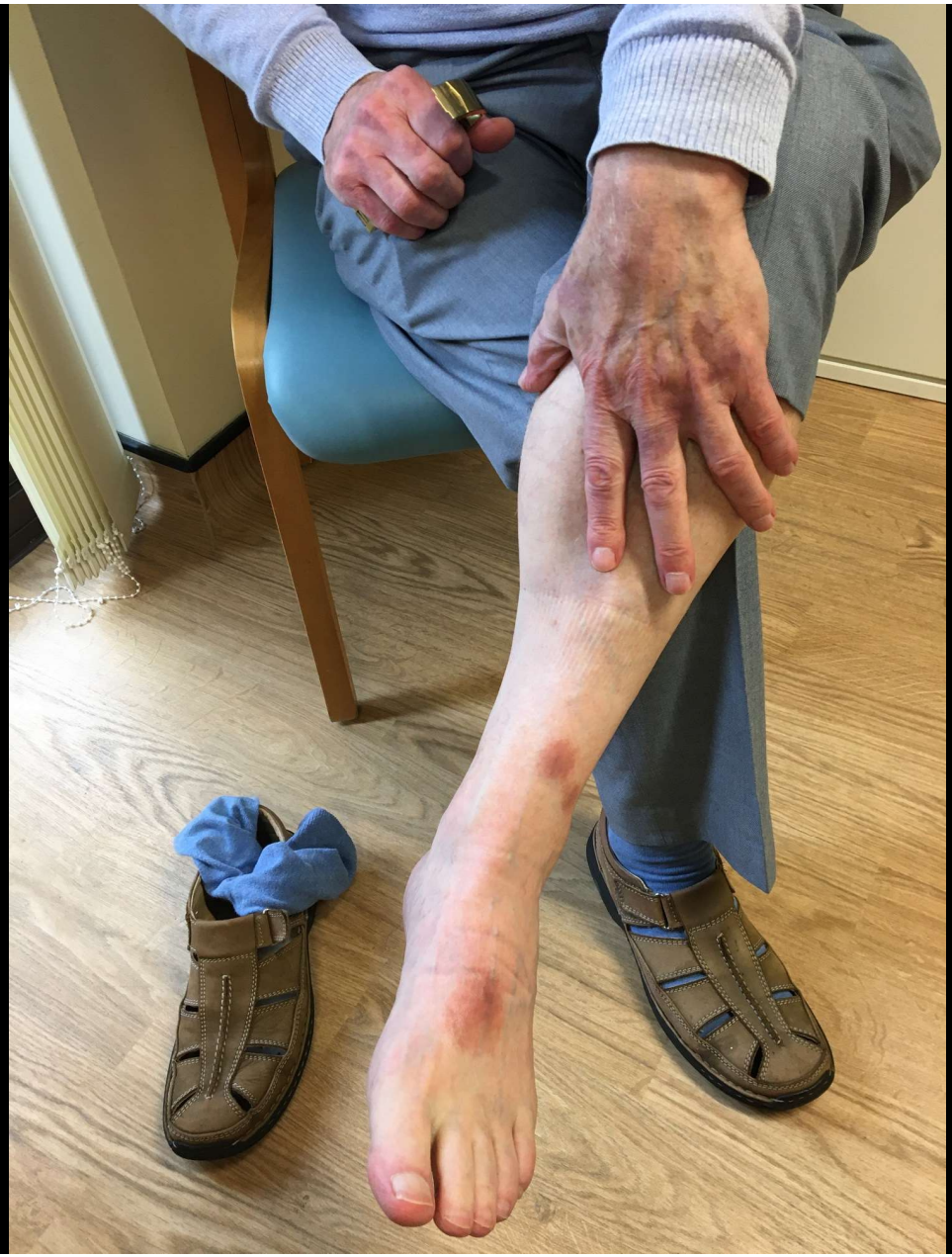


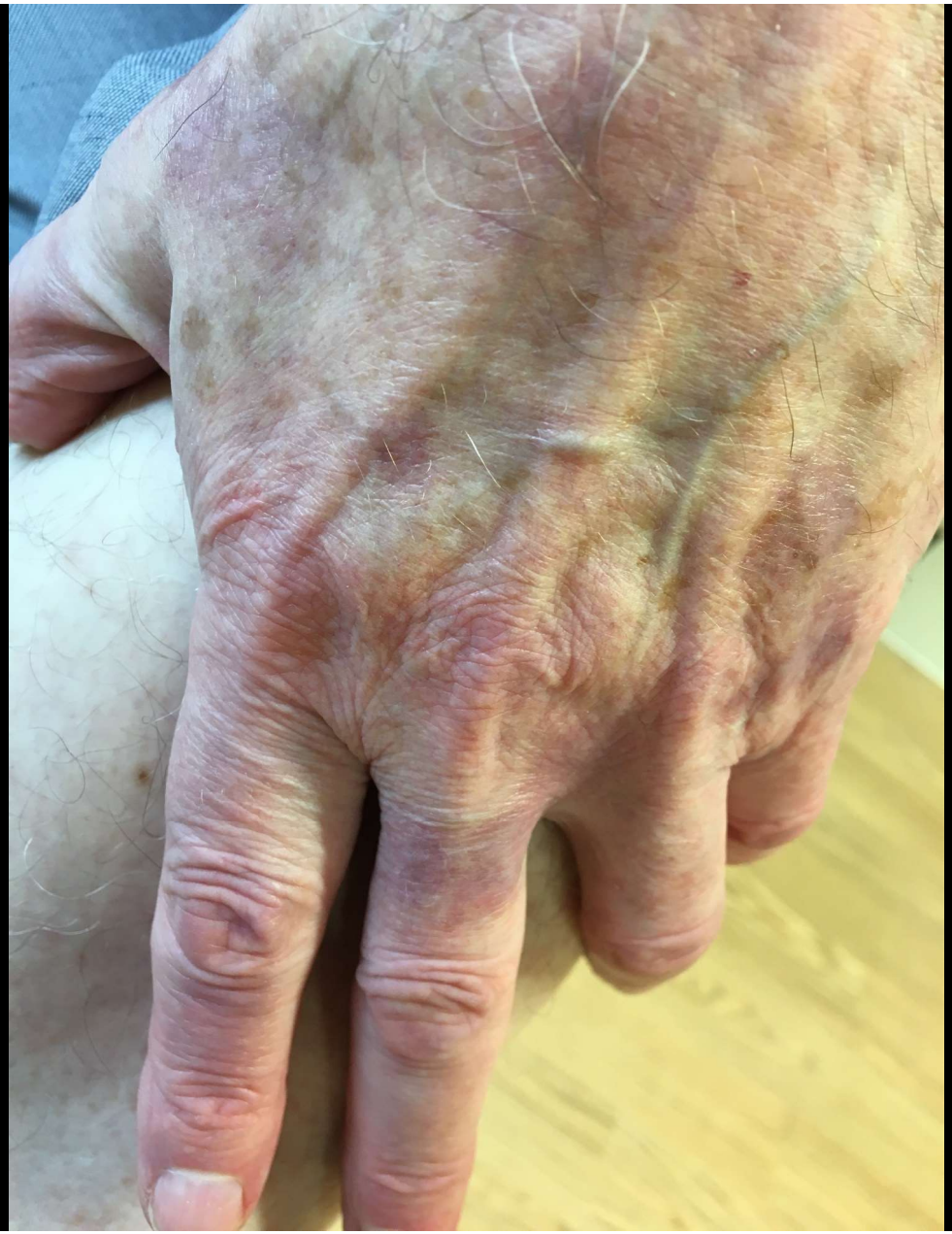
Impetigo - widespread



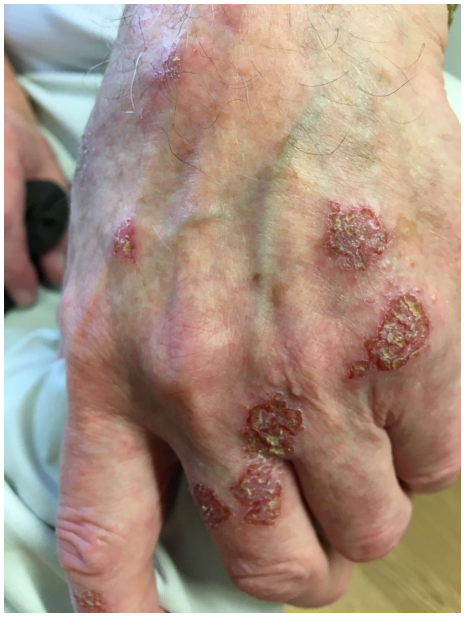






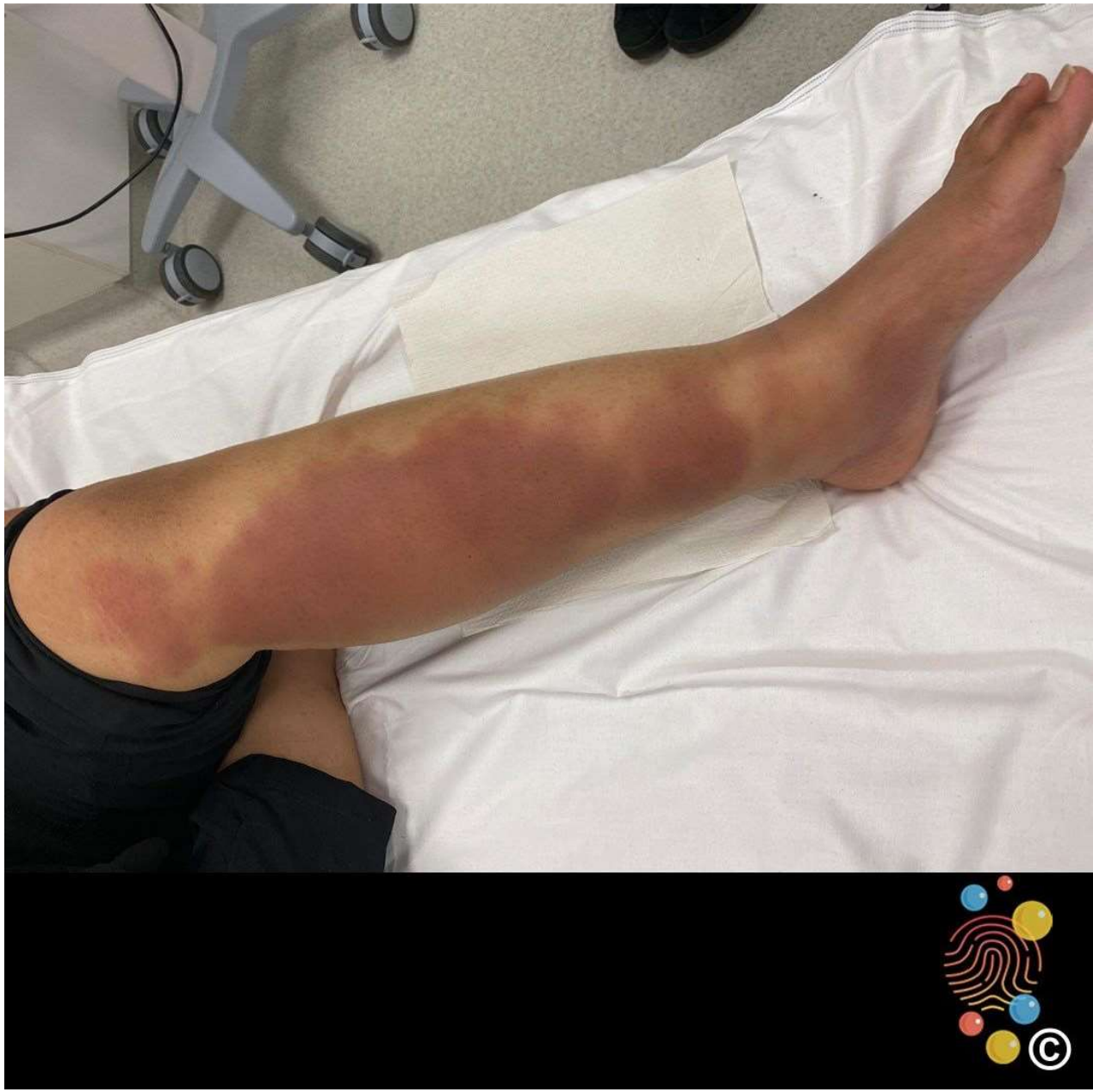


Discoid Eczema



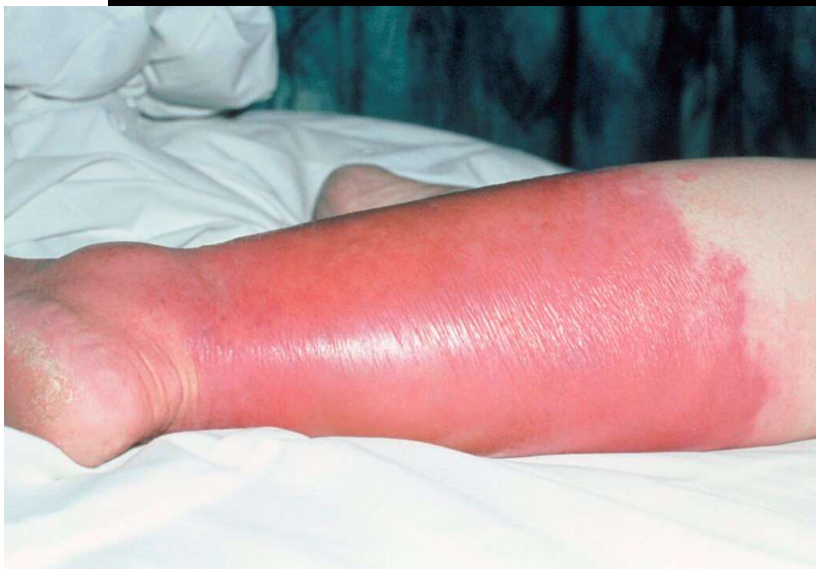
- Potent topical steroid is needed
- Antibiotics won’t help
- Steroid needs to be applied on top of the lesions, not just around them
- Need to use enough (finger tip units)
- Takes a week to be less itchy and 3-4 weeks to clear
- Lots of emollients helps prevent recurrence

Cellulitis

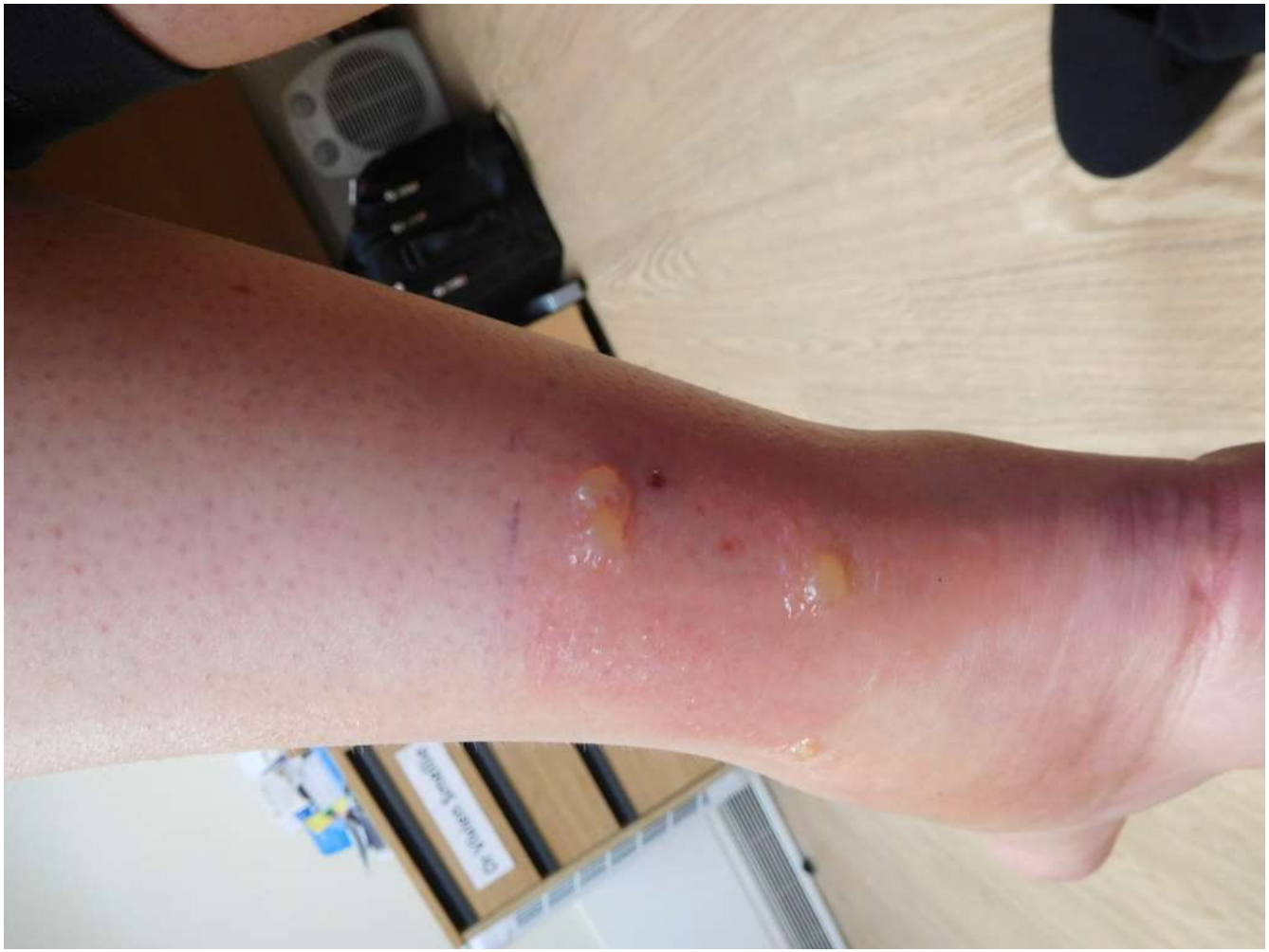


Cellulitis

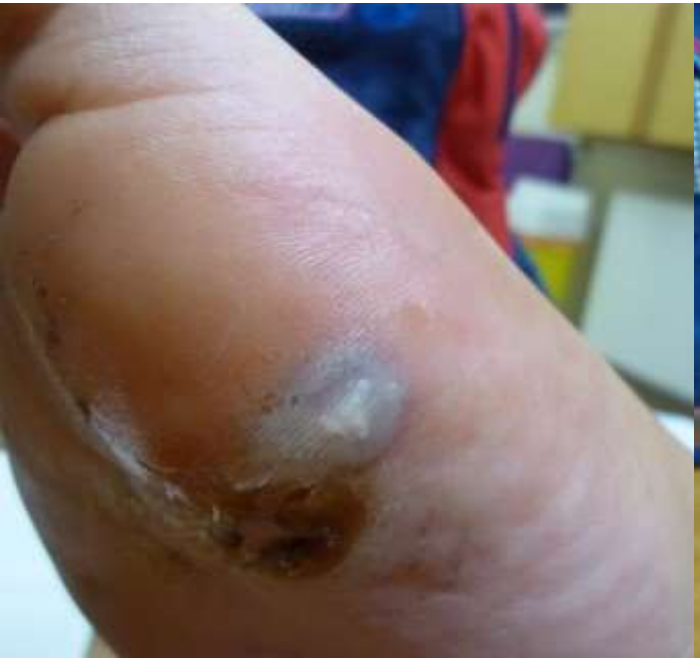
- Unilateral, well defined
- Painful, tender area
- Hot to touch
- Looks red on pale skin; purple/mauve on dark skin
- Usually febrile, unwell

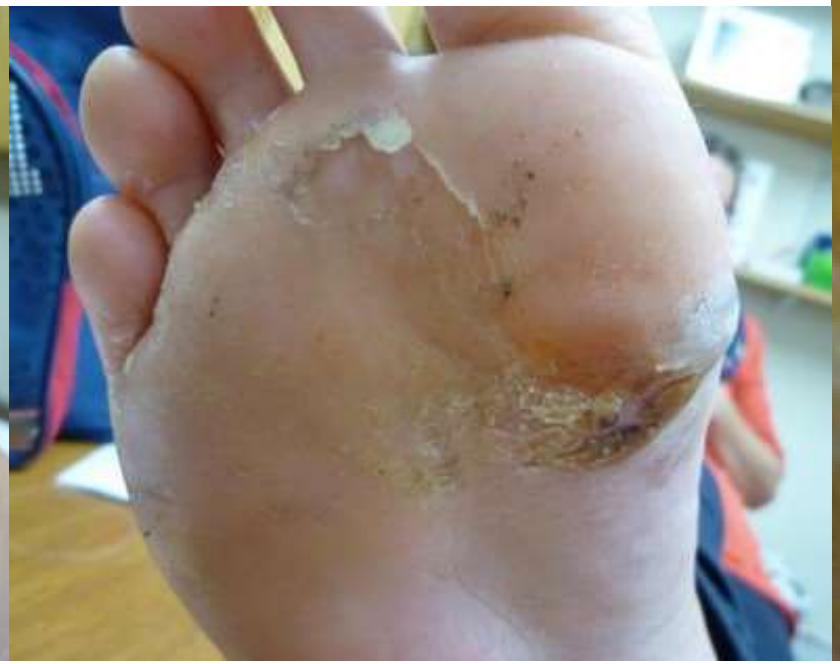


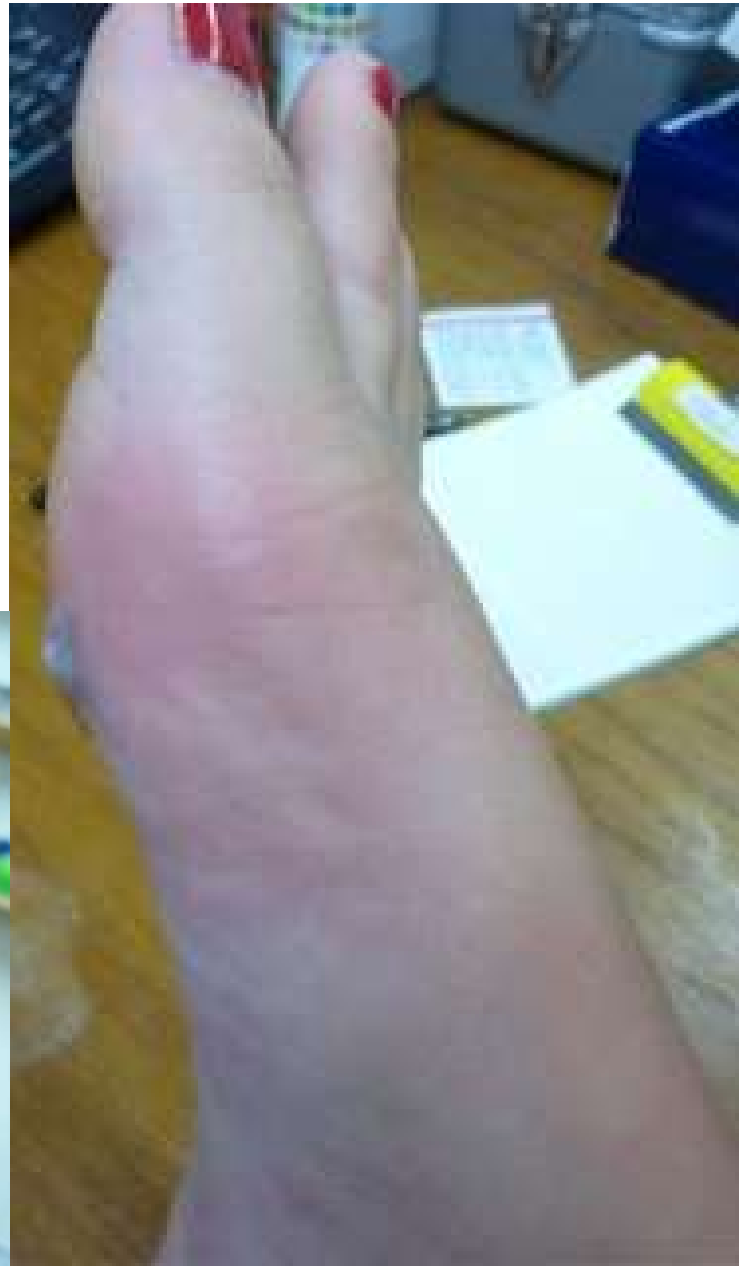
Cellulitis can be bullous too



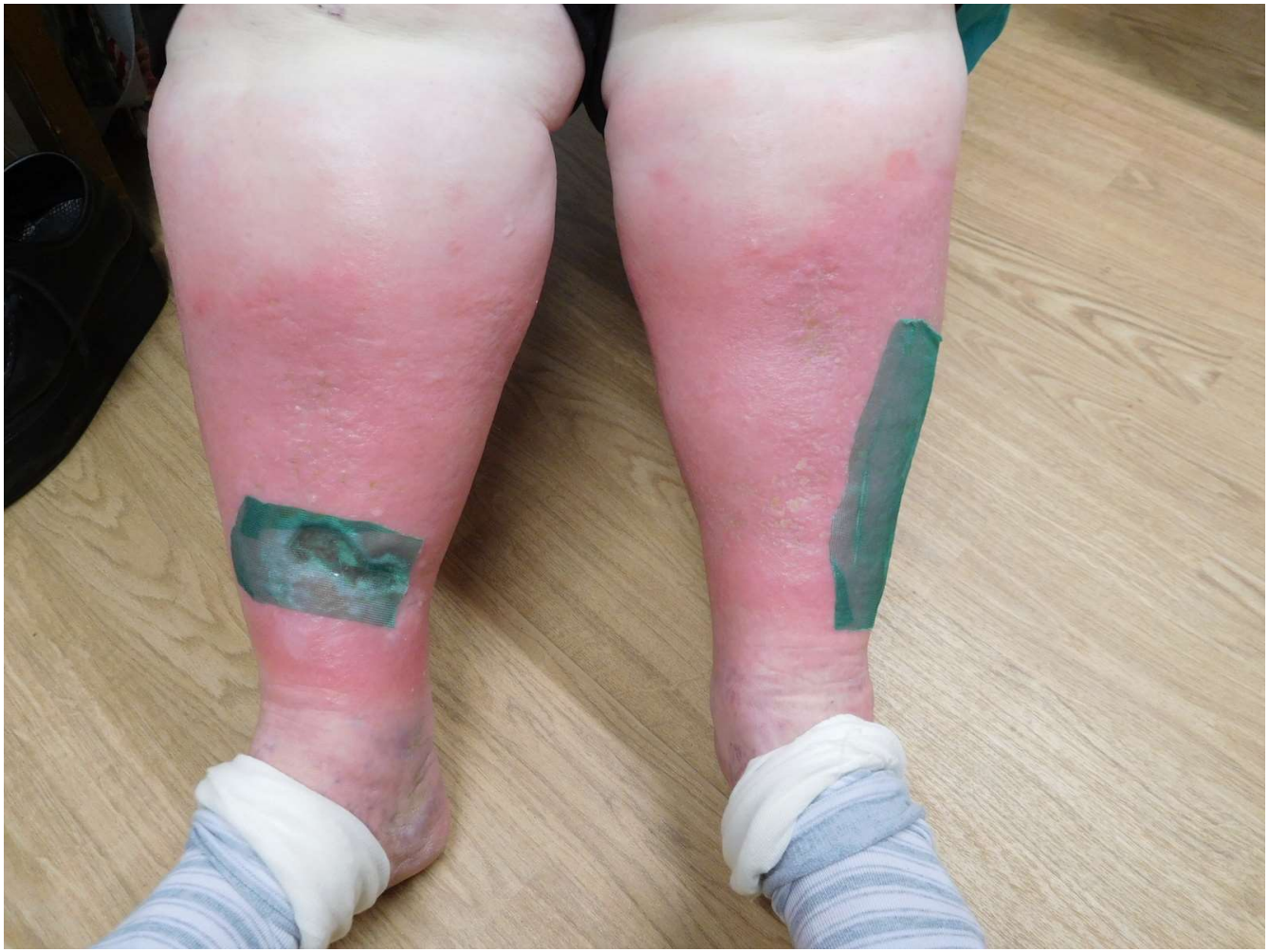
Cellulitis from bullous tinea pedis







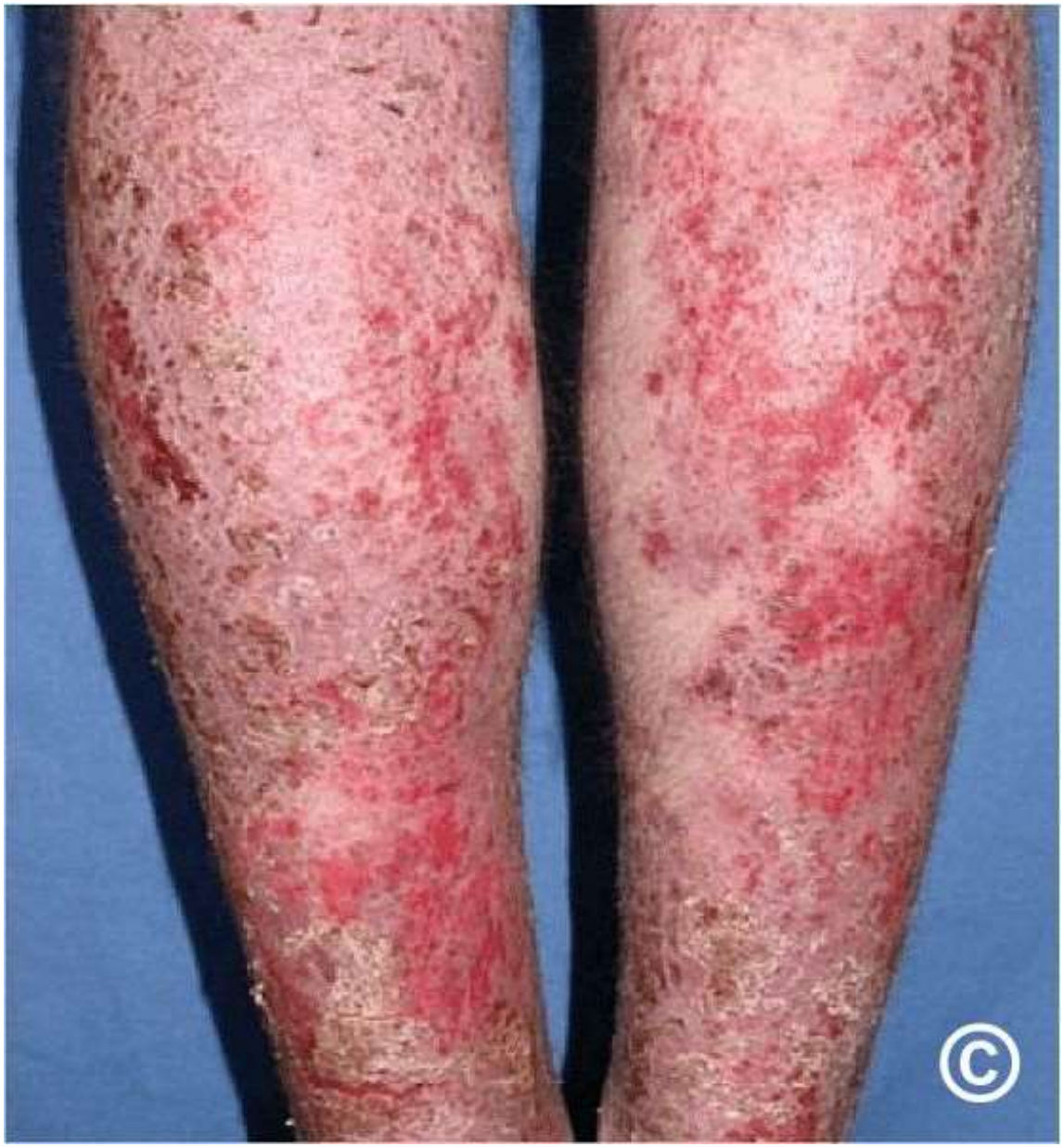
Not Cellulitis



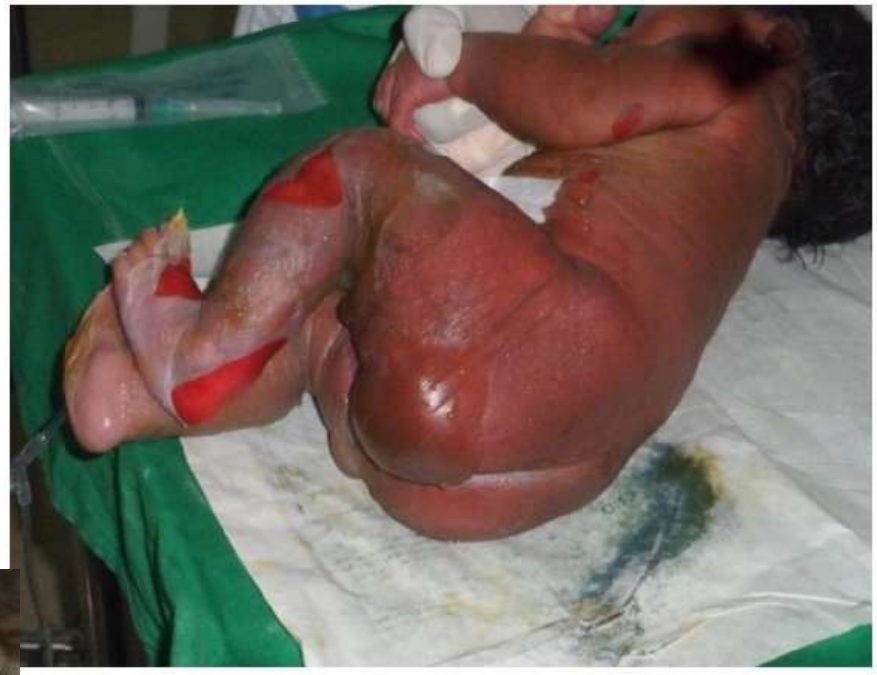
Cellulitis is never bilateral
Lipodermatosclerosis
Patient is well, afebrile
May be very painful
Often bilateral
Due to venous hypertension
Managed with compression, potent topical steroids, skin care

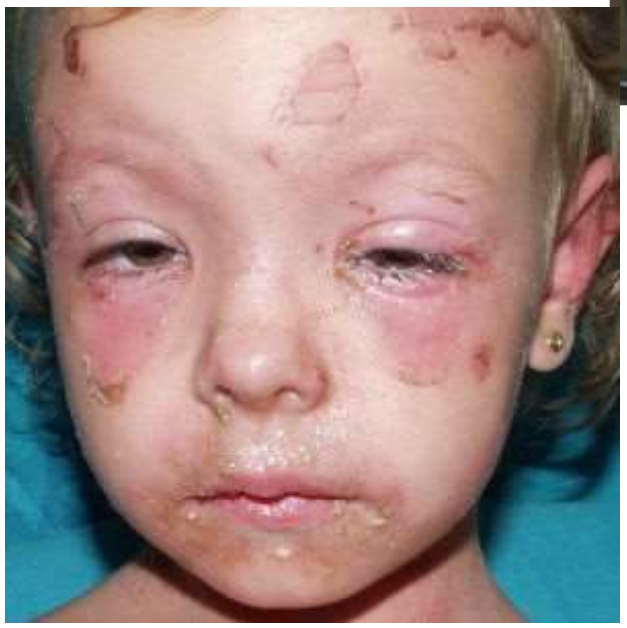
Not Cellulitis

Varicose eczema

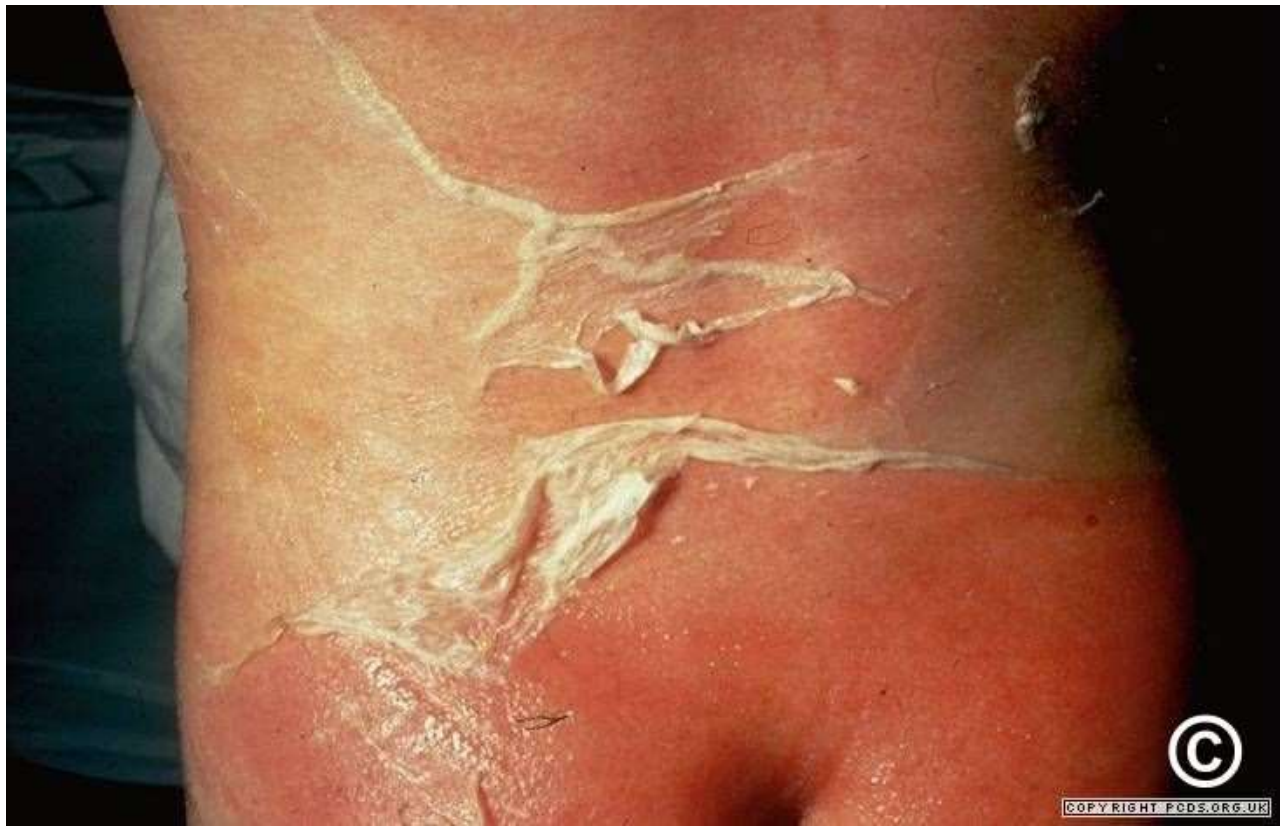


Staph Scalded Skin Syndrome





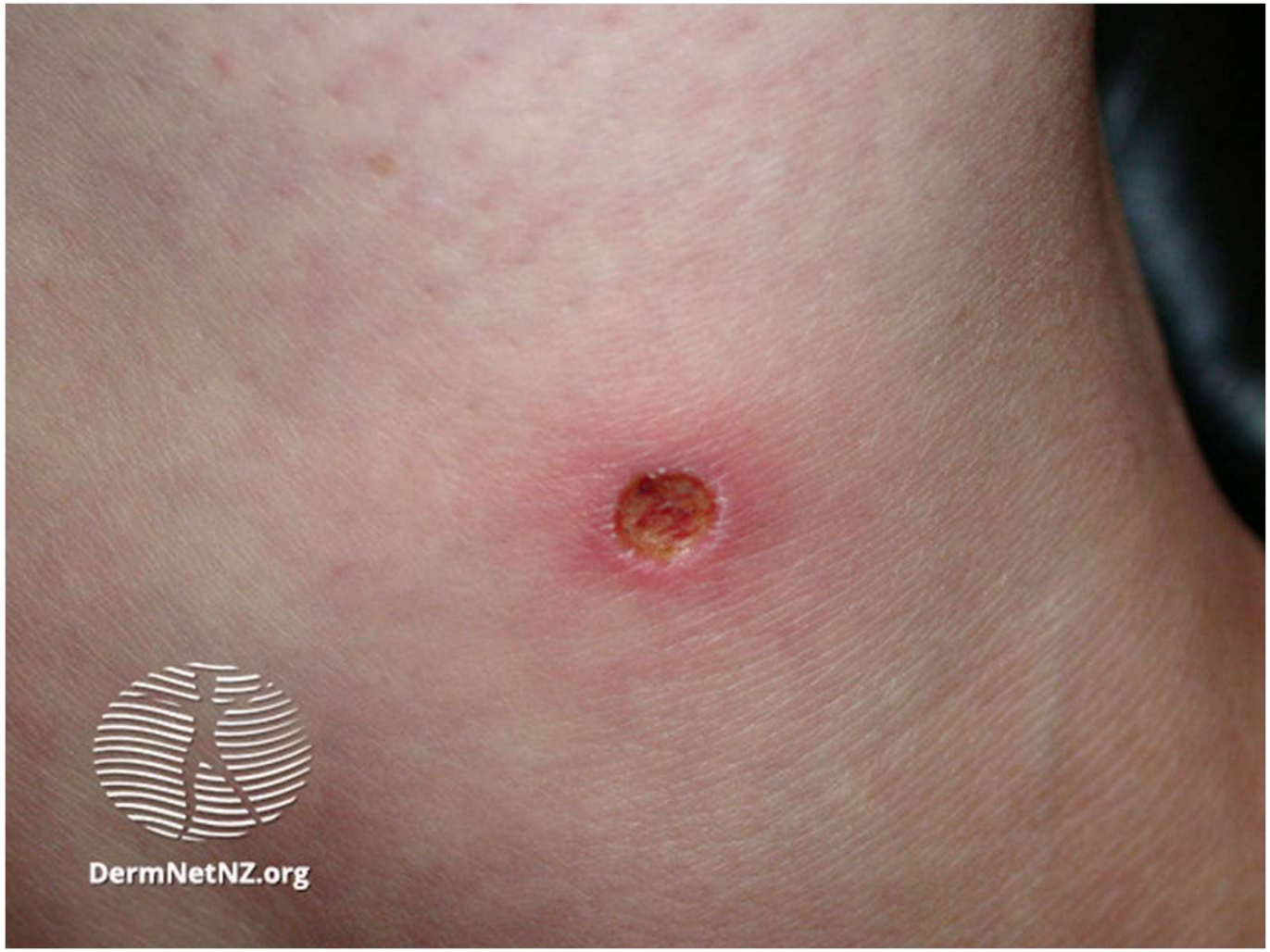
Staph scalded skin syndrome



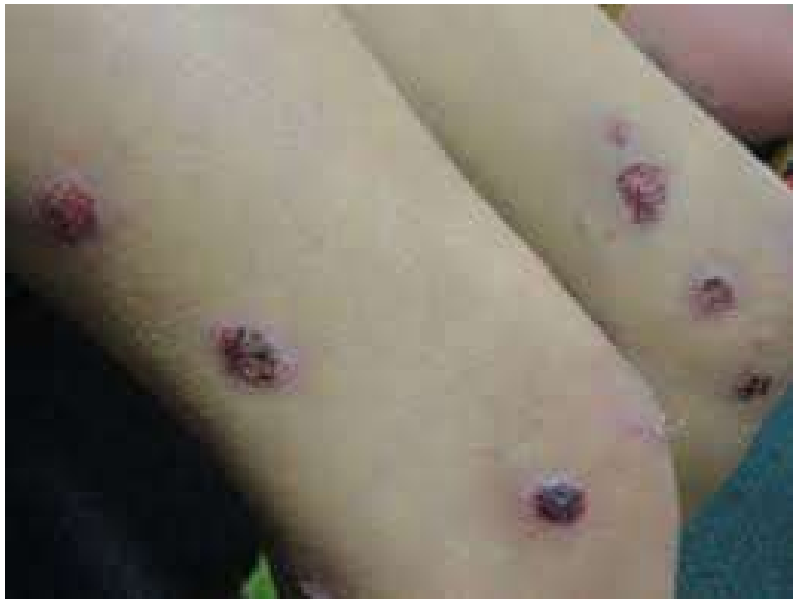
Usually under 5yo
may not be that unwell,
skin is non tender
Red then bullae then peels

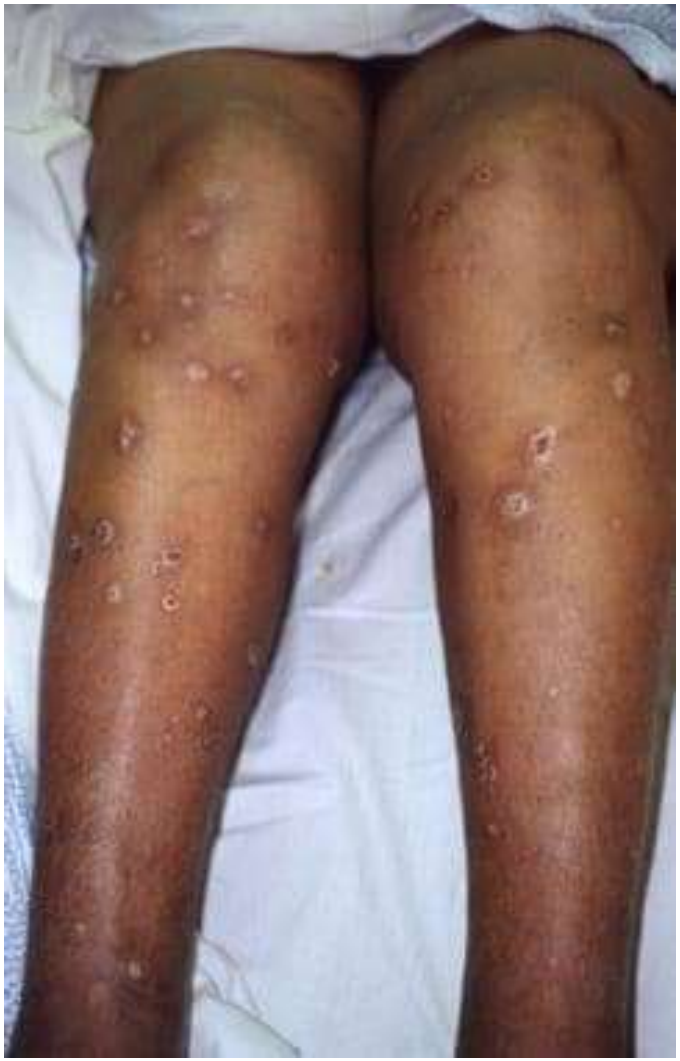
THIS IS INCREDIBLY RARE

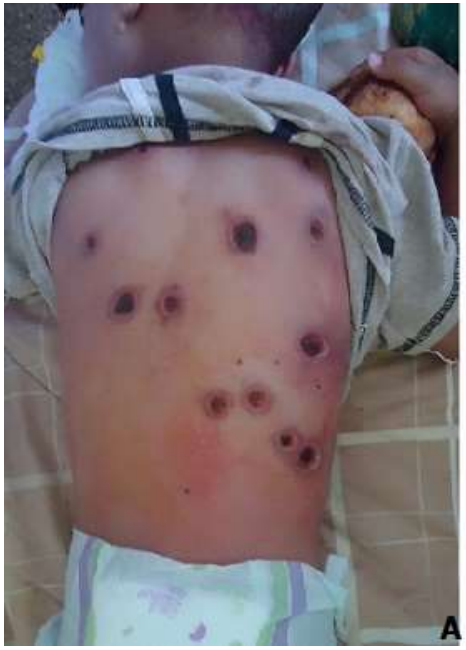
Ecthyma

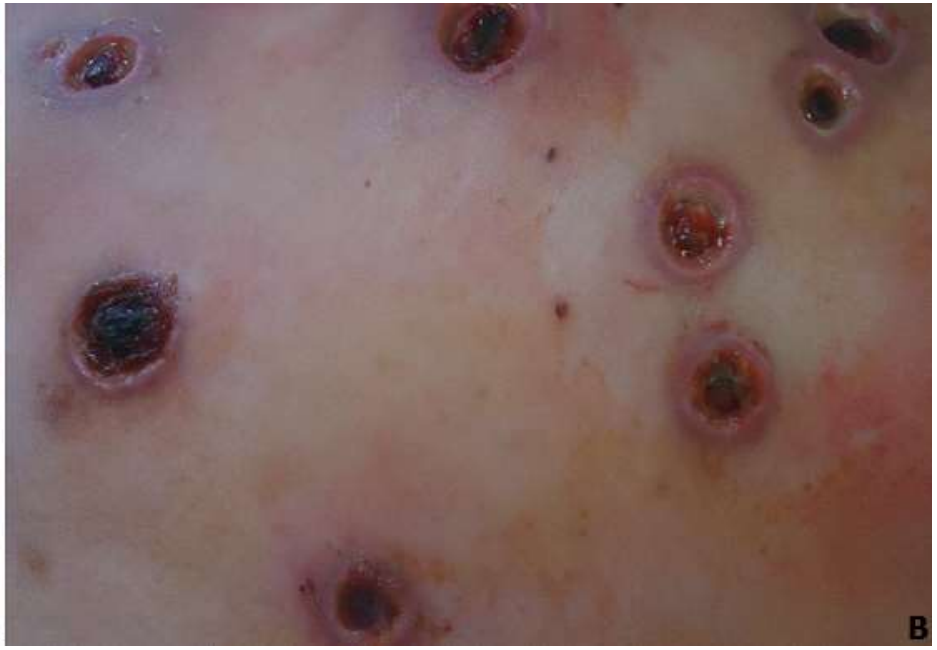


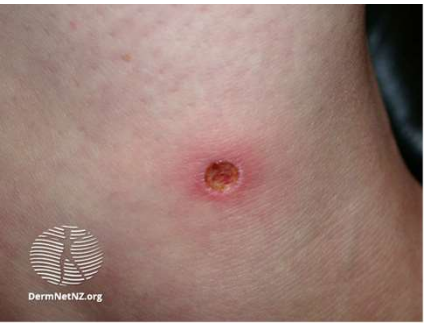
Ecthyma





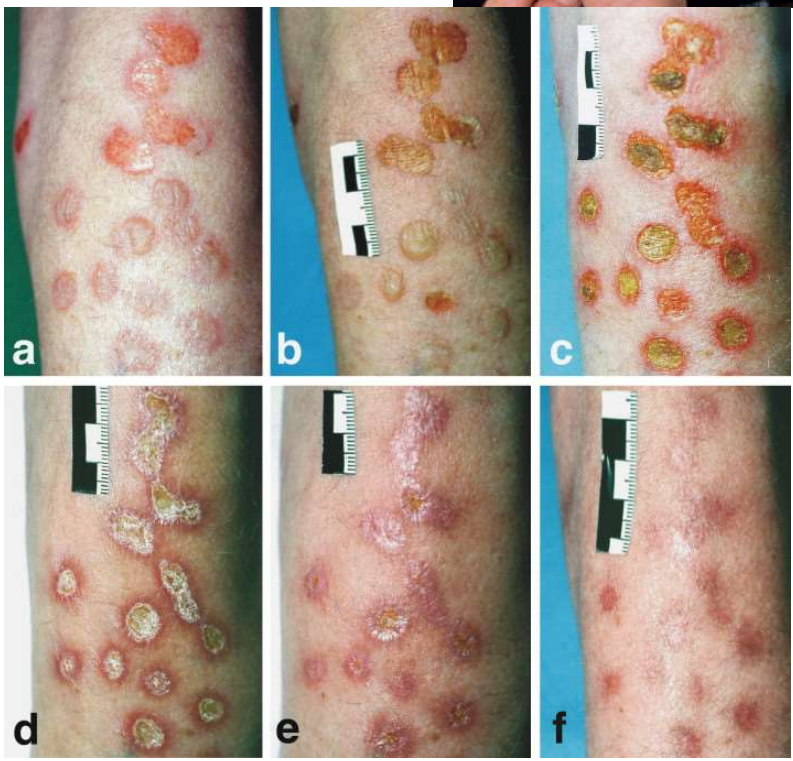




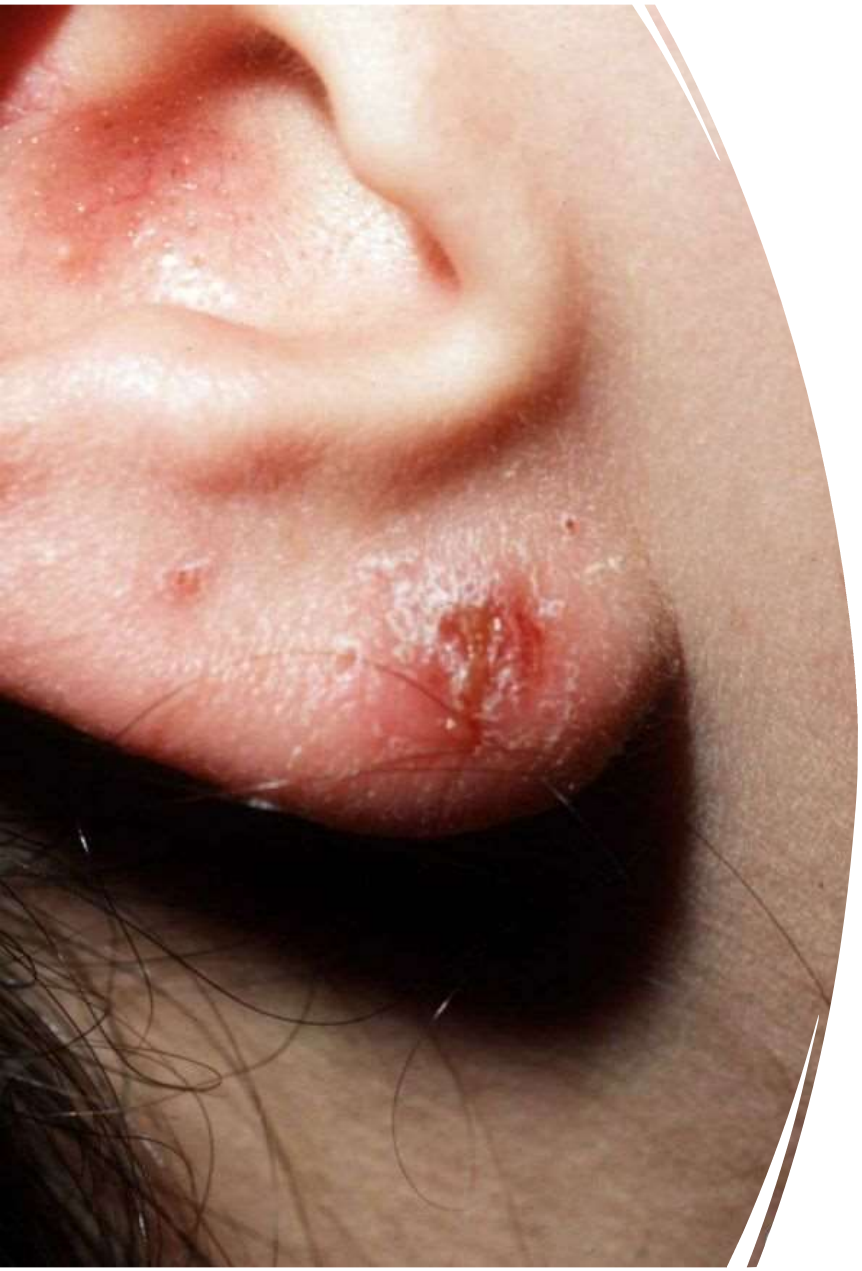


Ecthyma

- Deep skin infection, but localised
- Crusted sore, with underlying ulcer
- Causes scarring
- Differential diagnosis always includes non accidental injury
- Self inflicted or NAI cigarette burns can look very similar

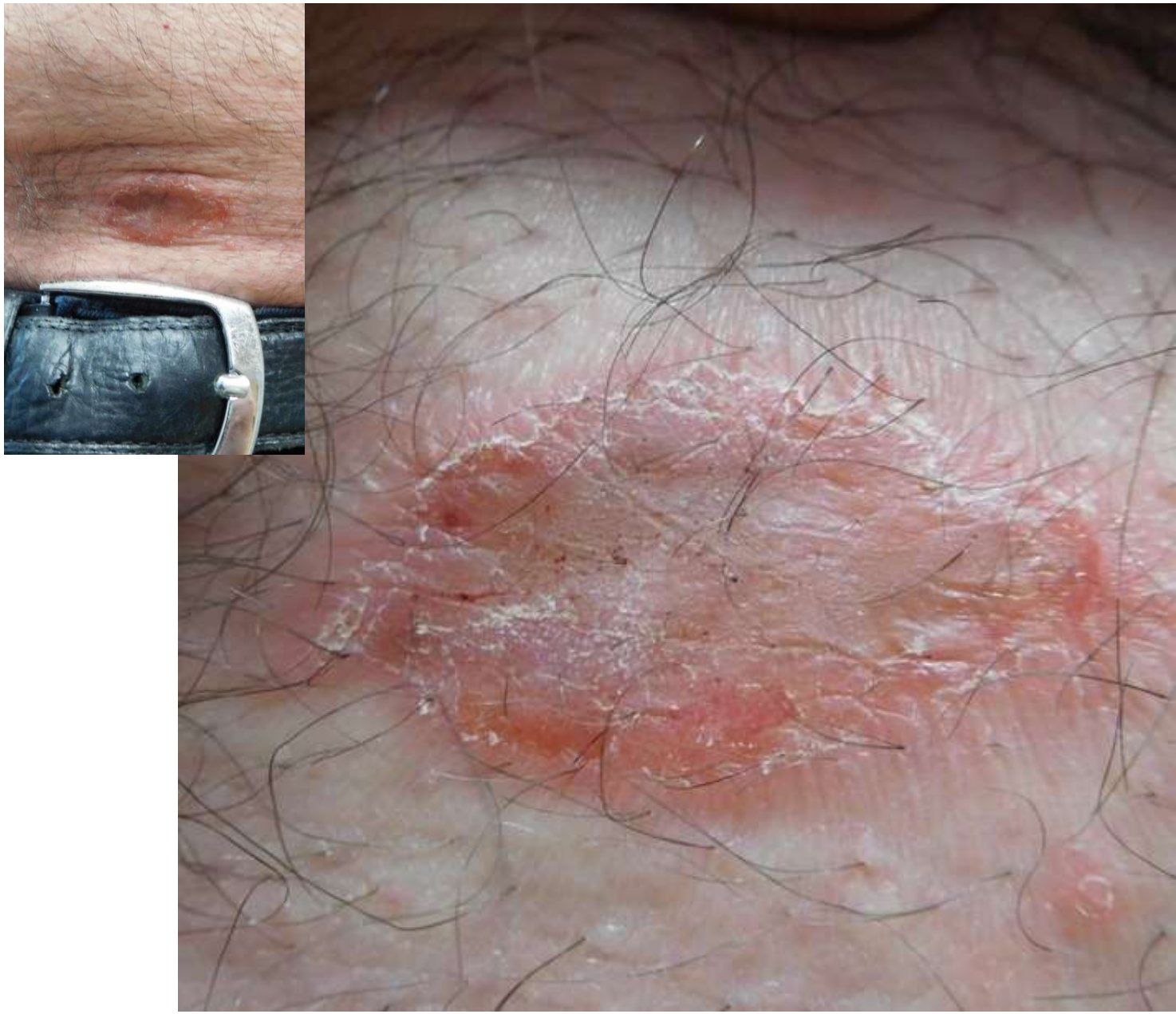


Maria Faller-Marquardt, Stefan Pollak, Ulrike Schmidt,
Cigarette burns in forensic medicine,
Forensic Science International,
Volume 176, Issues 2–3, 2008, Pages 200-208



Acute contact dermatitis

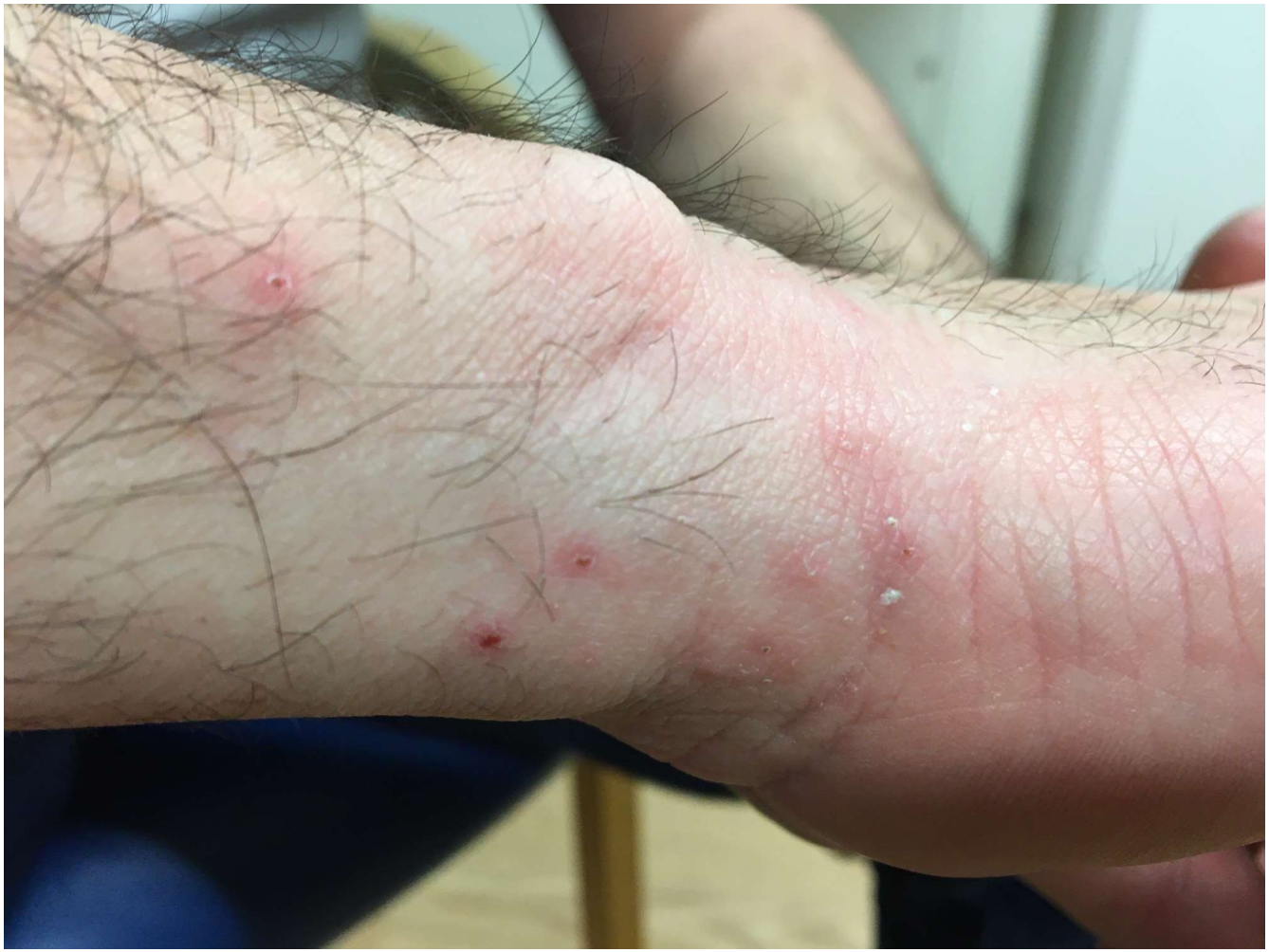
Acute contact dermatitis



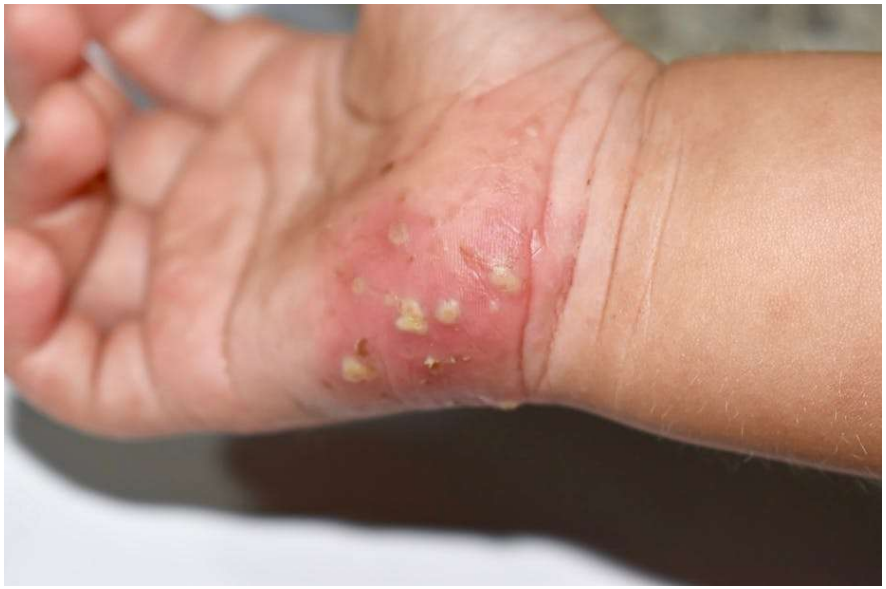
Acute contact dermatitis T/F

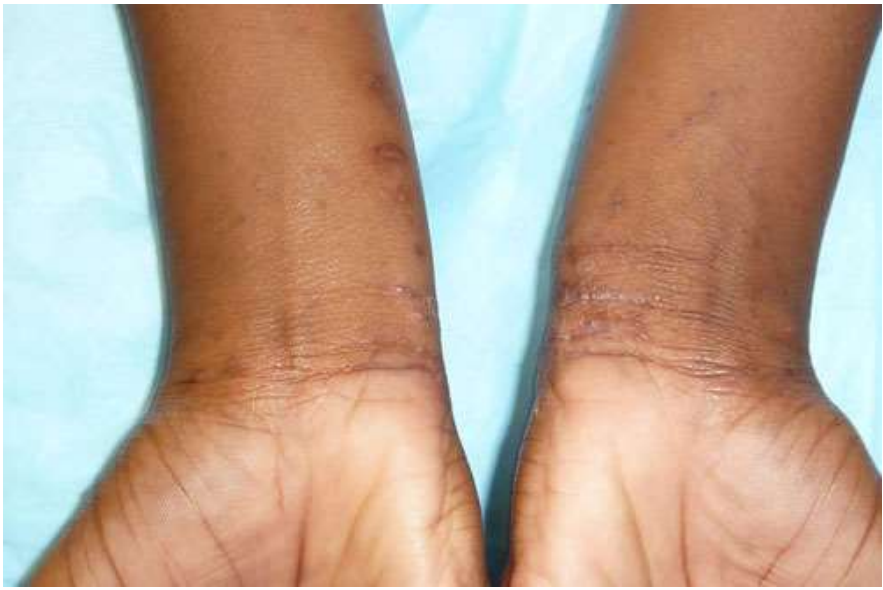
- Mainstay of treatment is to remove the allergen
- TRUE
- Mild to moderate potency steroid is helpful
- TRUE
- Antihisamines do not help
- TRUE

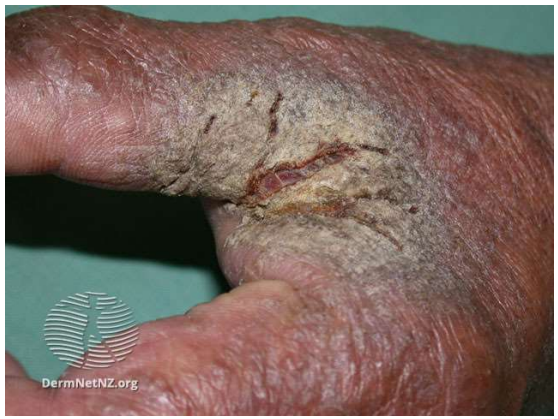
Scabies

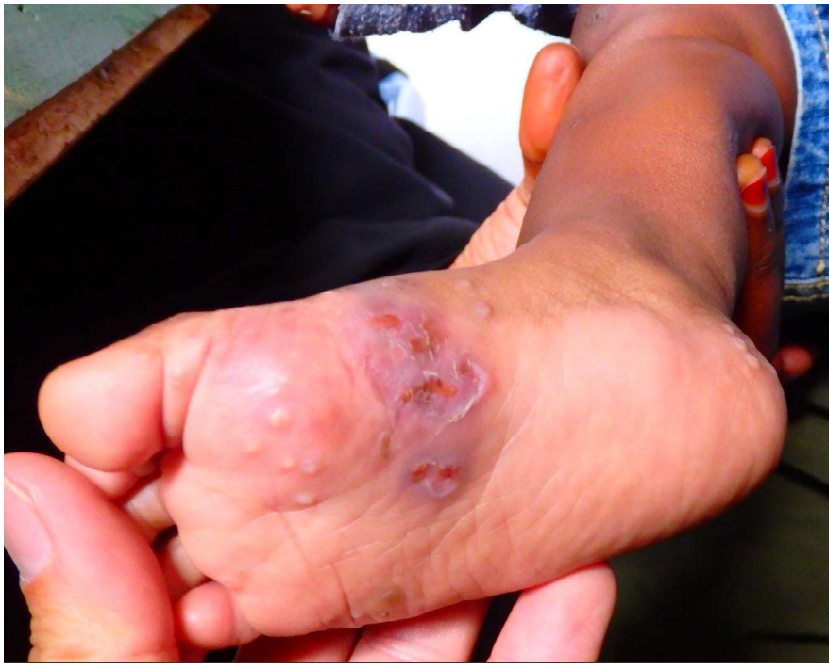


Scabies



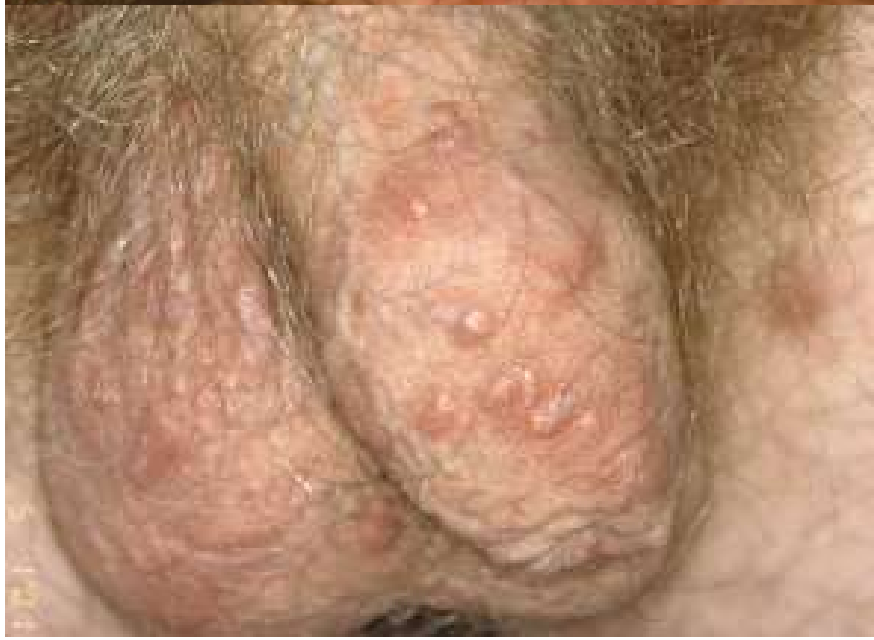






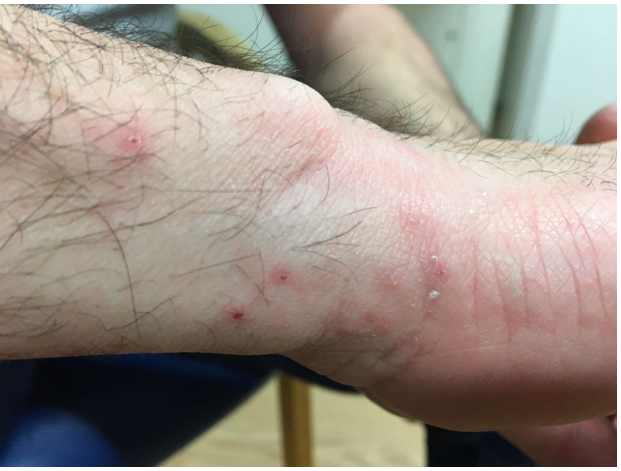
Scabies T/F

- Papules on the penis are scabies till proven otherwise
- TRUE
- Topical permethrin works for over 95% of cases
- FALSE
- The itch should get better within a week of treatment
- FALSE

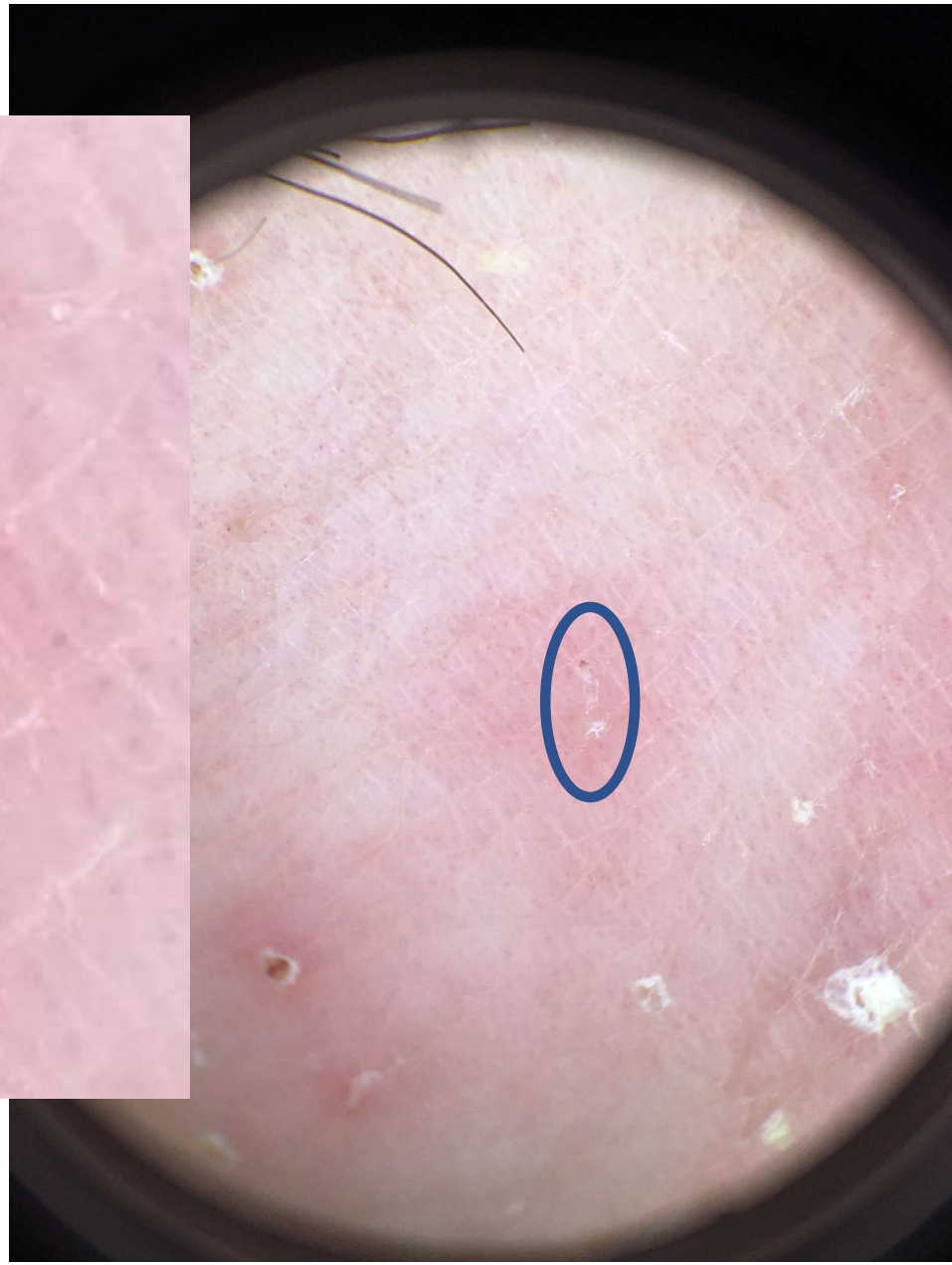


Scabies

- Treatment failure is very common, as is permethrin resistance
- Need to check it has been used properly – 2 treatments, a week apart for permethrin; treat everyone on same day; reapply if you wash your hands; treat face and scalp too; leave it on for 12 hours
- Wash clothes and bedding/towels after first application
- Takes 2-3 weeks for itch to improve
- If still itchy at 3-4 weeks, check for burrows again
- Crotamiton is useful for itch and mildly anti-scabetic too
- Oral ivermectin is now available as a licensed generic (POM)

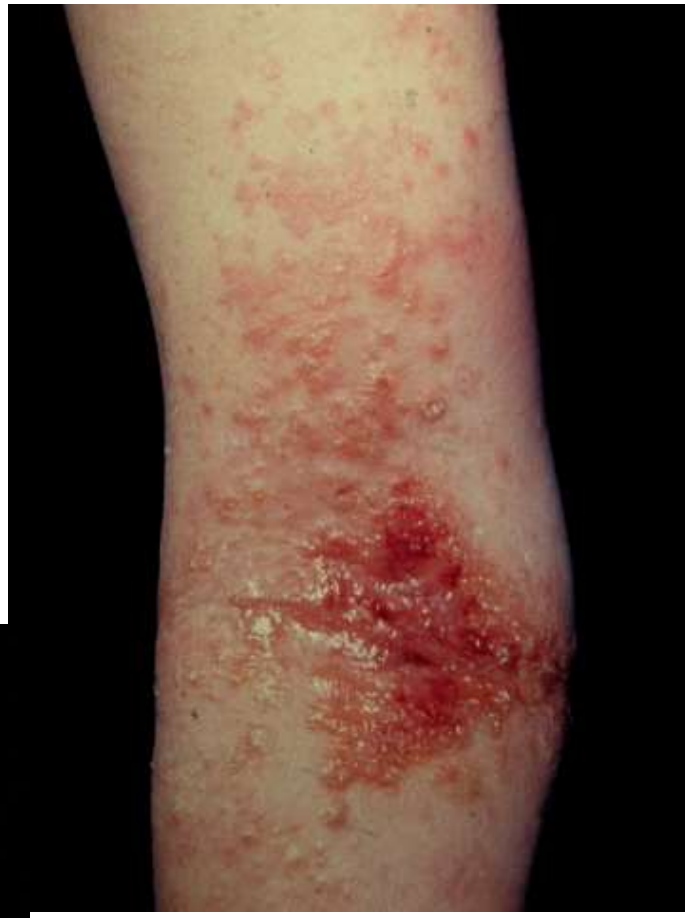


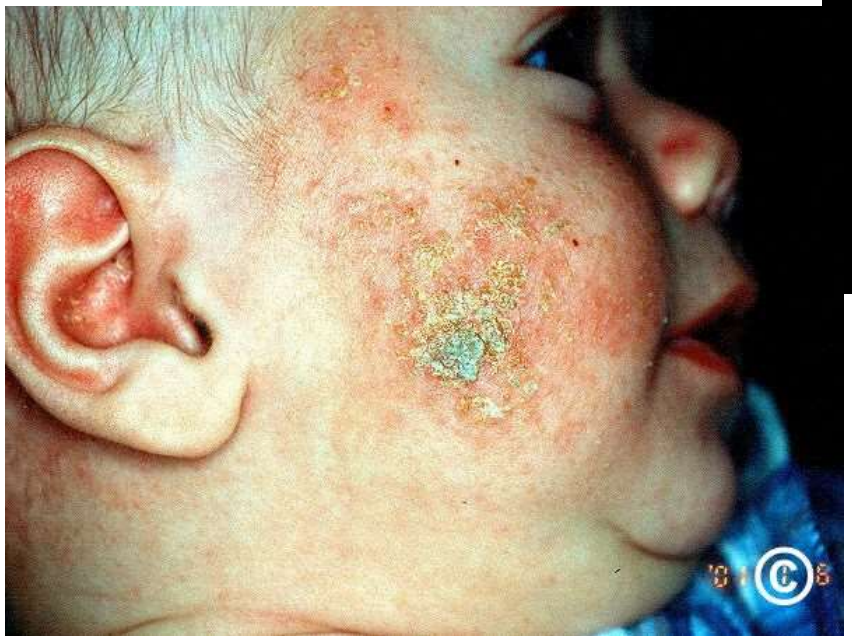
Scabies



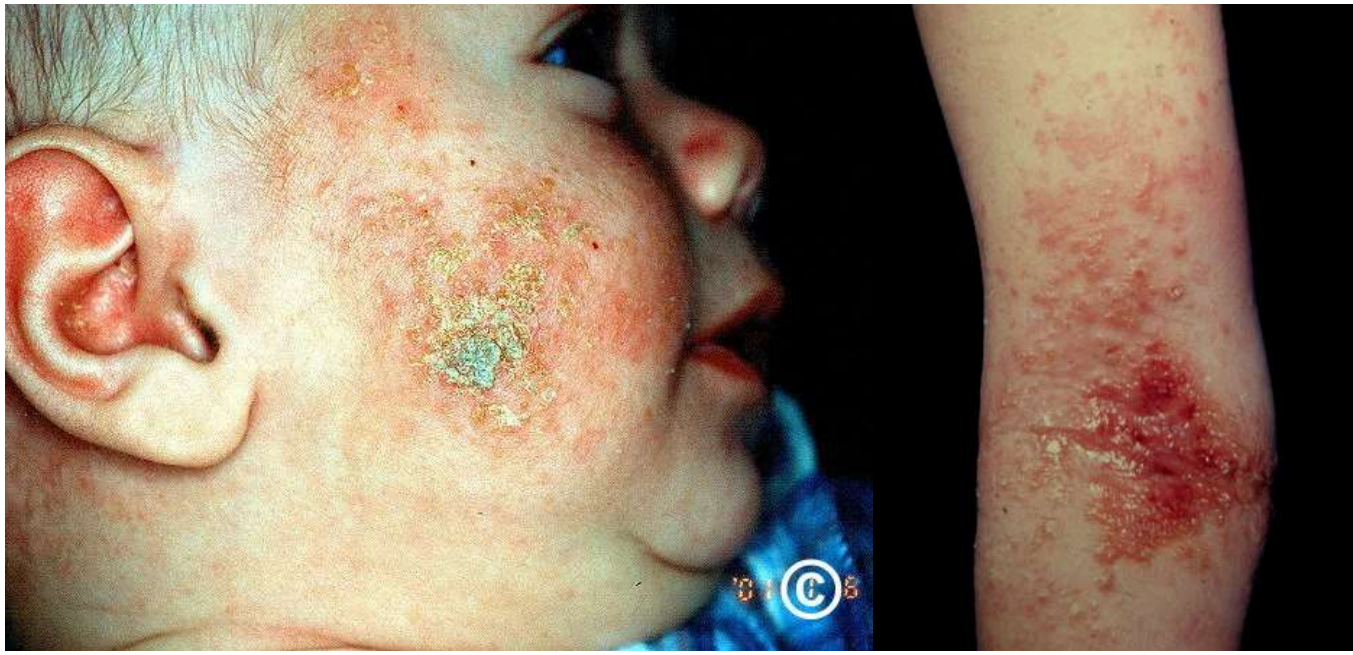
Acute Eczema with colonisation

Children with eczema
Developed golden crusts
Children are systemically well





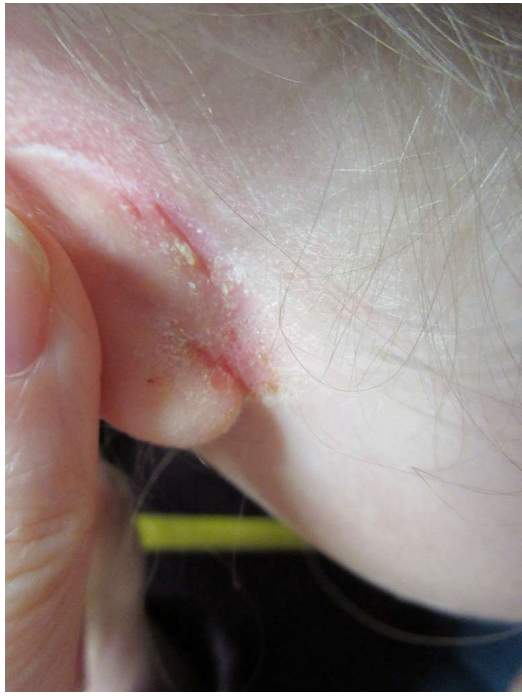
Acute Eczema with colonisation

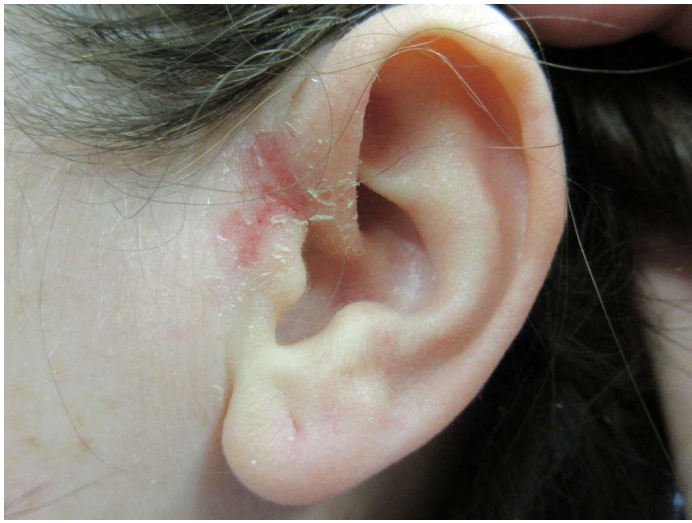


If the child is well, the evidence says NOT to give antibiotics, just topical steroids
Steroids applied onto the “infected” skin
It is colonised, rather than truly infected
Can use topical antiseptic washes when it is crusted (not all the time)
A prescriber may need to give this advice!

What should we do here?

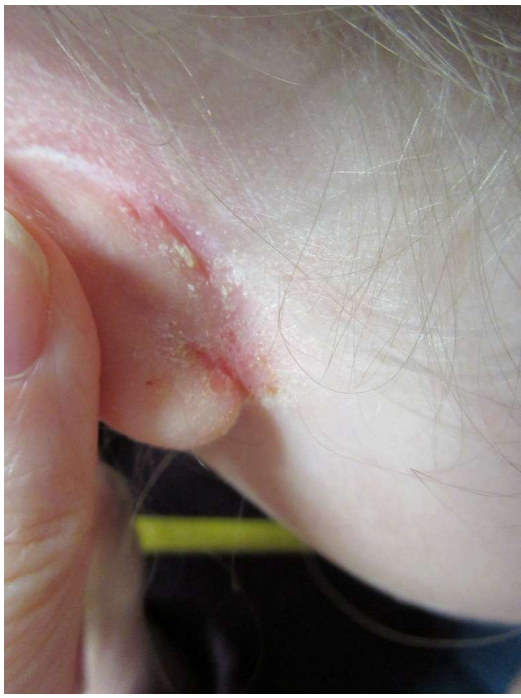
- Topical Eumovate

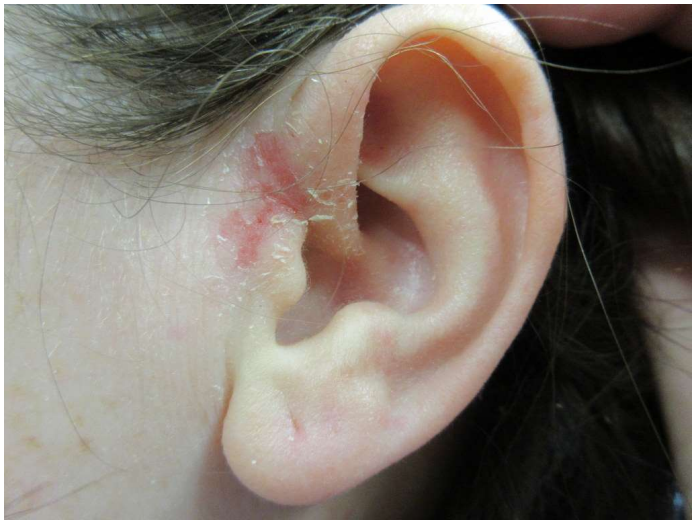




Acute Eczema - NO infection

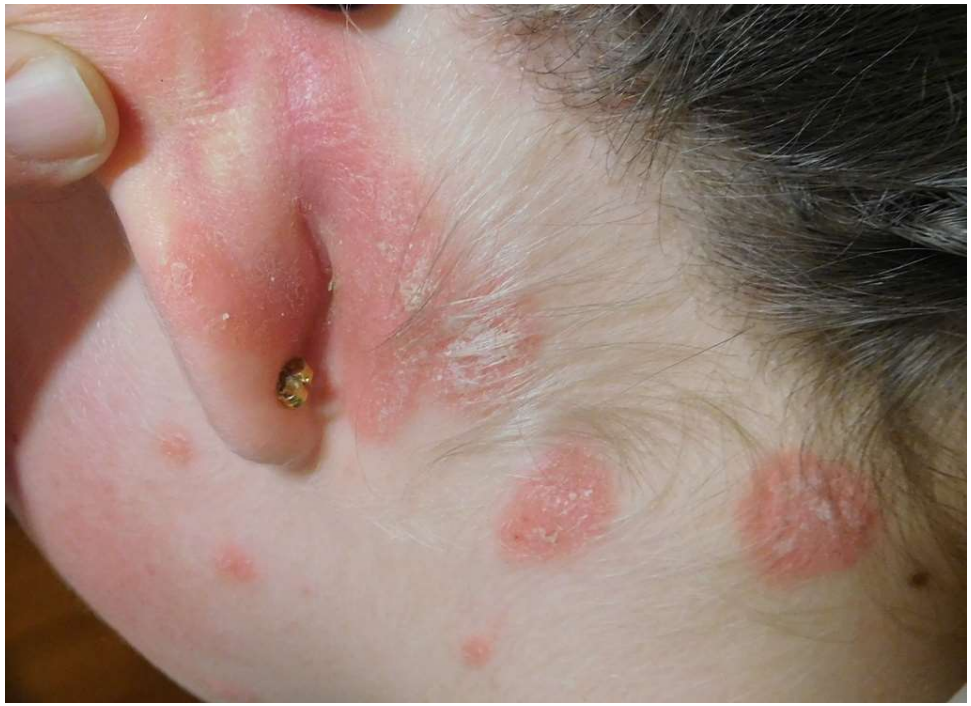
- Fissure behind the ear is diagnostic of eczema
- Often gets quite crusty but it’s colonisation, not infection
- Best treated with moderate potency steroid





What should we do here?

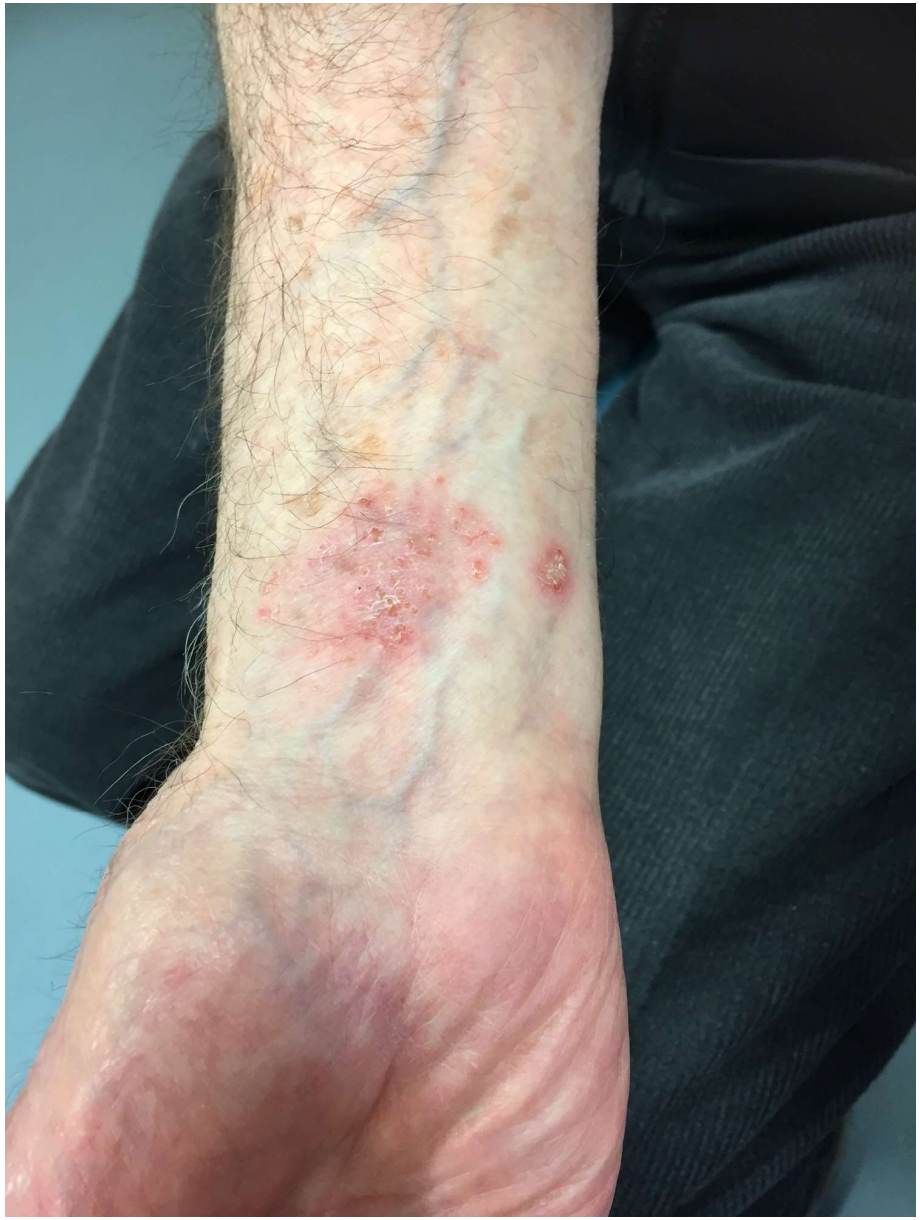
- Topical Eumovate
- Refer to GP if it’s a child, because they can be hard to manage and all children with psoriasis get a routine derm referral.



Psoriasis

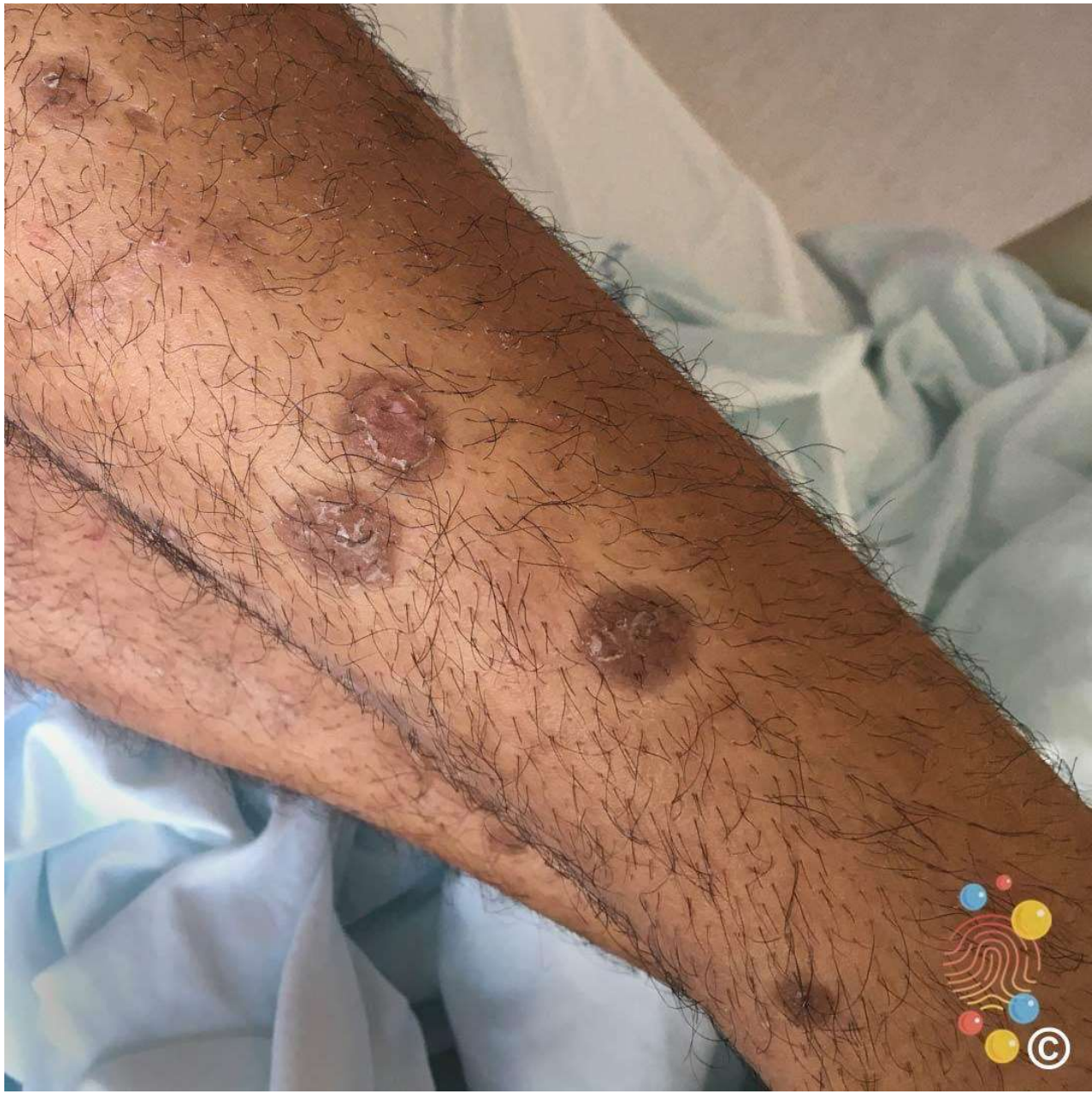
What should we do here?

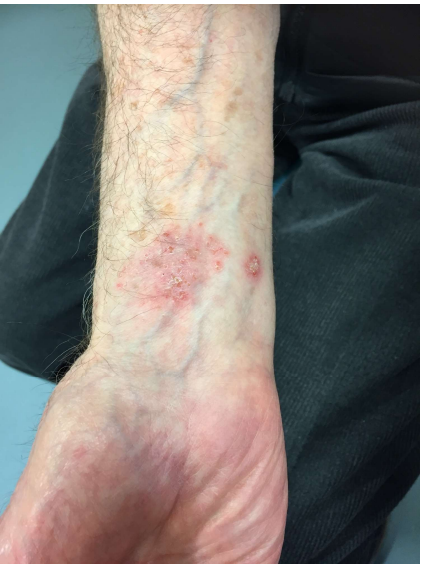
- Needs potent topical steroid



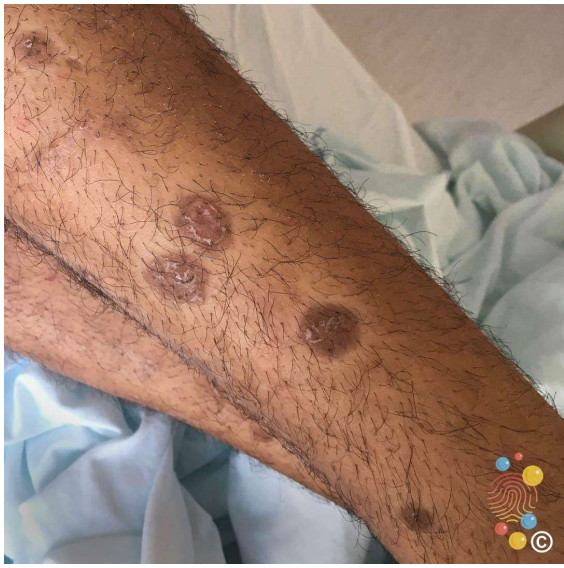
Discoid Eczema

Discoid Eczema



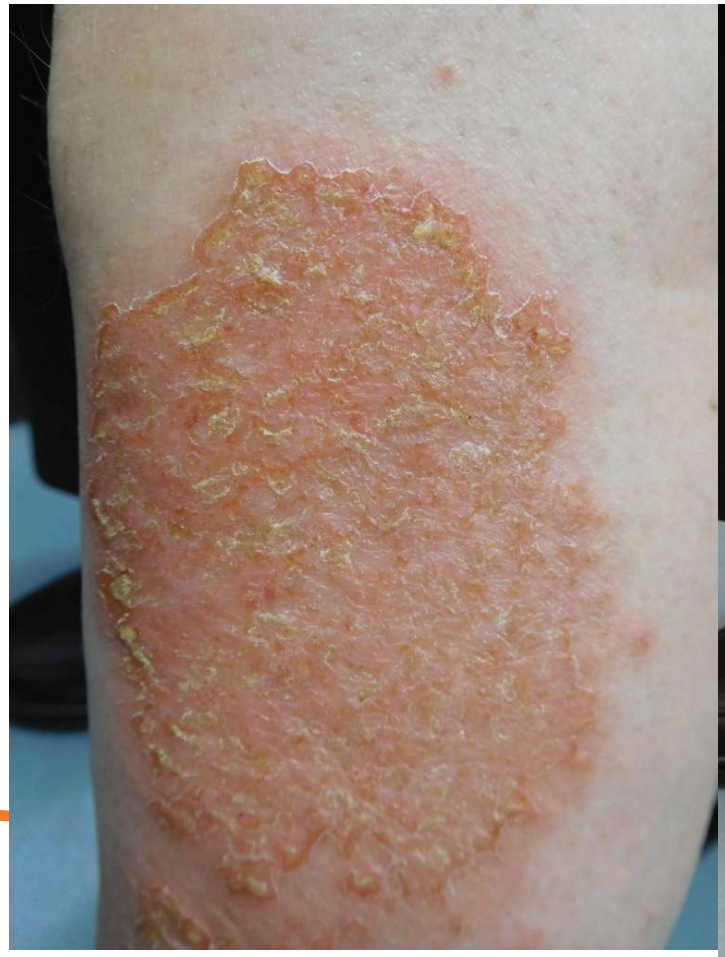


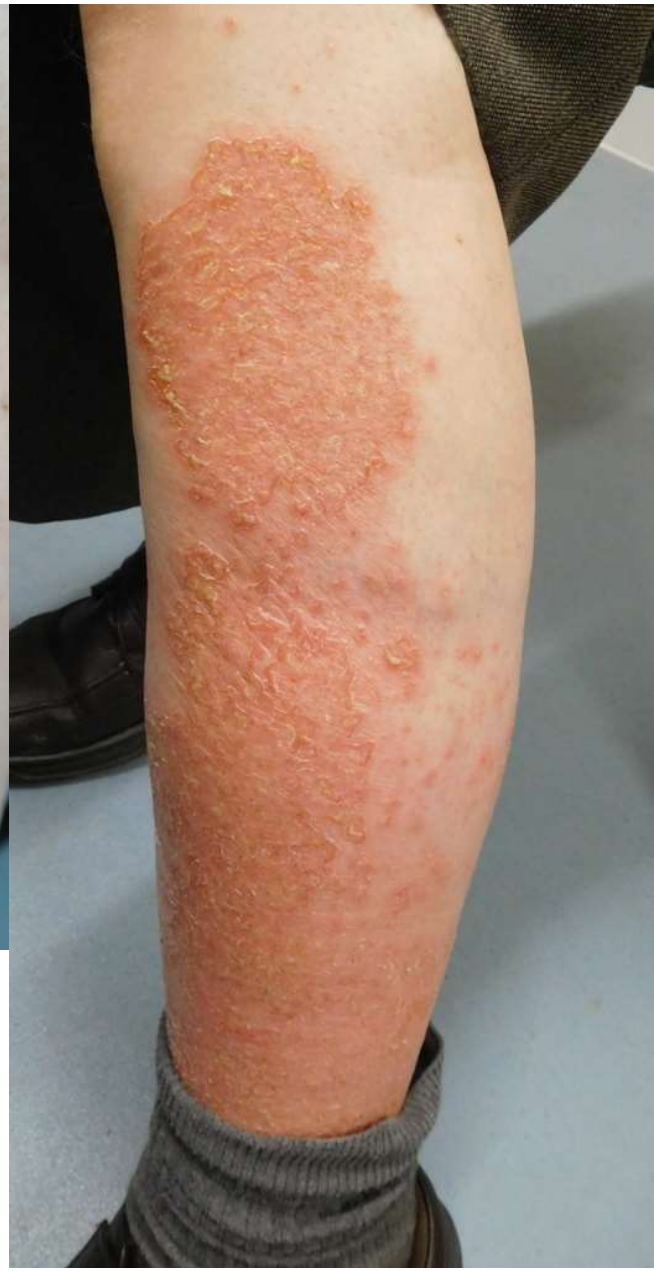
Discoid Eczema T/F



- Eumovate is a good option for treatment
- FALSE (not potent enough)
- Steroid should be applied sparingly, avoiding broken or infected skin
- FALSE (need to put it on the skin that needs it – which is the broken, infected-looking, area! Fingertip units rather than sparingly please)
- Advice should be given about skin care, soap substitutes, emollients
- TRUE

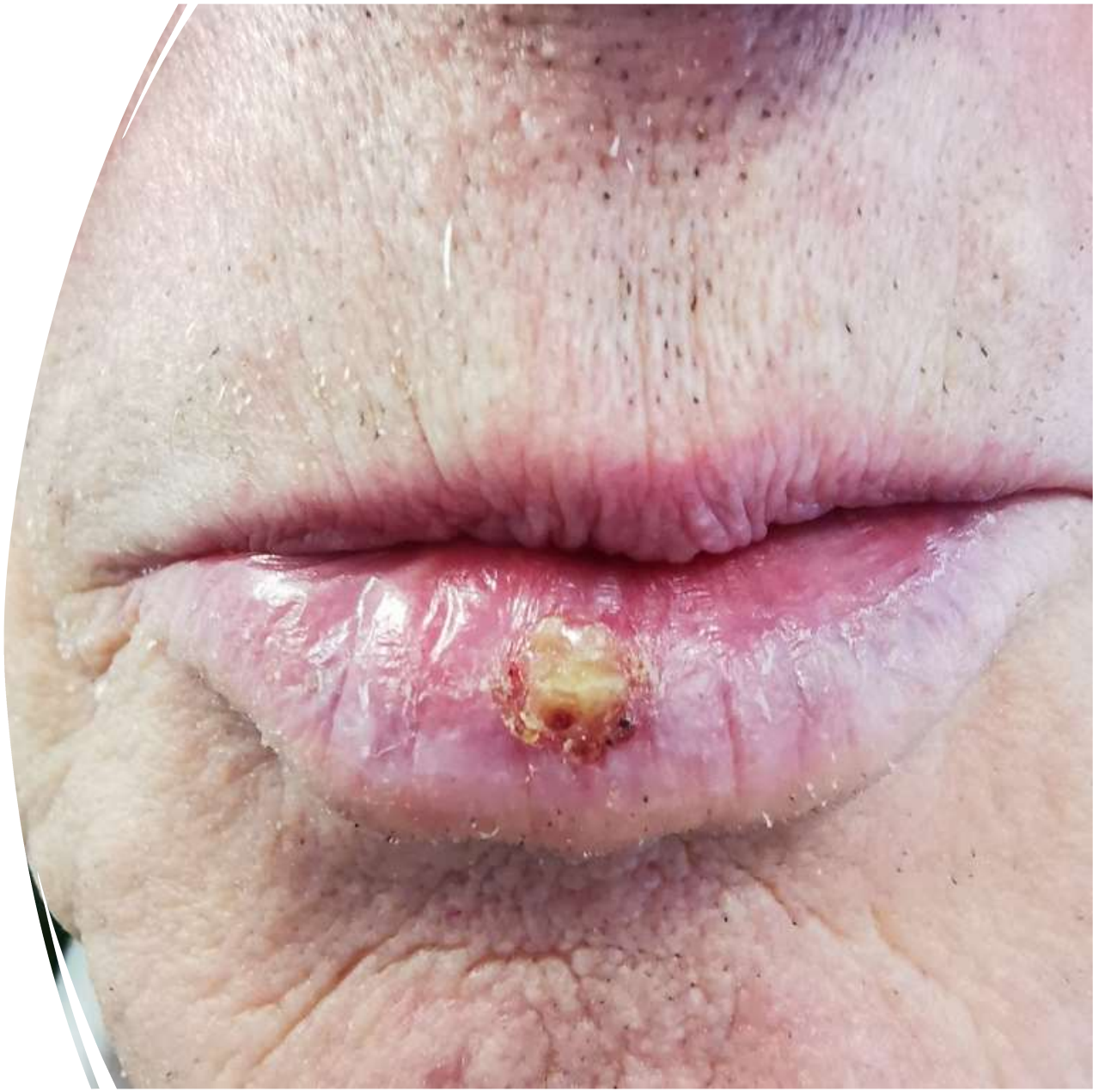
Discoid Eczema





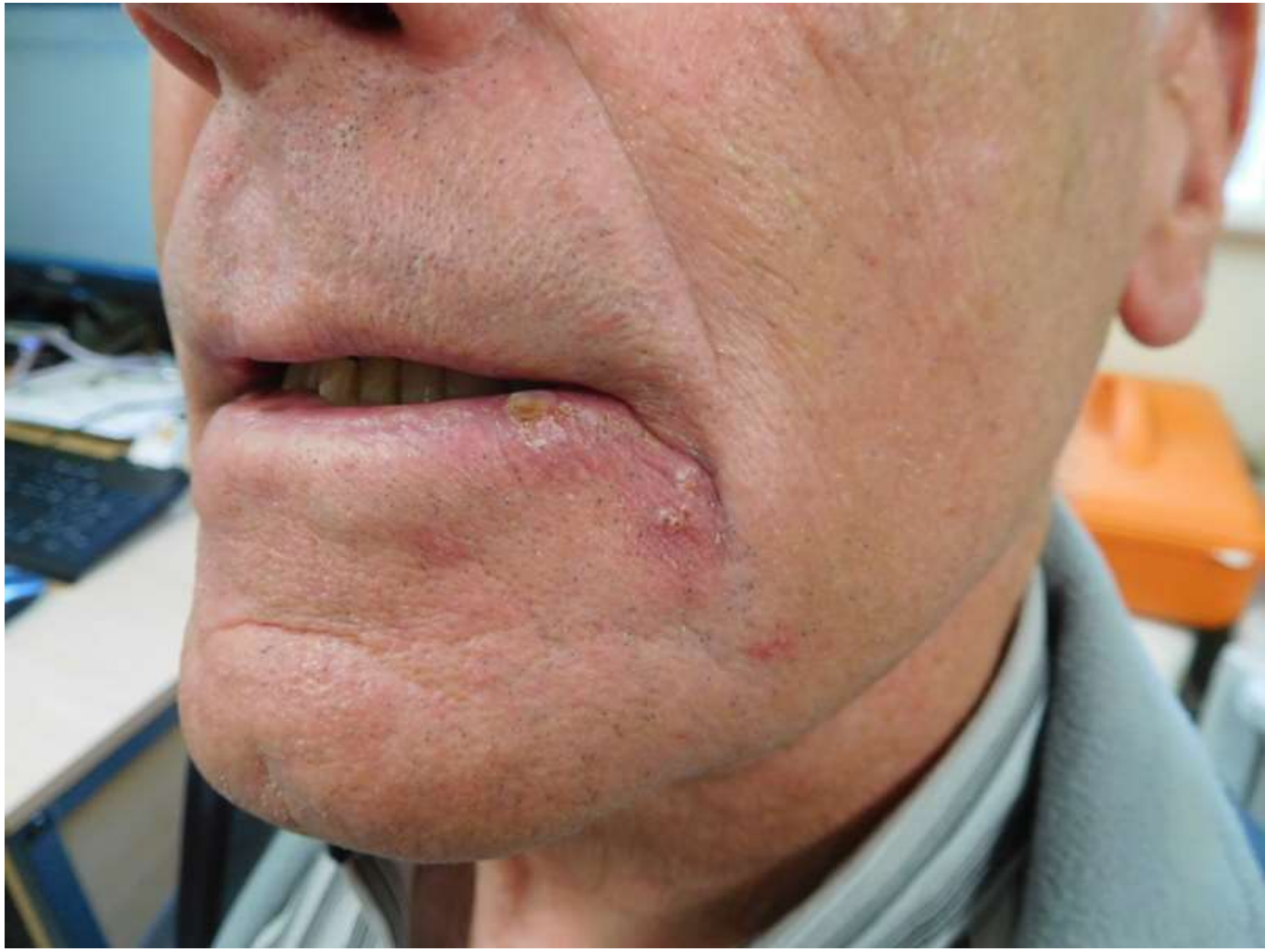
Cold sore

- Topical aciclovir

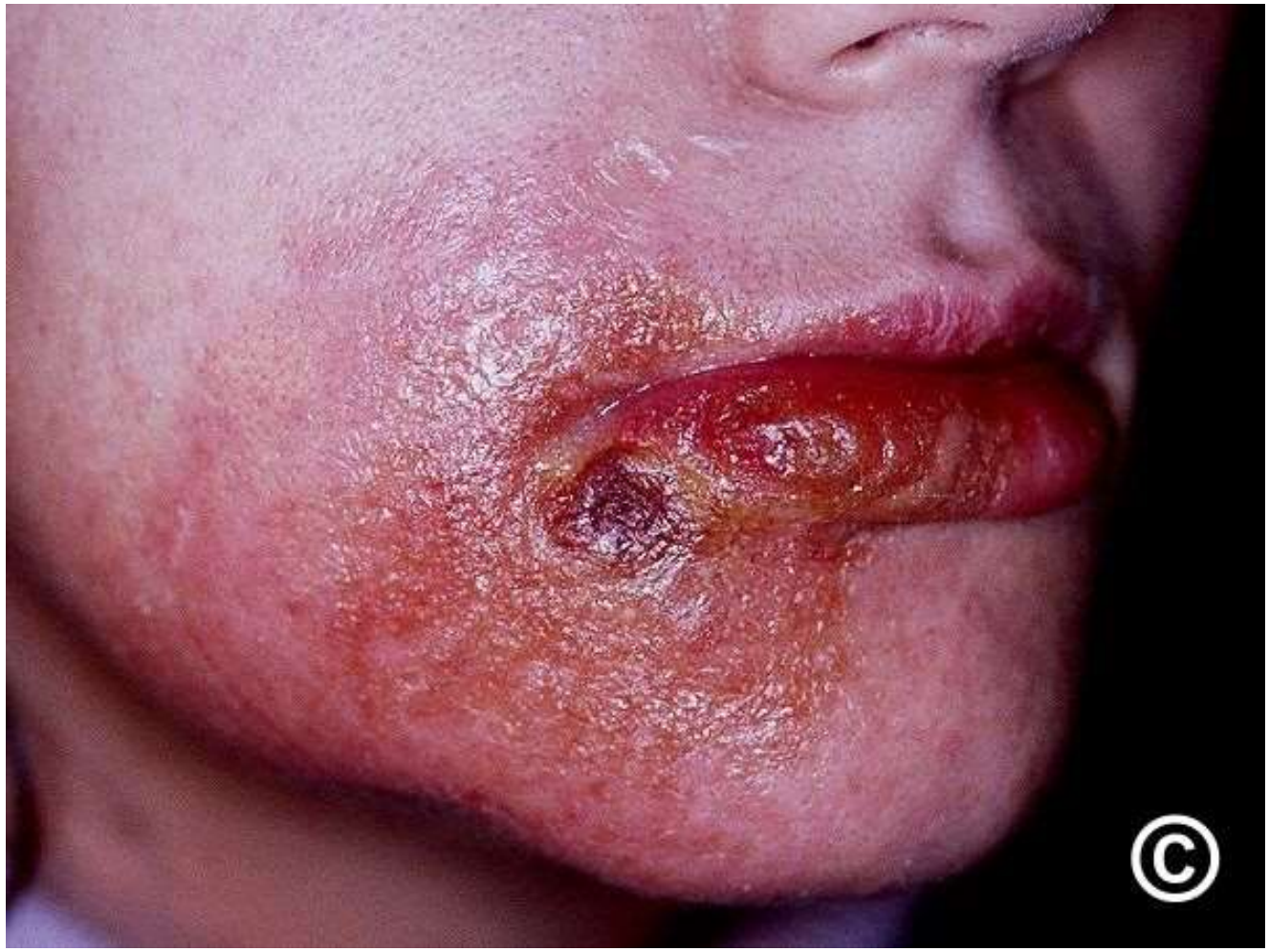


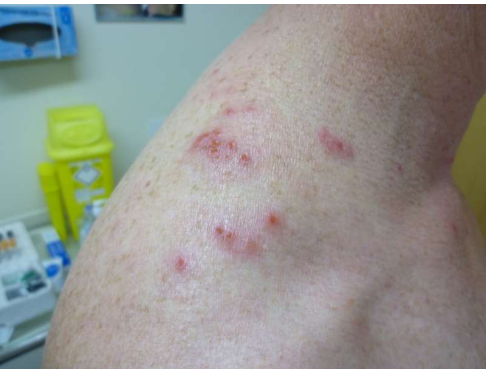
Cold sore with secondary impetigo

- Topical hydrogen peroxide

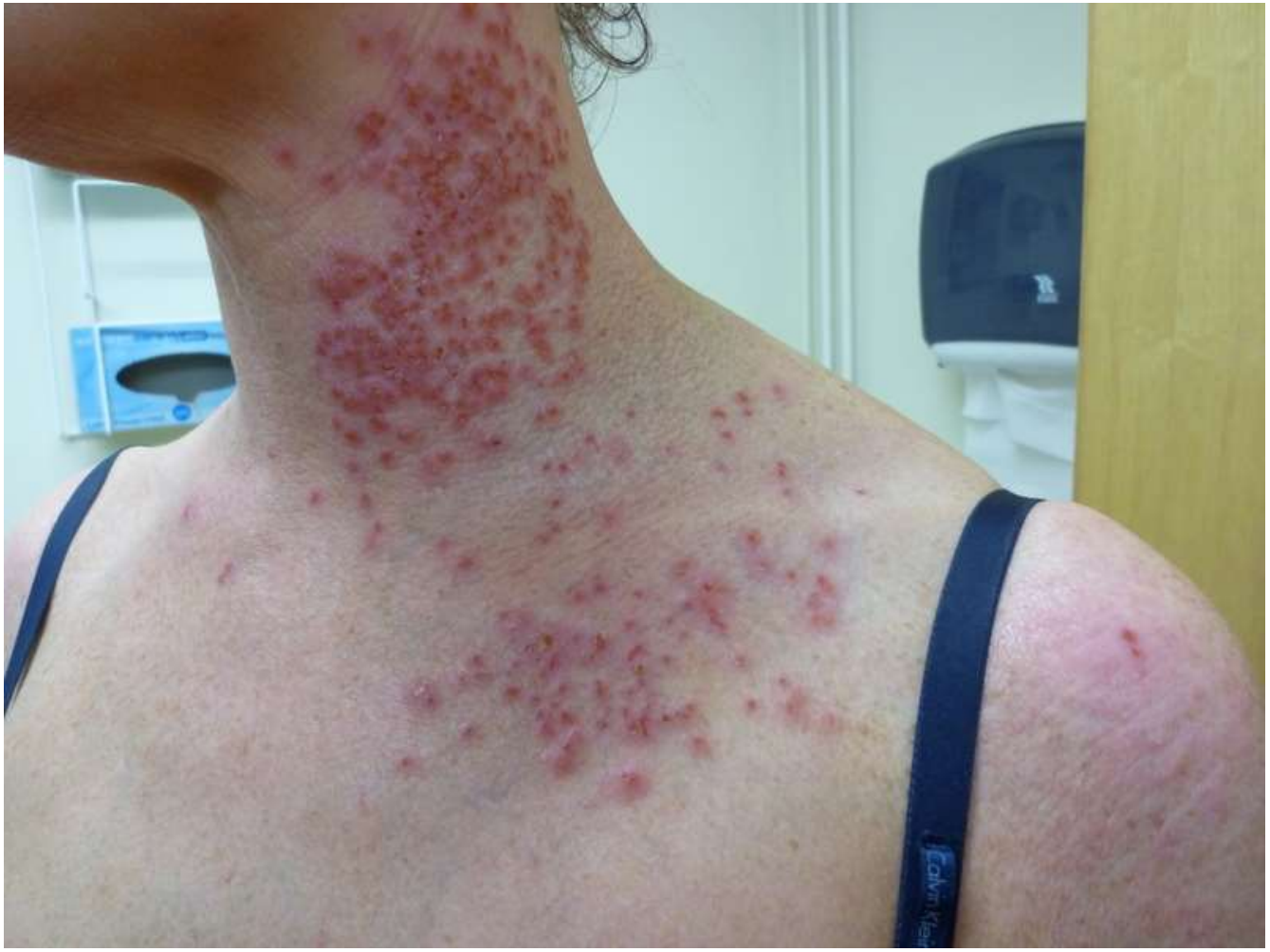


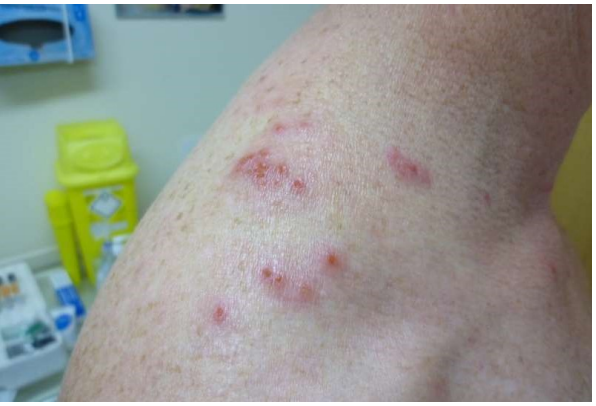
Cold sore with contact dermatitis to zovirax cream



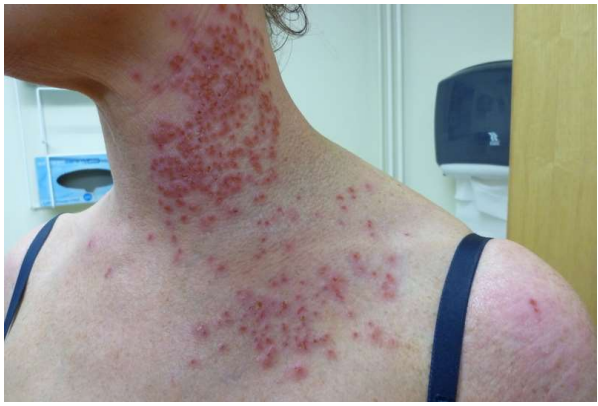


Eczema herpeticum



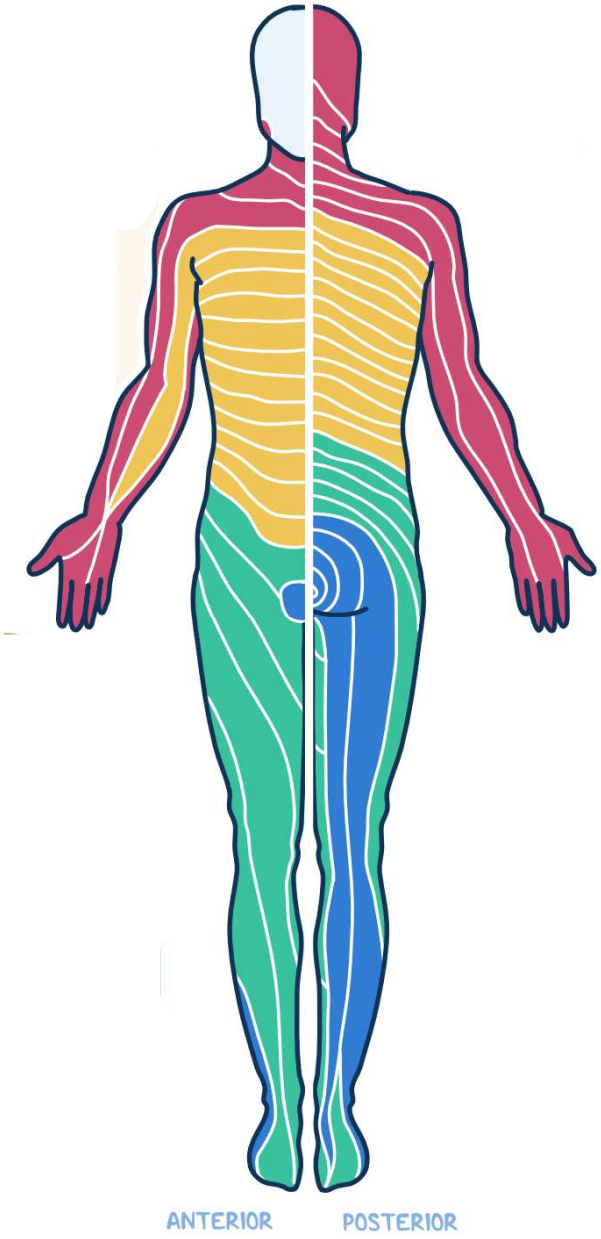


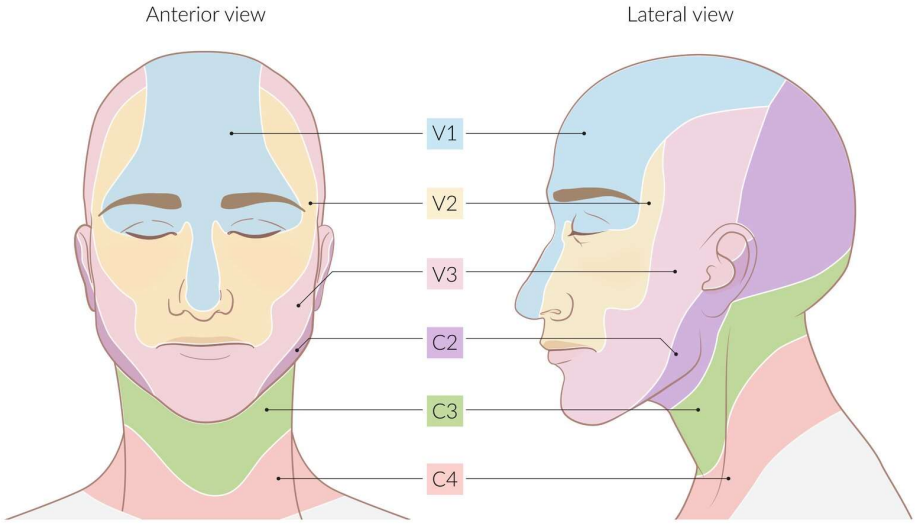
Eczema herpeticum

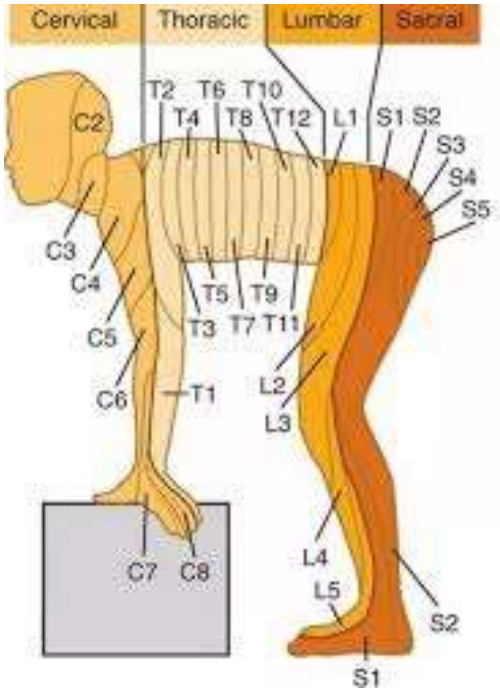


- Herpes simplex infection in abnormal skin (usually eczema)
- Can also be in skin treated with potent topical steroid
- Does not respect dermatomes
- Can be unwell, or get unwell very quickly (particularly children)
- Blisters look the same and are the same age
- Treatment is with oral acyclovir at the same dose as shingles anyway!

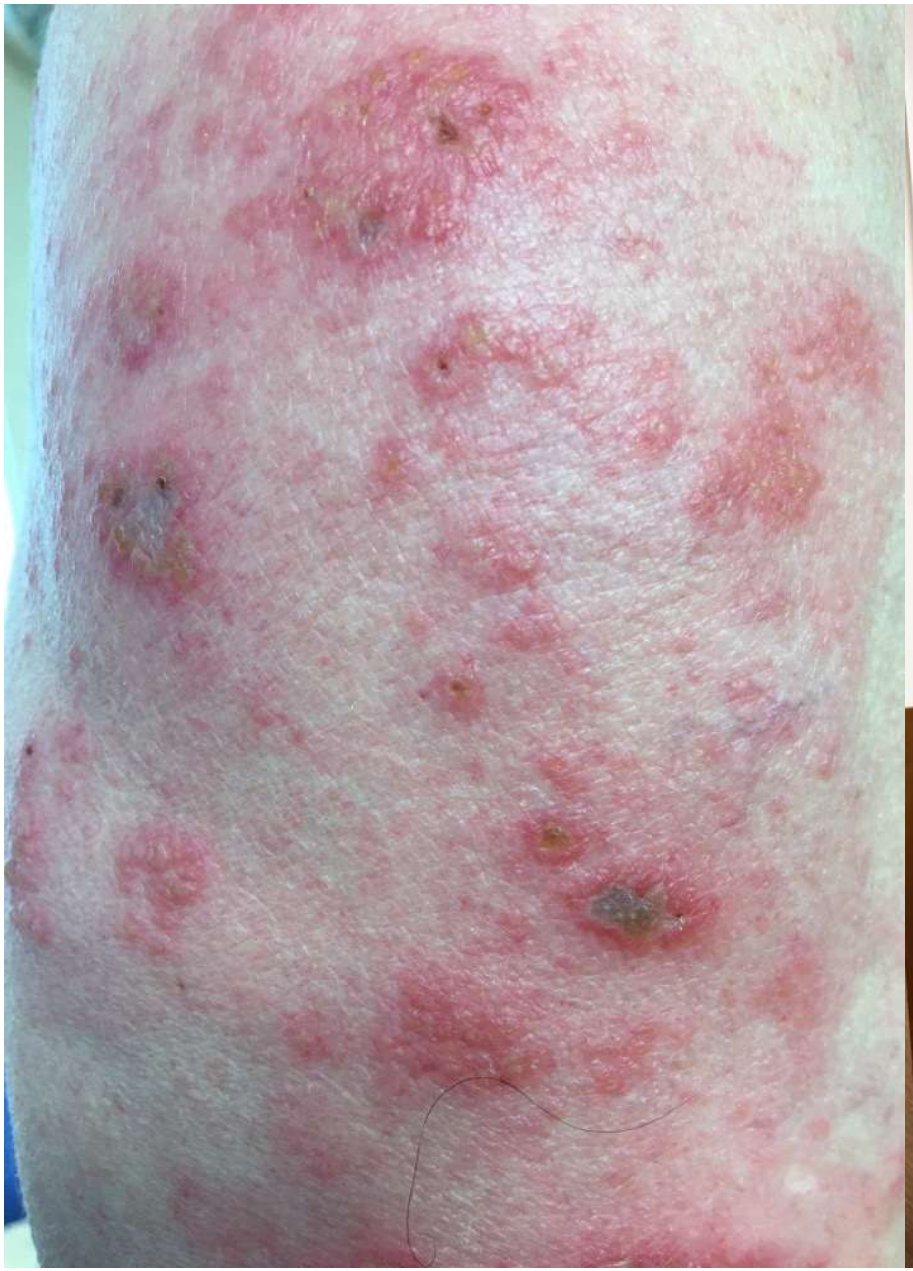
Dermatomes

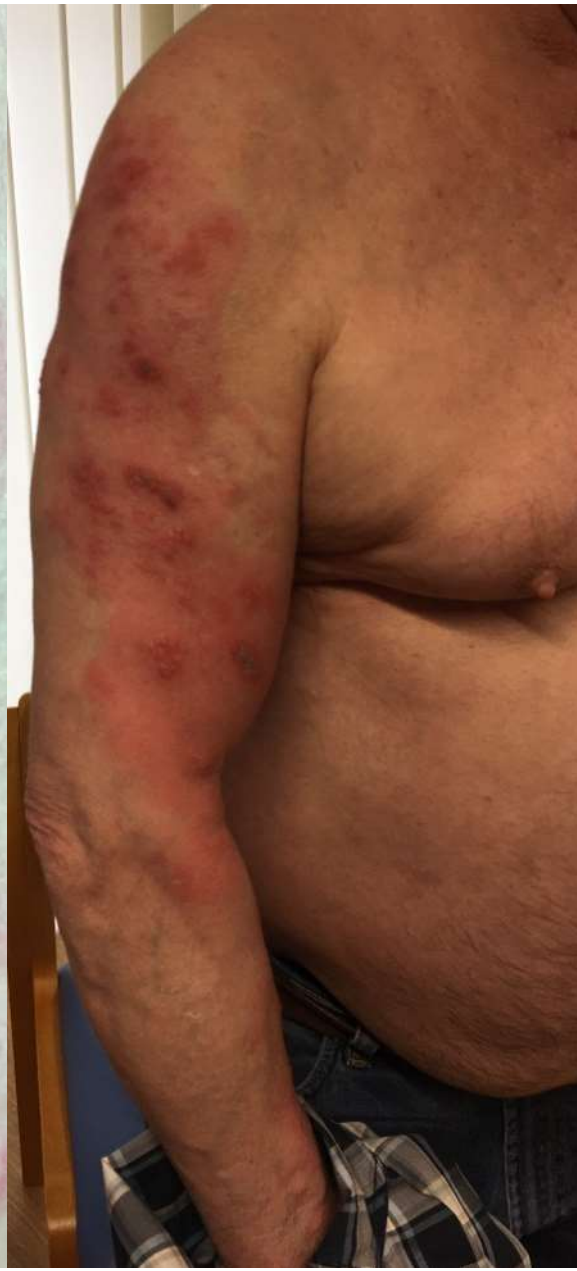

ANTERIOR
POSTERIOR


Anterior view
Lateral view
V1
V2
V3
C2
C3
C4

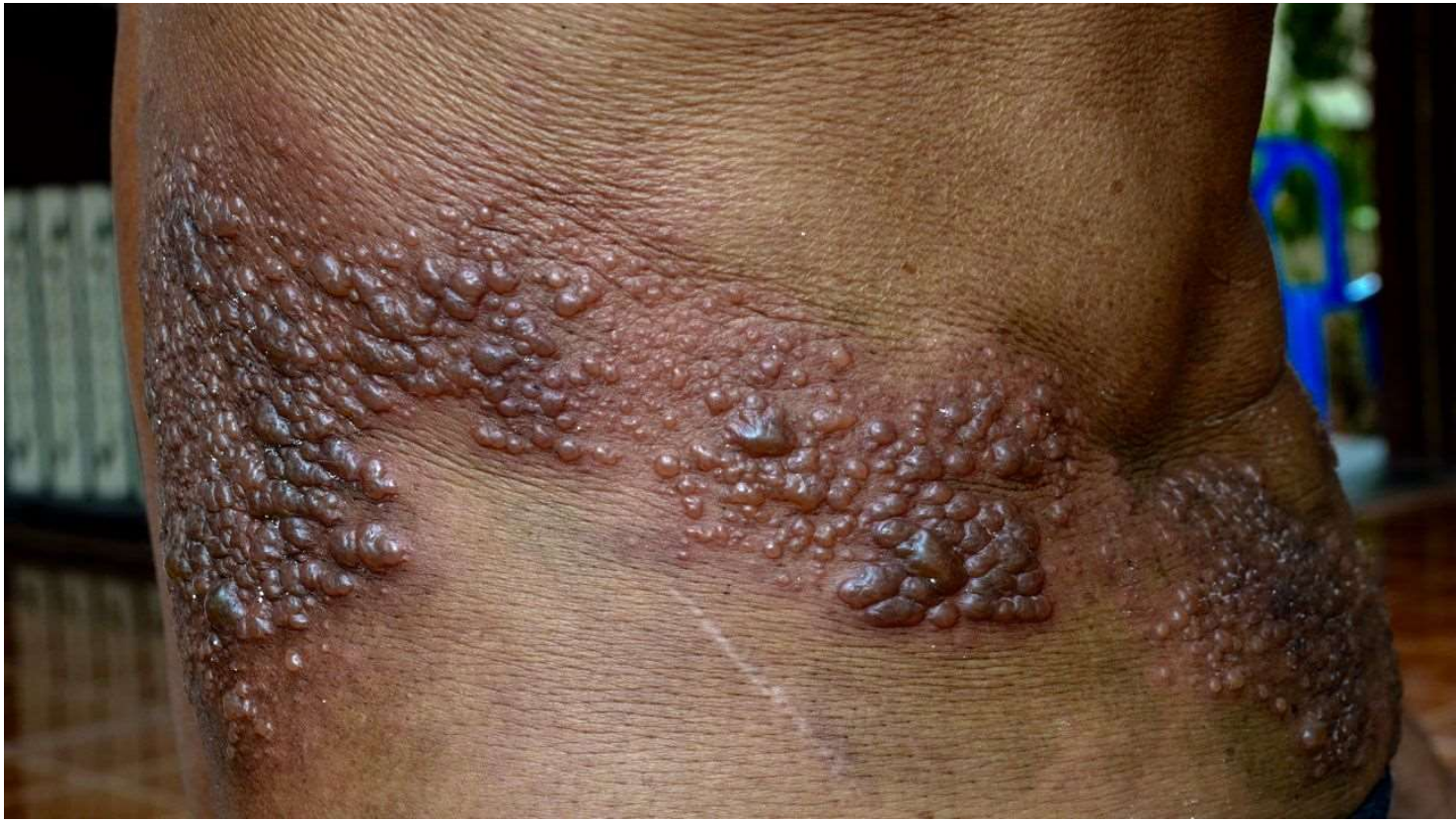

Cervical
Thoracic
Lumbar
Sacral
C2
C3
C4
C5
C6
C7
C8
T1
T2
T3
T4
T5
T6
T7
T8
T9
T10
T11
T12
L1
L2
L3
L4
L5
S1
S2
S3
S4
S5

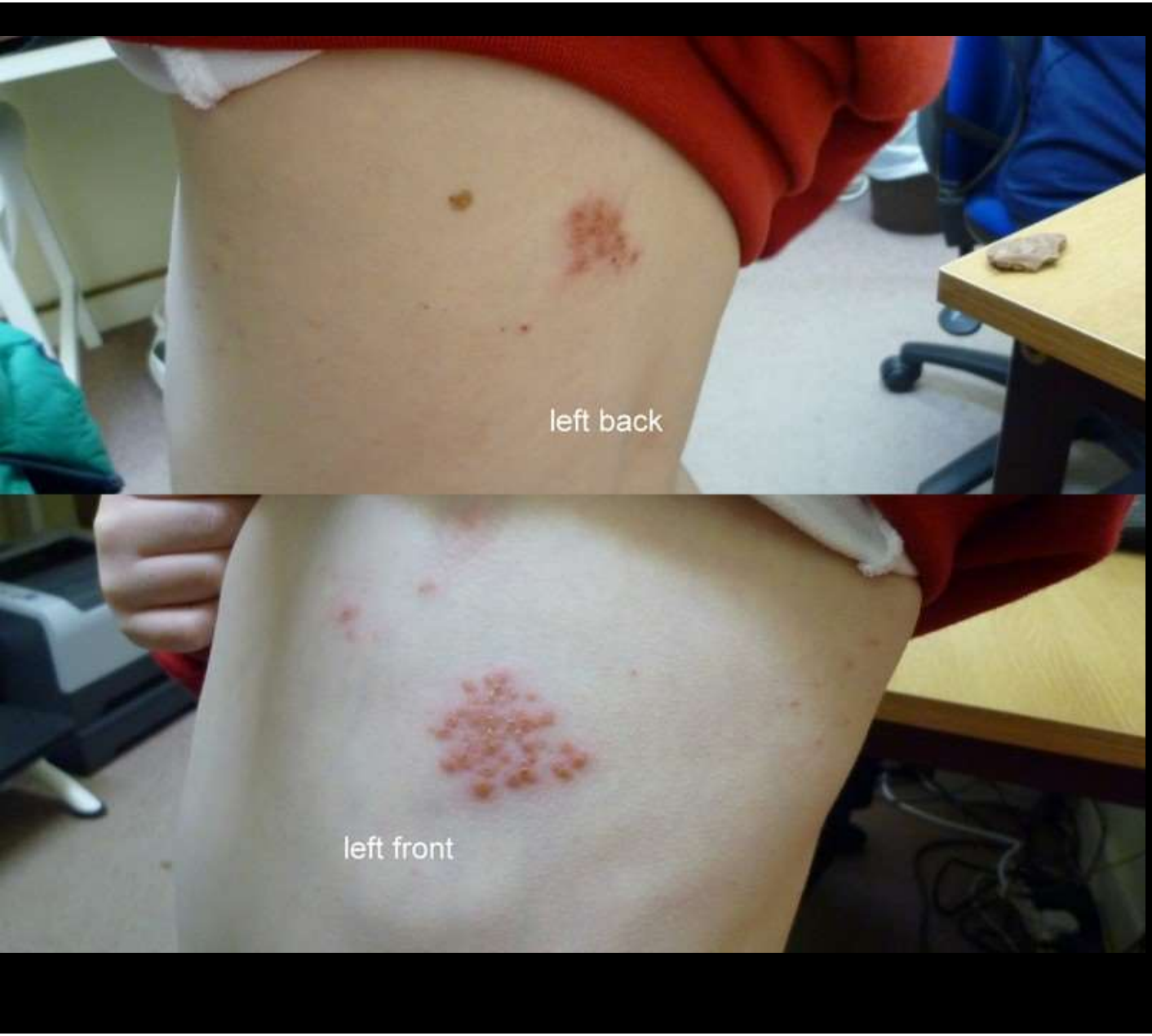
Shingles

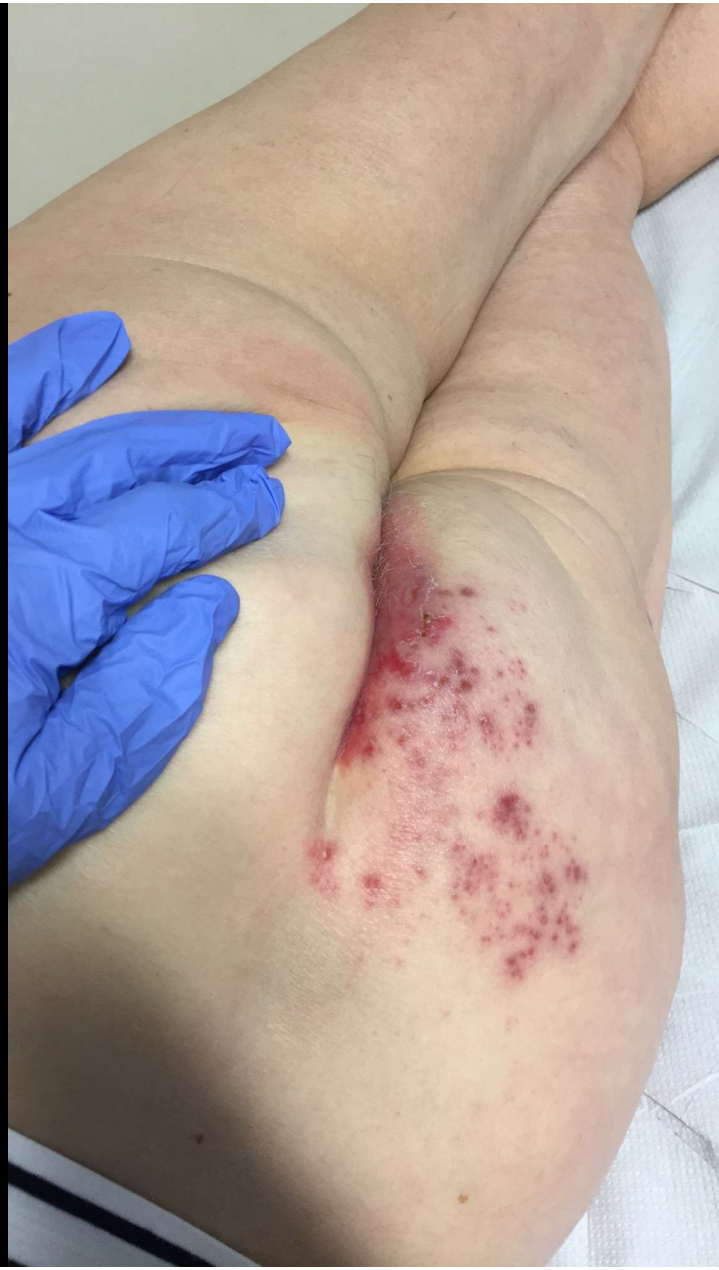




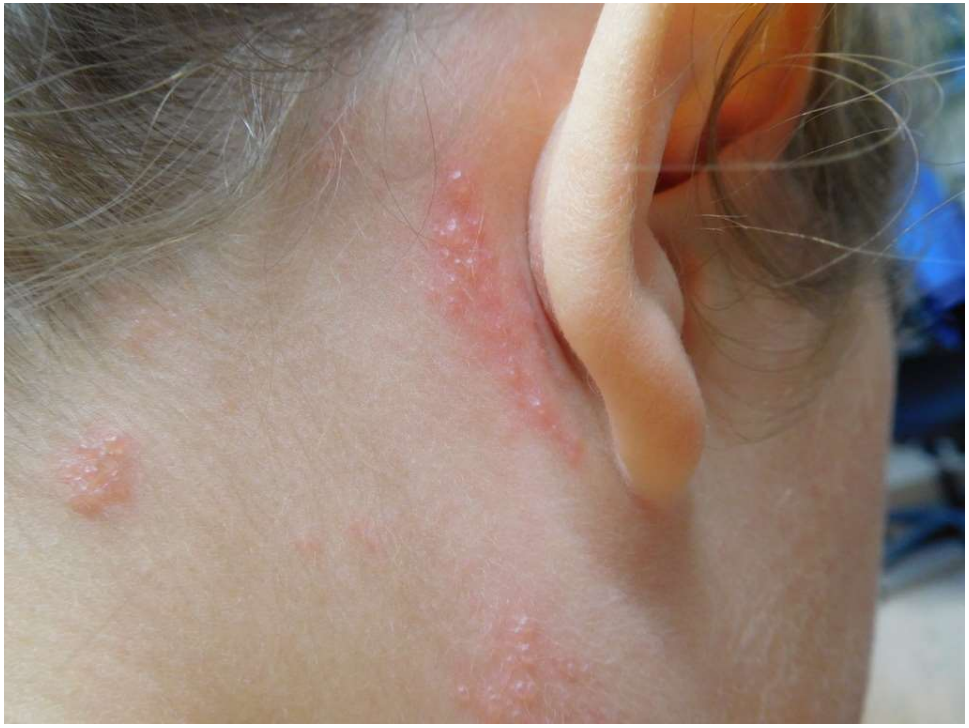
Shingles

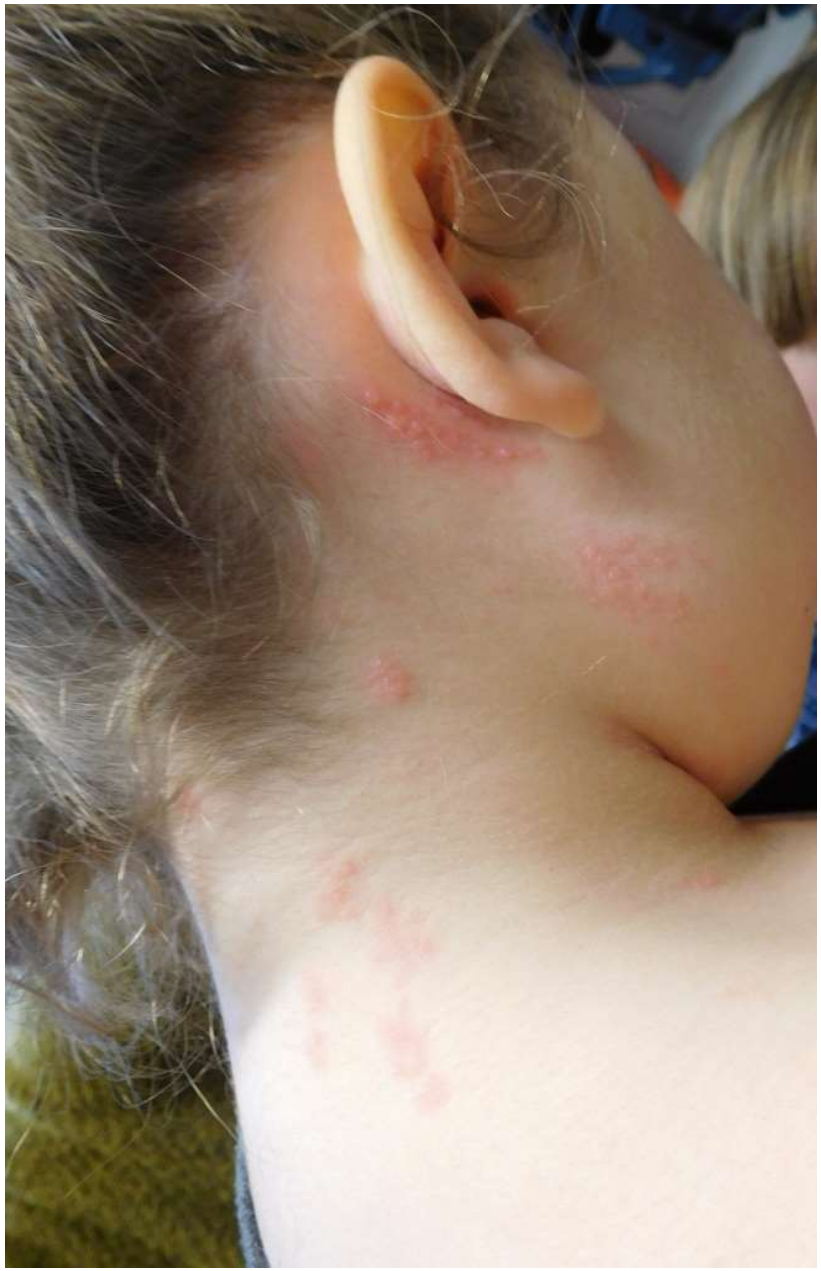


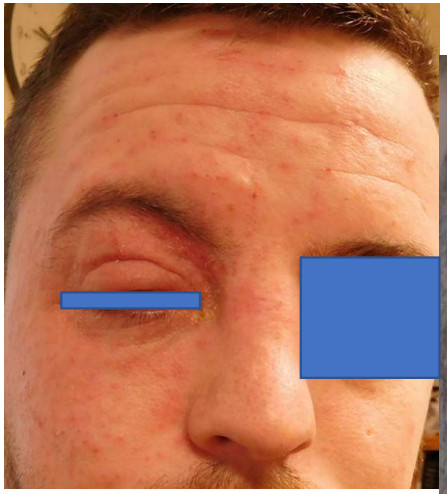
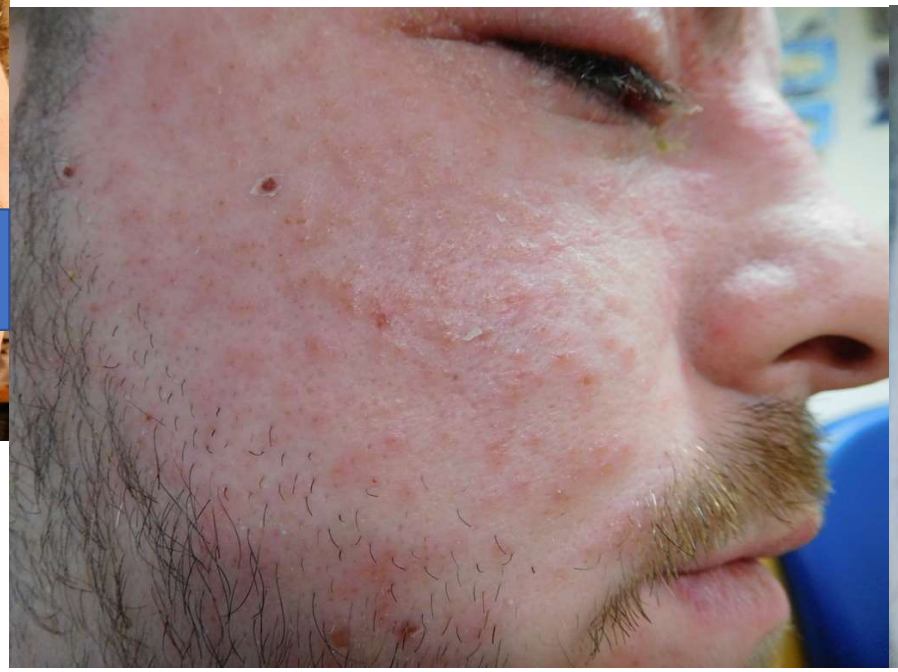
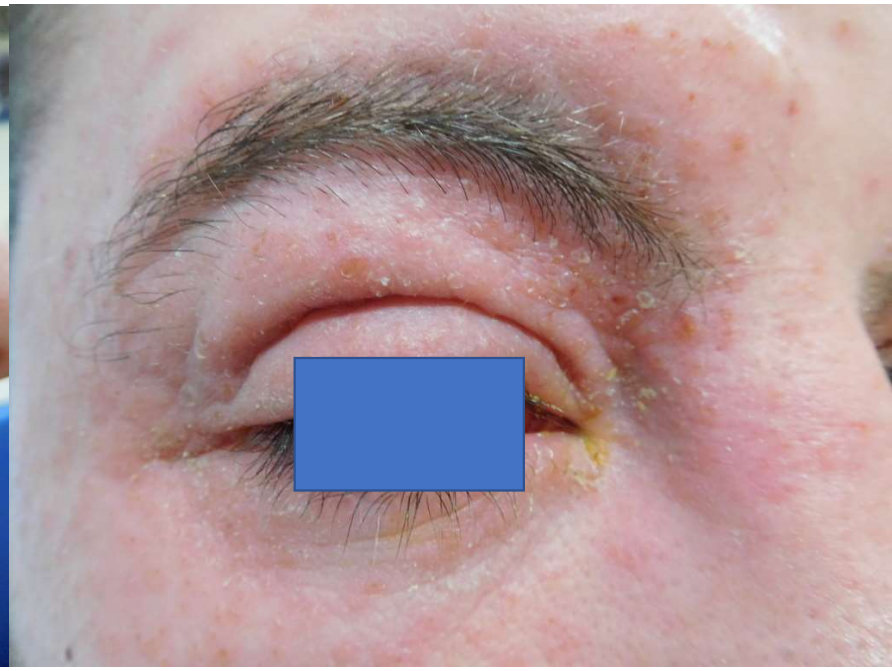

left back
left front



Shingles in a child – it happens, just need to have had chicken pox in the past.



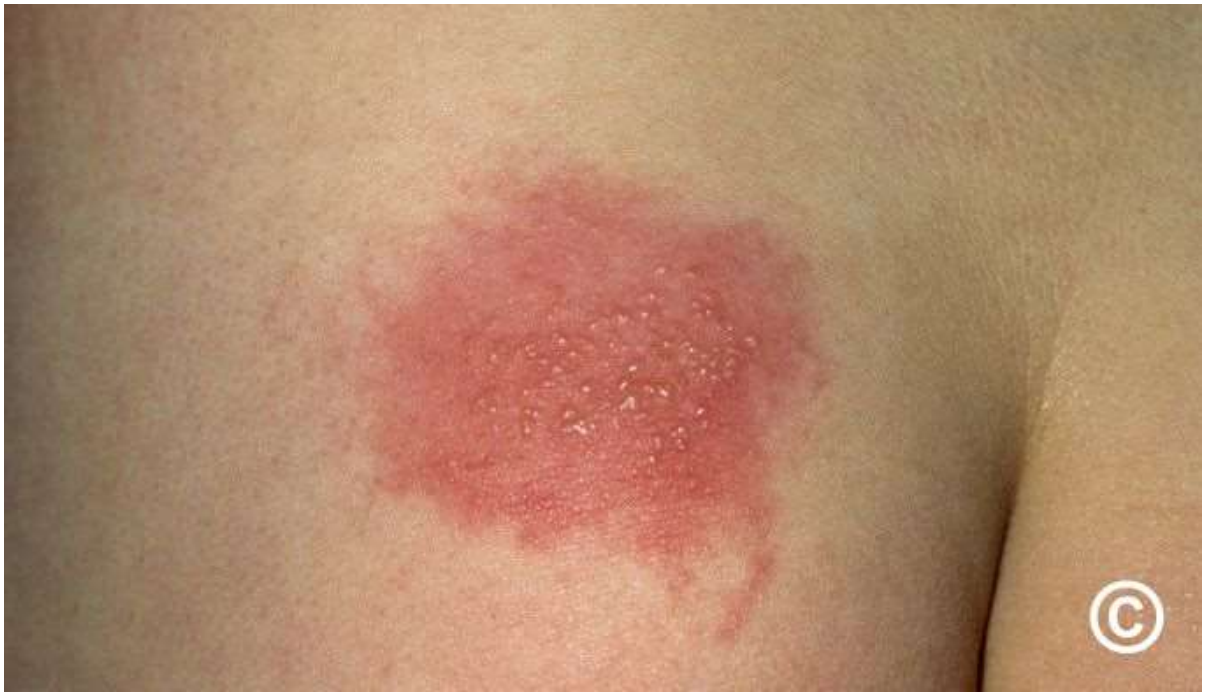


Eczema Herpeticum

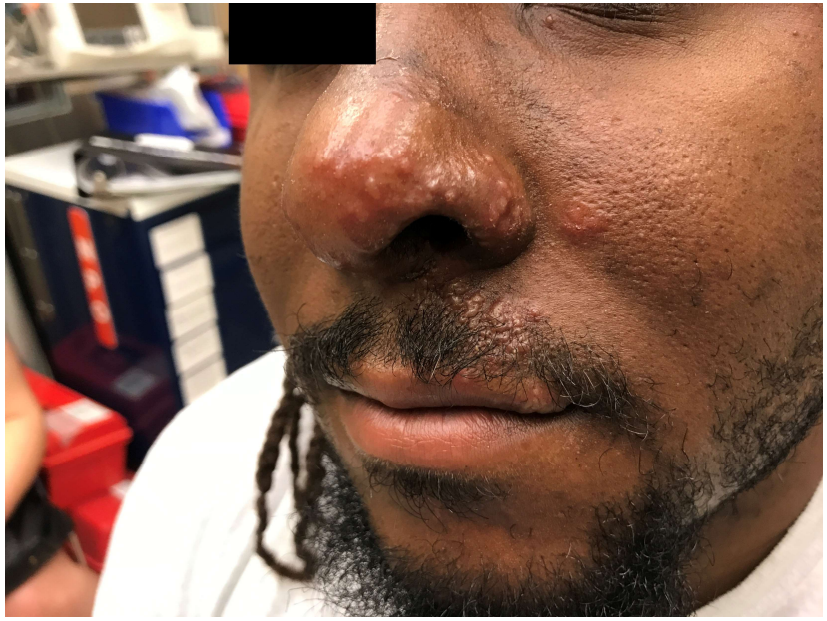
First herpes infection in abnormal skin (eg eczematous skin)
Send to eye casualty, same day, if near the eye.
A+E in children (or ask GP advice)

Recurrent shingles in the same place

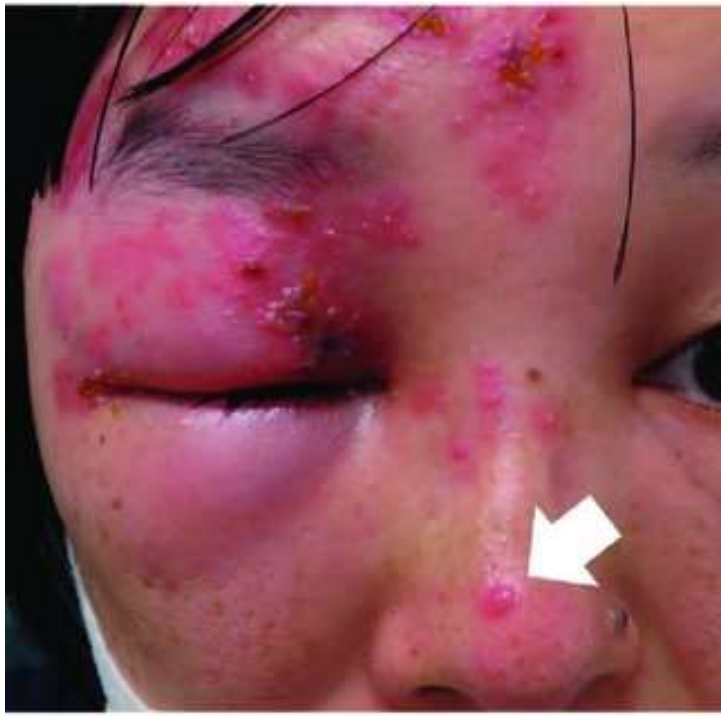


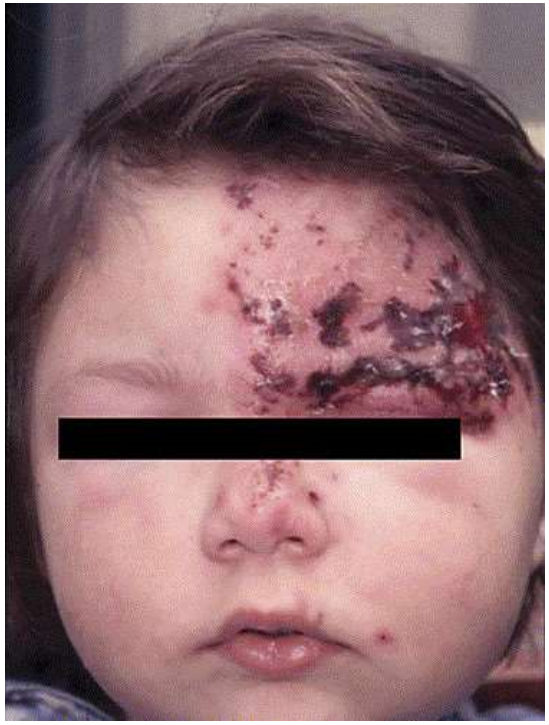
- Herpes simplex, not shingles!
- Prophylactic acyclovir can be really helpful if it recurs often
- Dose is lower than for shingles

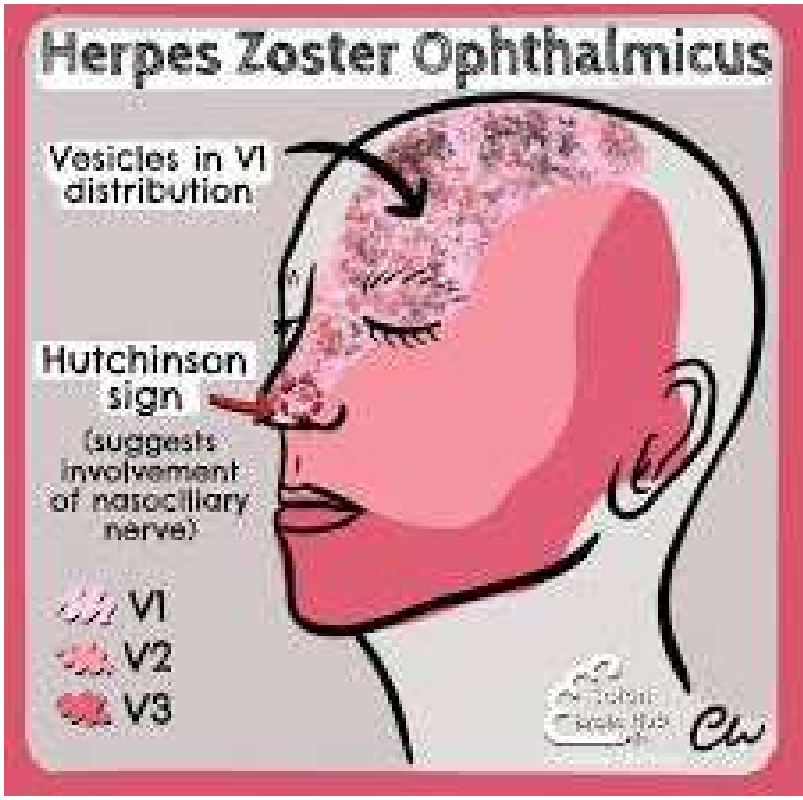
Shingles – Hutchinson's sign

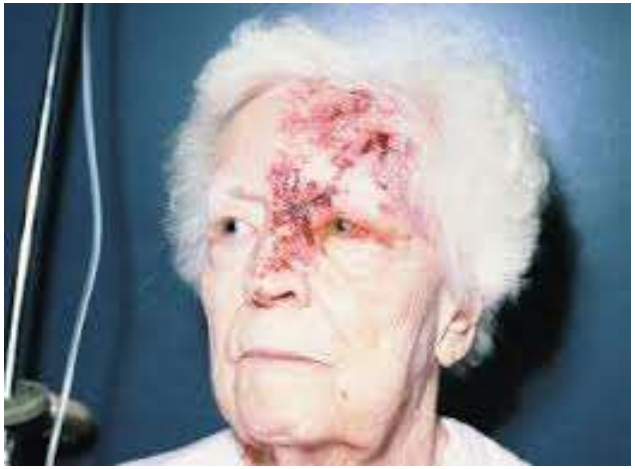


Shingles – Hutchinson's sign









Shingles (this is lifted from the PGD)

Refer urgently to a prescriber for further assessment if:

- Known or suspected pregnancy
- Pain inadequately controlled with over the counter analgesia
- Systemically unwell, but not showing signs or symptoms of sepsis
- Individuals where treatment under this PGD is not indicated/permitted but dermatological symptoms are present and require further assessment

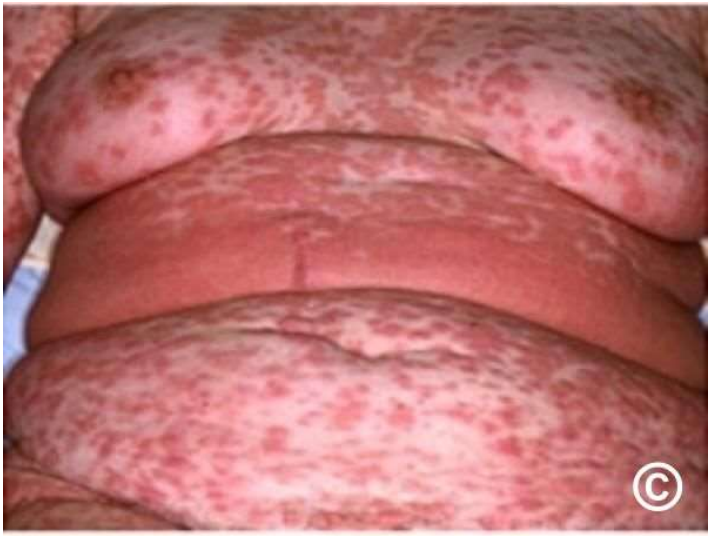
Refer urgently to A&E for further assessment if:

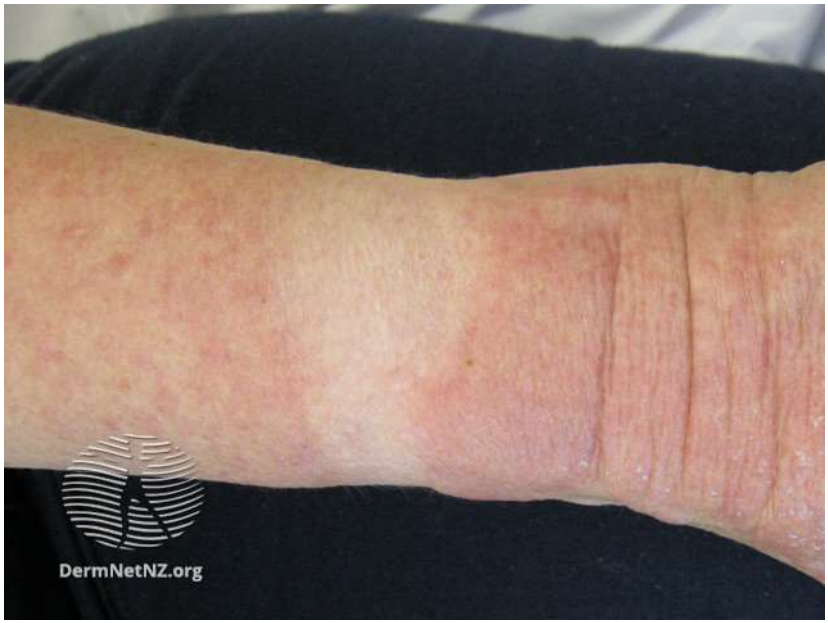
- Individual is severely immunosuppressed
- Individual is immunosuppressed and rash is widespread or severe or individual is systemically unwell
- Serious complications such as meningitis, encephalitis, myelitis or facial nerve paralysis are suspected
- Shingles in the ophthalmic distribution of the trigeminal nerve:
  Hutchinson's sign (rash on the tip, side or root on the nose)
  Visual symptoms
  Unexplained red eye

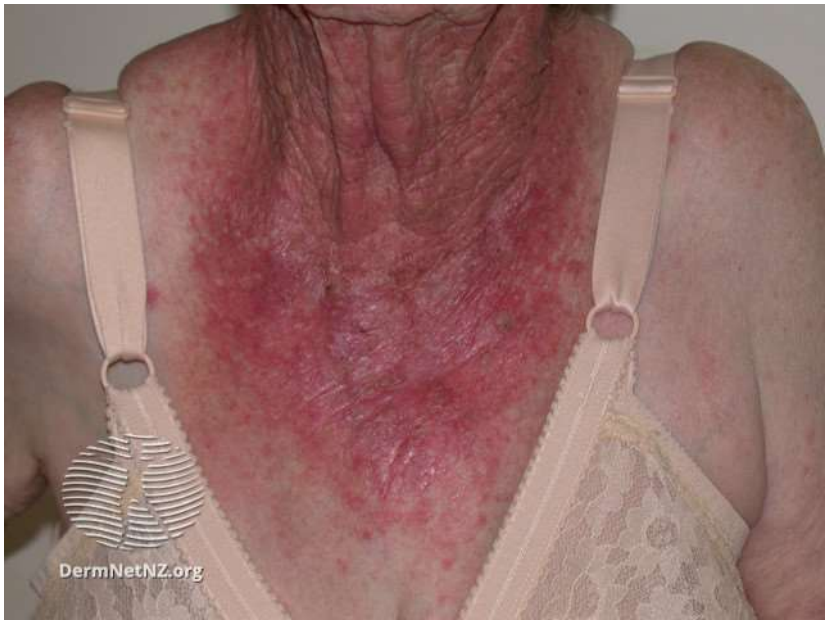
If sepsis or serious complications are suspected refer the individual urgently to A&E

Shingles

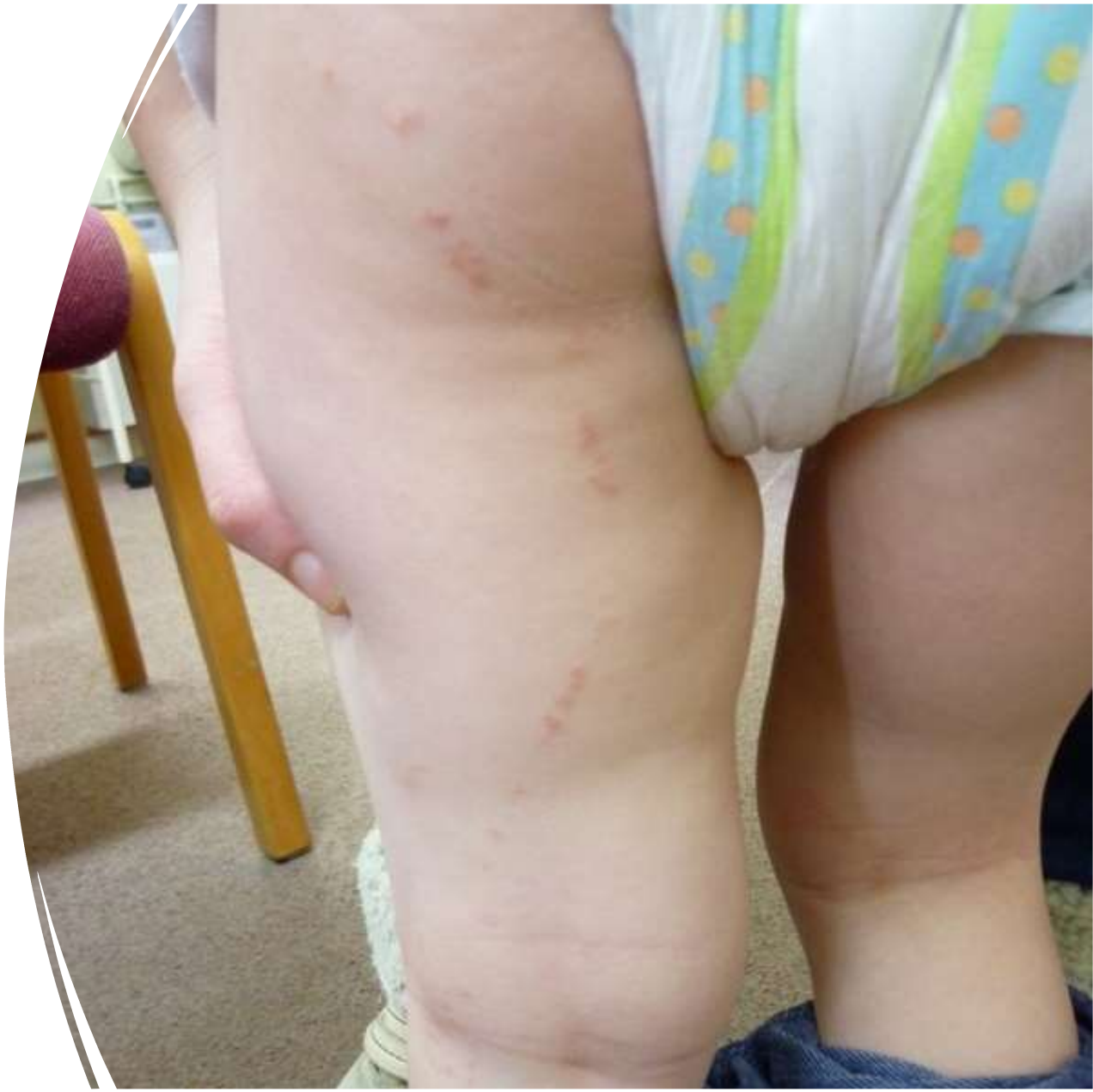
- Photosensitivity and urticaria as **v rare** side effects of acyclovir and valaciclovir (photosensitivity illustrated on the right)
- DRESS as **v rare** side effect of valaciclovir (illustrated below – pt is very unwell)



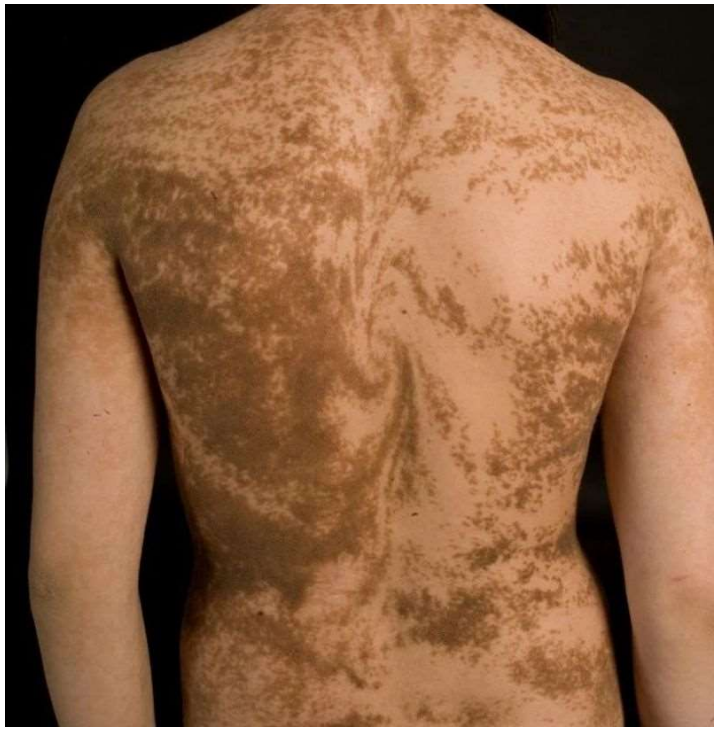


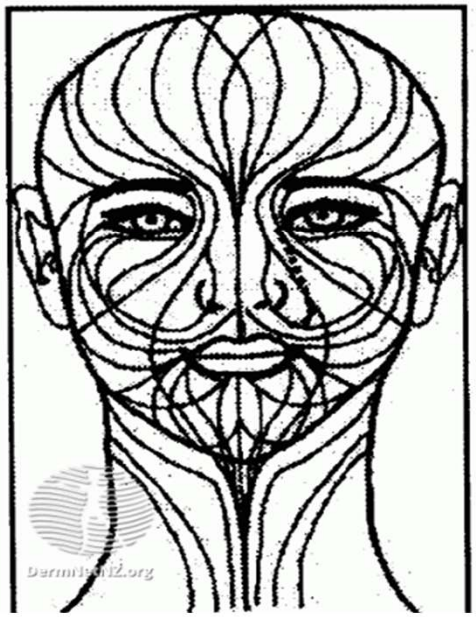


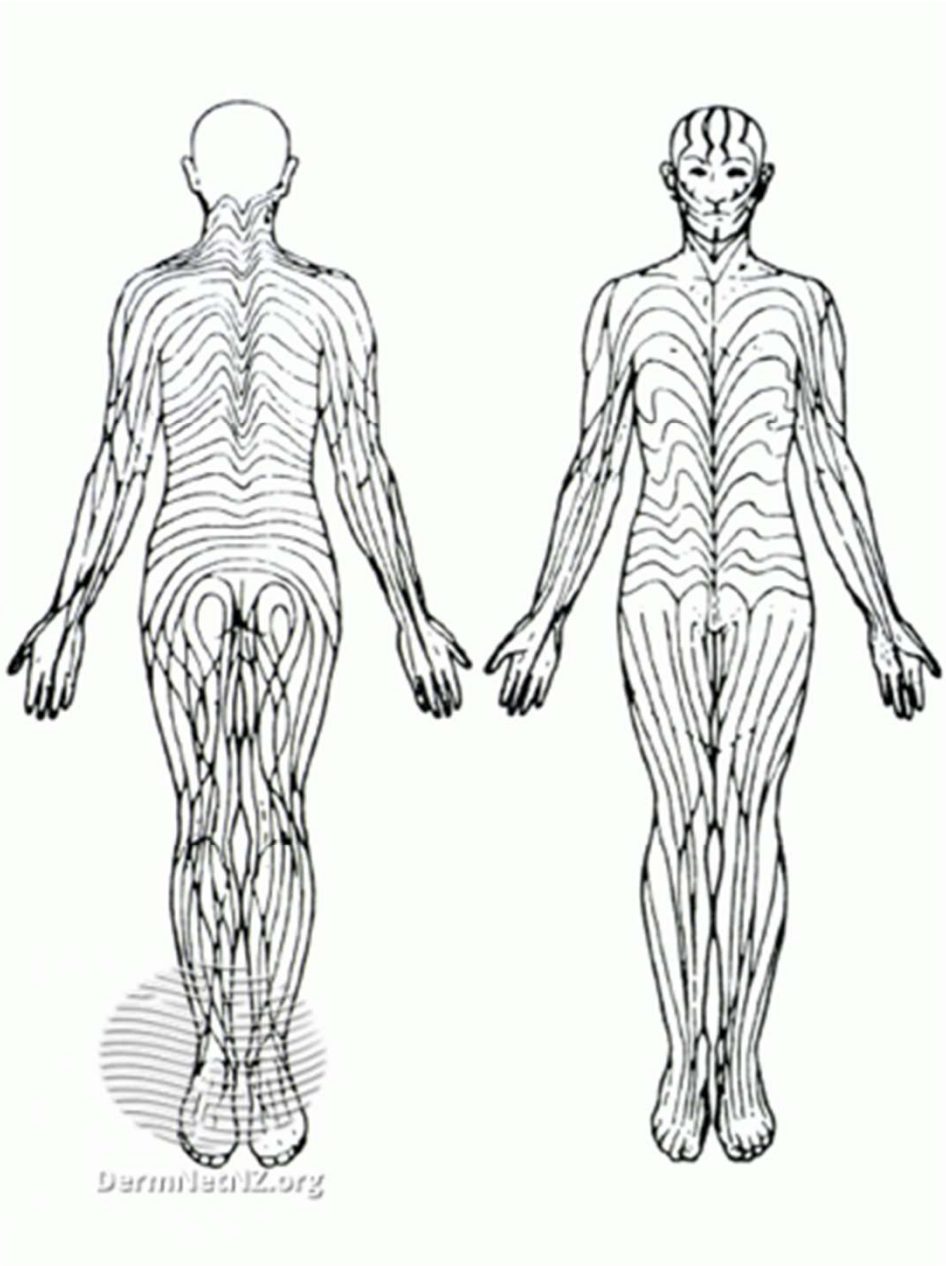
Lichen striatus



Blaschko’s lines

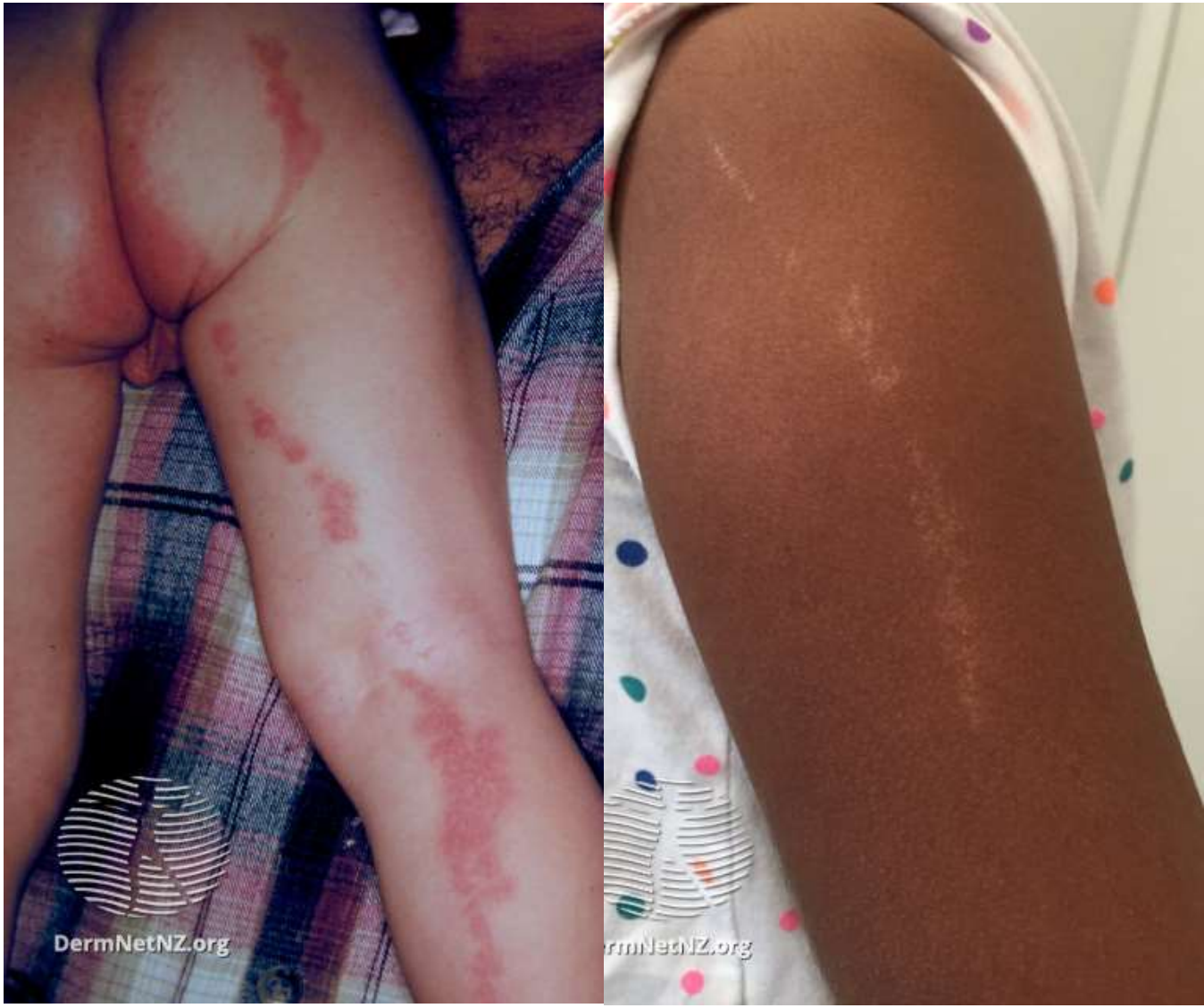






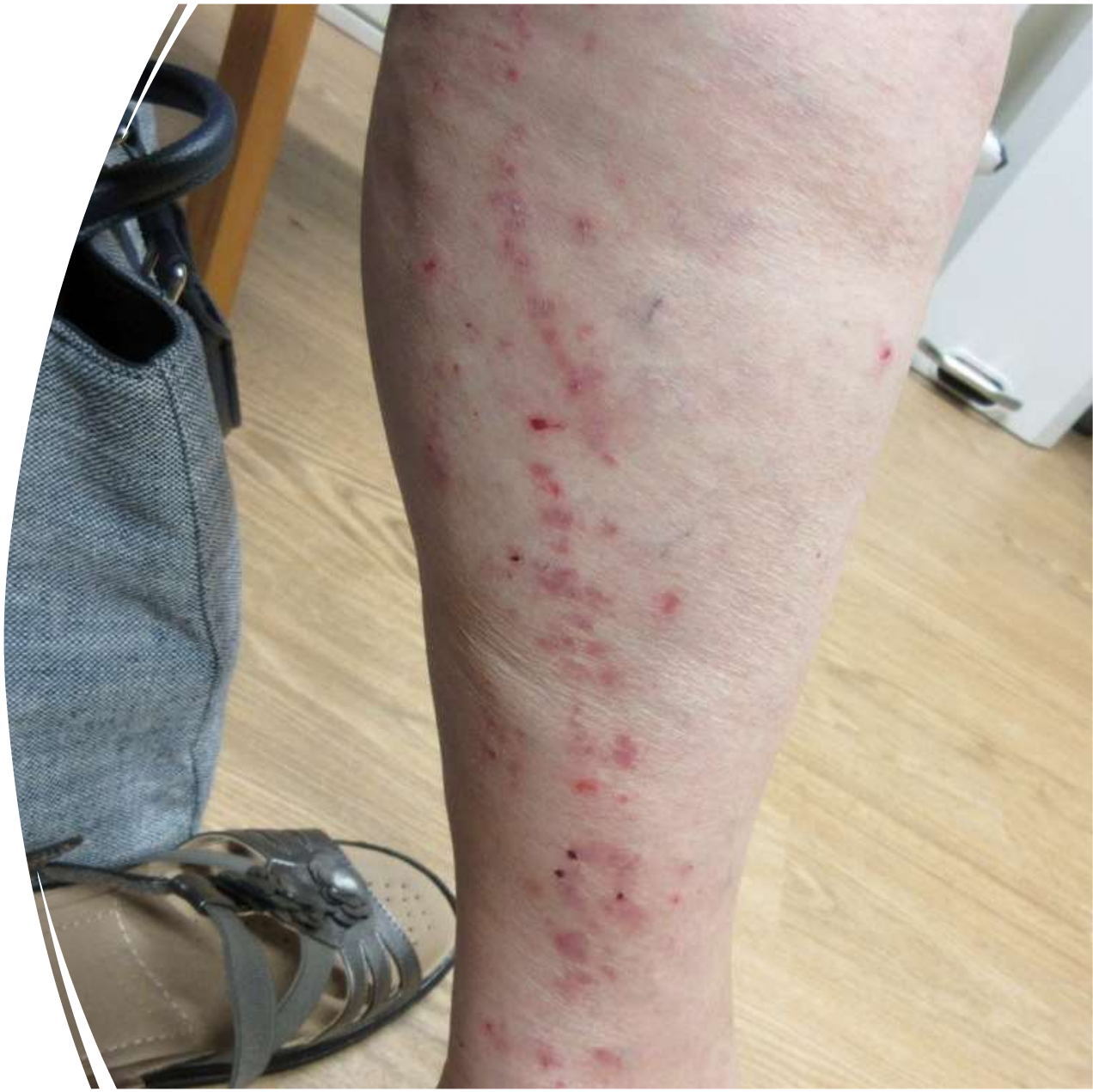
Lichen striatus

- Appears in Blaschko lines
- Children > adults
- Pink spots join together in a line
- Goes away on its own in 6m or so
- No treatment needed (emollients if itchy)

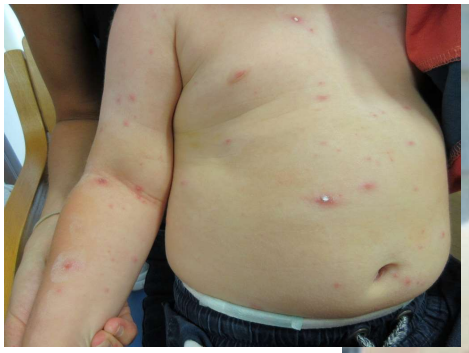


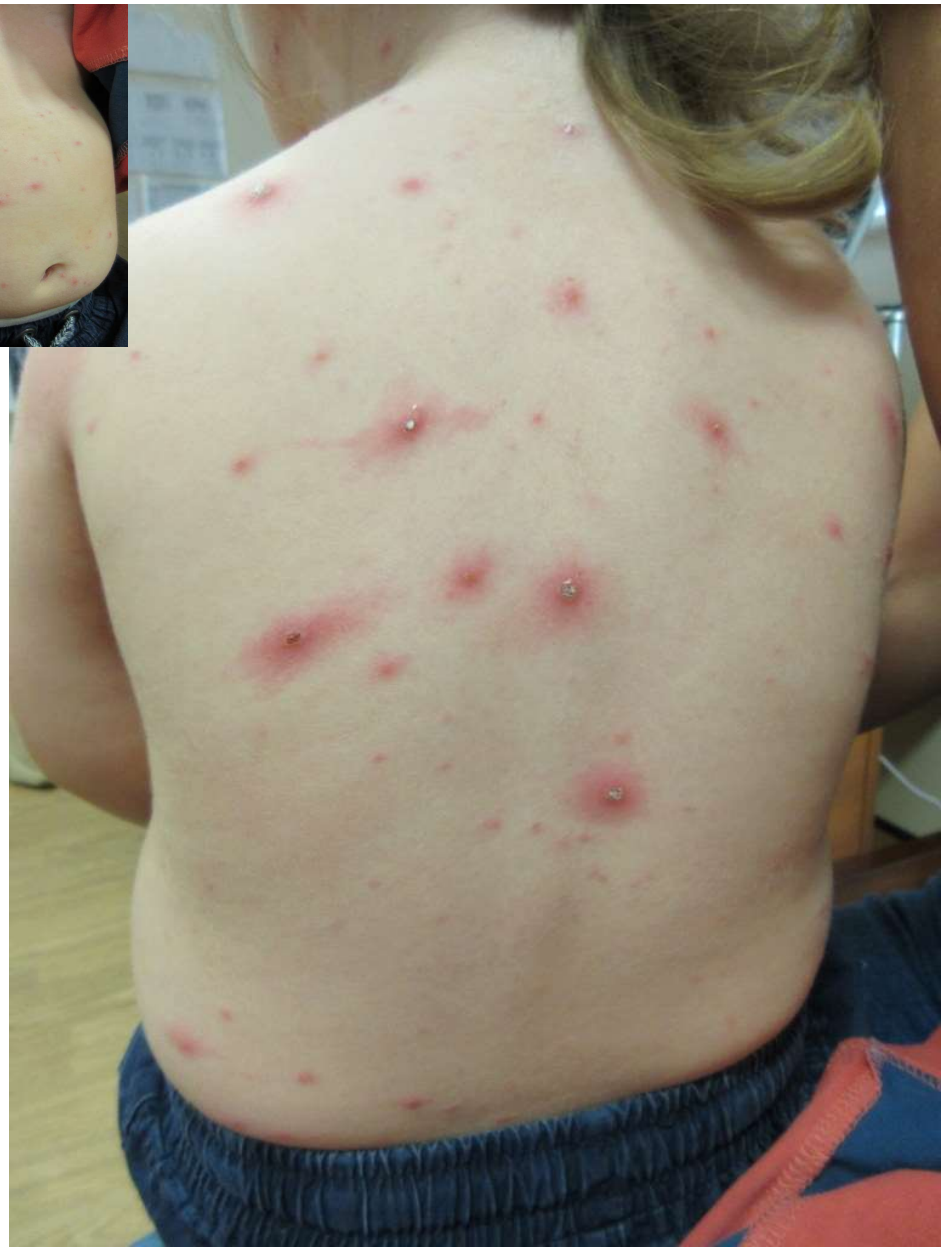
Blaschkiitis

Like lichen striatus but in adults
Can get all sorts of skin things in Blaschko lines; psoriasis, lichen planus, all sorts!



Chicken Pox

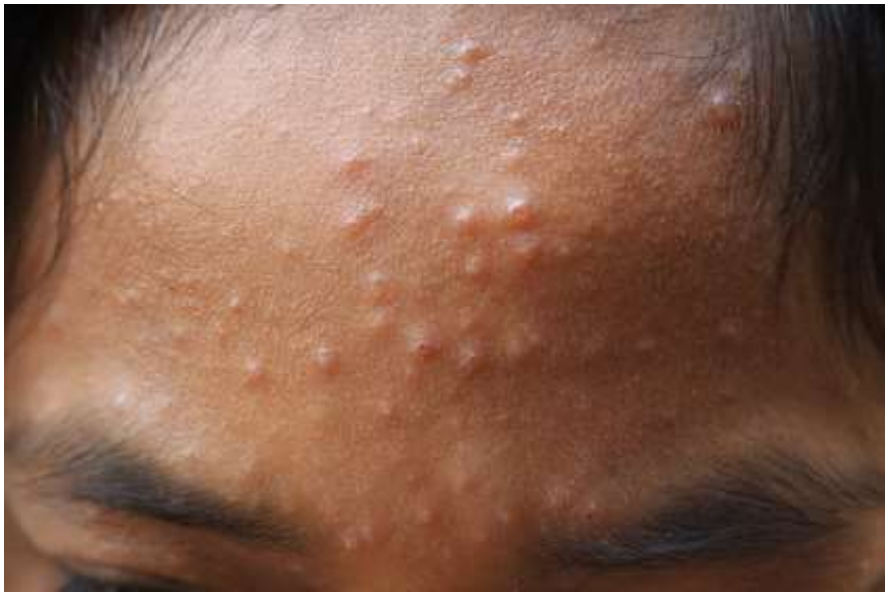


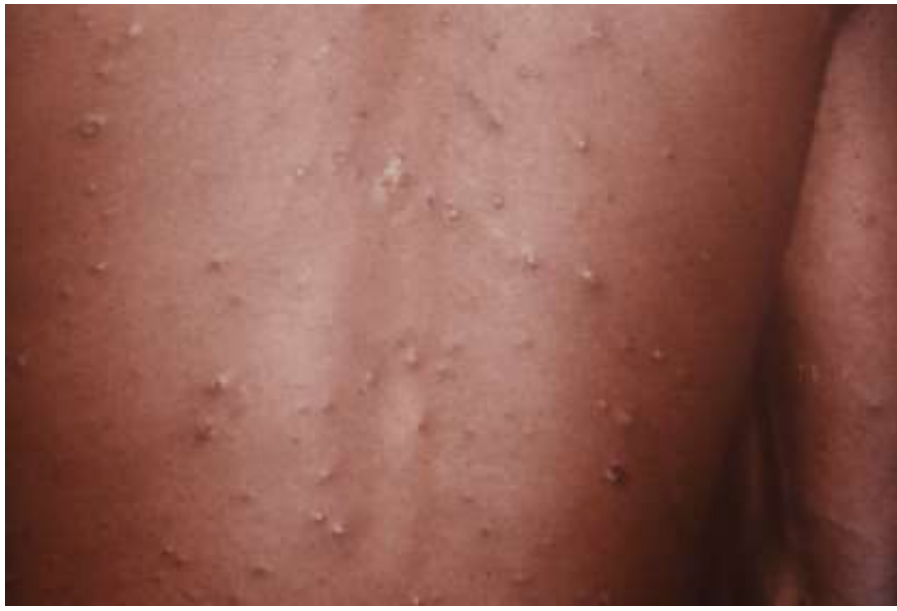


- Dew drop on a rose petal
- Spots come in crops
- Vesicles at different stages
- Usually starts on the trunk
- Symptomatic treatment but NO IBUPROFEN (associated with more skin infections)
- Spots should crust over after 5 days
- More serious in adults than in children

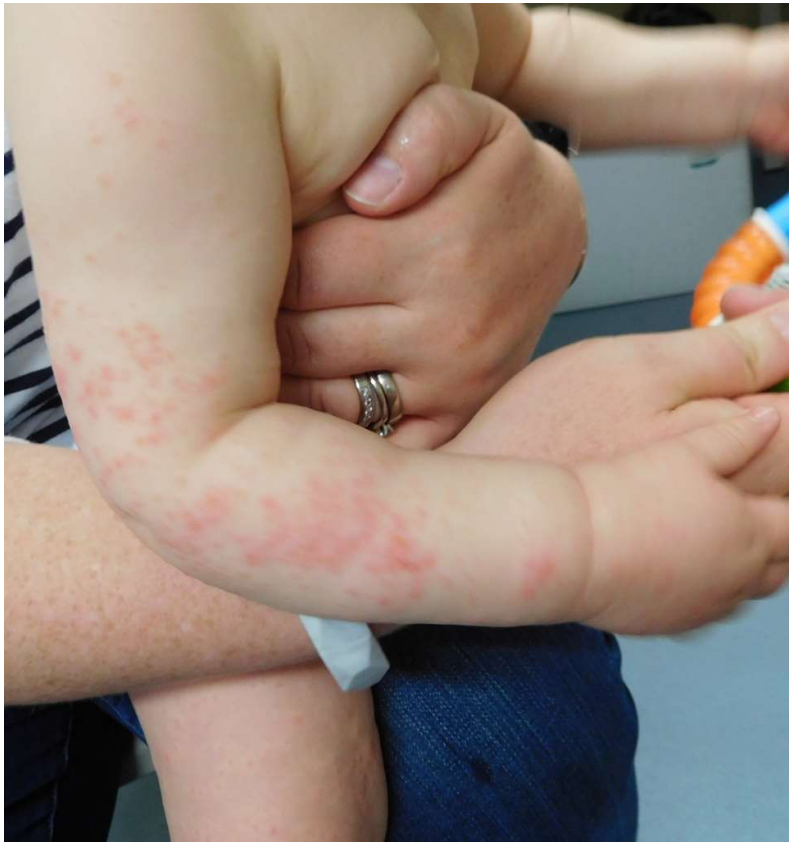
Chicken Pox

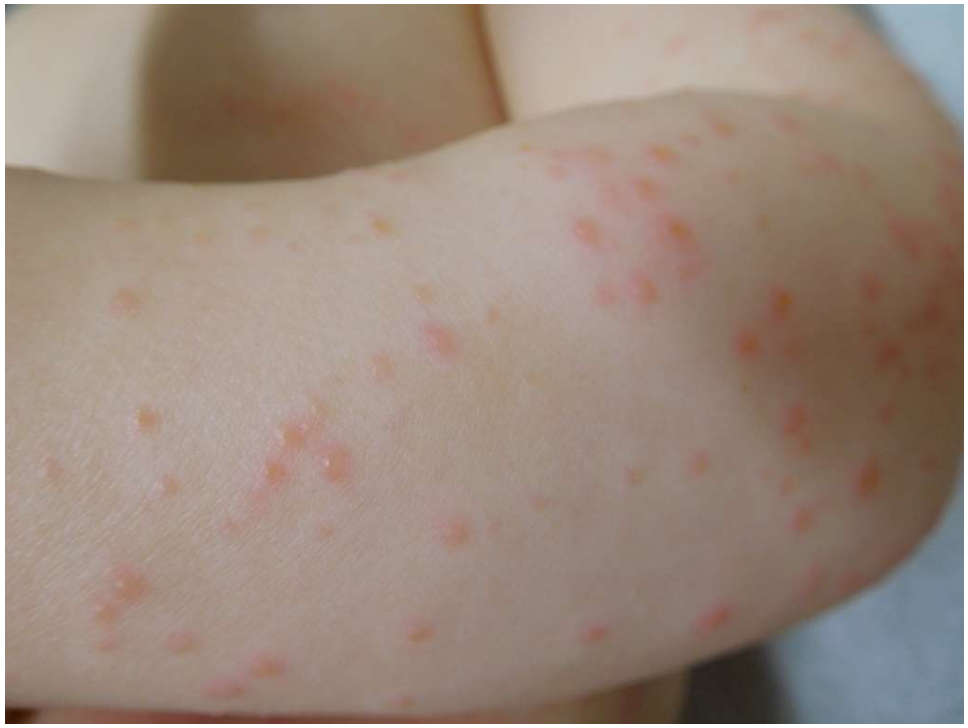
- Red flags:
- Chicken pox in pregnancy or breastfeeding
- Baby with chicken pox (<4 weeks old)
- Immune suppression
- Very unwell, particularly breathless or coughing, or confused / agitated
- Unable to eat or drink
- Signs of cellulitis

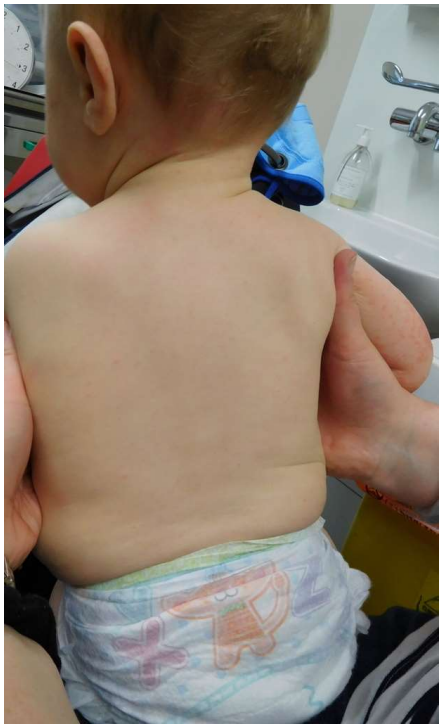




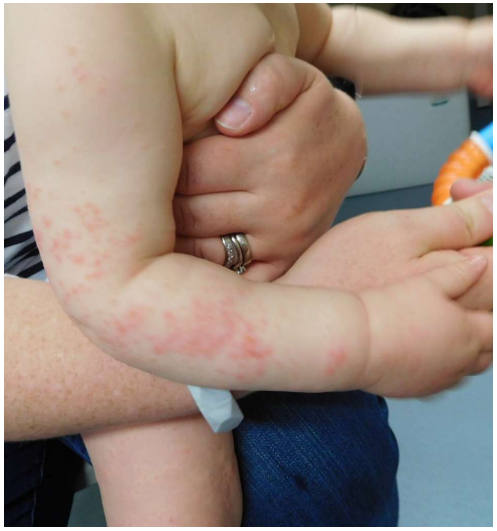
“Atypical” Hand foot and mouth

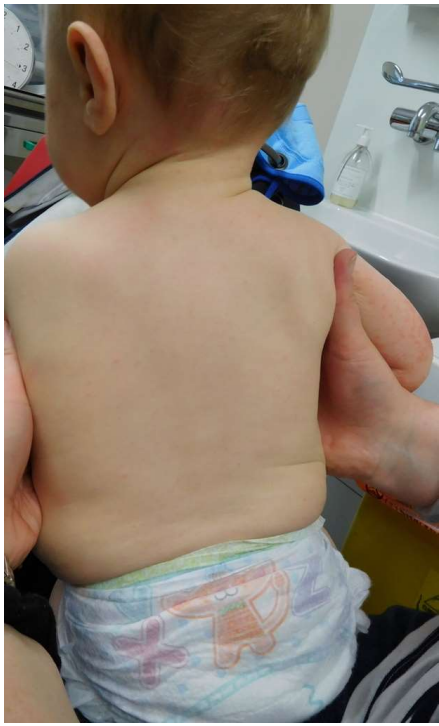






“Atypical” Hand foot and mouth



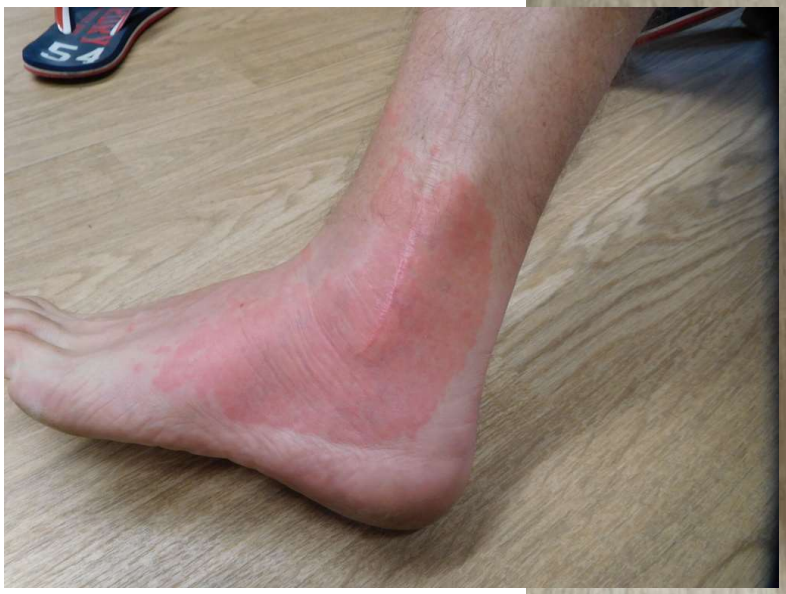


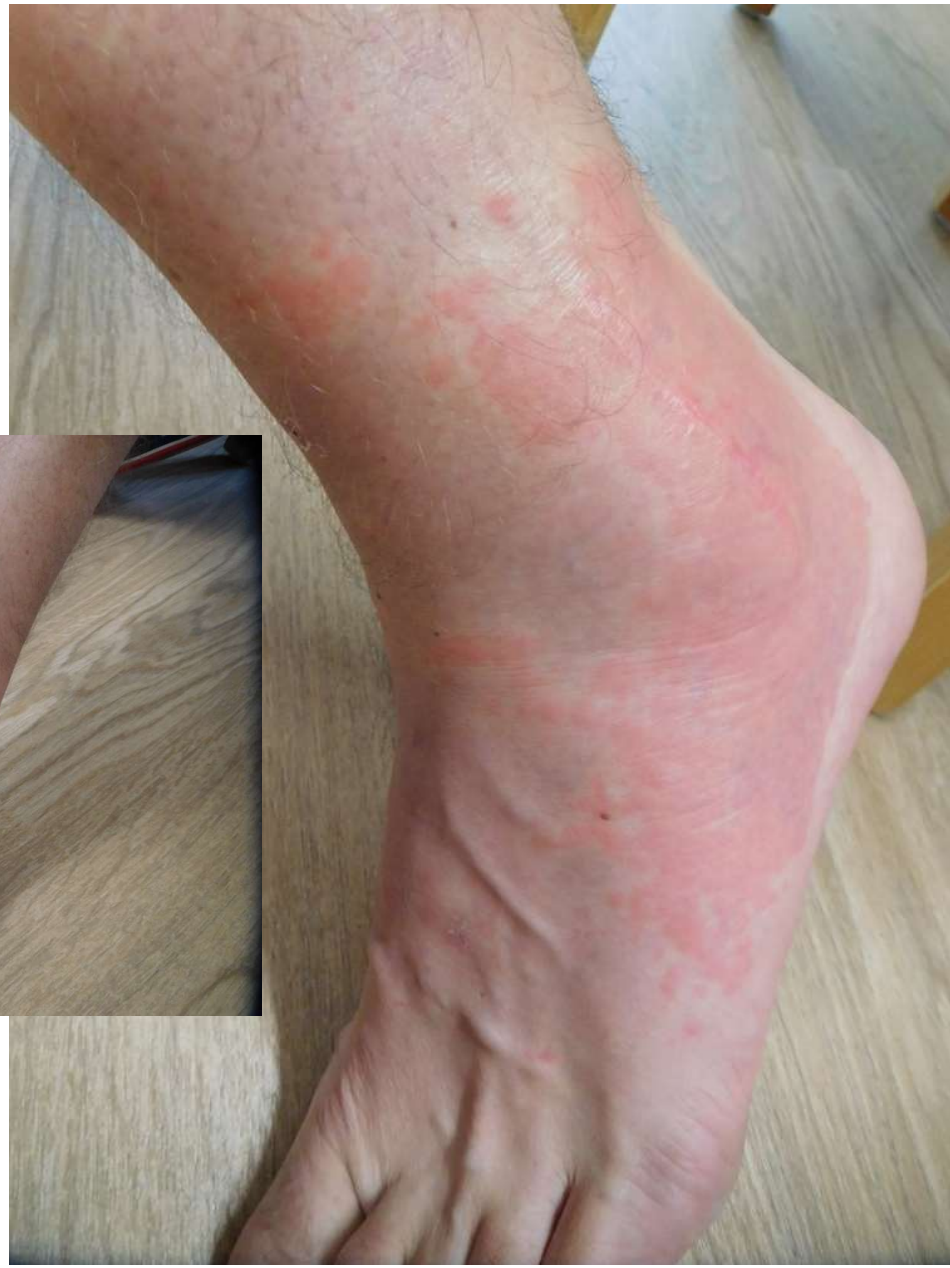
- Blistering rash that spares the trunk
- Child is generally well
- Symptomatic treatment if needed
- This is not chicken pox – still susceptible to chicken pox if not already had it!
- Can infect adults too (because the virus that causes HFMD mutated, so it’s a separate illness now. Adults won’t have had it as kids. The kids are well, adults feel fluey with it)
- Do NOT need to stay off school – the QR code takes you to the guidance poster

Rashes and skin infections	Recommended period to be kept away from school, nursery or childminders	Comments
Athlete's foot	None	Athlete's foot is not a serious condition. Treatment is recommended
Chickenpox*	Until all vesicles have crusted over	See: Vulnerable children and female staff – pregnancy
Cold sores, (Herpes simplex)	None	Avoid kissing and contact with the sores. Cold sores are generally mild and self-limiting
German measles (rubella)*	Four days from onset of rash (as per "Green Book")	Preventable by immunisation (MMR x 2 doses). See: Female staff – pregnancy
Hand, foot and mouth	None	Contact the Duty Room if a large number of children are affected. Exclusion may be considered in some circumstances
Impetigo	Until lesions are crusted and healed, or 48 hours after commencing antibiotic treatment	Antibiotic treatment speeds healing and reduces the infectious period
Measles*	Four days from onset of rash	Preventable by vaccination (MMR x 2). See: Vulnerable children and female staff – pregnancy
Molluscum contagiosum	None	A self-limiting condition
Ringworm	Exclusion not usually required	Treatment is required
Roseola (infantum)	None	None
Scabies	Child can return after first treatment	Household and close contacts require treatment
Scarlet fever*	Child can return 24 hours after commencing appropriate antibiotic treatment	Antibiotic treatment recommended for the affected child. If more than one child has scarlet fever contact PHA Duty Room for further advice
Slapped cheek (fifth disease or parvovirus B19)	None once rash has developed	See: Vulnerable children and female staff – pregnancy
Shingles	Exclude only if rash is weeping and cannot be covered	Can cause chickenpox in those who are not immune i.e. have not had chickenpox. It is spread by very close contact and touch. If further information is required, contact the Duty Room. SEE: Vulnerable Children and Female Staff – Pregnancy
Warts and verrucae	None	Verrucae should be covered in swimming pools, gymnasiums and changing rooms

Insect bite – non infected

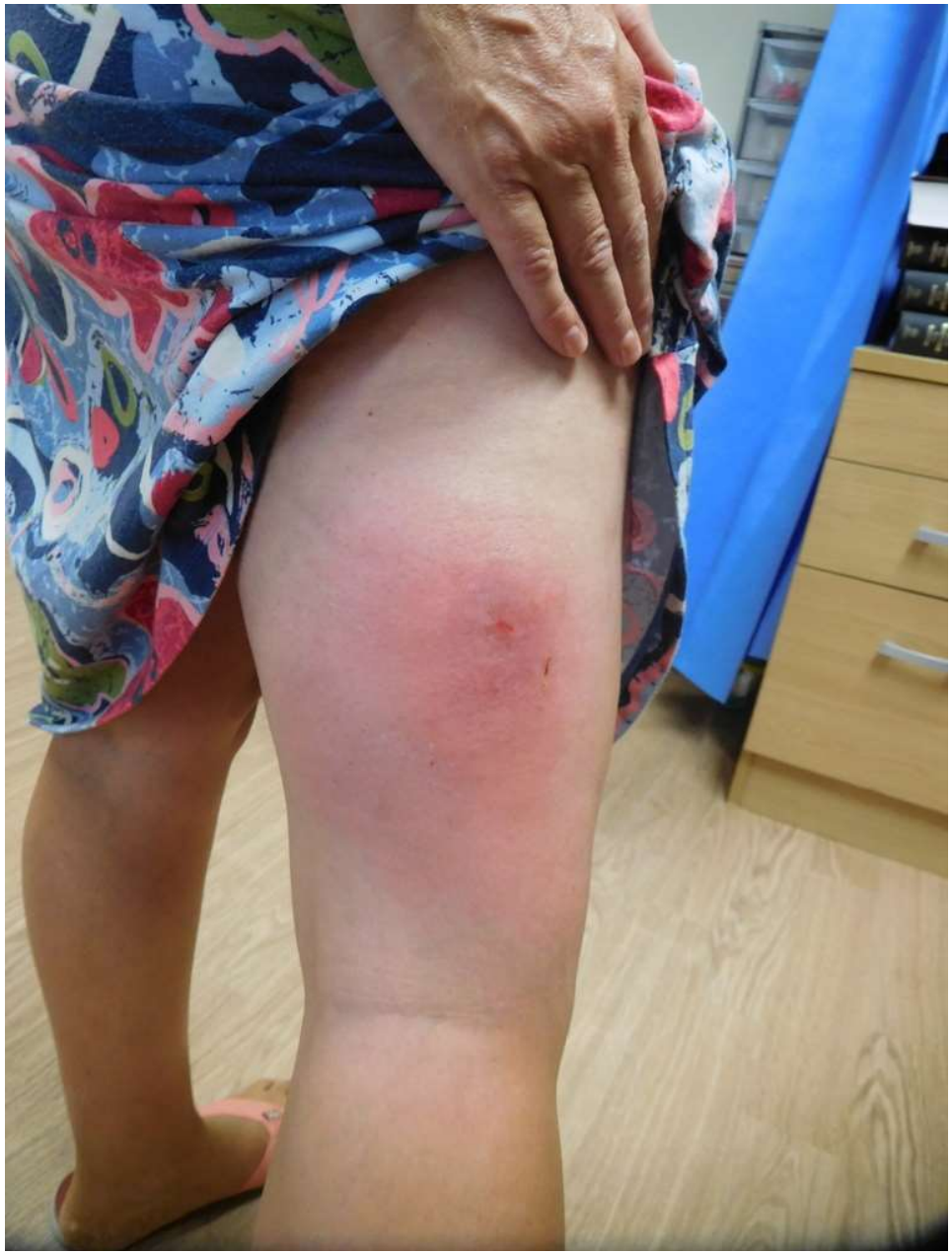
- Topical hydrocortisone
- Topical Eumovate
- Oral antihistamine





Insect bite – infected

- Oral flucloxacillin / clarithromycin
- +/- Oral antihistamine



Insect bite – non infected

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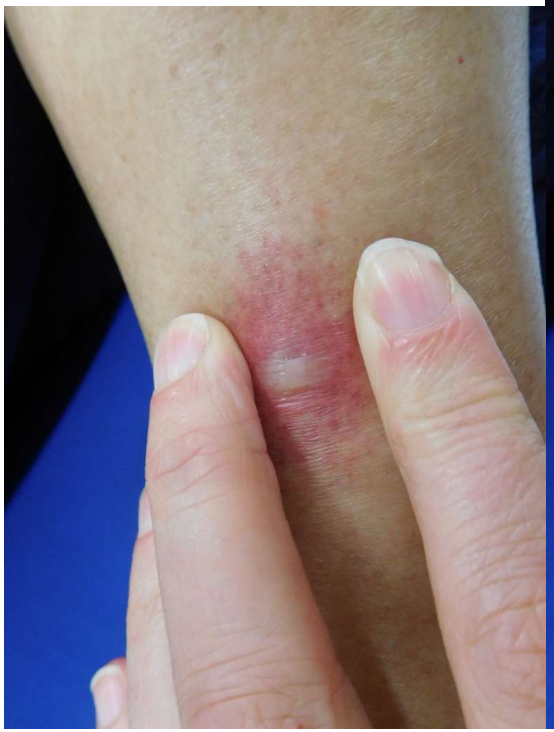
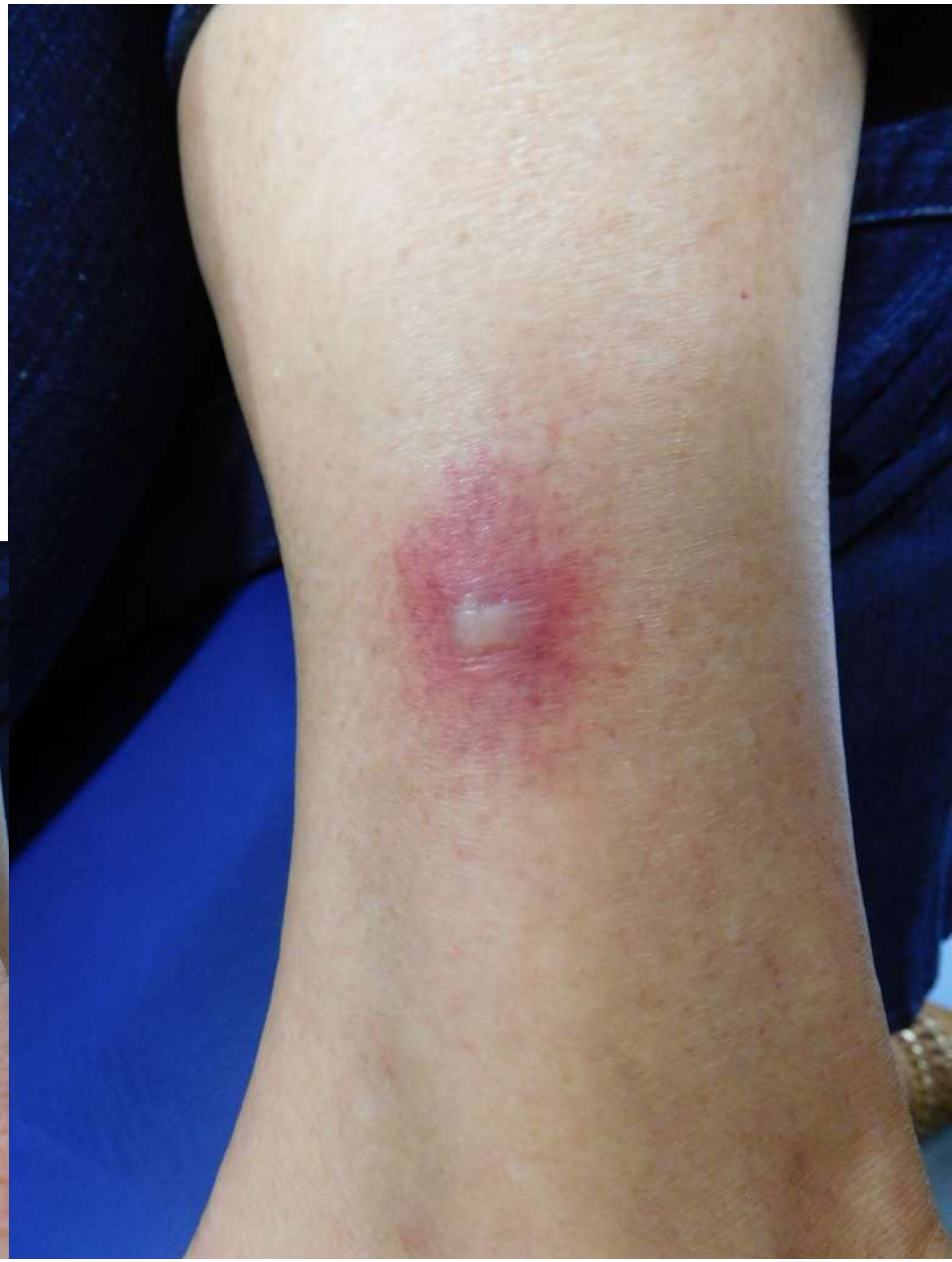
- Topical Eumovate
- Oral antihistamine





Insect bite – non infected

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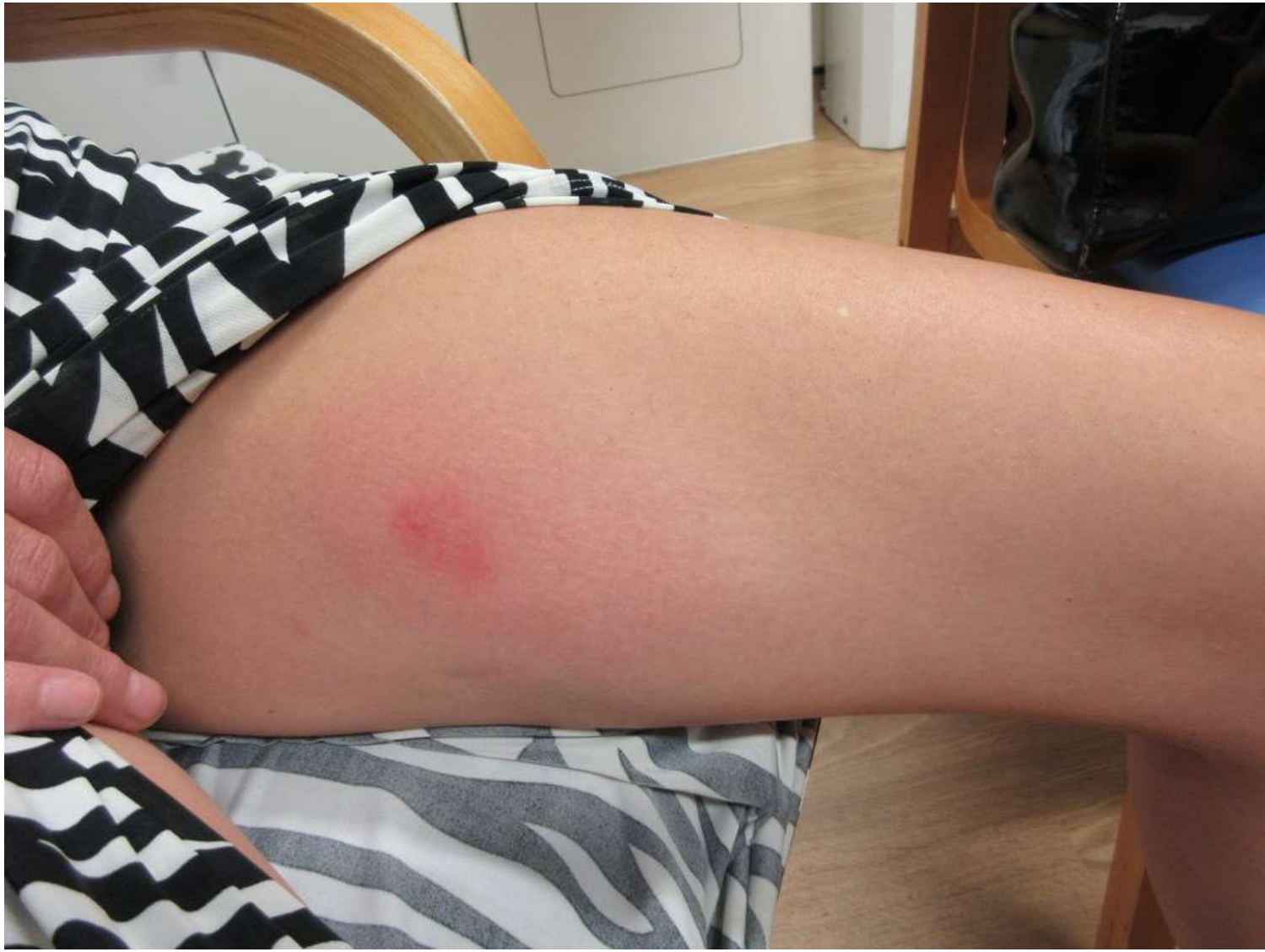
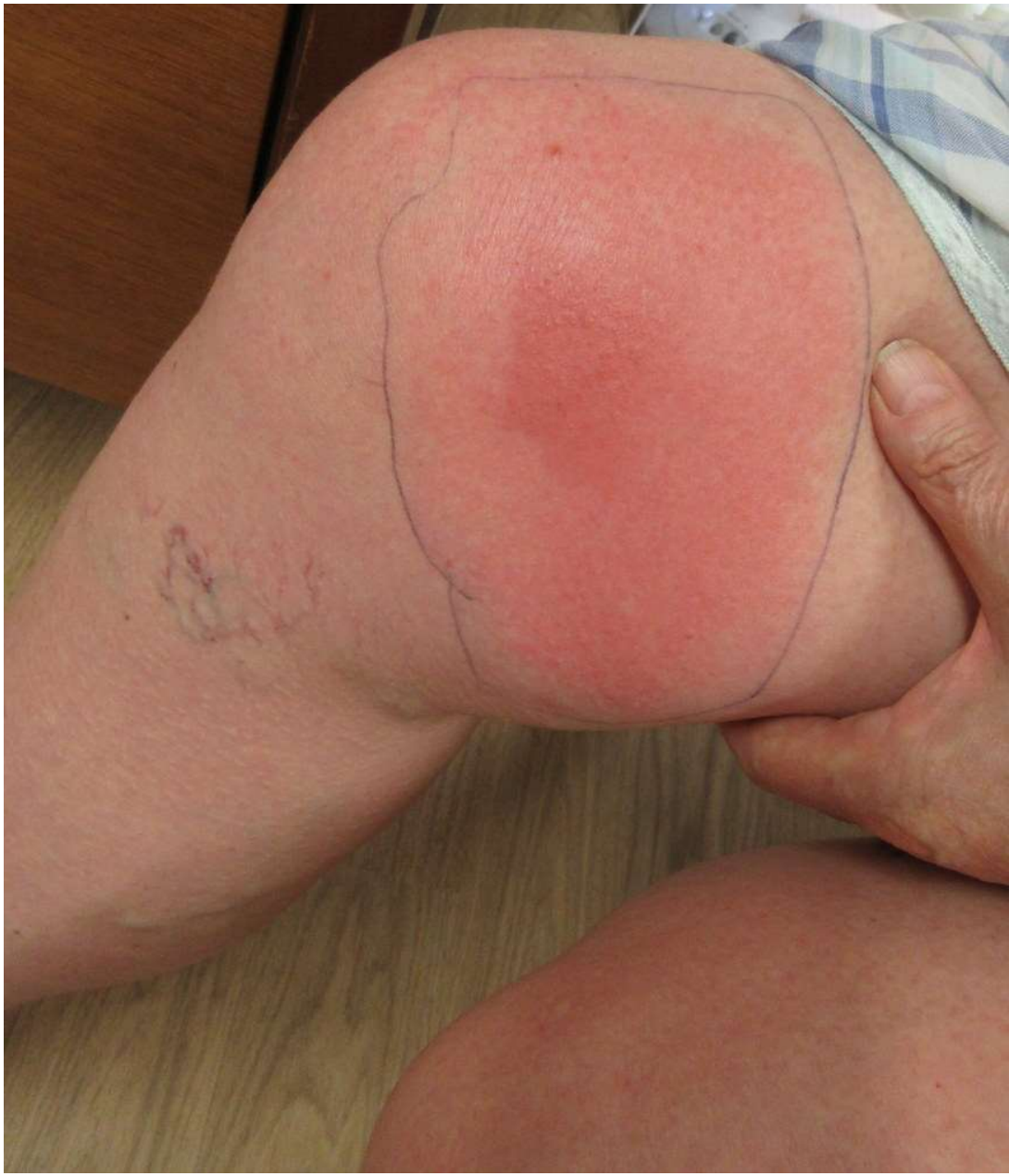


Insect bite – infected

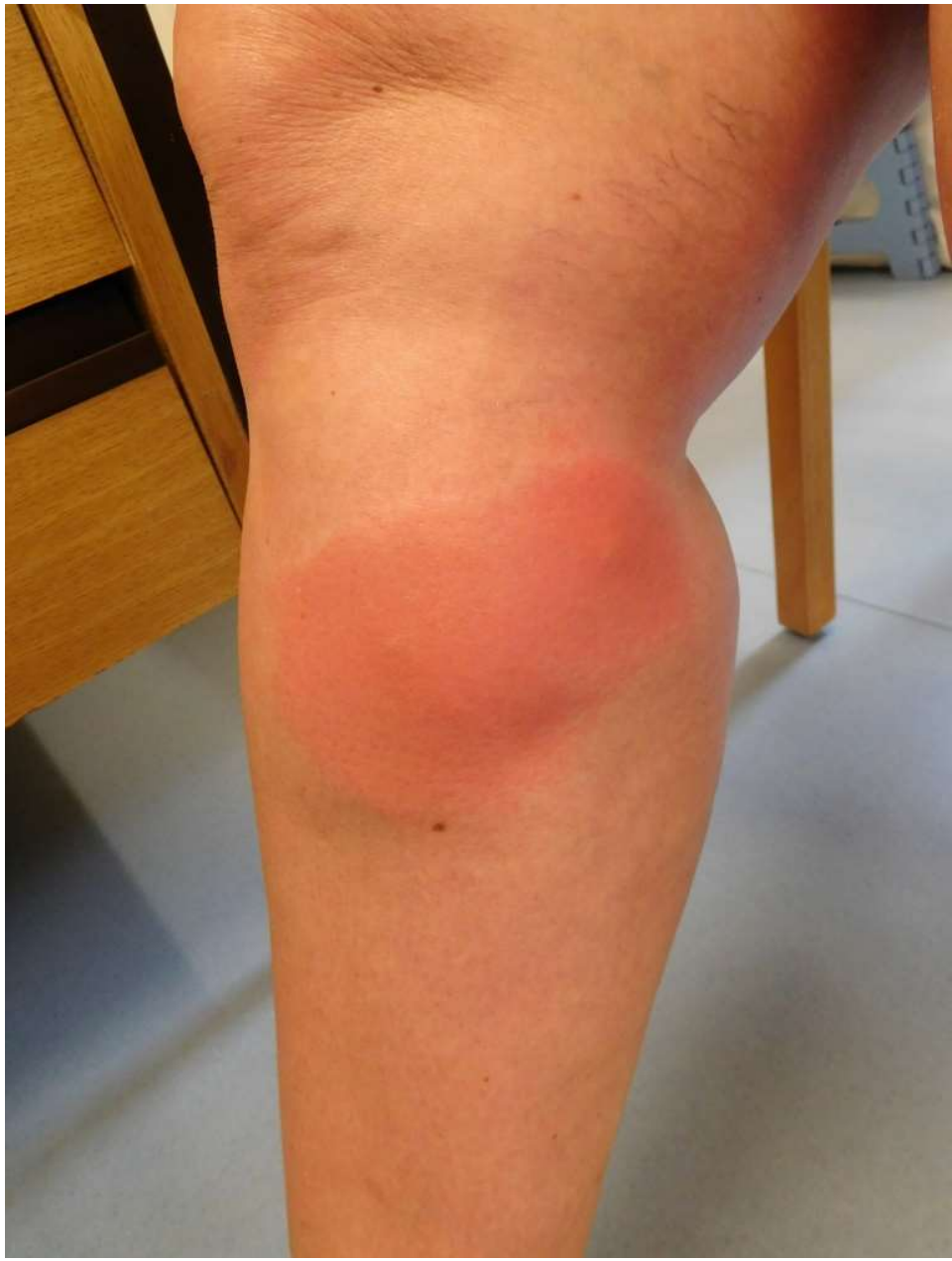
- Oral flucloxacillin / clarithromycin



Insect bite – non infected

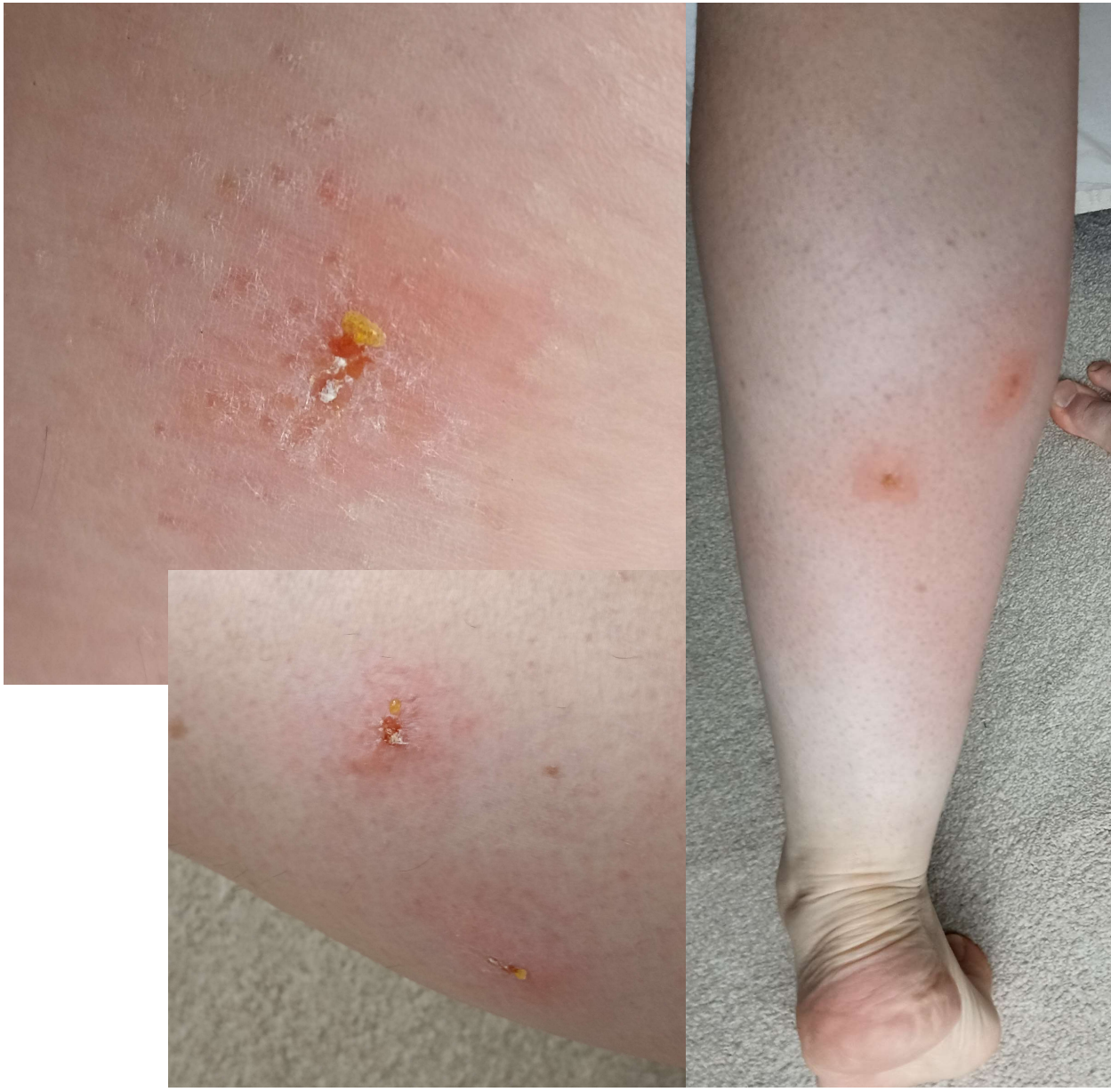
- Topical hydrocortisone
- Topical Eumovate
- Oral antihistamine

- Urticaria reaction to bites is raised and itchy – infection is flat and tender.



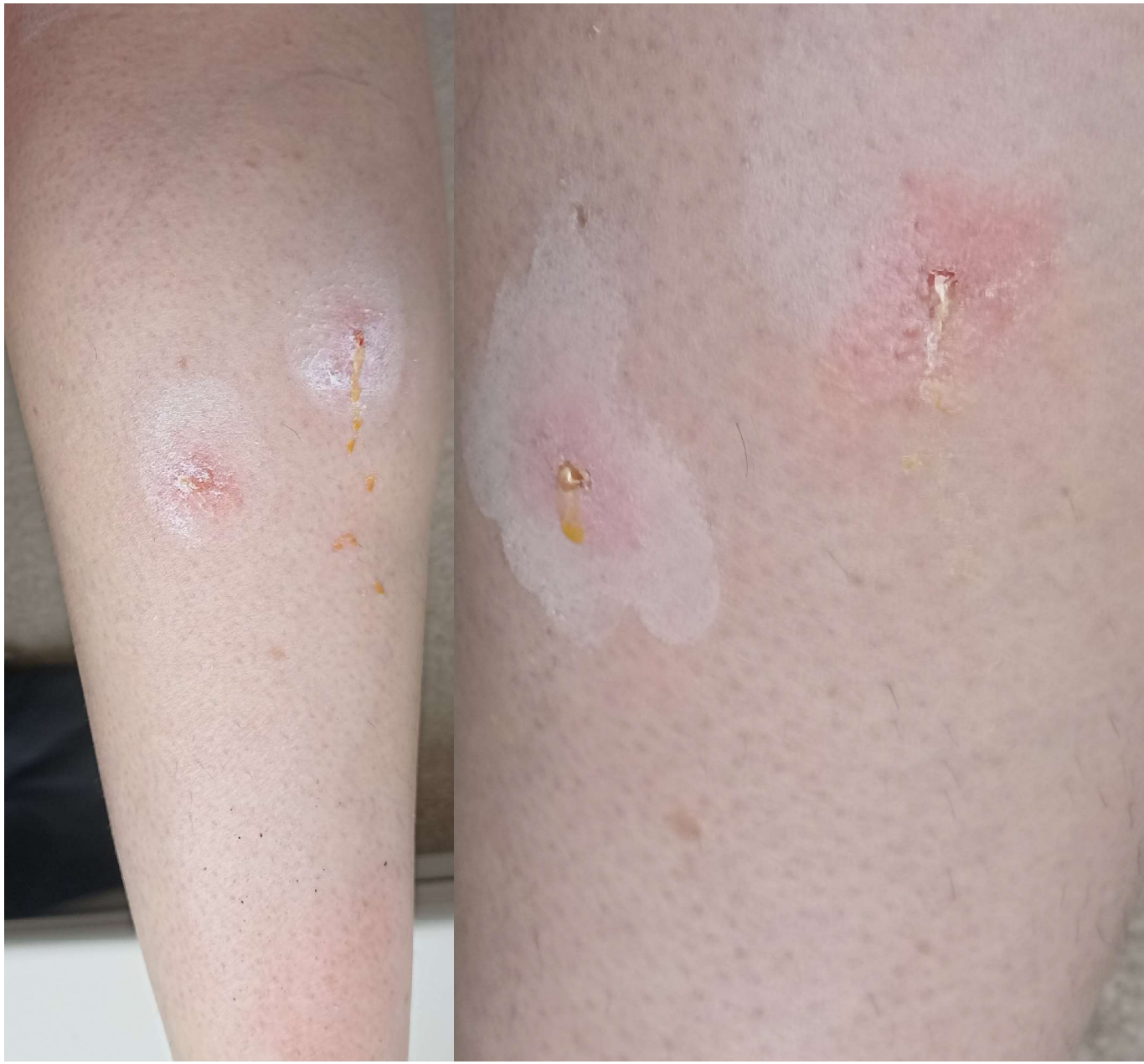
Insect bite – infected (impetigo)

- Sudocrem!

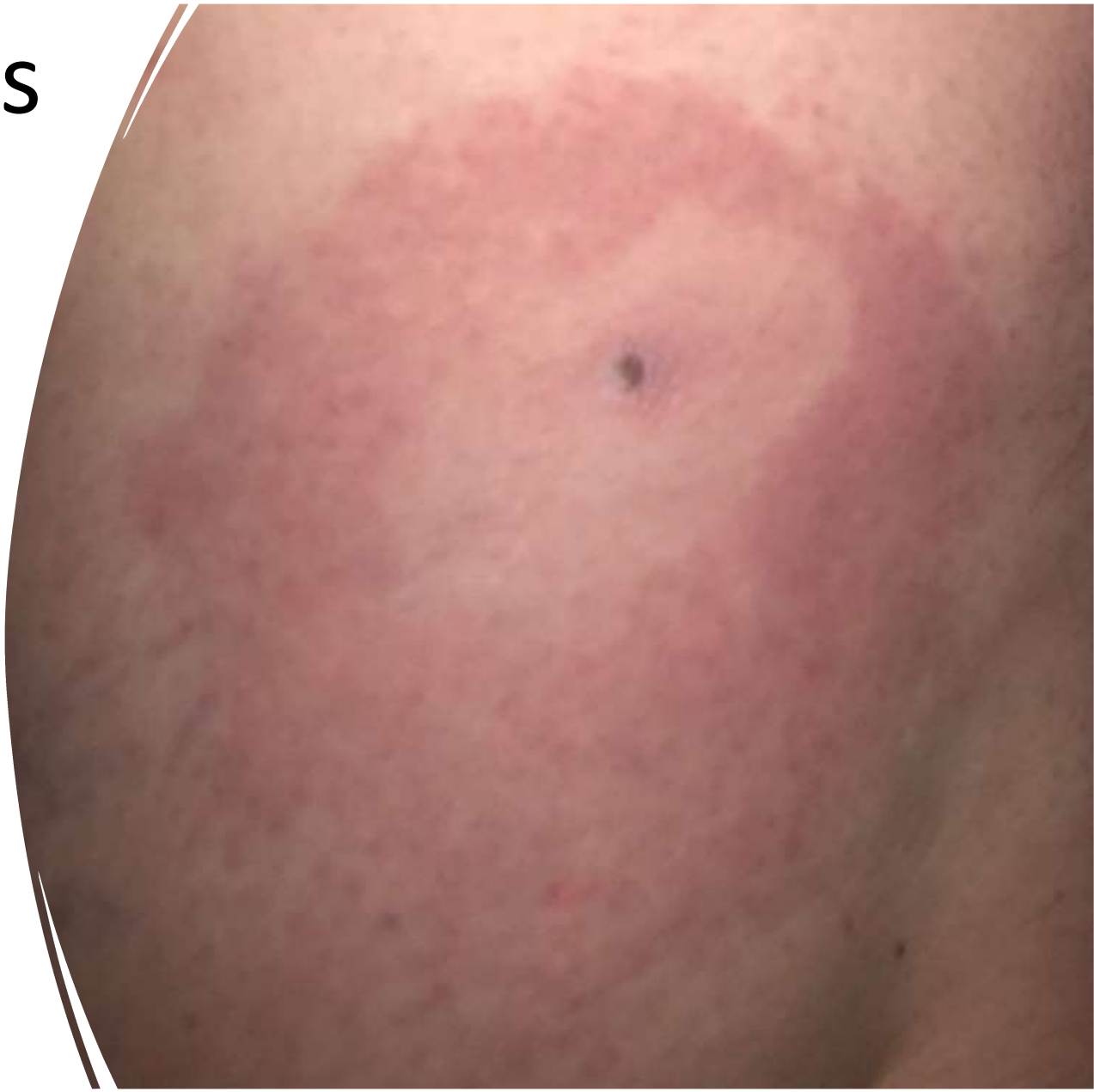


Insect bite – infected (impetigo)

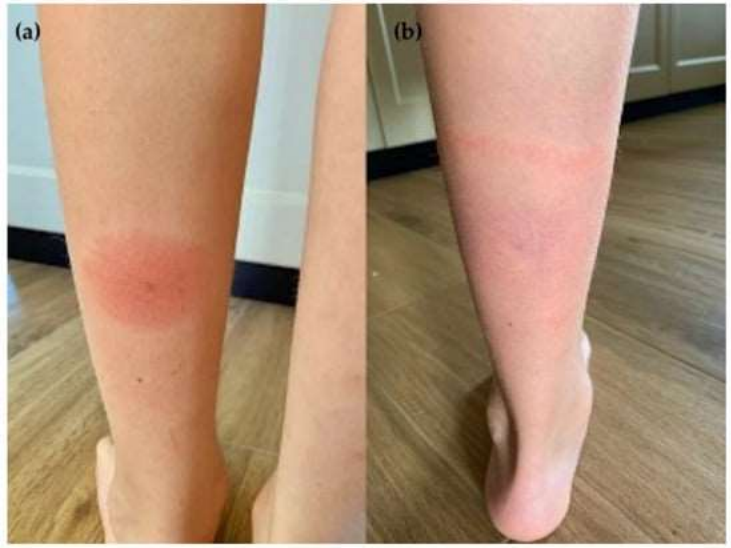
- Topical hydrogen peroxide if you want
- Or just keep cleaning it and carry on sudocrem (which worked)



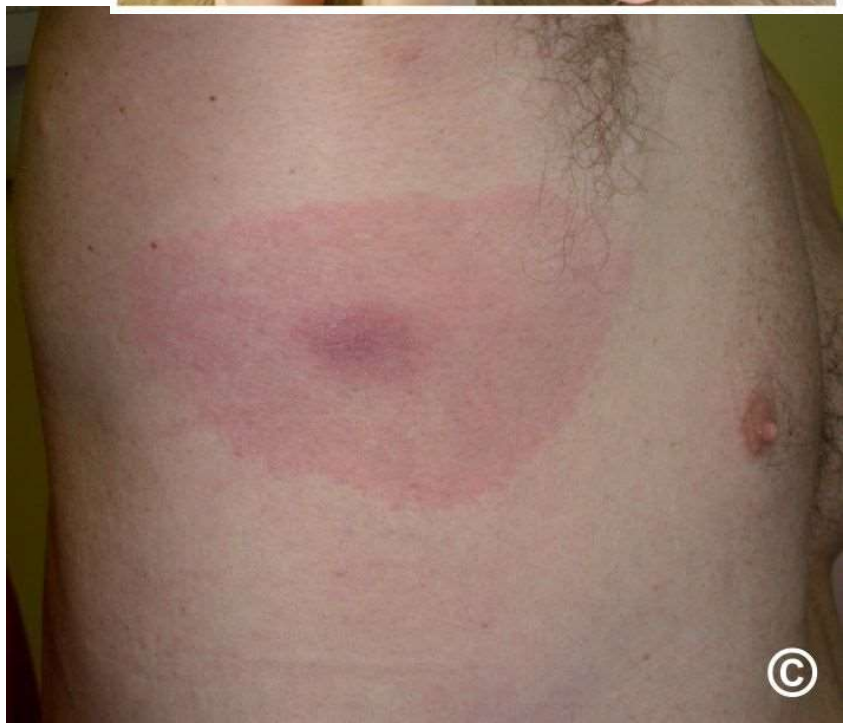
Erythema migrans (Lyme)



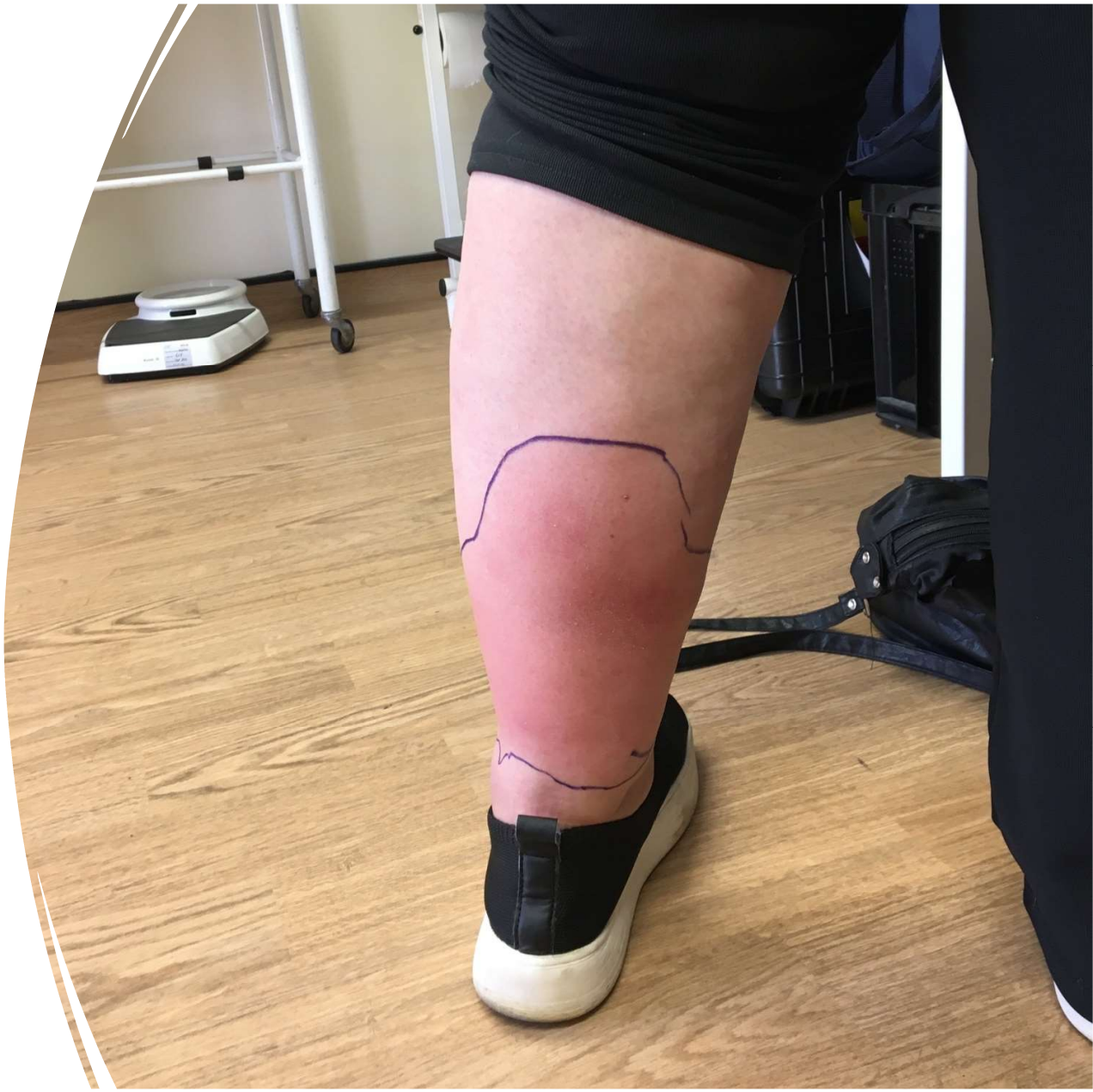
Erythema migrans (Lyme)



- Tick bite from female Ixodes tick
- Risk highest in Spring and Summer
- Usually takes 36-72 hours for tick to transmit Lyme
- Rash usually appears a week later (up to a month later)
- Rash takes 3-4 weeks to fade (or longer)
- Long term problems if not treated promptly

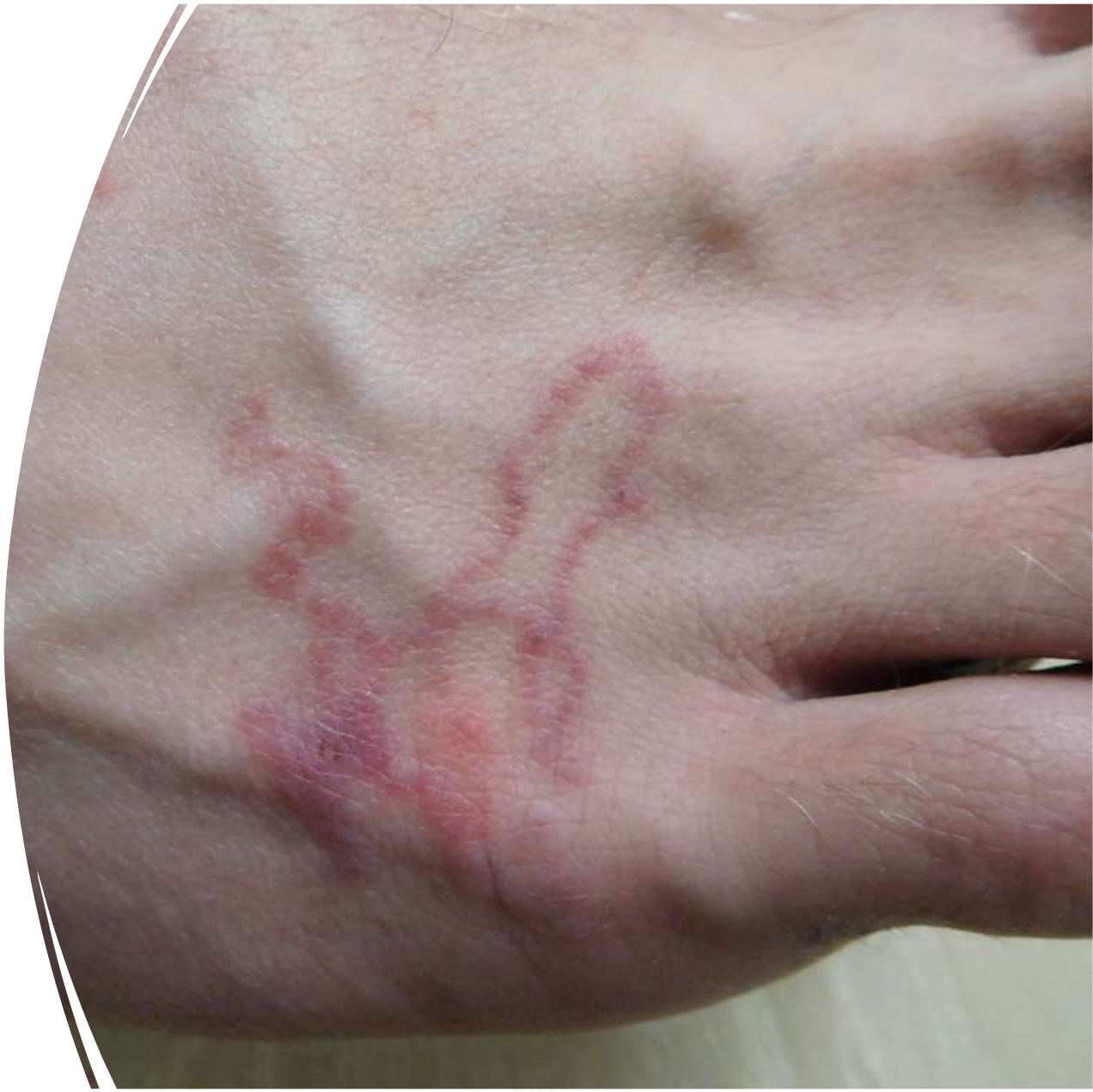


Cellulitis



Cutaneous Larva Migrans

- Hookworm larva
- Itchy ++++
- Self limiting if untreated
- Usual treatment is oral ivermectin

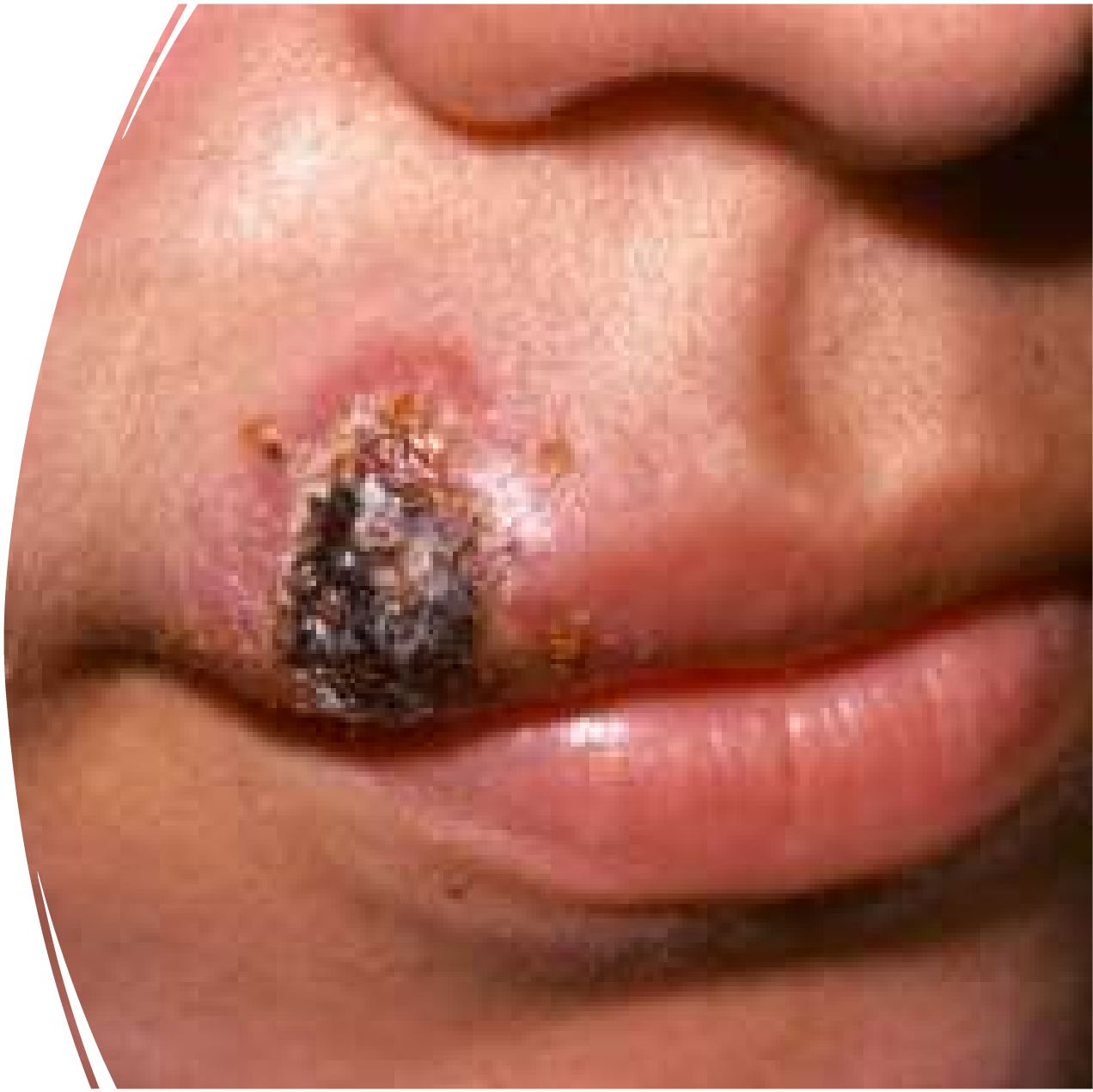


Rare weird and wonderfuls

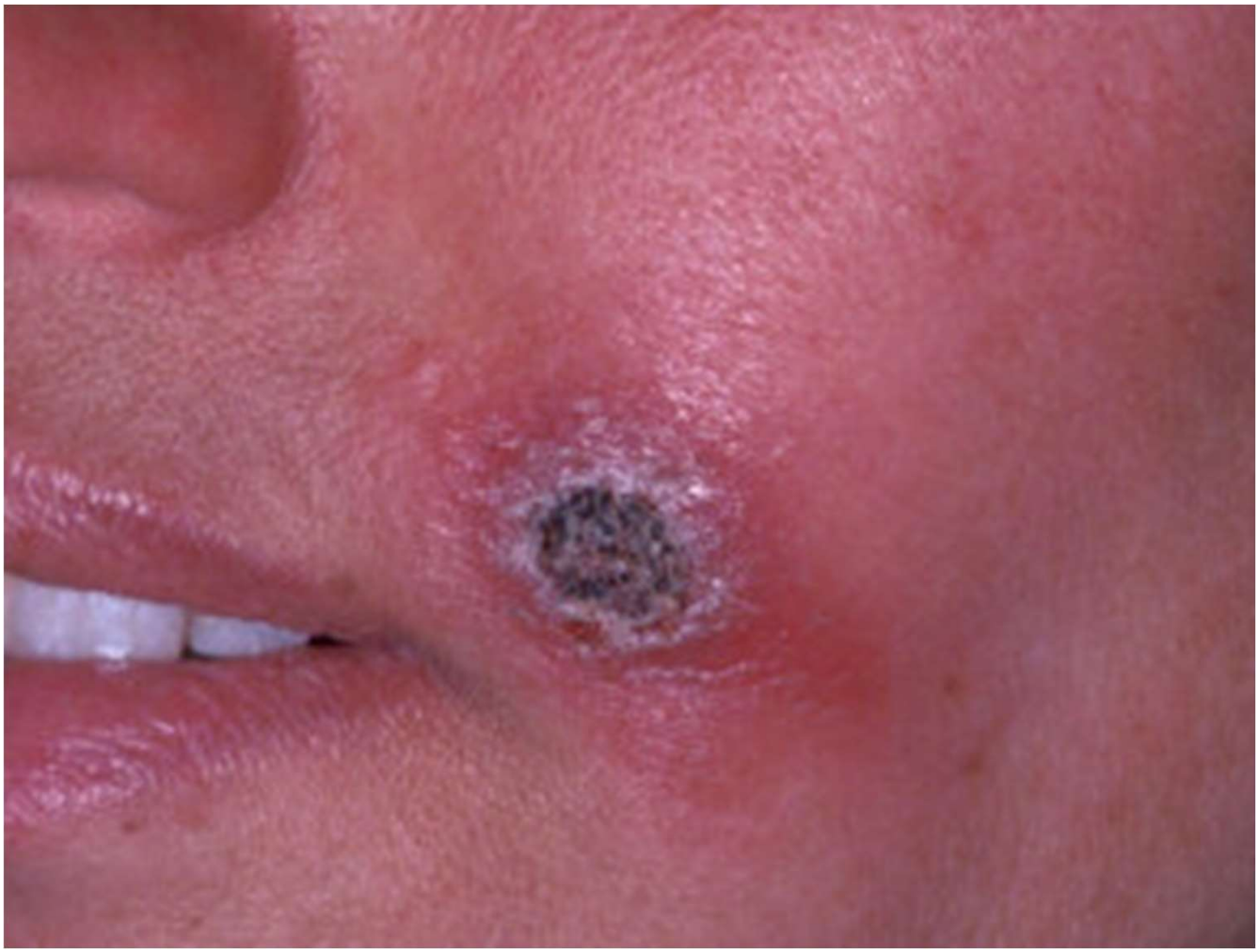
Cutaneous Leishmaniasis

Painless, 4 weeks duration
Started as a papule then an ulcer than this crusted scab

- Parasite carried by sandflies
- American and non-American forms are different
- Travel history matters
- Southern France and Spain have Leishmania



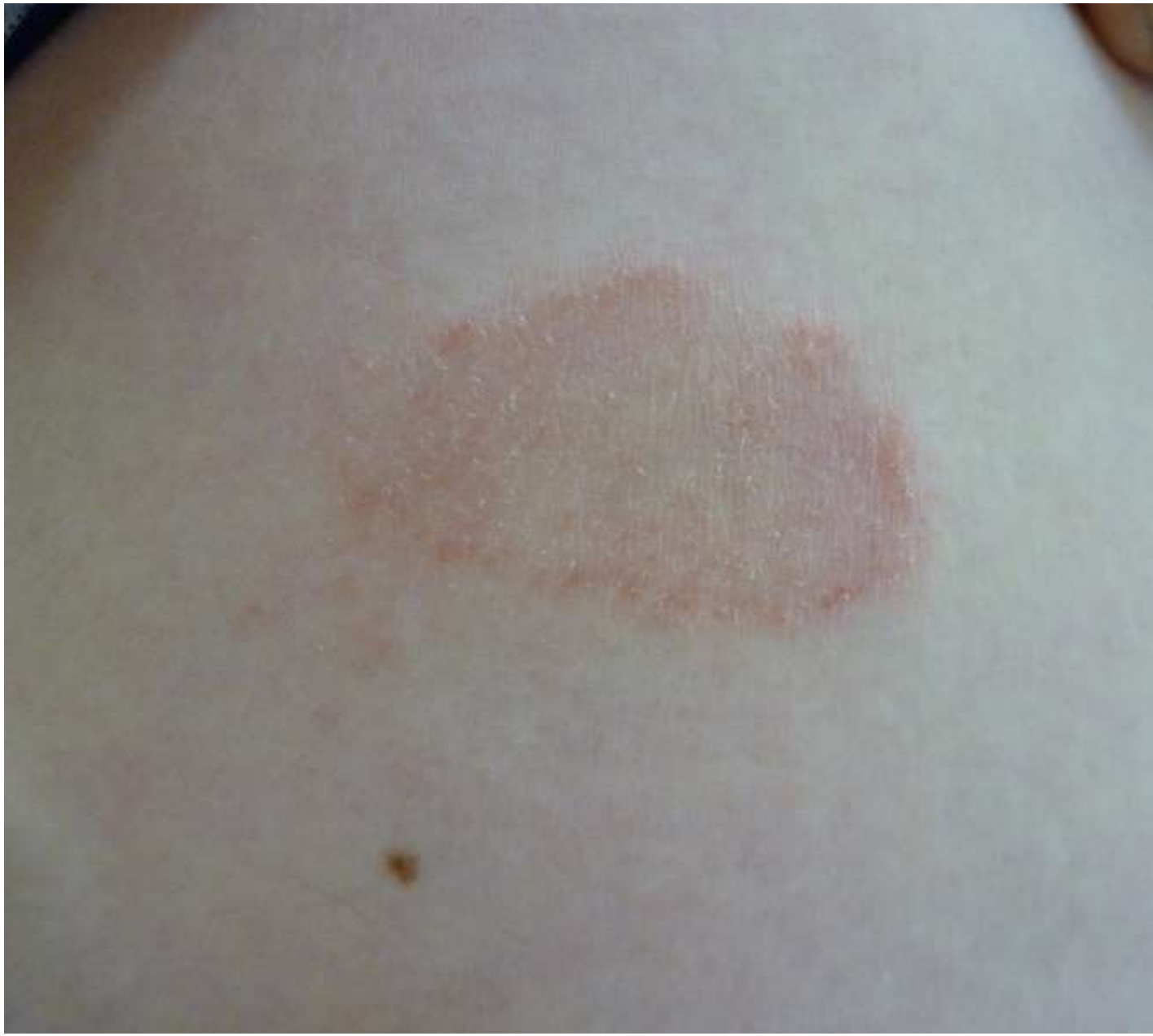
Cutaneous Leishmaniasis

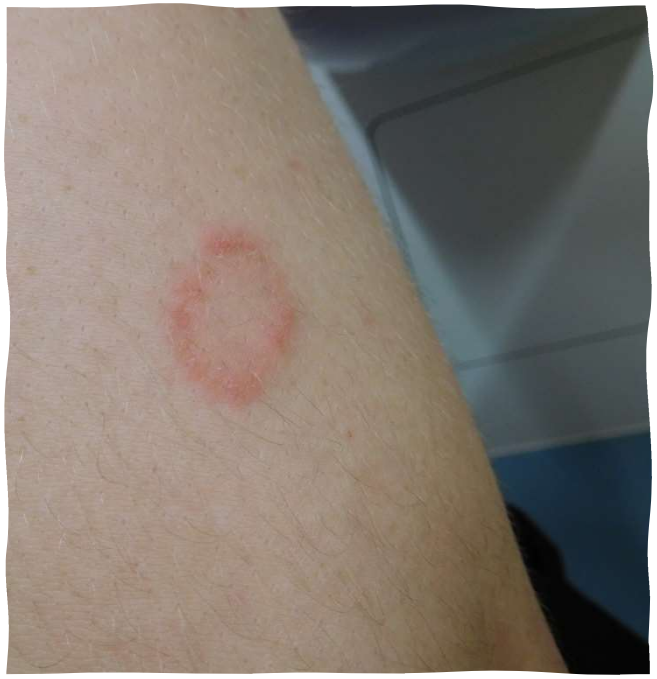
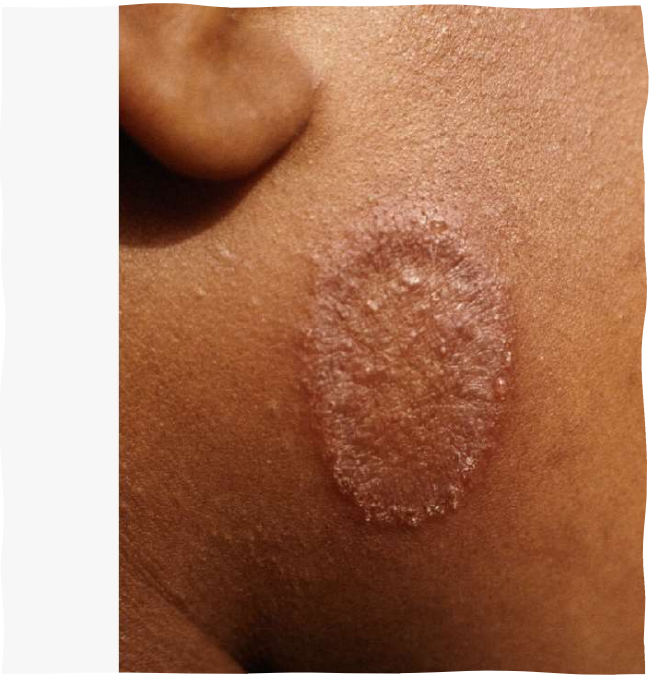
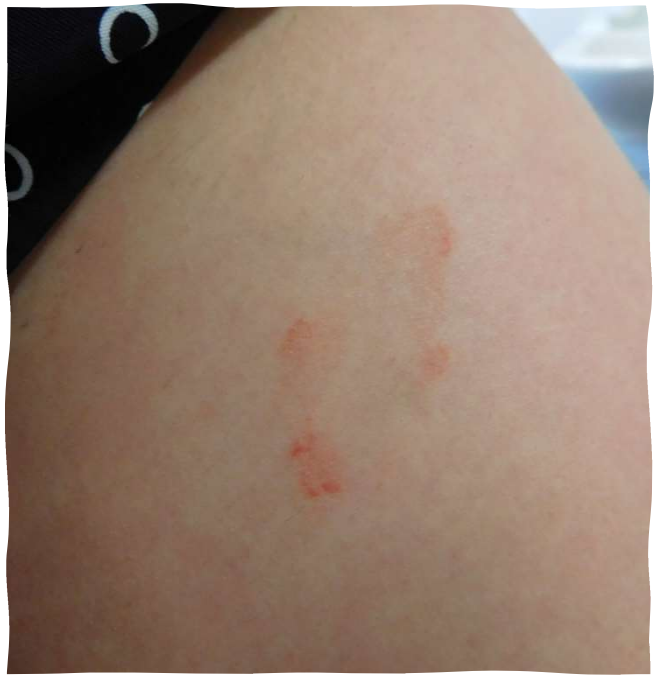


Some other useful tips

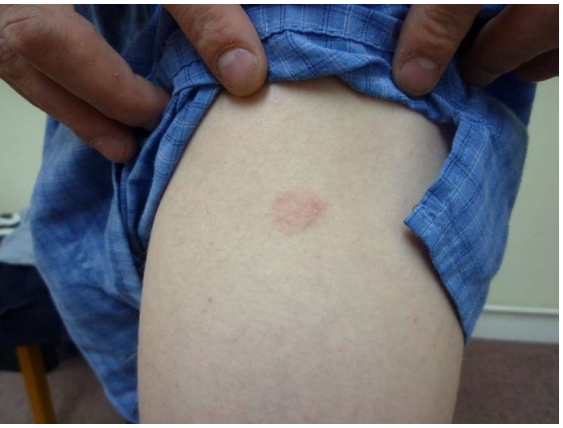
Scaly red plaques

Ringworm



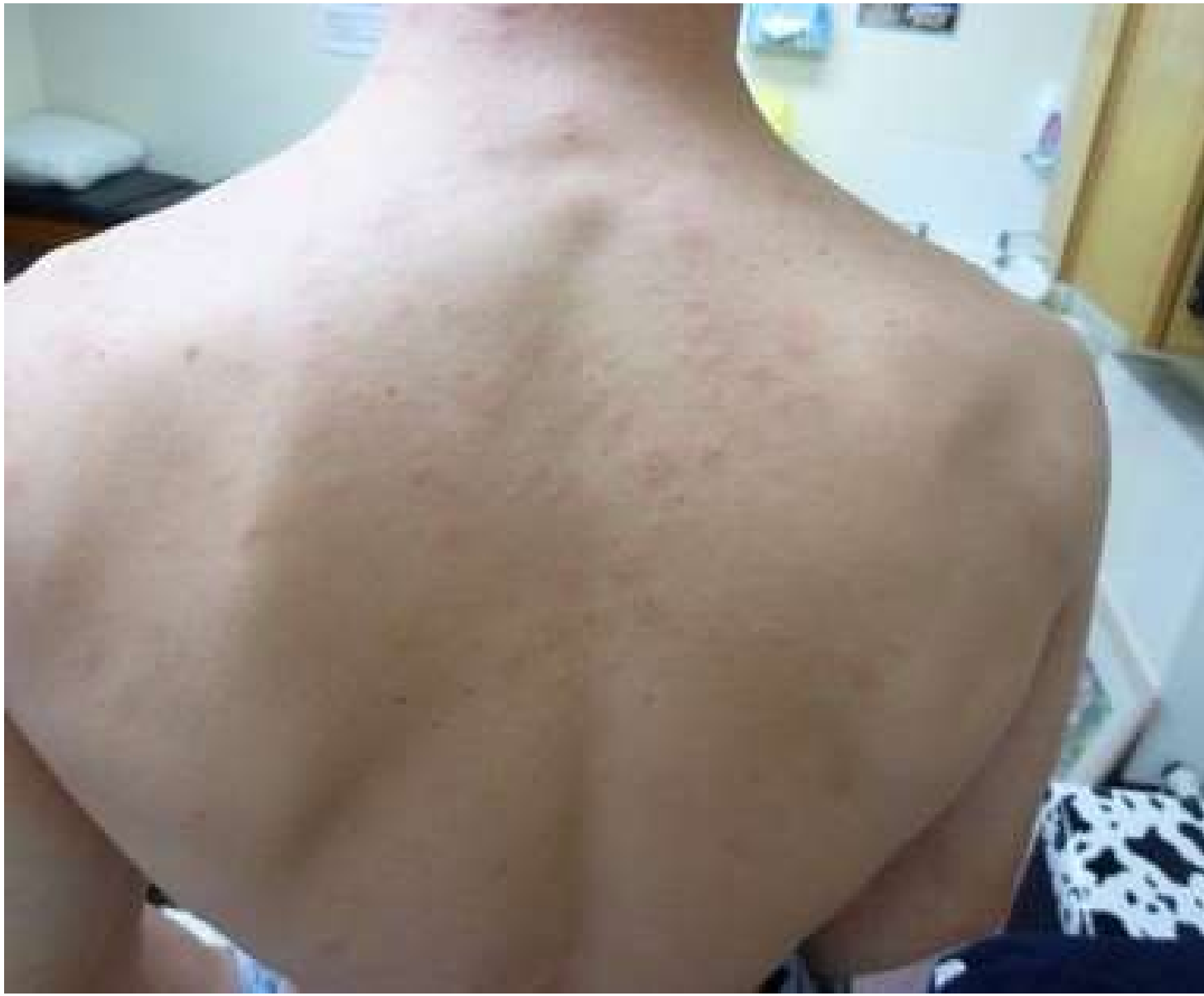




Ringworm

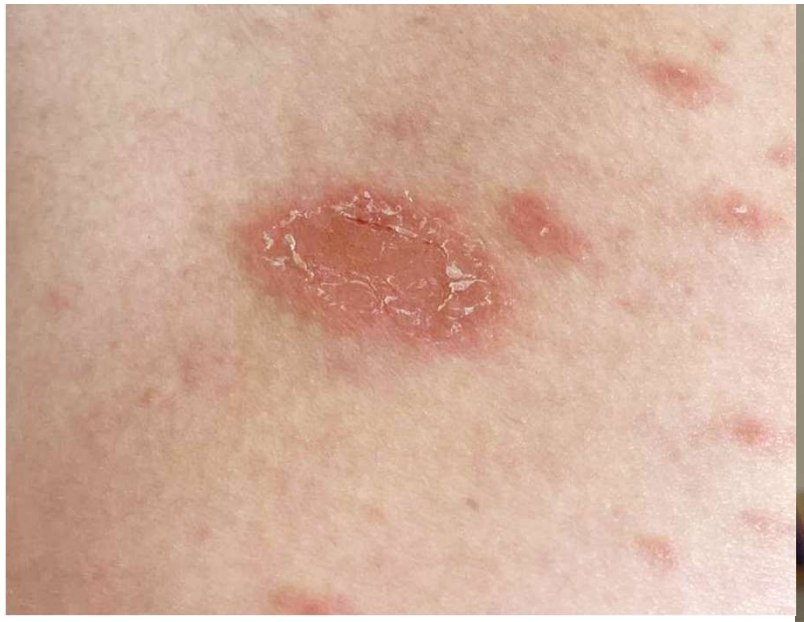


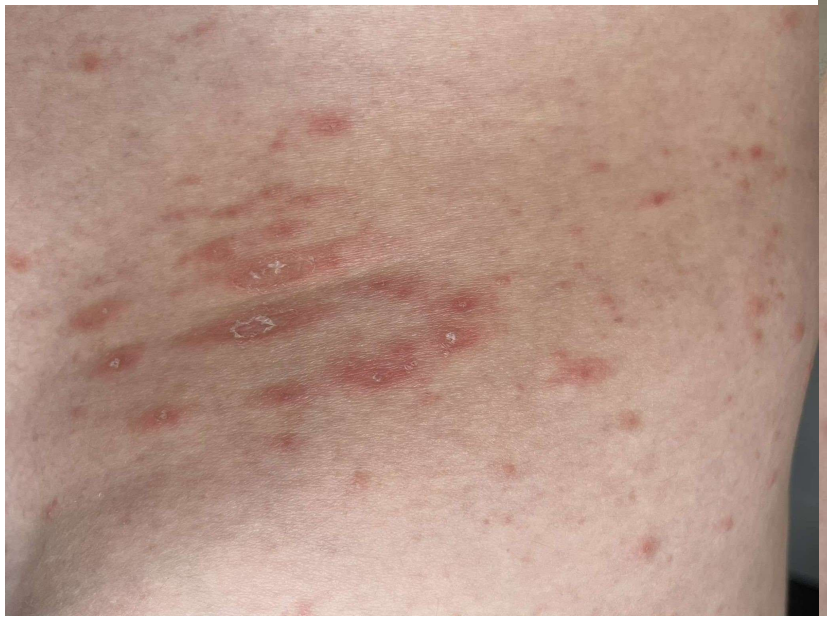
Pityriasis Rosea

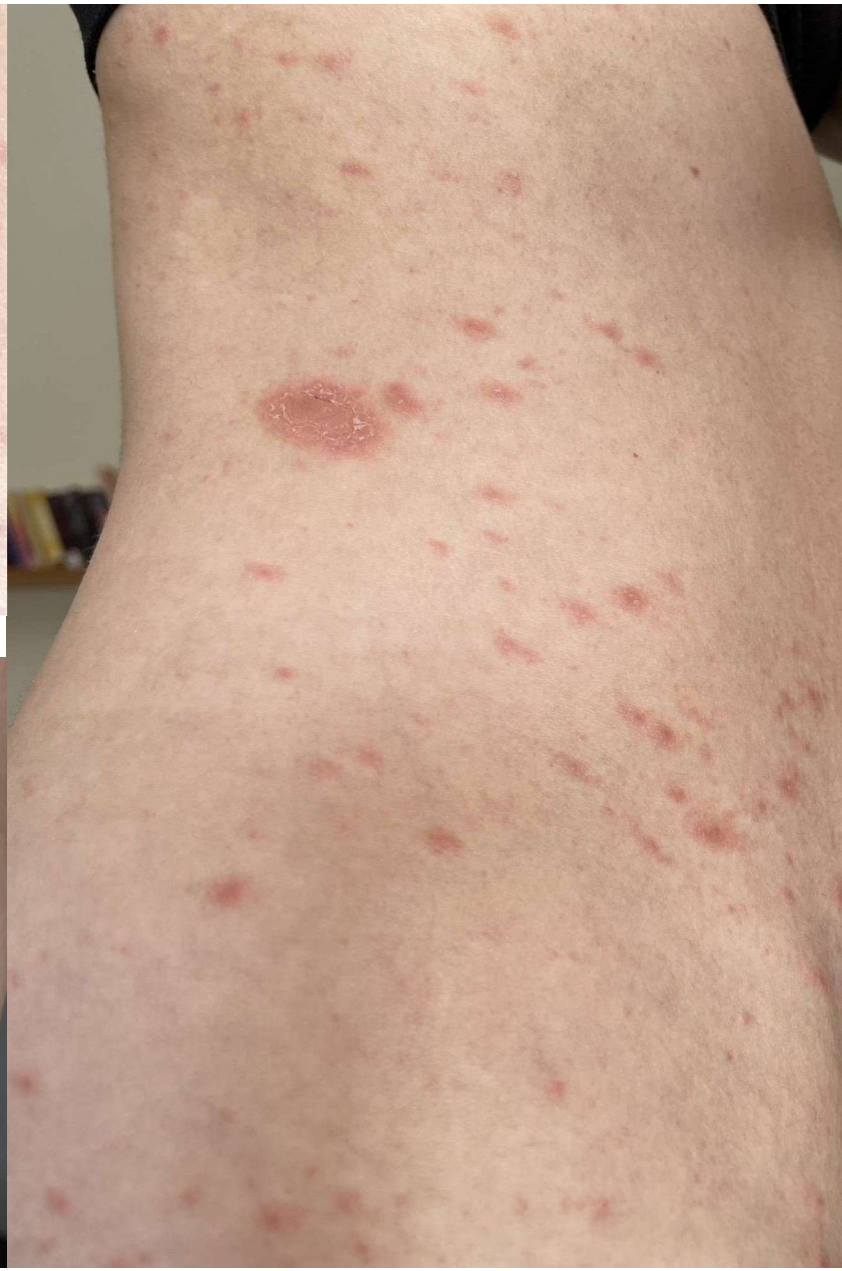
Starts with a lesion that looks like ringworm, then gets this rash a week later.



Pityriasis Rosea







Pityriasis Rosea T/F

The rash is in the distribution of a Christmas tree on the back

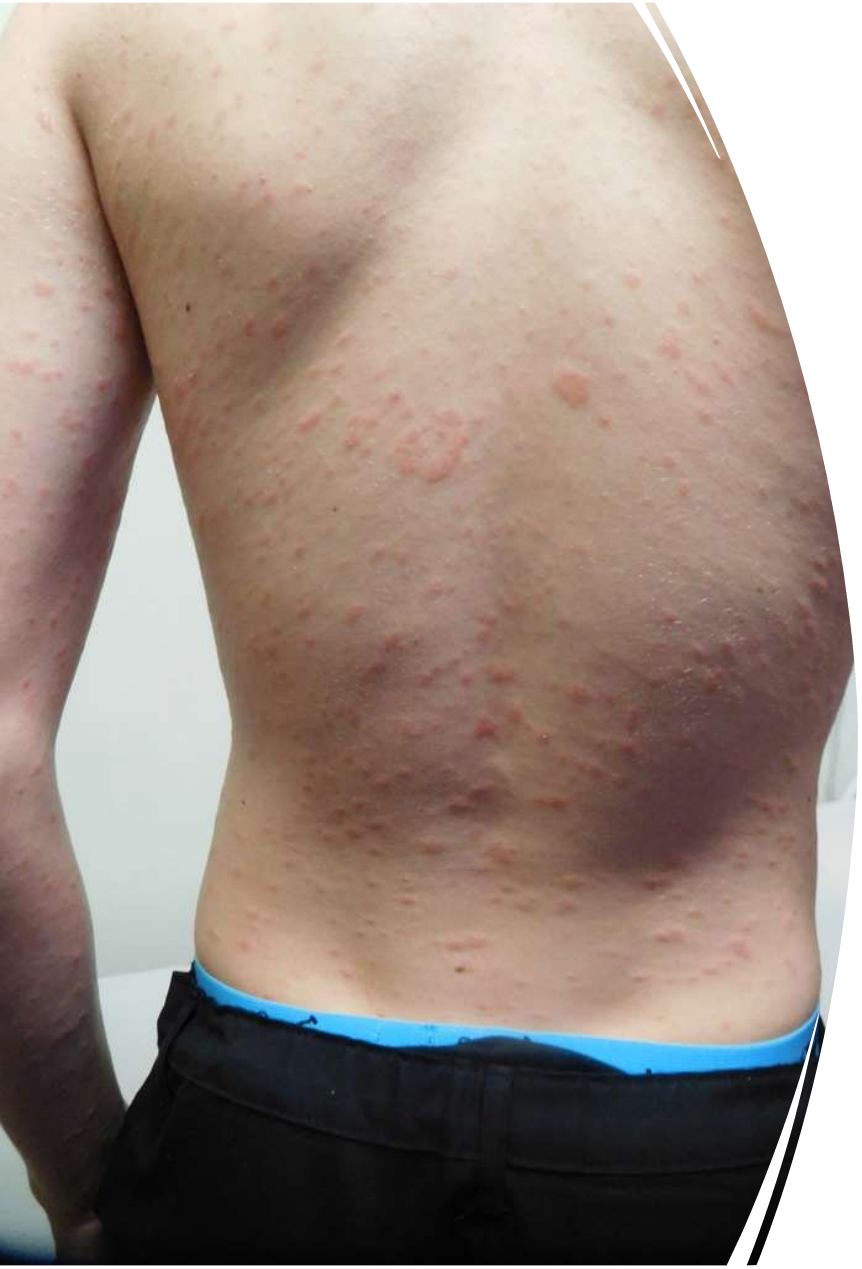
Well now…

The rash should go away on its own

TRUE

The rash clears within a couple of weeks

FALSE (takes 6-10 weeks)



Pityriasis Rosea T/F

It is asymptomatic for the majority of people, once the rash is visible

TRUE (25% may have itch though, and many have a prodrome)

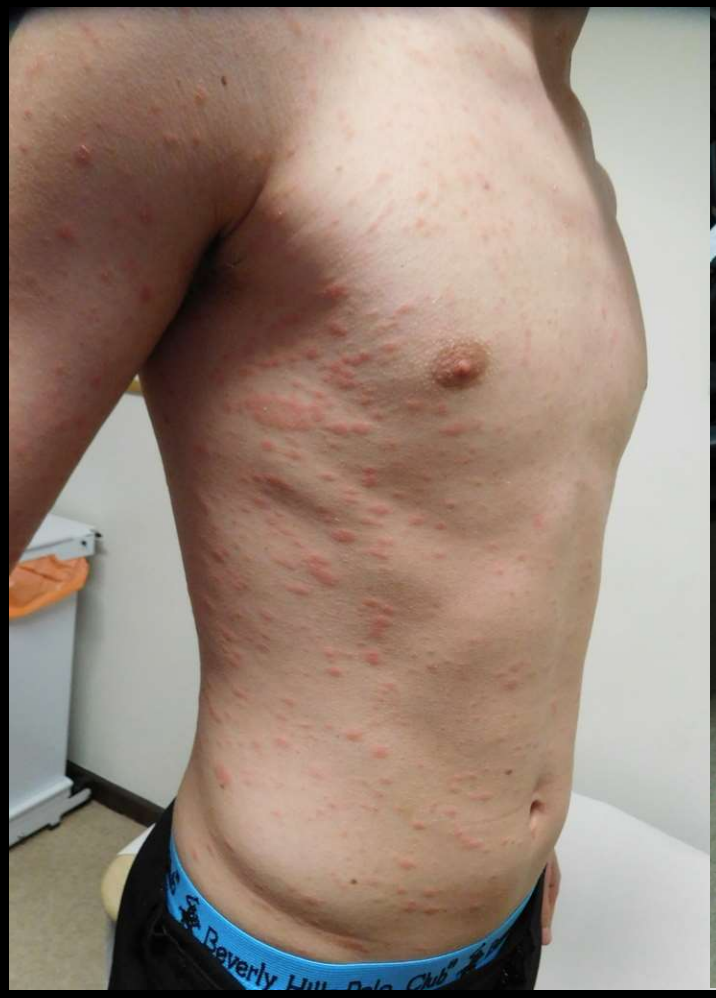
Pityriasis Rosea is absolutely safe in pregnancy

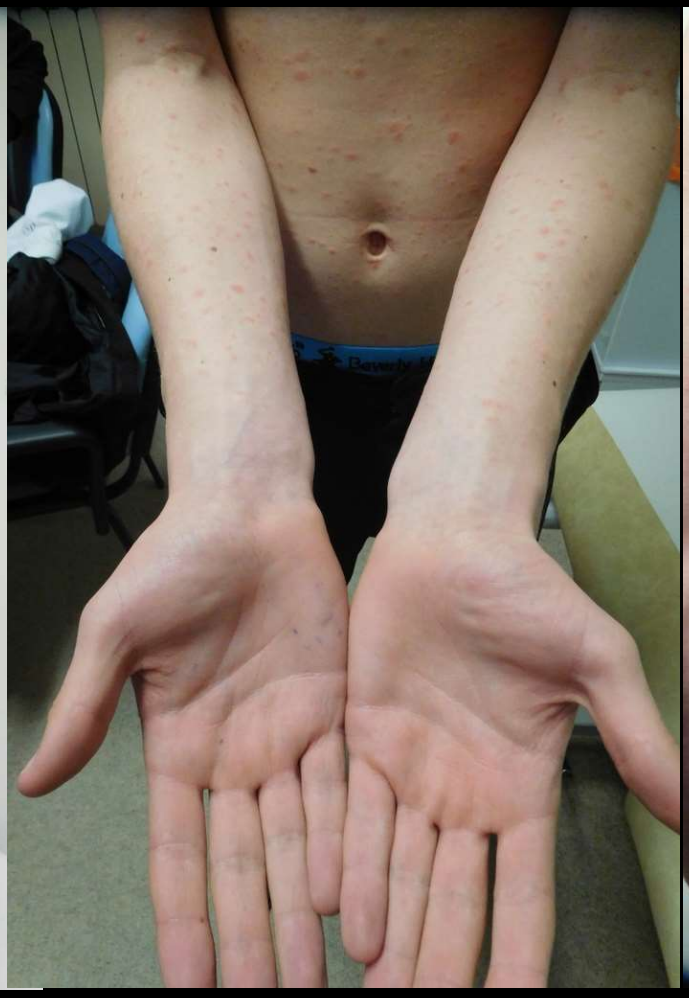
FALSE – the vast majority are fine, but association with prem delivery and late miscarriage/fetal loss

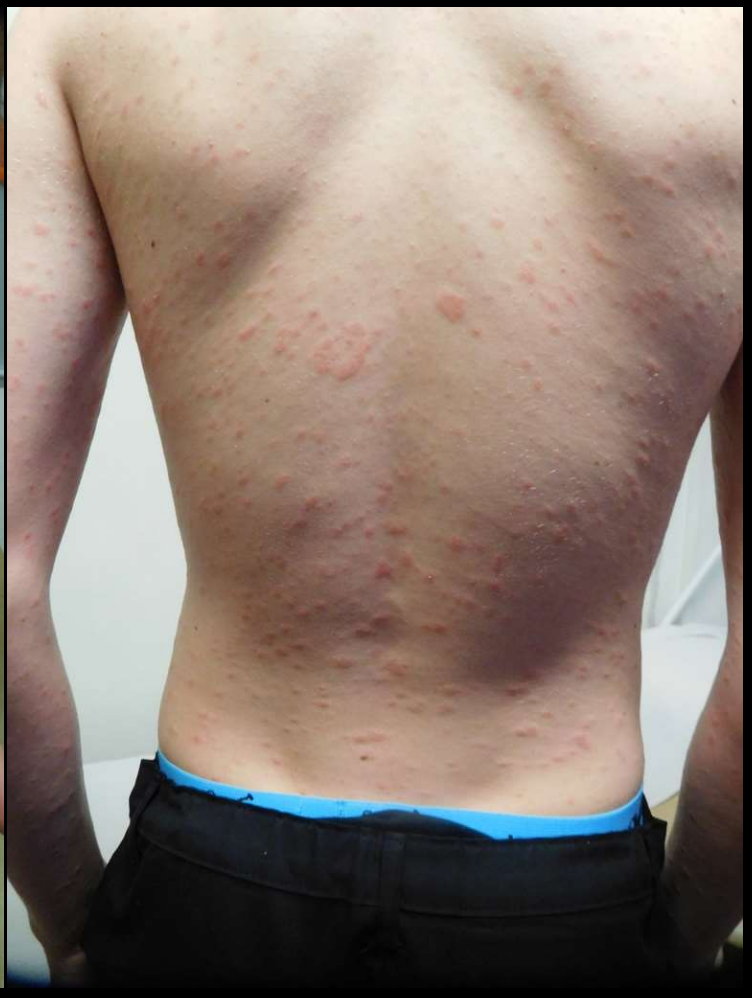
Pityriasis Rosea never recurs

FALSE (but very low rate of recurrence)

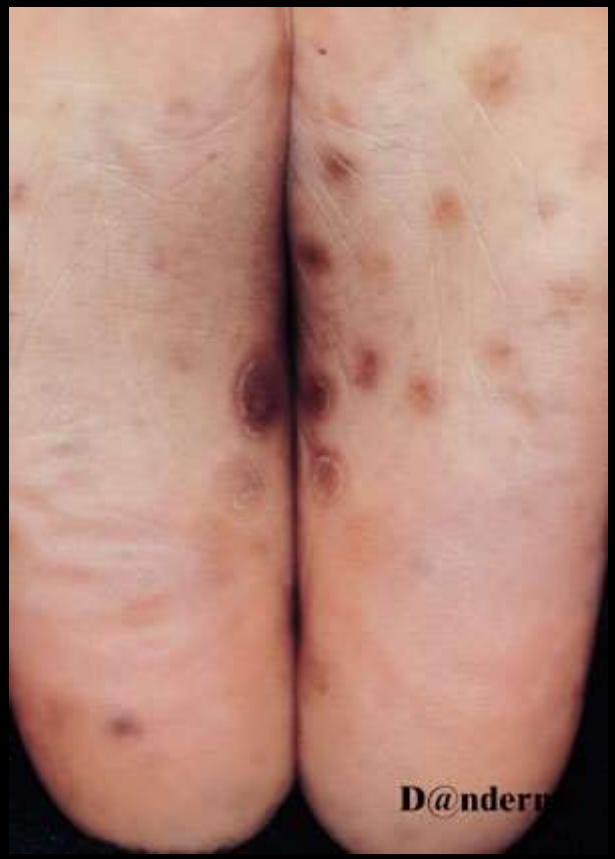
There's something else we need to check…

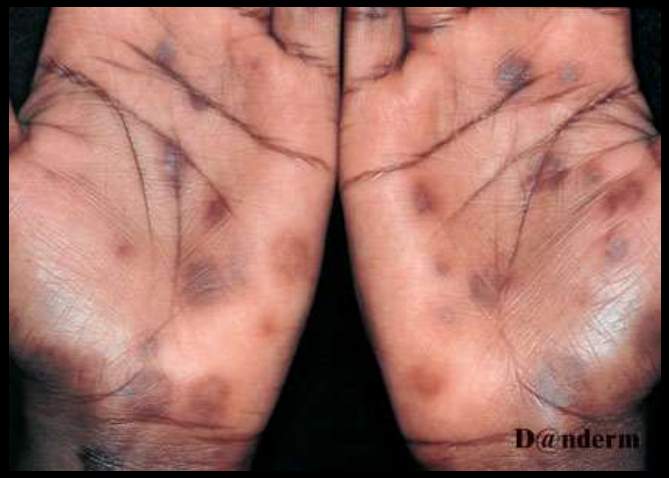


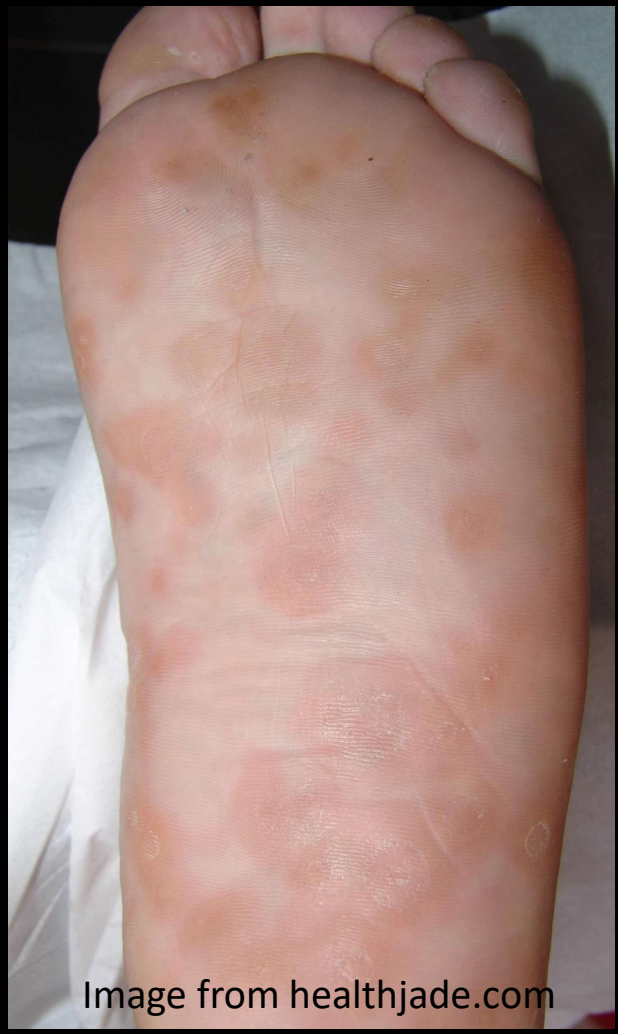


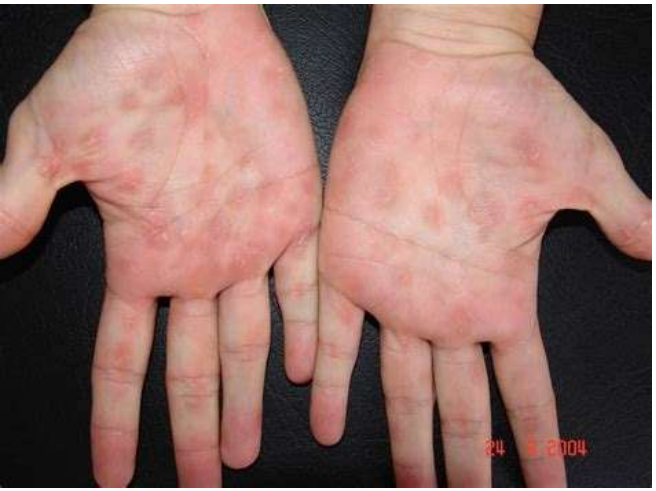


Secondary Syphilis

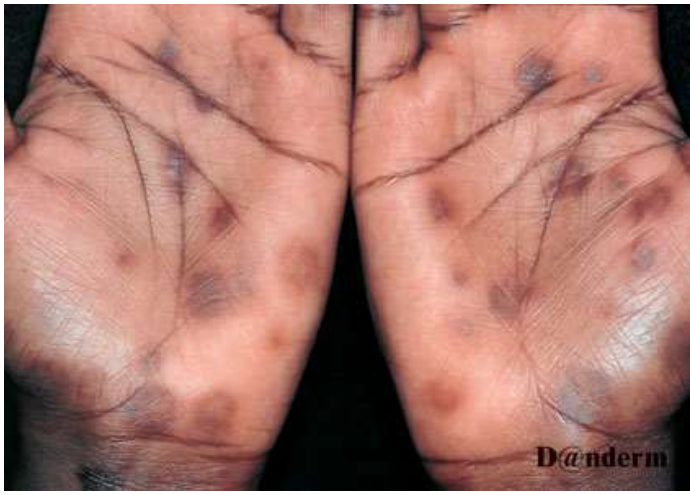








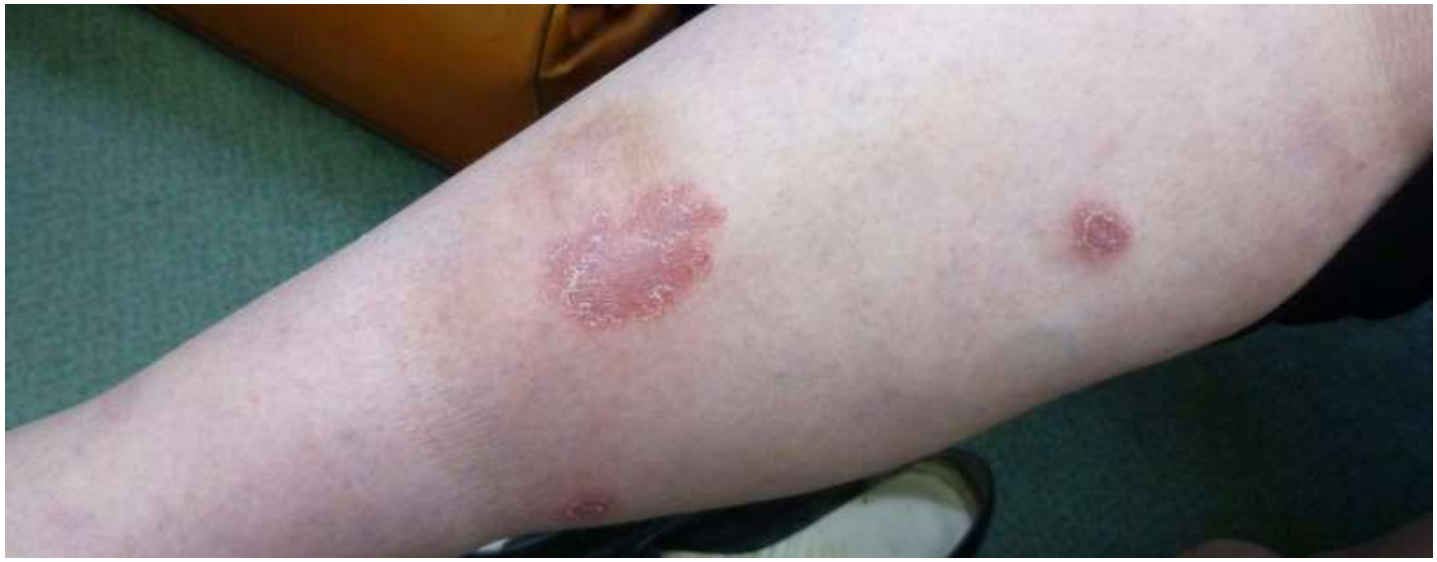
Secondary Syphilis



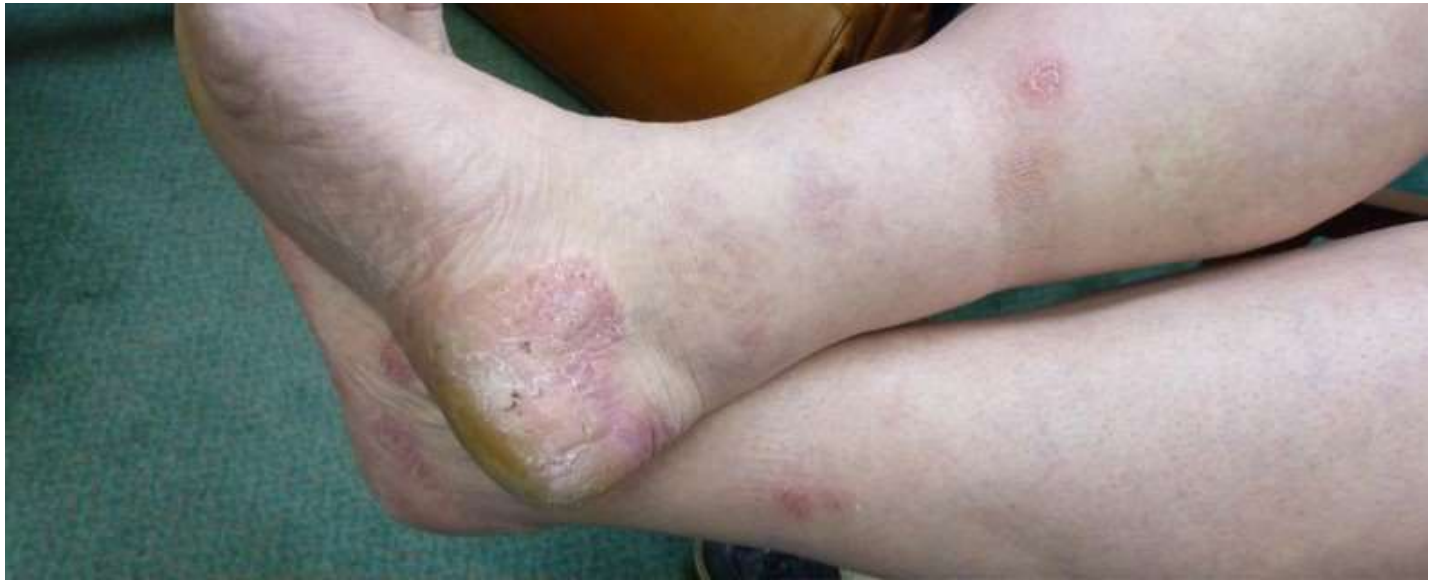
Syphilis rates are rising

Check palms and soles

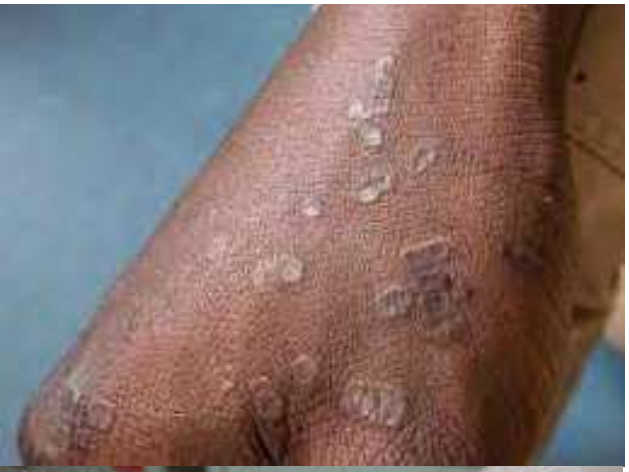
Don’t trust anyone!

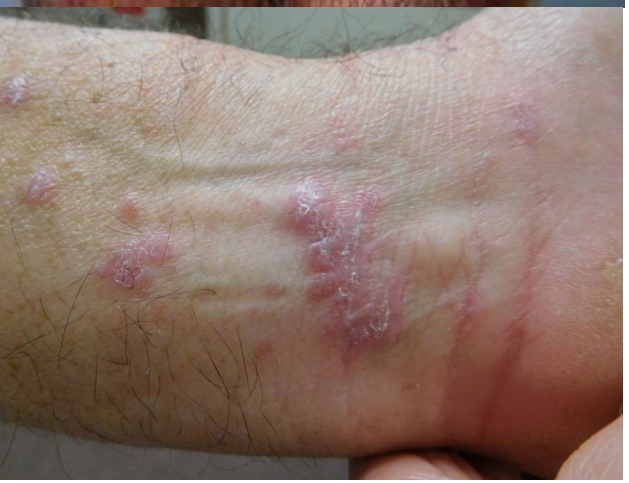


Psoriasis



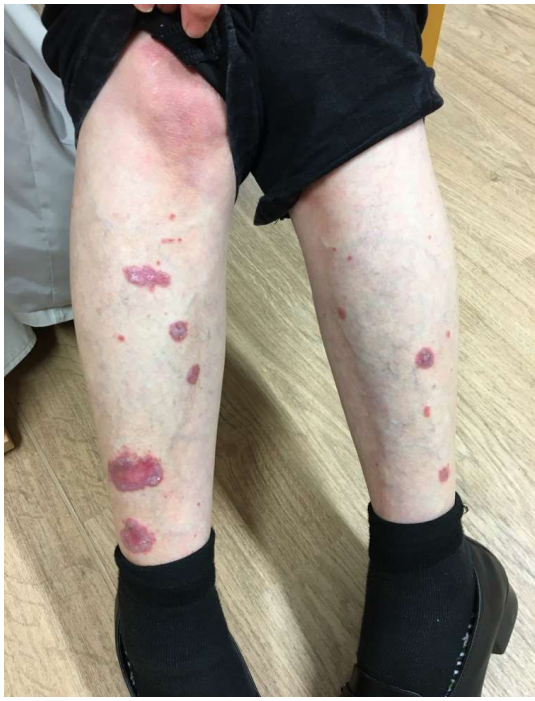
Check elsewhere
Well defined red scaly lesions
Ask about bits, bumcracks and belly buttons

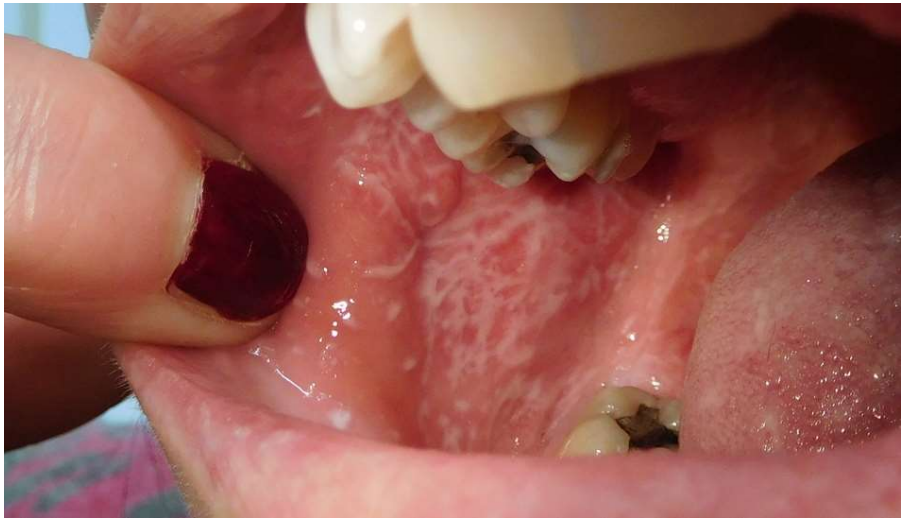


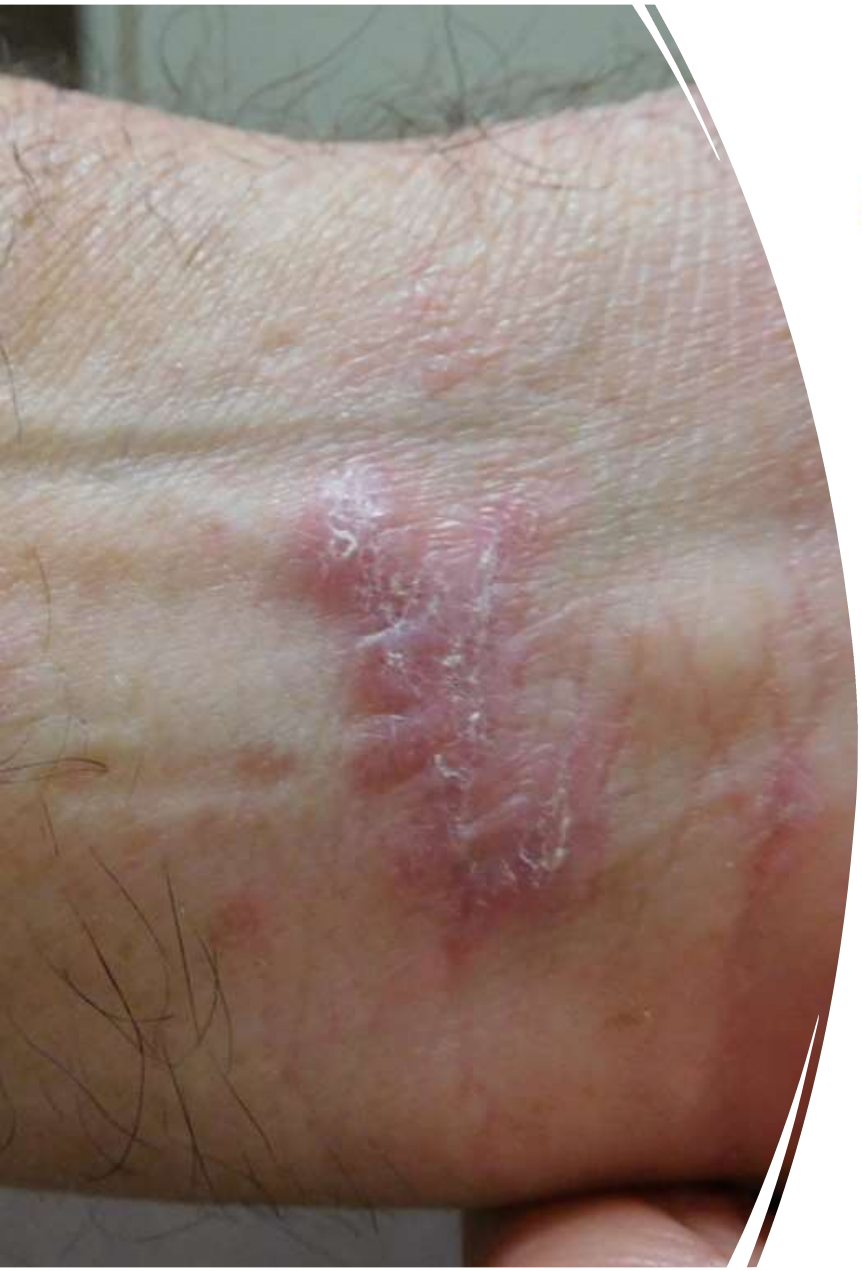


Lichen Planus

Purple polygonal pruritic papules
White Wickham's striae on surface
Koebnerises into scratches and scars
Dermoscopy is diagnostic
Check elsewhere…

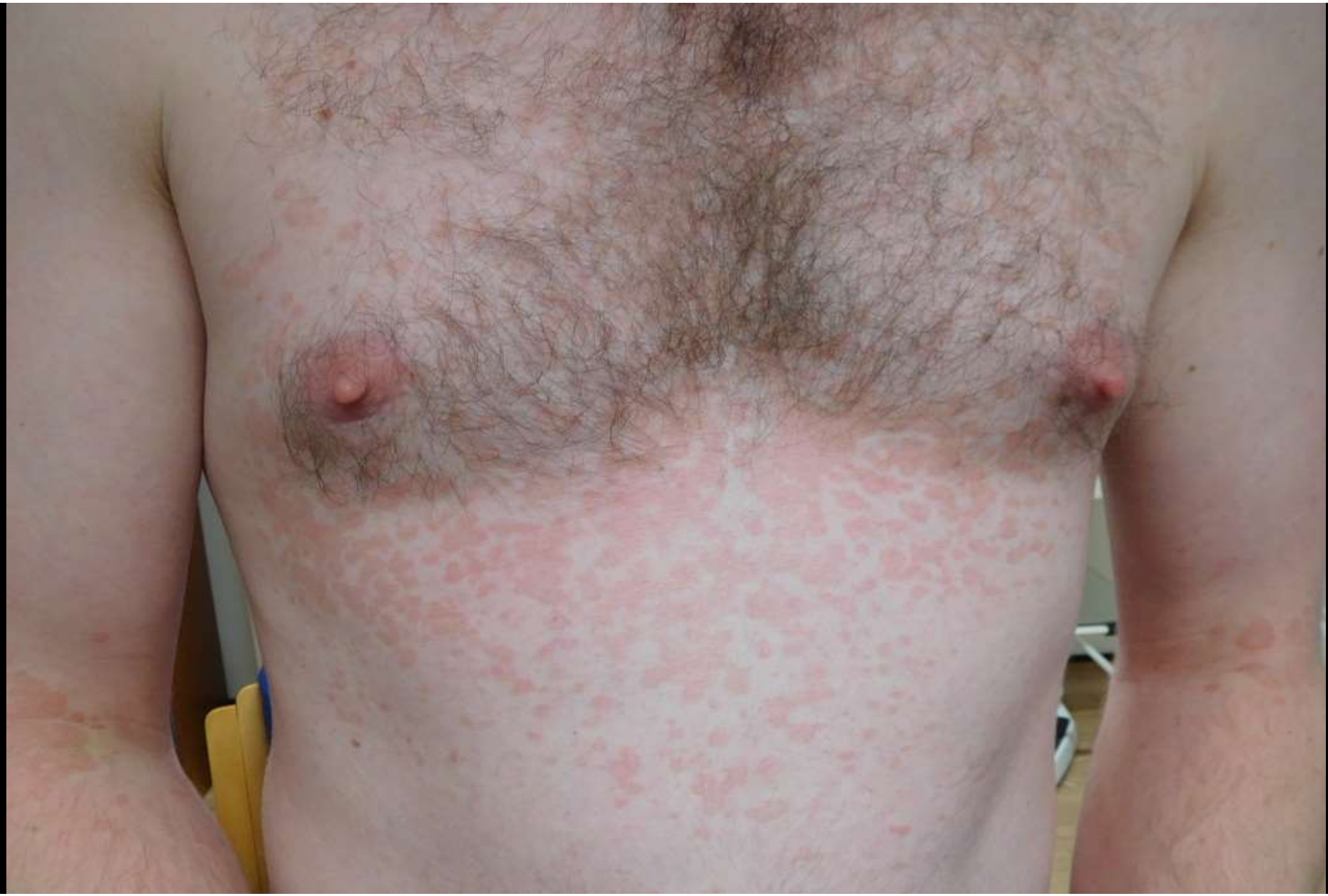


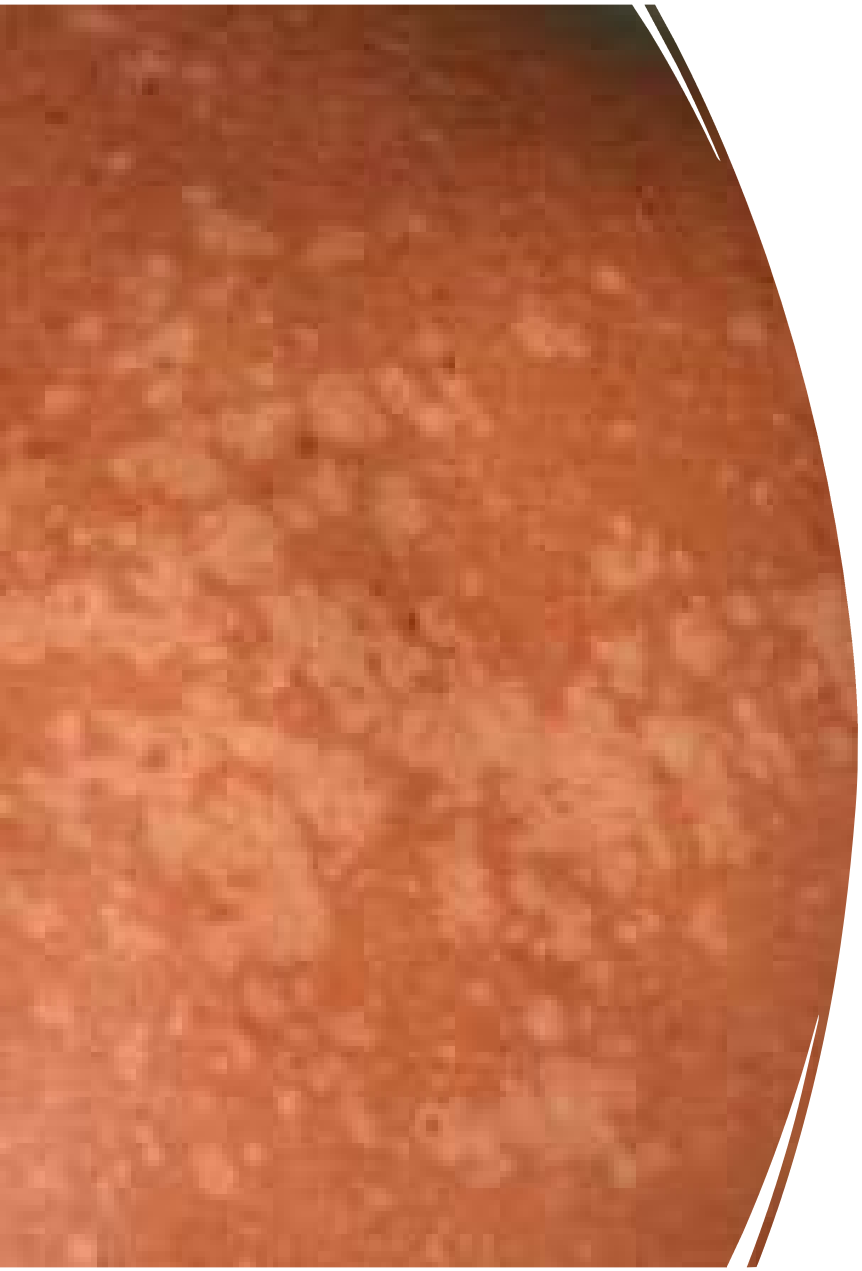




Lichen Planus

- Itchy, and easily mistaken for fungal infection early on
- Usually bilateral, symmetrical (unlike fungus)
- 50% of patients clear in nine months / 85% by 18 months.
- LP can relapse in 20% of cases
- Treat with potent or superpotent topical steroid
- Needs urgent derm referral if they have any sign of:
  - Scarring alopecia
  - Nail destruction
  - Ulceration, usually of genitals





Pityriasis Versicolor T/F

Pityriasis Versicolor is caused by a yeast infection

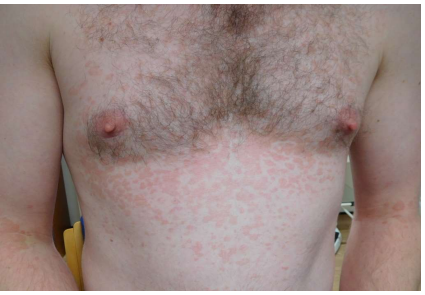
TRUE

It can be treated with topical azole antifungals

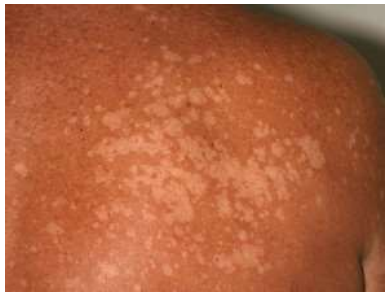
TRUE

Oral ketoconazole is a good choice

FALSE (oral ketoconazole has been withdrawn)



Pityriasis Versicolor



Pink types:

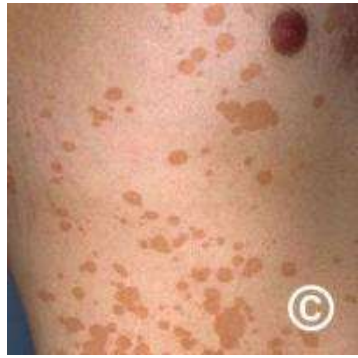
It induces inflammation

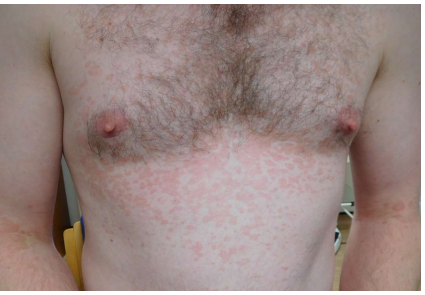
Pale type:

Malassezia produces azelaic acid which causes the depigmentation

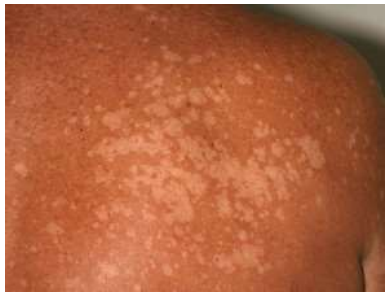
Dark types:

It induces enlarged melanosomes in the basal melanocytes



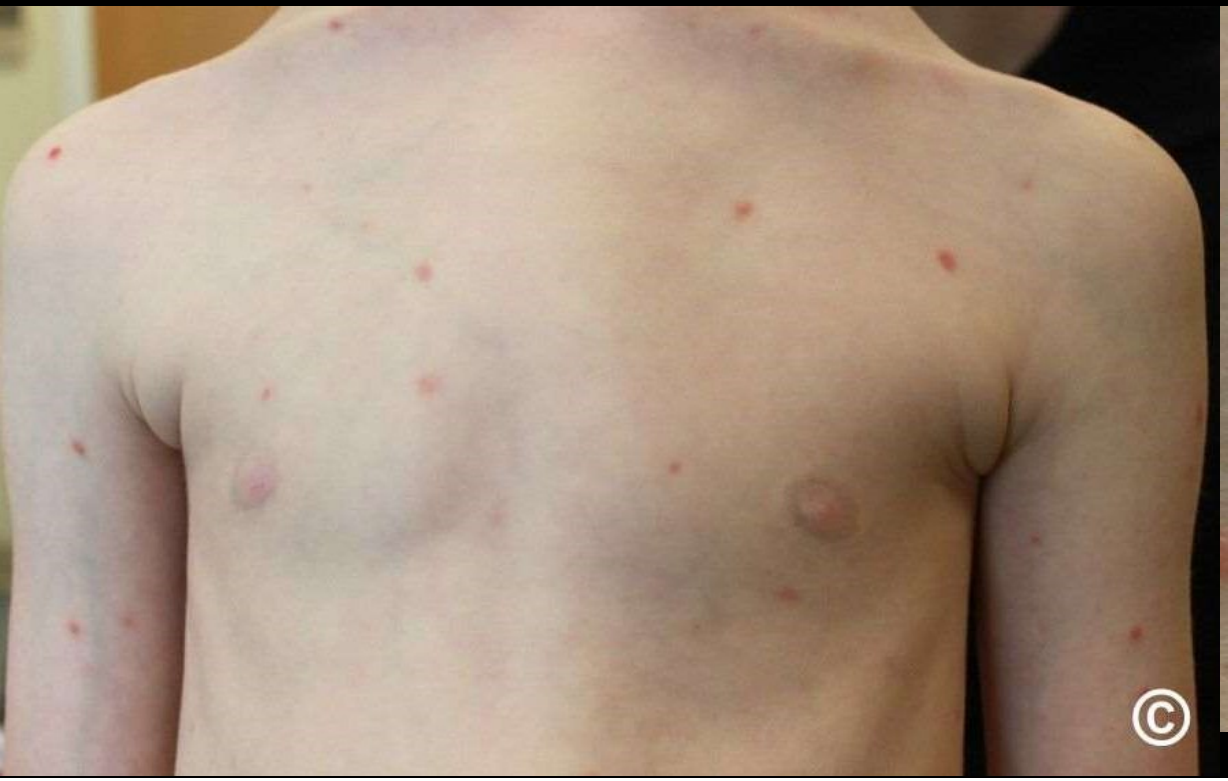


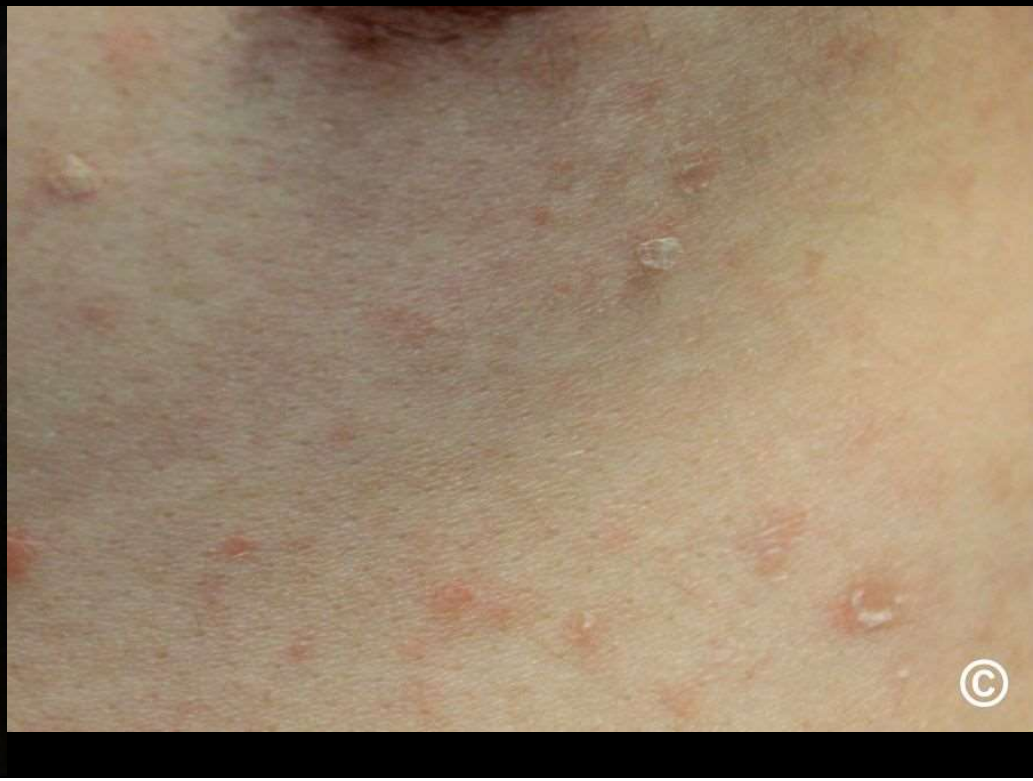
Pityriasis Versicolor top tips

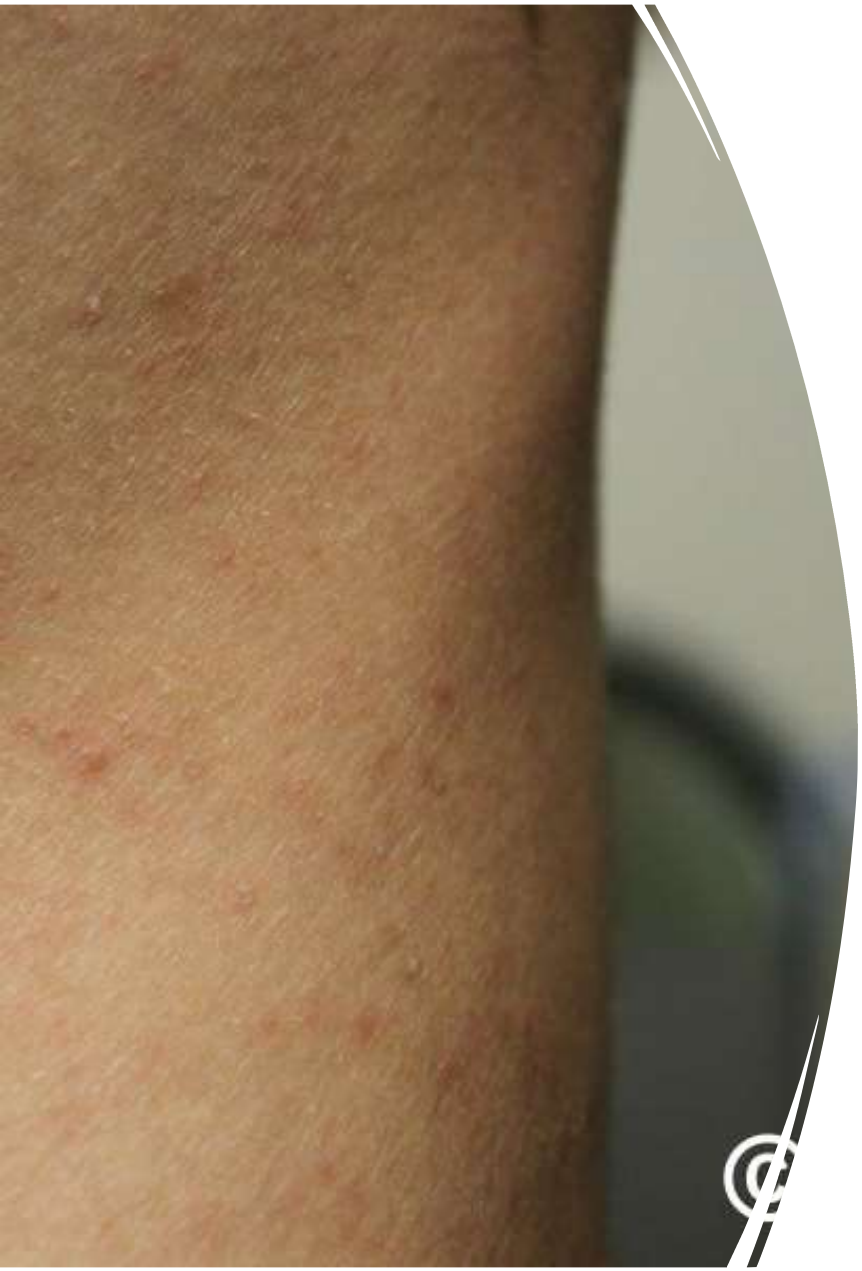


- It only needs treating if there is active infection – indicated by scale
- It takes a long time for dyspigmentation to resolve completely
- A suntan will make it more obvious, even if it is not still active
- Recurrence is common
- Topical antifungal shampoos (ketoconazole, Selsun, Dercos) can be used
- Oral itraconazole works well:
  - 200mg od for 7 days (as in BNF)
  - 400mg stat, get sweaty, let the sweat dry and then shower it off, repeat after a week (off licence)
- Antidandruff shampoo can help longer term

A healthy young boy
Gradual onset, asymptomatic spots with scale





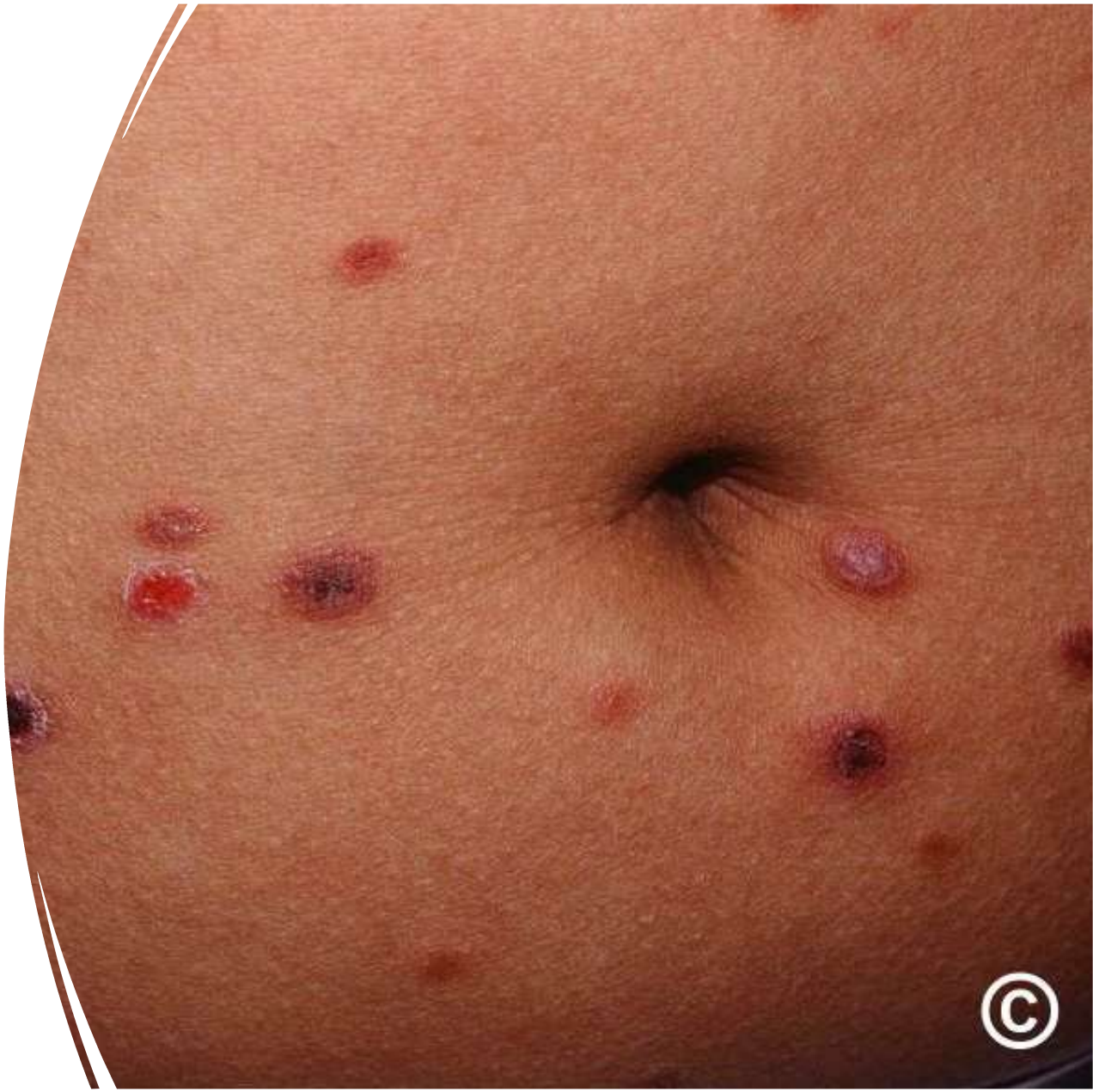


Pityriasis Lichenoides Chronica

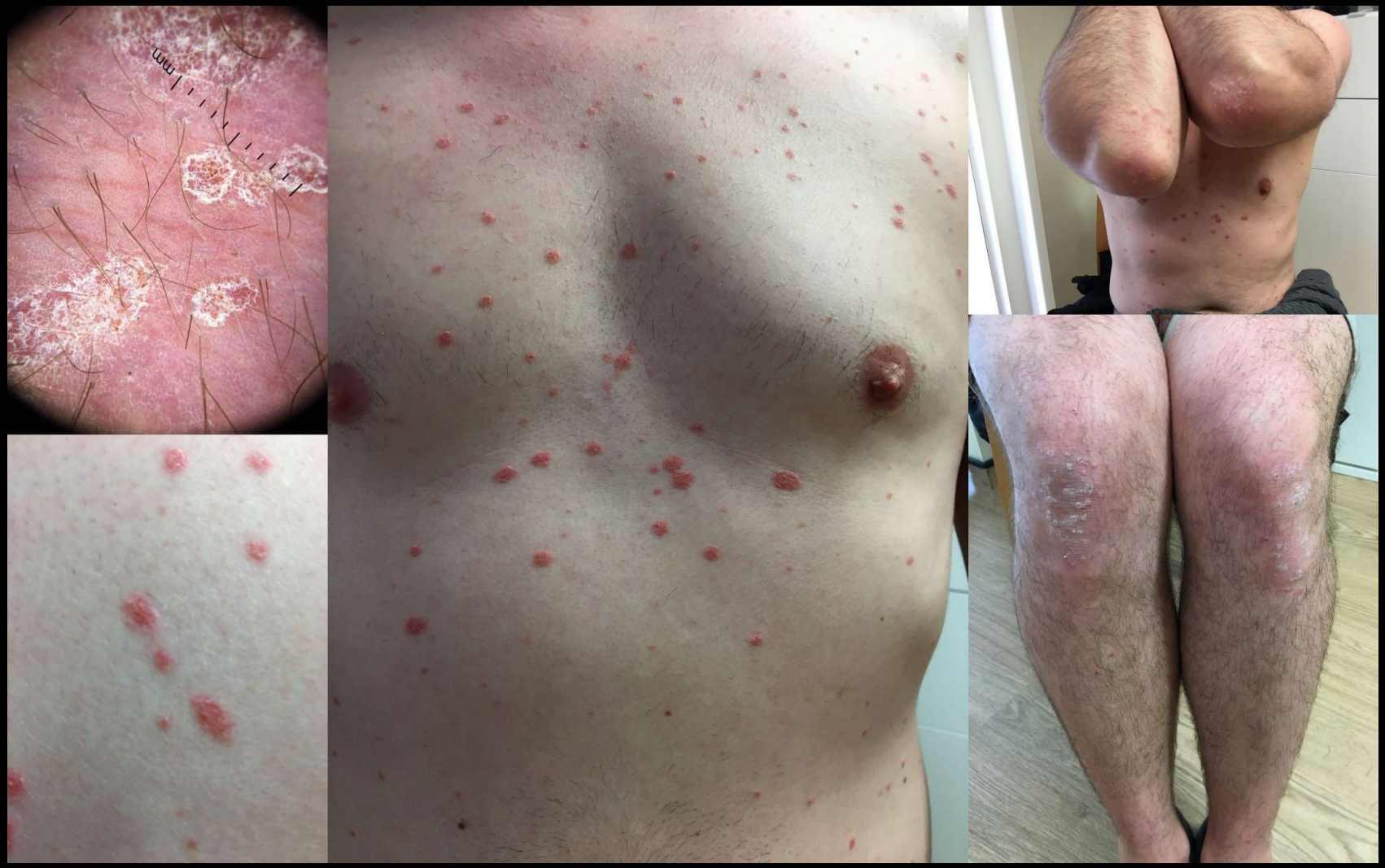
- Starts as pink spots that soon develop a single, mica-like, scale
- Scale comes off to leave a brown-purple area
- Lesions at different stages simultaneously
- Asymptomatic, self limiting
- Lasts for months to years
- Often improves with sunlight
- Very common but usually not diagnosed!

PLEVA

- Pityriasis lichenoides et varioforma acuta
- Much more sudden in onset
- Trunk, buttocks, proximal limbs (spares face and extremities)
- Papule > vesicle > crust > scar
- Mimics chicken pox
- Lasts a few weeks



Sudden appearance of multiple small scaly plaques

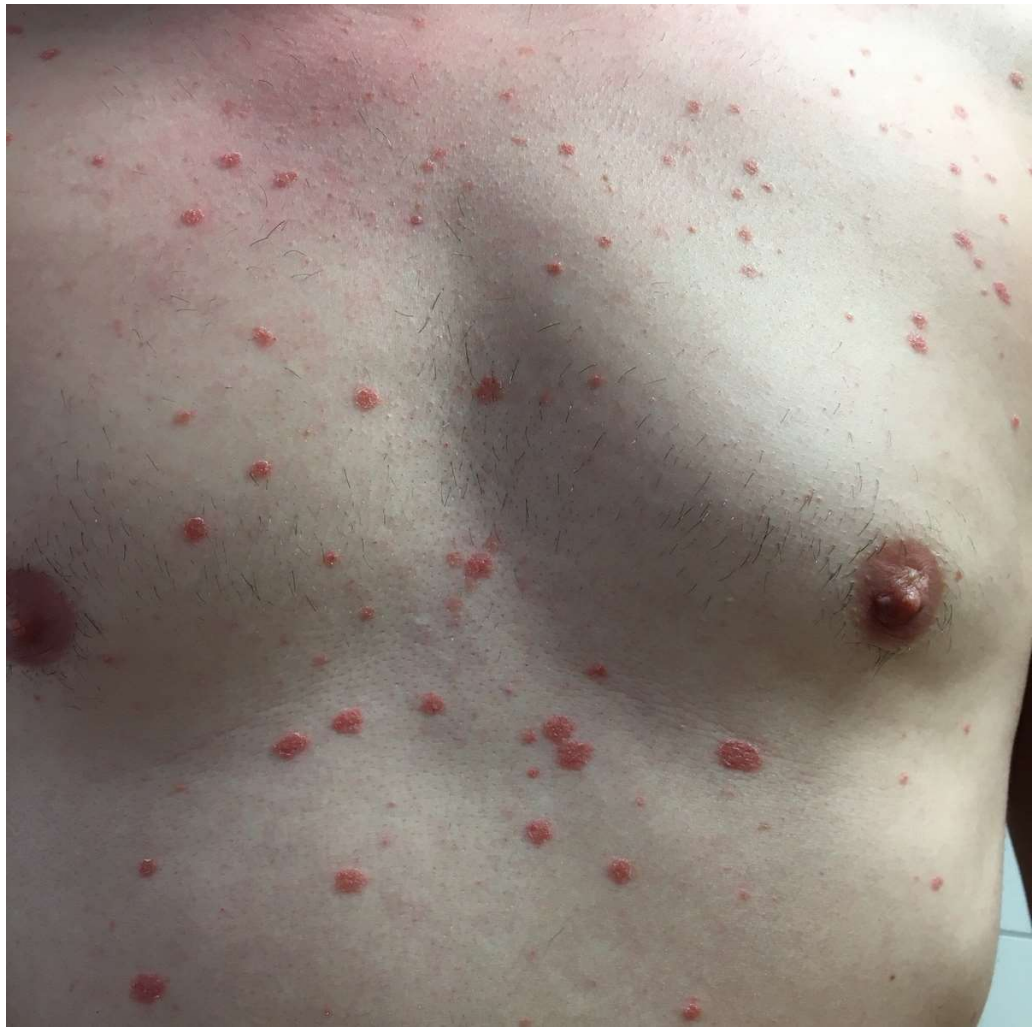


Guttate psoriasis

An important differential diagnosis

Exorex lotion and sunlight can help (not sunbeds!)

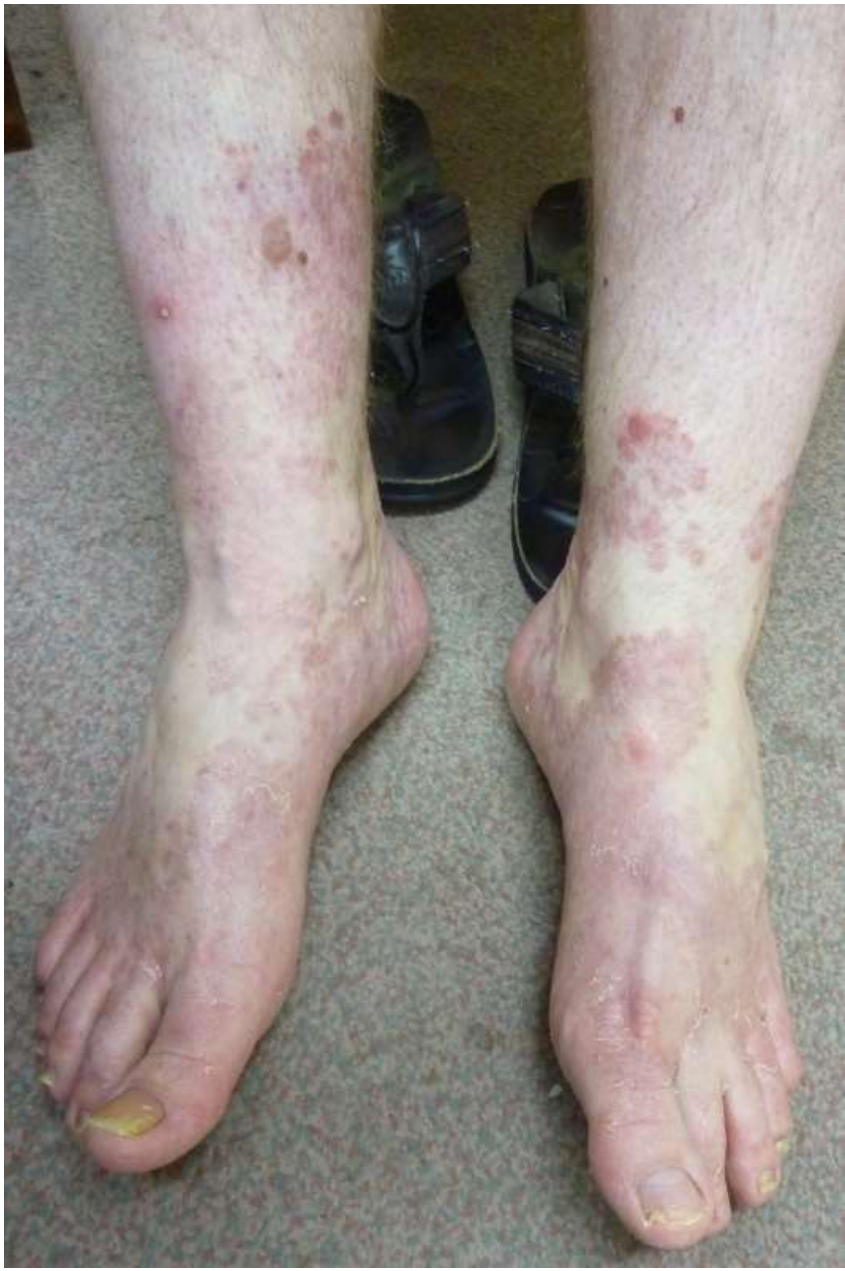
(I often use Enstilar but not licensed for guttate, as it has potent steroid and you have to apply it to skin between lesions too)



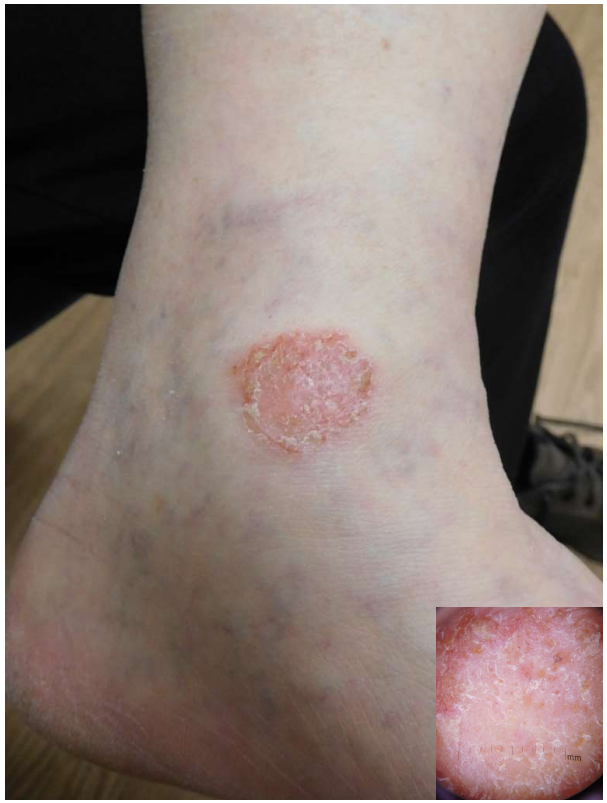
Tinea incognito

Had eczema on his lower legs, and has been using OTC eumovate. Stops it itching but it is slowly spreading

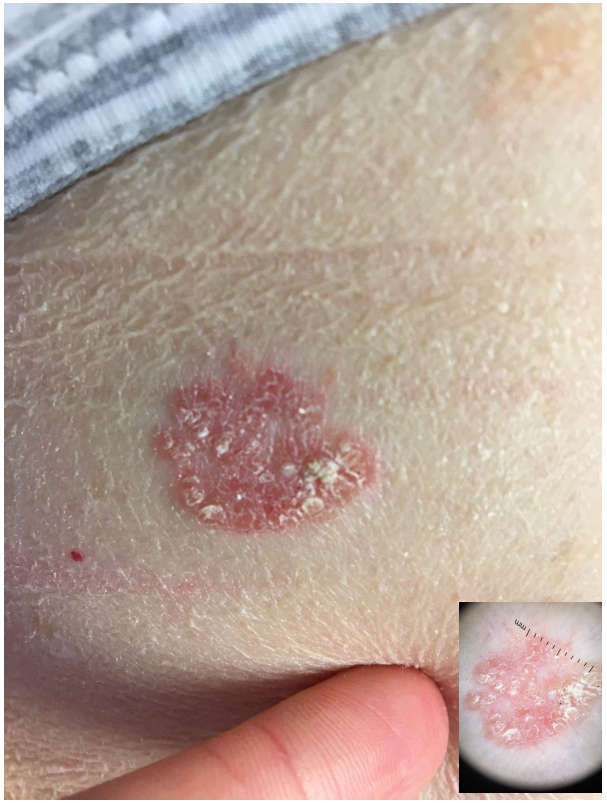
- This is why it's best to try antifungal treatment first if uncertain diagnosis
- Combined preparations (daktacort, canesten HC, trimovate) are NOT suitable for fungal infections



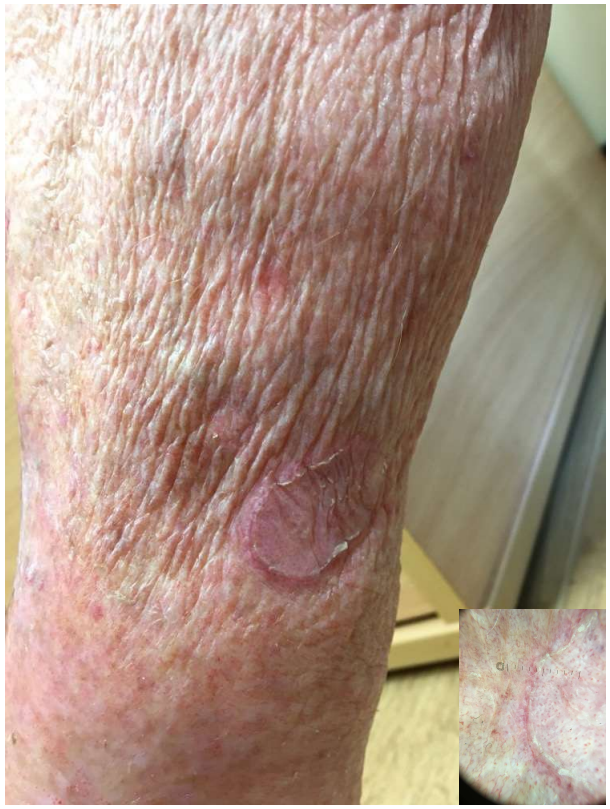
Solitary scaly plaque on a leg



Discoid Eczema

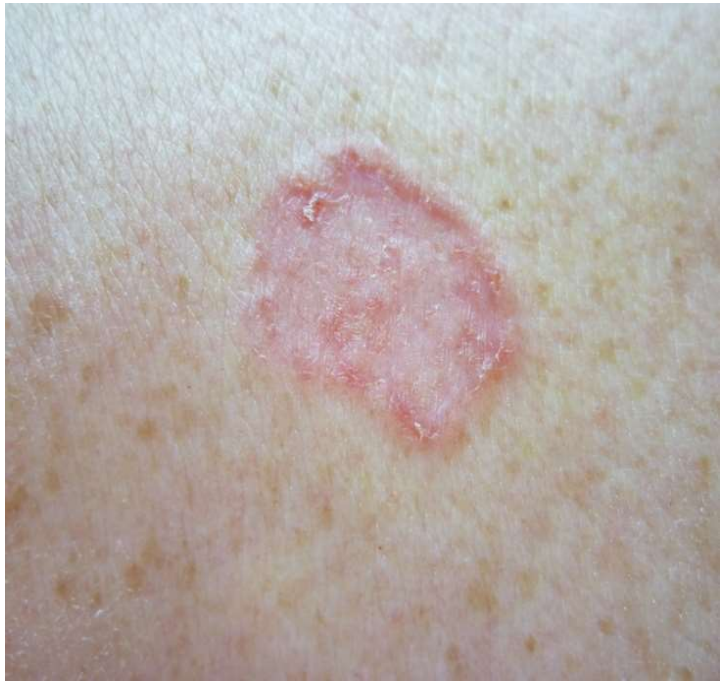


Bowen's

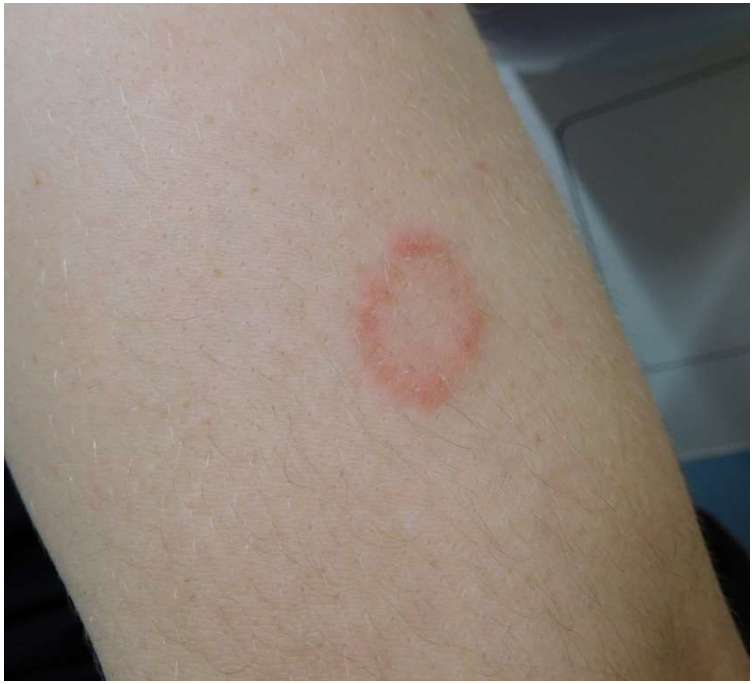


Porokeratosis

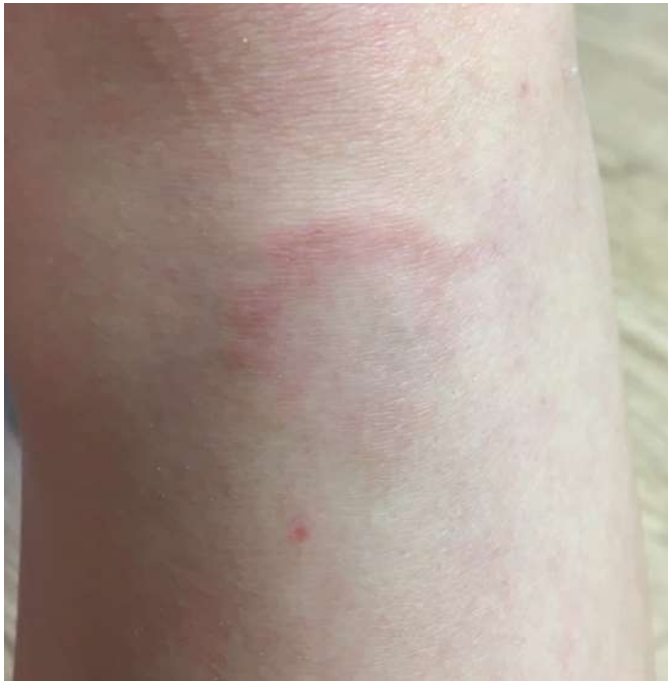
Solitary scaly plaque on a leg



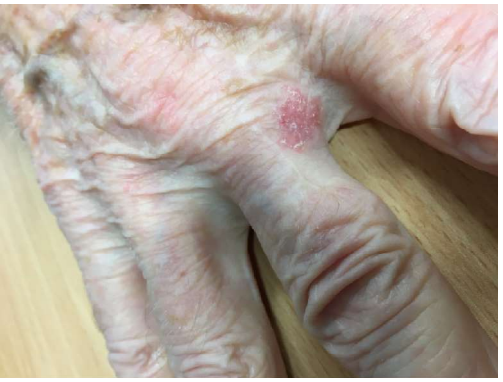
Superficial BCC



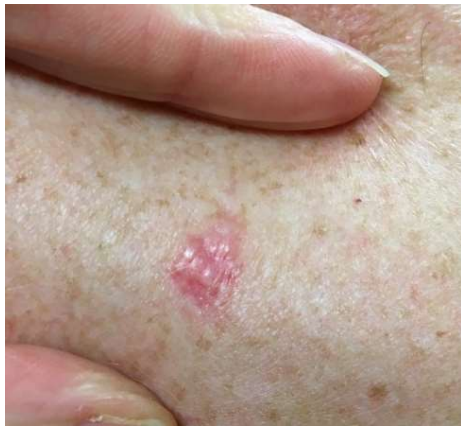
Ringworm



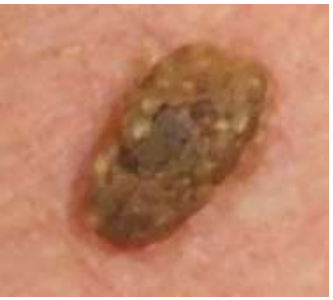
Granuloma Annulare



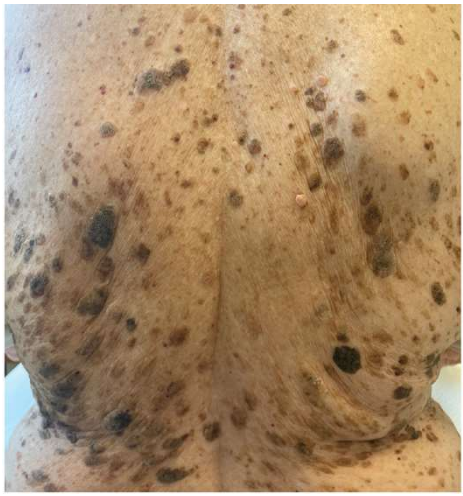
BCC / Bowen's / skin cancers



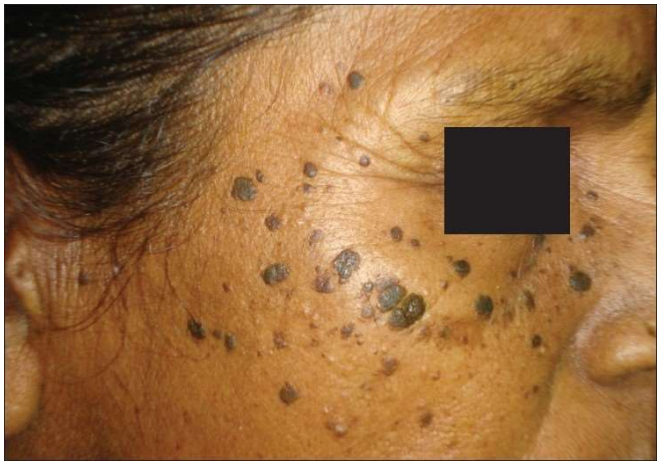
- BCC often looks shiny on the surface / pearly if stretched
- A non healing ulceration for 3 weeks plus suggests BCC
- Surface vessels are commonly seen on BCCs
- Bowen's is scaly and looks like a patch of eczema but doesn't clear with antifungals or steroids
- If in doubt, topical antifungals first (bd for 3 weeks)
- Then potent topical steroid (prescriber)
- Then consider Bowen's and skin cancers
- What is the commonest benign lesion that is mistaken for a skin cancer?



Seborrhoeic keratoses

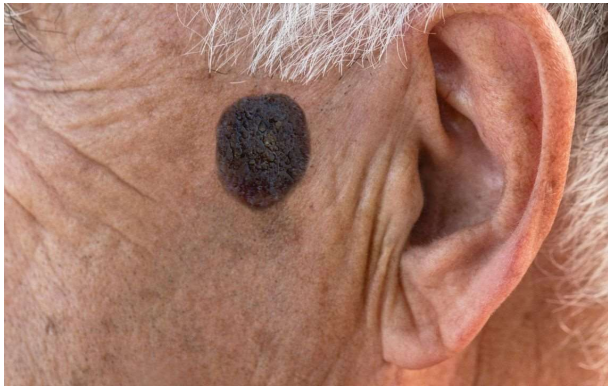


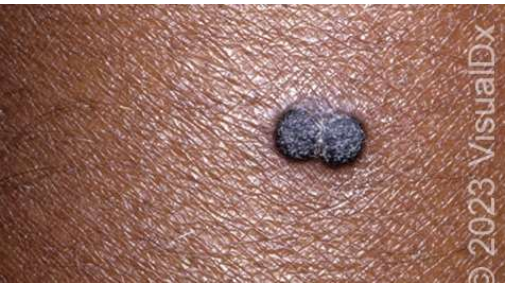
- Very common benign lesions
- Generally not related to sun damage
- Harmless “barnacles”



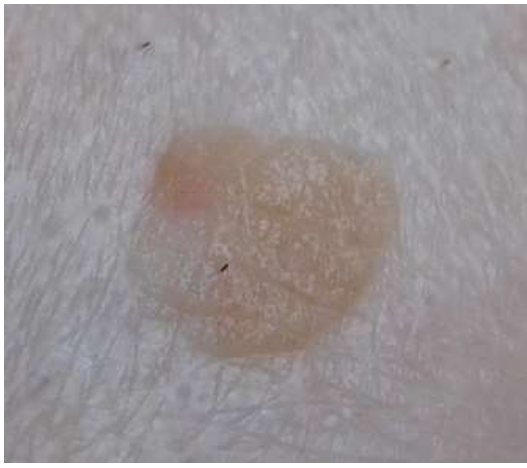
- BUT

- They often fall foul of the ABCD rule for melanoma
- Commonly mistaken for melanomas
- Commonly referred on 2ww



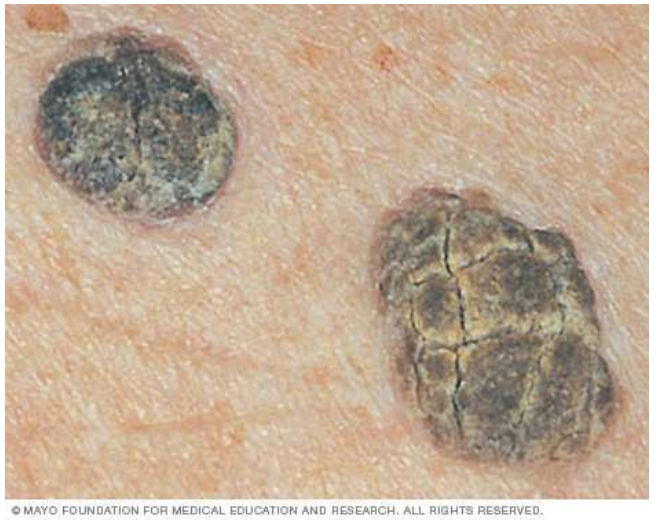


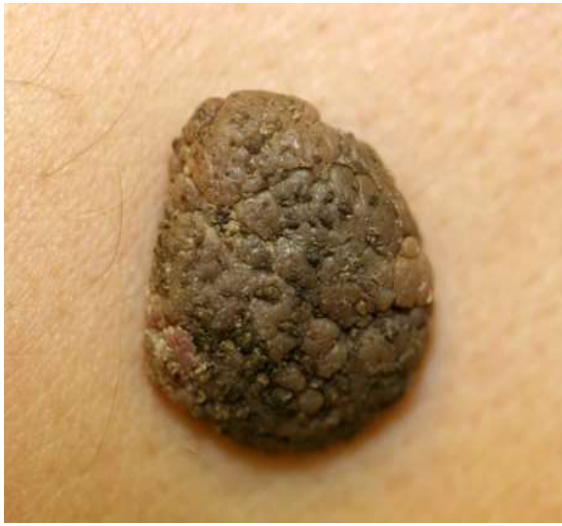
Seborrhoeic keratoses

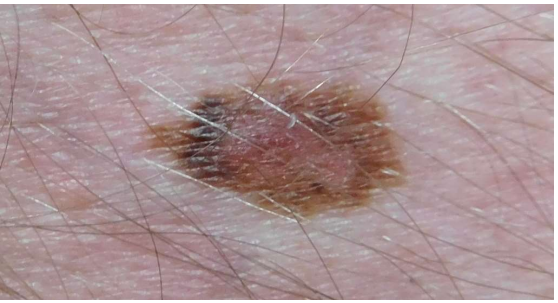


- Clinically:
- Rough surface, with pits crypts and fissures
- Well defined edge
- Bits often drop off
- Colour may be white – flesh coloured – pink - brown – black
- Often irregular
- Often bleed if traumatised
- Needs dermoscopy!

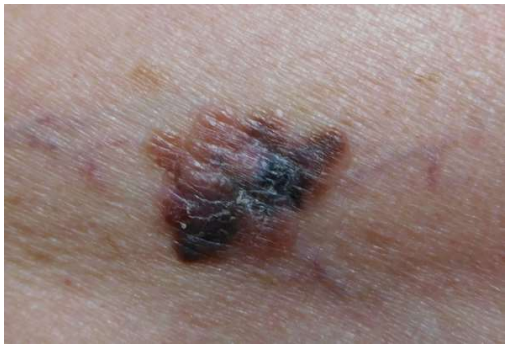
Routinely though (a few weeks)



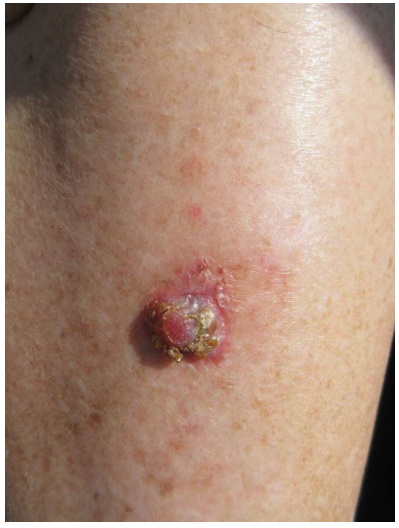


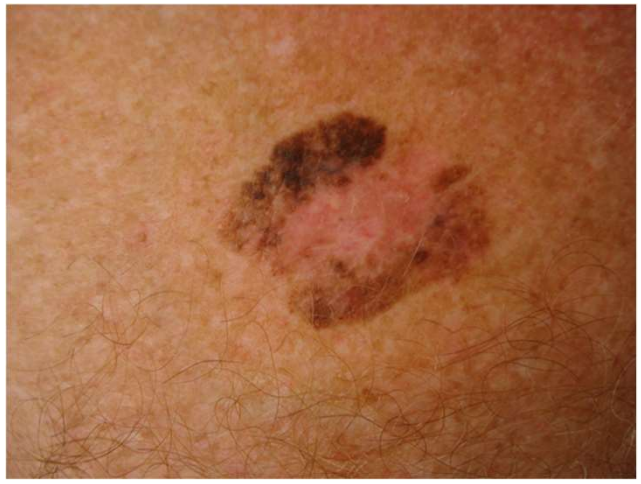


Lesions tips



- Beware of asymmetric or multicoloured lesions
- If it looks like a seb k it needs (routine) dermoscopy
- Anything that doesn't heal in 3 weeks needs dermoscopy
- Raised, firm, growing lesions need urgent GP review (within a week)





Summary

- Pharmacy first is a great idea, but will take time to get confident
- Beware “insect bites” that have been gradually enlarging over weeks
- Keep tick removers in stock!
- Single scaly lesions – trial of topical antifungal is a sensible first step, whatever the diagnosis
- Papules on the penis = scabies
- Check rashes of shingles against a dermatome diagram
- Shingles on forehead – check tip of nose
- Red eye with shingles or vesicular rash on face = high risk
- Check a travel history

Summary

- Check out the PCDS website for differential diagnoses
- If you are interested in skin, come along (virtually) to one of our skin clubs:

Southwest skin club – me and Hannah Wainman
Weds evenings alternate months, 7.30-8.30pm
Fewer cases, in proper (basic) detail
Email DABRW@leo-pharma.com

Oxford skin club – 2 Oxford dermatologists
Tues evenings, monthly, 7.30-9pm
More cases, still v interactive
Email Imelda.murphy@dermal.co.uk

Free 45min online webinar on Thurs 2nd May 7.30 – 8.15pm from PCDS