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Approved by the Fife Area Drug and Therapeutics Committee

Introduction

Community Pharmacy Minor Ailment Service

All conditions being treated should be minor ailments. Minor ailments are generally described as common, often self limiting conditions. They normally require little or no medical intervention and can be managed by self care and the use of products that are available to buy without a doctor's prescription.

Chronic and potentially more serious illness, requiring medical attention, should be referred to a GP. Pharmacists should be alert to those patients presenting with symptoms of an underlying disease. Each individual must be assessed and a clinical judgement made on the most appropriate treatment pathway followed. As in any consultation, general lifestyle advice should also be offered where appropriate.

Medicines included in Minor Ailment Service

A national formulary for the Minor Ailment Service (MAS) based on the BNF is the reference point for payment purposes for products provided under the MAS.

Medicines which are available for prescribing by community pharmacists include:

- all Pharmacy (P) and General Sales List (GSL) medicines in the Scottish Drug Tariff that are not blacklisted
- dressings and appliances from Part 2 of the Drug Tariff
- selected items from Part 3 of the Drug Tariff
- prescription Only Medicines (POMs) which are underpinned by a series of national core Patient Group Directions (PGDs).

Blacklisted Pharmacy (P) and General Sales List (GSL) medicines

The Black List (Schedule 10) is published at www.psd.scot.nhs.uk. Scroll down to pictures – choose pharmacists, then pharmacy guidance and then schedule 10 guidance.

Alternatively if you are a pharmacy contractor, the latest blacklisted medicines can be found at www.communitypharmacy.scot.nhs.uk

Allowable items from the Drug Tariff

Items from Part 3 Scottish Drug Tariff which are prescribable are listed below:

- Bug Buster Head Lice detection and eradication kit
- Nitty Gritty Nit Comb
- Sodium Chloride (saline) nasal drops
- Sodium bicarbonate ear drops 10ml
- Saliva preparations.

NHS Fife Minor Ailment Service (MAS) Formulary

This document has been developed to:

- provide a formulary list which complies with the Fife Joint Formulary
- provide a list of medicines for which there is an evidence base
- provide guidance to facilitate consistency of prescribing choices
- provide a smaller range of medicines, allowing prescribers to become more familiar with their indications and contra-indications
- assist in making appropriate and cost-effective choices.

The formulary provides pharmacists with a recommended list from which a variety of minor ailments can be treated. Most entries are listed by generic drug name due to the difference of branded preparation available in pharmacies. The medicines listed should be used within their P or GSL licensed indication. The formulary is not exhaustive and other P and GSL medicines can be used for the treatment of minor ailments using the professional judgement of the pharmacist. The formulary will be reviewed and updated annually.

The formulary is arranged according to BNF category and includes the following information:

> Recommended first and second line options.
> Drug entries listed alphabetically.
> Suggested quantities to be prescribed.
> Generic advice comments relating to the ailment or medicines.
> Some examples of counselling points.
> Some sections with examples of when referral to a GP should be considered.

Useful contacts

Any comments regarding the formulary and queries about inclusions or omissions should be directed to your Pharmacy Champion. A formulary submission form is included at the back of the formulary to request the addition of an item to the formulary.

Pharmacy champions

Fiona Eastop
Kirkcaldy and Levenmouth area
tel: (Mon, Tues and Sat) 01592 873725
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West Fife area
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New Community Pharmacy ePharmacy Programme website
www.communitypharmacy.scot.nhs.uk/index.htm

IM&T Facilitator
Dawn Balfour
tel: 01592 226928
fax: 01592 714240
email: dbalfour@nhs.net

For all ePharmacy Minor Ailment Service (MAS) enquiries, contact Practitioner Services Department (PSD) on 0131 275 6600.

For all technical enquiries, please contact your PMR supplier.

For any stationary supplies, contact Primary Care Supplies, Primary Care Department, Cameron Hospital, Windygates Tel. 01592 226766 and request Pharmaceutical Monthly Order Form.

1 Gastrointestinal system

1.1 Dyspepsia and gastro-oesphageal reflux disease

Indigestion

First choice: Co-magaldrox SF (Maalox® or Mucogel®)
Second choice: Gaviscon® Advance products

1.1.1 Antacids and simeticone

Gastrocote® tablets	100
Gaviscon® Advance liquid	Up to 500 ml
Gaviscon® Advance tablets	60
Infacol®	50 ml
Maalox® suspension	500 ml
Mucogel® suspension	500 ml

1.2 Antispasmodics and other drugs altering gut motility

Hyoscine butylbromide 10mg tablets (Buscopan IBS®)	20
Mebeverine 135mg tablets (Colofac IBS®)	15
Peppermint oil 0.2mg capsules (Colpermin®, Mintec®)	20 or 100, 84

1.3 Ulcer healing drugs

1.3.1 H_2-receptor antagonists

Ranitidine 75mg tablets	4 or 8

Good practice points

- Normal lifestyle advice is necessary, e.g. weight loss, smoking, alcohol.
- Liquid antacids are more effective than tablets.
- Ranitidine should only be used short term. If problems persist, refer to GP.
- Compound alginates preparations are less powerful antacids than co-magaldrox but may be more effective for heartburn.

Examples of counselling points

- Avoid large meals, eat little and often.
- Do not rush your food.
- Avoid spicy and greasy foods as they can often worsen heartburn.
- Some heartburn remedies can stop other medicines form working. Check if the heartburn remedy would interfere with other medicines.

When to advise patient to contact their GP

> Symptoms suggestive of underlying disease, e.g. progressive difficulty swallowing, progressive unintended weight loss or sudden onset of symptoms, coughing up blood, blood in vomit or stools.
> Symptoms are persistent (longer than 5 days) or recurrent.
> Pain is severe or radiating.
> Pain worsens on effort.
> Persistent vomiting.
> Adverse drug reaction is suspected.

1.4 Acute diarrhoea

First choice: **oral rehydration salt sachets**
Second choice: **loperamide**

Oral rehydration salt sachets, e.g. Dioralyte®	6/20

1.4.2 Antimotility drugs

Loperamide 2mg capsules	12

Good practice points

> First-line treatment of acute diarrhoea is rehydration therapy.

Examples of counselling points

> The diarrhoea normally stops within 48–72 hours without treatment.
> Replacement of fluids is of particular importance especially in children and the elderly.

When to advise patient to contact their GP

> Adults and children >3 years: diarrhoea of duration of greater than 3 days.
> Children 1–3 years: diarrhoea of duration of greater than 2 days.
> Children < 1 year: diarrhoea of duration of greater than 1 day.
> In severe cases referral should be recommended immediately.
> Association with severe vomiting and fever.
> Suspected drug-induced reaction to prescribed medication.
> History of change of bowel habit.
> Presence of blood or mucus in stools.
> Patients with chronic diarhhoea.

1.6 Laxatives

Constipation (acute)

First choice: **senna**
Second choice: **glycerin or bisacodyl supps**

Constipation (chronic)

First choice: **ispaghula husk sachets**
Second choice: **senna or lactulose**

1.6.1 Bulk-forming laxatives

Ispaghula Husk sachets	10/30

1.6.2 Stimulant laxatives

Bisacodyl tablets	20
Bisacodyl suppositories	12
Glycerin suppositories	12
Senna liquid	100 ml
Senna tablets	20

1.6.4 Osmotic laxatives

Lactulose solution	300 ml

Good practice points

> Normal counselling advice on diet/exercise is necessary.
> Constipation in children normally requires a GP referral.

Examples of counselling points

> Drink more fluids but no tea, coffee, cola or alcohol.
> Never put off going to the toilet when you know you need to go.
> Ispaghula sachets should not be taken immediately before going to bed.
> Lactulose may take up to 48 hours to act.

When to advise patient to contact their GP

> Persistent change in bowel habit.
> Presence of abdominal pain, vomiting, bloating.
> Blood in stools or melaena.
> Prescribed medication suspected of causing symptoms.
> No relief of symptoms within 7 days.

1.7 Local preparations for anal and rectal disorders

Haemorrhoids

First choice: **Anusol®**
Second choice: **Anusol Plus HC®**

1.7.1 Soothing haemorrhoidal preparations

Anusol® cream	23 g
Anusol® ointment	23 g
Anusol® suppositories	12

1.7.2 Compound haemorrhoidal preparations with corticosteroids

Anusol Plus HC® ointment	15 g
Anusol Plus HC® suppositories	12

Good practice points

> Patients should be advised to increase their fluid and fibre intake to avoid hard stools.

> Good toilet hygiene is important.

Examples of counselling points

> Increase your fluid intake, not tea, coffee, cola or alcohol.

> Increase your fibre intake.

> Take some form of regular exercise.

> Do not strain when you go to the toilet – try to relax.

> Treatment should be for no longer than 7 days with hydrocortisone products.

When to advise patient to contact their GP

> Symptoms suggestive of underlying disease, e.g. profuse bleeding, blood in the stools or melaena, extremely painful haemorrhoids, anaemia-like symptoms, change in bowel habit towards looser stools and/or increased stool frequency persisting 6 weeks or more (especially in middle age or elderly).

> Duration of longer than 3 weeks.

> Change of bowel habit (persisting alteration from normal bowel habit).

> Suspected drug-induced constipation.

> Associated abdominal pain/vomiting.

3 Respiratory system

3.4 Antihistamines, hyposensitisation and allergic emergencies

Allergy

Non sedating antihistamines

First choice: **cetirizine**
Second choice: **loratidine**

Sedating antihistamines

First choice: **chlorphenamine**

3.4.1 Antihistamines

Non sedating

Cetirizine 10mg tablets	7/30
Cetirizine oral solution 5mg/5ml	70 ml
Loratidine 10mg tablets	7/30
Loratidine syrup 5mg/5ml	100 ml

Sedating

Chlorphenamine 4mg tablets	30
Chlorphenamine oral solution 2mg/5ml	150 ml

Also see Nasal allergy (12.2.1) and Eye - Other anti-inflammatory products (11.4.2).

Good practice points

> Acute urticaria is usually self-limiting, and if mild, treatment is often unnecessary. Oral antihistamines are useful. Sedating oral antihistamines may be particularly helpful if sleep is disturbed.

> Drowsiness is a significant side effect of sedating antihistamines.

> Drowsiness is rare with non sedating antihistamines, however it can occur and may affect performance of skilled tasks and excess alcohol should be avoided.

Examples of counselling points

> For hayfever, start taking before season starts and continue throughout. Advise to go to GP for regular prescription if required.

> Avoid going out when the pollen count is high.

When to advise patient to contact their GP

> Wheezing or shortness of breath, tightness of chest.

> Persisting painful ear or sinuses.

> Purulent conjunctivitis.

> No improvement in symptoms after 10 days.

3.8 Aromatic inhalations

Menthol crystals	5 g

Examples of counselling points

> Ensure correct directions for use are given and that awareness is raised over the dangers of using boiling water.

3.9 Cough preparations

First choice: **no treatment**

Good practice points

> None of the remedies available for the management of cough (cough suppressants, expectorants or demulcents) are proven to provide any benefit.

Simple SF linctus	200 ml
Simple paediatric SF linctus	Up to 200 ml
Pholcodine SF linctus	200 ml
Pholcodine paed. SF linctus	Up to 200 ml

Good practice points

> All recommended liquids should be sugar-free if at all possible.

> Pholcodine linctus may be indicated for dry or painful cough if sleep is affected.

Examples of counselling points

> Drink plenty of fluids.

> Chesty coughs can last up to two weeks whilst dry coughs can continue for three to four weeks.

> Smokers can suffer more with their coughs, advice can be given on smoking cessation.

When to advise patient to contact their GP

> Persistent cough with alarm symptoms, e.g. weight loss, fluid retention, wheezing.

> Cough lasting 2 weeks or more.

> Sputum yellow, green, rusty or blood stained.

> Chest pain.

> Shortness of breath.

> Whooping cough or croup.

> Recurrent nocturnal cough.

> Suspected adverse drug reaction (e.g. ACE inhibitors).

3.10 Systemic nasal decongestants

Also see section 12.2.2 Topical Nasal decongestants.

Pseudoephedrine 60mg tablets	12*

* MHRA has restricted the quantity of pseudoephedrine to a total of 720mg due to concerns about its abuse in production of amphetamine-like agents. This is an interim measure until reclassification as a POM in 2009.

Good practice points

> Systemic decongestants provide short-term relief of congestive symptoms (3–10 hours).

Examples of counselling points

> Inhalation of warm, moist air can be useful in the management of symptoms.

4 Central nervous system

4.6 Drugs used in nausea and vertigo

Cinnarizine 15mg tablets (Stugeron®)	15
Domperidone 10mg tablets (Motilium 10®)	10
Prochlorperazine 3mg buccal tablets (Buccastem M®)	8

Good practice points

> Anti-emetics should be prescribed only when the cause of vomiting is known otherwise they may delay diagnosis, particularly in children.

> The drug should be chosen according to the aetiology of vomiting.

> Nausea during the 1st trimester of pregnancy does not generally require drug therapy.

Examples of counselling points

> Anti-emetics may cause drowsiness.

> Anti-emetics used to treat motion sickness are best taken prophylactically.

When to advise patient to contact their GP

> Severe nausea and vomiting during pregnancy.

> Prolonged vomiting of unknown cause.

> Vomiting lasting more than 48 hours and not responding to treatment.

> Adverse drug reaction due to an anti-emetic.

> Problems with swallowing (dysphagia).

4.7 Analgesics

Mild pain

First choice: **paracetamol or ibuprofen**

Mild to moderate pain

First choice: **paracetamol + ibuprofen**

Non opioid analgesics

Paracetamol 500mg tablets	Up to 96
Paracetamol oral suspension SF 120mg/5ml	Up to 200 ml
Paracetamol oral suspension SF 250mg/5ml	Up to 200 ml

Compound analgesics

Co-codamol 8/500 mg tablets	32

Also see section 10.1.1 Non-steroidal anti-inflammatory drugs.

4.7.4 Antimigraine drugs

Analgesics with anti-emetics

Migraleve Pink tablets	12 or 24

Good practice points

> There is significant potential for accidental overdose. Prescribers should be aware that the patient may be taking other analgesic preparations (prescribed, OTC or 'borrowed').

> Paracetamol is preferable to ibuprofen in the elderly.

> Co-codamol 8/500mg tablets are no more effective than paracetamol.

> Compound analgesics may produce opioid side-effects and complicate the treatment of overdose.

Examples of counselling points

> Rest is essential to allow the injury to recover.

> Cold packs should be applied to reduce swelling and bruising.

> The area should be elevated if possible to remove fluid from area of injury.

When to advise patient to contact their GP

> Headache associated with injury/trauma.
> Severe headache of more than 4 hours duration.
> Suspected adverse drug reaction.
> Prolonged headache in children under 12 years old.
> Severe occipital headache (across the back of the head).
> Headache is worse in the mornings and then improves.
> Associated drowsiness, visual disturbances, neck stiffness or vomiting.

5 Infections

5.2 Antifungal drugs

Impetigo See section 13.11.6.

Vaginal candidiasis (thrush)

First choice: **clotrimazole pessary ± clotrimazole cream**
Second choice: **fluconazole**

See section 7.2.2 for topical treatment of vaginal and vulval infections.

Fluconazole 150mg tablets*	1

* National PGD in place to allow supply of 1 capsule POM pack.

5.5 Anthelmintics

5.5.1 Drugs for threadworms

First choice: **mebendazole**

Mebendazole 100mg tablets	1 per infected person
Piperazine with sennosides oral powder	1 pack (2) per infected person

Good practice points

> Personal hygiene before eating and after toileting should be emphasised. If re-infection is suspected It is beneficial to give a second dose after 2 weeks. All family members should be treated at same time even if they have no symptoms.
> Mebendazole is not licensed for children under two years; piperazine salts are less effective but licensed for this age group.

Examples of counselling points

> Underwear should be worn in bed to prevent scratching.
> Finger nails should be cut short.

When to advise patient to contact their GP

> Infection other than threadworm suspected.
> Recent travel abroad.
> Medication failure
> Pregnancy.

7 Urinary tract disorders

7.2 Treatment of vaginal and vulval conditions

7.2.2 Vaginal and vulva infections

Vaginal candidiasis (thrush)

First choice: clotrimazole pessary ± clotrimazole cream
Second choice: oral fluconazole (see section 5.2)

Clotrimazole 500mg vaginal pessary	1
Clotrimazole 2% cream	20 g
Clotrimazole 10% vaginal cream	5 g

Good practice points

> Vaginal candidiasis should be treated with either an antifungal pessary or intravaginal cream inserted high into the vagina, or a single dose of oral fluconazole.
> The application of topical antifungal creams are not always necessary but can be used to treat vulvitis and supplement primary treatment.
> There is no evidence that treating the partner of a women suffering from candidiasis is helpful.
> Fluconazole can be used in patients aged 16 to 60 years of age.

Examples of counselling points

> Avoid strongly perfumed bath additives.
> External creams need to be applied for seven days after symptoms have cleared.
> Clotrimazole preparations have a damaging effect on latex condoms and diaphragms.

When to advise patient to contact their GP

> Recurrent episodes of infection.
> Signs of bacterial infection.
> Unresponsive to appropriate treatment.
> Diabetic patients.

7.4 Drugs for genito-urinary disorders

7.4.3 Drugs used in urological pain

Potassium/sodium citrate sachets	6
Potassium citrate oral solution	200 ml

Good practice points

> Young women with symptoms of urinary frequency and dysuria are likely to have a urinary tract infection which will require antibiotic treatment.

Examples of counselling points

> Patients with cystitis should increase their fluid intake.
> Avoid alcohol, tea and coffee as they can irritate the bladder.
> Cranberry juice products have been shown to help prevent urinary tract infections.

When to advise patient to contact their GP

> All men and children.
> Associated fever, nausea/vomiting.
> Haematuria.
> Vaginal discharge.
> Recurrent cystitis or duration longer than 2 days.
> Pregnancy.

9 Nutrition and blood

9.2 Fluids and electrolytes

9.2.1.2 Oral rehydration therapy

Oral rehydration salts, e.g. Dioralyte®	6/20

10 Musculoskeletal and joint diseases

10.1 Drugs used in rheumatic diseases and gout

Mild pain

First choice: **paracetamol or ibuprofen**

Mild to moderate pain

First choice: **paracetamol + ibuprofen**

10.1.1 Non-steroidal anti-inflammatory drugs (NSAIDs)

Ibuprofen 200mg tablets	48
Ibuprofen 400mg tablets	24
Ibuprofen oral suspension 100mg/5ml	100 ml

See section 4.7.1 for paracetamol containing products.

Good practice points

> Relative contra-indications to NSAIDs include heart failure, hypertension, renal impairment, peptic ulceration, caution in asthma; absolute contra-indications include proven hypersensitivity to aspirin or any NSAID.

> The combination of a NSAID and low dose aspirin may increase the risk of gastro-intestinal side effects, this combination should be avoided if possible.

Examples of counselling points

> NSAIDs must be taken with or after food.

10.3 Drugs for the relief of soft-tissue inflammation

10.3.2 Rubefacients and other topical antirheumatics

Ketoprofen 2.5% gel (generic or Oruvail®)	30g
Salicylate containing gels (Algesal®, Movelat®, Transvasin®)	50g, 100g, 40g or 80g

Good practice points

> Ketoprofen gel should be used for the short term acute treatment of sprains and strains.

> Ketoprofen should not be used in chronic inflammation or if patient on oral NSAIDs.

11 Eye

11.3 Anti-infective eye preparations

Bacterial conjunctivitis

First choice: **no treatment**
Second choice: **chloramphenicol**

11.3.1 Antibacterials

Chloramphenicol eye drops 0.5%*	10 ml

* National PGD in place to allow supply of 10ml POM Pack.

Good practice points

> Most cases of acute bacterial conjunctivits are self-limiting. Consider washing affected eye(s) regularly with boiled and cooled water for minor problems.

> Treatment should be given if condition has not resolved spontaneously after 5 days.

> If both eyes are infected, supply a separate bottle of eye drops for each eye.

> Patients with a suspected serious cause of 'red eye', e.g. moderate to severe eye pain, reduced and or blurred vision, should be referred to a GP immediately.

> Contact lenses should not be worn until infection has resolved and for 24 hours after treatment is completed.

> Further information on chloramphenicol eye drops can be found on RPSGB website (www.rpsgb.org/pdfs/otcchloramphenicoleyedropsguid.pdf).

Examples of counselling points

> Keep the product in the fridge.

11.4 Corticosteroids and other anti-inflammatory preparations

Eye symptoms associated with hay fever

First choice: **sodium cromoglicate**
Second choice: **Otrivine-Antistin®**

11.4.2 Other anti-inflammatory preparations

Sodium cromoglicate 2% eye drops	5/10 ml
Otrivine-Antistin® eye drops	10 ml

See section 3.4.1 for systemic antihistamines.

Good practice points

> Sodium cromoglicate is used to treat allergic conjunctivitis. It has a prophylactic action and must be used regularly even when symptoms improve. Patients should be advised that it may take several days to be effective and that instant relief should not be expected.

> Otrivine-Antistin® can cause systemic effects and is not recommended for long term use.

Examples of counselling points

> Once opened the eye drops should be discarded after 28 days.

11.8 Miscellaneous ophthalmic preparations

11.8.1 Tear deficiency, ocular lubricants and astringents

Tear deficiency/ocular lubricants

First choice: **hypromellose eye drops**
Second choice: **Carbomers (drops) or Lacri-Lube® (ointment)**

Hypromellose 0.3% eye drops	10 ml
Lacri-Lube® eye ointment	3.5/5 g
Carbomers (Liquivisc®/Viscotears®)	10 g

Good practice points

> The severity of the condition and patient preference will often guide the choice of preparation.

When to advise patient to contact their GP

> If condition lasts longer than 2 weeks.

> Pains or signs of infection, i.e. purulent discharge.

12 Ear, nose and oropharynx

12.1 Drugs acting on the ear

12.1.3 Removal of ear wax

Ear wax

First choice: Olive oil or sodium bicarbonate 5% ear drops

Olive oil	10 ml
Cerumol®	11 ml
Otex®	8 ml
Sodium bicarbonate 5% ear drops	10 ml

Good practice points

> Ear wax should only be removed only if it causes symptoms of discomfort or hearing loss.

> Patients should be advised not to use cotton buds to clean ear wax as this can push the wax back towards the ear drum aggravating the impaction.

> Some proprietary preparations containing organic solvents can irritate the meatal skin, and in most cases simple remedies, i.e. olive oil, are just as effective and less likely to cause irritation.

Examples of counsellling points

> The patient should lie with the affected ear uppermost for 5–10 minutes after a generous amount of the softening remedy has been introduced.

12.2 Drugs acting on the nose

12.2.1 Drugs used in nasal allergy – corticosteroids

Nasal steroid

First choice: beclometasone nasal spray

Beclometasone nasal spray	100 or 180 doses
Fluticasone nasal spray (Flixonase®)	150 doses

See section 3.4.1 for treatment with systemic antihistamines.

Good practice points

> Patients should be advised that beclometasone nasal spray will take several days to take effect and instant relief should not be expected.

12.2.2 Topical nasal decongestants

Sodium chloride 0.9% nasal drops	10 ml
Xylometazoline 0.1% drops	10 ml
Xylometazoline 0.05% paediatric drops	10 ml

See section 3.10 for systemic nasal decongestants.

Good practice points

- Sodium chloride 0.9% nasal drops may relieve nasal congestion by helping liquefy nasal secretions.
- Topical nasal decongestants can lead to rebound congestion on withdrawal and should be used short-term (usually for no longer than 7 days).

12.3 Drugs acting on the oropharynx

12.3.1 Drugs used for oral ulceration and inflammation

First choice: **benzydamine ± chlorhexidine**
Second choice: **hydrocortisone pellets or Adcortyl in Orabase® for mouth ulcers**

Adcortyl in Orabase® for mouth ulcers	5 g
Benzadymine 0.15% oral rinse	300 ml
Benzadymine 0.15% spray	30 ml
Chlorhexidine 0.2% mouthwash	300 ml
Choline salicylate gel	15 g
Hydrocortisone 2.5mg pellets	20

Good practice points

- There is some evidence that chlorhexidine gluconate may reduce the duration and severity of each episode of ulceration.
- Benzydamine mouthwash can be used 10 minutes before meals to relieve pain in patients suffering form mouth ulcers.

When to advise patient to contact their GP or dental practitioner

- Duration of longer than 3 weeks or frequent recurrence.
- Very painful.
- Associated weight loss.
- Involvement of mucus membranes.
- Rash.
- Suspected adverse drug reaction.
- Diarrhoea.

12.3.2 Oropharyngael anti-infective drugs

Miconazole oral gel 24mg/ml	15 g

When to advise patient to contact their GP

- Duration of longer than 3 weeks.
- Associated weight loss.
- Involvement of mucus membranes.
- Rash.
- Suspected adverse drug reaction.
- Diarrhoea.

12.3.3 Lozenges and sprays

There is no convincing evidence that these products have a beneficial action and they can irritate the tongue and lips.

12.3.5 Treatment of dry mouth

Artificial saliva e.g. Luborant®, Glandosane®	60 ml/50 ml

Good practice points

> Dry mouth may be caused by drugs with antimuscarinic side-effects.

> Simple measures such as sipping cool drinks, sucking ice or sugar free fruit pastilles, or chewing sugar-free gum may be helpful.

13 Skin

13.2 Emollient and barrier preparations

13.2.1 Emollients

Emollients (ointments)

First choice: **emusifying ointment**
Second choice: **Epaderm®**

Emollients (creams)

First choice: **Diprobase®**
Second choice: **Doublebase®**

Aqueous cream	100/500 g
Diprobase®	50 g
Doublebase®	100 g
E45®	50/125 g
Epaderm®	125 g
Emulsifying ointment	500 g

Good practice points

> Emollients should be applied regularly to maintain improvement; most are best applied after a shower or bath.

> Once only trial of emollient, if no improvement, then refer to GP.

13.2.1.1 Emollient bath additives

Good practice points

> Recent evidence has shown that these products provide no benefit.

> Aqueous cream and emulsifying ointment are preferred as soap substitutes. Most emollients can be used as soap substitutes by wetting the skin first, then washing with cream or ointment, then rinsing off.

13.2.2 Barrier preparations

Zinc and castor oil cream	50/100 g
Conotrane®	100 g
Sudocrem®	125 g

Good practice points

> For nappy rash, advice should be given to parents/carers to ensure that nappies are changed frequently. The rash may clear when left exposed to the air.

> Barrier preparations should be applied liberally after each nappy change.

13.3 Topical local anaesthetics and antipruritic preparations

Calamine aqueous cream	100 g
Calamine lotion	200 ml
Crotamiton 10% cream	30 g
Crotamiton 10% lotion	100 ml

Good practice points

> Emollients are useful for pruritis associated with dry skin.

> Calamine lotion is useful for sunburn and chickenpox.

> Acute urticaria is usually self-limiting, and if mild, treatment is often unnecessary. Sedating oral antihistamines may be particularly helpful if sleep is disturbed.

13.4 Topical corticosteroids

First choice: **Hydrocortisone 1%**

Hydrocortisone 1% cream	15 g
Clobetasone 0.05% cream	15 g

Good practice points

> Topical corticosteroids are not recommended in urticaria, rosacea, acne or undiagnosed, possibly infective, disorders.

> Topical corticosteroids should be applied thinly, only to the affected area, for a maximum of 7 days. If the condition does not improve, the patient should be referred to a GP.

> A once daily application is often sufficient but topical corticosteroids should not be used more than twice a day.

13.6 Acne and rosacea

13.6.1 Topical preparations for acne

Products containing benzoyl peroxide 2.5, 5 or 10%, e.g. PanOxyl®, Quinoderm®	40 g

Good practice points

> Benzoyl peroxide should be used in increasing strengths regularly to the entire acne prone area.

Examples of counselling points

> Benzoyl peroxide may bleach clothing.

When to advise patient to contact their GP

> Acne in the very young.
> Severe/extensive cases.
> Acne causing scarring.
> Failed medication (no improvement in 2 months).
> Suspected drug induced acne.

13.7 Preparations for warts and calluses

Salicyclic acid preparations, e.g. Occlusal® solution	10 ml

Good practice points

> The skin surface should be rubbed with a file or pumice stone, and the surrounding skin protected, before each application. If the application becomes painful, treatment should be withheld for a few days then recommenced.

Examples of counselling points

> Treatment may be required for up to 3 months.

When to advise patient to contact their GP

> Changed appearance of lesions: colour, size.
> Bleeding or itching.
> Genital or facial warts.
> Immuncompromised patients.

13.9 Shampoos and scalp preparations

First choice: **Coal tar preparations, e.g. T/Gel®**
Second choice: **Ketoconazole preparations, e.g. Nizoral®, Dandrazol®**

Nizoral® or Dandrazol®	60 ml
T/Gel®	125 ml

Good practice points

> Treatment depends on the severity of the condition. Shampoo formulations are preferred for moderate scaly scale conditions whereas more severe conditions may require an ointment.
> Ketoconazole shampoo is often helpful for seborrhoeic dermatitis of the scalp.
> Cradle cap in infants should be treated with olive oil.

13.10 Anti-infective skin preparations

13.10.2 Antifungal preparations

First choice: clotrimazole
Second choice: terbinafine cream

Clotrimazole 1% cream	20 g
Miconazole 2% cream	30 g
Terbinafine cream (Lamisil® AT cream)	7.5 g

Good practice points

> Treatment with antifungal creams should be continued for 14 days after symptoms resolve.
> Patients should be advised of good foot hygiene and measures to prevent reinfection.
> The licences for OTC terbinafine differ depending on preparation. All versions are licensed for tinea pedis (athlete's foot) and tinea cruris (Jock itch). Spray and gel are licensed for tinea corpis (ringworm).
> Terbinafine is not licensed for children under 16 years.

When to advise patient to contact their GP

> Severe infection affecting parts of the foot other than the toes.
> Recurrent episodes of the infection or unresponsive to treatment.
> Signs of bacterial infection.
> Diabetic patients.
> Involvement of toenails.

13.10.3 Antiviral preparations

Aciclovir 5% cream	2 g

Good practice points

> Aciclovir is best applied early, when prodromal changes of sensation are felt but before vesicles appear.

Examples of counselling points

> Wash hands regularly to avoid spreading the virus.
> Use a separate towel for the cold sore area.

When to advise patient to contact their GP

> Babies, young children and patients with atopic eczema.
> Failure of an established sore to resolve (lasting longer than 2 weeks).
> Severe, worsening or painless sore.
> History of frequent cold sores.
> Eye affected.
> Immunocompromised patients.

13.10.4 Parasiticidal preparations

Head lice

First choice: malathion or phenothrin

Scabies

First choice: permethrin or malathion

Malathion 0.5% liquid	50/200 ml
Malathion 0.5% lotion	50/200 ml
Phenothrin 0.5% liquid	50/200 ml
Phenothrin 0.5% lotion	50/200 ml
Permethrin crème rinse	59 ml
Permethrin 5% dermal cream	30 g
Dimeticone lotion 4%	

Good practice points

- For lice, only those with confirmed infection should be treated. Patients should be advised to follow the product instructions carefully. Treatment should be repeated after 7 days.
- Wet combing should be used in conjunction with the insecticides to check for effectiveness. If treatment fails, a different insecticide should be used.
- Dimeticone is suitable alternative if patients do not wish to use conventional insecticides.
- For scabies, lotions/creams should be applied to the whole body, talking care to treat the webs of finger and toes, and brushing the preparation under the ends of finger nails.
- Treatments should be reapplied to any areas of the body, e.g. hands, which are washed during the application.
- For more information refer to NHS Fife Guidelines on the Management of Head Lice and Management of Scabies at http://www.fifeadtc.scot.nhs.uk following link to Infection Control.

13.10.5 Preparations for minor cuts and abrasions/boils

Magnesium sulphate paste	25 g

13.11.6 Oxidisers and dyes

Hydrogen peroxide 1% (Crystacide®)	10g

Good practice points

- Crystacide may be used to treat superficial bacterial skin infections such as impetigo. It should be applied 2–3 times daily for up to 3 weeks.
- May bleach fabrics.

Notes

Notes

Minor Ailment Service Formulary submission form

Pharmacists wishing to request that a product be added to the Minor Ailment Formulary should complete the information below. The form should be returned to:

Clinical Effectiveness Pharmacist
Cameron House
Cameron Hospital
Windygates
Fife KY8 5RG.

Please provide as much information as possible about the predicted use, and mark the envelope 'MAS Request'.

Please complete sections 1 – 11.

Minor Ailment Service Formulary submission form

1a Name of product:

1b Brand of product:

1c Manufacturer:

2 Formulation(s), e.g. tablets, etc:

3 Strength(s) and pack size(s):

4 How many patients per month would receive this from your pharmacy if it were included in the MAS Formulary?

5 Why is this product required and any comments (e.g. indications for use, age group)?

6a Do you envisage it would replace a product currently in the MAS Formulary?

- ☐ Yes
- ☐ No

6b If Yes, which product(s)?

7 Name of pharmacist:

8 Address:

9 Contact telephone number:

Email:

10 Signature:

11 Date:

Please do not write in this section

Date received:

☐ Pharmacy champions ☐ P&FD Group ☐ PCDPs

Recommendation

☐ Recommended for formulary inclusion

☐ Not recommended for formulary inclusion

☐ Further consideration required