# NI Medicines Management Formulary

# BNF Chapter 13 – Skin

# (Adult)

## Version Control Record

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| **Summary** | Northern Ireland Formulary Chapter 13 Skin |
| **Purpose** | Draft for consultation |
| **Operational Date** | |
| **Review Date** | |
| **Version Number** | 3.0 |
| **Supersedes Previous** | 2.12 |
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| **Lead Author Position** | Pharmacy Information Coordinator |
| **Additional Author(s)** | Skin Panel for Prescribing Advice |

**Approval Process**

| | | **Date** | **Version** |
|---|---|---|---|
| **Prescribing Guidance Editorial Group**<br>**-electronic correspondence**<br>**- discussed at PGEG meeting** | | | |

**Dissemination to HSC**

| **Areas** | |
|---|---|
| NI Formulary website | |

# Skin

# BNF Chapter 13

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## 13.1 Management of skin conditions

General notes

- Creams are more cosmetically acceptable than ointments. Gels are particularly suitable for application on the face and scalp while lotions are used for moist conditions and hairy areas. Ointments are much less likely to sensitise and are suitable for chronic dry lesions. Pastes are less occlusive than ointments and can be used to protect inflamed, lichenified, or excoriated skin
- Skin reactions are the most common adverse effects of emollients. Emollients containing active ingredients e.g. antiseptics are not generally recommended because they increase the risk of skin reactions. If sensitivity to emollients is a known problem, prescribe a cream with few additives or an ointment (generally less excipients).
- Unlicensed 'specials' may be required when a suitable licensed product isn't available. These products can be very expensive. Please adhere to the British Association of Dermatologists (BAD) list of preferred specials - available here
- Certain multi-ingredient skin preparations e.g. emollients should be prescribed by BRAND name as generic prescribing may not be practical or may lead to confusion due to multiple ingredients.
- It is important that skin preparations are prescribed in **appropriate quantities.** The tables below are a useful guide but consider individual circumstances.

The table below lists quantities suitable for an adult for twice daily application of a non-steroid dermatological preparation for **four weeks**

| *Body area* | *Non-corticosteroid cream/ointment* | Lotions |
|---|---|---|
| *Face* | 60 to 120g | 400mls |
| *Both hands* | 100 to 200g | 800mls |
| *Scalp* | 200 to 400g | 800mls |
| *Both arms* | 400 to 800g | 800mls |
| *Both legs* | 400 to 800g | 800mls |
| *Trunk* | 1600g | 2000mls |
| *Groins and genitalia* | 60 to 100g | 400mls |

The table below lists quantities suitable for an adult for single daily application for **two weeks** for steroid cream/ ointment

| *Body area* | *Corticosteroid cream/ointment* |
|---|---|
| *Face and neck* | 15 to 30g |
| *Both hands* | 15 to 30g |
| *Scalp* | 15 to 30g |
| *Both arms* | 30 to 60g |
| *Both legs* | 100g |
| *Trunk* | 100g |
| *Groins and genitalia* | 15 to 30g |

- The **Fingertip unit** may also be helpful to guide the amount of topical steroid to apply
- Refer to BNF for information on topical corticosteroid preparation potencies.

## 13.2 Emollients and barrier preparations

### 13.2.1 Emollients

*Ointments*

| Choice | Drug |
|---|---|
| Formulary choices | Epimax® ointment (Liquid paraffin 40%, yellow soft paraffin 30%) *cost effective option*<br>or<br>Zeroderm ® ointment (Liquid paraffin 40%,white soft paraffin 30%, emulsifying wax 30%)<br>or<br>Hydromol ® ointment (emulsifying wax 25.5%, yellow soft paraffin 30%, liquid paraffin 42.5%)<br>or<br>Cetraben ointment (35% white soft paraffin, 45% light liquid paraffin) |

*Creams*

| Choice | Drug |
|---|---|
| Formulary choices | Epimax® original cream (white soft paraffin 15%, liquid paraffin 6%)<br>or<br>Epimax® excetera cream (white soft paraffin 13.2%, liquid paraffin 10.5%)<br>or<br>Epimax® oatmeal cream (colloidal oatmeal)<br>or<br>Epimax® paraffin-free cream (hydrogenated caster oil)<br>or<br>Zeroveen® cream (Glycerol 12.6%, liquid paraffin 5%) |
| * **Note:** caution on fire hazard applies to paraffin free emollients also – see Cautions below. | |

## Prescribing notes

- There is no evidence that any one emollient is better than another but there is wide inter-patient variability in response to treatments. The emollients of choice are therefore the least expensive ones that are effective, which the patient finds acceptable and is prepared to use
- Ointments should be used for dry skin and chronic eczema. Creams should be used for acute inflammatory eczema
- Emollients should be applied as liberally and frequently as possible. They are best applied when the skin is moist but they can, and should, be applied at other times as well. Ideally, emollients should be applied every 4 hours or at least 3-4 times daily
- Emollients should be prescribed in **appropriate quantities** *[add jump to quantities table]*.
- Emollients should be applied in the direction of hair growth
- Emollient bath and shower preparations are not recommended for use due to a lack of robust evidence of clinical effectiveness.
- Many standard emollients (creams and ointments) can be used as a soap substitute. See 13.2.1.1 *[add jump]*
- Products that come in pump-dispensers may be more suitable for long-term use in order to reduce the risk of microbial contamination. For emollients that come in tubs, a clean spoon should be used to remove required amount of emollient from the tub.

## Cautions

- CAUTION - there is a fire hazard associated with emollients. The risk is greater when they are applied to large areas of the body and clothing, or dressings become soaked with the emollient. Following new information, warnings about the risk of severe and fatal burns are being extended to all emollients whether they contain paraffin or not. Advise patients who use these products not to smoke or go near naked flames, and warn about the easy ignition of clothing, bedding, dressings, and other fabric that have dried residue of an emollient product on them Resources available to support safe use include MHRA Drug Safety Update Dec 2018 and MHRA Safe Use of Emollient Guidance July 2020

*Other formulations*

| Choice | Drug |
|---|---|
| 1st choice | MyriBase® gel (isopropyl myristate 15%, liquid paraffin 15%) |
| 2nd choice | Or<br>Emollin® spray (liquid paraffin 50%, white soft paraffin 50%) |

*Urea containing formulations*

| Choice | Drug |
|---|---|
| 1st choice | Balneum® Intensiv cream (urea 5%, ceramide 0.1%)<br>or<br>Flexitol 10% urea cream<br><br>or<br>Flexitol 25% urea heel balm |

Prescribing notes

- Products containing urea should not be used unless simple emollients have been tried unsuccessfully.
- Urea products are particularly useful in patients with particularly dry skin, hyperkeratotic scaling and ichthyotic conditions
- Urea may cause stinging and irritation for some people

*Emollients containing antimicrobials*

| Choice | Drug |
|---|---|
| Reserve<br><br>Avoid unless infection present or is a frequent complication | Dermol® lotion (benzalkonium chloride 0.1%, chlorhexidine dihydrochloride 0.1%, isopropyl myristate 2.5%, liquid paraffin 2.5%)<br>Or<br>Dermol® Cream (benzalkonium chloride 0.1%, chlorhexidine dihydrochloride 0.1%, isopropyl myristate 10%, liquid paraffin 10%) |

Prescribing notes

- Preparations containing an antimicrobial should be avoided unless infection is present or is a frequent complication. Emollients containing antimicrobials are for **short term use** and should not be used for more than 2 weeks due to increased risk of sensitisation and bacterial resistance.

### 13.2.1.1 Emollient bath and shower preparations

Prescribing notes

- Emollient bath and shower preparations are not recommended for use due to a lack of robust evidence of clinical effectiveness.
- Many standard emollients (creams and ointments) can be used as a soap substitute. Ointments that are completely immiscible with water (such as white soft paraffin alone or white soft paraffin / liquid paraffin 50:50) are not suitable.
- Soap substitutes should be applied to the skin before or during bathing / showering / washing and then rinsed off. Patients can be advised to to mix a small amount (around teaspoonful) of emollient in the palm of their hand with a little warm water and spread it over damp or dry skin. This should not replace the regular use of a leave-on emollient. It is particularly important to apply the leave-on emollient after bathing / showering / washing, once the skin has been gently patted dry with a towel.

- Warn people that extra care is required when emollients are used in the bath or shower as they make surfaces slippery.

13.2.2. Barrier preparations

| Choice | Drug |
|---|---|
| 1st choice | Barrier preparations can be purchased 'over-the-counter' and self-care should be encouraged where appropriate |

Prescribing Notes

- Refer to wound care formulary for additional skin protectors *[add jump]*
- Barrier preparations often contain water-repellent substances such as dimeticone or other silicones. They are used on the skin around stomas, bedsores and pressure sores in the elderly where the skin is intact. Where the skin has broken down, barrier preparations have a limited role in protecting adjacent skin. Barrier preparations are not a substitute for adequate nursing care

## 13.3. Topical local anaesthetics and antipruretics

Prescribing Notes

- Promote self-care for treatment of minor conditions such as insect bites and stings. Over-the-counter treatments can help to treat symptoms of pain and itching
- Pruritus may be caused by systemic disease, skin disease or as a side-effect of medication. Where possible, the underlying cause should be identified and treated
- Widespread itch – see NICE CKS
- Topical antihistamines, crotamiton and local anaesthetics are not recommended as they are only marginally effective and can cause sensitization

## 13.4 Topical corticosteroids

*Mild corticosteroid*

| Choice | Drug |
|---|---|
| 1st choice | Hydrocortisone 0.5% cream; Hydrocortisone 1% cream and ointment |

Prescribing notes

- Hydrocortisone 0.5% has a limited role but where required please prescribe the cream (hydrocortisone 0.5% ointment is very high cost (£44 for 15g – Feb 23)
- Hydrocortisone 2.5% cream and 2.5% ointment are also very high cost. Furthermore, there is no benefit in increasing the strength of hydrocortisone from 1% to 2.5%: instead, patients should be moved up the steroid potency ladder, i.e. to a moderately potent steroid
- Please refer to topical corticosteroid prescribing notes here *[add jump]*

*Moderately potent corticosteroid*

| Choice | Drug |
|---|---|
| 1st choice | Betamethasone valerate 0.025% (Betnovate-RD®); cream and ointment |
| | Or |
| | Clobetasone butyrate 0.05% (Eumovate®); cream and ointment*<br>**Prescribe by brand name**<br>*Do not prescribe the 15g OTC pack due to high cost |

*Potent corticosteroid*

| Choice | Drug |
|---|---|
| 1st choice | Betametasone valerate 0.1% (Betnovate®); cream, ointment, scalp applications, lotion<br>or<br>Fluocinolone acetonide 0.025% (Synalar®); cream, gel and ointment<br>or<br>Mometasone furoate 0.1%; cream, ointment, scalp lotion |

*Very potent corticosteroid*

| Choice | Drug |
|---|---|
| 1st choice | Clobetasol propionate 0.05% (Dermovate®); cream, ointment, scalp application<br>**Prescribe by brand name** |

Prescribing notes

- Topical corticosteroids provide symptomatic relief in atopic dermatitis (atopic eczema) and are safe in the short term. The potency should be matched to the disease severity and the affected site; weaker corticosteroids should be used on the face and flexures
- Parents/carers need reassurance about the value of topical steroids used appropriately
- Topical corticosteroids are **not** recommended in urticaria, rosacea, acne or when a primary infective disease is suspected (unless the infection is being treated)
- In order to avoid confusion between clobetasol propionate 0.05% (Dermovate®) and clobetasone butyrate 0.05% (Eumovate®), these products should be prescribed by BRAND name
- Topical corticosteroids should be used for a limited time until settled and/or reviewed after an agreed interval. Once a clinical response is seen, withdraw the corticosteroid gradually to avoid rebound

- In order to minimize side-effects, it is important to apply once to twice daily to affected areas only. The weakest steroid that controls the disease effectively should be also chosen to reduce the risk of topical steroid withdrawal reactions, see MHRA Drug Safety Update September 2021. A step-up approach (less potent to more potent) or a step-down approach (more potent to less potent) may be involved. Reduce strength and frequency of topical corticosteroid application as the condition settles
- A general rule of thumb is that emollient use should exceed steroid use by 10:1 in terms of quantities used for most patients
- Emollients and topical steroids should not be applied at the same time (a minimum interval of 20 minutes should be left if possible); patient preference will dictate whether emollient or topical corticosteroid is applied first
- Gloves should be worn during, or hands washed after, application of large quantities of steroid preparations
- The risk of systemic side-effects increases with prolonged use on thin, inflamed or raw skin surfaces, use in flexures, or use of more potent corticosteroids. Only mild corticosteroids should generally be used on the face
- Patients prescribed very potent topical corticosteroids (clobetasol propionate 0.05%) should be reviewed regularly (at least monthly) and the preparation should not be prescribed on repeat prescription, except on specialist advice
- Patients receiving long term treatment (several weeks) with a potent or very potent topical corticosteroid should be advised to carry a steroid emergency card

*Choice of formulation*

- Water-miscible corticosteroid creams are suitable for moist areas, e.g. axillae or groin or for weeping lesions
- Ointments are generally chosen for dry, lichenified or scaly lesions or where a more occlusive effect is required (occlusion increases both efficacy and side-effects)
- Gels/lotions may be useful when minimal application to a large or hair-bearing area is required or for the treatment of exudative lesions
- The inclusion of urea or salicylic acid increases the penetration of the corticosteroid

## *13.4.1 Topical corticosteroids with antimicrobials*

### *Mild corticosteroid with antimicrobial*

| Choice | Drug |
|---|---|
| 1st choice | Hydrocortisone 1%/ clotrimazole 1%; cream (Canesten HC®)*<br>*Do not prescribe the 15g OTC pack due to high cost<br><br>or<br>Hydrocortisone 1% / miconazole nitrate 2%; cream and ointment (Daktacort®) *<br>*Do not prescribe the 15g OTC pack due to high cost<br><br>or<br>Hydrocortisone 1%/ fusidic acid 2% cream (Fucidin H®) |

### *Moderately potent corticosteroid with antimicrobial*

| Choice | Drug |
|---|---|
| Reserve | clobetasone butyrate 0.05%, oxytetracycline 3%, nystatin 100,000 units per gram (Trimovate®) |

- Trimovate is expensive and less costly options should be considered where appropriate.

### *Potent corticosteroids with antimicrobial*

| Choice | Drug |
|---|---|
| 1st choice | Betamethasone (as valerate) 0.1%, fusidic acid 2%; cream and lipid cream (Fucibet®)<br>or<br>Betamethasone 0.05%, clotrimazole 1% cream (Lotriderm®) |

Prescribing notes

- See also section 13.4 prescribing notes (topical corticosteroids)
- The benefit of including antibacterials or antifungals with a topical corticosteroid is uncertain. Such combinations may have a place in inflammatory skin conditions associated with bacterial or fungal infection, such as infected eczema.
- Sensitisation is more likely to occur with corticosteroid/ antimicrobial combinations than with topical corticosteroids alone. They are indicated for short term use only (typically 5-7 days). Longer term use increases the risk of resistance and sensitisation
- The difference in potency between **Fucidin H®** (hydrocortisone 1%- mild corticosteroid) and **Fucibet®** (betamethasone-potent corticosteroid) should be noted
- Prescribers should be aware that there is increasing resistance to fusidic acid; prudent use is encouraged to preserve the systemic efficacy of this antibiotic for life-threatening infections. Treatment with Fucidin H® or Fucibet® should be for a **maximum of 7 days** to prevent bacterial resistance. These products are not suitable for “repeat prescriptions”.
- Consider whether oral antibiotics are more appropriate. Topical treatment is useful for small areas of skin infection (e.g. in flexure areas and skin folds) but, if the infection is more widespread, then an oral agent may be more suitable

**Cautions –** *add jump to section 13.10.2*

## 13.5 Preparations for eczema and psoriasis

### 13.5 1. Preparations for eczema

Topical preparations for eczema

| Choice | Drug |
|---|---|
| First-line management in primary care | Emollients (see section 13.2.1 )<br><br>Topical corticosteroid (see section 13.4 ) |

Prescribing notes

- Refer to NICE CKS Eczema – atopic
- All patients with eczema should use emollients along with soap substitutes
- Exacerbation of eczema may represent secondary bacterial or viral infection. Refer to NICE NG190 for management of secondary bacterial infection of eczema and other common skin conditions.

### 13.5.2. Preparations for psoriasis

General Notes

- Refer to NICE CG153 Psoriasis: assessment and management, NICE CKS Psoriasis and to the BAD website for a range of Patient Information Leaflets on Psoriasis
- The formulary provides advice on topical treatments for chronic plaque psoriasis. See resources above for further information including, specialist treatments, identification of co-morbidities (e.g. cardiovascular risk), when to consider referral and the management of other forms of psoriasis
- Offer topical treatments, considering patient preference, cosmetic acceptability, practicalities of application to the site(s) and extent of psoriasis
- Discuss the variety of formulations available and use:
  - creams, lotion or gel for widespread psoriasis

- lotion, solution or gel for scalp or hair-bearing areas
- ointment to treat areas with thick adherent scale

- In people whose psoriasis has not responded satisfactorily to a topical treatment discuss:
  - whether they have any difficulties with application, cosmetic acceptability or tolerability and offer an alternative formulation if appropriate
  - other possible reasons for non-adherence
- Arrange a review appointment after starting a new topical treatment after 4 weeks in adults

Topical preparations for Chronic Plaque Psoriasis

*Trunk and limbs*

Vitamin D and analogues

| **Choice** | **Drug** |
|---|---|
| 1st choice | Calcipotriol 50 micrograms/g |
| Combination product (where adherence is an issue) | Calcipotriol 50microgram/g, betamethasone 500microgram/g **prescribe generically** |
| | Or |
| Reserve | Enstilar® foam (calcipotriol 50micrograms/g, betamethasone 500microgram/g) |

Coal tar products

| **Choice** | **Drug** |
|---|---|
| Formulary choice | Coal tar<br>Exorex® lotion (100mls/ 250mls) (coal tar 5% in an emollient basis) |

## Prescribing notes

- Dual therapy of a potent topical corticosteroid plus a topical vitamin D preparation is first line (both applied once a day, but one in the morning and the other in the evening) for up to 4 weeks as initial treatment. See NICE CG153 for further details on treatment recommendations.
- A combination product (calcipotriol 50microgram/g and betametasone 500microgram/g) can be used where adherence is an issue. Enstilar® (calcipotriol and betamethasone cutaneous foam) is an alternative where calcipotriol 50microgram/g and betametasone 500microgram/g ointment is not tolerated
- Coal tar preparations are effective but may stain skin, hair and clothes. Newer, branded products are preferred because the older non-branded products contain crude coal tar (coal tar BP) which is smellier and usually messier to use.
- If tar pomade (an unlicensed product) is being prescribed, it should be prescribed in "conventional proportions" which are significantly less expensive than bespoke mixtures ordered from "specials" manufacturers. The "conventional" proportions are:
    - coal tar solution 6%, salicylic acid 2%, emulsifying ointment to 100g; pack size is 200g

### *Scalp*

## Corticosteroid-containing products

| Choice | Drug |
|---|---|
| 1st choice | *Potent topical corticosteroid*<br>Betacap® Scalp Application (betametasone valerate 0.1%) |
| 2nd choice Combination products | *Corticosteroid /Salicylic acid (for scaling)*<br>Diprosalic® scalp application<br><br>Or<br><br>*Corticosteroid / vitamin D analogue*<br>Calcipotriol 50microgram/g, betamethasone 500microgram/g gel (generic) |

## Coal tar products (3rd line agents)

| Choice | Drug |
|---|---|
| Formulary choices | Exorex® lotion (100mls/ 250mls) (coal tar 5% in an emollient basis)<br><br>*Coal tar /Salicylic acid (for scaling)*<br>Sebco® scalp ointment (coal tar solution 12%, salicylic acid 2%, precipitated sulphur 4% in coconut oil emollient basis)<br><br>and / or<br><br>Shampoos |

## Prescribing notes

- Offer a potent corticosteroid applied once daily for up to 4 weeks as initial treatment for people with scalp psoriasis. Refer to NICE CG153 for further details on treatment recommendations
- Salicylic acid 2% may enhance loss of scale
- Coal tar preparations are effective but may stain skin, hair and clothes. Newer, branded products are preferred because the older non-branded products contain crude coal tar (coal tar BP) which is smellier and usually messier to use.
- Do not offer coal tar-based shampoos alone for the treatment of severe scalp psoriasis
- Sebco® scalp ointment is a licensed alternative to coal tar pomade
- If tar pomade (an unlicensed product) is being prescribed, it should be prescribed in “conventional proportions” which are significantly less expensive than bespoke mixtures ordered from “specials” manufacturers. The “conventional” proportions are:
    - coal tar solution 6%, salicylic acid 2%, emulsifying ointment to 100g; pack size is 200g
- Topical vitamin D preparations alone can be used where corticosteroids are not tolerated, or if there is mild-moderate scalp psoriasis

*For face or flexures*

| Choice | Drug |
|---|---|
| 1st choice | Mild/moderate potency topical corticosteroid - see section 13.4<br>**Max 2 week course** |

Prescribing notes

- The face and flexures are particularly vulnerable to steroid atrophy and corticosteroids should only be used for short term treatment of psoriasis (1-2 weeks per month)
- Refer to NICE CG153 for further details on treatment recommendations

13.5.3. Drugs affecting the immune response (specialist treatments)

(a) Topical calcineurin inhibitors

| Choice | Drug |
|---|---|
| Specialist Initiation | Tacrolimus (Protopic®) ointment 0.03%, 0.1% |

Prescribing notes

- Immunomodulatory agents (e.g. tacrolimus, or pimecrolimus for short-term use) are an alternative to topical steroids in eczema. They should be considered if the patient is intolerant to or has failed with conventional corticosteroid therapy. Refer to NICE TA82
- Calcineurin inhibitors are also an option for the treatment of psoriasis of the face, flexures or genitals if the response to short-term moderate potency corticosteroids is unsatisfactory, or they require continuous treatment to maintain control and there is a serious risk of local steroid-induced side-effects. They should be initiated by healthcare professionals with expertise in treating psoriasis
- Treatment with tacrolimus or pimecrolimus should be initiated only by physicians (including general practitioners) with a special interest and experience in dermatology,

- They should not be used in the context of recurrent herpes simplex infection, and patients should be advised on photoprotection
- The long-term adverse effects of tacrolimus and pimecrolimus are unknown. The MHRA Drug Safety Update December 2014 reminded prescribers of a possible risk of malignancies including lymphomas and skin cancer with the use of tacrolimus ointment. Since then, further studies have provided more reassurance regarding their safety, with no causal link with cancer shown. However longer term data is needed

b) Oral agents

- A number of disease modifying anti-rheumatic drugs (DMARDs) are used in the management of dermatological conditions. DMARDs on the AMBER list are initiated by specialists in secondary care and can be prescribed by GPs under a shared care arrangement. Please refer to Red Amber List for further details including shared care guidelines as appropriate

## 13.6 Acne and rosacea

### 13.6.1 Acne

Offer people with acne a 12-week course of 1 of the following according to severity:

### Any severity

| Choice | Drug |
|---|---|
| Formulary choices | Adapalene 0.1%/benzoyl peroxide 2.5%, adapalene 0.3%/benzoyl peroxide 2.5% (Epiduo®) gel<br><br>**or**<br><br>Clindamycin 1%/tretinoin 0.025% (Treclin®) gel |

### Mild to moderate

| Choice | Drug |
|---|---|
| Formulary choices | *As per any severity*<br><br>**or**<br><br>Clindamycin 1% /benzoyl peroxide 5%, Clindamycin 1%/ benzoyl peroxide 3% - (Duac®) gel |

## Moderate to severe acne

| Choice | Drug |
|---|---|
| Formulary choices | *As per any severity*<br><br>**or** |
| Topical preparation plus an oral antibiotic | Adapalene 0.1%/benzoyl peroxide 2.5%, adapalene 0.3%/benzoyl peroxide 2.5% (Epiduo®) gel<br><br>plus lymecycline 408mg capsules<br><br>or<br><br>plus doxycycline 100mg capsules<br><br>**or** |
| Topical preparation plus an oral antibiotic | Azelaic acid 20% (Skinoren®) cream<br><br>plus lymecycline 408mg capsules<br><br>or<br><br>plus doxycycline 100mg capsules |

### Prescribing Notes

- For full prescribing information refer to NICE NG198.
- Treatment courses should be of 12 weeks duration (positive effects can take 6 to 8 weeks to become noticeable).
- Do not prescribe a combination of a topical antibiotic and an oral antibiotic.
- Do not use monotherapy to treat acne.
- Topical benzoyl peroxide monotherapy should only be considered as an alternative treatment if the above treatments are contraindicated, or the patient wishes to avoid using a topical retinoid, or an antibiotic (topical or oral).
- Topical treatment should be applied sparingly to all the affected areas, not just the spots.

- To reduce the risk of skin irritation associated with topical treatments start with alternate-day or short-contact application (for example washing off after an hour). If tolerated, progress to using a standard application.
- Exposure to sunlight or UV radiation should be avoided or minimized during treatment.

In those with childbearing potential:

- Topical retinoids and oral tetracyclines are contraindicated during pregnancy and when planning a pregnancy**,** an effective contraception must be used or an alternative treatment chosen.
- If a person being treated for acne wishes to use hormonal contraception, consider a combined oral contraceptive pill in preference to the progestogen-only pill. See 7.3.1 for COC choices (add jump).

- Review first-line treatment at 12 weeks and
  - **in people whose treatment includes an oral antibiotic:**
    - if their acne has completely cleared consider stopping the antibiotic but continuing the topical treatment
    - if their acne has improved but not completely cleared, consider continuing the oral antibiotic, alongside the topical treatment, for up to 12 more weeks
    - if acne fails to respond adequately consider referral to a consultant dermatologist-led team.
  - **in people whose treatment does not includes an oral antibiotic:**
    - if their acne has completely cleared consider stopping treatment. If appropriate, an appropriate maintenance treatment is a fixed combination of topical adapalene and topical benzoyl peroxide
    - if the acne fails to respond adequately:
      - mild to moderate: offer a different option from the choices above. If this also fails consider referral to a consultant dermatologist-led team.
      - moderate to severe: offer a different option which includes an oral antibiotic from the choices above.

- Only continue treatment that includes an antibiotic (topical or oral) for more than 6 months in exceptional circumstances. Review at 3 monthly intervals, and stop the antibiotic as soon as possible.

*Oral retinoids*

- Oral Isotretinoin should only be used for severe forms of acne resistant to adequate courses of standard therapy with systemic antibacterials and topical therapy - see MHRA alert
- Oral isotretinoin is a RED list medication and is only prescribable by a specialist dermatology team in secondary care

## 13.6.2) Rosacea- topical and oral treatment

*Topical agents*

| Choice | Drug |
|---|---|
| 1st choice | Azelaic acid (15%) gel (Finacea®)<br>Or<br>Metronidazole 0.75% topical cream (or gel) |
| 2nd choice | Ivermectin (Soolantra®) 10mg/g cream |

*Oral agents (moderate to severe papulopustular rosacea)*

| Choice | Drug |
|---|---|
| 1st choice | Doxycycline 100mg capsules<br>or<br>Lymecycline capsules 408mg |

Prescribing Notes

- Mild rosacea is best treated with a topical agent
- Topical metronidazole is usually preferred as it is well tolerated
- Azelaic acid may be more effective, especially in people who do not have sensitive skin. It may cause more adverse effects e.g. stinging and burning
- Pustular rosacea is best treated with systemic antibiotics
- Courses of antibiotics usually last 6-12 weeks and are repeated intermittently

- Brimonidine gel (Mirvaso®) can be considered for the treatment of moderate to severe persistant erythema. It may not reduce erythema in all cases and will not have any effect on papules, pustules or phymatous changes. Telangiectasia may be accentuated as general redness is reduced
- Doxycycline 40mg controlled release (Efracea®) can be considered if doxycycline 100mg is not tolerated
- Cosmetics can often cover up rosacea effectively, and some patients may benefit from the use of skin camouflage (see section 13.8.2)

## Cautions

- Brimonidine gel (Mirvaso®): Systemic cardiovascular effects including bradycardia, hypotension and dizziness have been reported after application. It is important to avoid application to irritated or damaged skin, including after laser therapy. See Drug Safety Update June 2017

## 13.7 Preparations for warts and calluses

| Choice | Drug |
|---|---|
| 1st choice | Most warts resolve without treatment.Preparations for warts and verrucae should not be routinely prescribed. Encourage self-care with OTC products as appropriate |

Prescribing Notes

- Most warts resolve without treatment within months and treatment is required only if the warts are painful, unsightly, persistent, or cause distress
- Treatments are available over-the-counter from pharmacies and many patients can be encouraged to self-care
- Verrucae can be treated in community pharmacy under the Pharmacy First Scheme
- These preparations are suitable for all cutaneous warts except facial and genital warts
- Refer anogenital warts to Genito Urinary Medicine (GUM) clinic

## 13.8 Sunscreens and camouflagers

### 13.8.1. Sunscreen preparations

| Choice | Drug |
|---|---|
| 1st choice | SunSense® Ultra 50+<br>50mls/125mls/500mls |
| 2nd choice | Uvistat® SPF 30 or 50<br>125mls<br>or<br>Uvistat® Lipscreen SPF 50 |
| **Only prescribe where ACBS criteria are met** | |

Prescribing Notes

- Sunscreens are only prescribable for ACBS approved conditions i.e. skin protection against UV radiation in abnormal cutaneous photosensitivity resulting from genetic disorders or photodermatoses (including vitiligo, lupus erythematosus, hydroa

vacciniforme, solar urticaria and rare genoderamoses such as xeroderma pigmentosum) , those resulting from radiotherapy, chronic or recurrent herpes simplex labialis, or evidence of photosensitivity caused by drugs such as demeclocycline, phenothiazines or amiodarone. For further details see PrescQIPP Sunscreens bulletin

- Endorse all appropriate prescriptions with 'ACBS'
- Patients medically advised to minimise sunlight exposure may be at risk from vitamin D deficiency and should be advised to purchase a Vitamin D supplement
- For optimum photoprotection, sunscreen preparations should be applied thickly and frequently (approximately 2 hourly)
- Preparations with an SPF less than 30 should not be prescribed

*Photodamage (actinic keratosis)*

| Choice | Drug |
|---|---|
| 1st choice<br><br>Lesion-specific treatment<br><br>Or<br><br>Smaller areas of field change* (e.g. area size of palm or most of forehead) | Fluorouracil 5% cream (Efudix®) |
| 1st choice<br><br>Larger areas of field change* | Diclofenac sodium 3% gel (Solaraze®) |

*[text to be hidden and linked to] - Field change refers to areas of skin that have multiple AK associated with a background of erythema, telangiectasia and other changes seen in sun-damaged skin. These areas are probably more at risk of developing squamous cell carcinoma (SCC), especially if left untreated and, as such, it is recommended that they should be treated more vigorously. **As such, the treatments should be applied to the whole area of field change and not just the individual lesions.**

Prescribing Notes

- Refer to Primary Care Dermatology Society (PCDS) guidance for details on management, patient information leaflet and other treatment options
- Actinic keratoses are pre-malignant but transformation to squamous cell carcinoma is rare. Patients must be referred if diagnosis is uncertain, if lesions become thickened or tender or in those with more widespread / severe actinic damage. **If SCC is suspected, refer to secondary care urgently**
- Patients should be advised to use high SPF sunscreen and to minimise exposure of the skin to direct sunlight and to avoid sun lamps
- An emollient may be sufficient for mild lesions
- Fluorouracil cream is effective against most types of non-hypertrophic actinic keratosis
- Patients using diclofenac gel should be reviewed after 3 months and consideration given to switching to other therapies if therapy is unsuccessful
- Refer to PCDS for information on alternative treatment options including the products below (please note most of these products can cause skin irritation):
    - Actikerall® (fluorouracil 0.5% together with salicylic acid 10%) can be used for low to moderately thick hyperkeratotic actinic keratosis; for individual lesions or smaller areas of field change
    - Klisyri cream (tirbanibulin) for individual lesions or smaller areas of field change; short treatment period (5 days)
    - Aldara cream® (5% imiquimoid) for smaller areas of field change
    - Zyclara® (3.75% imiquimoid) for larger areas of field change

## 13.8.2 Camouflagers

| Choice | Drug |
|---|---|
| 1st choice | Dermacolor® |
| **Only prescribe where ACBS criteria are met** | |

Prescribing Notes

- Camouflagers are prescribable for postoperative scars and other deformities, and as an adjunctive therapy for emotional disturbances due to disfiguring skin disease e.g. vitiligo
- Prescriptions should be endorsed “ACBS”
- Dermacolor® is available as a camouflage cream and a fixing powder

## 13.9 Shampoos and other preparations for scalp and hair conditions

General Notes

- Dandruff is considered a mild form of seborrhoeic dermatitis. Patients should be encouraged to manage mild dandruff with long term over the counter treatments.
- Ketoconazole should be considered for more persistent or severe dandruff or for seborrhoeic dermatitis of the scalp
- Corticosteroid gels and lotions can also be used
- Shampoos containing coal tar and salicylic acid may also be useful
- Patients who do not respond to these treatments may need to be referred to exclude the possibility of other skin conditions

Shampoos

| Choice | Drug |
|---|---|
| 1st choice | Capasal® shampoo 250mls (coal tar 1%, coconut oil 1%, salicylic acid 0.5%)<br>or<br>Polytar Scalp shampoo 150mls<br>or<br>T/gel® shampoo 125mls/250mls (coal tar extract 2%) |

Shampoo with antifungal

| Choice | Drug |
|---|---|
| 1st choice | Nizoral® 2% Shampoo (ketoconazole 2%) 120mls |

Scalp treatments

| Choice | Drug |
|---|---|
| 1st choice | Cocois® ointment: (coal tar solution 12%, salicylic acid 2%, precipitated sulphur 4% in coconut oil emulsion basis) |

Prescribing Notes

- Treatment depends on the severity of the condition. Shampoo formulations are preferred for moderate scaly scalp conditions, whereas more severe conditions may require an ointment
- Ketoconazole shampoo is often helpful for seborrhoeic dermatitis of the scalp

Caution

- Cocois® and Capasal® contain coconut oil

*Hirsuitism – add link to Chapter 7*

## 13.10 Anti-infective skin preparations

General Notes

- See Chapter 5 (*add jump)* for guidance on the management of
  - Abscesses/ Boils
  - Cellulitis / Impetigo
  - Bites
  - Athletes Foot
  - Fungal skin and nail infections

*Bacterial Infection in eczema*

- Refer to NICE NG190 (2-page visual summary) for management of secondary bacterial infection of eczema and other common skin conditions. In people who are not systemically unwell, do not routinely offer either a topical or oral antibiotic for secondary bacterial infection of eczema.

13.10.1.1. Antibacterial preparations only used topically

| Choice | Drug |
|---|---|
| **For MRSA only** | Mupirocin 2% cream/ ointment (Bactroban®)15g |

- Discuss with microbiologist or local infection-control team. Should only be used for localised infections and not for longer than 7 days.

Cautions

- Mupirocin (Bactroban®) ointment should not be used in conditions where absorption of large quantities of polyethylene glycol is possible, especially if there is evidence of moderate or severe renal impairment.

### 13.10.1.2. Antibacterial preparations also used systemically

| Choice | Drug |
|---|---|
| 1st choice | Fusidic acid 2% cream<br>Sodium fusidate 2% ointment<br>Or<br>Metronidazole 0.75% cream/gel |

Prescribing Notes

- To avoid the development of resistance, fusidic acid should only be used for **localised infections and not be used for longer than 7 days**.
- For acute impetigo, refer to Primary Care Antibiotic Guidelines
- Topical antibacterials should be avoided in leg ulcers unless used for short courses for defined infections; treatment of bacterial colonization is generally inappropriate
- Metronidazole gel is helpful for secondary infections of fungating tumours

### 13.10.2 Antifungal preparations

- Athlete's foot and Groin area infection (Dhobie itch) can be managed and treated in community pharmacy under the Pharmacy First Service
- Refer to Primary Care Antibiotic Guidelines for management of athlete's foot, fungal skin infections and fungal nail infections

### 13.10.3 Antiviral preparations

| Choice | Drug | Dosage |
|---|---|---|
| 1st choice | No treatment<br>Or<br>Aciclovir cream 5%<br>(encourage OTC purchase) | Dose:<br>Apply to lesions every 4 hours (5 times daily) for 5-10 days, starting at first sign of attack |

Prescribing Notes

- Topical antiviral preparations should not be routinely prescribed. They only reduce mean duration of an episode by less than a day, and need to be initiated at the onset of symptoms before vesicles appear
- Topical aciclovir is available over-the-counter and can be used by people who find it helpful
- Systemic treatment is necessary for buccal or vaginal infections and for herpes zoster (shingles)
- Consider oral antiviral treatment for people with persistent, severe or prolonged episodes of recurrent labial herpes simplex infections or those who are immunocompromised

### 13.10.4 Parasiticidal preparations

*Scabies*

| Choice | Drug |
|---|---|
| 1st choice | Permethrin cream 5% |
| 2nd choice | Malathion 0.5% liquid in an aqueous base (Derbac- M®) |

Prescribing Notes

- Scabies can be treated in community pharmacy under the Pharmacy First Service
- Refer to BAD website for Patient Information Leaflet on scabies
- All members of the household and close contacts should be treated simultaneously
- Aqueous preparations are preferable. Alcoholic solutions are not recommended due to irritation of excoriated skin and the genitalia
- Treatment should be applied to the whole body including the scalp, neck, face, and ears. Particular attention should be paid to the webs of fingers and toes and lotion brushed under the ends of nails.
- Clothes, towels and bed linen should be washed at high temperatures at time of treatment
- It is important to warn users to reapply treatment to the hands if they are washed

- The itch, and eczema, of scabies can persist for 4-6 weeks after the infestation has been eliminated and treatment for pruritus and eczema may be required. Crotamiton, a topical corticosteroid, or a sedating antihistamine at night may be of benefit

*Head lice*

- Head lice can be managed and treated in community pharmacy under the Pharmacy First Service. A variety of products are also available to purchase over-the-counter.

*Pubic lice*

| Choice | Drug |
|---|---|
| 1st choices | Malathion 0.5% liquid in an aqueous base (Derbac- M®)<br>or<br>Permethrin cream 5% |

Prescribing Notes

- Refer to NICE CKS Public Lice
- Consider referral to Genito Urinary Medicine (GUM) clinic
- Alcoholic lotions are not recommended due to irritation of excoriated skin and genitalia
- Products should be applied to beards and moustaches but not applied to the face or scalp hair
- Refer to NICE CKS for treatment of pubic lice affecting the eye lashes
- A different insecticide should be used if a treatment course fails

## 13.11 Skin cleansers, antiseptics, and desloughing agents

Prescribing notes

- Refer to NICE CKS for the management of venous leg ulcers
- **Potassium Permanganate**: There is a risk of death or serious harm from accidental ingestion of potassium permanganate preparations. Refer to the Safety, Quality and Standards Circular (HSC (SQSD) 16/22) Inadvertent oral administration of potassium permanganate issued in response to a National Patient Safety Alert. Prescribers must ensure that measures are put in place to **avoid oral ingestion of potassium permanganate**. See NI Medicines Management Newsletter July 2022 for further advice and references

13.11.2 Chlorhexidine salts

| Choice | Drug |
|---|---|
| 1st choice | Chlorhexidine gluconate 4% (Hibiscrub®) |

Caution

- There is a risk of anaphylactic reaction due to chlorhexidine allergy. Healthcare professionals should be aware that there is a potential for anaphylactic reaction to chlorhexidine and ensure that all known allergies are recorded in patient notes. Allergic reactions to products containing chlorhexidine should be reported to the MHRA

## 13.12 Antiperspirants

| Choice | Drug |
|---|---|
| 1st choice | Aluminium chloride hexahydrate 20% in an alcoholic basis (Anhydrol Forte®)<br><br>**Available to purchase OTC - encourage self-care** |

Prescribing Notes

- Aluminium chloride is a potent antiperspirant used in the treatment of hyperhidrosis