City and Hackney Clinical Commissioning Group
Homerton University Hospital Foundation Trust

Emollient Guideline and Formulary

Reviewed and Updated:	March 2017
Approved:	31.3.17
Review:	31.3.19

This guideline and formulary has been reviewed and updated in collaboration with the City & Hackney CCG medicines management team, the CCG GP Dermatology Lead, and a Consultant Dermatologist from Homerton NHS Foundation Trust.

These guidelines should not replace clinical judgement but are meant as an aid/resource in the management of patients in City and Hackney with emollients.

Approved by JPG March2017, review date March 2019.

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FORMULARY PRODUCTS AND PRESCRIBING GUIDE

– CHOOSING THE BEST EMOLLIENT FOR YOUR PATIENT

SCOPE OF GUIDELINE

This guideline is for use in the management of patients with a diagnosed dermatological condition or if skin integrity is at risk through xerosis or pruritus. Its purpose is to support prescribing, and 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 and should be encouraged to do so. For severe eczema, secondary care specialist advice should be sought as formulations outside the scope of this guideline may be required. (Refer to C&H CCG Eczema Guidelines)

Patients should be assessed to diagnose a dermatological condition.

EMOLLIENTS

An emollient is as a substance whose main action is to occlude the skin surface and to encourage build-up of water within the stratum corneum. It should be applied frequently – at least twice per day.

ALLERGY

People can be allergic to, or react to, a variety of irritants which may cause contact dermatitis. This should be considered if, after applying an emollient, the patient's skin condition worsens or the patient complains of a stinging sensation.
There are some ingredients in emollients that are not recommended for sensitive skin.
It is necessary to ensure patients are aware of this.

EXCIPENTS IN PRODUCTS ASSOCIATED WITH SENSITISATION (rare reports)

Excipients		
Beeswax	Edetic acid (EDTA)	*N*-(3-Chloroallyl) hexaminium chloride (quaternium 15)
Benzyl alcohol	Ethylenediamine	Polysorbates
Butylated hydroxyanisole	Fragrances	Propylene glycol
Butylated hydroxytoluene	Hydroxybenzoates (parabens)	Sodium metabisulphite
Cetostearyl alcohol (including cetyl and stearyl alcohol)	Imidurea	Sorbic acid
Chlorocresol	Isopropyl palmitate	Wool fat and related substances including lanolin

MANAGING THE INTERFACE BETWEEN PRIMARY AND SECONDARY CARE

The following principles have been supported by consultants from Homerton Hospital.

- The hospital dermatologist will not routinely prescribe emollients in an out-patient 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 prescribed and used, unless an alternative is clinically indicated and there are compelling clinical reasons to change. This should be stated in discharge summary.

PRESCRIBING IN CHILDREN UNDER 12 YEARS

Based on the clinical experience of hospital dermatologists, greasy based emollients are preferable in children.

These should be considered after engaging with parents / carers.
It is necessary to ensure adequate quantities for children are prescribed in primary care, as experience from hospital dermatologists indicates that families often do not use enough emollients.
Compliance should be checked.

Prescribers should advise that emollients should be easily available to use at nursery and school. Consider a greasy emollient for use at home and a lighter cream at nursery and school to aid adherence and improvement in outcomes.

PRODUCT SELECTION

- **Patient choice and compliance are important.**
- **There is no evidence from controlled trials to support the use of one emollient over another.**
- **Selection is based on**
    - The known physiological properties of emollients.
    - Patient acceptability / preference – patients will not use a product if they think it does not work or if it is unpleasant to apply, contributing to waste.
    - Dryness of the skin – understanding severity will govern product selection.
    - Correct hydration potency - generally “fairer” skins don't tolerate oily moisturisers whereas those with pigmented skins need much heavier emollients.
    - Area of skin involved.
    - Lowest acquisition cost.

LEAVE-ON EMOLLIENTS

EMOLLIENTS CONTAINING PARAFFIN

Paraffin-based products such as white soft paraffin (WSP) or emulsifying ointment can ignite easily by a naked flame. (NPSA alert 2007/8 Paraffin Based Emollients and Fire Risk)

This risk will be greater when these preparations are applied to large areas of the body and when clothing or dressing becomes soaked with the emollient. Patients should be told to keep away from fire or flames and not to smoke when using these preparations. The risk of fire should be considered when using large quantities of any paraffin based emollient. Bedding and clothing should be washed regularly to minimise the build-up of impregnated paraffin.

AQUEOUS CREAM

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 without the tendency to cause irritation.

BATH EMOLLIENTS

Bath emollients are non-formulary and are not recommended by C&H CCG due to the risk of falls.
An appropriate emollient (e.g. emulsifying ointment) should be used in warm bath water rather than a specific **bath emollient** product.
In exceptional circumstances when this is recommended (by a Dermatologist for a child), a cost-effective choice should be made e.g. NOT Aveeno® bath emollient.

OILVE 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 damage the skin barrier. Olive oil for the treatment of dry skin and infant massage should be discouraged.

Colloidal oatmeal containing emollients are borderline substances & may only be prescribed in accordance with the Advisory Committee on Borderline Substances (ACBS) for the clinical conditions agreed (see current BNF).

LEAVE-ON EMOLLIENTS

When choosing an emollient for a patient, how hydrating the very greasy emollients are should be considered, while remembering, how tolerable the watery emollients are.

LIGHT EMOLLIENTS — HEAVY EMOLLIENTS

Light or creamy	Opaque Gel	Rich cream / Ointment	Greasy	Very Greasy
FIRST LINE				
Epimax® Cream (500g Flexi-dispenser (no contamination issues)) (Like Aquamax. Same lipid content as Diprobase.) (Lanolin-free) £2.49	**Isomol ®** Gel (500g Flexi-dispenser (less wastage than a pump dispenser) (Like Doublebase.) £2.92	**Zeroderm ®** Ointment (500g Tub) (Like Epaderm + Hydromol Ointment) £4.10	**Emulsifying** Ointment (500g tub) (Like Hydrous Ointment) £2.12	**50:50** 50% White Soft Paraffin (WSP):50% Liquid Paraffin (LP) £2.21
SECOND LINE				
ZeroAQS® (500g Tub Cream) (Same as aqueous cream. A cost-effective alternative in primary care. Cheaper than Aquamax.) £3.29	**Zerodouble®** Gel (Tube / squeeze bottle 475g) (Like Doublebase Gel) £4.71	**Hydrous®** Ointment (500g Tub) (Like Emulsifying Ointment) £4.89	White Soft Paraffin (**WSP**)	£3.23
THIRD LINE				
Zerobase® Cream £5.26 **Aquamax ®** Cream (Contains lanolin) £3.99	**Doublebase®** Gel £5.83	**Diprobase®** Cream £6.23	**Hydromol®** Ointment £4.89	

Prices verified March 2017

ANTIMICROBIAL CONTAINING EMOLLIENTS

<table>
<tr>
<td rowspan="2">There is limited evidence to support use of antiseptic/antimicrobial containing emollients and routine use should be avoided.
Their use should be restricted to recurrent infections for limited periods only.
Please note, in selected cases, where recurrent infection is a contributory factor to relapse, they may play an important role in stabilising the patient's condition.</td>
<td>Antimicrobial containing emollients should be used for short periods of time AND only when clinically indicated.

FORMULARY FIRST LINE

Dermol 500 Lotion®</td>
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<tr>
<td>FORMULARY SECOND LINE

Dermol® Cream (prefered 2nd line choice).

Eczmol® Cream/Lotion</td>
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QUANTITIES OF EMOLLIENT PRESCRIBING IN ADULTS

There is wide inter-patient variability in response to treatments.

A small pack of the first line formulary emollient should be prescribed initially for the patient to determine if this is suitable for them. A larger quantity then can be considered after this point. For emollients, the general rule is 600g per patient per week.

It is vital that a patient with a diagnosed skin condition uses large quantities to keep their condition under control. **Do not prescribe emollients for patients with dry skin without diagnosed skin condition**, these patients should be encourage to purchase emollients over-the-counter.

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.

At all other times, emollients should be applied at least twice a day, aiming for 3 to 4 times a day depending on the extent of dryness.

NB. The more emollients are used, the less likely a steroid will be required.

SOAP SUBSTITUTES All emollients (except for white soft paraffin (WSP) alone) can be used as a soap substitute. 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. The patient information leaflets (PILS) of these products may not say that they can be used as soap substitutes. This should be discussed with the patient at the point of prescribing and can be emphasised by the community pharmacist.	**FORMULARY FIRST LINE** Emulsifying ointment Epimax® cream
	FORMULARY SECOND LINE ZeroAQS®
	FORMULARY THIRD LINE Aquamax® Any cream or ointment except 50:50 or WSP

UREA CONTAINING EMOLLIENTS

Urea-containing emollients are well suited to the care of large areas of skin (over long periods) in patients with atopic eczema. They should be avoided for use in minor dry skin and should not replace established emollients. It is recommended that such emollients are used as an add-on therapy to the regular emollient regimen, once or twice a day. In clinical practice, not all patients will tolerate urea- containing products. They can cause stinging and are also expensive.	**First Line** • Balneum Cream ® • Aquadrate ® • Hydromol Intensive® **Second Line** • Nutraplus • Calmurid - Used by paediatric hospital dermatologists for ichthyosis. - To be used with caution in patients with eczema. • Dermatonics® Once Heel Balm

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