CHAPTER 5

DERMATOLOGY

Skin lesions are best characterised by their morphologic appearance which allows consideration of a suitable differential diagnosis.

5.1 BULLAE

5.1.1 EPIDERMOLYSIS BULLOSA

Q81.9

DESCRIPTION

Congenital, hereditary blistering skin lesions with onset in the newborn. Lesions have an erythematous base. Involvement of the mucous membranes as well as loss of nails may occur.

GENERAL AND SUPPORTIVE MEASURES

» May require monitoring in a high or intensive care unit.
» Aseptic aspiration of bullae on the side can be performed to relieve pressure (ensure the roof of the blister remains intact to protect underlying skin).
» Prevent infection with appropriate wound care.
» Attend to fluid and nutrition balance.

Important to manage baseline pain and procedural pain, see Chapter 20: Pain Control.

REFERRAL

» All cases for biopsy, classification of type and management plan.

5.1.2 STAPHYLOCOCCAL SCALDED SKIN SYNDROME

L00

DESCRIPTION

Blistering skin condition that presents like scalded skin.

GENERAL AND SUPPORTIVE MEASURES

» Appropriate wound care.

MEDICINE TREATMENT

- Cloxacillin, IV, 50 mg/kg/dose 6 hourly for 5 days.
  - Neonates:
    Week 1–2 of age: administer 12 hourly.
    Week 2–4 of age: administer 8 hourly.

OR

- Cephalexin, oral, 25 mg/kg/dose 6 hourly for 7 days.
  Where weight is unknown:
  - Child < 2 years: 125 mg.
  - Child 2–10 years: 250 mg.
  - > 10 years: 500 mg.

OR

- Flucloxacillin, oral, 25 mg/kg/dose 6 hourly for 7 days.

LoE III[1]

Penicillin allergy:

- Clindamycin, oral, 6 mg/kg/dose, 6 hourly for 10 days.

For pain:
See Chapter 20: Pain Control, section 20.1.2: Management of pain.

REFERRAL

» Recalcitrant cases.

5.1.3 CHRONIC BULLOUS DISEASE OF CHILDHOOD

L12.2

DESCRIPTION

Tense blisters that lead to ulceration involving the groin, face and trunk.

DIAGNOSTIC CRITERIA

» Skin biopsy with immunofluorescence.

GENERAL AND SUPPORTIVE MEASURES

» Appropriate wound care.

REFERRAL

» All cases.

5.2 ERYTHEMA AND DESQUAMATION

5.2.1 ERYTHEMA MULTIFORME

L51.9

DESCRIPTION

An acute, self-limiting and commonly recurrent inflammatory eruption of the skin with variable involvement of the mucous membranes and without systemic symptoms.

Symmetrically distributed crops of target lesions, (dark centre, an inner, pale ring surrounded by an outer red ring) often involving palms and soles, are characteristic. This condition is mainly caused by:

» medicines, e.g. sulphonamides, phenytoin, phenobarbitone,
» exposure to toxic substances, and
» infections, e.g. herpes simplex and mycoplasma.

Complications include:

» conjunctivitis,
» uveitis,
» corneal scarring,
» fluid loss,
» infections,
» anaemia, and
» oesophageal strictures.

DIAGNOSTIC CRITERIA

Iris or target lesions consisting of a dark centre, an inner pale ring and an erythematous outer border. In erythema multiforme these lesions are pathognomonic.

Erythematous macules evolve into papules, vesicles, bullae, urticarial plaques or patches of confluent erythema. The centre of the lesion may be vesicular, purpuric or necrotic.

Erythema multiforme minor

Prodromal symptoms are generally absent. Symmetric crops of skin lesions of diverse morphology, primarily on the extensor surfaces of the arms and legs and often including soles and palms with relative sparing of the mucous membranes and the trunk.

Erythema multiforme major (often equated with Stevens-Johnson syndrome)

A serious, systemic condition involving the skin and at least two mucous membranes.

Eruption may be preceded by non-specific prodromal symptoms including:

» malaise,
» fever,
» rigors, or
» upper respiratory tract infection.

Cutaneous lesions tend to rupture, leaving the skin denuded leading to fluid loss, with high risk of infection. Anaemia is common. The oral mucosa is frequently involved.

GENERAL AND SUPPORTIVE MEASURES

» May require care in a high or intensive care unit.
» Examine daily for systemic involvement, infection and ocular lesions. If infection is suspected, send blood and skin lesion specimens for culture and sensitivity before initiating antibiotic therapy.
» Do not puncture bullae or vesicles.
» Cool compresses and wet dressings.
» Encourage oral fluids to prevent adhesions.
» Regular supervised oral, genital and eye care to prevent adhesions and scarring.
» Maintain fluid balance. Beware of shock.
» Nasogastric feeds if unable to eat; IV alimentation if enteral feeds are not possible.
» Stop all potentially causative medicines.

MEDICINE TREATMENT

For pain

These patients require effective pain control.
Change of dressing protocol: See Chapter 20: Pain Control.

Dressings

Skin hygiene, daily cleansing and bland, non-adherent dressings as needed.

Do not use silver sulfadiazine if Stevens-Johnson syndrome is thought to be due to cotrimoxazole or other sulphonamide.

Antibiotic therapy

For secondary infections:

Use IV antibiotics if the oral route cannot be used.

- Cloxacillin, IV, 50 mg/kg/dose 6 hourly.

OR

- Cephalexin, oral, 25 mg/kg/dose 6 hourly.
  Where weight is unknown:
  - Child < 2 years: 125 mg.
  - Child 2–10 years: 250 mg.
  - > 10 years: 500 mg.

OR

- Flucloxacillin, oral, 25 mg/kg/dose 6 hourly.

LoE III[1]

Penicillin allergy:

- Clindamycin, oral, 6 mg/kg/dose, 6 hourly.

Reconsider choice of antibiotic when the results of cultures become available or the child does not improve.

If Herpes Simplex Virus (HSV) is suspected to be the cause:

- Aciclovir, oral, 250 mg/m^2/dose 8 hourly for 7 days.

For oral lesions

- Chlorhexidine 0.2%, 15 mL as a mouthwash.
  - Use as needed.
  - Do not swallow.

Note: The use of systemic corticosteroids is not recommended.

REFERRAL

» Erythema multiforme not responding to adequate therapy.
» Erythema multiforme with ocular involvement.

5.2.2 STEVENS-JOHNSON SYNDROME (SJS)/TOXIC EPIDERMAL NECROSIS (TEN)

L51.1/ L51.2

DESCRIPTION

Life-threatening, acute hypersensitivity reaction with systemic upset, epidermal necrosis, and mucous membrane involvement. TEN and SJS are different ends of the same spectrum: in TEN, epidermal necrosis involves > 30% of body surface area, while in SJS the involvement is < 10%.

This condition is usually due to medication, e.g. sulphonamides, non-nucleoside reverse transcriptase inhibitors (especially nevirapine), antiepileptics (phenytoin, phenobarbitone, carbamazepine, lamotrigine), allopurinol, laxatives (phenolphthalein).

Complications include:

» dehydration, electrolyte disturbances and shock,
» hypoalbuminaemia,
» hypo- and more commonly hyperthermia,
» high output cardiac failure,
» secondary infection and sepsis; and
» adhesions and scarring.

DIAGNOSTIC CRITERIA

Cutaneous lesions may start as a dusky red macular rash, progressing to confluence with epidermal necrosis and large flaccid blisters which rupture, leaving large areas of denuded skin. Mucous membrane erosions are common and multi-organ involvement may be present.

GENERAL AND SUPPORTIVE MEASURES

» May require care in high or intensive care unit.
» Examine daily for systemic involvement, infection and ocular lesions. If infection is suspected, send blood and skin lesion specimens for culture and sensitivity before initiating antibiotic therapy.
» Do not puncture bullae or vesicles.
» Cool compresses and wet dressings.
» Regular supervised oral, genital and eye care to prevent adhesions and scarring.
» Encourage oral fluids, to prevent adhesions.
» Maintain fluid balance. Beware of shock.
» Nasogastric feeds if unable to eat; IV alimentation if enteral feeds are not possible.
» Stop all potentially causative medicines.

MEDICINE TREATMENT

For pain

These patients require effective pain control.
Change of dressing protocol: See Chapter 20: Pain Control.

Dressings

Skin hygiene, daily cleansing and bland, non-adherent dressings as needed.

Do not use silver sulfadiazine if Stevens-Johnson syndrome is thought to be due to cotrimoxazole or other sulphonamide.

Empiric antibiotic therapy

For secondary infections:

Use IV antibiotics if the oral route cannot be used.

- Cloxacillin, IV, 50 mg/kg/dose 6 hourly.

OR

- Cephalexin, oral, 25 mg/kg/dose 6 hourly.
  Where weight is unknown:
  - Child < 2 years: 125 mg.
  - Child 2–10 years: 250 mg.
  - > 10 years: 500 mg.

OR

- Flucloxacillin, oral, 25 mg/kg/dose 6 hourly.

LoE III[1]

Penicillin allergy:

- Clindamycin, oral, 6 mg/kg/dose, 6 hourly.

Reconsider choice of antibiotic when the results of cultures become available or the child does not improve.

For oral lesions

- Chlorhexidine 0.2%, 15 mL as a mouthwash.
  - Use as needed.
  - Do not swallow.

Note:
The use of systemic corticosteroids is not recommended.

REFERRAL

» Discuss with a specialist, if considering re-initiation of medicine treatment.

5.3 MACULES AND PAPULES

5.3.1 DRUG REACTIONS

L27.0

Commonly associated with:

» sulphur-containing agents,
» penicillin,
» antiepileptics (e.g. carbamazepine, lamotrigine),
» NSAIDs,
» anti-tuberculosis drugs, and
» non-nucleoside reverse transcriptase inhibitors.

A variety of rashes may occur, including:

» erythema multiforme (see section 5.2.1),
» urticarial eruptions,
» measles-like maculopapular rash, or
» fixed drug reactions, which are flat or slightly raised, purple, symmetrical patches of < 0.5 cm in size.

Lesions recur upon re-exposure to the causative agent and may present as blisters.

GENERAL AND SUPPORTIVE MEASURES

» Stop causative agents.

MEDICINE TREATMENT

Antihistamines

For children 2 years and older:

- Cetirizine, oral, as a single dose.
  - Children 2–6 years: 5 mg.
  - Children 6–12 years: 10 mg.

LoE III[2]

For children less than 2 years:

- Chlorphenamine, oral, 0.1 mg/kg/dose as a single dose at night. (Maximum 4 mg).

Where the oral route cannot be used:

- Promethazine, IV, 0.1 mg/kg/dose 8–12 hourly. (Maximum 25 mg).

REFERRAL

» Systemic involvement with organ dysfunction.

5.3.2 ACNE

L70

DESCRIPTION

An inflammatory condition of hair follicles leading to comedone formation; inflammatory papules and/or nodules that can cause scarring and post inflammation hyper-pigmentation, on healing.

DIAGNOSTIC CRITERIA

» Black-heads or white-heads (comedones).

GENERAL AND SUPPORTIVE MEASURES

» Avoid greasy and oily topical products.
» Discourage excessive facial washing.

MEDICINE TREATMENT

<u>For mild acne</u>

- Benzoyl peroxide 5%, gel, apply in the morning to affected areas as tolerated.
  - Wash off in the evening.
  - If ineffective and tolerated, increase application to 12 hourly.
  - If ineffective after 4 months, move to topical retinoid therapy.

<u>For comedonal acne</u>

Topical retinoid, e.g.:

- Tretinoin cream/gel 0.05%, topical, applied sparingly once daily at bedtime until substantial improvement.
  - To limit skin irritation, introduce topical retinoid gradually – apply on alternate days (at night) for 1–2 weeks.
  - Avoid contact with eyes and mucous membranes.
  - To prevent irritation, limit exposure to sunlight, especially with concomitant use of doxycycline.

<u>For inflammatory acne</u>

- Doxycycline, oral, 100 mg once daily for a maximum of 3 months.

AND

Topical retinoid, e.g.:

- Tretinoin cream/gel 0.05%, topical, applied sparingly once daily at bedtime.

Tretinoin is teratogenic.
Do not use where pregnancy is a possibility.
If used, ensure adequate contraception.

Teratogenic risk also applies to males.

To avoid sun irritation:

- Sunscreen, topical, applied daily.

REFERRAL

» Ineffective treatment: referral for consideration of isotretinoin oral therapy.
» Recalcitrant and/or fulminant acne.
» Psychologically disturbed or depressed patient.
» Young females with premenstrual flare or with clinical signs of hyperandrogenism for consideration of oral contraceptives.

5.3.3 CELLULITIS AND ERYSIPELAS

L03.9/A46

DESCRIPTION

Infection of the skin and subcutaneous tissue usually caused by streptococci, staphylococci or *H. influenzae.* In cellulitis, the border of the lesion is indistinct.

Erysipelas

The affected area is:

» well demarcated with clear borders,
» very tender and warm,
» bright red and swollen.

Erysipelas must be distinguished from necrotising fasciitis, where there is infection and inflammation by a gas-forming organism that spreads rapidly along the fascial tissue.
Complications include septicaemia.

DIAGNOSTIC CRITERIA

» Acutely ill child with fever and malaise.
» Affected area is swollen, indurated, erythematous and tender, with regional lymphadenopathy.

GENERAL AND SUPPORTIVE MEASURES

» Ensure adequate nutrition and hydration.

» Elevate the affected limb to reduce swelling.
» Exclude eczema, an immunocompromised state, diabetes and underlying osteomyelitis.

MEDICINE TREATMENT

Choice of intravenous or oral antibiotics depends on the severity of the condition.

Severe disease

- Cloxacillin, IV, 50 mg/kg/dose 6 hourly for 5 days.

Non-severe disease

- Cephalexin, oral, 25 mg/kg/dose 6 hourly for 7 days.
  Where weight is unknown:
  - Child < 2 years: 125 mg.
  - Child 2–10 years: 250 mg.
  - > 10 years: 500 mg.

OR

- Flucloxacillin, oral, 25 mg/kg/dose 6 hourly for 7 days.

LoE III[1]

Penicillin allergy:

- Clindamycin, oral, 6 mg/kg/dose, 6 hourly for 10 days.

For pain:

- Paracetamol, oral, 15 mg/kg/dose, 6 hourly as required.

If needed, **ADD**

- Ibuprofen, oral, 5–10 mg/kg/dose, 6–8 hourly for 72 hours.
  - Child < 30 kg, maximum dose: 500 mg/day.

REFERRAL

» **Urgent**: necrotising fasciitis.
» Poor response to therapy.
» Recurrent cellulitis.

5.3.4 ECZEMA

L20.9

DESCRIPTION

An inflammatory itchy skin condition characterised by:
» Vesicles, weeping and crusting during the acute stage.
» Scaling and lichenification during the chronic stage.

DIAGNOSTIC CRITERIA

» Intractable itch.
» Family history of allergies.
» Onset under the age of 2 years

» Dry skin.
» Typical distribution: face, flexures of knees and elbows, and creases of neck.

GENERAL AND SUPPORTIVE MEASURES

» Avoidance measures: use neutral soaps and rinse clothes properly after washing.
» Keep fingernails short to prevent scratching.
» Wrap with dressings soaked in sodium chloride 0.9%.
» Avoid sunlight and recommend the use of sunscreen.

MEDICINE TREATMENT

Antihistamine:
For children 2 years and older:

- Cetirizine, oral, as a single dose.
  - Children 2–6 years: 5 mg.
  - Children 6–12 years: 10 mg.

LoE III [2]

For children less than 2 years:

- Chlorphenamine, oral, 0.1 mg/kg/dose as a single dose at night. (Maximum 4 mg).

To relieve skin dryness:

- Emulsifying ointment.

For baths, as a soap substitute:

- Aqueous cream.

For the face and skin folds:

- Hydrocortisone 1%, topical, 12 hourly.

For the body:

- Betamethasone 0.1%, topical, undiluted applied once daily for 7 days.
  - Moisturise with emulsifying ointment during therapy and in subsequent weeks.

Secondary infection

Bacterial

- Cephalexin, oral, 25 mg/kg/dose, 6 hourly.

Viral

If HSV suspected:

- Aciclovir, oral, 250 mg/m^2/dose 8 hourly for 7 days

Note:
- Short-term use of topical steroids is recommended (as outlined above)
- Oral corticosteroids do not have a role in the management of this condition.

REFERRAL
» Recalcitrant cases.
» Concomitant food allergy (allergy clinic).

5.3.5 CANDIDIASIS
B37.2

DESCRIPTION
Skin infection involving axillae, neck and perineum. Commonly occurs in immunocompromised individuals. Involvement of mouth and perineal regions suggests systemic disease.

DIAGNOSTIC CRITERIA
Clinical
» Red, raw-looking patches with satellite white pustular lesions on an erythematous base.
» Mucosal involvement.

Investigations
» Wet preparation with potassium hydroxide or biopsy and culture.

GENERAL AND SUPPORTIVE MEASURES
» Control underlying immunosuppressive state, e.g. diabetes, HIV.
» Personal hygiene of mothers prior to breastfeeding.

MEDICINE TREATMENT
- Imidazole cream 1%, e.g. clotrimazole, topical, applied 8 hourly for 14 days.

If no response:
- Fluconazole, oral, 3–6 mg/kg/day for 14 days.

REFERRAL
» Recalcitrant infection.

5.3.6 PSORIASIS
L40.9

DESCRIPTION
An inflammatory condition of the skin and joints.

DIAGNOSTIC CRITERIA

» Scaly, red, itchy papules and plaques over scalp, perineum, and skin folds and extensor surfaces.
» Nails may be opaque, deformed and crumbling.
» Occasional pustules are seen.

GENERAL AND SUPPORTIVE MEASURES

» Avoid precipitants, e.g. medication (such as antiepileptic and antimalarial agents).

MEDICINE TREATMENT

Local plaques

To remove scales in children 12 years and older:

- Salicylic acid 2% and coal tar in white soft paraffin, applied 8 hourly.

OR

- Face: Hydrocortisone 1%, topical, applied 12 hourly.
- Body: Betamethasone 0.1%, topical, applied 12 hourly.

For scalp lesions

To remove scales on scalp:

- Salicylic acid 2% in white soft paraffin, if required, in children 12 years and older.

AND

- Wash with mild coal tar shampoo.

AND

- Betamethasone 1% scalp application, apply 12 hourly.

LoE III[3]

Severe pustular psoriasis (in consultation with a specialist)

- Prednisone, oral, 1–2 mg/kg as a single daily dose for 7 days.

REFERRAL

» Severe psoriasis and recalcitrant cases.
» Intolerance to salicylic acid.
» No response to treatment.

5.3.7 URTICARIA

L50.9

DESCRIPTION

An itchy, inflammatory skin and mucosal condition recognised by wheal and flare reaction. May be acute or chronic, often due to irritants, insect bites or allergens. Secondary infective features include excoriation, vesicles and pigmentary changes. Chronic papular eruptive urticaria is often seen in HIV-infected individuals.

DIAGNOSTIC CRITERIA

» History of a recent infection or parasitic infestation.
» History of allergen exposure.
» Wheal and flare reaction ('hives').
» Positive skin test if due to allergy.

GENERAL AND SUPPORTIVE MEASURES

» Limit exposure to precipitants, e.g. drugs, allergens and toxins.
» Limit exposure to insects by using topical insect repellent which contains more than 10% diethyltoluamide (DEET).
» Search for and treat an underlying infection or parasitic infestation.
» Wrap with dressings soaked in sodium chloride 0.9%.

MEDICINE TREATMENT

- Chlorphenamine, oral, 0.1 mg/kg/dose as a single dose at night.

AND

- Betamethasone 0.1%, topical, applied twice daily as required.
  - Useful when applied immediately after an insect bite.

Severe chronic urticaria

For children 2 years and older:

- Cetirizine, oral, as a single dose.
  - Children 2–6 years: 5 mg.
  - Children 6–12 years: 10 mg.

LoE III[2]

REFERRAL

» Recurrent cases.
» Recalcitrant and chronic cases.

5.3.8 TINEA CAPITIS

B35.0

Refer to the Primary Healthcare Standard Treatment Guidelines and Essential Medicines List, 2020:

- Chapter 5: Skin Conditions, section 5.5.2.3: Scalp infections – Tinea capitis.

5.4. PURPURA

D69.9

5.4.1 MENINGOCOCCAEMIA

A39.2/A39.4

DESCRIPTION

Palpable bleeding into skin caused by *N. meningitides* and is associated with rapid spread.

This is a medical emergency and can be fatal.
See Chapter 8: Infective/Infectious Diseases, section 8.27: Sepsis.

5.4.2 HENOCH-SCHÖNLEIN PURPURA

D69.0

See Chapter 12: Rheumatology and Vasculitides, section 12.1: Henoch-Schönlein purpura (HSP).

5.4.3 IMMUNE THROMBOCYTOPENIC PURPURA (ITP)

D69.3

See Chapter 3: Blood and Blood Forming Organs, section 3.10: Immune thrombocytopenic purpura (ITP).

5.5. VESICLES AND PUSTULES

5.5.1 INFECTIONS

R23.8/L08.9

See Chapter 8: Infective/Infectious Diseases, section 8.25: Varicella (chickenpox) and section 8.26: Zoster.

5.5.2 SKIN AND MUCOSAL DISORDERS IN HIV

Skin and mucosal disorders are more severe in immune suppressed (HIV-infected) patients and may be worsened by IRIS. HIV may present initially with skin or mucosal lesions, or these lesions may develop during the course of the illness.

Lesions respond to antiretroviral therapy together with treatment for the specific skin and/or mucosal disorder. Skin eruptions or rashes are relatively common in HIV-infected patients and may be due to antiretroviral and other medicines.

Conditions that are more common in patients with HIV, and that may be present atypically include:
» Papular pruritic eruption.
» Kaposi sarcoma.

5.5.2.1 HIV PAPULAR PRURITIC ERUPTION

T78.4

DESCRIPTION

A chronic itchy condition with a relapsing course. In HIV-infected patients, insect bites may be severe and recalcitrant with post-inflammatory pigmentation and scarring.

DIAGNOSTIC CRITERIA

» Initial lesion is a pruritic urticarial spot with a central red punctum.
» Lesions progress to pruritic papules with or without blisters. Scratching lesions may cause inflammatory changes, erosions, crusts or scabs with secondary infection.
» Post-inflammatory pigmentation and scarring are common.

GENERAL AND SUPPORTIVE MEASURES

» Prevent insect bites with use of, insect repellents.
» Eradicate fleas and other insects.

MEDICINE TREATMENT

- Calamine lotion, topical, applied as needed.

AND

- Chlorphenamine, oral, 0.1 mg/kg/dose 6 hourly.

AND

- Betamethasone 0.1%, topical, applied 12 hourly for 3 days.

THEN, until pruritus subsides:

- Face: Hydrocortisone 1%, topical applied 12 hourly.
- Body: Betamethasone 0.1%, topical applied 12 hourly.

Treat secondary infection with an appropriate antibiotic, if indicated.

Treatment of HIV. See Chapter 9: Human Immunodeficiency Virus Infections.

REFERRAL

» No response to treatment.

5.5.2.2 KAPOSI SARCOMA

C46.9

DESCRIPTION

Kaposi sarcoma is a vascular tumour that can present anywhere on the skin and oral mucosa. Lymph nodes and internal organs, primarily lungs and gastrointestinal tract, may also be involved.

It is associated with human herpes virus 8 and occurs most commonly in immunocompromised HIV-infected patients.
It can be asymptomatic and indolent or aggressive, characterised by explosive growth and death.

DIAGNOSTIC CRITERIA

» Presents with skin lesions on the limbs, particularly the lower leg and foot, but may occur anywhere on the body.
» Lesions (skin and mucosal) may be bruise-like patches, purple or purple-red plaques, subcutaneous papules or nodules.
» Lymphoedema, ulceration and secondary bacterial infection may occur.

GENERAL AND SUPPORTIVE MEASURES

» Counselling to assist patient in dealing with the condition.

MEDICINE TREATMENT

» Manage in consultation with an oncologist.
» Treat secondary infection with an appropriate antibiotic, if indicated.
» Treatment of HIV. See Chapter 9: Human Immunodeficiency Virus Infections.
» Supportive treatment, e.g. pain. See Chapter 20: Pain Control, section 20.1.2: Management of pain.

REFERRAL

» All suspected cases for initial diagnosis.
» Kaposi sarcoma cases unresponsive to ART.
» Extensive progressive disease.

5.5.2.3 WARTS

B07

MEDICINE TREATMENT

<u>Common warts</u>

- Salicylic acid 25% ointment, applied under plaster nightly.
  - Protect surrounding skin with petroleum jelly.
  - Repeat until the wart falls off.

Genital warts

- Podophyllin resin 20%, applied under plaster nightly.
  - Protect surrounding skin with petroleum jelly.
  - Repeat until the wart falls off.

REFERRAL

» Extensive warts involving the face.
» Genital warts: Refer to STI clinic.

5.5.3 IMPETIGO

L01

Refer to the Primary Healthcare Standard Treatment Guidelines and Essential Medicines List, 2020:
» Chapter 5: Skin Conditions, section 5.4.2: Impetigo.

5.5.4 CUTANEOUS HAEMANGIOMAS

D18.0

DESCRIPTION

Benign tumours of the vascular endothelium that may be classified as either congenital or infantile. They are characterised by abnormal proliferation of endothelial cells and abnormal blood vessel architecture.
» Congenital haemangiomas: Fully grown at birth, and are either rapidly involuting or non-involuting.
» Infantile haemangiomas: Usually appear before 4 weeks of age and continue to grow until 5 months.

DIAGNOSTIC CRITERIA

» Most haemangiomas can be diagnosed clinically.

GENERAL AND SUPPORTIVE MEASURES

» Counselling to assist the patient in dealing with the condition.

REFERRAL

» Life-threatening haemangiomas (airways), function-threatening haemangiomas, ulcerating lesions, multiple lesions (> 5 lesions); for consideration of propranolol.
» Diagnostic uncertainty.
» Failure to respond to therapy.
» Peri-ocular haemangioma.
» Suspected airway haemangioma.
» Large segmental haemangioma on the face, neck or vital organ for echocardiogram.

» Propranolol pre-treatment evaluation reveals cardiac or pulmonary abnormalities.

References

[1] Flucloxacillin dose: The British National Formulary for Children 2014-2015. BMJ Group, Pharmaceutical Press, RCPCH Publication Ltd. AND South African Medicines Formulary. 11th Edition. Division of Clinical Pharmacology. University of Cape Town. 2014

[2] Cetirizine: South African Medicines Formulary. 11th Edition. Division of Clinical Pharmacology. University of Cape Town. 2014.

[3] Psoriasis therapy: Mosca M, Hong J, Hadeler E, Brownstone N, Bhutani T, Liao W. Scalp Psoriasis: A Literature Review of Effective Therapies and updated Recommendations for Practical Management. Dermatol Ther. 2021, 11:769-797.