Grŵp Strategaeth Meddyginiaethau Cymru Gyfan
All Wales Medicines Strategy Group

# All Wales Common Ailments Service Formulary




**August 2023**

**(November 2026 – Updates to 'Cold sores', 'Constipation', 'Infantile colic', 'Mouth ulcers', 'Scabies', 'Teething', and 'Warts and verrucae' 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

This monograph supports the management of mild to moderate acne vulgaris for individuals aged 12 years and over.

## 1.1 About the ailment[1,2]

Acne vulgaris is a common type of chronic skin condition that primarily affects the face, back, and chest. It is most common in adolescence, but may affect those in any age group. Non-inflammatory lesions called 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 changes. Acne severity varies along a continuum and is often categorised as follows:

- **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]

- Scarring (hypertrophic or atrophic scars which can be extensive).
- Post-inflammatory hyperpigmentation or depigmentation (both are more common in people with skin of colour).
- Psychosocial problems such as low self-esteem, social isolation, depression and anxiety.

## 1.3 When to refer[2-4]

| **Intermediate risk - Amber – Advise the individual to see a GP, call NHS 111 or see a pharmacist independent prescriber as appropriate for same day assessment.** |
|---|
| • Sudden severe acne and systemic effects (fever, arthralgia or myalgia) (acne fulminans).<br>• Acne conglobata – a severe form of nodulo-cystic acne with interconnecting sinuses and abscesses, which can lead to acne fulminans. |

**Low risk - Green – Advise the individual to see a GP or Pharmacist Independent Prescriber for routine assessment.**

- Mild to moderate acne that has not responded to a 12-week course of ONE of the treatments below.
- Moderate to severe acne (large number of inflammatory lesions, especially if there are nodules or cysts present).
- Medical disorder or medication that may be contributing to the acne:
    - androgens
    - corticosteroids
    - isoniazid
    - ciclosporin
    - lithium
    - anti-seizure drugs (phenytoin, carbamazepine, phenobarbital, valproate, lamotrigine, levetiracetam, oxcarbazepine)
- Acne of any severity (or acne-related scarring), that is causing or contributing to psychological distress or a mental health disorder.
- Women with features of:
    - BOTH polycystic ovary syndrome AND hyperandrogenism (irregular periods, androgenic alopecia and hirsutism); OR
    - hyperandrogenism alone
- Features of rosacea (facial skin thickening, centrofacial redness (persistent or transient), centrofacial papules/pustules/visible blood vessels).
- Diagnostic uncertainty.

### 1.4 Overview of treatment[1,2]

Treatment should be offered to reduce the severity of skin lesions and other complications, and to prevent recurrence and scarring.

Individuals with acne vulgaris should be offered a 12-week course of ONE of the treatment options below, applied once daily in the evening initially; frequency can be reduced if skin irritation occurs. The considerations in table 1 and patient preference should be taken into account when selecting a treatment option. If the individual is unable to tolerate the treatment supplied (e.g. due to skin irritation), despite the measures described below in section 1.6, an alternative product can be supplied. The alternative product can be started once any irritation from the original product has resolved and should be continued for 12 weeks.

**Mild to moderate acne**

- 1st line option - ONE of the following combination products:
  - Topical adapalene 0.1% / benzoyl peroxide 2.5% gel or adapalene 0.3% / benzoyl peroxide 2.5% gel
  - Topical clindamycin 1% / tretinoin 0.025% gel
  - Topical benzoyl peroxide 3% / clindamycin 1% gel or benzoyl peroxide 5% / clindamycin 1% gel

**OR**

- 2nd line option:
  - If the above options are contraindicated or the person wishes to avoid using a topical retinoid or antibiotic, consider topical benzoyl peroxide as monotherapy.

Treatment should be reviewed at 12 weeks by the GP to assess treatment success and if there is a need for maintenance treatment.

### 1.5 Treatments[2-10]

**Table 1. Topical treatment**

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

| Medication | Dose | Considerations |
|---|---|---|
| **Adapalene 0.1% / benzoyl peroxide 2.5% gel**<br>**or**<br>**Adapalene 0.3% / benzoyl peroxide 2.5% gel** | Apply ONCE a day in the evening to the entire acne affected area.<br>(see PGD) | • Not for use during pregnancy.<br>• Adapalene 0.1% / benzoyl peroxide 2.5% gel may be used in breastfeeding.<br>• Adapalene 0.3% / benzoyl peroxide 2.5% gel should NOT be used in breastfeeding.<br>• Preferred option for people with skin of colour (reduces risk of post inflammatory hyperpigmentation).<br>• Preferred option if mainly comedonal acne.<br>• Does not contain antibiotics so less risk of bacterial resistance.<br>• Can bleach hair and fabrics.<br>• Can cause photosensitivity. |
| **Clindamycin 1% / tretinoin 0.025% gel** | Apply ONCE a day in the evening to the entire acne affected area.<br>(see PGD) | • Not for use during pregnancy or breastfeeding.<br>• Higher risk of bacterial resistance with this combination as it does not contain benzoyl peroxide.<br>• Can cause photosensitivity. |
| **Benzoyl peroxide 3% / clindamycin 1% gel**<br>**or**<br>**Benzoyl peroxide 5% / clindamycin 1% gel** | Apply ONCE a day in the evening to the entire acne affected area.<br>(see PGD) | • Can be used with caution during pregnancy and breastfeeding.<br>• Avoid if only comedonal acne.<br>• Can bleach hair and fabrics.<br>• Can cause photosensitivity. |
| **Benzoyl peroxide 5% gel** | Apply ONCE daily initially. Can be applied up to TWICE a day if tolerated.<br>Reduce frequency if there is irritation.<br>(see PGD) | • Can be used during pregnancy and breastfeeding.<br>• Can bleach hair and fabrics.<br>• Can cause photosensitivity.<br>• Not as effective as above combined preparations. |

**Table 2. Formulary Information**
Supply sufficient quantity to complete a 12-week treatment course

| Medication | Legal class | Pack size | Maximum number of consultations per episode† Maximum number of episodes per year |
|---|---|---|---|
| **Adapalene 0.1% / benzoyl peroxide 2.5% gel or Adapalene 0.3% / benzoyl peroxide 2.5% gel** | POM | 60 g | A maximum of 2 consultations per episode (maximum of 3 consultations per episode if benzoyl peroxide/clindamycin gel supplied as product expiry is 2 months after dispensing so a further consultation needed to supply full course).<br><br>An alternative product should only be supplied due to intolerance and not treatment failure.<br><br>A maximum of 1 episode per year. |
| **Clindamycin 1% / tretinoin 0.025% gel** | POM | 30 g | |
| **Benzoyl peroxide 3% / clindamycin 1% gel or Benzoyl peroxide 5% / clindamycin 1% gel** | POM | 30 g<br>60 g | |
| **Benzoyl peroxide 5% gel** | P<br>Supply via PGD in pregnancy / breastfeeding | 30 g<br>60 g | |

† 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[2-5,8]

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.
- Regular moisturiser use can maintain the skin barrier and reduce irritation effects of topical treatments and prevent flare-up of inflammatory lesions.

**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**

- Topical treatments take time to work (typically 6 – 8 weeks to become noticeable) and may irritate the skin (dryness, discomfort, redness, peeling and blistering), especially at the start of treatment.
- If irritation occurs, either reduce frequency or stop until irritation settles then re-introduce at reduced frequency.
- To reduce the risk of skin irritation in those with sensitive skin, consider alternate-day or short contact application (wash off after an hour) initially. This is advised for people with skin of colour to reduce the risk of hyperpigmentation. Increase to daily use as tolerated.
- Apply the product sparingly to the entire acne affected area (not just visible spots), after washing the skin with a mild cleanser, then gently pat skin dry. Excessive use will not improve efficacy but may increase the risk of skin irritation.
- 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).
- Benzoyl peroxide can have a bleaching effect, avoid contact with hair and clothes. Wash hands after applying the gel.
- It is important to adhere to treatment, seek medical advice if acne does not start to improve within 6-8 weeks, or sooner if it becomes worse.

**Signposting**[7]

The British Association of Dermatologists runs a website called Acne Support that offers impartial expert advice on acne, including topics such as preventing acne and covering acne. Available at: https://www.acnesupport.org.uk.

| |
|---|
| 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[11-14]

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[11]

- 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[11,12,15-18]

**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.

**High Risk - Red**

**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.

**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).

**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.**

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

**Low risk - Green**

- 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[11,12]

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[1,11,12,14,19-21]

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).<br>Useful for intermittent symptoms, rhinorrhoea and congestion.<br>Each bottle lasts 6 weeks.<br>Counsel on nasal spray technique (section 2.6).<br>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.<br>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.<br>If on a 10 mg dose, only supply if unable to swallow tablets.<br>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.<br>(see PGD) | | |
| **Fexofenadine 120 mg tablets** | | | ONE tablet DAILY.<br>(see PGD) | Do not use in pregnancy.<br>Do not use in breastfeeding. |
| **Loratadine 10 mg tablets** | | **Over 31 kg:**<br>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:**<br>ONE 5 mL spoonful DAILY.<br><br>**31 kg and over:**<br>TWO 5 mL spoonfuls (10 mL) DAILY. | **Up to 31 kg:**<br>ONE 5 mL spoonful DAILY.<br><br>**31 kg and over:**<br>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.<br>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.<br>(see PGD) | One drop in each eye FOUR times daily.<br>(see PGD) | Can be used in pregnancy or breastfeeding.<br>May cause transient stinging, burning or blurring of vision on instillation.<br>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.<br>Can be increased to TWO sprays in each nostril DAILY short term until control achieved, then reduce to ONE spray in each nostril DAILY.<br>(see PGD) | TWO sprays in each nostril DAILY, reducing to ONE spray in each nostril DAILY once control achieved.<br>(see PGD) | Can be used alone or in combination with antihistamines.<br>They reduce inflammation of the nasal mucosa and are more effective than antihistamines in reducing nasal congestion, rhinorrhoea and ocular symptoms.<br><br>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.<br><br>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:**<br>ONE spray in each nostril DAILY.<br>Can be increased to TWICE daily short term until control achieved, then reduce to DAILY.<br>(see PGD) | ONE spray in each nostril DAILY.<br>Can be increased to TWICE daily short term until control achieved, then reduce to DAILY.<br>(see PGD) | TWO sprays in each nostril DAILY, reducing to ONE spray in each nostril DAILY once control achieved.<br>Can be increased to TWICE daily short term until control achieved then reduce to DAILY.<br>(see PGD) | |
| **Mometasone furoate 50 micrograms per dose nasal spray** | **Over 3 years:**<br>ONE spray in each nostril DAILY.<br>(see PGD) | ONE spray in each nostril DAILY.<br>(see PGD) | TWO sprays in each nostril DAILY, if necessary, increase to FOUR sprays DAILY.<br>Reduce to ONE spray in each nostril DAILY when control achieved.<br>(see PGD) | |

**Table 3: Formulary information**

| Medication | Legal class | Pack size | Maximum number of consultations per episode† and Maximum number of episodes† per year |
|---|---|---|---|
| **Azelastine 140 micrograms per dose nasal spray** | POM | 20 mL<br>22 mL | **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.**<br><br>**Only supply for subsequent presenting episodes (after initial supply) if treatment has been effective.**<br><br>† 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. |
| **Cetirizine 10 mg tablets** | P | 30 | |
| **Cetirizine 1 mg/mL oral solution sugar free** | P | 200 mL | |
| **Fexofenadine 30 mg tablets** | POM | 60 | |
| **Fexofenadine 120 mg tablets** | POM | 30 | |
| **Loratadine 10 mg tablets** | P | 30 | |
| **Loratadine 5 mg / 5 mL oral solution sugar free** | P | 100 mL | |
| **Sodium cromoglicate 2% w/v eye drops preservative free** | P | 10 mL | |
| **Sodium cromoglicate 2% w/v eye drops** | POM | 13.5 mL | |
| **Fluticasone furoate 27.5 micrograms per dose nasal spray** | POM | 120 dose | |
| **Fluticasone propionate 50 micrograms per dose nasal spray** | POM | 150 dose | |
| **Mometasone furoate 50 micrograms per dose nasal spray** | POM | 140 dose | |

### 2.6 Advice for patients[11,22-25]

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

This monograph supports the management of athlete's foot for individuals from 1 month of age onwards.

### 3.1 About the ailment[26,27]

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 or red patches between the toes
- red, sore and flaky patches on the feet
- scaly, blistering skin that may crack and bleed

### 3.2 Possible complications[28]

- Secondary bacterial infection e.g. cellulitis of the lower leg (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[28,29]

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

- Individuals under 1 month of age.
- Individuals under 1 year of age with marked inflammation.
- Severe or extensive disease, including significant pain and discomfort.
- Signs of bacterial infection (weeping, pus or yellow crusts).
- No improvement after 1 week of treatment.
- Immunocompromised individuals.
- Diagnostic uncertainty.
- Recurrent infection (more than 2 episodes in previous 12 months).
- Suspicion of undiagnosed diabetes (e.g. increased thirst, increased urination, fatigue, unintentional weight loss) – treatment can be provided but also refer for same day assessment.
- 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

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

- Infection has spread to toenails.

### 3.4 Overview of treatment[1,28,30-34]

Topical antifungal cream can be supplied for mild, non-extensive disease.

- 1st line (individuals aged 12 years and over)
  - terbinafine 1% cream
- 2nd line (if terbinafine contra-indicated, unsuitable or unavailable)
  - clotrimazole 1% cream or miconazole 2% cream

If there is associated marked inflammation, a topical steroid cream can be supplied for individuals aged 1 year and over, **in addition** to an antifungal:

- hydrocortisone 1% cream –this can be used for a maximum of 7 days.

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[1,19,28,30-33]

**Table 1: Topical Antifungals**

| Medication | Dose | Considerations |
|---|---|---|
| **Terbinafine 1% cream** | **Individuals aged 12 years and over.**<br>Apply thinly ONCE or TWICE a day for SEVEN days.<br>(see PGD) | • Do not use during pregnancy and breastfeeding.<br>• No known significant drug interactions.<br>• Some products may not be licensed for use in those under 16 years of age – see PGD.<br>• Caution: flammable. |
| **Clotrimazole 1% cream** | **Individuals aged 1 month and over.**<br>Apply thinly TWO to THREE times a day for at least ONE month. Apply until all lesions are healed and then for a further 1-2 weeks.<br>Maximum duration of use is 6 weeks.<br>(see PGD) | • Can be used during pregnancy and breastfeeding (see PGD).<br>• A strip of about 0.5 cm long is enough to treat an area about the size of an adult hand.<br>• Topical clotrimazole may increase tacrolimus levels.<br>• Caution: flammable. |
| **Miconazole 2% cream** | **Individuals aged 1 month and over.**<br>Apply thinly TWICE a day for at least TWO weeks. Apply until all lesions are healed and then for a further 10 days.<br>Maximum duration of use is 6 weeks. | • Use with caution during pregnancy and breastfeeding.<br>• Avoid use if individual taking warfarin.<br>• Caution: flammable. |

**Table 2: Topical corticosteroid – if indicated, supply in addition to topical antifungal**

| Medication | Dose | Considerations |
|---|---|---|
| **Hydrocortisone 1% cream** | **Individuals aged 1 year and over.**<br>Apply thinly ONCE daily for a MAXIMUM of 7 days (see PGD). | • Can be used during pregnancy and breastfeeding (see PGD).<br>• Used for inflammatory symptoms of athlete's foot.<br>• Must only be used in combination with a topical antifungal.<br>• Apply 15-30 minutes after the topical antifungal.<br>• Short term use only, maximum 1 supply per episode.<br>• Caution: flammable. |

**Table 3: Formulary information**

| Medication | Legal class | Pack size | Maximum number of consultations per episode† Maximum number of episodes per year |
|---|---|---|---|
| **Terbinafine 1% cream** | POM | 15g<br>30g | A maximum of 2 consultations per episode.<br>A maximum of 2 episodes per year.<br>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.<br>Only supply for subsequent presenting episodes (after initial supply) if treatment has been effective.<br><br>† 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. |
| **Clotrimazole 1% cream** | P<br>(supply via PGD) | 20g | |
| **Miconazole 2% cream** | P | 30g | |
| **Hydrocortisone 1% cream** | POM | 15g | |

### 3.6 Advice for patients[26-28,32]

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 has not shown any improvement within a week of treatment.
- Do not smoke or go near naked flames when using these products. Fabric that has been in contact with the products burns more easily and there is a risk of severe burns and serious fire hazard.

**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 (dab rather than rub), 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**

- Use a separate towel for the feet and wash it regularly.
- Do not share towels.
- 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[35,36]

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[35,37]

- 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.

**High risk – Red**

**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**

**Intermediate risk – Amber**

**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**

| Low risk – Green |
| --- |
| • Pain stopping day-to-day activities.<br>• 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.<br>• Osteoporosis or osteoarthritis. (may need a more urgent assessment depending on symptoms).<br>• Trauma that does not require attendance to A&E (see “red” referral criteria above).<br>• 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[35,37,38]

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[1,37,39-42]

**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.<br>• To be taken with or just after food, or a meal.<br>• Can cause abdominal pain, nausea, dyspepsia, headache.<br>• Caution in asthma.<br>• See Table 1 for risk factors for GI adverse effects.<br>• 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.<br>• Not for use in heart failure, renal or liver impairment, hypertension, ischaemic heart disease, peripheral arterial disease, cerebrovascular disease.<br>• 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.<br>• 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.<br>• Tablets should be swallowed whole and not broken or crushed.<br>• To be taken with or just after food, or a meal. Can cause heartburn, nausea, vomiting, constipation and diarrhoea.<br>• Caution in asthma.<br>• See Table 1 for risk factors for GI adverse effects.<br>• 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.<br>• Not for use in heart failure, renal or liver impairment, hypertension, ischaemic heart disease, peripheral arterial disease, cerebrovascular disease.<br>• 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.<br>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<br>84 | A maximum of 1 consultation per episode.<br>A maximum of 1 episode per year.<br><br>† 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)

This monograph supports the management of chickenpox in children from the age of 2 months to under 14 years old. Individuals who are pregnant, immunocompromised or under 2 months old who are suspected to have chickenpox should be referred to the most appropriate clinician for urgent/same day assessment (see table 5.3 (not suitable for assessment by pharmacist independent prescribers)).

**Important advice about protecting others**
Consider if any high-risk individuals (neonates, pregnant women, immunosuppressed) have had significant exposure to the individual with chickenpox from 24 hours before the rash appeared until all the lesions are dry and have crusted over. High-risk individuals may need post exposure prophylaxis (refer to most appropriate clinician e.g. midwife/GP/NHS 111).
The UKHSA Guidelines on post-exposure prophylaxis (PEP) for varicella or shingles provides further information on who to refer for post exposure prophylaxis.

### 5.1 About the ailment[43-45]

Chickenpox (varicella) is a highly contagious viral infection that causes an acute fever and blistered rash. Most cases occur in children before they are 10 years old. It has an incubation period of 7–21 days and is usually a self-limiting disease which resolves without complications after 1-2 weeks. Treatment is aimed at relieving symptoms and ensuring hydration is maintained.

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 but can be harder to see on brown and black skin
- these spots 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 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 from 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[44-46]

- Secondary bacterial skin infection (caused by scratching) – sudden high-grade or prolonged pyrexia (often after initial improvement), erythema and tenderness surrounding the original chickenpox lesions; redness may be harder to see or appear a different colour on darker skin tones.
- Dehydration (due to vomiting and diarrhoea) 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 month old, adolescents, adults, pregnant women and immunocompromised individuals.

### 5.3 When to refer[44-46]

**High Risk – Red – Action: Advise the individual to seek urgent specialist advice without delay**

**Refer individuals to seek immediate medical attention if:**

- pregnant
- immunosuppression concerns
- child under 1 month old, neonates are at increased risk of disseminated or haemorrhagic varicella
- babies born prematurely (<37 weeks old) and where baby's age is less than 4 weeks counting from their original due date (adjusted age).

**Intermediate Risk – Amber – Action: Advise the individual to see a GP or call NHS 111 for same day assessment**

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

- child 1 to < 2 months old
- signs present of being systemically unwell or showing symptoms suggestive of complications
- individual has chronic skin, heart or respiratory disease
- persistent or recurrent fever (may indicate secondary infection)
- individual on long-term salicylate treatment
- breastfeeding women
- diagnostic uncertainty

### 5.4 Overview of treatment[44,47,48]

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

### 5.5 Treatments[1,19,49-53]

**Table 1. Analgesic / antipyretic: if pain or fever causing distress**
Refer to the BNF/BNFC or SmPC for full details of interactions, adverse effects, cautions and contraindications.

| Medication | Dose | Considerations |
|---|---|---|
| **Paracetamol**<br>**120 mg in 5 mL sugar free oral suspension** | **Infants 2-3 months**: 60 mg every 4-6 hours MAX 2 doses in 24 hours<br>**Infants 3-6 months**: 60 mg every 4-6 hours MAX 4 doses in 24 hours<br>**Infants 6-24 months**: 120 mg every 4-6 hours MAX 4 doses in 24 hours<br>**Child 2-4 years**: 180 mg every 4-6 hours MAX 4 doses in 24 hours<br>**Child 4-6 years**: 240 mg every 4-6 hours MAX 4 doses in 24 hours | Not licensed for:<br>• infants < 2 months old<br>• infants 2-3 months old and < 4 kg or born prematurely (< 37 weeks) |
| **Paracetamol**<br>**250 mg in 5 mL sugar free oral suspension** | **Child 6-8 years:** 250 mg every 4-6 hours MAX 4 doses in 24 hours<br>**Child 8-10 years:** 375 mg every 4-6 hours MAX 4 doses in 24 hours<br>**Child 10-12 years:** 500 mg every 4-6 hours MAX 4 doses in 24 hours<br>**Child 12-14 years:** 500-750 mg every 4-6 hours MAX 4 doses in 24 hours | Not licensed for children < 6 years old<br>A maximum of 1 x 200 mL paracetamol 250 mg in 5 mL sugar free suspension may be supplied for children 10 years old and over who are unable to take paracetamol tablets. |
| **Paracetamol**<br>**500 mg tablets** | **Child 10-14 years:** 500 mg every 4-6 hours MAX 4 doses in 24 hours | Not recommended for child < 10 years old. |

**Table 2. Antihistamine to treat itch**

| Medication | Dose | Considerations | |
|---|---|---|---|
| **Chlorphenamine 2 mg in 5 mL oral solution**<br>**(Piriton®)**<br>Only Piriton® brand licensed to treat itch related to chickenpox | **Child 1-2 years:** 1 mg every 12 hours MAX 2 doses in 24 hours<br>**Child 2-6 years:** 1 mg every 4-6 hours MAX 6 doses in 24 hours<br>**Child 6-12 years:** 2 mg every 4-6 hours MAX 6 doses in 24 hours<br>**Child 12-14 years:** 4 mg every 4-6 hours MAX 6 doses in 24 hours | Not licensed for children < 1 year old | Sedating antihistamine to help relieve itching, may cause drowsiness which can be beneficial at night.<br>May cause dry mouth and nausea. |
| **Chlorphenamine 4 mg tablets**<br>**(Piriton®)**<br>Only Piriton® brand licensed to treat itch related to chickenpox (in pack size 30) | **Child 6-12 years:** 2 mg every 4-6 hours MAX 6 doses in 24 hours<br>**Child 12-14 years:** 4 mg every 4-6 hours MAX 6 doses in 24 hours | Not licensed for children < 6 years old | |

**Table 3. Astringent to alleviate itch**

| Medication | Dose (all ages) | Considerations |
|---|---|---|
| **Calamine lotion** | Apply to the affected area when required. | Shake the bottle before each use.<br>Dab onto affected area using cotton wool.<br>Evidence for use is anecdotal. |

**Table 4. Formulary information**

| Medication | Legal class | Pack size | Maximum number of consultations per episode† and Maximum number of episodes per year |
|---|---|---|---|
| **Paracetamol 120 mg in 5 mL sugar free oral suspension** | P | 100 mL | A maximum of 1 consultation per episode.<br>A maximum of 1 episode.<br><br>† 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. |
| **Paracetamol 250 mg in 5 mL sugar free oral suspension** | P | 200 mL | |
| **Paracetamol 500 mg tablets** | P | 32 | |
| **Chlorphenamine 2 mg in 5mL oral solution** | P | 150 mL | |
| **Chlorphenamine 4 mg tablets** | P | 30 | |
| **Calamine lotion** | GSL | 200 mL | |

### 5.6 Advice for patients[44-46]

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.
- Do not cold sponge if fever present – this can constrict blood vessels under the skin, trapping in heat and making the fever worse.
- 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
  - severe rash, or a rash that bruises or bleeds into the skin (haemorrhagic rash)
- During the period of infectivity (until all lesions are dry and have crusted over), 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 1 month
  - pregnant women who have not had chickenpox in the past or who have not received full vaccination against chickenpox.

See section 5.0 for important advice about protecting others.

| |
|---|
| 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 child's GP. |

## 6.0 Cold sores

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

### 6.1 About the ailment[54-57]

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

**Presentation:**

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

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

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

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

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

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

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

### 6.4 Overview of treatment[54]

Provide advice only.

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

### 6.5 Advice for patients[54-57]

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

**General advice**

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

**Self-care**

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

**Avoiding transmission**

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

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

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

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

# 7.0 Conjunctivitis (bacterial)

## 7.1 About the ailment[16,61-64]

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.[64].

## 7.2 Possible complications[16]

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

## 7.3 When to refer[65,66]

**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.

**High Risk - Red**

**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**

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

**the individual is unable to access a WGOS registered optometrist without delay, advise them to attend Emergency eye casualty or A&E without delay.**

### 7.4 Overview of treatment[16,64]

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[1,16,19,64,67,68]

| 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)<br>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[16,69]

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[70,71]

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

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

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

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

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

Many factors can cause constipation including:

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

Examples of secondary causes of constipation:

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

### 8.2 Possible complications[70]

Complications of chronic constipation include:

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

### 8.3 When to refer [70,72-77]

**High risk – Red**

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

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



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

**Intermediate risk – Amber**

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

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

**Low risk – Green**

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



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

### 8.4 Overview of treatment[70,77,78]

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

**For non-opioid induced constipation, including breastfeeding individuals:**

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

**If an individual is pregnant:**

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

**If an individual has opioid-induced constipation:**

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

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

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

### 8.5 Treatments[1,70,79-86]

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

**Table 1: Laxative options**

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

| Medication | Laxative type | Dose | Considerations |
|---|---|---|---|
| **Ispaghula husk 3.5 g effervescent granules gluten free sugar free sachets** | Bulk forming | ONE sachet TWICE daily, preferably after food, with at least 150 mL liquid | **1st line in non-opioid symptoms and pregnancy.**<br>Suitable for breastfeeding.<br>Useful if dietary intake of fibre is difficult. Adequate fluid intake is important.<br>Not recommended for people taking constipating drugs like opioids.<br>Can cause bloating and flatulence.<br>Should be taken at least 1 hour before going to bed (not immediately before).<br>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.<br>Avoid in those with diabetes, those taking thyroid hormones, phenylketonuria, renal impairment and potassium-restricted diet.<br>Usually effective within 2 to 3 days. |
| **Macrogol compound oral powder sachets NPF sugar free** | Osmotic | ONE to THREE sachets DAILY in divided doses<br>Dissolve in at least 125 mL water<br>see PGD | **1st line for opioid induced symptoms.**<br>For other patients, use if bulk forming laxative ineffective or not tolerated.<br>Suitable for pregnancy and breastfeeding.<br>Can cause bloating and flatulence.<br>Adequate fluid intake is important.<br>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.<br>2nd line in pregnancy and breastfeeding.<br>Can cause bloating and flatulence, abdominal pain, cramps, nausea or vomiting.<br>Adequate fluid intake is important.<br>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.<br>Not suitable for people with lactose intolerance and galactosaemia.<br>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.**<br>Contraindicated in pregnancy and breastfeeding.<br>Option if stools are soft but difficult to pass or if there is a sensation of inadequate emptying.<br>Can cause abdominal cramps, diarrhoea, nausea or vomiting.<br>Avoid in intestinal obstruction, IBD, abdominal pain, dehydration.<br>Urine may be discoloured (yellowish-brown); this is harmless.<br>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.**<br>**Useful alternative for people who find it hard to increase fluid intake in both opioid and non-opioid induced symptoms.**<br>Avoid in pregnancy.<br>Suitable in breastfeeding.<br>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:**<br>A maximum of 2 consultations per episode.<br>A maximum of 2 episodes per year.<br><br>**Non-opioid induced constipation:**<br>A maximum of 3 consultations per episode.<br>A maximum of 2 episodes a year.<br><br>† Episode: one episode constitutes an appropriate number of consultations (as defined above) in which lifestyle advice or treatment is provided. Resolution of symptoms or onward referral would define the end of the episode. |
| **Macrogol compound oral powder sachets NPF sugar free** | P | 30 | |
| **Lactulose 3.1–3.7 g / 5 mL solution** | P | 500 mL | |
| **Docusate 100 mg capsules** | P | 30 | |
| **Senna 7.5 mg tablets** | P | 20 | |

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

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

**Lifestyle measures**

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

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

**Laxative treatment**

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

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

## 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[87]

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[87,88]

- 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[29,87,89,90]

**High risk – Red**

**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**

**Intermediate risk – Amber -**
**(Pharmacists should use their judgement to determine the urgency of the referral)**

**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.

**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.



**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[87,91,92]

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[87,92-96]

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

**In alignment with *NHS Wales Eye Health Care: Future Approach for Optometry Services*, patients experiencing an acute eye problem (such as dry eye) should be seen, in the first instance, by a Welsh General Ophthalmic Services (WGOS)-registered optometrist.**
**This monograph supports the management of dry eye for individuals aged 18 years of age and over AND who are unable to access a WGOS-registered optometrist for an eye examination within the same working day (unless considered low risk).**

### 10.1 About the ailment[97,98]

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 – this may be a burning, stinging or a “gritty” foreign body sensation
- transient blurring of vision
- redness of the eyelid or conjunctiva
- eye fatigue e.g. discomfort when looking at bright lights or when wearing contact lenses
- itching, tearing and dryness (not always present)
- stringy mucous discharge

Dry eye disease can be exacerbated by the following factors:

- Ocular e.g. blepharitis, age related lacrimal gland deficiency, eyelid aperture disorders such as eyelid retraction.
- Systemic e.g. Sjogren’s syndrome, HIV.
- Skin e.g. rosacea.
- Neuromuscular e.g. reduced blink interval due to Bell’s palsy or Parkinson’s disease.
- Environmental/other e.g. air conditioning, central heating, cigarette smoke, cooking fumes, reduced blink interval due to digital device use or reading, vitamin A deficiency.
- Iatrogenic e.g. contact lens use, damage to the eye or eyelid (from injury or surgery) or some medications such as anticholinergics, retinoids, oral contraceptives or HRT.

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

### 10.2 Possible complications[97]

- Negative impact on daily activities including driving, reading, work, study and sleep.
- Depression and anxiety (due to impact on quality of life).
- Severe complications (usually associated with an underlying systemic condition), such as corneal scarring, thinning, ulceration, infection or neovascularisation.
- Poor outcomes of refractive, cataract and corneal surgery.

The following are rare complications:

- corneal perforation
- severe visual loss

### 10.3 When to refer [97]

**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, appropriate treatments can be offered below as an interim solution until a visit to an optometrist can be arranged.**

***** 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.

*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 | |
|---|---|
| **Refer individuals with the following to WGOS-registered optometrist for triage without delay. If the individual is unable to access WGOS advise them to attend emergency eye casualty or A&E without delay:**<br>• Suspected acute glaucoma, keratitis/iritis/uveitis, or corneal ulceration; symptoms include:<br>  ○ marked redness in affected eye(s) along with any eye pain, headache* and/or photophobia*<br>  ○ change in visual acuity (unrelated to watering or tearing)<br>  ○ halos around lights, flashing lights/wavy lines, nausea/vomiting.<br>• Inability to open the eye or keep it open<br>• Diplopia.<br>• Any contact lens wearers**.<br>• Recent eye surgery/eye procedure or severe pain or visual loss.<br>• History of trauma (mechanical, chemical or ultraviolet) or possible foreign body.<br>• Suspected gonococcal (e.g. discharge is mucopurulent, copious and rapidly progressive) or chlamydial conjunctivitis.<br>• Possible herpes infection (crops of vesicles, ulcers or pustules present on the eyelid or around the eye).<br>• Suspected periorbital or orbital cellulitis.<br><br>*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 the most appropriate clinician (GP, A&E or other clinician) that avoids delay in diagnosis and treatment.**<br><br>• Serious underlying cause suspected e.g. Stevens-Johnson syndrome<br>• Individuals presenting with possible symptoms of meningitis (headache, photophobia **AND** fever). |

**Contact lens wearers presenting with symptoms of dry eye disease should be encouraged to arrange an examination with their **prescribing optometrist.** 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 prescribing optometrist is not feasible, the individual should be referred to any WGOS-registered optometrist for triage. If the individual is unable to access WGOS triage, advise them to attend emergency eye casualty or A&E without delay. They should be advised to take their contact lenses with them as special diagnostic tests may be required).

| Intermediate risk - Amber | |
|---|---|
| **Advise the following individuals seek same-day triage by a WGOS-registered optometrist. If individual is unable to access triage by a WGOS-registered optometrist the same day, advise them to see a GP (or community pharmacist independent prescriber if appropriate) for same day assessment.**<br><br>• Persistent or worsening symptoms despite 4 weeks management.<br>• Abnormal eyelid function or anatomy.<br>• Individuals who have been using topical ophthalmic medicines (e.g. glaucoma medications or medications that are not preservative-free and have been used >4 times a day).<br>• Diagnostic uncertainty associated with eye symptoms.<br>• Individuals under 18 years of age. | **Advise the following individuals to see a GP or community pharmacist independent prescriber as appropriate for same day assessment.**<br><br>• Suspected undiagnosed, underlying systemic condition e.g. Sjogren's syndrome.<br>• Systemic involvement e.g. weight loss/fever.<br>• Diagnostic uncertainty. |

| Low risk - Green – Advise the individual to see a WGOS- registered optometrist or GP for routine assessment. |
|---|
| • Medications that may exacerbate dry eyes, such as systemic retinoids, oral contraceptives/hormone replacement therapy, antihistamines, beta-blockers, anticholinergics and psychotropics. Treat and refer. |

### 10.4 Overview of treatment[97,99]

Lifestyle measures (as detailed in Section 10.6 Advice for patients) are recommended first line for symptomatic relief. If these alone do not manage symptoms, tear substitutes may be used in conjunction with lifestyle measures.

Symptomatic treatments such as tear replacement and ocular lubricant products may be offered to people with dry eye disease, but these do not treat the cause. Dry eye disease is chronic in nature and so long-term treatment is usually needed. This may be continued by the individual's optometrist, GP or consultant depending on diagnosis.

Tear replacement and lubricant formulations include:

- **drops/gels** (preferred for daytime use)
- **ointments** (used 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 (moderate-to-severe eye disease) and/or
- is intolerant of preservatives in tear supplements and/or is using multiple topical preserved eye preparations

A treatment for dry eye disease can be tried for 4 weeks with a follow-up appointment arranged with an optometrist by the individual.

### 10.5 Treatments[1,97,100-102]

**Table 1: Treatment options for Dry Eye Disease**

| Medication | Dose | Considerations for all preparations – suitability for use in pregnancy/lactation may vary according to manufacturer |
|---|---|---|
| **Hypromellose 0.3% eye drops** | 1 drop 2 to 4 times daily as needed. | 1st line treatment option.<br>May cause mild stinging or temporary blurred vision.<br>Hypromellose prolongs the contact time of other topically applied drugs commonly used in other eye conditions. |
| **Carbomer '980' 0.2% eye drops** | 1 drop 2 to 4 times daily as needed. | May cause mild discomfort or temporary blurred vision. |
| **Polyvinyl alcohol 1.4% eye drops**<br>**(Liquifilm Tears® 1.4% eye drops)** | 1 drop 2 to 4 times daily as needed. | May cause mild irritation, redness or blurred vision. |
| **Retinol palmitate with white soft paraffin, light liquid paraffin, liquid paraffin and wool fat**<br>**(Hylo Night® eye ointment)** | Apply at NIGHT before sleep as needed. | For use as an adjunct to another eye lubricant where symptoms are:<br>• impacting quality of sleep; and/or<br>• leading to discomfort, or difficulty opening the eyes, on waking<br>May cause temporary visual disturbance. |

**Table 2: Formulary information**

| Medication | Legal class | Pack size | Maximum number of consultations per episode† and Maximum number of episodes† per year |
|---|---|---|---|
| **Hypromellose 0.3% eye drops** | P/Medical device | 10 mL | **A maximum of 2 consultations per episode.**<br>**A maximum of 1 episode per year.**<br><br>**Only supply for subsequent presenting episodes (after initial supply) if treatment has been effective.**<br><br>† 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. |
| **Hypromellose 0.3% eye drops preservative free** | P/Medical device | 10 mL<br>30 x 0.5mL | |
| **Carbomer '980' 0.2% eye drops** | P/Medical device | 10g | |
| **Carbomer '980' 0.2% eye drops preservative free** | P/Medical device | 10g<br>30 x 0.6 mL | |
| **Polyvinyl alcohol 1.4% eye drops (Liquifilm Tears® 1.4% eye drops)** | Medical device | 15 mL | |
| **Polyvinyl alcohol 1.4% eye drops preservative free (Liquifilm Tears® 1.4% eye drops preservative free)** | Medical device | 30 x 0.4 mL | |
| **Retinol palmitate with white soft paraffin, light liquid paraffin, liquid paraffin and wool fat (Hylo Night® eye ointment)** | Medical device | 5g | |

### 10.6 Advice for patients[97-99,103]

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.
- Keep computer screens below eye level and take regular screen breaks.

**Lifestyle measures**

- Warm compresses, eyelid 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 when there's infection or inflammation present.
- Though evidence is limited, having a healthy, balanced diet with flaxseed as well as foods containing omega 3 and 6 (such as oily fish, nuts, seeds, eggs and green leafy vegetables) may be beneficial.
- Reduce alcohol intake and/or engage with smoking cessation services if indicated.

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)

This monograph supports the management of dry skin associated with contact dermatitis and atopic eczema for individuals aged one month and above. Mild dry skin should be managed via self-care and emollients should not be supplied via the common ailments service for non-clinical cosmetic purposes.

### 11.1 About the ailment[104-108]

**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 may be 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, characterized by dry itchy skin. 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. Atopic eczema can appear anywhere on the body, with the insides of elbows and backs of knees (joint creases), wrists and neck (flexural pattern) being commonly affected areas. In infants, eczema primarily affects the face, scalp and extensor surfaces of the limbs. There may be small patches or widespread areas and there may be episodic flares and then periods of remission.

**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 dry, itchy, 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[109,110]

- Skin infections:
  - bacterial (may present as typical impetigo or as worsening eczema – increased redness, oozing, and crusting of the skin)
  - fungal
  - viral (e.g. herpes simplex – indicated by grouped vesicles and punched-out erosions)
- Psychological effects:
  - behavioural problems and fearfulness in preschool children
  - teasing, bullying and impaired performance and social development in school children
  - reduced self-esteem, distress and depression in teenagers and adults
  - sleep disturbance

**Atopic eczema is associated with other atopic and non-atopic comorbidities such as asthma, hay fever, food allergy and eosinophilic oesophagitis.**

### 11.3 When to refer[99,105,109,111]

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

- Signs of disseminated herpes simplex infection:
  - widespread lesions that may coalesce into large, denuded bleeding areas
  - fever, lymphadenopathy, malaise

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

- Signs of infected dry skin (e.g. weeping, crusting, pustules, fever, malaise, inflammation, erythema, pain) refer for same day assessment unless managing a fungal infection which is allowed under a relevant CAS formulary monograph; fungal skin infections (body and groin), athlete's foot or nappy rash (refer to relevant CAS monograph).
- Babies less than 1 month old.
- Children less than 1 year old who are symptomatic despite regular emollient use.
- Moderate symptoms of dry skin:
  - in a child under 12 years of age
  - covering an area greater than both hands
  - affecting the face, head, neck, axillae, groin or genitalia
- Severe symptoms of dry skin (widespread areas of affected skin, incessant itching, severely fissured/cracked/bleeding skin, alteration of pigmentation).
- Diagnostic uncertainty.

**Low risk – Green – Advise the individual to see a GP or Pharmacist Independent Prescriber for routine assessment.**

- Persistent or recurrent symptoms.
- Symptoms not responding to treatment.
- Dry skin of any severity that is causing or contributing to psychological distress or a mental health disorder. Treat and refer.
- Contact dermatitis suspected to be due to occupational exposure to an irritant. Treat and refer.
- Individuals on medical oxygen if there are concerns about increased fire risk (e.g. also a known smoker).

### 11.4 Overview of treatment[99,105,107,109,110,112]

- Avoidance of the irritant/allergen, if possible, is the most important element of treatment and prevention of contact dermatitis.
- 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.
- It may be necessary to try a range of emollients before the person settles on the best combination for them. 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.
- It may be more convenient to use better tolerated products like creams or gels in the day and use ointments at night.
- Evidence to support the use of bath additive and shower products is limited and there is no consensus on their benefit. They are not recommended for NHS use in children or adults.

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

Emollients containing antiseptics (for example benzalkonium chloride) are no longer recommended as a leave on product as they can exacerbate dryness and irritation.

A topical steroid can be added in addition to the emollient treatment and used for 5–14 days depending on response as per the treatment table below.

- Hydrocortisone 1% cream/ointment: for children aged 1 year and over, 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[39,112]

**Table 1: Emollient: No active ingredient**

| Medication | Usage instructions | Considerations |
|---|---|---|
| **Liquid paraffin 11% cream**<br>**Isopropyl myristate 15%/ liquid paraffin 15% gel**<br>**White soft paraffin: liquid paraffin cream (ingredients in varying ratios)**<br>**White soft paraffin: liquid paraffin (50:50) ointment** | Apply to skin frequently and continue as part of daily skincare regime.<br><br>See section 11.6 Advice for patients below. | • Refer to local health board formulary for appropriate choice of emollient.<br>• Pump dispensers minimise the risk of bacterial contamination and are useful for those with limited dexterity.<br>• Suitable for use in pregnancy and breastfeeding (do not apply on chest area immediately prior to breastfeeding).<br>• Ointments dissolved in hot water can be used as a soap substitute.<br>• 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.<br>• Caution: flammable. Extra caution required for individuals using medical oxygen. |

**Table 2: Emollient: Active ingredient**

| Medication | Usage instruction | Considerations |
|---|---|---|
| Urea-containing | **Adults and children aged 1 year and over**<br>Refer to product labelling (usually once or twice daily) | • Can help to soften skin that is hard<br>• Caution: flammable. Extra caution required for individuals using medical oxygen. |
| Urea and lauromacrogol-containing | **Adults and children aged 1 year and over**<br>Refer to product labelling (usually twice daily) | • Can help relieve itchy skin<br>• Caution: flammable. Extra caution required for individuals using medical oxygen. |

**Table 3: Topical steroid – adjunct to emollient treatment**

| Medication | Usage instructions | Considerations |
|---|---|---|
| **Hydrocortisone 1% cream/ointment**<br>(**Mildly potent** - for an acute flare of mild eczema) | **Adults and children aged 1 year and over**<br>Apply thinly ONCE daily until flare controlled and for a further 48 hours.<br>Maximum duration of use: FOURTEEN days.<br>(see PGD) | • Creams are preferred by most people, especially for daytime use and when used on visible areas.<br>• Ointments have a stronger emollient effect but are greasy and may be more suitable for use at night.<br>• Suitable for use in pregnancy and breastfeeding<br>  ○ Cream is preferred choice in breastfeeding – easier to wash off (see PGD)<br>• Caution: flammable. |
| **Clobetasone 0.05% cream/ointment**<br>(**Moderately potent** - for an acute flare of moderate eczema) | **Adults and children aged 12 years and over.**<br>**Treatment of delicate areas (e.g. flexures)**<br>Apply thinly ONCE daily until flare controlled and for a further 48 hours. Aim for a maximum duration of use of FIVE days.<br>**Treatment of all other areas**<br>Apply thinly ONCE or TWICE daily until flare controlled and for a further 48 hours. Maximum duration of use: FOURTEEN days (see PGD). | |

**Table 4: Formulary information**

| Medication | Legal class | Pack size | Maximum number of consultations per episode† Maximum number of episodes per year |
|---|---|---|---|
| **Liquid paraffin 11% cream** | Medical device | 50g<br>500g | First episode could be two consultations in order to include trial of therapy. Subsequent episodes should only be a single consultation.<br>First consultation – provide either:<br>A) a choice of up to three different 30–100 g preparations as a trial of therapy or to establish preference **OR**<br>B) a maximum of 2 x 500 g preparations if the individual already has a preference.<br><br>Only 1 supply of topical corticosteroid should be made per episode and only issue if using adequate quantities of emollients (could be in the first or second consultation).<br><br>A maximum of 2 consultations per episode.<br>A maximum of 2 episodes per year.<br><br>† 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. |
| **Isopropyl myristate 15%/ liquid paraffin 15% gel** | Medical device | 100g<br>500g | |
| **White soft paraffin: liquid paraffin cream (ingredients in varying ratios)** | Medical device | 50g<br>100g<br>500g | |
| **White soft paraffin: liquid paraffin (50:50) ointment** | Medical device | 500g | |
| **Urea-containing** | Medical device | 30g<br>100g | |
| **Urea and lauromacrogol-containing** | GSL | 100g | |
| **Hydrocortisone 1% cream/ointment (for an acute flare of mild eczema)** | P/POM (Supply via PGD) | 15g<br>30g | |
| **Clobetasone 0.05% cream/ointment (for an acute flare of moderate eczema)** | POM (Supply via PGD) | 30g | |

### 11.6 Advice for patients[104,109]

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

- It is best to prevent dry skin from getting worse by applying plenty of emollient regularly. This helps keep the skin barrier healthy and protected.
- For emollients that come in pots, use a clean spoon or spatula (rather than fingers) to remove the emollient, this helps to minimise contamination.
- Do not share emollients with others as they can become contaminated with bacteria.
- 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) can be applied before or after the emollient; leave 15-30 minutes between applications to allow the first product to be absorbed.
- Topical steroids should be applied thinly to the affected areas and only during an eczema flare.
- There is a serious 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.
- Atopic eczema may affect skin pigmentation (causing the skin to become lighter or darker).

### Signposting[107,108]

- The British Association of Dermatologists (BAD) has produced patient information leaflets on Atopic eczema, Contact dermatitis and Hand dermatitis (https://www.skinhealthinfo.org.uk/a-z-conditions-treatments/)
- Eczema UK (previously called The National Eczema Society) has various factsheets on eczema and treatments available on their website (www.eczema.org).

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|---|
| 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[113]

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[114]

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

### 12.3 When to refer[113,115-117]

**High risk –Red**

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

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

**Intermediate risk – Amber**

**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.**

| Low risk – Green |
| --- |
| • 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[113,118]

- 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[1,29,119-123]

**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.<br>Care in hypercalcaemia, nephrocalcinosis and recurrent renal calculi.<br>Suitable in pregnancy/breastfeeding.<br>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.<br>Caution in highly restricted salt diet.<br>Suitable in pregnancy/breastfeeding.<br>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<br>(see PGD) | Should be taken at least 30 minutes before food.<br>Lansoprazole may interfere with the absorption of other medicinal products where gastric pH is an important determinant of oral bioavailability.<br>Can cause nausea, diarrhoea, vomiting and stomach-ache.<br>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<br>(see PGD) | Recommended to take in the morning, swallowed whole with half a glass of water. Capsules must not be chewed or crushed.<br>Omeprazole may interfere with the absorption of other medicinal products where gastric pH is an important determinant of oral bioavailability.<br>Can cause nausea, diarrhoea, vomiting and stomach-ache<br>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.<br><br>† 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.<br><br>† 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[113,123]

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 Fungal skin infections (body and groin)

This monograph supports the management of fungal skin infections (ringworm) and candidal intertrigo for individuals one month of age onwards when the affected area is the body and/or groin. Infections involving the face, scalp or nails are not included in the scope of this monograph. Refer to CAS nappy rash monograph for management of individuals from one month to 6 years who wear a nappy and present with symptoms of fungal infection of the groin/nappy area.

### 13.1 About the ailment[29,34,124-126]

Ringworm is a superficial fungal skin infection predominantly caused by dermatophytes, also referred to as tinea corporis when it affects the body and tinea cruris when it affects the groin.

Ringworm is usually transmitted in 4 main ways:

- human to human – direct contact with an infected person or autoinoculation from fungal infection of the hands, feet or nails (these should be treated at the same time to prevent recurrence – Refer to CAS athlete's foot monograph).
- animal to human – direct contact with an infected animal (e.g. dog, cat, guinea pig, 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 (sweat rash) is a superficial inflammatory skin rash affecting skinfolds (e.g. groin, under the breasts, axillae and buttock folds) caused by skin-on-skin friction, heat and moisture. Secondary infection can occur, usually caused by *Candida*.

Ringworm and intertrigo rashes may be accompanied by itching and soreness in the affected areas.

**Table 1: Features of the infections**.

| Ringworm affecting the body (tinea corporis) | Ringworm affecting the groin (tinea cruris) | Intertrigo with secondary candidal infection (candidal intertrigo) |
|---|---|---|
| • Typically affects the trunk, arms and legs.<br>• 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).<br>• The penis and scrotum are often spared.* | • Affects skinfolds, especially deep skin folds where moisture is trapped and circulation limited.<br>• The scrotum is usually affected when the groin area is involved.* |
| • Red or pink (may appear different on darker skin tones and may be less noticeable). | • Red to red-brown (may appear different on darker skin tones and may be less noticeable). | • Red (may appear different on darker skin tones and may be less noticeable). |
| • 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).<br>• No satellite lesions.*<br>• No clear central area.<br>• The typical scaly edge may be lost in moist flexures. | • Usually uniformly red and moist.<br>• Fringed irregular edge and pustular or papular satellite lesions may be seen.*<br>• No clear central area.<br>• No scaly edge. |
| • Usually asymmetrical. | • Uniform scale. | • Usually symmetrical. |

* The main distinguishing features between tinea cruris and candidal intertrigo affecting the groin.

### 13.2 Possible complications[124]

- Secondary bacterial infection (e.g. skin is very macerated or pustular) -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.
- Candidal skin infections can lead to systemic/invasive candidiasis in severely immunocompromised individuals.

### 13.3 When to refer[124]

| High risk - Red – Action: Advise the individual to attend A & E without delay |
|---|
| • Signs of marked systemic illness or sepsis (including changes in cognitive function, behaviour or mental state e.g. confusion, drowsiness or slurred speech). |

| Intermediate risk - Amber - Advise the individual to see the most appropriate clinician (GP, NHS 111, pharmacist independent prescriber) that avoids delay in diagnosis and treatment. |
|---|
| • Individuals under 1 month of age.<br>• Individuals under 1 year of age with marked inflammation.<br>• Severe or extensive disease (including disease affecting the face/scalp/nails).<br>• Secondary bacterial infection.<br>• No improvement after 1 week of treatment.<br>• Symptoms that have not cleared after completing the treatment course.<br>• Immunocompromised individuals.<br>• Diagnostic uncertainty or if there is an atypical appearance.<br>• Recurrent infection (more than 2 episodes in previous 12 months).<br>• Suspicion of undiagnosed diabetes (e.g. increased thirst, increased urination, fatigue, unintentional weight loss) – treatment can be provided but also refer for same day assessment.<br>• Individuals with diabetes if, in the opinion of the pharmacist:<br>  ○ there are concerns regarding diabetic control of the individual.<br>  ○ 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)<br>  ○ the individual is unsure how to manage their diabetes |

### 13.4 Overview of treatment[34,124]

Topical antifungal cream can be supplied for fungal skin infections if there is mild, non-extensive disease.

- 1st line (individuals aged 12 years and over)
  - terbinafine 1% cream

- 2nd line (if terbinafine contra-indicated, unsuitable or unavailable)
  - clotrimazole 1% cream or miconazole 2% cream

If there is associated marked inflammation, a topical steroid cream can be supplied to individuals aged 1 year and over, in addition to an antifungal:

- hydrocortisone 1% cream

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.

### 13.5 Treatments[29,30,33,124]

**Table 2: Topical Antifungals**

| Medication | Dose | Duration | Considerations |
|---|---|---|---|
| **Terbinafine 1% cream** | Individuals aged 12 years and over.<br>Apply thinly to the affected area ONCE or TWICE a day.<br>(see PGD) | TWO weeks.<br>(see PGD) | • Do not use during pregnancy and breastfeeding.<br>• No known significant drug interactions.<br>• Some products may not be licensed for use in those under 16 years of age (see PGD).<br>• Caution: flammable. |
| **Clotrimazole 1% cream** | Individuals aged 1 month and over.<br>Apply thinly to the affected area TWO to THREE times a day.<br>(see PGD) | At least ONE month.<br>Apply until symptoms cleared and then for a further 1-2 weeks.<br>Maximum duration of use is 6 weeks.<br>(see PGD) | • Can be used during pregnancy and breastfeeding. (see PGD).<br>• A strip of about 0.5 cm long is enough to treat an area about the size of an adult hand.<br>• Topical clotrimazole may increase tacrolimus levels.<br>• Caution: flammable. |
| **Miconazole 2% cream** | Individuals aged 1 month and over.<br>Apply to the affected area TWICE a day. | At least TWO weeks.<br>Apply until all lesions are healed and then for a further 10 days.<br>Maximum duration of use is 6 weeks. | • Use with caution during pregnancy and breastfeeding.<br>• Avoid use if individual taking warfarin.<br>• Caution: flammable. |

**Table 3: Topical corticosteroid – if indicated, supply in addition to topical antifungal**

| Medication | Dose | Duration | Considerations |
|---|---|---|---|
| **Hydrocortisone 1% cream** | Individuals aged 1 year and over<br>Apply thinly ONCE or TWICE a day.<br>(see PGD) | For SEVEN days and then:<br>• Stop if symptoms resolved.<br>• Continue for further 7 days if significant improvement in symptoms.<br>• Stop if no improvement after 7 days and see GP. | • Can be used during pregnancy and breastfeeding (see PGD).<br>• Used for inflammatory symptoms.<br>• Must only be used in combination with a topical antifungal.<br>• Apply 15-30 minutes after the topical antifungal.<br>• Short term use only.<br>• Caution: flammable. |

**Table 4: Formulary information**

| Medication | Legal class | Pack size | Maximum number of consultations per episode† Maximum number of episodes per year |
|---|---|---|---|
| **Terbinafine 1% cream** | POM | 15g<br>30g | A maximum of 1 consultation per episode.<br>A maximum of 2 episodes per year.<br>Only supply for subsequent presenting episodes (after initial supply) if treatment has been effective.<br><br>† 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. |
| **Clotrimazole 1% cream** | P<br>(supply via PGD) | 20g | |
| **Miconazole 2% cream** | P | 30g | |
| **Hydrocortisone 1% cream** | POM | 15g | |

### 13.6 Advice for patients[30,33,124,126,127]

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).
- Do not smoke or go near naked flames when using these products. Fabric that has been in contact with the products burns more easily and there is a risk of severe burns and serious fire hazard.

**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.

## 14.0 Haemorrhoids

For the treatment of non-pregnant individuals aged 16 years and over. If presentation of symptoms is consistent with haemorrhoids and it is the patient's first time experiencing these, treatment may be provided, but the patient should also be referred to their GP. No subsequent treatments should be provided without a GP diagnosis.

### 14.1 About the ailment[128,129]

Haemorrhoids (piles) are abnormally swollen vascular mucosal cushions in the anal canal. They may be external or internal and some people develop both. 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)

### 14.2 Possible complications[128]

- Skin tags which can cause problems with hygiene and secondary irritation.
- Maceration of the perianal skin, due to mucus discharge.
- Ulceration (from thrombosis of external haemorrhoids).
- Anal stenosis.
- Incarceration of prolapsed haemorrhoidal tissue which can cause severe pain, ischaemia, thrombosis or gangrene.
- Perianal sepsis (rare).
- Anaemia from continuous or excessive bleeding (rare).

### 14.3 When to refer[116,130]

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.**

- Prolonged and/or profuse bleeding.
- Severe rectal pain AND systemic symptoms.
- Suspected perianal or pelvic sepsis.

**Intermediate risk – Amber – Action: Advise the individual to see a GP, call NHS111 or a see a pharmacist independent prescriber for same day urgent assessment**

- Moderate – severe abdominal pain.
- Significant rectal bleeding or blood mixed in stools.
- Very painful perianal lump or lesion.
- Fever and/or appearing systemically unwell.
- Severe rectal pain.
- Tenesmus not associated with haemorrhoids (continuously feeling the need to defecate without producing significant amount of faeces, or after passing a normal amount of stool).
- Pus leaking from haemorrhoids.
- If anal or colorectal cancer suspected due to:
    - unexplained appetite or weight loss.
    - patient reporting anal or rectal mass or anal ulceration.
    - patient reporting abdominal mass.
    - change in bowel habit that has lasted longer than 3 weeks.
- In pregnancy or up to 6 weeks post childbirth.
- Diagnostic uncertainty.

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

- Recurrent symptoms (refer to table 3).
- No response to treatment after 7 days.

### 14.4 Overview of treatment[128]

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

1) Laxative treatment if acute constipation is thought to be a contributing factor– refer to CAS constipation monograph. If chronic constipation is thought to be a contributing factor, refer to GP or appropriate prescriber for review.
2) Dietary and lifestyle advice. (see "Advice for patients" section)
3) Simple analgesia and/or topical haemorrhoidal preparations.

Ideally, treatments should only be provided once a diagnosis has been made by a GP. However, if the pharmacist is satisfied the presentation of symptoms is consistent with haemorrhoids and it is the patient's first time experiencing these, treatment may be provided, but the patient should also be referred 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, they do not cure haemorrhoids, but they can ease symptoms such as discomfort and itch. 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 (e.g. herpes simplex or perianal thrush).

## 14.5 Treatments[1,39,40,128,131-134]

**Table 1: Haemorrhoid preparation options**
Refer to the BNF or SmPC for full details of interactions, adverse effects, cautions and contraindications.

| Medication | Preparation type | Dose | Considerations |
|---|---|---|---|
| **Lidocaine HCl 0.7%, zinc oxide 6.6% cream (Germoloids® cream)** | Local anaesthetic<br>For pain, burning and itching. | Apply morning and evening and after defecation.<br>Max. 4 times in 24 hours with minimum of 3–4 hours between applications. | • **Germoloids® preparations** may be used with caution in breastfeeding individuals.<br>• **Anusol® preparations** should be avoided in breastfeeding individuals and individuals under 18 years of age due to product licensing.<br>• **Anusol HC® preparations** may be used with caution in breastfeeding individuals (see PGD).<br>• **Scheriproct®** preparations may be used with caution in breastfeeding individuals (see PGD).<br>• All formulations contain potential sensitisers. Advise the individual to discontinue treatment if symptoms get worse and to use for no longer than 7 days.<br>• Excessive application should be avoided.<br>• Evidence does not suggest that any preparation is more effective than another. |
| **Lidocaine HCl 0.7%, zinc oxide 6.6% ointment (Germoloids® ointment)** | Local anaesthetic<br>For pain, burning and itching. | Apply morning and evening and after defecation.<br>Max. 4 times in 24 hours with minimum of 3–4 hours between doses. | |
| **Lidocaine HCl 13.2 mg /zinc oxide 283.5 mg suppositories (Germoloids® suppositories)** | Local anaesthetic<br>For pain, burning and itching. | ONE suppository to be inserted into the rectum morning and night and after defecation.<br>Maximum of 4 suppositories in 24 hours with a minimum of 3-4 hours between suppositories. | |
| **Bismuth oxide 21.4 mg, balsam peru 18 mg, zinc oxide 107.5 mg cream (Anusol® cream)** | Mild astringent/antiseptic/lubricant<br>For itchiness/irritation. | Apply in the morning and evening and after defecation until condition controlled. | |
| **Bismuth subgallate 22.5 mg, bismuth oxide 8.75 mg, balsam peru 18.75 mg, zinc oxide 107.5 mg (Anusol® ointment)** | Mild astringent/antiseptic/lubricant<br>For itchiness/irritation. | Apply in the morning and evening and after defecation until condition controlled. | |
| **Bismuth subgallate 59 mg, bismuth oxide 24 mg, balsam peru 49 mg,** | Mild astringent/antiseptic/lubricant<br>For itchiness/irritation. | ONE suppository to be inserted into the rectum in the morning, at night and after defecation. | |

| Medication | Preparation type | Dose | Considerations |
|---|---|---|---|
| **zinc oxide 296 mg (Anusol® suppositories)** | | | |
| **Hydrocortisone 2.5 mg, bismuth subgallate 22.5 mg, bismuth oxide 8.75 mg, balsam peru 18.75 mg, benzyl benzoate 12.5 mg, zinc oxide 107.5 mg (Anusol HC® ointment)** | Local corticosteroid/astringent<br>For pain, irritation and inflammation.<br>(see PGD) | Apply in the morning, at night and after defecation.<br>Apply up to a maximum of 4 times a day for a maximum of 7 days. | • Long term use of corticosteroid preparations can cause skin sensitisation, ulceration or permanent damage due to thinning of the perianal skin and should be avoided.<br>• Continuous or excessive use of corticosteroid preparations carries a risk of adrenal suppression and systemic corticosteroid effects. |
| **Hydrocortisone 10 mg, bismuth subgallate 59 mg, bismuth oxide 24 mg, balsam peru 49 mg, benzyl benzoate 33 mg, zinc oxide 296 mg (Anusol HC® suppositories)** | Local corticosteroid/astringent<br>For pain, irritation and inflammation.<br>(see PGD) | ONE suppository to be inserted into the rectum in the morning, at night and after defecation up to a maximum of 3 times a day for a maximum of 7 days. | |
| **Cinchocaine 0.5% / prednisolone 0.19% ointment (Scheriproct® ointment)** | Local corticosteroid/anaesthetic<br>For pain, irritation and inflammation.<br>(see PGD) | Apply thinly twice a day for 5-7 days.<br>Note: for rapid improvement it may be applied 3-4 times on the first day. | |
| **Cinchocaine 1 mg / prednisolone hexanoate 1.3 mg suppositories (Scheriproct® suppositories)** | Local corticosteroid/anaesthetic<br>For pain, irritation and inflammation.<br>(see PGD) | ONE suppository to be inserted into the rectum daily after defecation for 5-7 days.<br>Note: for severe cases ONE suppository to be inserted into the rectum two to three times a day. | |

**Table 2: Analgesic options**

| Medication | Dose | Considerations |
|---|---|---|
| **Paracetamol 500mg tablets** | ONE or TWO tablets up to FOUR times a day.<br><br>See Table 4. Paracetamol dosing table below for dose modifications. | • Paracetamol should not be taken more frequently than every 4 hours.<br>• No more than 4 doses should be administered in a 24-hour period.<br>• Caution and advise dose reduction if any risk factors for hepatotoxicity present (see Table 4 below).<br>• Consider if individual is taking any other paracetamol-containing products prior to supply and advise accordingly.<br>• Check pack details for brands that carry a lactose intolerance warning and any other warnings/cautions/advice. |

**Table 3: Formulary Information**

| Medication | Legal class | Pack size | Maximum number of consultations per episode† Maximum number of episodes per year |
|---|---|---|---|
| **Paracetamol 500 mg tablets** | P | 32 tablets (2 boxes can be supplied per consultation) | A maximum of 1 consultation per episode if previously undiagnosed by GP. Patient should also be referred to GP.<br><br>A maximum of 2 consultations per episode if haemorrhoids have been previously diagnosed by GP.<br><br>A maximum of 2 episodes per year.<br><br>† 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. |
| **Lidocaine HCl. 0.7%, zinc oxide 6.6% cream (Germoloids® cream)** | GSL | 25 g | |
| **Lidocaine HCl 0.7%, zinc oxide 6.6% ointment (Germoloids® ointment)** | GSL | 25 mL | |
| **Lidocaine HCl 13.2 mg /zinc oxide 283.5 mg suppositories (Germoloids® suppositories)** | GSL | 12 suppositories | |
| **Bismuth oxide 21.4 mg, balsam peru 18 mg, zinc oxide 107.5 mg cream (Anusol® cream)** | GSL | 23 g | |
| **Bismuth subgallate 22.5 mg, bismuth oxide 8.75 mg, balsam peru 18.75 mg, zinc oxide 107.5 mg (Anusol® ointment)** | GSL | 25 g | |
| **Bismuth subgallate 59 mg, bismuth oxide 24 mg, balsam peru 49 mg, zinc oxide 296 mg (Anusol® suppositories)** | GSL | 12 suppositories | |
| **Hydrocortisone 2.5 mg, bismuth subgallate 22.5 mg, bismuth oxide 8.75 mg, balsam peru 18.75 mg, benzyl benzoate 12.5 mg, zinc oxide 107.5 mg (Anusol HC® ointment)** | POM | 30 g | |
| **Hydrocortisone 10 mg, bismuth subgallate 59 mg, bismuth oxide 24 mg, balsam peru 49 mg, benzyl benzoate 33 mg, zinc oxide 296 mg (Anusol HC® suppositories)** | POM | 12 suppositories | |
| **Cinchocaine 0.5% / prednisolone 0.19% ointment (Scheriproct® ointment)** | POM | 30 g | |
| **Cinchocaine 1 mg / prednisolone hexanoate 1.3 mg suppositories (Scheriproct® suppositories)** | POM | 12 suppositories | |

**Table 4: Paracetamol dosing and dose/dosing interval adjustments in ADULTS[40]**

| Dose of ORAL paracetamol in ADULT patients WITHOUT risk factors for paracetamol toxicity and body weight over 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 or more** | 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**
- **alcohol dependency**
- **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.
- **malnourished patients** – 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 more than recommended amounts, particularly if nutritionally compromised.

### 14.6 Advice for patients[128,135,136]

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 (damp wipes may be used 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.
- Generally, treatment should be applied morning and night, and after a bowel movement.
- Anaesthetic-containing preparations should only be used for a few days because they may cause sensitisation of the anal skin.
- Corticosteroid-containing preparations should be used for no longer than 7 days because prolonged use may lead to skin atrophy, contact dermatitis, and skin sensitisation. Excessive application should be avoided, as systemic absorption can occur through the rectal mucosa.
- Local adverse effects may occur on application, such as burning, erythema, exfoliation, or irritation.
- Once the haemorrhoid has healed, dietary and lifestyle measures should be continued to reduce the risk of recurrence.

| |
|---|
| 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. |

## 15.0 Head lice

This monograph supports the management of head lice infestation (of hair on the scalp) for individuals from 1 month of age onwards. A live louse must be seen (by pharmacist or individual / parent / carer) to diagnose an infestation.

### 15.1 About the ailment[137,138]

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 oval-shaped translucent eggs (ova) which hatch after 7 to 10 days. After a further 7 to 10 days, the hatched lice begin to lay eggs. Empty yellow-white egg-shells (nits) may be seen attached strongly to the hair.

Head lice infestation is often asymptomatic, itchy scalp may occur due to a skin reaction to the lice bites or saliva. It can take 1-3 months to become sensitised to louse saliva and experience itching following an initial infestation, itching can develop sooner with subsequent infestations. 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 comb suitable for detection is the best way to confirm the presence of lice. Wet combing with conditioner is more accurate than dry combing as lice move less when wet. Combing hair over a piece of white or light coloured paper can help to identify lice dislodged by the combing process.

All household members and other close contacts should use a head lice detection comb, and those with live lice should start treatment on the same day to avoid reinfection. Each individual treated should have a CAS consultation record in Choose Pharmacy.

### 15.2 Possible complications[137-139]

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 caused by scratching which can occasionally lead to secondary skin infection
- swollen lymph glands in response to infection
- anxiety, distress, and stigma
- loss of sleep caused by itching and missed days of school

### 15.3 When to refer[137,140]

| Intermediate risk - Amber – Action: Advise the individual to see a GP, call NHS 111, see a Pharmacist Independent Prescriber as appropriate for assessment. |
|---|
| • Scalp inflammation or signs of infection (scalp impetigo, furunculosis, swollen lymph nodes, excoriated skin). |

| Low risk - Green – Action: Advise the individual to see a GP or Pharmacist Independent Prescriber for routine assessment. |
|---|
| • Infestation persisting after 4 complete treatments have failed.<br>• Under 1 month of age.<br>• Under 6 months of age if wet combing treatment has failed.<br>• Diagnostic uncertainty. |

### 15.4 Overview of treatment[137]

Treatment options depend on age, individual / parent /carer preference, treatment history and contra-indications. 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 lice comb to physically 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® spray gel formulation has 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 and it has an unpleasant smell

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 and 10 days later

**Treatment failure**

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

- 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
- 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)

## 15.5 Treatments[1,137,140-143]

### Table 1. Wet combing

| Treatment | Method | Considerations |
|---|---|---|
| **Head lice comb (suitable for detection and removal of head lice):**<br>Bug Buster kit®<br>Nitty Gritty NitFree steel nit comb®<br>Nitcomb–S1® | FOUR wet combing sessions spaced over TWO weeks (on day 1, 5, 9 and 13).<br>• Wash hair with usual shampoo, apply ample conditioner, then use a normal comb to untangle hair.<br>• Switch to the fine-toothed head lice comb, making sure that the teeth of the comb slot into the hair at the roots touching the scalp.<br>• 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).<br>• Remove any lice by wiping or rinsing the comb.<br>• Work methodically through the hair, section by section, so that all of the hair is combed.<br>• Rinse out the conditioner and repeat the combing procedure on the wet hair. | • Suitable from 1 month of age.<br>• 1st line in pregnancy and breastfeeding.<br>• It takes about 10 minutes to complete the process on short hair, and 20–30 minutes for long, frizzy, or curly hair.<br>• Two combing procedures are recommended at each treatment session.<br>• A fifth detection session should be done on day 17 to check for treatment success (no live lice). |

**Table 2. Physical insecticides**

| Medication | Instructions for use | Considerations |
|---|---|---|
| **Dimeticone 4% lotion (Hedrin® Lotion)** | Apply ONCE weekly for TWO doses. Follow product instructions. | • Suitable from 6 months of age.<br>• 1st line insecticide in pregnancy and breastfeeding.<br>• 1st line for individuals with eczema or asthma.<br>• Risk of serious burns if hair is exposed to ignition source during treatment (including the morning after overnight application, until hair is washed). |
| **Dimeticone 4% spray gel** | Apply ONCE. Follow product instructions. | • 2nd line insecticide from 6 months to 2 years of age due to lack of data.<br>• 2nd line insecticide in pregnancy and breastfeeding.<br>• Suitable for individuals with asthma.<br>• Risk of serious burns if hair is exposed to ignition source during treatment. |
| **Cyclomethicone 50% / Isopropyl myristate 50% solution (Full Marks Solution®)** | Apply ONCE weekly for TWO doses. Follow product instructions. | • Suitable from 2 years of age.<br>• 2nd line insecticide in pregnancy and breastfeeding.<br>• Suitable for individuals with asthma.<br>• Lack of information for individuals with skin conditions.<br>• Risk of serious burns if hair is exposed to ignition source during treatment. |
| **Isopropyl alcohol/ Benzyl alcohol Mousse 1.5% / 1.5% (Vamousse® head lice treatment)** | Apply ONCE. Follow product instructions. | • Suitable from 2 years of age.<br>• 2nd line insecticide in pregnancy and breastfeeding due to lack of data.<br>• Not recommended for individuals with asthma.<br>• Lack of information for individuals with skin conditions.<br>• Risk of serious burns if hair is exposed to ignition source during treatment. |

**Table 3. Chemical insecticides (3rd line treatment for all individuals)**

| Medication | Instructions for use | Considerations |
|---|---|---|
| **Malathion 0.5% aqueous liquid (Derbac M®)** | Apply ONCE weekly for TWO doses. Follow product instructions. | • Suitable from 6 months of age.<br>• Can be used in pregnancy or breastfeeding if wet combing and dimeticone treatment ineffective.<br>• Suitable for individuals with eczema or asthma.<br>• Skin irritation, hypersensitivity reactions (such as anaphylaxis, angioedema, and swollen eyes), and chemical burns have been reported with malathion products.<br>• Resistance has been reported.<br>• Has an unpleasant smell. |

**Table 4. Formulary information**
Provide sufficient quantities for treatment course.

| Treatment | Legal class | Pack size | Maximum number of consultations per episode† and Maximum number of episodes per year |
|---|---|---|---|
| **Head lice comb** | Medical device | 1 | A maximum of 4 consultations per episode.<br>A maximum of 3 episodes per year.<br><br>† 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. |
| **Dimeticone 4% lotion (Hedrin® Lotion)** | P | 50 mL / 150 mL | |
| **Dimeticone 4% spray gel** | Medical device | 60 mL | |
| **Isopropyl alcohol/ Benzyl alcohol Mousse 1.5% / 1.5% (Vamousse® head lice treatment)** | Medical device | 160 mL | |
| **Cyclomethicone and Isopropyl myristate solution (Full Marks Solution®)** | Medical device | 100 mL / 200 mL | |
| **Malathion 0.5% aqueous liquid (Derbac M®)** | P | 150 mL | |

### 15.6 Advice for patients[137,139]

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 wash clothing or bedding at a high temperature or fumigate.
- Essential oil-based treatments, herbal treatments and head lice shampoos 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).
- Hair should be kept away from naked flames, cigarettes and other sources of ignition, especially during treatment with products containing dimeticone, Vamousse® or Full Marks Solution® as these products will not stop the hair from burning.
- Care should be taken if insecticides are spilt as they may be a slip hazard.

| |
|---|
| If you feel you are not improving, or are getting worse, despite 4 complete treatments per infestation, please make an appointment to discuss with your GP. |

## 16.0 Infantile colic

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

### 16.1 About the ailment[144-146]

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

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

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

Symptoms include:

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

### 16.2 Possible complications[144]

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

### 16.3 When to refer[144]

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

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

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

### 16.4 Overview of treatment[144]

Provide advice only

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

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

### 16.5 Advice for patients[144]

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

**Strategies for management**

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

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

**Reassurance/support to parents/guardians**

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

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

## 17.0 Ingrowing toenail

Management of ingrowing toenails within the Common Ailments Service is limited to the provision of advice.

### 17.1 About the ailment[147-149]

Ingrowing (or ingrown) toenails are a common problem (especially in teenagers and young adults) in which the nail grows into the skin of the toe, creating a painful area, often on the big toe. The skin around the nail may be red, painful and swollen. Ill-fitting shoes and improper trimming of toenails are the two most common causes for ingrowing toenails.

If the nail fold becomes infected, symptoms 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. Overgrowth of skin tissue over the infected nail fold can occur. In some cases, there may be a fever. The foot should be examined to make the diagnosis.

### 17.2 Possible complications

Infection with possible systemic involvement.

### 17.3 When to refer[147-149]

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

- Individuals who are systemically unwell (same day assessment).
- Signs of infection (same day assessment).
- Diabetic or poor circulation.
- Conditions affecting the nerves or feeling in the feet (neuropathy).
- Immunocompromised.

**Low risk – Green - Action: Advice can be provided if appropriate AND advise the individual to see a GP, podiatrist or pharmacist independent prescriber (PIP) for routine assessment.**

- Co-existing nail disease (thickening of the nail is a sign of fungal nail infection; not considered appropriate for management via PIPs).
- No improvement after 3 weeks of conservative treatment, or sooner if symptoms get worse.
- If medication is suspected to be a cause e.g. isotretinoin.
- Diagnostic uncertainty.

### 17.4 Overview of treatment[148]

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 (see amber referral box in section 17.3).

### 17.5 Advice for patients[148,150]

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

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

**To resolve the condition**

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, posture, gait, 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, gently file any sharp edges with a nail file.
- Do not cut nails too short or too low at the sides.
- Ask someone to help (e.g. a podiatrist) to trim the nails regularly if there is any loss of feeling in the feet, if the individual has diabetes, is taking steroids or anticoagulants, or cannot see their feet very well.
- Wear comfortable shoes, cotton socks or tights that provide space around the toes.
- Keep 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 or Podiatrist. |

## 18.0 Mouth ulcers (simple aphthous)

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

### 18.1 About the ailment[99,151,152]

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

There are three different types, that can occur simultaneously:

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

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

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

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

### 18.2 Possible complications[151,152]

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

### 18.3 When to refer[151-155]

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

| **Intermediate risk - Amber – Advise the individual to see the most appropriate clinician (GP, dentist, NHS 111, pharmacist independent prescriber, sexual health clinician) that avoids delay in diagnosis and treatment.** |
| --- |
| • Signs of systemic illness or fever.<br>• Unable to eat or drink.<br>• Worsening pain/redness or bleeding.<br>• Severe ulceration unresponsive to simple topical treatments.<br>• Ulcers in crops of up to 100 (herpetiform).<br>• Immunosuppression suspected (e.g. on medication that can cause bone marrow suppression).<br>• Atypical sites (e.g. gums or palate, or non-oral sites e.g. genitalia [consider referral to sexual health service]).<br>• Child under 12 years old.<br>• Diagnostic uncertainty (e.g. painless ulcers, concurrent symptoms which may indicate underlying systemic disease such as pallor, joint pain/skin rashes/diarrhoea). |

| Low risk - Green – Treatment can be provided if appropriate AND advise the individual to see a GP (or dentist) for routine assessment. |
|---|
| • Ulcers more than 1 cm diameter (major aphthous).<br>• Suspected adverse drug reaction to a prescribed medicine (AMBER referral if immunosuppression suspected).<br>• Recurrent severe mouth ulcers (more than 2 times a year).<br>• Ulceration suspected to be caused by local trauma from sharp and/or broken teeth, dentures or orthodontic appliances.<br>• Initial presentation in someone over 30 years old. |

### 18.4 Overview of treatment[151,156]

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

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

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

**Table 1: Topical treatments**

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

**Table 2: Formulary information**

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

### 18.6 Advice for patients[151-153,155]

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

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

**Lifestyle changes**

To reduce recurrence, avoid precipitating factors such as:

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

**Self-care to reduce ulcer pain once developed**

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

**Other self-help options**

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

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

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

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

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

## 19.0 Nappy rash

This monograph supports the management of nappy rash in individuals from birth to 6 years of age.

### 19.1 About the ailment[160-163]

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 bottom, possibly including the whole nappy area
- skin that looks sore and is hot to the touch
- spots, pimples or blisters (may be harder to see on brown and black skin)

Nappy rash is common in the first 2 years of life. Mild nappy rash usually resolves in 2-4 days and doesn't appear to be bothersome, but if the rash is severe the individual may feel uncomfortable and be distressed.

### 19.2 Possible complications[160,162,163]

Nappy rash that lasts longer than 3 days may indicate:

- Secondary *Candida* (fungal) infection. This can appear as sharply marginated redness involving the skinfolds; there can also be satellite lesions. It can cause an inflamed rash to look brighter or darker red. *Candida* infection in the nappy area can be associated with oral thrush (refer to CAS oral thrush monograph). Recent antibiotic use can increase the risk of *Candida* infection.
- Secondary bacterial infection (*Staphylococcus aureus* and *streptococcus*). This can cause marked redness with exudate. There may be papules, pustules, blisters, folliculitis and possible abscesses if severe.

### 19.3 When to refer[162,163]

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

- Individual appears systemically unwell – same day assessment.
- Rash that 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 multiple shiny, smooth, red, moist flat -topped 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 gluteale infantum - rare)
- Diagnostic uncertainty.
- Suspicion of immunosuppression – treatment can be supplied but also refer.
- Rash that does not resolve following treatment, gets worse or spreads to other areas.

### 19.4 Overview of treatment[163]

- Asymptomatic cases/mild erythema – thinly apply a barrier preparation at each nappy change to protect the skin, such as white soft paraffin or a combination preparation of zinc and castor oil ointment.
- Inflamed rash that is causing discomfort – individuals over 1 month old can 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, clotrimazole 1% cream can be issued but advise avoiding the barrier preparation until the infection has settled.

### 19.5 Treatments[19,163]

**Table 1: Topical preparations**

| Medication | | Dosing instructions | Considerations |
|---|---|---|---|
| **Barrier preparation** | **Zinc and castor oil ointment** | **Suitable from birth.**<br>Apply thinly to the whole nappy area at **each** nappy change. | • Contains arachis oil and beeswax.<br>• Caution: flammable. |
| | **White soft paraffin solid** | **Suitable from birth.**<br>Apply thinly to the whole nappy area at **each** nappy change. | • Caution: flammable. |
| **Topical steroid** | **Hydrocortisone 1% cream**<br>(see PGD) | **Suitable from 1 month of age onwards.**<br><br>Apply thinly ONCE daily until symptoms settle or maximum of SEVEN days. | • Apply topical hydrocortisone first and wait a few minutes before applying the barrier preparation.<br>• Caution: flammable. |
| **Topical antifungal** | **Clotrimazole 1% cream**<br>(see PGD) | **Suitable from 1 month of age onwards.**<br><br>Apply thinly to the affected area TWO to THREE times a day for at least 14 days (continue for 7 days after symptoms clear).<br>Maximum duration of use is 4 weeks. | • A strip of cream (about 0.5 cm long) is enough to treat an area about the size of an adult hand.<br>• Use instead of barrier/steroid preparation if rash persists and *Candida* suspected.<br>• Caution: flammable. |

**Table 2: Formulary information**

| Medication | | Legal class | Pack size | Maximum number of consultations per episode† Maximum number of episodes per year |
|---|---|---|---|---|
| **Barrier preparation** | **Zinc and castor oil ointment** | GSL | 500 g | A maximum of 2 consultations per episode. A maximum of 2 episodes per year. † Episode: one episode constitutes an appropriate number of consultations (as defined above) in which lifestyle advice or treatment is provided. Resolution of symptoms or onward referral would define the end of the episode. |
| | **White soft paraffin solid** | GSL | 500 g | |
| **Topical steroid** | **Hydrocortisone 1% cream** | POM | 15 g | |
| **Topical antifungal** | **Clotrimazole 1% cream** | P Supply via PGD | 20 g | |

### 19.6 Advice for patients and carers[161-163]

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. Fabric that has been in contact with the products burns more easily and there is a risk of severe burns and serious fire hazard.

Nappy rash usually clears up after about 2-4 days and can usually be prevented, if you follow this advice:

- make sure the 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 daily – but avoid bathing more than twice a day as this may dry out the skin
- do not use soap, bubble bath, or lotions
- dry the nappy area gently after washing – pat dry and avoid vigorous rubbing
- leave the nappy off for as long and as often as you can to let fresh air get to the skin
- do not use talcum powder as it contains ingredients that could irritate the skin
- avoid using tight fitting plastic pants over nappies as this can worsen nappy rash by keeping in moisture

If you feel the nappy rash is not improving, or is getting worse, despite lifestyle and/or advised treatment, please make an appointment to discuss with your child's GP.

## 20.0 Oral thrush

This monograph supports the management of oral thrush in individuals over 4 weeks of age with known risk factors for developing the infection.

### 20.1 About the ailment[164,165]

Oral thrush (also known as oral candidiasis) is a yeast infection caused by *Candida*. Colonisation with candida is usually asymptomatic but when mucosal barriers are disrupted, or defences lowered an overgrowth of candida can lead to infection. It is not usually contagious and can generally be cleared easily with treatment.

Signs and symptoms in children and adults include:

- white or yellow spots or plaques in the mouth that can be wiped off, leaving behind red patches that may bleed but are not usually painful
- generalised erythema which may be asymptomatic or feel sore, burn or itch – most common presentation when caused by antibiotic or steroid treatment
- change in taste
- angular cheilitis
- denture stomatitis

Signs and symptoms in babies include:

- white coating on tongue (may look like cottage cheese) that does not easily rub off
- drooling or difficulty feeding

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

- babies and the elderly (due to immature or weakened immune systems)
- people who wear dentures or have poor dental hygiene
- immunocompromised people or people with poor health
- recent antibiotic or steroid treatment
- diabetes mellitus
- excessive mouthwash use
- poor diet and nutritional deficiency including lack of iron, folate or vitamin B12
- smokers

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

### 20.2 Possible complications[164,166]

- Chronic pain or discomfort.
- Nappy rash in babies caused by spread of candida – refer to CAS nappy rash monograph.
- Spread of candida from mouth of breastfeeding baby to nipple of breastfeeding woman (causing nipple and/or breast thrush which can be painful).
- Impaired speech.
- Impaired eating / chewing limiting oral intake.
- Immunocompromised individuals may develop:
    - oesophageal candidiasis, causing painful or difficult swallowing
    - invasive / systemic candidiasis (which has a high mortality rate)

### 20.3 When to refer[164,167]

Pharmacists should utilise local knowledge and refer individuals as necessary to the most appropriate clinician (A&E, GP, dentist, 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** |
|---|
| • Extensive, severe infection such as oesophageal candidiasis, characterised by:<br>  ○ new onset difficulty or pain on swallowing<br>  ○ retrosternal pain<br>  ○ systemically unwell |

| **Intermediate Risk - Amber – Action: Refer the individual to most appropriate clinician (GP, dentist or other clinician) that avoids delay in diagnosis and treatment** |
|---|
| • Diagnostic uncertainty.<br>• Babies under 4 weeks of age.<br>• Children under 16 years who are immunocompromised.<br>• Symptoms not resolved after 7 days of treatment.<br>• No obvious risk factor (see: ‘About the ailment’ section).<br>• Possible severe immunocompromise (e.g. due to chemotherapy or HIV).<br>• Single red, red and white or white plaques that cannot be rubbed off may be pre-malignant – refer urgently to a dentist.<br>• Women breastfeeding a baby with oral thrush when there is concern the woman may have nipple thrush (new onset pain in both nipples or breasts after feeding.<br>• Individuals taking DMARDs (can be treated, but also refer to check for severe immunosuppression). |

| Low risk - Green – Action: Treatment can be provided if appropriate AND advise the individual to see a GP for routine assessment. |
|---|
| • Recurrent episodes of oral thrush (as in line with table 2).<br>• Diabetes – review of diabetic control advised. |

### 20.4 Overview of treatment[164]

Topical antifungals can be used to treat oral thrush. Miconazole gel should be used first line if it is suitable for the individual and the product is available.

### 20.5 Treatments[1,164]

**Table 1: Topical antifungals**

| Medication | Dose | | Considerations |
|---|---|---|---|
| **Miconazole 20 mg/g oromucosal gel sugar free** | Infants aged 4 to 23 months (see PGD) | 1.25 mL (1/4 measuring spoon) of gel to be applied to the affected area(s) FOUR TIMES DAILY after meals for up to 7 days (or until symptoms resolve if sooner) and then for a further 7 days.<br>**Maximum duration of use: 14 days** | • From 4 months onwards, provided swallowing reflex sufficiently developed.<br>• From 5-6 months onwards if born pre-term.<br>• Not for use during pregnancy.<br>• Use with caution in breastfeeding. |
| | Adults and children aged 2 years and over (see PGD) | 2.5 mL (1/2 measuring spoon) of gel to be applied to the affected area(s) FOUR TIMES DAILY after meals for up to 7 days (or until symptoms resolve if sooner) and then for a further 7 days.<br>**Maximum duration of use: 14 days** | |
| **Nystatin oral suspension 100,000 units/mL** | Infants aged over 4 weeks, children and adults (see PGD) | 1 mL to be dropped into the mouth FOUR TIMES DAILY for up to 7 days (or until symptoms resolve if sooner) and then for a further 2 days.<br>**Maximum duration of use: 9 days** | • Suitable for use during pregnancy and breastfeeding. |

**Table 2: Formulary information**

| Medication | Legal class | Pack size | Maximum number of consultations per episode† Maximum number of episodes per year |
|---|---|---|---|
| **Miconazole 20 mg/g oromucosal gel sugar free** | POM | 80 g | A maximum of 1 consultation per episode.<br>A maximum of 2 episodes per year.<br>(episodes must be 6 months apart)<br><br>† 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. |
| **Nystatin oral suspension 100,000 units/mL** | POM | 30 mL | |

### 20.6 Advice for patients[99,164,165]

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

**Treatment**

- Try to ensure treatment is kept in the mouth for as long as possible – avoid swallowing immediately.
- Administer after food or drink.
- 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. using denture fixative agents), and removed at night / for at least 6 hours daily.
- Clean and disinfect dentures daily and allow to air dry to help kill residual candida.
- Brush gums and tongue with a soft toothbrush if no teeth.
- 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 1 week, please make an appointment to discuss with your GP.

## 21.0 Scabies

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

### 21.1 About the ailment[168-172]

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

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

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

### 21.2 Possible complications[173]

Scabies infestation may lead to:

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

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

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

### 21.4 Overview of treatment[174,175]

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

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

## 21.5 Treatments[1,49,174-180]

**Table 1. Scabicide**

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

**Table 2. Medication to treat itch**

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

**Table 3. Formulary information**

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

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

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

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

**Treatment information**

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

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

**Decontamination and reducing transmission risk**

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

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

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

## 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[29,181-186]

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[182,187-191]

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[29,182,185-187,189,191-198]

**High risk - Red**

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**

**Intermediate risk – Amber**

- 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.

**Low risk – Green**

- 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[1,182,191,199,200]

**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**<br>Scoring criteria developed in a UK primary care setting in 2013 | **Can be used in adults and children aged over 15 years**<br>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:<br>1. **FEVER** in the last 24 hours<br>2. **P**urulent tonsils<br>3. **A**ttend rapidly (patient attended within 3 days of the onset of symptoms)<br>4. **I**nflamed tonsils (severe)<br>5. **N**o cough or coryza<br><br>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:<br>1. tonsillar exudate<br>2. tender anterior cervical lymph nodes or lymphadenitis<br>3. absence of cough<br>4. history of fever (over 38ºC)<br><br>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**<br>➢ Excluded from PGD for antibiotic supply. Advise that antibiotics are not needed. Do not offer RADT.<br>➢ Refer to the "Advice for Patients" section below.<br>**Score of 2 or 3**<br>➢ Consider if the patient is likely to benefit from antibiotic treatment and, where this is the case, carry out a RADT.<br>➢ 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).<br>**Score of 2 or 3 with a POSITIVE RADT result for Strep A**<br>➢ 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).<br>• 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**<br>➢ Excluded from PGD for antibiotic supply. Advise that antibiotics are not needed. Do not offer RADT.<br>➢ Refer to the "Advice for Patients" section below.<br><br>**Score of 3 or 4 with a POSITIVE RADT result for Strep A**<br>➢ If the person is systemically very unwell or showing signs of a more serious condition or at high risk of complications:<br>• check referral criteria and refer immediately as appropriate.<br>➢ If the person is **not** systemically very unwell; **not** showing signs of a more serious condition; and **not** at high risk of complications:<br>• consider supplying antibiotic immediately |

| | | |
|---|---|---|
| | • Advise seeking advice from GP or A&E if the person becomes systemically very unwell.<br>• Refer to the "Advice for patients" section below.<br>➢ 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.<br>• Advise the person (if practical) to return to the pharmacy if symptoms fail to improve over the next 48 hours for reassessment.<br>• Advise seeking advice from GP or A&E if the person becomes systemically very unwell.<br>• Refer to the "Advice for patients" section below.<br>**Score of 4 or 5, with a POSITIVE RADT result for Strep A**<br>➢ If the person is systemically very unwell or showing signs of a more serious condition or at high risk of complications:<br>• check referral criteria and refer immediately as appropriate.<br>➢ If the person is **not** systemically very unwell; **not** showing signs of a more serious condition; and **not** at high risk of complications:<br>• 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.<br>• 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.<br>○ Advise the person (if practical) to return to the pharmacy if symptoms fail to improve over the next 48 hours for reassessment.<br>○ Advise seeking advice from GP or A&E if the person becomes systemically very unwell.<br>○ Refer to the "Advice for patients" section below.<br>**Negative RADT tests**<br>➢ 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.<br>➢ Consider if symptom relief is needed – refer to "symptom relief" section above.<br>➢ If their symptoms worsen, or new symptoms develop, return for assessment.<br>➢ Advise seeking advice from GP or A&E if the person becomes systemically very unwell.<br>➢ 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.<br>• 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.<br>○ Advise the person (if practical) to return to the pharmacy if symptoms fail to improve over the next 48 hours for reassessment.<br>○ Advise seeking advice from GP or A&E if the person becomes systemically very unwell.<br>○ Refer to the "Advice for patients" section below.<br>**Negative RADT tests**<br>➢ 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.<br>➢ Consider if symptom relief is needed – refer to "symptom relief" section above.<br>➢ If their symptoms worsen, or new symptoms develop, return for assessment.<br>➢ Advise seeking advice from GP or A&E if the person becomes systemically very unwell.<br>➢ Refer to the "Advice for patients" section below. |

## 22.5 Treatments[1,182,191,201-210]

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

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

<table>
<tr><th>Medication</th><th>Children aged 5 years</th><th>Children aged 6-11 years</th><th>Adults and children aged 12 years and over</th><th>Considerations<br>(see PGDs for full details on exclusions, cautions, side effects)</th></tr>
<tr><td>Phenoxymethylpenicillin<br><br>250 mg tablets<br>125 mg / 5 mL oral solution or sugar free<br>250 mg / 5 mL oral solution or sugar free</td><td>125 mg FOUR times daily for TEN days<br>OR<br>250 mg TWICE daily for TEN days</td><td>250 mg FOUR times daily for TEN days<br>OR<br>500 mg TWICE daily for TEN days</td><td>500 mg FOUR times daily for TEN days<br>OR<br>1000 mg TWICE daily for TEN days</td><td>• First line if no penicillin allergy.<br>• Swallow tablets whole with water.<br>• Take on an empty stomach (an hour before food or 2 hours after food).<br>• Use liquid formulation in swallowing difficulty.<br>• Suitable for pregnancy or breastfeeding.</td></tr>
<tr><td rowspan="2">Amoxicillin<br><br>250 mg capsules<br>500 mg capsules<br>250 mg / 5 mL oral suspension or sugar free<br>500 mg / 5 mL oral suspension or sugar free</td><td colspan="4">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.</td></tr>
<tr><td>500 mg THREE times daily for TEN days</td><td>500 mg THREE times daily for TEN days</td><td>500 mg THREE times daily for TEN days</td><td>• First line if phenoxymethylpenicillin unavailable AND no penicillin allergy.<br>• Note that individuals, particularly adolescents with concurrent infection with glandular fever/Epstein-Barr virus (EBV) have an increased frequency of amoxicillin associated skin rashes.<br>• Use liquid formulation in swallowing difficulty.<br>• Suitable for pregnancy or breastfeeding.</td></tr>
<tr><td>Clarithromycin<br><br>250 mg tablets<br>500 mg tablets<br>125 mg / 5 mL oral suspension<br>250 mg / 5 mL oral suspension</td><td colspan="2">Dose is based on body weight if under 40kg.<br><br>For FIVE days<br><br>12-19 kg: 125 mg TWICE daily<br>20-29 kg: 187.5 mg TWICE daily<br>30-40 kg: 250 mg TWICE daily</td><td>500 mg TWICE daily for FIVE days</td><td>• First line in penicillin allergy. It can be used if other first line treatment unavailable.<br>• First line in penicillin allergy AND breastfeeding.<br>• Not suitable for pregnancy.<br>• Swallow tablets whole with water.<br>• Can be taken with or after food.<br>• Nausea, vomiting, abdominal discomfort, and diarrhoea are the most common adverse effects of macrolides.</td></tr>
</table>

| 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.<br>• Tablets not suitable for children under 12 years of age. |
| **Erythromycin**<br>**250 mg tablets**<br><br>**Erythromycin ethyl succinate**<br>**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<br><br>**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.**<br>• It can be used if other first line treatment unavailable.<br>• **Second line in penicillin allergy AND breastfeeding.**<br>• Tablets not suitable for children less than 8 years old, oral suspension is recommended.<br>• Swallow tablets whole with water.<br>• Can be taken with or after food.<br>• Nausea, vomiting, abdominal discomfort, and diarrhoea are the most common adverse effects of macrolides. |

**Table 5: Formulary information**

| Medication | Legal class | Pack size | Quantity to supply per consultation | Maximum number of consultations per episode† and Maximum number of episodes per year |
|---|---|---|---|---|
| **Paracetamol 120 mg in 5 mL sugar free oral suspension** | P | 100 mL | 1 | **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**<br>See the latest good practice guidance for back up antibiotic prescribing.<br>**A maximum of 2 episodes in 6 months**<br>† 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.<br>#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. |
| **Paracetamol 250 mg in 5 mL sugar free oral suspension** | P | 200 mL | 1 | |
| **Paracetamol 500 mg tablets** | P | 32 | 1 | |
| **Ibuprofen 100 mg in 5 mL sugar free oral suspension** | P | 100 mL | 1 | |
| **Ibuprofen 200 mg tablets** | P | 24 | 1 | |
| **Ibuprofen 400 mg tablets** | P | 24 | 1 | |
| **Phenoxymethylpenicillin 125 mg / 5 mL oral solution or sugar free** | POM | 100mL | For 10 days | |
| **Phenoxymethylpenicillin 250 mg / 5 mL oral solution or sugar free** | POM | 100 mL | For 10 days | |
| **Phenoxymethylpenicillin 250 mg tablets** | POM | 28 | 40 or 80 | |
| **#Amoxicillin 250 mg / 5 mL oral suspension or sugar free** | POM | 100 mL | For 10 days | |
| **#Amoxicillin 500 mg / 5 mL oral suspension or sugar free** | POM | 100 mL | For 10 days | |
| **#Amoxicillin 250 mg capsules** | POM | 21 | 60 | |
| **#Amoxicillin 500 mg capsules** | POM | 21 | 30 | |
| **Clarithromycin 125 mg / 5 mL oral suspension** | POM | 70 mL | For 5 days | |
| **Clarithromycin 250 mg / 5ml oral suspension** | POM | 70 mL | For 5 days | |
| **Clarithromycin 250 mg tablets** | POM | 14 | For 5 days | |
| **Clarithromycin 500 mg tablets** | POM | 14 | 10 | |
| **Erythromycin ethyl succinate 250 mg / 5mL oral suspension or sugar free** | POM | 100 mL | For 5 days | |
| **Erythromycin 250 mg gastro resistant tablets** | POM | 28 | 40 | |

### 22.6 Advice for patients[182-184,192-195,198,211-213]

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:**

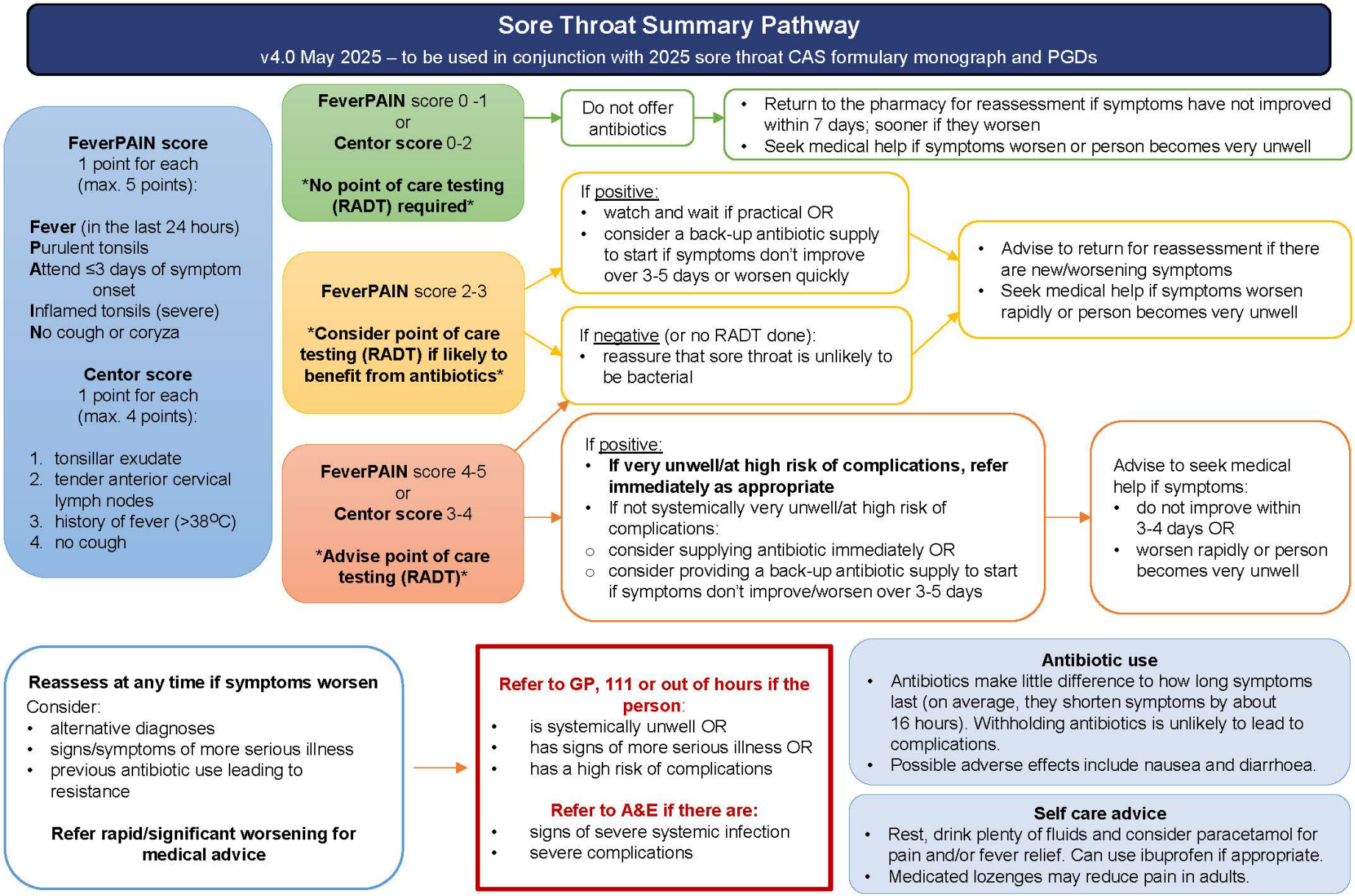
- Some people may find medicated lozenges containing a local anaesthetic, NSAID or antiseptic useful.
- Benzydamine gargles or spray are NOT available through CAS as there is little evidence for their effectiveness for pain relief in sore throat.
- There is no evidence for zinc lozenges, herbal remedies 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:**

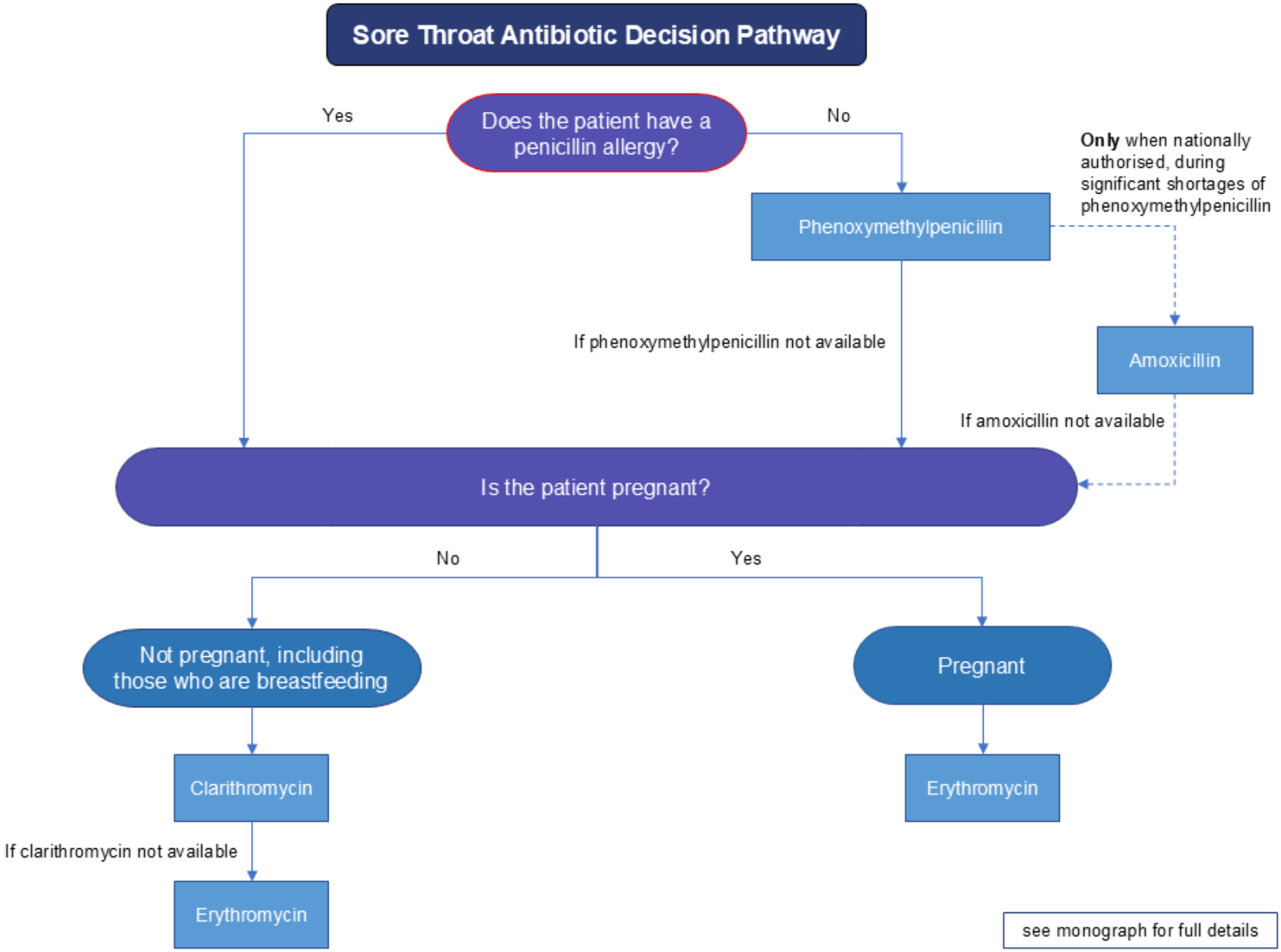
- Rest and take simple painkillers at regular intervals to relieve pain and fever.
- Avoid smoking and smoky environments.
- If you have a high temperature or you do not feel well enough to do your normal activities, try to stay at home and avoid contact with other people until you feel better.
- Drink 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
If phenoxymethylpenicillin not available
Amoxicillin
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

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

### 23.1 About the ailment[214,215]

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

Signs and symptoms include:

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

### 23.2 Possible complications[214]

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

### 23.3 When to refer[214,215]

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

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

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

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

### 23.4 Overview of treatment[214,216]

Self-care measures should be tried in the first instance (see section 23.6).
Oral simple analgesia can be taken if needed. Monotherapy with a full therapeutic dose of paracetamol **OR** ibuprofen alone is usually suitable first line. If the response is inadequate, switching analgesics should be considered before trying dual therapy (for individuals under 16 years of age, “dual therapy” means alternating between the two analgesics rather than taking both at the same time).

## 23.5 Treatments[39,214]

### Table 1: Pain relief for pain associated with teething

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

**Table 2: Formulary information**

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

### 23.6 Advice for patients[214-216]

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

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

**Self-care measures**

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

**Dental care**

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

**Medication for symptom relief**

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

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

# 24.0 Threadworms

## 24.1 About the ailment[217,218]

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[217]

- 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[217]

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



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

### 24.4 Overview of treatment[217,218]

- 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[19,217-222]

**Table 1: Anthelmintic**

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

**Table 2: Formulary information**

| Medication | Legal class | Pack size | Maximum number of consultations per episode† Maximum number of episodes per year |
|---|---|---|---|
| **Mebendazole 100 mg chewable tablets sugar free** | POM | Maximum 2 x 100mg tablets (from splitting a pack of 6 tablets) | A maximum of 1 consultation per episode.<br>A maximum of 2 episodes per year.<br><br>† 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. |
| **Mebendazole 100 mg / 5 mL oral suspension** | POM | 30 mL | |

### 24.6 Advice for patients[217,218,222]

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[223]

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[223]

- 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[64,223-226]

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.<br>• Severe symptoms, getting worse quickly, signs of sepsis or systemically very unwell/severe pain.<br>• Confusion, drowsiness or slurred speech.<br>• Systemically unwell and at risk of immunosuppression.<br>• Skin changes – very cold, or a strange colour or rash develop.<br>• Presence of blood clots in urine along with struggling to pass urine.<br>• 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:<br>  ○ genital symptoms - dryness, burning or irritation of the vulva or vagina, vulvovaginal atrophy.<br>  ○ sexual symptoms - lack of lubrication (including during sexual activity), discomfort/pain (including during sexual activity), post-coital bleeding, impaired function (decreased arousal, orgasm, desire).<br>  ○ urinary symptoms - urgency, dysuria and recurrent UTI.<br>• Vaginal or urethral discharge, irritation, itch or skin rash not associated with vulvovaginal candidiasis (signpost to a sexual health clinic if appropriate).<br>• 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[223,227]

- **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[64,223,228]

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

| Medication | Dose | Considerations |
|---|---|---|
| **Ibuprofen**<br>**100 mg / 5 mL sugar free oral suspension**<br>**200 mg tablets**<br>**400 mg tablets** | **Adults and Children 16 years and over:** 200-400 mg THREE times daily | • Take with or after food.<br>• Caution in asthma.<br>• Contraindications to NSAIDs include: heart failure, hypertension, ischaemic heart disease, peripheral arterial disease, cerebrovascular disease, renal impairment and peptic ulceration.<br>• NSAIDs with low dose aspirin may increase the risk of gastrointestinal side effects; avoid if possible.<br>• If gastro-protection is required, consider supplying paracetamol instead.<br>• Avoid with warfarin or anticoagulants. |
| **Paracetamol**<br>**120 mg / 5 mL sugar free oral suspension**<br>**250 mg / 5 mL sugar free oral suspension**<br>**500 mg tablets** | **Child 16 -17 years:** 0.5-1 g every 4-6 hours MAXIMUM 4 doses in 24 hours<br><br>**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.<br>• 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**<br>**100 mg modified-release capsules** | 100 mg TWICE daily (every 12 hours) for THREE days | • Swallow capsules whole with water.<br>• Take with or just after food, or a meal.<br>• May discolour the urine (dark yellow or brown colour). |
| **Trimethoprim**<br>**200 mg tablets**<br>**50 mg / 5 mL oral suspension sugar free** | 200 mg TWICE daily (every 12 hours) for THREE days | • Swallow tablets whole with water.<br>• Use liquid formulation in swallowing difficulty.<br>• Suitable for breastfeeding. |

**Table 4: Formulary information**

| Medication | Legal class | Pack size | Quantity to supply per consultation | Maximum number of consultations per episode† and Maximum number of episodes per year |
|---|---|---|---|---|
| **Ibuprofen 100 mg in 5 mL sugar free oral suspension** | P | 100 mL | 1 | **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**<br>See the latest good practice guidance for back up antibiotic prescribing.<br>**A maximum of 1 episode in a 6-month period or 2 episodes in a 12-month period**<br>† Episode: one episode constitutes an appropriate number of consultations (as defined above) in which lifestyle advice or treatment is provided. Resolution of symptoms or onward referral would define the end of the episode. |
| **Ibuprofen 200 mg tablets** | P | 24 | 1 | |
| **Ibuprofen 400 mg tablets** | P | 24 | 1 | |
| **Paracetamol 120 mg in 5 mL sugar free oral suspension** | P | 100 mL | 1 | |
| **Paracetamol 250 mg in 5 mL sugar free oral suspension** | P | 200 mL | 1 | |
| **Paracetamol 500 mg tablets** | P | 32 | 1 | |
| **Nitrofurantoin 100 mg modified-release capsules** | POM | 6 | For 3 days | |
| **Trimethoprim 200 mg tablets** | POM | 6 | For 3 days | |
| **Trimethoprim 50 mg / 5 mL oral suspension sugar free** | POM | 100 mL | For 3 days | |

## 25.6 Advice for patients[223,226,228-230]

### 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**

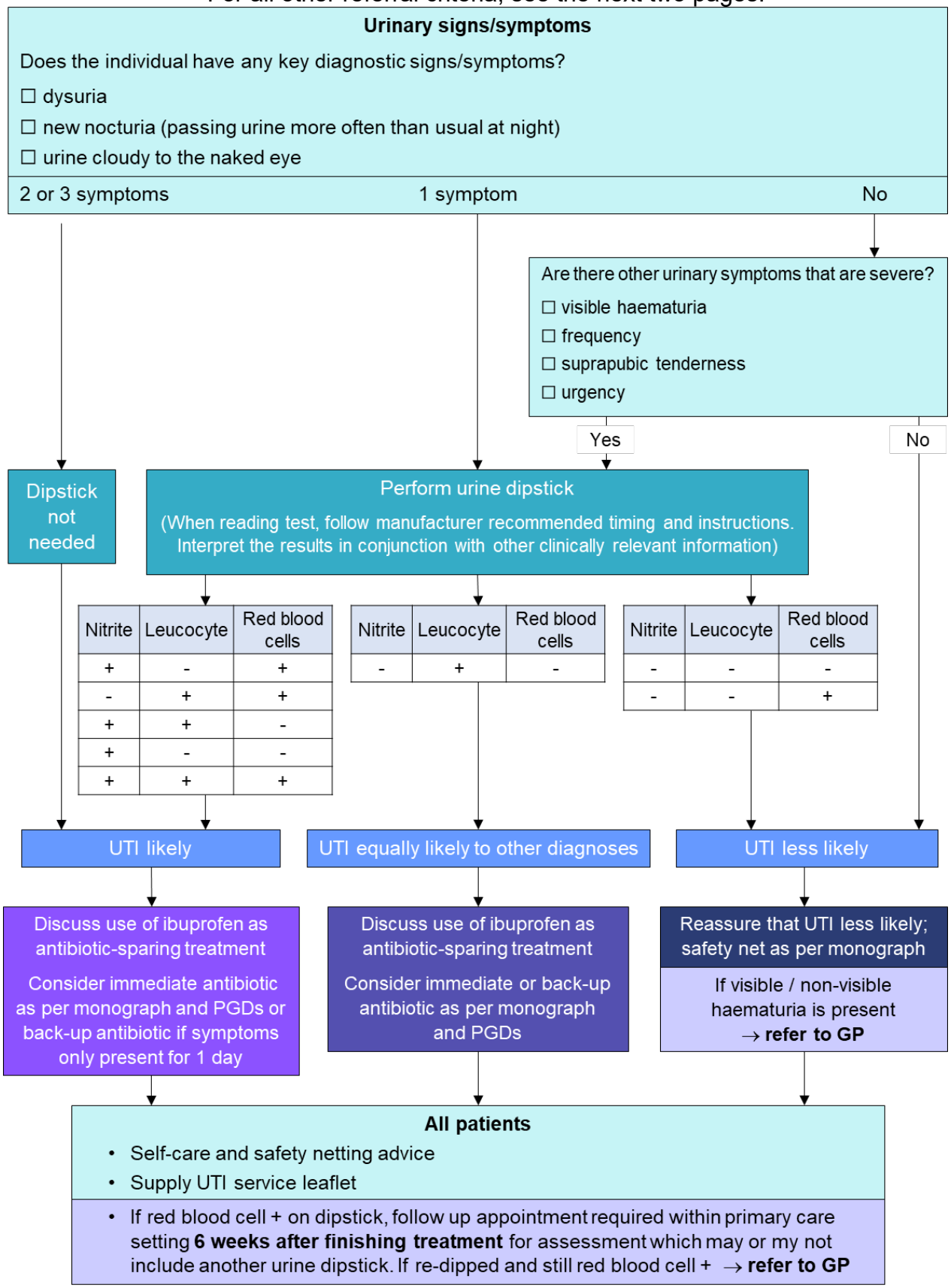
Antibiotics (nitrofurantoin, trimethoprim)

- 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:
  - genital symptoms - dryness, burning or irritation of the vulva or vagina, vulvovaginal atrophy.
  - sexual symptoms - lack of lubrication (including during sexual activity), discomfort/pain (including during sexual activity), post-coital bleeding, impaired function (decreased arousal, orgasm, desire).
  - 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 thrush

This monograph supports the management of vulvovaginal thrush in individuals between 16 and 60 years of age, including pregnant women.

## 26.1 About the ailment[231,232]

Vulvovaginal thrush (genital candidiasis) is a symptomatic inflammation of the vagina and/or vulva caused by a superficial fungal infection, usually *Candida albicans*.

Common symptoms include:

- vulval and/or vaginal itching and irritation
- a white, non-malodorous, vaginal discharge
- soreness and stinging during sex or urination

## 26.2 Possible complications[231]

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.

Candida infection can be spread to male partners causing erythematous areas on the glans area of the penis, itching and/or irritation.

### 26.3 When to refer[231,232]

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

- Individuals who are systemically unwell – refer for same day assessment.
- Abdominal pain, a foul-smelling or coloured discharge, increased urinary frequency or abnormal vaginal bleeding– refer for same day assessment.
- Uncertain diagnosis e.g. patient has had a previous sexually transmitted infection and it may have returned, vaginal discharge without itching unlikely to be caused by fungal infection.
- Vulval or vaginal ulcers, blisters or sores.
- Severe infection (symptoms include erythema, vaginal fissuring and/or oedema, vulval excoriation).
- Recurrent infection (more than 2 symptomatic episodes in the previous 12 months).
- Suspicion of undiagnosed diabetes (e.g. increased thirst, increased urination, fatigue, unintentional weight loss) – treatment can be provided but also refer for same day assessment.
- Individuals 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.

**Low risk – Green – Action: Advise the individual to see a GP or sexual health clinician for routine assessment.**

- Symptoms have not resolved fully within 7 days of appropriate treatment.

### 26.4 Overview of treatment[231]

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 pessary as a single dose in non-pregnant individuals and for 7 days during pregnancy (if oral therapy is contraindicated).
- **3rd line:** clotrimazole 10% cream as a single dose at night in non-pregnant individuals and for 7 days during pregnancy (if 1st or 2nd line therapy contraindicated or not tolerated).
- If there are vulval symptoms, consider topical clotrimazole 1% cream in addition to a 1st, 2nd or 3rd line option.

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

## 26.5 Treatments[39,231]

### Table 1: Antifungals

| Medication | Individuals who are not pregnant | During pregnancy | Considerations |
|---|---|---|---|
| **Fluconazole 150 mg capsules** | ONE capsule as a single dose<br>(see PGD) | Avoid | • Not suitable while breastfeeding.<br>• Swallow capsule whole. |
| **Clotrimazole 500 mg pessaries** | Insert ONE pessary into the vagina at night as a single dose using the applicator<br>(see PGD) | Insert ONE pessary into the vagina at night for 7 nights. Manually insert, do not use the applicator<br>(see PGD) | • Suitable for use while breastfeeding.<br>• Insert as high into the vagina as possible.<br>• Can damage latex contraceptives and inactivate spermicidal contraceptives.<br>• Avoid during menstrual period (unless only mild spotting). |
| **Clotrimazole 10% vaginal cream** | ONE applicatorful to be inserted into the vagina at night for a single dose<br>(see PGD) | ONE applicatorful to be inserted into the vagina at night for 7 nights<br>(see PGD) | • Only supply if pessary is not suitable.<br>• Suitable for use while breastfeeding.<br>• Can damage latex contraceptives and inactivate spermicidal contraceptives.<br>• Avoid during menstrual period (unless only mild spotting). |
| **Clotrimazole 1% cream** | Apply thinly to the affected area TWO to THREE times a day for maximum of 14 days<br>(see PGD) | Apply thinly to the affected area TWO to THREE times a day for maximum of 14 days<br>(see PGD) | • Suitable for use while breastfeeding.<br>• May cause local irritation.<br>• Can damage latex contraceptives and inactivate spermicidal contraceptives. |

**Table 2: Formulary information**

| Medication | Legal class | Pack size | Maximum number of consultations per episode† Maximum number of episodes per year |
|---|---|---|---|
| **Fluconazole 150 mg capsules** | POM | 1 | A maximum of 2 consultations per episode. 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 or sexual health clinician.<br><br>A maximum of 2 episodes per year. (only supply a second treatment if the first episode resolved within 2 weeks)<br><br>† 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. |
| **Clotrimazole 500 mg pessaries** | POM | 1 | |
| **Clotrimazole 10% vaginal cream** | POM | 5 g | |
| **Clotrimazole 1% cream** | P (supply via PGD) | 20 g | |

### 26.6 Advice for patients[231,233,234]

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 or unscented soap, to clean or moisturise the vulval area, and dry properly
- avoid potential irritants in toiletries (including scented 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
- if using a pessary or intra-vaginal cream, avoid treatment during the menstrual period (unless there is only mild spotting) 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

- 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; if vaginal intercourse takes place, condoms are recommended to prevent infection being transferred
- latex contraceptives such as condoms or diaphragms may be damaged by topical thrush treatment and may not be effective; additional precautions should be used during treatment and for at least five days after using these products
- avoid use of complementary therapies such as application of yoghurt, topical or oral probiotics, and tea tree or other essential oils
- clotrimazole 1% cream is flammable: keep your body away from fire or flames after you have put on the cream
- see GP or sexual health clinician if symptoms not resolved within 7 days
- If appropriate, individuals can order free home testing kits for sexually transmitted infections from Public Health Wales - https://phw.nhs.wales/topic/sexual-and-reproductive-health/ or collect from a participating community pharmacy.

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

## 27.0 Warts and verrucae

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

### 27.1 About the ailment[235]

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

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

### 27.2 Possible complications[235]

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

### 27.3 When to refer[235]

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

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

| Low risk - Green - Advise the individual to see a GP for routine assessment. |
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| • If warts are unresponsive to salicylic acid after 12 weeks. |

### 27.4 Overview of treatment[235]

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

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

### Salicylic acid limitations

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

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

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

## 27.5 Treatments[235-241]

**Table 1: Treatment options for warts/verrucae**

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

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

**Table 2: Formulary information**

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

### 27.6 Advice for patients[235-239,242]

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

**Treatment considerations with salicylic acid**

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

**Lifestyle measures**

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

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

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

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

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

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| 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 |
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| August 2023 | Original guidelines document published. |
| December 2023 | The following section has been updated to align with the latest NICE Clinical Knowledge Summary advice:<br>• 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:<br>• Athlete's Foot & Ringworm monographs have been updated to align with the Terbinafine 1% cream PGD.<br>• Dry eye monograph has been updated to include Evolve® carbomer 980 gel (preservative free) as a treatment option.<br>• 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:<br>• Constipation monograph has been updated to reflect the correct name for Macrogol in the dictionary of medicines and devices.<br>• 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:<br>• 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.<br>• 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, |

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| | non-complicated, 16 – 64 years; not pregnant or catheterised) monographs:<br>• Sore throat - minor layout change made to 'Sore throat antibiotic decision pathway' to improve clarity.<br>• 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:<br>• 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.<br>• 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.<br>• 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.<br>• 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).<br>• Threadworm monograph has been updated to align with NICE CKS advice for threadworm. |
| July 2026 | Updates to Acne vulgaris, Athletes foot, Chickenpox, Dry eye, Dry skin, Fungal skin infections, Haemorrhoids, Head lice, Ingrowing toenail, Nappy rash, Oral Thrush and Vulvovaginal thrush.<br><br>• Acne vulgaris monograph has been updated to align with NICE CKS advice. Adapalene 0.1% / benzoyl peroxide 2.5% gel, Adapalene 0.3% / benzoyl peroxide 2.5% gel and Clindamycin 1% / tretinoin 0.025% gel have been added as treatment options.<br>• Athlete's foot monograph has been updated to align with NICE CKS advice. Treatment recommendations have been updated, with terbinafine 1% cream moved to first line and clotrimazole 1% and miconazole 2% included as second-line options. |

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

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