Specials Recommended by the British Association of Dermatologists for Skin Disease

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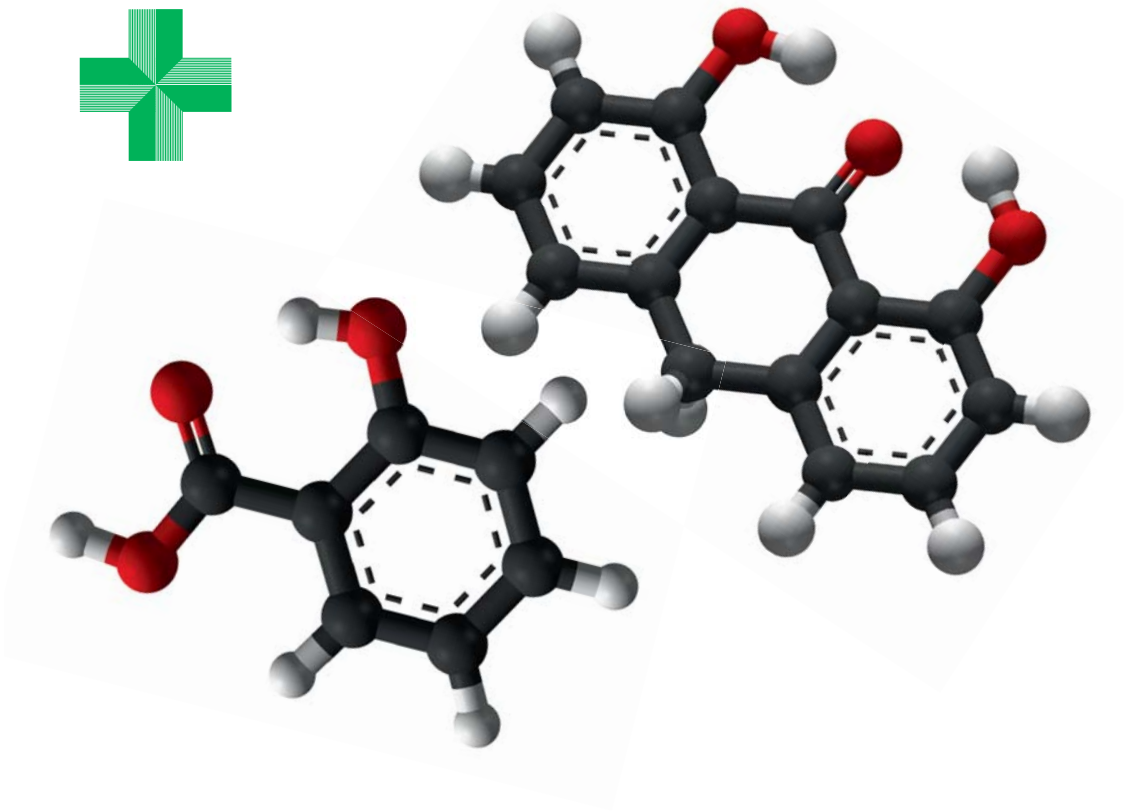

On behalf of the
BAD Specials Working Group

2018

BNF

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Abstract

Most prescribing uses licensed medicines whose safety and efficacy are assured. For many common dermatological diseases including psoriasis and eczema, the range of licensed medicines is limited. As a result, Dermatology prescribing may rely significantly on unlicensed creams and ointments (known as 'Specials') containing tars, dithranol, salicylic acid, steroids and other active constituents in a range of concentrations and bases. 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 optimise quality of care, adherence to the revised British Association of Dermatologists (BAD) list of preferred Specials (2018) is encouraged.

Keywords

Prescribing; Medicines Optimisation; GIRFT; Specials

This booklet can be accessed electronically at
www.bad.org.uk/specials

Background

The overwhelming majority of medical treatment is delivered by prescription of licensed medicines which have been approved for sale in the U.K. by a Marketing Authorisation (MA), formerly known as a Product Licence (PL), from the Medicines and Healthcare products Regulatory Agency (MHRA) or the European Medicines Agency (EMA). The core purpose of the regulatory process is rigorous assessment of quality, safety and efficacy. All licensed medicines must have an MA before they can be placed on the U.K. market.

For common dermatological conditions such as psoriasis and eczema, the range of appropriate licensed medicines may be limited, and prescribing can rely significantly on unlicensed creams and ointments (known as 'Specials') containing ingredients like tars, dithranol, salicylic acid, steroids and other active constituents in a range of concentrations and bases. Similarly, the range of licensed medicines such as oral liquids for groups of patients including babies, young children and older people unable to swallow tablets or capsules, or for whom the available strengths are not appropriate, is relatively limited. The small size of the potential market is a key factor. Investment in the development of licensed forms of these preparations is discouraged by the prohibitively high cost of development and because manufacturers view such products as unlikely to be profitable.

When suitable licensed medicines are not available, the Medicines Act allows doctors to prescribe and specify the formulation of any medicine which they judge to be essential to meet the patient's "special clinical need". Prescribers have a professional and ethical responsibility to prescribe an unlicensed medicine only when there is no available licensed product which meets the patient's clinical need.

There is significant clinical experience and circumstantial evidence of the efficacy of Specials in dermatological practice. Almost all practising clinicians will be familiar with patients having had a Special prescribed previously who have found it extremely effective, such that they and the patient are keen to continue treatment with it, in the continuing absence of a directly equivalent licensed product.

Many Dermatology Special creams and ointments used in the treatment of conditions like eczema and psoriasis have been prescribed with benefit for over 50 years, therefore, the evidence base for their use is almost entirely empirical and clinical trials are unlikely ever to be carried out. The potential for licensed versions of these products is limited by the difficulty of designing stable formulations with shelf lives of at least 3 years (the minimum usually necessary for commercial viability) and by lack of data on safety and efficacy derived from clinical trials, essential to meet regulatory criteria. The lack of consensus about optimum strengths, bases and formulations further compromises commercial potential.

Medicines are the most frequently and widely used NHS treatment and account for over 12% of NHS expenditure. The Medicines Value Programme and the Getting It Right First Time (GIRFT) are Department of Health and Social Care (DHSC) & NHS England strategies involving all English NHS staff, patients, clinicians and the voluntary sector. They aim to improve the quality and delivery of NHS care while reducing costs, and to make and re-invest savings to support frontline services. Pressure on the NHS to do more with less will continue.

Licensed and Unlicensed Medicines

Specials may be made in several ways. Most products used in secondary care are manufactured in hospital pharmacy facilities licensed and inspected by the MHRA. In terms of quality, safety and efficacy, the key differences between licensed medicines, batch-manufactured Specials, and extemporaneously dispensed medicines (bespoke Specials) are summarised in Table 1. Unlicensed medicines are often disproportionately expensive in primary care. The reasons for this are complex, but include the bespoke nature of these medicines, the absence of any legal control mechanism on manufacturing and dispensing fees, and financial incentives in community dispensing to seek preparations at higher cost.

ATTRIBUTES	LICENSED MEDICINE	SPECIAL	EXTEMPORANEOUSLY DISPENSED MEDICINE
How they are manufactured	Rigorously tested for quality, safety & efficacy; made in very large batches	Tested for quality but not for safety or efficacy; made in small batches	Not tested. Dispensed in single packs
Raw materials, process, packing, final product, storage and distribution	✓✓✓	✓✓✓	Variable
Formulation	✓✓✓	✓	Variable
Stability & Shelf-life	✓✓✓	✓	No Data
Labelling & PIL	✓✓	✓	Variable
Pack to pack consistency / Continuity	✓✓✓	✓✓	No Data
Indicative cost comparison in primary care	£	£££	££££

TABLE 1 Schematic comparison of cost and quality of licensed medicines, Specials and extemporaneously dispensed medicines; PIL: patient information leaflet

Specials and Dermatology

Until 2008 when the cost of Specials in primary care began to rise sharply (to £120m in England in 2009/10, of which up to £30m was topical medicines), their use in primary care attracted little attention. In 2018, detailed data on the range of Dermatology Specials prescribed by GPs remain poor. Since 2014, Clinical Commissioning Groups (CCGs) throughout England have in many cases prevented GPs from prescribing Dermatology Specials by making them 'Red' drugs, i.e. for hospital-only prescribing. This has been driven by cost concerns, rather than safety issues.

In secondary care, formulary and budgetary controls are strict and prescribing is consultant-led. Most Dermatology Specials are provided to secondary care from NHS Specials Manufacturing Units, which are more cost-effective. Even in secondary care there have been some problems with patients accessing Specials, leading to clinician de-skilling and a shift towards the use of costly and potentially more toxic immunosuppressants.

NHS hospital pharmacy manufacturing units in 2012 were routinely making at least 95 different products containing coal tar and 75 containing dithranol. In 2013, the BAD was concerned that, despite their previously recommended list of 106 Specials (2008), slight differences in prescribing preferences were resulting in the use of many slightly different products (Table 2). This variety was making all Specials more difficult for patients to access. Since the publication of the BAD 2014 revised and shortened list of 40 Specials, there has been a shift towards rationalised prescribing and batch manufacture, but there is still variation in prescribed formulations, which in turn increases costs.

PRIMARY ACTIVE INGREDIENT	NUMBER OF PRODUCTS ROUTINELY MANUFACTURED BY HOSPITALS IN 2012	NUMBER OF PRODUCTS RECOMMENDED ON BAD LIST		
		2008	2014	2018
Tar	95	27	6	5
Dithranol	75	22	9	8
Salicylic acid	123	18	6	4
Steroid	31	7	4	5

TABLE 2 Comparison of numbers of products routinely made by NHS hospitals and those recommended by the BAD in the 2008, 2014 and 2018 lists

The BAD set up a Specials Working Group in 2013 which included representatives of the Department of Health, Clinical Reference Groups, CCGs, The Royal College of General Practitioners, The Primary Care Dermatology Society, The Royal Pharmaceutical Society, The British National Formulary, patient support groups and consultant dermatologists. The Working Group has since changed its name to the Medicines Working Group and extended its membership to representatives of the Royal College of Paediatrics and Child Health, Royal College of Ophthalmologists, the Association for Palliative Medicine, the Society of Oral and Mucosal Medicine, the Society for Metabolic Medicine and the Endocrine Society. Currently, it is collaborating with the Royal College of Physicians, the National Audit Office, NHS Improvement and the Department of Primary Health Care Sciences at the University of Oxford.

Following a survey of all U.K. consultant dermatologists in 2013, a much-abbreviated list of 40 BAD preferred Specials was agreed on by the Working Group in 2014 and published both on the BAD website and in booklet form. This was widely adopted by local formulary groups in England for prescribing in secondary care. Following a further membership survey in 2017 and review of the availability of new licensed products, the preferred list has been updated again in 2018. For example, glycopyrronium bromide liquid is now licensed at 5 mg/5 ml and can be diluted for iontophoresis, so this has been removed; coconut compound ointment is now widely and cheaply available at pharmacies and has been deleted; and OrabaseTM protective paste is now classified as a medical device and is on the Drugs Tariff. It is expected to become available again as a licensed medicine in 2019.

It is hoped that adherence to this new BAD Specials List 2018 in prescribing will allow patients easier access to these treatments, at less cost to the NHS.

Secondary Care and Primary Care

In secondary care, long-established acceptance of local formularies, a comprehensive pharmacy infrastructure and closely-monitored departmental budgets mean that choice of medicine is influenced at the point of prescribing, steps are taken locally to verify the quality of all medicines – whether purchased or locally made – and costs are closely monitored.

In primary care, GPs rely primarily on electronic prescribing software to guide their choice of medicines. Only a minority of Specials is currently listed by prescribing software, although the Working Group has made every effort to have the BAD-preferred Specials listed. GPs who used to prescribe Dermatology Specials based on previous experience, local consultant prescribing and information from the patient, are now largely prevented from doing so by local CCGs. This results in either the patient being denied their medicine, or the costs being transferred to secondary care. It is now very unusual for community pharmacists to "extemporaneously dispense" unlicensed medicines in the pharmacy. Instead, when an order from a community pharmacy is placed, Specials are made to order by Specials manufacturers and delivered to the pharmacy via a third-party wholesaler or distributor. The community pharmacist's choice of supplier is likely to be influenced by company policy, by historical purchasing patterns and by speed of promised delivery.

The England and Wales Specials Drug Tariff Part VIIIB was introduced in November 2011 to seek evidence of product quality and as a mechanism to control cost. The current list, regularly revised, includes only a few of the BAD's preferred Specials, but also a number of other non-preferred dermatological preparations. The products it lists seem to have been chosen originally on the basis of frequency of prescription and cost to the NHS (in primary care) rather than on the basis of clinical preference. It remains the aim of the Working Group implementing the new BAD Specials List 2018 that all 39 preparations listed will be referred to in the Drug Tariff in the correct base, and that preferred lists for our partner medical specialties will also be listed. The England and Wales Tariff prices for Dermatology Specials far exceed the price for which such items are available from NHS suppliers. Scotland has its own Tariff-setting system, and a low Tariff price for the same items, due to strict cost-control measures. The Drugs Costs Bill 2017 (England and Wales) has the ultimate intention of controlling costs similarly, but no mechanism has been agreed yet. The DHSC is hoping to introduce into legislation a method of cost control for Specials in 2019, which could include a 'best value' quote system or central procurement.

Rationalisation of the range of Dermatology Specials prescribed in primary and acute care offers patients and the NHS a range of benefits but may also be gradually forced on healthcare providers by external factors beyond their direct control: accessing raw materials like dithranol and coal tar can be difficult, and costs have increased. If preparation of Specials can be limited to a few specialist manufacturing units, costs can be reduced due to bulk buying and manufacture.

The BAD remains very concerned about the cost of Specials in primary care, and the Working Group is working closely with parliamentarians to address this issue. We encourage CCGs, GPs, Dermatology nurse specialists and pharmacists to work with local clinical colleagues in primary and secondary care to encourage adoption, and further development, of the BAD Specials List 2018 to reflect expert clinical opinion accurately.

1.	Treatment more readily available to patients with shorter access time
2.	Reduced price variability between manufacturers; better value for money
3.	Fewer bespoke products and greater reliance on quality-assured, batch-manufactured Specials with increased shelf life
4.	Prescribing simplified, and risk of error reduced
5.	Increased opportunity for new licensed products
6.	Medicines Value Programme /GIRFT objectives achieved

TABLE 3 Benefits of adhering to the BAD Specials List 2018

1.	Encourage use of licensed medicines whenever they will provide empirically demonstrated benefit without increasing either toxicity or overall costs
2.	Prescribe Dermatology Specials only from the BAD list except in special circumstances, and/or encourage colleagues locally and nationally to do likewise
3.	Feedback to the BAD via the link on their website about desired changes (additions or deletions), to influence reviews of the list
4.	Raise awareness of the BAD list with colleagues in primary & secondary care and with commissioners.
5.	Encourage colleagues to develop and implement a local joint Dermatology formulary (primary and secondary care) including Specials

TABLE 4 How all healthcare practitioners can help to achieve these benefits for patients and the NHS

The authors wish to thank the BAD, all members of the BAD Medicines Working Group, past and present, and their affiliated organisations.

Current members of the BAD Medicines Working Group

Deirdre Buckley, Chair	Consultant Dermatologist, Bath
David Eedy, *BAD Past President*	Consultant Dermatologist, Craigavon Area Hospital Group Trust
Simon Bath	Production Manager, Tayside Pharmaceuticals, Dundee
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Archana Pradeep	Quality and Safety Group, Royal College of Ophthalmologists
Stephen Tomlin	Consultant Pharmacist, Lead for the Children's Medicines Service, Evelina Children's Hospital, London
Robin Lachmann	Consultant in Inherited Metabolic Disease, The National Hospital for Neurology and Neurosurgery, London
Aoife Gleeson	Consultant in Palliative Medicine, Aneurin Bevan University Health Board, representing the Association for Palliative Medicine
Jane Setterfield	Consultant Dermatologist with interest in Mucosal Disease, St Johns Institute of Dermatology
John Wass	Professor of Endocrinology, Oxford University Hospitals NHS Foundation Trust
Emma Quinn	Medicines Management Information Co-ordinator, Health and Social Care Board, Northern Ireland
Carla Renton	Information and Communications Manager, Psoriasis Association
Berkeley Greenwood	All-Party Parliamentary Group on Skin

BAD SPECIALS LIST 2018

Prescribing guidance and volumes

EMOLLIENTS AND BARRIERS

Propylene glycol 20% w/w in aqueous cream	**100 g**
As a moisturiser, to use on very dry skin conditions, including on the palms and soles. Works well as a barrier, enhances penetration of other treatments like topical steroids. Use when urea-based preparations, e.g. Eucerin® and Aquadrate®, are ineffective, unsuitable or not tolerated.	
Propylene glycol 40% w/w in aqueous cream	**100 g**
As a moisturiser, to use on very dry skin conditions, including on the palms and soles. Works well as a barrier, enhances penetration of other treatments like topical steroids. Use when urea-based preparations, e.g. Eucerin® and Aquadrate®, are ineffective, unsuitable or not tolerated.	
Propylene glycol 50% w/w in water	**100 ml**
As a humectant, to use on very dry skin conditions, including hereditary hyperkeratotic diseases. Works well as a barrier, enhances penetration of other treatments like topical steroids. Use when urea-based preparations, e.g. Eucerin® and Aquadrate®, are ineffective, unsuitable or not tolerated.	

STEROID COMBINATIONS

Salicylic acid 5% w/w / propylene glycol 47.5% w/w in clobetasol propionate 0.05% (Dermovate®) cream	**100 g**
Very potent steroid; propylene glycol increases penetration of clobetasol propionate (Dermovate®). To use on the palms and/or soles for hyperkeratotic eczema, palmoplantar pustulosis and psoriasis where it is persistent, severe and not responding to clobetasol propionate (Dermovate®) and emollients alone. It can be used once daily under occlusion for short periods (a maximum of 2 weeks) and then without occlusion for a few weeks more. Keep the frequency of application to a minimum to reduce the risk of atrophy and tachyphylaxis. Please see NICE guidelines on psoriasis (all ages) and atopic eczema (children and young people) for advice on safe appropriate use of corticosteroids. http://guidance.nice.org.uk/	
Propylene glycol 40% w/w in clobetasol propionate 0.05% (Dermovate®) Cream	**100 g**
Very potent steroid. Use for severe inflammatory disease without hyperkeratosis, or at sensitive skin sites e.g. the vulva.	
Coal tar solution BP 5% w/w in betamethasone valerate 0.025% w/w ointment	**100 g**
Use for moderate to severe psoriasis of the trunk and limbs when other treatments such as Vitamin D analogues have been ineffective. Apply directly to affected skin once or twice daily (often as a night-time treatment) for 2-4 weeks then decrease the frequency of application. Use with caution if the skin is very inflamed or if there are pustules, as tar can be an irritant.	

Coal tar solution BP 3.3% w/w and propylene glycol 20% w/w in fluocinolone acetonide 0.025% (Synalar®) gel	**100 g**
Use for very inflamed hyperkeratotic scalp psoriasis. Massage it into the affected scalp, leave for 1-3 hours then shampoo out. Best done in the evenings.	
Beclomethasone dipropionate 0.0025% w/w in WSP BP ointment (formerly known as Propaderm® 1 in 10)	**100 g**
Mild steroid used for severe and resistant atopic eczema in children. For once or twice daily application, usually under wet wraps.	

TARS

We would like to remind colleagues that there are three different Coal Tar products listed in the BP. These three products are NOT treated by pharmacy staff as interchangeable. It is up to the prescriber to specify in full the ingredients of the product they want.

- Coal Tar BP (also known as Crude Coal Tar) is the undiluted natural substance
- Coal Tar Solution BP is a solution of 20% Coal Tar BP in alcohol BP
- Coal Tar Solution, Strong BP is a solution of 40% Coal Tar BP in alcohol BP (with added polysorbate as surfactant)
- A product such as Coal Tar Solution BP 5% in Yellow Soft Paraffin contains the equivalent of Coal Tar BP 1%
- A product such as Coal Tar Solution, Strong 5% in Yellow Soft Paraffin contains the equivalent of 2% Coal Tar BP
- A product such as Coal Tar BP 5% in Yellow Soft Paraffin contains the same amount of Coal Tar BP as Coal Tar Solution 25% in Yellow Soft Paraffin or Coal Tar Solution, Strong BP 12.5% in Yellow Soft Paraffin

Coal tar scalp application ('coal tar pomade'; coal tar solution BP 6% w/w / salicylic acid 2% w/w in emulsifying ointment)	**100 g**
Coal tar BP 2% w/w in YSP	**100 g**
Coal tar BP 5% w/w in YSP	**100 g**
Coal tar BP 10% w/w in YSP	**100 g**
Coal tar solution BP 6% w/w and salicylic acid 6% w/w in Ung. Merck	**100 g**

These preparations are used for moderate to severe chronic plaque psoriasis, including in day treatment centres at Dermatology departments:

- when other topical treatments such as Vitamin D analogues and the commercial tar preparation Exorex® 5% lotion (100 ml, £8.11) have been ineffective or unsuitable
- where phototherapy is less effective (e.g. lower leg)
- where the patient does not wish to take or is unsuitable for systemic treatment.

Tar may be combined with phototherapy. It may be used at home; patients should be provided with detailed information and education on its use. Tars are anti-inflammatory and anti-pruritic.

Apply directly on affected skin once or twice daily for 2-4 weeks, beginning at lower concentrations and increasing the strength of tar, if necessary, once the lower strengths have been tolerated in terms of irritation, staining of clothes and smell. Can be used intermittently or continuously if well-tolerated. Avoid use if the skin is very inflamed or if there are pustules, as tar can be an irritant. Tar preparations can be applied under occlusion, but it may increase the risk of irritation. Long-term use of tar is safe, with the main drawback being cosmetic acceptability and possible irritancy. Tar scalp application (pomade) is massaged into scalp at 1 cm intervals and washed out with shampoo after 12-24 hours.

ICHTHAMMOL

Ichthammol 1% w/w and zinc oxide 15% w/w in YSP	**200 g**

Ichthammol is used to treat acutely inflamed atopic eczema. It is also used in paste bandages (Ichthopaste® £3.45) for chronic lichenified eczema. Treatment is often initiated at Dermatology day treatment centres but may be continued in the community. Apply twice daily until inflammation settled.

DITHRANOL PREPARATIONS

Dithranol in Lassar's paste 0.1% w/w	**100 g**
Dithranol in Lassar's paste 0.5% w/w	**100 g**
Dithranol in Lassar's paste 1% w/w	**100 g**
Dithranol in Lassar's paste 2% w/w	**100 g**
Dithranol in Lassar's paste 4% w/w	**100 g**
Dithranol in Lassar's paste 10% w/w	**100 g**
Dithranol in Lassar's paste 15% w/w	**100 g**
Dithranol scalp application 0.4% w/w ('dithranol pomade'; dithranol 0.4% w/w, salicylic acid 2% w/w, emulsifying wax BP 25% w/w, liquid paraffin to 100%)	**100 g**

Dithranol in Lassar's paste (a combination of salicylic acid and zinc oxide) is effective in moderate to severe chronic plaque psoriasis:

- when other topical treatments (vitamin D analogues, commercial tar preparations and commercial dithranol preparations, e.g. Dithrocream®) have been ineffective or unsuitable
- where phototherapy is contraindicated or less effective, e.g. lower leg
- where the patient does not wish to take or is unsuitable for systemic treatment

It may be combined with phototherapy. Treatment is often initiated at Dermatology day treatment centres but may in some cases be continued by patients at home once they have been instructed how to use it safely.

Dithranol cannot be used when plaques are very inflamed, excoriated or have pustules. Treatment should start with the lowest concentration applied on thick plaques once daily, using it for 30 to 60 minutes and then washing it off. Every few days, the concentration can be gradually increased depending on tolerance and any irritant effects, until the plaques are completely impalpable. The skin will have brown staining, which will fade once treatment has been discontinued.

Dithranol can be used as long contact treatment for more than one hour; this is usually done under nursing supervision under a tubular dressing. The lower concentrations may be left for increasing periods more safely once treatment is established and tolerance time known.

Dithranol can irritate healthy skin. It stains the skin, clothing and shower or bath surfaces. It is a safe and effective treatment, suitable for long-term use, continuous or intermittent.

Dithranol scalp application (pomade) is to be applied to scalp psoriatic plaques, left for 20-60 minutes and then washed off.

KERATOLYTICS

Salicylic acid 2% w/w and sulfur 2% w/w in aqueous cream	**100 g**
Salicylic acid 5% w/w in emulsifying ointment	**100 g**
Salicylic acid 10% w/w in emulsifying ointment	**100 g**
Salicylic acid 20% w/w in emulsifying ointment	**100 g**

Salicylic acid softens keratin and makes scales easier to remove; the effects are concentration-dependent. Higher concentrations can irritate or burn normal skin.

Use for hyperkeratotic psoriasis, hyperkeratotic eczema, viral warts, lichen simplex, ichthyosis, keratodermas, callus, keratosis pilaris and other hyperkeratotic conditions where emollients and commercial preparations are ineffective. Commercial preparations may be urea-based (e.g. Calmurid® £5.70) or salicylic-acid based (e.g. Salactol™ paint (16.7% salicylic acid with 16.7% lactic acid; 10 ml, £1.71) or Verrugon® ointment (50% salicylic acid; 6 g, £4.44)). There are also commercial preparations of 2% salicylic acid in emulsifying ointment which contain wool alcohols (lanolin) (£8.08/450 g). Salicylic acid 2% with sulfur 2% in aqueous cream is a helpful treatment for facial seborrhoeic dermatitis.

ORAL AND MUCOSAL PREPARATIONS

Tacrolimus 0.1% w/w in Orabase™	**50 g**
Tacrolimus 0.3% w/w in Orabase™	**50 g**
Triamcinolone acetonide 0.1% w/w in Orabase™	**50 g**

Use for ulcerative and erosive inflammatory and mucosal skin disease including around stomas.

Orabase™ protective paste has been deleted from the list; it is now classified as a medical device and is available cheaply; currently, it is on the Drug Tariff at £2.16 per 30 g.

MISCELLANEOUS

Diphenylcyclopropenone in acetone 0.00001-6.0% w/v	**10 ml**

Diphenylcyclopropenone (DCP) is a highly sensitising agent used to treat alopecia areata and resistant viral warts as topical immunotherapy. It should be applied only in Dermatology departments by a trained professional. Applying it to the patient's skin carries a risk of sensitising the person carrying out the treatment. Bottles should be handled wearing protective gloves.

Glycopyrrolate 2% w/w in cetomacrogol cream	**100 g**

Use to treat disabling facial hyperhidrosis. Apply to affected sites twice daily. Do not order glycopyrrolate 0.05% w/v in water 250 ml as a Special; use the licensed 5 mg / 5 ml preparation of glycopyrrolate and dilute appropriately. Use with an iontophoresis machine to treat hyperhidrosis.

Hydroquinone 5% w/w, hydrocortisone 1% w/w and tretinoin 0.1% w/w in a non-aqueous gel	**100 g**

Use to treat melasma, in conjunction with a strong sunscreen. Do not use for more than 6 months due to the risk of ochronosis. A commercially available similar preparation may be obtained called Pigmanorm® (price range from £52.36 to £144.46 per 15 g pack).

Reflectant (Dundee) sunscreens – coffee, coral pink, beige	**50 g**

Used to treat photosensitivity disorders where the patient is sensitive to visible light, most commonly solar urticaria and porphyrias, particularly erythropoietic protoporphyria.

Eosin solution 2% w/v	**100 ml**

Used for ulcerative, erosive or weeping wounds, or inflammatory skin disease, including around stomas. Apply when dressing or device is changed.

Sucralfate 4% in emulsifying ointment	**50 g**
Use for flexural healing wounds. Especially useful in rectal or gynaecological cancer patients, post-radiotherapy and chemotherapy. Also useful for peristomal and perianal erosion and leaking fistulae. Can be used concomitantly with topical corticosteroids. A commercial cicalfate cream may be purchased at pharmacies.	
Sirolimus 0.1% in WSP	**30 g**
Sirolimus 0.5% in WSP	**30 g**
Use for facial angiofibromata in tuberose sclerosis. Start at 0.1% concentration in infants and at 0.5% in teenagers with thicker lesions. In females of childbearing age, use the higher strength with caution, as there may be some systemic absorption.	
Phenol 2% w/w in compound zinc paste BP	**50 g**
Used for intractable pruritus ani, unresponsive to moderate strength topical steroid and barrier preparations.	
Trichloroacetic acid 90% w/w	**10 ml**
Used to destroy facial xanthelasmata; highly irritant.	

Notes

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