Dermatology consult guide

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In a hurry? Make sure you know

- Is the patient clinically well?
- Is there a fever +/- an acute rash?
- Is there mucosal surface involvement? (eyes, mouth, genitals)
- Is there blistering, erosions or ulcers? (epidermal detachment)
- Is the patient's pain out of proportion to the physical exam?
- Is the dermatological concern an acute or chronic problem?
    - If chronic -> consider outpatient referral.
- Has the patient been seen by a dermatologist (publicly or privately) previously?
    - If yes -> who, when, why, are there previous investigations and an existing treatment plan for this concern, has the patient been taking the prescribed treatment?

What history should JMOs know/collect?

- Patient demographics
- Why is the patient in hospital?
- When and where (anatomically) did the rash start?
    - Is there mucosal surface involvement? (eyes, mouth, genitals)
- How has the rash evolved?
- Rash description
- Skin symptoms?
    - Itch, burning, pain?
- Systemic symptoms?

    - Fevers, headaches, arthralgias, myalgias, fatigue, weight loss, swollen lymph glands?
    - Treatment to dermatological concern thus far?
- Drugs
    - Patient's medications, including topicals, OTC and complimentary medicines and any changes over last 2 months.
    - Medications received whilst inpatient.
- Allergies & specific reaction (where appropriate):
    - Sick contacts & recent travel (where appropriate).
    - Personal and family history of melanoma +/- non-melanoma skin cancers (where appropriate).
    - Previous/current immunosuppression? (where appropriate)
    - Personal history of malignancy.

What examinations and investigations should JMOs perform/collect results of?

- Skin exam
    - lesion morphology – flat (macule/patch), raised (papule/plaque/nodule), filled (pustule/vesicle/bullae), crust, scale, excoriation, erosions, ulcers, etc.
    - lesion texture – palpable, soft, firm, blanchable, compressible, tender, indurated, atrophied, etc.
    - colour – erythematous, blue, black, brown, etc.
    - configuration – targetoid, linear, dermatomal
    - distribution – flexural surfaces, truncal, acral, symmetrical, sun exposed sites, localised, widespread
    - including mucous membranes, palms and soles
- Lymph node exam
- Skin swab for bacterial MCS, viral PCR / NAT (where appropriate)
- Skin scrapings for mycology (where appropriate)
- Leukocyte and eosinophil count

What additional information would impress you?

- Completed drug chart (e.g. documentation of all drugs patient has been exposed to over the last 3 to 6 months, particularly noting any antibiotics, anticonvulsants, NSAIDs and sulpha drugs)
- Patient's ethnicity
- Personal and family history of autoimmune diseases
- Abdominal exam for hepatosplenomegaly

- Nail involvement

What are common mistakes/omissions made by JMOs?

- Not examining the patient (look, feel).
- Not ascertaining whether the patient is known to a dermatologist and if there is a current plan in place:
    - including private dermatologists, and liaising with them if this is a chronic problem.
- Mistaking the causative drug responsible for a drug reaction to be the one started a day or two before the rash onset. Drug reactions typically occur from drugs commenced 10 to 14 days prior to rash onset.
- Inform dermatology registrar if finding it difficult to describe skin exam with correct terminology, try using simple terminology for what you can see and feel.
- Not considering outpatient referrals for chronic dermatological concerns.
- Sending bacterial MCS swabs to investigate for viruses – a tip to remembering swabs, **B**lue for **B**acterial (medium: amies gel), green for viral (medium: VTM bactericidal).

Helpful Resources

Hospital Guidelines
DermNetNZ – www.dermnetnz.org/
Australasian College of Dermatologists – www.dermcoll.edu.au/

Tags: #allergy,#consult guide,#dermatologist,#dermatology,#rashes,#referral,#requesting a consult,#skin exam