Referral Criteria for Leeds Community Dermatology & BCC Service

Exclusion Criteria

The service does not include the delivery of those services which form part of the essential and additional primary care services (unless they are failing to respond to primary treatments) such as:

- Mild/moderate acne
- Mild/moderate childhood atopic eczema
- Discoid eczema
- Generalised pruritus
- Urticaria
- Angioedema
- Tinea/fungal/recurrent bacterial/viral infections
- Pityriasis Versicolor
- Plaque psoriasis confined to discrete areas

In addition, the following clinical exclusion criteria apply:

Exclusion	Where they should be referred to
Warts, including plantar warts (verrucas)	Manage in primary care / self-care / community pharmacy
Melasma/Chloasma	Excluded from NHS Treatment
Suspected skin cancers (Melanoma, SCC, high risk BCC)	Referred to secondary care on 2ww
Pigmented lesions e.g. mole monitoring	Pigmented lesions clinic (Secondary Care)
Male/Female Pattern Hairloss	Only private treatment available
Patients requiring phototherapy e.g. PUVA/UVB	Secondary Care
Contact allergy testing (patch testing)	Secondary Care
Wounds/leg ulcers	Tissue Viability
Laser Service	Secondary care
Dermatological emergencies	PCAL

Removal of benign skin lesion / Intralesional Injection of keloid or hypertrophic scar. Referral made using the Leeds removal of benign skin lesion / intralesional injection of keloid or hypertrophic scar referral form. (Visible on Leeds Health Pathways – Link below) Removal of Benign Skin Lesions, Keloid and Hypertrophic Scarring (leedsth.nhs.uk)	Community Minor Surgery Services

Leeds Community Dermatology Collaborative

Information required for a referral to the *Leeds Community Dermatology and BCC Service* through ERS (Single point of Access)

DART Form with background information about

- Brief history
- Treatments already tried
- Possible diagnosis
- Photographs (if in a non-intimate area), Dermatoscopic if possible

NB Referrals may be rejected with insufficient information to Triage

Condition / Procedure	Primary Care Treatment	Suitable for Community Dermatology	Referral to Secondary Care
1. Acne	**Mild to moderate acne can be managed in primary care.** See Leeds Health Pathways for treatment options - http://nww.lhp.leedsth.nhs.uk/LeedsPathways/Detail.aspx?ID=12#7	**Refer to Community for treatment of Acne with Isotretinoin for:** • Scarring acne - ensure they are on treatment whilst awaiting dermatology appointment – send photos so we can distinguish scarring/ hyperpigmentation at triage • Acne that hasn't responded to two different oral antibiotics along side a topical agent, each used for 3 months minimum • Have none of the exceptions noted to the right (which require treatment in secondary care)	**Refer to secondary care dermatology if** • Patients with current mental health problems or mental health problems in the preceding 24 months • Patients currently taking anti-depressant medications for mental health conditions • Patients with significant physical co-morbidities • Patients who have already had x 2 courses of Isotretinoin

2. Actinic Keratoses (AK)	**Principles** • The majority of actinic keratosis can be managed in primary care. Lesions are normally asymptomatic • Recent growth, pain/tenderness, bleeding or ulceration suggest transformation into an SCC See Leeds Health Pathways for treatment options - http://nww.lhp.leedsth.nhs.uk/LeedsPathways/Detail.aspx?ID=15 Useful information and Photos on Primary Care Dermatology Society (PCDS) page Actinic keratosis, solar keratosis (pcds.org.uk)	**Refer to Community for:** Confirmation of diagnosis of probable AK - photographs, with Dermatoscopic images are helpful in these circumstances	**Refer to secondary care dermatology if:** • Immunosuppressed patients • Patients <40 years old • Suspected SCC **If skin cancer is suspected please use the dedicated skin cancer referral form**
3. Eczema	**Principles** • Ensure trigger factors are considered and managed (e.g. dryness, stresses, secondary infection, irritants and/or allergen exacerbation) • Review Compliance and ensure possible associated	**Refer to Community for:** Moderate eczema that has failed to respond to recommended primary care treatment	**Red flags:** • **Eczema Herpeticum suspected – refer acutely to hospital via PCAL (children) or oncall reg (adults)** • **Severe bacterial secondary infection suspected (blistering, severe pain, erosions, weeping or crusting)**

	atopic conditions are managed or referred appropriately (asthma, rhinitis, atopic eye or gastrointestinal disease). See Leeds Health Pathways for treatment options including emollient and steroid ladder - **http://nww.lhp.leedsth.nhs.uk/LeedsPathways/Detail.aspx?ID=13#8**		**Refer Secondary Care dermatology if:** • Diagnostic uncertainty • Severe eczema that has failed to respond to treatment as recommended on LHP • Eczema with failure to thrive • Eczema associated with recurrent skin infection • Significant impact of skin problems on quality of life e.g. frequent time off school due to eczema • Where systemics/UVB may be required
4. Alopecia	PCDS guidelines available for all types of Alopecia Alopecia (pcds.org.uk)	**Refer to Community for:** • Alopecia Areata for consideration of intralesional steroids • Diffuse/patchy Hairloss for diagnosis **Exclusions** Male/female Pattern Hairloss	**Refer to Secondary Care for:** • Scarring alopecia
5. Psoriasis	**Principles** • Chronic relapsing condition and successful management may	**Refer to Community:** • To optimise topical treatment plan	**Refer to secondary care dermatology if:** • Moderate to severe disease, at any site, that has failed to respond to appropriately used topical

	require trial of various different treatments **Treatment in primary care:** See Leeds Health Pathways for treatment options http://nww.lhp.leedsth.nhs.uk/LeedsPathways/Detail.aspx?ID=14 **NB** Emollients should be prescribed in **all cases** and **applied frequently**	Most candidates who have not responded to topical treatments are suitable for systemic treatment therefore require a referral to secondary care	treatments for greater than 3 months or if too widespread to use topical treatment safely and likely to need phototherapy or systemic treatment • Acute unstable psoriasis or generalised erythrodermic or pustular psoriasis **– refer acutely to hospital via PCAL (children) or oncall reg (adults)** • Nails for consideration of systemic treatment if functional impairment is present or large impact on quality of life
6. Rosacea	**Principles** • Patients should be advised to avoid direct sunlight and to wear a high factor sun block daily. • Avoid trigger factors (e.g. alcohol) if can be identified See Leeds Health Pathways for treatment options - **http://nww.lhp.leedsth.nhs.uk/common/guidelines/detail.aspx?ID=190**	**Refer to Community for:** • Diagnostic uncertainty • Optimisation of combination treatment in non-responders	**Refer to secondary care dermatology:** • Severe disease, development of pyoderma faciale • Laser treatment is indicated i.e. Fixed erythema, flushing, telangiectasia (inflammation needs to be controlled prior to laser treatment) • Rhinophyma **If your patient has severe ocular rosacea with keratitis or uveitis refer direct to ophthalmology**

7. Tinea Capitis	See Leeds Health Pathways for treatment options - **http://nww.lhp.leedsth.nhs.uk/LeedsPathways/Detail.aspx?ID=67**	**Refer to Community for:** • Diagnostic uncertainty • Severe, extensive or recurrent infection	**Refer to secondary care dermatology if:** • Immunosuppressed patients • Suspected kerion (refer via PCAL)
8. Urticaria	**Treatment in primary care:** See Leeds Health Pathway for Treatment information Chronic Urticaria in Adults (leedsth.nhs.uk)	**Refer to Community:** If there is diagnostic uncertainty and none of the secondary care referral criteria (listed to the right) are present.	**Refer to secondary care dermatology if:** ▪ Failure to respond to treatment within LHP– referral to immunology or dermatology for consideration of 2nd line treatments, eg. immunosuppressive / biological agents. ▪ Individual lesions lasting longer than a day: consider urticarial vasculitis – refer to secondary care dermatology. ▪ Lesions leaving brownish marks: consider urticaria pigmentosa – refer to secondary care dermatology. ▪ Urticaria with other inflammatory skin lesions – if not clearly eczema, consider lupus erythematosus – refer to secondary care dermatology.

9. BCC	See DermNet NZ for photo examples of BCCs - https://www.dermnetnz.org/topics/basal-cell-carcinoma/	**Refer to Community Dermatology:** • Low risk BCCs (see criteria in next column for high risk lesions) • Patients >24 years old • Lesions <2cm in diameter, clearly defined & below the level of the Clavicle (see exclusions) • Must be a primary lesion (not recurrent or previous incomplete excision) • Lesions should be Nodular, Cystic or Superficial Subtype NB: Dermoscopy can be very helpful in diagnosing BCCs and should be used whenever possible	**Refer to secondary care dermatology:** • Patients who are: ○ Aged 24 or under ○ Immunosuppressed or have Gorlin's syndrome • Lesions that are: ○ >2cm below the clavicle ○ Pigmented ○ recurrent ○ Have poorly defined margins ○ are located: • Above the clavicle • On the nose or lips, or around/on the eyes or ears ▪ Over important underlying structures (e.g. major vessels) ▪ In an area where surgical closure may be difficult (e.g. digits or front of shin) ▪ In an area where excision may lead to poor cosmetic result **N.B Refer as 2ww (using suspected skin cancer form) if there is particular concern that a delay may have significant impact, because of factors such as lesion site (any**

			lesion within 1cm of the tarsus of the eyelid or the medial and lateral canthus or adjacent to external auditory meatus.) or size
10. Removal of Benign Skin Lesion		Please refer directly to preferred Minor Operations Service (MOPs) using appropriate forms. Community Dermatology only performs diagnostic biopsies	
11. Keloids and Hypertrophic Scar		Please refer directly to preferred Minor Operations Service (MOPs) using appropriate forms	
13. Iontophoresis for Hyperhidrosis		**Referral Criteria** - After assessment by a Dermatology clinician (Video or telephone consultation appropriate) - Referrals accepted for localised hyperhidrosis where topical treatments have failed; - patient is prepared to commit to a month course and then purchase a machine for ongoing home management. - One area treated ie hands, feet or axillae only - Treatment only available at Street Lane Surgery site	
14. Skin Camouflage		**Referral Criteria**	

		- After assessment by a Dermatology Clinician (Could be straight from triage) - Disfiguring skin condition and DLQI over 10 - Patient willing and able (or carer) apply skin cam products - Treatment only available at Street Lane Surgery site	
15. Treatment Resistant Scabies		This service is exclusively for the assessment of exceptional cases of treatment failure where you are confident the patient and contacts have complied with first line treatment as per the guidelines for topical treatment. The service will comprise of examination of the patient and initiation of oral Ivermectin if appropriate, after which the patient will be discharged. Responsibility for review of treatment will be the responsibility of the referrer. Criteria for prescription of Oral Ivermectin: • Patient (and any contacts) has had **2** courses of topical Permethrin treatment (one course is 2 applications at day 0 and day 7, so 2 courses is a total of 4 applications) AND used appropriately • Patients who have ongoing signs of Scabies infection 6 weeks post permethrin i.e. evidence of new burrows/infection, not just persistent rash • Patients weighing 15 kg or above Having read the criteria above, do you wish to refer to Community care? N.B By selecting 'Yes', you are	

		confirming that the patient meets the criteria for community care referral listed above Please note, members of a patient contact group who also meet the criteria above require **individual referrals** to the service (please try to note the names of other contacts being referred so they can be seen together were possible)	