Medicines Formulary

Skin

Contents:

For full information on treatment, side effects, cautions and contraindications, see electronic British National Formulary (www.bnf.org) or the relevant summary of product characteristics (www.medicines.org.uk).

For information on preparing intravenous medicines for administration, see Medusa Injectable Medicines Guide for the NHS (see Clinical Guidance home page)

1. Emollient preparations – general advice

Suitable quantities of **emollients** to be prescribed for specific areas of the body (assuming the emollient is used twice daily for one week) are:

area of the body	creams / ointments	lotions
face	15–30g	100mL
both hands	25–50g	200mL
both arms or both legs	100–200g	200mL
trunk	400g	500mL
groins and genitalia	15–25g	100mL

An average adult requires 25g to cover whole body once.

NOTE: These quantities will need to be increased significantly for patients with severe exacerbations of skin disease when emollients will need to be applied 5–6 times a day.

If a rash is weeping / exudative use a cream or lotion. These are non occlusive and will allow evaporation to occur.
If a rash is dry and scaly, use an ointment. The occlusive base will help to retain moisture.

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2. Eczema and dry skin

The mainstay of treatment for eczema and dry skin is regular use of emollients. Mild-to-moderate eczema can be managed with emollients alone. In more severe case, short bursts of moderate-to-high potency topical corticosteroids are required. Emollients can reduce a patient's topical corticosteroid requirement.

Inflammation of the skin can lead to loss of its barrier function. Emollients are moisturisers that soothe, smooth and hydrate the skin, leaving a protective layer that traps moisture and prevents the penetration of irritants by forming a protective barrier.

An emollient provides a surface film of lipids and restores some of the barrier function. The importance of regular emollient use, particularly after skin washing and instead of soap, should be emphasised to patients.

Patients with dry, lichenified rashes should use emollients liberally, both directly onto the skin and when bathing.

All possible causes of contact dermatitis should be excluded. For dry, scaly eczema, emollients are essential to help reduce the use of topical steroids. A systemic antipruritic may also be required.

i) Emollients

NOTE: Patient choice is paramount when selecting an emollient for regular use.
Emollients are most effective if used regularly. Empowering patients to choose their own emollient is established good practice and helps to increase concordance.

- **For acute exacerbations — greasier emollients (ie, ointments) are more effective**
- **For maintenance treatment (between exacerbations) — lighter emollients (ie, creams and lotions) are often more tolerable.**

Many patients will require more than one emollient to suit their lifestyles (eg, a lighter one for use during the day, and a greasier one for use at night).

If the emollient products listed prove unsuitable for a particular patient, clinicians should choose a cost-effective alternative, this should be communicated to the GP if recommended form secondary care..

For more information on the differences between emollients, and for tips on emollient use, see **Emollients — advice for use**.

Directions
Apply as a thin coating three or four times a day (using a downward motion in the direction of hair growth to avoid precipitating folliculitis). Take care if emollients are used in the bath as the surface will become slippery. Use regularly, particularly after skin washing.

NOTE: Aqueous cream is NOT an effective moisturiser and can irritate some patients' skin. It should NEVER be used as a leave-on emollient.

Greasier emollients

First choice
- **Oily cream** (hydrous ointment BP)
- **Emulsifying ointment**
- **50% liquid paraffin / 50% white soft paraffin** — particularly useful for dermatology inpatients, patients with very dry, scaly skin, and for applying to the skin surrounding leg ulcers (this is prone to becoming very dry)

Second choice
- **Hydromol®** ointment

Third choice
- **Epaderm®** ointment
- **Diprobase®** ointment

Clinicians are advised to use small quantities of cream to allow patients to find an emollient that suits them, but then prescribe larger quantities for regular use.

Emollient creams

First choice
- **E45®** cream — lowest cost, try first
- **Cetraben®** cream
- **Diprobase®** cream
- **Doublebase®** gel

Second choice
- **Epaderm®** cream

- **Oilatum®** cream
- **Oilatum Junior**® cream

Third choice
- **Hydromol®** cream — considerably more expensive than other formulary choices

Emollient lotions

First choice
- **E45®** lotion

Second choice
- **QV®** lotion

Bath/shower products

Patients with chronic skin conditions often require total emollient therapy (ie, a mixture of emollients including one to use as a soap substitute or bath oil). Care should be taken when using bath oils because they can make the bathtub slippery and some are unsuitable for application directly onto the skin.

First choice
- **Emulsifying** ointment

Second choice — for showering
- **Oilatum gel®** (as soap substitute)
- **Doublebase** bath and shower emollient® (as soap substitute)

Second choice — for use in the bath
- **Oilatum®** (bath emollient)
- **QV®** bath oil

Other emollients

The following preparations should ONLY be prescribed on the advice of a dermatology specialist:
- **Dermamist®** spray
- **Emollin®** spray
- **Aveeno®** cream

Urea-containing creams

Urea applied topically can help to treat persistent itching. See section 5 ("**Pruritis and itching**").

ii) Corticosteroids

If corticosteroid use is indicated ointments are preferable to creams as they have a deeper, more prolonged emollient effect and increase the penetration of steroid. It is worth trying different topical steroids within the same potency classification since there can be inter-patient variability. The potency should be kept to the lowest that is effective.

Site (for adult patients)	acute eruption	reduce to
face	moderate	mild
trunk/limbs	potent	moderate
scalp	Very potent / potent	potent
hands / feet	Very potent	potent

As a guide if no response is achieved after short-term use of two different preparations in the following quantities, refer to a dermatologist.

Suitable quantities of **corticosteroids** for two weeks' treatment are:

- Trunk: 100g to 200g
- Arms and legs: 100g to 200g
- Whole body: 300g to 400g

Central serous chorioretinopathy is a retinal disorder that has been linked to the use of corticosteroids – please refer to the **MHRA drug safety update, August 2017** at: https://www.gov.uk/drug-safety-update/corticosteroids-rare-risk-of-central-serous-chorioretinopathy-with-local-as-well-as-systemic-administration

Mild potency

- **Hydrocortisone 1% cream / ointment**

Moderately potent

- **Clobetasone butyrate (Eumovate®) 0.05% cream / ointment**
- **Betamethasone valerate (Betnovate-RD®) 0.025% cream / ointment**
- **Fludroxycortide (Haelan®) 0.0125% cream / tape (4microgram/cm^2)**
- **Fluocinolone acetonide (Synalar 1-in-4®) 0.00625% cream / ointment**
  NOTE: Considerably more expensive than other preparations. Only use for patients who are intolerant of other corticosteroids

Potent — do not use on children without specialist advice

- **Betamethasone valerate (Betnovate®) 0.1% cream / ointment / lotion / scalp application**
- **Betamethasone diproprionate (Diprosone®) 0.05% cream / ointment**
- **Fluocinonide (Metosyn®) 0.05% ointment**
- **Fluocinolone acetonide (Synalar®) 0.025% cream / ointment / gel**
  NOTE: Considerably more expensive than other preparations. Only use for patients who are intolerant of other corticosteroids
- **Betamethasone valerate (Betesil®) plasters —** for initiation by dermatologists **ONLY** for chronic lichenified eczema

For resistant eczema and hyperkeratotic patches (particularly on the hands and feet)
Betamethasone 0.05% and salicylic acid 3% (Diprosalic®) ointment

Very potent — do not use without specialist advice

- **Clobetasol propionate (Dermovate®) 0.05% cream / ointment / scalp application**

Directions
Apply thinly once or twice daily (wash hand(s) after use). Patients should be advised that one fingertip unit (the amount of cream that is squeezed from a standard tube along an adult's fingertip) is sufficient to cover an area of the body the size of two of the same

adult's hands.

iii) Tacrolimus and pimecrolimus

Tacrolimus and pimecrolimus (consultant dermatologist initiation only) are used for patients with moderate to severe eczema that affects mainly the head, neck and flexures. Tacrolimus is more potent but can cause stinging and burning during the first few days of treatment.

(Tacrolimus is licensed for topical use in moderate to severe eczema. Pimecrolimus for mild to moderate eczema.)

Tacrolimus and pimecrolimus are reserved to treat patients for whom:

- Stronger corticosteroids are required on sensitive areas such as the face
- Stronger corticosteroids are being required most of the time
- Signs of corticosteroid-induced skin damage are appearing

First choice
Tacrolimus (Protopic®) 0.03%, 0.1% ointment Apply 0.1% ointment, thinly, twice daily until lesion clears (usually for 2 weeks) then reduce to once daily or change to 0.03% ointment (once or twice a day).
NOTE: Emollients should not be used for two hours before tacrolimus ointment is applied
NOTE: Patients should avoid exposure to sunlight

Second choice
Pimecrolimus (Elidel®) 1% cream Apply, to the affected area(s) of skin, twice daily.

CSM Advice: Prescribers should use topical tacrolimus and pimecrolimus to minimise patient exposure to corticosteroids and thereby reduce the risk of side effects. Treatment should:

- **Only be initiated by physicians with experience of diagnosing and treating atopic dermatitis**
- **Not be given to patients with congenital or acquired immunodeficiencies, or to patients receiving immunosuppressive therapy**
- **Not be applied to malignant or potentially malignant skin lesions**
- **Be the lower strength of tacrolimus ointment (0.03%) wherever possible**
- **Be applied thinly and to affected skin surfaces only**
- **Be used for as shorter duration as possible**

If no improvement occurs (after 6 weeks using pimecrolimus or 2 weeks using tacrolimus), or if the disease worsens, the diagnosis of eczema should be re-evaluated and other therapeutic options considered.

iv) Treatment for specific types of eczema

Other treatments are available for certain types of eczema. These include:

a) Locally infected eczema
b) Widespread infected eczema
c) Severe eczema

d) Severe chronic hand eczema
e) Seborrhoeic eczema of the scalp

a) Locally infected eczema

Steroids should not be used if infection is present without specific anti-infective therapy being given concomitantly. Several steroid-antibiotic combinations are available:

Mild steroid/anticandida

- **Nystaform HC® cream / ointment —**
  NOTE: effective only against yeast and Candida (NOT fungal) infections

Moderate steroid/antibacterial/anticandida

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

Potent steroid/antibacterial

- **Betametasone 0.1%, clioquinol 3% (Betnovate C®) cream / ointment**
- **Fluocinolone acetonide 0.025%, clioquinol 3% (Synalar C®) cream / ointment**
  NOTE: Use fluocinolone only if intolerant to betametasone

Mild steroid/antifungal

- **Hydrocortisone 1% / miconazole 2% (Daktacort ®) cream**
  (See MHRA Drug Safety Alert- Topical miconazole: reminder of potential for serious interactions with warfarin).
- **Hydrocortisone 1% / clotrimazole 1% (Canesten HC®) cream**

Potent steroid/antifungal

- **Betamethasone dipropionate 0.05%, clotrimazole 1% (Lotriderm®) cream**

Directions
Apply thinly once or twice daily (wash hand(s) after use).

b) Widespread infected eczema

First line — only for short-term use
Dermol 500® lotion Apply to skin or use as soap substitute as required.
And
Dermol 600® bath emollient Add up to 30mL to a bath of warm water as required.

Second line — only for short-term use
Eczmol® cream Apply to skin or use as a soap substitute when needed if the skin appears to be infected

For weeping eczema — for use in hospital, by district nurses or experienced practice nurses **ONLY**
Potassium permanganate Dissolve one tablet (400mg) in 4 litres of water (stains skin and clothing).

If infection is widespread and microbiologically proven
Flucloxacillin 250mg, orally, four times a day for 7 days
Or
Clarithromycin 250mg, orally, twice a day for 7 days

c) Severe eczema

If patients are unable to maintain control of their eczema using topical treatment, second line treatments may be used. These should **ONLY** be initiated by a dermatology consultant.

Methotrexate (prescribe 2.5mg tablets ONLY) 2.5 to 10mg, orally, **ONCE WEEKLY**. Increase according to response in steps of 2.5 to 5mg. Usual dose: 7.5 to 15mg per week. Max: 30mg per week.
And
Folic acid 5mg, orally, daily (except on the day the methotrexate is taken)
NOTE: All patients prescribed oral methotrexate must be issued with the National Patient Safety Agency Patient Information Leaflet and Patient-held Monitoring Booklet.
Or
Azathioprine 1 to 3mg/kg, orally, daily. Doses should be adjusted within these parameters according to response
Or
Ciclosporin (Capimune®) 1.5mg/kg, orally, twice daily. Increase to 2.5mg/kg twice daily after 2 to 4 weeks if good response not achieved

Shared care guidelines are available for:

- **Methotrexate**
- **Ciclosporin**
- **Azathioprine**

d) Severe, chronic hand eczema — secondary care ONLY

Alitretinoin 30mg, orally, once a day. Discontinue after 12 weeks if no improvement is seen. Maximum licensed duration: 24 weeks. If patient experiences unacceptable side effects, reduce dose to 10mg daily.
NOTE: PbR drug exclusion — document indication on prescription

e) Seborrhoeic eczema of the scalp

Mild seborrhoeic eczema of the scalp can be treated with a tar or antifungal shampoo. A corticosteroid scalp application (see previous section on corticosteroids) may be necessary in more severe cases.

Polytar® liquid Apply once or twice weekly for at least 3 weeks
Or
Ketoconazole 2% shampoo Apply once or twice weekly for 2 to 4 weeks. Can use prophylactically every 1 to 2 weeks if required

3. Psoriasis

All patients with psoriasis should be encouraged to use emollients regularly. See "***emollients***" in section 2 ("Dry skin and eczema").

i) Mild or chronic plaque psoriasis

First choice (for use in primary care)

- **Calcipotriol 50micrograms/g ointment, scalp application** Apply once or twice daily to skin or twice daily to scalp.
- **Calcitriol (Silkis®) 3micrograms/g ointment** Apply twice daily to no more than 35% of body surface area. Max: 30g per day.
- **Tacalcitol (Curatoderm®) 4micrograms/g ointment** Apply once daily, preferably at bedtime. Max: 40micrograms applied per day.

For resistant plaques or troublesome scalp psoriasis, a combination of calcipotriol and a corticosteroid is appropriate for short periods (ie, 4 weeks) or regular intermittent periods (eg, twice a week).

- **Betamethasone and calcipotriol 0.05% / 50microgram/g (Dovobet®) ointment, gel or (Enstilar®) foam.** Apply once daily to no more than 30% of the body surface. The ointment is licensed for psoriasis on the body. The gel is licensed for scalp and body. Usually, no more than 4g (1 teaspoon) is sufficient to treat the scalp.

For acute exacerbations (**ONLY** use routinely in secondary care)

- **Dithranol (Dithrocream®) 0.1%, 0.25%, 0.5%, 1%, 2% cream** Apply to the affected area daily as needed. Start with 0.1% and titrate upwards every 2 days to the maximum tolerated dose. Low-strength creams (0.1% to 0.5%) can be left on overnight. Higher strength creams should be washed off after 1 hour. If burning occurs during this process, **clobetasone butyrate (Eumovate®) 0.05% ointment** should be applied to the sore areas. When the soreness has settled, the titration regimen is restarted at the previously tolerated strength
- **Dithranol 2%, 4%, 6%, 8%, 10% in Lassar's Paste (unlicensed)** Apply once a day — retain on skin for between 30 minutes and 4 hours, then wash off. Can be used twice a day in severe cases.
- **Dithranol in salicylic acid 2% and emulsifying ointment (unlicensed)** Apply once a day — retain on skin for between 30 minutes and 4 hours, then wash off. Can be used twice a day in severe cases.
- **Crude coal tar 2%, 5%, 10% in yellow soft paraffin** Apply once a day — retain on skin for 30 minutes to 4 hours, then wash off. Can be used twice daily in severe cases.

Dithranol stains hair, clothing, surroundings (eg, bath) and is highly irritant to unaffected skin, which often limits its use.

NOTE: Dithranol can be prescribed in primary care only after a diagnosis of psoriasis has been confirmed by a specialist and it is practical to do so

ii) Scalp psoriasis

Coal tar liquids and shampoos are useful for scalp psoriasis.

- **Polytar® liquid 150mL, 250mL, 500mL** Apply once or twice weekly
- **Coal tar 1%, coconut oil 1%, salicylic acid 0.5% (Capasal®) shampoo 250ml** Apply daily as necessary
- **Coal tar solution 12%, salicylic acid 2%, precipitated sulphur 4% (Sebco®) 40g, 100g** Apply to scalp daily as necessary

iii) Widespread, small psoriatic plaques

The following coal tar creams and lotions are useful for widespread small plaques — such as for guttate psoriasis.

- **Coal tar extract 5%, hydrocortisone 0.5%, allantoin 2% (Alphosyl HC®) cream 100g** Apply thinly to affected area twice daily
- **Coal tar solution 5% (Exorex®) lotion 100mL, 250mL** Apply to skin or scalp two or three times a day

For secondary care

- **Crude coal tar 2%, 5%, 10% in yellow soft paraffin 80g** Apply once a day — retain on skin for between 30 minutes and 4 hours, then wash off. Can be used twice a day in severe cases.
- **Salicylic acid 2%, coal tar 12% solution in emulsifying ointment (aka SCALP — SaliCylic Acid Liquor Picis) (unlicensed) 250g** Apply once or twice daily (often used at night, then washed off the following morning)
- **Salicylic acid 2% in white soft paraffin 500g** Apply once or twice daily to areas of mild hyperkeratosis
- **Salicylic acid 2%, 5%, 10%, 20% in emulsifying ointment (unlicensed) 100g** Apply once daily, usually at night, then wash off the following morning

iv) Flexural psoriasis

Clobetasone butyrate 0.05%, oxytetracycline 3%, nystatin 100,000 units/g (Trimovate®) cream Apply to the affected area twice a day.
Or
Hydrocortisone 1%, miconazole 2% (Daktacort®) cream Apply to the affected area twice a day (See MHRA Drug Safety Alert- Topical miconazole: reminder of potential for serious interactions with warfarin).

v) Severe psoriasis (Dermatologist initiation ONLY)

For severe, difficult to manage psoriasis the following oral treatments may be recommended by a dermatology specialist in secondary care. Choice of agent depends on type of psoriasis, cautions / contraindications, tolerability and adverse effects.

- **Methotrexate (prescribe 2.5mg tablets ONLY)** 2.5 to 10mg, orally, **ONCE WEEKLY**. Increase according to response in steps of 2.5 to 5mg. Usual dose: 7.5 to 15mg per week. Max: 30mg per week.
  And
  Folic acid 5mg, orally, daily (except on the day the methotrexate is taken)

NOTE: All patients prescribed oral methotrexate must be issued with the National Patient Safety Agency Patient Information Leaflet and Patient-held Monitoring Booklet.

- **Ciclosporin (Capimune®)** 1.5mg/kg, orally, twice daily. Increase to 2.5mg/kg twice daily after 2 to 4 weeks if a good response is not achieved.
- **Azathioprine** 1 to 3mg/kg, orally, daily. Doses should be adjusted within these parameters according to response
  NOTE: Unlicensed indication
- **Acitretin** 10 to 25mg, orally, daily. Adjust according to response. Usual maintenance: 25 to 50mg daily. Max: 75mg daily. Exclude pregnancy before and during treatment. Women should be advised to avoid pregnancy for at least one month before, during and for at least two years after treatment.
  NOTE: Hospital only medicine
- **Hydroxycarbamide (unlicensed)** 500micrograms, orally, once daily. Increase according to response to a maximum of 2g daily.
- **Mycophenolate mofetil** 500mg, orally, daily. Dose increased according to response to a maximum of 1g three times a day.
- **Fumaric acid (dimethyl fumarate; unlicensed) N.B** **MHRA Drug safety update- updated advice on risk of progressive multifocal leukoencephalopathy**
  Increase dose as indicated in the table below (available as 30mg and 120mg tablets):
  NOTE: Hospital only medicine

Week	Dose of oral Fumaderm® (dimethyl fumarate)
1	30mg daily in the morning
2	30mg twice daily
3	30mg three times a day
4	120mg daily in the morning
5	120mg twice daily
6	120mg three times a day
7	240mg in the morning, 120mg in the afternoon and evening
8	240mg in the morning and evening, 120mg in the afternoon
9	240mg three times a day

- **Apremilast** Initially 10 mg daily on day 1, then 10 mg twice daily on day 2, then 10 mg in the morning and 20 mg in the evening on day 3, then 20 mg twice daily on day 4, then 20 mg in the morning and 30 mg in the evening on day 5, then maintenance 30 mg twice daily.
  NOTE: To be initiated by a dermatology consultant ONLY, as per NICE technology appraisal 419 (https://www.nice.org.uk/guidance/ta419)

Shared care protocols are available for:

- **Methotrexate**
- **Ciclosporin**
- **Azathioprine**

Biological agents

For patients whose psoriasis is not controlled with the treatments listed above, biological therapies might be suitable. See **Psoriasis (severe and very severe) — Treatment with biological agents (Adults) (hospital only document)** for information on when biological therapies are indicated, and which one should be selected.

These include:
Adalimumab 80mg, by SC injection, as a starting dose, then 40mg after one week, then 40mg every fortnight. Review efficacy after 16 weeks.
NOTE: To be initiated by a dermatology consultant ONLY, as per NICE technology appraisal 146 (https://www.nice.org.uk/guidance/ta146)

Or
Etanercept 50mg, by SC injection, weekly. Alternatively, 25mg twice weekly can be given. Review efficacy after 12 weeks.
NOTE: To be initiated by a dermatology consultant ONLY, as per NICE technology appraisal 103 (https://www.nice.org.uk/guidance/ta103)

Or
Ustekinumab Review efficacy after 16 weeks. Dosing as follows:
For patients weighing 100kg or less: 45mg, by SC injection, stat, then give second dose after 4 weeks, then give subsequent doses every 12 weeks.
For patients weighing over 100kg: 90mg, by SC injection, stat, then give a further 45mg after 4 weeks, and then give subsequent doses of 45mg every 12 weeks.
NOTE: To be initiated by a dermatology consultant ONLY, as per NICE technology appraisal 180 (https://www.nice.org.uk/guidance/ta180)

Or
Infliximab 5mg/kg, by IV infusion over 2 hours as a first dose. Administer in 250mL sodium chloride 0.9% via an in-line, sterile, non-pyrogenic, low protein binding filter — pore size 1.2 micrometer or less; infusions prepared by Pharmacy Aseptic Unit. Give further 5mg/kg doses 2 and 6 weeks after the first infusion, then every 8 weeks thereafter. Review efficacy after 10 weeks.
NOTE: To be initiated by a dermatology consultant ONLY, as per NICE technology appraisal 134 (https://www.nice.org.uk/guidance/ta134)

Or
Secukinumab 300 mg , by SC injection at weeks 0, 1, 2 and 3, followed by monthly maintenance dosing starting at week 4. Review efficacy after 12 weeks.
NOTE: To be initiated by a dermatology consultant ONLY, as per NICE technology appraisal 350 (https://www.nice.org.uk/guidance/ta350)

Or
Ixekizumab 160 mg by SC injection, at week 0, followed by 80 mg every 2 weeks until week 12. After week 12, 80 mg every 4 weeks. Review efficacy after 12 weeks.
NOTE: To be initiated by a dermatology consultant ONLY, as per NICE technology appraisal 442 (https://www.nice.org.uk/guidance/ta442)

4. Skin irritation – prevention (use of barrier creams)

Barrier preparations are used to give protection against irritation from repeated exposure to body fluids. There is little evidence to prove efficacy.

Primary care

First choice
Conotrane® cream

Second choices
Drapolene® cream
Sudocrem®

Secondary care

First choice (secondary care)
Metanium®

Second choices
Cavilon®
Or
Antipeol (only available in secondary care)

Directions
Apply to the affected area when required.

5. Pruritus or urticaria

Pruritus can be exacerbated by dry skin. If eczema present consider use of emollients. Systemic antihistamines are a useful adjunct, generally sedating antihistamines work best.

Urticaria will respond to non-sedating antihistamines. All of the currently available non-sedating antihistamines can be used at 2–3 times their maximum licensed dose for this indication (although such use is not licensed).

Sedating antihistamines
Chlorpheniramine 4mg, orally, up to four times a day as needed
Or
Hydroxyzine (very sedating) 25mg orally at night, increase if necessary to 25mg 3 or 4 times daily
Or
Promethazine 10mg-20mg 2 or 3 times daily.
NOTE: VERY sedating. Exercise caution in use outside of hospital

Non-sedating antihistamines
Cetirizine 10 to 20mg, orally, daily (licensed maximum: 10mg daily).
Or
Loratidine 10mg, orally, daily
Or
Fexofenadine 180 to 360mg, orally, daily.
NOTE: Non-sedating antihistamines do NOT relieve eczematous itch

For severe chronic spontaneous urticaria
Omalizumab
NOTE: To be initiated by a dermatology consultant ONLY, as per NICE technology appraisal 339 (www.nice.org.uk/ta339)

For patients with resistant pruritus (without urticaria)
First choice
Urea-containing creams (eg, **E45 Itch Relief Cream**®, **Balneum Plus**®, **Nutraplus**®)

Second choice
Menthol 1% in oily cream (potentially very costly in primary care)

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6. Acne and rosacea

i) Mild acne

Mild acne can be treated with topical preparations alone. Both comedones and inflamed lesions respond well to benzoyl peroxide. Benzoyl peroxide and tretinoin can be used in combination if required, one being applied in the morning and one in the evening. Tretinoin is more effective where comedones predominate.

First choice
Benzoyl Peroxide 5% gel Apply once or twice daily

Second choice
Tretinoin (Retin-A®) 0.025% cream Apply thinly once or twice daily
Or
Adapalene (Differin®) 0.1% cream/gel Apply once daily at night

Third choice
Benzoyl Peroxide 5% gel and **Adapalene (Differin®) 0.1% cream/gel** — the two products should be trialled together, dosing as above

Fourth choice
Benzoyl peroxide 2.5% / adapalene 0.1% (Epiduo®) gel Apply once a day in the evening

ii) Inflammatory acne

First choice — mild inflammatory acne
Benzoyl peroxide 5% / clindamycin 1% (Duac Once Daily®) Apply once daily in the evening
Or
Isotretinoin 0.05% / erythromycin 2% (Isotrexin®) Apply thinly once or twice daily
Treat for a minimum of 3 months. If adequate antibiotic therapy does not produce a satisfactory response, patients should be referred to a dermatologist.

First choice — severe inflammatory acne
Oxytetracycline 500mg, orally, twice daily.

Second choices
Erythromycin 500mg, orally, twice daily
Or
Trimethoprim 300mg, orally, twice daily (unlicensed dose)
Or
Lymecycline 408mg, orally, daily

Treatment must be given for a minimum of 3 months; expect a 60% improvement during this time. If adequate antibiotic therapy does not produce a satisfactory response, patients should be referred to a dermatologist.

Hormonal treatment (female patients)
Co-cyprindiol 1 tablet, orally, daily for 21 days; start on day 1 of menstrual cycle and repeat after a 7-day interval. Useful for women who also wish to have oral contraception, who have a greasy complexion or who experience peri-menstrual flares.
iii) Severe nodulocystic acne *— Consultant dermatologist only*

Isotretinoin 500 micrograms/kg, orally, daily for 4 weeks. Then increase to 1mg/kg daily in one or 2 divided doses for a further 14 weeks. Exclude pregnancy before and during treatment. Women should be advised to avoid pregnancy for at least one month before, during and for at least two years after treatment. Baseline liver function tests and lipid levels should be done.
NOTE: Lower doses and intermittent treatment have been used successfully in some patients

iv) Mild to moderate rosacea

First choice
Metronidazole (Rozex®) 0.75% cream / gel Apply to the affected areas twice daily for 3 to 4 months. If sustained improvement is evident, continue for a further 3 to 4 months.

Second choice if above treatment fails
Ivermectin cream Apply to the affected areas once daily for 4 months (if no improvement after 3 months the treatment should be discontinued).

v) Severe rosacea

Ivermectin cream Apply to the affected areas once daily for 4 months (if no improvement after 3 months the treatment should be discontinued).
Or
Oxytetracycline 500mg, orally, twice daily for 6 to 12 weeks.
Or
Lymecycline 408mg, orally, daily for 6 to 12 weeks
NOTE: Unlicensed indication
Or
Metronidazole 200mg, orally, three times a day for 6 to 8 weeks
NOTE: Unlicensed indication
Or
Erythromycin 500mg, orally, twice daily for 6 to 12 weeks

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7. Topical fungal infections

Mild skin infections

Clotrimazole 1% cream Apply two to three times a day. Continue treatment for at least one month.
Or
Clotrimazole 1% / hydrocortisone 1% (Canesten HC®) cream Apply once or twice a day. Continue treatment for at least one month.
Or
Miconazole 2% cream Apply twice a day. Continue treatment for at least one month (See MHRA Drug Safety Alert- Topical miconazole: reminder of potential for serious interactions with warfarin).
Or

Miconazole 2% / hydrocortisone 1% (Daktacort®) cream Apply twice a day. Continue treatment for at least one month (See MHRA Drug Safety Alert- Topical miconazole: reminder of potential for serious interactions with warfarin).

Severe skin infections and extensive skin infection
NOTE: Skin scrapings or hair samples must be sent for mycological examination before systemic treatment starts.
Terbinafine 250mg, orally, once daily. Continue treatment for 2 to 6 weeks.
Or
Itraconazole 400mg, orally, twice daily for 7 days. Continue treatment for 2 to 3 weeks

Scalp infections
Ketoconazole 2% shampoo. Continue treatment for 4 to 6 weeks.

Nail infections
NOTE: Nail clippings must be sent for microbiological analysis and the presence of fungal organisms confirmed before treatment starts.

First choice (if just one nail affected)
Amorolfine 5% nail lacquer Apply to infected nails once or twice weekly. Treat fingernails for 6 months and toenails for 9 to 12 months.

Second choice (or first choice if several nails affected)
If the above treatments failed
Terbinafine 250mg, orally, once daily. Continue for 6 weeks for fingernail infections and 3 months for toenail infections.
Or
Itraconazole 400mg, orally, twice daily for 2 or 3 pulses of treatment. Each pulse of treatment lasts 7 days. For fingernail infections, 2 pulses of treatment (with 3 weeks in between) are required. For toenail infection, 3 pulses of treatment (with 3 weeks between each) are required.
NOTE: Patients treated in primary care should commence topical preparations before using oral preparations.
In secondary care the treatment choice is at the discretion of the consultant and is dependent on the severity of infection and previous treatments used.

8. Scabies

Treatment should be from the neck down in most healthy adults, paying particular attention to under rings, the webs on fingers and toes and brushing the lotion under the ends of nails. For babies and bed-bound patients, the scalp, neck, face, and ears should also be treated. All members of the household and close contacts should be treated simultaneously. Do not apply after a hot bath.

First choice

Permethrin 5% (Lyclear Dermal Cream®) Apply to whole body. Wash off after 8 to 12 hours. If two applications of treatment are necessary, they should be used 7 days apart. **Apply to hands, and soles of feet. If hand washing is necessary before time for final removal do not forget to re-apply to the affected area.**

9. Head and pubic lice

a) Head lice

Chemical preparations for head louse infection should never be recommended or used unless a living, moving louse has been found on a patient's head. Ideally, if one member of the household has a current infection, detection combing of all members should be undertaken, and only those found to be infected should be treated. There is no need to keep children with head lice away from school. Treatment choices are as follows:

First choice
Dimeticone 4% lotion Rub in sufficient lotion to cover dry hair from the base to the tip ensuring that no part of the scalp or hair is left uncovered. Allow hair to dry naturally and remove by washing after 8 hours. Repeat the treatment after seven days.
Second choice
Malathion 0.5% aqueous liquid Rub in sufficient lotion to cover dry hair from the base to the tip ensuring that no part of the scalp or hair is left uncovered. Allow hair to dry naturally and remove by washing after 12 hours. Repeat the treatment after seven days. Application of malathion for more than 3 consecutive weeks should be avoided.

Third choice
Wet combing Only suitable in primary care

b) Pubic lice

First choice
Malathion 0.5% aqueous liquid Apply to whole body including beard and moustache if necessary. Allow to dry naturally and remove by washing after 12 hours or overnight. Repeat the application if necessary after seven days.

Second choice
Permethrin 5% cream Adults 18 years and over: Sufficient cream should be applied to cover the pubic region, peri-anal, inner thighs down to the knees and any hair that grows up from the pubic area to the chest/stomach. Repeat the application if necessary after seven days.

10. Warts

First choice
Salicyclic acid 16.7% / lactic acid 16.7% (Salactol®) paint Apply daily (avoid unaffected skin), allow the area to dry and cover with a plaster. If necessary the wart can be gently

pared every few days. Stop treatment if there is excessive irritation. Do not use on the face or mucous membranes.

Second choice

- **Salicylic acid 12%, lactic acid 4% (Salatac®) gel**

If there is no response after several months, cryotherapy may be considered. However, there is no evidence that cryotherapy is any more effective than topical treatment.

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11. Melasma

Melasma is a condition that causes patches of tanned or darkly discoloured skin. Historically, it has been treated with a specially manufactured product called “Manchester Bleaching Cream”, although this has become difficult to obtain.

Topical products containing hydroquinone can help to depigment the skin, although melasma often resolves spontaneously over several months. If treatment is indicated, the following preparation should be used where possible.

Hydrocortisone 1%, hydroquinone 5% in tretinoin 0.1% lotion Apply to the affected area daily for 3 to 4 months.
NOTE: Advise patient to apply lotion sparingly using a cotton bud
NOTE: To be prescribed by hospital clinicians ONLY