RASH TALK®

The Topical Dermatology Magazine

Spring 2024

We're Back – Bigger and Better!

The year was 1987, the Bangles were top of the charts, and the ever-humorous Rash Talk® dermatology magazine began to land on the desks of many healthcare professionals, nationwide.

Do you remember Rash Talk®?

Originally founded by Dr Rupert Mason, Rash Talk® was packed full of topical issues both in and out of the clinic (accompanied with a sizeable dose of satire). It quickly became a much-loved publication of its time, and successfully ran until the late 2000s.

The baton of ownership has now been proudly passed to Derma UK, who have relaunched today's Rash Talk® as a modern, ongoing discussion programme, both on and off the page. It sees dermatology and medical experts 'talk rash' about everything skin related – sharing best practice, invaluable expertise, and success stories, whilst answering questions on the topics that healthcare professionals want to hear about most.

Dermatology and beyond

In addition to 'in-clinic' matters, the team behind Rash Talk® is passionate about encouraging lively discussion around wellbeing, lifestyle, and technological impacts beyond core dermatology – with a sharp eye on new developments and the future of dermatology.

Press play

As you peruse this re-launch edition of Rash Talk®, please make use of the QR codes which link to recorded, topical discussions and more helpful resources. This includes:

- The launch podcasts held live at the BDNG annual conference
- Rash Talk® Dermatology Question Time® webinar
- Top Tips to Combat Itch
- Potent Steroids: Under Occlusion vs Cream
- An interview with Dr Rupert Mason - Rash Talk's® original founder.

Regular chat

Expect regular 'Rash Talking' in each edition from our founder Dr Rupert Mason, bringing you his thoughts and advice on various topics via his very own 'Rupert Reflects' column, alongside a 'Recommended Reads' section, which provides further information and useful resources available for download.

Join the discussion!

Derma UK is committed to supporting the practice and development of dermatology and is proud to lead the Rash Talk® discussion. At the heart of it all are the topics that you'd most like to hear about, so do let us know if there's something you'd like us to cover; you can reach us at rashtalk@dermauk.co.uk.

We hope you enjoy this first, re-launch edition, and don't forget to subscribe to be the first to hear about the next Rash Talk® discussion events, get early access to resources, submit questions, gain CPD hours and more!

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Date of preparation: January 2024

Meet the Founder

BDNG Editor Rob Mair interviews the Original Rash Talk® Founder, Dr Rupert Mason

"It's very exciting to see Rash Talk® *return. I'm delighted to be a part of it, and I'm happy to help in any way I can."*

The original Rash Talk® launched in 1987, casting a wry and humorous eye over the world of dermatology. The magazine aimed to provide a light-hearted read for dermatologists, with as much emphasis on the staff room as the clinic.

It certainly struck a chord with the audience, running for 25 years. Fondly-remembered, often irreverent but always compelling – those are the traits the new Rash Talk® will be hoping to emulate, whether that's in podcast, webinar or print form. Here, Dr Rupert Mason talks through its history.

When Rash Talk® was initially launched, it was designed to be light-hearted and used for promotion and marketing – but for it to run for 25 years, there must have been more to it to make it so successful?

I'd love to say that it was all carefully planned, but really, it was a way of getting our name out there. I'd written a lot in the past, so I came up with some ideas – which quickly snowballed – and we went to print. We suddenly had lots of little columns.

We used to have a spoof question and answer on the back page, which was reasonably controversial. I used to do interviews with prominent dermatologists – the occasional professor at Cambridge or Oxford – and not delve too much in into their CVs, but into their domestic life and why they went into dermatology. It was human-interest led, and I think it was popular because there was nothing like it.

The human-interest side is important, and I think that's reflected in our approach in *Dermatological Nursing*, especially in the BDNG Meets and wellbeing columns. So that's really an indication of the legacy.

And that's really flattering. We certainly enjoyed it! It's nice to think that there's a bit of a legacy there.

As largely a one-man band, was it a stressful project?

Writing to a deadline and facing blank pages when the next edition is coming up – that was stressful. But you get in the habit of it. You're constantly thinking of material. Everything I read that was vaguely medical, I would make a mental note of. And there was always the possibility of rehashing past articles or ideas. Everyone has their favourite themes, or something you enjoy having a little moan about.

What were some of your favourite themes and moans?

It's not so much a favourite theme, but in terms of rehashing stuff, early in my career, I submitted a story to the GP journal *Pulse* for their writer of the year competition, and it's the only thing I ever won. The story was purely fictional; it was about a patient, and I was the doctor, and I'd given the male patient female hormones for some nonsense reason – hay fever or something. So, the patient would take them and found that he lost his libido. And of course, I was having an affair with his wife. It was of its time – it's not the sort of thing I think we'd see in Rash Talk® now – but I'd rehashed and retold the story a few times.

Publishing has changed a lot, so where do you see Rash Talk® fitting in terms of today's world?

It is very exciting to see Rash Talk® return. I'm delighted to be a part of it, and I'm happy to help in any way I can. It's a whole new era when you think of podcasts and webinars. It means things can be entertaining and informative, and you can do things now that just wouldn't have been possible 25 years ago.

PODCAST 1

The Practice of Dermatology:

Can dermatology appointments be held remotely or is face-to-face still best practice?

When the first Covid lockdown was introduced in March 2020, healthcare professionals were plunged into an alien world and forced to adapt to new ways of conducting patient appointments.

While some dermatology nurses continued to work in day centres, like Lucy Moorhead, a nurse consultant in inflammatory skin diseases, others - like dermatological specialist nurse Sarah Copperwheat - underwent a complete shift to remote working and video consultations.

At last year's British Dermatological Nursing Group annual conference, held in Harrogate in September, Sarah and Lucy came together on a Rash Talk® podcast to discuss the benefits and pitfalls of these methods.

The challenges of remote working

Sarah says the switch to remote consultations posed various challenges, with some patients unable to access the internet, computers or smart phones. There were also issues with patients failing to answer calls or answering when they were busy, making it difficult to discuss sensitive matters.

As well as logistical challenges, some professionals struggled with the switch. "Mentally, [remote working] can be boring and draining," Sarah said. "It works for some people and others hate it. I always tell my team, if it's really not for you, then just say."

For this reason, Sarah says it's important to hold daily check-ins with staff members who work from home, as well as monthly virtual one-to-ones, and face-to-face meetings at least once a year.

"If we're employing people to work remotely, we need to look after their mental health," she said.

Adapting pathways

However, remote consultations also have their benefits, and Lucy says her clinic has continued to use pathways that were developed during the pandemic. For example, before Covid, when a patient started a biologic or a systemic treatment, they would come back to the clinic four weeks later for a face-to-face visit. Now, these appointments are conducted virtually.

PODCAST 2

Living with Eczema and Psoriasis:

Long term effects and wellbeing

Visible, chronic skin conditions like eczema and psoriasis can have a substantial psychological impact on patients.

According to a 2020 report by the All Party Parliamentary Group on Skin (APPGS), 98% of skin disease patients feel their condition affects their emotional and psychological wellbeing, yet only 18% have received some form of psychological support.

Both children and adults are at increased risk of poor mental health because of their skin condition, and Sarah says she often encounters children with eczema or psoriasis who are bullied at school for looking different to their peers.

Comparatively, adults are often reluctant to socialise or begin an intimate relationship due to insecurities about their appearance or fears about their skin flaking, with some unable to pursue career aspirations due to soreness and pain.

This can have a huge impact on patients' wellbeing, but this isn't always addressed during consultations, Sarah says.

Lucy and Sarah say it is therefore important to monitor patients' quality of life with the Dermatology Life Quality Index (DLQI), and mental health with the Patient Health Questionnaire-9 and GAD-7 (General Anxiety Disorder-7).

In addition, patients should be asked directly about how they are feeling.

"If a patient tells me they're feeling a bit down, I never shy away from asking whether they've had thoughts of self-harm," Sarah says.

"I think it's very important that we ask these questions. Just because we ask, doesn't mean people are going to do anything," she added.

Patients should also be informed that, regardless of their DLQI score, they can self-refer to talking therapies such as cognitive behavioural therapy (CBT) should their mental health worsen.

A holistic approach to patient consultations

As well as monitoring mental health, Lucy says dermatology nurses should ask patients about

Lucy says these methods help clinicians to see more patients in any one day, with most patients preferring this method too, as they no longer have to take time off work or travel long distances to clinics.

However, Sarah says that while telephone and video consultations "have their place", she doesn't think they should be used as a "replacement" for face-to-face consultations. "It needs to be a complementary addition," she said.

Vulnerable patients

As the NHS becomes more reliant on digital communications, Lucy says we must consider how this will affect vulnerable patient groups. While this is likely to save clinicians and patients time and money, there is also a risk that some patients may become excluded.

Lucy says some patients have already dropped out of her clinic because they are unable to request an appointment using digital communication methods. This means they are solely presenting at A&E when their skin condition gets too difficult to cope with.

Sarah and Lucy agree that plans must be put in place to prevent vulnerable patients from slipping through the cracks, adding that face-to-face appointments should be offered when needed.

Listen to the full podcasts here:

their overall health, too. In her clinic, Lucy has implemented the Vital 5 initiative, which advocates for health improvements across five areas: blood pressure, obesity, smoking, alcohol and mental health.

Lucy says nurses are well-placed to ask patients about these factors, as they can often talk to patients while administering treatments.

Drinking too much alcohol and eating a poor diet can worsen skin conditions, so this initiative can improve burdensome symptoms as well as improving overall health.

Patients can also be signposted to non-clinical interventions such as habit reversal therapy. This form of therapy teaches patients how to undo or reduce unconscious habits and break the itch-scratch cycle, which can be difficult to manage.

Nurses can also signpost patients to the National Eczema Society and the Psoriasis Association, which both have a host of free, helpful resources on their websites, enabling patients to take control of their skin condition.

In combining these approaches, nurses can improve their patients' overall health, yielding better long-term outcomes and reducing pressure on the NHS.

Rupert Reflects

By Dr Rupert Mason

Great Expectations

Rash Talk® was born in 1987. It was a time of the printed word before the arrival of its modern digital counterpart. The fledgling publication was accompanied by its own Summary of Product Characteristics. True to the template that still exists today, the SmPC detailed items such as dosage and administration, contra-indications, and side-effects. Indications were whimsically described as "a restorative for labourers in the vineyard of healthcare; an emollient for the callouses of healing hands".

And here we are 37 years later. The burden borne by today's labourers in the vineyard of healthcare is as great as ever, if not greater. The demands of professional life pile ever higher. Targets must be hit, budgets must be met, protocols must be followed and boxes must be ticked. And all this before you have even started to practise medicine.

One of the less well recognised but significant pressures faced by today's healthcare professionals is the growing public expectation of omnipotence. Each scientific advance in healthcare and accompanying media coverage helps to nurture a general belief that science is all-powerful and, when faced with medical failure, a disbelief that "in the 21st century this could happen". An unrealistic faith in medical science has been extended to include its practitioners, forgetting that they all share the very human quality of fallibility.

For those of you who feel daunted by the expectation of omnipotence, consider the advice of Sir William Osler (1849-1919). Aged 26, he was appointed professor at McGill University and went on to become one of the founding professors of Johns Hopkins Hospital. In 1905 he was made professor at Oxford University. Among his many legacies is a slim volume entitled *The Student Life*, in which he offers the following advice to those embarking on their medical career: "Start out with the conviction that absolute truth is hard to reach in matters relating to our fellow creatures, healthy or diseased, that slips in observation are inevitable even with the best trained faculties, that errors in judgement must occur in the practice of an art which consists of balancing probabilities."

Notwithstanding the extraordinary advances in medicine, its practice remains an art which consists of balancing probabilities. Omnipotence is for a higher authority, not the poor old labourers in the vineyard of healthcare. For you we have revived this seasoned restorative. Take it whole or in divided doses with fluids. Clinical experience suggests you may be rewarded with a transient sense of wellbeing.

Top Tips to Combat Itch

A Rash Talk® Dermatology Question Time webinar

Watch the full webinar here:

Itch is a major concern for patients with skin conditions, and this was reflected in a recent Rash Talk® *Dermatology Question Time* webinar. The constant feeling of needing to scratch can be draining – not to mention painful – so it's little surprise the panel faced plenty of questions on the topic.

The meeting was chaired by the British Dermatological Nursing Group's outgoing President, Rebecca Penzer-Hick, and featured several experts including Dermatology Nurse Consultant Fiona Elliott, Pharmacist Rod Tucker, Dermatologist Dr James Britton, and Angelika Razzaque, a GP and Associate Specialist in Dermatology.

Practical ways to break the itch-scratch cycle

During the webinar, Fiona Elliott tackled the issue of itch, offering up several practical ways patients could attempt to break the frustrating itch-scratch cycle. These included:

- Patting or tapping the skin, rather than scratching
- Using cool, damp towels on the skin if it feels hot
- Having short, lukewarm baths rather than hot baths or showers
- Keeping nails short
- Wearing cotton or silk clothes
- Using emollients regularly
- Using apps or star charts as positive ways to track and reward when patients don't itch.

However, one of her most useful tips was to use antihistamines around bedtime. She said: "Get the patient to take their antihistamine at least two hours before they go to bed, especially on a night where they tend to be itching or scratching more."

Systemic or dermatological itch?

In response to a question on poor kidney function, part of the discussion centred on identifying the cause of the itch, and the need to identify underlying or systemic causes. Here, Dr Razzaque urged professionals to think about distinguishing the symptoms. "In many inflammatory skin conditions – eczema, psoriasis and so on – you have skin signs. There is redness, there is scaling, there might be hyperpigmentation or lichenification. You see there is an active process in the skin. If it is a systemic underlying condition, you have pruritus without the skin signs."

Menthol Strength Guide

- **0.5%** recommended for children/elderly people/ vulnerable skin
- **1%** general pruritus/starting point for most adults
- **2%** or **5%** for increasing severity of itchy skin

Methoderm should only be used on infants below 2 years under the direction of a clinician.

Magical menthol

Finally, Rebecca asked the panellists about their experiences of using menthol in their treatment armoury, which acts as a coolant on the skin.

Fiona said: "It's useful to keep the menthol emollient in the fridge. I use these when there is pruritus without any sort of physical dermatosis, and a lot of patients find the 2% menthol emollients really quite useful."

Menthol elicits the same cool sensation as low temperature through the TRPM8 receptor

8-28°C: when **TRPM8 receptor** is activated by menthol or thermal stimuli in the cool range

Recommended Reads Helpful resources for healthcare professionals and patients

National Eczema Society: Habit Reversal Advice
https://eczema.org/information-and-advice/treatments-for-eczema/mental-health-support/#habit-reversal

St John's DermAcademy: Educational videos for Healthcare Professionals
https://www.stjohnsdermacademy.com/healthcare-professionals-videos

SkinFood: Your 4-Step Solution to Healthy, Happy Skin
Dr Thivi Maruthappu – available at major book retailers online and in-store

BDNG Methoderm Product Review – by Cristina Galbraith
https://bdng.org.uk/derma-uk/

Steroid Plaster Application Video and Resources
Betesil.co.uk

Samples of Menthol in Aqueous Cream and Emollients
Available free to healthcare professionals at Dermauk.co.uk

Discover more at rashtalk.co.uk

- Can dermatology appointments be held remotely or is face-to-face still best practice?
- Living with Eczema and Psoriasis: Long term effects and wellbeing
- Rash Talk® Dermatology Question Time® - Five Dermatology Experts answer your questions
- BDNG Editor Rob Mair interviews the Original Rash Talk® Founder, Dr Rupert Mason

Got a question or topic you'd like us to address? Email us at rashtalk@dermauk.co.uk

Potent Steroids: Under Occlusion vs Cream

Watch Video: How to apply a Steroid Plaster

by Polly Buchanon, Clinical Editor, *Dermatological Nursing*

Holistic assessment is continually encouraged in dermatology nursing. This article takes the opportunity to reflect on topical corticosteroid (TCS) prescribing and the considerations to be made when deciding how and what formulation to prescribe. In particular, focus will be placed on the pros and cons of prescribing potent topical corticosteroids, 'open application' versus 'under occlusion.'

Topical corticosteroid applications remain the mainstay of treatment for many chronic inflammatory skin conditions.

There are three important considerations when deciding what to prescribe:

1. Patient understanding and concordance
2. Nature, extent and distribution of inflammatory condition
3. Joint decision-making.

Traditionally, TCS applications are openly applied to the skin using a reducing regimen. Creams and ointments can be messy, sticky, and cumbersome to apply. In recent years, there has been the development of fixed dose applications within medicated plasters and tapes.

Patient understanding and concordance

There remains considerable steroid phobia with patients and health professionals. This can lead to skin conditions being under-treated. Yet we must ensure any topical treatment is safe, effective and person-centred.

Therefore, always consider what TCS would be clinically effective and would suit the patient's ability and lifestyle. Alongside a daily emollient programme, always consider a TCS treatment plan that is uncomplicated and simple to apply, preferably once daily. Twice daily applications of TCS creams or ointments can be forgotten or omitted due to time constraints. A fixed dose medicated TCS plaster, such as Betesil 2.250 mg medicated plaster, or tape delivers a constant medication release for 12-24 hours, which avoids over or under-dosing. Reduction in frequency of application can effectively wean the patient off the TCS as the skin condition resolves.

Cross contamination has been an issue with fingertip application of topical creams and ointments over time, which can be a hygiene concern for patients. Betesil 2.250 mg medicated plasters are individually packaged in foil, which can be reclosed for future use and supports hygienic use.

Nature, extent and distribution of inflammatory condition

During assessment, the nature, extent and distribution of the skin condition is considered. TCS creams and ointments are suitable for widespread inflammatory skin conditions such as eczema and psoriasis. However, in difficult to treat or localised areas, often a TCS under occlusion or impregnated plaster can provide sustained TCS delivery, enhancing rapid resolution and patient experiences. The plaster can be cut to size and applied to isolated lesions, digits, palms, soles and joints.

Joint decision-making

Following a holistic assessment and discussion, a joint decision to treat with a potent TCS is made with the patient. Consider safety, effectiveness and patient centred-ness. This will include financial costs and benefits of each product whether it be TCS open application or under occlusion.

The table highlights the key considerations with TCS under occlusion and open application.

	Potent Steroid Plaster	Potent Steroid Cream (alone/under bandage)
Metered dose/24hr release	✔	✘
Targeted application	✔	✘
Helps patient compliance	✔	✘
Manages risk of under/overdose	✔	✘
Won't rub off	✔	✘
Individually packaged	✔	✘
Quick to apply	✔	✔
No preparation needed	✔	✔
Protection of lesion	✔	✘
Does not stain clothes/bedding	✔	✘
Widely known/understood	✘	✔

Visit Betesil.co.uk to access prescribing information for Betesil 2.250 mg medicated plaster

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Abbreviated Prescribing Information for BETESIL® 2.250 mg medicated plaster. Please refer to the full Summary of Product Characteristics (SmPC) prior to prescribing.
Presentation: A colourless, medicated plaster, containing 2.250 mg of betamethasone valerate (corresponding to 1.845 mg of betamethasone). **Indications:** Indicated in adults for the treatment of inflammatory skin disorders which do not respond to treatment with less potent corticosteroids, such as eczema, lichenification, lichen planus, granuloma annulare, palmoplantar pustulosis and mycosis fungoides. Also suitable for chronic plaque psoriasis localized in difficult to treat areas (e.g., knees, elbows, and anterior face of the tibia). Overall, the surface area treated with BETESIL should not exceed 5% of the body surface). **Dosage and Administration:** Apply the medicated plaster to the skin area to be treated once a day. Do not exceed the maximum daily dose of six medicated plasters and the maximum treatment period of 30 days. A new medicated plaster must be applied every 24 hours. Wait at least 30 minutes between one application and the next. Once an appreciable improvement has been obtained, discontinue application and consider continuing treatment with a less potent corticosteroid. The safety and efficacy in children aged <18 years has not yet been established. For full details of usage please refer to the relevant section of the SmPC. **Contraindications:** Hypersensitivity to the active substance or to any of the excipients listed in section 6.1. Cutaneous tuberculosis and viral skin infections (including vaccinia pustules, herpes zoster and herpes simplex). Exudative lesions and primary skin infections caused by fungi or bacteria (e.g. syphilitic skin lesions). Acne, acne rosacea, perioral dermatitis, skin ulcers, burns and frostbite. Do not apply to face. Do not use on patients under 18 years of age. **Precautions and Warnings:** Caution in patients with visual disturbance. Cataract, glaucoma or rare diseases such as central serous chorioretinopathy have been reported with systemic and topical corticosteroid use. Use of topical corticosteroids on large areas of the body and for prolonged periods, as well as the use of an occlusive dressing can cause a temporary suppression of the hypothalamus-pituitary-adrenal axis, leading to secondary hypoadrenalism and adrenal hypercorticism, including the Cushing's syndrome. In these situations, treatment should be discontinued gradually and under strict control of a doctor due to the risk of acute adrenal insufficiency. Sudden withdrawal of the treatment in psoriatic patients, may also lead to symptoms exacerbation or generalized pustular psoriasis. Prolonged use in diffuse psoriasis (except for the treatment of isolated plaques) or diffuse eczema or application on lesions located in skin folds is not recommended, as these conditions may increase systemic absorption. The use of occlusive bandages, especially with plastic material, may increase this effect. The symptoms of this are: facial redness, weight changes (fat increase in body and face and loss in legs and arms), reddish streaks on stomach, headache, menstrual alterations, or an increase in unwanted face and body hair. In this regard, it is known that certain skin areas (face, eyelids, armpits, scalp and scrotum) absorb more easily than others (skin on the knees, elbows, palms of the hands and feet on soles). Long term continuous or inappropriate use of topical steroids can result in the development of rebound flares after stopping treatment (topical steroid withdrawal syndrome). Application of topical medicinal products, especially if prolonged, may give rise to hypersensitivity reaction. Skin atrophy has also been reported after three-week treatment periods. In case of drug intolerance, for example if skin irritation or contact dermatitis occurs during treatment, it is necessary to stop the medicated plaster application and start suitable treatment (see section 4.8 of the SmPC, "Undesirable effects"). Corticosteroids may affect the results of the nitroblue tetrazolium test (NBT) for diagnosing bacterial infections by producing false negatives. Medicinal products containing corticosteroids must be used with caution in patients with impaired immune system function (T-lymphocytes) or in those being treated with immunosuppressive therapy. The product contains methyl parahydroxybenzoate and propyl parahydroxybenzoate, which may cause hypersensitivity reactions (possibly delayed). There are no or limited amount of data from the use of betamethasone valerate in pregnant women. Studies in animals have shown reproductive toxicity (see section 5.3). Betesil is not recommended during pregnancy and in women of childbearing potential not using contraception. **Undesirable effects:** Commonly reported side effects are skin and subcutaneous tissue disorders, occurring in about 15% of patients treated. All cases reported during controlled clinical trials were found to be common (≥1/100, <1/10): skin atrophy, telangiectasia, pustules, papules, furuncle, erythema, pruritus, skin erosion. These undesirable effects are local effects on the skin in the plaster application area. The frequency of withdrawal syndrome is not known. No systemic effects have been observed. Prescribers should consult the summary of product characteristics for other more general considerations on side effects reported with use of corticosteroids for cutaneous use. **Precautions for Storage:** Do not store above 25°C. Store the medicated plaster in its original sachet to preserve its integrity. For storage conditions after first opening of the medicinal product, see SmPC. **Legal Category:** POM. **Package Quantities:** A carton containing four or eight envelopes, each envelope contains one 75 cm x 10 cm medicated plaster containing 2.250 mg of betamethasone valerate. **Marketing Authorisation Number and Holder:** PL 21039/0009. IBSA FARMACEUTICI ITALIA S.R.L. VIA MARTIRI DI CEFALONIA 2 LODI -26900 ITALY. **Basic NHS Price:** £13.98 per pack of four BETESIL® 2.250 mg medicated plasters. £27.46 per pack for eight BETESIL® 2.250 mg medicated plasters. **Date of preparation of Prescribing Information:** November 2023.
Further information can be found in the Summary of Product Characteristics or from: Derma UK Ltd, The Toffee Factory, Lower Steenbergs Yard, Quayside, Ouseburn, Walker Rd, Newcastle upon Tyne, Tyne and Wear, NE1 2DF.

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) BNF, Topical corticosteroids. Last accessed October 2023
2) Betesil SmPC

BET/107/0124
Date of preparation January 2024

Issue 2 coming September 2024. Subscribe at rashtalk.co.uk