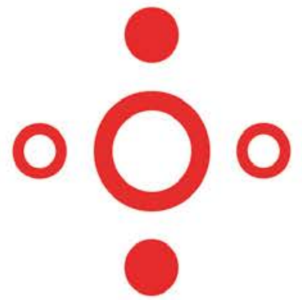
Grŵp Strategaeth Meddyginiaethau Cymru Gyfan
All Wales Medicines Strategy Group



All Wales Common Ailments Service Formulary

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August 2023

(November 2025 – Updates to ‘Back pain’, ‘Constipation’, ‘Diarrhoea’, ‘Dyspepsia’ and ‘Threadworm’ monographs, further details can be found in the ‘Updates’ section at the end of the document).

This document has been prepared by the Welsh Medicines Advice Service, with support from the All Wales Prescribing Advisory Group (AWPAG) and the All Wales Therapeutics and Toxicology Centre (AWTTC), and has subsequently been endorsed by the All Wales Medicines Strategy Group (AWMSG).

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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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1.0 Acne vulgaris

1.1 About the ailment[1,2]

Acne vulgaris is a common type of acne that primarily affects the face, back, and chest. It is most common in adolescence, but may affect those in any age group. Comedones (blackheads and whiteheads) are always present but there may also be inflammatory lesions known as papules (small red bumps that may feel sore), and pustules (pus-filled spots). There may be larger nodules or cysts which are often painful. The skin and hair may appear oily and there may be scarring and pigmentation.

- **Mild acne** — predominantly non-inflamed lesions (open and closed comedones) with few inflammatory lesions.
- **Moderate acne** — more widespread with an increased number of inflammatory papules and pustules.
- **Severe acne** — widespread inflammatory papules, pustules and nodules or cysts. Scarring may be present.

1.2 Possible complications[1,2]

More serious types of acne that should be referred, include:

- **conglobata** - a severe form of nodulo-cystic acne with interconnecting sinuses and abscesses
- **acne fulminans** - a very serious form of acne conglobata that is associated with systemic symptoms (such as fever and arthralgia)

1.3 When to refer to GP (or Pharmacist Independent Prescriber if thought to be appropriate)[2-4]

Refer individuals:

- under 12 years of age
- when one first line treatment has not worked and the acne is mild to moderate
- with moderate to severe acne with a large number of inflammatory lesions (especially if there are nodules or cysts present)
- with fever or arthralgia (urgent same day referral)
- when oral therapies have previously been used for acne
- when medication (e.g. anabolic steroids, lithium and some anti-epileptic drugs) may be contributing to the acne
- with acne of any severity (or acne-related scarring), that is causing or contributing to psychological distress or a mental health disorder
- if there is diagnostic uncertainty

1.4 Overview of treatment[2]

Patients with acne vulgaris should be offered a 12-week course of a first line treatment option to be applied once daily in the evening initially; frequency can be reduced if skin irritation occurs.

Mild to moderate acne

- A combined topical benzoyl peroxide (3% or 5%) and topical clindamycin (1%) preparation (i.e. Duac Once Daily® gel). If Duac Once Daily® gel is not suitable, consider referral to the GP for treatment with a topical clindamycin/retinoid combination preparation (e.g. Treclin®) or a topical benzoyl peroxide/adapalene combination preparation (e.g. Epiduo®).
- Consider topical benzoyl peroxide as monotherapy if the above options are contraindicated or the person wishes to avoid using a topical retinoid or antibiotic.
- First line treatment should be reviewed at 12 weeks by the GP to assess treatment success and if there is a need for maintenance treatment.

Moderate to severe acne

Refer to GP for assessment.

1.5 Treatments[1,2-6]

Medication	1st line			2nd line Only offer if, after discussion with the individual, other options not thought to be suitable (including those available via GP)	
Generic name	Benzoyl peroxide (3% or 5%) with clindamycin (1%) gel (Duac Once Daily® gel)			Benzoyl peroxide 5% gel	
Legal class	POM (supply via PGD)			P Supply via PGD for an individual who is pregnant/breastfeeding	
Pack size		30 g	60 g	30 g	60 g
Maximum number of packs to supply per consultation	1st	2	2	4	2
	2nd	1	1	The maximum quantity supplied will be sufficient to complete a 12-week treatment course	
Maximum number of consultations per episode†	2*			1	

Maximum number of episodes per year	1	1
Dosing instructions	As per PGD	Apply once daily initially. Can be applied up to twice a day if tolerated. Reduce frequency if there is irritation.
Key information to consider prior to supply	Not recommended in individuals under 12 years of age	
	See PGD ***N. B** Manufacturer gives a shelf life of 2 months after dispensing. Individuals will need a further consultation for final month's supply	Supply via PGD for an individual who is pregnant/breastfeeding
	Refer to the BNF/SPC for full details on interactions, adverse effects, cautions and contraindications.	
Counselling advice	See PGD	• Allergic contact dermatitis occurs in 1 in 500 people. Stop treatment and seek advice if itching and swelling of the eyes occurs. • Bleaching may occur. Avoid contact with hair or clothes. • Dry, red, peeling or blistering skin may occur, including a burning, itching sensation at the start of treatment. Start with alternate-day or short-contact application (washing off after an hour). If skin irritation occurs, reduce the frequency of application or stop use (at least temporarily). • Avoid repeated exposure to sunlight or other sources of UV light (e.g. sun bed).

† 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.

1.6 Advice for patients[2-4]

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

Skin care/cleansing

- Acne is not caused by poor hygiene; avoid over-cleaning the skin (which may cause dryness and irritation).
- Try not to pick or squeeze spots because this aggravates them and may cause scarring.
- Use a non-alkaline (skin pH neutral or slightly acidic) synthetic detergent cleansing product twice daily on acne-prone skin.
- If dry skin is a problem, use a fragrance-free water-based emollient.
- Shower as soon as possible after exercise as sweat can irritate acne.
- Wash hair regularly and avoid letting it fall across the face.

Diet

- There is not enough evidence to support specific diets for treating acne but do maintain a healthy diet.

Cosmetic products

- Avoid using heavy make-up/ cosmetics.
- Avoid oil-based comedogenic skin care products, make-up and sunscreens.
- If make-up is used it should be removed at the end of the day.

Treatment

- Treatment with products containing benzoyl peroxide takes time to work (typically up to 6 weeks to become noticeable).
- Apply the product sparingly after washing the skin with a mild cleanser, then gently pat skin dry.
- Avoid applying to the eyes, mouth, angles of nose and mucous membranes, eczematous, broken or sunburned skin.
- Treatments may cause increased sensitivity to sunlight – avoid sun and UV light, or wear oil-free sunscreen (SPF 30 or above).
- If skin is sensitive, start at a lower frequency (e.g. three times per week), increasing to daily as tolerated.
- Seek medical advice if the acne does not improve within 6 weeks, or sooner if it becomes worse.

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.

2.0 Allergic rhinitis

A summary pathway for this condition is available at https://www.wmic.wales.nhs.uk/cas-allergic-rhinitis-summary

2.1 About the ailment[7-10]

Allergic rhinitis is an inflammatory disorder of the nose which occurs when the nasal mucosa becomes sensitised to allergens. Bilateral symptoms typically develop within minutes of allergen exposure. It is commonly associated with and can exacerbate asthma, allergic conjunctivitis, rhinosinusitis, eczema and sleep disturbances.

Classic symptoms include:

- sneezing.
- nasal itching.
- rhinorrhoea (nasal discharge that is clear and may be yellow-coloured).
- congestion.

Outward signs may include:

- persistent mouth breathing.
- rubbing at the nose.
- presence of an obvious transverse nasal crease.
- frequent sniffing and throat clearing.
- allergic shiners – dark circles under the eyes due to nasal congestion.

Additional symptoms may include:

- cough.
- itching of the palate, throat and ear.
- postnasal drip.
- features suggestive of chronic nasal congestion i.e.
  - snoring.
  - mouth breathing.
  - halitosis.

Eye symptoms occurring with allergic rhinitis, referred to as rhino conjunctivitis include:

- bilateral itching (sometimes described as burning or stinging).
- redness, puffiness.
- tearing.

Symptoms can be intermittent (less than 4 days a week **or** for less than four consecutive weeks) or persistent (at least 4 days a week **and** for more than 4 consecutive weeks) and can be classified as:

- seasonal (hay fever) – symptoms occur at the same time each year due to e.g. grass and / or tree pollen.
- perennial – symptoms occur throughout the year due to e.g. house dust mites, animal dander.
- occupational – symptoms due to exposure to allergens in the work environment e.g. flour, latex gloves, chlorine, wood dust, laboratory animals.

2.2 Possible complications[7]

- Reduced quality of life adversely affecting work and social life.
- Impaired school or work performance.
- Disturbed sleep.
- Reduced concentration.
- Irritability.
- Possible development of asthma, sinusitis or nasal polyps.
- Worsening of obstructive sleep apnoea syndrome (OSAS).
- Oral allergy syndrome – oral itching and swelling due to cross-reactivity between aeroallergens, e.g. birch pollen, fruits and vegetables.

2.3 When to refer to GP (or Pharmacist Independent Prescriber if thought to be appropriate)[7,8,11-14]

Wales General Ophthalmic Services (WGOS) registered optometrist (which may require onward referral to ophthalmology)
Individuals with an eye problem, including those that need urgent attention, can access free eye examinations by visiting a WGOS registered optometrist practice. A list of registered practices is available at WGOS 2 – Examination for Urgent Eye Problems and NHS 111 Wales.

Pharmacists should utilise local knowledge and refer individuals as necessary to the most appropriate clinician (A&E, GP, Optometrist or community pharmacist independent prescriber) that will avoid delay in diagnosis and treatment.

<table>
<tr><th colspan="2">Red - High Risk</th></tr>
<tr><td>

Refer individuals with the following to WGOS:

- Acute glaucoma, keratitis / iritis, or corneal ulceration is suspected, presence of pseudomembrane. Symptoms include:
  - marked redness in affected eye(s) along with, headache*, any eye pain and / or photophobia*.
  - halos around lights, flashing lights/wavy lines, nausea/vomiting.
  - change in visual acuity (unrelated to watering or tearing).
- Inability to open the eye or keep it open.
- Pupils that look unusual.
- Any contact lens wearers – individuals should also be advised not to wear contact lenses until they have been assessed and further advice obtained from their optometrist (if same-day assessment by the optometrist is not feasible, the individual should be referred to eye casualty and should be advised to take their contact lenses with them as special diagnostic tests may be required).
- History of trauma (mechanical, chemical or ultraviolet) or possible foreign body.
- Suspected gonococcal (e.g. discharge is mucopurulent, copious and rapidly progressive) or chlamydial conjunctivitis.
- Possible herpes virus infection (crops of vesicles, ulcers or pustules present on the eyelid or around the eye).
- Suspected periorbital or orbital cellulitis.

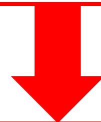
* If individual presents with headache, photophobia **AND** fever, refer to the most appropriate clinician (GP or A&E) that avoids delay to rule out meningitis.

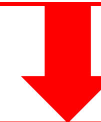
</td><td>

Refer individuals with the following to the most appropriate clinician (GP, A&E or other clinician) that avoids delay in diagnosis and treatment:

- Suspicion of undiagnosed severe systemic condition such as rheumatoid arthritis or immunocompromise.
- Individuals presenting with possible symptoms of meningitis (headache, photophobia **AND** fever).

</td></tr>
</table>

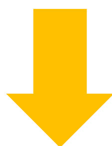




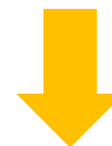
Action: Advise the individual to call or attend a Wales General Ophthalmic Service (WGOS) for triage without delay. NHS 111 Wales - Search Results. If the individual is unable to access a WGOS registered optometrist without delay, advise them to attend Emergency eye casualty or A&E without delay.

Action: Advise the individual to attend A&E, see a GP or other appropriate clinician without delay.

Amber - Intermediate risk	
Refer individuals with the following to WGOS (where onward referral to ophthalmology may be required): • Suspected atopic keratoconjunctivitis. (chronic symptoms with a history of asthma or eczema, severe itching, tearing and swelling). • Suspected vernal keratoconjunctivitis. (severe itching, copious fibrinous discharge, worse in the Spring). • Severe or treatment-resistant allergic conjunctivitis. • Diagnostic uncertainty associated with eye symptoms.	**Refer individuals with the following to the GP (or community pharmacist independent prescriber if appropriate)**: • Unilateral symptoms, blood stained or discoloured nasal discharge, recurrent epistaxis, facial or nasal pain or tenderness, anosmia. • Nasal obstruction and / or structural abnormality such as deviated nasal septum which makes intranasal drug treatment difficult. • Diagnostic uncertainty. • Lower respiratory tract symptoms or loss of asthma control.



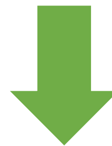
Action: Advise individual to attend a WGOS Optometrist for eye symptoms. If individual is unable to access a WGOS registered optometrist the same day, advise them to see a GP (or community pharmacist independent prescriber if appropriate) for same day assessment.



Action: Advise individual to see a GP or community pharmacist independent prescriber as appropriate for same day assessment.

Green - Low risk

- Suspected infective rhinitis or infective sinusitis (if symptoms are worsening after 5 days or symptoms have not improved after 10 days).
- Symptoms that may be medication-related e.g. decongestants (rebound congestion), alpha-blockers, ACE inhibitors, beta-blockers, chlorpromazine, aspirin, NSAIDs, phosphodiesterase inhibitors and cocaine.
- Symptoms that may be due to non-allergic cause:
    - chemical – perfumes, tobacco, smoke, odours.
    - physical – changes in temperature or humidity or with exercise.
    - endocrine – hormonal rhinitis should be considered if coincides with pregnancy or starting the oral contraceptive pill, hormone replacement therapy or hypothyroidism.
    - food and drink – alcohol, sulphites, spicy foods.
    - systemic – defect in mucus production.
    - structural – aging.
- Symptoms that are persistent or refractory despite optimal treatment (see treatment options included in the allergic rhinitis treatment pathway).



Action: Advise individual to see a GP (or community pharmacist independent prescriber if appropriate) for routine assessment

2.4 Overview of treatment[7,8]

Initial management should include advice on sources of information and support, possible use of saline nasal irrigation (can be bought OTC or made at home and allergen avoidance. (see Allergic rhinitis - NHS for instructions on how to clean your nose with a homemade saltwater solution).

Ask about:

- type, frequency, timing, persistence, and location of symptoms (indoors or outdoors).
- housing conditions, pets and occupation.
- severity of symptoms and impact on the person's quality of life e.g. sleep, concentration, mood, behaviour, fatigue, leisure activities, school and work.
  - mild symptoms: no impact on sleep, no impairment of daily activities, leisure and or sport, no impairment of school or work, no troublesome symptoms.
  - moderate to severe symptoms: sleep disturbance, impairment of daily, leisure or sport activities, impairment of school or work, troublesome symptoms.
- drugs that may cause or aggravate symptoms, previous treatments and their effectiveness.
- family history of atopy.

For ***mild-to-moderate intermittent symptoms***, initial treatment options include:

- an intranasal antihistamine OR
- a non-sedating oral antihistamine AND/OR
- for additional eye symptoms suggestive of allergic conjunctivitis: mast cell receptor inhibitor eye drops (i.e. sodium cromoglicate eye drops).

If ***initial drug treatment is ineffective or symptoms are persistent***, treatment options include:

- addition of a regular intranasal corticosteroid during periods of allergen exposure.

For ***moderate-to-severe*** *or* ***persistent symptoms***, treatments options include:

- an intranasal corticosteroid OR
- combination of intranasal corticosteroid AND intranasal antihistamine.

Oral antihistamines can be offered as an alternative to the intranasal antihistamine if the patient prefers.

2.5 Treatments[1,7,8,10,15-17]

Stepwise approach starting with non-pharmacological measures, see section 2.6 Advice for patients:

- Allergen avoidance.
- Barrier ointment around the nostrils.
- Nasal filters, nasal saline irrigation.

Table 1: Antihistamine and eye symptom treatment options
Refer to the BNF/BNFC or SmPC for full details of interactions, adverse effects, cautions and contraindications.
If symptoms persist or treatment is ineffective after 2-4 weeks of treatment advise patient to return for add on treatment (except for sodium cromoglicate, see below).

Medication	Children aged 2-5 years	Children aged 6-11 years	Adults and children aged 12 years and above	Considerations
Azelastine 140 micrograms per dose nasal spray		ONE spray in each nostril TWICE daily. (see PGD)	ONE spray each nostril TWICE daily. (see PGD)	Quicker onset than oral treatments (15-30 minutes). Useful for intermittent symptoms, rhinorrhoea and congestion. Each bottle lasts 6 weeks. Counsel on nasal spray technique (section 2.6). Can be used in pregnancy or breastfeeding, very small amounts found in milk, advise to monitor infant for drowsiness, irritability, dry mouth and changes in feeding.
Cetirizine 10 mg tablets		HALF a tablet TWICE daily.	ONE tablet DAILY.	May be more sedating than loratadine. Caution in epilepsy. Can be used in pregnancy and breastfeeding, very small amounts found in milk, advise to monitor infant for drowsiness, irritability, dry mouth and changes in feeding.

Medication	Children aged 2-5 years	Children aged 6-11 years	Adults and children aged 12 years and above	Considerations
Cetirizine 1 mg/mL oral solution sugar free	ONE 2.5 mL spoonful TWICE daily.	ONE 5 mL spoonful TWICE daily.	TWO 5 mL spoonfuls (10 mL) DAILY.	May be more sedating than loratadine. Caution in epilepsy. If on a 10 mg dose, only supply if unable to swallow tablets. Can be used in pregnancy or breastfeeding, very small amounts found in milk, advise to monitor infant for drowsiness, irritability, dry mouth and changes in feeding.
Fexofenadine 30 mg tablets		ONE tablet TWICE daily. (see PGD)		
Fexofenadine 120 mg tablets			ONE tablet DAILY. (see PGD)	Do not use in pregnancy. Do not use in breastfeeding.
Loratadine 10 mg tablets		**Over 31 kg:** ONE tablet DAILY.	ONE tablet DAILY.	Can be used in pregnancy and breastfeeding, very small amounts found in milk, advise to monitor infant for drowsiness, irritability, dry mouth and changes in feeding.
Loratadine 5 mg / 5 mL oral solution sugar free	**Up to 31 kg:** ONE 5 mL spoonful DAILY. **31 kg and over:** TWO 5 mL spoonfuls (10 mL) DAILY.	**Up to 31 kg:** ONE 5 mL spoonful DAILY. **31 kg and over:** TWO 5 mL spoonfuls (10 mL) DAILY.	TWO 5 mL spoonfuls (10 mL) DAILY.	If on a 10 mg dose, only supply if unable to swallow tablets. Can be used in pregnancy or breastfeeding, very small amounts found in milk, advise to monitor infant for drowsiness, irritability, dry mouth and changes in feeding.
Sodium cromoglicate 2% w/v eye drops		ONE drop in each eye FOUR times daily. (see PGD)	One drop in each eye FOUR times daily. (see PGD)	Can be used in pregnancy or breastfeeding. May cause transient stinging, burning or blurring of vision on instillation. If symptoms persist after 4 weeks or treatment ineffective, **refer to WGOS registered optometrist.**

Table 2: Intranasal corticosteroid treatment options

- If symptoms persist after 4 weeks refer to GP or pharmacist independent prescriber.
- Do not switch to an alternative corticosteroid preparation if trial of a steroid nasal spray is ineffective as they all have comparable efficacy.
- Onset of action is 6-8 hours after the first dose, but maximal effect may not be seen until after 2 weeks.

Medication	Children aged 2-5 years	Children aged 6-11 years	Adults and children aged 12 years and above	Considerations
Fluticasone furoate 27.5 micrograms per dose nasal spray		ONE spray in each nostril DAILY. Can be increased to TWO sprays in each nostril DAILY short term until control achieved, then reduce to ONE spray in each nostril DAILY. (see PGD)	TWO sprays in each nostril DAILY, reducing to ONE spray in each nostril DAILY once control achieved. (see PGD)	Can be used alone or in combination with antihistamines. They reduce inflammation of the nasal mucosa and are more effective than antihistamines in reducing nasal congestion, rhinorrhoea and ocular symptoms. They can be used in pregnancy or breastfeeding if non-pharmacological measures are insufficient. They act locally and have lower systemic absorption than oral preparations. See section 2.6 advice for patients for nasal spray technique to reduce the incidence of nasal irritation and stinging.
Fluticasone propionate 50 micrograms per dose nasal spray	**Over 4 years:** ONE spray in each nostril DAILY. Can be increased to TWICE daily short term until control achieved, then reduce to DAILY. (see PGD)	ONE spray in each nostril DAILY. Can be increased to TWICE daily short term until control achieved, then reduce to DAILY. (see PGD)	TWO sprays in each nostril DAILY, reducing to ONE spray in each nostril DAILY once control achieved. Can be increased to TWICE daily short term until control achieved then reduce to DAILY. (see PGD)	
Mometasone furoate 50 micrograms per dose nasal spray	**Over 3 years:** ONE spray in each nostril DAILY. (see PGD)	ONE spray in each nostril DAILY. (see PGD)	TWO sprays in each nostril DAILY, if necessary, increase to FOUR sprays DAILY. Reduce to ONE spray in each nostril DAILY when control achieved. (see PGD)	

Table 3: Formulary information

<table>
<tr><th>Medication</th><th>Legal class</th><th>Pack size</th><th>Maximum number of consultations per episode[†] and
Maximum number of episodes[†] per year</th></tr>
<tr><td>Azelastine 140 micrograms per dose nasal spray</td><td>POM</td><td>20 mL
22 mL</td><td rowspan="12">A maximum of 6 months of treatment can be provided in any 12-month period, with a maximum of 3 months treatment supplied at any one time.

Only supply for subsequent presenting episodes (after initial supply) if treatment has been effective.

[†] 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.</td></tr>
<tr><td>Cetirizine 10 mg tablets</td><td>P</td><td>30</td></tr>
<tr><td>Cetirizine 1 mg/mL oral solution sugar free</td><td>P</td><td>200 mL</td></tr>
<tr><td>Fexofenadine 30 mg tablets</td><td>POM</td><td>60</td></tr>
<tr><td>Fexofenadine 120 mg tablets</td><td>POM</td><td>30</td></tr>
<tr><td>Loratadine 10 mg tablets</td><td>P</td><td>30</td></tr>
<tr><td>Loratadine 5 mg / 5 mL oral solution sugar free</td><td>P</td><td>100 mL</td></tr>
<tr><td>Sodium cromoglicate 2% w/v eye drops preservative free</td><td>P</td><td>10 mL</td></tr>
<tr><td>Sodium cromoglicate 2% w/v eye drops</td><td>POM</td><td>13.5 mL</td></tr>
<tr><td>Fluticasone furoate 27.5 micrograms per dose nasal spray</td><td>POM</td><td>120 dose</td></tr>
<tr><td>Fluticasone propionate 50 micrograms per dose nasal spray</td><td>POM</td><td>150 dose</td></tr>
<tr><td>Mometasone furoate 50 micrograms per dose nasal spray</td><td>POM</td><td>140 dose</td></tr>
</table>

2.6 Advice for patients[7,18-21]

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

Lifestyle:

- Allergen avoidance (if a specific identified allergen is the cause of symptoms). Examples include:
  - wearing wraparound sunglasses to protect your eyes from pollen.
  - use hypoallergenic bedding and covers – wash bedding regularly at 60°C or more.
  - dust with a damp cloth and use a vacuum with a HEPA filter.
  - do not allow pets in bedrooms, wash them if possible and regularly groom them outside the home (preferably by a person who is not allergic).
  - regularly wash your pet's bedding and clean any furniture they've been on.
  - avoid drying clothes outside when pollen count high.
  - where possible, keep your home dry and well-ventilated; resolve any damp/condensation issues.
  - avoid walking in grassy, open spaces, particularly during the early morning, early evening, and during mowing, when the pollen count is high.
  - keep windows shut in cars and buildings when pollen count is high.
  - shower or wash hair following high pollen exposure.
  - apply an effective allergen barrier, e.g. masks, cream or balm around the nose.
- Signpost to information and support:
  - for hay fever and allergen avoidance direct patient to the Allergy UK website.
  - for pollen forecast direct patient to https://www.metoffice.gov.uk/weather/warnings-and-advice/seasonal-advice/pollen-forecast.

Medication:

- Correct technique is very important when using nasal sprays for optimal response:
  - blow the nose gently to make sure nostrils are clear.
  - shake the container well and look down.
  - press a finger against the side of the nose to close one nostril.
  - put the nozzle just inside the nose aiming for the outside wall.
  - squeeze once or twice (as per dosing instructions) in different directions, while breathing in gently through the nose, do not sniff.
  - repeat for the other nostril.
- A video demonstration of the technique can be found on the Itchy Sneezy Wheezy website.

- Seek medical advice (or WGOS registered optometrist advice if eye symptoms are not improving/worsening) if symptoms do not improve after initial treatment (including corticosteroid nasal spray and/or sodium cromoglicate eye drops where appropriate); or if fever, shortness of breath, recurrent epistaxis or nasal pain occurs.

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.

3.0 Athlete's foot

3.1 About the ailment[22,23]

Athlete's foot (tinea pedis) is a superficial fungal infection of the feet and toes, but can spread to involve the sole, the sides of the foot and the toenails. The foot should be examined to confirm the diagnosis.

Symptoms include:
- itchy, white patches between the toes
- red, sore and flaky patches on the feet
- scaly, blistering skin that may crack and bleed

3.2 Possible complications[24]

- Secondary bacterial infection (immunocompromised people are at increased risk).
- Spread of fungal infection (e.g. to hands due to scratching) – inappropriate use of topical corticosteroids can also cause infection spread, and change lesion appearance.
- Reaction to the fungus causing a disseminated itchy, papular or vesicular eruption, around the outer helix of the ear, which may also affect the trunk or limbs. This may accompany the start of oral antifungal treatment, and may be misinterpreted as a widespread fungal infection.

3.3 When to refer to GP (or Pharmacist Independent Prescriber if thought to be appropriate)[24]

- Severe or extensive disease.
- Signs of bacterial infection.
- Immunocompromised individuals.
- Recurrent episodes.
- No improvement after 1 week of treatment.
- Significant pain and discomfort.
- Individuals who have diabetes and:
    - there are concerns regarding diabetic control
    - the individual is at increased risk of detrimental symptoms associated with poorly controlled diabetes; symptoms can include thirst, blurred vision, fatigue and increased frequency of urination, poor sensation to extremities and poor circulation
    - the individual is unsure how to manage their diabetes
- Individuals under 1 month of age
- Diagnostic uncertainty

3.4 Overview of treatment[1,24-28]

Supply treatment to people who have not yet received any for this episode:

- Topical antifungals (for mild, non-extensive disease):
    - clotrimazole 1% cream
    - miconazole 2% cream/
    - terbinafine 1% cream (for adults aged 18 years and over)
- hydrocortisone 1% cream – if there is associated marked inflammation, this can be used short-term, in addition to antifungal cream but not alone

Treatment with a topical antifungal cream may be repeated in the future if there is a good response to topical treatment and there are recurrent episodes of mild, non-extensive disease.

3.5 Treatments[1,15,24-28]

Medication	Options			If inflammation present (adjunct)
Generic name	Terbinafine 1% cream	Clotrimazole 1% cream	Miconazole nitrate 2% cream (Daktarin®)	Hydrocortisone 1% cream
Legal class	POM (supply via PGD)	P (supply via PGD)	P	POM (supply via PGD)
Pack size	30 g	20 g	30 g	15 g
Maximum number of packs to supply per consultation	1	3	2	1
Maximum number of consultations per episode†	2	2	2	2
	If an alternative treatment option is being supplied within the same episode, pharmacists must first determine if individual is using the preparation correctly, in correct quantities for the duration specified.			

Maximum number of episodes per year	2	2	2	2
Dosing Instructions	See PGD	Apply 2–3 times a day for at least 4 weeks.	Apply twice a day, for 2–6 weeks depending on severity. Continue for 10 days after the affected area has healed.	See PGD
Key information to consider prior to supply	See PGD	Topical clotrimazole may increase tacrolimus levels.	Do not issue miconazole to people using interacting medicines, particularly warfarin; consider clotrimazole instead. Manufacturer advises caution in pregnancy and lactation.	See PGD
	Choice is based on contraindications and individual's preference – similar cost and efficacy.			
	Refer to the BNF/SPC for full details on interactions, adverse effects, cautions and contraindications.			
Counselling advice	Avoid contact with the eyes and mucous membranes during use. Do not smoke or go near naked flames while using these creams: serious fire hazard (clotrimazole). **See PGDs**			
Relative cost of treatment course (£–£££)	££	£-£££	££-£££	£

[†] 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.

3.6 Advice for patients[22-24,27]

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

When treating the infection

- Wash and dry the affected skin before applying the treatment and clean your hands afterwards.
- Antifungal treatment should be applied to the affected skin and surrounding area.
- Do not scratch affected skin as this can spread the infection to other parts of your body.
- Seek medical advice if the condition does not improve within a week of treatment.

To prevent recurrence

- Wear footwear that keeps the feet cool and dry, leaving shoes and socks off as much as possible when at home.
- Wear a fresh pair of cotton socks every day.
- Change to a different pair of shoes every 2–3 days.
- Wash the feet daily, then dry them thoroughly, especially between the toes.
- Avoid using moisturisers between the toes because this may help fungi to multiply.
- Antifungal dusting powders may help prevent re-infection.

To reduce transmission risk

- Do not share towels, and wash them frequently.
- Avoid going barefoot in public places (wear protective footwear, e.g. flip-flops, in communal changing areas).

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.

4.0 Back pain – (For individuals aged 16 to less than 50 years)

This monograph supports the management of acute, self-limiting, simple, lower back pain with an identifiable cause 'e.g. muscle strain or minor injury' for individuals aged 16 to less than 50 years.

4.1 About the ailment[29,30]

Acute lower back pain without radiculopathy (loss of sensation or weakness in the limbs) can also be described as simple, non-specific, mechanical or musculoskeletal in nature. Non-specific back pain means that the pain is not due to any specific or underlying disease that can be found. Often the cause may be an over-stretch (sprain or strain) of a ligament or muscle. It can also occur immediately after lifting something heavy or after an awkward twisting movement. Symptoms include stiffness and/or soreness of the lumbosacral region (lower back including the area that connects the spine to the pelvis). Symptoms often improve on their own within a few weeks.

Certain factors may increase the risk of sustaining an episode of acute, simple lower back pain, such as muscle strain or minor injury. These include:

- obesity
- physical inactivity
- occupational factors (e.g. heavy lifting, bending, twisting)
- stressful life events or depression

It is important to be aware that back pain can be caused by serious conditions (see section 4.3 below). Some examples include:

- spinal cord compression (cauda equina syndrome, CES)
- infection (discitis, vertebral osteomyelitis, spinal or epidural abscess)
- spinal fracture
- cancer

4.2 Possible complications[29,31]

- Time off work leading to psychosocial and economic implications, reduced productivity, and loss of employment.
- Development of chronic pain and associated syndromes.
- Immobility, physical deconditioning and increased risk of falls.
- Impact on daily activities and sleep.
- Psychiatric comorbidities such as depression, anxiety and somatisation (e.g. where stress can cause physical symptoms) increase the risk of progression to chronic disabling pain.

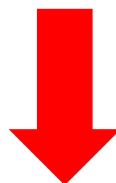
4.3 When to refer

Pharmacists should utilise local knowledge and refer individuals as necessary to the most appropriate clinician (A&E, GP, or community pharmacist independent prescriber) that will avoid delay in diagnosis and treatment.

Red – high risk

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

- Sudden onset of lower back pain with tingling, weakness or numbness in the arms or legs.
- **Severe or sudden** neurological deficit such as major motor weakness of knee extension, ankle eversion or foot dorsiflexion.
- New onset saddle anaesthesia or paraesthesia (tingling or numbness of the genitals or buttocks).
- Sudden, severe or progressive difficulty with walking or change in gait.
- Recent onset of bladder dysfunction, e.g. difficulty with urination, impaired sensation of flow, urine retention or incontinence, (late sign).
- Recent onset of bowel dysfunction, e.g. loss of sensation of rectal fullness, faecal incontinence (late sign).
- Sudden onset of severe central spinal pain, relieved by lying down.
- History of trauma such as a road traffic collision or fall from a height. Strenuous lifting in people with osteoporosis also needs to be considered.
- Sudden onset visible deformity of the spine.
- Localised spinal tenderness AND systemic symptoms.

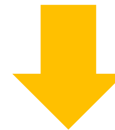


Action: Call 999 or advise the individual to attend A&E urgently

Amber – intermediate risk

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

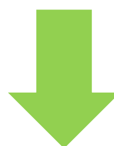
- Fever, is systemically unwell or has had a recent infection e.g. urinary tract infection.
- Pain that is progressive or gradual in onset.
- Sudden onset of severe or rapidly worsening radiating pain in one or both legs.
- Progressive neurological deficit such as major motor weakness of knee extension, ankle eversion or foot dorsiflexion.
- Sudden or new-onset erectile or sexual dysfunction.
- Severe, unremitting back pain including if it prevents sleep.
- Spinal pain aggravated by straining e.g. when coughing, sneezing or defaecating.
- No symptomatic improvement after 4-6 weeks conservative back pain home treatment/therapy.
- Unexplained weight loss.
- History of a past or current diagnosis of cancer (breast, lung, prostate, renal and gastric cancer are more likely to metastasise to the spine).
- Concern the pain is caused by other conditions e.g. sciatica, neuropathies, shingles, intra-abdominal pathology (gall stones, kidney stones, etc).
- Claudication (muscle pain or cramping in legs when walking or exercising).
- History of intravenous drug use.
- Risk of immunosuppression (e.g. due to cancer treatment/high doses of oral steroids/other immunosuppressants, or conditions that lower the immune system, like HIV infection).
- Pregnancy or less than 6 weeks post-partum (refer to midwife or GP).



Action: Advise the individual to see a GP or call NHS 111 for same day urgent assessment

Green – low risk

- Pain stopping day-to-day activities.
- Psychosocial indicators suggesting an increased risk of progression to long term distress, disability and pain. Examples include low mood, if the individual is worried about pain or struggling to cope, social withdrawal, avoiding activities due to fear of pain and pain impacting other areas of life.
- Osteoporosis or osteoarthritis. (may need a more urgent assessment depending on symptoms).
- Trauma that does not require attendance to A&E (see “red” referral criteria above).
- Diagnostic uncertainty or where the cause of the back pain is unclear or unknown.



Action: Refer to GP for routine assessment or see an appropriate community pharmacist independent prescriber (i.e. where this is within the specific independent prescriber’s scope of practice).

4.4 Overview of treatment[29,31,32]

Advise on non-pharmacological methods to control pain first:

- patient education, encouragement to return to normal activity and exercise, and self-care temperature treatments (ice, heat) are the first steps in therapy (refer to list of resources in Section 4.6 Advice for patients, below).

If these are ineffective, and / or symptom relief is needed to return to normal activity:

- non-steroidal anti-inflammatory drugs (NSAIDs).
    - if an individual has any risk factors for an NSAID-induced GI adverse event, (see table 1 below), DO NOT SUPPLY an NSAID. The individual should be referred to a GP or appropriate independent prescriber for consideration of an NSAID **AND** a PPI.

Table 1: Risk factors for GI adverse effects:

Risk factors for NSAID-induced GI adverse events include:

- age over 65 years*
- high dose of an NSAID.
- history of gastroduodenal ulcer, GI bleeding, or gastroduodenal perforation.
- concomitant use of medications that are known to increase the likelihood of upper GI adverse events (e.g. antiplatelets, anticoagulants, corticosteroids and selective serotonin reuptake inhibitors [SSRIs]).
- serious comorbidity, such as cardiovascular disease, hepatic or renal impairment (including dehydration), diabetes, or hypertension.
- heavy smoking.
- excessive alcohol consumption.
- previous adverse reaction to NSAIDs.
- prolonged requirement for NSAIDs.

* N.B. This risk factor alone will exclude an individual from receiving a medication supply under CAS.

4.5 Treatments[1,31,33-36]

Offer non-pharmacological options before discussing medication

- Advise the individual to resume ordinary daily activity as soon as possible, keep moving and exercise.
- Apply heat (e.g. a covered hot water bottle/patch). Heat may allow a short-term reduction in joint pain, stiffness and muscle spasm.
- Apply cold. Cold application (frozen peas wrapped in a damp towel) can reduce pain and swelling from recent injury (sprains and strains), apply to the source of inflammation in the back.
- Massage, if recommended by a trained professional (e.g. a physiotherapist), combined with exercise, may improve short-term symptoms.
- A physiotherapy consultation is an option an individual may wish to seek through the NHS or privately. GP surgeries can provide detail on whether direct self-referral is available.

Table 2: Analgesic treatment options

Medication	Dose	Considerations
Ibuprofen 200 mg tablets	ONE or TWO tablets up to THREE times a day	• The lowest effective dose should be used for the shortest duration necessary. • To be taken with or just after food, or a meal. • Can cause abdominal pain, nausea, dyspepsia, headache. • Caution in asthma. • See Table 1 for risk factors for GI adverse effects. • Not for use in recurrent peptic ulcer/haemorrhage (2 or more distinct episodes of proven ulceration or bleeding) or history of gastrointestinal bleeding or perforation related to previous NSAID therapy. • Not for use in heart failure, renal or liver impairment, hypertension, ischaemic heart disease, peripheral arterial disease, cerebrovascular disease. • Not to be taken alongside any other NSAIDs or medications that increase the risk of ulceration or bleeding such as anticoagulants, SSRI's or corticosteroids. • Check pack details for brands that carry a lactose intolerance warning and any other warnings/cautions/advice.
Naproxen 250 mg tablets	ONE or TWO tablets TWICE a day (see PGD)	• The lowest effective dose should be used for the shortest duration necessary. • Tablets should be swallowed whole and not broken or crushed. • To be taken with or just after food, or a meal. Can cause heartburn, nausea, vomiting, constipation and diarrhoea. • Caution in asthma. • See Table 1 for risk factors for GI adverse effects. • Not for use in recurrent peptic ulcer/haemorrhage (2 or more distinct episodes of proven ulceration or bleeding) or history of gastrointestinal bleeding or perforation related to previous NSAID therapy. • Not for use in heart failure, renal or liver impairment, hypertension, ischaemic heart disease, peripheral arterial disease, cerebrovascular disease. • Not to be taken alongside any other NSAIDs or medications that increase the risk of ulceration or bleeding such as anticoagulants, SSRI's or corticosteroids. See PGD for further details.

Table 3: Formulary information

Medication	Legal class	Pack size	Maximum number of consultations per episode† and Maximum number of episodes per year
Ibuprofen 200 mg tablets	P	24 84	A maximum of 1 consultation per episode. A maximum of 1 episode 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.
Naproxen 250 mg tablets	POM	28	

4.6 Advice for patients

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

Advise the individual to report any red flag signs or symptoms and/or seek advice if symptoms worsen and/or seek a follow-up with the GP if symptoms persist after 4 weeks.

Patient education

- Signpost to patient support websites, such as NHS Health A to Z for self-management advice including exercises and stretches for back pain (see links below).
- Encourage return to daily activities/work as soon as possible; normal back movements may cause some pain, but this should not be harmful if activities are resumed gradually.
- Advise on expected time course of pain.
- Advise individual to seek help for depression/other psychological conditions that may worsen symptoms.

Lifestyle

- Weight loss (if appropriate).
- Keep as active as possible and exercise regularly to reduce risk of recurrent episode.
- Avoid occupational hazards/activities which may worsen symptoms e.g. heavy lifting.

Signposting

- The NHS website has a section on back health including useful exercises: https://www.nhs.uk/conditions/back-pain/
- The Backcare website has various leaflets, including top 10 tips for back pain, back pain in the workplace and exercises for back pain: https://backcare.org.uk/
- The Chartered Society of Physiotherapy (www.csp.org.uk) list several patient resources in their web section “Back pain”.
- Keele University’s STarT Back resources (https://startback.hfac.keele.ac.uk/patients/) include written and animated information as well as an augmented reality app.
- The Live Well With Pain website is an interactive self-management approach to various aspects of pain control.

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

5.0 Chickenpox (in children under 14 years of age)

5.1 About the ailment[37-39]

Chickenpox (varicella) is a highly contagious viral infection that causes an acute fever and blistered rash, mainly in children. It has an incubation period of 7–21 days and generally self-resolves. Treatment is aimed at relieving symptoms and ensuring hydration is maintained. Chickenpox is usually a self-limiting, relatively mild disease without complications.

Typical features include a prodrome of nausea, fever, headache, myalgia, loss of appetite and general malaise.

Diagnosis of chickenpox can be made clinically from the characteristic rash:

- the rash usually presents as small, itchy, red spots on the scalp, face, trunk and proximal limbs
- these progress over 12–24 hours forming clear vesicles and pustules which are intensely itchy
- palms, soles and mucous membranes may be affected, with painful and shallow oral or genital ulcers
- crusting usually occurs within 5 days of the onset of the rash, and crusts fall off after 1–2 weeks
- immunosuppressed individuals with chickenpox may have an atypical rash and more extensive lesions (which may be haemorrhagic)
- the most infectious period is within 24 hours before the rash appears and infectivity continues until all the lesions have crusted over (usually about 5 days after the rash appears)

5.2 Possible complications[38-40]

- Secondary bacterial skin infection – sudden high-grade or prolonged pyrexia (often after initial improvement), erythema and tenderness surrounding the original chickenpox lesions; the redness may be harder to see or appear a different colour on darker skin tones.
- Dehydration – reduced urine output, lethargy, cool peripheries, reduced skin turgor.
- Chest infection – persistent cough, difficulty breathing and chest pain.
- Neurological complications including encephalitis - confusion, irritability, drowsiness, vomiting, weakness, severe headache and neck stiffness.

If any of the above are present medical attention must be sought immediately

Severe disease and complications are more likely to occur in children younger than 1 year of age, adolescents, adults, pregnant women and immunocompromised individuals.

5.3 When to refer to GP (or Pharmacist Independent Prescriber if thought to be appropriate)[38-40]

Refer to the GP or NHS 111 immediately for same day assessment if:

- the child is under 2 months old
    - urgently refer any babies born prematurely (< 37 weeks where baby's age is less than 4 weeks adjusted) because neonates are at increased risk of disseminated or haemorrhagic varicella
- signs present of being systemically unwell or showing symptoms suggestive of complications
- immunosuppression concerns or the individual has chronic skin, heart or respiratory disease
- persistent or recurrent fever present (may indicate secondary infection)
- treatment is required (and the appropriate treatment must be prescribed)
- diagnostic uncertainty

5.4 Overview of treatment[38,41]

- Paracetamol can be considered if fever or pain is causing distress.
- Topical calamine lotion can be used to alleviate itch.
- Chlorphenamine may be useful to treat itch, especially if sleep is disturbed.
- NSAIDs should be avoided in children with varicella as they may be associated with increased risk of skin infections.

5.5 Treatments[1, 8, 42-44]

Medication	Analgesic/antipyretic: if pain or fever causing distress			Astringent: to alleviate itch	Antihistamine: for treating itch	
Generic name	Paracetamol 120 mg in 5 mL sugar-free oral suspension	Paracetamol 250 mg in 5 mL sugar-free oral suspension	Paracetamol 500 mg tablets	Calamine lotion	Chlorphenamine 2 mg in 5 mL oral solution Only Piriton® syrup licensed	Chlorphenamine 4 mg tablets Only Piriton® tablets licensed in this pack size
Legal class	P	P	P	GSL	P	P
Pack size	100 mL	200 mL	32	200 mL	150 mL	30

Maximum number of packs to supply per consultation	1			1	1	
Maximum number of consultations per episode[†]	1			1	1	
Suggested maximum number of episodes per year	1			1	1	
Dosing instructions	As per pack	As per pack	As per pack	As per pack	As per pack	As per pack
Key information to consider prior to supply	Not licensed for children < 2 months old.	A maximum of 1 x 200 mL suspension may be supplied for children over 12 years who are unable to take paracetamol tablets.	As per pack	As per pack	Not licensed for children < 1 year old.	Not licensed for children < 6 years old.
	Refer to the BNF/SPC for full details on interactions, adverse effects, cautions and contraindications.					
Counselling Advice	See pack for further details			As per pack	Sedating antihistamine to help relieve itching may cause drowsiness, dry mouth and nausea.	

[†] 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.

5.6 Advice for patients[38-40]

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

- Ensure adequate fluid intake to avoid dehydration – ice lollies can be used if the child is not drinking.
- Wear smooth, cotton fabrics, avoid over heating or shivering.
- Keep nails short and clean to minimise scarring and secondary bacterial infection from scratching.
- Bathe in cool water – dab or pat the skin dry afterwards, rather than rubbing it.
- Cooling creams or gels may ease itching.
- Children with chickenpox should be kept away from school or nursery until the last blister has scabbed over.
- Air travel may not be allowed until 5 days after appearance of the last spot (when it has crusted over) – parents/carers should contact their airline and travel insurance companies.
- Seek urgent medical advice if there are signs of deterioration or complications such as:
  - bacterial superinfection – the skin around the chickenpox blisters is hot, painful and red, but redness may be harder to see on brown or black skin; there may be sudden fever (often after initial improvement)
  - dehydration – feeling thirsty, dizzy or tired, dark yellow and strong-smelling pee, peeing little, and fewer than 4 times a day, dry mouth lips and eyes
  - chest infection – persistent cough, wheezing, difficulty breathing and chest pain
  - drowsiness, confusion, vomiting, weakness, severe headache and neck stiffness
- During the period of infectivity, a child with chickenpox should avoid contact with:
  - people who are immunocompromised (e.g. those receiving cancer treatment or high doses of oral steroids or other immunosuppressants or those with conditions that reduce immunity)
  - infants aged less than 4 weeks
  - pregnant women

If you feel your child is not improving, or is getting worse, despite adhering to advice and/or trialling medication options if appropriate, please make an appointment to discuss with your GP.

6.0 Cold sores

6.1 About the ailment[45-47]

Cold sores are caused by the herpes simplex virus (HSV) infecting the lips, cheeks, nose or oropharyngeal mucosa, and are commonly passed on by skin contact. 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.

Cold sores usually resolve on their own without treatment within 10–14 days without scarring. They are contagious and may be irritating or painful while they heal.

Presentation:

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

6.2 Possible complications[45,48]

- Lip adhesions which may limit mouth opening.
- Dehydration from poor oral intake due to painful swallowing.
- 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 (follicular).
- During first infection, self-inoculation to hands/digits or genital area.
- Erythema multiforme.
- Tracheobronchitis, pneumonia and oesophagitis.

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

6.3 When to refer to GP (or EHEW optometrist if eye involvement or Pharmacist Independent Prescriber if thought to be appropriate)[45-50]

- Babies <6 months old.
- Pregnant women, particularly near term with primary oral HSV.
- Uncertain diagnosis/atypical lesions.
- Frequent (e.g. ≥6 episodes/year), persistent and/or severe episodes of recurrent HSV.
- In immunocompromised individuals, including those having chemotherapy for cancer and with conditions such as HIV.
- Suspected infection of the eye or genital areas with herpes simplex (suspected genital herpes can also be referred to the local genito-urinary or sexual health clinic).
- 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) or if no significant improvement is seen after 10 days.
- Red flags for oral cancer such as hoarseness, persistent ulceration, red or white patches in the mouth or a mass inside the oral mucosa.
- Unable to swallow due to pain and at risk of dehydration.
- Erythema multiforme.

6.4 Overview of treatment[45]

There is no good quality evidence that topical antivirals (other than those specially formulated for ocular involvement and issued following a consultation with an optometrist/GP) are effective in reducing pain or healing time. They need to be initiated at the onset of symptoms before vesicles appear, and applied frequently for at least 4–5 days.
Topical analgesics or anaesthetics, mouthwash, and lip barrier preparations are similarly not routinely recommended. However, oral simple analgesia such as paracetamol or ibuprofen can be taken if needed.

6.5 Treatments[45]

Advice only.

6.6 Advice for patients[45-48]

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

General advice

- Antiviral treatment is not usually needed for healthy people, and topical preparations, such as aciclovir (other than for the eye area, in which case an optometrist's advice should be sought) and other topical anaesthetic/barrier treatments are not proven to reduce pain or healing time.
- 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 5–7 days.

Avoiding transmission

- 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 after the cold sore is touched.
- Cold sores are passed on through direct contact with an affected area, therefore avoid kissing or skin contact with other people especially babies under 6 weeks old and anyone who has a weakened immune system; the infection can cause more serious problems for these people.
- The virus cannot be caught from objects such as food, eating utensils or towels (unless warm pus is present on these items).
- Lip balms should not be shared when sores are present.
- Avoid performing oral sex until the cold sores have completely healed.
- 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

Self-care

- Eat cool, soft foods while the cold sore is tender, and drink plenty to avoid dehydration.
- Avoid 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 prevent cold sores in people whose cold sores are triggered by the sun.
- Analgesics such as paracetamol or ibuprofen (if there are no contraindications) can be taken to treat pain and fever if needed.
- Children who are well do not need to be excluded from nursery or school.

- Seek medical advice if condition deteriorates (e.g. the lesion increases in size or spreads, new lesions develop after the initial outbreak, persistent fever, inability to eat or drink) or no significant improvement is seen after 10 days.

Topical treatment

- Although topical antiviral preparations, such as aciclovir, and other topical anaesthetic/barrier treatments are not proven to reduce pain or healing time, some people may find them helpful – they can be purchased over-the-counter.
- Topical antiviral preparations should be used at the time of onset of prodromal symptoms before vesicles appear (if possible) and until lesions have healed.
- Creams, gels and other topical treatments should be dabbed on the cold sores rather than rubbed in to minimise damage to the blisters which may cause pain or viral spread.
- Hands should be washed thoroughly with soap and water before and after touching cold sores and after applying creams to them.

Signposting

- The Herpes Viruses Association leaflet “About cold sores” can be found at: https://herpes.org.uk/cold-sores/
- The British Association of Dermatologists leaflet on Herpes simplex can be found at: https://www.bad.org.uk/pils/herpes-simplex/

7.0 Conjunctivitis (bacterial)

7.1 About the ailment[12,51-54]

Conjunctivitis is inflammation of the conjunctiva due to causes such as allergic or immunological reactions, infection (viral, bacterial or parasitic) and mechanical irritation. It is difficult to differentiate viral and bacterial conjunctivitis clinically. Up to 80% of all cases of acute conjunctivitis may be caused by viral infection. Between 50-75% of cases of infective conjunctivitis in children are thought to be due to bacterial infection.

Symptoms include:

- acute onset red eye
- discomfort that may be described as 'grittiness', a 'foreign body' or 'burning' sensation
- watering and discharge that may cause transient blurring of vision

Bacterial conjunctivitis can be associated with:

- development of symptoms in one eye initially, then affecting the other eye 1-2 days later.
- absent or mild pruritus.
- mild photophobia (see section 7.3 When to refer).
- yellow-white purulent or mucopurulent sticky discharge that causes crusting of the lids, which may be stuck together on waking.
- concomitant bacterial otitis media, sinusitis or pharyngitis.

Most cases of bacterial conjunctivitis resolve without treatment within 5–7 days.[54].

7.2 Possible complications[12]

Uncommonly, visual loss and structural eye damage occur (contact lens wearers and immunocompromised people are at greatest risk).

7.3 When to refer[55,56]

Wales General Ophthalmic Services (WGOS) registered optometrist (which may require onward referral to ophthalmology)
Individuals with an eye problem, including those that need urgent attention, can access free eye examinations by visiting a WGOS registered optometrist practice. A list of registered practices is available at WGOS 2 – Examination for Urgent Eye Problems and NHS 111 Wales.

Pharmacists should utilise local knowledge and refer individuals as necessary to the most appropriate clinician (A&E, GP, Optometrist or community pharmacist independent prescriber) that will avoid delay in diagnosis and treatment.

Red - High Risk

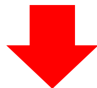
Refer individuals with the following to WGOS:

- Acute glaucoma, keratitis / iritis, or corneal ulceration is suspected, presence of pseudomembrane. Symptoms include:
    - marked redness in affected eye(s) along with, headache*, any eye pain and / or photophobia*.
    - halos around lights, flashing lights/wavy lines, nausea/vomiting.
    - change in visual acuity (unrelated to watering or tearing).
- Pupils that look unusual.
- Cloudy eye.
- Suspected gonococcal (e.g. discharge is mucopurulent, copious and rapidly progressive) or chlamydial conjunctivitis.
- Possible herpes virus infection (crops of vesicles, ulcers or pustules present on the eyelid or around the eye).
- Suspected periorbital or orbital cellulitis.
- Recent (in the last 6 months) eye surgery/eye procedure or laser treatment.
- History of trauma (mechanical, chemical or ultraviolet) or possible foreign body.
- Pain on ocular movement.
- Any contact lens wearers – individuals should also be advised not to wear contact lenses until they have been assessed and further advice obtained from their optometrist (if same-day assessment by the optometrist is not feasible, the individual should be referred to eye casualty and should be advised to take their contact lenses with them as special diagnostic tests may be required).
- Worsening symptoms despite treatment, or symptoms that reoccur or persist for more than 7 to 10 days after initiating treatment.
- Conjunctivitis thought to be due to molluscum contagiosum (presence of clusters of small round papules which may be white pink or brown with a waxy, shiny appearance).
- Diagnostic uncertainty.

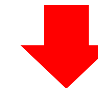
* If individual presents with headache, photophobia **AND** fever, refer to the most appropriate clinician (GP or A&E) that avoids delay to rule out meningitis.

Refer individuals with the following to most appropriate clinician (GP, or other clinician) that avoids delay in diagnosis and treatment:

- Red sticky eye in neonates 30 days old or less.
- Conjunctivitis associated with an undiagnosed severe systemic condition such as rheumatoid arthritis or immunocompromise.
- Pregnant.
- Breastfeeding.
- Individuals presenting with possible symptoms of meningitis (headache, photophobia **AND** fever).



Action: Advise the individual to call or attend a Wales General Ophthalmic Service (WGOS) for triage without delay. NHS 111 Wales - Search Results. If the individual is unable to access a WGOS registered optometrist without delay, advise them to attend Emergency eye casualty or A&E without delay.



Action: Advise the individual to see a GP or other appropriate clinician without delay.

7.4 Overview of treatment[12,54]

Routine use of topical antibiotics (i.e. chloramphenicol 0.5% eye drops or chloramphenicol 1% eye ointment) is not recommended in uncomplicated cases, as most cases are self-limiting and self-care measures can usually ease symptoms, with resolution within 5–7 days without treatment. See Section 7.6 Advice for patients below.

Treat with topical antibiotics if symptoms are moderate-severe, or if circumstances require rapid resolution as follows:

- a backup treatment strategy may be appropriate – advise the person to re-attend the pharmacy for review if symptoms have not improved within 3 days or sooner if symptoms worsen.
- a backup supply may be made if re-attendance is not practical (e.g. owing to access to transport, or the opening time of the pharmacy) for the individual to initiate topical antibiotics if symptoms have not improved within 3 days or sooner if symptoms worsen.
- advise individuals if symptoms have not resolved, get worse or re-emerge following a treatment course, or they develop other eye symptoms, to make an appointment with an optometrist for follow-up.

7.5 Treatments[1,12,15,54,57,58]

Medication	Treatment options	
Generic name	Chloramphenicol 0.5% eye drops	Chloramphenicol 1% eye ointment
Legal class	POM (supply via PGD)	
Pack size	10 mL	4 g
Maximum number of packs to supply per consultation	1	
Maximum number of consultations per episode†	1 (where treatment is supplied at first consultation) 2 (where the first consultation is advice and the second is as part of a backup prescribing strategy)	
Maximum number of episodes per year	2	
Dosing instructions	See PGD	
Key information to consider prior to supply & counselling advice	See PGD	See PGD

† 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.

7.6 Advice for patients[12,59]

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

- Bacterial conjunctivitis is usually self-limiting and resolves within 5-7 days without treatment.
- Symptoms may be eased with self-care measures such as:
  - wiping eyelashes gently with cooled, boiled water to clean off crusts with a clean cotton wool pad (1 piece for each eye).
  - Cool compresses applied gently e.g. clean wet flannel around the eye area for a few minutes.
- Good hygiene is essential; hands should be washed regularly with soap and water, particularly after touching infected secretions.
- Avoid rubbing the eyes.
- Pillows or towels should not be shared, and close contact with others should be avoided (individuals may be infectious for up to 14 days).
- Wash pillowcases and face cloths in detergent and hot water.

There is no recommended exclusion period from school, nursery or childminders for isolated cases. Nurseries and primary schools may have their own individual exclusion policy.

If you feel you are not improving, or are getting worse, despite implementation of advice and/or completion of a treatment course, please make an appointment to discuss with your optometrist in the first instance. If you are unable to obtain an appointment with your optometrist in a reasonable timescale, please discuss symptoms 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[60,61]

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.

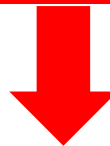
8.2 Possible complications[60]

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 [60,62-67]

Red – high risk
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.



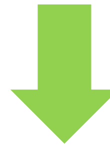
Action: Advise the individual to attend A&E without delay.

Amber – intermediate risk
• 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.

Green – low risk

- 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[60,67,68]

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[1,60,69-76]

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.** Option if stools are soft but difficult to pass or if there is a sensation of inadequate emptying. Avoid in pregnancy. Suitable for breastfeeding. 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[60,62,65,67]

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.

9.0 Diarrhoea – acute

Management of acute diarrhoea within the common ailments service is limited to the provision of advice. Advice can be provided to individuals aged over 1 year, with no other risk factors, presenting with diarrhoea of less than 7 days duration. Individuals with risk factors identified in section 9.3 below should be referred with appropriate urgency depending on presentation. The reason for referral should be provided to the patient and documented in the Choose Pharmacy System.

9.1 About the ailment[77]

Diarrhoea is the passage of three or more loose or liquid stools per day (or more frequently than is normal for the individual). Acute diarrhoea (usually defined as lasting less than 14 days) is common and in most cases will resolve within 5 -7 days without any intervention.

Acute diarrhoea in the community is commonly caused by viral infection (e.g. norovirus and rotavirus). Bacteria (e.g. *Campylobacter, Salmonella, E. coli and C.diff*) and parasites are less common causes of acute diarrhoea. Other symptoms that can occur alongside infectious diarrhoea are vomiting, crampy abdominal pain, fever, headache and aching limbs.

Other causes of acute diarrhoea are:

- medication e.g. laxatives, antibiotics magnesium-containing antacids, metformin, PPI's, glucagon like peptide (GLP-1) agonists e.g. tirzepatide, semaglutide, exenatide etc.
- food allergy.
- acute appendicitis.
- anxiety.
- initial presentation of a chronic cause (e.g. inflammatory bowel disease).

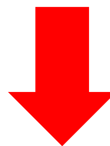
Assessment for acute diarrhoea should include determining the onset, duration, frequency and severity of symptoms and attempting to ascertain the underlying cause.

9.2 Possible complications[77,78]

- Dehydration and electrolyte disturbance increases the risk of life-threatening illness and death, particularly in young infants, children and older people.
- Underlying, undiagnosed health conditions e.g. Crohn's disease, ulcerative colitis and coeliac disease may initially be mistaken for acute diarrhoea.

9.3 When to refer[77,79-81]

Red – high risk
If an individual with diarrhoea presents with the following signs or symptoms, urgent medical attention is advised: • Signs of marked systemic illness or sepsis. • They have features of severe dehydration or shock e.g. increased pulse rate, tiredness, weakness dry mucous membranes, decreased urine output, marked hypotension and altered mental status. • If the individual is vomiting **and** unable to retain oral fluids **and** are at risk of severe dehydration e.g. children.



Action: Call 999 or advise the individual to attend A&E urgently

<table>
<tr><th colspan="2">Amber – Intermediate risk
(Pharmacists should use their judgement to determine the urgency of the referral)</th></tr>
<tr><td>Refer the following individuals who present with diarrhoea:
• Children less than 3 years and elderly/frail adults with diarrhoea for more than 2 days.
• Children 3 years and over with diarrhoea for more than 3 days.
• Children who have passed six or more diarrhoeal stools in the last 24 hours.
• Those working in the food industry, health care workers, elderly residents in care home.
• Recent contact with a person with diarrhoea caused by E. coli, C. diff, Giardia.
• Co-existing medical conditions e.g. immunocompromised, acute ulcerative colitis, diabetes, kidney disease, cardiac disease.
• Suspicion of C. diff (recent antibiotic course, PPI or hospital admission). Same day assessment recommended.
• Suspected adverse reaction to prescribed medication such as colchicine, digoxin, metformin, SSRIs, laxatives etc.
• Patients taking medicines that could precipitate AKI (e.g. angiotensin-converting enzyme inhibitors, diuretics) or when reduced absorption is a significant concern (e.g. anticonvulsants, warfarin).
• Pregnant women (refer to midwife).
• Recent travel abroad or suspected food poisoning.
• Recent visit (in the last 2 weeks) to a farm or petting zoo.</td>
<td>Refer individuals with diarrhoea and the following symptoms:
• Severe vomiting lasting more than 1-2 days.
• Persistent fever.
• History of change in bowel habit.
• Unexplained weight loss.
• Presence of blood, pus or mucus in stools.
• Severe abdominal pain, tenderness or distension.
• Suspicion of abdominal or rectal mass.
• Repeated episodes.
• Bouts of diarrhoea alternating with constipation.
• Diagnostic uncertainty.</td></tr>
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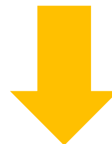


Action: Advise the individual to see a GP, call NHS 111 or see a pharmacist independent prescriber as appropriate for assessment.

9.4 Overview of treatment[77,82,83]

Most cases of acute diarrhoea are viral and self-limiting, with nearly half of episodes lasting less than a day. In many other instances a stool sample is required to rule out various pathology. Treatment with anti-diarrhoeal medication (e.g. loperamide) is therefore not routinely recommended, and so not included in this monograph.

Loperamide may be purchased for the symptomatic treatment of acute diarrhoea in adults and children over 12 years old as per the product licence and the pharmacist's clinical judgement.

It is worth noting:

- viral diarrhoea generally lasts 2-3 days.
- untreated bacterial diarrhoea generally lasts 3-7 days.
- protozoal diarrhoea can be present for weeks to months without treatment.

9.5 Advice for patients[77,83-87]

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

Diet

- Drink plenty of fluids such as water or squash (small sips can help if nausea is present).
- Carry on breastfeeding or bottle feeding a baby with diarrhoea, if they are being sick, small feeds more often than usual may help.
- Oral rehydration sachets can be taken.
- Eat when you feel able. If you do feel like eating, avoid fatty, spicy or heavy food at first. Plain foods such as wholemeal bread and rice are good foods to try initially.
- Fruit juice/fizzy drinks can make diarrhoeal symptoms worse so these should be avoided.
- If indicated, reduce intake of caffeine or food additives such as sorbitol, which can cause diarrhoea.
- If indicated, reduce alcohol intake (can cause a toxic effect on intestinal epithelium or rapid gut transit).

Lifestyle

- Stay at home and get plenty of rest.
- Wash hands frequently with soap and water to avoid transmission.
- Anxiety can worsen diarrhoea - you can ask your community pharmacist or GP for signposting to relevant wellbeing resources if you feel these may help.

- If symptoms are thought to be due to infectious pathogens:
    - do not prepare food for other people, if possible.
    - do not share towels, flannels, cutlery or utensils.
    - clean toilet seats, flush handles, taps, surfaces and door handles every day.
    - stay off school/childcare facilities/work until there has been no diarrhoea for at least 2 days, particularly if accompanied by vomiting.
- If you take a combined oral contraceptive pill and have very severe (6-8 watery stools in 24 hours), a back-up birth control method (such as condoms) should be used alongside the pill and for 7 days after recovering.

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.

10.0 Dry eye disease

10.1 About the ailment[88,89]

Dry eye disease is a condition affecting the ocular surface, characterised by loss of homeostasis of the tear film and a reduction in the quality or quantity of tears. It usually affects both eyes but symptoms may be asymmetrical.

Symptoms include:

- irritation of the eye – including a “gritty” or burning sensation
- transient blurring of vision
- ocular fatigue e.g. discomfort when looking at bright lights or when wearing contact lenses
- itching, tearing and dryness

It can be exacerbated by factors including:

- age related lacrimal gland deficiency
- some medications e.g. anticholinergics, retinoids, long-term topical eye preparation use
- lid aperture disorders
- damage to the eye or eyelid e.g. from injury or surgery
- blepharitis
- underlying conditions e.g. rosacea, Sjogren’s syndrome
- lifestyle e.g. contact lens use, prolonged reading/computer use
- environmental causes

Dry eye disease can usually be managed with self-care, lifestyle changes and, if required, pharmacological treatments.

10.2 Possible complications[88]

- Impact on daily activities including driving, reading and sleep.
- Depression and anxiety (due to impact on quality of life).
- Corneal scarring, thinning, ulceration, infection or neovascularisation.
- Poor outcomes of refractive, cataract and corneal surgery.

The following are rare complications and usually associated with an underlying condition:

- corneal perforation
- severe visual loss

10.3 When to refer [88]

When dry eye disease is suspected, referral to a WGOS registered optometrist for an eye examination is recommended in the first instance because certain underlying medical conditions can be associated with dry eye disease. In exceptional circumstances if the individual is unable to access a WGOS registered optometrist promptly, because of distance and or travel difficulties, treatments can be offered below as appropriate and as an interim solution until a visit to an optometrist can be arranged.

Emergency eye casualty or A&E for same day assessment

- Suspected acute glaucoma, keratitis/iritis, meningitis or corneal ulcer; symptoms include:
    - marked redness in eye(s) along with one or all of moderate-to-severe eye pain, headache and/or photophobia
    - sudden loss of vision
- Diplopia.
- Suspected gonococcal (copious, rapidly progressive discharge) or chlamydial conjunctivitis.
- Possible herpes infection.
- Suspected periorbital or orbital cellulitis.
- Corneal involvement (e.g. photophobia and watering) associated with soft contact lens use.
- Recent eye surgery/eye procedure or severe pain or visual loss.
- History of trauma (mechanical, chemical or ultraviolet) or possible foreign body.
- Serious underlying cause suspected e.g. Stevens-Johnson syndrome or ocular cicatricial pemphigoid.

WGOS registered optometrist (which may require onward referral to Ophthalmology)
Individuals with an eye problem, including those that need urgent attention, are entitled to a free Eye Health Examination at an accredited WGOS registered optometrist.

Refer the following:

- flashing lights/wavy lines, headache or vomiting
- restricted or painful eye movements
- contact lens wearers
- persistent or worsening symptoms despite 4-6 weeks management
- diagnosis requiring specialist assessment (apply a lower threshold for obtaining specialist advice for younger people)

- deterioration in vision
- abnormal lid function or anatomy
- diagnostic uncertainty
- individuals under 18 years of age

Appropriate referral should be made to the optometrist (for onward referral to specialist) if there is:

- suspected undiagnosed, underlying systemic condition e.g. Sjogren's syndrome
- systemic involvement e.g. weight loss/fever

Contact lens wearers presenting with symptoms of dry eye syndrome should be encouraged to arrange an examination with their prescribing optometrist.

10.4 Overview of treatment[88]

Symptomatic treatments such as tear replacement and ocular lubricant products selected in a prioritised manner, may be offered to people with dry eye syndrome, but these do not treat the cause. They should be used **in conjunction** with self-management/lifestyle measures as detailed in Section 10.6 Advice for patients.

Tear replacement and lubricant formulations include:

- **drops** (preferred for day time use)
- **ointments/gels** (use before bed as they often cause temporary blurring of vision)

Preservative-free formulations should be used if an individual:

- requires drops to be administered more than four times daily
- is intolerant of preservatives
- is using multiple topical preserved medicines

A treatment for dry eye syndrome can be tried for 4–6 weeks with a follow up appointment arranged with an optometrist.

10.5 Treatments[1,88]

Medication	1st line options					Adjunctive treatment
Generic name	Hypromellose 0.3% eye drops	Carbomer '980' 0.2% eye drops		Polyvinyl alcohol 1.4%		Retinol palmitate with white soft paraffin, light liquid paraffin, liquid paraffin and wool fat
Suggested brand	Non-proprietary	Evolve® carbomer 980 gel[90] (preservative free)	Viscotears® liquid gel	Sno Tears®	Refresh Ophthalmic® (preservative free)	Hylo-night
	Preservative free formulations are recommended if the individual is intolerant of preservatives in tear replacement options and/or they have moderate-to-severe dry eye disease requiring topical preparations > 4 times per day and/or is using multiple topical eye preparations (e.g. for other conditions)					
Legal class	P	Medical device	P	Medical device	Medical device	Medical device
Pack size	10 mL	10 g	10 g	10 mL	30 x 0.4 mL	5 g
Maximum number of packs to supply per consultation	1	1	1	1	4	1
Maximum number of consultations per episode†	2	2	2	2	2	2
Maximum number of episodes per year	1	1	1	1	1	1

<table>
<tr><td>Dosing instructions</td><td>1–2 drops into the eye 3 times daily as needed</td><td>Apply 3–4 times daily or as needed</td><td>1 drop into affected eyes 3–4 times a day</td><td colspan="2">1–2 drops into the eye when needed</td><td>Use before sleep as required</td></tr>
<tr><td rowspan="2">Key information to consider prior to supply</td><td>Suitable for use in pregnancy/lactation</td><td>Suitable for use in pregnancy/lactation</td><td>Not suitable in pregnancy or lactation (refer to SPC)</td><td colspan="2">Suitable for use in pregnancy/ lactation</td><td>Use in addition to other lubricants if severe morning dry eyes is an issue.

Suitable for use in pregnancy/lactation.</td></tr>
<tr><td colspan="6">Refer to the BNF/SPC for full details on interactions, adverse effects, cautions and contraindications.</td></tr>
<tr><td rowspan="2">Counselling advice</td><td>Can be dosed up to hourly until symptoms improve, then decrease the frequency.

If applying 2 drops in the same sitting, leave 5–10 minutes between drops.</td><td></td><td></td><td colspan="2">If applying 2 drops in the same sitting, leave 5–10 minutes between drops.</td><td>May cause temporary visual disturbance.</td></tr>
<tr><td colspan="6">• Wearing glasses instead of contact lenses allows the eyes to rest and reduce further irritation.</td></tr>
<tr><td>Relative cost of treatment course (£–£££)</td><td>£</td><td>£££</td><td>££</td><td>£</td><td>££</td><td>£££</td></tr>
</table>

† 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.

10.6 Advice for patients[88,89]

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

Making lifestyle and environmental changes can reduce the symptoms of dry eyes and, in mild cases, this may be sufficient to avoid the need for treatment.

Environmental changes

- Use a humidifier to moisten ambient air and avoid exposure to air conditioning or drafts.
- Avoid exposure to cigarette and other smoke.
- Reduce alcohol consumption.
- Keep computer screens below eye level and take regular screen breaks.

Lifestyle measures

- Warm compresses, lid hygiene and massage (especially useful if blepharitis is present).
- Limit the use of contact lenses if these cause irritation (changing lens type or solution may also help).
- Avoid wearing eye make-up.
- Reduce alcohol intake and/or engage with smoking cessation services if indicated.

Medication review

Review medications that may exacerbate dry eyes, such as:

- systemic retinoids
- topical ophthalmic medications e.g. glaucoma medications or those being used > 4 times daily and are not preservative-free
- oral contraceptives/hormone replacement therapy
- antihistamines
- beta-blockers
- anticholinergics
- psychotropics

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 be reviewed with your optometrist in the first instance. If you are unable to make an appointment with your optometrist in a reasonable timescale, please discuss symptoms with your GP.

11.0 Dry skin (includes contact dermatitis and atopic eczema)

11.1 About the ailment[91-93]

Dry skin (xeroderma) is the overarching term for skin that may crack, itch, peel or flake; it can also feel rough and tight (especially after bathing or showering). Dry skin is usually temporary but can be longer term, particularly in cases of contact dermatitis and atopic eczema. Dry skin may cause lighter skin to appear red, while darker skin can look dark brown, purple or grey. It may be harder to recognise dry skin in darker skin tones.

Atopic eczema (atopic dermatitis) is the most common form of eczema. It is more common in children where it is usually a chronic condition, but may improve significantly or clear completely as the child gets older. It can also occur for the first time in adults. The insides of elbows and backs of knees (joint creases), wrists and neck (flexural pattern), face and scalp are the most commonly affected areas. There may be small patches or widespread areas.

Contact dermatitis is a type of eczema triggered by contact with a particular substance e.g. make-up, medication, detergent and metals (e.g. nickel) causing the skin to become cracked and blistered. The reaction usually develops within a few hours or days of exposure to the irritant/allergen and improves when the aggravating substance is removed.

11.2 Possible complications[94,95]

- Skin infections (fever, lymphadenopathy and malaise may be present):
  - bacterial (may present as typical impetigo or as worsening eczema)
  - fungal
  - viral (e.g. herpes simplex)
- Psychological effects:
  - behavioural problems and fearfulness in preschool children
  - impaired performance
  - teasing and bullying in school children
  - distress and depression in teenagers and adults
- Other atopic and non-atopic comorbidities such as asthma, hay fever, food allergy and eosinophilic oesophagitis.

11.3 When to refer to GP (or Pharmacist Independent Prescriber if thought to be appropriate)[92,95]

- Signs of infection (e.g. weeping, crusting, pustules, fever, malaise, inflammation, erythema).
- Moderate-severe or severe symptoms.
- Persistent or recurrent symptoms.

- Symptoms not responding to treatment.
- Psychological effects.
- Babies less than 1 month old.
- Diagnostic uncertainty.

11.4 Overview of treatment[94,96]

- The mainstay of treatment is liberal and frequent application of emollients for all mentioned indications, even once skin is clear.
- Regular use of emollients can help avoid steroid treatment.
- There is no evidence from controlled trials to support the use of one emollient over another, so offer an emollient according to the dryness of the skin, and individual preference/tolerance.
- Experience has shown that proprietary products are often preferred by patients to non-proprietary products; it may be false economy to choose a preparation solely on the basis of price.
- The evidence to support use of bath additive and shower products is limited and there is no consensus on their benefit.
- Creams, gels and lotions are generally better for inflamed areas of skin as the evaporation of water-based products may cool the skin.
- Ointments are more effective than creams and are recommended for non-inflamed areas, however, they are often poorly tolerated, affecting compliance.

Emollients containing active ingredients are not generally recommended because they increase the risk of skin reactions, but they may be useful in some people, for example:

- lauromacrogols are reputed to relieve itch
- urea may improve skin hydration by enhancing the moisture-retaining ability of emollients, thereby improving their efficacy
- antiseptics (for example benzalkonium chloride) have a limited role in protecting infection-prone skin

A topical steroid can be added in addition to the emollient treatment and used for 7–14 days depending on response as per the treatment table below.

- Hydrocortisone 1% cream/ointment: for mild eczema where there are areas of dry skin and infrequent itching (with or without small areas of redness which may appear darker or purple in darker skin tones)
- Clobetasone 0.05% cream/ointment: for children aged 12 years and over, with an acute flare of moderate eczema where there are areas of dry skin, frequent itching and redness/inflammation which may appear darker/purple in darker skin tones (with or without excoriation and localised skin thickening)

11.5 Treatments[33,96]

Medication	Emollient: No active ingredient								Emollient: Active ingredient				Topical steroid		
	1st line								2nd line				adjunct to emollient treatment		
Generic name	Liquid paraffin 11% cream		Isopropyl myristate 15%/ liquid paraffin 15% gel		White soft paraffin: liquid paraffin cream (ingredients in varying ratios)			White soft paraffin: liquid paraffin (50:50) ointment	Urea-containing (e.g. Aquadrate® cream)		Antiseptic-containing (e.g. Dermol® 500 lotion)	Lauromacrogol-containing (e.g. Balneum® Plus cream)	Hydrocortisone 1% cream/ointment (for an acute flare of mild eczema)		Clobetasone 0.05% cream/ointment (for an acute flare of moderate eczema)
Legal class	Medical device		Medical device		Medical device			Medical device	Medical device		P	GSL	P/POM (supply via PGD)		POM (supply via PGD)
Pack size	50g	500g	100g	500g	50g	500g	100g	500g	30g	100g	500g	100g	15g	30g	30g
													Via PGD		Via PGD
Max. no. of packs to supply per consultation	1	2	1	2	1	2	1	2	1	1	1	1	1	1	1
Maximum number of consultations per episode†	2	2	2	2	2	2	2	2	2	2	2	2	1	1	1
Max. no. of episodes per year	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
Dosing instructions	• Apply frequently and generously, even once skin is clear.								Refer to product labelling				See PGD (Refer to the BNF for quantities of topical corticosteroid required to treat a body area in finger-tip units (FTUs) for an adult/child).		

<table>
<tr>
<td rowspan="2">Key information to consider prior to supply</td>
<td colspan="12">
Brands are suggestions only: refer to local health board formulary for appropriate choice of emollient.
First episode could be two consultations in order to include trial of therapy. Subsequent episodes should only be a single consultation.
First consultation – provide <u>either</u>:
a) a choice of up to three different 50–100 g pots as a trial of therapy or to establish preference OR
b) a maximum of 2 x 500 g pots if the individual already has a preference.
Where possible, issue an emollient with a pump dispenser to minimise the risk of bacterial contamination.
For emollients that come in pots, advise that using a clean spoon or spatula (rather than fingers) to remove the emollient, helps to minimise contamination.
Ointments dissolved in hot water are suitable soap substitutes.
It may be necessary to try a range of emollients before the person settles on the best combination for them.
If sensitivity to emollients is a known problem, issue a cream with fewer additives or an ointment to reduce the chance of a further reaction.
Patients on medical oxygen who require an emollient should not use any paraffin-based products due to flammability concerns.
Individuals should not smoke or go near naked flames while using these creams: serious fire hazard.
Suitable for use in pregnancy and breastfeeding (do not apply on chest area immediately prior to breastfeeding)
</td>
<td colspan="3">See PGD

Hydrocortisone 1% cream/ointment:
Can supply P for ages ≥10 years and over
If < 10 years, supply POM

Clobetasone 0.05% cream/ointment: supply POM pack

Only issue if using adequate quantities of emollients.

Refer if not resolving.</td>
</tr>
<tr>
<td colspan="15">Refer to the BNF/SPC for full details on interactions, adverse effects, cautions and contraindications.</td>
</tr>
<tr>
<td>Counselling advice</td>
<td colspan="12">
If a skin reaction occurs, stop using the emollient and trial a different one.
Flammable: see “Advice for Patients” section below.
Do not share emollients with others as they can become contaminated with bacteria.
</td>
<td colspan="3">If using an emollient, wait 15-30mins prior to application of the steroid cream.

See PGD for further details</td>
</tr>
<tr>
<td>Relative cost of treatment course (£–£££)</td>
<td>£</td><td>£££</td><td>££</td><td>£££</td><td>£</td><td>£££</td><td>£</td><td>£££</td><td>£</td><td>£££</td><td>£££</td><td>£££</td><td>£-££</td><td>£-££</td><td>£</td>
</tr>
</table>

† 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.

11.6 Advice for patients[94,96]

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

- It is better to prevent dry skin becoming worse by using lots of emollient and applying it often, this will preserve the skin barrier.
- Application advice is as follows:
  - frequency depends on the severity of the condition; for very dry skin, apply the emollient every 2–3 hours
  - use emollients during or after washing; if it is used during washing, the bath/shower will become slippery so take care not to fall
  - dry the skin after washing and apply the emollient while the skin is still moist
  - smooth emollients into the skin along the line of hair growth, rather than rubbing them in
- Topical corticosteroids (if used) should be applied at least 30 minutes after the emollient.
- Topical steroids should be applied thinly and only during an eczema flare
- There is a fire risk associated with the build-up of emollient residue on clothing and bedding; do not smoke or go near naked flames.
- Washing clothing or fabric at a high temperature may reduce emollient build-up but may not totally remove it.
- Keep nails short and avoid scratching the area; gently smoothing a moisturiser on to skin can help alleviate itching.
- Avoid trigger factors if possible.
- Avoid soaps, detergents and bubble bath when washing as they can damage the skin.

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.

12.0 Dyspepsia

The monograph supports the management of dyspepsia for adults 18 years and over with no risk factors. Individuals with risk factors identified in section 12.3 below should be referred with appropriate urgency depending on presentation. The reason for referral should be provided to the patient and documented in the Choose Pharmacy system.

12.1 About the ailment[97]

Dyspepsia is a group of upper gastrointestinal symptoms which typically present for four or more weeks. These include:

- upper abdominal pain/discomfort
- heartburn
- acid reflux
- nausea and/or vomiting (if recurrent vomiting, see "when to refer to GP" section)

Symptoms can be caused by gastro-oesophageal reflux disease (GORD), peptic ulcer disease and functional dyspepsia. Symptoms can also be caused or exacerbated by various medicines, for example:

- alpha-blockers
- anticholinergics
- benzodiazepines
- beta-blockers
- bisphosphonates
- calcium-channel blockers
- corticosteroids
- nitrates
- nonsteroidal anti-inflammatory drugs (NSAIDs)
- theophyllines
- tricyclic antidepressants

Existing medicines (both prescribed and OTC) should be reviewed to identify potential causes/contributory factors.

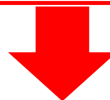
12.2 Possible complications include[98]

- Oesophageal ulceration.
- Bleeding which may precipitate anaemia.
- Stricture.
- Dental problems and bad breath.

12.3 When to refer[97,99-101]

Red – High risk

- Pain on exertion, pain in neck/left shoulder, history of myocardial infarction (MI).

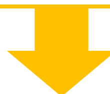


Action: Advise the individual to attend A&E without delay.

Amber – Intermediate risk

If an individual presents with dyspepsia and other features that puts them at higher risk of a more serious underlying cause, refer to an appropriate clinician. Examples include:

- Unintentional weight loss or loss of appetite.
- Anaemia suspected e.g. tiredness, fatigue, pale skin, feeling faint, palpitations.
- Altered bowel habit.
- Persistent nausea and/or vomiting.
- Jaundice.
- Newly diagnosed diabetes and the individual is ≥ 60 years of age
- Difficulty swallowing that has not been investigated and diagnosed.
- Signs of bleeding e.g. blood in stools/urine/vomit.
- History of Barrett's oesophagus.
- Tender, swollen, abdomen or a mass reported on self-examination.
- Previous gastric/peptic ulceration.
- New onset, persistent or unexplained dyspepsia in someone aged 55 years and over.
- Symptoms not relieved following 4-weeks of appropriate treatment (either antacids, alginates, PPIs or a combination, including if an individual has had *Helicobacter pylori* eradication therapy previously).
- Diagnostic uncertainty.



Action: Advise the individual to see a GP, call NHS 111 or see a pharmacist independent prescriber (PIP) as appropriate for assessment.

Green – Low risk
• Prescribed medication thought to be an exacerbating factor. See section 12.1 for examples.

Action: Treatment can be provided if appropriate AND advise the individual to see the clinician responsible for the treatment prescribed.

12.4 Overview of treatment[97,102]

- Offer advice on lifestyle modification in the first instance.
- If lifestyle modifications (see “advice for patients” below) are not successful, an antacid (purchased OTC) and/or alginate can be tried for symptom relief and symptom control. Long-term, continuous use of antacids or alginates is not recommended.
- If there is no reduction in symptoms, or symptoms are severe, a full-dose PPI can be trialled.
- If symptoms have not resolved after 4 weeks of attempted treatment, they should seek further advice from a GP or PIP.
- To reduce the risk of rebound hypersecretion (although this is unlikely in a short treatment period of 4 weeks), the individual’s PPI dose could be tapered towards the end of the treatment course; an alginate may be used if symptoms recur.
- If symptoms persist after this, the person should make an appointment to discuss with their GP.

12.5 Treatments[1,79,103-107]

Table 1: Alginate options – if lifestyle modifications alone do not offer symptom relief

If symptoms persist or treatment is ineffective after 2 weeks, advise the patient to return for a trial of a PPI.

Medication	Adults	Considerations
Sodium alginate 500 mg / 5 mL and potassium bicarbonate 100 mg / 5 mL oral suspension sugar free	5–10 mL after meals and at bedtime	Avoid in renal impairment or congestive cardiac failure and in those on low sodium/potassium diets. Care in hypercalcaemia, nephrocalcinosis and recurrent renal calculi. Suitable in pregnancy/breastfeeding. A time-interval of 2 hours should be considered between administration of alginates and other medicinal products.
Sodium alginate 500 mg and potassium bicarbonate 100 mg chewable tablets sugar free	1–2 tablets after meals and at bedtime	Contains aspartame. Caution in highly restricted salt diet. Suitable in pregnancy/breastfeeding. A time-interval of 2 hours should be considered between administration of alginates and other medicinal products.

Table 2: Proton Pump Inhibitor (PPI) options to take in combination with an alginate if required

Medication	Adults	Considerations
Lansoprazole 30 mg capsules	Take ONE capsule ONCE daily (see PGD)	Should be taken at least 30 minutes before food. Lansoprazole may interfere with the absorption of other medicinal products where gastric pH is an important determinant of oral bioavailability. Can cause nausea, diarrhoea, vomiting and stomach-ache. It may take 48 hours for the medication to start being effective. During this period, an individual with ongoing symptoms may need to take a concomitant antacid (purchased OTC) or alginate (via CAS or purchased OTC)
Omeprazole 20 mg capsules	Take ONE capsule ONCE daily (see PGD)	Recommended to take in the morning, swallowed whole with half a glass of water. Capsules must not be chewed or crushed. Omeprazole may interfere with the absorption of other medicinal products where gastric pH is an important determinant of oral bioavailability. Can cause nausea, diarrhoea, vomiting and stomach-ache It may take 48 hours for the medication to start being effective. During this period, an individual with ongoing symptoms may need to take a concomitant antacid (purchased OTC) or alginate (via CAS or purchased OTC)

Table 3: Formulary information

Medication	Legal class	Pack size	Maximum number of consultations per episode† Maximum number of episodes per year
Sodium alginate 500 mg / 5 mL and potassium bicarbonate 100 mg / 5 mL oral suspension sugar free	P	500 mL	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.
Sodium alginate 500 mg and potassium bicarbonate 100 mg chewable tablets sugar free	P	60 tablets (can supply 2 packs per consultation)	
Lansoprazole 30 mg capsules	POM	28	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.
Omeprazole 20 mg capsules	POM	28	

12.6 Advice for patients[97,107]

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

Lifestyle

- Eat healthily and try to maintain a healthy weight. Losing weight is advisable if BMI > 25 kg/m^2 (and BMI not raised due to increased muscle mass).
- Avoid trigger foods e.g. coffee, chocolate, tomatoes, fatty/spicy foods.
- Eat smaller meals and avoid missing meals. Evening meal should be 3–4 hours before going to bed, if possible.
- Avoid smoking (request smoking cessation advice if desired).
- Keep alcohol consumption to recommended limits.
- Relaxation strategies can reduce stress/anxiety/depression. These include breathing exercises (https://www.nhs.uk/mental-health/self-help/guides-tools-and-activities/breathing-exercises-for-stress/) and well-being tips (https://www.nhs.uk/every-mind-matters/mental-health-issues/anxiety/)
- Raise your head and shoulders when in bed – this can stop stomach acid coming up while you sleep.

Other

- Some medicines may cause symptoms of dyspepsia, or make them worse. If you feel this relates to you, check the information leaflets of any new or existing medicines and/or discuss with the pharmacist or your GP.

If you feel you are not improving, or are getting worse, despite 4 weeks' worth of lifestyle and/or medication changes, please make an appointment to discuss with your GP.

13.0 Haemorrhoids

13.1 About the ailment[108]

Haemorrhoids (piles) are abnormally swollen vascular mucosal cushions in the anal canal. They may be external or internal. Bright red, painless rectal bleeding is the most common symptom, typically occurring with defecation and seen as streaks on the toilet paper, in the toilet bowl and/or outside of the stool (but not mixed with it).

Other symptoms include:

- anal itching or irritation
- feeling of rectal fullness, discomfort, or of incomplete evacuation on bowel movements
- soiling
- anal pain (with prolapsed, strangulated internal haemorrhoids, or thrombosed external haemorrhoids)

Contributing factors include:

- constipation (may be due to a low fibre diet)
- straining while trying to pass stools
- older age
- hereditary factors (possibly due to a congenital weakness of the venous walls)
- heavy lifting
- chronic cough
- conditions that cause raised intra-abdominal pressure (such as pregnancy, childbirth, and space-occupying lesions)

13.2 Possible complications[108]

- Skin tags.
- Maceration of the perianal skin.
- Ischaemia.
- Ulceration.
- Thrombosis or gangrene.
- Anal stenosis.
- Severe pain caused by incarceration of prolapsed haemorrhoidal tissue.
- Perianal sepsis (rare).
- Anaemia from bleeding (rare).

13.3 When to refer

A&E or call 999

- Extreme pain.
- A lot of blood/bleeding that does not stop.
- Suspected perianal sepsis.

GP (or Pharmacist Independent Prescriber if thought to be appropriate)[109]

- Suspected infection e.g. fever/pus leaking from piles (urgent referral).
- Change in bowel habit.
- Moderate-severe abdominal pain.
- Night-time diarrhoea for several nights.
- Unexplained appetite or weight loss.
- Rectal bleeding or occult blood in faeces.
- Painful perianal lump or lesion.
- Severe pain in the affected area.
- Severe or recurrent symptoms.
- Non-response to treatment after 7 days or worsening symptoms.
- In pregnancy or breastfeeding.
- People under 18 years of age.
- Diagnostic uncertainty.

13.4 Overview of treatment[108]

Management of haemorrhoids is aimed at keeping stools soft and easy to pass; symptomatic relief is as follows:

1) lifestyle advice (see “Advice for patients” section)
2) simple analgesia and/or topical haemorrhoidal preparations
3) laxative treatment if constipation is a contributing factor – refer to CAS constipation monograph

Ideally, treatments should only be provided once a diagnosis has been made by a GP. However, on the first presentation of symptoms, treatment can be provided but refer the patient to their GP. No subsequent treatments should be provided without a GP diagnosis.

There is no evidence that one topical haemorrhoidal preparation is more effective than another. Preparation choice should be based on the risk of adverse effects and the person's symptoms and preference. Creams and ointments are generally used for external haemorrhoids and suppositories for internal haemorrhoids.
Consider the following:

- mild astringents or lubricants relieve local irritation and are less likely to cause skin sensitisation
- local anaesthetics help alleviate pain, burning, and itching, but can sensitise the anal skin; lidocaine is the preferred topical anaesthetic because others are more irritant
- topical corticosteroids may reduce inflammation and pain, but prolonged use may lead to skin atrophy, contact dermatitis and skin sensitisation; exclude local infection before use

13.5 Treatments[33,34,108,110]

Paracetamol dosing and dose/dosing interval adjustments in ADULTS

Dose of ORAL paracetamol in ADULT patients WITHOUT risk factors for paracetamol toxicity and ≥50 kg	
500 mg or 1 gram up to four times daily (minimum 4 hours between doses). Maximum 4 grams in 24 hours.	
Dose of ORAL paracetamol in ADULT patients WITH risk factors* for paracetamol toxicity	
Body weight	**Dose reduction up to a maximum of 15mg/kg body weight per dose**
33 kg to < 40 kg	500 mg up to four times a day (minimum 6 hours between doses). Maximum 2 grams in 24 hours.
40 kg to < 50 kg	500 mg or 1 gram up to four times a day (minimum 6 hours between doses). Maximum 3 grams in 24 hours.
≥ 50 kg	500 mg or 1 gram up to four times a day (minimum 4 hours between doses). Maximum 3 grams in 24 hours.

*Risk factors for paracetamol toxicity:

- body weight less than 50kg
- chronic alcohol overconsumption
- severe liver disease
- increasing age and/or frailty – where paracetamol might have been prescribed for significant periods and who have morbidities and polypharmacy, which can further increase their risk of inadvertent overdose and toxicity
- chronic malnutrition – with nutritional deficiency and/or chronic debilitating illness and therefore likely to be glutathione deplete e.g. acute or chronic starvation (patients not eating for a few days), eating disorders (anorexia or bulimia), cystic fibrosis, AIDS, cachexia, alcoholism, cirrhosis
- chronic dehydration

- hepatic enzyme induction or evidence of ongoing liver injury e.g. long-term treatment with liver enzyme-inducing drugs such as carbamazepine, phenobarbital, phenytoin, primidone, rifampicin, rifabutin, efavirenz, nevirapine, St John's wort; regular consumption of ethanol in excess of recommended amounts, particularly if nutritionally compromised

Refer to local health board formulary to guide appropriate choice of haemorrhoid product

Medication	Simple analgesia	Topical haemorrhoidal preparations				
Symptoms	Pain	Pain, burning and itching				
Generic name	Paracetamol 500 mg tablets	Lidocaine hydrochloride monohydrate 0.5%/ allantoin 0.5% ointment (Anodesyn® ointment)	Lidocaine hydrochloride monohydrate 10.25 mg/ allantoin 10.25 mg suppositories (Anodesyn® suppositories)	Lidocaine HCl. 0.7%, zinc oxide 6.6% cream (Germoloids® cream)	Lidocaine HCl 0.7%, zinc oxide 6.6% ointment (Germoloids® ointment)	Lidocaine HCl 13.2 mg /zinc oxide 283.5 mg suppositories (Germoloids® suppositories)
Legal class	P	GSL	GSL	GSL	GSL	GSL
Pack size	32	25 g	12	25 g	25 ml	12
Maximum number of packs to supply per consultation	2	1	1	1	1	1
Maximum number of consultations per episode†	1 if previously undiagnosed by GP 2 if haemorrhoids have been previously diagnosed by GP					
Maximum number of episodes per year	2					

Dosing instructions	As per pack and dosing table above	Apply as required	1 suppository twice daily after defecation	Apply at least twice daily and after defecation. Max. 4 times in 24 hours with minimum of 3–4 hours between doses		1 suppository twice daily after defecation
Key information to consider prior to supply	As per pack	General warnings for local anaesthetics/steroids: • contraindicated if there is infection • avoid prolonged use (maximum 7 days) As per pack				
	Refer to the BNF/SPC for full details on interactions, adverse effects, cautions and contraindications.					
Counselling advice	As per pack	All formulations contain potential sensitisers. Advise the individual to discontinue treatment if symptoms get worse and to use for no longer than 7 days.				
Relative cost of treatment course (£-£££)*	£	££	££	££	££	££
*	£= less than £1 £= £1 to £3.50 £££= over £3.50					

† 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.

Medication	Topical haemorrhoidal preparations						
	Mild astringent/antiseptic/lubricant			Local corticosteroid/astringent		Local corticosteroid/anaesthetic	
Symptoms	Itchiness and irritation			Pain, irritation and inflammation			
Generic name	Bismuth oxide, balsam peru, zinc oxide cream (see product for specific amounts) (Anusol® cream)	Bismuth subgallate, bismuth oxide, balsam peru, zinc oxide (see product for specific amounts) (Anusol® ointment/suppositories)		Hydrocortisone, bismuth subgallate, bismuth oxide, balsam peru, benzyl benzoate, zinc oxide (see product for specific amounts) (Anusol HC® ointment/suppositories)		Cinchocaine 0.5% / prednisolone 0.19% ointment (Scheriproct® ointment)	Cinchocaine 1 mg / prednisolone hexanoate 1.3 mg suppositories (Scheriproct® suppositories)
Legal class	GSL	GSL	GSL	POM (supply via PGD)	POM (supply via PGD)	POM (supply via PGD)	POM (supply via PGD)
Pack size	23 g	25 g	12	30 g	12	30 g	12
Maximum number of packs to supply per consultation	1	1	1	1	1	1	1
Maximum number of consultations per episode†	1 if previously undiagnosed by GP 2 if haemorrhoids have been previously diagnosed by GP						
Maximum number of episodes per year	2						
Dosing instructions	**Adults**: 1 suppository or application of cream or ointment in morning, at night and after each bowel evacuation until condition controlled			See PGD		See PGD	See PGD
Key information to consider prior to supply	As per pack			See PGD			
	Refer to the BNF/SPC for full details on interactions, adverse effects, cautions and contraindications.						

Counselling advice	All formulations contain potential sensitisers. Advise the person to discontinue treatment if symptoms get worse and to use for no longer than 7 days.						
Relative cost of treatment course (£–£££)*	££	££	££	££	£££	££	££
*	£= less than £1 ££= £1 to £3.50 £££= over £3.50						

† 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.

13.6 Advice for patients[108,111,112]

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

Lifestyle advice

- Keep stools soft, and don't strain on the toilet. The following may help:
  - eat plenty of fibre (e.g. fruit and vegetables, cereals, and wholegrain bread); increasing dietary intake should be done gradually to minimise flatulence and bloating
  - try to maintain a healthy weight; losing weight is recommended if indicated (e.g. BMI > 25 kg/m^2 where increased BMI is not due to increased muscle mass)
  - drink plenty of fluids, ideally water; avoid too much alcohol, caffeine and sugary drinks
  - avoid painkillers that contain codeine as it can cause constipation
  - avoid non-steroidal anti-inflammatory drugs (NSAIDs) if there is rectal bleeding (in which case you would need to make an appointment to discuss with your GP)
  - exercise regularly as per recommended guidelines
  - do not delay going to the toilet
- Ensure good perianal hygiene (may wish to use damp wipes rather than dry paper; pat dry rather than rub around bottom).
- A warm bath or applying an ice pack wrapped in a towel to the area may help ease discomfort.
- External haemorrhoids may be gently pushed back inside.

Treatment advice

- Treatments only provide symptomatic relief and do not cure haemorrhoids.
- If there is extreme pain, a lot of blood, or bleeding that does not stop go to A&E or call 999.
- Seek advice from your GP or call 111 urgently if:
  - you have haemorrhoids and your temperature is very high, or you feel hot and shivery and generally unwell

  - you have pus leaking from your bottom
- Seek advice from your GP if this is the first presentation, if symptoms are not relieved following one week of treatment or if you are concerned by any symptoms including:
  - tummy pain that doesn't go away quickly
  - diarrhoea (watery poo) at night for several nights
  - unexplained weight loss
  - bleeding or severe pain from the anus
  - lasting change in toilet habit
  - painful lump or other change around the anus
  - recurrent haemorrhoids
  - worsening symptoms

If you feel you are not improving, or are getting worse, despite 7 days' worth of lifestyle and/or medication changes, please make an appointment to discuss with your GP.

14.0 Head lice

14.1 About the ailment[113-115]

Head lice are grey-brown parasitic insects, about the size of a sesame seed, that infest the hair and feed on blood from the scalp. They lay eggs which hatch after 7 to 10 days. After a further 7 to 10 days, the hatched louse begins to lay eggs. Empty yellow-white egg-shells (nits) may be seen attached to the hair.

Symptoms of head lice infestation include:

- itchy scalp
- feeling something moving through the hair

Itchy scalp or the presence of eggs alone is not sufficient to diagnose active infestation; a live louse must be seen.

Systematic combing using a fine-toothed head lice detection comb (not a nit comb) is the best way to confirm the presence of lice. Wet combing with conditioner is more accurate than dry combing as the louse moves less when wet.

All household members and other close contacts should use a lice detection comb, and those with live lice should be treated on the same day to avoid reinfection.

14.2 Possible complications[113-115]

Complications are rare but include:

- rash on the back of the neck and behind the ears, caused by a hypersensitivity reaction to louse faeces
- excoriation and secondary skin infection
- anxiety, distress, and stigma
- loss of sleep caused by itching and missed days of school

14.3 When to refer to GP (or Pharmacist Independent Prescriber if thought to be appropriate)[113]

- Scalp inflammation or signs of infection.
- Infestation persisting after treatment with all appropriate methods.
- Under 6 months of age.
- Diagnostic uncertainty.

14.4 Overview of treatment[113]

Treatment options depend on person/carer preference, treatment history and contra-indications. Insecticides should only be supplied if the person is able to supply evidence of a live louse. Lice found using detection combing can be attached to sticky tape and brought to the consultation to aid diagnosis.

Treatment options include:

- **wet combing** with a fine-toothed head louse comb to remove the lice; the Bug Buster® kit is the only head lice removal (and detection) method that has been evaluated in randomised controlled trials, and it is available on the NHS – clinical trials report cure rates of 38% and 52% at 14–15 days
- **physical insecticides** are effective in 70% of cases; dimeticone lotion (Hedrin®) is poorly effective against eggs, however Hedrin® Once formulations have good ovicidal activity
- **chemical insecticides** – malathion 0.5% aqueous liquid (Derbac-M®) is the only one recommended in the UK, but resistance has been reported

Detection combing should be done after all treatments to confirm success. Treatment is successful if no living lice are found on the scalp. Nits may be present (they can remain attached for up to 8 months) but no further treatment is necessary.
Detection combing should be carried out on the days shown below:

- after wet combing - detection comb on day 17 to check for any live head lice
- after insecticide products with a single application – detection comb on day 1 and day 10
- after using products with two applications – detection comb one day after the last treatment

Treatment failure

Advise that close contacts should be assessed to identify possible sources of re-infestation and treated simultaneously.

- After insecticide treatment:
  - check that the treatment course was complete with correct application time, technique, and volume of product
  - repeat the same treatment or switch to a different treatment, as appropriate (if malathion has been used, consider the possibility of resistance)
- After wet combing (live louse found on Day 17):
  - confirm correct combing technique, sufficient duration of combing, and sufficient combing sessions
  - advise the person to repeat wet combing or consider using an appropriate insecticide

14.5 Treatments[1,113]

Medication	Wet combing	Physical insecticides					Chemical insecticide
	1st line	1st line		2nd line			3rd line
Generic name	Louse detection **or** nit comb	Dimeticone 4% lotion	Dimeticone 4% spray gel	Dimeticone 92% spray with comb	Isopropyl alcohol/ Benzyl alcohol Mousse 1.5%/1.5%	Isopropyl myristate and cyclomethicone solution	Malathion 0.5% aqueous liquid
Suggested brand	Detection and nit comb: Bug Buster® Nit combs: Nitty Gritty NitFree comb® Nitcomb–S1®, Nitcomb–M2® or Portia®	Hedrin® Lotion	Hedrin® Once Spray Gel (contains Penetrol)	NYDA®	Vamousse®	Full Marks Solution®	Derbac M®
Legal class	Medical device	P	Medical device	Medical device	Medical device	Medical device	P
Pack size	1	150 mL	100 mL	50 mL	160 mL	100 mL/ 200 mL/ 300 mL	150 mL
Maximum number of packs to supply per consultation	1	Provide sufficient quantities to allow all members of the household to be treated simultaneously for 2 doses. The names of all those who will be treated should be documented. Typically, 50 mL should be sufficient for short to shoulder length hair; and 150mL should be sufficient for long, thick hair.					
Maximum number of consultations per episode†	4 (if there is treatment failure for an infestation, the same treatment can be repeated, or different ones tried). Refer to GP if symptoms persist after 4 complete treatments per infestation.						
Maximum number of episodes per year	3						
Dosing instructions	As per pack	Contact time and application frequency (once or twice) varies between products – see manufacturer's advice.					

		Contact time: minimum 8 hours	Contact time: minimum 15 mins	Contact time: minimum 8 hours	Contact time: minimum 15 mins	Contact time: 10 mins	Contact time: 12 hours
Key information to consider prior to supply	Combs for egg/nit removal (nit combs) are not suitable for use as louse detection combs because their teeth are usually less than a width of a nit apart. The Bug Buster® kit has been evaluated when used alone in clinical trials. All other nit combs should be used as part of treatment alongside insecticides. Bug Buster® kit is reusable by a whole family.	Suitable in pregnancy and breastfeeding. Suitable from 6 months of age onwards. Suitable for people with eczema and asthma.	Should be suitable in pregnancy and breastfeeding but advise Hedrin® Lotion in the first instance. Suitable from 6 months of age onwards. Suitable for people with asthma.	Contraindicated in pregnancy and breastfeeding. Suitable from 2 years of age onwards.	Manufacturer advises if pregnant/ breastfeeding to discuss with GP prior to use. Suitable from 2 years of age onwards. Not recommended for people with asthma.	Caution in pregnancy and lactation. Suitable from 2 years of age.	Caution in pregnancy or breastfeeding. Suitable from 6 months onwards. Skin irritation, hypersensitivity reactions (such as anaphylaxis, angioedema, and swollen eyes), and chemical burns may occur. Resistance has been reported.
	Refer to the BNF/SPC for full details on interactions, adverse effects, cautions and contraindications.						
Counselling advice	See below – wet combing method	• Treat all affected household members on the same day. • Treatment should be applied to all areas of the scalp and to all of the hairs, from their roots to their tips. • The product should be left on for the time recommended by the manufacturer, then washed off. The instructions that come with the treatment should be read to ensure that it is used safely and to avoid the development of resistance. • There is a risk of serious burns if the head lice product ignites. Individuals should not smoke around treated hair and should keep away from flames, cigarettes, and other sources of ignition, including in the morning after overnight application until hair is washed.					

† 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.

14.6 Advice for patients[113,115]

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

General advice

- There is no evidence that head lice prefer either clean or dirty hair.
- Children who are being treated for head lice can still attend school.
- There is no need to treat clothing or bedding.
- Essential oil-based treatments and herbal treatments are not recommended.
- It is not possible to prevent head lice infestation, but children of primary school age should be examined regularly at home (using a detection comb) to identify infestation early.
- The itch may last days to weeks after successful treatment.
- Detection combing should be done after treatment to check for any live head lice (louse eggs alone and/or itching do not indicate treatment failure).

Wet combing method

- Physically removes lice from the hair through systematic combing of wet hair.
- It takes about 10 minutes to complete the process on short hair, and 20–30 minutes for long, frizzy, or curly hair.
- Two combing procedures are recommended at each treatment session.

Method:

- wash the hair using ordinary shampoo and apply ample conditioner, before using a normal comb to untangle the hair
- when the hair is untangled, switch to the fine-toothed louse detection comb, making sure that the teeth of the comb slot into the hair at the roots touching the scalp
- draw the comb through to the ends of the hair, then check the comb for lice after each stroke (ensure there is good lighting; a magnifying glass may help)
- remove any lice by wiping or rinsing the comb
- work methodically through the hair, section by section, so that all of the hair is combed
- rinse out the conditioner and repeat the combing procedure on the wet hair

If you feel you are not improving, or are getting worse, despite 3 complete treatments per infestation, please make an appointment to discuss with your GP.

15.0 Infantile colic

15.1 About the ailment[116-118]

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.

Although the exact underlying cause is unknown and may reflect the normal distribution of infant crying, it may also be caused by:

- abnormal gastrointestinal motility
- inadequate amounts of lactobacilli/increased amounts of coliform bacteria in the intestinal microflora
- psychosocial factors e.g. family tension, parental anxiety, inadequate parent-infant interaction, overstimulation of the infant, misinterpretation of crying

Symptoms include:

- 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

15.2 Possible complications[116]

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

15.3 When to refer to GP (or Pharmacist Independent Prescriber if thought to be appropriate)[116]

- Infants who are not thriving and/or have symptoms that are not improving or are severe.
- Symptoms that haven't improved after 4 months (an alternative underlying cause for symptoms should be considered).
- Parents/guardian feel unable to cope with the infant's symptoms despite reassurance and advice.
- Diagnostic uncertainty.

15.4 Overview of treatment[116]

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

Therefore, for the management of infantile colic, advice, support and/or onward referral alone are recommended.

15.5 Advice for patients[116]

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

Strategies for management

- Holding, rocking or bathing the infant in a warm bath may help soothe them.
- "White noise" (e.g. vacuum cleaner/hairdryer).
- Ensure an optimal winding technique is used during and after feeds.
- Continue breastfeeding wherever possible.

Reassurance/support to parents/guardians

- Infantile colic is a common condition which should resolve by 6 months of age.
- "Cry-sis" is a support group for families with excessively crying or sleepless children, their website is available at www.cry-sis.org.uk and they also run a national telephone helpline (0845 122 8669).
- The "My baby is crying all the time" section on the Healthier Together website (https://www.hwehealthiertogether.nhs.uk/parentscarers) may be useful.
- Parental/guardian access to appropriate support and wellbeing (e.g. friends, family, health visitor) and rest whenever possible is very important.
- 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 GP.

16.0 Ingrowing toenail

16.1 About the ailment[119,120]
Ingrowing (or ingrown) toenails are a common problem (especially in teenagers and young adults) in which the nail grows into the toe, creating a painful area, often on the big toe. The skin around the nail may be red, painful and swollen.

Symptoms of infection include increasing pain (maybe throbbing), swelling and redness near the ingrown nail, and yellow or green pus near the nail or under the nearby skin. In some cases, there may be a fever.

The foot should be examined to make the diagnosis.

16.2 Possible complications
Infection with possible systemic involvement.

16.3 When to refer to GP (or Pharmacist Independent Prescriber if thought to be appropriate)[119,120]
Further advice can be obtained from a podiatrist (depending on the location, this may need to be private) or GP.

Refer people who:
- are diabetic
- have a condition affecting the nerves or feeling in the feet (neuropathy)
- are immunocompromised
- show signs of infection which may require antibiotics, incision and drainage
- have co-existing nail disease
- do not improve after 7 days of conservative treatment, or sooner if symptoms get worse
- if there is diagnostic uncertainty

16.4 Overview of treatment[120]
Provide advice only.

When the ingrowing part of the toenail is small, non-surgical (or conservative) interventions will relieve symptoms, help cure the problem and prevent recurrence. Antibiotics may be needed to treat infection.

16.5 Advice for patients[120]

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

To resolve the condition

Painkillers, such as paracetamol, can be used to help relieve pain.

If the ingrowing part of the nail is small, it may be prevented from becoming worse, and sometimes cured, by the following:

- soak the toe in water for 10 minutes to soften the folds of skin around the affected nail
- using a cotton wool bud, push the skin fold over the ingrown nail down and away from the nail – start at the root of the nail and move the cotton wool bud towards the end of the nail
- repeat each day for a few weeks, allowing the nail to grow
- as the end of the nail grows forward, push a tiny piece of cotton wool or dental floss under it to help the nail grow over the skin and not grow into it; change the cotton wool or dental floss each time the foot is soaked
- do not cut the nail but allow it to grow forward until it is clear of the end of the toe; then cut it straight across, not rounded off at the end

There are variations of this method – the principle is to keep the skin from growing over the edge of the nail.

To prevent recurrence

Possible causes of ingrowing toenails include incorrect trimming of the nail, tearing toenails off, wearing constricting footwear, sweaty feet, injury and natural shape of the nail – most of which can be prevented.

The following can help prevent recurrence:

- trim the nail straight across to help prevent pieces of nail digging into the surrounding skin; the corner of the nail should be visible above the skin
- do not cut nails too short or too low at the sides
- see a podiatrist to have the toenails trimmed if there is any loss of feeling in the feet or if the person cannot see them very well
- wear comfortable shoes, tights or cotton socks that provide space around the toes
- keep the feet clean and dry; let air get to the toes when possible

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

17.0 Mouth ulcers (simple aphthous)

17.1 About the ailment[121,122]

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 pale yellow, with erythema around the area.
There are three different types, that can occur simultaneously:

- minor ulcers (85% cases) are less than 1cm in diameter, occur in groups of up to six and heal in 7–14 days without scarring
- major ulcers (10% cases) are usually 1-3cm in diameter, 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
- herpetiform ulcers (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 and Crohn's disease.

Adverse reaction to medication may be a cause of the ulcers e.g. nicorandil, beta-blockers and NSAIDs.

17.2 Possible complications[121,122]

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

17.3 When to refer to GP (or Pharmacist Independent Prescriber if thought to be appropriate)[121-125]

- 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.
- Children < 12 years.
- Initial presentation in someone over 30 years old.
- Painless ulcers.
- Recurrent mouth ulcers (> 2 times a year).
- Suspected adverse drug reaction to a prescribed medicine.
- Atypical sites (e.g. gums or palate, or non-oral sites e.g. genitalia).
- Signs of systemic illness or fever.
- Ulcers in crops of up to 100 (herpetiform).

- Ulcers > 1 cm diameter (major aphthous).
- Immunosuppression suspected (e.g. on chemotherapy).
- Unable to eat or drink.
- Worsening pain/redness or bleeding.
- Severe ulceration unresponsive to topical treatments.
- Diagnostic uncertainty.

A list of dentists accepting NHS patients can be accessed via NHS 111 or NHS Direct Wales.

17.4 Overview of treatment[121,126]

- 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 (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
- If simple therapies are insufficient, a topical corticosteroid e.g. hydrocortisone oromucosal tablets, may be offered

17.5 Treatments[121,122,125,127-129]

Medication	1st-line treatment options		2nd-line treatment option
Properties	**Antiseptic/antimicrobial**	**Analgesic/anti-inflammatory**	**Analgesic/anti-inflammatory**
Generic name	Chlorhexidine digluconate 0.2% w/v mouthwash	Benzydamine 0.15% oromucosal spray	Hydrocortisone 2.5 mg muco-adhesive buccal tablets
Legal class	GSL	P	P
Pack size	300 mL	30 mL	20
Maximum number of packs to supply per consultation	1	1	1
Maximum number of consultations per episode†	1	1	1

Maximum number of episodes per year	2	2	2
Dosing instructions	**Adults and children 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.	**Adults and children 12 years and over:** Use 4 to 8 sprays every 1.5 to 3 hours as needed.	**Adults and children 12 years and over:** Slowly dissolve 1 tablet up to 4 times daily by keeping the tablet in close proximity to the ulcer (the individual can use their tongue to help with this). Use for no more than 5 days at a time.
Key information to consider prior to supply	Ensure individual can safely gargle. Can be used in pregnancy and breastfeeding.	Not advisable in patients with hypersensitivity to acetylsalicylic acid or other NSAIDs. Caution in history of bronchial asthma. Not suitable in pregnancy or breastfeeding.	Only use in children 12 years and over. Not for use in people with untreated oral infection. Not suitable in pregnancy or breastfeeding. Refer to the BNF/SPC for further details on interactions, cautions and contraindications.
	Refer to the BNF/SPC for full details on interactions, adverse effects, cautions and contraindications.		
Counselling advice	May discolour teeth and tongue. To help combat this, avoid drinks that contain tannin (e.g., tea, coffee, or red wine). Leave at least a 30 to 60-minute interval between using the mouthwash and brushing teeth (or having something to eat/drink) as some ingredients in toothpaste can inactivate chlorhexidine.	May cause numbness and stinging that lasts a few minutes.	May prevent an ulcer from fully erupting if used early. The tablets should not be sucked. If the ulcers have not healed after 5 days of treatment (completion of one pack), or if they recur quickly after healing, a doctor should be consulted.

† 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.

17.6 Advice for patients[121-123,125,130]

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 containing chocolate, coffee, peanuts and gluten-containing products
- toothpaste containing sodium lauryl sulfate
- 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:

1) dissolve half a teaspoon of salt in a glassful of warm water
2) take some of the dissolved solution in your mouth and swill around then spit out; DO NOT SWALLOW

These steps can be repeated as often as needed.

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

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.

18.0 Nappy rash

18.1 About the ailment[131,132]

Nappy rash is inflammation of the skin in the area of the body covered by a nappy and is primarily an irritant contact dermatitis. Irritants such as urine, faeces, and faecal enzymes lead to skin breakdown, typically of the perineum and convex surfaces of the buttocks, with sparing of the skin folds.
Features include:

- red patches on the baby's bottom, possibly including the whole area
- skin that looks sore and is hot to the touch
- spots, pimples or blisters

Although all babies can get nappy rash, it doesn't usually develop in newborns. Most babies with mild nappy rash don't feel sore, but if the rash is severe the baby may feel uncomfortable and be distressed.

18.2 Possible complications[133]

Candida (fungal) infection can occur as it thrives on the inflamed skin. This can appear as sharply marginated redness involving the skin creases and can cause an inflamed rash to look brighter or darker red. Antifungal cream can be used to treat it.

18.3 When to refer to GP (or Pharmacist Independent Prescriber if thought to be appropriate)[133,134]

Refer if:

- the rash presents in the following ways:
  - severe redness/soreness with or without exudate (possible bacterial infection)
  - with punched out ulcers or erosions with elevated borders (possible erosive diaper dermatitis)
  - with smooth, red, moist papules or nodules in the nappy area, around the perianal skin, and involving genital, suprapubic, and buttock skin (suspected perianal pseudoverrucous)
  - with asymptomatic, cherry-red, 0.5–4 cm plaques and nodules (suspected granuloma gluteal infantum - rare)
- the baby appears systemically unwell
- there is diagnostic uncertainty

Refer babies where there is suspicion of immunosuppression, but supply appropriate treatment.

18.4 Overview of treatment[134]

- Asymptomatic cases/mild erythema – thinly apply a barrier preparation at each nappy change to protect the skin, such as a soft white paraffin or a combination preparation of zinc and castor oil ointment or cream.

- Inflamed rash that is causing discomfort – babies over 1 month old could be treated with hydrocortisone 1% cream (via a PGD) applied once daily, in addition to the barrier preparation until symptoms settle; or for a maximum of 7 days (whichever comes first).
- If the rash persists and *Candida* infection is suspected, a clotrimazole preparation could be issued but advise avoiding the barrier preparation until the infection has settled.

18.5 Treatments[15,134,135]

Medication	1st line: barrier preparation			2nd line: topical steroid	3rd line: topical antifungal
Generic name	Zinc and castor oil ointment	Zinc and castor oil cream	White soft paraffin	Hydrocortisone 1% cream	Clotrimazole 1% cream
Legal class	GSL	GSL	GSL	POM (as individual treated is < 10 years old)	P (can also supply via PGD)
Pack size	500 g	225 g	500 g	15 g	20 g
Maximum number of packs to supply per consultation	1	1	1	1	1
Maximum number of consultations per episode[†]	2	2	2	1	1
Maximum number of episodes per year	2	2	2	2	2
Dosing instructions	Apply thinly at each nappy change			Apply thinly once daily until symptoms settle or for a maximum of seven days	Apply 2–3 times a day and rub in gently until the area is healed
Key information to consider prior to supply	Contains arachis oil and beeswax			*For babies > 1 month old* **In addition to:** barrier preparation if rash appears inflamed/is causing discomfort	**Instead of:** barrier/steroid preparation if rash persists and *Candida* suspected
	Refer to the BNF/SPC for full details on interactions, adverse effects, cautions and contraindications.				

Counselling advice	Caution: flammable. Keep your body away from fire or flames after you have put on the medicine.	If using a barrier/steroid combination, apply topical hydrocortisone first and wait a few minutes before applying the barrier preparation. Caution: flammable. Keep your body away from fire or flames after you have put on the medicine.	A strip of cream (about 0.5cm long) is enough to treat an area about the size of an adult hand

† 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.

18.6 Advice for patients[132]

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

Do not smoke or go near naked flames when using these products – risk of severe burns and serious fire hazard.

Nappy rash usually clears up after about 3 days and can be prevented, if you follow this advice:

- make sure the baby's nappy fits properly; if it is too tight then it can irritate the skin and if it is too loose, then the nappy will not be able to soak up urine properly
- change wet or dirty nappies as soon as possible after wetting or soiling
- clean the whole nappy area gently but thoroughly, wiping from front to back; use water or fragrance-free and alcohol-free baby wipes
- bathe the baby daily – but avoid bathing them more than twice a day as this may dry out their skin
- do not use soap, bubble bath, or lotions
- dry the baby gently after washing them – avoid vigorous rubbing
- lie the baby on a towel and leave their nappy off for as long and as often as you can to let fresh air get to their skin
- do not use talcum powder as it contains ingredients that could irritate the baby's skin

If you feel your baby is not improving, or is getting worse, despite lifestyle and/or advised treatment, please make an appointment to discuss with your GP.

19.0 Oral candidiasis

19.1 About the ailment[136,137]

Oral candidiasis (also known as oral thrush) is an infection caused by *Candida*. It can be asymptomatic although may cause discomfort if severe. Signs and symptoms include white spots or plaques in the mouth that can be wiped off, leaving behind red patches, generalised erythema and a change in taste. Babies may drool or have difficulty feeding. It is not usually contagious.

Risk factors for oral thrush (making it more common in these groups):

- babies and the elderly
- people who wear dentures
- immunocompromised people or people with poor health
- people who have had recent antibiotic or steroid treatment
- diabetes mellitus
- excessive mouthwash use
- iron, folate or vitamin B12 deficiency
- smokers

Oral thrush may be the first presentation of an undiagnosed condition.

19.2 Possible complications[136]

- Chronic pain or discomfort.
- Impaired speech and/or chewing.
- Immunocompromised individuals may develop oesophageal candidiasis, causing painful or difficult swallowing; this can lead to systemic candidiasis.

19.3 When to refer to GP (or Pharmacist Independent Prescriber if thought to be appropriate)[136,138]

- Babies under 4 weeks old.
- Symptoms not resolved after 7 days of treatment.
- Difficulty or pain on swallowing.
- Pregnancy or breastfeeding – provide treatment but always refer.
- Extensive, severe infection or systemically unwell.
- No obvious risk factor (see: ‘About the ailment’ section).
- Possible severe immunocompromise (e.g. due to chemotherapy or HIV).

- Single red or red and white plaque that cannot be rubbed off (erythroplakia/erythroleukoplakia) may be pre-malignant – refer urgently to a dentist.
- Treatment may be provided to individuals taking DMARDs or steroids but always refer.
- Diabetes – provide treatment but always refer.
- Diagnostic uncertainty.

19.4 Overview of treatment[136]

Antifungal treatment

19.5 Treatments[136]

Medication	1st line	2nd line
Generic name	Miconazole 20 mg/g oromucosal gel sugar free	Nystatin oral suspension 100,000 units/ml
Legal class	POM (supply via PGD)	POM (supply via PGD)
Pack size	80 g	30 ml
Maximum number of packs to supply per consultation	2	2
Maximum number of consultations per episode†	1	1
Maximum number of episodes per year	2 (episodes must be 6 months apart)	2 (episodes must be 6 months apart)
Dosing instructions	See PGD	See PGD
Key information to consider prior to supply	See PGD	See PGD
Counselling advice	See PGD	See PGD

† 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.

19.6 Advice for patients[136,137]

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

Treatment

- Try and ensure treatment is kept in the mouth for as long as possible – avoid swallowing immediately.
- Administer after meals.
- Seek medical advice if symptoms persist after 7 days.

Prevention

- Maintain good dental and denture hygiene – dental prostheses and orthodontic appliances should be fitted and secured properly during the day (e.g. denture fixative agents), and removed at night/for at least 6 hours daily.
- Clean and disinfect dentures daily.
- Stop smoking – provide/signpost to smoking cessation advice.
- Ensure good inhaler technique for corticosteroids – risk of oral candidiasis can be reduced by using a spacer device with a corticosteroid inhaler and rinsing the mouth with water (or cleaning the teeth) after using the inhaler.
- Sterilise babies' dummies and bottles.

If you feel you are not improving, or are getting worse, despite lifestyle modifications and/or treatment for 2 weeks, please make an appointment to discuss with your GP.

20.0 Ringworm (tinea corporis), tinea cruris and intertrigo

20.1 About the ailment[139]

Fungal infections of the body (*tinea corporis*) and groin (*tinea cruris*) are superficial skin infections predominantly caused by dermatophytes.
The infection is usually transmitted in 4 main ways:

- human to human – direct contact with an infected person
- animal to human – direct contact with an infected animal (e.g. dog, cat, cattle)
- object to human – indirect contact with fomites (e.g. objects or materials which carry infection such as clothing, towels or bed linen)
- soil contact – geophilic infections from fungi or moulds in the soil (rare)

Intertrigo describes the involvement of flexural areas of the skin where folds are moist. It is intensified by friction and heat, typically causing redness and inflammation which appears as a red rash in lighter skin tones (may appear darker/skin coloured/purple in darker skin tones).

The table below shows features of the infection depending on which area of the body is affected

Body (ringworm)	Groin (tinea cruris)
• Single or multiple ring-shaped patches of varying sizes (usually 1–5 cm) which enlarge outwards.	• Affects the inguinal folds and proximal medial thighs (the perianal skin, buttocks and above the waistline may also be affected). • In men, the penis and scrotum are often spared.
• Red or pink (may appear different on darker skin tones).	• Red to red-brown (may appear different on darker skin tones).
• Flat or raised lesions with an active scaly, advancing edge and ***with*** a clear central area.	• Flat or slightly raised plaques with active borders (there may be pustules or vesicles within lesions) and ***without*** a clear central area. • The typical scaly edge may be lost in moist flexures.
• Usually asymmetrical.	• Uniform scale.

20.2 Possible complications[139]

- Secondary bacterial infection (immunocompromised people are at increased risk).
- Fungal infection of the hand (typically the dominant hand) may develop as a result of scratching the affected area.
- Extensive spread of fungal infection and change in morphology of lesions due to inappropriate use of topical corticosteroids leading to difficulty in diagnosis.

20.3 When to refer to GP (or Pharmacist Independent Prescriber if thought to be appropriate)[139]

- Severe or extensive disease (including affecting the face/scalp), particularly immunocompromised individuals.
- Individuals with diabetes if, in the opinion of the pharmacist:
  - there are concerns regarding diabetic control of the individual
  - the individual is at increased risk of detrimental symptoms associated with poorly controlled diabetes (symptoms can include thirst, blurred vision, fatigue and increased frequency of urination)
  - the individual is unsure how to manage their diabetes
- Reinfection or recurrence of fungal infection that is frequent and/or not mild.
- Symptoms that have not improved after using advised treatment.
- Secondary bacterial infection.
- Babies under 1 month of age.
- Diagnostic uncertainty.

20.4 Overview of treatment[139]

Treatment with a topical antifungal cream can be advised if there is mild, non-extensive disease in children and adults. It may be repeated in the future if there is a good response and any recurrent episodes remain mild and non-extensive.

Options include:

- terbinafine cream (adults aged 18 years and over) **OR**
- an imidazole e.g. clotrimazole cream or miconazole cream
- in addition, a mildly potent topical corticosteroid such as hydrocortisone 1% cream can be used for 7 days if there is associated marked inflammation; it should not be used alone

20.5 Treatments[139]

Medication	1st line			Only supply in combination with a topical antifungal if marked inflammation associated with fungal skin infection or intertrigo present
Generic name	Terbinafine 1% cream	Clotrimazole 1% cream	Miconazole 2% cream (Daktarin® 2% cream)	Hydrocortisone 1% cream
Legal class	POM (see PGD)	P (can supply via PGD)	P	POM (supply via PGD)
Pack size	30 g	20 g	30 g	15 g
Maximum number of packs to supply per consultation	1	4 (depending on area affected and individual's body habitus)	1	1
Maximum number of consultations per episode†	1	1	1	1
Maximum number of episodes per annum	2	2	2	2
Dosing instructions	Apply thinly to the affected area once or twice a day for 1–2 weeks	Apply to the affected area 2–3 times a day and continue for at least 4 weeks.	Apply to the affected area twice daily. Continue for 10 days after all skin lesions are healed to prevent relapse.	Apply thinly once or twice daily for 7 days (see below for further details).

Key information to consider prior to supply	**See PGD**	Interaction with tacrolimus (increases plasma tacrolimus levels). Avoid concurrent use. Not to be used during pregnancy.	Licensed for use in children (age range not specified by manufacturer). Caution should be exercised with oral anticoagulants. Anticoagulant effect should be monitored during treatment. Caution during pregnancy and breastfeeding.	**See PGD** Not to be used on the face. Not to be supplied in pregnancy or breastfeeding.
	Refer to the BNF/SPC for full details on interactions, adverse effects, cautions and contraindications.			
Counselling advice	**See PGD**	A strip of cream approx. 0.5 cm long is enough to treat an area about the size of a hand. Avoid contact with eyes and mucous membranes.	Avoid contact with eyes and mucous membranes.	**See PGD** If symptoms have resolved after 7 days, stop the corticosteroid. If there has been a significant improvement in symptoms, continue for a further 7 days. If there is no response, discontinue and for GP review. If applying another preparation alongside hydrocortisone cream, apply it first then wait 15-30minutes prior to application of the hydrocortisone cream
	Do not smoke or go near naked flames while using these creams: serious fire hazard.			
Relative cost of treatment course (£–£££)	££	£–£££	£	£

[†] 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.

20.6 Advice for patients[139,140]

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

Lifestyle

- Avoid hot, humid climates or working in high temperature environments.
- Avoid wearing tight-fitting clothing; wear loose-fitting clothes made of cotton or a material designed to keep moisture away from the skin.
- Maintain good hygiene by washing affected skin areas daily, then drying thoroughly, especially in the skin folds.
- Avoid scratching affected skin, as this may spread infection.
- Do not share towels, and wash them frequently, to reduce the risk of transmission.
- Wash clothes and bed linen frequently to eradicate fungal spores.
- Eat healthily and try to maintain a healthy weight. Losing weight is advisable if BMI > 25 kg/m^2 (and BMI not raised due to increased muscle mass).
- Take your pet to the vet if you think they might have ringworm (for example, if you notice patches of missing fur)

Other

- Hyperhidrosis can worsen symptoms – seek advice from your GP for treatment options

If you feel you are not improving, or are getting worse, despite lifestyle and/or medication changes within the timeframes discussed with the pharmacist, please make an appointment with your GP.

21.0 Scabies

21.1 About the ailment[141-143]

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.

Symptoms include intense itching, particularly at night, along with a raised blotchy rash that can develop into spots. The rash usually spreads across the whole body other than the head (where it may develop in young children, elderly people and immunocompromised individuals).

Symptoms usually take 2–6 weeks to develop after becoming infected.

21.2 Possible complications[144]

Scabies infestation may lead to:

- secondary bacterial infection – due to entry of bacteria into the compromised skin barrier; this may result in 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 to GP (or Pharmacist Independent Prescriber if thought to be appropriate)[145]

- Infants under 2 years old
- Severe rash, broken skin or secondary bacterial infection
- Individuals who appear systemically unwell
- Suspected crusted scabies
- Treatment failure (after 2 courses of treatment for scabies have failed in one episode) or if itching persists for longer than 2–4 weeks after the final treatment application
- Diagnostic uncertainty

21.4 Overview of treatment[145,146]

Scabies will not go away untreated and so the primary management involves the application of scabicides such as permethrin 5% cream or malathion 0.5% liquid (detail below).

21.5 Treatments[1,145,147]

Medication	1st line	2nd line (If permethrin ineffective/unsuitable)	If significant night-time itch		If post-scabietic itch is present less than 4 weeks after a treatment course is completed	
Generic name	Permethrin 5% w/w cream	Malathion 0.5% liquid (Derbac-M® 0.5% liquid)	Chlorphenamine		Crotamiton 10% cream (Eurax®)	
			4 mg tablets	2 mg/5 mL solution		
Legal class	P	P	P	P	P	
Pack size	30 g	150 mL	28 tablets	150 mL	30 g	100 g
Maximum number of packs to supply per consultation	4 (but see information in comments section below)	4 (but see information in comments section below)	1	1	1	1
Maximum number of consultations per episode†	2				1	
Maximum number of episodes per year	2	2	2		2	

Dosing instructions	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.	**Adults and children over 2 years old:** Apply once weekly for 2 doses by applying preparation over whole body, and wash off after 24 hours. If hands are washed with soap within 24 hours, they should be retreated.	**Adults and children over 12 years of age:** Two 5 mL doses every 4 to 6 hours up to a maximum of 6 doses in 24 hours as needed. **Children aged 6 to 12 years:** One 5 mL dose every 4 to 6 hours up to a maximum of 6 doses in 24 hours as needed. **Children aged 2 to 5 years:** One 2.5mL dose every 4 to 6 hours up to a maximum of 6 doses in 24 hours as required.	**For children 3 years of age and over:** Apply to the affected area(s) 2–3 times daily as needed for a total of 3–5 days.

Key information to consider prior to supply	–Children 23 months and below should be diagnosed and treated via the GP. –Sufficient quantities should be provided to allow all members of the household to be treated simultaneously. The names of all those who will be treated with the treatments provided should be documented. –In cases where the head, neck, scalp, and ears are treated, the dosage may be increased to ensure total body coverage. –Larger patients may require up to two 30 g packs per application for adequate treatment. –Contraindicated if known hypersensitivity to permethrin cream components, or other pyrethroids or pyrethrins. Also contraindicated in broken or secondarily infected skin. –If allergy to chrysanthemums, use malathion. –Manufacturer suggests suitable for use in pregnancy/breastfeeding.	–Assess quantity to supply based on individual's body habitus. –Does not contain alcohol, so may be more suitable for those with asthma or eczema. –No known effects in pregnancy and breastfeeding; use with caution. –Sufficient quantities should be provided to allow all members of the household to be treated simultaneously. The names of all those who will be treated with the treatments provided should be documented.	–Contraindicated in acute asthma. –This medicine should not be given to patients taking MAOI's or within 14 days of stopping such treatment. –Advised not to use during pregnancy or breastfeeding.	–Exclude exudative wounds, acute eczema, broken or very inflamed skin prior to supply. –For use in pregnancy and breastfeeding under medical supervision only.
	Refer to the BNF/SPC for full details on interactions, adverse effects, cautions and contraindications.			

Counselling advice	-**Adults and children over 2 years old**: Apply permethrin 5% cream over whole body but **NOT** the head and face. Wash off after 8–12 hours. If hands are washed with soap within 8 hours of application, they should be treated again with cream. -**Elderly or immunocompromised:** Apply permethrin 5% cream over the whole body **INCLUDING** the neck, face, ears and scalp. -If symptoms persist for longer than 2–4 weeks after the last treatment application and/or if new burrows have appeared since treatment, advise retreatment for the same episode. -Do not smoke or go near naked flames-risk of severe burns.	-Apply to the entire skin surface but not the head and face. -Do not wash off or bathe for 24 hours. -If hands or any other parts must be washed during this period, the treatment must be reapplied to those areas immediately. -Treatment should be repeated after 7 days. -Family members and close contacts should also be treated simultaneously. -Itching and rash may persist for up to 4 weeks after treatment, despite successful eradication of the scabies. -Do not smoke or go near naked flames-risk of severe burns.	-May cause drowsiness. If affected do not drive or operate machinery. -Avoid alcohol.	-Use after a warm bath/shower to well dried skin. -Rub into entire body surface area (excluding face and scalp). -Will provide relief from irritation for 6 to 10 hours after application. -Do not smoke or go near naked flames-risk of severe burns.

† 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.

21.6 Advice for patients[142,145]

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

Treatment information

- When applying cream/liquid, particular attention should be paid to:
  - areas between fingers and toes
  - under nails
  - wrists
  - armpits

  - external genitalia
  - breasts
  - buttocks
- Other than crotamiton cream, the cream should be applied to cool dry skin (not after a hot bath) and allowed to dry before dressing.
- The cream is flammable and can make fabrics (including clothing and bedding) catch fire; do not go near naked flames or smoke.
- The cream should not be applied to broken skin, mucous membranes, or near the eyes.
- Corticosteroids for eczematous-like reactions should be withheld until after completion of 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 4 weeks after successful treatment of scabies.

Decontamination

- Bedding, clothing, and towels of all potentially infested contacts 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.
- All members of the household should be treated simultaneously (within 24 hours).
- Affected person(s), including children, can go back to work or school 24 hours after the first treatment.
- Any sexual partners within the past month, and/or any other close personal contacts (even if asymptomatic) should be contacted by the individual as they should seek treatment also.

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.

22.0 Sore throat

This monograph supports the management of sore throat in **adults and children aged 5 years and over**. It includes the symptomatic management of sore throat and, where appropriate, the supply of antibiotics.

22.1 About the ailment[79,148-153]

Acute sore throat is a symptom resulting from inflammation of the upper respiratory tract. Four regions are principally involved – the pharynx, the larynx, the tonsils (if present) and rarely the epiglottis. It is usually caused by a self-limiting viral or bacterial infection. There is no evidence that sore throats caused by bacterial infection are more severe than those caused by viral infection, or that the duration of the illness is significantly different. Symptoms resolve within 3 days in 40% of people, and within 1 week in 85% of people. Antibiotics for streptococcal sore throat decrease symptom duration by around 16 hours and are indicated in some situations. See section 22.6 Advice for patients.

Sore throat is often associated with the common cold, COVID-19, influenza, streptococcal infection, pharyngoconjunctival fever, acute herpetic pharyngitis, and infectious mononucleosis (glandular fever). Sore throat caused by glandular fever may take up to 2 weeks to resolve, with associated lethargy continuing for some time afterwards. If *Candida* infection is suspected see oral thrush formulary monograph of the All Wales Common Ailments Service (CAS). The most common bacterial cause of sore throat is Group A beta-haemolytic Streptococcus (GABHS) which may cause pharyngitis, tonsillitis, or scarlet fever.

Symptoms of sore throat include:

- a painful throat especially when swallowing.
- a dry, scratchy throat.
- redness in the back of the mouth.
- if present, red, swollen tonsils with or without white spots or exudate. The absence of tonsils does not exclude a bacterial cause of sore throat.
- bad breath.
- swollen, tender neck glands.
- hoarseness may be present if there is laryngeal involvement.
- malaise.
- headache, nausea, vomiting and abdominal pain.
- fever.
- rhinorrhoea, nasal congestion, and a mild cough. The absence of a cough or runny nose makes a bacterial rather than a viral infection more likely.

Non-infectious causes of sore throat are uncommon and include:

- medicines that can cause blood disorders leading to infection. (e.g. cytotoxic drugs, carbimazole, clozapine, and sulfasalazine).
- physical irritation from gastro-oesophageal reflux disease, a nasogastric tube or chronic cigarette smoke.
- hay fever.
- Kawasaki disease (mainly affects children under 5. Presents with a high temperature lasting 5 days or more and with one or more of the following symptoms: rash, swollen neck glands, dry, red, cracked lips, swollen bumpy red tongue (strawberry tongue), red inside the mouth and back of the throat, swollen and red hands and feet, red eyes).

22.2 Possible complications[149,154-158]

A sore throat may result in significantly reduced fluid intake, which may lead to dehydration. Children and older adults are more at risk of dehydration. Symptoms of dehydration include:

- feeling thirsty.
- dark yellow, strong-smelling urine.
- peeing less often than usual.
- feeling dizzy or lightheaded, or feeling tired.
- a dry mouth, lips and tongue.
- sunken eyes.

Additional complications include:

- otitis media (most common).
- peri-tonsillar abscess (quinsy). Symptoms include:
    - fever, neck pain and or stiffness, difficulty opening the mouth, a muffled voice, a displaced uvula, and an enlarged, displaced tonsil, with swelling of the peri-tonsillar region.
- acute sinusitis.
- retropharyngeal abscess – suggested by severe sore throat that does not resolve after a few days. There may be difficulty opening the mouth or neck swelling.
- parapharyngeal (deep neck) abscess.
- epiglottitis (inflammation of the flap of tissue that sits beneath the tongue at the back of the throat which may restrict the oxygen supply to the lungs; can be fatal). Symptoms include:
    - severe and acute onset of sore throat, fever, muffled voice, drooling, and stridor.
    - children with epiglottitis may prefer to sit leaning forward, adults may sit erect with shortness of breath.
    - **do not examine throat if epiglottis suspected as this may cause airway closure.**

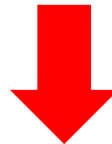
- measles (notifiable disease) – if symptoms suggest measles e.g. fever, cough, rhinitis, conjunctivitis, maculopapular rash with or without Koplik spots in the mouth, follow local guidance.
- scarlet fever (notifiable disease) – due to infection with an erythrogenic toxin-producing strain of streptococci.
  - presents as a 'scarlatina' rash which is described as red, generalised and pinpoint (punctate) with a rough sandpaper-like texture. On white skin the rash looks pink or red. It might be harder to see on brown or black skin, but you can still feel it.
- streptococcal toxic shock syndrome.
- Lemierre's syndrome (septic thrombophlebitis of the jugular vein.)
- acute rheumatic fever, acute glomerulonephritis and reactive arthritis (these are rare in developed countries).

22.3 Checklist for referral[79,149,152-154,156,158-165]

Red – high risk

Use clinical judgment to determine whether referral to A&E is necessary in vulnerable individuals (children, very old people, those who are immunosuppressed or immunocompromised)

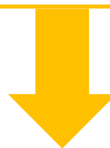
- Difficulty breathing.
- Drooling or difficulty swallowing or opening mouth.
- Stridor.
- Severe symptoms, getting worse quickly.
- Signs of marked systemic illness or sepsis (including changes in cognitive function, behaviour or mental state e.g. confusion, drowsiness or slurred speech).
- Systemically unwell **and** at risk of immunosuppression.
- Coughing up blood (more than just a few spots or streaks of blood present in the phlegm).
- Skin changes – very cold, or a strange colour or rash develop.
- Crushing central chest pain.
- Severe headache and vomiting.
- Suspected peri-tonsillar abscess (quinsy) or cellulitis, parapharyngeal abscess, retropharyngeal abscess, or Lemierre's syndrome (as there is a risk of airway compromise or rupture of the abscess). (severe neck pain, neck stiffness, visible neck swelling)
- Dehydrated, unable to take fluids or passing little or no urine and/or have dry mucous membranes.
- Kawasaki disease. Presents with a high temperature lasting 5 days or more and with one or more of the following symptoms: rash, swollen neck glands, dry, red, cracked lips, swollen bumpy red tongue (strawberry tongue), red inside the mouth and back of the throat, swollen and red hands and feet, red eyes.



Action: Advise the individual to attend A&E urgently

Amber – Intermediate risk

- Immunocompromised due to:
  - medical condition (e.g. HIV/AIDs, leukaemia, asplenia, aplastic anaemia)
  - taking immunosuppressant medicine e.g. cancer treatments, high-dose steroids, disease modifying anti-rheumatic drugs (DMARDs) (e.g. methotrexate, azathioprine and sulfasalazine)
  - taking medicines that can cause idiosyncratic neutropenia (e.g. carbimazole, sulfasalazine and clozapine).
- Abnormal breathing pattern (but not struggling for breath).
- Rash, flushed cheeks and swollen tongue could be a sign of scarlet fever. This normally occurs in children, but can occur at any age.
- Persistently high temperature over 38°C uncontrolled by paracetamol or ibuprofen.
- Oral mucositis.
- Coughing up small amounts of blood (no more than a few spots or streaks of blood present in the phlegm)
- Suspected bacterial infection despite negative antigen test (particularly in a child) requires referral for throat culture.
- High risk of serious complications because of pre-existing comorbidity, including:
  - significant heart disease (including valvular heart disease)
  - history of rheumatic fever
  - uncontrolled diabetes
  - lung, renal, liver or neuromuscular disease
  - cystic fibrosis
  - very old people – as there is no agreed defined age for this, an age of ≥ 75 years can be considered. It is also important to consider frailty of the individual as some younger, frail patients may be at risk of complications.
- Systemically very unwell where there are no features indicating urgent referral to A&E.
- Persistent mouth ulcer lasting longer than 3 weeks
- Persistent alteration in voice, hoarseness, lasting longer than 3 weeks, or is present with no other symptoms.
- Additional symptoms atypical of acute sore throat that could indicate rare infectious causes of sore throat, including: ulceration, signs of bleeding, skin, genital or eye lesions, rash, abdominal symptoms, hand or foot symptoms, grey/green oropharyngeal membranes.

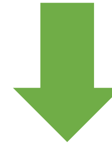


Action: Advise the individual to see a GP, call NHS 111, or see an appropriate* community pharmacist independent prescriber for same day assessment

* within the Independent Prescriber's scope of practice.

Green – low risk

- Persistent symptoms that haven't improved after 7 days. Refer sooner if symptoms worsen. Sore throat after 7 days with lethargy, fever, swollen lymph nodes, muscle aches, chills and sweats, loss of appetite and headache may indicate glandular fever, especially if patient is 15 to 24 years old.
- Repeated episodes (more than 7 episodes per year for one year, 5 per year for 2 years, or 3 per year for 3 years) need referral as they may benefit from tonsillectomy. Refer the individual sooner if clinically appropriate.
- Refer as clinically appropriate for any other concerns.



Action: Refer to GP for routine assessment

22.4 Assessment and overview of treatment[1,149,158,166,167]

Symptom relief

Paracetamol or ibuprofen can be supplied to help ease pain and fever.
Medicated lozenges containing a local anaesthetic and NSAID or an antiseptic agent may help pain in adults.

Antibiotic treatment

Assessment of the person is required to ensure appropriate antimicrobial management. Differentiating a viral sore throat from that caused by GABHS on the basis of examination is difficult. NICE recommends that the FeverPAIN or Centor criteria should be used along with examination of the person to determine the likelihood of streptococcal infection (and therefore the need for antibiotic treatment). Rapid antigen diagnostic test (RADT) can be used where appropriate to increase the certainty of diagnosis.

Table 1: Scoring tools to identify individuals more likely to benefit from antibiotic treatment

	FeverPAIN	Centor
Background	**Can be used in adults and children aged 5 years and above** Scoring criteria developed in a UK primary care setting in 2013	**Can be used in adults and children aged over 15 years** Scoring criteria developed in US emergency department setting in 1981**.**
Method	The **FeverPAIN score** is scored out of 5 depending on how many of the following are present: 1. **FEVER** in the last 24 hours 2. **P**urulent tonsils 3. **A**ttend rapidly (patient attended within 3 days of the onset of symptoms) 4. **I**nflamed tonsils (severe) 5. **N**o cough or coryza A FeverPAIN score of 0 or 1 is thought to be associated with a 13-18% likelihood of isolating GABHS. A score of 2 or 3 is thought to be associated with a 34-40% likelihood of isolating GABHS. A score of 4 or 5 is thought to be associated with a 62-65% likelihood of isolating GABHS.	The **Centor criteria** are scored out of 4 depending on how many of the following are present: 1. tonsillar exudate 2. tender anterior cervical lymph nodes or lymphadenitis 3. absence of cough 4. history of fever (over 38ºC) A Centor score of 0, 1 or 2 is thought to be associated with a 3-17% likelihood of isolating GABHS. A score of 3 or 4 is thought to be associated with a 30-56% likelihood of isolating GABHS.
Outcome	**Score of 0 or 1** ➢ Excluded from PGD for antibiotic supply. Advise that antibiotics are not needed. Do not offer RADT. ➢ Refer to the "Advice for Patients" section below. **Score of 2 or 3** ➢ Consider if the patient is likely to benefit from antibiotic treatment and, where this is the case, carry out a RADT. ➢ If the patient is less likely to benefit from antibiotics, provide symptomatic treatment and give advice on actions to take if symptoms worsen (see "Advice for patients" section below). **Score of 2 or 3 with a POSITIVE RADT result for Strep A** ➢ Watch and wait if practical (consider circumstances [e.g. weekends and bank holidays]; evidence that antibiotics make little difference to how long symptoms last. Most people feel better after 1 week, with or without antibiotics, and possible adverse effects from them may result). • Advise the person to return to the pharmacy for reassessment if symptoms fail to improve over the next 48 hours.	**Score of 0, 1 or 2** ➢ Excluded from PGD for antibiotic supply. Advise that antibiotics are not needed. Do not offer RADT. ➢ Refer to the "Advice for Patients" section below. **Score of 3 or 4 with a POSITIVE RADT result for Strep A** ➢ If the person is systemically very unwell or showing signs of a more serious condition or at high risk of complications: • check referral criteria and refer immediately as appropriate. ➢ If the person is **not** systemically very unwell; **not** showing signs of a more serious condition; and **not** at high risk of complications: • consider supplying antibiotic immediately

	• Advise seeking advice from GP or A&E if the person becomes systemically very unwell. • Refer to the "Advice for patients" section below. ➢ Consider providing a back-up antibiotic supply to start if symptoms do not improve or worsen over the next 3 to 5 days or if they worsen rapidly or significantly at any time. • Advise the person (if practical) to return to the pharmacy if symptoms fail to improve over the next 48 hours for reassessment. • Advise seeking advice from GP or A&E if the person becomes systemically very unwell. • Refer to the "Advice for patients" section below. **Score of 4 or 5, with a POSITIVE RADT result for Strep A** ➢ If the person is systemically very unwell or showing signs of a more serious condition or at high risk of complications: • check referral criteria and refer immediately as appropriate. ➢ If the person is **not** systemically very unwell; **not** showing signs of a more serious condition; and **not** at high risk of complications: • consider supplying antibiotic immediately with advice, depending on clinical condition; bearing in mind other circumstances (e.g. weekend/bank holiday), the unlikely event of complications if antibiotics are not taken and possible adverse effects. • consider providing a back-up antibiotic supply to start if symptoms do not improve or worsen over the next 3 to 5 days or if they worsen rapidly or significantly at any time. o Advise the person (if practical) to return to the pharmacy if symptoms fail to improve over the next 48 hours for reassessment. o Advise seeking advice from GP or A&E if the person becomes systemically very unwell. o Refer to the "Advice for patients" section below. **Negative RADT tests** ➢ Reassure the patient that even though they are unwell and may have exudate on their tonsils, the sore throat is not likely to be due to a streptococcal bacterial infection and so antibiotics will be unlikely to help. ➢ Consider if symptom relief is needed – refer to "symptom relief" section above. ➢ If their symptoms worsen, or new symptoms develop, return for assessment. ➢ Advise seeking advice from GP or A&E if the person becomes systemically very unwell. ➢ Refer to the "Advice for patients" section below.	with advice, depending on clinical condition; bearing in mind other circumstances (e.g. weekend/bank holiday), the unlikely event of complications if antibiotics are not taken and possible adverse effects. • consider providing a back-up antibiotic supply to start if symptoms do not improve or worsen over the next 3 to 5 days or if they worsen rapidly or significantly at any time. o Advise the person (if practical) to return to the pharmacy if symptoms fail to improve over the next 48 hours for reassessment. o Advise seeking advice from GP or A&E if the person becomes systemically very unwell. o Refer to the "Advice for patients" section below. **Negative RADT tests** ➢ Reassure the patient that even though they are unwell and may have exudate on their tonsils, the sore throat is not likely to be due to a streptococcal bacterial infection and therefore antibiotics will be unlikely to help. ➢ Consider if symptom relief is needed – refer to "symptom relief" section above. ➢ If their symptoms worsen, or new symptoms develop, return for assessment. ➢ Advise seeking advice from GP or A&E if the person becomes systemically very unwell. ➢ Refer to the "Advice for patients" section below.

22.5 Treatments[1,149,158,168-177]

Table 2: Treatments for pain and pyrexia associated with sore throat

Medication	Adults and children aged 5 years and older	Considerations
Paracetamol **120 mg / 5 mL sugar free oral suspension** **250 mg / 5 mL sugar free oral suspension** **500 mg tablets**	**Child 5 years**: 240 mg every 4-6 hours MAX 4 doses in 24 hours **Child 6-8 years:** 250 mg every 4-6 hours MAX 4 doses in 24 hours **Child 8-10 years:** 375 mg every 4-6 hours MAX 4 doses in 24 hours **Child 10-12 years:** 500 mg every 4-6 hours MAX 4 doses in 24 hours **Child 12-16 years:** 500-750 mg every 4-6 hours MAX 4 doses in 24 hours **Child 16 -17 years:** 0.5-1 g every 4-6 hours MAX 4 doses in 24 hours **Adults 18 years and over:** See table 3 below	• A maximum of 1 x 200 mL paracetamol 250 mg in 5 mL sugar free suspension may be supplied for children over 12 years who are unable to take paracetamol tablets. • If taking paracetamol regularly and the individual is on warfarin, advise INR test 5 to 7 days later. • Suitable for pregnancy and breastfeeding.
Ibuprofen **100 mg / 5 mL sugar free oral suspension** **200 mg tablets** **400 mg tablets**	**Child 5-6 years:** 150 mg THREE times daily **Child 7-9 years:** 200 mg THREE times daily **Child 10-11 years:** 300 mg THREE times daily **Adults and Children 12 years and over:** 200-400 mg THREE times daily	• Take with or after food. • Caution in asthma and children at risk of dehydration. • Contraindications to NSAIDs include: heart failure, hypertension, ischaemic heart disease, peripheral arterial disease, cerebrovascular disease, renal impairment and peptic ulceration. • NSAIDs with low dose aspirin may increase the risk of gastrointestinal side effects; avoid if possible. • If gastro-protection is required consider supplying paracetamol instead. • Avoid with warfarin, anticoagulants and in pregnancy. • Suitable in breastfeeding.

Table 3: Paracetamol dosing and adjustments in adults

Dose of ORAL paracetamol in ADULT patients WITHOUT risk factors for paracetamol toxicity and ≥ 50kg	
500 mg or 1 gram up to four times daily (minimum 4 hours between doses). **Maximum 4 grams in 24 hours.**	
Dose of ORAL paracetamol in ADULT patients WITH risk factors for paracetamol toxicity*	
Body weight	**Dose reduction up to a maximum of 15 mg/kg body weight per dose**
33 kg to < 40 kg	500 mg up to four times a day (minimum 6 hours between doses). Maximum 2 grams in 24 hours.
40 kg to < 50 kg	500mg or 1 gram up to four times a day (minimum 6 hours between doses). Maximum 3 grams in 24 hours.
≥ 50 kg	500mg or 1 gram up to four times a day (minimum 4 hours between doses). Maximum 3 grams in 24 hours.

* Risk factors for paracetamol toxicity:

- body weight less than 50 kg.
- chronic alcohol overconsumption.
- severe liver disease.
- increasing age and/or frailty – where paracetamol might have been prescribed for significant periods and who have morbidities and polypharmacy, which can further increase their risk of inadvertent overdose and toxicity.
- chronic malnutrition – with nutritional deficiency and/or chronic debilitating illness and therefore likely to be glutathione deplete e.g. acute or chronic starvation (patients not eating for a few days), eating disorders (anorexia or bulimia), cystic fibrosis, AIDS, cachexia, alcoholism, cirrhosis.
- chronic dehydration.
- hepatic enzyme induction or evidence of ongoing liver injury – e.g. long-term treatment with liver enzyme-inducing drugs such as carbamazepine, phenobarbital, phenytoin, primidone, rifampicin, rifabutin, efavirenz, nevirapine, St John's wort; regular consumption of ethanol in excess of recommended amounts, particularly if nutritionally compromised.

Table 4: Antibiotic treatments for bacterial sore throat

Medication	Children aged 5 years	Children aged 6-11 years	Adults and children aged 12 years and over	Considerations (see PGDs for full details on exclusions, cautions, side effects)
Phenoxymethylpenicillin **250 mg tablets** **125 mg / 5 mL oral solution or sugar free** **250 mg / 5 mL oral solution or sugar free**	125 mg FOUR times daily for TEN days **OR** 250 mg TWICE daily for TEN days	250 mg FOUR times daily for TEN days **OR** 500 mg TWICE daily for TEN days	500 mg FOUR times daily for TEN days **OR** 1000 mg TWICE daily for TEN days	• **First line if no penicillin allergy.** • Swallow tablets whole with water. • Take on an empty stomach (an hour before food or 2 hours after food). • Use liquid formulation in swallowing difficulty. • Suitable for pregnancy or breastfeeding.
Amoxicillin **250 mg capsules** **500 mg capsules** **250 mg / 5 mL oral suspension or sugar free** **500 mg / 5 mL oral suspension or sugar free**	**Supply of amoxicillin is only permitted under this service where there is a significant shortage of recommended antibiotics. Items will not be available to issue from Choose Pharmacy unless this has been authorised nationally.**			
	500 mg THREE times daily for TEN days	500 mg THREE times daily for TEN days	500 mg THREE times daily for TEN days	• **First line if phenoxymethylpenicillin unavailable AND no penicillin allergy.** • Note that individuals, particularly adolescents with concurrent infection with glandular fever/Epstein-Barr virus (EBV) have an increased frequency of amoxicillin associated skin rashes. • Use liquid formulation in swallowing difficulty. • Suitable for pregnancy or breastfeeding.
Clarithromycin **250 mg tablets** **500 mg tablets** **125 mg / 5 mL oral suspension** **250 mg / 5 mL oral suspension**	Dose is based on body weight if under 40kg. For FIVE days **12-19 kg:** 125 mg TWICE daily **20-29 kg:** 187.5 mg TWICE daily **30-40 kg:** 250 mg TWICE daily		500 mg TWICE daily for FIVE days	• **First line in penicillin allergy.** It can be used if other first line treatment unavailable. • **First line in penicillin allergy AND breastfeeding.** • Not suitable for pregnancy. • Swallow tablets whole with water. • Can be taken with or after food. • Nausea, vomiting, abdominal discomfort, and diarrhoea are the most common adverse effects of macrolides.

Medication	Children aged 5 years	Children aged 6-11 years	Adults and children aged 12 years and over	Considerations (see PGDs for full details on exclusions, cautions, side effects)
				• Use liquid formulation in swallowing difficulty. • Tablets not suitable for children under 12 years of age.
Erythromycin **250 mg tablets** **Erythromycin ethyl succinate** **250 mg / 5 mL oral suspension or sugar free**	250 mg FOUR times daily for FIVE days	**6-7 years:** 250 mg FOUR times daily for FIVE days **8-11 years:** 500 mg FOUR times daily for FIVE days	500 mg FOUR times daily for FIVE days	• **First line in penicillin allergy AND pregnant or at risk of pregnancy.** • It can be used if other first line treatment unavailable. • **Second line in penicillin allergy AND breastfeeding.** • Tablets not suitable for children less than 8 years old, oral suspension is recommended. • Swallow tablets whole with water. • Can be taken with or after food. • Nausea, vomiting, abdominal discomfort, and diarrhoea are the most common adverse effects of macrolides.

Table 5: Formulary information

<table>
<tr><th>Medication</th><th>Legal class</th><th>Pack size</th><th>Quantity to supply per consultation</th><th>Maximum number of consultations per episode[†] and Maximum number of episodes per year</th></tr>
<tr><td>Paracetamol 120 mg in 5 mL sugar free oral suspension</td><td>P</td><td>100 mL</td><td>1</td><td rowspan="19">A maximum of one consultation per episode where an antibiotic is supplied at first consultation
OR
two consultations where the first is advice and the second is a consultation as part of a backup prescribing strategy
See the latest good practice guidance for back up antibiotic prescribing.

A maximum of 2 episodes in 6 months

[†] 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.

[#]Supply of amoxicillin only permitted where there is a significant shortage of recommended antibiotics. Items will not be available from Choose Pharmacy unless this has been authorised nationally.</td></tr>
<tr><td>Paracetamol 250 mg in 5 mL sugar free oral suspension</td><td>P</td><td>200 mL</td><td>1</td></tr>
<tr><td>Paracetamol 500 mg tablets</td><td>P</td><td>32</td><td>1</td></tr>
<tr><td>Ibuprofen 100 mg in 5 mL sugar free oral suspension</td><td>P</td><td>100 mL</td><td>1</td></tr>
<tr><td>Ibuprofen 200 mg tablets</td><td>P</td><td>24</td><td>1</td></tr>
<tr><td>Ibuprofen 400 mg tablets</td><td>P</td><td>24</td><td>1</td></tr>
<tr><td>Phenoxymethylpenicillin 125 mg / 5 mL oral solution or sugar free</td><td>POM</td><td>100mL</td><td>For 10 days</td></tr>
<tr><td>Phenoxymethylpenicillin 250 mg / 5 mL oral solution or sugar free</td><td>POM</td><td>100 mL</td><td>For 10 days</td></tr>
<tr><td>Phenoxymethylpenicillin 250 mg tablets</td><td>POM</td><td>28</td><td>40 or 80</td></tr>
<tr><td>[#]Amoxicillin 250 mg / 5 mL oral suspension or sugar free</td><td>POM</td><td>100 mL</td><td>For 10 days</td></tr>
<tr><td>[#]Amoxicillin 500 mg / 5 mL oral suspension or sugar free</td><td>POM</td><td>100 mL</td><td>For 10 days</td></tr>
<tr><td>[#]Amoxicillin 250 mg capsules</td><td>POM</td><td>21</td><td>60</td></tr>
<tr><td>[#]Amoxicillin 500 mg capsules</td><td>POM</td><td>21</td><td>30</td></tr>
<tr><td>Clarithromycin 125 mg / 5 mL oral suspension</td><td>POM</td><td>70 mL</td><td>For 5 days</td></tr>
<tr><td>Clarithromycin 250 mg / 5ml oral suspension</td><td>POM</td><td>70 mL</td><td>For 5 days</td></tr>
<tr><td>Clarithromycin 250 mg tablets</td><td>POM</td><td>14</td><td>For 5 days</td></tr>
<tr><td>Clarithromycin 500 mg tablets</td><td>POM</td><td>14</td><td>10</td></tr>
<tr><td>Erythromycin ethyl succinate 250 mg / 5mL oral suspension or sugar free</td><td>POM</td><td>100 mL</td><td>For 5 days</td></tr>
<tr><td>Erythromycin 250 mg gastro resistant tablets</td><td>POM</td><td>28</td><td>40</td></tr>
</table>

22.6 Advice for patients[149-151,159-162,165,178-180]

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

General advice for patients:

- Colds, most coughs, sinusitis, ear infections, sore throats, and other infections often get better without antibiotics, as your body can usually fight these infections on its own. Sore throat usually gets better within 7 days, with or without antibiotics.
- Taking antibiotics makes bacteria that live inside your body more resistant so the antibiotics may not work when you really need them.
- Antibiotics can cause side effects such as rashes, thrush, stomach pains, diarrhoea, reactions to sunlight, other symptoms, or being sick.
- Use an appropriate information leaflet from the **TARGET**: Respiratory tract infection resource suite: Patient facing materials (rcgp.org.uk) as a discussion tool and provide a copy.

If antibiotics are not supplied and CAS is NOT available:

- Return to the pharmacy or contact GP if symptoms do not improve after 7 days or earlier if symptoms worsen.
- Seek advice from GP or A&E if the person becomes systemically very unwell.
- Advise on criteria for urgent medical advice below.

If antibiotics are not supplied and CAS is available:

- Reassure patient that while they may feel unwell and experience pain and discomfort with the sore throat, treating the sore throat with antibiotics will not help and might cause adverse effects.
- Return to the pharmacy if symptoms do not improve after
    - 7 days if FeverPAIN score 0 or 1 or Centor score of 0,1 or 2**;**
    - 48 hours if FeverPAIN score 2 or more; or Centor score of 3 or more

  or earlier if symptoms worsen.
- Seek advice from GP or A&E if the person becomes systemically very unwell.
- Advise on criteria for urgent medical advice below.

If antibiotics are supplied:

- Seek advice from GP if symptoms worsen or do not improve within 3–4 days; seek advice from GP or A & E if the person becomes systemically very unwell.
- Advise on criteria for urgent medical advice below.

Over-the-counter treatments:

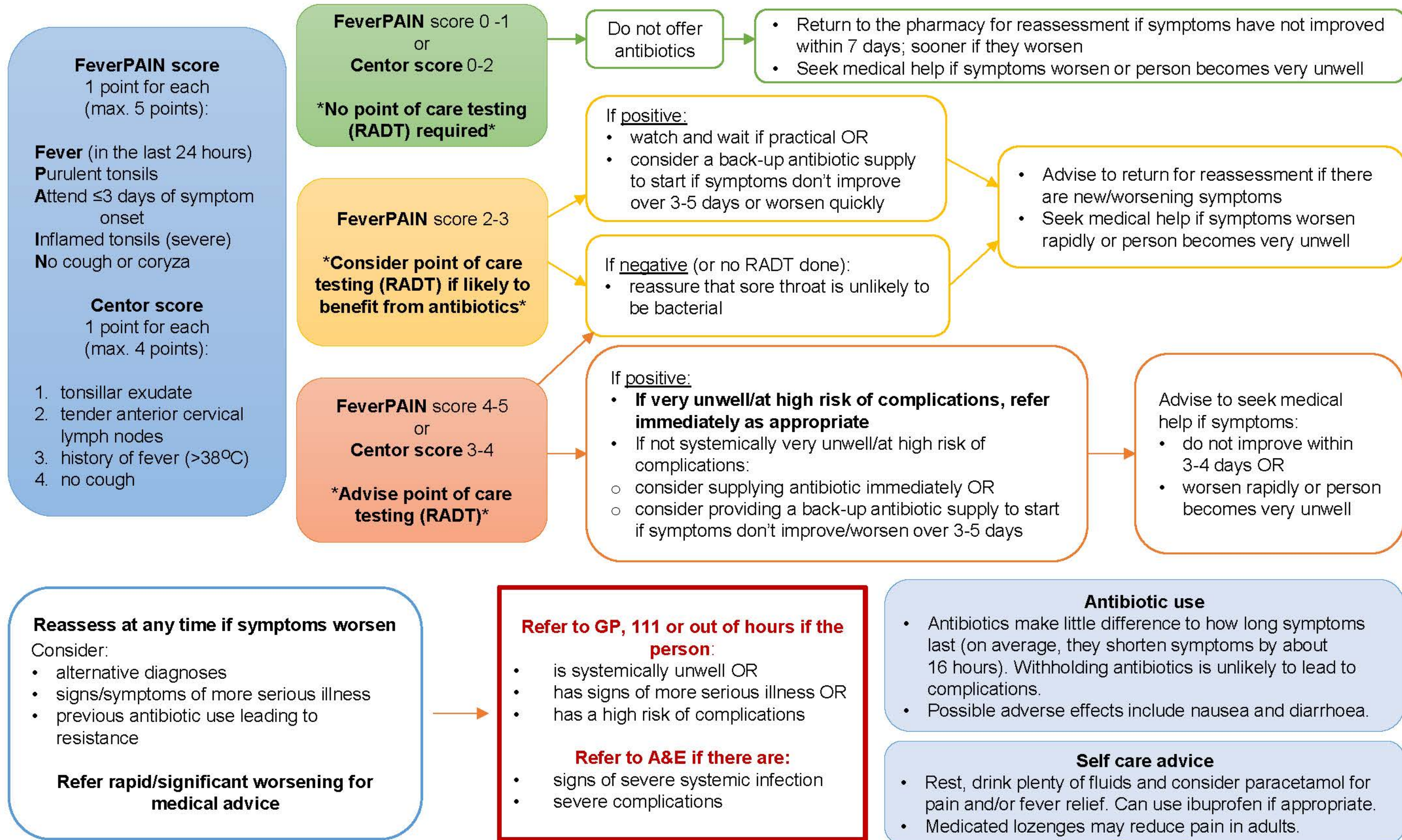
- Some people may find medicated lozenges containing a local anaesthetic, NSAID or antiseptic useful.
- Benzydamine gargles or spray are NOT available through CAS as there is little evidence for their effectiveness for pain relief in sore throat.
- There is no evidence for zinc lozenges, herbal remedies or acupuncture.
- Adults and older children may find sucking hard sweets, ice cubes or ice lollies provide symptomatic relief.
- Adults can try a warm saline gargle (half a teaspoon of salt in a glassful of warm water at frequent intervals), but do not swallow. This is not suitable for young children.

Lifestyle:

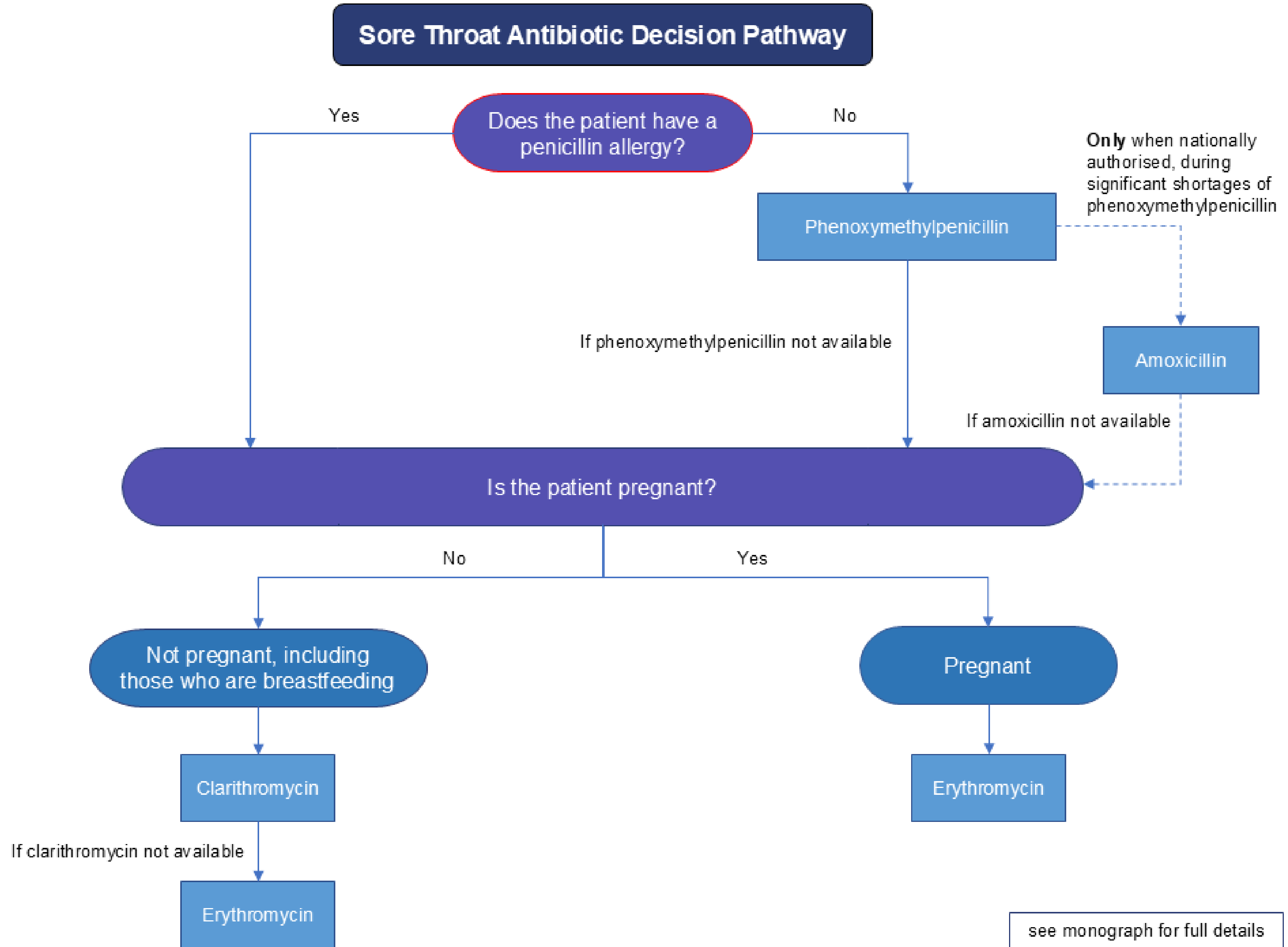
- Rest and take simple painkillers at regular intervals to relieve pain and fever.
- Avoid smoking and smoky environments.
- If you have a high temperature or you do not feel well enough to do your normal activities, try to stay at home and avoid contact with other people until you feel better.
- Drink plenty of fluids to avoid dehydration.
- Eat cool and soft foods. Hot drinks should be avoided as these can exacerbate pain.
- Children may return to school or day care after fever has resolved and they are no longer feeling unwell, and/or after taking antibiotics for at least 24 hours.

Advise the patient to seek urgent medical advice if there is:

- difficulty breathing, speaking or stridor.
- drooling, difficulty swallowing saliva or liquids.
- muffled voice.
- skin changes – very cold, or a strange colour or rash develop.
- confusion, drowsiness or slurred speech.
- severe headache and sickness.
- severe pain or feeling a lot worse.
- passing little to no urine.
- chest pain.
- coughing up blood (more than just a few spots or streaks of blood).
- one-sided neck or throat swelling.



Summary of information from - NICE CKS: Sore throat – acute. September 2024. Available at: https://cks.nice.org.uk/topics/sore-throat-acute/. Accessed April 2025


Sore Throat Antibiotic Decision Pathway
Does the patient have a penicillin allergy?
Yes
No
Phenoxymethylpenicillin
Only when nationally authorised, during significant shortages of phenoxymethylpenicillin
Amoxicillin
If phenoxymethylpenicillin not available
If amoxicillin not available
Is the patient pregnant?
No
Yes
Not pregnant, including those who are breastfeeding
Pregnant
Clarithromycin
Erythromycin
If clarithromycin not available
Erythromycin
see monograph for full details

23.0 Teething

23.1 About the ailment[181,182]

Teething occurs when the teeth emerge through the gums. Most children start teething around 4–12 months of age and have their full set of teeth at around 2 to 3 years old. Signs and symptoms of teething are generally mild and usually occur about 3–5 days before each tooth erupts.

Signs and symptoms include:

- pain
- increased biting
- 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
- red flushed cheeks or face

23.2 Possible complications[181]

Teething itself is a normal physiological process and is not associated with severe or systemic symptoms. Presence of these would suggest other underlying conditions and should be referred.

23.3 When to refer to GP (or Pharmacist Independent Prescriber if thought to be appropriate)[181,182]

- Fever (raised temperature above 38°C).
- Diarrhoea – there may be a change in the passage of stools at teething time, but it should not cause diarrhoea (refer to Section 9.0 Diarrhoea).
- Any infant who is systemically unwell, in severe distress or has prolonged symptoms.
- Diagnostic uncertainty.

23.4 Overview of treatment[181,183]

First-line treatment is with self-care measures.
Consider paracetamol and/or ibuprofen for symptomatic relief in infants over 3 months of age if self-care hasn't helped.

23.5 Treatments[33,181]

Medication	1st line	2nd line
Generic name	Paracetamol 120 mg in 5 mL sugar-free paediatric oral suspension	Ibuprofen 100 mg in 5 mL sugar-free oral suspension
Legal class	P	P
Pack size	100 mL	100 mL
Maximum number of packs to supply per consultation	1	1
Maximum number of consultations per episode†	2	
Maximum number of episodes per year	2	
Dosing instructions	As per pack directions	
Key information to consider prior to supply	Only use if self-care methods do not help. Limit to children over 3 months of age. **Refer to the BNF/SPC for full details on interactions, adverse effects, cautions and contraindications.**	
Counselling advice	As per pack directions	

† 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.

23.6 Advice for patients[181-185]

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 or cold wet flannel (never tie the teething ring around the infant's neck, as it is a choking hazard); solid rings are preferred over gel or liquid filled rings, which could leak
  - chilled fruit and vegetables (e.g. banana, apple, carrot or cucumber) for children who have been weaned; sugar-free products are preferred (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.
- Cool, sugar-free drinks can help soothe gums.

Dental care

- As soon as teeth erupt, brush them using a toothbrush and fluoride toothpaste – use a tiny smear for babies, and a pea-sized amount for children.
- For children under 3 years old, use a toothpaste with a fluoride level of 1000 ppm (parts per million) twice daily.
- Encourage parents/carers to take their child to the dentist before the first tooth erupts, at about six months of age.

Medication for symptom relief

- Teething gels that contain a local anaesthetic (e.g. Bonjela® Junior gel and Dentinox® Teething gel) are not recommended as they can cause harm if swallowed.
- If teething gels are used, they are only available under the supervision of a pharmacist.
- Bonjela® Junior gel is not licensed for children under the age of 5 months.
- 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 or homeopathic remedies) are of benefit for teething symptoms.

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.

24.0 Threadworms

24.1 About the ailment[186,187]

Threadworms are small, thin, white thread-like parasitic worms about 2–13 mm long that infest the human gut. They do not usually cause serious problems and are common in children (particularly 4- to 11-year-olds), household contacts of infected children and people living in institutions, but anyone can be affected. Female worms lay tiny eggs around the anus. This causes intense itching which is usually worse at night. The worms might be visible in stools or around the anus. Adult threadworms survive for about 6 weeks and infection is maintained by swallowing fresh eggs. Infection is unlikely to resolve without treatment.

24.2 Possible complications[186]

- Lack of sleep (due to itching) with subsequent daytime irritability and difficulty concentrating.
- Bedwetting.
- Weight loss (loss of appetite).
- Excoriation and secondary infection of the perianal skin.
- Disease in other sites due to worm migration (e.g. the urethra and female genito-urinary tract).
- Associated appendicitis which is an uncommon post-operative pathological finding (occurring in 1-2% of appendicitis cases).
- Colitis, abscess and granuloma formation may occur within the intestines, along the perineal skin, and within the peritoneum (extremely rare).

24.3 When to refer[186]

Green – Low risk
• Individuals less than 6 months of age and hygiene measures alone ineffective or not acceptable. • Pregnancy and hygiene measures alone ineffective or not acceptable. • Frequent recurrences (3 or more episodes in a 12-month period). • Diagnostic uncertainty.

Action: Advise the individual to see an appropriate clinician for routine assessment

24.4 Overview of treatment[186,187]

- Treat the person if threadworms seen or eggs have been detected.
- Treatment options include:
  - hygiene measures alone (undertaken for 6 weeks), **OR**
  - mebendazole and hygiene measures (undertaken for 2 weeks)
    - mebendazole is unlicensed for children under 2 years of age but it can be offered as an option from 6 months of age.
    - mebendazole is given as a single dose, but as reinfection is common, a 2nd dose may be given after 2 weeks.
- Treat all household members over 6 months old at the same time unless contraindicated, as asymptomatic infection is common.

24.5 Treatments[15,186-191]

Table 1: Anthelmintic

<table>
<tr><th>Medication</th><th>6 months old to adult</th><th>Considerations</th></tr>
<tr><td>Mebendazole 100 mg chewable tablets sugar free</td><td>100 mg for 1 dose, if reinfection occurs, second dose may be needed after 2 weeks.</td><td rowspan="2">Mebendazole is contraindicated in women who are pregnant.
Unlicensed for use in children under 2 years.
Not for treatment in individuals with known severe or chronic hepatic disease.
Tablets may be chewed or swallowed whole.
May be used in breastfeeding individuals.
Each individual treated should have their own CAS consultation recorded in Choose Pharmacy.
See PGD for further details.</td></tr>
<tr><td>Mebendazole 100 mg / 5 mL oral suspension</td><td>100 mg for 1 dose, if reinfection occurs, second dose may be needed after 2 weeks.</td></tr>
</table>

Table 2: Formulary information

<table>
<tr><th>Medication</th><th>Legal class</th><th>Pack size</th><th>Maximum number of consultations per episode†
Maximum number of episodes per year</th></tr>
<tr><td>Mebendazole 100 mg chewable tablets sugar free</td><td>POM</td><td>Maximum 2 x 100mg tablets (from splitting a pack of 6 tablets)</td><td rowspan="2">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.</td></tr>
<tr><td>Mebendazole 100 mg / 5 mL oral suspension</td><td>POM</td><td>30 mL</td></tr>
</table>

24.6 Advice for patients[186,187,191]

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

- Hygiene measures should be undertaken for 2 weeks if combined with mebendazole treatment, or for 6 weeks if used alone.
- Two doses of mebendazole will be supplied for each household member (unless contraindicated); the second dose should be taken 2 weeks after the first if the infection hasn't cleared.

Home hygiene measures (undertake on the first day of treatment)

- Wash sleepwear, bed linen, towels and soft toys at a hot temperature.
- Thoroughly vacuum and damp-dust all rooms, paying particular attention to the bedrooms, including vacuuming mattresses, rinse the cloth in hot water frequently throughout dusting, then throw it away.
- Disinfect kitchen and bathroom surfaces, using hot water.
- Avoid shaking any material that may be contaminated with eggs, such as clothing or bed sheets.

Personal hygiene measures for all treated individuals (for 2 weeks if combined with drug treatment or for 6 weeks if used alone)

- Wear close-fitting underwear at night and change every morning.
- Use cotton gloves to help prevent night-time scratching; wash and change these, bed linen and nightwear daily for several days after treatment.
- Bath or shower immediately on rising each morning, washing around the anus to remove any eggs laid by the worms during the night.

General personal hygiene measures for all household members

- Wash hands thoroughly with soap and warm water, including scrubbing under the nails, first thing in the morning, after using the toilet or changing nappies, and before eating or preparing food.
- Avoid nail biting and finger sucking and keep fingernails short.
- Avoid sharing towels or flannels.
- Avoid scratching around the anus.
- Keep toothbrushes in a closed cupboard and rinse them thoroughly before use.
- Children do not need to be excluded from school or nursery.

If you feel you are not improving, or are getting worse, despite the introduction of lifestyle measures and treatment courses as discussed with the pharmacist, please make an appointment to discuss with your GP.

25.0 Urinary tract infection in people assigned female at birth (AFAB) with female genitalia (lower, non-complicated, 16 – 64 years; not pregnant or catheterised)

This monograph supports the management of non-complicated lower urinary tract infection (UTI) in people AFAB with female genitalia **aged 16 to 64 years** who are not pregnant or catheterised. It includes symptomatic management of UTI and, where appropriate, the supply of antibiotics. Individuals assigned male at birth or individuals with a history of genital reconstructive surgery are excluded.

This service was formally known as the Community Pharmacy Urinary Tract Infection Service or UTI additional clinical service. This terminology may appear in other documentation issued prior to 01 October 2025.

25.1 About the ailment[192]

A lower UTI is an infection of the bladder, usually caused by bacteria *(Escherichia coli* in 70-95% cases) from the gastrointestinal tract. An acute, uncomplicated UTI usually resolves within a few days.
Typical clinical features (in the absence of vaginal discharge or irritation) include:

- dysuria – discomfort, pain, burning, tingling or stinging associated with urination.
- frequency – passing urine more often than usual.
- urgency – a strong desire to empty the bladder, which may lead to urinary incontinence.
- change in urine appearance/consistency:
  - urine may appear cloudy to the naked eye, or change colour or odour (please exclude other possible causes of urine discolouration e.g. food / drinks / medications)
  - haematuria may present as red/brown discolouration of urine or as frank blood
- nocturia – passing urine more often at night.
- suprapubic discomfort/tenderness.

The above features may be absent, in particular in those with underlying cognitive impairment. In these cases, a UTI may present with:

- generalised non-specific clinical features e.g. delirium, lethargy, anorexia, reduced ability to carry out activities of daily living

25.2 Possible complications[192]

- Ascending infection which can lead to:
  - pyelonephritis, renal and peri-renal abscess
  - impaired renal function, renal failure
  - urosepsis
- UTI in pregnancy can result in pre-term delivery and/or low birthweight.

25.3 When to refer[54,192-195]

Pharmacists should utilise local knowledge and refer individuals as necessary to the most appropriate clinician (A&E, GP, or community pharmacist independent prescriber) that will avoid delay in diagnosis and treatment.

High risk (Red) – Action: Advise the individual to attend A&E without delay
• Difficulty breathing. • Severe symptoms, getting worse quickly, signs of sepsis or systemically very unwell/severe pain. • Confusion, drowsiness or slurred speech. • Systemically unwell and at risk of immunosuppression. • Skin changes – very cold, or a strange colour or rash develop. • Presence of blood clots in urine along with struggling to pass urine. • Not passing urine all day.

Intermediate risk (Amber) – Action: Advise the individual to see a GP, call NHS 111, or see a pharmacist independent prescriber for a same day assessment

- Haematuria (visible or non-visible) without any other UTI symptoms, urinary retention or unexplained by menstruation.
- Haematuria in an individual taking an anticoagulant.
- Loin pain.
- Pelvic/abdominal mass.
- Rigors.
- Nausea, vomiting.
- Persistent symptoms, treatment failure or risk factors for resistant/complicated/recurrent UTI which include:
    - co-morbidities such as immunosuppression, e.g.
        - individuals on long-term corticosteroids.
        - individuals undergoing chemotherapy.
        - individuals on immunosuppressants.
    - co-morbidities such as uncontrolled diabetes mellitus, i.e.
        - there are concerns regarding individual diabetic control.
        - the individual is at increased risk of detrimental symptoms associated with poorly controlled diabetes; symptoms can include thirst, blurred vision, fatigue, increased frequency of urination.
        - the individual is unsure how to manage their diabetes.
    - structural or neurological abnormalities of the urinary tract, or stent in the urinary tract.
    - kidney stones/history of kidney stones.
    - severe hepatic impairment.
    - individuals assigned male at birth.
    - individuals with a history of genital reconstructive surgery or urological surgery.
    - the presence of symptoms for more than 7 days.
    - taking prophylactic antibiotic therapy for recurrent UTI.
    - residence in a long-term care facility.
    - recent travel to a country with increased antimicrobial resistance (outside northern Europe and Australasia).
    - previous antibiotic-resistant UTI (e.g. atypical or resistant infecting organisms).
    - hospitalisation for more than 7 days in the last 6 months.
    - any previous UTIs in the past 6 months or 2 or more UTIs in the past 12 months.

- Symptoms (typically sudden onset and systemic) suggestive of upper UTI, e.g. pyelonephritis, such as:
    - myalgia.
    - rigors or raised temperature of 37.9ºC or higher.
    - nausea and vomiting.
    - flank/loin pain (typically unilateral) with or without abdominal pain/tenderness.
- If urinary symptoms are thought to be caused by:
    - urological or genitourinary conditions, e.g.
        - atrophic vaginitis.
        - lichen sclerosis.
        - lichen planus.
        - urolithiasis.
        - interstitial cystitis.
    - dermatological conditions, e.g.
        - psoriasis.
        - irritant or contact dermatitis.
    - spondyloarthropathies, e.g.
        - reactive arthritis.
        - Behçet's syndrome.
    - malignancy (in addition consider if persistent haematuria is present).
    - alternative or serious diagnoses, e.g. ectopic pregnancy.
    - other infections, e.g.
        - sexually transmitted infections such as chlamydia, gonorrhoea, genital herpes simplex.
        - candida (N.B. consider treatment through the Common Ailments Service as an alternative to referral).
        - threadworm (N.B. consider treatment through the Common Ailments Service as an alternative to referral).
        - tuberculosis.
        - schistosomiasis (an acute or chronic parasitic disease caused by trematode worms).
    - trauma, e.g. due to genitourinary procedures, sexual intercourse, sexual abuse or physical activity (such as cycling).
- Pregnancy or recently given birth, terminated a pregnancy or had a miscarriage in the last 6 weeks.

Low risk (Green) – Action: Treatment can be provided if appropriate AND advise the individual to see a GP for a routine assessment

• If urinary symptoms are thought to be caused by genitourinary syndrome of menopause:
  o genital symptoms - dryness, burning or irritation of the vulva or vagina, vulvovaginal atrophy.
  o sexual symptoms - lack of lubrication (including during sexual activity), discomfort/pain (including during sexual activity), post-coital bleeding, impaired function (decreased arousal, orgasm, desire).
  o urinary symptoms - urgency, dysuria and recurrent UTI.
• Vaginal or urethral discharge, irritation, itch or skin rash not associated with vulvovaginal candidiasis (signpost to a sexual health clinic if appropriate).
• Medication-related e.g. opioids and nifedipine (this list is not exhaustive) – supply antibiotics if applicable and safe but refer for review of medication.

25.4 Assessment and overview of treatment[192,196]

- **Self-care measures for symptom relief**
  - Analgesia - ibuprofen or paracetamol can help settle mild discomfort/pain (ibuprofen is the preferred choice if appropriate).
  - Non-steroidal anti-inflammatory drugs have been shown to minimise self-limiting symptoms, avoiding the need for antibiotic therapy and reduce the risk of subsequent antimicrobial resistance. Consider ibuprofen as first-line treatment in those who describe their UTI symptoms as mild. Consider and discuss the risks and benefits of using an NSAID or antibiotic in those with moderate to severe UTI symptoms. Document this decision and rationale in the consultation notes.
  - Hydration - intake of adequate quantities of fluids is important. Do not recommend cranberry products or urine alkalinising agents.

- **Antibiotic treatment**

  Assessment of the individual is required to ensure appropriate antimicrobial management:
  - nitrofurantoin OR
  - trimethoprim

25.5 Treatments[54,192,197]

Table 1: Treatments for pain and pyrexia associated with urinary tract infection

Medication	Dose	Considerations
Ibuprofen **100 mg / 5 mL sugar free oral suspension** **200 mg tablets** **400 mg tablets**	**Adults and Children 16 years and over:** 200-400 mg THREE times daily	• Take with or after food. • Caution in asthma. • Contraindications to NSAIDs include: heart failure, hypertension, ischaemic heart disease, peripheral arterial disease, cerebrovascular disease, renal impairment and peptic ulceration. • NSAIDs with low dose aspirin may increase the risk of gastrointestinal side effects; avoid if possible. • If gastro-protection is required, consider supplying paracetamol instead. • Avoid with warfarin or anticoagulants.
Paracetamol **120 mg / 5 mL sugar free oral suspension** **250 mg / 5 mL sugar free oral suspension** **500 mg tablets**	**Child 16 -17 years:** 0.5-1 g every 4-6 hours MAXIMUM 4 doses in 24 hours **Adults 18 years and over:** See table 2 below	• A maximum of 1 x 200 mL paracetamol 250 mg in 5 mL sugar free suspension may be supplied for those who are unable to take paracetamol tablets. • If taking paracetamol regularly and the individual is on warfarin, advise INR test 5 to 7 days later.

Table 2: Paracetamol dosing and adjustments in adults

Dose of ORAL paracetamol in ADULT patients WITHOUT risk factors for paracetamol toxicity and ≥ 50kg	
500 mg or 1 gram up to four times daily (minimum 4 hours between doses). Maximum 4 grams in 24 hours.	
Dose of ORAL paracetamol in ADULT patients WITH risk factors for paracetamol toxicity*	
Body weight	**Dose reduction up to a maximum of 15 mg/kg body weight per dose**
33 kg to < 40 kg	500 mg up to four times a day (minimum 6 hours between doses). Maximum 2 grams in 24 hours.
40 kg to < 50 kg	500 mg or 1 gram up to four times a day (minimum 6 hours between doses). Maximum 3 grams in 24 hours.
≥ 50 kg	500 mg or 1 gram up to four times a day (minimum 4 hours between doses). Maximum 3 grams in 24 hours.

* Risk factors for paracetamol toxicity:
- body weight less than 50 kg.
- chronic alcohol overconsumption.
- severe liver disease.
- increasing age and/or frailty - where paracetamol might have been prescribed for significant periods and who have morbidities and polypharmacy, which can further increase their risk of inadvertent overdose and toxicity.
- chronic malnutrition - with nutritional deficiency and/or chronic debilitating illness and therefore likely to be glutathione deplete e.g. acute or chronic starvation (patients not eating for a few days), eating disorders (anorexia or bulimia), cystic fibrosis, AIDS, cachexia, alcoholism, cirrhosis.
- chronic dehydration.
- hepatic enzyme induction or evidence of ongoing liver injury - e.g. long-term treatment with liver enzyme-inducing drugs such as carbamazepine, phenobarbital, phenytoin, primidone, rifampicin, rifabutin, efavirenz, nevirapine, St John's Wort; regular consumption of alcohol in excess of recommended amounts, particularly if nutritionally compromised.

Table 3: Antibiotic treatments for UTI (immediate or back-up)

Medication	Dose	Considerations (see PGDs for full details on exclusions, cautions, side effects)
Nitrofurantoin **100 mg modified-release capsules**	100 mg TWICE daily (every 12 hours) for THREE days	• Swallow capsules whole with water. • Take with or just after food, or a meal. • May discolour the urine (dark yellow or brown colour).
Trimethoprim **200 mg tablets** **50 mg / 5 mL oral suspension sugar free**	200 mg TWICE daily (every 12 hours) for THREE days	• Swallow tablets whole with water. • Use liquid formulation in swallowing difficulty. • Suitable for breastfeeding.

Table 4: Formulary information

<table>
<tr><th>Medication</th><th>Legal class</th><th>Pack size</th><th>Quantity to supply per consultation</th><th>Maximum number of consultations per episode† and Maximum number of episodes per year</th></tr>
<tr><td>Ibuprofen 100 mg in 5 mL sugar free oral suspension</td><td>P</td><td>100 mL</td><td>1</td><td rowspan="9">A maximum of one consultation per episode where an antibiotic is supplied at first consultation OR two consultations where the first is advice and the second is a consultation as part of a backup prescribing strategy

See the latest good practice guidance for back up antibiotic prescribing.

A maximum of 1 episode in a 6-month period or 2 episodes in a 12-month period

† 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.</td></tr>
<tr><td>Ibuprofen 200 mg tablets</td><td>P</td><td>24</td><td>1</td></tr>
<tr><td>Ibuprofen 400 mg tablets</td><td>P</td><td>24</td><td>1</td></tr>
<tr><td>Paracetamol 120 mg in 5 mL sugar free oral suspension</td><td>P</td><td>100 mL</td><td>1</td></tr>
<tr><td>Paracetamol 250 mg in 5 mL sugar free oral suspension</td><td>P</td><td>200 mL</td><td>1</td></tr>
<tr><td>Paracetamol 500 mg tablets</td><td>P</td><td>32</td><td>1</td></tr>
<tr><td>Nitrofurantoin 100 mg modified-release capsules</td><td>POM</td><td>6</td><td>For 3 days</td></tr>
<tr><td>Trimethoprim 200 mg tablets</td><td>POM</td><td>6</td><td>For 3 days</td></tr>
<tr><td>Trimethoprim 50 mg / 5 mL oral suspension sugar free</td><td>POM</td><td>100 mL</td><td>For 3 days</td></tr>
</table>

25.6 Advice for patients[192,195,197-199]

Lifestyle

Prevention

- Do not drink a lot of alcoholic or caffeinated drinks, as they may irritate your bladder.
- Drink plenty of fluids, particularly water so that you urinate regularly during the day and do not feel thirsty.
- Do not have lots of sugary food or drinks as they may encourage bacteria to grow.
- Non-spermicidal lube / condoms or a different type of contraception would be preferred / recommended.
- Wash the genital area with warm water (including before and after sex) and avoid using soap and douching.
- Urinate as soon as possible after sex.
- Wear cotton or breathable underwear instead of tight, synthetic underwear such as nylon.
- Promptly change sanitary or incontinence pads if they’re soiled.

Some hygiene behaviours which may help prevent UTIs include:

- Do not hold urine in if you feel the urge to go; when you do go, ensure you empty your bladder fully.
- Wipe from front to back when you go to the toilet.
- Keep the genital area clean and dry.

Active UTI

- Rest.
- Hydration – drink enough fluids so you pass pale urine regularly during the day. Cranberry products or urine alkalinising agents are not currently recommended as there is no evidence they help ease symptoms or treat a UTI if the infection has already started.
- Avoid having sex until the UTI has cleared as this may aggravate symptoms.

Medication

Simple analgesia, e.g. ibuprofen or paracetamol (ibuprofen is the preferred choice if appropriate) may help relieve pain and could help reduce the need for antibiotics.

- You should return for reassessment if symptoms do not improve within 48 hours or if they worsen at any time.

Treatment

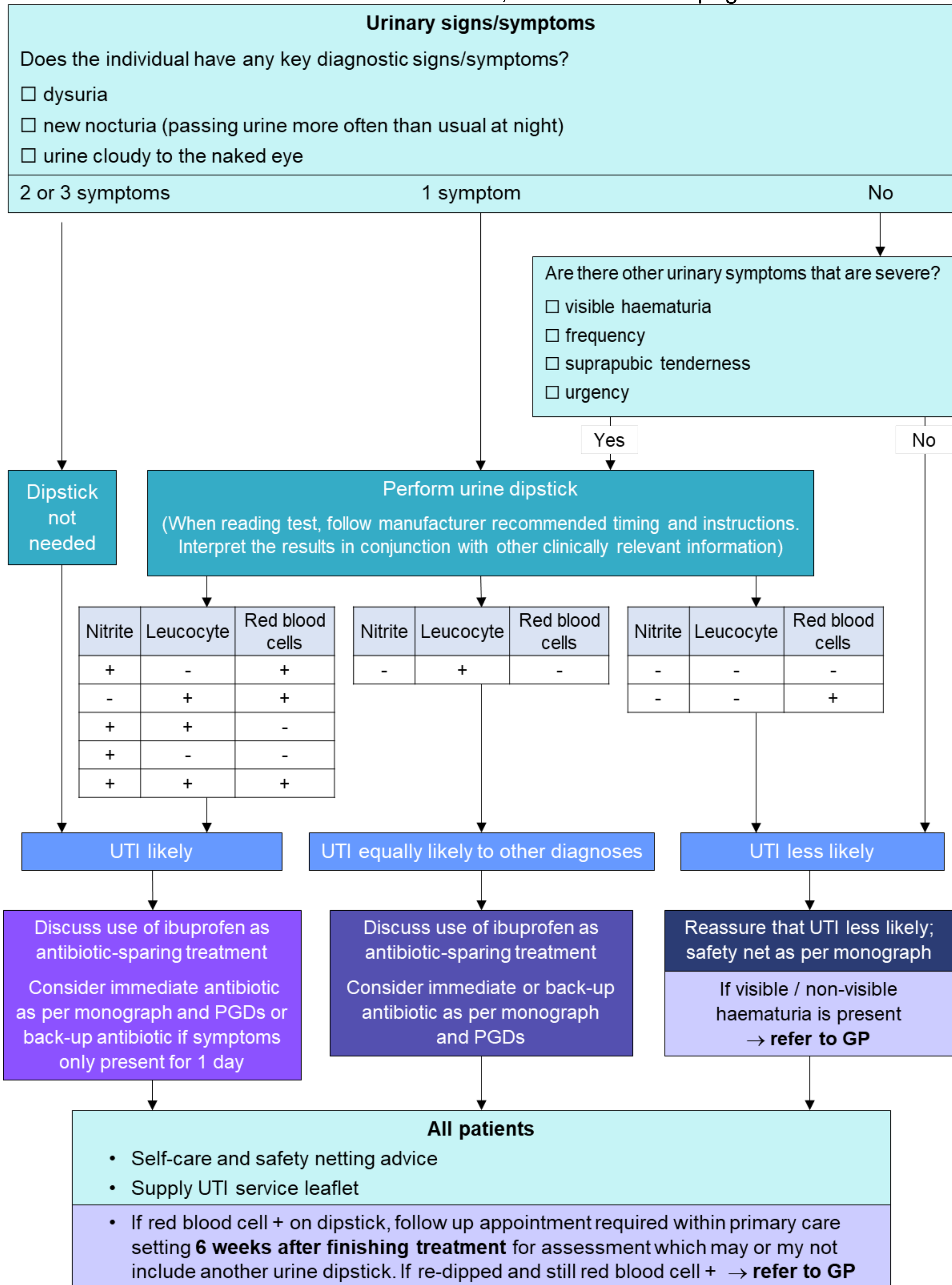
Antibiotics (nitrofurantoin, trimethoprim)

- If symptoms are mild and there are no risk factors for complicated infection, a back-up supply of antibiotics can be made that you do not start immediately, or you can return for reassessment if symptoms do not improve within 48 hours or if they worsen at any time. The pharmacist will discuss which of these options will be most appropriate in your case.
- Seek urgent medical review if symptoms worsen rapidly or significantly at any time, or fail to improve within 48 hours of starting antibiotics.
- When considering management options, pharmacists should interpret information derived from urinalysis in conjunction with other clinically relevant information.
- Individuals with visible haematuria in the context of a likely UTI should be advised that blood in the urine can be a symptom of a UTI or other conditions, but is rarely a sign of something more serious. If after completing their course of treatment and feeling better, they still have visible blood in the urine, they should make a same day GP appointment to rule out other causes of the haematuria.
- For individuals who have visible or non-visible haematuria, advise to return six weeks after completing their course of treatment [9] for a follow up assessment which may or may not include another urine dipstick. The follow up appointment should be within the primary care setting, with a pharmacist, GP or suitably trained healthcare professional. If the patient is:
  1. Symptomatic – urine dipstick not required. Patient to be referred for GP same day assessment.
  2. Asymptomatic and positive for red blood cells on urine dipstick – patient to be referred for GP routine assessment.
  3. Asymptomatic and negative for red blood cells on urine dipstick – no action required.
- Use an appropriate information leaflet from the TARGET: Urinary tract infection resource suite: Patient facing materials (rcgp.org.uk) as a discussion tool and provide a copy.

> 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 or another healthcare provider as directed by your pharmacist.

Flowchart for people assigned female at birth (AFAB) with female genitalia (16 – 64 years) with suspected UTI

Excludes individuals with recurrent UTI (i.e. 1 previous episode in the last 6 months, or 2 or more previous episodes in the last 12 months); pregnant; catheterised.
For all other referral criteria, see the next two pages.



Referral criteria

High risk (Red) – Action: Advise the individual to attend A&E without delay

- Difficulty breathing.
- Severe symptoms, getting worse quickly, signs of sepsis or systemically very unwell/severe pain.
- Confusion, drowsiness or slurred speech.
- Systemically unwell and at risk of immunosuppression.
- Skin changes – very cold, or a strange colour or rash develop.
- Presence of blood clots in urine along with struggling to pass urine.
- Not passing urine all day.

Intermediate risk (Amber) – Action: Advise the individual to see a GP, call NHS 111, or see a pharmacist independent prescriber for a same day assessment

- Haematuria (visible or non-visible) without any other UTI symptoms, urinary retention or unexplained by menstruation.
- Haematuria in an individual taking an anticoagulant.
- Loin pain.
- Pelvic/abdominal mass.
- Rigors.
- Nausea, vomiting.
- Persistent symptoms, treatment failure or risk factors for resistant/complicated/recurrent UTI which include:
  - co-morbidities such as immunosuppression, e.g.
    - individuals on long-term corticosteroids.
    - individuals undergoing chemotherapy.
    - individuals on immunosuppressants.
  - co-morbidities such as uncontrolled diabetes mellitus, i.e.
    - there are concerns regarding individual diabetic control.
    - the individual is at increased risk of detrimental symptoms associated with poorly controlled diabetes; symptoms can include thirst, blurred vision, fatigue, increased frequency of urination.
    - the individual is unsure how to manage their diabetes.
  - structural or neurological abnormalities of the urinary tract, or stent in the urinary tract
  - kidney stones or history of kidney stones.
  - severe hepatic impairment.
  - individuals assigned male at birth.
  - individuals with a history of genital reconstructive surgery or urological surgery.
  - the presence of symptoms for more than 7 days.
  - taking prophylactic antibiotic therapy for recurrent UTI.
  - residence in a long-term care facility.
  - recent travel to a country with increased antimicrobial resistance (outside northern Europe and Australasia).
  - previous antibiotic-resistant UTI (e.g. atypical or resistant infecting organisms).
  - hospitalisation for more than 7 days in the last 6 months.
  - any previous UTIs in the past 6 months or 2 or more UTIs in the past 12 months.
- Symptoms (typically sudden onset and systemic) suggestive of upper UTI e.g. pyelonephritis, such as myalgia, rigors or raised temperature of 37.9ºC or higher, nausea and vomiting, flank/loin pain (typically unilateral) with or without abdominal pain/tenderness.
- If urinary symptoms are thought to be caused by:
  - urological or genitourinary conditions, e.g. atrophic vaginitis, lichen sclerosis, lichen planus, urolithiasis, interstitial cystitis.
  - dermatological conditions, e.g. psoriasis, irritant or contact dermatitis.
  - spondyloarthropathies, e.g. reactive arthritis, Behçet's syndrome.
  - malignancy (in addition, consider if haematuria present).
  - alternative or serious diagnoses, e.g. ectopic pregnancy.
  - other infections, e.g. sexually transmitted infections (such as chlamydia, gonorrhoea, genital herpes simplex), candida†, threadworm†, tuberculosis, schistosomiasis.
  - trauma, e.g. due to genitourinary procedures, sexual intercourse, sexual abuse or physical activity (e.g. cycling).
- Pregnancy or recently given birth, terminated a pregnancy or had a miscarriage in the last 6 weeks.

† Consider treatment through the Common Ailments Service as an alternative to referral

Low risk (Green) – Action: Treatment can be provided if appropriate AND advise the individual to see a GP for a routine assessment
• If urinary symptoms are thought to be caused by genitourinary syndrome of menopause: o genital symptoms - dryness, burning or irritation of the vulva or vagina, vulvovaginal atrophy. o sexual symptoms - lack of lubrication (including during sexual activity), discomfort/pain (including during sexual activity), post-coital bleeding, impaired function (decreased arousal, orgasm, desire). o urinary symptoms - urgency, dysuria and recurrent UTI. • Vaginal or urethral discharge, irritation, itch or skin rash not associated with vulvovaginal candidiasis (signpost to a sexual health clinic if appropriate). • Medication-related e.g. opioids and nifedipine (this list is not exhaustive) – supply antibiotics if applicable and safe but refer for review of medication.

26.0 Vulvovaginal candidiasis

26.1 About the ailment[200,201]

Vulvovaginal candidiasis (genital thrush) is a symptomatic inflammation of the vagina and/or vulva caused by a superficial fungal infection.
Common symptoms include:

- vulval or vaginal itching and irritation
- a white, odourless vaginal discharge
- soreness and stinging during sex or urination
- redness

26.2 Possible complications[200]

Recurrent infection can be problematic. There may be a poor or partial response to therapy with persistence of symptoms between treatments which may result in reduced quality of life and psychosexual difficulties.

26.3 When to refer to GP (or Pharmacist Independent Prescriber if thought to be appropriate)[200,201]

- Individuals under 16 years of age and over 60 years of age.
- Immunocompromised individuals.
- Women with diabetes if:
    - there are concerns regarding the individual's diabetic control and/or the individual is at increased risk of detrimental symptoms associated with poorly controlled diabetes; symptoms include thirst, blurred vision, fatigue and increased frequency of urination
    - the individual is unsure how to manage their diabetes
- Abdominal pain, a foul-smelling discharge, increased urinary frequency or abnormal vaginal bleeding.
- Symptoms have not resolved fully within 7 days of appropriate treatment.
- Individuals who have nausea, vomiting or diarrhoea or are otherwise systemically unwell.
- Uncertain diagnosis e.g. patient has had a previous sexually transmitted infection and it may have returned.

26.4 Overview of treatment[200]

Antifungal drug treatment options and preparations depend on the woman's age, co-morbidities, personal preference, drug cautions and contraindications:

- **1st line:** fluconazole as a single 150 mg oral dose
- **2nd line:** clotrimazole 500mg intravaginal pessary as a single dose can be considered if oral therapy is contraindicated

- **3rd line:** clotrimazole 10% intravaginal cream as a single dose at night (if oral azole or intravaginal imidazole therapy contraindicated or not tolerated)
- If there are vulval symptoms, consider topical clotrimazole cream in addition to a 1st or 2nd line option

N.B Treatment failure — occurs in up to 20% of women receiving imidazole treatment for acute infection.

26.5 Treatments[33,200]

<table>
<tr><th>Medication</th><th>1st line</th><th>2nd line
(If oral therapy contraindicated)</th><th>3rd line
(if oral azole or 2nd line intravaginal imidazole therapy contraindicated or not tolerated)</th><th colspan="2">In addition to 1st, 2nd or 3rd line therapy if there are vulval symptoms</th></tr>
<tr><td rowspan="2">Generic name</td><td rowspan="2">Fluconazole
150 mg capsule</td><td rowspan="2">Clotrimazole
500 mg intravaginal pessary</td><td rowspan="2">Clotrimazole 10% intravaginal cream
(Canesten Internal®)</td><td colspan="2">Clotrimazole cream</td></tr>
<tr><td>1%</td><td>2%</td></tr>
<tr><td>Legal class</td><td>P
(supply via PGD)</td><td>P
(supply via PGD)</td><td>POM
(supply via PGD)</td><td colspan="2">P
(supply via PGD)</td></tr>
<tr><td>Pack size</td><td>1</td><td>1</td><td>5 g</td><td colspan="2">20 g</td></tr>
<tr><td>Maximum number of packs to supply per consultation</td><td>1</td><td>1</td><td>1</td><td colspan="2">1</td></tr>
<tr><td>Maximum number of consultations per episode†</td><td colspan="5">2
Both supplies should occur within a 7-day period.
If symptoms have not fully resolved within 7 days the individual should be referred to their GP.</td></tr>
<tr><td>Maximum number of episodes per year</td><td colspan="5">2
(only supply a second treatment if the first episode resolved within 2 weeks)</td></tr>
<tr><td>Dosing instructions</td><td colspan="5">See PGD</td></tr>
<tr><td>Key information to consider prior to supply</td><td colspan="5">See PGD</td></tr>
<tr><td>Counselling advice</td><td colspan="5">See PGD</td></tr>
</table>

† 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.

26.6 Advice for patients[200,202]
Patient information leaflets in English and Welsh are available on the Welsh Medicines Advice Service website.

Advise about the following:

- use water and an emollient, instead of soap, to clean or moisturise the vulval area, and dry properly
- avoid potential irritants in toiletries (including soaps or shower gels), antiseptics, wipes, and 'feminine hygiene' products
- avoid vaginal douching
- avoid washing underwear in biological washing powder and avoid fabric conditioners
- wear cotton underwear
- avoid tight-fitting clothing and non-absorbent clothing
- see GP if symptoms not resolved within 7 days
- if using a pessary or intra-vaginal cream, avoid treatment during the menstrual period due to the risk of the pessary or cream being washed out by the menstrual flow. The treatment should be finished before the onset of menstruation; do not use tampons, intravaginal douches, spermicides or other vaginal products while using the pessary or intra-vaginal cream
- latex contraceptives such as condoms or diaphragms may be damaged by topical thrush treatment and may not be effective; alternative precautions should be used for at least five days after using these products
- it is preferable to avoid having sex until a course of treatment has been completed and the infection has cleared up; partners do not need treatment unless they have symptoms
- avoid use of complementary therapies such as application of yoghurt, topical or oral probiotics, and tea tree or other essential oils

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

27.0 Warts and verrucae

27.1 About the ailment[203]

Cutaneous warts are small, rough growths caused by infection of keratinocytes with certain strains of the human papilloma virus. They can appear 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. Warts usually resolve spontaneously within 2–3 years (in adults, resolution may take 5–10 years).

27.2 Possible complications[203]

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

27.3 When to refer to GP (or Pharmacist Independent Prescriber if thought to be appropriate)[203]

- Wart(s) on the face, intertriginous or anogenital regions.
- Hairy or bleeding warts, or those that have changed in appearance.
- Immunocompromised individuals.
- Extensive areas affected.
- If warts are persistent and unresponsive to salicylic acid after 12 weeks.
- Individuals with diabetes or people who have poor circulation to the hands or feet.
- A wart associated with significant pain.
- Individual < 2 years of age.
- Uncertain diagnosis.

27.4 Overview of treatment[203]

There is a strong case for not treating warts for most people since they usually clear spontaneously, 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, or if the person requests treatment for persistent warts. Facial warts should not be treated in primary care.

Salicylic acid is the first line treatment of choice. 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
- mucous membranes
- irritated or reddened skin
- infected areas
- areas of poor healing such as neuropathic feet
- warts affecting patients with impaired blood circulation

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

27.5 Treatments[203-208]

Medication	Treatment options			
Generic name	Salicylic acid 16.7%; lactic acid 16.7% (Salactol™ collodion paint)	Salicylic acid 26% cutaneous solution (Occlusal®)	Salicylic acid 26% gel (Bazuka™ Extra strength)	Salicylic acid 40% medicated plasters (Scholl™ Verruca Removal System)
Legal class	P	P	P	P
Pack size	10 mL	10 mL	5 g	30
Maximum number of packs to supply per consultation	1	1	1	Up to 3
Maximum number of consultations per episode†	1	1	1	1
Maximum number of episodes per year	2	2	2	2

Dosing instructions	Follow product-specific directions for guidance.			
Key information to consider prior to supply	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.			
	Licensed in pregnancy and breastfeeding. Avoid in people allergic to elastic adhesive plaster. Allergy may develop to colophony in the product. Suitable for palmar warts on the back of the hand.	Safety not established in pregnancy and breastfeeding: use with caution	Licensed in pregnancy and breastfeeding.	Licensed for common warts on the feet and hands in people 16 years old and over. Contraindicated in pregnancy and breastfeeding.
	Refer to product packaging for minimum age suitable for receiving treatment			
	Refer to the BNF/SPC for full details on interactions, adverse effects, cautions and contraindications.			
Counselling advice	• Salicylic acid is flammable. Avoid smoking or going near open flames when using this treatment-risk of serious injury • If the surrounding skin becomes sore, stop the treatment for a few days until it settles, then re-start treatment • Wash hands after applying salicylic acid and avoid inhaling the vapour • Salicylic acid may cause damage to fabrics and other materials • There is a small risk of skin allergy to the treatment when the surrounding skin becomes red and itchy, rarely local skin discoloration may occur – stop if this occurs. • Continue treatment as per product information leaflet			

† 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.

27.6 Advice for patients[203-207]

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

General information

- Although unsightly, warts are not harmful, do not usually cause symptoms and resolve eventually without treatment.
- Warts are contagious but the risk of transmission is low.
- There is no need to avoid sports or swimming, but take measures to avoid transmission.

To reduce the risk of transmission

- Wear flip-flops in communal showers.
- Avoid sharing shoes, socks and towels.
- Avoid scratching lesions, biting nails or sucking fingers that have warts.
- Keep feet dry and change socks daily.
- Cover with a waterproof plaster when swimming.

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.

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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.