

STUDENT

PACK

2021

Welcome to the Dermatology Resource Centre

STAFF ON THE UNIT

Consultants

Dr C M Dobson (Consultant-clinical lead in Dermatology)

Dr S. Ahmed (Locum Consultant)

Dr Abu Jubain (Speciality Doctor)

Dr Yew (GP Special Interest)

Nurse in Charge

Senior Staff Nurse Kathryn Farron

Specialist Nurses

Elaine Stringfellow.

Michelle Banks.

Sue Holden

Staff Nurses

Kathryn Farron

Karen Cornah.

Rachael Drysdale

Val Bamber

Bex Scott

Francesca Blackburn

Jenny Tillotson

Aime Timmins

HCA's

Melanie Horne

Annette Cook

Hannah Ollerhead

Raju Varghese

Debbie Prince

Ward Clerk

Janice Wilson

Environment

We share the building with Diabetes, with the diabetic section to the left, dermatology to the right and reception in the middle.

The resuscitation trolley is housed on the dermatology corridor.

Whilst on this placement, we hope to give you some experience of the clinics, both consultant and nurse led, and the various treatments and diagnostic tests carried out by our trained staff.

Some of these are outlined below:

Monday

- Dr Dobson (CMD) clinic –AM
- CNS Elaine Stringfellow (ES) minor ops (BX)– AM
- Dr Ahmed clinic (SA)- AM/PM
- Dr. Abu Jubain AM/PM
- CNS Michelle Banks (MB) clinic -AM/PM
- CNS Sue Holden (SH) clinic -AM

Tuesday

- Dr Ahmed clinic – AM /minor ops-PM
- CNS Elaine Stringfellow – AM/PM,
- Dr Dobson– AM/ PM cancer patient F/U clinic
- Dr Abu Jubain AM/PM
- CNS Michelle Banks clinics- AM/PM .
- CNS Sue Holden clinic -AM/PM

Wednesday

- Dr Dobson clinic –AM with CNS Stringfellow/ PM with CNS Banks
- CNS Michelle Banks .-AM
- CNS Elaine Stringfellow minor ops -PM
- CNS Sue Holden

Thursday

- Dr Abu Jubain –AM/PM
- CNS Elaine Stringfellow -AM CDH & MDT meeting PM RPH
- Dr Dobson – AM& MDT meeting PM RPH
- Dr Ahmed CDH clinics- AM
- CNS Michelle Banks -AM
- CNS Sue Holden –AM

Friday

- Dr Dobson 2 week rule/minor operations–AM, Patch test-PM
- CNS Michelle Banks -AM
- Dr Abu Jubain- AM/PM
- Dr Yew-AM
- Dr Ahmed AM/PM

Phototherapy (UVB / PUVA)

These clinics run from 08.00 until 18:00 Monday to Friday and are always staffed by registered nurses, suitably trained in phototherapy. Several skin conditions respond well to phototherapy, and will be discussed during your experience in these clinics.

Patch Tests

Patients attend for three sessions in the course of one week.

On Monday (nurse led clinic) the patches are put in place and the patient given instructions as to how to keep them in place and keep them dry.

On Wednesday the patient returns for the patches removed (nurse led clinic) and the first reading. This is carried out by trained staff and findings are recorded.

On Friday the patient is seen by the dermatologist in his / her clinic. The consultant carries out the second reading and discusses the findings and conclusion.

Minor Operations

Types of minor operations carried out are:

- Excision of lesions
- Punch biopsies
- Curettage and cautery
- Botox injections (for excessive sweating)

We hope that you would be able to be present and observe in the minor op theatre.

Working Hours

The Outpatient department is open from 8am until 6pm. We are closed weekends and bank holidays.

Student Nurses will work each day Monday to Friday 9-5pm to achieve the maximum benefits from this allocation.

Lunch breaks are taken to fit in with clinic finishing times and we take lunch together on the unit. Most staff brings sandwiches with them but it is possible to purchase lunch from the WRVS shop across the way or from the staff canteen in the main hospital.

Fridge

We do have a fridge for storage of sandwiches etc.

Lockers

We have some lockers within the department but these are limited so we would advise you not to bring valuables with you if at all possible.

Sickness and absence

If unable to attend placement, please telephone 01257 247648 / 7645 and inform the nurse in charge each day of sickness at 0800hrs. The university will also have to be notified.

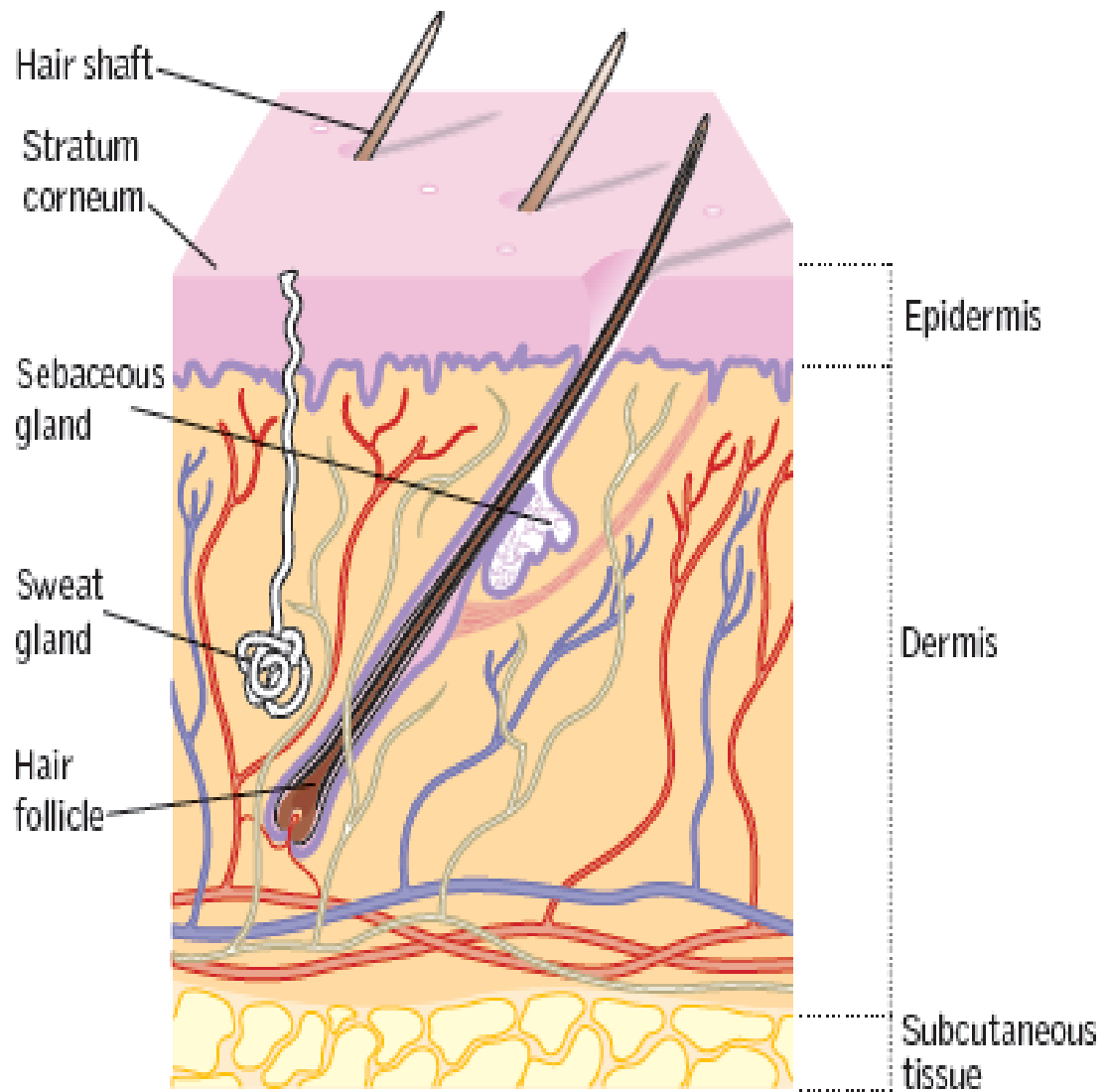
Mobiles and Facebook.

We will require a contact number for yourself and next of kin to be used in case of emergencies only. Once you have finished placement, these numbers will be destroyed.

Any information regarding this department whether social or professional must not be discussed on Social Media. It is deemed a breach of the data Protection Act and the Trust Governance Information Policy, and can lead to dismissal.

Skin-The Largest Body Organ

Structure of the skin



Information on conditions treated in dermatology can be obtained from

- Leaflets on the unit

- Discussions with staff members.

USEFUL WEBSITES

- www.bad.org.uk
- www.dermnet.com
- www.dermnet.com
- www.photonet.scot.nhs

A learning experience timetable has been created for your weeks on Dermatology and relevant Spoke placements are available but please alert your practise assessor if there are areas of particular interest to you.

We hope you enjoy your allocation!

Emollient Therapy

Emollients are non-cosmetic moisturizers which come in the form of creams, ointments, lotions and gels. Emollients help skin to feel more comfortable and less itchy. They keep the skin moist and flexible, helping to prevent cracks. (National Eczema Society 2019).

Emollients soothe, smooth and hydrate the skin and are indicated for all dry or scaling disorders. Their effects are short lived and they should be applied frequently even after improvement occurs. They are useful in dry and eczematous disorders, and to a lesser extent in psoriasis. The choice of an appropriate emollient will depend on the severity of the condition, patient preference, and the site of application. (NICE 2019)

As well as restoring the skin barrier function, the high lipid content has a slightly anti-inflammatory effect and used appropriately can reduce the amount of topical corticosteroids needed (Holden 2002).

Function and mode of action of emollients.

Occlusive – These increase the moisture content of the stratum corneum by providing an oil layer on the skins surface to contain water and prevent evaporation

Humectants – These draw water from the dermis and retain it in the epidermis as a result of their low molecular weight and water attraction properties. These emollients help to prevent cracking and desquamation.

Anti-pruritic -They have a slightly anaesthetising effect, which may reduce itching symptoms.

Anti-inflammatory – Emollients can be mildly anti-inflammatory. They are useful in the treatment of chronic inflammatory skin conditions if used effectively and frequently.

Rehydration – They rehydrate the skin and prevent water loss.

Skin barrier restoration – These emollients form a film over the skins surface and increase its ability to retain water. Damage to the skins protective barrier can occur in eczema and psoriasis.

(Buchanan and Courtenay 2007, Watkins 2008)

Creams: They are emulsions of oil and water and are well absorbed, easy to spread and less greasy than ointments.

Ointments: They are the greasiest type of emollient and are useful for

chronic, very dry and thickened skin.

Lotions: These are made up of more water and less fat than creams and contain preservatives to prolong use. They are light and easily spread and can be cooling.

Soap substitutes: Cleanse the skin and add moisture at the same time.

Common Emollients for Dry Skin Conditions

Aquadrate	Cream containing urea for dry, scaling and itching skin.
Aqueous cream	Light non-greasy cream. For use as a soap substitute.
Aveeno	Cream for eczema, xeroderma, ichthyosis and senile pruritus associated with dry skin.
Balneum Plus	Cream containing urea for dry scaling and itching skin.
Calmurid	Cream containing urea for dry scaling and itching skin. Can be diluted with aqueous cream.
Cetaben	Emollient cream for inflamed damaged dry or chapped skin including eczema.
Dermamist	Spray application for dry skin conditions including eczema ichthyosis and pruritus in older people
Dermol	Cream with added antimicrobials for dry and itchy skin conditions including eczema.
Diprobase	Cream or ointment for dry skin conditions.
Doublebase	Gel or emollient shower or wash gel for dry chapped or itchy skin conditions.
E45	Cream, emollient wash cream or lotion for symptomatic relief of dry skin conditions such as those associated with atopic eczema and contact dermatitis.
E45 Itch Relief Cream	Cream containing urea for dry scaling and itching skin.
Emollin	Spray application for dry skin conditions.
Emulsifying ointment	Greasy ointment that can be used as a soap substitute.
Epaderm	Ointment for use as an emollient or soap substitute.
Eucerin Intensive	Cream or lotion containing urea for dry skin conditions including eczema, xeroderma and hyperkeratosis.
Hydromol	Cream or ointment that can be used as an emollient bath additive or soap substitute.
Hydrous ointment	Ointment for dry skin conditions including eczema and dermatitis.
Lipobase	Cream also for use during treatment with topical corticosteroids.
Liquid and	Greasy ointment known as 50:50 – 50% liquid paraffin and 50% white soft paraffin. paraffin ointment

white soft paraffin	
Oilatum	Cream or shower emollient for dry skin conditions including dermatitis. Oilatum Junior is also available.
QV	Available as a cream, lotion or wash for dry skin conditions including eczema and psoriasis, ichthyosis and pruritis. It can also be used as a soap substitute.
Ultrabase	Cream for dry skin conditions.
Unguentum M	Cream for dry skin conditions that can also be used for nappy rash.
White soft paraffin.	Greasy moisturiser used for more severely dry and cracked skin
Yellow soft paraffin.	Greasy moisturiser used for more severely dry and cracked skin
	(British National Formulary 2011)

Common emollient bath Additives

Aveeno	Bath oil or colloidal bath additive for excema, xeroderma and pruritis associated with dry skin.
Balneum	Bath oil for dry skin conditions, including those associated with dermatitis or eczema where itching is experienced.
Cetraben	Emollient bath additive for dry skin conditions including eczema.
Dermal 600	Bath emollient with added antimicrobials for eczema and dry skin conditions.
Diprobath	Bath additive for dry skin conditions including eczema.
Doublebase	Emollient bath additive for dry skin conditions including eczema ichthyosis and pruritus in older people.
E45	Emollient bath oil for eczema xeroderma, ichthyosis and senile pruritis associated with dry skin.
Emulsiderm	Liquid emulsion with added antimicrobials for dry skin conditions including eczema and ichthyosis.
Hydromol	Bath and shower emollient for dry skin conditions including eczema ichthyosis and pruritus in older people.
Oilatum	Emollient bath additive or junior emollient bath additive for dry skin conditions including eczema ichthyosis and pruritis in older people.
Oilatum Plus	Bath additive with added antimicrobials for topical treatment of eczema including eczema at risk from infection.
QV	Bath oil for dry skin conditions including eczema, ichthyosis and pruritus in older people.

(British National Formulary 2011)

These products are added to lukewarm bath water or applied whilst taking a lukewarm shower. Avoidance of hot water is recommended as blood vessels dilate and make itching symptoms worse. Complete emollient therapy includes the use of a number of different emollient products used in combination. These include bath oils, soap substitutes and a leave on emollients.

Emollients are best applied when the skin is moist. They can be applied as often as is required to keep skin supple. They should be applied in the direction of the hair growth, in a stroking action, in sufficient quantities to be visible on the skin for a few minutes until absorbed.

Skin Cancer

The three most common malignant skin cancers are *basal cell carcinoma*, *squamous cell carcinoma* and *melanoma* – each gets its name from the type of skin cell it arises from.

Skin cancer usually develops in the epidermis and so a tumour can usually be seen, and therefore often be detected at an early stage. It is the most commonly diagnosed type of cancer, primarily caused by the ultraviolet radiation from sun exposure. Other causes include smoking tobacco, HPV infections, some genetic syndromes, chronic non-healing wounds, immunosuppressive medications, and environmental carcinogens or artificial UV radiation such as tanning beds.

Basal Cell Carcinoma (BCC)

Usually found on sun exposed areas of the skin – thought to be caused by UV-B radiation via the direct DNA damage. Most commonly seen on the face – they rarely metastasize or cause death, and are easily treated with surgery or radiation.

BCC's appear pearly, translucent/fleshy in colour with tiny blood vessels on the surface – or ulceration, and are often mistaken for a sore that does not heal.

Squamous Cell Carcinoma (SCC)

Also common, but less so than BCC's, they metastasize more frequently than BCC's but nevertheless this rate remains quite low. They appear commonly as red, crusted or scaly patches or bumps – often a very rapidly growing tumour, and may develop into a large mass if left untreated.

SCC's are also thought to be caused by UV-B radiation via indirect DNA damage.

Malignant Melanoma (MM)

Considered the most serious type of skin cancer as they have the potential to metastasize more frequently than BCCs and SCCs and can cause death if they spread.

MMs are predominantly caused by UV-A radiation via the indirect DNA damage.

The common appearance is an asymmetrical area with an irregular border colour variation, and often greater than 6mm in diameter. Warning signs of MM's include change in size, shape, colour or elevation of a mole. A new mole appearing during adulthood or new pain, itching, ulcerating or bleeding are also indications of MM's.

Providing that MMs are diagnosed early, and removed by excision, the prognosis can be very good, this does however depend on the depth of invasion measured in millimetres (mm) from the granular layer of the

epidermis to the deepest malignant cells. This is known as 'Breslow's thickness'.

Treatments

Treatment of skin cancer depends on the type, location of the cancer, age of the patient, and if it is a primary or recurrence. Currently, surgical excision is the most common form of treatment for skin cancers.

Radiotherapy is the use of X-rays to destroy cancerous cells, and used to treat BCCs and SCCs for reasons such as the cancer is too large or in a difficult site for surgery, if the patient is not fit or does not want surgery, when radiotherapy may give a better cosmetic result than surgery, or when there has been a large operation to remove a cancer and it is considered that radiotherapy might reduce the risk of recurrence.

Photodynamic Therapy (PDT) is a technique which aims to concentrate a photosensitising agent in only those skin cells affected by the disease, then destroy only those cells by irradiation 'tuned' to the photosensitiser leaving the unaffected skin cells relatively unharmed. (Newport Course Lectures 2011). This treatment is used for BCCs, and the photosensitising agent is called Metvix which is applied to the skin 4 hours prior to the irradiation and occluded using an appropriate dressing. The red light is positioned which releases the oxygen which then destroys the cell. PDT can be very painful, expensive and time consuming, however it can achieve excellent results from only 1-2 treatments, and tends to have very good cosmetic outcomes.

A sun tan is actually a sign that our skin is already harmed by UV radiation and is trying to defend itself against further damage which can increase the risk of developing skin cancers. Extensive sun exposure is thought to be responsible for the vast majority of cases and so can easily be prevented, or at least the risks reduced.

Sunscreen with a high sun protection factor (SPF) will help prevent the skin from burning and the damage that can cause skin cancer, and using a sunscreen that offers UVA and UVB protection will also defend against premature skin aging and skin cancer. However, a sun screen only offers protection when applied as often and in the amounts recommended by the product.

The most effective sun protection is clothing and avoiding sun exposure between the hours of 11 and 3 when it is thought to be the most harmful.

References

Independent Nurse 'Skin Cancer' March 2006 .

A guide to diagnosing pigmented skin lesions 'The good the bad and the ugly'

Richard Ashton – consultant dermatologist – Royal Hospital Haslar Gosport
England.

Course Lectures 'Photodynamic Therapy' Newport 2011.

Cancer Research UK 'Surgery for skin cancer' 2012.

BAD 'skin cancers' 2012.

NICE Guidelines 2019

The National Eczema Society 2019