DHA TELEHEALTH CLINICAL GUIDELINES FOR VIRTUAL MANAGEMENT OF SEBORRHEIC DERMATITIS – 18

Version 2

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Health Policies and Standards Department Health Regulation Sector (2024)

INTRODUCTION

Health Regulation Sector (HRS) forms an integral part of Dubai Health Authority (DHA) and is mandated by DHA Law No. (14) of the year (2021) amending some clauses of law No. (6) of 2018 pertaining to the Dubai Health Authority (DHA), to undertake several functions including but not limited to:

- Developing regulation, policy, standards, guidelines to improve quality and patient safety and promote the growth and development of the health sector;
- Licensure and inspection of health facilities as well as healthcare professionals and ensuring compliance to best practice;
- Managing patient complaints and assuring patient and physician rights are upheld;
- Governing the use of narcotics, controlled and semi-controlled medications;
- Strengthening health tourism and assuring ongoing growth; and
- Assuring management of health informatics, e-health and promoting innovation.

The DHA Telehealth Clinical Guidelines aim to fulfil the following overarching DHA Strategic Priorities (2026):

- Pioneering Human-centered health system to promote trust, safety, quality and care for patients and their families.
- Make Dubai a lighthouse for healthcare governance, integration and regulation.
- Leading global efforts to combat epidemics and infectious diseases and prepare for disasters.

- Pioneering prevention efforts against non-communicable diseases.
- Become a global digital health hub.
- Foster healthcare education, research and innovation.

ACKNOWLEDGMENT

The Health Policy and Standards Department (HPSD) developed this Guideline in collaboration with Subject Matter Experts and would like to acknowledge and thank these health professionals for their dedication toward improving quality and safety of healthcare services in the Emirate of Dubai.

Health Regulation Sector

Dubai Health Authority

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EXECUTIVE SUMMARY

Telehealth is based on Evidence Based Practice (EBP) which is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of the individual patient. It means integrating individual clinical expertise with the best available external clinical evidence and guidelines from systematic research.

EBP is important because it aims to provide the most effective care virtually, with the aim of improving patient outcomes. As health professionals, part of providing a professional service is ensuring that practice is informed by the best available evidence.

This guideline is presented in the format comprising of clinical history/symptoms, differential diagnosis, investigations and management. Identification of 'Red Flags' or serious conditions associated with the disease is an essential part of this telehealth guideline as it aids the physician to manage patients safely and appropriately by referrals to ER, family physicians or specialists for a face to face management.

The terms "dermatitis" and "eczema" are frequently used interchangeably. When the term "eczema" is used alone, it usually refers to atopic dermatitis (atopic eczema). "Eczematous" also connotes some scaling, crusting, or serous oozing as opposed to mere erythema. The term "dermatitis" is typically used with qualifiers (e.g., "contact dermatitis") to describe several different skin disorders.

Eczematous dermatoses are common, representing approximately 10 to 30% of dermatologic consultations across different populations and ethnic groups. Specific types of eczematous

dermatitis are more common in some age groups. As an example, atopic dermatitis is far more common in children than in adults, whereas asteatotic eczema and nummular eczema are typically seen in older adults.

Most common types of eczematous dermatoses are:

- Seborrheic Dermatitis
- Atopic Dermatitis
- Contact Dermatitis
- Juvenile Plantar Dermatosis
- Stasis Dermatitis
- Asteatotic Eczema
- Dyshidrotic Eczema
- Nummular Eczema

DEFINITIONS/ABBREVIATIONS

Virtual Clinical Assessment: Is the evaluation of the patient's medical condition virtually via telephone or video call consultations, which may include one or more of the following: patient medical history, physical examination and diagnostic investigations.

Patient: The person who receives the healthcare services or the medical investigation or treatment provided by a DHA licensed healthcare professional.

ABBREVIATIONS

DHA	:	Dubai Health Authority
EBP	:	Evidence Based Practice
ER	:	Emergency Room
KOH	:	Potassium Hydroxide
PUVA	:	Psoralen and Ultraviolet A
SLE	:	Systemic Lupus Erythematosus

1. BACKGROUND

1.1. Seborrheic dermatitis has a biphasic incidence, occurring in infants between the ages of 2 weeks and 12 months and, later, during adolescence and adulthood. The prevalence of clinically significant seborrheic dermatitis is approximately 3%, with peak prevalence in the third and fourth decades. Men are affected more frequently than women.

2. SCOPE

2.1. Telehealth services in DHA licensed Health Facilities.

3. PURPOSE

3.1. To support the implementation of Telehealth services for patients with complaints of Seborrheic Dermatitis in Dubai Health Authority (DHA) licensed Health Facilities

4. APPLICABILITY

4.1. DHA licensed physicians and health facilities providing Telehealth services.

4.2. Exclusion for Telehealth services are as follows

4.2.1. Emergency cases where immediate intervention or referral is required.

4.2.2. Prescribe Narcotics, Controlled or Semi-Controlled medications.

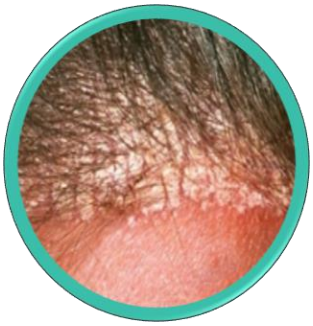
5. RECOMMENDATION

5.1. Virtual Clinical Assessment

5.1.1. Clinical History

The cause of seborrheic dermatitis is not known. Seborrheic dermatitis is not a disease of the sebaceous glands nor is the rate of sebum excretion increased in patients with seborrheic dermatitis. However, sebaceous glands appear to be necessary for the development of seborrheic dermatitis as indicated by the predilection for body sites with increased numbers of sebaceous glands and larger sebaceous glands (face, scalp, upper trunk, external auditory meatus, and anogenital area).

a. Scalp



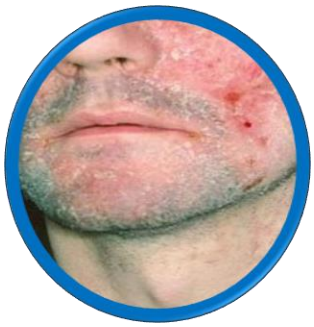
The mildest and most common form of scalp seborrheic dermatitis is dandruff, also known as pityriasis sicca, in which the scalp shows fine, white, diffuse scaliness without underlying erythema.

Dandruff may be asymptomatic or accompanied by mild pruritus.

More severe forms of scalp seborrheic dermatitis present with visible inflammation, consisting of patchy, orange to salmon colored or grayish plaques covered with yellowish, greasy scales (pityriasis steatoides), mostly over the temporoparietal area or with concretions of scale around hair shafts (pityriasis amiantacea). Lesions may extend to the postauricular areas, where they often develop fissures,

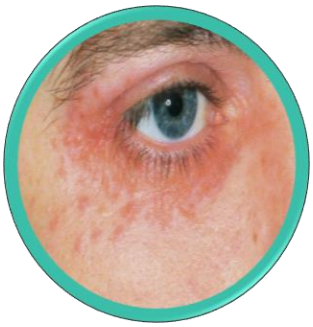
oozing, and crusting, and to the outer canal and concha of the ear, sometimes with marked pruritus and superinfection (otitis externa).

b. Face



Facial lesions favor the forehead below the hairline, the eyebrows and glabella, and the nasolabial folds. They may extend to the cheeks and malar areas in a butterfly distribution. The mustache and beard area are frequently involved in men with facial hair. Shaving helps with treatment and control of the disease.

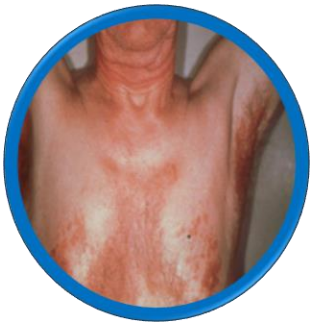
c. Periocular



Blepharitis with redness of the free margin of the eyelids and yellow crusting between the eyelashes may be the sole manifestation of seborrheic dermatitis or may accompany its more classic distribution.

d. Trunk

Five patterns of truncal involvement have been described



- Moist, erythematous intertrigo of the axillae, inframammary folds, umbilicus, & genitocrural area
- The "petaloid pattern," consisting of polycyclic, finely scaly, thin plaques over the sternum or interscapular area
- Annular or arcuate, round to oval, slightly scaly plaques on the trunk, sometimes with hypopigmented central clearing, known as "seborrheic eczematids"
- The pityriasiform pattern mimicking pityriasis rosea, comprised of 5 to 15 mm, oval-shaped, scaly lesions distributed along the skin tension lines
- The psoriasiform pattern with larger red, rounded plaques, covered with thicker scales

5.1.2. Clinical Course

Seborrheic dermatitis is a chronic, relapsing condition that may go on for decades. It tends to worsen with stress and during the cold and dry winter months. It tends to improve during the summer months, probably from sun exposure, although it may be precipitated by psoralen plus ultraviolet

A (PUVA) therapy. The available treatments do not cure seborrheic dermatitis and must be repeated or continued intermittently to prevent recurrence.

5.1.3. Diagnosis

The diagnosis of seborrheic dermatitis is usually made clinically based on the appearance and location of the lesions. This can be done by:

a. Virtual video consultation

b. Viewing pictures sent by the patient

6. RED FLAGS

6.1. Non-blanching rash in an unwell patient

6.2. Areas of rapidly worsening, painful eczema

6.3. Possible fever, lethargy or respiratory distress

6.4. Clustered blisters consistent with early-stage cold sores

6.5. Punched-out erosions (circular, depressed, ulcerated lesions) usually 1–3 mm that are uniform in appearance (these may coalesce to form larger areas of erosion with crusting)

6.6. Recurring infections

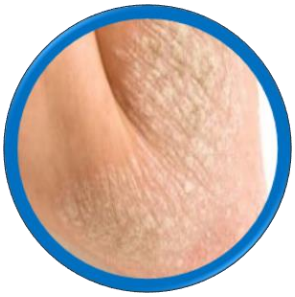
6.7. Spreading from broken skin (such as venous leg ulcers)

6.8. Recent tick bite (especially if in a known geographical risk area for Lyme disease)

6.9. Pregnancy

7. DIFFERENTIAL DIAGNOSIS

7.1. Psoriasis



Psoriasis is the main condition in the differential diagnosis of seborrheic dermatitis in adolescents and adults. Sometimes the two diseases may coexist, and the term "sebopsoriasis" has been given to those cases where the distinction cannot be made. Usually, in Psoriasis:

7.1.1. Lesions are sharply demarcated and erythematous

7.1.2. The scales are more abundant and silvery white

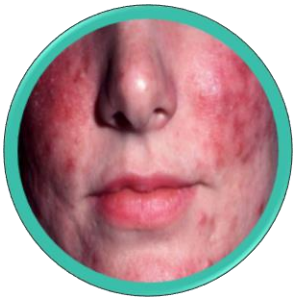
7.1.3. In most cases the extensor areas such as the elbows and knees are involved, although the lesions can occur in the body folds (inverse psoriasis)

7.1.4. Characteristic nail changes as well as the presence of arthritis or a positive family history may help establish the diagnosis of psoriasis

7.1.5. Arthritis

7.1.6. Positive family history may help establish the diagnosis of psoriasis

7.2. Rosacea



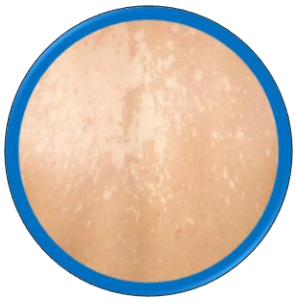
Rosacea is another condition that commonly targets the face and sometimes coexists with seborrheic dermatitis. In contrast with seborrheic dermatitis, rosacea shows a

predominance of telangiectasia and papulo-pustules, with frequent involvement of the nose, malar, and perioral areas and minimal or no scaliness.

7.3. Allergic contact dermatitis

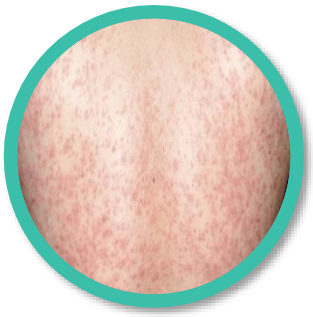
Allergic contact dermatitis may be suspected in patients with seborrheic dermatitis that does not respond to standard therapy, especially if pruritus is the predominant symptom. Allergic contact dermatitis may occur concurrently or be a complication of seborrheic dermatitis in patients allergic to components of topical medications for seborrheic dermatitis or regular skin and hair care products. This condition will be discussed in detail in another clinical guidance

7.4. Tinea versicolor



On the trunk, petaloid lesions of seborrheic dermatitis may be mistaken for tinea versicolor, which usually lacks erythema.

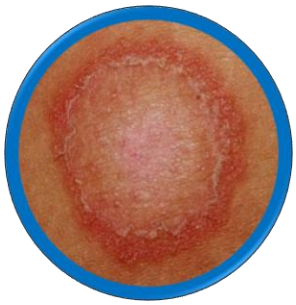
7.5. Pityriasis rosea



Pityriasis rosea is distinguished from seborrheic dermatitis by its abrupt onset, presence of a herald patch, and resolution within a few weeks. The pityriasiform variant of seborrheic dermatitis should be suspected when lesions appear more progressively, persist for more than three

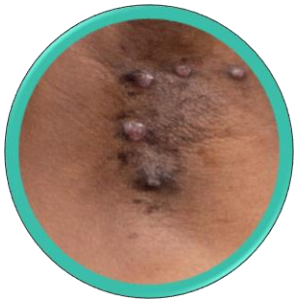
months, and are accompanied by lesions on areas usually spared by pityriasis rosea (the face and intertriginous areas).

7.6. Tinea corporis



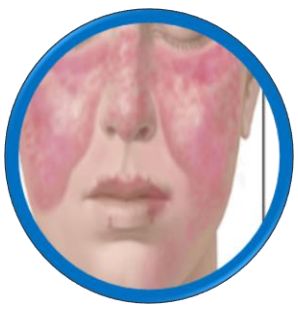
Annular or arciform seborrheic dermatitis lesions on the trunk can be confused with tinea corporis. Tinea corporis can be ruled out by negative potassium hydroxide (KOH) microscopic examination and negative fungal culture and this will warrant a referral

7.7. Secondary syphilis



Secondary syphilis can trigger widespread pityriasiform or psoriasiform eruptions that can be mistaken for seborrheic dermatitis. Additional signs such as palmoplantar and mucosal lesions or peripheral adenopathy should be looked for, and appropriate serologic testing ordered when indicated and hence will need referral to the specialist dermatologist

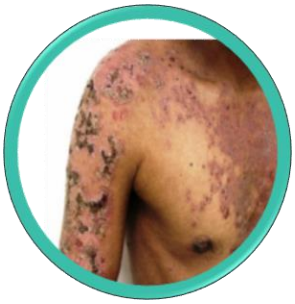
7.8. Lupus erythematosus



Seborrheic dermatitis of the face may be mistaken for the butterfly eruption of acute systemic lupus erythematosus (SLE) or the discoid plaques of cutaneous LE. The acute eruption of SLE rarely involves the nasolabial sulcus or

crosses the bridge of the nose. Discoid lesions exhibit atrophy and sometimes scarring, along with adherent scales that may have "carpet tacking" on their undersurface (spiny projections that plug dilated follicular openings). Histologic examination and serologic testing for antinuclear autoantibodies should be performed to confirm the diagnosis and hence a referral to specialist dermatologist is required.

7.9. Pemphigus foliaceous



Pemphigus foliaceous is characterized by erythema, scaling, painful erosions, and crusting that first appear on the face and scalp and later involves the chest and back. Histology, direct immunofluorescence, and the measurement of circulating autoantibodies against desmoglein establish the diagnosis and hence a referral to specialist dermatologist is required.

8. MANAGEMENT

Refer to APPENDIX 1 for the Virtual Management of Seborrheic Dermatitis Algorithm.

Seborrheic dermatitis is a chronic condition. The main goal of therapy is to clear the visible signs of the disease and reduce associated symptoms, such as erythema and pruritus. Repeated or long-term maintenance treatment is often necessary. Management usually will include patient advice and pharmacological treatment.

8.1. Patient advice:

8.1.1. Avoid using or touching whatever might have caused your rash

8.1.2. Protect the skin from anything that might irritate it or cause an allergy. For example, wear gloves if need to work with harsh soaps.

8.1.3. Try using soothing skin products to help with the itching and discomfort. Things that might help include:

a. Unscented, thick moisturizing cream or petroleum jelly

b. A special kind of bath called an oatmeal bath

8.1.4. Avoid direct sunlight

8.1.5. Soften and remove scales from your hair. Apply mineral oil or olive oil to the scalp. Leave it in for an hour or so. Then comb or brush the hair and wash it.

8.1.6. Wash the skin regularly. Rinse the soap completely off the body and scalp. Avoid harsh soaps and use a moisturizer.

8.1.7. Avoid styling products. Stop using hair sprays, gels and other styling products while on treatment.

8.1.8. Avoid skin and hair products that contain alcohol. These can cause the disease to flare up.

8.1.9. Wear smooth-textured cotton clothing. This helps keep air circulating around the skin and reduces irritation.

8.1.10. If patient has a beard or mustache, shampoo facial hair regularly. Seborrheic dermatitis can be worse under mustaches and beards. Shampoo with 1% ketoconazole daily until symptoms improve. Then switch to shampooing once a week. Or shaving might ease the symptoms.

8.1.11. Gently clean the eyelids. If the eyelids show signs of redness or scaling, wash them each night with baby shampoo and wipe away scales with a cotton swab. Warm or hot compresses also may help.

8.1.12. Gently wash the baby's scalp. If the infant has cradle cap, wash the scalp with nonmedicated baby shampoo once a day. Gently loosen the scales with a small, soft bristled brush before rinsing out the shampoo. If scaling persists, first apply mineral oil to the scalp for a couple of hours.

8.2. Pharmacological Treatment

The available treatments include topical antifungal agents, topical anti-inflammatory agents, and several topical agents with nonspecific antimicrobial, anti-inflammatory, or keratolytic properties. Oral antifungal agents may be a therapeutic option in patients with moderate to severe seborrheic dermatitis that is not adequately controlled with topical therapies.

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option in patients with moderate to severe seborrheic dermatitis that is not adequately controlled with topical therapies.

8.2.1. Topical antifungals

Topical antifungal agents like ketoconazole 2% applied once or twice daily is well established in the treatment of seborrheic dermatitis of the scalp and face

8.2.2. Topical anti-inflammatory agents

Topical corticosteroids are widely used for the treatment of seborrheic dermatitis because they reduce inflammation, erythema, and pruritus. Topical calcineurin inhibitors (tacrolimus and pimecrolimus) may be used as an alternative to topical corticosteroids because of their anti-inflammatory properties and lack of adverse effects associated with prolonged use of topical corticosteroids (e.g., skin atrophy, telangiectasia). Refer to APPENDIX 2 for comparison of representative topical corticosteroid preparations (classified according to US system)

8.2.3. Other topical agents

Topical agents available over the counter in various vehicles for the treatment of seborrheic dermatitis include selenium sulfide, lithium succinate and gluconate, zinc pyrithione, salicylic acid and coal tar.

8.2.4. Oral antifungal agents

Oral antifungal agents including itraconazole, ketoconazole, fluconazole, and terbinafine, may be a treatment option for seborrheic dermatitis involving multiple body areas and for recalcitrant dermatitis that is not adequately controlled with topical therapies. However, evidence supporting their use is limited.

8.3. Seborrheic dermatitis of the scalp

8.3.1. For patients with mild seborrheic dermatitis of the scalp who have diffuse, fine desquamation without inflammation (dandruff), an antifungal shampoo is recommended. Antifungal shampoos include ketoconazole 2%, ciclopirox 1%, zinc pyrithione 1% and selenium sulfide 2.5% shampoo. Five to 10 mL of shampoo should be left on for three to five minutes before rinsing off as follows:

a. Ketoconazole shampoo should be used twice a week for two to four weeks in the treatment phase.

b. Ciclopirox shampoo: Apply ~5 mL to wet hair; lather and leave on hair and scalp for ~3 minutes; rinse. May use up to 10 mL for longer hair. Repeat twice weekly for 4 weeks; allow a minimum of 3 days between applications; if no improvement after 4 weeks of treatment, re-evaluate diagnosis

8.3.2. Subsequently, the use of the medicated shampoo once a week may be helpful to prevent relapse. Minor adverse effects, such as irritation and/or burning sensation, are common with antifungal shampoo. Patients sometimes complain that their shampoo is no longer effective. Given that some strains of Malassezia eventually become resistant to azole antifungals, it may be wise to effectuate, every few weeks to months, a rotation among shampoos based on different molecules.

8.3.3. For patients with moderate to severe seborrheic dermatitis of the scalp who have scale, inflammation, and pruritus, an antifungal shampoo (e.g., ketoconazole 2% shampoo) in combination with a high-potency topical corticosteroid is recommended, in a formulation (lotion, spray aerosol, or foam) of patient choice. Topical corticosteroids can be used daily for two to four weeks

8.3.4. The addition of a salicylic acid shampoo to the above regimen may be helpful for patients with thick scalp.

8.4. Seborrheic dermatitis of the face

8.4.1. For patients with seborrheic dermatitis of the face, a low-potency topical corticosteroid cream, a topical antifungal agent (ketoconazole 2% cream, other azole creams, or ciclopirox cream, or a combination of the two is recommended.

8.4.2. The topical corticosteroid cream is applied to the affected areas once or twice daily only until symptoms subside to avoid potential adverse effects associated with prolonged use of topical corticosteroids on the face.

8.4.3. Topical calcineurin inhibitors (tacrolimus 0.1% ointment and pimecrolimus 1% cream) may be used as an alternative to topical corticosteroids for the treatment of facial seborrheic dermatitis. For men with seborrheic dermatitis of the face who have mustaches and beards, ketoconazole 2% shampooing of the facial hair daily until remission and then once per week is suggested. A low-potency corticosteroid can be added to the initial treatment to control inflammation and itching.

8.5. Seborrheic dermatitis of the trunk and intertriginous areas

8.5.1. Treatment options include:

a. Topical antifungal agents

b. Topical corticosteroid creams

c. Combination of the two

8.5.2. A low-potency topical corticosteroid cream should be used in the intertriginous areas; medium potency topical corticosteroids can be used for seborrheic dermatitis involving the chest or the upper back. The topical corticosteroid cream is applied to the affected areas once or twice daily only until symptoms subside to avoid potential adverse effects.

8.5.3. Alternative topical antifungal agents include ketoconazole 2% cream, other azole creams, and ciclopirox cream. Topical antifungal agents are applied to affected areas once or twice daily until symptoms subside. Adverse effects are uncommon with topical antifungal agents.

8.6. Patient follow up calls:

After prescribing medication a follow up call should be done to assess patient response to treatment.

9. REFERRAL CRITERIA

9.1. Refer to Family Physician/ Specialist Dermatologist

9.1.1. Severe or refractory seborrheic dermatitis

9.1.2. Coexistent seborrheic dermatitis and rosacea

9.1.3. Seborrheic blepharitis

9.1.4. Seborrheic dermatitis in immunocompromised patients

9.1.5. Psychosocial problems related to atopic eczema

9.1.6. Non-blanching Rash in an unwell patient

9.1.7. Areas of rapidly worsening, painful eczema

9.1.8. Possible fever, lethargy or respiratory distress (possibly to be referred to ER)

9.1.9. Clustered blisters consistent with early-stage cold sores

9.1.10. Punched-out erosions (circular, depressed, ulcerated lesions) usually 1–3 mm that are uniform in appearance (these may coalesce to form larger areas of erosion with crusting)

9.1.11. Recurring infections

9.1.12. Spreading from broken skin (such as venous leg ulcers)

9.1.13. Recent tick bite (especially if in a known geographical risk area for Lyme disease)

9.1.14. Pregnancy

REFERENCES

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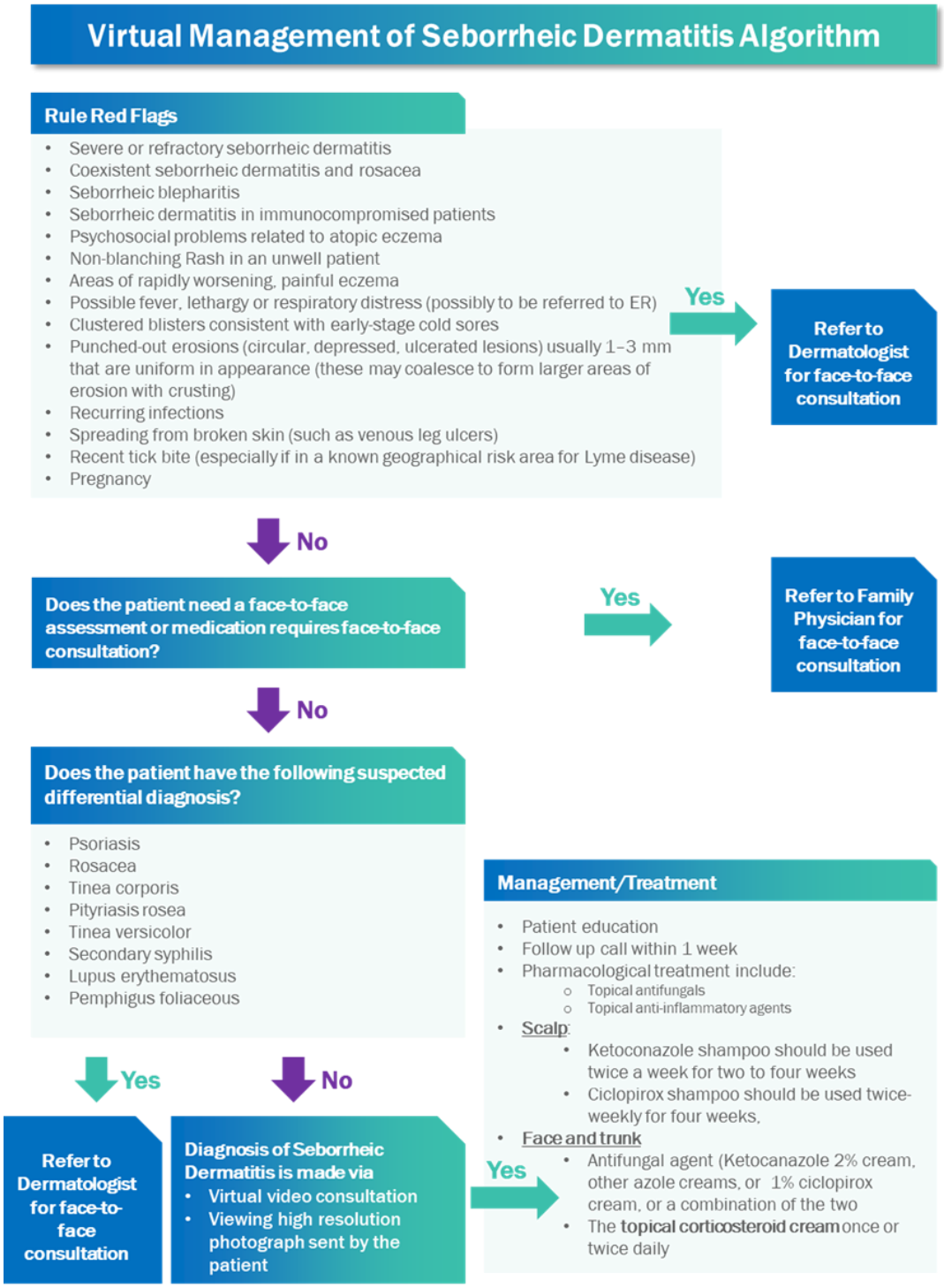
APPENDICES

APPENDIX 1 – VIRTUAL MANAGEMENT OF SEBORRHEIC DERMATITIS ALGORITHM



APPENDIX 2 – COMPARISON OF REPRESENTATIVE TOPICAL CORTICOSTEROID PREPARATIONS

(Classified According To The US System)

Potency group	Corticosteroid	Type/form	Trade name	Available strength %
Super-high potency (group 1)	Betamethasone dipropionate, augmented	Ointment, optimized	Diprolene	0.05
		Lotion	Diprolene	0.05
		Gel		0.05
	Clobetasol propionate	Ointment	Temovate	0.05
		Cream	Temovate	0.05
		Cream, emollient base	Temovate E	0.05
		Gel	Temovate	0.05
		Lotion	Clobex	0.05
		Foam aerosol	Olux-E	0.05
		Foam aerosol (scalp)	Olux	0.05
		Shampoo	Clobex	0.05
		Solution (scalp)	Temovate, Cormax	0.05
		Spray aerosol	Clobex	0.05
	Diflucortolone valerate	Ointment, oily cream	Nerisone Forte	0.3
	Fluocinonide	Cream	Vanos	0.1
	Flurandrenolide	Tape (roll)	Cordran	4 mcg/cm^2
	Halobetasol propionate	Ointment	Ultravate	0.05
		Cream	Ultravate	0.05
		Lotion	Ultravate	0.05
High potency (group 2)	Amcinonide	Ointment	Cyclocort¶, Amcort¶	0.1
	Betamethasone dipropionate	Ointment	Diprosone	0.05
		Cream, augmented formulation (AF)	Diprolene AF	0.05
	Clobetasol propionate	Cream	Impoyz	0.025
	Desoximetasone	Ointment	Topicort	0.25
		Cream	Topicort	0.25
		Spray	Topicort	0.25

		Gel	Topicort	0.05
	Diflorasone diacetate	Ointment	ApexiCon¶, Florone¶	0.05
		Cream, emollient	ApexiCon E	0.05
	Fluocinonide	Ointment	Lidex¶	0.05
		Gel	Lidex¶	0.05
		Cream anhydrous	Lidex¶	0.05
		Solution	Lidex¶	0.05
	Halcinonide	Ointment	Halog	0.1
		Cream	Halog	0.1
	Halobetasol propionate	Lotion	Bryhali	0.01
High potency (group 3)	Amcinonide	Cream	Cyclocort¶, Amcort¶	0.1
		Lotion	Amcort¶	0.1
	Betamethasone dipropionate	Cream, hydrophilic emollient	Diprosone	0.05
	Betamethasone valerate	Ointment	Valisone¶	0.1
		Foam	Luxiq	0.12
	Desoximetasone	Cream	Topicort LP	0.05
	Diflorasone diacetate	Cream	Florone¶	0.05
	Diflucortolone valerate	Cream, oily cream, ointment	Nerisone	0.1
	Fluocinonide	Cream aqueous emollient	Lidex-E¶	0.05
	Fluticasone propionate	Ointment	Cutivate	0.005
	Mometasone furoate	Ointment	Elocon	0.1
	Triamcinolone acetonide	Ointment	Kenalog¶	0.5
		Cream	Triderm, Aristocort HP¶	0.5
Medium potency (group 4)	Betamethasone dipropionate	Spray	Sernivo	0.05
	Clocortolone pivalate	Cream	Cloderm	0.1
	Fluocinolone acetonide	Ointment	Synalar¶	0.025
	Flurandrenolide	Ointment	Cordran	0.05
	Hydrocortisone valerate	Ointment	Westcort	0.2
	Mometasone furoate	Cream	Elocon	0.1
		Lotion	Elocon	0.1

		Solution	Elocon¶	0.1
	Triamcinolone acetonide	Cream	Kenalog¶	0.1
		Ointment	Kenalog¶	0.1
		Ointment, hydrous	Trianex	0.05
		Aerosol spray	Kenalog	0.2 mg per 2 second spray
		Dental paste	Oralone	0.1
Lower-mid potency (group 5)	Betamethasone dipropionate	Lotion	Diprosone	0.05
	Betamethasone valerate	Cream	Beta-Val, Valisone¶	0.1
	Desonide	Ointment	DesOwen, Tridesilon¶	0.05
		Gel	Desonate	0.05
	Fluocinolone acetonide	Cream	Synalar¶	0.025
	Flurandrenolide	Cream	Cordran	0.05
		Lotion	Cordran	0.05
	Fluticasone propionate	Cream	Cutivate	0.05
		Lotion	Cutivate	0.05
	Hydrocortisone butyrate	Ointment	Locoid	0.1
		Cream	Locoid, Locoid Lipocream	0.1
		Lotion	Locoid	0.1
		Solution	Locoid	0.1
	Hydrocortisone probutate	Cream	Pandel	0.1
	Hydrocortisone valerate	Cream	Westcort¶	0.2
	Prednicarbate	Cream, emollient	Dermatop	0.1
		Ointment	Dermatop	0.1
	Triamcinolone acetonide	Lotion	Kenalog¶	0.1
		Ointment	Kenalog¶	0.025
Low potency (group 6)	Alclometasone dipropionate	Ointment	Aclovate	0.05
		Cream	Aclovate	0.05
	Betamethasone valerate	Lotion	Beta-Val, Valisone¶	0.1
	Desonide	Cream	DesOwen, Tridesilon¶	0.05

		Lotion	DesOwen, LoKara	0.05
		Foam	Verdeso	0.05
	Fluocinolone acetonide	Cream	Synalar¶	0.01
		Solution	Synalar¶	0.01
		Shampoo	Capex	0.01
		Oil (scalp)Δ	Derma-Smoothe/FS Scalp	0.01
		Oil (body)Δ	Derma-Smoothe/FS Body	0.01
	Triamcinolone acetonide	Cream	Kenalog¶, Aristocort¶	0.025
		Lotion	Kenalog¶	0.025
Least potent (group 7)	Hydrocortisone (base, ≥2%)	Ointment	Hytone	2.5
		Cream	Hytone, Nutracort¶	2.5
		Lotion	Hytone, Ala Scalp, Scalacort	2.5 or 2
		Solution	Texacort	2.5
	Hydrocortisone (base, <2%)	Ointment	Cortaid, Hytone, Nutracort	1
		Cream	Cortaid, Hytone, Synacort	1
		Gel	Cortizone 10 gel	1
		Lotion	Aquanil HC, Sarnol-HC, Cortizone 10	1
		Spray	Cortaid	1
		Solution	Cortaid, Noble, Scalp relief	1
		Ointment	Cortaid	0.5
		Cream	Cortaid	0.5
	Hydrocortisone acetate	Cream	MiCort-HC	2.5
		Lotion	Nucort	2
	Hydrocortisone acetate with pramoxine 1% combination	Ointment	Pramosone	1 or 2.5
		Cream	Pramosone, Analpram-HC	1 or 2.5

Lotion	Pramosone, Analpram-HC	1 or 2.5
Aerosol foam	Epifoam	1