Specials Recommended by the British Association of Dermatologists for Skin Disease

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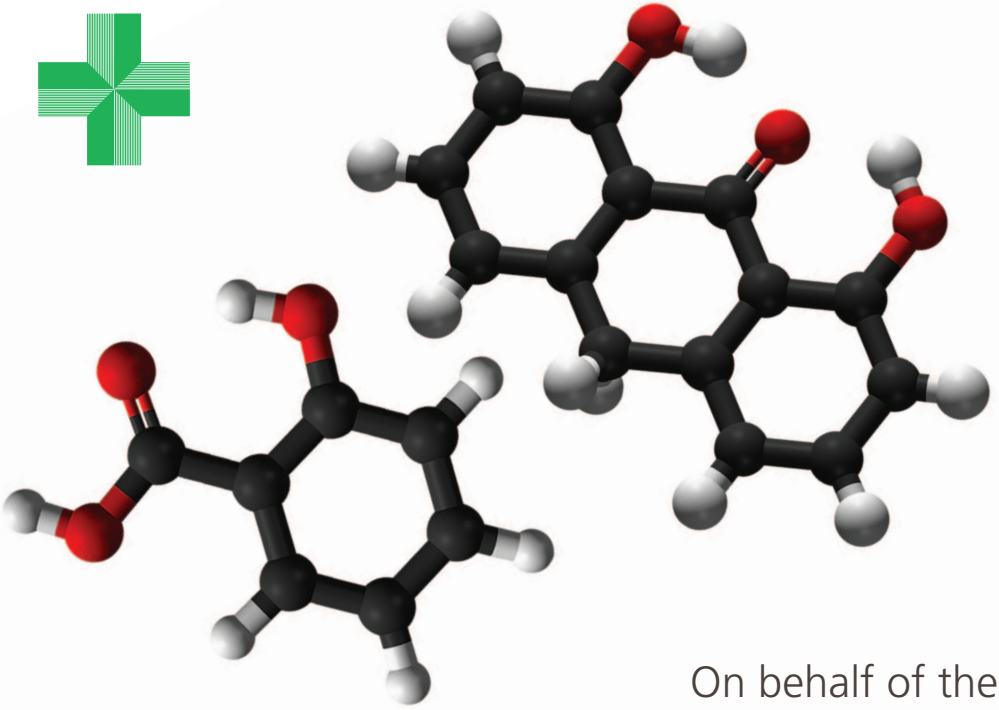

On behalf of the
BAD Specials Working Group

2014

Logos for stakeholder representations on the BAD Specials Working Group

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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 to optimise quality of care, adherence to the revised British Association of Dermatologists (BAD) list of preferred Specials (2014) is encouraged.

Keywords

Prescribing; QIPP; Specials

This booklet can be accessed electronically at www.bad.org.uk/healthcare-professionals/clinical-standards/specials.

Background

The overwhelming majority of medical treatment is delivered by prescription of licensed medicines which have been approved for sale in the UK 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 UK 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 aren't 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 derived from clinical trials on safety and efficacy 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 Quality, Innovation, Productivity and Prevention initiative (QIPP) is a Department of Health strategy involving all English NHS staff, patients, clinicians and the voluntary sector. It aims to improve the quality and delivery of NHS care while reducing costs, to make £20bn efficiency savings by 2014/15. Savings will be reinvested to support frontline services. Pressure on the NHS to do more with less will continue well beyond this.

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. Paradoxically, given the lack of assurance about safety and efficacy and concern about product quality, unlicensed medicines are disproportionately (very) 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.

TESTED & QUALITY ASSURED?	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
Safety, efficacy	✓✓✓	No Data	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. Initial attempts by PCT medicines management teams to investigate were hampered by a lack of data. Although steadily improving, detailed data on the range of Dermatology Specials prescribed by GPs remains poor. Even in secondary care, where formulary control is well established and prescribing is consultant-led, NHS hospital pharmacy manufacturing units routinely make at least 95 different products containing coal tar and 75 containing dithranol. 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.

PRIMARY ACTIVE INGREDIENT	NUMBER OF PRODUCTS ROUTINELY MANUFACTURED BY HOSPITALS IN 2012	NUMBER OF PRODUCTS RECOMMENDED ON BAD LIST (2008)
Tar	95	27
Dithranol	75	22
Salicylic acid	123	18
Steroid	31	7

TABLE 2 Comparison of numbers of products routinely made by NHS hospitals and those recommended by the BAD in the 2008 list

The BAD set up a Specials Working Group in 2013 which includes representatives of the Department of Health, Clinical Reference Groups, Clinical Commissioning Groups, the Royal College of General Practitioners, the Primary Care Dermatology Society, the Royal Pharmaceutical Society and consultant dermatologists. Following a survey of all UK consultant dermatologists, a much abbreviated list of 40 BAD preferred Specials was agreed on by the working group in 2014.

It is hoped that adherence to this new BAD Specials List 2014 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 are currently listed by prescribing software and decisions are likely to be dependent on previous experience, local consultant prescribing and information from the patient. It is now very unusual for community pharmacists to "extemporaneously dispense" unlicensed medicines in the pharmacy. Instead, 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. Until controls were introduced by the Drug Tariff for the first time in November 2011, there was no requirement to seek evidence of product quality and no mechanism to control cost. In its current form, launched in November 2011 and revised in May 2014, the England and Wales Drug Tariff includes only seven dermatological preparations. The products it does list seem to have been chosen on the basis of frequency of prescription and cost to the NHS (in primary care) rather than on the basis of clinical preference. It is the aim of the working group implementing the new BAD Specials List 2014 that all 40 preparations will be referred to in the Drug Tariff.

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 is rapidly getting harder and costs are escalating dramatically. 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 is very concerned about the cost of Specials in primary care. We encourage 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 2014 to accurately reflect expert clinical opinion.

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.	QIPP objectives achieved

TABLE 3 Benefits of adhering to the BAD Specials List 2014

1.	Encourage use of licensed medicines whenever they are likely to be of benefit
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 to influence the biennial 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 Specials Working Group and their affiliated organisations.

Members of the BAD Specials Working Group

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Richard Logan	Consultant Dermatologist, Bridgend
Stephen Kownacki	Executive Chair, PCDS
Joe Brogan	Head of Pharmacy and Medicines Management, Health and Social Care Board NI
Colette McBride	Production Manager, Victoria Pharmaceuticals, Belfast
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Susan Cooper	Medical member of the Specialised Dermatology CRG; Consultant Dermatologist, Oxford
Imran Rafi	Chair, Clinical Innovation & Research Centre, RCGP
Catherine Duggan	Director of Professional Development and Support, RPS
Ruth Wakeman	Head of Professional Support, RPS
Julie Greenfield	Manager, Pharmacy Forum NI

BAD SPECIALS LIST 2014

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. 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 Dermovate® cream	**100 g**

Very potent steroid; propylene glycol increases penetration of 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 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 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 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.

TARS

Cade oil 12% w/w and salicylic acid 6% w/w in emulsifying ointment	**100 g**
Coal tar scalp 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, mainly in day treatment centres at Dermatology departments:

- when other topical treatments such as Vitamin D analogues and commercial tar preparations such as Exorex® 5% lotion (100 ml, £8.11), Psoriderm® 6% cream (225 ml, £9.42) or Carbo-Dome® 10% cream (30 g, £4.77) 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. Occasionally, 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 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 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	**100 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 8% 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 pomade 0.4% w/w (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.

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

KERATOLYTICS

Coconut oil 25% w/w in emulsifying ointment	**100 g**

Use as a scalp moisturiser and anti-inflammatory for the removal of thick scales in psoriasis, seborrhoeic dermatitis, pityriasis amiantacea and scalp atopic dermatitis, where commercial preparations such as Cocois® (40 g, £6.22) or Sebco™ (40 g, £4.54) have been inadequately effective. Rub firmly into scalp skin, leave overnight under a shower cap, and wash out next morning.

Salicylic acid 2% w/w and sulphur 2% w/w in aqueous cream	**100 g**

Sulphur is antiseptic, anti-parasitic and anti-seborrhoeic; salicylic acid at lower concentrations is mildly keratolytic. Use on scaly, inflamed conditions of the face or scalp, such as treatment-resistant seborrhoeic dermatitis, once or twice daily.

Salicylic acid 2% w/w in emulsifying ointment	**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 are 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, £3.12)).

Zinc and salicylic acid paste (Lassar's paste) half-strength	**100 g**

Half-strength Lassar's paste is used to prevent and treat irritant and/or flexural dermatitis where other barrier preparations such as Metanium® ointment (£2.01) have been ineffective. It has a skin barrier and mild anti-bacterial effect.

It can be useful when applied to fissures in hand dermatitis or applied with bandages in exudative eczematous conditions.

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.	
Glycopyrollate 0.05% w/v in water	**250 ml**
Use with an iontophoresis machine to treat hyperhidrosis.	
Glycopyrollate 2% w/w in cetomacrogol cream	**100 g**
Use to treat disabling facial hyperhidrosis. Apply to affected sites twice daily.	
Hydroquinone 5% w/w, hydrocortisone 1% w/w and tretinoin 0.1% w/w in a non-aqueous gel 0.3% w/v	**100 g**
Use to treat melasma, in conjunction with a strong sunblock. Do not use for more than 6 months due to the risk of ochronosis. A commercially available similar preparation may be obtained called Pigmanorm® (Mawdsley Brooks £17.60).	
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.	
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**
Used for ulcerative and erosive inflammatory skin disease including around stomas.	
Eosin solution 2% w/v	**100 ml**
Used for erosive dermatitis, especially around stomas, appliances and intertrigo. Apply when dressing or device changed.	
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/v	**10 ml**
Used to destroy facial xanthelasmata; highly irritant.	

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