

Dr Ahmed Kazmi

Belmatt Dermatology Training Afternoon London, 9th February 2023



Dr Ahmed Kazmi MBChB MRGP
MRCP (Derm) FRACGP
Consultant Dermatologist & GP

1

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A bit about me

- UK/Australia
- GP training first
- Then Derm Training
- Melbourne hair fellowship
- My interests:
 - Medical education
 - Hair and scalp disorders
 - Psychodermatology
 - Skin of colour dermatology/pigmentary disorders
 - Transgender medicine
- Currently: deciding what to do with my life
- ahmedkazmi@doctors.org.uk
- Insta/Twitter/Youtube/Facebook: @drahmedkazmi

2

Overview

- Derm essentials 101
- Mastering topicals
- Mastering 'eczema'

Aims

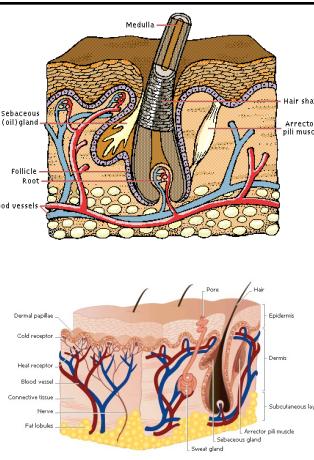
1. Leave feeling you understand the principles of skin and describing/categorising rashes better
2. Feel more confident and competent giving advice regarding topicals with your customers/patients, right from today
3. Leave feeling more confident and competent helping to manage eczema with your customers/patients, right from today

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3

SKIN FUNCTIONS

- Body Covering
 - Keep tissue fluids in
 - Keep chemicals out
 - Keep bacteria, fungi, and viruses out
- Permit movement of underlying muscles & joint
- Sensors for touch, pain, and temperature
- Adornment
- Vitamin D production
- Temperature regulation
 - sweating, blood flow
- Sun protection
 - Detoxification/activation of drugs and chemicals
- Immunosurveillance
 - Langerhans cells, t-lymphocytes

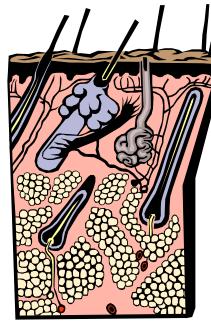


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4

Anatomy Of Skin

- Epidermis
 - Outer layer contains the stratum corneum
 - The rate limiting step in dermal or percutaneous absorption is diffusion through the epidermis
- Dermis
 - Much thicker than epidermis
 - True skin & is the main natural protection against trauma
 - Contains
 - Sweat glands
 - Sebaceous glands
 - Blood vessels
 - Hair
 - Nails
- Subcutaneous Layer
 - Contains the fatty tissues which cushion & insulate



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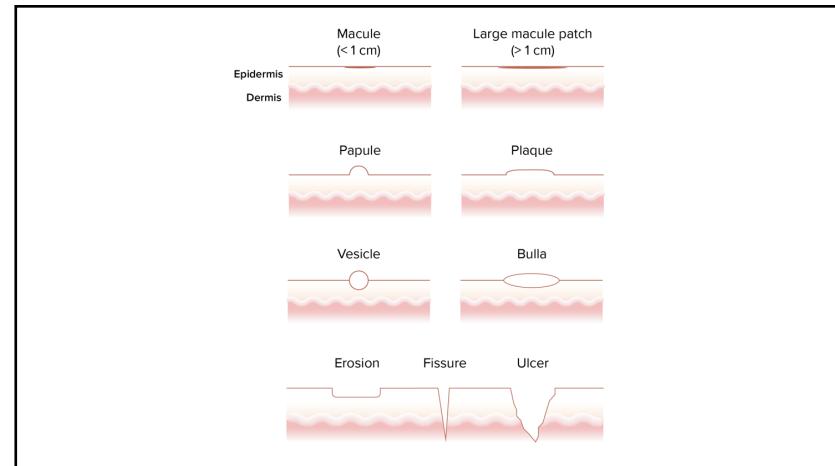
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Epidermis

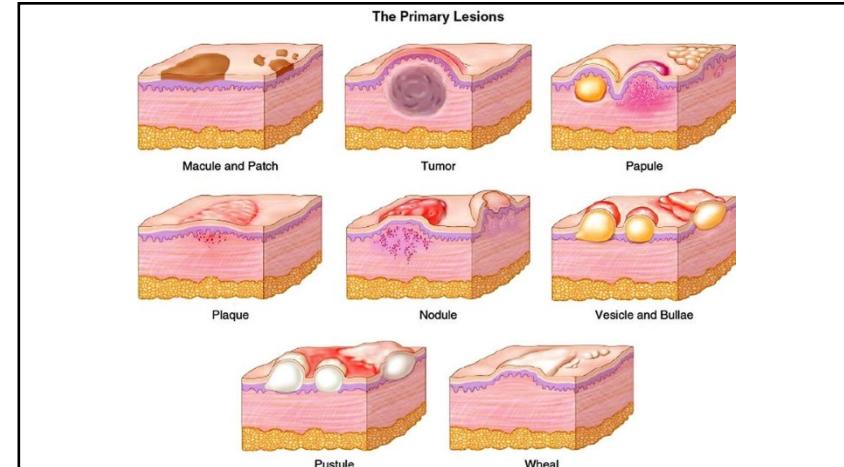
- keratinocytes—stratified squamous
 - Accelerated formation in palms and soles
 - Constant friction results in callus
- Scattered among these are:
- melanocytes—pigment-producing cells.
 - Merkel cells—detect sensation
 - Langerhans cells—phagocytic cells. Activate immune system

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6



7



8

DISPLAY 21-1 Types of Skin Lesions	
LESSON	DESCRIPTION
Bulla	raised, fluid-filled lesion larger than a vesicle; (plural, bullae)
Fissure	crack or break in the skin
macule	flat, colored spot
nodule	solid, raised lesion larger than a papule; often indicative of systemic disease
papule	small, circular, raised lesion at the surface of the skin
plaque	patch
pustule	raised lesion containing pus; often in a hair follicle or sweat pore
ulcer	lesion resulting from destruction of the skin and perhaps subcutaneous tissue
vesicle	small, fluid-filled, raised lesion; a blister or bleb
wheel	anatomically distinct, slightly raised area often associated with hives; seen in urticaria (hives) such as resulting from allergy
	
	
	
	
	

9

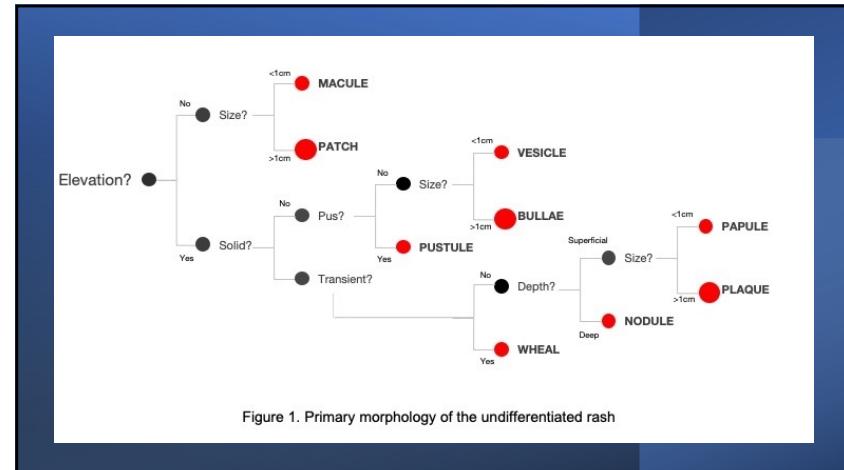
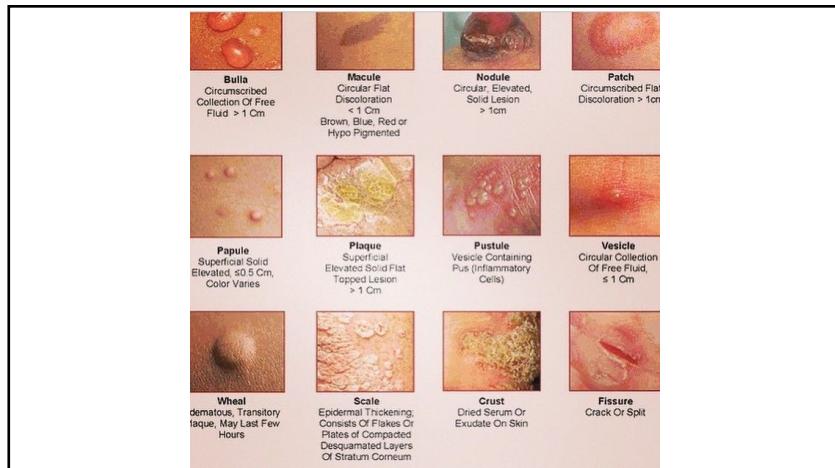


Figure 1. Primary morphology of the undifferentiated rash

10



11

Dermlish

Primary lesion	Location/Distribution	Other features/Morphology
Macule- small and flat	Acral	Erythematous
Patch- large and flat	Symmetrical	Violaceous
Papule- small bump	Flexural	Crusting
Nodule- large bump	Extensor	Hyperkeratotic
Plaque- large, spread out and raised	Disseminated	purpuric
Vesicle- little blister	Periocular	Petechial
Bulla- large blister	Perioral	Indurated
	Mucosal	Eczematous
	Genital	Psoriasiform
	Segmental	Annular
	Dermatomal	Polycyclic
	Blashkoid	Perinotic

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12

Another way of looking at it

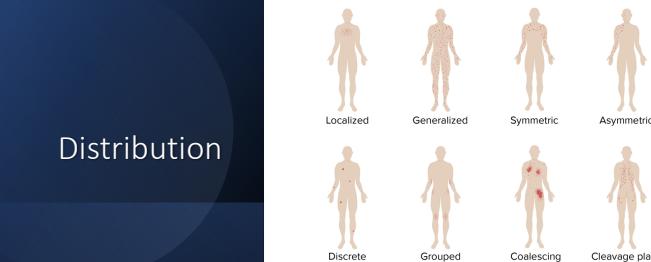
Dermish		
Overall entity	Is it a rash or a solitary lesion	'a single lesion' 'widespread rash'
Distribution	Where on the body is it located and is there a pattern to this	Acral, truncal, Flexural Extensor, scalp
Configuration	What is the shape and outline of the affected area/areas	Anular, discoid, nummular, livedoid, well demarcated
Morphology and surface	What is the form/structure of the affected area/s	Macular, papular, nodular, bullous, vesicular, pustular Eczematous, psoriasiform, hyperkeratotic
Colour	Colour of the affected areas, surrounding skin and the rest of the skin	Erythematous, violaceous, blanched
Secondary changes	Any subsequent changes?	Ulcerated, crusted, eroded, excoriated

<https://dermnetnz.org/topics/terminology>

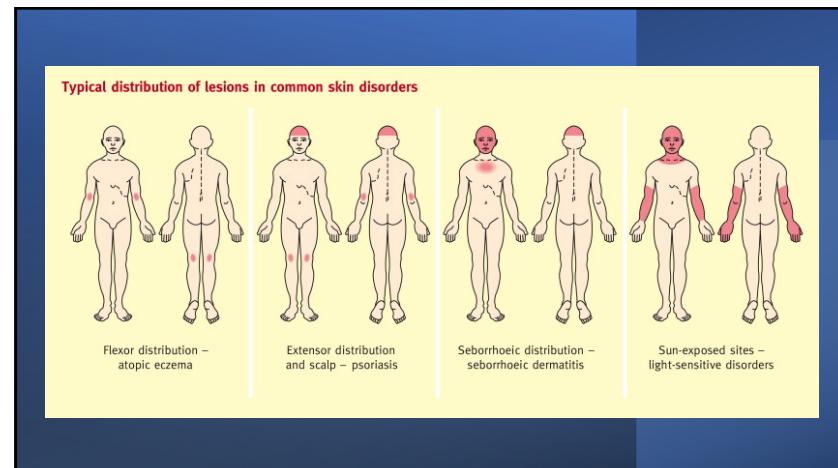
<https://camls-us.org/wp-content/uploads/2018/05/Handout-Fundamentals-of-Dermatology.pdf>

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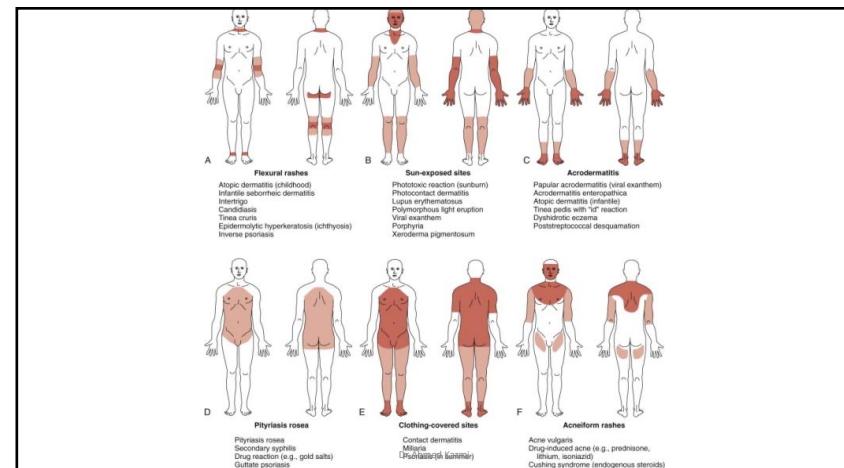
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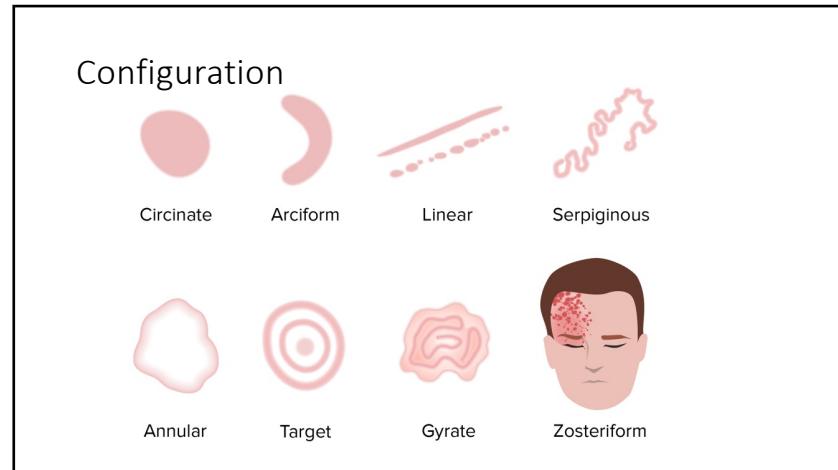
14



15



16



17



18



19



20



21

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Mastering Dermatology Topicals (Focus on OTC products)

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DGM DipClinDerm

22

Mastering Topicals

- Sunscreens
- Emollients
- Medicated shampoos
- Cleansers and washes
- Retinols/Retinoids

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23

Sun screens

	PHYSICAL SUNSCREEN	CHEMICAL SUNSCREEN
MADE WITH	MINERALS	UV FILTERS
WORKS BY	BLOCKING THEN REFLECTING UV RAYS AWAY	ABSORBING THEN RELEASING UV RAYS FROM SKIN
WEIGHT	GENERALLY THICKER HARD TO BLEND	GENERALLY LIGHTER NON-STICKY
WHITE CAST?	YES	NO
WAITING TIME?	NONE WORKS INSTANTLY	YES AT LEAST 30M
RE-APPLICATION	YES	YES
SKIN TYPE	SENSITIVE SKIN ROSACEA	OILY SKIN

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24

Chemical Sunscreens ('non mineral')



25

Physical sunscreens (mineral)



26

Hybrid Sunscreens



27



28

Emollients (they are medicine)

- Functions:
 - barrier
 - slow down moisture loss
 - reduce itch
 - improve skin appearance
 - soap substitute
- Types: Varying thickness, leave-on, soap substitute, bath emollient
- Extras: antimicrobial, urea, humectant, lauromacrogol, menthol, crotamiton, TCA, (tar)

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Real life emollient ladder example

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29

UK formulary



<https://www.nhs.uk/conditions/emollients/>

<https://www.dorsetccg.nhs.uk/Downloads/aboutus/medicines-management/Other%20Guidelines/Emollient%20comparison%20chart.pdf>

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30

Emollients

- Patient pitfalls:
- Not using enough
- Not applying often enough
- Over rubbing
- Rubbing into hands when applying
- Rubbing against the direction of hair growth
- SLS e.g. aqueous cream
- Using tubs
- Flammability
- Slips



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31



Shampoos

Patient pitfalls

- Not leaving on long enough
- Accepting they might smell
- Accepting they might dry out hair
- Maintenance!

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32

Cleansers & Washes

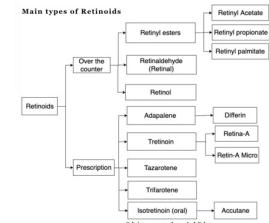
- Not left on correct duration
- Unrealistic expectations
- No ongoing prophylactic use
- Not rinsing off fully
- Thinking they are 'gentle'
- 'natural'
- Can use shampoos as washes to



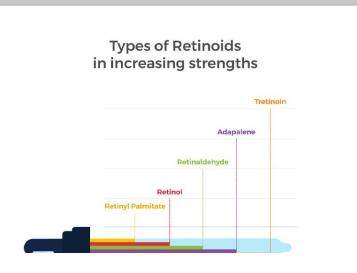
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33

Patients love retinoids



Types of Retinoids in increasing strengths



34

Retinoids

- Bypassing irritancy
 - Using tiny amount
 - Building up
 - Avoiding sensitive areas
 - Avoiding other products
 - Moisturise if needed
- Photosensitivity
- Pregnancy
- Bleaching
- Combing with other agents
- Info sheet



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35

Eczema: How to be a BOSS in 5 simple steps

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36

Tip 1: DO NOT CALL IT 'ECZEMA'

- How many types of Eczema can you name?
- Atopic dermatitis
- Venous eczema
- Discoid eczema
- Irritant contact dermatitis
- Allergic contact dermatitis
- Asteatotic eczema
- Dishidrotic eczema/ pompholyx



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37

Tip 2: Educate Patients



- What do you say?
- Cause
- Prognosis
- Treatment (HOW not just WHAT)
- Associations
- Steroid safety

38

Tip 3: Know your emollients (they are medicine)

- Functions:
 - barrier
 - slow down moisture loss
 - reduce itch
 - improve skin appearance
 - soap substitute
- Types: Varying thickness, leave-on, soap substitute, bath emollient
- Extras: antimicrobial, urea, humectant, laurocrogol, menthol, crotamiton, TCA, (tar)



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39

Tip 4: Know your steroids

- Steroid ladder
- Which one for which body part/age group
- Ointment vs cream
- With 'extras'
- Duration of treatment
- 'Step up' vs 'step down'
- Scalp applications/gels
- Shampoos
- Tachyphylaxis/allergy
- Aware of side effects/risks



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40

Steroids

Class	Potency	Generic name and strength
Class I	Very potent	Clobetasol propionate 0.05%
Class II	Potent	Betamethasone dipropionate 0.025%
		Betamethasone valerate 0.1%
		Betamethasone dipropionate 0.05%
		Diflucortolone valerate 0.1%
		Fluocinolone acetonide 0.025%
		Hydrocortisone butyrate 0.1%
		Mometasone furoate 0.1%
		Triamcinolone acetonide 0.1%
Class III	Moderate	Alclometasone dipropionate 0.05%
		Betamethasone valerate 0.025%
		Clobetasone butyrate 0.05%
		Fluocinolone acetonide 0.00625%
		Fluocortolone 0.25%
Class IV	Mild	Hydrocortisone 0.1%-2.5%
		Fluocinolone acetonide 0.0025%

BNF: British National Formulary

Topical Steroids Ladder

Least Potent	Hydrocortisone Clobetasone (Eumovate)	Delicate sites face, axilla, anterior neck, inner thigh, groin)
↓	Betamethasone (Betnovate) Mometasone (Elocon)	Body
Most Potent	Clobetasol (Dermovate)	Hands and feet

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Cheat guide- Skin

- Hydrocortisone 1% ointment (Hydrocortisone 1 %)
- Eumovate ointment (Clobetasone Butyrate 0.05%)
- Betnovate ointment (Betamethasone valerate 0.1%)
- Dermovate ointment (Clobetasol dipropionate 0.05%)

Cheat guide- Scalp

- Betnovate scalp application (Betamethsone valerate 0.1%)
- Etrivex shampoo (clobetasol propionate 0.05%)

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41

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Tip 5:
Understand eczema in ethnic skin



Call: D Wellach

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42

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Identifying erythema in pigmented skin

Ask	Ask the patient
Compare	Try to compare different areas of the body
Photos	Ask to look at photos
Feel	Feel the skin (pain, warmth)
Clues	Look for other clues: epidermal change, oedema, blisters
Blanching	Test for blanching

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43

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Erythema



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44

Eczema in Black people

More common in black children (USA data 19% vs 14%, x1.7RR) **TRUE**

More likely to resolve with adulthood **TRUE**

More likely to be lichenified **TRUE**

More likely to be papular **TRUE**

More likely to be follicular **TRUE**

More likely to be associated with pigmentary changes **TRUE**

More likely to have severe disease **TRUE**

More likely to have prurigo nodularis **TRUE**

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45



46



47



48

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"Eczema:
Basically Emollients & Steroids"

49

Red flags- ABCD for melanoma

50

IDENTIFYING SKIN CANCER

BASAL CELL CARCINOMA	SQUAMOUS CELL CARCINOMA	MELANOMA
APPEARANCE		
Pearly/waxy bump or flat brown lesion.	Firm red pimple/nodule or scaly patch.	Existing mole that bleeds, itches or changes shape/color; large brownish patch or smaller spot with black, red or white speckles.
SEVERITY		
Most easily treated form; least likely to spread.	Easily treated if detected early; more likely to spread than basal cell carcinoma.	Most serious form; needs to be diagnosed early, as later it can be difficult to treat and spreads easily.

Generally, any new/changing skin lesion present more than 6 weeks needs prompt review by a clinician.

This includes:

- New Papule
- New Nodule
- New Erosion
- New Ulceration
- New Macule
- New Patch
- New Plaque

Every locality will have published their own specific guidelines- read them and keep them on your wall.

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51

Pan-London Suspected Cancer Referral Guide – Skin

RISK FACTORS for skin cancers
Include the following:

- Photo-damaged skin
- Previous skin cancer
- Family history
- Organ transplant
- Immunosuppressive therapy

BASEAL CELL CARCINOMA
Consider a **suspected cancer pathway referral** for patients if they have a skin lesion that raises the suspicion of a basal cell carcinoma
Only consider a suspected cancer pathway referral for an appointment within 2 weeks for patients with a skin lesion that raises the suspicion of a basal cell carcinoma if there is particular concern about a delay may have a significant impact, because of factors such as lesion site or size. The following features warrant a suspected skin cancer referral:

- Diagnosis in doubt (possible SCC or basi-squamous lesion)
- Rapidly growing
- Pigmented lesion
- Significant site: eyelid, lip margin or nose

 Follow the NICE guidance on improving outcomes for patients with skin tumours including melanoma: the management of low risk basal cell carcinomas in the community (2010 update) for advice on who should excise suspected basal cell carcinomas.

MELANOMA
Refer using a **suspected cancer pathway referral** (for an appointment within 2 weeks) in patients with a suspicious pigmented skin lesion with a weighted 7-point checklist score of 3 or more.
Each major feature scores 2 points. Each minor feature scores 1 point.

Major Features of the lesions (scoring 2 points each):	Minor Features of the lesions (scoring 1 point each):
<ul style="list-style-type: none"> Change in size Oozing Irregular shape Inflammation Irregular colour 	<ul style="list-style-type: none"> Largest diameter 7 mm or more Change in size Oozing Irregular shape Inflammation Irregular colour

SQUAMOUS CELL CARCINOMA
Refer using a **suspected cancer pathway referral** (for an appointment within 2 weeks) for patients with a skin lesion that raises the suspicion of squamous cell carcinoma.
These are commonly on the face, scalp or back of hand and often larger than 1 cm in diameter. These can present with the following features:

- Pain/tenderness
- Crusting/non-healing lesion with induration
- Documented expansion over 8 weeks

SUSPECTED SKIN CANCER REFERRAL

Referral is due to CLINICAL CONCERNs that do not meet NICE/pan-London referral criteria (the GP MUST give full clinical details in the 'additional clinical information' box at the time of referral)

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Example skin cancer referral pathway (London)

13

Example 2ww melanoma referral

SKIN: MELANOMA

Reason For Referral

NB: Clinicians may use EITHER the ABCD rules OR NICE weighted 7-point checklist:
A B C D rules apply to pigmented skin lesions. Change often occurs in 3-12 months.
 Melanomas are generally not keratotic (crusty), unlike Seborrhoeic Keratoses.
 Please indicate if there has been any change in:

A. Asymmetry (change in symmetry)
 B. Border (change to be irregular, blurred edges)
 C. Colour (change in colour or change to have more than one colour, even if lighter)
 D. Diameter (change in diameter, especially if change to be greater than 6mm)

OR: NICE weighted 7-point checklist score of **5** or more

MAJOR features of the lesions (correct 2 points each):	MINOR features of the lesions (correct 1 point each):
Change in size	Largest diameter 7 mm or more
Irregular shape	Inflammation
Irregular colour	Oozing
	Change in sensation

Additional important clinical information

Previous history of skin cancer
 Family history of skin cancer
 Immunocompromise
 Pacemaker (or another electronic implanted device?)

Please include the history and location of the lesion and attach any photographs.

53

Example SCC/BCC 2ww referral

SKIN: SQUAMOUS CELL CARCINOMA and CRITICAL SITE BASAL CELL CARCINOMA

Reason For Referral

SQUAMOUS CELL CARCINOMA (SCC)
 These are from Keratinocytes and usually have adherent keratin. Poorly differentiated SCCs can just be ulcerated skin. Well differentiated SCCs can look like a warty growth or a non-healing ulcer. In some cases, a keratin core is present (possible keratoacanthoma) which should be referred in case they are SCCs.

Features:

- Expansion over weeks to months
- Tender
- Keratin producing (adherent)
- Ulcerated/pink lesion

Critical Site Basal Cell Carcinoma (BCC)
 Documentation of critical site refer to DIC

***Critical site**

- Eyelid margin
- Nostril rim
- Vermilion border of lip
- External auditory meatus

Additional Important Clinical Information:

Previous history of skin cancer
 Family history of skin cancer
 Immunocompromise
 Anticoagulants
 Pacemaker (or another electronic implanted device)

Please include the history and location of the lesion and attach any photographs to the referral.

Can this patient expire:

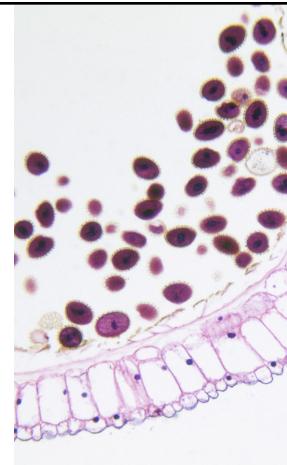
Remote: Telephone consultation
 Remote: Photography & email capability
 Remote: Travel to clinical site for Tele-Dermatology Photo Centre
 Hospital: Face to face
 Video: Video showing straight on and elevation views are most useful.
 Video does not usually show enough definition for accurate assessment

Additional important clinical information:

54

Rash red flags

1. Abrupt onset and widespread
2. Blistering/ erosions
3. Mucosal involvement
4. Systemic upset
5. Skin pain
6. Non blanching lesions
7. Erythema more than 80-90% BSA
8. High risk patient e.g. infant, gravid immunocompromised



55

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- Mastering 'eczema'

Aims

1. Leave feeling you understand the principles of skin and describing/categorising rashes better
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3. Leave feeling more confident and competent helping to manage eczema with your customers/patients, right from today