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The place for dermatology

Last month I had to present the United Lincolnshire Hospitals NHS Trust’s mortality data and action plan at a ‘mortality summit’ with our clinical commissioning group partners and the local area team from NHS England. As a dermatologist, whose specialty is generally regarded as somewhat less than acute, I felt uncomfortable. I recalled the aphorism, ‘skin patients never die, but nor do they get better!’ Of course, our work has changed greatly over the past 20 years; the increasing prevalence of melanoma and the widespread adoption of immunomodulatory treatments ensure we do look after patients in their final months of life and many of our patients do ‘get better’.

Consequently, the necessary skill set of, and the resources required by, dermatologists, have changed significantly. We no longer need large numbers of beds, but we do need: good operating facilities; outpatient investigations, such as patch testing; therapies, such as phototherapy; and an IT infrastructure to monitor complex drug regimens. We need to liaise with our colleagues in pathology and, increasingly, those on the acute medical admissions unit. A recent audit of ward visits undertaken by the dermatology team showed that in over 70% of cases the diagnosis suggested by the referring team was incorrect.

The holy grail of all the challenges and changes we face is providing seamless integrated care for our patients. They present in the community and most are managed there. A few touch secondary care – but they need to return back home. We need to work together to get this right and this means we need to understand each other’s needs better.

Running alongside our mortality review (or the ‘Keogh Review’) we are, in Lincolnshire, closely examining our activities to meet the financial challenges facing all health communities (the ‘Nicholson Challenge’). While much of this involves looking closely at loss-making services, it also raises the question of where services should be provided. This issue contains an article by my colleague Julia Schofield considering this matter from a dermatology perspective. One, often neglected, aspect is the interaction between members of the dermatology team. The sharing of problems and the dispensing of advice, along with rigorous clinical governance, are essential to maintaining services of the quality that patients expect. One of the most attractive features of dermatology, as a specialty, is its convivial and collegiate culture.

Of course, politics is a peripheral activity for most of us – it is patient contact that really counts. Julie Halford has raised the profile of hyperhidrosis in the UK over many years. Her article on the management of hyperhidrosis describes a stepped approach to helping hyperhidrosis sufferers, whose life can be made miserable. One of the conundrums we face in seeking to deliver a comprehensive service is that conditions that have a great impact on patients’ lives tend to be allocated a lower priority than those that cause death. The great joy, and challenge, of clinical medicine is the interaction with the whole spectrum of humanity. The article by Alia Ahmed and colleagues on artefactual skin disorders reminds us of some of that diversity, and the associated challenges. Looking back over 20 years of consultant practice, approximately half the times I have been called into casualty out of hours, (fortunately, an uncommon event) has been for dermatitis artefacta.

Finally, Barry Monk gives us his take on mortality reviews!
Hyperhidrosis – how to help our patients

Sweating is essential to maintain normal body temperature. It is controlled by the sympathetic nervous system, although the nerves involved actually use acetylcholine as the neurotransmitter, acting on the eccrine glands. A normal adult can produce over 0.5 l of sweat per hour, although acclimatised individuals in a hot environment can produce up to 3–4 l per hour. Hyperhidrosis is a distressing problem that can have a devastating effect on sufferers’ lives. It is probably best defined as perspiration in excess of the physiological amount necessary to maintain thermal homeostasis.

Patients with hyperhidrosis can be divided into two groups:
- Primary hyperhidrosis, in which the cause is unknown. This may be localised to specific areas of the body, such as the hands, feet or axillae, or it may be generalised.
- Secondary hyperhidrosis, in which the excessive sweating is due to an underlying disorder. Like primary hyperhidrosis, it may be localised or generalised.

This article describes how to manage patients with primary, localised hyperhidrosis.

Primary hyperhidrosis

Primary hyperhidrosis affects both sexes equally and all races. It may present in young children, but patients more commonly present in adolescence as they become more aware of their bodies. In 60–80% of cases the patient has a positive family history. The condition always starts before 25 years of age. While any part of the body may be affected – such as the face, head, neck, back or groin – it is the hands, feet and axillae that are most commonly the focus of concern. Sodden hands, feet or axillae cause embarrassment and the inability, at times, to carry out simple tasks – such as dealing with paper, keyboards, mobile phones, metal and electrics – is considered a significant disability that makes some occupations impossible. Those who suffer from plantar hyperhidrosis often have sodden and smelly shoes, and may be ostracised or bullied by their peers. Many sufferers are even too embarrassed to hold the hands of their loved ones.
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- Dermol Cream: 100g tube £2.86, 500g pump dispenser £6.63, PL00173/0171
- Dermol 600 Bath Emollient: 600ml bottle £7.55, PL00173/0155

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Date of preparation: February 2012.

Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard. Adverse events should also be reported to Dermal.

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www.dermal.co.uk
Secondary hyperhidrosis

Secondary hyperhidrosis has many causes, including febrile illnesses, heart disease, malignancy, diabetes, hyperthyroidism, infection, Parkinson’s disease, stroke, alcoholism, menopause, pregnancy and obesity. Drugs are also a common cause of secondary hyperhidrosis, with over 300 different types reported as being implicated in the condition, especially antipsychotics, antidepressants (including selective serotonin reuptake inhibitors), cholinesterase inhibitors, insulin and angiotensin-converting enzyme inhibitors. It is also important to remember that illegal drugs, such as amphetamines and cannabis, can also be a cause. Secondary hyperhidrosis can start at any age and, although usually bilateral, depending on the cause, it may be unilateral and localised. Treatment for these patients is directed to resolving the underlying condition or stopping the medication.2

Assessing the patient

The following steps should be taken when assessing a patient with hyperhidrosis.

- **History.** The first step is to determine the type of hyperhidrosis and the disability it is causing to the patient. Some simple questions to ask the patient at this stage are listed in Box 1.

- **Examination.** A brief physical examination is useful to confirm the presence and location of the hyperhidrosis (see Figures 1a–d). It is also useful to look for possible causes of secondary hyperhidrosis; for example, lymphadenopathy, signs of alcoholism, a rapid pulse, and so forth. This may suggest some relevant tests, such as a thyroid function test or a chest X-ray.

- **Tests.** There are two tests that are commonly used to assess patients with hyperhidrosis. The starch-iodine test is used to confirm the presence of sweating and can accurately localise its origin. It is particularly useful as a prelude to injecting botulinum toxin, to ensure it is administered at the correct site. An iodine solution is applied to the sweaty area and after it dries, starch is sprinkled on the area. The starch-iodine combination turns a dark blue colour where there is excess sweat (see Figures 2a–b). Some UK centres perform gravimetric tests where the filter paper is weighted on accurate scales and then placed on the affected area to absorb the sweat for a predetermined time, after which it is weighed again. This gives a semi-quantitative assessment of the problem. It is used in some settings to determine if patients qualify for botulinum toxin injections for axillary hyperhidrosis. A common threshold is 100 mg of sweat from each armpit in five minutes.

The stepladder for managing localised hyperhidrosis

Most patients can achieve acceptable control of their symptoms by simple measures, such as appropriate clothing choice and use of antiperspirants. Those who struggle, and/or whose symptoms are more severe, may need more aggressive treatment. A therapeutic stepladder (see Figure 3) should be used to explain the options to patients and to structure the approach.

Conservative measures

Simple measures include wearing black or white clothing to disguise the obvious signs of sweating, and avoiding synthetic and tight-fitting clothing, which tend to prevent sweat evaporating. Absorbent socks, designed specifically for sweaty feet, and the use of absorbent powder such as ZeaSORB® (Stiefel) can also help. A further useful

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**Box 1. Questions to ask patients**

- In which body area do you suffer from excessive sweating?
- Do you sweat at night, or just during the day?
- How old were you when the problem started?
- Does this problem run in your family?
- What provokes the sweating?
- How does this problem affect your work or social life?
- What does your excessive sweating prevent you from doing?
- What do you choose not to do because of this problem?
strategy is to avoid trigger factors, such as crowded rooms, alcohol and spicy foods. Many antiperspirants are irritants, so using emollient wash creams and moisturisers in preference to soap-based products can also help. The Hyperhidrosis Support Group’s website is of great help to many patients. For those patients whose hyperhidrosis is related to anxiety, a small dose of propranolol 40 mg prior to the provoking situation can help.

Topical antiperspirants
In primary care, patients are generally prescribed aluminium chloride antiperspirants, such as Driclor® (Stiefel) or Anhydrol® Forte (Dermal), which are applied at night to dry skin. These are most helpful for axillary hyperhidrosis, but, unfortunately, many patients find that they cause irritation. To some extent, this can be mitigated by using them only three nights a week and applying hydrocortisone cream 1% in the morning. An alternative preparation, which some find less irritating, is SweatStop® antiperspirant (SweatStop), which can be purchased online.

Anticholinergic medication
Anticholinergic (antimuscarinic) drugs are useful for some patients, although the side-effects (such as dry mouth, constipation, palpitations and blurred vision) often prevent or limit their use and they are contraindicated in those with glaucoma, urinary obstruction and ulcerative colitis. Propantheline bromide is readily available and cheap – start with 15 mg daily and increase, if tolerated, to 15 mg three times daily. An alternative, which some patients find helpful, is oxybutynin, which is available as a modified release preparation, Lyrinel® XL (Janssen). Start with 2.5 mg daily and slowly increase the dose to a maximum of 10 mg daily. Glycopyrronium bromide (Robinul® [Mercury]) is reputed to be better tolerated. It is also available as an unlicensed preparation from Idis (cost £64 for 100 x 1 mg tablets). It is taken on an empty stomach and patients should start with 1 mg daily and increase through 1 mg three times daily to a maximum of 5 mg daily.

Iontophoresis
Iontophoresis, the passage of an electric current through the skin, is the fourth step of treatment for primary hyperhidrosis and significantly reduces sweating in the treated limb in most pa-
tients. It is safe and practical and can be practised in a clinical setting or at home. It is particularly useful for the hands and feet, but less so for the axillae. Published studies indicate that tap water iontophoresis is successful for palmar and plantar hyperhidrosis in about 85% of cases, and for the axillae in about 70% of cases. Although other areas of excessive sweating have been treated with some success, this is not standard practice.

The mechanism of action is not known. There are several hypotheses as to how it works.

- Electrical current and mineral particles in the water act to thicken the outer layer of skin, blocking the flow of sweat. Once output is interrupted, sweat production in the area stops.
- Iontophoresis may, temporarily, cause a functional impairment of the sweat duct – either by completely blocking sympathetic nervous system transmission to the gland, or by changing the cellular secretory physiology.
- Iontophoresis may cause a plug on the sweat gland or induce an electrical charge in the gland that disrupts secretion.
- Iontophoresis decreases pH in the sweat duct, which may contribute to eccrine gland dysfunction.

During iontophoresis, the patient places their hands, or feet, in a water bath, through which a low voltage electric current is passed for ten to 20 minutes. The polarity is then reversed and a further period of treatment is given. For the axillae, special pads are used (see Figures 4 a–d). While some patients experience slight discomfort, most tolerate it without any problems. A course of iontophoresis typically involves seven treatment sessions (Days 1, 2, 4, 7, 10, 15 and 22). To maintain the effect, maintenance treatments are given as soon as the area starts to become clammy again. In practice, a good strategy is to administer the first course in the clinic, to ensure that it works and that the patient knows how to use the equipment, after which many patients buy their own machine to continue treatment at home.

Pure water (deionised or distilled) is a poor electrical conductor, as it poses a high electrical resistance. Ionised salt in water makes it capable of conducting electricity. Tap water usually contains enough minerals to conduct current, but mineral content in water varies, so the results achieved with tap water iontophoresis vary. In general, it appears that if the water is very soft, then the treatment is less effective. Strategies to improve the efficacy of iontophoresis include using bottled water (Badoit®) and adding sodium bicarbonate to tap water (a teaspoon in each bath of water).

The efficacy of iontophoresis can be enhanced by using glycopyrrium bromide 0.05% solution in place of tap water, but this can cause anticholinergic side-effects and carries the same contraindications as oral anticholinergics.

Iontophoresis is widely practised in the UK, in most dermatology departments, some podiatry clinics and a few GP practices. The machines used in the UK hospitals are simple, rechargeable, battery-operated and come with a set-up manual and DVD. They are available from STD Pharmaceuticals (Idrostar®). Iontophoresis is contraindicated in patients with cardiac pacemakers (metal implants around the treatment area), in pregnancy and in those with a peripheral neuropathy.

**Botulinum toxin**

Botulinum toxin type A interferes with the release of acetylcholine from cholinergic neurons. Although it is only licensed for axillary hyperhidrosis, it can also be used to treat the palms, but is less successful in this area and also very painful. The benefit is temporary, usually lasting for between one and three months, but the treatment can then

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**Key points**

- Hyperhidrosis can have a devastating effect on a sufferer’s life.
- Aluminium chloride antiperspirants should be used as the first choice of treatment.
- Iontophoresis should be used for palmar and plantar hyperhidrosis if specialist antiperspirants fail.
- Botulinum toxin is useful for axillary hyperhidrosis.
- Only ever consider referring for surgery if all else has failed.
be repeated.15 The injections are very painful, but this is otherwise well tolerated and side-effects, such as muscle paralysis, are uncommon. However, availability on the NHS is limited, as this is usually classed as a low priority procedure.

To perform this technique, the area of hyperhidrosis is carefully demarcated using the starch-iodine test. The treatment area is marked out into squares measuring 1.5 cm² and then two units of botulinum toxin are injected intradermally into the centre of each (see Figure 2b). No more than 100 units are given at any one time. Botulinum toxin is contraindicated in patients who are hypersensitive to any of the ingredients, in pregnancy to toxin is contraindicated in patients who are hyper- sensitive to any of the ingredients, in pregnancy and breastfeeding, and in those with disorders of the neuromuscular junction, such as myasthenia gravis, myopathies and Lambert Eaton syndrome. The two products commonly used in the UK are Botox® (Allergan) and Dysport® (Ipsen).

Surgery

Endoscopic transthoracic sympathectomy, in which the sympathetic ganglion is cut selectively, is now rarely performed, as more conservative therapeutic options for severe palmar hyperhidrosis have become available. It can lead to severe compensatory sweating, often making the patient’s life quite unbearable (see Figure 5).

Excision, retrodermal curettage, subdermal liposuction and laser sweat ablation are all methods of surgically excising the sweat gland in the axillae. This is useful if there is a small ‘hot spot’ of sweat production. There are few practitioners in the UK and success rates are variable. However, some who do perform it are getting good long-term results. Newer methods are not generally available, but may become so in the future.

Declaration of interest

The authors declare that they have no conflicting interests.

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These are challenging times in the NHS – structurally and financially. The reforms outlined in the Health and Social Care Act 2012 are being implemented rapidly. This is at a time when cost savings are high on the agenda of commissioners and providers of care, despite the emphasis placed on delivering high-quality, patient-centred care. The changes will see more competition in the NHS marketplace, so clarity of which services sit best where, and for what reasons, would be helpful to inform the new clinical commissioning groups (CCGs). This article considers the specific issues relating to the configuration of dermatology services and, in particular, the question of whether dermatology has a place in secondary care. Before answering this question, consideration will be given to the meaning of ‘secondary care’ and ‘dermatology’.

**Secondary care definition**

What is meant by the term secondary care? In the UK healthcare system, the first point of call for patients is primary care – typically, the GP or a member of the primary healthcare team. The GP then acts as the ‘gatekeeper’ to specialist or secondary care services. Figure 1 shows examples of primary and secondary care services and their links to national, regional and local organisations since April 2013. There are a range of secondary care services – from intermediate care to tertiary or regional supra-specialist services – which are much more niche, dealing with those patients with more complex diseases (see Table 1). However, for the purpose of this article, secondary care is presumed to mean a district general or teaching hospital. Further on, I will discuss the merits of using levels and locations of care rather than the traditional primary/secondary care definitions.

What is meant by a secondary care dermatology service? Secondary care dermatology services are based in district general hospitals and larger teaching hospitals, and provide care in a range of locations, including community settings (such as GP surgeries and community hospitals). Around
50% of referrals to secondary care dermatology services are for the diagnosis and management of skin lesions, including skin cancers, and this activity creates large amounts of skin surgery. Around 10–15% of secondary care activity relates to the management of the common inflammatory skin conditions, including acne, eczema and psoriasis. Multidisciplinary working is an important part of the dermatology secondary care service, particularly for patients with skin cancer, where links between dermatologists, plastic and reconstructive surgeons, ophthalmologists, maxillofacial surgeons, oncologists and histopathologists are essential to optimise patient care and meet national standards for cancer services. Phototherapy and day treatment services are an essential part of the secondary care service for the management of patients with inflammatory skin disorders, and have largely removed the need for hospitalisation – except in the case of life-threatening dermatoses. The dermatology team has an important role in visiting the wards of the hospital in which they are based, with data suggesting that consultants spend about two to four hours a week on ward work. This ward work involves the diagnosis and management of patients admitted with other co-morbidities who have a concurrent dermatological problem.

Secondary care dermatology services are delivered by teams of specialist healthcare professionals, including consultants, specialty doctors, specialist dermatology nurses and GPs with a special interest in dermatology (GPwSIs). In most departments in the UK, the consultant will have responsibility for the teaching and training of other healthcare professionals, including medical students, GPs, junior hospital doctors and dermatologists and nurses in training. The amount of research undertaken by specialist dermatology units is variable, but even busy district general hospital departments will mostly be treating patients with biological therapies and are involved in entering this cohort of patients into the British Association of Dermatologists Biologic Interventions Register – a research project collecting information about the long-term risks and benefits of these new treatments.

Secondary care dermatology specialist nurses provide a range of services, including patch testing, phototherapy, day treatment, nurse-led clinics for childhood eczema and psoriasis, second-line treatment, drug monitoring and skin surgery. They offer support to patients with long-term skin conditions, particularly in the context of supporting self-management and also for skin cancer. They also have a role in the explanation and practical demonstration of how to use treatments.

### Co-location of dermatology in secondary care settings

The advantages of the dermatology service to the secondary care organisation could be perceived as

![Table 1. Levels and location of care](https://www.dermatologyinpractice.co.uk/dermatology-in-practice-2013-vol-19-no-2)
greater than the benefits to the dermatology team that come from being part of a large NHS organisation. Rapid access to specialist dermatology advice can prevent hospital admissions, particularly for red legs.3 Prompt assessment of inpatients with acute dermatological problems improves patient care and reduces length of hospital stay. The dermatologist’s understanding of the skin manifestations of systemic disease is helpful to acute physicians. Of equal importance is the fact that, in the NHS marketplace, dermatology is usually an income generator for the organisation.

For the dermatology team, the main advantage to being part of a secondary care organisation is ready access to multidisciplinary working, particularly with histopathologists, but also in relation to the wider overlap between dermatological and other diseases.

The costs of running a large NHS organisation are high, with management, capital and facility costs being significant. Profits from dermatology income generation are likely to be offset against losses sustained by other clinical specialties and cost savings have to be shared between income generators and income losers. Only in large departments is dermatology likely to have a designated dermatology business team; usually, the business team will oversee a range of clinical specialties, of which dermatology will be just one.

**Factors that determine co-location**

What determines co-location in secondary care settings? Much of a dermatology service can, theoretically, be provided in a well-equipped community hospital with suitable outpatient and minor surgery facilities. Co-location is most important – and is, arguably, essential – for multidisciplinary team working, especially for skin cancer, where access to reliable and efficient histopathology services is crucial. While phototherapy services can, theoretically, be provided outside of large NHS hospitals, there is a careful balance to be struck. Patients receiving phototherapy usually need treatment twice or three-times weekly for six to eight weeks. Therefore, proximity to a local service has to be balanced against economies of scale, as the required equipment is expensive and utilises specially trained staff in the delivery of this type of care. Co-location in secondary care premises is therefore not essential, but an out-of-hospital community service would need to justify investment in equipment and staff and enough activity for the service to run at reasonable capacity.

The use of more effective outpatient therapies makes it less and less necessary to provide access to designated inpatient beds. However, timely dermatological input to patients in hospital with other problems who develop a dermatological problem is best achieved by dermatology services being co-located in hospital settings.

Other issues, such as availability of specific dermatological treatments (for example, liquid nitrogen, isotretinoin and methoxypsoralen), do not require co-location in a hospital setting.

**Location and levels of care**

To try to design patient-centred dermatology services, it is important to recognise that the location for the delivery of dermatology services will be determined by the complexity of the dermatological problem being managed. Around 13 million people visit their GP with a skin condition each year in England and Wales, the commonest reason why people present to their GP with a new problem.4 However, only about 750,000 (approximately 6%) are referred to see specialists.5 The huge spectrum of dermatological diseases means that while some patients will have straightforward conditions that are easily managed without the need for expensive facilities or equipment, others will need access to highly sophisticated treatment and expertise. For example, excision of a basal cell carcinoma might be simple and readily performed in a suitably equipped community hospital or, alternatively, might require the specialist skills of a team providing Mohs micrographic surgery in a more sophisticated clinical setting.

Because of this variation in the complexity of the care needed by patients with skin disease, it may be more helpful to think about levels and locations of care (see Table 1). Using this approach, the patient case-mix that can be managed, and the services that can be provided in particular locations can be reviewed and determined based on...
complexity and appropriateness of facilities. The challenge, then, is to provide joined up services across a range of locations. This is likely to be best facilitated by a hub that provides the full range of secondary care services (and some supra-specialist services), including the necessary multidisciplinary links to ensure optimal care for people with skin cancer. Spokes can then be geographically determined by patient need. Links to the hub need to be well developed, so that the patient pathway is seamless for those who need access to more specialist hub-based services.

The verdict
Some think that the provision of dermatology services in secondary care is unnecessarily hospital-centric, with dermatology being perceived as an outpatient-based specialty that does not need to be hosted by a large, busy, acute ward-based hospital. Detractors of hospital-based dermatology services also believe that there are significant cost savings to be made by relocating services into community settings. While there is some truth in the idea that patients with straightforward skin conditions can be managed safely and effectively in well-equipped community facilities, there are sound counterarguments to this view. Large numbers of patients with skin cancer will only receive optimal care if the multidisciplinary working, across the range of specialties, readily available in an acute hospital, is facilitated. Economies of scale mean that some dermatology services may be more cost-effectively provided in secondary care settings. Research, teaching, and the management of patients with complex dermatological problems and skin conditions associated with co-morbidities, will all be enhanced by the facilities and clinical networking that a secondary care hospital provides. Inpatients undoubtedly benefit from ready access to a dermatology opinion and some patients with serious, life-threatening skin conditions require hospitalisation. Logic, therefore, suggests that a robust specialist dermatology hub, based in a secondary care setting supported by spokes in community settings, is most likely to best fit the aspiration of the Health and Social Care Act 2012 to deliver high-quality patient-centred care.

Declaration of interest
None declared.

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Those of us who read this journal already have an interest in dermatology. However, we are a worrying minority in primary care. Skin problems account for a considerable part of our workload and 24% of the population visit their GP each year with a skin problem.1 Furthermore, over 90% of skin problems are managed exclusively in primary care.

Around 55% of UK medical graduates go into general practice, yet undergraduate teaching of dermatology in our medical schools is woefully inadequate (barely a week in many). Also, only one in five vocational training schemes offer any formal dermatology training during the specialist training years. This is a disgrace; we are simply not training doctors to be ‘fit for purpose’. It is no surprise, therefore, that skin disease care in general practice is strongly criticised by patient support groups, the British Association of Dermatologists and many others. We need the Royal College of GPs and the General Medical Council to take effective action, now.

Dermatology has one of the highest number of referrals of any specialty. A GP is ten times more likely to be sued for delayed diagnosis of a melanoma than any other cancer, so it is hardly surprising GPs are anxious about diagnosis. Melanoma incidence has increased by 50% over the past 13 years. Recognising and appropriately managing a basal cell carcinoma is crucial, especially as the incidence is more than the sum of all other tumours. Yet, I regularly hear of hospital dermatology departments swamped with urgent referrals of benign lesions. Not only is this a waste of NHS resources, it is also additional work for primary care and a cause of considerable, unnecessary worry to patients. GPs are now at the forefront of commissioning, responsible for the rational use of local NHS resources. We should be demanding higher standards of GP education in dermatology to ensure this waste is addressed and that patients always receive competent care of their skin disease in the community.

I am delighted to hear that a board has been convened to look at the issues of doctor training in the UK (‘Shape of Training’). This board is due to publish its recommendations this autumn. Hopefully, these will address the gulf between patient needs and the knowledge and skills of the current GP workforce in dermatology. We urgently need robust recommendations regarding the training of doctors in the management of skin disease, although their input will take a decade or more to effect any improvement.

If you have not recently visited the Primary Care Dermatology Society website, you are in for a treat. It offers superb information on educational events around the country and authoritative, succinct advice on managing skin disease.

Please also note our annual membership is only £30 (tax deductible). Our raison d’être is education in dermatology, and the larger our membership, the more our voice will be heard.
Dermatitis artefacta (DA) is a factitious skin disorder, which often occurs as a response to traumatic life events (such as physical/sexual abuse as a child or adult, or bereavement), or as a behaviour that may result in secondary gain (for example, financial reward or attention from others). Less often, it is the result of a dissociated state.¹ Patients will create skin lesions themselves and then deny having done so. It is notoriously difficult to engage these patients with health services. DA is recognised in the Diagnostic and Statistical Manual of Mental Disorders (4th edn) as a mental health disorder, under the label of ‘factitious disorder’.²

Incidence

DA is a diagnosis of exclusion, which makes it difficult to identify. It is also an area of taboo, making it difficult to explain to patients. Therefore, the reported incidence of DA is low (0.03%).³ There will be an element of under-reporting and misdiagnosis contributing to this figure also. Comorbid diagnoses include borderline personality disorder, obsessive-compulsive disorder, depression, psychosis and learning difficulties. DA is seen most frequently in young females, the female-to-male ratio being 3:1, although sex and gender associations must be regarded with caution. The disorder can present at any age, but is more common in young adults and adolescents.³

History

A good history will help to reveal the key features of DA and also identify any precursors. Apart from the skin symptoms, it is important to explore the personal history of the patient. Examples of the types of questions to ask are:

- Tell me about your skin – how and when did the lesions appear?
- What makes the lesions better or worse?

It is likely that the patient will give a hollow history of the events preceding the skin lesions. The lesions will typically be described as occurring overnight or acutely in the presenting morphology; systemic features of illness will be absent; and patients may have been seen by other healthcare professionals who could not give them a diagnosis, despite several investigations. The lesions may improve when occluded or when the patient has been admitted to hospital.

The state of the patient’s skin will be a cause of grave concern and patients will be looking for a diagnosis to explain the skin lesions. If other healthcare professionals have seen the patient and no firm diagnosis has been established, it is likely they will feel frustrated. It is important to listen to their story and acknowledge the difficulties that their skin problems are causing to their daily life. This is the foundation of the doctor-patient relationship that will later allow the clinician to explore the patient’s psyche.
Psychological assessment
The patient needs to be assessed for psychiatric co-morbidities, such as depression, as well as the direct impact their skin problems have on their daily life. Any psychological assessment requires the clinician to make an assessment of suicidal ideation. By asking the patient about significant life events, their childhood and details of their support network, the clinician can start to investigate possible precursors to DA. Any suggestion of ongoing abuse of a vulnerable adult or child needs the immediate attention of the appropriate services, such as the vulnerable adults’ team or child protection services.

An assessment of the patient’s social and relationship history gives an idea of what factors in their life can be affected by their skin, as well as a description of their social status and home situation. Psychosocial factors, such as poor coping mechanisms, a dysfunctional family life, poor quality of life and inadequate social support, have all been implicated in DA.

General health
Any medical history requires details about past medical history, current medications, allergies, family history and a review of systems to assess any other significant symptoms. This gives a good overview of the patient’s general medical health.

Examination
Skin examination will reveal non-resolving lesions of differing morphology; for example, ecchymoses, excoriation, ulcers or blisters. Lesions may also be geometric in shape, so it is important to look for sharp edges that are distinct from otherwise ‘normal’ skin. The areas covered by the lesions will typically be those that are accessible to the patient – limbs, face and trunk are common examples. The central back is often spared. There are a number of different ways the patient might inflict the skin lesions; the most common ones are: scratching with fingernails, burning with cigarettes or caustic agents, application of suction devices, cutting with sharp or blunt objects and the use of an aerosol spray to cause a burn. It may be useful to consider what the causative agent might be during the skin examination. For example, rounded, clear, fluid-filled blisters of differing sizes affecting the limbs, trunk and face may be secondary to aerosol burns.

Differentials
The differentials to consider are organic disease (malignancy, vasculitis, cutaneous infections, inflammatory skin disease, immunobullous disease, drug reaction and organic skin disease), dysaesthetic disease (trigeminal trophic syndrome) and deliberate self-harm, as well as factitious injury.2,3

Investigation
As DA is a diagnosis of exclusion, patients will require a full work-up to rule out organic pathology. It is useful to review which tests have been performed prior to the current assessment to avoid duplication and delay in treatment. Over-investigation reinforces the patient’s belief in skin disease and should be avoided where possible. The types of investigations to consider are: blood tests, skin biopsies, and skin/wound swabs, but these will be dependent on the clinical picture. Medical photography should be utilised with the patient’s consent as it provides a record of lesions and their history can thus be tracked. Secondary complications (for example, skin infection and scarring) should be treated as appropriate.

Management
Confrontation should be avoided in patients with DA. These patients are unlikely to admit causing the lesions and are prone to ‘doctor shopping’.3–5 This presents a challenge to health services when trying to engage patients.

Both the skin and psyche require treatment. Patients should be reassured that their skin is being cared for as this can improve the psychological distress associated with skin lesions. Skin support is offered in the form of topical treatments such as emollients, antimicrobial washes and occlusive bandaging, as well as treatment of any complications, such as wound infection and scarring. Psychological support is offered by the clinician during interactions with the patient, and more formally through a trained clinical psychologist. By referring patients to other healthcare professionals, the support network is increased and expert help is provided in the areas needed. The suggestion of psychological therapy may not be attractive to the patient. There are a number of ways to approach this, the most helpful being the acknowledgement that skin disease can cause stress and vice versa. Therefore, a certain amount of time spent with a psychologist can be useful for patients to teach them strategies of how to cope with their skin problems.

Medical treatments for DA have included antipsychotic agents and antidepressants. Selective serotonin reuptake inhibitors may be useful where there is associated anxiety, depression or an obsessive-compulsive disorder, and citalopram is often the drug of choice.6 Treatment with antipsychotics is best considered in conjunction with a psychiatry opinion.4,6
Imperative to the successful management of DA is the establishment of a good doctor–patient relationship, so that the underlying psychological issues can be explored. Finding out why DA is occurring is more important than finding out how the lesions are being inflicted. The possibility of DA lesions occurring in dissociative states is a less well-known phenomenon. Unless the patient is witnessed in an altered state of consciousness inflicting the lesions, one cannot be sure that this is what is occurring. However, dissociative states are not that rare and it is possible that it is a greatly under-diagnosed cause of DA in patients.7

**Psychodermatology**

Once the diagnosis of DA is suspected, referral to psychodermatology services is recommended. Specialist psychodermatology services are cost-effective and they offer a holistic approach to DA with access to a number of healthcare professionals (such as clinical psychologists and psychiatrists).8 The patient is seen in a joint clinic, run by dermatologists and psychiatrists, and the emphasis is placed on an empathic and non-judgemental approach that will hopefully facilitate further discussions as to why DA is occurring. The multidisciplinary team typically consists of dermatologists, psychiatrists, clinical psychologists, child psychologists, specialist nurses, neuropsychologists, social workers and child protection services (where necessary).

**Prognosis**

There are reports of suicide and attempted suicide in patients with DA.9,10 Therefore, regular contact with medical services and assessment of suicide risk is recommended. A child’s prognosis improves as they grow older, learn coping skills and are less inclined to harm their skin.11 DA has a tendency to ‘wax and wane’ depending on the life events of the patient – thus, ongoing review is advised.8

**Conclusion**

Patients with DA typically present to dermatology clinics and dermatologists are pivotal in the diagnosis and management of this condition. Once the diagnosis is suspected, prompt referral can avoid unnecessary investigation and inappropriate treatment. Psychodermatology services are best placed to effectively manage patients with DA by addressing their skin problems as well as the underlying psychological distress associated with DA.

**Declaration of interest**

The authors declare that there is no conflict of interest.

**References**


**Key points**

- The discovery of non-resolving and morphologically bizarre lesions in a patient should raise the clinician’s suspicion of dermatitis artefacta (DA).
- A detailed social and psychiatric/psychological history can help identify possible precursors of DA.
- Confronting the patient about their condition is rarely a helpful approach to managing DA.
- Skin support is a part of the management of DA.
- Multidisciplinary services are needed to effectively manage patients with DA.
- It is important to address the underlying reason why the DA is occurring, rather than to concentrate too much on how the patient is causing it.
A new approach to true field-direct treatment of actinic keratoses

Zyclara (3.75% imiquimod) cream provides a new field-directed treatment to treat actinic keratoses (AKs) across large areas of sun-damaged skin such as the full face or balding scalp. These premalignant cutaneous lesions appear predominantly on areas of skin exposed to the sun and are one of the commonest skin conditions seen by dermatologists, with recent figures suggesting the prevalence is increasing.

Why use field-directed treatment? Guidelines recommend treating all AKs because of the risk of progression to squamous cell carcinoma (SCC). Some treatments for AKs target clinically evident AK lesion but there is growing recognition that that photodamaged skin is likely to contain visible and invisible subclinical AK lesions across a wide area or field. As a result, field-directed treatment may offer a better approach to achieving good long-term clearance rates by targeting both clinically visible and subclinical AKs at one timepoint and reducing recurrence from subclinical lesions.

Fig 11: Typical actinic keratoses

Advantages compared to previous treatments

- Zyclara (3.75% imiquimod) treats a much larger area of skin than was possible with previous treatments, for example with 5% imiquimod cream (25cm² maximum).
- Clinical studies have shown good efficacy, with two studies showing complete and partial clearance in more than half (59.4%) of patients by eight weeks after treatment of multiple AKs on the face or balding scalp with 3.75% imiquimod.
- Good short-term efficacy translates into long-term clearance, with complete clearance sustained for over 12 months in more than 40% of whose AKs were initially cleared.
- Zyclara is well tolerated, with very few (2/160) patients discontinuing treatment in pivotal trials.
- Patients find the once-daily, two-cycle Zyclara regimen convenient and it helps to encourage good compliance (>95% of patients with compliant in the pivotal study).

Dr Jonathan Bowling, Consultant Dermatologist, Oxford University NHS Hospitals Trust, Oxford, comments: “It is sensible to clear the field when treating AKs. This enables us to find and treat skin changes earlier, which may be a better approach to achieve high long-term clearance rates.” He adds: “Zyclara’s once-daily, two-cycle regimen with two weeks on and two weeks off is simple and easy for patients to follow. Together with good tolerability this should improve adherence.”


Zyclara (imiquimod 3.75%) cream. Indications: Zyclara is indicated for the topical treatment of clinically typical, nonhyperkeratotic, large, visible or plausible actinic keratoses (AK) of the full face or balding scalp in immunocompetent adults when other topical treatment options are contraindicated or less appropriate. Usage: Treatment should be initiated and monitored by a physician. Apply up to 2 sachets, once daily, before bedtime to the skin of the affected treatment area for two treatment cycles of 2 weeks each separated by a 2-week no-treatment cycle or as directed by the physician. The treatment area is the full face or balding scalp. The safety and efficacy of imiquimod in AK in children and adolescents below the age of 18 years have not been established. For external use only. Contact with eyes, lips, and nostrils should be avoided. The treatment area should not be bandaged or otherwise occluded. Apply as a thin film to the entire treatment area and rub in until the cream vanishes. Partially-used sachets should be discarded and not reused. Leave on the skin for approximately 8 hours; after this time it is recommended treating all AKs because of the risk of progression to squamous cell carcinoma (SCC). Some treatments for AKs target clinically evident AK lesion but there is growing recognition that that photodamaged skin is likely to contain visible and invisible subclinical AK lesions across a wide area or field. As a result, field-directed treatment may offer a better approach to achieving good long-term clearance rates by targeting both clinically visible and subclinical AKs at one timepoint and reducing recurrence from subclinical lesions.

Local skin reactions are common but generally decrease in intensity during therapy or resolve after cessation of therapy. Rarely, intense local inflammatory reactions including skin weeping or erosion can occur after a few applications. There is an association between the complete clearance rate and the intensity of local skin reactions. These local skin reactions may be related to the stimulation of local immune response. Imiquimod has the potential to exacerbate inflammatory conditions of the skin. If required by the patient’s comfort or the intensity of the local skin reaction, a rest period of several days may be taken. Treatment can be resumed after the skin reaction has moderated. The intensity of the local skin reactions tend to be lower in the second cycle than in the first treatment cycle. Flu-like systemic signs and symptoms may accompany, or even precede, intense local skin reactions and may include fatigue, nausea, fever, myalgias, arthralgias, and chills. An interruption of dosing or dose adjustment should be considered. Use with caution in patients with reduced haematologic reserve. Patients with cardiac, hepatic or renal impairment were not included in clinical trials. Caution should be exercised in these patients. Use with caution in immunocompromised patients and/or patients with autoimmune conditions and consider balancing the benefit of treatment for these patients with the risk associated either with the possibility of organ rejection or graft-versus-host disease or a possible worsening of their autoimmune condition. No data are available on re-treating AK that have cleared after two cycles of treatment and subsequently recur. Steryl alcohol and cetyl alcohol may cause local skin reactions. Methylparahydroxybenzoate (E218) and propylparahydroxybenzoate (E216) may cause allergic reactions (possibly delayed). No interaction studies have been performed but use caution in patients who are receiving immunosuppressive drugs. Avoid using with any other imiquimod creams in the same treatment area. No data are available on the use of Zyclara during pregnancy or breast feeding and there is no data on the risk to human fertility. There is no or negligible influence on the ability to drive or use machinery. Side effects: Herpes simplex, skin infection, lymphadenopathy, haemoglobin, white blood cell and platelet counts decreased, anorexia, blood glucose increased, arthralgia, headache, dizziness, nausea, diarrhea vomiting, erythema, scab, skin exfoliation, skin oedema, skin ulcer, skin hypopigmentation, dermatitis, erythema multiforme, Stevens-Johnson syndrome, cutaneous lupus erythematosus, skin hyperpigmentation, myalgia, arthralgia, application site effects, including erythema, stinging, exfoliation dryness, oedema, ulcer, discharge, reaction, pruritus, pain, swelling, burning, irritation and rash, fatigue, pyrexia, influence like illness, pain, chest pain. Consult the Summary of Product Characteristics before prescribing, particularly in relation to side effects, precautions and contra-indications. Legal Category: POM Package quantity and basic NHS price: Pack of 28 sachets £113.00. Product licence number: EU/1/12/783/002. Marketing authorisation holder: Meda AB, Pipers väg 2A, 170 73 Solna, Sweden. Date of preparation of prescribing information: January 2013 UK/Zyclar/13/0003

Advertising Feature

Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard. Adverse events should also be reported to Meda Pharmaceuticals Ltd. UK/Zyclar/13/0015 Date of preparation: March 2013.
The sad death of the post-mortem

I recently asked a group of final year medical students how many post-mortem examinations they had seen during their student years. The answers varied between none and one, and most seemed surprised that I even asked the question.

Their experience could not have been more different from my own, now rather distant days at Westminster Medical School (itself now sadly also deceased). Every day, promptly at 1.30 pm, one was expected to attend the Department of Pathology. The Professor of Medicine and senior consultants would all be there, along with housemen and students. The pathologists would then demonstrate their findings from two cases that they had dissected that morning. If one of the cases was one that you had clerked on admission, you would be asked to present a brief history.

It was an extraordinary learning opportunity. To see at first hand a dissecting aneurysm or a pulmonary embolism, for example, was far more vivid than anything that you could have seen in a textbook. More importantly, one also learnt the fallibility of clinical diagnosis, the true cause of death having often proved to be something quite different than what had been expected. As much as anything else, the whole process taught us all humility; as students and juniors we would be deeply struck by the fact that senior, and eminent, doctors still found time to attend and to learn. I still believe that observing a patient’s post-mortem examination is a final act in the caring process.

Nowadays, hospital post-mortems are a rarity. My colleagues tell me that the process of getting consent from relatives is now so long-winded that they have given up asking. Even the number of post-mortems performed by coroners is falling, at least partly for cost reduction reasons (the coroner’s service has to pay for the autopsy); in any case, these are not performed for educational purposes.

In recent months we have been hearing the horrific details of what went wrong at Stafford Hospital. Perhaps most frightening of all is the fact that much of what went wrong there is seen in many other hospitals in the NHS and, albeit on a smaller scale, in our everyday experience of the NHS. The common theme is that doctors and nurses felt pressurised to put less value on the care of individual patients than they do on the corporate need to achieve targets. In doing this, we seem to have lost sight of our real professional purpose. Politicians and managers now seem to have such a controlling influence over how medicine is practised that it is difficult to see how we can fully reverse this process. One small step would be to reintroduce the lunchtime post-mortem demonstration into hospitals. It would be a salutary reminder of our fallibility and a constant reminder of what really matters in medicine.

For those of you who like reading ‘Monk’s moments’ for the jokes, I do apologise if I have been a little more sombre than usual. I hope to get back to my normal level of frivolity and irreverence next time.

Declaration of interest
None declared.
The dermal anchor – an evolving trend

A 22-year-old, morbidly obese Caucasian female, who was 38 weeks pregnant, presented to the emergency room with complaints of sudden onset of diffuse abdominal pain accompanied by nausea and vomiting. This was the patient’s first pregnancy and her prenatal course had been uncomplicated thus far. The patient denied any medical or surgical history, she was given intravenous hydration and labs were drawn. When the labs returned, the diagnosis of acute pancreatitis was made, as evidenced by an amylase of 2,188 u/l and a lipase of 3,154 u/l with all other labs within normal limits. At that point, the patient was sent to have a right upper quadrant ultrasound to rule out gallstone pancreatitis. Imaging results showed a dilated gallbladder with gallstones extending into the neck of the gallbladder, but no evidence of dilation of the common bile duct, indicating an obstructive pathology. The patient was admitted to the labour and delivery antepartum service and was given aggressive fluid hydration as well as narcotics for pain management. Gastroenterology, as well as surgery, were consulted, the consensus being that conservative management was reasonable at this point given the patient’s pregnancy status and the fact that there was no evidence of an obstructive aetiology. On Day 3 of admission the patient had markedly improved clinically and was discharged. At Week 39, the patient was induced and went on to deliver a live born male infant, weighing 3.512 kg, with Apgar scores of 9 and 9. Postpartum Day 1 was complicated by, again, nausea and vomiting and the return of the same pain as seen a week earlier. Labs were drawn and, again, her amylase was elevated at 1,789 u/l, and her lipase was 2,049 u/l. Gastroenterology ordered a magnetic resonance cholangiopancreatography (MRCP), which would determine the aetiology of the recurring pancreatitis.

Dermal anchor

Since the procedure would be done under MRI, a standard screening questionnaire was carried out by the nursing staff and it was found that the patient had a metal stud piercing protruding from her chest. When questioned further by the physician, the patient stated that the tattoo parlour told her that if she wanted to have it taken out, she would need to have a physician do it for her.

The particular piercing the patient had is called a dermal anchor. The piercing had been placed two years earlier in a tattoo parlour in Long Island, New York. Information about the tattoo parlour was obtained from the patient and the parlour was contacted. The parlour said that the piercing is placed with the idea that it is permanent and removal is not discussed with clients, nor is it something that is performed at that particular parlour. The piercing artist went on to say that the dermal anchor – an evolving trend
anchor could be placed on any body surface, with the most popular being the face and chest. He stated that he places approximately six to ten implants a week. The process by which the dermal anchor is placed is done with surgical instruments on any of the six tattoo parlour chairs available when the client shows up for the piercing. The area is prepped with simple isopropyl alcohol and, with the piercing artist wearing latex gloves, a 2–3 mm dermal punch is used to bore a hole in the client’s skin. Once the biopsy has been done, the anchor is grasped by a surgical clamp, a haemostat or Kelly forceps, and slipped in the hole made by the dermal punch. Once the anchor is in place, the head or bead that is seen from the external skin surface is screwed on to the anchor and the piercing is finished. When asked where the tattoo parlour got their surgical instruments, including the dermal punch, he responded, ‘on the internet, of course’. There was no autoclave at their establishment for sterilisation.

Removal
A discussion took place at the patient’s bedside about how she must have no metal on her body when she undergoes the MRCP. She verbally stated her understanding and signed a consent for her piercing to be excised. The area was draped and cleansed with povidone-iodine. An attempt was made to unscrew the external component of the piercing from the anchor, but it was fixed and the anchor was twisting under her skin causing pain, so this was abandoned. Lidocaine hydrochloride 2% and epinephrine were injected around the site and a No. 11 surgical scalpel blade was used to make a 0.5 cm excision at the base of the piercing. The head of the piercing was grasped with Kelly forceps and the piercing was removed. Two interrupted sutures were placed at the incision site with 4-0 Monocryl® (Ethicon) and adequate haemostasis afterwards. The patient tolerated the procedure well.

Shortly after, the patient went for her MRCP. The findings were oedema within the gallbladder wall, with many stones extending to the neck of the gallbladder. Once again, there was no obstruction noted, but the common bile duct was dilated, with the widest point being 1.5 cm. With aggressive hydration and pain medications, the patient improved clinically and was scheduled for a laparoscopic cholecystectomy one week postpartum. The patient underwent the cholecystectomy without complications and made a full recovery.

Conclusion
This report demonstrates a unique obstacle in the medical management of a patient with an acute issue. Body piercing is emerging as a form of body art, with certain non-traditional piercings becoming well accepted in Western society. Because of the intimate nature of many of the piercings, demographic data on body piercing are not easily obtained. The use of unsterilised needles, needle bars, tubes, forceps, jewellery, scalpels and dermal punches can result in blood-borne infections, such as hepatitis B virus, hepatitis C virus and HIV. It is reported that frequent infections (45%) and skin irritations (39%) are prevalent at piercing sites, often because no aftercare instructions are provided to clients getting the piercing. The number of self-reported complications remains around 17–35%. Additionally, findings from recent studies suggest that these individuals look to the internet or return to the piercer for assistance, instead of seeing their healthcare provider, due to concern over the clinician’s perceived lack of adequate knowledge and judgmental perspectives about
body art, and limited educational resources about piercings. Piercers and tattooists generally work without medical supervision, and techniques are often passed on from one piercer or tattooist to another directly. Even though they have become very common, body modifications still exist within the realm of ‘epidemiological silence’. However, they have a significant impact on public health and concern all healthcare professionals, ranging from GPs to emergency units. Regulations on body modifications are heterogeneous, especially in Europe and the USA. While piercers are knowledgeable regarding the techniques and procedures of body piercing, treatment for health concerns and complications related to piercings should be provided by knowledgeable clinicians. Non-judgmental, informative care is crucial when complications arise. Yet, as you work with those who have piercing complications, remember that removing a piercing does not remove the individual’s motive or rationale for obtaining the piercing. Often, within about six months, they might obtain another, so applicable education about piercing care remains vital for preventing further, or repeated, sequelae.

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

References
6. 6. www.medicalnewstoday.com/releases/41238.php (last accessed 20/02/13)

Key points
- A dermal anchor is a piercing that is placed with the intention that it will be permanent.
- Unsterilised piercing equipment can transmit hepatitis B virus, hepatitis C virus and HIV infection.
- There may be reluctance on the patient’s part to report any piercing complications to a healthcare provider because of the concern that they will judge them, or that it will not be something they are qualified to help them with.
- It is important that patients are properly educated about patient care. Even if they have a piercing removed, it is likely that they will go on to obtain another one in the future.

Oxford Specialist Handbooks in Paediatrics: Paediatric Dermatology

Lewis-Jones, S (ed.).
Oxford; Oxford University Press, 2010: £44.99

The great Harold Ellis, Professor of Surgery at Westminster Hospital, was reputed to have told his students, ‘The most important thing to do if the emergency bleep goes off – is to go to the toilet! First, it gives you time to think; second – there may not be time to go later.’ To my mind, the Oxford Handbook series of books were designed as ideal companions for those moments when one is confronted with a problem under pressure, providing the succinct practical advice required in such a situation.

The Oxford Specialist Handbook (OSH) series is a development from the Oxford Handbook of Clinical Medicine series. It is more restricted in focus, but has the same overall aim of providing practical advice in a succinct format. The OSH Paediatric Dermatology does what is says on the tin; it provides an accessible guide to skin problems in children. The authors are members of the British Society for Paediatric Dermatology whose contributions have been skillfully woven together by Sue Lewis-Jones to provide an accessible practical guide for paediatricians, GPs and trainees in dermatology.

The guide adopts a practical format, which is accessible in clinical settings. The topics are arranged by presentation (neonatal problems, body distribution, rashes, colour changes and so forth), so it is easy to quickly get to the right section – once you have mastered the ability to examine skin and clarify in your mind the main features. This is the main drawback. I gave the book to a couple of GP registrars in my clinic. They liked the format, but struggled until they were able to think through what they were hearing, seeing – and feeling with their fingers. The book then became much more useful.

The pictures help greatly and the cross-referencing within the book, and references to guidelines, add considerably to its utility. I particularly liked the line diagrams and the boxes to highlight important practical points.

Clinical medicine is best learned as an apprentice, backed up with reading and theory. This book tries to offer a shortcut, facilitating the rapid formation of a diagnosis and treatment plan. It is probably at its best when used to give a quick ‘heads up’ in clinic, which can then inform the subsequent discussion with the master craftsman.

www.dermatologyinpractice.co.uk
PCDS Spring Meeting 2013

The 2013 Primary Care Dermatology Society (PCDS) Spring Meeting was held in Manchester on 16–17 March. The meeting was addressed by Professors Giuseppe Argenziano and Iris Zalaudek. An alternative programme was held in the morning and also well attended. Resident PCDS surgical trainer Dr Christy Chou led a practical skin surgery workshop.

In the dermoscopy masterclass, Professor Argenziano reminded us of the need to put the clinical and dermoscopic pictures together. He gave us seven rules to avoid missing melanomas.
1. Beware the stand-out lesion (the ‘ugly duckling’) even if small.
2. Inspect the whole skin of high-risk patients.
3. If you cannot say that the lesion is OK after careful dermoscopic evaluation for ten seconds, then it probably is not (ten-second rule).
4. Consider a 12-week follow-up of questionable flat naevi, then excise if you are still unsure at review.
5. Excise doubtful nodular lesions. If these are melanomas, they are too dangerous to leave.
6. Some lesions should be removed if there is a clear history of recent change, even if apparently benign.
7. Review the histopathology if it does not seem to match the clinical picture.

Non-pigmented lesions

In her presentation Professor Zalaudek spoke about vessels in non-pigmented lesions, first reminding us that glass plate contact dermoscopes compress vessels and obscure features. This can be compensated by light touch or using ultrasound gel. A three-step algorithm was proposed: study the morphology of the vessels, study their distribution, and look for additional lesion features (for example, scale or pigmented structures). It was noted that truly non-pigmented melanomas were quite rare – residual pigment could often be seen if looked for. We now talk of hypopigmented rather than amelanotic melanomas.

Truly irregular vessels (mixed-up pattern defying description) suggest malignancy, whether it is Merkel cell carcinoma, atypical basal cell carcinoma, squamous cell carcinoma, cutaneous metastasis or melanoma.

Professors Argenziano and Zalaudek, and colleagues at the International Dermoscopy Society, have posted dermoscopy videos on YouTube.

Hair and nail problems

On Saturday afternoon Dr Andrew Messenger looked at hair and nail problems. Intralosomal triamcinolone was said to often work for alopecia reta when given early on. Inject up to 2 ml in all of 10 mg/ml at various sites just under the dermis, repeating at four-to-eight-week intervals. Atrophy is possible and trials are lacking.

Dr Ophelia Dadzie spoke about hair problems in the black population. Various hair management techniques are used involving heat, metal implants, oils and alkalis. Hair in people of black African descent accumulates more micro knots and fractures, as shown by electron microscopy, and this, combined with highly interventional hairdressing techniques, causes increased fragility.

IMPACT of psoriasis

Professor Chris Griffiths delivered a presentation about the ongoing IMPACT psoriasis studies. These promise to triangulate findings from several areas of investigation, which will hopefully deliver a new evidence-based clinical and holistic approach to the 1.8 million patients we heard live with psoriasis in the UK. Professor Griffiths reminded us, quoting patients’ own words, how dismal many of them felt about the care they were offered. Some spent a lot of money on alternative therapies, or went overseas for methotrexate and instant access ultraviolet light therapy, when others had given up due to their clinician’s perceived lack of interest. A simple intervention, like giving a laminated A4 guide to practices, led to more appropriate referrals. The outcomes of IMPACT are awaited with interest.

The outcomes of IMPACT are awaited with interest

History of skin disease

A fascinating final presentation on the history of medicine, by distinguished medical historian Lesley Smith of the Tutbury Castle Museum, wearing full costume, encouraged us to research medical history of skin disease in former times, a subject on which too little was known. She also gave us – possibly too much – information about personal and sexual matters in the Tudor era. Anyone interested in novel uses of lemons can search on the castle’s website (www.tutburycastle.com).

The above is a much abbreviated account of an exceptional conference. The PCDS continues to grow and build on success; we hope you will join us in future.
For Actinic Keratosis

ZOCLRÁ
3.75% imiquimod cream
An Lmax product

Reveals and treats clinical and subclinical AK lesions

Zyclara 3.75% cream (imiquimod). Indications: Zyclara is indicated for the topical treatment of clinically typical, nonhyperkeratotic, nonpruritic, visible or palpable actinic keratoses (AK) of the full face or balding scalp in immunocompetent adults when other topical treatment options are contraindicated or less appropriate. Dosage: Treatment should be initiated and monitored by a physician. Apply up to 2 sachets, once daily, before bedtime to the skin of the affected treatment area for 2 treatment cycles of 2 weeks each separated by a 2-week no treatment cycle or as directed by the physician. The treatment area is the full face or balding scalp. The safety and efficacy of imiquimod in AK in children and adolescents below the age of 18 years have not been established. For external use only. Contact with eyes, lips, and nostrils should be avoided. The treatment area should not be bandaged or otherwise occluded. Apply as a thin film to the entire treatment area and rub in until the cream vanishes. Partially used sachets should be discarded and not reused. Leave on the skin for approximately 8 hours; after this time it is essential that the cream is removed by washing the area and the hands with mild soap and water. Contraindications: Hypersensitivity to the active substance or to any of the excipients. Warnings and precautions: Lesions clinically atypical for AK or suspicious for malignancy should be biopsied to determine appropriate treatment. Not recommended until the skin has healed after any previous medicinal products or surgical treatment. Use of sunscreen is encouraged, and patients should minimize or avoid exposure to natural or artificial sunlight. Not recommended for the treatment of AK lesions with marked hyperkeratosis or hypertrrophy as seen in cutaneous horns. During therapy and until healed, affected skin is likely to appear noticeably different from normal skin. Local skin reactions are common but generally decrease in intensity during therapy or resolve after cessation of therapy. Rarely, intense local inflammatory reactions including skin reddening or erosion can occur after only a few applications. There is an association between the complete clearance rate and the intensity of local skin reactions. These local skin reactions may result from the stimulation of local immune response, which has the potential to exacerbate inflammatory conditions of the skin. If required by the patient’s discomfort or the intensity of the local skin reaction, a period of several days may be taken. Treatment can be resumed after the skin reaction subsides. The intensity of the local skin reactions tends to be lower in the second cycle than in the first treatment cycle. Flu-like systemic signs and symptoms may accompany or even precede intense local skin reactions and may include fatigue, nausea, fever, myalgias, arthralgia, and chills. An interruption of dosing or dose adjustment should be considered. Use with caution in patients with reduced hematologic reserve. Patients with cardiac, hepatic or renal impairment were not included in clinical trials. Caution should be exercised in these patients. Use with caution in immunocompromised patients and/or patients with autoimmunity conditions and consider balancing the benefit of treatment for these patients with the risk associated with either the possibility of organ rejection or graft-versus-host disease or a possible worsening of their autoimmune condition. No data are available on re-treating AK that have cleared after two cycles of treatment and subsequently recur. Stearyl alcohol and cetyl alcohol may cause local skin reactions. Methyl parahydroxybenzoate (≥ 2%), and propyl parahydroxybenzoate (> 1%) may cause allergic reactions (possibly delayed). No interaction studies have been performed but use with caution in patients who are receiving immunosuppressive drugs. Avoid using with any other imiquimod creams in the same treatment area. No data are available on the use of Zyclara during pregnancy or breast-feeding and there are no data on the risk to human fertility. There is no or negligible influence on the ability to drive or use machinery. Side effects: Herpes simplex skin infection, lichen planus, hyperkeratosis, white birest cell and platelet counts decreased. Anorexia, blood glucose increased, insomnia, depression, headache, dizziness, nausea, diarrhea, vomiting, rhinorrhea, scab, skin excitation, skin oedema, skin ulcer, skin hyperpigmentation, dermatitis, erythema multiforme. Stevens-Johnson syndrome, cutaneous lupus erythematosus, skin hyperpigmentation, myalgia, arthralgia, application site effects, including erythema, swelling, exfoliation, dryness, oedema, ulcer, discharge, reaction, pruritus, swelling, burning, irritation and rash, fatigue, pyrexia, influenza-like illness, pain, chest pain. Consult the Summary of Product Characteristics before prescribing, particularly in relation to side effects, precautions and contraindications. Legal Category: POM. Package quantity and basic NHS price: Pack of 28 sachets £133.00. Product licence number: EU/2279/002. Marketing authorisation holder: Meda AB, Pipars väg 2A, 170 73 Solna, Sweden. Date of preparation of prescribing information: January 2013. UK/ZYC/13/0003

UK/ZYC/13/0005 Date of preparation: February 2013.


Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard. Adverse events should also be reported to Meda Pharmaceuticals Ltd.
well written beneficial in practice excellent reviews clear and well presented very helpful and informative good range of articles easy to read topical I like the format practical advice on management interesting and informative nice clear summaries very relevant materials excellent good layout concise very useful I learnt something new today spot on

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