Monash Health Referral Guidelines
DERMATOLOGY

EXCLUSIONS

Services not offered by Monash Health

- Laser and cosmetic procedures
- For allergy services including Skin Prick Testing: refer to Immunology and Allergy

CONDITIONS

INFLAMMATORY SKIN CONDITIONS

Acne
Blistering eruption
Dermatitis (eczema)
Drug eruption
Hidradenitis suppurativa
Psoriasis
Rash of unknown cause
Rosacea
Urticaria

INFECTIONS & INFESTATIONS

Bacterial folliculitis
Mollusca Contagiosum
Pityriasis versicolor
Scabies
Tinea
Warts

TUMOURS

Melanomas
Non-melanoma skin cancer
Naevi
Congenital Naevi

PAEDIATRICS

Atopic Dermatitis (Childhood Eczema)
Infantile Haemangiomas

HAIR CONDITIONS

Alopecia areata
Androgenetic alopecia

NAIL CONDITIONS

Nail dystrophy

PRURITUS

Itch without a rash

PIGMENTARY DISORDERS

Melasma
Vitiligo

PREGNANCY

Pregnancy related rashes

Head of unit: A/Prof Adrian Mar
Program Director: Prof. William Sievert
Last updated: 06/11/2023

Monash Health Referral Guidelines
DERMATOLOGY

REFERRAL
How to refer to Monash Health

Secure eReferral by HealthLink is now our preferred method of referral.

Find up-to-date information about how to send a referral to Monash Health on the **eReferrals page on our website**.

CONTACT US

Medical practitioners
To discuss complex & urgent referrals contact on call registrar via Main Switchboard 9594 6666

General enquiries
Phone: 1300 342 273

PRIORITY
All referrals received are triaged by **Monash Health clinicians** to determine **urgency of referral.**

EMERGENCY

For emergency cases please do any of the following:
- send the patient to the Emergency department OR
- Contact the on call registrar OR
- Phone 000 to arrange immediate transfer to ED

URGENT

The patient has a condition that has the potential to deteriorate quickly with significant consequences for health and quality of life if not managed promptly.

ROUTINE

The patient's condition is unlikely to deteriorate quickly or have significant consequences for the person's health and quality of life if the specialist assessment is delayed beyond one month

Head of unit: A/Prof Adrian Mar

Program Director: Prof. William Sievert

Last updated: 06/11/2023

INFLAMMATORY SKIN CONDITIONS

ACNE

Presentation

- Acne is a potentially scarring condition and the presence of existing scars or moderate to severe disease should prompt active treatment with a systemic agent
- The psychological impact of acne on the individual should always be considered

Initial GP Work Up

- Assess for oligo/anovulation and signs of hyperandrogenism in women that might suggest underlying PCOS

Management Options for GP

- Topical benzoyl peroxide and a topical retinoid, either separately or in a combined product, and topical clindamycin are suitable for mild to moderate acne
- Oral antibiotics for a 3-6 month course and oral anti-androgen therapy for women can be considered for moderately severe acne

WHEN TO REFER?

Routine

Severe (nodulocystic or scarring) acne should be considered for referral to a dermatologist for treatment with oral isotretinoin

BACK

BLISTERING ERUPTIONS

Presentation

- Autoimmune blistering (bullous) skin diseases present with spontaneous blisters and erosions of the skin and sometimes mucosal surfaces; bullous pemphigoid is the most common, while pemphigus vulgaris is potentially the most serious

Initial GP Work Up

- Consider swab testing to exclude bullous impetigo and herpes zoster

Management Options for GP

- Specialist assessment and treatment is required

WHEN TO REFER?

Urgent

- Oral involvement affecting food intake or conjunctival or genital involvement require an urgent referral
- Patients with an extensive symptomatic blistering eruption may be seen more urgently if specified

Routine

Bullous skin eruptions should be referred to the clinic for specialist management

BACK

INFLAMMATORY SKIN CONDITIONS (cont'd)

DERMATITIS (ECZEMA)

Presentation

- Dermatitis (eczema) is characterised by focal itchy red plaques that may be scaly or thickened (lichenified); weeping of the skin is suggestive of this diagnosis
- Crusting and erosions suggest secondary infection with *Staph aureus* or *Herpes Simplex Virus* respectively
- Dermatitis recurring in a localised area raises the possibility of an allergic contact dermatitis

Initial GP Work Up

- Consider bacterial or viral swabs if clinically infected

Management Options for GP

- All patients must avoid long hot showers and soap (although a soap substitute that does not lather can be considered); heaters should be kept low
- Active dermatitis is treated with a topical steroid ointment (low potency for the face; mid to high potency for the body), applied at least once daily until the eczematous plaques have completely flattened; this usually requires 1-3 weeks of continuous use for flexural eczema but may require up to 6 weeks of continuous use for lichenified plaques (including lichen simplex chronicus and nodular prurigo)
- ***Note:*** long term widespread application of topical steroids must be avoided, especially in infants or children, as systemic absorption can occur
- Once the dermatitis has resolved, daily moisturising is required
- For chronic and relapsing cases the topical steroid can be applied 2-3 times a week as a part of the maintenance treatment
- For severe flares consider wet dressings (especially in children) or a short course of oral Prednisolone (especially in adults) 0.5mg/kg daily for 5 days
- For infected dermatitis consider oral antibiotics (eg. cephalexin or flucloxacillin) and/or oral antivirals (eg. aciclovir)

WHEN TO REFER?

Emergency

Any rash causing erythroderma (ie. widespread erythema of the skin) with malaise and loss of temperature control (ie. shivering) should be referred directly to the ED

Urgent

Widespread chronic dermatitis that severely impacts the patient's quality of life or dermatitis that has been significantly exacerbated by secondary infection requires urgent specialist assessment in the Dermatology Clinic

Routine

- Patients with chronic dermatitis not responding to topical therapy require specialist assessment to consider UV or systemic therapy
- The Paediatric Eczema Clinic is a nurse-led clinic that runs alongside the Dermatology Clinic
- The Allergic Contact Dermatitis Clinic assesses patients considered by a dermatologist to have a possible allergic contact cause for their dermatitis; such patients are investigated with the use of patch testing; patients with possible allergic contact dermatitis should be referred to the General Dermatology Clinic for initial assessment

BACK

INFLAMMATORY SKIN CONDITIONS (cont'd)

DRUG ERUPTION

Presentation

- Most drug eruptions present as an acute widespread non-scaly ("morbilliform", ie. measles-like) eruption
- Drug rashes typically occur 1-2 weeks after the commencement of the offending medication but the onset may sometimes be delayed by up to several months (especially for anticonvulsants)
- Mucosal involvement may indicate toxic epidermal necrolysis and should prompt immediate referral; severe drug eruptions may be associated with a fever and in some cases lymphadenopathy and systemic illness (ie. drug hypersensitivity syndrome)

Initial GP Work Up

- Consider blood tests: FBE, U&Es, LFTs

Management Options for GP

- If a morbilliform eruption is considered to be due to a drug allergy, the suspected medication should be ceased immediately and a possible drug eruption recorded in the medical history
- Symptomatic treatment may include a moisturiser and topical steroids (mid to high potency)
- Oral steroids (ie. short course prednisolone) can be considered but is rarely required
- Antihistamines are usually beneficial in treating urticaria and are less useful in morbilliform drug eruptions

WHEN TO REFER?

Emergency

- Any rash causing erythroderma (ie. widespread erythema of the skin) with malaise and loss of temperature control (ie. shivering) should be referred directly to the ED
- Mucosal erosions, skin pain, blisters and fever may indicate the development of toxic epidermal necrolysis and such cases require immediate referral to the ED
- High fever, lymphadenopathy, eosinophilia and systemic illness may indicate a drug hypersensitivity syndrome and should prompt referral to the ED

Urgent

Severe drug eruptions may be referred urgently to the Dermatology Clinic

Routine

- Persistent rashes where the possibility of a drug cause is considered are appropriate for referral to the Dermatology Clinic
- In vitro or in vivo testing for drug allergies is not performed in the department

BACK

INFLAMMATORY SKIN CONDITIONS (cont'd)

HIDRADENITIS SUPPURATIVA

Presentation

- Hidradenitis suppurativa presents as recurrent painful "boils" in the axillae, inguinal and submammary regions and occasionally affects the genital area and buttocks
- This condition often progresses to scarring with discharge and sinus formation
- Early diagnosis and treatment is required in order to prevent permanent disfigurement and psychological distress

Initial GP Work Up

- This condition is not primarily infective and therefore skin swabs are ***not*** needed

Management Options for GP

- Oral antibiotics for a 3-6 month course (eg. doxycycline, minocycline, metronidazole, trimethoprim + sulphamethoxazole)
- Antiandrogen therapy may be of benefit in some female patients
- Failure to adequately respond to the above treatment should prompt a specialist referral to consider treatment with adalimumab (TNF-antagonist)
- Lifestyle modification including weight loss and smoking cessation should be emphasised

WHEN TO REFER?

Urgent

Severe hidradenitis suppurativa unresponsive to standard therapy and having a significant impact on the patient's quality of life may be referred to the Dermatology Clinic on an urgent basis

Routine

Hidradenitis suppurativa is often best managed jointly between a dermatologist and general practitioner

BACK

INFLAMMATORY SKIN CONDITIONS (cont'd)

PSORIASIS

Presentation

- Psoriasis presents with thickened scaly plaques typically located on the limb extensors, scalp, lower back and buttocks
- Psoriasis is usually more scaly but less itchy than dermatitis

Initial GP Work Up

- Associated inflammatory arthritis of the hands, feet or back may require a Rheumatology assessment

Management Options for GP

- A potent topical steroid +/- calcipotriol is applied daily for up to 8 weeks and then intermittently as required
- For thickened plaques consider short-contact treatment with 10% LPC, 10% salicylic acid, 0.5% dithranol cream applied for 10-20 minutes and then washed off; used daily until the plaques have flattened
- Natural UV exposure on a daily basis (eg. 15 minutes before 10am or after 4pm in the summer) is usually beneficial

WHEN TO REFER?

Emergency

Any rash causing erythroderma (ie. widespread erythema of the skin) with malaise and loss of temperature control (ie. shivering) should be referred directly to the ED

Urgent

Widespread psoriasis that severely impacts the patient's quality of life requires urgent specialist assessment in the Dermatology Clinic

Routine

Patients with psoriasis not responding to standard topical therapy require specialist assessment to consider UV or systemic therapy

BACK

RASH OF UNKNOWN CAUSE

Presentation

- The scope of presentations of skin eruptions is vast and while most are inflammatory or reactive in nature, rashes may sometimes be a manifestation of an infective cause or rarely a neoplasm (eg. cutaneous lymphoma)
- The most important consideration, regardless of the age of the patient, is the presence or absence of systemic illness: unwell patients in the presence of a rash require a prompt assessment and diagnosis

Initial GP Work Up

- Consider blood tests: FBE, U&Es, LFTs
- Consider a skin biopsy

Management Options for GP

- In the absence of systemic illness consider symptomatic treatment which may include the use of a moisturiser, cool compress, and the application of a moderate to potent topical steroid

WHEN TO REFER?

Emergency

Any rash associated with significant systemic illness, including general malaise, fever, headaches or loss of temperature control (ie. shivering) should be referred to ED

Urgent

A rapidly evolving and widespread skin eruption where the diagnosis is uncertain and the patient's wellbeing is significantly compromised should be referred for an urgent assessment in the Dermatology Clinic

Routine

Patients with a rash of unknown cause require a specialist assessment and management.

BACK

INFLAMMATORY SKIN CONDITIONS (cont'd)

ROSACEA

Presentation

- Rosacea may manifest as persistent facial erythema and flushing; red papules and pustules; or rhinophoma
- Ocular rosacea includes blepharitis and keratitis
- Topical steroids applied to the face may induce a form of rosacea

Management Options for GP

- Papulopustular and ocular rosacea are treated with oral antibiotics
- Topical agents including antibiotics, azelaic acid and ivermectin can be considered for mild papular disease
- Topical brimonidine may reduce facial erythema temporarily
- Papular disease that is unresponsive to oral antibiotics may respond to oral isotretinion (specialist only)
- Rhinophima should initially be treated with oral antibiotics but may require oral isotretinoin or ablative laser therapy
- Fixed erythema, including telangiectasiae, usually responds well to vascular laser therapy

WHEN TO REFER?

Routine

- Referral for oral isotretinoin may be considered for papulopustular rosacea unresponsive to oral antibiotics or for rhinophima
- The Dermatology Clinic does not currently provide treatment with laser therapies

BACK

INFLAMMATORY SKIN CONDITIONS (cont'd)

URTICARIA

Presentation

- Urticaria is characterised by itchy weals (hives) where lesions last for less than 24 hours and respond to antihistamine treatment; angioedema may occur in some cases
- Acute urticaria may be caused by a viral or bacterial infection, a food or drug, or an insect sting
- Chronic urticaria persists for greater than 6 weeks and is considered to be autoimmune in basis
- Angioedema may be associated with urticaria and can also be allergic (acute) or chronic and relapsing in nature
- For acute urticaria a thorough history is needed to determine a possible allergic cause; skin prick or RAST testing may have a role and assessment by an Allergist can be considered for recurrent or severe cases

Initial GP Work Up

- For chronic urticaria screening blood tests are ***not*** required

Management Options for GP

- Antihistamines are used for symptomatic control; current guidelines support the safe use of non-sedating antihistamines in a dose range that is higher than indicated on standard packaging
- Known trigger factors should be avoided; these may include aspirin and nonsteroidal anti-inflammatory drugs
- Avoiding excessive heat and the use of a soothing lotion (eg. 0.5% menthol in aqueous cream) may be of benefit

WHEN TO REFER?

Emergency

- Angioedema is a medical emergency when the airway is threatened

Urgent

Chronic idiopathic urticaria that severely affects the patient's quality of life may be referred urgently to the Dermatology Clinic

Routine

- Chronic idiopathic urticaria that is not adequately responsive to antihistamines may require treatment with additional systemic agents under the care of a specialist
- The Dermatology Clinic does not provide assessment or treatment of allergy related acute urticaria. Click here to refer to the Immunology and Allergy Service

BACK

INFECTIONS & INFESTATIONS

BACTERIAL FOLLICULITIS

Presentation

- Folliculitis is usually due to *Staph aureus*
- So-called “hot tub” folliculitis is due to *Pseudomonas* in the setting of inadequately chlorinated warm water

Initial GP Work Up

- A skin swab may assist in confirming the diagnosis and a nasal swab may identify *Staph* carriage

Management Options for GP

- Application of an antiseptic wash (eg. triclosan) for 5 minutes and then washed off, initially daily and then 3 times weekly may be beneficial
- Intranasal mupirocin can be considered to treat *Staph* carriage
- Oral antibiotics for 1-3 months may be required (eg. cephalexin or doxycycline) but long term antibiotics should be avoided if possible

WHEN TO REFER?

Routine

Folliculitis is usually best managed in the general practice setting

BACK

MOLLUSCUM CONTAGIOSUM

Management Options for GP

- Ensure any concomitant eczema is adequately treated
- Tape stripping (eg. Micropore™ tape applied over the lesions and changed at bath time) or benzoyl peroxide gel (2.5% or 5%) applied bd to induce an irritant reaction can be of benefit in some cases
- In older children gentle cryotherapy can be tried with or without EMLA applied prior; freezing for 5 seconds may be sufficient, repeating every 2-3 weeks
- Cantharone™ (cantharadin) is an effective treatment that induces an irritant reaction. It is applied by a doctor directly to each lesion and repeated every 4 weeks

WHEN TO REFER?

Routine

- Mollusca are usually best managed in the general practice setting
- Referral for treatment with cantharidin therapy can be considered

BACK

INFECTIONS & INFESTATIONS (cont'd)

PITYRIASIS VERSICOLOR

Initial GP Work Up

- Pityriasis versicolor is usually diagnosed clinically but a skin scraping may help to confirm the diagnosis

Management Options for GP

- Mild cases are treated with an antifungal shampoo (eg. ketaconazole) applied for 10 minutes before washing off; daily for 5 days
- An antifungal cream (eg. ketaconazole) applied overnight for 2 weeks may be needed for unresponsive cases
- Fluconazole 50mg daily for 2-6 weeks may be required for more extensive cases
- The regular use of an antifungal shampoo or fluconazole 150mg monthly may be required to prevent a recurrence in severe cases
- Successful treatment leads to the loss of scale, however patients should be advised that the hypopigmentation may take months to resolve

WHEN TO REFER?

Routine
Pityriasis versicolor is usually best managed in the general practice setting

BACK

SCABIES

Management Options for GP

- Permethrin 5% Cream applied for 8-12 hours
- Ivermectin 12mg (four 3mg tablets) stat
- For both of these treatments consider repeating 10 days later
- Itchiness may yet take several weeks to completely settle
- Sometimes secondary impetigo may need to be treated

WHEN TO REFER?

Routine
Scabies is usually best managed in the general practice setting

BACK

INFECTIONS & INFESTATIONS (cont'd)

TINEA

Presentation

- Tinea can mimic dermatitis but is typically distributed in an asymmetrical pattern
- Papules and pustules may be present, especially if topical steroids have been mistakenly applied

Initial GP Work Up

- A skin scraping will usually confirm the diagnosis

Management Options for GP

- Topical antifungals are appropriate for most cases
- Oral griseofulvin or terbinafine is appropriate for persistent or severe cases

WHEN TO REFER?

Routine
Tinea is usually best managed in the general practice setting

BACK

WARTS

Management Options for GP

- Keratolytic therapy with OTC preparations containing salicylic acid
- Cryotherapy every 2-3 weeks
- Immunotherapy with the contact sensitizer diphencyprone (DCP) can be considered for common and plantar warts
- Podophyllotoxin or imiquimod cream can be considered for genital warts
- Intralesional bleomycin is a treatment option for recalcitrant warts; it is performed by a dermatologist under local anaesthetic

WHEN TO REFER?

Routine

- Warts are usually best managed in the general practice setting
- Referral of recalcitrant warts for treatment with DCP therapy or bleomycin injections can be considered

BACK

TUMOURS

MELANOMA OR POSSIBLE MELANOMA

Initial GP Work Up

- An excisional biopsy should be considered
- A partial biopsy is ***not*** advised

Management Options for GP

- Re-excision with an adequate surgical margin in accordance with the Australian Guidelines for the Management of Melanoma

WHEN TO REFER?

Urgent

- Biopsy - proven melanomas
- Suspicious lesions requiring biopsy or excision
- Referral to either the Dermatology or the Plastic Surgery departments at Monash is appropriate

BACK

NON-MELANOMA SKIN CANCER

Initial GP Work Up

- Biopsy

Management Options for GP

- Superficial basal cell carcinomas (BCCs) can be treated with imiquimod cream, photodynamic therapy (PDT) or surgical excision
- Other BCC subtypes (nodular, morphoeic) can be treated by surgical excision or superficial radiotherapy
- Squamous cell carcinomas (SCCs) vary in terms of risk and urgency for treatment; surgical excision or superficial radiotherapy are suitable treatment options
- Bowen's disease (SCC in situ) can be treated with cryotherapy, 5-fluorouracil cream, imiquimod cream or PDT

WHEN TO REFER?

Urgent

An urgent referral is require for SCCs that are:

- rapidly enlarging
- >2cm in diameter
- located on the scalp, lip or ear
- occurring in an immunosuppressed patient
- demonstrating perineural invasion on biopsy

Other high priority non-melanoma skin cancers:

- Nodular or morphoeic BCCs
- Other SCCs

Routine

- Superficial BCCs
- Bowen's disease

BACK

TUMOURS (cont'd)

NAEVI

WHEN TO REFER?

Routine
- The Dermatology Clinic does not see patients with benign naevi requiring a routine skin check
- Skin checks of at-risk patients are best managed in the general practice setting, and the use of baseline and serial photography can be considered

Presentation
- Patients with a large number of melanocytic naevi (MN) have an increased risk of melanoma, even though the majority of melanomas arise de novo rather than from existing naevi
- A dysplastic melanocytic naevus (DMN) is defined as being >5mm in diameter with at least a part being macular, and has an ill-defined border with irregular pigment distribution; the presence of >4 DMNs is also a risk factor for developing melanoma

Management Options for GP
- Patients with large MN +/- DMN counts should be considered for baseline photography; digital cameras, smartphones or tablet computers can be used by patients and their doctors to assist with melanoma surveillance

BACK

CONGENITAL NAEVI

WHEN TO REFER?

Routine
- Giant CMN are appropriate for referral to the Dermatology Clinic
- Small or intermediate sized CMN that are troublesome cosmetically can be referred to the Plastic Surgery Department for an opinion regarding surgical excision

Presentation
- Small (<2cm diameter) congenital melanocytic naevi (CMN) do not have a risk for malignant transformation; the risk in intermediate sized CMN is very small
- Giant (>20cm diameter) CMN have a 5% lifetime risk for the development of melanoma

Management Options for GP
- Small and intermediate sized CMN can be monitored with photography

BACK

PAEDIATRICS

ATOPIC DERMTATITIS (CHILDHOOD ECZEMA)

Management Options for GP

- See the section on the management of dermatitis here

WHEN TO REFER?

Routine

- The Paediatric Eczema Clinic is a nurse-led clinic that runs alongside the Dermatology Clinic; education on the use of topical therapy and wet dressings is provided
- Referrals are made to the General Clinic

BACK

INFANTILE HAEMANGIOMA

- Infantile haemangiomas usually develop soon after birth and grow rapidly over the first 3 months
- Oral propranolol can arrest the enlargement of these lesions and is most effective if initiated within the first 6 weeks after birth

WHEN TO REFER?

Urgent

Prompt referral is required to assess the need to treat with topical or oral propranolol

BACK

HAIR CONDITIONS

ALOPECIA AREATA

Management Options for GP

- Topical steroid (lotion) in young children and intralesional steroids (Kenacort KA10) in older children and adults is usually effective in cases of localised alopecia areata
- Rapidly evolving or extensive alopecia areata requires systemic therapy
- Early treatment is advised

WHEN TO REFER?

Urgent

Rapid hair loss due to alopecia areata requires prompt assessment and treatment by a dermatologist

Routine

Alopecia areata that is not responsive to standard therapy requires assessment and treatment by a dermatologist

BACK

ANDROGENETIC ALOPECIA

Initial GP Work Up

- Consider blood tests: TSH, iron studies

Management Options for GP

- Topical minoxidil
- For women, consider anti-androgen therapy with spironolactone or cyproterone acetate
- For both men and women consider oral minoxidil (1mg daily, or 5mg twice weekly); finasteride (1mg daily or 5mg 1-2 times weekly) or dutasteride (0.5mg daily)
- Some evidence exists for the benefit in some cases of platelet-rich plasma and light devices

WHEN TO REFER?

Routine

Androgenetic alopecia is usually best managed in the general practice setting, although referral of severe cases can be considered

BACK

NAIL CONDITIONS

NAIL DYSTROPHY

Initial GP Work Up

- Nail clipping for microscopy and culture

Management Options for GP

- Dermatophyte infections are treated with oral terbinafine or itraconazole for 3 - 6 months
- Non-dermatophyte fungal infections can be treated with the same medications however the success rate is lower
- Topical antifungals and laser therapy are effective in treating some patients with onychomycosis
- Oncycholysis can be managed by keeping the nail short and the nail bed dry; white vinegar soaks (1:10 vinegar-to-water) for a few minutes daily can treat Pseudomonas infection; a topical steroid lotion applied under the lifted nail may promote reattachment of the nail
- Psoriatic nail disease may require systemic therapy
- Pincer nail deforming and onychogryphosis cannot be managed with medical treatment; referral to a podiatry service may be appropriate

WHEN TO REFER?

Routine

Nail conditions that cause a significant impact on the patient's quality of life and cannot be treated with antifungal medications or simple measures may be appropriate for referral to the Dermatology Clinic

BACK

PRURITUS

ITCH WITHOUT A RASH

Initial GP Work Up

- History: medications (eg. opioids, aspirin), distribution (eg. head lice, neuropathic if localised), lymphoma B symptoms, responsiveness to antihistamines
- Examination: dry skin, signs of scabies, lymphadenopathy
- Consider blood tests: FBE, U&Es, LFTs, TSH, Fe studies, ESR, HIV

Management Options for GP

- In the absence of systemic illness consider symptomatic treatment which may include the use of a moisturiser, cool compress, and the application of a moderate to potent topical steroid
- Antihistamines and tricyclic antidepressants may be helpful in some cases
- Non-haematological malignancies are rarely the cause for pruritus however in the setting of weight loss or other suspicious signs this possibility needs to be considered

WHEN TO REFER?

Routine

Referral of patients with pruritus in the absence of a rash is appropriate where the initial work-up has been unable to identify a cause and basic management has failed.

BACK

PIGMENTARY DISORDERS

MELASMA

Management Options for GP

- Oestrogen and/or progresterone may trigger melasma and therefore discontinuing oral medicines, implants or devices containing these hormones can be considered
- Sunlight needs to be avoided and this includes visible as well as UV radiation. Mixing a broad-spectrum sunscreen with make-up and applying this year-round is advisable
- An extemporaneously compounded cream comprising 4% hydroquinone, 0.1% tretinoin, and 1% hydrocortisone is often beneficial and should be applied daily for a 6 month period. This product should not be used during pregnancy and long-term use should be avoided
- Laser therapy is not routinely recommended due to poor efficacy and the risk of post-inflammatory hyperpigmentation

WHEN TO REFER?

Routine

Patients with troublesome melasma that has not responded to standard therapy may be referred to the Dermatology Clinic

BACK

VITILIGO

Management Options for GP

- Vitiligo requires prompt treatment in order to halt its progression and maximise the chances of repigmentation
- A moderate to potent topical steroid should be applied daily to the affected areas for at least 1 month
- UV therapy must be commenced promptly as it both suppresses the autoimmune process and may induce repigmentation; patients should be informed that vitiligo may become more prominent during treatment as the surrounding skin tans, however there is no risk of melanoma in the white skin due to an absence of melanocytes in these areas
- “Heliotherapy” involves exposing the skin gently to natural sunlight. The exposure time depends on UV radiation levels but may for example be 15 minutes daily before 10am or after 4pm during a Melbourne summer (without sunscreen). Obviously sunburn is to be avoided.
- Phototherapy booths offer a more accurate dosage of UVB; this treatment is available at Monash

WHEN TO REFER?

Urgent

Rapidly progressing vitiligo requires prompt treatment with topicals, UVB therapy and sometimes oral immunosuppressive agents, and urgent referrals to the Dermatology Clinic are appropriate in such cases

Routine

Without early treatment vitiligo may be permanently disfiguring. Therefore all cases of vitiligo should receive specialist assessment to enable appropriate treatment to be initiated

BACK

PREGNANCY

PREGNANCY RELATED RASHES

Initial GP Work Up

- Consider a skin biopsy

Management Options for GP

- Exacerbations of acne can be treated with topical clindamycin; retinoids both topically and orally must be avoided
- Exacerbations of eczema or psoriasis can be treated with short courses of topical betamethasone diproprionate
- Pruritic urticated papules and plaques of pregnancy (PUPPP) typically presents as an itchy red papular rash on the abdominal striae usually commencing in the 3rd trimester of the first pregnancy; it may spread to the trunk and proximal limbs; PUPPP resolves post-partum but may require the use of cool compresses, topical steroids, antihistamines and in severe cases systemic steroids
- Pemphigoid gestationis is a rare blistering disease similar to bullous pemphigoid which typically occurs in the 2nd trimester; it is pruritic and may worsen during the pregnancy; topical steroids can be initiated before review by a dermatologist

WHEN TO REFER?

Urgent

Pemphigoid gestationis or any rash that causes significant discomfort despite standard therapy is appropriate for an urgent referral to the Dermatology Clinic

Routine

The treatment of skin conditions during pregnancy may require a dermatologist opinion or specialised therapy such as UVB therapy and therefore referral may be appropriate

BACK