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The Topical Dermatology Magazine

Issue 03 / Spring 2025

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Prescribing emollients: The big debate

AI in dermatology: Pros and cons

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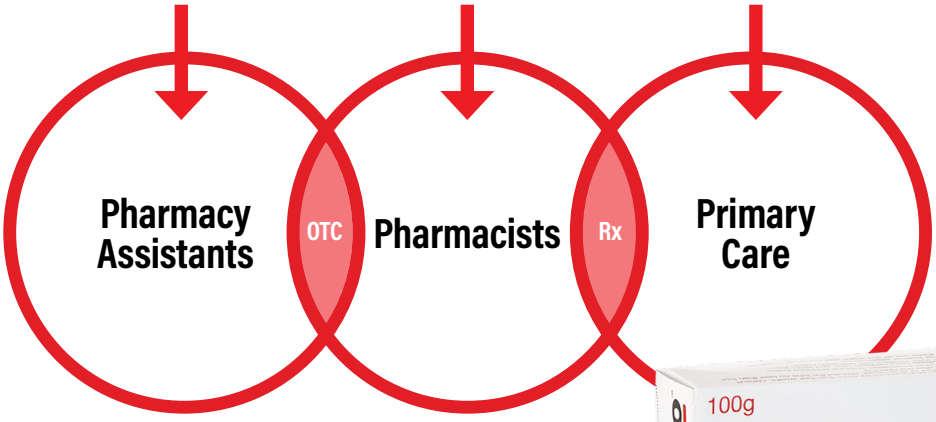

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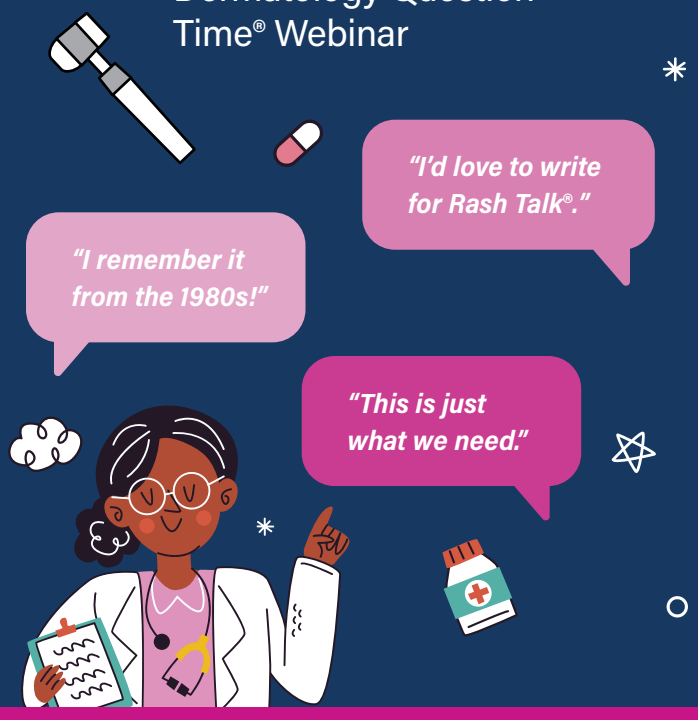
Inside this Issue



Rupert Reflects

By Dr Rupert Mason
Rash Talk® founder

The Morgan Test

In this edition of Rash Talk® Dr Angela Goyal is providing us with some useful tips on managing eczema in Primary Care. I worked in general practice in the era of five-minute appointments, and any tips on how to squeeze a quart into that particular pint pot were very welcome. One handy stratagem I discovered involved a small toy car I used to keep on my desk. Not just any car – a Morgan Plus 4 to be precise. This came to be a vital aid in the triage of my paediatric patients. Frequently, a child would be attracted to the car and quickly start racing it across the desktop or along the floor while mum would be painting a contrasting picture of a tired, pale little waif who won't eat and 'is not himself'. I soon realised that the child who ignored my Morgan and sat listlessly on mum's lap during the consultation merited greater scrutiny than his more energetic counterpart.

"I believe a clinician's intuition still has validity"

Over the years every clinician develops an awareness of little behavioural clues that assist the diagnostic and therapeutic process. They are not infallible, they can be misleading, but even in this digital age, I believe a clinician's intuition still has validity. Of course, the Morgan test requires patient and doctor to be physically together. No telephone or Zoom call can reveal the same behavioural subtleties. As these newer forms of consultation expand, will it be at the expense of honing intuitive clinical skills?

I don't know what happened to my toy Morgan, but I do know that all these years later I've got a real one parked in the garage. For future reference, if you happen to hear that it is not receiving due love and attention, you will know that I am seriously unwell.

Emollients: To prescribe or not prescribe? That is the question

The British Dermatology Nursing Group talks to Julie Van Onselen – Dermatology Lecturer Practitioner and Dermatology Clinical Nurse Specialist.

Emollients are an important medical therapy for patients with various inflammatory skin conditions, including eczema, psoriasis, and ichthyosis. They help protect and soothe the outer layer of the skin, improving barrier function and preventing the entry of irritants and allergens.

Over the years, emollients have become more sophisticated [1] and include creams, ointments, gels, lotions, sprays, washes, and bath and shower additives, available as non-proprietary and/or proprietary products. [2]

There is no evidence from controlled trials to support using one emollient over another, but patient preference determined after a period of testing will usually identify the most appropriate treatment. Prescribers should also consider disease extent, dry skin severity, age and patient lifestyle. [2-4]

Even though studies show that it is false economy to prescribe solely based on price, [4] patients increasingly report that their preferred emollient on prescription has been switched to a cheaper and sometimes less effective alternative. In some cases, patients are not being prescribed any emollient at all. [5]

Is there growing resistance to prescribing emollients in primary care?

Most emollient prescribing occurs in primary care, and clinical commissioning groups (CCGs) will have a local formulary with recommendations on which emollients to prescribe. GPs are advised, where possible, to prescribe the emollient with the 'lowest acquisition' cost from the range of emollients listed in their local formulary. [5, 6]

This is despite studies suggesting that the prescription of an emollient to treat dry skin and eczema may be associated with reduced costs of care, mainly because of fewer visits to health professionals and prescriptions overall. In addition, prescribing emollients appropriately was associated with a potential for less antibiotic and potent topical steroid use. [7]

Another issue is that guidance from NHS England published in 2018 on prescribing over-the-counter medications stipulated that emollients should no longer be prescribed for 'mild dry skin'. Some CCGs and GPs have misinterpreted that to mean that people with eczema should no longer be prescribed emollients. [4,5,8]

Dr Bruce Warner, Deputy Chief Pharmaceutical Officer NHS England & NHS Improvement, tried to clear up the issue by writing to the British Association of Dermatologists and the Dermatology Council of England. In his correspondence, he said that the NHS England Clinical Working Group responsible for the guidance did not intend it to be used as a mechanism to initiate a blanket ban on emollients. [9]

"Script-switching to similar emollients is not cost effective as it can lead to a lot of waste. No two emollients are the same, and patients will only use formulations that suit them" Julie Van Onselen

He added: "*If CCGs have implemented the guidance as intended, patients with chronic and severe skin conditions should still be able to receive their emollients on prescription as it is a chronic condition. The recommendation in this guidance only applies to those with mild dry skin.*"

> ***"If secondary care doctors recommend a specific emollient and stipulate the reasons for prescribing it, that would actually be really helpful to primary care"***
> Julie Van Onselen

Postcode lottery of emollient prescribing

According to Julie Van Onselen, a dermatology clinical nurse specialist with 30 years of experience in primary and secondary care, the lack of consensus from local formularies has led to inequitable regional variations on emollient prescribing.

"There is a postcode lottery on emollient prescribing that has become more apparent since the Covid-19 pandemic," she says. *"As there is no NICE guidance on eczema care for adults, prescribing decisions vary widely from formulary to formulary. There is also a knowledge gap across primary care and emollients are typically under-prescribed and under-used.*

Also, script-switching to similar emollients is not cost effective as it can lead to a lot of waste. No two emollients are the same, and patients will only use formulations that suit them. This results in suboptimal treatment of dry skin and eczema and may increase the occurrence of flares."

Why is it important for patients to follow complete emollient therapy?

As an emollient is a substance whose primary action is to occlude the skin surface and to encourage buildup of water within the stratum corneum, the recommended amount of emollient to be used is 500g per week for older children and adults, and 250g per week for younger children. It should also be applied frequently, at least three times per day.[5]

Most patients will require complete emollient therapy (CET) for optimum management of dry skin conditions, which involves using a leave-on emollient and products to wash and bathe or shower.

However, as of September 2018, emollient bath additives are no longer included in local formularies. This is because the BATHE study found that emollient bath oils didn't have any additional benefit for children who were using leave-on emollients to wash with, and it was used as a reason to stop prescribing emollient wash products altogether.[10]

At the time, the National Eczema Society expressed concern about the methodology of the BATHE study to NHS England. It made a case for emollient wash products to remain on prescription, but NHS England did not amend the guidance.[5] They can still be prescribed, but only at a GP's discretion or if recommended by a secondary care specialist due to the specific nature of the patient's condition.

"If secondary care doctors recommend a specific emollient and stipulate the reasons for prescribing it, that would actually be really helpful to primary care," Van Onselen adds.

"Although it is time-consuming for secondary care, it is important for them to discuss the rationale behind their decisions and why that specific treatment needs to be continued by primary care. It could be because that formulation is a humectant, or the combination of certain ingredients gives the patient adequate skin barrier repair.

Emollients are not a 'nice to have' for many patients, but essential first-line treatment and switching their preferred emollients leads to frustration and non-compliance. As nurses, we know that the most expensive emollient is the one that goes unused."

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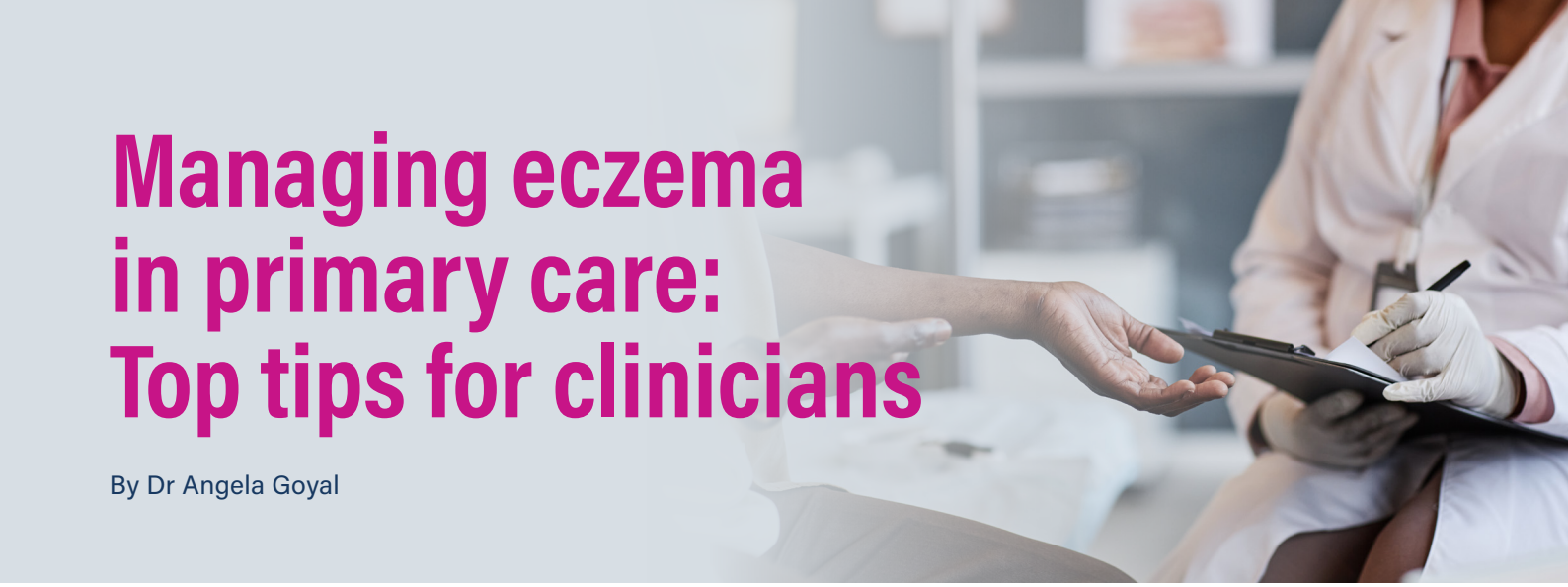
What is your experience of emollient prescribing? Share your experience - scan QR code

Managing eczema in primary care: Top tips for clinicians



By Dr Angela Goyal

Eczema, also known as atopic dermatitis, is a chronic inflammatory skin condition characterised by dry, itchy skin and a rash. Atopic dermatitis affects up to 25% of children and 2-3% of adults. [1]
The prevalence of eczema has doubled or tripled in industrialised countries during the past 30 years. [2]

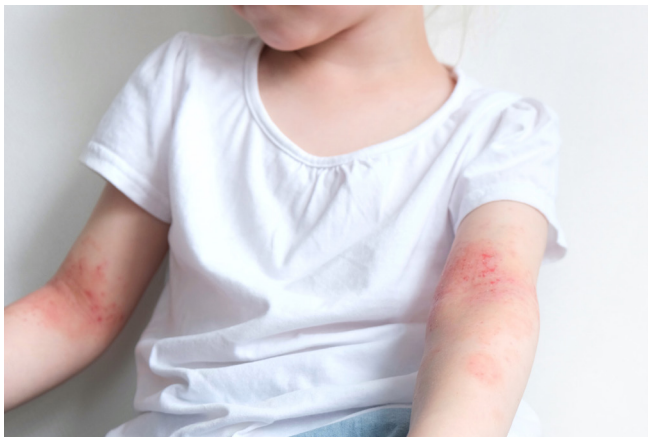
Dr Angela Goyal

Dr Angela Goyal is a GP with Extended Role in Dermatology. She is Education Lead and a Clinical Lead for the Leeds Community Dermatology Collaborative. Angela is an influential speaker, both nationally and internationally in dermatology.

Healthcare practitioners in primary care are often the first point of contact for diagnosis, treatment and ongoing management. This article provides an overview of the key aspects of managing eczema in primary care, focusing on the clinical features, how to diagnose and management strategies.

Presentation and diagnosis

It is Monday morning, and your first consultation is with distressed parents, concerned that baby Jack can't stop itching all over.



Given the parents – as well as Jack – are unlikely to have had much sleep over the weekend, firstly acknowledge the distress experienced by the whole family, as this can really help with the flow of the consultation.

Eczema is diagnosed through history-taking and clinical examination. Differential diagnoses such as psoriasis, contact dermatitis, scabies and fungal infections can present similarly so should be considered.

a) Key features in the history

- Itchy skin (pruritus), which is often worse at night
- Chronic or relapsing
- A personal or family history of atopy (asthma, hay fever, or eczema).

b) Clinical features on examination

The condition can vary in severity, from mild localised patches to widespread involvement.

Distribution

In infants, the cheeks are a common site. As the child becomes older, the flexures are affected, and it can be widespread when severe.

Morphology

Look for dryness, fine scale and ill-defined erythema (redness). There may also be vesicles, weeping and crusting, excoriations and lichenification (thickened skin due to chronic scratching).

Treatment strategies

As previously mentioned, recognising the impact eczema is having on the patient and family is vital. Treatments need to be explained and followed up with written information or links to useful resources. Mention pre-payment certificates and check patient understanding and compliance.

The cornerstone of eczema management in primary care is the use of topical therapies.

Emollients

Regular use of emollients is essential to hydrate the skin, reduce itch and dryness, and improve the skin's barrier function. These should be prescribed as the first line of treatment, with emphasis on frequent application. Despite the well evidenced benefits, emollients are under-prescribed in primary care, resulting in sub-optimal eczema treatment and an increased risk of flares. [3]

Topical corticosteroids

For flare-ups, topical corticosteroids are the most effective anti-inflammatory agents. Low-potency steroids (e.g., hydrocortisone 1%) are suitable for the face and sensitive areas, while higher-potency options (e.g., betamethasone valerate) can be used for more severe cases and on the body of adults. It is important to monitor for side effects such as skin thinning, especially with prolonged use.

Oral antihistamines

These can be useful for controlling itching, especially at night.

Oral corticosteroids

In cases of severe flare-ups, short courses of oral steroids may be prescribed. However, these should be used cautiously due to the risk of side effects.

Identifying and reducing triggers

Understanding and managing eczema triggers is vital for preventing flare-ups. Common triggers include:

Irritants: Patients should be advised to use a soap substitute i.e., the emollient they have been prescribed, instead of shower gel or soap.

Cold and dry weather can worsen eczema. Encouraging regular moisturisation, especially during winter months, is crucial.

Other triggers include stress, overheating, aeroallergens, house dust mites, animal dander and foods.

Referral to secondary care

While most eczema cases can be managed in primary care, referral to dermatology may be required for severe or refractory cases. Indications for referral include:

- Persistent or severe eczema despite appropriate treatment, diagnostic uncertainty, or if allergic contact dermatitis is suspected
- Need for advanced treatments, such as systemic immunosuppressants.

Management in secondary care may include: phototherapy orsystemic medications e.g., methotrexate, ciclosporin, azathioprine or mycophenolate mofetil. Newer treatments for eczema include biologics and Janus kinase (JAK) inhibitors.

Conclusion

Managing eczema in primary care is very satisfying for the clinician, and when done well can be life-changing for the patient. It is important to make an accurate diagnosis and give ongoing patient education. Regular use of emollients, appropriate topical therapy and lifestyle modifications are essential for effective control. Additionally, addressing the psychosocial impact of eczema can significantly improve patient outcomes. By providing holistic care and ensuring timely referrals when necessary, primary care practitioners play a vital role in improving the quality of life for patients with eczema.

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Emollient tips

Prescribe large quantities of emollients – 250-500g / week

Ensure emollients are on repeat prescriptions

Avoid aqueous creams which contain sodium lauryl sulphate

Creams and gels are lighter and easier to use

Ointments – these are good for skin that is very dry, but they are harder to use

The same emollient can double up as a soap substitute – this reduces prescription costs to the patient

Patients should be using a lot more emollients than medicated topicals - by a factor of at least ten

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AI in dermatology: hype, threat or the next big thing?

By Dr Stephen Hayes

Everyone is talking about Artificial Intelligence (AI), not least in dermatology. The December 2024 ***Journal of the European Academy of Dermatology and Venerology (JEADV)*** was a special issue on Digital Intelligence in Dermatology. An editorial stated '*AI has demonstrated remarkable potential in the classification of skin lesions for melanoma screening, with algorithms achieving diagnostic accuracy comparable to that of expert dermatologists* ***in controlled settings****. However, there remains a considerable gap between the development of these AI systems and their integration into clinical practice. Whether patients and clinicians truly trust and accept these tools* ***for real-world use*** *has been largely unexplored.'* [1]

AI's potential applications include medical education, smartphone apps, decision support, teledermatoscopy, and digital screening. I will address these in turn, based on my reading of expert opinion from the journals and numerous international conferences I attended since 2015. The EADV has issued a position statement on AI which reflects hope and caution.[2]

What is AI?

December's *JEADV* editorial defines AI as '*The broad field encompassing various technologies that enable machines to perform human-like tasks.*' We see AI in science fiction, from Robby the Robot in **Forbidden Planet**, the sinister HAL computer in **2001: A Space Odessey** and other films like **Robocop**, **War Games**, **The Matrix**, animated children's film **Wild Robot** (which I saw and enjoyed last autumn) and even the **Wallace and Gromit** Christmas special, which featured an AI garden gnome robot.

AI now surrounds us. We carry it in our pockets and handbags. When I use a search engine to look something up online, and then get bombarded with adverts for similar products, that's AI algorithms, which are programmed to detect certain signals and respond. Skin lesion diagnostics machines work in a similar way.

Snap!

AI lesion diagnosis machines are like Snap!, a picture card game you play with a child, teaching them to recognise animals – elephant, crocodile, lion, camel etc. The computer does the same thing but faster. Their neural networks are trained on large numbers of dermoscopic lesion images which are stored in memory banks that can be rapidly searched.

Let's say your device has 1,000 images each of basal cell carcinoma (BCC), squamous cell carcinoma (SCC), melanoma, seborrhoeic keratosis, naevi, dermatofibroma and haemangioma. You then show it a high quality dermoscopic image of a lesion, and it very quickly compares it with all the images in its memory to give you the best match with a percentage probability. And it works. The best machines have been tested against clinicians and outperform generalists and most experts. But that's in controlled conditions. At this point in time, real world clinical trials are still very few.

Dr Stephen Hayes

Dr Stephen Hayes worked in Southampton from 1985 to 2023 as a GP, GPwSI in dermatology, and associate specialist until retiring in 2023. He is a joint vice president of the 7th World Congress of Dermoscopy to be held in Lyon, France, in May 2027. He has taught all over the British Isles and blogs at www.dermoscopy.wordpress.com and has 2 dermoscopy books on Kindle.

Learning through play

AI is already being used in medical education, with (for example) dermoscopy learning games. Two free apps, **DermaChallenge** and **Youdermoscopy** let you test and improve your skills by playing against the machine.[3] DermaChallenge is available on the University of Vienna website along with other goodies, while Youdermoscopy is a downloadable app.

Patient-used smartphone apps

This is more controversial. The idea that people can buy an app to advise on their skin lesions sounds great, given GPs' limited training and the shortage of dermatologists, but like a drug or medical device, such apps need to be tested for efficacy and safety. This is not reliably happening yet: a systematic review in the *BMJ* concluded that smartphone skin lesion diagnostics apps were unreliable.[4]

The companies who sell the apps don't want to be sued for missed melanomas, so the diagnostic sensitivity level is set high with low specificity. **Dr Alan Halpern**, of the Sloan-Kettering Cancer Institute, New York, said at a recent conference *'Don't worry that AI is going to take your job, worry rather that it will flood your clinic with anxious patients whose smartphone has told them their harmless mole might be a melanoma so they should get it checked urgently.'* It costs the app makers nothing to cover their backs by telling users to see a dermatologist urgently. These apps are selling briskly in the USA and Scandinavia. Be aware!

Decision support and teledermatoscopy

The best AI machines have been shown to be reliable when used on good quality dermoscopy images in controlled conditions. Such devices can take the place of an experienced senior colleague or second opinion. This is likely to be of most value for trainees, doctors working in isolation, highlands and islands etc.

I foresee a situation whereby a GP, nurse or even a technician can take a high quality dermoscopic image of a suspicious lesion and email it to a distant AI device which will triage it. We know that remote teledermatology advice can work with human experts, but issues of time, cost, regulation and logistics remain to be thrashed out. The main reason for failed teledermoscopy consultations remains poor image quality. You can get round this problem by using professional photographers, as they did in South Wales,[5] although with modern equipment and a little training, any person of average intelligence and manual dexterity ought to be able to take good enough images.

AI in skin screening

There is broad agreement that universal population skin screening does not satisfy the World Health Organization (WHO) approved **Wilson and Jungner** criteria.[6] Results from Germany where it has been trialled since 2008 have been disappointing.[7] There is, however, a cohort of patients with known risk factors (e.g., occupation, age, skin type, naevus count, personal and family history of melanoma) who have a significant increased melanoma risk, and should have screening. Can AI help?

At the EADV congress in Amsterdam in September 2024, I heard a short presentation on the use of AI to determine who would most benefit from screening. This was based on a few questions and a facial photograph. The AI examined the photo for skin type and photo-ageing which, taken together with age, occupation and personal history, could calculate skin cancer risk.

The machine will see you now

Some devices can take full skin maps and process the data. Multiple cameras create a 3D map of the whole skin, numbering and measuring every lesion. Maps can be repeated and compared at intervals, looking for new and changing lesions.

Perhaps your high-risk patient has a map done in April and 387 lesions are recorded, measured, mapped and numbered. The scan is repeated in November, and now there are 390 lesions. Number 172 over the left scapula has grown from 3.6mm to 7.4mm and changed shape. A dermatologist might overlook this, but the machine won't. She can now apply her handheld dermoscope to lesions 172, 388, 389 and 390 and ignore the other 386 lesions that haven't changed (no change, no cancer). This could save a lot of time, a scarce and costly resource for dermatologists. But the machine needs a guiding hand.

At the October 2024 World Congress of Dermoscopy in Buenos Aires, **Professor Aimilios Lallas** told us how 10 consecutive high-risk patients were mapped, and 45 lesions of concern identified. When examined by an expert with a dermoscope, only three out of 45 needed excision. So, AI can pick out lesions of concern, but it tends to overdiagnose. That's OK, as long as we use clinical judgement and don't slavishly excise every lesion that's flagged up.

Cost effectiveness of AI skin lesion screening

A state-of-the-art AI skin screening device costs serious money and needs its own room, regular servicing, and dedicated staff to operate it. Is it cost effective?

Having done around 10,000 full skin checks 'the old fashioned way' over the last decade, I can say that it's relatively boring work, but I picked up hundreds of BCCs and three or four small melanomas a year. Catching a BCC at 4mm diameter rather than three years later at 12mm when it declares itself by scabbing reduces surgical cost and morbidity but won't save a life. But for every 30 or so BCCs there is a potentially deadly melanoma. Given the eye watering cost of melanoma oncology drugs, preventing just one melanoma from metastasising by early detection would save enough money to pay for a screening doctor and nurse for a year. Maybe AI could cover its cost if we used it to identify the right cohort to screen and reduced the dermatologist's time used in the screening process?

Concerns about AI

The EADV position statement identified eight key concerns about AI *'...including risks associated with inaccuracy and improper user education, a decline in professional skills, the influence of non-medical commercial interests, data security, direct and indirect costs, regulatory approval and the necessity of multidisciplinary implementation.'* [(2)] As noted, the technology is already here and being rolled out whether we like it or not, so we should engage with the process.

In conclusion

AI already enables us to do things like shop, game, learn and collaborate with friends and colleagues. But, like other technologies, it can go wrong and have unexpected side effects. The expert consensus is that we should welcome and exploit the possible benefits but proceed with caution. It's not about man versus machine, but man with machine doing better than either alone – if we do it right.

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Rash Talk® Symposium

Tackling tough questions at the BDNG conference

The first Rash Talk® Symposium covered a wide range of topics at the BDNG's annual conference

"Think of me as a benign Fiona Bruce" is how Rupert Mason introduced Rash Talk®'s first-ever Dermatology Question Time symposium at the BDNG's 2024 annual conference in Harrogate.

The lively session's format closely followed that established by the BBC's flagship political debate, bringing together an expert panel to tackle some of the most pertinent questions in dermatology care. Lead nurse prescriber Sarah Copperwheat, nurse consultant Lucy Moorhead, and dermatology specialist nurse Val Anderson answered for the panel. Rupert Mason asked the questions.

Isotretinoin: The good and the bad

The first question, chosen at random, was on the topic of isotretinoin and asked:

"Acne treatment with isotretinoin has always been met with conflicting views. What do you think to those? And what do you say to those who think it is dangerous and has a lot of side effects?"

"As with all systemic drugs, they need to be used in the correct way, with the correct monitoring and supervision by people who feel competent and confident to do so."

Sarah Copperwheat was the first to tackle the question. She said that when it is appropriately used, *"the difference it can make is amazing."* However, she acknowledged that the patient experience has sometimes not matched this expectation. To alleviate this, Sarah called for more research into this area so people can make informed choices regarding treatment and to ensure prescribers feel reassured about the currently limited data.

In response, Lucy Moorhead echoed Sarah's concerns, saying that, in light of the new MHRA guidance, many people who may benefit from isotretinoin treatment may find it harder to access. Nevertheless, she also cautioned that: *"As with all systemic drugs, they need to be used in the correct way, with the correct monitoring and supervision by people who feel competent and confident to do so."*

Expert Panel:

Sarah Copperwheat - Dermatology Specialist Nurse & Lead Nurse Prescriber.

Lucy Moorhead - Nurse Consultant in Inflammatory Skin Disease.

Val Anderson - Dermatology Advanced Nurse Practitioner.

Chaired by Dr Rupert Mason - Rash Talk® Founder.

"I found it totally transformational; a brilliant drug, which used in the right hands is incredible."

There followed a lively discussion involving people with experience prescribing isotretinoin, with Rupert concluding that there was a consensus in the room in favour of the drug's use. Drawing on his experience, he said he *"found it totally transformational; a brilliant drug, which used in the right hands is incredible."*

Treading an ethical line

The second question focused on when to intervene if someone hasn't mentioned a skin complaint, using the treatment of acne as an example. In this instance, it is supposed that when out in the community and doing ordinary activities, like shopping or going for a meal, people working in dermatology may see members of the public experiencing skin problems. The question put to the panel asked whether they would say something unsolicited about the treatments that might be available to them.

For Sarah, such a discussion raised issues of professional and personal boundaries, not to mention duty of care and any mental health discussions. She said: *"I'd probably want to [say something], but I would then worry about the effect my comment would have on their mental health."*

Managing itch

The next question focused on the best advice for managing itch—a common question with a myriad of possible answers.

Drawing on her experience as a community advanced nurse practitioner, Valerie Anderson said that the first thing to do is establish whether you're seeing a patient with an itch and a rash or if there's an itch without a rash. She warned about ensuring all diagnostic tests are carried out, especially if there is no rash, so that clinicians can rule out any systemic causes.

Regarding itch management, she said they prescribe a lot of menthol creams, which provide appropriate relief to patients. These are easy to use, and *"You can use them as often as you like, but I do always warn people not to use them extensively, all over their skin, initially, because of the risk of them feeling so cold that they get quite hypothermic and feel unwell,"* she said.

She next recommended getting a comprehensive history so that it is possible to understand what is driving the itch. She said that you need to *"make sure that you're working out what's happening in the home environment, what their jobs are, whether there's any potential for contact allergens to be involved, all those sorts of things."*

In summary, she said that for some patients, *"chronic itch can be worse than chronic pain"* due to its impact on sleep patterns and wellbeing, so she advised the audience to always be mindful of its impact.

Building on this, Lucy mentioned that they're starting to understand the impact of sleep deprivation and now know it is vitally important for mental health. Equally, all of the panellists discussed the benefits of habit reversal and cognitive behavioural therapy, and acknowledged it can play an important role in helping with the urge to itch. This led to discussion points being raised from the floor around the psychosocial aspects of itch, and the importance of exploring this with patients.

Advanced treatments under challenging circumstances

The final question considered the use of more advanced therapies in the management of facial eczema. Lucy took this to mean someone who had started on biologic treatment and used that premise as the basis for her answer.

Initially, Lucy said they would do any patch and allergy testing to understand if anything was driving the eczema, and advise on the use of topical treatments. In the case of really severe eczema, she said they may also consider a *"short blast"* of potent topical steroids to get the facial eczema under control.

If someone was coming to the clinic with severe facial eczema while on biologic treatment, however, she would remind them to ensure they're still doing the basic topicals as well. This is because, *"some patients assume when they start the newer treatments that they don't have to carry on, or that it's nice to have a break from all the creaming."*

"Some patients assume when they start the newer treatments that they don't have to carry on, or that it's nice to have a break from all the creaming."

In response, Sarah and Valerie discussed the need for gradually stepping down steroids, as well as discussing the use of steroids around the eyes. Valerie also pointed out that being meticulous in understanding where the eczema is appearing on the body can help you determine whether it's a contact allergy or something else.

The final question considered the skin changes that can occur during menopause and the value of using topical treatments.

Valerie responded by highlighting the fact that 46% of women attending menopause clinics report having some form of a skin issue, making this a hot topic and something which those working in dermatology should be aware of. She went on to say that, in menopause, the reduction of oestrogen leads to a reduction in the ceramides and the hyaluronic acids in the skin, which in turn reduces the skin barrier function, resulting in dry, scaly and/or itchy skin. Here, she advised against using products that might irritate the skin. She also suggested using products that moisturise and hydrate the skin to help prevent dryness.

For hot flushes, meanwhile, she said patients could consider using menthol-based preparation products, as these can provide immediate itch and heat relief. She also sign-posted to the Primary Care Dermatology Society, which, she said, has great guidelines around rosacea management.

Rash Talk® Featured Podcasts

Chaired by Teena Mackenzie – Consultant Nurse Dermatology, Lead Education and Development Nurse, BDNG.

Managing a Scaly Scalp with Sebco™ Scalp Treatment

Led by Dr Angelika Razzaque, GP and Associate Specialist in Dermatology

Sebco™

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- Characteristics of common scaly scalp conditions
- Recommended treatment routes
- The role of Sebco™ in treating scaly scalps
- Benefits of a combination treatment
- Partnering pomades with scalp steroids
- Tips for applying Sebco™ Scalp Treatment
- How patients can access Sebco™

Menthoderm® – Managing Itch with Menthol

Led by Valerie Anderson, Dermatology Advanced Nurse Practitioner.

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- Different types of pruritus and what conditions it can be caused by
- Menthol's role in helping to cool and soothe skin
- Menthoderm®: SLS-free menthol in aqueous cream
  - What is it for, what does it contain?
  - Its role in helping to alleviate itch
  - Benefits and guidance on using different strengths of menthol
  - How to break the itch-scratch cycle
  - Application advice

Latest Rash Talk® Dermatology Question Time® Webinar

Led by Sarah Copperwheat - Dermatology Specialist Nurse & Lead Nurse Prescriber, Lucy Moorhead - Nurse Consultant in Inflammatory Skin Disease, and Val Anderson - Dermatology Advanced Nurse Practitioner.

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Expert answers to your most pressing questions!

- When should a rash raise concern?
- How is AI impacting dermatology, and is it all positive?
- What is the best approach for managing comorbidities?
- Applying different potencies of topical steroids: where, why, and how
- Using topical treatments to help relieve menopausal skin symptoms
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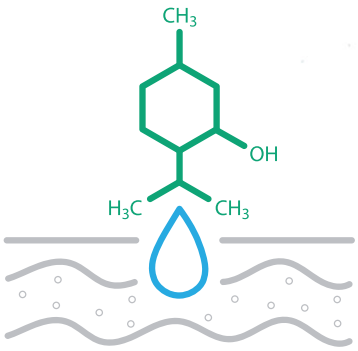

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MENAQ/02/0125 Date of preparation: January 2025

Issue 4 coming September 2025. Subscribe at rashtalk.co.uk