BRITISH ASSOCIATION OF DERMATOLOGISTS
HEALTHY SKIN FOR ALL

British Association of Dermatologists Specialist Advice templates for common dermatology advice: Teledermatology Advice and Guidance

The British Association of Dermatologists Teledermatology Working Party Group is developing a central resource of common responses to Advice and Guidance (A&G) requests and Referrals. The aim is to support local, regional, and national exchange of Specialist Advice between primary and secondary care clinical teams and ensure Specialist Advice can be readily shared with patients where indicated.

Shared responses are an optional resource which can be adapted locally to support standardisation and digital productivity when processing A&G requests and referrals.

The responses can be used to support:

- A&G requests returned with advice.
- A&G requests converted to an appointment – interim advice to optimise primary care treatment for patients on the outpatient waiting list.
- Referrals returned with advice.

Digital responses can be inserted into e-RS using digital dictation commands, or copy and paste (Ctrl C, Ctrl V), with the aim of future integration into digital advice and referral platforms.

This is a dynamic resource which is being developed in conjunction with GIRFT and National Outpatient Recovery and Transformation Programme and will be continually updated and adapted.

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1. Appropriate threshold for A&G requests

Please remember to only use the Advice and Referral (A&G) service at the point that an outpatient referral would otherwise be considered, and in line with GP referral criteria.
British Association of Dermatologists Referral guidelines
Home Page - British Association of Dermatologists (bad.org.uk)

Primary Care Dermatology Society Concise Treatment and Referral Guidelines for common skin conditions Concise guidance: National Primary Care Treatment and Referral Guidelines for Common Skin Conditions (pcds.org.uk)
Insert xxxxx local referral guidelines xxxxx

2. Actinic Keratosis

Thank you for the clinical information which suggests a diagnosis of actinic keratosis. The treatment plan below can be shared with the patient and prescribed from primary care. If this fails, please contact dermatology through the Advice and Refer Teledermatology Service (A&G).

National Dermatology referral guidelines for Actinic Keratosis can be found here: British Association of Dermatologists (bad.org.uk)

Treatment options for Actinic Keratoses (delete options not prescribed):

5- Fluorouracil cream (Efudix) - apply once or twice daily for 3-4 weeks. Efudix cream will cause the skin to become temporarily inflamed during treatment. If there is significant inflammation, reduce the treatment frequency to alternate days or less for 6-8 weeks in total. Keep the cream away from pets.
Patient information is available here:
5-fluorouracil cream - BAD Patient Hub (skinhealthinfo.org.uk)
Actinic keratoses - BAD Patient Hub (skinhealthinfo.org.uk)

Imiquimod cream 5% - apply three times a week for 4 weeks. Imiquimod cream will cause the skin to become temporarily inflamed during treatment. If there is significant inflammation, reduce the treatment frequency.
Patient information is available here:
Imiquimod cream – BAD Patient Hub (skinhealthinfo.or.uk)
Actinic keratoses - BAD Patient Hub (skinhealthinfo.org.uk)

Imiquimod cream 3.75% - apply once daily for 2 weeks and repeat course after 2 weeks. Imiquimod cream will cause the skin to become temporarily inflamed during treatment. Clearance should occur by 8 weeks after treatment. If there is significant inflammation, reduce the treatment frequency.
Patient information is available here:
Imiquimod cream – BAD Patient Hub (skinhealthinfo.or.uk)
Actinic keratoses - BAD Patient Hub (skinhealthinfo.org.uk)

Actikerall (0.5% 5FU/10% salicylic acid solution) - apply once daily for 6-12 weeks.
Clearance should occur by 8 weeks after treatment.
Patient information is available here:
Actinic keratoses - BAD Patient Hub (skinhealthinfo.org.uk)

Tirbanibulin ointment 1% - apply once daily for 5 days to cover the treatment field of up to 25cm2 (5cm x 5cm). Clearance should occur by 8 weeks after treatment.
Patient information is available here:
Actinic keratoses - BAD Patient Hub (skinhealthinfo.org.uk)

3. Atopic Eczema Treatment - Child

Thank you for the clinical information which suggests atopic eczema. The treatment plan below can be shared with the parents and prescribed from primary care. If the eczema progresses despite this treatment plan or is severe and not responding to potent corticosteroids on the body, please contact dermatology through the Advice and Refer Teledermatology Service (A&G) and we will triage to an appropriate clinic appointment.

National Dermatology referral guidelines for Atopic eczema can be found here: British Association of Dermatologists (bad.org.uk)

Treatment for eczema flare-ups (when skin is inflamed and itchy):

Body, legs and arms: Mometasone or Betnovate 0.1% ointment (strong steroid) - apply once daily to for 3-7 days, and repeat as required (avoid strong steroid on face and skin flexures e.g. elbow and knee creases, armpits, groins and genitalia).

Face and skin flexures (elbow and knee creases, armpits, groins, and genitalia): Clobetasone butyrate or betnovate RD 0.025% ointment (medium steroid) - apply once daily for 3-5 days and repeat as required. Continue steroid treatment for 2 days after the eczema has cleared.

Maintenance treatment to reduce flare-ups (for areas of skin which regularly flare):
Tacrolimus ointment 0.03% or 0.1% (steroid-free) – apply twice daily until eczema controlled then twice a week (face, flexures, body, limbs)
Pimecrolimus cream 1% (steroid-free) - apply twice daily until eczema controlled (face and neck)
Mometasone ointment – apply twice a week (body and limbs)
Clobetasone ointment – apply twice a week (face and flexures)
Regular emollient 2-3 times a day as required.

Patient Information
Atopic eczema - BAD Patient Hub (skinhealthinfo.org.uk)
Treatments for Eczema | National Eczema Society
Eczema Care Online
British Society for Paediatric & Adolescent Dermatology (bspad.co.uk)

My Eczema Tracker App - The University of Nottingham

4. Atopic Eczema Treatment - Adult

Thank you for the clinical information which suggests atopic eczema. The treatment plan below can be shared with the patient and prescribed from primary care. If the eczema progresses despite this treatment plan or is severe and is not responding to potent corticosteroids on the body, please contact dermatology through the Advice and Refer Teledermatology Service (A&G) and we will triage to an appropriate clinic appointment.
National Dermatology referral guidelines for Atopic eczema can be found here: British Association of Dermatologists (bad.org.uk)

Treatment for eczema flare-ups (when skin is inflamed and itchy):

Body, legs and arms: Mometasone or Betnovate 0.1% ointment (strong steroid) - apply once daily to for 3-7 days and repeat as required (avoid strong steroid on face and skin flexures e.g. elbow and knee creases, armpits, groins and genitalia).

Face and skin flexures (elbow and knee creases, armpits, groins and genitalia): Clobetasone butyrate or betnovate RD 0.025% ointment (medium steroid) - apply once daily for 3-5 days, and repeat as required.
Continue steroid treatment for 2 days after the eczema has cleared.

Maintenance treatment to reduce flare-ups (for areas of skin which regularly flare)
Tacrolimus ointment (steroid-free) 0.1% – apply twice daily until eczema controlled then twice a week (face, flexures, body, limbs)
Mometasone ointment – apply twice a week (body and limbs)
Clobetasone ointment – apply twice a week (face and flexures)
Regular emollient 2-3 times a day as required.

Patient Information
Atopic eczema - BAD Patient Hub (skinhealthinfo.org.uk)
Treatments for Eczema | National Eczema Society
Eczema Care Online
My Eczema Tracker App - The University of Nottingham

5. Benign skin lesions

Benign skin lesions are not routinely commissioned for removal on the NHS unless they are unavoidably and significantly traumatised on a regular basis, with evidence of this causing regular bleeding or resulting in infections requiring 2 or more courses of antibiotics a year or other criteria as documented in the Benign Skin and Subcutaneous Lesions Commissioning Policy.
Removal of benign skin lesions: Academy of Medical Royal Colleges Guidance

Removal of benign skin lesions - EBI (aomrc.org.uk)
Insert xxxxx local benign skin lesion policy xxxxx

6. Bowen's disease

Thank you for the clinical information which suggests Bowen's disease. The treatment plan below can be shared with the patient and prescribed from primary care. If this fails, please contact dermatology through the Advice and Refer Teledermatology Service (A&G).

National Dermatology referral guidelines for Bowen's disease can be found here:
British Association of Dermatologists (bad.org.uk)

Treatment for Bowen's disease
5- Fluorouracil cream (Efudix) - apply once or twice daily for 3-4 weeks. Efudix cream will cause the skin to become temporarily inflamed during treatment. If there is significant inflammation, reduce the treatment frequency to alternate days or less for 6-8 weeks in total. Keep the cream away from pets.

Patient information:
5-fluorouracil cream - BAD Patient Hub (skinhealthinfo.org.uk)

7. Hand Dermatitis

Thank you for the clinical information which suggests hand dermatitis, for which the treatment plan below is recommended in primary care. If the dermatitis progresses after 3 months despite this topical treatment plan, please contact dermatology through the Advice and Refer Teledermatology Service (A&G) to support triage to an appropriate clinic appointment.

Hand care:
Use copious amounts of a bland unperfumed emollient cream (ointment if the skin is very dry and at night). Apply repeatedly throughout the day and whenever the skin feels dry. Avoid repeated and prolonged contact with irritating chemicals and water. Stop all liquid soaps and bar soaps, and avoid direct prolonged hand contact with detergents, cleansers, bubble baths and shower gels. Use a soap free antiseptic cleanser (such as Dermol 500 lotion) for washing the hands both at home and at work, but do not use this as a leave-on moisturiser.

Treatment for hand dermatitis:
Clobetasol propionate (Dermovate) ointment - apply 1 fingertip unit per hand once daily to the affected areas for up to 4 weeks (squeeze steroid from the tube to cover the length of index fingertip – about 1 inch = 1 fingertip unit). Repeat as required.
As the hand eczema improves consider reducing the strength of topical steroid to: Mometasone or Betnovate 0.1% ointment (strong steroid) - apply once daily to the affected areas for 1-2 weeks, repeated as required.

Maintenance treatment:
Tacrolimus ointment 0.1% for preventative treatment twice a week.
Clobetasol propionate or Mometasone ointment twice a week
Continue treatment even after the dermatitis has cleared as it can take several months for the skin barrier to return to normal.

Patient information:
Hand dermatitis/hand eczema - BAD Patient Hub (skinhealthinfo.org.uk)
How to care for your hands - BAD Patient Hub (skinhealthinfo.org.uk)
Fingertip unit | DermNet (dermnetnz.org)

8. Pigmented naevus without dermoscopy

On the basis of the history and macroscopic images provided, the clinical information suggests a benign pigmented mole (benign melanocytic naevus). However, as there are no dermoscopic images attached it is important that you consider a 2WW referral if the lesion is changing in size or develops an irregular shape or irregular colour or other suspicious features in line with 2WW skin referral guidance.

Patient information: Melanocytic naevi (pigmented moles) - BAD Patient Hub (skinhealthinfo.org.uk)

9. Psoriasis

Thank you for the clinical information which suggests psoriasis, for which the treatment plan below is recommended in primary care. If the psoriasis progresses after 4 weeks despite this topical treatment plan, please contact dermatology through the Advice and Refer Teledermatology Service (A&G) to support triage to an appropriate clinic appointment.

National Dermatology referral guidelines for Psoriasis can be found here:
British Association of Dermatologists (bad.org.uk)

Treatment for Psoriasis:

Body, legs and arms: Enstilar foam® or Dovobet gel® (strong steroid with vitamin D) - apply once daily for up to 4 weeks until clear and repeat as required (avoid strong steroid on face and skin flexures eg elbow and knee creases, armpits, groins and genitalia).

Face and skin flexures (elbow and knee creases, armpits, groins and genitalia): Clobetasone butyrate or betnovate RD 0.025% ointment (medium steroid) - apply once daily for 3-5 days and repeat as required.
Consider Protopic ointment (steroid-free) 0.1% daily until clear then twice a week.

Scalp: Betnovate 0.1% scalp application or Enstilar foam® or Dovobet gel® (strong steroid) - apply once daily for 1-2 weeks until clear and repeat as required (avoid face and neck). Use 1-2 times a week as maintenance treatment if required.

Coal tar shampoo (eg Capasal®, Psoriderm®, Polytar®)
Consider Cocois® or Sebco® ointment 2-3 times a week.

Patient information
Psoriasis - an overview - BAD Patient Hub (skinhealthinfo.org.uk)
Psoriasis - topical treatments - BAD Patient Hub (skinhealthinfo.org.uk)
Psoriasis - treatments for moderate or severe psoriasis - BAD Patient Hub (skinhealthinfo.org.uk)
The Psoriasis Association (psoriasis-association.org.uk)

10. Seborrheic keratosis without dermoscopy

On the basis of the history and macroscopic images provided, the clinical information suggests a benign seborrheic keratosis (insert macroscopic features xxxxxx e.g. warty stuck-on appearance, follicular plugs, milia-like cysts, fissures and ridges xxxxx).

However, as there are no dermoscopic images attached it is important that you consider a 2WW referral if the lesion is changing in size or develops an irregular shape or irregular colour or other suspicious features in line with 2WW skin referral guidance.

Patient information: Seborrhoeic keratosis - BAD Patient Hub (skinhealthinfo.org.uk)

11. Urticaria

Thank you for the clinical information which suggests urticaria, for which the treatment plan below can be prescribed from primary care. If the urticaria progresses despite this treatment, please contact dermatology through the Advice and Refer Teledermatology Service (A&G) to support triage to an appropriate clinic appointment.

National Dermatology referral guidelines for Urticaria can be found here: British Association of Dermatologists (bad.org.uk)

Treatment for urticaria
Avoid histamine-releasing drugs such as aspirin, codeine, non-steroidal anti-inflammatory drugs and ACE inhibitors, and environmental triggers such as extreme heat and cold.
If symptoms are not controlled with standard doses of low-sedating antihistamine (for example cetirizine, loratadine or fexofenadine), consider increasing up to 4 times the standard dose if no contraindications, reducing to lower doses when symptoms are controlled. A full blood count and CRP and/or ESR is recommended in primary care.

Patient information
Urticaria and angioedema - BAD Patient Hub (skinhealthinfo.org.uk)
uas7_tool_-_urticaria_activity_score.pdf (immunowiki.com)