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SKINTELLIGENCE ACADEMY

Estimated educational content: 1 hour

Complete Emollient Therapy and application techniques

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OVERVIEW
LEARNING OBJECTIVES

CPD

Continuing Professional Development

This module contains an estimated 1 hour of educational content, which can be included as part of your personal development and learning plan.

Overview

Emollients are first-line therapy for dry skin symptoms – itch, scale, crust and fissures – which are features of chronic inflammatory skin conditions. Dry skin is caused by the loss of integrity of the stratum corneum, which inevitably results in the breakdown of the skin barrier, due to decreased levels of Natural Moisturising Factors (NMFs) and the breakdown of lipid lamellae from around the corneocytes.[1]

Complete Emollient Therapy (CET) is the cornerstone of treatment and essential for addressing and preventing dry skin, helping to reduce symptoms, improve skin health and quality of life.

Learning objectives

This module is aimed at primary care healthcare professionals who regularly manage patients with dry skin conditions.

The learning objectives for this module are to:

- Increase evidence-based knowledge on Complete Emollient Therapy (CET) for dry skin conditions, including use of different formulations
- Improve clinical confidence in advising and educating patients on emollient choice and emollient application

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Quick Facts

Emollients prevent trans-epidermal water loss (TEWL) by providing an occlusive layer over the stratum corneum surface.[1]

Clinical learning

Introduction to emollients

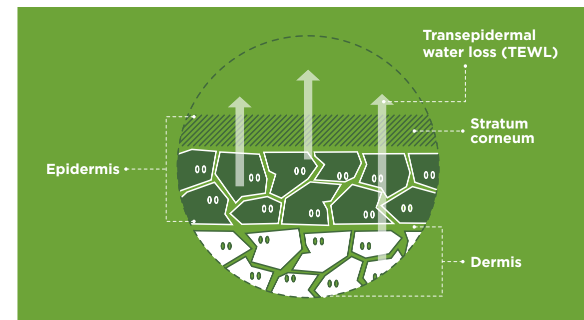
Emollients are the most important treatment in all dry skin conditions.[1] Rehydrated skin is better able to restore its protective barrier function[2], preventing the penetration of irritants, allergens and bacteria, which can cause or exacerbate the skin condition.

Definition of emollients

An emollient is defined as a lipid or oil that hydrates and improves the appearance of the skin, reduces clinical symptoms of dryness and scaling and improves sensations, including itching and tightness.[2]

Emollients are medical moisturisers and the terms ‘emollient’ and ‘moisturiser’ are used interchangeably.

Emollients prevent transepidermal water loss (TEWL) by providing an occlusive layer over the stratum corneum surface.[1] The water trapped under the occlusive emollient layer passes back into the corneocytes, which swell and improve the integrity of the skin barrier.[1] Some emollients contain humectant ingredients, such as the natural moisturising factors (NMFs) glycerine and urea, which work to reduce moisture loss by drawing water from the dermis into the epidermis. These types of emollients therefore have an occlusive and humectant effect.[2]



Quick Fact

The key principle of Complete Emollient Therapy (CET) is that everything that goes on the skin should be emollient-based.

Emollients soften, smooth and rehydrate the skin, helping to reduce the clinical signs of dry skin.[2] Emollients make the skin feel more comfortable and less itchy. They keep the skin moist and flexible, helping to prevent cracks, known as fissures. Unfortunately, they tend to be underused, but when used correctly as a daily skin care regime, emollients can reduce the need for topical steroids.[3] Emollient therapy is not just about prescribing appropriate formulations but also about educating the patient and helping them understand how and when to use them.[1]

Complete Emollient Therapy

The fundamental treatment regimen for dry skin and eczema is Complete Emollient Therapy (CET), which is defined as:

> *"Everything that goes on the skin should be emollient-based and all soaps replaced with emollient wash products[1]"*

The goal of CET is to keep the skin well moisturised in order to repair the skin barrier. In so doing, CET helps to protect against common pathogens that can penetrate the skin, causing irritation and inflammation.

The key principle is to use emollients daily to wash with, followed by application of leave-on emollients to keep the skin well moisturised. Often, this means using a range of emollient formulations.

Emollients as soap substitutes

Soap bars, liquid soap, bubble baths and cosmetic washes can dry out the skin because they contain detergents which remove skin lipids.[4] Soap substitutes can be used instead to cleanse the skin, but patients should be advised that emollient soap substitutes do not foam, which can take a little while to get used to. Emollient washing creams are very effective cleansers too.[1]

Important Information

If emollient products come into contact with dressings, clothing and bedding, the fabric can be easily ignited with a naked flame. It is recommended to keep away from fire when using these products.[4]

Types of emollients

There are several different types of emollients, in the form of lotions, creams, ointments, bath and shower oils, and soap substitutes.

Lotions

Lotions have a high water content, which makes them easy to spread, and they are light and cool on the skin.

Lotions are less effective at rehydrating very dry skin compared with creams and ointments.[2] This is because this type of formulation has the highest water content, thereby producing a lesser occlusive effect and lower efficacy of skin-barrier repair. They are useful for patients with mild to moderately dry skin, especially for day-time use as quick absorption time makes them more cosmetically acceptable.[1]

Creams

Creams contain a mixture of oil and water, so are more effective than lotions at preventing TEWL. They are quite easy to spread and are not greasy, so many people prefer them to ointments for daytime use, from a practical and cosmetic point of view.[2] It is important to note that all creams (and lotions) contain preservatives, which may potentially cause skin reactions in some patients.

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TYPES OF EMOLLIENTS

Ointments

Ointments are thicker and greasier than creams and lotions[2], which makes them very effective at occlusion but their greasiness can be cosmetically undesirable for some patients. Ointments contain fewer preservatives than creams and lotions, and can therefore be more suitable for people who may react to additives.[5]

Bath and shower oils

Bath and shower preparations can be a useful way to get moisturisers onto the skin. Bath oils are added to bath water and emollient shower preparations directly to the skin during showering. Emollient bath and shower oils clean and hydrate the skin, coating it with a thin film of oil, which traps moisture.[1] Some bath and shower products have additional antimicrobial and anti-itch properties[1], which can be beneficial for certain patients, such as patients whose eczema has become infected.

Dissolving an ointment-based emollient in hot water and then vigorously incorporating it into the bath water to disperse it can be used in place of bath oils.[2] Alternatively, patients can use an emollient as a soap substitute, as bathing or showering is considered an integral part of a thorough Complete Emollient Therapy (CET) programme. This is particularly important for patients who may also suffer some degree of irritation from chemicals such as chlorine, which are added to water to keep it free from bacteria.

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Quick Fact

Patient preference is essential - if the patient does not like the type of emollient prescribed, they are much less likely to use it, resulting in poor adherence.[6]

Choosing emollients for your patient

As a general rule, the drier the skin, the greasier the occlusive emollient should be. Greasier products are more effective due to their effect on reducing TEWL. In addition to choosing an emollient appropriate to the level of skin dryness, considering patient preference is essential - if the patient does not like the type of emollient prescribed, they are much less likely to use it, resulting in poor adherence.[6]

Very dry skin is best treated with an ointment, moderately dry skin with a cream, and slightly dry skin with a lotion.[4] Note, however, that humectant emollient creams containing NMFs can produce similar hydration to an ointment, so emollients formulated with humectants are suitable for all severities of dry skin.[1]

It is helpful to provide samples as, sometimes, finding the right emollient for the patient can be down to trial and error. Remember, all patients are individuals and what suits one person may not suit another.[6] Emollient choice should be discussed at initial consultation and at follow-up.

For recurrent skin infections, consider using leave-on lotions or bath additives containing antimicrobial properties.[4]

Some skin conditions produce thickened scale and hyperkeratosis, for example psoriasis and ichthyosis, which will respond to products with added salicylic acid and/or urea, which reduce scale, helping moisturisers to penetrate the skin.[4]

Quick Fact

Emollients should be applied at least twice a day. For someone with a very dry skin condition, patients should try to apply emollients 3-4 times per day.[4]

Applying emollients

Frequency of application

The frequency of emollient application depends on the severity of the dry skin condition. Emollients should be applied at least twice a day. For someone with a very dry skin condition, patients should try to apply emollients 3-4 times per day.[4]

Many patients underestimate the frequency with which an emollient should be applied, so it is important to emphasise to patients that frequency of emollient use should be far greater than that of other therapies they may be given.[3]

Emollients should also be used during washing and as a leave-on product after washing. When applying emollients after washing, the skin should be gently patted dry, leaving it slightly moist before applying the emollient product.[4] The emollient should then be left to absorb into the skin, not rubbed in, which may cause aggravation and itch.

In many cases a patient's lifestyle may impact on their treatment regimen, so it is important to ensure that you discuss this with patients and help them identify how to implement this into their day-to-day activities.[4]

Quick Fact

It is recommended that an adult should use at least 500g of emollient per week and a child at least 250g.[1]

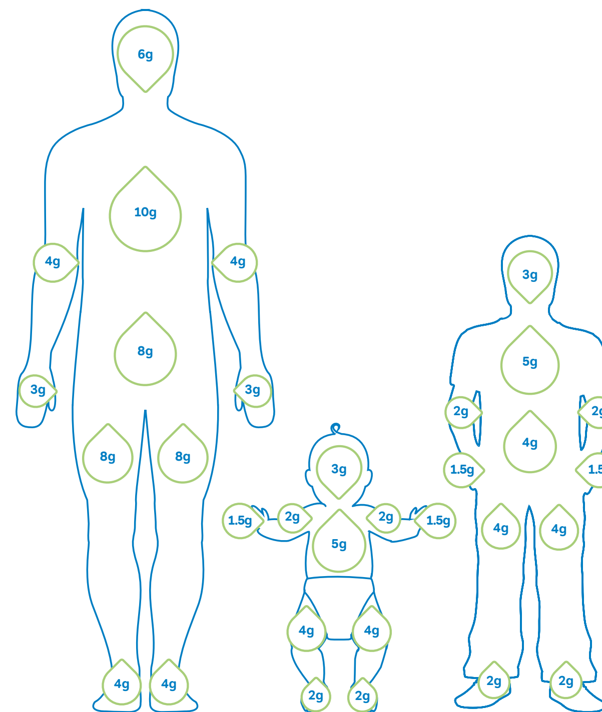
Applying emollients

Quantities

It is recommended that an adult should use at least 500g of emollient per week and a child at least 250g.[1] Emollients should be prescribed in 500g tubs and pumps to ensure patients adhere to guidance on the quantity of emollient required per application, and the frequency with which it is applied. Smaller quantities should only be prescribed as samples, although smaller containers can be useful for portable use away from the home.

Many patients underestimate the quantity of emollient that should be applied,[3] so take time to explain how much needs to be used on different parts of the body. It is also useful to quantify these amounts using well-known devices. For example, explaining that 4g is roughly one teaspoon or the equivalent of one pump from a pump dispenser.

Body maps, such as those shown below, can be used to help patients quantify the amount of emollient required for each area of their body.



Quick Fact

Emphasise to patients and carers that they should continue to use emollients even when the dry skin has improved, as their skin barrier still needs constant repair. This will help prevent flare ups in the future.[7]

Applying emollients

Application techniques

Not only is compliance with daily emollient regimens much more likely if a patient understands the therapeutic effects of emollients, but better outcomes are also more likely if the patient has been shown how to apply products properly,[4] so take time to demonstrate to your patient or their carer how to apply emollients effectively.

Key information to discuss and demonstrate to patients includes:

- Before applying an emollient, hands should be washed to avoid cross-infection
- Fingernails should be kept short and smooth in order to reduce the likelihood of accidental scratching of the skin[4]
- Emollients should be applied gently in the direction of hair growth in long, smooth strokes. Applying against the direction of hair growth can aggravate hair follicles, causing folliculitis, particularly when greasy ointments are used. It is also not recommended to rub up and down, or rub continuously until the product is absorbed as this can generate heat and aggravate itching[4]
- For application of large quantities of cream, gel or lotion, if the emollient is not in a pump dispenser, advise patients/carers to scoop out the required amount for one application with a clean spoon to reduce the possibility of contamination

Emollients should be applied all over the body as, with dry skin conditions, all of the skin is affected.[4] Emollients should be used continually, both during and between flares. It is key to explain to patients that twice-daily (minimum) emollient application is a maintenance treatment, used as a means of preventing future flares.[7]

Emollients may also be applied under tubular bandages, garments, wet wraps and wound dressings. Occluding the skin in these ways enhances the penetration and, therefore, efficacy of the emollient.[4] However, please be aware of healthcare professional guidelines around the use of paraffin-based emollients with bandages and clothing. Infected skin should also not be covered with bandages and wet wraps.[8]

Quick Fact

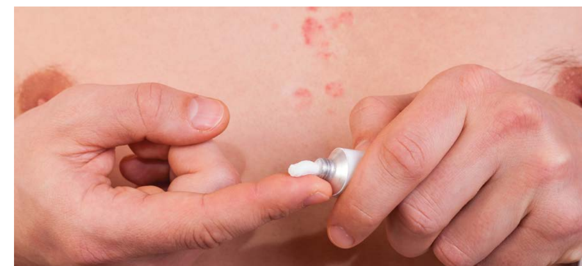
Topical steroids can be applied either before or after emollient application, ensuring a period of at least 15 minutes is left between the two applications.[7]

Applying emollients in relation to other therapeutic topical products

Topical steroids

First, it's important to establish with your patient that topical steroids should not be used to provide an emollient effect.[3] Rehydration and associated repair of the skin's protective barrier is achieved by emollient therapy, which remains the foundation for managing dry and problematic skin. Further, there is evidence to show that intensive use of emollients will reduce the need for topical steroids.[3,4]

In moderate to severe cases of some dry skin conditions such as eczema, topical steroids can be applied **either before or after** emollient application. What remains important is that a period of around 15 minutes is left between the two applications[7], so that the topical steroid is not diluted in strength by the emollient.[4]



Other topical treatments

A gap of at least 15 minutes should be left between application of topical treatments for psoriasis and emollients, including vitamin D analogues, dithranol and tar. Topical calcineurin inhibitors have precise instructions – there should be a 2-hour gap between emollients and tacrolimus (Protopic®); for pimcrolimus (Elidel®) a short gap is recommended.[9]

Consultation hints and tips

Time with patients is short, so make sure you cover the following:

1 Explain the importance of skin barrier repair and why emollients are necessary to achieve it

Emollients are first-line therapy for all dry skin conditions, including eczema, psoriasis and ichthoysis. The skin barrier requires constant repair. This is achieved by the daily use of emollients for washing and moisturising – known as Complete Emollient Therapy (CET).

2 Ask the patient which emollient(s) they are using, how much they use, and how often

The patient may already be prescribed an emollient, or range of emollients – find out which are used for washing and moisturising. Ask how much they use on a weekly basis. Do they use emollients every day as a regular routine? How many times a day are the emollients applied?

Write down for the patient how much and how often they should be applied.

3 Offer the patient a choice of emollients – more than one product may be needed for Complete Emollient Therapy (CET) to be successful

Does the patient like the emollient they are using? Does the emollient treat their dry skin? Is it cosmetically acceptable? Patients can often find one emollient to use for washing and moisturising. Sometimes more than one product may be required to achieve CET. For example a patient may prefer an ointment at night and a cream in the day; or a bath oil, lotion or cream may be preferred for washing.

Consultation hints and tips

4 Give precise instructions on emollient application, including how to use for washing, showering and bathing

Revise application techniques with the patient: cover the body with emollient using long, smooth downward strokes and let the emollient soak in. Emollients can be used as a soap substitute by applying in this way before getting into the shower or bath and washing off. After washing, reapply emollients and leave on.

5 Discuss prescription and OTC options. Prescribe in generous amounts to reduce the need for frequent pharmacy visits

Patients should be prescribed emollients as first-line therapy for dry skin conditions. The patient should ask for their emollient(s) to be added to a repeat prescription. If the patient pays prescription charges, it is more cost effective to have a prescription prepayment certificate (PPC).

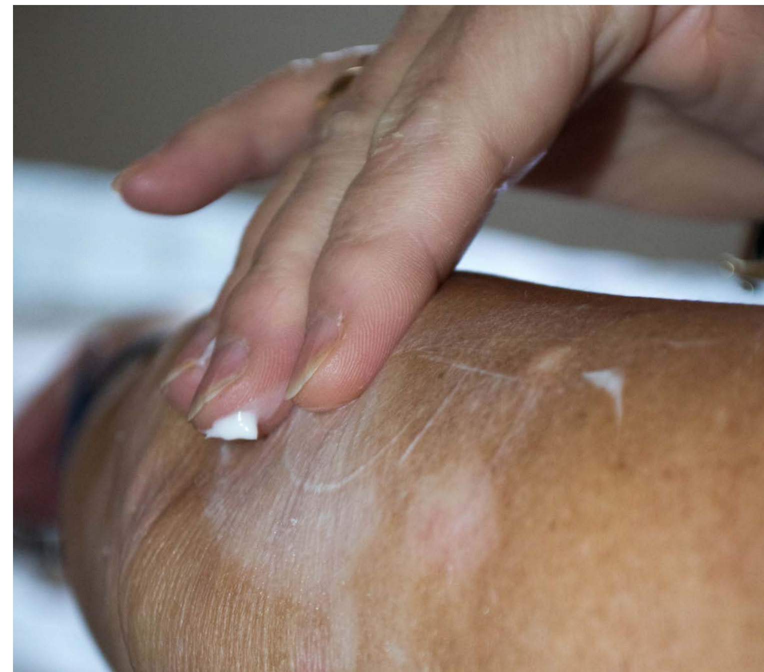
For more information on PPCs, visit: www.nhsbsa.nhs.uk/help-nhs-prescription-costs/nhs-prescription-prepayment-certificate-ppc

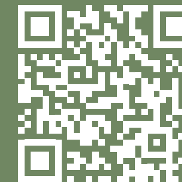
6 Review the patient in 4 weeks to assess the effectiveness of CET

Patient review is very important to assess the effectiveness of emollient therapy, check the patient is happy with their emollient choice, and revise application techniques and amounts applied. Patient review helps with adherence and ensures patient understanding of an emollient regimen.

Criteria for referral

If Complete Emollient Therapy (CET) in combination with topical treatments is not controlling your patient's skin condition, or it is becoming more severe and you are confident that they are adhering to your treatment guidelines, then referral to a dermatology specialist should be considered.





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Summary of learning

Dry skin conditions are very common and all healthcare professionals should be aware of the place of emollient therapy in managing mild-to-moderate skin conditions.

1. Patient education and patient choice are both equally important for treatment adherence and achieving the best possible outcomes for managing the symptoms of dry skin conditions
2. Complete Emollient Therapy (CET) is essential daily management for chronic inflammatory skin conditions, where dry skin is a key symptom
3. The key principle of CET is that everything that goes on the skin should be emollient based

Continuing Professional Development

This clinical learning booklet has been endorsed by the CPD Certification Scheme and can be used as a CPD resource.

If you are a GP, you can use it towards your CPD accreditation scheme and as part of your Personal Development Plan (PDP).

If you are a nurse, you can use it towards NMC revalidation for both individual and participatory learning.

Individual learning may involve you reflecting on your learning, and identifying points to improve practice in caring for patients with skin care needs – see questions below to help with this reflection.

Individual learning – enquiry-based reflection

Recall a patient case where skin symptoms or dry skin conditions were present:

1. What were the skin symptoms identified?
2. What treatment plan did you introduce for the patient?
3. How did you explain emollient use and application techniques?
4. What can you do in the future to improve patient outcomes?

Further reading

British Association of Dermatologists:

www.bad.org.uk

Primary Care Dermatology Society:

www.pcds.org.uk

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