

Review Article

Nursing in Dermatology

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Abstract: Nurses in dermatology perform a number of specific procedures in health care. Dermatological examination includes clinical examination of the skin and visible mucous membranes, with appropriate diagnostics, when a swab is taken for mycological or bacteriological treatment in case of suspicion of infection. In case of need for histopathological confirmation or exclusion of a certain diagnosis, a biopsy sample is taken or other diagnostic procedures and laboratory tests are indicated. After diagnosis, the decision is made for appropriate treatment according to the guidelines of modern dermatology. One of the most common standardized procedures in health care is the application of local therapy. This specifically means applying the drug to the surface of the skin, scalp or nails in a particular form - creams, ointments, solutions or oils. In addition to local therapy, the use of ultraviolet radiation, ie phototherapy, also plays an important role in the treatment of various dermatoses. Nurses prepare and educate patients before performing this form of therapy. In patients with chronic wounds on the lower legs, the nurse conducts local therapy in the form of compresses, solutions, gels. This form of therapy must be performed with the use of compression therapy set by a nurse. In monitoring and conducting therapy for chronic wounds, a list for monitoring chronic wounds is used. Nurses keep nursing records for patients on the hospital ward, using a transfer list and a list to track chronic wounds. The most important role of the nurse is to educate through the implementation of various forms of local therapy during the stay in the hospital and thus help the patient in the application of local therapy at home after discharge from the hospital.

Keywords: Dermatology, Skin, Disease, Nurse.

INTRODUCTION

The examination of skin diseases requires a lot of patience, listening to what the patient has to say, being sympathetic, and trying to gain the patient's confidence so that they tell you their problems openly and without any hesitation [1]. This is especially important in an Eastern culture where the patients do not want to reveal any problem relating to genital disorders.

History taking is similar to the history taking in other branches of medicine, e.g., history of the present complaints, past illness, family history, systemic illness, etc. Particular emphasis is laid on the drug history. In the first place, we do not want to give the same medicine that the patient has already been receiving; for example, in acne we would not like to repeat tetracycline if it has shown no response so far. Medicines applied on the skin can change the morphology of the lesion, e.g., the use of steroids leads to tinea incognito, which should be kept in mind while dealing with asymmetric rashes. In many cases, drugs are the cause of lesions, e.g., psoriasis may be due to the use of b-blockers for hypertension.

A proper history and examination should lead the clinician to come to a provisional diagnosis. A few questions asked after the examination will help the clinician to come to a final diagnosis, e.g., psoriasis may be due to drug intake. In only a few cases will further investigations be required.

Skin diseases affect a significant proportion of the population and can seriously impact on a person's health and well-being [2]. They can affect how a person undertakes their activities of living as well as how they interact with others and how others interact with them. Each time a healthcare professional interacts with those they care for, they are observing the patient's skin as they undertake care activities; it is essential therefore that they have an understanding of

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the function of the skin so as to recognise problems that can occur. There are several areas of practice where the healthcare professional will come into contact with those who experience problems of the skin and they are ideally placed to offer these people support with respect to some of these conditions.

Some skin conditions have the potential to cause stigma, such as eczema and psoriasis; the healthcare professional, as advocate, can correct any misunderstanding concerning contagion and help to improve the individual's social well-being. Often appearance and image are associated with success and achievement, and the blemish-free individual represented in the media (in many Western societies) is the image to which many strive; however, this is not always possible for those with skin conditions. Society places much emphasis on physical appearance and for those who have skin problems this can become increasingly challenging. People with skin problems may experience difficulties in other aspects of their lives, e.g. from a sexual relationship perspective, and also concerning issues associated self-esteem and self-concept – altered body image can have a profound effect on the individual, their partner and their family.

Skin

The skin is the most accessible organ of the human body [3]. Its most basic function is simply a protective one. As a barrier, the skin holds off desiccation and disease by keeping moisture in and pathogens out. Nevertheless, characterization of the skin as mere “plastic wrap” is a gross underestimation of the anatomic and physiologic complexity of this vital structure.

Unlike parenchymal organs, end-organ dysfunction or failure is not a prerequisite for the diagnosis of a skin disease, because all skin diseases can be observed clinically irrespective of their functional effects. Among the spectacular array of neoplastic, inflammatory, infectious, and genetic cutaneous disorders, some elicit only trivial aberrations in skin structure or function, whereas others lead to profound and morbid consequences.

The skin is an organ that consists of three layers: epidermis, dermis, and subcutis [4]. The outer epidermal layer is predominantly composed of keratinocytes and scattered melanocytes. The dermis consists of connective tissue, blood vessels, nerves, hair follicles, and skin adnexal glands. The hypodermis, or subcutis, is predominantly composed of fat tissue.

The surface of the skin is constantly abraded, and the epidermis is constantly regenerated from the proliferating cells in the basal layer. This is essential for maintaining the integrity of the skin and its primary function—protection against external injury. Intact skin represents a formidable barrier; therefore, it is imperative that the body keep its “armor” intact.

The epithelial components of the dermis, often referred to as skin appendages, are anatomically distributed in an uneven manner. Hair follicles, with the sebaceous glands attached to them, are prominent on the scalp but are not evident on the palms or plantar side of the foot. Eccrine sweat glands are present all over the body, except for some sites, such as the margins of the lips and nipples. The primary function of these sweat glands is perspiration and thus, indirectly, thermoregulation. Apocrine or odoriferous sweat glands are located in some areas, such as the axilla and pubic region. Under the control of sex hormones, these glands produce a clear, sweat-like fluid that is rich in organic substances. The organic components of sweat decompose under the influence of skin bacteria, resulting in distinct odors.

The hypodermis, or subcutis, is the third layer of the skin. It is predominantly composed of fat cells and connective tissue. The thickness of this layer, which is poorly demarcated from the overlying dermis, varies. Its primary function is to provide thermal and mechanical protection to the body by its fat pad.

The overall objective of the nursing intervention is to provide support to patients who have skin disease, in order to enhance their mental health and thus enable them to cope with their condition as effectively as possible [5]. Nurses will already have a significant skill-set that they can draw on to achieve this, what is outlined here are ways to develop these skills further. This should not be mistaken as an attempt to train people into being therapists with specific abilities. Instead, communication skills will be discussed along with some techniques used in cognitive behavioural therapy (CBT). These can be incorporated into developing a set of professional competencies relevant to the area of work. Should a patient's needs go beyond the nurses level of competency, referral on to other practitioners e.g. a clinical psychologist, should always be considered.

Examination

In the first visit, it is advisable to examine the whole body, even if the patient insists that the lesion is only on one part of the body [1]. The patients may be unwilling to show lesions on the genitals, or the lesions on the back can be missed if not examined. Many melanomas, of the back have been diagnosed this way. Always palpate and examine the

lesions; this not only reassures the patient but also helps in the diagnosis. For example, induration is characteristic of squamous cell carcinoma; some dermal nodules if they are deep down can only be felt.

The important points to be noted in a rash are: whether the rash is acute or chronic, localized or generalized, dermatomal or nondermatomal, symmetrical or asymmetrical, eczematous or noneczematous, permanent or evanescent, scaly or nonscaly. Color of the rash should also be noted, whether it is erythematous, skin-colored, pigmented, purplish, yellowish, or white. The morphology of the rash also provides a clue to diagnosis; note whether the rash is nummular (round), discoid (disc-like), annular (ring-like), oval, irregular, gyrate (wave-like), reticulate (net-like), and arcuate (curved). The type of rash helps in categorizing the skin disease; see whether the rash is composed of macules, papules, vesicles, bullae, and pustules. Note the symptoms; is the rash pruritic or nonpruritic, painful or nonpainful? Lichenification and scratch marks are indicative of pruritic disorders. Finally, look for scarring in a lesion; it is specific of some disorders such as discoid lupus erythematosus. Scarring should be especially noted in hairy areas, as the scar indicates that hair growth will not occur at these sites.

The important points to be noted for a skin growth are: the onset, whether slow or rapid; site of growth, whether head and neck, sun-exposed areas, trunk or extremities. Is the lesion single or multiple, if multiple is it localized or generalized? Size and morphology of the growth should be noted, is it papular, plaque-like, or nodular? Is the size 6 mm? Is the growth umbilicated or nonumbilicated? Does it have a punctum or not? Is the surface of the growth smooth, verrucous, scaly, or nonscaly? Color of growth helps in diagnosis; pigmented growths should be examined carefully to exclude melanoma. See whether the pigmentation is uniform, or are there color variations. Large pigmented growths with irregular color variations should be considered suspicious of malignancy. Is the color of the growth pearly, yellowish, erythematous or skin-colored? (Color variations can occur due to different skin photo types; this should be kept in mind.) Is the growth painful or nonpainful? Finally, the consistency of the growth is felt, is the growth soft, firm, indurated, rubbery, malleable, or hard?

Lesions are palpated to determine texture, size, and firmness [6]. All lesions should be described as to size, location, color, surface characteristics, pain, discomfort, itching, and bleeding. Note when the patient first discovered the lesion.

Specific nursing care related to cryosurgery includes preparing the patient for the procedure. Minor discomfort can be expected with little or no local anesthesia. Expect swelling, local tenderness, and hemorrhagic blister formation 1 to 2 days after the procedure. After the procedure, the area is cleansed as ordered and prescribed ointments are applied.

Specific nursing care for curettage and electrodesiccation include preparing the patient for the procedure. After local anesthesia, a dermal curette is used to scrape away the lesion, followed by electrodesiccation of the remaining wound; the wound heals by secondary intention, usually with minimal scarring. After the procedure the wound is cleansed and dressed as prescribed.

Aging Skin

Human skin is the largest and the most complex organ functioning as a physical and biochemical barrier to protect the human body from water loss as well as environmental insults including pathogens, chemicals, physical agents and solar ultraviolet radiation (UVR) throughout life [7]. More than that, the skin provides crucial physiological functions including immune defense, thermoregulation, sensing, endocrine as well as metabolism.

Aging is a chronological process accompanied by a progressive loss of physiological function in multiple organs. Skin undergoes an aging process accompanied by physical changes, clinical manifestations and significant psychological consequences. According to recent statistics, around 25% of Americans are expected to be 65 years or older by the year 2030. Therefore, it is important to understand the chronological skin aging process and its accompanying physiological consequences for medical reasons and for the personal care industries.

Aging of skin is both extrinsic and intrinsic [1]. Intrinsic aging is the natural aging, which affects the skin as it affects other organs of the body. Extrinsic aging is due to ultraviolet radiation that affects the skin only. Intrinsic aging is universal and inevitable, while extrinsic aging is neither universal nor inevitable. We can prevent the effects of ultraviolet damage by using protective measures against ultraviolet light, but intrinsic aging is not preventable.

Cutaneous changes of aging are:

- Dry and rough skin
- Thinning of the skin
- Patchy pigmentation
- Wrinkles

- Loss of elasticity
- Decreased tone
- Decreased resistance to mechanical, compressive, and shearing forces acting on the skin
- Easy bruising and purpura
- Facial telangiectasia
- Angulated scars
- Decrease in tactile sensations
- Graying of the hair
- Density of hair decreases
- Increase of terminal hair in the ear and eyebrows of men, slight hirsutism in women
- Rate of nail growth decreases
- Loss of subcutaneous fat

Dermatoses in Neonates and Infants

The skin of neonates and infants differ from adults in the following ways [1]:

- In neonates and during early infancy, the skin defenses are not fully developed, the skin is vulnerable to physical, chemical, and microbial attack.
- The surface area to the weight ratio is higher than at other times of life; there is a greater hazard from increased absorption of topically applied medicaments. Serious toxicity can occur from the application of topical steroids, salicylic acid, neomycin, boric acid, aniline dyes, hexachlorophene, and related antiseptics.
- The rate of transepidermal water loss through intact and non sweating skin of the newborn is high, indicating immaturity of the skin barrier function. Dehydration rapidly develops.
- Hypothermia develops rapidly in widespread skin rashes.
- During early weeks of life, the blood levels of some hormones are similar to that of the mother, e.g., androgens levels are high and these are the cause of neonatal acne.
- Scratching does not seem to develop until around 6 months of age.

Some specific skin diseases of childhood are nappy rash, atopic dermatitis, cradle cap, napkin psoriasis, staphylococcal scalded skin syndrome, lip licking, juvenile plantar dermatosis, bullous disease of childhood, acrodermatitis enteropathica, and congenital ichthyosis.

Dermatoses in Old Age

Many dermatoses of the elderly reflect the higher prevalence of systemic diseases such as diabetes mellitus, vascular insufficiency, and various neurological syndromes [1]. Some diseases such as cutaneous infections may be due to reduced local skin care. Reduced tolerance to systematically affected drugs is well documented. Delay in dermal clearance of absorbed substances and possible reduced metabolic capacity may render the elderly susceptible to both beneficial and adverse affects of the topical application of drugs.

Skin diseases of old age include pruritus, senile xerosis, asteotic eczema, peripheral leg ulcers, herpes zoster, and skin tumors. Some benign growths of old age are acrochordon, cherry angiomas, seborrhoeic keratosis, lentigo, and sebaceous hyperplasia.

Aesthetic Treatments

There is an increase in the number of nurses and other healthcare providers who want to learn about nonsurgical aesthetic treatments and add them into their practice [8].

Undeniably, aesthetic practice is a broad combination of nursing, medicine, and art. The notion that aesthetics is informal or rudimentary can lead to exaggerated levels of practitioner confidence. Some practitioners delve into aesthetics without proper education or training, and this leads to dissatisfied patients and unsuccessful practices or, worse, legal action.

Nurse practitioners (NP) are advanced practice registered nurses (APRN) and are legally able to diagnose conditions and prescribe medications and treatments for patients in the United States (US). Alternatively, registered nurses (RN) in the United States are not legally able to diagnose conditions or prescribe medications and treatments, and they must have a qualified provider to diagnose and prescribe treatment. Then, after diagnosis and treatment prescription from a qualified provider, in most states, the RN is legally allowed to provide the appropriate aesthetic treatment to the patient. However, nursing laws vary in different countries, and nurses must understand the regulatory mandates that govern their practice to avoid disciplinary measures or legal action. It is vital to understand the legal framework of the country, state, or region where the nurse practices aesthetics.

In medical dermatology, several different treatments may be needed over time to treat, for example, a psoriatic patient [9]. Similarly in cosmetic dermatology no one technique can reverse all the changes of photoageing, and treatments must be tailored to the individual. The techniques used most commonly are the application of emollients and retinoid creams, facial peels, injection of botulinum toxin and dermal fillers, and laser and light sources. As a general rule, the choice of treatment depends on the depth of the pathological changes. Superficial changes, such as pigmentary ones and early keratoses (Glogau I and II), are best treated with agents acting on the epidermis, such as topical retinoids and shallow facial peels. In contrast, wrinkles caused by dermal changes and underlying volume loss need treatment that reaches the deeper layers of the skin – such as ablative laser therapy or the injection of fillers.

Wounds

During the past several decades, major advances have been made in the practice of skin and wound care [10]. Clinicians now closely monitor coordinated cellular and biochemical events that occur in skin and wound healing. Manufacturers of skin and wound care products are partnering with clinicians to identify materials that help manage simple and complex skin conditions and wounds. At the same time, standards for describing skin and wounds are being developed to help the clinician document skin and wound assessment. Now, more than ever before, a solid foundation of information exists to accelerate skin and wound healing. But despite these advances, the incidence and prevalence of chronic wounds—such as pressure ulcers, venous ulcers, and diabetic ulcers—in the United States has risen to epidemic proportions.

Chronic wounds can exact an emotional, physical, and financial toll on the patient and his caregivers. Frustration and confusion continue to arise among clinicians when trying to determine a wound management pathway for a wound or skin condition, when to change to a different type of dressing or drug, how to document the progress of the wound or skin appropriately, and how to track outcomes based on care practices.

Some solutions to these dilemmas can be found by understanding the delicate balance of art and science. Art refers to the team member's skill and application technique in using the preferred management modality for skin and wound care. Science refers to the team member's knowledge and understanding of the disease and of the preferred modality used in managing the patient's care. Art and science—the fundamental tools of skin and wound healing—directly affect clinical and financial outcomes for the patient.

Millions of people in the United States and around the world will suffer from acute and chronic wounds [11]. It is estimated that 300,000 people are hospitalized each year in the United States due to acute wounds along with 11 million people affected. Chronic wounds affect approximately 6.5 million people, and it costs an excess of 25 billion annually to treat these wounds, a number that represents 2% of annual health care spending. These alarming numbers are mainly the result of an aging population and a rise in the incidence of diabetes. For example, roughly five million people suffering from diabetes will develop chronic wounds that will fail to heal. In recent decades, clinicians and scientists have expanded upon their knowledge of the mechanisms of wound repair and wound care. As a result, the goal of wound therapy has shifted from managing symptoms to a more practical approach that will ultimately promote optimal wound healing and improve patients' quality of life. Despite these advancements wound healing remains a challenge. Stem cells are essential for tissue homeostasis and repair, and their versatility holds tremendous potential for tissue regeneration in a number of different clinical applications, including acute and chronic wounds. The unique self-renewal and differentiation capacity of stem cells make them attractive alternative to traditional wound treatments. Stem cell therapy aims to enhance cutaneous regeneration by completely restoring the structure and function of tissue so it is indistinguishable from its native state.

Malignant wounds, also known in the literature as fungating tumors, tumor necrosis, ulcerative malignant wounds, or fungating malignant wounds, present both a physical and an emotional challenge for the patient, caregiver, and clinician [12]. These wounds are frequently associated with pain, odor, bleeding, and an unsightly appearance. They may be a blow to self-esteem and may cause social isolation just when the patient needs more time with loved ones. The goals in the care of patients with malignant wounds include managing wound exudate, odor, bleeding, and pain; preventing infection; and promoting the emotional welfare of the patient and family.

COVID-19

Healthcare workers, particularly nurses, are at high risk of being infected because they are in the closest proximity to patients [13]. The pandemic of COVID-19 is stressful for healthcare workers. Current research has already shown that healthcare professionals suffer from psychological distress due to COVID-19 pandemic. They experience considerable psychological distress when working with patients diagnosed with COVID-19, including social isolation, role conflicts, fear, and anxiety.

The fear and anxiety caused by an infectious disease can be devastating if not appropriately identified and managed. Due to the sudden outbreak of the disease, we do not know what nurses experience when caring for patients with COVID-19, especially during the situation where nurses are sent away from their usual work environments to work in the epicenter. These nurses have been working in the epicenters for more than a month now. It is essential to understand the psychological changes in these nurses and ways to manage their stress. This information is urgently needed by nurse leaders to design plans for stress management and interventions to maintain nurses' psychological well-being. The purpose of this study is to examine the psychological experience and change process of nurses in the epicenter of COVID-19 and to provide strategies that nurses could use to handle their stress.

Treatment

Skin is the most accessible organ to treat [1]. There are many therapeutic approaches to skin disease. These are by topical application of drugs, intralesional injections, oral medication, physical therapy, and surgery. The topical approach is timeconsuming; a large amount of medication may be required to produce the desired effect and it may not be aesthetical and pleasing to the patient. Patients often complain of the color, smell, and greasiness of ointments. However, this approach has the advantage of delivering the drug to the target organ, and does not have the side effects of systemic toxicity if used within the required limits, and above all the results can be seen by the naked eye.

In the treatment of dermatological problems, the multior interdisciplinary approach encourages each discipline to bring its own training, skills, and experience to the problem-solving and treatment options for complete care of the patient [14]. Each member of the team has a professional interest in their patient, while working in a team environment encourages each member to bring their own skills, experience, and perspective to the table. This also gives each member the flexibility to develop a care plan that meets all of the patients needs, medical and nonmedical. The team approach can be used for problem solving and for exchange of information and ideas in caring of the patient for best outcomes.

How a multidisciplinary approach works can be illustrated by considering a scenario in the pathway of care for the patient. The patient goes to his/her primary care physician (PCP), who refers the patient to a dermatologist. The communication between these two medical professionals is a vital link to the overall care of the patient. Nursing staff, lab staff, and scheduling staff are all needed to efficiently guide the patient through the healthcare pathway. Social work staff may assist in coordinating care through resources and referrals, especially for continuance of care at home. Psychiatrists, occupational therapists, and physical therapists may be called on for collaborative and collateral consultations and parallel treatments. All of these professionals on the team play an integral part in total patient care. This is especially important for dermatological care since the skin is an external organ and what afflicts the skin is often seen by other people. Their reactions can be almost as significant to the patient as the problem itself.

CONCLUSION

The nurse monitors, observes the patient, notices and reports on all changes that occur in relation to the patient. The nurse must have a good command of communication skills as well as be able to recognize non-verbal indicators of the patient's discomfort in time (facial expression, body language, vision, way of answering a question, etc.). Patients suffering from skin diseases are primarily affected by the quality of life due to the appearance of the skin. The fact that health is impaired is extremely stressful in every person, and in patients whose disease is expressed on the skin and damages its appearance and visible to its environment, it is an additional source of stress. Therefore, such patients need to be approached with warmth, understanding and respect because the disease can significantly affect self-image and diminish self-esteem. Patients with skin diseases often point out that the most important cause of their psychological problems is precisely the way other people react to their disease, not the disease itself. Because of such negative experiences, the patient often develops a sense of stigma, and he develops negative expectations. Research has shown that such feelings and beliefs are not the result of a patient's hypersensitivity, but a reaction to the stigma actually experienced. The nurse must understand the patient's cognitions and the way he experiences himself and his illness in his social environment because the experience of his own physical appearance is a very personal experience. Satisfaction with physical appearance has a significant impact on psychosocial health. There is a known link between dissatisfaction with physical appearance and depression, social self-esteem, feelings of security and social anxiety. Acceptance of one's own physical appearance is one of the preconditions for psychological stability, and the nurse provides significant assistance to the patient with her approach.

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