RASH TALK®
The Topical Dermatology Magazine
Founded in 1987... still proudly supporting dermatology today
Issue 04 / Spring 2026

In this issue:

Dermatology Through the Decades

The team behind Rash Talk®; 25 years and still counting

Rash Talk® is owned and produced by Derma UK Ltd. Dr Rupert Mason, founder of Rash Talk®, talks with Nic Pass, owner and co-founder of Derma UK, which is celebrating its 25th anniversary in 2026.

"Congratulations on your 25th anniversary, Nic. In recognition of this milestone, this issue of Rash Talk® stretches in time from the development of Sebco® to advances in teledermatology. Worryingly, you and I go back a lot longer than 25 years, and I remember well when you and the much missed Rob Grove, who sadly died a few years ago, decided to start a fledgling pharmaceutical company specialising in dermatology. It was a brave move and deserves recognition. But rather than dwell in the past, I have deliberately focused my questions on the future. An aspect that I know is uppermost in your mind, and will, I trust, be of interest to our readers.

Q: As a small company, Derma UK doesn't have the research and development (R&D) resources of a large multinational pharmaceutical company. What is your strategy with regard to the development and introduction of new therapies for dermatology?

Most multinational pharma companies focus on the explosion of highly effective but very expensive biologics to treat more severe dermatological conditions. Derma seeks to treat the majority of mild to moderate skin diseases with effective and proven value for money medicines, based upon known chemical entities delivered in novel formulations or delivery systems. Working with, listening to and responding to the needs of healthcare professionals (HCPs) has helped Derma to develop products and formulations to meet the needs of its patients.

Q: Have you seen the relationship between the pharma industry and clinicians change over the past 25 years?

The relationships remain solid, but access for communication has become more difficult; notably post COVID-19. All medical professionals face an increasing mountain of demand with resources not keeping pace. Available time during the working week has become squeezed and communication with industry has suffered as a consequence. It requires some innovative thinking to overcome the constraints of time and our re-birth of Rash Talk® is one example of trying to maintain communication via an easily accessible and entertaining medium.

Q: How do you see that relationship progressing over the next 25 years?

The rapid pace of change, both in the availability of dermatological treatments and the impact of AI and non face-to-face communications, will continue to change the landscape for medical professionals, patients and the pharma industry. It would be a struggle to forecast the changes in the type and scale of communication 10 years ahead, albeit face-to-face communication will always be needed to build both trust and long-term relationships; 25 years ahead... pass me the crystal ball!

Thank you, Nic. Good luck over the next 25".

Derma UK

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Abbreviated Prescribing Information for Sebco®
Please refer to the full Summary of Product Characteristics (SmPC) prior to prescribing.
Presentation: Ointment containing coal tar solution 12%, salicylic acid 2%, sulfur for external use 4%. **Uses:** Treatment of common scaly scalp disorders such as psoriasis, eczema, seborrheic dermatitis and dandruff. **Dosage:** Gently rub into scalp, leave in contact for approximately one hour. Wash out using warm water and mild shampoo. For severe scalp conditions, use daily for 3-7 days until improvement is obtained then intermittently as necessary. For less severe conditions such as dandruff use intermittently as necessary, e.g., once a week. If symptoms persist after 4 weeks consult your doctor. For children 6-12 years use under medical supervision only. Not recommended for use on children under six years. **Contraindications:** Skin infections of the scalp or known sensitivity to any of the ingredients. Use in Pregnancy and Lactation: Should not be used during pregnancy, except for short-term treatment of a small area of the scalp. To be used at the discretion of the prescribing doctor. **Warnings and Precautions:** Instruct patients not to smoke or go near naked flames - risk of severe burns. Fabric (clothing, bedding, dressings etc) that has been in contact with this product burns more easily and is a serious fire hazard. Washing clothing and bedding may reduce product build-up but not totally remove it. Avoid contact with eyes, and any areas of broken skin. Coal tar may stain clothes and jewellery. Remove or protect these items during treatment. **Side Effects:** May cause skin irritation, folliculitis and rarely photosensitivity. In the event of such a reaction, discontinue use. Prescribers should consult the Summary of Product Characteristics in relation to other side effects. **Pharmaceutical Precautions:** Store below 25°C. Do not refrigerate. Replace the cap after use and return tube to carton. Discard tube no later than 4 weeks after opening. **Package Quantities:** 100g tube, 40g tube. **Basic NHS Price:** 40g £11.53, 100g £16.99. **Legal Category:** GSL. **Marketing Authorisation Number:** PL 19876/0001. Full prescribing information is available on request. **Marketing Authorisation Holder:** Derma UK Ltd, The Toffee Factory, Lower Steenbergs Yard, Ouseburn, Newcastle upon Tyne NE1 2DF, UK. "Sebco" and "Derma UK" are registered Trademarks.
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Inside this Issue

Rupert Reflects

By Dr Rupert Mason
Rash Talk® founder

Different Times

Stephanie Gallard's tale of the journey of Sebco from extemporaneous Ung Cocois Co to licensed medicine triggered a memory of an earlier *Rash Talk®*. In 1991, I interviewed Dr David Williams, then retired dermatologist and ex-Dean of King's College Hospital, and asked him to recount his involvement with the development of griseofulvin, the first and for many years the only oral antifungal agent available. After the war, ICI (later to become Glaxo) chemists were working on potential antifungal agents and had identified griseofulvin's chemical structure. In August 1958, a paper published in *Nature* reported successful control of fungal infections in guinea pigs with oral griseofulvin.

The news was spotted by David Williams in London and Harvey Blank, a titan of American dermatology, in Miami. Independently, both immediately requested supplies of the drug for clinical use and, unencumbered by any ethical restrictions, started recruiting patients. Within a few weeks, the clinical results were clear to see.

The annual meeting of the American Academy of Dermatology that year was booked for December and an excited Blank planned to present his preliminary results at the meeting. He knew he had a showstopper and was determined to give it maximum impact on a world stage. Meanwhile, a patriotic Williams got wind of his plan and was not happy.

"Griseofulvin was a British drug and I was determined that we should be the first to break the news," he told me. The race to publish before the AAD had begun. *"I remember phoning the editor of* The Lancet *on the last Friday of November,"* Williams recalled. *"I explained the situation and he agreed to publish. He asked me to send him the paper, and I had to confess I hadn't written it yet. The next morning, Saturday, I sat down and wrote the paper and delivered it by hand to his house in London the next day. The journal published it on the following Thursday".*

Six days later, Harvey Blank presented his paper at the AAD to huge acclaim. It was even reported in *The Wall Street Journal*, but history rightly records that the first report on the clinical use of griseofulvin in fungal disease was by the British team of Williams, Marten and Sarkany in *The Lancet* of 6th November 1958.

From Apothecary Art to Approved Medicine

A 70-year-old scalp remedy worth learning from

By Dr Stephanie Gallard

Where it all began – a family of pharmacists

I registered as a qualified pharmacist in 1991 (having started as a Saturday dispenser in the mid-80s), trained as a doctor in the mid-90s, qualified as a dermatology GP with a special interest (GPSI) thereafter, and I have seen countless topical products come and go over 40 years. Not as many as my dad – who qualified as a pharmacist in the mid-1960s – or even my grandad, who was Chairman of Ayrton Saunders, a large pharmaceutical wholesaler in the 1950s.

My father and I were both trained to do "extemporaneous dispensing" – a now largely lost art usually involving a glass or marble slab, a large palette knife and an exhausting 30 minutes or so of blending what seemed like immiscible ingredients. As such, I can remember the exhausting task of making "12% LPC scalp ointment" – which, for the uninitiated, was 12% coal tar solution, or Liquor Picis Carb, in emulsifying ointment with a variety of other additions, including salicylic acid.

It was time consuming, very messy – and, I suspect, occasionally rather variable between various pharmacies, depending on how accurate you were with the balance, and the exact angle you held your measuring cylinder at to see the tare lines!

"My father and I were both trained to do "extemporaneous dispensing" – a now largely lost art usually involving a glass or marble slab, a large palette knife and an exhausting 30 minutes or so of blending"

Gallard family pharmacy - Kenny (Hoylake) Pharmacy in Merseyside

Stephanie's grandfather - Chairman of Ayrton Saunders pharmaceutical wholesaler 1950s

Stephanie aged 18 late 1980s - with father and pharmacist Mr Michael Gallard at family pharmacy

Sebco® Scalp ointment – a heritage but unbettered formula

The modern pharmacist of today does not need such a skill. 12% LPC scalp ointment is still a staple of the UK dermatology clinician's repertoire, but the formula is now instantly available off the shelf within seconds as a tube of Sebco® - a licenced medicinal product - guaranteeing easy dispensing and a safe, reproducible, quality-controlled product. As a bordering on pharmaceutical antique myself, I decided to investigate the history and provenance of that little white, red and black tube.

The original product was formulated by the St John Institute of Dermatology in the 1950s as Ung Cocois Co – containing 12% coal tar solution, 2% salicylic acid and 4% sulphur in a coconut oil base.

A combination treatment to increase adherence

The ingredients are peculiarly synergistic in dealing with an itchy flaky scalp – the coal tar is anti-itch, anti-inflammatory, antiseptic, and by slowing down skin cell turnover reduces scalp plaque and scale. Salicylic acid is markedly keratolytic, acting to loosen the scale already present. Sulphur is also keratolytic but also provides anti-fungal and antibacterial properties, handy as psoriatic plaques are usually colonised by *Malassezia furfur*. The coconut oil base itself is extremely moisturising on a dry flaky scalp, helping to soothe itch further. Furthermore, by leading to a decrease in scalp flake and scale, Sebco® helps other agents applied to the scalp – such as steroids, or vitamin D analogues – penetrate further when they are subsequently applied. As a combination product, it treats multiple problems at once, which explains its extensive product licensing for scalp psoriasis, eczema, seborrheic dermatitis and dandruff.

The formula is now instantly available off the shelf within seconds as a tube of Sebco® - a licenced medicinal product - guaranteeing easy dispensing and a safe, reproducible, quality-controlled product

Treat simply and easily OTC and primary care without referral

However, despite the long-term heritage as an effective prescription treatment, it remains a General Sales List product (GSL), meaning it can be sold over the counter by pharmacists and pharmacy assistants, as well as being advised for purchase by all members of the primary care team.

Practical tips from decades of use

Sebco® is licenced for use on the scalp for one hour – but my personal tips include leaving it on overnight where possible under a shower hat, as the warm occlusive atmosphere under the hat can aid penetration. I also tend to recommend using a coal tar shampoo on dry hair before getting in the shower to aid the detergent action. The PCDS website produces some excellent handy tips here! It also has a highly distinctive aroma, but it is always possible to apply a cosmetic conditioner on top afterwards.

As a combination product, it treats multiple problems at once

So, to summarise my professional career, I trained as a pharmacist in the late 80s, as a doctor in the mid-90s and qualified as a dermatology GPSI early this century(!), in the company of Sebco®. As a pharmacist, I have stuck labels on the box (never the tube!). As a GP, I have added it to repeat prescriptions when patients have been seen by dermatology. As a dermatology GPSI for 20 years, I have written hundreds, maybe thousands, of prescriptions of my own. Directly and indirectly, I am responsible for hundreds upon hundreds of clear scalps across the Northwest of England. Not a bad record to have.

Dr Stephanie Gallard

Stephanie has been a community GPSI in Dermatology for Liverpool University Foundation Trust Hospitals for 20 years. She lectures, locally and nationally, to upskill GPs and all other primary care professionals in dermatology, and works with many professional and educational organisations. She sits on the PCDS Executive, and is a medical adviser to the National Eczema Society.

Rash Talk® Symposium

Taking the Heat Out of Hot Dermatological Topics

Rash Talk® Live returned to the BDNG Conference with wide-ranging discussions on topical steroid withdrawal, mental health assessments, and more...

Following the success of Rash Talk®'s 2024 symposium at the BDNG Conference, host Rupert Mason once again convened with a panel of dermatology experts to tackle some tough questions as part of the 2025 event.

Joining Rupert this year were consultant dermatologist Tom King, from Sheffield. Melanie Sutherland, a nurse consultant with an interest in inflammatory disease at the Norfolk and Norwich Hospital, and Karen Stephen, a specialist nurse from Dundee with a passion for understanding the psychological impact of skin disease.

Impact of Skin Disease on Psychosocial Well-being

With the promise of an interactive session, Rupert got proceedings underway by asking Karen about the impact of skin disease on a person's psychosocial wellbeing, the mental health assessment required for drug monitoring, and the difficulty of integrating these issues into consultations.

Karen started by acknowledging the challenges she faces, but noted that having 30-minute consultations allows her the opportunity to ask much broader questions and to have a conversation with the patient. Karen also said that the psychological aspect of skin disease is now much more widely known about, drawing attention to talks on the menopause, hidradenitis suppurativa (HS) and hair loss, which had taken place over the conference days, and which had all covered the psychological burden.

One practical change highlighted by Karen was her shift in consultation style. *"To begin with, it was one that was a very medical model, involving a lot of questions to get to the root of a diagnosis and a treatment plan. Now there are lots more open questions. I start every consultation with, 'how have things been either since your referral or since I saw you last,' which opens the door for people to share a lot more."*

Karen also referred to several useful tools, including PHQ9 and GAD-7, but noted her preference for the SWIFT tool, a holistic assessment tool that covers *"all aspects of someone's life to get a full flavour of their psychosocial impact."*

Identifying lower leg cellulitis

The second question – a swing from the *"general to the specific,"* according to Rupert – led to a discussion on the identification and diagnosis of lower leg cellulitis.

Melanie took the reigns when answering this question and noted that when she started her dermatology career, cellulitis was often misdiagnosed because there were several differential diagnoses, and it didn't fall under dermatology's purview.

To aid a swift diagnosis, Melanie stressed the need for thorough history-taking and for professionals to ask the right questions. She also said that one tell-tale sign is that cellulitis is often unilateral rather than bilateral. The duration was also another strong indicator. *"If it's been there for weeks or months, it probably isn't acute cellulitis,"* she said. Other things to consider were systemic symptoms – signs of feeling unwell, fever, nausea, etc. – whether it was hot to the touch and whether it had spread over the limb.

Given the risks of sepsis, she said that, as a condition, it is probably over-treated with antibiotics. On this, Rupert asked whether knowing when to stop antibiotics was one of the key decisions, to which Melanie replied, *"Most people only need one to two weeks of antibiotics."*

Topical steroid withdrawal and the challenges for healthcare professionals

The next question in the session, on the emerging trend of topical steroid withdrawal, was tackled by Tom.

Setting the scene, he said, *"If you went back 10 years and asked a dermatologist about topical steroid withdrawal, they would say that it doesn't exist."* He also drew attention to the work being undertaken by the British Association of Dermatologists, which he said has a working group looking into it and has recently published a position statement on the topic.

In acknowledging the condition's complexity, he said it is probably multifactorial rather than a single condition. He said that topical steroids cause vasoconstriction and can cause redness and oedema, as well as exacerbating other skin problems like acne and rosacea. Furthermore, steroids have an anti-inflammatory effect, which means once treatment is stopped, conditions can flare up again.

Tom said that he believes patients are more at risk if they are using potent or very potent steroids over a large surface area for a longer period of time, and they are at higher risk if using them on areas like the face. *"The face is one of those areas that I'd be quite comfortable using steroids on for a week or two, but if you're using them for a longer period, then you need to think about other treatment strategies which don't involve steroids,"* he said.

On the flip side, however, Tom discussed the challenges professionals face when patients arrive with fixed ideas.

"You might have patients that tend to be younger, tend to be engaged in social media – TikTok, Instagram – they're reading a lot about this, and there is a lot of steroid phobia. Patients will say they've had these reactions when, when you actually ask them a few more questions, they've only used hydrocortisone for a few days. That isn't steroid withdrawal, that's that steroid phobia. So, our job is to try to untangle this quite complex thing.

"It's often quite emotional. I find it quite important to not be too confrontational with patients. You don't want to disengage them. They'll very quickly make an impression of you as a healthcare professional. If you come in and try to dismiss all of their concerns, they're not going to listen to you. So, acknowledging their concerns, and even if you don't think it's steroid withdrawal, trying to find alternative strategies."

Expert Panel:

Dr Thomas King –
Consultant Dermatologist and Lecturer

Melanie Sutherland –
Dermatology Consultant Nurse

Karen Stephen –
Dermatology Specialist Nurse

Dr Rupert Mason –
Chair: Rash Talk Founder and Retired GPER

Choice of emollients

The final question of the session focused on emollient choice, particularly for children with atopic dermatitis and very dry skin.

Tom again tackled this topic and said that, thinking back to medical school, in such cases, ointments would be considered the most effective. Yet, he said, referencing a 2022 paper from *The Lancet Child and Adolescent Health,* which found that no type of emollient – be that ointments, gels, creams and lotions – was more superior compared to the other.

He said that this paper has changed his practice, because *"no emollient would be effective if they're sat in the bathroom cupboard and not going on to the skin."* With that in mind, Tom said it was important that patients are offered choice, and that different emollients may be preferred depending on the setting – for example, at school or before bed.

With that, Rupert wrapped up an entertaining and informative session for an engaged audience. Rash Talk® Live once again return to the BDNG Conference later this year – we hope to see you there!

Rash Talk® Webinars & Featured Podcasts

Webinar: Dermatology Question Time® - Autumn 2025

Led by:
Sarah Copperwheat – Dermatology Specialist Nurse & Lead Nurse Prescriber
Lucy Moorhead – Nurse Consultant in Inflammatory Skin Disease
Val Anderson – Dermatology Advanced Nurse Practitioner

- Moisturiser for acne patients on isotretinoin
- Side effects of systemics – when to be concerned
- How long can patients use topical steroids as maintenance
- Enforcing recommended emollient use to parents
- Formulary choices: advising which emollient to use
- Treating eczema in children
- How to best manage non-compliant parents
- Best treatment for eyelid eczema

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Webinar: Dermatology Question Time® - Winter 2025

Led by:
Rececca Penzer-Hick – Chair: Dermatology Specialist Nurse and Lecturer
Dr Thomas King – Consultant Dermatologist and Lecturer
Polly Buchanan – Community Dermatology Nurse Practitioner
Julie Van Onselen – Dermatology Clinical Nurse Specialist and Lecturer
Dr Angela Goyal – GP with Extended Role in Dermatology

- Distinguishing facial rashes
- AI tools for analysing rashes/ inflammatory skin
- Support strategies for itchy skin at night
- Eczema and gut health
- Impact of mental health medications on the skin
- Twenty-nail dystrophy
- Plus much more!

Scan to watch the webinar

Podcast: 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®

Podcast: 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

Menopause and Lifestyle Medicine: A Holistic Approach to Women's Health

By Dr Maryam Rafique

Menopause is a natural biological transition defined by the permanent cessation of menstruation due to declining ovarian hormone production, predominantly oestrogen, but also progesterone and testosterone. Although the mean age of menopause in Caucasian women is approximately 51 years, this varies with ethnicity. Symptoms often begin during the perimenopause, which may start 4–12 years earlier, reflecting the gradual hormonal fluctuations that precede the final menstrual period.

Common symptoms and health implications

There are over 100 recognised menopausal symptoms, reflecting the diversity of oestrogen receptors throughout the body. Although produced by one organ, oestrogen exerts systemic effects, including playing a crucial role in cardiovascular health, bone density, cognition, memory and skin integrity. At least 75% of women experience symptoms related to oestrogen deficiency, with around 25% reporting severe and debilitating effects. Common symptoms include hot flushes, sleep disturbance, mood changes, and cognitive difficulties such as "brain fog", all of which can significantly impair quality of life.

Weight gain and increased central adiposity are frequently observed, contributing to greater cardiometabolic risk. The reduction in oestrogen also leads to skin thinning, reduced collagen and elasticity, impaired hydration, with some women developing new inflammatory or sensitivity-related skin conditions.

Adjunctive topical therapies, such as a menthol cream like Menthoderm®, may help soothe irritated skin and support thermoregulation following hot flushes or physical activity due to its cooling and soothing properties. This can improve sleep quality by reducing itching and also support mental wellbeing and stress management.

Common symptoms include hot flushes, sleep disturbance, mood changes, and cognitive difficulties such as "brain fog"

Lifestyle medicine as a framework for menopause care

Women will spend approximately one-third of their lives in the post-menopausal state, making a holistic, patient-centred approach essential. Lifestyle medicine (LM) provides an effective framework to support women through this transition by addressing the upstream causes of disease and empowering individuals to take ownership of their health through sustainable lifestyle change. LM focuses on modifying daily habits that influence long-term physical and psychological wellbeing and complements pharmacological treatments with evidence-based lifestyle interventions.

Menthol cream like Menthoderm® may help soothe irritated skin and support thermoregulation following hot flushes

The core principles of LM recognise the influence of socioeconomic, cultural, environmental, and psychological factors on health. They promote sustainable, personalised behavioural change through strategies such as motivational interviewing and goal setting, alongside the assessment of modifiable lifestyle factors - the six pillars. These pillars are interconnected and provide multiple opportunities for meaningful health improvement.

Applying the six pillars in clinical practice

Regular physical activity is essential for preserving muscle mass and bone density, both of which decline during menopause, helping to reduce the risk of osteoporosis and frailty. It also supports metabolic health, cognition and sleep quality.

Restorative sleep underpins cardiovascular health, cognitive function, and metabolic regulation.

Nutrition plays a central role in supporting hormonal balance, metabolic health, and inflammatory control, with a diet rich in whole foods, adequate protein, healthy fats, and fibre contributing to weight management and disease prevention.

Reducing harmful substances, such as alcohol, is crucial, as stress during menopause may increase reliance on maladaptive coping behaviours.

Stress management strategies, including cognitive behavioural approaches and biopsychosocial support models, are particularly valuable during menopause, a period often associated with significant hormonal, emotional, and social change.

Social connection remains vital, as strong relationships are consistently associated with improved physical and psychological health outcomes.

Women will spend approximately one-third of their lives in the post-menopausal state, making a holistic, patient-centred approach essential

The menopausal transition can be significantly improved through a holistic and individualised LM approach, empowering women to take ownership of their health and enhancing their quality of life.

References:

1. https://thebms.org.uk/wp-content/uploads/2023/06/20-BMS-TfC-Menopause-in-ethnic-minority-women-JUNE2023-A.pdf

Dr Maryam Rafique

Dr Maryam Rafique is an NHS General Practitioner at Killick Street Health Centre, supporting a diverse patient population across Islington, Camden, and Hackney; also working as a private GP at Refuah Medical Centre. With a focus on women's health, paediatrics, dermatology and lifestyle medicine, Dr Rafique aims to enhance patient outcomes while integrating evidence-based practices and fostering a culture of learning and support.

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(1) National Institute for Health and Care Excellence, Topical local antipruritics, http://bnf.nice.org.uk/treatment-summary/topical-local-antipruritics.html (last accessed January 2026)

(2) British National Formulary (BNF), LEVOMENTHOL, https://bnf.nice.org.uk/medicinal-forms/levomenthol.html (last accessed January 2026)

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Hair Loss – Tips on How to Assess and Manage Patients in Primary Care

By Dr Angela Goyal

Patients who present with hair loss are often very distressed and attend the clinician hoping for solutions. It can pose a challenging consultation, making it difficult to diagnose confidently and manage the distress of the patient.

The subject of alopecia encompasses many conditions; too many to cover in this article, so I will focus on top tips and 2 common conditions.

My top tips for these consultations are:

Being sensitive helps with patient anxiety.

A thorough history and examination help to demonstrate that you are taking their problem seriously.

Take time to explain the diagnosis and management.

Give a good explanation of prognosis - many patients worry they are going to go completely bald.

Assessment:

Aims of assessment are to:

- Ascertain if this is a scarring alopecia, as this will require an urgent referral to secondary care dermatology for management.
- Confidently diagnosing common causes of alopecia is important as these can be managed in primary care.

Pointers to a scarring alopecia:

- History
- pain or itching
- boils on the scalp – may indicate folliculitis decalvans or acne keloidalis nuchae
- ears affected – may indicate discoid lupus erythematosus.

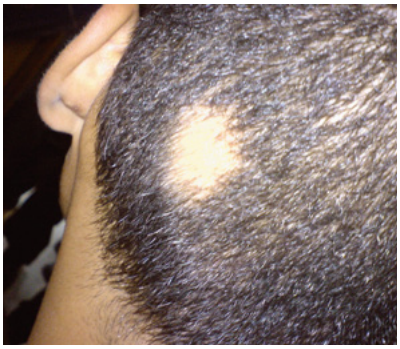
Examination:

- Atrophic, shiny appearance
- Loss of hair follicle openings
- Redness and scaling around hair follicles – may indicate lichen planopilaris or discoid lupus erythematosus
- Loss of eyebrows and scarring alopecia from the frontal scalp progressing backwards indicates frontal fibrosing alopecia.

Refer patients with scarring alopecia early to dermatology, as once hair follicles are lost, they will not grow back.

Common conditions that can be managed initially in primary care

Alopecia areata



Typically appears as a few small, smooth bald patches but it could present or rapidly become extensive involving anywhere up to the whole scalp and body. There is usually no pain or itch. There may be a trigger of a stressful period. The skin where hair is lost is smooth to touch and when you look closely with a dermatoscope, you will see exclamation mark hairs at the periphery if the alopecia is active. You may also see fine or white regrowth when it is in recovery, or you may see both together. Treat with a very potent topical steroid. Intralesional steroid injections of triamcinolone are used for non-extensive patchy hair loss. Full regrowth is common with alopecia areata when there are no or few poor prognostic indicators. When it is more extensive, refer for systemic treatments or the newly approved JAK inhibitors.

Telogen effluvium

The main complaint these patients present with is that their hair is shedding and much thinner all over. Even where there is not much for you to see on the scalp, they will notice a big difference in volume of the hair from previously.

There may have been physical or mental stress or childbirth a few months preceding the hair loss, so it is important to ask about this. They may not have itch or pain unless there is coexisting seborrheic dermatitis. On examination, the hair may be thinner at the parietal scalp than elsewhere. For these patients, you must check ferritin levels and treat until above 70, as iron deficiency is a common cause. Check full blood count (FBC), thyroid function tests (TFT) and possibly tissue transglutaminase (TTG [for coeliac screening]), and zinc also. This condition can achieve almost full regrowth if the stressor is identified and treated.

Other important conditions to know about include:

- Secondary syphilis – can present with diffuse or patchy hair loss, which is worth checking
- Tinea capitis
- Traction alopecia
- Male and Female pattern alopecia.

For more comprehensive guidance on alopecia please see https://www.pcds.org.uk/clinical-guidance/alopecia-an-overview

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.

Advances in Teledermatology

By Rebecca Thomas

Introduction

Teledermatology is one of the earliest and most successful applications of telemedicine, reflecting the visual nature of dermatological diagnosis. First reported in Norway in 1993, it has since evolved into an established component of modern dermatology services.

For clarity, teledermatology refers to the remote assessment of skin conditions using clinical information and images transmitted digitally for specialist review. This differs from dermoscopy, which is a diagnostic technique using a handheld device to visualise subsurface skin structures. In contemporary practice, dermoscopic images are often captured and incorporated into teledermatology pathways, enhancing diagnostic accuracy.

The COVID-19 pandemic accelerated the adoption of teledermatology worldwide. What began as a necessity to maintain access to care while minimising face-to-face contact has now become a sustainable and effective model, particularly through store-and-forward teledermatology, which is widely embedded across UK primary and secondary care pathways.

Advances in teledermatology

Key developments over the past decade include:

- High-resolution clinical and dermoscopic imaging, improving diagnostic confidence for both pigmented and non-pigmented lesions
- Secure, web-based platforms enabling asynchronous specialist review
- Expansion into community settings, including GP practices, pharmacies, and outreach clinics
- Enhanced triage pathways for suspected skin cancer and selected inflammatory dermatoses.

Collectively, these advances have improved access to specialist opinion, supported earlier diagnosis, and reduced unnecessary referrals to secondary care.

Teledermatology and NICE guidance

NICE recognises teledermatology as a valuable tool when appropriately implemented. Current guidance supports:

- Use of teledermatology for triage and advice and guidance, particularly for suspected skin cancer
- Acquisition of high-quality clinical and dermoscopic images by trained healthcare professionals
- Robust governance frameworks, data security, and clear referral pathways
- Integration with existing urgent cancer pathways, including the two-week wait system.

Importantly, NICE emphasises that teledermatology should support, not replace, face-to-face assessment where clinically indicated.

By Rebecca Thomas

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Case example: Community teledermatology using a digital imaging system

As part of a community teledermatology service, a digital imaging system (DermoSight) was introduced to support standardised image capture and reporting. The system comprised a dedicated camera device and secure software, operated by trained healthcare professionals.

During consultations, clinicians obtained a structured clinical history alongside high-quality macroscopic and dermoscopic images, captured using standardised protocols. Images and clinical data were uploaded to a secure platform for asynchronous dermatologist review. Management recommendations included advice and guidance, treatment planning, referral to community services, or escalation to secondary care when appropriate.

Figure 1. Digital imaging system capturing macroscopic and dermoscopic images. Image courtesy of ScreenCancer UK.

This model supported the assessment of both skin lesions and inflammatory dermatoses, enabling early identification of lesions requiring urgent review while safely managing low-risk conditions in the community.

Education and training

Safe and effective teledermatology relies on appropriate education and governance. Healthcare professionals involved in image capture must be competent in:

- Clinical and dermatological photography
- Dermoscopic image acquisition
- Recognition of red-flag features
- Understanding referral criteria and escalation thresholds.

Ongoing training and audit are essential to maintain diagnostic accuracy and patient safety.

Findings and clinical implications

A key strength of the service was the use of dedicated imaging equipment, allowing consistent macroscopic and dermoscopic image capture. This standardisation supported reliable remote assessment and improved diagnostic confidence.

By contrast, teledermatology pathways relying on non-standardised or patient-submitted images often produce variable image quality, which may affect clinical decision-making and referral thresholds.

These findings highlight the value of structured clinical information combined with standardised imaging in supporting appropriate escalation of suspected malignancy, meeting cancer waiting-time targets, and optimising NHS resource utilisation. High levels of patient and staff satisfaction were reported.

Conclusion

Teledermatology has evolved from an innovative adjunct to a core component of modern dermatology services. Advances in imaging, secure digital platforms, and integrated referral pathways have demonstrated clear benefits for patients and healthcare systems. When implemented in line with NICE guidance and supported by robust training and governance, teledermatology can enhance diagnostic efficiency, improve access to specialist care, and reduce pressure on secondary services.

Supporting Evidence and Guidance

1. ScreenCancer UK – Provides education, clinical support, and service development resources focused on early cancer detection, screening pathways, and workforce training. https://screencancer.com
2. DeepX Health – Offers evidence-based digital health insights and resources related to dermatology innovation, artificial intelligence, and telemedicine applications in clinical practice. https://www.deepxhealth.com
3. British Association of Dermatologists (BAD) – Provides professional guidance on teledermatology services, including clinical standards, governance considerations, and best practice recommendations. https://www.bad.org.uk/clinical-services/teledermatology
4. National Institute for Health and Care Excellence (NICE) – Health Technology Guidance (HTG746) outlining evidence-based recommendations for the use of digital technologies in dermatology pathways. https://www.nice.org.uk/guidance/htg746

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(1) British National Formulary (BNF), LEVOMENTHOL, https://bnf.nice.org.uk/medicinal-forms/levomenthol.html (last accessed January 2026)

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