**Derbyshire Medicines Management, Prescribing and Guidelines**
**Derbyshire Primary Care Formulary**

**Chapter 13: DRUGS ACTING ON THE SKIN**
**Updated: November 2022**

**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

- Emollients- Patient Information Leaflet
- 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**<br>Twice daily application for 1 week for adults | **Creams & Ointments**<br>Twice daily application for 1 week for adults | **Corticosteroids**<br>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. Urea Heel and Foot Products (Dermatonic ONCE Heel Balm 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

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

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 emollients. 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 fabric that have dried residue of an emollient product on them.

#### 13.2.1.1 Emollient bath additives

All Shower and bath emollients have been classified as Do Not Prescribe (DNP) by JAPC and are not recommended for prescribing due to the lack of evidence of efficacy. Drug and Therapeutics Bulletin (DTB: Vol. 45 No. 10 – October 2007) questioned the benefit of bath emollients. A randomised controlled trial (BATHE, 2018 https://www.bmj.com/content/361/bmj.k1332) found no evidence of clinical benefit from including emollient bath additives in the standard management of eczema in children. There is no consensus of clinical opinion that such therapy is effective. All of the emollients included in the formulary can be used as a soap substitute. The majority of 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.

Aqueous cream is no longer recommended as an emollient, but may be considered as a soap substitute. However, adverse effects are possible with any use. See SPS for further information.

### 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) | | *1st line in lower risk patients* |
| **Drapolene cream** (cetrimide, benzalkonium chloride) | | |
| **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 alternative barrier preparations to Cavilon. 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.

### 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. Most insect bites and stings are not serious and will get better within a few hours or days. Over-the counter treatments can help ease symptoms, such as painkillers, creams for itching and antihistamines. 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 (Dermacool). 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.

### 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% cream 15g<br>1% cream/ointment 15g, 30g, 50g |
| **Moderate**<br><br>If formulary choices not available | **Betamethasone valerate 0.025% (Audavate RD)** cream/ ointment 100g<br>**Clobetasone butyrate 0.05% (Eumovate)** cream/ ointment 30g<br><br>Fluocinolone acetonide 0.00625% (Syalar 1 in 4 dilution) cream/ ointment 50g |
| **Potent**<br><br>If formulary choices not available | **Betamethasone valerate 0.1% (Audavate)** cream/ ointment 30g, 100g<br>**generic** scalp application100ml<br><br>Hydrocortisone Butyrate 0.1% (Locoid) cream/ ointment100g |
| **Very Potent**<br><br>If formulary choices not available | **Clobetasol propionate 0.05% (ClobaDerm)** cream/ ointment 30g, 100g<br><br>Clobetasol propionate 0.05% (Dermovate) 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. They 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 September 2021 topical corticosteroids- risk of topical steroid withdrawal reactions
    - long-term continuous or inappropriate use of topical corticosteroids, particularly those of moderate to high potency, can result in the development of rebound flares after stopping treatment – there are reports of such flares taking the form of a dermatitis with intense redness, stinging, and burning that can spread beyond the initial treatment area
    - when prescribing a topical corticosteroid, consider the lowest potency needed
    - advise patients on the amount of product to be applied; underuse can prolong treatment duration
    - inform patients how long they should use a topical corticosteroid, especially on sensitive areas such as the face and genitals
    - inform patients to return for medical advice if their skin condition worsens while using topical corticosteroid, and advise them when it would be appropriate to re-treat without a consultation

- for patients currently on long-term topical corticosteroid treatment, consider reducing potency or frequency of application (or both)
- 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

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

Topical corticosteroids with antibiotic preparations – *limited indications only*

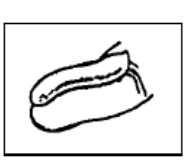
1. Combination products containing a corticosteroid and an antibacterial preparation are not routinely recommended. Topical steroids should not be used routinely on clinically infected skin unless the infection is being treated.
2. CKS advises that if there are extensive areas of infected eczema a short course of suitable oral antibiotic may be indicated. If there are localised areas of infection, consider a trial of topical antibiotic (as separate products or combined with a corticosteroid) on an individual basis, for a maximum of 2 weeks. 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

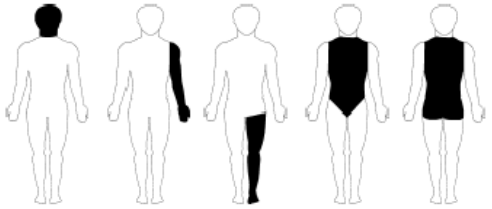
1. Trimovate (Clobetasone/nystatin/oxytetracycline) is **GREY** after consultant/specialist (including GPwSI) recommendation.

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*
### 13.5.2 Preparations for Psoriasis

*See appendix 1 – psoriasis pathway and NICE Clinical Guideline 153*

**Calcitriol** (Silkis) ointment 100g
**Calcipotriol** (Dovonex) ointment 30g
**Coal tar 6% / Lecithin 0.4%** (Psoriderm) 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 Dovonex (calcipotriol alone).
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. If patient needing continuous daily tacrolimus without break for >6 months or if flare not improving to refer back to dermatology. Intermittent use for >6 months as per treatment plan in clinic letter is acceptable.
3. Pimecrolimus cream 1% and tacrolimus ointment 0.03% are not recommended for use in children aged 2 years or below. Tacrolimus ointment 0.1% should not be used in children under 16 years of age.
4. 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** 1%/3% gel, 1%/5% gel
**Clindamycin+ tretinoin (Treclin)** 1%/0.025% gel
**Adapalene** 0.1% cream, gel
**Azelaic acid (Skinoren)** cream 20% 30g
**Benzoyl peroxide** 4% cream, 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 of 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. Do not prescribe oral and topical antibiotics at the same time.

### 13.6.2 Oral preparations for acne

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

The use of minocycline in the management of acne is not recommended (DTB Vol 5 May 2013). 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 3-4 menstrual cycles 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 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 30g, 40g

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.

### 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.

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 |
|---|---|---|---|
| Uvistat cream/ | 30<br>50 | 125mL<br>125mL | £0.06<br>£0.07 |
| Lip screen | 50 | 5g | -- |

*MIMS November 2022

### 13.8.1 Photodamage

*Below preparations are **Green** when prescribed in line with local actinic keratosis management guideline.*

**Fluorouracil 5% cream (Efudix)**

**Fluorouracil 0.5%/salicylic acid 10% (Actikerall)**

**Solaraze gel** (diclofenac 3%, sodium hyaluronate 2.5%)

1. Ingenol mebutate gel (Picato) has been re-classified as **Do Not Prescribe (DNP)** as its licence has been suspended as a precautionary measure while the European Medicines Agency continues to investigate concerns about a possible increased risk of skin malignancy. MHRA February 2020.
2. Imiquimod 5% is **RED** and restricted for specialist use.
3. Imiquimod 3.75% (Zyclara) is classified as **Do Not Prescribe (DNP)** as this is less cost-effective than current standard therapy.
4. Solaraze gel has occasionally been prescribed in error as a topical NSAID. This is very expensive.
5. Products should be prescribed as an acute script, and not added to repeat medication list.
6. 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.

### 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 a mild detergent shampoo once or twice weekly to rid the scalp of scale. Shampoos containing selenium sulphide are of no more value than other shampoos.

**Eflornithine** cream

1. **GREEN** - 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 the majority of 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%** (Fucidin) 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 |
| **Rozex** (Metronidazole) cream/gel 0.75% 30, 40g | *For rosacea* |

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.

**Clotrimazole** 1% cream 20g, 50g
**Terbinafine** 1% cream 15g, 30g

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/PHE antimicrobial guidance recommends that for dermatophyte infection of the skin, treat with topical terbinafine. It is fungicidal, with shorter treatment time (1-4 weeks), and more effective than with fungistatic imidazoles (e.g. clotrimazole). Use topical imidazole if candida possible.
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 Antimicrobial Treatment Guide)
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 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 aciclovir 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.

### 13.10.4 Parasiticidal preparations

**Permethrin** 5% **(Lyclear)** dermal cream 30g *1st 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 treatment of scabies malathion 0.5% aqueous liquid may also be used.
2. For head lice self-care with either wet combing, dimeticone 4% lotion, or malathion 0.5% aqueous liquid.
3. 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.
4. For dimeticone and malathion:
   - Use two applications seven days apart (12 hours/overnight contact time).
   - 2-3 days after final application of insecticide: check hair thoroughly with a detector comb.
   - 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.
5. 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.

### 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) encouraged self-care with e.g. Aluminium chloride hexahydrate 20% solution.

## 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. Betnovate) applied once daily plus vitamin D or a vitamin-D analogue (e.g. Silkis / 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. Silkis / calcitriol ointment)

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

- A potent corticosteroid (e.g. Betnovate) 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. Betnovate) 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. Eumovate) 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 healthcare professionals with expertise in treating psoriasis. Refer.

### 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. Silkis / 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. Silkis / 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. Dermovate) 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

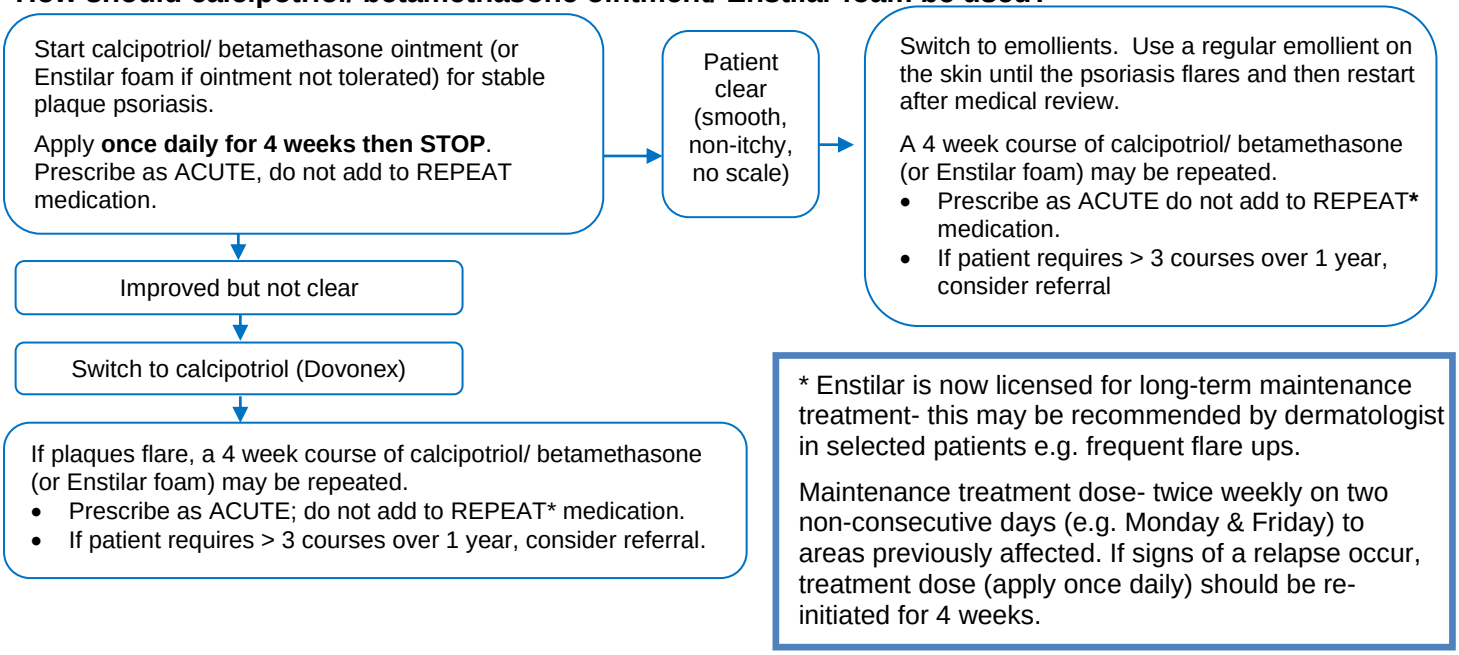
## Appendix 2 – Guidance for General Practitioners on the use of calcipotriol/ betamethasone ointment/gel and Enstilar Cutaneous Foam used in line with topical treatment strategies for adults with psoriasis

### 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 Dovonex (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?