All Wales Medicines Strategy Group

Grŵp Strategaeth Meddyginiaethau Cymru Gyfan

All Wales Choose Pharmacy Formulary

May 2015

This report has been prepared by a multiprofessional collaborative group, with support from the All Wales Prescribing Advisory Group (AWPAG) and the All Wales Therapeutics and Toxicology Centre (AWTTC), and has subsequently been endorsed by the All Wales Medicines Strategy Group (AWMSG).

Please direct any queries to AWTTC:

All Wales Therapeutics and Toxicology Centre
University Hospital Llandough
Penlan Road
Llandough
Vale of Glamorgan
CF64 2XX

awttc@wales.nhs.uk
029 2071 6900

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CONTENTS

.....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 Guidelines
- Clinical Knowledge Summaries
- NHS Direct (Wales)
- Medicines Resource Centre (MeReC) bulletins
- Welsh Medicines Resource Centre (WeMeReC) bulletins

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.....

ACNE

General information

Diagnostic features: Commonly affects adolescents and young adults, with comedones (blackheads and whiteheads) and pus-filled spots (pustules) affecting the face, shoulders, back and chest. The skin and hair may have an oily appearance.

Mild to moderate acne, comedones and inflamed lesions respond well to benzoyl peroxide[1]. Treatments are effective but take time to work (typically 8–12 weeks) and may irritate the skin, especially at the start of treatment[2].

Referral to GP information

Refer people with severe acne, e.g. with significant inflammation or extensive pustules or scarring.
Refer when oral therapies have previously been used for acne.
Refer people under 12 years of age.

Treatment(s) offered	Pack size	Maximum number of packs to be supplied	Number of episodes per year	Information/instructions
Benzoyl peroxide 2.5% gel	40 g	1	1	Start with lowest strength, unless this has already been tried recently. Adjust the strength at intervals of 2 weeks or after one supply has been used. If irritation occurs reduce the strength. Use the minimum effective concentration. Total supply: up to 3 packs per episode, issued at separate consultations.
Benzoyl peroxide 5% gel	40 g	1	1	
Benzoyl peroxide 5% cream	40 g	1	1	
Benzoyl peroxide 10% gel	40 g	1	1	
Advice for patient on how to resolve/manage condition				*Link to leaflet*

- Try not to pick or squeeze your spots as this usually aggravates them and may cause scarring.
- Wash the affected area no more than twice a day with a mild soap or cleanser, but do not scrub the skin too hard as this could irritate it.
- If dry skin is a problem use a fragrance-free water-based emollient.
- Avoid using too much make-up and cosmetics, use non-comedogenic make-up and remove before going to bed.
- Apply treatment sparingly after washing and drying affected area of the skin.
- Benzoyl peroxide can have a bleaching effect, so avoid getting it on your hair or clothes.
- Benzoyl peroxide may cause increased sensitivity to sunlight, avoid exposure and advise patient to wear sunscreen.
- 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, reduction in the frequency of application may be required, at least temporarily, to help overcome this problem.
- 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.

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

ATHLETE'S FOOT

General information

A person with athlete's foot has an itchy, white, scaly, cracked/macerated/dry rash on the bottom and sides of his or her feet and between the toes. The foot should be examined to confirm the diagnosis.

Treatment should be supplied for the first presentation only.

Sprays and powders are not recommended.

If there is co-existing dermatitis, a mild topical steroid can be used in addition to antifungal cream but not alone (see Dry skin section).

Referral to GP information

This is a condition often managed by pharmacies – refer as per current practice.
Refer people with poorly controlled diabetes, who have not been reviewed by the GP in the last 3 months.

Treatment(s) offered	Pack size	Maximum number of packs to be supplied	Number of episodes per year	Information/instructions	
Clotrimazole 1% cream	20 g	1	2	Cream should be used for at least 2 weeks.	Choice is based on person's preference – similar cost and efficacy.
Miconazole 2% cream	30 g	1	2	Treatment should be continued for at least one week after disappearance of all signs and symptoms.	

Advice for patient on how to resolve/manage condition — **Link to leaflet**

- Wear footwear that keeps the feet cool and dry.
- Wear cotton socks.
- Change to a different pair of shoes every 2–3 days.
- After washing, dry the feet thoroughly, especially between the toes.
- Do not share towels and wash them frequently.

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

BACKACHE (ACUTE)

General information

The aim is to provide initial advice.
People known to have chronic backache and those already taking analgesics should be excluded from treatment under the scheme.
Advise that 90% of people recover within 6 weeks. Most people with acute low back pain are functioning normally within a few days and are pain-free (or nearly pain-free) within 3 weeks[3].

Provide the AWMSG leaflet: Medicines for mild to moderate pain relief.
Paracetamol is usually recommended to treat lower back pain. If paracetamol proves ineffective, an NSAID such as ibuprofen may be used instead[4].

Referral to GP information

Red Flags[3]:

- Age under 20 or over 55 years
- Trauma
- History of cancer
- Drug abuse
- Immunosuppression
- No improvement after 2 weeks of treatment, or a change (deterioration) in the type of pain

Emergency – Seek immediate medical advice as the following symptoms may indicate spinal cord compression:

- Fever of 38ºC (100.4ºF) 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
- Inability to pass urine
- Numbness around the genitals, buttocks or back passage
- Pain that is worse at night[5]

Treatment(s) offered	Pack size	Maximum number of packs to be supplied	Number of episodes per year	Information/instructions
Back Book	1	1	2	Link to purchase supplies of Back Book

Paracetamol 500 mg tablets	32	2	2 – the second at least 6 months after the first episode	Dosing advice is important. Encourage regular use of paracetamol. Ibuprofen may be prescribed simultaneously; however, it will not always be indicated. A further supply may be issued 1–2 weeks after the initial consultation if symptoms persist. The person will need to be reassessed.
Ibuprofen 400 mg tablets	24	1	2 – the second at least 6 months after the first episode	Relative contraindications to NSAIDs include heart failure, hypertension, 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. Maximum daily dose 1200 mg.
Advice for patient on how to resolve/manage condition				**Link to purchase supplies of Back Book**
• What you do in the early stages is very important. Rest for more than a day or two usually does not help and may actually prolong pain and disability[6]. • Your back is designed for movement: it needs movement – a lot of movement. The sooner you get moving and doing your ordinary activities as normally as possible, the sooner you will feel better[6]. • The people who cope best with back pain are those who stay active and get on with life despite the pain[6].				

.....END OF 'BACKACHE (ACUTE)' SECTION.....

CHICKEN POX – IN CHILDREN UNDER 14 YEARS

General information

The person would normally have to be present in the pharmacy for an accurate diagnosis to be made.

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 (commonly about 5–6 days after the onset of illness). During the period of infectivity, advise a person with chicken pox to avoid contact with:

- people who are immunocompromised (e.g. those receiving cancer treatment or high doses of oral steroids, or those with conditions that reduce immunity);
- pregnant women;
- infants ≤ 4 weeks.

Children with chicken pox should be kept away from school or nursery for 5 days from the onset of the rash.
Air travel is not allowed until 6 days after the last spot has appeared.

Encourage and monitor fluid intake and seek medical attention if signs of dehydration develop (e.g. reduced urine output, lethargy, cold peripheries, reduced skin turgor).

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 with fever who appear distressed.

Evidence suggests that there are elevated risks of skin complications in people with varicella when exposed to NSAIDs. For this reason it is recommended that NSAIDs are avoided in children with chicken pox[7].

Referral to GP information

If the pharmacist is unsure about the diagnosis, the person should be referred to the GP.
Refer if the person is systemically unwell, their condition deteriorates or they develop complications.
Parents of young children with chicken pox should be particularly aware of bacterial superimposed skin infection, manifesting as sudden high grade pyrexia (often after initial improvement), erythema and tenderness surrounding the original chicken pox lesions. Parents should also be alert to the symptoms of superimposed chest and/or ear infections and be advised to seek medical attention if they present.

Advise person to seek medical attention if signs of dehydration develop (e.g. reduced urine output, lethargy, cold peripheries, reduced skin turgor).

<table>
<tr><th>Treatment(s) offered</th><th>Pack size</th><th>Maximum number of packs to be supplied</th><th>Number of episodes per year</th><th colspan="2">Information/instructions</th></tr>
<tr><td>Paracetamol 120 mg in 5 ml sugar-free suspension</td><td>100 ml</td><td>1</td><td>1</td><td colspan="2" rowspan="3">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 with fever who appear distressed.
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 use paracetamol tablets.</td></tr>
<tr><td>Paracetamol 250 mg in 5 ml sugar-free suspension</td><td>200 ml</td><td>1</td><td>1</td></tr>
<tr><td>Paracetamol 500 mg tablets</td><td>32</td><td>1</td><td>1</td></tr>
<tr><td>Chlorphenamine 2 mg in 5 ml sugar-free liquid</td><td>150 ml</td><td>1</td><td>1</td><td>Not indicated for children < 1 year old.</td><td rowspan="2">Chlorphenamine is infrequently used in the treatment of chicken pox – only provide if sleep is disturbed or child is in significant distress.</td></tr>
<tr><td>Chlorphenamine 4 mg tablets</td><td>28</td><td>1</td><td>1</td><td>Not indicated for children < 6 years old.</td></tr>
<tr><td colspan="4">Advice for patient on how to resolve/manage condition</td><td colspan="2">Link to leaflet</td></tr>
<tr><td colspan="6">• Ensure adequate fluid intake to avoid dehydration.
• Dress appropriately to avoid overheating or shivering.
• Wear smooth, cotton fabrics.
• Keep nails short to minimise damage from scratching.</td></tr>
</table>

.....END OF 'CHICKENPOX – IN CHILDREN UNDER 14 YEARS' SECTION.....

COLD SORES

General information

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 as they only reduce the mean duration of an episode and pain by less than a day, and need to be initiated at the onset of symptoms before vesicles appear. The treatment needs to be applied frequently for a minimum of 4–5 days and does not provide a cure or prevent future episodes of cold sores[8].

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 those who are immunocompromised.

Advise the individual 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 no significant improvement is seen after 7 days.

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

Advice for patient on how to resolve/manage condition	*Link to leaflet*

- Avoid touching the lesions.
- Avoid kissing until the lesions have completely healed.
- Do not share items that come into contact with lesion area (e.g. lipstick or lip gloss).
- Avoid oral sex until all lesions are completely healed.
- There is a risk of transmission to the eye if contact lenses become contaminated.
- For those people in whom the sun triggers cold sores, a sun block (SPF 15 or greater) would be the most effective prophylactic measure.

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 after touching lesions.
- Dab topical medications on rather than rub in to minimise mechanical trauma to the lesions.
- Not share medication with others.

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

COLIC				
General information				
The most useful intervention is support for parents and reassurance that infantile colic will resolve, often by 4 months[9]. Advice is available from other healthcare professionals, e.g. health visitor. 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/health visitor information				
Refer those infants whose parents feel unable to cope despite advice and reassurance.				
Treatment(s) offered	**Pack size**	**Maximum number of packs to be supplied**	**Number of episodes per year**	**Information/instructions**
Advice only				
Advice for patient on how to resolve/manage condition				*Link to leaflet*
• Reassure the parents 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 months. • 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' 'time out'. • Other strategies that may help to soothe a crying infant include: – Gentle motion (e.g. pushing the pram, rocking the crib) – 'White noise' (e.g. vacuum cleaner, hairdryer, running water) – Bathing in a warm bath. • Encourage parents to look after their own well-being: – Ask family and friends for support – parents need to be able to take a break. – Rest when the baby is asleep. – Meet other parents with babies of the same age.				

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

CONJUNCTIVITIS (BACTERIAL)

General information

People with conjunctivitis commonly describe a sticky eye, WITHOUT visual disturbance (in conjunctivitis, any visual disturbance is cleared with a blink).

People should be made 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 1–2 weeks.

For most people, use of 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 three days and are not improving OR
- condition has deteriorated over recent days OR
- condition is severe or likely to become severe, providing 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.

Schools and childcare organisations may require treatment before allowing a child to return[10]. However, the Health Protection Agency (HPA) advises that the child need not normally be excluded from nursery or school, except for during an outbreak situation[11].

Referral to GP/optometry information

Refer urgently if:

- vision is reduced
- person has significant photophobia
- person has had recent eye surgery
- person has restricted or painful eye movements

Those people who have an eye problem that needs urgent attention or those 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 Care Wales.

Refer people to an accredited optometrist if:

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

Refer children under two years old and pregnant or breastfeeding women to their GP.

Refer patients with a personal or family history of blood dyscrasias.

Contact lens wear can be a confounding factor in conjunctivitis and referral of a person to their optometrist should be recommended in all cases.

Treatment(s) offered	Pack size	Maximum number of packs to be supplied	Number of episodes per year	Information/instructions
Chloramphenicol 0.5% eye drops	10 ml (via PGD)	2 – if both eyes affected	2 (second at least 6 months after the first)	Cannot be supplied to children < 2 years or pregnant or breastfeeding women
Chloramphenicol 1% eye ointment	4 g (via PGD)	2 – if both eyes affected	2 (second at least 6 months after the first)	
Advice for patient on how to resolve/manage condition				*Link to leaflet*

- 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.
- A child should have his/her own towel.

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

CONSTIPATION

General information

Constipation can be broadly defined as a real or perceived significant change in normal bowel habit that is unsatisfactory because of infrequent stools, difficult passage of hard stools, or seemingly incomplete defecation[12].

Only treat acute situations.

Advise the person about lifestyle measures – increasing dietary fibre, maintaining adequate fluid intake, and exercising.

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

Check whether drug-induced (e.g. anticholinergic agents, opioid analgesics, calcium salts, iron salts, calcium antagonists especially verapamil, and tricyclic antidepressants).

Referral to GP information

Refer children < 18 years.

Refer if:

- blood in the stools
- unexplained weight loss
- abdominal pain
- rectal mucus
- co-existing diarrhoea
- persistent symptoms (with altered diet and use of laxatives for 2 weeks)
- 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)
- previous medicines have failed

Treatment(s) offered	Pack size	Maximum number of packs to be supplied	Number of episodes per year	Information/instructions
Lactulose 3.1–3.7 g/5 ml liquid	500 ml	1	2	• Treatment should be selected from options available depending on individual preference, and consideration of severity, type and duration of symptoms by pharmacist. • Start treatment with a bulk-forming laxative (ispaghula
Macrogols ‘3350’ sachets	30	1	2	

Ispaghula husk (Fybogel®) sachets	30	1	2	husk – adequate fluid intake is important; advise that ispaghula husk might take some days to have an effect); if stools remain hard add or switch to an osmotic laxative (lactulose or macrogols). • If stools are soft but difficult to pass or if emptying is inadequate, add a stimulant laxative (senna or bisacodyl or docusate sodium). • Adjust the dose according to symptoms and response. • Advise that laxatives should be stopped once the stool becomes soft and passes easily.
Senna 7.5 mg tablets	20	1	2	
Bisacodyl 5 mg EC tablets	20	1	2	
Docusate sodium 100 mg capsules	30	1	2	
Advice for patient on how to resolve/manage condition				*Link to leaflet*
Lifestyle measures can improve symptoms, e.g. increasing dietary fibre, maintaining adequate fluid intake, and exercising.				

.....END OF 'CONSTIPATION' SECTION.....

DIARRHOEA

General information

Attempt to ascertain the underlying cause. Ask about:

- contact with anyone with acute diarrhoea and/or vomiting,
- exposure to a known source of enteric infection (possibly contaminated water or food),
- recent travel abroad,
- recent laxative use, medicines known to cause diarrhoea (e.g. proton pump inhibitors [PPIs]),
- hospital admission or antibiotic use in preceding 8 weeks (increased risk of *Clostridium difficile* infection).

Assess the severity of the illness. Ask about:
The frequency and severity of symptoms (frequency and consistency of stools, frequency of vomiting, ability to eat and drink).
Dehydration is an important complication of diarrhoea, particularly in children and the elderly; it is essential to assess urinary output.

Review medications – certain medications may be affected by severe diarrhoea (e.g. warfarin, anticonvulsants, and the oral contraceptive pill)[13].

Referral to GP information

Adults

Refer:

- pregnant women;
- people with significantly reduced urinary output;
- people who are systemically unwell (may need to send stool sample);
- when diarrhoea has occurred following foreign travel (may need to send stool sample);
- when person has recently received course of antibiotics or been in hospital in the preceding 8 weeks (may need to send stool sample to rule out *C. difficile*);
- when person is over 16 years and diarrhoea is persistent (> 1 week);
- when person has vomiting that has lasted more than 48 hours or is ill or dehydrated;
- 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);
- when diarrhoea is disturbing sleep.

Other factors that may be relevant for earlier referral to GP include (use clinical judgment):

- Older age (people 60 years of age or older are more at risk of complications).
- Home circumstances and level of support.

Children

Refer:

- children younger than 1 year;
- infants who were of low birth weight;
- children who have passed more than five diarrhoeal stools in the previous 24 hours;
- children who have vomited more than twice in the previous 24 hrs;
- 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 malnutrition[15].

• Fever. • Abdominal pain and tenderness. • Increased risk of poor outcome, for example: – Coexisting medical conditions – immunodeficiency, lack of stomach acid, inflammatory bowel disease, valvular heart disease, diabetes mellitus, renal impairment, rheumatoid disease, systemic lupus erythematosus. – Drugs – certain medicines can exacerbate dehydration and renal failure, e.g. immunosuppressants or systemic steroids, PPIs, angiotensin-converting enzyme inhibitors, diuretics[13], sartans, anti-inflammatory painkillers and metformin[14].	

Treatment(s) offered	Pack size	Maximum number of packs to be supplied	Number of episodes per year	Information/ instructions
No treatments have been included in this section. The use of oral rehydration salt (ORS) as supplemental fluid applies to a small group of children, in particular those at increased risk of dehydration, listed above. This higher risk group has been included in the referral criteria for clinical assessment.				

Advice for patient on how to resolve/manage condition	*Link to leaflet*
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: • continuing breastfeeding and other milk feeds; • encouraging fluid intake; • discouraging the drinking of fruit juices and carbonated drinks, especially in those at increased risk of dehydration; • offering ORS solution as supplemental fluid to those at increased risk of dehydration (see Treatments offered)[15]. Children should not attend any school or other childcare facility while they have diarrhoea or vomiting. Children should not go back to school or other childcare facility until at least 48 hours after the last episode of diarrhoea or vomiting. Advise the person to eat small, light meals and avoid fatty and spicy foods.	

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

DRY EYES

General information

Explain that assessment by an optometrist is required. Those with an acute 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 Care Wales.

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

Referral to GP/optometry information

Those people who have an eye problem that needs urgent attention or those 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 Care Wales.

When the condition of dry eyes is suspected, the person should normally be referred to an accredited optometrist.

Referral is recommended as 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 for same-day assessment.
Symptoms include:

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

Refer people using contact lenses. Preservative-free ocular lubricants are available for those who use contact lenses after optometrist consultation.

Treatment(s) offered	Pack size	Maximum number of packs to be supplied	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) for adequate relief.	Normally to be provided on the advice of an optometrist who should specify for each person the preparation to be supplied. Preservative-free preparations should only be supplied when the optometrist advises it is necessary because of allergy
Hypromellose preservative-free eye drops (Lumecare®)	30 x 0.5 ml	1	1		
Carbomer ‘980’ 0.2% eye drops (Viscotears®)	10 g	1	1		
Carbomer ‘980’ 0.2% preservative-free eye drops (Viscotears®)	30 x 0.6 ml	1	1		
Liquid paraffin eye ointment (Lacri-Lube®)	3.5 g	1	1		

Clinitas Gel®	10 g	1	1		to the preservative and/or moderate to severe eye disease.
VitA-POS®	5 g	1	1		
Advice for patient on how to resolve/manage condition					*Link to leaflet*
Advise that 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: • good eyelid hygiene to control blepharitis – present in most people with dry eye syndrome[16]; • 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, and selective serotonin reuptake inhibitors (SSRIs); • using a humidifier to moisten ambient air; • stopping smoking[17]; • ensuring that computer monitor, if used frequently for long periods, is at or below eye level. Advise person to avoid staring at the screen and to take frequent breaks to close/blink eyes.					

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

DRY SKIN

General information

Provide self-care advice.
Identify potential trigger factors[18] including:

- irritants, e.g. soaps and detergents (including shampoos, bubble baths, shower gels and washing-up liquids)
- skin infections
- contact allergens, cosmetics, hair dyes, nickel, chromium, some plants
- food allergens
- inhalant allergens

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 effective[19].

Referral to GP information

Refer those with:

- Infected eczema. The following symptoms and signs suggest 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	Number of episodes per year	Information/instructions
Emollients (creams not bath oils etc.):	Cetraben® cream	50 g 500 g	1 1	2 2	Less greasy: Cetraben® cream, Doublebase® gel, Diprobase® cream, Epaderm® cream More greasy: hydrous ointment, Hydromol® ointment, white soft paraffin: liquid paraffin (50:50) 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. Avoid aqueous cream as an emollient. First episode could be two consultations in order to include trial of therapy. Subsequent episodes should only be a single
	Doublebase® gel	100 g 500 g	1 1	2 2	
	Diprobase® cream	50 g 500 g	1 1	2 2	
	Epaderm® cream	50 g 500 g	1 1	2 2	
	Hydrous ointment	500 g	1	2	
	Hydromol® ointment	125 g 500 g	1 1	2 2	

	White soft paraffin: liquid paraffin (50:50)	500 g	1	2	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 patient already has a preference. Second consultation – Provide a 500 g pot of preferred product if not supplied at first consultation.
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 becomes 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 unless via PGD Not to be supplied for use on the face unless via PGD. Hydrocortisone 2.5% could be provided if the patient has established dermatitis and has a mild flare-up, and if 1% has been previously used and found to be ineffective. Patient should be referred 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					**Link to leaflet**
Emulsifying ointment *or* white soft paraffin: liquid paraffin (50:50) in contact with dressings and clothing is easily ignited by a naked flame. The risk is greater when these preparations are applied to large areas of the body, and clothing or dressings become soaked with the ointment. People should be told to keep away from fire or flames, and not to smoke when using these preparations. The risk of fire should be considered when using large quantities of any paraffin-based emollient.					

.....END OF 'DRY SKIN' SECTION.....

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, and often occur 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.

No topical haemorrhoidal preparations are licensed for use during pregnancy.

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

Referral to GP information

Refer those with:

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

Refer pregnant women.

Treatment(s) offered	Pack size	Maximum number of packs to be supplied	Number of episodes per year	Information/instructions
Paracetamol 500 mg tablets	32	2	2 – the second at least 6 months after the first.	
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

Scheriproct® suppositories	12 (via PGD)	1	2 – the second at least 6 months after the first.	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.
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: • 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.
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				*Link to leaflet*
Lifestyle advice: • increase daily fibre intake and consume 6–8 glasses of fluid daily • avoid straining during defecation • maintain good perianal hygiene • avoid excessive caffeine intake[20]				

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

HAY FEVER

General information

Reminder: It may not be necessary to treat hay fever, especially in children if they are not upset by symptoms.
Try to identify causative allergen and give advice on allergen avoidance.
If providing treatment, follow stepped approach (unless oral treatment alone has been found to be insufficiently effective, in which case provide appropriate combination for symptoms):

1. Treat with an antihistamine.
2. If this does not control symptoms and:
   - Congestion persists: treat with steroid nasal spray in addition;
   - Rhinorrhoea persists: refer to GP for anticholinergic;
   - Eye symptoms persist: treat with sodium cromoglicate eye drops.
3. If symptoms still not controlled, check compliance and technique. If both acceptable, refer to GP.

For people who want an “as-required” treatment for occasional symptoms, provide an antihistamine.
For people who want preventive treatment to control more frequent or persistent symptoms, explain the importance of regular treatment and good nasal spray/drop technique to control symptoms.
Advise to continue treatment until no longer likely to be exposed to the suspected allergen.

Referral to GP information

Refer if pregnant or breastfeeding.

If nasal blockage is a problem in the absence of rhinorrhoea, nasal itch and sneezing, refer to GP for examination to check for nasal polyps, deviated nasal septum and mucosal swelling. If unilateral nasal discharge, especially in a young child, refer to check for a trapped foreign body.

Contact lens wearers should be advised that their contact lenses may exacerbate their eye symptoms. They should be advised to visit their optometrist.

Those people who have an eye problem (see CONJUNCTIVITIS for symptoms and signs) that needs urgent attention or those 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 Care Wales.

If symptoms not controlled after the steps above, refer to GP.

Treatment(s) offered	Pack size	Maximum number of packs to be supplied	Number of episodes per year	Information/instructions	
Cetirizine 10 mg tablets	30	1	6	Only if > 6 years	If no improvement

Cetirizine 1 mg/ml sugar-free oral solution	200 ml	1	6	Only if > 2 years	in symptoms after 1 month of treatment, refer to GP. Restrict to 6 months, supplying 1 month at a time
Loratadine 10 mg tablets	30	1	6	Only if > 2 years **AND** body weight > 30 kg	
Loratadine 1 mg/ml oral solution	100 ml	1	6	Only if > 2 years	
Chlorphenamine 4 mg tablets	28	3	6	Due to sedative properties only likely to be appropriate in occasional circumstances. Only if > 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 if > 1 year	
Sodium cromoglicate 2% eye drops	13.5 ml (via PGD)	1	6		
Beclometasone 50 microgram nasal spray	200 spray unit (via PGD)	1	6	People over 6 years only	
Advice for patient on how to resolve/manage condition					*Link to leaflet*
Ensure regular treatment and good nasal spray/drop technique to control symptoms. When pollen count is high: • Stay indoors as much as possible and keep windows and doors shut. • Avoid cutting grass, large grassy places and camping. • Shower and wash your hair after being outdoors, especially after going to the countryside. • Wear wrap-around sunglasses when you are out. • Keep car windows closed and consider buying a pollen filter for the air vents in your car. These should be changed at every service.					

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

HEAD LICE

General information

If head lice are detected in an individual they should be treated by wet combing. This is effective if undertaken appropriately. Wet combing can be encouraged with the supply of a detection comb. Should this method be unacceptable to the person/carer, people may purchase a chemical or insecticidal treatment.

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 simultaneously[21,22]. The first-line treatment for all affected individuals should be wet combing – Hedrin® should only be supplied if wet combing is unacceptable or ineffective. Hedrin® should only be supplied if an individual is able to supply evidence of a live louse.

Give advice on detection and wet combing.

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 prove effective. Therefore, Hedrin® could be used first line in these people.

Referral to GP information

Refer people with scalp inflammation.

Treatment(s) offered	Pack size	Maximum number of packs to be supplied	Number of episodes per year	Information/instructions
Detection comb	1	1	2 – the second at least 6 months after the first	First-line treatment
Dimeticone 4% lotion (Hedrin®)	150 ml	2	2 – the second at least 6 months after the first	Second-line, if person returns after 2 weeks still with head lice despite having undertaken wet combing correctly for 2 weeks. Rub into dry hair and scalp, allow to dry naturally, shampoo after minimum 8 hours (or overnight), repeat application after 7 days. Keep hair away from fire and flames during treatment[23,24].
Advice for patient on how to resolve/manage condition				**Link to leaflet**

Wet combing method - The wet combing method is described below[25]:

- 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.
- Work methodically through the hair, section by section, so that the whole hair is combed.
- Rinse out the conditioner and repeat the combing procedure in the wet hair.
- Repeat the procedure on day 5, 9 and 13 to clear any young lice as they hatch, before they have time to reach maturity.
- Continue until no lice are found on three consecutive sessions[21].
- 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 prove effective.

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

INDIGESTION AND REFLUX

General information

Provide lifestyle advice including healthy eating, weight reduction, reducing alcohol intake and smoking cessation, and advise to avoid known precipitants[26].
Check for potential medicines-related exacerbation or cause.
For gastro-oesophageal reflux disease (GORD) and uninvestigated dyspepsia offer a full-dose PPI for 1 month[26].

Referral to GP information

Refer all children (< 18 years).
Refer if diagnostic uncertainty including pain on exertion, history of myocardial infarction.
Refer if 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
  - progressive difficulty swallowing
  - abdominal swelling
  - persistent vomiting
- is over 55 years of age with persistent or unexplained dyspepsia
- is taking NSAIDs

Treatment(s) offered		Pack size	Maximum number of packs to be supplied	Number of episodes per year	Information/instructions
PPIs	Omeprazole 20 mg capsules	28 (via PGD)	1	2	Offer full-dose PPI for 1 month for GORD and uninvestigated dyspepsia[26]. Omeprazole would be the first-line PPI. Lansoprazole should be considered if there are interactions with existing medication.
	Lansoprazole 30 mg capsules	28 (via PGD)	1	2	
Compound alginates. One of:	Peptac®	500 ml	1	2	Currently Peptac® is the most cost-effective option.
	Gaviscon Advance®	500 ml	1	2	
Advice for patient on how to resolve/manage condition					*Link to leaflet*
Lifestyle advice: healthy eating, weight reduction, reduced alcohol intake, smoking cessation and avoiding known precipitants[26].					

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

INGROWING TOENAIL

General information

Ingrowing toenails are a common problem 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.

The foot should be examined to make the diagnosis.

When the ingrowing toenail is at a mild to moderate stage, non-surgical (or conservative) interventions relieve symptoms, prevent the ingrown toenail getting worse, help cure the problem, and prevent recurrence (e.g. soaking the toe in warm salty water or placing a cotton wisp under the ingrowing nail edge [for further details see *Advice for patient* section below]).

Antibiotics may be needed to treat infection.

Referral to GP information

Further advice can be obtained from a podiatrist (depending on the location, this may need to be private) or GP.
Refer if there is:

- A fluctuant which may require incision and drainage
- Recurrent infection
- Chronic infection
- Co-existing nail disease

Refer if no improvement after 7 days of conservative treatment, or sooner if symptoms are getting worse.

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

Advice for patient on how to resolve/manage condition	Link to leaflet

Possible causes include improper trimming of the nail, tearing nails off, or wearing constricting footwear.
Practise good foot hygiene by taking care of your feet and regularly washing them, using soap and water.
Trim the nail straight across to help prevent pieces of nail continuing to dig into the surrounding skin.
Gently push the skin away from the nail using a cotton bud (this may be easier after using a small amount of olive oil to soften the skin).
Wear comfortable shoes that are not too tight and provide space around your toes.
Painkillers, such as paracetamol, can be used to help relieve any pain.
If the ingrowing part of the nail is small, it may be prevented from becoming worse, and sometimes cured, by the following[27].

- 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 you soak your foot.
- Do not cut the nail but allow it to grow forward until it is clear of the end of the toe. Then cut it straight across, not rounded off at the end.

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

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

INTERTRIGO/RINGWORM				
General information				
Ringworm diagnostic features: Typically 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. Intertrigo commonly affects occluded skin creases such as groins, under breasts and axillae. Most cases of skin ringworm and groin infections can be treated using an over-the-counter antifungal cream.				
Referral to GP information				
Refer people with severe inflammation, signs of bacterial infection, unresponsive rash or recurrent episodes.				
Treatment(s) offered	**Pack size**	**Maximum number of packs to be supplied**	**Number of episodes per year**	**Information/instructions**
Clotrimazole 1% cream	20 g	1	2 – second episode at least 6 months after the first	There is insufficient evidence to recommend one preparation over another. The cream should be applied twice daily and used for 1–2 weeks after the rash has gone.
Miconazole 2% cream	30 g	1	2 – second episode at least 6 months after the first	
Hydrocortisone 1% cream	15 g	1	2 – second episode at least 6 months after the first	Antifungal and hydrocortisone treatment should only be used for moderate and severe conditions. Use combined treatment when there is associated eczematous intertrigo and, in the first few days only, in significantly inflamed ringworm[28].
Advice for patient on how to resolve/manage condition				*Link to leaflet*
• 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. • Wear loose-fitting clothes made of cotton or a material designed to move moisture away from the skin.				

.....END OF 'INTERTRIGO/RINGWORM' SECTION.....

MOUTH ULCERS

General information

Minor aphthous ulcers typically heal within 10–14 days without scarring.
Major aphthous ulcers may take several weeks to heal and often leave a scar.
Major ulcers occur less frequently than minor ulcers.

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

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 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 2 weeks.

Trigger points for referral:

- children < 10 years;
- duration > 14 days;
- painless;
- signs of systemic illness;
- ulcers > 1 cm diameter;
- ulcers in crops of 5–10 or more;
- person on chemotherapy.

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 referred.

Treatment(s) offered	Pack size	Maximum number of packs to be supplied	Number of episodes per year	Information/instructions
Hydrocortisone 2.5 mg oromucosal tablets	20	1	1	1 lozenge 4 times daily, allowed to dissolve slowly in the mouth in contact with the ulcer. Only use in children over 12 years.

Advice for patient on how to resolve/manage condition	*Link to leaflet*

Identify and avoid precipitating factors, where possible, to minimise recurrence.
Most mouth ulcers will often not require specific treatment or medication and will normally heal naturally, if they are:

- infrequent,
- mild, and
- do not interfere with daily activities (e.g. eating).

However, if you have a mild mouth ulcer, there are some self-care tips you can follow which may help your ulcer to heal quicker:

- Use a soft toothbrush when brushing your teeth.
- Avoid eating hard foods, such as toast. Try to stick to foods that are softer and easier to chew.
- Try to reduce your stress levels, perhaps by doing something that you find relaxing, such as yoga, meditation, or exercise.
- Many people find that eating certain foods, such as chocolate, coffee and peanuts, can make them more prone to developing an ulcer. If you know that eating a particular food provokes an ulcer for you, avoid eating that food until your ulcer has completely healed.

If your ulcer has a specific cause, such as a sharp tooth, then it will normally heal naturally once the cause has been treated. If you suspect a sharp tooth is causing your ulcer, visit your dentist, who should be able to repair the tooth, allowing the ulcer to heal by itself.

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

NAPPY RASH

General information

Diagnostic features: Mild rash restricted to the nappy area.
Common causes:
(i) 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.
(ii) Candidal fungal infection presenting as sharply marginated redness involving the skin creases. Candidal infection is the most likely cause if there are satellite lesions (small areas of redness separate from most of the affected area).

Offer advice on preventing nappy rash.

Referral information

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.

Treatment(s) offered	Pack size	Maximum number of packs to be supplied	Number of episodes per year	Information/instructions	
Metanium®	30 g	1	1	This is the preferred treatment choice as it is preservative-free.	Provide advice and referral if appropriate.
Sudocrem®	60 g	1	1	Consider Sudocrem® rather than Metanium® if larger quantities are needed.	
Clotrimazole 1% cream	20 g	1	1		
Advice for patient on how to resolve/manage condition				*Link to leaflet*	

To reduce exposure to irritants (urine, faeces and friction), advise parents and carers to:

- 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:
  - use water, or fragrance- 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.....

ORAL THRUSH

General information

Oral thrush can cause discomfort or be asymptomatic. Commonly recognised by generalised erythema and white adherent patches in the mouth.

Prescribe topical therapy for initial course of 7 days.

Provide counselling if person is on corticosteroid inhaler. 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.
Assess patient's inhaler technique or advise to discuss with GP or practice nurse.

Referral to GP information

If no obvious precipitant, such as recent broad spectrum antibacterials, steroid inhaler, dentures or diabetes, refer to GP to exclude immunosuppression.
If the person is immunocompromised provide one course as symptomatic treatment but refer.
Refer people with poorly controlled diabetes, who have not been reviewed by the GP in the last 3 months.
Refer if the person presents with a single plaque that cannot be rubbed off (leukoplakia).

Treatment(s) offered	Pack size	Maximum number of packs to be supplied	Number of episodes per year	Information/instructions
Miconazole oral gel	80 g (via PGD)	1	2 (must be 6 months apart)	Generally considered first-line treatment[29]. Miconazole is absorbed to the extent that potential interactions need to be considered[30]. Do not issue miconazole to people using interacting medicines, particularly warfarin; consider nystatin. All doses to be given after food. Keep the gel in the mouth for as long as possible. The usual dose is 2.5 ml, four times a day for adults; however, for localised lesions of the mouth, a small amount of gel may be applied directly to the affected area with a clean finger. Continue topical therapy for 2 days after symptoms have resolved.
Nystatin	30 ml (via PGD)	1	2 (must be 6 months apart)	For people taking medicines that interact with miconazole[29]. All doses to be given after food. The usual dose is 1 ml four times a day for adults. Continue topical therapy for 2 days after symptoms have resolved. Only Nystan® should be given due to high cost of generic preparation.

Advice for patient on how to resolve/manage condition	*Link to leaflet*
• Maintain good dental/denture hygiene. • Give up smoking, if applicable[29].	

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

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 those 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.					
Treatment(s) offered	**Pack size**	**Maximum number of packs to be supplied**	**Number of episodes per year**	**Information/instructions**	
Permethrin 5% cream	30 g	See Information/ instructions	1	First line treatment[31,32].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. Treatment should be washed off after 8–12 hours. Reapply treatment if it is washed off during this treatment period. 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.	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.
Malathion 0.5% (Derbac M® Liquid)	200 ml	See Information/ instructions	1	Use if permethrin is inappropriate[31,32]. 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. 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		
Chlorphenamine 2 mg in 5 ml sugar-free solution	150 ml	1	1		
Cetirizine 10 mg tablets	30	1	1		
Cetirizine 1 mg/ml sugar-free oral solution	200 ml	1	1		
Loratadine 10 mg tablets	30	1	1		
Loratadine 1 mg/ml oral solution	100 ml	1	1		
Advice for patient on how to resolve/manage condition					*Link to leaflet*
Mites on clothes, linen, etc. can be killed by machine washing (at > 50^{o}C) on the day of application of the first treatment.					

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

SORE THROAT AND TONSILLITIS
General information
Non-medicinal advice: see below. Antibiotics will make little difference to symptoms and may have adverse effects e.g. diarrhoea, vomiting and rash[33]. 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 explains to people why they did not receive antibiotics[34].
Referral to GP information
Refer: • those with persistent sore throat, e.g. 2-week duration. Refer sooner if symptoms worsen; • after 1 week if person has sore throat and lethargy (possible symptoms of glandular fever, especially if 15 to 25 years old); • immunocompromised people, e.g. HIV-positive or AIDS diagnosis, leukaemia, asplenia, organ transplant or receiving DMARDs, chemotherapy or carbimazole; • if the person is systemically unwell or has symptoms and signs suggestive of serious illness and/or complications; • if the person is at high risk of serious complications because of pre-existing comorbidity. This includes people with significant heart, lung, renal, liver or neuromuscular disease, immunosuppression, cystic fibrosis and young children who were born prematurely; • if the person is older than 65 years with acute cough and two or more of the following criteria, or older than 80 years with acute cough and one or more of the following criteria: - hospitalisation in previous year; - type 1 or type 2 diabetes; - history of congestive heart failure; - current use of oral glucocorticoids[33]. The following may be useful when considering whether to refer on to a GP for further assessment. The GP may use the Centor criteria for predicting the presence of a bacterial infection in patients with acute sore throat. The four Centor criteria are: • Presence of tonsillar exudate • Presence of tender anterior cervical lymphadenopathy or lymphadenitis • History of fever • Absence of cough The presence of three or more Centor criteria suggests the person may benefit from antibiotic treatment[33].

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	2	First line. A maximum of 1 x 200ml paracetamol 250 mg in 5 ml sugar-free suspension may be supplied for children over 12 years who are unable to use paracetamol tablets.
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	Second line. Caution in children at risk of dehydration.
Ibuprofen 200 mg tablets	24	1	2	
Ibuprofen 400 mg tablets	24	1	2	
Advice for patient on how to resolve/manage condition				*Link to leaflet*

- Adults or older children may find sucking throat lozenges, hard-boiled sweets, ice cubes or flavoured frozen desserts (e.g. ice lollies) provides symptomatic relief.
- Avoid smoking or smoky environments.
- Simple analgesics will help temperature and discomfort.
- Ensure adequate fluid intake to avoid dehydration if fever is present. Avoid drink or food that is too hot, as this could irritate the throat.
- Try a warm saline mouthwash (half a teaspoon of salt in a glassful of warm water) at frequent intervals, but do not swallow the mouthwash.
- Be advised that the condition is self-limiting and is likely to get better within 7 days, with or without antibiotic treatment.

.....END OF ‘SORE THROAT AND TONSILLITIS’ SECTION.....

TEETHING				
General information				
Teething can cause discomfort. Other symptoms should not be attributed to teething. Pyrexia is not due to teething and an alternative cause should be sought. 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				
Advise the parent to seek medical advice if the infant becomes systemically unwell (e.g. with a high fever), as this indicates an underlying condition unrelated to teething.				
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 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*
• Gentle rubbing on the gum with a clean finger may provide relief. • Under supervision, give the child something clean to chew on: – teething ring (cooled in the fridge [never freezer] sometimes helps – check instructions with the ring) or cold wet flannel; – for children who have been weaned, consider use of chilled fruit or vegetables (such as bananas or cucumber); – avoid objects that can easily be broken into hard pieces as these are a choking risk; – sugar-free products are preferred as they do not promote tooth decay. Teething biscuits and rusks are not recommended if they contain sugar.				

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

THREADWORMS					
General information					
Treat person if threadworms have been seen or eggs detected. Treat all household members at same time, unless contraindicated. Treatment is given as a single dose. As reinfection is very common, a second dose may be given after 2 weeks. Pack size will be two treatments for every household member (could include tablets and liquid). Children do not need to be excluded from school.					
Referral to GP information					
Refer if person is pregnant or breastfeeding, or is a child < 6 months.					
Treatment(s) offered	**Pack size**	**Maximum number of packs to be supplied**	**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[35]. Use in children less than 2 years is unlicensed.	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.
Mebendazole (Vermox®) 100 mg tablets	6 (via PGD)	See Information/ instructions	1	Only if person > 6 months[35]. Use in children less than 2 years is unlicensed.	
Advice for patient on how to resolve/manage condition				*Link to leaflet*	
Treatment should be combined with hygiene measures: • Environmental – on first day of treatment: – wash sleepwear, bed linen, towels and soft toys at normal temp and rinse well; – vacuum and dust, especially bedrooms, including mattresses; – clean bathroom thoroughly, damp-dust surfaces and rinse cloth in hot water frequently. • Personal – for 2 weeks when combined with drug treatment: – wear close-fitting underwear at night and change every morning; – use cotton gloves to prevent scratching and wash them daily; – bathe/shower on rising and wash around anus to remove eggs. • General household – all the time for all family: – wash hands and scrub under nails every morning on rising, after using the toilet, changing nappies, eating or preparing food; – discourage nail biting/finger sucking; – avoid use of shared towels or flannels.					

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

VAGINAL THRUSH				
General information				
Common symptoms include white odourless discharge with vaginal soreness and vulval itching. Maximum of two treatments in 6 months (only prescribe a second treatment if the first episode resolved promptly).				
Referral to GP information				
Refer people < 16 and > 60 years, pregnant or breastfeeding women and immunocompromised women. Refer women with poorly controlled diabetes, who have not been reviewed by the GP in the last 3 months.				
Treatment(s) offered	**Pack size**	**Maximum number of packs to be supplied**	**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. Local mild burning or irritation may occur on application of pessaries and creams.
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, PGD required to avoid interactions.
Advice for patient on how to resolve/manage condition				*Link to leaflet*
Advise women about the following personal hygiene measures and how to avoid potential irritants: • Use a soap substitute to clean the vulval area and do not clean the vulval area more than once per day. • Use emollients as moisturisers several times a day to protect the skin. Use an emollient in the bath. • Avoid potential irritants in toiletries, antiseptics, douches, wipes, and 'feminine hygiene' products. • Avoid washing underwear in biological washing powder and avoid fabric conditioners.				

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

VERRUCA

General information

To reduce risk of transmission:

- cover with waterproof plaster when swimming;
- wear flip-flops in communal showers;
- avoid sharing shoes, socks and towels.

There is no need to exclude person from sports or swimming, but take measures to avoid transmission as above.
Consider treatment if verruca is painful (e.g. on sole of foot), if it is persisting, unsightly or causing distress – many resolve spontaneously within months or up to 2 years.

Referral to GP information

Refer if diagnosis uncertain, multiple recalcitrant warts, person immunocompromised, extensive affected areas e.g. mosaic, persistent and unresponsive to salicylic acid and people with diabetes.

Treatment(s) offered	Pack size	Maximum number of packs to be supplied	Number of episodes per year	Information/instructions
Salicylic acid 16.7% (Salactol® collodion paint)	10 ml	1	1	For people > 2 years. How to apply: • Before applying, soak area to soften for 5–10 minutes in warm water; and then pat the skin dry with own towel; • Peel off any remaining film from previous application; • Avoid applying to surrounding skin (using soft paraffin or specially designed plasters); • Debride surface of verruca with emery board once or twice a week to remove excess hard skin; • Do not apply to extensively affected areas because of risk of scarring; • Apply daily for up to 12 weeks.
Salicylic acid 12% (Salatac® gel)	8 g	1	1	
Salicylic acid 50% (Verrugon®)	6 g	1	1	This should only be used if lower strengths of salicylic acid have been ineffective.
Glutaraldehyde 10% (Glutarol®)	10 ml	1	1	• Apply twice daily for up to 12 weeks; • Before applying soak the affected area in hot soapy water for 2–3 minutes and then dry with own towel; • Gently rub away any loose hard skin from the surface of the verruca with an emery board or a piece of pumice stone;

				• Carefully apply 2 coats of the paint to the top of the verruca only; • Avoid spreading onto surrounding healthy skin; • Allow the first coat to dry for a few minutes before applying the second coat.
Advice for patient on how to resolve/manage condition				*Link to leaflet*
Keep feet dry and change socks daily.				

.....END OF 'VERRUCA' SECTION.....

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LINKS

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

Back Book: www2.nphs.wales.nhs.uk:8080/BackBookRequests.nsf/MainForm

CRY-SIS website: www.cry-sis.org.uk

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

NHS Direct Wales Head lice Leaflet:
www.nhsdirect.wales.nhs.uk/encyclopaedia/h/article/headlice/?print=1

NHS Direct Wales Ingrown Toenail Leaflet:
www.nhsdirect.wales.nhs.uk/Encyclopaedia/i/article/ingrowntoenail/

HPA Antibiotic Information Leaflet: www.rcgp.org.uk/clinical-and-research/target-antibiotics-toolkit/~/media/Files/CIRC/TARGET/Patient-Antibiotic-leaflet.ashx