Use of emollients in psoriasis management

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Psoriasis is a common skin problem that can cause significant distress to primary care patients, as well as representing a significant burden to healthcare resources. Often seen by community nurses, psoriasis is a condition that requires careful management as well as extensive knowledge of the different presentations. This article, the second in a series looking at the identification and treatment of psoriasis, examines the use of emollients in psoriasis treatment, focusing on the aims, benefits and efficacy of these topical treatments.

There is often a lack of understanding or confusion over the types of treatments recommended. This is where community nurses can provide valuable knowledge of the types of topical treatment available and how to use them to maximum effect (Table 1).

Awareness of the different types of topical therapies, from the ‘bland’ moisturisers through to more potent steroid-based treatments, is essential for nurses when seeking to guide patients. Each type of topical therapy has a role to play in the treatment of mild-to-severe chronic plaque psoriasis and by understanding the value of all, patients may be encouraged to commit

KEYWORDS: Dermatology ■ Psoriasis ■ Treatment ■ Emollients
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WHAT IS THE PURPOSE

of emollients?

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(Dunning, 2007).

The terms ‘emollient’ and

‘moisturisers’ are used interchangeably

within dermatology practice, but the

main difference is that emollients are lipids. These work by ‘trapping’ the skin’s natural moisture, therefore reducing water loss by evaporation; they also function as humectants, which enhance the skin’s capacity to hold water and protect it from further dehydration (Duffil, 1998; Nordqvist, 2014). Humectants tend to draw moisture from a humid environment to the skin and enhance water absorption from the epidermis (outer layer of the skin); they usually contain urea and glycerine. There are products available that act as both humectants and occluders (Penzer, 2012) — an occlusive cream or ointment will create a fine film layer over the skin therefore preventing evaporation (Duffil, 1998). Thicker products with a higher grease content are ideal for occlusion, trapping in the skin’s natural moisture.

There are several benefits to using emollients (Figure 2). While visually, cosmetic improvement can be aided by the smoother, less scaled appearance of the skin, emollients also reduce cracking or fissuring of the skin and can ease itch (pruritis) (Tucker, 2016). Often, itch is directly linked with dry skin, resulting in a natural response to scratch, which in turn can harm the skin’s surface and provide an ideal opportunity for infection (Davis, 2003).

Emollients have few side-effects, although contact dermatitis can occasionally develop if the patient is sensitive to specific ingredients in a particular product. Other side-effects include (British Dermatological Nursing Group [BDNG], 2012):

Folliculitis (minor infection of the hair follicles) due to poor application (i.e. against the direction of the hair)

Slipping in the bath/shower due to the oil content of the product

Potential fire risk when using paraffin-based emollients.

DIFFERENCES BETWEEN TYPES OF EMOLLIENT

Emollient formulations vary, however, and different preparations will be appropriate at different times (Table 1). A complete topical therapy regimen should include a range of products to enhance the positive aspects of each treatment. Ideally, any skin care regimen should be planned to suit the patient’s lifestyle, but kept simple to enhance concordance. It may be necessary to provide the patient with a written plan to guide them in when, where and how particular emollients should be applied.

Soap substitutes

As the name suggests, this type of emollient is designed to replace soaps, shower gels and bubble baths, which can lead to deterioration of the skin by stripping its natural lipids, while the resultant increase in pH can lead to irritation and further skin damage (Kirsner and Froelich, 1998). Included in this classification

Table 1: Content and effectiveness of emollients

<table>
<thead>
<tr>
<th>Lotion</th>
<th>Cream</th>
<th>Gel</th>
<th>Ointment</th>
<th>Spray</th>
</tr>
</thead>
<tbody>
<tr>
<td>Content</td>
<td>The least oily and most water-based, meaning they are the least effective in moisturising the skin</td>
<td>Mix of water and oil</td>
<td>High oil content with humectants and glycerol</td>
<td>High oil content</td>
</tr>
<tr>
<td>Effectiveness</td>
<td>Effective short-term</td>
<td>Absorbs into the skin quickly but short-lived meaning regular application is required</td>
<td>Contains preservatives that can cause skin irritation</td>
<td>Lotions are useful for hairy areas, such as scalp and ‘weepy’ skin</td>
</tr>
</tbody>
</table>

NOTES

Practice point

Topical therapies are the first-line treatment for psoriasis and can be used alongside other forms of psoriatic treatments, including phototherapy, systemic and biologic therapies.
Doublebase™ Emollient Shower Gel
Doublebase™ Emollient Wash Gel
Isopropyl myristate 15% w/w,
Liquid paraffin 15% w/w.
Uses: Highly moisturising and protective hydrating gels for dry skin conditions. Directions: Adults, children and elderly. Use regularly, as required, as soap substitutes.

Doublebase™ Emollient Bath Additive
Liquid paraffin 65% w/w.
Uses: For the relief of dry skin conditions. Directions: Adults, children and the elderly: Add to a bath of warm water. Soak and pat dry.

Contra-indications, warnings, side effects etc:
Please refer to SPC for full details before prescribing. Do not use if sensitive to any of the ingredients. In the rare event of a reaction stop treatment. Take care not to slip if using in the bath or shower.

Package quantities, NHS prices and MA numbers:
Doublebase Shower: 200g shower pack £5.21, PL00173/0196. Doublebase Wash: 200g pump dispenser £5.21, PL00173/0402. Doublebase Bath: 500ml bottle £5.45, PL00173/0200.

Legal categories: Doublebase Shower & Doublebase Bath GSL.

MA holder:
Dermal Laboratories,
Tatmore Place, Godstone, Herts, SG4 7QR, UK.

Date of preparation:
September 2016. ‘Doublebase’ is a trademark.

Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.mhra.gov.uk.
Adverse events should also be reported to Dermal.

www.dermal.co.uk

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are lotions that contain antimicrobial properties such as chlorhexidine, triclosan and/or benzalkonium chloride, which are ideal if the patient’s skin is prone to breakdown and, therefore, at risk of infection (Flavell, 2016).

It is worth noting that the cheaper option of using aqueous cream can actually exacerbate skin conditions; while initially designed as a soap substitute to be washed off, aqueous cream is regularly used as a leave-on cream, which then acts as an irritant (Lawton, 2013). The Medicines and Healthcare products Regulatory Agency (2013) advised that aqueous cream should not be used in any format.

**Emollient bath additives**

These are generally applied to wet skin, according to the manufacturer’s instructions. For example, a warm bath using bath oil can be an effective method of moisturising the skin, on leaving the bath a fine occlusive film is left on the skin. It leaves the skin softer and therefore more receptive to other topical drug treatments (Psoriasis and Psoriatic Arthropathy Alliance [PAPAA], 2016). It is worth noting that long, hot baths can be prone to dehydrating the skin. Caution when leaving the bath is essential. When getting out of the bath/shower, it is beneficial to pat the skin dry gently and immediately apply an emollient to lock in moisture (Psoriasis Association, 2016).

**Emollient creams and ointments**

There are many formulations and brands of cream and ointment available (Table 1). Some patients will favour one over the others for a variety of reasons, including:

- Smell
- Potential for ‘stinging’
- Thickness
- Ability to reach areas of the body with the product, i.e. the back or legs.

When applying an ointment that comes in a tub, it is advisable to remove it from the tub using a spoon rather than fingers; this will help to prevent contamination and infection (Flavell, 2016).

![Image](https://example.com/image.png)

**Figure 2.** Benefits of emollients.

**CHOOSING THE CORRECT TYPE OF EMOLLIENT**

First, assessing the patient’s skin condition is vital. Community nurses should attempt to evaluate how dry, flaky or scaly the skin appears and whether it is vulnerable to breakdown. Older people’s skin is often prone to tearing and shearing and is generally more fragile due to reduced turgor (the normal rigid state of the skin’s cells) or elasticity, a natural part of the ageing process that can cause further complications such as a high risk of infection or inflammation (White, 2012).

Generally, products that are easy to apply without adding friction to the skin are most suitable, while products that come in spray format may be worth considering.

There are a couple of emollient sprays available on prescription, i.e. Dermamist® (Alliance) (10% white soft paraffin in a basis containing liquid paraffin and fractionated coconut oil, dissolved in butane) and Emolmin® (C D Medical) (50% white soft paraffin and 50% liquid paraffin, dissolved in volatile silicone, which evaporates on application to the skin) (National Eczema Society, 2016). These products are ideal for patients who are unable to reach their backs or lower legs. They contain a white soft paraffin BP in a hygienic spray can. They have many advantages, including the ease of applying an emollient so quickly, they do not feel greasy, there is no waste, and it is a simple and efficient way to apply a treatment that can often feel time-consuming. It is worth considering that as no rubbing in is needed, they are beneficial for particularly tender skin.

Patient preference is crucial in encouraging the regular use of emollients, and, as mentioned above, individuals will have their own reasons for favouring certain products, whether due to odour, greasiness, irritation, or how the product feels when it is applied directly to the skin. Some emollients can feel ‘grainy’ on the skin or may be hard to apply for very hirsute people.

If a patient’s mobility causes them problems when attempting to apply an emollient, a spray can be useful, as can ‘rollers’ that are normally used to paint behind radiators; these can be ‘loaded’ with the emollient and applied to the body. This was the author’s suggestion when first starting in dermatology 15 years ago and she has found that many patients have reported this to be an effective method of applying moisturisers to their backs. Figure 3 outlines practices that patients should avoid when adhering to an emollient therapy regimen.
the process of choosing their own emollients. The results highlighted that patients who were involved in the decision-making around their own treatment were more prepared to try different types of emollients on different body sites, were more satisfied with their eventual choice of emollient, and also had a greater understanding of why a particular emollient worked for them. Ultimately, the respondents felt that they were part of the treatment process, not just a patient being told what would work for them.

**HOW MUCH EMOLLIENT SHOULD BE USED?**

It is recognised that regular use of emollients can reduce the need for topical steroids, however, patients are often not prescribed enough emollient due to a lack of understanding or cost restrictions (Diaz, 2013). GPs will often prescribe a 500g pot of emollient to last up to a month, however, the recommended amount of emollient to be used in eczema, for example, states that an adult should apply 600g per week (250g per child) (British Association of Dermatologists [BAD] and Primary Care Dermatology Society, 2006).

As well as other dry skin conditions, psoriasis also needs to be treated with liberal applications of emollient on a regular basis, with the ideal regimen consisting of a twice-daily application to the whole body (NHS Choices, 2014).

If the patient’s hands are particularly affected, it is worth keeping pots of emollient by the bedside or beside the sofa, for example, so that it is accessible for regular use.

**APPLICATION**

To reduce the risk of folliculitis, emollients should be applied in a smooth downward stroke following the direction of hair growth, (Pringle and Penzer, 2002). Excessive ‘rubbing’ of the emollient on the skin can also create a barrier, as a vigorous rubbing action brings blood to the surface and this friction reduces the ability for the emollient to be absorbed into the skin. Towel drying should be performed gently for this reason (Penzer and Ersser, 2010). Some emollients will also become ‘gritty’ with excessive rubbing.

**Can regular ‘beauty’ creams be used?**

There is no reason cosmetic products cannot be used, if this means the patient is more inclined to moisturise. There is a higher tendency for preservatives to be added to these products, which can therefore cause irritation or contact allergies. However, if the skin is more likely to be kept hydrated and there are no complications, then they are acceptable. Often, additional treatments with active ingredients are necessary for patients with psoriasis; this will be discussed in the following article of this series.

**CONCLUSION**

Emollients are a simple form of treatment to be used when psoriasis is first diagnosed, providing an effective base from which to start management of the condition. Equally, they can be used alongside other forms of psoriasis treatment.

For community nurses, guiding patients through the various products available will be more productive than simply instructing them to use a certain product; involving patients in decision-making can encourage them to take more responsibility for their own care. Taking time to discuss the

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**Remember...**

Beauty products are not classed as emollients, but due to scent, texture and patient preference, certain products will be favoured over the ‘clinically-advised’ treatments. Providing the patient is aware that these products contain more preservatives, if it means that they are more likely to use a hydrating treatment, it is better than nothing at all. In the author’s experience, the main reason for choosing ‘normal’ moisturisers is a financial one, as costs of prescriptions can prevent patients obtaining emollients and other treatments.
mode of action and effects of different treatments with patients, as well as allowing them to try a selection of available products, will allow them to feel that they are participating in their own care, rather than being dictated to.

A full emollient regimen should include a range of products for washing the skin and managing the condition at appropriate times of the day. For example, it is recommended that a lighter topical treatment, such as a cream, is applied during the day and heavier, greasier products are used in the evening. A soap substitute can be used throughout the day when washing hands but a greasier option can be used in the shower. Encourage patients to decant their usual treatments into smaller pots for use throughout the day (PAPAA, 2016). Ultimately, community nurses should attempt to keep any emollient regimen as simple as possible.

Furthermore, Cork et al. (2003) found that intensive education regarding the use of emollients, as well as other topical treatments, resulted in patients using more moisturisers with positive improvement to the skin condition, eczema in this study. This study highlighted the value in providing a clear, patient-focused explanation and demonstration of topical treatments to the skin.

The next article in this series takes a look at topical treatments and the active ingredients that have a specific role in treating various forms of psoriasis.

**REFERENCES**


