

PHC Chapter 5: Skin Conditions

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5.1 DRY SKIN

L85.3

DESCRIPTION

- » The skin is dry and rough, together with varying degrees of scaling.
- » Severe forms are mainly inherited, e.g. ichthyosis.
- » Milder forms (xeroderma), seen as dryness with only slight scaling are common in the elderly and some chronic conditions, e.g. HIV disease, malignancies and atopic eczema.

GENERAL MEASURES

- » Avoid the use of soap.

MEDICINE TREATMENT

- Soap substitutes, e.g.:
- Aqueous cream (UEA).
 - Rub on skin, before rinsing off completely.
 - Aqueous cream should not be used as an emollient.
- Emollient, e.g.:
- Emulsifying ointment (UE)

5.2 ITCHING (PRURITUS)

L29.0-3/L29.8-9

DESCRIPTION

Itching may be:

- » localised or generalised,
- » accompanied by obvious skin lesions or skin conditions e.g. eczema, chicken pox,
- » accompanied by many systemic diseases, e.g. hepatitis,
- » caused by scabies and insect bites.

GENERAL MEASURES

- » Diagnose and treat the underlying condition.
- » Trim fingernails.
- » Avoid scratching.

MEDICINE TREATMENT

- Calamine lotion, apply when needed.

For pruritus associated with dry skin:

- Emollient, e.g.:
- Emulsifying ointment (UE).

If pruritis is severe and requires short term control:Children

Chlorphenamine, oral, 0.1 mg/kg/dose 6 to 8 hourly. See dosing table: Chapter 23.

Adults

LoE: IVb'

- Chlorphenamine, oral, 4 mg, 6 to 8 hourly.

Note: Chlorphenamine is sedating and may only be required in the evening for mild cases.

If pruritis is severe and requires long term control, e.g. for chronic pruritus:Children: 2 to 6 years of age

Cetirizine, oral, 5 mg once daily. See dosing table: Chapter 23.

Children >6 years of age and adults

- Cetirizine, oral, 10 mg once daily.

REFERRAL

- » No improvement after 2 weeks.
- » Underlying malignancy or systemic disease suspected.

5.3 ACNE VULGARIS

L70.0-5/L70.8-9

DESCRIPTION

- » Acne is an inflammatory condition of the hair follicle.
- » It is caused by hormones and sebum gland keratinisation, leading to follicular plugging producing comedones and proliferation of *Propioni bacterium* acnes.
- » Distributed on face, chest and back.
- » Occurs more commonly in adolescence, but may also occur in adulthood.
- » May also occur as a result of the inappropriate use of topical steroids, or as a side effect of medicine e.g. Isoniazid.

Mild acne:

Predominantly consists of non-inflammatory comedones.

Moderate acne:

Consists of a mixture of non-inflammatory comedones and inflammatory papules and pustules.

Severe acne:

It is characterised by the presence of widespread nodules and cysts, as well as a preponderance of inflammatory papules and pustules.

GENERAL MEASURES

- » Do not squeeze lesions.
- » Avoid greasy or oily cosmetics and hair grooming products that block the hair follicle openings.
- » Discourage excessive facial washing.

MEDICINE TREATMENT**Mild inflammatory acne:**

- Benzoyl peroxide 5%, topical, apply in the morning to affected areas as tolerated.
 - Wash off in the evening.
 - If ineffective and tolerated, increase application to 12 hourly.
 - Avoid contact with eyes, mouth, angles of the nose and mucous membranes. LoE:IVb²

Moderate inflammatory acne:

- Benzoyl peroxide 5%, topical, apply in the morning to affected areas as tolerated.
 - Wash off in the evening.
 - If ineffective and tolerated, increase application to 12 hourly.
 - Avoid contact with eyes, mouth, angles of the nose and mucous membranes. LoE:IVb³

AND

- Doxycycline, oral, 100 mg daily for 3 months. A
 - Review patient after 3 months of treatment.
 - It should be taken with meals.
 - Do not take it together with iron preparations and antacids. LoE:IVb⁴

Note: Doxycycline should always be used with a topical agent and should not be used as monotherapy.

For non-inflammatory acne:**Topical retinoids**

- » Main therapeutic objective is to control comedone formation.
- » Introduce topical retinoids gradually as a night-time application to limit skin irritant effects, as they are not photo-stable and degrade when exposed to sunlight (e.g. start twice a week and titrate up).

CAUTION

Do not use if pregnant or planning pregnancy.
Limit exposure to sunlight. If sunburn occurs, discontinue therapy until the skin has recovered. LoE:IIIa⁵

- Tretinoin, topical, apply at night to affected areas for at least 6 weeks.
 - Review patient after 6 weeks' treatment.
 - Minimise exposure to sunlight. If sunburn occurs, discontinue therapy until the skin has recovered.
 - Acne may worsen during the first few weeks.
 - Apply about a pea-sized amount to entire face. Avoid contact with eyes and area around mouth and nose.

REFERRAL

- » All severe cases.
- » Poor response to treatment.

5.4 BACTERIAL INFECTIONS OF THE SKIN**5.4.1 BOIL, ABSCESS**

L02.0-4/L02.8-9/H00.0/H60.0/N76.4/J34.0 + (B95.6)

DESCRIPTION

- » Localised bacterial skin infection of hair follicles or dermis, usually with *S. aureus*.
- » The surrounding skin becomes:
 - swollen
 - hot
 - red
 - tender to touch

Note:

- » Check blood glucose level if diabetes is suspected or if the boils are recurrent. Boils in diabetic or immunocompromised patients require careful management.
- » For axillary abscesses and pustules, see Section 5.17: Hidradenitis suppurativa.

GENERAL MEASURES

- » Encourage general hygiene e.g.: frequent showering, keeping nails short.
- » Drainage of abscess is the treatment of choice. Perform surgical incision only when the lesion is fluctuant.

MEDICINE TREATMENT

Systemic antibiotics are seldom necessary, unless the following features are present:

- » swollen, tender lymph nodes in the area
- » extensive surrounding cellulitis
- » fever
- » boils on the face

Antibiotics are also indicated in immunocompromised patients, diabetic patients, and neonates:

Children ≤ 7 years of age:

- Cefalexin, oral, 25 mg/kg/dose 12 hourly for 5 days. A See dosing table:Chapter 23.

OR

- Flucloxacillin, oral, 12–25 mg/kg/dose 6 hourly for 5 days. A See dosing table:Chapter 23.

Children >7 years of age and adults:

- Cefalexin, oral, 500 mg 6 hourly for 5 days. A

OR

- Flucloxacillin, oral, 500 mg 6 hourly for 5 days. A

For severe penicillin allergy:

Z88.0

Children

- Macrolide, e.g.:
- Azithromycin, oral, 10 mg /kg/dose daily for 3 days. W See dosing table: Chapter 23.

Adults

- Macrolide, e.g.:
- Azithromycin, oral, 500 mg daily for 3 days. W

REFERRAL

- » Poor response to treatment.
- » Abscesses of the palm of the hand and pulp space abscess of the fingers.
- » Features of severe sepsis requiring intravenous antibiotics.
- » Deep abscess e.g. ischiorectal and breast abscess.

5.4.2 IMPETIGO

L01.0-1

DESCRIPTION

- » A common contagious skin infection caused by streptococci or staphylococci.
- » Predominantly occurs in children.
- » Often secondary to scabies, insect bite, eczema or tinea capitis.
- » Clinical features:
 - » pus containing blisters - erosion of blisters with honey-coloured crusts
 - commonly starts on the face or buttocks » spreads to neck, hands, arms and legs
- » Post-streptococcal glomerulonephritis is a potential complication.

GENERAL MEASURES

- » Counsel on good personal and household hygiene to avoid spread of the infection and to reduce carriage of organisms.
- » Trim finger nails.
- » Wash and soak sores in soapy water to soften and remove crusts.
- » Continue with general measures until the sores are completely healed.
- » Check urine for blood if the sores have been present for more than a week.

MEDICINE TREATMENT

- Povidone iodine 5%, cream or 10% ointment, apply 8 hourly.

If extensive or systemic signs of infection (fever, unwell, fatigued), ADD:Children ≤ 7 years of age:

- Cefalexin, oral, 25 mg/kg/dose 12 hourly for 5 days. A See dosing table: Chapter 23.

OR

- Flucloxacillin, oral, 12–25 mg/kg/dose 6 hourly for 5 days. **A** See dosing table: Chapter 23.

Children >7 years of age and adults:

- Cefalexin, oral, 500 mg 6 hourly for 5 days. **A**

OR

- Flucloxacillin, oral, 500 mg 6 hourly for 5 days. **A**

LoE:IVb ⁶

For severe penicillin allergy:

Z88.0

Children

- Macrolide, e.g.:
- Azithromycin, oral, 10 mg/kg/dose daily for 3 days. **W** See dosing table: Chapter 23.

Adults

- Macrolide, e.g.:
- Azithromycin, oral, 500 mg daily for 3 days. **W**

Note: If impetigo has improved, but has not completely cured, give a 2nd 5-day course of antibiotics.

REFERRAL

- » No improvement after second course of antibiotics.
- » Presence of blood on urine test strip for longer than 5 to 7 days.
- » Clinical features of glomerulonephritis. See Section 8.3.1: Nephritic syndrome.

5.4.3 CELLULITIS

L03.0-3/L03.8-9

DESCRIPTION

- » A diffuse, spreading, acute infection within skin and soft tissues, commonly caused by streptococci.
- » Characterised by:
 - oedema
 - increased local temperature
 - redness
 - no suppuration
- » Frequently associated with lymphangitis and regional lymph node involvement.
- » Commonly occurs on the lower legs, but may occur elsewhere.
- » May follow minor trauma.
- » May present as an acute fulminant or chronic condition.
- » May occur with systemic manifestations of infection:
 - fever
 - chills
 - hypotension
 - tachycardia
 - delirium/altered mental state

GENERAL MEASURES

- » Elevate the affected limb to reduce swelling and discomfort.

MEDICINE TREATMENT

Children ≤ 7 years of age

- Cefalexin, oral, 25 mg/kg/dose 12 hourly for 5 days. A See dosing table: Chapter 23.

OR

- Flucloxacillin, oral, 12–25 mg/kg/dose 6 hourly for 5 days. A See dosing table: Chapter 23.

Children >7 years of age and adults

- Cefalexin, oral, 500 mg 6 hourly for 5 days. A

OR

- Flucloxacillin, oral, 500 mg 6 hourly for 5 days. A

LoE: IVb ⁷

For severe penicillin allergy:

Z88.0

Children:

- Macrolide, e.g.:
- Azithromycin, oral, 10 mg/kg/dose daily for 3 days. A See dosing table: Chapter 23.

Adults:

- Macrolide, e.g.:
- Azithromycin, oral, 500 mg daily for 3 days. A

Severe cellulitis:

Refer for parenteral antibiotics.

REFERRAL

Urgent

- » Children who have significant pain, swelling or loss of function (to exclude osteomyelitis).
- » Haemorrhagic bullae, gas in the tissues or gangrene.
- » Extensive cellulitis.
- » Recurrent cellulitis associated with underlying conditions, e.g. lymphoedema.
- » Cellulitis with systemic manifestations, e.g. confusion, hypotension.
- » Poorly controlled diabetic patients.
- » Involvement of the hand, face and scalp.

Non-urgent

- » Inadequate response to initial antibiotic treatment.

5.4.4 CHRONIC LOWER LEG ULCERS

L97

DESCRIPTION

- » A chronic relapsing disorder of the lower limbs.
- » Associated with vascular insufficiency (predominantly venous insufficiency) and patient immobility.
- » Commonly associated with neuropathy, infections, neoplasia, trauma or other rare conditions.

GENERAL MEASURES

- » If the ulcer is oedema- or stasis-related, rest the leg in an elevated position.
- » In venous insufficiency, compression (bandages or stockings) are essential to achieve and maintain healing, provided the arterial supply is normal.
- » In patients with arterial insufficiency, avoid pressure on bony prominences and toes.
- » In patients with neuropathy, relieve pressure from the area.
- » Exclude diabetes with finger prick blood glucose test.
- » Avoid topical application of home remedies.
- » Stress meticulous foot care and avoidance of minor trauma. Encourage patients with neuropathy not to walk barefoot, check their shoes for foreign objects, examine their feet daily for trauma and to test bath water before bathing to prevent getting burnt.
- » Avoid excessive local heat.
- » Walking and exercises are recommended.

MEDICINE TREATMENT

Refer for assessment and initiation of treatment.

Local wound care:

Topical cleansing:

Use bland, non-toxic products to clean the ulcer and surrounding skin.

For clean uninfected wounds:

- Sodium chloride, 0.9% or sterile water.

Dress frequently with:

- Moistened dressing e.g. gauze with sodium chloride, 0.9%.

LoE: IIIb ⁸

For exudative, infected wounds:

- Povidone-iodine 5% cream, topical apply daily

LoE: IVb ⁹

For venous ulcers:

- Paraffin gauze dressing.

REFERRAL

- » No improvement after 1 month.
- » All foot ulcers.
- » Ulcers with atypical appearance.
- » Venous ulcers that are persistently infected, or have offensive odour.

5.5 FUNGAL INFECTIONS OF THE SKIN

5.5.1 CANDIDIASIS, SKIN

B37.2

Vaginal candidiasis: See Section 12.1: Vaginal discharge syndrome (VDS).

DESCRIPTION

A skin infection caused by *C. albicans*.

Most common sites for infection are skin folds such as:

- » under the breasts
- » axillae
- » nail folds
- » natal cleft
- » groins
- » neck folds, peri-anal, perineum and groins in infants

The skin lesions or sores:

- » are red raw-looking patches
- » appear moist (weeping)
- » have peripheral outlying white pustules, red scaly lesions which become confluent

GENERAL MEASURES

- » Exclude diabetes.

MEDICINE TREATMENT

- Imidazole, e.g.:
- Clotrimazole 1%, topical, apply 3 times daily for 14 days.

5.5.2 RINGWORM AND OTHER TINEAS

Fungal infections affecting the body (tinea corporis; tinea versicolor), feet (tinea pedis), scalp (tinea capitis) and nails (tinea unguium). These infections may be contagious.

5.5.2.1 RINGWORM – TINEA CORPORIS

B35.4

DESCRIPTION

- » Clinical features include:
 - itchy ring-like patches
 - patches slowly grow bigger
 - raised borders
- » As the patch extends a clear area develops in the center which may become hyperpigmented in dark skin.
- » Extensive disease is common in HIV, often with no evidence of the patches developing clear centres.

GENERAL MEASURES

- » Prevent spreading the infection to others.
- » Do not share clothes, towels, or toiletries (especially combs and hair brushes).
- » Wash skin well and dry before applying medicine treatment.

MEDICINE TREATMENT

- Imidazole, e.g.:
- Clotrimazole 1%, topical, apply 3 times daily.
 - Continue using cream for at least 2 weeks after lesions have cleared.

Note: Treat any secondary skin infection with antibiotics. See Section 5.4.2: Impetigo.

REFERRAL

- » Extensive disease.

5.5.2.2 ATHLETE'S FOOT – TINEA PEDIS

B35.3

DESCRIPTION

- » A common contagious fungal infection of the foot, characterised by itching, burning and stinging between the toes or on the sole.
- » The skin between the toes is moist and white (maceration) and may become fissured. There is also associated erythema, scaling and peeling.
- » Secondary eczema of the hands may be an associated condition. See Section 5.8.1: Eczema, atopic.
- » Vesicles may occur in inflammatory cases.
- » Pain and tenderness in the web spaces may indicate secondary bacterial infection.
- » Re-infection is common.

GENERAL MEASURES

- » Discourage the use of shared bathing or swimming areas, whilst infected.
- » Keep feet dry:
 - wear open sandals,
 - do not wear socks of synthetic material,
 - dry between toes after washing the feet or walking in water.
- » Wash and dry feet twice daily before applying medicine treatment.

MEDICINE TREATMENT

- Imidazole, e.g.:
- Clotrimazole 1%, topical, apply twice daily for 4 weeks.

Note: For nail infection, see Section 5.6.3: Nail infections – *tinea unguium*.

REFERRAL

- » No improvement after 4 weeks.

5.5.2.3 SCALP INFECTIONS – TINEA CAPITIS

B35.0

DESCRIPTION

- » Round or patchy bald areas with scales and stumps of broken off hair.

GENERAL MEASURES

- » Avoid shaving head in children.
- » Do not share toiletries such as combs and hair brushes.

MEDICINE TREATMENTChildren:

- Fluconazole, oral, 6 mg/kg once daily, for 28 days. See dosing table: Chapter 23.

LoE: IIb¹⁰Adults:

- Fluconazole, oral, 200 mg weekly, for 6 weeks.

LoE: IIIb¹¹

Note: Do not give to women of child-bearing age unless they are on effective contraceptive.

5.5.2.4 PITYRIASIS VERSICOLOR – TINEA VERSICOLOR

B36.0

DESCRIPTION

- » Round macules which are often lighter than normal skin (but may be darker).
- » Mostly found on the upper chest and back, less common on the neck, face, abdomen and upper limbs.
- » Macules on the chest and back often coalesce, and the condition spreads with the formation of new macules on the periphery.
- » Pigmentation may take months to return to normal after treatment.
- » Recurrences are common, especially in hot weather.

GENERAL MEASURES

- » Avoid wearing clothing that impairs ventilation in hot weather to reduce perspiration.

MEDICINE TREATMENT

- » Oral antifungal therapy is not indicated.
- Selenium sulfide, 2.5% suspension, apply once weekly for three weeks.
 - Lather shampoo on affected parts.
 - Leave on overnight, then wash off the following day.

LoE: IVb¹²

5.5.2.5 NAIL INFECTIONS – *TINEA UNGUIUM*

See Section 5.6.3: Nail infections – *tinea unguium*.

5.6 NAILFOLD AND NAIL INFECTIONS

5.6.1 PARONYCHIA, ACUTE

L03.0

DESCRIPTION

- » Small subcutaneous collection of pus under the nailfold.
- » Often associated with cutting nails too short, or nail biting.

GENERAL MEASURES

- » Avoid cutting finger nails too short.
- » Avoid nail biting.

MEDICINE TREATMENT

- » Drain abscess by puncture or incision.

Adults:

- Flucloxacillin, oral, 500 mg 6 hourly for 5 days. A

5.6.2 PARONYCHIA, CHRONIC

L03.0

DESCRIPTION

- » Chronic, red, swollen nailfold, lifted off the nail plate with whitish pus.
- » Commonly caused by working in water and contact with household detergents.

GENERAL MEASURES

- » Avoid hand contact with household detergents, washing powders and fabric softeners.
- » Wear rubber gloves when washing clothes, linen and kitchen utensils to keep hands clean and dry as far as possible.

MEDICINE TREATMENT

- Corticosteroid, potent, topical, e.g.: (Doctor prescribed)
- Betamethasone 0.1%, topical, apply at night until lesions have cleared.
 - Wash hands, then massage cream into the nailfold.

If secondary infection is present, indicated by pain and tenderness in the nail fold, treat with antibiotics (see Section 5.4.2: Impetigo).

LoE: IIIb¹³

REFERRAL

- » No response to treatment.

5.6.3 NAIL INFECTIONS – TINEA UNGUIUM

B35.1

DESCRIPTION

- » Nails are lifted, distorted, crumbling and discoloured.
- » One or more nails may be affected.

GENERAL MEASURES

- » Topical treatment is generally ineffective for fungal nail infections.
- » Systemic treatment is often unsuccessful and recurrent infections are common if repeat exposure is not prevented.

REFERRAL

- » Patients that are distressed by cosmetic appearance.

5.7 PARASITIC INFESTATIONS OF THE SKIN**5.7.1 LICE (PEDICULOSIS)****DESCRIPTION**

An infestation of the body with parasitic lice.

Clinical features include:

- » Itching,
- » bite marks,
- » presence of secondary eczema, or secondary infection.

CAUTION

Do not use commercial insect sprays as they are toxic.
Lotions used for the treatment of lice are toxic when swallowed.

Note: Treat secondary infection with antibiotics. See Section 5.4.2: Impetigo.

5.7.1.1 HEAD LICE

B85.0

DESCRIPTION

Head lice are common in children. The eggs (nits) appear as fixed white specks on the hair.

GENERAL MEASURES

- » Use a fine tooth comb to comb out the nits after washing hair.
- » Shaving of the head may expedite treatment, where socially acceptable.
- » Prevent spread by treating other contacts.
- » Remove nits from eyelashes by application of white soft paraffin.

MEDICINE TREATMENT

- Permethrin 5%, topical
 - Apply permethrin 5% lotion to towel-dried or dry hair. Comb into hair repeatedly with a normal comb until scalp is covered completely.
 - Remove lice and nymphs with fine lice comb by dividing scalp into sections and combing away from scalp.
 - Rinse lice comb in a white bowl filled with hot water between hair strokes to identify removed lice, or detach on white tissue paper. Paralysed and dead lice will present as dark spots (like ground pepper).
 - Take note of the physical size of removed lice and nymphs, as the size should get smaller with consecutive treatments.
 - Keep on combing with fine lice comb, rinsing or wiping comb frequently.
 - Permethrin 5% lotion is safe and can be left in the hair for up to one hour.
 - After combing, rinse hair with lukewarm water and wash permethrin 5% lotion out with normal shampoo (more than one foaming might be needed).
 - Repeat this procedure every 5 days for 3 weeks.
 - Thereafter, carry out frequent inspections to detect new infestations early.
 - **Do not** apply to broken skin or sores.
 - **Avoid** contact with eyes.

LoE: IIIb ¹⁴

5.7.1.2 BODY LICE

B85.1/B85.4

DESCRIPTION

- » Body lice live in the seams of clothing and only come to the skin to feed.
- » **Note:** Body lice may carry typhus fever.

GENERAL MEASURES

- » Regularly wash bed linen and underclothes in hot water and expose to sunlight.

MEDICINE TREATMENT

Adolescents and adults:

- Benzoyl benzoate 25% lotion, undiluted, once weekly for 3 weeks.
 - Apply over the whole body, excluding the neck and face.
 - Leave on overnight and wash off the next day.
 - **Note:**
 - Avoid contact with eyes and broken skin or sores.
 - The lotion is toxic if swallowed.
 - Do not continue if a rash or swelling develops.
 - Itching may continue for 2–3 weeks after treatment.

LoE:IIIb ¹⁵

5.7.1.3 PUBIC LICE

B85.3/B85.4

DESCRIPTION

- » Pubic lice are acquired as STIs and nits are found on pubic hair and eyelashes.

GENERAL MEASURES

- » Prevent spread by treating other contacts.

MEDICINE TREATMENT

- Benzoyl benzoate 25% lotion, apply once weekly for two weeks
 - Apply to affected area.
 - Leave on for 24 hours, then wash thoroughly.
 - Repeat in 7 days.

For pediculosis of the eyelashes or eyebrows:

- Yellow petroleum jelly (Note: Do not use white petroleum jelly near the eyes).
 - Apply to the eyelid margins (cover the eyelashes) daily for 10 days to smother lice and nits.
 - Do not apply to eyes.

LoE:IVb

REFERRAL

- » Lice infestation of eyelashes in children to exclude suspected sexual abuse.

5.7.2 SCABIES

B86

DESCRIPTION

- » An infestation with the parasite *Sarcoptes scabiei*.

- » Commonly occurs in the skin folds. The infestation spreads easily, usually affecting more than one person in the household.
- » Clinical features include:
 - intense itching, which is more severe at night,
- » small burrows between fingers, toes, elbow areas and buttocks where the parasite has burrowed under the skin,
 - secondary infection which may occur due to scratching with dirty nails,
 - vesicles and pustules on the palms, soles, and sometimes scalp, in small babies.

GENERAL MEASURES

- » Treat all close contacts simultaneously even if they are not itchy.
- » Cut finger nails and keep them clean.
- » Wash all linen and underclothes in hot water.
- » Expose all bedding to direct sunlight.
- » Put on clean, washed clothes after medicine treatment.

MEDICINE TREATMENT

Children <6 years of age:

- Permethrin 5%, topical, apply lotion undiluted to the whole body from neck to feet
 - Leave on overnight (8 to 12 hours) and wash off the following morning. LoE: IVb¹⁶

If permethrin is unavailable for children <6 years of age:

- Benzoyl benzoate 25% lotion:
 - Children 0 months to 1 year of age:
 - o Dilute 1 part of benzoyl benzoate to 3 parts of water to form an emulsion of 6%.
 - o Apply diluted emulsion to the whole body from neck to feet as described above.
 - Children 1 to 6 years of age:
 - o Dilute 1 part of benzoyl benzoate with an equal amount of water to form an emulsion of 12.5%.
 - o Apply diluted emulsion to the whole body from neck to feet as described above. LoE: IVb¹⁷

Children ≥ 6 years of age and adults:

- Benzoyl benzoate 25% lotion, applied undiluted to the whole body from neck to feet.
 - Allow the lotion to remain on the body for 24 hours, then wash off using soap and water.
 - Treatment may be repeated after 24 hours **once** within 5 days for severe infestations.
 - All infested persons living in the household, or likely to contract the infestation, should be treated at the same time.

If benzoyl benzoate is unsuccessful:

- Permethrin 5%, topical, apply lotion undiluted to the whole body from neck to feet.
 - Leave on overnight (8–12 hours) and wash off the following morning.

LoE: IIIb¹⁸**Note:**

- Benzoyl benzoate and permethrin are toxic if swallowed.
- Avoid contact with eyes and broken skin or sores.
- Do not continue if rash or swelling develops.
- Itching may continue for 2–3 weeks after treatment.
 - Treatment may need to be repeated again after one week.
- Treat secondary infection with antibiotics. See Section 5.4.2: Impetigo.

5.7.3 SANDWORM

B76.0

DESCRIPTION

- » Creeping eruption (cutaneous larva migrans) caused by *Ancylostoma braziliense*, a hookworm of dog or cat.
- » Larvae of ova in soil penetrate skin commonly through the feet, legs, buttocks or back and cause a winding thread-like trail of inflammation with itching, scratching dermatitis and bacterial infection.

MEDICINE TREATMENT

- Albendazole, oral:
 - Children <2 years of age: 200 mg daily for 3 days
 - Children ≥ 2 years of age and adults: 400 mg daily for 3 days

ANDChildren

- Chlorphenamine, oral, 0.1 mg/kg/dose 6 to 8 hourly. See dosing table: Chapter 23.

AdultsLoE: IVb¹⁹

- Chlorphenamine, oral, 4 mg, 6 to 8 hourly.

Note: Chlorphenamine is sedating and may only be required in the evening for mild cases.

5.8 ECZEMA AND DERMATITIS**5.8.1 ECZEMA, ATOPIC**

L20.0/L20.8-9

DESCRIPTION

- » An inflammatory disorder with an itchy red rash or dry rough skin.
- » In babies it appears at approximately 3 months.
- » Family history of asthma, hay fever or atopic dermatitis is common.
- » Clinical features:

- occurs on the inner (flexural) surfaces of elbows and knees, the face and neck,
- » can become chronic with thickened scaly skin (lichenification),
- secondary bacterial infection may occur with impetigo or pustules,
- » can be extensive in infants ,
- very itchy at night.
- » Eczema is usually a chronic condition and requires long-term care.
- » Sufferers of atopic eczema are particularly susceptible to herpes simplex and may present with large areas of involvement with numerous vesicles and crusting surrounded by erythema (eczema herpeticum). See Section 5.13: Herpes simplex.

GENERAL MEASURES

- » Avoid direct skin contact with woollen or rough clothes.
- » Avoid overheating by blankets at night.
- » Trim fingernails to prevent scratching.
- » Counsel on good personal hygiene with regular washing to remove crusts and accretions, and to avoid secondary infection.
- » Diet modification has no role in atopic eczema treatment.
- » Avoid soap on affected areas.

MEDICINE TREATMENT

(For management of severe eczema, start at step 3.)

STEP 1

- Avoid soap, use soap substitutes such as aqueous cream (UEA).
 - Rub on skin, then rinse off completely.
 - Do not use aqueous cream as an emollient.
- Emollient, e.g.:
- Emulsifying ointment (UE).

If no response within seven days/worsening symptoms:

STEP 2

- Hydrocortisone 1% topical, applied twice daily for 7 days.
 - Apply sparingly to the face.
 - Do not apply around the eyes.

If there is a response:

Reduce the use of the hydrocortisone cream to once daily for a further few days, then stop and maintain treatment with:

- Aqueous cream (UEA) as a wash-off soap.

AND

- Emollient, e.g.:
- Emulsifying ointment (UE).

If no response within seven days or severe eczema:

STEP 3

- Corticosteroid, potent, topical, e.g.: (Doctor prescribed)

- Betamethasone 0.1%, topical, apply ointment once daily for 7 days.
 - **Do not** apply to face, neck and flexures.

LoE: IIb²⁰

If there is a response:

Reduce use of corticosteroid ointment for a further few days, then stop and maintain treatment with:

- Aqueous cream (UEA) as a soap.

AND

- Emollient, e.g.:
- Emulsifying ointment (UE).

If the patient is itching:

Children:

- Chlorphenamine, oral, 0.1 mg/kg/dose at night for a maximum of 2 weeks. See dosing table: Chapter 23.

LoE: IVb²¹

Adults:

- Chlorphenamine, oral, 4 mg, at night for a maximum of 2 weeks.
 - **Note:** Chlorphenamine is sedating.

If itch is not controlled or is more severe during the day, switch to:

Children: 2 to 6 years of age:

- Cetirizine, oral, 5 mg once daily. See dosing table: Chapter 23.

Children >6 years of age and adults:

- Cetirizine, oral, 10 mg once daily.

LoE: IVb

REFERRAL

- » No improvement in 2 weeks.
- » Infants and children requiring more than 1% hydrocortisone cream.
- » Extensive involvement.
- » Eczema herpeticum.

5.8.2 ECZEMA, ACUTE, MOIST OR WEEPING

L20.0/L20.8-9

DESCRIPTION

- » A form of eczema with small or large vesicles, associated with oozing and eventual crusting and scaling.
- » Yellow pustules with crust indicate secondary sepsis.

GENERAL MEASURES

- » Sodium chloride, 0.9% dressings, applied daily or twice daily.
Avoid use of soap on affected areas.

MEDICINE TREATMENT

- Topical steroids, e.g.:
- Hydrocortisone 1% topical, applied 12 hourly, until improved.
 - Topical steroids should be applied to both moist and dry inflamed areas.

Antibiotic treatment if secondary infection is present:Children ≤7 years of age:

- Cefalexin, oral, 25 mg/kg/dose 12 hourly for 5 days. **A** See dosing table: Chapter 23.

OR

- Flucloxacillin, oral, 12–25 mg/kg/dose 6 hourly for 5 days. **A** See dosing table: Chapter 23.

Children >7 years of age and adults:

- Cefalexin, oral, 500 mg 6 hourly for 5 days. **A**

OR

- Flucloxacillin, oral, 500 mg 6 hourly for 5 days. **A**

Severe penicillin allergy:

Z88.0

Children:

- Macrolide, e.g.:
- Azithromycin, oral, 10 mg /kg/dose daily for 3 days. **W** See dosing table: Chapter 23.

Adults:

- Macrolide, e.g.:
- Azithromycin, oral, 500 mg daily for 3 days. **W**

If the patient is itching:Children

- Chlorphenamine, oral, 0.1 mg/kg/dose at night. See dosing table: Chapter 23.

Adults

- Chlorphenamine, oral, 4 mg, at night.

LoE: IVb²²**Note:** Chlorphenamine is sedating.**If itch is not controlled or is more severe during the day, switch to:**Children: 2–6 years of age

- Cetirizine, oral, 5 mg once daily. See dosing table: Chapter 23.

Children >6 years of age and adults

- Cetirizine, oral, 10 mg once daily.

LoE: IVb

For itching in children <2 years of age:

- Calamine lotion, applied on the skin.

REFERRAL

- » No improvement after a week.
- » Severe acute moist or weeping eczema.

5.8.3 DERMATITIS, SEBORRHOEIC

L21.0-1/L21.8-9

DESCRIPTION

- » Dandruff is an uninfamed form of seborrhoeic dermatitis.
- » Pruritus may or may not be present in seborrhoeic dermatitis.
- » The scalp, face, ears and skin folds e.g. axillae, groins, under the breasts are commonly affected.
- » May become very extensive, particularly in infants and HIV infected patients.

GENERAL MEASURES

- » Trim nails.
- » Avoid scratching affected areas.
- » Avoid perfumed soap.

MEDICINE TREATMENT

- Hydrocortisone 1% topical, apply twice daily until improved.
 - Then apply once or twice weekly for maintenance as needed.

For severe dermatitis:

- Corticosteroid, potent, topical, e.g.: (Doctor prescribed)
- Betamethasone 0.1%, topical, apply ointment once daily for 5–7 days.
 - Do not apply to face neck and flexures.

LoE: IIb²³**For itching scalp, scaling and dandruff:**

- Selenium sulphide, 2.5% suspension, apply weekly.
 - Lather on the scalp.
 - Rinse off after 10 minutes.
 - Apply weekly, until improved, then every second week to maintain control.

5.9 NAPPY RASH

L22

DESCRIPTION

- » A diffuse reddish eruption in the nappy area, usually caused by irritation from:

- persistent moisture and irregular cleaning and drying of the nappy area,
 - diarrhoeal stools,
 - underlying skin conditions in some cases, or
 - improper rinsing of nappies to remove urine and stool breakdown products.
- » Rash is predominantly on areas in contact with the nappy, and spares the flexures.

GENERAL MEASURES

- » Prompt changing of soiled nappies.
- » Avoid waterproof pants.
- » Expose nappy area to air if possible especially with severe nappy dermatitis.
- » Educate caregiver on washing, rinsing and drying of the nappy when soiled.

MEDICINE TREATMENT

- Zinc emollient, e.g.:
- Zinc and castor oil, topical, apply ointment after each nappy change.

If rash involves the flexures, suspect candida:

- Imidazole, e.g.:
- Clotrimazole 1%, topical, apply cream beneath zinc and castor oil ointment after each nappy change until symptoms are resolved.

REFERRAL

- » No improvement after 3 days of treatment.

5.10 ALLERGIES

5.10.1 URTICARIA

L50.0-6/L50.8-9

DESCRIPTION

- » Urticaria is a skin disorder characterised by itchy wheals (hives).
- » There are many causes, including allergic, toxic or physical:
- » Allergic urticaria may be caused by drugs, plant pollen, insect bites or foodstuffs, e.g. fish, eggs, fruit, milk and meat.
 - Commonly caused by medicines e.g. aspirin, NSAIDs, or codeine.

GENERAL MEASURES

- » Take detailed history to determine trigger factors.
- » Lifestyle adjustment.

MEDICINE TREATMENT

Note: Avoid the use of oral corticosteroids.

LoE: IVb

Children

- Chlorphenamine, oral, 0.1 mg/kg/dose at night. See chlorphenamine dosing table, Chapter 23.

LoE:IVb²⁴Adults

- Chlorphenamine, oral, 4 mg, 6 to 8 hourly.

For long term use in adults and school going children:Children: 2–6 years of age

- Cetirizine, oral, 5 mg once daily. See dosing table: Chapter 23.

Children >6 years of age and adults

- Cetirizine, oral, 10 mg once daily.
- Calamine lotion, applied on the skin.

REFERRAL

- » No improvement or response after 24 hours.

5.10.2 ANGIOEDEMA

T78.3 + (Y14.99/Y34/Y57.9)

DESCRIPTION

- » Localised oedema of the subcutaneous tissue affecting particular parts of the face i.e. lips, eyes and tongue. May also affect the larynx, causing life threatening airway obstruction and anaphylaxis.
- » ACE-inhibitors are the most common cause in adults. Other causes include other medicines and allergies.

GENERAL MEASURES

- » Stop all suspected agents e.g. ACE-inhibitor.
- » In the case of airway obstruction, a definitive airway must be established if oedema is extensive or progressing.

MEDICINE TREATMENT**If urticaria and/or itch present (no imminent airway compromise):**

- Cetirizine, oral, 10 mg as a single dose.

LoE:IVb

OR

- Promethazine, IM, 25 to 50 mg immediately.

In severe cases where airway obstruction is present:Adults

- Adrenaline (epinephrine), 1:1000 solution, 0.5 mL into the lateral thigh, administered immediately and repeated every 5 to 15 minutes as needed.

Children

- Adrenaline (epinephrine), IM, 0.01 mL/kg of 1:1000 solution, administered immediately.
 - Maximum dose of 0.3 mL

AND

- Hydrocortisone, IV, 100 mg as a single dose.

Note: Observe all cases until resolution.

REFERRAL

- » Failure to respond.
- » No obvious cause found.
- » Severe ACE-inhibitor induced angioedema.

5.10.3 FIXED DRUG ERUPTIONS

L27.0-1

DESCRIPTION

- » Dark coloured round macules that can occur anywhere on the body following the ingestion of a medicine to which the patient has become allergic.
- » They recur on the same spot and increase in number with each successive attack.
- » In the acute stage they are itchy, red around the edge or even bullous.

GENERAL MEASURES

- » Stop the suspected offending medicine(s).

MEDICINE TREATMENT**Acute/active stage**

- Hydrocortisone 1%, topical, apply daily for 5 days.

LoE: IVb

REFERRAL

- » Widespread eruptions.

5.10.4 PAPULAR URTICARIA

L50.8

DESCRIPTION

- » Hypersensitivity response to insect bites.
- » Initial lesion is a red papule, which may blister, become excoriated, and then heal with hyperpigmentation. Usually occur in crops over several months.

- » Common and often severe in HIV infections. (See Section 11.3.12: Papular pruritic eruption.)

GENERAL MEASURES

- » Reduce exposure to insects by treating pets, using mosquito nets and fumigating houses regularly. Use of insect repellents may be helpful.

MEDICINE TREATMENT

New, inflamed lesions:

- Hydrocortisone 1%, topical, apply daily for 5 days.

For relief of itch:

Children

- Chlorphenamine, oral, 0.1 mg/kg/dose 6–8 hourly. See dosing table:

LoE:IVb ²⁵

 Chapter 23.

Adults

- Chlorphenamine, oral, 4 mg, 6–8 hourly.

Note: Chlorphenamine is sedating and may only be required in the evening for mild cases.

For long term use in adults and school going children:

Children 2–6 years of age:

- Cetirizine, oral, 5 mg once daily. See dosing table: Chapter 23.

Children >6 years of age and adults:

- Cetirizine, oral, 10 mg once daily.

REFERRAL

- » Non-responsive and chronic cases.

5.10.5 ERYTHEMA MULTIFORME

L51.0/L51.8-9

DESCRIPTION

- » A self-limiting and commonly recurrent inflammatory eruption of the skin.
- » May involve mucous membrane (but not more than one surface), and usually without systemic symptoms.
- » Usually lasts for 10–14 days before complete recovery occurs.
- » Symmetrically distributed crops of target lesions (dark centre, an inner, pale ring surrounded by an outer red ring) occur on the extremities, and in particular, on the backs of the hands and forearms, palms and soles.
- » This condition is usually due to an infection, commonly herpes simplex or mycoplasma.

REFERRAL

- » All patients with systemic symptoms or mucosal involvement.
- » Unsure of the diagnosis.

5.10.6 SEVERE CUTANEOUS ADVERSE DRUG REACTIONS**5.10.6.1 STEVENS-JOHNSON SYNDROME (SJS)/TOXIC EPIDERMAL NECROLYSIS (TEN)**

L51.1/ L51.2

DESCRIPTION

- » An acute, systemic condition with vesico-bullous lesions involving the skin and mucous membranes (≥ 2 mucosal surfaces), but occasionally only the mucous membranes.
- » The eruption may start as widespread red irregular macules and patches. There may be a vesicle or bulla in the central area of the lesion. The blisters rupture leaving denuded areas of skin. Mucous membrane erosions often with slough covering the surface are frequently seen.
- » Toxic epidermal necrolysis (TEN) is a more severe form of the condition and is suggested if the skin lesions cover $>30\%$ of the body surface area. The mucous membranes such as the mouth, eyes and vagina are also more severely affected.
- » The condition is usually caused by medicines e.g. sulphonamides, anti-retrovirals (nevirapine), anti-epileptics (phenytoin, phenobarbitone, carbamazepine, lamotrigine).
- » Systemic involvement with multi-organ dysfunction is common.

GENERAL MEASURES

- » Immediate withdrawal of offending medicine.
- » Patients usually require care in a high or intensive care unit with dedicated nursing.

REFERRAL

- » All patients.

5.10.6.2 DRUG REACTION WITH EOSINOPHILIA AND SYSTEMIC SYMPTOMS (DRESS)

L27.0 + (D72.1)

DESCRIPTION

- » Severe hypersensitivity reaction to a medicine.
- » Typically occurs within 3 months of starting the offending medicine.
- » Clinical symptoms include:

- maculopapular rash	- fever $>38^{\circ}\text{C}$
- lymphadenopathy	- hepatitis or other organ involvement

- eosinophilia and/or other blood count abnormalities
- » Medicines that commonly induce the DRESS syndrome include phenobarbital, carbamazepine, phenytoin, lamotrigine, allopurinol, sulphonamides, abacavir, nevirapine and levetiracetam.

REFERRAL

- » All patients.

5.11 PITYRIASIS ROSEA

L42

DESCRIPTION

- » A common disease of unknown cause, probably due to a viral infection as it occurs in minor epidemics.
- » Most common in young adults but any age may be affected.
- » The rash involves the trunk, neck and mainly proximal parts of the limbs.
- » Presents as pink papules and macules. The macules are oval and have a thin collar of scale towards, but not at, the periphery of the lesions.
- » The eruption is usually preceded by a few days by one larger, oval, slightly scaly area (“herald patch”), commonly found in the scapular area or abdomen. The macules on the thorax characteristically lie parallel to the long axis of the ribs (“Christmas tree” distribution).
- » The itch is usually mild and there are few or no constitutional symptoms. It is self-limiting and resolves within about 6–8 weeks.

GENERAL MEASURES

- » Counsel on the benign but prolonged nature of the condition.

MEDICINE TREATMENT

Children

- Chlorphenamine, oral, 0.1 mg/kg/dose at night. See dosing table: LoE: IVb²⁶
Chapter 23.

Adults

- Chlorphenamine, oral, 4 mg at night.

Note: Chlorphenamine is sedating.

If itch is not controlled or more severe during the day, switch to:

Children: 2 to 6 years of age

- Cetirizine, oral, 5 mg once daily. See dosing table: Chapter 23.

Children >6 years of age and adults:

- Cetirizine, oral, 10 mg once daily.

LoE: IVb

5.12 MOLLUSCUM CONTAGIOSUM

B08.1

DESCRIPTION

- » Infectious disease caused by a poxvirus.
- » Presents with dome-shaped papules with a central depression (umbilication). Varies from occasional lesions to large crops of lesions particularly in immunocompromised or HIV-infected patients.
- » Papules are commonly seen on the face in children, but may be found at any skin site, except on the palms and soles. They may also occur on the genitalia as an STI.
- » Most infections resolve spontaneously except in the immunocompromised.

GENERAL MEASURES

In non-genital molluscum contagiosum:

- » Allow lesions to heal spontaneously if the lesions are few in number and the patient not immunocompromised.
- » Manual removal of lesions or expression of contents is not recommended as it may result in unintentional inoculation of other parts of the body, increase the risk of spread to others, or result in secondary bacterial infection.

LoE:IVb²⁷

In genital molluscum contagiosum:

- » Counsel on risk reduction for transmission of STIs.
- » Counsel that the partner(s) should be notified, examined, and treated.

MEDICINE TREATMENT

- Tincture of iodine BP, applied to core of individual lesions using an applicator.

LoE:IIIb²⁸

CAUTION

Beware of hypersensitivity to iodine.

REFERRAL

- » Extensive disease.
- » Those failing to respond to simple measures.
- » Peri-ocular lesions to an ophthalmologist.

5.13 HERPES SIMPLEX

B00.0-4/B00.7-9

DESCRIPTION

- » Infection caused by herpes simplex virus type 1 or 2.
- » Primary herpes infection involving gingivostomatitis (usually type 1) or the genital area (usually type 2) may be extensive, and may occur at other sites, e.g. the face.

- » It is characterised by grouped crusted vesicles surrounded by erythema. The vesicles rupture soon after forming, producing discrete ulcers.
- » Recurrences are usually mild and last a few days, except in immunosuppressed patients. Recurrences of oral herpes may be triggered by other respiratory tract infections or exposure to ultraviolet light.
- » Sufferers of atopic eczema are particularly susceptible to the virus and may present with large areas of involvement with numerous vesicles and crusting surrounded by erythema (eczema herpeticum).
- » Herpes simplex mucocutaneous ulceration that persists for >1 month is an AIDS-defining illness. See Section 11.3.10: Herpes simplex ulcers, chronic.
- » Herpes simplex infection may be the precipitating event in many cases of erythema multiforme.

GENERAL MEASURES

Keep the skin lesions clean and dry.

MEDICINE TREATMENT

Extensive herpes, eczema herpeticum or chronic mucocutaneous ulcerations:

Children <15 years of age:

- Antiviral, (active against herpes simplex) e.g.:
- Aciclovir, oral, 250 mg/m²/dose, 8 hourly for 7 days. See dosing table: Chapter 23.

Children ≥ 15 years of age and adults:

- Antiviral, (active against herpes simplex) e.g.:
- Aciclovir, oral, 400 mg, 8 hourly for 7 days.

LoE: IIIb ²⁹

5.14 HERPES ZOSTER

See Section 11.3.11: Herpes zoster (Shingles).

5.15 WARTS

DESCRIPTION

A common, infectious, self-limiting condition of the skin or mucous membrane caused by human papilloma virus.

5.15.1 COMMON WARTS

B07

DESCRIPTION

- » Seen most often on the hands and fingers, but can be found anywhere on the body.
- » Raised nodules with a rough 'warty' surface.

GENERAL MEASURES

- » Usually does not require treatment as they will resolve spontaneously .

MEDICINE TREATMENT

- Salicylic acid, 15 to 30%, topical liquid application.
 - Protect surrounding skin with petroleum jelly.
 - Apply daily to wart and allow to dry.
 - Occlude for 24 hours.
 - Soften lesions by soaking in warm water and remove loosened keratin by light abrasion.
 - Wash affected area well, dry, reapply the wart paint, and occlude.
 - Repeat process daily until the wart disappears.

LoE: IIIb³⁰**REFERRAL**

- » Extensive warts.

5.15.2 PLANE WARTS

B07

DESCRIPTION

- » Very small warts that are just slightly raised.
- » Present as smooth, flat, skin-coloured or slightly pigmented surface.
- » Frequently present on the face, backs of the hands, and knees.
- » Commonly seen in immunocompromised patients.

MEDICINE TREATMENT

These warts are notoriously difficult to treat with a poor response.

- Salicylic acid, 2%, topical.

LoE: III³¹**REFERRAL**

- » Failure to respond.
- » Extensive cases involving the face.

5.15.3 PLANTAR WARTS

B07

DESCRIPTION

- » Commonly appear on the pressure-bearing areas of the soles and can be painful and interfere with walking.
- » Lesions often have a flat, circular appearance, as pressure on the sole of the foot forces them deep into the dermis. They have a rough surface and are often thick and hard due to increased keratin formation.
- » As they are contagious, walking barefoot in communal areas should be discouraged.

MEDICINE TREATMENT

- Salicylic acid, 15 to 30%, topical liquid application.
 - Protect surrounding skin with petroleum jelly.
 - Apply daily to wart and allow to dry.
 - Occlude for 24 hours.
 - Soften lesions by soaking in warm water and remove loosened keratin by light abrasion.
 - Wash affected area well, dry, reapply the wart paint and occlude.
 - Repeat process daily until the wart disappears.

LoE: IIIb³²**REFERRAL**

- » No response to treatment.
- » Diabetic patients.

5.15.4 GENITAL WARTS: CONDYLOMATA ACCUMINATA

See Section 12.12: Genital warts (GW): condylomata accuminata.

5.16 PSORIASIS

L40.0-5/L40.8-9

DESCRIPTION

- » Inflammatory condition of the skin and joints of unknown aetiology. Lesions present as scaly, itchy plaques, especially on the extensor surfaces of the knees, elbows, sacrum and scalp.
- » Psoriasis may spread to involve other sites, although the face is usually spared.
- » The nails and skin folds are often involved.
- » Often aggravated by stress, and may be provoked by HIV disease.

GENERAL MEASURES

- » Counselling regarding precipitating factors and chronicity.
- » HIV test, if acute onset and patient has risk factors for HIV infection.
- » Encourage sun exposure as tolerated.

MEDICINE TREATMENT

For flares (if delay experienced in obtaining a dermatological consultation):

- Coal tar (Liquor picis carbonis - LPC) BP 5%, topical one to four times daily.

OR

- Corticosteroid, potent, topical, e.g.: (Doctor prescribed)
- Betamethasone 0.1%, topical, apply 12 hourly.
 - Decrease according to severity, reduce to hydrocortisone 1%, topical, and then stop.

LoE: IVb³³

REFERRAL

- » All patients, if diagnosis is not already confirmed.
- » Complications such as pustular psoriasis, acute flares, chronic local plaques.

5.17 HIDRADENITIS SUPPURATIVA

L73.2

DESCRIPTION

- » A chronic disorder of the pilosebaceous follicles, involving the formation of abscesses and cysts, often accompanied by scarring and sinus tract formation.
- » Commonly found in axillae, groin, between the thighs, perianal and perineal areas.
- » Flare-ups may be triggered by perspiration, hormonal changes (such as menstrual cycles), humidity and heat, and friction from clothing.

GENERAL MEASURES

- » Avoid tight clothing or clothing made of non-breathable material.

REFERRAL

- » All patients with abscesses, infected cysts or sinuses suspected to be due to hidradenitis suppurativa.

5.18 HYPOPIGMENTORY DISORDERS**5.18.1 ALBINISM**

E70.3

DESCRIPTION

- » Congenital disorder characterised by the complete or partial absence of pigment in the skin, hair and eyes.
- » Albinism is associated with a number of visual symptoms or defects such as photophobia, nystagmus, strabismus, and amblyopia.
- » Lack of skin pigmentation increases a person's susceptibility to sunburn and skin cancers.

GENERAL MEASURES

To avoid sunburn and skin damage:

- » Avoid sun exposure during periods of maximum intensity (i.e. between 10:00 and 15:00).
- » Wear a wide-brimmed hat and long-sleeved top when exposed to the sun.
- » Wear sunscreens with a high sun protection factor (SPF); a SPF of between 20 and 30 will provide adequate protection. The product should also provide protection against both UVA and UVB rays.
- » To reduce photophobia and prevent retinal damage:

- Wear sunglasses that preferably have UV filters.
Check skin regularly for signs of skin cancer such as a new spot or growth on their skin.

MEDICINE TREATMENT

- Zinc oxide, topical ointment.
 - Apply evenly to all sun exposed areas at least 15 minutes before going out into the sun.

LoE: IVb³⁴

OR

- High potency (SPF) sunblock, topical (UV block).
 - Apply evenly to all sun exposed areas at least 15 minutes before going out into the sun.

LoE: IVb³⁵

REFERRAL

- » To dermatologist for regular skin checks.
- » To ophthalmologist for visual rehabilitation and regular eye checks.

5.18.2 VITILIGO

L80

- » Autoimmune disease characterised by patches of the skin losing their pigment.
- » Presents as pale patchy areas of depigmented skin which tend to occur on the extremities.
- » They are most prominent on the face, hands and wrists. The loss of pigmentation is particularly noticeable around body orifices such as the mouth, eyes, nostrils, genitalia, and umbilicus.
- » The patches often begin in areas of skin that are exposed to the sun.
- » New patches appear over time and can occur over large portions of the body, or can be restricted to a particular area.

GENERAL MEASURES

- » Encourage sun exposure, moderate sun exposure is beneficial.

MEDICINE TREATMENT

- High potency (SPF) sunblock, topical (UV block)
 - Apply evenly to all sun exposed areas at least 15 minutes before going out into the sun.

LoE: IVb³⁶

REFERRAL

- » All patients.

5.19 PRESSURE ULCERS/SORES

L89.0-3/L89.9

DESCRIPTION

- » Localised damage to the skin and underlying tissue that usually occurs over bony
- » prominences as a result of pressure, or pressure in combination with shear force and/or friction.
- » The most common sites are the skin overlying the sacrum, coccyx, heels, and hips, but other sites can also be affected.
- » Pressure ulcers most commonly develop in individuals who are immobile, including those bedridden or confined to a wheelchair.
- » Other factors increasing the risk of pressure ulcer development are:
 - Skin wetness e.g. incontinence.
 - Reduced blood flow e.g. arteriosclerosis.
 - Reduced skin sensation e.g. paralysis or neuropathy.

GENERAL MEASURES

Skin care

- » The skin should be kept clean and dry. Ensure that the skin folds are dried thoroughly.

Wound odour

- » Regular cleansing, debridement and management of infection.
- » Activated charcoal dressings may be used.

Pressure redistribution

- » Repositioning and turning at regular intervals, every 2-4 hours. Individual receiving palliative care should be repositioned in accordance with the individual's wishes, comfort and tolerance.
- » Avoid positioning the individual on the wound if erythema is present.

MEDICINE TREATMENT

Cleanse the skin prior to application of a barrier product.

- Zinc and castor oil, topical ointment.

LoE:IIIb³⁷

For pain:

See Chapter 20: Pain.

REFERRAL

- » Patients with pressure sores or those at high risk of development of pressure sores to rehabilitation services, if available.

LoE:IIIb³⁸

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SOUTH AFRICAN NATIONAL DEPARTMENT OF HEALTH
NEMLC SUMMARY REPORT ON UPDATES MADE TO THE
THE STANDARD TREATMENT GUIDELINES AND ESSENTIAL MEDICINE LIST GUIDANCE
PRODUCTS

PRIMARY HEALTHCARE LEVEL
PHC CHAPTER 5: Skin Conditions

Report Version	Date	Detail
V1.0	8 June 2026	Levetiracetam, oral- Added to list of medicines associated with Drug reaction with eosinophilia and systemic symptoms (DRESS)

Specific guidance products

No	Guidance Product	Tick	Number
1.	PHC Level STGs – Chapter 5: Skin Conditions	✓	1

Summary Tables

Medicine Amendments

STG/SECTION	GUIDANCE PRODUCTS (Tick relevant)				MEDICINE / MANAGEMENT	ADDED / DELETED / AMENDED	TI* CONSIDERATIONS (if applicable)
	PHC STGs & EML	AH STG & EML	PaedH STG & EML	TQ EML			
<i>Report Version v1.0</i>							
Section 5.10.6.2 Drug Reaction with Eosinophilia and Systemic Symptoms (DRESS)	✓				Levetiracetam, oral	Added to the list of medicines associated with a risk of causing DRESS	N/a
<i>Report Version v2.0</i>							
xxx							

5.10.6.2

DRUG REACTION WITH EOSINOPHILIA AND SYSTEMIC SYMPTOMS (DRESS)

A published SAHPRA Dear Healthcare Professional letter (DHPL) dated 09 March 2026, reporting an association of Drug reaction with eosinophilia and systemic symptoms (DRESS) with the use of levetiracetam-containing medicines with symptoms appearing within 2 weeks to 2 months after initiating treatment as included below refers.



Levetiracetam- D.pdf

The NEMLC could not identify any robust, published incidence rates^{1,2,3,4} for DRESS associated with the use of levetiracetam at this stage to support adding a caution box to the STGs. The NEMLC acknowledged the SAHPRA DHPL as highlighting the risk of DRESS with levetiracetam as a rare but serious risk to support early recognition.

The STG has been amended as follows:

PHC Ch 5: Skin Conditions	
Change from:	Change to:
<p>5.10.6.2 DRUG REACTION WITH EOSINOPHILIA AND SYSTEMIC SYMPTOMS (DRESS) L27.0 + (D72.1) DESCRIPTION » Severe hypersensitivity reaction to a medicine. » Typically occurs within 3 months of starting the offending medicine. » Clinical symptoms include: - maculopapular rash - fever >38°C - lymphadenopathy - hepatitis or other organ involvement - eosinophilia and/or other blood count abnormalities » Medicines that commonly induce the DRESS syndrome include phenobarbital, carbamazepine, phenytoin, lamotrigine, allopurinol, sulphonamides, abacavir, nevirapine. REFERRAL » All patients.</p>	<p>5.10.6.2 DRUG REACTION WITH EOSINOPHILIA AND SYSTEMIC SYMPTOMS (DRESS) L27.0 + (D72.1) DESCRIPTION » Severe hypersensitivity reaction to a medicine. » Typically occurs within 3 months of starting the offending medicine. » Clinical symptoms include: - maculopapular rash - fever >38°C - lymphadenopathy - hepatitis or other organ involvement - eosinophilia and/or other blood count abnormalities » Medicines that commonly induce the DRESS syndrome include phenobarbital, carbamazepine, phenytoin, lamotrigine, allopurinol, sulphonamides, abacavir, Nevirapine and levetiracetam. REFERRAL » All patients.</p>

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