I am pleased to report another increase in the Trustees Committee. We are delighted to welcome Sandra Webb who is the Secretary of the Xeroderma Pigmentosum Society and who will provide further support and oversight of the Executive Committee activities.

Sandra completes our Trustees and allows a quorum to be achieved even when holidays or sickness intervene.

It may surprise you to know that no-one knows how many and what type of GPwSIs we have in dermatology! The Department of Health, the BAD, PCTs/CCGs and even the PCDS cannot tell you, not only where and who you are but perhaps more worryingly, what is the level of training and compliance with the established guidelines.

To find out some of this information we will be sending out questionnaires to all of you who have identified yourselves as a GPwSI to tell us of others in your area of work who are called GPwSIs that we may not be aware of. This is to try to get an overall view of the changes going on and the degree of integration between the different specialists in primary, intermediate and secondary care. Contacts will be in batches and we ask you to find out as much as possible of “GPwSIs” whether as part of a secondary care team, independent clinics or even within traditional practices. This is not a policing measure but we are getting increasing queries...
A new emollient with long lasting protection

😊 **Doublebase Dayleve Gel** is a new, advanced gel formulation combining high levels of emolliency with exceptionally long lasting protection, and the convenience of as little as twice daily application.

**Doublebase Dayleve™ Gel**

Isopropyl myristate 15% w/w, liquid paraffin 15% w/w.

Long lasting **leve-on** gel

Doublebase Dayleve™ Gel Prescribing Information.

**Uses:** Long lasting, highly moisturising and protective hydrating gel for dry skin conditions. **Directions:** Adults, children and the elderly: Apply direct to dry skin morning and night, or as often as necessary. **Contra-indications, warnings, side effects etc:** Please refer to SPC for full details before prescribing. Do not use if sensitive to any of the ingredients. In the unlikely event of a reaction stop treatment. **Package quantities, NHS prices and MA number:** 100g tube £2.65, 500g pump dispenser £5.29, PL00173/0199. **Legal category:** P **MA holder:** Dermal Laboratories, Tatmore Place, Gosmore, Hitchin, Herts, SG4 7QR. ‘Doublebase’ and ‘Dayleve’ are trademarks. **Date of preparation:** September 2011.

Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.gov.uk. Adverse events should also be reported to Dermal.
regarding availability of staff by CCGs and there are concerns about misuse of the title GPwSI. In addition we hope to encourage non-members to join and contribute to the ongoing debate about the changing roles in dermatology.

Last year the Essential Dermatology series of one-day conferences proved very successful as the PCDS roadshow traversed the country educating over 600 GPs and VTS registrars as well as some nurse practitioners. Proving the concept has led to a further eleven to be scheduled for this year as well as two “Level 2” days designed to cover a wider range of conditions but still aimed at our less experienced or knowledgable colleagues. Please point out these courses to your partners and registrars and if you have access to course organisers or any other educational organisation please either pass on the contact details to Carol at the PCDS office or ask her for publicity leaflets or Pdfs.

The PCDS has education of GPs as its prime objective and we need your help to promulgate our services. This also applies to the remaining four Dermoscopy for Beginners day courses also listed on the website.

It appears the Spring meeting in London will be a sell out for an opportunity to see the world-renowned dermoscopist Professor Giuseppe Argenziano from Naples, with his colleague Professor Iris Zalaudek from Austria. Such an event costs considerably more to organise but the demand for places has confirmed our belief that high quality meetings will be successful. In the Summer at Chesford Grange, Warwickshire on June 16th/17th we are delighted that Dr Ralf Hartmann will join us to reprise his fascinating and very humorous presentation on his 20 years in dermatology which includes his experience running the German Army hospital in Berlin. He will also enlighten us about the dermatological requirements from his tours of service in Afghanistan and perhaps what we might meet on our troops’ return. In addition we have a wide range of homegrown experts as well as a debate about Vitamin D!

Cardiff in September also promises to provide a wide range of subjects and educational levels to suit all our members. Indeed, with the practical surgical meetings, the advanced dermoscopy and the ever popular Scottish meeting this year in Dundee in November we will provide more than 25 meetings in 2012.

We look forward to seeing many of you at a meeting, hearing of your activities and helping you with your education.

Stephen Kownacki
Executive Chair
As I’m writing the Spring Editorial, I guess that Spring must be on its way. It didn’t feel like that this morning when I had to wear a facemask running on the moors for fear of developing frostbite. We did have a couple of premature daffodils in the village but they froze and then subsequently wilted. Hopefully by the time this comes to print, the Siberian weather will seem a distant memory.

I’ve recently been made aware of a great online learning dermatology resource, it’s called e-dermatology and there is a short article with more details included later. If you have time take a look, subscribe and highlight it to your GP registrars, F2 docs and medical students. Also watch this space for developments to the PCDS website. There is currently work going on behind the scenes developing a new website, which, hopefully will be ready in the near future.

Please have a look at the first of two articles on cutaneous vasculitis by Jon Goulding. I saw him give a talk on the subject at the Clinical Assistants’ meeting last year, which was excellent. He has a knack of making a very complicated subject seem very easy. There’s also a really helpful table with all the investigations needed for cutaneous vasculitis and the reasons for testing. Great to have at hand when you’re feeling frazzled in the middle of a busy clinic!

Bob Sarkeny has also promised me an article on Photodermatoses, hopefully at the end of the year.

Most of you will be aware that there have been changes to the Cosmetic Camouflage service, which was, until recently, provided by the British Red Cross. It has now become part of ‘Changing Faces’. Details about referring and contacting them for advice are also available in the Bulletin.

I was really pleased to hear that the Psoriasis Association has been awarded the Information Standard, an initiative supported by the Department of Health to signpost trustworthy information to the public. If you are not aware of it, it’s another great resource for patients, offering them information and support – www.psoriasis-association.org.uk

If anyone is a little bit square, like me and likes to dabble in histology, there are some great e tutorials on You-tube called ‘Dermpath made simple’. The one on Actinic Keratoses has just temporarily distracted me from the job in hand. They are by Dr Ian McColl, Tugan, (Gold Coast Australia). They show dermoscopy and also histopathology of benign, premalignant and malignant lesions. I would really recommend them – http://www.youtube.com/user/DermConsult?feature=watch

Right, must dash, see you at our Spring Meeting in London for more dermoscopy. I’m really excited about seeing our overseas Speakers Professor Giuseppe Argenziano and Professor Iris Zalaudek. It’s been a few years since I last saw them in Cardiff.

Helen Frow
This 50 year old man has just returned from working in a rural area of China at sites near the Korean and Vietnamese borders. Two weeks following his return he complained of constipation, generalised aches, feverishness, sweating, dark urine and fatigue.

During examination this rash was noted. The patient was sure the rash had developed suddenly within the past hour. The rash blanched on pressure, was maculopapular and confluent in some areas (Figs 1 and 2). Other findings were generalised tender lymphadenopathy and an eschar on right lateral elbow (Fig 3).

What is the most likely diagnosis?

The diagnosis is tsutsugamushi disease or scrub typhus. It is caused by a rickettsia micro-organism, orientia tsutsugamushi. Orientia tsutsugamushi is transmitted from its natural rodent reservoir by larval trombiculid mites, Trombicula akamushi and T deliensis (chiggers). These are common in soil and scrub in these parts of the Far East as well as the South-West Pacific. The incubation period is 6 to 21 days (usually about 10). In our patient it was 14 days.

Other illnesses caused by rickettsia species include Rocky Mountain Spotted Fever, Q fever and louse typhus. Rickettsia are positioned somewhere between bacteria and viruses. They only survive inside cells.

The severity of scrub typhus depends on complications due to vasculitis in various tissues and organs and varies widely from self-limiting to life-threatening illness. Usually fever, headache, conjunctivitis, cough, anorexia, vomiting, start 7 to 10 days after a bite. A firm papule, which becomes vesicular before it dries to leave a black, scab-like, crust develops at the site of the bite (Fig 3). Regional, tender lymphadenopathy may develop and become generalised. Seven to ten days later a generalised maculopapular rash suddenly develops (Figs 1 and 2). This may fade rapidly or last 7 to 10 days. In our patient it was gone within 24 hours. 10% get no rash. The rash is often more pronounced near the site of the bite.

Serious complications are uncommon, especially if the diagnosis is made early and appropriate treatment instituted. They include bronchopneumonia, heart failure, meningoencephalitis, myocarditis/endocarditis and renal failure. Doxycycline is the treatment of choice regardless of age. Scrub typhus responds to a single 200 mg dose. Dental staining is unlikely to be a problem in children with a single dose regime. Definitive diagnosis is with serology, but do not delay what is a simple and effective treatment. Referral to hospital is needed if any suspicion of complications.

Dr Johnny Loughnane, GP Limerick
Before we move on to more complex skin surgery, this is a
good time to pause and consider a few important aspects
when planning or undertaking your surgical clinics in
community settings.

Operating Room

Make sure the room you are using for operating is of a good
size with wide doors for wheelchair access. It has to be big
equal to allow space around all sides of the operating table, a
minimum of 3.5m x 3.5m is recommended. One should be able
to stand or sit comfortably at any location around the table to
allow a relaxed operating position at any point of the body
(Photo 1). Remember it may be necessary to change sides or
position during an operation to ease dexterity at the procedure
site. If you are not relaxed during the procedure you won’t be
able to do your job properly. Carpet is not a suitable covering for
the floor. Floors must have an easily washable, non-slip surface
without skirting boards which collect dust.

Clean and aseptic areas need to be separated from dirty zones,
for example the scrub sink should not be next to a sink used for
washing contaminated equipment. Waste items need to be
removed to an easily accessible site following the procedure.
Restrict access to the area to the people who will be involved in
the actual operating list.

Medical and surgical supplies are best stored in cupboards
rather than on open shelving. Your room requires plenty of
smooth, clean, uncluttered work surfaces to put all the
materials which will be needed for the operating list. These
items include gloves, drapes, skin prep, clean instruments,
packs of swabs, a selection of sutures etc. These areas should
be easy to clean down with anti-bacterial impregnated wipes,
also free of grooves, scratches and gaps which allow dirt and
bacteria to gather.

Operating Table

Ideally the operating table or couch needs to be anti-static, have
variable height control with an adjustable back rest and have the
facility to move into a ‘head down’ position in the event of a
patient feeling faint. The couch should be easy to clean and
comfortable for the patient. Check the maximum weight
restriction and never exceed this weight limit. Inspect the
covering of the couch and pillows regularly to ensure they are
intact. Any blood spills should be removed using specialised
blood cleaning products.

Lighting

Effective and successful performance during an operation is
enhanced by having good lighting. Lighting should not cause
shadowing or glare and ideally it should have adjustable levels.
Ineffective lighting can have a real impact on patient safety
through poor performance, lengthened procedures, uncertainty
and even errors.

A head light unit is comfortable and light, there is no heat
generated and is great for undertaking the excision of cysts as it

Sewing with Christy

Christy’s tips and advice for safe and
efficient operating
will not need adjusting (Photo 2). The battery will last 3-4 hours and is a relatively cheap option compared to a fixed light unit. The head lamp can be used in different rooms and locations. However, it is not cheap, the Heine head light unit is about £1400, and some of the more expensive models have a combined magnifying loop.

Free standing, mobile LED lighting is available with variable light intensity and is a cheaper option. Ideally, two lamps are better than one to prevent shadowing at all angles, however, this increases purchasing and maintenance costs. Another downside is the cabling and extra equipment, creating clutter around the operating table, increasing the risk of trips and falls.

For more information on lighting, the NHS Purchasing and Supply Agency (2010), has produced a Buyer’s Guide to Operating Theatre Lights which gives general guidance on buying the most appropriate product.

Operating Room Staff

Both the British and Scottish Associations of Anaesthetists suggest that in any theatre setting, when any form of anaesthetic is being introduced, along with the person administering the anaesthetic, a minimum of two other people should be in attendance. One of the support staff should be a trained nurse for reasons of safety in the event of an untoward incident. The BMA also supports the advice that trained nursing support should be provided for patients undergoing minor surgery.

Two operating assistants, one scrub nurse and one circulating staff member will allow for increased safety during the operating schedule and an effective throughput of patients. It can be very frustrating and time consuming if someone has to de-glove and interrupt an operation if extra equipment is needed or instruments are dropped. If a quick response to a change in the patient’s condition is required then having extra staff to help out may take too long.

I do appreciate this could be difficult to achieve in a general practice setting, perhaps make sure there is a second trained support staff present when attempting more complex procedures.

Equipment

A smooth topped, stainless steel trolley is best for placing the instruments on, shelves should have fixed down-turned corners. The trolley should be wide enough to be able to lay out all your instruments and keep any sharps safe and clearly visible. The trolley should be covered with sterile drapes to prevent infection and cleaned with suitable impregnated cloths following each procedure.

A lower shelf is useful for your equipment such as a sharps bin, bipolar or hyfrecator (high frequency eradicator).

Instruments

Either invest in good quality instruments which can be sterilized and re-used or buy disposable instruments. The initial outlay for
re-usable instruments is expensive as a few sets will be required to allow for turnaround through your local CSSD department. It is better to buy individual disposable instruments as the ones in the packs tend to be rather cumbersome (Photo 3). Also, for some procedures, such as shave excision, only a few instruments will be required so it is cheaper to order your disposable instruments separately. Economy is very important for GP practices undertaking surgical procedures.

In a basic skin surgery set you will need a suture holder such as the Halsey or Kilner, approximately 14cm in length. This is small and compact enough for skin surgery but your choice will also depend on the size of your hands. Include a fine-toothed Adson forceps which won’t damage tissue at the wound edges. A fine non-toothed Adson is great for suture removal when holding the suture material in the same alignment as the forceps, but in skin surgery non-toothed forceps will tend to crush tissue edges.

Curved, blunt tipped scissors are useful as they can be used as dissecting scissors and for cutting sutures at the end of procedures. Skin hooks are optional but very helpful when excising cysts and lipomas.

If your hyfrecator has had little effect controlling heavy bleeding, an artery clip or forceps is a valuable instrument for clamping large bleeding vessels before tying off with a polyfilament suture such as 4.0 Vicryl. Single filament sutures are too slippery for knots to be secured.

**Cautery**

To control bleeding during skin surgery I recommend that you at least invest in a hyfrecator but not the hot wire cautery type which tend to burn tissue rather than cauterise and have tips which require sterilising. Hyfrecators such as the Conmed 2000 use cheap sterile tips at approximately £1 each or non-sterile for 50 pence, sterile and non-sterile sheaths are also available to cover the handle and cable. This device is also useful as it has both monopolar and bipolar applications (Photo 4).

Heavy bleeding from the ends of cut vessels can be dealt with safely and efficiently using bipolar cautery which directs the current between the tips of the forceps producing significantly less tissue damage than monopolar cautery. Bipolar cautery also reduces the risk of interfering with pace makers, making it safer than monopolar cautery which uses the body as the earth route to complete an electrical circuit. This is why an electro-surgery machine using bipolar forceps is the gold standard and they are found in all hospital theatres.

The downside is they are an expensive investment (£2500 plus) and can be costly to use as a set of bipolar leads is approximately £180 and will need sterilising. The safety of these forceps and leads however, are only guaranteed for fifty uses. Single use bipolar forceps and leads are available at £20 a set and can be kept in reserve for those cases where bleeding will not stop using hyfrecation. This can save you a lot of embarrassment and more importantly is safer for the patients.
**Anticoagulants/antiplatelet Drugs**

When patients are taking warfarin the MHRA (2009) states that “For surgery when there is no risk of severe bleeding, surgery can be performed with an INR of less than 2.5”. Ask patients to have an INR check a week before their planned surgery.

Be aware that patients on aspirin tend to have excessive micro vascular bleeding which can make your procedure much more difficult.

Any concerns about post op bleeding or risk of haematoma due to anticoagulant/antiplatelet medication can be minimised by using plain local anaesthetic (without adrenaline). If meticulous haemostasis is established before closure of the wound and a pressure dressing applied for 24 hours post-op, complications can be reduced.

N.B. If there is an indication for patients to stop taking Warfarin or Aspirin before a surgical procedure then it may be prudent to refer them to secondary care.

**Infection Control**

Surgical site infections account for approximately 15% of all health-care associated infections. Bacterial contamination is a necessary precursor to surgical site infection, skin bacteria are always present, despite thorough skin preparation. However, bacterial contaminants may also enter a wound from exogenous sources including the air in the operating room, instruments or the surgical team coming into contact with the wound.

Here are a few considerations to minimise the risks of developing a surgical site infection:

Preoperative preparation plays a vital role in preventing wound infection. Appropriate skin preparation for the scrub team and patient with the use of antiseptic agents reduces the number of skin bacteria.

Some studies link hair removal prior to surgery to an increase in surgical site infection and have suggested that no hair be removed. This is due to micro damage to skin surface from shaving and makes the skin less efficient as a barrier to infection. If hair must be removed then do so immediately before surgery … personally I rarely have to cut or shave a patient’s hair prior to surgery. You could consider using KY gel to keep hair away from the wound area.

Intra-operative factors such as the operating room environment, cleanliness of surfaces, sterilisation of instruments, designated surgical attire (hats and shoes), sterile drapes and scrub suits (e.g. sterile gloves and gowns) also reduce contamination of the surgical wound.

Bear in mind that two of the most important principles to prevent surgical site infection are a good aseptic technique and minimising the duration of the operation.

One final consideration…..

In 2008 the World Health Organisation (WHO) launched the Surgical Safety Checklist to reduce complications and improve the safety of patients undergoing any surgical procedure (including local anaesthesia), in a theatre or procedure room. Although this is not a legal requirement organisations are encouraged to pragmatically assess the relevance of the use of the checklist to their own areas of practice.

For more information visit: [http://www.nrfs.npsa.nhs.uk/resources/?EntryId45=59860](http://www.nrfs.npsa.nhs.uk/resources/?EntryId45=59860)

Happy cutting!

Once again many thanks to Caron Woodward, Dermatology Specialist Nurse in helping me to write this article.

**Christy Chou**

Trust Surgeon
Department of Plastic Surgery
University Hospital of Durham
and Primary Care Skin Surgeon
Darlington and County Durham PCT
e-dermatology was introduced in 2009 as an on-line educational resource which was principally designed for dermatology trainees. The project has gone from strength to strength and now boasts close to 100 twenty-minute sessions, live and available to use.

Originally, we were invited to develop a project of approximately 600 sessions, mapped to the training curriculum. However, in the new financial climate we have reduced the size of the project and amalgamated the content into a more manageable 190 sessions, due for completion in 2013. It is hoped that this condensing, of the project, will be an advantage, as it will result in a more focussed resource.

In recent months, e-dermatology’s educational value has been increasingly recognised by Consultants, SAS doctors, GPs, medical students and trainees alike and subsequently is now being made available to a much wider audience than was originally anticipated.

e-dermatology is a product of the British Association of Dermatologists, in partnership with the Department of Health and has a small, but dedicated, team involved in the ongoing development of e-learning sessions. Each session that goes live is devised around one of two template types.

The first and possible most widely used session type is the ‘Scenario’ where users are asked to interact with a typical clinical situation and attempt to establish the correct diagnosis. Educational points are presented throughout the session, along with information on most of the potential diagnoses mentioned throughout each session.

The second style of session is based more around the acquisition of knowledge, via a series of interactive and educational pages on any given subject matter. These sessions tend to rely more on information and supporting images to relay the educational material to users.

Examples of both these templates can be found by visiting our website at www.e-lfh.org.uk/dermatology and clicking the ‘Sample sessions’ link.

e-dermatology is now available to anyone based in the UK that has a valid NHS email address. If you have not registered already then please visit our website and simply use the ‘Access the e-learning’ link to begin the process. You should be sent your details within a week of registration.

More good news is that there are now plans to make e-dermatology available to non-NHS employees, both inside and outside the UK, for a small fee. If this is something that is of interest to you then either keep an eye on the website for updates and additional information, or email Scott Mountifield (Project Manager) on scott.mountifield@e-lfh.org.uk to be kept up-to-date on when this will go live.

Apart from developing exciting sessions, covering all areas of the curriculum, trainees now have the opportunity to assess their ability to answer SCE-style questions on-line with e-dermatology. Trainees will also soon have a link to the e-dermatology website in their e-portfolio.

To keep development flowing and the project constantly updated, the project team try to upload new sessions every 6-8 weeks. The following sessions are among the latest additions to our ever-growing list of live e-learning.

Emollient Therapy in Atopic Dermatitis
Seborrhoeic Dermatitis
Asteatotic Eczema
Nodular Prurigo
Lichen Simplex
Burning Mouth Syndrome
Recurrent Oral Ulceration
Non Sexually Transmitted Genital Infections – Male
Non Sexually Transmitted Genital Infections – Female
Vitamin D Analogues

As e-dermatology goes forward into 2012, the one thing that helps us in our quest for the best possible learning resource is user feedback. The project team welcome any feedback on both existing sessions and developments you would like to see in the future.

If you have any suggestions that you wish to share with the project team then please don’t hesitate to get in touch with either Scott Mountifield (scott.mountifield@e-lfh.org.uk) or Robert Charles-Holmes (robert.charles-holmes@swft.nhs.uk).

Scott Mountifield
Jonathan Bowling needs no introduction to the members of the PCDS. He has been a key speaker for us and the wider dermatological family, for a number of years and his knowledge of and enthusiasm for the subject of dermoscopy are an inspiration to us all.

Being asked to write a review of this, his first book on the subject, feels a little like being asked to produce a critique of the tablets of stone that Moses brought down the mountain.

However, having spent some time with this book, I can report that it is a concise and clear book that will serve well as a primer for those dipping their toes into the dermascopical seas, but will also act as a reference guide for more experienced practitioners. It does perhaps stretch the point to describe itself as ‘The’ illustrated guide and it is the place of the reviewer to mention that other guides are available…

The layout is clear and easily read – a stylised graphical representation of a feature is followed by several photographs showing the same features in-vivo. There are also the appropriate references for those who wish to take the next step and find the source papers for the lesions described.

There is a section about choosing an instrument, a section on how to use it and even tips for getting better photographs. The pictures are well chosen and of a sufficiently high resolution to demonstrate all they need to. An image gallery of common and less common lesions completes the book.

Although, on first glance it appears to be short on text, for what is a visual subject, what text there is feels more than adequate. Overall, this is a book I can wholeheartedly recommend – even more so if you have attended a dedicated dermoscopy course, where it will serve as both revision and a complement to the face to face education.

Julian Peace

News from North of the Border (of Burundi)

Muraho! (Good day in Kinyarwandan), I’m writing this from Gahini hospital in Rwanda. (If you wish to see a short video of it, google it.) My first patient here said he was getting a pacemaker next week. I said he would look funny with a Kenyan lad 2 metres in front of him all the time!

I’m here on sabbatical and my small project is to set up a teledermatology service as there are no Consultant Dermatologists in Rwanda. Five Scottish consultants have kindly agreed to receive pictures from Rwanda of conditions for advice on diagnosis and management. Resources are, however, very sparse. There are no emollients here and Wim Schonbee the doctor I am shadowing suggests udder cream, used when milking goats and cows, as the nearest equivalent. There are no topical treatments for acne nearby so patients have to go to Kigali the capital city which is 85km away if they want it. Doxycycline is fortunately plentiful. The first photograph I sent was a picture of podoconiosis which is not a contact irritant dermatitis due to having an MP3 player plugged into your ears constantly but a nonfilarial elephantiasis due to walking barefoot on volcanic soil.

Enough of Rwanda – if you wish to hear more about it the Committee has pencilled me in for a workshop on my experiences here at the Scottish meeting.

The rest of the programme is coming along and there will be the usual top notch speakers and subjects, so put the 10th/11th November in your diary for the extravaganza at the Apex Hotel in Dundee.

What do you call a Dundee lass in a white shell suit???? – the bride.

What do you call a Dundee lad in a suit??? – the accused!

That’s enough of these jokes or I’ll not be welcome in the land of jam, jute and journalism come November.

Murabeho (farewell in Kinyarwandan)

Iain Henderson
My Approach to Cutaneous Vasculitis

This is the first of two articles doing exactly what it says on the tin. They are offered to try to break down into a manageable format what may be seen as an impenetrable topic and a potentially dangerous clinical problem. In the first I will provide a pragmatic approach to consider the range of possible aetiologies for a vasculitic-looking skin rash, cover the key points in history-taking and clinical examination of such patients and suggest those investigations which should be included in a ‘vasculitis screen’ and why. In the second, I will review the principal clinical features and optimal management of the most commonly encountered skin-limited vasculitis, cutaneous leukocytoclastic vasculitis, alongside some rarer subtypes.

Vasculitis – What is it?
The term vasculitis refers to inflammation and necrosis of blood vessels. There are numerous variants and pathogenesis is complex and dependent on the precise aetiology, though usually driven by an immune-mediated process. Broadly, vasculitis may be limited to one organ system (i.e. limited or localised vasculitis, see Figure 1), or involve several (i.e. systemic vasculitis). This is a crucial distinction to bear in mind since it is often difficult to distinguish the two clinically without recourse to further investigations, and the implications of the latter are clearly manifold.

A second useful thought process is to consider whether the vasculitic-looking rash one is inspecting is occurring as a de novo phenomenon (i.e. primary vasculitis), as a consequence of another process (i.e. secondary vasculitis), or whether in fact an entirely different disease is manifest (i.e. ‘vasculitis mimics’). Table 1 shows the range of primary vasculitides, subdivided by size of vessel affected according to the Chapel Hill Consensus Classification. Each of these conditions may present predominantly with skin signs. Secondary vasculitis may occur in response to a variety of triggering situations and common broad indicative categories accompanied by key examples of each are listed in Table 2. It is worth bearing in mind that despite extensive investigation, up to 50% of vasculitis cases involving the skin end up being labelled as idiopathic, though this doesn’t diminish the importance of performing investigations in the first place.

Table 1: Chapel Hill Consensus Classification

<table>
<thead>
<tr>
<th>Large-vessel vasculitis</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Giant cell arteritis</td>
</tr>
<tr>
<td>• Takayasu’s arteritis</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medium-vessel vasculitis</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Classic polyarteritis nodosa</td>
</tr>
<tr>
<td>• Kawasaki disease</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Small-vessel vasculitis</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Wegener’s granulomatosis</td>
</tr>
<tr>
<td>• Churg-Strauss syndrome</td>
</tr>
<tr>
<td>• Microscopic polyangiitis (polyarteritis)</td>
</tr>
<tr>
<td>• Henoch-Schonlein purpura</td>
</tr>
<tr>
<td>• Essential cryoglobulinaemia</td>
</tr>
<tr>
<td>• Cutaneous leukocytoclastic vasculitis</td>
</tr>
</tbody>
</table>

Table 2: Some causes of secondary vasculitis

| Infections | e.g. meningitis, endocarditis |
| Drugs      | e.g. antibiotics, allopurinol |
| Connective tissue diseases | e.g. rheumatoid arthritis, systemic lupus erythematosus |
| Malignancy | e.g. haematologic, solid organ |
Vasculitis – What is it not?

A huge array of disparate disease entities may generate skin rashes which appear clinically indistinguishable from cutaneous vasculitis. Broad categories of potential ‘vasculitis mimics’ with typical examples are presented in Table 3 and some illustrative cases in Figure 2. These demonstrate the need to keep an open mind when presented with an apparently vasculitic skin rash and to actively consider differential diagnoses so as not to miss such conditions. Again the importance of performing suitable investigations is highlighted, in particular deciding whether a skin biopsy is merited.

Table 3: Potential ‘vasculitis mimics’

<table>
<thead>
<tr>
<th>Category</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coagulopathies</td>
<td>e.g. immune thrombocytopenic purpura, thrombotic thrombocytopenic purpura, disseminated intravascular coagulation, warfarin or heparin necrosis</td>
</tr>
<tr>
<td>Bland occlusive disorders</td>
<td>e.g. cryoglobulinaemias, thromboemboli, cholesterol emboli</td>
</tr>
<tr>
<td>Others</td>
<td>e.g. calciphylaxis, capillaritis, Sweet syndrome</td>
</tr>
</tbody>
</table>

History-taking

As with all clinical problems a comprehensive history is of vital importance, but this is particularly true when assessing patients with apparent vasculitis. Taking care to establish the precise chronology of symptoms and events in the lead-up to the presentation of the rash is likely to shed light on the aetiology of the problem. A review of past medical history may indicate pre-existing medical conditions with a propensity to develop vasculitis. A thorough drug history including prescribed, over-the-counter, herbal and alternative remedies may identify culprit medications: drugs are an especially common cause of secondary vasculitis. Finally, a complete review of systems is recommended, particularly to pick up febrile symptoms which might indicate an infective aetiology and those specific symptoms which raise suspicion of a primary systemic vasculitis (see Table 4).

Clinical Examination

Patients with apparent vasculitis deserve a thorough clinical examination to allow honing of the diagnostic process and to prioritise management. A general assessment of the state of illness of the patient is important, including recording vital signs such as temperature (?infective cause) and blood pressure (?hypertension in renal involvement). A complete skin examination is needed. The classic skin lesions identified in cutaneous vasculitis are palpable purpura, which may appear as papules, nodules or plaques. An enormous range of additional skin signs may be seen however, including vesicles, bullae, pustules, ulcers, livedo, urticated lesions, oedema and necrosis1,2. The nails and nail-folds should be inspected closely for evidence of splinter haemorrhages (?endocarditis) and abnormal capillaries (?connective tissue disease) respectively. Examination of other systems will be directed to some extent by...
the history, but as a minimum it is worth auscultating the heart to pick up new murmurs which might indicate infective endocarditis.

**Investigations – the ‘vasculitis screen’**

A broad range of investigations is indicated for a patient presenting with apparent vasculitis – unfortunately there are no short-cuts! To aid the memory, I think in terms of the following categories: urinalysis, blood tests, radiology, histology and ‘specials’. Urinalysis is simple to perform in the clinic and should comprise a dip test to establish whether protein or blood is present, with the sample then sent for microscopy (to identify casts), both of which help to exclude renal involvement. The blood tests ideally required are numerous, and may be subdivided into those sent to haematology, biochemistry, immunology and microbiology. Table 5 provides a breakdown of such tests, including the rationale for requesting each. Radiology refers simply to a chest radiograph which should probably be performed in all patients unless there is a compelling contra-indication (seeking evidence of malignancy, infection, or pulmonary involvement in the systemic vasculitides). Histology refers to a skin biopsy and a low threshold for undertaking one is recommended since it is quick and easy to perform, allows one to confirm the diagnosis of vasculitis and simultaneously excludes mimics. A punch biopsy from lesional skin is usually sufficient, though a deeper incisional biopsy is suggested if a larger-vessel vasculitis is suspected. Sending a (lesional) biopsy sample for direct immunofluorescence may be very helpful, particularly to demonstrate the presence of IgA in cases of Henoch-Schönlein purpura. ‘Special’ investigations will not routinely be requested, but examples include cardiac Echocardiography when endocarditis is suspected and those organised by other specialists such as angiography in polyarteritis nodosa.

**5 Top Tips**

1. When a patient presents with a possible vasculitic rash, consider whether the process is likely to be primary, secondary or a vasculitis mimic.
2. Actively consider and seek to exclude the possibility of systemic involvement in any patient with vasculitis involving the skin.
3. Patients with vasculitis may be complex and deserve time to allow a thorough clinical assessment to be conducted.
4. A comprehensive set of screening investigations is recommended in such patients.
5. Maintain a low threshold for undertaking a skin biopsy in such patients.

**References**


**Table 5: Blood tests suggested for cases of apparent vasculitis**

<table>
<thead>
<tr>
<th>Category</th>
<th>Test</th>
<th>Indication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haematology</td>
<td>FBC+film</td>
<td>Anaemia of chronic disease, ↑white cell count in infection, ↓platelets in coagulopathies, ↑eosinophils in Churg-Strauss, evidence of haematologic malignancy etc</td>
</tr>
<tr>
<td></td>
<td>ESR</td>
<td>Marker of infection, inflammation or malignancy</td>
</tr>
<tr>
<td></td>
<td>Clotting Screen</td>
<td>Coagulopathies</td>
</tr>
<tr>
<td>Biochemistry</td>
<td>U+Es</td>
<td>Renal impairment in systemic vasculitis or renal syndrome</td>
</tr>
<tr>
<td></td>
<td>LFTs</td>
<td>May be abnormal in systemic vasculitides e.g. GCA</td>
</tr>
<tr>
<td></td>
<td>CRP</td>
<td>Marker of infection, inflammation or malignancy</td>
</tr>
<tr>
<td></td>
<td>CK</td>
<td>Dermatomyositis</td>
</tr>
<tr>
<td></td>
<td>Cryoglobulins</td>
<td>Cryoglobulinaemia</td>
</tr>
<tr>
<td>Immunology</td>
<td>Igs+electrophoresis</td>
<td>Paraproteinaemia, myeloma etc</td>
</tr>
<tr>
<td></td>
<td>ANA (+/- ENA, dsDNA)</td>
<td>Connective tissue diseases</td>
</tr>
<tr>
<td></td>
<td>ANCA</td>
<td>Systemic vasculitides e.g. Wegener’s granulomatosis</td>
</tr>
<tr>
<td></td>
<td>C3, C4</td>
<td>Connective tissue diseases, urticarial vasculitis etc</td>
</tr>
<tr>
<td></td>
<td>RhF</td>
<td>Rheumatoid arthritis</td>
</tr>
<tr>
<td>Microbiology</td>
<td>Hepatitis B+C serology</td>
<td>Viral hepatitis</td>
</tr>
<tr>
<td></td>
<td>HIV serology</td>
<td>HIV infection</td>
</tr>
<tr>
<td></td>
<td>ASOT</td>
<td>Recent Streptococcal infection</td>
</tr>
<tr>
<td></td>
<td>Blood cultures</td>
<td>Infective endocarditis</td>
</tr>
</tbody>
</table>
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- Pigmentation problems
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Rekha Patel
Press & Communications Officer
Changing Faces
As we enter the year of the bicentenary of Charles Dickens’ birth, it falls to me again to present a small selection of delights from the pages of journals dermatological. A tale of two journals, perchance – or perhaps an old curiosity or two. But that’s enough about me, on with the fun!

Rosacea seems to be a disease that I see more and more frequently. A multinational team has helpfully done a systematic review to assess the evidence base, efficacy and safety of available treatments. The study looked at trials of treatment in moderate to severe disease. Sadly, much of the data was considered to be at risk (or at an unclear risk) of bias but there did seem to be evidence to support the use of topical metronidazole, azelaic acid and oral doxycycline 40mg. Ciclosporin ophthalmic emulsion was also shown to be helpful in treating ocular rosacea but I wouldn’t advise it just yet in primary care. The doxycycline story is of interest. Trials showed no significant difference in efficacy between 40mg and 100mg preparations, but the lower dose showed significantly fewer adverse effects (at a significantly increased cost, it must be added).

From Italy comes more data about the possible association between non melanoma skin cancer and previous human papilloma virus (HPV) infection. A consistent pattern was found of seropositivity for beta and gamma HPV types and the risk of developing a second squamous cell carcinoma in patients who had already had one such tumour removed. No such association was found for basal cell carcinoma. This does not demonstrate a causal relationship – but does add further data to that little corner of the cancer research field.

A surprising paper now comes our way from France. I call this surprising because I had assumed that corticosteroid phobia was a British institution – it always seemed to follow articles in certain elements of our tabloid press. Not so – a questionnaire was given to patients attending a variety of dermatology departments in France. Almost 81% of respondents admitted to fears regarding the use of topical corticosteroids and 36% admitted non-adherence to treatment because of such fears. It would seem that steroid phobia is a more widespread and complex phenomenon than I (we?) first thought...

Back to skin cancer – it’s never far away from these pages... The incidence of malignant melanoma continues to rise and the incidence in males is now catching up with the incidence in females – at least in England, from whence this study comes. Anatomical site was also studied and it shows that the incidence is particularly increasing on trunk and arms, along with an increase in head and neck lesions in males. Males seem to be increasing their sun exposure, and have a relatively poorer compliance with sun protection than females. Could do better, it would seem, would read the midterm report for us chaps.

In amongst all the seriousness, there is occasionally a paper that begs to be included – such is the case with a paper from Taiwan entitled ‘Cutaneous larva migrans induced by swallowing live pond loaches’. The title is self explanatory, and it’s apparently a folk remedy to ‘enhance physical function’. Helpfully, the paper also states that well cooked pond loaches are harmless. Still, I wouldn’t recommend the practice and neither, I would imagine, would the loaches.

Back to the grind. It’s always nice to find papers that balance each other. After the mention of steroid phobia above, here’s a timely reminder that topical treatments can have systemic effects. Pregnant women will often need treatment with
topical corticosteroids (TCS). Little, however, is known of the effects of TCS on the fetus. Or rather, was known... This is another multinational attempt to create robust guidelines. There is good evidence to show that potent and very potent TCS can cause fetal growth retardation, but no association was demonstrated with orofacial cleft, preterm labour or fetal death as had previous been supposed. Mild and moderate potency steroids appear safe – relatively.

Whilst we await the results of a European study into co-morbidity associated with psoriasis, a Taiwanese group here reports their findings. They found an association between psoriasis and a variety of diseases including cardiovascular disease, metabolic diseases, renal failure, liver diseases, hepatitis B or C, asthma and peptic ulcers. The more severe the psoriasis, the more there was a likelihood of a co-morbidity. This adds to the data set, but it must be stated that some of these associations may be particular to the population studied.

From a close friend of the PCDS comes a piece of justification for the continuing existence of the society. From surveillance data collected via the RCGP in 2006 and subsequent trend data, it appears that skin conditions are the most frequent reason for consultation in general practice exceeding the incidence for all other major disease groupings. More evidence, as if we needed it, that there is a desperate need for dermatology education and training for all medical students and for continuing education for all primary health care professionals.

We have been continually reminded about the rising tide of pre-malignant skin lesions yet the treatment options for them remain rather limited. In many areas of the country, some therapies are even ‘red traffic lighted’ and cannot be used in primary care. A new option, therefore, is to be welcomed – as is data from Professor Stockfleth in Berlin demonstrating its efficacy. He compared a combination of low-dose 5-fluorouracil and salicylic acid (5-FU/SA) against 3% diclofenac in hyaluronic acid and vehicle. Both clinical and histological clearance were looked at and it was found that 5-FU/SA was superior in terms of clearance, but at the cost of slightly more local side effects. The treatment is, of course, lesion directed and has no effect on field changes. It will be interesting to see comparison data between it and 5-FU cream, or imiquimod cream...

Those of you of a certain vintage will be gladdened by the report coming out of Korea regarding grey hair. Many of us will have noticed that grey hair is not only thicker than pigmented hair, but it also grows faster. By looking at the expression of genes within pigmented and grey hair, it was noted that grey hair was noticed to have several upregulated genes and proteins. So, folks, grey hair is actually associated with more active hair growth. That’s got to be good...hasn’t it?

Dermoscopy is now a recognised part of the dermatological armamentarium. It is particularly useful in improving the diagnostic accuracy of melanoma. However, most criteria were described in the context of superficial melanoma. Its value has been considered to be less when used in the context of nodular lesions. Until now. The accurate diagnosis of nodular melanomas can be greatly improved by looking for the presence of blue-black colouration when associated with one or more of the standard ABCD features. Indeed, only 9.4% of positive pigmented lesions were found to be benign and only 6.8% of negative lesions were found to be histopathologically melanoma.

Finally, a timely reminder that patients are often entirely dependent upon us for the information about both their disease and their treatment. It is the latter part that seems to be often neglected. A team in France looked at prescriptions issued for topical preparations for patients with psoriasis. Almost two thirds of the prescriptions did not include sufficient information for the patient to adequately manage their treatment. Either electronic pro-formas or an individual treatment/management plan significantly improves both compliance and response to treatment. As we so often say in the PCDS, education is the key to so many things – in this case for both doctors and their patients.
A 29 year old woman, whose mother is of Chinese origin, presented with a two year history of areas of abnormal pigmentation across her shoulders, arms and chest. Associated with this she also complained that in the cold her fingers went white, then blue and finally red. Over the past year, she had experienced some difficulty swallowing associated with some nausea and vomiting and had lost a stone and a half. Upon examination she had marked reticulate hyper- and hypo-pigmentation over her neck, upper backs and upper arms (see photos). Objectively, the skin over her fingers felt tight and thickened, though she had not been aware of any change. Dermoscopy of her nail folds demonstrated capillary loops and dropout bilaterally. She had a positive prayer sign in the hands. A few telangiectasiae were present over her face and chest.

A clinical diagnosis of probable systemic sclerosis was made.

Her ANA was positive with a nuclear pattern (titre 640). DNA binding autoantibodies 6 iu/ml. Her SCL 70 (anti-DNA topoisomerase 1) was positive and subsequent immunology confirmed U3RNP positivity.

A biopsy from an abnormal area of skin on her back showed: ‘Mild laminated hyperkeratosis. Pigmentary incontinence surrounds papillary dermal vessels. Some of the eccrine glands are trapped in fibrous tissue and miniaturized. The papillary and reticular dermal collagen is sclerotic and hyalinised. These changes are consistent with scleroderma’.

An upper GI endoscopy showed poor peristalsis in the whole of the upper GI tract and almost absent peristalsis in the oesophagus. A chest CT scan showed normal lungs. An echocardiogram and lung function tests were normal.

Her Raynaud’s was improved with GTN patches, but she could not tolerate the postural hypotension that this caused. Subsequently she has tolerated Losartan 25mg with some minimal relief of her Raynaud’s. In the recent very cold weather, I have started her on low dose Nifedipine 5mg daily, with a view to increasing that if she can maintain her blood pressure (currently 108/70 sitting, 104/64 standing). She understands the importance of looking after the skin on her hands and feet by using emollients and keeping these areas warm and dry.

Her BMI is just under 20kg/m2 and she has seen a dietician who has recommended high energy food supplements.

Her tertiary care specialist started her on Mycophenolate Mofetil and Prednisolone 5mg in the New Year. Her biochemistry and haematology monitoring remains stable and she has already reported some subjective improvement in her general well being.

Systemic sclerosis

Also known as Scleroderma, or by the acronym CReST (Calcinosis cutis, Raynaud’s, oEsophageal involvement, Sclerodactyly, Telangiectasia) is a connective tissue disorder where collagen
is deposited in a number of areas of the body in association with vascular damage.

**There are two main types:**

Limited cutaneous scleroderma is essentially the CReST spectrum. Roughly 30% of patients develop primary pulmonary hypertension, which is the most worrying and potentially life-threatening complication. Without this complication (as in this case) the prognosis is good, otherwise the 5-year survival is only about 70%. Annual lung function tests are recommended.

Diffuse scleroderma is more rapidly progressive with greater multi-organ involvement and a worse prognosis. ANA is positive in a speckled pattern in 90% cases. SCl-70 is present in 30-40% patients with the diffuse form. Anti-centromere antibody is more common in the limited form (up to 90%), but only in 10% with diffuse scleroderma.

The differential diagnosis needs to include morphoea (no Raynaud’s and normal nail folds). Certain drugs (such as Penicillamine) can produce a scleroderma like picture. Scleromyxoedema is typically associated with haematological malignancies presenting with waxy, skin coloured papules typically on the face and extremities. In this condition, the skin feels thickened in the same way as with scleroderma and the patient ultimately may develop a similar pinched facies, but telangiectasiae and calcinosis are absent.

George Moncrieff

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**Dermoscopy Case: An Ugly Duckling?**

This 62 year old male, had a pigmented lesion on his back, noticed by his wife.

The plain view shows a pigmented lesion on the right, which sticks out, a little but can only with difficulty be called a real ‘ugly duckling’. The close up is not very odd looking, with possible differentials being a seborrhoeic wart or benign naevus from the visual.

Dermoscopy confirms it is melanocytic due to the reticular pigment network. There is a hazy, purplish out of focus area, by contrast with the well-focussed network. This is a blue-white veil which when present in a definite melanocytic lesion (which this is due to the network) is almost pathognomonic of melanoma. Also the network is thickened and irregular in places, developing onto a black blotch bottom centre.

The histology revealed an 8mm Breslow thickness melanoma

Stephen Hayes
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- 26th April BRISTOL
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- 6th September STIRLING
- 13th September CARDIFF
- 27th September PRESTON
- 11th October LEEDS
- 1st November MAIDSTONE

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- 27th April CARDIFF
- 28th June LEICESTER
- 5th September GLASGOW

**PCDS 2012:**
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  9th March
  Cavendish Conference Centre
  London
- **Summer Meeting**
  16th & 17th June
  Chesford Grange, Kenilworth
  Warwickshire
- **Autumn Meeting**
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