Emollient Guidelines and Formulary in Primary Care

This document is intended to guide cost effective and preferred emollient choice when initiating or changing emollient therapy for prescribers in primary care. The guidance has been produced in collaboration with Secondary care.

Contents

Date approved: Waltham Forest and East London Medicines Optimisation and Commissioning Committee (WEL MOCC), November 2019
NHS Newham CCG, NHS Tower Hamlets CCG and NHS Waltham Forest CCG
Date of review: November 2021

Emollient Guidelines and Formulary

COST EFFECTIVE FORMULARY PRODUCT CHOICE

NHS England OTC guidance: For conditions such as mild dry skin, and mild irritant dermatitis, patients should be encouraged to purchase over the counter[1].

When prescribing emollients please ensure that, the indication is a documented dermatological condition. Please document the indication in the patient's records and review patients annually to ensure appropriateness of treatment.

The Zeroderma® and AproDerm® range of emollients arecost effective products. Please use the table below as a guide to selecting the most cost effective emollient for your patient.

LEAVE-ON EMOLLIENTS

HEAVY EMOLLIENTS → **LIGHT EMOLLIENTS**

Greasy	Rich cream/ointment	Opaque Gel	Light or creamy
First Line: Cost Effective Choices (All cost <£5/500g. Each column is listed in ascending order of cost (Drug Tariff August 2019))			
• White Soft Paraffin (WSP) • Liquid and white soft paraffin 50:50 Ointment • Emulsifying Ointment	• AproDerm® Ointment • AproDerm® Cream • Zeroderm® Ointment • Hydrous Ointment®	• AproDerm® Gel • Zerodouble® Emollient gel	• Epi-max® • Zero AQS® Emollient Cream • Aquamax® cream • Zerocream® Emollient Cream contains PARABENS
Second Line: to be used when first line not suitable / tolerated (More expensive than first line options. All cost approx. >£5/500g)			
• Hydromol Ointment®	• Cetraben® Cream & Ointment • Diprobase® Ointment • Diprobase® Cream	• Doublebase® Emollient gel	• AproDerm® Colloidal Oat Cream • Zerobase® Emollient Cream • Zeroveen® Emollient Cream • QV cream® contains PARABENS

Date approved: Waltham Forest and East London Medicines Optimisation and Commissioning Committee (WEL MOCC), November 2019
NHS Newham CCG, NHS Tower Hamlets CCG and NHS Waltham Forest CCG
Date of review: November 2021

COST EFFECTIVE OPTIONS

When initiating treatment, cost should be taken into consideration alongside patient choice when selecting a product or changing products.

Cost Effective Zeroderma® and AproDerm® range FORMULARY PRODUCTS	Branded Emollient equivalent to Zeroderma® and AproDerm® range
Zeroveen® Cream or AproDerm® Colloidal Oat Cream	Aveeno® Cream (non-formulary)
Zeroveen® Cream or AproDerm® Colloidal Oat Cream	Aveeno® Lotion (non-formulary)
AproDerm® Ointment	Cetraben® Ointment/ Epaderm® ointment (non-formulary) Diprobase® ointment/Hydromol® ointment
AproDerm Emollient Cream	Epaderm® cream (non-formulary) /Cetraben® cream/ Diprobase® cream/E45 cream (non-formulary)
Zero AQS® Cream	Aqueous Cream (soap substitute only)
Zerobase® Cream or AproDerm® Emollient Cream	Diprobase® Cream
Zeroderm® ointment	Epaderm® ointment (non-formulary)
Zerodouble® gel or AproDerm® Gel	Doublebase® Gel
AproDerm® Gel	MyriBase® gel
Zerocream® Emollient Cream	E45® Cream (non-formulary)
Zeroderm® Ointment	Epaderm® Ointment (non-formulary)
Zerolatum® Bath	Oilatum® Junior Bath

Date approved: Waltham Forest and East London Medicines Optimisation and Commissioning Committee (WEL MOCC), November 2019
NHS Newham CCG, NHS Tower Hamlets CCG and NHS Waltham Forest CCG
Date of review: November 2021

FORMULARY CHOICE

	FORMULARY FIRST LINE	NON-FORMULARY
SOAP SUBSTITUTE Soap, liquid cleansers and perfumed products should be avoided as are very drying. Emollient soap substitutes do not foam but are just as effective at cleaning the skin as soap. Soap substitutes can either be applied before bathing, showering or washing, or while in the water[2]	• **Zero AQS® cream** • **Aquamax® cream** • **Emulsifying ointment** • **Epi-max® Cream**	**Aqueous Cream** (Please note: Formulary for Barts Health for use as soap substitute where SLS content is not an issue. Patients can be offered cost effective alternatives in primary care subject to choice)
BATH EMOLLIENTS **Not to be prescribed for mild dry skin conditions in children or adults** **As per NHSE consultation recommendations prescribers in primary care should not initiate bath and shower preparations for any new patient. However where clinically advised by specialist and appropriate, prescribing may continue**. **The WEL Bath Emollients Position statement is available on the Prescribing Intranet Page here.** Sufficient time (10-20 minutes) must be spent in the bath to allow the emollient to be absorbed onto the skin[2] Bubble baths are extremely drying and potentially irritating to skin[2] A daily bath removes dirt and skin debris, which could cause infection	**Use emollient products as bath emollients** Any emollient (except Liquid and white soft paraffin 50:50 ointment) can be dissolved in some hot water and added to the bath water as a bath additive[3] Cream emollient as a soap substitute in the bath can also be used. Patients should use a non-slip matt. Emollient bath products are non-formulary unless indicated in exceptional clinical cases (Patients under the care of Specialist): • **Zerolatum® Emollient Bath Additive** (The same 60% w/w liquid paraffin base as Oilatum Junior) • **Zeroneum® Bath Additive** (Similar to Balneum Bath oil contains perfume and soya bean oil) • **Dermalo® Bath Emollient** (**All age groups** can use Dermalo® Bath Emollient, including babies)	**Emollient bath products are non-formulary unless indicated in exceptional clinical cases (Patients under the care of Specialist)**
ANTIMICROBIAL CONTAINING EMOLLIENTS Use should be targeted and short term Avoid adding to repeat prescription	**Dermol® 500 Lotion** **Use for short periods of time only when clinically indicated and review regularly** Revert to non-antimicrobial containing emollient once condition is controlled.	

Date approved: Waltham Forest and East London Medicines Optimisation and Commissioning Committee (WEL MOCC), November 2019
NHS Newham CCG, NHS Tower Hamlets CCG and NHS Waltham Forest CCG
Date of review: November 2021

UREA CONTAINING EMOLLIENTS	**First line**
Avoid use for moisturising skin. May soothe itching but does not prevent skin from drying. Urea is a keratin softener and hydrating agent used in the treatment of dry, scaling conditions (including ichthyosis). Target use to specific groups, e.g. those with scaling skin, or those who have tried other emollients without success	• **ImuDERM® emollient** - Urea 5% • **Balneum® cream or Balneum® Plus cream** - Urea 5% • **Hydromol Intensive® Cream** - Urea 10% • **Nutraplus® cream** - Urea 10% • **Aquadrate® cream** - Urea 10% **Second Line** • Calmurid® cream- used by paediatric hospital dermatologists for ichthyosis. **Not to be used in eczema** • Dermatonics® Once Heel Balm

Non-formulary products: not to be prescribed	**The following bath emollients are non-formulary (unless indicated in exceptional clinical cases-Patients under the care of Specialist)**
• **Aqueous cream (non-formulary in primary care)** • **Aveeno® preparations** • **E45® preparations** • **Epaderm® preparations** • **Shower gels e.g. Dermol ® 200 shower gel** • **Flexitol® heel balm**	• Zeroneum® Bath oil • Dermalo® Bath Emollient • Balneum® Plus Bath oil • Hydromol® bath and Shower Emollient • Zerolatum® Emollient Bath additive • Dermol® 600 bath emollient wash

Please refer to Appendix 1 page 13 for list of formulary products and main ingredients. For information on full list of ingredients and excipients, refer to https://www.medicines.org.uk/emc/

Date approved: Waltham Forest and East London Medicines Optimisation and Commissioning Committee (WEL MOCC), November 2019
NHS Newham CCG, NHS Tower Hamlets CCG and NHS Waltham Forest CCG
Date of review: November 2021

PRESCRIBING GUIDE
CHOOSING THE BEST EMOLLIENT FOR YOUR PATIENT

This is a document to help support prescribing and should not over-ride clinical judgement.

INFORMATION

Choosing an emollient depends upon balancing the hydrating strength of very greasy emollients against the tolerability of watery emollients. Note that the very watery emollients are generally reserved as soap substitutes. Patient choice, education and managing patient expectations are important. Please consider the following:

PARABENS

- Some patients can be sensitive to parabens and therefore, should be avoided e.g. **Zerocream®, QV® cream, E45®** *(non-formulary)*
- People can be allergic to, or react to, a variety of irritants any of which may cause contact dermatitis, but there are many known ingredients that are not recommended for sensitive skin such as sodium lauryl sulphate, wool fat, lanolin and perfumes [2,6]
- Always ensure patients presenting with dry skin conditions are aware of this fact and advise accordingly.
- Product selection is based on:

  a. **Severity and affected skin**: understanding severity will govern product selection.
  b. **Correct hydration potency**: oily based products retain skin moisture and better moisturisers. High water based products are more pleasant to use but not as effective at retaining moisture. Patient's skin type is important. For example 'fairer' skins often do not tolerate oily moisturisers whereas those with pigmented skins need much heavier emollients.
  c. **Patient preference**: patient will not use a product if they think it does not work or not pleasant to apply, contributing to waste. **Compliance is most important factor when prescribing emollients.**

POINTS TO CONSIDER WHEN PRESCRIBING EMOLLIENTS

- There is no evidence from controlled trials to support the use of one emollient over another, therefore selection is based on the known physiological properties of emollients, patient acceptability, dryness of the skin, area of skin involved and lowest acquisition cost[(7)]
- Patient lifestyle and preference - may prefer light moisturiser during day and greasy one at night.
- Previous emollients - may have tried other moisturisers with little benefit.
- Cost - emollients vary greatly in price; therefore use the most cost effective as listed in the Drug Tariff.
- The greasier an emollient is the more effective it is at retaining hydration.

Leave-on emollients should be prescribed in large quantities (250-500g weekly) for severe cases. This encourages improvement in eczema and decreases the amount of topical steroid needed. Refer to BNF section 13.1.2 for suitable quantities for prescribing.[8]

Date approved: Waltham Forest and East London Medicines Optimisation and Commissioning Committee (WEL MOCC), November 2019
NHS Newham CCG, NHS Tower Hamlets CCG and NHS Waltham Forest CCG
Date of review: November 2021

TYPES OF EMOLLIENTS

Emollient is defined as a substance whose main action is to occlude the skin surface and to encourage build-up of water within the stratum corneum.[3]Generally, the greasier an emollient is the more effective it is. All should be applied frequently – at least twice per day.

Lotions

- high water content so easily spread and absorbed
- Needs reapplying frequently on very dry skin
- Good for very mild dry skin and also for the face

Creams

- Less greasy but more effective than mild emollients
- More cosmetically acceptable than oil based moisturisers
- Mixture of water and fat, well absorbed
- Creams and lotions are generally better for red, inflamed areas of skin because it is believed that the evaporation of water-based products cools the skin.

Ointments

- Oily preparation generally greasy and occlusive
- No preservatives less likely to irritate skin than creams or lotions
- Useful for very dry and thickened skin, ideal under wet wraps. Not suitable for weeping eczema
- They do not usually contain preservatives and are therefore less likely to cause skin reactions.

Aqueous cream is no longer considered suitable as a leave-on emollient or soap substitute for diagnosed dermatological conditions due to its tendency to cause irritant reactions[9]

DIRECTIONS FOR ADMINISTRATION

It is essential to provide instructions on the correct use of emollients, with clear demonstrations where appropriate[15, 16.]

Healthcare professionals should provide the following advice to patients and carers:

- Emollients should be applied immediately after washing or bathing to maximise the effect of skin hydration.
- Emollient preparations contained in tubs should be removed with a clean spoon or spatula to reduce bacterial contamination of the emollient.
- Emollients should be applied in the direction of hair growth to reduce the risk of folliculitis.
- The frequency of application will vary depending on the person's condition and circumstances, but for very dry skin, application of an emollient every 2–3 hours should be considered normal.
- To facilitate frequent application, the person should consider keeping separate packs of emollients at work or school
- If a topical corticosteroid is prescribed, emollients should be applied at least 30 minutes before or after the steroid.

  However, there appears to be no real consensus on the optimal order or timing of the application of emollients and topical steroids in conjunction with each other.
- Emollient products should not be shared with other people as they can become contaminated with the bacteria.
  - Pump dispensers minimize the risk of bacterial contamination.

- For emollients that come in pots, using a clean spoon or spatula (rather than fingers) to remove the emollient helps to minimize contamination.

- Patients should avoid the use of soaps, detergents, and bubble bath when washing, as these have an emulsifying effect on the lipids of the skin and can be very damaging to the skin. Instead, a suitable soap substitute should be used, for instance an ointment dissolved in hot water (or lotion in warm water).

Patient information leaflet on emollients: click here

To access the National Eczema society factsheet on Emollients click here

QUANTITIES OF EMOLLIENT PRESCRIBING IN ADULTS

- A trial of cost-effective emollients suitable for the patient should be prescribed in small packs initially for the patient to decide which is the most suitable for them. A larger quantity then can be considered after this point. For emollients, the general rule is 600g per week – for an adult.
- This table suggests suitable quantities to be prescribed for an adult for a minimum of twice-daily application for one week. ***For children approximately half this amount is suitable.***

Area of application	Creams and Ointments (Flare-up)	Creams and Ointments	Lotions (Flare-up)	Lotions
Face	50-100g	15-30g	250ml	100ml
Both hands	100-200g	25-50g	500ml	200ml
Scalp	100-200g	50-100g	500ml	200ml
Both arms or both legs	300-500g	100-200g	500ml	200ml
Trunk	1000g	400g	1000ml	500ml
Groin and genitalia	50-100g	15-25g	250ml	100ml

Note: During a flare-up, patients should aim to apply the emollients every 2 hours where possible. All other times, emollients should be applied at least twice a day but is dependent on the extent of dryness and may require more applications.

OLIVE OIL AND OTHER NATURAL OILS IN NEONATAL SKIN

There is no evidence to support use of natural oils; olive oil has the potential to promote the development of and exacerbate existing, atopic dermatitis as it can significantly damages the skin barrier. A preterm infant's skin has a much thinner protective skin barrier than a term baby. The use of olive oil, which is high in oleic acid, has a damaging effect on the skin's protective barrier[10, 11]

PRESCRIBING IN CHILDREN UNDER 12 YEARS[15, 16]

Based on clinical experience of hospital dermatologists, greasy based emollients are preferable in children – these should be considered after engaging with parents/carers.

Healthcare professionals should use a stepped approach for managing atopic eczema in children. This means tailoring the treatment step to the severity of the atopic eczema.
Healthcare professionals should offer children with atopic eczema a choice of unperfumed emollients to use every day for moisturising, washing and bathing. This should be suited to the child's needs and preferences, and may include a combination of products or one product for all purposes

Emollients should form the basis of atopic eczema management and should always be used, even when the atopic eczema is clear. Management can then be stepped up or down, according to the severity of symptoms.

- Emollients should be easily available to use at nursery, pre-school or school[15]. A greasy emollient for use at home and a lighter cream at nursery, pre-school or school can aid compliance and improvement.
- Where emollients (excluding bath emollients) and other topical products are used at the same time of day to treat atopic eczema in children, the different products should ideally be applied one at a time with several minutes between applications where practical. The preferences of the child and parents or carers should determine which product should be applied first.
- Healthcare professionals should inform children with atopic eczema and their parents or carers that they should use emollients and/or emollient wash products instead of soaps and detergent-based wash products.
- It is good practice to review repeat prescriptions of individual products and combinations of products with children with atopic eczema and their parents or carers at **least once a year** to ensure that therapy remains optimal.

QUANTITIES

When prescribing, consideration to suitable quantities should be based on clinical severity and need of patients:

- Child with severe eczema can use 2 x 500g of emollient per month.
- Leave-on emollients should be prescribed in large quantities (250-500g weekly).This encourages improvement in eczema and decreases the amount of topical steroid needed.
- Ensure adequate quantities for patient are prescribed in primary care, as experience from hospital dermatologist is that families do not use enough emollients. 250g/week is sufficient for total body coverage of a child.

GPs should prescribe up to 1000g/month if patient requests and compliance should be checked

Date approved: Waltham Forest and East London Medicines Optimisation and Commissioning Committee (WEL MOCC), November 2019
NHS Newham CCG, NHS Tower Hamlets CCG and NHS Waltham Forest CCG
Date of review: November 2021

EMOLLIENTS AND FIRE RISK [4, 5]

Emollients are an important and effective treatment for chronic dry skin conditions and people should continue to use these products. There is a fire risk with all paraffin-containing emollients, regardless of paraffin concentration, and it also **cannot be excluded with paraffin-free emollients.** Therefore, it is important to ensure patients and their carers understand the fire risk associated with the build-up of residue on clothing and bedding and can take action to minimise the risk.

- Patients should be counselled on safe application.
- Paraffin-based products such as white soft paraffin or emulsifying ointment can ignite easily by the naked flame. This risk will be greater when these preparations are applied to large areas of the body and when clothing or dressing becomes soaked with ointment[4]

All patients and their families should be warned regarding the following risks:

- The risk of fire should be considered when using large quantities of any paraffin-based emollient (E.g. application of 100g or more at once or over a short period).
- Bedding and clothing should be washed regularly to minimise the build-up of impregnated paraffin.
- Patients should be told to keep away from open or gas fires or hobs and naked flames, including candles etc. and not to smoke when using these paraffin containing preparations.
- Medical oxygen is non-flammable but strongly supports combustion (including some materials that do not normally burn in air). It is highly dangerous in the presence of oils, greases, tarry substances and many plastics due to the risk of spontaneous combustion with high-pressure gases. Therefore, patients on medical oxygen who require an emollient **should not use any paraffin based product**.
- Patients who require large quantities of emollient (100g or more) should use a water based product (e.g. cream or lotion) rather than a paraffin based one (e.g. ointment) to reduce the fire risk.

Click here to access MHRA/CMH advice.

NHS ENGLAND GUIDANCE [1,12]

The guidance for which over the counter items should not be prescribed in primary care; lists 35 minor health conditions for which it is now recommended that OTC medicines should no longer be routinely prescribed[1].

Included in the guidance is the **treatment of acute conditions such as mild dry skin, mild irritant dermatitis, and seborrhoeic dermatitis (Cradle cap-infants)**.

Prescribers are encouraged **not** to prescribe emollients for such conditions unless exceptionalities are met.

The guidance also makes clear that these restrictions do not apply to people with long-term conditions, nor should they be applied to patients who the prescriber considers unable to self-care due to medical, mental health or significant social vulnerability.

NHS England consultation on items that should not routinely be prescribed in primary care, version 2 June 2019[12] has provided guidance on bath and shower preparation as follows:

- **Prescribers in primary care should not initiate bath and shower preparations for any new patient.**
- **Prescribers should de-prescribe bath and shower preparations where appropriate and substitute with "leave-on" emollients.**

SELF-CARE

- Patients with dry skin not related to a dermatological condition should be encouraged to buy an emollient of their choice from retail outlets.
- Self-care messages should be promoted for adults and children with a dermatological conditions:
  i. Increase emollient use when there is an exacerbation of the condition.
  ii. Application of emollient should not be followed by immediate topical steroid use – should allow time interval (12- 20 minutes)
  iii. Adequate hydration is important for skin health
  iv. Triggers should be identified and exposure minimised
  v. Emollients should be applied correctly. Apply liberally and frequently, even when skin condition has improved. It is important to use appropriate amounts to ensure adequate hydration/application[14]

BATH AND SHOWER PREPARATIONS [12]

As per NHSE consultation recommendations prescribers in primary care should **not initiate** bath and shower preparations for any new patient.[12, 14] In such cases prescribers should de-prescribe bath, shower preparations where appropriate, and substitute with "leave-on" emollients.

Please note: Prescribing of Bath preparations should continue in primary care for patients with severe eczema if recommended by a specialist.

(Bath oils are not recommended)

- Avoid bubble baths and soaps, as they can be irritant.
- Use an emollient as a **soap substitute** e.g. ZeroAQS® (all the emollients, except for white soft paraffin alone, can be used in this way)
- Leave-on emollients should be used as soap substitutes for washing as conventional soaps/wash products strip the skin of natural oils and cause shedding of skin cells.
- Encourage to bathe regularly

Functions of the bath routine are to:

- Clean the skin preventing infection by removing scales, crusts, dried blood and dirt from the skin.
- Moisturise the skin and reduce discomfort caused by dry skin
- Hydrate the skin making it more receptive to active topical therapy, e.g. topical corticosteroids

ANTISEPTIC/ANTIMICOBIAL CONTAINING EMOLLIENTS

There is limited evidence to support use of antiseptic/antimicrobial containing emollients[6, 13] and routine use should be avoided. Their use should be restricted to recurrent infection for limited periods only. In selected cases, where recurrent infection is a contributory factor to relapse, they can play an important role in stabilizing the patient's condition.

Formulary first line choice: Dermol® 500 Lotion, which can be used as a bath emollient.

Please note, **do not** prescribe bath additive Dermol® 200 Shower Gel and Dermol® 600 Bath emollient.

Date approved: Waltham Forest and East London Medicines Optimisation and Commissioning Committee (WEL MOCC), November 2019
NHS Newham CCG, NHS Tower Hamlets CCG and NHS Waltham Forest CCG
Date of review: November 2021

UREA CONTAINING EMOLLIENTS[14]

Urea is a keratin softener and hydrating agent used in the treatment of dry, scaling conditions (including ichthyosis). Urea can cause stinging and irritation for some people, and preparations are generally more costly. It is therefore reasonable to target use to specific groups, e.g. those with scaling skin, or those who have tried other emollients without success.

Urea containing emollients should not replace established emollients and be avoided for use in minor dry skin It is important to note emollient products containing urea are not all interchangeable.

These are well suited to the care of large areas of skin – even over long periods – in patients with atopic eczema. It is recommended that such emollients be used once or twice a day as an add-on therapy to their regular emollient regimen as they can cause stinging.

Additional active ingredients in urea containing preparations may include salicylic acid or lactic acid (keratolytic properties), or lauromacrogols (this has a local anaesthetic properties, and soothes and relieves itchy skin). It is important to ensure that product(s) selected are indicated for the intended use.

Formulary first-line choice

- **ImuDERM® Emollient (in the absence of itching)**
- **Balneum® cream or Balneum ® Plus cream**
- **Hydromol Intensive® Cream**
- **Nutraplus® cream**
- **Aquadrate® cream**

MANAGING THE INTERFACE BETWEEN PRIMARY AND SECONDARY CARE

Consultants from Bart's Health have supported the following principles. The hospital and GPs are expected to adhere to the NHS England guidance and make recommendations in line with the NHSE guidance.

- The hospital dermatologist will not routinely prescribe emollients in an outpatient setting, but may make recommendations to GPs to prescribe emollients without specifying the product.
- When a patient is admitted to hospital, their current emollients will be used, unless there are compelling clinical reasons to change them which should be stated in discharge summaries.
- If a hospital dermatologist recommends a non-formulary emollient during an admission, GPs can switch to a formulary emollient unless there are exceptions due to clinical reasons that must be stated. Aqueous cream is more cost effective for hospital use in Barts Health. However, it is non-formulary in primary care; therefore, patients discharged with aqueous cream should be changed to Zero AQS®.
- Patients admitted to hospital should be prescribed with their current emollients, except where an alternative is clinically indicated.

UNLICENSED 'SPECIALS' PRODUCTS[17, 18]

Most prescribing aims to use licensed medicines whose safety and efficacy is assured. For many common dermatological conditions, the range of licensed medicines is limited. Dermatology prescribing can lead to the use of unlicensed creams and ointments (known as 'Specials'). This is of particular concern in primary care where lack of effective price controls and a mechanism to ensure independent scrutiny of product quality has increased costs and concern about standards. To address these concerns and help to optimise quality of care, adherence to the revised **British Association of Dermatologists (BAD)** list of preferred Specials (2018) is encouraged.

Before prescribing an unlicensed special, consider

- Is a licensed product available
- Is it a special recommended by the BAD (see BAD list)
- If the item is not included on the BAD specials list and recommended by Secondary care, **please DO NOT,** prescribe. Refer back to the secondary care dermatologist to prescribe.

The use of unlicensed specials should be discussed with the patient and documented in the notes. Do not add unlicensed specials to the repeat prescriptions list. Ensure that the condition is reviewed regularly.[13] Review all patients that are on non-approved formulations and assess whether there is a continued need for prescribing and whether patients should be on these formulations long term[1]

USEFUL PATIENT RESOURCES

- **NHS** http://www.nhs.uk.
- **National Eczema society** http://www.eczema.org
- **National Psoriasis Foundation**: www.psoriasis.org
- **Support and information on psoriasis and psoriatic arthritis** http://www.papaa.org/resources/about-psoriasis

Date approved: Waltham Forest and East London Medicines Optimisation and Commissioning Committee (WEL MOCC), November 2019
NHS Newham CCG, NHS Tower Hamlets CCG and NHS Waltham Forest CCG
Date of review: November 2021

REFERENCES

1. **NHS England guidance on conditions for which over the counter items should not be routinely prescribed in primary care.** https://www.england.nhs.uk/medicines/conditions-for-which-over-the-counter-items-should-not-routinely-be-prescribed/
2. **MeReC Bulletin.** The use of emollients in dry skin conditions. Number 12, 1998, Vol. 9, pp. 45-48.
3. **BDNG in association with Dermatological Nursing**. *Best Practice in Emollient Therapy: A statement for Healthcare Professionals.* s.l.: Dermatological Nursing, December 2012
4. **Medicines and Healthcare Products Regulatory Agency. Emollients: new information about risk of severe and fatal burns with paraffin-containing and paraffin-free emollients**. s.l: Medicines and Healthcare Products Regulatory Agency, 18 December 2018 https://www.gov.uk/drug-safety-update/emollients-new-information-about-risk-of-severe-and-fatal-burns-with-paraffin-containing-and-paraffin-free-emollients
5. **PresQIPP Bulletin 49: Cost effective emollients with no, or low paraffin content.** May 2013: https://www.prescqipp.info/media/1268/b49-emollients-20.pdf.
6. **National Institute of Clinical Excellence (NICE).** *Clinical Knowledge Summaries Dermatitis-Contact.* s.l: NICE, July 2018.
7. **PresQIPP Bulletin b76:** Emollients May 2015: https://www.prescqipp.info/media/1307/b76-emollients-briefing-20.pdf.
8. **British National Formulary-National Institute for Health and Care Excellence (BNF- NICE) Treatment summaries: Skin conditions. Accessed October 2018.** https://bnf.nice.org.uk/treatment-summary/skin-conditions-management.html.
9. **Medicines and Healthcare Products Regulatory Agency**. *Drug Safety Update Aqueous cream: may cause skin irritation.* s.l: Medicines and Healthcare Products Regulatory Agency, March 2013.
10. **Infant.** De Meza T: *Should we use olive oil or sunflower oil on a preterm infant's skin*? Infant 2013; 9(5): 170-72.)
11. **British National formulary for Children BNFc National Institute for Health and Care Excellence BNF-NICE. Accessed October 2018**- https://bnfc.nice.org.uk/treatment-summary/emollient-and-barrier-preparations.html
12. **NHS England consultation,** version 2, June 2019. Items, which should not routinely be prescribed in primary care: Guidance for CCGs. https://www.england.nhs.uk/wp-content/uploads/2017/11/items-which-should-not-be-routinely-precscribed-in-pc-ccg- guidance-v2.pdf.
13. **Specialist Pharmacy service (SPS).** Clinical evidence for emollient bath and shower preparations https://www.england.nhs.uk/wp-content/uploads/2017/11/annex-b-sps-evidence-review-bath-emollients.pdf.
14. **National Institute of Clinical Excellence (NICE).** *Clinical Knowledge Summaries Eczema.* s.l: NICE, last revise January 2018. Accessed October 2018. https://cks.nice.org.uk/eczema-atopic#!prescribinginfosub:1
15. **National Institute of Clinical Excellence (NICE).** Atopic eczema in under 12s: diagnosis and management Published: 12 December 2007. https://www.nice.org.uk/guidance/cg57/resources/atopic-eczema-in-under-12s-diagnosis-and-management-pdf-975512529349
16. **National Institute of Clinical Excellence (NICE).** Atopic eczema in under 12s: diagnosis and management Published: 12 **Quality statement 4**: Quality standard [QS44] Published date: September 2013 Provision of emollients https://www.nice.org.uk/guidance/qs44/chapter/Quality-statement-4-Provision-of-emollients
17. **PrescQIPP Bulletin B168 Dermatology Specials (SPOT-List):** https://www.prescqipp.info/our-resources/bulletins/bulletin-168-dermatology-specials-spot-list/
18. **Specials Recommended by the British Association of Dermatologists for Skin Disease** 2018. Deirdre Buckley, Tim Root and Simon Bath. http://www.bad.org.uk/shared/get-file.ashx?itemtype=document&id=6248

19. ***Interventions to reduce Staphylococcus aureus in the management of atopic eczema***. Birnie Andrew J., Bath-Hextall Fiona J., Ravenscroft Jane Catherine., Williams Hywel C.s.l.: John Wiley & Sons, Ltd, 2008, Cochrane Database of Systematic Reviews, Vol. 3.
20. **UKMI Can topical steroids be applied at the same time as emollients?** Medicines Q&A 258.2. Date prepared: 2/11/12.

APPENDIX 1- INGREDIENTS OF FORMULARY PRODUCTS

Description	Emollient	Formulary position	Ingredients and additional information
GREASY LEAVE-ON EMOLLIENT	Emulsifying ointment	First line	Emulsifying wax 30%, White Soft Paraffin 50%, Liquid Paraffin 20%.
	Liquid and white soft paraffin 50:50 ointment	First line	White Soft Paraffin 50: Liquid Paraffin: 50
	White Soft Paraffin (WSP)	First line	White Soft Paraffin
	Hydromol® ointment	Second line	Liquid Paraffin 40%, White Soft Paraffin 30%, Cetomacrogol Emulsifying. **Consider Switching To AproDerm® Ointment or Zeroderm® (SIMILAR, BUT NOT IDENTICAL)**
RICH CREAM/OINTMENT LEAVE-ON EMOLLIENT	Zeroderm® cream	First line	Liquid Paraffin 40%, White Soft Paraffin 30%, Cetearyl Alcohol **Consider switching Hydromol® and Epaderm® to Zeroderm® (similar, but not identical)**
	AproDerm® Ointment	First line	Liquid Paraffin 5%, White Soft Paraffin 95%,
	AproDerm® Cream	First line	Liquid Paraffin 6%, White Soft Paraffin 15%,
	Hydrous® Ointment	First line	Dried magnesium sulfate 0.5%, phenoxyethanol 1%, wool alcohols ointment 50%
	Cetraben® cream	Second line	White soft paraffin 13.2% w/w, Light liquid paraffin 10.5% w/w Contains humectant – glycerin**.** Available as cream and ointment
	Diprobase® cream	Second line	White Soft Paraffin 15%, Liquid Paraffin 6% **Consider Switching To AproDerm® Emollient Cream or Zerobase® (SIMILAR, BUT NOT IDENTICAL)**
OPAQUE GEL LEAVE-ON EMOLLIENT	Zerodouble® gel	First line	Isopropyl myristate 15%w/w, liquid paraffin 15%w/w. Pack size is 475g. DO NOT prescribe 500g (5x100g is more expensive than Doublebase)
	AproDerm® Gel	First line	Isopropyl myristate 15%w/w, liquid paraffin 15%w/w.
	Doublebase® Gel	Second line	Isopropyl myristate 15%w/w, liquid paraffin 15%w/w. **Consider Switching To AproDerm Gel or Zerodouble®**
LIGHT OR CREAMY LEAVE-ON EMOLLIENT	Zero AQS® Cream	First line	White Soft Paraffin 15%. Liquid Paraffin 6% Same ingredients as Aqueous cream but does not contain SLS.
	Zerobase® cream	First line	Liquid paraffin 11% w/w, White Soft Paraffin 10%
	Aquamax® Aquamax®	First line	White soft paraffin 20%, liquid paraffin 8% **Consider Instead Of Aqueous Cream (SIMILAR, BUT NOT IDENTICAL)**
LIGHT OR CREAMY LEAVE-ON EMOLLIENT	Zerocream® Cream	First line	Light Liquid Paraffin 12.6%, White Soft Paraffin 14.5%, Anhydrous Lanolin 1.0% Similar formulation to E45 but not identical **CONTAINS PARABENS, LANOLIN**

Description	Emollient	Formulary position	Ingredients and additional information
	AproDerm® Emollient Oat Cream	Second line	Colloidal oatmeal in emollient base
	QV cream®	Second line	Aqua (water), paraffinum liquidum, glycerin, petrolatum, cetearyl alcohol, squalane, dimethicone, ceteth-20, stearic acid, laureth-3, glyceryl stearate, methylparaben, dichlorobenzyl alcohol
	Zeroveen® cream	Second line	Colloidal oatmeal in emollient base
SOAP SUBSTITUTE	Zero AQS® Cream	First line	White Soft Paraffin 15%. Liquid Paraffin 6%
	Aquamax® cream	First line	Light Liquid Paraffin 8%, white soft paraffin 20%, phenoxyethanol 1%
	Emulsifying ointment	First line	Emulsifying wax 30%, White Soft Paraffin 50%, Liquid Paraffin 20%.
	Epi-max® cream	First line	Purified Water Ph. Eur., White Soft Paraffin, Liquid Paraffin, Polysorbate 60, Cetosteryl Alcohol, Phenoxyethanol
	Aqueous cream	Non-formulary in primary care.	White Soft Paraffin 15%. Liquid Paraffin 6% **CONTAINS: SLS NOTE:** Formulary for Barts Health NHS Trust
ANTIMICROBIAL CONTAINING EMOLLIENTS	Dermol 500 Lotion®	First line	Benzalkonium Chloride 0.1% w/w; Chlorhexidine Dihydrochloride 0.1% w/w; Liquid Paraffin 2.5% w/w; Isopropyl Myristate 2.5% w/w.
UREA CONTAINING EMOLLIENTS	ImuDERM® Emollient	First line	UREA (5%) and Glycerine (5%)
	Balneum® Cream	First line	Urea 5%, ceramide 0.1%
	Balneum® Plus Cream	First line	Urea 5%, Lauromacrogols 3,0 %
	Hydromol Intensive®	First line	Urea 10%
	Nutraplus® cream	First line	Urea 10%
	Aquadrate® cream	First line	Urea 10%
	Calmurid® cream	Second line	Urea 10%, Lactic acid 5%
	Dermatonics® Once Heel Balm	Second line	Urea 25%. **CONTAINS LANOLIN**
EMOLLIENT BATH PRODUCTS *NON-FORMULARY UNLESS INDICATED IN EXCEPTIONAL CLINICAL CASES* **As per NHSE consultation recommendations prescribers in primary care should not initiate bath and shower preparations for any new patient.**	Zeroneum® Bath Oil	Non-Formulary	Soya bean oil, refined 83.35% w/v
	Dermalo® Bath Emollient	Non-Formulary	Acetylated wool alcohols 5%, liquid paraffin 65%
	Dermol 600®	Non-Formulary	Liquid Paraffin 25.0% w/w; Isopropyl Myristate 25.0% w/w; Benzalkonium Chloride 0.5% w/w.
	Balneum Plus® Bath Oil	Non-Formulary	Lauromacrogols 3.0% w/w and Urea 5.0% w/w, Cream
	Hydromol Bath & Shower Emollient	Non-Formulary	Light liquid paraffin (37.8%) and isopropyl myristate (13%).
	Zerolatum® Emollient	Non-Formulary	Liquid paraffin 65%, wool alcohols 5%

For full list of ingredients/excipients/cautions, see BNF/SPC.

Version Control	Process
Draft 1	Dec 2015 – consultation with GPwSI Dermatology, Newham, Waltham Forest, Tower Hamlets CCG
Draft 2	Jan 2016 – consultation with Barts Health dermatology healthcare professionals
Draft 3	Jan 2016 – consultation with Newham CCG Medicines Management Committee
Draft 4	Jan 2016 – consultation with WEL Group
Draft 5	Jan 2016 – meeting with Dr Anthony Bewley, Dr Barry Sullman, Wajid Qureshi, Anisha Sharma
Draft 6	Feb 2016 – Re-formatting by Dr Barry Sullman, Wajid Qureshi, Anisha Sharma
Draft 7	Feb 2016 – wider consultation
Draft 8	May 2016 – Comments from Dr Anna Livingstone, GP Prescribing Lead for Tower Hamlets CCG
Update of Guide-lines	September 2018- Discussion with Newham CCG and Tower Hamlets CCG.
Update of Guide-lines Draft 1	October 2018- meeting and comments from Dr Gibbon Consultant Dermatologist Whipps cross Hospital, Barts Health, Gurdeep Kenth and Baljit Sahota
Update of guidelines Draft 2	August 2019-comments from Dr Bryan McDonald, Consultant Dermatologist Barts health, and wider consultation
Update of Guide-lines – final draft	September 2019 – approved at the Waltham Forest and East London Medicines Optimisation and Commissioning Committee (WEL MOCC)
Amendments to 2019 Update	November 2019 – clarification to Bath Emollient recommendations following feedback from Newham GPSwI's. Approved by WEL MOCC.

This guideline was developed in collaboration with Newham, Tower Hamlets and Waltham Forest CCG medicines management teams, GPwSI Dermatology, Consultant Dermatologists and Specialist Dermatology nurses from Barts Health.

Key contributors:
Dr Sanjay Parmar, GPwSI Dermatology, Newham CCG
Dr Barry Sullman, Prescribing Lead GP, Newham CCG
Dr Anna Livingstone, GP Prescribing Lead for Tower Hamlets CCG
Dr Monir Miah, GPwSI Dermatology, Tower Hamlets CCG
Dr Shereen Rahman, GPwSI Dermatology, Waltham Forest CCG
Dr Padma Mohandas, GPwSI Dermatology, Waltham Forest CCG
Dr Anthony Bewley, Consultant Dermatologist, Bart's Health
Dr David Paige, Consultant Paediatrician Dermatologist, Bart's Health
Dr Karen Gibbon, Consultant Dermatologist, Whipps Cross Hospital, Bart's Health
Dr Sasha Dhoat, Consultant Dermatologist, Royal London Hospital, Bart's Health
Dr Portia Goldsmith, Consultant Dermatologist, Bart's Health
Jean Robinson, Clinical Nurse Specialist Paediatric Dermatology, Royal London Hospital, Bart's Health
Wajid Qureshi, Lead Prescribing Adviser, Newham CCG

Date approved: Waltham Forest and East London Medicines Optimisation and Commissioning Committee (WEL MOCC), November 2019
NHS Newham CCG, NHS Tower Hamlets CCG and NHS Waltham Forest CCG
Date of review: November 2021

Date approved: Waltham Forest and East London Medicines Optimisation and Commissioning Committee (WEL MOCC), November 2019
NHS Newham CCG, NHS Tower Hamlets CCG and NHS Waltham Forest CCG
Date of review: November 2021