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Approach to requests in practice

1. Gather Information

Use a history taking tool to gather the required information. These are only a guide, and the line of questioning should be specific for each case and patient.

W	**Who** is the patient: Age, weight, male/female, pregnant/breastfeeding
W	**What** is the complaint/symptoms
H	**How Long**: duration of the symptoms
H	**Have** they tried anything: has a particular product been tried and been unsuccessful
A	**Any idea**: does the patient know what might have caused their symptoms
A	**Allergies**: to any medications, products, or foods: assess the details of the allergy to determine if it is a true allergy
M	**Medications**: any medications being taken, including vitamins, supplements, and anything natural/herbal
M	**Medical conditions**: current medical conditions and whether the patient has a family history
R	**Recommend**: pharmacological and non-pharmacological options and advice
R	**Refer**: if any red flag or unusual symptoms are present. All patients should be prompted to visit their doctor if symptoms worsen or do not resolve.

To narrow down a diagnosis or to gather further information ask more narrow questions or use LINDOCARRF mnemonic:

L	**Location:** where is the problem located
I	**Intensity:** how severe are the symptoms
N	**Nature:** can you explain how the symptoms feel
D	**Duration:** how long have the symptoms been there for
O	**Onset:** when did the symptoms start. Is there anything that might have contributed to your symptoms
C	**Concomitant factors:** are there any other symptoms being experienced
A	**Aggravating factors:** does anything worsen the symptoms
R	**Relieving factors:** does anything make the symptoms better
R	**Radiation:** usually a question for pain – does the pain radiate anywhere
F	**Frequency:** how often do these symptoms occur

2. Identify the problem/complaint/condition

a. Make an assessment or diagnosis: clearly state what you believe the problem is or what the potential problem is.

b. Explain the diagnosis/condition to the patient, using easy to understand language

3. Counsel the patient

4. Recommend an evidence-based treatment, considering the appropriateness for the patient (i.e., age, allergies, previously used treatments, pregnant/breastfeeding.

5. Provide the patient with information on how to use the recommended product. This includes the method for use, the dose, frequency, and duration.

6. Advise the patient of any adverse effects they may encounter whilst using the treatment

7. Provide non-pharmacological advice and lifestyle recommendations. Tailor the information to the patient

8. Offer take-home information such as fact sheets, Self-Care cards, information booklets, consumer medicines information (CMI) leaflets, and support service information (e.g., QuitLine information for smoking cessation)

9. Summarise the key points of the interaction. To ensure the patient understands, ask them to explain it back to you.

10. Refer the patient if no improvement within a set time frame

Skin Conditions

Acne

- **Symptoms:**
    i. Acne lesions which can be open/closed comedones, pustules, papules, nodules, and cysts which present on the face and in more severe cases may also affect the trunk
    ii. Severity can be determined by the morphology and extent of symptoms.
- **Referral Points:**
    i. Moderate to severe acne
    ii. Affecting mental health (regardless of severity)
    iii. Suspected cause is an acnegenic drug (anabolic steroids, some combined oral contraceptives, oral corticosteroids, lithium)
    iv. Female and also presents with hirsutism, obesity, or menstrual irregularity (suspected PCOS)
    v. OTC treatment failure
- **OTC Treatment:**
    i. **Benzoyl Peroxide cream or gel (Benzac ® Gel OR Oxy® Vanishing Cream)**: Use 2.5% products in patients with a history of dermatitis or 5% products in all other patients. 10% products have no additional efficacy and may increase adverse effects.
        - **Use:** Wash face with a gentle cleanser then apply gel/cream to all areas of inflammation (not just individual spots). Leave on for ~2 hours then wash off for the first 3 days, followed by applying and leaving it on overnight if no irritation occurs. **Maximum use is twice daily if required**. Use for at least 6 weeks to determine efficacy and if a benefit is seen, continue for 4-6 months.
        - **Adverse effects:** Skin tension or a burning, stinging or itching sensation and a small amount of peeling or reddening of the skin. **Minimise adverse effects by wearing sunscreen and using a moisturiser.** If adverse effects are intolerable, reduce application frequency to every second day
        - **Counselling Points:**
            a. Cream is more suitable for dry skin whereas gel is more suitable for oily skin
            b. Benzoyl peroxide is a mild bleaching agent. It may remove colour from towels and pillowcases so use a white face towel and do not be alarmed if pillowcases/linen become discoloured

    ii. **Azelaic Acid 15% Gel (Finacea®)**
        - **Use:** wash face with a gentle cleanser then apply gel to all areas of inflammation (not just individual spots) **twice daily.** Massage gel into the skin gently until it vanishes. Use regularly over several months to determine efficacy
        - **Adverse effects:** burning, itching, stinging/tingling, redness, skin dryness

General Counselling for acne

a. All creams, moisturisers, face washes and sunscreen should be non-comedogenic and fragrance and soap free. Makeup should be mineral-based and oil-free

b. Diet generally doesn't influence progression or flares of acne but if the patient finds that a certain food aggravates their acne it should be avoided

c. Do not use other acne products as this can increase skin irritation.

d. Avoid popping pimples as this can increase scarring

Alopecia (Androgenetic)

- **Symptoms: age-related hair change in patients with a genetic predisposition**

  i. Men: begins with a bitemporal recession, advancing to baldness on the scalp vertex

  ii. Female: initially with diffuse thinning that leads to a widened part line on the crown and a smaller ponytail volume. Sparse frontal hairline and episodic bursts of hair shedding are common.

- **Referral Points:**

  i. Suspected tinea capitis

  ii. Sudden onset

  iii. Trichotillomania

  iv. OTC treatment failure

  v. <18yo

- **OTC Treatment:**

  i. **Minoxidil 5% lotion OR foam (Regaine®)**: 1mL (or 1g foam) twice daily for men or once daily for women. Avoid using in patients that are pregnant or breastfeeding or <18yo. Foam may be more suitable if lotion is causing local irritation or greasiness

     - **Use:** ensure scalp and hair is completely dry before application. Massage 1mL twice daily to scalp, beginning at centre of affected area. Do not wash hair for at least 4 hours after application. Do not apply any headwear for at least 1 hour after application.

     - **Adverse effects:** allergic-type reactions, itching and other skin irritations of the treated area of the scalp, eczema, dry skin/scalp flaking.

- **AVOID:** hair/skin/nails multivitamin: no evidence of efficacy

- **Counselling and Lifestyle Advice:**

  - It may take 3-4 months before any benefit is seen.

  - An INCREASE in hair shedding may occur within the first 2-6 weeks.

  - Continual treatment is required to maintain any hair growth (i.e., hair grown will be lost on cessation of product).

  - Stop treatment if no benefit seen after 6 months.

  - Sun protection is required while using minoxidil: apply sunscreen 4 hours after applying minoxidil OR wear a hat after 1 hour of applying minoxidil

Cutaneous Candidiasis

- **Symptoms:**

  i. Patches of moist, red, shiny rash with vesicles and satellite pustules. There is no defined border, develops slowly and minimal itch.

  ii. It occurs in flexures, the sub mammary area and other skin folds.

iii. Usually occurs in patients with predisposing factors (e.g., broad-spectrum antibiotic therapy, diabetes, general debility, immune incompetence, obesity, immobility).

- **Referral Points:**

  i. Secondary bacterial infection suspected

  ii. Diabetic patient

  iii. OTC treatment failure

- **OTC Treatment**

  i. **Antifungal therapy:**

  - **Clotrimazole 1% cream (Canesten®)** applied topically twice daily for 14 days
  - **Miconazole 2% cream (Daktarin®)** applied topically twice daily for 14 days
  - **Nystatin 100,000 units/g cream (Mycostatin®)** topically twice daily for 2 weeks

  ii. **Antifungal and corticosteroid combination therapy:**

  - Clotrimazole 1%/Hydrocortisone 1% cream applied twice daily for 1 week to settle redness and inflammation followed by clotrimazole alone for 2 more weeks

  iii. **AVOID:**

  - Hydrocortisone cream alone
  - Terbinafine cream

  iv. **Counselling:**

  - **How much to use:** One fingertip unit (FTU) is the amount of cream or ointment, squeezed out of a tube, from the tip of an adult's index finger to the first crease in the finger. One FTU is enough to cover an area of skin twice the size of a flat adult hand with the fingers together.
  - Avoid tight clothing, and wear breathable fabric
  - Wash skin regularly with a soap substitute
  - Ensure skin is completely dry after bathing
  - Consider broaching the topic of weight loss if obesity is a contributing factor

Dermatitis

- **Symptoms:** The cardinal feature is the presence of itch

  i. **Atopic Dermatitis (eczema):** erythematous, scaly eruption, which in the acute state is weeping/crusted and in the chronic state is lichenified (thickened), with dryness and cracking and fissures. It is a chronic relapsing/remitting condition. The distribution of lesions varies with age: in infancy it tends to start on the face. In childhood it mainly affects the knee/elbow flexures, wrists, and ankles. In adults the distribution is similar to childhood with additional low-grade involvement of the trunk and face

  - **Ask about a family history of atopic (allergic) conditions such as asthma and hayfever** as there is a predisposition to develop eczema in these patients

  ii. **Allergic Contact Dermatitis (ACD):** Rash that develops following a **single** exposure to an allergenic substance.

iii. **Irritant Contact Dermatitis (ICD):** Rash that develops following **repeated** exposure to an irritating substance. This accounts for the majority of industrial cases as soap, detergents, chemicals, and solvents are the most common culprits. The affected sites are any area that come into contact with the irritant.

- **Consider the occupation of the patient during questioning.**

- **Referral Points**

i. Suspected secondary bacterial infection

ii. Severely compromised skin condition

iii. Suspected psoriasis

iv. OTC treatment failure after 7 days

v. <2 years old

vi. Severe eczema or lichenification (thickened skin)

- **OTC Treatment**

i. **Topical Corticosteroids**

- **Hydrocortisone 1% cream or ointment (Sigmacort®, Cortic®, Dermaid®):** Apply to the affected area 1-2 times daily for up to 7 days. Ointment may be more suitable for thicker skin, such as the hands, feet, or lichenified wrists/ankles

- **Clobetasone Butyrate 0.05% ointment (Kloxema®):** Apply to the affected area 1-2 times daily for up to 7 days.

ii. **Skin Maintenance**

- Daily bathing is not harmful if a soap-free and fragrance-free wash is used, and emollient is applied liberally afterwards.

- If the skin is very dry use dispersible oils when bathing

- Examples of emollients are included in the section regarding dry skin. They should be applied 2-4 times daily and especially after bathing

- If the skin is very itchy make an oatmeal bath (put half a cup of oats in a sock or stocking and add this to the bathwater)

iii. **Sedating Antihistamines**

- Sedating antihistamines may be used if sleep is interrupted, but the cause of itching is not attributed to histamine release, so these have limited use. **Avoid** less-sedating antihistamines

- **AVOID:**

i. Antifungal cream

ii. Products with unnecessary additives such as fragrance, tea-tree oil, or lanolin

- **Counselling and Lifestyle Advice**

i. For corticosteroids use the fingertip unit guideline for amount: One fingertip unit is the amount of cream or ointment, squeezed out of a tube, from the tip of an adult's index finger to the first crease in the finger. One fingertip unit is enough to cover an area of skin twice the size of a flat adult hand with the fingers together. You can measure the area of skin to be treated by holding a flat adult hand, with the fingers together, over the affected skin

ii. Avoid irritating/aggravating factors

- For ICD, management involves avoidance of the irritants responsible for the condition, but this is often not possible and the best that can be achieved is reduced exposure by using protective clothing and gloves.
- For ACD Management is through complete avoidance (not reduction in exposure) of the allergen, which may not always be practical, but is necessary.

iii. Reduce trauma from scratching by cutting nails short

iv. Wear light breathable cotton clothing

v. Modifying the diet has limited benefit in patients

Dry Skin

- **Symptoms:**
  i. Dry, red, irritated skin, which may be flaking, scaling, peeling, or cracking
- **Referral Points**
  i. Suspected psoriasis
  ii. Severely broken or bleeding skin
  iii. Suspected secondary bacterial infection
- **OTC Treatment:** relieves the symptoms of dry skin and optimise skin hydration
  i. Greasier emollients are better for more dry skin

Light/Non-greasy	→	This includes lotions which should be AVOIDED as they are not moisturising enough
Slightly greasy	→	Aqueous cream. Emollient properties can be altered by adding olive oil or white soft paraffin (WSP)
Moderately greasy	→	Glycerin 10% in sorbolene cream. Formulations in tubs sting less than formulations in a pump
Very greasy	→	Emulsifying ointment
	→	50% WSP and 50% liquid paraffin

- **Counselling and Lifestyle Advice**
  i. Moisturisers can be applied at any time but are most effective when they are applied to damp skin (i.e., after bathing or washing the face/hands)
  ii. Fabrics can soak some of these emollients and become more flammable. Keep away from naked flames and change clothing/bedding daily
  iii. White soft paraffin is the greasiest, thus most emollient but is often not cosmetically acceptable

Seborrheic Dermatitis

A chronic inflammatory skin condition, which mainly affects hairy areas in individuals with a tendency to dandruff. The success of treatments directed against yeasts has suggested that overgrowth of Malassezia yeast plays an important part in the development of seborrheic dermatitis

- **Symptoms:**
    i. **May be asymptomatic**
    ii. Characteristic greasy, yellowish scales
    iii. Itch and dandruff in mild cases
    iv. Well demarcated, red scaly rash which generally does not form plaques or become thickened.
    v. If it affects the face it can cause a *butterfly rash*
- **Referral Points**
    i. OTC treatment failure
    ii. Psoriasis
    iii. Spreading rash
    iv. Signs of secondary bacterial infection
    v. Symptoms that appear after holidaying in a warm climate
- **OTC Treatment**
    i. **First line treatment for mild scalp seborrheic dermatitis (including dandruff) is to use a standard shampoo once daily until the scalp is clear**
    ii. **Anti-Yeast Shampoo:** Response to shampoo can diminish so rotate between the different shampoos
        - **Ketoconazole 1% or 2% shampoo (Nizoral®):** massage into wet hair twice weekly for 2 weeks then once weekly thereafter. To use, apply to wet scalp, lather, leave for 3-5 minutes then rinse.
        - **Selenium Sulphide 2.5% shampoo (Selsun®):** Lather into wet hair for 2-3min, then rinse thoroughly. Use twice weekly initially until clear, then as needed thereafter
        - **Miconazole 2% shampoo (HairScience for Dandruff®):** Thoroughly wet hair and scalp then apply a small amount of shampoo, massage well and leave on the scalp for 3-5 minutes then rinse. Use 2-3 times weekly for 4 weeks then once weekly thereafter if required
    iii. **Antifungal and Corticosteroid Combination Cream:** Use if facial involvement (butterfly rash).
        - **Hydrocortisone 1% + Clotrimazole 1% cream (Hydrozole®):** Apply to the affected areas 1-2 times daily until skin clear. Refer if no improvement in 1 week
- **AVOID:**
    i. Head lice treatments
- **Counselling and Lifestyle Advice**
    i. Regular face and hair washing can help to reduce yeast burden**.**

Fungal Skin Infections

- **Symptoms:**
    i. Also known as **tinea corporis** or **ringworm,** it manifests as an annular (ring-shaped) rash with a defined border and central clearing. An infection of the trunk and limbs, it is more common in children than adults.

ii. **Tinea pedis** (Athlete's foot) is a common infection of the feet in adults. It presents as maceration in the toe webs, especially between the last digits, scaly distribution on the soles of feet. There may be some acute blistering and oozing which can predispose towards secondary bacterial infection. Infection may spread to the nails, which can become discoloured, thickened, or dystrophic. The area is generally malodourous and itchy.

iii. **Tinea capitis** (on the scalp) presents with one or more patches of hair loss on the scalp. The bald skin in this area is usually scaling and reddened and may be itchy. **Requires referral for oral antifungal agents**

- **Referral Points:**

i. Large areas of the trunk involved

ii. OTC treatment failure

iii. Diabetes

iv. Signs of a secondary bacterial infection

v. Diabetic or immunocompromised patients

- **OTC Treatment**

i. **Terbinafine 1% cream or gel (Lamisil®):** for recent onset or localised tinea of the trunk, limbs, face or between fingers/toes: apply topically to the affected area once or twice daily for 7-14 days. Symptoms should improve within a few days, continue for 7 days after resolution

ii. **AVOID:**

- Hydrocortisone cream

iii. **Counselling and Lifestyle Advice**

- After bathing ensure that skin is completely dry, especially between the toes
- Hot wash all clothing and linen that has been in contact with the affect area
- For tinea pedis: avoid walking barefoot in public showers, pools, or other communal spaces – wear thongs. Choose breathable shoes, change socks regularly and dust shoes with antifungal powder

Pityriasis Versicolour

A common condition caused by *Malassezia* yeasts

- **Symptoms:**

i. Patches of hyper/hypopigmentation which present as well demarcated macules, generally limited to the upper trunk, but may also affect the whole trunk, upper arms, or neck. It does not present on the face.

ii. May be slightly itchy but is often asymptomatic.

iii. More common in young adult males and exacerbated by heavy sweating

- **Referral Points:**

i. OTC treatment failure

- **OTC Treatment:**

i. **Antifungal Agent**