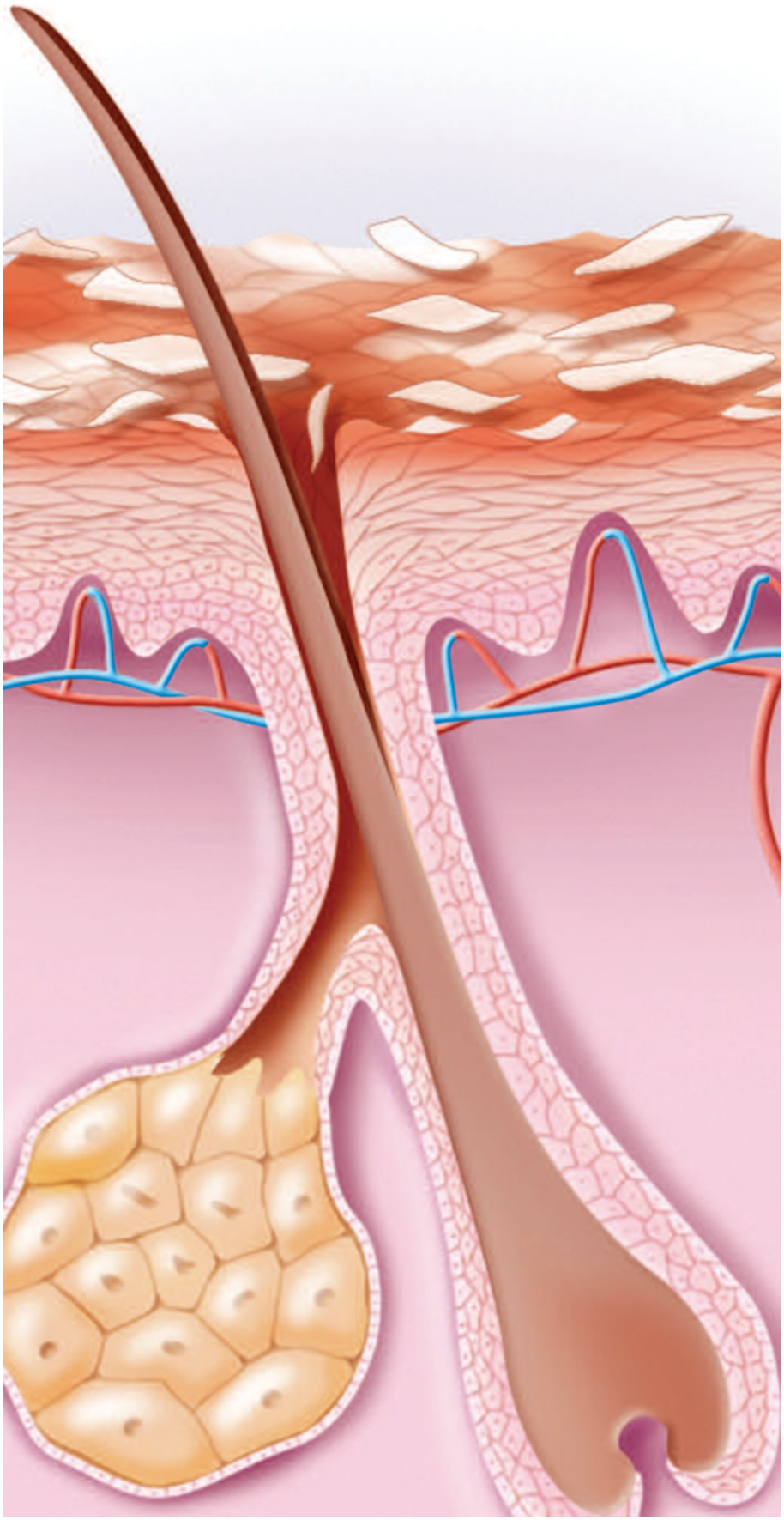
Spring 2015 Volume 21 Number 1 www.dermatologyinpractice.co.uk

Dermatology

in practice



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References:

1. Gallagher J. *et al.* Poster presented at EADV Congress 2009.
2. Dermol Range – Total Unit Sales since launch. Dermal Laboratories Ltd. Data on file.

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Guidelines – they get everywhere!

There was a time when doctors were able to consider a problem, and then, drawing on their education, training and experience, recommend a treatment without fear of challenge or contradiction. Those days are long gone. We are now subjects of scrutiny, and while this has benefits when it comes to reining in the maverick, it does make life more pedestrian. However, at least we do not need to think too hard, as once the diagnosis is established, the guidelines provide a recipe to follow.

Of course, making the diagnosis in the first place is often the tricky part. Last week, in a peripheral clinic in Louth, I saw a female patient who I proudly diagnosed with telangiectasia macularis eruptiva perstans. I felt very pleased with myself, especially when I looked through the notes to see just how many of my colleagues had missed the (quite obvious) diagnosis over the years. My guilty pleasure came to an abrupt end when I found she had consulted a Dr Neill Hepburn with exactly the same problem in 1997, and he too had failed to make the diagnosis.

In this issue, Ashish Sharma and Frances Humphreys give us an update on the British Association of Dermatologists' (BAD) guidelines for the management of bullous pemphigoid. I always enjoy the discussions at our clinical governance meetings when these guidelines appear, and we have the opportunity to challenge each other about our individual practice.

Of course, guidelines work for most patients, but not all. In dermatology, where we can see the rash or lesion, it's difficult to argue that a treatment has worked when it is obvious to all that it is still there. Perhaps this, combined with the ease of applying a treatment to the affected organ, led to the development of many dermatology 'Specials'. As Tim Root *et al* explain, these are immensely useful but hard-to-source treatments, and the subject of valuable work by a small subgroup of the BAD. I wish them every success, as it will make life easier for me, and much better for my patients, when they achieve ready access to these medications at a reasonable cost.

Guidelines work for most patients, but not all

Our appearance affects how we react, and also how others react to us. Aileen Alexander describes how hyperhidrosis dominated her life as a young doctor and the trials of her journey through the healthcare system. Andrew Affleck *et al* explain some approaches to managing patients with body dysmorphic disorder. These are issues we all need to understand so that we can treat our patients appropriately.

I am writing this editorial with a wry smile. We just had a Care Quality Commission inspection and concerns were raised about ventilation and air exchange rates in our procedure rooms. We are now frantically trying to understand, and agree upon, what actions should be taken (if any) to ensure that we are providing care in a safe environment. It's not something I had thought much about before, but I am rapidly acquiring a working knowledge, not only of airflow rates but also of NHS technical memoranda. Those guidelines – they get everywhere!

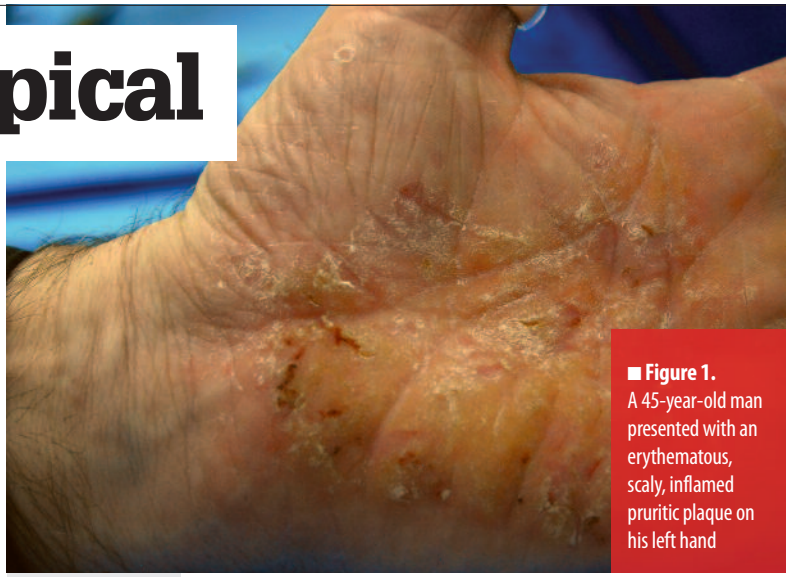
Neill Hepburn, Editor

Doctors are expected to practice according to strict guidelines and regulations

MARTIN RUEGNER/GETTY IMAGES

DERMATOLOGY IN PRACTICE 2015; Vol 21 No 1

The cost of topical medicines



■ **Figure 1.** A 45-year-old man presented with an erythematous, scaly, inflamed pruritic plaque on his left hand

Emilia Duarte Williamson MD FRCP Consultant Dermatologist, East Kent Hospitals

Deirdre A Buckley MD FRCP Consultant Dermatologist, Royal United Hospital, Bath; Chairperson of the Specials Working Group of the British Association of Dermatologists

Tim Root BSc (Pharm) FRPharmS Acting Director, East and South England Specialist Pharmacy Services

A 45-year-old man presented with an erythematous, scaly, inflamed, pruritic plaque on his left hand (see Figure 1). There were no lesions elsewhere. He was not atopic. Scrapings for mycology were negative and he was diagnosed with psoriasiform eczema. He was very troubled with the itchy and sore rash, which impaired his daily activities and work.

The initial prescription was Fucibet® (Leo Pharma) (fusidic acid 2% and betamethasone valerate 0.1% cream), paraffin-based emollients, soap substitutes and cotton gloves. Due to a lack of improvement, the topical steroid was changed to Dermovate® (GSK) (clobetasol propionate 0.05%) ointment, which resulted in only slight improvement during the next three weeks. Following a referral to the dermatology clinic and subsequent patch testing, which was negative, the patient was prescribed one of the Specials from the updated British Association of Dermatologists (BAD) Specials list 2014;[1] that is, propylene glycol 40% w/w in Dermovate cream. At the follow-up appointment four weeks later, the plaque had cleared and the patient was using the cream only twice weekly.

The BAD Specials list

In clinical practice, when skin conditions are severe and do not respond to available licensed topical preparations, dermatologists have the option of prescribing unlicensed Specials – topical formulations that can be more effective than available licensed treatments. These medicines usually have a mixture of components – like propylene glycol, steroids, tars, dithranol, salicylic acid and others, in different concentrations – and vehicles to help them penetrate thick and inflamed skin. In many cases, the use of these formulations can avoid the need for oral treatments, such as oral steroids or immunosuppressants, which have many potential and undesirable side effects.

Specials licensing potential

The majority of medicines on the BAD list have been prescribed for over 50 years and their appropriate use is taught in dermatology clinics. The evidence base for their use is almost entirely empirical, and the clinical trials needed to show that they meet regulatory criteria for safety and efficacy are unlikely to ever be carried out.

The potential for developing them into licensed products is further reduced by the limited scale of their use, the difficulty of designing stable formulations with shelf lives of at least three years (the minimum usually necessary for commercial viability) and the lack of consensus about optimum strengths, bases and formulations. Most of these topical treatments are initiated exclusively by dermatologists or GPs with a special interest in dermatology (GPwSIs), and may be prescribed on an ongoing basis by GPs, to continue the treatment of patients who have responded well.

Issues with prescribing Specials

In 2008, the BAD compiled a list of the most commonly prescribed Specials' formulations. However, in recent years, many practising dermatologists around the UK have reported delays in acquisition, short shelf life and high prices, which can vary by a factor of ten or more in primary care, depending on how and from where the pharmacy has obtained the product. There was also concern among specialist NHS manufacturing units about the quality and safety of some of the products obtained from non-NHS manufacturing units. These issues were brought to the attention of the BAD Therapy and Guidelines subcommittee, and the BAD Specials Working Group was formed in late 2013. This group involves dermatologists, pharmacists and representatives of the British National Formulary (BNF), Primary Care Dermatology Society, Royal College of General Practitioners and Royal Pharmaceutical Society.

A survey questionnaire was sent to BAD members across the country, asking them to share their views about the 2008 Specials list. A new, shorter list was drafted, and subsequently reviewed and completed by a group of dermatologists with the help of senior pharmacists. The mode of use, indications and contraindications were added to the list to facilitate the prescription of Specials. This

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Doublebase Gel: 100g tube £2.65, 500g pump dispenser £5.83, PL00173/0183.
Doublebase Dayleve Gel: 100g tube £2.65, 500g pump dispenser £6.29, PL00173/0199.

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new list was launched during the BAD annual meeting in 2014.

Discussion is currently under way with representatives from the Department of Health in England about including all products on the BAD Specials list in the Drug Tariff as a means of establishing agreed NHS prices.

The aim of the list is also to allow all BAD-preferred products to be identified as such on GP electronic prescribing systems. The list is also referenced at relevant points in the BNF.

It is hoped that greater awareness and regular revision of the BAD 2014 list of preferred Specials will make prescribing and dispensing these medications safer and easier for those concerned.

In the long-term, it is hoped that alterations in prescribing practice will result in higher demand for a smaller range of unlicensed topical medicines. This, in turn, will mean that more of these unlicensed products will be readily available to pharmacists as batch-manufactured products and, therefore, quality will be assured at prices that represent a fair return on investment for manufacturers, as well as best possible value for the NHS as a whole. Ultimately, it is possible that a few of the most commonly and consistently prescribed preparations might become available as licensed medicines, which represent the gold standard for drug quality, safety and efficacy ■

Declaration of interest
Tim Root and Deirdre A Buckley have declared that they have no conflicts of interest. Emilia Duarte Williamson has been invited to attend congresses by pharmaceutical companies and has been a medical advisor for Novartis, but she has no conflict of interest related to this article.

Reference

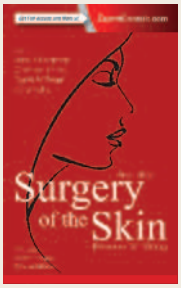
1. www.bad.co.uk/specials (last accessed 04/02/15)

Key points

- The British Association of Dermatologists (BAD) Specials list consists of unlicensed topical preparations that can be prescribed for skin conditions that do not respond to licensed preparations.
- The original BAD list of Specials was compiled in 2008, but problems such as delays in acquisition, short shelf life and high prices led to a revision of the list.
- An amended, shorter list of Specials was published by the BAD Specials Working Group in 2014; it includes their mode of use, indications and contraindications.
- The BAD Specials Working Group is in discussion with the Department of Health in England about including the amended list of products in the Drug Tariff, and thus establishing agreed NHS prices.

Surgery of the Skin, 3rd edn

Robinson JK, Hanke CW, Siegel DM, Fratila A.
Elsevier Saunders, 2015: £189
ISBN: 9780323260275



Content: ★★★
Teaching: ★★☆
Reference: ★★☆
Illustrations: ★★☆
Readability: ★★☆

***Surgery of the Skin,* 3rd edn is a definitive textbook of procedural dermatology. Boasting 850 pages supplemented by online content, which includes video demonstrations, it addresses every aspect of skin surgery that you are likely to need to know about (and in my case many more).**

It starts by covering basic surgical concepts such as anatomy, anaesthesia, instruments, sutures and wound healing. It then goes on to cover essential surgical skills, including cryosurgery, electrosurgery, excisions and random flap repairs. It covers these areas quickly but thoroughly. While it would certainly be overwhelming as a first book, it does cover these topics well and the practical focus, which provides many useful tips, is excellent. The videos really help.

I found the section covering aesthetic surgical procedures interesting, although my personal practice in this area is very limited. It is just an area of procedural dermatology I am not temperamentally suited to! However, it appears to be well-written, and the advice given is sensible.

This is followed by a section on special procedures – a miscellany of topics ranging from keloid management, through Mohs' surgery for hidradenitis, on to vitiligo surgery. It certainly challenged me to think a little more about how I manage keloids – perhaps I should be more aggressive and consider surgery with post-surgical prophylactic perilesional steroids.

Overall, this third edition of *Surgery of the Skin* is a great addition to the library of any dermatology trainee or practicing procedural dermatologist. I found it easy to read, interesting and helpful, as well as being well-presented and nice to handle ■

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Potassium iodide: a Dickensian drug for dermatological diseases

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Potassium iodide, a drug of long historical heritage, remains a useful and important part of a dermatologist's armamentarium in the treatment of neutrophilic dermatoses and panniculitis, as well as infections such as sporotrichosis. Here we report an illustrative case of granulomatous panniculitis treated with potassium iodide to excellent clinical effect. We also provide a review of the important aspects surrounding the prescription of potassium iodide, including indications, dosage regimens and side effect profile.

The mechanism of action of potassium iodide remains largely unknown

Illustrative case

A 72-year-old man presented with bilateral tenderness of the lower legs following a protracted period of immobility. Previous medical history included type 1 diabetes mellitus and benign prostatic hypertrophy. Examination revealed multiple tender nodules, superimposed on thickened, woody skin with overlying red–brown discolouration upon the lower limbs. Nodule histology revealed granu-lomatous panniculitis. Initial graded compression, topical corticosteroids and massage failed to control symptoms. The patient was subsequently given colchicine (500 mg twice daily) but, even when the dose was reduced to 500 mg once daily, he was unable to tolerate the drug because of gastrointestinal side-effects. He also developed widespread exanthem in response to hydroxychloroquine.

Potassium iodide was initiated at 300 mg three times daily, and this treatment was followed by a rapid resolution of the skin lesions. Over the course of two months, the dose was gradually tapered. Within two weeks of cessation, the nodules recurred, therefore potassium iodide was recommenced with good clinical effect.

Uses of potassium iodide

Iodine was identified and subsequently used for the treatment of hyperthyroidism in the early 19th century. Since then, it has been trialled in an array of dermatological diseases with varying degrees of success.[1,2]

Currently, potassium iodide is reported to be beneficial for the treatment of infections (including cryptococcosis, sporotrichosis and pythiosis), neutrophilic dermatoses (Sweet's syndrome, pyoderma gangrenosum), panniculitis (erythema nodosum [see Figure 1], nodular vasculitis, subacute migratory nodular panniculitis), Behçet's syndrome and erythema multiforme.

The mechanism of action of potassium iodide remains largely unknown. A proposed mechanism of action involves the inhibition of neutrophilic production of toxic oxygen intermediates[3] and neutrophilic chemotaxis,[4] which would account for its efficacy in neutrophilic dermatoses.

Dosage

Reported starting dose is 300 mg three times daily for inflammatory dermatoses and 600 mg three times daily for mycoses, increased to a maximum of 6 g daily if tolerated. Potassium iodide appears to be efficacious and fast-acting, with improvements reported in as few as two days.

Adverse effects

Gastrointestinal side effects (nausea, vomiting, diarrhoea and abdominal cramps) are common and can be offset by a gradual dose increase.

Potassium iodide use can inadvertently precipitate an acneiform eruption, dermatitis herpetiformis or bullous pemphigoid. Iododerma, a polymorphous eruption occurring on the head, neck, trunk or limbs with a neutrophilic dermal infiltrate on histology, is more commonly observed in patients with underlying malignant or chronic inflammatory diseases.[2,5]

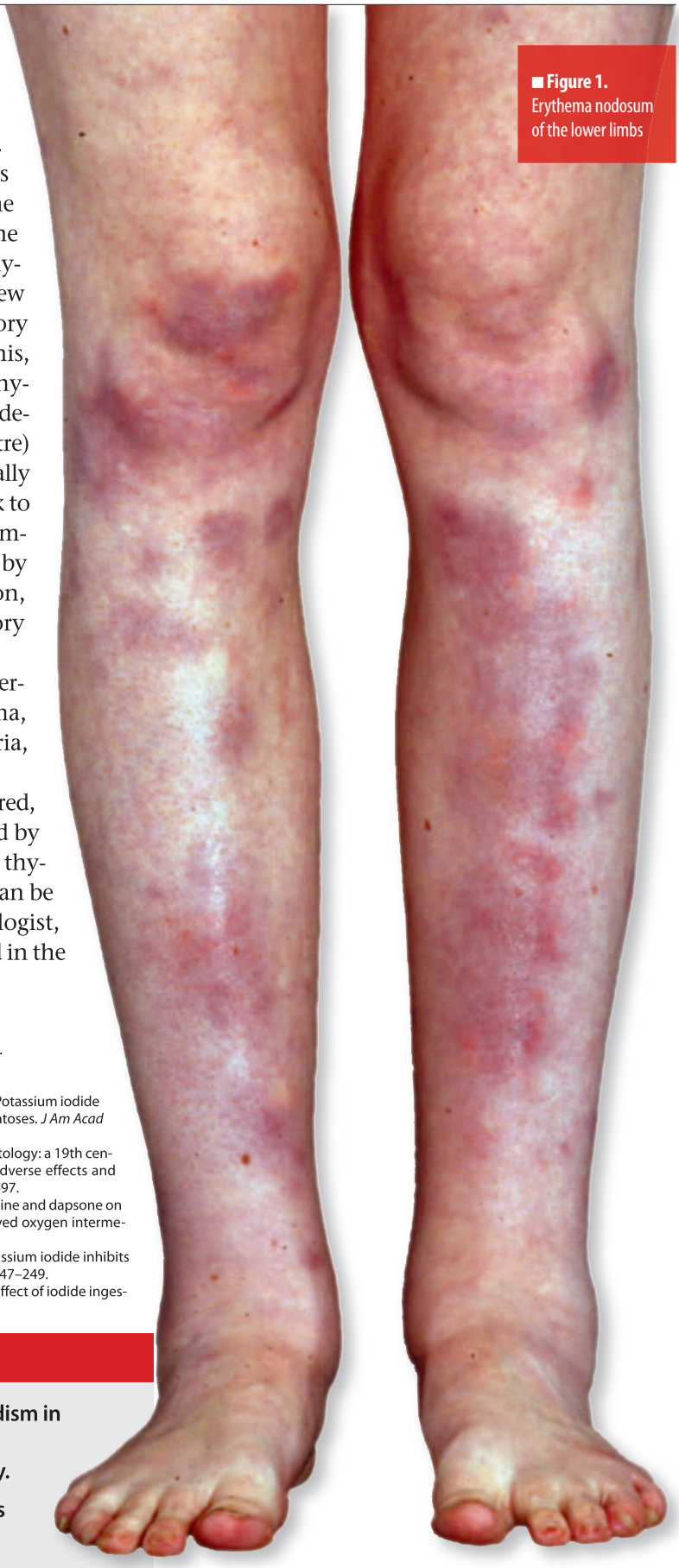
The protracted use of potassium iodide exposes patients to risks of potassium and iodide toxicity. The risk of hyperkalaemia is increased in patients with pre-existing renal failure or those concurrently using angiotensin-converting-enzyme inhibitors or potassium sparing diuretics. Symptoms of iodide toxicity include: burning mouth, hypersalivation, metallic taste, soreness of the teeth and gums, and severe headache.

Thyroid dysfunction

Both hypothyroidism and hyperthyroidism can result from potassium iodide administration. Prolonged excessive exogenous iodide exposure predisposes to the Wolff–Chiakoff effect, in which the thyroid gland stops producing thyroid hormone.[6,7] During the first few weeks of therapy, autoregulatory mechanisms normally negate this, allowing the user to remain euthyroid. Afterwards, if potassium iodide-induced hypothyroidism (and goitre) occurs, cessation of treatment usually means thyroid function goes back to normal. The Jod–Basedow phenomenon is hyperthyroidism induced by exogenous iodide administration, and is seen where autoregulatory mechanisms have failed.[8]

Other reported side effects of therapy include pulmonary oedema, angio-oedema, myalgia, urticaria, eosinophilia, lymphadenopathy.

Provided side effects are monitored, both by looking at symptoms and by measuring electrolytes, renal and thyroid function, potassium iodide can be a useful adjunct for the dermatologist, and it continues to be widely used in the developing world ■



■ **Figure 1.** Erythema nodosum of the lower limbs

Declaration of interest
The authors declare that there is no conflict of interest.

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Key points

- Iodine started to be used for treating hyperthyroidism in the 19th century. Potassium iodide has since been found to have a wide range of uses in dermatology.
- Indications for potassium iodide include infections such as sporotrichosis and cryptococcosis, and neutrophilic dermatoses such as pyoderma gangrenosum and Sweet's syndrome.
- Potassium iodide is associated with a range of side-effects, including gastrointestinal symptoms, hyperkalaemia and thyroid dysfunction, so monitoring patients is essential.

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References: 1. Del Rosso J, *et al. Cutis* 2008; 81:405-408. **2.** Schlessinger J, *et al. J Drug Dermatol* 2007; 6:607-15. **3.** US Patent No 5,721,275, 1998. **4.** Dréno B, Layton A. Onset of action and efficacy of novel clindamycin 1% tretinoin 0.025% formulation for acne vulgaris. Presented at AAD 2013 Poster 6406. **5.** Treclin® SPC.

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UK/TRE/14/0036(1) Date of preparation: September 2014.

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DERMATOLOGY IN PRACTICE 2015; Vol 21 No 1

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The BAD guidelines for bullous pemphigoid – a summary

The British Association of Dermatologists (BAD) updated its guidelines on bullous pemphigoid in 2012.[1] This article provides a quick summary for busy readers.

Bullous pemphigoid (BP) is a blistering autoimmune disease that commonly affects the elderly, with a mean age of onset of 80 years. Autoantibodies attack the adhesion complex of the basement membrane zone (BMZ), which connects the epidermis and dermis. The two main autoantigens in the BMZ are BP230 and BP180.

Clinical features

Patients may present with tense blisters on normal or erythematous skin. The subepidermal location leads to thick-walled and usually intact blisters (see Figure 1), compared with the intraepidermal blisters of pemphigus vulgaris, which are thin-walled and easily ruptured. Erosions or frank bullae may be present in the oral and genital mucosa. The distribution may be generalised or localised, which dictates appropriate management. A pre-bullous stage, with pruritus associated with erythema or urticated plaques (see Figure 2), may precede bullae formation by many months, or it may be the only clinical manifestation of the disease.

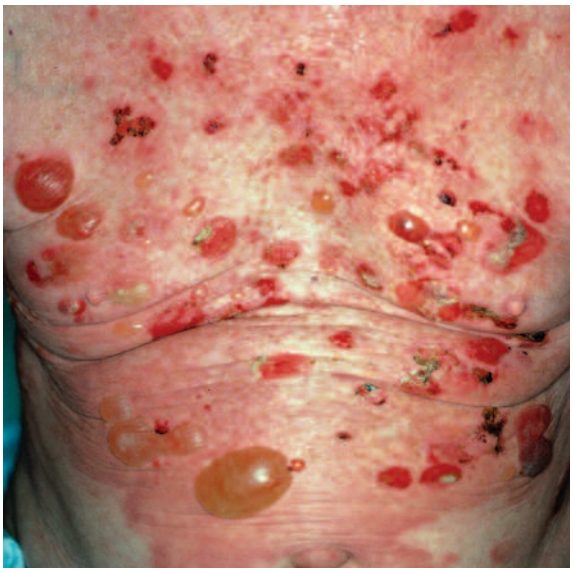
Investigation

Diagnosis is confirmed by carrying out a skin biopsy of a fresh blister, showing subepidermal clefting with an eosinophilic inflammatory infiltrate. Direct immunofluorescence performed on a sample of peri-lesional skin will show linear deposition of immunoglobulin (Ig) G and C3 along the BMZ. Indirect immunofluorescence may show circulating antibodies in the patient's serum.

Management

BP is usually a self-limiting disease lasting from months to years. Elderly patients with active blistering can have an associated mortality that is double that of the general elderly population.

Treatment options differ according to whether the disease is localised or generalised, but in both cases treatment aims to control symptoms while minimising toxic side effects.



YALE DERMATOLOGY PRESENTATIONS SLIDE COLLECTION

Figure 1. Multiple tense bullae arising on normal and erythematous skin. Several of the bullae have ruptured, leaving circular erosions

Systemic steroids

Treatment with oral prednisolone leads to rapid suppression of inflammation and blistering. Starting doses can be titrated for patients with mild (0.3 mg/kg), moderate (0.5 mg/kg) or severe disease (0.75–1 mg/kg). Improvement is usually seen within one to four weeks, with fewer or no new blisters, after which the dose is gradually reduced at fortnightly intervals. A suggested protocol is a rapid reduction to 15 mg daily, then reductions by 2.5 mg to 10 mg, and then a gradual reduction by 1 mg each month.

Around 50% of patients will relapse at some point, indicating the need for a higher dose of prednisolone for longer periods. Patients may require treatment for many months, or even indefinitely. Monitoring of blood pressure and blood glucose and analysis of urine are required for the duration of treatment, along with the prescription

of bone protection (for example, a bisphosphonate) and stomach protection (for example, a proton-pump inhibitor).

Intravenous methylprednisolone can be used for severe and refractory cases, but carries a high mortality risk from infection and cardiac failure.

Topical corticosteroids

Topical steroids are the first-line treatment for localised or moderate disease. Trials have shown the benefit of topical clobetasol propionate 0.05% ointment/cream, applied either once (20 g) or twice (40 g) daily to all the body, including unaffected skin. Significant benefit was seen with this treatment compared with oral prednisolone (1 mg/kg) in disease control, adverse events and mortality, for the management of extensive disease (>10 blisters/day), with equal effects in moderate disease (<10 blisters/day).

A survey of 326 UK dermatologists showed that 98% of respondents used topical steroids as sole treatment in localised BP and 34% in generalised BP; they also routinely used topical steroids as an adjunct (92%), mostly applied to the lesions only (86%); 66% used topical steroids continuously until relapse, while the remaining 34% discontinued treatment once remission had been achieved.

Antibiotics and nicotinamide

Antibiotics with an anti-inflammatory effect are used as first-line treatment by 10% of German dermatologists, and as part of management by 80% of UK dermatologists. Doxycycline (200–300 mg daily) is the most commonly used, followed by minocycline (100–200 mg daily), lymecycline (408 mg daily) and tetracycline (500–2,000 mg daily). The current BLISTER trial is comparing doxycycline with prednisolone.[2] Nicotinamide can be used in combination with these antibiotics, at doses starting at 500 mg daily, gradually increased to 1,500–2,500 mg daily to minimise gastric side effects.

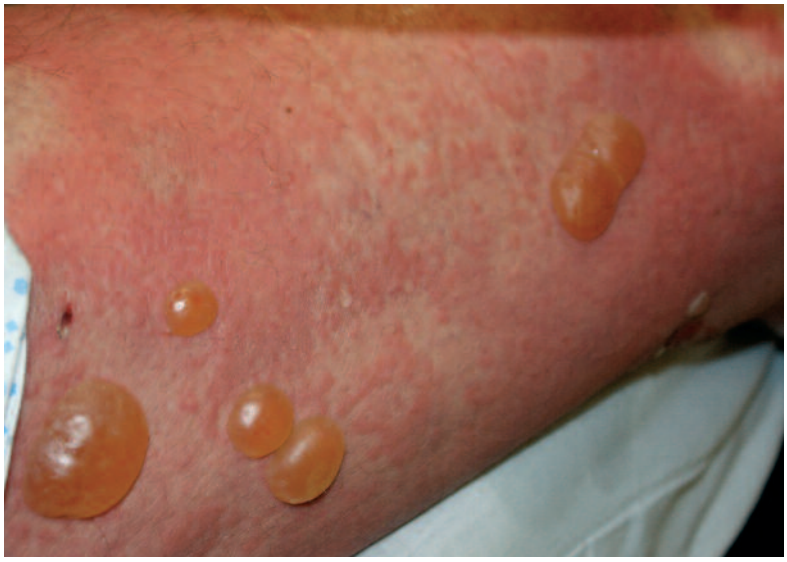
Other therapies

Methotrexate can be an effective treatment, either as monotherapy or in combination with topical or oral steroids, but there have been no controlled trials to date.

Azathioprine is commonly prescribed as a steroid-sparing agent, at doses of up to 2.5 mg/kg daily. Myelosuppression is a potential side effect, which can be minimised by measuring thiopurine methyltransferase activity. There is no conclusive evidence for its use.

Intravenous immunoglobulin can be used for severe, steroid-unresponsive disease, where rapid improvement is needed. Each cycle of treatment costs around £5,000, with one study showing that an average of 15 cycles is required.

Mycophenolate mofetil, dapsone, cyclophosphamide, chlorambucil and ciclospirin can be considered in refractory cases, but these are not for routine use.



YALE DERMATOLOGY RESIDENTS' SLIDE COLLECTION

■ **Figure 2.** Pink urticarial papules and plaques, with tense bullae containing serous fluid

Skin care

Patient comfort can be improved with the following practical steps. Blisters should be left intact if possible, to prevent secondary bacterial infection. If large and painful, the blister can be pierced with a sterile needle, leaving the roof intact to act as a biological dressing. For open and raw areas, potassium permanganate soaks are useful as an astringent, and soap substitutes containing antiseptic can be used. Such areas should have topical steroids applied to aid healing. Non-adherent dressings can be applied and held in place with an elasticated stockinette ■

Declaration
The authors declare that there is no conflict of interest.

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1. Venning VA, Taghipour K, Mustapha MMF, Highet AS and Kirtscig G. British Association of Dermatologists' guidelines for the management of bullous pemphigoid 2012. *Br J Dermatology* 2012; **167:** 1200–1214.
2. UK Clinical Research Network. BLISTER Study / The Bullous Pemphigoid Steroids and Tetracyclines Study. http://public.ukcrn.org.uk/Search/StudyDetail.aspx?StudyID=4611 (last accessed 28/01/15)

Key points

- Bullous pemphigoid is a blistering autoimmune disease that commonly affects the elderly, the mean age of onset being 80.
- For localised disease, topical steroids and good skin care may be sufficient. Antibiotics with an anti-inflammatory effect can be tried if progression occurs.
- For generalised disease, oral prednisolone is the most effective treatment. Patients may be on treatment for many months or years, or even indefinitely.

Prescribing Information: OTEZLA®▼ (apremilast) 10mg, 20mg and 30mg film coated-tablets.

Refer to the Summary of Product Characteristics (SPC) before prescribing.

Presentation: 10mg, 20mg and 30mg film coated-tablets. **Indications:** *Psoriatic arthritis*: OTEZLA®, alone or in combination with Disease Modifying Antirheumatic Drugs (DMARDs), is indicated for the treatment of active psoriatic arthritis (PsA) in adult patients who have had an inadequate response or who have been intolerant to a prior DMARD therapy. *Psoriasis*: OTEZLA® is indicated for the treatment of moderate to severe chronic plaque psoriasis in adult patients who failed to respond to or who have a contraindication to, or are intolerant to other systemic therapy including cyclosporine, methotrexate or psoralen and ultraviolet-A light (PUVA). **Dosage and administration:** Treatment with OTEZLA® should be initiated by specialists experienced in the diagnosis and treatment of psoriasis or psoriatic arthritis. The recommended dose of OTEZLA® is 30mg twice daily taken orally, morning and evening, approximately 12 hours apart, with no food restrictions. The film-coated tablets should be swallowed whole. To reduce risk of gastrointestinal symptoms, an initial dose titration is required according to the following schedule: Day 1: 10mg in morning; Day 2: 10mg in morning and 10 mg in evening; Day 3: 10mg in morning and 20mg in evening; Day 4: 20mg in morning and 20mg in evening; Day 5: 20mg in morning and 30mg in evening; Day 6 and thereafter: 30mg twice daily. No re-titration is required after initial titration. If patients miss a dose, the next dose should be taken as soon as possible. If it is close to the time for their next dose, the missed dose should not be taken and the next dose should be taken at the regular time. During pivotal trials the greatest improvement was observed within the first 24 weeks of treatment. If a patient shows no evidence of therapeutic benefit after 24 weeks, treatment should be reconsidered. The patient's response to treatment should be evaluated on a regular basis. Clinical experience beyond 52 weeks is not available in psoriasis. **Special populations:** *Paediatric population*. The safety and efficacy of apremilast in children aged 0 to 17 years have not been established. No data are available. *Elderly patients*: No dose adjustment is required for this patient population. *Patients with renal impairment*: No dose adjustment is needed in patients with mild and moderate renal impairment. The dose of apremilast should be reduced to 30mg once daily in patients with severe renal impairment (creatinine clearance of less than 30mL per minute estimated by the Cockcroft-Gault equation). For initial dose titration in this group, it is recommended that OTEZLA® be titrated using only the morning doses and the evening doses be skipped. *Patients with hepatic impairment*: No dose adjustment is necessary for patients with hepatic impairment. **Contraindications:** Hypersensitivity to the active substance(s) or to any of the following excipients: Microcrystalline cellulose, Lactose monohydrate, Croscarmellose sodium, Magnesium stearate, Polyvinyl alcohol, Titanium dioxide (E171), Macrogol 3350, Talc, Iron oxide red (E172). The 20mg tablets also contain iron oxide yellow (E172). The 30mg tablets also contain iron oxide yellow (E172) and iron oxide black (E172). OTEZLA® is contraindicated in pregnancy and should be excluded before treatment can be initiated. **Special warnings and precautions:** Patients with rare hereditary problems of galactose intolerance, lapp lactase deficiency or glucose-galactose malabsorption should not take this medicinal product. OTEZLA® should be dose reduced to 30mg once daily in patients with severe renal impairment. Apremilast may cause weight loss. Patients who are underweight at the start of treatment should have

INDICATION

OTEZLA is indicated for the treatment of moderate to severe chronic plaque psoriasis in adult patients who failed to respond to or who have a contraindication to, or are intolerant to other systemic therapy including cyclosporine, methotrexate or psoralen and ultraviolet-A light (PUVA).[1]

Otezla® (apremilast) 30mg tablets

their body weight monitored regularly. In the event of unexplained and clinically significant weight loss, these patients should be evaluated by a medical practitioner and discontinuation of treatment should be considered. Women of childbearing potential should use an effective method of contraception to prevent pregnancy during treatment. Apremilast should not be used during breast-feeding. No fertility data is available in humans. **Interactions:** Co-administration of strong cytochrome P450 3A4 (CYP3A4) enzyme inducer, rifampicin, resulted in a reduction of systemic exposure of apremilast, which may result in a loss of efficacy of apremilast. Therefore, the use of strong CYP3A4 enzyme inducers (e.g. rifampicin, phenobarbital, carbamazepine, phenytoin and St. John's Wort) with apremilast is not recommended. In clinical studies, apremilast has been administered concomitantly with topical therapy (including corticosteroids, coal tar shampoo and salicylic acid scalp preparations) and UVB phototherapy. There was no clinically meaningful drug-drug interaction between ketoconazole and apremilast. Apremilast can be co-administered with a potent CYP3A4 inhibitor such as ketoconazole. There was no pharmacokinetic drug-drug interaction between apremilast and methotrexate in psoriatic arthritis patients. Apremilast can be co-administered with methotrexate. There was no pharmacokinetic drug-drug interaction between apremilast and oral contraceptives containing ethinyl estradiol and norgestimate. Apremilast can be co-administered with oral contraceptives. **Side effects:** The most commonly reported adverse reactions in Phase III clinical studies have been gastrointestinal disorders including diarrhoea and nausea. The other most commonly reported adverse reactions included upper respiratory tract infections, headache, and tension headache. The most common adverse reactions leading to discontinuation during the first 16 weeks of treatment were diarrhoea, and nausea. The overall incidence of serious adverse reactions was low and did not indicate any specific system organ involvement. Prescribers should consult the summary of product characteristics in relation to other side-effects. **NHS list price:** £265.18 per 14 day titration pack; £550 per pack of 56 tablets (30mg). **Legal category:** POM. **Marketing authorisation numbers:** EU/1/14/981/001, EU/1/14/981/002 and EU/1/14/981/003. **Marketing authorisation holder:** Celgene Ltd, 1 Longwalk Road, Stockley Park, Uxbridge, UB11 1DB, United Kingdom. **Date of preparation:** January 2015. **Approval code:** UK-I&I140098.

Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.mhra.gov.uk Adverse events should also be reported to Celgene Drug Safety Tel: 0808 238 9908; Fax: 0844 801 0468

References:

1. OTEZLA Summary of Product Characteristics available at www.medicines.org.uk **2.** Reich K, Papp K, Gordon KB, *et al.* Long-term Safety and Tolerability of Apremilast in Patients With Psoriasis: Pooled Safety Analysis of Two Phase 3, Randomized, Controlled Trials (ESTEEM 1 and 2) (abstract). *Abstract presented at: 23rd Annual Meeting of the European Academy of Dermatology and Venereology (EADV)* 2014; October 8–12; Amsterdam, The Netherlands.

Date of Preparation: February 2015 UK-I&I140057

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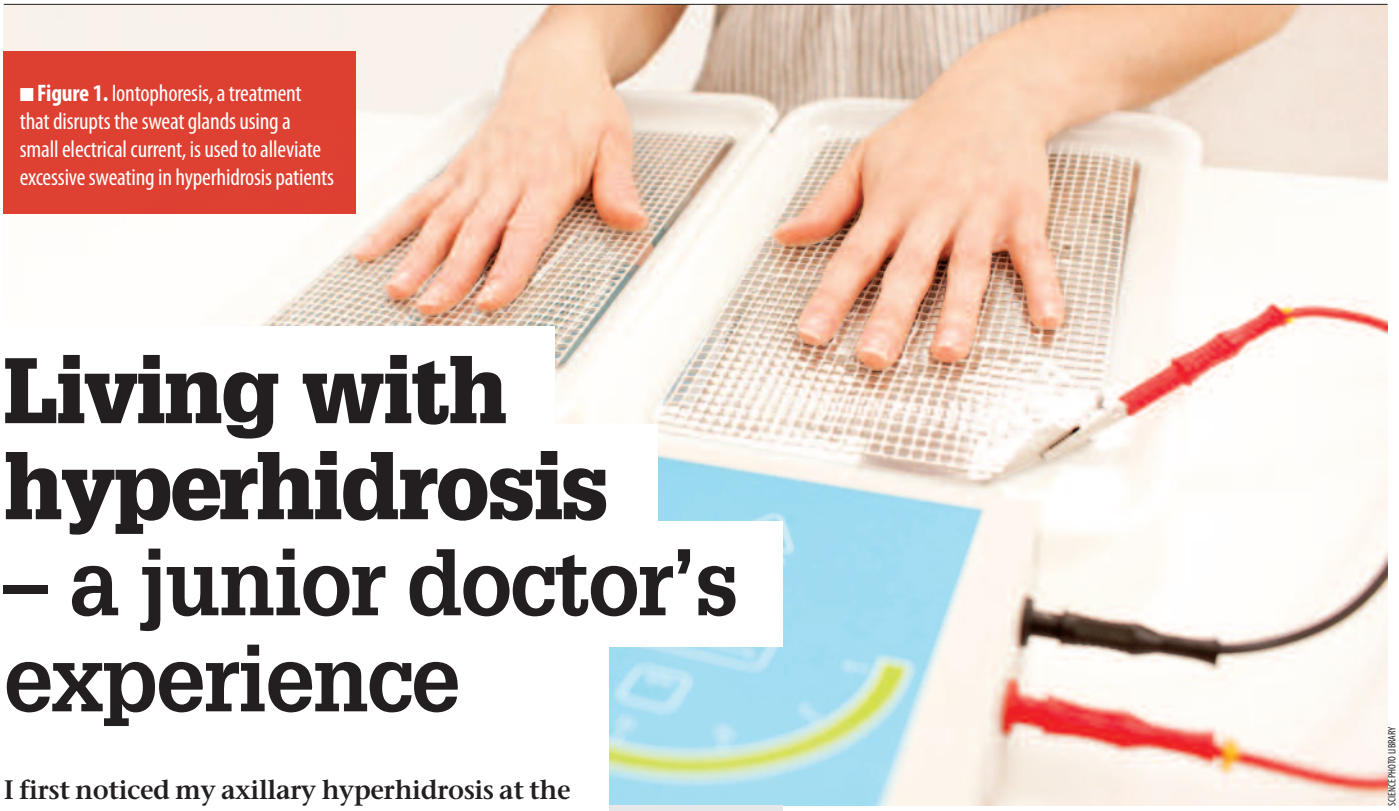

■ **Figure 1.** Iontophoresis, a treatment that disrupts the sweat glands using a small electrical current, is used to alleviate excessive sweating in hyperhidrosis patients

SCIENCE PHOTO LIBRARY

Living with hyperhidrosis – a junior doctor's experience

Aileen Alexander
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I first noticed my axillary hyperhidrosis at the age of 15. I felt dirty, wet and cold all the time and I had a constant paranoia that I smelt and would be judged by my peers. Even in the summer I felt I had to wear a black cardigan to hide my huge sweat patches. My mother had to scrub and bleach my white undergarments, which would stain yellow a few days after purchase. The matter only got worse; it was all I could think about in class. I concurrently suffered from severe acne, for which I was prescribed a course of isotretinoin. I was badly bullied at school for my acne; this plus the hyperhidrosis destroyed my self-esteem.

It was my mum who realised that something wasn't right. It wasn't normal to sweat so much, and it was impacting on my confidence and my schoolwork. She took me to see a GP, an extremely approachable, male locum doctor. Much to my relief, he immediately made the right diagnosis and prescribed Anhydrol Forte® (Dermal), a topical roll-on agent to be used on my axilla in the evening. This worked almost straightaway and very well – I was absolutely delighted. I soon learnt, however, that if I used it too much or too often it would burn and scar my underarms. Almost a decade on, my axillary hyperhidrosis is very well controlled with this agent, which I use as little as once fortnightly.

It wasn't normal to sweat so much, and it was impacting on my confidence

Once my axillary hyperhidrosis was under control, I realised that my feet were also becoming increasingly sweaty. I had multiple bilateral verrucae and, looking back, I realise that this was probably due to my feet being permanently damp. No amount of foot powder would prevent my feet from being wet. Wearing damp socks or shoes was extremely uncomfortable. Imagine putting on wet socks every morning and then wearing them all day – my shoes would even squeak when I walked.

Fortunately, I didn't have any infections, as I was extremely particular about cleaning my feet; I would shower in the morning, then wash my feet after school and then again before bed. Needless to say, I got through a lot of socks! Again, I felt dirty, uncomfortable and embarrassed. I had a course of liquid nitrogen treatment for my verrucae after school. The doctor's practice was less then a mile from school, but my mum would pick me up, drive three miles home for me to wash my feet and three miles back for me to have my treatment, so that I wouldn't fear the nurse might judge me. Summer was more bearable as I could wear sandals, but my feet were permanently cold because of the evaporating sweat. I saw the GP again, who told me that the only option was to use Anhydrol Forte on my feet. I tried this, but with no benefit.

Online information

When I began medical school, I became fed up with buying expensive comfortable shoes for the wards and throwing them away a few months later. It didn't matter what I wore; cotton socks and leather shoes made no difference. I was unable to jog or run, due to my excessive sweating causing blisters before I would reach one kilometre.

A few years on, I came across information about hyperhidrosis online. It mentioned iontophoresis, a treatment that disrupts the sweat glands using a small electrical current through tap water on the

affected areas (see Figure 1). I wanted this treatment badly – anything to make my condition more bearable. I would have paid any amount of money to buy or try out the machine there and then. I saw my GP who had no knowledge of iontophoresis and refused to refer me. I was a fourth-year medical student and had a little bit more self-confidence by then. I couldn't bear to continue like this anymore so, completely out of character, I demanded a referral.

Dermatology referral

Many months later, I was eventually seen by a dermatology specialist nurse. She could see how bad my feet were, with cuts between my great and second toes, and my soles looked like they had been in bath water for too long. I was immediately offered oral oxybutynin. I was given a note for my GP to have it prescribed and began taking it straightaway. I cannot explain how excited I was at the prospect of having dry feet! As suggested, I titrated the dose up to the maximum. Oxybutynin had some effect, but this was limited: while no longer completely soaked, my feet were still very wet. I also experienced side effects: dry mouth and dry eyes, the latter preventing me from wearing my contact lenses.

Following this failed treatment, I was extremely eager to try iontophoresis. Despite not being initially given a follow-up appointment, I was eventually seen and put on a waiting list of many months. The Channel 4 programme 'Embarrassing Bodies' had increased awareness of hyperhidrosis and more people were being referred than ever before, but the department only had one machine. When my turn finally came, I followed the treatment protocol over a few weeks. At that point I was working as a junior doctor in general surgery. The dermatology nurses were kind and non-judgemental, which put me at ease. I thoroughly enjoyed my appointments. They were my time out, a chance for a sit-down and a 'blether', as we would say up in Scotland. After this treatment course my feet were much drier.

Today I wouldn't say that my feet sweat the same as everyone else's, but they are much more manageable. I ruin less shoes and I can run. I still have to use talcum powder in my socks and shoes, but I am comfortable. I also need to use the iontophoresis machine regularly, but this is not an issue: I have purchased my own machine. With iontophoresis and Anhydrol Forte, the sweating on both my feet and hands is under control. This has literally changed my life.

An embarrassing subject

For many, hyperhidrosis is an extremely embarrassing subject to broach. During my last job in general practice, patients with hyperhidrosis came to me as their first port of call. It is often their 'hidden agenda'.

My hope is that more healthcare professionals will be educated about the impact that hyperhydrosis has on patients' quality of life and about the treatment options available, so that more people like me can be referred and receive the benefits of treatment ■

Declaration of interest
The author declares that there is no conflict of interest.

Resources

Hyperhidrosis SUPPORT GROUP

The UK Hyperhidrosis Support Group is an online group for healthcare professionals and patients. It is led by Julie Halford, a specialist nurse who volunteers her spare time to the group. As well as speaking at national meetings, Julie Halford aims to use the website to educate patients and clinicians about the condition.

- Individual advice is offered to all enquries sent through the website, particularly on the NHS and private treatments, and how to access them
- The website contains useful medical information, including protocols for treatment and clinical papers on hyperhidrosis. A regular newsletter is also published and distributed to people who have joined a mailing list
- Julie Halford has written several clinical papers on hyperhidrosis, and she regularly speaks to dermatologists and dermatology nurses in order to update them on the latest treatments
- Glossy patient information leaflets are available on request for display in outpatient departments and GP surgeries

For more information or advice, email:
info@hyperhidrosisuk.org

Other useful websites:

» Iontophoresis
www.iontophoresis.info

» Aluminium chloride antiperspirant with aloe vera
www.sweatstop.co.uk

» Silver and copper socks
www.silversock.co.uk
or www.cuxsongerrard.com

» Hydrosal gel
www.hydrosalgel.com

» T shirts
www.esteemclothingprotectors.co.uk
or www.sweat-help.com

» Absorbent soles
www.simplyfeet.co.uk

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Body image concern in dermatology – could we do better?

Part 2 – How to recognise, and assess the severity of, body dysmorphic disorder (BDD). How to engage with and treat patients with body image concern or BDD, in a dermatology setting

Key points from Part 1

- Body image concern is a distressing condition, which may impact on quality of life.
- Body dysmorphic disorder (BDD) should be considered in cases of severe body image concern.
- Patients with body image concern and BDD are over-represented in dermatology clinics, and it is important that dermatologists can recognise these individuals.
- If BDD is suspected, a detailed psychological assessment is needed including screening for depressive disorder and suicidal ideation.

Recognising body dismorphic disorder and assessing severity

Clinical experience has shown that the behaviour of the patient's friends and family can provide a clue to the patient's diagnosis of body dismorphic disorder (BDD); for example, they may attempt to reassure the patient by saying things like:

- 'Stop being silly'
- 'You look fine'
- 'You're so vain'
- 'You're so selfish'
- 'What are you worrying about?'

If body image concern or BDD is suspected, the patient should be asked to rate how noticeable they consider the area on their skin to be, out of 10, when 0/10 is 'nothing to see' and 10/10 is 'as noticeable as it could be'. A discordance of more than 5/10 between the patient's and the clinician's rating suggests body image concern, and the need for further assessment. The clinician should enquire about the patient's dissatisfaction with other body sites; for example, their nose, breasts and body shape and size. Disproportionate concern about several body sites simultaneously or over time is strongly suggestive of BDD and should prompt further assessment (see Box 1).

Box 1. Further assessments to be carried out on patients with possible body dysmorphic disorder (BDD)

- Screening for suicidal ideation and depression
- Screening for other possible associations; eg, indoor tanning habit, obsessive exercise or body-building
- Medical history
- Drug history (including alcohol and recreational drugs)
- Condensed psychiatric history: risk factors for BDD, depression/other associated psychiatric illness; eg, anorexia nervosa or bulimia
- Mental state examination and psychosis

Engaging with patients

Reassuring the patient that the perceived disfigurement is minor is not enough. This approach is ineffective and may even be harmful, triggering feelings of shame, guilt, helplessness, frustration and anger. Instead, it can be helpful to discuss the level of distress, and to focus on what treatment is available to alleviate that distress, rather than on the perceived disfigurement. Helpful phrases in these situations include:

- 'I can see that this is a huge problem for you'
- 'I'm sorry to hear that this is taking over your life'
- 'This is a serious problem and continuing in this way is not desirable'
- 'It sounds like every day is a real battle for you'
- 'Other people have gone through a similar experience to you; you are not alone'
- 'Body image concern is a recognised problem and there are different ways to help'
- 'There's no quick fix, but with time, effort and understanding, we'll be able to get you back on track'.

Treating patients

Unless the underlying diagnosis is made, patients can be frustrating to treat, often appearing as being

'difficult' and 'demanding' because they ask for inappropriate or excessive treatment for their minimal or even non-existent defect.[1,2]

Although this has not been adequately studied, clinical impressions suggest that outcomes following treatment and surgery in this group are often poor, as the concern may simply shift to another part of the body. Honesty and empathy should be employed when explaining to the patient that they appear to have a known and treatable body image problem, and when providing educational material about the condition.

Ideally, all suitable patients with BDD would be seen by a clinical psychologist, but in reality this does not occur due to a lack of resources. In cases of severe BDD, a low threshold for psychological or psychiatric referral should be used.

Currently, the only evidence-based treatment options, according to two randomised controlled trials for BDD, are selective serotonin re-uptake inhibitors (SSRIs) at high doses for at least 12–16 weeks (similar to the treatment of obsessive-compulsive disorder [OCD]), and cognitive behavioural therapy.[2,3] Antipsychotics should be used cautiously by those familiar with their use, and generally only if the above treatments have failed. They can be prescribed either as a monotherapy or in a lower dose to complement an SSRI. The National Institute of Health and Care Excellence has produced guidance on the management of OCD and BDD.[4]

Conclusion

A significant but disproportionate body image concern is a common presenting complaint in dermatology clinics, but does not always equate to BDD. The symptom complex – psychological, emotional and behavioural – should be clearly listed.

The complexity of the psychology of appearance concern should not be underestimated. Further detailed psychological and/or psychiatric assessment is desirable before settling on a diagnosis.

As dermatologists, we are trained to make a physical diagnosis, and most skin diseases have an organic basis. Sometimes we change our minds, and psoriasis becomes eczema, or acne becomes rosacea, and it does not really matter – retraction of the original label is not harmful.

However, dermatologists should only make psychiatric diagnoses if they have had appropriate training and experience. Erroneous psychiatric labelling, including of BDD, may cause the patient harm, so psychiatric diagnoses should be made with caution, supported by appropriate clinical findings. Ideally, all patients with significant body image concern should be assessed and managed by clinical psychology and/or psychiatry, but such resources can be difficult to access.

Recommended further reading

1. Phillips KA. *The Broken Mirror: Understanding and Treating Body Dysmorphic Disorder*, revised edition. Oxford University Press USA, 2005.
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7. BDD help. www.bddhelp.co.uk (last accessed 06/02/15)
8. BDD central. www.bddcentral.com (last accessed 06/02/15)

Facilitated cognitive behavioural therapy using internet-based resources may have an increasing role in the management of BDD in the future[5] ■

Please note that only those appropriately trained and qualified to treat body dismorphic disorder should do so.

Declaration of interest
The authors declare that there is no conflict of interest.

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4. National Institute of Health and Care Excellence. *Obsessive-compulsive disorder: Core interventions in the compulsive disorder and body dysmorphic disorder.* www.nice.org.uk/guidance/cg031 (last accessed 06/02/15)
5. Enander J, Ivanov VZ, Andersson E *et al.* Therapist-guided, Internet-based cognitive-behavioural therapy for body dysmorphic disorder (BDD-NET): a feasibility study. *BMJ Open* 2014; **4:** e005923.

Key points

- Surgical and medical treatments of the perceived cutaneous 'problem' in body dismorphic disorder (BDD) are cautioned, as the problem may simply shift to another area of the body.
- When dealing with BDD, it is important that dermatologists focus on the patient's distress, rather than the skin complaint.
- Engagement with clinical psychology or psychiatry services is desirable for optimum outcomes in BDD patients.
- Individually tailored psychological therapy (for example, cognitive behavioural therapy) and selective serotonin re-uptake inhibitors are the treatments of choice.

Correction

The authors would like to make a correction to Part 1, published in *Dermatology in practice* Vol 20 No 4. The final paragraph should have read: 'It may be better to wait until further, more detailed assessment is performed, ideally by a psychiatrist, before making a definitive diagnosis. The use of descriptive terms such as body image concern, body image dissatisfaction, body image stress, poor self-image, disproportionate concern or overvalued ideas about appearance is a useful approach in the shorter term.'

PCDS

PRIMARY CARE **DERMATOLOGY** SOCIETY

Dr Angelika Razzaque MBBS MRCGP DFSRH DPD PCertMedEd
Vice Chair PCDS Executive Committee, GP partner and trainer, South East London, Clinical Director, Lewisham CCG

Another year has passed, and the PCDS has been consistent in providing education in dermatology throughout the country. The society has been in existence for 20 years, an anniversary that was accordingly celebrated during our spring meeting in March 2014. The meeting took place at Chesford Grange, Kenilworth, the venue that we have chosen again for this year's spring meeting, which takes place on the 14th and 15th of March. The programme promises another successful event, with lectures focusing on applications of skin disease in other specialties; for example, genetics, oral medicine, psychiatry and rheumatology, to name a few. Have a look at the PCDS website for the full programme content as well as for an overview of our educational events in 2015.

Things have been busy around the issue of accreditation and re-accreditation of GPwSIs in dermatology. Some of our committee members have actively participated in the pilot run, led by the BAD in conjunction with the RCGP. I am sure the experience and learning will be shared in the future with everyone either already working as a GPwSI, or contemplating doing so.

For those of you who, like me, work in general practice and are aiming to improve dermatology services for their patients, the new NHS Five Year Forward View, advocated by Simon Stevens and published in October 2014, might offer opportunities to do so through local CCGs. Remember, patient experience is highly valued and emphasised in the report. We all know too well that our patients with acute and chronic skin conditions experience a great variation in service provision, and that the variation in education, which starts at medical school, is a contributing factor. The PCDS is working tirelessly with all stakeholders to bring home the message that education is key for the benefit of patients.

May I use this opportunity to signpost you to the excellent website of the society, which not only hosts a wealth of educational material, but also patient information, in order to support self-care – another aim of the Five Year Forward View. There is a new feature on the website, 'case of the month', a case scenario with questions to answer and CPD points to earn. Have a look at the January case, a woman with a symptomatic rash around her mouth.

We hope to see some of the *Dermatology in practice* readers at our events, as we highly rate interaction with clinicians involved in the treatment of patients suffering from skin disease. It greatly informs our direction in terms of education as well as involvement in policies. If you would like to get involved with the society or sign up as a member, please email **pcds@pcds.org.uk** and our fantastic support team will get in touch with you ■

Keeping it sharp

Barry Monk
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Sheffield was once famous the world over for steel-making; indeed the local football team, Sheffield United, is still nicknamed 'the Blades'. Sadly, as with much of British industry, steel-making in Sheffield has all but vanished. But one rather remarkable company is still flourishing: Swann-Morton Ltd still manufactures its renowned surgical blades in the city, as it has for over eighty years, and its blades are almost certainly the ones you use every day in your dermatology clinic. And if you do, you will be in good company, because these products are used by doctors all over the world.

The survival of this company may be unusual, but its history is even more peculiar. Walter Swann, the co-founder of the company, began his business career in 1917, the year of the Russian revolution, and it was a subject that always fascinated him. So when, in 1932, he founded a business initially selling razor blades, he was determined to run it in a rather revolutionary fashion. He began by producing a hand-written document, still proudly displayed at the company head office, outlining the philosophy of the company. Two of the most striking points were that employees were to be regarded as the most important asset of the company and treated accordingly, and that if anything went wrong it was the fault of the managers, who should be dispensed with. He also bought an orchard in Kent (which is still owned by the company) so that the workers would have a regular supply of fresh fruit.

As the company prospered, especially after it had switched to producing surgical blades, Walter Swann, who had no heirs, began to wonder about the long-term future. He changed the articles of association so that Swann-Morton became owned, as it still is today, 50% by the employees and 50% by a charitable trust. Profits from each year (and the company does indeed make a profit) are distributed to the workforce. Perhaps even more remarkably, this profit is achieved while giving staff ten weeks' holiday a year, a 35-hour working week and private health insurance (as well as fruit). Managers are invariably appointed from within the company and, notwithstanding Mr Swann's threats, no-one has actually been sacked since 1940.

It does seem remarkable, at a time when the NHS seems determined to spend extraordinary amounts of money on management consultants, that we can't just learn from Walter Swann's homespun but remarkably successful philosophy; the next time you are doing a biopsy, do spend a second thinking about this extraordinary man ■

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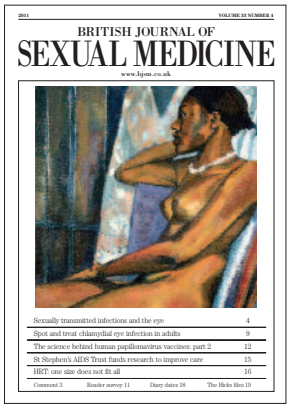

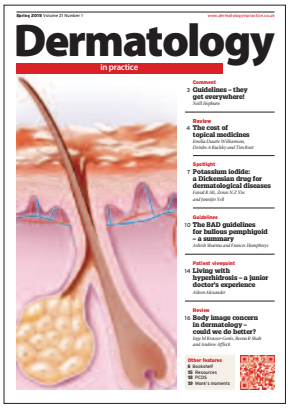

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