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1.0 Action for AWMSG

AWMSG members are asked to consider the recent minor updates to the All Wales Common Ailments Service Formulary document (originally published in August 2023, latest update published in November 2026), which is provided here for information. The updates have been highlighted and were focused on the following sections:

- Cold sores
- Constipation
- Infantile colic
- Mouth ulcers
- Scabies
- Teething
- Warts and verrucae

This enclosure only includes the updated sections listed above. The full document is available here.

Please note: The monographs within this document are intended to provide the clinical framework to support the safe and efficient delivery of the Common Ailments Service component of the Clinical Community Pharmacy Service. The monographs **do not** include the operational detail of the Common Ailment service. They should be read in conjunction with the service specification document, and service providers must ensure that they are aware of, and adhere to, all relevant legal and regulatory requirements that are applicable to this service.

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6.0 Cold sores

Management of cold sores within CAS is limited to the provision of advice. Advice can be provided to immunocompetent individuals aged 6 months and over. Individuals with risk factors identified in section 6.3 below should be referred with appropriate urgency depending on presentation. The reason for referral should be provided to the individual.

6.1 About the ailment[54-57]

Cold sores are caused by the herpes simplex virus (HSV) infecting the lips, cheeks or nose, and are commonly passed on by skin contact. Cold sores usually resolve on their own without treatment within 7 to 10 days without scarring. They are contagious and may be irritating or painful while they heal. After the first infection, the virus settles in a nearby nerve sheath and remains there lifelong. For many, the virus lies dormant and causes no symptoms. However, periodically, in some people, the virus may reactivate and cause clinical infection. Typically, recurrent episodes are shorter and less severe than the primary infection.

Presentation:

- A cold sore usually starts with a tingling, itching or burning feeling, and over the next 48 hours, one or more painful small fluid-filled blisters appear anywhere on the face, but typically at the mucocutaneous junction of the lips.
- The blisters then burst and can take several days to crust over forming scabs.
- The scabs slowly disappear over a week or so, leaving no scar.

6.2 Possible complications[25,54,57,58]

- Dehydration from poor oral intake due to painful swallowing, and fever.
- Eczema herpeticum (in patients with atopic eczema, extensive eruptions of herpes simplex can appear on the face and neck).
- Eye disease – ocular herpes simplex can result from autoinoculation; some symptoms include pain, discharge, ulceration and sensitivity to light.
- Cold sores in the beard area (follicular infection), may be caused by autoinoculation from shaving.
- During first infection, self-inoculation to hands/digits or genital area causing vesicular lesions (fluid filled vesicles that may break to form ulcers, which become crusted).
- Erythema multiforme.
- Herpes simplex infection can be very serious and potentially fatal for young babies (neonatal herpes).

Rarely*:* hepatitis, meningitis, encephalitis, myelitis and radiculopathy

6.3 When to refer[54-57,59,60]

Intermediate risk - Amber – Advise the individual to see the most appropriate clinician (GP, NHS 111, pharmacist independent prescriber, dentist, sexual health clinician or optometrist) as appropriate for urgent assessment.
• Red flags for oral cancer such as hoarseness, persistent unexplained ulceration (lasting more than 3 weeks), red or white patches in the mouth or a suspicious lump on the lip or in the oral mucosa. • Babies under 6 months old. • Pregnant women in third trimester with first episode of cold sores. • Suspected infection of the genital area with herpes simplex (can also be referred to the local genito-urinary or sexual health clinic). • Suspected infection of the eye with herpes simplex (refer to WGOS-registered optometrist). • Unable to swallow due to pain and at risk of dehydration. • Immunocompromised individuals, including those having chemotherapy for cancer and with conditions such as HIV. • Deterioration of condition (e.g. the lesion increases in size or spreads, new lesions develop after the initial outbreak, persistent fever, inability to eat or drink). • Uncertain diagnosis/atypical lesions.

Low risk - Green – Advise the individual to see a GP for routine assessment.
• No significant improvement is seen after 5 to 7 days. • Frequent (e.g. more than 6 episodes/year) and/or severe episodes of recurrent cold sores.

6.4 Overview of treatment[54]

Provide advice only.

There is no good quality evidence that topical antivirals are effective in reducing pain or healing time for cold sores. However, some people may find them helpful. If this is the case, they may be purchased over-the-counter. They need to be initiated at the onset of symptoms before vesicles appear and applied frequently until lesions have healed. Topical analgesics or anaesthetics, mouthwash, and lip barrier preparations are similarly not routinely recommended but can be purchased over-the-counter by individuals if they find them helpful. Oral simple analgesia can be taken if needed. Monotherapy with a full therapeutic dose of paracetamol **OR** ibuprofen alone is usually suitable first line. If the response is inadequate, switching analgesics should be considered before trying dual therapy (for individuals under 16 years of age, “dual therapy” means alternating between the two analgesics rather than taking both at the same time).

6.5 Advice for patients[54-57]

Patient information leaflets in English and Welsh are available on the Welsh Medicines Advice Service website.

General advice

- Oral antiviral treatment is not usually needed for healthy people, and topical antivirals/anaesthetics/barrier treatments are not proven to reduce pain or healing time.
- Any topical treatments used should be dabbed on the cold sores rather than rubbed in, to minimise damage to the blisters which may cause pain or viral spread.
- Self-care measures are recommended.
- Seek medical advice if symptoms worsen (for example the lesion spreads, new lesions develop, or there is persistent fever or difficulty taking fluids), or if there is no significant improvement after 5 to 7 days.
- Children who are well do not need to be excluded from nursery or school.

Self-care

- Eat cool, soft foods while the cold sore is tender, and drink plenty to avoid dehydration.
- To help reduce the risk of cold sores appearing, avoid or minimise exposure to known trigger factors, such as ultraviolet light (sunlight), stress, extremes of temperature, fatigue or trauma to the area.
- Sunscreen or sunblock lip balm (SPF 15 or above) may help reduce recurrent episodes in people whose cold sores are triggered by the sun.
- Analgesics such as paracetamol and/or ibuprofen (if there are no contraindications) can be taken to treat pain and fever if needed. See explanation in section 6.4 regarding dual therapy.

Avoiding transmission

- Cold sores can be spread easily.
- Try to avoid touching cold sores as they are very infectious until they have 'scabbed over' and are completely dry.
- Wash your hands with soap and water immediately before and after touching cold sores and after applying creams to them to avoid spreading the virus to other parts of your body or to other people.
- Until the cold sore has fully healed:
    - avoid kissing (and anyone else coming into contact with the cold sore), especially babies under 3 months old, pregnant women and anyone who has a weakened immune system; the infection can cause more serious problems for these individuals.

  - avoid anyone else coming into contact with objects in contact with the cold sore (e.g. lip balm, eating and drinking utensils, towels).
- Contact lenses could become contaminated with the cold sore virus and infect the eyes. To avoid this:
  - do not use saliva to moisten them
  - wash hands before handling contact lenses
  - wear glasses during the period of infectivity and seek advice from your local optometrist if you have any concerns regarding eye involvement

Signposting
The British Association of Dermatologists leaflet on Herpes simplex can be found at: https://www.bad.org.uk/pils/herpes-simplex/

If you feel you are not improving, or are getting worse, despite following suggested advice, please make an appointment to discuss with your GP

8.0 Constipation

A treatment summary for this condition is available at https://www.wmic.wales.nhs.uk/cas-constipation-summary

8.1 About the ailment[70,71]

Constipation is defecation that is unsatisfactory because of infrequent stools, difficulty passing stools or seemingly incomplete emptying of the bowel. Typically, bowel movements occurring less than three times a week may be regarded as constipation. However, it may also present as daily bowel movements with other associated symptoms. The information below provides more details.

- Non-daily bowel movements with stools being dry, lumpy and hard. These may be:
  - large and infrequent (e.g. passed every 7–10 days) or
  - small and relatively frequent (e.g. passed every 2–3 days).
- Daily bowel movements, but with associated symptoms such as:
  - excessive straining.
  - lower abdominal pain or discomfort.
  - abdominal distension.
  - bloating.

In the elderly, it is worth bearing in mind that in addition to the above, constipation may present as non-specific symptoms such as:

- confusion or functional decline.
- nausea or loss of appetite.
- overflow diarrhoea.
- urinary retention.

In practice, constipation is often defined as passage of stools less frequently than the person's normal pattern.

Many factors can cause constipation including:

- physical factors e.g. female sex, during pregnancy and older age.
- dietary factors e.g. low fibre diet, low calorie intake and dehydration.
- toileting habits e.g. lack of privacy, difficult access to a toilet or changes in normal routine/lifestyle.
- lack of exercise or reduced mobility.
- psychological factors e.g. anxiety, depression or an eating disorder.

Examples of secondary causes of constipation:

- Endocrine and metabolic disease e.g. diabetes mellitus, hypothyroidism.
- Neurological conditions e.g. history of cerebrovascular disease, Parkinson's disease, spinal cord injury, tumours.
- Structural abnormalities e.g. anal fissures, haemorrhoids, inflammatory bowel disease (IBD).
- Medicines e.g. analgesics (opioids, NSAIDs), verapamil (also, to a lesser extent, other calcium channel blockers), antidepressants, iron, diuretics, aluminium-containing antacids, calcium supplements, anticholinergics, sedating antihistamines, some antiepileptics and antipsychotics.

8.2 Possible complications[70]

Complications of chronic constipation include:

- faecal loading or impaction (this may lead to incontinence, megacolon, obstruction, perforation, ulceration, urinary infections, rectal bleeding and prolapse).
- progressive faecal retention, distention of the rectum, and loss of sensory and motor function.
- haemorrhoids or anal fissure.

8.3 When to refer [70,72-77]

High risk – Red

If an individual with constipation presents with the following signs or symptoms, a more serious underlying cause needs to be excluded.

- Intestinal obstruction or perforation. Symptoms include frequent and forceful vomiting sometimes with presence of bile, difficulty passing gas, feeling of fullness even without eating much, sometimes diarrhoea occurs.
- Paralytic ileus. Symptoms include nausea, abdominal distension or tenderness, recent abdominal or non-abdominal surgery, acute conditions e.g. pneumonia, trauma and systemic conditions e.g. sepsis.
- Existing clozapine treatment (urgent review).
- Toxic megacolon. Symptoms include abdominal pain, tenderness and distension, fever, chills, changes in mental state.
- Symptoms of spinal cord injury e.g. new onset pain, tingling, weakness or numbness in one or both legs.



Action: Advise the individual to attend A&E without delay.

Intermediate risk – Amber

- Blood or mucous in the stools, rectal bleeding, anal pain.
- Rectal bleeding and or anal pain (not associated with known haemorrhoids). Refer to CAS haemorrhoids monograph
- Unexplained weight loss, appetite loss, tiredness.
- Severe abdominal pain.
- Suspected abdominal or rectal mass or lump.
- Co-existing diarrhoea.
- Colonic atony or faecal impaction.
- Crohn's disease or ulcerative colitis.
- Faecal urgency.
- Tenesmus (continuously feeling the need to defecate without producing significant amounts of faeces, or after passing a normal amount of stool).
- Age under 18 years.
- Pregnant/breastfeeding AND opioid induced constipation.
- Sudden altered bowel habit AND aged over 60 years.
- Manual measures being used to relieve constipation.
- Persistent symptoms including individuals who have tried altered diet and use of laxatives.
- History of prolonged use of laxatives.
- Palliative care involvement (e.g. individual is on a palliative care pathway).
- Associated fever, nausea or vomiting.
- Associated urinary symptoms, urinary incontinence or retention or dyspareunia.
- Concomitant iron deficiency anaemia.
- Age 60 years and over AND non-iron deficiency anaemia.
- Presence of confusion, delirium, functional decline.
- Neurological conditions e.g. history of cerebrovascular disease, Parkinson's disease, tumours.

Action: advise the individual to see a GP or call NHS 111 or see a pharmacist independent prescriber* as appropriate for same day assessment.

Low risk – Green

- Persistent bloating (over 3 weeks).
- Prescribed medicine suspected to be the cause, for example (list not exhaustive) aluminium containing antacids, iron or calcium supplements, analgesics such as opiates and NSAIDs, antimuscarinics such as procyclidine and oxybutynin, tricyclic antidepressants, antipsychotics such as amisulpride and quetiapine **(EXCEPT CLOZAPINE)**, antiepileptics such as carbamazepine and phenytoin, antihistamines such as hydroxyzine, antispasmodics such as dicycloverine or hyoscine, calcium channel blockers such as verapamil, diuretics such as furosemide.
- Endocrine and metabolic disease e.g. diabetes mellitus, hypothyroidism.



Action: Treatment can be provided if appropriate AND advise the individual to see a GP for routine assessment.

8.4 Overview of treatment[70,77,78]

Relief of short-term constipation (less than 3 months)
If lifestyle changes (see section 8.6 Advice for patients below) are not effective, offer oral laxatives using a stepped approach (see constipation treatment summary).
The aim of treatment is to increase stool frequency or ease of stool passage by increasing water content or accelerating bowel transit. Treatment is selected depending on individual preference and consideration of severity, type and duration of symptoms.

For non-opioid induced constipation, including breastfeeding individuals:

- **1st line** – a bulk-forming laxative (i.e. ispaghula husk).
- **if stools remain hard or difficult to pass, add or switch to** an osmotic laxative (e.g. a macrogol) and/or stool softener (e.g. docusate sodium).
  - **if a macrogol is ineffective or not tolerated** offer treatment with lactulose instead and/or stool softener (e.g. docusate sodium).
- **if stools are soft but difficult to pass, or if there is a sensation of inadequate emptying** add a stimulant laxative (e.g. senna, docusate).

If an individual is pregnant:

- **1st line** – a bulk-forming laxative (i.e. ispaghula husk).
- **if stools remain hard or difficult to pass, or if there is a sensation of inadequate emptying, add or switch to** an osmotic laxative (e.g. a macrogol)
  - **if a macrogol is ineffective or not tolerated** offer treatment with lactulose instead.

If an individual has opioid-induced constipation:

- avoid bulk-forming laxatives.
- **1st line** - use an osmotic laxative and a stimulant laxative (senna or docusate). Refer individual as appropriate.

N.B pregnant or breastfeeding individuals presenting with opioid-induced constipation should not be treated under this monograph.

Doses should be adjusted according to symptoms and response, in line with licensed doses.
Advise that laxatives should be gradually reduced and stopped once the stool becomes soft and passes easily without straining, at least 3 times a week.

8.5 Treatments[1,70,79-86]

Start with non-pharmacological measures such as increasing dietary fibre and ensuring adequate fluid intake and activity levels. If ineffective or inadequate, offer treatment with oral laxatives using a stepped approach. These treatments should be trialled in a step wise fashion for a period determined by the usual timeframe of the effectiveness of the product and the patient's symptoms.

Table 1: Laxative options

Refer to the BNF or SmPC for full details of interactions, adverse effects, cautions and contraindications.

Medication	Laxative type	Dose	Considerations
Ispaghula husk 3.5 g effervescent granules gluten free sugar free sachets	Bulk forming	ONE sachet TWICE daily, preferably after food, with at least 150 mL liquid	**1st line in non-opioid symptoms and pregnancy.** Suitable for breastfeeding. Useful if dietary intake of fibre is difficult. Adequate fluid intake is important. Not recommended for people taking constipating drugs like opioids. Can cause bloating and flatulence. Should be taken at least 1 hour before going to bed (not immediately before). Take other medicines 30–60 minutes before or after ispaghula. If also taking iron supplements, these should be taken at least 1 hour before or 4 hours after ispaghula. Avoid in those with diabetes, those taking thyroid hormones, phenylketonuria, renal impairment and potassium-restricted diet. Usually effective within 2 to 3 days.
Macrogol compound oral powder sachets NPF sugar free	Osmotic	ONE to THREE sachets DAILY in divided doses Dissolve in at least 125 mL water see PGD	**1st line for opioid induced symptoms.** For other patients, use if bulk forming laxative ineffective or not tolerated. Suitable for pregnancy and breastfeeding. Can cause bloating and flatulence. Adequate fluid intake is important. Usually effective within 2-3 days.

Medication	Laxative type	Dose	Considerations
Lactulose 3.1–3.7 g / 5 mL solution	Osmotic	Between 15 mL and 45 mL daily initially (can be in divided doses). This dose can be adjusted to between 15 mL and 30 mL daily after treatment effect established.	Used for opioid and non-opioid-induced symptoms if macrogol ineffective or not tolerated. 2nd line in pregnancy and breastfeeding. Can cause bloating and flatulence, abdominal pain, cramps, nausea or vomiting. Adequate fluid intake is important. The dose normally used in constipation should not pose a problem for diabetics. A dose of 30 mL provides 116 KJ (28 kcals) and is unlikely to adversely affect diabetics. Not suitable for people with lactose intolerance and galactosaemia. Usually effective within 2-3 days.
Senna 7.5 mg tablets	Stimulant	ONE to TWO tablets at bedtime	**1st line for opioid induced symptoms alongside osmotic laxative.** Contraindicated in pregnancy and breastfeeding. Option if stools are soft but difficult to pass or if there is a sensation of inadequate emptying. Can cause abdominal cramps, diarrhoea, nausea or vomiting. Avoid in intestinal obstruction, IBD, abdominal pain, dehydration. Urine may be discoloured (yellowish-brown); this is harmless. Usually effective within 8-12 hours.
Docusate 100 mg capsules	Stool softener and stimulant	ONE capsule to be taken TWO to THREE times a day. Maximum 5 capsules daily see PGD	**Option for opioid induced symptoms alongside osmotic laxative.** **Useful alternative for people who find it hard to increase fluid intake in both opioid and non-opioid induced symptoms.** Avoid in pregnancy. Suitable in breastfeeding. Usually effective within 12-72 hours.

Table 2: Formulary Information

Medication	Legal class	Pack size	Maximum number of consultations per episode† Maximum number of episodes per year
Ispaghula husk 3.5 g effervescent granules gluten free sugar free sachets	P	30	**Opioid induced constipation:** A maximum of 2 consultations per episode. A maximum of 2 episodes per year. **Non-opioid induced constipation:** A maximum of 3 consultations per episode. A maximum of 2 episodes a year. † Episode: one episode constitutes an appropriate number of consultations (as defined above) in which lifestyle advice or treatment is provided. Resolution of symptoms or onward referral would define the end of the episode.
Macrogol compound oral powder sachets NPF sugar free	P	30	
Lactulose 3.1–3.7 g / 5 mL solution	P	500 mL	
Docusate 100 mg capsules	P	30	
Senna 7.5 mg tablets	P	20	

8.6 Advice for patients[70,72,75,77]

Patient information leaflets in English and Welsh are available on the Welsh Medicines Advice Service website.

Lifestyle measures

- Eat a healthy, balanced diet with regular meals.
- Your diet should contain whole grains, vegetables, fruits or fruit juice high in sorbitol (e.g., apples, apricots, grapes, raisins, peaches, pears, plums, prunes, raspberries, and strawberries).
- Increase dietary fibre; aim for 30g of fibre a day (increase gradually, to minimise bloating and flatulence) – beneficial effects of this may take several weeks to be observed. Coarse wheat bran will be more beneficial than finely ground. Other options to increase fibre intake include wheatgerm, flaxseed and linseed.
- Avoid dehydration by drinking plenty of water (8–10 cups per day). Further information can be found on the British Dietetic Association website: Fluid (water and drinks) and hydration - British Dietetic Association (BDA).
- Exercise regularly.
- Respond straight away to the sensation of needing to go to the toilet; try not to hurry, make sure you have enough time to empty your bowel.

- Try resting feet on a low stool while going to the toilet, so that the knees are above the hips; this can make passing stools easier.
- Avoid codeine-containing products as these make constipation worse; paracetamol is not known to cause constipation so can be taken for minor pain if no other exclusions apply.

Laxative treatment

- Ensure adequate fluid intake to avoid dehydration and obstruction.
- If an effect is not seen within 3 days of taking ispaghula, lactulose or macrogols, return to the pharmacy for further advice.
- If an effect is not seen within 12–72 hours of taking senna or docusate, seek medical advice.
- Laxatives should be gradually reduced and stopped once the stool becomes soft and passes easily without straining, at least 3 times a week.
- Ideally, laxatives should only be taken occasionally and for up to a week at a time.

If you feel you are not improving, or are getting worse, despite lifestyle changes and/or completion of a treatment course, please make an appointment to discuss with your GP.

16.0 Infantile colic

Management of infantile colic within CAS is limited to the provision of advice to parents / guardians of infants from birth to less than 5 months old who **otherwise appear healthy and have no concerning symptoms** other than repeated episodes of excessive and inconsolable crying.

16.1 About the ailment[144-146]

Infantile colic is recurrent and prolonged periods of infant crying, fussing or irritability that occur without obvious cause, and cannot be prevented or resolved by caregivers in an infant that otherwise appears to be healthy and thriving.
It is a self-limiting condition which usually starts within the first few weeks of life, improves by 3–4 months and resolves by 5–6 months of age.

The exact underlying cause is unknown and may reflect a neurodevelopmental stage exacerbating normal infant crying. It may also be caused by:

- abnormal gastrointestinal motility
- reduced gut microbiome diversity leading to increased gas production
- psychosocial factors e.g. family tension, parental anxiety, inadequate parent-infant interaction, overstimulation of the infant, misinterpretation of crying

Symptoms include:

- inconsolable crying that often occurs in the late afternoon or evening
- drawing knees up to abdomen or arching back when crying
- fist clenching/going red in the face/passing flatus

16.2 Possible complications[144]

- Premature cessation of breastfeeding and/or premature weaning onto solid foods.
- Family tension and parent-infant attachment difficulties.
- Increased risk of infant maltreatment.
- Parental or caregiver stress, fatigue, anxiety or depression.
- Loss of confidence in parenting skills.

16.3 When to refer[144]

High risk - Red – Advise the individual to attend A & E without delay.
• Weak abnormally high-pitched or continuous cry (may indicate potentially serious illness).

Intermediate risk - Amber – Provide advice AND advise the individual to see a health visitor, GP or NHS 111 for assessment typically within 24-48 hours. Pharmacists should use their judgement to determine the urgency of referral.
• Infants who have lost weight or are not thriving and/or have symptoms that are not improving or are severe. • Parents/guardian feel unable to cope with the infant's symptoms despite reassurance and advice.

Low risk - Green – Provide advice AND advise the individual to see a health visitor or GP for routine assessment.
• Symptoms that haven't improved after 4 months of age (an alternative underlying cause for symptoms should be considered). • Diagnostic uncertainty.

16.4 Overview of treatment[144]

Provide advice only

There is insufficient, good quality evidence for the use of the following management strategies and so they are **NOT** recommended:

- simeticone (such as Infacol®) or lactase (Colief®)
- probiotic or herbal supplements
- maternal diet modification if breastfeeding, or changing the infant milk formula preparation
- manipulative strategies such as spinal manipulation or cranial osteopathy

16.5 Advice for patients[144]

Patient information leaflets in English and Welsh are available on the Welsh Medicines Advice Service website.

Strategies for management

- Holding, gentle rocking or bathing the infant in a warm bath may help soothe them.

- "White noise" (e.g. vacuum cleaner/hairdryer). Background/white noise can be downloaded as an app.
- Sitting or holding the infant upright during feeding to stop them swallowing air.
- Ensure an optimal winding technique is used during and after feeds.
- Continue breastfeeding wherever possible.
- Reducing environmental stimuli.

Reassurance/support to parents/guardians

- Infantile colic is a common condition which should resolve by 5-6 months of age.
- Parental/guardian access to appropriate support and wellbeing (e.g. friends, family, health visitor) and rest whenever possible is very important.
- Put the baby down in a safe place (e.g. cot) for a few minutes if unable to cope with crying. After a few minutes when you are feeling calm, go back and check on the baby. Practising calming strategies may help.
- The ICON campaign (https://www.iconcope.org) provides support and advice on strategies to help people who care for babies to cope with crying. ICON stands for:
  I – Infant crying is normal
  C – Comforting methods can help
  O – It's Okay to walk away
  N – Never, ever shake a baby
- "Cry-sis" is a support group for families with excessively crying or sleepless children, their website is available at https://www.cry-sis.org.uk and they also run a national telephone helpline 9am-10pm daily (0800 448 0737).
- The "My baby is crying all the time" section on the Healthier Together website (https://www.hwehealthiertogether.nhs.uk/parentscarers) may be useful.
- Meeting other parents/carers with children of similar age to share experiences may also be beneficial.

If you feel your baby is not improving, or is getting worse, despite trialling management strategies, please make an appointment to discuss with your baby's GP.

18.0 Mouth ulcers (simple aphthous)

This monograph supports the management of mouth ulcers (not associated with an underlying systemic disorder) for immunocompetent individuals from the age of 12 years onwards.

18.1 About the ailment[99,151,152]

Mouth ulcers are painful sores that can occur anywhere in the mouth. The most common type are aphthous ulcers. Aphthous ulcers are small, round or oval, usually white or pale yellow, with an inflamed red outer edge.

There are three different types, that can occur simultaneously:

- minor ulcers (approximately 85% cases) are less than 1cm in diameter, usually occur singularly or in groups of up to six and heal in 7–14 days without scarring
- major ulcers (approximately 10% cases) are usually around 1cm in diameter or larger, usually only one or two appear at a time but can occur in groups of up to six and have a raised, irregular border; they usually take several weeks to heal and often leave a scar (see referral boxes)
- herpetiform ulcers (approximately 5% cases) present as multiple (5–100) pinhead-sized ulcers that may fuse to form much larger, irregular-shaped ulcers; they can be very painful and usually last 10–14 days

Many people have infrequent recurrences (once or twice a year), but some have almost continuous disease activity. Disease activity tends to decrease over time.

Aphthous-like ulcers look similar to aphthous ulcers but are associated with an underlying systemic disorder e.g. vitamin B12, iron or folate deficiency, some viruses and immunodeficiency, Behçet's syndrome, Coeliac disease and inflammatory bowel disease.

Mouth ulcers can occur as an adverse drug reaction (for example to nonsteroidal anti-inflammatory drugs, nicorandil, or beta-blockers) or as a sign of medication induced bone marrow suppression (e.g. chemotherapy, carbimazole, azathioprine). There may be a temporal relationship to starting or increasing the dose of the medication.

18.2 Possible complications[151,152]

Secondary bacterial infections are uncommon and associated with increased pain and redness. There may also be a fever.

18.3 When to refer[151-155]

High risk - Red – Advise the individual to seek an URGENT appointment (dentist or GP).
• Solitary ulcer present for three weeks or more, that has no obvious repeat trauma to the area requires URGENT dental (or medical) assessment to exclude oral cancer.

Intermediate risk - Amber – Advise the individual to see the most appropriate clinician (GP, dentist, NHS 111, pharmacist independent prescriber, sexual health clinician) that avoids delay in diagnosis and treatment.

- Signs of systemic illness or fever.
- Unable to eat or drink.
- Worsening pain/redness or bleeding.
- Severe ulceration unresponsive to simple topical treatments.
- Ulcers in crops of up to 100 (herpetiform).
- Immunosuppression suspected (e.g. on medication that can cause bone marrow suppression).
- Atypical sites (e.g. gums or palate, or non-oral sites e.g. genitalia [consider referral to sexual health service]).
- Child under 12 years old.
- Diagnostic uncertainty (e.g. painless ulcers, concurrent symptoms which may indicate underlying systemic disease such as pallor, joint pain/skin rashes/diarrhoea).

Low risk - Green – Treatment can be provided if appropriate AND advise the individual to see a GP (or dentist) for routine assessment.

- Ulcers more than 1 cm diameter (major aphthous).
- Suspected adverse drug reaction to a prescribed medicine (AMBER referral if immunosuppression suspected).
- Recurrent severe mouth ulcers (more than 2 times a year).
- Ulceration suspected to be caused by local trauma from sharp and/or broken teeth, dentures or orthodontic appliances.
- Initial presentation in someone over 30 years old.

18.4 Overview of treatment[151,156]

Treatment aims to ease the pain when ulcers occur, to help them heal as quickly as possible and to prevent infection.

- Frequency, duration and severity of symptoms help to determine the management of aphthous ulcers.
- Mild, infrequent mouth ulcers that do not interfere with daily activities (e.g. eating) may not need to be treated.
- Simple therapies can be used alone or in combination with each other; these include:
  - topical anaesthetic agent (e.g. containing lidocaine) – see further details in *"Advice for patients"* below
  - topical analgesic/anti-inflammatory agent e.g. benzydamine
  - topical antimicrobial agent e.g. chlorhexidine gluconate mouthwash

18.5 Treatments[151,152,155,157-159]

Table 1: Topical treatments

Medication	Dose	Considerations
Chlorhexidine gluconate 0.2% mouthwash **(Antiseptic/antimicrobial)**	**Adults and children aged 12 years and over**: Rinse mouth with 10 mL TWICE a day for ONE minute. Spit out after use. Continue use for 48 hours after the lesions have healed.	• Can be used in pregnancy and breastfeeding. • May contain alcohol. • Ensure individual can safely gargle. • May discolour teeth and tongue. To help combat this, brush teeth before using and avoid drinks that contain tannin (e.g., tea, coffee, or red wine). • Rinse mouth thoroughly after brushing as some ingredients in toothpaste can inactivate chlorhexidine. • If mucosal irritation occurs, dilute each dose with an equal volume of water or discontinue use. • Wait at least 30 minutes after use before eating or drinking to maximise effectiveness.
Benzydamine 0.15% oromucosal spray sugar free **(Analgesic/anti-inflammatory)**	**Adults and children aged 12 years and over:** Use 4 to 8 sprays every 1.5 to 3 hours as needed.	• Not suitable in pregnancy or breastfeeding. • Contains alcohol. • Caution in history of bronchial asthma due to risk of bronchospasm. • Not advisable in patients with hypersensitivity to acetylsalicylic acid or other NSAIDs. • May cause numbness and stinging that lasts a few minutes.

Table 2: Formulary information

Medication	Legal class	Pack size	Maximum number of consultations per episode† Maximum number of episodes per year
Chlorhexidine gluconate 0.2% mouthwash	GSL	300 mL	A maximum of 1 consultation per episode. A maximum of 2 episodes per year. † Episode: one episode constitutes an appropriate number of consultations (as defined above) in which lifestyle advice or treatment is provided. Resolution of symptoms or onward referral would define the end of the episode.
Benzydamine 0.15% oromucosal spray sugar free	P	30 mL	

18.6 Advice for patients[151-153,155]

Patient information leaflets in English and Welsh are available on the Welsh Medicines Advice Service website.

Mouth ulcers need time to heal but will usually go away by themselves. Seek medical advice if the ulcer becomes very large and sore or doesn't resolve within 3 weeks.

Lifestyle changes

To reduce recurrence, avoid precipitating factors such as:

- foods that are acidic and/or contain chocolate, coffee, peanuts (and gluten-containing products for some individuals)
- toothpaste containing sodium lauryl sulfate (SLS)
- trauma e.g. from sharp, broken teeth or orthodontic appliances/dentures

Self-care to reduce ulcer pain once developed

- Use a soft toothbrush when brushing teeth.
- Avoid eating crunchy foods; try to stick to those that are softer and easier to chew.
- Avoid spicy, salty, acidic foods or drinks.
- Drink cool drinks through a straw.

Other self-help options

Some people find that salt (saline) mouthwashes help soothe ulcer pain. The following method can be tried and repeated as often as needed:

1) Dissolve half a teaspoon of salt in a glassful of warm water, allow the solution to cool (a tepid solution is more soothing).
2) Take some of the dissolved solution in your mouth and swill around then spit out; DO NOT SWALLOW.

A topical anaesthetic (e.g. containing lidocaine) may provide fast, effective relief from the pain of mouth ulcers, including those caused by denture irritation.

Signposting: Information on accessing NHS dental services in Wales can be found on the NHS 111 Wales website or by calling NHS 111.

If you feel you are not improving, or are getting worse, despite lifestyle modifications and/or 7 days of treatment; please make an appointment to discuss with your GP or dentist.

21.0 Scabies

This monograph supports the management of scabies in individuals 2 years of age and over and the treatment of household contacts (symptomatic and asymptomatic) to ensure that treatment occurs simultaneously. Each individual treated should have their own CAS consultation recorded in Choose Pharmacy.

21.1 About the ailment[168-172]

Scabies is a very itchy, highly contagious skin infestation caused by a mite that is up to 0.5mm long and burrows into the skin where it lays eggs. These burrows can often be seen in the interdigital web spaces. Scabies is spread by direct skin-to-skin contact, and so is more prevalent in overcrowded living conditions but can affect anyone.

The main symptom is intense itching, particularly at night. A raised blotchy rash that can develop into spots may also appear. The rash usually spreads across the whole body other than the head and neck (where it may develop in young children and elderly people). The spots may be more difficult to see on brown and black skin. The absence of itching does not exclude scabies for people with neurological conditions with decreased/loss of sensation.

Symptoms usually take 3–6 weeks to develop after becoming infected the first time but occur earlier (at 1-3 days) in a reinfested individual.

21.2 Possible complications[173]

Scabies infestation may lead to:

- secondary bacterial infection – due to entry of bacteria into the compromised skin barrier; this may result in cellulitis, impetigo, folliculitis, furunculosis, ecthyma, or abscess
- secondary eczematisation – may be due to scratching and/or the irritant effects of topical medication
- nodular scabies – pruritic nodules of the axillae, groin, and male genitalia that can persist for weeks or months following treatment due to a prolonged immune response to mite antigens

21.3 When to refer[99,168,174,175]

Intermediate risk - Amber - Advise the individual to see the most appropriate clinician (GP, NHS 111, pharmacist independent prescriber) that avoids delay in diagnosis and treatment.
• Individuals who appear systemically unwell. • Individuals under 2 years of age. • Suspected crusted scabies (hyperinfestation with mites leading to thickened crusted, flaky skin). • Broken skin and/or signs of bacterial infection (weeping, pus or yellow crusts). • Treatment failure (after 2 courses of treatment for scabies have failed in one episode) or if itching is not improving 4-6 weeks after the final treatment application. • Individuals with clinical features of scabies if permethrin 5% cream is unsuitable (see section 21.5 table 1). • Compliance with topical treatment likely to be an issue. • Diagnostic uncertainty.

21.4 Overview of treatment[174,175]

Permethrin 5% cream is an effective topical treatment for eradication of scabies. If an individual with clinically diagnosed scabies cannot use permethrin 5% cream, they should be referred to an appropriate prescriber (as per amber referral criteria) for consideration of treatment with oral ivermectin (prescription only medicine).

Malathion 0.5% liquid is not as effective as permethrin 5% cream. Malathion 0.5% liquid can be supplied as an alternative treatment for identified contacts who are asymptomatic if permethrin 5% cream is unsuitable. It can also be used for treating symptomatic individuals if permethrin is unsuitable or ineffective (after considering if the permethrin 5% cream has been used correctly and whether reinfestation has likely occurred) AND treatment with oral ivermectin is unsuitable or declined.

21.5 Treatments[1,49,174-180]

Table 1. Scabicide

Medication	Dose	Considerations
Permethrin 5% cream	Due to the great variability in body area and skin types, precise dosage recommendations are not possible but suggested doses are: **Adults and children over 12 years of age:** Usually, up to one tube (30 g) once weekly for 2 doses. Some adults may need to use an additional tube for full body coverage but should not use more than two tubes (60 g in total) at each application. **Children aged 6–12 years:** up to half a tube (15 g) once weekly for 2 doses. **Children aged 2–5 years:** up to a quarter of a tube (7.5 g) once weekly for 2 doses. Apply permethrin 5% cream over whole body. Wash off after 8–12 hours. If hands or any other body parts are washed with soap within 8 hours of application, they should be treated again with cream.	• 1st line treatment for symptomatic individuals and asymptomatic contacts. • Contraindicated if known hypersensitivity to permethrin cream, its components, or other pyrethroids or pyrethrins including chrysanthemums. • Some permethrin 5% cream tubes contain latex. • No known effects in pregnancy and breastfeeding; use with caution. • The cream should not be applied to broken skin, mucous membranes or near the eyes. • Avoid in those with pre-existing skin conditions such as eczema. • Can cause skin discomfort after application (usually mild and transient). • Caution: flammable.
Malathion 0.5% liquid **(Derbac-M® 0.5% liquid)**	Assess quantity to supply based on individual's body habitus. **Adults and children aged 2 years and over:** Apply once weekly for 2 doses by applying preparation over whole body, wash off after 24 hours. If hands or any other body parts are washed with soap within 24 hours, they should be retreated.	• 2nd line treatment for asymptomatic contacts (if permethrin unsuitable). • Use for individuals with clinical features of scabies only if permethrin unsuitable/ineffective AND referral for oral treatment not appropriate/declined. • No known effects in pregnancy and breastfeeding; use with caution. • The liquid should not be applied to broken skin, mucous membranes or near the eyes. • Contains ingredients that may cause delayed allergic reactions.

Table 2. Medication to treat itch

Medication	Dose	Considerations
Chlorphenamine 2 mg in 5 mL oral solution	**Child 2-6 years:** 1 mg (2.5 mL) every 4-6 hours MAX 6 doses in 24 hours **Child 6-12 years:** 2 mg (5 mL) every 4-6 hours MAX 6 doses in 24 hours **Adults and children 12 years and over:** 4 mg (10 mL) every 4-6 hours. MAX 6 doses in 24 hours	• May cause drowsiness. If affected do not drive or operate machinery. • Sedating effects enhanced by alcohol. • May cause anticholinergic adverse effects. • Limit to only at night if only nocturnal itch. • Tablets not licensed for children under 6 years old. • Contraindicated if taking MAOI's or within 14 days of stopping such treatment. • Manufacturers advise not to use during pregnancy or breastfeeding.
Chlorphenamine 4 mg tablets	**Child 6-12 years:** 2 mg every 4-6 hours. MAX 6 doses in 24 hours **Adults and children 12 years and over:** 4 mg every 4-6 hours MAX 6 doses in 24 hours	
Crotamiton 10% cream (Eurax®)	**Child 3 years and over:** Apply to the affected area(s) 2–3 times daily as needed	• Consider for post-scabietic itch that is present less than 4 weeks after a treatment course is completed. • Can provide relief from irritation for 6 to 10 hours after application. • Not for use in pregnancy, use of an emollient can be advised. • Use during breastfeeding under medical supervision only. Do not apply to nipple area. • Caution: flammable.

Table 3. Formulary information

Medication	Legal class	Pack size	Maximum number of consultations per episode† and Maximum number of episodes per year
Permethrin 5% cream	P	30 g	A maximum of 2 consultation per episode. A maximum of 2 episodes per year. † Episode: one episode constitutes an appropriate number of consultations (as defined above) in which lifestyle advice or treatment is provided. Resolution of symptoms or onward referral would define the end of the episode.
Malathion 0.5% liquid (Derbac-M® 0.5% liquid)	P	150 mL	
Chlorphenamine 2 mg in 5 mL oral solution	P	150 mL	
Chlorphenamine 4 mg tablets	P	28	
Crotamiton 10% cream	GSL	30 g 100g	

21.6 Advice for patients[169,172,174,175]

Patient information leaflets in English and Welsh are available on the Welsh Medicines Advice Service website.

Any sexual partners within the past month, and/or any other close personal contacts should be contacted by the individual as they should also seek treatment (even if asymptomatic). Where a contact presents at a pharmacy where the index case has been treated under CAS, treatment may be provided to that individual under CAS.

Treatment information

- Remove all clothes (and ideally all jewellery) and wash before treatment with cool (not hot) water, ensuring skin creases and areas under nails are cleaned thoroughly.
- Apply permethrin cream/malathion liquid to the WHOLE body (except around the eyes). The product information may suggest not treating the scalp and face but it is best that all these areas are treated.
- The treatment is best applied at night to clean, cool, dry skin. When applying cream/liquid, particular attention should be paid to:
  - areas between fingers and toes
  - under nails (nails should be cut short)

  - wrists
  - armpits
  - external genitalia
  - breasts
  - buttocks
- Allow the cream/liquid to dry before dressing.
- The cream/liquid should not be applied to broken skin, mucous membranes, or near the eyes.
- If breastfeeding, remove the cream/liquid from nipples before feeding and reapply afterwards.
- Corticosteroids for eczematous-like reactions should be withheld until after finishing scabies treatment as there is a risk of exacerbating the scabies infestation by reducing the immune response to the mite.
- Itching may continue for up to 6 weeks after successful treatment of scabies.
- Permethrin cream and crotamiton cream is flammable and can make fabrics (including clothing and bedding) catch fire more easily; do not go near naked flames or smoke.

Decontamination and reducing transmission risk

- Bedding, clothing and towels of all potentially infested individuals should be decontaminated by washing at a high temperature (at least 60°C) and drying in a hot air dryer; alternatively, items can be sealed in a plastic bag for at least 72 hours before use.
- All members of the household should be treated simultaneously (within 24 hours).
- Affected individuals, including children, can go back to work or school 24 hours after the first treatment.

If appropriate, individuals can order free home testing kits for sexually transmitted infections from Public Health Wales - https://phw.nhs.wales/topic/sexual-and-reproductive-health/ or collect from a participating community pharmacy.

If you feel you are not improving after 4 weeks, or are getting worse, despite recommended treatment, please make an appointment to discuss with your GP.

23.0 Teething

This monograph supports the provision of advice for children from birth to 36 months old, including pain relief options for children between 3 and 36 months.

23.1 About the ailment[214,215]

Teething occurs when the teeth emerge through the gums. Most children start teething around 4 to 12 months of age and have their full set of deciduous teeth at around 2 to 3 years old. Signs and symptoms of teething are generally mild and usually start approximately 3 to 5 days before each tooth erupts. Symptoms tend to decrease with age; no specific symptom or sign is diagnostic for teething.

Signs and symptoms include:

- pain
- increased biting and chewing
- dribbling / drooling
- gum-rubbing
- sucking
- mildly raise temperature (not above 38°C)
- irritability
- wakefulness
- ear-rubbing
- facial rash
- decreased appetite
- disturbed sleep
- tender, red and swollen gums
- flushed cheek or face

23.2 Possible complications[214]

Teething itself is a normal physiological process and symptoms are generally mild and self-limiting. Presence of signs and symptoms as set out below, may suggest an underlying condition and should be referred.

23.3 When to refer[214,215]

High risk - Red - Advise the individual to arrange an urgent (within 2 hours) face-to-face assessment (GP/111) to guide whether urgent hospital admission is required.

- Temperature ≥ 38°C in infants under 3 months.

Intermediate risk - Amber - Advise the individual to see a GP, call NHS 111 or see a pharmacist independent prescriber as appropriate for same day assessment.

- Signs of infection that may present with overlapping symptoms e.g. otitis media, croup, oral thrush, respiratory or urinary tract infections and primary herpetic gingivostomatitis
- Temperature ≥ 39°C in children aged 3–6 months
- Temperature ≥ 38°C in children aged 3 months and over for 5 days or more
- Any child who is systemically unwell, in severe distress or has prolonged symptoms
- Children with diarrhoea for more than 2 days or who have passed six or more diarrhoeal stools in the last 24 hours.
- Systemic symptoms
- Diagnostic uncertainty

23.4 Overview of treatment[214,216]

Self-care measures should be tried in the first instance (see section 23.6).

Oral simple analgesia can be taken if needed. Monotherapy with a full therapeutic dose of paracetamol **OR** ibuprofen alone is usually suitable first line. If the response is inadequate, switching analgesics should be considered before trying dual therapy (for individuals under 16 years of age, “dual therapy” means alternating between the two analgesics rather than taking both at the same time).

23.5 Treatments[39,214]

Table 1: Pain relief for pain associated with teething

Medication	Dose	Considerations
Paracetamol 120 mg in 5 mL oral suspension paediatric sugar-free	**Child 3-5 months:** 60 mg every 4-6 hours; max. 4 doses in 24 hours **Child 6-23 months:** 120 mg every 4-6 hours; max. 4 doses in 24 hours **Child 2-3 years:** 180 mg every 4-6 hours; max. 4 doses in 24 hours	• 1st line (unless contraindicated). • Only babies weighing over 4kg and born after 37 weeks should be considered for supply. • Paracetamol should not be taken more frequently than every 4 hours. • No more than 4 doses should be administered in a 24-hour period. • Consider if individual is taking any other paracetamol-containing products prior to supply and advise accordingly. • Check pack details for brands that carry a lactose intolerance warning and any other warnings/cautions/advice.
Ibuprofen 100 mg in 5 mL oral suspension sugar-free	**Child 3-5 months:** 50mg 3 times a day; max. daily dose (in 24 hours) to be given in 3-4 divided doses. **Child 6-11 months:** 50mg 3-4 times a day; max. daily dose (in 24 hours) to be given in 3-4 divided doses. **Child 1-3 years:** 100mg 3 times day; max. daily dose (in 24 hours) to be given in 3-4 divided doses.	• Only babies weighing over 5kg and born after 37 weeks should be considered for supply. • Take with/after milk or food. • Caution in asthma and children at risk of dehydration. • Check pack details for brands that carry a lactose intolerance warning and any other warnings/cautions/advice.

Table 2: Formulary information

Medication	Legal class	Pack size	Maximum number of consultations per episode† Maximum number of episodes per year
Paracetamol 120 mg in 5 mL sugar-free paediatric oral suspension	GSL P	100mL	A maximum of 2 consultations per episode. A maximum of 2 episodes per year. † Episode: one episode constitutes an appropriate number of consultations (as defined above) in which lifestyle advice or treatment is provided. Resolution of symptoms or onward referral would define the end of the episode.
Ibuprofen 100 mg in 5 mL sugar-free oral suspension	GSL P	100mL	

23.6 Advice for patients[214-216]

Patient information leaflets in English and Welsh are available on the Welsh Medicines Advice Service website.

Offer reassurance that teething is normal and not an illness. Symptoms are generally mild and self-limiting.

Self-care measures

- Gently rub the gum with a clean finger.
- Under supervision, allow the child to bite on a clean, cool (not frozen) object (avoid objects that can easily be broken into hard pieces because they may be a choking risk); suitable examples include:
  - a chilled teething ring from the fridge; solid rings are preferred over gel or liquid filled rings, which could leak. Never tie the teething ring around the infant's neck (as it is a choking hazard) or put it in the freezer (could damage baby's gums).
  - a cold wet flannel
  - chilled raw fruit and vegetables (e.g. apple, carrot, cucumber or melon) for children who have been weaned.
  - a sugar-free product (avoid teething biscuits or rusks) so as not to cause tooth decay
- Cuddle, reassure and distract the child with play.
- Wipe away excess saliva regularly to reduce risk of facial rash.

Dental care

- As soon as teeth erupt, brush them twice daily using a toothbrush and a toothpaste with a fluoride level of 1000 ppm (parts per million) – use a tiny smear for babies and children up to 3 years old.
- Encourage parents/carers to take their child to the dentist when the first tooth erupts, or at the latest, by their first birthday.

Medication for symptom relief

- Teething gels that contain a local anaesthetic like lidocaine (e.g. Bonjela® Junior gel and Dentinox® Teething gel) are not recommended as they can cause harm if swallowed. They vary in licensing for minimum age and indication i.e. some are not licensed for teething.
- If teething gels are used, they should only be used on the advice of a pharmacist where recommended dose and frequency should be strictly followed.
- Oral gels containing salicylates must never be used in children under 16 years old because of the risk of Reye's syndrome.
- There is no good evidence that complementary treatments (e.g. herbal teething powder/granules or homeopathic remedies) are of benefit for teething symptoms. Note: these may contain sugars which are bad for oral health. They may also contain lactose.
- Both teething gels and powders/granules may contain alcohol.

If you feel your child is not improving, or is getting worse, despite self-care advice and/or treatment options, please make an appointment to discuss with your GP.

27.0 Warts and verrucae

This monograph supports the management of simple warts and verrucae for individuals 2 years and over. People with anogenital warts (which affect the skin around the anus and/or genital skin) are excluded.

27.1 About the ailment[235]

Cutaneous warts are small, rough growths caused by infection of keratinocytes with certain strains of the human papillomavirus (HPV). They are usually spread by direct skin-to-skin contact, or indirectly via contact with contaminated floors or surfaces (e.g. swimming pools). They are common and can appear at any age, anywhere on the skin, but are most commonly seen on the hands and feet; a verruca (plantar wart) is a wart on the sole of the foot.

Incidence of warts is thought to increase during school years, reaching a peak in adolescence and early adulthood, before declining in later adulthood. It is unusual to see them in infants and very young children. Warts may clear spontaneously at any time or persist for years. Resolution is usually more rapid for children.

27.2 Possible complications[235]

- Spread of the wart and local infection caused by picking at it.
- Malignant changes (rare, except among immunosuppressed patients).

27.3 When to refer[235]

Intermediate risk - Amber - Advise the individual to see a GP, call NHS 111, contact a sexual health service or see a pharmacist independent prescriber as appropriate for assessment within a timescale considered clinically suitable.

- Individual < 2 years of age.
- Psychosocial impact (e.g. teasing at school, embarrassment, unsightly appearance).
- Local infection.
- Nail dystrophy and destruction (from warts around the fingernails or toenails).
- A wart associated with significant pain.
- People with diabetes or who have poor circulation to the hands or feet.
- Extensive areas affected.
- People who are immunosuppressed, including transplant patients.
- Hairy or bleeding warts, or those that have changed in appearance.
- Wart(s) on the face or in skin folds.
- Warts in the anogenital region – refer to sexual health service.
- Uncertain diagnosis.

Low risk - Green - Advise the individual to see a GP for routine assessment.

- If warts are unresponsive to salicylic acid after 12 weeks.

27.4 Overview of treatment[235]

There is a strong case for not treating warts for most people since they usually clear spontaneously, are not harmful, and treatment may be prolonged or cause side effects (e.g. skin irritation). Treatment should be considered if the wart is painful (e.g. on the sole of the foot), cosmetically unsightly, persistent, or if the person requests treatment.

General advice (lifestyle measures in section 27.6) should be provided to all people presenting with warts or verrucae, whether treating or not.

Salicylic acid limitations

There is insufficient evidence to recommend any particular salicylic acid preparation over another, however a weaker strength preparation (17% or less, such as Salactol™ paint or Salatac™ gel) is recommended for warts on the back of the hands, as scarring is more likely to occur.

Salicylic acid is the first line treatment of choice. However, it is not suitable for use on:

- the face
- intertriginous (skin folds) or anogenital regions
- moles or birthmarks
- warts with hair growing out of them, red edges, or an unusual colour
- open wounds, irritated or reddened skin or any area that is infected
- mucous membranes or large areas of skin
- areas of poor healing such as neuropathic feet or in those with impaired blood circulation such as diabetes
- children under the age of 2 years. Some products have different product licensing according to age, meaning a higher age restriction. Check products for this prior to supply. See Table 1.

27.5 Treatments[235-241]

Table 1: Treatment options for warts/verrucae

Medication	Dose	Considerations None of these products are suitable for use in children under 2 years of age. See individual products for age restrictions. Avoid salicylic acid in children or teenagers during or immediately after chickenpox, influenza, or other viral infections owing to a theoretical risk of Reye's syndrome.
Salicylic acid 16.7%/ lactic acid 16.7% (Salactol™ paint)	Apply at NIGHT for up to 12 weeks.	• There are no or limited data on use during pregnancy; use should therefore be avoided unless it is for short-term treatment of a single small wart or verruca. Safety during breastfeeding has not been established; use with caution. • Recommended for warts on the back of the hands as higher strength preparations may cause scarring. • Highly flammable-keep away from open flames.
Salicylic acid 26% cutaneous solution (Occlusal®)	On first use, apply TWICE to the wart allowing the first application to dry before applying the second. Thereafter repeat once daily. Application at NIGHT may mean the product is less likely to be rubbed off. Do not continue for more than 12 weeks.	• There are no or limited data on use during pregnancy; use should therefore be avoided unless it is for short-term treatment of a single small wart or verruca. Safety during breastfeeding has not been established; use with caution. • Clinically visible improvement should occur in 1-2 weeks, but maximum effect may be expected after 4-6 weeks. • Highly flammable-keep away from open flames.
Salicylic acid 12% / Lactic acid 4% gel (Salatac™ gel)	Apply at NIGHT for up to 12 weeks.	• There are no or limited data on use during pregnancy; use should therefore be avoided unless it is for short-term treatment of a single small wart or verruca. Safety during breastfeeding has not been established; use with caution. • Recommended for warts on the back of the hands as higher strength preparations may cause scarring. • Highly flammable-keep away from open flames.

Salicylic acid 40% medicated plasters (Scholl™ Verruca Removal System brand only)	Apply ONE plaster every 2 days for up to 12 weeks.	• Not to be used in under 16 years of age due to product licensing. • Not to be used in pregnancy and breastfeeding due to product licensing. • For use on hands and feet only.
Salicylic acid 26% gel (Bazuka™ Extra strength)	Apply at NIGHT for up to 12 weeks.	• There are no or limited data on use during pregnancy; use should therefore be avoided unless it is for short-term treatment of a single small wart or verruca. Safety during breastfeeding has not been established; use with caution. • Highly flammable-keep away from open flames.

Table 2: Formulary information

Medication	Legal class	Pack size	Maximum number of consultations per episode† Maximum number of episodes per year
Salicylic acid 16.7%/lactic acid 16.7% (Salactol™ paint)	P	10mL	**A maximum of 1 consultation per episode. A maximum of 2 episodes per year.** † Episode: one episode constitutes an appropriate number of consultations (as defined above) in which lifestyle advice or treatment is provided. Resolution of symptoms or onward referral would define the end of the episode.
Salicylic acid 26% cutaneous solution (Occlusal®)	P	10mL	
Salicylic acid 12% / Lactic acid 4% gel Salatac™ gel	P	8g	
Salicylic acid 40% medicated plasters (Scholl™ Verruca Removal System)	GSL	30	
Salicylic acid 26% gel (Bazuka™ Extra strength)	P	5g	

27.6 Advice for patients[235-239,242]

Patient information leaflets in English and Welsh are available on the Welsh Medicines Advice Service website.

Treatment considerations with salicylic acid

- Different salicylic acid products are used in different ways. Always read the instructions that come with the product before use. Your pharmacist can provide further advice if you are still unsure. Treatment is usually as follows:
  - Wash hands after applying salicylic acid and avoid inhaling the vapour.
  - Before applying the paint or gel, soak the affected area in warm water and file away any thickened skin with a pumice stone or emery board. Care should be taken not to scrape the surrounding healthy skin.
  - The product needs to be applied daily (every other day for the medicated plaster) for up to three months. It is important to keep using the product; if treatment is not continued it is unlikely to work.
  - If the wart becomes too sore, stop treatment for a few days until it settles then re-start it. Applying a barrier ointment such as petroleum jelly to protect the skin surrounding a wart before applying the salicylic acid may reduce the likelihood of the skin becoming sore.
- You must not apply salicylic acid to the face, because of the risk of skin irritation which may cause scarring, or damage to eyes. Avoid contact with mucous membranes.
- Salicylic acid is flammable. Avoid smoking or going near open flames when using treatments due to the risk of serious injury.
- Salicylic acid may cause damage to fabrics and other materials.

Lifestyle measures

To reduce the chances of warts spreading to other areas of your body:

- Avoid scratching lesions, biting nails or sucking fingers that have warts.
- Keep feet dry and change socks or tights daily.
- When treating the wart, dispose of any skin filings hygienically, and do not use the emery board or pumice stone for anything else.

To reduce the chances of warts spreading to other people there is no need to avoid activities such as sports or swimming, but the following measures can be implemented:

- Avoid going barefoot in public places, wear flip-flops or other appropriate footwear in communal showers.
- Avoid sharing shoes, socks and towels.
- Cover the wart with a waterproof plaster when swimming. The use of swimming socks is discouraged.

More information can be found on the Primary Care Dermatology Society website: https://www.pcds.org.uk/patient-info-leaflets/warts

If you feel you are not improving, or are getting worse, despite lifestyle adjustments and/or completing a 12-week treatment course, please make an appointment to discuss with your GP.

28.0 References

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Updates

Date of update publication	Details of update
August 2023	Original guidelines document published.
December 2023	The following section has been updated to align with the latest NICE Clinical Knowledge Summary advice: • Sore throat.
June 2024	Added monograph for 'Urinary tract infection in women and transgender males who have not undergone sex reassignment surgery (lower, non-complicated, 16 – 64 years; not pregnant or catheterised)'.
September 2024	Updates to Athlete's Foot, Dry eye disease and Ringworm monographs: • Athlete's Foot & Ringworm monographs have been updated to align with the Terbinafine 1% cream PGD. • Dry eye monograph has been updated to include Evolve® carbomer 980 gel (preservative free) as a treatment option. • Sore throat monograph has been updated to clarify antibiotic treatment via the STTT service is for adults and children aged 6 years and over.
November 2024	Updates to the Constipation and Dry skin monographs: • Constipation monograph has been updated to reflect the correct name for Macrogol in the dictionary of medicines and devices. • Dry skin monograph has been updated to align with PGD information for Clobetasone 0.05% cream and ointment.
January 2025	Updates to Nappy rash monograph following the discontinuation of Metanium® nappy rash ointment, it has been replaced with white soft paraffin.
April 2025	The Conjunctivitis (bacterial) monograph has received minor updates throughout and now includes a referral criteria to Wales General Ophthalmic Services (WGOS) registered optometrist. WGOS has replaced Eye Health Examination Wales.
June 2025	Updates to Allergic rhinitis and Sore throat monographs: • Allergic rhinitis monograph has been updated throughout, with fexofenadine added as a treatment option. The monograph underwent consultation and was endorsed by the AWMSG in April 2025. • Sore throat monograph has received minor updates throughout. The treatment age has been changed to adults and children aged 5 and over in line with the new service specification for CAS.
October 2025	Updates to Sore throat and Urinary tract infection in people assigned female at birth (AFAB) with female genitalia (lower,

	non-complicated, 16 – 64 years; not pregnant or catheterised) monographs: • Sore throat - minor layout change made to 'Sore throat antibiotic decision pathway' to improve clarity. • Urinary tract infection monograph revised due to a change in the service specification, from October 1st the UTI service will become a mandatory part of the common ailments service.
November 2025	Updates to the Back Pain, Constipation, Diarrhoea, Dyspepsia and Threadworm monographs: • Back pain monograph has been updated throughout. Changes include refining the patient cohort to those aged 16 to less than 50 years with self-limiting back pain caused by muscle strain or minor injury, and the removal of paracetamol and topical ibuprofen 10% gel as treatment options. The monograph underwent consultation and was endorsed by AWMSG in September 2025. • Constipation monograph has been updated to align with NICE Clinical Knowledge Summary (CKS) advice. The treatment section now includes specific guidance for individuals who are pregnant or breastfeeding. • Diarrhoea monograph has been updated to align with NICE CKS advice for diarrhoea and gastroenteritis. Information on medicines that may cause diarrhoea is now included in the *When to Refer* boxes. • Dyspepsia monograph has been updated to align with NICE CKS advice for dyspepsia. The treatment section now provides clearer guidance on when to use an alginate or a proton pump inhibitor (PPI). • Threadworm monograph has been updated to align with NICE CKS advice for threadworm.
July 2026	Updates to Acne vulgaris, Athletes foot, Chickenpox, Dry eye, Dry skin, Fungal skin infections, Haemorrhoids, Head lice, Ingrowing toenail, Nappy rash, Oral Thrush and Vulvovaginal thrush. • Acne vulgaris monograph has been updated to align with NICE CKS advice. Adapalene 0.1% / benzoyl peroxide 2.5% gel, Adapalene 0.3% / benzoyl peroxide 2.5% gel and Clindamycin 1% / tretinoin 0.025% gel have been added as treatment options. • Athlete's foot monograph has been updated to align with NICE CKS advice. Treatment recommendations have been updated, with terbinafine 1% cream moved to first line and clotrimazole 1% and miconazole 2% included as second-line options.

	• Chickenpox monograph updated throughout, including revised scope, referral advice for pregnant or immunocompromised individuals and infants under 2 months. • Dry eye disease monograph has been updated throughout. The scope and referral sections now clarify that patients with eye problems should be directed to a Welsh General Ophthalmic Services (WGOS)-registered optometrist where appropriate. • Dry skin monograph has been updated throughout. The reference to Aquadrate has been removed from the urea-containing cream options as it has been discontinued. • Fungal skin infections monograph updated throughout, including title change from Ringworm, Tinea cruris and Intertrigo. A scope statement has been added to clarify that infections affecting the face, scalp, and nails are not included within this monograph. • Haemorrhoids monograph has been updated throughout. The eligible age range has been amended to include non-pregnant individuals aged 16 years and over. Anodesyn® ointment and suppositories removed from treatment options due to low usage and suitable alternatives available via CAS. • Head lice monograph has been updated to align with NICE CKS advice. The eligible age range has been amended to include individuals aged 1 month and over. The Portia comb and NYDA (dimeticone 92% spray have been removed from the monograph as they are no longer available. • Ingrowing toenail monograph has been updated with revised referral criteria. • Nappy rash monograph has been updated to align with NICE CKS advice. Zinc and castor oil cream has been removed from the monograph because this product is no longer available. • Oral thrush monograph has been updated throughout, including changing the terminology from “candidiasis” to “thrush” to align with patient information leaflets. Individuals who are pregnant or breastfeeding are now included within scope, with treatment options provided and no referral required unless other referral criteria are met. • Vulvovaginal thrush monograph has been updated to align with NICE CKS advice. The terminology has been updated from “candidiasis” to “thrush” to align with patient information leaflets. Clotrimazole 2% cream has been removed from the monograph as it is more expensive than clotrimazole 1% with no evidence of superior efficacy.

November 2026	Updates to Cold sores, Constipation, Infantile colic, Mouth ulcers, Scabies, Teething, and Warts and verrucae. • Cold sores monograph has been updated throughout. Updates include revised advice on simple analgesia and avoiding transmission. • Constipation monograph has been updated to align with NICE CKS and SPC advice. Senna is now contraindicated in pregnancy and breastfeeding. • Infantile colic monograph has been updated throughout. Updates include revised referral criteria and signposting to the ICON campaign. • Mouth ulcers monograph has been updated throughout. Updates include removal of hydrocortisone 2.5 mg muco-adhesive buccal tablets following discontinuation. • Scabies monograph has been updated throughout. Updates include revised referral and treatment advice, updated guidance on the use of permethrin and malathion, and referral for consideration of oral ivermectin. Advice on treating household and close contacts has also been updated. • Teething monograph has been updated to align with NICE CKS advice, including revised referral criteria and advice on simple analgesia. • Warts and verrucae monograph has been updated throughout, including revised referral and treatment advice. Salatac® gel has been added as a treatment option.