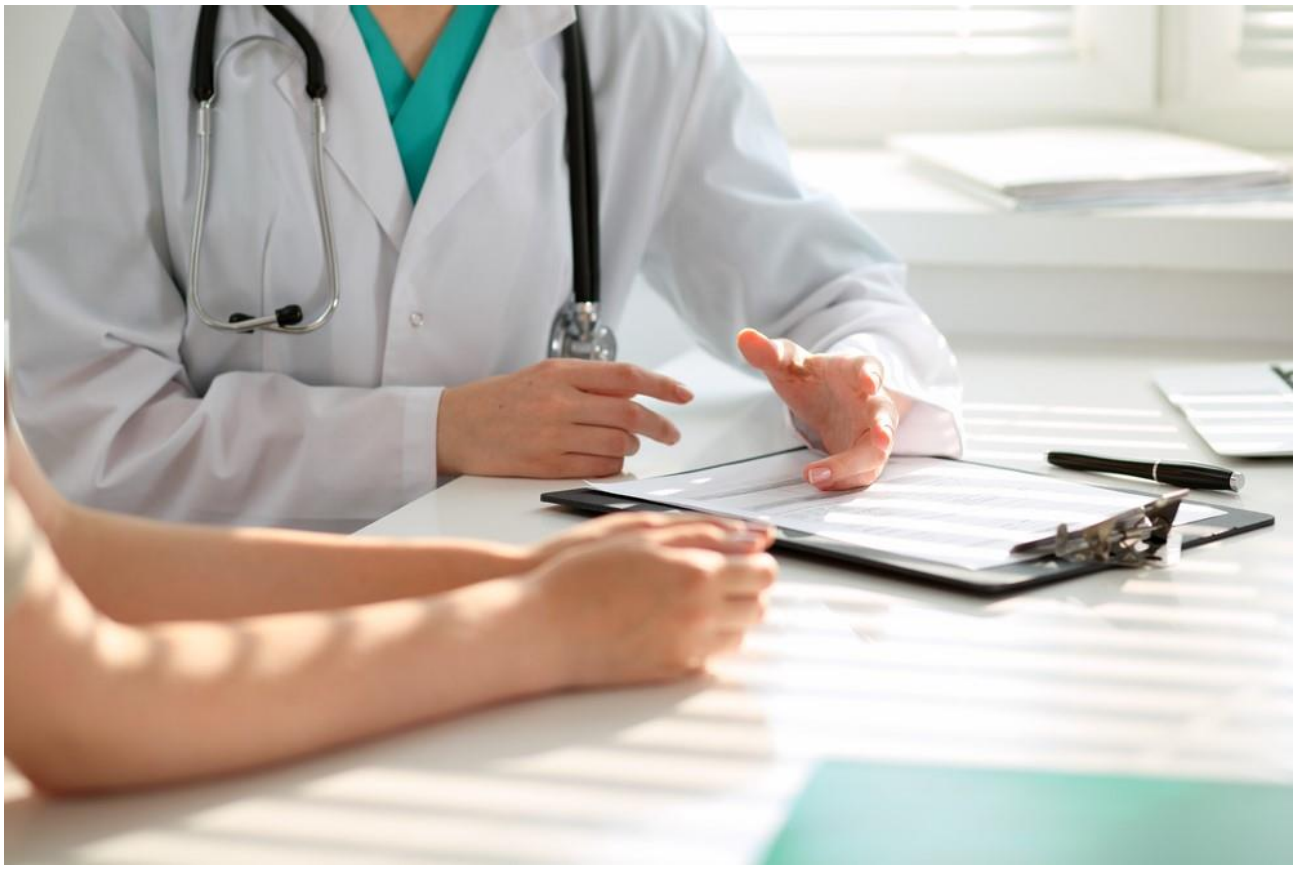

DMC Healthcare
Prescribing Guide

DMC Dermatology Formulary 2021

BHR ICP version

DMC Healthcare Ltd

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Contents

Introduction

This prescribing guidance is based on advice from the British Association of Dermatologists https://www.bad.org.uk and Primary Care of Dermatological Society Guidelines http://www.pcds.org.uk and has been revised in conjunction with latest evidence, encompassing the Summary of Product Characteristics (SmPC), for each medicine, available on the Electronic Medicines Compendium (EMC) which is compiled by each manufacturer, after MHRA review and authorization and in the UK, in accordance with ABPI standards.

DMC Healthcare is not affiliated, nor driving the commercial agenda of any pharma company, in relation to sequencing and switching of medicines, as per their therapeutic indications.

Please review the Medicines Template on EMIS and be aware of the alerts available on both EMIS and SystmOne, when recording prescribing decisions.

- These systems are aligned and updated by the MHRA, NICE and NHSE governing bodies.
- EMIS also provides helpful up-to-date links to Patient Information Leaflets, the advice from which may be incorporated into the Action Plan, that is attached to the letter that is then sent to the referring GP practice/ Patient.

It is the duty of the prescribing physician, to ensure each patient is assessed on an individual patient basis and that prescribing advice and decisions are recorded as part of Good Medical Record Keeping, in accordance with the GMC Good Medical Practice Guidance.

We do not encourage clinicians to issue any medications that are not aligned to the SmPC for the medication, nor outside of their local policies, which must be viewed in conjunction with this DMC Formulary Guidance.

Off-label medicines or 'specials' should be requested under special circumstances and should not be routinely prescribed. Any unlicensed medicines should only be prescribed if supported by guidance and evidence and a named contact should be provided to support the prescribing if needed.

Each prescribing judgement made outside of the recommendations (e.g. off license/ off-label issues) needs to be evaluated through risk assessment and record via the governance team dmc.governance@nhs.net
We encourage these individual incidences to be reported by email, or by DATIX, as part of mandatory clinical governance.

Writing to Primary Care GP & Clinicians

Please ensure when DMC clinicians are asking GP practices to continue or initiate products, it is imperative to ensure you help manage patient's expectations by informing them that they will be required to purchase OTC products in line with BHR ICP position statements. This information should be reflected in any written correspondence (clinic / discharge letters) you send on to the GP practice and patients.

Useful Links

Please ensure you refer to the EMC SmPC for each medicine and contact the manufacturer, with any specific queries: https://www.medicines.org.uk/emc

You have a duty of care, to fulfil all Yellow Card Reporting Responsibilities. Access to the link is available here: https://yellowcard.mhra.gov.uk/

Please also inform the governance team via email or complete a DATIX of the safety-related event/ reaction that took place.

GMC Guidance on ethics around medicines
The 2013 GMC Prescribing Guide is available on our SharePoint: https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/prescribing-andmanaging-medicines-and-devices

ABPI guidance on prescribing
https://www.abpi.org.uk/our-ethics/appropriate-prescribing/

BMJ Article on Good Medical Record Keeping https://www.bmj.com/content/348/bmj.f7716

MDU Good Record Keeping Guidance
https://www.themdu.com/guidance-and-advice/guides/good-record-keeping

Conditions

1.0 Acne

Isotretinoin (oral): Consultant only, in accordance with CCG policy. – **Not for primary care prescribing**

Topical treatment: Avoid topical antibiotics as sole agents.
There is no evidence that retinoids or Benzyl peroxide prevent antibiotic resistance developing in combination products.

- Benzyl Peroxide (BPO)5% – **advise to self-care and buy OTC**
- 0.1% adapalene gel
- Epiduo (adapalene and benzyl peroxide) gel, other options include Treclin gel (clindamycin and tretinoin).
- Oral antibiotics: Prescribe one-month supply or as per local CCG agreement in place.
- GP to repeat thereafter as advised or deemed clinically appropriate, repeating for a course duration of **normally 3 months**. Ideally 3 months, evidence suggests that for most patients there is little additional benefit in using antibiotics for more than 3 months in any given treatment period - however, patients relapsing quickly after stopping treatment may be better suited to 6-month courses
- 408mg od Lymecycline (oral)– first line. For severe acne referred to secondary care or GPwSI high dose of lymecycline 408mg BD can be considered for up to 4 weeks when Isotretinoin cannot be started straight away or at all.
- 100mg od Doxycycline (oral) – second line if response to lymecycline is poor. Counsel patient on photosensitivity.
- 500mg bd Erythromycin (oral). Macrolides should generally be avoided due to high levels of resistance but can be used is tetracyclines are contraindicated e.g. in pregnancy.
- 300mg bd Trimethoprim (oral)
- 200mg od Spironolactone (off-label) (oral) **specialists prescribing only**.
- Dianette® (cyproterone 2mg in combination with ethinyl estradiol): last line for severe acne where other treatments (topical or systemic antibiotics) have failed in women of child-bearing age. There

is a rare but increased VTE risk; counsel patients to remain vigilant for signs and symptoms for DVT/PE. Review regularly and withdraw upon resolution of symptoms. The need to continue treatment should be evaluated periodically by the treating physician. Please refer to the MHRA guidance.

- Low dose cyproterone (2mg) in combination with ethinyl estradiol, is contraindicated in patients with previous or current meningioma.
- Acne in pregnancy: The mainstay of treatment should be topical treatment, either benzoyl peroxide preparations or 2% topical erythromycin (topical retinoids are contraindicated).
  The option of oral erythromycin 500 mg BD should be discussed with the patient if the potential benefits outweigh the possible risks, for example in scarring acne.

2.0 Actinic Keratosis

- Sun block/sun avoidance advice (**advise to selfcare and buy OTC**)
- Cryotherapy
- Fluorouracil 5% cream (ideally bd for 3 weeks) topically
- Daylight PDT with Metvix® for large areas by specialists in secondary care

3.0 Bowen's Disease

1st line: Cryotherapy or Curettage & Cautery
2nd line: Fluorouracil 5% cream - ideally bd for 3 weeks topically

4.0 Cradle Cap (Seborrhoeic dermatitis – infants)

Refer to position statement – Prescription should not be offered

A prescription for treatment of cradle cap should not routinely be offered in primary care as the condition is self-limiting and will clear up on its own without the need for treatment.

Cradle cap is harmless and does not usually itch or cause discomfort. It usually appears in babies in the first two months of their lives and clears up without treatment within weeks to a few months.

5.0 Dandruff

A prescription for treatment for dandruff should not routinely be offered in primary care as the condition is appropriate for self- care. A GP appointment is unnecessary.

Patients should be encouraged to manage mild dandruff with long term over the counter treatments.

6.0 Discoid Lupus

1st line: Sun block advice. Sunsense (**patients to self-care and buy OTC**)

2nd line: Topical steroids (see below)

3rd line: Tacrolimus 0.1% ointment 30g topically. Only for patients aged 16 and over.

4th line: Oral hydroxychloroquine 5mg/kg per day. Maximum one month
DMC to arrange hospital ophthalmology review within 6 months of starting and every 5 years as per RCOpth guidelines 2018. Switch brands if GI upset
Use with caution if taking oral Tamoxifen or poor renal function
Efficacy increased if prescribed at 5mg/kg and smoking stopped- please ensure medical record up to date regards smoking cessation advice given and accepted by patient. (Secondary care only)

Low dose Mepacrine with low dose Hydroxychloroquine occasionally more effective than monotherapy. – **DMC to retain prescribing of this**

7.0 Topical Steroids

Topical steroids: Many options are available and listed below are the most commonly prescribed and recognised. Patients and other doctors will be familiar with the common products and their relative potency. Please refer to the online BNF for further information.

Prescribe generically

- Betamethasone valerate 0.025% 30g/100g - cream or ointment
- Betamethasone valerate 0.1% application or mousse - cream, ointment, lotion, scalp
- Clobetasol propionate 0.05% - cream, ointment or scalp application
- Mometasone furoate 0.1% - cream, ointment or scalp application
- Clobetasone butyrate 30g - cream or ointment
- Fucibet Cream - Short term only - Maximum two weeks
- Hydrocortisone 0.5% or 1% - ointment or cream

- Fluocinolone acetonide 0.025% 30g/60g gel
- Trimovate® Cream - this is expensive (although often Eumovate is more than sufficient and more cost effective)
- Clobetasol Propionate 0.05% Shampoo- short contact to minimize exposure to superpotent steroid where treatment is likely to be prolonged. Also, the most practical vehicle for the scalp when the hair is long.
- Diprosalic ointment or scalp application is **expensive**. - Avoid as no evidence that it is more efficacious than non-salicylic acid containing scalp or skin products - even if very scaly.

Combination products of topical steroid plus antibiotic or anti-septic or anti-fungal agent show no added advantage compared to topical steroid alone. These are often expensive and increase the risk of antibiotic resistance and contact allergy.

8.0 Dry eyes/ Sore tired eyes

Refer to BHR ICP position statement

A prescription for treatment of dry eyes should not routinely be offered in primary care as the condition is appropriate for self- care.

Most cases of sore tired eyes resolve themselves. Patients should be encouraged to manage both dry eyes and sore eyes by implementing some self-care measures such as good eyelid hygiene and avoidance of environmental factors alongside treatment.

Mild to moderate cases of dry eye syndrome or sore tired eyes can usually be treated using lubricant eye treatments that consist of a range of drops, gels and ointments that can be easily be purchased over the counter.

There is an exception for 'Red Flag' symptoms. This should be recorded and discussed with GP and/or ophthalmologist for referral.

Consider an ocular lubricant in line with the BHR formulary.

9.0 Eczema

Please also see section appendix D - emollients

1st line: Topical steroids (see above)

2nd line: Fludroxycortide 4 micrograms per square centimetre tape - prescribe 50cm roll (not 2m roll) hand and foot fissures or localised areas of lichenification. Betesil medication plaster (betamethasone valeate 2.25mg) is alternative.

3rd line: Tacrolimus 0.1% ointment 30g topically. Only licensed for patients aged 16 and over.

4th line: Pimecrolimus 1% (topical) if Tacrolimus (topical) not tolerated.

5th line: Tapering course of oral prednisone starting at 30mg or 40mg (if greater than 80kg) per day and reducing by 5mg per week to zero.

When infected – prescribe oral antibiotic or oral anti-viral (if Herpes Simplex Virus a concern). Flucloxacillin for 7 days or Clarithromycin if penicillin allergic.

Secondary Care Referral for second line systemic agents or phototherapy

10.0 Fungal/Tinea

1st line: Oral Terbinafine 250mg OD. Course length varies – refer to BNF

2nd line: Oral Itraconazole (in most situations) 200mg. Course length varies – refer to BNF

3rd line: Pulse Itraconazole (Nail Infections)

100mg daily for one week – Repeat every month for 6 months (more cost effective and safer than terbinafine)
Prescribe a 1-month supply. GP can re-prescribe to complete the course once initiated in clinic.

4th line: Children – consider Terbinafine as an "off-label" alternative for children

1-17 years old (not recommended below 10kg).
10-19kg – 62.5mg daily (quarter of a 250mg tablet)

29-39 kg – 125mg daily (half of a 250mg tablet)

Over 40kg – standard adult dose of 250mg daily

Fungal infection of the toenails requires 3 to 6-month continuous treatment (depending on severity) of terbinafine or itraconazole. To be prescribed by DMC for one month and continued by GP as recommended.

11.0 Head lice

Refer to BHR ICP position statement

A prescription for treatment of head lice will not routinely be offered as the condition is appropriate for self-care.

Live head lice can be treated by wet combing; chemical treatment is only recommended in exceptional circumstances and in these cases over the counter medicines can be purchased from a pharmacy.

If appropriate, everyone in the household needs to be treated at the same time - even if they do not have symptoms.

12.0 Insect bites and stings

A prescription for treatment for insect bites and stings will not routinely be offered in primary care as the condition is appropriate for 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.

13.0 Infrequent cold sores of the lip

Refer to BHR ICP position statement

A prescription for treatment of cold sores should not routinely be offered in primary care as the condition is self-limiting and will clear up on its own without treatment.

Cold sores caused by the herpes simplex virus usually clear up without treatment within 7 to 10 days. Antiviral creams are available over the counter from pharmacies without a prescription and if used correctly, these can help ease symptoms and speed up the healing time.
To be effective, these treatments should be applied as soon as the first signs of a cold sore appear. Using an antiviral cream after this initial period is unlikely to have much of an effect.
Exceptions include immunocompromised patients and 'Red flag' symptoms

14.0 Lichen Planus

1st line: Tapering course of oral prednisone starting at 30mg or 40mg (if greater than 80kg) per day and reducing by 5mg per week to zero.
Secondary Care Referral for second line systemic agents or phototherapy.

15.0 Mild dry skin

Refer to BHR ICP position statement

A prescription for treatment of dry skin should not routinely be offered in primary care as the condition is appropriate for self- care.

Emollients are often used to help manage dry, itchy or scaly skin conditions. Patients with mild dry skin can be successfully managed using over the counter products on a long-term basis.

16.0 Mild irritant dermatitis

Refer to BHR ICP position statement

A prescription for treatment of contact dermatitis should not routinely be offered in primary care as the condition is appropriate for self-care.

It is most commonly caused by irritants such as soaps, washing powders, detergents, solvents or regular contact with water.

Treatment normally involves avoiding the allergen or irritant and treating symptoms with over the counter emollients and topical corticosteroids.

17.0 Minor burns and scalds

Refer to BHR ICP position statement

A prescription for treatment of minor burns and scalds should not routinely be offered in primary care as the condition is appropriate for self-care.

However more serious burns always require professional medical attention. Burns requiring hospital A&E treatment include but are not limited to:

- all chemical and electrical burns;
- large or deep burns;
- burns that cause white or charred skin;
- burns on the face, hands, arms, feet, legs or genitals that cause blisters.

18.0 Mouth Ulcers

A prescription for treatment of mouth ulcers should not routinely be offered in primary care as the condition is appropriate for self-care.

Mouth ulcers are common and can usually be managed at home, without seeing your dentist or GP. However, OTC treatment can help to reduce swelling and ease any discomfort.

19.0 Nappy Rash

A prescription for treatment of nappy rash should not routinely be offered in primary care as the condition is appropriate for self-care. Nappy rash can usually be treated at home using barrier creams purchased at the supermarket or pharmacy.

Nappy rash usually clears up after about three to seven days if recommended hygiene tips are followed.

20.0 Pruritus

Investigate cause and treat or GP to treat

1st line: **Emollients (refer to CCG for emollient formulary)**

Refer to BHR ICP position statement

or Localised topical steroids

2nd line:- Doxepin hydrochloride 5% Cream-(topical)

3rd line: Emollients and Topical Steroids and Oral Amitriptyline – Maximum 50mg nocte

Secondary Care Referral for second line systemic agents or phototherapy

21.0 Psoriasis

Emollients should be used as both soap substitutes and leave on preparations for all patients, alongside active topical therapies.

1st line: Generic topical steroids

2nd line: Enstilar® Foam topically (calcipotriol & betamethasone dipropionate) – daily/as needed. Also effective on scalp psoriasis. Counsel patient to shake well before use and warn that is highly flammable.

3rd line: Dithrocream® topical (5 strengths should be prescribed as one item on prescription). Useful for small areas

Note: Do not prescribe calcipotriol & betamethasone dipropionate ointment / gel as both are less effective than the foam formulation

For face and flexures

1st line: 0.1% tacrolimus topical ointment – for face or flexures only. (Licensed for adults and adolescents aged 16 years and above(.

2nd line: Calcitriol 3mcg/g ointment topically

Cocois Ung Coco – where topical steroids have failed to work on the scalp

Note: Calcitriol 3mcg/g ointment *mane plus Betnovate or Mometasone nocte is cheaper than Dovobet ointment or gel*

22.0 Ringworm/Athlete's foot

Refer to BHR ICP position statement

A prescription for treatment of ringworm or athlete's foot will not routinely be offered in primary care as the condition is appropriate for self-care except for Lymphoedema or history of lower limb cellulitis.

23.0 Rosacea

1st line: Topical metronidazole (Rozex®) 0.75% cream 30g – cheaper than most generic topical metronidazole preparations

2nd line: Ivermectin (Soolantra®) 10mg/g cream (most effective topical) or Azelaic acid (Finacea®) 15% cream are options. Soolantra® prescribing is non formulary product at BHR ICP – specialist to retain prescribing.

Oral Antibiotics

- Lymecycline 408mg od orally
- Doxycyline 100mg OD orally

Aim for 3 months in total. One month and GP to re-prescribe. Re-prescribe as 3 monthly courses if patient relapses. If the patient does not respond to two repeated courses or two types of antibiotics, especially if they are starting to scar, the patient should be referred for consideration of Isotretinoin

If the above are not tolerated. Can recommend the only licensed oral agent for Rosacea:

- Doxycycline M/R 40mg (Efracea®) orally

For Steroid Induced Rosacea - (peri-oral dermatitis)

- Lymecycline 408mg od for 8weeks orally

For redness and burning

- Mirvaso® gel – (topical 0.03% brimonidine) Only licensed product available (see BNF for further information.
- Does not work for static redness or facial thread veins.

  Must effectively treat inflammatory rosacea (papules and pustules) or skin dryness before using. Must use daily to avoid rebound flares. Refer to the MHRA warning regarding prescribing advise to minimise risk of symptom exacerbation. https://www.gov.uk/drug-safety-update/brimonidine-gel-mirvaso-risk-of-exacerbation-of-rosacea

24.0 Scabies

Refer to BHR ICP position statement

- 30gm Permethrin Cream 5% (topical) – **to purchase OTC**

  Permethrin cream prevents re-infection for up to 2 weeks so not everybody needs to be treated at exactly the same time.
  Close family and friends will also have to purchase this OTC

25.0 Seborrhoeic Dermatitis

Scalp formulations

- Ketoconazole 2% shampoo (adolescents and adults) – leave on for 5 minutes then rinse off
- Selenium sulphide shampoo - leave on for 5 minutes then rinse off

Other topical preprations

- Daktacort Cream / Ointment 30g (off-label) topical available over the counter
- Clobetasone butyrate 0.05% cream 30g-topical
- Hydrocortisone Cream 1% 15g / 30g topical
- Mometasone furoate 0.1% Cream 30g topical
- Tacrolimus 0.1 % ointment-30gm topical. Only for patients aged 16 and over.

26.0 Sunburn

Refer to BHR ICP position statement

A prescription for treatment of sunburn should not routinely be offered in primary care as the condition is appropriate for self- care.
Most people manage sun burn symptoms themselves or prevent symptoms developing, using sun protection, by using products that can easily be bought in a pharmacy or supermarket.

27.0 Urticaria

BAD patient information sheet essential (see www.bad.org.uk)

1st line: Stool sample for Ova, Cysts & Parasites; if recent foreign travel & check skin for parasitic worms.

2nd line: Thyroid Function Test if urticaria is chronic

3rd line: Biopsy if individual lesions last more than 24hrs

4th line: Prescribe a maximum 2 weeks of anti-histamine (available OTC)

5th line: Provide patient and GP with a list of alternative non-sedating antihistamines to work through

For example:

- Cetirizine 40mg od
- Fexofenadine 180mg od. Off-label use of Fexofenadine 180mg BD and up to 360mg BD is an unlicensed dose prescribed for chronic spontaneous urticaria and this dose of non-sedating antihistamines may be required to adequately control symptoms.
- Loratadine or Desloratadine 10mg od
- Ranitidine 300mg od or bd (Since June 2020 Ranitidine shortage, prescribe the above until available) consider Famotidine / Nizatidine

Additional actions as per Primary Care Dermatology Society Guidelines

- GP /patient to remove NSAIDs or Aspirin
- GP to stop ACE inhibitor or ACE receptor antagonist
- GP to add in Ranitidine (H2 blocker).
- GP to add in Montelukast 10mg od for physical or aspirin aggravated urticaria (contra-indicated if parasitic worm infection present).

28.0 Warts and Verrucae

Refer to BHR ICP position statement

A prescription for treatment of warts and verrucae will not routinely be offered in primary care as the condition is appropriate for self-care.
Several treatments can be purchased from a pharmacy to get rid of warts and verrucae more quickly if patients require treatment.

29.0 Xerosis

Glycerol or urea containing emollients (see emollients section) Dermol 200 – patient to buy O.T.C

DMC Medicines of Low Priority

This document lists relevant dermatology medicines that have been assessed by the CCG and considered to be of low priority for prescribing and as such, unsuitable for prescribing on the NHS. Please review patients prescribed these medicines for appropriateness, safety and cost-effectiveness and determine whether to continue treatment if the patient fulfils circumstances listed below, in which use might be appropriate or change the medicines to a more cost-effective choice or stop prescribing the medicine.

Please refer to https://www.england.nhs.uk/medicines-2/items-which-should-not-be-routinely-prescribed/ for a complete list.

1. Bath & Shower Gels

Refer to BHR ICP position statement

Bath Oils and Tar Shampoos show little clinical efficacy and must not be prescribed. Emollient creams and ointments can be prescribed in the bath.

2. Bone protection

GP to manage:

- Oral Alendronate 70mg Weekly

  Should be prescribed only after 3 months of oral corticosteroids

  (any dose – whether continuous or intermittent) as per National Guidelines

GP to manage and prescribe:

- Cholesterol, Thyroid or Iron correction unless urgent action required

3. Bandages

Tube Bandages – as dry dressings over Topical Steroid

- Tubifast 3m or 5m Prescribe 1m for torso
- Comfifast 3m or 5m Prescribe 1m for torso (cheaper) Paste – leave on for two days. Tubifast or Comfifast over the top

- Ichthyopaste Prescribe as 6m
- Viscopaste Prescribe as 6m
- Zipzoc Prescribe as 'Carton of 4'. Leave on for several days.

Wet Wraps - No evidence that any better than straight forward bandages

- Two layers of Tube Bandage. Bottom layer wet. Top layer dry.

  Steroid / Emollient underneath

4. Camouflage Topical Preparations and Covering Creams

Camouflage topical preparations are prescribable on the NHS in accordance with the ACBS guidance for disfiguring skin conditions (birthmarks, mutilating lesions and scars) on the recommendation of a specialist only.
Circumstances in which use might be appropriate: The Drug Tariff Part XV - borderline substances, specifies that the following products can be prescribed on FP10 prescription (by endorsement of ACBS) as covering creams for concealment of postoperative scars, birthmarks, mutilating skin lesions and as an adjunctive therapy in the relief of emotional disturbances due to disfiguring skin disease, such as vitiligo.

- Covermark® Classic Foundation and Finishing Powder
- Veil® Cover Cream and Finishing Powder

Suggested alternative: Can be purchased over the counter if ACBS criteria is not met.

5. Eflornithine cream (Vaniqa®) for hirsutism

Refer to BHR ICP position statement

Eflornithine cream (Vaniqa®) cream for hair removal should not be prescribed.

Background and evidence: There is no evidence of its efficacy in comparison to existing treatments and it is substantially more expensive. It needs to be used indefinitely but the long-term benefits and safety have not been established (past 24 weeks).
Suggested alternative: Systemic licensed therapies.

6. Gamolenic Acid (Evening Primrose Oil)

Background and evidence: Product licenses for gamolenic acid were withdrawn in October 2002 due to lack of efficacy following a review by the Committee on Safety of Medicines (CSM) of all the relevant information which did not support the standard of efficacy required at that time, for the authorisation of these products as medicines for the treatment of eczema and mastalgia. **No alternative. Not recommended for prescribing on the NHS.**

7. Sun Protection

Refer to BHR ICP position statement

A prescription for sun protection should not routinely be offered in primary care as the condition is appropriate for self-care except for ACBS approved indication of photodermatoses (i.e. where skin protection should be prescribed)

Prescribable sunscreens are:

- LA Roche-Posay Anthelios XL SPF 50+ Melt In Cream
- Sunsense Ultra (Ego) SPF 50+
- Uvistat Lipscreen SPF 50
- Uvistat Suncream SPF 50

These preparations are marked 'ACBS'. This means they can be prescribed for skin protection against ultraviolet radiation in the following specific conditions ONLY:

- Abnormal cutaneous photosensitivity resulting from genetic disorders (albinism or xeroderma pigmentosum)
- Photodermatoses resulting from radiotherapy
- Chronic or recurrent herpes simplex labialis.
- Vitiligo

Preparations with SPF less than 30 should not normally be prescribed. Advisory sunscreen because of risk of skin cancer is not a qualifying condition and should be regarded as routine sun protection.

Suggested alternatives: For routine sun protection, patients should be advised to self purchase sunscreen preparations with dual protection against UVB and UVA rays with an SPF value minimum of 30.

8. Prednisolone 5mg enteric coated tablets

Background and evidence: Enteric coated prednisolone formulations were developed in the 1950s to abate ulceration from the direct action of corticosteroids on the gastric submucosa.

However, enteric coating will make no difference unless they reduce efficacy (as per pharmacokinetic studies noting a slower and lower time to peak plasma concentration). The reduction in ulceration by using enteric preparations is speculative only. EC-coated tablets may be associated with less predictable absorption and in certain conditions where plasma levels of prednisolone needs to be stable and predictable, the EC coated preparations would be unsuitable.
Suggested alternative: Prednisolone 5mg tablets

9. Probiotics

Probiotics should not routinely be prescribed due to limited clinical evidence. Exception is made for ACBS approved indication: Maintenance of remission of ileoanal pouchitis induced by antibacterials.

10. Vitamins and minerals

Refer to BHR ICP position statement

Vitamins and minerals should not routinely be prescribed due to limited clinical evidence.

Vitamins and minerals are essential nutrients which most people can and should get from eating a healthy, varied and balanced diet. In most cases, dietary supplementation is unnecessary.

Any prescribing not in-line with listed exceptions should be discontinued. This guidance does not apply to prescription only vitamin D analogues such as alfacalcidol and these should continue to be prescribed.

Exceptions include:

- Medically diagnosed deficiency, including for those patients who may have a lifelong or chronic condition or have undergone surgery that results in malabsorption. Continuing need should however be reviewed on a regular basis.
- NB maintenance or preventative treatment is not an exception.
- Calcium and vitamin D for osteoporosis.

- Malnutrition including alcoholism (see NICE guidance)
- Patients suitable to receive Healthy start vitamins for pregnancy or children between the ages 6 months to their fourth birthday.

11. Silk garments

Refer to BHR ICP position statement

- Prescribers in primary care should not initiate silk garments for any patient. No routine exceptions have been identified.
- The CLOTHES trial concluded that using silk garments for the management of eczema is unlikely to be cost-effective for the NHS.
- There is currently no UK guidance which recommends the use of silk garments for any clinical condition.
- NICE guidance on treatment of atopic eczema in children (2007) made no recommendations about the use of such garments in the management of eczema, though they included one of the largest studies in their review2.

Appendix A1: DMC Medicines Optimisation Policy

There is an increasing range of resources on health promotion and the management of minor – self - treatable illnesses.

Many community pharmacies are also open extended hours including weekends and are ideally placed to offer advice on the management of minor conditions and lifestyle interventions.

Useful Links

Find out more about the conditions for which over the counter medicines will no longer be prescribed:
https://www.england.nhs.uk/medicines/items-which-should-not-be- routinely-prescribed/

The Royal Pharmaceutical Society offers advice on over the counter products that should be kept in a medicine cabinet at home to help patients treat a range of self- treatable illnesses:
https://www.rpharms.com/resources/ultimate-guides-and- hubs/patient-engagement-hub/

NHS England Patient information leaflets:
https://www.england.nhs.uk/publication/prescribing-of-over-the-counter-medicines-ischanging/

Self-Care for minor ailments: http://www.selfcareforum.org/wp-content/uploads/2011/10/haynes-self-care-minimanual.pdf

Exemptions

- Patients prescribed an OTC treatment for a long-term condition
- For the treatment of more complex forms of minor illnesses
- For those patients that have symptoms that suggest the condition is not minor
- Treatment for complex patients (e.g. immunosuppressed patients).
- Patients on prescription only treatments.
- Patients prescribed OTC products to treat an adverse effect or symptom of a more complex illness and/or prescription only medications should continue to have these products prescribed on the NHS.
- Circumstances where the product license doesn't allow the product to be sold over the counter to certain groups of patients. This may vary by medicine, but could include babies, children and/or women who are pregnant or breastfeeding. Community Pharmacists will be aware of what these are and can advise accordingly.
- Patients with a minor condition suitable for self-care that has not responded sufficiently to treatment with an OTC product.
- Patients where the clinician considers that the presenting symptom is due to a condition that would not be considered a minor condition.
- Circumstances where the prescriber believes that in their clinical judgement, exceptional circumstances exist that warrant deviation from the recommendation to self-care.
- Individual patients where the clinician considers that their ability to self-manage is compromised because of medical, mental health or significant social vulnerability to the extent that their health and/or wellbeing could be adversely affected, if reliant on self-care. To note that being exempt from paying a prescription charge does not automatically warrant an exception to the guidance.
  Consideration should also be given to safeguarding issues.

Restricted or Prohibited Use

- Acitretin, Allotretinoin and Fumaric Acid Esters are not prescribed or dispensed in community service clinics

- Refer patients for Methotrexate, Azathioprine, Dapsone and other systemic agents to Secondary Care. Except in Worcestershire.
- Treatment for Melasma should not be prescribed (eg Alezaic acid, Pigmanorm or Klingmans).
- Vaniqa cream for hair removal should not be prescribed.
- Finasteride for female excess hair or male/female hair loss should not be prescribed.
- Bath Oils and Tar Shampoos show little clinical efficacy and must not be routinely prescribed.
- Avoid topical antibiotics as sole agents.
- There is no evidence that retinoids or Benzyl peroxide prevent antibiotic resistance developing in combination products.
- Mirvaso gel does not work for static redness or facial thread veins
- Combination products of topical steroid plus antibiotic or anti-septic or antifungal agent show no added advantage compared to topical steroid alone. These are often expensive and increase the risk of antibiotic resistance and allergic contact allergy.
- Wet Wraps - No evidence that any better than straight forward bandages
- DIPROSALIC ointment or scalp application is EXPENSIVE. Avoid as no evidence that it is more efficacious than non-salicylic acid containing scalp or skin products - even if very scaly.
- Gamolenic Acid (Evening Primrose Oil) is not recommended for prescribing on the NHS.

Appendix A: DMC Patient Letter Template

Dear <<Title>><<Last Name>>,

Here at DMC Healthcare, we are constantly reviewing our prescribing to ensure all patients have access to the best, most effective treatments available. As you will be aware there is significant pressure on the NHS to ensure that resources are used in the most cost-effective way to ensure the best care for all patients.

The team has recently been reviewing all the patients at the surgery who are currently prescribed various medications where a small change can help us to make significant savings for the NHS as a whole.

Please select one of the TWO options below and remove as appropriate

You are currently taking <<enter medication>> and we recommend <<enter new medication/ stay with this medicine>>, which is available for you to purchase over-the-counter at your pharmacy. As such <<enter medication>> has now been stopped and will no longer be available on prescription.

We do not anticipate that you will experience any adverse reactions from this change. Please read the information leaflet enclosed in your new pack. I hope you will find this satisfactory and if you have any queries regarding this change, do not hesitate to ask your community pharmacist, nurse or GP.

Please do not hesitate to get in touch with any feedback, we welcome your input:
info@dmchealthcare.co.uk

Kind regards,

DMC HEALTHCARE SPECIALITY SERVICES DERMATOLOGY TEAM

Appendix B1: DMC Hyperhidrosis Clinical Guide & Prescribing Recommendations

Hyperhidrosis can be defined as sweating in excess of the body's homeostatic requirements and can range from moderate moisture to severe dripping.

Primary hyperhidrosis only affects certain parts of the body, most commonly the armpits, then the feet and hands or more rarely, the face or scalp; some patients exhibit primary hyperhidrosis at more than one location. Symptoms typically start during childhood or adolescence and peak in the third decade. Hyperhidrosis can lead to emotional and physical impairment, affecting professional and social activities and reducing health-related quality of life.

- Patients with a Hyperhidrosis Disease Severity Scale (HDSS) score of 1–2 should be treated in primary care and not referred to secondary care
- Refer to a dermatologist if there is evidence that treatment (first-line: topical aluminium chloride; second-line: oral systemic anticholinergics [oxybutynin or propantheline; see below regarding glycopyrrolate]) in primary care has been provided and proved unsuccessful (or are contra-indicated) and the patient has an HDSS score of 3–4.
- Prescribing of oral systemic glycopyrrolate is not routinely commissioned (in primary or secondary care) for newly diagnosed patients with hyperhidrosis. Existing patients receiving oral glycopyrrolate should be assessed and switched to oxybutynin or propantheline whenever possible or referred as appropriate (see below).
- Tap-water iontophoresis is commissioned for palmoplantar and axillary hyperhidrosis provided:
- Patient has an HDSS score of 3–4 AND there is evidence that treatment in primary care (as outlined above) has been provided and proved unsuccessful Patients receive initial treatment (7 sessions) in the hospital setting. Maintenance therapy varies according to the individual. The addition of anticholinergic drugs (e.g. glycopyrrolate) to water is not routinely funded.

- Botulinum toxin type A (BTX-A) is commissioned for axillary hyperhidrosis provided:
    - Patient has an HDSS score of 3–4 AND there is evidence that treatment in primary care (as outlined above) has been provided and proved unsuccessful
- If successful, treatment may be repeated when sweat production is back to 50% of baseline (or HDSS score of 3 or 4), with a minimum treatment interval of 6 months (i.e. maximum of two BTX-A treatments per year).
- BTX-A is not routinely funded for palmar, plantar or craniofacial hyperhidrosis
- Endoscopic Thoracic Sympathectomy (ETS) is not routinely commissioned

It is widely recommended by experts that treatment depends on disease severity, focal location, and patient preferences, but usually follows a step-by-step approach moving from conservative to more invasive interventions. The level of evidence to support the use of each intervention at different anatomical sites varies considerably.

Topical aluminium chloride

Although the evidence for topical aluminium salts is limited, it is widely recommended by experts for the initial management of primary focal hyperhidrosis.

Oral anticholinergics

Propantheline bromide is the only oral anticholinergic licensed for hyperhidrosis. Oxybutynin hydrochloride is used off-label and oral preparations of glycopyrronium bromide (glycopyrrolate) are not licensed or available in the UK for treating hyperhidrosis – they must be either imported or prepared by 'specials' manufacturers.
There is only limited evidence that oral glycopyrrolate reduces sweating in this population, and even less for oral propantheline. Oxybutynin appears to be a reasonable alternative to glycopyrrolate considering the evidence base for oxybutynin is at least as good, and it offers savings on drug costs.

Iontophoresis

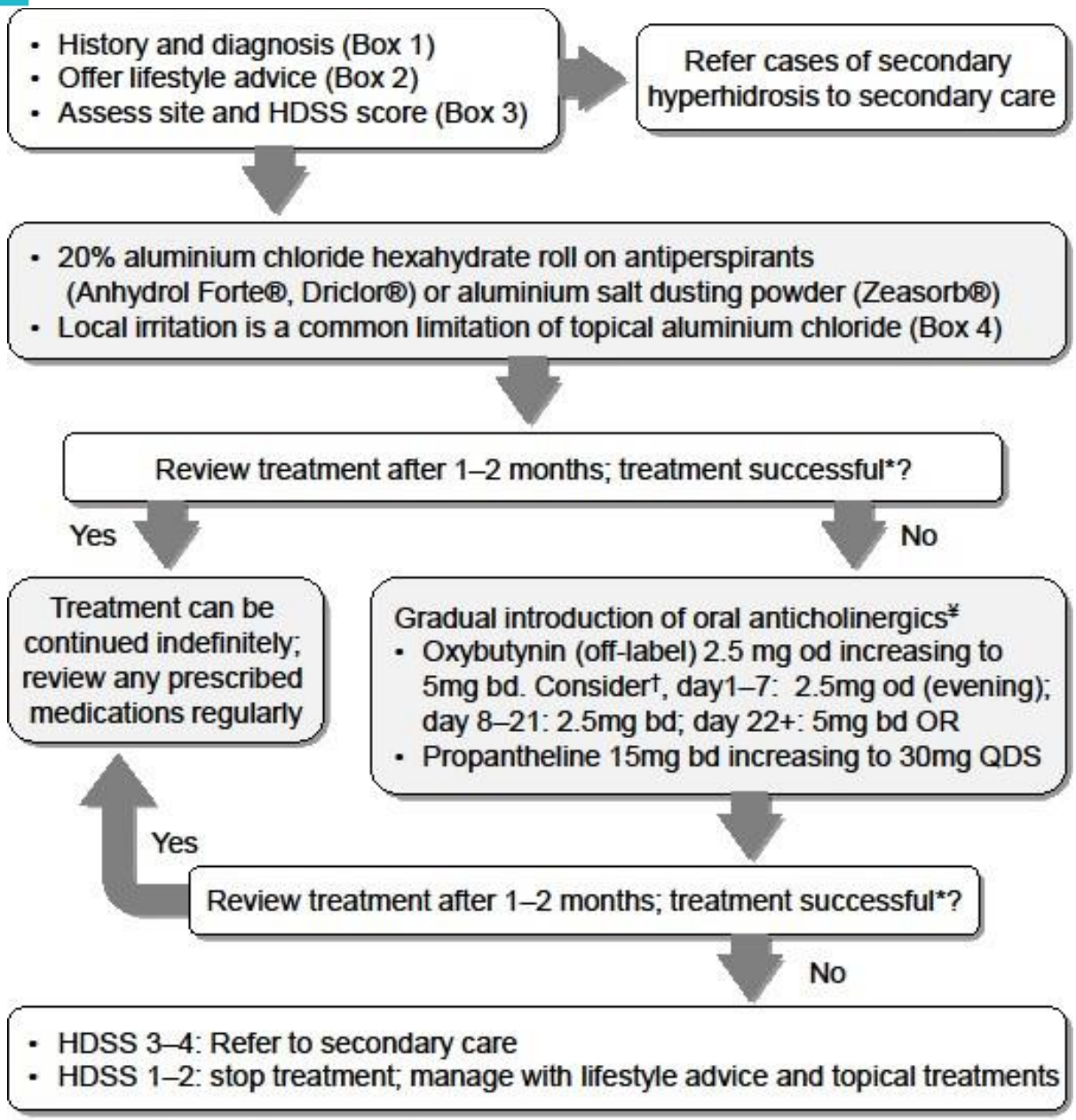
Clinical opinion and several small studies support tap water iontophoresis in palmoplantar disease. Clinical opinion also suggests iontophoresis for axillary disease may be effective in practice, despite a lack of compelling, published evidence. The evidence for adding glycopyrronium bromide solution is more limited (compared to tap-water iontophoresis), is associated with systemic adverse events and drug costs are high

BTX-A

BTX-A is only licensed for hyperhidrosis of the axillae. Several large randomised controlled trials have demonstrated the effectiveness of BTX-A for treating axillary disease. BTX-A for palmar and plantar hyperhidrosis is more painful and the evidence base is less robust (especially for plantar disease). Also, higher doses of BTX-A per hand or sole than per axillae are generally required and transient muscle weakness has been reported. There is only limited evidence for BTX-A for craniofacial hyperhidrosis.

Surgery

Endoscopic Thoracic Sympathectomy (ETS) – the most widely used surgical procedure for hyperhidrosis – is major surgery performed under a general anaesthetic and carries a significant risk of irreversible side effects and complications.

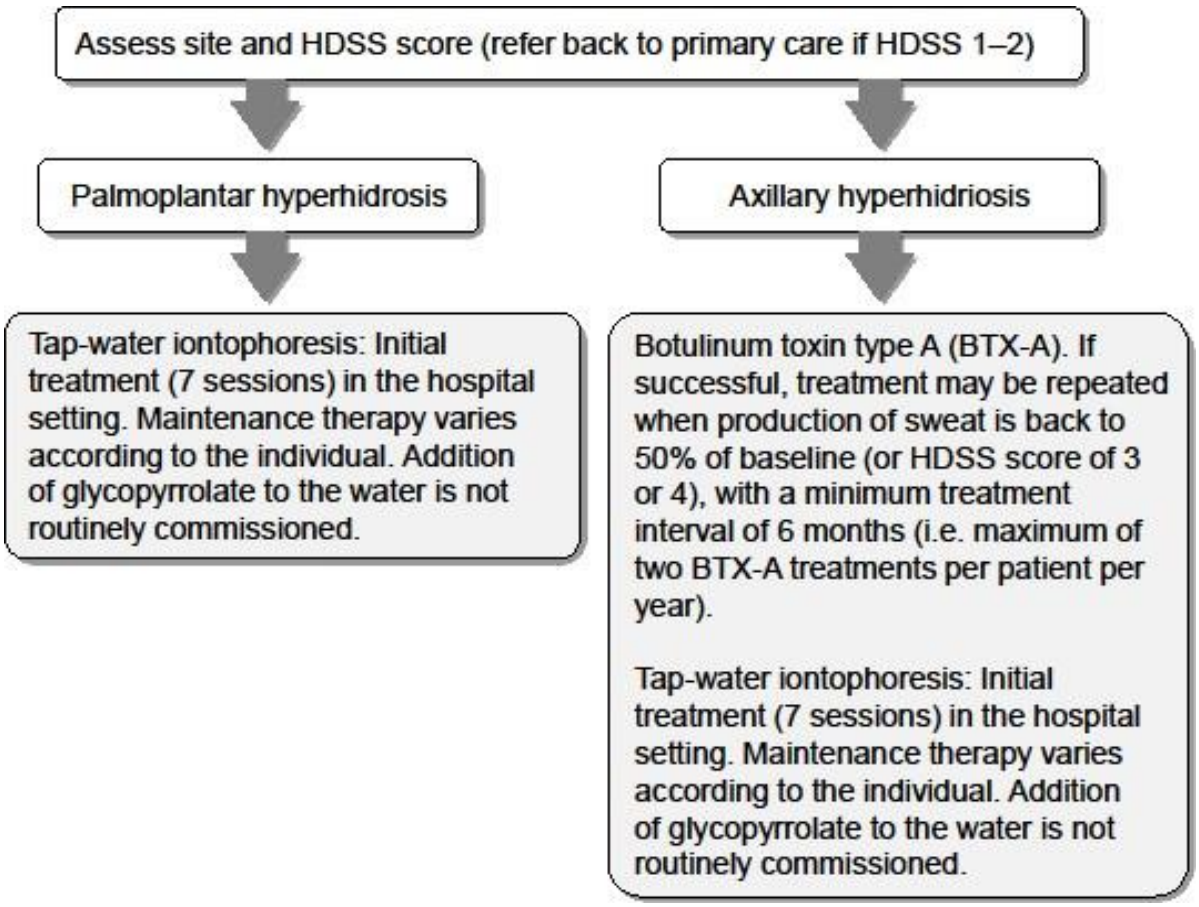


* Successful treatment: Reduction in HDSS score from 3–4 to 1–2. Treatment failure: no change in HDSS or lack of tolerability for treatment.

¥ Glycopyrrolate (unlicensed) is not routinely commissioned. Existing patients should be assessed and switched whenever possible.

† Wolosker N et al. *J Vasc Surg* 2012;55:1696–700.

Appendix B2: DMC Hyperhidrosis Secondary Care



Appendix B2: DMC Hyperhidrosis Useful Data Collection Boxes

Box 1 – Diagnosis of hyperhidrosis

Primary focal hyperhidrosis can be diagnosed when focal, visible, excessive sweating occurs in at least one of the following sites: axillae, palms, soles, or craniofacial region, and:

- has lasted at least 6 months, and has no apparent cause, and has at least two of the following characteristics: bilateral and relatively symmetrical impairs daily activities
- frequency of at least one episode per week onset before 25 years of age
- positive family history
- cessation of local sweating during sleep

If symptoms have lasted less than 6 months or onset is at 25 years of age or older, primary focal hyperhidrosis remains a likely diagnosis if other criteria are met, but extra care should be taken to exclude an underlying cause.

If the presentation is characteristic, and there is no evidence of an underlying cause, no laboratory tests are needed.

For people with suspected secondary focal or generalised hyperhidrosis, the history, examination, and investigations should look for an underlying cause. Appropriate management will often include a referral to secondary care.

Box 2 – Lifestyle advice

Managing patient expectations is important. Give links to patients for further information: Hyperhidrosis Support Group (www.hyperhidrosisuk.org/).
Patients should be advised:

- to avoid known triggers that make sweating worse, such as spicy foods, crowded rooms, alcohol and caffeine
- to use antiperspirant spray frequently, rather than deodorants
- to avoid wearing tight, restrictive clothing and man-made fibres, such as nylon
- that wearing black or white clothing can help to minimise the signs of sweating

- that armpit shields can help to absorb excessive sweat and protect your clothes (these can be obtained via the internet or the Hyperhidrosis Support Group)
- to wear socks that absorb moisture, such as thick, soft socks that are made of natural fibres, or sports socks designed to absorb moisture. Avoid wearing socks that are made of synthetic materials and change socks at least twice a day.
- to buy shoes that are made of leather, canvas or mesh, rather than synthetic material
- to avoid using soap-based cleansers, especially when using aluminium salts. Use emollient washes and moisturisers instead.

Box 3 – Hyperhidrosis Disease Severity Scale (HDSS) score

	Measuring the impact on health-related quality of life may reflect the severity of hyperhidrosis more accurately than isolated quantitative measurements of sweat production, since the level of sweating which causes problems varies between individuals. The easy to use and validated Hyperhidrosis Disease Severity Scale (HDSS) should be used (http://www.sweathelp.org/pdf/HDSS.pdf):	
	How would you rate the severity of your hyperhidrosis?	
1	My sweating is never noticeable and never interferes with my daily activities	Mild
2	My sweating is tolerable but sometimes interferes with my daily activities	Mild
3	My sweating is barely tolerable and frequently interferes with my daily activities	Severe
4	My sweating is intolerable and always interferes with my daily activities	Severe

Box 4 – Application of topical treatments

Anhydrol Forte®, Driclor® should be:

- applied to dry skin of the axillae, feet, hands, or face (avoiding the eyes). Initially for a few hours, gradually increasing to overnight. Care should be taken to ensure that the area of application is completely dry and that the skin is not shaved for 24hrs before or after application.
- always washed off at the first sign of significant sweating and in the morning used every 1–2 days, as tolerated, until the condition improves and then as required, which may be up to every 6 weeks
- Consider soaking lotion pads for application to the face

For plantar hyperhidrosis, Zeasorb® can be used

Local irritation is a common limitation of topical aluminium chloride. It can be managed by the use of topical emollients and soap substitutes, a reduction in the frequency of application, or giving a short course of 1% hydrocortisone cream for up to 2 weeks.

Appendix C: Position Statements from BHR

Position statement on the prescribing for skin rashes

Following the local Spending NHS Money Wisely public consultation, the Governing Bodies of the BHR CCGs met in common on 14th December 2017 to agree changes to prescribing across Barking and Dagenham, Havering and Redbridge.

From 8th January 2018
Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups (BHR CCGs) no longer supports the prescribing for mild skin rashes

Decision

- The decision to stop prescribing over the counter (OTC) medicines used to treat mild skin rashes applies to ALL patients across Barking and Dagenham, Havering and Redbridge, where the below listed exceptions do not apply
- These products include alphosyl shampoo 2 in 1, calamine aqueous cream, calamine lotion, drapolene cream, capasal shampoo, acriflex cream, germolene (not an exhaustive list)

Exceptions

BHR CCGs have agreed exceptions to this recommendation, where they accept that prescribing should continue. Prescriptions may be considered in the following circumstances:

- For moderate to severe skin rashes e.g. psoriasis
- Skin rashes that require the use of a prescription only medicine including steroid creams

This decision was made because:

- BHR CCGs believe treatments for OTC medications to treat mild skin rashes should be bought from a supermarket or pharmacy. These medicines can often be purchased cheaper than the NHS would pay via a prescription
- GPs still have the ability to prescribe for patients when the exceptions apply
- BHR CCGs have a duty to spend taxpayer's money wisely, to make sure they get the best value possible – especially when NHS funding is being severely squeezed and more patients are being seen with more complex health issues than ever before

Position statement on the prescribing of head lice and scabies treatments

Following the local Spending NHS Money Wisely public consultation, the Governing Bodies of the BHR CCGs met in common on 29th June 2017 to agree changes to prescribing across Barking and Dagenham, Havering and Redbridge.

From 10th July 2017
Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups (BHR CCGs) no longer supports the prescribing of head lice and scabies treatments

Decision

- The decision to stop the prescribing of head lice and scabies treatments applies to ALL patients across Barking and Dagenham, Havering and Redbridge. BHR CCGs have agreed NO exceptions to this recommendation

This decision was made because:

- BHR CCGs believe treatments for head lice and scabies should be bought from a pharmacy, who can advise how to use them
- BHR CCGs believe that scabies outbreaks within a care home should be treated by the home through their homely remedies policies'
- BHR CCGs have a duty to spend taxpayer's money wisely, to make sure they get the best value possible – especially when NHS funding is being severely squeezed and more patients are being seen with more complex health issues than ever before

Position Statement on prescribing Eflornithine 11.5% (Vaniqa®) cream

Following the Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups (BHR CCGs) Area Prescribing sub-Committee (APC) meeting held on Tuesday 26th June 2018, the BHR CCGs agree to stop prescribing of Eflornithine 11.5% (Vaniqa®) cream.

From Tuesday 17th April 2018,
Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups (BHR CCGs) no longer supports the prescribing of Eflornithine 11.5% (Vaniqa®) cream

Decision

- The decision to stop the prescribing of Eflornithine 11.5% (Vaniqa®) cream applies to **ALL** patients across Barking and Dagenham, Havering and Redbridge.
- BHR CCGs have agreed **NO** exceptions to this recommendation
- Prescribers are **not** to undertake any new requests to prescribe Eflornithine 11.5% (Vaniqa®) cream on the NHS
- Prescribers should review and de-prescribe Eflornithine 11.5% (Vaniqa®) cream prescribed to their patients

This decision was made because:

- Eflornithine 11.5% cream (Vaniqa®) offers very little benefit for the management of facial hirsutism. There is limited evidence for efficacy and patient satisfaction with Eflornithine 11.5% cream (Vaniqa®)
- BHR CCGs recommend patients to self-fund cosmetic treatments for reduction in hair growth or hair removal (e.g. shaving, plucking, depilatory cream, laser treatment, and electrolysis) as the primary options for patients with hirsutism ☐ BHR CCGs have a duty to spend taxpayer's money wisely, to make sure they get the best value possible – especially when NHS funding is being severely squeezed and more patients are being seen with more complex health issues than ever before

Position statement on prescribing for suncreams

Following the local Spending NHS Money Wisely public consultation, the Governing Bodies of the BHR CCGs met in common on 14th December 2017 to agree changes to prescribing across Barking and Dagenham, Havering and Redbridge.

From 8th January 2018
Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups (BHR CCGs) no longer supports prescribing of suncreams.

Decision

- The decision to stop prescribing for suncreams/screens/blocks applies to ALL patients across Barking and Dagenham, Havering and Redbridge, where the below listed exceptions do not apply

Exceptions

- BHR CCGs have agreed exceptions to this recommendation, where they accept that prescribing should continue. These include:
  Patients that need screening from direct sunlight due to skin cancer and/or protection from UV radiation in proven abnormal cutaneous photosensitivity (Photodermatoses) as advised by a dermatology specialist

This decision was made because:

- BHR CCGs have agreed to enforce the current NHS restriction for prescribing of sunscreens on the NHS (restrictions set by Advisory Committee on Borderline Substances)
- BHR CCGs believe patients who do not fit the agreed exception should purchase suncreams from a suitable retailer
- Suncreams can often be purchased cheaper than the NHS would pay via a prescription.
- BHR CCGs have a duty to spend taxpayer's money wisely, to make sure they get the best value possible – especially when NHS funding is being severely squeezed and more patients are being seen with more complex health issues than ever before.

Position statement on the prescribing of rubefacients

Following the local Spending NHS Money Wisely public consultation, the Governing Bodies of the BHR CCGs met in common on 29th June 2017 to agree changes to prescribing across Barking and Dagenham, Havering and Redbridge.

From 10th July 2017
Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups (BHR CCGs) no longer supports the prescribing of rubefacients

Decision

- The decision to stop the prescribing of rubefacients applies to ALL patients across Barking and Dagenham, Havering and Redbridge. BHR CCGs have agreed NO exceptions to this recommendation
- These products include Algesal cream, Balmosa cream, Deep Freeze cold gel 2%, Movelat cream, Movelat gel, Ralgex Heat spray and Transvasin Heat Rub (not an exhaustive list)
- It should be noted that creams, gels and sprays which contain non-steroidal anti-inflammatory drugs (NSAIDs) are not considered rubefacients

This decision was made because:

- The National Institute for Health and Clinical Excellence's (NICE) clinical guideline on osteoarthritis does not recommend rubefacients for treating osteoarthritis
- There is a lack of evidence to support the use of rubefacients in acute or chronic musculoskeletal pain
- If people want to continuing using rubefaciest, they are widely available to purchase at reasonable cost at supermarkets, pharmacies and other retailers
- BHR CCGs have a duty to spend taxpayer's money wisely, to make sure they get the best value possible – especially when NHS funding is being severely squeezed and more patients are being seen with more complex health issues than ever before

Position statement on the prescribing of emollient bath oils, shower gels, washes and shampoos

Following the local Spending NHS Money Wisely public consultation, the Governing Bodies of the BHR CCGs met in common on 14th December 2017 to agree changes to prescribing across Barking and Dagenham, Havering and Redbridge.

From 8th January 2018
Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups (BHR CCGs) no longer supports the prescribing of emollient bath oils, shower gels, washes and shampoos

Decision

- The decision to stop emollient bath oils, shower gels, washes and shampoos applies to ALL patients across Barking and Dagenham, Havering and Redbridge.

Prescribing alternative

BHR CCGs have agreed that emollients creams and ointments can be prescribed for use in the bath

<u>This decision was made because</u>:

- BHR CCGs believe it is more cost-effective to prescribe emollient creams and ointments for use in the bath
- Patients can purchase emollient bath oils, shower gels, washes and shampoos if they wish to continue using these products
- BHR CCGs have a duty to spend taxpayer's money wisely, to make sure they get the best value possible – especially when NHS funding is being severely squeezed and more patients are being seen with more complex health issues than ever before

Position statement on the prescribing of silk garments

Following the NHS England guidance 'Items which should not routinely be prescribed in primary care: Guidance for CCGs (version 2, June 2019) the following changes to prescribing have been agreed across Barking and Dagenham, Havering and Redbridge.

From 17th September 2019
Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups (BHR CCGs) no longer supports the prescribing of silk garments

Decision

- The decision to stop silk garments applies to ALL patients across Barking and Dagenham, Havering and Redbridge. BHR CCGs have agreed NO exceptions to this recommendation

This decision was made because:

- The clinical evidence relating to their use is weak.
- Silk garments for the management of eczema is unlikely to be cost-effective for the NHS and we have a duty to spend taxpayer's money wisely

Reference:

NHS England and NHS Improvement. Items which should not routinely be prescribed in primary care: Guidance for CCGs. Version 2, June 2019. Publishing approval reference 000608 https://www.england.nhs.uk/publication/items-whichshould-not-be-routinely-prescribed-in-primary-care-guidance-for-ccgs/

PrescQIPP Silk and antimicrobial garments 2.0 B160 February 2017
https://www.prescqipp.info/media/1659/b160-silk-and-antimicrobial-garments-20.pdf

Thomas KS and Bradshaw LE et al. Randomised controlled trial of silk therapeutic garments for the management of atopic eczema in children: the CLOTHES trial. Health Technology Assessment Vol 21, issue 16. April 2017
https://www.journalslibrary.nihr.ac.uk/hta/hta21160/#/abstract

Appendix D BHR Emollient Guidance and Formulary

Rationale for prescribing emollients

This guidance has been developed for use in the management of patients with a diagnosed dermatological condition. These are:

1. Eczema (also known as dermatitis) is a dry skin condition. Atopic eczema (also known as atopic dermatitis) is a chronic, itchy, inflammatory skin condition that affects people of all ages, although it presents most frequently in childhood. It is typically an episodic disease of flares (exacerbations, which may occur as frequently as two or three times each month) and remissions; in severe cases, disease activity may be continuous. The term 'atopic' is used to describe a group of conditions (eczema, asthma, hay-fever, and food allergy) that are linked by an increased activity of the allergy component of the immune system. Atopic eczema is a genetic condition based on the interaction between a number of genes and environmental factors. In most cases there will be a family history of either eczema or one of the other 'atopic' conditions i.e. asthma or hay fever.

2. Contact dermatitis is a type of eczema triggered by contact with a particular substance. Contact dermatitis can be caused by:
    a. an irritant – a substance that directly damages the outer layer of skin
    b. An allergen – a substance that causes the immune system to respond in a way that affects the skin.

Contact dermatitis is most commonly caused by irritants such as soaps and detergents, solvents or regular contact with water.

Considerations before prescribing emollients

1. There is no evidence from controlled trials to support the use of one emollient over another
2. Prescribe an emollient **according to the dryness of the skin, and individual preference/tolerance.** The key to successful management is finding the correct balance between these factors
3. Offer the product with the lowest acquisition cost from the formulary below that is appropriate to their condition
4. Once opened, emollients can continue to be used up to their expiry date, specified on the container unless the manufacturer has advised otherwise- this also applies to **care homes**
5. Aqueous cream is generally not recommended because of the high risk of developing skin reactions:
    - A clinical audit found that the use of aqueous cream results in a significant proportion of people developing sensitization reactions, so it should be avoided[1]
    - The Medicines and Healthcare products Regulatory Agency (MHRA)[2] warns that Aqueous cream may cause local skin reactions, such as stinging, burning, itching, and redness, when it is used as a leave-on emollient, especially in children with atopic eczema. The reactions, which are not generally serious, often occur within 20 minutes of application but can occur later, and may be due to sodium lauryl sulfate or other additives

A prescription for treatment of dry skin **should not** routinely be offered in primary care as the condition is appropriate for self-care. Patients with mild dry skin can be successfully managed
Guidance updated by Saiqa Mughal, using over the counter (OTC) products on a long termPrescribing Advisor/QIPP Pharmacist, BHR CCGs-basis
Date: 25th October 2019, version 6

Categories of emollients

- **Creams and gels:** Creams and gels are emulsions of oil and water and their less greasy consistency often makes them more cosmetically acceptable than ointments. They are well absorbed and generally more effective than light emollients. They usually contain preservatives and ingredients to stabilise the cream, this can cause risk of sensitivity.
- **Ointments:** Ointments are the greasiest preparations, made up of oils or fats. They do not usually contain preservatives; could be suitable for those with sensitivities but shouldn't be used on weeping eczema

Lotions and Sprays: no evidence of clinical efficacy noted and hence to be considered for self-care by patients if they so wish to use them.

Guidance updated by Saiqa Mughal, Prescribing Advisor/QIPP Pharmacist, BHR CCGs Date: 25th October 2019, version 6

Quantities to be prescribed for Adults

- Emollients are typically under-prescribed and under-used for diagnosed skin conditions. This results in suboptimal treatment of dry skin and eczema, and may increase the occurrence of flares[2]
- Once the preferred choice of emollient is known, encourage appropriate usage by prescribing generous amounts (for example 500 g) to be used regularly (often four times daily)
- Where possible, pump-dispensers should be prescribed when large quantities of emollients are required. This is because they are more convenient than other containers and are less likely to become contaminated by potential pathogens

Twice daily application for an adult (approximately)		
Area of body	**One week Supply**	**One month supply**
Face	15g -30g	60g - 120g
Both hands	25g -50g	100g – 200g
Scalp	50g - 100g	200g – 400g
Both arms / both legs	100g - 200g	400g – 800g
Trunk	400g	1600g
Groin and genitalia	15g - 25g	60g – 100g

For children reduce quantity approximately by half (Information from this fact sheet is based on the PrescQIPP Bulletin 76 (May 2015): Cost-effective prescribing of emollients)

Guidance updated by Saiqa Mughal, Prescribing Advisor/QIPP Pharmacist, BHR CCGs Date: 25th October 2019, version 6

Formulary product choices:

OINTMENTS **VERY GREASYGREASY** For very dry skin +/- acute flare. Low risk of sensitivity	• White soft paraffin (WSP) • Emulsifying ointment, 500g tub (£2.99) *(Ingredients: Emulsifying wax 30%, WSP 50% & LP 20%.* *Potential skin sensitizer: CetylCetostearyl/Stearyl alcohol)* • 50:50 Ointment tub (500g £3.17) *(Ingredients: WSP 50%+LP 50%)* • Epimax Ointment (500g tub £3.95) *(Ingredients: Liquid Paraffin, Cetomacrogol Emulsifying Wax, Yellow Soft Paraffin.* *Potential skin sensitizer: CetylCetostearyl/Stearyl alcohol and Macrogol Cetostearyl Ether 22)* • AproDerm Ointment (500g tub £3.95) *(Ingredients: WSP 95%+LP 5%)* • Zeroderm Ointment (500g tub £4.10) *(Ingredients: WSP+LP.* *Potential skin sensitizer: Cetostearyl alcohol and polysorbate 60)*	OTHER INFO **MHRA/CHM advice (updated December 2018)** Healthcare professionals must ensure that patients and their carers understand the fire risk associated with the build-up of residue on clothing and bedding and can take action to minimise the risk • There is a fire risk with all paraffin-containing emollients, regardless of paraffin concentration, and it **cannot** be **excluded with paraffin-free emollients** • A similar risk may apply to products that are applied to the skin over large body areas, or in large volumes for repeated use for more than a few days Healthcare professionals should advise patients not to smoke or go near naked flames because clothing, bedding, dressings, and other fabrics that have been in contact with an emollient or emollient-treated skin can rapidly ignite. Washing these materials at high temperature may reduce emollient build-up but not totally remove it[5]. Index: **= can be used a soap substitute** WSP= White Soft Paraffin LP= Liquid Paraffin

		 Emulsifying Ointment BP EPimax OINTMENT fontus AproDerm Zerederm CINTAENT

OAT BASED EMOLLIENTS **Colloidal oatmeal containing emollients are BORDERLINE substances & may only be prescribed in accordance with the advice of the Advisory Committee on Borderline Substances (ACBS) for the clinical conditions listed** (Endogenous and exogenous eczema, Xeroderma and Ichthyosis) can be used as soap substitute	AproDerm Colloidal Oat Cream (500ml pump £5.80) *(Ingredients: Avena Sativa Kernel Flour 1%, Purified Water, Olive Oil, Apricot Kernel Oil, Glycerin, Sucrose Stearate, Cetearyl Alcohol, Glyceryl Stearate SE, Dimethicone, Phenoxyethanol, Vitamin F Ethyl Ester, Ethylhexylglycerin, Xanthan Gum, Disodium EDTA, Vitamin E.* *Potential skin sensitizer: CetylCetostearyl/Stearyl alcohol)* Zeroveen (500ml pump £5.89) *(Ingredients: Glycerol, Isopropyl Palmitate, Liquid Paraffin, Distearyldimonium Chloride, Avena Sativa Kernel Flour, Cetyl Alcohol, Dimethicone, White Soft Paraffin, Benzyl Alcohol, Allantoin, Stearyl Alcohol, Allantoin, Stearyl Alcohol, Microcrystalline Wax, Myristyl Alcohol, Sodium Chloride, Purified Water.* *Potential skin sensitizer: Isoprogyl Palmitate, cetyl alcohol, benzyl alcohol, Stearyl alcohol and myristyl alcohol)*	**MHRA/CHM advice (updated December 2018)** Healthcare professionals must ensure that patients and their carers understand the fire risk associated with the build-up of residue on clothing and bedding and can take action to minimise the risk There is a fire risk with all paraffin-containing emollients, regardless of paraffin concentration, and it **cannot** be **excluded with paraffin-free emollients** A similar risk may apply to products that are applied to the skin over large body areas, or in large volumes for repeated use for more than a few days Healthcare professionals should advise patients not to smoke or go near naked flames because clothing, bedding, dressings, and other fabrics that have been in contact with an emollient or emollient treated skin can rapidly ignite. Washing these materials at high temperature may reduce emollient build-up but not totally remove it. 

CREAMS Light moisturising properties (**consider self-care**) can be used as a soap substitute	• Epimax ExCetra Cream (500g Flexi-dispenser £2.95) (**cost effective alternative to Cetraben**) *(Ingredients: LP+WSP and Glycerin. Potential skin sensitizer: CetylCetostearyl/Stearyl alcohol and Phenoxyethanol*) • ZeroAQS Cream (500 tub £3.29) *(Ingredients: Macrogol Cetostearyl Ether 1.8% w/w, Cetostearyl Alcohol, Chlorocresol, Liquid Paraffin, White Soft Paraffin, Purified Water. Potential skin sensitizer:* CetylCetostearyl/Stearyl alcohol and Chlorocresol) • Aquamax Cream 500g (screw top container £3.99) *(Ingredients: Purified water, White soft paraffin, Cetostearyl alcohol, Liquid paraffin, Polysorbate 60, Phenoxyethanol. Potential skin sensitizer: CetylCetostearyl/Stearyl alcohol, Phenoxyethanol and polysorbate 60*) • ExoCream (500ml pump £3.99)* (**cost effective alternative to E45**) *(Ingredients: benzalkonium chloride (0.1% w/w), chlorhexidine dihydrochloride (0.1% w/w), liquid paraffin (10% w/w) and isopropyl myristate. Potential skin sensitizer: Cetyl alcohol, sodium cetostearyl sulphate, methyl hyroxybenzoate and propyl hydroxybenzoate)* • Zerocream (500g pump dispenser £4.08) *(Ingredients: Liquid Paraffin, White Soft Paraffin, Lanolin Anhydrous (wool fat), Glyceryl Monostearate, Cetyl Alcohol, Sodium Cetostearyl sulphate, Citric Acid Monohydrate (E330), Carbomer, Purified Water, Sodium Hydroxide, Sodium Methyl Hydroxybenzoate, Sodium Propyl Hydroxybenzoate. Potential skin sensitizer: CetylCetostearyl/Stearyl alcohol, Lanolin derivatives and Phenoxyethanol)* • Exmaben cream (500g pump £4.25) *(Ingredients: Yellow Soft Paraffin Bp, Liquid Paraffin Ph.Eur, Emulsifying Wax and Purified Water. Potential skin sensitizer: Cetostearyl Alcohol, Sodium Lauryl Sulphate and Chlorocresol)*	**MHRA/CHM advice (updated December 2018)** Healthcare professionals must ensure that patients and their carers understand the fire risk associated with the build-up of residue on clothing and bedding and can take action to minimise the risk There is a fire risk with all paraffin containing emollients, regardless of paraffin concentration, and it **cannot** be **excluded with paraffin-free emollients** A similar risk may apply to products that are applied to the skin over large body areas, or in large volumes for repeated use for more than a few days Healthcare professionals should advise patients not to smoke or go near naked flames because clothing, bedding, dressings, and other fabrics that have been in contact with an emollient or emollient-treated skin can rapidly ignite. Washing these materials at high temperature may reduce emollient build-up but not totally remove it. 

GEL Light moisturising properties (**consider selfcare**)	• AproDerm gel (500g pump dispenser £3.99) **(comparable to DoubleBase)** *(Ingredients: Liquid Paraffin (15%) and Isopropyl Myristate (15%), Aqua, Glycerin, Polyacrylate-13, Polyisobutene, Polysorbate-20, Phenoxyethanol, Benzoic Acid, Dehydroacetic Acid, Ethylhexylglycerin. Potential skin sensitizers: Isopropyl myristate)* • Zerodouble gel (500g pump dispenser £4.90) *(Ingredients: Isopropyl Myristate 15%, Liquid Paraffin 15%, Glycerol, Acrylate C10-C30 Alkyl Acrylate Cross Polymer, Sorbitan Laurate, Triethanolamine, Phenoxyethanol and Purified Water. Potential skin sensitizers: Triethanoiamine, Phenoxyethanol and Isopropyl myristate)* • DoubleBase gel (500g pump dispenser £5.83) *(Ingredients: isopropyl myristate (15% w/w) and liquid paraffin (15% w/w), glycerol, carbomer, sorbitan laurate, trolamine, phenoxyethanol and purified water. Potential skin sensitizers: Triethanoiamine, Phenoxyethanol and Isopropyl myristate)*	MHRA/CHM advice (updated December 2018) • Healthcare professionals must ensure that patients and their carers understand the fire risk associated with the build-up of residue on clothing and bedding and can take action to minimise the risk • There is a fire risk with all paraffin-containing emollients, regardless of paraffin concentration, and it **cannot** be **excluded with paraffin-free emollients** • A similar risk may apply to products that are applied to the skin over large body areas, or in large volumes for repeated use for more than a few days Healthcare professionals should advise patients not to smoke or go near naked flames because clothing, bedding, dressings, and other fabrics that have been in contact with an emollient or emollient-treated skin can rapidly ignite. Washing these materials at high temperature may reduce emollient build-up but not totally remove it. 

PARAFFIN FREE	• Epimax Paraffin-Free Ointment (500g £4.99) **(comparable to Epaderm ointment**) *(Ingredients: plant derived hydrogenated Castor Oil.* *Potential skin sensitizers: CetylCetostearyl/Stearyl alcohol*) • AproDerm Colloidal Oat Cream (500ml pump £5.80) *(Ingredients: Avena Sativa Kernel Flour 1%, Purified Water, Olive Oil, Apricot Kernel Oil, Glycerin, Sucrose Stearate, Cetearyl Alcohol, Glyceryl Stearate SE, Dimethicone, Phenoxyethanol, Vitamin F Ethyl Ester, Ethylhexylglycerin, Xanthan Gum, Disodium EDTA, Vitamin E.* *Potential skin sensitizer: CetylCetostearyl/Stearyl alcohol)*	**MHRA/CHM advice (updated December 2018)** • Healthcare professionals must ensure that patients and their carers understand the fire risk associated with the build-up of residue on clothing and bedding and can take action to minimise the risk • There is a fire risk with all paraffin-containing emollients, regardless of paraffin concentration, and it **cannot** be **excluded with paraffin-free emollients** • A similar risk may apply to products that are applied to the skin over large body areas, or in large volumes for repeated use for more than a few days Healthcare professionals should advise patients not to smoke or go near naked flames because clothing, bedding, dressings, and other fabrics that have been in contact with an emollient or emollient-treated skin can rapidly ignite. Washing these materials at high temperature may reduce emollient build-up but not totally remove it. 

SKIN INFECTION	• Dermol 500 lotion (500ml pump dispenser £6.04) *(Ingredients: benzalkonium chloride (0.1% w/w), chlorhexidine dihydrochloride (0.1% w/w), liquid paraffin (2.5% w/w) and isopropyl myristate (2.5% w/w). Potential skin sensitizers: Cetostearyl alcohol and isopropyl myristate)* Dermol cream (500g pump £6.63) • *(Ingredients: liquid paraffin, isopropyl myristate, benzalkonium chloride and chlorhexidine hydrochloride. Potential skin sensitizers: Cetostearyl alcohol, benzalkonium chloride and phenoxyethanol)*	**MHRA/CHM advice (updated December 2018)** • Healthcare professionals must ensure that patients and their carers understand the fire risk associated with the build-up of residue on clothing and bedding and can take action to minimise the risk • There is a fire risk with all paraffin-containing emollients, regardless of paraffin concentration, and it **cannot** be **excluded with paraffin-free emollients** • A similar risk may apply to products that are applied to the skin over large body areas, or in large volumes for repeated use for more than a few days • Healthcare professionals should advise patients not to smoke or go near naked flames because clothing, bedding, dressings, and other fabrics that have been in contact with an emollient or emollient-treated skin can rapidly ignite. Washing these materials at high temperature may reduce emollient build-up but not totally remove it. **Used for short term use only**. 

UREA CONTAINING EMOLLIENTS	• imuDERM cream (500g pump £6.55) *(Ingredients: Urea 5%, glycerol 5%. Potential skin sensitizers: CetylCetostearyl/Stearyl alcohol, benzalkonium chloride, phenethyl alcohol and cetrimonium bromide)* • Flexitol 10% urea cream (500g pump £11.77, 150g tube £5.00) *(Ingredients: Urea 10%, Purified water, lanolin, cetostearyl alcohol, glycerine, dimeticone, paraffin oil light, glyceryl monostearate, decyl oleate, PEG-20 stearate, phenoxyethanol, sodium PCA, shea butter, panthenol, tocopheryl acetate, benzyl alcohol, butylated hydroxytoluene, perfume. Potential skin sensitizers: cetostearyl alcohol, phenoxyethanol, benzyl alcohol and perfume)*	**MHRA/CHM advice (updated December 2018)** • Healthcare professionals must ensure that patients and their carers understand the fire risk associated with the build-up of residue on clothing and bedding and can take action to minimise the risk • There is a fire risk with all paraffin-containing emollients, regardless of paraffin concentration, and it **cannot** be **excluded with paraffin-free emollients** • A similar risk may apply to products that are applied to the skin over large body areas, or in large volumes for repeated use for more than a few days Healthcare professionals should advise patients not to smoke or go near naked flames because clothing, bedding, dressings, and other fabrics that have been in contact with an emollient or emollient-treated skin can rapidly ignite. Washing these materials at high temperature may reduce emollient build-up but not totally remove it. Urea based which helps if itching not resolved with emollient. **Low or no paraffin content**. 

Emollient Quick Reference Guide and Formulary

Description	Emollient	Cost (Sept 2019)	Ingredients and additional information
OINTMENTS **Very greasy-greasy** can be used as a soap substitute **except for WSP**	White soft paraffin (WSP)		White soft paraffin
	Emulsifying ointment, 500g	£2.99	Ingredients: Emulsifying wax 30%, WSP 50% & LP 20%. Potential skin sensitizer: CetylCetostearyl/Stearyl alcohol
	50:50 Ointment, 500g	£3.17	Ingredients: WSP 50%+LP 50%
	Epimax Ointment, 500g	£3.95	Ingredients: Liquid Paraffin, Cetomacrogol Emulsifying Wax, Yellow Soft Paraffin. Potential skin sensitizer: CetylCetostearyl/Stearyl alcohol and Macrogol Cetostearyl Ether 22
	AproDerm Ointment, 500g	£3.95	Ingredients: WSP 95%+LP 5%
	Zeroderm Ointment, 500g	£4.10	Ingredients: WSP+LP. Potential skin sensitizer: Cetostearyl alcohol and polysorbate 60
CREAMS Light moisturising properties (consider self-care)	Epimax ExCetra Cream, 500g **(cost effective alternative to Cetraben)**	£2.95	Ingredients: LP+WSP and Glycerin. Potential skin sensitizer: CetylCetostearyl/Stearyl alcohol and Phenoxyethanol
	ZeroAQS Cream, 500g	£3.29	Ingredients: Macrogol Cetostearyl Ether 1.8% w/w, Cetostearyl Alcohol, Chlorocresol, Liquid Paraffin, White Soft Paraffin, Purified Water. Potential skin sensitizer: CetylCetostearyl/Stearyl alcohol and Chlorocresol
	Aquamax Cream, 500g	£3.99	Ingredients: Purified water, White soft paraffin, Cetostearyl alcohol, Liquid paraffin, Polysorbate 60, Phenoxyethanol. Potential skin sensitizer: CetylCetostearyl/Stearyl alcohol, Phenoxyethanol and polysorbate 60
	ExoCream, 500g (**cost effective alternative to E45)**	£3.99	Ingredients: benzalkonium chloride (0.1% w/w), chlorhexidine dihydrochloride (0.1% w/w), liquid paraffin (10% w/w) and isopropyl myristate. Potential skin sensitizer: Cetyl alcohol, sodium cetostearyl sulphate, methyl hyroxybenzoate and propyl hydroxybenzoate

Description	Emollient	Cost (Sept 2019)	Ingredients and additional information
Oat based emollients	AproDerm Colloidal Oat Cream,500ml 	£5.80	Ingredients: Avena Sativa Kernel Flour 1%, Purified Water, Olive Oil, Apricot Kernel Oil, Glycerin, Sucrose Stearate, Cetearyl Alcohol, Glyceryl Stearate SE, Dimethicone, Phenoxyethanol, Vitamin F Ethyl Ester, Ethylhexylglycerin, Xanthan Gum, Disodium EDTA, Vitamin E. Potential skin sensitizer: CetylCetostearyl/Stearyl alcohol
	Zeroveen, 500ml	£5.89	Ingredients: Glycerol, Isopropyl Palmitate, Liquid Paraffin, Distearyldimonium Chloride, Avena Sativa Kernel Flour, Cetyl Alcohol, Dimethicone, White Soft Paraffin, Benzyl Alcohol, Allantoin, Stearyl Alcohol, Allantoin, Stearyl Alcohol, Microcrystalline Wax, Myristyl Alcohol, Sodium Chloride, Purified Water. Potential skin sensitizer: Isoprogyl Palmitate, cetyl alcohol, benzyl alcohol, Stearyl alcohol and myristyl alcohol
	Aquamax Cream,  500g	£3.99	Ingredients: Purified water, White soft paraffin, Cetostearyl alcohol, Liquid paraffin, Polysorbate 60, Phenoxyethanol. Potential skin sensitizer: CetylCetostearyl/Stearyl alcohol, Phenoxyethanol and polysorbate 60
	ExoCream, 500g (**cost effective alternative to E45)**	£3.99	Ingredients: benzalkonium chloride (0.1% w/w), chlorhexidine dihydrochloride (0.1% w/w), liquid paraffin (10% w/w) and isopropyl myristate. Potential skin sensitizer: Cetyl alcohol, sodium cetostearyl sulphate, methyl hyroxybenzoate and propyl hydroxybenzoate

Description	Emollient	Cost (Sept 2019)	Ingredients and additional information
GEL Light moisturising properties (consider self-care) **GEL** Light moisturising properties (consider self-care)	AproDerm gel, 500g **(comparable to DoubleBase)**	£3.99	Ingredients: Liquid Paraffin (15%) and Isopropyl Myristate (15%), Aqua, Glycerin, Polyacrylate-13, Polyisobutene, Polysorbate-20, Phenoxyethanol, Benzoic Acid, Dehydroacetic Acid, Ethylhexylglycerin. Potential skin sensitizers: Isopropyl myristate
	Zerodouble gel, 500g	£4.90	Ingredients: Isopropyl Myristate 15%, Liquid Paraffin 15%, Glycerol, Acrylate C10-C30 Alkyl Acrylate Cross Polymer, Sorbitan Laurate, Triethanolamine, Phenoxyethanol and Purified Water. Potential skin sensitizers: Triethanoiamine, Phenoxyethanol and Isopropyl myristate
	DoubleBase gel, 500g	£5.83	Ingredients: isopropyl myristate (15% w/w) and liquid paraffin (15% w/w), glycerol, carbomer, sorbitan laurate, trolamine, phenoxyethanol and purified water. Potential skin sensitizers: Triethanoiamine, Phenoxyethanol and Isopropyl myristate
	AproDerm gel, 500g **(comparable to DoubleBase)**	£3.99	Ingredients: Liquid Paraffin (15%) and Isopropyl Myristate (15%), Aqua, Glycerin, Polyacrylate-13, Polyisobutene, Polysorbate-20, Phenoxyethanol, Benzoic Acid, Dehydroacetic Acid, Ethylhexylglycerin. Potential skin sensitizers: Isopropyl myristate

	Zerocream, 500g	£4.08	Ingredients: Liquid Paraffin, White Soft Paraffin, Lanolin Anhydrous (wool fat), Glyceryl Monostearate, Cetyl Alcohol, Sodium Cetostearyl sulphate, Citric Acid Monohydrate (E330), Carbomer, Purified Water, Sodium Hydroxide, Sodium Methyl Hydroxybenzoate, Sodium Propyl Hydroxybenzoate. Potential skin sensitizer: CetylCetostearyl/Stearyl alcohol, Lanolin derivatives and Phenoxyethanol
	Exmaben cream, 500g	£4.25	Ingredients: Yellow Soft Paraffin Bp, Liquid Paraffin Ph.Eur, Emulsifying Wax and Purified Water. Potential skin sensitizer: Cetostearyl Alcohol, Sodium Lauryl Sulphate and Chlorocresol
PARAFFIN FREE	Epimax Paraffin free ointment, 500g	£4.99	Ingredients: plant derived hydrogenated Castor Oil. Potential skin sensitizers: CetylCetostearyl/Stearyl alcohol
	AproDerm Colloidal Oat Cream, 500ml	£5.80	Ingredients: Avena Sativa Kernel Flour 1%, Purified Water, Olive Oil, Apricot Kernel Oil, Glycerin, Sucrose Stearate, Cetearyl Alcohol, Glyceryl Stearate SE, Dimethicone, Phenoxyethanol, Vitamin F Ethyl Ester, Ethylhexylglycerin, Xanthan Gum, Disodium EDTA, Vitamin E. Potential skin sensitizer: CetylCetostearyl/Stearyl alcohol
Skin infection For short term use	Dermol 500 lotion, 500ml 	£6.04	Ingredients: Benzalkonium chloride (0.1% w/w), chlorhexidine dihydrochloride (0.1% w/w), liquid paraffin (2.5% w/w) and isopropyl myristate (2.5% w/w). Potential skin sensitizers: Cetostearyl alcohol and isopropyl myristate
	Dermol cream, 500g 	£6.63	Ingredients: Liquid paraffin, isopropyl myristate, benzalkonium chloride and chlorhexidine hydrochloride. Potential skin sensitizers: Cetostearyl alcohol, benzalkonium chloride and phenoxyethanol
Urea containing emollients	ImuDERM cream, 500g	£6.55	Ingredients: Urea 5%, glycerol 5%. Potential skin sensitizers: CetylCetostearyl/Stearyl alcohol, benzalkonium chloride, phenethyl alcohol and cetrimonium bromide
	Flexitol 10% Urea Cream, 500g	£11.77	Ingredients: Urea 10%, Purified water, lanolin, cetostearyl alcohol, glycerine, dimeticone, paraffin oil light, glyceryl monostearate, decyl oleate, PEG-20 stearate, phenoxyethanol, sodium PCA, shea butter, panthenol, tocopheryl acetate, benzyl alcohol, butylated hydroxytoluene, perfume. Potential skin sensitizers: cetostearyl alcohol, phenoxyethanol, benzyl alcohol and perfume

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Approved by BHR CCGs Area Prescribing sub-Committees: September 2019

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