Common Skin Conditions:

Services you can provide

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Dermatology Clinical Educator

Learning Outcomes

- Recognise features of common skin conditions – eczema, psoriasis, acne and rosacea
- Understand treatments available that can be prescribed and recommended within a pharmacy setting
- Increase your confidence to treat common skin conditions so patient avoids GP visit
- Discuss upcoming PGDs for using hydrocortisone and also treating impetigo
- Describe top tips on using whole range of treatments that patients may have been prescribed which will aid concordance
- Discuss when patients may need further invention and who patients may be signposted to

Eczema

Eczema, also known as dermatitis, is an inflammation of the skin[1]

Mild cases – skin is red, dry, itchy skin[1]

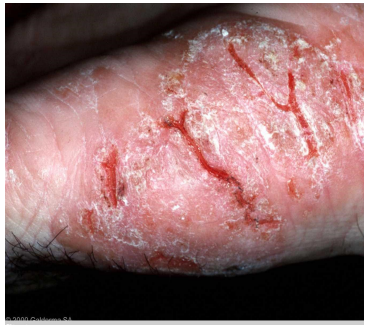
Severe cases – weeping, crusting and bleeding[1]

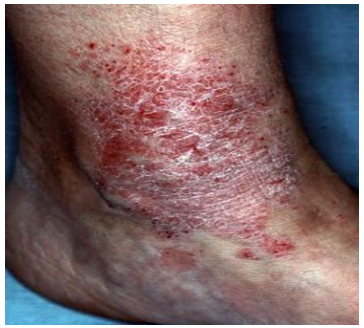
Affects people of all ages but primarily seen in children

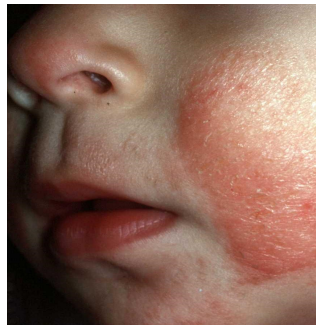
Several different forms exist, each of which have distinct signs and symptoms[2]

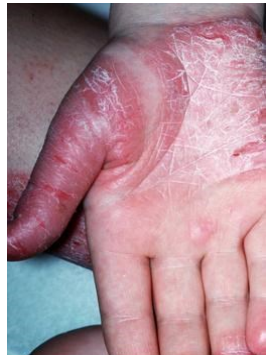
They can differ greatly with regards to cause, clinical presentation, exacerbating factors and duration[2,3]

Treatment and management approaches must reflect these differences[3]



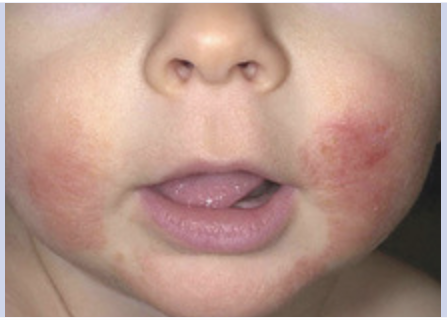
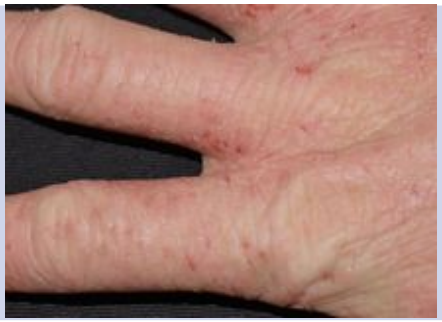
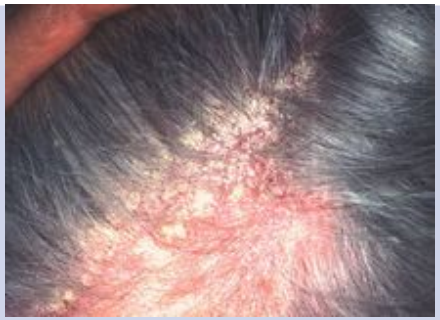
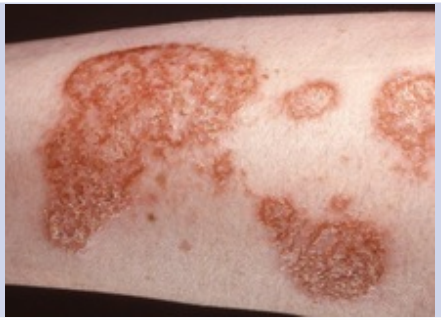






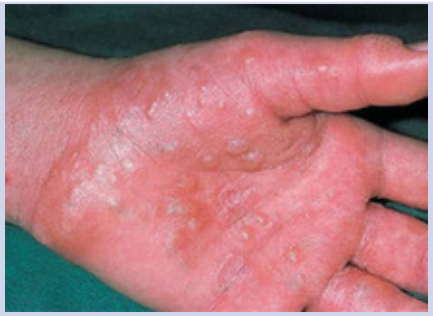
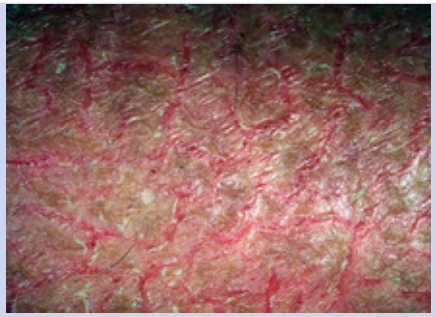
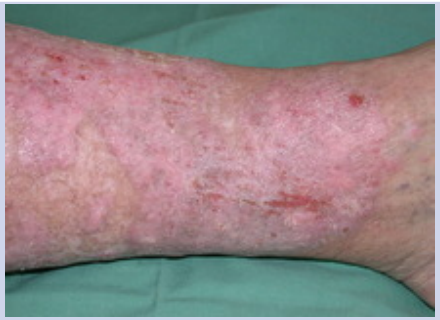
1. NES. Atopic Eczema. http://www.eczema.org/atopic. 2. NES. Types of Eczema. http://www.eczema.org/types-of-eczema. 3. NICE. Treatment Summary. https://bnf.nice.org.uk/treatment-summary/eczema.html.

Types of Eczema[1]

			
Atopic	**Contact**	**Seborrhoeic**	**Discoid**
Refers to a personal and family tendency to develop eczema, asthma and/or hay fever.	Is the most common type of work related skin disease.	Tends to affect the scalp, face, torso and flexures.	Is very distinct with ‘coin shaped’ discs of eczema the size of a fifty pence piece.

1. National Eczema Society. Types of Eczema. http://www.eczema.org/types-of-eczema.

Types of Eczema[1]

		
Pompholyx	**Asteatotic**	**Varicose**
Key characteristic is blistering that is restricted to the hands and feet.	Almost always affects people over the age of 60.	Also called gravitational or stasis eczema) is common later in life.

1. National Eczema Society. Types of Eczema. http://www.eczema.org/types-of-eczema.

Stepped Treatment Approach[1]

Mild	Moderate	Severe
Emollients	Emollients	Emollients
Mild potency topical corticosteroids	Moderate potency topical corticosteroids	Potent topical corticosteroids
	Topical calcineurin inhibitors	Topical calcineurin inhibitors
	Bandages and dressings	Bandages and dressings
		Phototherapy
		Systemic therapy

1. NICE Guidance. http://pathways.nice.org.uk/pathways/eczema.

Total Emollient Therapy

Emollients are applied as[1-3]:

- Leave-on (applied directly to skin)
- Soap substitutes (specially designed product for washing)
- Bath and shower oils (added to water or directly to skin in shower)

Leave on emollients[2]:

- Lotions
- Creams
- Gels
- Ointments/Spray

BATHE 2018 found no additional benefit of pouring emollient additives into bath if using leave on emollients and soap substitutes[3]

1. NICE Guidance. http://pathways.nice.org.uk/pathways/eczema. 2. NES Emollient Factsheet. 2016. http://www.eczema.org/emollients. 3. Santer M, et al. *BMJ.* 2018;361:k1332. doi: 10.1136/bmj.k1332..

Emollient Types[1]

Lotions - cooling on evaporation and good for hairy areas/weeping areas

Creams – emulsion of oil in water (60%). Contain preservatives which can lead to allergic reactions but are often preferred for daytime use or on wet skin

Ointments – greasier, thicker, can stain clothes, but better occlusion and hydration. Ointments should not be used on weeping eczema.

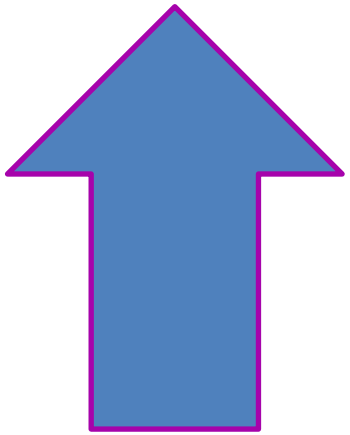
Bath and Shower Oils – ideal for people with extensive areas of very dry skin

Hydrating Gels – have a consistency between cream and ointment. Good for hair bearing sites

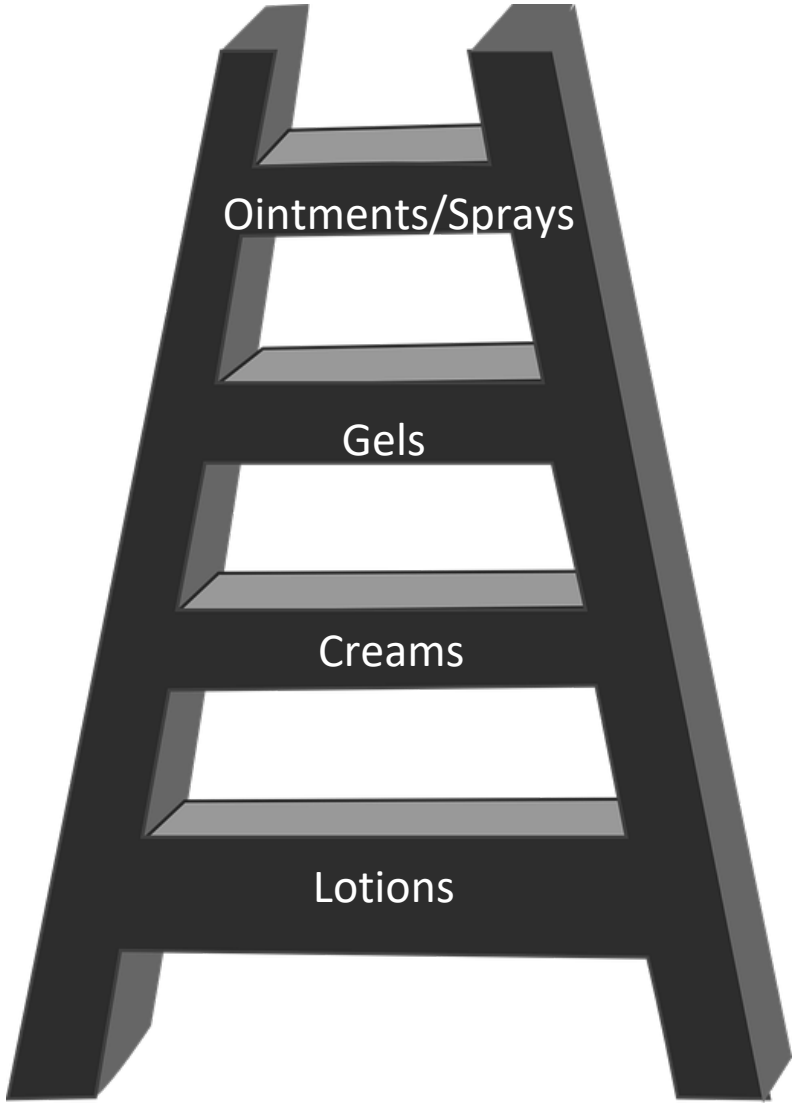
Aerosol sprays – are good for fragile or painful skin, children like them, elderly (who may not be able to reach areas)

1. NES Emollient Factsheet. 2016. http://www.eczema.org/emollients.

Leave On Emollient Oil Content[1]



Increasing levels of oil content



1. NES Emollient Factsheet. 2016. http://www.eczema.org/emollients.

Application of leave on emollients

Frequency	• Use frequently ideally every few hours but at least twice a day
Where to apply	• Apply to all skin, not just areas of dryness
Bathing	• After every bath or shower, pat skin dry and immediately reapply leave on emollient
How to apply	• Apply emollient in direction of hair growth – downward stroking, avoid rubbing up and down
Use with other treatments	• Use emollients alongside other prescribed treatments. Leave a period of 20 – 30 minutes between two treatments
Decant ointments	• Avoid putting fingers in to pots of ointments – use a spoon or spatula to take out the right amount
Mainstay of all treatment	• Continue to use the emollient even when the dryness has improved

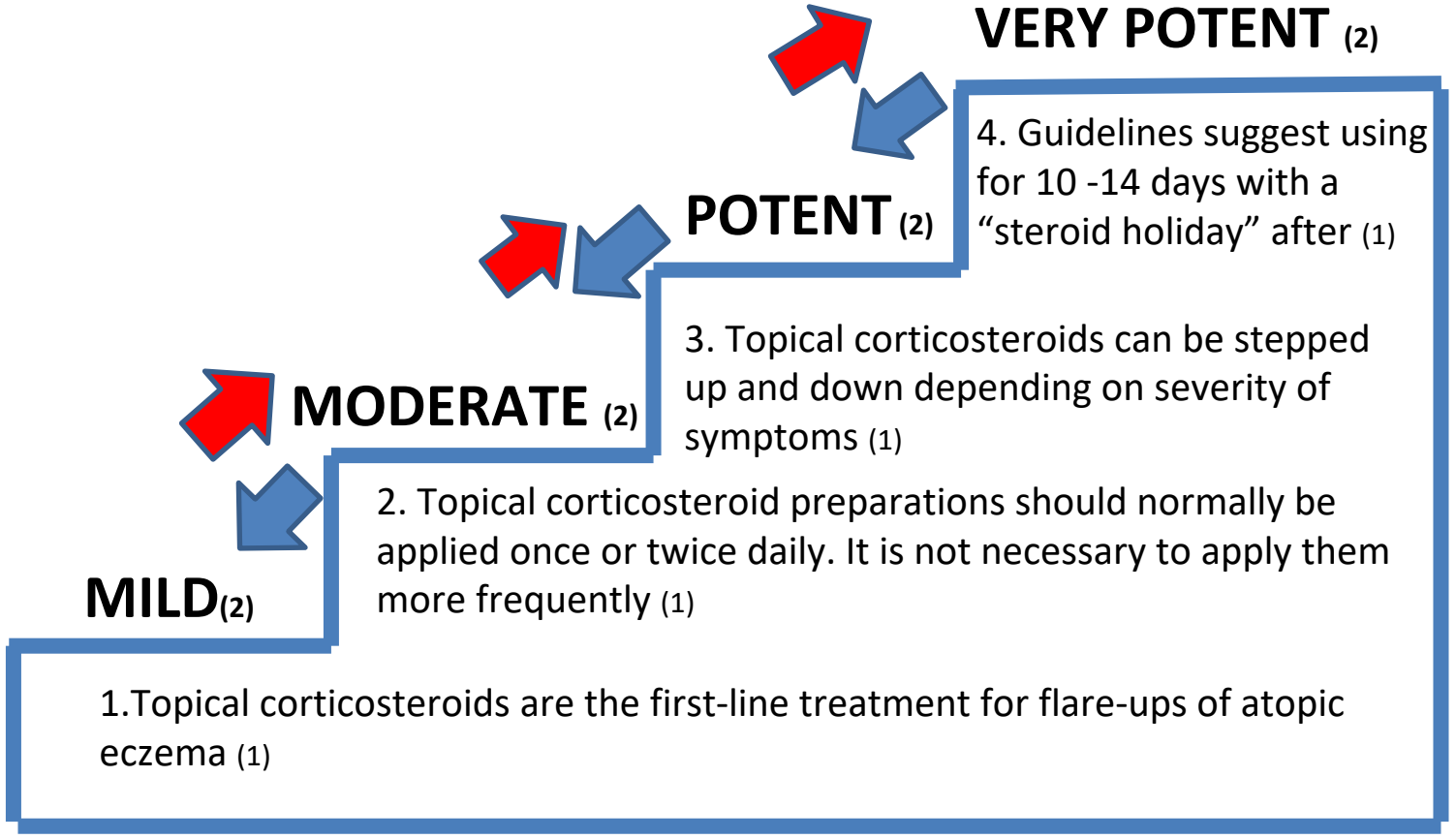
NES Emollient Factsheet. 2016. http://www.eczema.org/emollients.

Topical Steroids[1]

Strengths:	Formulations:
• Mild • Moderate • Potent • Very Potent	• Ointments • Creams • Lotions • Scalp applications • Shampoos and mousses • Impregnated tape

1. NES Topical Steroids Factsheet. 2016. http://www.eczema.org/corticosteroids

Tailoring Topical Steroid Treatment[1-3]



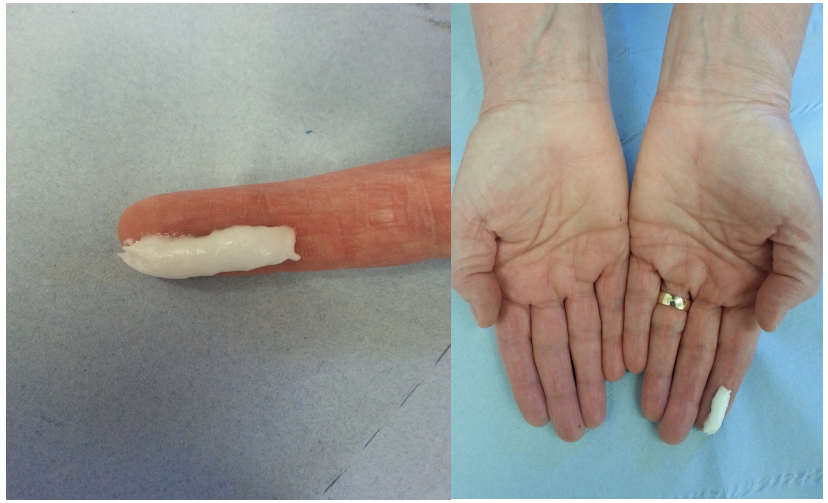
1. NICE Guidance. http://pathways.nice.org.uk/pathways/eczema. 2. NES Topical Steroids Factsheet. 2016. http://www.eczema.org/corticosteroids. 3. NICE Technology appraisal guidance. www.nice.org.uk/guidance/ta81.

Finger Tip Unit[1]

One FTU is the amount of topical steroid that is squeezed out from a standard tube along an adult's fingertip

A fingertip is from the very end of the index finger to the first crease in the finger

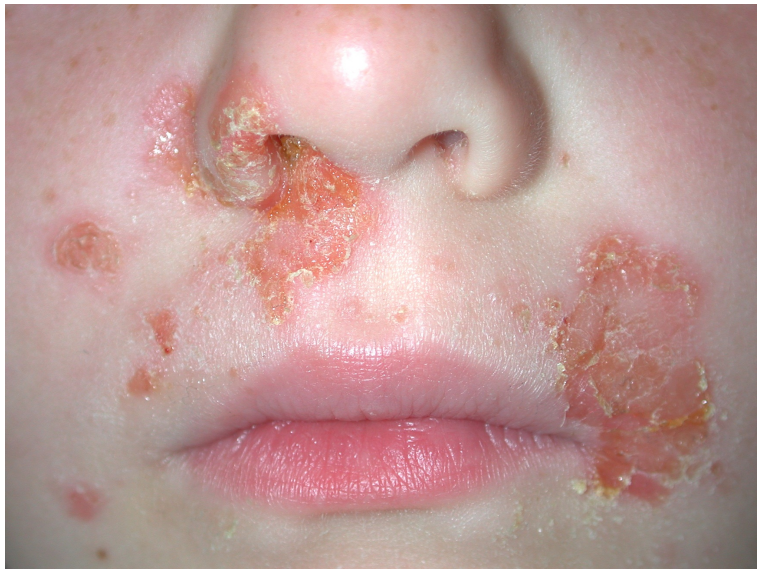
One FTU is enough to treat an area of skin twice the size of the flat of an adult's hand with the fingers together

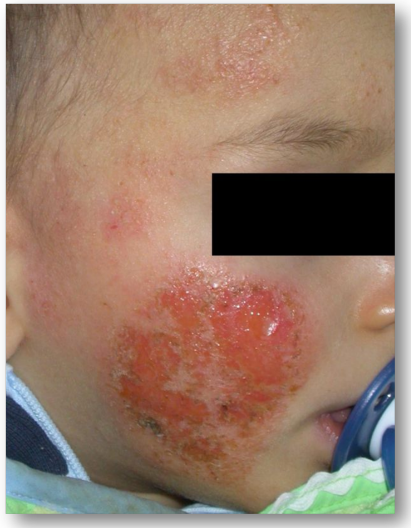


Please consult individual SPCs for licensed indications

1. NES Topical Steroids Factsheet. 2016. http://www.eczema.org/corticosteroids

Impetigo





- Caused by Staph A
- Can be mixed infection
- Contagious
- Thin roofed vesicles
- Yellow exudate
- Mainly face & neck
- Lesions heal centrally

Treatment of Impetigo

Non-bullous infection - topical or oral antibiotics

Mild/Local infections –

- Topical fusidic acid 7 – 10 days (mupirocin if resistant)
- Cover area affected
- Wash hands regularly
- Separate towels and flannels

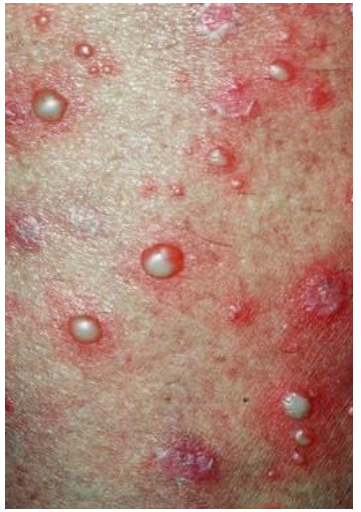
More widespread

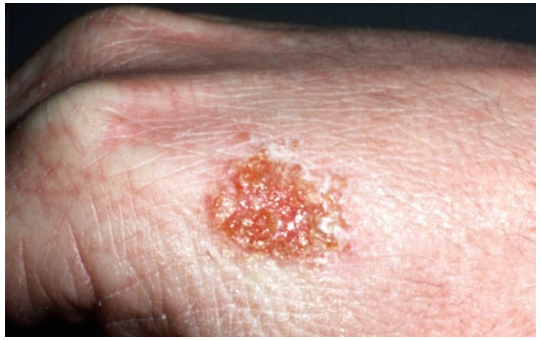
- Oral antibiotic 7 days

Persistent or recurrent infection

- Nasal Mupirocin 5 days both nostrils
- Antimicrobial soap substitute

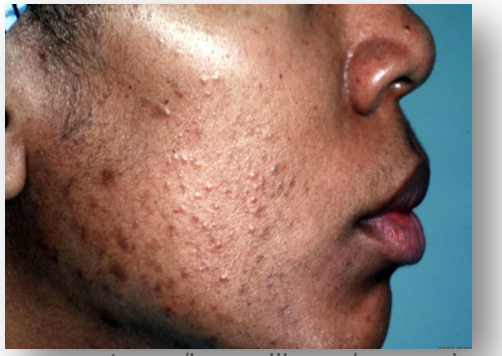
Bullous infection usually requires treatment with an oral antibiotic



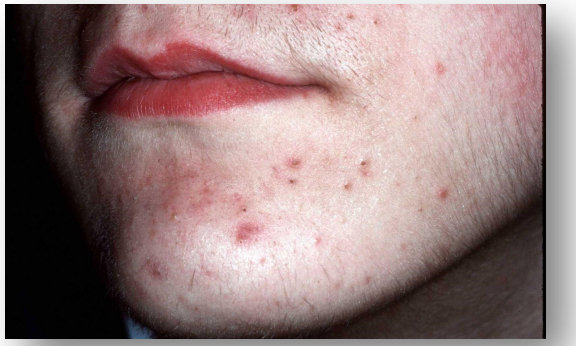


Acne - Background

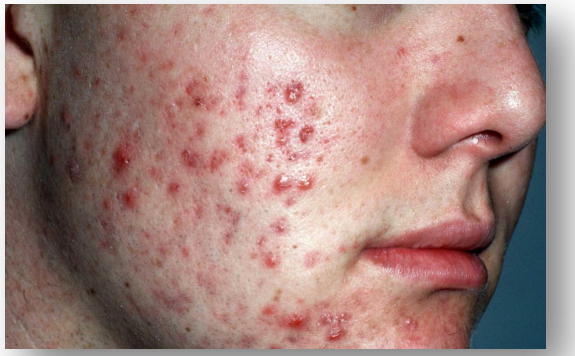
- Acne is a common and chronic disorder of the pilosebaceous unit[1]
- Acne manifests in areas with larger, more numerous sebaceous glands, such as the face, neck, back, chest, shoulders and upper arms[1]
- Acne lesions can be separated into[1,2]:
  - Inflammatory (papules, pustules or nodules/cysts)
  - Non-inflammatory (closed or open comedones, microcomedones)
- Most people with acne have a mixture of inflammatory and non-inflammatory lesions[2]



www.dermquest.com/imagelibrary/acnevulgaris/033510H



www.dermquest.com/imagelibrary/acnevulgarisis/035285H



www.dermquest.com/imagelibrary/acnevulgaris/033781V

1. Williams HC, et al.. *Lancet*. 2012;379(9813):361-372. 2. Nast A, et al. http://www.euroderm.org/edf/index.php/edf-guidelines/category/4-guidelines-acne.

Grading

- There is no universally agreed grading system[1]
- Acne is often categorised by lesion type and severity into[1,2]:

LESION TYPE	MILD	MODERATE	SEVERE
			
Non-inflammatory: Comedones	<20	20-100	>100
Inflammatory: Papules, Pustules or Nodules/ Cysts	<15	15-50	>50
TOTAL	**<30**	**30-125**	**>125**

1. NICE CKS https://cks.nice.org.uk/acne-vulgaris. 2. Gold MH, at al. *J Clin Aesthet Dermatol*. 2009;2(4):40-44.

PCDS Guidance – Acne

Treatment graded by the predominant present	Comedones	Papules	Pustules	Nodules/Cysts*
Topical Retinoid Tretinoin, Isotretinoin & Adapalene	+++	++	+	+
Benzoyl Peroxide (BPO)		+++	+++	+
Azelaic Acid 20% – Skinoren	+	++	++	+
Topical Antibiotics		++	+++	
Topical Retinoid/BPO – Epiduo	+	++	+++	+
Topical Retinoid/ Antibiotic Combination – Treclin	+	++	+++	
Topical Antibiotic/ BPO Combination – Duac		++	+++	
Oral Antibiotics		++	+++	+++
Combined Oral Contraceptives (for females only)		++	++	++
Legend	**+++ Strong recommendation**	**++ Moderate recommendation**	**+ Low recommendation**	

1. Bewley T, et al. http://www.pcds.org.uk/ee/images/uploads/general/Acne_Treatment_2015-web.pdf.

*Treatment can be initiated, but patients should be referred. Please consult individual SPCs for licensed indication

Practical Advice for Managing Acne

- Topical retinoids should be used for all grades of acne[1]
- Irritation with topical retinoids and BPO can be ameliorated by gradual introduction[1]
- Concurrent use with light non-comedogenic emollients may be useful[1]
- Azelaic acid may be beneficial in patients with darker skin[1]
- BPO can cause bleaching of fabric[1]
- Oral antibiotics should not be used as sole treatment[1]
- Combine systemic antibiotics with topical agents to reduce bacterial resistance[2]
- All treatments should be routinely reviewed at 12 weeks[2]

Please consult individual SPCs for licensed indications

1. Bewley T, et al. http://www.pcds.org.uk/ee/images/uploads/general/Acne_Treatment_2015-web.pdf. 2. NICE CKS https://cks.nice.org.uk/acne-vulgaris.

Self Care[1]

- Avoid picking and squeezing spots
- Early intervention can help avoid permanent scarring
- Treatments used correctly can take at least two months to show improvement
- Irritation may occur with treatments so build up treatments gradually
- Use oil-free or non-comedogenic soap substitutes, moisturisers and makeup
- Little evidence that foods cause acne, but a balanced diet will benefit health overall

1. BAD Acne. 2017. http://www.bad.org.uk/shared/get-file.ashx?id=65&itemtype=document.

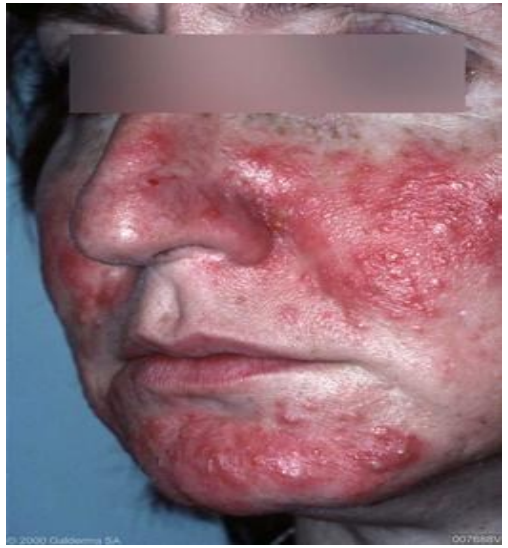
Rosacea - Background

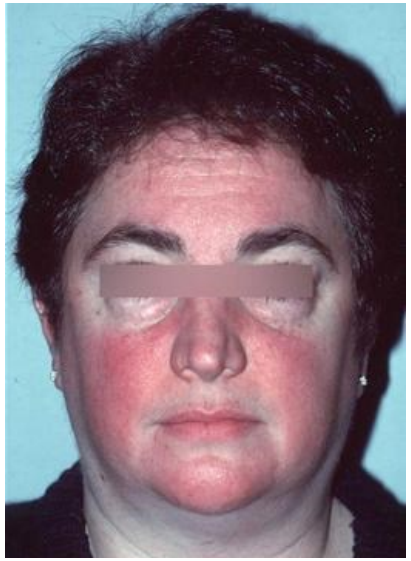
Rosacea is a common and chronic inflammatory disorder, affecting the cheeks, nose, chin and forehead[1-3]

Clinical features include flushing, erythema, papules and pustules, telangiectasias, dryness, burning, edema, or skin thickening[2,4,5]

Many patients have >1 of these clinical features[5]

There is no diagnostic test for rosacea[6]

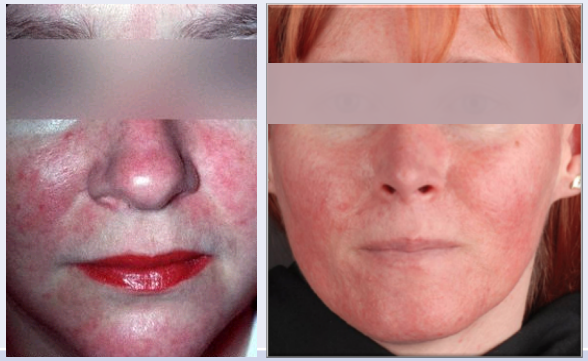
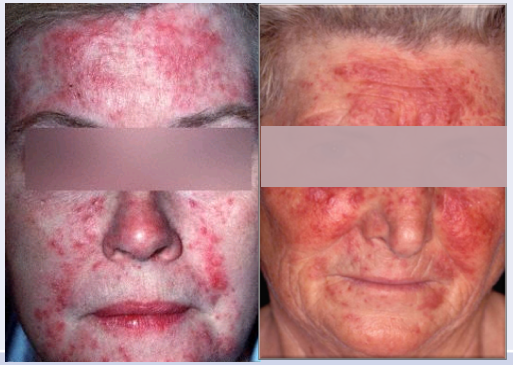




1. Del Rosso JQ, et al. *Cutis*. 2013;92:234-240. 2. NICE CKS https://cks.nice.org.uk/rosacea-acne. 3. Gallo RL, et al. *J Am Acad Dermatol*. 2018;78(1):148-155. 4. Feldman SR, et al. *J Manag Care Spec Pharm*. 2014;20:623-629. 5. Tan J, et al. *J Am Acad Dermatol*. 2013;69:S27-35. 6. Tan J; ROSCO coauthors. *Br J Dermatol*. 2017;177(2):598-599.

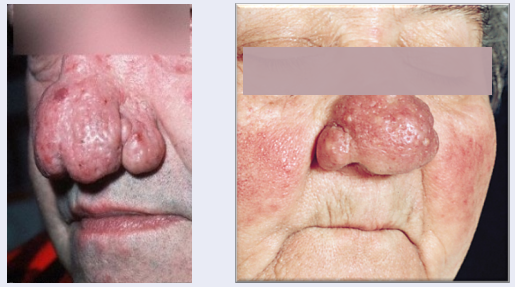
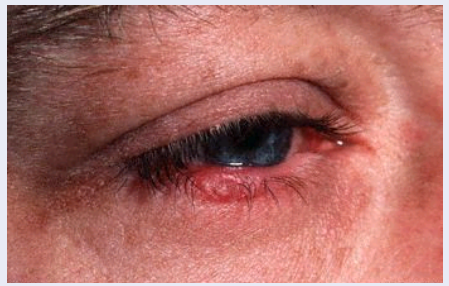
https://www.dermquest.com/image-library/image/5044bf007688VB

2002 NRS Diagnostic Subtypes[1]

Subtype 1	Subtype 2
Erythematotelangiectatic	Papulopustular
	
• Flushing and persistent central facial erythema +/-telangiectasia • Sparing of periocular and nasolabial region • Oedema, stinging/ burning, scaling may be present	• Central facial erythema and telangiectasia • Transient pustules and/or papules present centrally or peri-orally. • Frequently associated burning/ stinging

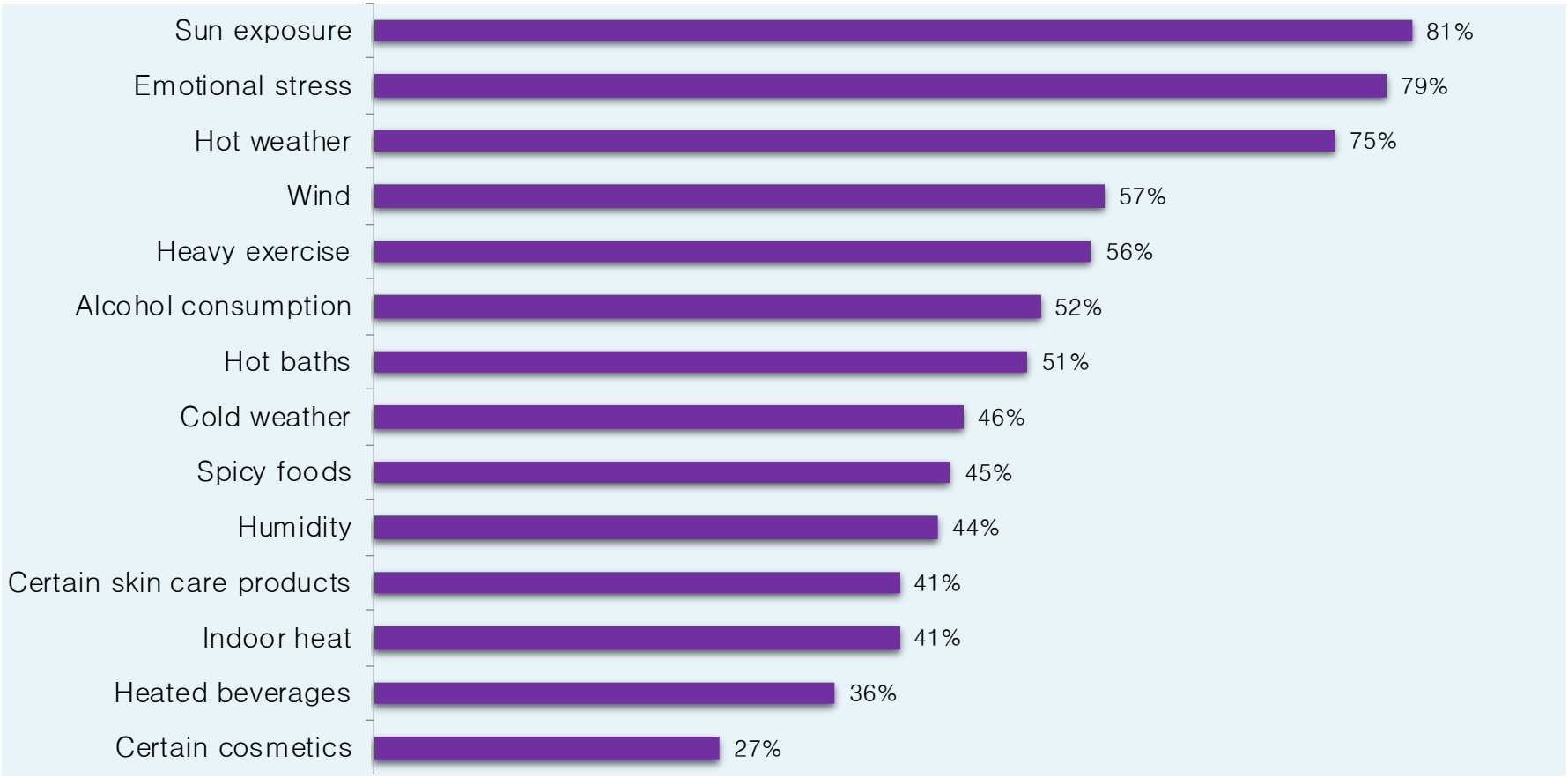
1. Wilkin J, et al. *J Am Acad Dermatol.* 2002;46(4):584-587.

2002 NRS Diagnostic Subtypes[1]

Subtype 3	Subtype 4
Phymatous	Ocular
	
• Thickening skin, irregular surface nodularities with enlargement and prominent pores • Tissue hyperplasia • Typically on the nose (Rhinophyma) • Males > females 10:1	• Burning , stinging, dryness • Foreign-body sensation • Eye photosensitivity, itching, blurred vision • Telangiectasia of conjunctiva + lid margin, stye, infections. • Lid/periocular erythema • Blephritis, conjunctivitis

1. Wilkin J, et al. *J Am Acad Dermatol.* 2002;46(4):584-587.

Rosacea Triggers[1]



1. NRS. http://www.rosacea.org/patients/materials/triggersgraph.php.

PCDS Guidance – Rosacea[1]

Product	Flushing, Erythema & Telangiectasia	Papules & Pustules	Ocular
Ivermectin 1% Cream (Soolantra®)		+++	
Azelaic Acid Gel (Finacea 15%®)		++	
Metronidazole Gel or Cream 0.75% (Acea®, Metrogel®, Metrosa®, Rosiced®, Rozex®, Zyomet®)		+	
Brimonidine Gel 0.33% (Mirvaso®)	++		
Eye Lubricants			+++
Doxycycline MR 40mg (Efracea®)		+++	
Doxycycline 100mg Lymecycline 408mg caps (Tetralysal®)		++	++
Oxytetracycline 250-500mg		+	+
Erythromycin/Clarithromycin 250-500mg		+	
Isotretinoin		++	
Intense Pulsed Light (IPL)	+++		
Pulsed Dye Laser (PDL)	++		
Clonidine 25-50mcg	++		
Propranolol 10-40mg	+		
Carvedilol 3.125-6.25mg	+		
Legend +++ Strong recommendation ++ Moderate recommendation + Low recommendation			

Please consult individual SPCs for licensed indication

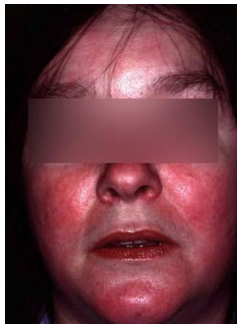
1. Frow H, et al. 2016. Available at http://www.pcds.org.uk/ee/images/uploads/general/Rosacea_PCDS.pdf.

+++ Strong recommendation ++ Moderate recommendation + Low recommendation

Management

Please consult individual SPCs for licensed indications.

Subtype 1
Erythematotelangiectatic



+++ Intense Pulsed Light

++ Brimonidine Gel 0.33%

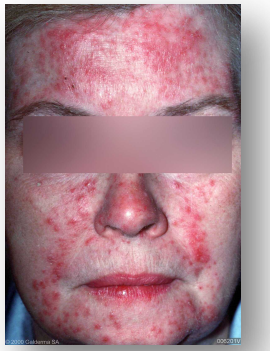
++ Pulsed Dye Laser

++ Clonidine 25-50 mcg TDS

+ Propranolol 10-40mg TDS

+ Carvedilol 3.125-6.25mg TDS

Subtype 2
Inflammatory Papulopustular



+++ Ivermectin 10mg/g cream 1%

+++ MR Doxycycline 40mgs OD

++ Doxycycline 100mg/ Lymecycline 408mg

++ Azelaic Acid 15%

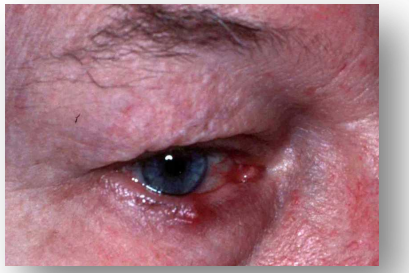
++ Isotretinoin

+ Metronidazole gel/cream 0.75%

+ Oxytetracycline 250-500mgs b.d

+ Erythromycin/Clarythromycin 250-500mgs b.d

Subtype 4
Ocular



+++ Eyelid hygiene measures, ocular lubricants

++ Doxycycline 100mg/ lymecycline 408mg OD

+ Oxytetracycline 250-500mg BD

Refer to ophthalmologist

1. NICE CKS https://cks.nice.org.uk/rosacea-acne. 2. Starr O. https://patient.info/health/skin-rashes/rosacea. 3. Dahl MV. https://www.uptodate.com/contents/rosacea-pathogenesis-clinical-features-and-diagnosis.

Self Care[1,2]

Provide patient with BAD PIL

Protect skin with perfume-free sun block

Avoid rubbing or scrubbing the face

Avoid perfumed soaps

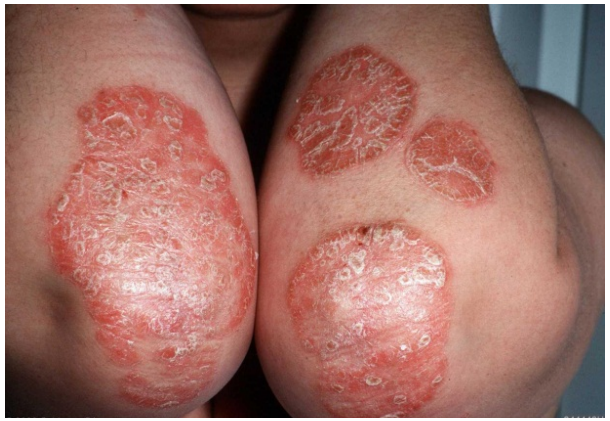
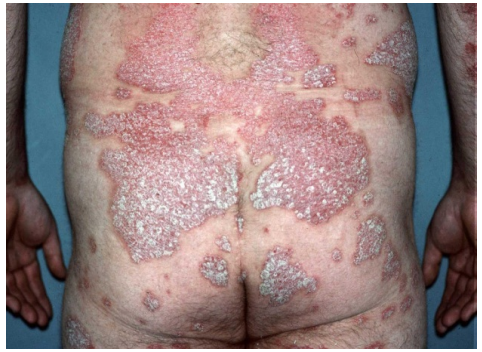
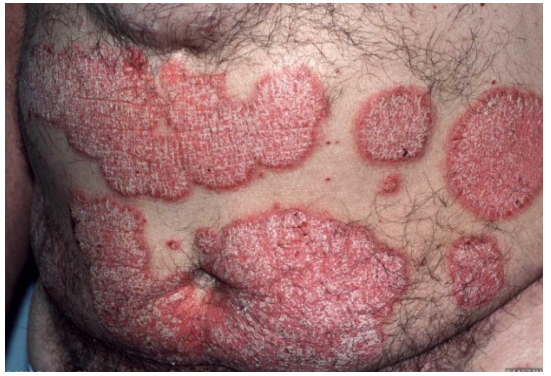
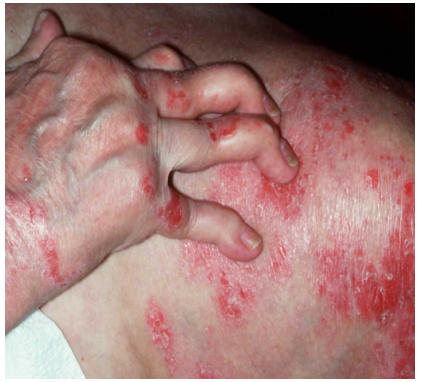
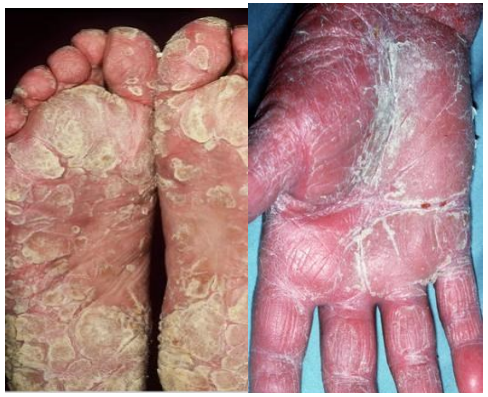
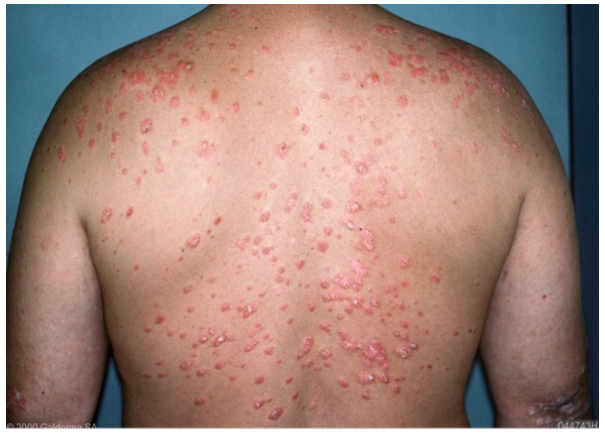
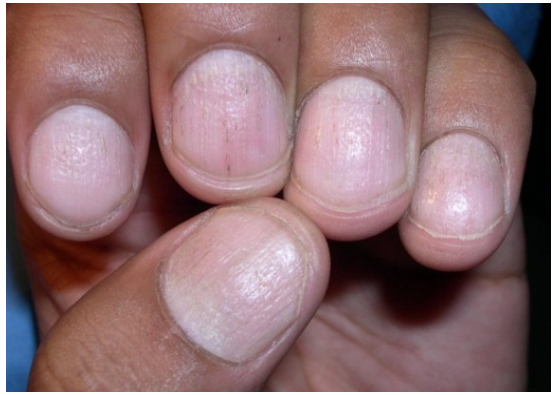
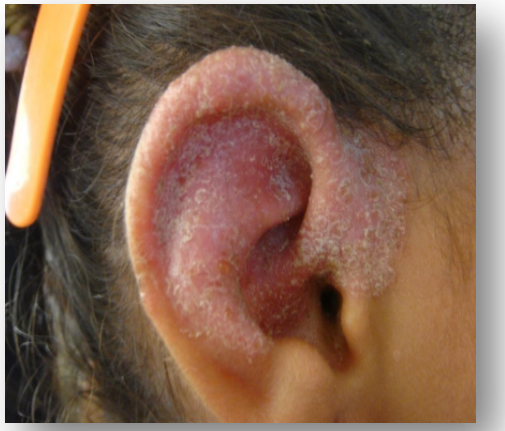
Avoid exacerbating factors

Generally emollients are soothing

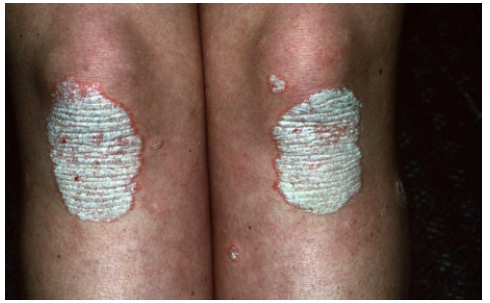
Use an unperfumed moisturiser on a regular basis

1. BAD. http://www.bad.org.uk/shared/get-file.ashx?id=229&itemtype=document. 2. Cunliffe T. http://www.pcds.org.uk/clinical-guidance/rosacea. 3. Starr O. https://patient.info/health/skin-rashes/rosacea.

Psoriasis

Background



Psoriasis is a complicated, chronic inflammatory, multi-aetiological auto-immune condition[1-3]

- Non-contagious and re-occurring[2,3]
- Predominantly affects skin, nails and joints[2,3]

Characterized by well-demarcated, erythematous plaques with silver scale and associated with a variety of comorbidities[1]

Aetiology remains unclear, although there is evidence for genetic predisposition[2]

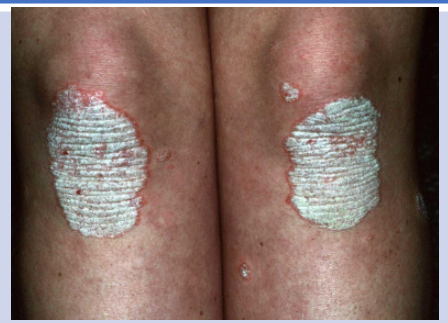
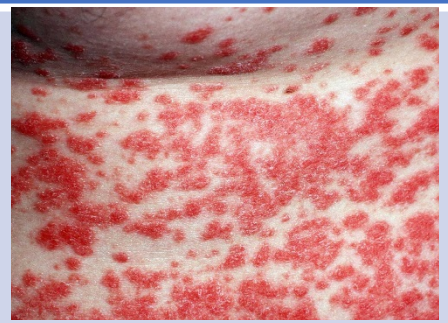
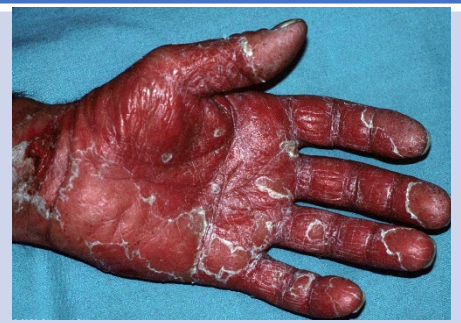
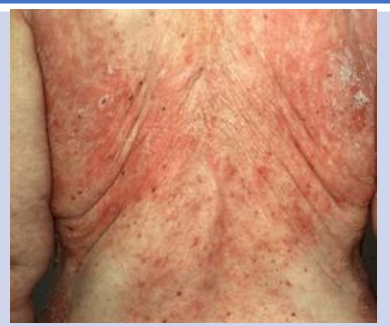
Recent research shows the role of the immune system in psoriasis causation[2,3]

Psoriasis can also be provoked by external and internal triggers[2]

Other presentations, such as guttate, pustular, erythrodermic, inverse, and nail psoriasis also occur[1]

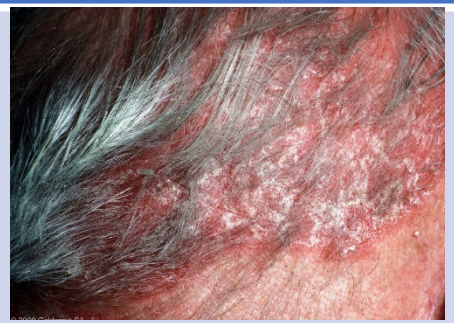
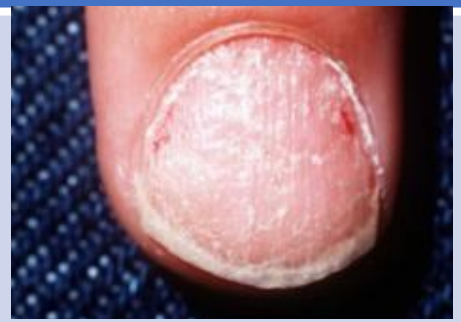
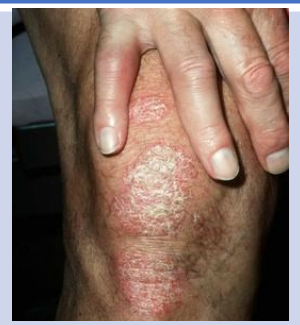
1. Feldman SR. www.uptodate.com/contents/epidemiology-clinical-manifestations-and-diagnosis-of-psoriasis. 2. WHO Global report on psoriasis. 2016. http://apps.who.int/iris/bitstream/handle/10665/204417/9789241565189_eng.pdf;sequence=1. 3. Psoriasis Association. About Psoriasis. 2016. www.psoriasis-association.org.uk/psoriasis-and-treatments/default.aspx.

Clinical Manifestations[1]

			
Chronic Plaque	**Guttate Psoriasis**	**Pustular Psoriasis**	**Erythrodermic**
Most common form, usually present with symmetrically distributed cutaneous plaques	Abrupt appearance of multiple small psoriatic papules and plaques	Can have life-threatening complications, most severe variant (von Zumbusch) presents with the acute onset of widespread erythema, scaling, and sheets of superficial pustules	Uncommon manifestation that may be acute or chronic. It is characterized by generalized erythema and scaling from head to toe

1. Feldman SR. https://www.uptodate.com/contents/epidemiology-clinical-manifestations-and-diagnosis-of-psoriasis.

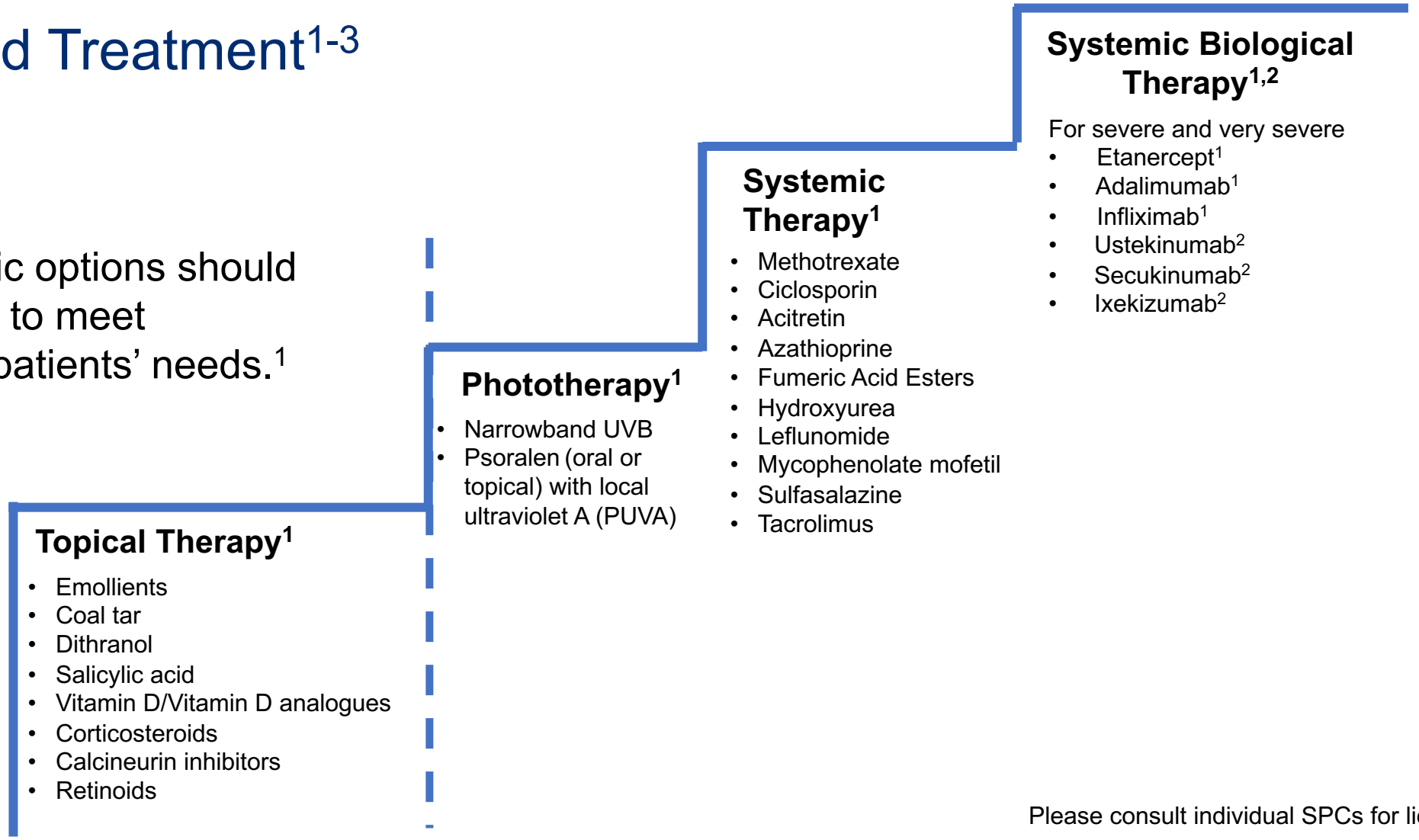
Clinical Manifestations[1,2]

			
Scalp Psoriasis	**Inverse Psoriasis**	**Nail Psoriasis**	**Psoriatic Arthritis**
Affects approximately 50% of patients	Involves the intertriginous areas, including the inguinal, perineal, genital, intergluteal, axillary, or inframammary regions	Most often noted after the onset of cutaneous disease, but also may occur concurrently or prior, occasionally, nail involvement is the only manifestation of psoriasis	Affects approximately 10-30% of those with skin symptoms; usually in the hands and feet and, occasionally, the large joints

1. Feldman SR. https://www.uptodate.com/contents/epidemiology-clinical-manifestations-and-diagnosis-of-psoriasis 2. Habashy J. https://emedicine.medscape.com/article/1943419-clinical. .

Stepped Treatment[1-3]

Therapeutic options should be tailored to meet individual patients' needs.[1]



Please consult individual SPCs for licensed indications

1. Ngan V. 2014. www.dermnetnz.org/topics/guidelines-for-the-management-of-psoriasis/. 2. NICE Pathways. https://pathways.nice.org.uk/pathways/psoriasis#path=view%3A/pathways/psoriasis/systemic-biological-therapy-for-psoriasis.xml&content=view-index. 3. Wikipedia. Psoriasis Treatment Ladder. Available at https://en.wikipedia.org/wiki/File:Psoriasis_treatment_ladder.svg.

Topical Treatments – Emollients[1,2]

NICE Guideline assumes that emollients have been prescribed when appropriate, before the treatment pathway starts

Emollients reduce dryness, cracking, scaling of the skin, including itch

May be the only treatment necessary for mild psoriasis

Consider using humectants

1. NICE Clinical guideline. nice.org.uk/guidance/cg153. 2. BNF MedicinesComplete. https://www.medicinescomplete.com/#/content/bnf/_155920033

PCDS Guidance Psoriasis Pathway

Type of Psoriasis	Treatment
Plaque psoriasis	Vitamin D/Potent steroid combination product first line, once daily until lesions flatten. Review at 8-12 weeks. If response sub-optimal then: 1) Review adherence 2) Descale 3) Consider using tar products
Scalp psoriasis	1) Descale using tar/salicylic acid/coconut oil. Massage in and leave overnight 2) Treat ongoing inflammation with potent topical steroids 3) Maintenance therapy with tar shampoos, bi-weekly steroids and descaling products as required
Face, Flexures and genitalia	Moderate potent topical steroids Vitamin D ointment (calcitriol or tacalcitrol) Calcineurin inhibitors (tacrolimus)

http://www.pcds.org.uk/ee/images/uploads/general/Psoriasis_Treatment_2019-web.pdf Accessed 10.12.19

Resources

www.pcds.org – psoriasis, acne and rosacea pathways

www.bad.org

Differential Diagnosis in Dermatology 4tn ed. Ashton, Leppard and Cooper