NHS Borders NHS Fife NHS Lothian

East Region Formulary

Skin Chapter (Adult)

24/03/2022

/1 /2 etc.	First line, second line, etc. choice(s)within the pathway
i	Key information to note for these recommendations
SI	Specialist Initiation: may be continued in a primary care setting
SUO	Specialist Use Only: must only be prescribed by a specialist
UM	Unlicensed Medicine: a medicine with no UK marketing authorisation
UI	Unlicensed Indication: licensed medicine being used outside the terms of its licence

Healthier Scotland
Scottish Government

Table of Contents

Parasite infections **6**
Head lice 6
Treatment of head lice 6
Pubic lice 7
Treatment of pubic lice 7
Scabies 8
Treatment of scabies 8
Skin conditions **9**
Acne 9
Treatment of mild to moderate acne 9
Treatment of moderate to severe acne 11
Treatment of severe acne (specialist supervision only treatment) 14
Actinic keratosis 15
Treatment of single or a few scattered actinic keratosis 15
Treatment of multiple (field) actinic keratosis – smaller areas of field change 17
Treatment of multiple (field) actinic keratosis – larger areas of field change (>25 square cm) 18
Treatment of multiple (field) actinic keratosis – specialist management 19
Boils 19
Cannulation 20
Topical anaesthetics for venepuncture 20
Cosmetic camouflage 21
Treatment with camouflagers 21
Dermatitis - contact 22
General prescribing notes for all adult pathways 22
Treatment with emollients (light weight) 24
Treatment with emollients (heavy weight) 25

Treatment with emollients (special circumstances) 26
Treatment with urea containing emollients 27
Treatment with soap substitutes and emollients for showering and bathing 28
Treatment with mild topical corticosteroids 29
Treatment with moderate topical corticosteroids 30
Treatment with potent topical corticosteroids 32
Treatment with very potent topical corticosteroids 34
Eczema 35
General prescribing notes for all adult pathways 35
Treatment with emollients (light weight) 37
Treatment with emollients (heavy weight) 38
Treatment with emollients (special circumstances) 39
Treatment with urea containing emollients 40
Treatment with soap substitutes and emollients for showering and bathing 41
Treatment with mild topical corticosteroids 42
Treatment with moderate topical corticosteroids 43
Treatment with potent topical corticosteroids 45
Treatment with very potent topical corticosteroids 47
Treatment of staphylococcal skin infection with inflammatory skin condition (e.g. eczema) 48
Treatment with topical corticosteroids combined with antimicrobials 49
Treatment of inflammatory skin conditions with antiseptics and astringents (specialist initiation) 51
Treatment with topical ichthammol preparations 52
Treatment with topical immunosuppressants 53
Systemic therapies in the treatment of moderate to severe eczema and atopic dermatitis 54
Biologic treatment of moderate to severe atopic dermatitis 56
Hirsutism 57
Treatment of hirsutism 57

Hyperhidrosis 58
Treatment with antiperspirants 58
Nappy rash 59
Treatment with barrier preparations 59
Pruritus 60
Topical treatment of pruritus 60
Oral antihistamines for the treatment of pruritis 61
Psoriasis 63
Treatment of mild to moderate psoriasis on the skin or scalp 63
Specific treatment of the face or flexures 66
Specific treatment of the trunk, limbs or scalp 68
Systemic therapies in the treatment of psoriasis - initial systemic therapies 71
Biologic treatment of chronic plaque psoriasis 73
Biologic treatment of psoriasis with psoriatic arthritis 77
Biologic treatment of chronic plaque psoriasis with inflammatory bowel disease 81
Biologic treatment of chronic plaque psoriasis in pregnancy 84
Alternative systemic treatment of chronic plaque psoriasis 85
Rosacea 86
Topical treatment 86
Systemic treatment 88
Seborrhoeic dermatitis 89
Scalp treatments for seborrhoeic dermatitis 89
Skin cleansing 90
Topical cleansers 90
Topical disinfectants 90
Sunscreening 91
Prescribable sunscreens for ACBS conditions 91

Superficial basal cell carcinoma 92
Treatment of superficial basal cell carcinoma 92
Urticaria 93
Oral treatment of chronic urticaria 93
Treatment of chronic spontaneous urticaria 95
Warts 96
Treatment of cutaneous and plantar warts 96
Specialist dermatology management 97
Cutaneous T-cell lymphoma 97
Treatment of skin manifestations of cutaneous T-cell lymphoma (commonly mycosis fungiodes) 97
Hidradenitis suppurativa 98
Treatment of Hidradenitis suppurativa 98
Photochemotherapy with psoralens and ultraviolet A (PUVA) 99
Treatment of skin conditions with PUVA 99

Group	Parasite infections
Condition	Head lice

Guidance links	NICE CKS: Head lice

Pathway 1	Treatment of head lice

/1	**Dimeticone**	Dimeticone 4% lotion	Apply once weekly for 2 doses, rub into dry hair and scalp, allow to dry naturally, shampoo after minimum 8 hours (or overnight).
/2	**Malathion**	Malathion 0.5% aqueous liquid	Apply once weekly for 2 doses, rub preparation into dry hair and scalp, allow to dry naturally, remove by washing after 12 hours.

Prescribing notes

- Dimeticone coats head lice and interferes with water balance in lice preventing the excretion of water; it is less active against eggs and treatment should be repeated after 7 days.
- During treatment with dimethicone 4% lotion, keep away from fire, especially naked flames and burning cigarettes, hair can burn readily if ignited.
- Head lice should be treated with lotion or liquid. Products with short application times e.g. cream rinse and mousse formulations, are not recommended. Shampoos are diluted too much during use to be effective and should not be used.
- Aqueous formulations are preferred in severe eczema, asthmatic patients and small children.
- Malathion should not be applied at intervals of less than 1 week or for more than 3 consecutive weeks since effectiveness is not increased.
- In pregnancy, dimeticone or wet combing are preferred. If malathion is required, the liquid in aqueous base should be used.
- Permethrin is not recommended for the treatment of head lice since currently available formulations are diluted too much during use.
- Routine treatment of family members is unnecessary, but contacts should have detection combing for live lice and then treatment if positive.
- Nit combs and devices are available via Pharmacy First.

Group	Parasite infections
Condition	Pubic lice

Guidance links	NICE CKS: Pubic lice

Pathway 1	Treatment of pubic lice

/1

	Malathion	Malathion 0.5% aqueous liquid	Apply once weekly for 2 doses, apply preparation over whole body, allow to dry naturally, wash off after 12 hours or overnight. See product information for treatment of crab (pubic) lice in adults.
OR	**Permethrin**	Permethrin 5% cream	See product information for treatment of crab (pubic) lice in adults.

Prescribing notes	

- A second treatment is needed after 7 days to kill lice emerging from surviving eggs.
- Alcoholic lotions are not recommended due to irritation of excoriated skin and genitalia.
- If treatment is not effective, a different insecticide should be used for the second course.
- Depending on the clinical situation treat pubic lice infestation of the eye lashes with either inert occlusive ophthalmic ointment or permethrin 1% lotion:
    - Inert occlusive ophthalmic ointments should be used for people under the age of 18 years, and for those who are pregnant or breastfeeding.
    - Occlusive ophthalmic ointment should be applied to the eyelid margins twice a day for 10 days.
    - If permethrin 1% lotion is appropriate the person should be advised to apply the product to the eyelashes keeping the eyes closed during application and wash off after 10 minutes.

Group	Parasite infections
Condition	Scabies

Guidance links	NHS Scotland Dermatology Patient Pathways NICE CKS: Scabies

Pathway 1	Treatment of scabies

/1

Permethrin	Permethrin 5% cream	Apply over whole body (including the scalp, neck, face and ears in the young and elderly) and wash off after 8-12 hours. Repeat application after 7 days unless under 2 years of age. If hands are washed with soap within 8 hours of application, they should be treated again with cream.

OR

In pregnancy or permethrin allergy

Malathion	Malathion 0.5% aqueous liquid	Apply once weekly for 2 doses, apply preparation over whole body, and wash off after 24 hours, if hands are washed with soap within 24 hours, they should be retreated.

Prescribing notes	• All members of the household and close contacts should be treated simultaneously. • Aqueous preparations are preferable to alcoholic lotions. • Clothes and bedlinen should be washed at time of treatment.

Group	Skin conditions
Condition	Acne

Opening text	For treatment of acne in children over 12 years, refer to the adult pathways below.
Guidance links	NICE NG198: Acne vulgaris management NHS Scotland Dermatology Patient Pathways

Pathway 1	Treatment of mild to moderate acne

/1

See prescribing notes for additional guidance.

	Benzoyl peroxide + Clindamycin	Duac Once Daily gel (3% and 1%) Duac Once Daily gel (5% and 1%)	Apply once daily, dose to be applied in the evening.
OR	**Clindamycin + Tretinoin**	Treclin 1%/0.025% gel	Apply daily, to be applied thinly at bedtime.
OR	**Adapalene + Benzoyl peroxide**	Epiduo 0.1%/2.5% gel Epiduo 0.3%/2.5% gel	Apply once daily, to be applied thinly in the evening.

/2

Alternative monotherapy if first line options are contraindicated, or person wishes to avoid using a topical retinoid or antibiotic.

Benzoyl peroxide	Benzoyl peroxide 5% gel	Apply 1-2 times a day, preferably apply after washing with soap and water.

/3

Alternative monotherapy if other options are contraindicated.

Adapalene	Adapalene 0.1% gel Adapalene 0.1% cream	Apply once daily, apply thinly in the evening.

/4

Alternative for patients with contraindications to other options or who wish to avoid topical retinoids

Erythromycin + Zinc acetate	Zineryt lotion	Apply twice daily.

Prescribing notes	• Mild to moderate acne includes people who have 1 or more of:
	  ○ any number of non-inflammatory lesions (comedones)
	  ○ up to 34 inflammatory lesions (with or without non-inflammatory lesions)
	  ○ up to 2 nodules.
	• Topical treatment takes at least 30 days to become effective.
	• Adapalene + Benzoyl peroxide (Epiduo) – not for use during pregnancy, use with caution during breastfeeding. Can cause skin irritation, photosensitivity, and bleaching of hair and fabrics.
	• The higher strength EpiDuo gel (adapalene 0.3% and benzoyl peroxide 2.5% gel) is recommended in the treatment of moderate acne that is mostly inflammatory in nature, when comedones and numerous papules and pustules are present e.g. on the entire face.
	• Clindamycin + Tretinoin (Treclin) – not for use during pregnancy or breastfeeding. Can cause skin irritation and photosensitivity.
	• Benzoyl peroxide + Clindamycin (Duac Once Daily) – can be used with caution during pregnancy and breastfeeding. Can cause skin irritation, photosensitivity, and bleaching of hair and fabrics.
	• The choice of treatment depends on whether the acne is predominantly inflammatory or comedonal and its severity.
	• Topical retinoids are recommended for comedonal acne; they may initially cause redness and peeling of the skin but this settles with time. Build up frequency and duration of application over 2-3 weeks, this may reduce redness. Several months of treatment may be needed to achieve an optimal response and the treatment should be continued until no new lesions develop.
	• Exposure to sunlight of areas treated with retinoids should be avoided or minimised. Topical retinoids are best applied at night.
	• Adapalene is less irritant than other topical retinoids.
	• Topical retinoids should be avoided in severe acne involving large areas.
	• Tetracyclines and retinoids (systemic or topical) must be avoided in pregnancy. Females of childbearing age must use effective contraception (oral progestogen-only contraceptives not considered effective) when using topical retinoids and related drugs including: adapalene, Epiduo gel and Treclin gel.
	• Gel or cream is dependent on patient preference, typically gel is the preferred formulation for patients with acne. If the patient finds the gel formulation drying they may find the cream formulation more acceptable.

Pathway 2 Treatment of moderate to severe acne

/1

Topical adapalene with benzoyl peroxide, plus an oral antibiotic (see below).

Adapalene + Benzoyl peroxide	Epiduo 0.1%/2.5% gel Epiduo 0.3%/2.5% gel	Apply once daily, to be applied thinly in the evening.

AND

Oral lymecycline or doxycycline are preferred options. For patients who cannot tolerate consider replacing with erythromycin.

Lymecycline	Lymecycline 408mg capsules	408mg daily for at least 8 weeks
OR		
Doxycycline	Doxycycline 100mg capsules	100mg daily for 12 weeks initially, then review

/2

Topical azelaic acid, plus an oral antibiotic (see below).

Azelaic acid	Azelaic acid 20% cream Azelaic acid 15% gel	Apply twice daily, discontinue if no improvement after 1 month.

AND

Oral lymecycline or doxycycline are preferred options. For patients who cannot tolerate consider replacing with erythromycin.

Lymecycline	Lymecycline 408mg capsules	408mg daily for at least 8 weeks
OR		
Doxycycline	Doxycycline 100mg capsules	100mg daily for 12 weeks initially, then review

/3

For females in the treatment of moderate to severe acne related to androgen-sensitivity, if the chosen first-line treatment is not effective, consider adding co-cyprindiol or an alternative combined oral contraceptive pill.

Co-cyprindiol	Co-cyprindiol 2000microgram/35microgram tablets	1 tablet daily for 21 days, to be started on day 1 of menstrual cycle; subsequent courses repeated after a 7-day interval (during which withdrawal bleeding occurs). Time to symptom remission is at least 3 months; review need for treatment regularly.

Prescribing notes	• Moderate to severe acne this includes people who have either or both of:
	  ○ 35 or more inflammatory lesions (with or without non-inflammatory lesions)
	  ○ 3 or more nodules.
	• Adapalene + Benzoyl peroxide (Epiduo) – not for use during pregnancy, use with caution during breastfeeding. Can cause skin irritation, photosensitivity, and bleaching of hair and fabrics.
	• The higher strength EpiDuo gel (adapalene 0.3% and benzoyl peroxide 2.5% gel) is recommended in the treatment of moderate acne that is mostly inflammatory in nature, when comedones and numerous papules and pustules are present e.g. on the entire face.
	• Azelaic acid – not for use in pregnancy, during breastfeeding, or under the age of 12.
	• People who cannot tolerate or have contraindications to oral lymecycline or oral doxycycline, consider replacing these medicines with oral erythromycin.
	• Oral antibiotics may cause systemic side effects and antimicrobial resistance.
	• Oral antibiotic duration is initially 12 weeks, then review. If acne has completely cleared consider stopping the antibiotic but continuing the topical treatment. If acne has improved but not completely cleared, consider continuing the oral antibiotic, alongside the topical treatment, for up to 12 more weeks. Only continue a treatment option that includes an antibiotic (topical or oral) for more than 6 months in exceptional circumstances. Review at 3 monthly intervals, and stop the antibiotic as soon as possible.
	• Assess response to oral antibiotics at three months. If poor response, change to alternative oral antibiotic but continue for six months minimum.
	• Oral tetracyclines can cause photosensitivity.
	• Tetracyclines (systemic or topical) must be avoided in pregnancy.
	• Systemic antibacterial treatment is useful for inflammatory acne if topical treatment is not adequately effective. Systemic antibacterial treatment should always be accompanied with a topical treatment. If combination adapalene and benzoyl peroxide or azelaic acid is not tolerated alternative topical options include adapalene or benzoyl peroxide.
	• Switch to an alternative antibiotic if no response after 6 months.

	• Antibiotics should not be co-prescribed by the systemic and topical route. • For details on co-cyprindiol in relation to contraception and alternative combined oral contraceptive pill options see the Contraception recommendations in the Obstetrics, gynaecology, and urinary-tract disorders chapter of the formulary. • The progesterone only contraceptive pill or progestin implants with androgenic activity should be avoided in females with acne. • Co-cyprindiol is a treatment for moderate to severe acne where other treatments have failed and only in those patients may it also be used as an oral contraceptive. Co-cyprindiol should be withdrawn 3-4 cycles after the treated condition has completely resolved. If ongoing contraception is required, substitution with another combined oral contraceptive is likely to maintain the improvement. • Co-cyprindiol is no more effective than an oral broad-spectrum antibacterial. • Co-cyprindiol should not be used solely for contraception due to a higher risk of venous thromboembolism than low-dose combined oral contraceptives. The risk of VTE is rare but this remains an important side effect. Healthcare professionals should be vigilant for signs of DVT or PE in patients prescribed co-cyprindiol. • Gel or cream is dependent on patient preference, typically gel is the preferred formulation for patients with acne. If the patient finds the gel formulation drying they may find the cream formulation more acceptable..

Pathway 3	Treatment of severe acne (specialist supervision only treatment)

/1

Consider in people older than 12 years who have a severe form of acne that is resistant to adequate courses of standard therapy with systemic antibiotics and topical therapy.

Isotretinoin SUO	Isotretinoin 5mg capsules Isotretinoin 10mg capsules Isotretinoin 20mg capsules	Initially 500 micrograms/kg daily in 1–2 divided doses, increased if necessary to 1 mg/kg daily for 16–24 weeks; maximum 150 mg/kg per course. As further improvement of the acne can be observed up to 8 weeks after discontinuation of treatment, a further course of treatment should not be considered until at least this period has elapsed. Refer to NICE guidance on management of relapse.

Prescribing notes	• Treatment failure of severe acne with oral antibiotics indicates referral to a consultant dermatologist for consideration of treatment with oral isotretinoin. Oral isotretinoin (Roaccutane) is a toxic and teratogenic drug which is only prescribable by a consultant dermatologist. Prescription of systemic isotretinoin for women is only possible if adequate contraception is undertaken (Pregnancy prevention programme). See MHRA Drug Safety Update and manufacturer's risk minimisation materials on the electronic medicines compendium for oral isotretinoin preparations. • Isotretinoin is a black triangle medicine and all suspected adverse reactions, including any sexual and psychiatric adverse reactions, should be reported via the Yellow Card scheme. For further advice, see MHRA Drug Safety Update.

Group	Skin conditions
Condition	Actinic keratosis

Guidance links	NHS Scotland Dermatology Patient Pathways

Pathway 1	Treatment of single or a few scattered actinic keratosis

/1

Generally, no treatment indicated except for emollients and sunscreen. Consider treatment for patients with high risk disease.

/2

Fluorouracil	Efudix 5% cream	Apply 1-2 times a day for 3-4 weeks (usual duration of initial therapy), apply thinly to the affected area, maximum area of skin 500 cm^2 (e.g. 23 cm × 23 cm) treated at one time, alternative regimens may be used in some settings

OR

Can be used in immunocompetent patients with slightly palpable and/or moderately thick hyperkeratotic actinic keratosis (grade I/II). It is an alternative to first line options of fluorouracil cream where the addition of salicylic acid 10% is deemed beneficial. For use in patients with <10 isolated lesions of actinic keratoses where cryotherapy is unsuitable.

Fluorouracil + Salicylic acid	Actikerall 5mg/g / 100mg/g cutaneous solution	Apply once daily for up to 12 weeks, reduced to 3 times a week if severe side-effects occur and until side-effects improve, to be applied to the affected area, if treating area with thin epidermis, reduce frequency of application and monitor response more often; maximum area of skin treated at one time, 25 cm^2 (e.g. 5 cm x 5 cm).

/3

Imiquimod SI	Aldara 5% cream 250mg sachets	Apply 3 times a week for 4 weeks, to be applied to lesion at night, and left on the skin for approximately 8 hours, assess response after a 4

		week treatment-free interval; repeat 4-week course if lesions persist, maximum 2 courses.

Prescribing notes	• Actinic keratosis (AK) are pre-malignant but transformation to squamous cell carcinoma is rare. Patients must be referred if diagnosis is uncertain or if lesions become thickened or tender. See the NHS Scotland Dermatology Patient Pathways. • Skin inflammation is common with topical fluorouracil and the concomitant use of a moderate/potent topical corticosteroid can be used. • Imiquimod 5% cream (Aldara) can be used on specialist advice based on the size or number of lesions which may limit the efficacy and/or acceptability or following unsuccessful treatment with cryotherapy, diclofenac 3% gel or fluorouracil cream. It should be used for nonhyperkeratotic, nonhypertrophic AK on the face or scalp.

Pathway 2	Treatment of multiple (field) actinic keratosis – smaller areas of field change

/1

Smaller areas of field change (e.g. an area the size of a palm or most of the forehead)

	Fluorouracil	Efudix 5% cream	Apply 1-2 times a day for 3-4 weeks (usual duration of initial therapy), apply thinly to the affected area, maximum area of skin 500 cm^2 (e.g. 23 cm × 23 cm) treated at one time, alternative regimens may be used in some settings
OR	**Fluorouracil + Salicylic acid**	Actikerall 5mg/g / 100mg/g cutaneous solution	Apply once daily for up to 12 weeks, reduced to 3 times a week if severe side-effects occur and until side-effects improve, to be applied to the affected area, if treating area with thin epidermis, reduce frequency of application and monitor response more often; maximum area of skin treated at one time, 25 cm^2 (e.g. 5 cm x 5 cm).

/2

	Imiquimod SI	Aldara 5% cream 250mg sachets	Apply 3 times a week for 4 weeks, to be applied to lesion at night, and left on the skin for approximately 8 hours, assess response after a 4 week treatment-free interval; repeat 4-week course if lesions persist, maximum 2 courses.

Prescribing notes	• Actinic keratosis (AK) are pre-malignant but transformation to squamous cell carcinoma is rare. Patients must be referred if diagnosis is uncertain or if lesions become thickened or tender. See NHS Scotland Dermatology Patient Pathways. • Skin inflammation is common with topical fluorouracil and the concomitant use of a moderate/potent topical corticosteroid can be used. • Fluorouracil 0.5% / salicylic acid 10% cutaneous solution (Actikerall) can be used in immunocompetent patients with slightly palpable and/or moderately thick hyperkeratotic actinic keratosis (grade I/II). It is an alternative to first line options of fluorouracil cream where the addition of salicylic acid 10% is deemed beneficial. For use in patients with <10 isolated lesions of actinic keratoses where cryotherapy is unsuitable.

	• Imiquimod 5% cream (Aldara) can be used on specialist advice based on the size or number of lesions which may limit the efficacy and/or acceptability or following unsuccessful treatment with cryotherapy, diclofenac 3% gel or fluorouracil cream. It should be used for nonhyperkeratotic, nonhypertrophic AK on the face or scalp. • Imiquimod 3.75% cream (Zyclara) is restricted for initiation by a specialist for the treatment of large field actinic keratosis (>25cm^2).

Pathway 3	**Treatment of multiple (field) actinic keratosis – larger areas of field change (>25 square cm)**

/1

Care should be taken when prescribing diclofenac gel. Only the 3% strength (Solaraze) is licensed for use in actinic keratosis.

	Diclofenac sodium	Solaraze 3% gel	Apply thinly twice daily for 60-90 days; max 8g daily
OR	**Imiquimod** SI	Zyclara 3.75% cream 250mg sachets	Apply once daily for up to 12 weeks, reduced to 3 times a week if severe side-effects occur and until side-effects improve, to be applied to the affected area, if treating area with thin epidermis, reduce frequency of application and monitor response more often; maximum area of skin treated at one time, 25 cm^2 (e.g. 5 cm x 5 cm).

Prescribing notes	• Actinic keratosis (AK) are pre-malignant but transformation to squamous cell carcinoma is rare. Patients must be referred if diagnosis is uncertain or if lesions become thickened or tender. See NHS Scotland Dermatology Patient Pathways. • Skin inflammation is common with topical fluorouracil and the concomitant use of a moderate/potent topical corticosteroid can be used. • Imiquimod 3.75% cream (Zyclara) is restricted for initiation by a specialist for the treatment of large field actinic keratosis (>25cm^2).

Pathway 4	Treatment of multiple (field) actinic keratosis – specialist management

/1

	Aminolevulinic acid hydrochloride SUO	Ameluz 78mg/g gel	See product literature
OR	**Methyl aminolevulinate** SUO	Metvix 16% cream	See product literature

Prescribing notes	• Actinic keratosis (AK) are pre-malignant but transformation to squamous cell carcinoma is rare. Patients must be referred if diagnosis is uncertain or if lesions become thickened or tender. See NHS Scotland Dermatology Patient Pathways. • Aminolevulinic acid (as hydrochloride) (Ameluz) or methyl aminolevulinate (Metvix) can be used for treatment of actinic keratosis of mild to moderate intensity on the face and scalp (Olsen grade 1 to 2) where photodynamic therapy (PDT) would be beneficial. As this treatment involves PDT, its use is restricted to secondary care only.

Group	**Skin conditions**
Condition	**Boils**

This section only contains Pharmacy First recommendations.

Group	**Skin conditions**
Condition	**Cannulation**

Pathway 1	**Topical anaesthetics for venepuncture**

/1

	Lidocaine + Prilocaine	Emla 5% cream	Apply 1-5 hours before procedure (2-5 hours before procedures on large areas e.g. split skin grafting), a thick layer should be applied under occlusive dressing.
OR	**Tetracaine**	Ametop 4% gel	Adult - Apply contents of up to 5 tubes (applied at separate sites at a single time or appropriate proportion) to site of venepuncture or venous cannulation and cover with occlusive dressing; remove gel and dressing after 30 minutes for venepuncture and after 45 minutes for venous cannulation.

Prescribing notes	• Topical local anaesthetics may be absorbed through mucosal surfaces. • Local anaesthetics may occasionally cause sensitisation.

Group	Skin conditions
Condition	Cosmetic camouflage

Guidance links	NICE BNF: Camouflagers Changing Faces: Skin Camouflage Service

Pathway 1	Treatment with camouflagers

Prescribing notes	• Camouflagers are prescribable for postoperative scars, other deformities, and as an adjunctive therapy for emotional disturbances due to disfiguring skin disease e.g. vitiligo. • Refer patients directly to Changing Faces. • Prescriptions should be endorsed “ACBS”. • Use of Dermacolor, Covermark and Veil products should follow ACBS guidance.

Group	Skin conditions
Condition	Dermatitis - contact

Opening text	See general prescribing notes below for information on fire risk with all paraffin based and paraffin free emollients.
Guidance links	NHS Scotland Dermatology Patient Pathways

Pathway 1	General prescribing notes for all adult pathways

Prescribing notes	• There is a risk of severe and fatal burns with all paraffin based emollients regardless of the paraffin concentration. Data suggest there is also a risk for paraffin-free emollients. Patients who use these products should not smoke or go near naked flames. Emollients can transfer from the skin onto clothing, bedding, dressings, and other fabric. Once there, they can dry onto the fabric and build up over time. In the presence of a naked flame, fabric with emollient dried on is easily ignited. Although emollients are not flammable in themselves or when on the skin, when dried on to fabric they act as an accelerant, increasing the speed of ignition and intensity of the fire. • Patient clothing and bedding should be changed regularly - preferably daily. Washing clothing or bedding at a high temperature may reduce the emollient build up but not totally remove it. • Resources are available for health and social care professionals to support the safe use of emollients see MHRA guidance. • A similar risk may apply for other products which are applied to the skin over large body areas, or in large volumes for repeated use for more than a few days. • NHS Scotland's Dermatology Patient Pathways have been developed to provide an accessible resource for primary care practitioners to support the diagnosis and management of patients presenting with common skin conditions. • The vehicle used in topical preparations influences skin hydration, has a mild anti-inflammatory effect and facilitates penetration of the active component. • Creams are more cosmetically acceptable than ointments because they are less greasy and easier to apply. Gels may be used on the face and scalp while lotions have a cooling effect and are used for moist conditions and hairy areas. Lotions in alcoholic basis can sting if used on broken skin. Ointments are greasy preparations and are much less likely to sensitise and are suitable for chronic dry lesions. Creams and lotions are absorbed into the skin more quickly than ointments or gels. • Pastes can be used to protect inflamed, lichenified, or excoriated skin. • Possible contact sensitivity to preservatives or antiseptics is the reason for the range of topical agents. • Rarely, severe adverse effects can occur on stopping treatment with topical corticosteroids, often after long-term continuous or inappropriate use of moderate to high potency products. To reduce the risks of these events, prescribe the topical corticosteroid of lowest potency needed and ensure patients know how to use it safely and effectively. See MHRA warning - Topical corticosteroids: information on the risk of topical steroid withdrawal reactions.

Unlicensed / Special Manufacture Preparations

- The British Association of Dermatologists (BAD) list of preferred unlicensed dermatological preparations ('Specials') is available at the BAD website.
- Use a licensed product wherever available. Consider cost versus benefit of a licensed preparation versus an unlicensed preparation (often in excess of £100). If an unlicensed topical preparation is required, consider only those listed on the BAD list.
- If prescribing specials, prescribe appropriate quantities, as expiry dates are likely to be short for these unlicensed specials products. Do not put the special onto a repeat prescription and ensure that the condition is reviewed regularly.
- If a 'Specials' product is required Dermatologists in the East Region have agreed to use only BAD approved 'Specials' whenever possible.

Quantities are based on single daily application for 2 weeks in adults:

Body area	**Corticosteroid cream/ointment**
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

Quantities are based on twice daily application for 1 week in adults:

Body area	**Non-corticosteroid cream/ointment**
Face	15 to 30g
Both hands	25 to 50g
Scalp	50 to 100g
Both arms	100 to 200g
Both legs	100 to 200g
Trunk	400g
Groins and genitalia	15 to 25g

Pathway 2 Treatment with emollients (light weight)

/1		**Liquid paraffin**	Zerobase 11% cream	Apply as often as required
/2		**White soft paraffin + Liquid paraffin**	Oilatum cream Cetraben cream	Apply as often as required
	OR	**QV**	QV cream	Apply as often as required
	OR	**Liquid paraffin + Isopropyl myristate**	Zerodouble gel	Apply as often as required
	OR	**Zeroveen**	Zeroveen cream	Apply as often as required
	OR	**White soft paraffin**	QV 5% skin lotion	Apply as often as required

Prescribing notes	• The choice of emollient should be based on the severity of the condition, patient preference, site of application and preparation cost. • See general prescribing notes pathway above for information on fire risk with all paraffin based and paraffin free emollients. • Emollients soothe, smooth and hydrate the skin and are indicated for all dry scaling disorders. • Emollients should be applied regularly (up to 3-4 times per day) to maintain improvement; and are particularly effective applied after a shower or bath. • Emollients should be applied in the direction of hair growth. • Most emollients (apart from white soft paraffin 50%/liquid paraffin 50%) may be used as soap substitutes (hand washing and in bath/shower) by firstly wetting the skin, washing with the cream or ointment, then rinsing off. Alternatively, emollients can be put on the skin before bathing or showering and then washed off to reduce stinging from broken areas. • If emollients are being applied to the whole body twice daily, children may need 250g per week and adults 500g per week. • It is more cost-effective to prescribe emollients in large pack sizes and products that come in pump dispensers may be more suitable for long term use in order to reduce the risk of microbial contamination. • Preparations containing antimicrobials or antiseptics should only be used when treating patients with infected eczema or when antisepsis is required.

Pathway 3	Treatment with emollients (heavy weight)

/1	**Emulsifying wax + Yellow soft paraffin**	Hydromol ointment	Massage into skin as often as required; may be used as a soap substitute

/2	**White soft paraffin + Liquid paraffin**	White soft paraffin 50% / Liquid paraffin 50% ointment	Apply as often as required
OR	**Emulsifying wax + Liquid paraffin + White soft paraffin**	Emulsifying ointment	Apply as often as required; may be used as a soap substitute
OR	**Hydrous**	Hydrous ointment	Apply as often as required

Prescribing notes	• The choice of emollient should be based on the severity of the condition, patient preference, site of application and preparation cost. • See general prescribing notes pathway above for information on fire risk with all paraffin based and paraffin free emollients. • Emollients soothe, smooth and hydrate the skin and are indicated for all dry scaling disorders. • Emollients should be applied regularly (up to 3-4 times per day) to maintain improvement; and are particularly effective applied after a shower or bath. • Emollients should be applied in the direction of hair growth. • Most emollients (apart from white soft paraffin 50%/liquid paraffin 50%) may be used as soap substitutes (hand washing and in bath/shower) by firstly wetting the skin, washing with the cream or ointment, then rinsing off. Alternatively, emollients can be put on the skin before bathing or showering and then washed off to reduce stinging from broken areas. • If emollients are being applied to the whole body twice daily, children may need 250g per week and adults 500g per week. • It is more cost-effective to prescribe emollients in large pack sizes and products that come in pump dispensers may be more suitable for long term use in order to reduce the risk of microbial contamination. • Preparations containing antimicrobials or antiseptics should only be used when treating patients with infected eczema or when antisepsis is required.

Pathway 4	Treatment with emollients (special circumstances)

/1

Dermamist Spray is specialist initiation only as it is more expensive than other formulations but may be useful in patients suffering from Toxic Epidermal Necrolysis and where patients are unable to apply other formulations.

White soft paraffin SI	Dermamist 10% spray	Spray from a distance of approximately 8 inches. Spray sparingly; over application may cause the skin to feel oily. Do not spray on face.

OR

Where a steroid-sparing, anti-inflammatory action is required, Adex gel can be used under specialist initiation only.

Adex SI	Adex gel	Apply three times daily or as often as required

OR

For use by carers where reduced frequency of application is essential, it can be used twice daily to provide effective relief in dry skin conditions.

Liquid paraffin + Isopropyl myristate	Doublebase Dayleve gel	Apply morning and night

Prescribing notes	• The choice of emollient should be based on the severity of the condition, patient preference, site of application and preparation cost. • See general prescribing notes pathway above for information on fire risk with all paraffin based and paraffin free emollients. • Emollients soothe, smooth and hydrate the skin and are indicated for all dry scaling disorders. • Emollients should be applied regularly to maintain improvement; and are particularly effective applied after a shower or bath. • Emollients should be applied in the direction of hair growth.

Pathway 5	Treatment with urea containing emollients

/1

	Urea	Flexitol 10% Urea cream	Apply 1–2 times a day
OR	**Urea + Lauromacrogols**	Balneum Plus cream	Apply twice daily

Prescribing notes	• Preparations containing urea are suitable for the treatment of very dry or hyperkeratotic, scaling skin conditions. Balneum plus is suitable for general skin care. Flexitol 10% Urea cream is suitable for general skin care and for the skin on the hands and feet.

Pathway 6 Treatment with soap substitutes and emollients for showering and bathing

/1	**Emulsifying wax + Yellow soft paraffin**	Hydromol ointment	Use as a soap substitute
/2	**Emulsifying wax + Liquid paraffin + White soft paraffin**	Emulsifying ointment	Use as a soap substitute
/3	Without antiseptic		
	Liquid paraffin + Isopropyl myristate	Hydromol Bath & Shower emollient	Apply to wet skin and rinse.
OR	**QV Gentle**	QV Gentle wash	To be used as a soap substitute.
/4	With antiseptic		
	Dermol 500	Dermol 500 lotion	To be applied to the skin or used as a soap substitute.

Prescribing notes	• Most emollients (apart from white soft paraffin 50%/liquid paraffin 50%) may be used as soap substitutes (hand washing and in bath/shower) by firstly wetting the skin, washing with the cream or ointment, then rinsing off. Alternatively, emollients can be put on the skin before bathing or showering and then washed off to reduce stinging from broken areas. • Addition of emollient bath products can make baths slippy • A convenient way to apply emulsifying ointment and Hydromol ointment is as “soap balls”, which are made by putting a scoop of the ointment into tubinette or stockinette. • The presence of antiseptics (e.g. benzalkonium chloride) in emollients can rarely cause allergic reactions or irritation - this should be considered if skin becomes irritated, and an alternative product prescribed. • Dermol 500 lotion contains an antiseptic, so may be suitable for patients who specifically require an antiseptic soap substitute e.g. infected eczema.

Pathway 7	Treatment with mild topical corticosteroids

/1

Select the lowest potency topical corticosteroids for effective treatment, this may mean using different products for different areas to be treated.

Hydrocortisone	Hydrocortisone 1% cream Hydrocortisone 1% ointment	Apply 1-2 times daily, to be applied thinly.

Prescribing notes	• Often local specialists recommend once daily application of a topical corticosteroid and if no benefit after review at 7-10 days, will consider a higher potency topical corticosteroid rather than increasing the frequency of application. • To minimise the risk of side-effects, reduce the frequency of application as the condition settles or step-down potency. The risk of systemic side-effects increases with prolonged use particularly on thin skin surfaces, use in flexures, or use of more potent corticosteroids. Occlusion increases efficacy and side-effects. Only mild corticosteroids should generally be used on the face. • There is no benefit in changing to a higher percentage strength of topical hydrocortisone. Instead, patients should be moved up the steroid potency ladder i.e. to a moderately potent steroid. • The potency of the steroid should be stepped up or stepped down depending on the severity of symptoms. • Water-miscible corticosteroid creams are suitable for moist areas e.g. axillae or groin or for weeping lesions. • Ointments are generally chosen for dry, lichenified or scaly lesions or where a more occlusive effect is required. • Mixing topical preparations (e.g. steroid, emollient) on the skin should be avoided where possible; apply emollient and corticosteroid at different times of the day. • Topical corticosteroids are not recommended in urticaria, rosacea, acne or when a primary infective disease is suspected. • Topical corticosteroids should not be used on infected skin unless the infection is being treated • Topical corticosteroids should not routinely be added to repeat dispensing systems. • Gloves should be worn during, or hands washed after, application of large quantities of steroid preparations. • For the use of topical corticosteroids for lichen sclerosus, see the Obstetrics, gynaecology, and urinary-tract disorders chapter of the formulary. • Loss of effect with time (tachyphylaxis) can occur with prolonged use of topical corticosteroids. Intermittent use is preferred to continuous use.

Pathway 8 Treatment with moderate topical corticosteroids

/1

Select the lowest potency topical corticosteroids for effective treatment, this may mean using different products for different areas to be treated. Note similar sounding drug name: clobetaSOL 0.05% is a very potent topical steroid, clobetaSONE 0.05% is a moderately potent topical steroid.

Clobetasone	Clobetasone 0.05% cream Clobetasone 0.05% ointment	Apply 1-2 times daily, to be applied thinly.

/2

Select the lowest potency topical corticosteroids for effective treatment, this may mean using different products for different areas to be treated.

Betamethasone	Betamethasone valerate 0.025% cream Betamethasone valerate 0.025% ointment	Apply 1-2 times daily, to be applied thinly.
OR		
Fluocinolone acetonide	Fluocinolone acetonide 0.00625% cream Fluocinolone acetonide 0.00625% ointment	Apply 1-2 times daily, to be applied thinly.

Prescribing notes	• Often local specialists recommend once daily application of a topical corticosteroid and if no benefit after review at 7-10 days, will consider a higher potency topical corticosteroid rather than increasing the frequency of application. • To minimise the risk of side-effects, reduce the frequency of application as the condition settles or step-down potency. The risk of systemic side-effects increases with prolonged use particularly on thin skin surfaces, use in flexures, or use of more potent corticosteroids. Occlusion increases efficacy and side-effects. Only mild corticosteroids should generally be used on the face. • The potency of the steroid should be stepped up or stepped down depending on the severity of symptoms. • Water-miscible corticosteroid creams are suitable for moist areas e.g. axillae or groin or for weeping lesions. • Ointments are generally chosen for dry, lichenified or scaly lesions or where a more occlusive effect is required. • Mixing topical preparations (e.g. steroid, emollient) on the skin should be avoided where possible; apply emollient and corticosteroid at different times of the day. • Topical corticosteroids are not recommended in urticaria, rosacea, acne or when a primary infective disease is suspected. • Topical corticosteroids should not be used on infected skin unless the infection is being treated • Topical corticosteroids should not routinely be added to repeat dispensing systems. • Gloves should be worn during, or hands washed after, application of large quantities of steroid preparations.

	• For the use of topical corticosteroids for lichen sclerosus, see the Obstetrics, gynaecology, and urinary-tract disorders chapter of the formulary. • Fludroxycortide tape can be used for localised areas that also require occlusion. It is applied for 12 hours each day. Please note this is a moderately potent steroid. • Loss of effect with time (tachyphylaxis) can occur with prolonged use of topical corticosteroids. Intermittent use is preferred to continuous use.

Pathway 9 Treatment with potent topical corticosteroids

/1

Select the lowest potency topical corticosteroids for effective treatment, this may mean using different products for different areas to be treated.

Betamethasone	Betamethasone valerate 0.1% cream Betamethasone valerate 0.1% lotion Betamethasone valerate 0.1% ointment	Apply 1-2 times daily, to be applied thinly.

/2

Select the lowest potency topical corticosteroids for effective treatment, this may mean using different products for different areas to be treated.

Fluocinolone acetonide	Fluocinolone acetonide 0.025% cream Fluocinolone acetonide 0.025% gel Fluocinolone acetonide 0.025% ointment	Apply 1-2 times daily, to be applied thinly.
OR		
Mometasone	Mometasone 0.1% cream Mometasone 0.1% ointment	Apply once daily, to be applied thinly.

Prescribing notes	• Often local specialists recommend once daily application of a topical corticosteroid and if no benefit after review at 7-10 days, will consider a higher potency topical corticosteroid rather than increasing the frequency of application. • To minimise the risk of side-effects, reduce the frequency of application as the condition settles or step-down potency. The risk of systemic side-effects increases with prolonged use particularly on thin skin surfaces, use in flexures, or use of more potent corticosteroids. Occlusion increases efficacy and side-effects. Only mild corticosteroids should generally be used on the face. • The potency of the steroid should be stepped up or stepped down depending on the severity of symptoms. • Potent corticosteroids should generally be avoided on the face and skin flexures • In general, the most potent topical corticosteroids should be reserved for recalcitrant dermatoses such as chronic discoid lupus erythematosus, lichen simplex chronicus, hypertrophic lichen planus, and palmoplantar pustulosis. • Water-miscible corticosteroid creams are suitable for moist areas e.g. axillae or groin or for weeping lesions. • Ointments are generally chosen for dry, lichenified or scaly lesions or where a more occlusive effect is required. • Mixing topical preparations (e.g. steroid, emollient) on the skin should be avoided where possible; apply emollient and corticosteroid at different times of the day.

	• Topical corticosteroids are not recommended in urticaria, rosacea, acne or when a primary infective disease is suspected. • Topical corticosteroids should not be used on infected skin unless the infection is being treated • Topical corticosteroids should not routinely be added to repeat dispensing systems. • Gloves should be worn during, or hands washed after, application of large quantities of steroid preparations. • Palms of the hands and soles of the feet may require potent or very potent steroids. • For the use of topical corticosteroids for lichen sclerosus, see the Obstetrics, gynaecology, and urinary-tract disorders chapter of the formulary. • Loss of effect with time (tachyphylaxis) can occur with prolonged use of topical corticosteroids. Intermittent use is preferred to continuous use.

Pathway 10	Treatment with very potent topical corticosteroids

/1

Select the lowest potency topical corticosteroids for effective treatment, this may mean using different products for different areas to be treated. Note similar sounding drug name: clobetaSOL 0.05% is a very potent topical steroid, clobetaSONE 0.05% is a moderately potent topical steroid.

Clobetasol	Clobetasol 0.05% ointment Clobetasol 0.05% cream	Apply 1-2 times daily, to be applied thinly.

Prescribing notes	• Topical steroids should be applied once daily initially, if no benefit after 7-10 days, change to twice daily for a further 7-10 days. • To minimise the risk of side-effects, reduce the frequency of application as the condition settles or step-down potency. The risk of systemic side-effects increases with prolonged use particularly on thin skin surfaces, use in flexures, or use of more potent corticosteroids. Occlusion increases efficacy and side-effects. Only mild corticosteroids should generally be used on the face. • The potency of the steroid should be stepped up or stepped down depending on the severity of symptoms. • Potent corticosteroids should generally be avoided on the face and skin flexures • In general, the most potent topical corticosteroids should be reserved for recalcitrant dermatoses such as chronic discoid lupus erythematosus, lichen simplex chronicus, hypertrophic lichen planus, and palmoplantar pustulosis. • Water-miscible corticosteroid creams are suitable for moist areas e.g. axillae or groin or for weeping lesions. • Ointments are generally chosen for dry, lichenified or scaly lesions or where a more occlusive effect is required. • Mixing topical preparations (e.g. steroid, emollient) on the skin should be avoided where possible; apply emollient and corticosteroid at different times of the day. • Topical corticosteroids are not recommended in urticaria, rosacea, acne or when a primary infective disease is suspected. • Topical corticosteroids should not be used on infected skin unless the infection is being treated • Gloves should be worn during, or hands washed after, application of large quantities of steroid preparations. • Palms of the hands and soles of the feet may require potent or very potent steroids. • For the use of topical corticosteroids for lichen sclerosus, see the Obstetrics, gynaecology, and urinary-tract disorders chapter of the formulary. • Loss of effect with time (tachyphylaxis) can occur with prolonged use of topical corticosteroids. Intermittent use is preferred to continuous use. • Patients prescribed very potent topical corticosteroids should be reviewed regularly (at least monthly) and the preparation should not be prescribed on repeat prescription except on specialist advice.

Group	Skin conditions
Condition	Eczema

Opening text	See general prescribing notes below for information on fire risk with all paraffin based and paraffin free emollients.
Guidance links	NHS Scotland Dermatology Patient Pathways

Pathway 1	General prescribing notes for all adult pathways

Prescribing notes	• There is a risk of severe and fatal burns with all paraffin based emollients regardless of the paraffin concentration. Data suggest there is also a risk for paraffin-free emollients. Patients who use these products should not smoke or go near naked flames. Emollients can transfer from the skin onto clothing, bedding, dressings, and other fabric. Once there, they can dry onto the fabric and build up over time. In the presence of a naked flame, fabric with emollient dried on is easily ignited. Although emollients are not flammable in themselves or when on the skin, when dried on to fabric they act as an accelerant, increasing the speed of ignition and intensity of the fire. • Patient clothing and bedding should be changed regularly - preferably daily. Washing clothing or bedding at a high temperature may reduce the emollient build up but not totally remove it. • Resources are available for health and social care professionals to support the safe use of emollients see MHRA guidance. • A similar risk may apply for other products which are applied to the skin over large body areas, or in large volumes for repeated use for more than a few days. • NHS Scotland's Dermatology Patient Pathways have been developed to provide an accessible resource for primary care practitioners to support the diagnosis and management of patients presenting with common skin conditions. • The vehicle used in topical preparations influences skin hydration, has a mild anti-inflammatory effect and facilitates penetration of the active component. • Creams are more cosmetically acceptable than ointments because they are less greasy and easier to apply. Gels may be used on the face and scalp while lotions have a cooling effect and are used for moist conditions and hairy areas. Lotions in alcoholic basis can sting if used on broken skin. Ointments are greasy preparations and are much less likely to sensitise and are suitable for chronic dry lesions. Creams and lotions are absorbed into the skin more quickly than ointments or gels. • Pastes can be used to protect inflamed, lichenified, or excoriated skin. • Possible contact sensitivity to preservatives or antiseptics is the reason for the range of topical agents. • Rarely, severe adverse effects can occur on stopping treatment with topical corticosteroids, often after long-term continuous or inappropriate use of moderate to high potency products. To reduce the risks of these events, prescribe the topical corticosteroid of lowest potency needed and ensure patients know how to use it safely and effectively. See MHRA warning - Topical corticosteroids: information on the risk of topical steroid withdrawal reactions.

- Exacerbation of eczema may represent secondary bacterial or viral infection (eczema herpeticum). Appropriate swabs should be taken, and appropriate anti-infective therapy prescribed.

Unlicensed / Special Manufacture Preparations

- The British Association of Dermatologists (BAD) list of preferred unlicensed dermatological preparations ('Specials') is available at the BAD website.
- Use a licensed product wherever available. Consider cost versus benefit of a licensed preparation versus an unlicensed preparation (often in excess of £100). If an unlicensed topical preparation is required, consider only those listed on the BAD list.
- If prescribing specials, prescribe appropriate quantities, as expiry dates are likely to be short for these unlicensed specials products. Do not put the special onto a repeat prescription and ensure that the condition is reviewed regularly.
- If a 'Specials' product is required Dermatologists in the East Region have agreed to use only BAD approved 'Specials' whenever possible.

Quantities are based on single daily application for 2 weeks in adults:

Body area	**Corticosteroid cream/ointment**
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

Quantities are based on twice daily application for 1 week in adults:

Body area	**Non-corticosteroid cream/ointment**
Face	15 to 30g
Both hands	25 to 50g
Scalp	50 to 100g
Both arms	100 to 200g
Both legs	100 to 200g
Trunk	400g
Groins and genitalia	15 to 25g

Pathway 2 Treatment with emollients (light weight)

/1		**Liquid paraffin**	Zerobase 11% cream	Apply as often as required
/2		**White soft paraffin + Liquid paraffin**	Oilatum cream Cetraben cream	Apply as often as required
	OR	**QV**	QV cream	Apply as often as required
	OR	**Liquid paraffin + Isopropyl myristate**	Zerodouble gel	Apply as often as required
	OR	**Zeroveen**	Zeroveen cream	Apply as often as required
	OR	**White soft paraffin**	QV 5% skin lotion	Apply as often as required

Prescribing notes	• The choice of emollient should be based on the severity of the condition, patient preference, site of application and preparation cost. • See general prescribing notes pathway above for information on fire risk with all paraffin based and paraffin free emollients. • Emollients soothe, smooth and hydrate the skin and are indicated for all dry scaling disorders. • Emollients should be applied regularly (up to 3-4 times per day) to maintain improvement; and are particularly effective applied after a shower or bath. • Emollients should be applied in the direction of hair growth. • Most emollients (apart from white soft paraffin 50%/liquid paraffin 50%) may be used as soap substitutes (hand washing and in bath/shower) by firstly wetting the skin, washing with the cream or ointment, then rinsing off. Alternatively, emollients can be put on the skin before bathing or showering and then washed off to reduce stinging from broken areas. • If emollients are being applied to the whole body twice daily, children may need 250g per week and adults 500g per week. • It is more cost-effective to prescribe emollients in large pack sizes and products that come in pump dispensers may be more suitable for long term use in order to reduce the risk of microbial contamination. • Preparations containing antimicrobials or antiseptics should only be used when treating patients with infected eczema or when antisepsis is required.

Pathway 3	Treatment with emollients (heavy weight)

/1		**Emulsifying wax + Yellow soft paraffin**	Hydromol ointment	Massage into skin as often as required; may be used as a soap substitute
/2		**White soft paraffin + Liquid paraffin**	White soft paraffin 50% / Liquid paraffin 50% ointment	Apply as often as required
	OR	**Emulsifying wax + Liquid paraffin + White soft paraffin**	Emulsifying ointment	Apply as often as required; may be used as a soap substitute
	OR	**Hydrous**	Hydrous ointment	Apply as often as required

Prescribing notes	• The choice of emollient should be based on the severity of the condition, patient preference, site of application and preparation cost. • See general prescribing notes pathway above for information on fire risk with all paraffin based and paraffin free emollients. • Emollients soothe, smooth and hydrate the skin and are indicated for all dry scaling disorders. • Emollients should be applied regularly (up to 3-4 times per day) to maintain improvement; and are particularly effective applied after a shower or bath. • Emollients should be applied in the direction of hair growth. • Most emollients (apart from white soft paraffin 50%/liquid paraffin 50%) may be used as soap substitutes (hand washing and in bath/shower) by firstly wetting the skin, washing with the cream or ointment, then rinsing off. Alternatively, emollients can be put on the skin before bathing or showering and then washed off to reduce stinging from broken areas. • If emollients are being applied to the whole body twice daily, children may need 250g per week and adults 500g per week. • It is more cost-effective to prescribe emollients in large pack sizes and products that come in pump dispensers may be more suitable for long term use in order to reduce the risk of microbial contamination. • Preparations containing antimicrobials or antiseptics should only be used when treating patients with infected eczema or when antisepsis is required.

Pathway 4	Treatment with emollients (special circumstances)

/1

Dermamist Spray is specialist initiation only as it is more expensive than other formulations but may be useful in patients suffering from Toxic Epidermal Necrolysis and where patients are unable to apply other formulations.

White soft paraffin SI	Dermamist 10% spray	Spray from a distance of approximately 8 inches. Spray sparingly; over application may cause the skin to feel oily. Do not spray on face.

OR

Where a steroid-sparing, anti-inflammatory action is required, Adex gel can be used under specialist initiation only.

Adex SI	Adex gel	Apply three times daily or as often as required

OR

For use by carers where reduced frequency of application is essential, it can be used twice daily to provide effective relief in dry skin conditions.

Liquid paraffin + Isopropyl myristate	Doublebase Dayleve gel	Apply morning and night

Prescribing notes	• The choice of emollient should be based on the severity of the condition, patient preference, site of application and preparation cost. • See general prescribing notes pathway above for information on fire risk with all paraffin based and paraffin free emollients. • Emollients soothe, smooth and hydrate the skin and are indicated for all dry scaling disorders. • Emollients should be applied regularly to maintain improvement; and are particularly effective applied after a shower or bath. • Emollients should be applied in the direction of hair growth.

Pathway 5	Treatment with urea containing emollients

/1

	Urea	Flexitol 10% Urea cream	Apply 1–2 times a day
OR	**Urea + Lauromacrogols**	Balneum Plus cream	Apply twice daily

Prescribing notes	• Preparations containing urea are suitable for the treatment of very dry or hyperkeratotic, scaling skin conditions. Balneum plus is suitable for general skin care. Flexitol 10% Urea cream is suitable for general skin care and for the skin on the hands and feet.

Pathway 6 Treatment with soap substitutes and emollients for showering and bathing

/1

Emulsifying wax + Yellow soft paraffin	Hydromol ointment	Use as a soap substitute

/2

Emulsifying wax + Liquid paraffin + White soft paraffin	Emulsifying ointment	Use as a soap substitute

/3

Without antiseptic

Liquid paraffin + Isopropyl myristate	Hydromol Bath & Shower emollient	Apply to wet skin and rinse.
OR		
QV Gentle	QV Gentle wash	To be used as a soap substitute.

/4

With antiseptic

Dermol 500	Dermol 500 lotion	To be applied to the skin or used as a soap substitute.

Prescribing notes	• Most emollients (apart from white soft paraffin 50%/liquid paraffin 50%) may be used as soap substitutes (hand washing and in bath/shower) by firstly wetting the skin, washing with the cream or ointment, then rinsing off. Alternatively, emollients can be put on the skin before bathing or showering and then washed off to reduce stinging from broken areas. • Addition of emollient bath products can make baths slippy • A convenient way to apply emulsifying ointment and Hydromol ointment is as “soap balls”, which are made by putting a scoop of the ointment into tubinette or stockinette. • The presence of antiseptics (e.g. benzalkonium chloride) in emollients can rarely cause allergic reactions or irritation - this should be considered if skin becomes irritated, and an alternative product prescribed. • Dermol 500 lotion contains an antiseptic, so may be suitable for patients who specifically require an antiseptic soap substitute e.g. infected eczema.

Pathway 7	Treatment with mild topical corticosteroids

/1

Select the lowest potency topical corticosteroids for effective treatment, this may mean using different products for different areas to be treated.

Hydrocortisone	Hydrocortisone 1% cream Hydrocortisone 1% ointment	Apply 1-2 times daily, to be applied thinly.

Prescribing notes	• Topical corticosteroids should be tailed off and withdrawn as the condition settles (ideally over 1-3 weeks) but may need to be used intermittently in chronic eczema. • Often local specialists recommend once daily application of a topical corticosteroid and if no benefit after review at 7-10 days, will consider a higher potency topical corticosteroid rather than increasing the frequency of application. • To minimise the risk of side-effects, reduce the frequency of application as the condition settles or step-down potency. The risk of systemic side-effects increases with prolonged use particularly on thin skin surfaces, use in flexures, or use of more potent corticosteroids. Occlusion increases efficacy and side-effects. Only mild corticosteroids should generally be used on the face. • There is no benefit in changing to a higher percentage strength of topical hydrocortisone. Instead, patients should be moved up the steroid potency ladder i.e. to a moderately potent steroid. • The potency of the steroid should be stepped up or stepped down depending on the severity of symptoms. • Water-miscible corticosteroid creams are suitable for moist areas e.g. axillae or groin or for weeping lesions. • Ointments are generally chosen for dry, lichenified or scaly lesions or where a more occlusive effect is required. • Mixing topical preparations (e.g. steroid, emollient) on the skin should be avoided where possible; apply emollient and corticosteroid at different times of the day. • Topical corticosteroids are not recommended in urticaria, rosacea, acne or when a primary infective disease is suspected. • Topical corticosteroids should not be used on infected skin unless the infection is being treated • Topical corticosteroids should not routinely be added to repeat dispensing systems. For intermittent use in chronic eczema it may be appropriate to include topical steroids on repeat prescription provided there are clear instructions on intermittent use and regular review of therapy. • Gloves should be worn during, or hands washed after, application of large quantities of steroid preparations. • For the use of topical corticosteroids for lichen sclerosus, see the Obstetrics, gynaecology, and urinary-tract disorders chapter of the formulary. • Loss of effect with time (tachyphylaxis) can occur with prolonged use of topical corticosteroids. Intermittent use is preferred to continuous use.

Pathway 8 Treatment with moderate topical corticosteroids

/1

Select the lowest potency topical corticosteroids for effective treatment, this may mean using different products for different areas to be treated. Note similar sounding drug name: clobetaSOL 0.05% is a very potent topical steroid, clobetaSONE 0.05% is a moderately potent topical steroid.

Clobetasone	Clobetasone 0.05% cream Clobetasone 0.05% ointment	Apply 1-2 times daily, to be applied thinly.

/2

Select the lowest potency topical corticosteroids for effective treatment, this may mean using different products for different areas to be treated.

Betamethasone	Betamethasone valerate 0.025% cream Betamethasone valerate 0.025% ointment	Apply 1-2 times daily, to be applied thinly.
OR		
Fluocinolone acetonide	Fluocinolone acetonide 0.00625% cream Fluocinolone acetonide 0.00625% ointment	Apply 1-2 times daily, to be applied thinly.

Prescribing notes	• Topical corticosteroids should be tailed off and withdrawn as the condition settles (ideally over 1-3 weeks) but may need to be used intermittently in chronic eczema. • Often local specialists recommend once daily application of a topical corticosteroid and if no benefit after review at 7-10 days, will consider a higher potency topical corticosteroid rather than increasing the frequency of application. • To minimise the risk of side-effects, reduce the frequency of application as the condition settles or step-down potency. The risk of systemic side-effects increases with prolonged use particularly on thin skin surfaces, use in flexures, or use of more potent corticosteroids. Occlusion increases efficacy and side-effects. Only mild corticosteroids should generally be used on the face. • The potency of the steroid should be stepped up or stepped down depending on the severity of symptoms. • Water-miscible corticosteroid creams are suitable for moist areas e.g. axillae or groin or for weeping lesions. • Ointments are generally chosen for dry, lichenified or scaly lesions or where a more occlusive effect is required. • Mixing topical preparations (e.g. steroid, emollient) on the skin should be avoided where possible; apply emollient and corticosteroid at different times of the day. • Topical corticosteroids are not recommended in urticaria, rosacea, acne or when a primary infective disease is suspected. • Topical corticosteroids should not be used on infected skin unless the infection is being treated

	• Topical corticosteroids should not routinely be added to repeat dispensing systems. For intermittent use in chronic eczema it may be appropriate to include topical steroids on repeat prescription provided there are clear instructions on intermittent use and regular review of therapy. • Gloves should be worn during, or hands washed after, application of large quantities of steroid preparations. • For the use of topical corticosteroids for lichen sclerosus, see the Obstetrics, gynaecology, and urinary-tract disorders chapter of the formulary. • Fludroxycortide tape can be used for localised areas that also require occlusion. It is applied for 12 hours each day. Please note this is a moderately potent steroid. • Loss of effect with time (tachyphylaxis) can occur with prolonged use of topical corticosteroids. Intermittent use is preferred to continuous use.

Pathway 9 Treatment with potent topical corticosteroids

/1

Select the lowest potency topical corticosteroids for effective treatment, this may mean using different products for different areas to be treated.

Betamethasone	Betamethasone valerate 0.1% cream Betamethasone valerate 0.1% lotion Betamethasone valerate 0.1% ointment	Apply 1-2 times daily, to be applied thinly.

/2

Select the lowest potency topical corticosteroids for effective treatment, this may mean using different products for different areas to be treated.

Fluocinolone acetonide	Fluocinolone acetonide 0.025% cream Fluocinolone acetonide 0.025% gel Fluocinolone acetonide 0.025% ointment	Apply 1-2 times daily, to be applied thinly.
OR		
Mometasone	Mometasone 0.1% cream Mometasone 0.1% ointment	Apply once daily, to be applied thinly.

Prescribing notes	• Topical corticosteroids should be tailed off and withdrawn as the condition settles (ideally over 1-3 weeks) but may need to be used intermittently in chronic eczema. • Topical steroids should be applied once daily initially, if no benefit after 7-10 days, change to twice daily for a further 7-10 days. • To minimise the risk of side-effects, reduce the frequency of application as the condition settles or step-down potency. The risk of systemic side-effects increases with prolonged use particularly on thin skin surfaces, use in flexures, or use of more potent corticosteroids. Occlusion increases efficacy and side-effects. Only mild corticosteroids should generally be used on the face. • The potency of the steroid should be stepped up or stepped down depending on the severity of symptoms. • Potent corticosteroids should generally be avoided on the face and skin flexures • In general, the most potent topical corticosteroids should be reserved for recalcitrant dermatoses such as chronic discoid lupus erythematosus, lichen simplex chronicus, hypertrophic lichen planus, and palmoplantar pustulosis. • Water-miscible corticosteroid creams are suitable for moist areas e.g. axillae or groin or for weeping lesions. • Ointments are generally chosen for dry, lichenified or scaly lesions or where a more occlusive effect is required.

	• Mixing topical preparations (e.g. steroid, emollient) on the skin should be avoided where possible; apply emollient and corticosteroid at different times of the day. • Topical corticosteroids are not recommended in urticaria, rosacea, acne or when a primary infective disease is suspected. • Topical corticosteroids should not be used on infected skin unless the infection is being treated • Gloves should be worn during, or hands washed after, application of large quantities of steroid preparations. • Palms of the hands and soles of the feet may require potent or very potent steroids. • For the use of topical corticosteroids for lichen sclerosus, see the Obstetrics, gynaecology, and urinary-tract disorders chapter of the formulary. • Loss of effect with time (tachyphylaxis) can occur with prolonged use of topical corticosteroids. Intermittent use is preferred to continuous use.

Pathway 10 Treatment with very potent topical corticosteroids

/1

Select the lowest potency topical corticosteroids for effective treatment, this may mean using different products for different areas to be treated. Note similar sounding drug name: clobetaSOL 0.05% is a very potent topical steroid, clobetaSONE 0.05% is a moderately potent topical steroid.

Clobetasol	Clobetasol 0.05% ointment Clobetasol 0.05% cream	Apply 1-2 times daily, to be applied thinly.

Prescribing notes

- Topical corticosteroids should be tailed off and withdrawn as the condition settles (ideally over 1-3 weeks) but may need to be used intermittently in chronic eczema.
- Topical steroids should be applied once daily initially, if no benefit after 7-10 days, change to twice daily for a further 7-10 days.
- To minimise the risk of side-effects, reduce the frequency of application as the condition settles or step-down potency. The risk of systemic side-effects increases with prolonged use particularly on thin skin surfaces, use in flexures, or use of more potent corticosteroids. Occlusion increases efficacy and side-effects. Only mild corticosteroids should generally be used on the face.
- The potency of the steroid should be stepped up or stepped down depending on the severity of symptoms.
- Potent corticosteroids should generally be avoided on the face and skin flexures
- In general, the most potent topical corticosteroids should be reserved for recalcitrant dermatoses such as chronic discoid lupus erythematosus, lichen simplex chronicus, hypertrophic lichen planus, and palmoplantar pustulosis.
- Water-miscible corticosteroid creams are suitable for moist areas e.g. axillae or groin or for weeping lesions.
- Ointments are generally chosen for dry, lichenified or scaly lesions or where a more occlusive effect is required.
- Mixing topical preparations (e.g. steroid, emollient) on the skin should be avoided where possible; apply emollient and corticosteroid at different times of the day.
- Topical corticosteroids are not recommended in urticaria, rosacea, acne or when a primary infective disease is suspected.
- Topical corticosteroids should not be used on infected skin unless the infection is being treated
- Gloves should be worn during, or hands washed after, application of large quantities of steroid preparations.
- Palms of the hands and soles of the feet may require potent or very potent steroids.
- For the use of topical corticosteroids for lichen sclerosus, see the Obstetrics, gynaecology, and urinary-tract disorders chapter of the formulary.
- Loss of effect with time (tachyphylaxis) can occur with prolonged use of topical corticosteroids. Intermittent use is preferred to continuous use.
- Patients prescribed very potent topical corticosteroids should be reviewed regularly (at least monthly) and the preparation should not be prescribed on repeat prescription except on specialist advice.

Pathway 11	Treatment of staphylococcal skin infection with inflammatory skin condition (e.g. eczema)

/1

Treatment of secondary bacterial infection of eczema with topical antibiotic therapy may be appropriate in very localised lesions. When skin swab culture result is available confirming staphylococcal infection only use topical fusidic acid when sensitivity is confirmed.

Fusidic acid	Fusidic acid 2% cream	3 times a day for 5-7 days

Prescribing notes	• Do not routinely offer either topical or oral antibiotic if not systemically unwell. Take skin swabs if there are clinical signs of infection. If an oral antibiotic is appropriate for empirical treatment see recommendations for cellulitis. • Increasing concerns about the development of resistance have led to topical antibiotic therapy being discouraged. • For more information see NICE NG190 'Secondary bacterial infection of eczema and other common skin conditions: antimicrobial prescribing'. • Guidance on the treatment of skin infections including impetigo can be found in the Infections chapter of the formulary.

Pathway 12 Treatment with topical corticosteroids combined with antimicrobials

/1

Mild topical corticosteroids with antimicrobial

	Hydrocortisone + Clotrimazole	Hydrocortisone 1% + Clotrimazole 1% cream	Apply thinly twice daily for 7 days
OR	**Hydrocortisone + Miconazole**	Hydrocortisone 1% + Miconazole 2% cream	Apply two or three times a day for 7 days

/2

Moderate topical corticosteroids with antimicrobial

	Clobetasone + Oxytetracycline + Nystatin	Clobetasone 0.05% + oxytetracycline 3% + nystatin 100,000 units/g cream	Apply thinly once or twice a day for 7 days

/3

Potent topical corticosteroids with antimicrobial

	Betamethasone + Clioquinol	Betamethasone valerate 0.1% / Clioquinol 3% cream Betamethasone valerate 0.1% / Clioquinol 3% ointment	Apply thinly two or three times a day. Adult duration up to 7 days. If used in childhood, or on the face, courses should be limited to five days and occlusion should not be used.
OR	**Betamethasone + Fusidic acid**	Betamethasone valerate 0.1% + fusidic acid 2% cream	Apply twice a day for a maximum of 2 weeks
OR	**Fluocinolone acetonide + Clioquinol**	Fluocinolone acetonide 0.025% + clioquinol 3% cream Fluocinolone acetonide 0.025% + clioquinol 3% ointment	Apply thinly 2–3 times a day for 7 days

/4

Very potent topical corticosteroids with antimicrobial and antifungal

Clobetasol + Neomycin + Nystatin SI	Clobetasol 500microgram / Neomycin 5mg / Nystatin 100,000units/g cream Clobetasol 500microgram / Neomycin 5mg / Nystatin 100,000units/g ointment	On specialist advice

Prescribing notes	• Antibacterials and antifungals with corticosteroids may have a role if there is associated infection. Long term use of products containing antibacterials and antifungals increases the likelihood of resistance and sensitisation. Normally products should be used on a regular basis but for a short period only, usually 7 days. • For more information see NICE NG190 secondary bacterial infection of eczema and other common skin conditions: antimicrobial prescribing. • Topical corticosteroids should be tailed off and withdrawn as the condition settles (ideally over 1-3 weeks). Where it is desirable to alter steroid frequency when treating an infection prescribe a separate topical antimicrobial to be applied regularly for a short duration to avoid the development of resistance. • Occlusion increases efficacy and side-effects. Only mild corticosteroids should generally be used on the face. • The potency of the steroid should be stepped up or stepped down depending on the severity of symptoms. • Potent corticosteroids should generally be avoided on the face and skin flexures • In general, the most potent topical corticosteroids should be reserved for recalcitrant dermatoses such as chronic discoid lupus erythematosus, lichen simplex chronicus, hypertrophic lichen planus, and palmoplantar pustulosis. • Water-miscible corticosteroid creams are suitable for moist areas e.g. axillae or groin or for weeping lesions. • Ointments are generally chosen for dry, lichenified or scaly lesions or where a more occlusive effect is required. • Mixing topical preparations (e.g. steroid, emollient) on the skin should be avoided where possible; apply emollient and corticosteroid at different times of the day. • Topical corticosteroids are not recommended in urticaria, rosacea, acne or when a primary infective disease is suspected. • Topical corticosteroids should not be used on infected skin unless the infection is being treated • Topical corticosteroids with antimicrobials should not be put on repeat dispensing systems. • Gloves should be worn during, or hands washed after, application of large quantities of steroid preparations. • Palms of the hands and soles of the feet may require potent or very potent steroids. • For the use of topical corticosteroids for lichen sclerosus, see the Obstetrics, gynaecology, and urinary-tract disorders chapter of the formulary. • Loss of effect with time (tachyphylaxis) can occur with prolonged use of topical corticosteroids. Intermittent use is preferred to continuous use.

	• Combination antifungal/ mild potency steroid can be used for seborrhoeic dermatitis affecting the face. For more information on the management see NHS Scotland Dermatology Patient Pathways – seborrhoeic dermatitis.

Pathway 13 Treatment of inflammatory skin conditions with antiseptics and astringents (specialist initiation)

/1

Antiseptic/astringent topical solutions used on dermatology advice for inflammatory skin conditions with concurrent bacterial or fungal infection FOR EXTERNAL USE ONLY

	Eosin SI	Eosin 2% solution UM	On specialist advice
OR	**Benzalkonium** SI	Benzalkonium chloride 1% solution UM	On specialist advice
OR	**Potassium permanganate** SI	Potassium permanganate 400mg tablets for cutaneous solution	On specialist advice

Prescribing notes	• For more information see NICE NG190 secondary bacterial infection of eczema and other common skin conditions: antimicrobial prescribing. • Potassium permanganate soaks are not suitable for dry skin conditions and may leave a brown stain on skin, nails and the bath or vessel holding the solution.

Pathway 14 Treatment with topical ichthammol preparations

/1

Consider the addition of a topical ichthammol for acutely inflamed eczema, where initial treatment of eczema with emollients and corticosteroids is not effective

	Ichthammol + Zinc oxide	Zinc oxide 15% and Ichthammol 1% in Yellow soft paraffin (UM)	For acutely inflamed atopic eczema, apply twice daily until inflammation settled
OR	**Ichthammol**	Ichthammol 1% in Yellow soft paraffin (UM)	Apply 1-3 times daily

Prescribing notes	• Ichthammol has anti-inflammatory properties and can be a useful addition to emollients and corticosteroid therapy. • When ichthammol preparations are introduced as an add-on therapy there is increased absorption of topical corticosteroids, therefore the potency of concurrent steroid therapy may require reduction. • 1% ichthammol in YSP is an option for easier application and wash off. • ichthammol 1%/zinc oxide 15% in Yellow Soft Paraffin and ichthammol 1% in Yellow Soft Paraffin unlicensed specials are available from NHS Scotland specials service (formerly Tayside pharmaceuticals). • See the Wound section of the formulary for information on ichthopaste bandages for chronic lichenified skin conditions such as chronic eczema.

Pathway 15 Treatment with topical immunosuppressants

/1

Second line for patients suffering moderate eczema uncontrolled by topical steroids or those at risk of significant steroid-induced adverse effects

	Tacrolimus SI	Tacrolimus 0.03% ointment Tacrolimus 0.1% ointment	Apply twice daily until lesion clears (consider other treatment if eczema worsens or no improvement after 2 weeks), initially 0.1% ointment to be applied thinly, reduce frequency to once daily or strength of ointment to 0.03% if condition allows
OR	**Pimecrolimus** SI	Pimecrolimus 1% cream	Apply twice daily until symptoms resolve (stop treatment if eczema worsens or no response after 6 weeks).

Prescribing notes

- For the purposes of this guidance, atopic eczema that has not been controlled by topical corticosteroids refers to disease that has not shown a satisfactory clinical response to adequate use of the maximum strength and potency that is appropriate for the patient's age and the area being treated.
- Tacrolimus 0.03% ointment is recommended, within its licensed indications, as an option for the second-line treatment of moderate to severe atopic eczema in adults and children aged 2 years and older that has not been controlled by topical corticosteroids where there is a serious risk of important adverse effects from further topical corticosteroid use, particularly irreversible skin atrophy.
- Tacrolimus 0.1% ointment is recommended, within its licensed indications, as an option for the second-line treatment of moderate to severe atopic eczema in adults and adolescents aged 16 years and older that has not been controlled by topical corticosteroids where there is a serious risk of important adverse effects from further topical corticosteroid use, particularly irreversible skin atrophy. Review need of preventative therapy after 1 year.
- Tacrolimus 0.1% ointment can also be used for the prevention of flares in patients aged 16 years and over with moderate to severe atopic eczema in accordance with the licensed indications.
- Pimecrolimus 1% cream is recommended, within its licensed indications, as an option for the second-line treatment of moderate atopic eczema on the face and neck in children aged 2 to 16 years that has not been controlled by topical corticosteroids where there is a serious risk of important adverse effects from further topical corticosteroid use, particularly irreversible skin atrophy.
- Tacrolimus and pimecrolimus can be initiated by a physician (including GPs) with a special interest and experience in dermatology, where eczema is uncomplicated and topical corticosteroid usage has not given sustained benefit or is considered likely to cause adverse effects. GPs are advised to seek advice from the dermatology department where support is required to initiate treatment and to support discussion with the patient on the risks and benefits of available alternative treatment options.

Pathway 16 Systemic therapies in the treatment of moderate to severe eczema and atopic dermatitis

/1

Initial systemic therapies for severe eczema or atopic dermatitis where conventional therapy ineffective or inappropriate.

Methotrexate SI	Methotrexate 2.5mg tablets UI	Severe atopic eczema unresponsive to conventional therapy. The usual dose is methotrexate 10 to 25mg once weekly.
Ciclosporin SI	Cappimune 25mg capsules Cappimune 50mg capsules Cappimune 100mg capsules Neoral 10mg capsules Neoral 100mg/ml oral solution	Short-term treatment of severe atopic dermatitis where conventional therapy ineffective or inappropriate (administered on expert advice). Adult, initially 1.25 mg/kg twice daily (max. per dose 2.5 mg/kg twice daily) usual maximum duration of 8 weeks but may be used for longer under specialist supervision, if good initial response not achieved within 2 weeks, increase dose rapidly up to maximum. Short-term treatment of very severe atopic dermatitis where conventional therapy ineffective or inappropriate (administered on expert advice). Adult, 2.5 mg/kg twice daily usual maximum duration of 8 weeks but may be used for longer under specialist supervision.
Azathioprine SI	Azathioprine 25mg tablets Azathioprine 50mg tablets	Severe refractory eczema, normal or high TPMT activity. Adult 1–3 mg/kg daily. Severe refractory eczema, intermediate TPMT activity. Adult 0.5–1.5 mg/kg daily.
Alitretinoin SI	Alitretinoin 10mg capsules Alitretinoin 30mg capsules	Severe chronic hand eczema refractory to potent topical corticosteroids. Adult (prescribed by or under supervision of a consultant dermatologist) 30mg once daily; reduced if not tolerated to 10mg once daily for 12–24 weeks total duration of treatment, discontinue if no response after 12

		weeks, course may be repeated in those who relapse.

Prescribing notes	**General notes** • Systemic treatments for moderate to severe eczema or atopic dermatitis are initiated by specialists and include methotrexate, ciclosporin, alitretinoin or azathioprine. Alternative treatment includes systemic corticosteroids or biologic therapy. Biologic therapy should be offered in line with SMC advice, see the pathway for biologic treatment of moderate to severe atopic dermatitis for more details. • For treatments continuing in primary care responsibility for monitoring to be agreed, refer to individual board shared care policies for more information. **Methotrexate** • Methotrexate can be prescribed, after specialist initiation, for severe atopic eczema unresponsive to conventional therapy. • To avoid prescribing, dispensing and administration errors only the 2.5mg strength of methotrexate should be prescribed and dispensed. The patient should be advised on the dose and frequency for taking methotrexate. New measures have been implemented to prompt healthcare professionals to record the day of the week for intake and to remind patients of the dosing schedule and the risks of overdose due to continued reports of inadvertent overdose. For further advice see MHRA Drug Safety Update September 2020. • The patient should be advised to report immediately any signs of methotrexate toxicity. • Regular monitoring of full blood count, renal function and liver function should be undertaken in line with local protocols. **Ciclosporin** • Ciclosporin can be prescribed, after specialist inititiation for atopic dermatitis where conventional therapy is ineffective or inappropriate. Preparations should be prescribed by brand name only due to differences in bio-availability. • The formulary choice for ciclosporin is Capimune (10mg capsules and liquid formulation must be prescribed as Neoral). • Patients on ciclosporin should be regularly monitored for adverse effects including hypertension and renal impairment. **Azathioprine** • Azathioprine (off-label) can be prescribed, after specialist initiation, for severe refractory eczema or as a steroid sparing agent in severe autoimmune bullous dermatoses. It is contraindicated if there is absent or very low thiopurine methyltransferase (TPMT) activity. **Alitretinoin** • Alitretinoin is accepted for use in adults with severe hand eczema unresponsive to treatment with potent topical corticosteroids. It should be prescribed only by, or under the supervision of, a consultant dermatologist and be dispensed by a hospital-based

	pharmacy. It is teratogenic and females of childbearing age must practice effective contraception and engage with a pregnancy prevention programme. Refer to MHRA/CHM advice: Oral retinoid medicines: revised and simplified pregnancy prevention educational materials for healthcare professionals and women (June 2019).

Pathway 17	Biologic treatment of moderate to severe atopic dermatitis

/1	**Dupilumab** SUO	Dupixent 200mg/1.14ml solution for injection pre-filled syringes Dupixent 300mg/2ml solution for injection pre-filled syringes	Refer to product literature.
OR	**Baricitinib** SUO	Olumiant 2mg tablets Olumiant 4mg tablets	Refer to product literature.

Prescribing notes	• Dupilumab is available for the treatment of moderate-to-severe atopic dermatitis for patients aged 6 years and over who are candidates for systemic therapy. Use is restricted to patients who have had an inadequate response to existing systemic immunosuppressants such as ciclosporin, or in whom such treatment is considered unsuitable. • Baricitinib is available for the treatment of moderate to severe atopic dermatitis in adult patients who are candidates for systemic therapy and who have failed at least one current systemic immunosuppressant due to intolerance, contraindication or inadequate disease control.

Group	Skin conditions
Condition	Hirsutism

Pathway 1	Treatment of hirsutism

/1	**Co-cyprindiol**	Co-cyprindiol 2000microgram/35microgram tablets	1 tablet daily for 21 days, to be started on day 1 of menstrual cycle; subsequent courses repeated after a 7-day interval (during which withdrawal bleeding occurs), time to symptom remission, at least 3 months; review need for treatment regularly.
/2	**Eflornithine**	Eflornithine 11.5% cream	Apply to the affected area twice daily, at least eight hours apart.

Prescribing notes	• Co-cyprindiol may be effective for moderately severe hirsutism. Treatment is required for 6–12 months before benefit is seen. • Co-cyprindiol should be stopped 3-4 months after the hirsutism has completely resolved. Courses may be repeated if there is a recurrence. • For further information on the safe prescribing of co-cyprindiol see the Contraception recommendations in the Obstetrics, gynaecology, and urinary-tract disorders chapter of the formulary. • Eflornithine is restricted to use in women for whom alternative drug therapy is ineffective, contraindicated or considered inappropriate. It should be discontinued if there is no improvement after 4 months of treatment.

Group	Skin conditions
Condition	Hyperhidrosis

Pathway 1	Treatment with antiperspirants

/1	**Aluminium chloride**	Aluminium chloride 20% solution	Apply once daily, apply liquid formulation at night to dry skin, wash off the following morning, reduce frequency as condition improves – do not bathe immediately before use.
/2	**Glycopyrronium bromide** SI	Glycopyrronium bromide 0.05% cream UM Glycopyrronium bromide 1% cream UM Glycopyrronium bromide 2% cream UM	As per specialist advice.
/3	**Botulinum A toxin** SI	Botox 50unit powder for solution for injection vials Botox 100unit powder for solution for injection vials Botox 200unit powder for solution for injection vials	As per specialist advice

Prescribing notes	• Glycopyrronium bromide may be prescribed on the recommendation of a specialist as a 0.05%, 1% or 2% cream. • Botulinum toxin may be prescribed and administered by specialists for axillary hyperhidrosis.

Group	**Skin conditions**
Condition	**Nappy rash**

Pathway 1	**Treatment with barrier preparations**

/1

	Dimeticone + Benzalkonium	Conotrane cream	Apply to the affected area(s) several times a day, as necessary.
OR	**Metanium**	Metanium Nappy Rash ointment	Apply several times daily as necessary, spread the ointment thinly so the skin texture can be clearly seen through the ointment.
OR	**Sudocrem**	Sudocrem antiseptic healing cream	Apply a thin layer to the skin as required.

Prescribing notes	• Urinary (nappy) rash may clear if skin is left exposed to air; if associated with yeast (candida) infection, an antifungal cream such as clotrimazole cream is useful. • See Wound section of the formulary for further advice in relation to urinary incontinence barrier preparations.

Group	Skin conditions
Condition	Pruritus

Guidance links	NHS Scotland Dermatology Patient Pathways

Pathway 1	Topical treatment of pruritus

/1

Aqueous calamine cream is available via pharmacy first so patients should be directed there.

Crotamiton	Crotamiton 10% cream	Apply 2-3 times daily

/2

Menthol	Menthol 1% in Aqueous cream (UM)	Apply 1-2 times a day

Prescribing notes	

- Pruritus may be caused by systemic disease, skin disease or as a side-effect of medication. Where possible the underlying cause should be identified and treated.
- Anti-pruritics should be considered when an emollient on its own has been ineffective in relieving symptoms.
- 1% menthol in aqueous cream is useful for patients with non-specific itch.
- Menthol in aqueous cream is an appropriate choice for the elderly. A range of strengths are included as stinging may be associated with the higher strengths.
- Topical antihistamines and local anaesthetics are not recommended as they are only marginally effective and can cause sensitisation.
- Crotamiton is useful for pruritus persisting after treatment of scabies.
- Emollient preparations may be useful for pruritus due to dry skin; sedating oral antihistamines may also be helpful for itch (see Allergy recommendations in the Respiratory chapter of the formulary).
- Calamine is useful for itch associated with chickenpox.

Pathway 2 Oral antihistamines for the treatment of pruritis

/1

Oral antihistamines can be used in combination with topical treatments.

	Cetirizine	Cetirizine 10mg tablets Cetirizine 1mg/ml oral solution sugar free	10mg daily.
OR	**Loratadine**	Loratadine 10mg tablets Loratadine 5mg/5ml oral solution sugar free	10mg daily.

OR

Oral antihistamines can be used in combination with topical treatments. Sedating antihistamine can be helpful for troublesome nocturnal itch. Avoid in the elderly, chlorphenamine has strong anticholinergic effects – see prescribing notes

	Chlorphenamine	Chlorphenamine 4mg tablets Chlorphenamine 2mg/5ml oral solution sugar free	Adult, 4mg every 4–6 hours; maximum 24mg per day. Elderly, 4mg every 4–6 hours; maximum 12mg per day.

/2

Oral antihistamines can be used in combination with topical treatments. Sedating antihistamine can be helpful for troublesome nocturnal itch. Avoid in the elderly, hydroxyzine has strong anticholinergic effects – see prescribing notes

	Hydroxyzine	Hydroxyzine 25mg tablets	Adult, initially 25mg daily, dose to be taken at night; increased if necessary to 25mg 3–4 times a day. Elderly, initially 25mg daily, dose to be taken at night; increased if necessary to 25mg twice daily.

Prescribing notes	• Pruritus may be caused by systemic disease, skin disease or as a side-effect of medication. Where possible the underlying cause should be identified and treated. • Emollient preparations may be useful for pruritus due to dry skin.

	• Antihistamines (including non-sedative antihistamines) can cause day time somnolence, and patients should be aware of this potential side-effect, particularly in relation to driving or operating machinery. • If there is troublesome nocturnal itch, consider a short-term trial of a sedating oral antihistamine, such as chlorphenamine or hydroxyzine. • Sedating antihistamines such as chlorphenamine and hydroxyzine have strong anticholinergics effects and should be avoided in the elderly. Medicines with strong anticholinergics effects have long been linked to impaired cognition and falls risk, and more recently have also been linked to increased morbidity and mortality. Further information about anticholinergic load can be read in the Scottish Government Polypharmacy Guidance.

Group	Skin conditions
Condition	Psoriasis

Guidance links	NHS Scotland Dermatology Patient Pathways

Pathway 1	Treatment of mild to moderate psoriasis on the skin or scalp

/1

Note, coal tar preparations can stain skin, clothing, baths and floors.
Mild to moderate psoriasis: Exorex. **Mild scalp psoriasis**: coal tar shampoo. **Moderate psoriasis**: Coal tar in Yellow soft paraffin.

Coal tar	Exorex lotion	Apply 2-3 times a day, to be applied to skin or scalp; in elderly, lotion can be diluted with a few drops of water before applying.
	Coal tar extract 2% shampoo	Scalp disorders, including psoriasis, apply 1-2 times weekly.
	Coal tar 2% in Yellow soft paraffin UM Coal tar 5% in Yellow soft paraffin UM	Apply 1-3 times a day, start application with low-strength preparations.
	Coal tar 10% in Yellow soft paraffin SUO UM Coal tar 20% in Yellow soft paraffin SUO UM	Under supervised use in Dermatology Treatment Centres only.

OR

Mild to moderate scaly scalp psoriasis: soften and remove scale with Sebco.

Sebco	Sebco ointment	Apply to the affected area of the scalp, shampoo off after 1 hour. Apply once weekly as required, alternatively apply daily for the first 3-7 days (if severe).

/2

Note, coal tar preparations can stain skin, clothing, baths and floors.

	Coal tar + salicylic acid	Coal tar 10% / Salicylic acid 2% in Emulsifying ointment (UM)	On specialist advice.
OR	**Salicylic acid**	Salicylic acid 5% in Yellow soft paraffin (UM) Salicylic acid 10% in Yellow soft paraffin (UM) Salicylic acid 20% in Yellow soft paraffin (UM) Salicylic acid 40% in Yellow soft paraffin (UM)	On specialist advice.

Prescribing notes	• Emollients may also be used, see emollient pathway within the Eczema condition page. • Emollients are useful in softening scaling and reducing irritation in inflammatory / plaque psoriasis. • Treatment choice depends on site, extent of psoriasis and patient preference and tolerance. It may be appropriate to treat psoriasis in specific sites, such as the face and flexures, usually with a mild corticosteroid, and psoriasis of the scalp, palms, and soles with a potent corticosteroid. • "Lotion" should be specified when prescribing Exorex since the cream is "pay and report". • Phototherapy, methotrexate, ciclosporin, acitretin should be initiated on specialist advice only, with responsibility for monitoring agreed. • Coconut oil is an effective emollient for use in scalp dermatitis, psoriasis and keratosis and can be purchased over the counter. • Mild scalp psoriasis should be treated with a tar based shampoo. • For moderate scalp psoriasis or for itchy scalps a steroid scalp application can be used short-term. Normally applied in the morning. • Mousse/foam formulations of steroids can be used in patients with sensitive skin or where there is local scalp irritation. • Scalp psoriasis is usually scaly, and the scale may be thick and adherent. This requires softening with an ointment, cream, or oil and usually combined with salicylic acid as a keratolytic. • Salicyclic acid preparations may be useful where there is a marked scaling of the skin or scalp. • Sebco should be left on for at least an hour, often more conveniently overnight, before washing it off. **Unlicensed / Special Manufacture Preparations** • The British Association of Dermatologists (BAD) list of preferred unlicensed dermatological preparations ('Specials') is available at the BAD website.

	• Use a licensed product wherever available. Consider cost versus benefit of a licensed preparation versus an unlicensed preparation (often in excess of £100). If an unlicensed topical preparation is required, consider only those listed on the BAD list. • If prescribing specials, prescribe appropriate quantities, as expiry dates are likely to be short for these unlicensed specials products. Do not put the special onto a repeat prescription and ensure that the condition is reviewed regularly. • If a ‘Specials’ product is required Dermatologists in the East Region have agreed to use only BAD approved ‘Specials’ whenever possible.

Pathway 2 Specific treatment of the face or flexures

/1

Mild corticosteroid

Hydrocortisone	Hydrocortisone 1% cream Hydrocortisone 1% ointment	Apply 1-2 times daily, to be applied thinly.

/2

Moderate corticosteroid. Note similar sounding drug name: clobetaSOL 0.05% is a very potent topical steroid, clobetaSONE 0.05% is a moderately potent topical steroid.

Clobetasone	Clobetasone 0.05% cream Clobetasone 0.05% ointment	Apply 1-2 times daily, to be applied thinly.

/3

Moderate corticosteroid

Betamethasone	Betamethasone valerate 0.025% cream Betamethasone valerate 0.025% ointment	Apply 1-2 times daily, to be applied thinly.
OR		
Fluocinolone acetonide	Fluocinolone acetonide 0.00625% cream Fluocinolone acetonide 0.00625% ointment	Apply 1-2 times daily, to be applied thinly.

Prescribing notes	• Rarely, severe adverse effects can occur on stopping treatment with topical corticosteroids, often after long-term continuous or inappropriate use of moderate to high potency products. To reduce the risks of these events, prescribe the topical corticosteroid of lowest potency needed and ensure patients know how to use it safely and effectively. See MHRA warning - Topical corticosteroids: information on the risk of topical steroid withdrawal reactions. • Treatment choice depends on site, extent of psoriasis and patient preference and tolerance. • Topical use of potent corticosteroids on widespread psoriasis can lead to systemic as well as to local side-effects. It is reasonable, however, to prescribe a mild to moderate topical corticosteroid for a short period (2–4 weeks) for flexural and facial psoriasis and to use a more potent corticosteroid such as betamethasone for psoriasis of the scalp, palms, or soles.

	• Emollients are useful adjuncts to other more specific treatments for psoriasis. • Emollients are useful in softening scaling and reducing irritation in inflammatory / plaque psoriasis. • It may be appropriate to treat psoriasis in specific sites, such as the face and flexures, usually with a mild corticosteroid, and psoriasis of the scalp, palms, and soles with a potent corticosteroid. • Topical vitamin D analogues may be alternated with a moderately potent steroid. • Topical use of potent corticosteroids on widespread psoriasis can lead to systemic as well as to local side-effects. It is reasonable, however, to prescribe a mild to moderate topical corticosteroid for a short period (2–4 weeks) for flexural and facial psoriasis and to use a more potent corticosteroid such as betamethasone for psoriasis of the scalp, palms, or soles.

Pathway 3 Specific treatment of the trunk, limbs or scalp

/1

Consider +/- potent corticosteroid. Calcitriol may be less irritant than calcipotriol and therefore better tolerated.

Calcitriol	Calcitriol 3micrograms/g ointment	Apply twice daily, not more than 35% of body surface to be treated daily; maximum 30g per day.
OR		
Calcipotriol	Calcipotriol 50micrograms/g ointment	Apply 1-2 times a day, when preparations are used together maximum total calcipotriol 5mg in any one week (e.g. scalp solution 60ml with ointment 30g or scalp solution 30ml with ointment 60g); maximum 100g per week.

/2

Potent corticosteroid considered +/- calcitriol or calcipotriol.

Betamethasone	Betamethasone valerate 0.1% cream Betamethasone valerate 0.1% lotion Betamethasone valerate 0.1% ointment	Apply 1-2 times daily, to be applied thinly.
OR		
Fluocinolone acetonide	Fluocinolone acetonide 0.025% cream Fluocinolone acetonide 0.025% gel Fluocinolone acetonide 0.025% ointment	Apply 1-2 times daily, to be applied thinly.

OR

Individual preparations should be used in the first instance, however a combination product can be used where adherence is an issue e.g. Dovobet and Enstilar).

	Calcipotriol + Betamethasone	Calcipotriol 0.005% / Betamethasone dipropionate 0.05% ointment	Stable plaque psoriasis: Apply once daily for 4 weeks; if necessary, treatment may be continued beyond 4 weeks or repeated, on the advice of a specialist, apply to a maximum 30% of body surface, when different preparations containing calcipotriol used together, max. total calcipotriol 5mg in any one week; maximum 15g per day.
		Dovobet gel	See BNF for dose.
		Enstilar 50micrograms/g / 0.5 mg/g cutaneous foam	See BNF for dose.
OR	**Salicylic acid + Betamethasone**	Diprosalic 0.05%/3% ointment	Apply 1-2 times a day, max 60g per week.

/3

Very potent corticosteroid for treatment of the scalp. Note similar sounding drug name: clobeta**SOL** 0.05% is a very potent topical steroid, clobeta**SONE** 0.05% is a moderately potent topical steroid.

	Clobetasol	Etrivex 500micrograms/g shampoo	See BNF for dose.
OR	**Salicylic acid + Betamethasone**	Diprosalic 0.05%/2% scalp application	Apply a few drops 1-2 times a day.

Prescribing notes	• Rarely, severe adverse effects can occur on stopping treatment with topical corticosteroids, often after long-term continuous or inappropriate use of moderate to high potency products. To reduce the risks of these events, prescribe the topical corticosteroid of lowest potency needed and ensure patients know how to use it safely and effectively. See MHRA warning - Topical corticosteroids: information on the risk of topical steroid withdrawal reactions. • Calcitriol may be less irritant than calcipotriol and therefore better tolerated. • Treatment choice depends on site, extent of psoriasis and patient preference and tolerance. • Emollients are useful in softening scaling and reducing irritation in inflammatory / plaque psoriasis. • Coconut oil is an effective emollient for use in scalp dermatitis, psoriasis and keratosis and can be purchased over the counter. • Mild scalp psoriasis should be treated with a tar based shampoo. • For moderate scalp psoriasis or for itchy scalps a steroid scalp application can be used short-term. Normally applied in the morning.

	• Mousse/foam formulations of steroids can be used in patients with sensitive skin or where there is local scalp irritation. • Scalp psoriasis is usually scaly, and the scale may be thick and adherent. This requires softening with an ointment, cream, or oil and usually combined with salicylic acid as a keratolytic. • Salicyclic acid preparations may be useful where there is a marked scaling of the skin or scalp. • It may be appropriate to treat psoriasis in specific sites, such as the face and flexures, usually with a mild corticosteroid, and psoriasis of the scalp, palms, and soles with a potent corticosteroid. • To gain rapid improvement in plaque psoriasis, short term (4 weeks) and intermittent use of a potent topical corticosteroid or a potent topical corticosteroid plus a topical vitamin D analogue is recommended. • For the long term topical treatment of plaque psoriasis, a vitamin D analogue is recommended. • Potent to very potent topical corticosteroids are not recommended for regular use over prolonged periods because of concern over long term adverse effects. • Topical vitamin D analogues may be alternated with a moderately potent steroid. • Phototherapy, methotrexate, ciclosporin, acitretin should be initiated on specialist advice only, with responsibility for monitoring agreed. • When different preparations containing calcipotriol are used e.g. cream and scalp solution, the total maximum weekly dose should not be exceeded e.g. 60g cream or ointment with 30ml of scalp solution or 60ml of scalp solution with 30g of cream or ointment.

Pathway 4	Systemic therapies in the treatment of psoriasis - initial systemic therapies

/1

Initial systemic therapies for severe psoriasis where conventional therapy ineffective or inappropriate. Systemic treatments for severe psoriasis are initiated by specialists. For treatments continuing in primary care responsibility for monitoring to be agreed, refer to individual board shared care policies for more information.

	Methotrexate SI	Methotrexate 2.5mg tablets	For severe psoriasis (administered on expert advice). The usual dose is methotrexate 10 to 25mg once weekly.
OR	**Ciclosporin** SI	Cappimune 25mg capsules Cappimune 50mg capsules Cappimune 100mg capsules Neoral 10mg capsules Neoral 100mg/ml oral solution	For severe psoriasis where conventional therapy ineffective or inappropriate (administered on expert advice). Adult, initially 1.25 mg/kg twice daily (max. per dose 2.5 mg/kg twice daily), increased gradually to maximum if no improvement within 1 month, initial dose of 2.5 mg/kg twice daily justified if condition requires rapid improvement; discontinue if inadequate response after 3 months at the optimum dose; max. duration of treatment usually 1 year unless other treatments cannot be used.
OR	**Acitretin** SUO	Acitretin 10mg capsules Acitretin 25mg capsules	For severe extensive psoriasis resistant to other forms of therapy (under expert supervision). Adult, initially 25–30mg daily for 2–4 weeks, then adjusted according to response to 25–50mg daily, increased to up to 75mg daily, dose only increased to 75mg daily for short periods in psoriasis.

Prescribing notes	**General notes** • Systemic treatments for psoriasis are initiated by specialists and include phototherapy, methotrexate, ciclosporin or acitretin. Alternative systemic treatments for specialist initiation include apremilast and dimethyl fumarate or pSoralen and ultraviolet A light (PUVA). See recommendations for treatment of skin conditions with methoxyPsoralen and UltraViolet A light (PUVA).

- Biologic therapy should be offered to patients requiring systemic therapy if methotrexate and ciclosporin have failed, are not tolerated or are contraindicated and the psoriasis has a large impact on physical, psychological or social functioning, clinically relevant depressive or anxiety symptoms and one or more of the following disease severity criteria apply:
    - the psoriasis is extensive, defined as BSA > 10% or PASI ≥ 10
    - the psoriasis is severe at localized sites and associated with significant functional impairment and/or high levels of distress (for example nail disease or involvement of high-impact and difficult to treat sites such as the face, scalp, palms, soles, flexures and genitals).
- See the pathways for biologic treatment of psoriasis and alternative systemic therapies (apremilast and dimethyl fumarate) for more details.

Methotrexate

- Methotrexate can be used for severe psoriasis.
- To avoid prescribing, dispensing and administration errors only the 2.5mg strength of methotrexate should be prescribed and dispensed. The patient should be advised on the dose and frequency for taking methotrexate. New measures have been implemented to prompt healthcare professionals to record the day of the week for intake and to remind patients of the dosing schedule and the risks of overdose due to continued reports of inadvertent overdose. For further advice see MHRA Drug Safety Update September 2020.
- The patient should be advised to report immediately any signs of methotrexate toxicity.
- Regular monitoring of full blood count, renal function and liver function should be undertaken in line with local protocols.

Ciclosporin

- Ciclosporin can be prescribed for severe psoriasis where conventional therapy is ineffective or inappropriate. Preparations should be prescribed by brand name only due to differences in bio-availability.
- The formulary choice for ciclosporin is Capimune (10mg capsules and liquid formulation must be prescribed as Neoral).
- Patients on ciclosporin should be regularly monitored for adverse effects including hypertension and renal impairment.

Acitretin

- Oral acitretin is a toxic and teratogenic drug which is only prescribable by a consultant dermatologist. Prescription of systemic acitretin for women is only possible if adequate contraception is undertaken (Pregnancy prevention programme). Refer to MHRA/CHM advice: Oral retinoid medicines: revised and simplified pregnancy prevention educational materials for healthcare professionals and women (June 2019).

Pathway 5 Biologic treatment of chronic plaque psoriasis

/1

See prescribing notes for restrictions related to the use of these medicines. Adalimumab is the first choice therapy on account of the overall administration and acquisition cost. Other biologic therapies are listed in alphabetical order. Where more than one treatment is suitable select the most cost-effective choice taking into account administration and acquisition costs.

Adalimumab SUO	Amgevita 20mg/0.4ml solution for injection pre-filled syringes Amgevita 40mg/0.8ml solution for injection pre-filled syringes Amgevita 40mg/0.8ml solution for injection pre-filled pens	Dose according to product literature

/2

Brodalumab SUO	Kyntheum 210mg/1.5ml solution for injection pre-filled syringes	Dose according to product literature

OR

Certolizumab is first line biologic in women of childbearing age who have not yet completed their family as it is safe to use in pregnancy and breastfeeding.

Certolizumab pegol SUO	Cimzia 200mg/1ml solution for injection pre-filled syringes Cimzia 200mg/1ml solution for injection pre-filled pens	Dose according to product literature
OR **Etanercept** SUO	Benepali 25mg/0.5ml solution for injection pre-filled syringes Benepali 50mg/1ml solution for injection pre-filled syringes Benepali 50mg/1ml solution for injection pre-filled pens	Dose according to product literature
OR **Guselkumab** SUO	Tremfya 100mg/1ml solution for injection pre-filled pens	Dose according to product literature

OR	**Infliximab** SUO	Remsima 100mg powder for concentrate for solution for infusion vials Remsima 120mg/1ml solution for injection pre-filled pens Remsima 120mg/1ml solution for injection pre-filled syringes	Dose according to product literature
OR	**Ixekizumab** SUO	Taltz 80mg/1ml solution for injection pre-filled pens Taltz 80mg/1ml solution for injection pre-filled syringes	Dose according to product literature
OR	**Risankizumab** SUO	Skyrizi 75mg/0.83ml solution for injection pre-filled syringes Skyrizi 150mg/1ml solution for injection pre-filled syringes Skyrizi 150mg/1ml solution for injection pre-filled pens	Dose according to product literature
OR	**Secukinumab** SUO	Cosentyx 150mg/1ml solution for injection pre-filled syringes Cosentyx 150mg/1ml solution for injection pre-filled pens Cosentyx 300mg/2ml solution for injection pre-filled pens	Dose according to product literature
OR	**Tildrakizumab** SUO	Ilumetri 100mg/1ml solution for injection pre-filled syringes	Dose according to product literature
OR	**Ustekinumab** SUO	Stelara 45mg/0.5ml solution for injection pre-filled syringes Stelara 45mg/0.5ml solution for injection vials Stelara 90mg/1ml solution for injection pre-filled syringes	Dose according to product literature

Prescribing notes	**General notes**
	• Systemic treatments for psoriasis are initiated by specialists and include phototherapy, methotrexate, ciclosporin or acitretin. Alternative systemic treatments for specialist initiation include apremilast and dimethyl fumarate or pSoralen and ultraviolet A light (PUVA). See recommendations for treatment of skin conditions with methoxyPsoralen and UltraViolet A light (PUVA).
	• Biologic therapy should be offered to patients requiring systemic therapy if methotrexate and ciclosporin have failed, are not tolerated or are contraindicated and the psoriasis has a large impact on physical, psychological or social functioning, clinically relevant depressive or anxiety symptoms and one or more of the following disease severity criteria apply:
	  ○ the psoriasis is extensive, defined as BSA > 10% or PASI ≥ 10
	  ○ the psoriasis is severe at localized sites and associated with significant functional impairment and/or high levels of distress (for example nail disease or involvement of high-impact and difficult to treat sites such as the face, scalp, palms, soles, flexures and genitals).
	• See the pathways for biologic treatment of psoriasis and alternative systemic therapies (apremilast and dimethyl fumarate) for more details.
	• Refer to British Association of Dermatologists guidelines for biologic therapy for psoriasis 2020: a rapid update. Br J Dermatol 2020; 183 (4) 6328-637.
	• In NHS Fife refer to NHS Fife High cost drugs pathway for adults with psoriasis.
	
	Restrictions
	• **Adalimumab** is recommended for the treatment of chronic plaque psoriasis in adults which has failed to respond to standard systemic treatments (including ciclosporin and methotrexate) or to PUVA therapy, or when standard treatments cannot be used because of intolerance or contra-indications. Its use should be restricted to severe disease (PASI score > or equal to 10 and a DLQI score of >10). Adalimumab should be withdrawn if the response is not adequate after 16 weeks (PASI 75 response from baseline).
	• **Brobalumab** is recommended for the treatment of moderate to severe plaque psoriasis in adult patients who are candidates for systemic therapy. Use is restricted to patients who have failed to respond to standard systemic therapies (including ciclosporin, methotrexate and phototherapy), are intolerant to, or have a contra-indication to these treatments.
	• **Certolizumab** is recommended for patients with moderate to severe psoriasis who have failed to respond to standard systemic therapies (including ciclosporin, methotrexate and phototherapy), are intolerant to, or have contraindications to these treatments.
	• **Certolizumab** is first line biologic in women of childbearing age who have not yet completed their family as it is safe to use in pregnancy and breastfeeding.
	• **Etanercept**, within its licensed indications is recommended for the treatment of adults with plaque psoriasis only when the following criteria are met. The disease is severe as defined by a total Psoriasis Area Severity Index (PASI) of 10 or more and a Dermatology Life Quality Index (DLQI) of more than 10; the psoriasis has failed to respond to standard systemic therapies including ciclosporin, methotrexate and PUVA (psoralen and long-wave ultraviolet radiation); or the person is intolerant to, or has a contraindication to, these treatments.

	• **Guselkumab** is recommended for the treatment of moderate to severe plaque psoriasis in adults who are candidates for systemic therapy. It is for patients who have failed to respond to conventional systemic therapies (including methotrexate, ciclosporin and phototherapy), are intolerant to, or have a contraindication to these treatments. • **Infliximab** is recommended for the treatment of severe plaque psoriasis in adults which has failed to respond to standard systemic treatments (including ciclosporin and methotrexate) or to PUVA therapy, or when standard treatments cannot be used because of intolerance or contraindications. Infliximab should be withdrawn if the response is not adequate after 10 weeks (PASI 75 response from baseline or a 50% reduction and a 5 point reduction in DLQI from baseline). • **Ixekizumab** is recommended for the treatment of moderate to severe plaque psoriasis in adult patients who are candidates for systemic therapy. Use is restricted to patients who have failed to respond to standard systemic therapies (including ciclosporin, methotrexate and phototherapy), are intolerant to, or have a contra-indication to these treatments. • **Risankizumab** is recommended for the treatment of moderate to severe plaque psoriasis in adult patients who are candidates for systemic therapy. Use is restricted to patients who have failed to respond to standard systemic therapies (including ciclosporin, methotrexate and phototherapy), are intolerant to, or have a contra-indication to these treatments. • **Secukinumab** is recommended for the treatment of moderate to severe plaque psoriasis in adult patients who are candidates for systemic therapy. Use is restricted to patients who have failed to respond to standard systemic therapies (including ciclosporin, methotrexate and phototherapy), are intolerant to, or have a contra-indication to these treatments. • **Tildrakizumab** is recommended for the treatment of moderate to severe plaque psoriasis in adult patients who are candidates for systemic therapy. Use is restricted to patients who have failed to respond to standard systemic therapies (including ciclosporin, methotrexate and phototherapy), are intolerant to, or have a contra-indication to these treatments. • **Ustekinumab** is recommended for the treatment of moderate to severe plaque psoriasis in adult patients who are candidates for systemic therapy. Use is restricted to patients who have failed to respond to standard systemic therapies (including ciclosporin, methotrexate and phototherapy), are intolerant to, or have a contra-indication to these treatments. Continued treatment should be restricted to patients who achieve a PASI 75 response within 16 weeks.

Pathway 6 Biologic treatment of psoriasis with psoriatic arthritis

/1

See prescribing notes for restrictions related to the use of these medicines. Adalimumab is the first choice therapy on account of the overall administration and acquisition cost. Other biologic therapies are listed in alphabetical order. Where more than one treatment is suitable select the most cost-effective choice taking into account administration and acquisition costs.

Adalimumab SUO	Amgevita 20mg/0.4ml solution for injection pre-filled syringes Amgevita 40mg/0.8ml solution for injection pre-filled syringes Amgevita 40mg/0.8ml solution for injection pre-filled pens	Dose according to product literature

/2

Brodalumab SUO	Kyntheum 210mg/1.5ml solution for injection pre-filled syringes	Dose according to product literature

OR

Certolizumab is first line biologic in women of childbearing age who have not yet completed their family as it is safe to use in pregnancy and breastfeeding.

Certolizumab pegol SUO	Cimzia 200mg/1ml solution for injection pre-filled syringes Cimzia 200mg/1ml solution for injection pre-filled pens	Dose according to product literature
OR **Etanercept** SUO	Benepali 25mg/0.5ml solution for injection pre-filled syringes Benepali 50mg/1ml solution for injection pre-filled syringes Benepali 50mg/1ml solution for injection pre-filled pens	Dose according to product literature
OR **Guselkumab** SUO	Tremfya 100mg/1ml solution for injection pre-filled pens	Dose according to product literature

OR	**Infliximab** SUO	Remsima 100mg powder for concentrate for solution for infusion vials Remsima 120mg/1ml solution for injection pre-filled pens Remsima 120mg/1ml solution for injection pre-filled syringes	Dose according to product literature
OR	**Ixekizumab** SUO	Taltz 80mg/1ml solution for injection pre-filled pens Taltz 80mg/1ml solution for injection pre-filled syringes	Dose according to product literature
OR	**Risankizumab** SUO	Skyrizi 75mg/0.83ml solution for injection pre-filled syringes Skyrizi 150mg/1ml solution for injection pre-filled syringes Skyrizi 150mg/1ml solution for injection pre-filled pens	Dose according to product literature
OR	**Secukinumab** SUO	Cosentyx 150mg/1ml solution for injection pre-filled syringes Cosentyx 150mg/1ml solution for injection pre-filled pens Cosentyx 300mg/2ml solution for injection pre-filled pens	Dose according to product literature
OR	**Ustekinumab** SUO	Stelara 45mg/0.5ml solution for injection pre-filled syringes Stelara 45mg/0.5ml solution for injection vials Stelara 90mg/1ml solution for injection pre-filled syringes	Dose according to product literature

Prescribing notes	**General notes**
	• Systemic treatments for psoriasis are initiated by specialists and include phototherapy, methotrexate, ciclosporin or acitretin. Alternative systemic treatments for specialist initiation include apremilast and dimethyl fumarate or pSoralen and ultraviolet A light (PUVA). See recommendations for treatment of skin conditions with methoxyPsoralen and UltraViolet A light (PUVA).
	• Biologic therapy should be offered to patients requiring systemic therapy if methotrexate and ciclosporin have failed, are not tolerated or are contraindicated and the psoriasis has a large impact on physical, psychological or social functioning, clinically relevant depressive or anxiety symptoms and one or more of the following disease severity criteria apply:
	  ○ the psoriasis is extensive, defined as BSA > 10% or PASI ≥ 10
	  ○ the psoriasis is severe at localized sites and associated with significant functional impairment and/or high levels of distress (for example nail disease or involvement of high-impact and difficult to treat sites such as the face, scalp, palms, soles, flexures and genitals).
	• See the pathways for biologic treatment of psoriasis and alternative systemic therapies (apremilast and dimethyl fumarate) for more details.
	• Refer to British Association of Dermatologists guidelines for biologic therapy for psoriasis 2020: a rapid update. Br J Dermatol 2020; 183 (4) 6328-637.
	• In NHS Fife refer to NHS Fife High cost drugs pathway for adults with psoriasis.
	
	Restrictions
	• **Adalimumab** is recommended for the treatment of chronic plaque psoriasis in adults which has failed to respond to standard systemic treatments (including ciclosporin and methotrexate) or to PUVA therapy, or when standard treatments cannot be used because of intolerance or contra-indications. Its use should be restricted to severe disease (PASI score > or equal to 10 and a DLQI score of >10). Adalimumab should be withdrawn if the response is not adequate after 16 weeks (PASI 75 response from baseline).
	• **Brobalumab** is recommended for the treatment of moderate to severe plaque psoriasis in adult patients who are candidates for systemic therapy. Use is restricted to patients who have failed to respond to standard systemic therapies (including ciclosporin, methotrexate and phototherapy), are intolerant to, or have a contra-indication to these treatments.
	• **Certolizumab** is recommended for patients with moderate to severe psoriasis who have failed to respond to standard systemic therapies (including ciclosporin, methotrexate and phototherapy), are intolerant to, or have contraindications to these treatments.
	• **Etanercept**, within its licensed indications is recommended for the treatment of adults with plaque psoriasis only when the following criteria are met. The disease is severe as defined by a total Psoriasis Area Severity Index (PASI) of 10 or more and a Dermatology Life Quality Index (DLQI) of more than 10; the psoriasis has failed to respond to standard systemic therapies including ciclosporin, methotrexate and PUVA (psoralen and long-wave ultraviolet radiation); or the person is intolerant to, or has a contraindication to, these treatments.
	• **Guselkumab** is recommended for the treatment of moderate to severe plaque psoriasis in adults who are candidates for systemic therapy. It is for patients who have failed to respond to conventional systemic therapies (including methotrexate, ciclosporin and phototherapy), are intolerant to, or have a contraindication to these treatments.

	• **Infliximab** is recommended for the treatment of severe plaque psoriasis in adults which has failed to respond to standard systemic treatments (including ciclosporin and methotrexate) or to PUVA therapy, or when standard treatments cannot be used because of intolerance or contraindications. Infliximab should be withdrawn if the response is not adequate after 10 weeks (PASI 75 response from baseline or a 50% reduction and a 5 point reduction in DLQI from baseline). • **Ixekizumab** is recommended for the treatment of moderate to severe plaque psoriasis in adult patients who are candidates for systemic therapy. Use is restricted to patients who have failed to respond to standard systemic therapies (including ciclosporin, methotrexate and phototherapy), are intolerant to, or have a contra-indication to these treatments. • **Risankizumab** is recommended for the treatment of moderate to severe plaque psoriasis in adult patients who are candidates for systemic therapy. Use is restricted to patients who have failed to respond to standard systemic therapies (including ciclosporin, methotrexate and phototherapy), are intolerant to, or have a contra-indication to these treatments. • **Secukinumab** is recommended for the treatment of moderate to severe plaque psoriasis in adult patients who are candidates for systemic therapy. Use is restricted to patients who have failed to respond to standard systemic therapies (including ciclosporin, methotrexate and phototherapy), are intolerant to, or have a contra-indication to these treatments. • **Ustekinumab** is recommended for the treatment of moderate to severe plaque psoriasis in adult patients who are candidates for systemic therapy. Use is restricted to patients who have failed to respond to standard systemic therapies (including ciclosporin, methotrexate and phototherapy), are intolerant to, or have a contra-indication to these treatments. Continued treatment should be restricted to patients who achieve a PASI 75 response within 16 weeks.

Pathway 7 Biologic treatment of chronic plaque psoriasis with inflammatory bowel disease

/1

See prescribing notes for restrictions related to the use of these medicines. Adalimumab is the first choice therapy on account of the overall administration and acquisition cost. Other biologic therapies are listed in alphabetical order. Where more than one treatment is suitable select the most cost-effective choice taking into account administration and acquisition costs.

Adalimumab SUO	Amgevita 20mg/0.4ml solution for injection pre-filled syringes Amgevita 40mg/0.8ml solution for injection pre-filled syringes Amgevita 40mg/0.8ml solution for injection pre-filled pens	Dose according to product literature

/2

Certolizumab is first line biologic in women of childbearing age who have not yet completed their family as it is safe to use in pregnancy and breastfeeding.

	Certolizumab pegol SUO	Cimzia 200mg/1ml solution for injection pre-filled syringes Cimzia 200mg/1ml solution for injection pre-filled pens	Dose according to product literature
OR	**Etanercept** SUO	Benepali 25mg/0.5ml solution for injection pre-filled syringes Benepali 50mg/1ml solution for injection pre-filled syringes Benepali 50mg/1ml solution for injection pre-filled pens	Dose according to product literature
OR	**Guselkumab** SUO	Tremfya 100mg/1ml solution for injection pre-filled pens	Dose according to product literature
OR	**Infliximab** SUO	Remsima 100mg powder for concentrate for solution for infusion vials	Dose according to product literature

		Remsima 120mg/1ml solution for injection pre-filled pens Remsima 120mg/1ml solution for injection pre-filled syringes	
OR	**Risankizumab** SUO	Skyrizi 75mg/0.83ml solution for injection pre-filled syringes Skyrizi 150mg/1ml solution for injection pre-filled syringes Skyrizi 150mg/1ml solution for injection pre-filled pens	Dose according to product literature
OR	**Ustekinumab** SUO	Stelara 45mg/0.5ml solution for injection pre-filled syringes Stelara 45mg/0.5ml solution for injection vials Stelara 90mg/1ml solution for injection pre-filled syringes	Dose according to product literature

Prescribing notes	**General notes**
	• Systemic treatments for psoriasis are initiated by specialists and include phototherapy, methotrexate, ciclosporin or acitretin. Alternative systemic treatments for specialist initiation include apremilast and dimethyl fumarate or pSoralen and ultraviolet A light (PUVA). See recommendations for treatment of skin conditions with methoxyPsoralen and UltraViolet A light (PUVA).
	• Biologic therapy should be offered to patients requiring systemic therapy if methotrexate and ciclosporin have failed, are not tolerated or are contraindicated and the psoriasis has a large impact on physical, psychological or social functioning, clinically relevant depressive or anxiety symptoms and one or more of the following disease severity criteria apply:
	  ○ the psoriasis is extensive, defined as BSA > 10% or PASI ≥ 10
	  ○ the psoriasis is severe at localized sites and associated with significant functional impairment and/or high levels of distress (for example nail disease or involvement of high-impact and difficult to treat sites such as the face, scalp, palms, soles, flexures and genitals).
	• See the pathways for biologic treatment of psoriasis and alternative systemic therapies (apremilast and dimethyl fumarate) for more details.
	• Refer to British Association of Dermatologists guidelines for biologic therapy for psoriasis 2020: a rapid update. Br J Dermatol 2020; 183 (4) 6328-637.
	• In NHS Fife refer to NHS Fife High cost drugs pathway for adults with psoriasis.

Restrictions

- **Adalimumab** is recommended for the treatment of chronic plaque psoriasis in adults which has failed to respond to standard systemic treatments (including ciclosporin and methotrexate) or to PUVA therapy, or when standard treatments cannot be used because of intolerance or contra-indications. Its use should be restricted to severe disease (PASI score > or equal to 10 and a DLQI score of >10). Adalimumab should be withdrawn if the response is not adequate after 16 weeks (PASI 75 response from baseline).
- **Certolizumab** is recommended for patients with moderate to severe psoriasis who have failed to respond to standard systemic therapies (including ciclosporin, methotrexate and phototherapy), are intolerant to, or have contraindications to these treatments.
- **Etanercept**, within its licensed indications is recommended for the treatment of adults with plaque psoriasis only when the following criteria are met. The disease is severe as defined by a total Psoriasis Area Severity Index (PASI) of 10 or more and a Dermatology Life Quality Index (DLQI) of more than 10; the psoriasis has failed to respond to standard systemic therapies including ciclosporin, methotrexate and PUVA (psoralen and long-wave ultraviolet radiation); or the person is intolerant to, or has a contraindication to, these treatments.
- **Guselkumab** is recommended for the treatment of moderate to severe plaque psoriasis in adults who are candidates for systemic therapy. It is for patients who have failed to respond to conventional systemic therapies (including methotrexate, ciclosporin and phototherapy), are intolerant to, or have a contraindication to these treatments.
- **Infliximab** is recommended for the treatment of severe plaque psoriasis in adults which has failed to respond to standard systemic treatments (including ciclosporin and methotrexate) or to PUVA therapy, or when standard treatments cannot be used because of intolerance or contraindications. Infliximab should be withdrawn if the response is not adequate after 10 weeks (PASI 75 response from baseline or a 50% reduction and a 5 point reduction in DLQI from baseline).
- **Risankizumab** is recommended for the treatment of moderate to severe plaque psoriasis in adult patients who are candidates for systemic therapy. Use is restricted to patients who have failed to respond to standard systemic therapies (including ciclosporin, methotrexate and phototherapy), are intolerant to, or have a contra-indication to these treatments.
- **Ustekinumab** is recommended for the treatment of moderate to severe plaque psoriasis in adult patients who are candidates for systemic therapy. Use is restricted to patients who have failed to respond to standard systemic therapies (including ciclosporin, methotrexate and phototherapy), are intolerant to, or have a contra-indication to these treatments. Continued treatment should be restricted to patients who achieve a PASI 75 response within 16 weeks.

Pathway 8 Biologic treatment of chronic plaque psoriasis in pregnancy

/1

See prescribing notes for restrictions related to the use of certolizumab.

Certolizumab pegol SUO	Cimzia 200mg/1ml solution for injection pre-filled syringes Cimzia 200mg/1ml solution for injection pre-filled pens	Dose according to product literature

Prescribing notes

General notes

- Refer to British Association of Dermatologists guidelines for biologic therapy for psoriasis 2020: a rapid update. Br J Dermatol 2020; 183 (4) 6328-637.
- In NHS Fife refer to NHS Fife High cost drugs pathway for adults with psoriasis.
- Certolizumab is recommended for patients with moderate to severe psoriasis who have failed to respond to standard systemic therapies (including ciclosporin, methotrexate and phototherapy), are intolerant to, or have contraindications to these treatments.
- Certolizumab is first line biologic in women of childbearing age who have not yet completed their family as it is safe to use in pregnancy and breastfeeding.

Restrictions

- **Certolizumab** is recommended for patients with moderate to severe psoriasis who have failed to respond to standard systemic therapies (including ciclosporin, methotrexate and phototherapy), are intolerant to, or have contraindications to these treatments.

Pathway 9 Alternative systemic treatment of chronic plaque psoriasis

/1

See prescribing notes for restrictions related to the use of these medicines.

Apremilast SI	Otelza 10mg tablets Otelza 20mg tablets Otelza 30mg tablets	Dose according to product literature

/2

Dimethyl fumarate SUO	Skilarence 30mg gastro-resistant tablets Skilarence 120mg gastro-resistant tablets	Dose according to product literature

Prescribing notes

- In NHS Fife refer to NHS Fife High cost drugs pathway for adults with psoriasis.

Apremilast

- Apremilast is approved for use for the treatment of moderate to severe chronic plaque psoriasis in adult patients who have failed to respond to or who have a contraindication to, or are intolerant to other systemic therapy including ciclosporin, methotrexate or pSoralen and ultraviolet A light (PUVA).
- Where more than one treatment is suitable for an individual (including options from the biologic therapies) select the most cost-effective choice taking into account administration costs and medicine acquisition costs.
- Apremilast may be considered as a suitable treatment option prior to biologic therapy in those patients whom adherence to blood monitoring is considered to be a concern, those patients who would prefer a tablet over injection and as a treatment when other drugs are contraindicated.
- Apremilast can be considered as an alternative for patients with either psoriasis alone or psoriasis in combination with psoriatic arthtitis.
- Refer to MHRA Drug Safety Update February 2017: Apremilast (Otezla): Risk of suicidal thoughts and behaviour.

Dimethyl fumarate

- Dimethyl Fumarate (Skilarence) is accepted for the treatment of moderate to severe plaque psoriasis in adults in need of systemic medicinal therapy. It is restricted for use in patients in whom other non-biologic systemic treatments (methotrexate, ciclosporin and acitretin) are not appropriate or have failed and who are considered unsuitable for biologic therapy given their current disease state or personal preference.
- See MHRA Drug Safety Update January 2021: Dimethyl fumarate (Tecfidera): updated advice on the risk of progressive multifocal leukoencephalopathy (PML) associated with mild lymphopenia.

Group	Skin conditions
Condition	Rosacea

Guidance links	NHS Scotland Dermatology Patient Pathways

Pathway 1	Topical treatment

/1

Metronidazole	Metronidazole 0.75% cream Metronidazole 0.75% gel	Apply twice daily for 2-3 months
OR		
Azelaic acid	Azelaic acid 15% gel	Apply twice daily, discontinue if no improvement after 1 month

/2

For moderate to severe persistent facial erythema associated with rosacea. Patients should be reviewed after 1 month to determine benefits of ongoing treatment.

Brimonidine	Brimonidine 3mg/g gel	Apply once daily until erythema subsides, apply thinly, divide dose over forehead, chin, nose, and cheeks, max. 1g of gel per day.

OR

For the treatment of moderate to severe inflammatory lesions of rosacea. Discontinue if no improvement after 3 months.

Ivermectin	Ivermectin 10mg/g cream	One application a day for up to 4 months.

Prescribing notes	• Rosacea has four clinical variants (erythematotelangectasic, papulopustular, rynophymatous and ocular) and treatment should be targetted • Papulopustular Disease can be treated with a topical / oral agent or both. • There is no effective treatment for redness of the skin due to rosacea; camouflage creams may be required (see cosmetic camouflage section).

	• Mild rosacea is best treated with a topical agent. Topical agents should be used for 2-3 months then intermittently as required. • Azelaic acid gel is more cosmetically acceptable to patients, as moisturisers and make up can be applied on top of it. • Azelaic acid has antimicrobial and anticomedonal properties. • The pustules and papules of rosacea respond to topical metronidazole or to topical azelaic acid. • To avoid exacerbation or rebound symptoms of rosacea brimonidine gel should be initiated with a small amount of gel (less than the maximum dose) for at least 1 week and the dose then gradually increased based on tolerability and response to treatment. Patients should be advised to stop treatment and consult a doctor if their symptoms worsen during treatment (increased redness or burning).

Pathway 2	Systemic treatment

/1

	Lymecycline	Lymecycline 408mg capsules (UI)	408mg daily for 2-3 months
OR	**Doxycycline**	Doxycycline 100mg capsules (UI)	100mg once daily for 2-3 months

OR

Erythromycin is a less cost effective choice than lymecycline or doxycycline but is licensed for rosacea

Erythromycin	Erythromycin stearate 500mg tablets Erythromycin ethyl succinate 500mg tablets Erythromycin ethyl succinate 250mg/5ml oral suspension sugar free	500mg twice daily for 2–3 months

Prescribing notes	• There is no effective treatment for redness of the skin due to rosacea; camouflage creams may be required (see cosmetic camouflage recommendations). Brimonidine 0.33% gel (Mirvaso) applied once daily may be used in patients with moderate to severe persistant facial erythema associated with rosecea for as long as facial erythema is present. • Pustular rosacea is best treated with systemic antibiotics. If no improvement after 3 months, the patient should be switched to an alternative antibiotic.

Group	Skin conditions
Condition	Seborrhoeic dermatitis

Guidance links	NHS Scotland Dermatology Patient Pathways

Pathway 1	Scalp treatments for seborrhoeic dermatitis

/1	**Capasal**	Capasal Therapeutic shampoo	Apply according to product information
OR	**Sebco**	Sebco ointment	Apply according to product information
OR	**Coal tar**	Coal tar extract 2% shampoo	Scalp disorders, including psoriasis, seborrhoea, eczema, pruritus and dandruff, apply 1-2 times weekly
OR	**Ketoconazole**	Ketoconazole 2% shampoo	For treatment of seborrhoeic dermatitis and dandruff apply twice weekly for 2-4 weeks.

/2	**Benzalkonium**	Dermax Therapeutic 0.5% shampoo	Apply as required.

Prescribing notes	
	• Treatment depends on the severity of the condition. Shampoo formulations are preferred for moderate scaly scalp conditions whereas more severe conditions may require an ointment. • Ketoconazole shampoo is often helpful for seborrhoeic dermatitis of the scalp. • Use emollients for dry flaky skin. See Dermatitis – contact treatment with emollients pathways for choices. • Mild potency steroid, topical antifungal, or a combination product with both may be used for mild disease affecting the face. For choices see Eczema 'Treatment with mild topical corticosteroids' and 'Treatment with topical corticosteroids combined with antimicrobials' pathways. • Refer to NHS Scotland Dermatology Patient Pathways – seborrheic dermatitis for more information and management of disease in other sites, moderate disease and severe or resistant cases.

Group	Skin conditions
Condition	Skin cleansing

Pathway 1	Topical cleansers

/1

Tap water

Prescribing notes	• For recommended soap substitutes for skin cleansing in contact dermatitis and eczema, see the 'Treatment with soap substitutes and emollients for showering and bathing' pathway in the Dermatitis - contact and Eczema sections.

Pathway 2	Topical disinfectants

/1

	Chlorhexidine	Chlorhexidine gluconate 0.05% solution Chlorhexidine gluconate 0.5% solution Chlorhexidine gluconate 1% solution Chlorhexidine gluconate 2% solution Chlorhexidine gluconate 4% solution Chlorhexidine gluconate 20% solution	Consult product literature
OR	**Povidone-Iodine**	Videne 10% antiseptic solution	Consult product literature
OR	**Chlorhexidine + isopropyl alcohol** SUO	ChloraPrep solution (various) ChloraPrep with Tint solution (various)	Consult product literature

Prescribing notes	• Povidone-iodine may produce systemic adverse effects, such as metabolic acidosis, hypernatraemia and renal impairment, if applied to large wounds or severe burns.

Group	Skin conditions
Condition	Sunscreening

Pathway 1	Prescribable sunscreens for ACBS conditions

/1

Prescriptions should be endorsed “ACBS”

Uvistat	Uvistat sun cream SPF 30 Uvistat sun cream SPF 50	Apply as required
	Uvistat lipscreen SPF 50	Apply as required

OR

Prescriptions should be endorsed “ACBS”

Sunsense	Sunsense ultra lotion SPF 50+	Apply as required

Prescribing notes	• The choice of sunscreen depends on individual patient need, tolerance and evidence of sensitivity to excipients. • The Advisory Committee on Borderline Substances (ACBS) criteria for its listed sunscreens are “When prescribed for skin protection against ultraviolet radiation and/or visible light in abnormal cutaneous photosensitivity causing severe cutaneous reactions in genetic disorders (including xeroderma pigmentosum and porphyrias), severe photodermatoses (both idiopathic and acquired) and in those with increased risk of ultraviolet radiation causing severe adverse effects due to chronic disease (such as haematological malignancies), medical therapies and/orprocedures. • Prescriptions should be endorsed “ACBS”. • For optimum photoprotection, sunscreen preparations should be applied thickly.

Group	Skin conditions
Condition	Superficial basal cell carcinoma

Guidance links	NHS Scotland Dermatology Patient Pathways

Pathway 1	Treatment of superficial basal cell carcinoma

/1

Imiquimod SI	Aldara 5% cream 250mg sachets	Apply cream for 6 weeks, 5 times per week (example: Monday to Friday) prior to normal sleeping hours, and leave on the skin for approximately 8 hours.
Fluorouracil SI	Efudix 5% cream	See BNF for dose.

Prescribing notes	• For more information, see NHS Scotland Dermatology Patient Pathways for non-melanoma skin cancers. • Imiquimod cream 5% may be prescribed by dermatologists for the topical treatment of small superficial basal cell carcinoma in adults in whom standard treatment with surgery or cryotherapy is contraindicated.

Group	Skin conditions
Condition	Urticaria

Opening text	Recommendations for allergic emergencies are contained in the Respiratory chapter of the formulary.
Guidance links	NHS Scotland Dermatology Patient Pathways EAACI/GA2LEN/EDF/WAO Urticaria guideline BSACI: Chronic Urticaria and angioedema BAD: Urticaria in adults and children

Pathway 1	Oral treatment of chronic urticaria

/1		**Cetirizine**	Cetirizine 10mg tablets Cetirizine 1mg/ml oral solution sugar free	10mg daily
	OR	**Loratadine**	Loratadine 10mg tablets Loratadine 5mg/5ml oral solution sugar free	10mg daily
/2		**Fexofenadine**	Fexofenadine 180mg tablets	180mg daily

Prescribing notes	• See NICE CKS: guidance on Managing Urticaria. • Recommendations for allergic rhinitis, nasal allergies and vasomotor rhinitis are contained in the Ear, nose and oropharynx chapter of the formulary. • Antihistamines should be taken for at least two weeks for the full effect to be seen. Change to an alternative antihistamine after 4-6 weeks if symptoms have not improved. • Night time dosing may be effective for patients whose sleep is disturbed by itching. • Chlorphenamine may be added at night if sleep is disturbed by itching. • Cimetidine or ranitidine may also be added for resistant cases. • Topical treatments may be helpful see section on pruritis for more information. • Fexofenadine 180mg may be used when cetirizine and/or loratadine have been ineffective or where sedation is a problem.

	• Antihistamines should be taken regularly for best control. However, if urticarial flares occur at specific times, then they may instead be taken 1 hour before the anticipated exacerbation. • Chlorphenamine may be given by slow intravenous injection for emergency treatment of severe angioedema. For more information, see prescribing notes on allergic emergencies in the Respiratory chapter of the formulary for more information. • Antihistamines (including non-sedative antihistamines) can cause day time somnolence, and patients should be aware of this potential side-effect, particularly in relation to driving or operating machinery • Refer to local RefHelp guidance for more information on the management of urticaria and when to refer. **Up dosing of oral antihistamines (if licensed dose is ineffective)** • Provided there are no contra-indications, local specialists recommend a trial of gradual dose increase up to a maximum of four times the licensed daily dose of either cetirizine, fexofenadine, desloratadine or levocetirizine. • Recommended step wise increments - begin with the standard licensed once daily dose. Then increase stepwise if tolerated until symptoms improve - twice daily, three times a day, then up to a maximum of four times daily. • Refer to the links at the start of the section for supporting information for the off-label dosing. • Advise the patient regarding the unlicensed dose regime and document in the notes that the discussion has taken place.

Pathway 2	Treatment of chronic spontaneous urticaria

/1

As add-on therapy for the treatment of chronic spontaneous urticaria in adult and adolescent (12 years and above) patients with inadequate response to H1 antihistamine treatment.

Omalizumab SUO	Xolair 75mg/0.5ml solution for injection pre-filled syringes Xolair 150mg/1ml solution for injection pre-filled syringes	Dose according to product literature

Prescribing notes	• SMC have advised that omalizumab (Xolair) is accepted for restricted use within NHS Scotland as add-on therapy for the treatment of chronic spontaneous urticaria in adult and adolescent (12 years and above) patients with inadequate response to H1 antihistamine treatment.

Group	Skin conditions
Condition	Warts

Guidance links	NHS Scotland Dermatology Patient Pathways

Pathway 1	Treatment of cutaneous and plantar warts

/1	**Salicylic acid + Lactic acid**	Salactol paint	Apply daily, treatment may need to be continued for up to 3 months
/2	**Salicylic acid**	Occlusal 26% solution	Apply daily, treatment may need to be continued for up to 3 months
		Verrugon complete 50% ointment	Apply daily, treatment may need to be continued for up to 3 months
OR	**Glutaraldehyde**	Glutaraldehyde 10% solution	Apply twice daily

Prescribing notes	

- These preparations are suitable for all cutaneous warts exceptfacial andgenital warts.
- The wart surface should be rubbed with a file or pumice stone, and the surrounding skin protected, before each application. If application becomes painful, treatment should be withheld for a few days then recommenced.
- Wart removing preparations are keratolytic. They can cause irritation and application to normal or broken skin should be avoided. Surrounding skin to the wart can be protected by applying soft paraffin.
- Treatment should be continued for at least 3 months and then reviewed.
- In exceptional circumstances dermatology specialists may recommend formaldehyde 4% solution for plantar warts. For more information see the Primary Care Dermatology Society guidance on warts.
- Warts may regress on their own and treatment is required only if the warts are painful, unsightly, persistent, or cause distress.

Group	Specialist dermatology management
Condition	Cutaneous T-cell lymphoma

Pathway 1	Treatment of skin manifestations of cutaneous T-cell lymphoma (commonly mycosis fungiodes)

/1

Treatment of mycosis fungoides-type T-cell lymphoma (see prescribing notes)

Chlormethine SUO	Ledaga 160 micrograms/g gel	Refer to product literature

/2

Second line treatment for patients with advanced (stages IIb or III) cutaneous T-cell lymphoma (see prescribing notes)

Bexarotene SUO	Targretin 75mg capsules	Refer to product literature

Prescribing notes	• The position of specialist treatment in this specialist dermatology pathway is not intended to guide on place in therapy. The place in therapy is directed by a dermatology specialist prescriber experienced in the management of the condition, use is in line with relevant local or national guidance. • Refer to specialist guidelines for the management of Mycosis fungoides-type T-cell lymphoma. • The patient information leaflet on Mycosis fungoides-type T-cell lymphoma from the British Association of Dermatologists provides an overview of available treatment options. • Most patients are managed with 'skin directed therapy (SDT)' there are a number of options used by specialists including steroid creams and phototherapy. • Ledaga is approved for use in line with national guidance for the Topical treatment of mycosis fungoides-type cutaneous T-cell lymphoma (MF-type CTCL) in adult patients. • SMC recommendation - bexarotene (Targretin) is recommended for use in Scotland as a second line treatment for patients with advanced (stages IIb or III) cutaneous T-cell lymphoma. Bexarotene treatment should normally be initiated and supervised by haematologists, dermatologists or oncologists and used for patients who have proved refractory both to local skin directed therapy and to at least one systemic treatment.

Group	Specialist dermatology management
Condition	Hidradenitis suppurativa

Pathway 1	Treatment of Hidradenitis suppurativa

/1

	Adalimumab SUO	Amgevita 20mg/0.4ml solution for injection pre-filled syringes Amgevita 40mg/0.8ml solution for injection pre-filled syringes Amgevita 40mg/0.8ml solution for injection pre-filled pens	Refer to product literature

Prescribing notes	• The position of specialist treatment in this specialist dermatology pathway is not intended to guide on place in therapy. The place in therapy is directed by a dermatology specialist prescriber experienced in the management of the condition, use is in line with relevant local or national guidance. • Refer to specialist guidelines for the management of hidradenitis suppuritiva. The patient information leaflet on hidradenitis suppuritiva from the British Association of Dermatologists provides an overview of available treatment options. • Treatment is tailored to the individual, there are a number of management strategies to choose from. Among the possible treatment options are antibacterial skin lotions such as clindamycin topical lotion (off-label). • Adalimumab is indicated for the treatment of active moderate to severe hidradenitis suppuritiva (HS) (acne inversa) in adult patients with an inadequate response to conventional systemic HS therapy.

Group	Specialist dermatology management
Condition	Photochemotherapy with psoralens and ultraviolet A (PUVA)

Pathway 1	Treatment of skin conditions with PUVA

/1

Methoxsalen is also known as Methoxypsoralen-8 or psoralen

Methoxsalen SUO	Methoxsalen 10mg tablets UM	Refer to hospital guidelines

/2

Methoxsalen SUO	Methoxsalen 0.005% gel UM	Refer to hospital guidelines

Prescribing notes	• The position of specialist treatment in this specialist dermatology pathway is not intended to guide on place in therapy. The place in therapy is directed by a dermatology specialist prescriber experienced in the management of the condition, use is in line with relevant local or national guidance. • Methoxypsoralen (methoxsalen) and UltraViolet A light (PUVA) is used for a number of different skin conditions. • Refer to specialist guidelines for phototherapy treatment. • For more information, refer to the patient information leaflets from the British Association of Dermatologists: Oral phototherapy, Topical phototherapy. • Methoxsalen in conjunction with ultraviolet A light (PUVA) phototherapy is to be used for psoriasis when topical therapies and conventional phototherapy have proven insufficient and before consideration of systemic treatment/immunosuppressant therapy. • Oral methoxsalen to be used preferentially if suitable/indicated. • Methoxsalen gel is to be used when oral systemic equivalents are not indicated.