STANDARD TREATMENT WORKFLOW (STW)

ACNE and ROSACEA

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Standard Treatment Workflow (STW)

ACNE AND ROSACEA

ICD-10-L70-71

Acne is a common dermatosis of adolescence and often persists into adulthood.

Rosacea often mimics acne but has distinct management issues.

WHEN TO SUSPECT?

ACNE
- Pustules/ papules
- Painful nodules containing pus
- Cysts
- Scarring
- Sites: Face and/or trunk
- Symptoms: None/pain/prickling

ROSAECA
- Persistent erythema, telangiectasia
- Papules and pustules in absence of comedones
- Sites: Convergent of the face (cheeks, forehead, nose, chin)
- Bulbous enlargement of nose, rhinophyma
- Symptoms: Sensitive to hot and spicy food, and emotional triggers

USEFUL INFORMATION
- Acne and rosacea can co-exist
- It is important to treat acne early so that scarring is minimal
- In Indian scenario, consider "topical corticosteroid induced acne and rosacea"

ADDITIONAL INFORMATION FOR CLINICAL EVALUATION

- History of cosmetica/ topical steroid use: as such or in combination with creams/liniments
- History of recent drug intake: Drug-induced acne
- History of cutaneous oil/ hormonal changes

DIFFERENTIALS OF ROSACEA
- Connective tissue diseases like lupus erythematosus or dermatomyositis:
  Photosensitivity, presence of Raynaud's phenomenon, arthralgia, muscle weakness, dyspnea, dysphagia, oral/genital ulcers, abdominal pain, frothy urine, seizures, or allopurinol.
- Steroid induced rosacea: Photosensitivity, hypertrichosis, atrophy and pigmentary changes, prior history of topical corticosteroid application for a long time.
- Seborrheic dermatitis: Predominantly involvement of nasolabial folds, eyebrows with erythema and greasy scales.
- Contact dermatitis or atop dermatitis: Significant itching, excoriation and crusting.

ACNE VARIANTS AND DIFFERENTIALS
- Acne conglobata: Severe scarring on trunk and face with nodular lesions
- Drug induced acne: (with corticosteroids/ antiandrogenic drugs/ antitubercular drugs/ vitamin and protein supplements): Extensive, monomorphic papules and papules in absence of comedones
- Topical corticosteroid induced acne: Hypertrichosis, shaggy, skin, pigmented changes with papulo-pustules
- Hormonal acne: Adult female with seborrhea, hirsutism, androgenetic alopecia, insulin resistance and PCOS, praemunarial flare, menstrual irregularities and prominent involvement of mandibular area
- Occupational acne: Predominantly comedones with history of exposure to cutting oil/ petroleum products
- Acne excoriata: Predominantly picked and excoriated lesions with prominent pigmentation.
- Acne fulminans: Fever and bone pains in association with severe necrotic acne lesions
- Hidradenitis suppurativa: Association to consider when axillae/graves/ other flexures are involved with polymorphic comedones/ pustules/ nodules/ abscesses/ scarring

DIFFERENTIALS OF ACNE

- Stop unsupervised topical corticosteroid and cosmetic use on face
- Clean face with soap/ mild cleanser
- Mild/moderate acne: 2.5% Benzoyl peroxide gel or 0.025% Tretinoin cream or 1% Adapalene gel with Clindamycin gel for local application, at night time
- Moderate acne, not controlled with topical: Cap Roxycycline 100mg OD for minimum of 4-6 weeks
- Severe nodulocystic acne: Isotretinoin treatment at tertiary level after documentation of normal lipid profile and liver functions
- Acne fulminans: start Prednisolone 0.5-1 mg/kg/day and refer to higher center
- Hormonal acne: Treatment with anti-androgens at tertiary level
- Drug induced acne: Stop offending drugs if possible; treatment as per severity as detailed above

MANAGEMENT

ACNE

- Avoid triggers (alcohol, caffeine, spicy food, cosmetics, topical steroids)
- Photo-protection
- Mild papulopustular rosacea: topical Azelaic acid (15%) or Metronidazole (1%) or Ivermectin (1%)
- Moderate disease, not controlled with topical: Cap Doxycycline 100mg OD for minimum of 4-6 weeks
- Severe/ phymatous: external rosacea: refer to a specialist for low dose Isotretinoin/Interventional treatment

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