

## DERMOL®

---

### 1. Product Name

---

Dermol, 0.05% w/w, cream.

Dermol, 0.05% w/w, ointment.

---

### 2. Qualitative and Quantitative Composition

---

Each 1 g of cream or ointment contains 0.5 mg of clobetasol propionate.

Excipients with known effect include:

Dermol Ointment: Propylene glycol

Dermol Cream: Cetostearyl alcohol, Propylene glycol and Chlorocresol.

For the full list of excipients, see section 6.1.

---

### 3. Pharmaceutical Form

---

The water-miscible cream and the paraffin-based ointment are both white in appearance.

---

### 4. Clinical Particulars

---

#### 4.1 *Therapeutic indications*

Treatment of resistant dermatoses such as psoriasis (excluding widespread plaque psoriasis), recalcitrant eczemas, lichen planus and discoid lupus erythematosus and other skin conditions which do not respond satisfactorily to less active steroids.

#### 4.2 *Dose and method of administration*

##### **Dose**

Creams are especially appropriate for moist or weeping surfaces. Ointments are especially appropriate for dry, lichenified or scaly lesions.

**Clobetasol propionate belongs to the most potent class of topical corticosteroids (Group IV) and prolonged use may result in serious undesirable effects (see section 4.4). If treatment with a local corticosteroid is clinically justified beyond 4 weeks, a less potent corticosteroid preparation should be considered. Repeated but short courses of clobetasol propionate may be used to control exacerbations (see details below).**

##### ***Adults, elderly and children over 1 year***

Repeated short courses of DERMOL Cream or Ointment may be used to control exacerbations.

In very resistant lesions, especially where there is hyperkeratosis, the effect of DERMOL Cream or Ointment can be enhanced, if necessary, by occluding the treatment area with polythene film. Overnight occlusion only is usually adequate to bring about a satisfactory response. Thereafter improvement can usually be maintained by application without occlusion.

If the condition worsens or does not improve within 2-4 weeks, treatment and diagnosis should be re-evaluated.

Treatment should not be continued for more than 4 weeks. If continuous treatment is necessary, a less potent preparation should be used.

The maximum weekly dose should not exceed 50gms/week.

Therapy with clobetasol should be gradually discontinued once control is achieved and an emollient continued as maintenance therapy.

Rebound of pre-existing dermatoses can occur with abrupt discontinuation of clobetasol.

### ***Recalcitrant dermatoses: patients who frequently relapse***

Once an acute episode has been treated effectively with a continuous course of topical corticosteroid, intermittent dosing (once daily, twice weekly, without occlusion) may be considered. This has been shown to be helpful in reducing the frequency of relapse.

Application should be continued to all previously affected sites or to known sites of potential relapse. This regimen should be combined with routine daily use of emollients. The condition and the benefits and risks of continued treatment must be re-evaluated on a regular basis.

### ***Special populations***

#### **Elderly**

Clinical studies have not identified differences in responses between the elderly and younger patients. The greater frequency of decreased hepatic or renal function in the elderly may delay elimination if systemic absorption occurs. Therefore the minimum quantity should be used for the shortest duration to achieve the desired clinical benefit.

#### **Renal and hepatic impairment**

In case of systemic absorption (when application is over a large surface area for a prolonged period) metabolism and elimination may be delayed therefore increasing the risk of systemic toxicity. Therefore the minimum quantity should be used for the shortest duration to achieve the desired clinical benefit.

#### **Paediatric**

Clobetasol is contraindicated in children under one year of age.

Children are more likely to develop local and systemic side effects of topical corticosteroids and, in general, require shorter courses and less potent agents than adults.

Care should be taken when using clobetasol propionate to ensure the amount applied is the minimum that provides therapeutic benefit.

Courses should be limited, if possible, to five days and reviewed weekly. Occlusion should not be used.

#### **Method of administration**

Apply thinly and gently rub in using only enough to cover the entire affected area once or twice daily until improvement occurs (in the more responsive conditions this may be within a few days), then

reduce the frequency of application or change the treatment to a less potent preparation. Allow adequate time for absorption after each application before applying an emollient.

### ***Application to the face***

Courses should be limited to five days if possible and occlusion should not be used.

Route of administration: Cutaneous

## **4.3 Contraindications**

Hypersensitivity to the active substance or to any of the excipients listed in section 6.1.

The following conditions should not be treated with clobetasol:

- Untreated cutaneous infections
- Rosacea
- Acne vulgaris
- Pruritus without inflammation
- Perianal and genital pruritus
- Perioral dermatitis.

Clobetasol is contraindicated in dermatoses in children under one year of age, including dermatitis and nappy eruptions.

## **4.4 Special warnings and precautions for use**

Cases of osteonecrosis, serious infections (including necrotizing fasciitis) and systemic immunosuppression (sometimes resulting in reversible Kaposi's sarcoma lesions) have been reported with long-term use of clobetasol propionate beyond the recommended doses (see section 4.2). In some cases, patients used concomitantly other potent oral/topical corticosteroids or immunosuppressors (e.g., methotrexate, mycophenolate mofetil). If treatment with local corticosteroids is clinically justified beyond 4 weeks, a less potent corticosteroid preparation should be considered.

Clobetasol should be used with caution in patients with a history of local hypersensitivity to other corticosteroids or to any of the excipients in the preparation. Local hypersensitivity reactions (see section 4.8) may resemble symptoms of the condition under treatment.

Manifestations of hypercortisolism (Cushing's syndrome) and reversible hypothalamic-pituitary-adrenal (HPA) axis suppression, leading to glucocorticosteroid insufficiency, can occur in some individuals as a result of increased systemic absorption of topical steroids. If either of the above are observed, withdraw the medicine gradually by reducing the frequency of application, or by substituting a less potent corticosteroid. Abrupt withdrawal of treatment may result in glucocorticosteroid insufficiency (see section 4.8).

Risk factors for increased systemic effects are:

- Potency and formulation of topical steroid
- Duration of exposure
- Application to a large surface area
- Use on occluded areas of skin (e.g. on intertriginous areas or under occlusive dressings (in infants the nappy may act as an occlusive dressing))
- Increasing hydration of the stratum corneum
- Use on thin skin areas such as the face
- Use on broken skin or other conditions where the skin barrier may be impaired
- In comparison with adults, children and infants may absorb proportionally larger amounts of topical corticosteroids and thus be more susceptible to systemic adverse effects. This is

because children have an immature skin barrier and a greater surface area to body weight ratio compared with adults.

### **Infection risk with occlusion**

Bacterial infection is encouraged by the warm, moist conditions within skin folds or caused by occlusive dressings. When using occlusive dressings, the skin should be cleansed before a fresh dressing is applied.

### **Use in psoriasis**

Topical corticosteroids should be used with caution in psoriasis as rebound relapses, development of tolerances, risk of generalised pustular psoriasis and development of local or systemic toxicity due to impaired barrier function of the skin have been reported in some cases. If used in psoriasis careful patient supervision is important.

### **Concomitant infection**

Appropriate antimicrobial therapy should be used whenever treating inflammatory lesions which have become infected. Any spread of infection requires withdrawal of topical corticosteroid therapy and administration of appropriate antimicrobial therapy.

### **Chronic leg ulcers**

Topical corticosteroids are sometimes used to treat the dermatitis around chronic leg ulcers. However, this use may be associated with a higher occurrence of local hypersensitivity reactions and an increased risk of local infection.

### **Application to the face**

Application to the face is undesirable as this area is more susceptible to atrophic changes.

If used on the face, treatment should be limited to only 5 days.

### **Application to the eyelids**

If applied to the eyelids, care is needed to ensure that the preparation does not enter the eye, as cataract and glaucoma might result from repeated exposure. If clobetasol cream or ointment enters the eye, the affected eye should be bathed in copious amounts of water.

### **Visual disturbance**

Visual disturbance has been reported with systemic and topical corticosteroid use. If a patient presents with symptoms such as blurred vision or other visual disturbances, the patient should be considered for referral to an ophthalmologist for evaluation of possible causes which may include cataract, glaucoma or rare diseases such as central serous chorioretinopathy (CSCR) which have been reported after use of systemic and topical corticosteroids.

### **Paediatric population**

In infants and children under 12 years of age, long-term continuous topical corticosteroid therapy should be avoided where possible, as adrenal suppression can occur.

Children are more susceptible to develop atrophic changes with the use of topical corticosteroids.

### ***Duration of treatment for children and infants***

Courses should be limited, if possible, to five days and reviewed weekly. Occlusion should not be used.

## **Topical steroid withdrawal syndrome**

Long term continuous or inappropriate use of topical steroids can result in the development of rebound flares after stopping treatment (topical steroid withdrawal syndrome). A severe form of rebound flare can develop which takes the form of a dermatitis with intense redness, stinging and burning that can spread beyond the initial treatment area. It is more likely to occur when delicate skin sites such as the face and flexures are treated. Should there be a reoccurrence of the condition within days to weeks after successful treatment a withdrawal reaction should be suspected. Reapplication should be with caution and specialist advice is recommended in these cases or other treatment options should be considered.

## **Excipients**

DERMOL Cream and Ointment contain propylene glycol which may cause skin irritation.

DERMOL Cream also contains:

- cetostearyl alcohol which may cause local skin reactions (e.g. contact dermatitis)
- chlorocresol which may cause allergic reactions.

DERMOL Ointment contains paraffin.

- Healthcare professionals should be aware that if DERMOL ointment comes into contact with dressings, clothing and bedding, the fabric can be easily ignited with a naked flame. Patients should be warned of this risk and advised to keep away from fire when using DERMOL Ointment.
- Instruct patients not to smoke or go near naked flames due to the risk of severe burns. Fabric (clothing, bedding, dressings etc) that has been in contact with DERMOL Ointment burns more easily and is a serious fire hazard. Washing clothing and bedding may reduce product build-up but not totally remove it.

## **4.5 Interaction with other medicines and other forms of interaction**

Co-administered medicines that can inhibit CYP3A4 (e.g. ritonavir and itraconazole) have been shown to inhibit the metabolism of corticosteroids leading to increased systemic exposure. The extent to which this interaction is clinically relevant depends on the dose and route of administration of the corticosteroids and the potency of the CYP3A4 inhibitor.

## **4.6 Fertility, pregnancy and lactation**

### **Pregnancy**

There are limited data from the use of clobetasol in pregnant women.

Topical administration of corticosteroids to pregnant animals can cause abnormalities of foetal development including cleft palate and intrauterine growth retardation (see section 5.3).

The relevance of this finding to humans has not been established. Administration of clobetasol during pregnancy should only be considered if the expected benefit to the mother outweighs the risk to the foetus. The minimum quantity should be used for the minimum duration.

### **Breast-feeding**

The safe use of clobetasol propionate during lactation has not been established.

It is not known whether the topical administration of corticosteroids could result in sufficient systemic absorption to produce detectable amounts in breast milk. Administration of clobetasol during lactation should only be considered if the expected benefit to the mother outweighs the risk to the infant.

If used during lactation, clobetasol should not be applied to the breasts to avoid accidental ingestion by the infant.

## **Fertility**

There are no data in humans to evaluate the effect of topical corticosteroids on fertility.

Clobetasol administered subcutaneously to rats had no effect upon mating performance; however, fertility was decreased at the highest dose (see section 5.3).

## **4.7 Effects on ability to drive and use machines**

There have been no studies to investigate the effect of clobetasol on driving performance or the ability to operate machinery. A detrimental effect on such activities would not be anticipated from the adverse reaction profile of topical clobetasol.

## **4.8 Undesirable effects**

Adverse drug reactions (ADRs) are listed below by MedDRA system organ class and by frequency. Frequencies are defined as: very common ( $\geq 1/10$ ), common ( $\geq 1/100$  and  $< 1/10$ ), uncommon ( $\geq 1/1,000$  and  $< 1/100$ ), rare ( $\geq 1/10,000$  and  $< 1/1,000$ ) and very rare ( $< 1/10,000$ ), including isolated reports.

### **Post-marketing data**

#### ***Infections and Infestations***

Very rare: Opportunistic infection

#### ***Immune system disorders***

Very rare: Hypersensitivity, generalised rash

#### ***Endocrine disorders***

Very rare: Hypothalamic-pituitary adrenal (HPA) axis suppression:  
Cushingoid features (e.g. moon face, central obesity), delayed weight gain/growth retardation in children, osteoporosis, hyperglycaemia/gluco-suria hypertension, increased weight/obesity, decreased endogenous cortisol levels, alopecia, trichorrhexis

#### ***Skin and subcutaneous tissue disorders***

Common: Pruritus, local skin burning/skin pain

Uncommon: Skin atrophy\*, striae\*, telangiectasis\*

Very rare: Skin thinning\*, skin wrinkling\*, skin dryness\*, pigmentation changes\*, hypertrichosis, exacerbation of underlying symptoms, allergic contact dermatitis/dermatitis, pustular psoriasis, erythema, rash, urticaria, acne

Not known: withdrawal reactions – redness of the skin which may extend to areas beyond the initial affected area, burning or stinging sensation, itch, skin peeling, oozing pustules (see section 4.4)

\* Skin features secondary to local and/or systemic effects of hypothalamic-pituitary adrenal (HPA) axis suppression.

#### ***General disorders and administration site conditions***

Very rare Application site irritation/pain

#### ***Eye disorders***

Very rare: Cataract, central serous chorioretinopathy, glaucoma.

Not known (cannot be estimated from available data): Vision, blurred (see also section 4.4)

## Reporting of suspected adverse reactions

Reporting suspected adverse reactions after authorisation of the medicine is important. It allows continued monitoring of the benefit/risk balance of the medicine. Healthcare professionals are asked to report any suspected adverse reactions <https://nzphvc.otago.ac.nz/reporting/>.

## 4.9 Overdose

### Symptoms and signs

Topically applied clobetasol may be absorbed in sufficient amounts to produce systemic effects. Acute overdosage is very unlikely to occur, however, in the case of chronic overdosage or misuse, the features of hypercortisolism may occur (see section 4.8).

### Treatment

In the event of overdose, clobetasol should be withdrawn gradually by reducing the frequency of application or by substituting a less potent corticosteroid because of the risk of glucocorticosteroid insufficiency.

For further advice on management of overdose please contact the National Poisons Information Centre (0800 POISON or 0800 764 766).

---

## 5. Pharmacological Properties

---

### 5.1 *Pharmacodynamic properties*

Pharmacotherapeutic group: Corticosteroids, very potent (group IV), ATC code: D07AD01

#### Mechanism of action

Topical corticosteroids act as anti-inflammatory agents via multiple mechanisms to inhibit late phase allergic reactions including decreasing the density of mast cells, decreasing chemotaxis and activation of eosinophils, decreasing cytokine production by lymphocytes, monocytes, mast cells and eosinophils, and inhibiting the metabolism of arachidonic acid.

#### Pharmacodynamic effects

Clobetasol propionate is a very potent topical corticosteroid with anti-inflammatory, antipruritic and vasoconstrictive properties, which is of particular value when used in short courses for conditions which do not respond satisfactorily to less active corticosteroids.

### 5.2 *Pharmacokinetic properties*

#### Absorption

Topical corticosteroids can be systemically absorbed from intact healthy skin. The extent of percutaneous absorption of topical corticosteroids is determined by many factors, including the vehicle and the integrity of the epidermal barrier. Occlusion, inflammation and/or other disease processes in the skin may also increase percutaneous absorption.

Mean peak plasma clobetasol propionate concentrations of 0.63 nanograms/mL occurred in one study eight hours after the second application (13 hours after an initial application) of 30 g clobetasol propionate 0.05% ointment to normal individuals with healthy skin. Following the application of a second dose of 30 g clobetasol propionate cream 0.05%, mean peak plasma concentrations were slightly higher than the ointment and occurred 10 hours after application.

In a separate study, mean peak plasma concentrations of approximately 2.3 nanograms/mL and 4.6 nanograms/mL occurred respectively in patients with psoriasis and eczema three hours after a single application of 25 g clobetasol propionate 0.05% ointment.

## Distribution

The use of pharmacodynamic endpoints for assessing the systemic exposure of topical corticosteroids is necessary due to the fact that circulating levels are well below the level of detection.

## Biotransformation

Once absorbed through the skin, topical corticosteroids are handled through pharmacokinetic pathways similar to systemically administered corticosteroids. They are metabolised, primarily in the liver.

## Elimination

Topical corticosteroids are excreted by the kidneys. In addition, some corticosteroids and their metabolites are also excreted in the bile.

## 5.3 Preclinical safety data

### Carcinogenesis

Long-term animal studies have not been performed to evaluate the carcinogenic potential of clobetasol propionate.

### Genotoxicity

Clobetasol propionate was not mutagenic in a range of *in vitro* bacterial cell assays.

### Fertility

In fertility studies, subcutaneous administration of clobetasol propionate to rats at doses of 6.25 to 50 micrograms/kg/day produced no effects on mating, and fertility was only decreased at 50 micrograms/kg/day.

### Pregnancy

Subcutaneous administration of clobetasol propionate to mice ( $\geq 100$  micrograms/kg/day), rats (400 micrograms/kg/day) or rabbits (1 to 10 micrograms/kg/day) during pregnancy produced foetal abnormalities including cleft palate and intrauterine growth retardation.

In the rat study, where some animals were allowed to litter, developmental delay was observed in the F1 generation at  $\geq 100$  micrograms/kg/day and survival was reduced at 400 micrograms/kg/day. No treatment-related effects were observed in F1 reproductive performance or in the F2 generation.

---

## 6. Pharmaceutical Particulars

---

### 6.1 List of excipients

DERMOL Cream also contains:

- propylene glycol,
- glycerol monostearate,
- glyceryl monostearate/ PEG stearate,
- cetostearyl alcohol,
- white beeswax,
- citric acid monohydrate,
- chlorocresol,
- sodium citrate dihydrate,
- purified water.



DERMOL Ointment also contains:

- white soft paraffin,
- propylene glycol,
- sorbitan sesquioleate.

## **6.2 Incompatibilities**

Not applicable.

## **6.3 Shelf life**

2 years (cream).

3 years (ointment).

## **6.4 Special precautions for storage**

Store at or below 25°C, out of direct sunlight.

Contents are flammable, keep away from fire, flame or heat.

## **6.5 Nature and contents of container**

Aluminium tube with HDPE/LLDPE cap. Pack-size of 30 g.

## **6.6 Special precautions for disposal and other handling**

Patients should be advised to wash their hands after applying DERMOL Cream or Ointment unless it is the hands that are being treated.

Do not use near a naked flame.

---

## **7. Medicines Schedule**

Prescription Medicine

---

## **8. Sponsor Details**

Viatrix Ltd  
PO Box 11-183  
Ellerslie  
AUCKLAND  
[www.viatrix.co.nz](http://www.viatrix.co.nz)  
Telephone 0800 168 169

---

## **9. Date of First Approval**

7 November 1991

---

## **10. Date of Revision of the Text**

01 September 2022

## Summary table of changes

Section	Summary of changes
All	Minor editorial updates
4.4	Information on Topical steroid withdrawal syndrome added
4.8	Information added on withdrawal reactions
6.1	Correction of citric acid from anhydrous to monohydrate salt.
10	New date of revision of text

Dermol® is a Viatrix company trade mark.