Skin, hair and nail problems are very common in general practice, making up 15-20% of an average GP’s workload. The problem may present as the primary reason for the patient attending or may be part of a list of problems the patient brings to the GP. Sometimes a patient may be embarrassed or reluctant to discuss their skin problems with their GP, with the mistaken belief that the problem is trivial or that they should not be wasting their GP’s time. Others may try to pack in as much into a consultation as possible to try and get value for money in these recessionary times.

The GP’s heart often sinks when he hears the words “do you mind having a quick look at Johnny’s spots”? at the end of a long consultation. This can be difficult and frustrating for the GP as the explanation and management plan for something that is often easy to diagnose such as acne or psoriasis can be complex and time-consuming to explain to the patient.

The GP should be realistic and may have to invite the patient back for another consultation to deal with their problem more comprehensively. Writing a quick prescription, without having time to deal with lifestyle changes and any non-prescription items that the patient may have to use, is often doomed to failure.

Many GPs struggle with dermatology problems in general practice because of the lack of education in this area both at the undergraduate and postgraduate level. This is a shame, since with some basic education and some basic skills, many dermatology problems can be easily dealt with in general practice.

The diagnosis and treatment of most dermatology problems rarely requires complicated or expensive modalities such as CT scans or operating theatres. Treatment usually involves simple topical or oral treatments, and many lumps and bumps can easily be excised or removed with basic surgical skills that are well within the scope of many GPs. Despite this, it is surprising how difficult it can be to treat something as simple as a wart without proper training and equipment.

Most dermatology textbooks are written by hospital-based doctors and a disproportionate amount of space is given to the rare and dramatic skin complaints at the expense of the more common and mundane problems that GPs frequently come across.

There are more diagnoses in dermatology (> 2,000) than in any other specialty in medicine. Despite this, there are only seven common dermatology problems that are seen in general practice (see Table 1). Most GPs should be able to confidently diagnose and manage most patients with mild to moderate forms of these problems.

It is important to realise that common problems present commonly. When faced with an unusual rash or lesion it is more likely to be an unusual presentation of a common problem, rather than a rare dermatology diagnosis. It is also important to realise that the classical textbook descriptions of lesions and rashes are not always how they present in clinical practice. For example, basal cell carcinomas rarely present as the classical textbook description of a pearly white ulcerated nodule with raised rolled edges.

Dermatology in primary can be very different than that seen in hospital dermatology departments. In general practice we often see diseases at an early stage when the clinical signs are vague and ill-defined. Patients may have overlap of more than one skin problem (e.g., acne and rosacea or psoriasis and seborrhoeic dermatitis). The clinical features may be altered by the patient’s own interventions (self medications, scratching, etc). We also see patients at the other end of the spectrum with chronic skin problems that are unresponsive or only partially controlled with hospital treatments.

It is important to realise that while the skin specialist may know more about the disease, the GP knows more about the patient. The GP is ideally suited to manage patients with simple straightforward skin diseases as we can manage the patient holistically, dealing not only with the physical problems but also the psychological and social aspects of their skin problems.

Some skin problems may involve other organ systems (atopic children may have asthma and allergic rhinitis as well as eczema) and the GP can manage all aspects of the illness rather than just the skin component. Also, many skin problems can have associated underlying pathology (e.g.

<table>
<thead>
<tr>
<th>Most common dermatological problems seen in practice</th>
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<tbody>
<tr>
<td>• Acne</td>
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<tr>
<td>• Eczema/dermatitis</td>
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<tr>
<td>• Psoriasis</td>
</tr>
<tr>
<td>• Skin tumours (benign and malignant)</td>
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<tr>
<td>• Skin infections (bacterial, viral, fungal and parasitic)</td>
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<tr>
<td>• Wound care including leg ulcers</td>
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<tr>
<td>• Allergic disorders including urticaria</td>
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</tbody>
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Table 1
It is important to have some knowledge about the function of the skin and terminology in dermatology (see Table 3). The terminology can be difficult and confusing, especially for anyone who has not studied Latin or Greek. However, it is important to understand the basic terms, as many of the diagnostic terms are based on the descriptive nature of the rash.

Knowing the meaning of the words can make it easier to understand the underlying problem and remember the words, eg. ‘pityriasis’ means shedding of flaky scales, ‘keratosis’ means an overgrowth of layers of horny skin, and ‘lichen’ means scale tightly adherent to the skin like fungus (lichen) on a rock.

Diagnosis in dermatology, like most other specialties, involves careful history-taking (see Table 2) and a thorough physical examination. However, in dermatology, the history-taking may be carried out during or after the examination in order to save time and be more focused with questioning.

Even when the diagnosis is obvious (eg. acne or psoriasis) a careful history is still important to identify any precipitating or aggravating factors, the response to previous treatments and to assess the patients’ attitude about their complaint and their expectations regarding treatment. Sometimes mild disease (eg. acne) may have to be treated more aggressively if the patient is extremely upset about the problem.

A dietary history is sometimes necessary as excess sugar, fats, caffeine or alcohol may precipitate or aggravate certain skin problems. A dietary history may also reveal the possibility of an underlying food allergy or a dietary deficiency (eg. calcium, iron, folic acid, etc.).

A drug history (oral or topical, prescribed or non-prescribed) is also important, particularly when faced with an unusual rash. Occupations, hobbies, pets, foreign travel, contact with others with similar symptoms, underlying medical problems (eg. diabetes, systemic lupus erythematosus, etc) and family history may also be relevant.

**Physical examination**

A thorough physical examination is important when dealing with difficult to diagnose rashes, as important clues to the diagnosis may be found in hidden areas such as the scalp, the groin or between the toes or in the nails. Good light (daylight if possible) and a warm room are helpful. Make-up should be removed when examining the face. A complete head to toe examination is sometimes necessary when the diagnosis is not clear and when dealing with patients with skin cancer or suspicious moles. In addition, by examining all the skin you may also find other significant skin, hair or nail pathology that the patient was not aware of.

When examining all the skin, it is not necessary to strip the patient completely. I usually get the patient to take off their top clothing (including their bra if necessary) and examine that area first. I then get them to put their top clothes back on before removing their lower clothes (including their underwear if necessary). By retaining at least half of their clothing they retain some dignity and feel less exposed. Great care and sensitivity is required when examining children who can be very easily embarrassed. Also, young female adults may want a chaperone before examining intimate areas. Very often, explaining why you need to examine these areas can alleviate fears and embarrassment.

A magnifying light is extremely useful when examining and treating small lesions. Dermoscopy (skin microscopy) is very useful when diagnosing suspicious pigmented lesions and can also be useful in diagnosing scabies.

When examining a rash, first study the form of the individual lesions, then the pattern of the lesions on the body and their spatial relation to each other. Many rashes can look similar when you examine the individual lesions but they often have distinctive patterns that will help with the
When examining scaly or scabby lesions it is advisable to remove the scale or scab to reveal what is underneath (eg. a nodule, a superficial ulceration or an erythematous macular area) which will help in making the diagnosis. Palpating a lesion (eg. the characteristic pebbly feel of a dermatofibroma) or feeling a rash (eg. the typical feel of keratosis pilaris or psoriasis) can often help in the diagnosis and also reassure the patient that it is not contagious. However, if any lesion is bleeding or weeping, gloves must be worn. Careful hand-washing between all patients is important, especially if you palpate the skin.

Absolute recognition of a rash or a lesion is desirable although not essential once one can rule out more serious pathology such as a melanoma or a serious skin infection. A good atlas of dermatology or a good website with lots of pictures is a great help when struggling with a diagnosis and when trying to explain the nature of a problem to a patient (see Table 3).

Investigations

Sometimes special investigations may be necessary, such as skin scrapings for fungal stain and culture or a punch biopsy, which can often be done during a routine consultation. It is often unhelpful to take a biopsy of vague, non-specific rashes unless you are looking for a specific diagnosis that has a characteristic histological feature such as lupus or dermatitis herpetiformis. It is best to send your histology specimens to a pathologist who has a special interest in dermato-histopathology with as much clinical details as possible. Allergy testing such as IgE and RAST test, skin prick testing or skin patch testing is sometimes necessary to discover underlying allergies that may or may not already be suspected from the history. Allergy testing may also be necessary to exclude allergies such as food allergies that the patient or parents may falsely believe is responsible for their skin problem as a result of spurious ‘allergy tests’ carried out.

Treatment

When treating dermatology patients it is very important to explain whether you are aiming to cure or simply control the problem. You have to give realistic expectations as to how long it will take for the treatment to work as, unlike other branches of medicine, with dermatology problems, everything is on the surface for the patient to see and monitor themselves. For example, psoriasis usually takes six to 12 weeks to improve and acne can take three to six months to clear. If you don’t tell them this from the outset, the patient may give up their treatment too early or shop around for another opinion.

Follow-up is also important to check compliance and encourage the patient to continue with the treatment. If the patient is not responding it is important to check compliance with treatment and review the original diagnosis. I usually use what I call the ‘rule of three’. This means that if a patient comes back to you three times with the same problem not improved, I will refer the patient on to another colleague with more experience in the area for their opinion. Otherwise, the patient may lose confidence in you and will probably default on follow-up and go elsewhere.

It is important to reassure patients that their rash is not infectious or cancerous (when it isn’t), as this will often be their biggest fear. It is also important to confidently inform the patient that you can treat their condition (either cure or improve the visual appearance of the condition) or if you can’t, that you can get someone else who can.

When treating patients, I usually have a plan of action with a list of differential diagnoses and treatment options that I will record in the original consultation. Should the patient not improve on follow-up, I will revert to my original notes to see what I was thinking of on the first visit. A busy practitioner will not remember what they were thinking of a month previously. As my dad used to say “bad ink is better than a good memory” – write it down!

Some dermatology problems may be temporarily improved on the day the patient visits you. Always ask the patient whether the problem is good or bad on the day they visit. Photos of the rash that the patient may have taken on their phone or home camera can often help in making a diagnosis. The clinical signs may be much different on a follow-up visit so you don’t always have to make a definitive diagnosis on the first visit.

While prescription medications are often necessary when treating dermatology patients, the non-prescription or over the counter items can often be as important or more important (eg. moisturisers, soap substitutes, gloves, acne washes, non-comedogenic make-ups, etc). I like to show the patient or parents what these products look like by having various tubes and pots in my clinic. It is helpful to demonstrate how to apply the various products. Lifestyle modification may also be necessary in order to alleviate the problem or prevent relapse (eg. weight-loss, alcohol reduction or avoidance, dietary restrictions, etc). Patients may also need psychological help to manage scratching, squeezing or picking their rash or lesion. Some dermatology patients can have deep psychological problems such as body dysmorphic disorder, delusional parasitosis or dermatitis artefacta that may need psychiatric assessment.

Because there is a lot of fear and anxiety associated with skin problems, it is sometimes useful to guide the patient to a good website, that will explain the diagnosis and treatment in simplistic terms (see Table 3). As treatment plans can be complicated, and the patient will only remember a small amount of what you tell them, patient information handouts explaining the treatments are very useful.