BNF Chapter 13 – Skin Formulary

Introduction to prescribing emollients

Emollients are fundamentally important for managing dry skin conditions. In eczema care they are vital to promote barrier function and reduce the likelihood of acute flares. For patients with psoriasis emollients can thin plaques and reduce scaling and for those with generally dry skin (particularly the elderly) skin quality can be improved significantly. For all patient groups emollients make the skin feel more comfortable and can improve quality of life.
All patients using specific topical treatments, such as topical steroids or vitamin D analogues should make regular use of emollients.

Which emollient to prescribe?

Patients should use the least expensive emollient that is effective, cosmetically acceptable and which they are prepared to use regularly. This is because there is a:

- Lack of good quality evidence comparing emollients
- Wide inter patient variability in response to particular products

Emollients should be SLS (sodium lauryl sulfate) free as this can cause skin irritation when used in leave on emollients.

When choosing emollients for an individual patient consider:

Patient's preference and lifestyle – emollients must be cosmetically acceptable to the patient, if they are too sticky or greasy they may not be used. In this formulary options have been selected that reflect a range of options at good value for money.
After taking into account patient preference emollients should be chosen upon the basis of disease severity. The table below is designed to help in that decision making. Topical emollient choices start with simple emollients (creams and ointments) and move on to more complex emollients with added ingredients which are for more moderate to severe disease or when a patient fails to respond to the simpler products.
Alongside topical emollients, soap substitutes should be prescribed as soaps (including bubble baths) will dry the skin – thus aggravating dry skin conditions. Bath additives are not recommended routinely if a soap substitute is being used.

General skin care

The elderly are particularly vulnerable to skin break down and therefore need particular attention with regards to skin washing and protection. It is advised that soap substitutes are routinely used along with a simple emollient to reduce likelihood of skin breakdown. After washing the skin should be gently but thoroughly dried, especially in skin folds. If incontinence is an issue scrupulous skin hygiene is vital. If a barrier product is needed it should be applied according to manufacturers instructions with due consideration to the impact it has on the absorbency of incontinence pads. Emollients containing dimeticone may act as a sufficient barrier.

How much emollient to prescribe

As a general rule no prescriptions for less than 500g should be written. If a patient has a dry skin condition and is using their emollient as a soap substitute they can easily use 500g per week.

Patient education

Patients should be clear about how to use their emollients:
(1) How often (whenever the skin is dry, usually 3-4 times a day)
(2) How long (may be ongoing especially in eczema)
(3) How much (enough to leave skin feeling slightly tacky, more specific quantities are documented in BNF)
(4) How to apply (smooth gently into skin following lie of hair)
(5) When to apply in relation to other topical treatments (leave emollient to sink in for at least half an hour before applying other treatments)

Additional information

Advice on expiry dates for creams and ointments once opened (based on advice from East Anglian Academic Pharmacy Practice Unit): -

- Tubs, pots or plastic tubes - one month
- Metal tubes - three months
- Pumps - manufacturers expiry

It is not advisable for patients to share pots due to the risk of cross contamination. Please prescribe appropriate quantities to avoid wastage.

Emollients: new information about risk of severe and fatal burns with paraffin-containing and paraffin-free emollients

Warnings about the risk of severe and fatal burns have been extended to all paraffin-based emollients regardless of paraffin concentration. Data suggest there is also a risk for paraffin-free emollients. Patients who use these products should be advised not to smoke or go near naked flames, and be warned about the easy ignition of clothing, bedding, dressings, and other fabric that have dried residue of an emollient product on them.
See MHRA Drug Safety Update

BNF Chapter 13 – Skin Formulary

Formulary Key

1st line formulary choice		Encouraged
Alternative formulary choice		On Formulary
2nd line formulary choice		2nd Line
Shared Care (TAG Amber)		Shared Care Agreement

13.1 Dry and scaling skin disorders

13.1 Emollients and barrier preparations

Select the appropriate priority patient group and then working with your patient, select the treatment they are most likely to concord with from the table below. http://www.bdng.org.uk/documents/EmollientBPG.pdf

Formulary examples			Product Information	When to use
First Line				
SIMPLE EMOLLIENT CREAMS- water in oil emulsion, main mechanism of action is as an occlusive on the skin surface.				
Indicated for patients with clinical, dermatological indications only. Simple emollients for dry skin can be purchased. See Skin Care - Emollients Best Practice Bulletin for management of dry in skin in care home residents **For patients with mild dry skin coinditions, do not routinely offer a prescription but advise patient to manage condition using over the counter products - see** NHSE guidance				
Note Patient Safety alert regarding fire risk with paraffin based emollients (see page 1).				
EPIMAX 6% LP, 15% WSP	Encouraged	500g Flexi dispenser	Free of SLS, lanolin, parabens and perfume. Light consistency.	First line emollient therapy for all patients including children. Take in to account patient preference. May be preferred for day time use. Can also be used as a soap substitute.
EXOCREAM 1% lanolin, 14.5% WSP, 12.6% LP	Encouraged	500g pump	**Equivalent to E45** **Note contains lanolin**	
ZEROBASE 11% LP, 10% WSP	On Formulary	500g pump	Free of SLS, lanolin, parabens and perfume. Thicker consistency	
SIMPLE EMOLLIENT OINTMENTS - Higher content of lipid, often 100%, providing greater level of occlusion				
EPIMAX OINTMENT	Encouraged	500g Tub	Liquid paraffin 40%,Yellow Soft Paraffin 30% **Paraffin free version available**	First line emollient therapy for all eczema patients. Take into account patient preference, dryness of skin, body site. May be preferred for night time use because of level of greasiness.
EMULSIFYING OINTMENT	On Formulary	500g Tub	Emulsifying wax 30%, White Soft Parafin 50%, Liquid Parafin 20%	
Fifty:50	On Formulary	500g Tub	White Soft Parafin 50%, Liquid Parafin 50%	
EMOLLIENT WASH PRODUCTS AND BATH ADDITIVES: There is no evidence of clinical benefit from using emollient bath additives for eczema BATHE Trial BMJ.				
Such products are NOT recommended on prescription. All simple creams and ointments (except gels and Fifty:50 ointment) can be used as soap substitutes.				
ANY SIMPLE CREAM or OINTMENT	Encouraged			Essential when soap avoidance is a necessary part of treatment i.e all eczema patients. May be helpful for those with more extensive generalised psoriasis
QV GENTLE WASH	2nd Line		Glycerol 10%, light liquid paraffin 10%, white soft paraffin 5%	
Second line				
HUMECTANT EMOLLIENTS: Water in oil emulsions containing an added humectant which increases hydration in the stratum corneum				
EXCETRA	Encouraged	500g Flexi dispenser	4.5% Glycerol, 13.2% White soft paraffin, 10.5% Light liquid paraffin. **Cost effective alternative to Cetraben**	Second line where simple emollients are not effective i.e. eczema patients. First line for patients with psoriasis and other dry hyperkeratotic skin conditions
ISOMOL GEL	Encouraged	500g Flexi dispenser	Isopropyl myristate 15%, Liquid Parafin 15%, 10% glycerol. **Cost effective alternative to Doublebase.**	
QV CREAM	2nd Line	500g Pump	Glycerol 10%, light liquid paraffin 10%, white soft paraffin 5%	

DERMATONICS ONCE HEEL BALM		200g	Urea 25% - for Callused, anhydrotic, fissured and hard footskin. **Short term use for patients with diabetes, then use simple emollient.**	
CONSIDER REFERRAL TO COMMUNITY DERMATOLOGY NURSING SERVICE, WHERE AVAILABLE, IF SECOND LINE EMOLLIENTS ARE NEEDED				
https://www.knowledgeanglia.nhs.uk/KMS/Norwich/Home/ClinicalInformation/Other/Dermatology.aspx				
Other more advanced emollients				
EPIMAX Oatmeal		300ml and 500ml pump	1% colloidal oatmeal. Low paraffin content: helpful for facial dryness & those who do not tolerate paraffin based products.	Second line emollient therapy. Consider when adherence to treatment is a particular problem
DOUBLEBASE DAYLEVE		500g pump	Isopropyl myristate 15%, liquid paraffin 15%. Once daily application for when concordance is a problem.	
EMOLLIN (Spray)		150mls and 240mls	Liquid paraffin 50%, white soft paraffin 50%. For hard to reach areas or if skin is too sensitive to touch.	**Note increased fire risk due to fine mist created by spray application.**
CONSIDER REFERRAL TO COMMUNITY DERMATOLOGY NURSING SERVICE, WHERE AVAILABLE, IF ADHERENCE TO TREATMENT IS A PARTICULAR PROBLEM				
https://www.knowledgeanglia.nhs.uk/KMS/Norwich/Home/ClinicalInformation/Other/Dermatology.aspx				
Emollients with Antimicrobials				
ANTISEPTIC EMOLLIENTS for use as a soap substitute: Oil in water emulsion with added antibacterial				
DERMOL LOTION		500ml Pump	Benzalkonium chloride 0.1%, chlorhexidine HCl 0.1%, isopropyl myristate 10%, liquid paraffin 10%) **Not for use as leave on emollient as not effective for dry skin.**	**Short term use only** in eczema patients where recurrent infections are a problem - Not for repeat prescribing.

Risk of anaphylactic reaction due to chlorhexidine allergy - MHRA alert October 2012

The MHRA states that they do not hold a comprehensive list of products which contain chlorhexidine. Examples of products which contain chlorhexidine are: antiseptic creams, wipes, cleansers and skin preparations; antiseptic mouthwashes, toothpastes and dental implants; eye drops and contact lens solutions; antiseptic lozenges and throat sprays; urinary catheters; central venous catheters; and antimicrobial dressings.

- Be aware of the potential for an anaphylactic reaction to chlorhexidine.
- Ensure that known allergies are recorded in patient notes.
- Check the labels and instructions for use to establish if products contain chlorhexidine prior to use on patients with a known allergy.
- If a patient experiences an unexplained reaction, check whether chlorhexidine was used or was impregnated in a medical device that was used.
- Report allergic reactions to products containing chlorhexidine to the MHRA.

Further guidance on anaphylaxis is available from NICE http://guidance.nice.org.uk/CG134/Guidance/pdf/English, the Resuscitation Council http://www.resus.org.uk/pages/reaction.htm and the AAGBI http://www.aagbi.org/safety/allergies-and-anaphylaxis

Barrier Preparations

Ointment based emollients, zinc ointment or emollients containing dimeticone may be more appropriate as barrier preparations for compromised skin. These are avaialble to be purchased over the counter (OTC) from pharmacies.
If there is a clinical indication for a barrier cream, please refer to AGEM CSU wound care formulary.

13.2 Infections of the skin

For many skin infections and cellulitis, systemic antibacterial treatment is more appropriate:
See AGEM CSU Antibiotics Formulary.
* To minimise the development of resistance it is advisable to only prescribe topical agents that are not used systemically.
PLEASE CHECK WITH LOCAL INFECTION CONTROL FOR UP TO DATE MANAGEMENT PROTOCOLS

13.2.1 Bacterial skin infections		
MUPIROCIN CREAM 2% or OINTMENT	15g 15g	**Bactroban** To avoid the development of resistance **use for patients with MRSA only** and do not use for more than 10 days
NASAL OINTMENT	3g	
FUSIDIC ACID CREAM or OINTMENT	15g, 30g	**Fucidin** three to four times daily - **7 days only.** Do not put on repeat prescription. Use only when necessary due to emergence of resistance of staphylococci to fusidic acid
METRONIDAZOLE 0.75% GEL or CREAM	30g, 40g	**Prescribe as cost effective brand - Rozex.** Cream is useful where the skin is dry
13.2.2 Fungal skin infections		
For uncomplicated fungal skin infections in **low risk patients,** encourage self care with treatment **over the counter** (OTC).Clotrimazole 1%, miconazole 2% and Terbinafine 1% products are all available to purchase for treatment of fungal skin infections. Note restrictions on supply for children apply.		
To prevent relapse, local antifungal treatment should be used for 1-2 weeks after the disappearance of all signs of infection.		
For oral treatments – **see section 5.2**		
TERBINAFINE	T: 250mg	**Only to be prescribed following mycological confirmation of fungal infection. See, below for** Caution in Hepatic and Renal impairment, pregnancy and breastfeeding.

Audit Standards for prescribing oral terbinafine

- Patients should have positive mycology before commencing treatment
- Patients should receive a maximum of 4 months treatment – treatment length varies depending on the condition and area being treated, see BNF.
- Prescription should be acute for the treatment course and not placed on repeat
- Prescriptions should be written as generic Terbinafine
- Patients should have a baseline LFT done before commencement of treatment

Treatment of nail infections in Adults

Whilst systemic treatment is recommended for most people as it is more effective than topical, it should only be prescribed for those who are significantly affected by fungal nail infection and only after positive mycology has been obtained. It is important that a suitable sample is obtained - not just nail, but some skin scrapings from toe web and subungual matter is required.

- For systemic treatment, **oral terbinafine is recommended for first-line** use, with itraconazole as an alternative.
- Topical treatment should only be used in superficial white onychomycosis and possibly in early distal and lateral subungual onychomycosis (DLSO) where the infection is confined to the distal edge of the nail, or when systemic treatment is contraindicated.
- Current UK guidelines advise against the routine use of oral and topical treatments in combination, as there is insufficient evidence of benefit.
- Antifungal nail solutions are on the PrescQIPP DROP List (Drugs to Review for Optimised Prescribing) as they are considered low priority and poor value for money.

PrescQIPP DROP List

13.2.3 Parasitic skin infections		
For Scabies		
• Apply to the whole body including scalp, face, ears and neck and under nails (both on hands and feet) • Apply to cool, dry skin **NOT** after a hot bath, and leave on the skin for 8 to 24 hours as directed on the product • Treat the infected person and all close contacts within the last 2 months • Apply a second treatment after 7days as first treatment will not have killed unhatched mites • The itch may persist for a couple of weeks even if treatment is successful		
MALATHION AQUEOUS LOTION 0.5%	50ml, 200ml	**Derbac-M** See BNF for usage instructions
PERMETHRIN 5% CREAM	30g	**Lyclear Dermal Cream** See BNF for usage instructions

For Head Lice

Wet combing method (at least 30mins every 4 days- see BNF for more details) - mechanically removes head lice and is the preferred method of treatment

Headlice treatment should **NOT** be prescribed. **Encourage patients to purchase OTC as part of self care.** Malathion (Derbac M) and Permethrin (Lyclear) are severely affected by resistance and should no longer be recommended. Silicone (**Hedrin 4% Lotion**) and silicone/oil mixtures (**Full Marks Solution**) are more effective , however these may be difficult to apply and wash off (*The Pharmaceutical Journal, Vol 297, No 7893 Sept 2016)*

- **Head lice treatment should not be used unless live lice seen**
- Ensure sufficient product is purchased to adequately treat the hair of the individual(s).
- Ensure product is applied thourghly and spread through the hair with a comb to adequately coat all sections.
- Some treatments require a second application
- If live lice still found 2-3 days after second treatment, consider trying a different agent
- All related cases of confirmed infection should be treated at same time with the same insecticide
- Avoid alcoholic formulations where severe eczema or asthma or small children
- **Refer to community pharmacist for advice**

For Crab Lice

Permethrin (Lyclear Dermal Cream) and **malathion (Derbac M lotion)** are used to eliminate crab lice (Pthirus pubis). An aqueous preparation should be applied, allowed to dry naturally and washed off after 12 hours; a second treatment is needed after 7 days to kill lice emerging from surviving eggs. All surfaces of the body should be treated, including the scalp, neck, and face.

13.2.4 Viral skin infections

ACICLOVIR 5% CREAM	2g, 10g	Prescribe generically **2g Available OTC** May be cheaper for patient to purchase

13.3. Inflammatory skin conditions

Topical Corticosteroids Potencies

Potency	Example	Formulary Brand Example
MILD	Hydrocortisone 0.5-1%	**Generic**
	Hydrocortisone combinations	**Eurax-HC**
	Hydrocortisone with **antimicrobials**	**Canesten-HC, Fucidin H, Timodine, Nystaform HC, Terra-Cortril**
MODERATE	Clobetasone Butyrate	**Eumovate**
POTENT	Betamethasone Valerate	**Betacap, Bettamousse, Betnovate,**
	Betamethasone Valerate with **antimicrobials**	**Fucibet**
	Betamethasone Dipropionate	**Diprosalic, Diprosone**
	Mometasone Furoate	**Elocon**
VERY POTENT	Clobetasol Propionate	**Dermovate**

See notes on use of topical cortico-steroids in the BNF. These should be prescribed with an emollient as well to maximise cutaneous absorption for a steroid sparing effect. Twenty to thirty minutes should be left between application of emollient and topical steroid if possible, to avoid dilution of ingredients. Finger Tip Units (FTUs) are helpful in measuring steroids. One FTU = 0.5g, so 30g tube = 60 FTUs. One FTU is sufficient to cover an area the size of two flat palms.

Topical steroids should be prescribed as a course with a planned review date, especially if potent or very potent steroids are being used. In general these should not be put on repeat prescription. For prolonged courses and particularly in eczema care, frequency and/or potency should be gradually reduced towards the end of the course.

NICE suggests if a topical steroid doesn't appear to be / is no longer working, consider switching to a different steroid of the same potency, especially in children.

Choice of Formulations: The majority of dermatoses should be managed with an ointment rather than cream

Creams: Suitable for moist or weeping areas – contain preservatives avoid with chronic eczema

Ointments: Generally chosen for dry, thickened or scaly lesions, or where more occlusive effect required

Lotions: May be useful when minimal applications to a large or hair-bearing area are required

The preparation containing the **least potent drug** at the **lowest strength**, which is effective, is the one of choice; dilution should be avoided wherever possible.			
Special extemporaneous preparations are very expensive and unlicensed and generally unnecessary so proprietary preparations should always be used where possible.			
Topical Corticosteroids			
NICE TA81 **recommends that corticosteroids should not be applied to the affected skin of people with atopic eczema more than twice a day.**			
HYDROCORTISONE CREAM / OINTMENT		0.5%: 15g, 30g 1%: 15g, 30g	1% is the usual strength used.
Hydrocortisone 1% is available OTC - but can only be sold *for treatment of allergic contact dermatitis, irritant dermatitis, insect bites & mild to moderate eczema but NOT for children under 10 years, pregnant women or for use on the face, anogenital region or on broken or infected skin.*			
Compound Preparations			
CLOTRIMAZOLE 1% + HYDROCORTISONE 1%		Cream 30g	**Canesten HC** **Available OTC** (15g) for fungal infections
NYSTATIN 100,000 units + DIMETHICONE + BENZALKONIUM CHLORIDE + HYDROCORTISONE 0.5%		Cream 30g	**Timodine** Store in a fridge
NYSTATIN 100,000 units + chlorhexidine 1% + HYDROCORTISONE		Cream 30g 0.5% HC Ointment 30g 1% HC	**Nystaform HC**
FUSIDIC ACID 2% + HYDROCORTISONE 1%		Cream 30g	**Fucidin H** **Max. 2 weeks treatment**
OXYTETRACYCLINE HYDROCHLORIDE 3% + HYDROCORTISONE 1%		Ointment 30g	**Terra-Cortril** **Max. 7 days treatment**
Moderately Potent Topical Cortico-steroids			
CLOBETASONE BUTYRATE 0.05%		Cream: 30g, 100g Ointment: 30g, 100g	**Eumovate** - Only moderate potency product available as 30g tube
BETAMETHASONE 0.025% in a water miscible 1 in 4 dilution		Cream 0.05% 100g Ointment 0.05% 100g	**Betnovate RD**
Eumovate 15g is available OTC - but can only be sold *for short-term treatment of eczema in adults and children over 12 years*			
Potent Topical Corticosteroids			
First Line			
BETAMETHASONE DIPROPIONATE 0.05%		Cream: 30g, 100g Ointment: 30g, 100g	Prescribe by brand: **Diprosone**
BETAMETHASONE VALERATE 0.1%		Cream: 30g, 100g Ointment: 30g, 100g Scalp Application: 100ml	Prescribe by brand: **Betnovate**
Second Line			
MOMETASONE FUROATE 0.1%		Cream: 30g, 100g Ointment: 30g, 100g Scalp Lotion: 30ml	**Elocon** Apply once daily. More expensive. Has S/E profile of a moderate steroid
BETAMETHASONE In a hydrocolloid plaster		4 plasters	**Betasil** Can cut to size, does not need to be kept sterile. For use in steroid responsive dermatoses in small isolated patches. See BNF guidance. Use overnight, remove plaster and wash skin in morning. Not to be used at the same time as other steroid preparations.

Compound Preparations

Drug	Formulation	Notes
BETAMETHASONE VALERATE 0.1% with FUCIDIC ACID 2%	Cream 30g, 60g	**Fucibet *See note under 13.2** Only to be used for localised secondary infection of eczema. **Max of 7 days to minimise bacterial resistance. Do not put on repeat.**
BETAMETHASONE DIPROPIONATE 0.05% + SALICYLIC ACID 3% (2% SCALP APPLICATION)	Ointment: 30g, 100g Scalp Application: 100ml	**Diprosalic** Contains Salicylic acid for hyperkeratotic conditions e.g. of the palms and soles

Very Potent Topical Corticosteroids

Drug	Formulation	Notes
CLOBETASOL PROPIONATE 0.05%	Cream: 30g, 100g Ointment: 30g, 100g Scalp Application: 30ml, 100ml	**Dermovate** Max 50g per week Not for use on children, face or flexures For short term use only (4 weeks max). **Do not put on repeat.**

Pimecrolimus (Elidel cream), Tacrolimus (Protopic) ointment - (TAG GREEN): May be prescribed for eczema non-responsive to topical steroids or for maintenance, second line by a practitioner experienced with treating atopic eczema or at the request of a Consultant, or specialist practitioner.
NICE guidance now recommends Pimecrolimus (Elidel cream), Tacrolimus (Protopic) ointment for facial, flexural and genital psoriasis.

Preparations for Psoriasis

NICE guidelines CG153: The Assessement and Management of Psoriasis

Prescribing emollients for patients with psoriasis should always be considered as they reduce scaling and can enhance penetration of topical medications when used as part of the daily skin care regime.

Vitamin D and Analogues

First line for adults with trunk or limb psoriasis: Offer a potent corticosteroid applied once daily **plus** vitamin D or a vitamin D analogue applied **once daily** (applied separately, one in the morning and the other in the evening) for up to 4 weeks.

Drug	Formulation	Notes
CALCIPOTRIOL	Ointment: 30g Scalp Sol: 60ml, 120ml	**Dovonex** Generic scalp solution available Apply one or twice daily. (once daily if used with topical corticosteroids). Avoid face and flexures. Max: 100g per week (less in children – **see BNF**) From 6-18years Gel can also be used on the scalp
CALCITRIOL	Ointment: 30g, 100g	**Silkis** Apply twice daily to not more than 35% of body surface. Max: 30g per day Only recommended for children over 12 For non-stable plaque psoriasis a systematic review (Ashcroft et al BMJ 2000) showed this to be more effective than calcipotriol or tacalcitol
TACALCITOL	Ointment: 30g, 60g, 100g	**Curatoderm** Apply once a day, preferably at bedtime. Max: 10g per day. Can be used on any body site – avoid eyes. Only recommended for children over 12

If satisfactory control of trunk or limb psoriasis is not acheived after a maximum of 8 weeks, offer vitamin D or a vitamin D analogue alone applied **twice daily.**

Compound Preparations - stable plaque psoriasis when vitamin D analogues are not effective or if patient concordance is an issue

Drug	Formulation	Notes
DOVOBET **Betamethasone dipropionate 0.05% & calcipotriol 50micrograms/g**	Ointment: 30g, 60g, 120g Gel: 30g, 60g, 120g	Once daily application, maximum 30% body area, for up to 4 weeks at a time and then alternately with Vitamin D analogue. Max: 100g / week Now licensed for children >12years max OD Stop once plaques have flattened. Gel better for scalp. **Potent steroid - Do not put on repeat.**
ENSTILAR **Betamethasone dipropionate 0.05% & calcipotriol 50micrograms/g**	Cutaneous Foam: 60g	

Tars			
If twice-daily application of vitamin D or a vitamin D analogue does not result in satisfactory control of trunk or limb psoriasis in adults after 8–12 weeks, offer either: ● a potent corticosteroid applied twice daily for up to 4 weeks (see section 13.4) or ● a coal tar preparation applied once or twice daily.			
COAL TAR 1% (EXOREX)		Lotion: 100ml	**Available OTC** - can be used on scalp or skin up to three times daily CHILD / ELDERLY: - dilute with a few drops of water before applying.
Dithranol			
Option for treatment resistant psoriasis of the trunk or limbs			
DITHRANOL		Cream: 0.1%, 0.25%, 0.5%,1%, 2%	0.1-0.5% suitable for overnight treatment. 1-2% max. 1 hour treatment. Stains skin, hair and fabrics.
Management of scalp psoriasis			
Thinner plaques should be managed with topical steroid or vitamin D analogue (or the two in combination). If plaques are thick, treating them using Sebco ointment may be necessary initially to thin them before moving on to specialist vitamin D treatments. Sebco should be left on lesions from 1 - 12 hours, using comb to remove softened scale. Wash off with tar shampoo.			
Potent Topical Corticosteroids			
First line for scalp psoriasis			
BETAMETHASONE VALERATE 0.1%		Scalp Application: 100ml	**Betacap** Prescribe generically Contains coconut oil
If treatment with a potent corticosteroid does not result in satisfactory control after 4 weeks consider topical agents to remove scale			
COAL TAR 12% + SALICYLIC ACID 2% + SULPHUR 4% SCALP OINTMENT		40g, 100g	**Sebco Ointment** Apply to scalp initially daily and reduce as scalp improves shampoo off as above
BETAMETHASONE DIPROPRIANATE 0.05% + SALICYLIC ACID 2%		Scalp App: 100ml	**Diprosalic** Contains Salicylic acid in alcoholic base
Vitamin D may be used alone only in those who cannot use steroids or with mild to moderate scalp psoriasis.			
CALCIPOTRIOL		Scalp Sol: 60ml, 120ml	**Dovonex** Apply twice daily. Max: 60ml per week. Less if used with ointment or cream – See BNF Not recommended in children
Very Potent Topical Corticosteroids			
If the response to treatment with a potent corticosteroifor scalp psoriasis remains unsatisfactory			
CLOBETASOL PROPRIONATE 0.05%		125ml	**ETRIVEX SHAMPOO (clobetasol 0.05%)** Suitable for thin but extensive plaques Apply thinly OD, rinse off after 15minutes, reduce frequency after clinical improvement. Maximum duration of treatment 4 weeks. Adults over 18 years only.
Drugs affecting the immune response			
METHOTREXATE		Tabs: 2.5mg Pre-filled injections	**WEEKLY DOSING** THIS DRUG REQUIRES REGULAR MONITORING PRESCRIBE INJECTION BY BRAND – **METOJECT PENS** Shared Care Agreement in place

Shampoos

Coal tar-based shampoos should not be used alone for the treatment of severe scalp psoriasis.

Product	Pack size	Notes
COAL TAR 1% + SALICYLIC ACID SHAMPOO 0.5%	250ml	**Capasal** Also useful in Psoriasis To be used in conjunction with other topicals or as maintenance for milder disease
COAL TAR EXTRACT 5% SHAMPOO	250ml	**Alphosyl 2 in 1** Also useful in Psoriasis To be used in conjunction with other topicals or as maintenance for milder disease

13. 4 Perspiration

Hyperhidrosis can be treated with over the counter high strength antiperspirants. An antiperspirant containing aluminium chloride is usually the first line of treatment and is sold in most pharmacies.

Advise patient to purchase as per NHSE Guidance.

Advice should be offered on modifying behaviour to avoid identified triggers, avoiding tight fitting clothing and man-made fibres.

Glycopyrronium bromide tablets and oral solutions are not recommended, unlicensed products with weak evidence for use .

NICE Evidence Summary ESUOM16: Hyperhydrosis: oral glycopyrronium bromide

13.5 Photodamage

Local guidelines for treatment of Actinic Keratoses are available on Knowledge Anglia:

Actinic keratoses-Primary care treatment

Guidance is available from the Primary Care Dermatology Society (PCDS)

General measures

Advise patient on UV protection and use of emollients to distinguish between dry scaly areas of normal skin. Inform patient of which skin changes need to be reported - transformation in to Squamous Skin Cancer (SCC) can be indicated by recent growth, discomfort, bleeding or ulceration.

Product	Pack size	Notes
CALMURID (10 % urea, 5% lactic acid)	100g, 500g	Keratolytic preparation: reduce scale.

Lesion specific treatment

Product	Pack size	Notes
FLUOROURACIL CREAM 5%	40g	**Efudix** Skin will become inflamed during course of treatment. Apply once daily (for face AK) or twice daily (for trunk AK). Initial course of therapy is three to four weeks.
FLUOROURACIL CREAM 0.5% + SALICYLIC ACID 10%	25ml	**Actikerall.** Licensed for moderately thick hyperkeratotic AK. Apply once daily for max. 12 weeks.

Field changes (areas of skin that have multiple AK associated with erythema, telangiectasia and other changes seen in sun damaged skin): These areas are more at risk of developing SCC and is recommended they are treated more vigourously. Treatments should be applied to whole area of field change and not just lesions. Small areas of field change may be treated with Flurouracil cream 5%.

If treatment with Efudix and Actikerall have been tried and are ineffective consider referral for specialist review.

Product	Strength / dose		Notes
INGENOL MEBUTATE	**For face and Scalp:** 150mcg/1g - apply once daily for 3 days		**Picato. TAG Green - Prescribable at request of Specialist**
	For trunk and extremities: 500mcg/1g - apply once daily for 2 days		
INGENOL MEBUTATE (PICATO)	Gel: **150**micrograms/g		For face and scalp - apply for 3 consecutive days only
	Gel: **500**micrograms/g		For trunk and extremites - apply for 3 consecutive days only

IMIQUIMOD		**37.5mg/1g** Apply once daily for 2 weeks, to be applied at bedtime to lesion on face or balding scalp, repeat course after a 2-week treatment-free interval, assess response 8 weeks after second course; maximum 2 sachets per day.	**Zyclara. TAG Green - Prescribable at request of Specialist**
		50mg/g Apply 3 times a week for 4 weeks, to be applied to lesion at night, assess response after a 4 week treatment-free interval; repeat 4-week course if lesions persist, maximum 2 courses.	**Aldara. TAG Green - Prescribable at request of Specialist**

Sunscreens

Borderline Substances: Prescriptions must be marked "ACBS" by the prescriber

These preparations are regarded as "drugs" only when prescribed for the following conditions:

Abnormal cutaneous photosensitivity resulting from genetic disorders or photodermatoses including vitiligo e.g. discoid lupus erythematosus, polymorphic light eruption, porphyria and skin malignancy resulting from radiotherapy

Increase risk of skin malignancy from immunosupression e.g. following renal transplant

Chronic or recurrent herpes symplex labialis

NB Patients with solar damage e.g., solar keratosis, basal cell carcinomas **should not routinely** be prescribed sunscreens. However if they are recommended patients should be advised to buy them.

If a sunscreen is needed use Factor 50+ for example, Soltan which is a broad spectrum sunscreen available without prescription.

Sunsense Ultra (UVB-SPF 60)	Lotion 50ml roll-on, 125ml, 500ml pump pack	Water resistant
UVISTAT (UVB SPF 50)	125ml, lip screen 5g	Fragrance free

13.6 Pruritus

ANTIPRURITIC EMOLLIENTS with anti-pruiritic agents in them: for itchy patients where systemic causes of itch have been eliminated and where treatments for dry skin have not worked or are not appropriate.

ADEX GEL	100g tube 500g pump	Isopropyl myristate, liquid paraffin, glycerol and nicotinamide	Elderly patients with dry and inflamed skin to reduce need for topical corticocosteroids.
IMUDERM	500g pump	Urea 5%, glycerol 5%	

13.7 Acne and Rosacea

The choice of agent used in the management of patients with acne depends on the type, severity and extent. For example topical retinoids are particularly effective in managing comedonal acne.

Mild, inflammatory acne on the face can be managed with benzoyl peroxide, a topical retinoid or topical antibiotic. Topical antibiotics should not be used as monotherapy but instead in combination with topical retinoids or benzoyl peroxide.

Systemic antibiotics however, should be considered for moderate facial and truncal acne. Treatment of this group of patients is more effective if the systemic antibiotics are combined with a topical retinoid or benzoyl peroxide. Oral antibiotics should not be used in combination with topical antibiotics.

The majority of therapies become effective over a period of months and frequent alterations in therapy should be avoided. Ideally if tolerated, treatment should be continued for a period of 3 months and extended to 6 months, if an initial response is documented.

The following patients should be considered for referral to secondary care for Isotretinoin therapy:

- Patients with severe nodular or cystic acne
- patients with moderate acne with scarring
- Patients with moderate acne which has either failed to respond to 6 months of treatment with conventional treatment, or which has relapsed rapidly following systemic antibiotic therapy

13.7.1 Acne

All treatment should be tried for at least three months before deciding on efficacy. Some may be irritant, in which case the frequency of use may be reduced and/or use a lower strength.

Topical Retinoids and related preparations			
First Line for mild to moderate acne (predominantly comedonal)			
ADAPALENE 0.1%		Cream: 30g Gel: 30g	**Differin** Use for comedones and greasy skin. Less irritant than Isotretinoin. Use at night to avoid photosensitivity Avoid in pregnancy
ISOTRETINOIN 0.05%		Gel 30g	**Isotrex** Apply thinly 1-2 times a day
First Line for predominantly pustular acne			
AZELAIC ACID 20%		Cream: 30g	**Skinoren** Apply 1-2 times a day. Max: 10g/day. Max length of treatment 6 months. Particularly useful to those sensitive to benzoyl peroxide
BENZOYL PEROXIDE 2.5 to 10%		Gel: 40g Cream: 40g	**PanOxyl** Start treatment with lower strength preps and work upwards if necessary.
Note that Benzoyl Peroxide products may bleach fabrics and hair.			
Combination of pustular and comedonal			
BENZOYL PEROXIDE 2.5% + ADAPALENE 0.1%		45g	**Epiduo.** Apply once daily in the evening, can cause bleaching of clothes and bedding
Antibiotic combination products: Non antibiotic with antibiotic			
BENZOYL PEROXIDE 5% + CLINDAMYCIN 1%		Gel: 25g, 50g	**Duac Once Daily**. Apply in the evening
ERYTHROMYCIN 40mg + ZINC ACETATE 12mg/ml		Lotion: 30ml, 90ml	**Zineryt** Use on entire area not just spots
Second Line for mild to moderate - Topical Retinoids and related preparations with antibacterials			
ISOTRETINOIN 0.05% + ERYTHROMYCIN 2%		Gel: 30g	**Isotrexin** Apply sparingly once or twice a day for a minimum of 6-8 weeks. **CONTAINS RETINOID**
ERYTHROMYCIN 4% + TRETINOIN 0.025%		Soln: 25ml	**Aknemycin Plus** Apply once or twice a day for 9-12 weeks **CONTAINS RETINOID**
Oral treatment with antibiotics			
First Line			
OXYTETRACYCLINE		T: 250mg	500mg twice daily. Not to be used in children under 12 years or women of childbearing age without adequate contraception. Useful for inflammatory acne if topical treatment not adequate.
Second line			
DOXYCYCLINE		C: 100mg	100mg once daily Alternative where Oxytetracycline not suitable
Third line			
CLARITHROMYCIN		T: 500mg	500mg twice daily.
Hormonal			
CO-CYPRINDIOL		T: 2000/35 (2mg Cyproterone acetate, 35 micrograms Ethinylestradiol)	**Prescribe generically** Courses lasting a few months are usually enough – stop once resolved. Repeat if necessary. See BNF.

13.7.2 Rosacea			
METRONIDAZOLE 0.75%		Gel: 40g Cream: 40g	**Prescribe as cost effective brand -Rozex** Licensed only for acute exacerbations of acne rosacea Apply twice daily
AZELAIC ACID 15%		Gel:30g	**Finacea** Apply twice daily
IVERMECTIN 1%		Cream: 30g	**Soolantra** Papulopustular Rosacea. **TAG Double Green**
Systemic tetracycline, oxytetracycline, erythromycin or doxycycline 40mg (Efracea) can be used for Rosacea.			
13.8 Scalp and hair conditions			
See also 13.3 for topical cortico-steroids			
KETOCONAZOLE 2% SHAMPOO		120ml	**Nizoral Available OTC** First line for seborrhoeic dermatitis Treatment of pityriasis versicolor apply once daily for a maximum of 5 days, leave on for 3-5 minutes before rinsing
POLYTAR LIQUID		250ml	May be useful in seborrhoeic dermatitis (including Twice weekly for three weeks then as required
COAL TAR EXTRACT 5% SHAMPOO		250ml	**Alphosyl 2in1** Also useful in Psoriasis
COAL TAR 1% + SALICYLIC ACID SHAMPOO 0.5%		250ml	**Capasal** Also useful in Psoriasis
COAL TAR 12% + SALICYLIC ACID 2% + SULPHUR 4% SCALP OINTMENT		40g, 100g	**Sebco Ointment** Apply to scalp initially daily and reduce as scalp improves, shampoo off after 1-12 hours
13.9 Skin Cleansers and Antiseptics			
See AGEM CSU Wound Care Formulary for further details of wound and skin care management			
If infection is not suspected, emollients not containing antimicrobials can be used as skin cleansers.			
13.10 Skin disfigurement			
Camouflagers			
ACBS products, please refer to part XV of the Drug Tariff for prescribed for post-operative scars and other deformities and as an adjunctive therapy in the relief of emotional disturbances due to disfiguring skin disease such as vitiligo.			
Silicone gel and gel sheet dressings to reduce and prevent hypertrophic and keloid scarring are **TAG Double Red** due to poor evidence for use and expense.			
13.11 Superficial soft tissue injuries and thrompheblitis			
Topical circulatory preparations such as heparinoids are **TAG Double Red** - not recommended for routine use as they are of limited clinic value and effectiveness			
13.12 Warts and calluses			
Please advise patient to buy over the counter (OTC) treatment. Salicylic acid paint/gel Will give 80% clearance if applied daily for 3 months. If used for 3 months it is as effective as cryotherapy.			
PREPARATIONS FOR URTICARIA			
Antihistamines			
BNF Statement: "Although drowsiness is rare, nevertheless patients should be advised that it can occur and may affect performance of skilled tasks (e.g. driving); excess alcohol should be avoided".			
Non-sedating Antihistamines			
First Line			
CETIRIZINE (Generic)		T: 10mg L: 5mg/5ml	Adults & children over 6 years 10mg daily Child 2-6 years 5mg daily **Available OTC**
LORATADINE (Generic)		T: 10mg L: 5mg/5ml	Adult & children over 6 years 10mg daily Child 2-5 years 5mg daily **Available OTC**

Second Line – for patients who do not respond to first-line choices or are at risk of adverse effects – especially when Consultants may recommend higher than licensed doses.		
FEXOFENADINE	T: 180mg	Not recommended for children under 12 years Only the 180mg tablet licensed for urticaria
Sedating Antihistamines – can be used in combination with non-sedating antihistamines particularly for additional relief / control of pruritus at night.		
CHLORPHENAMINE	T: 4mg L: 2mg/5ml	4mg 4-6 hrly (max: 24mg/24hrs) **Available OTC** Child: 1month-2 years 1mg twice daily. 2-5 years 1mg 4-6 hourly. Max 6mg daily 6-12 years 2mg 4-6 hourly. Max 12mg daily

SKIN FORMULARY FURTHER RESOURCES

The following links will provide you with supplementary information that will be useful when providing care for people with skin problems.

TAG Guidance

Pharmacological treatment options for patients with Actinic Keratosis in Norfolk & Waveney

https://nww.knowledgeanglia.nhs.uk/LinkClick.aspx?fileticket=YiZkB7cOzqk%3d&tabid=1672&portalid=1&mid=2074

NICE Guidance

Psoriasis: http://guidance.nice.org.uk/CG153
Eczema in childhood: http://guidance.nice.org.uk/CG57
Topical steroids: http://guidance.nice.org.uk/TA81
Skin cancer: http://guidance.nice.org.uk/CSGSTIM

Clinical Knowledge Summaries
http://cks.nice.org.uk/fungal-nail-infection

Emollient Best Practice Guide
http://www.bdng.org.uk/documents/EmollientBPG.pdf

National Eczema Society Website
http://www.eczema.org/

Psoriasis Association
https://www.psoriasis-association.org.uk/

Primary Care Dermatology Society clinical guidance
http://www.pcds.org.uk/a-z-clinical-guidance/clinical-a-z-list

British Association of Dermatologists clinical guidelines
http://www.bad.org.uk//site/622/default.aspx

Community Dermatology Nursing Service Referral Form
https://www.knowledgeanglia.nhs.uk/KMS/Norwich/Home/ClinicalInformation/Other/Dermatology.aspx