CHAPTER 13  SKIN

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<tr>
<td>11/09</td>
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<td>J Von der Werth, G Ells</td>
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<td>03/13</td>
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<tr>
<td>02/14</td>
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</tr>
</tbody>
</table>

Adapted from Plymouth Area Joint Formulary and East Surrey Joint Formulary
13.1 Management of skin conditions

In order to treat skin conditions effectively, it is important to make a correct diagnosis.

Notes:

1. With skin disease, it is extremely important to consider patient acceptability of a product to maximise patient compliance. There is a wide range of products available and patient acceptance of individual products is very variable.

2. The aim of this formulary is to provide guidance on initial choice of products. It is anticipated that this formulary includes sufficient first (Green) and second (Blue) line agents to cover 80-90% of requirements and is expected to cover the vast majority of primary care needs. However, in specific circumstances dermatologists may need to use products not listed in this formulary. In such cases, prescribers will be provided with sufficient information to continue prescribing by the specialist initiating the treatment.

3. Where a consultant asks a GP to prescribe a non-formulary agent they should state that formulary agents have been tried and not tolerated by the patient.

4. In many cases generic prescribing will be difficult because products contain a combination of active ingredients. In this chapter, brand names are used for products which should not be prescribed generically.

5. Greasy preparations (ointments) are often preferable to creams in most circumstances because:
   - They contain fewer skin sensitisers
   - They are more hydrating (i.e. water retaining)
   - There is better penetration of active ingredients

   However, patient preference, cosmetic acceptability or activity may necessitate a combination of ointments and creams, for example, patients may prefer to apply creams during the day and use ointments at night, or different preparations on different parts of the body.

   - ‘Pot’ Hygiene - when supplying patients with pots of emollient, it is important to educate them about the hygiene required. Patients should be advised to decant from the pot onto a plate/bowl etc. using a spoon or a spatula. Hands should not be put into the pot as this will lead to the introduction of foreign particles.

Extemporaneous preparation

A product should only be extemporaneously prepared when there is no product with a marketing authorisation available. Depending on the formulation this may be done in a pharmacy, or by a specials manufacturer, depending on the formulation. Where a specials manufacturer prepares the product, additional charges will be incurred. The cost can, and usually does, exceed £100 for a cream. The cost is usually the same whether 500g or 50g of a product is ordered. Specials all have a very short shelf life with an expiry date of a maximum of 28 days from manufacture. Commercially available products should be prescribed, unless otherwise advised by the dermatology team.

13.1.2 Suitable quantities for prescribing

The table below shows suitable quantities of dermatological preparations to be prescribed for specific areas of the body based on twice daily application for one week.

See section 13.4 for suitable quantities for corticosteroid preparations.

<table>
<thead>
<tr>
<th></th>
<th>Ointments and creams</th>
<th>Lotions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Face</td>
<td>15 – 30 g</td>
<td>100 ml</td>
</tr>
<tr>
<td>Both hands</td>
<td>25 – 50 g</td>
<td>200 ml</td>
</tr>
<tr>
<td>Scalp</td>
<td>50 – 100 g</td>
<td>200 ml</td>
</tr>
<tr>
<td>Both arms or both legs</td>
<td>100 – 200 g</td>
<td>200 ml</td>
</tr>
<tr>
<td>Trunk</td>
<td>400 g</td>
<td>500 ml</td>
</tr>
<tr>
<td>Groins and genitalia</td>
<td>15 – 25 g</td>
<td>100 ml</td>
</tr>
</tbody>
</table>
13.1.3 Excipients and sensitisation

The following excipients in topical preparations may rarely be associated with sensitisation. Throughout this formulary, the presence of these excipients in products is indicated to aid product selection.

- Beeswax
- Benzyl alcohol
- Butylated hydroxyanisole
- Butylated hydroxytoluene
- Cetostearyl alcohol (incl. cetyl and stearyl alcohol)
- Chlorocresol
- Edetic acid (EDTA)
- Ethylenediamine
- Fragrances
- Hydroxybenzoates (parabens)
- Imidurea
- Isopropyl palmitate
- N-(3-Chloroallyl) hexaminium chloride (quaternium 15)
- Polysorbates
- Propylene glycol
- Sorbic acid
- Sodium metabisulphite
- Wool fat and related substances incl. lanolin

Notes:
1. Generic ointments or creams may differ in the excipients used in the formulations. Patients should be informed of this and advised which excipients they should avoid. In a small number of cases, branded preparations should, therefore, be prescribed.
2. If a patient is not responding to treatment, consider the effect of sensitizers in the product.

13.2 Emollient and barrier preparations

13.2.1 Emollients

Notes:
1. Emollients are essential in the management of dry skin conditions, but are underused in general practice. They reduce water loss from the epidermis resulting in softer, suppler skin. Used regularly, emollients may reduce flare-ups of eczema and the need for topical corticosteroids.
2. Patients should use the least expensive emollient that is effective, cosmetically acceptable and which they are prepared to use regularly.
3. It is necessary to provide a wide range of emollients as not only can patients become sensitised to the ingredients, but can also develop intolerance to the product.
4. Generally, ‘greasy’ preparations provide the best emollient effect. For cosmetic reasons, patients may prefer a less oily preparation for daytime use, or for use on areas such as the face.
5. Lotions have a cooling effect and are useful on hairy areas.
6. Careful explanation of how to use emollients, as well as how much to use, may encourage compliance. Sufficient quantities should be prescribed once the agent of choice is established.
7. Patients with atopic eczema often find emollients cause stinging or irritation of the skin. Therefore an alternative preparation must be considered taking into account excipients.
8. Patients may require a ‘handbag sized tube’ for use at school, work or travel.

Creams / Lotions

Aqueous Cream
- Cream
  Excipients include cetostearyl alcohol

Aveeno®
- Cream
- Lotion
  Limited use by ACBS see BNF

Diprobase®
- Cream
  Excipients include cetostearyl alcohol, chlorocresol

Doublebase®
- Gel
  Excipients: none as listed in section 13.1.3.

Cetraben®
- Cream
  Excipients include cetostearyl alcohol, hydroxybenzoates (parabens)

Notes:
1. Aqueous cream may cause local skin reactions, such as stinging, burning, itching, and redness.
when it is used as a leave-on emollient, particularly in children with atopic eczema. The reactions, which are not generally serious, often occur within 20 minutes of application but can occur later. Reactions may be due to the presence of sodium lauryl sulfate or other ingredients. If a patient reports or shows signs of skin irritation with the use of aqueous cream, treatment should be discontinued and an alternative emollient that does not contain sodium lauryl sulfate should be tried. See MHRA Drug Safety Update March 2013

### Preparations containing urea

<table>
<thead>
<tr>
<th>Brand</th>
<th>Formulation</th>
<th>Urea Percentage</th>
<th>Excipients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calmurid®</td>
<td>Cream</td>
<td>10%</td>
<td>Urea 10%, lactic acid 5%</td>
</tr>
<tr>
<td>Eucerin®</td>
<td>Lotion</td>
<td>10%</td>
<td>Urea 10%</td>
</tr>
</tbody>
</table>

**Notes:**
1. Non-allergic cutaneous reactions to aqueous cream in children with atopic eczema are very common. It should only be used as a soap substitute rather than a “leave on” emollient.
2. Aveeno® ACBS - has limited use only (see BNF)
3. Calmurid® can be useful for ichthyosis and thickened skin on the soles of the feet.

### Ointments

<table>
<thead>
<tr>
<th></th>
<th>Ointment</th>
<th>Excipients</th>
</tr>
</thead>
<tbody>
<tr>
<td>50:50 Liquid and White Soft Paraffin</td>
<td>Epaderm®</td>
<td>Ointment</td>
</tr>
<tr>
<td></td>
<td>Emolliin®</td>
<td>Spray</td>
</tr>
<tr>
<td></td>
<td>Emulsifying Ointment</td>
<td>Ointment</td>
</tr>
<tr>
<td></td>
<td>Hydromol®</td>
<td>Ointment</td>
</tr>
<tr>
<td></td>
<td>Hydrous Ointment</td>
<td>Ointment (oily cream)</td>
</tr>
<tr>
<td></td>
<td>Yellow soft paraffin BP</td>
<td>Yellow petroleum jelly</td>
</tr>
<tr>
<td></td>
<td>White soft paraffin BP</td>
<td>White petroleum jelly</td>
</tr>
</tbody>
</table>

**Notes:** Emollin is useful for areas where self-application of cream is difficult e.g on the back. It is also useful in children and the elderly where rubbing a cream in may be a problem.

### Emollient plus antimicrobial – where secondary infection is suspected

<table>
<thead>
<tr>
<th>Brand</th>
<th>Lotion</th>
<th>Excipients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dermol® 500</td>
<td></td>
<td>cetostearyl alcohol</td>
</tr>
</tbody>
</table>

### 13.2.1.1 Emollient bath additives

**Notes:**
1. Addition of emollients to the bath may be beneficial in some patients. Fewer baths and more showers are recommended. Choice is based on patient preference.
2. Emulsifying ointment and aqueous cream may be acceptable to many patients as a bath emollient. These products are best whisked with hot water in a jug before adding to bath water.
3. Aqueous cream can be used as a soap substitute.
4. Patients should be aware of the potential dangers of slipping in the bath or shower if emollients are added - the use of a bath mat may reduce this risk. Parents may also wish to be cautious when removing children from the bath.

<table>
<thead>
<tr>
<th>Brand</th>
<th>Bath oil</th>
<th>Add 20-60ml to bath; infants: 5-15ml</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balneum®</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
First line drugs  Second line drugs  Specialist drugs  Hospital only drugs

### Antimicrobial / emollient combination products

Notes:
1. If not responding to the above preparations, the addition of an antimicrobial may be warranted, although the routine prophylactic use of antiseptic/emollient combinations is **not recommended**.
2. Dermol® 500 and Dermol® 200 should be used as soap substitutes and not added to the bath.
3. A short course of an **oral antibiotic** may be appropriate in patients with physical signs of infection.

### Barrier preparations

**Zinc and castor oil ointment BP**
- **Zinc oxide 7.5%, castor oil 50%**
  - For nappy and urinary rash
  - Excipients include beeswax, cetostearyl alcohol, peanut oil

Notes:
1. The BNF states that barrier creams are no substitute for adequate nursing care, or regular nappy changing and it is doubtful they are any more effective than the traditional compound zinc ointments.
2. **Sudocrem** contains five of the listed excipients with a greater chance of causing skin sensitisation. Sudocrem offers no advantage over zinc and castor oil ointment and is a more expensive product.
3. For barrier products specifically for continence issues, please see the latest version of **The Continence Team Formulary**.

### Topical local anaesthetics and antipruritics

**Aqueous cream with menthol**
- **Arjun® 0.5% cream**
- **Dermacool 0.5%, 1%, 2% cream**

**Crotamiton**
- **Eurax® cream**
- **Eurax® lotion**
- **Xepin®**

**Doxepin**

Notes:
1. An emollient may be of value where the pruritus is associated with dry skin.
2. **Crotamiton** dries skin, and is therefore not suitable for use in eczema.
3. Eurax® lotion appears to be more soothing than cream.
4. Sedating antihistamines can prove valuable in breaking the itch-scratch-itch cycle.
5. Calamine preparations are often ineffective and have little proven benefit. In addition they dry the skin and cause the pruritus to worsen.
6. **Doxepin** is useful for some patients with intractable itch.
13.4 Topical corticosteroids

Notes:

1. **Emollients are an essential component** in the treatment of atopic eczema and psoriasis and can reduce the need to use topical steroids. **All patients** with dry skin conditions should be using an effective and cosmetically acceptable emollient regimen. Soaps and detergents should also be avoided by using substitutes such as those listed in BNF section 13.2.1.1.

2. Many patients are reluctant to use topical corticosteroids because of the fear of local and systemic effects. Patients should be reassured that side-effects are rarely seen when mild or moderately potent steroids are used in short courses.

3. It is important to prescribe the appropriate potency of steroid according to the severity of the disease. Flare-ups can be treated with a potent or very potent steroid and then stepped down to an appropriate potency of steroid or even an emollient.

4. Patients should be initiated on the highest potency topical corticosteroid that is clinically required and then stepped down. The patient may be stepped down to a lower potency steroid or the frequency of use of a higher potent steroid can be reduced, for example:

   Once / Twice Daily → Alternate Days or less frequently, as necessary

5. **Active treatment** is more likely to get the skin condition under control

6. Caution must be used when selecting corticosteroids for different parts of the body. For the face and other sensitive areas of the body, a lower potency corticosteroid should be used.

7. **“To be spread thinly”** is a cautionary warning that must legally be included on the label of topical steroid preparations. This can mean different things to different people and can worry some patients. It is important to explain to patients the correct application and ensure adequate coverage of affected areas.

8. **Choice of Preparation**: Ointments are preferable to creams as they have a deeper, more prolonged emollient effect and increase the penetration of steroid. They are also less likely to cause irritation and/or sensitisation to the product, as they do not contain preservatives.

9. Patients may prefer creams for application to the face and can be more suitable for moist or weeping lesions.

10. Ideally, topical steroids should only be used for short periods to treat exacerbations of the disease.

11. For patients requiring maintenance therapy of steroids, it is important to review prescribing at least every 3 months. For patients using steroids short term, the need for repeat prescriptions should be reviewed every four weeks.

12. The long-term use of potent and very potent steroids should be recommended by a dermatologist / nurse specialist.

13. Reminding patients to dispose of unwanted or out of date medicines by returning them to a pharmacy for disposal may be worthwhile, as reuse of a microbial contaminated steroid product could be harmful.

14. Topical steroids should not be used routinely on clinically infected skin, unless the infection is being treated. A short course of a suitable oral antibiotic maybe indicated.

**NICE Guidance TA 81: Frequency of application of topical corticosteroids for atopic eczema (August 2004)**

- Topical corticosteroids for atopic eczema should be prescribed for application only once or twice daily. Once a day may be as effective as twice daily application.

- Where more than one alternative topical corticosteroid is considered clinically appropriate within a potency class, the drug with the lowest acquisition cost should be prescribed, taking into account pack size and frequency of application.
How much to prescribe?
The table below shows suitable quantities of topical corticosteroids to be prescribed for specific areas of the body based on **twice daily application for one week**. Some patients may require larger quantities, depending on total surface area.

<table>
<thead>
<tr>
<th>Ointments and creams</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Face and neck</td>
<td>15 – 30 g</td>
</tr>
<tr>
<td>Both hands</td>
<td>15 – 30 g</td>
</tr>
<tr>
<td>Scalp</td>
<td>15 – 30 g</td>
</tr>
<tr>
<td>Both arms</td>
<td>30 – 60 g</td>
</tr>
<tr>
<td>Both legs</td>
<td>100 g</td>
</tr>
<tr>
<td>Trunk</td>
<td>100 g</td>
</tr>
<tr>
<td>Groins and genitalia</td>
<td>15 – 30 g</td>
</tr>
</tbody>
</table>

**Mild Potency**

**Hydrocortisone**
- Ointment: 0.5%, 1%, 2.5%
- Cream: 0.5%, 1%, 2.5%

Excipients for the cream may differ depending on generic or proprietary preparation, see BNF

**Note:** Skin creams and ointments containing hydrocortisone (alone or with other ingredients) is available for purchase from pharmacies but only for the treatment of allergic contact dermatitis, irritant dermatitis, insect bite reactions and mild to moderate eczema. It **cannot be sold** for application to eyes/face, anogenital region, for use in pregnancy or children under 10 years and broken or infected skin (including cold sores, acne and athlete’s foot) and has a license for a maximum of one week’s duration.

**Moderate Potency**

**Betamethasone valerate**
- Betnovate RD® 0.025% ointment
- Betnovate RD® 0.025% cream

Excipients: ointment: none as listed in section 13.1.3. Cream: cetostearyl alcohol, chlorocresol

**Clobetasone butyrate**
- Eumovtae® 0.05% ointment
- Eumovate® 0.05% cream

Excipients: ointment: none as listed in section 13.1.3.

**Notes:**
1. Clobetasone butyrate (Eumovate®) cream 15g can be purchased from pharmacies but only for short-term symptomatic treatment and control of patches of eczema and dermatitis (but not seborrhoeic dermatitis) in adults and children over 12 years.
2. Due to the risk of potential errors due to similar names, clobetasol and clobetasone preparations should always be prescribed by brand.

**Potent**

**Betamethasone valerate**
- 0.1% ointment
- 0.1% cream

Excipients: ointment: none as listed in section 13.1.3. Cream: varies between products, see BNF.

**Mometasone furoate**
- Elocon® 0.1% ointment
- Elocon® 0.1% cream


**Very Potent**

**Clobetasol propionate**
- Dermovate 0.05% ointment
- Dermovate® 0.05% cream

Excipients: ointment: propylene glycol. Cream: beeswax (or beeswax substitute), cetostearyl alcohol, chlorocresol, propylene glycol.

**Note:** Due to the risk of potential errors due to similar names, clobetasol and clobetasone preparations should always be prescribed by brand.

**Scalp applications**

**Fluocinolone acetonide**
- Synalar® gel 0.025%

Excipients include hydroxybenzoates (parabens), propylene glycol

**Mometasone furoate**
- Elocon® scalp lotion 0.1% in aqueous isopropyl alcohol base.

Excipients include propylene glycol
Antimicrobial / steroid combination products

Note: The advantages of including other substances (such as antibacterials or antifungals) with steroids in topical preparations are debatable, but they may have a place where there is associated bacterial or fungal infection.

Mild Potency

Daktacort®
- Cream
- Ointment
  (Hydrocortisone 1%, miconazole nitrate 2%)

Note:
1. Daktacort® is available in a pack size of 30g. A 15g size is available for sale by pharmacies as Daktacort HC®, but this is only available for sale for athlete's foot and candidal intertrigo.
2. Take care with use on the face as it may cause a peri-oral dermatitis.

Timodine®
- Cream
  (Hydrocortisone 0.5%, benzalkonium chloride soln 0.2%, nystatin 100,000 units/g, dimeticone '350' 10%)

Fucidin H®
- Cream
- Ointment
  (Hydrocortisone 1%, sodium fusidate 2%)

Moderate Potency

Trimovate®
- Cream
  (Clobetasone butyrate 0.05%, oxytetracycline 3%, nystatin 100,000 units/g)

Potent

FuciBET®
- Cream
  (Betamethasone valerate 0.1% fucidic acid 2%)

Betnovate-C®
- Cream
- Ointment
  (Betamethasone 0.1%, clocloquinol 3%)

13.5 Preparations for eczema and psoriasis

13.5.1 Preparations for eczema

Oral Retinoids for Eczema

Alitretinoin
- Toctino® Capsules 10mg, 30mg

NICE Guidance TA 177: Alitretinoin for the treatment of severe chronic hand eczema (August 2009)

Alitretinoin is recommended as a treatment option for adults with severe chronic hand eczema that has not responded to potent topical corticosteroids. Treatment should be stopped as soon as an adequate response has been achieved or the eczema remains severe at 12 weeks or an adequate response has not been achieved by 24 weeks.

Notes: Alitretinoin should be prescribed only by or under the supervision of a consultant dermatologist. Alitretinoin is teratogenic and must not be given to women of childbearing potential unless they use effective contraception and then only after detailed assessment and explanation by the physician. Prescriptions should be supplied in accordance with the Pregnancy Prevention Programme.

Treatment of eczema

Emollients and soap substitutes: Emollients are very important in the treatment of eczema as the skin is usually dry and lacks the natural oily protective barrier. They also soften and smooth the skin and improve itching that may be present. They must be used frequently, at least twice daily, on all areas of
the skin, even where there is no visible sign of eczema.

**Topical steroids:** Steroids are useful where there is an *inflammatory component* to the disease and to reduce itching. The strength and type of steroid prescribed depends on the age of the patient, the site affected, the severity of the eczema and whether or not infection is present. The use of the *least potent steroid to control symptoms* is advised.

**Topical Immuno-modulators:** Tacrolimus and pimecrolimus are **NOT** recommended for mild atopic eczema or as first-line treatment. NICE has recommended (August 2004) that topical pimecrolimus and tacrolimus are options for atopic eczema not controlled by maximal topical corticosteroid treatment or if there is a risk of important corticosteroid side-effects (particularly skin atrophy). The license does not include children under 2 years (see current BNF)

**Antihistamine treatment:** The use of oral antihistamines is often ineffective in the treatment of itching associated with eczema. Itching is generally worse in the warmth of the bed and can often interfere with sleep. Sedating antihistamines can be useful in this situation but should only be prescribed for short periods of up to one month.

**Treatment of infection:** Once the skin is broken, it is common to get an infection on top of the eczema. This often affects the legs, wrists, hands and face, makes the patient feel unwell and limits movement. Infection with *Staphylococcus aureus* can be the cause of an acute flare up of atopic eczema and should be treated accordingly, e.g. flucloxacillin, erythromycin. It is also helpful to use products containing antiseptics, such as Dermol®.

**Other treatments:** Applying a dry tubular bandage or garments over topical treatments or using paste bandage or ‘wet wrapping’ on severe eczema can be helpful when proving difficult to control. Seek advice from dermatology specialist department.

**NICE Referral Advice for Atopic Eczema in Children (December 2001)**

Most children with atopic eczema can be managed in primary care. Referral to a specialist service, which may be prompted by features such as sleep disturbance and school absenteeism, is advised if:

- **** infection with disseminated herpes simplex (eczema herpeticum) is suspected
- *** the disease is severe and has not responded to appropriate therapy in primary care
- *** the rash becomes infected with bacteria (manifest as weeping, crusting, or development of pustules), and treatment with an oral antibiotic plus a topical corticosteroid has failed
- ** the rash is giving rise to severe social or psychological problems
- ** treatment requires the use of excessive amounts of potent topical corticosteroids
- * management in primary care has not controlled the rash satisfactorily. Ultimately, failure to improve is probably best based upon subjective assessment by the child or parent
- * the patient or family might benefit from additional advice on application of treatments (e.g. bandaging techniques)
- * contact dermatitis is suspected and confirmation requires patch testing (this is rarely needed)
- * the child has uncontrolled eczema and dietary factors are suspected (refer directly to dietician)

**Key to referral timings:** Arrangements should be made so that the patient:

- **** is seen immediately (within a day)
- *** is seen urgently (maximum 2 weeks)
- ** is seen soon (not defined)
- * has a routine appointment
13.5.2 Preparations for psoriasis

Management of Psoriasis – see NICE CG 153: Psoriasis
1. There is no cure for psoriasis, although there are effective treatments.
2. Treatment is suppressive, aimed at inducing a remission or making the amount of psoriasis tolerable to the patient.
3. For the majority of patients, the disease follows a chronic course, interspersed with periods of remission.
4. Relapses are difficult to predict and cannot be prevented with topical therapy.
5. The need for treatment will often be dictated by the patient's own perception of his or her disability.

A simple regimen for the initial topical treatment of chronic plaque psoriasis can be outlined as follows:

**General measures:** Emollients used as frequently as needed and use of soap substitutes and bath additives

**For localised plaque psoriasis** e.g. on the elbows or knees, the following topical preparations (listed in no particular order) can be tried. The exact choice will depend on the doctor and patient taking factors such as side effects into consideration:

- **Topical steroids** – can be very useful for limited psoriasis or flexural psoriasis. The weaker steroids often do not work very well on thick patches, but may work better on the face or in the skin folds.
- **Tar preparations** – can help, but many find them “messy and smelly” and can stain clothing
- **Dithranol** – can cause severe skin irritation and should only be prescribed by those experienced in its use. It should only be used for short contact periods of 30-60 minutes. Dithranol in Lassar’s paste, however, is used for long contact – 12-24 hours. This can cause a problem of contact for partners and is “messy”.
- **Calcipotriol / calcitriol** – more expensive than other topical treatments, but more effective than the alternatives, other than for guttate psoriasis when vitamin D derivatives are generally less effective.
- **Combination of calcipotriol and steroids** – Combining the use of corticosteroid with calcipotriol may be beneficial in chronic plaque psoriasis. The drugs may be used separately at different times of the day or used together in a single formulation. Eczema co-existing with psoriasis may be treated with a corticosteroid, or coal tar, or both.

**For more widespread plaque psoriasis** e.g. on the trunk or the limbs, the same treatments may be appropriate, with the proviso that dithranol may be impractical to apply to several small lesions. Patients should be considered for second line treatment i.e. oral medication or phototherapy.

**For scalp psoriasis:**

- **Olive oil or coconut oil** – can be used on infected and heavily scaled scalps to remove thickened skin.
- **Tar based shampoos** – usually first line, followed by a potent topical steroid preparation, or calcipotriol scalp application. Other options include “Cocos Ointment (2% salicylic acid, 4% sulphur and 12% coal tar), which needs to be applied for more than 1 hour at a time.

Those patients with extensive disease, who need systemic treatment, will require close monitoring under the supervision of a consultant dermatologist, because of the potential toxicity of these drugs. The dermatologist will also be involved in the care of difficult cases where the site or unresponsiveness of the rash, are important factors. Where plaque psoriasis is severe and has failed to respond to oral systemic therapies and PUVA, NICE has approved the use of biologics in certain circumstances (see section 13.5.3

**NICE Referral Advice for Psoriasis (December 2001)**

Most patients with psoriasis can be managed in primary care. Referral to specialist services, which may be prompted by features such as sleep disturbance, social exclusion, reduced quality of life or reduced self-esteem, is advised if:

**** the patient has generalised pustular or erythrodermic psoriasis
*** the patient’s psoriasis is acutely unstable
*** the patient has widespread guttate psoriasis (so that he/she can benefit from early phototherapy)
the condition is causing severe social or psychological problems
the rash is sufficiently extensive to make self-management impractical
the rash is in a sensitive area (such as face, hands, feet, genitalia) and the symptoms particularly troublesome
the rash is leading to time off work or school which is interfering with employment or education
the patient requires assessment for the management of associated arthropathy
the rash fails to respond to management in general practice. Failure is probably best based on the subjective assessment of the patient. Sometimes failure occurs when patients are unable to apply the treatment themselves.

Refer to section 13.5.1 for key to referral timing

Calciptoriol
Apply once or twice daily

- **Dovonex**® cream 50microgram/g 60g, 120g, Max: 100g weekly adults; 75g weekly child over 12 years; 50g weekly child 6-12 years
- **Dovonex**® scalp solution 50 microgram/ml; 60ml, 120ml Max: 60ml weekly - less if used with cream; Child – not recommended

Calcipotriol with betamethasone

- **Dovobet**® ointment 50micrograms/g plus betamethasone 0.05% 60g, 120g Max: Adults 30% of body area, 15 g daily, 100g weekly for 4 weeks
- **Dovobet**® gel 5micrograms/g plus betamethasone 0.05% 60g Max: Adults, 1-4g daily usually for up to 4 weeks for scalp or 8 weeks for non scalp areas

Calcitriol
Apply twice daily

- **Silkis**® ointment 3micrograms/g 30g, 100g Max: 30g daily to no more than 35% of body surface area

Coal tar
Apply 2 – 3 times daily

- **Exorex**® lotion: prepared coal tar 1% in an emollient basis Child and elderly: dilute with a few drops of water

Dithranol

- **Dithrocream**® cream 0.1%, 0.25%, 0.5%, 1%, 2% 0.1% - 0.5% suitable for overnight treatment; 1%-2% max: 1 hour
- **Dithranol in Lassar’s Paste, BP**
  - Usual strengths: dithranol 0.075% -10%
  - Lassar’s Paste – zinc oxide 24%, salicylic acid 2% starch 24%, white soft paraffin 50%

Acitretin

- **Neotigason**® capsules, 10mg, 25mg

Puvasoralen 8

- Bath lotion 1.2%
- Emulsion 0.15%
- Tablets 10 mg

8-methoxy-psoralen

5-methoxy-psoralen

Notes:

1. **Calcitriol** should be applied to the face with caution, as there is an increased risk of irritation on this area. There is limited clinical experience for the use of calcitriol prescribed for more than 6 weeks. It is not licensed for use in children.

2. **Calcipotriol**: when more than one calcipotriol preparation is used together, the maximum total of calcipotriol in any one week should not exceed 5mg e.g. 60ml scalp solution with 30g cream OR 60g cream with 30ml scalp solution

3. **Dovobet**® is a combination of calcipotriol and betamethasone 0.05% and is licensed for the initial topical treatment of stable plaque psoriasis vulgaris amenable to topical therapy.

4. The recommended duration of treatment with **Dovobet**® should not exceed 4 weeks. However, alternating monthly between Dovobet® and Dovonex® ointment is possible. Dovobet® is contraindicated in guttate, erythrodermic, exfoliative and pustular psoriasis. Refer to the SPC for further contra-indications and prescribing information.

5. **Irritant preparations** (tar, dithranol, vitamin D derivatives) should be avoided in flexural psoriasis. A mild or moderate steroid, such as Eumovate® cream, is appropriate.

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**First line drugs** | **Second line drugs** | **Specialists drugs** | **Hospital only drugs**
---|---|---|---

Adapted from Plymouth Area Joint Formulary and East Surrey Joint Formulary

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6. For **severe resistant psoriasis**, oral treatments (acitretin, ciclosporin, hydroxyurea or WEEKLY methotrexate) may be initiated and supervised by a consultant. [For ciclosporin and methotrexate, refer to BNF Chapter 8.]

7. For **scalp preparations** see BNF section 13.9

8. **5-methoxypsoralen** should be used where the patient is sensitive to 8-methoxypsoralen.

9. Treatment should only be maintained whilst plaque raised. Once flat with simple red discolouration, simple emollient to be applied.

### 13.5.3 Drugs affecting the immune response

**Tacrolimus**
- Ointment 0.03%, 0.1%: 30g, 60g
- **Excipients include beeswax**

**Note:** apply only until lesions clear, as per BNF, in accordance with NICE guidance

**Pimecrolimus**
- Cream 1%: 30g, 60g, 100g
- **Excipients include benzyl alcohol, cetyl alcohol, propylene glycol, stearyl alcohol**

**Note:** apply only until symptoms resolve, as per BNF, in accordance with NICE guidance

**NICE Guidance TA 82: Tacrolimus and pimecrolimus for atopic eczema (August 2004)**

1.1 **Not recommended for mild atopic eczema or as first-line treatment.**

1.2 Topical **Tacrolimus** is recommended as an option for the second-line treatment of **moderate to severe atopic eczema in adults and children aged 2 years and older** that has not been controlled by topical corticosteroids, where there is a serious risk of important adverse effects from further topical corticosteroid use, particularly irreversible skin atrophy.

**Pimecrolimus** is recommended as an option for the second-line treatment of **moderate atopic eczema** on the face and neck in children aged 2 to 16 years that has not been controlled by topical corticosteroids, where there is a serious risk of important adverse effects from further topical corticosteroid use, particularly irreversible skin atrophy.

1.3 For the purposes of this guidance, **atopic eczema that has not been controlled by topical corticosteroids** refers to disease that has not shown a satisfactory clinical response to adequate use of the maximum strength and potency that is appropriate for the patient’s age and the area being treated.

1.4 Tacrolimus and pimecrolimus should only be initiated by physicians with a special interest and experience in dermatology and only after careful discussion with the patient about the potential risks and benefits of all appropriate second-line treatment options.

**Cytokine Modulators**

<table>
<thead>
<tr>
<th>Drug</th>
<th>Brand</th>
<th>Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adalimumab</strong></td>
<td>Humira®</td>
<td>SC every 2 weeks</td>
</tr>
<tr>
<td><strong>Etanercept</strong></td>
<td>Enbrel®</td>
<td>SC once or twice weekly</td>
</tr>
<tr>
<td><strong>Infliximab</strong></td>
<td>Remicade®</td>
<td>IV 3 dose induction then every 8 weeks</td>
</tr>
<tr>
<td><strong>Ustekinumab</strong></td>
<td>Stelara®</td>
<td>SC 2 dose induction then every 12 weeks</td>
</tr>
</tbody>
</table>

All of the above agents have been approved by NICE for use in psoriasis of varying degrees of severity. Choice of agent will depend upon clinical and patient factors as determined by the specialist.

**NICE Guidance TA 146: Adalimumab for the treatment of adults with psoriasis (June 2008)**

Adalimumab is recommended for the treatment of plaque psoriasis which has failed to respond to standard systemic treatments (including ciclosporin and methotrexate) and phytochemotherapy, or when standard treatments cannot be used because of intolerance or contraindications. Adalimumab should be withdrawn if the response is not adequate after 16 weeks.
**NICE Guidance TA 103: Etanercept and efalizumab for plaque psoriasis in adults (July 2006)**

Etanercept is recommended for the treatment of severe plaque psoriasis which has failed to respond to standard systemic treatments (including ciclosporin and methotrexate) and phytochemotherapy, or when standard treatments cannot be used because of intolerance or contraindications. Etanercept should be withdrawn if the response is not adequate after 12 weeks.

Marketing authorisation for efalizumab has been suspended hence NICE guidance on the use of efalizumab in plaque psoriasis has been suspended.


Infliximab is recommended for the treatment of very severe plaque psoriasis which has failed to respond to standard systemic treatments (including ciclosporin and methotrexate) or to phytochemotherapy, or when standard treatments cannot be used because of intolerance or contraindications. Infliximab should be withdrawn if the response is not adequate after 10 weeks.

**NICE Guidance TA 180: Ustekinumab for the treatment of adults with moderate to severe psoriasis (September 2009)**

Ustekinumab is recommended for the treatment of severe plaque psoriasis which has failed to respond to standard systemic treatments (including ciclosporin and methotrexate) and phytochemotherapy, or when standard treatments cannot be used because of intolerance or contraindications. Ustekinumab should be withdrawn if the response is not adequate after 16 weeks.

### 13.6 Acne and rosacea

**NICE Referral Advice for Acne, December 2001**

Most patients with acne can be managed in primary care. However, referral to a specialist service is advised if they:
***
- have a very severe variant such as fulminating acne with systemic symptoms (acne fulminans)
- have severe acne or painful, deep nodules or cysts (nodulocystic acne) and could benefit from oral isotretinoin
- have severe social or psychological problems, including a morbid fear of deformity (dysmorphophobia)
- are at risk of, or are developing, scarring despite primary care therapies
- have moderate acne that has failed to respond to treatment, which should generally include several courses of both topical and systemic treatment over a period of at least 6 months. Failure is probably best based upon a subjective assessment by the patient
- are suspected of having an underlying endocrinological cause for the acne (such as polycystic ovary syndrome) that needs assessment

*Refer to section 13.5.1 for key to referral times*

**Notes:**

1. Treatment of acne should be commenced as early as possible with patients reassessed every two to three months initially.
2. Patients presenting with acne with a suspected endocrinological cause should be referred to an endocrinologist.
3. Patients should be counselled that an improvement might not be seen for up to a couple of months. Stress to patients the importance of good compliance.
4. **Mild acne** should initially be treated with topical agents; drug choice depends on whether comedonal or inflammatory lesions predominate. Benzoyl peroxide or topical retinoids are first choice agents for mild comedonal acne whereas benzoyl peroxide is the topical agent of choice for mild inflammatory acne.
5. **Moderate to severe acne**: treatment requires the use of both systemic and topical agents.
6. **Systemic therapy**: oral antibiotics are the main stay. An adequate dose should be given for at least 2 months before deciding a patient has failed to respond.
7. Treatment should not be used for longer than necessary (usually between 6 and 12 months).
8. The first choice antibiotic agent is **oxytetracycline** 500mg BD, as it is effective and inexpensive. See the East Sussex Health Economy Medicines Committee “Management of Infection Guidance for Primary Care and Non-Acute Community Settings" Jan 2006 for further information.
9. Tetracycline or doxycycline are other alternatives. Erythromycin is best reserved for patients in whom other antibiotics are unsuitable, aspropionibacterial resistance to this drug is relatively common.
10. Although not locally recommended, where minocycline is used, if treatment to be continued for longer
than six months, patients should be monitored at least three monthly thereafter for signs and symptoms of hepatitis or SLE or unusual pigmentation. Patients should be advised to report any unusual pigmentation without delay and minocycline should be discontinued.

11. If acne returns, reuse the same drug if the previous response was satisfactory with that agent.

12. Avoid concomitant oral and topical treatment with chemically dissimilar antibiotics.

### 13.6.1 Topical preparations for acne

#### Topical benzoyl peroxide and azelaic acid

**Benzoyl peroxide**
- PanOxyl® aquagel: 2.5%, 5%, 10%
- PanOxyl® cream: 5%
- PanOxyl® gel: 10%
- PanOxyl® wash: 10%

**Azelaic acid**
- Skinoren® cream, 20%

**Notes:**
1. Benzoyl peroxide is effective in mild to moderate acne. Both comedones and inflamed lesions respond well to benzoyl peroxide. It is usual to start with a low strength of benzoyl peroxide and increase the concentration gradually.
2. Antibacterial resistance of propionibacterium acne is increasing, and there is cross-resistance between erythromycin and clindamycin. To avoid development of resistance, when possible use non-antibiotic antimicrobials e.g. benzoyl peroxide.
3. Benzoyl peroxide is available over the counter at a lower cost than prescription charges.
4. Benzoyl peroxide may bleach clothing.
5. Azelaic acid may be an alternative to benzoyl peroxide where skin irritation is a problem.
6. If acne does not respond after 2 months then consider a topical antibacterial with benzoyl peroxide.

#### Topical antibacterials for acne

**Zinadclin®**
- Gel containing clindamycin 1%

**Duac® Once Daily**
- Benzoyl peroxide 5%, clindamycin 1% in aqueous basis.

**Zineryt®**
- Topical solution containing erythromycin 40mg, zinc acetate 12mg/ml in ethanol

**Notes:**
1. Concomitant oral and topical treatment with chemically dissimilar antibiotics should be avoided.

#### Topical retinoids and related preparations for acne

**Adapalene** *(Differin®)*
- Cream
- Gel

**Tretinoin** *(Retin A®)*
- Cream, 0.025%
- Gel, 0.01%, 0.025%
- Lotion, 0.025%

**Notes:**
- **Adapalene**
  - Excipients include: cream: hydroxybenzoates, disodium edetate. Gel: disodium edetate, hydroxybenzoates, propylene glycol
- **Tretinoin**
  - Excipients include: cream: butylated hydroxytoluene, sorbic acid, stearyl alcohol
  - Gel and Lotion: butylated hydroxytoluene
Notes:
1. Patients should be advised:
   - Redness and skin peeling may occur for several days, but usually settles with time
   - Acne may worsen for the first few weeks
   - To avoid ultraviolet lamps and minimise exposure to sunlight
   - To allow peeling (e.g. from benzoyl peroxide) to subside before using a topical retinoid
2. Topical retinoids should not be used in pregnancy and women of childbearing age must use adequate contraceptive precautions while using a retinoid.
3. Topical retinoids should be avoided in severe acne involving large areas.
4. Exposure to UV light (including sunlight, solariums) should be avoided; if sun exposure is unavoidable, an appropriate sunscreen or protective clothing should be used.
5. Use of retinoids with abrasive cleaners, comedogenic or astringent cosmetics should be avoided.

Other topical preparations for acne

Notes:
1. The BNF states that these products are considered to be less suitable for prescribing.
2. Salicylic acid is available in various preparations for sale direct to the public for mild acne.
3. Preparations containing sulphur and abrasive agents are not considered beneficial for acne.
4. Nicotinamide has limited clinical evidence and its place in the treatment of acne is unclear. Therefore, it has not been included in the formulary.

13.6.2 Oral preparations for acne

Co-cyprindiol
- Dianette® tablets

Isotretinoin
- Capsules 5 mg, 20 mg 

Hospital supply only

Notes:
   Prescribers are reminded that:
   - Dianette® is not indicated for use solely as an oral contraceptive.
   - Dianette® is a treatment for women with severe acne that has not responded to oral antibiotics, or for moderately severe hirsutism.
   - Dianette® should be withdrawn 3 to 4 cycles after the treated condition has completely resolved.
   - The incidence of VTE in Dianette® users is higher than that in women who use low-dose oestrogen COCs.
   - Dianette® is contraindicated in women with a personal or close family history of confirmed, idiopathic VTE and in those with a known current venous thrombotic or embolic disorders.
   - Women who have severe acne or hirsutism may have an inherently increased cardiovascular risk.
2. **Isotretinoin** is a toxic drug that should only be prescribed by, or under the supervision of a consultant dermatologist. It is usually given for 16 weeks; repeat courses are not normally required. Side effects of isotretinoin include severe dryness of the skin and mucous membranes, nosebleeds, joint pains and muscle pain on exercise.
3. **Isotretinoin is teratogenic** and must not be given to women of childbearing age unless effective contraceptive measures are being taken and then only after detailed assessment and explanation by the physician. Current legislation requires all women of childbearing age to be enrolled into a Pregnancy Prevention Programme. Refer to current BNF for further cautions and blood tests required before and during treatment.
4. Patients taking isotretinoin must not take vitamin preparations containing more than 4000-5000 i.u. of vitamin A.
5. The MHRA stipulates that prescriptions for isotretinoin should be issued from a hospital based pharmacy only.
### 13.7 Preparations for warts and calluses

**Salicylic acid**
- Salactol® Paint; salicylic acid 16.7%, lactic acid 16.7% in flexible collodion
- Cuplex® Gel; salicylic acid 11%, lactic acid 4% in a collodion basis

**Podophyllum**
- Podophyllin Paint, Compound, BP
  For external genital warts. Applied weekly in genitourinary clinic (or at a general practitioner’s surgery by a trained nurse after screening for other sexually transmitted diseases)

**Imiquimod**
- Aldara® Cream 5%
  For external genital and perianal warts. **May damage latex condoms and diaphragms.** Excipients include benzyl alcohol, cetyl alcohol, stearyl alcohol, hydroxybenzoates (parabens), polysorbate 60

**Silver nitrate sticks**
- 70%, 90% (hospital only)
- Avoca® 40%, 95%

**Notes:**
1. Viral warts and verrucas are benign and self-limiting and can be managed within primary care; treatment may be required for up to three months.
2. Cryotherapy is not appropriate for viral warts on the feet since it is usually ineffective; it can cause significant scarring and can exacerbate warts. Surgical treatment is also inappropriate.
3. Silver nitrate sticks are used for cauterisation in theatre and umbilical granulomas in primary care.

### 13.8 Sunscreens and camouflagers

#### 13.8.1 Sunscreening preparations

**Sunsense® Ultra**
- Lotion; SPF 50+

**Uvistat®**
- Cream; SPF 30

**Notes:**
1. These products can only be prescribed for the following indications on FP10 and must be endorsed ACBS:
   - Skin protection against ultraviolet radiation in abnormal cutaneous photosensitivity resulting from genetic disorders;
   - Photodermatoses, including vitiligo and those resulting from radiotherapy;
   - Chronic or recurrent herpes simplex labialis.
2. For optimum photoprotection, sunscreen preparations should be applied thickly and frequently (approximately 2 hourly). In photodermatoses, they should be used from spring to autumn. As maximum protection from sunlight is desirable, prescribe preparations with the highest SPF.
3. For general use, moisturisers and sunscreens with SPF of at least 15 should be first line.
Adapted from Plymouth Area Joint Formulary and East Surrey Joint Formulary

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Notes:
1. The 2007 British Association of Dermatologists guidelines suggest that ‘no therapy’ or ‘emollient only’ are reasonable options for mild actinic keratoses. Where treatment is warranted, the table below specifies the formulary treatment options.

<table>
<thead>
<tr>
<th>Actinic keratosis Grade 1</th>
<th>Actinic keratosis Grade 2</th>
<th>Actinic keratosis thick, hyperkeratotic lesions Grade 3</th>
<th>Small superficial basal cell carcinomas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diclofenac 3% gel (Solaraze®)</td>
<td>Fluorouracil 5% cream (Efudix®)</td>
<td>Liquid Nitrogen/ curettage</td>
<td>Imiquimod 5% cream (Aldara®)</td>
</tr>
<tr>
<td>Ingenol mebutate gel (Picato®) ▼</td>
<td>Ingenol mebutate gel (Picato®) ▼</td>
<td>Moderately thick hyperkeratotic actinic keratosis</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fluorouracil 0.5%/ salicylic acid 10% solution (Actikerall®)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>For face, scalp, genital areas</td>
<td>Imiquimod 5% cream (Aldara®)</td>
</tr>
</tbody>
</table>

2. Diclofenac gel 3% is licensed for the treatment of mild actinic keratosis. Treatment should continue for 60 to 90 days and the optimal therapeutic effect may not be seen for 30 days after stopping treatment.

3. Ingenol mebutate gel is a short treatment course of 2 days (trunk and extremities) or 3 days (face and scalp) when adherence to diclofenac gel is likely to be problematic.

4. Fluorouracil cream is effective against most types of non-hypertrophic actinic keratosis and should be applied thinly usually for 3-4 weeks.

5. Imiquimod is best reserved for more widespread actinic keratoses resistant to initial treatment with liquid nitrogen or Fluorouracil cream.

6. Imiquimod should be rubbed in and allowed to stay on the treated area for 8 hours, then washed off with mild soap and water. For the treatment of actinic keratoses it is applied alternate days for 4 weeks. A second application should follow 4 weeks later if lesions have failed to respond to the first treatment. Patients must be warned of the irritant effects with Imiquimod and should be instructed to withhold treatment if any form of soreness develops until all soreness has subsided.

7. Imiquimod is highly effective in the treatment of superficial basal cell carcinomas on the torso or limbs. It is applied 5 days out of 7 for 6 weeks. Patients need to be carefully counselled with regards to potential side effects of the treatment and need to be reviewed about 6 weeks after treatment completion to check results.

### Hydroquinone 5% with tretinoin 0.1% and hydrocortisone 1%

**Notes:**

Pigmanorm is a depigmenting cream for the treatment of melasma. It should be applied once daily, only to hyperpigmented skin and for usually one or two months. If there has been no response after 3 months of treatment this should be stopped.

The cream should only be applied with great caution to patients with dark skin. It should not be applied in conjunction with intense sun exposure. Treatment can lead to irritant and allergic reactions and should thus be withheld if skin irritation develops. No more than 10% of the face should be treated at a time.

This product is only available through the hospital.

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First line drugs | Second line drugs | Specialist drugs | Hospital only drugs
13.8.2 Camouflagers

Notes:
The Drug Tariff specifies that the following products can be prescribed on FP10 prescription (by endorsement of ACBS) as covering creams and concealment of birthmarks for postoperative scars and other deformities and as adjunctive therapy in the relief of emotional disturbance due to disfiguring skin disease, such as vitiligo.

- Covermark® Classic Foundation and Finishing Powder
- Dermacolor® Camouflage Cream and Fixing Powder
- Keromask® Finishing Powder and Masking Cream
- Veil® Cover Cream and Finishing Powder

(See BNF for excipients)
Further information can be obtained from the British Red Cross Camouflage Clinic at ESHT

13.9 Shampoos and some other scalp preparations

Removal of thick skin

<table>
<thead>
<tr>
<th>Product</th>
<th>Formulation</th>
<th>Excipients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Olive oil®</td>
<td>Liquid</td>
<td>Excipients include cetostearyl alcohol</td>
</tr>
<tr>
<td>Cocos®</td>
<td>Liquid</td>
<td></td>
</tr>
<tr>
<td>Shampoos</td>
<td>Scalp ointment</td>
<td></td>
</tr>
<tr>
<td>Polytar®</td>
<td>Liquid</td>
<td>Excipients include fragrance, imidurea, polysorbate 80</td>
</tr>
<tr>
<td>Ceanel Concentrate®</td>
<td>Shampoo</td>
<td>Excipients: none as listed in section 13.1.3</td>
</tr>
<tr>
<td>Ketoconazole</td>
<td>Shampoo 2%</td>
<td>Excipients include imidurea</td>
</tr>
<tr>
<td>T/Gel®</td>
<td>Shampoo</td>
<td>Excipients include fragrance, hydroxybenzoates (parabens), imidurea, tetrasodium edetate</td>
</tr>
<tr>
<td>(Coal Tar extract 2%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

13.10 Anti-infective skin preparations

13.10.1 Antibacterial preparations

13.10.1.1 Antibacterial preparations only used topically

SMAC Report 1997: Topical antimicrobial agents and disinfectants

The use of topical antimicrobial agents has long been discouraged, on the grounds that it carries a particular risk of selecting resistance. However, some topical antibacterial use is defensible, for example:

- the use of sulphonamides with silver nitrate to prevent and treat burn wound infections
- the use of mupirocin to eliminate colonisation and superficial infections caused by MRSA. Nevertheless, mupirocin can be abused, e.g. by being given as blanket treatment or prophylaxis.

<table>
<thead>
<tr>
<th>Product</th>
<th>Formulation</th>
<th>Excipients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Silver sulfadiazine</td>
<td>Cream, 1% 20g, 50g, 250g, 500g</td>
<td>Excipients include cetyl alcohol, polysorbates, propylene glycol</td>
</tr>
<tr>
<td>Mupirocin</td>
<td>Ointment or cream, 2%</td>
<td>Excipients: cream: benzyl alcohol, cetyl alcohol, stearyl alcohol. Ointment: none as listed in section 13.1.3</td>
</tr>
<tr>
<td>Polyfax®</td>
<td>Ointment, (polymyxin B sulphate 10,000units, bacitracin zinc 500units/g)</td>
<td>Excipients: none as listed in section 13.1.3</td>
</tr>
</tbody>
</table>

Notes:
1. Silver sulfadiazine is used in the treatment of infected burns. Once opened 250g and 500g pots of silver sulfadiazine (Flamazine®) cream should be discarded 24 hours after opening.
2. Mupirocin ointment and cream are not interchangeable – the prescription should specify formulation required. It should only be used on recommendation of Infection Control or Microbiology. It should not be used for longer than 10 days.
3. Mupirocin should ideally be kept in reserve to avoid resistance developing and is particularly useful in treating MRSA. Mupirocin (Bactroban® nasal) is of value when the carriage of Staphylococcus aureus in the nose or ears has to be cleared.
13.10.1.2 Antibacterial preparations also used systemically

**Fusidic acid**
- Cream 2%, 15g, 30g
  
  NB Please see notes below

**Metronidazole**
- **Rozex®** cream or gel, 0.75%
- **Metrotop®** gel 0.8%

Excipients: **Rozex® cream**: benzyl alcohol, isopropyl palmitate. **Rozex® gel**/disodium edetate, hydroxybenzoates (parabens), propylene glycol

Excipients include butylated hydroxyanisole, cetyl alcohol

**Notes:**
1. Staphylococcal resistance develops rapidly to **Fucidin**, making repeat courses unrealistic, therefore topical treatment of impetigo with Fusidic acid cream/ointment is not recommended in this formulary.
2. Topical metronidazole preparations are licensed for different indications: acne rosacea (**Rozex®**) and malodorous tumours and skin ulcers (**Metrotop®**). Therefore, it is important to prescribe the appropriate branded product.

13.10.2 Antifungal preparations

**Yeast infections**

**Clotrimazole**
- Cream 1%
- Spray 1%
- Solution 1%

Excipients for the cream may differ depending on generic or proprietary preparation. Spray contains propylene glycol

**Miconazole nitrate**
- Cream 2%

Excipients vary depending on generic or proprietary preparation

**Dermatophyte infections**

**Ketoconazole** **SLS**
- **Nizoral®** cream 2%

Excipients include cetyl alcohol, polysorbates, propylene glycol, stearyl alcohol

**Terbinafine**
- Cream 1%

Excipients include benzyl alcohol, cetyl alcohol, polysorbate 60, stearyl alcohol

**Notes:**
1. **Canesten®** spray is included for the treatment of pityriasis versicolor.
2. **Terbinafine** cream is not licensed for use in children under 12 years.
3. **Ketoconazole** (**Nizoral®**) cream can only be prescribed when treating seborrhoeic dermatitis or pityriasis versicolor. FP10 prescriptions must be endorsed “SLS” (see Drug Tariff)
4. Tinea infection of the nail should be treated orally once a positive culture from nail clippings has been observed. Refer to the East Sussex Health Economy Medicines Committee “Management of Infection Guidance for Primary Care and Non-Acute Community Settings” Jan 2006 for further information.

13.10.3 Antiviral preparations

**Aciclovir**
- Cream 5% 2g, 10 g

Excipients may differ depending on generic or proprietary preparation

**Notes:**
1. Aciclovir cream is licensed for the treatment of initial and recurrent labial and genital herpes simplex infection. Systemic treatment is necessary for buccal or vaginal infections, and for herpes zoster (shingles)
2. Treatment should begin as soon as possible when the patient is symptomatic (pro-dromal phase) i.e. tingling. Once there is any sign of a lesion, evidence shows that aciclovir is only as effective as a base cream.

13.10.4 Parasiticidal preparations

**Suitable quantities of Parasiticidal preparations**

<table>
<thead>
<tr>
<th></th>
<th>Skin creams</th>
<th>Lotions</th>
<th>Cream rinses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scalp (head lice)</td>
<td>-</td>
<td>50-100ml</td>
<td>50-100ml</td>
</tr>
<tr>
<td>Body (scabies)</td>
<td>30-60g</td>
<td>100ml</td>
<td>-</td>
</tr>
<tr>
<td>Body (crab lice)</td>
<td>30-60g</td>
<td>100ml</td>
<td>-</td>
</tr>
</tbody>
</table>

These amounts are an approximate guide. Large / tall individuals may require larger quantities. It is important that total skin surface is covered and products should be re-applied after hand washing.
### Scabies (Sarcoptes scabiei)

**Permethrin**
- Lyclear® Dermal Cream
  - Excipients include butylated hydroxytoluene, wool fat derivative

**Malathion**
- Quellada M® Liquid
  - Excipients include cetostearyl alcohol, fragrance, hydroxybenzoates (parabens)

**Notes:**
1. Permethrin (Lyclear® dermal cream) is the preferred agent except in children under 2 years of age.
2. Malathion (Quella M®) liquid is preferred for children aged 6 months – 2 years.
3. When scabies is diagnosed, close household contacts (bed partners and children) will also require treatment. Generally, it requires 5 minutes skin-to-skin contact to acquire the infection. The patient is contagious from a few days of acquiring the infection, when no signs of the infection may be present.
4. Itching, particularly at night, is the main symptom of scabies in otherwise healthy individuals. It is usually delayed one to two months after exposure except when the patient has been exposed before, in which case itching can start after one day. It is important to advise the patient that itching still occurs after treatment and this does not always imply treatment failure.
5. It is advised that patients apply treatment before going to bed and leave on overnight. If hands are washed, it is necessary to reapply. Treatment is usually applied below the jaw line and including the soles of feet and genitalia, however, for elderly and the young, it is applied from the head to toes. When applying, work down from the jaw-line to the feet, then sit down and apply to the feet. All household members should be treated at the same time.
6. Crusted or Norwegian scabies affecting mainly immuno-suppressed patients and patients in nursing residential homes, is more difficult to treat and requires more applications of treatment. Advice should be sought from a dermatologist. If an outbreak is suspected in a nursing or residential home, it is important to inform Public Health to look at mass treatment of staff and residents. Unfortunately, sometimes patients receive a steroid preparation for the treatment of itchy skin / rash rather than being correctly diagnosed as scabies.

### Head Lice Pediculus humanus capitis (see policy overleaf)

**Dimeticone**
- Hedrin® Lotion 4%

**Notes:**
1. The Surrey and Sussex Health Protection Unit recommend just two first line treatments for head lice: Hedrin® lotion or “Bug Busting”.
2. Hedrin® lotion is included in the Nurse Prescribers' Formulary and can be purchased from pharmacies.
3. One 50ml bottle is sufficient to treat one person but people with long hair may need larger volumes.
4. Hedrin® lotion should be rubbed into dry hair and scalp, ensuring the scalp is fully covered. It should be worked into the hair, spreading the liquid evenly from the roots to the tips and allowed to dry naturally. It should be left on for at least 8 hours, or overnight, before washing the hair with normal shampoo, rinsing thoroughly and drying.
5. The lotion must then be re-applied after seven days to treat lice that have hatched after the first treatment. Failure to repeat the treatment may result in the return of infestation.
6. Carry out detection combing after the second treatment to see if the infestation is clear. If not clear, Hedrin® can be re-applied as it is non-toxic. If following a third application there are still signs of infestation it is possible that either the product was not used correctly or the patient has been re-infected and contacts should be assessed.

### 13.10.5 Preparations for minor cuts and abrasions

**Surgical tissue adhesive**

**Notes:**
Tissue adhesives are used for the closure of minor skin wounds and for additional suture support. They should be applied by an appropriately trained healthcare professional.

### 13.11 Disinfectants and cleansers
13.11.1 Alcohols and saline

**Industrial methylated spirit, BP**

**Surgical spirit, BP**

**Sodium chloride 0.9%**
- Irripods®
- Stericlens®

**Notes:**
Drinking water can be used to irrigate the majority of wounds where a sterile product is not indicated, e.g. a chronic leg ulcer.

13.11.2 Chlorhexidine salts

**Hydrex®**
- Surgical Scrub, chlorhexidine gluconate 4% in an alcoholic solution

**Notes:**
1. Hydrex® is used for pre-operative hand and skin preparation and for general hand disinfection.
2. The use of chlorhexidine is not recommended in the community. It is used for patients with MRSA in hospital and does not need to be continued after discharge. A 5-7 day course of mupirocin and chlorhexidine wash is used to decolonise patients with MRSA.

13.11.4 Chlorine and iodine

**Povidone-iodine**
- Betadine® antiseptic solution
- Videne® antiseptic solution

**Notes:**
1. Chlorinated solutions are considered less suitable for prescribing.
2. Regular use of iodine compounds must be avoided on patients with thyroid disease or those receiving lithium therapy. It may also interfere with thyroid function tests.

13.11.5 Phenolics

**Triclosan**
- Aquasept® skin cleanser

**Notes:**

1. Directions: 1 tablet to be dissolved in 4 litres of water to provide a 0.01% (1 in 10,000) solution (BNF) [Rose wine colour]
2. Potassium permanganate stains; keep out of contact with clothing, fabrics etc. It may be irritant if the solution is too strong.
3. Do not use a ceramic basin or bath as these will stain.

13.11.6 Astringents, oxidisers and dyes

**Potassium permanganate**
- Permitabs® solution tablets 400mg

**Notes:**
1. Appropriate wound management requires the underlying cause to be treated rather than to use preparations to promote wound healing. Therefore, none of these agents have been included here.

13.11.7 Preparations for promotion of wound healing

**Notes:**

**13.12 Antiperspirants**

**Aluminium salts**
- Anhydrol Forte®
- Driclor®:
- ZeaSORB® dusting powder

**Notes:**

- Excipients: none as listed in section 13.1.3
- Excipients: none as listed in section 13.1.3
- Excipients include fragrance
Notes:
1. Aluminium chloride is a potent antiperspirant used in the treatment of severe hyperhidrosis.
2. It can cause skin irritation, and the patient should be warned to avoid contact with eyes or mucous membranes, and to avoid use on broken or irritated skin. The patient should not shave the axillae or use depilatories within 12 hours of application.

13.13 Topical circulatory preparations

Note:
No products have been included in this formulary as they are of little value and are considered as being less suitable for prescribing. Chilblains are best managed by avoidance of exposure to cold. Neither systemic nor topical vasodilator therapy has been established as being effective.

Wound management products and elastic hosiery: Please refer to Wound Care Formulary

Useful references:

Primary Care Dermatology Society: www.pcds.org.uk
British Association of Dermatologists: www.bad.org.uk
Prodigy Guidance www.prodigy.nhs.uk