DERMATOLOGY TRIAGE GUIDELINES

<u>Note:</u> Cryotherapy, curettage and cauterization in relation to warts verrucae and other skin lesions <u>should be treated in general practice</u>

CONDITION	Primary Care Management advice or guidelines	Dermatology Nurse	Brighton & Sussex Dermatology Community Clinics	LES 08 Community Dermatology	DES 04 Minor Surgery	Brighton and Sussex Dermatology Hospital Clinics
Acne Vulgaris	See full primary care management protocol in triage folder and on [BDS 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	Do not accept unless diagnostic uncertainty or suspected SCC (soreness, bleeding, growth above skin surface, or unresponsive to topical treatments. Full primary care management protocol in triage folder and on [BDS website](#)		Combined Consultant/GPwSPI/SpR Lesion Clinic			Upgrade patients to 2-week clinics if suspected SCC on GP referral letter – refer to Consultant triage
Allergy	Patchy-Testing/Allergy Tests – not usually helpful in urticaria. Only useful suspected contact dermatitis. No referrals for food allergy. Reject urticaria referral if primary care management not tried first for 6-weeks.		GPwSPI Inflammatory Clinic or Consultant Clinic			**Urticaria** Only refer if considered severe and resistant to treatment with Ceterizine 10mg daily for 6-weeks +/- Hydroxyzine 25mg at night (advise re sedation)
Alopecia Areata (patchy hair loss)	GP could try a topical steroid ointment e.g. synalar gel BD for 4 weeks. Reject referral if topical treatments not tried unless severe psychological		GPwSPI Clinic When patients have progressive loss and GP requires support in managing them. Treatments usually ineffective other than topical Minoxidil (OTC) or oral			Only if progressive/ undiagnosed hair loss or evidence of scarring

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	disturbance or widespread loss.		iron supplements (low ferritin)			
Atypical Naevi	No mole surveillance service at present. Individual risk of a skin lesion changing is less than 1 in 1000 in patients with >100 naevi and no h/o melanoma. Reject referral. Refer suspected change as **2WW**		Combined Consultant/GPwSPI/SpR Lesion Clinic			If the GP is concerned re melanoma then should be sent as a 2 week rule to skin lesion clinic. Upgrade if suspected MM as **2WW**
Basal Cell Carcinoma (BCC) **Superficial type on trunk & limbs**	Low Risk Trunk/Limbs <2cm Skin lesions can be directly booked into LES Superficial may respond to topical creams or PDT if biopsy depth < 2mm.		**Community/Hospital Clinics** **Superficial Low Risk (Trunk/Limbs)** Surgical GPwSPI treatment of lesions trunk/limbs or topical immune-modulatory therapy or skin surgery or PDT. For excision if biopsy depth >2mm. Book directly for excision if clinical diagnosis certain.	**LES EXCISION** Nodular Low Risk BCC Lesions <2cm Trunk or Limbs For excision if biopsy depth >2mm	**DES EXCISION** Not suitable for DES excision	**Lesions >2cm** Consultant clinic review for large superficial or nodular lesions. Superficial depth <2mm may respond to PDT, Imiquinod or Surgical Excision. Nodular/large lesions excision or radiotherapy if facial. Radiotherapy not trunk.
Basal Cell Carcinoma (BCC) **Nodular/ ulcerated/ invasive, face, trunk or limbs**	High Risk Above clavicle. Routine Referral Skin Lesion Clinics Size>2cm Consultant Clinic					**High Risk (Face) or Lesions >2cm** Consultant clinic review for excision, radiotherapy or plastic surgery
Benign Naevi/ Moles	Dermatology does not offer a mole surveillance service because the detection rate of melanoma is exceptionally small.			**Do not treat for cosmetic reasons. Must be functional problem.** Histology essential.	**Do not treat for cosmetic reasons. Must be functional problem.** Histology essential.	

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	Refer all patients with suspected melanoma as 2-week rule referrals if there is a history in change of size, shape, colour, bleeding or symptoms.			Treatment if persistently and significantly symptomatic lesions only. Take care re scarring	Treatment if persistently and significantly symptomatic lesions only. Take care re scarring	
Bowen's Disease/ Intra Epidermal Carcinoma	Primary care can treat with cryotherapy or Efudix once daily for 4-6 weeks. Risk of transformation to a SCC is less than 1 in 200. Treatment may not be necessary in elderly patients with other co-morbidities.		Combined Consultant/GPwSPI/SpR Lesion Clinic. Treatment cryotherapy, Efudix, Imiquinod, PDT or surgery. Biopsy may be required.			
Chondrodermatitis nodular helicis	Typically painful nodule on ear that is the same side that the patient sleeps. Treatment usually conservative. Consider topical Rectogesic ointment that improves blood supply to cartilage. **Only refer for diagnostic doubt or severe symptoms**		Combined Consultant/GPwSPI/SpR Lesion Clinic Biopsy may be required but only if suspicious of AK/SCC or BCC. Very symptomatic failed on conservative management for excisional surgery but 20-30% risk of recurrence due to field change.			Abnormal cartilage can be removed by skin surgery with a shave and local skin flap. Consultant or senior SpR surgery lists. 20-30% risk of recurrence.

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Congenital Naevi	Elective surgery for removal is not considered necessary as risk of transformation is very low. Only accept changing congenital naevi as 2-week referrals or paediatric clinic if no history of change.		Combined Consultant/GPwSPI/SpR Lesion Clinic			Do not treat for cosmetic reasons. Refer only if malignant risk. If any concern of change, GP should refer under **2WW** >20cm diameter or 2cm in neonate as routine
Dermatofibroma/ Histiocytoma	Treatment not usually necessary unless history of rapid growth or change. Skin surgery likely to leave scar that is worse than appearance of skin lesion. Reject referral unless history of change. Excision required LES service.		Combined Consultant/GPwSPI/SpR Lesion Clinic Biopsy may be required.	**LES SERVICE** LES referral only appropriate if severe symptoms. Very rare malignant potential. Needs formal excision with margin and histology. Histology essential.	**LES SERVICE** Only remove if painful or very irritating. Very rare malignant potential. Histology essential.	Referral not necessary unless history of change and diagnostic concern with regards to sarcoma or skin cancer. Refer as **2WW**
Diffuse hair loss	Dermatology referral usually not necessary unless history of scarring, atypical history, or co-existent acne. Serum testosterone level excludes neoplastic causes. All scarring alopecia should be referred. Minoxodil 2% (OTC) may be recommended for diffuse androgenic hair loss.		GPwSPI Inflammatory Clinic or Consultant Inflammatory Clinic			Severe scarring or inflammatory disease may need specialist hair clinic at BGH
Eczema	See full primary care management protocol	**(Default)** If **mild to moderate**:				Only send to Dermatology OPD if **severe** - Systemic treatment or not responding

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	in triage folder and on BDS website	support, education and topical treatment, default to nurse-led clinics for assessment. Nurse will refer on to GPwSI if necessary or phototherapy.				to topical treatment, or diagnosis uncertain
Epidermoid/Pilar (sebaceous) Cysts	PAP required for secondary care.			Yes - **default** (adults only, excluding large face & front of neck, but including back of neck and scalp) **Do not remove for cosmetic reasons.** Excise symptomatic lesions or if history of repeated infection. Histology essential.	Yes - **default** (adults only, excluding face & front of neck, but including back of neck and scalp) **Do not remove for cosmetic reasons.** Excise symptomatic lesions or if history of repeated infection. Histology essential.	**Yes** (all children and adults-face & front of neck only) Prior Approval required.
Hyperhidrosis	Generalised hyperhidrosis is difficult to treat as most drugs cause sedation and are not tolerated. Axillary hyperhidrosis can be treated by topical aluminium salts. Botox injections may be used in severe cases for axilla. Palmer hyperhidrosis may respond to Iontophoresis if topical fail.		**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/feet.

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	See full primary care management protocol in triage folder and on BSD Website					
In-growing Toe Nails	Do not refer to dermatology. Referrals rejected.				**(Default)** Some DES practices do this.	Yes, only podiatry if opportunity for relieving pressure.[1]
Intertrigo	Should be managed in primary care. Try Trimovate cream twice daily for 2-weeks if severe cases.		GPwSPI Inflammatory Clinic or Consultant Clinic if diagnosis uncertain.			
Keloid scars	Primary care treatment with Haelen Tape or topical Dermovate for 6-8 weeks. Generally cosmetic problem unless functional problems. Reject referral unless topical treatments tried first or cosmetic.		GPwSPI Inflammatory Clinic or Consultant Clinic for steroid injection with Adcortyl or Kenalog (not used for facial unless consultant approved).			Consultant review severe or complicated keloid scars.
Keratin Horn	Keratin horns may be seen by LES/Des if not growing in size and small. Rapid growth may be early SCC. Treatment is surgical plus histology. If history less than 6-weeks refer as **2WW**		Combined Consultant/GPwSPI/SpR Lesion Clinic Biopsy may be required.	LES Stable large keratin horns need surgical excision with margin 3mm and histology	DES Stable small keratin horns need curettage or excision with 3mm margin and histology	**2WW only** e.g. suspicion of SCC with history growth <6-weeks

[1] Need clarity from Podiatry

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Keratoacanthoma	**2WW Clinic only** Upgrade GP referral to 2WW.		Combined Consultant/GPwSPI/SpR Lesion Clinic Biopsy may be required.			**2WW Clinic**
Lentigo Maligna	**2WW only** Upgrade GP referral to 2WW GP unlikely to make this diagnosis without a biopsy.		Combined Consultant/GPwSPI/SpR Lesion Clinic Biopsy may be required.			**2WW Clinic**
Lichen Sclerosus	Trial topical steroid for mild/moderate cases. Accept for dermatology for diagnostic uncertainty or failure of treatment with topical steroid treatment		Female GPwSPI clinic working with a Consultant or a Consultant Clinic.			Difficult/complicated cases to sub-specialist vulval clinics. Screening in other clinics usually necessary unless previous consultant review or complex medical problems.

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Lipomata	Lipomata are usually slow growing and may be inherited by families. NHS will not cover treatment unless there is a history of growth or change. Refer as 2-week referral if history of rapid change or to skin lesion clinic to exclude a sarcoma. Functional problems may warrant excision by LES service. Refer for Dermatology LES service.		Combined Consultant/GPwSPI/SpR Lesion Clinic	**Do not treat for cosmetic reasons.** Excise only if causing significant functional 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** Refer all cases as 2-week		Combined Consultant/GPwSPI/SpR Lesion			**2WW**

[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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	referral		Clinic Biopsy may be required.			
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. Azaleic acid, or tretinoin cream or gel 0.025% are available on NHS prescription but take 10-16 weeks to work effectively. 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. Treatment typically takes 6-8 weeks to work to inhibit melanon synthesis. 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	Primary care management only. Consider Fucidin H for inflammation that may occur for 5-10 days. Molludab (Potassium Hydroxide) is a new treatment that can be effective and is applied topically. Natural history is resolution over 12-18 months.		GPwSPI Inflammatory Clinic or Skin Lesion Clinic			Only accept if HIV positive or history of immunosuppression.
Psoriasis	See full protocol in triage folder and on <u>BSD website</u>	**(Default)** Over 16s only. Guttate, plaque, hands <u>or</u> feet, palmar plantar pustulosis. Excludes vulval/genital psoriasis. Nurse will refer on if	Vulval/genital psoriasis.			If systemic treatments in the past or severe or acute.

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		necessary (for GPwSI or 2 care for light treatment/systemics).				
Pyogenic Granuloma	**2WW only** Only remove if clear history of trauma and age<40 years. Refer all other cases as 2WW. GP referral letter upgraded		Combined Consultant/GPwSPI/SpR Lesion Clinic			
Undiagnosed Rashes	Accept referral and assess if GPwSPI or Consultant required.		GPwSPI Inflammatory or Consultant Inflammatory Clinic			Severe rashes requiring urgent consultant review or SpR urgent review >70% Body Surface Area eg erythroderma, severe drug reaction
Rosacea	Accept referral if diagnostic uncertainity or failure of topical and oral treatment (lymecycline 408mg daily for 4-weeks). Laser therapy not available through NHS but is effective in resistance cases.		GPwSPI Inflammatory Clinic or Consultant Clinic.			
Pityriasis Rosea	Reject referral. Advise treatment with Nizoral Shampoo dilutely as a wash for 12-16 weeks twice weekly. Pigmentation takes several weeks to recover.		GP should diagnose and reassure and only refer if not improving or very severe. GPwSPI Inflammatory Clinic			

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Pseudofolliculitis barbae	Advise course of oral lymecycline for 8-weeks and topical Chlorhexidine 4% wash dilutely. Reject unless above tried.		GPwSPI Inflammatory Clinic			
Seborrhoeic Warts/ Keratosis	Reject dermatology referral (cosmetic). Treatment should be in primary care. Functional impairment or Inflammed large lesions may need curettage by DES with histology.		Combined Consultant/GPwSPI/SpR Lesion Clinic if diagnosis uncertain	Not suitable for LES service	Cryo should be done by GP. Cautery only plus histology if large and very symptomatic. Histology essential.	
Skin tags	Reject dermatology referral (cosmetic). Functional may be seen by DES or Community Eye Clinic. PAP required.			Not suitable for LES service	Only if causing functional problems Do not treat for cosmetic reasons.	
Solar Comedones/Giant Comedones	Reject dermatology referral (cosmetic). PAP required.			Not suitable for LES service	Yes (< 5 cm) *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	Reject dermatology referral (cosmetic). Referral only for history of change or suspected Lentigo Maligna with variable pigment or network pigment		Combined Consultant/GPwSPI/SpR Lesion Clinic if diagnosis uncertain or suspected lentigo maligna			Refer to consultants if possible Lentigo Maligna
Spider Naevi/ Campbell de Morgan Spots	Reject dermatology referral (cosmetic). Return to practice and remind GPs that if they occur in children they very often resolve spontaneously.					
Squamous Cell Carcinoma (SCC)	**2WW only** **Upgrade Referral as 2WW**		Combined Consultant/GPwSPI/SpR Lesion Clinic			**2WW only**
Urticaria	**Urticaria** Only refer if considered severe and resistant to treatment with Ceterizine 10mg daily for 6-weeks +/- Hydroxyzine 25mg at night (advise re sedation)		GPwSI Inflammatory Clinic			
Vascular Angiomata	Reject dermatology referral unless history of bleeding or rapid growth or suspicion amelanotic melanoma (usually like a pyogenid granuloma in adults >40 with no history of trauma. Refer 2-week referral if history of significant change or skin lesion clinic.		Combined Consultant/GPwSPI/SpR Lesion Clinic	Not suitable LES service	(Small haemangioma <10mm) **As long as correct diagnosis is made.** Do not treat for cosmetic reasons. Treat for functional problem, e.g. bleeding. Histology essential if curettage.	(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 or any suggestion of brown pigment or past history naevus same site**

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Viral Warts – face, knee & groin	Reject dermatology referral unless HIV or immunosuppressed. Eyelids to Community Eye Service via BICS.		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	Reject dermatology referral. Treatment should be in primary care. Topical therapy, curettage and cryotherapy all have similar efficacy.					Problematic verruca refer to Podiatry[3]
Vitiligo (hyper/ hypo)	Reject referral unless diagnostic uncertainty. Trial of Synalar Gel bd for 4-weeks on new areas. Generally unresponsive to treatment.		GPwSI Inflammatory Clinic			
Leg ulceration	Mangament should be in primary care or tissue viability. REJECT REFERRALS unless: History of change/rolled edges ?SCC ?BCC. History to suggest contact dermatoitis for dressings Mulitple or purple-edge to ulcer suggesting pyoderma					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

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

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	gangrenosum.					foot) to Martin Turns. *Patients must be able to travel to clinics (no transport provided).*
Gravitational/ Stasis/ Varicose Eczema	Reject referral. Treatment should be in primary care with community wound care teams. Suggest trial of topical Dermovate ointment for 2-weeks daily for treatment for disease flares and emollients. Consider below-knee compression with class II stockings.					
Unknown lesions	Accept referral of undiagnosed skin lesions to skin lesion clinic unless referral is cosmetic. Upgrade to skin lesion clinic if rapid history of change.		Combined Consultant/GPwSPI/SpR Lesion Clinic			Hospital Skin Lesion Clinics Upgrade 2WW if history suggestive SCC/MM or SARCOMA