

SOUTH AFRICAN PRIMARY HEALTHCARE & ADULT HOSPITAL LEVEL ESSENTIAL MEDICINES LIST

CHAPTER 5: SKIN CONDITIONS

NEMLC RECOMMENDATIONS FOR MEDICINE AMENDMENTS (2020-4)

The Primary Health Care (PHC) Skin Conditions chapter underwent detailed clinical editing and editorial changes for clarity.

Medicine amendment recommendations, with supporting evidence and rationale are listed below.

Kindly review the medicine amendments in the context of the respective standard treatment guideline (STG) and supporting medicine reviews. *All reviews and costing reports may be accessed at:* <https://www.health.gov.za/nhi-edp-stgs-eml/>.

A: MEDICINE AMENDMENTS:

| SECTION | MEDICINE/MANAGEMENT | ADDED/DELETED/AMENDED/ NOT ADDED/ RETAINED |
|--|--|--|
| 5.2 Itching (Pruritus) and 5.8.1 Ectopic eczema and 5.8.2 Eczema, acute, moist, or weeping and 5.10.1 Urticaria and 5.10.4 Papular urticaria and 5.11 Pityriasis rosea | Antihistamines | Caution box for <2 years deleted |
| | Chlorphenamine, oral | Retained and amended |
| | Cetirizine, oral | Retained and amended |
| 5.3 Acne vulgaris | Benzoyl peroxide, topical | Retained |
| | Topical, retinoids | Directions for use amended |
| | Doxycycline, oral | Directions for use amended |
| 5.4.1 Boils, abscess | Povidone iodine | Not added |
| | Children ≤ 7 years of age: Cefalexin | The dosing of cefalexin was aligned to the PHC paediatric dosing table, chapter 23 for children ≤ 7 years of age |
| 5.4.2 Impetigo | Flucloxacillin, oral | Indication amended |
| | Cefalexin, oral | Indication amended |
| | Children ≤ 7 years of age: Cefalexin | The dosing of cefalexin was aligned to the PHC paediatric dosing table, chapter 23 for children ≤ 7 years of age |
| 5.4.3 Cellulitis | Flucloxacillin, oral | Retained |
| | Cefalexin, oral | Retained |
| | Children ≤ 7 years of age: Cefalexin | The dosing of cefalexin was aligned to the PHC paediatric dosing table, chapter 23 for children ≤ 7 years of age |
| | Amoxicillin, oral | Not added |
| | Clindamycin, oral | Not added |
| 5.4.4 Chronic lower leg ulcers | Hydrocolloid dressings | Not added |
| | Moistened dressing e.g., gauze with Sodium chloride, 0.9%. | Retained |
| 5.5.2.4 Pityriasis versicolor – Tinea versicolor | Selenium sulfide, 2.5% suspension | Directions for use amended |
| 5.6.3 Nail infections – Tinea unguium | Fluconazole, oral | Not added |
| 5.7.1.1 Head lice | Permethrin 5%, topical | Retained |
| 5.7.2 Scabies -children <6 years of age | Permethrin 5% topical | Retained |
| | Benzoyl benzoate 25% lotion | Added |
| 5.8.1 Ectopic eczema | Emollient | Retained as a therapeutic class |
| | Emulsifying ointment (UE) | Retained as an example of class (emollient) listed in the STG |
| | Cetamacrogol | Not added as an example of class (emollient) – already included on the therapeutic interchange database |
| | Corticosteroid, potent, topical | Retained as a therapeutic class |

| SECTION | MEDICINE/MANAGEMENT | ADDED/DELETED/AMENDED/ NOT ADDED/ RETAINED |
|--|---|---|
| | Betamethasone 0.1%, topical | Retained as an example of class (potent corticosteroid) listed in the STG |
| | Fluocinolone, topical | Not added as an example of class (potent corticosteroid) – already included on the therapeutic interchange database |
| 5.8.2 Eczema, acute, moist or weeping | Hydrocortisone 1% topical | Retained |
| | Betamethasone 0.1%, topical | Not added |
| | Fluocinolone, topical | Not added |
| | <u>Children ≤ 7 years of age:</u> Cefalexin | The dosing of cefalexin was aligned to the PHC paediatric dosing table, chapter 23 for children ≤ 7 years of age |
| 5.8.3 Dermatitis, seborrhoeic | Corticosteroid, potent, topical: | retained as a therapeutic class |
| | Betamethasone 0.1%, topical: | retained as an example of class (potent corticosteroid) listed in the STG |
| | Fluocinolone, topical: | not added as an example of class (potent corticosteroid) – already included on the therapeutic interchange database |
| 5.9 Nappy Rash | Topical corticosteroid | Not added |
| 5.10.3 Fixed drug eruptions | Potent topical corticosteroid | Not added |
| 5.10.4 Papular urticaria <i>- new inflamed lesions</i> | Hydrocortisone 1%, topical | Retained |
| | Fluocinolone, topical | Not added |
| | Hydrocortisone 1%, topical | Retained |
| | LPC 5% | Not added |
| 5.11 Pityriasis rosea | Calamine lotion | Not added |
| | Hydrocortisone 1%, topical | Not added |
| | Aqueous cream | Deleted |
| 5.12 Molluscum contagiosum | Benzoyl peroxide, topical | Not added |
| | Tincture of iodine BP | Retained |
| 5.15.1 Common Warts | Histofreeze | Not added |
| 5.16 Psoriasis | Corticosteroid, potent, topical | Retained as a therapeutic class |
| | Betamethasone 0.1%, topical | Retained as an example of class (potent corticosteroid) listed in the STG |
| | Fluocinolone, topical | Not added as an example of class (potent corticosteroid) – already included on the therapeutic interchange database |
| | Biologics | Not added |
| 5.17 Hidradenitis suppurativa | Monoclonal antibodies | Not added |
| | Steroids | Not added |
| | Antibiotics | Not added |
| 5.18.1 Albinism | Zinc oxide, topical | Retained, directions for use not amended |
| | Titanium dioxide, topical ointment/cream (UV block) | Retained, directions for use not amended, product name revised to high potency (SPF) sunblock, topical (UV Block) |
| | Titanium dioxide, topical ointment/cream (UV block) | Retained, product name revised to high potency (SPF) sunblock, topical (UV Block) |
| 5.19 Pressure Ulcers/ Sores | Referral criterion (for rehabilitation) | Added |

**The dosing of cefalexin in the chapter was aligned to the PHC paediatric dosing table, chapter 23 for children ≤ 7 years of age.*

B: MEDICINE AMENDMENTS 2025

| SECTION | MEDICINE/MANAGEMENT | ADDED/DELETED/AMENDED/ NOT ADDED/ RETAINED |
|--------------------------|---------------------------|---|
| 5.3 Acne vulgaris | Benzoyl peroxide, topical | Retained, STG amended from “gel” to “topical” |

5.2 ITCHING (PRURITUS) and 5.8.1 ECTOPIC ECZEMA and 5.8.2 ECZEMA, ACUTE, MOIST, OR WEEPING and 5.10.4 PAPULAR URTICARIA and 5.11 PITYRIASIS ROSEA

The NEMLC recommended at the meeting of the 23 June 2022¹ that the PHC/Adult Hospital Level ERC review the caution of restricting chlorphenamine to children older than 2 years of age and align the dosing with guidance in the Paediatric Hospital Level STGs and EML.

Thus, the following caution box was deleted throughout the STGs, and the weight-band dosing tables for chlorphenamine will be updated in chapter 23: Standard paediatric dosing tables to include dosing for children <2 years of age, accordingly.

| |
|--|
| CAUTION Do not give an antihistamine to children < 2 years of age. |
|--|

Chlorpheniramine: retained

Cetirizine: retained and amended

Guidance for antihistamines was made consistent throughout these STGs for short-term use with chlorphenamine and long-term/chronic use with non-sedating antihistamine, cetirizine.

If pruritis is severe and requires short term control:

Children

- Chlorphenamine, oral, 0.1 mg/kg/dose 6–8 hourly. See chlorphenamine dosing table, chapter 23.

Adults

- Chlorphenamine, oral, 4 mg, 6–8 hourly.

Note: Chlorphenamine is sedating and may only be required in the evening for mild cases.

If pruritis is severe and requires long term control, e.g. for chronic pruritus

Children: 2–6 years of age

- Cetirizine, oral, 5 mg once daily. See cetirizine dosing table, chapter 23.

Children > 6 years of age and adults

- Cetirizine, oral, 10 mg once daily.

Level of Evidence: Expert opinion

Several external comments were received to amend management with antihistamines in these clinical settings. However, no supporting evidence was submitted, despite follow-up requests.

5.3 ACNE VULGARIS

Benzoyl peroxide, topical: retained

Following consultation with the Paediatric Hospital Level Committee, it was agreed that the current recommendation of benzoyl peroxide for mild acne be retained, which was supported at the NEMLC meeting on 23rd June 2022².

Topical, retinoids: directions for use amended

¹ Minutes of the NEMLC meeting of 23 June 2022

- The Medicines Control Council (MCC) had issued a safety alert in 2007 for promethazine contra-indication in children less than 2 years of age, as serious life-threatening cases of respiratory depression, including fatalities have been reported

<https://www.bing.com/ck/a?!&p=4b3c6391536fd84aJmItDHM9MTY2MTEExNjMyMiZp23VpZD0xYiBjZDE2OC05OWY0LTQxZDQyTmNS01ODBlYmM2NThkMGUmaW5zaWQ9NTE0Mw&ptn=3&hsh=3&fclid=e65d78bc-2195-11ed-accd-88709b8260e8&u=a1aHR0cHM6Ly93d3cuc2FocHJhLm9yZy56YS9zYWZldHktYWxlcnRzL21zYS1wcm9tZXRoYXppbmUtMi8&ntb=1>

² Minutes of the NEMLC meeting of 23 June 2022

External comments on gradual titrated administration of topical retinoids, applying a “pea-sized” amount to the face and avoiding contact with eyes, and the area around the mouth and nose was accepted as pragmatic advice; and the STG text was amended as follows:

For non-inflammatory acne:

Topical retinoids

Main therapeutic objective is to control comedone formation.

Introduce topical retinoids gradually as a night-time application to limit skin irritant effects, as they are not photo-stable and degrade when exposed to sunlight (e.g. start twice a week and titrate up).

CAUTION

Do not use if pregnant or planning pregnancy.
Limit exposure to sunlight. If sunburn occurs, discontinue therapy until the skin has recovered.

- Tretinoin, topical, apply at night to affected areas for at least 6 weeks.
 - Review patient after 6 weeks’ treatment.
 - Minimise exposure to sunlight. If sunburn occurs, discontinue therapy until the skin has recovered.
 - Acne may worsen during the first few weeks.
 - Apply about a pea-sized amount to entire face. Avoid contact with eyes and area around mouth and nose.

Level of Evidence: Expert opinion

Doxycycline: directions for use amended

Following an external comment, the STG text was amended as follows:

- Doxycycline, oral, 100 mg daily for 3 months.
 - Review patient after 3 months of treatment.
 - It should be taken with meals.
 - Do not take it together with iron preparations and antacids.
- Note:** Doxycycline should always be used with a topical agent and should not be used as monotherapy.

However, an external comment to extend the duration of use for doxycycline from 3 months to 6 months was submitted without supporting evidence and was not considered, noting the concerns of antibiotic resistance.

5.4.1 BOIL, ABSCESS

Povidone iodine scrub: not added

An external comment was received for povidone iodine scrub as an anti-Staphylococcus measure for recurrent boils, without supporting evidence. Staining of clothing was also a concern. Available evidence³ that was identified suggests chlorhexidine as a topical antiseptic and an adjunctive interventional strategy for reducing the risk of staphylococcal postoperative surgical site infections.

5.4.2 IMPETIGO

The NEMLC recommended at the meeting of the 25 August 2022⁴ that the PHC/Adult Hospital Level ERC review the evidence for the retention and recommendation of cefalexin for *S Aureus* infections in relation to other antibiotics. An evidence review⁵ was summarized including two Cochrane Reviews^{6,7} (low & moderate quality review) and

³ Edmiston CE Jr, Bruden B, Rucinski MC, Henen C, Graham MB, Lewis BL. Reducing the risk of surgical site infections: does chlorhexidine gluconate provide a risk reduction benefit? Am J Infect Control. 2013 May;41(5 Suppl):S49-55.

⁴ Minutes of the NEMLC meeting of 25 August 2022.

⁵ Cefalexin: National Department of Health: Affordable Medicines, EDP- Primary Healthcare and Adult Hospital Level. Medicine Review: Evidence summary of the use of cephalixin for S Aureus skin infections, September 2022.

⁶ Kilburn SA, Featherstone P, Higgins B, Brindle R. Interventions for cellulitis and erysipelas. Cochrane Database Syst Rev. 2010 Jun 16;2010(6):CD004299. doi: 10.1002/14651858.CD004299.pub2. PMID: 20556757; PMCID: PMC869318

⁷ Koning S, van der Sande R, Verhagen AP, van Suijlekom-Smit LW, Morris AD, Butler CC, Berger M, van der Wouden JC. Interventions for impetigo. Cochrane Database Syst Rev. 2012 Jan 18;1(1):CD003261. doi: 10.1002/14651858.CD003261.pub3. PMID: 22258953; PMCID: PMC7025440

Practice Guidelines for the Diagnosis and Management of Skin and Soft Tissue Infections: 2014 Update by the Infectious Diseases Society of America (IDSA)⁸.

In September 2022, an additional search brought up a protocol of a study that is still underway entitled antibiotic therapy for skin and soft tissue infections: a protocol for a systematic review and network meta-analysis (biomedcentral.com)⁹. Remaining, studies date back to the 1990's and early 2000's.

In summary:^{Error! Bookmark not defined.}

- The Cochrane reviews could not definitively recommend one antibiotic treatment over another
- It was unclear if oral antibiotics are superior to topical antibiotics for the management of impetigo.
- Penicillin was not as effective as other antibiotics as an intervention for the management of impetigo.
- Mostly there was no significant difference between cefalexin and other treatments, however cefalexin was the most effective treatment (significantly different versus penicillin) in the treatment of non-bullous impetigo. In this case *S aureus* was the most common cause of impetigo in a paediatric population and cefalexin was the most effective treatment.

Level of Evidence: Low to Moderate certainty evidence

Cefalexin, oral: retained

The dosing of cefalexin was aligned to the PHC paediatric dosing table, chapter 23 for children ≤ 7 years of age.

Flucloxacillin, oral: retained & indication amended

As not all cases of impetigo need antibiotics, the indication for cefalexin/flucloxacillin was amended to: '*If extensive or systemic signs of infection (fever, unwell, fatigued)*', for clarity purposes.

5.4.3 CELLULITIS

Flucloxacillin, oral: retained

Cefalexin, oral: retained

Amoxicillin: not added

Clindamycin, oral: not added

The dosing of cefalexin was aligned to the PHC paediatric dosing table, chapter 23 for children ≤ 7 years of age.

External comment to replace flucloxacillin/cefalexin with amoxicillin/clindamycin without supporting evidence was not considered, noting that macrolides are already included as an alternative for severe penicillin allergy. A summary of the evidence¹⁰ for the use of cefalexin in *S Aureus* skin infections showed that cefalexin might be the more effective treatment (significantly different versus penicillin in a pediatric population). Furthermore, the IDSA guidelines recommend cefalexin in combination with other antibiotics for both streptococci and Methicillin-resistant *Staphylococcus aureus* (MRSA) but also indicate that cefalexin alone is efficacious in pure cellulitis.¹¹

⁸ Intravenous antibiotics (severe cellulitis and erysipelas): Stevens DL, Bisno AL, Chambers HF, Dellinger EP, Goldstein EJ, Gorbach SL, Hirschmann JV, Kaplan SL, Montoya JG, Wade JC; Infectious Diseases Society of America. Practice guidelines for the diagnosis and management of skin and soft tissue infections: 2014 update by the Infectious Diseases Society of America. Clin Infect Dis. 2014 Jul 15;59(2):e10-52. <https://www.idsociety.org/practice-guideline/skin-and-soft-tissue-infections/>

⁹ Bartoszko JJ, Mertz D, Thabane L, Loeb M. Antibiotic therapy for skin and soft tissue infections: a protocol for a systematic review and network meta-analysis. Syst Rev. 2018 Sep 11;7(1):138. doi: 10.1186/s13643-018-0804-8. PMID: 30205844; PMCID: PMC6134765.

¹⁰ Cefalexin: National Department of Health: Affordable Medicines, EDP- Primary Healthcare and Adult Hospital Level. Medicine Review: Evidence summary of the use of cephalosporins for *S Aureus* skin infections, September 2022.

¹¹ Intravenous antibiotics (severe cellulitis and erysipelas): Stevens DL, Bisno AL, Chambers HF, Dellinger EP, Goldstein EJ, Gorbach SL, Hirschmann JV, Kaplan SL, Montoya JG, Wade JC; Infectious Diseases Society of America. Practice guidelines for the diagnosis and management of skin and soft tissue infections: 2014 update by the Infectious Diseases Society of America. Clin Infect Dis. 2014 Jul 15;59(2):e10-52. <https://www.idsociety.org/practice-guideline/skin-and-soft-tissue-infections/>

5.4.4 CHRONIC LOWER LEG ULCERS

Hydrocolloid dressings: *not added*

Moistened dressing e.g. gauze with Sodium chloride, 0.9%: *retained*

External comment was submitted without evidence to include hydrocolloid dressings for local wound care. There is no evidence to support the superiority of one dressing type over another when applied under appropriate multilayer compression bandaging¹².

5.5.2.4 PITYRIASIS VERSICOLOR – TINEA VERSICOLOR

Selenium sulfide, 2.5% suspension: *directions for use amended*

Directions for use was amended as follows for pragmatic purposes:

- » Oral antifungal therapy is not indicated.
- Selenium sulfide, 2.5% suspension apply once weekly for three weeks.
 - Lather shampoo on affected parts.
 - Leave on overnight, then wash off the following day.

Level of Evidence: Expert opinion

5.6.3 NAIL INFECTIONS – TINEA UNGUIUM

Fluconazole, oral: *not added*

An external comment to include oral fluconazole was not considered, as the STG provides guidance for referral to secondary level of care if patients are distressed by cosmetic appearance.

Fluconazole was historically not added as evidence reviewed by the Expert Review Committee (2014) indicated minimal benefit of fluconazole for tinea unguium with mainly open label RCTs showing higher cure rates.¹³ Therapy is also noted as costly.

5.7.1.1 HEAD LICE

Permethrin 5%, topical: *retained*

5.7.2 SCABIES

Children < 6 years of age

Permethrin 5%, topical: *retained*

Benzyl benzoate 25% lotion: *added*

There have been consistent reports of supply issues with permethrin 5%, thus guidance was provided to consider diluted benzyl benzoate in young children, aligned with SAMF¹⁴.

The STG text was updated as follows:

If permethrin is unavailable for children < 6 years of age:

Benzoyl benzoate 25% lotion:

- Children 0 months to 1 year of age:
 - Dilute 1 part of benzoyl benzoate to 3 parts of water to form an emulsion of 6%.
 - Apply diluted emulsion to the whole body from neck to feet as described above.

Level of Evidence: Guidelines

¹² Palfreyman SJ, Nelson EA, Lochiel R, Michaels JA. Dressings for healing venous leg ulcers. Cochrane Database Syst Rev. 2006 Jul 19;(3):CD001103. doi: 10.1002/14651858.CD001103.pub2.

¹³ National Essential Medicines List Committee Implementation Slides- 2012

¹⁴ SAMF, 2022

5.8.1 ECZEMA, ATOPIC

Emollient: retained as a therapeutic class

Emulsifying ointment (UE): retained as an example of class (emollient) listed in the STG

Cetamacrogol: not added as an example of class (emollient) – already included on the therapeutic interchange database

Corticosteroid, potent, topical: retained as a therapeutic class

Betamethasone 0.1%, topical: retained as an example of class (potent corticosteroid) listed in the STG

Fluocinolone, topical: not added as an example of class (potent corticosteroid) – already included on the therapeutic interchange database

5.8.2 ECZEMA, ACUTE, MOIST OR WEEPING

Hydrocortisone 1% topical: retained

Betamethasone 0.1%, topical: not added

Fluocinolone, topical: not added

The dosing of cefalexin was aligned to the PHC paediatric dosing table, chapter 23 for children ≤ 7 years of age.

External comment without supporting evidence to replace mild topical corticosteroids with potent topical corticosteroids was not considered, noting that historically, hydrocortisone 1% cream was added as a water based topical steroid for the treatment of acute and weeping eczema¹⁵; while the PHC STGs and EML recommends doctor prescribing of potent topical corticosteroids.

5.8.3 DERMATITIS, SEBORRHOEIC

Corticosteroid, potent, topical: retained as a therapeutic class

Betamethasone 0.1%, topical: retained as an example of class (potent corticosteroid) listed in the STG

Fluocinolone, topical: not added as an example of class (potent corticosteroid) – already included on the therapeutic interchange database

5.9 NAPPY RASH

Topical corticosteroid: not added

External comment without evidence, to include topical steroids for the treatment of nappy rash was not considered, noting that guidance is provided for referral to secondary level of care if there is no improvement after 3 days.

5.10.3 FIXED DRUG ERUPTIONS

Potent topical corticosteroid: not added

External comment without evidence, to include potent topical corticosteroids was not considered, noting that the PHC STGs and EML recommends doctor prescribing of potent topical corticosteroids.

5.10.4 PAPULAR URTICARIA

Hydrocortisone 1%, topical: retained

Fluocinolone, topical: not added

External comment without supporting evidence to replace hydrocortisone 1%, topical with potent topical corticosteroid, fluocinolone, was not considered, noting that the PHC STGs and EML recommends doctor prescribing of potent topical corticosteroids.

¹⁵ Primary Healthcare Essential Medicines List NEMLC Report. Chapter 5: Skin. 28 November 2013.

LPC 5%: not added

External comment without supporting evidence to consider LPC 5% to relieve itching was not considered.

5.10.4 PAPULAR URTICARIA

Hydrocortisone 1%, topical: retained

Fluocinolone, topical: not added

External comment without supporting evidence to replace hydrocortisone 1%, topical with potent topical corticosteroid, fluocinolone, was not considered, noting that the PHC STGs and EML recommends doctor prescribing of potent topical corticosteroids.

LPC 5%: not added

External comment without supporting evidence to consider LPC 5% to relieve itching was not considered. Review of the literature did not result in high certainty evidence for the use of LPC 5% in the treatment of papular urticaria.

5.11 PITYRIASIS ROSEA

Calamine lotion: not added

Hydrocortisone 1%, topical: not added

Aqueous cream: deleted

External comment without supporting evidence to consider calamine lotion and topical mild corticosteroids and to remove aqueous cream for the management of pityriasis rosea was received. Guidelines for management of the condition were sought but evidence to support the addition of calamine or topical corticosteroids for this indication could not be justified.

At the NEMLC meeting on the 25 August 2022 it was raised that there might be a safety issue with the use of aqueous cream due to the ingredient sodium lauryl sulphate which can be irritant¹⁶, and therefore NEMLC recommended the use of aqueous cream should be reconsidered. Although sodium lauryl sulphate free products are available on the market, no evidence could be found for the explicit use of aqueous cream in pityriasis rosea, and therefore aqueous cream was removed from the PHC STG and EML for this indication.

5.12 MOLLUSCUM CONTAGIOSUM

Benzoyl peroxide: not added

Tincture of iodine BP: retained

External comment without supporting evidence for benzoyl peroxide as an irritant to allow lesions to become inflamed and then involute was received. Review of the literature showed that the Centers for Disease Control (CDC) recommendations¹⁷ suggest physical removal of lesions through cryotherapy (freezing the lesion with liquid nitrogen), curettage and laser therapy all outside the scope of PHC level. The CDC guidance does not recommend the patient try and remove lesions or the fluid inside of lesions as it may unintentionally autoinoculate other parts of

¹⁶ Aqueous cream: may cause skin irritation. <https://www.gov.uk/drug-safety-update/aqueous-cream-may-cause-skin-irritation#:~:text=Although%20aqueous%20cream%20is%20useful,%2C%20burning%2C%20itching%20and%20redness.> 11 March 2014.

¹⁷ Molluscum contagiosum. Centers for Disease Control. <https://www.cdc.gov/poxvirus/molluscum-contagiosum/treatment.html>.

the body, risk spreading it to others and result in bacterial infection. A Cochrane review showed that iodine is used as a treatment option but no single treatment is convincingly effective in the treatment of molluscum contagiosum¹⁸.

Level of Evidence: Low certainty systematic review evidence and Guidelines

5.15.1 COMMON WARTS

Histofreeze: not added

External comment without supporting evidence for histofreeze was received. Review of the available evidence showed that Histofreeze would require a portable cryosurgical system at a high cost and therefore was not included.

5.16 PSORIASIS

Corticosteroid, potent, topical: retained as a therapeutic class

Betamethasone 0.1%, topical: retained as an example of class (potent corticosteroid) listed in the STG

Fluocinolone, topical: not added as an example of class (potent corticosteroid) – already included on the therapeutic interchange database

Biologics: not added

External comments received from two manufacturer motivating for early use of biologics in patients with psoriasis, was not accepted. However, the matter was referred to the Tertiary and Quaternary Expert Review Committee for consideration.

5.17 HIDRADENITIS SUPPURATIVA

Monoclonal antibodies: not added

Steroids: not added

Antibiotics: not added

External comment received from a manufacturer for antibiotic, steroids and biologics for the management of hidradenitis suppurativa. However, individualised management of patients is required with treatment of symptoms and comorbidities. Treatment varies and includes therapeutics such as topical treatment, anti-androgenic medicines and spironolactone. The STGs do provide for management of furuncles and abscesses. Refractory therapy includes the following therapeutic options: rifampicin, dapson, laser therapy, surgery and monoclonal antibodies. The matter pertaining to monoclonal antibodies was referred to the Tertiary and Quaternary Expert Review Committee for consideration.

In addition, the following text was added to the STG:

Referral

» All patients with abscesses, infected cysts or sinuses suspected to be due to hidradenitis suppurativa

5.18.1 ALBINISM

Zinc oxide, topical ointment: retained, directions for use not amended

Titanium dioxide, topical ointment/cream (UV block): retained, directions for use not amended, product name revised to high potency (SPF) sunblock, topical (UV Block)

¹⁸ van der Wouden JC, van der Sande R, Kruijthof EJ, Sollie A, van Suijlekom-Smit LW, Koning S. Interventions for cutaneous molluscum contagiosum. Cochrane Database Syst Rev. 2017 May 17;5(5):CD004767. doi: 10.1002/14651858.CD004767.pub4. PMID: 28513067; PMCID: PMC6481355.

External comment *without* supporting evidence to re-apply sunscreens at least every 2 hours was received. Although sunscreens are recommended for hypo pigmentation,¹⁹ and drug information sites²⁰ indicate that most sun screens can be easily removed from the skin and therefore should be reapplied every one to two hours for adequate protection (especially after swimming and severe perspiration); the practicality of the reapplication at least every 2 hours could not be guided by strong evidence.

5.18.2 VITILIGO

Titanium dioxide, topical ointment/cream (UV block): retained, product name revised to high potency (SPF) sunblock, topical (UV Block)

External comment *without* supporting evidence to remove UV blocks in vitiligo was received. Review of the available evidence indicated that sunscreens are recommended in the management of vitiligo, and was retained with a revision of the active ingredient of the treatment from titanium dioxide, topical ointment/ cream to high potency (SPF) sunblock, topical (UV Block)

Text encouraging patients to only use sunscreen when the sun is at its strongest was deleted from the STG, as application of sunscreen was deemed appropriate at any time of the day.

The STG was revised as follows:

From

MEDICINE TREATMENT

- Titanium dioxide, topical ointment/cream (UV block),
 - o Only use when sun is at its strongest i.e., between 10:00 and 15:00.
 - o Apply evenly to all sun exposed areas at least 15 minutes before going out into the sun during this time

To

MEDICINE TREATMENT

- High potency (SPF) sunblock, topical (UV block)
 - Apply evenly to all sun exposed areas at least 15 minutes before going out into the sun.

5.19 PRESSURE ULCERS/SORES

Referral criterion (for rehabilitation): added

Referral criterion was added for referral to rehabilitation on receipt of motivation from RuReSA and Rehabilitation Associations of SA in collaboration with the Department of Health and Rehabilitation Sciences, Stellenbosch University for electrical stimulation for wound management in addition to standard care to improve healing²¹; and for prevention of pressure sores e.g., wheelchair users should be referred to rehabilitation for wheelchair and transfers training^{22 23}.

The STG text was amended as follows:

Referral

¹⁹ Hill JP, Batchelor JM. An approach to hypopigmentation. *BMJ*. 2017 Jan 12;356:i6534. doi: 10.1136/bmj.i6534. PMID: 28082370.

²⁰ Sunscreen Agent (Topical application). <https://www.drugs.com/cons/sunscreen-agent-topical-application.html>

²¹ Arora M, Harvey LA, Glinsky JV, Nier L, Lavrencic L, Kifley A, Cameron ID. Electrical stimulation for treating pressure ulcers. *Cochrane Database Syst Rev*. 2020 Jan 22;1(1):CD012196. <https://pubmed.ncbi.nlm.nih.gov/35244315/>

²² Harvey LA, Glinsky JV, Bowden JL. The effectiveness of 22 commonly administered physiotherapy interventions for people with spinal cord injury: a systematic review. *Spinal Cord*. 2016 Nov;54(11):914-923. <https://pubmed.ncbi.nlm.nih.gov/27349607/>

²³ Wang J, Ren D, Liu Y, Wang Y, Zhang B, Xiao Q. Effects of early mobilization on the prognosis of critically ill patients: A systematic review and meta-analysis. *Int J Nurs Stud*. 2020 Oct;110:103708. <https://pubmed.ncbi.nlm.nih.gov/32736250/>

Refer patients with pressure sores or those at high risk of development of pressure sores to rehabilitation.

POST PUBLICATION AMENDMENTS:2025

5.3 ACNE VULGARIS

Benzoyl peroxide, topical: *retained*

Following the publication of chapter, the NDoH Bid Specification Committee requested NEMLC to update the STG text to recommend benzoyl peroxide “topical” instead of “gel” in order to allow for wider choice of products in the market. The STG has been amended as follows:

| PHC Chapter 5: Skin Conditions | |
|--|---|
| Section: 5.3 Acne Vulgaris | |
| Amended from | Amended To |
| MEDICINE TREATMENT Mild inflammatory acne: • Benzoyl peroxide 5%, gel, apply in the morning to affected areas as tolerated. o Wash off in the evening. o <u>If</u> ineffective and tolerated, increase application to 12 hourly. o Avoid contact with eyes, mouth, angles of the nose and mucous membranes. | MEDICINE TREATMENT Mild inflammatory acne: Benzoyl peroxide 5%, topical, apply in the morning to affected areas as tolerated. Wash off in the evening. If ineffective and tolerated, increase application to 12 hourly. Avoid contact with eyes, mouth, angles of the nose and mucous membranes. |