Managing Dermatological Complaints in the GP practice

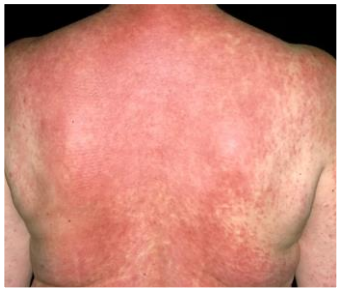
25th January 2025

Dr Stephanie Menzies
Institute of Dermatologists (Rooms)
Beacon Hospital (Surgery)

Beacon Hospital
THIS IS MODERN MEDICINE

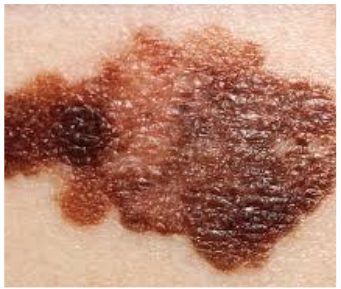
Referral patterns

Rashes



- Rosacea
- Periorificial dermatitis
- Eyelid dermatitis

Lesions

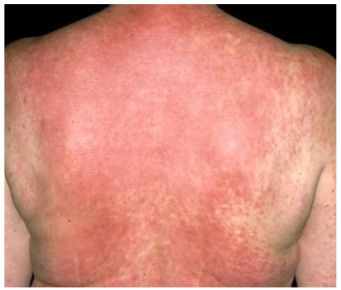


Hair loss

Nails

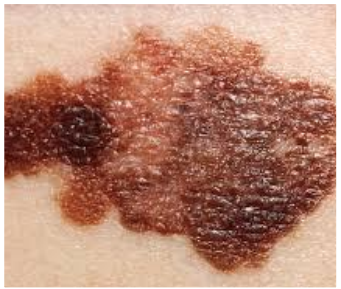
Referral patterns

Rashes



- **Rosacea**
- **Periorificial dermatitis**
- **Eyelid dermatitis**

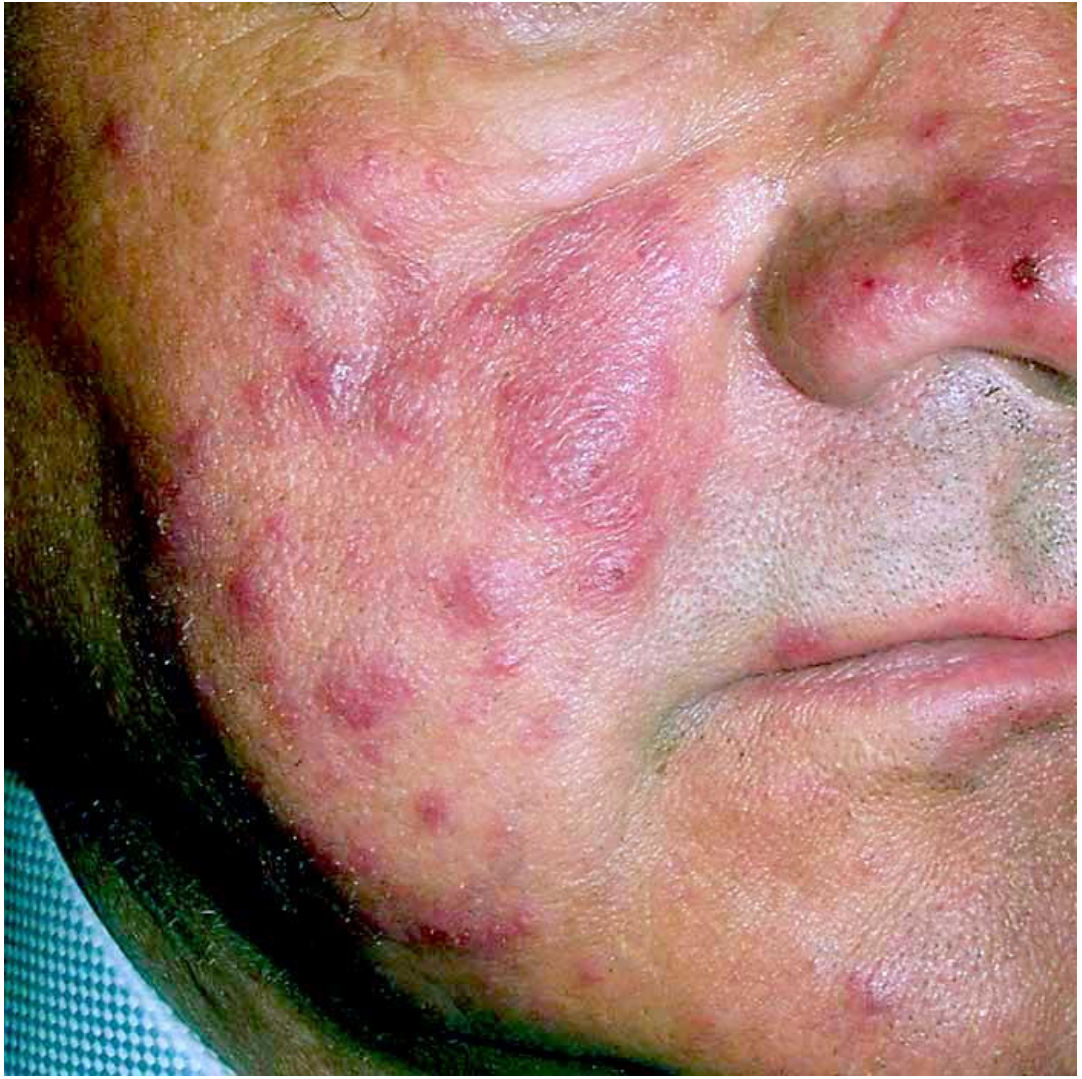
Lesions



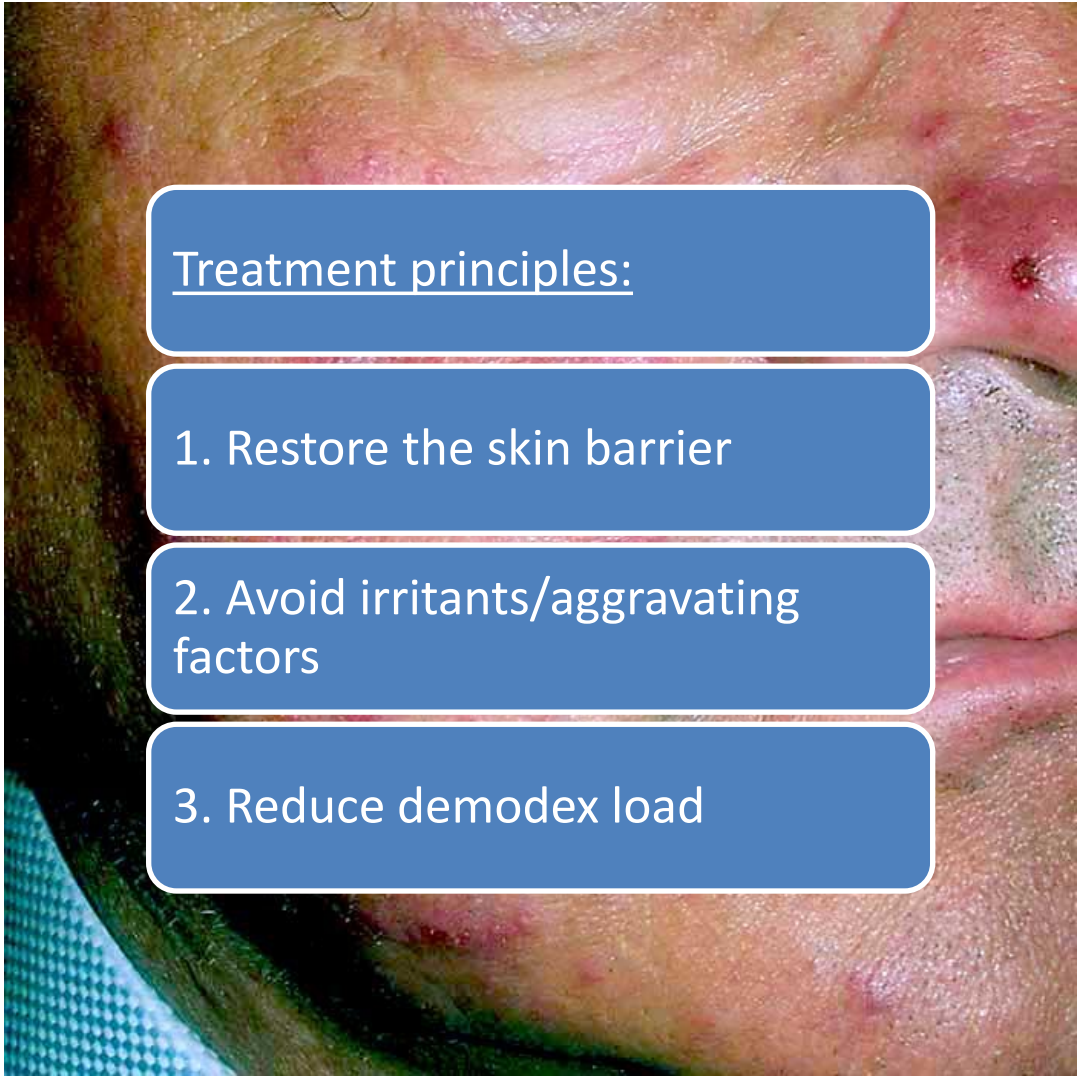
Hair loss

Nails

1. Rosacea



1. Rosacea


Treatment principles:
1. Restore the skin barrier
2. Avoid irritants/aggravating factors
3. Reduce demodex load

1. Rosacea

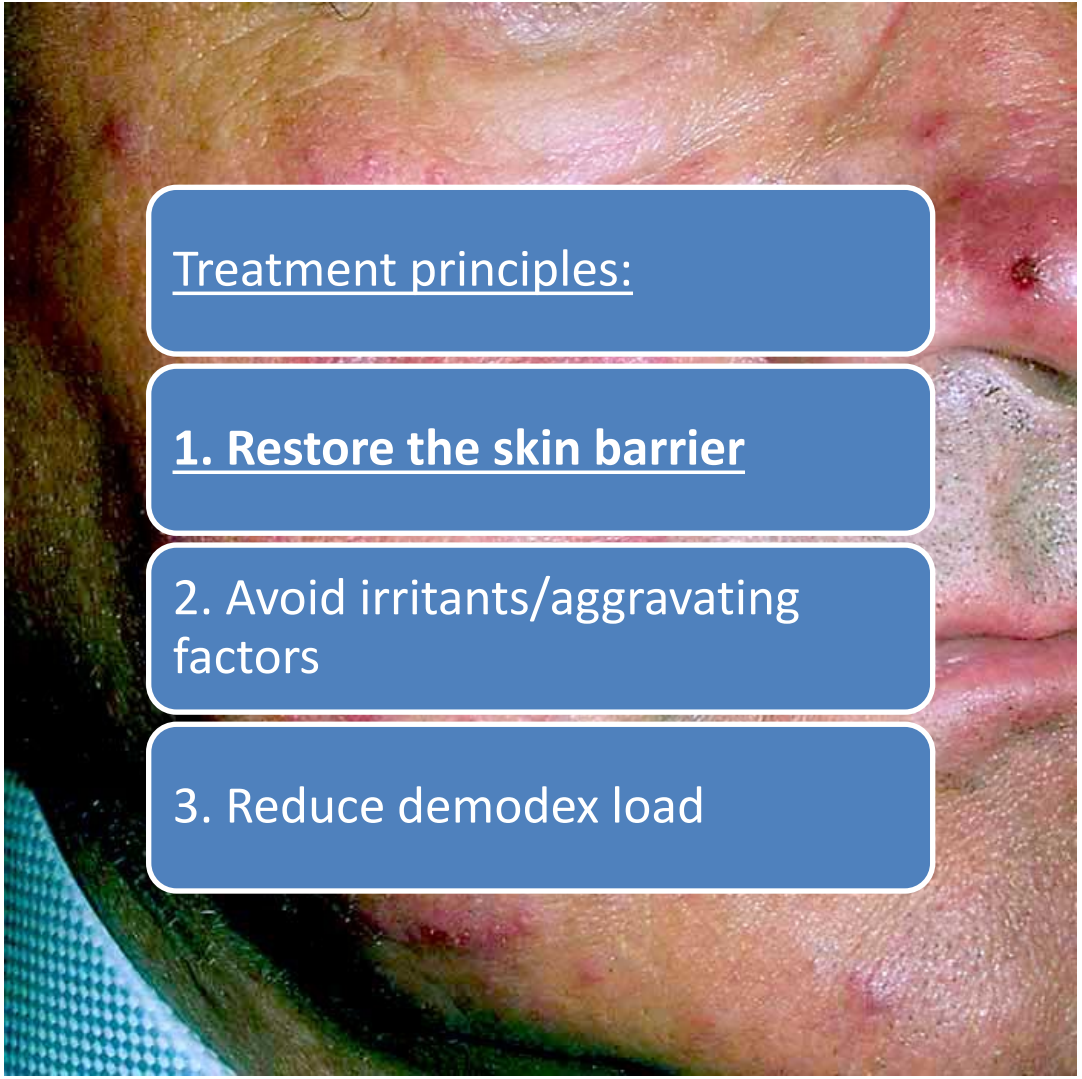
Treatment principles:

1. Restore the skin barrier

2. Avoid irritants/aggravating factors

3. Reduce demodex load

1. Rosacea



Treatment principles:

1. Restore the skin barrier

2. Avoid irritants/aggravating factors

3. Reduce demodex load

1. Rosacea

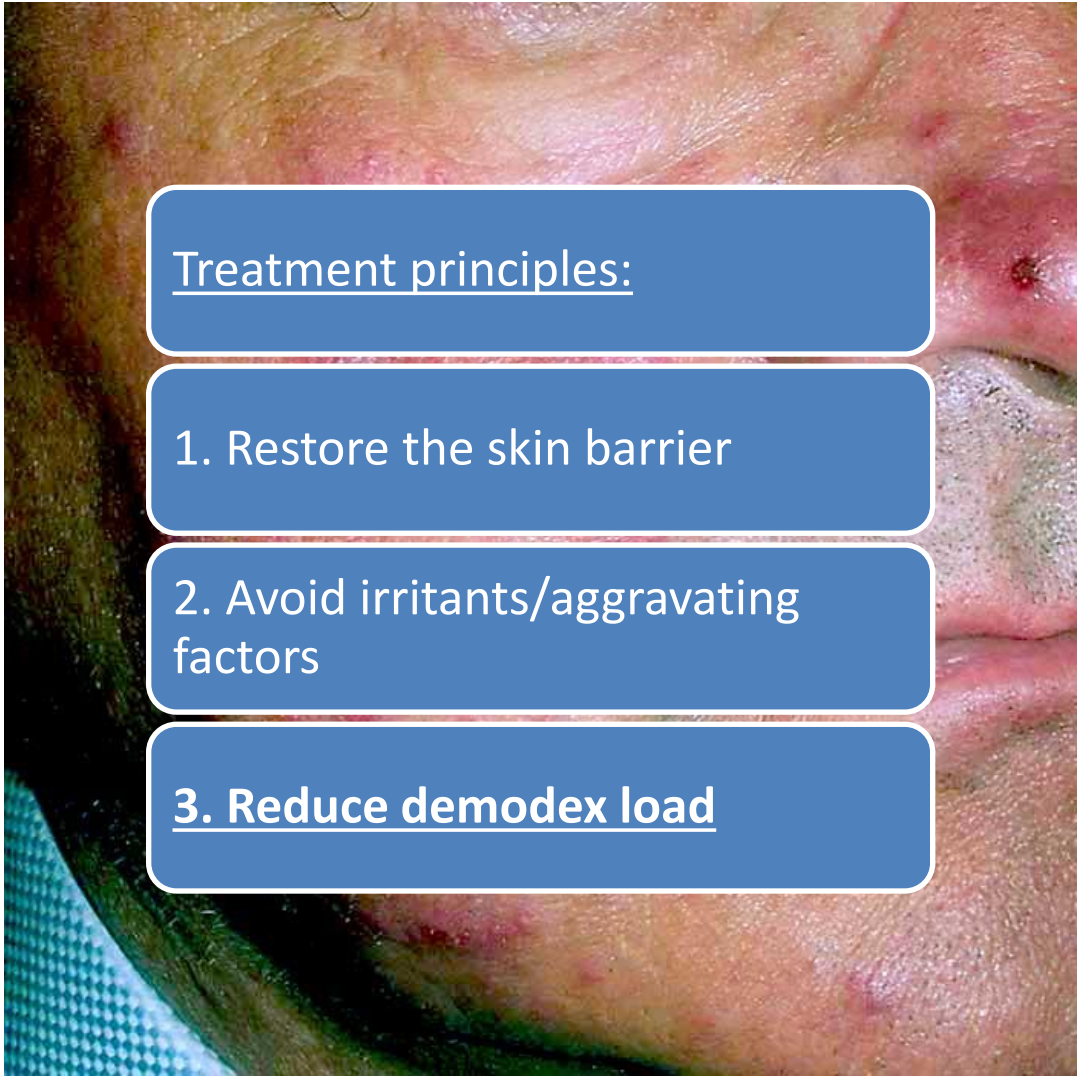
Treatment principles:

1. Restore the skin barrier

2. Avoid irritants/aggravating factors

3. Reduce demodex load

1. Rosacea



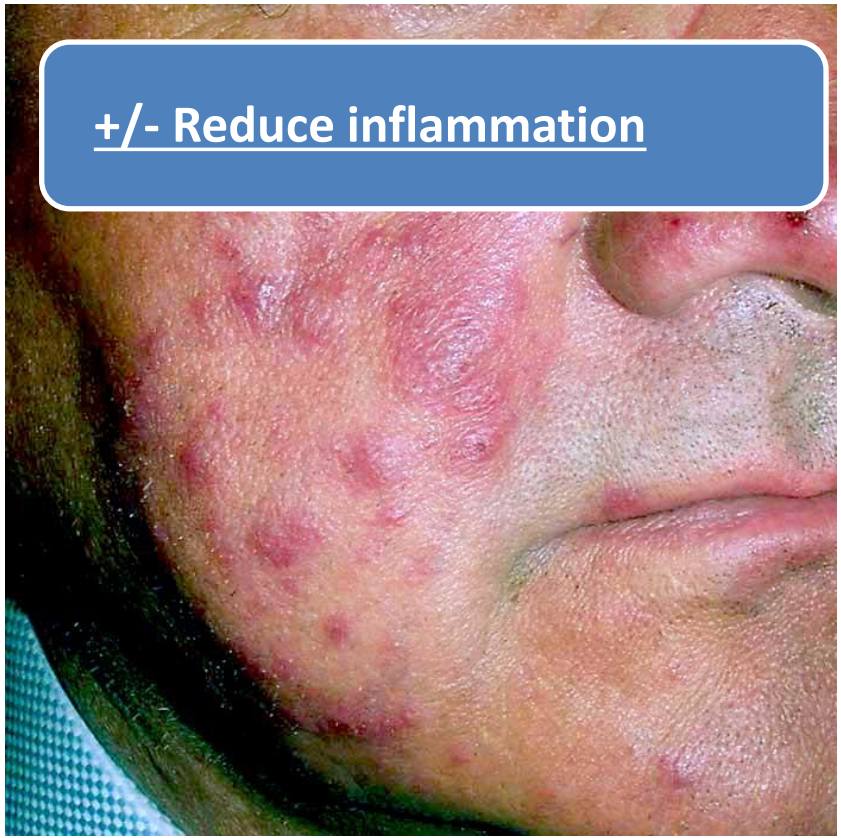
Treatment principles:

1. Restore the skin barrier

2. Avoid irritants/aggravating factors

3. Reduce demodex load

Rosacea - Papulopustular



+/-Oral antibiotics*

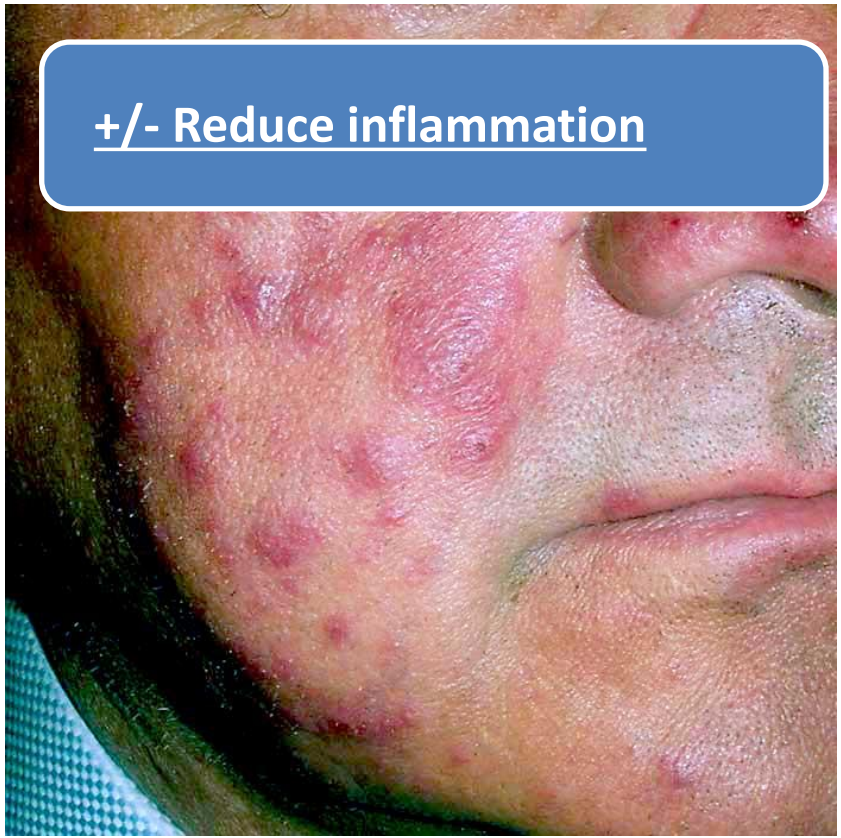
- Doxycycline 100mg OD – BD
- Tetralysal 300mg OD – BD
- Doxycycline MR 40mg OD

3/12 duration → Repeat for flares

Review at 4/12

Soolantra once daily (nocte) to entire face long-term

Rosacea - Papulopustular



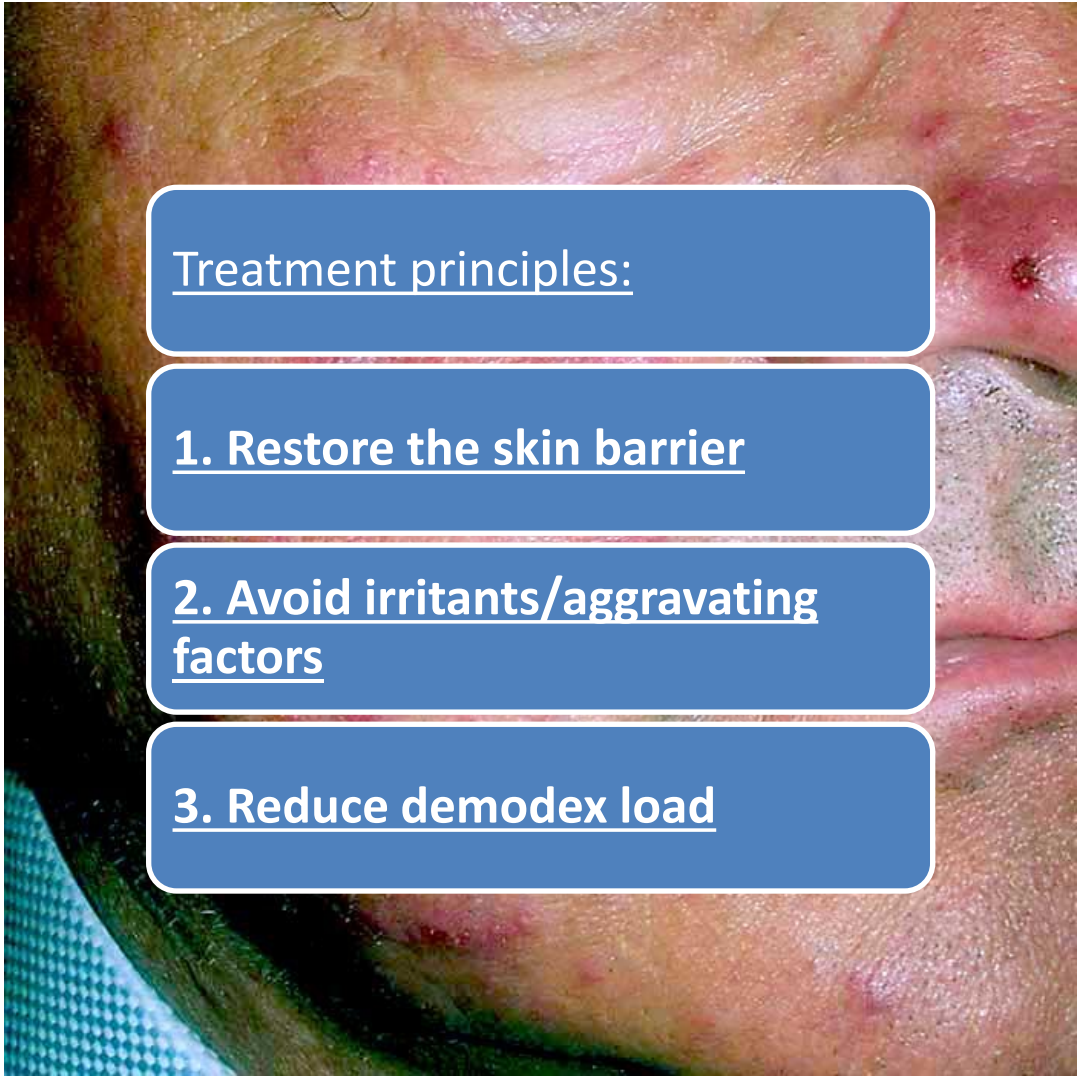
- +/-Oral antibiotics*
- Doxycycline 100mg OD – BD
- Tetralysal 300mg OD – BD
- Doxycycline MR 40mg OD

- 3/12 duration → Repeat for flares
- Review at 4/12

- Soolantra once daily (nocte) to entire face long-term

1. Rosacea

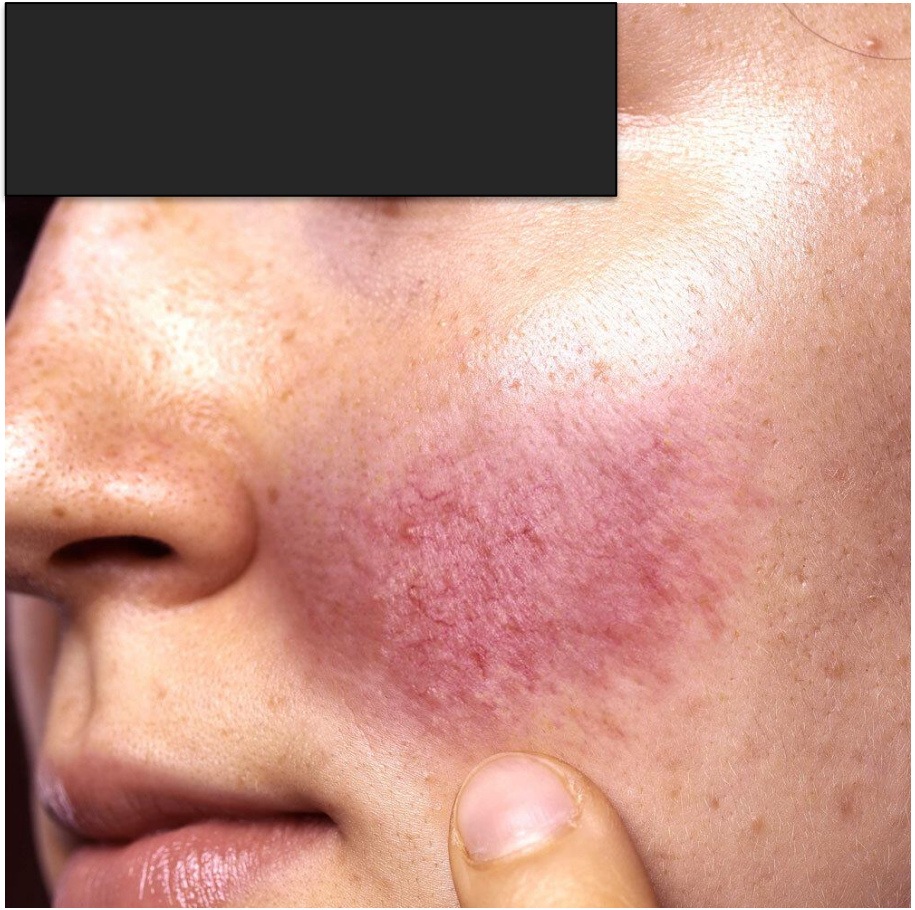
Consistency is key



When to refer?

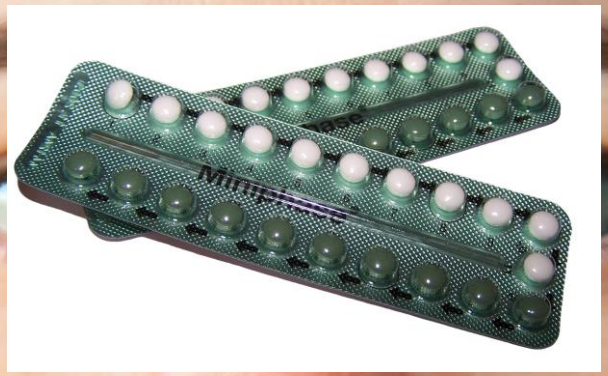
Diagnostic uncertainty
Persistent disease
Severe disease
Phymatous rosacea
Significant psychological distress
Ocular rosacea (ophthalmology)

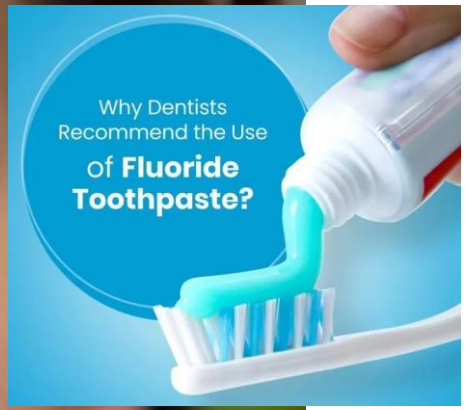
Rosacea - Erythrotelangiectatic



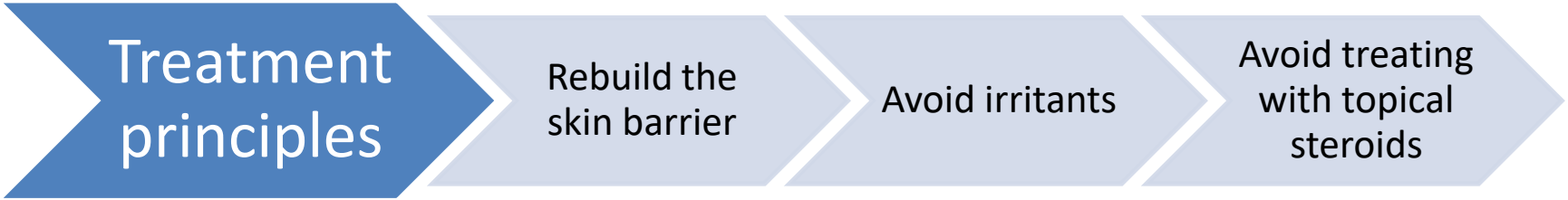
2. Periorificial dermatitis

2. Periorificial dermatitis

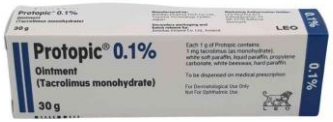




2. Periorificial dermatitis



2. Periorificial dermatitis



- **Simplify skin care**

  'Zero therapy' – many clear with this alone within 2-3 months

  Stop all products except:

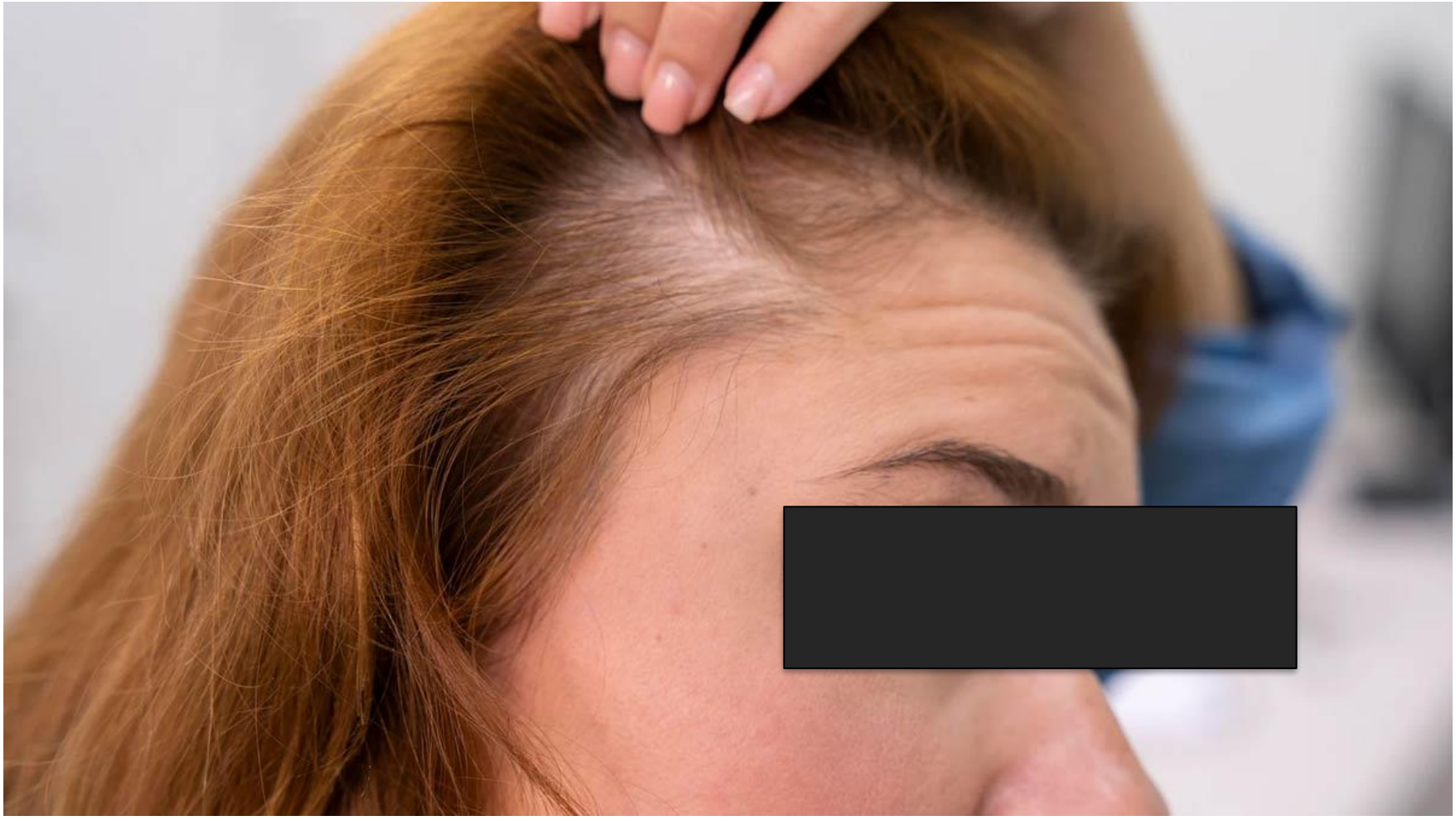
  - CeraVe hydrating cleanser to wash

  Bland emollient e.g. silcocks base, CeraVe lotion/cream

- **Mild**
  - Protopic 0.1% ointment BD, Erythromycin 2% BD, Rosex cream OD x 8/52
- **Moderate to severe** or if above treatment fails
  - Doxycycline 100mg OD/BD x 8/52
  - Tetralysal 300mg

Once resolved:
Continue gentle skin care practices
Cautious reintroduction of products e.g. 1 new product per week

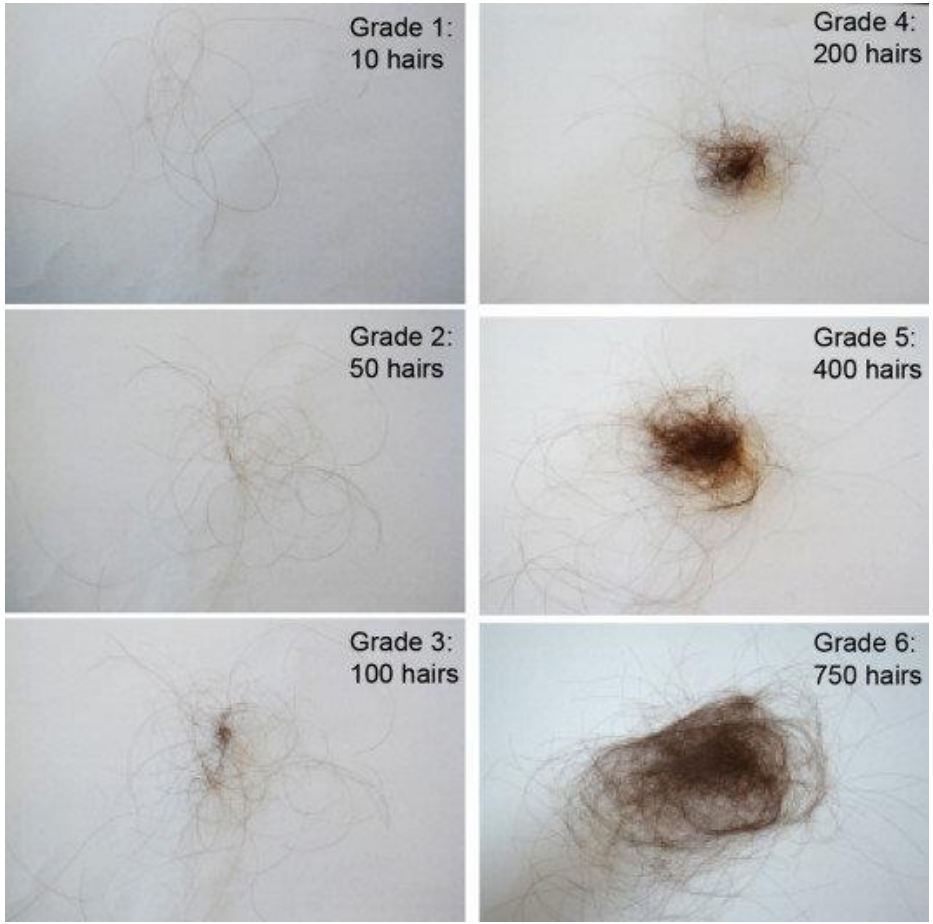
3. Hair loss



3. Hair loss


30%
Thinning of hair ponytail
Increased visibility of scalp through hair

3. Hair loss - Important considerations



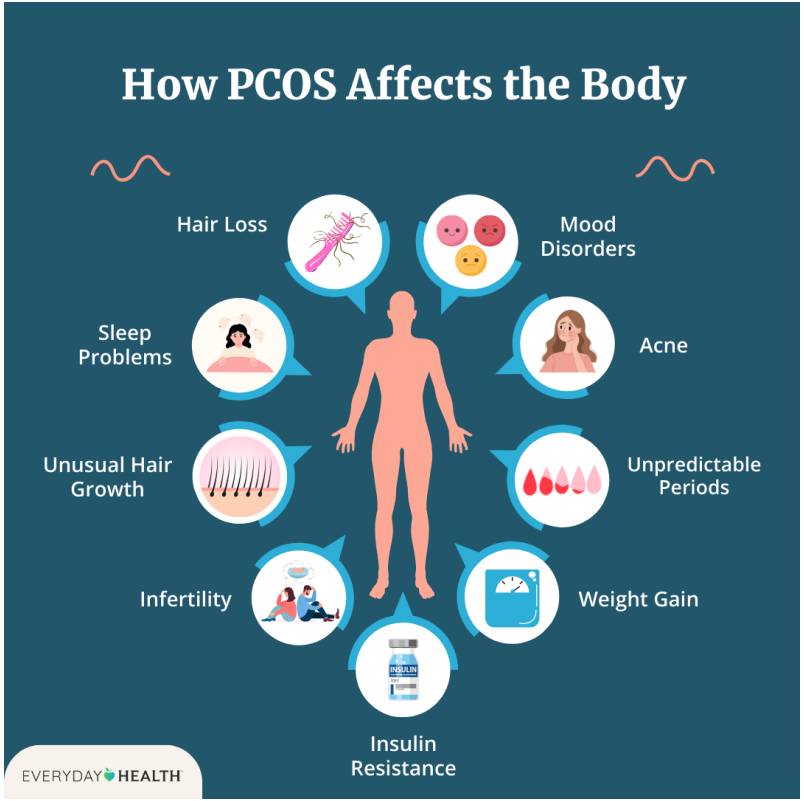
Quantify the hair loss

Sinclair shedding scale

Normal hair loss

50-150 hairs per day

Approach to hair loss in GP



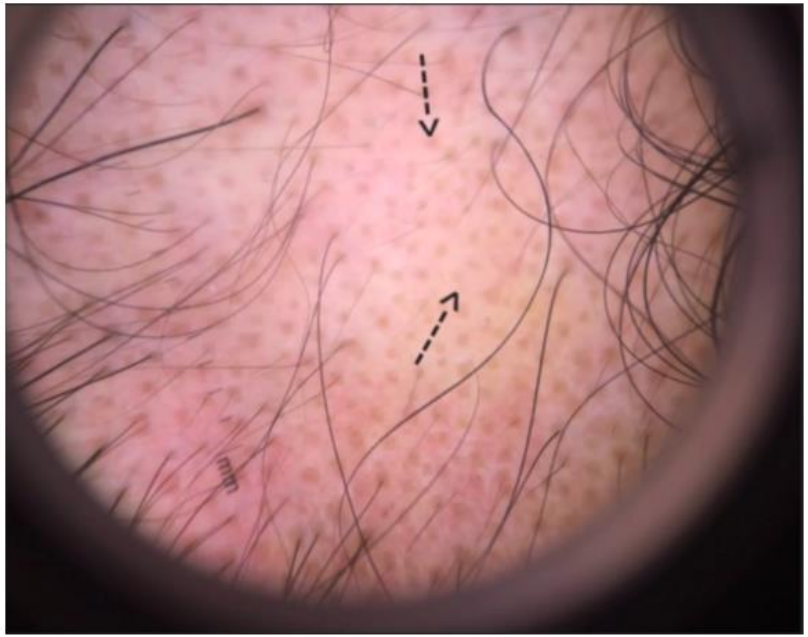
3. Hair loss – Hair pull test

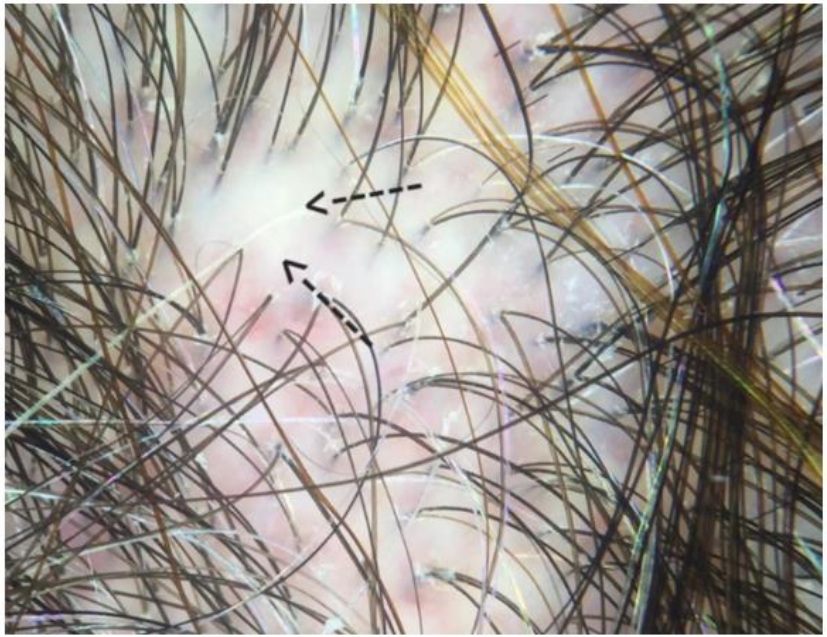
>/= 6 hairs fall out → Positive test

Alopecia areata, androgenetic alopecia, telogen effluvium, scarring alopecias

Nonscarring versus scarring alopecia

Absence of follicular ostia → SCARRING ALOPECIA





Identification of scarring alopecia should trigger immediate referral to dermatology

Investigations for hair loss

- Labs
    - TFT's
    - Iron studies
    - Ferritin >70 mcg/L
    - Vitamin D

- Additional tests for scarring alopecia
    - ANA/ENA
    - Skin biopsy

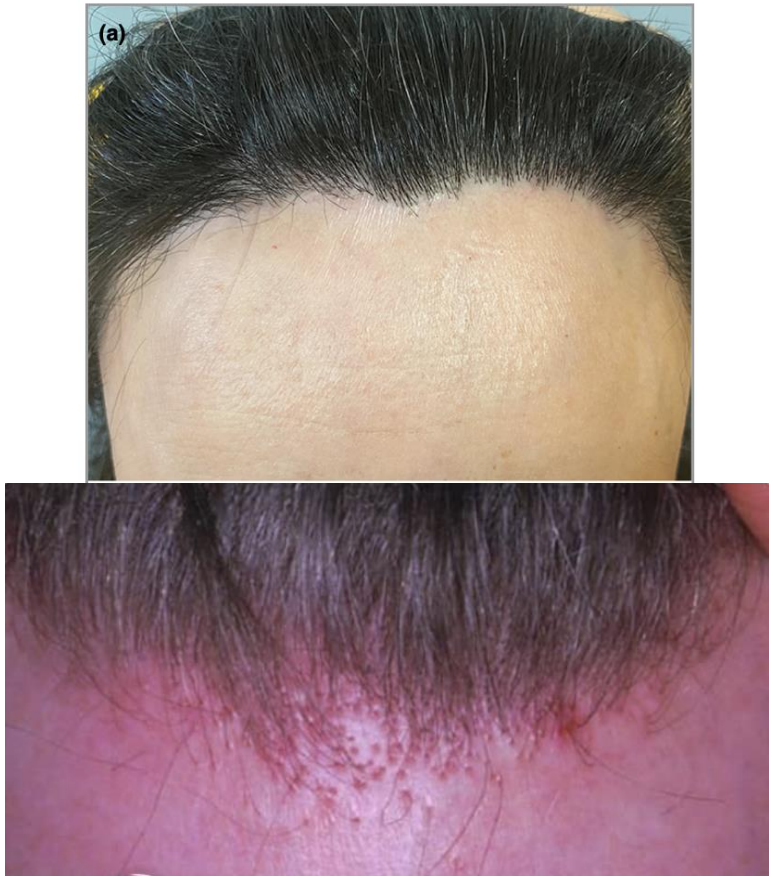
- +/- Hormonal profile (free and total testosterone, DHEAS as initial screening test)

Treatment tips for hair loss

- Dependent on cause of alopecia

- Often dual pathology
  - Minoxidil 5% foam daily topical
    - Onto scalp, 2 hours before bed
    - Initial shedding common 4-6 weeks (follicles transition from telogen to anagen)
    - At least 4-12 months to assess efficacy
    - SE's - scalp pruritus, flaking, facial hypertrichosis (reversible 4/12)
  - Nizoral shampoo
  - Replace iron if needed (ferritin >70mcg/L)
  - Vitamin D supplementation if needed

Frontal fibrosing alopecia

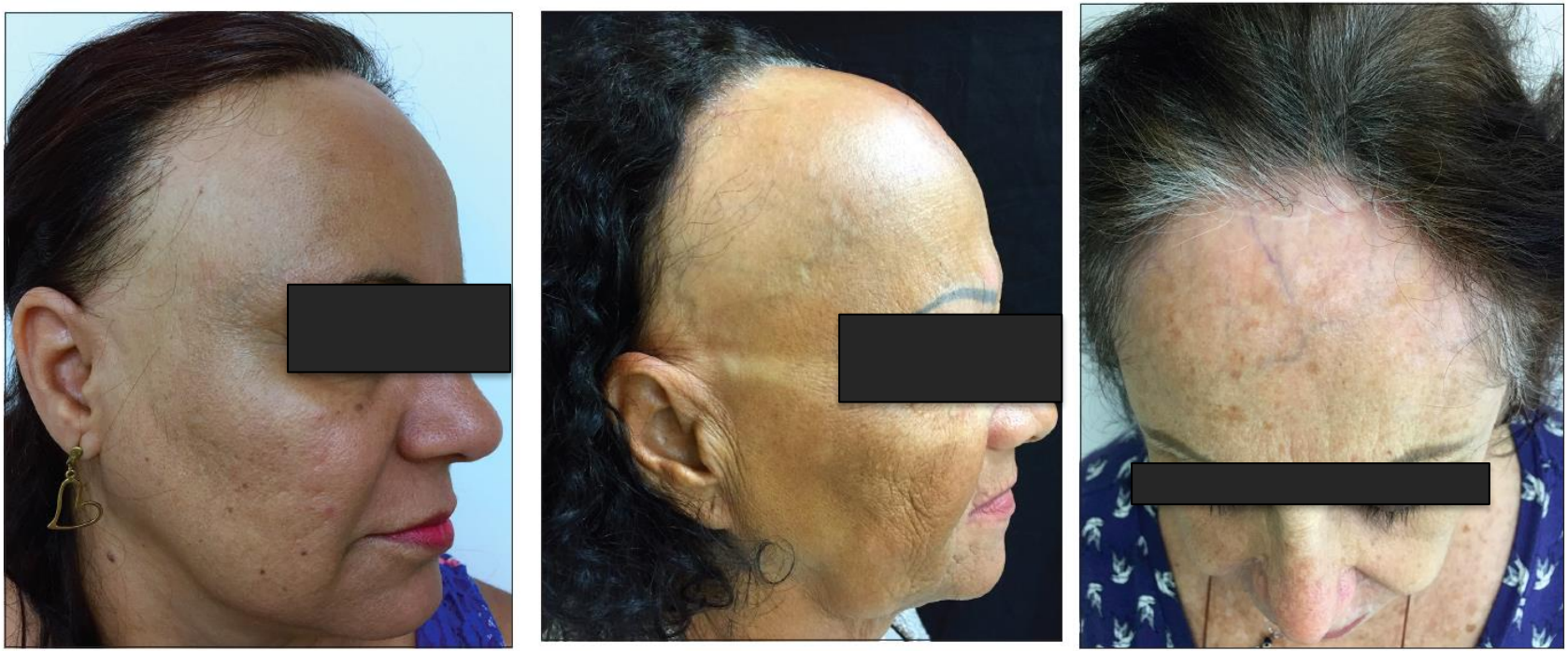


Lymphocytic scarring alopecia
Perifollicular erythema/scale
Frontal hairline
    +/- posterior hairline, eyebrows
    +/- Facial papules

+/- burning, pruritus, pain

Olsen et al. (2021), Guidelines for clinical trials of frontal fibrosing alopecia: consensus recommendations from the International FFA Cooperative Group (IFFACG)*. Br J Dermatol, 185: 1221-1231.

Frontal fibrosing alopecia



Fernandes Melo et al. Ten clinical clues for the diagnosis of frontal fibrosing alopecia. Indian Journal of Dermatology, Venereology and Leprology. 2019

Frontal fibrosing alopecia

Treatment goals:

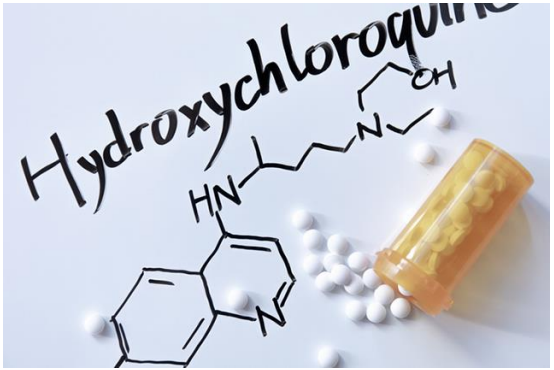
1. Halt scarring process

2. Achieve disease control

Manage expectations!

Cannot reverse hair loss

Frontal fibrosing alopecia



Sample treatment plan:

Dermovate scalp application to frontal hairline 6-8/52

Protopic 0.1% ointment nocte

Minoxidil 5% foam daily

IL triamcinolone every 8 weeks

Systemic agents:

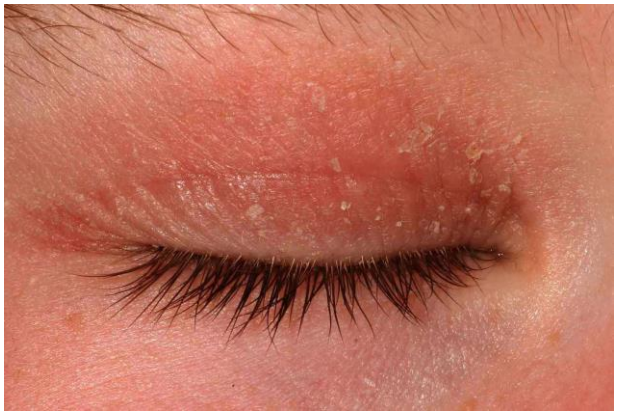
- Hydroxychloroquine 200mg OD/BD
- Doxycycline 100mg OD

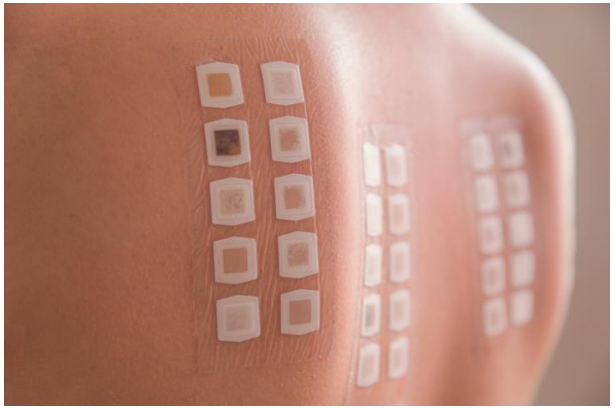
Treat concomitant disorders e.g. androgenic alopecia

4. Eyelid dermatitis

Up to **50%** with have allergic contact dermatitis

Consider referral for patch testing



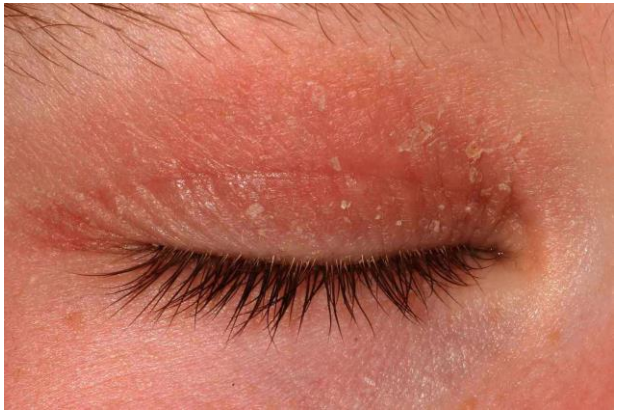


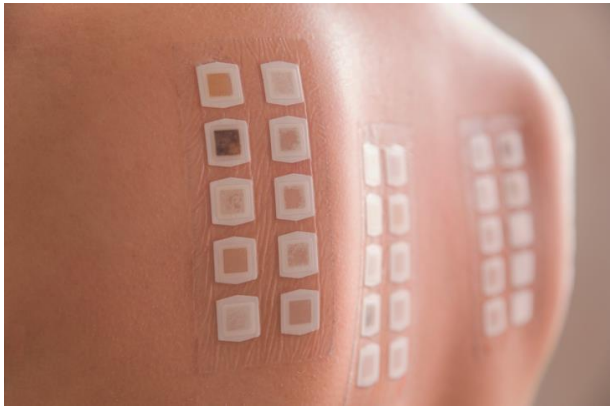
Beacon Hospital

4. Eyelid dermatitis

Management principles:

1. Restore the skin barrier
2. Avoid irritants/allergens
3. Treat beyond skin clearance





Beacon Hospital

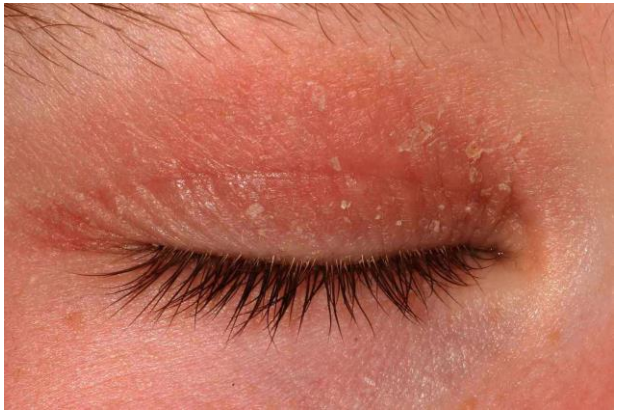
4. Eyelid dermatitis

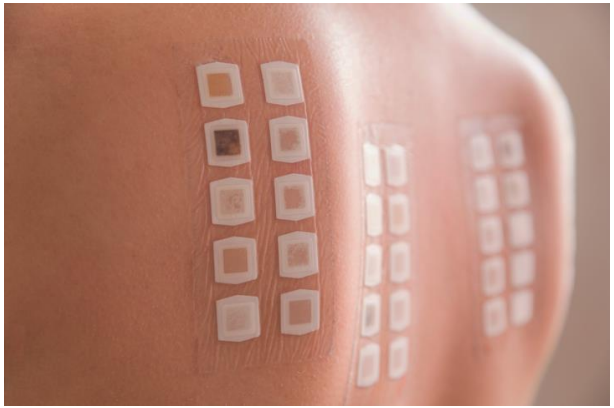
Management principles:

1. Restore the skin barrier

2. Avoid irritants/allergens

3. Treat beyond skin clearance





Beacon Hospital

4. Eyelid dermatitis

1. Gently cleanse
   Silcock's base or Bioderma Atoderm intensive eye

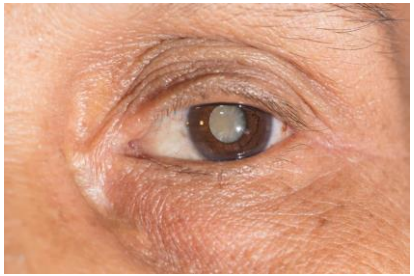
2. Moisturise
   Silcock's base or Bioderma Atoderm intensive eye

3. Acute flare

Hydrocortisone 1% ointment OD x 2/52 then

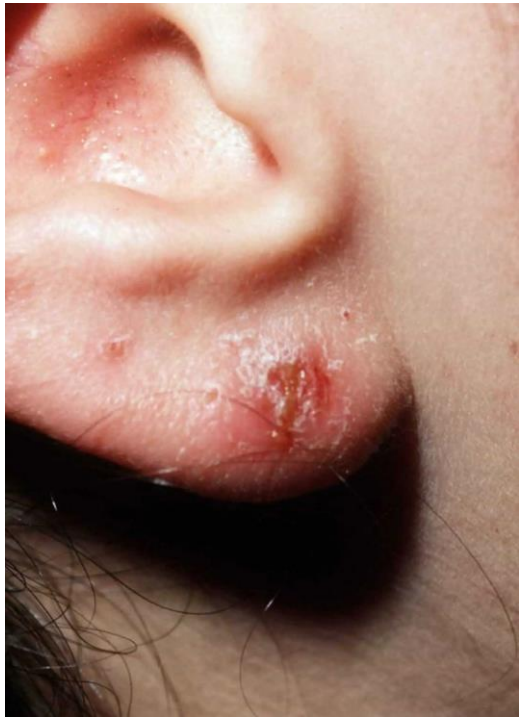
Protopic 0.1% ointment nocte x 2/52 then alternate nights x 2/52 then twice/week as maintenance

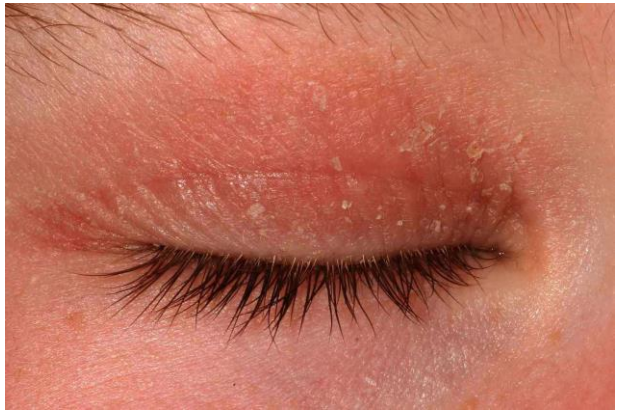
***Protopic – can cause burning/stinging for first 7-10 days but this resolves if you persist with treatment**

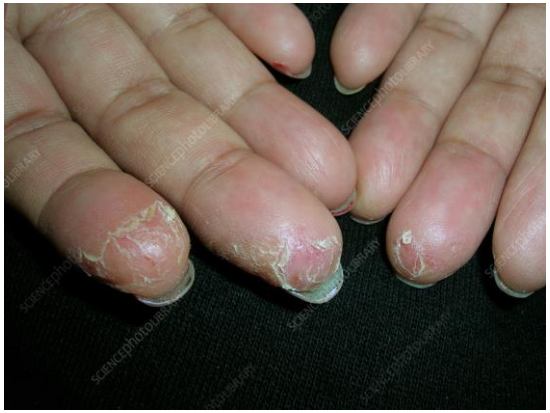


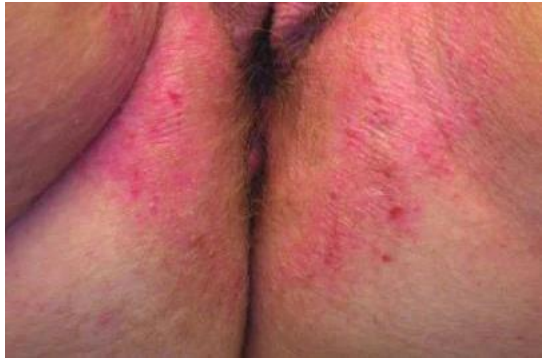
Beacon Hospital

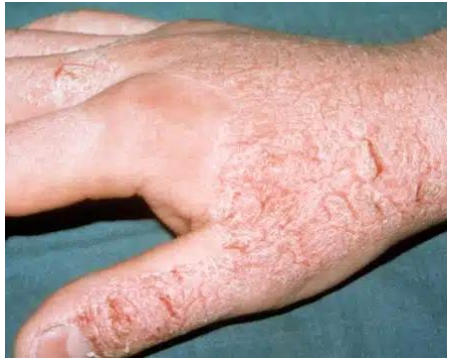
When to refer for patch testing?











PATIENT INFORMATION LEAFLET

HAIR LOSS MALE PATTERN (ANDROGENETIC ALOPECIA)

WHAT ARE THE AIMS OF THIS LEAFLET?

This leaflet has been written to help you understand more about male pattern alopecia. It tells you what it is, what causes it, what it looks like, how it is diagnosed, what treatments are available, and where you can get more information about it.

WHAT IS MALE PATTERN HAIR LOSS?

Male pattern hair loss (MPHL) is the most common type of hair loss in men. It is also known as androgenetic alopecia. It can affect men of any age.

WHAT CAUSES MALE PATTERN HAIR LOSS?

MPHL is caused by a combination of genetic and hormonal factors. A hormone called dihydrotestosterone (DHT) causes a change in the hair follicles on the scalp. In a process termed "miniaturisation", hairs produced by the affected follicles become gradually thinner and lighter in colour until eventually the follicles shrink completely and stop producing hair.

IS MALE PATTERN HAIR LOSS HEREDITARY?

Yes. It is believed this can be inherited from either or both parents. Over 190 genes have been identified as contributing, which helps to explain how MPHL affects family members to varying degrees of severity and at different ages.

WHAT DOES MALE PATTERN HAIR LOSS FEEL AND LOOK LIKE?

Men can become aware of scalp hair loss or a receding hairline at any time after puberty. There are usually no symptoms on the scalp, though some men describe scalp symptoms such as itch.

The usual pattern of hair loss is a receding frontal hairline and loss of hair from the top of compared to hairs in unaffected areas, before they become absent.

Hair loss can have significant psychological impact on affected individuals. This can lead to decreased self-esteem and body image concerns. It is important to address your emotional wellbeing with your healthcare professional who can provide appropriate support and treatment options.

HOW IS MALE PATTERN HAIR LOSS DIAGNOSED?

The diagnosis is usually based on the history of scalp hair loss on the front/ top of the head or receding hairline, the pattern of hair loss and a family history of similar hair loss. The skin on the scalp looks normal on examination.

CAN MALE PATTERN HAIR LOSS BE CURED?

No, there is no cure. However, it tends to progress very slowly, from several years to decades. An earlier age of onset may lead to quicker progression.

HOW CAN MALE PATTERN HAIR LOSS BE TREATED?

Licensed topical and oral treatments:

- Applying 5% minoxidil liquid or foam to the scalp may help to slow down the progression of hair loss and acts as a hair growth stimulant. It is not available on an NHS prescription. The liquid or foam should be applied to the affected scalp (not the hair) using a dropper or pump spray device. It should be spread over the affected area lightly and does not need to be massaged in. Minoxidil can cause skin reactions such as dryness, redness, scaling and/or itchiness at the site of application and should not be applied if there are cuts or open wounds. It needs to be used for at least 6 months and possibly up to 12 months before any benefit may be noted. Any benefit is only

HOW CAN MALE PATTERN HAIR LOSS BE TREATED?

Licensed topical and oral treatments:

- Applying 5% minoxidil liquid or foam to the scalp may help to slow down the progression of hair loss and acts as a hair growth stimulant. It is not available on an NHS prescription. The liquid or foam should be applied to the affected scalp (not the hair) using a dropper or pump spray device. It should be spread over the affected area lightly and does not need to be massaged in. Minoxidil can cause skin reactions such as dryness, redness, scaling and/or itchiness at the site of application and should not be applied if there are cuts or open wounds. It needs to be used for at least 6 months and possibly up to 12 months before any benefit may be noted. Any benefit is only

Beacon Hospital

Useful resources – skin disease in pregnancy

EUROPEAN ACADEMY OF DERMATOLOGY & VENEREOLOGY

Information Leaflet for Patients

Rosacea in Pregnancy

The aim of this leaflet

This leaflet has been written to help you understand more about rosacea in pregnancy. It will discuss what rosacea is, what causes it, and what can be done about it.

BMJ

BMJ 2014;348:g3489 doi: 10.1136/bmj.g3489 (Published 3 June 2014)

CLINICAL REVIEW

Skin disease in pregnancy

Samantha Vaughan Jones *consultant dermatologist*[1], Christina Ambros-Rudolph *consultant dermatologist*[2], Catherine Nelson-Piercy *professor of obstetric medicine*[3]

[1]Department of Dermatology, Ashford and St Peter's Foundation Trust, Chertsey, Surrey KT16 0PZ, UK; [2]Department of Dermatology, Medical University of Graz, Austria; [3]Women's Services, Guy's and St Thomas' Foundation Trust, London

Thank you

smenziesoffice@instituteofdermatologists.ie

Beacon Hospital