Pharmacy Teaching

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Topics/Questions

- Use/choice of emollient
- Use of topical steroids
- Use of Dermol
- Use of bath products
- Psoriasis – dermatology plan vs license use
- Choice of antihistamine for pruritus

Emollients

- Creams
- Ointments
- Lotions
- With antimicrobial component
- With urea

- The most effective emollient is the one the patient is happy to use!
- Recent updates to formulary

Emollients

- Epimax – gel, cream, ointment
- Epimax Excetra cream – more cost effective
- Oilatum cream
- Aproderm colloidal cream – similar to Aveeno
- Emulsifying ointment
- Hydromol ointment
- Emollin spray – useful for difficult to reach areas/patients with sensory issues

- Encourage patients to also use as soap substitutes
- Emphasise importance of long term use and the limitations of emollients alone

With Urea

- Good for keratosis pilaris, ichythyoses, hyperkeratotic conditions
- Imuderm (5% urea %% glycerine)
- Dermatonic Heel Balm (25% urea)

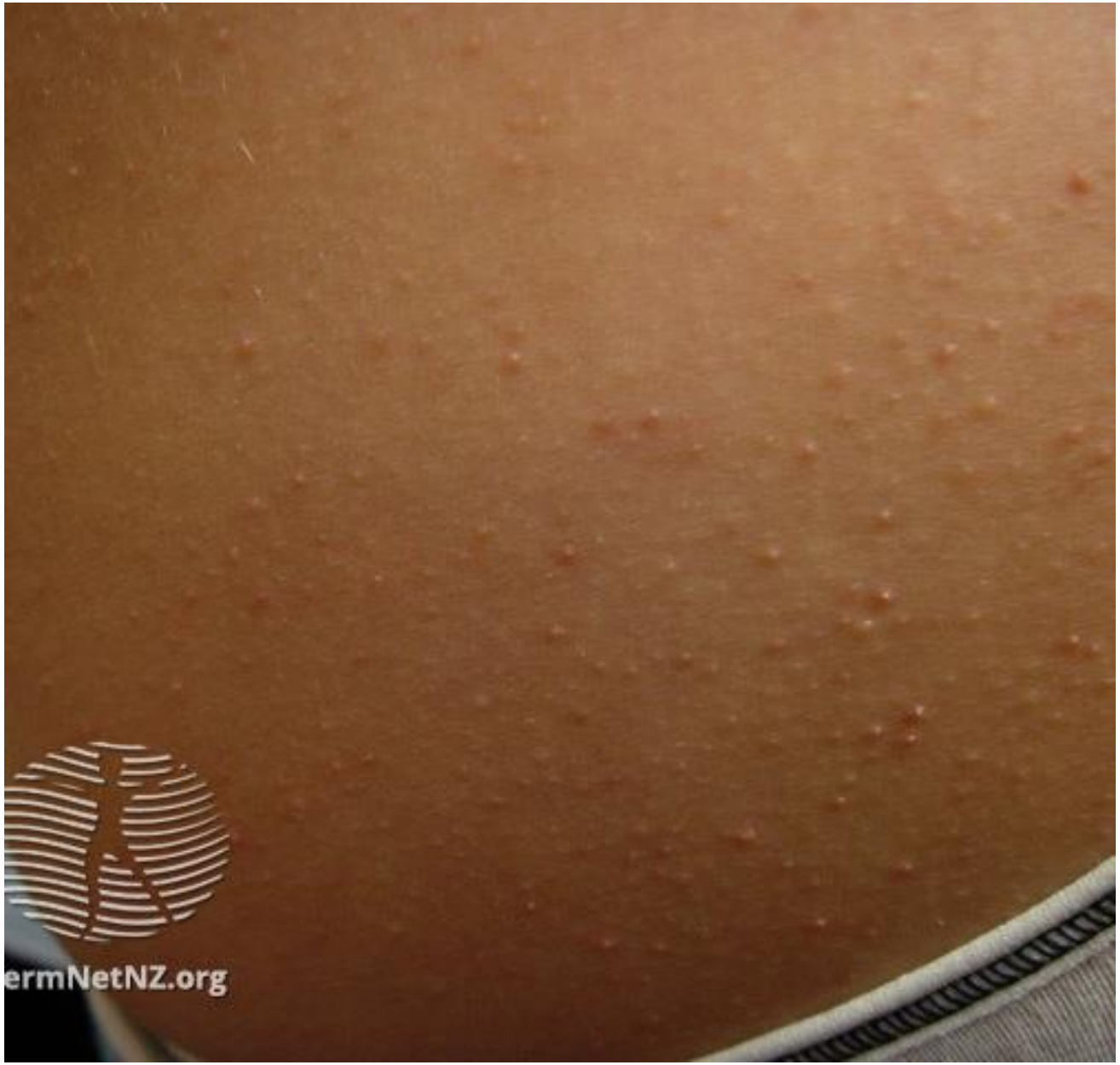
Dermol lotion

- Antimicrobials – Benzalkonium chloride and chlorhexidine dihydrochloride
- Soap substitute and leave on product
- Small risk of sensitisation to Benzalkonium chloride
- Useful for recurrently infected eczema, folliculitis, leg ulcers
- May not be suitable as main emollient for very dry skin/severe eczema

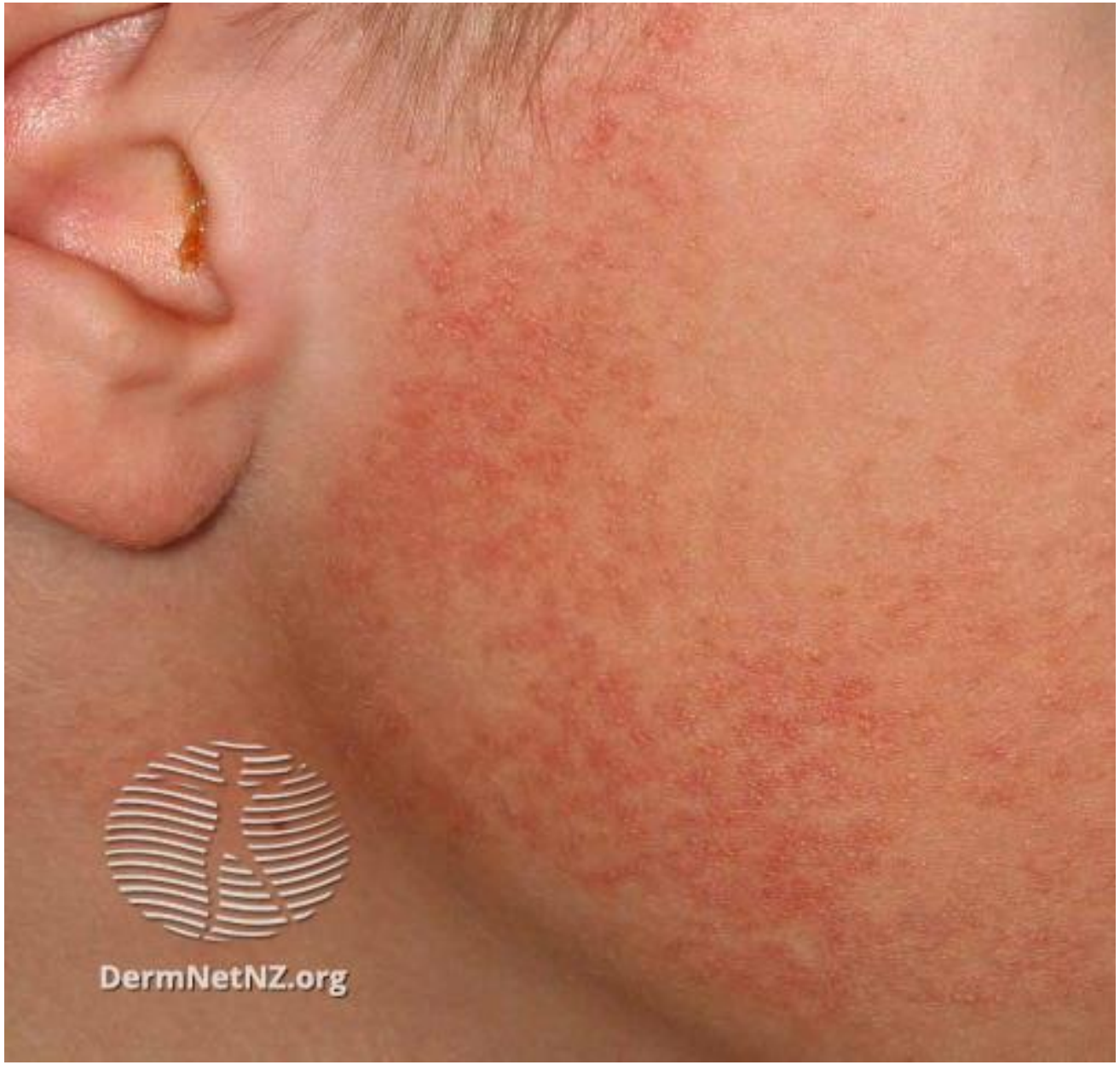
Indications for urea/salicylic acid based emollients

- Dry, scaly skin conditions
- Ichythyotic conditions
- Keratosis pilaris

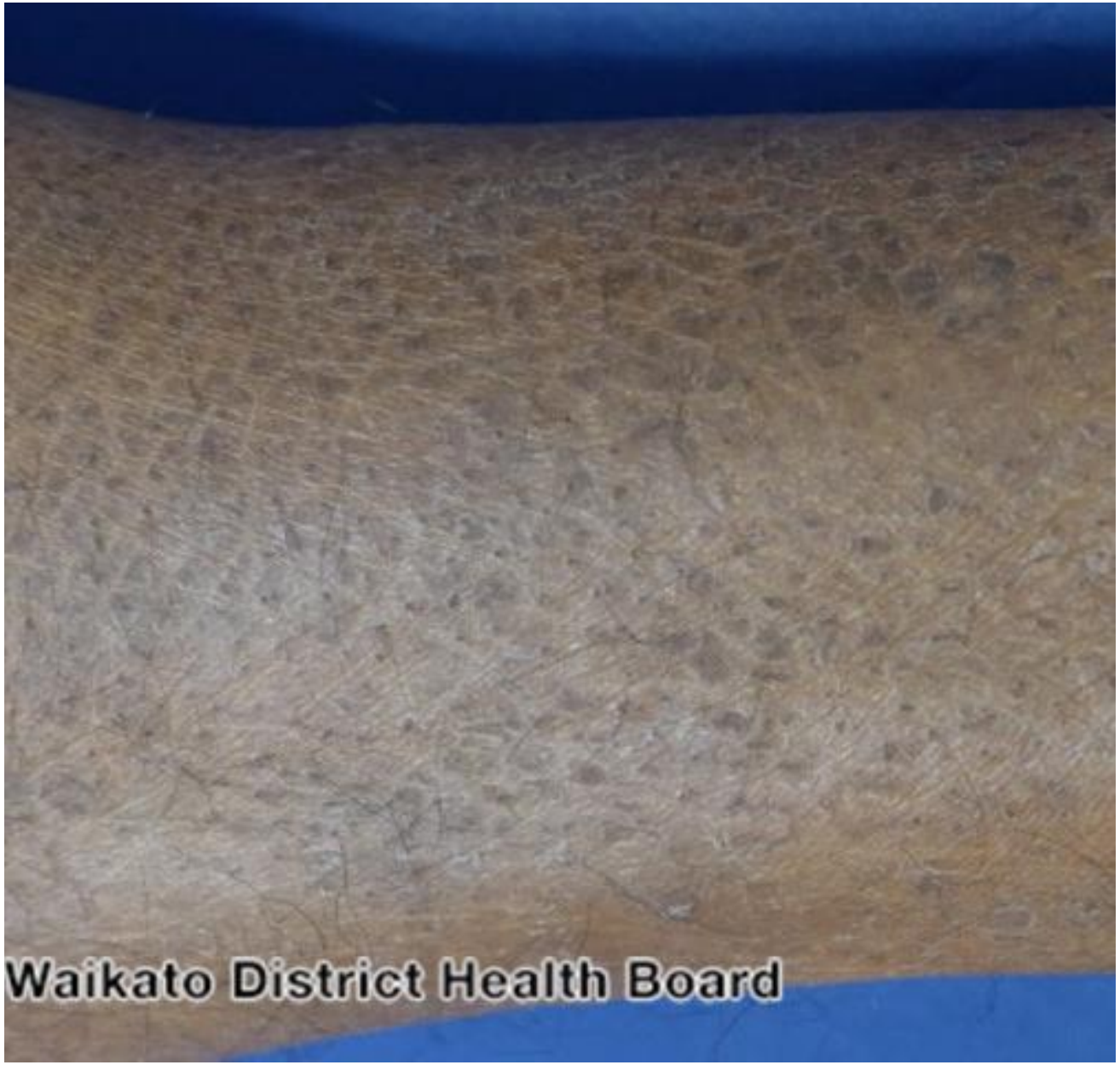
Keratosis pilaris



Keratosis pilaris

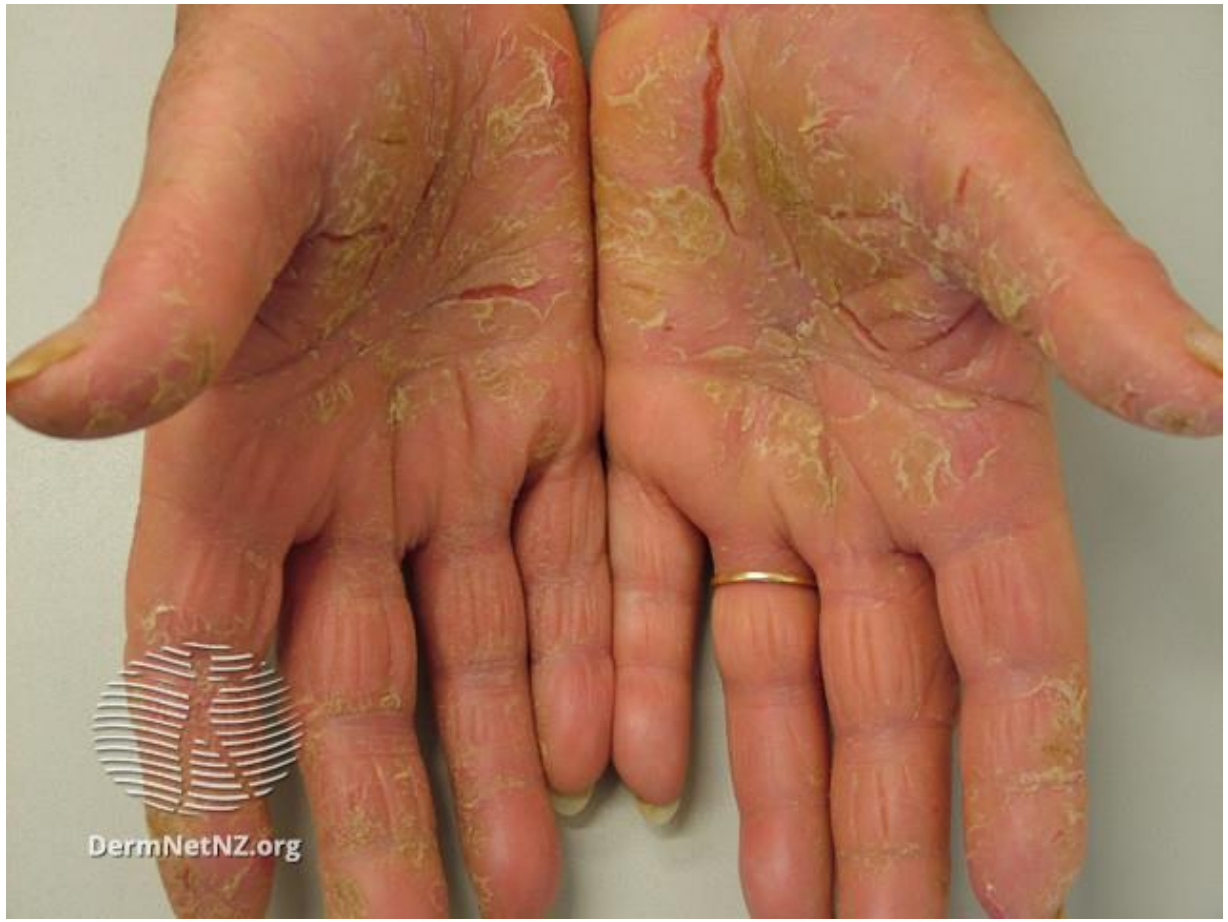


Ichthyosis vulgaris



Ichthyosis

Psoriasis with hyperkeratosis



Emollients

Compliance is key

Ensure patient understand the role of an emollient

Ensure understanding of how to use ie before active treatments, application technique, avoidance of cross contamination

Emphasise importance of long term use even once improved

Back up with information from patient support/websites

Quantities – twice daily for 1 week

- Face – 5-30g
- Hands – 25-50g
- Scalp – 50-100g
- Both arms or legs – 100-200g
- Trunk – 400g
- Groin/genital area - 15-25g

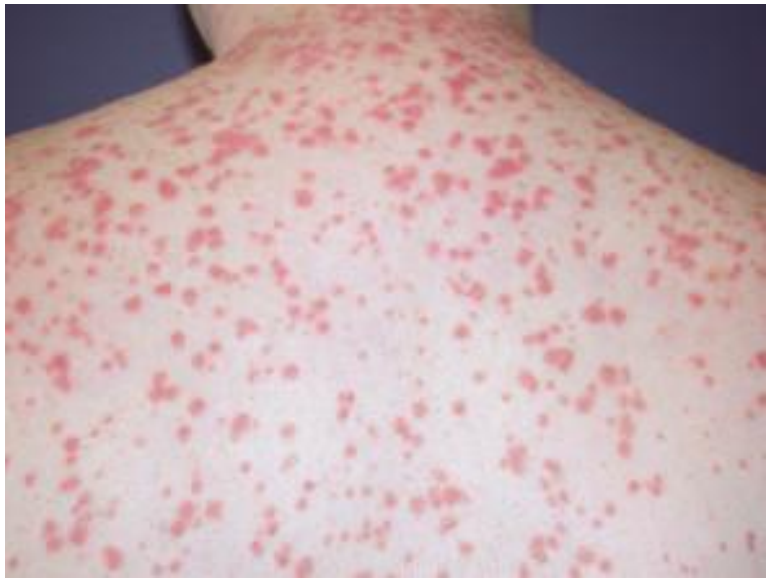
- Some patients will require much greater quantities – common source of frustration with prescriptions

Psoriasis

- Very common dermatosis
- 2-3% of population
- Any area/all of the skin

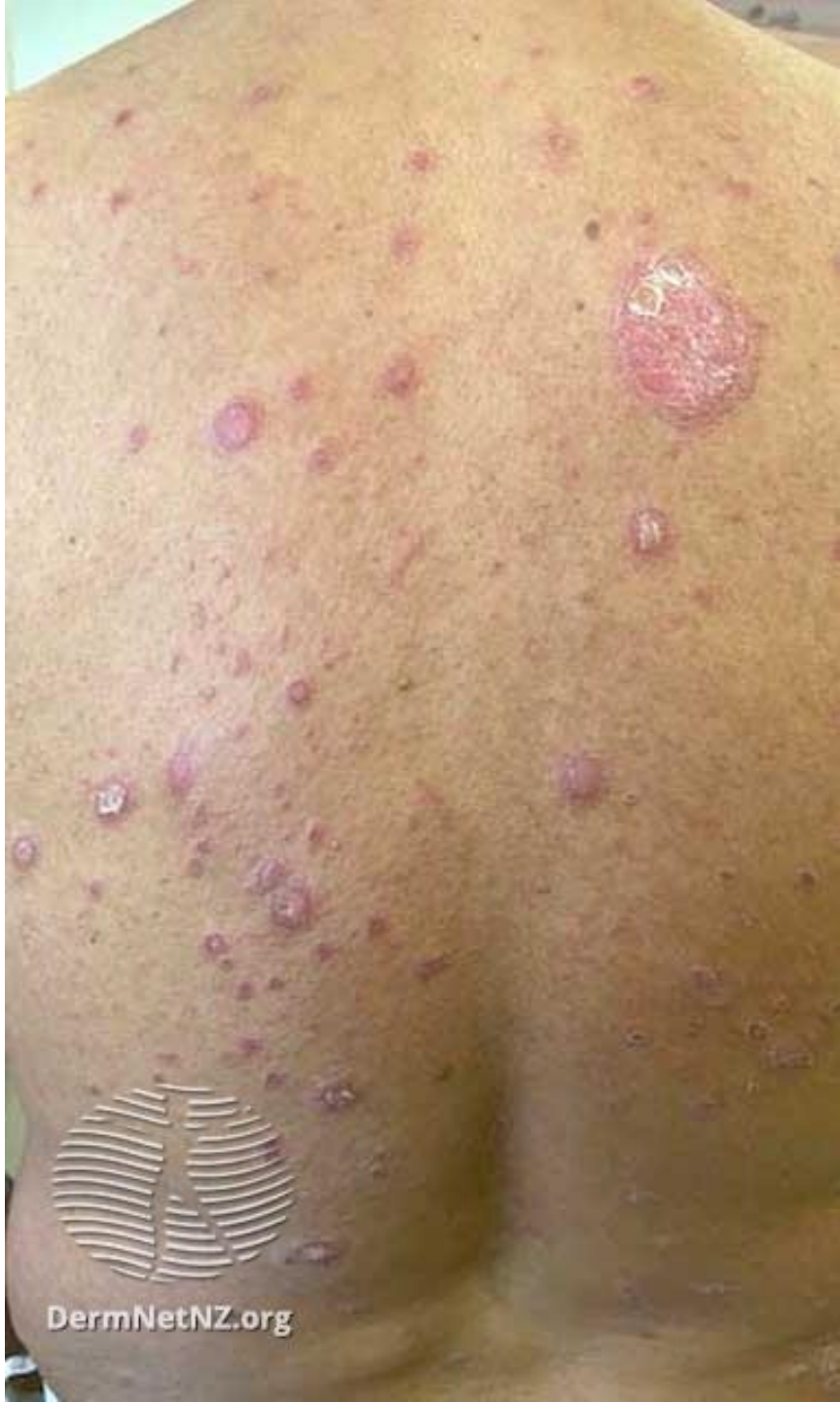
Psoriasis

- Guttate psoriasis



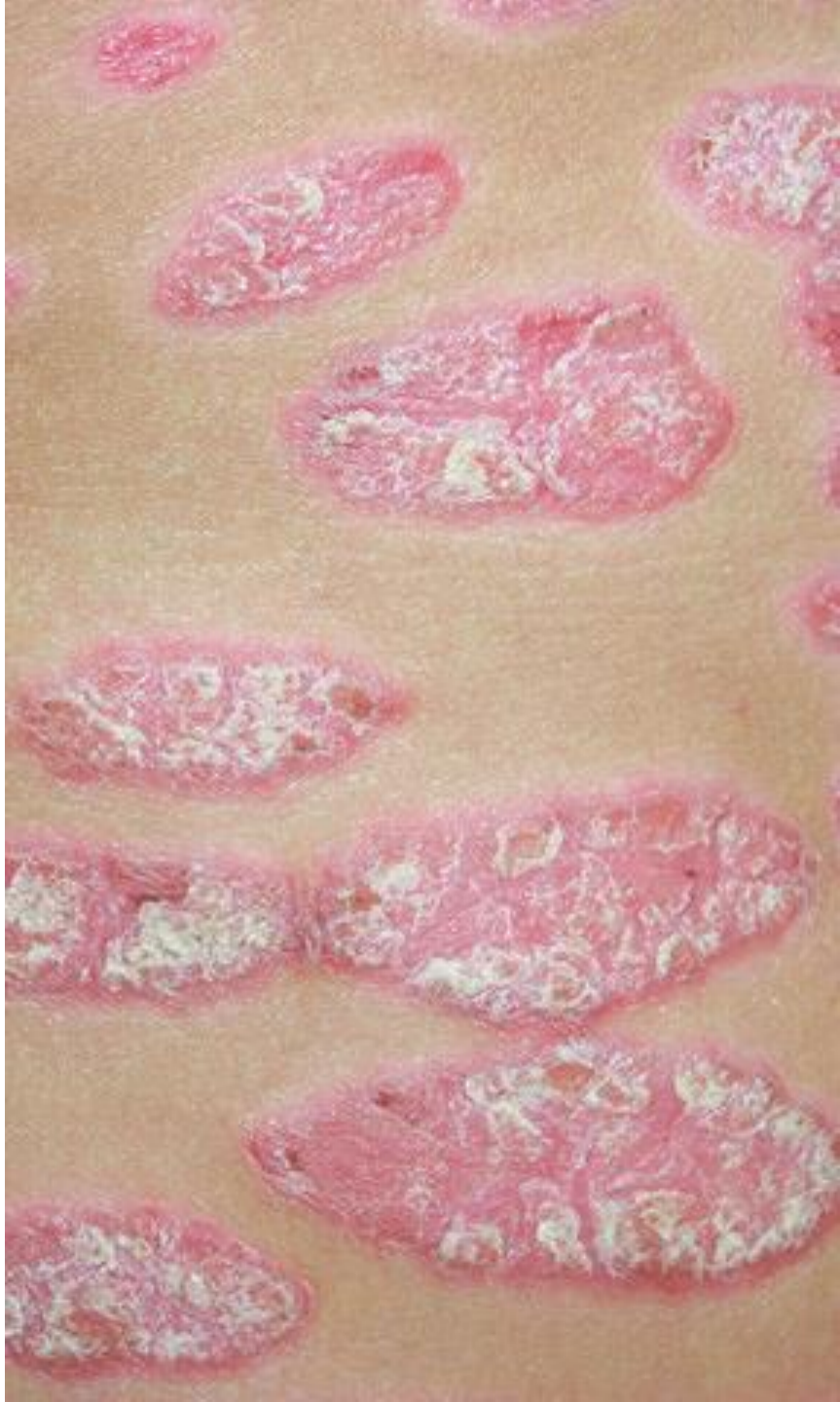
Psorasis

- Chronic plaque psoriasis

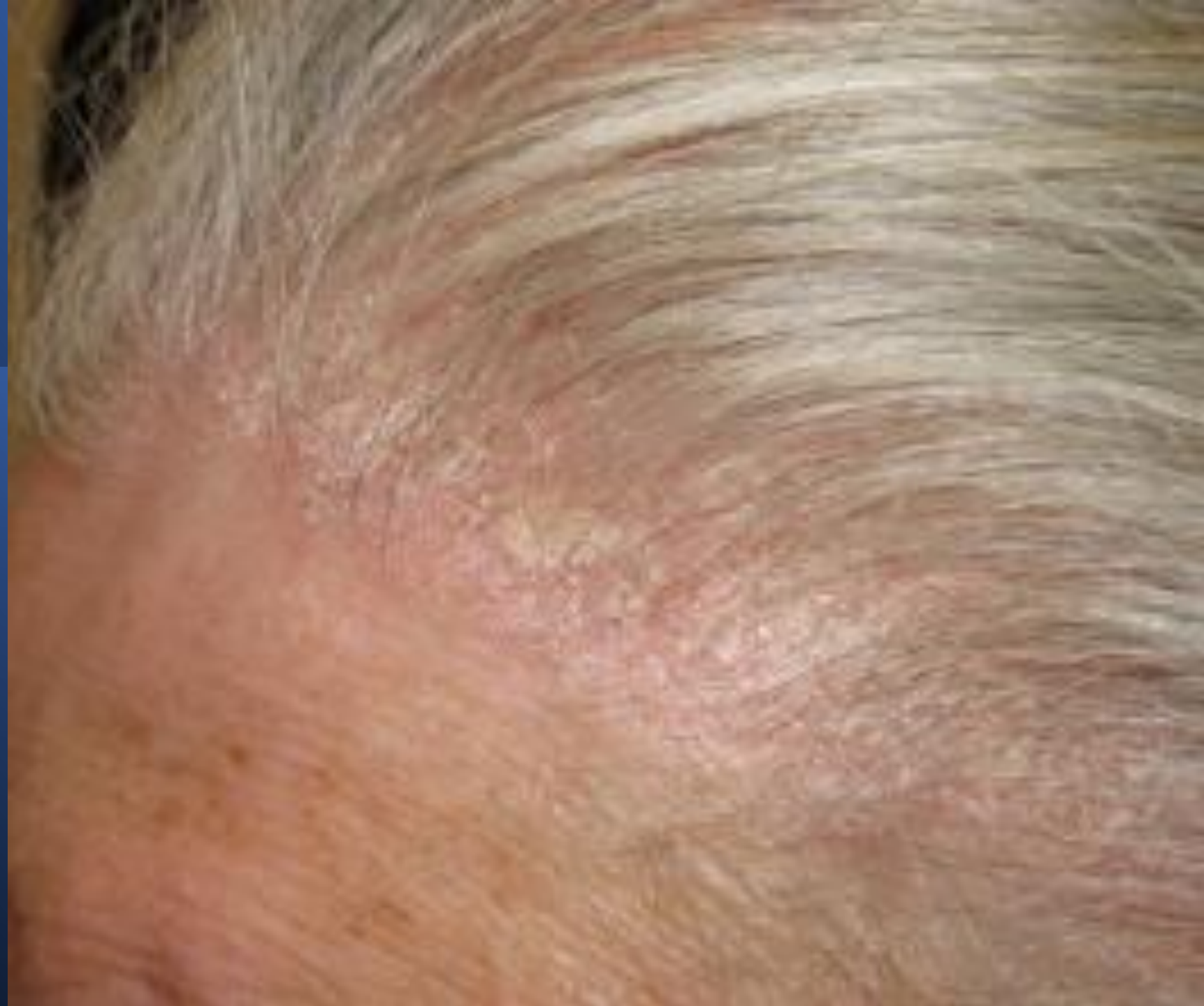


Psoriasis

- Chronic plaque psoriasis



Psoriasis



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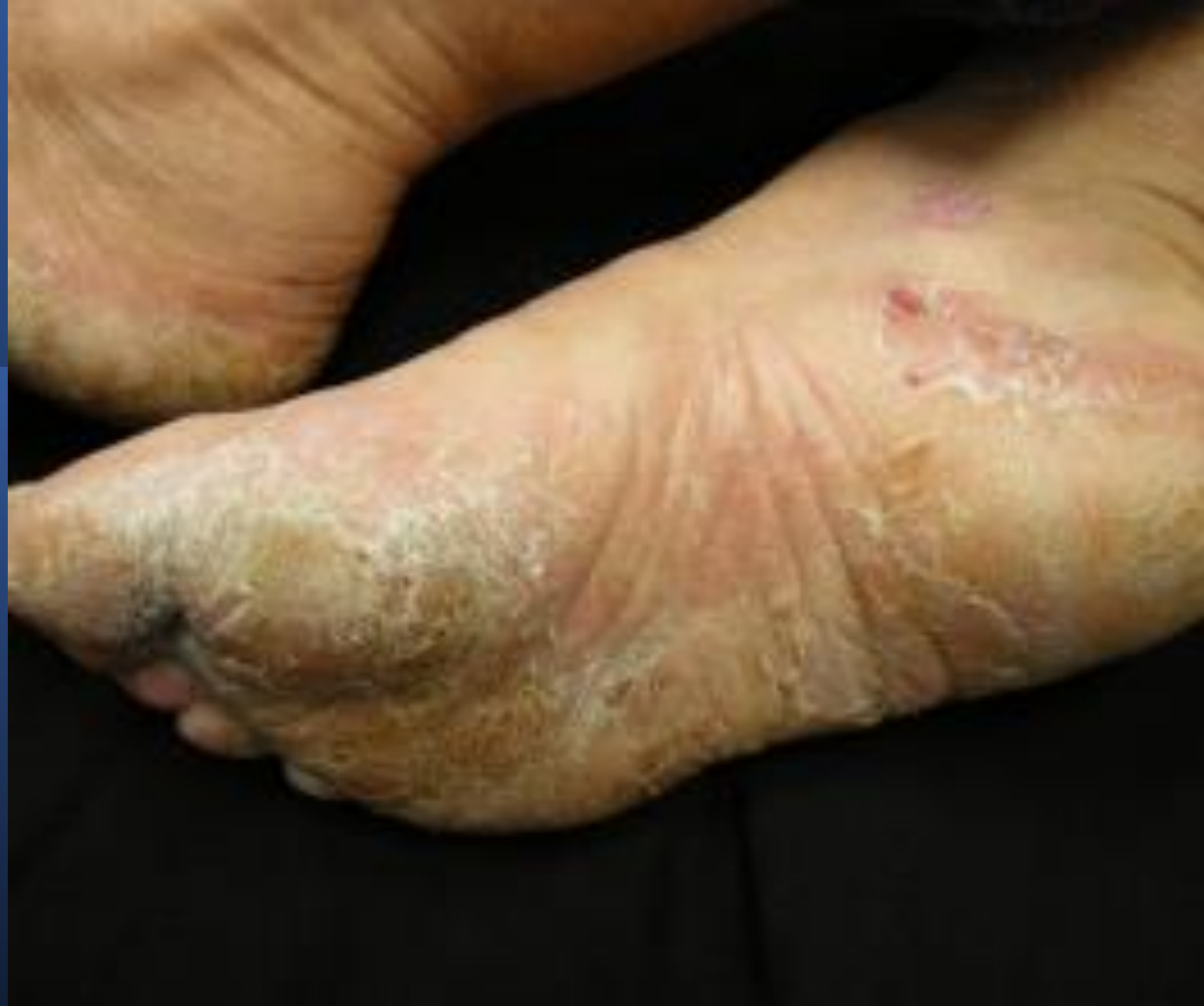

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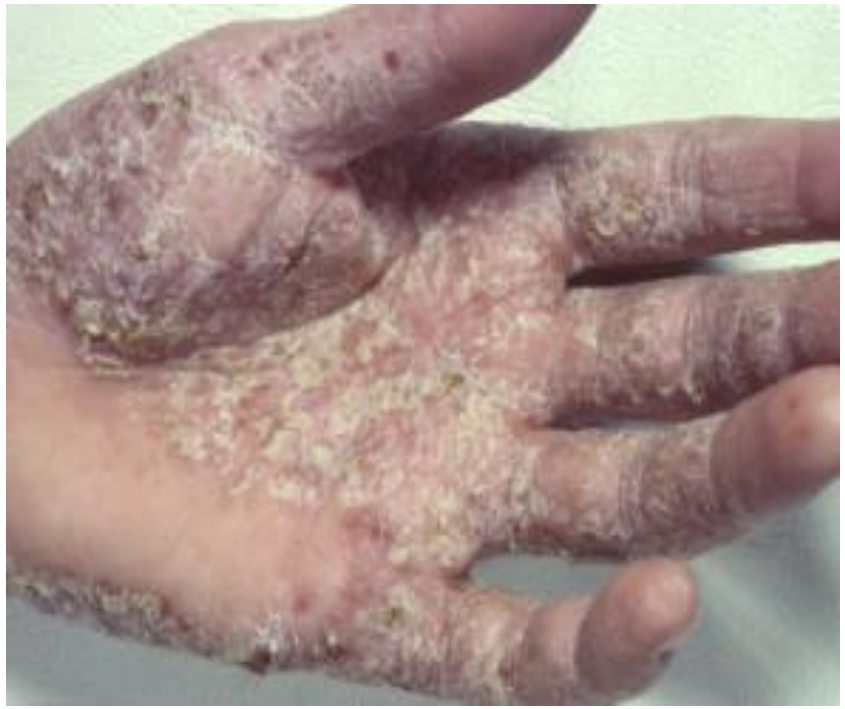


Psoriasis-management

- Emollients
- Topical steroids – mild-moderately potent (except palms and soles)
- Vitamin D analogues/combination treatments – Dovobet/Enstilar
- Coal tar products
- Salicylic acids/combination treatment such as Sebco, diprosalic

Psoriasis

- Phototherapy/TLO1/PUVA
- Systemic treatments – MTX, ciclosporin, retinoids, fumaric acid esters
- Biologics –Adalimumab first line

- All often combined with topical treatments
- Lifestyle modification – ETOH, smoking etc

Psoriasis

- Very chronic/long term condition requiring maintenance treatment
- Management plan needs to include both intensive short term plus longer term treatment
- Dovobet/Enstilar – both licensed for use for a defined period 4/52
- May require longer than 4/52 at sites such as soles and palms
- Advise to taper off rather than stop abruptly due to rebound effect

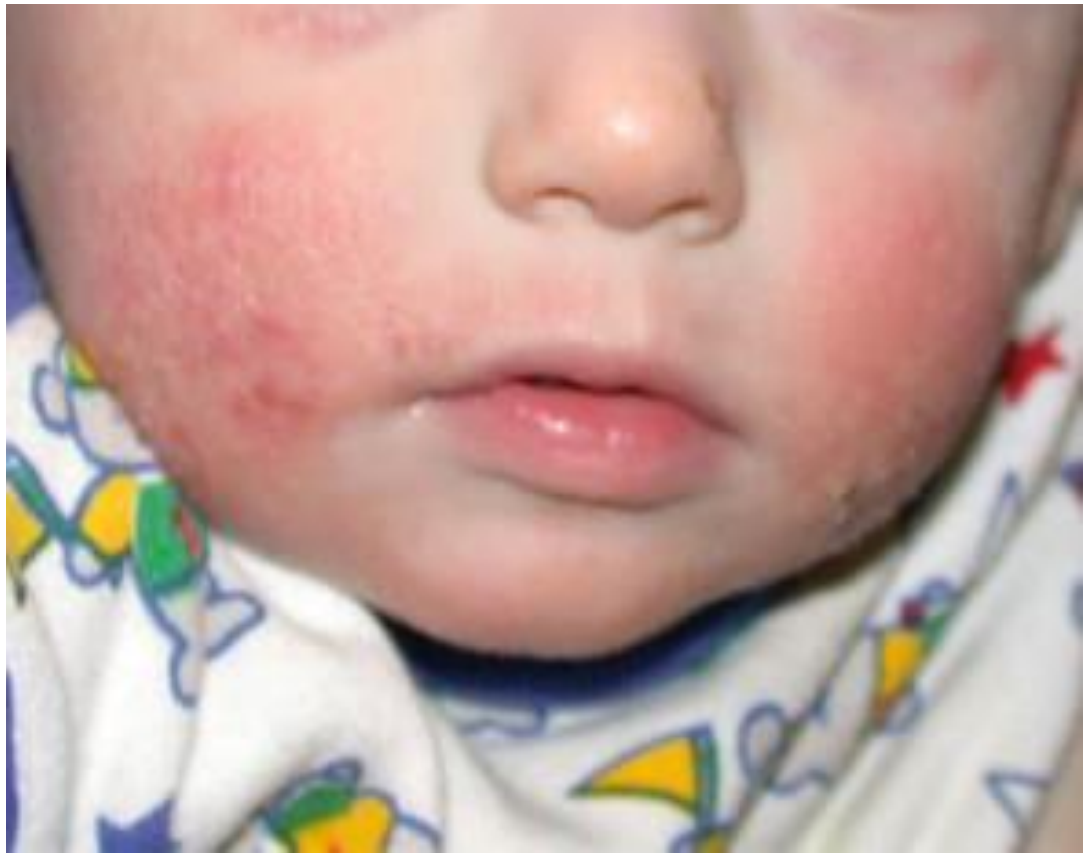
Eczema

- Very common inflammatory dermatosis
- Atopic eczema
- Discoid eczema
- Seborrhoeic eczema
- Pompholyx eczema
- Contact dermatitis
- Gravitational/varicose

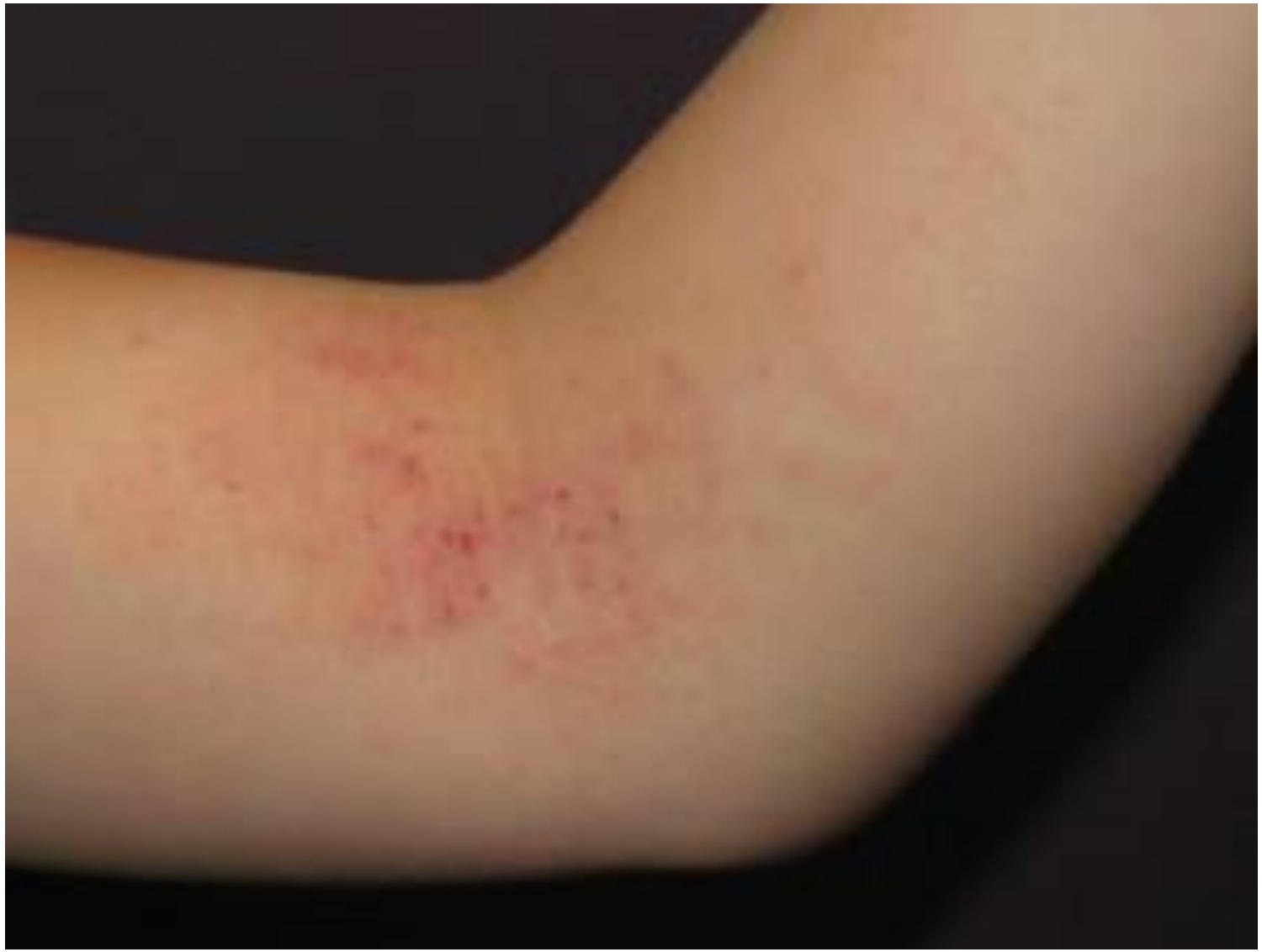
Eczema

- Atopic eczema
- Commonly occurs with asthma/hayfever/urticaria
- Most common type to affect children
- Flexural or generalised

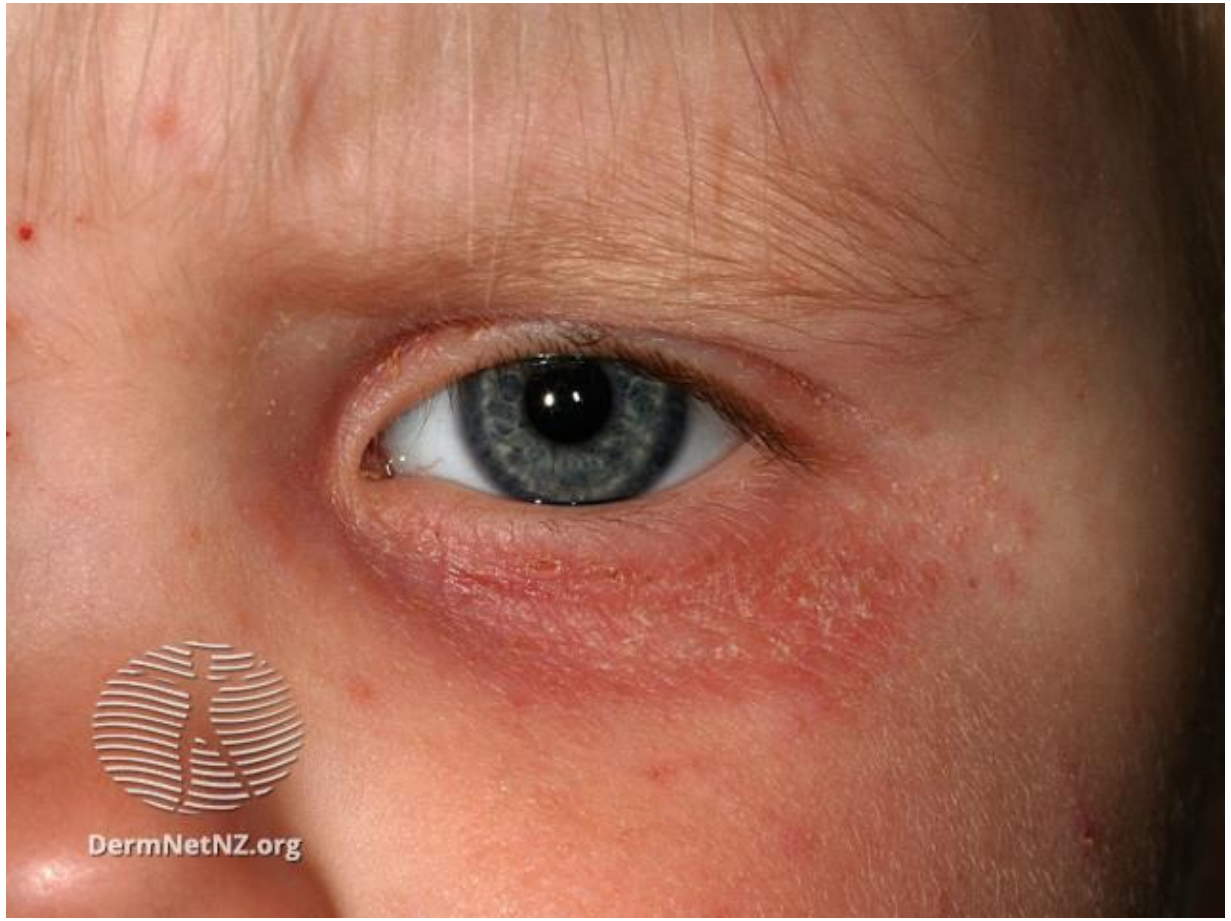
Eczema



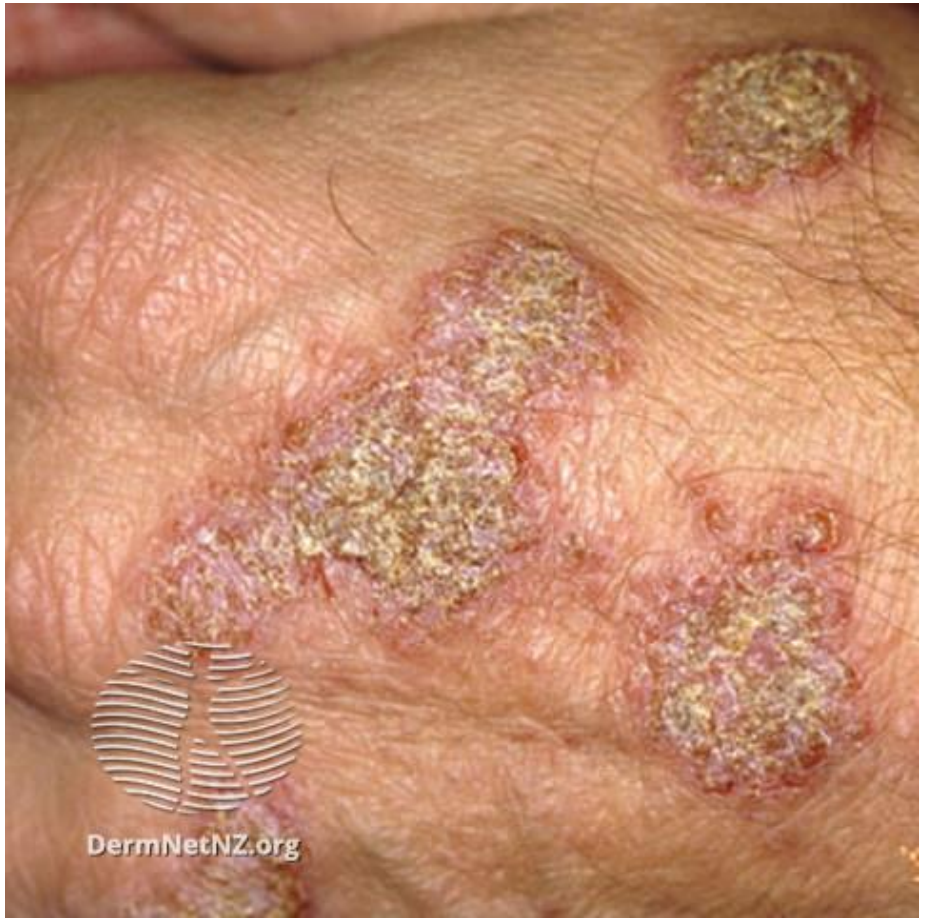
Eczema



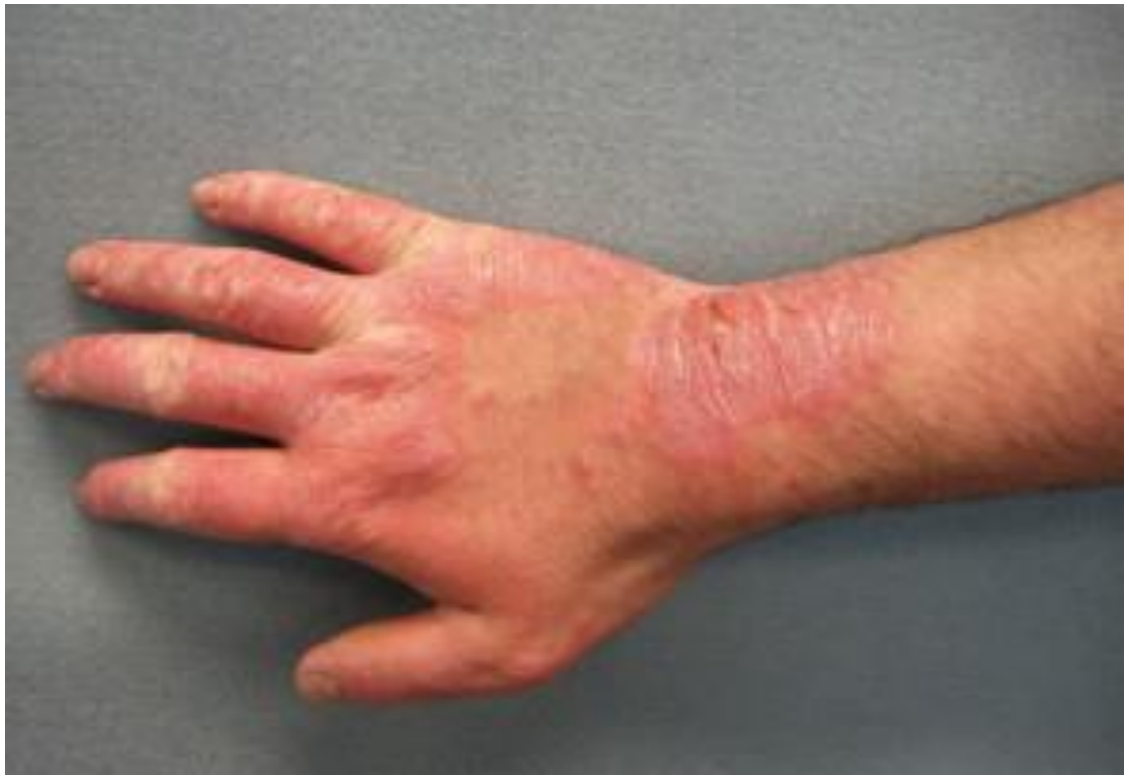
Eczema



Discoid eczema



Contact dermatitis



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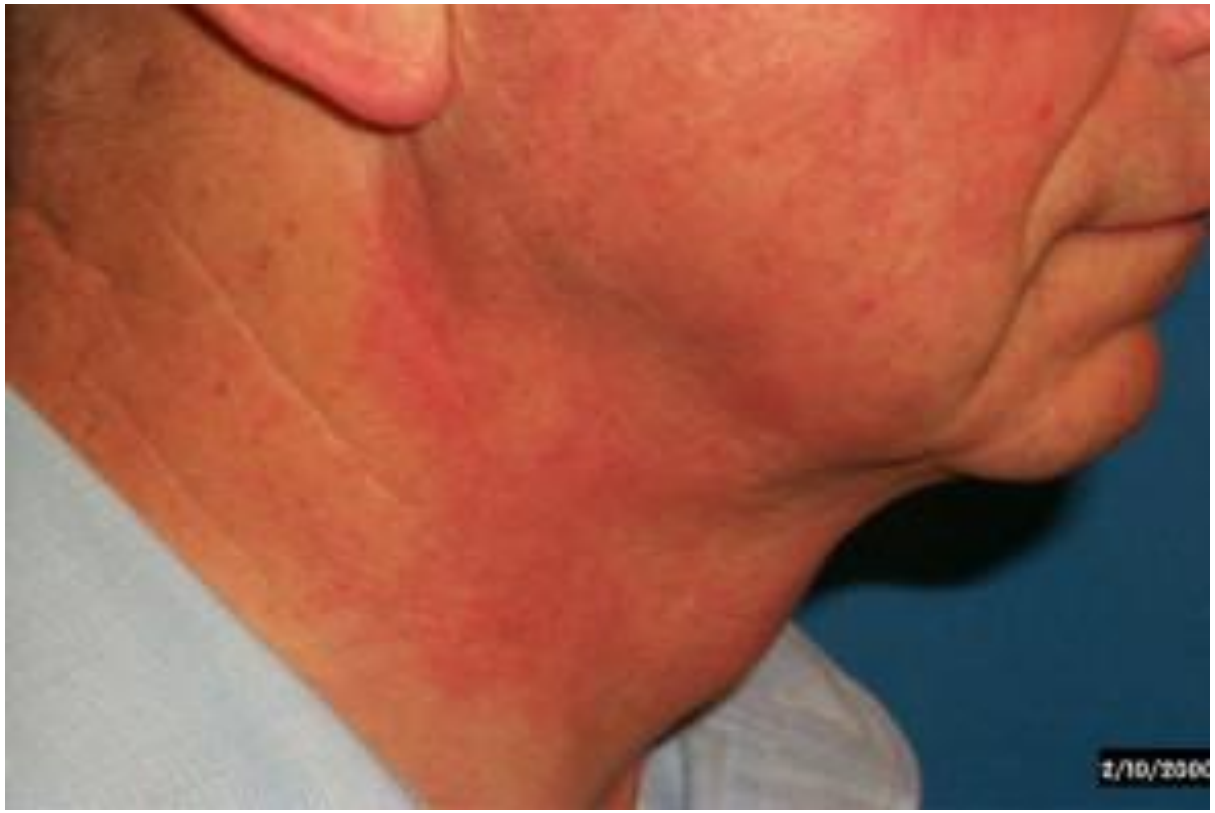
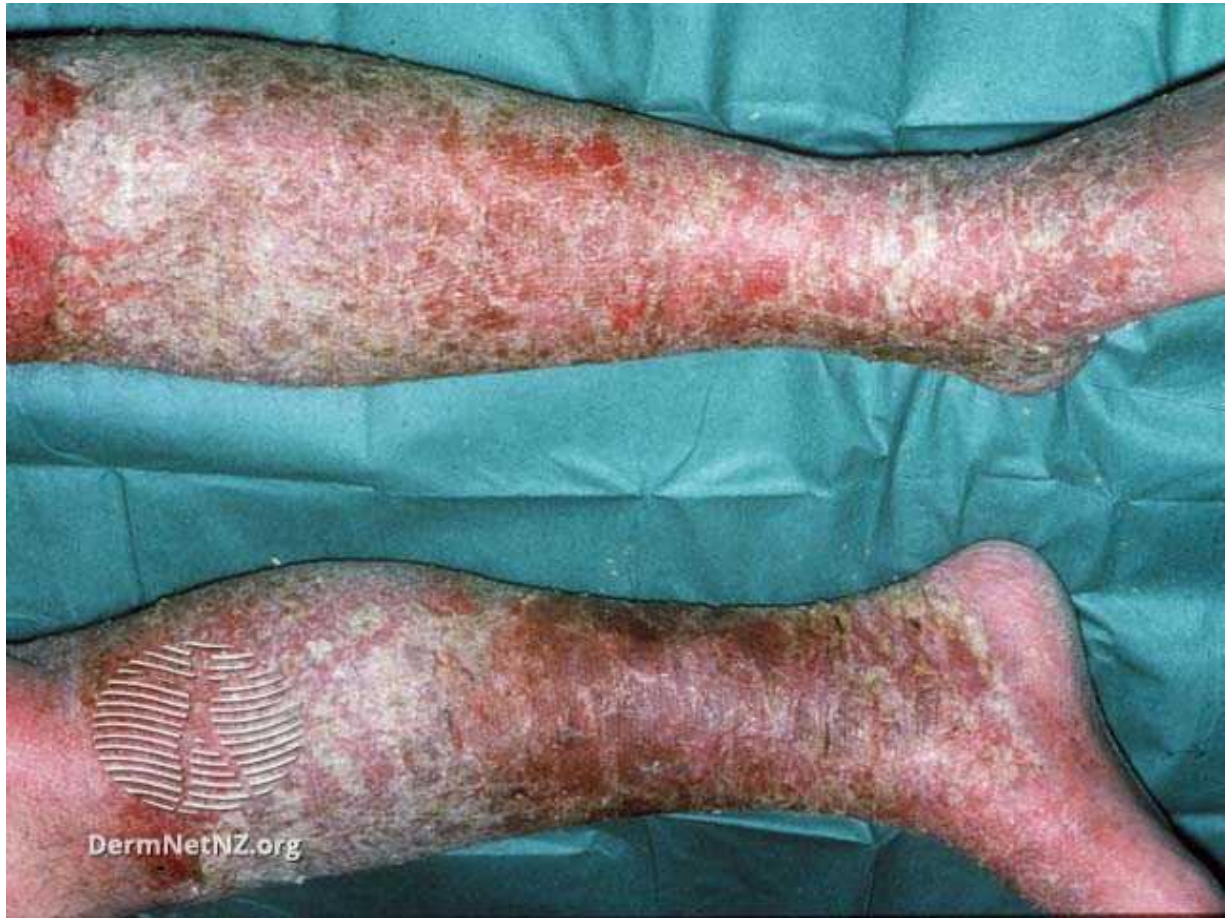
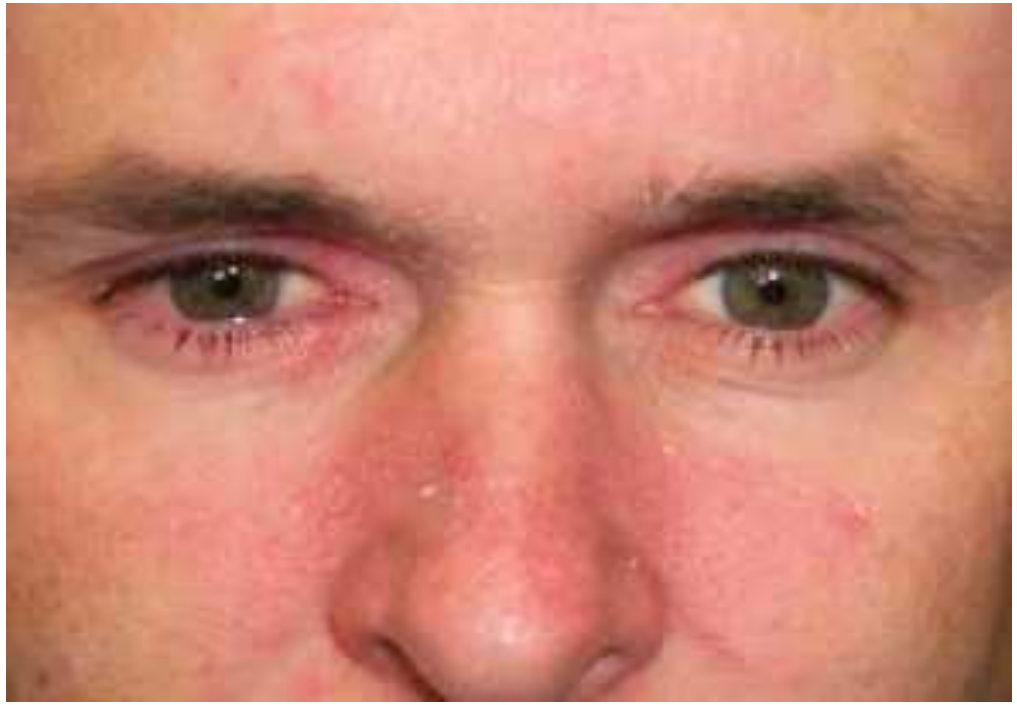


Eczema – gravitational and contact



Seborrhoeic dermatitis



Seborrhoeic dermatitis

Treatment

- General advice – national eczema society/BAD website
- Emollients/soap substitutes
- Topical steroids – regularly to clear/control and then maintenance
- Calcineurin inhibitors
- Seb derm – combination antifungals/topical steroids

Treatment

- Wet wraps
- Phototherapy
- Systemic steroids – short courses
- Systemic immunosuppressant –MTX, ciclosporin, MMF
- Biologics –dupilumab, tralokinumab
- Jak inhibitors –baricitinib, upadacitinib, abrocitinib

Eczema

- Sedating rather than nonsedating antihistamines
- Hydroxyzine nocte
- Atopic patients can often tolerate high dose without drowsiness
- In combination with topical/systemic treatment
- Caution in elderly patients

Urticaria - chronic

- Non sedating antihistamines – fexofenadine
- Can be combined with a sedating antihistamine at night
- May need to increase dosage beyond licence
- Maximum dose fexofenadine 360mg bd
- Topical treatment – limited value but Dermacool can help
- Second line – sodium chromoglycate, immunosuppressants
- Omalizumab

Treatment of pruritus

- Effective treatment dependent on underlying cause
- Easier to manage if directly related to a specific skin condition
- Likely to improve once inflammation is settled
- Emollients/Dermacool
- Non sedating and sedating antihistamines
- Phototherapy
- Second line immunosuppressants

Further advice

- www.bad.org.uk
- DermNet
- National eczema society
- Psoriasis association

- Photos in presentation are from dermnz website