PrescQIPP
Community Interest Company

Emollients

Emollients have a key role in treating dry skin conditions, including eczema and psoriasis.[1-4] A recent Cochrane review of emollients in eczema found that most showed some beneficial effects. However, it was not possible to reliably determine if one emollient is better than another.[5] The rationale for using emollients in psoriasis is to improve the skin's barrier function, reduce scale, and possibly increase the penetration and effectiveness of some active topical treatments.[4] Emollients are also used for dry, fragile and/or itching skin associated with ageing.[2,6]

This document is intended to support decision making regarding choice of emollient when initiating or changing emollient therapy. Further resources including Bulletin 228: Emollients, paraffin content and risk of fire and Bulletin 240: Care homes – Emollients and barrier preparations are available on the dermatology webkit https://www.prescqipp.info/our-resources/webkits/dermatology/

Recommendations

- Agree a local list of emollients that have a lower acquisition cost with local dermatologists and other key stakeholders. This should be a starting point for prescribing. Cost charts are provided below to support local decision-making.
- Consider the risk of severe and fatal burns with paraffin-containing and paraffin-free emollients. Advise patients who use these products not to smoke or go near naked flames, and warn about the easy ignition of clothing, bedding, dressings, and other fabric that have dried residue of an emollient product on them.[7]
- Ensure that the indication is a documented dermatological condition:
  - » Prescribing of emollients for non-clinical cosmetic purposes is not recommended and should be reviewed.
  - » Mild dry skin can be managed via self-care.[8] Community pharmacists can support self-care by providing advice, recommending appropriate emollients and referring people to their GP where necessary.[9]
- Choose an emollient from the locally agreed formulary after discussion with the person being treated in order to match choice to their lifestyle and increase adherence.[10,11] Consider the person's preference and needs when selecting a product, taking into account the severity of the condition and site of application.[1,12]
- Check sensitivities and previous emollients that have been unsuccessfully tried before prescribing.
- Initially, prescribe a small quantity of emollient on an acute prescription to gauge suitability for the individual.
- Once a suitable emollient is found, prescribe a sufficient amount (see Table 1, page 11) that can be included on a repeat prescription.
- For repeat prescriptions of emollients, it is usually preferable to select the largest pack size, which often cost less per gram or millilitre.

Recommendations

- Do not prescribe moisturisers and creams that are not licensed medicines or medical devices (listed as appliances in part IXA of the Drug Tariff). These are considered to be cosmetic treatments. Note: There are a small number of exceptions where products are classified as borderline substances.
- People with eczema should be advised to wash with a regular leave-on emollient that is suitable for use as a soap substitute. A lower acquisition cost option should be chosen. Warn people that they make surfaces slippery.[2]
- Aqueous cream carries a higher risk of causing skin irritation particularly in children with eczema, possibly due to its sodium lauryl sulphate (SLS) content.[13] Some authorities advise avoiding its use entirely.[3,10] Many emollients have been reformulated to remove SLS, so there are several lower acquisition cost alternatives to aqueous cream (NB. emulsifying ointment contains SLS).[14]
- Avoid routine use or long-term use of emollients containing antimicrobials. NICE recommend using topical antiseptics as adjunct therapy to decrease bacterial load in children who have recurrent infected atopic eczema. However they can be irritant and occasionally cause contact allergic dermatitis.[1]
- If emollients containing urea are recommended locally, specify when they should be tried. Urea has hydrating and keratolytic properties[4,12,15] and is used in the treatment of dry, scaling conditions (including ichthyosis).[12] Urea may cause transient burning and stinging,[5] and preparations are generally more costly. It is therefore reasonable to target use to specific groups, e.g. where skin is hyperkeratotic (thickened)[15] or scaling, in ageing skin or for people who have tried other emollients without success.[10]
- Prescribe pump dispensers to minimise the risk of bacterial contamination, when they are available for the person's selected emollient. For emollients in pots, a clean spoon or spatula should be used (rather than fingers) to remove the required amount.[2,3] Tubes may also be less vulnerable to bacterial contamination than pots,[16] but the cost per gram/millilitre is often greater.
- Review repeat prescriptions of individual products and combinations of products with children with atopic eczema and their parents or carers at least once a year to ensure that therapy remains optimal in accordance with NICE guidance.[1]
- Prescriptions for adults should generally be reviewed annually, although this may not be necessary in very mild conditions, e.g. people with small areas of mild eczema that require minimal intervention.[3]

Prescribing considerations

- Advise people to use their emollient liberally and frequently (at least two to four times a day; very dry skin may require application every two to three hours).[2-4]
- Generally, the greasier the product the more effective it is as an emollient, as it is able to trap more moisture in the skin. However, greasier emollients can be less acceptable or tolerable leading to decreased adherence. People may be more willing to use a greasier product at night, with a better tolerated product (such as a cream) used during the day.[3]
- Ointments are the greasiest preparations, composed of oils or fats. They contain less water than other emollients and therefore require fewer (or no) preservatives.[3,14] They can therefore be useful for people with sensitivities. However, they can exacerbate acne and can cause folliculitis when overused.[16] Emollients should be applied in the direction of hair growth to reduce the risk of folliculitis.[3,14]
- Creams and gels are emulsions of oil and water and their less greasy consistency often makes them more cosmetically acceptable.[16]

- Lotions have a higher water content than creams, which makes them easier to spread but less effective as emollients.[16] They may be preferred for very mildly dry skin,[16] as well as for hairy areas of skin.[14]
- Lotions can be more expensive than a lower acquisition cost gel, cream or ointment, and should only be selected where there is a clear rational. They should be purchased for self-care for mild dry skin.[8]
- Aerosol formulations such as sprays and a mousse are also available.[12] They are generally more costly, but sprays may have a role where application without touching the skin is advantageous.
- Sensitivities to excipients can occur and should be checked before prescribing; excipients are listed in the Summary of Product Characteristics (for licensed medicines), plus the BNF indicates the presence of some specific excipients that are associated with sensitisation in topical preparations.[12] Subscribers to MIMS can access 'Emollients, Potential Skin Sensitisers as Ingredients' table, to check the presence of potential allergens in moisturising treatments.
- Many of the emollients in this bulletin are classed as appliances and are listed in part IXA of the Drug Tariff. They can be prescribed on the NHS as they are listed in the Drug Tariff.
- A small number of emollients are classed as borderline substances and are only available on NHS prescriptions for specified conditions. Products to which this applies are annotated with 'ACBS' (Advisory Committee on Borderline Substances) in the charts that follow.

Safety: risk of severe and fatal burns with paraffin-containing and paraffin-free emollients

The National Patient Safety Agency (NPSA) and Medicines and Healthcare products Regulatory Agency (MHRA) have highlighted the danger of fire and serious injury for patients who smoke or go near naked flames when they use paraffin based emollients on their skin which is then covered with dressings or clothing.[7,17-19] In 2018, the MHRA strengthened their advice and extended the warning about risk of severe and fatal burns to all paraffin based emollients regardless of paraffin concentration and indicated that data suggest there is also a risk for paraffin-free emollients.[7] Clinicians should weigh up the risks and benefits of using emollients before prescribing. Further information on this matter is available at www.prescqipp.info in Bulletin 228: Emollients, paraffin content and risk of fire, which recommends that:

- Patients who use nasal cannulae (prongs) for oxygen administration can apply a water based moisturiser (such as KY jelly) to the lips and nose to prevent drying and cracking. Paraffin based products are not recommended as they can plug air holes and are a fire hazard.
- Patients prescribed large quantities of any emollient to treat skin conditions (e.g. application of 100g or more at once, or over a short period of time e.g. a week) must be counselled about the risk of fire.
- Paraffin and non-paraffin containing preparations could contaminate clothing or dressings so they ignite rapidly. To reduce the risk, advise patients where appropriate, that while emollients are in contact with clothing or dressings they should:
  - keep away from open or gas fires, halogen heaters and naked flames, including candles
  - avoid gas hobs for cooking
  - not smoke and never smoke in bed.
- Bedding and clothing should be changed daily and washed at the highest temperature recommended by the fabric care instructions to minimise the build up of impregnated paraffin/emollient, although it won't totally remove it.
- Be aware that emollients may seep into bandages which are not changed as regularly and therefore pose a fire risk if exposed to a naked flame.

- The fire risk of using small amounts of paraffin based emollients is minimal.
- Prescribers should consider doing a risk assessment with the patient when prescribing emollients and give advice to reduce modifiable risk factors.
- If risk factors cannot be reduced, particularly with high risk patients such as those who have a history of smoking or have memory problems/are confused, prescribers may wish to seek advice from the local fire service. County fire services offer a free home fire safety check and some have useful information on their websites.

Adherence and shared decision making

Emollient therapy is time consuming and often needed long-term. Continuous use is necessary, which means persisting with the treatment regimen even when the eczema or psoriasis is in remission.[1,4] Efficacy is dependent on adherence to treatment,[5] but adherence to emollient treatment is perceived to be poor.[11]

Informed, shared decision making based on a range of emollients is thought to be key in encouraging adherence and optimising emollient treatment for conditions such as eczema.[5,10] Prescribing may involve trialling different emollients (in small quantities) until a suitable preparation that is acceptable to the individual is found.

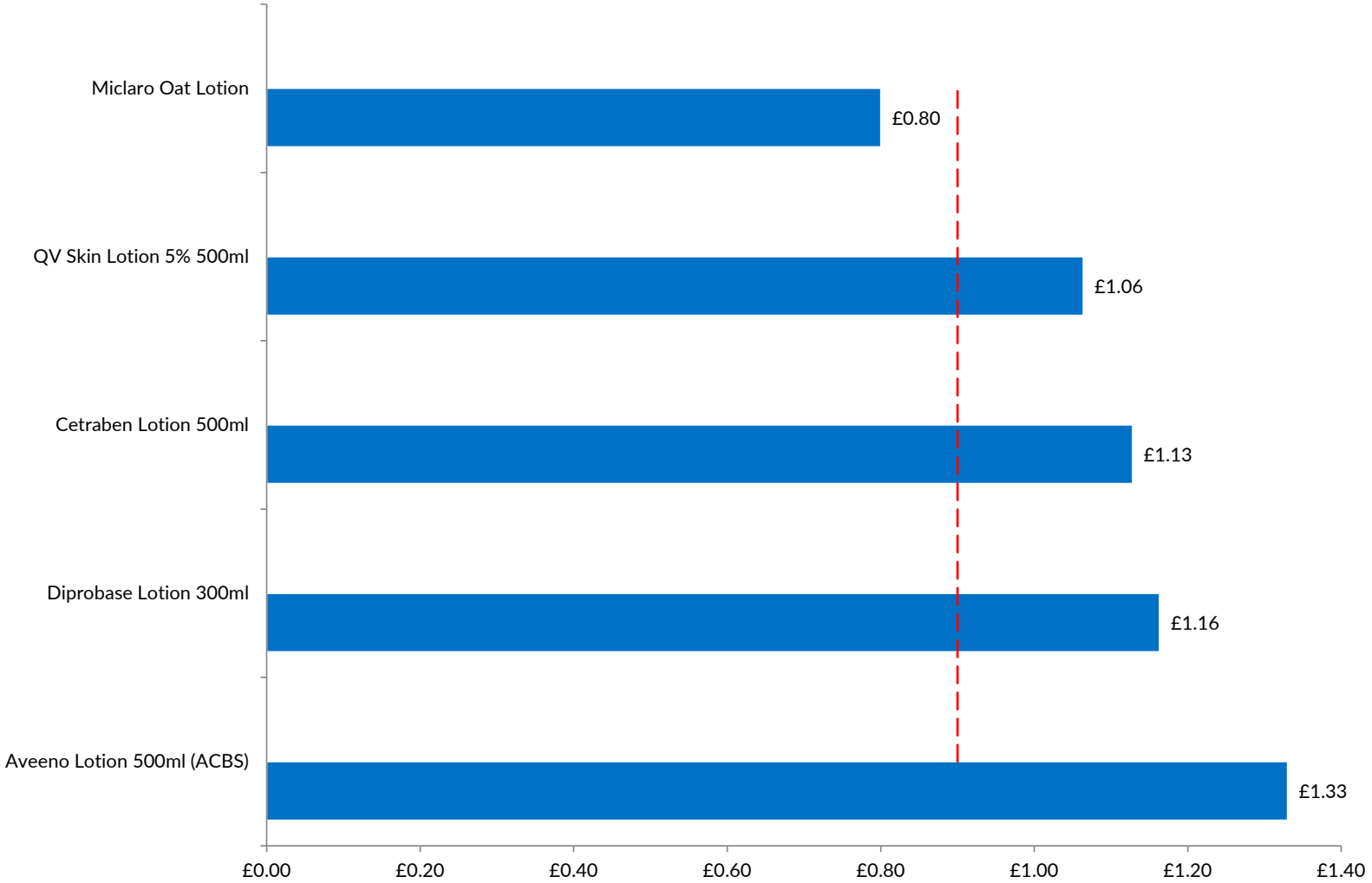
Information (including written information) about treatment should be provided and/or signposted. It should explain the rationale for continued emollient treatment, self-care advice and application information (such as technique, quantity to apply and frequency). A range of information sources for the public can be found in Appendix 1.

Emollient cost charts

The charts below show the cost per 100g/100ml of different groups of emollients (based on their largest pack size) and are intended to support local decision-making in relation to emollient formulary choices. Costs have been calculated based on prices listed in the Drug Tariff June 2020 or MIMS June 2020.

For gels, creams and ointments a threshold value of £0.90 per 100g/100ml has been used to estimate national savings (see 'National cost savings' below). The threshold is represented with a red dotted line.

Chart 1: Cost per 100g/100ml of all emollient lotions (June 2020)



Lotions should be purchased for self-care for mild dry skin.

Chart 2: Cost per 100g/100ml of all emollient creams (June 2020)

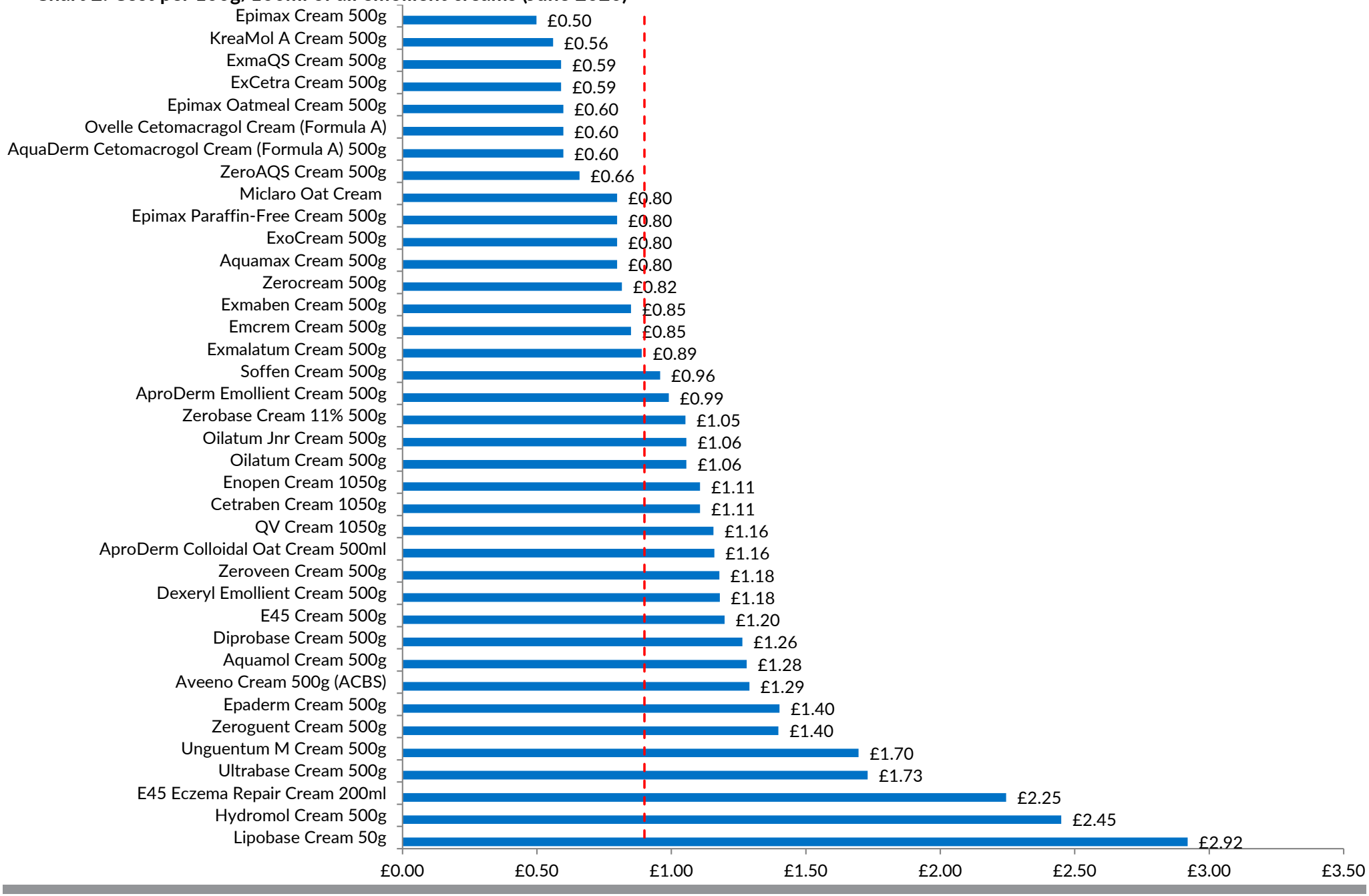


Chart 3: Cost per 100g/100ml of all emollient gels (June 2020)

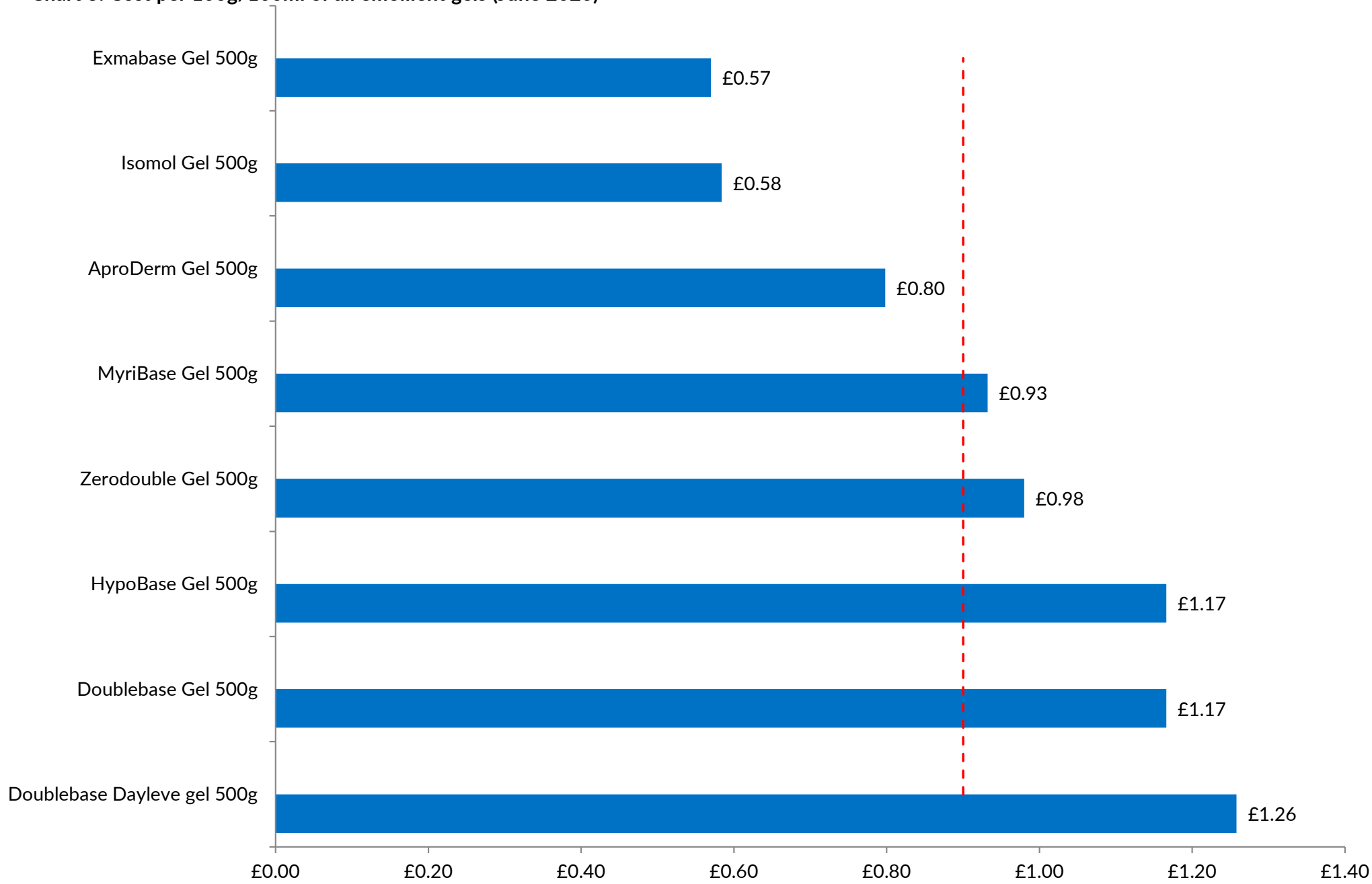


Chart 4: Cost per 100g/100ml of all emollient ointments (June 2020)

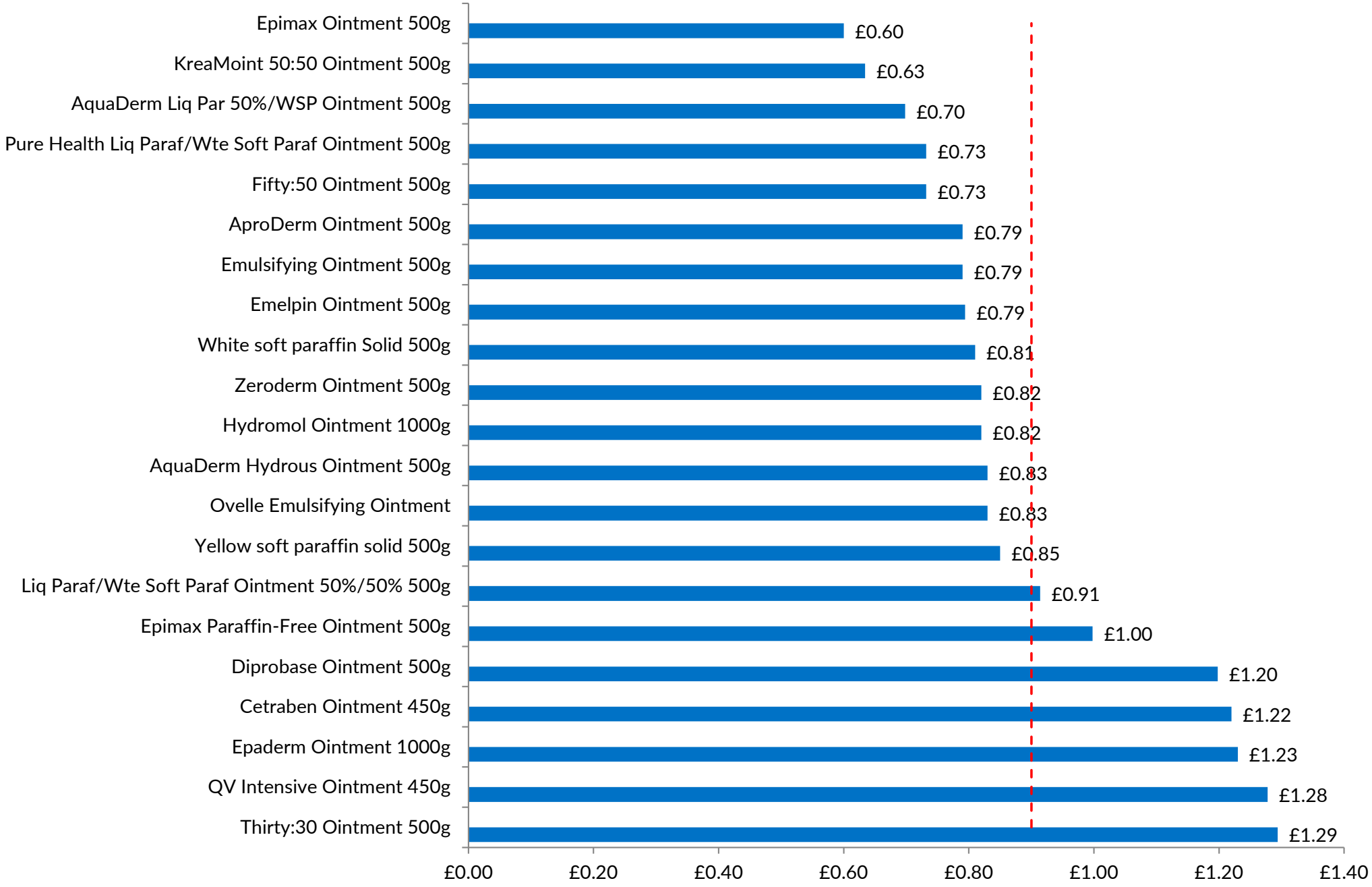
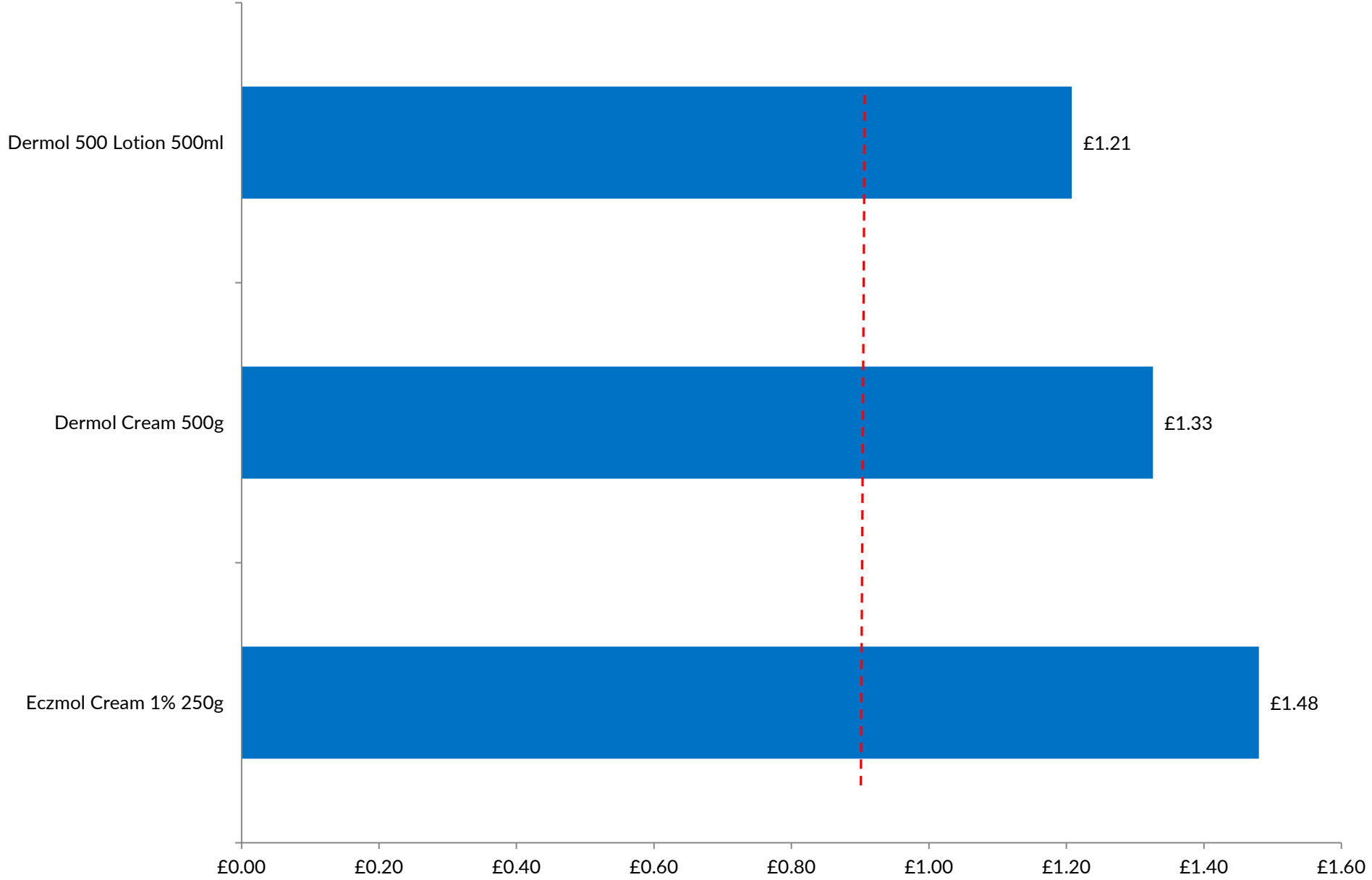
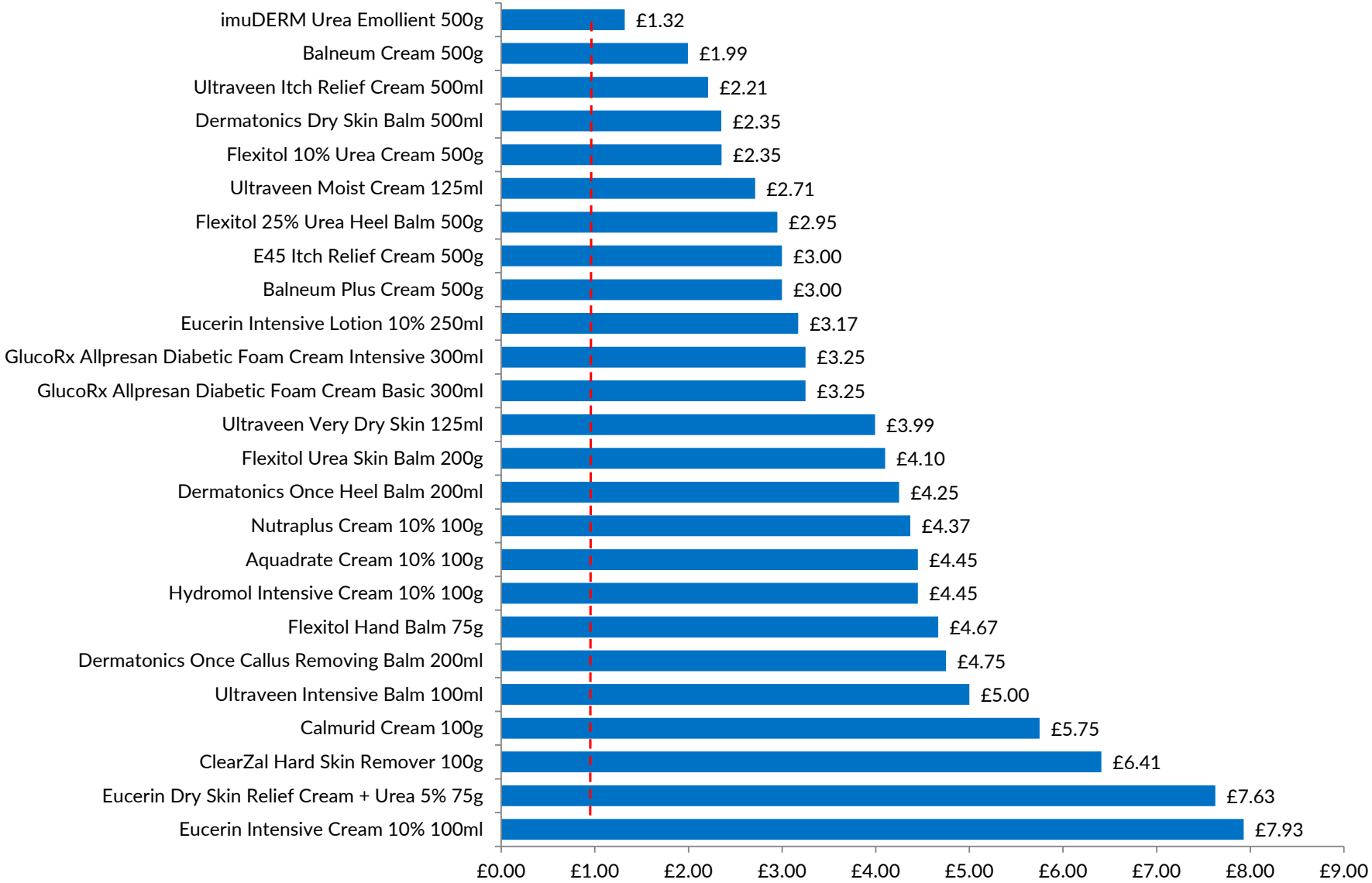


Chart 5: Cost per 100g/100ml of all emollients with antimicrobials (June 2020)



Use of leave-on emollients with antimicrobials should be short-term and targeted. There are no products that cost below the £0.90 per 100g/100ml threshold.

Chart 6: Cost per 100g/100ml urea containing emollients (June 2020)



Emollient products containing urea are not all interchangeable. The urea content of products varies widely and some contain additional active ingredients such as salicylic acid or lactic acid (keratolytic properties), or lauromacrogols (reputed to reduce itch). Ensure that product(s) selected are indicated for the intended use.

There are no products that cost below the £0.90 per 100g/100ml threshold.

Table 1. Suitable quantities of emollients for prescribing for a week and a month[12]

Body site	Creams or ointments		Lotions	
	One week supply	One month supply	One week supply	One month supply
Face	15-30g	60-120g	100ml	400ml
Both hands	25-50g	100-200g	200ml	800ml
Scalp	50-100g	200-400g	200ml	800ml
Both arms or legs	100-200g	400-800g	200ml	800ml
Trunk	400g	1600g	500ml	2000ml
Groins & genitalia	15-25g	60-100g	100ml	400ml
These amounts are usually suitable for an adult for twice daily application. They may be useful as a starting point for prescribing but should be adjusted as necessary for the individual.				

Bath and shower emollients and soap substitutes

The use of bath and shower emollients is controversial and, until recently, evidence to inform practice was lacking.[3,20,21] It is generally accepted that soap is drying and potentially irritating to skin and is best avoided by those with dry skin conditions.[1-3] There is therefore clinical consensus that soap substitutes are necessary for people with dry skin conditions to wash with. However, there is less agreement about the benefits of emollient bath additives i.e. products comprising of oil or emulsifiers (or both) that are added to bath water with the intention of leaving a film of oil on the skin.[22]

The recently published BATHE study aimed to address some of the uncertainty regarding emollient bath additives (i.e. those that are poured into bath water). This pragmatic randomised controlled trial (n=483) in children with eczema (aged one to eleven years) found no evidence of a clinically meaningful benefit from emollient bath additives, when used in addition to standard eczema management.[22]

This study provides the first randomised controlled trial of emollient bath additives for children with eczema. Its findings indicate that efforts and resources should be targeted at effective use of leave-on emollients and soap substitutes in children with eczema, rather than the use of bath emollients. It seems reasonable to follow a similar approach in adults, considering the lack of evidence in this group.

Questions still remain about optimal regimens for soap substitutes.[22] Proprietary wash products (such as soap substitute shower gels) can be expensive, and evidence to justify their use over lower-cost alternatives is lacking. People with eczema should therefore be advised to wash with a regular leave-on emollient that is suitable for use as a soap substitute. A lower acquisition cost option should be chosen (see Charts 2 & 4).

People that prefer to use proprietary wash products as soap substitutes should be advised to purchase them over-the-counter. Prescribing may be considered if the person finds using a leave-on emollient for washing unacceptable and the clinician considers that the patient's ability to purchase their own bath and shower emollients is compromised as a consequence of medical, mental health or significant social vulnerability to the extent that their health and/or wellbeing could be adversely affected if reliant on purchasing these products themselves. Being exempt from paying a prescription charge does not automatically warrant an exception to the guidance.

Considerations

- Many standard emollients (creams and ointments) can be used as a soap substitute. Ointments that are completely immiscible with water (such as white soft paraffin alone) are not suitable.[23]

- Soap substitutes should be applied to the skin before or during bathing / showering / washing and then rinsed off.[14]
- Individual acceptability (and therefore adherence) is likely to be key in finding an effective product, so it may be preferable to offer a range of lower acquisition cost options.
- People that prefer to use a proprietary wash product as a soap substitute should be advised to purchase it over-the-counter, unless there are exceptional circumstances (see above).
- Bath emollients containing antimicrobials may have a role in decreasing bacterial load in those with recurrent eczema infection. Use should be short-term and the rationale discussed with the patient / carer.[1,3]
- Regardless of the type of product the person uses to wash with, it should not replace the regular use of a leave-on emollient. It is particularly important to apply the leave-on emollient after bathing / showering / washing, once the skin has been gently patted dry with a towel.[2,3]
- Warn people that extra care is required when emollients are used in the bath or shower as they make surfaces slippery.[2,16]

National cost savings (Based on NHSBSA ISP data August to October 2019)

In England and Wales, annual spend on emollients (including bath and shower emollients) is over £95.4 million. Review of emollient prescribing could lead to an annual cost saving across England and Wales of approximately £24.4 million. This equates to £39,327 per 100,000 patients. The savings could be achieved by:

- Prescribing gels, creams and ointments that cost less than £0.90 per 100g/100ml (for the largest pack size).
- Reducing the prescribing of lotions by 50% by recommending a lower acquisition cost gel/cream/ointment or self-care, where appropriate.
- Stopping prescribing emollients that are not in the BNF or Drug Tariff (excluding the small number of products that are borderline substances where ACBS recommendations apply).
- Stopping prescribing bath and shower emollients (without an antibacterial).
- Reducing the prescribing of bath and shower emollients (with an antibacterial) by 50%, by ensuring use is short term and targeted appropriately.

It is recognised that some of the savings for lotions and bath and shower emollients will be offset by increased use of alternatives.

Table 2. National annual cost savings per type of emollient (based on NHSBSA ISP data August to October 2019)

Emollient type	Total annual spend	Potential 12-month savings across England and Wales	Savings per 100,000 patients
Gels*	£8.4 million	£2.03 million	£3,281
Creams*	£38 million	£8.7 million	£14,009
Ointments*	£10.3 million	£1.5 million	£2,281
Lotions#	£1.3 million	£659k	£1,062
Not in BNF/Drug Tariff§	£3.3 million	£3.3 million	£5,344
Bath and shower emollients (without an antibacterial)§	£6.1 million	£6.1 million	£9,826
Bath and shower emollients (with an antibacterial)#	£4.2 million	£2.1 million	£3,384
Total		£24.4 million	£39,327

*Savings based on switching to products that cost less than £0.90 per 100g/100ml (on average 27% cheaper than other products)

#Savings based on 50% reduction in prescribing.

§Savings based on nil prescribing.

The national annual spend on bath and shower emollients (without an antimicrobial) is significant at over £6.1 million. Savings may be made by discontinuing prescribing of these products in favour of using lower acquisition cost regular emollients as soap substitutes. Further savings could be made by ensuring that the prescribing of bath and shower emollients containing antimicrobials is short-term and restricted.

The national annual spend on emollients containing urea is £9.8 million. These products are generally more costly and savings may be made by ensuring their use is targeted to specific situations, such as where skin is hyperkeratotic (thickened) or scaling, for ageing skin or where treatment with other emollients has failed.

For general first line emollient options there are many other products available at a lower acquisition cost.

In addition to the emollients listed in the BNF and Drug Tariff, preparations not listed in either are also being prescribed. The national annual spend on these products is over £3.3 million. These products are not classed as either medicines or appliances. They are classed as cosmetics and should not be prescribed.

The national annual spend on aerosol emollients (sprays and mousse) is £317k. These products are more costly. Sprays may have a role where no-touch application is preferred.

Summary

Informed, shared decision-making based on a range of emollients is thought to be key in encouraging adherence and optimising emollient treatment. The best use of resources can be achieved by having a range of lower acquisition cost emollients available and ensuring that products for more specialised use (such as those containing antimicrobials, urea or in spray formulations) are used appropriately.

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Appendix 1 – Sources of information for the public

Eczema

NHS Choices – Atopic eczema https://www.nhs.uk/conditions/atopic-eczema/

The National Eczema Society produces a number of factsheets, including one on emollients. Access via http://www.eczema.org/emollients

The Nottingham Support Group for Carers of Children with Eczema produces a number of information leaflets. Subjects include 'Skin moisturisers in atopic eczema' and 'Bathing and showering'. Access via http://www.nottinghameczema.org.uk/information/index.aspx#Treatments

The British Association of Dermatologists has a Patient Information Leaflet about Atopic eczema. Access via http://www.bad.org.uk/for-the-public/patient-information-leaflets

Psoriasis

NHS Choices – Psoriasis https://www.nhs.uk/conditions/psoriasis/

The Psoriasis and Psoriatic Arthritis Alliance have a number of resources, including one about 'Emollients and psoriasis'. Access via http://www.papaa.org/further-information/emollients-and-psoriasis

The British Association of Dermatologists has a Patient Information Leaflet about Psoriasis – topical treatments. Access via http://www.bad.org.uk/for-the-public/patient-information-leaflets

General

NHS Choices – Emollients https://www.nhs.uk/conditions/Emollients

Briefing	https://www.prescqipp.info/our-resources/bulletins/bulletin-239-emollients/
Implementation tools	
Data pack	https://pdata.uk/#/views/B239_Emollientsupdate/FrontPage?:iid=1

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