EDITORIAL
What do NHS changes mean for our ‘Cinderella’ speciality?
BDNG Conference 2014: why change the formula? Moving on and evolving
Show your strengths and increase your profile

CLINICAL SKILLS
Surgical skin cancer management
Nursing patients with xeroderma pigmentosum in the UK

PRACTICE DEVELOPMENT
Habit reversal for habitual scratching in younger children with atopic eczema

CASE REPORT
‘Do you want to know what grinds my gears?’ A 14-year-old boy coping with atopic eczema
Challenges of leprosy diagnosis: a perspective from Nepal

PODIATRY FOCUS
Friction foot blisters: a review of the risk factors, treatment and prevention

CLINICAL STUDY
Screening for psychological distress in patients with a chronic skin disease

REFLECTIONS
The next step towards a PhD: practical issues around data collection and analysis

RESEARCH REPORT
Antibiotic use in children may increase eczema risk

ASK THE PHARMACIST
Drug shortages, tan enhancers and generic substitution

NEWS AND VIEWS
Conference 2013
Our prize journey to the ADNA, Sydney
‘Wound Healing and Skin Integrity’ book review
UK DCTN: update of activities
Scottish Dermatological Nursing Society celebrates 10 years
Non-medical prescribing news/Mind & Skin Special Interest Group
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References:

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What do NHS changes mean for our ‘Cinderella’ speciality?  
Nick Evans  
6

BDNG Conference 2014: why change the formula? Moving on and evolving  
Carrie Wingfield  
8

Show your strengths and increase your profile  
Rebecca Penner  
10

Surgical skin cancer management  
Nadine Hachach-Haram, Jenny Geh  
12

Nursing patients with xeroderma pigmentosum in the UK  
Sally Turner, Katie Mullard, Hiva Fassihi, Robert Sarkany  
20

Habit reversal for habitual scratching in younger children with atopic eczema  
Christopher Bridgett, Iman Ogoo  
28

‘Do you want to know what grinds my gears?’ A 14-year-old boy coping with atopic eczema  
Harvinder Tagger, Mark Gibbs  
32

Challenges of leprosy diagnosis: a perspective from Nepal  
Max deSanche, Edmund Wee, Ashok Sheresthra  
34

Screening for psychological distress in patients with a chronic skin disease  
Satveer Mahil  
41

The next step towards a PhD: practical issues around data collection and analysis  
Tracey Riley  
42

Antibiotic use in children may increase eczema risk  
Andrew Sibley  
44

Drug shortages, tan enhancers and generic substitution  
Rod Tucker  
46

Dermatology services in Hull and East Yorkshire  
Janet Osgerby  
49

Living with lupus  
Jane Dunnage  
50

Our prize journey to the ADNA, Sydney  
Heather Baines, Tracey Thompson  
58

‘Wound Healing and Skin Integrity’ book review  
Karina Jackson  
59

UK DCTN: update of activities  
Carron Layfield  
60

Scottish Dermatological Nursing Society celebrates 10 years  
Sheila Yosef  
61

Non-medical prescribing news/Mind & Skin Special Interest Group  
Kathy Radley/Reena Shah  
62
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What do NHS changes mean for our ‘Cinderella’ speciality?

Nick Evans

It's nearly two years since I stopped full-time work after almost 40 years as an NHS manager. However; the habits of a working life die slowly, and as well as continuing to wake up at 6am every morning (although I no longer get up) I still experience the same reaction when I see or hear NHS headlines. What sort of reaction? Well, it will be familiar to many of those reading this journal — a mixture of pride, anxiety, protectiveness and worry; the precise blend being determined by the media coverage and how close the particular item is to my home territory. The NHS seems to be more in the headlines than ever before, with emergency and acute services inevitably to the fore. I say ‘inevitably’, because media and public interest will always focus on the lifesaving, the high tech and the cutting edge in healthcare. However, alongside the interminable fly-on-the-wall TV coverage of acute care (everything from air ambulances to A&E departments to emergency surgery — and that’s just tonight) there is a developing political and public debate about the need for the NHS to change if it is to be able to meet the changing needs of our growing and ageing population in the future.

When I first began to learn about dermatology services 13 years ago, the ‘Cinderella’ label was widely used, and with some justification. Starved of funding, disregarded by managers and a mystery to many clinicians, skincare services were experiencing the sort of crisis that is beginning to afflict acute services across the wider NHS now. As we might expect, the sorts of changes embraced by the dermatology world over the last decade — developing the capacity of general practice, making better use of nursing skills, seamless service provision across primary and secondary care, reducing the volume of care delivered in acute hospital settings — are now being floated as necessary and essential for the wider NHS if it is to continue to deliver for us all into the future. Alongside the debate about acute services, the financial pressures and the ever-increasing demands for care, we are also seeing one of the greatest structural reorganisations of the NHS has ever experienced.

The advent of Clinical Commissioning Groups finally puts the commissioning process in the hands of GPs, who are beginning to be faced with making decisions about the best use of limited resources available for their patients’ care.

So what does all this mean for skin disease and its care now? Despite the changes and improvements achieved by the dermatology community in the last 10 years (and they are considerable), it seems to me that there remains a whiff of crisis in the air. Levels of training in dermatology in general practice remain very variable, access to specialist services is still woeful in some parts of England, and spending on skincare services remains an easy and tempting target for hard-pressed commissioners.

What can we do as the dermatology community? I am fortunate in having recently taken on the role of chairing the advisory group to the All Party Parliamentary Group on Skin, a group set up 20 years ago precisely to increase understanding about skincare issues in Parliament, and to achieve improvements in the treatment and management of patients with skin disease. In doing so I have once again been struck by the level of commitment and engagement, not just between healthcare professionals, but encompassing patient organisations, the drug industry, MPs and peers. Dermatology is rare, if not unique, in having this engagement, and it remains one of its great strengths. Paradoxically, alongside this strength, skin disease and skin care continue to struggle with a low public profile. ‘Paradoxically’ because the widespread nature of skin disease and the absence of ‘quick-fix’ cures might suggest a greater level of public interest than seems to be the case, although skin conditions do now seem to feature regularly on Embarrassing Bodies. This latter may offer something of an explanation — many skin diseases carry social stigma, with sufferers reluctant to reveal or discuss their conditions with others.

Skin disease and its care continue to suffer from a low profile. This is something that we must all address in our daily encounters with the wider world. So what can we do as the dermatology community? I am fortunate in having recently taken on the role of chairing the advisory group to the All Party Parliamentary Group on Skin, a group set up 20 years ago precisely to increase understanding about skincare issues in Parliament, and to achieve improvements in the treatment and management of patients with skin disease. In doing so I have once again been struck by the level of commitment and engagement, not just between healthcare professionals, but encompassing patient organisations, the drug industry, MPs and peers. Dermatology is rare, if not unique, in having this engagement, and it remains one of its great strengths. Paradoxically, alongside this strength, skin disease and skin care continue to struggle with a low public profile. ‘Paradoxically’ because the widespread nature of skin disease and the absence of ‘quick-fix’ cures might suggest a greater level of public interest than seems to be the case, although skin conditions do now seem to feature regularly on Embarrassing Bodies. This latter may offer something of an explanation — many skin diseases carry social stigma, with sufferers reluctant to reveal or discuss their conditions with others. 

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BDNG Conference 2014: WHY CHANGE THE FORMULA? MOVING ON AND EVOLVING

Carrie Wingfield

As most of our members are aware, the British Dermatological Nursing Group has made a firm decision regarding the future organisation of the annual conference, with the 2013 meeting really being the dry run. For the 23rd conference in July this year, the BDNG took on all of the administration for the first time, resulting in a more streamlined and cost-effective level of management with no financial loss. As from 2014, the BDNG will be holding a separate conference from that of the British Association of Dermatologists, but will coincide dates in the same city with adjoining venues. If this is news to some of you, please refer to our website for the background to this decision.

After the success of the 2013 conference, with record attendance of 313 members — including those who attended the launch of our new Dermatology Nursing School — you may well ask “why change the formula?” The consistent reply is that all organisations have to evolve, develop and respond to change; to stay static just because that is the way it has been is a grave and unrealistic error for any organisation, charitable or otherwise. But more specifically, taking into account the BDNG’s limited financial resources, changes to the way the BAD is making financial donations to charitable organisations such as ourselves was threatening to put the overall success of our conference in jeopardy and limit our financial forward planning.

After the conference the BAD, following an educational grant bid from the BDNG, donated £20k to our organisation, which was received with great gratitude. However, this sum is not guaranteed on a recurring annual basis and does not wholly support the true costs of the conference. We also have to remember that we are not an organisation whose total educational resources revolve around a three-day event, but we are one that supports regional BDNG educational events throughout the year — these are now better attended and more affordable to many of our members, as demonstrated by your replies to our recent educational survey.

Although there were no comments from attendees at this year’s AGM following the announcement of the separate conference, and despite a 75% vote in favour of the separate conference, we are well aware of members’ misgivings, concerns and the unspoken anxiety that has filtered back to the executive committee about moving away from the BAD conference. We ask that you have faith and give some credence to the BDNG as a professional organisation that has as much value, standing and credibility for dermatology nurses as the BAD has for its medical membership. Please be reassured that we are still working with the BAD on many other projects and will continue to do so, as reinforced by the joint statement published on our website by Professor Bunker and myself.

The 23rd BDNG Annual Conference —
Glasgow, 30 June-2 July, 2014

Next year’s conference will be held in the Crown Plaza Hotel, Glasgow, which is an adjoining venue to the SECC where the BAD will be holding their event. We will be supported by industry and there will be a BDNG gala dinner open to all BDNG delegates at no extra cost. This will be held on the first night of conference so as not to clash with the BAD dinner. We have moved the President’s dinner out of the conference as it was felt that two dinners at conference is not required and this will be held at a later date in the year with smaller attendance.

We will continue with the Stone Achievement Award and Team Award and these will now be presented at the gala dinner instead of at the AGM. We will be looking to expand the awards for dermatology nurses in future years.

The 2014 educational programme has already been written following the evaluations of the 2013 conference and our thanks to all of you who submitted. We are in the process of finalising the programme together with our corporate sponsor packages. The programme thus far will include:

- 33 educational lectures
- Best Practice workshops
- Specific educational stream for experienced nurses
- Derm Nursing School
- Treatment challenges
- Conference dinner dance and awards included in delegate fee.

We intend to advertise this as early as we can in the autumn with full details, including accommodation and travel.

I sincerely hope that you will continue to support the BDNG in its goal of providing dermatology education to our members, and look forward to seeing many of you next year in Glasgow. Thank you to all who have voiced your opinions. Despite the inevitable frustrations that go with making the final call, they really helped to frame how we conducted this transition.
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Dosage: Cream – apply to dry skin areas as required and rub in. Bath additive – Adults: add one or two capfuls; Children: add half/one capful to a warm water bath or apply with a wet sponge to wet skin before showering. Contra-indications: Hypersensitivity to any of the ingredients. Special Warnings and Precautions: Care should be taken if allergy to any of the ingredients is suspected. Care should also be exercised when entering or leaving the bath. Avoid contact with the eyes. Side Effects: (Refer to the SmPC) Very rarely, mild allergic skin reactions including rash and erythema have been observed, in which case the product should be discontinued.


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New look packs for 2013
Show your strengths and increase your profile

Rebecca Penzer

had a great time at conference this year. I thought the programme was outstanding and showed a real shift away from the modular approach to more substantial talks with plenty of content. I met up with some old friends, but what struck me was that there were fewer of us ‘old guard’ around and instead lots of new and enthusiastic faces — I think this bodes well for the future of dermatology nursing. I just hope that the organisations we work for recognise the level of commitment, skill and intellect they have within the speciality.

I suspect, however, that we will have to get ever more creative about making sure our employers do understand what we do and how we add value to patients and their families. Being part of an organisation like the BDNG may provide you with some avenues for increasing your profile. How about the following as some ideas?

1) Write a unit profile for the journal — this is relatively straightforward, requiring around 700 words describing what you do, a bit of history about your service and what the future may hold. Pictures are always welcome. This is great publicity for you and your employer.

2) Nominate a colleague for the Stone Award. As conference approaches there will be a call for nominations for a nurse who has made a significant contribution to dermatological nursing. This is not a lifetime achievement award, but instead is there to recognise people who go above and beyond and have really made a contribution to dermatological nursing. The application process is not arduous and, again, it is a wonderful way of highlighting the work of dermatology nurses in your area.

3) Write an article for the journal. Getting published is always impressive and a way of catching the attention of your employer (and yes, I know I am always nagging about putting your thoughts onto paper for the journal, but that’s what an editor is supposed to do!)

4) Submit a poster for conference next year. Start thinking about it now so that you give yourself plenty of time.

Our ever wonderful managing editor, Julia Pearey, sent me an email in August entitled ‘September issue and mild panic’. Now, Julia never panics so I knew this was serious. We were having some problems with copy for our next issue of Dermatological Nursing. With the best planning in the world this sometimes happens, as expected articles don’t arrive or are being rewritten following review; it is one of the vagaries of producing a journal. In the end we are fine and you should be holding a substantial issue containing plenty of interesting articles. But this is a perfect opportunity once again for me to say… Keep Julia Sane — write an article for DN!

As always, the article that hits me hardest in this issue is the Patient Voice. It is so frustrating to read of services that do not measure up and we need to be doing so much more to meet the psychosocial needs of people with skin disease. We also have a case study of a 14-year-old boy with eczema, who describes the frustrations of living with the condition, and a contribution from the mum of a child with eczema, who describes how she used the Combined Approach to transform her child’s life.

All these are great examples of how we use the journal to explore directly the impact of skin disease on patients’ lives. Perhaps you should send a copy of the journal, highlighting the relevant articles, to your boss or employer to reinforce the message that skin disease is never ‘just skin’ to those with the conditions.

And finally…some great news. You may remember that the Ichthyosis Support Group were very actively campaigning at conference to get us to sign up to support their application to the National Lottery. All their hard work has paid off as they have won the National Lottery Award for a Project in the Health Category. Congratulations to Mandy and the team — what a fabulous achievement! For more information about the award see the ISG web page at: www.ichthyosis.org.uk/ichthyosis-support-group-win-national-lottery-award-2013/. We will be featuring more on the ISG’s success in the next issue of the journal.
Tough on moderate atopic dermatitis, gentle on her skin...

**References:**

**Elidel® Prescribing Information.** Elidel 10mg/g cream. **Presentation:** 6g. **Contraindications:** Treatment of patients aged 2 years and over with mild or moderate atopic dermatitis where treatment with topical corticosteroids is either inadvisable or not possible. This may include: intolerance to or lack of effect of topical corticosteroids or use on the face and neck where prolonged intermittent treatment with topical corticosteroids may be inappropriate. **Doseage and administration:** Apply a thin layer of Elidel to the affected skin twice daily and rub in gently and completely. For children (2-11 years) and adolescents (12-17 years) the posology and method of administration are the same as for adults. Cream may be applied immediately after Elidel. **Contra-indications:** Hypersensitivity to pimecrolimus, other macrolactams or to any of the excipients. **Precautions:** Elidel cream should not be used in patients with congenital or acquired immunodeficiencies or in patients on therapy that causes immunosuppression. It should not be applied to potentially malignant, pre-malignant skin lesions or areas affected by acute cutaneous viral infections (herpes simplex, chicken pox). Elidel has not been evaluated for its efficacy on malignant, pre-malignant skin lesions or areas affected by acute cutaneous viral infections (herpes simplex, chicken pox). Elidel has not been evaluated for its efficacy and safety in the treatment of clinically infected atopic dermatitis. Before commencing treatment with Elidel, clinical infections at treatment sites should be cleared. In the presence of herpes simplex skin infection (Elidel treatment at the site of infection should be discontinued until the viral infection has cleared. Patients with severe atopic dermatitis may have an increased risk of skin bacterial infections (impetigo) during treatment with Elidel. Use of Elidel may cause mild and transient reactions at the site of application such as a feeling of warmth and/or burning sensation. If the application site reaction is severe, the risk-benefit of treatment should be re-evaluated. Care should be taken to avoid contact with eyes and mucous membranes. If accidentally applied to these areas, the cream should be thoroughly wiped off and/or rinsed off with water. Physicians should advise patients on appropriate sun protection measures, such as minimisation of the time in the sun, of sunscreen product and covering the skin with appropriate clothing. Elidel contains corticosteroid and alcohol which may cause local skin reactions and propylene glycol, which may cause skin irritation. In transplant patients, prolonged systemic exposure to intense immunosuppression following systemic administration of calcineurin inhibitors has been associated with an increased risk of developing lymphomas and skin malignancies. Patients who receive Elidel 10mg/g cream and who develop lymphadenopathy should have the etiology of their lymphadenopathy investigated in the absence of a clear etiology for the lymphadenopathy or in the presence of acute infectious mononucleosis. Elidel 10mg/g cream should be discontinued. Patients who develop lymphadenopathy should be monitored to ensure that the lymphadenopathy resolves. Elidel is not recommended in patients with neutropenia, patients with a history of or who are at risk of developing lymphoma. Elidel should not be used during pregnancy. Breastfeeding mothers may use it but should not apply it to the breast in order to avoid unintentional oral uptake by the newborn. **Undesirable effects:** Skin infections; allergic reactions; skin discoloration (e.g. hypopigmentation, hyperpigmentation); alcohol intolerance, application site burning, irritation, pruritus, erythema, rash, pain, paraesthesia, desquamation, dryness, oedema; anaphylactic reactions. Prescribers should consult the Summary of Product Characteristics in relation to other side-effects. Special precautions for storage: Do not store above 25°C. Do not freeze. **Legal category:** POM. **Marketing Authorisation Holder:** Meda Pharmacuticals Ltd, Skewrey House, Parsonage Road, Takeley, Bishops Stortford CM22 6PU. Date of amendment of prescribing information: January 2012.
Skin cancer is the most common form of cancer (Martinez, Otley, 2001) with an incidence rate that has quadrupled over the past 30 years, higher than any of the top cancers in the UK (Skin Cancer UK, 2013). Multidisciplinary efforts both in primary and hospital-based settings are required to promote effective strategies for prevention, diagnosis as well as treatment (Martinez, Otley, 2001; Skin Cancer UK, 2013). Treatment usually has 3 main goals: early detection, complete eradication, and the preservation or restoration of form and function (Martinez, Otley, 2001). This is where the role of the sub-speciality plastic surgeon/skin cancer surgeon in the multidisciplinary team is key. The aim of this article is to give an overview and some insight into the role of the skin cancer plastic surgeon, to outline commonly and rarely performed procedures, and to provide a description of the post-operative course that the patient is likely to encounter if surgery is undertaken. The more common forms of cancers are discussed in this article, which are basal cell carcinomas (BCC), squamous cell carcinomas (SCC) and melanomas (MM).

Incidence
In 2010, 12,800 people were diagnosed with malignant melanoma, a rate of 17/100,000 pop, and 99,549 people were diagnosed with non-melanoma skin cancer (including SCC and BCC), a rate of 113/100000 pop (Skin Cancer UK, 2013).

The incidence of melanoma and BCC is on the rise in the younger, working age group (Skin Cancer UK 2013). Reasons for this may include the increasing popularity of overseas holidays with increased sun exposure. However, it is also common to see these types of cancers in older patients with multiple comorbidities (Skin Cancer UK, 2013; Fleming et al, 1995). Factors such as diabetes, asthma, cardiac implants, stents, transplants and the use of drugs, which can affect surgical outcomes, are enquired about and need to be anticipated. Mobility and aftercare can be significant issues, especially when recovery requires a degree of immobilisation (Neville et al, 2007; Fleming et al, 1995).

Treatment options
Multiple factors need to be considered when deciding on a course of treatment for skin cancer: These include disease factors such as the type of skin cancer, histopathological subtype, size and location, and patient factors such as comorbidities, fitness for surgery, life expectancy and psychosocial factors (Martinez, Otley, 2001; Neville et al, 2007), as well as treatment factors such as the local facilities, skill set available, restoration/preservation of function, cosmetic outcome and the subsequent morbidity (Martinez, Otley, 2001; Neville et al, 2007). In tandem with the increase in incidence rates, there has been an increase in treatment options available, necessitating multidisciplinary team management to decide on the best treatment options for the patient (Neville et al, 2007).

Skin cancer operations range from simple biopsies to complex chemotherapeutic interventions, as well as Mohs micrographic surgery and robotic-assisted surgery. Ultimately, the key to effective treatment is early detection (Fleming et al, 1995), prompt treatment and complete excision (Neville et al, 2007; Fleming et al, 1995). Treatment can be ablative, involving cryotherapy and curettage, Mohs micrographic surgery, surgical excision and radiotherapy (Martinez, Otley, 2001; Neville et al, 2007; Fleming et al, 1995). Some of the more rarely performed procedures, seen only in a few centres in the UK, are described.

The role of the skin cancer surgeon is to decide on the safest and most effective way to treat the patient, using the most appropriate surgical incisions for reconstruction once the tumour is excised.

For skin cancer, surgery is considered the main form of curative treatment (Martinez, Otley, 2001; Neville et al, 2007; Fleming et al, 1995). The role of the skin cancer surgeon is to decide on the safest and most effective way to treat the patient, using the most appropriate surgical incisions for reconstruction once the tumour is excised. It is not always straightforward, as evidenced by the wide range of treatments that can be offered to a patient with even the most common form of skin cancer, BCC.
We will describe a range of common reconstructive options available to the surgeon, as well the post-operative care for each. Size is not so much of a concern as the site of the tumour and tissue loss. The concerns of reconstruction are first and foremost functional and then cosmetic and, finally, the reconstruction of a small area of specialised tissue such as the nose can be very complex.

There is a group of patients who are not fit for, or may choose not to have, surgery and have chronic wounds that need to be supported by the specialist skin surgeon (Figure 1).

Commonly performed procedures
When melanoma is removed with a wide, local excision, all the subcutaneous tissue to the level of the fascia should be excised and most lesions can be closed directly. When this is not possible, other reconstructive tools need to be considered. The use of common techniques to replace tissues will be discussed.

Skin graft
Skin grafting is the transplantation of skin from one part of the body to another (McGregor, 2000). Classically, a skin graft is the most common procedure in plastic surgery (McGregor, 2000). They can be full thickness, including the epidermis and dermis, or partial thickness/split skin graft, including the epidermis and part of the dermis. The donor site is closed directly leaving a straight-line scar. A partial thickness/split skin graft, where the skin is taken as a superficial shaving of the epidermis and part of the dermis, leaves a raw area to heal by secondary intention (McGregor, 2000). Split skin grafts can be performed under local anaesthetic if the patient can tolerate it (Figure 2).

This results in a donor site that can be very moist as it heals (McGregor, 2000), and can also be painful and itchy. The inner adherent dressing should be left in tact for at least 14 days. The outer, often moist dressings should be replaced at 1 week.

Post-operatively, significant care is required at the grafted site. Fortunately, these dressings can all be left intact for 1 week before being reviewed (McGregor, 2000). Specialist nurses form a fundamental part of the team in supporting these wounds post-operatively. Healing can take more than 2 weeks. Protective dressings can be required for that time. Skin grafts can sometimes appear to have lifted off until the wounds are seen at 3 to 4 weeks. Both these sites should be kept out of the bath or shower for at least 2 weeks, but thereafter may be healed enough to allow washing. Immunosuppressed patients can carry a higher risk of slow wound healing.

Tumours which extend to the bone cannot be grafted and require complex reconstructive surgery. One way to close such defects is the use of artificial dermis and a split skin graft (Figures 3 & 4). Examples are Integra© (Integra LifeSciences, Plainsboro, NJ) (McGregor, 2000; Chalmers et al, 2010). Otherwise, vascularised tissue such as local flaps or free tissue transfer may be required.

Local flaps
Local flaps can be used to replace ‘like for like’ tissue from a nearby site (McGregor, 2000). This involves moving the local tissue, without disconnecting it, to fill a defect (Figure 5). Risks associated with raising local flaps include new areas of scarring, bleeding, dehiscence, loss of part or the entire flap, swelling of the flap and paraesthesia (McGregor, 2000).
The use of a local flap can mean sutures are present for 1 to 2 weeks post-operatively. Although flaps have remained on their blood supply, they still may be compromised by bleeding, swelling or pressure and require monitoring (McGregor, 2000). Small areas can appear to open up during the first week or two. If this occurs, these are usually dressed and kept moist to allow for healing by secondary intention. Otherwise flaps are usually fine to wash.

Free tissue transfer
This involves moving vascularised tissue from one part of the body to another. These are complex operations for which the patient must be carefully consented and prepared for.

Less commonly offered procedures found only in specialist units
Sentinel node biopsy (SNB) in the management of melanoma
The management of melanoma has evolved over the years (Holmes et al, 1977), particularly when considering the management of regional lymph nodes (Holmes et al, 1977). Factors that are important in providing prognostic information are Breslow thickness, mitotic rate, and ulceration (Mitra et al, 2010). More significantly, the sentinel node status has been identified as the single most important prognostic factor. No significant overall survival benefit has been demonstrated, but this remains the most accurate prognostic test for melanoma (Mitra et al, 2010).

The sentinel node was first identified by Morton et al in 1992 as “the initial lymph node upon which the primary tumour drains” usually via a lymph vessel originating from the tumour (Morton et al, 1992) (Figure 6).

SNB identifies occult regional metastasis (Andtbacka, Gershenwald, 2009). Patients with stage IB or above are offered an SNB and are counselled about the procedure and the risks involved (Andtbacka, Gershenwald, 2009). A trained surgeon should carry out this procedure. The patient must be fit enough to tolerate a general anaesthetic and agree to the procedure and completion dissection

Lymphoedema is the main unwanted complication of groin/pelvic dissection, and has around a 30% rate of occurrence: this can be permanent.

If further disease is found (Andtbacka, Gershenwald, 2009), the patient is consented for the technique, which involves the use of a radioisotope scan and an intradermal injection of blue dye (Andtbacka, Gershenwald, 2009). Allergic reactions can occur and the test may not yield a result because of technical issues (Andtbacka, Gershenwald, 2009). Other risks include seroma formation, lymphoedema and failure of the technique. The patient must be made aware that the sentinel node test is a prognostic test only. It does not guarantee that spread has not occurred, but has been shown to be the most sensitive prognostic test available, especially if the Breslow’s depth, ulceration and mitotic rate are not clear from the initial primary melanoma (Mitra et al, 2010, Andtbacka, Gershenwald, 2009).

It is important that complete excision biopsies are performed if an MM is suspected, as incision biopsies can lead to sampling errors or disrupt the true Breslow’s depth. SNB generally should not be performed after wide local excision has occurred as the lymphatics around the area may have been disrupted. Ideally SNB, if indicated, should be offered at the same time as the wider excision. Lesions suspicious for MM should be excised and biopsied by a trained skin surgeon.

Complete lymph node dissections
A complete block dissection (CLND) is an operation to remove the entire basin of lymph nodes from a site identified as having lymph node involvement. It can be offered after a positive SNB or histopathological and radiological confirmation of metastatic melanoma. It is usually performed in the groin/pelvis, the axilla or the head and neck.

Groin/pelvic dissection
The BAD guidance advises groin dissection alone for micrometastases, but groin and pelvic dissection for more than two palpable nodes (Marsden et al, 2010). This operation is performed under a general anaesthetic. Patients may need to have a catheter placed for 24 hours and the scar will be from the right iliac fossa and across the groin crease into the thigh (Figure 7).

Lymphoedema is the main unwanted complication, and has around a 30% rate of occurrence; this can be permanent. A compression garment worn day and night for six weeks post-surgery has been shown to reduce the risk of lymphoedema in some patients (Johnson et al, 1982). We therefore prescribe two garments, above waist to toe compression garments, measured for and applied from day 1 post-op if possible for 6 weeks. Furthermore, when the pelvis has been entered, there is a small risk of a hernia occurring, so activities such as heavy lifting and sudden twisting are restricted for 6 weeks post-operatively.

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Reference:

Figure 8(a). Da Vinci® robotic system (Intuitive Surgical, Sunnyvale, CA, US) being used during pelvic node dissection. (b) Abdomen post-op: minimal scarring with the use of laparoscopic ports/Da Vinci system. The bruising is secondary to Clexane injections given for four weeks post surgery. (c) The four-arm Da Vinci® Si (Intuitive Surgical, Sunnyvale, CA, US).

and wound breakdown. Post-operatively they need drains for at least 2 weeks, and 28 days of post-operative low molecular weight heparin should be considered in patients undergoing extensive lymph node clearance as they are at higher risk of thrombosis. Local guidelines on venous thromboembolism prophylaxis should be followed.

For those patients who need only pelvic dissection, a retroperitoneal access incision or an abdominal wall incision can be performed. However, at Guy’s and St Thomas’, in the suitable patient, the skin cancer surgeon would offer the patient a pelvic complete dissection using the surgical robot to aid in reducing the postoperative stay recovery time and the risk of abdominal hernia developing. To our knowledge, this is not routinely offered in any other unit in the UK.

The Da Vinci® robotic system (Intuitive Surgical, Sunnyvale, CA, US) has afforded the skin cancer surgeon a magnified three-dimensional vision that allows for robot-assisted pelvic node dissection (Figure 8), with enhanced dexterity and confidence that meticulous clearance can be performed (Ross et al, 2013) avoiding complications associated with open dissection. This technology is still new with a steep learning curve and its development has allowed patients to be discharged earlier; with reduced surgical scars.

Axillary dissection
The axillary block dissection for MM is different to that of breast cancer in that the lymph nodes are removed from both the armpit and the back of the pectoralis minor. These patients are also drain-dependant post-operatively (Figure 9) and this can continue for up to several weeks (Marsden et al, 2010). Lymphoedema following axillary dissection occurs at a rate of 10-30% (Starritt et al, 2004) and is less common compared to axillary lymph node clearance for breast cancer as only two levels are cleared (Starritt et al, 2004). An arm sling is often provided to patients who have undergone this procedure to help alleviate heaviness of the arm, but caution should be applied to immobilisation as they are prone to stiffness, both from the shoulder and the axillary incision. Post-operative physiotherapy can often be required.

Figure 9. Post-op axilla dissection shows the scar along the axilla and drains in situ. These are kept in until the drainage is minimal.
The procedure of neck dissection has a similar post-op course, but drains here tend to be in for a shorter period of time. There is a risk of injury to the major structures and nerves of the head and neck, thus the patient must be fully informed. Patients having head and neck surgery should be treated within the remit of a head and neck multidisciplinary team.

**Surgical procedures available to the skin cancer surgeon for the management of non-melanoma skin cancer (NMSC)**

**Mohs reconstruction**

Mohs micrographic surgery is a technique that involves excising the lesion followed by simultaneous histopathological analysis to assess for complete clearance of the tumour margins (Fleming et al, 1995; Mohs, 1978). This technique has the ability to allow tissue-sparing resection of tumours. Once the margins are cleared the patient can be left with a defect that needs complex reconstruction. We manage these in teams with Mohs surgeons resecting the tumours and the plastic surgery team reconstructing the defect.

Certain anatomical areas are more difficult to reconstruct than others. For example, in patients with nasal tumours, skin as well as the underlying cartilage may be lost and this requires a staged reconstruction. The skin surgeon can harvest septal, conchal or rib cartilage to reconstruct the underlying scaffold followed by a forehead flap to replace the lost skin. This staged reconstruction will necessitate serial procedures under general or local anaesthesia.

**Other techniques for symptomatic control of local recurrence in skin cancers**

**Ablative therapy**

Ablation of lesions may be required for palliation of symptoms. Not all tumours can be completely excised for cure. Some lesions can be debilitating in terms of the need for dressings, the offensive odour (Figure 10) or the anaemia caused by prolonged, chronic bleeding. This may be carried out as a local or general anaesthetic day case with excision or ablation of the tumour by cutting, cautery or CO2 laser.

**CO2 laser**

Historically CO2 laser was used for aesthetic resurfacing; however, it is also part of the armament of the skin cancer surgeon treating a select group of patients with low-risk skin cancer, namely BCC (Holt, 1988) and actinic keratosis (Holt, 1988).

Based on a study carried out by Humphreys et al, pulsed CO2 laser treatment can be effective in ablating superficial BCC, making sure a 4mm margin is used and at least 3 passes applied (Humphreys et al, 1998). However, we would prefer surgical excision and histological examination of the margins in BCCs if possible. The CO2 laser is also indicated for the destruction of multiple, small in-transit metastases, particularly on the limbs for melanoma. This is particularly helpful if they arise in a widespread pattern.

This procedure is usually carried out in day-surgery theatre and requires local anaesthesia to help the patient tolerate the discomfort (Krupa Shankar et al, 2009).

**Cryosurgery**

Cryosurgery is the application of extreme cold effects, usually liquid nitrogen, to cause deep destruction to abnormal as well as normal tissues (Lee, Miller, 2009). It is a useful office-based treatment in the management of pre-cancerous skin growths as well as low-risk NMSC, such as superficial BCC and pre-cancerous lesions such as actinic keratoses (Telfer et al, 2008; Lee, Miller, 2009). This is carried out in 3 cycles of 20-second treatments per area (Telfer et al, 2008).

Cryosurgery can be carried out in the outpatient setting and does not require anaesthesia (Telfer et al, 2008; Lee, Miller, 2009). Again these wounds are usually left to heal by secondary intention, with daily wash and the use of antibiotic cream.

Cryosurgery carries the risk of hypo-pigmentation, pain and discomfort, hypertrophic scarring, alopecia and recurrence (Lee, Miller, 2009). Patients are usually warned that blistering and redness may develop as part of the inflammatory process and that this will settle.

Appropriate laser safety is necessary. Post-operatively, topical antibiotics such as chloramphenicol are applied and hydrocolloid dressings are used (Krupa Shankar et al, 2009). Occlusive dressings can be kept for up to 5-7 days to allow the healthy granulation tissue to develop (Krupa Shankar et al, 2009).

It is a well-tolerated procedure and produces good cosmesis. Patients must be advised that they may require repeat procedures and about the risk of hyper-/hypo-pigmentation and the importance of sunscreen. It is useful on patients with multiple in-transit lesions. It is commonly used in those with small, lower limb in-transits from melanoma.

**Photodynamic therapy (PDT)**

This is a technique of chemo-destruction using a photosensitising agent, applied topically. This is available via dermatology services, and is not widely practised by skin cancer surgeons. It is a technique more suited to superficial BCCs, present in larger areas and is offered by specialist dermatology units.

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We manage these in teams with Mohs surgeons resecting the tumours and the plastic surgery team reconstructing the defect.

**Figure 10. Ablative surgery can be used to treat fungating lesions. CO2 laser can be used to treat multiple smaller lesions.**

Curettage and electrodesiccation involves the use of a sharp curette followed by electrodesiccation to destruct the base of the tumour (Johnson et al, 1982) and is indicated for well circumscribed NMSCs usually <1 cm (Johnson et al, 1982). It can be a popular technique for those with multiple tumours. The principal of curettage is based on the premise that tissue invaded by tumour is more friable than normal skin architecture and therefore will be easily curetted allowing the base to be treated with cautery. Usually these wounds can be left to heal by secondary intention (Johnson et al, 1982). The use of CO2 laser to ablate multiple small tumours requires regular dressings for at least two weeks post surgery.

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Non-resectable metastases can be dealt with by way of electrochemotherapy or ECT (NICE, 2013). This is a relatively new treatment option for patients with skin cancers (BCC, SCC and MM) (NICE, 2013) that has been extensively used now in Europe, and there is data from randomised control trials, such as the Multicenter European Standard Operating Procedure of Electrochemotherapy (ESOPE) project (Gehl et al, 2006) and non-randomised trials (NICE, 2013) to support its continued use. ECT involves the injection of bleomycin, a chemotherapeutic agent, into the tumour. The passage of an electric current via two probes simultaneously allows the passage of the agent into the tumour cells by increasing cell membrane permeability, thus enhancing the cytotoxic effect of the drug (NICE, 2013). The electric current can cause muscle spasms and pain, therefore patients require a general anaesthetic. The tumour is monitored and previous cases have shown that it begins to resolve and reduce over a period of around 2 to 4 weeks (Gehl et al, 2006). Promising results have been shown in skin metastases from recurrent breast cancer. This is now a NICE recognised treatment for skin lesions.

ECT can be carried out in day surgery and after treatment; a dry dressing can be applied. Dressing support and review are required for around 6 weeks post-operatively.

Isolated limb perfusion & infusion

This procedure, only offered in four units in the UK, can be useful in local disease control for a limb affected by recurrent melanoma or other skin cancers. It is an invasive procedure which is performed in specialist units for those patients who are fit enough to tolerate it. It is beyond the scope of this article.

The Skin Team

The skin cancer surgeon is one of many members of the Skin Team, including the dermatologist, clinical nurse specialist, oncologist, histopathologist, radiologist, psychologist and the patient. The role of the multidisciplinary team is to meet regularly to discuss cases, carry out research and audit and agree on the favoured treatment options and improve continuity of care. The clinical nurse specialist provides care and support to the patients. Any member of the team can also act as the key worker: The skin cancer surgeon is vital in deciding the safest and most effective way to treat the patient surgically, taking into account cure, restoration of form and function as well as cosmetic outcome. Advances in skin cancer treatment mean many options can be available and it is important that the patient is involved in the decision-making process.

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**References**


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Item code: UKSOY1554

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Job code: UKSOY1650. Date of preparation: February 2013
‘Children of the night’ and ‘moon children’ are examples of the names used to describe those with xeroderma pigmentosum (XP), a severe, lifelong, genetic DNA repair disorder. Those with XP live their life in potential fear of daylight, which has the ability to harm them. Normal everyday tasks many people take for granted expose people with XP to skin cancer-inducing ultraviolet (UV) radiation. However, if protective measures are put in place early in life, some of the complications seen from XP — in particular skin cancers — can be reduced or avoided altogether. This article looks at the national specialised service that was established at St John’s Institute of Dermatology, London, in 2010. The service provides a new model of care for XP patients of all ages in the UK, centred around the XP CNS working as an autonomous outreach practitioner as well as being part of a hospital-based XP multidisciplinary team. The patient’s care is shared between local services and the national XP centre.

**Key words**
- Xeroderma pigmentosum
- Clinical Nurse Specialist (CNS)
- Genetic skin disorder
- Photo protection
- Skin cancer

**Key points**
- Developing a national highly specialised XP service
- Role of the XP Clinical Nurse Specialist
- Caring for patients with xeroderma pigmentosum

**Introduction**

The National Xeroderma Pigmentosum (XP) specialist centre is based at St Thomas’ Hospital and treats all patients from around the UK with the rare hereditary DNA repair disorder xeroderma pigmentosum. The aims of the service are to provide a consistent excellent standard of care to any patient diagnosed with XP in the UK, from aiding with diagnosis to providing expert advice to both patients and those caring for these patients. This includes support through initial diagnosis to education about the condition and suggestions on how to ‘live’ as safely as possible to minimise the high risk of skin cancers developing. How the service has evolved from a nursing point of view will be highlighted.

**What is xeroderma pigmentosum?**

XP (meaning dry, pigmented skin) was first described by Hebra & Kaposi (1874). It is an autosomal recessive inherited condition (*Figure 1*) affecting both males and females whatever their race. This means if both parents are carriers there is a 1 in 4 (25%) chance of having a child with the condition.

**Autosomal recessive inheritance**

![Figure 1](commons.wikimedia.org)
In Western Europe the incidence is estimated at 2.3 per million live births (Kleiger et al, 2008).

The normal DNA nucleotide excision repair pathway is defective in those with XP, meaning when the skin is exposed to ultraviolet radiation (UVR) it is unable to repair the damage caused (Lehmann, 2011). XP is subdivided into 8 groups: A-G and XPV, depending where along the repair pathway the defect occurs.

Clinical symptoms

There does appear to be a wide variety of clinical symptoms both within each group and between each group (Lehmann et al, 2011). A summary of these can be seen in Table 1. Even with a ‘normal’ nucleotide excision repair (NER) there is an established and well-documented link between sunlight damaging the skin and skin cancers in the general population. So if this pathway is defective, there is an estimated 10,000-fold increase in non-melanomas developing in patients diagnosed with XP, with age 9 being the reported medium of the first cancer and a 2,000-fold increase in melanomas under the age of 20 years (Bradford et al, 2011). Those diagnosed can also experience ocular involvement ranging from ocular surface problems, eyelid abnormalities and neuro-ophthalmology to eye cancers (Ramkumar et al, 2011).

Some patients have also been found to have neurological involvement, including hearing loss, loss of reflexes, peripheral neuropathy, ataxia and memory loss (Bradford et al, 2011). The neurological symptoms these patients experience is an area recognised as needing more research as it is not connected to UV radiation exposure. A theory is that the typical metabolism in the central nervous system produces oxidative damage and maybe the NER is involved in repairing some of this.

An aim of the national service is to highlight these symptoms to health professionals, therefore increasing awareness. If XP is suspected, a patient should be referred to the service using the contact details at the end of the article. We welcome telephone calls from any nurse or health professional if they wish to discuss how to refer in more detail or have questions about potential XP symptoms seen in their patients.

**Diagnosis**

If XP is suspected from the clinical picture in a family with no previous history of the condition, a punch skin biopsy is obtained from a non-sun-exposed site, typically the buttock. This biopsy is sent to the Genome Damage and Stability Centre, University of Sussex. If XP is diagnosed, further tests often identify the defective gene (complementation analysis) and causative mutation (Lehmann et al, 2011).

**National XP service**

As a joint collaboration between the XP support group headed by Sandra Webb (a mother of a child with XP), Dr Robert Sarkany (Consultant Dermatologist at St John’s Institute of Dermatology) and Prof Alan Lehmann (Professor of Molecular Genetics at Sussex University), it was recognised that those diagnosed with XP could benefit from a national specialist service. Funding from the Department for Health was granted in 2010. Since April 2013, NHS England is now responsible for this funding and commissions all the highly specialised services, which were set up to improve the lives of those affected by very rare diseases of which XP is one (http://www.specialisedservices.nhs.uk/).

Prior to 2010, some patients already received good care from their local dermatologist, but this wasn’t always the case and very few patients also had access to a good ophthalmologist, neurologist, geneticist, and psychologist who knew about XP.

The service now consists of a diverse multidisciplinary team (dermatologist, dermatology surgeon, neurologist, psychologist, ophthalmologist, diagnostic scientist, clinical nurse specialists (CNS), geneticist and XP Support Group). Two CNSs, one for paediatrics and one for adults, have been employed since 2011. They are the only full-time members in the team and so are seen as the central point of contact for both patients and those caring for them.

**Development of XP nursing service**

When the nurses were first appointed there were around 40 patients already referred to the service. This has since grown to 72 patients. The distribution of these referrals can be seen in Figure 3. By various members of the team each targeting their own specialty, the profile and awareness of the condition has grown and referrals are being made from around the UK to the XP national service.

As XP CNSs it has been challenging to learn all about the condition to become experts. We were lucky enough to be awarded a grant from the British Dermatological

![Figure 2. Lentigines on an adult with XP.](image-url)
Nursing Group (BDNG) to go to Bethesda, Washington DC, to spend a week with the only other nurse who has extensive experience of XP working at the National Institute of Health. This centre is a large research facility catering for the whole of the US. This was an invaluable experience and, although the model of care is different here in the UK to that in the US, important international links have been established. A collaboration of consultant colleagues, the XP Support Group and those affected by XP have all contributed towards our growing expertise in caring for those with this condition. We are now in a position to educate our peer group and have used the BDNG national conference as a platform from which to present our work.

Caring for patients with XP
At present there is no cure for those diagnosed, but skin symptoms can be hugely improved by appropriate protection (Lehmann et al, 2011). The sooner a patient can be diagnosed, the earlier these protective measures can be discussed with the patient.

The XP CNS can help educate and support these patients through diagnosis and throughout their lives.

### Table 2.

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<th>Photo protection measures.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sun behaviour and lifestyle</strong></td>
</tr>
<tr>
<td>- High factor sunscreen 50+ with a high UVA rating to be applied 2-3 hourly to all sun-exposed sites</td>
</tr>
<tr>
<td>- Lip balm with a high SPF</td>
</tr>
<tr>
<td><strong>When outside</strong></td>
</tr>
<tr>
<td>- Long-sleeved/legged clothing, dense weave fabric</td>
</tr>
<tr>
<td>- Gloves/socks to cover extremities</td>
</tr>
<tr>
<td>- Hat, not forgetting back of neck</td>
</tr>
<tr>
<td>- Visor with UV protective film (Figure 4)</td>
</tr>
<tr>
<td>- Wrap-around sunglasses/thick glasses to protect eyes</td>
</tr>
<tr>
<td>- Long hairstyles can help with protection</td>
</tr>
<tr>
<td><strong>When inside</strong></td>
</tr>
<tr>
<td>- UV can penetrate glass, so windows to be checked for UVR, and clear protective UV window film can be applied if necessary. This is for the house as well as the car</td>
</tr>
<tr>
<td>- Light bulbs can emit UVR, these can be tested with a UV meter and covered or changed</td>
</tr>
</tbody>
</table>

Photo protection
As it is known that those with XP cannot repair damage caused by UVR, it makes sense to protect against it — ie photo protection. A summary of suggested measures to reduce exposure to UVR and advice given to patients on protection from UVR can be seen in Table 2. These are in

Figure 3. Distribution of patients with XP in the UK.

Figure 4. Child wearing UV protective clothing.
For
• Inflammatory psoriasis
• Atopic dermatitis
• Seborrhoeic dermatitis of the scalp

ELOCON® CREAM, OINTMENT AND SCALP LOTION
mometasone furoate
PRESCRIBING INFORMATION
Please refer to the full Summary of Product Characteristics (SPC) text before prescribing this product.
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 MSD (tel: 01992 467272).

PRESENTATION: Elocon Cream 30 g or 100 g; Elocon Ointment 30 g or 100 g, containing 0.1% w/w mometasone furoate; Elocon Scalp Lotion 30 ml bottle containing 0.1% w/w mometasone furoate. USES: Elocon Cream and Ointment are indicated for the treatment of inflammatory and pruritic manifestations of psoriasis (excluding widespread plaque psoriasis) and atopic dermatitis. Elocon Scalp Lotion is indicated for the treatment of inflammatory and pruritic manifestations of psoriasis and seborrhoeic dermatitis of the scalp. DOSAGE AND ADMINISTRATION: Elocon Cream or Ointment: A thin film of cream or ointment should be applied to the affected areas of skin once daily. Elocon Scalp Lotion: A few drops of scalp lotion should be applied to affected scalp sites once daily and gently massaged in. CONTRAINDICATIONS: Elocon should not be used on wounds or skin which is ulcerated or in hypersensitivity to mometasone furoate, other corticosteroids or to any of the ingredients. Elocon Cream or Ointment: Facial rosacea, acne vulgaris, skin atrophy, perioral dermatitis, perianal and genital pruritus, nappy eruptions, bacterial, viral, parasitical and fungal infections. PRECAUTIONS: Erolcon treatment should be discontinued if irritation or sensitisation develops or in the presence of infection not adequately controlled by antifungal or antibacterial therapy. Systemic absorption can cause reversible hypothalamic-pituitary-adrenal (HPA) axis suppression with a potential for glucocorticosteroid insufficiency after withdrawal of treatment. Efficacy and safety of Elocon in patients below 2 years of age have not been established. In the event of contact with the face (cream and ointment only) or in children should be restricted to 5 days and occlusion should not be used. Long-term continuous use should be avoided in all patients irrespective of age. Use in psoriasis may result in rebound relapse following withdrawal, the risk of rebound is greater in extensive or widespread plaque psoriasis. As with all glucocorticoids, avoid sudden discontinuation. When long-term treatment is stopped, a rebound phenomenon can develop which takes the form of dermatitis with intense redness, stinging and burning. This can be prevented by slow reduction of treatment, e.g. intermittent usage before discontinuation. Glucocorticoids can change the appearance of some lesions and make it difficult to establish adequate diagnosis and delay healing. Elocon topical preparations are not for ophthalmic use, care must be taken to keep the preparation away from the eyes, including the eye-lids because of the very rare risk of glaucoma simplex or subcapsular cataract. The cream, ointment and scalp lotion contain propylene glycol which may cause local skin irritation. The cream also contains hydroxy alcohol which may cause local skin reactions (e.g. contact dermatitis). PREGNANCY AND LACTATION: During pregnancy treatment with Elocon should only be given on the physician's order and application on large surface areas over a prolonged period of time should be avoided. There is inadequate evidence of safety in human pregnancy, therefore the benefit/risk to the patient and fetus should be carefully considered. Like other topical glucocorticoids, the possibility that fetal growth may be affected by glucocorticoid passage through the placental barrier should be considered. During lactation treatment with Elocon should only be administered after careful consideration of the benefit/risk relationship. If treatment with higher doses or long term application is indicated, breast-feeding should be discontinued. SIDE EFFECTS: Refer to SPC for complete information on side effects. Local reactions include: very rare (1/10,000): folliculitis, burning sensation, pruritus; not known (cannot be estimated from data available): infection, furuncle, paraesthesia, dermatitis contact, skin hypopigmentation, hypertrichosis, skin striae, dermatitis acnetiform, skin atrophy, application site pain or reactions, skin dryness, irritation, dermatitis, peri- oral dermatitis, skin maceration, milia and telangiectasias. Psoriatic patients may demonstrate greater susceptibility to topical corticosteroid-induced hypothalamic-pituitary-adrenal axis suppression and Cushing's Syndrome. Other less common and rarely reported side effects are listed in the SPC. OVERDOSE: Excessive prolonged use can suppress HPA function, resulting in secondary adrenal insufficiency which is usually reversible. If HPA axis suppression is noted, attempts should be made to withdraw the drug, reduce frequency of application or to substitute for a less potent steroid. Accidental oral ingestion is unlikely to produce harmful effects due to the low steroid content of each container. Basic NHS Price: Cream: 30 g = £4.36; 100 g = £12.58; Ointment: 30 g = £4.32; 100 g = £12.44; Scalp Lotion: 30 ml = £4.36. Marketing Authorisation numbers: Elocon Cream – PL 00025/0577; Elocon Ointment – PL 00025/0578; Elocon Scalp Lotion – PL 00025/0579. Marketing Authorisation holder: Merck Sharp & Dohme Limited, Hodfod Road, Hoddesdon, Hertfordshire EN11 9BU, UK.
addition to the recommendations given to the general public about sun protection to reduce incidences of skin cancers (NICE, 2011).

UVR can be found in all types of daylight including sun and shade. UVR can also pass through window glass (Almutawa et al, 2013) and can be found in light emitted from some types of light bulb. However; as bulbs are continually evolving it is difficult to be prescriptive as to which are safe and which are not. It would also depend on how far away the bulb will be from the affected person (Klein et al, 2009).

Exactly how much UVR is needed to cause DNA damage, whether it is a one-off insult or a build-up of cumulative damage in a person with XP, is not known. It is still unclear whether this varies between people and between complementation groups. But as UVR is invisible it can be hard for patients to know when they are exposing themselves to levels that they may be able to reduce with some simple precautions. This is where a UV meter, a device that can indicate if UVR levels are high or not, can sometimes be useful. It is not a medical device so should be used with caution and in conjunction with good judgement. Details of these can be found at www.gstt.nhs.uk/xp.

In a recent department audit, 87% of patients with XP who had a meter felt it had altered how they managed their photo protection.

As is the case with many chronic conditions, patient compliance with professional health advice can be a challenge (WHO, 2003) and this is no different with XP. This has been recognised and is something that we are planning on researching further to enable us to help this population.

School/university/workplace visits
Due to the photo protective measures required to maintain maximum safety from UVR in every aspect of a child’s and adult’s life, the XP nurses have been able to provide an outreach service to these establishments to help educate staff and advise on measures required to maximise UVR protection for the patient. This involves meeting key staff and educating them about XP in addition to assessing UVR risk around the building.

A checklist for schools was devised (Table 3). Visits are arranged with consent from the patients and families.

Although this outreach is available to all patients with XP, it is the children and young adults in full-time education that have consented to these visits; working adults have preferred to discuss their UV protection rather than have an outreach visit. Results of these visits are soon to be published.

A yearly teachers’ XP study day, to enable those with a pupil at their school to meet others to swap tips and ideas, meet the XP team and learn more about the condition, is now in its second year and has had positive evaluation.

Outreach home visit
Patients are also offered an outreach visit by the XP CNS to their homes. This has proved particularly helpful around diagnosis when sometimes a patient can feel overwhelmed by information given in a clinic environment. It gives them time to consider questions regarding their diagnosis and to invite other family members, if wanted, to hear more about XP in a familiar environment. It also provides an opportunity to have their house assessed for UVR risk so suggestions can be made on how this can be improved and how any modifications can be achieved.

For other patients who may find travelling to London difficult, home visits have helped by keeping them up-to-date on new developments within XP and have provided an opportunity for the XP CNS to meet the local health/social care professionals involved in that patient’s care, cementing good shared care.

To ensure equitable access to the XP national service these home visits are offered to all patients with XP in the UK, irrespective of where they live.

**XP clinics**
Multidisciplinary clinics are held on the 2nd Friday (adults) 4th Friday (children) and 5th Friday (young adults) in the month. These are held at St Thomas’ Hospital in London. They consist of 45-minute appointments on a rotation, seeing members of the MDT during the morning, up to 5 appointments each. At lunchtime the team meets to discuss the patients seen and the care required. The afternoon is spent with investigations as required — hearing tests, nerve conduction studies, neuropsychology testing, photography and skin surgery. The patients see the lead consultant for full feedback and a chance to ask questions or catch up with research. These appointments are followed up with a detailed clinic letter to local clinicians and services involved in that patient’s care.

Patients are educated to have knowledge of what to be aware of and who to contact if they are concerned about any suspicious lesions on their skin between appointments. This may be the XP service or a local contact depending on the individual and what services are available locally.

As many of our patients have low vitamin D levels, as a result of photo protection, vitamin D levels are checked.
Skcin have now launched the ‘Sun Safe Schools’ Award Scheme. A comprehensive on-line resource assisting primary schools across the UK in their duty of care to ensure that our children grow up with sufficient knowledge of sun safety and that primary school children are adequately protected against the sun’s harmful rays.

If you would like to assist the project by encouraging primary schools in your area to get on board please contact: charlotte.fionda@skcin.org  For further information about the initiative please visit:

www.sun safeschools.co.uk
and patients prescribed supplementation as required.

Follow-up appointments are offered on an individual basis. It is suggested that most patients are seen at least yearly in this specialist clinic and by a dermatologist every three months to ensure precancerous skin lesions can be removed at an early stage (Fassihi, 2013). These three-monthly appointments are often by the local dermatologist.

In between visits liaison between local services is proactive as required.

**Patient education material**
Apart from the published leaflets (Table 4), which have proved useful to parents and adults with XP, it has been highlighted that there is little information and resources available to teach children about XP. This is currently being addressed. We are working with interested parents, who are being proactive in developing books aimed at promoting discussion between an adult and child about XP, and ideas for board games and educational materials are also in development.

**Feedback from patients**
To monitor the quality of the service one of the measures is patient satisfaction. The feedback has been exceptional, with any constructive comments leading to service improvements. Feedback from patients is also obtained via the patient support group, which also has been positive.

<table>
<thead>
<tr>
<th>Table 4.</th>
<th>Leaflets available for those with XP.</th>
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<tbody>
<tr>
<td>Xeroderma pigmentosum</td>
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<tr>
<td>When a child with xeroderma pigmentosum is starting at your school</td>
<td></td>
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<tr>
<td>Vitamin D and xeroderma pigmentosum</td>
<td></td>
</tr>
<tr>
<td>Useful resources for xeroderma pigmentosum</td>
<td></td>
</tr>
<tr>
<td>Transition from child to adult services for people with xeroderma pigmentosum</td>
<td></td>
</tr>
<tr>
<td>Xeroderma pigmentosum: using a UV meter</td>
<td></td>
</tr>
<tr>
<td>Xeroderma pigmentosum clinic</td>
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</table>

**The future**
The priority of the national XP service is to continue to provide excellent clinical care to those with the condition. There are, however, still many unanswered questions regarding XP. Having a large cohort of these patients enables opportunity for research to help improve future knowledge and subsequent care. Many of these patients are consenting to being included in this research for the future.

International links are also being developed to share ideas between countries and to promote excellent XP care wherever a patient may live.

**Conclusion**
Although there is currently no cure for XP, we hope that raising awareness of the condition and its common signs and symptoms will lead to earlier diagnoses for these patients. Once a diagnosis is made, meticulous UV protection can be implemented, leading to better outcomes and quality of life.

Having a national service for this rare condition means that patients and families can feel supported rather than isolated. In addition, seeing a large cohort of patients with XP at one centre enables us to advance our knowledge of the condition and to carry out research that could lead to significant improvements in medical and nursing care. The XP CNS is central to the multi-disciplinary service, working with the patients’ local health services to maintain continuity of care. The role of the CNS will continue to evolve in order to meet the needs of the service and this unique patient group.

**Sources of further information**
XP Support Group — offers advice and practical help to anyone affected by XP t: 01494 456 192 e: info@xpsupportgroup.org.uk w: www.xpsupportgroup.org.uk

www.gstt.nhs.uk/xp — for advice on how to refer, and also to download the leaflets listed in Table 4.

**References**


With over half of children reluctant to have cream applied, many parents worry that they’re not treating their child’s eczema well enough. In fact, in a recent survey of over 500 parents, 79% told us that they use distraction methods to encourage them to comply.

That’s why we developed ‘Beat the Itch with QV’, a game for children with dry and sensitive skin conditions such as eczema. The app, available on iPhone and iPod Touch, features our loveable bear, Qool Vince, in a race against time to apply his QV emollients before he gets too itchy.

It’s a fun, interactive way to distract children during the often challenging task of applying emollient and can help improve compliance.

Tell parents to download their FREE ‘Beat the Itch with QV’ app now from the App Store, or visit www.qvskincare.co.uk for more information.

www.qvskincare.co.uk
Habit reversal for habitual scratching in younger children with atopic eczema

Christopher Bridgett, Iman Ogoo

The Combined Approach to atopic eczema, using behaviour modification to optimise conventional treatment, was first introduced by a Swedish dermatologist, Dr Peter Norén, in the 1980s. In the first part of this article, Christopher Bridgett suggests how this approach, which combines habit reversal with topical treatment, can be successfully used to treat younger children, either in a clinical setting or using a self-help format. In the second part, a patient’s mother, Iman Ogoo, relates how the self-help format of the approach transformed the life of her two-year-old son.

In the 1980s, research in Sweden (Norén, 1995) showed that combining the behaviour modification technique habit reversal with optimal use of standard topical treatment produced better results when treating atopic eczema than when standard treatment is used on its own. The Combined Approach to atopic eczema has been since used successfully mainly with adults and older children (Bridgett, 2000), but the manual for practitioners also has a chapter describing an adapted programme for younger children, together with a suggested protocol and a patient’s handbook (Bridgett et al 1996; www.atopicskindisease.com).

The main evidence base for both of these programmes remains the findings of the original research with adults, where the participants were instructed through face-to-face contact. However, the instructions require the treatment to be carried out as a self-help approach, away from the clinical setting. Further research may clarify the importance of having face-to-face clinical instruction and support, but the case report below aims to illustrate that such support is by no means essential for a successful outcome. If it is included, it requires no special training in behaviour therapy.

For all children the programme necessarily involves their parents, and the younger the child, the more the parents need to be involved. This is especially so for children younger than four years, for whom the following programme is appropriate. It may be important when planning the use of this programme to consider if either of the parents have chronic atopic eczema. If this is the case, they will benefit from first tackling their own condition with The Combined Approach before following the approach with their child. Discovering the effectiveness of the programme for themselves can be an important preliminary to embarking on the approach with their child.

When the approach is offered as a clinic-based programme, it is recommended a series of clinic visits are arranged, first for assessment, next for treatment, then for follow-up, as set out in the suggested protocol.

Assessment
The Combined Approach may be indicated for a child when atopic eczema seems not to be responding completely to topical treatment; over time it relapses and remits without clearing up altogether. Between episodes of acute eczema, or ‘flares’, the skin is affected by chronic eczema, or lichenification. Chronic eczema is especially associated with acute flares. At assessment there may be both acute and chronic eczema present; although the focus of The Combined Approach is on treating chronic eczema, any acute eczema present will be treated at the same time by the treatment programme.

Key words
- Chronic atopic eczema
- Younger children
- Educational programme
- Optimised topical treatment
- Habit reversal

Key points
- Chronic atopic eczema in a child can be associated with profound negative quality-of-life effects for both the child and the child’s family.
- Chronic atopic eczema is usually associated with inadequate use of standard topical treatment and habitual scratching.
- The Combined Approach is an easy-to-follow educational programme that can clear chronic atopic eczema in a few weeks.
- It can be used successfully in a self-help format, or as a clinic-based approach with minimal professional support.

Christopher Bridgett is a Fellow of The Royal College of Psychiatrists, Honorary Clinical Lecturer at Imperial College School of Medicine, London, and an Honorary Member of the British Association of Dermatologists. Iman Ogoo is a mother of three and lives in London, where she runs Imanmade — Natural Skin Care, providing handmade skin products for sensitive skin.
At the first appointment the link between chronic eczema and habitual scratching is explained. The nature of habitual behaviour is reviewed and habit reversal introduced, referring to the patient handbook. Habits are largely unconscious and need making conscious to change them successfully. For adults and older children a hand tally counter is used by the patient over a week to achieve this. This also shows how much scratching is happening, and also when. However, for younger children a tally counter is unnecessary. The parents, and others that can be recruited, replace the hand tally counter. Over a few days three lists are drawn up. The first is of all the trigger factors that seem to make the child’s eczema worse. The second is of all the things that the child enjoys doing, especially those that will keep his hands busy. Finally, by watching the child for a couple of days, all the situations and activities that are especially linked with the child’s scratching are noted, and listed in the handbook. This is then referred to when planning treatment.

Treatment
The treatment programme is set out in the patient’s handbook. As for adults and older children, it is important with younger children to ensure topical treatment is optimal by reviewing its rationale, and giving clear instructions regarding areas to be treated and potencies of topical steroids to be used (NICE, 2007). While acute eczema responds to a few days’ topical treatment, chronic eczema requires up to four weeks’ treatment with The Combined Approach. For the first intensive phase of habit reversal a period of four days is planned involving enough people to ensure that the child has someone with them all of the time, night and day. A long weekend may prove ideal.

During this period, as well as the use of optimised topical treatment with emollient and topical steroids, those involved take it in turns to ensure that the skin is left alone by the child for long enough, without anyone ever saying “Stop scratching!”

The emphasis needs rather to be on what should be done. Reference is made to the second list above for ideas to use: habit reversal for a young child consists of distractions and diversions — with careful attention to those times and activities when scratching is known to be likely. With the young child, during the first intensive period of the programme, this must include dealing with scratching while asleep, for example by holding the hands, offering soothing encouragement, and employing sufficient distraction until sleep continues without further scratching.

Usually after the initial four days the night-time ‘sentry duty’ is no longer necessary. Topical treatment needs to be continued now, with habit reversal measures during the day, as initially planned. The child is praised and given attention when seen to be playing without rubbing and scratching. During the next four weeks topical treatment with emollients and topical steroids continues, until the skin appears to have healed completely — ‘the look good point’. Then, rather than stopping the topical steroid, we recommend it is continued on the previously affected areas for up to a week longer, though the potency of the steroid, or its frequency of application, can be reduced. This continuing treatment beyond ‘the look good point’ achieves ‘hidden healing’. This reduces the risk of early relapse by ensuring that all of the underlying inflammatory process has been effectively treated. While acute eczema benefits from continuing the topical steroid for two or so days after the superficial flare has remitted (NICE, 2007), for chronic eczema this period is extended to about a week.

Follow-up
A review at four weeks often reveals that healing has been sufficiently advanced to reduce topical treatment, while attention and praise for not scratching has been maintained. Continuing appropriate use of emollient therapy is now essential. This needs discussion, with further reference to the patient handbook. The correct topical steroids to be used for acute eczema are listed, and the importance of having them available to use when necessary is emphasised, together with instructions on how they are to be used.

As with the programme for adults and older children, from now on progress is determined by treating all episodes of acute eczema promptly and thoroughly. The factors listed initially that provoked acute eczema need remembering and clear advice on recognition of the signs of acute eczema is given, supported by the patient handbook. If future acute episodes are correctly treated, habitual scratching and chronic eczema can be prevented from returning, with the quality of everyone’s lives improving as a result.

Summary
1. Chronic atopic eczema is associated with both inadequate use of standard topical treatment and habitual scratching.
2. The Combined Approach for chronic atopic eczema in younger children involves the family in an educational treatment programme.
3. The approach involves combining optimised topical treatment with the easy-to-use habit reversal technique for habitual scratching.
4. No specialised training is required. It can be entirely successful as a self-help format, but it is also easy to introduce in the clinic with appropriate practitioner support.
5. Support for The Combined Approach is available online at www.atopicskindisease.com

References
www.atopicskindisease.com Atopic Skin Disease: The Online Community for Practitioners and Patients
In contrast to the clinic-based programme, the following case report illustrates the self-help format for the Combined Approach.

Iman’s Story*

I live in London, UK. I am a mother of three boys, and the youngest two have eczema and life-threatening allergies. My youngest son (almost 3 years) had had a particularly difficult time with both aspects of his health. He endured constant eczema flare-ups, and I often felt he would scratch for no reason, especially when stressed — for example if he didn’t get his own way. Bedtime was very traumatic on a daily basis: he would wake throughout the night screaming and claw at his skin until he bled. This happened every night for two years, and affected the whole family. My youngest son often grumpy and tearful throughout the day. It was a very upsetting and stressful time. Then I read about The Combined Approach on the internet (www.atopickindisease.com). It confirmed my suspicion that my toddler was often scratching out of habit. I quickly decided to try the approach with him, though I had to let go of my dislike for topical steroids and convince myself that they could be a part of the solution.

Aside from preparing myself mentally, I also had to clear time in my busy schedule to give the constant attention needed for the first few days of the programme. While waiting for a time when I would be free to focus on implementing the first four intense days, I introduced my son to some distraction techniques, such as holding his hands while watching TV and using toys to occupy his hands. I’m glad that I introduced these tactics beforehand, as when we started properly he was then familiar with them. I did my best to refrain from saying “stop scratching”, which is easier said than done, and to use positive reinforcement instead. We started the programme on a Friday so we could make full use of a weekend, and we stayed at home during this period to minimise disruptions. I was already happy to moisturise with my preferred handmade emollients: now I began also to use the prescribed steroid creams and ointments, combining the topical treatment with several distraction techniques to combat the habitual scratching. I tried several distraction techniques to keep his hands busy.

I tried to be creative — I invented songs to sing with my son as I moisturised him, making up the words as I went along, ensuring I involved a lot of clapping and actions to keep his hands busy. At other times, I would just hug him so his hands were wrapped around me. New and exciting items such as felt-tip pens were fantastic ways to divert his attention when he was being stubborn with scratching. I’d help him to colour in pictures, handing a new colour to him when he went to scratch. Simple ball games were great for when we were out in the garden. In the intensive stage, his father and older brothers (aged 8 and 9) were the only others helping me to care for him. I taught my sons the basics of the approach, and got them to help with distraction techniques. I also had to tell them not to tell him to “stop scratching” or make a fuss if they saw him scratching, but to quietly hold his hands and play with him. Their involvement was invaluable as he looks up to them and often mimics what they do.

I also let my son’s nursery know about the programme, so that they could help me to use the strategies when he was with them in the weeks following the intensive weekend. It was important to let his grandparents know too, for the weekends. Otherwise I learnt to speed up his moisturising, and getting changed, as I realised these had been taking a long time to get done, and it was better to keep these processes short!

Within a few days he was hardly scratching at all. It was quite remarkable. Although his skin cleared up very quickly, I continued to use the topical steroids to complete the ‘hidden healing’ period. His first post-programme flare-up happened within a month, but I persevered with the programme and all further flare-ups have been minor. I continue to use topical steroids when he has further flare-ups, but it is not now necessary to use them for prolonged periods. In fact I hardly use them now and I’m aiming to get to the point where I do not use them at all!

My son’s skin is so much better now: no more scratching until he bleeds. He sleeps better; he is so much happier, and so am I! It’s lovely to watch him now enjoy activities with other children without stopping to scratch all the time.

*Iman Igoo first told her story to Christopher Bridgett at http://www.atopickindisease.com/articles/iman
Emollient application doesn’t have to be a challenge with NEW Diprobase Lotion, as it is easy to apply and rapidly absorbed. Even from the first application Diprobase Lotion is clinically proven to relieve the itching associated with eczema and dry, sensitive skin. It is particularly suitable for mild eczema and use between flare-ups, so you can feel confident that your patients’ skin is always protected.

Prescribe Diprobase Lotion today – the soothing formulation patients can trust.

Diprobase Prescribing Information

Uses: Diprobase Cream and Ointment are emollients, with moisturising and protective properties, indicated for follow-up treatment with topical steroids or in spacing such treatments. They may also be used as aollients for topical steroids. Diprobase products are recommended for the symptomatic relief of red, inflamed, damaged, dry or chapped skin, the protection of raw skin areas and as a pre-treatment emollient for dry/sensitive skin to alleviate drying effects. **Dosage:** The cream or ointment should be thinly applied to cover the affected area completely, massaging gently and thoroughly into the skin. Frequency of application should be established by the physician. Generally, Diprobase Cream and Ointment can be used as often as required. **Contra-indications:** Hypersensitivity to any of the ingredients. **Side-effects:** Skin reactions including pruritus, rash, erythema, skin oedema, burning sensation, hyperpigmentation, pain, dry skin and bullous dermatitis have been reported with product use. **Package Quantities:** Cream: 50g tubes, 500g pump dispensers; Ointment: 50g tubes, 900g tubs. **Basic NHS Costs:** Cream: 50g tube = £3.28, 500g pump = £6.03; Ointment: 50g tube = £3.28, 500g tub = £6.03. **Marketing Authorisation Numbers:** Cream: PL 00025/0575; Ointment: PL 00025/0574. **Marketing Authorisation Holder:** Merck Sharpe & Dohme Limited, Shire Road, Hoddesdon, EN11 9BU, UK. **PI Code:** DERM-1053797-0000. **Date of Revision of Text:** September 2012.

Reference: 1. MSD, data on file, DOF-001.

Active Ingredients: None. **Legal Category:** Medical device. **Uses:** Diprobase Lotion is an emollient with moisturising and protective properties, recommended for the management of eczema and other dry skin conditions. Relieves and soothes dry or scalded skin.

**Side-effects:** No skin reactions have been reported with product use. **Contra-indications:** Hypersensitivity to any of the ingredients. **Dosage:** Apply as often as required. **Package Quantities:** 300ml pump pack, 50ml tubes. **NHS Price:** 300ml £3.49, 50ml £1.28. **Date of preparation:** July 2013.

Please refer to the full SPC text before prescribing this product. 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 MSD (tel: 01992 467272).
“Do you want to know what grinds my gears?” A 14-year-old boy coping with atopic eczema

Harvinder Tagger, Mark Gibbs

Atopic eczema can have a profound and negative impact on quality of life and coping with the condition. Factors that can affect coping are described. This case report also gives an insight into the experiences of a 14-year-old with chronic atopic eczema and the impact it has on his mood and daily life.

The impact of living with atopic dermatitis can have a profound and negative effect on the quality of life of children and young people in many cases. A review of the impact of atopic eczema on the lives of children and their families reported on the effects of symptoms contributing to tiredness, mood changes and impaired psychosocial functioning of children, particularly at school (Lewis-Jones, 2006). Embarrassment, comments, teasing and bullying can lead to social isolation and may result in feelings of depression. For families, this may lead to a restriction of normal family life, due to difficulties with complicated treatment regimes and increased work in caring for a child with eczema.

Papadopoulos and Bor (1999) discuss how skin conditions can contribute to a range of psychological problems in affected individuals, such as low self-esteem, social anxiety, altered self-concept and depression. This may be especially important for young people when dealing with academic pressures, peer relationships and developing one’s own sense of self in relation to living life with eczema.

Although psychological factors are widely considered to be important in atopic eczema, there have not been many studies exploring to what extent. Absolon et al (1997) investigated the degree of psychological difficulty experienced by children with atopic eczema. It was reported that there was twice the rate of psychological disturbance in children in the eczema group compared with the control group (children with minor skin lesions), and significantly for children with moderately severe eczema and severe eczema, but not for children with very mild eczema. The findings indicated that school-aged children with moderate and severe atopic eczema are at high risk of developing psychological difficulties, which may have implications for their academic and social development.

This article highlights some of the above issues with a young person called Mark, a 14 year old who has had atopic eczema since his early childhood. Mark’s mother gave written permission and Mark gave written assent to share his experiences of how eczema impacts on his life. Therefore, this article has been co-written for the purposes of helping health professionals working in the area of dermatology to understand how living with atopic eczema can interfere with daily life and the frustrations it can bring for a young person.

Mark was 9 years old when he was first referred to the paediatric psychology service with concerns around his behaviour in response to the treatment of his eczema, which was creating frustration and tension with his parent. There were also concerns around Mark’s behaviour around food, eating things which would aggravate his many allergies and intolerances. The underlying factors to these behaviours were formulated as difficulties in coping with the various aspects of managing eczema and coping with having the condition.

Beuf (1990) identifies a number of aspects that influence coping with a dermatological condition. While severity and visibility of the condition are important factors, family functioning (eg, parental support; stability), social support (eg, involvement in social activities, peer and teacher support) and psychological attributes (eg, self-esteem, humour; creativity) are seen to have a stronger effect on how a person copes. The initial sessions with Mark helped to identify the areas of his life that not only caused him difficulties but also to reflect on the protective factors that helped him to do...
the ‘day-in, day-out’ treatment that was expected of him. Initially, this was done using a creative approach of life-size drawings of him where he could express his likes and dislikes, his concerns about having eczema, as well as the things he enjoyed to build his self-esteem. Further work was done with his parent about support and managing the behaviour around eczema.

As part of a recent piece of work for an English lesson at school, Mark had to write about things that annoyed him. This highlighted the different areas that were affected for him on a personal level and how he copes, and they can be related to the factors reported by Beuf (1990). As well as providing the direction for further psychological support, it is hoped that his work gives an insight into how he experiences life with eczema, and Mark agreed to share this.

Mark wrote: “Do you wanna know what really grinds my gears? It’s my eczema, especially when it gets red... it hurts quite bad and I get bullied for it every day without fail. What everyone seems to think... is that my eczema is a rash and that you can catch it, but you can’t. Whenever I get bullied for it being red, it makes me even more red because stress can cause it to flare up, which then makes me upset.

One of the main reasons why I hate eczema has to be getting bullied for it... when I leave grease on the table, when I’m red, when I scratch and sometimes I get bullied when you can’t even see any eczema just because ‘they’ know I’ve got it... However, there are some people that have stuck by me ever since I first knew them.

There can be times when my eczema really hurts to the extent that I can’t bear it any more... There are times when I have ‘feelings’ and ‘thoughts’ that no one knows about... Some people have noticed that when I’m down... I don’t speak a word I’m just silent... you could hear a pin drop in my room.

This really annoys me... when I get rid of it and it comes back (10 times worse than before, so I could be trying to get rid of my eczema for like 2 weeks, then BOOM! One day I wake up and it’s all come back again. That’s one of the reasons why I don’t like waking up either, because it’s dark red and it’s gone all blotchy.

Every night I’ve got to change my bandages so I take off the old horrible ones and I have to put creamed leggings, vests and socks on... but what annoys me is how long it takes. Sometimes it can take 20 minutes but sometimes it can take me up to 3 hours to do, depending on how my eczema feels. Oh yeah, I really hate baths because they really sting my cuts”.

Mark also wrote for this article his experiences of coming to the hospital for his dermatology (seeing Helen) and psychology (seeing Harvey) appointments. He commented that “most of the time it’s alright, but when I come to see Helen for my eczema, I don’t really enjoy it in case it’s red. When my eczema is not red then it’s fine. When I see Helen I automatically know why I’m seeing her (eczema), but when I see Harvey I don’t really know what I’m going to be saying or doing. However, when I see Harvey it’s fun when I do different activities to reflect on my mood. I also like seeing Harvey because I can tell him anything”.

Mark’s writings highlight the day-to-day concerns that he faces. One of the strategies to be able to manage and cope is being able to express the annoyances and frustrations before addressing and challenging the thoughts and feelings of how eczema can interfere and affect life. As suggested by Beuf (1990) a number of areas, as well as visibility and severity of the condition, can mediate how a person copes with having a dermatological condition. For Mark, it appears that the severity of his condition affects his own wellbeing but that comments from peers can lead to feelings of social isolation.

As the review by Lewis-Jones (2006) highlighted, embarrassment, comments and bullying frequently cause social isolation and feelings of depression. If not addressed, these can lead to additional problems with emotional wellbeing that is likely to interfere with the management of the condition. For Mark, this is shown by his reflections on how the redness of the eczema leads to bullying, the stress of which leads to increased redness. This contributes to him feeling low and upset, and wanting to spend time by himself.

These patterns of behaviour indicate the link between a number of areas, and the recommendations for practitioners working in the field of dermatological care would be to consider how wide-ranging the impact can be for an individual having to manage and cope with atopic eczema. It would be worth thinking with young people, in addition to how they are managing the treatment of their condition, how they are managing in other areas of their life, in particular school and peer relationships. This would potentially allow the person to be able to express any concerns that they have and also to facilitate a discussion around their emotional wellbeing. Hopefully, considering all of these factors and identifying ways to address them would allow children and young people to adjust and cope with having a dermatological condition and make parts of life less grinding.

References
Background
Leprosy (Hansen’s disease) is a chronic infectious disease that remains a significant public health problem in a large number of developing countries and continues to be the leading infectious cause of disability worldwide. Importantly, a key factor in the acquisition of a leprosy-induced disability is a delay in diagnosis and treatment, which is common due to the wide variety of ways in which the disease can manifest (Rodrigues et al, 2011).

Differentiating the potentially debilitating disease that is leprosy from more common benign dermatoses can prove to be a great challenge with high stakes. Here we present a case from a hospital in Nepal, which illustrates how leprosy closely resembled the common benign yeast infection, pityriasis versicolour.

Presentation
A 16-year-old Nepalese student from the leprosy endemic Terai region of Nepal presented to the outpatient department at Lalgadh Hospital. He described the development of persistent but non-itchy, non-tender hypopigmented skin patches over the past year (Figures 1, 2). The patient was otherwise well, but concern about the cosmetic appearance of these lesions had led him to seek medical advice. Importantly, the patient had no significant past medical history or close contact with any leprosy-affected individuals.

Max deSancha is a final year podiatry student from Salford University. He is doing a qualitative research project on Nepalese health beliefs that surround foot ulcers in leprosy at Lalgadh Hospital. Nepal. Edmund Wee is a final year medical student from Melbourne University specialising in tropical dermatology diagnosis and treatment at Lalgadh Hospital, Nepal. Ashok Sheresthra is a Healthcare Assistant specialising in tropical dermatology diagnosis and treatment at Lalgadh Hospital, Nepal.

Interestingly, preliminary examination findings were more suggestive of pityriasis versicolour than leprosy. On inspection, the lesions were well-circumscribed, small circular hypopigmented macules in a symmetrical distribution on the upper chest, lower back and shoulders, closely resembling pityriasis versicolour. Furthermore, initial neurological examination was unremarkable and revealed no peripheral nerve enlargement or weakness typical of leprosy. Significantly, the hypopigmented macules on his trunk were not anesthetic.

Nevertheless, careful examination revealed a single lesion (4 x 8cm) on the right upper arm that was both hypopigmented and anesthetic (Figure 3) prompting further investigation for leprosy.

Investigations
Investigations confirmed that the patient had multibacillary leprosy, with slit-skin smears from lesions demonstrating large numbers of acid-fast bacilli. Furthermore, microscopy of skin scrapings with potassium hydroxide preparation was negative for fungi.

Treatment, outcome and follow-up
After establishing a diagnosis of leprosy, the patient was started on a course of multi-drug therapy (MDT) to eliminate the Mycobacterium leprae infection responsible for the disease. Given that investigations indicated the patient had a high bacterial burden typical of multibacillary leprosy, a 12-month MDT course of rifampicin, clofazamine and dapsone was started in accordance with WHO treatment recommendations (WHO, 2013).

Fortunately, in light of this patient’s timely diagnosis, his risk of long-term disability was greatly reduced. However, the patient will be required to attend regular review appointments to monitor for and address any leprosy reactions and associated neurological complications that could still arise.

Discussion
Leprosy is a chronic infectious disease caused by the M. leprae bacterium. The transmission of leprosy is not well understood, though it is thought to be spread via respiratory droplets. Most people infected with M. leprae do not develop clinical leprosy, but currently there are no available tests to diagnose subclinical infection. In susceptible patients there is a long incubation period of 2-12 years before symptoms of infection manifest (Suzuki et al, 2012).

Importantly, leprosy can have a wide range of presentations, depending on the immune response of the patient (Suzuki et al, 2012). Leprosy commonly presents with hypopigmented anaesthetic macules or plaques, and suspicion should be raised if a patient from an endemic area

Summary/key points
- Leprosy is a chronic infectious disease that can mimic many benign dermatoses.
- Delayed diagnosis often leads to profound disability associated with irreversible peripheral neuropathy.
- Although rare, cases of leprosy are still detected in many developed countries including the UK.
- Vigilance is advised when managing dermatological complaints in patients from endemic countries. The presentation of hypopigmented, anaesthetic lesions should raise suspicion of leprosy.
- According to WHO statistics, leprosy endemic countries with the highest numbers of new cases include India, Brazil and Indonesia. However, regions of endemicity exist in many other developing countries.
develops such lesions. Nevertheless, the skin lesions that occur in leprosy are very diverse, and may be hyper-, hypo- or de-pigmented, erythematous, raised or nodular. Loss of hair and dry skin may also occur within skin lesions due to the loss of autonomic innervation. On occasion, lesions may not be anaesthetic and diagnosis may depend on the presence of other signs and symptoms:

- Peripheral nerve thickening (ulnar and common peroneal nerves commonly affected)
- Signs and symptoms of peripheral neuropathy in limbs (anaesthesia, paraesthesia, muscle weakness). Local injury or ulceration may occur due to sensory loss.
- In advanced cases, changes in facial appearance such as enlarged ear lobes, saddle nose deformity and infiltration of the forehead and lower face can occur; giving rise to ‘leonine’ facies.
- Immunological leprosy reactions (type I or II) may also occur at any time during the course of the disease and even after treatment, manifesting as acute episodes with symptoms ranging from erythema and oedema of skin lesions to multiple tender nodules, fever, arthritis, neuritis and iritis.

Diagnosis is also aided by split-skin smears (involving microscopy of dermal tissue fluid) that may show acid fast bacilli in some cases. PCR-based diagnostic methods have also been described. Significantly, M. leprae cannot be cultured in vitro and this is not a means for diagnosis (Suzuki et al, 2012).

Leprosy is classified into two distinct categories, paucibacillary and multibacillary, that require distinct MDT regimes. Paucibacillary cases have a lower bacterial burden undetectable on skin smear and are usually associated with <6 skin lesions. In contrast, multibacillary cases have a high bacterial load with multiple bacilli detected on skin smear and ≥6 skin lesions. Multibacillary cases require a 12-month course of MDT with rifampicin, clofazamine and dapson, while paucibacillary cases require a 6-month course consisting of rifampicin and dapson only (WHO, 2013).

Importantly, unless leprosy is treated early with MDT, peripheral neuropathy cannot be avoided, and without preventative measures progressive neuropathic ulceration will ultimately lead to devastating deformities, autoamputation and physical disability. In many countries the disease is complicated by an enduring social stigma which may be even more debilitating than the physical disability itself (Suzuki et al, 2012).

This case is an example of how diagnosing leprosy can be challenging even in an endemic area. Following preliminary assessment, the most favourable differential diagnosis was pityriasis versicolour given the appearance of the skin lesions and the fact that this condition is extremely common. As a matter of course, sensory testing was undertaken given the endemicy of leprosy in Nepal, leading to a diagnosis of leprosy that would have otherwise been missed. This demonstrates how increased vigilance is advisable when managing dermatological complaints in patients from leprosy endemic countries.

Given the heterogeneity of presentations in leprosy, diagnosis is often delayed, especially in developed countries where the disease is rare. In the UK alone, between 2001 and 2010, 129 cases were reported (Public Health England, 2013). Previous studies have shown that late diagnosis in the UK is common and associated with permanent nerve damage and disability (Lockwood et al, 2001). Health professionals, particularly those involved in refugee and immigrant health, play a crucial part in differentiating leprosy from other benign skin conditions and facilitating its early diagnosis and treatment. It is hoped that with increased awareness, leprosy-related misdiagnoses can be avoided and subsequent disability prevented.


References


Friction foot blisters: a review of the risk factors, treatment and prevention

Dr Farina Hashmi, PhD, FCPodMed, is a Research Fellow at the School of Health, Sport and Rehabilitation Sciences, University of Salford

Incidence
Friction blisters present in people of all ages and activity levels but those at increased risk are runners (Brennan, 2002; Mailler-Savage, Adams, 2006), hikers (Kogut, Rodewald, 1994), those wearing incorrect footwear or hosiery (Dai et al, 2006) and the military (Patterson, Leister, 1980; Knapik, Hamlet, 1996). The sites most commonly affected by friction blisters are the toes, the heel and the plantar surface of the foot.

The physiology of blister creation
Friction blisters are specific to the palmoplantar skin (Basler et al, 2004) due to its unique structure, in particular thicker stratum corneum, compared to skin elsewhere on the body (Akers, Sulzberger, 1972; Akers, 1977). The thick epidermis is firmly held down by the dermis, therefore minimising the movement of the epidermis across the dermis and consequently reducing the effects of shear. When the external shear forces exceed the binding forces of the skin, a cleft forms between the stratum granulosum and stratum spinosum epidermal layers (Sulzberger et al, 1966; Akers, Sulzberger, 1972; Akers, 1977), which gradually fills with tissue fluid. Researchers have recorded the clinical signs and symptoms as a friction blister forms on the posterior aspect of the heel (Hashmi et al, 2013). Initial shear application causes exfoliation of the most superficial layers of the stratum corneum and then the skin appears to redden. With continued rubbing a small pale area develops in the centre of the ‘hot spot’ and it is at this point that the individual feels a burning or stinging sensation. Eventually the pale area of skin elevates allowing for the tissue fluid to occupy the area gradually (Figure 1). The pain caused by the blister is due to the trauma experienced by the skin as well as the accumulation of fluid in a relatively small area. Hydrostatic pressure influences the ingress of fluid into the blister; therefore if the blood supply to the skin is compromised in anyway the pressure reduces and less fluid moves into the intraepidermal cleft. Dawson et al (2004) classified the stages of development of a blister to aid the diagnosis and management of each specific stage (Figure 2).

Risk factors associated with friction blisters
There are many factors that can place foot skin at increased risk of blistering. Some have already been mentioned; however there are many others that are summarised briefly below.

The risk factors for blistering can be divided into two categories:
1) Intrinsic factors, which refer to systems associated with the body that alter the structure and function of skin, and
2) Extrinsic factors, referring to changes in the environment that can influence the behaviour of skin.
Skin moisture

Skin moisture can be considered to be both an intrinsic and extrinsic risk factor for blistering. Epidermal moisture can influence the mechanical behaviour of skin and can also alter the frictional forces generated between the skin surface and the contact materials (eg, socks). Moist skin is more susceptible to friction blistering (Akers, 1977; Bush et al, 2000), primarily because the coefficient of friction is higher in moist skin compared to dry or excessively wet skin (Naylor, 1955; Highley et al, 1977). In the case of being an excess amount of moisture on the skin, the fluid acts as a lubricant and when the skin is relatively dry, the exfoliated layers of stratum corneum cells form a powder that also has a lubricating effect. With this in mind, feet that tend not to sweat excessively, such as those of the elderly and children, are less likely to be at risk. However, it must be noted that other changes in an aging foot, as a consequence of peripheral vascular disease and systemic disease, make the skin susceptible to physical trauma and breakdown.

Changes in environmental conditions, such as humidity and temperature, particularly within the shoe, influence the moisture of the skin. High temperatures and sweat accumulation lead to increased skin irritation during running (Hennig et al, 2005). Therefore, the appropriate choice of footwear, socks and topical preventative therapies is imperative for young adults who are prone to having sweaty feet and blistering. There will be more on treatment and prevention options later on in this article.

Intrinsic factors

Data collected from people after specific army training activities show the rate of incidence of blister to be three times greater in females compared to males (Patterson, Leister, 1980; Patterson, et al 1994). It is not clear why this difference exists. One possible explanation could be that males have a thicker epidermis compared to females (Sandby-Moller et al, 2003), however this inference comes from data collected from skin sites on the upper body and not the feet. Patterson et al (1980, 1994) also noted from their military training studies that Caucasian skin showed a higher risk of blistering than black skin. Some researchers have gone as far as to suggest that different sock materials should be used by the two different skin types, ie, nylon socks by fair-skinned people and a cotton athletic sock by black-skinned people, however there is little scientific evidence to support this recommendation.

Due to the painful nature of a friction blister, sufferers may be inclined to alter the way they walk to offload the painful area, therefore increasing the risk of musculoskeletal foot and ankle injuries (Bush et a, 2000). Altered gait may also subject other skin sites to extraordinarily high pressures, therefore compounding the problem further and causing more blisters to form elsewhere. If an individual experiences repeated episodes of blistering after taking part in a specific type of activity, it would be wise to conduct a biomechanical assessment to determine whether foot structure and mobility is compromised in such a way that excessive pressures are generated at specific points on the foot. Some chronic diseases affect body position and mobility, which could result in increased plantar pressure loading (Sanders et al, 1995).

Extrinsic risk factors

Poorly fitting footwear appears to be a key factor that contributes to blister creation, however the only published works in this area originate from military exercise studies (Bush et al, 2000). No research to date has been carried out on different types of footwear and their contribution to blistering. However, more work in the area of socks and friction has been conducted. As the socks are in direct contact with the skin it is generally agreed that sock fibres contribute to the reduction of shear forces when in contact with foot skin (Herring, Richie, 1990). The primary action of socks is the reduction of friction force by wicking moisture away from the skin surface (Knapik, Hamlet, 1996). A cotton sock has a greater capacity to hold water compared to an acrylic or polyester sock after running (Herring, Richie, 1990). The fibres in a cotton sock swell as the moisture is absorbed. Once the fibres become saturated by fluid, the wicking effect is reduced therefore causing an increase in moisture on the surface of the skin and consequently increasing the risk of blistering (Herring, Richie, 1990; Baussan et al, 2010). This fundamental knowledge supports the need for a sock comprising a material that should not only allow moisture to move away from the surface of the skin but also provide a constant, low coefficient of friction when in contact with it.

Blister prevention and treatment options

The preventative measures for friction blisters reported in the literature focus on the reduction of friction and shear forces, and the prevention or removal of moisture from the surface of the skin. These measures range from foot-care advice to the use of lubrication and antiperspirants in addition to appropriate socks, insoles and footwear.
Foot-care advice
In the case of people who lead active lives and are prone to blistering, the first line of action should be foot-care advice, focusing on informing the individual of the effective preventative measures that can be taken. Bush et al (2000) observed fewer repeated incidences of blistering in patients who attended clinical appointments for foot-care advice. Bush further hypothesised that foot-care advice at the beginning of basic training may result in fewer friction blisters.

Lubrication
Friction forces on the skin surface can be reduced by the application of a lubricant (Naylor, 1955). Despite the ability of mineral oils to hydrate the skin, via occlusion, they also provide lubrication to the skin. The lubricating effect is thought to overcome the increased friction generated by hydration (Highley et al, 1977). However, this beneficial effect is short-lived as constant rubbing by an external stimulus may cause the film barrier to be removed, leaving the underlying hydrated skin exposed to the same external stimulus. This has led to the development of relatively effective lubricating balms, which generally contain hydrogenated vegetable fat, petrolatum or ccaprylic triglyceride (an oil substitute). The majority of these products work well in preventing skin chafing on the torso in runners. The evidence regarding efficacy of these treatments in preventing foot blisters is yet to be obtained.

An alternative method of lubrication is dry lubrication. The use of a powder such as Zeasorb (Steifel laboratories Inc, Coral Gables, Florida) has been shown to be effective in the prevention of friction blisters (Basler et al, 2004). There are many blister prevention powders on the market, ranging from loose powder to compact powder sticks and of which the main base component is talcum powder. The sticks are more ‘user friendly’ as the loose powders tend to cling to surfaces including clothes.

Antiperspirants
Antiperspirant use is aimed at reducing sweat production on the surface of the skin. The true effect of these products only manifests after a few days of use prior to taking part in a specific activity; for example Knapp et al (1998) conducted a double-blind study on a group of 667 military cadets where half were instructed to apply an antiperspirant to their feet daily for 6 days before a 21km hike. The other half (controls) was asked to do the same with a placebo. The results showed that the incidence of blister was low in those who had applied antiperspirant for 3 or more days compared to the controls. However, there was a high incidence of skin irritation reported (57%). The active ingredient in the majority of antiperspirants is aluminium chlorohydrate (also used in deodorants), which reduces the production of perspiration. There are many foot preparations on the market that are made up of this ingredient.

Socks
The best types of socks that will reduce the risk of blistering are generally made of synthetic fibres such as acrylic (Herring, Richie, 1990; Brenda, 1991) or polyester (Knapik, Hamlet, 1996; Van Tiggelen et al, 2009). These materials are desirable because they reduce friction and keep the foot dry. Recent innovations have led to the production of specific anti-blister socks, which are not only made from low friction fabrics but they also have a double layer composition which dissipates the shear forces, generated by external factors, before they reach the skin surface.

Insoles and shoes
Insoles and orthotics are not typically used in the management of blisters; however the insole could be an area for further exploration as it interfaces between the shoe and the foot. Although it has been identified that insoles made from a cushioning material absorb vertical forces on compression, it is not known whether specific insole material and design can reduce shear forces.

The correct shoe fit can reduce the likelihood of blister formation but it is not clear what constitutes well-fitting footwear in this context. It is known that some shoes increase the risk of developing a friction blister; ie, a military boot is more likely to cause a blister than a running shoe. However, it has also been reported that wearing a military boot before basic military training can provide protection from blistering (Patterson et al, 1994).

Plasters and bandages
Plasters and bandages can be used to both treat and prevent blisters. The BursaTek bandage (SAM Medical, Tualatin, OR, USA) is the only bandage that has been tested for efficacy in blister prevention. The design of the bandage comprises a dome-shaped material that has the properties of a bursa, therefore absorbing friction. When compared to a range of blister prevention bandages (11 in total) the BursaTek bandage had the lowest coefficient of friction when in contact with the skin (Polliack, Scheinberg, 2006). In another study, Bursatek bandages were randomly applied to sites on the foot on a military 16km hike. None of the skin sites developed blisters (Sian-Wei Tan et al, 2008).

Hydrogel and hydrocolloid plasters are widely used in blister management. These plasters can be used to prevent friction damage to the skin and to treat an existing blister with a formed or denuded blister roof (Figure 2, Stages 3a and 3b). The hydrocolloids and hydrogels provide an optimum wound-healing environment and also help to relieve pain and cushion the blister (Read, 2001). The most well-known hydrocolloid plaster is Compeed. Hydrocolloids have slightly different material properties to hydrogels; however the two types of materials are effective in treating and preventing blisters. Hydrogel products are cheaper to manufacture than hydrocolloids and therefore provide a cost-effective alternative for some patients.

Treatment of blisters
Most blisters heal naturally and do not require medical attention. As new skin grows beneath the blister, the fluid contained within it will be slowly
reabsorbed and the skin on top will dry and peel off. This process normally takes 3-7 days. The unbroken skin over a blister provides a natural barrier to infection. This means that blisters should remain intact and unbroken. The blister should not be pierced, but should be allowed to break on its own once the skin underneath has healed. According to the information on the Feet For Life website (http://www.scpod.org/foot-health/common-foot-problems/blisters/), it is recommended that the blister is protected by foam or felt material of a thickness of approximately 1.5 to 2cm. A cavity should be cut in the pad, forming a ‘doughnut’ shape where the blister will sit. The pad should then be secured with tape or a soft gel-type dressing (Figure 3).

If the blister bursts, the skin that forms the roof of the blister should not be removed. The area should be gently pressed to disperse all the fluid inside. It is ideal for this to be done while the foot is in warm water with either salt or soap dissolved in it. The area should then be covered with a dry, sterile dressing and redressed daily until the skin has healed. Monitoring the healing of blisters in patients who are particularly ‘at risk’ (e.g., people with peripheral ischemia, neuropathy, compromised immunity, etc) is vital due to the increased risk of infection.

Blood blisters should also be left to heal naturally. As with other blisters, if a blood blister bursts it is important to keep the area clean and dry, and protect it with a sterile dressing to prevent infection.

Figure 2. Blister protection pad made from semi-compressed felt padding material. Remember to bevel the edges of the pad before applying to the foot (c), this is comfortable for the patient and also prevents the edges rolling away from the skin. Image (d) shows the pad on the posterior aspect of a heel without a blister. The blistered skin should sit within the cavity.
Summary

Friction foot blisters are a common problem often causing pain and infection, the consequences of which can have a detrimental impact on the quality of life of the individuals involved. As practitioners we are armed with sufficient evidence to provide comprehensive advice regarding the prevention and treatment of blisters. Although more scientific evidence is needed with regards to intervention efficacy, there are many useful measures that can be put in place to protect the foot from such damage.

References


Screening for Psychological Distress in Patients with a Chronic Skin Disease

Dr Satveer Mahil is a Specialist Registrar at St John’s Institute of Dermatology

A study to assess the psychological distress in patients with a chronic skin disease was carried out at St John’s Institute of Dermatology. 28 patients attending the day care centre completed a questionnaire and the Hospital Anxiety Depression Scale (HADS). The findings show that psychological morbidity in dermatology patients is not currently adequately recognised or managed.

The considerable psychological impact of chronic skin diseases such as eczema and psoriasis is being increasingly recognised and psychological distress has been shown to have an adverse effect on the onset and exacerbation of skin disease (Slominski, 2007; Arck et al 2006). NICE clinical guidelines on depression with a chronic physical health problem (CG91) recommend screening questions and advise using a validated measure to inform and evaluate treatment (NICE, 2009). We assessed the current screening of psychological distress in patients with a chronic skin disease attending the dermatology department of a tertiary referral centre and also trialled the use of the Hospital Anxiety and Depression Scale (HADS), a sensitive and specific self-reporting scale for screening for psychological distress in patients with medical conditions.

All patients attending the dermatology day centre in June 2012 for treatment of a chronic skin disease (defined as greater than 3 months’ duration) completed a questionnaire, which included whether the patient had been asked the NICE CG91 screening questions, their satisfaction with the current practice on recognition and management of psychological distress and their preferences on where psychological support should be arranged. All patients also completed the HADS.

28 completed questionnaires were received. 80% of patients were being treated for psoriasis and 20% for eczema. 61% of patients were male. 80% were aged greater than 40 years and 84% had exposed areas of skin affected. 75% had previously required systemic therapy for their skin disease and 50% were receiving systemic treatment at the time of questioning. The mean total score from HADS was 20.3 (range 5–36). 61% of patients had not been previously screened for psychological distress in the dermatology department and 78% of patients were not satisfied with the psychological support they had received.

61% of patients had not been previously screened for psychological distress; 78% were not satisfied with the psychological support they had received.

63% reported their emotional health affected the severity of their skin disease ‘often’ or ‘all the time’. 50% and 48% felt their emotional health affected work/study and personal relationships, respectively, ‘often’ or ‘all the time’. 88% preferred psychological support to be arranged via the hospital dermatology service rather than their GP.

These findings support previous studies showing that psychological morbidity in dermatology patients is not currently adequately recognised or managed (Richard et al, 2004; Picardi et al, 2004). A large proportion of patients scored highly on HADS, confirming elevated psychological distress in patients attending tertiary care, with a significant impact on quality of life, disease severity, interpersonal relationships and employment. The HADS may be used as a simple, validated measure for routine screening for psychological distress in patients with chronic skin disease and to identify those requiring formal psychological assessment. Our findings support closely co-ordinating psychological care with specialist skin care. Increased recognition of psychological distress in patients with chronic skin disease by dermatologists (as supported by NICE CG153) and access to psychological services will improve patient outcomes and facilitate efficient allocation of resources.

References
This article is the third in a series following the journey of a dermatology nurse conducting qualitative research in the practice setting for a PhD. So far on the journey, the author has considered the initial practice issue, which resulted in a tentative research question for a PhD proposal, the ethical issues and the literature review and methodology. The next stage is data collection and analysis within the process. There are many practical aspects to consider as well as theoretical aspects and sometimes there are few resources to help the researcher get a grip on how to manage these practicalities. This article hopes to address some of those aspects, to explain how they were dealt with in this instance and to offer some practical guidance on how best to navigate around these issues.

**Getting ready to gather data**

Before any data can be collected ethical clearance must be sought. Approval was given for this project for face-to-face interviews and also for two focus groups—one male and one female (Riley, 2012).

So far in the work, methodology had been considered; now it was time to address the method. Practically, I had to consider how to conduct the interviews, where to conduct them, also how to record and then transcribe the audio files. Choosing the sample was a priority, as respondents to the posters in clinical areas advertising for individuals with a chronic skin disorder to participate were starting to come forward. As the sample was purposive I was able to select the individuals after their initial contact in response to the posters and have a chat over the phone to ensure they were aware of the purpose of the research; the practical elements of their involvement and also to reassure with regard to information governance and confidentiality.

I discounted only one potential participant. This was because, while I was at pains to ensure the participants knew this was a research project and we were not disturbed, the interviews were recorded with a digital recorder and, although I had written consent from the participants before the interviews began, I also recorded verbal consent at the beginning of the interview to remind the participants of this fact. The audio file was then uploaded onto the hard drive of my Trust computer, which is password protected to ensure the files are secure.

Next, the process of transcription: the amount of time you will need to set aside to transcribe one hour of talking cannot be overemphasised. It can take in excess of 8 hours to transcribe a 60-minute interview, often much longer depending on how quickly your interviewees speak and the amount of dialogue in conversations they describe and quote. As well as having to transcribe word for word, it is often necessary to go back over the audio recording to check you have not misheard and to identify nuances such as “ah” and “erm.” My supervisor also reminded me of the importance of representing the participant accurately in the transcript; if a participant says “It was really tough”, this is not the same as them saying “It was really, really, really tough, I mean really tough.” This is where note taking can be valuable, although to the novice interviewer it can be somewhat distracting while trying to pick up on emerging themes and guide the direction of the interview at the same time.

**Top Tips!**

- Don’t underestimate how long it will take you to transcribe an interview that lasts 60 minutes.
- Be aware of participants who may think they are getting a one-hour consultation with a specialist nurse rather than a research interview, as this will most likely result in a waste of time for everyone.

**Conducting and transcribing the interviews**

The interviews took place in an office on Trust premises and I took pains to ensure the interviews were not disturbed. The interviews were recorded with a digital recorder and, although I had written consent from the participants before the interviews began, I also recorded verbal consent at the beginning of the interview to remind the participants of this fact. The audio file was then uploaded onto the hard drive of my Trust computer, which is password protected to ensure the files are secure.

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**The next step towards a PhD: practical issues around data collection and analysis**

Tracey Riley is a Dermatology Specialist Nurse for West Cumbria and a part-time PhD student with the University of Cumbria.
Reflections with my supervisors

My supervisors’ experience was invaluable as they guided and advised me on how to conduct the interviews. After the pilot interview we discussed the transcript as a first-level analysis of emerging data, but also as a critique of my interviewing style. We noted that a novice researcher can study other researchers’ transcript passages once published, but it is difficult to access real interview recordings to listen to as examples and therefore to listen to the raw data as it was collected, because of course this carries with it a different level of consent by the interviewee to share the contents with others.

My supervisors were wondering whether me being seen as a nurse rather than as a researcher was influencing what the participants told me. For example, in one interview I asked “How does it feel to have a skin disorder?” and the participant went on to discuss topical treatment regimes: “Well, as you probably know, I have to put on all these creams...” Would he have wanted to discuss topical treatments with a researcher who was not a nurse? Therefore there were considerations to be made around the subject of my role and I was careful to ensure that the interviewees were aware that this was not a therapeutic session.

Parkin (2000) reminds us that individuals often manipulate their performance during interactions to initiate responses from others, and that these mental processes are covert and we cannot openly acknowledge this process; nevertheless this is a factor to consider during the data gathering process. Potter and Wetherall (1987) comment that interviews as a method are contrived; we place a recorder in front of the interviewee and ask them to begin, and the amount of naturally occurring data is questionable. Silverman (2013) also points out that interviews do not give us direct access to the facts, but a representation of an experience. My stance is that, as long as the representation is given by the individual having the experience, then that will add to the richness of the data.

Once you have collected your data, what next? How do you begin the laborious process of data analysis and how do you keep track of the emerging findings? Until recent times, a researcher would have to go through the transcripts and quite literally cut out or highlight segments of passages or words to identify themes; these would need to be coded and the progress charted. Now there are computer-assisted software packages that eliminate much of the footwork, although it can be time-consuming navigating your way around the programme until you are confident.

Using a software package to manage data

There are several software packages on the market to help with the storage and archiving of qualitative data. These Computer Assisted Qualitative Data Analysis Systems (CAQDAS) do not do the analysis of the data for you, but once you are proficient with the package they are an excellent resource for managing the data. The programme being used for my project is ATLAS.ti but the choice will depend on the researcher’s preference, cost — if you purchase it personally — or whether your institution has access to the programme so you can upload it from the university library.

The researcher saves the gathered data in the original format interview transcripts, video clips, digital audio tapes or PDFs can be saved into the programme. Then the researcher needs to read or view the data and identify codes or themes, which are then saved and archived for later. The programme also allows the researcher to conduct searches, perhaps to identify how many times a certain word or phrase was used.

What about the focus groups?

Although I have ethical approval for two focus groups, I have decided to wait until I have conducted my scheduled face-to-face interviews and conducted more first-level analysis, as I suspect I may find that I have quite enough data. So far I have conducted seven interviews and have one more to arrange. As it stands I am beginning to recognise themes re-emerging regularly, such as:—

- Being watched and judged — “I can’t undress to go into the pool because people stare”.
- Taking personal responsibility and control — “I know that if I can just improve my health by eating better and not drinking alcohol, then I’ll be able to improve my skin”.
- Anticipation of deterioration and worsening of symptoms — “Even when you have a good spell you’re just waiting for it to come back”.
- Hierarchy of illness — “I was told I have a mild form of psoriasis but it seems more than mild to me”.

Interestingly, some themes are emerging that are contrary to how the participants describe their experiences. For example, a participant told me that he wouldn’t let psoriasis affect his life, then he went on to say it influences what he wears, new relationships and intimacy, and that it affects what he does and when. To me, that sounds like it is affecting his life.

At this stage I conducted another literature review and found that I am now looking at existing literature with a fresh eye and recognising parts of what I am reading in my own work. This includes illness perception and body dissatisfaction, illness representation, quality of life and psychological co-morbidities and behaviour models.

My research question has continued to evolve and now stands as: ‘What is the impact of the social construct of morphism on the individual with a chronic, transient skin disorder?’

The next article will include data analysis, as it is completed, and findings of the research.

References


www.bdng.org.uk Dermatological Nursing, 2013, Vol 12, No 3
Antibiotic use in children may increase eczema risk

Andrew Sibley

Recent research published in the British Journal of Dermatology has sought to explore the link between antibiotic use in early life and the development of eczema in children (Tsakok et al, 2013). This study caught my interest not only for its focus but also for its potential ramifications. In summary, the authors of this review state the use of antibiotics in early life may increase the risk of developing eczema by up to 40%. Importantly, they also stated the evidence was not conclusive and a better understanding of the complex relationship between antibiotic use and allergic disease is a priority for clinicians and health policymakers. Despite the authors’ careful and considered conclusion, an increasingly health-engaged general public may take this finding and bring it into the consultation room for nurses to tackle. In particular, the main finding of this study raised two questions in my mind. Firstly, what happens when parents read about the review or its main finding is presented in the media? Secondly, how will nurses deal with this discussion during consultations? Before discussing these issues, the context and study are outlined below.

Atopic eczema is one of the most common long-term skin diseases, affecting up to 20% of children worldwide (Ring et al, 2012) with the large majority (about 80%) of cases presenting before the age of 5 years. Interestingly, a worldwide increase in allergic disease has been reported over recent decades, particularly for children aged 6-7 years old from high income countries (Williams et al, 2008). The authors of the review in question (Tsakok et al, 2013) highlight the frequently discussed ‘hygiene hypothesis’ as an explanation for these findings. The hygiene hypothesis states that a lack of early childhood exposure to infectious agents, symbiotic micro-organisms (eg, gut flora or probiotics) and parasites increases susceptibility to allergic diseases by suppressing natural development of the immune system. Importantly, Tsakok et al (2013) suggest increased perinatal antibiotic exposure could conceivably skew the developing immune system towards atopy and clinical allergy.

With these issues in mind, and as a number of studies have suggested that early life exposure to antibiotics may lead to an increased risk of subsequent eczema, Tsakok et al (2013) conducted a systematic literature review on the association between antibiotic use antenatally, or in the first year of life, and the development of eczema. The systematic review sought cross-sectional, case-control, and cohort studies (up to March 2012) to primarily explore the link between antibiotic exposure prenatally and/or in the first year of life, and the subsequent development of eczema. A meta-analysis of studies involving children or young adults aged 0-25 years was conducted as part of the review. An important part of this analysis involved an assessment of the impact of antibiotic exposure during the first 12 months of life on subsequent eczema risk.

Twenty studies met the inclusion criteria, 13 were longitudinal and seven cross-sectional. Sixteen studies looked at postnatal exposure, three studies examined prenatal antibiotic exposure, and one study examined both. A quality assessment (modified Ottawa score) was conducted and included studies varied on quality but all were reasonably well designed and executed. Importantly, an analysis of the odds of developing eczema between studies of moderate quality and those of good quality found there was no difference in odds. An important drawback of 13 included studies was their reliance on self-reporting via questionnaires, which have known problems of over or under-reporting of issues depending on the individual completing the questionnaire.

A wide range of data was extracted from each included study, among which were estimates of effect size relevant to eczema outcome (adjusted odds ratios), study type, number of participants, age of participants, diagnostic criteria and exposure measures, the number of courses of antibiotics received, the number of infection episodes and the number of physician consultations.

Twenty studies examined the association between prenatal and/or postnatal exposure to antibiotics and development of eczema in early life. The pooled odds ratio for the 17 studies examining postnatal antibiotic exposure was 1.41. The pooled odds ratio for the 10 longitudinal studies was 1.40 compared to a pooled odds ratio of 1.43 for the seven cross-sectional studies. To help interpret this, an odds ratio (OR) equals the odds of exposure, of participants in the included studies, of those with eczema divided by the odds of exposure of those without eczema. The final test statistic can be interpreted in this way: an OR of ‘1’ would indicate there is no change in the frequency of exposure, a value greater than ‘1’ indicates an increased frequency of exposure and a value less than ‘1’ indicates a decreased frequency of exposure. The statistical value can quickly
be interpreted in this way: an OR of 1.41, as found for the 17 studies examining postnatal antibiotic exposure, represents an increased level of exposure (eczema development) for those using antibiotics in early life because the value exceeded one. Furthermore, this increase was a 40% increase based on the ‘40’ part of the 1.40 statistic. Importantly, when should we be impressed by the OR? For the type of studies in this review, statisticians often want to see a value greater than 3 or 4 (ie, OR 3.0 or 4.0) to be certain you have a really important finding. In those situations, you would be able to state the odds of eczema were 3 or 4 times greater (300% or 400%). This magnitude issue is reduced downward when the studies are higher quality and conducted using designs less likely to be affected by bias (eg, randomised controlled trials). Although the 40% increase in eczema development for those who took antibiotics in early life appears important, there are statistical issues that reduce the value of this finding.

Parent reactions & challenges for the healthcare profession

Tsakok et al stated in a recent press release via the British Association of Dermatologists: “The evidence is not conclusive and the researchers are not suggesting that parents should withhold antibiotics from children when doctors feel such treatment is necessary, but studies like this give an insight into possible avoidable causes and may help to guide medical practice.” Despite this statement, how will parents, the media and the general public view this finding and will they appreciate the subtle statistical/methodological caveats of the finding? It is possible that parents will now ask nurses about their child’s previous/future use of antibiotics. Importantly, nurses should not be surprised that patients and parents can be pro-active in their care. Government policy has increasingly encouraged them to take an active role in their health via initiatives such as the Expert Patient Programme. Moreover, government agencies have attempted to budget for health services based on a ‘fully engaged’ public (Dept of Health — Wanless report, 2002). In addition, traditional gatekeepers of knowledge are slowly being dismantled. For example, medical findings have largely been kept behind barriers such as academic journal subscriptions and have made life difficult for the public to view research — even though it’s often funded by the tax-payer. Due to an increase in access for and interest by the general public, nurses should be prepared to deal with sudden changes in patients'/parents’ views about treatment options as established knowledge is challenged by new research.

Internet-informed patients can induce a sense of anxiety among health professionals, who may fear losing control of the consultation, being viewed as ignorant, or being devalued by the patients (Ahluwalia et al, 2010). Interestingly, about a fifth of general practice nurses (21.9%) found information brought to consultations was off-putting and lengthened the consultation time (Dilliway, Maudsley, 2008). But, 87.1% of nurses also reported the information helped the consultation (Dilliway, Maudsley, 2008).

It would be normal to see nurses engage in sophisticated consultation techniques to deal with the sense of anxiety generated by internet-informed patients — as general practitioners were found to do in a previous study (Ahluwalia et al, 2010). Potentially, nurses may need to recognise and reflect on the emotional shock of being ‘caught out’ during the consultation by a legitimately sourced piece of research. In addition allow themselves to be ‘ok’ with the idea of admitting to a patient that they aren’t aware of that piece of research. Importantly, doctors in the Ahluwalia study asked probing questions of the patient’s new information but also demonstrated respect for the information in order to maintain a healthy dialogue. Of course, some of this will sound and feel a lot like concordant consultation behaviour.

In the context of antibiotics discussion raised by parents, nurses may have to take time to explain some of the subtleties of research methodology — like those outlined above. They could broach this topic in the context of the ‘hygiene hypothesis’ and how early antibiotic use may add to this problem. They might state while this hypothesis is popular with professionals and the public alike, it’s important to note a lack of high-quality studies investigating early antibiotic exposure and eczema development and this does not aid the hypothesis. Nurses may also be asked about different antibiotics on offer. They could engage parents with a finding from Tsakok et al’s review that stated different types of antibiotic may increase eczema development but only three studies in their review conducted such sub-group analyses. Thus, there remains a weak basis on which to have strong conclusions about different types of antibiotic effects on eczema development in early life. In order to deal with parents’ newly-held convictions about antibiotics and eczema, nurses may wish to engage in socratic questioning to guide parents toward more balanced views. They may ask questions (a) for clarification:‘why do you say that?’, (b) to probe assumptions:‘what could we assume instead?’, (c) that probe reasons and evidence:‘what do you think causes this to happen?’, (d) about viewpoints and perspectives:‘what is another way to look at it?’ and/or (e) that probe implications and consequences: ‘what are the consequences of that assumption?’

References


Why is it difficult for the pharmacist to obtain my regular prescription treatments?

A.

Since 2008, community pharmacists have been struggling to obtain supplies of some commonly used medicines and this includes both branded and generic medicines. Although medicine shortages are a problem for a small number of drugs (roughly 30-40 at any one time) this has caused a disproportionate problem for both pharmacists, who have to spend time trying to obtain these products, and patients, who become anxious when they are unable to obtain their medicines. In order to understand how this current problem has developed it is necessary to provide some background on how pharmacists get paid for dispensing.

There is no doubt that the number of prescription items dispensed (ie prescription volume) has increased over the last 10 years. In 2011-12, community pharmacists in England dispensed 885 million prescription items, an increase of 4% on the previous year (NHS Information Centre, 2012). The volume of prescription items has increased over the last 10 years and in the period 2002-3, pharmacists dispensed 566.3 million prescription items. As well as being reimbursed for the costs of the drugs supplied, pharmacists are paid (by the NHS) a professional fee per item, hence the more items they dispense, the greater their dispensing income. In addition, pharmacists are paid extra fees for dispensing specific items such as controlled drugs, trusses and hosiery, etc. There is little profit to pharmacists from dispensing, but any profit they do make comes from being able to purchase drugs at a lower cost than the reimbursement price. For example, a big pharmacy chain can purchase drugs in bulk at a lower cost and hence will make more profit from dispensing. In the past, pharmacists could increase their profit further by purchasing branded drugs from other countries in the European market. This was made possible by differences in the exchange rate which produced uneven pricing of pharmaceuticals between member countries. The dispensing of medicinal products in the UK designed for a particular Eurozone country became known as ‘parallel importing’ and this practice is not illegal, as European trade laws allow free movement of goods between member countries. The only stipulation for using medicines destined for use in another member country was that the product supplied is labelled in English and contains an English patient information leaflet. The downside to parallel importing was the potential shortage of medicines for patients in the countries from which the drugs were imported.

In the last 5 years, parallel importing has reduced as a consequence of differences in the exchange rate between sterling and the euro, such that price differentials favour the export of UK medicines into the Eurozone. Therefore more profit can be made by exporting drugs to the Eurozone than from importing them and ‘parallel exporting’ has, somewhat ironically, largely replaced parallel importing with the net result that many commonly prescribed drugs are unavailable in the UK, which has a direct impact on patient care.

There is little that pharmacists can do to resolve this problem, though some manufacturers have allowed pharmacists to purchase medicines directly from the company. If the supply problem is likely to continue for some time, most pharmacists will contact the prescriber and recommend an alternative product or refer the patient back to their GP. Fortunately, supply problems for dermatological drugs have been minimal except for some combination products such as Timodine® and Trimovate® cream. Furthermore, there doesn’t seem to be an end in sight for the current problem, leading to more frustration and inconvenience for pharmacists and patients alike.

References

What are tan enhancers and what effect can they have for patients using phototherapy?

A.

Societies tend to hold a tan in high regard and it is perceived as somehow beneficial (a “healthy tan”). Furthermore, research suggests that 7% of adults in the UK use sunbeds (Sunbed Association, 2013). However, a tan — especially one derived from using a sun bed — offers only limited protection to sunlight with a sun protection factor (SPF) of 2-4 (Cancer Research UK, 2013).

Increased public awareness of the dangers associated with over-exposure to sunlight has led the search for alternatives that circumvent the need for sunlight. Alternatives have included self-tanning products or ‘bronzers’ available in beauty salons as well as for home use, which frequently contain dihydroxyacetone (DHA). When applied to the skin DHA reacts with amino acids present in the skin to create dark pigments (melanoidins) and the resultant skin staining can last up to 10 days but actually provides a low SPF (3-4).

In recent years there has been increased interest in compounds known as melanotans, of which there are two: melanotan I and II. It was originally suggested that these compounds might have therapeutic benefits, especially for patients with fair skin who burn easily in the sun. In 2006 a randomised, double blind study showed that melanotan I was able to augment melanin production and induce photoprotection for patients who burn easily (Barnetson et al, 2006).

Melanotan I, now referred to as alfamelanotide and though not currently licensed, is undergoing several clinical trials as a treatment for rare skin diseases such as erythropoietic protoporphyria. In contrast, studies for melanotan II have shown that, while it can induce tanning, it is also associated with spontaneous penile erections as well as increasing libido. This fact has not gone unnoticed and there have been studies exploring this use (Hadley, Dorr, 2006) although an analogue of the drug was found to be more effective. Melanotan II is not commercially available and patients would normally have to obtain this illicitly via the internet. The drug has been used by body-builders to attain an instant tan but use has become more widespread and it has been dubbed a “Barbie doll drug”.

Mode of action of melanotans

In order to understand how the melanotans work it is necessary to briefly review the tanning process. When exposed to sunlight, ultraviolet (UV) radiation present in sunlight causes damage to keratinocyte DNA and this event initiates the tanning process by stimulating the release of α-melanocyte stimulating hormone (MSH) from keratinocytes. MSH induces the production of melanin by melanocytes present in the epidermis.

Melanin itself exists in two forms; eumelanin, which is a black-brown pigment, and phaeomelanin, which is yellow-red. Individuals with darker skin have a higher proportion of eumelanin than those with fairer skin. Melanin has a dual function: in response to UV radiation, it is transferred via organelles to form a protective cap over keratinocytes’ DNA to prevent further penetration of UV radiation to the deeper layers of the skin, and it also acts as an antioxidant, mopping up free radicles generated from the action of UV radiation on keratinocyte DNA. The melanotans, being structurally related to MSH, bind to its receptors in the skin, triggering the production of melanin.

Combining phototherapy with melanotans

The value of sunlight in the management of skin disorders has been known for hundreds of years and many patients with inflammatory skin disorders such as eczema or psoriasis regularly report improvements in their condition after exposure to sunlight. Nevertheless, over-exposure to sunlight can be harmful and phototherapy provides a means through which patients can achieve the benefits of light therapy in a controlled manner. Phototherapy dosing regimens vary but are normally incremental, either until erythema develops or the patient achieves the maximum dose.

If a patient were to use illicit melanotan prior to phototherapy, although this would provide a small amount of tanning, it would have little overall impact, merely increasing the dose of phototherapy that can be tolerated. Nevertheless, one potential danger identified from the use of melanotan is the potential to promote changes in melanocytic naevi and some reports in the literature suggest that use of these drugs causes darkening of such lesions, though the colour fades once the drug is discontinued.

There does not appear to be any evidence that the melanotans increase the risk of skin cancer and current studies suggest that these agents do in fact provide protection against sunburn and DNA damage from UV radiation (Langan et al, 2010). However, given that melanotans are not usually obtained from legitimate sources, the quality of the product cannot be guaranteed and patients should be advised to avoid the use of such drugs until legitimate and regulated supplies are more readily available.

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Are generic drugs as effective as the branded products?

Pressure to constrain prescribing costs through the use of generic drugs has been a widely accepted practice within the NHS for many years. The proportion of prescriptions written generically has risen over the last 30 years to the extent that generic prescribing accounted for 68.9% of all prescriptions in 2011 (NHS Information Centre, 2012).

A generic drug contains exactly the same amount of active ingredient as the corresponding branded product, although the excipients (ie, the fillers, colouring agents, etc) might be different. Generic drugs are bioequivalent to the branded product; that is, the rate and extent of absorption are virtually the same or within acceptable margins.

Nonetheless, bioequivalence does not necessarily imply therapeutic equivalence, i.e., that the two drugs have the same clinical effect. It has been argued that differences between the inert fillers used in the generic product might affect the metabolism of the generic drug but the available evidence suggests that this is not the case (Kesselheim et al, 2008). However, in practice, patients can sometimes experience idiosyncratic adverse reactions with certain formulations and it is therefore advisable to ensure that they are always dispensed the specific brand which suits them.

Bioequivalence of topical drugs

Measurement of the peak plasma levels of a topical drug is less relevant since the aim is to achieve therapeutic levels at a local site of action. Consequently, alternative strategies are necessary to demonstrate equivalence for topical drugs. This is easily achieved for topical corticosteroids using the vasoconstriction assay, which is based on the fact that topical steroids cause blanching. A topical steroid generic manufacturer therefore only needs demonstrate that their product induces a similar degree of blanching compared to the branded equivalent in order to obtain a license. For other topical therapies, such as antifungal drugs or vitamin D analogues for psoriasis, clinical endpoint studies are required. For instance, a generic anti-fungal drug can be assessed using mycological cure rates and a generic vitamin D analogue by an equivalent reduction in PASI score.

When generic substitution is not advisable

There are concerns that generic switching in specific therapeutic areas, such as the management of epilepsy, might affect seizure control although the available evidence does not support this concern (Kesselheim et al, 2010). There is also the worry that fluctuations in plasma levels will cause problems for drugs with a narrow therapeutic index, eg, phenytoin, warfarin and carbamazepine, though such concerns are not borne out in practice (Dentali et al, 2011). Despite this, the current BNF (Joint Formulary Committee, 2013, p293) suggests that different brands of the anti-epileptic drug carbamazepine may vary in bioavailability and recommends that it might be “prudent to avoid changing the formulation”. A similar note of caution applies to different versions of modified release products containing more than 60mg of diltiazem (an anti-anginal drug), where again the BNF suggests that such brands “may not have the same clinical effect”. Such products should therefore be prescribed by brand name rather than written generically (Joint Formulary Committee, 2013, p131).

Problems with dermatological drugs

There are few published studies to suggest any problems associated with differences in the bioavailability of dermatological treatments. However, one study found a five-fold increase in acute vestibular adverse reactions (eg, dizziness, nausea or vertigo) between generic and branded minocycline products used in the treatment of acne (Payette, Grant-Kels, 2012). Some studies in the early 1990s found differences between branded and generic topical steroids based on the vasoconstrictor assay; these comparisons are no longer relevant because generic manufacturers are required to show equivalence to the branded product using this assay.

In this way, pharmacists can ensure that the patient always receives the specific brand that suits them and is therefore likely to continue to use.

References


Dermatology services in Hull and East Yorkshire

Janet Osgerby

Hull and East Yorkshire Trust serves a population of six million in the immediate area and covers a much wider community for access to specialist services, across North and North East Lincolnshire and North Yorkshire. The dermatology department was established by the late Dr Kalman Keczkes in 1966, who was the first full-time consultant in the area, with the challenging task of setting up a new ward within a new hospital. This service operated on the Hull Royal Infirmary site, with a 26-bedded ward and a separate outpatients department. In the 1990s both services were combined and relocated to the Princes Royal Hospital. Here many of the services, which still continue today, were developed.

Overall the department endeavoured to enable patients to self-manage their skin condition as far as practicable. One innovative service that exemplifies this forward-thinking approach was the Frequent Flyer. This programme provided a rapid access helpline for patients who were experiencing difficulties or deterioration. Another essential development was the training of four senior nurses as prescribers, establishing them as Clinical Nurse Specialists, working alongside the Ward Sister role. This role was developed by the prescribers’ mentor, Dr Shernaz Walton. Finally a hub and spoke structure was developed to provide care closer to home and give patients a choice of location. Clinics, day cases and phototherapy began to be delivered within a different part of the city.

In 2010 the service relocated back to Hull Royal Infirmary into a dedicated new build. While the ward no longer exists, access to inpatient beds is still available within the same complex. Despite such challenges and changes many of the services developed in the early years still exist in a modern, relevant form, being complemented by the newer elements of the department.

Today a large outpatients houses the two consultants, Dr Shernaz Walton and Dr Javed Mohungoo, supported by an experienced staff team. The medical staff provide new and follow-up clinics alongside regular features such as the skin surveillance clinic, paediatric clinics and the ‘two-week wait’ clinic, where patients attend as new referrals and have surgery the same day if required. Alongside this work are the two theatres for our minor surgery lists. Finally our patch-testing clinic provides over 20 different series for contact allergy testing.

Our nursing team comprises 18 members: Clinical Nurse Specialists, a Clinical Support Worker; a full-time research nurse, an auxiliary nurse and senior and junior staff nurses. We are fortunate to have several staff who have worked within dermatology for over 30 years, who have shaped our service into what it is today. Christine Simpkin leads the phototherapy and photodynamic services across primary and secondary care. The award-winning biological service is managed by Yvonne Skelly, who also developed our biological programme; and finally our leg ulcer clinics were established by Angie Oswald, whose good work continues despite her changing role. A relatively new post within the department is that of the skin cancer specialist nurse. Karen Rhodes, our previous ward sister for many years, has taken on this role and manages the service.

Our nursing team provides day care services offering intensive topical treatments, education and monitoring; in addition to supporting all the clinics noted above. Some essential services are provided from 8am to 8pm, to enable patients to continue their normal daily lives.

Finally, research is a central aspect of the service, which is continually evolving. Various projects are currently being undertaken covering bullous pemphigoid (BLISTER), pyoderma gangrenosum (STOP GAP), acne, psoriasis and body image. Dr Shernaz Walton was awarded the BADBIR investigator’s award by the British Association of Dermatologists in 2011 and the same award for the BLISTER study in 2012. Peter Jones, Senior Research Nurse, won the Quarterly Award (March 2011 - July 2011) for recruitment into the BLISTER Study and the team also won an award for recruitment in the STOP GAP trial in 2011.

Expansion of service delivery within our communities presents a challenge for the future. Providing care closer to home will build on the work already undertaken in our hub and spoke approach. Other ambitions and challenges include increasing links with local schools and expanding our sun awareness promotion; in addition to the continued provision of medical and nurse training via the linking of Hull and York Universities. Finally we hope to build on all the years of development from our starting point in 1966 with Dr Keczkes and his challenge to create a new department in a new hospital.

Janet Osgerby is a Staff Nurse at the Dermatology Department, Hull and East Yorkshire Trust

www.bdn.org.uk

Dermatological Nursing, 2013, Vol 12, No 3
At the age of 26 I experienced joint and muscle pain together with inflamed glands, fatigue and night fevers. Unfortunately this was not taken seriously by my GP and I suppose my symptoms were mixed and difficult to associate with lupus. Eventually, after several weeks of extreme pain that made it impossible for me to go to work, my family persuaded me to go for a private consultation. This doctor immediately referred me to hospital and I was prescribed Plaquinil and steroids. Most of the symptoms subsided immediately and, although I had made contact with LUPUS UK and attended a couple of their meetings, I felt that my health problems were behind me. I felt great! I applied for a new job and began work as receptionist/administrator for a GP surgery, but after 18 months many of my symptoms returned.

My hair started to fall out gradually — small areas about the size of 50p coin. I managed to cover it, but eventually it became weaker and at the sides of my head it fell out, leaving permanent scarring of my scalp. My face was severely inflamed, first around the nose but increasing and spreading so quickly all over my face, ears, arms, back and legs. This was all extremely distressing. I was frequently on sick leave and eventually my family suggested that I stopped work to see if that would help reduce my health problems. My boss responded by saying I’d had so much sick leave that I was hardly at work anyway.

I have had many flares since then and each time I’ve experienced many different symptoms connected to the skin. My hands and feet were so severely cracked that flesh was exposed and bleeding, leaving me unable to do cooking, bathing, dressing — in fact anything that involved touching.

My hands and feet were so severely cracked that flesh was exposed and bleeding, leaving me unable to do cooking, bathing, dressing — in fact anything that involved touching. My scalp was similarly affected, looking as if a screwdriver had been inserted a few centimetres deep. Although these wounds have healed, the shape of my head feels different. My fingertips and ears can turn purplish and red, mainly in the cold weather; but I also have to avoid the sun in hot weather.

I was given many medications: immunosuppressive tablets, topical steroid creams, chemotherapy, some IV infusions and more tablets, but they seem to have worsened my skin condition and made my lupus symptoms worse. In my frustration about the situation and at the suggestion of friends, I asked for a second opinion and a referral to a lupus consultant. This was refused three times by my GP but eventually I succeeded in being transferred to St Thomas’s hospital where a thorough examination and case history was taken. At this stage the diagnosis was systemic lupus as well as discoid lupus. I started on Rituximab and most of my symptoms decreased, although the skin and hair scarring have not been reduced. At last I felt listened to, supported by my rheumatology consultant and assisted by staff.

I now experience shared care between rheumatology and dermatology departments, but this is not an ideal experience for patients as the approach between the departments varies widely and I do not feel that my experience of living with symptoms and the effectiveness of medications are listened to, whereas in rheumatology I am asked about how I feel about suggested drug regimes, and told to
This illness has had a huge impact on my life, especially as a young woman. I feel so embarrassed about the way I look, it has destroyed my confidence, particularly in trying to make friends, in relationships and in my search for a new job. I have experienced discrimination because of my appearance at work, in shops, and at my son’s school. It has made us withdraw from many aspects of normal life and I feel useless. I have had counselling in order to overcome these problems and even started a University course, but my lupus symptoms started again so I have had to drop out even though I was only studying part-time.

Day-to-day living is not easy but I keep trying to face up to it and to get better. I wish people would judge me by my personality and not by my appearance — and that includes some of the medical profession who I have felt have bullied me into taking their treatment rather than listening to my fears and concerns. I feel undermined and disempowered because my voice is simply ignored by members of the medical profession. I am made to feel that I have no right to comment on aspects of treatment and medication, and if I do, I’m quickly judged and said to have psychological issues!

The specialist dermatology nurse talked to me about thalidomide. I had heard about the devastating damage this had done to women and their babies in the past, so was worried about that and not at all keen to take it. I had to think about the pros and cons and then discuss them with my family and a trusted friend, as it was such a big decision to make. Eventually I agreed to start on it and was prescribed 50ml three times a day. After the 3rd dose I had a really bad reaction: I couldn’t lift my left hand, the next day I was really dizzy and stumbling about and the 3rd day I couldn’t lift my head from the pillow as everything felt weighed down with a sack of potatoes. So I had to stop taking it.

My dosage has now been adjusted, starting at 25ml and then increased to 50ml after 2-3 weeks, and this has reduced the side-effects. Increasing the dosage to 100ml has caused some weight gain, and my nerves are tested every six months to check for any damage. However, I have seen a big improvement in some of my skin symptoms, although obviously the scarring cannot be reversed.

The whole point of taking this particular medication was to reduce skin inflammation so that laser treatment could be considered and possibly begun. I have approached some organisations regarding laser treatment as the NHS has not been particularly helpful. Hopefully this will be the next step.
The 22nd Annual BDNG Conference, held at Liverpool ACC on July 9-11, was a resounding success, with a record 313 members attending. With this report we aim to give an overview of the conference sessions, which we hope will be helpful for those members who were unable to attend this year, while also providing a summary for those who were there.

**SCIENTIFIC SESSION**
On Tuesday 9 July, following the BDNG AGM, the scientific session opened the academic conference proceedings, with a keynote speaker followed by five selected papers and ending with an update from the UK Clinical Trials Network (UK DCTN).

**The Games people play when doing clinical trials**
Professor Hywel Williams, Director of the Centre of Evidence-Based Dermatology at University of Nottingham

Professor Williams reminded everyone that randomised clinical trials (RCTs) are the cornerstone of evidence-based medicine. RCTs should be critically evaluated, to ensure they have no potential for bias. However, you need to develop a ‘large nose’, to sniff out any flaws in RCTs, for there are ‘games people play’ to hide flaws.

Firstly, the study design: beware of avoidance of active, or inclusion of obscure competitors and placebo-controlled trials. This means that the study is not testing the differences between drugs with similar actions (for example, comparing new drugs to something known to be clinically ineffective). How are the trial and results analysed? Look at how the study samples were randomised and blinded. How is the data presented? Splitting data often improves sub-group analysis, but does this give a true picture? Intention to treat is very important; every patient should be analysed in a trial including those who dropped out — why did they drop out or stop early? The study report should be written up according to the Consolidated Standards of Reporting Trials (CONSORT) guidelines, which encourage transparent reporting of all RCTs. Further information can be found at: www.consort-statement.org

**Paper 1: Screening for psychological distress in patients with a chronic skin disease**
Dr Satveer Mahil, St John’s Institute of Dermatology, London

Dr Mahil informed us that the NICE guideline on depression in chronic disease (CG91) recommends assessing patients for psychological distress by screening questions and using validated measures to inform/evaluate treatments. Dr Mahil outlined how, at St John’s, the Hospital Anxiety and Depression Scale (HADS) was incorporated into the assessment of all patients attending the day treatment centre for treatment of a chronic skin disease. 28 patients completed questionnaires; the mean HADS score was 20.3 with 63% reporting that their emotional health affected the severity of their skin disease ‘often’ or ‘all the time’, 50% felt their emotional health affected work/study and 48% their personal relationships. The majority of respondents (88%) would prefer psychological support arranged via the hospital rather than their GP. This small study shows psychological morbidity has a huge impact for people with skin disease; and the findings support closely co-ordinating psychological care with specialised skin care. The study is covered in more detail on p41 of this issue. The HADS scale can be accessed at: www.hqlo.com/content/1/1/29

**Paper 2: Preceptorships in biologics**
Lucy Moorhead, St John’s Institute of Dermatology, London

Lucy Moorhead defined preceptorship as a period of practical experience and training, supervised by an expert or specialist in the particular field of nursing or medicine. St John’s have offered a two-day preceptorship for nurses working or interested in biological therapy for psoriasis. The programme involves working in a tertiary psoriasis clinic, attending an MDT meeting, recruitment to research (BADBIR) and a session in the nurse-led biologics intervention and monitoring clinic. The last cohort (7 nurses) all gave an excellent evaluation of the programme.

**Paper 3: A study to examine shared decision making from the perspective of the patient with the chronic disease psoriasis, managed in nurse-led care, using the theoretical framework of the Personal Construct Model and Repertory Grid Technique**
Nicole Lawson, Mid Cheshire Hospitals NHS Foundation Trust

Nicole Lawson presented an interesting psychology study which explored the area of chronic disease and nurse-led care. There is a firm belief that decisions regarding patient care should be shared in a partnership with patient and nurse. Using the repertory grid technique, eight personal constructs were identified that affected participants’ perspectives of shared decision making. These included being a good listener; trust and explanation. More information on the personal construct theory can be accessed at: www.centrepcp.co.uk/whatis.htm

**Paper 4: Improving ultraviolet protection in the school and workplace for patients with xeroderma pigmentosum**
Katie Mullard and Sally Turner, St John’s Institute of Dermatology, London

Katie Mullard and Sally Turner are clinical nurse specialists for children and adults with xeroderma pigmentosum (XP). They offer a patient-centred, family-orientated service for patients with XP in the UK. Their presentation focused on a recent project to determine whether their XP service could improve UV protection in the school and the workplace. They visited schools and workplaces to teach key staff and their patients about UV protection and assess whether material improvements could be made, using staff questionnaires and taking UV meter readings.
The education and support from the visits resulted in UV levels dropping significantly and teacher confidence and knowledge improving. An information leaflet has been produced to reinforce the importance of photoprotection in the school and workplace. More information on XP can be accessed at: http://xpsupportgroup.org.uk, and in the article on p20 of this issue.

Paper 5: Isotretinoin prescribing in hospital — a checklist combined with audit improves compliance with guidelines
Kathy Radley, Clinical Nurse Specialist Dermatology, Pilgrim Hospital Boston and Lecturer in Skin Health and Dermatology Care, University of Hull
Kathy Radley outlined the importance of clinical audit by discussing how the addition of a simple checklist helped improve patient care. A local prescribing guideline was agreed in 2005 with compliance monitored by a yearly audit. The results from the audit of compliance against the prescribing guideline were compared over the years, with a pre-treatment checklist introduced in 2009. By 2012, the checklist was completed, recording mood changes in patients’ notes; discussing teratogenicity, contraceptive methods, pre-treatment pregnancy test. The 2012 audit showed 100% of clinicians prescribing isotretinoin gave information leaflets and obtained the patient’s written consent; and 93% of clinicians recorded the method of contraception. This compared favourably with the BAD national isotretinoin audit (showing 74% recorded mood change and 90% completed the consent form). The use of a simple checklist with regular audit and feedback is required to improve performance. More information on the BAD national isotretinoin guidelines can be accessed at: www.bad.org.uk/site/622/default.aspx.

Update from the UK Dermatology Clinical Trials Network (UKDCTN)
Dr Carron Layfield, UK DCTN Network Manager, Centre of Evidence Based Dermatology, University of Nottingham
The scientific session concluded with a presentation from Dr Layfield on the UKDCTN. The network aims to conduct high-quality independent multi-centred randomised controlled clinical trials for the treatment or prevention of skin disease. Currently running are 8 fully-funded UKDCTN studies; including the CLOTHES study, comparing the cost-effectiveness of silk clothing with standard care, and the BEEP study looking at 1300 newborn babies with a family history of eczema, to see whether applying emollients to babies with healthy skin can prevent eczema. The UK DCTN has 700 members and is free to join dermatology nurses are encouraged and every two years a nursing prize is awarded. Previous winner Angela Steen described her experience of being awarded the UK DCTN network prize, which gave her support and training to complete her own research study on cellulitis. Angela commented that “my understanding of the research process and ability to critically assess evidence have been greatly enhanced and have given me the confidence to engage in research”. More information on the UK DCTN can be accessed at www.ukdctn.org and on p60.

ACADEMIC SESSIONS
The next two days of the BDNG conference, on 10-11 July, were filled with 14 concurrent academic sessions; a selection of these will now be reported on. Other sessions not covered in this report included: Lesion recognition, Lasers in dermatology; Interpreting blood results, Sun protection, Hand eczema, Is it really eczema or psoriasis — when the rash does not get better; Use of radiotherapy in dermatology; Patient consultation and history taking, and Tropical skin disease.

Medico legal issues for nurses
Lee Gledhill, Barrister and RGN, runs the Nurses Defence Service. He described the process of the Nursing and Midwifery Council (NMC) Fitness to Practice Process. This was illustrated with many examples of cases of reported misconduct brought to the NMC. The learning points from these reports emphasised the importance of working within the NMC Code of Conduct, ensuring practice is always up-to-date, working within limitations, having a good understanding of protocols and procedures and keeping good records.

Cultural issues
Dr Monica Bhushan, Consultant Dermatologist, Manchester, gave a fascinating insight into understanding patients’ cultures and working in a multi-racial society. She outlined the history of skin colour and society’s attitudes and beliefs towards colour; which have changed and evolved over the last 100 years. An understanding of our patients’ cultures can really make big differences to our care. Some examples are that Asian people avoid eye contact out of respect and do not...
allow being touched on the top of their heads or exposing the soles of their feet. Orthodox of the opposite sex to touch them, so will request a ‘same-sex’ clinician. In many cultures, it is important to be careful not to breach interpreters (when family members are used, slowly and ask very specific questions, such as patient confidentiality). It is important to speak create misunderstandings, even with the use of think has caused it? Other co-existent issues ‘what do you call the illness’? and ‘what do you consider unclean. Language barriers can also related to treatment with BRAF inhibitors has been published by Sinha et al, Br j Dermatol 167(5): 987-94. The dermatology nurse consultant’s role in skin surgery ensures continuity of patient care; but ongoing support and clinical supervision is essential. Hedgehog pathway inhibitors (vismodegib) are new targeted treatments for advanced basal cell carcinomas (BCC). Other treatment options for BCC include photodynamic therapy (91% clearance of nodular BCC in 3 months) or topical imiquimod (82% clearance of BCCs after 1 year). Different surgical options are required for different skin cancers. Nursing challenges in managing patients on systemic medication for melanoma include early reporting of adverse events and patient expectations. The BDNG Skin Cancer Nursing Competencies aim to support skin cancer nurses, or nurses entering the speciality in all settings in their career and educational pathway. This will ensure that those who suffer with skin cancers are cared for by competent nurses who have ‘an awareness to expert knowledge’ of their conditions.

### Table 1.

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<thead>
<tr>
<th>Highlights from the joint BDNG/BAD session — Wednesday 10 July</th>
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<tr>
<td>Key learning points</td>
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<tr>
<td>▶ BRAF mutation inhibitors are new treatments for BRAF-V600 mutation-positive metastatic melanoma</td>
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<td>▶ An algorithm to manage skin toxicities related to treatment with BRAF inhibitors has been published by Sinha et al, Br j Dermatol 167(5): 987-94</td>
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### Table 2.

<table>
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<th>The practical workshops are always very popular and in 2013 included:</th>
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<tr>
<td>▶ Cryotherapy</td>
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<td>▶ An introduction to dermoscopy</td>
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<td>▶ Examination of lymph nodes following cancer diagnosis</td>
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<tr>
<td>▶ Best practice in emollients Lunchtime focus sessions were excellent and well attended:</td>
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<tr>
<td>▶ Commissioning — Dr James Kingsland OBE, Clinical Lead, NHS Clinical Commissioning Community President, National Association of Primary Care</td>
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<tr>
<td>▶ Making your presentations presentable — Phil Carroll, Head of Marketing, Derma, UK</td>
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### Top tips and questions and answers with the BDNG sub-groups

In the popular sub-groups session, representatives of the 10 BDNG sub-groups highlighted latest news and top tips. This was followed by an informal Q&A session.

### Emollient formulations from insane to brilliant

Professor Michael Cork, Consultant Dermatologist, Sheffield, explored the spectrum of emollient formulations in current practice and looked to the future of new formulations. He gave an overview of the normal skin barrier and the comprised skin barrier in infants, people with atopic eczema and other dry skin diseases in the older person. Important factors to consider are maintaining a low skin ph of below 5.0, and preventing trans-epidermal water loss and the onslaught of environmental factors, including those within some emollient formulations, such as sodium lauryl sulfate (SLS). The insane formulations are those containing high SLS content, for example aqueous cream and emulsifying ointment. The brilliant formulations are humectant formulations containing natural moisturising factors (NMFs) and restorative lipids.

### Unusual presentations in paediatrics

Heulwen Wyatt, Clinical Nurse Specialist in Paediatric Dermatology, Gwent, shared case studies of children with unusual and rare dermatology conditions; these included Gorlin syndrome, Goltz syndrome, acrodermatitis enteropathica (zinc deficiency), abnormal rare cholesterol synthesis, Klippel-Trenaunay syndrome. Heulwen’s insight and experience of caring for these children and their families was inspirational. The main learning points were that it is important to always look and see the child first and not just the skin; and don’t assume that all skin conditions in children are correctly diagnosed, look for clues and follow your instinct, as many of the case studies shared were initially incorrectly diagnosed.

### HIV and the skin

David Page, Consultant Dermatologist, Barts and The London NHS Trust, commenced with a historical perspective of HIV and AIDS taking us back to the 1980s and pre-HIV treatment, which was established and changed the course of HIV in 1996. Many skin symptoms manifest as a result of HIV, which is often undiagnosed when the patient presents to the dermatologist; these include bacterial abscess, herpes infection, extensive tinea, nail disease, anginal chelitis, Kaposi’s sarcoma, pruritis and nodular prurigo. Existing inflammatory skin disease can become more severe; this is common with psoriasis. As a result of HIV treatment and immunosupression, eosinophilic folliculitis, severe seborrhoic dermatitis, warts and drug rashes are common. The key learning point was that still 25% of people with HIV do not know they have the disease and skin disease often manifests with late presentation. HIV testing for all should be an ‘opt out’ rather than an ‘opt in’ and should be included in all routine blood screening this should include pruritic screening in dermatology.

### BDNG e-posters

11 posters were available to view in e-poster format, covering a range of interesting topics regarding research and audit. These included phototherapy and vitiligo, awareness of the risks of sunbed use, skin cancer self-examination, fibroscanning for methotrexate-induced hepatotoxicity, and influencing factors in managing eczema, psoriasis and melanoma over time. The winning poster is featured and explained opposite.
Adherence to the guidelines is audited annually. The audit is performed using a pro forma and taken from the written record in the patient’s case notes. The results are then prepared and shared with the Trust-wide dermatology team at a clinical governance meeting. Although an annual audit, time taken preparing and presenting the results means it is not always exactly 12 months from the previous audit, and data was presented from audits in 2007, 2009, 2011 and 2012.

Results from the 2007 audit indicated most clinicians were adhering to the guidelines, although there was still some improvement required, but the 2009 audit showed decreasing adherence to the guidelines. Although there had been some change in staffing this was not demonstrating safe prescribing. After this audit a simple pre-treatment checklist was devised and each patient commencing isotretinoin has a copy printed, completed and put in the patient’s case notes. Anonymised results were shared at the clinical governance meeting, and individual clinicians were also informed privately of their performance. The 2012 audit shows significant improvement but still indicates areas for further improvement, especially around recording method of contraception and documenting the giving of a patient information leaflet.

A national audit for prescribing isotretinoin (BAD, 2012) identified 74% dermatologists recording mood change and 90% including a consent form. Local data compares favourably.

After discussion following the audit presentation, data for follow-up visits was also collected and a follow-up checklist developed which will be included in this year’s audit.

The study shows the utility of a simple checklist, but regular audit and feedback is required to improve performance.

**References**

BAD (2012) BAD national audit 2012: Compliance with isotretinoin — national guidance


Isotretinoin is licenced for severe forms of acne. National guidance on use is available as a BAD guideline (Goodfield et al, 2010) and local prescribing (and subsequently monitoring) guidelines were developed based on these, first used in 2005.

Safe and effective prescribing of isotretinoin was identified by the ULHT dermatology team as a key performance indicator; and
The Stone Award went to Trish Garibaldinos, Clinical Nurse Specialist, St John's Institute of Dermatology, Guy's and St Thomas's NHS Foundation Trust. She was nominated by the team at St John's Institute of Dermatology, as below.

"Trish is notoriously modest about her abilities and achievements and may be a little embarrassed to hear that we have nominated her for the Stone Award.

But Trish is an outstanding nurse, who has made a major contribution to dermatology nursing for over 25 years and we feel strongly that her commitment and contribution should be acknowledged and celebrated. We hope she will forgive us!

Trish has worked as a dermatology nurse since the mid 1980s, completing her ENB 393 dermatological nursing course in 1985. She started her dermatology career at St John's Hospital for Skin Diseases when this existed independently on Lisle Street, Leicester Square. She became Sister in Charge of phototherapy and when St John's moved to St Thomas's Hospital in 1989, Trish led a team in a new, larger, nurse-led day treatment and phototherapy department. She has played a significant role in teaching and developing many dermatology nurses and dermatologists during her tenure at St John's. In the last 5 years Trish has moved from a unit manager role into a purely clinical role as nurse specialist for photo-dermatology and is pioneering new nurse-led services in this area.

Trish always puts patients first. She works tirelessly to improve the quality of life for her patients. She is much loved by patients, and it is not surprising that patients have left large legacies to the Day Treatment Unit as a result of the treatment they have received from Trish and her team over the years, such is their devotion and gratitude to her. Trish is at her most characteristic when she drops everything to deal with a patient in person. She will always make herself available for patients and goes to great lengths to provide caring support. Trish won the Nursing Standard Dermatology Nursing Award in 1996 following nomination by her staff, who wanted recognition for the positive effect she had on both their working environment and patient care. Trish was personally acknowledged by actor Paul Eddington in the forward of his book following treatment under Trish’s care before dying from cutaneous lymphoma. “My most heartfelt thanks go to the medical team which has kept me going all this while. Foremost among them is Trish Garibaldinos.” When in a managerial role she always remained very ‘hands-on’ in her clinical work and continues to share her expert knowledge with colleagues and newcomers to dermatology.

Trish has continued to forge ahead with her personal development, qualifying as a nurse prescriber. She has been integral to the development of numerous clinical courses in dermatology and regularly teaches at many levels. She is a significant and reliable member of the dermatology multi-disciplinary team and her opinion and contribution is always highly valued. She is a co-author of evidence-based phototherapy guidelines and is a key player in the local dermatology medicines management group.

Trish played a key role in the early years of the BDNG, supporting Lyn Stone and colleagues in the development of the Group and acting as London regional representative. She also played an important role co-writing the phototherapy competencies for the RCN dermatology competencies project in 2004. She has worked with a number of patient organisations over the years, particularly the Vitiligo support group. She has fully supported and participated in research and audit studies that help to improve care and dignity for patients. Trish does not seek the limelight but sometimes this is thrust upon her and she will always respond positively when it's in the best interest of her dedicated subjects — dermatology and nursing. For example, Trish has ensured dermatological issues have received airplay through several appearances on the BBC 'City Hospital' television programme that was resident in our hospital for 3 years.

Trish strives for best practice and contributes significantly to raise standards of practice in her field of phototherapy. Recently Trish has played a central role in setting up and running the South East of England Phototherapy Network, which is the first organisation in this region and one of the first in the UK, to provide teaching training and support to phototherapists throughout the region. The response to the meetings Trish has arranged has been huge. All have been fully booked and attended by 65 phototherapists. Trish has also been running an oversubscribed phototherapy course on an annual basis for the last 10 years, which is always very well evaluated. Between courses Trish is constantly providing telephone advice to colleagues around the country and receives many visitors for one-to-one tuition. Trish co-leads the BDNG phototherapy sub-group and is driving forward an agenda to improve quality and safety of phototherapy in the UK.

Many people have worked with Trish over the years and all know she has the highest standards of care and gives endless amounts of time and thought to each patient. She takes pride in her practice as a nurse and to the service provided to patients. Her dedication to the speciality and contribution to dermatological nursing practice cannot be understated. Trish is an outstanding colleague, who has made a major contribution to dermatology in terms of patient care, staff training and regionally and nationally in terms of support of other units. She has great professional integrity and demonstrable loyalty to her vocation in dermatology nursing and is a very deserving recipient of The Stone Award."
Dinners & social events

The conference isn’t all work, work, work — it’s also a great opportunity to catch up with friends and colleagues at a variety of social events, as these photographs show.

President Carrie Wingfield, centre, greets guests at the Hard Days Night Hotel. Left to right: Alan Oppenheim of Ego Pharmaceuticals, Jenny Driscoll, Dr David and Tina Nicholls from New Zealand, Brenda Lim.

Guests gather for the annual dinner dance, held in the Great Hall of Liverpool’s historic St George’s Hall.

The President’s Dinner at the Hard Days Night Hotel: Jenny Driscoll, Brenda Lim and Barbara Page.

Karen Stephen with Brenda Lim, our international guest from Singapore, whom we also have to thank for many of these photos!

Left to right, Karen Stephen, Kathy Radley, Sheila Robertson, Fiona Reid, Brenda Lim, Julie van Onselen, Carrie Wingfield and Jenny Driscoll.

Exhibitors at Conference included Dermal, celebrating 50 years with an eye-catching big red bus display.

Views from our international colleagues

I thought that the BDNG meeting was wonderful. I was pleased to have the opportunity to come from Australia to attend and it was well worth the trip. For me the conference covered a good variety of topics. I liked that it not only included current clinical issues, but topics such as legal issues, presentation skills, cultural issues, sun protection and patient history taking. It was also lovely to have the opportunity to talk to so many nurses and gain some insight into dermatological nursing in the UK. I have returned to Australia with renewed motivation. A big thank you to you all for making me feel so welcome. I had a wonderful time and I hope that I will have the opportunity to attend the BDNG meeting again.

Jenny Driscoll, Clinical Nurse Specialist, Royal Prince Alfred Hospital, Sydney, Australia

I am grateful to the organising committee of BDNG 2013 for this invitation. The 4-day conference in Liverpool was indeed an enriching learning experience. I saw a wealth of knowledge displayed among the expert dermatology nursing speakers and participants. I was glad to be able to tap into their expert advice. I will highly recommend any nurse or healthcare professional in the field of skin care to attend the BDNG conference in the future. Thank you very much.”

Brenda Lim, Head-Nursing Department, National Skin Centre, Singapore
Our Prize Journey to the ADNA, Sydney

Heather Baines, Tracey Thompson

A major highlight of both Heather Baines’ and Tracey Thompson’s extensive nursing careers was receiving the Australian Travel Awards, jointly sponsored by Ego Pharmaceuticals and the BDNG, which enabled them to attend the Australian Dermatology Nursing Association (ADNA) conference in Sydney in May 2013. Here they describe their experiences of both the conference and other fascinating places they visited.

After many emails and phone calls, Heather and Tracey finally met in Sydney at the official pre-conference reception, together with Susan Maguire, the BDNG operations manager; Carrie Wingfield, the BDNG president, and Jane Jeavons, the ADNA president.

The ADNA annual two-day conference is completely separate from the dermatologists’ conference and takes place all day on a Saturday and Sunday (literally). Unlike the UK conference, the Australian conference started at 8am with the keynote speaker, Dr Noreen Nicol, commencing at 8:15am with ‘Dermatology nursing reaching across the globe for skin health’. All of the lectures were given in the same lecture theatre. On the first day there were 11 lectures at around 40 minutes each, plus the AGM. There were many excellent speakers covering a wide range of topics, from eczema to non-melanoma skin cancers. The Australian conference seemed to have a larger component of cosmetic dermatology with lectures on lasers and facial resurfacing. After each lecture, each speaker was invited by the chair to draw ticket numbers that were on our name badges for prizes — awarding those who attended the lecture!

Following Saturday’s conference, dinner was hosted by Ego Pharmaceuticals at Casa di Nico in Darling Harbour, and we were welcomed by Alan Oppenheim, Ego’s managing director. It was not a late night as Sunday commenced at 07:00 hours for the biologics breakfast lecture. This was followed by a further nine lectures before the conference closed at 4pm. Alan Oppenheim presented us with a framed certificate of attendance to the conference, which we will proudly show to our colleagues in the UK.

Terry at Ego spoke to both of us before the conference regarding visiting Ego’s head office in Melbourne. Past recipients had taken this tour and commented on how good it was, as it included visiting other centres relevant to their area of interest. Heather, a skin cancer CNS, was keen to visit the Skin and Cancer Foundation while Tracey, specialising in inflammatory diseases with a special interest in paediatrics, opted for the Royal Children’s Hospital.

A chauffeur picked us up from our hotel on the Tuesday morning and took us to our first stop, the Ego factory outside Melbourne, which was really interesting. In the UK Ego has very few products — mainly sunscreens and emollients. In Australia they cover everything from mosquito repellents to cosmetics. Wearing protective clothing, we were shown the strict processes that all Ego products have to go through, from checking the bulk ingredients from suppliers to mixing and bottling to ensure patients have excellent quality products. We met Alan and his wife, thanking him again for the award before being chauffeured to the Skin and Cancer Foundation in Melbourne.

There we were shown the facilities and treatments concerning phototherapy, iontophoresis (for hyperhidrosis and nail psoriasis), patch testing, radiotherapy, Mohs surgery and the minor surgery treatments. As a skin cancer nurse, Heather was interested in the surgical theatres and treatments offered. Tracey was particularly surprised by the size of the narrower phototherapy cabinets (the cabinet size was the same in Brisbane) and the use of iontophoresis with dexamethasone for nail psoriasis. The facilities and layout of the foundation were amazing.

Our final visit was to the recently-built Royal Children’s Hospital in Melbourne, which is home to a massive moving sculpture in the main entrance hall, a 40ft-high fish tank stretching up to the A&E department on the 4th floor, and a meerkat.
Wound healing and skin integrity: principles and practice

Book review by Karina Jackson

This is a must-have book for all dermatology departments and a key resource for all practitioners. It presents a comprehensive and integrated approach to the maintenance of skin integrity and wound management, cross-cutting specialties and professional domains. Each chapter is written by an international expert in their respective field and the clinical information is supported by evidence and is applicable to a UK audience. The book is divided into three logical and sequential sections: Principles of Best Practice; Challenging Wounds and Improving Skin Integrity Services, thereby taking a holistic approach to the subject matter. The first chapter introduces the principles of reviewing evidence to inform clinical decision making, setting out the framework which underpins the following clinically focused chapters, but also reminds the reader of the need for critical appraisal of new emerging evidence in the domain of skin and wound research.

Tracey Thompson: The NHS guidance to PASI scores and DLQI assessments for patients with severe psoriasis are different compared with Australia — PASI needs to be 15 before a biological agent can be considered. DLQIs are not used. However, there is guidance for patients with hand and/or foot psoriasis to have biologics as PASIs would be too low. The pharmaceutical benefits scheme (PBS) is very strict to use the 75% reduction, otherwise the patient is no longer given funding, whereas here in the NHS there is some consultant discretion. Heather and I noticed that many people have private health insurance in Australia, costing up to several hundred dollars a month, which made us feel very proud and fortunate to be part of the NHS.

I met my husband and children in Brisbane and we spent a week catching up with family and friends. I then visited my former dermatology lead, Mary Prentice CNS, and dermatology workplace colleagues including Dr Auld at Princess Alexandra Hospital, before stopping over in Kuala Lumpur on the way back to London. Thank you again to the BDNG, ADNA and Ego for this absolutely wonderful opportunity.

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The final section focuses on considerations in service provision, advancement of specialised knowledge and the continuous evolution of wound dressings. With an estimated annual global spend of US$70 billion on the management of wounds, the call for high-quality research and evaluation to inform standardisation in practice is made.

This book provides contemporary, concise and digestible clinical information on the management of a range of wounds, with the core philosophy of maintenance of skin integrity at its heart. Further suggested reading, guideline references and web resources are provided throughout. I would highly recommend it to any healthcare professional involved in assessment and maintenance of skin integrity.

Heather Baines: I am pleased to say that the NHS offers an excellent pathway for treating patients with skin cancer. Australia leads the field in health promotion for sun protection, particularly with children, and the UK is slowly following in their footsteps, but more education is required to prevent skin cancers. My husband and I stayed in Australia for a further 3 weeks and had the most fantastic holiday visiting northern Queensland. We will return in the future to explore more areas.

The authors would like to conclude with their own personal observations:

Heather Baines: I am pleased to say that the NHS offers an excellent pathway for treating patients with skin cancer. Australia leads the field in health promotion for sun protection, particularly with children, and the UK is slowly following in their footsteps, but more education is required to prevent skin cancers. My husband and I stayed in Australia for a further 3 weeks and had the most fantastic holiday visiting northern Queensland. We will return in the future to explore more areas.

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Karina Jackson is a Nurse Consultant, St John’s Institute of Dermatology, Guy’s and St Thomas’ NHS Foundation Trust and Clinical Editor of Dermatological Nursing.
UK Dermatology Clinical Trials Network: Update on Activities

This update focuses on newly funded UK DCTN studies and publication of the PATCH I study results.

New Studies
CLOTHES is a randomised controlled trial (RCT) of silk therapeutic clothing to assess the effectiveness and cost-effectiveness of silk therapeutic clothing for the long-term management of eczema in children with moderate/severe eczema. Funded by the National Institute for Health Research Health Technology Assessment Programme (NIHR HTA), the lead for the study is Dr Kim Thomas, a member of the UK DCTN Executive Committee and a Professor at the University of Nottingham. The trial aims to recruit 300 children aged 1 to 15 years with eczema. Children will be allocated to receive standard care plus silk therapeutic clothing (three sets of long-sleeved tops and leggings, or bodysuits for infants), or standard care alone. The trial is due to start recruiting in October 2013 and will continue for 3 years with individual participation lasting 8 months. Recruitment into this trial will be based in 4 secondary care hospitals: St Mary's Hospital in Portsmouth, Barnet and Chase Farm Hospital in Enfield, Addenbrooke's Hospital in Cambridge and Queen's Medical Centre in Nottingham.

BEEP
We are pleased to announce that we have secured funding (subject to contract) from the NIHR HTA for the BEEP trial — an RCT to investigate whether applying emollients for the first year of life can prevent eczema in a high-risk population. The Chief Investigator for this trial is Hywel Williams, Chair of the UK DCTN.

This will be a large trial; approximately 1300 newborn babies with a family history of eczema, asthma or hay fever will be recruited over a two-year period in 10 recruiting centres across the UK. The primary outcome is the proportion of infants with an assessor blinded diagnosis of when the child is 2 years old. Secondary outcomes include severity of eczema, time to onset, wheezing, adverse reactions, quality of life and cost effectiveness. The children will then be followed up until their 5th birthday to look at longer-term effects of the intervention. We are currently working to get the contract signed for the trial, which is planned to start in 2014.

HELP
This study aims to assess the best treatments for vulval erosive lichen planus when patients do not respond to first-line therapy. The study is funded by an NIHR Clinical Doctoral Fellowship awarded to Dr Rosalind Simpson, who is based at the Centre of Evidence Based Dermatology, University of Nottingham.

The RCT is planned to start in May 2014 and will be a multi-centre, four-armed, open label study investigating the use of hydroxychloroquine, methotrexate and mycophenolatemofetil against topical treatment alone. The study will aim to recruit 60-80 patients in a 12-month window at 10 centres across the UK.

HI-Light
HI-Light stands for Home Interventions and Light therapy for the treatment of vitiligo (also referred to as the HI-Light Vitiligo trial). We are just awaiting final confirmation of funding for the trial through the NIHR HTA programme. HI-Light will be a randomised controlled trial (RCT) of assessing hand-held narrowband UV devices, both alone and in combination with topical steroid, for early focal vitiligo. The CI for the study is Dr Jonathan Batchelor, a member of the UK DCTN Trial Generation and Prioritisation Panel and consultant dermatologist. Further details will follow in the next issue.

PATCH I study results published in New England Journal of Medicine
The PATCH I study was designed to test whether penicillin (250mg) taken twice a day for 12 months could prevent further attacks of cellulitis of the leg. Originally suggested as a study idea by the late Dr Neil Cox back in 2002, this Action Medical Research-funded study was the first UK DCTN fully-funded RCT. We are so proud to see the study results published in such a prestigious journal and would like to thank all who were involved in making the study a success.

A total of 274 patients from 28 hospitals across the UK and Eire, who had experienced at least two episodes of leg cellulitis in the last 3 years, were randomised to either penicillin or placebo and were followed up for a maximum of 3 years.

The results showed that patients in the penicillin group were less likely to have another attack of cellulitis compared with the placebo group (22% compared with 37%). However, this protection was gradually lost after patients stopped taking the medication at 12 months and, by 3 years, around half of all patients in both groups had suffered at least one further episode, so longer-term antibiotics may be required. Go to www.patchtrial.co.uk for more information.


To join the UK DCTN (which is free) please visit www.ukdctn.org
The SDNS was established in 2003 with the support of the British Dermatological Nursing Group (BDNG) and the Scottish Dermatological Society (SDS) to offer a specialty group for healthcare professionals with an interest in dermatology.

This year we celebrated our 10th anniversary and to mark the occasion our Annual General Meeting and Conference, focusing on changes in dermatology, was held at the Royal College of Physicians in Edinburgh on 2nd May. The day started with the AGM, with Carrie Wingfield, the BDNG President, and Susan Maguire, the Operations Manager for the BDNG, in attendance as SDNS members.

Polly Buchanan was voted on as chair elect and will take over as chair when Margaret Nicoll’s tenure of office ends in 2014. After a much appreciated extended term of office, Ann Joy stepped down as membership secretary. Janice Bianchi was elected to fill the void created by Ann’s departure. Two new regional representatives, Jay Jensen for Grampian and Anne Carlin for Greater Glasgow & Clyde (GG&C), were also voted onto the committee. Our membership now stands at 70.

We were fortunate to have two prominent keynote speakers. In the morning session Lynette Stone, CBE, founder member of the BDNG, provided us with a personal reflection on the history of dermatology nursing. Ros Moore, Chief Nursing Officer for Scotland, opened the afternoon session with a presentation on ‘The Professional Landscape for Dermatology Nursing’.

As part of the 10-year anniversary celebrations three posters, in the form of timelines, were designed and displayed at the conference. These highlighted the changes in the management of patients with psoriasis, melanoma and eczema. The timelines were also accepted for exhibition at the BDNG conference this year.

To round off a very successful day, the Barbara Page Dermatology Nurse of the Year was awarded to Suzanne Hartness, dermatology sister in Paisley Royal Alexandra Hospital. She was nominated by her colleagues for her commitment to dermatology nursing. Suzanne has been instrumental in the development of new services and new nursing skills and practice. She leads and supports a successful nursing team, who received the Chairman’s Award for Improving Health in 2012 in recognition for establishing a rapid access clinic for skin cancer services. Suzanne is described as exceptional by her colleagues, earning great respect not only from them, but from patients and managers also. A very worthy winner.

Dermatology in Scotland has again seen some major changes to service provision in the last 12 months, including:

- Relocation of services to new accommodation in Ayrshire & Arran, Lothian, Borders and Grampian.
- Grampian services have now been merged with other medical specialities resulting in a reduction in dedicated dermatology beds.
- Looking ahead to 2014/15, Glasgow will see the dermatology services at the Western Infirmary move to Gartnavel General Hospital and the Southern General Hospital services move into the New South Glasgow Hospitals Campus, presently under construction within the grounds of the existing Southern General Hospital and due to open early 2015.
- New services in the form of nurse-led clinics have been introduced in several regions. Paediatric eczema, adolescent psoriasis and eczema clinics, as well as transplant surveillance and vulval clinics, have been initiated in Fife.
- Skin camouflage clinics have been introduced in Lanarkshire and Borders, which has also started an iontophoresis clinic.
- A home phototherapy service was started in Ayrshire & Arran.
- Tayside region has been running some educational sessions on sun damage skin lesions/cancers for new staff and minimal residual activity updates for UV patients.
- Ayrshire & Arran dermatology department successfully hosted a lecture on iontophoresis in January this year.

Although the committee strives to provide regional study days at a low cost to members and non-members, it is proving increasingly difficult for staff to obtain study leave from their health boards, due to the pressure caused by staff shortages, and regrettably this year’s regional study day was cancelled. It is hoped that one will take place this autumn.

Finally, our congratulations go to our Founder and Honorary Chair of the SDNS, Barbara Page, and also to Karen Stevens, Lead Nurse, Dermatology in NHS Tayside, who have both been appointed as Honorary Clinical Lecturers at Dundee University for a period of three years to deliver clinical training in dermatology for second-year undergraduate students.

www.bdng.org.uk
The BDNG conference 2013 celebrated diversity and there was plenty in the programme for non-medical prescribers. Kathy Radley represented the sub-group at conference and Helena Murphy also attended for some of the time. An update of activity at the AGM, including a request for anyone interested in a committee position to join, did yield interest — thank you and watch this space for announcements! In the top tips session Kathy highlighted some issues from ‘NICE CG 153 — Psoriasis: the assessment and management of psoriasis’ relevant to non-medical prescribers. Issues around prescribing isotretinoin were the most-asked questions in the Q&A session. The scientific session, e-poster display and sessions on interpreting blood results and consultation and history taking also provided food for thought for prescribers, as did the session entitled ‘Emollient formulations from insane to brilliant!’ The conference brochure and some of the speakers’ presentations are available on the BDNG website and you can also read more about it on pp52-57.

The committee is busy putting together the non-medical prescribing educational meeting to be held in November in Manchester — do keep an eye on the website for confirmation of the programme and date. Please contact us via the BDNG if you have any topics you would like to see covered in the future at these popular events.

The committee will continue to update the non-medical prescribing sub-group area of the website along with the BDNG, as well as representing the BDNG on the BAD drugs and therapeutics committee.

There is space for another committee member from next summer; if interested, please email admin@bdng.org.uk. We are a friendly committee and this is a great way to get involved with the BDNG.

Erratum:
In the June 2013 issue of DN (Volume 12 No 2), we would like to point out that Tracey Thompson, a Ward Sister at Orpington Hospital, was the author of the non-medical prescribing news report, and not Sara Burr as stated.

Kathy Radley is a Clinical Nurse Specialist Dermatology, Pilgrim Hospital, Boston and Lecturer in Skin Health and Dermatology Care, University of Hull.

MIND & SKIN SPECIAL INTEREST GROUP

Psychodermatology is a developing specialism within dermatology. There is a very strong connection between the mind and the skin. Approximately 30% of people with a skin condition suffer from psychological distress. Many of us are working with people in dermatology and we may find certain situations challenging or we would like to learn a bit more about psychodermatology. In working with people with skin conditions we can encounter a range of difficulties that have a psychological component. For example, people with chronic skin conditions such as eczema or psoriasis may be anxious or depressed and/or scratch a great deal; people with skin cancer may have anxiety, depression, adjustment reactions or concerns about the appearance of skin lesions or scars; or people who pick their skin may have underlying psychological difficulties.

Mind & Skin, a new (initially London-based) special interest group has developed to cater for the needs of professionals working within dermatology with an interest in psychology. Initially the group is open to psychologists, nurses, counsellors and psychotherapists working with clients with skin conditions.

The aims of the group are:

- To have clinical peer supervision.
- To increase collaboration in psychodermatology research.
- To share clinical cases confidentially and offer a forum for safe discussion.
- To discuss theories, models and approaches specific to psychodermatology assessment, therapy and ways of working.
- To enhance our learning to improve client care.
- To develop and foster a holistic approach to the care of people with skin conditions and psychodermatology care within dermatology.

The group will meet approximately 3-4 times a year, either at the Royal London Hospital or near London Bridge on a Friday afternoon from 3.00-4.30pm. The next meeting is on 1st November at 3pm at the Royal London Hospital, Whitechapel.

If you would like to attend or to be added to the mailing list then please contact Dr Reena Shah, Clinical Psychologist, at reena.shah3@bartshealth.nhs.uk. Further details about the meeting will be provided to interested professionals via email. It’d be lovely to liaise with and maybe collaborate with the BDNG psychodermatology sub-group too.

We hope to see you there!
In July 2013, the Skin Cancer Nursing Competencies (SCNC) framework was published on the BDNG website (at www.bdng.org.uk/resources/skin_cancer_comp.html) and simultaneously introduced at the 2013 BDNG conference in Liverpool.

The competencies reflect collaboration of the BDNG with skin cancer nurses and were reviewed by professional organisations and colleagues. With the recent findings in the Francis Report, nursing competence has become a focus and ‘contemporary’ requisite — although for most qualified nurses, competence to deliver safe, evidence-based, high-quality and effective care to their patients has always been at the heart of their practice.

As the incidence of skin cancer in the UK continues on an upward trend, we are faced with significant growing demands on local and national skin cancer services. In 2010, approximately 100,000 non-melanoma skin cancers (NMSC) and 12,818 new cases of malignant melanoma were diagnosed (Cancer Research UK, 2013). Skin cancers are expected to rise by 46% by 2015 (Cancer Research UK, 2013). The total number of people diagnosed each year with malignant melanoma is forecast to exceed 20,000 by 2030 (Cancer Research UK, 2013). Therefore it is essential to plan how we, as healthcare professionals, can contribute in order to meet current and future needs.

Since the publication of ‘Improving Outcomes for People with Skin Cancer Including Melanoma’ (NICE, 2006 & 2010) and subsequent first peer review cycle for skin cancer, the number of Clinical Nurse Specialists (CNS) in skin cancer has increased significantly (NCAT, 2011), however; comparing caseload and CNS numbers to breast CNSs showed not too surprisingly a much higher caseload per skin cancer CNS compared to breast CNS colleagues. A recent survey by the Melanoma Task Force (2011) to all acute Trusts in the UK found that 17% (of 72% of Trusts that responded) was still without a skin cancer CNS. Mostly CNSs work in isolation and may come from a variety of backgrounds, such as dermatology, plastics and oncology, and nationally there have been reports of difficulty with recruitment. It is envisioned that the skin cancer nursing competencies will support skin cancer nurses in all settings in their career and educational pathway. This will ensure that those who suffer with skin cancers are cared for by competent nurses who have ‘an awareness to expert knowledge’ of their conditions. The SCNC will also offer an opportunity for newly-qualified nurses, or nurses seeking to change direction, to use the framework as a guide to gain insight and experience in the speciality with a view, in the long term, of aiding recruitment and retention in the speciality. Understandably the main focus of these competencies is on ensuring clinical quality assurance and maintaining safe and effective practice.

The SCNC are divided into six domains and each domain is divided into levels of competence:

- Level 1: entry point for registered nurses
- Level 2: competent nurse
- Level 3: specialist nurse

The appendices contain supporting evidence and information and practical competencies for minor surgical procedures, PDT and physical examination and follow-up.

Assessment can take various forms, but assessment tools that are familiar to our medical colleagues are available with the competencies on the BDNG website and can be downloaded and used as appropriate.

While timeframes to gain competence are individual and difficult to define, linking into an academic programme will help to focus achievement of competence, and formal OSCE examination at the end of a module requires a pass mark.

The BDNG website provides a list of all current institutions offering dermatology/ skin cancer educational programmes.

Saskia Reeken, Clinical Nurse Specialist Skin Cancer and Dermatology at Kingston Hospital NHSTrust, was the Project Lead on Skin Cancer Nursing Competencies, produced by the BDNG

References
NICE (2010) Improving outcomes for people with skin tumours including melanoma (update). National Institute for Health and Care Excellence
Executive Committee (Trustees)

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Other Posts

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New members welcome!

The sub-groups are always looking for new committee members. If you’re interested in joining any of the sub-groups, please email Sarah Shepherd at admin@bdng.org.uk. To contact any BDNG Committee member, please email admin@bdng.org.uk.
Why write for Dermatological Nursing?
Dermatological Nursing is a quarterly peer-reviewed publication that aims to provide cutting-edge articles on the treatment and management of dermatological conditions and the care of patients with skin problems. While the focus is on dermatological nursing, the information included will be relevant to other healthcare professionals. Writing for Dermatological Nursing can be a useful way to help develop and crystallise ideas about a specific topic, and may encourage exploration of an area in greater depth and lead to further understanding. Once you have made the decision to write for Dermatological Nursing, please contact the Managing Editor to ensure that what you are planning to write has not already been commissioned, and that it is appropriate for the readership. The article should be unpublished and have not been submitted for publication elsewhere.

Major articles published in Dermatological Nursing are available online at IngentaConnect, which offers the most comprehensive collection of academic and professional publications online. More than 5 million articles, available to a global audience, can be accessed by institutional and individual end users on a pay-per-view basis. Your article will therefore potentially reach a wide-ranging readership in dermatological, medical, and nursing circles.

Dermatological Nursing welcomes submissions for publication broadly in the following six categories:
- Clinical Skills/Clinical Review
- Science in Practice
- Research/Audit
- Practice development
- Policy Review
- Case reports

Once your idea has been given the all clear, the following guidelines should be adhered to when preparing your paper for submission.

Title page
The title page should include:
- Title of the article (ideally no more than 10 words)
- The full names of the authors
- Full details of each author’s current appointments, including place of work.

Abstract/Summary
This is typeset in bold at the beginning of the article. As a general guide, articles in the Research/Audit section of the journal have abstracts, while those in the other sections have a summary.
- The Abstract should be no longer than 180 words in length and should contain the following headings: Background, Aims, Methods, Results, Conclusions, Declaration of interest.
- The summary should be a very concise (no more than 90 words) accurate statement that captures the reader’s interest by setting the scene for the article.

Both the Abstract and the Summary should enable the reader to understand the scope and main conclusions of the article without having to read the rest of the paper.

Word count
Word count for all clinical articles (excluding title page, abstract/summary/tables) should not exceed 2800 words and 20 references. Case reports should not exceed 800 words and 5 references.

Short introduction
The introduction is designed to capture the reader’s interest by putting the article into the context of current clinical practice, quoting key references. It should also give the reader an idea of the objectives and contents of the paper: it should be clear and inviting.

Methods
For papers describing original work (usually in the Research/Audit section), a concise but informative account of all techniques (including statistical methods) used should be provided in order to enable the reader to reproduce the work if necessary. Published/standard methods can be referenced; detail is not necessary. However, variations to the published procedure should be described.

Results
For papers describing original work (usually in the Research/Audit section), a comprehensive and clear description of results with tables, graphs, etc., is required. As well as presenting data in pictorial form, a narrative account should be given, since the reader should not be expected to interpret results unaided. Where appropriate, statistical procedures should be used to indicate the variability of results and to test the significance of differences.

Discussion
Papers describing original work (usually in the Research/Audit section) require a discussion. This should not be a repetition of results. It should summarise and interpret your conclusions and comment on their significance in light or what is already known from the literature. Shortcomings in your work should be identified, and suggestions made as to what can be done to extend/confirm your findings.

Conclusions
For all papers, the conclusion should be succinct and logically ordered. It should identify gaps in knowledge and suggest future initiatives.

Headings
Throughout the article, use plenty of headings to break up the text and highlight the main points within the paper. Also remember to indicate the importance attached to each one.

Abbreviation and units
These should be defined at first mention. SI units should always be used.

Key words and key points
Please provide 5 key words to appear at the start of your article, and if possible 3–5 key point sentences that summarise the main themes of your paper.

Tables and illustrations
Tables and illustrations are helpful to demonstrate key data or points to the reader. It is the author’s responsibility to ensure that permission is received for reproduction. Please do not supply more than 10 tables or 10 figures. Please ensure all tables and illustrations have a table heading and figure legend, and are cited in the text.

Photographs
No more than 10 figures (photos should be provided as jpeg or tiff (300dpi), permission for reproduction is the author’s responsibility. All should have legends and should be clearly labelled, and cited in the text.

References
Dermatological Nursing uses the Harvard system of referencing (names cited in the text). The number of references should not exceed 20.

In the reference list:
- References should be listed in alphabetical order.
- The surname and initials of each author should be given in full for six or fewer authors. For seven or more, the names and initials of the first three should be given, followed by ‘et al’. The sequence for a journal reference is: author(s); year; journal; volume; page range.

Sequence, punctuation and layout for books are as follows:

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Exorex Lotion makes a logical first-line choice for treating psoriasis, a condition that can affect an individual’s enjoyment of life.\textsuperscript{1} With an emollient base containing a complex of esterified fatty acids, Exorex is as effective as calcipotriol and superior to a conventional coal tar product in mild-to-moderate psoriasis.\textsuperscript{2,3} So patients may well find themselves feeling more confident in their skin.

Effective psoriasis relief

Exorex Lotion

Coal tar solution 5% v/w cutaneous emulsion

Exorex Lotion Abbreviated Prescribing Information

Presentation: Cutaneous emulsion containing coal tar solution 5% v/w in an emollient base containing a complex of esterified essential fatty acids. 

Indications: Treatment of psoriasis of the skin and scalp. 

Dosage and administration: Adults and children over 12 years of age: Ensure that the lesions are clean. Apply a thin layer of Exorex two or three times per day to the affected areas. Massage gently and leave to dry. For young children under 12 years of age and the elderly: The emulsion may be diluted by mixing with a few drops of freshly boiled and cooled water in the palm of the hand. 

Contra-indications: Sensitivity to coal tar or any of the ingredients. Presence of folliculitis and acne vulgaris. Conditions characterised by photosensitivity. Inflamed or broken skin (open exuding wounds or infection of the skin). 

Warnings and precautions: Discontinue use if irritation occurs. Coal tar enhances photosensitivity of the skin, avoid exposure to direct sunlight after application. Apply with caution to the face and use with care near the eyes and mucous membranes. Do not apply to genital and rectal areas. 

Pregnancy and lactation: Inadequate evidence of safety, it is recommended that the use of coal tar in pregnancy and lactation be restricted to intermittent use, in a low concentration on a relatively small percentage of body surface and that use during the first trimester be avoided. 

Undesirable effects: Skin irritation, photosensitivity of the skin. Coal tar may cause acne-like eruptions of the skin. Refer to the Summary of Product Characteristics for further information. 

Package quantities and cost: 100ml £8.11; 250ml £16.24. 

Legal category: GSL. 

Marketing Authorisation Number: PL 06166/0001. 

Marketing Authorisation Holder: Forest Tosara Limited, Baldoyle Industrial Estate, Grange Road, Dublin 13, Ireland. 

Further information available from: Forest Laboratories UK Ltd, Riverbridge House, Anchor Boulevard, Crossways Business Park, Dartford, Kent DA2 6SL. 

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Date of preparation: August 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 Forest Laboratories UK Ltd. Tel: +44 (0) 1322 421800.