Emollient Prescribing Guideline for Primary and Secondary Care April 2017

NHS
Worcestershire Area Prescribing Committee

This guideline has been developed for use in the management of patients with a diagnosed dermatological condition or where skin integrity is at risk through xerosis or pruritus. Its application must be guided by professional judgement. Those people without a diagnosed dermatological condition requesting a general skin moisturiser may purchase these over the counter.

It is acknowledged that the best choice of emollient is the one which the patient will use both frequently and liberally. The guideline aims to support a wide choice, whilst minimising duplication of ingredients and excipients, and ensuring least expensive options are prioritised. For this reason, products within each category have been ranked in order of most cost-effective first. **Most cost-effective pack size based on prices February 2017. Other pack sizes may be available and more appropriate depending on intended duration of use. ** Reference: MIMS, March 2017*

Consistency / Formulation		Preferred products	Active ingredients	Advice, restrictions or similar products	Most cost-effective pack size*	Excipients**
Very greasy ointment	1	Emulsifying ointment	WSP 50%+ EW 30%+ LP 20%	Good for night time, very dry skin or scaly patches requiring softening	500g	Cetostearyl alcohol
	2	White soft paraffin in liquid paraffin (50:50)	LP 50%+ WSP 50%		500g	
Ointment	1	Hydromol ointment	YSP 30%+EW 30%+LP 30%	Equivalent to Epaderm	1000g	Cetostearyl alcohol
	2	Zeroderm ointment	LP 40%, WSP 30%	Similar to Epaderm and Hydromol ointments	500g	Cetostearyl alcohol
	3	Cetraben Ointment	LP 20 + EW 30% + WSP 50%		450g	Cetostearyl alcohol
Creams	1	Epimax	LP 6% + WSP 15%	Equivalent to aqueous cream	500g	Cetostearyl alcohol & phenoxyethanol
	2	ExCetra	LLP 10.5% WSP 13.2%	Equivalent to Cetraben	500g pump	Cetostearyl alcohol & phenoxyethanol
	3	ZeroAQS	LP 6% + WSP 15%+ macrogol cetosteryl ether 1.8%	Equivalent to aqueous cream	500g	Cetostearyl alcohol & phenoxyethanol
	4	Zerocream	LP 12.6%+WSP 14.5%, anhydrous lanolin 1%	Equivalent to E45	500g pump	Cetostearyl alcohol

Creams	5	Oilatum cream	LLP 6%, WSP 15%		1.05kg pump	Cetostearyl alcohol, Propylene glycol, Benzyl alcohol, sorbates
	6	Aproderm cream	WSP 15% + LP 6%		500g pump	Cetostearyl alcohol
	7	Zerobase	LP 11%, WSP 10%	Similar to Diprobase	500g pump	Cetostearyl alcohol

LP = Liquid Paraffin, WSP = White Soft Paraffin, EW = Emulsifying Wax, WP = White Paraffin, LLP = Light Liquid Paraffin, YSP = Yellow Soft Paraffin

Consistency / Formulation		Preferred products	Active ingredients	Advice, restrictions or similar products	Most cost-effective pack size*	Excipients
Gels	1	Isomol gel	LP 15%, isopropyl myristate 15%	Less excipients than Doublebase gel	500g	Triethanolamine
	2	Aproderm gel	LP 15%, isopropyl myristate 15%	Less excipients than Doublebase gel	500g pump	Phenoxyethanol
	3	Zerodouble gel	LP 15%, isopropyl myristate 15%	Same as Doublebase gel	475g	Phenoxyethanol & triethanolamine
Lotions	1	E45 lotion	LLP 4%, cetomacrogol, WSP 10%, hypoallergenic anhydrous wool fat		500ml pump	Isopropyl palmitate, benzyl alcohol & hydroxybenzoates
	2	QV lotion	WSP 5%		500ml	Cetostearyl alcohol & hydroxybenzoates
	3	Cetraben lotion	WSP 5%+LLP 4%+ glycerol 3%	Same as Doublebase gel	500ml pump	Cetostearyl alcohol & Phenoxyethanol
Preparations containing anti-microbials	1	Dermol 500 lotion	benzalkonium chloride 0.1%, chlorhexidine hydrochloride 0.1%, liquid paraffin 2.5%, isopropyl myristate 2.5%	Short term use only as a wash or skin emollient during skin infection only	500ml pump	Cetostearyl alcohol & phenoxyethanol
	2	Dermol cream	benzalkonium chloride 0.1%, chlorhexidine hydrochloride 0.1%, isopropyl myristate 10%, liquid paraffin 10%	Short term use only as a wash or skin emollient during skin infection only	500ml	Cetostearyl alcohol & phenoxyethanol
	3	Eczmol	Chlorhexidine gluconate 1% cream	Indicated where Dermol preparations have proved ineffective	250ml pump	Cetostearyl alcohol

Soap Substitute: Use any cream or ointment above as a soap substitute in the bath/ shower (except 50:50 because it may not lather well)

Consistency / Formulation		Preferred products	Active ingredients	Advice, restrictions or similar products	Most cost-effective pack size*	Excipients
Preparations containing urea Only to be used when a keratolytic is required e.g. hyperkeratosis, ichthyosis, extremely dry and/or fissured skin on hands and feet	1	ImuDERM	urea 5%, glycerine 5%	Can be used as a soap substitute	500g pump	Cetostearyl alcohol, benzyl alcohol, phenoxyethanol
	2	Balneum cream	urea 5%, ceramide 0.1%		500g pump	Cetostearyl alcohol, propylene glycol, sorbates
	3	Flexitol 10% urea cream	Urea 10%	Prescribe exact product to avoid selecting premium priced OTC variations such as heel balm and hand balm	500g	Cetostearyl alcohol, lanolin/ derivatives, benzyl alcohol, phenoxyethanol
	4	Flexitol heel balm	Urea 25%	**Restricted use** only for removing very thick keratin from palms/ soles and to treat very thick nails in conditions such as psoriasis or hyperkeratotic eczema	500g	Cetostearyl alcohol, lanolin/ derivatives, benzyl alcohol, phenoxyethanol

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Key Information For Emollient Prescribing:

- Emollients are essential in the management of diagnosed dermatological conditions but are often underused.
- When used correctly, emollients can help maintain and/or restore skin suppleness, prevent dry skin and itching.
- Regular use of sufficient emollient reduces the number of flare-ups and therefore reduces the need for corticosteroid treatment.
- Assess patient to diagnose a dermatological condition such as eczema, psoriasis or symptomatic xerosis or pruritus caused by systemic disease that threatens skin integrity e.g. in older patients.
- Emollients can be purchased over the counter by patients who do not have a diagnosed dermatological condition or risk to skin integrity.

There is no evidence from randomised 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 costs.

All primary and secondary care prescribers should where possible select the emollient with the lowest acquisition cost from the range available in our agreed preferred product list.

Newly diagnosed patients:
Offer the product with the lowest acquisition cost from the preferred list appropriate to their condition.

Existing patients with a diagnosed dermatological condition prescribed an emollient outside the preferred product list:
Review with a view to trialling a preferred emollient from the list above. If after discussion with the patient, they agree to switch existing emollient therapy, offer the product with the lowest acquisition cost from the above list by emollient formulation. If the patient prefers to continue on their existing product this choice should be respected.

Patients who have been reviewed in secondary care and require an emollient outside the preferred product list should have the rationale for the request provided to the primary care prescriber.

Sufficient quantities should be prescribed to allow liberal application as frequently as required.
The quantity of emollient prescribed will vary depending on:

- The size of the person.
- Extent and severity of the dermatological condition.
- If the emollient is also being used as a soap substitute.

As a guide, in generalised eczema, the recommended quantities used are 600 g/week for an adult and 250-500 g/week for a child.

Also offer smaller quantity packs for use at school or work in addition to the main prescription.

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:

	Face	Both hands	Scalp	Both arms or both legs	Trunk	Groin & genitalia
Creams and ointments	15-30g	25-50g	50-100g	100-200g	400g	15-25g
lotions	100ml	200ml	200ml	200ml	500ml	100ml

- Prescribe up to two different types of emollient to use at different times of day / different body areas / for when condition severity varies - one of which can be used as a soap substitute as well.
- 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 and availability of emollient creams with a lower acquisition cost.
- Emollients containing urea or antimicrobials are not generally recommended as the evidence to support their use is limited; however they may be useful in a select group of patients (see preferred list).
- Colloidal oatmeal containing emollients are NOT included in the formulary. They are associated with higher acquisition costs and there are no clear criteria as to where these should be used in favour of other, more cost-effective emollients.
- Emollient creams/ointments should be used as soap substitutes for washing as conventional soaps/wash products strip the skin of natural oils & cause shedding of skin cells.
- Locally, emollient bath additives and wash products are no longer considered a standard component of ‘total emollient therapy’ and are NOT included in the formulary. There is a lack of convincing evidence to support the use of bath emollients or wash products; the amount of emollient deposited on the skin during bathing/showering is likely to be far lower than with directly applied emollient creams/ointments which can also be used as soap substitutes; and, bath additive emollients will coat the bath and make it greasy and slippery. They are widely available to purchase.

Patients who have been reviewed in secondary care and require an emollient outside the preferred product list should have the rationale for the request provided to the primary care prescriber.

Counselling points for patients/parents/carers

WHAT is an Emollient?

Emollients (sometimes called moisturisers) are creams, ointments and lotions which help to prevent dry skin and itching by keeping it soft and moist and reduce the number of skin "flare ups".

What is the DIFFERENCE between emollients?

The difference between lotions, creams and ointments is their content of oil (lipid) and water. The oil content is lowest in lotions, intermediate in creams and highest in ointments. The higher the oil content, the greasier and stickier it feels and the shinier it looks on the skin.

As a general rule, the higher the oil content (the more greasy and thick the emollient), the better and longer it works but it may be messier to use.

Ointments: greasiest, usually do not contain preservatives (ingredients to help protect the product from bacteria/germs and increase its shelf-life) therefore are associated with less skin sensitivities, good for moderate-severe dry skin and night time application.

Creams: less greasy, normally contain preservatives so may cause skin irritation, usually need to be applied more often than ointments, good for day time application and weeping eczema.

Lotions: good for mildly dry skin, hairy areas of skin, face or weeping eczema; normally contain preservatives so may cause skin irritation.

WHICH Emollient is best?

There is **no "best emollient"**. The type (or types) to use depends on the dryness of the skin, the area of skin involved and patient preference.
More than one emollient may be required for use at different times of the day or for when the skin condition is more active.

HOW and WHEN to USE/APPLY an emollient?

Wash & dry hands before applying emollients to reduce the risk of introducing germs to the skin.

If using a tub, remove the required amount of emollient from the tub onto a clean plate/bowl using a spatula/ teaspoon to prevent introduction of germs to the container.

Apply emollients whenever the **skin feels dry / as often as you need.** This may be 2-4 times a day or more.

Apply emollients immediately after washing or bathing when skin has been dabbed dry. Emollients can and should be applied at other times during the day e.g. in extreme weather to provide a barrier from the cold. Emollients should continue to be **used after the skin condition has cleared** if the clinical condition justifies continued use. This will be assessed by your doctor or nurse.

Apply by smoothing them into the skin in **the direction the body hair naturally lies**, rather than rubbing them in.

Emollients should be **used as a soap substitute**, as normal soap tends to dry the skin.

Mix a small amount (around a teaspoonful) of soap substitute in the palm of your hand with a little warm water and spread it over damp or dry skin. Rinse and pat the skin dry, being careful not to rub it.

You can use soap substitutes for hand washing, showering or in the bath. They don't foam like normal soap but are just as effective at cleaning the skin.

Intensive use of emollients can reduce the need for topical corticosteroids, the quantity and frequency of use of emollients should be far greater than that of other therapies given.

If a **topical corticosteroid** is required, emollients should be applied at least 15-30 minutes before or after the topical corticosteroid.

Paraffin-based emollients are flammable; take care near any open flames or potential causes of ignition such as cigarettes.

WHERE to go for FURTHER INFORMATION

NHS Choices: *www.nhs.uk*
National Eczema Society: *www.eczema.org*
British Skin Foundation: *www.britishskinfoundation.org.uk*
National Psoriasis Foundation: *www.psoriasis.org*
Primary Care Dermatology Society – atopic eczema:
www.pcds.org.uk/clinical-guidance/atopic-eczema#management
British Association of Dermatologists: *www.bad.org.uk*

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