Dermatology Subcommittee of PTAC meeting held 15 May 2012

(minutes for web publishing)

Dermatology Subcommittee minutes are published in accordance with the *Terms of Reference for the Pharmacology and Therapeutics Advisory Committee (PTAC) and PTAC Subcommittees 2008*.

Note:

- that this document is not necessarily a complete record of the Dermatology Subcommittee meeting; only the relevant portions of the minutes relating to Dermatology Subcommittee discussions about an Application or PHARMAC staff proposal that contain a recommendation are generally published.
- that any part of the minutes relating to hospital pharmaceuticals and the establishment of a national Preferred Medicines List (PML) will be released, in a complete publication with the original Hospital Pharmaceuticals Subcommittee minutes and final recommendations made by PTAC, once PTAC have reviewed each therapeutic group.

The Dermatology Subcommittee may:

(a) recommend that a pharmaceutical be listed by PHARMAC on the Pharmaceutical Schedule and the priority it gives to such a listing;
(b) defer a final recommendation, and give reasons for the deferral (such as the supply of further information) and what is required before further review; or
(c) recommend that PHARMAC decline to list a pharmaceutical on the Pharmaceutical Schedule.

These Subcommittee minutes were reviewed by PTAC at its meeting on 2 & 3 August 2012, the record of which will be available on the PHARMAC website September 2012.

Contents

1 Therapeutic Group review

Antiacne preparations

1.1 The Subcommittee noted that there had been no growth in isotretinoin prescribing since 2006. Members considered this was likely to be due to the 'bad press' relating to its adverse effects. Members noted that it was easier to prescribe isotretinoin in New Zealand than America due to the lower level of paperwork.

1.2 The Subcommittee noted that PHARMAC had established some training information relating to isotretinoin when funded access had been widened to include Vocationally Registered Medical Practitioners and Nurse Practitioners. The Subcommittee noted that it was the responsibility of the College of General Practitioners to determine the competency of individual General Practitioners.

1.3 The Subcommittee considered there was an unmet need in the antiacne market especially for pregnant patients. The Subcommittee considered that a benzoyl peroxide preparation of 2.5 to 5% would be beneficial. Members noted that there would be no reason to use a higher strength (i.e. 10%) of benzyl peroxide as it was no more effective and had greater side effects. The Subcommittee recommended that PHARMAC fund topical benzoyl peroxide preparation of 2.5 to 5% with a medium priority.

1.4 The Subcommittee considered that a topical erythromycin presentation should not be subsidised for acne vulgaris as there would be potential for the emergence of significant antibiotic resistance.

1.5 The Subcommittee considered that rosacea is often treated with lower dosages of minocycline (50 mg per day) than acne (100-200 mg per day). Members considered that minocycline was primarily used for its anti-inflammatory action for this indication. The Subcommittee considered that minocycline had a better immunomodulatory effect and had less short term side effects than doxycycline (photosensitivity and heartburn). Members noted that minocycline had a greater long term risk due to its immunological actions, than doxycycline.

1.6 Members considered that approximately 10% of the population would have rosacea at some stage during their life.

1.7 The Subcommittee **recommended** fully funding low dose minocycline for rosacea with a medium priority.

Antifungals

1.8 The Subcommittee noted the recommendation for econazole foaming solution to be fully funded for the treatment of Pityriasis versicolor. The Subcommittee considered that the foaming solution would provide a more convenient treatment option for this condition. Members noted that ketoconazole shampoo used topically was as effective as econazole foaming solution however this required patients to apply the shampoo and leave it in on the skin for five minutes prior to washing off for a period of 15 days.

1.9 The Subcommittee noted that many patients had a successful eradication of the yeast following therapy, but had not re-pigmented following hypopigmentation. The Subcommittee

noted that Pityriasis versicolor often recurred and clinicians should ensure that the patient understands that treatment may need to be repeated over a long period.

1.10 The Subcommittee **recommended** fully funding econazole foaming solution for Pityriasis versicolor with a low priority.

1.11 The Subcommittee noted the recommendation from the Anti-Infective Subcommittee for itraconazole to be available for Pityriasis versicolor. The Subcommittee **recommended** that a limit of two capsules be included if access was widened for this indication; however, this might need to be repeated over a period of time.

Wart preparations

1.12 The Subcommittee noted the proposed price increase relating to podophyllotoxin for anogenital warts. The Subcommittee **recommended** that PHARMAC staff approach the Reproductive and Sexual Health Subcommittee for advice on this product.

2 Compression hosiery and wound healing

2.1 The Subcommittee noted the request for funding of compression hosiery for venous leg ulcers. The Subcommittee noted that at this time PHARMAC was predominately interested in compression hosiery, but considered PHARMAC should also consider compression bandages in the future.

2.2 Members noted that compression hosiery would typically be used to treat venous disease and related issues in the community. The Subcommittee noted that compression hosiery was currently mostly provided for venous ulcer management and prevention, however there was an increase of use in patients with lymphatic oedema, peripheral oedema and in heart failure patients to control oedema and that these areas would likely require funding in the future. Members noted that some patients were getting compression hosiery prescribed for sclero therapy without vascular assessment to exclude arterial disease and that this was inappropriate.

2.3 Members noted that some DHBs funded treatment for patients under DHB care but community patients were responsible for the on-going costs of replacement. The Subcommittee noted that in some patients surgery was an alternative for compression hosiery; however there were strict criteria for publicly funded surgery for venous complications and many patients did not meet the criteria.

2.4 The Subcommittee noted that compliance was a significant problem with compression hosiery. Members considered that education was important as patients had to understand the benefits of wearing hosiery consistently to achieve the full benefit from therapy. Members noted that training should include information on how and when to wear the hosiery. The Subcommittee also noted that a lifestyle plan should be included in the education.

2.5 The Subcommittee considered that there should be an assessment of arterial inflow prior to consideration of compression hosiery. Members noted that compression hosiery could be detrimental if used in certain patient groups. The Subcommittee recommended that patients be initiated on compression hosiery by a multidisciplinary team which included specialist wound care nurses.

2.6 The Subcommittee considered that on average a patient would require two pairs of hosiery a year, however certain patients may require more.

2.7 The Subcommittee noted that there were two main types of compression hosiery, circular weave and flat knit. Members considered that circular weave was more appropriate for 'champagne' legs, whilst flat knit was more durable and tended to control swelling to a greater extent. Members noted that a silicone top band was preferable as it held the hosiery up and caused less pain.

2.8 The Subcommittee considered that three strengths of compression hosiery would be required, mild (18-24 mmHg), moderate (20-40 mmHg) and strong (40-60 mmHg).

2.9 The Subcommittee noted that compression hosiery usually came in open and closed toe presentations and that the open toe was preferable. Members noted that custom made hosiery was often required for patients to ensure an appropriate fit and to achieve the optimal results from compression hosiery.

2.10 The Subcommittee **recommended** funding a minimum of five sizes of each type of compression hosiery and funding the facility for custom manufacture for other patients. Members considered that compression hosiery would likely be required lifelong for patients.

2.11 The Subcommittee **recommended** listing compression hosiery on the Pharmaceutical Schedule following compression bandaging with a medium priority. Members noted that a patient with venous ulcer disease should first have compression bandaging for three to four weeks, or until the legs have reduced to a more normal size, to allow for correct/optimal measurement/fitting of the compression hosiery.