

Approach Patient with Skin Rash in Primary Care Settings: Review

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ABSTRACT

Skin rashes are prevalent in basic care, and suboptimal results in chronic illnesses frequently result from inadequate adherence to treatment. While shared decision-making and self-management support may be beneficial, there is limited comprehension of patient engagement and the assistance offered by general practitioners. This review aims to evaluate the approach to patients with skin rashes in primary care settings. Effective collaboration between primary care clinicians and dermatologists is essential for maintaining high quality and cost efficiency in patient care. The training of general practitioners should align with the prevalence of dermatological issues and aim to enhance patient engagement in decision-making and facilitate self-management.

KEYWORDS: patient, skinrash.

1. Introduction

Dermatological issues are the predominant cause for initial consultations in primary care, with the majority of patients receiving exclusive management within this setting. Historically, dermatological training for general practitioners has been inadequate, resulting in a lack of trust among GPs in identifying and managing skin disorders [1]. Chronic dermatological issues can significantly affect patients, leading to diminished health-related quality of life, decreased work productivity, and substantial economical and psychological repercussions [2].

While the majority of people with inflammatory skin conditions such as eczema, psoriasis, and acne have mild to moderate severity, they necessitate elevated levels of self-management. Topical therapies are the primary method of management for most individuals; nevertheless, treatment failure frequently occurs due to poor adherence to prescribed regimens [3]. A robust evidence foundation exists for assisted self-management in asthma, where, similar to inflammatory skin disorders, therapy regimens adapt to varying symptoms. In contrast, much ambiguity persists

regarding the clinical and cost-effectiveness of interventions created thus far to enhance self-management in chronic inflammatory skin illnesses. An effective method to enhance patient self-management could involve collaborative decision-making regarding treatment options. Patients with long-term skin diseases prefer shared management with healthcare providers, and personalized care, including both verbal and written information [4].

Despite the promise of enhanced self-management and collaborative decision-making to improve outcomes in chronic skin illnesses, there has been less research investigating the substance or execution of general practitioner consultations with patients regarding dermatological issues [5].

2. Review:

Skin rashes resulted in 13 million physician visits in the United States in 2016. Dermatologist care may be necessary for patients suffering from lesions, unusual or resistant rashes, and other skin disorders, as well as patient education. Nonetheless, many of these illnesses are self-limiting and have straightforward remedies. Primary care professionals (PCPs) can manage these disorders, reducing the need for dermatologists and lowering healthcare expenses. Thus, co-management of skin disorders by primary care physicians and dermatologists is an essential topic. We have previously explored the presentation of rashes in the community, the use of teledermatology to standardize therapy of these disorders, and the co-management of skin cancer [1, 6].

The current study found that 14.2% of GP consultations included one or more skin problems, which is higher than the previously reported rate of 8.4% from a survey of general practices in the south east of Scotland but lower than the 24% assessed through analysis of the Royal College of General Practitioners (RCGP) Weekly Returns Service consultation data from England and Wales in 2006. However, it was not possible to determine how much of the total appointment time was spent discussing the skin problem. The median number of problems (two) discussed per appointment is consistent with past primary care research. The profile of skin disorders described in this study is similar to that of prior primary care consultation analyses, in which skin infections, eczema, and skin tumors (benign and malignant) were the most common [1, 2, 7].

Several studies have looked at how primary care physicians compare to specialists when it comes to disease diagnosis and treatment. Although PCP care may be comparable to that of specialists for certain conditions (e.g., hypertension and type 2 diabetes mellitus), this is not true for skin disease. Dermatologists provide more accurate diagnosis and treatment of skin problems than primary care physicians [8,9].

Patient satisfaction is another crucial part of treatment quality because, in the end, patients are the ones who pay for health care resources. However, little is known about patients' preferences for evaluating and treating skin problems. A prior study conducted in a dermatological practice found that patients were more satisfied with dermatologist care for their skin disease than with PCP care, and direct access to

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The findings that emollients and TCS were most frequently indicated and prescribed by GPs are consistent with national data on drug prescribing for skin diseases. However, this prescribing pattern is likely to change since emollient prescribing restrictions were introduced in England in 2017 [11].

Although healthcare policy and dermatology clinical standards encourage shared decision-making for treatment options, low levels of patient involvement were reported. Previous studies in the United States and Germany utilizing OPTION found low levels of observed shared decision making in primary care consultations, with mean total scores of 27.2 and 11.8, respectively. In contrast, research in secondary care have found a higher level of collaborative decision making. Lower scores in primary care could be attributed to improved doctor-patient continuity, with serial consultations necessary to capture 'disseminated' shared decision making [12,13].

Despite current dermatology guidelines supporting the use of customized self-management plans and referral to high-quality information, GPs did not regularly offer self-management guidance to patients, and no written information was provided. Although self-management guidance may be less appropriate to some of the difficulties reported in this study, such as a self-limiting rash, patients frequently have poor recollection for medical knowledge, which can be improved by providing supportive written material [14]. Previous study has shown that, while GPs value self-management support, it is not prioritised in time-limited visits for fear of breaking the clinician-patient connection, and physicians may prefer to focus on biological elements of care. Other challenges highlighted to GPs facilitating self-management include a lack of trust in sharing control, the ability to provide continuing support, and fears that patients may misuse drugs and fail to seek help when necessary [15,16].

This study's secondary care referral rate of 15.7% is comparable to a cross-sectional study of Scottish primary care visits for skin disorders in which 14% of patients were referred for specialist assessment [7]. This is higher than the previously reported 6.1% national estimate in England and Wales for 2006/2007. According to the RCGP Weekly Returns Service data, there are approximately two consultations per episode of skin disease in primary care, and frequent re-attendance (defined as three or more consultations for the skin problem) was observed in 25% (range 14-45%) of Scottish primary care consultations for skin problems [7, 16]. In comparison, the current study discovered that one-third of skin concerns not referred to secondary care were seen again within three months, with one-third of them being unscheduled visits. Reasons for re-attendance with skin disorders have not been thoroughly investigated, although the Scottish primary care consultations for skin problems study highlighted recurring treatment concerns, including a reluctance to prescribe suitable potencies of TCS in eczema [7,15,16].

Only 2.3% of patients used e-consult, with diagnoses of bullous, hair, and pigment problems, as well as psoriasis and acne, highly associated with escalation, and 73% requiring a follow-up visit to the dermatologist's office. Patients escalated through e-consult, like those in other contexts, may have had cosmetic concerns and a stronger

desire to visit a dermatologist in person. E-consult diagnosis frequently necessitate extra therapy visits. Alopecia areata is treated with in-office injections, which necessitates an in-office visit. Although we expect primary care physicians to treat mild plaque psoriasis with topical therapies, psoriasis frequently requires lifelong treatment, and once topical therapy is exhausted, patients may require dermatologist-prescribed systemic medications and phototherapy, though this review did not count phototherapy visits unless they included time with a dermatologist. Acne is a chronic illness that can be severe and disfiguring, and previous research have shown that protocolized treatment is effective. PCPs can prescribe and supervise initial acne treatment choices; however, more severe instances generally require dermatology [17,18].

Previous research on the success of co-management of dermatologic disorders utilizing various workflows and technologies frequently combined lesions, rashes, and other skin conditions, concealing differences across conditions that are critical to driving treatment effectiveness [19,20]. Other studies have focused solely on severe illnesses like psoriasis. A UK study found that dermatologists were used by 4% of PCPs for eczema, but not for other less severe conditions [21]. Skin rashes and other non-lesion conditions are common and require quick, effective, and cost-effective management. Many of these disorders can be properly detected and treated in basic care because they resolve on their own or are simply treated with anti-inflammatory and anti-infective drugs with low risk of side effects. Although PCPs manage the majority of patients with rash and other non-lesion conditions in our setting, face-to-face visits with a dermatologist are essential for making uncommon diagnoses, providing patient education, managing more difficult cases, and managing treatments that are not commonly used in primary care. Although dermatologists are in short supply, this study suggests that PCPs in our integrated setting should standardize care based on the patient's complexity rather than the PCP's practice preferences [17,22].

According to the research, people were more likely to trust a dermatologist than their primary care physician for the treatment of skin conditions, although they were still confident in their PCP's competence. This was true not only for diagnosis and treatment, but also for more invasive treatments like skin biopsy, liquid nitrogen injection, and cutaneous surgery. This study has significant quality-of-care implications, as PCPs are being educated in these procedures. Despite data demonstrating that dermatologists are better suited to treating skin diseases, patients may not be opposed to having their primary care physician play a larger role in providing this treatment [18,19,22].

Owen et colleagues [23] stated that 64% of patients in their study who had been treated by a PCP for a skin disease were satisfied with the care provided, which is similar to, but slightly lower than, the 78% we discovered. Possible explanations for the lower PCP satisfaction rate found in their study include the fact that 11% of participants had previously seen two or three physicians for their condition, implying that their patients had either higher expectations or more severe illness than we did. Furthermore, the skills of the university-affiliated physicians in our study may differ from those of the primary care physicians in the Owen et al. study. Interestingly, while all of the physicians in our study were trained in internal medicine, the PCP

Mousa Mohammed Hadi, Manal Ali Lahomood, Budur Saad Almushari, Eman Hassan Asiri, Mubarak Mohammed Alshahrani, Ahmad Mosa Ali Faqeeh, Fahad Jaber Alfaifi, Hussein Ali Azaybi, Abdulrahman Mohammed Alquhayb, Abdulghani Madi Alqahtani, Alhanouf Ali Ahmmed, Afnan Saad Alghanom group in their study included a large number of family physicians and general practitioners. According to previous study [22], family physicians and general practitioners outperform internists in terms of skin disease diagnostic ability.

3. Conclusion:

General practitioners frequently articulated and recorded a diagnosis for the dermatological issue. A drug was advised for two-thirds of dermatological issues, with over half being newly identified, predominantly provided by the general practitioner. Emollients and topical corticosteroids (TCS), often in combination with antimicrobials, were the most commonly recommended treatments, with general practitioners predominantly prescribing light to moderate dosage TCS. While pharmaceutical recommendations were prevalent, the practice of collaborative decision-making on treatment choices was found to be inadequate, and the self-management support provided by general practitioners was minimal, lacking both written materials and guidance to internet resources. The majority of skin issues were not referred to dermatological specialists, with general practitioners providing scheduled or contingent follow-up arrangements in two-thirds of instances, but documentation was only available for half of the cases. Despite the lack of referrals for most skin issues, re-attendance within three months of the initial visit was prevalent.

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