BNF Chapter 1
Gastro-intestinal System

1.1 Antacids (All available OTC)

Co-Magaldrox - Low Na^+ **-** cheaper if prescribed as Mucogel Brand

Alginate-containing (Reflux only)

Peptac Liquid - available as aniseed and peppermint flavour

1.2 Antispasmodics

Mebeverine
(135mg strength available OTC)

1.3 Ulcer Healing Drugs

Concomitant use of **clopidogrel and omeprazole or esomeprazole** is to be discouraged unless considered essential.
MHRA - Drug Safety Update – link

Lansoprazole 15mg Capsules – maintenance
Lansoprazole 30mg Capsules – treatment dose

Omeprazole 20mg **Capsules**
Omeprazole 2 x 20mg Capsules – (not as 40mg strength)

NSAID Prophylaxis - Lansoprazole 15-30mg Capsules Daily

1.4 Anti-motility

Loperamide 2mg Caps – available OTC

1.6 Laxatives

First line options also available OTC
Senna Tabs
Bisacodyl Tabs

Ispaghula Husk
Lactulose - 15ml BD then adjusted to patient's needs.
Ispaghula Husk and Lactulose both need to be used regularly. Ensure adequate fluid intake.

Macrogol '3350' - this is cheaper if prescribed as **Laxido Sugar-Free or Cosmocol brand.**

Relaxit Microenema

Prucalopride - Green specialist initiated

Prucalopride for the treatment of chronic constipation in women (NICE TA 211 December 2010)

Prucalopride is an option for the treatment of chronic constipation in women for whom treatment with at least 2 laxatives from different classes, at the highest tolerated recommended doses, for at least 6 months, has failed and invasive treatment is being considered. Prucalopride should be prescribed only by clinician's experienced in the treatment of chronic constipation. Treatment should be reviewed if prucalopride is not effective after 4 weeks - **link**

1.7 Local preparations for anal and rectal disorders

Anusol cream / ointment available OTC
Scheriproct ointment / suppositories

BNF Chapter 2

Cardiovascular System

2.1 **Positive Inotropic drugs**

Digoxin

2.2 **Diuretics**

Indapamide 2.5mg

NICE NG136: Hypertension in adults: diagnosis and management

Bendroflumethiazide 2.5mg
Furosemide

Spironolactone

NICE NG106: Chronic heart failure in adults: diagnosis and management

Eplerenone

Eplerenone - NPAG recommended that spironolactone should continue to be the first line mineralocorticoid receptor antagonist at all stages of heart failure. Eplerenone should be reserved for patients who have had a MI or side effects with spironolactone eg. gynaecomastia. This is on the basis that spironolactone has high quality, randomised controlled trial evidence of effectiveness from the RALES study in heart failure NYHA class III or IV and established data for hyperkalaemia risks. It is likely (but not known) that spironolactone would also be effective at other stages of heart failure as well as NYHA III and IV, and it has a broad licence for congestive cardiac failure which is not restricted to any heart failure class

2.4 **Beta-adrenoreceptor blocking drugs**

Atenolol
Propranolol
Bisoprolol
Carvedilol

Beta-blockers and ACE inhibitors are first line treatment for heart failure. A Beta-blocker licensed for heart failure should be used eg. Bisoprolol or Carvedilol. Dose titration is required, see below:

	Heart failure (target doses of preferred beta-blockers-if tolerated)
Bisoprolol	10mg OD
Carvedilol	25mg BD (in severe heart failure or body weight less than 85kg) 50mg BD (if body weight over 85 kg)

NICE NG106: Chronic heart failure in adults: diagnosis and management

2.5 **Alpha-Adrenoreceptor Blockers**

Doxazosin

Alpha-blockers only as 4th line antihypertensive agents unless there is compelling indication for their use eg. prostatism.

NICE NG136: Hypertension in adults: diagnosis and management

Do NOT use **Doxazosin XL** as it is “Double Red”.

2.5.5.1 **Angiotensin- converting enzyme inhibitors**

Ramipril
Lisinopril
Perindopril

2.5.5.2 **Angiotensin-II-receptor antagonists**

Losartan
Candesartan- drug of choice in heart failure if AIIRA required

	Heart failure (target doses of preferred ACEi and ARB-if tolerated)
Ramipril	10mg OD
Lisinopril	35mg OD
Perindopril	4mg OD
Candesartan	32mg OD
Losartan	150mg OD

NICE NG136: Hypertension in adults: diagnosis and management

Sacubitril valsartan (Entresto®)

Sacubitril valsartan is categorised in Northants as Green Specialist Initiated and is recommended as an option for treating symptomatic chronic heart failure with reduced ejection fraction, only in people:

- with New York Heart Association (NYHA) class II to IV symptoms **and**
- with a left ventricular ejection fraction of 35% or less **and**
- who are already taking a stable dose of angiotensin-converting enzyme (ACE) inhibitors or ARBs.

NICE TA388: Sacubitril valsartan for treating symptomatic chronic heart failure with reduced ejection fraction

2.6.2 **Nitrates, calcium-channel blockers and potassium channel activators**

Glyceryl Trinitrate- Spray and tablets
Monomil XL – first line nitrate
Isosorbide mononitrate- standard release asymmetric dosing (eg. 8am and 2pm)
Amlodipine
Verapamil

Diltiazem M/R- prescribe by brand.
Preferred brands are:

- Zemtard or Viazem XL- ONCE a day preparation
- Tildiem Retard- TWICE a day preparation

2.6.3 Nicorandil

Ivabradine – GREEN (SPECIALIST RECOMMENDED) for both angina and heart failure

NICE TA267: Ivabradine for treating chronic heart failure

2.6.4 **Peripheral Vasodilators and related drugs**

Naftidrofuryl oxalate

NICE TA223: Cilostazol, naftidrofuryl oxalate, pentoxifylline and inositol nicotinate for the treatment of intermittent claudication in people with peripheral arterial disease

2.8 **Anticoagulants**

Warfarin

Apixaban (Most cost-effective DOAC)
Edoxaban (Most cost-effective once a day DOAC)
Dabigatran
Rivaroxaban

Commissioning recommendations for national procurement for direct-acting oral anticoagulant(s) (DOACs)- January 2024

Apixaban and rivaroxaban are categorised as:

GREEN for stroke prevention in Atrial Fibrillation
GREEN (SPECIALIST INITIATED) for treatment and prevention of DVT and PE
RED for prevention of DVT post-knee and hip replacement

Dabigatran is categorised as:

GREEN for stroke prevention in Atrial Fibrillation
GREEN (SPECIALIST INITIATED) for treatment and prevention of DVT and PE
RED for prevention of DVT post-knee and hip replacement

Edoxaban is categorised as:

GREEN for stroke prevention in Atrial Fibrillation
GREEN (SPECIALIST RECOMMENDED) for treatment and prevention of DVT and PE

NICE TA355: Edoxaban for preventing stroke and systemic embolism in people with non-valvular atrial fibrillation

NICE TA275: Apixaban for preventing stroke and systemic embolism in people with nonvalvular atrial fibrillation

NICE TA249: Dabigatran etexilate for the prevention of stroke and systemic embolism in atrial fibrillation

NICE TA256: Rivaroxaban for the prevention of stroke and systemic embolism in people with atrial fibrillation

NICE TA261: Rivaroxaban for the treatment of deep vein thrombosis and prevention of recurrent deep vein thrombosis and pulmonary embolism

NICE TA287: Rivaroxaban for treating pulmonary embolism and preventing recurrent venous thromboembolism

2.9 Antiplatelet drugs

Aspirin 75mg
Clopidogrel - prescribed as the generic
Prasugrel
Ticagrelor

Dipyridamole 200mg m/r

NICE TA210: Clopidogrel and modified-release dipyridamole for the prevention of occlusive vascular events

2.12 Lipid-regulating drugs

NICE NG238: Cardiovascular disease: risk assessment and reduction, including lipid modification

Atorvastatin
Simvastatin
Pravastatin- for use in patients co-prescribed warfarin

Simvastatin: Increased risk of myopathy at high dose (80 mg)
MHRA (May 2010)
There is an increased risk of myopathy associated with high-dose (80 mg) simvastatin. The 80-mg dose should be considered only in patients with severe hypercholesterolaemia and high risk of cardiovascular complications who have not achieved their treatment goals on lower doses, when the benefits are expected to outweigh the potential risks.

MHRA/CHM advice: Statins: very infrequent reports of myasthenia gravis (September 2023)

There has been a very small number of reports of new-onset, or exacerbation of pre-existing, myasthenia gravis or ocular myasthenia associated with statin use, albeit very infrequent and no reported fatalities. In most cases, patients recovered after stopping statin treatment. However, a minority continued to experience symptoms, some of which recurred on rechallenge with the same, or an alternative, statin. Symptom onset ranged from a few days to 3 months after starting statin treatment.
Healthcare professionals are advised to refer patients who present with suspected new-onset myasthenia gravis symptoms, after starting a statin, to a neurologist—the statin may need to be discontinued if its risks outweigh the benefits. Healthcare professionals are also advised to counsel patients and their carers to:

- *inform their doctor, before taking a statin, if they have a history of myasthenia gravis or ocular myasthenia as it may exacerbate their symptoms;*
- *continue taking their statin unless they are advised to stop;*
- *inform their doctor if they experience symptoms such as weakness in the arms or legs that worsens after activity, double vision, drooping of the eyelids, difficulty swallowing, or shortness of breath;*
- *seek immediate medical attention if they develop severe breathing or swallowing problems.*

Ezetimibe

Do not prescribe as Ezetrol® brand as it is “Double Red”

NICE NG238: Cardiovascular disease: risk assessment and reduction, including lipid modification

Bempedoic acid

Nustendi (Bempedoic acid and ezetimibe)

NICE TA694: Bempedoic acid with ezetimibe for treating primary hypercholesterolaemia or mixed dyslipidaemia

Inclisiran- GREEN SPECIALIST RECOMMENDED

PCSK9 Inhibitors

The PCSK9 inhibitors Alirocumab and Evolocumab are “Red” (specialist prescribing in secondary care only).

NICE TA393: Alirocumab for treating primary hypercholesterolaemia and mixed dyslipidaemia

NICE TA394: Evolocumab for treating primary hypercholesterolaemia and mixed dyslipidaemia

SGLT2 Inhibitors

Dapagliflozin

NICE TA679: Dapagliflozin for treating chronic heart failure with reduced ejection fraction
NICE TA902: Dapagliflozin for treating chronic heart failure with preserved or mildly reduced ejection fraction

Tablet Press Extra (Nov 2021): New indication and NICE guidance relating to dapagliflozin in Heart Failure with reduced Ejection Fraction with or without Type 2 Diabetes

Empagliflozin

NICE TA773: Empagliflozin for treating chronic heart failure with reduced ejection fraction

NICE NG28: Type 2 diabetes in adults: management

BNF Chapter 3

Respiratory system

Which inhalation device?

Inhalation devices of **first choice** for children under 5 are pressurised metered-dose inhalers (**pMDI**), used with or without a **spacer device** (see 3.2.5) **link**

For older children, pM**DI plus spacer** is the first choice device for inhaled corticosteroids; however, for the short-acting bronchodilator (reliever), consideration should be given to a wider range of devices, depending on the needs of the individual. **link**

Patients and prescribers should also consider the **carbon footprint** of the inhaler device. The NHS has committed to reducing its carbon footprint by 51% by 2025 to meet the target in the Climate Change Act, including a shift to dry powdered inhalers (DPI) to deliver a reduction of 4%. DPIs and other newer types of inhalers like soft mist inhalers are less harmful to the environment than traditional metered dose inhalers (MDIs) and the NHS long term plan supports the use of these inhalers where it is clinically appropriate. NICE has produced a inhaler decision aid to facilitate discussion about inhaler options.
https://www.nice.org.uk/guidance/ng80/resources/inhalers-for-asthma-patient-decision-aid-pdf-6727144573

Patients should be given adequate **training** in the proper use of the device at initial prescription and their inhaler technique **assessed** from time to time thereafter.

Inhaler technique training should be kept simple.
In brief, to achieve optimum lung deposition, the inspiratory effort should be:
pMDI (aerosol) SLOW AND STEADY
DPI (dry powder inhaler) QUICK AND DEEP

Videos on how to use various inhaler devices can be found on the Asthma + Lung UK website: How to use your inhaler | Asthma + Lung UK (asthmaandlung.org.uk)

Before stepping up treatment for a patient, consideration should be given to the possibility that **poor compliance, lack of understanding or poor inhaler technique** could contribute to the apparent lack of symptom control by the medication.

Second choice of inhalation device is dependent on the needs of the patient, the reasons why the first device is deemed unsuitable, and the availability of a suitable alternative within the same drug group.

Northants ICB Asthma guidelines:
https://www.icnorthamptonshire.org.uk/download.cfm?doc=docm93jijm4n24720.pdf&ver=60554

Northants ICB COPD guidelines:
https://www.icnorthamptonshire.org.uk/download.cfm?doc=docm93jijm4n22752.pdf&ver=62863

3.1 Bronchodilators

3.1.1.1 ***Selective beta2 agonists***

Short-acting beta2 agonists:

- **Easyhaler Salbutamol Dry Powder inhaler 100 microgram per inhalation (low carbon footprint)**
- **Salamol (Salbutamol) CFC-free pMDI 100microgram per inhalation (high carbon footprint, lower volume propellant)**
- **Airomir (Salbutamol) CFC-free pMDI 100microgram per inhalation (high carbon footprint, lower volume propellant)**

Long acting beta2 agonists:

To ensure safe use, Commission on Human Medicines (CHM) has advised that for the management of chronic asthma, long-acting β2 agonists (formoterol and salmeterol) should:

- be added only if regular use of standard-dose inhaled corticosteroids has failed to adequately control asthma
- not be initiated in patients with rapidly deteriorating asthma
- be introduced at a low dose and the effect properly monitored before considering dose increase
- be discontinued in the absence of benefit
- be reviewed as clinically appropriate - stepping down therapy should be considered when good long-term asthma control has been achieved.
- combination inhalers should be prescribed when appropriate to aid compliance
- Patients should report any deterioration in symptoms after they start treatment with a long-acting β2 agonist.

- **Formoterol Easyhaler (low carbon footprint)**
- **Olodaterol Soft Mist Inhaler (Striverdi Respimat) – low carbon footprint**
- **Formoterol pMDI (high carbon footprint)**
- **Salmeterol pMDI* (high carbon footprint) or Accuhaler (low carbon footprint)**

*NB Some generic salmeterol pMDIs contain soya oil

3.1.2 ***Antimuscarinic bronchodilators***

Short Acting

- **Ipratropium pMDI (high carbon footprint)**

Long Acting

- **Tiotropium DPI (low carbon footprint):**
  Prescribe by brand:
  - **Acopair Neumohaler 18microgram tiotropium (device plus inhalation powder capsules)**
  - **Tiogiva 18 microgram tiotropium (device plus inhalation powder capsules or refill pack of capsules only).** Device may be used for up to 6 months before replacement but must be cleaned once a month.
- **Aclidinium (Eklira Genuair) (low carbon footprint)**
- **Tiotropium via "Respimat" device (soft mist inhaler – low carbon footprint) if unable to use dry powder inhaler.**

NB: Take the risk of cardiovascular side effects into account when prescribing tiotropium to patients with certain cardiac conditions, who were excluded from clinical trials of tiotropium (including TIOSPIR) See MHRA statement Feb 2015 Link

Spiriva Respimat in asthma: LAMA add-on treatment for specialist initiation only.

3.1.3 ***Theophylline***

Modified Release Theophylline tablet – *prescribe by brand*

- **Uniphyllin Continus**

3.1.4 ***Compound bronchodilator preparations: LAMA + LABA:***

Prescribe by BRAND

- **Duaklir Genuair** Aclidinium bromide (LAMA) + formoterol fumarate (LABA) (low carbon footprint)
- **Spiolto Respimat** Tiotropium bromide (LAMA) + olodaterol hydrochloride (LABA) (low carbon footprint)

3.1.5 ***Spacer devices***

Provide a spacer that is compatible with the person's metered-dose inhaler

- **A2A spacer**
- **EasyChamber**
- **Volumatic**
- **Aerochamber Plus**

How to use a spacer: 2 techniques

- **Single breath and hold:** How to use a pMDI inhaler with a spacer – single breath and hold | Asthma + Lung UK (asthmaandlung.org.uk)

- **Tidal breathing/multiple breath technique:** This is usually recommended if you can't hold your breath for five seconds after using your inhaler or if you are having an asthma attack.How to use a pMDI inhaler with a spacer – tidal breathing | Asthma + Lung UK (asthmaandlung.org.uk)

Advise people on spacer cleaning. Tell them:

- not to clean the spacer more than monthly, because more frequent cleaning affects their performance (because of a build-up of static)
- to hand wash using warm water and washing-up liquid and allow the spacer to air dry.
- To replace with a new spacer after 12 months' use.

3.2 ***Corticosteroids***

Monitoring of patients on inhaled corticosteroids (ICS):

- Physicians should remain vigilant for the development of pneumonia and other infections of the lower respiratory tract e.g. bronchitis in patients with COPD who are treated with inhaled drugs that contain steroids because the clinical features of such infections and exacerbation frequently overlap. Any patient with severe COPD who has had pneumonia during treatment with inhaled drugs that contain steroids should have their treatment reconsidered.
  Drug Safety Update October 2007 link

- Psychological and behavioural side effects may occur in association with use of inhaled and intranasal formulations of corticosteroids
  Drug Safety Update September 2010 link

Steroid Treatment Card (Blue)
Steroid Treatment Cards should be issued where appropriate to support communication of the risks associated with treatment and to record details of the prescriber, drug, dosage, and duration of treatment. Steroid treatment cards are available for purchase from the NHS Print online ordering portal http://www.nhsforms.co.uk
GP practices can obtain supplies through Primary Care Support England.
NHS Trusts can order supplies via the online ordering portal.

The prescriber is responsible for issuing the card. Its purpose should be discussed with the patient. The prescriber should ensure that the information on the card is kept up to date and should explain the instructions on the card when issuing one to the patient.

When to give a Steroid Treatment (blue) Card?
Systemic absorption may follow inhaled administration of corticosteroid particularly if high doses are used or if treatment is prolonged.
Steroid treatment cards should be considered at lower doses if there is concomitant use of: (i) intranasal and/or topical corticosteroids; OR (ii) medicines that inhibit the metabolism of corticosteroids (cytochrome p450 inhibiting drugs especially ritonavir, itraconazole and ketoconazole).

High doses of ICS:
Adults: > 800 micrograms daily of BDP (beclometasone dipropionate) or equivalent
Children: > 400 micrograms daily of BDP or equivalent

When **switching** between inhaled corticosteroid products beware of dose inequivalence.
https://www.icnorthamptonshire.org.uk/download.cfm?doc=docm93jijm4n22753.pdf&ver=60625

Prescribe inhaled corticosteroid inhalers by brand name to avoid differences in therapeutic equivalence between different corticosteroid molecules and between different particle-size formulations of the same molecule.

Single component inhaled corticosteroid:
products are only licensed for use in asthma, not COPD.

- **Budesonide Easyhaler – low carbon footprint**
- **Soprobec (replaces Clenil) (Beclometasone) cfc-free pMDI (high carbon footprint) plus spacer**

Combination (LABA/ICS) inhalers:

British Thoracic Society (BTS) guidance advises combination devices may increase adherence to therapy. As LABA monotherapy can increase the risk of asthma-related deaths, ICS/LABA combination inhalers should be used when both pharmacological components are indicated.
Prescribe by brand:

- **Fobumix Easyhaler (Budesonide plus formoterol DPI)** (low carbon footprint)

Licensed for asthma and COPD in adults. Three strengths, (equivalent to Symbicort Turbohaler range).

- **Fostair 100/6 NEXThaler** (Formoterol plus **fine-particle beclomethasone DPI**) (low carbon footprint)

Licensed for asthma and COPD in adults

- **Luforbec pMDI 100/6** (Formoterol plus **fine-particle beclomethasone**) (high carbon footprint)

Licensed for asthma and COPD in adults

- **Luforbec pMDI 200/6** (Formoterol plus **fine-particle beclomethasone**) (high carbon footprint)

Licensed for asthma only, in adults. High strength ICS.

- **Fostair 200/6 NEXThaler** (Formoterol plus **fine-particle beclomethasone DPI**) (low carbon footprint)

Licensed for asthma only, in adults. High strength ICS

- **Symbicort Turbohaler** (Budesonide plus formoterol DPI) 100/6 and 200/6. (low carbon footprint)

ICS/LABA DPI choice for asthma in children.

- **Combisal (pMDI):** Fluticasone and salmeterol: 25/50 and 25/125 (high carbon footprint)

ISC/LABA pMDI options for asthma in children.

MART (maintenance and reliever therapy):

Consider using a single combination inhaler as a "preventer" and "reliever" **("MART" or "SMART")** for patients with troublesome or on-going exacerbations eg. Fobumix Easyhaler (low and moderate dose), Symbicort Turbohaler (low and moderate dose), or Luforbec 100/6.

N.B. MART is NOT suitable for products containing salmeterol as LABA, only for LABA with fast onset of action e.g. formoterol.
Licensed options are age dependent.
Not all brand strengths/presentations have MART licence.

Triple therapy: ICS/LABA/LAMA

Patients with **severe COPD** which is not controlled on two inhaled drugs should be offered a third inhaled drug.

For patients already on triple therapy using 2 devices (e.g. LAMA plus LABA/ICS) it may be cost effective to prescribe this as a single fixed dose device.

- **Trimbow** Beclometasone (fine particle) 100micrograms plus formoterol 6 micrograms plus glycopyrronium 10 micrograms per metered actuation) **NEXThaler** (low carbon footprint) **or pMDI plus spacer (high carbon footprint)**

3.3 ***Cromoglicate, related therapy and leukotriene antagonists***

If asthma is uncontrolled on a low dose of ICS as maintenance therapy, offer a leukotriene receptor antagonist (LTRA) in addition to the ICS and review the response to treatment in 4 to 8 weeks. https://www.nice.org.uk/guidance/ng80/chapter/Recommendations#principles-of-pharmacological-treatment

- **Montelukast (licensed from age 6 months)**

Prescribers are reminded to be alert for neuropsychiatric reactions in patients taking montelukast

3.4 ***Antihistamines (purchase OTC for hayfever/seasonal allergic rhinitis)***

- **Cetirizine**
- **Loratadine**
- **Chlorphenamine**

3.7 ***Mucolytics***

4 week trial; stop if no benefit seen.

- **Acetylcysteine effervescent tablets 600mg**

BNF Chapter 4
Central Nervous System

4.1

Hypnotics and Anxiolytics

Insomnia Newer Hypnotic Drugs

NICE TA77 – (April 2004)

- When, after due consideration of the use of non-pharmacological measures, hypnotic drug therapy is considered appropriate for the management of severe insomnia interfering with normal daily life, it is recommended that hypnotics should be prescribed for short periods of time only, in strict accordance with their licensed indications.

- It is recommended that, because of the lack of compelling evidence to distinguish between zaleplon, zolpidem, zopiclone or the shorteracting benzodiazepine hypnotics, the drug with the lowest purchase cost (taking into account daily required dose and product price per dose) should be prescribed.

- It is recommended that switching from one of these hypnotics to another should only occur if a patient experiences adverse effects considered to be directly related to a specific agent. These are the only circumstances in which the drugs with the higher acquisition costs are recommended.

- Patients who have not responded to one of these hypnotic drugs should not be prescribed any of the others.

Benzodiazepine indications

1. Benzodiazepines are indicated for the short-term relief (two to four weeks only) of anxiety that is severe, disabling, or causing the patient unacceptable distress, occurring alone or in association with insomnia or short-term psychosomatic, organic, or psychotic illness.
2. The use of benzodiazepines to treat short-term ‘mild’ anxiety is inappropriate.
3. Benzodiazepines should be used to treat insomnia only when it is severe, disabling or causing the patient extreme distress - BNF

Diazepam (if liquid formulation required prescribe as Oral Suspension)
Zoplicone

Zaleplon, zolpidem and **zopiclone** are non-benzodiazepine hypnotics, but they act as the benzodiazepine receptor. They are not licensed for long-term use; dependence has bene reported in a small number of patients.

4.3

Antidepressant drugs

Depression
https://www.icnorthamptonshire.org.uk/download.cfm?ver=62856

First prescribe an SSRI in generic form unless there are interactions with other drugs; consider using citalopram or sertraline because they have less propensity for interactions.
When prescribing antidepressants, be aware that:

- dosulepin should not be prescribed
- non-reversible monoamine oxidase inhibitors (MAOIs; for example, phenelzine), combined antidepressants and lithium augmentation of antidepressants should normally be prescribed only by specialist mental health professionals.

Take into account toxicity in overdose when choosing an antidepressant for patients at significant risk of suicide. Be aware that:

- compared with other equally effective antidepressants recommended for routine use in primary care, venlafaxine is associated with a greater risk of death from overdose
- tricyclic antidepressants (TCAs), except for lofepramine, are associated with the greatest risk in overdose.

When prescribing antidepressants for older people:

- prescribe at an age-appropriate dose taking into account the effect of general physical health and concomitant medication on pharmacokinetics and pharmacodynamics
- carefully monitor for side effects

Sertraline (for patients with co-existing CHD)
Escitalopram (first line in epilepsy)
Fluoxetine (first line for <24 years of age)
Mirtazapine (sedative effect maybe beneficial in sleep disturbances)
Venlafaxine

4.6 Drugs used in nausea and vertigo

Metoclopramide not recommended for patients <20 years
Prochlorperazine
Betahistine

4.7 Analgesics

Limited amount of evidence that combinations containing low doses of opioid e.g. 8 mg codeine are more effective than aspirin or paracetamol alone. Soluble products not included due to high sodium content.

Paracetamol available OTC

Co-codamol tablets 8/500 **available OTC**

High strength

1st line - Co-codamol tablets 30/500

2nd line - Co-codamol capsules 30/500

No longer cheaper to prescribe separately

Codeine phosphate

Drugs in terminal care

Morphine – prescribe by brand, which must stay consistent

Preferred brand **– Zomorph® capsules (twice a day preparation)**

ZOMORPH capsules can be swallowed whole or opened and sprinkled on food.

Diamorphine
Fentanyl patches (pack of 5 only) preferred
brand Matrifen
Dexamethasone
Midazolam
Cyclizine
Levompromazine

4.74 Antimigraine drugs

Simple Analgesic plus anti-emetic

Several combination products are available

Reserve triptans for patients in whom adequate doses of analgesics and anti-emetics are not effective. Monitor patients and review if patient over using as potential for medication overuse headache.

Sumatriptan 50mg

Zolmitriptan 2.5mg tabs/orodispersible tabs

BNF Chapter 5 - Infection

PHE/NICE Summary of anti-microbial prescribing guidance - managing common infections LINK

PHE guidance on the management and treatment of Clostridium difficile infection LINK

5.1 ***Anti-bacterials***

5.1.1 ***Penicillins:***
Phenoxymethypenicillin (Pen V)
Amoxicillin
Flucloxacillin

Pivmecillinam 200mg for lower UTI only.

5.1.2 ***Cephalosporins:***
Cefalexin

5.1.3 ***Tetracyclines:***
Oxytetracyline
Lymecycline
Doxycycline

5.1.5 ***Macrolides:***
Clarithromycin (first choice macrolide)

Erythromycin (preferred for some indications in pregnancy and breast feeding) - see Summary link above LINK)

Azithromycin or Doxycycline for Chlamydia treatment

5.1.8 **Trimethoprim –** nitrofurantoin is preferred for most patients especially where risk of resistance is high e.g. over 70s. Trimethoprim should only be used in over 70s only where sensitivity has been confirmed on MSU.

5.1.11 **Metronidazole**

5.1.13 **Nitrofurantoin** prescribe as m/r capsules

5.2 ***Antifungal drugs***
Fluconazole
Itraconazole
Nystatin oral suspension

Treat fungal nail infections only after confirmed mycology. Topical preparations should be purchased rather than prescribed.

Terbinafine

5.3.2 ***Herpes virus infections***
Aciclovir

5.3.4 ***Influenza prophylaxis***

Oseltamivir
Zanamivir

NICE technology appraisal (TA168) (February 2009)

Oseltamivir and Zanamivir re recommended as possible treatments for people with flu if all of the following apply:

- **The person is in an 'at risk' group**
- **The person has a 'flu-like illness' and can start treatment within 48 hours (36 hours for Zanamivir treatment in children) of the first sign of symptoms.**
- **The Department of Health and Social Care has confirmed that the flu virus is known to be circulating and it is likely that a flu-like illness has been caused by the flu virus.**

BNF Chapter 6
Endocrine System

6.1 Drugs used in Diabetes

Insulins

Rapid-acting insulin
First line – **Trurapi**
This is a biosimilar insulin product to Novorapid - **ALWAYS prescribe by BRAND**
Trurapi is the formulary choice of **insulin aspart.**

Intermediate acting human isophane insulin
Insulin detemir
Insulin glargine –Semglee and Lantus are not interchangeable so prescribe by brand.
Semglee is recommended for new initiations.

Type 2 diabetes
See NICE guideline - Type 2 diabetes in adults: management (NG28) link

Offer intermediate acting **human isophane insulin (human NPH insulin)**, taken once or twice-daily according to need, consider starting both NPH and short acting either separately or pre-mixed human insulin.
Long acting Insulin analogues, Detemir and Glargine may be ***considered*** if:

- help is needed injecting insulin and a long acting analogue would reduce injections from twice to once daily
- lifestyle is restricted by recurrent symptomatic hypoglycaemic episodes
- would otherwise need twice daily NPH insulin in combination with oral blood glucose lowering drugs.

Antidiabetic drugs

Metformin is the **first line** choice in type 2 diabetics unless it is contraindicated or not tolerated. **Type 2 diabetes in adults: Management, NICE guidelines NG28 (June 2022) link**

Metformin MR should only be used where patients are unable to tolerate the standard release tablets, despite gradual dose-titration. The standard release formulation should always be used first line.

Assess the person's cardiovascular status and risk to determine whether they have chronic heart failure or established atherosclerotic cardiovascular disease or are at high risk of developing cardiovascular disease.

Based on the cardiovascular risk assessment for the person with type 2 diabetes:

- If they have chronic heart failure or established atherosclerotic cardiovascular disease, **offer** an SGLT2 inhibitor with proven cardiovascular benefit in addition to metformin.
- If they are at high risk of developing cardiovascular disease, **consider** an SGLT2 inhibitor with proven cardiovascular benefit in addition to metformin.

If metformin is contraindicated or not tolerated, or if monotherapy has not continued to control HbA1c to below the person's individually agreed threshold, consider adding:

- a DPP-4 inhibitor **OR**
    - First Line - **Sitagliptin**
    - If eGFR is below 60ml/min, consider **linagliptin** as it is excreted by the biliary system and no dose adjustment is required)
- **Pioglitazone** (see below) **OR**
- a sulfonylurea **OR**
- an SGLT2 inhibitor for people who meet the criteria in **NICE's technology appraisal guidance on canagliflozin, dapagliflozin and empagliflozin as monotherapies or ertugliflozin as monotherapy or with metformin for treating type 2 diabetes. [2015, amended 2022]**

Pioglitazone is contra-indicated in patients with cardiac failure or history of cardiac failure, hepatic impairment, diabetic ketoacidosis, history of bladder cancer, un-investigated macroscopic haematuria. Caution elderly.

Glucagon-like-peptide-1 analogue can be ***considered*** in combination with metformin and a SU or if triple therapy is not effective, not tolerated, or contra-indicated, for adults with BMI of 35 or higher **and** medical problems associated with obesity or a BMI lower than 35 in whom insulin isn't suitable.

Blood Glucose Testing strips and lancets

See Guidelines For Blood Glucose and Ketone Monitoring

FIRST LINE - meets the needs of majority of patients:

Type 2 diabetes and Type 1 diabetes that are NOT on an insulin pump or carbohydrate counting

Test Strips	Meter name	Benefits	Lancets	Cost (strips 50)	Manufacturer
Finetest Lite	**Finetest Lite Or Finetest Lite Smart (bluetooth enabled)**	**-0.5µl blood volume -Large display -Auto-coding Alternative site testing -Data download**	**Greenlan**	**£5.95**	**Neon** To order a meter 0800 1313378

Continuous Glucose Monitoring available on FP10 (See Guidelines For Blood Glucose and Ketone Monitoring)

Freestyle Libre 2/plus, Dexcom ONE and GlucoRx Aidex – available to patients with Type 1 diabetes. Prior Approval is required for all other patients.

Freestyle 3 – Prior Approval is required

Insulin Safety Needles

See Pen Needles and Safety Needle devices guidelines

The formulary pen needles of choice are standard screw-on, single-use needles which fit all leading insulin pen devices and GLP-1 pens

- **GlucoRx CarePoint: 4mm/31 gauge, 5mm/31gauge, 6mm/31gauge, 8mm/31gauge**
- **GlucoRx CarePoint Ultra: 4mm Ultra/32gauge**
- **Greenfine: 4mm/32 gauge, 5mm/31 gauge, 6mm/31 gauge, 8mm/31 gauge**

6.4

Sex Hormones

HRT

HRT increases the risk of venous thromboembolism, of stroke and, after some years of use, endometrial cancer (reduced by a progestogen) and of breast cancer. The CSM advises that the minimum effective dose should be used for the shortest duration, for the relief of menopausal symptoms. Treatment should be reviewed at least annually and for osteoporosis alternative treatments considered (BNF section 6.6). HRT does not reduce the incidence of coronary heart disease and it should not

be prescribed for this purpose.

HRT may be used in women with early natural or surgical menopause (before age 45 years), since they are at high risk of osteoporosis. For early menopause, HRT can be given until the approximate age of natural menopause (i.e. until age 50 years). Alternatives to HRT should be considered if osteoporosis is the main concern. In healthy women without symptoms, the risk of using HRT outweighs the potential benefit of preventing osteoporosis.

Women without uterus Elleste Solo 1mg, 2mg Evorel patches 25,50,75,100

Women with uterus
Cyclical therapy

- **Elleste Duet** 1mg, 2mg

Continuous combined therapy

- **Kliofem**
- **Kliovance**

6.6

Drugs affecting bone metabolism

First line **- Alendronic acid (sodium alendronate)**

Prescribe as **Alendronic Acid 70mg once a week** for the treatment of post-menopausal osteoporosis.

Prescribe as **Alendronic Acid 10mg once a day** for osteoporosis treatment in men and prevention of corticosteroid induced osteoporosis

BNF Chapter 7:
Genito-urinary system

1 Bladder and urinary disorders
1.1 Urinary frequency, enuresis and incontinence

Antimuscarinics (systemic):
Solifenacin 5mg-10mg od
Tolterodine immediate-release 1mg - 2mg bd
Fesoterodine MR 4mg - 8mg od
Tolterodine MR (Rx as Blerone XL) 4mg od

See OAB guidance - Overactive bladder prescribing pathway (icnorthamptonshire.org.uk

Overview | Urinary incontinence and pelvic organ prolapse in women: management | Guidance | NICE

1.2 Urinary retention

Alpha-adrenoceptor blockers:
Doxazosin tablets (not m/r)
Tamsulosin 400mcg m/r capsules

3. Contraception
3.1 Contraception, combined

Combined oral contraceptive content	Available products. Preferred formulary choices in bold	Notes
Ethinylestradiol 30mcg levonorgestrel 150mcg	**Levest** **Rigevidon** Maexeni Ovranette Microgynon 30 Microgynon 30 ED	Progestogen dominant pill
Ethinylestradiol 35mcg norethisterone 500mcg	**Brevinor**	*Oestrogen dominant pill*
Ethinylestradiol 30mcg desogestrel 150mcg	**Cimizt 30/150** Gedarel 30/150 Marvelon	*Consider in mild acne* *Note: MHRA advice on risk of VTE*
Ethinylestradiol 20mcg desogestrel 150mcg	**Bimizza** Gedarel 20/150 Mercilon	*Note: MHRA advice on risk of VTE*
Ethinylestradiol 30mcg gestodene 75mcg	**Millinette 30/75** Katya 30/75 Femodene	*Improved cycle control* *Note: MHRA advice on risk of VTE*
Ethinylestradiol 20mcg gestodene 75mcg	**Millinette 20/75** Sunya Akizza Femodette	*Note: MHRA advice on risk of VTE*
Ethinylestradiol 30mcg Levonorgestrel 50mcg Ethinylestradiol 40mcg Levonorgestrel 75mcg Ethinylestradiol 30mcg Levonorgestrel 125mcg	**TriRegol** Logynon	*Tri-phasic preparation* *Improved cycle control but requires better compliance*
Ethinylestradiol 35 mcg norgestimate 250mcg	**Lizinna** **Cilique**	
Co-cyprindiol 2000/35 (cyproterone acetate 2mg, ethinylestradiol 35mcg)	**Clairette** Dianette Co-cyprindiol 2000/35	*Severe acne, moderately severe hirsuitism.* *Should not be prescribed for the sole purpose of contraception. Prescriptions should be endorsed with the female symbol ♀ or CC*

The risk of VTE in association with drospirenone-containing pills, including Yasmin, is higher than that for levonorgestrel-containing 'second generation' pills and may be similar to the risk for 'third-generation' pills that contain desogestrel or gestodene. See full MHRA warning link
If Yasmin equivalent is still needed, please prescribe as **Yacella,** or **Dretine** brand (Ethinylestradiol 30mcg, Drospirenone 3mg)

3.3 Contraception, emergency

Ulipristal acetate 30mg
Emerres 1.5mg (Levonorgestrel 1500mcg)

Levonorgestrel 1500mcg:
Available OTC as **Levonelle One Step** from all pharmacies for over-16s.
Available from many pharmacies under PGD, including for under 16s

Ulipristal acetate 30mg:
Available OTC as **ellaOne** from all pharmacies

For choice of product see decision making algorithm in FSRH guideline on Emergency Contraception
https://www.fsrh.org/standards-and-guidance/documents/ceu-clinical-guidance-emergency-contraception-march-2017/

3.4 Contraception, oral progestogen-only

Desogestrel 75mcg Prescribe generically

Desogestrel has a 12-hour missed pill window and may be useful where poor compliance is likely. However, it is only recommended for use in women who cannot tolerate oestrogen-containing contraceptives or in whom these preparations are contraindicated.

4. Erectile and ejaculatory conditions

4.1 Erectile dysfunction

Sildenafil - "SLS" criteria no longer apply to generic sildenafil. Max 8 tablets per month
Tadalafil 10mg, 20mg PRN (not daily) – "SLS" criteria apply. Max 8 tablets per month
Tadalafil 5mg DAILY (5mg only; 2.5mg is double red) - "SLS" criteria apply.

Guidelines for drugs and devices used in the treatment of erectile dysfunction (icnorthamptonshire.org.uk)

BNF Chapter 9:
Blood and nutrition

1 Anaemias

1.2 Iron deficiency anaemia

Iron (oral): once daily (or alternate day) dosing
Ferrous sulphate 200mg tablets (65mg elemental iron)
Ferrous fumarate 210mg tablets (69mg elemental iron)
Ferrous gluconate 300mg tablets (37mg elemental iron) - consider using if GI tolerability issues persist even with alternate daily dosing of above preparations.
Ferrous fumarate 322mg tablets (106mg elemental iron) – high elemental iron content; side effects more likely.

Ferrous fumarate 140mg/5ml oral solution

Monitor the haematological response and modify as appropriate.

Iron-Deficiency-Anaemia-in-Adults.pdf (bsg.org.uk)

6 Vitamin Deficiency

Vitamin D

For the management of insufficiency (serum 25(OH)D 25-50nmol/L) and the routine prophylaxis of deficiency, vitamin D should be **purchased OTC** or, if eligible, obtained free of charge, or at a reduced cost, via the government's "Healthy Start" scheme www.healthystart.nhs.uk This includes prevention of deficiency in pregnant women, including those with high BMI and in other at risk groups.

For the treatment of deficiency (serum 25(OH)D <25nmol/L) vitamin D may be provided via NHS prescription. See Vitamin D guidelines for formulary preparations
Vitamind d guidelines (icnorthamptonshire.org.uk)

Vitamin D with calcium:

Calci D chewable tablets (once daily dose) (Colecalciferol 1,000unit / Calcium carbonate 2.5g chewable tablets)
Evacal D3 chewable tablets (Colecalciferol 400unit / Calcium carbonate 1.5g chewable tablets)
Accrete D3 film-coated tablets (swallowed whole or halved) (Colecalciferol 400unit / Calcium carbonate 1.5g tablets)

BNF Chapter 10
Musculoskeletal System

10.1 Non-steroidal Anti-inflammatory Drugs

NPAG does not recommend the use of coxibs. In high GI risk patients where simple analgesics provide inadequate relief then prescribe a traditional NSAID with Lansoprazole 15-30mg daily.

Ibuprofen available OTC

Naproxen
Avoid M/R preparations and E/C versions as they are considerably more expensive without additional benefits.

Diclofenac
There are now concerns about the cardiovascular safety which appear to have a similar risk to coxibs

10.3 Drugs for the Relief of Soft-tissue Inflammation

NICE Guidance: Osteoporosis. Consider topical NSAID if needed and no contra-indications (particularly if hand or knee involvement) Link

Fenbid Gel - only prescribe for long-term conditions as available OTC
(Ibuprofen 5% gel but should prescribe as Fenbid 100g)

BNF Chapter 11

Eye

11.3 Anti-infective Eye Preparations

Chloramphenicol 0.5% eye drops 10ml or 1% eye ointment 4g
- available OTC for acute bacterial conjunctivitis in adults and children over two

Fusidic Acid 1% MR eye drops 5g

11.4 Corticosteroids and Other Anti-inflammatory Preparations

11.4.1 Corticosteroid eye preparations

Should be prescribed on specialist recommendation

11.4.2 Other Anti-inflammatory Preparations

Sodium cromoglicate 2% eye drops 13.5 ml
- available OTC (10ml) for acute seasonal and perennial allergic conjunctivitis

Azelastine 0.05% eye drops 8ml

Antazoline 0.5% with xylometazoline 0.05% eye drops 8ml (Otrivine Antistin®)
- available OTC

11.6 Treatment of Glaucoma

Eye preparations for glaucoma should be prescribed on specialist recommendation.
See ‘Glaucoma Prescribing Guidelines’ link

11.8 Miscellaneous Ophthalmic Preparations

Advise self-care where possible and advise patient to purchase preparations OTC

See 'Guidance on the Use of Eye Lubricants for Dry Eye Conditions in Primary Care' ('Ocular Lubricant Guidelines') link

Standard Formulations

AaproMel Hypromellose® 0.3% or 0.5% eye drops 10ml (hypromellose)
one month expiry - available OTC

Clinitas Carbomer® 0.2% eye gel 10g (carbomer 980)
one month expiry - available OTC

Eyeaze Carmellose® 0.5% preservative free eye drops 10ml (carmellose)
three-month expiry - available OTC

Preservative Free Formulations (consider as detailed in Guidelines above)

Eyeaze Carmellose® 0.5% preservative free eye drops 10ml (carmellose)
three-month expiry - available OTC

ClinOptic HA® 0.1% or 0.21% preservative free eye drops 10ml (sodium hyaluronate)
six-month expiry - available OTC

Eyeaze HA 0.1% or 0.2% preservative free eye drops 10ml (sodium hyaluronate)
three-month expiry - available OTC

High Viscosity Formulations (for use at night in addition to daytime treatment)

Hylo Night® (previously Vita-POS®) preservative free eye ointment 5g (retinol palmitate with WSP, LLP, LP, and wool fat)
six-month expiry - available OTC

Xailin Night® eye ointment 5g (liquid paraffin with WSP and wool alcohols)
two-month expiry - available OTC

BNF Chapter 12

Ear, Nose and Oropharynx

12.1 Drugs acting on the Ear

12.1.1 Otitis Externa

First use aural toilet (if available) and simple analgesia

Acetic Acid 2% ear spray 5ml (Earcalm® spray)
- available over the counter (OTC)

Acetic Acid 2%/Dexamethasone 0.1%/Neomycin 0.5% ear spray 5ml (Otomize® ear spray)

12.1.3 Removal of Ear Wax

Sodium bicarbonate 5% ear drops 10ml
- available OTC

12.2 Drugs acting on the Nose

12.2.1 Drugs used in Nasal Allergy

Mild to moderate hay fever/seasonal rhinitis is listed by NHS England as a condition where OTC medicines should not routinely be prescribed in primary care. Most patients should be able to relieve symptoms with OTC treatments link

First line
Beclometasone 50mcg/dose aqueous nasal spray 200 sprays
- available OTC for adults for prevention and treatment of allergic rhinitis in 100 and 180 spray sizes

Second line
Budesonide 64mcg/dose nasal spray 120 sprays
- available OTC for adults for prevention and treatment of seasonal allergic rhinitis in 60 and 120 spray sizes

Fluticasone furoate 27.5mcg/dose 120 sprays (Avamys® nasal spray)
- available OTC for adults as fluticasone propionate 50mcg/dose nasal spray in 60 spray size

Ipratropium bromide monohydrate 21mcg/dose nasal spray (Rhinaspray® nasal spray) 180 sprays

See Tablet Press Extra 'Hay Fever Treatment Update - OTC' link
See 'Hay Fever Self Care Patient Information Leaflet' link

12.2.2 **Topical Nasal Decongestants**

Sodium chloride 0.9% nasal drops 10ml
- available OTC

12.2.3 **Nasal Preparations for Infection (nasal staphylococci)**

Chlorhexidine 0.1% and neomycin 0.5% nasal cream (Naseptin® nasal cream)

12.3 Drugs acting on the Oropharynx

12.3.1 **Drugs for Oral Ulceration and Inflammation**

Chlorhexidine gluconate 0.2% mouthwash 300ml
- available OTC (Corsodyl® mouthwash)

Benzydamine 0.15% mouthwash sugar free 300ml
- available OTC (Difflam® oral rinse)

12.3.2 **Oropharyngeal Anti-infective Drugs - Fungal Infections**

Miconazole 20mg/g oromucosal gel sugar free 80g (Daktarin® oral gel)
- available OTC in 15g size

Nystatin 100,000 units/ml oral suspension 30ml (Nystan® oral suspension)

12.3.5 **Treatment of Dry Mouth (artificial saliva products)**

Saliveze® mouth spray 50ml
- available OTC

Artificial Saliva Gel (Biotene Oralbalance® saliva replacement gel) 50g
- available OTC

BNF Chapter 13

Skin

13.2 Emollient and Barrier Preparations

There is no advantage in prescribing these products by generic name. Choice is largely based on patient preference.

13.2.1 Emollients

There is a fire risk with all paraffin-based emollients, and it cannot be excluded with paraffin-free emollients. See MHRA/CHM advice (updated December 2018): Emollients: new information about risk of severe and fatal burns with paraffin-containing and paraffin-free emollients. link

Mild dry skin is listed by NHS England as a condition where OTC medicines should not routinely be prescribed in primary care. Most patients should be able to relieve symptoms with OTC treatments. Emollients can continue to be prescribed for patients with long term dermatological conditions such as eczema and psoriasis. Link

'Zero®' products from Thornton and Ross provide cost effective equivalents to many commonly used emollients and soap substitutes and are suitable for initial prescribing in most cases. These should be first choice. Patients already established on more expensive products may be willing to try the equivalent 'Zero®' product.

See Northamptonshire Emollient Guidelines link
See Emollients and how to use them patient information leaflet link

Emollients for Mild Dry Skin

Creams containing paraffin for mild dry skin
Epimax® Moisturising Cream Flexi-dispenser 500g
Zerocream® pump 500g (like E45® cream)

Creams/lotions containing Colloidal Oatmeal for mild dry skin
Epimax® Oatmeal Cream Flexi-dispenser 500g

Zeroveen® pump 500g (like Aveeno®)
Aveeno® preparations are Borderline Substances and have been classed as Double Red. Aveeno preparations are available OTC if patients prefer to purchase them instead of the formulary choices.

Rich creams for mild dry skin
Zeroguent® cream 500g (like Unguentum M®)

Emollients for Moderately Dry Skin

Creams containing paraffin for moderately dry skin
Epimax® Original Cream Flexi-dispenser 500g
Zerobase® Cream Pump 500g (like Diprobase® Advanced Extra Cream)
Epimax® Excetra Cream Flexi-dispenser 500g (like Cetraben® Cream)

Gels containing paraffin for moderately dry skin
Epimax® Isomol Gel Flexi-dispenser 500g (like Doublebase Gel)
Zerodouble Gel® (like Doublebase® Gel)?

Creams containing urea for moderately dry skin
ImuDERM® Emollient 5% Urea pump 500g

Emollients for Severe Dry Skin

Ointments containing paraffin for severe dry skin
Epimax® Ointment 500g
Zeroderm® Ointment 500g (like Epaderm® or Hydromol®)

Creams containing urea 5% and 2auromacrogols 3% for severe dry skin
Balneum® Plus Cream 500g or 100g – use for itch if emollient alone not helped

Sprays containing paraffin
Emollin® Spray 240ml - use only when unable to use other preparations or where application without touching skin is necessary. Highly flammable.

Emollients with Anti-bacterial

Dermol® 500 lotion pump 500ml - for washing only when infection is a concern
Dermol® pump cream 500ml

Paraffin Free Emollient

Epimax® Paraffin Free Ointment 500g - for patients at high fire risk as per NPSA safety alert

Soap Substitutes
ZeroAQS® (does not contain sodium lauryl sulphate)
Aqueous cream (contains sodium lauryl sulphate)
Emulsifying ointment

13.2.1.1 **Emollient Bath and Shower Preparations**

These are not recommended due to lack of evidence of efficacy. All the emollients listed above can be used as soap substitutes. Preparations are available to purchase OTC if required.

Exceptions:
Balneum Plus® bath oil - used as a soak for managing itch that remains a problem despite optimum therapy

Dermol 600® bath emollient - used in recurrent infection especially in children. Review every six months.

Nappy Rash
Nappy rash is listed by NHS England as a condition where OTC medicines should not routinely be prescribed in primary care. Most patients should be able to relieve symptoms with OTC treatments. link

See Nappy Rash Self Care patient information leaflet link

13.4 Topical Corticosteroids

Hydrocortisone preparations
Prices vary considerably between pack sizes; prescribe 1% preparations as multiples of 30g, not 50g.
Hydrocortisone 2.5% is much more expensive than 1% and is 'Double Red'.
Consider clobetasone preparations if hydrocortisone 1% is not effective.

Mild potency steroids:
Hydrocortisone 1% cream/ointment
- available OTC

Hydrocortisone 0.5% cream/ointment

Moderate potency steroids:
Betamethasone 0.025% (Betnovate RD®) cream/ointment

Clobetasone butyrate 0.05% (Eumovate®) cream/ointment
-15g cream available OTC

Potent steroid:
Betamethasone 0.1% (Betnovate®) cream/ointment

Very potent steroid:
Clobetasol propionate 0.05% (Dermovate®) cream/ointment

Mild steroids with anti-microbial:
Hydrocortisone 1%/miconazole 2% cream/ointment (Daktacort® cream/ointment)
-15g cream available OTC

Hydrocortisone 1%/clotrimazole1% cream (Canesten HC®)
-15g available OTC

13.5 Preparations for Eczema and Psoriasis

specialist led

Calcipotriol (Dovonex®)

Dithranol preparations

Coal tar preparations

Salicylic acid preparations

13.5.3 Drugs affecting the Immune Response

Tacrolimus and pimecrolimus for atopic eczema NICE TA 82 (Aug 2004)
Only use when atopic eczema is not controlled by maximal topical corticosteroid treatment. Initiation by Specialist or GP with special interest and experience. link

13.6 Acne and Rosacea

Mild acne is listed by NHS England as a condition where OTC medicines should not routinely be prescribed in primary care. Most patients should be able to relieve symptoms with OTC treatments. link

See Northamptonshire Rosacea Guidance link

See Northamptonshire Acne Guidelines link
See Acne Self-care patient information leaflet link

Mild Acne
Adapalene 0.1% cream/gel (Differin®)

Benzoyl peroxide
- available to buy OTC (PanOxyl®)

Clindamycin 1% topical lotion/solution (Dalacin T®)

Moderate Acne
Adapalene 0.1% with benzoyl peroxide 2.5% gel (Epiduo®)

13.7 Preparations for Warts and Callouses

Warts and verrucae are listed by NHS England as a condition where OTC medicines should not routinely be prescribed in primary care. Most patients should be able to relieve symptoms with OTC treatments. link

Wart and verruca preparations are 'Double Red' and should not be prescribed in primary care. They are available to purchase OTC.

See Warts and Verrucas Self Care patient information leaflet link

Salicylic acid with lactic acid (Salatac® gel or Salactol® paint)
- available OTC

Salicylic acid (Occlusal® liquid)
- available OTC

13.9 Shampoos and other preparations for Scalp and Hair Conditions

Dandruff is listed by NHS England as a condition where OTC medicines should not routinely be prescribed in primary care. Most patients should be able to relieve symptoms with OTC treatments. link

See Dandruff Self Care patient information leaflet link

Coal tar with salicylic acid and sulfur ointment (Cocois® ointment)
- available OTC

Ketoconazole 2% shampoo
- available OTC

Coal Tar Extract Alcoholic 5% Alphosyl 2 in 1® shampoo
- available OTC

13.10 Anti-infective Skin Preparations

13.10.1 Antibacterial preparations

Fusidic acid 2% cream (Fucidin® cream) - up to 10 days only, to prevent resistance

Metronidazole 0.75% cream or gel (as Rozex® brand)

Silver sulphadiazine 1% cream (Flamazine® cream) - for infection in burns wounds

13.10.2 Antifungal preparations

Clotrimazole 1% cream (Canesten® cream)
- available OTC

Miconazole 2% cream (Daktarin® cream)
- available OTC

Fungal nail infections

Fungal nail infections are listed by NHS England as a condition where OTC medicines should not routinely be prescribed in primary care. Most patients should be able to relieve symptoms with OTC treatments. link

Fungal nail preparations are ‘Double Red’ drugs and should not be prescribed in Primary Care. They are available to purchase OTC.

See Fungal Nail Infection Self Care patient information leaflet link

13.10.4 Parasiticidal preparations

On current evidence, it seems reasonable to regard Dimeticone as a first line alternative to malathion and permethrin (ref DTB Vol 45 No 7 July 2007)

Dimeticone 4% lotion

- available OTC

Malathion 0.5% liquid
- available OTC

Permethrin 1% liquid
- available OTC

13.11 Skin Cleansers, Antiseptics and Desloughing Agents

13.11.1 Alcohols and Saline

Sodium chloride 0.9% solution

13.11.1 Oxidisers and Dyes

Potassium permanganate 0.1% solution diluted 1 in 10 to provide a 0.01% solution - see Guidance on the safe use of potassium permanganate soaks