DERMATOLOGY TRIAGE GUIDELINES

V2.9. **Updated 15-03-12**

COMMUNITY SERVICE SEES ADULTS & UNDER 16 for Acne and Eczema only

Questions? Please liaise with Ali or Melanie

Cryotherapy, curettage and cauterization in relation to warts verrucae and other skin lesions should be treated in general practice

CONDITION	Primary Care Management advice or guidelines	Dermatology Nurse	Brighton and Hove Skin Care (GPwSI)	LES 08 Community Dermatology	DES 04 Minor Surgery	Refer to Dermatology OPD
Acne Vulgaris	See full primary care management protocol in triage folder and on BICS website		If **moderate to severe**, refer for systemic treatments including Isotretinoin. Early referral if scarring.			**Severe** and **complicating factors** (i.e. severe depression, liver disease or hyperlidiaemia, serious comorbidities including severe migraine with visual disturbance)
Actinic Keratosis	See full primary care management protocol in triage folder and on BICS website		**(Default)**			Chronic lesions with diagnostic uncertainty.
Allergy	Refer for patch testing only if possible contact dermatitis, **NOT** for urticaria or food allergy.		Allergy testing for urticaria. GPwSI to review for patch testing.			If considered severe and resistant to treatment.
Alopecia Areata (patchy hair loss)	GP could try e.g. synalar gel BD for 4 weeks.		When patients have progressive loss and GP requires support in managing them.			Only if progressive/ undiagnosed hair loss
Atypical Naevi	No mole surveillance service at present.					If the GP is concerned re melanoma then should be sent as a 2 week rule. If it is a generally moley patient for review and monitoring, send to secondary care.
Basal Cell Carcinoma (BCC) **Superficial type on trunk & limbs**			GPSI for biopsy and consideration of topical treatment			If diagnosis needed
Basal Cell Carcinoma (BCC) **Nodular/ ulcerated/ invasive, face, trunk or limbs**			**Low Risk** below clavicle and < 1.5cm - GPwSI for diagnosis and treatment			**High Risk:** Above clavicle, and below clavicle if >1.5cm, recurrent, morphoeic

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Benign Naevi/ Moles				**Do not treat for cosmetic reasons. Must be functional problem.** Histology essential. Treatment if persistently and significantly symptomatic lesions only. Take care re scarring	**Do not treat for cosmetic reasons. Must be functional problem.** Histology essential. Treatment if persistently and significantly symptomatic lesions only. Take care re scarring	
Bowen's Disease/ Intra Epidermal Carcinoma			**(Default)** Diagnosis can be confirmed by biopsy in GP practice under DES, otherwise refer to GPwSI	For biopsy, but it would be better to send to GPSI. Possibly use for treating some patients if medical treatments have failed.		If difficult site or difficult patient – e.g. immunosuppressed, transplant etc.
Chondrodermatitis nodular helicis			If diagnostic certainty			If diagnostic uncertainty
Congenital Naevi						Do not treat for cosmetic reasons. Refer only if malignant risk. If any concern of change, GP should refer under 2 week rule. >20cm diameter or 2cm in neonate as routine
Dermatofibroma/ Histiocytoma			**(Default)** Do not remove for cosmetic reasons. Only refer if painful or very irritating. Very rare malignant potential. Histology essential.	Only remove if painful or very irritating. Very rare malignant potential. Histology essential.	Only remove if painful or very irritating. Very rare malignant potential. Histology essential.	Only if diagnostic uncertainty
Diffuse hair loss	Minoxodil can be tried bought over the counter.		If patient requests second opinion after routine investigation has			If scarring suspected

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			been normal.			
Eczema	See full primary care management protocol in triage folder and on BICS website	**(Default)** If **mild to moderate**: support, education and topical treatment, default to Community Dermatology Nurse. Nurse will refer on to GPwSI if necessary.				Only send to Dermatology OPD if **severe** - Systemic treatment or not responding to topical treatment, or diagnosis uncertain
Epidermoid/Pilar (sebaceous) Cysts	PAP required for secondary care.			Yes - **default** (adults only, excluding face & neck, but including scalp) **Do not remove for cosmetic reasons.** Excise symptomatic lesions or if history of repeated infection. Histology essential.	Yes (adults only, excluding face & neck, but including scalp) **Do not remove for cosmetic reasons.** Excise symptomatic lesions or if history of repeated infection. Histology essential.	**Yes** (all children and adults- face & neck only) Prior Approval required.
Hyperhidrosis	See full primary care management protocol in triage folder and on BICS website		**Yes (default) –** for discussion and information about Iontophoresis / Botox. Refer on if appropriate. If second Botox treatment is being requested, can go direct to secondary care.			**Yes**, if other treatment ineffective. If 2nd Botox treatment, can go direct to secondary care. Patient would normally self – refer for this unless they were treated in another trust previously. Ensure GP has followed necessary protocols. Iontophoresis for hands and feet.

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In-growing Toe Nails					**(Default)** Some DES practices do this.	Yes, only podiatry if opportunity for relieving pressure.[1]
Intertrigo	Should be managed in primary care.		If not responding then the diagnosis is probably not correct. Send to GPwSI who will decide if they want to see the patient or refer onto secondary care.			
Keloid scars			Default to GPwSI for steroid injection. GPwSI will refer on to secondary care if necessary.			If very extensive and unresponsive , they need to be referred with LPP funding to Charles Nduka (Plastic)
Keratin Horn			**(Default)** C&C or excision, histology required as risk of BCC or SCC			2WW only e.g. suspicion of SCC
Keratoacanthoma	**2WW only** **Return to practice** GP should refer as 2 week rule – include as SCC using proforma or send as letter. 2WW proforma being updated by SCN.					
Lentigo Maligna	**2WW only** **Return to practice** GP should refer as 2 week rule – include as SCC if using proforma or send as letter. GP unlikely to make this					

[1] Need clarity from Podiatry

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	diagnosis without a biopsy.					
Lichen Sclerosus						Seen in Vulval clinic.
Lipomata	**2WW?** Consider history, size and how fast it is growing. If large and rapid growth refer under 2WW.			**Do not treat for cosmetic reasons.** Excise only if causing significant problems. Histology essential. **Up to 3-4cm** *Some LES surgeons are happy with 4cm.* *Others would prefer not to excise larger than 3cm.* ***Note for PCA when booking:*** *Dr Patel – 3cm* *Dr Coxon – 4 cm* *Dr Bird – 4cm* *Dr Rogers – 4 cm*	**Do not treat for cosmetic reasons.** Excise only if causing significant problems. Histology essential. **Up to 3cm**	**Do not treat for cosmetic reasons.** Excise only if causing significant problems/awkward site. Prior Approval required. Consider history, size and how fast it is growing. If large and rapid growth refer under 2WW. **5cm and over** Large lipoma are difficult and most GP surgeons would find them hard to do. As little ones are not meant to be treated, most that require treatment should be done by derm/plastics. **General surgery** minor ops lists tend to be done by relatively inexperience SHOs. If a lipoma needs removal and gets LPP funding, then should be sent to dermatology.
Malignant Melanoma[2]						**2WW**
Melasma/Chloasma	Cosmetic. *Advice to GP:* Advise stopping hormone treatment (if appropriate) and constant sun block (bought by the patient). Retinova (tretinoin 0.05%) has been discontinued due to manufacturing problems. There is an equivalent called Airol that can be imported on private prescription.					

[2] What is the pathway for "iffy moles" or multiple moles with a family history of melanoma? Routine referral to derm dept for assessment, photography and education. F/up will be by patient, GP or possibly GPSI

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	Azaleic acid, tretinoin cream or gel 0.025% and hydroquinone bleaching creams are available on NHS prescription. Daily factor 30-50 applied first thing and allowed to sink in before applying any further make up. This needs to be done every single day of the year, sunny or not. If very sunny day and outside, then reapply every 3-4 hours. One day of sun will undo 6 months of treatment! Use of retin A (tretinoin 0.025%) or skinoren (azeleic acid 20%) should be between 3-6 months to assess efficacy. If no difference after 6 months (+ sunblock) then may not work. From a safety point of view, these can be used indefinitely if necessary. Pigmanorm (hydroquinone 5%, tretinoin 0.1%, hydrocortisone 1%) is available from Germany on named patient basis NHS or privately and GP can prescribe – OPD use Elm Grove Pharmacy to import it.					
Molluscum Contagiosum						Exceptional circumstances Spontaneous resolution normally occurs within 18-24 months. Refer only in exceptional circumstances e.g. HIV, Immunosuppressive therapy or other special circumstances. Call referring GP to use regular emollients to treat any coexisting eczema. Children should go to RAH but only in exceptional circumstances
Psoriasis	See full protocol in triage folder and on BICS website	**(Default)** Over 16s only. Guttate, plaque, hands or feet, palmar plantar pustulosis. Excludes vulval/genital psoriasis. Nurse will refer on if necessary (for GPwSI or 2 care for light treatment/systemics).	Vulval/genital psoriasis.			If systemic treatments in the past or severe or acute.
Pyogenic Granuloma	**2WW only** **Return to practice**					

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	GP should refer as 2 week rule – include as SCC using proforma or send as letter. 2WW proforma being updated by SCN.					
Undiagnosed Rashes						All to secondary care
Rosacea			**GP should treat.** Only refer if not responding to usual treatment or if diagnostic uncertainty.			
Pityriasis Rosea			GP should diagnose and reassure and only refer if not improving or very severe.			
Pseudofollicullitis barbae			**GPwSI**			
Seborrhoeic Warts/ Keratosis	Should receive cryotherpay by GP. If they are large and need cautery, then DES or LES			Cryo should be done by GP. Cautery only.	Cryo should be done by GP. Cautery only.	If diagnostic uncertainty Prior Approval Required
Skin tags	PAP required.			Only if causing functional problems Do not treat for cosmetic reasons.	**(Default)** Only if causing functional problems Do not treat for cosmetic reasons.	Prior Approval Required for secondary referral if on head/neck
Solar Comedones/Giant Comedones				Yes (<5cm) *Either LES or DES* Do not treat for cosmetic reasons. Remove only if causing if persistently and significantly symptomatic problems. Incise roof of lesion and express contents.	Yes (< 5 cm) *Either LES or DES* Do not treat for cosmetic reasons. Remove only if causing if persistently and significantly symptomatic problems. Incise roof of lesion and express contents.	Yes (>5cm) Larger lesions (>5mm) need formal excision if symptomatic.

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Solar Lentigines						Refer to secondary care if possible Lentigo Maligna Do not treat if cosmetic. May be treated privately with topical Retinova.
Spider Naevi/ Campbell de Morgan Spots	Do not treat. Return to practice and remind GPs that if they occur in children they very often resolve spontaneously.					
Squamous Cell Carcinoma (SCC)						**Yes** 2WW only
Urticaria			**GPwSI**			
Vascular Angiomata			If concern about diagnosis refer to GPSI	(Small haemangioma <10mm) ***Either LES or DES*** **As long as correct diagnosis is made**. Do not treat for cosmetic reasons. Treat for functional problem, e.g. bleeding.	(Small haemangioma <10mm) ***Either LES or DES*** **As long as correct diagnosis is made**. Do not treat for cosmetic reasons. Treat for functional problem, e.g. bleeding.	(Children and larger lesions) Small ones <10mm that are not bleeding do not need treating but smaller ones, 5mm that are bleeding may need treatment. **2WW** if black lesion.
Viral Warts – face, knee & groin			Warts on eyelids can be referred to the Community Eye Service via BICS.			Refer only in special circumstances e.g. HIV and Immunosuppressive therapy.
Viral Warts – hands & feet	Cryotherapy, curettage and cauterization in relation to warts verrucae and other skin lesions should be treated in general practice.					Problematic verruca refer to Podiatry[3]

[3] Read B.A.D. guidelines for treatment of warts and verrucas.

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	There is no evidence to support that cryotherapy is superior to topical therapy.					
Vitiligo (hyper/ hypo)			GPwSI			
Leg ulceration						Yes, only if malignancy or pyoderma/vasculitis suspected If **venous leg ulcer** refer to tissue viability leg ulcer clinic if LES not offered in patient's surgery. **Arterial leg ulcers** to be referred to vascular dept if consultant opinion required. Not suitable to LUC. **Diabetic ulcers** (usually on foot) to Martin Turns. *Patients must be able to travel to clinics (no transport provided).*
Gravitational/ Stasis/ Varicose Eczema	Should be offered by practice nurses and GPs.					Consider referral only if patch testing needed Varicose ulcer - refer if worry that there may be malignancy.
Unknown lesions			If longstanding and chronic			If new and changing rapidly, or resistant to all GP treatments then refer to OPD.