Common dermatology challenges in primary care

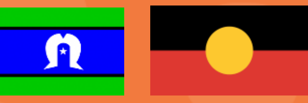
Tuesday March 31 2026

The content in this session is valid at date of presentation

Acknowledgement of Country

North Western Melbourne Primary Health Network would like to acknowledge the Traditional Custodians of the land on which our work takes place, the Wurundjeri Woi Wurrung People, the Boon Wurrung People and the Wathaurong People.

We pay respects to Elders past, present and emerging as well as pay respects to any Aboriginal and Torres Strait Islander people in the session with us today.



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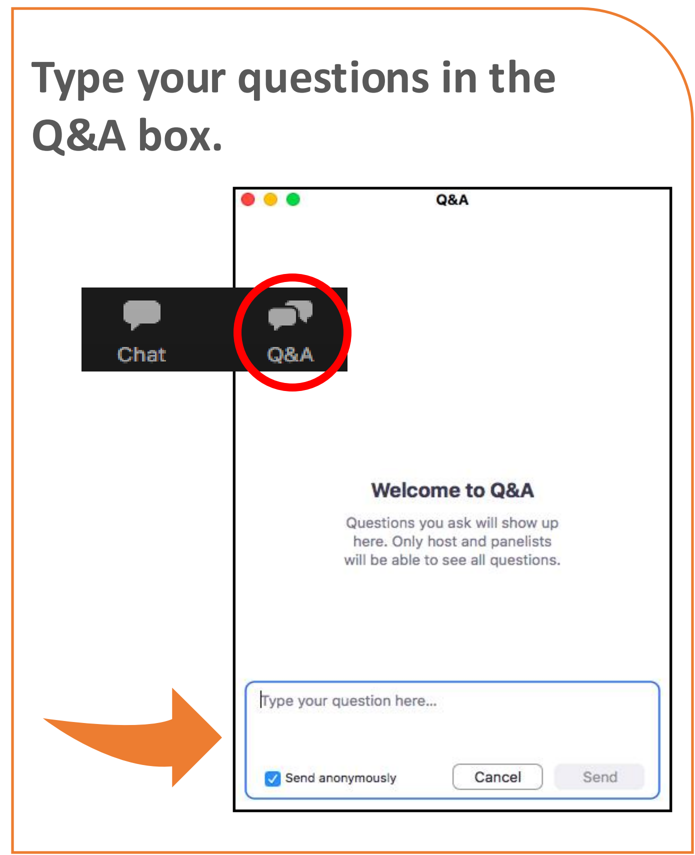
- Q&A will be at the end of the presentation
- Questions will be asked anonymously to protect your privacy

This session is being recorded.

You will receive a link to this recording and copy of slides in post session correspondence.

Type your questions in the Q&A box.



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To ensure we can issue your certificates and CPD please ensure you have joined the session using the same name as your event registration (or phone number, if you have dialled in).

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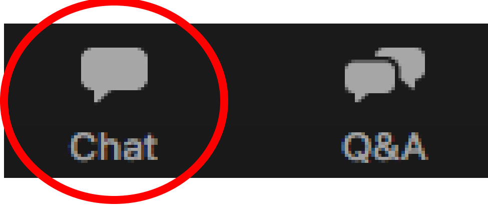

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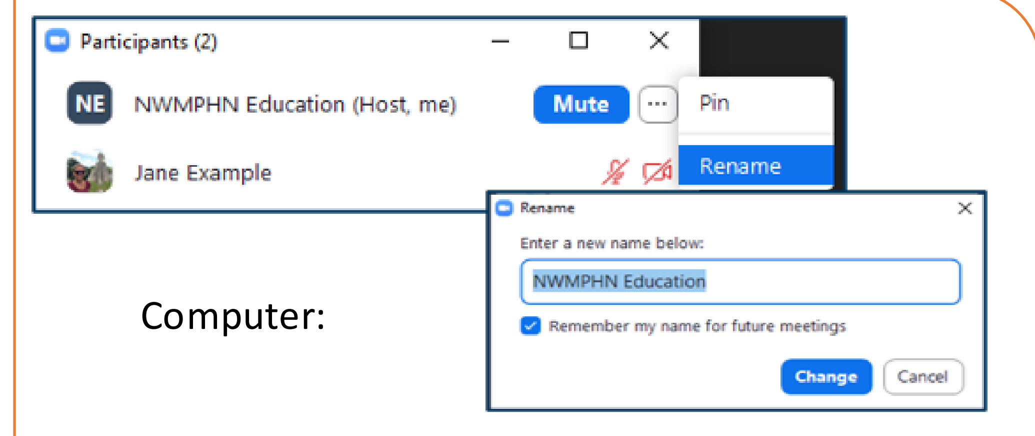
How to rename yourself

1. Click on **Participants**
2. If using
   - App: click on your name
   - Computer: hover over your name and click the 3 dots
   - Mac: hover over your name and click More
3. Click on **Rename**
4. Enter the name you registered with and click **Done / Change / Rename**

Computer:



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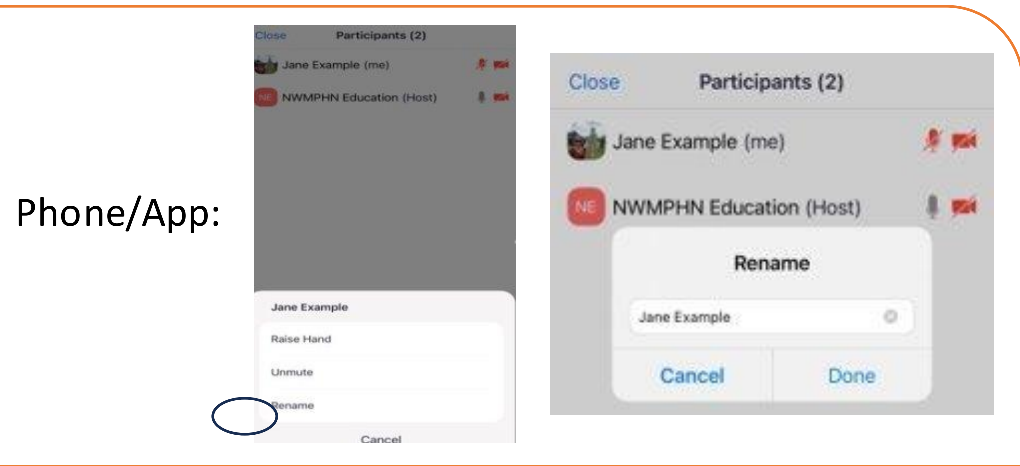


Speakers

***Dr Holly Sexton,** (MBBS (Hons), FACD) is an Australian-trained specialist dermatologist and Fellow of the Australasian College of Dermatologists.*

She completed her training at tertiary centres including Western Health, RCH, RMH, Austin Health, PMCC and Flinders Medical Centre in Adelaide.

Holly was awarded the ACD Travelling Scholarship and Founders Medal for her results in exit examinations. She provides dermatology services to the northern and western suburbs of Melbourne in private practice and public clinics at Western Health and Melbourne Health. She has broad interests including adult and paediatric medical dermatology and dermatologic surgery, and is currently undertaking additional fellowship training in Mohs micrographic surgery.

Measuring outcomes for today

To obtain Measuring Outcomes hours for this session use the RACGP's Measuring Outcomes Tool.

Follow these five steps:

1. Log-in to myCPD
2. At very top of myCPD, click on 'Log'
3. From drop-down menu, click on 'Measuring Outcomes Tool'
4. Complete the form
5. Once you have completed the form, go to top of form and click 'Submit'

Common dermatology challenges in primary care

31 March 2026

Your Clinical Management and Referral Resource

Localised Clinical Pathways
(Evidence-based guidance adapted for Melbourne clinicians)

Referral Information
(Clear referral instructions for local health services and hospitals)

Regular Updates
(Pathways reviewed and updated regularly by Clinical Editors)

CPD Hours
(Track and record CPD activities directly through Pathway page)

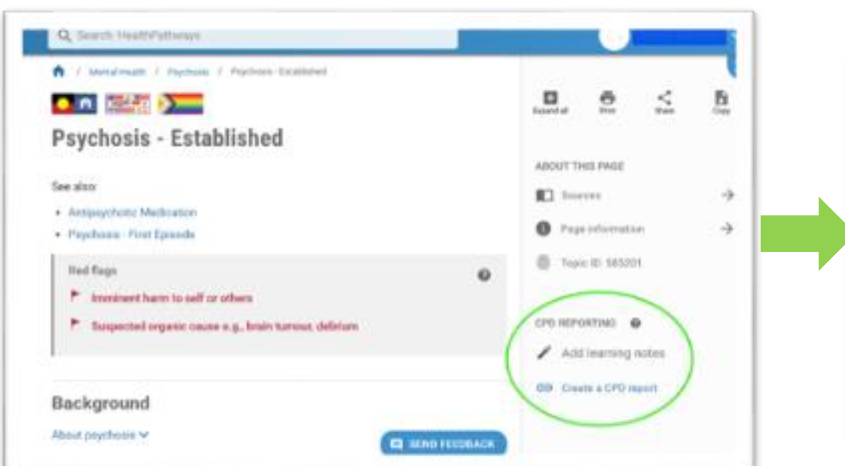
Collaborative Development
(Created by GPs, specialists, allied health and other health professionals)

Easy Access
(Web-based platform, mobile-friendly for point-of-care use)

Streamlined Workflow
(Quick navigation with Assessment, Management and Referral sections all in one place)

Free for Clinicians
(No cost access for all health professionals in North Western and Eastern Melbourne PHN catchments)

Log CPD Effortlessly with HealthPathways CPD Reporting



Step 1: Access a Pathway Page

- Navigate to a clinical pathway (e.g., *Psychosis – Established*).
- Click **“Add learning notes”** or **“Create a CPD report”** to begin tracking your CPD activity.

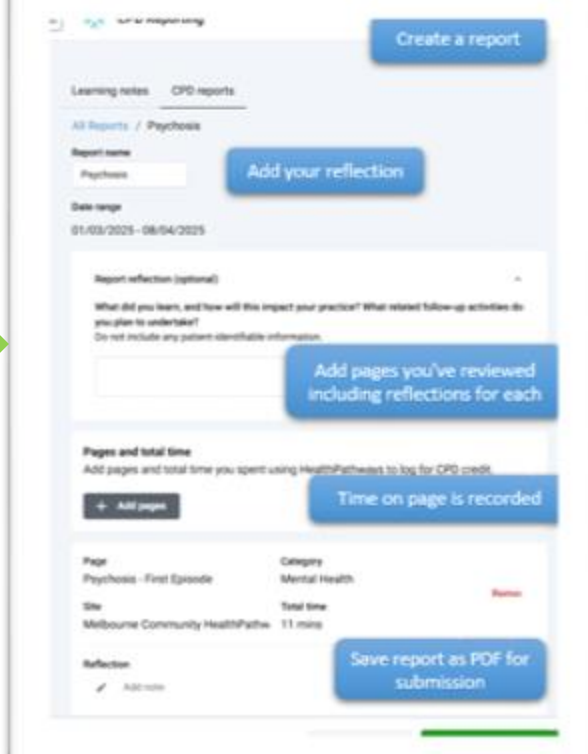
Add learning notes

What did you learn, and how will this impact your practice? What related follow-up activities do you plan to do?

For your convenience, include the CPD category (e.g., educational activities) and the date. This will make it easier to edit and create a thorough report later. Do not include any patient-identifiable information.

Step 2: Add Learning Notes

- Reflect on what you learned and how it will impact your practice.
- Include any planned follow-up activities.
- These notes are saved to your CPD record.



Step 3: Generate Your CPD Report

- Go to the **CPD Reporting** section.
- Add reflections, review pages, and confirm time spent.
- Export your report as a **PDF for submission**.

For further information on the CPD reporting tool, please see these videos:

- How to create a CPD report
- How to add learning notes

Search for the Eczema (Atopic Dermatitis) in Adults Pathway on the Homepage

Use the search bar to **quickly** locate clinical pathways or conditions

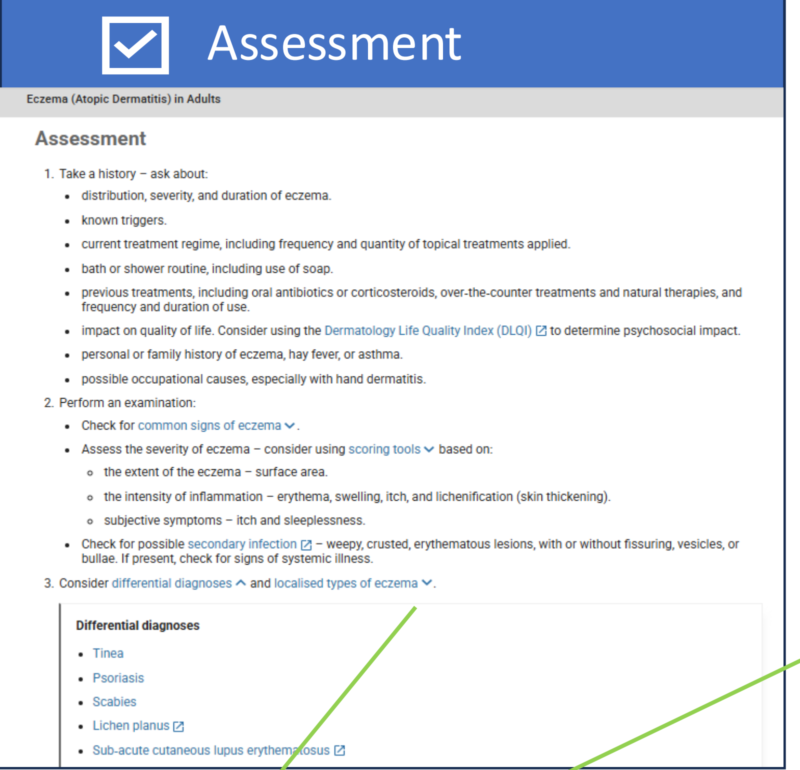
Use the left-hand menu to access clinical categories — **quick and easy to navigate**

Essential quick-access links for latest updates, Pathway updates, clinical resources and MBS items

Click '**Send Feedback**' to add comments and questions about this pathway.

Streamlined Navigation of Eczema (Atopic Dermatitis) in Adults Pathway

All Sections in One Place: Assessment, Management, and Referral sections on a single page, making it easy for GPs to quickly navigate the entire clinical pathway without switching screens.



Assessment

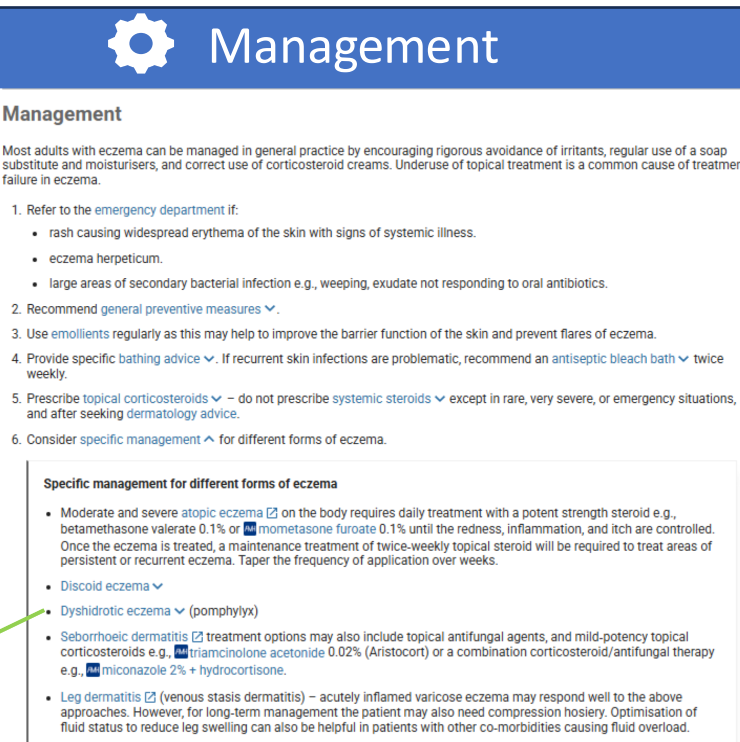
Eczema (Atopic Dermatitis) in Adults

Assessment

1. Take a history – ask about:
   - distribution, severity, and duration of eczema.
   - known triggers.
   - current treatment regime, including frequency and quantity of topical treatments applied.
   - bath or shower routine, including use of soap.
   - previous treatments, including oral antibiotics or corticosteroids, over-the-counter treatments and natural therapies, and frequency and duration of use.
   - impact on quality of life. Consider using the Dermatology Life Quality Index (DLQI) to determine psychosocial impact.
   - personal or family history of eczema, hay fever, or asthma.
   - possible occupational causes, especially with hand dermatitis.
2. Perform an examination:
   - Check for common signs of eczema.
   - Assess the severity of eczema – consider using scoring tools based on:
     - the extent of the eczema – surface area.
     - the intensity of inflammation – erythema, swelling, itch, and lichenification (skin thickening).
     - subjective symptoms – itch and sleeplessness.
   - Check for possible secondary infection – weepy, crusted, erythematous lesions, with or without fissuring, vesicles, or bullae. If present, check for signs of systemic illness.
3. Consider differential diagnoses and localised types of eczema.

Differential diagnoses

- Tinea
- Psoriasis
- Scabies
- Lichen planus
- Sub-acute cutaneous lupus erythematosus



Management

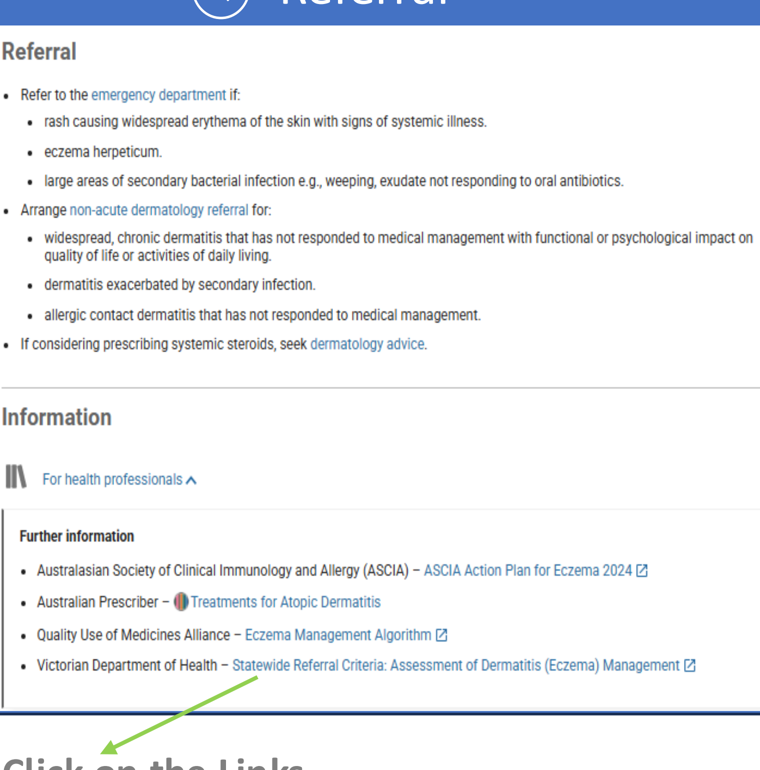
Management

Most adults with eczema can be managed in general practice by encouraging rigorous avoidance of irritants, regular use of a soap substitute and moisturisers, and correct use of corticosteroid creams. Underuse of topical treatment is a common cause of treatment failure in eczema.

1. Refer to the emergency department if:
   - rash causing widespread erythema of the skin with signs of systemic illness.
   - eczema herpeticum.
   - large areas of secondary bacterial infection e.g., weeping, exudate not responding to oral antibiotics.
2. Recommend general preventive measures.
3. Use emollients regularly as this may help to improve the barrier function of the skin and prevent flares of eczema.
4. Provide specific bathing advice. If recurrent skin infections are problematic, recommend an antiseptic bleach bath twice weekly.
5. Prescribe topical corticosteroids – do not prescribe systemic steroids except in rare, very severe, or emergency situations, and after seeking dermatology advice.
6. Consider specific management for different forms of eczema.

Specific management for different forms of eczema

- Moderate and severe atopic eczema on the body requires daily treatment with a potent strength steroid e.g., betamethasone valerate 0.1% or mometasone furoate 0.1% until the redness, inflammation, and itch are controlled. Once the eczema is treated, a maintenance treatment of twice-weekly topical steroid will be required to treat areas of persistent or recurrent eczema. Taper the frequency of application over weeks.
- Discoid eczema
- Dyshidrotic eczema (pomphylyx)
- Seborrhoeic dermatitis treatment options may also include topical antifungal agents, and mild-potency topical corticosteroids e.g., triamcinolone acetonide 0.02% (Aristocort) or a combination corticosteroid/antifungal therapy e.g., miconazole 2% + hydrocortisone.
- Leg dermatitis (venous stasis dermatitis) – acutely inflamed varicose eczema may respond well to the above approaches. However, for long-term management the patient may also need compression hosiery. Optimisation of fluid status to reduce leg swelling can also be helpful in patients with other co-morbidities causing fluid overload.
- Irritant contact dermatitis and allergic contact dermatitis – ideally require removal of patient from the precipitant (sometimes identified by patch testing).



Referral

Referral

- Refer to the emergency department if:
  - rash causing widespread erythema of the skin with signs of systemic illness.
  - eczema herpeticum.
  - large areas of secondary bacterial infection e.g., weeping, exudate not responding to oral antibiotics.
- Arrange non-acute dermatology referral for:
  - widespread, chronic dermatitis that has not responded to medical management with functional or psychological impact on quality of life or activities of daily living.
  - dermatitis exacerbated by secondary infection.
  - allergic contact dermatitis that has not responded to medical management.
- If considering prescribing systemic steroids, seek dermatology advice.

Information

For health professionals

Further information

- Australasian Society of Clinical Immunology and Allergy (ASCIA) – ASCIA Action Plan for Eczema 2024
- Australian Prescriber – Treatments for Atopic Dermatitis
- Quality Use of Medicines Alliance – Eczema Management Algorithm
- Victorian Department of Health – Statewide Referral Criteria: Assessment of Dermatitis (Eczema) Management

Click to Expand

Drop-down boxes appear throughout the pathway, click them to view supplementary information.

Click on the Links

Use the links to open related pathways and resources

Relevant and related Pathways

Relevant pathways

Eczema (Atopic Dermatitis) in Adults
Eczema in Children
Blistering Skin Conditions
Dermatology
Emollients (Moisturisers)
Fungal Skin Infections
Pruritus
Psoriasis
Rashes and Skin Lesions in Early Infancy
Scabies
Steroid Creams and Ointments for Eczema

CPD Hours for HealthPathways Use

Related pathways

Acne
Alopecia
Corns and Calluses
Fungal Nail Infections in Adults
Hair Loss Subsidy
Hidradenitis Suppurativa
Molluscum Contagiosum
Medication Shared Care and Monitoring Guidance

Referral pathways

Acute Dermatology Referral (Same-day)
Non-acute Dermatology Referral (> 24 hours)
Statewide Referral Criteria for Specialist Clinics

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Stay Informed: Access Case Studies and Monthly Bulletin

Case Study

Real clinical scenarios for everyday GP practice

- Concise, practical case studies designed to reflect real presentation in General Practice.
- Includes management summaries, pathway links and local service consideration for quick navigation.
- Access all case studies here.

Monthly Bulletin

HealthPathways
Melbourne

Putting knowledge into practice

melbourne.healthpathways.org.au

Want access to HealthPathways Melbourne? Register here for your HealthPathways account for up to date guidance on clinical and referral pathways for a range of conditions.

What you'll find in this edition

- HealthPathways Melbourne GP Mental Health Treatment Plan updates
- Statewide referral criteria news 1: dermatology
- Statewide referral criteria news 2: children's surgery and ophthalmology conditions
- Insight: HealthPathways Melbourne and Mercy Health
- Case study: Healthy travel preparation
- Case study: Assessing suspected melanoma

Monthly updates straight to your inbox

- Be the first to know about pathway updates, service changes , new case studies and employment opportunities

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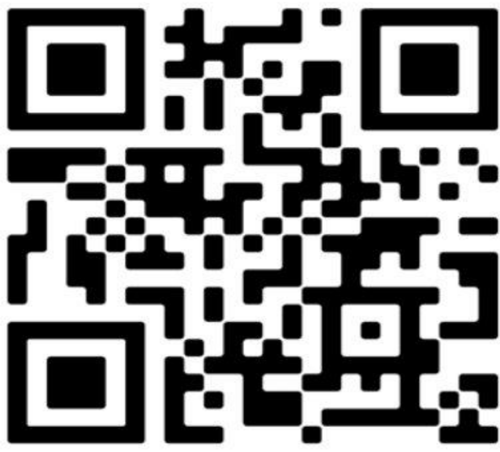

Community HealthPathways | Melbourne

Welcome

This website is for health professionals only.

Important update: individual HealthPathways accounts are now required

To enhance the security and personalisation of your HealthPathways experience, shared logins are no longer available. All users will now need to access the site with an individual HealthPathways account.

Sign in or register to request access.

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Get local health information, at the point of care

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Common Dermatology Challenges in Primary Care

Dr Holly Sexton
Dermatologist

Western Health, Melton Health Hub
Royal Melbourne Hospital

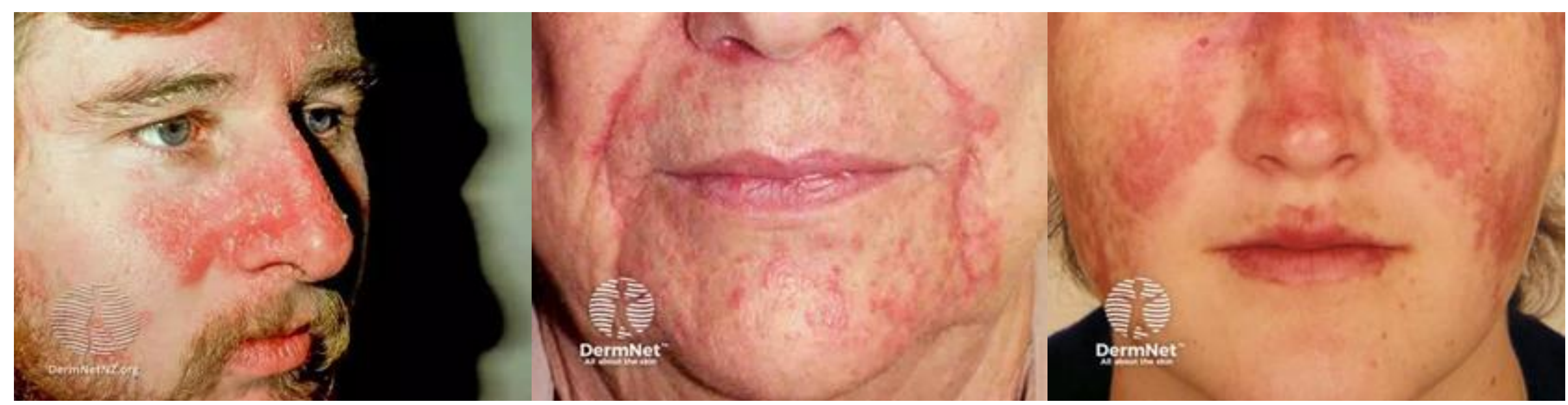
Preston Dermatology and Specialist Centre, Preston
Complete Skin Specialists, Sunbury

Overview

- A selection of common concerns:
  - Facial rash
  - Hyperpigmentation
  - New skin lesion
- Topical therapies
- Dermatology referrals
- Common investigations

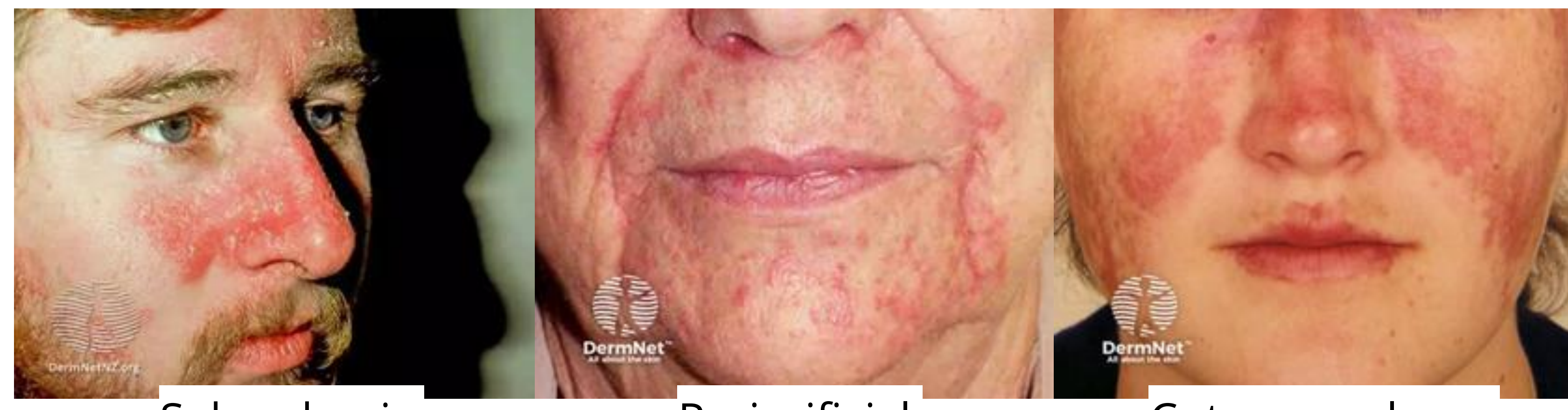
Common Concerns

How to approach the red face



How to approach the red face

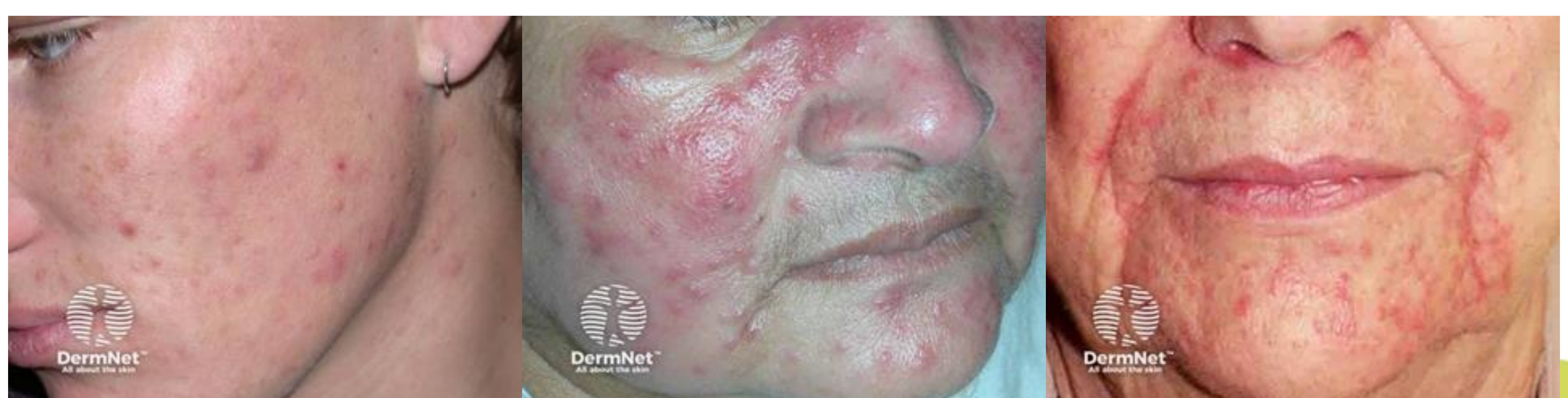
Rosacea | Dermatomyositis | Sun damage



Seborrhoeic dermatitis | Periorificial dermatitis | Cutaneous lupus

Facial rash

1. **Key points:**
   - History is key:
     - Where - ?periorificial, cheeks
     - When - ?triggering events (eg start of puberty, heat, alcohol, UV exposure), causes (steroid nasal sprays, topicals, orals)
     - Photosensitivity
   - Examination:
     - Types of lesions: pustules, comedones, cysts, scarring
     - Distribution: face (?involvement eyelids, more periorificial), extrafacial (?chest, back)



Facial rash

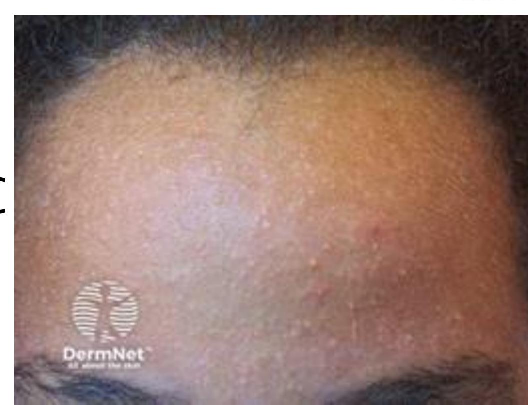
2. Common DDx / What not to miss:

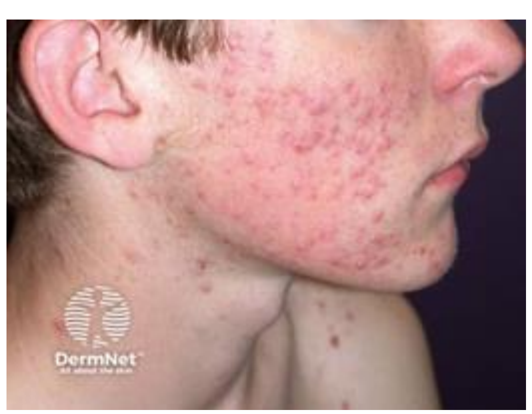
- DDx: acne, rosacea, periorificial dermatitis, seborrhoeic dermatitis

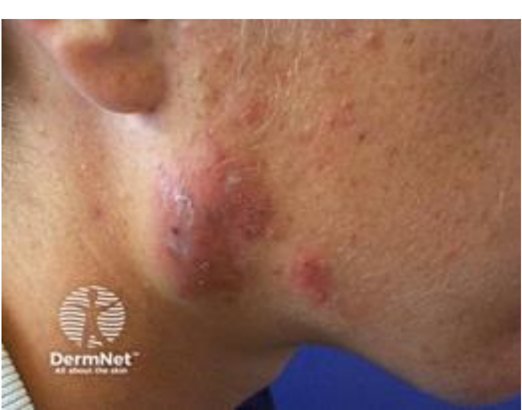
- What not to miss:
  - Autoimmune connective tissue disease eg cutaneous lupus - clues on history; review of systems
    - Extracutaneous implications, MDT management required
  - Irritant contact dermatitis, skin barrier dysfunction -> simplify +++ skincare regime
    - Different management approach, usually a more simple fix
  - Scarring process - acne, discoid lupus
    - Early recognition and treatment can prevent further scarring (challenging to treat)

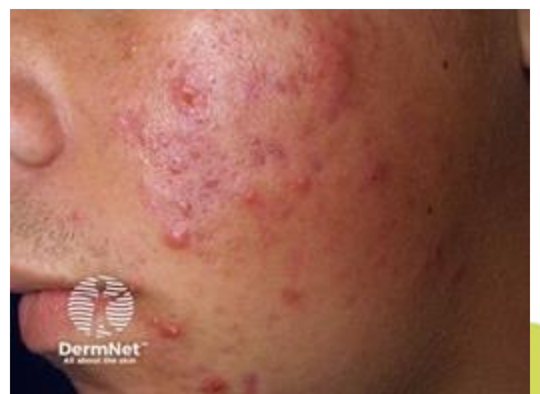
Acne

- ~85% adolescents. Can persist into / start in adulthood
- Pathogenesis:
    - Follicular hyperkeratinisation, sebum production, C acnes, inflammation
- **Clues:**
    - Presence of multiple lesions eg pustules, comedones
    - Spares eyelids
- **Don't miss:**
    - Psychosocial impact
- Treatment takes time to determine efficacy
- Refer early



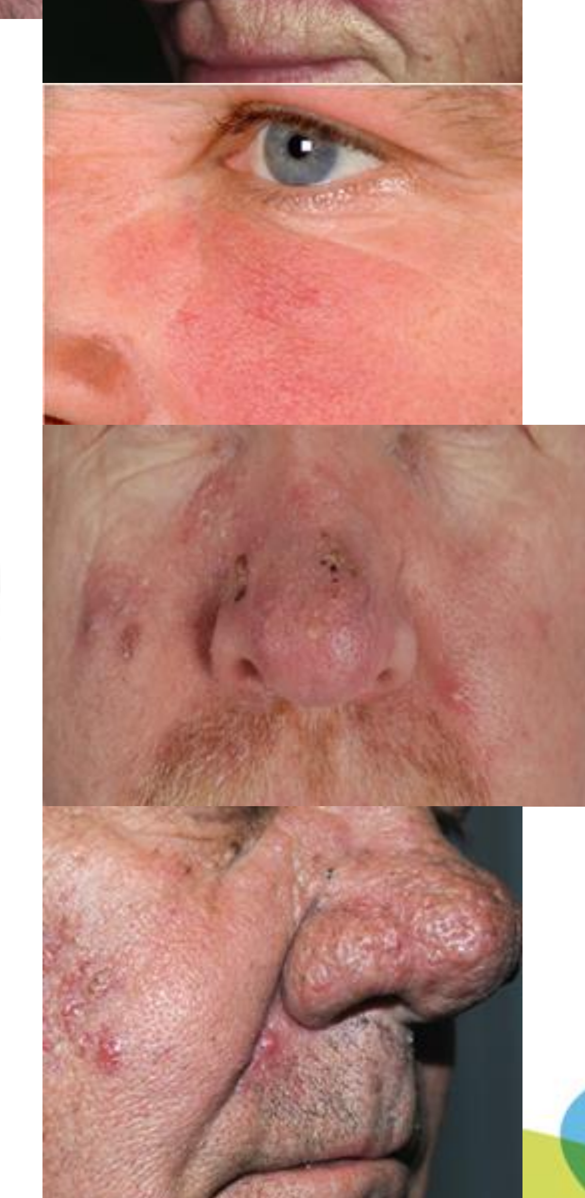






Rosacea

- Most common young to middle aged Caucasian women - but can affect all ages, genders, skin types
- Clinical features
  - Central facial erythema, background telangiectasia
  - Flushing - heat, emotions, spicy food, alcohol, caffeine, UV exposure
  - Papules and pustules
- Ocular symptoms common - dryness, gritty sensation, itching, burning
- **Clues:**
  - Flushing
  - No comedones
- **Don't miss:**
  - Ocular involvement
- Chronic, but manageable
- ***Can safely try:*** Azelaic acid 10-20% daily. Gentle skin care very important



Periorificial dermatitis

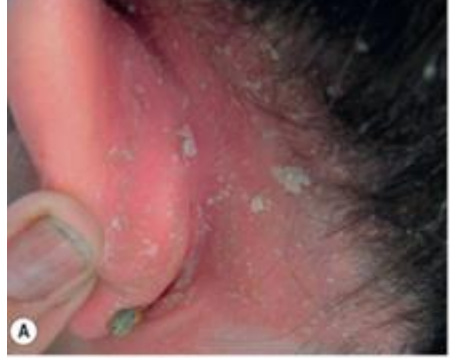
- Most common young to middle aged Caucasian women - but can affect all ages, genders, skin types
- Clinical features
  - Common triggers / causes: topical steroid use, inhaled steroids
  - Papules, pustules around orifices: mouth, nares, eyes
  - Often sensitive, burning skin
- **Clues:**
  - Papules, pustules in periorificial sites
  - No comedones, cystic lesions
  - Often spares skin immediately next to vermillion
- **Don't miss:**
  - Trigger - steroids, all forms
  - Key is history, any steroid use
- ***Can try:*** Stopping steroid, gentle skin care. Elidel (pimecrolimus 1% cream)
- Often require doxycycline 50-100mg PO daily ~8 weeks

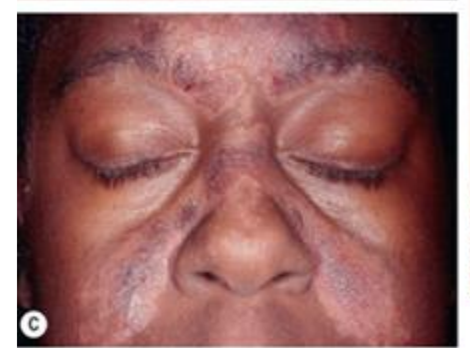
ern Health

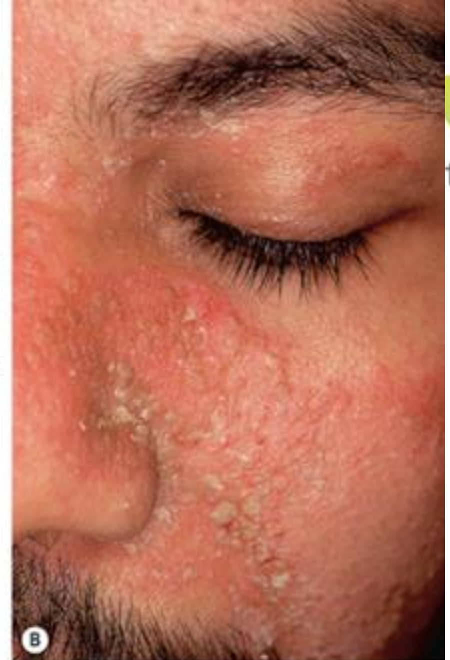
Seborrhoeic dermatitis

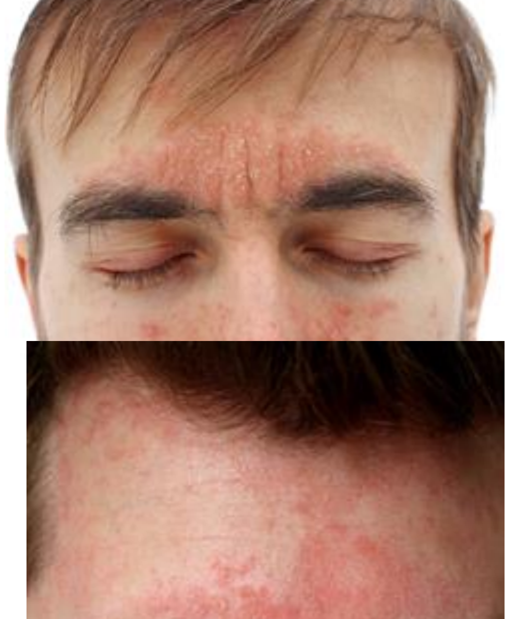
- Can affect all ages. In adulthood, peak in 40s-60s. M>F
- Clinical features
  - Central facial erythema
  - Greasy, waxy scale
  - Typical sites: scalp, upper forehead, brows / glabella, nose and nasolabial folds
    - Also chest
- Can have sensitive skin

- Clues in the distribution
- ***Can safely try:*** Resolve plus (clotrimazole / hydrocortisone 1%/1%) BD for 2-4 weeks







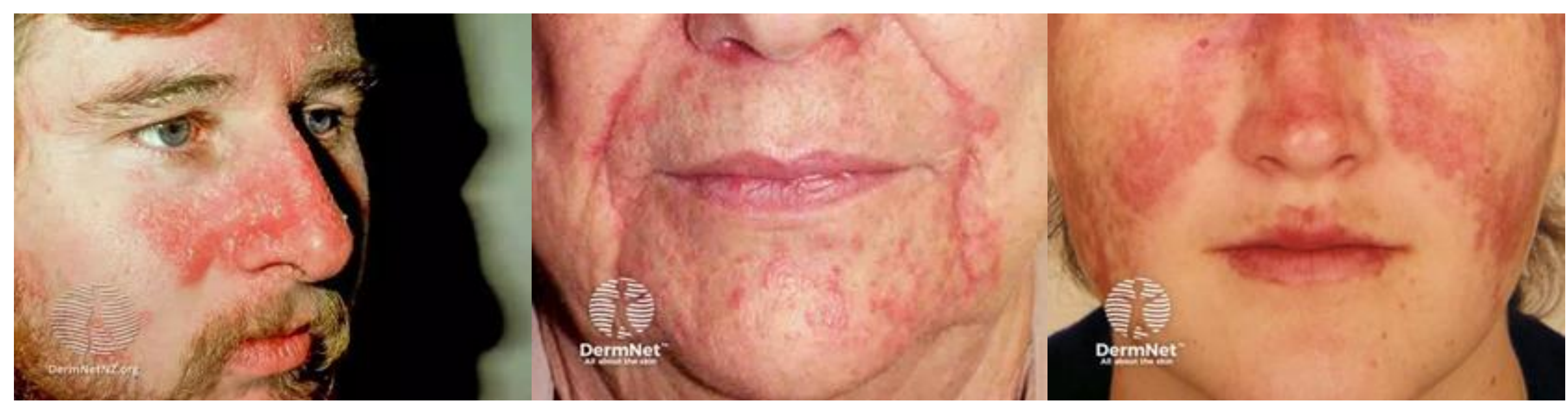


Facial rash

3. When to refer:

- Inadequate response with initial measures
- Diagnostic uncertainty
- **Acne:** Indication for isotretinoin
  - Severe cystic acne
  - Significant psychosocial impact
- **Rosacea:** phymatous rosacea, ocular involvement

Hard to distinguish on examination alone - history crucial



Facial rash

4. Additional resources:

- All About Acne

Facial pigmentation

1. **Key points:**
   - History is key:
     - Where/distribution
     - When - ?triggering events (eg summer, heat, pregnancy)
     - Acquired vs longstanding (eg cafe au lait macule)
     - Associated symptoms (eg pruritus)
     - Was there an initial inflammatory rash (ie is this just post inflammatory pigmentation)
   - Examination:
     - Distribution of involvement
     - Focal vs more widespread
     - Macular vs papular (eg dermatosis papulosa nigra)

Facial pigmentation

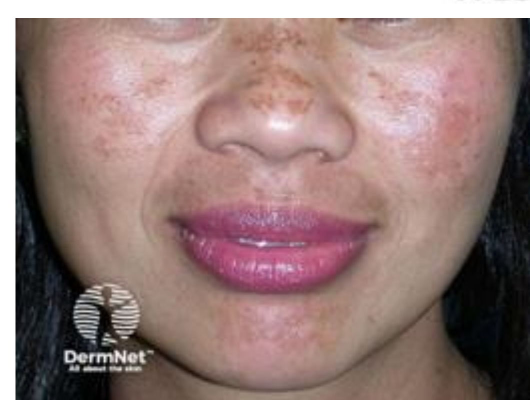
2. Common DDx / What not to miss:

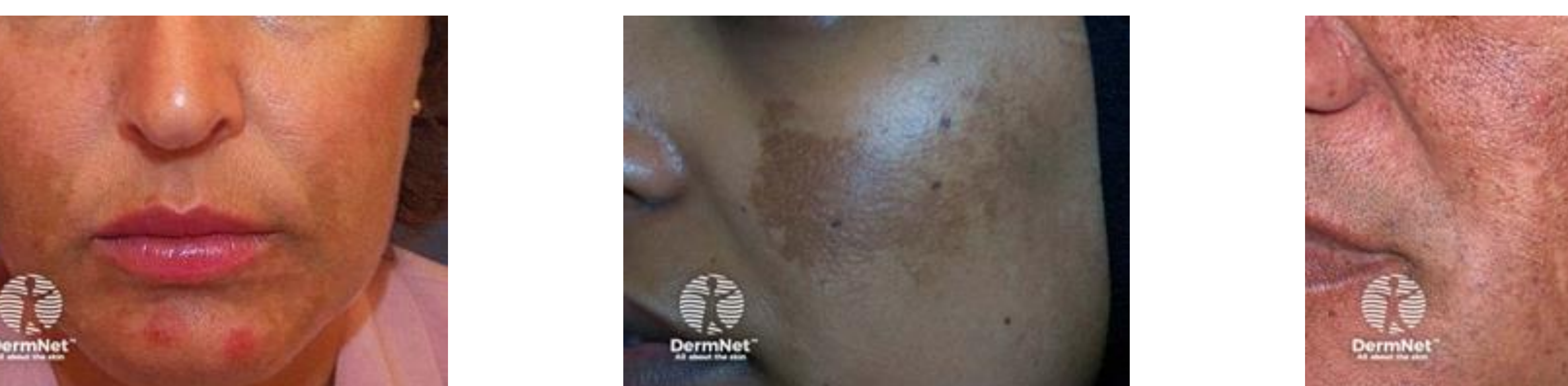
- DDx: melasma, solar lentigines, post inflammatory hyperpigmentation

- Not to miss:
  - Melanoma, lentigo maligna
  - Ongoing triggers / exacerbating factors such as UV
    - Will affect response to treatment

Melasma

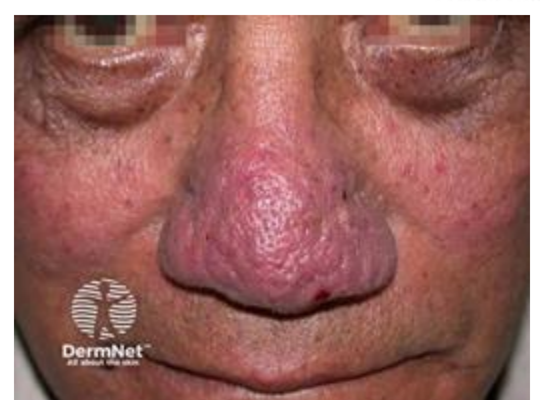
- Most common women, and darker skin phototypes
- Chronic and relapsing
- Triggers / exacerbating factors: UV, UV, UV
  - Hormones (pregnancy, OCP), heat, visible light
- Classified by distribution: centrofacial, malar, mandibular
- Clues:
  - Often symmetric, irregular borders
- Education about chronicity, potential for recurrence, and importance of UV is crucial

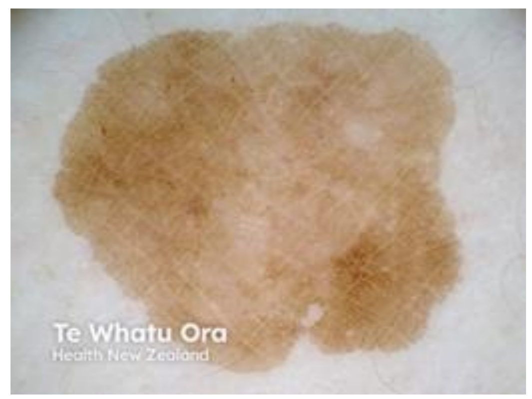




Solar lentigines

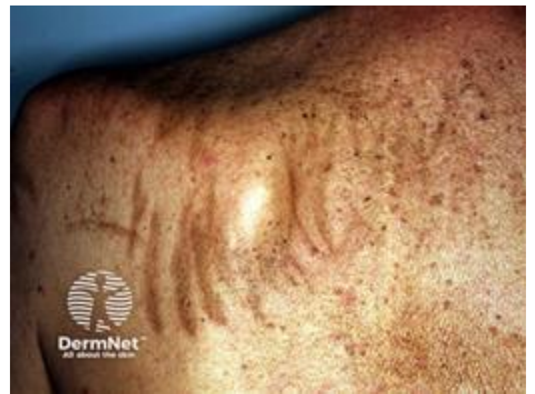
- Benign pigmented macule due to chronic UV exposure
- Most common: older age, lighter skin phototypes
- Dermoscopy clues: diffuse light brown, fingerprinting pattern, moth eaten borders
- **Clues:**
  - Flat, sharply demarcated
  - Non scaly, no warty texture (unlike seborrhoeic keratosis)
- **Don't miss:**
  - ABCDE features to suggest malignant pigmented lesion

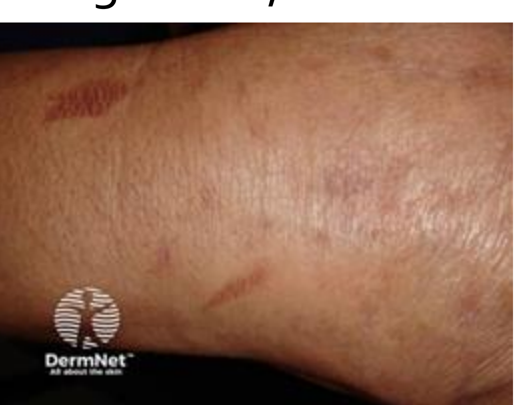


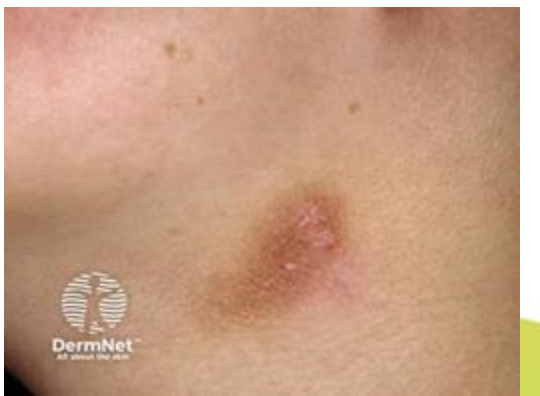


Post inflammatory hyperpigmentation

- Common change resulting from a preceding trauma or inflammation
- More common in skin of colour
- **Clues:**
  - History of trauma, injury or inflammatory dermatosis
  - Ill defined. No pigment network with dermatoscope
- **Don't miss:**
  - Ongoing exacerbating factor - eg irritating topical
- Set expectations. With management, less is more







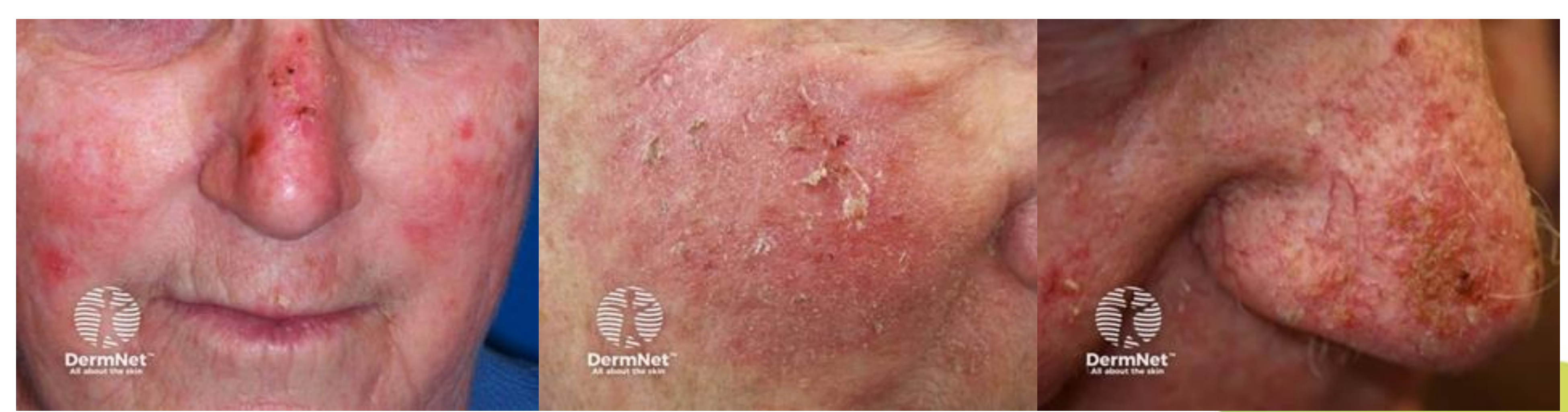
Facial pigmentation

3. When to refer:

- Diagnostic uncertainty
- Inadequate response to initial measures
- Procedural therapies

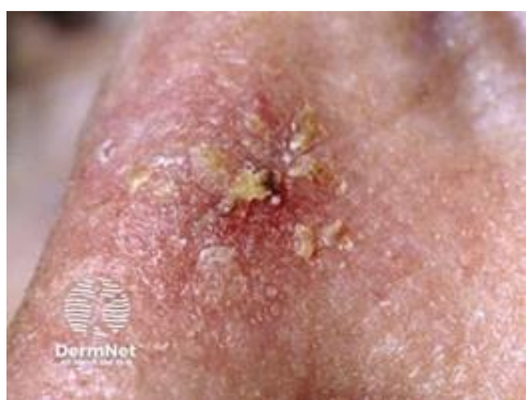
Suspicious skin lesion

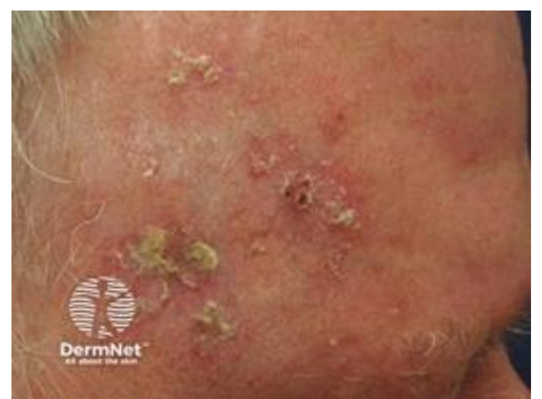
1. **Key points:**
   - History:
     - Growing, changing, tender
     - Bleeding, ulcerated
     - Previous treatment - what, when, outcome
   - Examination:
     - Distribution - ?photodistributed
     - Induration, tenderness
     - Dermoscopy
     - Lymph nodes

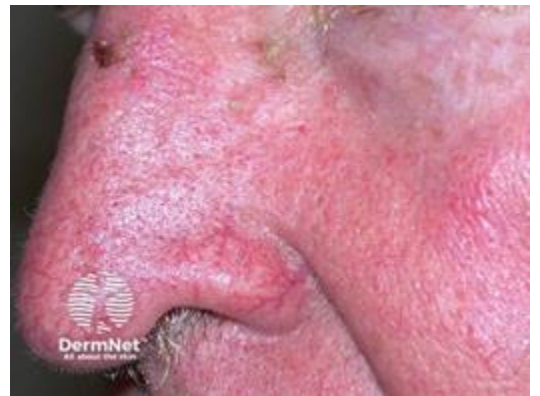


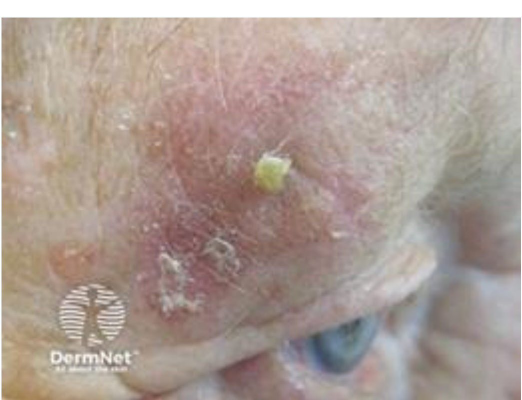
Actinic keratoses

- Precancerous lesions due to chronic UV radiation
- Risk factors: age, fair skin, history of UV exposure
- A marker of sun damage and increased skin cancer risk
- ~5-10% risk developing into SCC over time
- **Clues:**
  - Rough, scaly lesions or patches
  - Not indurated
- **Don't miss:**
  - NMSC
- Precancerous lesions → worthwhile treating
  - Various modalities depending on number, distribution, patient preference (eg cryotherapy, 5FU, imiquimod, photodynamic therapy)





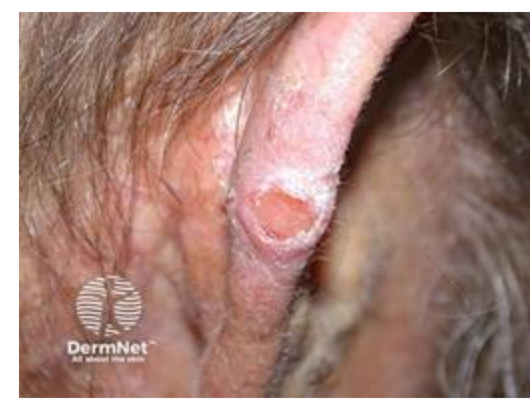


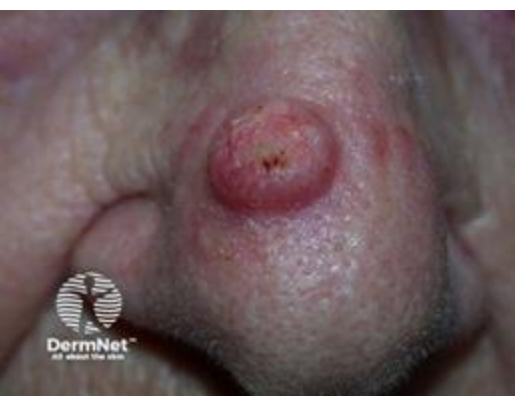


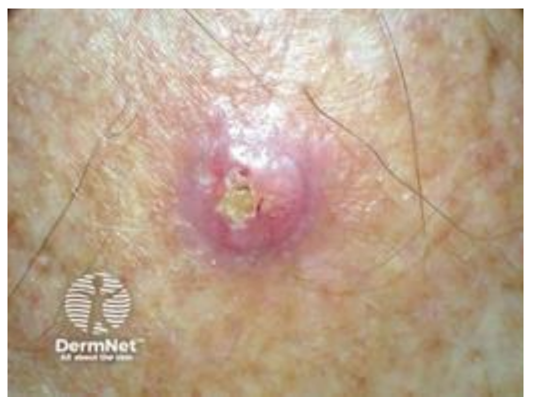
Non-melanoma skin cancer / keratinocyte carcinoma

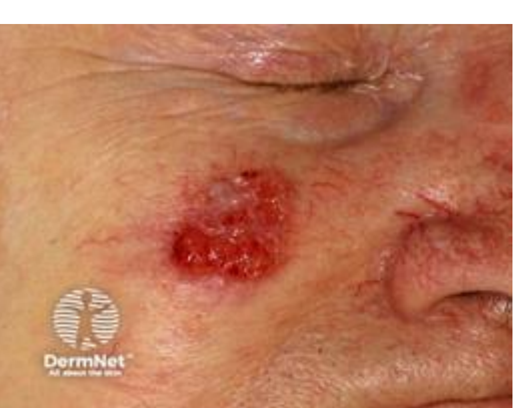
Western Health

- Includes a multitude of malignancies including SCC, BCC
- **Clues:**
  - Tender
  - Indurated
  - Rapid growth
  - Non healing sore, bleeds, often breaks down
- **Don't miss:**
  - Lymphadenopathy
  - High risk sites - head and neck
- Biopsy to determine lesion type, degree of differentiation -> to guide most appropriate management



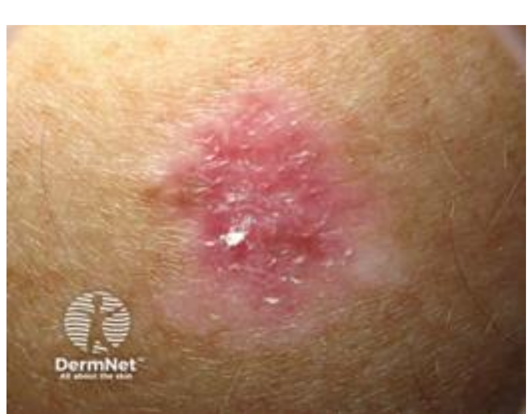


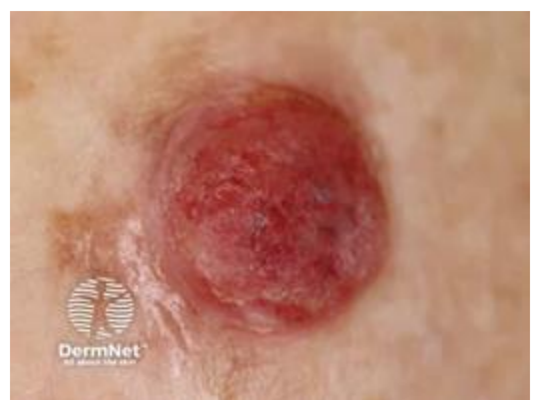


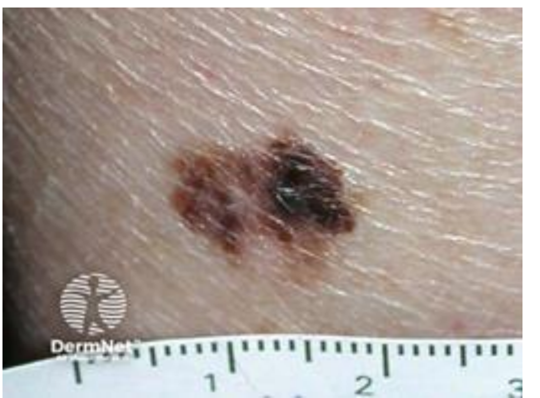


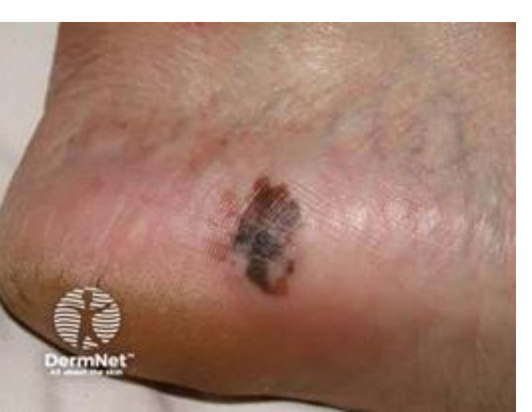
Melanoma

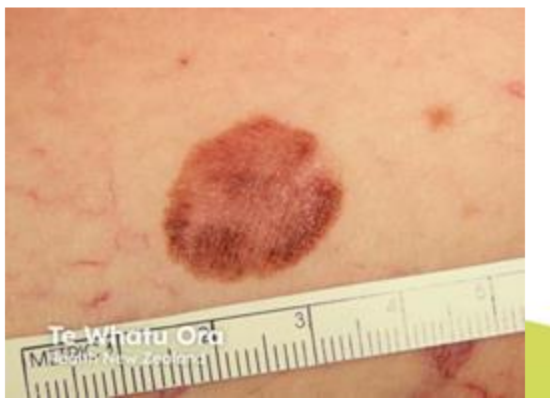
- Malignancy of melanocytes
- Many subtypes including: superficial spreading, nodular, desmoplastic, acral lentiginous
- **Clues:**
  - New or changing pigmented lesion
  - ABCDE - asymmetry, irregular border, multiple colours, large diameter, elevation
- **Don't miss:**
  - Lymphadenopathy
- Biopsy - gold standard is excisional biopsy with 2mm margin
- Further management, ongoing follow up depending on Breslow thickness











Suspicious skin lesion

3. When to refer:

- Inadequate response with initial measures
- Concern for NMSC in site challenging to biopsy
- Biopsy proven NMSC requiring further management
- High risk NMSC → consider referral to head and neck MDT

Management options:

- Wide local excision with GP, dermatologist, plastic surgeon
- Mohs micrographic surgery
- Public hospital - dermatology or plastic surgery (dependent on size, location, patient preference)

Suspicious skin lesion

4. Additional resources:

- Cancer Council - clinical practice guidelines for keratinocyte cancer

Clinical Guidelines

About Guidelines

/ Clinical Guidelines / Skin cancer clinical gu... / Clinical practice guide...

KERATINOCYTE CANCER

Clinical practice guidelines for keratinocyte cancer

Topical corticosteroids

- Many different brand names
- *Cannot compare % - different actives*
- **Face:**
  - Weak: hydrocortisone 1% (Dermaid, Cortic Ds - OTC). 1-2x daily, duration - until clear
  - Stronger: methylprednisolone aceponate 0.1% (Advantan, Supriad). 1-2x daily max 5-7/7
- **Body:**
  - Moderate: methylprednisolone aceponate 0.1% (Advantan, Supriad). 1-2x daily until clear
  - Stronger: Betamethasone dipropionate 0.05% (Eleuphrat, diprosone). 1-2x daily until clear

CORTICOSTEROID POTENCY CHART

Topical corticosteroids available in Australia

Note: even within groups, the drugs are arranged in orders of increasing potency: For example Advantan is less potent than Elocon which is less potent than Diprosone.

BRAND NAME	GENERIC
Mild (Class I)	
Dermaid: C 30g	Hydrocortisone (alcohol) 0.5%
Cortic-DS: O 30g 50g, C 30g 50g Dermaid: C 30g SC: 30g, Sp (30mls), Sol (30mls) Sigmacort: O 30g & 50g, C 30g & 50g	Hydrocortisone (alcohol or acetate) 1%
Moderately Potent (Class II)	
Desowen: AqL 60ml	Desonide 0.05%
Eumovate: C 30g Kloxema: C 30g	Clobetasone butyrate 0.05%
Aristocort: O C 100g 2tubes Tricortone O C 100g 2tubes	Triamcinolone acetonide 0.02%
Antroquoril: C100g 2tubes Betnovate 1/5: C 100g 2tubes Celestone-M: C 100g 2tubes Cortival 1/5: C 100g 2tubes	Betamethasone valerate 0.02%
Betonvate ½: C 15g Cortival ½: O C 15g	Betamethasone valerate 0.05%
Potent (Class III)	
Advantan FO 15g, O 15g, C 15g, AqL* 20g (not ml)	Methylprednisolone aceponate 0.1%
Elocon: O 15g, 45g, 50g, L 30ml Elocon Alcohol Free Cream: C 5g, 15g, 50g Novasone: O 15g, C 15g, L 30ml Zatamil: HG 15g & 45 g, O 15g 45g, L 30ml	Mometasone furoate 0.1%
Betnovate O C 30g	Betamethasone valerate 0.1%
Diprosone: O 5g, 15g, 50g, C 5g, 15g, 50g, L 30ml Eleuphrat: O 15 g, C 15g	Betamethasone dipropionate 0.05%
Very Potent (Class IV)	
Diprosone OV: O 30g, C 30g	Betamethasone dipropionate 0.05% in optimized vehicle
Clobex Shampoo 125ml	Clobetasol propionate 0.05%
Clobetasol O, C, L ***Compounded***	Clobetasol propionate 0.05%

O=Ointment

FO=Fatty Ointment

C=Cream

SC=Soft Cream

Sp=Spray

Sol=Solution

HG=Hydrogel

L=Lotion

AqL=Aqueous Lotion

Green= PBS/RPBS

*= only PBS for Eczema

Red=RPBS only

Black=Not on PBS

Topical corticosteroids (TCS)

- **Cream or ointment?**
  - Ointment - slightly more potent. More occlusive. More 'moisturising'
  - Cream - easier to spread. Less occlusive. More likely to sting
  - → patient preference
- **How much to give?**
  - Small tubes! 15g
  - PBS authority codes, based on BSA
  - Small area, face - 1-2 + repeats
  - Large area, body - 6-10 + repeats
- **How often?**
  - Once daily usually as effective as twice daily (saturation of receptors)
- **Before or after moisturiser?**
  - Does not matter. May not need moisturiser after generous application of TCS

Topical calcineurin inhibitors

- Non-steroid anti-inflammatory agents
- Safe on face and paediatrics (PBS available > 3 months old)
- Often sting initially, settles after a couple of weeks. ‘It’s making my rash worse’
- **Pimecrolimus / Elidel 1% cream:**
  - Ready made tubes
  - Prescription - authority for ‘atopic dermatitis’. 1+1
- **Tacrolimus 0.1%, cream or ointment:**
  - Compounded only. Commonly 30grams + repeats
  - Generally considered stronger / more potent
  - Can be more costly - encourage calling around for costing

$55 - 80 / 30g

The importance of the referral

- Referral is **<u>the most critical step</u>** to ensure a patient is appropriately triaged and seen in a timely manner
- Victorian Statewide Referral Criteria
    - Dermatology specific referral guidelines

Statewide referral criteria for referrals to public hospital dermatology services for adults and children

Reasons for referral

Dermatology - adults
Statewide referral criteria for referrals to public hospital dermatology services for adults

Dermatology - children
Statewide referral criteria for referrals to public hospital dermatological services for childre

Conditions

Alopecia
Criteria for referring adults with alopecia to a dermatology service in a Victorian public hospital

Assessment of acne management
Criteria for referring adults for assessment of acne management to a dermatology service in a Victorian public hospital

Assessment of dermatitis (eczema) management
Criteria for referring adults for assessment of dermatitis (eczema) to a dermatology service in a Victorian public hospital

Assessment of psoriasis management
Criteria for referring adults for assessment of psoriasis management to a dermatology service in a Victorian public hospital

Assessment of vitiligo
Criteria for referring adults for assessment of vitiligo to a dermatology service in a Victorian public hospital

Blistering eruptions, rash of unknown cause and adverse drug reactions
Criteria for referring adults with blistering eruptions, rash of unknown cause or adverse drug reactions to a dermatology service

Acne

Criteria for referral to public hospital service

- Severe acne (that is nodulocystic, widespread or with scarring) unresponsive to previous treatments (e.g. at least 4 months of oral antibiotics or combined oral contraceptive or both) that requires further advice on, or review of, the current management plan
- Advice on the management of acne when planning or commencing gender-affirming masculinising hormonal therapy.

Information to be included in the referral

Information that must be provided

- Reason for referral and expectation or outcome, anticipated by the patient, or their carer, and the referring clinician from referral to the health service
- The functional or psychological impact on quality of life or activities of daily living including impact on work, study, social activities or carer role
- Findings on physical examination
- Details of previous management including the course of treatment(s), assessment of adherence to current management plan and outcome of treatment(s)
- Current and complete medication history (including non-prescription medicines, herbs and supplements)
- Patient's age
- If the patient is pregnant and if the skin condition is thought to be related to the pregnancy or if the patient is planning a pregnancy.

Lesion

Criteria for referral to public hospital service

- Bopsy proven basal cell carcinomas
- Biopsy proven Bowen's disease
- Giant (larger than 20 centimetres) or pigmented congenital naevi or congenital naevi that are noted to be changing
- Pigmented naevi if melanoma is suspected and where biopsy is unable to be performed in primary care due to the size of the lesion or anatomical site (head or genitals)
- Squamous cell carcinomas where biopsy or excision is contraindicated in general practice due to anatomical site (head or genitals)
- Where there is biopsy confirmed concern for malignancy.

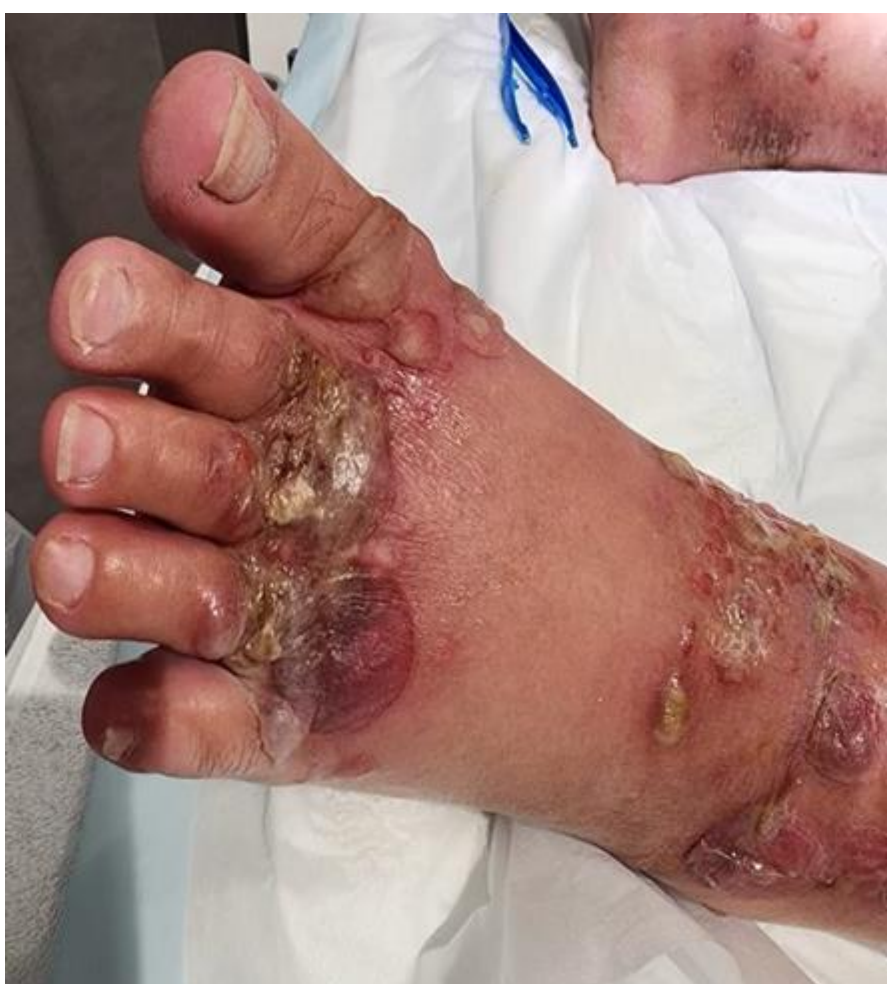
Information to be included in the referral

Information that must be provided

- Details of onset, duration, site, size and any recent changes in size of lesion(s) and speed of growth
- Biopsy results unless biopsy is unable to be performed in primary care due to the size of the lesion or anatomical site (head or genitals)
- If the patient is immunosuppressed
- Current and complete medication history (including non-prescription medicines, herbs and supplements and immunosuppressants).

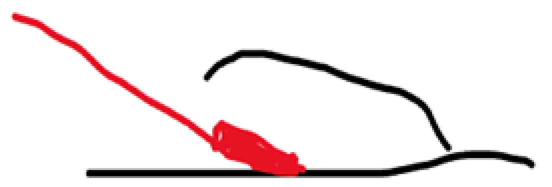
Ix – swab, bacterial MCS

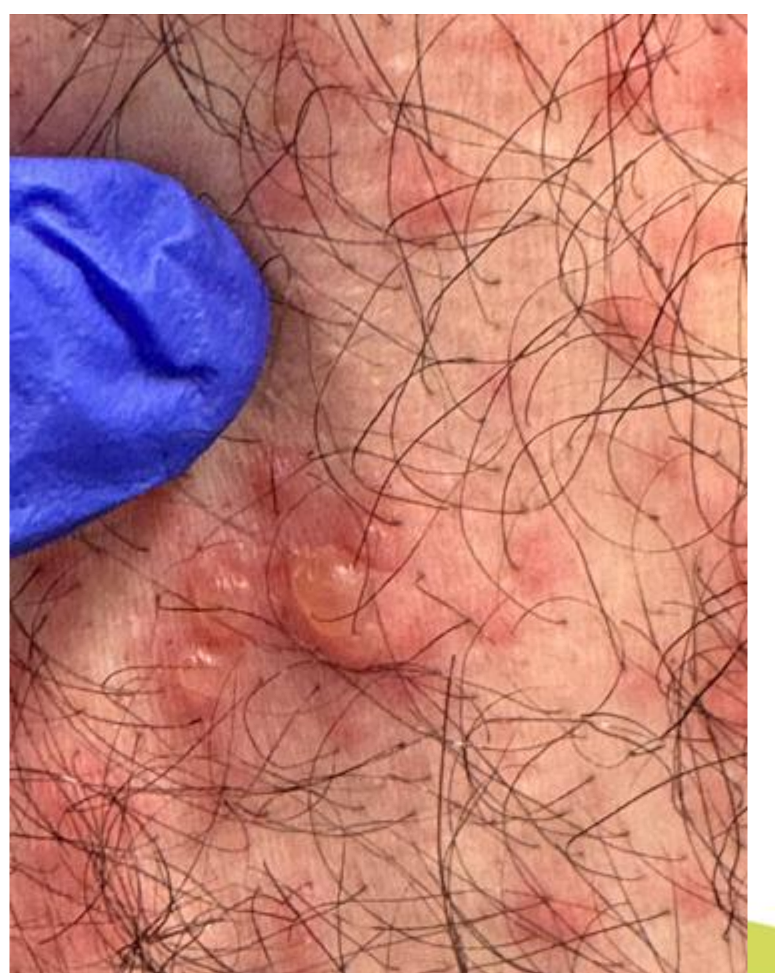
- Swab with gel medium
- Can wet with saline
- Aim to collect a decent amount of biological material onto the swab tip
- Rub firmly back and forth
  - Over crusting, ooze, discharge



Ix – swab, viral PCR

- DRY SWAB
- Aim to collect a decent amount of biological material onto the swab tip
- Best place – inside the base of a vesicle





Ix – scrape, fungal MCS

- Scrape of scaly / dry / flakey material into urine specimen jar
- Need:
  - o Urine speci jar (yellow top)
  - o Something firm / blade eg: scalpel blade, suture remover, forceps etc

- Perpendicular to skin. Rub firmly back and forth

DESCRIPTION: Skin

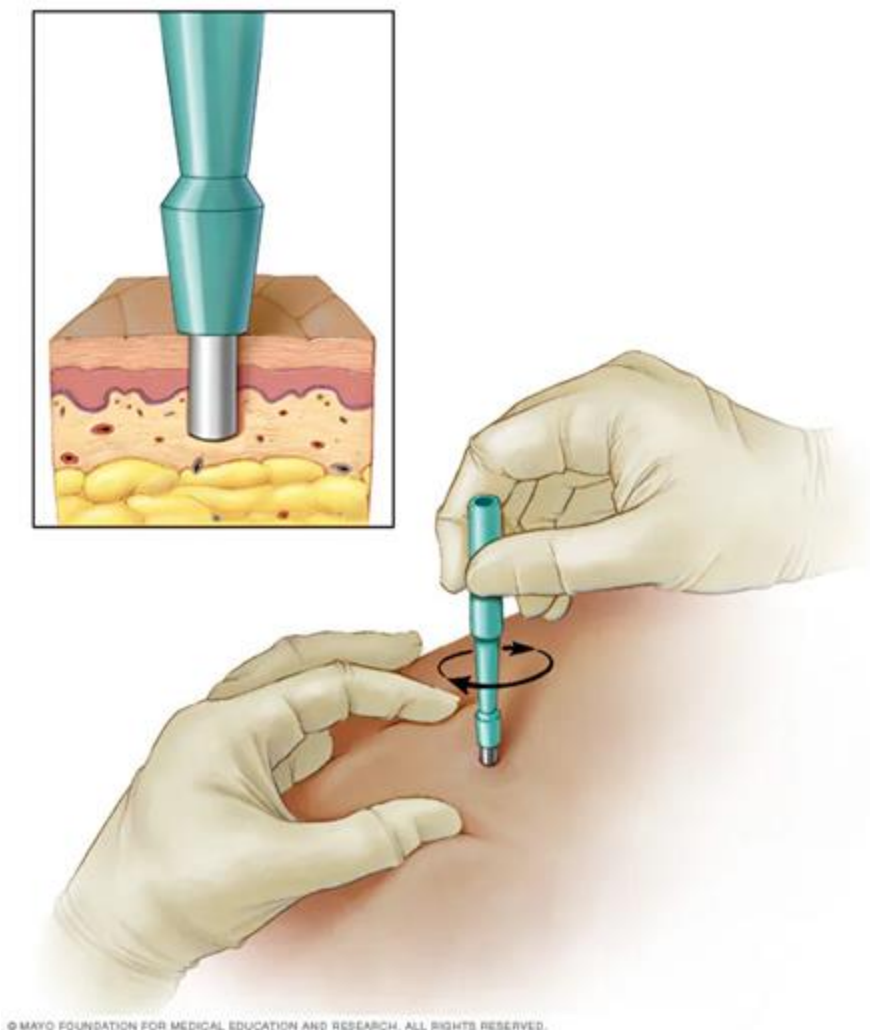
MICROSCOPY:
WET PREPARATION
Hyphae Not Seen
Yeast Not Seen

COMMENT:
Please submit skin scraping specimen without scalpel.

Ix - biopsy

- 3-4mm punch tool
- Local with adrenaline
- Histology / DIF / culture
    - Lesional vs perilesional
- Very technically easy

Western Health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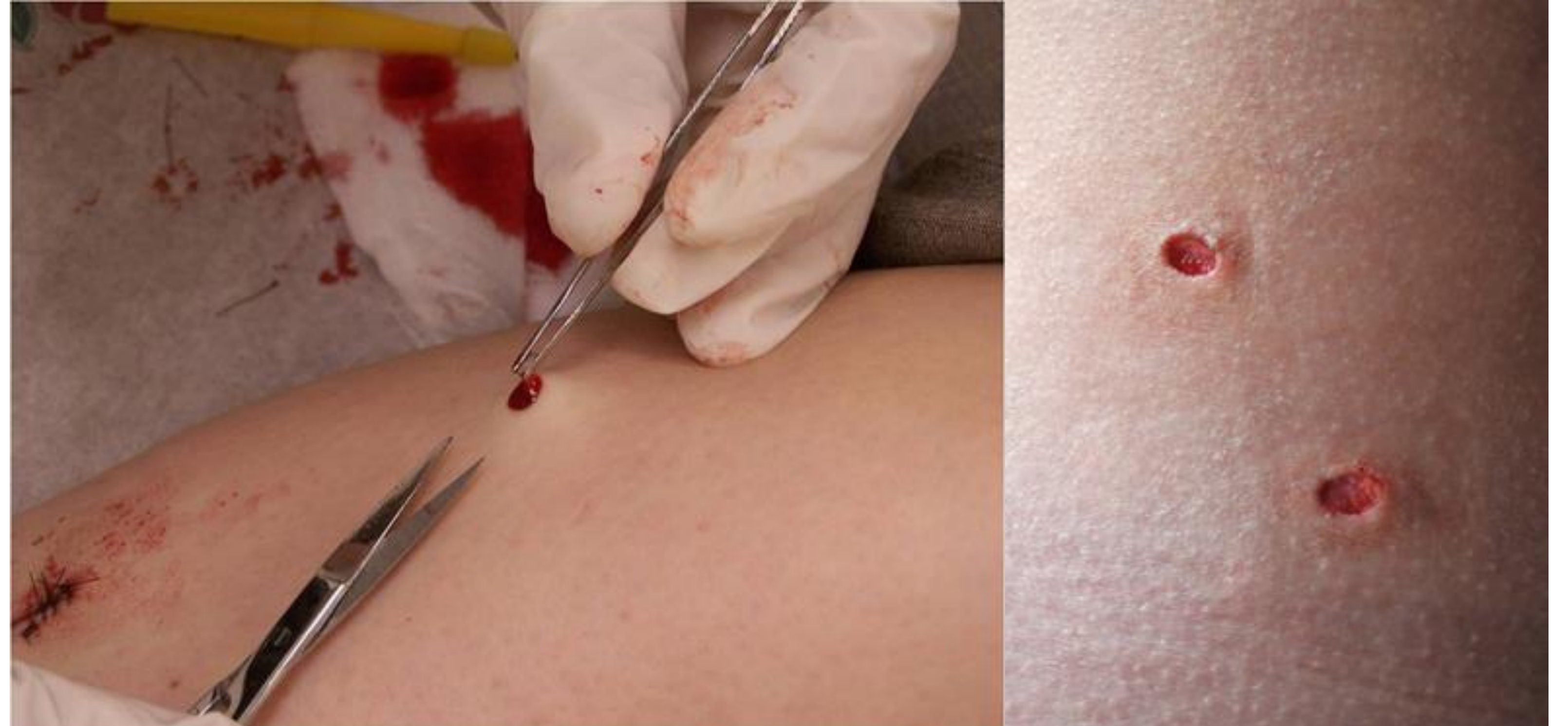

Western Health

KALTOSTAT
5cm X 5cm
10
Micropore
3M

smith&nephew
OPSITE Post-Op
Waterproof Dressings
Cuts, Grazes
& Stitches
3 dressings
Absorbent
Protective

Thank you!

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After this session you will receive:

1 *Slides, resources and the recording of this session within the week*

2 *RACGP CPD hours will be uploaded within 14 days.*

3 *Attendance certificate will be received within 4-6 weeks.*

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  nwmphn.org.au/resources-events/events
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  nwmphn.org.au/resources-events/resources

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