



British  
Association of  
Dermatologists

NHS England London,  
Skipton House,  
80 London Road,  
London, SE1 6LH

Tuesday 29<sup>th</sup> August 2017

NHS Clinical Commissioners,  
50 Broadway,  
London,  
SW1H 0DB

**Re: Items which should not routinely be prescribed in primary care: A Consultation on guidance for CCGs**

The British Association of Dermatologists (BAD) is a charity whose objectives are the practice, teaching, training and research of Dermatology.

We note that throughout the development of the policies and processes you have: *“Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.”*

The BAD fully accepts the need for economy and prudent spending when we have limited health care resources. However, the proposals in section 5 for future consideration in this document would result in undue suffering in vulnerable groups, increases in hospital admission rates and length of stays, and long-term increases in health service costs and inequality of healthcare.

In section 5 of the document there are a number of listed skin conditions that do not meet the criteria of minor, self-limiting or self-diagnosed. These include scabies, head lice, contact dermatitis, ringworm infection and athlete’s foot, and mild acne. Although OTC products are available, many of these conditions affect vulnerable patients who will not be able to afford treatment, or whose carers are not able to afford them, resulting in inequality of care. In contagious conditions patients may choose not to treat symptoms, due to cost, resulting in disease spread (e.g. head lice) or who are not symptomatic and are therefore not willing to pay for a treatment that is needed (e.g. scabies).

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Diseases such as scabies, lice, acne, eczema and fungal infections had profound impacts on the wellbeing of the poor in the 19th and 20th centuries before effective treatments were affordable and available.

Our specific concerns are as follows:

**(1) Scabies:** scabies outbreaks are common in residential homes for the elderly. In these outbreaks all residents, staff and their immediate contacts must be treated on the same day to contain the outbreak. In a nursing home with 50 residents and 30 staff each with an average of two close contacts, 240 people must be treated on the same day. The itch of scabies takes 6 weeks to begin after infection. Therefore, many infected people are unaware and are often reluctant to pay for treatment. In some people with suppressed immunity, due to illness or age, scabies may be non-itchy and individuals become covered in thousands of mites, forming crusts on the skin. These people are highly contagious and close contact on public transport would in time cause spread into the general community. Generalised scabies in the UK would particularly affect children, babies and individuals with compromised immune function, e.g. people living with HIV or organ transplants.

**(2) Lice:**

(2) Head Lice: failure to fund prescription treatment of head lice outbreaks in schools in deprived areas would result in public health problems in these schools. Chronic head lice infestation in deprived communities has been associated with secondary effects such as anaemia and developmental delay.

**(3) Mild acne:** there is evidence that treatment of mild acne prevents development of more severe scarring acne. Acne can have profound social and psychological effects, the severity of which is not necessarily related to the clinical severity of the condition. Even mild acne can be significantly disabling. Multiple studies have demonstrated the significant impact of acne and how it affects emotions, daily activities, social activities, study/work, and interpersonal relationships [Hazarika N, Archana M. The Psychosocial Impact of Acne Vulgaris. Indian J Dermatol. 2016, 61(5): 515–520.]. This excess psychosocial morbidity can be reduced by effective treatment [Tan J. Psychosocial Impact of Acne Vulgaris: Evaluating the Evidence. Skin Therapy Letter. 2004;9(7)]. Furthermore, acne is associated with a greater psychological burden than a variety of other disparate chronic disorders.

Failure to treat mild acne may lead to more severe acne, which is associated with severe depression and poor economic performance. Lower income families / individuals may not be willing or able to pay for OTC acne treatments.

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**(4) Contact dermatitis:** this is often treated with mild and moderate topical steroids together with emollients. Contact dermatitis often affects the face in adults or children. OTC topical steroids are not available for purchase to use on the face or in children. Treatment has to be under the direction of the doctor with appropriate referral to the local skin department for investigation of the contact dermatitis to identify the allergen and advice on avoidance.

**(5) Ringworm infections and athlete's foot:** these diseases are both fungal infections and treated with the same range of drugs. Scalp fungal infections in children could become epidemic in schools in less affluent parts of the UK, as is seen in some developing countries. Athlete's foot if untreated predisposes towards cellulitis, a severe bacterial infection of the leg, expensive to treat, which often then becomes a recurrent problem. Recurrent cellulitis results in lymphoedema of the leg which then leads to leg ulceration in the elderly and costs a vast amount of money to treat, with in-patient hospital stays and prolonged courses of antibiotics. Fungal infections are becoming more common as obesity and diabetes increase, particularly in the less affluent British population. Failure to treat the diseases of obesity would lead to longer term costs.

In Section 5 of the document there are examples listed of products used in treating the skin conditions listed. Included are antifungal creams, sunscreens, eczema creams and ointments. Our specific concerns relating to these being restricted to OTC are:

#### **(1) Sunscreens**

Sunscreens are especially important in the management of skin diseases caused by or exacerbated by exposure to daylight. These include severe allergies to sunlight and those with DNA repair disease who will die before the age of 20 without sun protection.

There is no doubt that skin cancer-prone genetic disorders such as xeroderma pigmentosum (XP) must have access to free sunscreens, as children with this devastating condition will go on to develop fatal skin cancer and die before their teenage years, unless they adopt strict photoprotection measures. Without sun protection, people with photosensitive diseases such as Gunther's disease, porphyria and lupus may develop extensive skin disease causing hospitalisation, requiring expensive drugs and may suffer permanent, disfiguring facial scarring. Similarly, there are severe "photo-allergies" such as chronic actinic dermatitis that make it impossible for the sufferers to venture outdoors without adequate photoprotection.



There are a small, but increasing number of patients on life-long immunosuppressive therapy to prevent rejection of an organ transplant, or who need long-term treatment with a photosensitizing drug such as azathioprine for suppression of severe inflammatory diseases such as ulcerative colitis or Crohn's disease. These drugs are essential for the welfare of these patients, yet their prolonged use is associated with multiple skin cancers bringing morbidity and mortality unless patients can adequately protect themselves from the sun (Harwood, C.A. et al. A surveillance model for skin cancer in organ transplant recipients: a 22-year prospective study in an ethnically diverse population. *Am J Transplant* 2013; 13, 119-29). It is essential to advocate use of appropriate sunscreens for these patients as their cancer risk is caused by prescribed drugs. Preventative use of sunscreen (on prescription) should save the NHS money as proven in population-based studies in Australia where skin cancer rates significantly reduced following monitored sunscreen use.

People with vitiligo have no protective pigment in the skin. These individuals also require sunscreen for exposed areas of skin to prevent burning and reduce skin cancer risk.

The BAD would be happy to work with you to identify those conditions for which sunscreens prevent disproportionate suffering.

## ***(2) Eczema creams and ointments***

### ***Emollients***

'Complete emollient therapy' is the mainstay of treatment for all patients with eczema as the most important part of their treatment. Emollients must be applied several times every day to help maintain skin barrier function. These form the basis of treatment and withholding these is likely to result in a large increase in hospital referrals, which the NHS would be unable to manage.

In addition, 1 in 5 children under five suffer with eczema. There is a significant negative impact on the psychological wellbeing and quality of life of parents of children with eczema. NICE guidance states that 250-500g of emollient per week should be used by a child under 12 years with atopic eczema. Withdrawing prescriptions for essential treatment, and the subsequent financial burden that this places on these families, is not acceptable. For some families, a choice will be made not to spend the £8-10 per week on emollient. This will result in a deterioration of eczema control in the community in one of our most vulnerable groups of patients.

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***Mild & moderate topical steroids***

These are available OTC only for short term use in adults (non-face) and not children. For chronic eczema, suitable treatment plans need to be discussed with the patient to ensure that the right amount and strength of steroid is applied. Small OTC tubes are not sufficient to control eczema, except in the mildest of cases. We assume that there is no consideration that all of these items should be removed from prescription. This would impact on the most vulnerable groups who may not be able to afford adequate treatment and will result in further suffering. Increased OTC steroid cream use will lead to increased inappropriate use in non-eczematous conditions, such as fungal infections and acne rosacea and overuse on sensitive areas such as the face and flexures.

We note that the exclusions in Section 4 of the document relate to specific drugs for specific indications. By contrast section 5 names diseases or treatments used to treat a wide range of diseases: the action is therefore too broad and will disadvantage some patients.

There are a number of treatments for skin diseases that can be prescribed, but have been identified by NICE as lacking evidence of effect in specific indications. We suggest that it would be better to start by considering such treatments. We would be happy to enter a dialogue with your team regarding this.

Yours sincerely,

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