
	<b>Nurse Practitioner CLINICAL PRACTICE GUIDELINE Skin Disorders – Rash</b>	
	<b>Scope</b>	<b>Outcomes</b>
<b>Nurse Practitioner</b>	<ul style="list-style-type: none"> <li>• Patients presenting with blanching non petichial rash</li> <li>• Patients presenting with minor skin inflammation</li> </ul>	Identify patients suitable for NP CPG.
<b>GP or ED</b>	<ul style="list-style-type: none"> <li>• Airway, respiratory or circulatory compromise</li> <li>• Angioedema face, hands and feet</li> <li>• Children &lt; than 12 months of age</li> <li>• Immunocompromised</li> <li>• Altered conscious state including effects of drugs / alcohol</li> <li>• History consistent with collapse</li> </ul>	Identify patients not suitable for NP CPG and redirect to GP or ED.
	<b>Assessment and Interventions</b>	<b>Outcomes</b>
<b>Primary Survey</b>	<ul style="list-style-type: none"> <li>• Airway</li> <li>• Breathing</li> <li>• Circulation</li> <li>• Disability</li> <li>• Environment</li> </ul>	Abnormal survey: Refer to ED immediately
<b>History</b>	<ul style="list-style-type: none"> <li>• Onset of rash</li> <li>• Associated illness and onset of symptoms, progression of symptoms, distribution</li> <li>• Treatment given pre attendance</li> <li>• Possible causes – medications, chemicals, infections, foods, bites or stings, travel Hx</li> <li>• Past medical history / medications</li> <li>• Allergies / immunisations</li> </ul>	Identify any patient not suitable for NP and refer to GP or ED.
<b>Focused Clinical Assessment</b>	<b>Assess and describe lesions</b> Classify by: <ul style="list-style-type: none"> <li>• Location</li> <li>• Blanching or non-blanching</li> <li>• Localized or generalized,</li> <li>• Pruritic or non pruritic</li> <li>• Vesicular, macular, papular, or urticarial</li> <li>• Exudate or crusting</li> <li>• Tenderness or pain</li> <li>• Fissuring</li> <li>• Temperature</li> <li>• Involvement of nail matrix</li> </ul>	Determine the extent of the problem. Identify patients not suitable for NP CPG exit and refer to GP or ED.
<b>Pain Assessment</b>	<ul style="list-style-type: none"> <li>• Pain Scale</li> </ul>	Determine the need for analgesia.

	Working diagnosis and Investigations	Outcomes
<b>Imaging</b>	<ul style="list-style-type: none"> <li>• Not usually required</li> </ul>	
<b>Pathology</b>	<ul style="list-style-type: none"> <li>• If morbilliform rash and clinically suspicious measles, mouth swab and urine for PCR indicated and Public Health Unit should be notified</li> <li>• <b>Impetigo:</b> Cultures of the lesions are required if initial treatment has failed. Swabs should be obtained from beneath the lifted edge of a crusted lesion</li> <li>• <b>Tinea / ringworm:</b> Skin scrapings from edge of lesion for M&amp;C prior to treatment to confirm diagnosis – exclude discoid eczema</li> <li>• <b>Vaginal Candidiasis:</b> swabs if infection recurrent or refractory disease</li> </ul>	Determine cause of infection which can exacerbate underlying skin disorder.
Interpretation of Diagnostic Features and Management Decisions		Outcomes
<p><b>Candidiasis:</b> Usual affected areas; the lining of the mouth, the groin, the armpits, the skin under the breasts in women, and the skin folds of the stomach. Bright red rash, sometimes with softening and breakdown of skin. Small pustules may appear, especially at the edges of the rash, and the rash may itch intensely or burn.</p>  <p><b>Paronychia:</b> infection of the nail fold by S.aureus often complicated by candidiasis.</p>	<p>NP review with view to discharge</p> <ul style="list-style-type: none"> <li>• Miconazol 2% oral gel for oral candidiasis QID</li> <li>• Nystatin Oral drops: infants / children / adults: 1ml 6 hourly.</li> <li>• Topical clotrimazole for skin lesions bd for 7-10 days</li> <li>• Corticosteroid creams used with antifungal creams may be used to quickly reduce itching and pain</li> <li>• Oral antifungal indicated for extensive disease or if the patient is systemically unwell – refer to GP</li> <li>• Patient education / health promotion – identify predisposing factors and eliminate</li> <li>• Exclude diabetes</li> <li>• Yeast infection facilitated by warm, moist environments</li> <li>• Keep the skin dry</li> <li>• Talcum powder with nystatin may help prevent recurrence</li> </ul> <ul style="list-style-type: none"> <li>• Topical clotrimazole for skin lesions bd for 7-10 days</li> <li>• Corticosteroid creams used with antifungal creams may be used to quickly reduce itching and pain</li> </ul>	Patient identified as suitable for NP CPG treated appropriately and discharged safely.



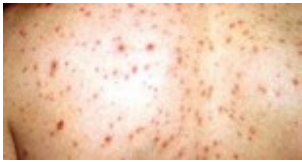

**Vaginal Infection;**  
white or yellow  
cheese like  
discharge from the  
vagina and burning,  
itching, and redness  
along the walls and  
external area of the  
vagina.


- used to quickly reduce itching and pain
- Oral antifungal indicated for extensive disease or if the patient is systemically unwell – refer to GP
- Patient education / health promotion – identify predisposing factors and eliminate
- Exclude diabetes
- Yeast infection facilitated by warm, moist environments
- Keep the skin dry
- Talcum powder with nystatin may help prevent recurrence
  
- Topical clotrimazole for skin lesions bd for 7-10 days
- Corticosteroid creams used with antifungal creams may be used to quickly reduce itching and pain
- Patient education / health promotion – identify predisposing factors and eliminate
- Yeast infection facilitated by warm, moist environments
- Keep the skin dry
- Talcum powder with nystatin may help prevent recurrence
  
- Vaginal cream; 1 applicator of clotrimazole into the vagina daily at bed time until contents of tube completed
- Vaginal pessary; 1 pessary into the vaginal daily at bed time until contents of pack completed
- Patient education / health Fungal infection facilitated by warm, moist environments the sharing of towels, clothing and toiletries



**Chickenpox:  
(Herpes Varicella)**  
May be asymptomatic.  
Symptoms; mild fever, anorexia and lethargy followed by eruption of the rash over 3 – 5 days.  
The rash consists of crops of itchy papules that quickly become vesicular and then crust over


- NP review with view to discharge
- Exclude rare complications; bacterial super infection, pneumonia, encephalitis, cerebellitis, hepatitis, arteritis and Reye syndrome. Refer to ED
  - Pregnant or early post partum women require urgent specialist review if not immune
  - Symptomatic treatment with Calamine lotion and cool compresses
  - Consider oral antihistamines at night to improve sleep if not contraindicated
  - Discuss infection precautions; infectious from 1-2 days before onset of rash until the



Patient identified as suitable for NP CPG treated appropriately and discharged safely.



<p>after the vesicles have ruptured. Lesions appear more concentrated over the face and trunk.</p> 		
<p><b>Dermatitis / Eczema:</b> Skin inflammation by irritation or allergic reaction; itching is usually severe; the rash varies from a mild, short-lived redness to severe swelling and clustered papulovesicles. Commonly, the rash contains tiny blisters.</p> 	<p>NP review with view to discharge</p> <ul style="list-style-type: none"> <li>• Remove triggers / irritants</li> <li>• Use soap substitutes</li> <li>• Bath in tepid not hot water, bath soak 10-15min daily to QID with bath oil or colloidal oatmeal</li> <li>• Moisturise regularly with Urea 10% or dimethicone</li> <li>• Topical Hydrocortisone 1% applied sparingly bd up to 5 days</li> </ul>	<p>Patient identified as suitable for NP CPG treated appropriately and discharged safely.</p>
<p><b>Erythema infectiosum:</b> Human parvovirus B19 Symptoms begin approx 4-14 days after infection. May have a low fever and feel mildly ill for a few days. Develop red cheeks that often look like they have been slapped as well as a rash, on the arms, legs, and trunk but not usually on the palms or soles. The rash can be itchy and consists</p>	<p>NP review with view to discharge</p> <ul style="list-style-type: none"> <li>• Treatment is aimed at relieving the symptoms</li> <li>• Antipruritics; topical crotamiton rubbed into affected areas 2-3 times daily</li> <li>• Fever is treated with paracetamol or ibuprofen</li> </ul>	<p>Patient identified as suitable for NP CPG treated appropriately and discharged safely.</p>



<p>of raised, blotchy red areas and lacy patterns, particularly on areas of the arms not covered by clothing, as the rash may be worsened by exposure to sunlight. The rash usually lasts 5-10 days. The rash may temporarily reappear in response to sunlight, exercise, heat, fever, or emotional stress over several weeks. In adolescents, mild joint pain and swelling may remain or come and go for weeks to months.</p> 		
<p><b>Erythrasma:</b> Corynebacterium Affects mainly adults, particularly obese middle-aged women or those with diabetes or living in the tropics. Often appears in areas where skin touches skin, such as the webs of the toes, genital area, armpits, skin folds, under the breasts or on the abdomen, perineum. Irregularly shaped pink or brown patches that may turn into fine scales. May be confused with a fungal infection;</p>	<p>NP review with view to discharge</p> <ul style="list-style-type: none"> <li>• Erythromycin <b>Adults / Children &gt; 12 years:</b> 250mg 6 hourly. Or 500mg 12 hourly</li> <li>• <b>Children &lt;12 years:</b> 30-50mg/kg/day 6 hourly</li> <li>• Take 1-2 hours before food</li> <li>• For 10 days</li> <li>• Antibacterial soaps may also help</li> <li>• Antifungal creams such as miconazole may be helpful if yeast or fungus is present in the affected areas</li> </ul>	<p>Patient identified as suitable for NP CPG treated appropriately and discharged safely.</p>

<p>however skin glows coral-red under an ultraviolet light.</p> 		
<p><b>Impetigo:</b> Staphylococcus aureus +/- Streptococcus pyogenes Lesions typically begin with a single 2 – 4 mm erythematous macule, which rapidly turns into a vesicle or pustule, which ruptures leaving a honey coloured crusted exudate. Spread to adjacent skin can be rapid. May be Bullous - blisters that erode rapidly leaving a brown crust.</p> 	<p>NP review with view to discharge</p> <ul style="list-style-type: none"> <li>• Soap and water OR</li> <li>• Aluminium acetate 13% solution diluted 1:20 to 1:40 before use OR</li> <li>• Potassium permanganate 0.1% solution diluted 1:10 before use, topically, 8-hourly to remove crusts</li> </ul> <p>PLUS</p> <ul style="list-style-type: none"> <li>• Topical 2% Mupirocin ointment tds for up to 10 days for limited disease</li> <li>• Oral antibiotics are indicated for more extensive disease and/or if the patient is systemically unwell</li> <li>• Patient education/ health promotion – especially cross infection</li> <li>• Emollient therapy to restore epidermal barrier</li> <li>• School/Day care exclusion until lesions are healed and crusted over and no longer weeping OR until 24 hours after commencing antibiotic treatment. Lesions should be covered</li> </ul>	<p>Patient identified as suitable for NP CPG treated appropriately and discharged safely.</p>
<p><b>Lice:</b> Pediculosis Severe itching in the infested area. Children may hardly notice head lice or may have only a vague scalp irritation. Female lice lay shiny grayish white eggs (nits) that can be seen as tiny globules firmly stuck to hairs near their</p>	<p>NP review with view to discharge</p> <ul style="list-style-type: none"> <li>• Permethrin 1%</li> <li>• Shampoos and creams containing pyrethrins plus piperonyl butoxide applied for 10 minutes then rinsed out</li> <li>• Repeated in 7-10 days to kill newly hatched lice</li> <li>• Removal requires a fine-tooth comb often packaged with the medication</li> <li>• Wet combing every 2 days increases effectiveness</li> <li>• Boil hair combs 30 seconds after use</li> <li>• If there are no nits within 5mm of the scalp, the person does not have any live lice</li> </ul>	<p>Patient identified as suitable for NP CPG treated appropriately and discharged safely.</p>

<p>base. Adult body lice and their eggs also may be found in the seams of clothing worn close to the skin. Public lice can be found by close inspection.</p> 	<ul style="list-style-type: none"> <li>• Nits of body lice are destroyed by throwing away infested clothing or decontaminating it by thorough laundering or dry cleaning</li> <li>• Children sent back to school once treatment has begun</li> </ul>	
<p><b>Roseola infantum:</b> herpesvirus 6 Usually children between 6 months and 3 years of age. Symptoms begin approx 5-15 days after infection. A fever 39.4C - 40.5C begins abruptly and lasts for 3-5 days. 5 to 15% of children may have seizures as a result of high fever. The child is usually alert and active. A few children have a mild runny nose, sore throat, or an upset stomach. The lymph nodes at the back of the head, the sides of the neck, and behind the ears may be enlarged. The fever usually disappears on the 4th day. About 30% of children develop a rash within a few hours to, at most, a day after the temperature falls. The rash is red and flat, but it may have raised areas, mostly</p>	<p>NP review with view to discharge</p> <ul style="list-style-type: none"> <li>• Antibody tests and a culture of the virus are rarely needed; however serology can be useful to differentiate from other viral infections causing rash</li> <li>• Fever is treated with paracetamol or ibuprofen</li> </ul>	<p>Patient identified as suitable for NP CPG treated appropriately and discharged safely.</p>

<p>on the chest and abdomen and less extensively on the face, arms, and legs. The rash is not itchy and may last from a few hours to 2 days.</p> 		
<p><b>Scabies:</b> Sarcoptes scabiei Intense itching, usually worse at night. The burrows of the mites are often visible as very thin lines up to 1.5cm long, sometimes with a tiny bump at one end. Sometimes, only tiny bumps are seen, many of which are scratched open because of the itching. The burrows can be anywhere on the body except the face. Common sites are the webs between the fingers and toes, the wrists, ankles, buttocks, nipples, and, in males, the genitals.</p> 	<p>NP review with view to discharge</p> <ul style="list-style-type: none"> <li>• Permethrin 5%</li> <li>• Left on the skin overnight and then washed off. Repeated in 7 days.</li> <li>• Asymptomatic persons require only 1 treatment</li> <li>• itching may persist for 2-4 weeks due to continued allergic reaction to the mite bodies</li> <li>• Itching may be treated with mild corticosteroid cream and antihistamines taken by mouth</li> <li>• The skin irritation and deep scratches may lead to a bacterial infection, which may require oral antibiotics.</li> <li>• Family members and people who have had close physical contact with a person with scabies should be treated as well</li> <li>• Clothing, bedding and soft toys used during the preceding few days should be washed in hot water and dried in a hot dryer or dry cleaned and retreated the day following treatment</li> </ul>	<p>Patient identified as suitable for NP CPG treated appropriately and discharged safely.</p>
<p><b>Shingles (Herpes Zoster)</b> Unilateral pain 3–5 days prior to eruption of vesicular or bullous eruptions</p>	<p>NP review with view to discharge Exclude complications:</p> <ul style="list-style-type: none"> <li>• Postherpetic neuralgia (pain persisting at least 1 month after rash has healed), ocular involvement, meningoencephalitis, superinfection, hepatitis, pneumonitis,</li> </ul>	<p>Patient identified as suitable for NP CPG and discharged safely</p>

<p>limited to a dermatome. Crusting of lesions occur over following 3 weeks. Malaise, fever or headache in early stages.</p> 	<p>peripheral motor weakness, cranial nerve syndromes – palsies,</p> <ul style="list-style-type: none"> <li>• Symptomatic treatment of prodromal stage – fever, headache, malaise</li> <li>• Wet dressings – saline/water 30 – 60 mins</li> <li>• 4 – 6 times daily may relieve irritation and pain</li> <li>• Calamine lotion may help relieve discomfort</li> <li>• Analgesia - see formulary</li> <li>• Antivirals in first 72 hours can be effective in accelerating healing and decreasing pain in patients &gt; 12 yrs. Consider antivirals if &lt; 24 hrs after onset of rash, refer to GP</li> <li>• Fluroscein staining/Slit lamp exam if lesion on face. Refer ophthalmic zoster urgently</li> <li>• Education and health promotion, especially infectious nature (i.e. risk of chickenpox if not exposed previously, from close contact)</li> </ul>	
<p><b>Tinea Corporis: (Ringworm)</b> Superficial fungal infection of the skin, other than on the hands, feet, scalp, face or groin. Well-demarcated scaly, annular, erythematous plaques or papules on the skin. Lesions may have gradually enlarged over time. The borders represent the active edge of the lesion and may be raised or scaly.</p>  <p><b>Tinea Pedis: (Athletes Foot)</b> Scaling with or without redness and itching. Scaling may involve a small area</p>	<p>NP review with view to discharge</p> <ul style="list-style-type: none"> <li>• Topical clotrimazole or miconazole tds for 2-4 weeks for limited disease</li> <li>• Oral antifungal indicated for extensive disease or if the patient is systemically unwell – refer to GP</li> <li>• Patient education / health promotion – especially cross infection</li> <li>• Fungal infection facilitated by warm, moist environments; public showers and swimming pools, the sharing of towels, clothing and toiletries, bare feet in public bathrooms</li> <li>• Ensure good personal hygiene i.e. drying between the toes, discard old shoes</li> <li>• School / Day care exclusion until lesions are healed</li> </ul> <ul style="list-style-type: none"> <li>• Topical clotrimazole tds for 2-4 weeks for limited disease</li> <li>• Oral antifungal indicated for extensive disease or if the patient is systemically unwell – refer to GP</li> <li>• Patient education / health promotion –</li> </ul>	<p>Patient identified as suitable for NP CPG treated appropriately and discharged safely.</p>

<p>or the entire sole of the foot. May be severe, with painful fissuring of the skin and blistering. May lead to bacterial infection.</p>  <p><b>Tinea Cruris: (Jock Itch)</b> More common in men than in women. Begins in the skinfolds of the genital area and may spread to the upper inner thighs. Usually the scrotum is not involved (unlike in yeast infection). The rash has a scaly, pink border.</p> 		
<p><b>Rashes accompanied by fever</b></p>	<p>NP review with view to discharge</p> <ul style="list-style-type: none"> <li>• Differential diagnosis Meningococcal disease exit CPG urgent referral to ED</li> <li>• Treatment is often just supportive.</li> <li>• Patient education and health promotion</li> <li>• Reassurance for parents</li> </ul>	<p>Patient identified as suitable for NP CPG treated appropriately and discharged safely.</p>
	<p><b>Patient Discharge Education</b></p>	<p><b>Outcomes</b></p>

<b>Follow up / When to see GP</b>	<ul style="list-style-type: none"> <li>• No improvement in 2-3 days of treatment</li> <li>• Extension of rash</li> <li>• Development of fever or general deterioration in condition</li> <li>• Pain associated with rash</li> <li>• <b>Scabies:</b> follow up 2 weeks &amp; 4 weeks to assess treatment/cure</li> </ul>	Ensure patient understands treatment and instructions for follow up. Patient is safe for discharge home.
<b>Patient Education</b>	<ul style="list-style-type: none"> <li>• Inform patient about treatment plan and importance of medical intervention and follow up</li> <li>• Lifestyle modification</li> </ul>	Optimise awareness Optimise compliance.
<b>Medication Instructions</b>	<ul style="list-style-type: none"> <li>• Verbal instructions from NP and as directed per prescription / pharmacist</li> </ul>	Optimise awareness Optimise compliance Optimise eradication of infection and prevent recurrence.
<b>Certificates</b>	<ul style="list-style-type: none"> <li>• Absence from work / school certificates</li> </ul>	Appropriate documentation completed.
<b>Letters</b>	<ul style="list-style-type: none"> <li>• Letter to GP as per patient consent for</li> </ul>	Appropriate documentation completed.
	<b>Medication</b>	<b>Outcomes</b>
All medication will be stored, labelled and dispensed in accordance with legislation. Analgesia given appropriate to allergies and current medications and medical history.		
<b>Simple analgesia S2 Mild</b>	<p><b>Paracetamol 500mg</b> 1 to 2 tablets 4–6 hourly Max 8 tablets in 24 hours</p> <p><b>Children 12 years:</b> ½ to 1 tablet 4-6 hourly Max 4 tablets in 24 hours</p> <p><b>Children &lt;1 year: Paracetamol drops</b> 1-3 months (4-6kg) 0.6-0.9ml 3-6 months (6-8kg) 0.9-1.2ml 6-12 months (8-10kg) 1.2-1.5ml 1-2 years (10-12kg) 1.5-1.8ml 4-6 hourly, max 4 doses/24 hours</p>	Patients given analgesia appropriate to allergies, current medications and past medical history.

<p><b>Combined analgesia Paracetamol &amp; Codeine S3</b></p>	<p><b>Paracetamol 500mg &amp; Codeine Phosphate 8mg</b>  <b>Adults:</b> 1 to 2 tablets 4–6 hourly  Max 8 tablets in 24 hours  <b>Children 12 years:</b> ½ to 1 tablet 4-6 hourly  Max 4 tablets in 24 hours</p> <p><b>Children &lt; 12 years</b>  <b>Painstop:</b> 6 hourly max 4 doses in 24 hours  1-2 years (10-12kg) 5-6mls  2-3 years (12-14kg) 6-7mls  3-4 years (14-16kg) 7-9mls  4-5 years (16-18kg) 9-10mls  5-6 years (18-20kg) 10-11mls  6-7 years (20-22kg) 11-12mls  7-8 years ( 22-24kg) 12-13mls  8-9 years (25-28kg)13-15mls  9-10 years (28-32kg) 15mls</p>	<p>Analgesia requirements determined by ongoing assessment of pain and adequate analgesia provided. Patients with excessive pain or pain unrelieved by analgesia require review by GP.</p>
<p><b>NSAIDS S4 Moderate</b></p>	<p><b>Add to paracetamol if still in pain:</b></p> <p><b>Ibuprofen</b> 200-400mg 4-6 hourly  Max 6 tablets in 24 hours</p> <p><b>Children &gt;12 years:</b> 200-400mg 4-6 hourly  Max 6 tablets in 24 hours</p>	
<p><b>Antihistamine S2</b></p>	<p><b>Promethazine:</b>  <b>Adults:</b> PO 25mg 8-12 hourly max 100mg/day  <b>Children 6-12 years:</b> PO 10 mg 8-12 hourly max 25mg/day</p> <p><b>Contraindicated for children &lt; 2 yrs old</b></p> <p><b>Cetirizine (Zyrtec) Non drowsy:</b>  <b>Adults / Children &gt;12 years:</b> 10 mg once daily may increase to 20mg once daily  <b>Children 6-12 years:</b> 5mg twice daily</p>	<p>Patients given medications appropriate to allergies, current medications and past medical history. Medication requirements determined by ongoing assessment of symptoms.</p>

<b>Steroid S4</b>	<b>Non infected inflammatory skin conditions:</b> Dermatitis, eczema, psoriasis <b>Hydrocortisone 1%:</b> topically, 2-4 times daily up to 5 days, with 2 days break if continuing treatment in between (not for use in young children)	
<b>Scabicides / Pediculicides (Unscheduled)</b>	<b>Scabies: Permethrin 5% Cream</b>  <b>Adults:</b> up to 1 30g tube as a single application <b>Children:</b> 5-12 years up to half a 30g tube (15g) as a single application 1-5 years up to quarter of a 30g tube (7.5g) as a single application  <b>Lice: Permethrin 1% Lotion</b> Apply to damp hair after washing with shampoo, leave for 10 minutes then rinse with warm water	
<b>Antifungal S2</b>	<b>Clotrimazole:</b> topically, apply sparingly and rub in well 2-3 times daily <b>Miconazole:</b> topically, apply sparingly and rub in well 2-3 times daily	
<b>Antifungal S4</b>	<b>Nystatin:</b> <b>Oral drops: infants / children / adults:</b> 1ml 6 hourly	
<b>Antipruritics Unscheduled</b>	<b>Crotamiton: (Eurax)</b> Rub cream into affected area 2-3 times daily, do not apply to whole of body in small children more than 1/day	

<p><b>Antibiotics</b> <b>S4</b></p>	<p><b>Impetigo</b> For mild or localized infections use, <b>Mupirocin</b> 2% topically, 8 hourly for 7-10 days</p> <p>For widespread or recurrent infections, use: <b>Di/flucloxicillin</b> <b>Adults / Children &gt; 12 years:</b> 250 mg 6 hourly <b>Children 2-10 years:</b> 125mg 6 hourly Take 1-2 hours before food.</p> <p>For patient hypersensitive to penicillin (excluding immediate hypersensitivity) use: <b>Cephalexin</b> <b>Adults:</b> 250mg 6 hourly <b>Children:</b> 25-50 mg/kg/day, in divided doses In 125mg/5ml suspension; Children 10 kg 2.5-5ml, 6 hourly 20kg; 5-10ml, 6 hourly 40kg; 10-20ml, 6 hourly For 10 days. Take 15 minutes before food</p> <p><b>Erythromycin</b> <b>Adults / Children &gt; 12 years:</b> 250mg 6 hourly Or 500mg 12 hourly <b>Children &lt;12 years:</b> 30-50mg/kg/day 6 hourly Take 1-2 hours before food For 10 days</p> <p>For patients with immediate penicillin hypersensitivity, use: <b>Roxithromycin</b> <b>Adults:</b>300 mg daily <b>Children:</b> 5-8 mg/kg/day, up to 150 mg bd For 5-10 days.</p>	
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## Formulary

### Cephalexin

<b>Indications</b>	Antibiotic. Infections due to susceptible streptococcal and staphylococcal Infections in people with mild to moderate penicillin allergy. including skin, skin structure, URTI and LRTI, community acquired pneumonia, tonsillitis, pharyngitis, impetigo.
<b>Dosage</b>	<b>Adults:</b> 250mg 6 hourly. <b>Children:</b> 25-50 mg/kg/day, in divided doses. <b>In</b> 125mg/5ml suspension; Children 10 kg 2.5-5ml, 6 hourly 20kg; 5-10ml, 6 hourly 40kg; 10-20ml, 6 hourly For 10 days. Take 15 minutes before food.
<b>Special Considerations</b>	Alternative for those with mild allergy to penicillin..
<b>Contraindications</b>	Major reaction to penicillin. Hypersensitivity to cephalosporin, carbapenems.

### Cetirizine

<b>Indications</b>	Allergies, chronic idiopathic urticaria in adults and children > 6years.
<b>Dosage</b>	<b>Adults / Children &gt;12 years:</b> 10 mg once daily may increase to 20mg once daily <b>Children 6-12 years:</b> 5mg twice daily.
<b>Special Considerations</b>	CNS stimulation in children.
<b>Contraindications</b>	Hypersensitivity to cetirizine. Children <6 years.

### Clotrimazole

<b>Indications</b>	Antifungal. Vaginal, vulvovaginal candidiasis. Treatment of yeast infections of the vagina, mouth, and skin such as athlete's foot, jock itch, and body ringworm.
<b>Dosage</b>	Rub cream into affected area 2-3 times daily, do not apply to whole of body in small children more than 1/day.
<b>Special Considerations</b>	Should not be applied to exudative wounds of eczema. Caution in pregnancy and young children. Check for underlying medical conditions.
<b>Contraindications</b>	Hypersensitivity to ingredients. Exudative wounds

## Crotamiton

- Indications** Pruritus, scabies. Itching due to hives, insect bites, stings, sunburn, allergies, miliaria (prickly heat),
- Dosage** Rub cream into affected area 2-3 times daily, do not apply to whole of body in small children more than 1/day
- Special Considerations** Should not be applied to exudative wounds of eczema. Caution in pregnancy and young children.
- Contraindications** Hypersensitivity to ingredients. Exudative wounds.

## Di/flucloxacilin

- Indications** Infections due to susceptible staphylococcal, other Gram +ve coccal infections including skin, skin structure, bone, pneumonia.
- Dosage** **Adults / Children > 12 years:** 250mg 6 hourly. Take 1-2 hours before food. Minimum of 5 days.  
Treatment should continue for a minimum of 48-72 hours beyond the time the patient becomes asymptomatic or after evidence of bacterial eradication is observed.
- Special Considerations** Warfarin, phenytoin.
- Contraindications** Hypersensitivity to penicillin. Children <6 years.

## Erythromycin

- Indications** Skin infections due to Staph.aureus and Step.pyrogens, and Corynebacterium.
- Dosage** **Adults / Children > 12 years:** 250mg 6 hourly. Or 500mg 12 hourly.  
**Children <12 years:** 30-50mg/kg/day 6 hourly.  
Take 1-2 hours before food.  
For 10 days.
- Special Considerations** Superinfection, recurrent use.
- Contraindications** Hypersensitivity to erythromycin. Hepatic insufficiency.

## Hydrocortisone Cream 1%

<b>Indications</b>	Non infective inflammatory dermatoses, e.g. eczema, dermatitis.
<b>Dosage</b>	Apply a thin layer into affected area 2-4 times daily, do not apply to whole of body in small children more than 1/day
<b>Special Considerations</b>	Have 2 day break after 5 days of treatment in ongoing treatment plans. Should not be applied to non treated infected wounds. Caution in pregnancy and young children.
<b>Contraindications</b>	Hypersensitivity to ingredients. TB, fungal, viral, bacterial untreated skin infections.

### **Ibuprofen**

<b>Indications</b>	Analgesia in acute pain. Temporary relief of migraine, headache.
<b>Dosage</b>	<b>&gt;12 years:</b> 200-400mg 4-6/24. Not to exceed 1200mg, (6 tablets) in 24 hours
<b>Special Considerations</b>	Combining an NSAID with paracetamol allows lower NSAID doses to be used. Intermittent use (for example, before activity or during a flare in pain) has a lower risk of adverse effects than continuous use.
<b>Contraindications</b>	Avoid NSAIDS in Heart Failure, Gastrointestinal disorders and Asthma sufferers.

### **Miconazole**

<b>Indications</b>	Topical antifungal. Skin, nail Infections including tinea, candidiasis, dermatophyte infections.
<b>Dosage</b>	Rub cream into affected area 2-3 times daily, do not apply to whole of body in small children more than 1/day.
<b>Special Considerations</b>	Not all strains of infection may be sensitive to miconazole. Caution in pregnancy and young children. Check for underlying medical conditions.
<b>Contraindications</b>	Hypersensitivity to ingredients. Exudative wounds

### **Nystatin**

<b>Indications</b>	Antifungal. Intestinal candidiasis.
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<b>Dosage</b>	Rub cream into affected area 2-3 times daily, do not apply to whole of body in small children more than 1/day.
<b>Special Considerations</b>	Should not be applied to exudative wounds of eczema. Caution in pregnancy and young children. Check for underlying medical conditions.
<b>Contraindications</b>	Hypersensitivity to ingredients. Exudative wounds

### Paracetamol

<b>Indications</b>	Simple analgesia for mild to moderate pain, and reduction of pyrexia. Simple analgesia for mild to moderate pain associated with fever.
<b>Dosage</b>	<b>ADULTS: Paracetamol 500mg:</b> 1 or 2 tablets 4 hourly. Not to exceed 8 tablets in 24 hrs. <b>Children 7-12 years:</b> ½ to 1 tablet 4 hourly. Not to exceed 4 doses in 24 hours <b>Children &lt;1 year: Paracetamol drops</b> 1-3 months (4-6kg) 0.6-0.9ml 3-6 months (6-8kg) 0.9-1.2ml 6-12 months (8-10kg) 1.2-1.5ml 1-2 years (10-12kg) 1.5-1.8ml 4-6 hourly, max 4 doses/24 hours
<b>Special Considerations</b>	Paracetamol-induced hepatotoxicity is very rare at therapeutic doses. The risk may be increased by poor nutrition or chronic alcohol abuse, although conclusive evidence for this is lacking. Inadvertent overdose, often from taking two paracetamol-containing preparations concurrently, is the more common cause of liver injury caused by paracetamol. Advise patients not to exceed the maximum daily dose and to avoid other paracetamol-containing preparations (such as cold and flu tablets).

**Note:** Fever is an adaptive physiologic mechanism with beneficial effects. Even in low doses paracetamol has been known to cause hepatotoxicity and its prolonged use to reduce temperature in children is contraindicated.

### Paracetamol & Codeine

<b>Indications</b>	Combined simple analgesia for mild to moderate pain, and reduction of pyrexia. Simple analgesia for mild to moderate pain associated with fever.
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**Dosage**                    **Paracetamol 500mg & Codeine 8 mg:**  
**ADULTS:** 1 or 2 tablets 3-4 hourly.  
 Not to exceed 8 tablets in 24 hrs.  
**Children 7-12 years:** ½ to 1 tablet 3-4 hourly.  
 Not to exceed 4 doses in 24 hours  
**Children < 12 years**  
**Painstop:** 6 hourly max 4 doses in 24 hours.  
 1-2 years (10-12kg) 5-6mls  
 2-3 years (12-14kg) 6-7mls  
 3-4 years (14-16kg) 7-9mls  
 4-5 years (16-18kg) 9-10mls  
 5-6 years (18-20kg) 10-11mls  
 6-7 years (20-22kg) 11-12mls  
 7-8 years ( 22-24kg) 12-13mls  
 8-9 years (25-28kg) 13-15mls  
 9-10 years (28-32kg) 15mls

**Special Considerations**    **May cause drowsiness. Caution in breastfeeding women.** Paracetamol-induced hepatotoxicity is very rare at therapeutic doses. The risk may be increased by poor nutrition or chronic alcohol abuse, although conclusive evidence for this is lacking. Inadvertent overdose, often from taking two paracetamol-containing preparations concurrently, is the more common cause of liver injury caused by paracetamol. Advise patients not to exceed the maximum daily dose and to avoid other paracetamol-containing preparations (such as cold and flu tablets).

**Note:** Fever is an adaptive physiologic mechanism with beneficial effects. Even in low doses paracetamol has been known to cause hepatotoxicity and its prolonged use to reduce temperature in children is contraindicated.

### Permethrin

**Indications**                Scabies, lice.

**Dosage**                     Rub cream into affected area 2-3 times daily, do not apply to whole of body in small children more than 1/day

**Special Considerations**    Caution in elderly and children < 2 years.

**Contraindications**        Hypersensitivity to permethrins or chrysanthemums.

### Promethazine

**Indications**                Allergies, antiemetic, sedation.

**Dosage**                    **Adults:** PO 25mg 8-12 hourly max 100mg/day  
                                  **Children 6-12 years:** PO 10 mg 8-12 hourly max 25mg/day

**Special Considerations**    This product may cause drowsiness.

**Contraindications**    Hypersensitivity. Use of MAOI. CNS depression

### **Roxithromycin**

**Indications**            Broad spectrum antibiotic. Infections due to susceptible Gram +ve and some Gram -ve bacteria, including skin, skin structure, URTI and LRTI, community acquired pneumonia, tonsillitis, pharyngitis, impetigo.

**Dosage**                    **Adults:** 300mg once daily. OR 150mg bd.  
  
                                  **Children:** 5-8 mg/kg/day, up to 150 mg bd  
                                  For 5-10 days.  
                                  Take 15 minutes before food.  
                                  5-10 days dependant on results.

**Special Considerations**    Alternative for those allergic to penicillin or cephalosporin.

**Contraindications**    Hypersensitivity to macrolides.