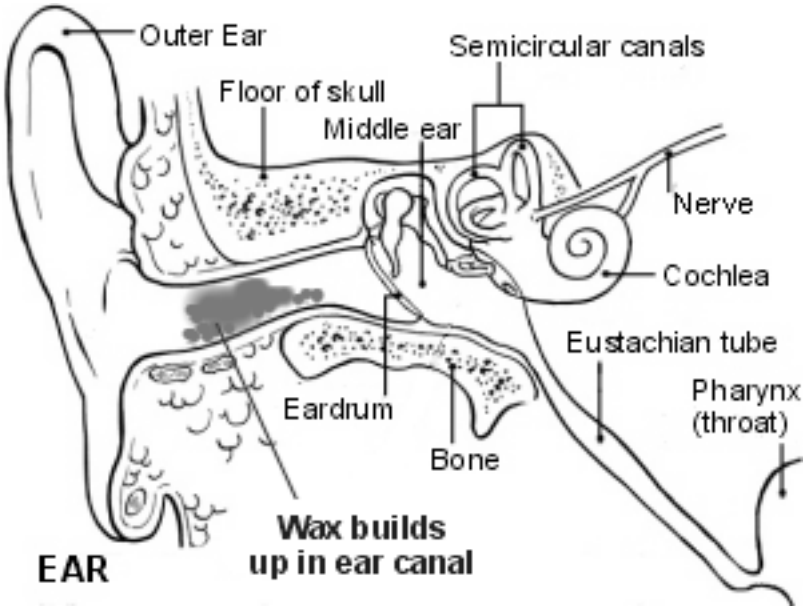
Top Tips for Minor Ailments

1. **Earwax**
2. **Fungal Nail Infections (Onychomycosis)**
3. **Olecranon Bursitis**
4. **Subungual Haematoma**
5. **Torticollis**
6. **Tremor**
7. **URTIs**
8. **Stye vs Chalazion**
9. **Mouth Ulcers**
10. **Ingrowing toenails**
11. **Molluscum Contagiosum**
12. **Trigger Finger**
13. **Bacterial Vaginosis**
14. **Allergic Rhinitis**
15. **Ganglion**
16. **Pruritus Ani**

Earwax

Earwax is a build-up of dead cells, hair, foreign material such as dust, and cerumen. Cerumen is the natural wax produced by glands in the ear. It forms a protective coating of the skin in the ear canal. Small amounts are made all the time. Flakes or crusts of earwax break off and fall out of the ear from time to time.



Remember:

1. Earwax only needs to be removed if it is dulling your hearing.
2. You can treat earwax yourself, ear irrigation is only required if the wax persists.

Treatment to start at home:

1. Lie on your side with the affected ear uppermost
2. Put 3 drops in the affected ear
3. Stay in this position for 2-3 minutes
4. This must be done 2-3 times a day for 3-7 days.

Remember DO NOT use cotton buds to clean your ear as these damage the small cells in the ear canal, which help the ear to push out the wax.

If your hearing does not improve using this method book in with the practice nurse for assessment for ear irrigation. Please use the olive oil eardrops for 5 days before the ear irrigation to ensure it is successful.

Fungal Nail Infections (Onychomycosis)

Causes

Dermatophytes (85-90%) e.g. trichophyton rubrum

Yeasts e.g. candida albicans

Non-dermatophyte moulds (rare) e.g. fusarium

Predisposing Factors

Nail disease e.g. trauma

Immunocompromised e.g. DM, HIV

Peripheral vascular insufficiency

Clinical Features

Thick, brittle, discoloured

Should note extent of nail disease, whether it affects adjacent skin and number of nails affected.

Management

Send nail clippings off for microscopy and culture to confirm diagnosis before starting treatment.

Start antifungals if:

- Positive microscopy – fungal elements seen
- Positive dermatophyte culture

Negative microscopy and culture does not exclude fungal nail infections, and repeat sample should be sent if high clinical suspicion.

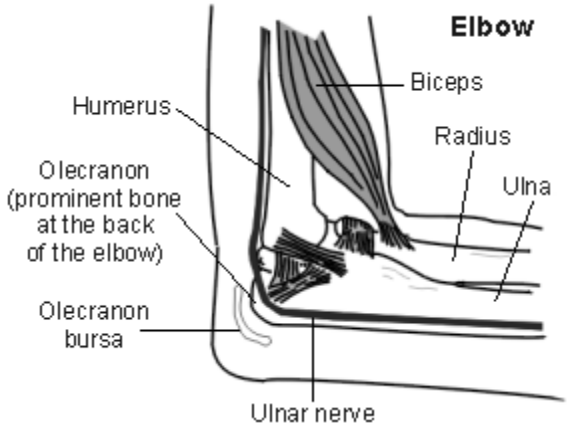
Topical treatment – superficial, early distal and lateral disease; 5% amorolfine; 6m fingernails, 12m toenails.

PO treatment – terbinafine; 3m fingernails; 6m toenails; itraconazole; 2 courses of 7days/month fingernails; 3 courses of 7 days/month toenails

Olecranon Bursitis- source GP notebook mostly

What is the olecranon bursa? where?
What are symptoms of bursitis/ How do patients present?
What are some imp questions in the history to try to differentiate the etiology?
How do you treat?

The olecranon bursa is a subcutaneous space which contains a fluid to provide smooth and almost frictionless movement between the skin, the subcutaneous tissue and the olecranon. Due to its superficial location it may become enlarged as a result of pressure or friction. The overall incidence of the disease is unknown. It is more common in males especially between the ages of 30 to 60 years



The risk of acquiring this condition is increased in people:
who are subjected to **repeated elbow trauma** e.g.-labourers such as miners, gardeners, carpet layers, and mechanics
with rheumatoid or crystalloid **arthritis** (e.g. gout)
with a history of **previous episodes** of olecranon bursitis
with **impaired immunity** caused by steroids, diabetes, renal impairment, alcohol abuse

If the bursa becomes painful then this may be due to infection, gout or rheumatoid arthritis. Look for tophi or rheumatoid nodules

Causes of olecranon bursitis can generally be classified as
Septic
seen in one third of presenting cases o usually caused when micro-organisms enter the bursa through soft tissue due to trauma, breaks in the skin or foci of infection, occasionally penetration through minute skin breaks could be considered in patients who lack a history of trauma or visible injury. 80-90% cases are due to S. aureus
The following are at risk of developing septic bursitis –
people with a history of **previous episodes** of olecranon bursitis. **impaired immunity** caused by steroids, diabetes, renal impairment, alcohol abuse (2)
Non-septic
usually caused by acute trauma, overuse, crystal deposition (e.g. gout), or systemic disease
majority occurs in males who are in the age group between 50 to 70 years
People undergoing chronic dialysis are suggested to be at an increased risk of developing olecranon bursitis.

Treatment is **not usually required** for non-painful, small olecranon bursae.
If there is **significant pain or swelling however, aspiration** is often necessary and the fluid should be sent for gram stain, culture and crystal microscopy.
In case of non septic bursitis which can be identified clinically, the following conservative methods will be helpful:
RICE: rest - immobilize the elbow until the swelling subsides, application of ice , use of an elbow pad - to minimise direct pressure on the swollen elbow, compressive bandage, elevation of the elbow, analgesia

In cases refractory to above conservative methods, consider aspiration of fluid and **injecting corticosteroids** in to the bursa
In traumatic and inflammatory cases steroid injection may be helpful. In septic cases, adequate drainage should be achieved and appropriate antibiotics commenced

flucloxacillin is the antibiotic of choice
in penicillin allergic patients erythromycin can be used
in patients who are ill, appear toxic and immune compromised, admission and parenteral antibiotic therapy should be considered - alter the antibiotic regimen according to the culture report and sensitivity
repeated aspiration may be necessary if fluid reaccumulates

If the **cause is gout or rheumatoid arthritis treat the conditions accordingly**

Aspiration of olecranon bursae can be for either diagnosis or for therapaeutic purposes
Aspiration may be carried out
1-acutely for relief of swelling and discomfort
2-to differentiate septic from non septic bursitis in cases where medical history and physical examination is insufficient
3-The appearance of the fluid may be used to identify the nature of bursitis:

If the aspirate is purulent - septic bursitis is the likely cause
in non septic bursitis - colour of the aspirate may range from straw colored to bloody
The bursal fluid aspirate should be sent (in a sterile container) to the laboratory for Gram staining, culture and microscopy

Presence of urate crystals indicate gout
30% of gram stain is negative in patients with septic bursitis
causative organisms can be identified (if not already received antibiotics) through bacterial culture
white cell count is greater than 100 x 109/litre (range 1-300) in septic cases
Aspiration technique

Sterile technique must be followed when aspirating for bursal fluid
Patient should be in supine position and the elbow should be flexed as much as the patient can comfortably tolerate. a 10 mL or 20 mL syringe, 18 or 20 gauge 1-inch needle is used. Insert the needle directly into the bursa, apply a pressure dressing after the procedure, The patient should be advised to:
-avoid strenuous activity for 48 hours
-treat any pain which might occur with ice and non steroidal anti inflammatory drugs

Subungual Haemtoma

A subungual haematoma is a collection of blood in the space between the nail bed and fingernail.

Subungual hematomas result from a direct injury to the fingernail.

A painless and small subungual hematoma usually requires no treatment. However, the pressure generated by pooled blood under the nail can be extremely painful.

Self-Care at Home

- Ice, elevation, and pain relief are recommended for minor hematomas.
- If the hematoma involves more than 50% of the area of the nail or the pain is severe, then medical attention is needed.

Medical Treatment for Subungual Hematoma

Several techniques are used to drain the blood beneath the nail. No single technique is preferred.

Occasionally, the finger or toe is numbed with a digital block. However, often the injection itself can cause as much if not more pain than the actual drainage of the hematoma.

The following are commonly used methods for draining subungual hematomas:

- Cautery: A battery-operated device is used to burn a hole in the nail until the blood is reached and drains out of the hole. This technique should not be used if the patient is wearing artificial acrylic nails which might be flammable!
- Needle: A large diameter needle is used to drill or bore into the nail to create a hole to allow the blood to drain out.
- Paper clip: A paper clip is opened so that the pointed end is free (the pointed end is the ideal diameter to use to trephine a hole in the nail). Then the pointed end is heated up, usually by passing it through a flame (tea light, burner), and used to burn through the nail, by applying pressure to the nail over the collection of blood). The metal often needs to be reheated during the procedure and reapplied to the nail. The patient has immediate relief from pain and discomfort once the hole is complete and the blood can escape)

Torticollis

If you have ever ricked your neck, you will know just how painful it can be.
Help is at hand, literally, with this hands on technique to relax the painful muscle spasm.
Easy 'brownie points' are won by this simple technique!

The physiological basis of the technique
When movements are made, each muscle is paired with one which makes the opposing movement I.e an antagonist. These muscles have reflex communication so that they don't oppose the action of the other inappropriately. For example when the biceps contract, the triceps relax. Similarly when the head is turned, the sternocleidomastoid muscle contracts, and there is reflex relaxation in the contralateral sternocleidomastoid

Using this to therapeutic advantage
With Torticollis, there is painful spasm in one of the sternocleidomastoids. By encouraging the patient to tense the contralateral sternocleidomastoid, they can achieve reflex relaxation in the muscle which is in spasm.

Usually when there is torticollis, the head is turned slightly to the non-painful side. Get the patient to press their chin towards the painful side, with gradually increasing pressure, against your hand, and the painful muscle will relax. As this happens the patient is usually able to turn their head as you gradually reduce your resistance, although I gradually return them to the central position before completing the treatment.

To the patient's pleasant surprise, they will find their neck immediately less painful with an Increased range of movement. I usually explain the principle of the treatment so they can repeat the exercise as and when necessary, until the problem has fully recovered.

Tremor

Postural - Maximal with maintained posture

Essential tremor:

- Both hands – difficulty writing, holding cups etc; often other body parts – titubation
- Absent at rest
- FHx
- No extrapyramidal or cerebellar features
- May be relieved by alcohol
- Propranolol may help

Physiological:

- Anxiety, thyrotoxicosis, alcohol, drugs (bronchodilators)

Rest

Parkinson's disease:

- typically assymetrical/unilateral. Tremor Rigidity Bradykinesia Postural instability
- pill-rolling
- disappears on action
- exacerbated by anxiety or stress

Other akinetic-regid states/parkinsonism:

- Parkinsons-plus – MSA; PSP
- Wilsons, neuroleptics (chlorpromazine), punch-drunk

Kinetic – during movement, often worse as target is approached – intention tremor

Cerebellar disease:

- DANISH
- MS, tumour, infarct, haemorrhage of cerebellum – ipsilateral signs
- Alcohol, hereditary ataxias, Drugs (Li) – truncal ataxia

URTIs

Otitis media:

- No statistically significant benefit from antibiotics in children <2 with unilateral otitis media of >2 with unilateral or bilateral otitis media.
- Need to have fever ≥38C for diagnosis.
- Groups likely to benefit from antibiotics: <2 with bilateral otitis media and children of any age with otorrhoea.
- http://www.npc.nhs.uk/therapeutics/common_infections/respiratory/resources/pda_rti_aom.pdf

Sore throat:

- Centor Criteria
  - Presence of tonsillar exudate
  - Presence of tender anterior cervical lymphadenopathy
  - History of fever
  - Absence of cough
- If 3 of 4 of these criteria are present, 40-60% chance of bacterial infection so offer Abx.
- If <3 of these criteria present, 80% chance the infection is not bacterial, antibiotics are unlikely to be appropriate.
- http://cks.nice.org.uk/sore-throat-acute

Mean duration of illnesses:

- Otitis media – 4 days
- Sore throat/tonsillitis – 1 week
- Common cold – 1½ weeks
- Acute rhinosinusitis – 2½ weeks
- Acute cough/bronchitis – 3 weeks

Styes (Hordeola) vs. Chalazion
Summarised from NICE clinical knowledge summaries

	Stye	Chalazion (Meibomian cyst)
Definition	Acute, localised infection or inflammation of the eyelid margin.	Sterile, chronic inflammatory granuloma caused by obstruction of a meibomian gland.
Presentation	Painful, localized swelling. Develops over several days. Generally affects only one eyelid.	Firm, localized eyelid swelling. Develops slowly over several weeks. Although there is initial discomfort, this usually settles and pain and tenderness are usually absent. More common on upper eyelid. 2-8mm in diameter.
Pathophysiology	Usually caused by staphylococcal infection. Can be: - External. Appears on the eyelid margin. Caused by infection of an eyelash follicle or associated sebaceous or apocrine gland. - Internal. Occurs on the conjunctival surface of the eyelid. Caused by infection of a meibomian gland (situated within the tarsal plate).	The meibomian glands (located in the tarsal plate, are a set of glands that run along the eyelid margin. They produce a lipid secretion which provides the lipid layer of the tear film. Obstruction of the gland duct causes the gland to enlarge and rupture, releasing the accumulating lipid contents into the surrounding eyelid soft tissue. This triggers an inflammatory reaction against the lipid content, which subsides with time. Consequently, the meibomian cyst often becomes painless and non-tender.
Natural history	Generally self-limiting and most resolve within 5-7 days. Recurrence is common if there is underlying blepharitis.	25-50% resolve spontaneously or with conservative treatment. Some resolve within 1-2 months, whilst others take up to 6 months or longer to resolve.
Risk factors	Chronic blepharitis Acne rosacea Ingrowth of eyelashes (trichiasis) Ectropion	Blepharitis Seborrhoeic dermatitis Rosacea
Complications	Infection may spread to neighbouring tissues, which can lead to periorbital cellulitis. A persistent internal stye can develop into a meibomian cyst (chalazion).	Rarely cause serious complications. Rarely, a meibomian cyst may become secondarily infected, spread and can cause preseptal cellulitis.
Management	Advise the patient: To apply a warm compress to the affected eye for 5-10 minutes. Repeat several times a day until the stye drains or resolves. Do not attempt to puncture the stye Avoid make up or contact lens use until	Advise the patient: Apply a warm compress to the affected eye for 5–10 minutes. Repeat this three to four times daily for up to 4 weeks. Explain that this will help to liquefy the lipid content of the cyst, thus encouraging drainage of the cyst contents.

	the area has healed. Do **not** prescribe a topical antibiotic unless there is evidence of conjunctivitis.	Avoid excessively hot compresses (to avoid scalding). Gently massage the meibomian cyst after application of the warm compress (to aid expression of the cyst contents). Clean the affected eyelid twice daily (to clear debris and oily secretions from the eyelid and lashes). Do **not** prescribe a topical or oral antibiotic.
Referral	Consider referral to an ophthalmologist if a stye is not resolving with conservative measures.	If the cyst does not improve or resolve over 3-4 weeks of conservative management offer: • Referral to an ophthalmologist for treatment (incision or curettage performed under local anaesthetic, or intralesional corticosteroid injection). • A 6-month period of watchful waiting • No treatment. Local CCG policy http://www.cambsphn.nhs.uk/Libraries/Surgical_Threshold_Policies/CHALAZION_MAY_15_-_V1.sflb.ashx Incision/excision of chalazia will be funded when all the following criteria are met: • Chalazia is causing significant irritation, pain or blurring of vision. • Conservative treatment with heat and compression have been tried for at least three months.
Patient information	http://patient.info/health/stye	http://patient.info/health/chalazion-leaflet

Mouth Ulcers – Take home messages

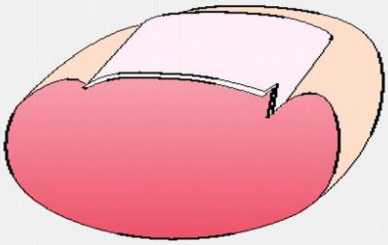
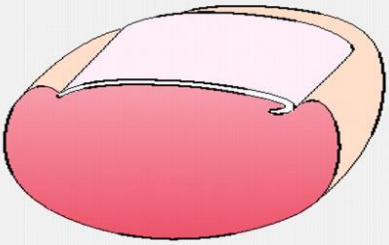
- Common and self-limiting
- Main Rx option: hydrocortisone lozenges
- Rule out more serious, but rarer causes
- If persists >3 weeks – refer to rule out oral Ca
- Regular dental check ups

Ingrowing Toenails

- Mainly affects young men, 10,000 new cases/yr
- Extrinsic and intrinsic factors
- Normal (younger pts) vs Abnormal nail

Presentation

- Painful, swollen toe
- Likely big toe
- 'I think it's infected'

	Improperly cut normal nail	Abnormal nail
		
Features	Normal nail plate; slightly convex from side to side	Abnormally wide nail or incurvated edge nail
Treatment	Advice on toenail trimming Chiropodist may remove offending nail spike Partial nail avulsion is rarely needed	Advice on toenail trimming Partial nail avulsion with segmental phenol ablation

- Pain, swelling, erythema, hyperhydrosis
- Infection and inflammation + abscess
- Granulation tissue and reduced drainage

Treatment

Partial nail avulsion with segmental phenol ablation - treatment of choice

Aftercare

- Salt water bathing
- Continued nail care
- Serous discharge can persist for several weeks

Molluscum contagiosum

Background

- Skin infection caused by molluscum contagiosum virus
- Very common. 80% of cases reported in under 15 year olds.
- Replication of virus in epidermis causes hyperplasia.

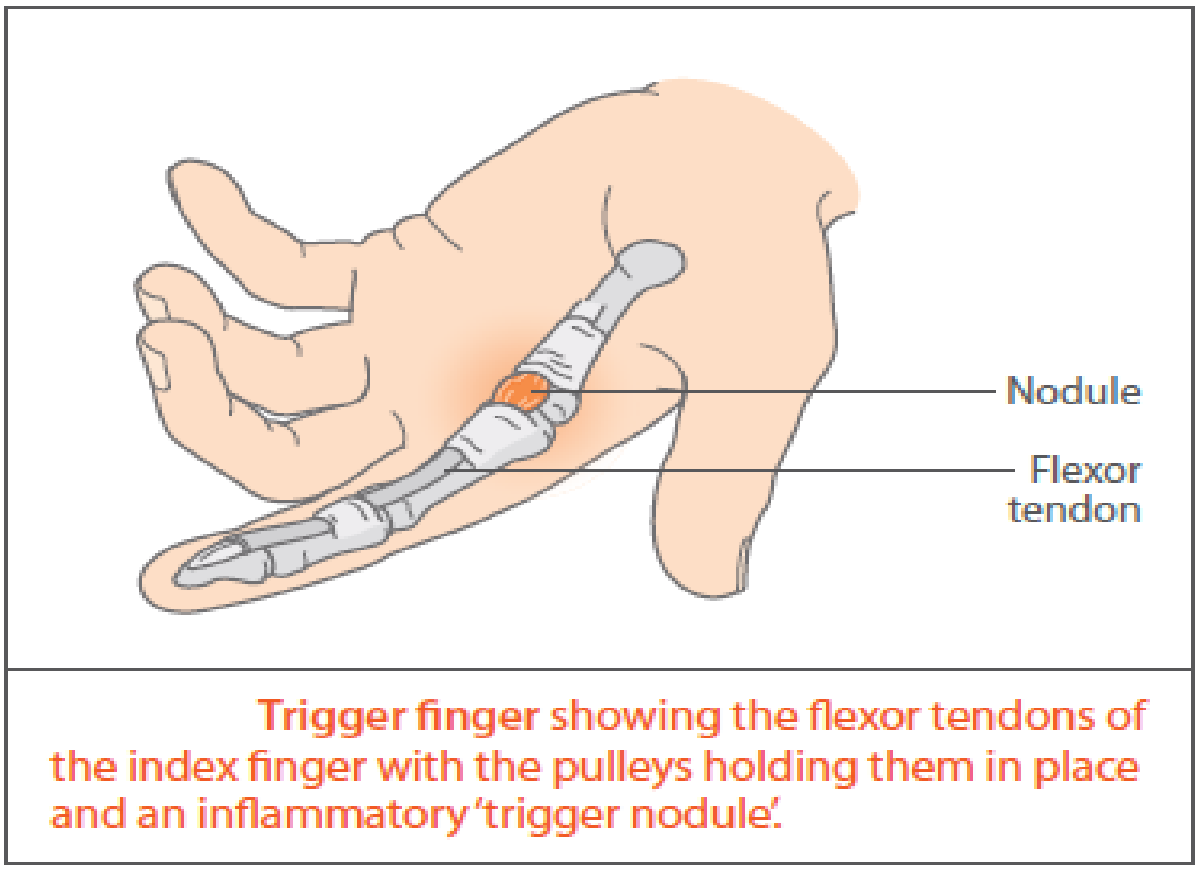
Clinical Features

- Develop over a 2 week period.
- Increased risk if immunocompromised or atopic eczema.
- Pinkish- pearly white coloured papules in clusters.
- Most common on trunks and flexures of children and genitals of adults.

Management

- Self limiting condition resolve within 18 months.
- Avoid transmission to others.
- If troublesome they can be squeezed at home or cryotherapy can be used.
- Consider screening for other STIs if anogenital lesions.
- Refer to HIV specialist if extensive and HIV +ve.

Trigger Finger



Trigger finger showing the flexor tendons of the index finger with the pulleys holding them in place and an inflammatory 'trigger nodule'.

Aetiology and Treatment Options

- Primary- Isolated trigger finger, Congenital
- Secondary- Diabetes, RA, Gout
- Treatment: Can use splints(conservative approach)
- Steroid injections placed within tendon sheath
- Surgical release- irreducible locked trigger finger should be referred urgently to prevent permanent contracture of finger

Bacterial Vaginosis

Overview and symptoms

- 35-50% vaginitis
- Bacteria within vagina is disrupted.
- White/grey discharge, which is thin/watery and has “fishy” odour.
- 50% women have no symptoms
- Not STI but increased rates in sexually active women.

Causes and associations

- Scented soaps/bubble baths.
- Vaginal deodorant/vaginal douching.
- IUD
- Differences between ethnic groups.
- Smoking
- Hormonal changes in menstrual cycle, semen in vagina and genetic factors.

Diagnosis

- Perform speculum examination and look for thin, greyish discharge which may have odour.
- Take vaginal swab and send to laboratory.
- Can check pH level in vagina – if >4.5 likely BV.
- Amsel’s criteria (need 3 of 4).

Treatment

- Metronidazole
- Clindamycin
- Vaginal pH correction
- Side effects
- Pregnancy

Significance

- In pregnancy:
    - Premature birth
    - Miscarriage
    - Premature rupture of membranes
    - Chorioamnionitis
    - Post-partum endometritis.
- In all patients:
    - Increased risk of STIs
    - Pelvic inflammatory disease

NICE Guidance

- Clinical knowledge summary on BV.
- Asymptomatic women shouldn’t be treated.
- Oral metronidazole treatment of choice.
- Consider removing IUD if repeated BV.
- Test of cure is not required.

Allergic Rhinitis

History

- Symptoms
- Effects on daily life
- Work out the allergen
    - Role of allergy-testing

Examination

Treatment 'DIY'

- Avoiding allergen
- Medications
    - Oral antihistamine (loratadine 10mg, cetirizine 10mg)
    - Intranasal steroid (beconase = beclometasone 50micrograms)
        - How to use
    - Others
        - Cromoglicate eye drops
        - Decongestants
        - Nasal ipratropium
        - 40mg oral prednisolone 7days
    - No
        - Sedating antihistamine
        - Steroid injections
        - Leukotriene receptor antagonists

Other Considerations

- Pregnancy
    - Beconase, nasal saline rinse
- Seasonal allergy
- Take home messages:
    - Remember other atopic conditions
    - Work out the allergen (formal testing = limited benefit)
    - Treatment: allergen avoidance, oral antihistamine, intranasal steroid (how-to-use)

Ganglion

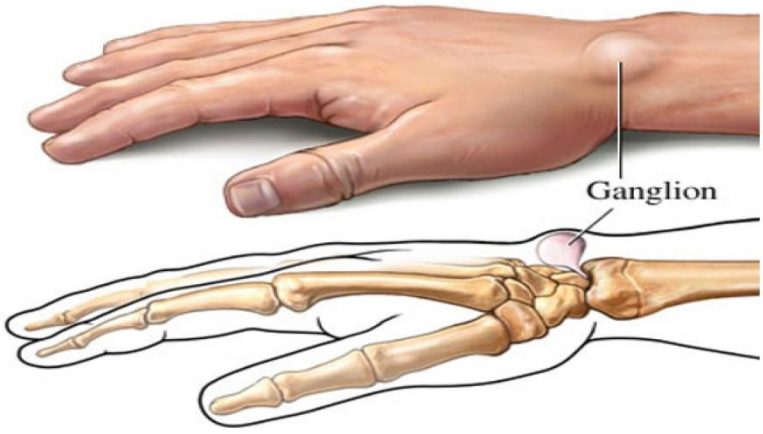
Background

- Smooth, firm, swelling
- Tethered to joint or tendon by pedicle
- Cause: ?Trauma/stress to joint or structural flaw
- Benign, usually painless
- Most common on wrists and hands and feet
- Range from 0.5-3cm
- More common in women
- O/E: Transilluminate

Treatment

- Best to leave alone if asymptomatic
- 50% resolve spontaneously

1. Traditionally used to 'smash with the family bible' – cyst bursts and fluid resorbed
2. Aspiration (+/- steroid injection) by GP
3. Surgical removal if symptomatic rather than for cosmetic reasons – ?funded by CCG



Pruritis Ani

Epidemiology

- 1-5 % of population
- Typical age 40-60
- 4x more common in men

Causes

Primary

Psychological or functional (faecal matter)

Secondary

a/ skin disorders (dermatitis, psoriasis, lichen)
b/ infections (Candida, HSV, HPV, syphilis, gonorrhoea, threadworms)
c/ rectal and anal pathology (cancer, fissure, haemorrhoids, chronic diarrhoea or constipation)
d/ systemic disease (diabetes, anaemia, leukaemia, lymphoma, thyroid or liver disease)
e/ drugs (corticosteroids, immunosuppressants, antibiotics, peppermint oil, colchicine)
f/ diet (caffeine, beer, chilli, tomatoes, milk, citrus)

History

- Itch at night- threadworms
- Dietary and local irritants
- Associated symptoms (change in BH-cancer, bleeding- haemorrhoids or cancer, discharge – infection, pain-fissure)
- Anal intercourse
- Hygiene
- Systemic disease
- Allergies

Examination

- External examination
- DRE (not in children)
- General examination- look for systemic or skin disease)

Management

- Self-care (hygiene, avoid dietary and local irritants, keep dry, short nail+cotton gloves)
- Topical creams – Bismuth subgallate, Zinc Oxide
- Mild topical corticosteroids
- Sedative antihistamines
- Injection with methylene blue
- Referral
    - After 4 weeks of conservative treatment
    - Colorectal surgeon or dermatologist

Top Ten Tips

1/Very common , men more than woman
2/Multiple causes- local, systemic
3/ Hygiene
4/ Irritants-dietary or local
5/ Threadworms in children
6/ Think about cancer!
7/ Think about STDs, ask about anal intercourse
8/ Think about systemic or skin disease
9/ History and examination crucial
10/ Refer if 4 week of conservative treatments did not help