REFERRAL GUIDELINES
DERMATOLOGY

Click on category to advance to that page:

Acne
- Mild Acne
- Moderate Acne

Naevi
- Benign naevi
- Congenital

Bullous Eruptions
- Pemphigoid
- Pemphigus

Skin cancers
- BCC
- SCC/Bowen’s disease
- Melanoma

Inflammatory Dermatoses
- Eczema/Dermatitis
- Psoriasis

Skin infections
- Bacterial
- Viral
- Parasitic

Services not provided:
- Laser and cosmetic procedures
- Allergy Skin Prick Testing

IMPORTANT:
The following information is required:

Demographic:
- Date of birth
- Contact details (incl. mobile)
- Referring GP details
- Usual GP (if different)
- Interpreter requirements

Clinical:
- Reason for referral
- Duration of symptoms
- Management to date and response to treatment
- Relevant pathology and imaging reports (please refer to specific guidelines)
- Past medical history
- Current medications and medication history if relevant
- Functional status
- Psychosocial history
- Dietary status
- Family history
- Diagnostics as per referral guidelines

PLEASE NOTE: All referrals received by Monash Health are triaged by clinicians to determine urgency of referral.

- Patients assessed as having an urgent need are offered an appointment within thirty days as assessed by the clinician.
- Patients assessed as having a non-urgent need for appointments in clinics where there is no waiting list, are offered an appointments within four months on a “treat in turn basis”.
- Patients assessed as having a non-urgent need for appointments in clinics that have a waiting list, referrers and patients will be notified of the expected wait times. Where the wait time does not meet patient needs, alternative service providers can be found by searching the Human Services Directory at http://humanservicesdirectory.vic.gov.au/Search.aspx

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Acne

Patient Presentation

- Mild Acne: refer to Mx options
- Moderate Acne: refer to Mx options
- Moderate Acne in a female

Initial GP Work Up

- Mild Acne
  - Apply Adapalene & Benzoyl Peroxide Gel nocte
    - if irritation occurs then apply for 2-4 hours only and wash off
    - if tolerated, then use for 3-6 months for maximal benefit
  - Apply Clindamycin Lotion or Erythromycin Gel
    - use for “active” papules or pustules
    - apply several times a day as needed

- Moderate Acne
  - Commence Doxycycline 100mg bd
  - If there is a clinical improvement after 1-2 months, then:
    - The dose can be reduced to 100mg daily (although 100mg bd for 6 months may be required)
    - A 6-12 month course may be needed, and then PRN after this
  - Doxycycline is safe for longer term treatment (assuming there are no GI symptoms, reflux oesophagitis or photosensitivity); it is preferable to Minocycline, which has a risk of hepatotoxicity (albeit low)
  - Alternatives are Cephalexin 500mg tds, Trimethoprim 300mg daily (preferably not combined with Sulfamethoxazole in case of allergy), or Roxithromycin 300mg daily; all for a 6-12 month course
  - Topicals (eg. Adapalene & Benzoyl Peroxide Gel) can be used as well

- Moderate Acne in a female
  - An alternative to oral antibiotics is hormonal therapy
  - Spironolactone commencing 50mg daily and if tolerated titrated to a maximum of 100mg bd
  - Cyproterone acetate, initially as the OCP (2mg daily) and increasing to 50-100mg daily for 10 days each month (together with the OCP to ensure regularity of menstrual periods); NB cyproterone acetate 50mg tablets are not available on the PBS unless there are other signs of hyperandrogenism present, eg. hirsuitism or androgenic alopecia
  - Treatment is for 6-12 months and if effective then these medications can be continued for years if required

Management Options For GP

WHEN TO REFER

- Moderate acne unresponsive to at least 12 months or oral antibiotic or hormonal therapy
- Severe acne (nodules, cysts or scarring (either pock scars or hypertrophic scars))
Bullous eruptions

Patient Presentation
- Bullous Pemphigoid causes tense blisters, often associated with an itchy red rash; typically in the elderly
- Pemphigus Vulgaris causes flaccid blisters which then form crusted erosions on the skin and scalp and usually with painful ulcers in the mouth

Initial GP Work Up
- These uncommon blistering eruptions should be managed by a specialist, including biopsy (which requires immunofluorescence staining)

WHEN TO REFER
- Bullous skin eruptions (i.e. blisters with clear or straw coloured fluid) should be referred to the clinic

Inflammatory Dermatoses

Patient Presentation
- Eczema / Dermatitis

Initial GP Work Up
- Bacterial swab if there is yellow crust
- Viral swab (for HSV) if there are painful erosions

Management Options For GP
- Management comprises a Treatment Phase (topical +/- oral steroids +/- oral antibiotics) and a Maintenance Phase (moisturisers +/- topical steroid 2-3 times a week only)
- Treat active eczema with a potent topical steroid ointment (not a cream), eg. Betamethasone Dipropionate Ointment tds until the rash has completely cleared, say 3 weeks, and then stop or use only 2-3 times a week
- Consider a short course of Prednisolone, eg. 0.5mg/kg/d for 10 days
- Oral antibiotics (eg. Cephalexin) should be considered in addition to topical steroids if there is any yellow crust
- Oral antivirals (eg. Acyclovir) should be considered if eczema herpeticum is suspected or confirmed on a swab
- For maintenance, use of a moisturiser every day (sorbolene cream with glycerine if mildly dry, QV™ cream if moderately dry, Dermoze™ if extremely dry)
- Avoid long hot showers and soap
- Consider wet dressings for acute flares; go to: http://www.monashhealth.org/page/Services/Services_A-E/Eczema_Care/

WHEN TO REFER
- Severe eczema uncontrolled by the measures above
- Consideration of treatment with UVB therapy, Azathioprine, Methotrexate or Cyclosporine
- Instruction of the use of wet dressings (mainly paediatric cases)
Inflammatory Dermatoses cont...

Patient Presentation | Initial GP Work Up | Management Options For GP
--- | --- | ---
Psoriasis | | 

- Assess if the condition is mild (limited plaques), moderate or severe
- For mild disease consider
  - potent topical steroid (e.g. Betametasone Diproprionate Cream) daily for 2 months, or Daivobet Ointment™ daily for 2 months; if this is beneficial then these can be used on and off as needed
  - 12% LPC, 10% salicylic acid, 0.1% dithranol cream (100g, 1 repeat on the PBS) applied for 20 minutes and then washed off, increasing time of application up to overnight; stop if irritation occurs
  - Natural UV exposure on a daily basis (unless there is a concern about skin cancer risk)
- For moderate or severe disease consider
  - Natural UV exposure

WHEN TO REFER

- Moderate or severe disease
<table>
<thead>
<tr>
<th>Patient Presentation</th>
<th>Initial GP Work Up</th>
<th>Management Options For GP</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Stable (in size) pigmented lesions</td>
<td></td>
<td>▪ Naevi are benign and therefore do not require referral</td>
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<td></td>
<td></td>
<td>▪ If a patient has multiple naevi or relatively large numbers of large naevi, then digital photography should be considered and can be done by the patient or GP. This can then be used as a baseline record for reference at future skin checks</td>
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</tbody>
</table>

**WHEN TO REFER**

- The Dermatology Clinic does not perform regular skin checks for benign lesions
- If there is a changing lesion (this is often best confirmed with a comparison with a previous photograph) then the patient could be referred for an opinion about this lesion

| Congenital naevus | | Congenital melanocytic naevi <2cm do not have any risk for melanoma |
|-------------------|--------------------------|
| | Giant congenital naevi (>20cm) have a 5% lifetime risk for melanoma |
| | Intermediate sized congenital naevi have a very small risk for transformation and can be monitored by the patient or GP, or referred to a Plastic Surgeon for excision |

**WHEN TO REFER**

- Giant congenital melanocytic naevi can be referred to the clinic
# Skin Cancers

## Patient Presentation

| BCC | Biopsy |

## Initial GP Work Up

- Biopsy

## Management Options For GP

- Superficial BCCs can be treated with Imiquimod cream prescribed on the PBS (following biopsy)
- Other BCCs (nodular, morphoeic, etc.) can be treated by surgical excision or superficial radiotherapy
- Superficial radiotherapy is an excellent treatment for all BCCs and is available at Peter MacCallum Moorabbin campus. It has an excellent cure rate and initial cosmetic outcome, however cosmetically skin hypopigmentation (chronic radiation dermatitis) occurs after 10-20 years. Therefore it is often reserved for patients over the age of 65 years. There is also a small theoretical risk of the treatment causing a non melanoma skin cancer in the treatment field.

## WHEN TO REFER

- Biopsy is preferred prior to referral
- Consider referral for the surgical management of a BCC (preferably after a biopsy has been performed to confirm the diagnosis)

| SCC / Bowen’s Disease | Biopsy |

## Initial GP Work Up

- Biopsy

## Management Options For GP

- Surgery is the mainstay of treatment for SCC
- Bowen’s Disease does not require urgent treatment; cryotherapy, Efudix Cream™ (bd for 3 weeks) or Imiquimod Cream (5 times a week for 3-6 weeks) are reasonal treatment options. Follow up at 3-6 months and then annually is required to ensure the lesion has cleared and does not recur

## WHEN TO REFER

- URGENT referral is required for SCCs >2cm in diameter; or rapidly growing lesions; or lesions on the scalp, lip or ear; or if the patient is immunosuppressed

| Suspected melanoma | Primary narrow excision for histology |

## Initial GP Work Up

- Primary narrow excision for histology

## Management Options For GP

- Suspected lesions should be excised before referral to ensure a diagnosis is confirmed immediately
- Re-excision with an adequate margin is required for histologically proven melanomas

## WHEN TO REFER

- Histologically confirmed melanoma requiring a re-excision
- Suspicious lesions which are not easy to excise
**Skin infection – bacterial**

**Patient Presentation**
- Folliculitis/furunculosis

**Initial GP Work Up**
- Skin swabs are generally not indicated as most cases are due to community acquired Staph aureus
- If there is a history of frequent “hot tub” use, then consider folliculitis due to *Pseudomonas*, which spontaneously resolves after the hot tub has been adequately cleaned

**Management Options For GP**
- Initially try the use of antiseptics (eg. Triclosan wash applied for 5 minutes and then washed off in the shower; initially daily and then once the condition is under control 3 times a week as preventative treatment)
- Oral antibiotics are usually needed
  - Cephalexin 500mg tds for 1-3 months (available on a PBS Authority Prescription); if this is effective then similar courses can be used on and off as needed; sometimes a course over 6 months is needed, in the same manner as the treatment of acne
  - Alternatively Doxycycline 100mg bd over a similar time period can be tried

**WHEN TO REFER**
- Recurrent extensive disease unresponsive to standard therapy, especially if causing significant debility
- Scalp folliculitis causing scarring alopecia (folliculitis decalvens)
- Recurrent “boils” in the axillae, groin or submammary regions, as this may be hidradenitis suppurativa, a condition which may cause extensive scarring if not treated adequately

**Skin infection – Viral**

**Common warts**
- Keratolytic therapy is first line. There are various OTC preparations of salicylic acid; most containing 15-30% sal. acid
- Cryotherapy is second line for patients who are able to tolerate it (generally not suitable for children less than 12 years old)
  - Wart should be frozen for 5-10 seconds (i.e. should be solid white for 5-10 seconds) and repeated every 2-4 weeks until completely resolved
- DCP therapy is suitable for children or where cryotherapy has failed; it is preferable to initially sensitise with a 2% solution and to have some experience with the use of this treatment

**Plantar warts**
- OTC keratolytic therapy is first line. A preparation of at least 20% is required
- A 70% salicylic acid paste can be applied, either by the doctor and kept on for 1 week, followed by paring of the wart +/- re-application; alternatively patients can be prescribed this preparation (made up with linseed oil or olive oil into a paste) and applied nocte
Skin infection – viral cont...

Patient Presentation

- Plane (flat) warts
- Genital Warts

Initial GP Work Up

Management Options For GP

- Cryotherapy is generally not useful as plantar warts are too “deep” and treatment is very painful; however, smaller warts may sometimes respond to freezing
- DCP therapy as above
- Intralesional bleomycin is the most effective treatment but is very painful and for specialist use only

- Plane (flat) warts
  - Try a topical retinoid (eg. Adapalene & Benzoyl Peroxide Gel) or Benzoyl Peroxide Gel (eg. 5%) applied 1-2 times a day to induce an irritant reaction; try for 3-4 weeks, reducing frequency of application if irritation occurs
  - Imiquimod Cream 5% applied daily for 2-3 weeks; an irritant reaction should be expected and generally would indicate likely success; the cream cannot be prescribed under the PBS for this indication
  - Cryotherapy is an effective treatment. It should be applied for a short period only (less than 5 seconds) and repeated every 1-2 weeks; caution should be applied if the skin is pigmented as hypopigmentation may result with excessive treatment; if cryotherapy is not tolerated, then the prior application of EMLA cream or equivalent could be considered

- Genital warts
  - Cryotherapy every 1-2 weeks is effective for “external” warts (intravaginal or intrarectal warts require gynaecological and surgical assessment respectively, with a view to diathermy). Consider EMLA or AnGel cream applied prior to cryotherapy to enable a sufficient dose to be administered
  - Podophyllotoxin is an over-the-counter preparation that can be self-applied by the patient
  - Imiquimod Cream 5% applied 3 times a week for 12 weeks can be considered after the main visible warts have been reduced in size with cryotherapy, however this treatment is not always needed
  - HPV vaccine is worthwhile considering

WHEN TO REFER

- Consider referral for DCP therapy or intralesional Bleomycin (plantar wart)
### Skin infection – viral cont...

#### Patient Presentation
- Mollusca contagiosum

#### Initial GP Work Up
- Ensure any concomitant eczema is adequately treated
- The most effective treatments for mollusca are cryotherapy and Cantharone™ (see below)
- Tape stripping (e.g. Micropore™ tape applied over the mollusca and changed at bath time) and Benzoyl Peroxide Gel (2.5% or 5%) bd can be used to induce an irritant reaction
- In children (say 6-12 years old) cryotherapy can be tried with EMLA applied 1 hour prior; freezing for 5 seconds may be sufficient; repeat every 2 weeks
- Cantharone™ (cantharadin) is applied by a doctor directly to each lesion, causing an irritant or blistering reaction; treatment is repeated every 4 weeks

#### WHEN TO REFER
- Consider referral if Cantharone™ is required

### Skin infection – Parasitic

#### Scabies

#### WHEN TO REFER
- Failure after recurrent treatments with Permethrin

#### Management Options For GP
- Permethrin 5% Cream applied for 8-12 hours
- Ivermectin 12mg (four 3mg tablets) stat
- For both of these treatments consider repeating 10 days later
- Itchiness may yet take several weeks to completely settle