Skin diseases in primary care:

what should GPs be doing?

LACK OF TRAINING IN SKIN DISEASE

Dermatology is a topic that appraisers report often appears at the top of GPs' educational needs. Perhaps we should not be surprised given the minimal dermatological teaching most GPs experience. In addition, skin is exposed for everyone to see and inadequacy on the part of a practitioner, either in diagnosis or management, is equally apparent to patient and doctor. This makes both parties uncomfortable and can lead to unnecessary referrals and poor care.

The evidence from a 2005 study showed 54% of people reported a skin problem in the preceding 12 months.¹ The Lambeth study, which used a physical examination, estimated that the overall proportion of the population with any form of skin disease was 55%, with 22.5% considered worthy of medical care (that is, moderate or severe).¹ There is therefore a huge amount of 'disease', most of which is managed for good or ill by the patients themselves or by primary care. A wealth of epidemiological information is revealed in the excellent *Skin Conditions in the UK: a Health Care Needs Assessment*.¹

It is not unreasonable for the public to expect their healthcare provider, most often a GP, to be able to recognise common skin conditions, know what useful therapeutic measures are available, and know when to seek expert help for diagnosis and exclusively specialist treatments. Sadly, the evidence from so many sources, such as patients and their support groups, our secondary care colleagues, and studies such as the IMPACT study in psoriasis,² all point to a significant lack of knowledge, and even more distressing, a lack of empathy from too many GPs. It vexes me that somehow doctors feel it acceptable to express ignorance of skin disease, which they would never do about other medical conditions for fear of criticism by their peers!

The study in this issue on patient/parent diagnosis of molluscum contagiosum³ is an example of the importance of diagnosis, especially to exclude serious disease and relieve anxiety. A very common complaint from patients is that they do not feel they are listened to and they would appreciate being asked how they feel and how they cope. I fear it can be a coping measure for us GPs to ignore what we do not understand. Even worse, we sometimes blame the patient for their distress; for example, *'your eczema is*

bad because you are scratching!'. Problems of adherence with prescribed treatment are highlighted in the Santer and Burgess study on experiences of carers managing childhood eczema and their views on its treatment.⁴ Here the patients and their carers felt unsupported and not taken seriously. In addition, there was confusing advice and perhaps inappropriate caution over prescribing topical corticosteroids and emollients. Clear, realistic advice is needed and patient fears must be addressed before they leave the surgery.

EDUCATION BY ALL MEANS!

So GPs should gain knowledge by whatever means suits their learning style, and fill in the gaps that many undergraduate medical courses still ignore and that are compounded by minimal vocational training schemes with dermatological educational content. If dermatology were taught at an early stage of medical training then enthusiasm and confidence in the subject could then be developed in the postgraduate clinical situation. In our society, the Primary Care Dermatology Society (PCDS), we attempt to plug these important educational gaps. When teaching around the UK we hear of minimal or absent factual training and, inevitably, much of our education is of a didactic, lecture-based style designed to deal with the inadequate basic knowledge left by previous courses. In addition, pointers to reliable web-based education and our ever-expanding website appeals to many (<http://www.pcds.org.uk/>).

Traditionally the apprentice style of education was, and, for the lucky few, still is, a good way to learn from an experienced colleague. This is especially helpful when using a dermatoscope to assess skin lesions, just as it is for the other 'scopes' (such as ophthalmoscopes and auroscopes). The development of dermoscopy, which has come late to the UK and is led strongly by the PCDS, provides primary care with an enhanced ability to be more confident

in diagnosing benign lesions such as seborrhoeic keratoses, which despite being benign constitute up to 80% and more of the 2-week wait for cancer referrals (personal communication, Dr Chris Bowers, dermatologist, and others, Exeter, 2014). The images provided by a dermatoscope are different from those garnered by the naked eye and thus another knowledge base has to be learned. Those of us who use dermoscopy regard it as a normal part of lesion diagnosis to which every practice, if not every practitioner, should have access. Details of our courses 'Dermoscopy for beginners' and 'Advanced dermoscopy' run in conjunction with Dr J Bowling are on our website, as are all our meetings around the UK.

The recent study reported in the *BJGP* for diagnosing melanoma using a weighted 7-point checklist using the MoleMate system is an example of an attempt to use technology to remove clinicians' skill, which is superficially attractive to CCGs and some GPs.⁵ However, the addition of an expensive piece of equipment did not reduce the benign lesions referred: *'the MoleMate system led to a higher proportion of benign lesions referred.'*⁵

Dermoscopists would claim that further accuracy and thus safety with economy is obtained using a dermatoscope. Evidence of the benign to malignant excision rates is a measure of the diagnostic accuracy, and illustrated by an Italian study which recorded that after less than a day's training GPs achieved a reduction from 18:1 to 4:1 benign to malignant referrals.⁶ It is important, not only from a cost viewpoint but also for patients, who, when given a skin cancer 2-week wait appointment, receive what they may perceive as a death sentence. They may experience 2 weeks of severe anxiety, especially after looking up melanoma on the internet only to be dismissed after 30 seconds with benign seborrhoeic keratosis.

I am disappointed by the study, in this

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issue, from east and south-east Scotland,⁷ which shows less good outcomes from primary care excision of skin cancers. Their conclusion is that Scotland should adopt the restrictive rules for basal cell carcinomas (BCCs) that we work under south of the border, rather than to raise the diagnostic and skill level of the primary care surgeons. Yet the enormous increase of skin cancers in the south of England is creating real coping problems for dermatologists. The figures do not show any breakdown of the individuals or units involved, which has always hampered primary care evidence. There may well be centres of excellence in primary care but with some poor performers bringing down the average. This has certainly been true in England, where audits as good as any in secondary care were not considered in the National Institute for Health and Care Excellence (NICE) deliberations before setting up *Improving Outcomes Guidance for Skin Cancer* in 2006.⁸ Because of the rules regarding excision of BCCs we can no longer demonstrate that we are competent to do so! A catch 22?

NOT FORGETTING INFLAMMATORY SKIN DISEASE

Lesions are only one important part of a GP's job and much overlooked patient suffering derives from inflammatory disease that, when severe, may mean the patient endures delayed help from a dermatologist because of the huge number of 'possible cancer' referrals. Recent ministerial suggestions of 'red flagging' those GPs missing cancers will not help this situation in the least.

The importance of holistic medicine is further supported by another article in this issue on psoriatic arthropathy and using the PEST Screening Questionnaire⁹ even when there is no visible skin psoriasis other than perhaps a few nail pits. There is increasing evidence that inflammation of the joints in psoriasis is more closely correlated to the inflammation in atherosclerotic plaques and thus cardiovascular disease than from skin lesions themselves.

It is important to discuss 'management' rather than just 'treatment' with regard

to skin conditions because so many are chronic and relapsing, and require long-term support over years, for which a good GP-patient relationship is ideal.

There have been relatively few totally new drugs available to primary care in the past 20 years. However, significant changes in the knowledge base about the way we use traditional drugs such as emollients and topical corticosteroids do not seem to have percolated through to the grass roots. Despite our efforts, patients still get prescribed tiny quantities of medications intended to cover large parts of their bodies. GPs, and indeed pharmacists, are inappropriately cautious about topical corticosteroids and their rare side effects, which frighten patients and lead to unnecessary continued suffering. It is more than 50 years since the concerns of the 'red face' caused by overuse of potent steroids on thin skin areas, but we still have steroid phobia even among doctors and pharmacists. GPWs and dermatologists spend infinitely more time persuading reluctant patients to use them appropriately than dissuading them from excessive use. It is recognised now that it is better to deal with inflammation, in eczema for example, by using a stronger topical corticosteroid (or topical calcineurin inhibitor) initially, then reducing the potency or using them intermittently long term. The need to use adequate quantities of emollients for all dry skin conditions and to continue long term is vital, effective, and so simple, but it rarely happens.

HELPING PATIENTS WITH THEIR SKIN IS OUR JOB

There are far too few dermatologists in the UK and that is not going to change in the near future. Thus patients rely on their GPs and primary care teams to have or gain the knowledge of diagnosis and management of the common skin diseases and lesions. Patients tell us we are not doing well enough and those of us with influence over medical training, not least the RCGP, have a duty to raise our game and equip future and existing GPs with the skills and empathy to improve patient care.

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The PCDS membership of over 1200 GPs are keen to play an increasing part as we enter our third decade of dermatological education.⁵

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Provenance

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