Chapter 13: Skin

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13.1 General principles

- Emollients are important in the management of atopic eczema and should be used regularly by all patients even when skin is clear.
- Choice of preparation should be based on severity of condition (a stepped approach), patient preference and site of application. Management can then be stepped up or down, according to the severity of symptoms.
- Prescribing of emollients for non-clinical cosmetic purposes is not recommended and should be reviewed. Mild dry skin can be managed via self-care.
- Promote patient self-care in the management of their skin conditions. See appendix 4 for further information on over the counter (OTC) products available from pharmacies.
- Do not prescribe bath emollients or additives unless recommended by specialist dermatology services. See criteria in the Sheffield STOP guidance. Consider using emollients suitable as soap substitutes or bath additives instead. See choices below or in the abbreviated guide to emollients.
- People with eczema should be advised to wash with a regular leave-on emollient as a soap substitute. Note that leave-on emollients may make surfaces slippery. See warning information on fire hazards with emollient use.
- Topical steroids used intermittently to control exacerbations of atopic eczema are effective and rarely cause side effects. However, see MHRA alert (September 2021) for information on the risk of topical steroid withdrawal reactions
- For detailed guidance refer to NICE CG57 Management of atopic eczema in children from birth up to the age of 12 years.

13.2 Emollients

Preparations in **bold** indicate first line choices. 2nd and 3rd line options are given in case of shortage of first line treatment and for patient preference. All three are formulary choices and non-formulary alternatives are provided in abbreviated guide to emollients. Emollient choices have been made by using multiple factors such as safety, cost-effectiveness, available ingredient information, supply availability and impact on greener NHS initiative. Choices will be checked on annual basis. Please refer to abbreviated guide to emollients used in primary care for more detailed choice, comparison and ingredient list, including paraffin-free, soap substitutes, bath additives and vegan options.

Creams:

Epimax® original	**500g Bottle (OTC)**
Epimax® excetra cream	500ml bottle (OTC)
ZeroAQS® cream	500g Tub (OTC)

Ointments:

Fifty:50 ointment	**500g Tub (OTC)**
Aproderm® ointment	500g Tub (OTC)
Zeroderm® ointment	500g Tub (OTC)

Gels:

Epimax® isomol gel	**500g Bottle (OTC)**
Aproderm® gel	500g Tub (OTC)
MyriBase® gel	500ml pump (OTC)

Lotions:

QV® skin lotion	**500ml Pump (OTC)**
Cetraben® lotion	500ml Pump (OTC)

Colloidal oatmeal preparations:

Epimax® oatmeal cream	**500ml Bottle (OTC)**
Miclaro® oat cream	500ml Pump (OTC)
AproDerm® colloidal oat cream	500ml Pump (OTC)

Emollients should be the first line treatment for mild dry skin conditions.

- There is no evidence that any one emollient is better than another but there is wide inter-patient variability in response to treatments. The emollients of choice are therefore the least expensive ones that are effective and which the patient finds acceptable and is prepared to use. Encourage self-care.
- If their current emollient causes irritation or is not acceptable, offer a different way to apply it or offer an alternative emollient.
- Sufficient quantities should be prescribed - for more guidance see here.
- Advise to use emollients liberally and frequently (at least two to four times a day; very dry skin may require application every two to three hours)
- Children with atopic eczema should be prescribed sufficient quantities (250-500g weekly) of unperfumed emollients for daily use.
- Creams and gel emollients are easier to apply but ointments have a better emollient effect (the greasier the product the more effective it is at keeping the skin hydrated).
- Atopic people are more likely to react to ingredients found in emollients compared with the general population, so it is important to anticipate potential sensitivity reactions. See abbreviated emollient guide and MIMS for more information.
- Emollients should be applied in the direction of hair growth to reduce the risk of folliculitis.
- Creams and ointments are suitable for use as soap substitutes for hand washing and in the bath. Epimax® cream (light cream) is available is a squeezy bottle; it's suitable for use in the shower or bath. Ointments (greasy) are available in tubs, therefore may be less suitable for use in a shower. When using as a soap substitute avoid application to and around eyes.
- If emollient is available in a tub, then use a spatula to dispense the emollient. This helps with infection control.

Patient education links:
http://www.nhs.uk/conditions/emollients/pages/introduction.aspx
http://www.eczema.org/emollients
Booklets and factsheets for both healthcare professionals and patients covering a range of issues relating to eczema are available from The National Eczema Society.
http://www.eczema.org

Fire hazard with emollients:
Many patients use emollients containing paraffin for dry skin conditions. Care must be taken when creams are applied as these can be transferred to clothing, bedding, bandages and any other flammable material. Patients should be warned and advised of the fire risk when using emollients. MHRA provides a safety advice on emollients use. Please consider using fire safety information, on how to reduce the risk of fire from emollients.

13.2.1 Preparations containing urea

Imuderm® cream (5% urea / 5 % glycerine)	500g pump pack (OTC)

Urea is a keratin softener and hydrating agent used in the treatment of dry, scaling conditions (including ichthyosis).
Preparations with urea should only be prescribed where standard emollients are ineffective. They should not be prescribed long term.
Emollient products containing urea are generally not interchangeable. The urea content of products varies, and some contain additional active ingredients such as salicylic acid, lactic acid or lauromacrogols.
It is occasionally used with other topical agents such as corticosteroids to enhance penetration of the skin.
Products containing urea tend to sting moderate to severe eczema skin and not tolerated well in younger children and babies due to irritation.

Patients managed by Podiatry Services may require preparations other than Imuderm® for foot treatment, e.g., Flexitol 25% Urea Heel Balm® cream (urea 25% cream, pack size 500g).
For training on Diabetic Foot Screen - see here.
Sheffield Diabetes Footcare Pathway.

13.2.2 Emollient bath additives

There is a lack of data on the clinical effectiveness of bath emollients, which are not substitutes for emollients applied directly to the skin.

Do not offer bath emollients or additives to children with atopic eczema unless recommended by specialist dermatology services. NICE CG57 2023 update recommends in establishing a personalised advice on washing routine in children with eczema.

NICE CG57 advises that health care professionals should offer children with atopic eczema a choice of unperfumed emollients for moisturising, washing and bathing. Many standard emollients (creams and ointments) can be used as a soap substitute. Ointments that are completely immiscible with water (e.g., white soft paraffin alone) are not suitable. For more information see here.

Leave-on emollients (creams / gels) should be applied to the skin before or during bathing / showering / washing and then rinsed off. Alternatively, melt approximately 4g (the size of a £2 coin) of ointment in hot water and add to the bath (best to do this under a running tap).

Regular application of leave-on emollient is necessary after skin has been gently patted dry with a towel.

Care with bath additives as they make skin and surfaces slippery. Some ointments can block drainage pipes.
Routine use of antiseptic / emollient products is not recommended.

People who prefer to use emollient bath additives as a soap substitute should be advised to purchase it over the counter. Please see Sheffield STOP guideline.

13.2.3 Barrier preparations

Medi Derma-S Total Barrier cream®	90g (OTC)
Medi Derma-S Total Barrier film®	28ml (OTC)
Medi Derma-PRO Foam & Spray Incontinence Cleanser®	250ml (OTC)
Medi Derm-PRO Skin protectant ointment®	115g (OTC)

For advice on Prevention & Management of Moisture Associated Skin damage (MASD) see here.

13.3 Antipuritics

Crotamiton (Eurax®) cream / lotion	30g,100g /100ml (OTC)

A standard emollient may be of value for itching associated with dry skin. Intractable pruritus may be treated with an oral sedating antihistamine (refer to BNF). Where possible treat the underlying cause. Emollients containing urea are more expensive than standard emollient therapy. Where urea-containing cream is required, consider Imuderm® cream.

13.4 Topical Corticosteroids

Hydrocortisone cream and ointment 1% **(Mild)** 30g

Hydrocortisone cannot be sold OTC for use on face, anogenital region, and broken or infected skin and should not be sold without medical advice for children under 10 years or for pregnant women, 15g tube available OTC

Clobetasone butyrate (e.g. Eumovate®) cream and ointment 0.05% **(Moderate)** 30g, 100g

Eumovate Eczema & Dermatitis® cream, for use in adults and children 12 years of age and over for up to 7 days, 15g tube available OTC

Betamethasone valerate (e.g. Betnovate® RD) cream and ointment 0.025% **(Moderate)** 100g

Betamethasone valerate (e.g. Betnovate®) cream and ointment 0.1% **(Potent)** 30g, 100g

Betamethasone valerate (e.g. Betacap®) scalp application 0.1% **(Potent)** 100ml

Clobetasol propionate (e.g. Dermovate®) cream and ointment 0.05% **(Very Potent)** 30g, 100g

- Use the least potent topical corticosteroids in the lowest concentration that is effective in controlling symptoms.
- See National Eczema Society and British Association of Dermatologists joint position statement on Topical Steroid Withdrawal and advice on Topical Steroid Addiction
- MHRA alert: Topical corticosteroids: information on the risk of topical steroid withdrawal reactions (September 2021)
- See fingertip unit guide and quantity to prescribe in appendix 2
- Emollient use should exceed steroid use by 10:1 in terms of quantity for atopic eczema.
- Short-term use 3-7 days, if possible, unless otherwise advised by a specialist.

There are no standard rules on whether to apply a topical steroid before or after using an emollient. Whichever order of care is used, it is important to leave as long a period as practical, 20–30 minutes between the two treatments. This is intended to avoid diluting the strength of the topical steroid preparation, and to prevent the spread of topical steroids to areas not affected by eczema.

See NICE CG57 for additional advice on use topical corticosteroids in children.
See NICE CKS and NICE TA81 for advice on Corticosteroids - topical treatment
See http://www.eczema.org/factsheets for patient information leaflet.

13.4.1 Topical corticosteroids with antimicrobials

Hydrocortisone acetate 1%, fusidic acid 2% (Fucidin H®) cream **(Mild)**	30g, 60g
Betamethasone valeate 0.1%, fusidic acid 2% (Fucibet®) cream **(Potent)**	30g, 60g

Moderate to severe infection should be managed with oral antibiotics. Topical antibiotics, with or without steroids, have little place in therapy and routine use is not recommended.
Avoid using fusidic acid for more than 7 days (due to the increased risk of sensitization and bacterial resistance).

13.5 Preparations for psoriasis

Vitamin D and analogues:

Calcipotriol ointment **-** max. 100g weekly	30g, 120g
Calcitriol (Silkis®) ointment - max. 30g daily, not more than 35% of body surface	100g

With betamethasone:

Calcipotriol with betametasone dipropionate 0.05% ointment **(Potent)**	30g, 60g, 120g
Calcipotriol with betametasone dipropionate 0.05% gel **(Potent)**	60g
Calcipotriol with betametasone dipropionate 0.05% foam (Enstilar®) **(Potent)**	60g
Betamethasone 0.05% Salicylic acid/2% scalp application (Diprosalic®) **(Potent)**	100ml

Tars:

Exorex® (coal tar 5%) lotion	100ml, 250ml
Sebco® scalp ointment – for thick scalp psoriasis	40g, 100g

Shampoos:

See BNF for more information.

Emollients may be sufficient for mild conditions and are useful adjuncts to more specific treatments.
If a vitamin D analogue is ineffective or not tolerated, then coal tar preparations should be considered in appropriate patients.

Calcipotriol should be applied to the plaque in a fairly thick layer, once or twice daily. Improvement usually becomes apparent within 2 weeks and continues for at least 8 weeks.
Calcitriol is less irritant than calcipotriol and suitable for application to face and flexures.

When using calcipotriol containing medicinal products, the maximum daily dose should not exceed 15g. The body surface area treated with calcipotriol containing medicinal products should

not exceed 30 %.

Calcipotriol with betamethasone preparations are **not** the first line treatment. Potent topical corticosteroids in psoriasis should be used with caution because of tolerance, rebound effects and side–effects, particularly on prolonged use or use on more than 30% body surface area.

Calcipotriol with betamethasone dipropionate 0.05% should be applied to the affected area once daily. The recommended treatment period is no more than 4 weeks.

Use of calcipotriol with betamethasone dipropionate 0.05% gel should be for no more than 4 weeks for scalp and non-scalp areas at a time with subsequent courses repeated after an interval of 4-8 weeks using calcipotriol alone.

If calcipotriol with betamethasone dipropionate 0.05% ointment or gel preparations are ineffective then consider Enstilar® foam for maximum of 4 weeks before referral to secondary care.

Light therapy is an option available from secondary care.
Oral retinoids should be prescribed by specialists (Red traffic light drugs).

For further information on psoriasis treatment see:
NICE CG153 (2012 updated 2017) Psoriasis: assessment and management
NICE QS 40 (2013) Psoriasis
NICE CKS Psoriasis

13.5.1 Drugs affecting the immune response

Immunosuppressants should be used under specialist advice only.
Shared Care Protocols are in place for methotrexate and azathioprine - **Amber** on traffic light drug list.

Topical tacrolimus and pimecrolimus are classified as green, when a prescriber is GPwSI in dermatology, or on their recommendation, or is competent in prescribing in dermatological conditions.
See NICE TA82 (2004) and PCDS for advice on the use of tacrolimus and pimecrolimus for atopic eczema.
Please note: While systemic absorption of tacrolimus and pimecrolimus is rarely detectable, it is increased in severe skin barrier disorders. The use tacrolimus ointment and pimecrolimus cream is not recommended in the following conditions:

- Netherton's syndrome
- Lamellar ichthyosis
- Generalized erythroderma
- Cutaneous Graft Versus Host Disease

13.6.1 & 13.6.2 Topical and oral preparations for acne

See separate clinical guideline for diagnosis, treatment, and support in acne.

13.6.1 Topical preparations:

Benzoyl peroxide (BPO) (e.g. Acnecide®) 5% w/w gel	30g, 60g (OTC)
Adapalene 0.1% (Differin®) cream/ gel - for comedonal acne	45g
Adapalene 0.1% / benzoyl peroxide 2.5% (Epiduo®) gel	45g
Adapalene 0.3% / benzoyl peroxide 2.5% (Epiduo®) gel	45g
Azelaic acid 20% (Skinoren®) cream	30g
for darker skin with hyperpigmentation associated with acne	
Treclin® (clindamycin 1%, 0.025% tretinoin) gel	30g
Duac Once Daily® (clindamycin 1%, benzoyl peroxide 3%) gel	30g
Duac Once Daily® (clindamycin 1%, benzoyl peroxide 5%) gel	30g, 60g

13.6.2 Oral preparations:

Doxycycline capsules – 100mg once daily (unlicensed)
Lymecycline capsules – 408mg once daily
Erythromycin tablets - 500 mg twice daily (if tetracyclines contra-indicated or not tolerated)
Trimethoprim tablets – 300mg twice daily (unlicensed) (if tetracyclines contra-indicated or not tolerated)

PCDS provides a primary care treatment pathway that summarises treatment options for acne and when to refer to dermatology consultant. This pathway should be used together with *Acne vulgaris* management guidelines by NICE.

Minocycline is associated with more severe adverse effects and should not be prescribed in primary care except where initiated by specialist and monitoring recommendations given.

Discussing treatment choices with a person with childbearing potential, cover:
That topical retinoids and oral tetracyclines are contraindicated during pregnancy and when planning a pregnancy and that they will need to use effective contraception or choose an alternative treatment option to these.

Hormone treatment

Co-cyprindiol (cyproterone/ ethinylestradiol 2mg/ 35micrograms) tablets
endorse the prescription if also used for contraception.
Alternative combined oral contraceptive pill (Unlicensed)

Oral isotretinoin is Red on traffic light drug list. Used in severe forms of acne (such as nodular or conglobate acne or acne at risk of permanent scarring) resistant to adequate courses of standard therapy with systemic antibacterial and topical therapy; The MHRA has adopted the recommendations of the European Medicines Agency with regard to prescribing isotretinoin for women, with the implementation of the Pregnancy Prevention Programme (PPP).

13.6.3 Topical and systemic preparations for rosacea

See Appendix 5 for place in therapy

Topical preparations:

Ivermectin 1% cream (Soolantra®) - Papulopustular rosacea **45g**
Metronidazole 0.75% cream, gel (Rozex®) - pustules and erythema of rosacea **30g, 40g**
Azelaic Acid 15% gel (Finacea®) - Papulopustular rosacea 30g
Brimonidine 3mg/g gel (Mirvaso®) - facial erythema of rosacea **(**Amber on Traffic light drug list) 30g

Oral preparations:

Doxycycline capsules – **100mg once daily (unlicensed)**
Erythromycin tablets - **500 mg twice daily**
Doxycycline 40mg modified release capsules – **40mg once daily** (consider discussion with dermatologist, for long-term treatment)

PCDS and NICE CKS provide guidance on treatment of rosacea.
PCDS provides a separate guide for primary care treatment pathway explaining, which creams, and antibiotics are suited for different type of rosacea. See Appendix 6: Rosacea, for further information.

13.7 Preparations for warts, corns and calluses

Salactol® paint (Salicylic acid 16.7%/ lactic acid 16.7 %) 10ml (OTC)
Duofilm® paint (Salicylic acid 16.7%/ lactic acid 15%) 15ml (OTC)

Encourage self-care first line. Apply daily, protecting surrounding skin; rub with file or pumice stone once weekly. Treatment may need to be continued for up to 3 months.

13.8 Sunscreen preparations

Anthelios Sunscreen Lotion SPF50+ 250ml (OTC)
Uvistat® Suncream SPF 50 125ml (OTC)

Encourage self-care. Preparations with SPF 50 are available OTC, also see appendix 4.

Only available on NHS for skin protection for photodermatoses, including drug related phototoxicity. Mark the prescription “ACBS” (see BNF, appendix 2) when prescribed for photodermatoses, including vitiligo and those resulting from radiotherapy; chronic or recurrent herpes simplex labialis.
http://www.patient.co.uk/doctor/Photosensitive-Eruptions-(Photodermatoses).html

Preparations with an SPF less than 30 cannot be prescribed on FP10.
For advice on the use sunscreen preparations see NICE NG34 (2016) on sunlight exposure: risks and benefits.
Water-resistant sunscreen is needed if sweating or contact with water is likely.

13.8.1 Preparations for actinic keratosis

Diclofenac sodium 3% gel (Solareze® gel)	50g,100g
5% 5- Fluorouracil cream (Efudix® cream)	40g
0.5% 5-Fluorouracil / 10% salicylic acid cutaneous solution (Actikerall®)	25ml

See Actinic Keratosis pathway for place in therapy and directions for use: Managing actinic keratosis

13.9 Shampoos and other preparations for scalp and hair conditions

Capasal® shampoo	250ml (OTC)
Nizoral (Ketoconazole) 2%	120ml (OTC)

Encourage Self-care first line also see appendix 4.

13.9.1 Preparations for Hirsutism

Eflornithine 11.5% cream – **Amber G** on traffic light drug list	60g

13.10.1 Topical antibacterial / antiseptic preparations

Hydrogen peroxide 1% cream – for non-bullous impetigo	25g, 40g
Fusidic acid 2% cream	15g, 30g
Mupirocin 2% - for MRSA	15g

There is an increasing resistance to topical preparations. Reserve for short term use of acute local infections and mupirocin for MRSA. Impetigo on small areas of skin may be treated with short-term hydrogen peroxide 1% (or fusidic acid 2% if hydrogen peroxide unsuitable or ineffective). If the impetigo is extensive or long-standing, an oral antibiotic (flucloxacillin or erythromycin if penicillin-allergy) should be used – see Chapter 5.

13.10.2 Antifungal preparations

Clotrimazole 1% cream	20g (OTC)
Clotrimazole 1% solution	20ml

For oral treatment of dermatophyte infections see Chapter 5 Treatment of Infections.

13.10.3 Antiviral preparations

Aciclovir 5% cream	2g (OTC)

Treatment of cold sore should begin as early as possible at first sign of attack. Unlikely to help

once the cold sore has erupted.

13.10.4 Parasiticidal preparations

Dimeticone 4% lotion (Hedrin®) - Headlice	50ml, 150ml (OTC)
Permethrin 5% cream - Scabies	30g

Headlice:

Non-drug treatment such as "Bug Busting" (wet combing) should be used 1st line. Information on prevention and treatment of headlice, which includes information on ''Bug Busting'' can be found here.

Head lice: all members of the affected household should be screened for infestation. Treat only if live lice are identified - use separate prescription for each person when dimeticone is required.

Use of dimeticone (Hedrin®) is restricted to second line with an exemption for patients unable to use the wet comb method (i.e., have tight curly hair, Afro-Caribbean descent).

Scabies:

All members of the affected household should be treated simultaneously – use separate prescription of permethrin for each person. Manufacturer of permethrin recommends application to the body but to exclude the head and neck. However, application should be extended to the scalp, neck and ears. Larger patients may require up to two 30g packs for adequate treatment.

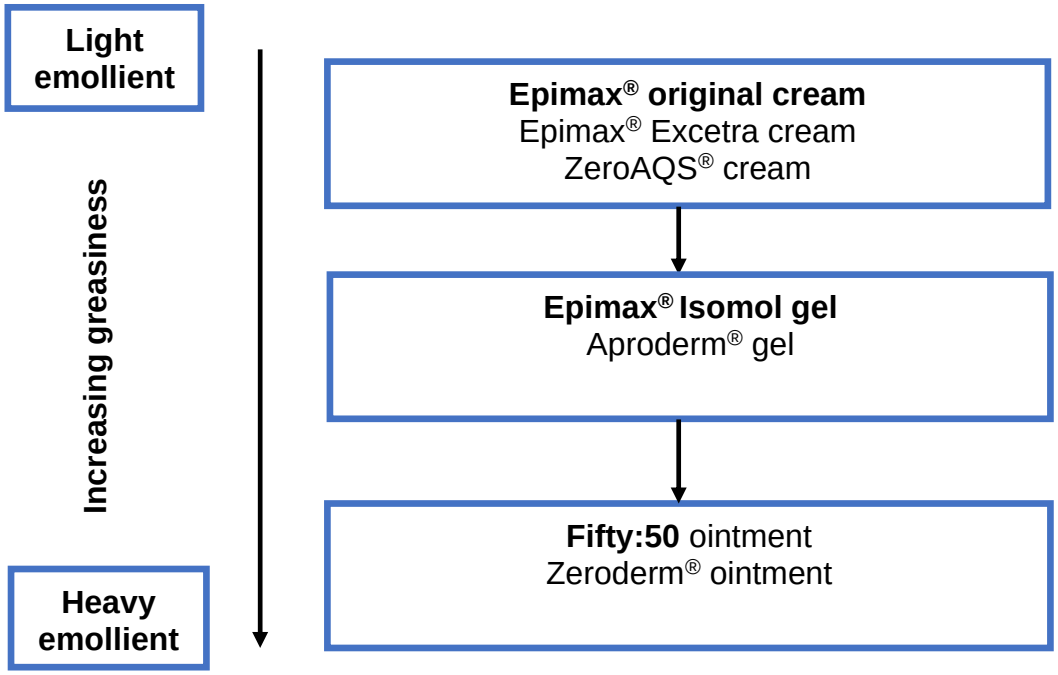
For patients in a care home, if just one resident has scabies they alone can be treated. The care home has a responsibility to inform the practitioners seeing that patient, who may wish to notify UK Health Security Agency Health Protection Team if advice and support is needed.
If there is more than one patient, then all the patients and staff are normally treated, and it is classed as an outbreak. The care home should notify Health Protection Team and they will advise the home.

UK Health Security Agency advice for schools (2021): Health protection in schools and other childcare facilities

Appendix 1: Choice of emollients and soap substitutes

Below are examples of emollients that can be used as soap substitutes, for further information please refer to emollient table, that provides more details and examples.
When using as a soap substitute avoid application to and around eyes.

Choice of Emollients / Soap Substitutes



Choice of Bath Emollients
(Routine use of proprietary bath additives is not recommended)

Below are examples of emollients that can be used as bath additives, for further information please refer to emollient table, that provides more details and examples.

- Do not prescribe bath emollients as per Sheffield STOP list
- Creams and ointments are suitable for use as soap substitutes for hand washing and in the bath. When using substitute emollient avoid application to and around eyes.
- Epimax® cream (light cream) is available is a squeezy bottle; it's suitable for use in the shower or bath. Ointments (greasy) are available in tubs, therefore may be less suitable for use in a shower.
- Ointments are preferable for use instead of bath additives. To use as a bath additive, melt about 4g (the size of a £2 coin) in hot water and add to the bath. Care should be taken as this can make the bath slippery and block drains.

Fifty:50 ointment
Zeroderm® ointment

Appendix 2: Suitable quantities for prescribing

Table 1**. Emollients** – suitable quantities to prescribe for specific areas of the body.

These amounts are suitable for **adults and children 12-18 years for twice-daily application for 1 week;** smaller quantities will be required for children under 12 years.

Area of body	Creams and Ointments (for one week)	Lotions (for one week)
Face	15 to 30g	100ml
Both Hands	25 to 50g	200ml
Scalp	50 to 100g	200ml
Both Arms or Both Legs	100 to 200g	200ml
Trunk	400g	500ml
Groins and genitalia	15 to 25g	100ml

Data from: BNF

Table 2. **Corticosteroid preparations** – suitable quantities to prescribe for specific areas of the body.

These amounts are suitable for an adult for a single daily application for two weeks.

Area of body	Creams and Ointments
Face and neck	15 to 30g
Both Hands	15 to 30g
Scalp	15 to 30g
Both Arms	30 to 60g
Both Legs	100g
Trunk	100g
Groins and Genitalia	15 to 30g

Data from BNF

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Appendix 3: Fingertip unit guide on quantity of topical corticosteroid to apply for children and adults

Eczema management plan

Sheffield Children's Hospital NHS
NHS Trust

Use the adult Fingertip Unit (FTU) as your guide

One adult **Fingertip Unit (FTU)**

The diagrams of a child (below) show how many adult **Fingertip Units** of cream or ointment are required to cover each area of the child's body.

Age	Face and neck	Arm and hand	Leg and foot	Trunk (front)	Trunk (back) & buttocks
	Number of FTUs				
3-6 mo	1	1	1½	1	1½
1-2 years	1½	1½	2	2	3
3-5 years	1½	2	3	3	3½
6-16 years	2	2½	4½	3½	5
Adult	2½	4	8	7	7

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Appendix 4: Examples of OTC products

Promoting patients to manage conditions with over-the-counter preparations is encouraged and in line with self-care advice. Wherever clinically appropriate encourage 'pharmacy first' and signpost patients to purchase self-care preparations 'over the counter' (OTC).

Examples of OTC products

This is a list of OTC products which can be purchased by patients but not all are listed in the Sheffield Formulary.

Emollients and bath emollients – all are OTC products and are available for self-selection (patients may need to ask for larger pack sizes at the pharmacy counter).

Barrier preparations

Medi Derma-S Total Barrier cream®	90g
Drapolene® cream	100g, 200g, 350g

Antipruritics:

Crotamiton cream e.g., Eurax®	30g 100g
Eurax lotion®	100ml

Suitable for adults and children aged 3 years and over, for dermatitis, dry eczema, allergic rash, heat rash, chickenpox, nettle rash, sunburn, insects' bits and stings

Corticosteroid preparations

Hydrocortisone 1% cream	15g
Hydrocortisone 1% ointment	15g

Hydrocortisone cannot be sold OTC for use on face, anogenital region, and broken or infected skin and should not be sold without medical advice for children under 10 years or for pregnant women

Eumovate Eczema & Dermatitis 0.05% Cream ®	15g

Clobetasone butyrate (Eumovate®) cream 0.05%
is only licensed for use in adults and children 12 years of age and over for up to 7 days

Mild topical corticosteroids with antimicrobials:

Clotrimazole/ Hydrocortisone (Canesten Hydrocortisone®) cream	15g

Only licenced for patients over 10 years of age, for sweat rash and athlete's foot, licenced for use for up to 7days

Miconazole/ hydrocortisone (Daktacort Hydrocortisone®) cream	15g

For patients 10 years and over, for treatment of sweat rash and athlete's foot, for maximum 7 days

Mild topical corticosteroids with crotamiton:

Eurax HC® cream 15g
For inflammation and pruritus associated with irritant and contact dermatitis, Scabies, insect bite reactions and mild to moderate eczema. Licenced for adults and children over 10 years, for up to one week

Preparations for acne

Acnecide® (benzyol peroxide 5%) gel 30g, 60g

Wart & verruca & calluses preparations

Salactol® 10ml
For the treatment of warts, verrucas, corns and calluses. May be used in adults and children

Glutarol™ 10% w/v 10ml
For the topical treatment of warts, especially plantar warts.

Duofilm® 15ml
Treatment of warts
For adults and children 2 years and over

Bazuka®, Bazuka Extra Strength® 5g
Can be used for adults and children, for the treatment of verrucas, warts, corns and callouses

Sunscreen preparations:

Wide variety available: e.g.
Uvistat® creams,
Anthelios® melt-in creams, lotions, gels

Shampoos:

Nizoral® (Ketoconazole shampoo), 60ml, 100ml
For adults and children to treat dandruff, seborrhoeic dermatitis

Selsun® 2.5% shampoo 50ml, 100ml, 150ml
For adults and children 5 years and over, to treat dandruff, seborrhoeic dermatitis

Capasal® shampoo 250ml
For adults and children, for the treatment of dry, scaly scalp conditions such as seborrhoeic eczema, seborrhoeic dermatitis, dandruff, psoriasis and cradle cap in children

Neutrogena T/gel® shampoo 125ml, 250ml
For adults and children, for the treatment of scalp psoriasis, seborrhoeic dermatitis and dandruff

Polytar 4% Scalp Shampoo 150ml
For adults and children over 12 years for the treatment of psoriasis, seborrhoeic dermatitis, eczema, pruritus and scaling associated with psoriasis, seborrhoeic dermatitis and eczema itchy, oily scalp, dandruff

Antifungal preparations:

Clotrimazole 1%, cream 20g
Athlete's Foot, ringworm, fungal nappy rash, intertrigo, external thrush symptoms in men and women, may be used for up to 4 weeks

Clotrimazole 2% cream (Canesten Thrush® cream) 20g
For treatment of external thrush, available for patients 16- 60 years of age. Canesten Thrush® Cream should not be used for more than two episodes in any six-month period

Miconazole 2% (Daktarin®) cream 15g
For athlete's foot, dhobie itch, intertigo and infected nappy rash. May be used for up to 10 days

Antiviral preparation:

Aciclovir 5% cream 2g
For adults and children to treat herpes labialis, for up to 10 days.

Appendix 5: Rosacea management

Rosacea is exacerbated by the following factors

- Increasing age.
- Photosensitive skin types.
- Ultraviolet radiation exposure.
- Smoking.
- Heat or cold ambient temperature.
- Spicy foods and hot drinks.
- Alcohol.
- Emotional stress and exercise.
- Drugs such as calcium-channel blockers (may worsen vasodilatation and flushing) and topical corticosteroids.

Encourage patients to record a symptom diary to aid the identification of triggers
Consider dietary, lifestyle and medication advice when prescribing treatment.
Please not some systemic absorption can follow the topical administration. Most notably increase in warfarin effect with ivermectin and metronidazole administrations.

Consider the need for psychological support or psychiatric interventions in people with rosacea who experience anxiety or depression. Please refer to acne guideline for mental health advice.

Some people with rosacea find it beneficial to wash their skin with emollients, moisturise regularly and use appropriate sun protection. Soaps and washing products that contain detergent are irritant in some people should be avoided if they worsen the symptoms.

Use of topical preparations for rosacea

Skin reactions are common with these creams and choice might be determined by this factor.

Ivermectin 1% cream (Soolantra®) – indicated for the topical treatment of inflammatory lesions of rosacea (papulopustular) in adult patients. Application is once daily and should be discontinued if no improvement after 3 months. Usually well tolerated and does not have antimicrobial resistance risk.

Metronidazole 0.75% cream, gel (Rozex®) - indicated in the treatment of inflammatory papules, pustules and erythema of rosacea. Application is twice daily (morning and evening). The average period of treatment is three to four months. Less effective than ivermectin and risk of antimicrobial resistance.

Azelaic Acid 15% gel (Finacea®) – indicated for treatment of papulopustular rosacea. Application is twice daily (morning and evening). No antimicrobial resistance concern but may cause skin irritation.

Brimonidine 3mg/g gel (Mirvaso®) - is indicated for the symptomatic treatment of facial erythema of rosacea in adult patients is classified as amber on TLDL. The MHRA has reported on the risk of exacerbation of rosacea and risk of systemic cardiovascular effects. Gel to be used once every 24 hours for as long as facial erythema persists. The maximum daily recommended dose is 1 g of gel in total weight, which corresponds to approximately five pea sized amounts. In some patients,

erythema and flushing can return with greater severity than was present at baseline. The amount of gel can be applied based on tolerability and patient response.

How to apply the cream:
Please note that most creams will have specific instructions on how to apply the cream. Please refer to individual patient information leaflets.
A pea-size amount of medicinal product to each of the five areas of the face: forehead, chin, nose, and each cheek. The medicinal product should be spread as a thin layer across the entire face, avoiding the eyes, lips, nostrils and mucosa.
Hands should be washed before and after applying the medicinal product.

Use of systemic preparations for rosacea
Whenever possible, avoid using long term antibiotics due to antimicrobial resistance. There is no optimal duration but consider pros and cons of oral antibiotic after 2-3 months.

British Association of Dermatologists guidelines 2021 recommends offering oral antibiotic for severe papulopustural rosacea.
Options include azithromycin, clarithromycin, doxycycline, erythromycin, lymecycline, oxytetracycline and are considered safe. There is insufficient evidence to establish superiority, but currently only one preparation (modified-release doxycycline) is licensed for treatment of papulopustular facial rosacea (without ocular involvement).

Return to **13.6.3 Topical and systemic preparations for rosacea**