

The RCGP Curriculum: Clinical Modules

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for implementation from 1 February 2016

➤ 3.21 Care of People with Skin Problems

Summary

- Around 24% of the population consult their general practitioner (GP) with a skin problem in any 12-month period¹
- About 14% of consultations with a GP are for the management of diseases of the skin. Maintaining competence in this area of medicine, is therefore essential for any GP²
- There is variable (and generally limited) training in dermatology at undergraduate level which means that GP trainees should review their current knowledge and skills³
- Currently about 90% of diseases of the skin are managed exclusively in Primary Care⁴. Most skin disease can and should still be appropriately and efficiently managed in primary care
- Skin disease can impact significantly on quality of life for patients and their families. GPs are in the ideal position to recognise this and help
- Skin cancer rates are increasing and outcomes depend on early diagnosis. GPs have a critical role in early diagnosis

¹ RCGP Birmingham Research Unit. *Weekly Returns Service Annual Report 2006*

² Kerr OC, Benton EC, Walker JJ *et al* Dermatological workload: primary versus secondary care. *British Journal of Dermatology* 2007: 157 (suppl. 1). Looked at burden of dermatological disease presenting across 13 general medical practices in Scotland, serving a population of 100,000, over a two week period. Skin complaints accounted for 14% of all consultations in this study

³ APPGS reports (1998, 2004, 2013)

Davies E, Burg,S. Audit of dermatological content of U.K. undergraduate curricula *British Journal of Dermatology* 2009: 160, 999-1005 www.ncbi.nlm.nih.gov/pubmed/19292717

See also www.ncbi.nlm.nih.gov/pubmed/19410336

Chiange Y *et al* (including C Griffiths & S Burge) Undergraduate dermatology education: a survey of UK medical students *British Journal of Dermatology* 2008: 159 (Suppl.1)

⁴ Information from Hospital Episode Stats (2008) (www.statswales.wales.gov.uk) and data extrapolated from Birmingham RCGP Research Unit prevalence data 2006 in fact gave a figure of 6.1% of consultations for a skin problem resulting in a referral to secondary care

Knowledge and skills guide

Core Competence: Fitness to practise

This concerns the development of professional values, behaviours and personal resilience and preparation for career-long development and revalidation. It includes having insight into when your own performance, conduct or health might put patients at risk, as well as taking action to protect patients.

This means that as a GP you should:

- Ensure that skin problems are not inappropriately dismissed as trivial or unimportant by healthcare professionals

Core Competence: Maintaining an ethical approach

This addresses the importance of practising ethically, with integrity and a respect for diversity.

This means that as a GP you should:

- Empower patients with chronic skin problems, including managing the effects of disfigurement

Core Competence: Communication and consultation

This is about communication with patients, the use of recognised consultation techniques, establishing patient partnership, managing challenging consultations, third-party consulting and the use of interpreters.

This means that as a GP you should:

- Identify symptoms that are within the range of normal and require no medical intervention, e.g. age-related changes such as dry skin/hair loss and innocent moles
- Appreciate the feelings engendered by skin disease, which include fears about contagion (the 'modern-day leper') and concerns about malignancy⁵
- Empower patients to adopt self-treatment and coping strategies, where possible, in such conditions as mild eczema and mild acne
- Appreciate the quantities of cream/ointment/lotion that should be prescribed to enable patients to treat their skin condition appropriately, and when to use each vehicle
- Whilst respecting dignity and observing appropriate hygiene measures, demonstrate that examining the skin and touching affected areas is acceptable
- Describe a skin lesion or rash using dermatologically accurate terms

⁵ See www.changingfaces.org.uk/home

Core Competence: Data gathering and interpretation

This is about interpreting the patient's narrative, clinical record and biographical data. It also concerns the use of investigations and examination findings, plus the adoption of a proficient approach to clinical examination and procedural skills.

This means that as a GP you should:

- Recognise the importance of skin-specific symptoms, e.g. itching and rash distribution
- Appreciate the importance of the social and psychological impact of skin problems on the patients' quality of life (sleep, disfigurement, messy treatment regimens etc.)
- Recognise the spectrum of patterns and distributions of rashes of different skin disorders
- Understand how to carry out more detailed tests where indicated, including skin scrapings and the use of Wood's light
- Be prepared to carry out appropriate examination of the skin, including:
 - Addressing the need to undress the patient sufficiently but with sensitivity to dignity
 - 'Difficult areas' such as the flexures, genitalia and mucous membranes

Core Competence: Making decisions

This is about having a conscious, structured approach to decision-making; within the consultation and in wider areas of practice.

This means that as a GP you should:

- Understand the 'alarm symptoms and signs' for skin cancers that necessitate fast-track referral
- Understand the different indications for patch and prick testing, and when these are appropriate
- Understand the role of histopathology and when to recommend incision or excision biopsy
- Know the indications for curettage, cautery and cryosurgery
- Be aware of likely scenarios for contact dermatitis, where patch testing may be needed
- Be able to distinguish benign from malignant skin conditions and make appropriate referrals

Core Competence: Clinical management

This concerns the recognition and management of common medical conditions encountered in generalist medical care. It includes safe prescribing and medicines management approaches.

This means that as a GP you should:

- Demonstrate appropriate history-taking for patients with skin problems, including past personal history, family history, chemical contacts, occupation and drug usage

- Understand how to recognise common skin conditions in primary care, e.g. eczemas, psoriasis and infections, and instigate appropriate treatment
- Recognise rarer but potentially important conditions and know when to refer to secondary care, e.g. bullous disorders and vasculitis
- Recognise emergency skin conditions, e.g. erythroderma, anaphylaxis and herpetic eczema, and act appropriately

Core Competence: Managing medical complexity

This is about aspects of care beyond managing straightforward problems. It includes multi-professional management of co-morbidity and poly-pharmacy, as well as uncertainty and risk. It also covers appropriate referral, planning and organising complex care, promoting recovery and rehabilitation.

This means that as a GP you should:

- Appreciate that pathology in other systems may lead to skin changes, e.g. skin manifestations of internal disease
- Know the association between psoriasis and arteriosclerosis
- Be able to advise regarding risk of long-term exposure to ultraviolet and sunburn, especially in children
- Be aware of inheritance of common skin diseases, such as eczema or psoriasis

Core Competence: Working with colleagues and in teams

This is about working effectively with other professionals to ensure good patient care. It includes sharing information with colleagues, effective service navigation, use of team skill mix, applying leadership, management and team-working skills in real-life practice, and demonstrating flexibility with regard to career development.

This means that as a GP you should:

- Be aware of primary care resources and when to refer to secondary care so that patients receive appropriate treatment (such as light therapy, biological therapies or immunosuppressant therapy)
- Be aware of local, alternative referral resources such as GPs with a Special Interest (GPwSIs) or specialist nurse practitioners
- Provide patients with information on referral options, if appropriate (GPwSI clinic/Expert Patients Programme (EPP)/specialist nurse/secondary care)

- Know about shared care protocols with secondary care for the follow up of patients with skin cancer/lichen sclerosis et atrophicus and, where negotiated with the secondary care provider, those on isotretinoin
- Consider the help of 'expert patients' for conditions like severe childhood atopic eczema or psoriasis
- Value the role of other members of the primary healthcare team (e.g. specialist health visitors for eczema and wet wrapping, district nurses/nurse practitioners for leg ulcers and wound management)

Core Competence: Maintaining performance, learning and teaching

This area is about maintaining performance and effective CPD for oneself and others, self-directed adult learning, leading clinical care and service development, participating in commissioning, quality improvement and research activity.

This means that as a GP you should:

- Be aware of the major advances in therapy, including biological treatments such as TNFalpha blockers and monoclonal antibodies, for severe disease that has failed to respond to standard second-line therapies
- Understand and implement the key national guidelines that influence healthcare provision for skin problems

Core Competence: Organisational management and leadership

This is about the understanding of organisations and systems, the appropriate use of administration systems, effective record keeping and utilisation of IT for the benefit of patient care. It also includes structured care planning, using new technologies to access and deliver care and developing relevant business and financial management skills.

This means that as a GP you should:

- Consider reviewing all referrals to establish whether the input of secondary care is 'value added' and to establish any learning points for similar cases (i.e. meeting doctors' educational needs (DENS))

Core Competence: Practising holistically and promoting health

This is about the physical, psychological, socioeconomic and cultural dimensions of health. It includes considering feelings as well as thoughts, encouraging health improvement, preventative medicine, self-management and care planning with patients and carers.

This means that as a GP you should:

- Understand the significant quality-of-life issues regarding common skin complaints, which can also impact on the entire family. You should also be aware of:
 - Sleep disturbance from itching, especially for children with eczema (which can also cause disturbed, restless nights for parents and interfere with education)
 - Isolation and loss of confidence, especially in young people with acne or disfigurement (e.g. vitiligo)
- Recognise how disfigurement (including problems like acne which can be seen by doctors as apparently clinically 'trivial') and cosmetic skin changes fundamentally affect patients' confidence, mood, interpersonal relationships and even employment opportunities
- Appreciate the impact of skin disease on family, friends and dependants, and on employers and employment (i.e. career choices)
- Empower patients to self-manage their skin condition as far as practicable
- Give advice on maintaining 'healthy skin', e.g. avoiding unnecessary chemicals and overexposure to sun

Core Competence: Community orientation

This is about involvement in the health of the local population. It includes understanding the need to build community engagement and resilience, family and community-based interventions, as well as the global and multi-cultural aspects of delivering evidence-based, sustainable healthcare.

This means that as a GP you should:

- Understand the effect of a patient's environment/occupation on skin conditions
- Know how to refer to rapid access clinics in secondary care where appropriate
- Understand that services other than the traditional secondary care, consultant-led service may be available, such as camouflage service and other patient support groups, and refer appropriately
- Recognise the evolving trends in disease demographics, e.g. the increasing incidence of skin cancers, an aging population and the increase in ethnic minorities
- Recognise how the cultural differences of your patient population might affect not only the spectrum of skin conditions but also their management
- Recognise the huge prevalence of skin disease in the community and its impact on patient's lives and healthcare resources
- Be aware of locally determined health service priorities, e.g. restrictions on prescribing oral terbinafine/Vaniqa®/topical immunomodulators

Case discussion

Mrs Jane Smith is 36 years old. She is a teacher and married to a computer engineer. They have two daughters, aged ten and eight. Apart from psoriasis she says she enjoys good health, apart from borderline hypertension (not currently on treatment) and a high BMI.

She has had psoriasis since her early teens. Initially this presented with guttate psoriasis after a sore throat, but that soon evolved into chronic stable plaques of psoriasis on the back of her elbows, front of her knees and scattered plaques on her torso – some quite small, others up to the size of the palm of her hand. From time to time she has less scaly, almost shiny, sore areas under her breasts and in her groin and umbilicus. In her scalp she has areas of very thickened scale, and she has a few plaques of psoriasis on the nape of her neck and behind her ears. She keeps her hair long to hide these. Her face, hands and feet are clear. Her nails are 'quite brittle' with a few areas of heaped-up scale under a few of them (especially her right index and middle fingers). She denies any joint pain or stiffness.

In the past she has noticed a significant deterioration in her psoriasis after a sore throat, and she continues to have a bad sore throat at least four or five times a year. Both Mrs Smith and her husband smoke up to 20 cigarettes a day. She rarely has any alcohol. She is on no medication other than the mini pill (her BMI is 31), which she continues, largely as it has stopped her periods.

She previously had about five courses of light therapy (as a teenager PUVA, but subsequently UV-B). The last course was at least five years ago.

She has tried steroids creams (up to Betnovate® strength), which have helped. More recently she has been using a vitamin D analogue ointment, but she says she finds this quite 'irritant' and so has abandoned it. She tells you that a further course of light therapy would be very inconvenient as she works all week. During the holidays she needs to be with the children.

As her GP you are aware that their marriage has been unhappy from time to time. Mrs Smith recently told you they were now sleeping in different bedrooms. They have not had a family holiday for some years.

You ask her how having psoriasis makes her feel and she bursts into tears. 'No one has ever asked me that before,' she says. She goes on to say it makes her feel dirty, uncomfortable and she is desperately embarrassed about it. It looks awful and she is aware she leaves a trail of skin scales wherever she goes. She refuses to take her daughters swimming and the idea of a beach holiday (which her daughters have been begging for) appals her. She is so unhappy about exposing her body that she cannot even get undressed in front of her husband. They have not made love for years. Recently she struggled to hide her tears when her daughter said, 'Why do you never wear pretty skirts like my friend Kirsty's mum?'

Reflective questions

To help you understand how the GP curriculum can be applied to this case, ask yourself the following questions:

Core Competence	Reflective Questions
Fitness to practise This concerns the development of professional values, behaviours and	How hard should I work to help her if she seems unmotivated?

personal resilience and preparation for career-long development and revalidation. It includes having insight into when your own performance, conduct or health might put patients at risk, as well as taking action to protect patients.	
Maintaining an ethical approach This addresses the importance of practising ethically, with integrity and a respect for diversity.	How can I balance my patients' needs with the availability of commissioned services?
Communication and consultation This is about communication with patients, the use of recognised consultation techniques, establishing patient partnerships, managing challenging consultations, third-party consulting and the use of interpreters.	Are there any lifestyle or complementary therapies that she might ask me about?
Data gathering and interpretation This is about interpreting the patient's narrative, clinical record and biographical data. It also concerns the use of investigations and examination findings, plus the adoption of a proficient approach to clinical examination and procedural skills.	What tools could I use to measure severity (DLQI / PDI)? ⁶
Making decisions This is about having a conscious, structured approach to decision-making; within the consultation and in wider areas of practice.	Am I confident I can diagnose psoriasis and distinguish it from other common skin conditions?
Clinical management This concerns the recognition and management of common medical conditions encountered in generalist medical care. It includes safe prescribing and medicines management approaches.	What topical treatments might I prescribe for the various affected areas? How would I approach discussions about the inheritance of psoriasis?
Managing medical complexity This is about aspects of care beyond managing straightforward problems. It includes multi-professional management of co-morbidity and poly-pharmacy, as well as uncertainty and risk. It also covers appropriate referral, planning and organising complex care, promoting recovery and rehabilitation.	Should I consider referring her for consideration of oral second-line therapies (e.g. methotrexate / ciclosporin)? If so, what advice would I give (note she is a smoker and has borderline hypertension)? If her treatment is going to be topical, how is she going to treat her back? How will I manage the complexity in this case?
Working with colleagues and in teams This is about working effectively with other professionals to ensure good patient care.	What resources might be available in the primary health care team to help me manage this patient?

⁶ The best access to the Dermatology Life Quality Index (DLQI) and Psoriasis Disability Index (PDI) is via www.dermatology.org.uk/quality/quality-life.html

<p>It includes sharing information with colleagues, effective service navigation, use of team skill mix, applying leadership, management and team-working skills in real-life practice, and demonstrating flexibility with regard to career development.</p>	
<p>Maintaining performance, learning and teaching</p> <p>This is about maintaining performance and effective CPD for oneself and others. This includes self-directed adult learning, leading clinical care and service development, participating in commissioning*, quality improvement and research activity.</p>	<p>What do I know about ‘complete emollient therapy’ and its place in the management of psoriasis?</p> <p>What advice would I give regarding the use of topical steroids in psoriasis (refer to NICE / SIGN guidelines 2012)</p>
<p>Organisational management and leadership</p> <p>This is about the understanding of organisations and systems, the appropriate use of administration systems, effective record keeping and utilisation of IT for the benefit of patient care. It also includes structured care planning, using new technologies to access and deliver care and developing relevant business and financial management skills.</p>	<p>What advice might I give about a pre-payment prescription?</p> <p>How can I record the distribution of her skin condition on the computer software?</p>
<p>Practising holistically and promoting health</p> <p>This is about the physical, psychological, socioeconomic and cultural dimensions of health. It includes considering feelings as well as thoughts, encouraging health improvement, preventative medicine, self-management and care planning with patients and carers.</p>	<p>What are her priorities for treatment?</p> <p>Mrs Smith is a smoker. Should I use this opportunity to discuss this with her?</p> <p>What is the additional risk of chronic, moderate or severe psoriasis accelerating atherosclerosis? How will I discuss CVS risk factors?</p> <p>Psoriatic arthritis is often unrecognised, but it is essential to manage this actively, as it is common and destructive (NICE / SIGN guidelines). How would I evaluate the presence of this in Mrs Smith’s case?</p>
<p>Community orientation</p> <p>This is about involvement in the health of the local population. It includes understanding the need to build community engagement and resilience, family and community-based interventions, as well as the global and multi-cultural aspects of delivering evidence-based, sustainable healthcare.</p>	<p>Do we provide sufficient support in the community for lifelong dermatological conditions?</p>

How to learn this area of practice

Work-based learning

In primary care

Skin diseases are common and many are chronic. They will therefore necessarily form a large part of your work as a GP. The patient is very likely to be an expert on their own skin and can often tell you a lot about their condition. One of the advantages of working in primary care is the ability to develop a 'longitudinal consultation' by inviting the patient to come back to discuss their skin problem. That provides a great opportunity to look up their condition in the meantime.

It is very easy to fall into the trap of dismissing many skin diseases as trivial (acne, for example), but patients tell us that although they have difficulty raising the issue of their skin problem or discussing it, even with a health professional. The truth is that it can have a considerable impact on their lives. Recognising this and treating the condition well makes an enormous difference.

Be prepared to ask difficult questions (e.g. 'Does your skin condition cause you any problems or embarrassment in your relationships or at work?') and always try to examine and feel skin rashes or lesions (usual hygiene measures of course). For a patient, the 'laying on of hands' by a healthcare professional dispels concerns of contagion and being 'untouchable', as well as helping them to believe you understand what they are experiencing.

Consider discussing with practice members all referrals that are made to dermatology specialists by yourself and your partners to establish what exactly you and your patients are hoping to achieve from the referral – in what way will it be value added? Review your referral again after the patient has been seen to decide whether the same benefit might have been achieved from resources available in primary care.

Consider arranging a Patient Satisfaction Questionnaire (PSQ) for patients with eczema or psoriasis in order to review your delivery of care. An annual Dermatology Life Quality Index (DLQI) assessment takes less than a minute to complete and would demonstrate to your patient that you are interested in the possible detrimental effect of their disease on their quality of life.

Also consider regularly auditing your patients who are on repeat prescriptions for psoriasis treatments. Have you considered whether they might have psoriatic arthritis, that they have previously dismissed as 'wear and tear'?

In secondary care

Attending community-based and GPwSI clinics both give you valuable learning opportunities for general practice. You can also reflect on each case and ask yourself: 'Why was referral deemed necessary and what value-added input has the specialist provided?'

Self-directed learning

Dermatology is high on the learning needs of most professionals working in primary care. As a result, you will find that talks on the subject are regularly included in many continuing education programmes. The Primary Care Dermatology Society (PCDS) mission is to educate and disseminate high standards of dermatology in the community. They run a regular series of 'Essential Dermatology'

days up and down the country, as well as education events on minor surgery and dermoscopy (i.e. skin surface microscopy for increasing the accuracy in diagnosing both pigmented and non-pigmented lesions).

The British Association of Dermatologists, together with CRUK have recently produced a web-based resource for lesion recognition in Primary Care

(www.doctors.net.uk/client/cruk/cruk_skin_toolkit_b09)

On a personal level, your friends and relations will also experience skin problems and talking to them about their experience can be very enlightening.

Learning with other healthcare professionals

Experienced GPs will have seen a lot of skin disease, so ask them for their thoughts. Our nursing colleagues too are a remarkable reservoir of knowledge, approaching patients with skin disease differently from GPs. Specialist health visitors or district nurses are also worth talking to, as of course is the specialist dermatology nurse practitioner.

Remember that your annual appraisal provides an opportunity to reflect on your particular learning needs and plans.

Formal learning

The Cardiff Diploma in Practical Dermatology (DPD) (www.dermatology.org.uk) and the Barts Diploma in London (www.londondermatology.org/index.html) are each largely distance, internet-based learning courses (three terms over a year) with a summative exam and qualification at the end.

Useful learning resources

Books and publications

A key resource is:

- Gawkrödger DJ. *Dermatology: an illustrated colour text (4th edn)* London: Churchill Livingstone, 2008

Other useful texts and resources include:

- Ashton R and Leppard B. *Differential Diagnoses in Dermatology* Oxford: Radcliffe Medical Press, 2004
- Bowling J. *Diagnostic Dermoscopy: the illustrated guide* Oxford: Wiley–Blackwell, 2011
- British Medical Association and Royal Pharmaceutical Society of Great Britain. *The British National Formulary* London: BMJ Books, updated annually
- British Medical Association, Royal Pharmaceutical Society of Great Britain, Royal College of Paediatrics and Child Health. *The Neonatal and Paediatric Pharmacists Group BNF for Children* London: BMA, 2005
- Burge S, Colver G, Lester R. *Simple Skin Surgery* Oxford: Blackwell Science, 1996

- Buxton P (ed). *ABC of Dermatology* (with CD-ROM) London: BMJ Publications, 2003
- Dawber R, Colver G, Jackson A. *Cutaneous Cryosurgery: principles and clinical practice* London: Martin Dunitz, 1992
- Du Vivier A. *Atlas of Dermatology* London: Churchill Livingstone, 2002
- Gawkrödger DJ. *Rapid Reference Dermatology* London: Mosby, 2004
- Hettiaratchy S, Papini R, Dziewulski P. *ABC of Burns* London: BMJ Books, 2004
- Hunter J, Savin J, Dahl M. *Clinical Dermatology* Oxford: Blackwell Science, 2002
- Jones R, Britten N, Culpepper L, et al (eds). *Oxford Textbook of Primary Medical Care* Oxford: Oxford University Press, 2004
- Lawrence C and Cox N. *Physical Signs in Dermatology* London: Mosby, 1998
- Levine GM, Calnan CD, White GM. *Colour Atlas of Dermatology* London: Mosby, 2003
- MacKie R. *Clinical Dermatology: an Oxford core text* Oxford: Oxford University Press, 2003
- Warrell D, Cox TM, Firth JD, Benz EJ (eds). *Oxford Textbook of Medicine (4th edn)* Oxford: Oxford University Press, 2004

Web resources

British Association of Dermatologists

More designed for secondary care, but this is an excellent resource for patient information leaflets (e.g. on phototherapy or isotretinoin). www.bad.org.uk

Cardiff University Dermatology Department

Good patient information resource. Also gives details of the Diploma in Practical Dermatology (DPD). www.dermatology.org.uk

Changing Faces

Patients who may benefit from 'skin camouflage' for scarring or disfiguring skin conditions can be referred to this service. Trained volunteers teach patients to cover and lessen disfigurements using specialist creams and powders. www.changingfaces.org.uk/Home

DermIS

Includes a photo library with a search function. www.dermis.net

Dermnet NZ

Good search engine. Excellent library of pictures and descriptions of diseases (including the uncommon), which can also be used for creating patient information leaflets. www.dermnetnz.org

DermQuest

This is an excellent picture library with news on clinical and research updates available for all. Other parts of the website can only be accessed by DermQuest members. www.dermquest.com

eGuidelines

Gives UK guidelines for dermatology in primary care. www.eguidelines.co.uk

e-Learning for Healthcare

The e-LfH e-dermatology resource provides an excellent series of over 100 tutorials. You will need your GMC number and an NHS email address in order to be allowed access. www.e-lfh.org.uk/projects/dermatology/register.html

Medscape

Medscape has easy-to-navigate, short dermatology articles. <http://emedicine.medscape.com/dermatology>

National Psoriasis Foundation

This site includes photos and short descriptions on psoriasis. www.psoriasis.org

National Rosacea Association

Includes patient education materials and information for physicians. www.rosacea.org

Primary Care Dermatology Society

This is the best web-based resource out there. It gives really good practical advice on managing the common skin problems seen in primary care (see clinical guidance section) and has excellent pictures. www.pcds.org.uk

Royal College of General Practitioners

RCGP resources include minor surgery information. www.rcgp.org.uk/clinical-and-research/clinical-resources/minor-surgery.aspx