Eczema

“I’m really worried about the amount of steroid cream I’m using to control my eczema.”

“How much do you use?” I asked.

“Well, as little as I can, but I’m really worried it’s too much. I’ve read all about it on the internet.” She produced the remains of a 30g tube of Betnovate.

“How long have you had this?”

“Well, umm, quite some time….”

I looked at the expiry date on the tube: 2009. I looked on our records. We’d last issued it in 2007.

“Do you think this is the only tube you have had from us? Could you have got any from anyone else?”

“No, definitely not, doctor. That’s the tube you gave me a while back. Do you think I am using too much?”

“No. I think 30g in 5 years couldn’t really be described as excessive…!”

Eczema: challenges for primary care

Eczema is one of the ‘bread and butter’ dermatological conditions that we see in primary care. It is the most common reason for a dermatological consultation, and it requires great patient and parent education because successful treatment relies on pretty intensive self-management. It can be difficult for us, and evidence shows that:

- Emollients are significantly underused and prescribed quantities are too small.
- The majority of children referred to outpatients have mild to moderate disease that could be managed in primary care.

A qualitative study of English GPs looked at their experiences and confidence in diagnosing and managing eczema. The following themes were identified (BJGP 2018;68:e73):

- Most felt confident in making the diagnosis, and reported using a ‘trial and error’ approach to prescribing emollients.
- They were uncertain about the quantities of emollient and topical steroid they should prescribe.
- They lacked confidence in when and whether to prescribe potent topical steroids.
- They perceived adherence to treatment to be low.
- They offered variable information to support self-care.
- Routine review was uncommon.
- GPs felt parents were overly focused on looking for an underlying cause, e.g. allergy, and that there was a ‘phobia’ about topical steroids.

A survey of patients and parents run by the National Eczema Society (1993) suggested that expectations were only ‘completely met’ in 12% of GP consultations about childhood eczema.

Eczema written action plans

We know that personalised action plans are an effective strategy in promoting self-management in asthma patients. Could they also be useful in patients with eczema? My initial reaction was… heck, yes!

This qualitative study looked at the views of parents and primary care professionals on a written action plan (BJGP 2018;68:e81). Both groups considered the idea favourably, preferring something that could be personalised and based on a step-up and down model. This data and other research has been used by the Department of Academic Primary Care at Bristol University to develop a written action plan.

If you are interested in trying this out, a link can be found in the Useful websites box below. The action plan could be completed by any member of the clinical primary care team and this might be worth discussing with your nursing team.

NICE and SIGN guidelines

SIGN produced guidance on eczema in 2011; it applies to adults and children (SIGN 2011, 125). In addition, the now rather older NICE guidance which applies just to children has some useful points (NICE 2007, CG57). This table is an amalgamation of the most helpful bits of both!
SIGN and NICE on eczema in adults and children

Diagnosis

Make a diagnosis of eczema in children with itchy skin and 3 or more of the following:

- Current or history of flexural dermatitis, e.g. in elbow or knee creases.
- Dermatitis on the cheeks and extensor surfaces if age <18m or less.
- History of dry skin in the past 12m.
- Personal history of atopy (i.e. hay fever, asthma).
- Family history of atopy in a first-degree relative if age <4y at presentation.

Note that in Asian, black Caribbean and black African children, the pattern may be different, with extensor involvement or a more discoid or follicular pattern.

Assess the severity based on impact on quality of life, sleep, education, etc.

Refer if:

- Diagnosis is uncertain.
- No response to topical treatment.
- Psychological impact or sleep problems.
- Recurrent secondary infections.

Admit now if:

Eczema herpeticum (widespread herpes simplex) is a dermatological emergency. It is a widespread herpes simplex infection. Consider this in children with:

- Rapidly worsening painful eczema.
- Child may be unwell with fever, distress, lethargy.
- Early clusters look like blisters of herpes but then develop punched-out erosions (usually 1–3mm), quite uniform in appearance and may coalesce.
- Requires same-day admission for systemic acyclovir +/- antibiotics.

Management

Step 1

Emollients
(use at all stages, not just step 1!)

Bath emollients are discussed later. There is little evidence for their use in those already using topical emollients.

Step 2

Topical steroids

Step 3

Tacrolimus
Phototherapy
Systemic therapies
(e.g. immunosuppressants, monoclonal antibodies – these are discussed later)

Step 1: Using emollients

Mainstay of treatment for everyone with eczema. Here are some top tips:

- Apply regularly (at least twice daily), even when eczema is under control.
- Children should be using 250–500g per week.
- Use as a soap substitute in the bath or shower.
- Apply in the direction hair grows to reduce risk of folliculitis.
- Use a pump dispenser to avoid contamination of cream.
- Continue in addition to any other treatment for eczema.

The best one is the one the patient will use!
### Step 2: Using topical steroids

**Know your potencies!**

This isn’t covered by NICE/SIGN but is summarised from the BNF (2011). This list is not exhaustive, but includes the commonly-used steroids and those where errors may occur!

Be especially careful not to confuse clobetasol with clobetasol or the two hydrocortisones!

*Remember, applying steroid under occlusion, e.g. bandaging or dressings, increases its potency.*

<table>
<thead>
<tr>
<th></th>
<th>Mild</th>
<th>Moderate</th>
<th>Potent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hydrocortisone ACETATE</strong> (often simply referred to as hydrocortisone)</td>
<td>≤2.5%</td>
<td>≤0.05%</td>
<td>≤0.025%</td>
</tr>
<tr>
<td><strong>Potent</strong></td>
<td><strong>Betamethasone 0.1%</strong></td>
<td><strong>Betamethasone 0.025%</strong></td>
<td><strong>Betamethasone 0.005%</strong></td>
</tr>
<tr>
<td><strong>(Betasone)</strong></td>
<td><strong>(Betasone Fx)</strong></td>
<td><strong>(Betasone Fx)</strong></td>
<td><strong>(Betasone Fx)</strong></td>
</tr>
<tr>
<td><strong>Oxycortone</strong></td>
<td><strong>(Oxycortone) (Oxycortone)</strong></td>
<td><strong>(Oxycortone) (Oxycortone)</strong></td>
<td><strong>(Oxycortone) (Oxycortone)</strong></td>
</tr>
<tr>
<td><strong>Acetone</strong></td>
<td><strong>(Acetone)</strong></td>
<td><strong>(Acetone)</strong></td>
<td><strong>(Acetone)</strong></td>
</tr>
<tr>
<td><strong>Mexitazine</strong></td>
<td><strong>(Mexitazine)</strong></td>
<td><strong>(Mexitazine)</strong></td>
<td><strong>(Mexitazine)</strong></td>
</tr>
<tr>
<td><strong>Very potent</strong></td>
<td>Clobetasol</td>
<td>Clobetasol</td>
<td>Clobetasol</td>
</tr>
<tr>
<td></td>
<td>(Vorinova)</td>
<td>(Vorinova)</td>
<td>(Vorinova)</td>
</tr>
<tr>
<td></td>
<td>(Vorinova)</td>
<td>(Vorinova)</td>
<td>(Vorinova)</td>
</tr>
<tr>
<td></td>
<td>(Vorinova)</td>
<td>(Vorinova)</td>
<td>(Vorinova)</td>
</tr>
</tbody>
</table>

### Consider the degree of inflammation of the area you are treating:

NICE says we should consider the degree of inflammation when choosing a steroid, and use a mild steroid for mild eczema, moderate steroid for moderate eczema, etc. It doesn’t really specify what it means! NICE GS5, accessed July 2017, offers the following helpful definitions:

- **Mild eczema** – infrequent itch, dryness, minimal redness.
- **Moderate eczema** – frequent itch, redness and some local thickening/erosions.
- **Severe eczema** – incessant itch, widespread dryness and redness, thickening and excoriations.

### Body region, e.g.:

- **Face** – mild potency (especially in children).
- **Flexures** (thinner skin) – mild to moderate potency.
- **Hands and feet in adults** (thicker skin) – may need a moderate or potent steroid.
- **Use with extreme caution around the eyes because of concerns about glaucoma and cataracts.**

### Age:

- Generally mild steroids are more appropriate for younger children.

### How often should steroids be applied?

- Apply once daily.
- Increase to twice daily only if there is not an adequate response.
- If no response after 7–14d, think infection.
- In individuals with moderate to severe eczema with frequent relapses, consider twice-weekly maintenance treatment, even when eczema is settled.
- Review every 3–6m to check for skin changes, e.g. atrophy, pigmentation.

### How much steroid should I use?

There are two ways of thinking about this: fingertip units and grams/fortnight. I suspect patients prefer the former, and clinicians prefer the latter! There is a useful PatientUK leaflet we can give out (the link is given in the ‘Other resources’ section below).

#### Fingertip units

The fingertip unit (FTU) is the amount of a ribbon of cream/ointment that sits along the length of the distal phalanx of an adult’s index finger when squeezed from a tube with a 5mm nozzle. It is used to give people an indication of how much topical steroid to use.

The unit is ALWAYS an ADULT’S distal phalanx, even when applying to small children.

<table>
<thead>
<tr>
<th>Skin to be covered</th>
<th>Baby 3–6m</th>
<th>Child 1–2y</th>
<th>Child 3–5y</th>
<th>Child 6–10y</th>
<th>Adult</th>
</tr>
</thead>
<tbody>
<tr>
<td>Face and neck</td>
<td>1</td>
<td>1.5</td>
<td>1.5</td>
<td>2</td>
<td>2.5</td>
</tr>
<tr>
<td>Trunk</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>3.5</td>
<td>7</td>
</tr>
</tbody>
</table>
Both legs and feet   3   4   6   9   16  
Both arms and hands   2   3   4   5   8  
Both hands           -   -   -   -   2  

How much steroid to prescribe:  
The BNF offers the following advice for a single daily dose for adults, for 2 weeks’ use:

<table>
<thead>
<tr>
<th>Skin to be covered</th>
<th>Grams/fortnight for ADULTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Face and neck</td>
<td>15–30g</td>
</tr>
<tr>
<td>Trunk</td>
<td>100g</td>
</tr>
<tr>
<td>Both legs</td>
<td>100g</td>
</tr>
<tr>
<td>Both arms</td>
<td>30–60g</td>
</tr>
<tr>
<td>Both hands</td>
<td>15–30g</td>
</tr>
<tr>
<td>Scalp</td>
<td>15–30g</td>
</tr>
<tr>
<td>Genitalia</td>
<td>15–30g</td>
</tr>
</tbody>
</table>

Step 3 treatments

Topical tacrolimus
- Third-line agent after emollients and topical steroids.
- Use only in moderate to severe eczema in those aged over 2y either where:
  - Topical steroid use has failed OR
  - Where further topical steroid use may cause adverse effects (e.g., skin atrophy). (NICE says should be used only by dermatologists or GPs in dermatology)
- Use short term, for intermittent boosts of treatment (not regular use).
- Do not use on infected skin as it may suppress normal immunological reaction.
- Do not use under bandages (except on dermatological advice) (NICE).

Phototherapy and systemic treatments (NICE)
- Used in severe eczema where severe impact on quality of life.
- Specialist use only!

Dressings
- Advise those with non-infected moderate to severe eczema to cover affected areas with a dry dressing to provide a physical barrier to scratching, and to aid retention of emollient.
- SIGN concludes that there was insufficient evidence to recommend wet-wrapping.

Antihistamines
- Not for routine use.
- Short-term sedating antihistamines can be considered if debilitating sleep disturbance.
- In severe eczema, or in mild eczema with severe itching, consider 1m trial of a non-sedating antihistamine. Continue only if beneficial (NICE).

Infections
If eczema isn’t responding to steroids, consider infection.
- Skin swabbing is not usually indicated.
- Use oral antibiotics for widespread infections, and topical for localised infections.
- Staph. aureus and Strep. are the commonest organisms.
  - Fluoroquinolides first-line for both.
  - Erythromycin in those allergic to penicillin.
  - Clarithromycin if intolerant of fluoroquinolones and erythromycin, or if resistant to fluoroquinolones.
- Topical antibiotics should be used for a maximum period of 2w.
- Antiseptics (chlorhexidine, triclocarban) can be used to decrease bacterial load in recurrent infected eczema, but do not use long term.
- If recurrent infections occur, consider swabbing the patient and family members for Staph. carriage.
- In eczema with a discoid appearance, remember to consider tinea infection (see below).
Steroid not working – is it infection? Could it be tinea?

We all know it isn’t always easy to get the right diagnosis with skin lesions in primary care. If people are not responding to treatment, consider the following:

Is it secondary bacterial infection? Treat this, then the steroids will start to work again.

Is this tinea?

Tinea can commonly be mistaken for discoid eczema or guttate psoriasis. If this happens, it represents some weeks down the line when the steroid has been regularly applied but the patient is not cured. This will change the appearance of the tinea. A BMJ review considered this issue and made the following recommendations (BMJ 2017;356:j973):

Application of steroids to tinea will change its appearance. It may:

- Lose distinct inflamed, scaly edge.
- Become widespread and change into bizarre shapes!
- If we look carefully, it nearly always still has an annular appearance.

Consider this possibility in eczema or psoriasis that is not responding to steroids as you would expect:

- Take skin scrapings (steroid does not usually affect the accuracy of these because the fungus is still present).
- Look for other clues such as nail disease.

Once confirmed:

- Stop all steroid preparations.
- Use oral or topical antifungals as detailed above, but, remember, a more prolonged course may be necessary.
- Topical treatments should be applied to 1cm beyond the edge of the lesion.
- Patients should continue antifungal treatments for at least 2w after resolution of the lesion.

Emollients – safety concerns

Goodbye aqueous cream?

An older study suggested we should stop using aqueous cream as an emollient. What exactly did the research show? (Br J Dermatol 2010;163:954).

The trial was small – just 6 people. All were healthy, with no skin diseases. Over a 4w period, aqueous cream was applied twice daily to the volar aspect of one forearm, and nothing to the other arm (the control).
At the end of the 4w period, the researchers found that aqueous cream thinned the skin and increased water loss!

NICE reminds us that aqueous cream is also associated with significant stinging, and that skin reactions are common (NICE 2007, CG57).

Why?
The main reason is thought to be that aqueous cream contains sodium lauryl sulphate, an anionic surfactant (as contained in soap) which is known to be a skin irritant. Interestingly, when aqueous cream was first developed, it was designed to be used to wash the skin, not to be left on as an emollient.

What does this mean in practice?
This is only a small trial, but the findings are significant – aqueous cream is doing the opposite of what we want it to.

As a practice, we have stopped prescribing aqueous cream, and are raising it with patients who have been prescribed aqueous cream whenever we see them.

So, what are we using as an alternative?
Aqueous cream was always down the less greasy (and therefore less effective) end of the emollient spectrum but, because it was less greasy, people tended to use it more than some of the greasier (and therefore more effective) products.

We emailed our local dermatologist about alternatives and his answer was great: "The best emollient is the one that the patient likes and will use, and finding this is often trial and error."

Fire risk
In December 2018, following reports of more than 50 deaths from fire associated with emollient use, the MHRA recommended that labelling and product information on emollients should include specific warnings of fire hazard (MHRA 2018):

* Patients should be given "clear advice not to smoke or go near naked flames, and information about the risk of severe burn injury or death when clothing, bedding and dressings with emollients dried on them are accidentally ignited".

This advice applies to all emollients, whether they contain paraffin or not.

(It was previously thought that only preparations containing more than 50% paraffins were of concern, but increased risk has now been shown even if emollients contain no paraffin at all.)

Bath emollients: time to stop prescribing?
The NHS spends £17 million on bath emollients every year. Do they work? For a long time, there has been an absence of evidence. Note, here we are talking about bath additives rather than soap substitutes.

A well-designed, UK, primary care RCT of nearly 500 children attempted to answer this question (BMJ 2018;361:k1332). It was a pragmatic trial where the children were randomised to no bath emollients or regularly prescribed emollients for 12m. They all continued their standard eczema treatment. The main outcome measure was improvement in a validated eczema symptom score (POEM). The trial found:

* No clinically meaningful benefit of using emollient bath additives in addition to standard eczema management (leave-on topical emollients, emollients as a soap substitute, and as-needed topical steroids).
* There was no statistically or clinically significant difference in POEM scores, and no difference in exacerbations, use of topical steroids or quality of life.

The accompanying editorial reminds us it was not a perfect study – as is the nature of RCTs, concordance with treatment was good in both arms, and 13% of the control group admitted to occasional use of bath emollients. When concordance with leave-on emollients is poor, bath emollients may be better than nothing.

The study was not powered to assess the relative benefits of the three different bath emollients that GPs/patients could choose – they all have the same mode of action, but it is possible that antibacterial-based products, not included in this study, may show more benefit in those with recurrent skin infections (BMJ 2018;361:k1791).

What does this mean in practice?
* When compliance with emollients is good, there may be no role for bath emollients. We could, quite literally, be throwing money (£17 million!) down the drain.

Time to review our practice?

Systemic treatments for eczema
The decision to start systemic treatments for eczema is very much a secondary care decision. However, there are a number of possibilities and an evolving evidence base for biologicals which may offer some hope for our most severely affected patients. An
editorial in the NEJM summarises the current situation (NEJM 2017;376:878).

Immunosuppressants, e.g. cyclosporine, have been most widely used, but have significant risks and side-effects.

Current interest is in the blockade of inflammatory cytokines thought to mediate itch and inflammation using biological treatment (monoclonal antibodies). Note that these studies were only in adult populations.

- A small, imperfect RCT study of nemolizumab showed a significant dose-dependent improvement in patient-reported itch (NEJM 2017;376:826).
- There have been 3 RCTs for dupilumab – two lasting 16w and one lasting 52w. They have all demonstrated a statistically significant improvement in symptoms when compared with placebo. One of the studies included patients who had failed to respond to ciclosporin. Adverse effects included nasopharyngitis and conjunctivitis. Long-term safety data is only available on a small number of patients. It is REALLY expensive (£1200 for 28d) (DTB 2018;56:30).
- A larger RCT of dupilumab showed that the drug improved a whole range of eczema-related outcomes, including clearance of disease, itch and quality of life. The NNT was 4 for clear, or almost clear, skin at 16w. There was a significant excess of cases of conjunctivitis in the dupilumab group (5–11% vs. 1–2% in the placebo arm), but no other adverse events. However, follow-up was only for 16w (NEJM 2016;375:2335). A longer trial is required.

The editorial comments that these drugs show promise but, predictably, larger cohorts, paediatric studies and longer follow-up periods are necessary before these become mainstream practice. Watch this space!

**Eczema and cardiovascular risk**

We are all aware that chronic inflammatory conditions increase the risk of cardiovascular disease, but I had never considered this in eczema.

A population-based cohort study using UK data from the CPRD investigated whether adults with active atopic eczema are at increased risk of cardiovascular disease (BMJ 2018;361:k1786).

It looked at nearly 400 000 adults with a diagnosis of atopic eczema, matched them with more than 1.5 million controls and followed them up for 5y. It calculated how ‘active’ the eczema was and graded its severity:

- Mild disease: default.
- Moderate disease: prescription of two or more potent steroids in a year or calcineurin inhibitor treatment.
- Severe disease: at the first point they received an immunosuppressant or phototherapy, or hospital referral for atopic eczema.

This was the case for 5% of the cohort.

**Results**

After correcting for known risk factors including smoking, lipids, BMI, BP, etc.:

- There was a relationship between active atopic eczema and cardiovascular risk.
- There was a small increased risk of:
  - Unstable angina (HR 1.25, 1.1–1.4).
  - Heart failure (HR 1.19, 1.1–1.3).
  - And even smaller risks for AF and stroke.
- There was no impact on the risk of cardiovascular death.
- The more severe an individual’s eczema or increased activity level of disease (>50% of the time over 5y), the greater the increase in cardiovascular risk.
- Individuals with severe eczema had a 40–50% increased risk of MI, unstable angina and AF, and a 70% increased risk of heart failure.

**What does this mean in practice?**

The theory behind why eczema may have this effect is that there is an association with increased platelet activation and therefore increased risk of clotting. The overall body of literature is inconsistent, and, generally, the risk in mild eczema seems to be low. However, the data in severe eczema is more compelling. What we don’t know is whether the increased cardiovascular risk is due to the disease itself or the systemic drugs we use to treat it!

The most clinically significant effect was seen in those with severe or very active disease. Part of our review of these patients should include considering their conventional cardiovascular risk factors and being aware that risk calculators may underestimate their risk.
**Eczema**

- Ensure patients understand that emollients are the mainstay of treatment. Apply liberally and regularly, even when there is no sign of eczema, in the direction of hair growth, and continue to apply even if topical steroids are needed.
- When prescribing steroids, know your hierarchy and choose carefully, especially thinking about the site of the body, age of the patient and disease severity. Know your fingertip units!
- If steroids are not working, think infection!
- Tacrolimus is a third-line agent. NICE recommends use by dermatologists/dermatology GPSIs only.
- Use antihistamines only in specific circumstances.
- For most, dietary interventions are unproductive.
- Refer eczema herpeticum as a same-day dermatological emergency.
- Which emollients are you using? Is it time to ditch aqueous cream?
- And what about bath emollients? How much money are you throwing down the plughole each year?

Audit your patients with a diagnosis of eczema:
- Do you prescribe adequate quantities of emollient?
- Do you prescribe topical steroids once daily?
- Do you prescribe bath emollients, and should you stop?

Quality improvement idea: could you incorporate written action plans and routine review into the management of your childhood eczema patients?

**For patients:**

National Eczema Society website – offers support forums, information leaflets: www.eczema.org

Videos on how to apply topical steroids and emollients can be found here: www.bad.org.uk/for-the-public/patient-information-videos

**For professionals:**

These are useful leaflets to give out for patient (and doctor!) education:

Access to the Eczema Written Action Plan: www.bristol.ac.uk/primaryhealthcare/researchthemes/apache/ewap

General eczema information: www.bad.org.uk/site/796/default.aspx

What is atopic eczema? www.patient.co.uk/showdoc/23068730

How to apply emollients: www.patient.co.uk/showdoc/27000766

Fingertip units of steroid: www.patient.co.uk/showdoc/27000762

We make every effort to ensure the information in these articles is accurate and correct at the date of publication, but it is of necessity of a brief and general nature, and this should not replace your own good clinical judgement, or be regarded as a substitute for taking professional advice in appropriate circumstances. In particular check drug doses, side-effects and interactions with the British National Formulary. Save insofar as any such liability cannot be excluded at law, we do not accept any liability for loss of any type caused by reliance on the information in these articles.
One day updates for GPs and all Primary Care Clinicians.

Keeping on top of every change to guidelines and the latest research can be a challenge. But we do all that legwork for you and jam-pack our one-day courses full of brand new updates to change your practice straightaway. Check our autumn dates on gp-update.co.uk for our most popular courses:

**The GP Update Course (RCGP accredited)**
**The Cancer Update Course**
**The Women’s Health Update Course**
**The MSK & Chronic Pain Update Course**
**Lead. Manage. Thrive!**
**Consultation Courses**

And with every course you get online access to:

- **500** searchable & referenced articles
- **97%** coverage of RCGP primary care curriculum
- **100s** of FREE learning activities to earn CPD credits
- **FREE** for 12 months!

**Roadshow 2019: Durham**

Perfect for anyone looking for an excuse to visit beautiful historic Durham and join us at a gorgeous spa hotel (and why not?), or anyone who wants to get their CPD in one great big hit (we’re all about efficiency)! Choose up to five courses and get £90 off if you book four!

Catch us at the Ramside Hotel & Spa and enjoy a little bit of luxury.
Red Whale Deep Dives are monthly webinars, created to support the educational needs of busy primary care practitioners. They’re designed to be a little bit different – capturing the magic of a face-to-face course, and transferring it to the small screen.

Why?
A lot happens in a year, and some subjects are better suited to a deeper exploration than we can offer on our action and information packed one-day Update courses.

The Red Whale team is always uncovering answers to niggly primary care conundrums, PUNS and DENS if you like – and we want to share them with you!

Sometimes you need a bit of inspiration to find those extra CPD points to complete your appraisal. Or you just need a bit more Red Whale in your life!

Red Whale Deep Dives are split into bite-sized learning chunks – so you can choose to watch the whole hour in one go, or just one short segment at a time. Watch them at a time which suits you – when you can relax and learn at your best – preferably with your feet up and a cuppa in hand, or a cheeky G&T!

Join us while we dive deep into those trickier areas of primary care – answering your conundrums and helping you change your practice. Catch our Deep Dives webinars live every month, or watch on demand afterwards – whenever it suits you!

NEW
www.gp-update.co.uk/deepdives
Red Whale Deep Dives give you:

- A chance to take a ‘deep dive’ into important, difficult or controversial topics in more detail.
- At least 3 ‘microlearning segments’ per webinar – or Quick Dips as we like to call them – perfect for fitting into your busy daily routine.
- Cases, quizzes and polls to test your knowledge.
- Great resources to download and use back at the surgery the next day.
- The most relevant information for primary care, delivered by the Red Whale team.

How it works

- You choose which webinars you want access to and buy them online.
- Each webinar lasts one hour and you can either watch them live on the dates and times shown or on demand.
- You’ll also have access to lots of useful resources to download and use straightaway in your practice!
- Get each webinar at an introductory discounted price of £20 per webinar (normally £25!).

Where do I sign up?

Visit gp-update.co.uk/deepdives to find out more about each webinar and sign up. After purchase, watch on-demand webinars straight away and get reminder emails for your upcoming live webinars.

www.gp-update.co.uk/deepdives