Derbyshire Medicines Management, Prescribing and Guidelines
Derbyshire Primary Care Formulary

Chapter 13: DRUGS ACTING ON THE SKIN
Updated: November 2024

The following prescribing guideline is relevant to the skin chapter and can be found here

- Acne vulgaris
- Actinic Keratosis- management
- Emollient Prescribing Guide

Relevant resources

- JUCD Atopic Eczema in Children

Specials

Specials are individually prepared formulations of existing drugs, made for a specific patient. They are usually considerably more expensive than standard preparations and are likely to incur additional prescribing costs e.g. out of pocket expenses. Creams/ointments not listed in the BNF will usually fall under the specials umbrella. It is advisable to follow these key principles:

1. Establish clinical need, is there a licensed alternative?
2. Different suppliers of the same special may have a different formulation, stability and potentially bioavailability.
3. Share the decision-making process with the patient.
4. Ensure regular review for ongoing need.
5. Consider issuing acute instead of repeat prescriptions to assess patient response.
6. Be aware that expiry date of products is likely to be short.
7. BNF states that diluted creams should normally be used within 2 weeks of preparation.
8. Consider prescribing a weaker propriety steroid rather than diluting more potent steroid.
9. Consider prescribing a trial of urea cream rather than a special cream containing salicylic acid e.g. instead of 10% salicylic acid cream consider 10% urea cream (Flexitol 10%, Aquadrate or Hydromol intensive), instead of 25% salicylic cream consider 25% urea cream (Dermatonics ONCE Heel Balm).

British Association of Dermatologist (BAD) is a charity that works closely with the Department of Health to advise the best practice and the provision of Dermatology services. It has produced a specials list to help to address concerns about high cost and lack of standards on unlicensed creams and ointments used for common dermatological conditions.

13.1 Management of skin conditions

13.1.2 Suitable quantities for prescribing for an adult

	Lotions Twice daily application for 1 week for adults	**Creams & Ointments** Twice daily application for 1 week for adults	**Corticosteroids** Once daily application for 2 weeks for adults
Face	100 ml	15 to 30g	15 to 30g
Both Hands	200 ml	25 to 50g	15 to 30g
Scalp	200 ml	50 to 100g	15 to 30g
Both arms	200 ml	100 to 200g	30 to 60g
Both legs	200 ml	100 to 200g	100g
Trunk	500 ml	400g	100g
Groins and genitalia	100 ml	15 to 25g	15 to 30g

13.2 Emollient and barrier preparations

See NICE clinical guidance CG57 - Management of atopic eczema in children.

1. Flexitol 10% urea cream, Imuderm emollient and Hydromol Intensive are classified as **GREEN**.

2. Urea Heel and Foot Products (Dermatonic ONCE Heel Balm 25% is the preferred brand) are **GREY**: restricted for use in diabetic patients and those with hyperkeratotic skin conditions, after an adequate trial of self-care with a standard emollient

13.2.1 Emollients

See Emollient Prescribing Guide. For treatments of minor conditions such as contact dermatitis and mild dry skin/sunburn, self-care is encouraged.

1. Emollient choice for an individual patient involves consideration of patient preference, consistency required, patient's lifestyle, and cost. There is some evidence to suggest that emollients may reduce the need to use topical steroids.
2. There is a fire risk with all paraffin-containing emollients, regardless of paraffin concentration, and it also cannot be excluded with paraffin-free products. A similar risk may apply for other products which are applied to the skin over large body areas or in large volumes for repeated use for more than a few days. Warn patient about the risk of severe and fatal burns with emollients (MHRA Dec 2018, MHRA Aug 2020). 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 fabrics that have dried residue of an emollient product on them.
3. Epimax ointment and Epimax paraffin free ointment are not recommended to be applied to the face due to the risk of ocular toxicity. See MHRA July 2024.

13.2.1.1 Emollient bath additives

All Shower and bath emollients are not recommended for prescribing due to the lack of evidence of efficacy and are not recommended by NICE (Recommendations | Atopic eczema in under 12s: diagnosis and management | Guidance | NICE).. There is no consensus of clinical opinion that such therapy is effective. All the emollients included in the formulary can be used as a soap substitute. Most bath oils and emollients can make objects very slippery, therefore caution must be taken when getting in and out of the bath, especially when caring for vulnerable groups such as older people or when handling babies.

13.2.2 Barrier preparations

Barrier preparations are no substitute for adequate nursing care and should not be used in isolation. See Derbyshire Wound Care formulary

Conotrane cream (dimeticone, benzalkonium chloride)		*500g*
Drapolene cream (cetrimide, benzalkonium chloride)		*100g, 200g, 350g*
Medi Derma S	cream, film spray/applicator	*for higher risk patients- see criteria below*

1. Medi Derma S, AproDerm and Zerolon are the cost effective barrier preparations. These are only indicated in certain situations:
   - **Peri-wound protection**: cream/film (spray, foam applicator) for protection from bodily fluids e.g. exudate
   - **Preventing incontinence dermatitis** in high risk patients (e.g. very acidic urine, diarrhoea)
     - Not all incontinence patients will require a barrier cream; professional judgement is required.
     - If skin is dry/fragile an emollient cream or gel could be applied after cleansing (apply sparingly).
     - Barrier creams can clog incontinence pads if applied too thickly.
   - **Stomas**: protecting broken or sore peristomal skin.
     - General barrier creams are NOT recommended as majority will reduce adhesion of bags/flanges.
     - Films/wipes reserved for selected patients only i.e. diabetics, palliative patients and difficult stomas
     - For acute prescription only
2. Zinc oxide, Sudocrem and Metanium are not recommended as they can become 'caked' making it difficult for healthcare workers to observe the skin properly and can also be difficult to remove.
3. Barrier creams should not routinely be prescribed for nappy rash in babies; suitable products are available OTC. See JUCD.

13.3 Topical local anaesthetics and antipruritics

For treatments of minor short-term conditions such as insect bites and stings, patients are encouraged to self-care or to consider using the pharmacy first scheme. Most insect bites and stings are not serious and will get better within a few hours or days. Over- the counter treatments (OTC) can help ease symptoms, such as painkillers, creams for itching and antihistamines. See JUCD.

CKS advice on management of wide-spread itch:

- Offer self-care advice. If the person has dry skin, recommend using emollients (see emollient guideline).
- If emollient does not provide adequate relief, consider a trial of menthol in aqueous cream e.g. Menthol 1% in aqueous cream. Note this recommendation is based on expert opinion.
- If above does not provide adequate relief consider using a sedating oral antihistamine e.g. chlorphenamine 4 mg at night (off-label indication). Stop after 2 weeks if no relief.

Preparations containing crotamiton are of uncertain value therefore not routinely recommended and can be purchased OTC.

13.4 Topical corticosteroids

Eczema

NICE TA81 recommends that topical corticosteroids are first-line treatment for flare-ups of atopic eczema and should be prescribed for application only once or twice daily. Guidelines from the British Association of Dermatologist suggest that the best way of using topical corticosteroids is probably twice daily for 10-14 days when the eczema is active, followed by a 'holiday period' of emollients only.

Psoriasis

See appendix 1 – psoriasis pathway and NICE Clinical Guideline 153 for advice on topical corticosteroids.

Topical corticosteroid preparation potencies

Mild	**Hydrocortisone** 0.5% 1%	cream 15g cream/ointment 15g, 30g, 50g
Moderate If formulary choices not available	**Betamethasone valerate 0.025%** **Clobetasone butyrate 0.05%** Fluocinolone acetonide 0.00625% (Synalar 1 in 4 dilution) Hydrocortisone Butyrate 0.1%	cream/ ointment 100g cream/ ointment 30g ointment 50g cream/ ointment100g
Potent	**Betamethasone valerate 0.1%**	cream/ ointment 30g, 100g scalp application100m
Very Potent	**Clobetasol propionate 0.05%**	cream/ ointment 30g, 100g

1. Ointments are preferable to creams as they have a deeper, more prolonged emollient effect and increase the penetration of steroid. Water-miscible corticosteroid creams are suitable for moist or weeping lesions, whereas ointments are generally chosen for dry, lichenfied or scaly lesions or where a more occlusive effect is required. Ointments are also less likely to cause irritation as they do not contain preservatives. Where possible, patients should be maintained on emollients only.
2. If topical steroids are required for maintenance, there should be periods each year when they are withdrawn for as long as possible and emollients used on their own.
3. National patient safety alert August 2020 - steroid emergency card to be issued by prescribers to help healthcare staff to identify appropriate patients and gives information on the emergency treatment if they are acutely ill, or experience trauma, surgery or other major stressors. Patients being treated with large quantities of potent or very potent topical glucocorticoids (≥200g per week) and those treated with potent or very potent topical glucocorticoids and significant amounts of other forms of glucocorticoid should be issued with a steroid emergency card. For further guidance on this see Exogenous steroids, adrenal insufficiency and adrenal crisis-who is at risk and how should they be managed safely.
4. MHRA May 2024: Topical steroids: introduction of new labelling and a reminder of the possibility of severe side effects, including Topical Steroid Withdrawal (TSW) Reactions
    - adverse reactions have been reported following long-term (generally 6 months or more) use of moderate or stronger potency topical steroids, particularly when used for eczema treatment – these reactions are often referred to as 'Topical Steroid Withdrawal Reactions'
    - symptoms of TSW can include intense redness, stinging, and burning of the skin that can spread beyond the initial treatment area
    - the risk of these and other serious reactions increases with prolonged use of higher potency steroid products

- moving forward, topical steroids will be labelled with information on their potency to assist with counselling patients
- when prescribing or dispensing topical steroids, advise on the amount of product to apply, how often, where to apply it and when to stop treatment
- if previous discontinuation was associated with reactions that raise suspicion of TSW, alternative treatments should be considered
- provide support to patients living with symptoms of TSW and review treatment plans with patients
- be vigilant for the signs and symptoms of topical steroid withdrawal reactions and review the position statement from the National Eczema Society and British Association of Dermatologists (updated February 2024)
- report suspected adverse drug reactions to the Yellow Card Scheme, including after discontinuation of topical steroids.

Topical corticosteroids with antifungal preparation
Hydrocortisone/clotrimazole (Mild potency) cream 30g

Topical corticosteroids with antibiotic preparations – *limited indications only*

1. Combination products containing a corticosteroid and an antibacterial preparation are not routinely recommended. Topical steroids should not be used routinely on clinically infected skin unless the infection is being treated.
2. CKS advises that in patients who are not systemically unwell, do not routinely offer either a topical or oral antibiotic for secondary bacterial infection of eczema. If an antibiotic is offered to people who are not systemically unwell with a secondary bacterial infection of eczema flucloxacillin is the first line choice. Clarithromycin if the patient has a penicillin allergy or a known resistance to flucloxacillin. Erythromycin should be chosen if the patient is pregnant and is allergic to penicillin. If there are localised areas of infection consider prescribing a topical antibiotic such as fusidic acid 2%. Avoid using combined corticosteroid/antibiotic preparations on a regular basis due to the increased risk of antibiotic resistance and sensitisation (due to inclusion of more additives).

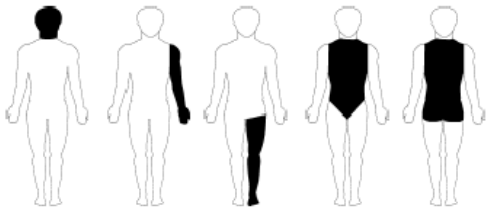
Corticosteroids with antifungal and antibacterial preparations

1. Trimovate (Clobetasone/nystatin/oxytetracycline) is **GREY** after consultant/specialist (including GPwSI) recommendation.

Fingertip guide

Patients who are prescribed steroids may be advised to use fingertip units (FTU) to measure the amount of steroid they need to apply to different parts of the body. A strip of cream or ointment equivalent to the length of the last joint of an adult's index finger is about half a gram.

ONE adult fingertip unit (FTU)*



Number of finger tip units (FTUs)

Age	Face & neck	Arm & hand	Leg & foot	Trunk (front)	Trunk (back) inc. buttocks
Adult	2½	4	8	7	7
Children:					
3-6 months	1	1	1½	1	1½
1-2 years	1½	1½	2	2	3
3-5 years	1½	2	3	3	3½
6-10 years	2	2½	4½	3½	5

* One adult fingertip unit (FTU) is the amount of ointment or cream expressed from a tube with a standard 5mm diameter nozzle, applied from the distal crease to the tip of the index finger.

13.5 Preparations for eczema and psoriasis

13.5.1 Preparations for eczema- *Hospital only – Ichthammol, Zinc oxide 20% stocking*

13.5.2 Preparations for Psoriasis

See appendix 1 – psoriasis pathway and NICE Clinical Guideline 153

Calcitriol ointment 100g
Calcipotriol ointment 30g
Coal tar 6% / Lecithin 0.4% cream 225ml
Cocois scalp ointment 40g, 100g (contains coal tar 12%, sulfur 4%, salicylic acid 2% in coconut oil)

1. Combination calcipotriol/ betamethasone is **GREY**. Do not add to repeat prescription. (Cost effective to prescribe generic ointment/ gel or Enstilar cutaneous foam) See appendix 2 for further guidance.
2. Note the potential for confusion between Dovobet (calcipotriol and 0.05% betamethasone) and Calcipotriol.
3. Combination calcipotriol/ betamethasone should not be used in patients with guttate, erythrodermic or pustular psoriasis.

13.5.3 Drugs affecting the immune response

Tacrolimus 0.03%, 0.1% ointment 30g, 60g
Pimecrolimus 1% cream 30g, 60g, 100g

1. Topical tacrolimus and pimecrolimus are **GREEN** consultant/specialist initiation, indicated for patients with moderate or severe atopic eczema age over 2 not responsive to topical steroids or requiring steroid sparing agent.
2. GP to continue as per treatment plan which should state circumstances to use e.g. flares, location/duration of treatment, strength/quantities to prescribe. Not to be put on repeat prescription. Refer back to dermatology if patient needing continuous daily tacrolimus without break for >6 months or if flare not improving. Intermittent use for >6 months as per treatment plan in clinic letter is acceptable.
3. Pimecrolimus cream 1% is licensed for children 3 months and older.
4. Tacrolimus ointment 0.03% is not recommended for use in children aged 2 years or below.
5. Tacrolimus ointment 0.1% is not recommended for use in children under 16 years of age.
6. Tacrolimus may be associated with a possible risk of malignancies. Findings from epidemiological studies have suggested a possible increased risk of cutaneous T-cell lymphoma in patients treated with topical tacrolimus ointment. Not be applied to potentially malignant or pre-malignant lesions or used in patients with immunodeficiencies. (MHRA June 2012)

13.6 Acne and Rosacea

13.6.1 Topical Preparations for Acne

See managing acne vulgaris guidance.
For treatments of minor short term conditions such mild acne, patients are encouraged to self-care. Several creams, lotions and gels for treating acne are available at pharmacies (e.g. benzoyl peroxide products). Treatments can take up to three months to work.

Adapalene+ Benzoyl peroxide (Epiduo) 0.1%/2.5% gel, 0.3%/2.5% gel
Benzoyl peroxide + clindamycin 3%/1% gel, 5%/1% gel
Clindamycin+ tretinoin (Treclin) 1%/0.025% gel
Adapalene 0.1% cream, gel
Azelaic acid cream 20% 30g
Benzoyl peroxide 5% gel

1. NICE NG198 recommends fixed combination topical products – Treclin, Epiduo or Duac first line for mild to moderate acne vulgaris. Choice of combination products should be made according to individual preference and cost. See Acne guideline for more detail.
2. To reduce risk of skin irritation (irritant dermatitis) with topical treatments, start with lowest strength. If necessary, start with alternate-day or short-contact application (washing off after 1h) and gradually progress to standard application if f tolerated.
3. Benzoyl peroxide (BPO) can cause bleaching of fabric.
4. Topical clindamycin (Dalacin T) is **DNP**- do not use as monotherapy to treat acne for new patients.
5. Isotretinoin is classified **RED**. See MHRA Oct 2023 and Acne guideline
6. Topical retinoids and oral tetracyclines are contraindicated during pregnancy therefore effective contraception needed or alternative treatment should be used. MHRA June 2019.

13.6.2 Oral preparations for acne

See antibiotic chapter for recommended oral antibiotics used in the treatment of acne.

Antibiotic monotherapy is poor management and will only partially treat the acne process. In order to minimise the development of antibiotic resistance always use a topical (non-antibiotic) agent alongside oral antibiotics. Even intermittent treatment can help prevent antibiotic resistance developing.

Minocycline is not recommended for use in acne as it is associated with an increased risk of adverse effects such as drug-induced lupus, skin pigmentation and hepatitis (See: Oral antibiotics | Prescribing information | Acne vulgaris | CKS | NICE). This has been classified by the Derbyshire JAPC as **'Do Not Prescribe (DNP)'**.

Co-cyprindiol (**Clairette**) 2000microgram/ 35microgram tablets

1. Should be considered when topical or oral antibiotics have failed. Clairette is the preferred brand.
2. The benefits outweigh the risks in women of reproductive age for the treatment of:
   - Skin conditions related to androgen sensitivity (eg, severe acne with or without seborrhoea)
   - Hirsutism
3. May take up to 2-6 months to improve acne. The need to continue treatment should be evaluated periodically; treatment should be discontinued 3 months after the woman's acne has resolved.
4. Although it is an effective contraception (additional hormonal contraceptive should not be used in combination), it is not licensed for the sole purpose of contraception.
5. The risk of Venous Thromboembolism (VTE) is rare but this remains an important side effect. Healthcare professionals should be vigilant for signs and counsel patients to remain vigilant for signs and symptoms MHRA June 2013.
6. If patients present with severe depression co-cyprindiol should be stopped immediately – see SPC.

13.6.3 Topical preparations for rosacea

Rozex (Metronidazole) 0.75% cream/gel 50g

Ivermectin cutaneous cream (Soolantra) — **GREEN** for papulopustular rosacea, once daily application for up to 4 months. If there is no improvement after 3 months, the treatment should be discontinued.

1. Brimonidine gel (Mirvaso) is classified by the Derbyshire JAPC as **RED** MHRA November 2016 have issued a warning regarding exacerbation of rosacea. MHRA June 2017 also advises to avoid application to irritated or damaged skin, including after laser therapy as systemic cardiovascular effects have been reported.

See section 13.10 for other indications for topical metronidazole.

13.7 Preparations for warts and calluses

No preparations are included for the treatment of warts and calluses as there are many products available for purchase over the counter e.g. Salactol. See Self Care guidance.

Anogenital Warts should be referred to the GUM clinic for treatment.

13.8 Sunscreens and camouflagers

13.8.1 Sunscreens - See Self Care guidance & JUCD advice.

JAPC classification **GREY**. Sunscreens on FP10 require prescription endorsement 'ACBS'. The conditions for which they may be prescribed as per drug tariff include: for skin protection against UV radiation and/or visible light in abnormal cutaneous photosensitivity causing severe cutaneous reactions in genetic disorders (including xeroderma pigmentosum and porphyrias), severe photodermatoses (both idiopathic and acquired) and in those with increased risk of UV radiation causing adverse effects due to chronic disease (such as haematological malignancies), medical therapies and/or procedures. SPF less than 30 should not normally be prescribed.

Sunscreen	SPF	Pack size	Cost/mL
Anthelios Sunscreen Lotion	50+	250mL	£0.05
Uvistat cream	30 50	125mL 125mL	£0.07 £0.08
Uvistat Lip screen	50	5g	--

*MIMS September 2024

13.8.1 Photodamage

See actinic keratosis management guideline.

Fluorouracil 5% cream	*1st line*
Fluorouracil 0.5%/salicylic acid 10%	*2nd line after Fluoracil 5% cream*
Diclofenac 3% gel	*2nd line after Fluoracil 5% cream*

1. Imiquimod 5% is **RED** and restricted for specialist use.
2. Imiquimod 3.75% (Zyclara) is classified as **Do Not Prescribe (DNP)** as this is less cost-effective than current standard therapy.
3. Diclofenac 3% gel has occasionally been prescribed in error as a topical NSAID. This is very expensive.
4. Products should be prescribed as an acute script, and not added to repeat medication list.
5. The British Association of Dermatologists suggests that no therapy or emollient only are reasonable options for mild actinic keratosis and there is inadequate evidence to justify treatment of all lesions to prevent malignant change.

13.8.2 Camouflagers

Camouflagers on FP10 require prescription endorsement 'ACBS' when prescribed for postoperative scars and other deformities and as adjunctive therapy in the relief of emotional disturbances due to disfiguring skin diseases, such as vitiligo.

Patients in Derbyshire can be referred for skin camouflage to Changing Faces, which is a charity that also provides a range of emotional support to patients living with scars. Changing faces will then recommend the best shade/products once the patient has been seen. If they meet the ACBS criteria these products can be prescribed, alternatively they can be purchased.

Camouflage products marked 'ACBS' can be prescribed on the NHS for postoperative scars and other deformities and as adjunctive therapy in relief of emotional disturbances due to disfiguring skin disease, such as vitiligo. Cleansing creams, milks and lotions are excluded.

Consider referring to Changing Faces for further support.

13.9 Shampoos and some other preparations for scalp & hair conditions

For treatments of minor short-term medical conditions patients are encouraged to self-care. For example:

Cradle cap in infants - Self-limiting and will clear up on its own without the need for treatment. BNF advice cradle cap in infants may be treated with coconut oil or olive oil applications followed by shampooing. See the BNF for the choice of coal tar shampoos.

Dandruff- The treatment of choice is the frequent use of an anti-dandruff shampoo once or twice weekly to rid the scalp of scale. There are several types available to purchase from supermarkets or pharmacies. Shampoos containing selenium sulphide are of no more value than other shampoos.

Eflornithine cream

1. **GREY after specialist recommendation** - Prescribing in adults (off-license) in primary care is permitted as per NHS England specialised services circular. See Transgender and Non-Binary Adults - Primary Care guidance. This should be done in close collaboration with the specialists at the Gender Identity Clinics.
2. **GREY** - for facial Hirsutism in women. There is limited evidence for efficacy and patient satisfaction with eflornithine. Before considering eflornithine cream:
    - Women who are overweight or obese should be encouraged to lose weight
    - Check underlying cause as hirsutism may result from serious medical conditions or from medications (e.g. ciclosporin, glucocorticoids or minoxidil)
    - The primary option for most women with hirsutism is self-funded cosmetic treatments for reduction of hair growth or removal (e.g. shaving, plucking, laser treatment or electrolysis)
    - Eflornithine should only be considered for use in women after failures of self-care and lifestyle measures, where alternative drug therapy e.g. co-cyprindiol, is ineffective, not recommended, contra-indicated or considered inappropriate.
    - Treatment with eflornithine does not remove hairs but slows down hair growth such that users require less frequent hair removal by other methods
    - Treatment should be discontinued if no effects are seen within 4 months

13.10 Anti-infective skin preparations

13.10.1 Antibacterial preparations

Fusidic Acid 2% cream, ointment 15g, 30g	*Local data shows the majority of Staph. Aureus strains are resistant to fusidic acid*
Anabact (Metronidazole) gel 0.75%	*For malodorous wounds*15, 30g

1. Silver Sulfadiazine Cream (Flamazine) is **GREY** - TVN recommendation as per wound care formulary or following specialist advice for radiotherapy reactions only.

13.10.2 Antifungal preparations

For treatments of minor, short-term medical conditions such as ringworm/athletes foot, patients are encouraged to self-care using treatments available over- the-counter. See JUCD for further information.

Clotrimazole 1% cream 20g, 50g
Terbinafine 1% cream 15g, 30g
Terbinafine 250mg tablets

1. Cutaneous fungal infections are most commonly due to dermatophytes (ringworm), candida and pityrosporum species. A fungal nail infection (onychomycosis) is mostly due to dermatophytes. Rarer cases of onychomycosis include candida and unusual moulds.
2. NICE CKS advises treatment with a topical antifungal cream if there is mild, non-extensive disease in children and adults. Options include terbinafine cream or an imidazole such as clotrimazole, miconazole, or econazole cream (available over-the-counter for specific age groups).
3. If dermatophyte infection is intractable or involves scalp, submit skin scrapings/ nail clippings for mycological confirmation prior to treatment.
4. Oral antifungals for nail infection are more effective than topical therapy (refer to Scenario: Management | Management | Fungal nail infection | CKS | NICE)
5. There is limited evidence to support the use of topical nail antifungals. Where treatment is indicated and systemic therapy is contraindicated (e.g. renal or hepatic impairment) amorolfine (**GREY**) is a treatment option. Examples of indications include where the condition is severe and debilitating, painful or in patients with peripheral vascular disease their use for cosmetic purposes is not supported.
6. Tioconazole is classified as **Do Not Prescribe (DNP)** not a cost effective choice.

13.10.3 Antiviral preparation

For treatments of minor self-limiting conditions such as cold sore (usually clear up without treatment within 7-10 days) patients are encouraged to self-care. There are doubts over the efficacy of topical acyclovir (**GREY**) in the management of recurrent herpes labialis. At best it offers only marginal benefits and only when started within a few hours of the first prodromal signs of an attack. It should not be prescribed and is available as an OTC preparation. See JUCD and NICE CKS for further information.

13.10.4 Parasiticidal preparations

Permethrin 5% **(Lyclear)** dermal cream 30g	*1st line for the treatment of scabies*
Malathion 0.5% aqueous liquid	*2nd line for the treatment of scabies*

For treatments of minor short term conditions such as head lice, self-care is encouraged. Treatments are available to purchase over-the-counter.

1. For head lice self-care with either wet combing, dimeticone 4% lotion, or malathion 0.5% aqueous liquid.
2. For wet combing
   - Treatment should not be used unless a living, moving louse is detected.
   - Bug busting requires meticulous use; 30 minutes each time over the whole scalp at 4-day intervals for a minimum of 2 weeks and continued until no lice are found on 3 consecutive sessions.
   - If prescription necessary, prescribe the most cost-effective comb.
3. For dimeticone and malathion:
   See JUCD or NICE CKS for further information. If adult lice are present, then go on to next choice of treatment. Always thoroughly investigate the reasons for treatment failure e.g. incorrect use.

MHRA March 2018 Head lice eradication products: risk of serious burns if treated hair is exposed to open flames or other sources of ignition, e.g., cigarettes.

1. For treatment of scabies malathion 0.5% aqueous liquid may also be used.

2. Permethrin is not licensed for use in patients under 2 months old.
3. Malathion is licensed for patients 6 months and older.
4. **Ivermectin** 3mg tablets are classified as **GREY** after specialist recommendation from dermatology, sexual health services and UKHSA for permethrin treatment resistant scabies. Confirmation should be obtained that topical treatment has been used correctly (including treatment of contacts and laundry) and not resolved the symptoms, or that there is evidence of ongoing infestation with the presence of burrows.

The dosage for classical scabies treatment is 200micrograms/kg taken in a single dose with food. A second dose should be given 7 days later to kill recently hatched mites.

In most circumstances the doses will be started by the specialist but the table below has been provided for the occasions where dosing assistance may be required, e.g. requests from UKHSA.

BODY WEIGHT (kg)	DOSE
15 - 24	One tablet (3mg)
25 - 35	Two tablets (6mg)
36 – 50	Three tablets (9mg)
51 – 65	Four tablets (12mg)
66 – 79	Five tablets (15mg)
≥ 80	Six tablets (18mg)

13.11 Disinfectants and cleansers

Sodium Chloride 0.9% (Normasol) solution 25ml, 100ml sachet

13.12 Antiperspirants

For treatments of minor conditions such as excessive sweating (hyperhidrosis) encourage self-care with e.g. Aluminium chloride hexahydrate 20% solution. See JUCD for further information.

Appendix 1 – Topical treatment strategies for adults with psoriasis (adapted from the BMJ 2012; 345 based on NICE CG153)

Trunk and limbs

Offer a potent corticosteroid (e.g. betamethasone) applied once daily plus vitamin D or a vitamin-D analogue (e.g. Calcitriol ointment) applied once daily (applied separately, one in the morning and the other in the evening) for up to 4 weeks as initial treatment

If there is little or no improvement at 4 weeks, discuss the next treatment option with the patient.

If once-daily application of a potent corticosteroid plus once-daily application of vitamin D or a vitamin-D analogue does not result in clearance, or satisfactory control after a maximum of 8 weeks:

Offer vitamin D or a vitamin-D analogue alone applied twice daily (e.g. Calcitriol ointment)

If twice-daily application of vitamin D or a vitamin-D analogue (e.g. Calcitriol ointment) does not result in clearance, near clearance, or satisfactory control after 8-12 weeks, offer either:

- A potent corticosteroid (e.g. betamethasone) applied twice daily for up to 4 weeks or
- A coal tar preparation (e.g. Psoriderm cream) applied once or twice daily

If a twice-daily potent corticosteroid (e.g. betamethasone) or coal tar preparation (e.g. Psoriderm cream) cannot be used, or a once-daily preparation would improve adherence:

Offer a combined product containing calcipotriol monohydrate and betamethasone dipropionate (e.g. Dovobet ointment or Enstilar foam if Dovobet ointment not tolerated) applied once daily for up to 4 weeks.

Face, flexures and genitals

Offer a short-term mild (e.g. hydrocortisone 1%) or moderate potency (e.g. clobetasone butyrate) corticosteroid applied once or twice daily (for a maximum of 2 weeks)

If the response to short-term moderate potency corticosteroids is unsatisfactory, or they require continuous treatment to maintain control and there is serious risk of local corticosteroid-induced side effects:

Offer a calcineurin inhibitor applied twice daily for up to 4 weeks. Calcineurin inhibitors should be initiated by a specialist with expertise in treating psoriasis.

Scalp

Offer a potent corticosteroid (e.g. betamethasone) applied once daily for up to 4 weeks as initial treatment

If treatment with a potent corticosteroid (e.g. betamethasone) does not result in clearance, near clearance, or satisfactory control after 4 weeks, consider:

- A different formulation of the potent corticosteroid (e.g. a shampoo or mousse) and/or
- Topical agents to remove adherent scale (e.g. agents containing salicylic acid, emollients, and oils e.g. Sebco ointment) before application of the potent corticosteroid

If the response to treatment with a potent corticosteroid (e.g. betamethasone) remains unsatisfactory after a further 4 weeks of treatment offer:

- A combined product containing calcipotriol monohydrate and betamethasone dipropionate (e.g. Dovobet gel) applied once daily for up to 4 weeks or
- Vitamin D or a vitamin-D analogue (e.g. Calcitriol ointment) applied once daily (only in those who cannot use steroids and with mild to moderate scalp psoriasis)

If continuous treatment with either a combined product containing calcipotriol monohydrate and betamethasone dipropionate (e.g. Dovobet gel) applied once daily or vitamin D or a vitamin-D analogue (e.g. Calcitriol ointment) applied once daily for up to 8 weeks does not result in clearance, near clearance, or satisfactory control, offer:

- A very potent corticosteroid (e.g. Clobetasol propionate) applied for up to twice daily for 2 weeks or
- Coal tar applied once or twice daily or
- Referral to a specialist for additional support with topical applications and/or advice on other treatment options

In people whose psoriasis has not responded satisfactorily to a topical treatment strategy, before changing to an alternative treatment:

- Discuss with the person whether they have any difficulties with application, cosmetic acceptability, or tolerability and where relevant offer an alternative formulation
- Consider other reasons for non-adherence in line with NICE CG76

In adults not controlled with topical therapy, see full guideline for recommendations on:

- Phototherapy
- Systemic (non-biological) treatment

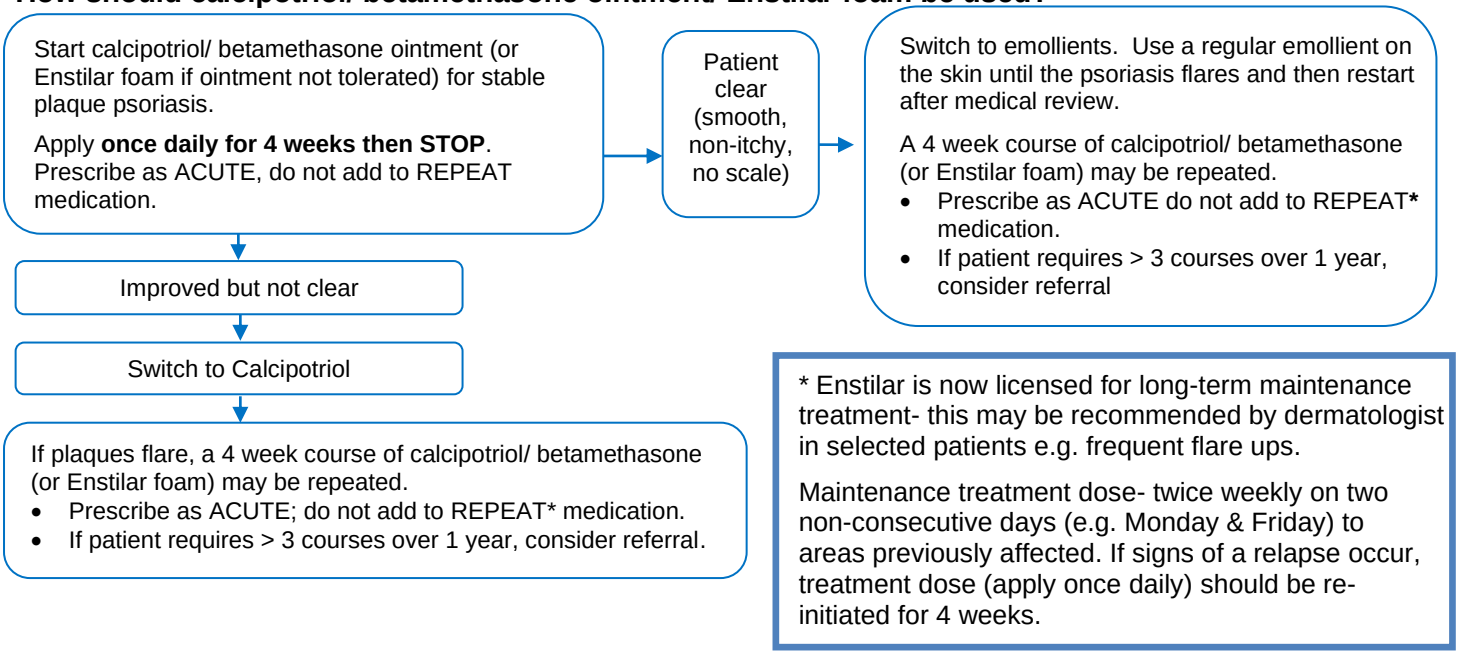
Appendix 2 – Guidance for General Practitioners on the use of calcipotriol/ betamethasone ointment/gel and Enstilar Cutaneous Foam used in line with topical treatment strategies for adults with psoriasis

When should you prescribe calcipotriol/ betamethasone ointment or Enstilar foam?

For patients with **stable** plaque psoriasis covering less than 30% body surface area who:

- have not responded to other topical treatments including Calcipotriol.
- patients whom you feel may need secondary care intervention.
- Enstilar (betamethasone/calcipotriol) is a cutaneous foam formulation, indicated for plaque psoriasis. It is an alternative for patients who are unable to tolerate calcipotriol/ betamethasone ointment, use in line with information below.

How should calcipotriol/ betamethasone ointment/ Enstilar foam be used?



* Enstilar is now licensed for long-term maintenance treatment- this may be recommended by dermatologist in selected patients e.g. frequent flare ups.

Maintenance treatment dose- twice weekly on two non-consecutive days (e.g. Monday & Friday) to areas previously affected. If signs of a relapse occur, treatment dose (apply once daily) should be re-initiated for 4 weeks.

When should you prescribe calcipotriol/ betamethasone gel?

For patients with scalp psoriasis who have not responded to other topical treatments

How should calcipotriol/ betamethasone gel be used?