**Referral Support Service**

**Dermatology**

**D07**

**Generalised Pruritus**

**Definition**

Pruritus is defined as the desire to scratch. When generalised it affects most or all of the body.

This can lead to anxiety, depression, skin damage etc, due to the prolonged chronic nature of the condition, and effect on sleep and daily life. Conversely, however, anxiety and depression may also be a trigger for pruritus.

**Skin signs**

* Excoriations
* Skin thickening (lichenification)

These should spare hard to reach areas. However, if there is a rash, this is not generalised idiopathic pruritus and the underlying diagnosis should be sought and treated accordingly.

**Causes**

* Dry skin- common in the elderly in winter, treat with lots of emollients
* Eczema,
* Dermographic urticaria
* Scabies are commonest – examine the skin very carefully
* In the elderly, consider pre-bullous pemphigoid- seek advice as to whether skin antibodies should be performed.
* Consider animal infestation (cat fleas can live in carpets for up to 2 years post cat)

If there is no rash except excoriations, consider:

* Anaemia, especially iron deficiency
* Uraemia
* Cholestasis, autoimmune liver disease
* Hypo and hyper-thyroidism
* Lymphoma – itch may precede diagnosis by several years'
* Carcinoma – especially in middle aged/elderly
* Medication- opiates/opioids and other prescribed medication may lead to itch, alcohol and illegal drug misuse may also trigger itch (especially opiates/opioids and amphetamines)
* Psychological-anxiety and depression can be the cause, more rarely, delusions of parasitosis if there are fixed ideas about infestation in the absence of evidence. If there is a history of complex psychological trauma, this can lead to skin sensations interpreted by the brain as itch.

**Exclude red flag symptoms**

* Check for lymph nodes (cervical, axillae and groins) and organomegaly i.e. hepatomegaly, splenomegaly
* A full general examination is essential, repeated if symptoms don’t settle

**Management**

* Pruritus blood screen- FBC, U and E, LFT, TFTs,CRP, ferritin, B12: consider ANA and ENA if clinical suspicion, skin antibodies in 60+. Consider further malignancy screen if symptomatic, as dictated by clinical features.
* CXR to rule out lymphoma
* Strong advice not to scratch is very important due to the itch/scratch/itch cycle – “the more you scratch the more you itch”. Also advise to keep cool, keep nails short and smooth. Cotton gloves at night can help to avoid skin damage. Lukewarm baths or showers or cool flannels can help. Applying emollients can help to reduce itch due to their cooling effect. Distraction can help many too. Habit reversal/ combined approach to itch cessation can be very helpful
* [Atopic Skin Disease](https://www.atopicskindisease.com/)
* **Standard emollients** and soap substitutes are essential
* If an emollient alone does not provide adequate relief, consider a trial (100g) of an emollient with an active ingredient for example menthol 0.5% (e.g. Dermacool®) or 1% in aqueous cream or topical crotamiton (Eurax®), balneum plus.
* If localised areas are particularly severe, topical local anaesthetics such as 5% prilocaine and lidocaine can be considered- warn that these take 20-40 minutes to take effect, od or bd.
* The use of potent topical steroids should be discouraged **unless there is active eczema**.
* **Sedating antihistimines**:
* Chlorphenamine 8mg nocte or tds
* Hydroxyzine 25-50mg nocte increased if appropriate to 25mg 3-4x daily (please consider [MHRA advice](https://www.gov.uk/drug-safety-update/hydroxyzine-atarax-ucerax-risk-of-qt-interval-prolongation-and-torsade-de-pointes) re: hydroxyzine).
* Care with sedative antihistamines – warn re: drowsiness especially in elderly

**Psychiatric medications and treatments for neuropathic itch**

* Amitriptyline- 10-50 mg nocte can help sleep and neuropathic itch, can alleviate anxiety, higher doses usually needed for this and management of depression however. Can cause sedation
* Mirtazapine 7.5mg or 15mg nocte can treat any associated depression and help sleep, can treat neuropathic itch
* SSRIs/SNRIs can manage anxiety and depression
* **Opioid antagonists- especially in patients with liver disease**- eg naltrexone 25mg od
* **Anti-epileptics-**gabapentin or pregabalin can help in some intractable pruritus, especially neuropathic itch and renal pruritus starting at 150mg bd, increasing as needed by effect up to 600mg total daily.

See BNF for additional prescribing information.

**Referral:** Not currently seen in dermatology due to lack of secondary care treatment options not covered in the management guidelines above.

If there is diagnostic doubt, please consider seeking advice and guidance.

**Useful information sources and references for this leaflet:**

* [**Patient information leaflet**](https://patient.info/skin-conditions/itching-leaflet)

**Clinician information sources**

* [Pruritus-Update-October-2017-Lay-review-October-20172.pdf (bad.org.uk)](https://cdn.bad.org.uk/uploads/2021/12/29200253/Pruritus-Update-October-2017-Lay-review-October-20172.pdf)
* <http://www.dermnetnz.org/systemic/itch.html> - for clinicians
* [Itching (Causes, Symptoms, and Treatment) (patient.info)](https://patient.info/doctor/itching-pro) - for clinicians
* [Pruritus (pcds.org.uk)](https://www.pcds.org.uk/clinical-guidance/pruritus-without-a-rash)
* [Atopic Skin Disease](https://www.atopicskindisease.com/)