South Manchester NHS
Primary Care Trust

South Manchester University Hospitals NHS
NHS Trust

Dermatology guidelines for GPs

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Introduction

These Guidelines have been adapted from Medway NHS Trust guidelines by the Dermatology Department of the South Manchester University Hospitals NHS and South Manchester Primary Care Trust.

The document offers recommendations for treatment of common skin conditions and defines the point at which secondary care may be needed.

These treatment recommendations should be followed before referrals are considered.

Withington Hospital

Buccleuch Lodge

Consultants

Dr H L Muston	Secretary	611 3921
Dr J E F Ferguson	Secretary	611 3921

Specialist nurses

Linda Rowen	Advanced Nurse Practioner	611 3773
Louise Frost	Specialist Nurse	
Evelyn Wemyss	Specialist Nurse	

Wythenshawe Hospital

Consultants

Dr H L Muston	Secretary	291 2401
Dr J E Ferguson	Secretary	291 2393

Hope Hospital

Consultants

Dr H L Muston	Secretary	206 1010
Dr J E F Ferguson	Secretary	206 1013

Referral

Urgent referrals

All referrals will be assessed and prioritised by a Consultant/Member of the Dermatology team. Urgent referrals may be faxed directly to the department on 611 3914.

If you wish to discuss a case with a Consultant, please telephone via the secretary's direct lines (see left).

Skin cancer

Referrals for possible melanomas and squamous cell carcinomas must be made using the HSC 205 document and faxed within 24 hours (Fax no 611 3326).

These patients will be assessed within two weeks of receipt. Referrals for other skin lesions, e.g. basal cell carcinoma, should be made in the usual way.

If there is no consultant available, the HSC 205 form will be referred on to Hope Hospital to ensure that patients are seen within two weeks.

Content of referral letter

The following information should be included:

- Nature of condition and duration
- Relevant past medical history
- All medication currently and previously used for this condition including dose, duration of treatment and response, plus all other concurrent medication
- Photographs (optional)

Section 1

Acne

Treatment aims:

- To reduce the severity of the disease
- To reduce the psychological impact on the individual
- To prevent long-term sequelae such as scarring

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

CLINICAL FEATURES	TREATMENT	THERAPEUTIC TIPS
MILD *Uninflamed lesions - Open and closed comedones (blackheads)*	Topical benzoyl peroxide	■ Start at 2.5% and increase to 5 or 10% ■ Lotion or gel preparations may reduce irritation
	Topical retinoids (avoid in pregnancy) ■ Adapalene - Differin ■ Isotretinoin - Isotrex ■ Tretinoin - Retin-A	If irritation occurs, reduce frequency of application and build up to daily over 2 - 3 weeks. If skin becomes excessively dry, add a moisturiser.
MILD - MODERATE *Comedones and papules / pustules*	Topical retinoid or topical benzoyl peroxide preparations +/- topical antibiotics ■ Clindamycin Phosphate lotion (Dalacin T) ■ Erythromycin / Zinc acetate solution (Zineryt) ■ Erythromycin 2%, 4% gel (Eryacne) ■ Benzoyl peroxide / erythromycin - 'Benzamycin' ■ Clindamycin, Benzoyl peroxide (Duac) ■ Erythromycin / isotretinoin - (Isotrexin)	Combination preparations may be more effective.

CLINICAL FEATURES	TREATMENT	THERAPEUTIC TIPS
MODERATE *More extensive inflamed lesions*	Systemic antibiotics ■ Oxytetracycline 500mg bd ■ Doxycycline 100mg od ■ Minocycline 100mg od ■ Erythromycin 500mg bd ■ Trimethoprim 300mg bd If treatment extended >6 months ANA/LFT's 3 monthly thereafter	■ Treat for 3 months and reassess ■ Should be > 70% improved ■ Stop at 6 months & continue with topicals ■ Repeat if relapses ■ Use alternative antibiotic if poor response **NB Minocycline - ANA/LFT required pre treatment and at 6 months.** Topical retinoids / benzoyl peroxide may be used in combination with systemic treatments.
MODERATE - SEVERE *Papules/pustules with deeper inflammation and some scarring*	Systemic treatment as above plus topical therapy Consider hormone therapy (females only) Ethinyloestradiol / Cyproterone acetate - (Dianette) or Desogestrel/ethinyloestradiol (Marvelon)	Treat for 4 - 6 months and reassess. (Slow onset of response). Antibiotics can be added if response is suboptimal.
SEVERE	Commence systemic therapy and refer for assessment for treatment with isotretinoin (Roaccutane).	
MAINTENANCE	Topical retinoid or topical benzoyl peroxide preparations	

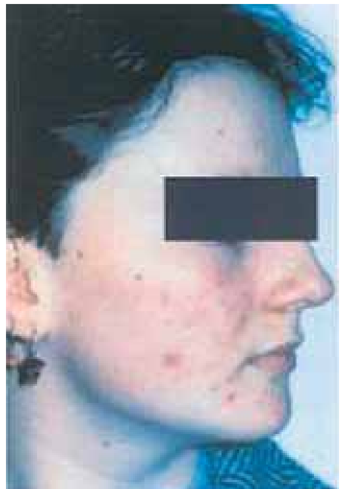
CRITERIA FOR REFERRAL

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

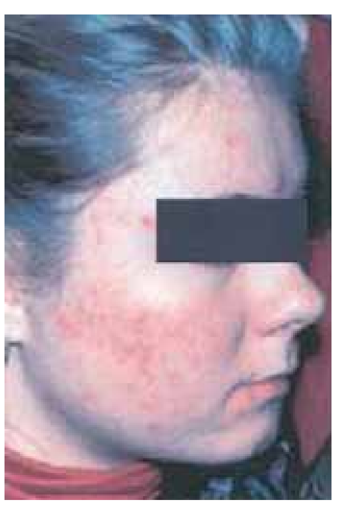
1. Severe nodulo-cystic acne (refer immediately)
2. Moderate acne that has failed to respond to prolonged (i.e. more than 6 months) courses of systemic antibiotic treatments.
3. Mild to moderate acne in patients who have an extreme psychological reaction to their acne and have failed to respond to prolonged courses of systemic antibiotic treatment and topical treatment.

Section 1

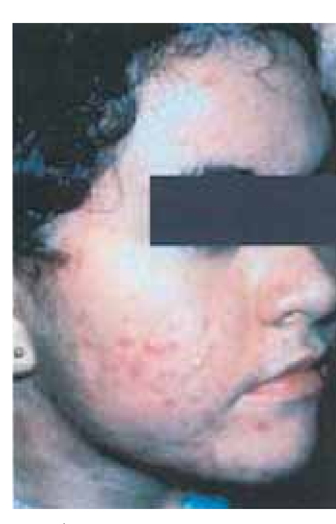
Mild



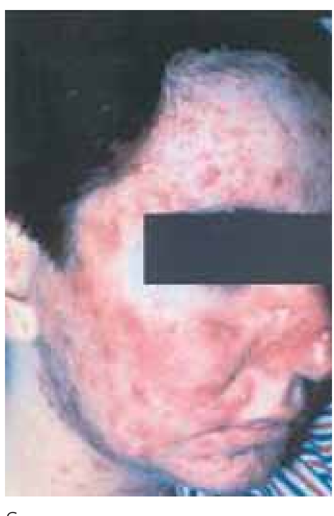
Mild/moderate



Moderate



Moderate/severe

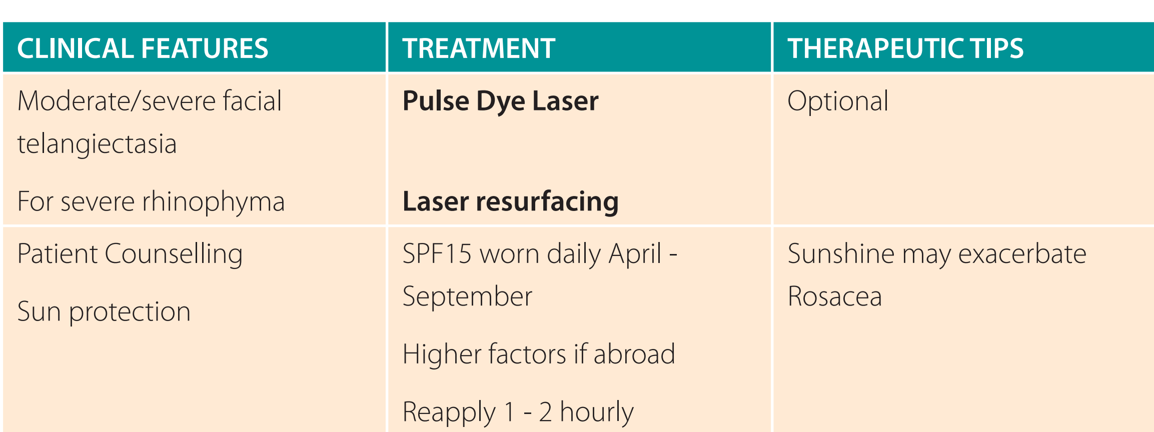


Severe

Section 2

Rosacea

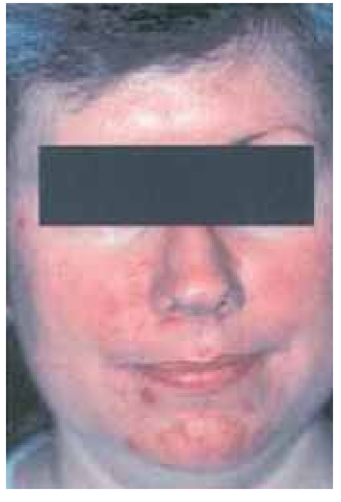
CLINICAL FEATURES	TREATMENT	THERAPEUTIC TIPS
■ Papules on an erythematous background ■ Pustules ■ Telangectiasia ■ Flushing often made worse by alcohol, spicy foods, hot drinks, temperature changes or emotion ■ Rhinophyma		Early treatment of rosacea is considered to be important as each exacerbation leads to further skin damage and increases the risk of more advanced disease. Intermittent therapy can be considered for those with very occasional flare-ups. Continuous therapy will be needed if there are frequent recurrences.
Mild to moderate cases or where systemic treatment is contraindicated.	**Topical treatment** ■ Metronidazole 0.75% - 1% gel/cream bd ■ Erythromycin/zinc acetate solution (Zineryt)	■ Continue for 6 - 8 weeks and re-assess ■ Cream for dry/sensitive skin ■ Gel for normal/oily skin
Moderate - Severe	**Systemic Treatments** ■ Oxytetracycline 500mg bd ■ Doxycycline 50 - 100mg od ■ Minocycline 100mg od	Continue therapy for 6 - 12 weeks – response is usually rapid. **NB Tetracycline is contra-indicated in pregnancy, lactation and renal disease.** **NB All 3 drugs can cause photosensitivity, ANA/LFTs required pre Minocycline and at 6 months.**
	■ Erythromycin 500mg bd	Not contraindicated in pregnancy
Ocular Rosacea	Refer to ophthalmologist	Advise patient on lid hygiene to manage blepharitis eg hot flannel scrubs bd



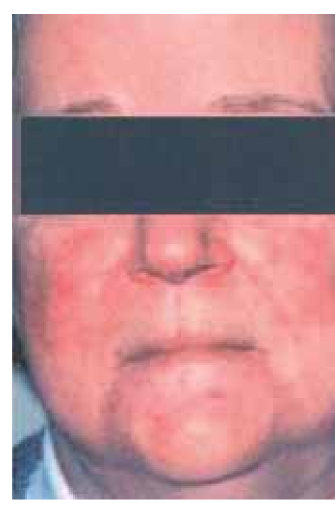
CLINICAL FEATURES	TREATMENT	THERAPEUTIC TIPS
Moderate/severe facial telangiectasia For severe rhinophyma	**Pulse Dye Laser** **Laser resurfacing**	Optional
Patient Counselling Sun protection	SPF15 worn daily April - September Higher factors if abroad Reapply 1 - 2 hourly	Sunshine may exacerbate Rosacea

CRITERIA FOR REFERRAL

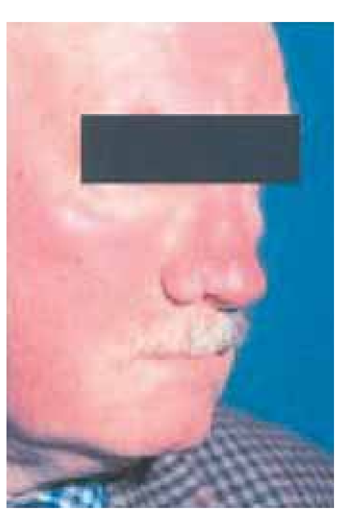
- Doubt over diagnosis
- Poor response to systemic therapy
- Rhinophyma / severe telangiectasia - Laser assessment
- Severe disease associated with the development of pyoderma faciale
- Severe Ocular Rosacea with keratitis or uveitis (refer to ophthalmologist)



Rosacea



Rosacea



Rosacea with rhinophymai

Section 3

Hand eczema

CLINICAL FEATURES

a) Endogenous Eczema (eg atopic)

b) Exogenous Eczema (eg irritant or allergic contact)

IRRITANT CONTACT DERMATITIS

Due to substances coming into contact with the skin, usually repeatedly, causing damage and irritation.

Substances such as:

- Detergents and soaps
- Shampoos and shaving gel
- Household cleaning products

ALLERGIC CONTACT DERMATITIS

A type IV allergic reaction to a specific substance in contact with the skin. eg biocides in coolant oils, chromate in cement.

All types of endogenous and exogenous eczema can present with either 'wet' (blistering and weeping) or 'dry' (hyperkeratotic and fissured) eczema.

TREATMENT

Avoidance of irritants

- Soap substitutes eg Aqueous cream.
- Gloves eg household PVC gloves should be used for wet work / dishwashing. Gloves may also be required for dry work eg gardening

Emollients

- Ointments are more effective than creams
- Apply frequently (2 - 4 hourly) and generously.

Creams:

Aqueous, E45, Diprobase etc.

Ointments:

Emulsifying, Diprobase, 50/50 white soft paraffin/liquid paraffin Epaderm, Hydramol

Topical Steroids

- Moderate to potent strength

Dry and scaly eczema

eg. Betnovate ointment bd for 4 - 6 weeks

Review and reduce to Betnovate RD/Eumovate.

Wet, weeping or blisters

- Burst blisters
- Potassium permanganate soaks 1:10,000 10-15 minutes twice daily for 5 - 7 days
- Flucloxacillin qds 14 days
- Betnovate-C cream/Fucibet cream bd for 2 - 3 weeks

When dry switch to Betnovate ointment/Betnovate RD ointment

THERAPEUTIC TIPS

Other skin conditions can mimic Eczema and should be kept in mind.

Examine the skin all over as this can provide clues to other diagnoses eg plaques in extensor distribution in psoriasis, scabetic nodules.

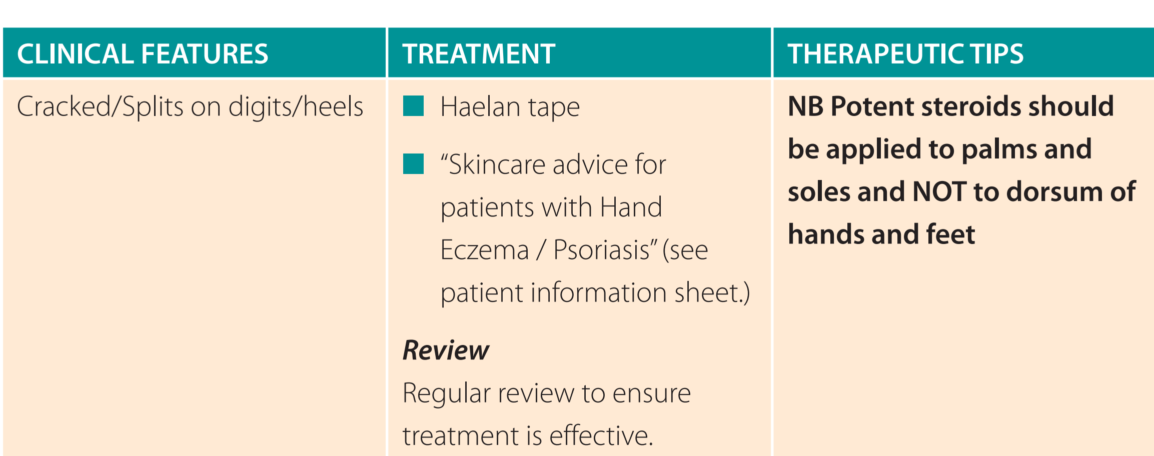
If allergic or irritant contact dermatitis is suspected, a careful occupational and social history should be taken. The patient may need Patch Tests.

Patch Testing

Is only of value in some patients with eczema. Patch Tests are of no value in type 1 reactions (eg food allergies, anaphylaxis or urticaria).

In practice the cause of eczema is often multifactorial and external factors may precipitate eczema in a constitutionally predisposed individual.

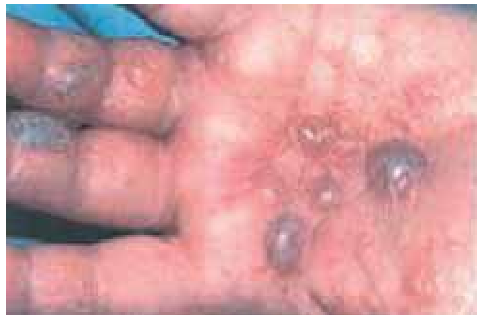
If eczema is present on only one hand fungal infection needs to be excluded by taking skin scrapings for mycology.



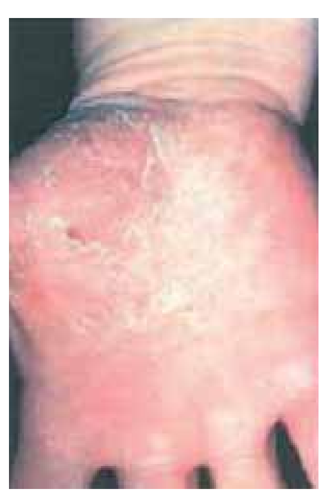
CLINICAL FEATURES	TREATMENT	THERAPEUTIC TIPS
Cracked/Splits on digits/heels	■ Haelan tape ■ "Skincare advice for patients with Hand Eczema / Psoriasis" (see patient information sheet.) ***Review*** Regular review to ensure treatment is effective.	**NB Potent steroids should be applied to palms and soles and NOT to dorsum of hands and feet**

CRITERIA FOR REFERRAL

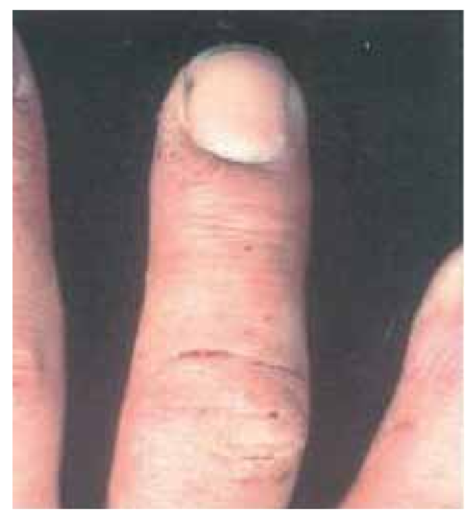
- If allergic contact dermatitis is suspected and Patch Testing is required.
- Severe chronic hand dermatitis, which is unresponsive to standard treatment. ie not significantly improved after 2 weeks



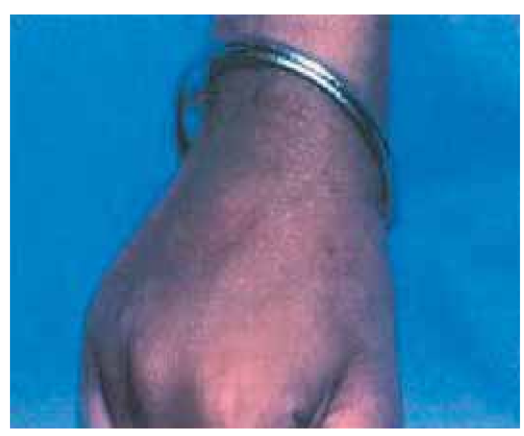
'wet' (blistering and weeping)



'dry' (hyperkeratotic and fissured eczema)



Splits and cracks 'dry' eczema



Lichenfied eczema

Consultants: Dr J E Ferguson
Dr H Muston

Dermatology Service
Buccleuch Lodge, Withington
Tel: 611 3912

Skin care advice for patients with hand eczema / dermatitis

Application of treatment

- Apply prescribed steroid cream/ointments generously twice a day until much improved, then daily.
- Use moisturisers to soften the skin frequently (at least twice a day).
- Use a soap substitute (Aqueous Cream, Diprobase Cream or Emulsifying Ointment) to wash.

Hand washing

Use lukewarm water and a soap substitute or simple soap to wash. Rinse thoroughly and dry hands carefully. Apply a moisturiser afterwards.

Washing up

- AVOID skin contact with detergents, polishes, solvents (white spirit) and cleansers (eg Swarfega).
- Always wear gloves and use long handled brushes for washing pans.
- Wear cotton gloves inside rubber or PVC gloves for increased comfort.

Housework

Wear cotton gloves for dry jobs such as polishing and rubber/PVC gloves for wet work.

Cooking

Avoid direct contact with oranges, lemons, grapefruits, garlic etc and raw meat and fish.

Shampooing hair

Wear gloves and avoid direct contact with shampoos and hair care products.

Skin protection in cold weather

Use plenty of moisturising creams and wear gloves to avoid drying and chapping of skin.

REMEMBER:

Hand care should be continued after the skin appears normal because the resistance of the skin to soaps and detergents is low for up to six months after the skin has healed and looks normal.

Section 4

Atopic eczema

CLINICAL FEATURES	TREATMENT	THERAPEUTIC TIPS
Atopic eczema is a common disease affecting up to 15% of children. Involvement of the face frequently occurs in infants. The characteristic flexural distribution is usually present by the age of 18 months. Spontaneous improvement tends to occur throughout childhood with complete clearance by teenage years in 50% +. Realistic treatment aims need to be discussed with the patient and parents/carers.	**Emollients** Emollients should be prescribed in all cases. **Added to the bath** eg: ■ Oilatum ■ Balneum ■ Aveeno **Shower preparations** ■ Oilatum shower gel ■ E45 emollient wash cream **Used directly on the skin during and after bathing:** ■ Aqueous cream ■ Diprobase cream ■ E45 cream ■ Aveeno ■ Hydromol **Greasier preparations** eg: ■ Emulsifying ointment ■ WSP (white soft parafin) ■ 50/50 = WSP/LP ■ Epaderm ■ Hydramol ointment Are better at hydrating dry skin	**Tips** ■ Soaps and detergents including bubble bath and shower gels should be avoided ■ Bathing is not harmful but soap substitutes and emollients should be used. ■ Choose cotton clothing and avoid wool next to the skin ■ Fingernails should be kept short to reduce skin damage from scratching.
Children ***Mild*** - Any site ***Mild/Moderate*** - Flexural/ Face	***Topical Steroids*** Hydrocortisone 1% ointment bd Hydrocortisone 1% ointment bd	**Tips** Use body surface area charts to calculate correct quantities 1% Hydrocortisone-containing preparations are safe for long term use. 1% Hydrocortisone is the only mild potency steroid

CLINICAL FEATURES	TREATMENT	THERAPEUTIC TIPS
Moderate - Trunk/Limbs ***Severe***	Clobetasone Butyrate 0.05% ointment bd (Eumovate) Start treatment as for moderate and refer	A moderately potent steroid Use 2 - 4 weeks, review and reduce to 1% Hydrocortisone
For eczema of any severity with a poor response to standard treatment	**Topical immunomodulaters** Pimecrolimus 1% cream equivalent strength to 1% hydrocortisone Tacrolimus 0.03% ointment equivalent to betnovate	Tacrolimus is very useful on the face, neck and flexures where potent steroids are contraindicated. Burning and irritation may occur and wears off within 7-10 days. Avoid in presence of viral infection e.g. herpes simplex.
Adults ***Mild*** - Any site ***Moderate*** - Any site ***Severe*** - Trunk/Limbs	Treatment as for children. See above Treatment as moderate T/L eczema as for children Betamethasone valerate 0.1% ointment	■ Creams are preferable in flexural sites ■ Ointments are preferable elsewhere A potent steroid Use 2 - 4 weeks, review and reduce to Clobetasone butyrate or 1% Hydrocortisone
For eczema of any severity with a poor response to standard treatment	Topical immunomodulaters Tacrolimius 0.1% ointment	Potency equivalent to strong steroids e.g. betnovate. Very useful on face and neck where potent steroids are relatively contra-indicated. Burning and irritation is common in first ten days and wears off. Avoid in presence of active viral infection e.g Herpes simplex or viral warts

CLINICAL FEATURES	TREATMENT	THERAPEUTIC TIPS
Infection Suspect infection if: ■ Poor response to topical steroid treatment ■ Weepy, crusting, bleeding ■ Sudden flare	**Substitutions - For infected skin** ***Instead of 1% Hydrocortisone use Steroid - Antibiotic combined preparations, e.g:*** ■ Hydrocortisone 1% Clotrimazole ■ Hydrocortisone 1% Miconazole nitrate ■ Hydrocortisone 1% Clioquinol 3% ■ Hydrocortisone 1% fusidic acid	Take skin swabs: Commonest pathogens: Staphylococcus aureus Streptococcus pyogenes
	Instead of Clobetasone butyrate 0.05% use ■ Trimovate cream *or* ***Instead of Betamethasone valerate 0.1% use*** ■ Betamethasone valerate 0.1% Clioquinol 3% ■ Betamethasone valerate 0.1% Neomycin sulphate 0.5% ■ Betamethasone valerate 0.1% Fusidic acid 2% ***If extensive or severe infection - ADD*** Oral antibiotics ■ Flucloxacilllin 500mg qds x 14 days or ■ Erythromycin 500mg qds x 14 days ***If recurrent infections occur Take nasal swabs from family members and if positive use:*** ■ Naseptin qds x 10 days or ■ Bactroban nasal bds x 5 days	Children over 2 yrs 250mg qds x 14 days To eradicate nasal carriage of Staphylococcus aureus

CLINICAL FEATURES	TREATMENT	THERAPEUTIC TIPS
	Bandaging Zinc paste bandages (Zipzoc) used alone or over topical corticosteroids can result in rapid improvement of lichenified eczema. Wet wrap dressings (e.g. Tubifast) may also be helpful, particularly at night	Bandaging techniques may be demonstrated by a suitably trained nurse or nurse specialist.
Allergies and allergy testing		No tests are available to confirm or refute food allergy as a cause of worsening eczema. RAST tests and skin prick tests are not helpful. Patch testing is used to investigate specific allergic contact eczema, a rare occurrence in children with atopic eczema.
	Keep dust down and in severe cases try protective coverings to pillows and bedding.	House dust mite can aggravate eczema in some children. Food allergies, especially to egg and dairy products only occasionally cause worsening of eczema.
	Consider exclusion diets only in difficult cases and abandon if no improvement apparent after 2 - 4 weeks.	Food allergy or intolerance is often a temporary phenomenon. An attempt should therefore be made every few months to re-introduce the food in question. Dietetic advice is required if exclusion diets are used for more than 2 - 4 weeks. The commonest manifestation of food allergy is urticaria not eczema.

CRITERIA FOR REFERRAL TO SPECIALIST NURSE CLINICS
(Community and hospital based)

Known cases of eczema for:

- Patient education / advice
- Review of treatment
- To learn techniques eg. wet wraps / paste bandages etc

CRITERIA FOR A REFERRAL TO DERMATOLOGIST

Only cases of severe or difficult eczema usually need to see a Dermatologist

- For consideration of second line treatment eg. phototherapy or cytotoxic drugs
- Eczema herpeticum
- If allergic contact dermatitis is suspected
- For in-patient treatment

Section 5

General notes on prescribing dermatology products for patients

The BNF recommended quantities of EMOLLIENTS to be given to ADULTS for twice daily application for one week are:

EMOLLIENTS/TWICE DAILY	CREAMS & OINTMENTS	LOTIONS
Face	15 - 30g	100ml
Both hands	25 - 50g	200ml
Scalp	50 - 100g	200ml
Both arms or both legs	100 - 200g	200ml
Trunk	400g	500ml
Groin and genitalia	15 - 25g	100ml

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

The recommended quantities of STEROIDS to be given to ADULTS for twice daily applications for one week are:

STEROIDS/TWICE DAILY	CREAMS & OINTMENTS
Face	15 - 30g
Both hands	15 - 30g
Scalp	15 - 30g
Both arms	30 - 60g
Both legs	100g
Trunk	100g
Groin and genitalia	15 - 30g

Prescribing topical steroids for children

Children, especially babies, are particularly susceptible to side effects. The more potent steroids are contra-indicated in infants less than one year, and in general should be avoided or used with great care for short periods.

How much topical treatment?

How much to apply

Adults

2.5 FTU - Face & neck

7 FTU - Trunk (front)

7 FTU - Trunk (back)

3 FTU - One arm

1 FTU - One hand

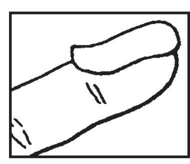
6 FTU - One leg

2 FTU - One foot

Children - number of FTU's

AGE	3-6 mths	1-2 yrs	3-5 yrs	6-10 yrs
Face & Neck	1	$1\frac{1}{2}$	$1\frac{1}{2}$	2
Arm & hand	1	$1\frac{1}{2}$	2	$2\frac{1}{2}$
Leg & Foot	$1\frac{1}{2}$	2	3	$4\frac{1}{2}$
Trunk (front)	1	2	3	$3\frac{1}{2}$
Trunk (back)	$1\frac{1}{2}$	3	$3\frac{1}{2}$	5

F.T.U. = Finger Tip Unit
(ref 1)



1 F.T.U. = 0.5g

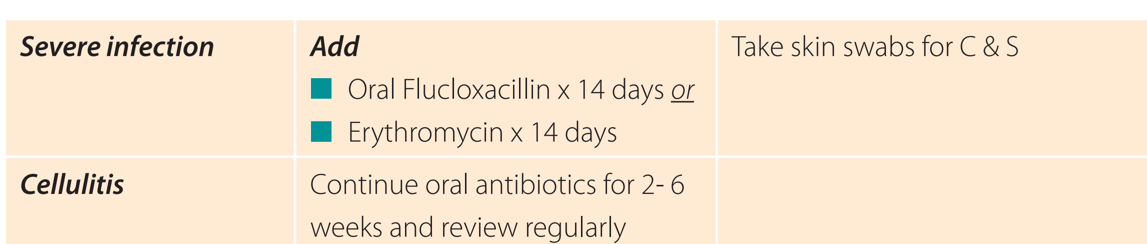
How much to prescribe (extensive body rash)

Children - dose depends on **PROPORTIONAL SURFACE AREA** (ref 2)

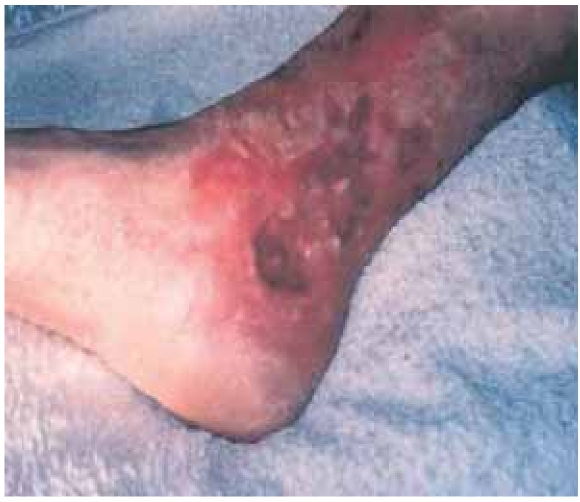
	% ADULT DOSE	DAILY (B.D. USE)	WEEKLY (B.D. USE)
Adult	100%	35.0g	245g
12yrs	75%	26.5g	183g
3-4 yrs	50%	17.5g	122g
Infant	25%	8.7g	61g

References: 1. Adapted from B.J. Derm. 1998; 138:293 and Clin. Exp. Derm 199; 16:444 2. Adapted from B.N.F.

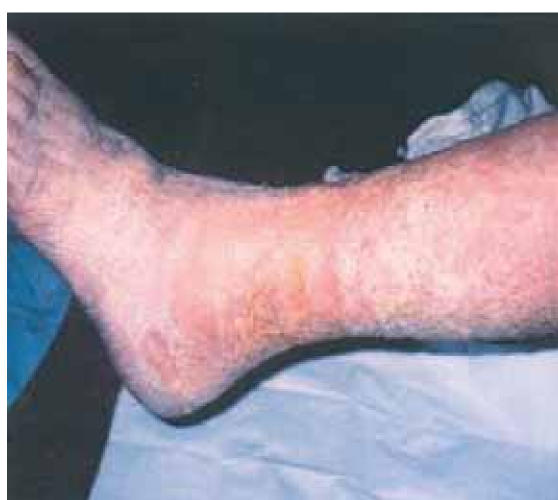
CLINICAL FEATURES	TREATMENT	THERAPEUTIC TIPS
Varicose eczema commonly co-exists with varicose ulcers	All patients need ■ Emollients Emulsifying ointment 50/50 WSP/LP Epaderm ■ Soap substitutes Aqueous cream E45 cream etc ■ Topical steroids ■ Below knee compression stockings	Class II Duomed, Sygvaris, Medi or similar stockings
Mild	1% Hydrocortisone ointment bd	Safe to use long term
Moderate - Severe or 'Discoid' eczema	Betamethasone valerate 1% (Betnovate) ↓ Betnovate RD ointment ↓ 1% Hydrocortisone ointment	Use 2 - 4 weeks only then reduce to lowest effective strength (1% Hydrocortisone)
Infection Wet, weeping or blisters	■ Burst blisters ■ Potassium permanganate soaks 1:10,000 for 10-15 minutes twice a day ***Substitute*** Steroid-antibiotic preparations eg. ■ Hydrocortisone 1% Clioquinol 3% *Instead of 1% Hydrocortisone* ■ Betamethasone valerate 0.1% Clioquinol 3% *Instead of Betamethasone valerate 0.1%*	Use creams if wet/weeping Use ointment if dry/scaly



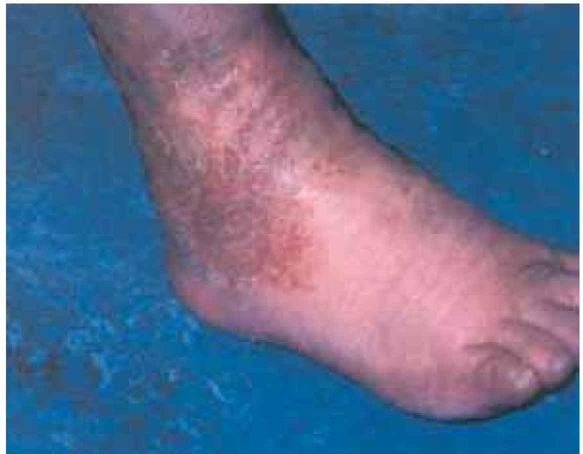
Severe infection	***Add*** ■ Oral Flucloxacillin x 14 days <u>*or*</u> ■ Erythromycin x 14 days	Take skin swabs for C & S
Cellulitis	Continue oral antibiotics for 2- 6 weeks and review regularly	



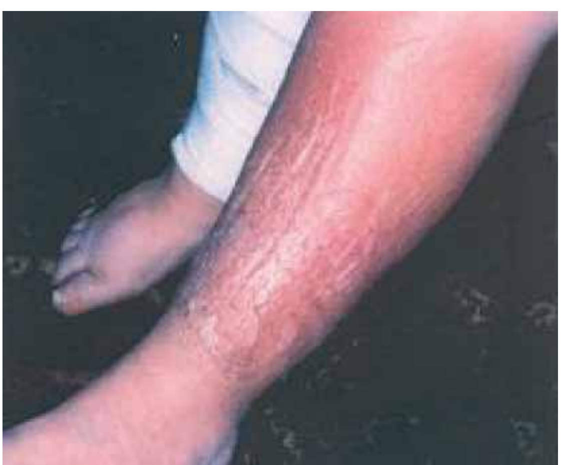
Wet/weepy infected eczema and ulcers



Dry/scaly eczema and ulcers



Blisters/weeping eczema



Dry/scaly eczema

Acquired allergic sensitivity to topical medicants (ie allergic contact dermatitis) is a common cause of failure to respond to treatment. Refer patients who fail to repond to standard treatment.

Section 7

Psoriasis

CLINICAL FEATURES	TREATMENT	THERAPEUTIC TIPS
Psoriasis is a chronic relapsing condition; mild to moderate disease can usually be managed in primary care. Before referral basic treatment should be tried as outlined.	**Chronic plaque psoriasis** First line therapy: **1. Vitamin D analogues** ■ Calcipotriol b.d. ■ Tacalcitol m.d.	Expect improvement to be gradual, achieving maximum effect over 6 - 12 weeks. If irritation occurs use 1% hydrocortisone or Eumovate ointment once daily and Vitamin D analogues once daily.
Use Body Surface Area charts to calculate correct quantity of treatment.	**2. Tar preparations** *Refined* ■ Psoriderm (6%) ■ Exorex lotion (1%) ■ Carbo-dome cream (10%)	Refined tar products are less smelly or messy than older unrefined preparations. May stain clothes or irritate. Expect slow response over 6 - 12 weeks.
	Crude ■ Betnovate 25% in coal tar paste (Betnovate ointment 1 part, coal tar paste 3 parts) mitte 200gm ■ 3% coal tar solution (CTS), 3% salicylic acid in Unguentum M ■ 5% CTS 2% salicylic acid in Unguentum M ■ 10% CTS 2% salicylic acid in Unguentum M	Crude Tar preparations are often very effective.

Section 7

CLINICAL FEATURES	TREATMENT	THERAPEUTIC TIPS
Chronic plaque psoriasis continued	**3. Dithranol preparations** ■ Dithrocream 0.1- 2% ■ Micanol 1%, 3% Always start with the lowest strength, applied daily to plaques for 15 - 30 minutes only, then wash off. Increase strengths weekly unless irritancy occurs. Prescribe range: eg ~ Dithrocream 0.1% ~ Dithrocream 0.25% ~ Dithrocream 0.5% ~ Dithrocream 1.0% ~ Dithrocream 2.0% as this counts as one prescription item	Can be used as 'short contact therapy' at home, avoiding face, flexures and genitals. Very effective if used correctly. Time consuming so only useful if patient is motivated. Stains everything including skin (temporary) and may burn.
	4. Topical Vitamin A Analogues ■ Tazarotene gel Apply daily and pretreat plaque and surrounding skin for one hour with Vaseline/WSP to reduce the risk of irritancy. Start with 0.05% increasing to 0.1%	May be useful in fairly limited disease (<10%) with well-defined plaques.
	5. Dovobet Once a day for a maximum of 4 - 8 weeks at any one time. Switch to treatments 1 - 4 above if any residual disease. Leave at least 2 months before repeating Dovobet.	Dovobet is a combination of calcipotriol and Betnovate. Prolonged use can cause skin thinning and rebound flare of psoriasis
	6. For very inflamed / very sensitive psoriasis intolerant of above treatments: Emulsifying ointment qds for 2 weeks Restart antipsoriatic treatment as skin improves	

CLINICAL FEATURES	TREATMENT	THERAPEUTIC TIPS
Guttate psoriasis Numerous small lesions, mostly on trunk, generally affecting children / young adults Self-limiting over 3 - 6 months. Often post streptococcal throat infection	Treat with emollients plus trials of tar preparations. (Psoriderm, Alphosyl HC to face / flexures) or Vitamin D analogues. Penicillin V 250mg - 500mg qds for 14 days	If severe or persistant refer for phototherapy.
Face / flexural psoriasis Smooth well demarcated areas in axillae, groins, inframammary folds and natal cleft. May occur alone or with chronic plaques elsewhere.	***Mild /moderate*** - Hydrocortisone 1%, Miconazole nitrate 2% cream (Dactacort) - Hydrocortisone 1%, clotrimazole 1% cream (Canesten HC) - Tacalcitol cream - Alphosyl HC Cream ***Moderate/severe*** - Trimovate cream (flexures) - Clobetasone butyrate 0.05% cream (hairline)	Apply twice daily until clear (2 - 4 weeks) Restart when relapses Safe for long term use. Apply once daily Apply twice daily - Restricted to 2 - 4 weeks use at any one time Review and reduce to hydrocortisone-based preparations

CLINICAL FEATURES	TREATMENT	THERAPEUTIC TIPS
Scalp psoriasis	***Mild***	
	■ Medicated shampoo Polytar Alphosyl 2 in 1 T-gel Capasal 2% Ketoconozole	
	Moderate	
	■ Shampoo + anti inflammatory lotion Calcipotriol scalp solution Betamethasone 0.1% solution Betamethasone 0.5% + salicylic acid Fluocinolone Acetonide gel	Often take 4 - 6 weeks for maximum effect
	±	
	■ Keratolytics for descaling thick plaques e.g. 5-15% salicylic acid in Unguentum M	Leave on overnight and wash out with shampoo. Repeat nightly until clear then prn.
	Severe	
	■ Anti inflammatory ointments Cocois / Ung Cocois Co SCC Sal cap + Ceanel shampoo	Apply overnight Wash out with Ceanel shampoo Repeat until clear then prn. Need approx 200g per week. For first 2 weeks See patient instruction leaflet

CRITERIA FOR REFERRAL

- Extensive / severe or disabling psoriasis
- Failure to respond to adequate treatment or rapid relapse post treatment
- Extensive acute guttate psoriasis
- Unstable and generalised pustular psoriasis

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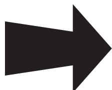
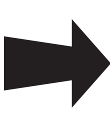
Instructions for using Dovobet in patients with stable plaque psoriasis

- Apply Dovobet once a day for up to 4 weeks
- Progress Review with Doctor at 4 weeks :-



CLEAR

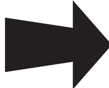
Stop Dovobet and use emollients



IMPROVED BUT NOT CLEAR

Start a second course of Dovobet for up to 4 weeks and REVIEW again

If not clear after 8 weeks of Dovobet - use alternative or refer.



NO BETTER

Stop Dovobet and use an alternative treatment e.g.

- Dithrocream
- Betnovate 25% + CTP
- Calcipotriol
- Tacalcitol

'Clearance' means the skin is flat to touch. Any red marks left will resolve without further treatment.

- Dovobet must *not* be used for more than 8 weeks at any one time.
- Dovobet can be used again after an interval of 8 weeks.

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Dithranol cream for psoriasis

Dithranol cream is an effective treatment for plaque psoriasis. Five strengths of cream are available:

0.1%	0.25%	0.5%	1%	2%
Blue	Red	Purple	Brown	Yellow
(weakest)				(strongest)

Select a test patch of psoriasis (knee or elbow) for the first treatment. If there are no problems with the test area, apply Dithranol cream once daily to psoriasis on the body and limbs. Avoid eyes, face, skin folds (e.g. underarms) and groins.

1. Apply the weakest strength (0.1%) of Dithranol cream to patches of psoriasis. Try to avoid putting it on normal skin.
2. Wash off after 30 minutes.
3. Apply moisturiser to skin afterwards.
4. Increase the strength of Dithranol cream every 3 - 5 days. Continue daily treatment until the skin clears (4 -6 weeks).
5. If your skin becomes sore, stop Dithranol cream for a few days and continue emollients. Restart treatment using a lower strength of Dithranol cream.

Successful treatment often involves increased redness of the psoriasis and brown staining of the surrounding skin. Dithranol also stains clothes. Baths/showers should be cleaned immediately after use to avoid permanent staining.

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Treatment of scalp psoriasis/eczema with Ung SCC Sal Cap or Ung Cocois Co

1. Massage generous amounts of the ointment into the affected areas of the scalp, or if it easier apply the ointment along multiple partings of the hair.
2. Leave the ointment on overnight and wash out with Ceanel shampoo OR leave on for 2 - 4 hours if preferred.
3. If using the overnight method, use a bathcap or old pillowcase as the ointment can stain.
4. The treatment should be carried out daily until the scaling is under control (often 7 - 10 days).
5. Once the scaling is under control use the treatment once or twice a week as required.
6. A hair conditioner or a combined shampoo/conditioner of your choice may be used after shampooing with Ceanel.
7. Failure to respond is usually always due to not applying enough ointment and/or maintaining daily treatment long enough: some patients need treatment for 3-4 weeks to get clear.

Section 8

Urticaria and angioedema

CLINICAL FEATURES	TREATMENT	THERAPEUTIC TIPS
Reassure the patient that it is benign and usually self-limiting. ***Minimise:*** ■ Overheating ■ Stress ■ Alcohol ***Review*** ■ Drug history The following drugs can cause and/or make worse all forms of urticaria:- aspirin, codeine, morphine, NSAIDs, ACE inhibitors and penicillin. ***Exclude:*** ■ C1 Esterase Inhibitor Deficiency (If angioedema is the only sign) ■ Insect bites	Antihistamines There is relatively little to choose between different antihistamines. Individuals may vary in their response to different agents. Use non-sedative antihistamines first. Antihistamines reduce, but do not suppress the rash unless the diagnosis is dermographism or cholinergic urticaria. Use continuous medication if attacks occur regularly. Use fast acting antihistamines as required for sporadic attacks. If there is no response to one agent after six weeks, double the dose or try a second and then a third agent. If there is discomfort at night disturbing sleep then a sedative antihistamine can be used. In some cases of severe acute urticaria such as a Penicillin reaction, a short reducing course of Prednisolone starting at 30mgs-40mgs od may be useful. Systemic steroids should be used for short periods only.	The cause of chronic urticaria, ie history > 3 months with weals lasting several hours or longer, is rarely found. Prick tests and RAST tests are of no value in urticaria. The cause of food allergy is usually obvious from the history. Contact urticaria is rare and the cause is obvious from the history. Patch tests have no place in the investigation of urticaria. Physical urticarias including: ■ Dermographism ■ Cholinergic urticaria ■ Cold urticaria ■ Solar urticaria ■ Pressure urticaria ■ Aquagenic urticaria ■ Delayed pressure urticaria can usually be identified from the history. Urticaria may follow non-specific infections, hepatitis, streptococcal infections, campylobacter and parasitic infestations. Rarely it may be a symptom of an underlying systemic disease such as thyroid disease or connective tissue disease.

Summary of non-sedating and low-sedating antihistamines

NAME	DRUG INTERACTIONS	COMMENTS
Acrivastine	None	Short acting. Avoid in renal impairment and pregnancy.
Cetirizine/Levocetirizine	None	Minimally sedating. Halve the dose in renal impairment. Avoid in pregnancy.
Fexofenadine	None	Avoid in pregnancy.
Mizolastine	Imidazoles, Macrolide antibiotics	Avoid in cardiac disease, pregnancy and severe hepatic impairment.
Loratidine/Desloratidine	None	Avoid in pregnancy.

More sedating antihistamines

NAME	DRUG INTERACTIONS	COMMENTS
Hydroxyzine	Yes	Sedative.
Chlorpheramine maleate	Yes	Mild to moderate sedataive. Ok in pregnancy.
Dothiepin Hydrochloride	Yes	Sedative.

Section 9

Generalised pruritus

CLINICAL FEATURES	TREATMENT	THERAPEUTIC TIPS
Dry skin, low grade eczema and scabies are the commonest cause of generalised pruritus. A full history and skin examination are required.	■ Standard emollients and soap substitutes eg Aqueous cream, Emulsifying ointment. ■ Crotamiton or Crotamiton combined with hydrocortisone cream. (Eurax HC) Apply twice daily /prn to pruritic areas. ■ 1% Menthol in Aqueous cream. Apply as often as necessary to pruritic areas. ■ Doxepin HCL cream (Xepin). Maximum 12g daily. No more than 10% BSA treated at any one time. If symptoms are still uncontrolled consider: Sedating antihistamines (nocte) ■ Hydroxyzine 25 - 75mg 10 - 30mg (elderly) ■ Chlorpheniramine maleate 2 - 4 mg also ■ Dothiepin 50 - 150mg ■ Doxepin 50 - 100 mg ■ Amytriptyline 25 - 150 mg	If **NO RASH** can be seen other than excoriations consider the following: ■ Anaemia Especially iron deficiency ■ Low serum iron without anaemia ■ Uraemia ■ Obstructive jaundice ■ Thyroid disease both hypo and hyperthyroidism ■ Lymphoma, especially in young adults ■ Carcinoma, especially in middle-age and elderly ■ Psychological Investigations: ■ FBC and differential ■ ESR ■ Urea and electrolytes ■ LFT's ■ Thyroid function tests ■ Iron studies Fe/TIBC/Ferritin ■ Chest X-ray **NB Pruritus may occasionally predate a lymphoma by several years. Regular follow-up is indicated for patients whose itching is unexplained.**

Viral warts

CLINICAL FEATURES	TREATMENT	THERAPEUTIC TIPS
Viral warts/verrucae No cure. Can only clear > 70% resolve spontaneously in 2 years. Plantar warts are more persistent. Topical treatment is as effective as cryotherapy for hand warts.	***Topical keratolytics*** ***Hand warts*** Use high concentrations of salicyclic acid. ***Adults*** Eg Occlusal (25% Salicylic acid) ***Children*** Eg Duofilm (16.7% Salicylic Acid) Salactol (16.7% Salicylic Acid) ***Plantar warts*** Verrugon (50% Salicylic Acid) Chiropody ***Cryotherapy*** Freeze times Face 5 - 7 seconds Hands 10 - 12 seconds Feet 1st freeze 15 seconds Thaw 1 - 2 minutes 2nd freeze 10 - 15 seconds	Use 'Soak-Pare-Paint' regimen (see patient information leaflet) ■ 3 months trial of treatment Up to 6 treatments
Plane warts (face/ hands)	No treatment or trial of Tretinoin 0.025% cream/gel for 4 weeks	Plane warts are notoriously resistant to treatment and usually get worse with cryotherapy/destructive treatments as a result of the Knoeber Phenomenon.
Filiform warts (face/ eyelids)	Cryotherapy Curettage & cautery	Topical keratolytics are too irritant for use on the face.

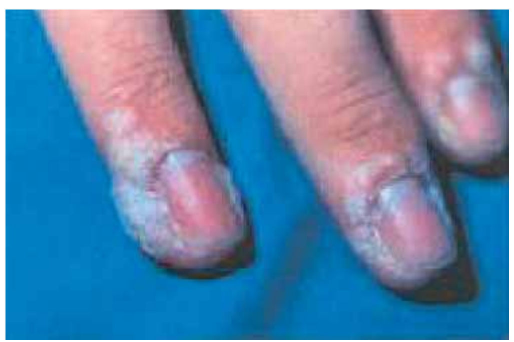
Viral warts

CRITERIA FOR REFERRAL

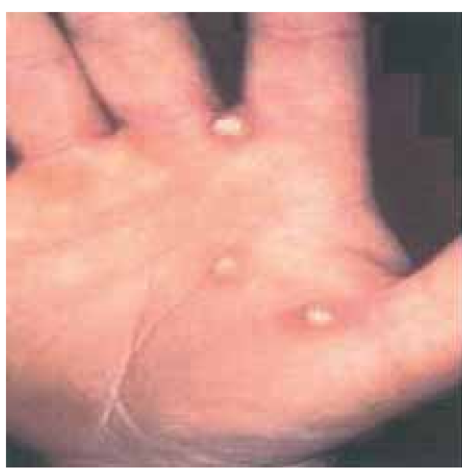
In general patients with viral warts/verrucae should not be referred;

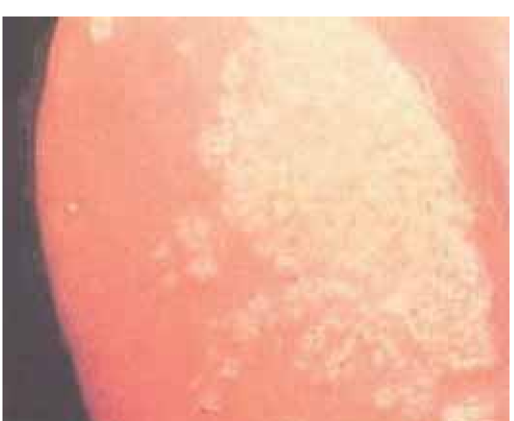
Patients may be referred if:

- Severe disabling warts despite six months of topical salicylic acid treatment + cryotherapy.
- Significant warts or mollusca in immunocompromised patients
- Atypical appearance, atypical site or atypical age (>35 years)
- It is unkind to treat children with cryotherapy for warts

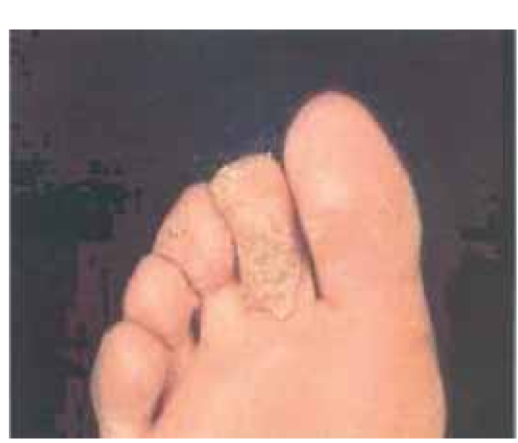


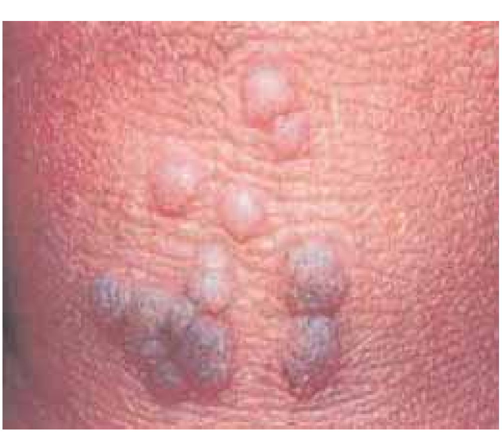
Viral Warts





Mosaic warts on heel





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Soak - pare - paint regime for warts

Warts are caused by an infection with the innocent human wart virus. There is no ideal treatment for warts but approximately 70% will clear within three months if treated with wart paint and a pumice stone. If left untreated, 70% of warts will clear in two years.

INSTRUCTIONS

1. Soak the affected area in warm water (or bath) for 10 minutes.
2. Rub down hard skin with a pumice stone or emery board.
3. Apply wart paint and allow to dry.
4. Repeat steps 1 - 3 each evening on each wart.

Do not stop treatment until one week after you think the wart is gone. If the wart starts to come back, start treating it again.

Persevere!

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Cryotherapy (Liquid Nitrogen) for Viral Warts

Liquid nitrogen is a freezing agent used to treat viral warts and other skin lesions. It destroys the wart and damages a small area of the surrounding skin in the process, resulting in swelling and sometimes blisters.

The skin usually heals uneventfully but there is a small risk of permanent scarring, pigmentation changes, nerve damage and infection at the site of treatment.

The success rate is approximately 70%. Usually several treatments (two to six) are required depending on the body site. Warts may recur even after successful treatment.

Aftercare for patients who have had liquid nitrogen treatment of viral warts

1) After the treatment, the area will swell and may blister. Sometimes the blister fills with blood.

   Blisters should be pricked with a sterile needle and an antiseptic cream (Savlon, Germolene or similar) applied twice a day until healing is complete. A dry dressing or a plaster may be used to cover the wounds. Healing usually takes 3 weeks.

2) Minor pain or discomfort from treatment usually responds to Paracetamol.

3) Increase in pain, swelling or discharge after a few days may mean you may have a secondary infection.

You should arrange to see your GP as antibiotics may be required.

If you need further information or advice please ring the contact number:

Tel:……………………………………………..

Molluscum contagiosum

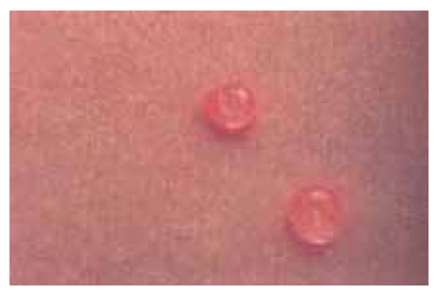
CLINICAL FEATURES	TREATMENT	THERAPEUTIC TIPS
Most lesions spontaneously resolve in 6 - 12 months. Resolution is often preceded by inflammation, swelling and crusting. Patchy dry skin surrounding mc is common.	**No Treatment** **OR** **Trial of hydrogen peroxide 1% cream (Crystacide) 3-6 weeks** Treat complications: *Infection* Topical fusidic acid cream ± oral Flucloxacillin/Erythromycin *Eczema* Treat dry skin (if necessary) with emollients eg E45 Cream. Not with topical steroids	
	Cryotherapy	■ Cryotherapy is very poorly tolerated by young children < 10 years. ■ Risk of permanent scar/ pigmentation changes.

CRITERIA FOR REFERRAL

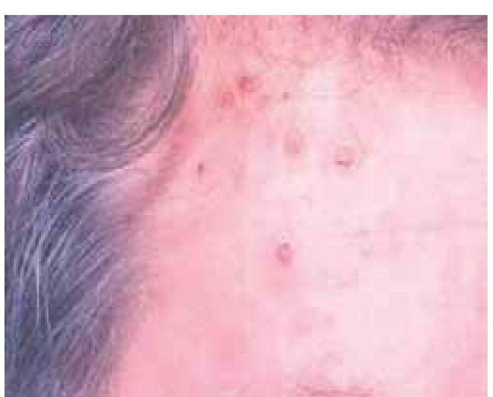
In general patients with Molluscum contagiosum should not be referred.

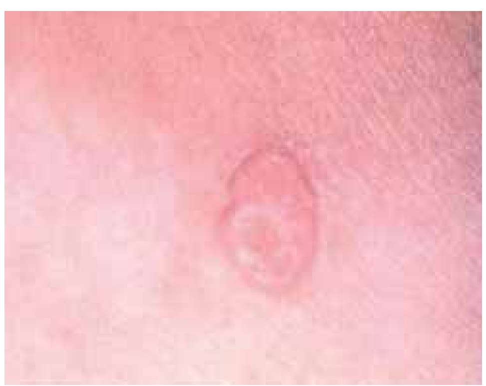
Patients may be referred if:

- Age >10, persistent lesions >1 - 2 years
- Facial lesions
- Giant molluscum
- Immunocompromised

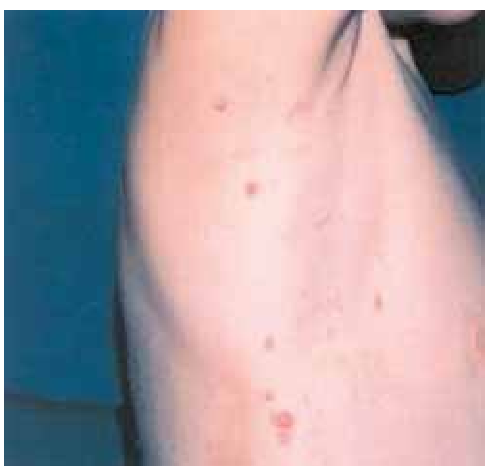


Molluscum contagioscum

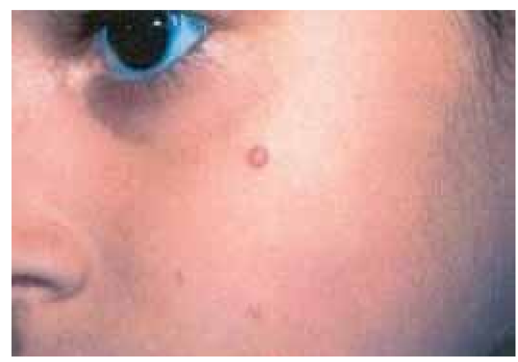




Giant molluscum



Molluscum with dry skin



Section 12

Scabies

CLINICAL FEATURES

Human scabies is an infestation caused by the mite Sarcoptes scabiei.

Mites are most readily transmitted from one person to another by close physical contact (in a warm atmosphere) ie sharing a bed, adults tending to children, children playing with each other or young people holding hands. An individual who has never had scabies before may not develop itching or a rash until 1 - 3 months after becoming infested.

There are

- Burrows on non hair bearing skin eg palms/ soles/wrists/ankles/sides of feet
- and often a widespread eczematous rash (sparing face in older children and adults)

There may be

- Inflammatory nodules on Male genitalia Periareola areas Axilla/groin especially in long standing cases
- Impetiginisation due to secondary infection with Staph. aureus

TREATMENT

Treat when there is a strong clinical suspicion of infestation.

The first step is to kill all mites in the skin using a scabicide.

Apply either:

- Malathion 0.5% Aqueous solution (Derbac-M) (apply with a paintbrush) Or
- Permethrin 5% (Lyclear Dermal cream)

All skin below the chin must be treated including the web spaces of the fingers and toes, under the nails and all body folds.

Malathion should be left on the skin for 24 hours and Permethrin for 8 - 12 hours.

One treatment is usually curative except in crusted (Norwegian) scabies.

Treat residual rash/itch with:

- Crotamiton/ hydrocortisone (Eurax HC)

For impetiginised rash

- Hydrocortisone 1% clinoquinol 3% (Vioform HC) Cream
  $\pm$ Flucloxacillin 7 - 10 days
- Inflamatory nodules settle spontaineously though this can take months.

THERAPEUTIC TIPS

It is essential that all members of the household and any other close social contacts of an infested person should receive treatment at the same time as the patient.

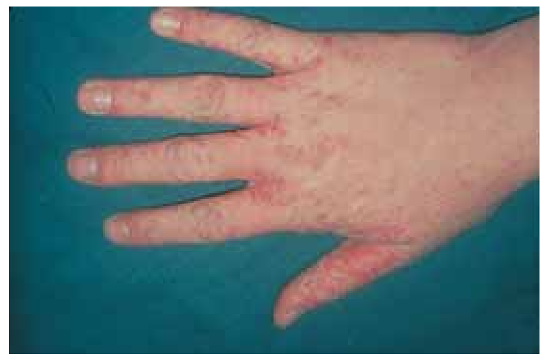
Remind patients to re-apply the scabicide after washing their hands.

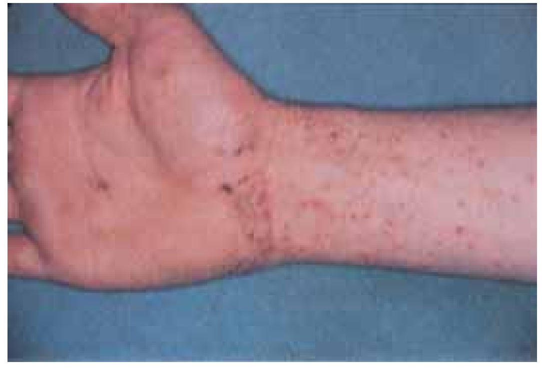
Disinfestation of clothing and bedding other than by ordinary laundering is not necessary.

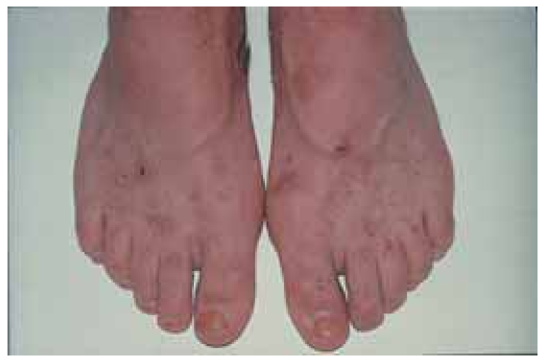
Mites are killed within 24 hrs but the pruritus and rash may take 3 - 6 weeks to settle.

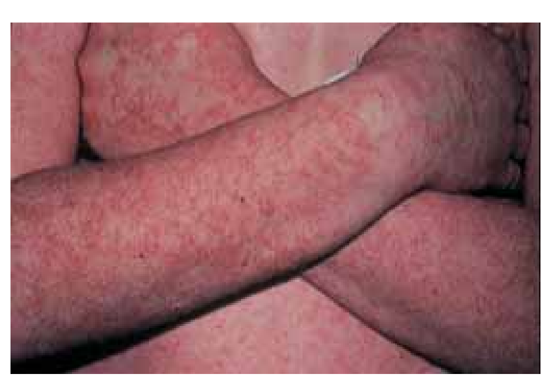
Do not allow repeated use of scabicides to pruritic areas as this may irritate the skin.

Sarcoptes Scabiei









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Instructions for patient with Scabies

Scabies is a skin disease caused by microscopic mites, which burrow into the skin. They are passed from person to person by close physical contact.

For the first couple of weeks following infestation the mites may cause no symptoms but the body then develops an allergic reaction to the mites and an itch rash appears. Because it takes some time for any symptoms to appear an individual is capable of passing on the mite to someone else before they know that they have to condition. For this reason all household contacts and close friends of a person with scabies should be treated even if they have no symptoms.

Scabies is NOT due to poor hygiene. Infestation with the scabies mite is not transmitted by clothing, bedding, lavatory seats etc and there is no need for any special cleaning of these.

How to Treat Scabies

1. Apply a thin layer of lotion or cream to every square inch of the body surface from the chin downwards using a clean paintbrush, or cotton wool. Ensure that all nooks and crannies of the body, especially between the fingers and toes, underneath the nails and in the genital area are adequately treated.
2. Leave lotion or cream on the skin for 24 hours before washing. If the hands or other areas are washed sooner than this, reapply the lotion or cream to these sites.
3. Your doctor may ask you to repeat this treatment after 24 hours.

IMPORTANT

The treatment will kill all the mites. The mites do not survive in bedding etc and it is not necessary to treat these separately. Itching may persist for 4 - 6 weeks after treatment and is managed with mild topical steroid creams and antihistamines by mouth.

Do not continue using the lotion or cream unless advised.

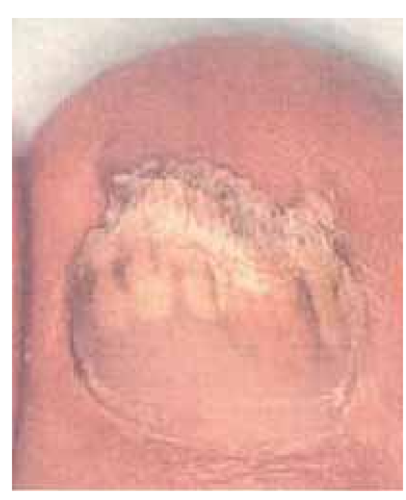
The body does not acquire immunity to scabies infestation and treatment does not prevent another attack. It is, therefore, very important that **ALL CLOSE CONTACTS** are treated at the same time.

Section 13

Onychodystrophy

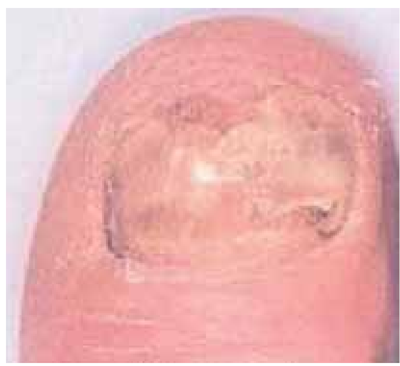
(thickened and dystropic nails)

CLINICAL FEATURES	TREATMENT	THERAPEUTIC TIPS
The thickness of nail plates is normally 0.5mm; this increases in manual workers and in certain disease states such including: ■ Onychomycosis (fungal / yeast infection) ■ Psoriasis ■ Chronic Eczema ■ Lichen Planus ■ Alopecia areata ■ Norwegian scabies ■ Darier's Disease ■ Old age ■ Trauma eg from footwear ■ Congenital ichthyosis	If mycology is positive and dystrophy does not extend to nail matrix (distal onychomycosis) use: ■ Amorolfine (Loceryl) lacquer weekly continued for 6 - 12 months. Alternatively oral treatment: For Fungal Infections ■ Terbinafine (Lamisil) 250mg od 12 - 16 weeks for toenails, 6 - 12 weeks for fingernails ■ Itraconazole (Sporanox) Pulse treatment, 3 pulses of Sporanox (200mg bd for 7 days) repeated monthly 3 cycles for toenails, 2 for fingernails) or 200mg od for 8 - 12 weeks For Yeast Infections Itraconazole (as above)	Examine all nails and all of the skin. Send samples (nail clippings including scrapings of thickened crumbly material from the underside of the nail if present) for mycology. Cultures take up to 6 weeks. If negative mycology, arrange for regular chiropody to keep nails short and offer a trial of treatment **Caution:** **Itranconazole - drug interactions** **NB Asymptomatic patients may be advised to 'leave well alone'** Terbinafine **is not** effective for yeast infections.

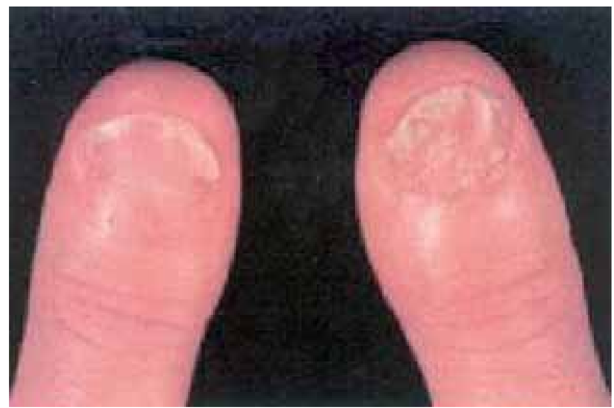


Non-matrix Onychomycosis

Non-matrix Onychomycosis
(superficial white Onychomycosis)



Matrix involved Onychomycosis



Psoriatic nail

Solar keratoses

Section 14

Solar keratoses

CLINICAL FEATURES	TREATMENT	THERAPEUTIC TIPS
Solar keratoses Also known as actinic keratoses, usually multiple, flat, pale or reddish-brown lesions with a dry adherent scale. The vast majority of solar keratoses DO NOT progress to squamous cell carcinoma. Evidence suggests that the annual incidence of transformation from solar keratoses to SCC is less than 0.1%. The risk is higher in immunocompromised patients. It is not necessary to refer all patients with solar keratoses.	■ Diclofenac Sodium (Solaraze) Apply twice daily for 90 days. ■ Topical 5-Flurouracil (Efudix) cream Apply once or twice daily for 2 - 4 weeks. ■ Cryotherapy Freeze for 10 - 15 seconds each **Preventative measures** ■ SP15 (Sunblock) April - September Apply to exposed areas (face, neck, hands) Hat with 3 inch brim for sunny days	Solaraze will produce much less inflammation than Efudix and is better tolerated. Less effective than Efudix for thicker lesions. Efudix is the ideal treatment for multiple, ill-defined solar keratoses. Its spares normal skin. It is safe, efficacious, with little systemic absorption. Marked inflammataion <u>should occur</u> prior to resolution and the patient must be warned to expect this. Advise patient to apply Efudix to only 1 or 2 lesions at a time. Optimum effect 1 month post treatment. Up to 3 cycles of treatment may be used with breaks of 1 - 2 weeks in between.

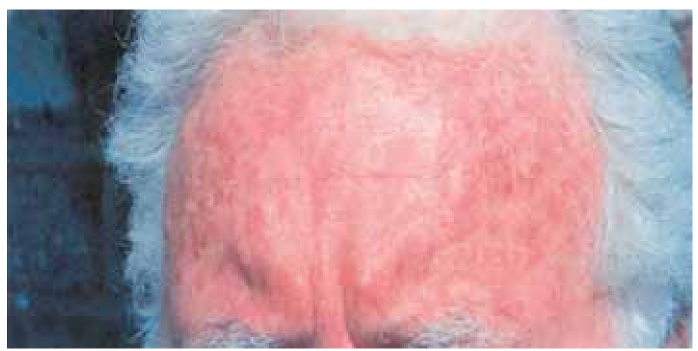
CRITERIA FOR REFERRAL

- If there is suspicion of malignancy
- If the lesions have not responded to treatment (1 - 3 cycles of Efudix cream or Solaraze gel for 90 days)

If the individual is on immunosuppressants (eg post renal transplant)

Consultants: Dr J E Ferguson
Dr H Muston

Patient information leaflet
Efudix (5 fluorouracil cream)



This preparation is for the treatment of sun damage, solar keratoses, pre cancers and superficial skin cancers. Efudix works by destroying the abnormal cells in the skin. It is usual for Efudix to produce some degree of redness and peeling in the process. Although the skin may be quite dramatically inflamed during treatment it usually heals well with little or no scarring.

INSTRUCTIONS ON THE USE OF EFUDIX (5 FLUOROURACIL CREAM)

1) Apply the cream once daily, with the exception of the legs where treatment will be required twice daily.
2) On more sensitive areas, like the face, it is best to wash Efudix off after two hours for the first day or two.
3) If more than a slight irritation develops, or the skin becomes very red and sore or if there is weeping or crusting discontinue treatment for two to five days. When the redness etc. has settled, try re-applying the cream again. Should further irritation occur, stop using the cream or you could produce a severe dermatitis.
4) If you have a severe reaction, stop treatment and apply 1% Hydrocortisone ointment twice daily to the inflamed area until the reaction has settled (usually one to two weeks).
5) If you have only a mild reaction, continue treatment for a month and then stop
6) After a break of treatment for one to two weeks restart steps one to five for one more cycle (face, two more cycles)
7) It generally takes four to eight weeks to clear lesions from the face, and two to three months to clear lesions from the legs.
8) Only treat one or two lesions at a time.

If you need further information / advice please ring

Contact no:…………………………………………..

Section 15

Skin cancer

CLINICAL FEATURES	TREATMENT	THERAPEUTIC TIPS
Basal cell carcinoma Common slow growing and locally invasive tumours. Most are easily recognised with a pearly rolled edge and later central ulceration. Pigmented and morphoeic (scar - like, poorly defined) BCC's are less common.	They are best managed by: 1) Excision Biopsy OR 2) Radiotherapy	In some cases radiotherapy may be the preferred option but a tissue diagnosis (ie incisional or punch biopsy) is required prior to referral to the oncology centre. **Fax to:** **611 3326** **Ring:** **234 2252** **for confirmation**
Squamous cell carcinoma Much less common. They may be slow growing, well differentiated, keratinising or rapidly enlarging, poorly differentiated tumours. Up to 5% may metastasise to regional lymph nodes.	Lesions with a high index of suspicion, especially if rapidly growing should be referred using the Melanoma/SCC HSC 205 proforma. Referrals should be faxed within 24 hours and the patients will be seen within two weeks.	
Malignant melanoma This is the most dangerous skin malignancy. Early detection and treatment is vital for optimizing outcome. **Melanoma subtypes** ■ Superficial spreading ■ Nodular ■ Amelanotic ■ Lentigo Maligna ■ Acral lentiginous and subungual	All suspicious moles must be referred using the Melanoma/ SCC HSC 205 proforma and will be seen within two weeks. Any lesion felt to be highly suspicious of melanoma will either be excised on the day of attendance or within 1 - 2 weeks.	

CRITERIA FOR REFERRAL

The following seven point checklist may be useful in deciding whether to refer a changing pigmented lesion.

Refer if at least one major or two minor criteria present.

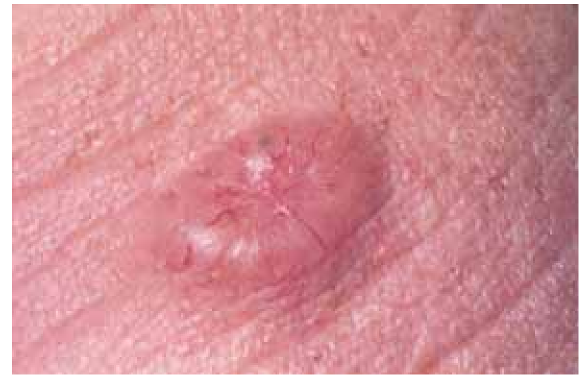
Major features

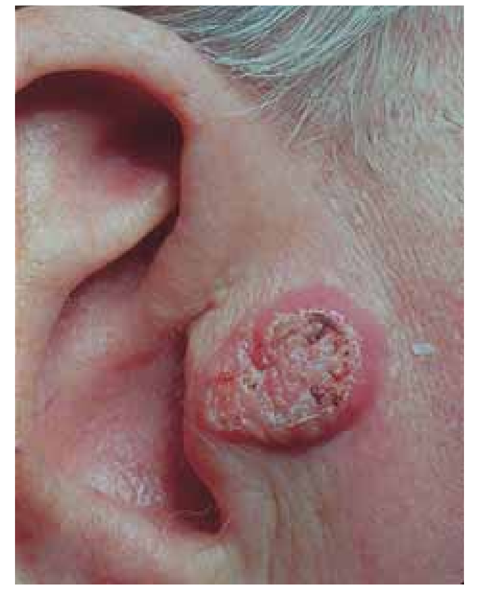
- Change in size
- Change in colour (variability of pigmentation)
- Change in shape (irregularity of edge)

Minor features

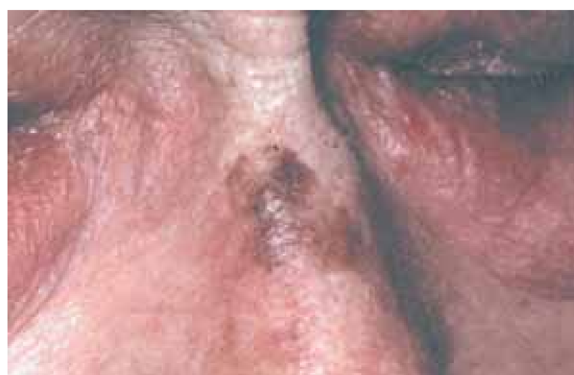
- Size > 6mm diameter
- Inflammation
- Bleeding/crusting
- Itch

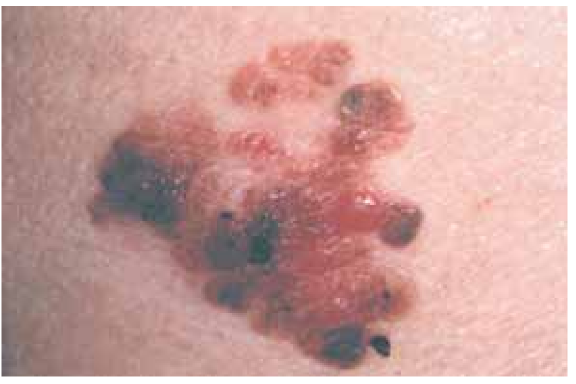
Non melanoma skin cancer

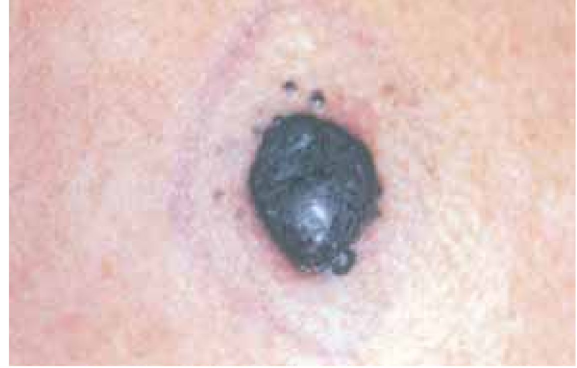

Basel cell carcinoma

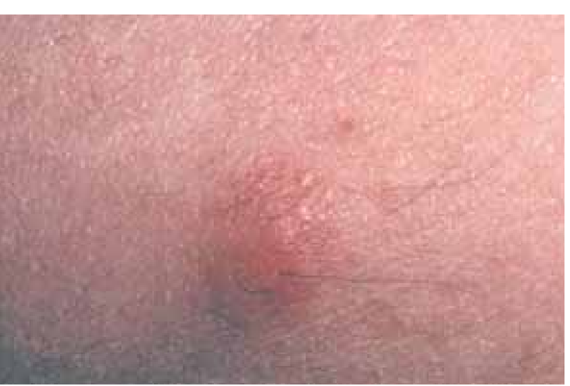

Squamous cell carcinoma

Malignant melanomas


Lentigo maligna melanoma


Superficial spreading malignant melanoma


Nodular melanoma


Amelanotic melanoma

Section 16

Patient support groups

Acne Support Group Miss Alison Dudley PO Box 230 Hayes, Middlesex , UB4 0UT Tel: 0208 841 4747 www.stopspots.org.uk	**National Eczema Society** Hill House, Highgate Hill London N9 5NA Tel: 020 7281 3553 Eczema Information Line: 0870 241 3604 (Mon - Fri 9 - 5pm) www.eczema.org
British Allergy Foundation Muriel A Simmons Deepdene House, 30 Bellegrove Road Welling , Kent DA16 3PY Tel: 020 8303 8525 Helpline: 020 8303 8583 (Mon-Fri 9 - 5pm) www.allergy.baf.com	**The Psoriasis Association** Milton House Milton Street Northampton NN2 7JG Tel: 01604 711129 • Fax: 01604 792894
Hairline International Ms Elizabeth Steel Lyons Court, 1668 High Street Knowle, West Midlands B93 0LY Tel: 01564 775281 • Fax: 01564 782270 www.hairlineinternational.com	**Raynaud's & Scleroderma Association Trust** 112 Crewe Road Alsager, Cheshire ST7 2JA Tel: 01270 872776 • Fax: 01270 883556 www.raynauds.demon.co.uk
Herpes Viruses Association (SPHERE) And Shingles Support Society Miss Marion Nicholson, Director 41 North Road, London N7 9DP Tel: 020 7607 9661 (office and Minicom) Helpline: 020 7609 9061 www.astrabis.co.uk/sites/herpesviruses/default.htm	**Changing Faces** 1 & 2 Junction Mews Paddington, London W2 1PN Tel: 020 7706 4232 Fax: 020 7706 4234 www.changingfaces.co.uk
Cancer BACUP 3 Bath Place, Rivington Street London EC2A 3DR Tel: Freephone 0808 800 1234 (9am - 7pm) Fax: 020 7696 9002 www.cancerbacup.org.uk	**The Vitiligo Society** 125 Kennington Road London SE11 6SF Tel: Freephone 0800 018 2631 Fax: 020 7840 0866 www.vitiligosociety.org.uk