

Enclosure No:	12/AWMSG/0218
Agenda item No:	17 – All Wales Common Ailments Formulary
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1.0 ACTION FOR AWMSG

AWMSG members are asked to consider the update of the *All Wales Common Ailments Formulary* for endorsement.

2.0 PURPOSE

The *All Wales Common Ailments Formulary* aims to improve patient access to consistent, evidence-based advice for the management of common ailments. The formulary was developed using recognised resources and involved multi-professional consultation to ensure the provision of consistent advice by pharmacists and GPs.

The project is pertinent to the following recommendations taken from the [AWMSG Five-year Strategy 2013–2018](#):

Improving health – Prescribing guidance

AWMSG will work with health boards and other stakeholders to promote the safe, effective and cost-effective use of medicines in Wales.

Fully integrated network of care

AWMSG will work with stakeholders so that care can be delivered in the most appropriate setting.

2.1 Process

Original document published – May 2013

Updated document published – May 2015

Current document to AWPAG – September 2017

Current document to consultation – October 2017

AWPAG meeting – December 2017

AWMSG Steering Committee meeting – January 2018

AWMSG meeting – February 2018

2.2 Stakeholders

- Chief Pharmacists
- Medicines and Therapeutics Committees
- Assistant Medical Directors
- Local Medical Committees
- Welsh Government
- Public Health Wales
- General Practitioners Committee Wales
- Royal College of GPs Wales
- Community Pharmacy Wales
- British Medical Association Wales
- Association of the British Pharmaceutical Industry
- Royal Pharmaceutical Society Wales
- Royal College of Nursing Wales
- Directors of Public Health

CONTENTS

INTRODUCTION..... 3

ACNE 4

ATHLETE’S FOOT 5

BACK PAIN (ACUTE) IN ADULTS 7

CHICKENPOX – IN CHILDREN UNDER 14 YEARS.....10

COLD SORES.....12

COLIC14

CONJUNCTIVITIS (BACTERIAL).....16

CONSTIPATION18

DIARRHOEA.....21

DRY EYES24

DRY SKIN/DERMATITIS27

HAEMORRHOIDS.....30

HAY FEVER.....32

HEAD LICE35

INDIGESTION AND REFLUX.....38

INGROWING TOENAIL.....40

INTERTRIGO42

MOUTH ULCERS.....44

NAPPY RASH46

ORAL THRUSH.....48

RINGWORM50

SCABIES.....52

SORE THROAT AND TONSILLITIS.....54

TEETHING57

THREADWORMS59

VAGINAL THRUSH.....61

WARTS AND VERRUCAE63

.....END OF ‘CONTENTS’ SECTION.....

INTRODUCTION

Evidence-based approach

The formulary was developed to provide evidence-based guidance for common ailments, which would support a consistent approach between pharmacists and GPs. It was developed via multi-professional discussion and consultation. The following resources were frequently used:

- [The British National Formulary \(BNF\)](#)
- [National Institute for Health and Care Excellence \(NICE\)](#)
- [Clinical Knowledge Summaries](#)
- [NHS Direct \(Wales\)](#)
- [Patient](#)
- [NHS Choices](#)

A patient information leaflet for each condition will be offered where possible to support the availability of consistent advice.

Acknowledgements

We would like to acknowledge the involvement of colleagues across Wales, their representation and advice at the working groups and contributions to consultations.

.....END OF 'INTRODUCTION' SECTION.....

DRAFT FOR ENDORSEMENT

ACNE				
General information				
<p>Diagnostic features: acne is a skin condition that commonly affects adolescents and young adults. Comedones (blackheads and whiteheads) and/or inflammatory lesions (papules) and pus-filled spots (pustules) can develop on the face, back and chest. The skin and hair may appear oily.</p> <p>In mild to moderate acne, comedones and inflammatory lesions respond well to benzoyl peroxide¹. Treatment is effective but takes time to work (typically 6–12 weeks) and may irritate sensitive skin, especially at the start of treatment².</p>				
Referral to GP information				
<p>Refer people with severe acne, e.g. with a large number of inflammatory lesions or scarring³.</p> <p>Refer when oral therapies have previously been used for acne.</p> <p>Refer when over-the-counter medication has not worked³.</p> <p>Refer people under 12 years of age.</p>				
Treatment(s) offered	Pack size	Maximum number of packs to be supplied	Suggested number of episodes per year	Information/instructions
Benzoyl peroxide 5% gel	30 g 60 g	3	1	Supply number of packs according to area to be treated.
Advice for patient on how to resolve/manage condition				<i>Link to leaflet</i>
<ul style="list-style-type: none"> • Try not to pick or squeeze spots because this usually aggravates them and may cause scarring. • Wash the affected area no more than twice a day with a mild soap or cleanser. Do not scrub too hard as this can irritate the skin and make the acne worse. • If dry skin is a problem, use a fragrance-free water-based emollient². • Avoid using too much make-up and cosmetics. Use water-based non-comedogenic make-up and remove it before going to bed³. • Apply the gel sparingly 20 minutes after washing and drying the affected area of the skin³. • Treatments should be applied to the entire affected area of the skin (e.g. all of the face) and not just to individual spots, usually every night or twice daily. • Benzoyl peroxide can cause redness and peeling of the skin with a burning, itching sensation especially at the start of treatment. If skin irritation occurs, it may be useful to reduce the frequency of application, at least temporarily, to help overcome this problem. • Benzoyl peroxide can have a bleaching effect, so avoid getting it on hair or clothes. • Benzoyl peroxide may cause increased sensitivity to sunlight, so avoid too much sun and UV light, or wear sunscreen³. 				

.....END OF 'ACNE' SECTION.....

DRAFT FOR ENDORSEMENT

ATHLETE'S FOOT

General information

A person with athlete's foot (tinea pedis) may have an itchy, white or red, scaly, blistering, cracked/macerated/dry rash most commonly between the toes. The rash can spread to involve the sole, the sides of the foot and the toe nails^{4,5}. The foot should be examined to confirm the diagnosis.

Treatment should be supplied only to those people who have not received previous treatment for this current episode.

Mild, non-extensive disease should be treated with topical clotrimazole 1% cream or miconazole 2% cream.

Antifungal dusting powders are of little therapeutic value in the treatment of fungal skin infections and may cause skin irritation; they may have some role in preventing re-infection¹.

If there is co-existing dermatitis, a mild topical steroid can be used in addition to antifungal cream but not alone (see [DRY SKIN](#)).

Referral to GP information

This is a condition often managed by pharmacies – refer as per current practice.

Refer people with severe or extensive disease, signs of bacterial infection or recurrent episodes. If there has been no improvement after 1 week of treatment or if there is pain and discomfort⁶.

Refer if the person is immunocompromised or if they have poorly controlled diabetes and have not been reviewed by their GP in the last 3 months.

Treatment(s) offered	Pack size	Maximum number of packs to be supplied	Suggested number of episodes per year	Information/instructions	
Clotrimazole 1% cream	20 g	3	2	Cream should be applied 2–3 times a day and used for at least 4 weeks.	Choice is based on the person's preference – similar cost and efficacy.
Miconazole 2% cream	30 g	2	2	Cream should be applied twice a day and treatment should be continued for at least 10 days after the affected area has healed ¹ . Do not issue miconazole to people using interacting medicines, particularly warfarin; consider clotrimazole.	
Hydrocortisone 1% cream	15 g (via PGD)	1	2	Antifungal and hydrocortisone treatment should only be used for skin that is particularly inflamed and/or itchy. Do not	

DRAFT FOR ENDORSEMENT

				give a corticosteroid treatment alone. Treatment with a steroid should not exceed 7 days ⁸ .	
Advice for patient on how to resolve/manage condition					<i>Link to leaflet</i>
<ul style="list-style-type: none"> • Wash and dry the affected skin before applying the treatment and clean your hands afterwards. • Treatment should be applied to the affected skin and surrounding area. <p>In general^{4-6,8}:</p> <ul style="list-style-type: none"> • Wear footwear that keeps the feet cool and dry. • Wear a fresh pair of cotton socks every day. • Change to a different pair of shoes every 2–3 days. • After washing, dry the feet thoroughly, especially between the toes. • Use talcum powder on the feet to prevent them getting sweaty. • Avoid using moisturisers between the toes because this may help fungi to multiply. • Take off shoes when at home and let air get to the feet. • Avoid scratching affected skin, as this may spread the infection to other sites. • To reduce the risk of transmission to other people, do not share towels and wash them frequently, and avoid going barefoot in public places (wear protective footwear, such as flip-flops, in communal changing areas). 					

.....**END OF 'ATHLETE'S FOOT' SECTION**.....

DRAFT FOR ENDORSEMENT

BACK PAIN (ACUTE) IN ADULTS

General information

The aim is to provide initial advice, to encourage regular back exercises and stretches and to continue with normal activities. People known to have chronic back pain and those already taking analgesics should be excluded from treatment under the scheme. Advise that most episodes of non-specific back pain improve over 2–4 weeks⁹. Provide the AWMSG leaflet: [Medicines for mild to moderate pain relief](#) (also available in [Welsh](#)). A nonsteroidal anti-inflammatory drug (NSAID) such as ibuprofen is the first-line pharmacological treatment if there are no contraindications. Avoid using an NSAID if the patient is taking warfarin. It should be used at the lowest effective dose for the shortest time possible. Consider the need for gastroprotection before recommending this treatment. If the person needs gastroprotection refer the person to their GP. Paracetamol alone is not recommended for managing low back pain⁹. The benefits of compound analgesic preparations containing paracetamol with a low dose of an opioid analgesic (e.g. 8mg of codeine phosphate per compound tablet) have not been substantiated but may still cause opioid side-effects and can complicate the treatment of overdose¹.

Referral to GP information

Red Flags⁹:

- age over 50 years
- trauma
- history of cancer
- intravenous drug abuse
- immunosuppression (e.g. due to cancer treatment or high doses of oral steroids (see BNF) or other immunosuppressants, or conditions that reduce immunity)
- diabetes
- tuberculosis or recent urinary tract infection.

Other symptoms that require referral⁹:

- No improvement after 3–4 weeks of treatment, or a change (deterioration) in the type of pain.
- Pain that prevents the person doing the usual activities of daily life.

Emergency – seek immediate medical advice as the following symptoms require further investigation^{9,10}:

- Fever of 38°C (100.4°F) or above.
- Unexplained weight loss.
- Swelling in the back.
- Constant back pain that doesn't ease after lying down.
- Pain in the chest or high up in the back.
- Pain down the legs and below the knees (neurological deficit in lower limbs [numbness, weakness]).
- Loss of bladder or bowel control or inability to pass urine.

DRAFT FOR ENDORSEMENT

<ul style="list-style-type: none"> • Numbness around the genitals, buttocks or back passage. • Pain that is worse at night. 				
Treatment(s) offered	Pack size	Maximum number of packs to be supplied	Suggested number of episodes per year	Information/instructions
Back Book	1	1	2	Link to purchase supplies of Back Book
Ibuprofen 400 mg tablets	24	1	2 – the second at least 6 months after the first episode	<p>Relative contraindications to NSAIDs include: heart failure, hypertension, ischaemic heart disease, peripheral arterial disease, cerebrovascular disease, renal impairment and peptic ulceration; caution in asthma. The combination of an NSAID and low-dose aspirin may increase the risk of gastrointestinal side effects; this combination should be avoided if possible. Consider the need for gastroprotection before recommending this treatment. Avoid using ibuprofen if the patient is taking warfarin.</p> <p>Maximum daily dose 1200 mg.</p> <p>A further supply may be issued 1–2 weeks after the initial consultation if symptoms persist up to a maximum of 3 weeks. The person will need to be reassessed.</p>
Paracetamol 500 mg tablets	32	2	2 – the second at least 6 months after the first episode	<p>Dosing advice is important.</p> <p>Paracetamol should not be used alone for managing low back pain.</p> <p>Encourage regular use of paracetamol in conjunction with ibuprofen if an NSAID alone is ineffective.</p> <p>A further supply may be issued 1–2 weeks after commencing dual therapy if symptoms persist up</p>

DRAFT FOR ENDORSEMENT

				to a maximum of 2 weeks. The person will need to be reassessed.
Advice for patient on how to resolve/manage condition				
<ul style="list-style-type: none"> • What is done in the early stages is very important. Resting for more than a day or two usually does not help and may actually prolong pain and disability¹¹. • The back is designed for movement: it needs movement – a lot of movement. The sooner a person gets moving and doing ordinary activities as normally as possible, the sooner they will feel better¹¹. • The people who cope best with back pain are those who stay active and get on with life despite the pain¹¹. • Local application of heat or cold (ensuring that the skin is protected) may relieve pain and muscle spasm. 				

.....**END OF 'BACKACHE (ACUTE) IN ADULTS' SECTION**.....

DRAFT FOR ENDORSEMENT

CHICKENPOX – IN CHILDREN UNDER 14 YEARS

General information

The child would normally have to be present in the pharmacy for an accurate diagnosis to be made. In most cases, the diagnosis can be made clinically from the characteristic chickenpox rash: small, red, raised spots on the scalp, face, trunk and proximal limbs which progress over 12–24 hours to blisters, papules, clear vesicles (which are intensely itchy), and pustules^{12,13}.

Advise that the most infectious period is 1–2 days before the rash appears, but that infectivity continues until all the lesions have crusted over (usually about 5–6 days after onset of the rash). During the period of infectivity, advise a child with chickenpox to 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)
- pregnant women
- infants aged ≤ 4 weeks.

Children with chickenpox should be kept away from school or nursery until the last blister has scabbed over^{12,13}.

Air travel may not be allowed until all blisters have scabbed over. Parents/carers of children with chickenpox to contact their airline and travel insurance company¹³.

Antipyretic agents can be considered in children to relieve fever and discomfort (headaches, aches and pains). However, they should not routinely be used with the sole aim of reducing body temperatures in children with fever who are otherwise well¹³.

Evidence suggests that there are increased risks of skin infections in children with varicella when exposed to NSAIDs. For this reason it is recommended that NSAIDs are avoided in children with chickenpox¹².

Referral to GP information

If the pharmacist is unsure about the diagnosis, the child should be referred to the GP.

Refer if the child is systemically unwell, their condition deteriorates, they develop complications or their symptoms have not started to improve within 6 days¹³.

Neonates are at increased risk of disseminated or haemorrhagic varicella¹². For this reason babies less than 4 weeks of age should be referred to their GP^{12,13}.

Children with chickenpox and parents/carers of young children with chickenpox should be aware of signs/symptoms of:

- skin bacterial superinfection¹² - sudden high-grade pyrexia (often after initial improvement), erythema and tenderness surrounding the original chickenpox lesions
- dehydration¹² – reduced urine output, lethargy, cool peripheries, reduced skin turgor
- chest infection¹³ - persistent cough, difficulty breathing and chest pain.

If any of the above are present they should be advised to seek medical attention.

DRAFT FOR ENDORSEMENT

Treatment(s) offered	Pack size	Maximum number of packs to be supplied	Number of episodes per year	Information/instructions	
Paracetamol 120 mg in 5 ml sugar-free suspension	100 ml	1	1	Not indicated for children < 3 months old. Paracetamol is the agent of choice. Antipyretic agents should not routinely be used with the sole aim of reducing body temperatures in children with fever who are otherwise well. The use of antipyretic agents should be considered in children to relieve fever and discomfort. 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.	
Paracetamol 250 mg in 5 ml sugar-free suspension	200 ml	1	1		
Paracetamol 500 mg tablets	32	1	1		
Chlorphenamine 2 mg in 5 ml sugar-free liquid	150 ml	1	1	Not indicated for children < 1 year old.	Chlorphenamine may be useful if sleep is disturbed or child is in significant discomfort. Note: only a few brands e.g. Piriton® liquid and tablets ^{14,15} and Boots Allergy Tablets ¹⁶ are licensed for the symptomatic relief of itching associated with chickenpox.
Chlorphenamine 4 mg tablets	28	1	1	Not indicated for children < 6 years old.	
Advice for patient on how to resolve/manage condition				<i>Link to leaflet</i>	
<ul style="list-style-type: none"> • Ensure adequate fluid intake to avoid dehydration. • Dress appropriately to avoid overheating or shivering. • Wear smooth, cotton fabrics. • Keep nails short and clean to minimise damage from scratching¹³. • Bathe in lukewarm or cool water – dab or pat the skin dry afterwards, rather than rubbing it. • Calamine lotion, moisturising creams or cooling gels may ease itching. 					

.....**END OF 'CHICKENPOX' SECTION**.....

DRAFT FOR ENDORSEMENT

COLD SORES

General information

Cold sores are small blisters that develop on the lips or around the mouth. They are caused by the herpes simplex virus and often start with a tingling, itching or burning sensation around the mouth.

Reassure the person that the condition is self-limiting and that lesions will heal without scarring within 7–10 days without treatment.

Give advice to minimise transmission.

Inform that children with cold sores do not need to be excluded from nurseries and schools.

Topical antiviral treatments are not included in the formulary because there is no good quality evidence that they are effective in reducing pain or healing time⁸. These topical treatments need to be initiated at the onset of symptoms before vesicles appear, be applied frequently for at least 4–5 days and do not provide a cure or prevent recurrences of cold sores¹⁸.

Referral to GP information

Consider referring pregnant women near term; there is a risk of herpes simplex virus transmission to the neonate, particularly at childbirth, if the mother with cold sores is actively shedding the herpes simplex virus.

Refer neonates and people who are immunocompromised.

People with frequent recurrences (more than 6 in a year).

Advise the person to seek medical advice if their condition deteriorates (e.g. the lesion spreads, new lesions develop after the initial outbreak, persistent fever, inability to eat or drink) or no significant improvement is seen after 5–7 days.

Treatment(s) offered	Pack size	Maximum number of packs to be supplied	Suggested number of episodes per year	Information/instructions
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Advice only

Advice for patient on how to resolve/manage condition

Link to leaflet

- The virus that causes cold sores is easily transmitted.
- Avoid touching the lesions.
- Avoid kissing until the lesions have completely healed especially newborn babies and anyone who is likely to be immunocompromised (e.g. people receiving cancer treatment or high doses of oral steroids [see BNF] or other immunosuppressants, or those with conditions that reduce immunity).
- Avoid oral sex until all lesions are completely healed.
- Do not share items that come into contact with lesion area (e.g. lipstick or lip balm).
- There is a risk of transmitting the infection to the eye if contact lenses become contaminated.
- Drink plenty of fluids to avoid dehydration.
- Avoid acidic or salty foods and eat cool, soft foods.
- Some people will get recurrences of cold sores – triggers include: having another infection (e.g. respiratory tract infection), fever, strong sunlight, fatigue, emotional upset or psychological stress, injury to the affected area and, in women at the time of their period¹⁹.

DRAFT FOR ENDORSEMENT

- If sunlight is a trigger for cold sores, using a sunscreen or sunblock lip balm (SPF 15 or greater) would help reduce recurrences¹⁸.

People should be aware that if purchasing topical therapy they should:

- Avoid touching the lesions, other than when applying medication.
- Wash hands with soap and water immediately before and after touching the lesions.
- Dab on topical medications rather than rub in to minimise mechanical trauma to the lesions.
- Not share medication with others.

.....END OF 'COLD SORES' SECTION.....

DRAFT FOR ENDORSEMENT

COLIC

General information

Infantile colic is a self-limiting condition which is defined clinically as repeated episodes of excessive and inconsolable crying in an infant that otherwise appears to be healthy and thriving. It occurs in 1 in 5 babies and tends to begin when a baby is a few weeks old²⁰. The exact underlying cause of infantile colic is not known, but may be due to indigestion, trapped wind or a temporary gut sensitivity to certain proteins or sugars in breast or formula milk. It has also been suggested that colic may be the extreme end of normal crying in babies²¹.

Typically, an infant with colic presents with intense crying bouts that most often occur in the late afternoon or evening and the infant may draw their knees up to their abdomen or arch their back when crying²⁰.

The most useful intervention is support for parents/carers and reassurance that infantile colic will resolve, often by 4–6 months²⁰.

Advice is available from other healthcare professionals, e.g. health visitor, GP.

Cry-sis is a charity providing support for families with excessively crying, sleepless and demanding children. Their helpline is available every day from 9am to 10pm (Tel: 0845 122 8669). The [Cry-sis website](#) also contains useful information.

Referral to GP/health visitor information

Refer those infants whose parents/carers feel unable to cope despite advice and reassurance²⁰.

Parents/carers should be advised to seek medical advice immediately if the baby²¹:

- has a weak, high-pitched, or continuous cry
- seems floppy when you pick them up
- isn't feeding
- vomits green (bile-stained) fluid
- has blood in their stool
- has a fever of 38°C or above (if they're less than three months old) or 39°C or above (if they're three to six months old)
- has a bulging fontanelle
- has a seizure
- turns blue, blotchy, or very pale
- has breathing problems, such as breathing quickly or grunting while breathing.

Treatment(s) offered	Pack size	Maximum number of packs to be supplied	Suggested number of episodes per year	Information/instructions
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Advice only. There is insufficient good-quality evidence to recommend the use of medicines or complementary therapies²⁰. Colic will eventually improve on its own²¹.

DRAFT FOR ENDORSEMENT

Advice for patient on how to resolve/manage condition	<i>Link to leaflet</i>
<ul style="list-style-type: none">• Reassure the parents/carers that their baby is well, they are not doing something wrong, the baby is not rejecting them, and that colic is common and is a phase that will pass within a few months²⁰.• Holding the baby through the crying episode may be helpful. However, if there are times when the crying feels intolerable, it is best to put the baby down somewhere safe (e.g. their cot) and take a few minutes of 'time out'²⁰.• Burp the baby during and after feeds²⁰.• Other strategies that may help to soothe a crying infant include²⁰:<ul style="list-style-type: none">– gentle motion (e.g. pushing the pram, rocking the crib)– 'white noise' (e.g. vacuum cleaner, hairdryer, running water)– bathing baby in a warm bath.• Encourage parents/carers to look after their own well-being²⁰:<ul style="list-style-type: none">– ask family and friends for support – parents/carers need to be able to take a break– rest when the baby is asleep– meet other parents/carers with babies of the same age.	

.....END OF 'COLIC' SECTION.....

DRAFT FOR ENDORSEMENT

CONJUNCTIVITIS (BACTERIAL)

General information

People with conjunctivitis will have a red eye and a discharge which may cause a sticky coating on the eyelid – usually on waking. There may also be a burning sensation and a feeling of grit in the eye but WITHOUT visual disturbance (in conjunctivitis, any visual disturbance is cleared by blinking). Bacterial conjunctivitis is usually associated with no or only mild pruritus.

Make people aware of the self-limiting nature of the condition and the possibility that antibacterial therapy is not necessary. Most people with bacterial conjunctivitis get better without treatment within 5–7 days, refer to advice section below.

For most people, using a topical ocular antibiotic makes little difference to recovery.

Chloramphenicol eye drops or eye ointment should only be supplied when there is purulent discharge or mild severity of red eye and one of the following:

- symptoms have been present for at least 3 days and are not improving, OR
- condition is severe or likely to become severe, providing that serious causes of a red eye can be confidently excluded.

Note: There are no agreed definitions of mild, moderate or severe conjunctivitis. It would seem reasonable to consider infective conjunctivitis to be severe when the person considers the symptoms to be distressing or signs are judged to be severe from clinical experience.

Advise the person that there is no recommended exclusion period from school, nursery or childminders for isolated cases²² but that many nursery and primary schools may nevertheless have an exclusion policy – check with school policy.

Referral to GP/optometry information

Refer urgently if:

- vision is reduced or in any way impaired
- person has significant photophobia
- person has had recent eye surgery
- person has restricted or painful eye movements.

People who have an eye problem that needs urgent attention or people with an apparent eye-related problem are entitled to have a free Eye Health Examination at an accredited optometrist practice. A list of optometrist practices that are accredited is available at [Eye Health Examination Wales](#).

Refer people to an accredited optometrist if:

- red eye and no discharge
- eye is painful

DRAFT FOR ENDORSEMENT

- there is redness and swelling around the eye
- there is a history of trauma or foreign body
- contact lenses are worn
- symptoms get worse despite treatment
- there has been no improvement in the person's signs or symptoms despite treatment.

Refer people to their GP if they:

- are under 2 years old
- are pregnant or breastfeeding and you consider they require treatment
- have a personal or family history of blood dyscrasias.

Treatment(s) offered	Pack size	Maximum number of packs to be supplied	Suggested number of episodes per year	Information/instructions
Chloramphenicol 0.5% eye drops	10 ml (via PGD)	1	2 (second at least 6 months after the first)	Cannot be supplied to children < 2 years or pregnant or breastfeeding women Refer to PGD.
Chloramphenicol 1% eye ointment	4 g (via PGD)	1	2 (second at least 6 months after the first)	
Advice for patient on how to resolve/manage condition				<i>Link to leaflet</i>
<ul style="list-style-type: none"> • Condition is usually self-limiting and will resolve within 1 week. • Good eye hygiene is essential. Wipe with cooled boiled water. • Wash hands regularly, particularly after touching infected secretions. • If symptoms worsen despite treatment, seek medical advice. • Don't share pillows or towels. 				

.....**END OF 'CONJUNCTIVITIS (BACTERIAL)' SECTION**.....

DRAFT FOR ENDORSEMENT

CONSTIPATION

General information

For short-term relief of constipation.

Constipation is defecation that is unsatisfactory because of infrequent stools, difficult stool passage or seemingly incomplete defecation. Stools are often dry and hard and may be abnormally large or abnormally small^{23,24}.

Offer oral laxatives if dietary measures are ineffective or while waiting for them to take effect.

Medicines that commonly cause constipation include: opioids, verapamil (also other calcium channel blockers to a lesser extent), tricyclic antidepressants, iron, diuretics, aluminium antacids, calcium, anticholinergics, sedating antihistamines, some antiepileptics and antipsychotics etc. Advise patient on how to manage their symptoms and if necessary refer to GP.

Treatment is selected depending on individual preference and consideration of severity, type and duration of symptoms:²³

- Start treatment with a bulk-forming laxative (ispaghula husk).
- If stools remain hard, add or switch to an osmotic laxative.
- If stools are still soft but difficult to pass or if emptying is inadequate, add a stimulant laxative (senna, bisacodyl or docusate).
- Adjust doses according to symptoms and response.
- Advise that laxatives should be stopped once the stool becomes soft and passes easily.

If the person has opioid-induced constipation:

- Avoid bulk-forming laxatives.
- Use an osmotic laxative (or docusate which softens stools) and a stimulant laxative.

Referral to GP information

Refer children < 18 years.

Refer if^{23,26}:

- rectal bleeding/blood in the stools
- unexplained weight loss or tiredness
- abdominal pain
- co-existing diarrhoea
- over 60 years of age and altered bowel habit
- persistent symptoms (with altered diet and use of laxatives for more than 2 weeks and stimulant laxatives for more than 7 days)
- tenesmus (continuous feeling of the need to defecate, i.e. without production of significant amounts of faeces, or after passing a normal amount of stool)

DRAFT FOR ENDORSEMENT

<ul style="list-style-type: none"> previous medicines have failed. 				
Treatment(s) offered	Pack size	Maximum number of packs to be supplied	Suggested number of episodes per year	Information/instructions
Ispaghula husk 3.5 g sachets	30	1	2	<p>One sachet twice daily with at least 150 ml liquid. Drink plenty of fluid.</p> <p>Take at least 1 hour before going to bed.</p> <p>Takes 2–3 days for the effects to be apparent.</p> <p>Short-term side effects can include bloating and flatulence.</p> <p>If taking other medicines advise them not to take the ispaghula husk at the same time, and to leave 30–60 minutes before or after their other medications²⁷.</p> <p>If taking iron supplements its best to take them at least 1 hour before or 4 hours after ispaghula husk²⁸.</p> <p>Prescribing information for ispaghula husk suggests that people with diabetes and people taking thyroid hormones require medical supervision whilst taking ispaghula husk²⁷. Consider using an alternative laxative for people with these conditions.</p>
Lactulose 3.1–3.7 g/5 ml liquid	500 ml	1	2	<p>Between 15 ml and 45 ml once or twice daily initially. This dose can be reduced to between 15 ml and 30 ml once or twice daily after it starts working. Lactulose is not suitable for people with lactose intolerance and galactosaemia.</p> <p>Short-term side effects of osmotic laxatives can include abdominal pain, bloating and flatulence, particularly if they eat a lot of fruit.</p>
Senna 7.5 mg tablets	20	1	2	<p>Senna: 1–2 tablets at bedtime.</p> <p>Bisacodyl: 1–2 tablets at bedtime.</p> <p>Milk, antacids or proton pump inhibitors should not be taken within 1 hour before or 1 hour after bisacodyl.</p> <p>Docusate sodium: up to 500 mg daily in divided doses can be taken. It is recommended to start with higher doses then reduce the dose once symptoms improve.</p> <p>Stimulant laxatives start to work in 6–12 hours.</p>
Bisacodyl 5 mg EC tablets	20	1	2	
Docusate sodium 100 mg capsules	30	1	2	

DRAFT FOR ENDORSEMENT

				<p>If they have not had stimulant laxatives before suggest they start with 1 tablet and increase to 2 if necessary. When bowel regularity returns to normal, treatment can be stopped²⁹. Short-term side effects can include abdominal pain. Counsel people who take diuretics, steroids and anti-arrhythmics with reference to diarrhoea and the risk of hypokalaemia.</p>
<p>Advice for patient on how to resolve/manage condition</p>				<p><i>Link to leaflet</i></p>
<p>Lifestyle measures can improve symptoms²⁴:</p> <ul style="list-style-type: none"> • Increase dietary fibre. Eat at least 18–30 g of fibre a day (increase gradually, to minimise bloating and flatulence). • Add some bulking agents like wheat bran to the diet. • Eat regularly. • Avoid dehydration by drinking plenty of water. • Exercise regularly. • Respond to the bowel’s natural pattern and do not delay going to the toilet. Identify a time and place to spend time on the toilet. • If constipation is causing pain or discomfort a painkiller can be taken, avoid codeine-containing products. • 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. 				

.....**END OF ‘CONSTIPATION’ SECTION**.....

DRAFT FOR ENDORSEMENT

DIARRHOEA

General information

Diarrhoea is the frequent passing of watery or loose stools. There is no agreed definition but the British Society of Gastroenterology defines diarrhoea as the abnormal passage of loose or liquid stools more than three times daily and/or a volume of stool greater than 200 g/day. Acute diarrhoea is usually defined as that lasting less than 4 weeks and chronic diarrhoea as that lasting more than 4 weeks. Most acute diarrhoea episodes are due to infection³⁰.

Attempt to ascertain the underlying cause. Ask about:

- fever
- contact with anyone with acute diarrhoea and/or vomiting
- exposure to a known source of enteric infection (possibly contaminated water or food, recent farm visits)
- recent travel abroad
- recent laxative use
- hospital admission or antibiotic use in preceding 8 weeks (increased risk of *Clostridium difficile* infection)
- the use of other drugs associated with diarrhoea e.g. allopurinol, angiotensin-II receptor blockers, digoxin, colchicine, cytotoxic drugs, magnesium-containing antacids, metformin, NSAIDs, PPIs, SSRIs, statins, theophylline, thyroxine and high-dose vitamin C³¹
- constipation with “overflow diarrhoea”
- anxiety or stress
- food intolerance or allergy
- chronic causes e.g. inflammatory bowel disease³¹.

Assess the severity of the illness. Determine the frequency and severity of symptoms, including the quantity and character of the stools, whether there is blood or mucus in stools; if vomiting too, ask about the frequency. Ask about signs and symptoms of dehydration. e.g. reduced urine output, lethargy, cool peripheries and reduced skin turgor.

Review medications:

- Certain medications may be affected by severe diarrhoea (e.g. warfarin, anticonvulsants, and the oral contraceptive pill)³².
- Certain medications (diuretics, ACE inhibitors) can exacerbate dehydration³³.

Management of diarrhoea is usually supportive with attention to fluid intake and nutrition. The priority for acute diarrhoea is the prevention or reversal of fluid and electrolyte depletion³¹. Oral rehydration solutions can be used to prevent dehydration for those at risk (frail, elderly, or people with comorbidities with which dehydration could be a problem; and children) and to treat dehydration that has already occurred³³. Antidiarrhoeal medication may help reduce diarrhoea and shorten its duration to enable the person to continue essential activities^{30,33}.

Referral to GP information

DRAFT FOR ENDORSEMENT

<p>Adults³² Refer:</p> <ul style="list-style-type: none"> • pregnant women • people with significantly reduced urinary output • people who are systemically unwell or dehydrated people over 60 and recent change in bowel habit • when person has recently received course of antibiotics or been in hospital in the preceding 8 weeks • diarrhoea is persistent (> 1 week) • when person has vomiting that has lasted more than 48 hours • if stools are very smelly and or have pus present³⁴ • when there is blood in the stool • when there is preceding weight loss • when person has painless, watery, high-volume diarrhoea (increased risk of dehydration) • nocturnal symptoms disturbing sleep – organic cause likely. <p>Other factors that may be relevant for earlier referral to GP include (use clinical judgment)^{32,33}:</p> <ul style="list-style-type: none"> • older age (people 60 years of age or older are more at risk of complications) • recent foreign travel • home circumstances and level of support • fever • abdominal pain and tenderness • faecal incontinence • increased risk of poor outcome, for example: <ul style="list-style-type: none"> – co-existing medical conditions - immunodeficiency, lack of stomach acid, inflammatory bowel disease, valvular heart disease, diabetes mellitus, renal impairment, rheumatoid disease, systemic lupus erythematosus – medicines that can exacerbate dehydration and renal failure (see above). 				<p>Children³⁰ Refer:</p> <ul style="list-style-type: none"> • children younger than 1 year • children with a high temperature that can't be brought down - over 38°C (under 3 months), over 39°C (3-6 months) • those who have blood or mucus in their stool • those who have severe tummy pain • children who are getting worse quickly • children with symptoms of dehydration (especially those who have sunken eyes, fast breathing, reduced skin turgor, are drowsy, confused or lethargic) • children with an underlying medical condition (heart or kidney problems, diabetes, history of premature birth) • children who have passed more than six diarrhoeal stools in the previous 24 hours • children who have vomited three times or more in the last 24 hours • symptoms not settling e.g. vomiting for more than 1–2 days or diarrhoea that is not settling after 3–4 days³⁵ • recent foreign travel • children who have not been offered or have not been able to tolerate supplementary fluids before presentation • infants who have stopped breastfeeding during the illness • children with signs of malnutrition³⁶.
Treatment(s) offered	Pack size	Maximum number of packs to be supplied	Suggested number of episodes per year	Information/ instructions
Advice only				

DRAFT FOR ENDORSEMENT

Advice for patient on how to resolve/manage condition	Link to leaflet
<p>If possible infective cause, give advice about minimising transmission. Give advice about maintaining fluid intake. For fluid management in children with gastroenteritis but without clinical dehydration, NICE CG84 recommends:</p> <ul style="list-style-type: none">• continuing breastfeeding and other milk feeds• encouraging fluid intake• discouraging the drinking of fruit juices and carbonated drinks, especially in children at increased risk of dehydration• offering ORS solution as supplemental fluid to children at increased risk of dehydration³⁶. <p>Adults and children should not attend work, school or childcare facilities while they have diarrhoea or vomiting. They should not go back to work, school or the childcare facility until at least 48 hours after the last episode of diarrhoea or vomiting^{30,36}.</p>	

.....**END OF 'DIARRHOEA' SECTION**.....

DRAFT FOR ENDORSEMENT

DRY EYES

General information

In most cases, dry eye syndrome can be managed with appropriate patient self-management and pharmacological treatments.

Assessment by an optometrist is required if:

- symptoms are not suitably controlled despite appropriate treatment for about 4–6 weeks
- diagnosis requires specialist assessment (apply a lower threshold for obtaining specialist advice for younger people)
- vision has deteriorated.

When the person re-attends after assessment by an optometrist, reinforce the information provided by the optometrist.

Generic treatments including lubricants, oily tear drops and eye ointments, selected in a prioritised manner may be prescribed to people with dry eye syndrome, but these treatments do not treat the root cause. Therefore, treatments should be used in conjunction with self-management methods.

A dry eye syndrome treatment should be tried for 4–6 weeks before assessing benefit³⁷.

Referral to optometry information

People who have an eye problem that needs urgent attention or people with an apparent eye-related problem are entitled to have a free eye examination at an accredited optometrist practice.

A list of optometrist practices that are accredited is available at [Wales Eye Care Services](#)³⁷.

When the condition of dry eyes is suspected, the person can also be referred to an EHEW accredited optometrist to have a free eye health examination. Referral is recommended because certain underlying medical conditions can be associated with dry eye syndrome, e.g. allergic conjunctivitis, Sjögren's syndrome, facial or trigeminal neuropathy, herpes zoster affecting the eye, chronic dermatoses of the eyelids, previous ocular or eyelid surgery, trauma, radiation therapy, burns. If acute glaucoma, keratitis or iritis is suspected, refer immediately.

Symptoms include:

- moderate-to-severe eye pain or photophobia
- marked redness in one eye
- reduced visual acuity.

Chronic dry eye is not funded by EHEW and therefore people with chronic dry eye should not be referred to this service.

Contact lens wearers presenting with dry eye syndrome should be encouraged to attend their prescribing optometrist³⁷. Preservative-free ocular lubricants are available for people who use contact lenses after optometrist consultation. Avoid paraffin-based products for people wearing contact lenses.

DRAFT FOR ENDORSEMENT

Treatment(s) offered	Pack size	Maximum number of packs to be supplied	Suggested number of episodes per year	Information/instructions	
Hypromellose 0.3% eye drops	10 mL	1	1	May need to be instilled frequently (e.g. hourly) initially for adequate relief until symptoms improve, then decrease the frequency	These products can be provided on the advice of an optometrist who can specify for each person the preparation to be supplied. Preservative-free preparations can be supplied when the optometrist advises it is necessary or because of allergy to the preservative and/or moderate to severe eye disease. If more than 6 applications are used daily, consider using a preservative-free product because the risk of irritation from the preservative increases with the frequency of dosing ³⁸
Hypromellose 0.3% preservative-free eye drops	10 mL	1	1		
Carbomer '980' 0.2% eye drops	10 g	1	1	3–4 times daily	
Carbomer '980' 0.2% preservative-free eye drops (Xalin gel™)	10 g	4	1	3–4 times daily	
Polyvinyl alcohol 1.4% eye drops	10 ml	1	1	3–4 times daily	
Polyvinyl alcohol 1.4% preservative-free eye drops	30 x 0.4 ml	4	1	3–4 times daily	
Liquid paraffin/white soft paraffin eye ointment with retinol palmitate preservative-free	5 g	1	1	Best used before sleep	
Liquid paraffin /white soft paraffin eye ointment preservative-free	5 g	1	1	Best used before sleep	Refer to local health board formulary for appropriate choice of eye drop.

DRAFT FOR ENDORSEMENT

Advice for patient on how to resolve/manage condition	Link to leaflet
<p>By taking suitable precautions, the symptoms of dry eyes can be lessened and, in mild cases, this may be sufficient to avoid the need for treatment. These precautions include:</p> <ul style="list-style-type: none">• Good eyelid hygiene to control the blepharitis – present in most people with dry eye syndrome. Eyelids should be cleaned in a stepwise manner twice daily, then once daily as symptoms improve³⁷.• Limiting the use of contact lenses if these cause irritation (optometrist assessment required).• Reviewing medication that exacerbates dry eyes, such as topical and systemic antihistamines, tricyclic antidepressants, beta blockers, diuretics and selective serotonin reuptake inhibitors (SSRIs)^{37,39}.• Using a humidifier to moisten ambient air.• Stopping smoking.• If using a computer monitor frequently for long periods, ensure that the monitor is placed at or below eye level. Advise person to avoid staring at the screen and to take frequent breaks to close or blink the eyes.• Avoid wearing eye make-up.	

.....**END OF 'DRY EYES' SECTION**.....

DRAFT FOR ENDORSEMENT

DRY SKIN/DERMATITIS

General information

Dry skin has a dull surface with a rough, scaly quality. The skin is less pliable and cracked⁴⁰.

Dry areas of skin may become red and itchy; indicating a form of atopic dermatitis has developed⁴⁰.

Identify potential trigger factors for dry skin including: hot, dry or cool, windy conditions; excessive bathing; contact with soaps, detergents and solvents; topical agents such as alcohol; irritation from rough clothing or abrasives⁴⁰.

In addition to the above, possible trigger factors for atopic dermatitis include animal dander, house dust mites, pollen, certain foods and stress⁴¹.

The mainstay of treatment of dry skin is moisturisers and emollients. They should be applied liberally and often enough to reduce itch, improve barrier function, prevent entry of irritants and reduce transepidermal water loss. In addition, a topical steroid can be given if the skin is itchy or there is dermatitis⁴⁰. Avoid aqueous cream as an emollient.

Once appropriate treatment for person has been determined then further supplies should be obtained through the GP.

Bath/shower emollients should not be supplied – there are no published randomised controlled trials on bath emollients and there is no consensus of clinical opinion that such therapy is effective⁴².

Referral to GP information

Refer those with:

- skin infection (signs suggestive of infection - erythema, inflammation, weeping, pustules, crusts, rapidly worsening rash, fever and malaise)
- rash failing to respond to therapy.

Treatment(s) offered	Pack size	Maximum number of packs to be supplied	Suggested number of episodes per year	Information/instructions	
Emollients (creams not bath oils etc.):	Cetraben [®] , Zerobase [®] or ZeroCream [®] cream	50 g 500 g	1 1	2 2	Refer to local health board formulary for appropriate choice of emollient.
	Doublebase [®] or Zerodouble [®] gel	100 g 475–500 g	1 1	2 2	Provide an emollient according to the dryness of the skin and individual preference. The key to successful management is finding the correct balance between these factors.
	Diprobase [®] cream	50 g 500 g	1 1	2 2	Creams and lotions are generally better for red, inflamed areas of skin. Ointments are preferable for dry skin (that is not

DRAFT FOR ENDORSEMENT

	Hydrous ointment	500 g	1	2	inflamed) because they are more effective than creams. However, they are usually poorly tolerated compared with cream; may be more convenient for night-time use ⁴¹ . First episode could be two consultations in order to include trial of therapy. Subsequent episodes should only be a single consultation. First consultation – Provide either a) a choice of up to three different 50–125 g pots as a trial of therapy or to establish preference or b) a 500 g pot if person already has a preference. Second consultation – Provide a 500 g pot of preferred product if not supplied at first consultation.
	Hydromol [®] ointment	125 g 500 g	1 1	2 2	
	White soft paraffin: liquid paraffin (50:50)	500 g	1	2	
	Soap substitutes Emulsifying ointment	500 g	1	2	Emollients should be prescribed to replace soap in people with dry skin requiring treatment. Ointments dissolved in hot water are suitable soap substitutes. Advise person to take care if bath/shower become slippery as a result of using any of these products.
	Hydrocortisone 1% ointment	15 g 30 g (via PGD)	1 1	2 2	Only issue if using adequate quantities of emollients. Not to be supplied to children < 10 years or pregnant women unless via PGD. Not to be supplied for use on the face unless via PGD. Hydrocortisone 2.5% could be provided if the person has established dermatitis and has a mild flare-up, and if 1% has been previously used and found to be ineffective. Continue for 48 hours after the flare is controlled ⁴¹ . Refer if not resolving.
	Hydrocortisone 1% cream	15 g 30 g (via PGD)	1 1	2 2	
	Hydrocortisone 2.5% ointment	via PGD	1	1	
	Hydrocortisone 2.5% cream	via PGD	1	1	
Advice for patient on how to resolve/manage condition					
Advise on the appropriate use of emollients: see link to leaflet					
Advise that where possible, they should avoid trigger factors known to exacerbate dry skin or dermatitis.					
When patients are being treated with a paraffin-based emollient product they should be advised not to smoke, use naked flames (or be near people who are smoking or using naked flames), or go near anything that may cause a fire while emollients are in contact with their medical dressings or clothing. People's clothing and bedding should be changed regularly—preferably daily—because emollients soak into fabric and can become a fire hazard ¹ . Refer to paraffin hazard leaflet: http://www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=60274&type=full&servicetype=Attachment .					

.....END OF 'DRY SKIN/DERMATITIS' SECTION.....

DRAFT FOR ENDORSEMENT

HAEMORRHOIDS

General information

Haemorrhoids are likely to be diagnosed on symptoms described by person. They may present with perianal itch and/or bright red bleeding, often occurring with defecation. The bleeding can vary from streaks on the toilet paper to blood dripping into the toilet. Blood is seen on the outside of the stool but is not mixed in with the stool.

Provide lifestyle advice (see below).

Provide symptomatic relief with analgesia such as paracetamol.

Advise that treatments only provide symptomatic relief and do not cure haemorrhoids. Ideally treatments should only be provided once a diagnosis has been made by a GP. On the first presentation of symptoms provide treatments and refer patient to GP – no subsequent treatments should be provided without a GP diagnosis.

Preparations containing corticosteroids should only be used for up to 7 days. Anaesthetic-containing products should only be used for a few days¹.

If constipated, advise and treat (see [CONSTIPATION](#)) but avoid stimulant laxatives that do not include a softening action. Recommend a bulk-forming laxative (e.g. ispaghula husk).

Referral to GP information

Refer those with:

- a change in bowel habit
- abdominal pain
- night-time diarrhoea for several nights
- unexplained weight loss
- rectal bleeding
- suspected infection.

Refer pregnant women and children under 18 years of age.

Treatment(s) offered	Pack size	Maximum number of packs to be supplied	Suggested number of episodes per year	Information/instructions
Paracetamol 500 mg tablets	32	2	2 – the second at least 6 months after the first.	If taking paracetamol regularly and on warfarin advise person to have an INR test 5–7 days later.

DRAFT FOR ENDORSEMENT

Scheriproct [®] ointment	30 g (via PGD)	1	2 – the second at least 6 months after the first.	Commonly used topical preparations for haemorrhoids all contain potential sensitisers and people should be advised to discontinue treatment if symptoms get worse and to use for no longer than a few days. Scheriproct [®] contains a local anaesthetic and a corticosteroid and Anusol [®] contains astringents and antiseptics. Refer to local health board formulary for appropriate choice of haemorrhoid product.
Scheriproct [®] suppositories	12 (via PGD)	1	2 – the second at least 6 months after the first.	
Anusol [®] cream	23 g	1	2 – the second at least 6 months after the first.	
Anusol [®] ointment	25 g	1	2 – the second at least 6 months after the first.	
Anusol [®] suppositories	12	1	2 – the second at least 6 months after the first.	
Ispaghula husk (Fybogel [®]) sachets	30	1	2 – the second at least 6 months after the first.	Provide a laxative if the person is constipated: <ul style="list-style-type: none"> • A bulk-forming laxative (e.g. ispaghula husk) is the preferred choice. • Lactulose (an osmotic laxative) or sodium docusate (a stimulant laxative with stool softening activity) are alternatives. • Refer to CONSTIPATION section for specific advice regarding these products.
Lactulose 3.1–3.7 g/5 ml liquid	500 ml	1	2 – the second at least 6 months after the first.	
Docusate sodium 100 mg capsules	30	1	2 – the second at least 6 months after the first.	
Advice for patient on how to resolve/manage condition				<i>Link to leaflet</i>
Lifestyle advice: <ul style="list-style-type: none"> • increase daily fibre intake; this should be done gradually to minimise flatulence and bloating • drink 6–8 glasses of fluid daily • avoid straining during defecation • do not delay going to toilet • maintain good perianal hygiene (may wish to use wipes rather than dry paper, pat dry rather than rub around bottom) • lose weight if overweight • take regular exercise • avoid or cut down on caffeine and alcohol intake⁴³. 				

.....**END OF 'HAEMORRHOIDS' SECTION**.....

DRAFT FOR ENDORSEMENT

HAY FEVER

General information

Hay fever is a common seasonal allergy to grass, tree or weed pollen. Symptoms include: sneezing, rhinitis, conjunctivitis, itchy throat, mouth, nose, ears, and cough caused by post-nasal drip. Less commonly loss of smell, headache, earache, facial pain or tiredness may occur. People with asthma may experience worsening of their symptoms⁴⁴.

Lifestyle changes, such as pollen avoidance, should be advised and may relieve symptoms without the need for medication^{44,45}. It may not be necessary to treat hay fever, especially in children if they are not upset by symptoms.

If providing treatment, follow a stepped approach:

- for people with occasional symptoms of allergic conjunctivitis, children aged 2–5 years and people who prefer an oral formulation treat with an oral antihistamine⁴⁴. Non-sedative antihistamines are preferred.
- for people with more persistent symptoms, and predominant symptom is nasal blockage, treat with an intranasal corticosteroid (people over 6 years)⁴⁶.
- If the predominant symptom is sneezing or nasal discharge treat with an oral antihistamine.

For people with signs of allergic conjunctivitis sodium cromoglicate eye drops may provide additional relief (not suitable for contact lens wearers)^{1,44,47}.

If symptoms are uncontrolled with the above treatment:

- reinforce advice about pollen avoidance and check compliance with first-line treatment
- for people taking an oral antihistamine, add an intranasal corticosteroid and review after 2–4 weeks
- for people using an intranasal corticosteroid, ensure they have a good technique. If they have, step up to the maximum licensed dose (for the age group) of the intranasal corticosteroid and review after 2–4 weeks
- for people with residual symptoms on maximum licensed dose of intranasal corticosteroid, continue with treatment and, if there is persistent nasal itch, sneezing, rhinorrhoea or allergic conjunctivitis, add an oral antihistamine
- if rhinorrhoea persists despite combined use of intranasal corticosteroid and antihistamine refer to GP for an anticholinergic
- if nasal blockage is a problem, consider the use of an intranasal decongestant for up to 7 days⁴⁴.

The importance of regular treatment and good nasal spray/eye drop technique to control symptoms should be explained⁴⁴. Treatment should be continued until exposure to the suspected allergen is no longer likely.

Referral to GP information

Refer to the GP if:

- person is pregnant or breastfeeding
- infection is suspected (e.g. green or yellow nasal discharge)

DRAFT FOR ENDORSEMENT

- uncontrolled symptoms continue after 2–4 weeks despite correct use of medication⁴⁵
- urgent resolution of severe symptoms affecting quality of life is required⁴⁴
- person is a child under 2 years requiring treatment
- there is nasal blockage in the absence of rhinorrhoea, nasal itch and sneezing
- there is unilateral nasal discharge, especially in a young child, to check for a trapped foreign body.

People with an eye problem (see [CONJUNCTIVITIS](#)) requiring urgent attention or people with certain eye-related problems are entitled to have a free Eye Health Examination at an accredited optometrist practice. A list of accredited practices is available at [Eye Care Wales](#).

Contact lenses may exacerbate eye symptoms. People who wear contact lenses should be advised to visit their optometrist if this is the case. Eye drops containing some preservatives (e.g. benzalkonium chloride) are unsuitable for people with contact lenses.

Treatment(s) offered	Pack size	Maximum number of packs to be supplied	Suggested number of episodes per year	Information/instructions	
Cetirizine 10 mg tablets	30	1	6	Only for people over 6 years.	If symptoms uncontrolled after 2–4 weeks of correct treatment, refer to the GP. Supply 1 month at a time. Restrict total treatment duration to 6 months. Children treated with high doses of steroid nasal spray for more than 3 months require height monitoring – refer to GP at 3 months.
Cetirizine 1 mg/ml sugar-free oral solution	200 ml	2	5	Only for people over 2 years.	
Loratadine 10 mg tablets	30	1	6	Only for people over 2 years AND body weight over 30 kg.	
Loratadine 1 mg/ml oral solution	100 ml	3	6	Only for people over 2 years.	
Chlorphenamine 4 mg tablets	28	3	6	Due to sedative properties only likely to be appropriate in occasional circumstances. Only for people over 6 years.	
Chlorphenamine 2 mg in 5 ml syrup	150 ml	1	6	Due to sedative properties only likely to be appropriate in occasional circumstances. Only for people over 1 year.	
Sodium cromoglicate 2% eye drops	13.5 ml (via PGD)	1	6	Only for people over 6 years.	

DRAFT FOR ENDORSEMENT

Beclometasone 50 microgram nasal spray	200 spray unit (via PGD)	1	6	Only for people over 6 years.	Check labelling for age appropriate formulation.
Advice for patient on how to resolve/manage condition					<i>Link to leaflet</i>
<p>Regular treatment and good nasal spray/eye drop technique are important to control symptoms. People should be advised to check weather reports for the pollen count and stay indoors when possible when it is high⁴⁵. Non-sedating antihistamines may still cause drowsiness which may affect driving ability especially if combined with alcohol. Consider buying a pollen filter for car air vents and change at each service. People who use a steroid nasal spray to control their symptoms should be advised to re-start treatment several weeks before the start of the pollination season⁴⁴.</p> <p>When the pollen count is high the person should:</p> <ul style="list-style-type: none"> • avoid pollen by closing windows, wearing wraparound sunglasses and avoiding grassy areas particularly during early morning, evening and night^{44,47} • avoid drying clothes outside • apply Vaseline® around their nostrils to trap the pollen • shower and wash their hair after being outdoors to remove pollen • vacuum regularly and dust with a damp cloth⁴⁵. 					

.....**END OF 'HAY FEVER' SECTION**.....

DRAFT FOR ENDORSEMENT

HEAD LICE

General information

Head lice are small, whitish or grey-brown insects that range from the size of a pinhead to the size of a sesame seed. White eggs or egg cases (nits) may be visible in the hair behind the ears or at the back of the neck. Symptoms may include itchy scalp, rash on the back of the neck and feeling as though something is moving through the hair⁴⁸. The itch may last 2-3 weeks after treatment. Scratching may rarely lead to excoriation and skin infection⁴⁹.

Head lice infestation should be confirmed by detection combing on wet or dry hair. At the same time all household members and other close contacts should use a detection comb to check for live head lice. All those with evidence of live head lice should be treated simultaneously⁴⁹.

If head lice are detected they should be treated by wet combing. This is effective if undertaken appropriately. Encourage wet combing by supplying a detection comb. If this method is unacceptable to the person/carer, they may purchase a chemical or insecticidal treatment. Hedrin[®] should only be supplied if wet combing is unacceptable or ineffective AND person is able to supply evidence of a live louse.

Afro hair or tightly curled hair can make treating a head lice infestation particularly difficult. Using an insecticidal lotion, such as Hedrin[®], and methodically combing small sections of hair at a time with a detection comb will usually be effective. Therefore, Hedrin[®] could be used first-line in these people.

Give advice on detection and wet combing. Recommend checking children's hair for lice every week or so⁵⁰. Parents/carers should inform the school as soon as possible if head lice are found on a child, but they do not need to exclude the child from school.

Referral to GP information

Refer people with scalp inflammation.

Treatment(s) offered	Pack size	Maximum number of packs to be supplied	Suggested number of episodes per year	Information/instructions
Detection comb	1	1	2 – the second at least 6 months after the first	First-line treatment – see also advice section.
Dimeticone 4% lotion (Hedrin [®])	150 ml	See information/ instructions	2 – the second at least 6 months after the first	Second-line, if a person returns after 2 weeks still with head lice despite having undertaken wet combing correctly for 2 weeks. It can be used in pregnant and breastfeeding women and in infants from 6 months of age ⁴⁹ . Sufficient quantities should be provided to allow all members of the household to be treated simultaneously. The names of all those who will be treated with the supplies provided should be documented.

DRAFT FOR ENDORSEMENT

				<p>Typically 50 ml should be sufficient for short to shoulder length hair and 150 ml should be sufficient for long, thick hair. Rub into dry hair and scalp, allow to dry naturally, shampoo after a minimum of 8 hours (or overnight), repeat application after 7 days. Keep hair away from fire and flames during treatment^{1,51}. Detection combing should be done on Day 9 or 10 since first treatment and Day 17. Treatment is successful if no live lice are found on both occasions.</p>
Cyclomethicone, isopropyl myristate (Full Marks®)	200 ml	See information/ instructions	2 – the second at least 6 months after the first	<p>Second-line, if a person returns after 2 weeks still with head lice despite having undertaken wet combing correctly for 2 weeks. Not suitable for infants under 2 years of age, pregnant or breastfeeding women⁴⁹.</p> <p>Sufficient quantities should be provided to allow all members of the household to be treated simultaneously. The names of all those who will be treated with the supplies provided should be documented.</p> <p>Typically 50 ml should be sufficient for short to shoulder length hair and 150 ml should be sufficient for long, thick hair.</p> <p>Rub in to dry hair, after 10 minutes use the comb to remove dead lice and eggs⁵². Repeat application after 7 days. Keep hair away from fire and flames during treatment.</p> <p>Detection combing should be done on Day 9 or 10 since first treatment and Day 17. Treatment is successful if no live lice are found on both occasions⁴⁹.</p>
Advice for patient on how to resolve/manage condition				
<p>Wet combing method^{48,53}:</p> <ul style="list-style-type: none"> • Wash the hair using ordinary shampoo and apply ample conditioner, before using a wide-toothed comb to straighten and untangle the hair. • Once the comb moves freely through the hair without dragging, switch to the louse detection comb. Make sure that the teeth of the comb slot into the hair at the roots with the bevel-edge of the teeth lightly touching the scalp. • Draw the comb down to the ends of the hair with every stroke and check the comb for lice. • Remove lice by wiping or rinsing the comb. 				

DRAFT FOR ENDORSEMENT

- Work methodically through the hair, section by section, so that the whole hair is combed.
- Rinse out the conditioner and repeat the combing procedure on the wet hair.
- Repeat the procedure on Days 5, 9 and 13 to clear any young lice as they hatch, before they have time to reach maturity.
- Detection combing should be done on Day 17 to check for any live head lice⁴⁸.
- Continue until no lice are found on 3 consecutive sessions⁴⁹.
- Afro hair: keeping hair short will make treatment easier. Alternatively, plaiting or braiding the hair can make it difficult for head lice to attach themselves to the bottom of the hair strand. Using a medicated lotion and methodically combing small sections of hair at a time with a detection comb will usually be effective.

.....END OF 'HEAD LICE' SECTION.....

DRAFT FOR ENDORSEMENT

INDIGESTION AND REFLUX

General information

Diagnostic features: symptoms of indigestion (dyspepsia), which are typically present for 4 weeks or more, include upper abdominal pain or discomfort, heartburn, acid reflux (with or without bloating), nausea or vomiting⁵⁴.

Check for potential medicines-related exacerbation or cause e.g. bisphosphonates, calcium channel blockers, corticosteroids, nitrates, non-steroidal anti-inflammatory drugs (NSAIDs) and theophyllines. Report suspected adverse reactions through the Yellow Card Scheme if appropriate.

For people with uninvestigated dyspepsia or 'reflux-like symptoms', whose symptoms persist despite lifestyle advice and use of antacids and/or alginates, offer full dose PPI therapy for 1 month⁵⁵.

In women who are pregnant offer lifestyle advice as below. If symptoms are not controlled adequately by these measures antacids and alginates may be recommended.

Referral to GP information

Refer all children (< 18 years).

Refer if diagnostic uncertainty including pain on exertion, pain in chin/left shoulder, history of myocardial infarction, previous gastric/peptic ulceration.

Refer if current medication e.g. NSAIDs is likely to be the cause or is exacerbating symptoms.

Refer if the person:

- has dyspepsia with one or more of the following:
 - chronic gastrointestinal bleeding: melaena (sticky black stools), blood in vomit or stools
 - progressive unintentional weight loss/ unexplained loss of appetite
 - progressive difficulty swallowing
 - abdominal swelling
 - persistent vomiting
- has signs of anaemia e.g. shortness of breath, lethargy
- is over 55 years of age with persistent or unexplained dyspepsia
- is of any age and has gastro-oesophageal symptoms that are unexplained or non-responsive to treatment.

Treatment(s) offered	Pack size	Maximum number of packs to be supplied	Suggested number of episodes per year	Information/instructions
Peptac [®]	500 ml	1	2	

DRAFT FOR ENDORSEMENT

Compound alginates. One of:	Gaviscon Advance [®]	500 ml	1	2	Currently Peptac [®] is the most cost-effective option. Refer to local health board formulary for appropriate choice of alginate.
PPIs	Omeprazole 20 mg capsules	28 (via PGD)	1	2	Omeprazole would be the first-line PPI. Lansoprazole should be considered if there are interactions with existing medication. Advise INR test 5–7 days after starting PPI if taking warfarin.
	Lansoprazole 30 mg capsules	28 (via PGD)	1	2	
Advice for patient on how to resolve/manage condition					<i>Link to leaflet</i>
<p>Lifestyle advice:</p> <ul style="list-style-type: none"> • healthy eating • weight reduction • reducing alcohol intake • smoking cessation • avoiding known precipitants such as coffee, chocolate and fatty/spicy foods • raising the head of the bed, eating smaller meals and having a main meal at last 3–4 hours before going to bed may help some people⁵⁵. <p>Explain to patient that treatment is for 1 month only and long-term use of PPIs is normally discouraged. To reduce the risk of rebound hypersecretion you could suggest that the person tapers their PPI towards the end of the treatment course and/or uses an alginate if symptoms recur. Depending on the severity of the person's symptoms you may wish to suggest PRN dosing when the person is symptomatic.</p>					

.....**END OF 'INDIGESTION AND REFLUX' SECTION**.....

DRAFT FOR ENDORSEMENT

INGROWING TOENAIL				
General information				
<p>Ingrowing toenails are a common problem (especially in teenagers and young adults) in which part of the nail penetrates the skin fold alongside the nail, creating a painful area, often on the big toe. The nail fold may be red, hot, tender, and swollen; occasionally a visible collection of pus may be present. Granulation tissue may also be seen.</p> <p>The foot should be examined to make the diagnosis.</p> <p>When the ingrowing toenail is at a mild to moderate stage, non-surgical (or conservative) interventions will relieve symptoms, prevent the ingrown toenail getting worse, help cure the problem, and prevent recurrence.</p> <p>Antibiotics may be needed to treat infection.</p>				
Referral to GP information				
<p>Further advice can be obtained from a podiatrist (depending on the location, this may need to be private) or GP.</p> <p>Refer if patient is diabetic or if there is:</p> <ul style="list-style-type: none"> • infection (acute, chronic or recurrent) which may require incision and drainage • co-existing nail disease. <p>Refer if no improvement after 7 days of conservative treatment, or sooner if symptoms are getting worse.</p>				
Treatment(s) offered	Pack size	Maximum number of packs to be supplied	Suggested number of episodes per year	Information/instructions
Advice only				
Advice for patient on how to resolve/manage condition				<i>Link to leaflet</i>
<p>Painkillers, such as paracetamol, can be used to help relieve any pain.</p> <p>If the ingrowing part of the nail is small, it may be prevented from becoming worse, and sometimes cured, by the following⁵⁶.</p> <ul style="list-style-type: none"> • Soak the toe in water for 10 minutes to soften the folds of skin around the affected nail. • Then, 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. <p>There are variations on this method – the principle is to keep the skin from growing over the edge of the nail.</p>				

DRAFT FOR ENDORSEMENT

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

Advise the person to:

- Practise good foot hygiene by taking care of their feet and regularly washing them, using soap and water.
- Trimming the nail straight across to help prevent pieces of nail digging into the surrounding skin.
- Wearing comfortable shoes, tights and socks that are not too tight and provide space around their toes.

.....END OF 'INGROWING TOENAIL' SECTION.....

DRAFT FOR ENDORSEMENT

INTERTRIGO				
General information				
<p>Intertrigo is an inflammation (rash) of the body folds, commonly affecting the groin, under the breasts and axillae. Skin may become moist and macerated, leading to fissuring (cracks) and peeling. Intertrigo can be classified as inflammatory (symmetrical; affecting armpits, groin, under the breasts and the abdominal folds) or infectious (unilateral and asymmetrical; caused by bacteria, yeasts or other types of fungi), but there is often overlap.</p> <p>Inflammatory intertrigo may be treated with low potency topical corticosteroid creams.</p> <p>Most cases of fungal infections can be treated using an over-the-counter antifungal cream⁵⁷.</p>				
Referral to GP information				
<p>Refer people with severe or extensive disease, signs of bacterial infection, rash unresponsive to treatment after 2 weeks or recurrent episodes⁵⁸.</p> <p>Refer if the person is immunocompromised or if they have poorly controlled diabetes and have not been reviewed by the GP in the last 3 months.</p>				
Treatment(s) offered	Pack size	Maximum number of packs to be supplied	Suggested number of episodes per year	Information/instructions
Clotrimazole 1% cream	20 g	2	2 – second episode at least 6 months after the first	<p>There is insufficient evidence to recommend one preparation over another.</p> <p>Clotrimazole cream should be applied 2–3 times a day for at least 2 weeks for candidal infections⁵⁹.</p> <p>Miconazole cream should be applied twice daily and continued at least 1 week after the rash has gone.</p> <p>Do not issue miconazole to people using interacting medicines, particularly warfarin; consider clotrimazole.</p>
Miconazole 2% cream	30 g	1	2 – second episode at least 6 months after the first	
Hydrocortisone 1% cream	15 g (via PGD if fungal)	1	2 – second episode at least 6 months after the first	
Advice for patient on how to resolve/manage condition				<i>Link to leaflet</i>
<ul style="list-style-type: none"> • Wash the affected skin daily and dry thoroughly afterwards, particularly in the skin folds. • Wash clothes and bed linen frequently to eradicate the fungus. • Do not share towels, and wash them frequently. 				

DRAFT FOR ENDORSEMENT

- Wear loose-fitting clothes made of cotton or a material designed to move moisture away from the skin.

.....**END OF 'INTERTRIGO' SECTION**.....

DRAFT FOR ENDORSEMENT

MOUTH ULCERS

General information

Aphthous ulcers are shallow, round or oval in shape, usually pale yellow in colour with erythema around the area.

Minor aphthous ulcers are the most common (80% cases) and are typically 2–8 mm in diameter. They heal in 10–14 days without scarring.

Major aphthous ulcers (10% cases) are deeper and larger than minor ulcers and have a raised, irregular border. They are often 1 cm or more in diameter, may take several weeks to heal and often leave a scar.

Herpetiform ulcers (5–10% cases) present as multiple (5–100) pinhead-sized ulcers that may fuse to form much larger, irregular-shaped ulcers. These ulcers are called 'herpetiform' because the clinical appearance suggests a viral cause, but they are not caused by viral infection. They usually last 10–14 days⁶⁰.

Consider if a medication may be a potential cause of the ulcers e.g. nicorandil, oral NRT and NSAIDs. Advise person to discuss with their GP if you think this may be a precipitating factor⁶⁰.

Experts recommend identification and avoidance of precipitating factors, (e.g. anxiety, stress, oral trauma, certain foods) where possible, to minimise recurrence⁶⁰.

Frequency, duration and severity of pain will help to determine the management of aphthous ulcers.

If ulcers are infrequent, mild and not interfering with daily activities (e.g. eating), treatment may not be needed.

Offer symptomatic treatment for pain, discomfort and swelling, especially when ulcers are causing problems with eating.

Referral to GP/dentist information

Advise the person to see a GP or dentist if there is worsening of the ulcer, or no improvement, or if the ulcer persists after 3 weeks.

Trigger points for referral:

- children < 12 years
- painless ulcers
- signs of systemic illness
- ulcers > 1 cm diameter (major aphthous)
- ulcers in crops of 5–10 or more (herpetiform)
- person is on chemotherapy.

Refer any patient who shows signs of severe dehydration as a result of oral ulceration.

Onset of aphthous ulceration after 30 years of age, systemic symptoms and presence of extra-oral ulcers suggest that the ulcers are part of a more complex disorder that warrants further investigation; therefore, such people should be referred⁶⁰.

DRAFT FOR ENDORSEMENT

Treatment(s) offered	Pack size	Maximum number of packs to be supplied	Suggested number of episodes per year	Information/instructions
Saline mouth wash			1	Rinse the mouth with a salt solution prepared by dissolving half a teaspoon of salt in a glass of warm water. This can be done as often as needed, do not swallow the mouthwash.
Chlorhexidine 0.2% mouthwash	300 ml	1	1	Rinse mouth with 10 ml twice a day. Spit out after use. Continue for 48 hours after the lesions have healed.
Hydrocortisone 2.5 mg oromucosal tablets	20	1	1	1 tablet 4 times daily, allowed to dissolve slowly in the mouth in contact with the ulcer. Only use in children 12 years and over.
Advice for patient on how to resolve/manage condition				<i>Link to leaflet</i>
<p>Most mouth ulcers will often not require specific treatment or medication and will normally heal naturally, if they are:</p> <ul style="list-style-type: none"> • infrequent • mild, and • do not interfere with daily activities (e.g. eating). <p>Identify and avoid precipitating factors, where possible, to minimise recurrence:</p> <ul style="list-style-type: none"> • Many people find that eating certain foods, such as chocolate, coffee and peanuts, can make them more prone to developing an ulcer. If the person knows that eating a particular food provokes an ulcer, to avoid eating that food until the ulcer has completely healed. • Trying to reduce stress levels, perhaps by doing something relaxing, such as yoga, meditation or exercise. <p>Self-care tips to follow which may help the ulcer to heal quicker:</p> <ul style="list-style-type: none"> • Using a soft toothbrush when brushing teeth. • Avoiding eating hard foods, such as toast. Trying to stick to foods that are softer and easier to chew. • Avoiding spicy or very salty foods or acidic drinks that may aggravate the pain. • If the ulcer has a specific cause, such as a sharp tooth or badly fitting dentures, then it will normally heal naturally once the cause has been treated. See the dentist to fix the tooth/dentures. <p>Oral painkillers, benzydamine spray or mouthwash or topical local anaesthetics may help to relieve the pain associated with the ulcer.</p>				

.....**END OF 'MOUTH ULCERS' SECTION**.....

DRAFT FOR ENDORSEMENT

NAPPY RASH				
General information				
<p>Diagnostic features: mild rash restricted to the nappy area. Common causes:</p> <ul style="list-style-type: none"> • Prolonged contact with urine or faeces. Typically there is redness over convex surfaces closest to the nappy (buttocks, genitals, pubic area and upper thighs) with sparing (no redness) in the deeper flexures. The rash has a glazed appearance if acute, or fine scaling if more long-standing. • Candidal fungal infection presenting as sharply marginated redness involving the skin creases. <i>Candida</i> infection is the most likely cause if there are satellite lesions (small areas of redness separate from most of the affected area)⁶¹. <p>Offer advice on preventing nappy rash.</p>				
Referral information				
<p>Refer to health visitor/baby clinics if signs of bacterial infection, such as marked redness with exudate, and vesicular and pustular lesions. Refer to GP if there is severe inflammation, baby is systemically unwell or has a fever.</p>				
Treatment(s) offered	Pack size	Maximum number of packs to be supplied	Suggested number of episodes per year	Information/instructions
Zinc and castor oil cream	100 g	1	1	Apply a thin layer at each nappy change.
Metanium [®]	30 g	1	1	Provide advice and referral if appropriate.
If nappy rash is causing discomfort				
Hydrocortisone 0.5% cream	15 g (via PGD)	1	1	Babies should be older than one month of age and use should be for a maximum of 7 days, applied once a day. N.B. Advise parents/carers to apply topical hydrocortisone first and wait a few minutes before applying the barrier preparation.
If nappy rash persists despite topical hydrocortisone (and if <i>Candida</i> infection is suspected)				
Clotrimazole 1% cream	20 g	1	1	Advise parents/carers not to use a barrier preparation until after the candidal infection has settled. Apply 2–3 times a day, continued for at least 2 weeks after the affected area has healed ⁵⁹ .

DRAFT FOR ENDORSEMENT

Advice for patient on how to resolve/manage condition	<i>Link to leaflet</i>
<p>To reduce exposure to irritants (urine, faeces and friction), advise parents and carers to:</p> <ul style="list-style-type: none">• consider using nappies with the greatest absorbency• leave nappies off for as long as is practically possible• clean and change the child as soon as possible after wetting or soiling:<ul style="list-style-type: none">– use water, or fragrance-free and alcohol-free baby wipes– dry gently after cleaning – avoid vigorous rubbing– bath the child daily, but avoid excessive bathing (such as more than twice a day) as this may dry the skin– do not use soap, bubble bath or lotions.	

.....END OF 'NAPPY RASH' SECTION.....

DRAFT FOR ENDORSEMENT

ORAL THRUSH

General information

Oral thrush can cause discomfort or be asymptomatic. Commonly recognised by generalised erythema, loss of taste or unpleasant taste in the mouth and white patches in the mouth that can be wiped off leaving behind red patches.

Advise topical miconazole therapy for initial course of 7 days and advise person to continue treatment for 7 days after symptoms resolve if using miconazole oral gel and 2 days if using nystatin.

All doses to be given after food.

Advise person not to eat or drink for 30 minutes after using the gel or liquid.

Referral to GP/dentist information

Refer if:

- symptoms not resolved after 7 days
- the person has difficulty or pain on swallowing
- no obvious precipitant, such as recent broad-spectrum antibacterials, steroid inhaler, dentures or diabetes; refer to GP to exclude immunosuppression
- the person is immunocompromised: provide 1 course as symptomatic treatment but refer
- the person has poorly controlled diabetes and has been reviewed by the GP in the last 3 months
- the person presents with a single red or red and white plaque that cannot be rubbed off (erythroplakia/erythroleukoplakia) as this may be pre-malignant. In this instance it is recommended that you refer this person urgently to a dentist.

Treatment(s) offered	Pack size	Maximum number of packs to be supplied	Suggested number of episodes per year	Information/instructions
Miconazole oral gel	80 g (via PGD)	2	2 (must be 6 months apart)	Generally considered first-line treatment ⁶² . Miconazole is absorbed to the extent that potential interactions need to be considered. Do not issue miconazole to people using interacting medicines, particularly warfarin ⁶³ ; consider nystatin. Apply the gel directly to the affected area with a clean finger and leave it in contact with the mucosa for as long as possible.
Nystatin	30 ml (via PGD)	2	2 (must be 6 months apart)	For people taking medicines that interact with miconazole ⁶² . The usual dose is 1 ml four times a day for adults and children from 4 weeks of age. Use the dropper to place the liquid inside the mouth onto the affected areas ¹ .

DRAFT FOR ENDORSEMENT

				Only Nystan® should be given due to high cost of generic preparation.
Advice for patient on how to resolve/manage condition				<i>Link to leaflet</i>
<ul style="list-style-type: none"> • Maintain good dental/denture hygiene. Dental prostheses and orthodontic appliances should be removed at night and brushed with gel. • Stop smoking, if applicable⁶². • Provide counselling if person is on corticosteroid inhaler. Assess the person's inhaler technique or advise to discuss with GP or practice nurse. The risk of oral candidiasis can be reduced by using a spacer device with a corticosteroid inhaler; rinsing the mouth with water (or cleaning a child's teeth) after inhalation of a dose may also be helpful. • In babies and young children it is important to apply a little at a time and to try to avoid the back of the mouth to reduce the risk of choking. 				

.....**END OF 'ORAL THRUSH' SECTION**.....

DRAFT FOR ENDORSEMENT

RINGWORM				
General information				
<p>Ringworm is a common fungal infection that presents with a circular patch of skin, mild redness, with an outer edge that is well demarcated and more inflamed and scaly than the paler centre. With time it tends to spread outwards. It can look like a ring that becomes gradually larger.</p> <p>Most cases of skin ringworm can be treated using an over-the-counter antifungal cream.</p>				
Referral to GP information				
<p>Refer people with severe or extensive disease, signs of bacterial infection, rash unresponsive to treatment after 2 weeks or recurrent episodes⁵⁸.</p> <p>Refer if the person is immunocompromised or if they have poorly controlled diabetes and have not been reviewed by the GP in the last 3 months.</p> <p>Refer if the scalp is involved as alternative formulations may be prescribed.</p>				
Treatment(s) offered	Pack size	Maximum number of packs to be supplied	Suggested number of episodes per year	Information/instructions
Clotrimazole 1% cream	20 g	1	2 – second episode at least 6 months after the first	<p>There is insufficient evidence to recommend one preparation over another.</p> <p>Clotrimazole cream should be applied 2–3 times a day for at least 4 weeks for ringworm infections⁵⁹.</p> <p>Miconazole cream should be applied twice daily and continued at least 1 week after the rash has gone⁷.</p> <p>Do not issue miconazole to people using interacting medicines, particularly warfarin; consider clotrimazole.</p>
Miconazole 2% cream	30 g	1	2 – second episode at least 6 months after the first	
Hydrocortisone 1% cream	15 g (via PGD)	1	2 – second episode at least 6 months after the first	
Advice for patient on how to resolve/manage condition				<i>Link to leaflet</i>
<ul style="list-style-type: none"> Wash the affected skin daily and dry thoroughly afterwards, particularly in the skin folds. 				

DRAFT FOR ENDORSEMENT

- Wash clothes and bed linen frequently to eradicate the fungus.
- Do not share towels, and wash them frequently.
- Wear loose-fitting clothes made of cotton or a material designed to move moisture away from the skin.

.....END OF 'RINGWORM' SECTION.....

DRAFT FOR ENDORSEMENT

SCABIES

General information

Diagnostic features: intense itch and rash, often worse at night and when hot; sometimes burrows can be seen in the interdigital web spaces.

Apply insecticide twice, with applications one week apart.

Consider symptomatic treatment for itching, e.g. an antihistamine. Itch may persist for 2–3 weeks after the infestation has been successfully treated, no new lesions should appear.

All people in the household and those with whom there is close contact need to be treated simultaneously (within a 24-hour period), regardless of whether they have symptoms.

Referral to GP information

Refer people with a severe rash or secondary infection, or who are systemically unwell, and infants under 2 years. Refer people with suspected crusted scabies (crusted, scaly plaques that may develop fissures) or after continued treatment failure (e.g. 2 courses of an insecticide have failed).

Treatment(s) offered	Pack size	Maximum number of packs to be supplied	Suggested number of episodes per year	Information/instructions	
Permethrin 5% cream	30 g	See information/instructions	1	<p>First-line treatment^{1,65}. Treatment should be applied to the whole body including scalp, neck, face and ears. Particular attention should be paid to the webs of fingers and toes and the lotion brushed under the ends of nails.</p> <p>Treatment should be washed off after 8–12 hours. Reapply treatment if it is washed off within 8 hours. Most people will only require 1 x 30 g pack per treatment i.e. 2 x 30 g packs to include repeat treatment. Larger people may require up to 2 x 30 g packs for each treatment, i.e. 4 x 30 g packs to include repeat treatment.</p>	<p>Sufficient quantities should be provided to allow all members of the household to be treated simultaneously. The names of all those who will be treated with the treatments provided should be documented.</p>
Malathion 0.5% (Derbac M [®] Liquid)	200 ml	See information/instructions	1	<p>Use if permethrin is inappropriate^{1,65}. Treatment should be applied to the whole body including scalp, neck, face and ears. Particular</p>	

DRAFT FOR ENDORSEMENT

				attention should be paid to the webs of fingers and toes and the lotion brushed under the ends of nails. Treatment should be washed off after 24 hours. Reapply treatment if it is washed off during this treatment period.	
Chlorphenamine 4 mg tablets	28	1	1	Not indicated for children < 6 years old.	
Chlorphenamine 2 mg in 5 ml sugar-free solution	150 ml	1	1	Not indicated for children < 1 year old.	
Advice for patient on how to resolve/manage condition					<i>Link to leaflet</i>
Mites on clothes, linen, etc. can be killed by machine washing (at > 50°C) on the day of application of the first treatment. Put any items you cannot wash in a plastic bag for 72 hours or more.					

.....**END OF 'SCABIES' SECTION**.....

DRAFT FOR ENDORSEMENT

SORE THROAT AND TONSILLITIS

General information

Non-medicinal advice: see below.

Most throat infections are caused by viruses. Antibiotics will make little difference to symptoms and may have adverse effects e.g. diarrhoea, vomiting and rash⁶⁶.

Reassure the person that the condition is self-limiting and is likely to get better within 7 days, with or without antibiotic treatment.

The [Royal College of General Practitioners Antibiotic Toolkit](#)⁶⁷ explains to people why they did not receive antibiotics and advise of the Antibiotic Guardian campaign at www.antibioticguardian.com⁶⁸.

The NICE guideline on sore throat (acute): antimicrobial prescribing NG84 (January 2018) has useful recommendations and can be accessed here: <https://www.nice.org.uk/guidance/ng84>

Referral to GP information

Urgent referral (including to A&E if very unwell)^{69,70}:

- respiratory distress
- drooling
- systemically very unwell
- unable to swallow
- difficulty opening mouth
- muffled voice – or making a high pitched sound as they breathe (stridor)
- dehydrated or unable to take fluids
- signs of being systemically unwell and at risk of immunosuppression.

Refer to GP:

- People with persistent symptoms that haven't started to improve after a week. Refer sooner if symptoms worsen.
- Where there is absence of a cough.
- After 1 week if person has sore throat and lethargy (suggests possible symptoms of glandular fever, especially if 15 to 25 years old).
- People who are immunocompromised (e.g. people receiving cancer treatment or high doses of oral steroids or other immunosuppressants [see BNF], or those with conditions that reduce immunity).
- If the person is systemically unwell or has symptoms and signs suggestive of serious illness and/or complications.
- If the person has a persistently high temperature over 38°C.
- If the person is at high risk of serious complications because of pre-existing comorbidity. This includes people with significant heart disease (including valvular heart disease), history of rheumatic fever, diabetes, lung, renal, liver or neuromuscular disease, cystic fibrosis and young children who were born prematurely.
- Repeated episodes (5 or more) per year or a lower threshold if other concerns.

DRAFT FOR ENDORSEMENT

- Sore throat in combination with rash, flushed cheeks and swollen tongue could be a sign of scarlet fever. This normally occurs in children, but can occur at any age.

Treatment(s) offered	Pack size	Maximum number of packs to be supplied	Suggested number of episodes per year	Information/instructions
Paracetamol 120 mg in 5 ml sugar-free suspension	100 ml	1	2	First-line for children or for adults who cannot tolerate ibuprofen. Not indicated for children < 3 months old. A maximum of 1 x 200 ml paracetamol 250 mg in 5 ml sugar-free suspension may be supplied for children over 12 years who are unable to take paracetamol tablets. If taking paracetamol regularly and on warfarin advise INR test 5 to 7 days later.
Paracetamol 250 mg in 5 ml sugar-free suspension	200 ml	1	2	
Paracetamol 500 mg tablets	32	1	2	
Ibuprofen 100 mg in 5 ml sugar-free suspension	100 ml	1	2	First-line in adults (may be more effective in adults at relieving symptoms) if not contraindicated. Second-line in children. Not indicated for children < 3 months old. Caution in children at risk of dehydration. Relative contraindications to NSAIDs include: heart failure, hypertension, ischaemic heart disease, peripheral arterial disease, cerebrovascular disease, renal impairment and peptic ulceration; caution in asthma. The combination of an NSAID and low-dose aspirin may increase the risk of gastrointestinal side effects; this combination should be avoided if possible. Consider the need for
Ibuprofen 200 mg tablets	24	1	2	
Ibuprofen 400 mg tablets	24	1	2	

DRAFT FOR ENDORSEMENT

			gastroprotection before recommending this treatment. Avoid using ibuprofen if the patient is taking warfarin.
Advice for patient on how to resolve/manage condition			<i>Link to leaflet</i>
<ul style="list-style-type: none"> • Be advised that the condition is self-limiting and is likely to get better within 7 days, with or without antibiotic treatment. • Seek further healthcare advice if symptoms do not improve within 7 days or worsen. • Simple analgesics will help temperature and discomfort. • Take painkillers at regular intervals to relieve pain and fever. • Adults and older children may find sucking throat lozenges, ice cubes or flavoured frozen desserts (e.g. ice lollies) provides symptomatic relief. • People may wish to try medicated lozenges to help reduce pain but their benefit is likely to be small. It is unclear if throat sprays containing an antiseptic plus local anaesthetic or benzydamine gargles help symptoms. • Avoiding smoking and smoky environments. • Drink plenty of cool or warm fluid and avoid very hot drinks that could irritate the throat. Eat cool and soft foods. • Adults can try a warm saline mouthwash or gargle (half a teaspoon of salt in a glassful of warm water at frequent intervals), but do not swallow the mouthwash – this is not suitable for young children. • Reinforce messages around preventing infections e.g. wash hands frequently, avoid sharing glasses or utensils with people who are ill, cough or sneeze into a tissue and dispose of it in the bin. 			

.....**END OF 'SORE THROAT AND TONSILLITIS' SECTION**.....

DRAFT FOR ENDORSEMENT

TEETHING

General information

Most children start teething around 4–12 months of age and have their full set of full teeth around 2 to 3 years old. Signs and symptoms of teething are generally mild and localised and usually occur about 3–5 days before each tooth eruption. They include: pain, increased biting, chewing, dribbling, drooling, gum-rubbing, sucking, irritability, wakefulness, ear-rubbing, decreased appetite and disturbed sleep. The infant may also have red and swollen gums and red flushed cheeks or face.

Teething is not associated with severe or systemic symptoms; presence of these would suggest other underlying conditions and should be referred⁷¹.

Cry-sis is a charity providing support for families with excessively crying, sleepless and demanding children. Their helpline is available every day from 9 am to 10 pm (Tel: 08451 228 669). The [Cry-sis website](#) also contains useful information.

Referral to GP information

Teething may cause mild temperature elevation (less than 38°C), but a raised temperature above 38°C would indicate a referral to a GP.

- Some parents/carers may note a change in the passage of stools at teething time, but teething should not cause diarrhoea and this would indicate a referral to the GP.
- Any infant who is systemically unwell or in severe distress should be referred to the GP to rule out other conditions.

Treatment(s) offered	Pack size	Maximum number of packs to be supplied	Suggested number of episodes per year	Information/instructions
Paracetamol 120 mg in 5 ml sugar-free oral suspension	100 ml	1	2	Only use if self-care methods do not help. Limit to children > 3 months.
Ibuprofen 100 mg in 5 ml sugar-free oral suspension	100 ml	1	2	

Advice for patient on how to resolve/manage condition

Link to leaflet

- Reassurance can be offered that teething is normal and not an illness. Symptoms are generally mild and self limiting.
- Advise that gentle rubbing of the gum with a clean finger may provide relief.
- Under supervision (in case of choking), the infant can be given something clean and cool to chew on:
 - teething ring - cooled in the fridge (as advised in the instructions). Do not put in the freezer as this could damage or burn gums if it gets frozen. Never tie the teething ring around the infant's neck, as it may be a choking hazard. Solid rings are preferred over gel or liquid filled rings, which could leak.
 - clean, cold, wet flannel
 - for infants who have been weaned, consider using chilled fruit or vegetables (such as pieces of bananas, cucumber, apple or carrot)

DRAFT FOR ENDORSEMENT

- teething biscuits and rusks are not recommended if they contain sugar, which can cause tooth decay even if only a few teeth are present
- advise to avoid objects that can easily be broken into hard pieces because they may be a choking risk.
- Cool, sugar-free drinks can also help soothe gums.
- Teething gels that contain a local anaesthetic are not recommended because their effectiveness is not proven and it is thought that the gel is simply rapidly removed from the site of discomfort by the tongue and saliva. There have also been reports of serious adverse effects with excessive use of topical anaesthetics.
- 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 evidence that complementary treatments are of any benefit for teething - for example, herbal teething powder or homeopathic remedies⁷¹.
- Dribbling during teething may cause a facial rash, gently wiping the face often with a clean, dry cloth or towel should help prevent this.
- NHS Choices has a video which may be useful to signpost parents and carers to – 'how to soothe my baby'
<http://www.nhs.uk/Conditions/pregnancy-and-baby/Pages/teething-tips.aspx>

Strongly advise parents and carers to register the infant with a dentist when the new teeth start to come through or as a minimum by age 1. NHS Choices has produced a video – 'how do I brush my child's teeth' - and parents and carers are encouraged to start cleaning teeth as soon as they come into the mouth <http://www.nhs.uk/Conditions/pregnancy-and-baby/Pages/looking-after-your-infants-teeth.aspx>.

.....END OF 'TEETHING' SECTION.....

DRAFT FOR ENDORSEMENT

THREADWORMS					
General information					
<p>Threadworms are small, thin, white thread-like worms about 2–13 mm long. They are common in children, but anyone of any age can be affected. Female worms lay tiny eggs, usually at night, around the back passage (anus) – these are too small to see but they cause itching around the anus. The worms might be visible in stools or around the anus – use a torch in the late evening – part the child’s buttocks and look at the anus⁷².</p> <p>Treat person if threadworms have been seen or eggs detected. Treat all household members, including adults and those without symptoms, at same time, unless contraindicated.</p> <p>Treatment could be hygiene measures alone (undertaken for 6 weeks) or mebendazole and hygiene measures (undertaken for 2 weeks). Hygiene measures alone are the only option for infants < 6 months and the preferred option for pregnant and breastfeeding women; for all others the choice is determined by personal preference and contraindications/cautions/interactions associated with mebendazole. Mebendazole is given as a single dose. As re-infection is common, a second dose may be given after 2 weeks¹. Pack size will be 2 treatments for every household member (could include tablets and liquid).</p> <p>Children do not need to be excluded from school or nursery⁷².</p>					
Referral to GP information					
Refer if person is pregnant or breastfeeding and is unwilling to undertake hygiene measures alone.					
Treatment(s) offered	Pack size	Maximum number of packs to be supplied	Suggested number of episodes per year	Information/instructions	
Mebendazole (Vermox®) 100 mg/5 ml suspension	30 ml (via PGD)	See Information/ instructions	1	Only if person > 6 months ⁷³ . Use in children less than 2 years is off-label.	Sufficient quantities should be provided to allow all members of the household to be treated simultaneously. The names of all those who will be treated with the supplies provided should be documented.
Mebendazole (Vermox®) 100 mg chewable tablets	6 (via PGD)	See Information/ instructions	1	Only if person > 6 months ⁷³ . Use in children less than 2 years is off-label.	
Advice for patient on how to resolve/manage condition				Link to leaflet	
<p>Hygiene measures should be undertaken for 2 weeks if combined with mebendazole treatment and for 6 weeks if used alone.</p> <ul style="list-style-type: none"> • Environmental hygiene measures — undertake on the first day of treatment: <ul style="list-style-type: none"> – Wash sleepwear, bed linen, towels, soft toys at normal temperatures and rinse well. – Thoroughly vacuum and damp-dust, paying particular attention to the bedrooms, including vacuuming mattresses - wash the cloth 					

DRAFT FOR ENDORSEMENT

- frequently in hot water then throw out the cloth after use.
- Thoroughly clean the bathroom and kitchen by 'damp-dusting' surfaces, washing the cloth frequently in hot water, then throw out cloth after use.
- Avoid shaking any material that may be contaminated with eggs, such as clothing or bed sheets.
- **Strict 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 underpants or knickers at night. Change them every morning.
 - Use cotton gloves to help prevent night-time scratching. Wash them daily.
 - Bath or shower immediately on rising each morning, washing around the anus to remove any eggs laid by the worms during the night.
 - For infants < 6 months advise cleansing the bottom gently but thoroughly at each nappy change and advise parents to wash their hands thoroughly before and after each nappy change.
- **General personal hygiene measures — encourage all the time for all household members:**
 - Wash hands and scrub under the nails first thing in the morning, after using the toilet or changing nappies, and before eating or preparing food.
 - Discourage nail biting and finger sucking and keep fingernails short.
 - Avoid the use of 'communal' or shared towels or flannels.
 - Keep toothbrushes in a closed cupboard and rinse them thoroughly before use.
 - Don't eat food in the bedroom.

.....END OF 'THREADWORMS' SECTION.....

DRAFT FOR ENDORSEMENT

VAGINAL THRUSH				
General information				
Common symptoms include white, odourless discharge with vaginal soreness and vulval itching. Maximum of 2 treatments in 6 months (only prescribe a second treatment if the first episode resolved promptly).				
Referral to GP information				
Refer: <ul style="list-style-type: none"> • people < 16 and > 60 years, pregnant or breastfeeding women and immunocompromised women • women with poorly controlled diabetes, who have not been reviewed by the GP in the last 3 months • if woman presents with foul smelling discharge, increased urinary frequency or abnormal vaginal bleeding • you are uncertain about the diagnosis e.g. patient has had a previous sexually transmitted infection and it may have returned. 				
Treatment(s) offered	Pack size	Maximum number of packs to be supplied	Suggested number of episodes per year	Information/instructions
Clotrimazole 10% cream (intra-vaginal)	5 g applicator pack (via PGD)	1	2	Damages latex condoms and diaphragms. Use alternative precautions for at least 5 days after treatment with these products. Local mild burning or irritation may occur on application of pessaries and creams. The intra-vaginal cream and pessary should be inserted high into the vagina at night. The external cream should be applied thinly to vulva and surrounding areas 2–3 times daily ¹ .
Clotrimazole 2% cream (external)	20 g	1	2	
Clotrimazole pessary 500 mg, use with clotrimazole 2% external cream	1 x pessary and 20 g (via PGD)	1	2	
Fluconazole 150 mg capsule	1 (via PGD)	1	2	For women taking other medications use via PGD.
Advice for patient on how to resolve/manage condition				<i>Link to leaflet</i>
Advise women about the following personal hygiene measures and how to avoid potential irritants ⁷⁴ : <ul style="list-style-type: none"> • Use a soap substitute to clean the vulval area and do not clean the vulval area more than once per day. 				

DRAFT FOR ENDORSEMENT

- Use emollients as moisturisers several times a day to protect the skin.
- Avoid potential irritants in toiletries, antiseptics, douches, wipes, and 'feminine hygiene' products.
- Avoid washing underwear in biological washing powder and avoid fabric conditioners.
- Avoid tight fitting clothing and non-adsorbent clothing.
- See GP if symptoms not resolved within 7 days.
- If using a pessary or intra-vaginal cream, to avoid treatment during the menstrual period due to the risk of the pessary or cream being washed out by the menstrual flow. The treatment should be finished before the onset of menstruation. Do not use tampons, intravaginal douches, spermicides or other vaginal products while using the pessary or intra-vaginal cream.

.....END OF 'VAGINAL THRUSH' SECTION.....

DRAFT FOR ENDORSEMENT

WARTS AND VERRUCAE

General information

Cutaneous warts are small, rough growths caused by infection of keratinocytes with certain strains of the human papilloma virus. They can appear anywhere on the skin but are most commonly seen on the hands and feet. A verruca (plantar wart) is a wart on the sole of the foot. There is a strong case for not treating warts for most people since they may clear spontaneously (usually within 2–3 years) 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 sole of the foot or near the nail), cosmetically unsightly or if the person requests treatment for persistent warts. Facial warts should not be treated in primary care⁷⁵.

Treatment choice depends on what is preferred by the person and what has been tried already. Salicylic acid should not be used on the face, intertriginous (skin folds) or anogenital regions; on moles or birthmarks; on warts with hair growing out of them, red edges, or an unusual colour; on open wounds, irritated or reddened skin, infected areas, or on areas of poor healing such as neuropathic feet.

Complications of the condition include spread caused by picking at the wart and local infection. Malignant changes are thought to be rare except among immunosuppressed patients.

Referral to GP information

The following should be referred to the GP:

- wart is on the face, intertriginous or anogenital regions
- uncertain diagnosis
- warts with hair growing out of them or that are bleeding, or have changed in appearance
- wart is associated with significant pain
- person is immunocompromised
- extensive areas are affected
- warts are persistent and unresponsive to salicylic acid
- people with diabetes or people who have poor circulation to the hands or feet.

Treatment(s) offered	Pack size	Maximum number of packs to be supplied	Suggested number of episodes per year	Information/instructions
Salicylic acid 16.7%;lactic acid 16.7% (Salactol™ collodion paint)	10 ml	1	1	For people > 2 years. General points on correct application: <ul style="list-style-type: none"> • Apply once daily at night for up to 12 weeks. • Before applying, debride the surface of the wart or verruca with an emery board and/or soften the area by soaking it in warm water for 5–10 minutes.

DRAFT FOR ENDORSEMENT

Salicylic acid 12% (Salatac™ gel)	8 g	1	1	<ul style="list-style-type: none"> • For subsequent applications, peel off any film remaining from the previous application and debride and soak as above. • Avoid applying the treatment to the surrounding skin by applying carefully to wart and protecting the surrounding skin with soft paraffin or plaster. • Do not apply to the face or extensively affected areas because of an increased risk of skin irritation and scarring⁷⁵. <p>Follow product-specific directions for further guidance. Note that collodion in Salactol™ should be avoided in people allergic to elastic adhesive plaster¹.</p>
Salicylic acid 50% (Verrugon™)	6 g	1	1	<p>This should only be used if lower strengths of salicylic acid have been ineffective. Licensed for plantar warts (verrucae) only⁷⁶. How to apply:</p> <ul style="list-style-type: none"> • fix self-adhesive ring with hole over verruca • squeeze ointment into hole onto verruca • cover ring with plaster • repeat daily after pumicing or filing the dead part of the verruca⁷⁶ <p>Check for allergies: wool fat and plasters.</p>
Advice for patient on how to resolve/manage condition				<i>Link to leaflet</i>
<p>Although unsightly, warts are not harmful, do not usually cause symptoms and resolve eventually without treatment. Warts are contagious but the risk of transmission is low. When using salicylic acid - if the surrounding skin becomes sore, stop the treatment for a few days until it settles then re-start treatment. There is a small risk of skin allergy to the treatment. If this occurs, the surrounding skin becomes red and itchy. Salicylic acid formulations are flammable – keep them away from away from flames or ignition sources^{77,78}. It is important to continue treatment until the wart has gone. Seek medical advice if the wart persists longer than 12 weeks of treatment.</p> <p>To reduce risk of transmission:</p> <ul style="list-style-type: none"> • cover with waterproof plaster when swimming • wear flip-flops in communal showers • avoid sharing shoes, socks and towels • avoid scratching lesions, biting nails or sucking fingers that have warts • keep feet dry and change socks daily. 				

DRAFT FOR ENDORSEMENT

There is no need to avoid sports or swimming, but take measures to avoid transmission as above.

.....**END OF 'WARTS AND VERRUCAE' SECTION**.....

DRAFT FOR ENDORSEMENT

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LINKS

AWMSG Analgesic Patient Information Leaflet:

www.awmsg.com/docs/awmsg/medman/Patient%20Information%20Leaflet%20-%20Medicines%20for%20Mild%20to%20Moderate%20Pain%20Relief.pdf

AWMSG Dry Eye Syndrome Guidance:

<http://www.awmsg.org/docs/awmsg/medman/Dry%20Eye%20Syndrome%20Guidance.pdf>

Back Book:

<https://www.tsoshop.co.uk/bookstore.asp?Action=Book&ProductId=9780117029491>

Cry-sis website: www.cry-sis.org.uk

NICE Guideline [NG15]. Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use: <https://www.nice.org.uk/guidance/ng15>

NICE Guideline [NG63]. Antimicrobial stewardship: changing risk-related behaviours in the general population: <https://www.nice.org.uk/guidance/ng63>

Paraffin hazard patient leaflet:

<http://www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=60274&type=full&servicetype=Attachment>

Public Health England. Antibiotic Information Leaflets via TARGET Antibiotic Toolkit webpage: <http://www.rcgp.org.uk/clinical-and-research/toolkits/target-antibiotic-toolkit.aspx>

Wales Eye Care Services website: <http://www.eyecare.wales.nhs.uk/>