Lanarkshire Minor Ailment Service Formulary

2nd Edition: March 2008

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Lanarkshire Minor Ailments Service Formulary

Introduction

There is one national formulary for the Minor Ailments Service (MAS) based on the BNF and it is the reference point for payment purposes for products provided under the MAS. The formulary is available to community pharmacists and includes all Pharmacy (P) and General Sales List (GSL) medicines that are not blacklisted, dressings and appliances from Part 2 of the Drug Tariff, selected items from Part 3 of the Drug Tariff and any Prescription Only Medicines (POMs) underpinned by a series of national core Patient Group Directions (PGDs).

The NHS Lanarkshire MAS Formulary has been developed to:

- provide a formulary list which complies with the Lanarkshire 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 variety of different branded preparations available in pharmacies. The medicines listed should be used within their P or GSL licensed indication. The MAS formulary is not exhaustive and other P and GSL medicines can be recommended using the professional judgement of the pharmacist. The formulary medicines chosen provide recommendations which have been made in consultation with other pharmacists and

using information from the established NHS Ayrshire and Arran and NHS Tayside pilot schemes.

The formulary is arranged according to BNF category and includes:

- recommended first and second line options.
- drug entries listed alphabetically.
- suggested quantities to be prescribed.
- general advice relating to the ailment or medicines.
- some examples of counselling points.
- examples of when it may be appropriate to refer the patient to their GP.

The information in the formulary is for guidance and the pharmacist must use their own professional judgement at all times.

Cost effectiveness and quality of prescribing are equally important. The service should only treat minor ailments which are generally described as common, often self limiting conditions that normally require little or no medical intervention and are usually managed by self care and the use of products that are available to buy. With the exception of a few long term minor ailments such as hay fever and teething where self care is recognised practice, chronic and potentially more serious illness requiring medical attention should be referred to a GP. Pharmacists should be alert to those patients presenting symptoms of an underlying disease. Each individual must be assessed and a clinical judgement made on the most appropriate treatment pathway to be followed. General lifestyle advice should also be offered where appropriate.

Whilst every precaution has been taken to ensure that the information contained in the Lanarkshire MAS Formulary is correct, it is the responsibility of the pharmacist to ensure that any medicine selected and prescribed is the most appropriate for the individual patient and that the dose and duration of therapy are correct.

Any comments regarding the formulary and queries about inclusions or omissions should be directed to your Pharmacy Champion. The formulary will be reviewed annually to ensure that it remains current with the medicines market and recommended treatments for minor ailments. A formulary submission form is included (page 27), which allows a request to be made to add an item to the formulary.

NHS Lanarkshire is very grateful to NHS Fife for providing Lanarkshire with the format of their MAS formulary.

Many thanks go to Laura Fraser, Salah Athmani, Dorothy Findlay, George Lindsay, Alastair Thorburn and Fiona Graham for their in-put in developing the 2nd edition of the Lanarkshire MAS Formulary.

1 Gastrointestinal system

Indigestion

First choice:	Co-magaldrox SF suspension
Second choice:	Compound alginate products
Infantile colic:	Infacol® liquid

1.1 Dyspepsia and gastro-oesophageal reflux disease

1.1.1 Antacids and simeticone

Co-magaldrox SF suspension (supply & endorse as Mucogel®)	500mL
Infacol® liquid	50mL

1.1.2 Compound alginate products:

Gastrocote® tablets	100
Peptac® suspension	500mL
Gaviscon® Advance liquid	up to 500mL
Gaviscon® Advance tablets	60

1.2 Antispasmodics and other drugs altering gut motility

Domperidone 10mg tablets (Endorse as Motilium® 10 tablets 10mg)	max 10

1.3 Ulcer healing drugs

H2- receptor antagonists

Ranitidine 75mg tablets	6 or 12

Good practice points

- Patients with symptoms suggestive of underlying disease should be referred to their GP. E.g. patients complaining of progressive difficulty swallowing, progressive unintended weight loss or sudden onset of symptoms especially in middle age or elderly, coughing up blood, anaemia- like symptoms.
- 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 alginate preparations are less powerful antacids than co-magaldrox.

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.

When to advise patient to contact their GP.

- Symptoms are persistent (longer than 5 days) or recurrent.
- Pain is severe or radiating.
- Blood in vomit or stools/melaena.
- Persistent vomiting.
- Treatment has failed (no improvement in symptoms after 5 days).
- Adverse drug reaction is suspected.
- Associated weight loss.

1.4 Acute diarrhoea

First choice:	oral rehydration salts
Second choice:	loperamide

Oral rehydration salt sachets (see also BNF section 9.2.1.2)

Electrolade® sachets	6 or 20
Dioralyte® sachets	6 or 20

1.4.2 Antimotility drugs

Loperamide 2mg capsules	up to 30
Imodium® 2mg capsules (supply and endorse as Imodium®)	18

Good practice points

- First line treatment of acute diarrhoea is rehydration therapy
- Patients with symptoms suggestive of underlying disease should be referred to their GP, e.g. blood in stools, major change in bowel habits especially in middle age or elderly.
- Patients with chronic diarrhoea should be referred to their GP.

Examples of counselling points

- Diarrhoea normally stops within 48-72 hours without treatment.
- Fluid replacement is particularly important in children and the elderly.

When to advise patients to contact their GP

- Adults and children > 6years: diarrhoea 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.

1.6 Laxatives

Constipation (acute)

Senna tablets/liquid
Glycerin suppositories or bisacodyl suppositories/tablets

Constipation (chronic)

Ispaghula husk sachets
Lactulose solution

1.6.1 Bulk-forming laxatives

Ispaghula husk sachets 3.4g/3.5g	30 or 60 sachets

1.6.2 Stimulant laxatives

Bisacodyl 5mg tablets	20
Bisacodyl 10mg suppositories	12
Glycerin 4g adult suppositories	12
Senna liquid	100mL
Senna tablets	20

1.6.4 Osmotic laxatives

Lactulose solution	300mL/500mL

Good practice points

- Investigation of reasons for constipation may lead to referral rather than a treatment under the MAS. Patients with symptoms suggestive of underlying disease should be referred to their GP, e.g. blood in stools, unexplained weight loss, jaundice, passage of mucus, major change in bowel habit especially in the middle aged or elderly.
- Normal counselling advice on diet/exercise is necessary.
- Constipation in children normally requires a GP referral.
- Lactulose is not recommended for long-term use in the elderly but can be prescribed along with a stimulant laxative as a short-term solution.

Examples of counselling points

- Drink more fluids but no tea, coffee, cola or alcohol.
- Eat more fibre found in wholemeal foods, fruit and fresh vegetables.
- Regular exercise improves bowel habits.
- 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 patients to contact their GP

- Persistent change in bowel habit.
- Presence of abdominal pain, vomiting, bloating.
- Blood in stools/ melaena.

- Prescribed medication suspected of causing symptoms.
- Failure of OTC medication (no relief of symptoms within 7 days).
- Possibility of faecal impaction with overflow diarrhoea
- Constipation in children.

1.7 Local preparations for anal and rectal disorders

1.7.1 Soothing haemorrhoidal preparations

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

1.7.2 Compound haemorrhoidal preparations with corticosteroids

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

Good practice points

- Patients with symptoms suggestive of underlying disease should be referred to their GP, e.g. profuse bleeding, blood that is dark, blood in the stools, extremely painful haemorrhoids, anaemia-like symptoms, change in bowel habit toward looser stools and/or increased stool frequency persisting 6 weeks or more (especially in middle age or elderly).
- 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 not be longer than 7 days with hydrocortisone products.

When to advise patient to contact their GP

- Duration of longer than 3 weeks.
- Change of bowel habit (persistent alteration from normal bowel habit).
- Presence of blood in stools/melaena.
- Suspected drug-induced constipation.
- Associated abdominal pain/vomiting.

3 Respiratory system

3.4 Antihistamines, hyposensitisation and allergic emergencies

Non-sedating antihistamines

First choice:	cetirizine
Second choice:	loratadine

Sedating antihistamine

First choice:	chlorphenamine

3.4.1 Antihistamines

Non-sedating

Cetirizine 10mg tablets	7/30
Cetirizine oral solution 5mg/5mL	up to 200mL
Loratadine 10mg tablets	7/30
Loratadine syrup 5mg/5mL	100mL

Sedating

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

Also see eye section 11.4.2 and nasal allergy section 12.2.1

Good practice points

- Patients complaining of wheezing, shortness of breath or chest tightness should be referred to their GP.
- 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 rare with non sedating antihistamines, however, patients should be advised that it can occur and may affect performance of skilled tasks and excess alcohol should be avoided.
- Drowsiness is a significant side effect of sedating antihistamines and therefore care should be taken when performing skilled tasks.

Examples of counselling points

- For hay fever, start taking before season starts and continue throughout.
- 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.
- Failed medication (no improvement in symptoms after 10 days)

3.8 Aromatic inhalations

Menthol crystals	5g

3.9 Cough preparations

Cough suppressants:

Pholcodine SF linctus	200mL
Pholcodine paediatric SF linctus	up to 200mL

Expectorants and demulcent cough preparations:

Simple SF linctus	200mL
Simple paediatric SF linctus	up to 200mL

It is recommended that any cough preparations supplied are done so in original patient packs as opposed to the packing down from stock bottles.

Good practice points

- Remedies available for the management of cough (cough suppressants, expectorants or demulcents) may provide limited benefit.
- The recent (March 2008) MHRA advice on the OTC cough and cold medicines for young children can be obtained on www.mhra.gov.uk The advice applies to cough medicines for young children <2 years old. Cough and cold medicines for those >2 years old are not affected.
- Several manufacturer's versions of glycerine, honey and lemon are on the NHS Blacklist, however if a contractor can obtain a non-blacklisted version then it is an appropriate product to recommend for coughs and colds. **In such cases the contractor must remember to endorse the CP2 with the price of the glycerine, honey and lemon preparation provided.**
- Persistent cough alongside other alarm symptoms, e.g. weight loss, fluid retention, wheezing, fever, is a reason for referral to a GP.
- 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 and dry coughs can continue for three to four weeks after a bout of cold/flu.
- Smokers can suffer more with their cough and advice can be given on smoking cessation.

When to advise patient to contact their GP

- Cough lasting 4 weeks or more.
- Sputum yellow, green, rusty or blood stained.
- Chest pain or pain when breathing in and out.
- Shortness of breath.
- Wheezing.
- Whooping cough or croup.
- Recurrent nocturnal cough.
- Suspected adverse drug reaction (e.g. ACE inhibitors).

- Failed medication (no improvement in symptoms after 5 days).
- Fever.

3.10 Systemic nasal decongestants

Pseudoephedrine 60mg tablets	12*
Pseudoephedrine 30mg/5mL	100mL

*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 possible reclassification as a POM in 2009.

See also Topical Nasal Decongestants (section 12.2.2)

Good practice points

- Sodium chloride 0.9% nasal drops may relieve nasal congestion by helping liquefy nasal secretions
- 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

Travel sickness	
Promethazine teoclate 25mg (supply and endorse as Avomine®)	28
Promethazine HCL 5mg /5mL SF elixir.	100mL
Cinnarizine 15mg tablets (supply pack of 15 tablets)	15
Hyoscine 300micrograms tablets (endorse with brand supplied)	12
Hyoscine 150micrograms tablets (endorse with brand supplied)	12

Good practice points

- Anti-emetics should be given to prevent motion sickness rather than after nausea or vomiting.
- The most effective drug for the prevention of motion sickness is hyoscine.
- The sedating antihistamines are slightly less effective against motion sickness but are generally better tolerated than hyoscine.
- If a sedative effect is desired then promethazine is useful but generally a slightly less sedating antihistamine such as cinnarizine is preferred.

Examples of counselling points

- There are many things you can do to prevent travel sickness or at least minimise the symptoms.
- Don't eat large meals or drink alcohol before or during travel. (cont over)
- Don't read. Focus on a stable view such as the horizon or fix your gaze on a distant object ahead. If the car passenger is a child then an elevated car seat that enables the child to look out of the window will often help.

- Open a window whenever possible to get some fresh air.
- Breathe slowly and deeply through your mouth.
- Allowing yourself to vomit can help reduce nausea but do not force yourself to be sick. If you are sick be sure to replace lost fluids with frequent small sips of cold still water.
- Avoid areas where there are strong odours or people are smoking.
- Sit in an area of the aeroplane or boat with the least motion, usually in the middle of the craft and turn on the overhead vent to increase air circulation.

When to advise patient to contact their GP

- Rarely, travel sickness can become progressively worse with each journey and will eventually require the attention of a doctor.

4.7 Analgesics

Mild pain
First choice: paracetamol OR ibuprofen
Mild to moderate pain
First choice: paracetamol PLUS ibuprofen

Non opioid analgesics

Paracetamol 500mg tablets	32
Paracetamol oral suspension SF 120mg/5mL	up to 200mL
Paracetamol oral suspension SF 250mg/5mL	up to 200mL
Ibuprofen 200mg tablets	24/48
Ibuprofen 400mg tablets	12/24
Ibuprofen 100mg/5mL suspension (syrup=POM)	up to 150mL

(see also non-steroid anti-inflammatory drugs BNF section 10.1.1)

Topical Analgesic

Transvasin® Heat Rub Cream	up to 40g

(see also BNF section 10.3.2)

Good practice points

- There is significant potential for accidental overdose. Prescribers should be aware of other analgesic preparations (prescribed, over the counter or 'borrowed') that patients may be taking.
- Paracetamol is preferable to ibuprofen in the elderly.
- Compound analgesics containing an opioid may produce opioid side-effects and can complicate matters in overdose.
- Co-codamol 8/500 tablets are no more effective than paracetamol.

Examples of counselling points

- Rest should be taken 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 the 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
- 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 or vomiting.
- Neck stiffness.

5 Infections

5.2 Antifungal drugs

Vaginal candidiasis (also see BNF section 7.2.2)

First choice: clotrimazole preparations
Second choice: fluconazole 150mg capsule

Clotrimazole 500mg vaginal pessary	1
Clotrimazole 1% cream	20g
Clotrimazole 2% cream	20g
Clotrimazole 10% vaginal cream (endorse and supply as Canesten® Internal Cream)	5g
Fluconazole 150mg capsule (supply and endorse with most cost effective 'Pharmacy Only' preparation available).	1

5.5 Anthelmintics

5.5.1 Drugs used for threadworms

First choice: mebendazole
Second choice: piperazine

Mebendazole 100mg chewable tablets (supply and endorse as Ovex® tablets)	1
Mebendazole 100mg/5mL suspension (supply and endorse as Ovex® suspension)	30mL
Piperazine 4g oral powder (supply and endorse as Pripsen®)	2 sachet pack

Good practice points

- Personal hygiene before eating and after toileting should be emphasised. If re-infection is suspected, it is beneficial to repeat the dose after 14 days.
- 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 is suspected.
- Recent travel abroad.
- Medication failure.
- Pregnancy

7 Urinary tract disorders

7.2 Treatment of vaginal and vulval conditions

7.2.2 Vaginal and vulval infections

Vaginal candidiasis
(also see BNF section 5.2)

First choice: clotrimazole preparations
Second choice: fluconazole 150mg capsule

Clotrimazole 500mg vaginal pessary	1
Clotrimazole 1% cream	20g
Clotrimazole 2% cream	20g
Clotrimazole 10% vaginal cream	5g
(endorse and supply as Canesten® Internal Cream)	
Fluconazole 150mg capsule	1

(supply and endorse with most cost effective 'Pharmacy Only' fluconazole preparation available).

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 woman suffering 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

Urinary cystitis

Choices: potassium citrate
sodium citrate

Potassium citrate sachets (endorse with brand supplied)	6
Potassium citrate oral solution	200mL
Sodium citrate sachets (endorse with brand supplied)	6

Good practice points

- Women with recurrent symptoms or symptoms suggestive of systemic disease should be referred to a GP, as should men or children presenting with symptoms of cystitis.
- Patients with cystitis should increase their fluid intake.

Examples of counselling points

- Avoid alcohol, tea 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.
- Loin pain or tenderness.
- Haematuria.
- Vaginal discharge.
- Duration longer than 2 days.
- Pregnancy.
- Recurrent cystitis.
- Failed medication.

9 Nutrition and blood

9.1.2 Drugs used in megaloblastic anaemias

Vitamin supplementation for pregnancy
Folic acid 400micrograms tablets 90
For use prior to and up until 12 weeks of pregnancy.

9.2 Fluids and electrolytes

9.2.1.2 Oral rehydration therapy

Oral rehydration salt sachets (see also BNF section 1.4)

First choice:	Electrolade® sachets	6 or 20
Second choice:	Dioralyte® sachets	6 or 20

10 Musculoskeletal and joint diseases

10.1 Drugs used in rheumatic diseases and gout

10.1.1 Non-steroidal anti-inflammatory drugs

Mild pain
First choice: paracetamol OR ibuprofen

Mild to moderate pain
First choice: paracetamol PLUS ibuprofen

Ibuprofen 200mg tablets	24/48
Ibuprofen 400mg tablets	12/24
Ibuprofen 100mg/5mL suspension (syrup=POM)	up to 150mL

(see also analgesic section BNF section 4.7)

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 used in relief of soft-tissue inflammation

10.3.2 Rubefacients and other topical antirheumatics

Transvasin® Heat Rub Cream 40g

Topical NSAIDs are of limited proven benefit. Topical rubefacients may provide symptomatic relief for patients who find massaging the skin helpful.

11 Eye

11.3 Anti-infective eye preparations

11.3.1 Bacterial conjunctivitis

First choice: no treatment
Second choice: chloramphenicol

Antibacterials

Chloramphenicol eye drops 0.5% 10mL
(The National PGD to allow supply of 10mL POM pack can be found on www.communitypharmacy.scot.nhs.uk , Health Boards, NHS Lanarkshire).

Chloramphenicol eye ointment 4g
(supply and endorse with the 'Pharmacy Only' brand supplied)

Good practice points

- Most cases of acute bacterial conjunctivitis are self-limiting. Treatment should be given if condition has not resolved spontaneously after 5 days.
- Patients with suspected serious cause of 'red eye' should be referred to a GP immediately, e.g. moderate to severe eye pain, reduced and or blurred vision.
- Contact lenses should not be worn until infection has resolved and for 24 hours after treatment is completed.
- Further information can be found from RPSGB Practice Guidance on OTC chloramphenicol eye drops. (www.rpsgb.org/pdfs/otcchlorampheneyedropsguid.pdf).

Examples of counselling points

- Keep the product in the fridge.

11.4 Corticosteroid and other anti-inflammatory preparations.

11.4.2 Other anti- inflammatory preparations

Hayfever – eye symptoms

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

Sodium cromoglicate 2% eye drops (endorse with brand supplied)	5/10mL
Otrivine-Antistin® eye drops	10mL

See also Antihistamines (section 3.4.1) and Nasal Allergy (section 12.2.1).

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 there may be several days before an effect is felt 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	10mL
Carbomer 974P (Liquivisc®)	10g
Carbomer 980 (Viscotears®)	10g
Lacri-Lube® eye ointment	3.5/5.0g

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

First choice: almond oil
Second choices: sodium bicarbonate
Cerumol® Ear Drops

Almond oil	25mL/50mL
Sodium bicarbonate 5% ear drops	10mL
Cerumol® Ear Drops (contains pea-nut oil)	11mL

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 skin.
- In most cases, simple remedies, i.e. almond oil are just as effective and less likely to cause irritation.
- If the wax is hard and impacted, the drops may be used twice daily for a few days before syringing; otherwise the wax may be softened on the day of syringing.

Examples of counselling 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 Nasal allergy

Nasal steroid

First choice: beclometasone nasal spray

Beclometasone nasal spray	100 or 180 doses

(Also see Antihistamines section 3.4.1 and Eye - other anti-inflammatory products section 11.4.2)

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

First choice: sodium chloride 0.9%
Second choice: xylometazoline

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

See also systemic nasal decongestants, section 3.10

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 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® paste
Teething gel: choline salicylate gel

Benzydamine 0.15% oral rinse	300mL
Benzydamine 0.15% spray	30mL
Chlorhexidine 0.2% mouthwash	300mL
Hydrocortisone 2.5mg pellets	20
Adcortyl in Orabase® Mouth Ulcer paste, specify 'Mouth Ulcer'	5g
Choline salicylate gel	15g

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 from mouth ulcers.
- If ulceration is very painful, recurrences are frequent and severe then the patients should be referred to their GP.

When to advise patients to contact their GP or dental practitioner.

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

12.3.2 Oropharyngeal anti-infective drugs

Miconazole oral gel 24mg/mL	15g

Examples of counselling points

- The gel should be held in the mouth on or near the lesions before swallowing.

When to advise patients to contact their GP or dental practitioner.

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

13 Skin

13.2 Emollient and barrier preparations

13.2.1 Emollients

Aqueous cream	100g/500g
Emulsifying ointment	500g
Doublebase® gel	100g/500g
Diprobase® cream	50g/500g

Soap substitutes

Aqueous cream	100g/500g
Emulsifying ointment	500g

13.2.1.1 Emollient bath/shower additives

Oilatum® Emollient bath additive	250mL/500mL
Oilatum® Shower emollient	125g

Good practice points

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

Examples of counselling points

- Emollient bath additives make the bath slippy and patients should be warned of the risk of falling.
- The practice of using an emollient immediately before a topical corticosteroid is inappropriate.

When to advise patient to contact their GP

- If no improvement after one trial of emollient.

13.2.2 Barrier preparations

Urinary or nappy rash

First choice: zinc and castor oil cream

Second choice: Sudocrem®

Zinc and castor oil cream	50g/100g
Sudocrem®	60g/125g

Good practice points

- For nappy rash, advice should be given to parents/carers that nappies are changed frequently. The rash may clear when left exposed to the air.
- When barrier preparations are used they should be applied liberally after each nappy change.

13.3 Topical local anaesthetics and antipruritic preparations

Allergy/itch

First choice: calamine cream/lotion or crotamiton cream/lotion

Calamine aqueous cream	100g
Calamine lotion	100mL/200mL
Crotamiton 10% cream	30g
Crotamiton 10% lotion	100mL

Good practice points

- Emollients are useful where pruritis is associated with dry skin.
- 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.
- Calamine lotion is useful for sunburn and chickenpox.

13.4 Topical corticosteroids

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

(supply and endorse as Eumovate Eczema & Dermatitis cream®)

(topical corticosteroids plus antifungal, see section 13.10.2)

Good practice points

- Topical corticosteroids are not recommended for use in urticaria, rosacea, acne or undiagnosed and possibly infective disorders.
- They should not be applied to the face or anogenital region.
- They should not be sold without medical advice for children under 10 years.
- 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 applied more than twice a day.

13.6 Acne and rosacea

13.6.1 Topical preparations for acne

Benzoyl peroxide 2.5%, 5% and 10% aqueous gel	40g

Good practice points

- Severe /extensive cases of acne should be referred to the GP
- Benzoyl peroxide should be used in increasing strength 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 acne
- Acne causing scarring
- Failed medication (no improvement in 2 months)
- Suspected drug induced acne.

13.7 Preparations for warts and calluses

Salactol® Paint (16.7% salicylic acid, 16.7% lactic acid)	10mL
Occlusal® Solution (26% salicylic acid)	10mL
Verrugon® ointment (50% salicylic acid)	5g
Carnation® Corn /Callous Caps (salicylic acid 40%) (contains pea-nut oil)	5

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

- Protect surrounding skin with white soft paraffin or plaster.
- Rub surface of wart weekly with file or pumice.
- Treatment may be required for up to 3 months.

When to advise patient to contact their GP

- Changed appearance of lesions: colour, size
- Bleeding
- Itching
- Genital warts
- Facial warts
- Immunocompromised patients

13.9 Shampoos and scalp preparations

Alphosyl® 2 in 1 shampoo	125mL/250mL
Capasal® shampoo	250mL
Polytar® Liquid (contains peanut oil)	150mL
Selenium sulphide 2.5% shampoo (endorse as Selsun®)	50mL
Ketoconazole 2% shampoo*	60mL/100mL

*for the treatment of seborrhoeic dermatitis of the scalp. Prescribe generically and endorse with the brand prescribed.

13.10 Anti-infective skin preparations

13.10.2 Antifungal preparations

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

Antifungal plus corticosteroid preparations

Canesten® HC cream	15g
Daktacort® HC cream	15g
Eurax® HC cream	15g

Good practice points

- Treatment with antifungal creams should be continued for 14 days after resolution of symptoms
- 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 to treat tinea pedis (athlete's foot) and tinea cruris (Jock itch) and the spray and gel are licensed for tinea corpis (ringworm).
- Terbinafine is not licensed for use in children 15 years and younger.

When to advise patient to contact their GP

- Severe infection affecting other parts of the foot.
- Recurrent episodes of the infection.
- Signs of bacterial infection.
- Diabetic patients
- Involvement of toenails.

13.10.3 Antiviral preparations

Aciclovir 5% cream	2g

Good practice points

- Aciclovir is best applied at the earliest possible stage, when prodromal changes of sensation are felt before vesicles appear.

Examples of counselling points

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

When to advise patient to contact their GP

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

13.10.4 Parasiticidal preparations

Head lice

Choices: malathion or phenothrin or dimeticone

Scabies

Choices: permethrin cream or malathion liquid

Crab lice

Choice: malathion liquid

Malathion 0.5% liquid (supply & endorse as Derbac-M®)	50mL/200mL
Malathion 0.5% lotion (supply & endorse as Prioderm®)	50ml/200mL
Phenothrin 0.5% liquid (supply & endorse as Full Marks® Liquid)	50mL/200mL
Phenothrin 0.5% lotion (supply & endorse as Full Marks® Lotion)	50mL/200mL
Dimeticone 4% lotion (supply & endorse as Hedrin®)	50mL/150mL
Permethrin 5% cream (supply & endorse as Lyclear® Dermal Cream)	30g

Good practice points

- For head lice, only those with confirmed infection should be treated. Treatment should be repeated after a 7 day period. If treatment fails, a different insecticide should be used for the next treatment.
- Wet combing should be advised in conjunction with the insecticides to check for effectiveness. The basic steps are:

1. Wash hair, rinse and towel dry.
2. Apply a lot of any hair conditioner to dampen hair.
3. Use an ordinary comb to straighten and untangle hair.
4. Part the hair in small sections (hair grips/slides may be required)
5. Using a head lice detection comb, slot comb into a section of the hair, as close to the scalp as possible with the teeth flat against the scalp. Then draw the comb right down to the hair tip.

6. Check the comb in good lighting, between each stroke. If live lice are found, treatment should be initiated (or repeated).

7. Remove any lice from the comb between each stroke by wiping the comb on a paper towel. A toothpick or nail brush may be needed to remove large lice. A magnifying glass may be useful.

8. Work methodically over the whole head, through all the sections of the hair, combing and cleaning between each stroke.

9. Add more conditioner and water if the hair starts to dry out.

10. Rinse the hair and dry as normal.

11. Encourage regular (at least weekly) hair grooming using the detection method to detect and prevent infection.

Alternatively, a Bug Busting Kit can be provided and the manufacturer's directions followed.

For scabies, the cream should be applied to the whole body, taking care to treat the webs of the fingers and toes. The cream should also be applied under the ends of the finger nails.
Treatments should be reapplied to any areas of the body, e.g. hands, which are washed during the application.

13.10.5	Preparations for minor cuts and abrasions	
	Magnesium sulphate paste	25g
13.11.4	Iodine	
	Povidine-iodine 10% ointment	20g
	(supply and endorse as Betadine® Ointment)	

Information on Pharmacy (P) and General sales list (GSL) medicines that are blacklisted

The minor ailment scheme NHS Black List can be viewed via the following web site:
www.communitypharmacyscotland.org.uk/contractor_services/publications/disallowed_items.asp

Minor Ailments Service Formulary submission form

Pharmacists wishing to request that a product be added to the Minor Ailments formulary should complete the information below. The form should be returned to:
Formulary/Clinical Effectiveness Pharmacist, Prescribing Department, Strathclyde Hospital, Airbles Road, Motherwell, ML1 3BW
Please provide as much information as possible about the product as well as the predicted use. Please mark the envelope 'MAS Request'

Please complete sections 1-11:

1a **Name of product:**

1b **Brand of product:**

1c **Manufacturer:**

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

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

4 **Approximately 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? Please include any comments about it's indications for use.**

6a **Should this product replace a product currently in the Lanarkshire MAS formulary?**

☐ **Yes** ☐ **No**

6b **If yes, which product should it replace?**

7 **Name of pharmacist:**

8 **Address:**

9 **Contact telephone number/email address:**

10 **Signature:**

11 **Date:**

<u>Please do not write in the section below</u>

Date received:

Recommendation:
☐ **Recommended for formulary inclusion**
☐ **Not recommended for formulary inclusion**
☐ **Further consideration required.**

Alphabetical list and index of formulary items.

Drug name and page number: