RASH TALK®

The Topical Dermatology Magazine

Issue 02 / Autumn 2024

Back with a Bang

What a landing! When Rash Talk® magazine returned earlier this year, we were flooded with fond memories shared by seasoned healthcare professionals who enjoyed reading the publication in the late 1980s!

Derma UK

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As we release issue two, we're delighted to hear that today's audience are enjoying Rash Talk® magazine's fresh, collaborative, and conversational style, alongside its quick and convenient digital content too.

As ever, Rash Talk® remains dedicated to covering the dermatology topics that you most want to hear about. We've been thrilled to receive numerous reader questions and clinical writing requests from healthcare professionals, who are keen to discuss topical issues, or share their clinical successes for the benefit of all fellow dermatology colleagues and patients alike.

You might be particularly interested to know that Dr Stephen Hayes – our expert dermoscopy writer – is indeed one of the original readers of Rash Talk® magazine from when it first launched in the 1980s.

Seemingly, talking skin is timeless!

Your Questions

Answered by Dr Angelika Razzaque, GP
Associate Specialist in Dermatology

Q: What is the recommended cause and treatment of perioral dermatitis? This is such an uncomfortable and challenging skin condition.

The exact cause of perioral dermatitis is not known. Topical steroids play a role even indirectly and should be stopped if directly applied to the face, and hands should be washed thoroughly after application to other body parts. Treatment can be with topical antibiotics or oral antibiotics for up to six weeks, depending on severity. This may need repeating should it reoccur.

Q: What is the best emollient?

Research in the usage of emollients in eczema so far has not identified a 'best emollient.' The general consensus is that the one the patient likes is the best, as it is most likely to be used – which is why sampling is key. Different formulations have different advantages e.g. lotions are better in hair bearing areas or flexures, whilst ointments generally last longer on the skin, improving skin barrier function. Certain additions to emollients, such as humectants for example, can increase hydrating and lasting effects. It is also important to prescribe enough quantity of emollient: 500g per week for an adult and 250-500g per week for a child.

Got a question or topic you'd like us to address?

Email **rashtalk@dermauk.co.uk**

Rupert Reflects

By Dr Rupert Mason
Rash Talk® founder

Penetrating the fog

One of the joys of dermatology has always been its visibility. The patient's problem is usually staring you in the face and the trick is to recognise it. The excellent article by Dr Stephen Hayes in this issue describes how this clarity is further enhanced by relatively recent diagnostic developments such as dermoscopy and algorithms.

By contrast, there are other realms of healthcare where the prospects for algorithmic analysis are obscured by the fog of 'illness behaviour'; a term I first encountered in a short article in the *British Medical Journal* (by Dr Kevin Barraclough, a GP in Gloucestershire.[1] Written in 2006, it described a scenario familiar to all GPs: a full surgery peopled by several patients suffering multiple symptoms, each potentially associated with an algorithm or guideline, that probably signify self-limiting rather than significant disease. The conundrum is to sort out the benign from the sinister, and back then, in those less litigious days, it was almost a badge of honour to do so at minimal cost to the NHS. Dr Barraclough explains that his decision to investigate or refer was heavily influenced by knowledge of prior "illness behaviour".

Through the years of caring for his patients, he had developed a deep and intimate knowledge of their individual tendencies to minimise or catastrophise symptoms and events. This resulted in an almost instinctive feeling about the relative severity of the presenting problem.

Re-reading this article today I am reminded of the strengths of the traditional relationship between the family doctor and a patient. Eighteen years ago, Dr Barraclough concluded his musings with chilling prescience. "It will be difficult", he wrote, "to include illness behaviour in any algorithm, or indeed, explain your inaction under scrutiny if a patient turns out to have serious disease. Yet if such considerations are lost in future, if a patient is always assessed by a new doctor without knowledge of prior health seeking behaviour, I am worried that the NHS will collapse under the weight of undiluted algorithmic investigation."

1. Brit Med J 2006;333; 709

"One of the joys of dermatology has always been its visibility."

How to Manage a Symptomatic Scalp

A Sebco™ scalp treatment review

By Dr Angelika Razzaque – GP, Associate Specialist in Dermatology

Our scalp is unlike the rest of our skin: it has a high follicular density and a high rate of sebum production. The relatively dark and warm environment provides ideal conditions for fungal and parasitic infections. The scalp is not spared from inflammatory conditions either. Visible flaking has a negative impact on patients' quality of life. A correct clinical diagnosis is important, especially since many of the common scalp conditions have similar symptoms and features. This article concentrates on the scaly scalp conditions: dandruff, seborrhoeic dermatitis, tinea capitis and psoriasis, and provides a common management approach.

Characteristics of conditions

All four conditions have scale in common to varying degrees:

- **In dandruff: scale is more white or grey**
- **In seborrhoeic dermatitis: scale is yellowish and greasy**
- **In tinea capitis: scale is white and dense**
- **In psoriasis: scale is silver-grey and often thicker**

Pruritus may also feature in all of the conditions, although it is variable in its degree and may be only mild in dandruff, tinea capitis and psoriasis. Distinguishing characteristics are presence of inflammation, alopecia and malassezia. Whilst there is no inflammation in dandruff, seborrhoeic dermatitis and psoriasis are characterised by this clinical sign and it can also be observed in tinea capitis e.g. in kerions. Alopecia is a possible consequence in tinea capitis and psoriasis only. The organism malassezia has been implicated with dandruff and seborrhoeic dermatitis but less so with psoriasis. In tinea capitis, microsporum and trichophyton species are the causative organisms.

Recommended treatment routes

Taking mycology samples for analysis is paramount for the identification of organisms and the targeting of treatment, as this plays a role in the management of tinea capitis. Dandruff, seborrhoeic dermatitis and psoriasis benefit from a combination of treatments: keratolytic, antiproliferative and antimicrobial agents.

In milder conditions, shampooing and using a keratolytic (e.g. salicylic acid) may be sufficient treatment. Some shampoos contain an antifungal (e.g. ketoconazole) which can improve flaking. Antiproliferatives, e.g. coal tar, reduce epidermal proliferation and dermal infiltrates. Topical steroids as adjunctive treatment may be helpful in patients with an inflammatory component.

Treatments need to be convenient and cosmetically acceptable. Combination treatments increase adherence. For the management of dandruff, seborrhoeic dermatitis and psoriasis, a combination of coal tar solution, salicylic acid and sulphur in an ointment formulation, such as Sebco™ scalp treatment, is a valuable option. Treatment with a combination product softens and removes scale, while also acting as an antiproliferative.

> ***"Combination treatments containing a coal tar solution, salicylic acid and sulphur in an ointment formulation soften and remove scale while also acting as an antiproliferative."***

Partnering pomades and scalp steroids

Combination treatments are convenient and increase patient adherence as various treatment steps are accomplished with one application.

Applying a combination product, e.g. Sebco™, first to soften and remove scale, before applying a topical steroid as an active anti-inflammatory component, enhances the action and overall treatment outcome.

This is important as patients are not just concerned about the scale and its associated shedding, but also the itch. This can be particularly disturbing at nighttime, and together with the shedding of scale leads to further embarrassment for the patient.

> ***"Applying a combination product, such as Sebco™, containing coal tar solution, salicylic acid and sulphur to first soften and remove scale, before applying a topical steroid as an active anti-inflammatory component, enhances the action and overall treatment outcome."***

Watch Sebco™ Application Video

Sebco™ application advice

It is important to advise patients on the application frequency and how to apply it. This also means advising on using the applicator on the tube.

- Usually, the hair is parted over the area of scale and the Sebco™ treatment applied along the affected area in a thin ribbon and gently massaged in.
- Contact with eyes should be avoided and hands washed afterwards.
- The treatment is left in place for one hour.
- Before washing out with warm water and shampoo, loosen the scale with fingers and comb out.
- This should be repeated daily depending on the degree of scale for up to seven days until it is under control.
- For maintenance, the Sebco™ combination treatment should be repeated as soon as signs of scale build up becomes apparent.
- The shampoo can be a medicated one or a mild shampoo of the patient's choice. Often, patients have trialled various products and settled on one that suits their needs.
- In skin of colour, the scalp is usually already very dry and frequent shampooing is not advisable as it further dries the scalp.
- For active treatment the same principles apply, however, for maintenance, a once weekly shampoo may be sufficient.

> ***"For maintenance, the Sebco™ combination treatment should be repeated as soon as signs of scale build up become apparent."***

Some patients find it difficult to tolerate the combination treatment for longer periods of time and treatment outcome might be compromised. Under these circumstances, any ointment can be applied to the affected areas in the same way and left for a few hours or overnight under a shower cap to soften scale. The combination treatment can still be used for up to one hour afterwards to benefit from the additional antiproliferative and anti-inflammatory effects.

Visit Sebco.info for prescribing information

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1. R. Grimalt. A Practical Guide to Scalp Disorders. Journal of Investigative Dermatology Symposium Proceedings (2007) 12, 10-14
2. Seborrhoeic eczema (pcds.org.uk)
3. Psoriasis: scalp psoriasis (pcds.org.uk)
4. Sebco™ - Scalp Ointment for Eczema, Dermatitis & Psoriasis (dermauk.co.uk)

Dermoscopy: What is it and Why Does it Matter?

By Dr. Stephen Hayes – Executive board member, International Dermoscopy Society, independent educator, and retired Associate Specialist in Dermatology

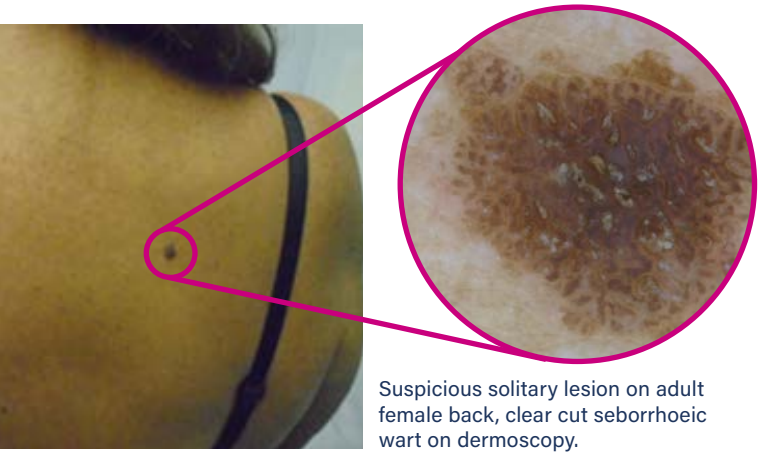
A dermoscope is a hand held microscope for skin lesions. It enables the user to see features invisible to the unaided eye and diagnose more accurately. Some training is required, but studies have shown that just one day makes a big difference.

We already use various scopes – stethoscope, auriscope etc – the dermoscope is just newer. Its arrival around 25 years ago was timely in view of the skin cancer epidemic. Melanoma now kills more people annually than road traffic accidents, cancer of the cervix and meningitis together.

Dermoscopy – an invaluable triage tool

Most skin lesions presented to GPs by worried patients are benign, but GPs get little training in skin lesion recognition and worry about missing a melanoma, so may over-refer. Working in a rapid access skin cancer clinic, I saw thousands of patients needlessly referred with seborrhoeic keratoses, innocent naevi, solar lentigines, dermatofibromas and subungual bleeds – all of which can be proven harmless in seconds with dermoscopy.

This matters. Patients with awful rashes often wait five months or more to be seen while dermatologists are busy seeing warts on the urgent cancer pathway. When referrals surge each summer, operating lists and general dermatology clinics are sometimes cancelled to free up staff and clinic space to prevent 'target breaches' for which managers can get busted! How can we avoid this misuse of resources?



Suspicious solitary lesion on adult female back, clear cut seborrhoeic wart on dermoscopy.

The stethoscope of the skin

First, we study the natural history and appearance of common and important lesions, then take a history, inspect and palpate, then apply the scope and formulate a diagnostic hypothesis. Most skin lesions will be one of the following five benign histological types. I will briefly discuss the key dermoscopic features of each:

Naevus: good overall symmetry, reticular network, even fade out at border, even featureless pattern, even globular pattern, 'fried egg' pattern (raised in centre, flat at periphery), absent melanoma clues (see below).

Keratosis: surface keratin, comedo like openings, milia like cysts, crypts and fissures, short looped vessels in halos (frogspawn sign), fingerprint or cerebriform pattern, abrupt border.

Haemangioma: clods of blood colour (red, blue, mauve or black if thrombosed) in an off-white matrix.

Dermatofibroma: irregular white scar-like centre, peripheral pigmentation made up of fine brown circles.

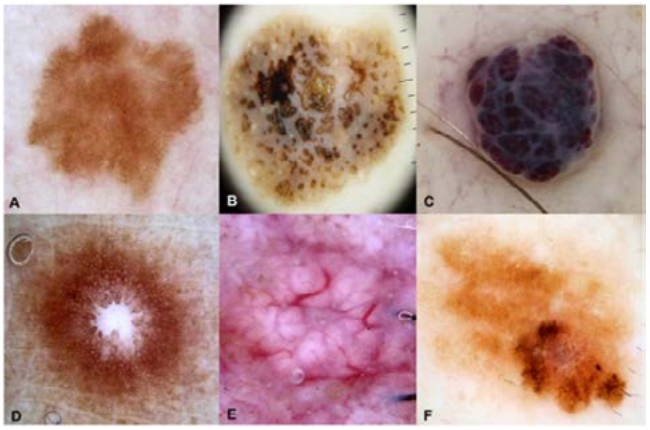
Sebaceous gland hyperplasia: crown-like vessels and white clods around a central pore.

Of course there is variation, and you won't see all features in every example. The learner needs to study many images to become familiar with the full range of presentations.

Most skin malignancies are **basal cell cancers** (BCCs). These are seldom lethal but can cause significant

morbidity and surgical costs, especially on the face, and are worth detecting earlier. They generally present as an asymptomatic pink patch or papule, which eventually starts to scab, and are most common in paler skin types and older patients. Dermoscopic features include a pink, or pink and white background, blue or blue/grey clods, shiny white clods and strands, and focused vessels. Multiple micro-erosions are seen in superficial BCCs, also peripheral radial lines and dark brown or grey clods within lighter clods.

Squamous cell cancers (SCCs) usually present as a 1cm plus new growing nodule on chronically sun damaged skin. Most occur in older white patients, and bald scalps are a typical site (go bald, get a hat!) and may be keratinised or ulcerated. White circles and radial looped or bizarre vessel patterns may be seen on dermoscopy, but diagnosis is mainly down to history and inspection.



Dermoscopy of naevus, keratosis, haemangioma, dermatofibroma, sebaceous gland hyperplasia and melanoma. Slide courtesy of Professor Cliff Rosendahl.

The dermoscopy of **melanomas** is fascinating and variable. Forget about the 'textbook' big, black, bleeding lump which has probably already metastasised. With dermoscopy, we can pick up melanomas at a much earlier – and curable – stage, as I saw on a sabbatical in Australia with skin cancer diagnostics researcher and teacher **Professor Cliff Rosendahl**. Cliff, with colleague **Professor Harald Kittler** of the University of Vienna, designed a new, effective and teachable modern algorithm 'Pattern Analysis' which is often called 'Chaos and Clues'.

Chaos and Clues – the master algorithm

Visualising the dermoscopic features is one thing, naming and interpreting them is another. A method has to be learned and used. The 'Chaos and Clues' approach is logical, easy to teach and works well. Essentially, if a flat, non-ulcerated skin lesion has an orderly arrangement of colours and structures on dermoscopy, it is OK, all the more so if there are diagnostic features of a specific benign lesion type.

If it is chaotic (poor symmetry, multiple structures, multiple colours) then we look for clues. Melanoma clues include thickened network, irregular dots and clods, segmental radial lines, shiny white lines, eccentric blotches, blue-white areas, angulated lines and polygons and a few others. Lots of new words, but with a good book, a course or two and engagement with the abundant free online resources that are available, it all becomes clear.

It has been the advice of the Primary Care Dermatology Society for some years that each GP surgery should have at least one team member who has intermediate level dermoscopy skills to triage patients before referring on the overcrowded urgent skin cancer pathway. This should, at the least, help control the growth in avoidable referrals on the urgent skin cancer pathway, which will benefit patients waiting to be seen for acne, psoriasis, eczema and other rashes, many of which cause more morbidity and reduced quality of life than most skin cancers.

Dermoscopy has come of age and is here to stay.

Dr Stephen Hayes
Retired Associate Specialist in Dermatology
Independent educator
Executive board member, International Dermoscopy Society

Dermoscopy learning resources

Primary Care Dermatology Society
www.pcds.org.uk provides a range of courses from beginner level to international masterclass, plus free tutorials and atlas

International Dermoscopy Society
www.dermoscopy-ids.org offers free membership, a Facebook page, Dermoscopedia, conferences, YouTube videos, and a free online journal (*Dermatology Practical and Conceptual*)

Dermnetnz.org The best general dermatology site is loaded with dermoscopy education

Dr Stephen Hayes blogs about skin cancer diagnostics at www.dermoscopy.wordpress.com, with case discussions, commentary and links to other resources.

© Dr Stephen Hayes, 24th June 2024

SLS – A Reminder of the Detrimental Effects of SLS-Containing Emollients on the Skin Barrier

By Julie Van Onselen – Dermatology Lecturer Practitioner and Dermatology Clinical Nurse Specialist

'Don't use soap.' 'Don't have bubble baths.' 'Don't use foaming wash products!' This is general patient advice for any patient with dry skin or an inflammatory skin condition. But why is this advice so important for skin care?

Soap and bubble bath contain surfactants, labelled on the product as sodium lauryl sulfate (SLS) or sodium laureth sulphate (SLES). SLS is contained in many personal care and cleaning products. Its purpose is to combine product qualities to make a formulation; for example, water and oil in a cleansing product will only mix when bonded, and the action of molecules blending causes foaming which dissolves dirt and grease for skin cleansing. In general, any skin care product that foams or bubbles is likely to contain SLS, and this includes some leave-on emollients, such as aqueous cream.

> ***"Up to 56% of patients prescribed an SLS-containing cream developed and immediate cutaneous reaction within 20 minutes of application, with symptoms of burning, stinging, itching and inflammation, which did not occur with other non-SLS emollients prescribed."***

People with dry and inflammatory skin conditions should avoid products that contain SLS. This evidence was first documented in 2003, in an audit at Sheffield Children's Hospital, where out of 100 children with atopic eczema, 71 were prescribed aqueous cream containing SLS, and up to 56% developed an immediate cutaneous reaction within 20 minutes of application, with symptoms of burning, stinging, itching and inflammation, which did not occur with other non-SLS emollients prescribed.[1] The conclusion from this study was that aqueous cream with SLS should not be used as a leave-on emollient for children with eczema, and this was endorsed by the MHRA.[2] However, aqueous cream continued to be prescribed in large amounts and from 2004 to 2008, emollient prescribing increased by 38% with aqueous cream the most prescribed treatment. In 2023-24, aqueous cream was still being prescribed by ICBs in NHS England and accounted for £528,240 of prescribing budget, which shows that prescribing of aqueous cream is widespread.[3]

In 2010, a study looked at the physical effects of SLS on the skin barrier of healthy volunteers, with no history of eczema. This study compared the forearms of volunteers, where aqueous cream (containing 1% SLS) was applied to one forearm, and no products to the corresponding forearm. This study proved the detrimental effect of SLS on a healthy skin barrier, as skin where aqueous cream containing SLS had been applied showed a decrease in stratum corneum thickness and increases in trans-epidermal water loss (TEWL).[4] This study was repeated in 2011 in people with atopic eczema, and application of aqueous cream (containing 1% SLS), showed elevation of TEWL and a decrease in stratum corneum integrity.[5] A further study investigated

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change in corneocytes maturity and protease activity in healthy volunteers, which gave evidence that aqueous cream containing SLS was associated with inflammatory activity.[6]

The role of the epidermal skin barrier in atopic eczema has been widely researched. Atopic eczema is an immunological disease which arises as a result of gene-environment interaction.[7] There is an elevation of stratum corneum proteases due to FLG-mutation, which increase TEWL and elevates skin pH, resulting in skin barrier disruption and breakdown, allowing allergy penetration and resulting in dry and inflammatory skin.[7]

"Menthol is a helpful ingredient for pruritus when added to a non-SLS containing emollient."

It is worth noting that today, many aqueous cream emollients are SLS-free. First-line therapy for atopic eczema and dry skin conditions is the intensive use of emollients, which includes replacing all soaps and avoiding harsh surfactant-based wash products. The evidence is clear on the detrimental effects of SLS: any emollient containing SLS used as a leave-on emollient and for washing will exacerbate skin barrier damage and not restore the skin barrier.

A key action of all emollients is skin barrier restoration. This advice is contained within dermatology professional guidance, including NICE, BAD, BDNG and PCDS. A current concern in emollient prescribing and formulary guidance is that it is often price rather than formulation driven. Today, there are many generic and low-priced aqueous cream emollients, alongside higher quality emollients, as well as aqueous cream with added menthol – many of which are SLS-free. It is important that healthcare professionals are aware that SLS is harmful for people with inflammatory skin conditions and older people without eczema, but with dry skin and vulnerable skin barriers. Menthol is a helpful ingredient for pruritus when added to a non-SLS containing emollient. In conclusion, all emollients containing SLS should not be prescribed or advised for any dermatology patient in any healthcare setting.

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Dermatology Question Time®

Back again by popular demand, the Rash Talk® – Dermatology Question Time® webinar saw a panel of five dermatology and medical experts answer your most-asked skin-related questions. Enjoy a few highlights below.

Chair – Rebecca Penzer-Hick
Dermatology Specialist Nurse and Senior Lecturer

Rod Tucker
Pharmacist with a Special Interest in Dermatology

To watch the full webinar visit rashtalk.co.uk.

Q: What is a rash?

A: Dr James Britton begins, "In a sentence – a rash is not a lesion. Dermatology is divided into tumors, usually the big three – melanoma, squamous cell carcinoma, and basal cell carcinoma – and then there's the rarer adnexal tumors. A rash is anything that isn't one of those. Then you're into pattern recognition of a rash. So, the big ones, eczema and psoriasis, all the different types of eczema, acne, and to a degree lichen planus granuloma annulare, and then after that you are into everything that's rare. Then there's the connective tissue diseases. With rashes, it's all about pattern recognition, the history, the speed of onset, and where it is; you just have to see a lot of rashes…and step back from the patient and think, what is the pattern and what is the differential that this could be."

Dr Angelika Razzaque adds, "It might also be helpful to a look at the PCDS website – Tim [Cunliffe] has developed an eruption pattern recognition tool… which may come up with a few diagnoses and then you might match that up with what you're seeing in front of you."

Q: What would you advise for treating an itchy rash?

A: Rod Tucker advises, "If the rash is itchy, a lot of pharmacists will reach for topical antihistamines, oral antihistamines, calamine lotion – and one thing I've used a lot is crotamiton cream."

Fiona Elliott adds, "Another thing that we tend to use is menthol-based products which really help somebody who is itchy."

Q: What are the best ways to encourage patients to use emollients – particularly people who don't like applying them?

A: Rod says, "Often patients don't understand their treatments, and don't use their emollient as they didn't think it worked – versus if they have itchy skin and they would put some topical steroid on, and it all went away. So, one of the ways is to conceptualise a rationale for why it is important to use emollients all

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Recommended Reads

Helpful resources for healthcare professionals and patients

PCDS Dermatology Diagnostic Tool
https://www.pcds.org.uk/general-dermatology-table#general-dermatology-diagnostic-table

National Eczema Society – Topical Steroid Withdrawal
https://eczema.org/information-and-advice/topical-steroid-withdrawal-tsw/

Dermoscopy Learning Resources
See page 6 for Dr Stephen Hayes' educational aids

Scalp Treatment Application Video and Resources
https://dermauk.co.uk/professional-product/sebco/

BDNG Menthoderm® Product Review
https://dermauk.co.uk/wp-content/uploads/2024/03/MEN2390224-Menthoderm-BDNG-Review-1.pdf

BDNG Betesil 2.250mg Medicated Plaster® Product Review
https://dermauk.co.uk/wp-content/uploads/2024/07/Betesil®-Medicated-Plaster-A-case-study-BDNG-Product-Review.pdf

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Fiona Elliott
Dermatology Nurse Consultant

Dr James Britton
Consultant Dermatologist

Dr Angelika Razzaque
GP, Associate Specialist in Dermatology

the time. I say, your skin is like a brick wall, and for whatever reason you're producing a defective wall, so it's effectively leaking, and your skin starts to dry out, things get in, and that makes it even more itchy. You're not ever going to produce an effective barrier. So, think about the emollient as repairing that wall, and if you do that, you won't need to reach for the topical steroids as much."

Fiona adds, "Emollient starter packs are very useful as patients can find one that they like, because if they find one they like, we all know that they're going to use it."

Rod agrees, "The most expensive treatment is the one that somebody doesn't use."

Q: There's been a lot in the press about topical steroid withdrawal – how do you manage topical steroids with patients and ensure they are used correctly?

A: Fiona says, "We've used topical steroids for over 70 years, and the benefits outweigh the risks for patients. Topical steroid withdrawal – also called TSW, red skin syndrome, or topical steroid addition – where they had stopped the steroids suddenly and had a re-bound, and it came back in areas where they never had eczema before. It might look darker, redder, they'll feel unwell and shivery. It is important that we say to patients that when we do use a six-week course of steroids you must complete the whole course or you'll get rebound. With topical steroids you need to wean off slowly – you can't just stop potent or very potent steroids."

Q: What hints and tips do you have for managing scalp psoriasis?

A: Angelika advises, "In terms of treatment, there are different degrees of severity of scalp psoriasis. Some may do well with topical treatments like Enstilar or Venusia cream, but for those that have very thick scale where you're struggling getting the active treatment to the underlying pathology, you probably need combination treatments to break down the scale before you actively treat it. Some may do very well with a simple greasy ointment applied for a few hours or even overnight, but some may need something a bit more medicated like Sebco™ ointment that has got coal tar, sulphur and salicylic acid, that offers various treatment approaches, and is applied, left for one hour, the scale loosens, is combed, and washed out, and then you can start using your active treatment."

Q: How does skin disease present in people who have darker skin tones?

A: James answers, "All the diagnoses are the same, except the big difference is, depending on the skin tone, that the erythema isn't the same. You've still got the same edge and pattern to it. The difficulty is that following on from the inflammation, you're either left with hypopigmentation, or significant hyperpigmentation, and that's the big thing to manage... You have to reassure and be patient that the pigment change will settle down, and be quite specific with the time."

Fiona adds, "The erythema is sort of a grey/purplish colour in some patients, and one things to note is that NICE will tell you that if you have a patient with skin of colour, you have to add an extra point to your PASI/EASI score."

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*NICE recommend a topical treatment containing salicylic acid and oils as a second line treatment for patients with scalp psoriasis[1]

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Abbreviated Prescribing Information for Sebco™
Please refer to the full Summary of Product Characteristics (SmPC) prior to prescribing.
Presentation: Ointment containing coal tar solution 12%, salicylic acid 2%, sulfur for external use 4%. **Uses:** Treatment of common scaly scalp disorders such as psoriasis, eczema, seborrheic dermatitis and dandruff. **Dosage:** Gently rub into scalp, leave in contact for approximately one hour. Wash out using warm water and mild shampoo. For severe scalp conditions, use daily for 3-7 days until improvement is obtained then intermittently as necessary. For less severe conditions such as dandruff use intermittently as necessary, e.g., once a week. If symptoms persist after 4 weeks consult your doctor. For children 6-12 years use under medical supervision only. Not recommended for use on children under six years. **Contraindications:** Skin infections of the scalp or known sensitivity to any of the ingredients. Use in Pregnancy and Lactation: To be used at the discretion of the prescribing doctor. **Warnings and Precautions:** Instruct patients not to smoke or go near naked flames - risk of severe burns. Fabric (clothing, bedding, dressings etc) that has been in contact with this product burns more easily and is a serious fire hazard. Washing clothing and bedding may reduce product build-up but not totally remove it. Avoid contact with eyes, and any areas of broken skin. Coal tar may stain clothes and jewellery. Remove or protect these items during treatment. Side Effects: May cause skin irritation, folliculitis and rarely photosensitivity. In the event of such a reaction, discontinue use. Prescribers should consult the Summary of Product Characteristics in relation to other side effects.

Pharmaceutical Precautions: Store below 25°C. Do not refrigerate. Replace the cap after use and return tube to carton. Discard tube no later than 4 weeks after opening. **Package Quantities:** 100g tube, 40g tube. **Basic NHS Price:** 40g £10.41, 100g £15.88. **Legal Category:** GSL. **Marketing Authorisation Number:** PL 19876/0001. Full prescribing information is available on request. **Marketing Authorisation Holder:** Derma UK Ltd, The Toffee Factory, Lower Steenbergs Yard, Ouseburn, Newcastle upon Tyne NE1 2DF, UK. "Sebco" and "Derma UK" are registered Trade Marks. **Date of Revision of Text:** January 2024.

Adverse events should be reported. Information about adverse event reporting can be found at www.mhra.gov.uk/yellowcard. Adverse events should also be reported to Derma UK Ltd, UK on 0191 375 9020.

References: 1. National Institute for Health and Care Excellence, Psoriasis, https://bnf.nice.org.uk/treatment-summaries/psoriasis/, last accessed 4th July 2024

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Derma UK

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