Disclosures

- None
Outline

- Rosacea
- Adult acne
- Cases

"It's just one zit. I'll put a little cream on it and it'll clear right up."
Rosacea

- Definition: chronic cutaneous inflammatory condition characterized by varying degrees of vascular hyperactivity, such as central facial erythema, papules, pustules, flushing, skin thickening, and ocular irritation.
- 4 subtypes:
  - Erythrotelangiectatic (ET)
  - Papular/pustular
  - Phymatous
  - Ocular
- All subtypes can overlap, one is not a precursor to another.
- Triggers: heat, sun, spicy food, alcohol, stress (extremes).
- Seborrheic dermatitis can be a coexisting condition and confounder.
Rosacea – ET type
Rosacea – papulopustular type
Rosacea – phymatous type (rhinophyma)
Rosacea – mixed subtypes
Management

- **For ALL**
  - Sunscreen, mild soaps, emollients
  - Avoidance of triggers and barrier preservation are key
  - Avoid steroids and irritants
  - Manage seborrheic dermatitis gently
  - Consider ophthalmology co-management depending on ROS
Management

- **ET**
  - Vasoconstrictive topicals (brimonidine, oxymetazoline)
  - Oral therapies anecdotal (clonidine, propranolol)
  - Laser options (most commonly pulsed dye laser)

- **Papular**
  - Topical or oral antibiotics or antiinflammatories (metronidazole, clindamycin, or azelaic acid gel)
  - Other topicals (ivermectin, calcineurin inhibitors) emerging
  - Acne therapies (benzoyl peroxide, salicylic acid, retinoids) often irritating

- **Phymatous**
  - Above measures in addition to surgical options, esp if airway involvement

- **Ocular**
  - Oral antibiotics, ophthalmology input for topicals/lubricants, strict sun protection
ADULT ACNE
Adult acne

- Definition: acne that develops or continues after age 25, more common in women
- Acne is marked by sebaceous gland disease, initiated by a follicular plug and manifesting as comedones, papules, pustules, cysts, and scarring depending on the severity of the inflammatory response, comorbidities, and genetic predisposition
Adult acne

- Cosmetica, excorié(e) common in adults, esp women
- In women, hormonal dysregulation may trigger
- In men, trunk/neck often involved, often a continuation of prior acne or part of hidradenitis or rosacea overlap
Adult female acne

- Lower face/beard distribution most common
- Triggers can be diverse, including pregnancy, PCOS, perimenopause, genetic factors, diet, medications
- Progesterone-containing birth control methods or medications worsen acne
- Identify causal factors, as traditional acne therapies can be underwhelming, and propensity for scarring high
Adult female acne
Adult female acne
Management

- Traditional oral contraceptive pills, spironolactone, and Rx topicals are most helpful
  - OCP per pt’s comorbidities and pregnancy plans
  - Spironolactone side effect profile milder than in traditional hypertension regimens (ex: 50 mg BID), no labs necessary
  - Low dosage oral or topical antibiotics for once daily use (ex: dapsone gel, clindamycin gel, doxycycline 50 mg qday), benzoyl peroxide use in shower as tolerated
  - Topical retinoid for night use (ex: tretinoin or adapalene cream or gel) to whole face
  - Mild cleansers otherwise, avoid irritants, avoid picking
- Isotretinoin an option if causative factors addressed
Management

- **Suspicion for polycystic ovarian syndrome (PCOS)?**
  - Most common cause of hyperandrogenism
  - Acne, hirsutism, irregular menstrual cycles, infertility, female pattern alopecia, and other signs of insulin resistance
  - Often shows no abnormalities on laboratory tests
  - Clinical suspicion should drive therapy
    - Oral contraceptive pill, spironolactone, metformin, and weight loss
    - Multidisciplinary management often necessary
  - Further workup indicated for severe, recalcitrant, or sudden onset of symptoms
    - Exclude virilizing tumors, congenital adrenal hyperplasia, Cushing disease/syndrome, hyperprolactinemia, acromegaly, and pregnancy
Management

- **Diet?**
  - Controversial

- **OTC explosion**
  - Kits, systems, devices (brushes, lasers) often expensive, require careful review of data for efficacy
  - Avoid over-treatment/intricate regimens, often irritating and/or triggers more acne

- **Acne as medication side effect?**
  - Avoid progesterone-only medications if possible
  - Others: topical or oral steroids, testosterone, anabolic steroids, halogens, antiepileptics, anti-TBs, lithium, cyclosporine, EGFRi (acne-like)
Case 1

- A 53 y/o male patient comes to you with years of easy flushing, prominent blood vessels, and pimples on the face. He has tried various OTC acne therapies, cortisone cream, and his wife helps him apply make-up before he goes to work. He is very frustrated.
What do you do next?

- What is this?
- What are his treatment options?
- What should he avoid?
Rosacea

- Rosacea is not acne (most acne topicals too irritating)
- For the papules, oral or topical antibiotics or antiinflammatories are appropriate
- For the redness, pulsed dye laser or vasoconstrictive topicals helpful
- For flushing, anecdotal reports abound, but avoidance of triggers is paramount, rule out systemic disease
- Sunscreen and barrier control daily is required
- Avoid irritants
The plan

- Pt will avoid topical steroids
- He will use mild soaps, sunscreen-containing moisturizer daily mixed with brimonidine gel, bland emollients at night, and we added doxycycline 50 mg daily to the regimen for a 2-3 month trial
- Avoidance of triggers was explained
- 3 months later, he only required sunscreen and topical metronidazole gel daily as needed
- He is considering pulsed dye laser treatment in the future
Case 2

- A 30 y/o female comes to your office, frustrated that she is getting severe acne on her lower face, the likes of which she had never experienced as a teenager. Her birth control method is a hormone-eluting IUD, inserted 3 months ago. She tried various OTC topical acne therapies with no improvement.
What do you do next?

- What is the likely cause of her acne?
- What are her treatment options?
- How should you counsel her?
Adult female acne

- The hormone-eluting IUD exacerbates her acne (progesterone analog)
- OCP, spironolactone, topical therapies are options depending on comorbidities, side effects/reliability with OCP, and pt pregnancy plans
The plan

- We switched her IUD to a copper form in conjunction with her gynecologist.
- In meantime, we initiated spironolactone 50 mg twice daily, added benzoyl peroxide wash in shower, and added tretinoin 0.025% cream nightly to the whole face.
- The dosage of spironolactone was decreased over time as the progesterone IUD effect diminished.
- (She did not want an OCP, so she will risk spotting and breast tenderness with spironolactone.)
Case 3 (extra)

- A 25-year-old woman with a history of rosacea presents with a several-month history of a new rash consisting of tiny clusters of pink papules, pustules, and dry scaly patches near the nose and mouth.
What do you do next?

- Is this acne or rosacea?
- What are her treatment options?
- What should she avoid?
Periorificial dermatitis

- Idiopathic facial eruption, most commonly occurring in women and children, some with a history of acne or rosacea
- Tiny pink papules, pustules, erythema, and scaly patches appear near the mouth, nose, and eyes
- Exacerbating factors include topical or inhaled steroids, irritating cosmetics, fluoridated toothpastes, and ultraviolet light
- Management includes avoidance of the above measures, topical anti-inflammatory and antibiotic medications, sun protection, and possible oral antibiotic therapy
The plan

- She will discontinue all topical steroids and any irritating grooming products
- She will use a sunscreen-containing moisturizer daily and bland emollient at night
- We added doxycycline 50 mg daily with food for 3 weeks
- Sometimes in the wintertime, this flares for her
American Acne and Rosacea Society (AARS)

- https://acneandrosacea.org
Conclusions

- Rosacea is not acne, and its triggers include environmental extremes and vasodilatory effects. Sun protection and barrier protection are paramount, and rosacea subtypes are managed in various capacities based on severity of patient symptoms.

- Adult acne is a common problem esp in women, and its management more heavily trends toward hormonal therapy compared to teenage acne. Comorbidities and medication triggers should be explored.

- Call us, we’re nice 😊
Thank you!

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References