NHS
Cheshire and Merseyside

Clinical Commissioning Policy

CMICB_Clin054
Polymorphic light eruption treatment
Category 2 Intervention - Only routinely commissioned when specific criteria are met

Contents

Last Reviewed: May 2025
This policy statement will be reviewed 5 years from the date of the last review unless new evidence or technology is available sooner.

1. Policy statement

1.1 Polymorphic light eruption (PLE) is extremely common and can usually be managed by sun avoidance techniques and high factor sunscreens.

1.2 Where appropriate, the rash may be treated with topical corticosteroids, oral antihistamines or corticosteroids.

1.3 Narrow band UVB phototherapy (light desensitisation) is not routinely commissioned except when all of the following criteria are satisfied:

- Symptoms have occurred throughout most of the summer on a recurrent basis

AND

- The symptoms are severe causing functional impairment and significantly affect the patient's quality-of-life

AND

- Persistent and sustained attempts at primary prevention and pharmacological management (see 1.1 & 1.2 above) have all failed

AND

- The diagnosis has been confirmed by a Consultant Dermatologist who confirms that phototherapy is likely to improve the patient's PLE.

1.4 UVA (PUVA) light treatment is not routinely commissioned.

2. Exclusions

2.1 None

3. Core Eligibility Criteria

3.1 There are several circumstances where a patient may meet a 'core eligibility criterion' which means they are eligible to be referred for this procedure or treatment, regardless of whether they meet the policy statement criteria, or the procedure or treatment is not routinely commissioned.

3.2 These core clinical eligibility criteria are as follows:

- Any patient who needs 'urgent' treatment will always be treated.
- All NICE Technology Appraisals Guidance (TAG), for patients that meet all the eligible criteria listed in a NICE TAG will receive treatment.
- In cancer care (including but not limited to skin, head and neck, breast and sarcoma) any lesion that has features suspicious of malignancy, must be referred to an appropriate specialist for urgent assessment under the 2-week rule.
  NOTE: Funding for all solid and haematological cancers are now the responsibility of NHS England.
- Reconstructive surgery post cancer or trauma including burns.
- Congenital deformities: Operations on congenital anomalies of the face and skull are usually routinely commissioned by the NHS. Some conditions are considered highly specialised and are commissioned in the UK through the National Specialised Commissioning Advisory Group (NSCAG). As the incidence of some cranio-facial congenital anomalies is small and the treatment complex, specialised teams, working in designated centres and subject to national audit, should carry out such procedures.
- Tissue degenerative conditions requiring reconstruction and/or restoring function e.g. leg ulcers, dehisced surgical wounds, necrotising fasciitis.
- For patients expressing gender incongruence, further information can be also be found in the current ICB gender incongruence policy and within the NHS England gender

services programme - https://www.england.nhs.uk/commissioning/spec-services/npc-crg/gender-dysphoria-clinical-programme/

4. Rationale behind the policy statement

4.1 Polymorphic light eruption (PLE) is an extremely common condition, which, in the vast majority of cases, can be prevented by sun avoidance and application of appropriate sunscreens or treatment with corticosteroids and/or antihistamines.

4.2 Narrow band UVB is indicated for the small cohort of people who do not respond to the above. UVB is also preferred to UVA because of less toxicity and greater efficacy.

4.3 This policy statement has been reviewed and agreed by a consultant dermatologist.

5. Summary of evidence review and references

5.1 Polymorphic Light Eruption (PLE) is the most common autoimmune-mediated photodermatosis which predominantly affects young females and with an overall prevalence of up to 20%. [1] It typically presents with pruritic papular or papulovesicular lesions on sun-exposed skin from spring to autumn. In most people, these can be prevented by using high factor topical sunscreens and a gradual increase in exposure to sunlight during this time period. However, in some, the sunlight exposure can result in florid PLE with an itchy, burning red rash which can cause embarrassment and restriction of outdoor activities during the holiday season.[2]

5.2 According to the British Association of Dermatologists[1], topical or oral corticosteroids as well as antihistamines may help to reduce the itching. In a few patients, desensitisation to the effects of the sunlight (i.e. phototherapy) may be considered. This is a way of increasing the skin's resistance by treating it with increasing doses of ultraviolet light in a special phototherapy cubicle. Treatment is given in the early Spring so the skin is ready to cope with the summer sun. Unfortunately, the protective effect wears off in the winter and may need to be repeated every Spring. Other treatment modalities include:- azathioprine, ciclosporin, hydroxychloroquine, b-carotene, nicotinamide, omega-3 fatty acids, antioxidants and Escherichia coli infiltrate.[3]

5.3 Phototherapy is available in two main formats. The first is psoralen augmented ultraviolet – A (PUVA) light therapy. This is the more traditional approach and requires administration of oral or topical psoralens before exposure to UVA.[3] The second is narrowband UV light (NB–UVB) which is generally considered before PUVA because of its lower risk of photocarcinogenesis, no risk of nausea or other side effects which are normally associated with psoralen. There is also the added benefit of no requirement to use eye protection following exposure.

5.4 Although NB–UVB is now preferred to PUVA, paradoxically perhaps, either of these treatments can still provoke polymorphic light eruption reactions of their own.[4,5] Despite this, desensitisation with predominantly NB – UVB is considered effective and well tolerated.[5] There is good evidence of superior efficacy of NB – UVB compared to PUVA [3] and the former is now in more common use.[6] However, NB – UVB still requires between 15 – 18 sessions in total, administered 3 times per week with cautious dose increments and the potential need for prophylactic corticosteroids in severe PLE patients.

[1] https://www.bad.org.uk/shared/get-file.ashx?id=117&itemtype=document

5.5 The British Association of Dermatologists and the British Photodermatology Group have produced guidelines which recommend that NB – UVB should be considered before PUVA although the latter is still an option if UVB has failed or has previously triggered an eruption. PUVA should also be considered before other systemic treatments.[3] However, these recommendations are based on low quality evidence.

5.6 In conclusion, polymorphic light eruption (PLE) is an extremely common condition, which, in the vast majority of cases, can be prevented by sun avoidance and application of appropriate sunscreens or treatment with corticosteroids and/or antihistamines. A minority of patients may require referral to a dermatologist for consideration of phototherapy (NB – UVB most likely) or the other systemic therapies. None of the neighbouring CCGs have a similar policy.

REFERENCES

1. Gong Y-Y, Rong W, Li L, et al. Successful treatment of polymorphic light eruption with UVA rush hardening: A report of 5 cases. *Photodermatology, photoimmunology & photomedicine* 2020;**36**(4):322-23. doi: 10.1111/phpp.12553
2. Combalia A, Fernández-Sartorio C, Fustà X, et al. Successful Short Desensitization Treatment Protocol with Narrowband UVB Phototherapy (TL-01) in Polymorphic Light Eruption. *Actas dermo-sifiliograficas* 2017;**108**(8):752-57. doi: 10.1016/j.ad.2017.04.004
3. Ling TC, Clayton TH, Crawley J, et al. British Association of Dermatologists and British Photodermatology Group guidelines for the safe and effective use of psoralen–ultraviolet A therapy 2015. *British Journal of Dermatology* 2016;**174**(1):24-55. doi: https://doi.org/10.1111/bjd.14317
4. Gruber-Wackernagel A, Hofer A, Legat F, et al. Frequency of occurrence of polymorphic light eruption in patients treated with photohardening and patients treated with phototherapy for other diseases. *Photodermatology, photoimmunology & photomedicine* 2019;**35**(2):100-05. doi: 10.1111/phpp.12429
5. Aslam A, Fullerton L, Ibbotson SH. Phototherapy and photochemotherapy for polymorphic light eruption desensitization: a five-year case series review from a university teaching hospital. *Photodermatology, photoimmunology & photomedicine* 2017;**33**(4):225-27. doi: 10.1111/phpp.12310
6. Ling TC. Phototherapy of the photodermatoses. *Journal of the Dermatology Nurses' Association* 2020;**12**(2)

6. Advice and Guidance

6.1 Aim and Objectives

6.1.1 This policy aims to ensure a common set of criteria for treatments and procedures across the region. This is intended to reduce variation of access to NHS services in different areas and allow fair and equitable treatment for all patients.

6.1.2 This policy relates to the commissioning of interventions which optimise clinical effectiveness and represent value for money.

6.1.3 This document is part of a suite of policies which the Integrated Care Board (ICB) uses to drive its commissioning of healthcare. Each policy is a separate public document in its own right but should be considered alongside all the other policies in the suite as well as the core principles outlined.

6.1.4 At the time of publication, the evidence presented per procedure/treatment was the most current available.

6.1.5 The main objective for having healthcare commissioning policies is to ensure that:
- Patients receive appropriate health treatments
- Treatments with no or a very limited evidence base are not used; and

- Treatments with minimal health gain are restricted.

6.1.6 Owing to the nature of clinical commissioning policies, it is necessary to refer to the biological sex of patients on occasion. When the terms 'men' and 'women' are used in this document (unless otherwise specified), this refers to biological sex. It is acknowledged that this may not necessarily be the gender to which individual patients identify.

6.2 Core Principles

6.2.1 Commissioning decisions by ICB Commissioners are made in accordance with the commissioning principles set out as follows:

- Commissioners require clear evidence of clinical effectiveness before NHS resources are invested in the treatment.
- Commissioners require clear evidence of cost effectiveness before NHS resources are invested in the treatment.
- Commissioners will consider the extent to which the individual or patient group will gain a benefit from the treatment.
- Commissioners will balance the needs of an individual patient against the benefit which could be gained by alternative investment possibilities to meet the needs of the community.
- Commissioners will consider all relevant national standards and consider all proper and authoritative guidance.
- Where a treatment is approved Commissioners will respect patient choice as to where a treatment is delivered, in accordance with the 'NHS Choice' framework.
- Commissioning decisions will give 'due regard' to promote equality and uphold human rights. Decision making will follow robust procedures to ensure that decisions are fair and are made within legislative frameworks.

6.3 Individual Funding Requests (Clinical Exceptionality Funding)

6.3.1 If any patients are excluded from this policy, for whatever reason, the clinician has the option to make an application for clinical exceptionality. However, the clinician must make a robust case to the Panel to confirm their patient is distinct from all the other patients who might be excluded from the designated policy.

6.3.2 The ICB will consider clinical exceptions to this policy in accordance with the Individual Funding Request (IFR) Governance Framework consisting of: IFR Decision Making Policy; and IFR Management Policy available on the C&M ICB website: https://www.cheshireandmerseyside.nhs.uk/your-health/individual-funding-requests-ifr/

6.4 Cosmetic Surgery

6.4.1 Cosmetic surgery is often carried out to change a person's appearance to achieve what a person perceives to be a more desirable look.

6.4.2 Cosmetic surgery/treatments are regarded as procedures of low clinical priority and therefore not routinely commissioned by the ICB Commissioner.

6.4.3 A summary of Cosmetic Surgery is provided by NHS Choices. Weblink: Cosmetic procedures - NHS

6.5 Diagnostic Procedures

6.5.1 Diagnostic procedures to be performed with the sole purpose of determining whether or not a restricted procedure is feasible should not be carried out unless the eligibility criteria are met, or approval has been given by the ICB or GP (as set out in the approval process of the patients responsible ICB) or as agreed by the IFR Panel as a clinically exceptional case.

6.5.2 Where a General Practitioner/Optometrist/Dentist requests only an opinion the patient should not be placed on a waiting list or treated, but the opinion given and the patient returned to the care of the General Practitioner/Optometrist/Dentist, in order for them to make a decision on future treatment.

6.6 **Clinical Trials**

6.6.1 The ICB will not fund continuation of treatment commenced as part of a clinical trial. This is in line with the Medicines for Human Use (Clinical Trials) Regulations 2004 and the Declaration of Helsinki which stipulates that the responsibility for ensuring a clear exit strategy from a trial, and that those benefiting from treatment will have ongoing access to it, lies with those conducting the trial. This responsibility lies with the trial initiators indefinitely.

7. Monitoring and Review

7.1 This policy remains in force until it is superseded by a revised policy or by mandatory NICE guidance or other national directive relating to this intervention, or to alternative treatments for the same condition.

7.2 This policy can only be considered valid when viewed via the ICB website or ICB staff intranet. If this document is printed into hard copy or saved to another location, you must check that the version number on your copy matches that of the one published.

7.3 This policy may be subject to continued monitoring using a mix of the following approaches:
- Prior approval process
- Post activity monitoring through routine data
- Post activity monitoring through case note audits

7.4 This policy will be kept under regular review, to ensure that it reflects developments in the evidence base regarding effectiveness and value.

8. Quality and Equality Analysis

8.1 Quality and Equality Impact Analyses have been undertaken for this policy at the time of its review.

9. Clinical Coding

9.1 **Office of Population Censuses and Surveys (OPCS)**
S12.1 Ultraviolet A light therapy to skin
S12.2 Ultraviolet B light therapy to skin
S12.3 Combined photochemotherapy and ultraviolet A light therapy to skin

9.2 **International classification of diseases (ICD-10)**
L56.4 Polymorphous light eruption

Document Control

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Version History
Version 0.2 – October 2021 – The amended policy statement is effectively the same as current, but it gives the prescriber more helpful guidance in the initial management, is based on best evidence and the layout is more logical. Change the title to “Narrow band UVB for the treatment of polymorphic light eruption” or “Polymorphic Light Eruption (PMLE) Treatment”. This excludes PUVA which is rarely used these days, is considered less effective but would still be open to an exceptional funding request.
Version 0.3 – April 2025 – following feedback from LMCs during public engagement exercise, wording in section 1.3 has been amended to provide clarity regarding timeframes & incorrect numbering references have been amended in section 1.3