PrescQIPP Community Interest Company

Dermatology specials (SPOT-List)

In England and Wales almost £1 million is spent annually on specials dermatology products. Of these £828,672 is for items that are not recommended for prescribing by the British Association of Dermatologists (BAD) with an average cost per item of £168 (range £1 to £1,183). This bulletin discusses the prescribing of dermatology specials products and offers advice on alternatives for treatment and appropriate review of treatment.

Recommendations

- Use a licensed product wherever available. Consider cost versus benefit of a licensed preparation versus an unlicensed preparation. If an unlicensed topical preparation is required, consider only those listed on the BAD list.
- Rationalise strengths of treatment prescribed and do not prescribe any formulation not recommended in the BAD specials list
- Develop a local formulary with dermatologists that lists the specials that can/will be prescribed locally and the circumstances under which these should be prescribed.
- Communicate with community pharmacists about which specials are on the local formulary and advise where they can be ordered at a reasonable cost.
- Prescribe proprietary products by brand (especially those with a complicated formula) to ensure the correct product is dispensed and a special is not inadvertently ordered.
- If a special is required, consider regular reviews for ongoing need.
- Consider whether it is appropriate locally to commission a service where prescribing of specials will remain with the specialist- this may be less costly option overall.
- If the GP is to prescribe, do not put the special onto a repeat prescription, and ensure that the condition is reviewed regularly.
- Review all patients that are on non-approved formulations and assess whether there is a continued need for prescribing and whether patients should be on these formulations long term.
- If prescribing specials, prescribe appropriate quantities, as expiry dates are likely to be short for these unlicensed specials products.

Background

Until 2008 when the cost of specials in primary care began to rise sharply (to £120m in England in 2009/10, of which up to £30m was topical medicines), the use of specials in primary care attracted little attention.[1] Initial attempts by PCT medicines management teams to investigate the increasing costs were hampered by a lack of data.[1] Although steadily improving, detailed data on the range of dermatology specials prescribed by GPs remains poor with many of these products being processed as unspecified specials. We have not included data on unspecified specials within this bulletin.[1]

The BAD was concerned that, despite their previously recommended list of 106 Specials (2008), slight differences in prescribing preferences were resulting in many slightly different products being used (see table 1).[1] This variety was making specials more difficult for patients to access and led to increasing costs.[1]

Even in secondary care, where formulary control is well established and prescribing is consultant-led, NHS hospital pharmacy manufacturing units manufacture a wide range of products and routinely make at least 95 different products containing coal tar and 75 containing dithranol.[1]

Table 1: Variety of specials routinely manufactured in NHS hospitals in 2012 vs number recommended on the BAD list in 2008

Primary active ingredient	Number of products routinely manufactured by hospital in 2012	Number of products recommended on BAD List (2008)
Tar	95	27
Dithranol	75	22
Salicylic acid	123	18
Steroid	31	7

Evidence

See the PrescQIPP dermatology webkit for resources on the use of licensed topical treatments for dermatological conditions: https://www.prescqipp.info/dermatology/projects/dermatology-webkit

Specials recommended by the British Association of Dermatologists (BAD) for skin disease

The BAD list was produced as common dermatological conditions such as psoriasis and eczema had a wide range of unlicensed products and strengths being prescribed to treat them and the BAD felt that these needed to be rationalised. This was of particular concern in primary care where lack of effective price controls and a mechanism to ensure independent scrutiny of product quality led to increased costs and concern about standards

Licensed medicines are the preferred treatment option, but in some cases the range of licensed products is limited and there may not be a licensed formulation available that meets the needs of an individual patient.

The BAD set up a Specials Working Group in 2013 which included representatives of the Department of Health, Clinical Reference Groups, Clinical Commissioning Groups, the Royal College of General Practitioners, the Primary Care Dermatology Society, the Royal Pharmaceutical Society and consultant dermatologists.[1] This group came together to create a prescribing guide of what unlicensed creams they felt were reasonable for specific dermatology indications; in most cases these products were for the treatment of eczema and psoriasis. The working group also suggested appropriate volumes of these products that should be prescribed. It is hoped that adherence to this new BAD Specials 2014 prescribing list will allow patients easier access to appropriate treatments, at a lower cost to the NHS.[1]

Eczema

Management of eczema involves the removal or treatment of contributory factors including occupational and domestic irritants. Known or suspected contact allergens should be avoided. Rarely, ingredients in topical medicinal products may sensitise the skin; the BNF lists active ingredients together with excipients that have been associated with skin sensitisation.[2] If treatment products are unsuitable for a patient as they contain an ingredient the patient is sensitive to and no other alternative is available, then a special may be required.

Skin dryness and the consequent irritant eczema require emollients applied regularly (at least twice daily) and liberally to the affected area; this can be supplemented with bath or shower emollients. The use of emollients should continue even if the eczema improves or if other treatment is being used.[2]

Topical corticosteroids are also required in the management of eczema; the potency of the corticosteroid should be appropriate to the severity and site of the condition. Mild corticosteroids are generally used on the face and on flexures; potent corticosteroids are generally required for use on adults with discoid or lichenified eczema or with eczema on the scalp, limbs, and trunk. Treatment should be reviewed regularly, especially if a potent corticosteroid is required. In patients with frequent flares (2–3 per month), a topical corticosteroid can be applied on two consecutive days each week to prevent further flares.

Bandages (including those containing ichthammol with zinc oxide) are sometimes applied over topical corticosteroids or emollients to treat eczema of the limbs.[2]

The NICE guideline on management of atopic eczema in children suggested a stepped/matched approach, matching potency of topical corticosteroids with severity of the eczema: mild potency topical corticosteroids for mild disease, moderate potency for moderate disease and potent topical corticosteroids reserved for short term use in severe eczema.[3]

The potency should be tailored to the age of the patient, the body region being treated, and the degree to which the skin is inflamed. For delicate areas of skin, such as the face and flexures, only mild or moderately potent preparations should be used. On the face, especially in children, it is reasonable to start with mildly potent topical corticosteroids. To optimise adherence to emollient therapy, creams, lotions, ointments, or a combination can be used, depending on patient choice. Prescriptions should be reviewed regularly; patients and parents/carers of children should be educated about regularly applying emollients onto dry skin and eczematous areas even when eczema is under control.[4] Specials are sometimes needed where a suitable potency of corticosteroid is not available as a licensed product.

Psoriasis

The BNF reviews individual components and makes recommendations on their use for treatment of psoriasis:[3]

- Coal tar has anti-inflammatory properties that are useful in chronic plaque psoriasis; it also has antiscaling properties. Crude coal tar (coal tar, BP) is the most effective form, typically in a concentration of 1-10% in a soft paraffin base, but few outpatients tolerate the smell and mess. Cleaner extracts of coal tar included in proprietary preparations, are more practicable for home use but they are less effective and improvement takes longer. Contact of coal tar products with normal skin is not normally harmful and they can be used for widespread small lesions; however, irritation, contact allergy, and sterile folliculitis can occur. The milder tar extracts can be used on the face and flexures. Tar baths and tar shampoos are also helpful.
- Dithranol is effective for chronic plaque psoriasis. Its major disadvantages are irritation (for which individual susceptibility varies) and staining of skin and of clothing. It should be applied to chronic extensor plaques only, carefully avoiding normal skin. Dithranol is not generally suitable for widespread small lesions nor should it be used in the flexures or on the face. Treatment should be started with a low concentration such as dithranol 0.1%, and the strength increased gradually every few days up to 3%, according to tolerance. Proprietary preparations are more suitable for home use; they are usually washed off after five to 60 minutes ('short contact'). Specialist nurses may apply intensive treatment with dithranol paste which is covered by stockinette dressings and usually retained overnight. Dithranol should be discontinued if even a low concentration causes acute inflammation; continued use can result in the psoriasis becoming unstable. When applying dithranol, the hands should be protected by gloves or they should be washed thoroughly afterwards.
- A topical corticosteroid is not generally suitable for long term use or as the sole treatment of extensive chronic plaque psoriasis; any early improvement is not usually maintained and there is a risk of the condition deteriorating or of precipitating an unstable form of psoriasis (e.g. erythrodermic psoriasis or generalised pustular psoriasis) on withdrawal. Topical use of potent corticosteroids on widespread psoriasis can also lead to systemic as well as local side-effects. However, topical corticosteroids used short-term may be appropriate to treat psoriasis in specific sites such as the face or flexures (with a mild or moderate corticosteroid), and psoriasis of the scalp, palms, and soles

(with a potent corticosteroid). Very potent corticosteroids should only be used under specialist supervision.

Combining the use of a corticosteroid with another specific topical treatment may be beneficial in chronic plaque psoriasis; the drugs may be used separately at different times of the day or used together in a single formulation. Eczema co-existing with psoriasis may be treated with a corticosteroid, or coal tar, or both.

It is important to consider the information above, and where possible use licensed products that can be found listed in the BNF before considering a special from the BAD list. If a special is required, ensure that patient has tried and is compliant with the licensed preparations as often patients can find them unsuitable for daily use in view of the smell and texture and may not use them as prescribed. If under a dermatologist, where possible ensure patient has regular reviews of their condition and if possible/considered appropriate locally, prescribing of specials should remain with the specialist. If the prescribing is transferred to primary care, avoid putting specials on repeat prescription and ensure volume prescribed is not excessive, as often these preparations have short expiry dates.

Benefits of adhering to BAD list

The BAD is very concerned about the cost of specials in primary care.[1] They encourage GPs, dermatology nurse specialists and pharmacists to work with local clinical colleagues in primary and secondary care to encourage adoption and further development of the BAD Specials List 2014 to accurately reflect expert clinical opinion.

The BAD have developed a template letter to accompany the list which advises patients to allow sufficient time when ordering their specials and signposts pharmacists to organisations where these specials can be ordered. It is available here: http://www.bad.org.uk/healthcare-professionals/clinical-standards/specials

Costs and savings available

In England and Wales almost £1 million is spent annually on specials dermatology products. Of these £828,672 is for items that are not recommended for prescribing by the British Association of Dermatologists (BAD) with an average cost per item of £168 (range £1 to £1,183) (ePACT October to December 2016)

When looking at prescribing data, there are several variations of strengths and combinations prescribed where there could be a suitable product on the BAD list. There are also preparations being prescribed from the older 2008 list.

It would be useful to review all patients that are prescribed special/unlicensed formulations to ascertain efficacy of the specials and continued need or whether patients should be on these formulations long term. Where appropriate, consider referring patients to a specialist for a review and consider using a licensed product wherever available. If an unlicensed topical preparation is required, consider only those listed on the BAD list.

If a review of prescribing led to a 20% reduction of prescribing of specials on the BAD list (as licensed alternatives could be used), **then approximately £30,012 could be saved annually. This equates to £49.54 per 100,000 patients.**

If all specials not on the BAD approved specials list were discontinued, **this could lead to annual savings of approximately £828,000. This equates to £1,368 per 100,000 patients.**

It is difficult to quantify the spend on dermatology specials that are processed as “unspecified specials” and whether they fall into the BAD approved list. The average monthly spend on unspecified dermatology specials is £126,000 (based on January 2017 data). If this is sustanined over a full year then the total cost would be over £1.5million per year.

Reviewing this prescribing could lead to significant savings.

All savings will be offset by alternative treatments prescribed, however if licensed products these are likely to be less expensive than a special.

References

1. Buckley D, Root T & Bath S. Specials Recommended by the British Association of Dermatologists for Skin Disease. Published November 2014. Accessed via http://www.bad.org.uk/healthcare-professionals/clinical-standards/specials on 3 April 2017.
2. National Institute of Health and Care Excellence. Psoriasis: The assessment and management of psoriasis. (CG 153): October 2012. Accessed via https://www.nice.org.uk/guidance/cg153 on 3rd April 2017.
3. Joint Formulary Committee. British National Formulary (online) London: March 2017. Accessed via https://www.evidence.nhs.uk/formulary/bnf/current on 3rd April 2017

Additional PrescQIPP resources

Data pack

Available here: https://www.prescqipp.info/datahub#visual-data-packs-from-2017

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Contact help@prescqipp.info with any queries or comments related to the content of this document.

Appendix 1: What preparations are recommended on BAD list 2014

The BAD guidance published in 2014 has listed the following preparations.

http://www.bad.org.uk/shared/get-file.ashx?itemtype=document&id=1848

Product	Category	Volume to prescribe	Additional information
Propylene glycol 20% w/w in aqueous cream	Emollients	100g	Use when urea-based preparations, are ineffective, unsuitable or not tolerated
Salicylic acid 5% w/w / propylene glycol 47.5% w/w in Dermovate® Cream	Steroid combination	100g	Very potent steroid, propylene glycol increases penetration of Dermovate®. To be used for short periods (a max two weeks). Please see NICE guidance for psoriasis for more information and BAD list
Propylene glycol 40% w/w in Dermovate® cream			Very potent steroid, use for severe inflammatory disease without hyperkeratosis, or at sensitive skin sites.
Coal tar solution BP 5% w/w in betamethasone valerate 0.025% w/w ointment			Use for moderate to severe psoriasis of the trunk and limbs when other treatments such as vitamin D analogues have been ineffective. Apply directly to affected skin once or twice daily (often as a night-time treatment) for 2-4 weeks then decrease the frequency of application. Use with caution if the skin is very inflamed or if there are pustules, as tar can be an irritant.
Coal tar solution BP 3.3% w/w and propylene glycol 20% w/w in Synalar® gel			Use for very inflamed hyperkeratotic scalp psoriasis. Massage it into the affected scalp, leave for 1-3 hours then shampoo out. Best done in the evenings

Product	Category	Volume to prescribe	Additional information
Cade oil 12% w/w and salicylic acid 6% w/w in emulsifying ointment	Tars	100g	These preparations are used for moderate to severe chronic plaque psoriasis, mainly in day treatment centres at dermatology departments. Used when other topical treatments such as vitamin D analogues and commercial tar preparations have been ineffective or unsuitable. Also used where phototherapy is less effective (e.g. lower leg) or where the patient does not wish to take or is unsuitable for systemic treatment. Tar may be combined with phototherapy. Occasionally, it may be used at home; patients should be provided with detailed information and education on its use. Tars are anti-inflammatory and anti-pruritic
Coal tar BP 2% w/w in YSP			
Coal tar BP 5% w/w in YSP			
Coal tar BP 10% w/w in yellow soft paraffin (YSP)			
Coal tar scalp pomade (coal tar solution BP 6% w/w / salicylic acid 2% w/w in emulsifying ointment)			
Coal tar solution BP 6% w/w and salicylic acid 6% w/w in Ung Merc			
Ichthammol 1% w/w and zinc oxide 15% w/w in YSP	Ichthammol	100g	Ichthammol is used to treat acutely inflamed atopic eczema. It is also used in paste bandages for chronic lichenified eczema. Treatment is often initiated at dermatology day treatment centres but may be continued in the community
Dithranol in Lassar's paste 0.1% w/w	Dithranol preparations	100g	Dithranol in Lassar's paste (a combination of salicylic acid and zinc oxide) is effective in moderate to severe chronic plaque psoriasis: used when other topical treatments (vitamin D analogues, commercial tar preparations and commercial dithranol preparations, have been ineffective or unsuitable, where phototherapy is contraindicated or less effective, e.g. lower leg or where the patient does not wish to take or is unsuitable for systemic treatment. It may be combined with phototherapy. Treatment is often initiated at dermatology day treatment centres but may in some cases be continued by patients at home once they have been instructed how to use it safely. For more information see BAD.
Dithranol in Lassar's paste 0.5% w/w			
Dithranol in Lassar's paste 1% w/w			
Dithranol in Lassar's paste 2% w/w			
Dithranol in Lassar's paste 4% w/w			
Dithranol in Lassar's paste 8% w/w			
Dithranol in Lassar's paste 10% w/w			
Dithranol in Lassar's paste 15% w/w			
Dithranol pomade 0.4% w/w (dithranol 0.4% w/w, salicylic acid 2% w/w, emulsifying wax BP 25% w/w, liquid paraffin to 100%)			

Product	Category	Volume to prescribe	Additional information
Coconut oil 25% w/w in emulsifying ointment	Keratolytics	100g	Use as a scalp moisturiser and anti-inflammatory for the removal of thick scales in psoriasis, seborrhoeic dermatitis, pityriasis amiantacea and scalp atopic dermatitis, where commercial preparations have been inadequately effective. Rub firmly into scalp skin, leave overnight under a shower cap and wash out next morning.
Salicylic acid 2% w/w and sulphur 2% w/w in aqueous cream			Sulphur is antiseptic, anti-parasitic and anti-seborrhoeic; salicylic acid at lower concentrations is mildly keratolytic. Use on scaly, inflamed conditions of the face or scalp, such as treatment-resistant seborrhoeic dermatitis, once or twice daily
Salicylic acid 2% w/w in emulsifying ointment			Salicylic acid softens keratin and makes scales easier to remove; the effects are concentration-dependent. Higher concentrations can irritate or burn normal skin. Use for hyperkeratotic psoriasis, hyperkeratotic eczema, viral warts, lichen simplex, ichthyosis, keratodermas, callus, keratosis pilaris and other hyperkeratotic conditions where emollients and commercial preparations are ineffective.
Salicylic acid 5% w/w in emulsifying ointment			
Salicylic acid 10% w/w in emulsifying ointment			
Salicylic acid 20% w/w in emulsifying ointment			
Zinc and salicylic acid paste (Lassar's paste) half strength			Half-strength Lassar's paste is used to prevent and treat irritant and/or flexural dermatitis where other barrier preparations have been ineffective. It has a skin barrier and mild anti-bacterial effect. It can be useful when applied to fissures in hand dermatitis or applied with bandages in exudative eczematous conditions.

Product	Category	Volume to prescribe	Additional information
Glycopyrrolate 2% w/w in cetomacrogol cream	Miscellaneous	100g	Use to treat disabling facial hyperhidrosis. Apply to affected sites twice daily.
Hydroquinone 5% w/w, hydrocortisone 1% w/w and tretinoin 0.1% w/w in a non-aqueous gel 0.3% w/v		100g	Use to treat melasma, in conjunction with a strong sunblock. Do not use for more than six months due to the risk of ochronosis. A commercially available similar preparation may be obtained called Pigmanorm®.
Phenol 2% w/w in compound zinc paste BP		50g	Used for intractable pruritus ani, unresponsive to moderate strength topical steroid and barrier preparations
Reflectant (Dundee) sunscreens – coffee, coral pink, beige		50g	Used to treat photosensitivity disorders where the patient is sensitive to visible light, most commonly solar urticaria and porphyrias, particularly erythropoietic protoporphyria.
Tacrolimus 0.1% w/w in Oralbase™		50g	Used for ulcerative and erosive inflammatory skin disease including around stomas.
Tacrolimus 0.3% w/w in Oralbase™		50g	
Triamcinolone acetonide 0.1% w/w in Oralbase™		50g	
Eosin solution 2% w/v		100ml	Used for erosive dermatitis, especially around stomas, appliances and intertrigo. Apply when dressing or device changed.
Trichloroacetic acid 90% w/v		10ml	Used to destroy facial xanthelasmata; highly irritant.
Diphenylcyclopropenone in acetone 0.00001-6.0% w/v		10ml	Diphenylcyclopropenone (DCP) is a highly sensitising agent used to treat alopecia areata and resistant viral warts as topical immunotherapy. It should be applied only in dermatology departments by a trained professional. Applying it to the patient's skin carries a risk of sensitising the person carrying out the treatment. Bottles should be handled wearing protective gloves.
Glycopyrrolate 0.05% w/v in water		250ml	Use with an iontophoresis machine to treat hyperhidrosis.