Topical Corticosteroids

Herefordshire and Worcestershire Medicines and Prescribing Committee

NHS
Herefordshire and Worcestershire
Clinical Commissioning Group

Potency	Topical Corticosteroid Preparation	Comments
Mild	**Hydrocortisone** 1% cream or ointment 15g, 30g, 100g	Other strengths of hydrocortisone offer no additional benefit and are not cost effective choices.
Moderate	For small quantities: **Clobetasone Butyrate** 0.05% (Eumovate) cream or ointment 30g For larger quantities: **Betamethasone valerate** 0.025% RD (Betnovate RD) cream or ointment 100g (more cost effective than 100g clobetasone)	
Potent	**Betamethasone valerate** 0.1% cream or ointment 30g, 100g If alternative required: **Hydrocortisone butyrate** 0.1% (Locoid) cream and ointment 30g, 100g **Mometasone furoate** 0.1% cream and ointment 30g, 100g For scalp application: **Betamethasone valerate** 0.1% scalp application 100ml	Betamethasone cream and ointment is category M so should be prescribed generically.
Very potent	**Clobetasol propionate** 0.05% (Dermovate) cream and ointment 30g, 100g	

Potency and Formulation[1]

- The potency of topical corticosteroid is determined by the amount of vasoconstriction they produce and relates to the degree to which they inhibit inflammation and their potential to cause side effects.
- The potency should match the severity of the condition being treated and use should be intermittent wherever possible. See ***eczema guidance*** and ***psoriasis guidance*** for condition specific information.
- Ointments are generally chosen for dry lichenified or scaly lesions or where a more occlusive effect is required, which can increase penetration of the steroid. They do not contain preservatives so can be less prone to irritating the skin.
- Water miscible creams and lotions are suitable for moist or weeping lesions and some patients find them cosmetically more acceptable.
- The likelihood of adverse effects occurring is directly related to the potency and amount of topical corticosteroids used. Therefore the least amount of the least potent topical corticosteroid to control the condition should be used, and the person should be monitored if they are persistently using large quantities.

Quantities for prescribing and application[1,2]

Suitable quantities of corticosteroid preparations to prescribe for specific areas of the body being treated are listed in the table below:

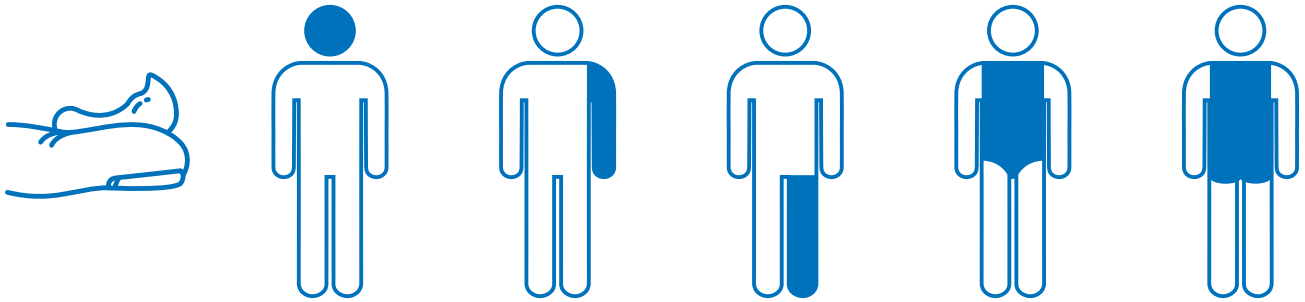
Area of body	Creams & Ointments
Face and neck	15g to 30g
Both hands	15g to 30g
Scalp	15g to 30g
Both arms	30g to 60g
Both legs	100g
Trunk	100g
Groins and genitalia	15g to 30g

The amounts specified are usually suitable for an **adult** for a **single daily application** for **2 weeks**.

Number of fingertip units (FTU) for application per body parts for children and adults:

ONE adult fingertip unit (FTU):

One adult fingertip unit (FTU) is the amount of ointment or cream expressed from a tube with a standard 5mm diameter nozzle, applied from the distal crease to the tip of the index finger.



Age	Face & neck	Arm & hand	Leg & foot	Trunk (front)	Trunk (back) inc. buttocks
Adult	2½	4	8	8	8 (trunk-back) 4 (buttocks)
Children:					
3-6 months	1	1	1½	1	1½
1-2 years	1½	1½	2	2	3
3-5 years	1½	2	3	3	3½
6-10 years	2	2½	4½	3½	5

Combined steroid and antimicrobial preparations[2,3,4]

- For clinically infected skin in line with local ***Primary Care Antimicrobial Guidance***:

  - Topical fusidic acid alone for very localised lesions only to reduce risk of resistance, NOT for repeated use
  - Oral flucloxacillin (or clarithromycin for penicillin allergic patients)

- The use of topical antibiotic and corticosteroid combination products are not routinely recommended.
- There is a lack of evidence from controlled trials to support the use of topical antibiotics to treat infected atopic eczema, with only one randomized controlled trial investigating this. Data from trials comparing the use of topical antibiotic and corticosteroid combination products have not shown the addition of an antibiotic component provides benefit beyond that of a corticosteroid alone and their regular use will increase the risk of antibiotic resistance.
- The use of topical antifungal preparations with corticosteroids is not recommended. NICE CKS[4] does not recommend these products because they are licensed to be used once or twice a day for a maximum of 7 days but topical antifungal treatment is usually required for a longer period. Prescribing a topical corticosteroid separately to the topical antifungal allows the corticosteroid to be used once or twice a day for the recommended maximum duration of 7 days, and the antifungal treatment to be continued for the recommended frequency and duration.

Advice to patients on appropriate use[1]

Explain about the potency of the topical steroid prescribed and ensure the person knows:

- How much to apply. Explain fingertip units, and advise the person to apply the topical corticosteroid sparingly to the affected area.
- Duration of use and the importance of not exceeding it.
- Frequency and site of application.
- How to apply it - including not to mix it with other topical products and applying it in the direction of hair growth when using on hair-bearing areas to help prevent folliculitis.

Download a patient information leaflet on topical corticosteroids is available from the British Association of Dermatologists.

- Adherence-related issues such as cosmetic acceptability and difficulties with administration should be considered and discussed at review, particularly where response to treatment is not as expected.
- Advise patients to continue using their emollient whilst using a topical corticosteroid and ensure that they are using it optimally. The best order of application has not been determined, but some recommend applying the emollient first. Emphasise the need for a gap between applications (e.g. 30 minutes) to avoid dilution of the corticosteroid.
- The CKS on topical corticosteroids recommends patients carry a steroid treatment card if they are receiving long term treatment (several weeks) with a potent or very potent topical corticosteroid. CKS consider this good practice on the basis that most topical corticosteroids may, under certain circumstances, be absorbed in sufficient amounts to cause systemic adverse effects.

References

1. PrescQIPP Bulletin. Topical corticosteroids. November 2015. Accessed at: *https://www.prescqipp.info/newsfeed/bulletin-116-topical-corticosteroids-now-available-to-all-prescqipp-users*
2. NICE CKS. Corticosteroids - topical (skin), nose, and eyes. November 2018. Accessed at: *https://cks.nice.org.uk/corticosteroids-topical-skin-nose-and-eyes#!scenario*
3. NICE Clinical Guideline 57: Atopic eczema in under 12s: diagnosis and management. December 2007. Accessed at: *https://www.nice.org.uk/guidance/cg57*
4. NICE CKS. Fungal skin infections – body and groin. May 2018. Accessed at *https://cks.nice.org.uk/fungal-skin-infection-body-and-groin#!scenario*

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