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UNDERSTANDING ROSACEA

Dermatologist, Dr Stefanie Williams explains the different types of rosacea and the misconceptions surrounding treatment

Rosacea is much more common than we may think because many people with rosacea are wrongly diagnosing themselves as having adult acne. We're seeing increasing numbers of rosacea patients in my clinic. Of course, this could be because I'm known nationwide for being a rosacea expert, but I think it could also be because people are becoming more aware of the existence of the condition; and are increasingly seeking help whether they think they might be experiencing rosacea or adult acne.

My typical rosacea patient is between 35 and 50 years of age, female and Caucasian; but I have also seen many people with darker skin types who have rosacea, and also many men with rosacea. It's not just women, but they're certainly the biggest patient cohort. The correct diagnosis can be difficult; both patients and non-dermatologist practitioners can be confused. For example, the patient might have been for a high street facial treatment; and if they have presented with pimples, they may have been misdiagnosed with acne. Another common misdiagnosis in these situations is being told that they have 'dehydrated', sensitive skin and should use rich, calming moisturisers. This, of course, is likely to trigger more inflammatory lesions.

Similarly, there's perioral dermatitis (POD) which is another chronic papulopustular facial skin condition. POD is not as common as acne and rosacea, but certainly, there are many patients who are misdiagnosed either with it, or as not having it. I think POD is a diagnosis that not many practitioners ever think of, but some rosacea patients might actually have POD, or vice versa, and the same with acne, so it is important to keep an open mind with regards to differential diagnosis. Another common scenario I see in clinic are patients who present with an overlap of rosacea and seborrheic dermatitis, also known as seb derm. These are particularly difficult to treat, as treatment for one condition may aggravate the other. This overlap of rosacea and seb derm is also diagnostically tricky, as on certain days one condition may be predominant, while on a different day, the other clinical aspect may be more visible. This is where a dermatologist with special interest in rosacea comes in handy!

Types of rosacea

Vascular rosacea

Vascular rosacea is very common and often occurs together with other forms of rosacea. If a patient has inflammatory rosacea (i.e. pustules and/or papules), they often also have vascular features at the same time. And then there is a group of patients who just have vascular rosacea without any inflammatory lesions. Vascular features include telangiectasias, fixed background erythema, and the coming and going of flushing. This is most commonly seen in the mid-face, but it can be broadly anywhere on the face, and in some patients it can extend to the neck and chest, but this is in a minority of cases.

Spicy food, alcohol and other environmental influences can often be a trigger for flushing, but we must be careful to distinguish that these are just triggers, and not the actual cause for the disease. So, vascular rosacea is not actually caused by drinking alcohol for example, contrary to a widespread myth, as the cause for rosacea is a genetic predisposition. But, it is true that certain types of alcohol may trigger a flare-up in certain people with red wine being a common culprit. Certain food, such as spicy dishes can also have the same effect of triggering a flare-up, as well as the sun, hot environments, cold winds or rapid changes in temperature, such as during the winter when you may come into a warm room or house having been outside. Those with vascular rosacea who like to ski may find that they get a flare-up in that environment.

Inflammatory rosacea

This is often mistaken for adult acne, due to its papulopustular nature. You've got the papules, which are the raised inflamed 'bumps', and the pustules, have a little pus-filled head on top. Typically, there

are no comedones (whiteheads or blackheads) in rosacea, as you would see with acne. However, some patients do have overlapping conditions and may present with both rosacea and adult acne, in which case you may see comedones in a rosacea patient. Commonly, if a patient has inflammatory rosacea, they also often have vascular rosacea features, too.

Phymatous rosacea

This is not as common as inflammatory and vascular rosacea subtypes. You will note a characteristic thickening of the skin, often on the nose, and the pores appear enlarged. The thickened area of skin can less commonly affect other areas of the face as well and may be noted on the cheeks or the forehead. This rosacea subtype is more common in men than in woman, with rhinophyma of the nose being the most common localisation. In rosacea, in particular the phymatous type, there is often an impaired lymphatic drainage in the skin.

Ocular rosacea

This is more common than you might think, as patients don't usually volunteer information about eye issues, because the symptoms may be mild or the patient thinks the eye issues are not related to their skin condition. However, if you consistently ask all your rosacea patients, '*Do you often have irritated, gritty-feeling eyes?*' and '*Do your eyelids sometimes get inflamed?*', many will respond in the affirmative. Ocular rosacea includes blepharitis - visible inflammation of the eyelids, or a frequent feeling of having something in the eyes, a gritty, dry, irritated feeling. It's not always visible, but rosacea patients often have an association with frequent irritation of the eye.

Neurogenic rosacea

One of the main features of neurogenic rosacea is a strong sense of discomfort with the skin. They may report a constant stinging or burning feeling on the skin, sometimes even going as far as noting throbbing or painful sensations. Neurogenic rosacea patients often don't just suffer with flushing, but often report the flushing as being painful and extremely uncomfortable. Patients with neurogenic rosacea may also have neurological or psychiatric comorbidities, and often benefit from a mental health referral.

Treatment for rosacea

The treatment approach for vascular and inflammatory rosacea is fundamentally different.

Inflammatory rosacea treatment

Inflammatory rosacea, i.e. papules and/or pustules, greatly benefits from anti-inflammatory prescription treatment, either topical or in more severe cases systemic. There are a variety of effective anti-inflammatory prescription creams available. In my clinical experience, a combination treatment with two prescription creams, with one used in the morning, and another in the evening, is much more effective than the more commonly prescribed monotherapy.

Topical Metronidazole 0.75% (e.g., Rosex®) is a staple topical anti-inflammatory antibiotic for rosacea management. It is often the first treatment prescribed by doctors in general practice. Unfortunately, GPs tend to prescribe the gel formulation, rather than a cream base, which in my experience often causes compliance issues and subsequently disappointing results, as the gel is less well tolerated. That's because the skin of rosacea patients is already inflamed and feeling tight and uncomfortable, which can be aggravated by a (more drying) gel formulation. I often see patients who have been treated by their GP already, and all too often they tell me that they have already tried Rosex® and '*it didn't work*'. However, simply changing them over from the Metronidazole gel to the cream, often does the trick, even more so if used in combination with a second topical. I often prescribe topical Metronidazol in combination with topical Azelaic Acid 15% (Finacea® gel). As this can be a little irritating, if introduced too quickly, it should be tapered in slowly and used as tolerated.

If a patient has very dry, irritated skin, then I would usually avoid using Finacea® gel and instead consider a different anti-inflammatory prescription cream such as Ivermectin 1% cream (Soolantra®). This reduces Demodex mites on the skin, but also has anti-inflammatory properties. I find Soolantra® cream particularly helpful for rosacea with follicular plugging, which can be a sign of an overgrowth of Demodex mites in the pores.

In other cases, I may prescribe topical Clindamycin for rosacea patients, such as Dalacin T lotion®, which is usually very well tolerated, even for very sensitive skin. However, I strongly recommend avoiding the 'solution' version of Dalacin T, which is alcohol-based, and not suitable for rosacea patients, as it is too irritating.

Most rosacea patients report dry, sensitive skin, but there are some rosacea cases with more seborrhoeic skin, in which case a topical prescription retinoid, such as Tretinoin (e.g., Ketrel® cream) or Adapalene (Differin® cream) are very useful adjuncts. Again, I highly recommend using the cream formulation of Differin®, not the gel base, as the gel adds unnecessary irritancy. As with any retinoid introduction, but even more so in rosacea patients, it's imperative to taper them in slowly and use them as tolerated, even if that's just 2 or 3 times per week.

In the case of inflammatory rosacea, combination treatment regimens are, in my experience, far superior for achieving clearance compared to using a single option. An example treatment programme may include:

- Rosex® cream in the morning
- Finacea® gel in the evening, as tolerated
- Alternatively, Soolantra® cream in the evening, if follicular plugging is visible

If a three-month programme of topical treatments for mild-to-moderate inflammatory rosacea is not successful, then we often need to add systemic treatments. One of the options is to prescribe Doxycycline at a low dose of only 40mg (Efracea® tablets). This is a slow-release, low dose Doxycycline used for its anti-inflammatory properties, rather than as an antibiotic as such. In most patients, this low dose is enough to achieve a good therapeutic response, in my experience. However, in those few patients not responding to this low dose, a higher dosed oral Tetracycline may be considered. It's important in my opinion not to prescribe oral antibiotics on their own, but always in combination with topical treatment in order to improve response and long-term outcomes.

Often the aim of oral treatment is to

kick-start the process in moderate disease and then try to hold the improved condition with topical maintenance treatment, (for example, after 2-3 months of oral and topical combination treatment). However, this is not always possible, if the disease activity is too high. This means that whenever the oral antibiotic is stopped, the patient will experience a flare-up.

In those cases that cannot be maintained without continuous oral antibiotics, or in more severe cases, I recommend referring to a dermatologist for consideration of oral isotretinoin (Roaccutane®). For rosacea, many dermatologists favour ultra-low-dose isotretinoin (off-licence), for example, only 5-10mg per day, or even intermittent use of, for example, 5 or 10mg, three times per week. In my clinical experience this works well in the majority of rosacea patients, and is better tolerated than higher daily doses. For any female patients on oral isotretinoin, implementing the Pregnancy Prevention Programme (PPP) is of course of utmost importance.

Steroid creams are strictly contraindicated in rosacea (and POD, perioral dermatitis, for that matter), which is another not uncommon mistake seen in general practice. This is often the case, when rosacea may overlap with seborrhoeic dermatitis, and, for example, Daktacort® cream is prescribed. Topical steroids such as Daktacort can aggravate rosacea or even trigger steroid-induced rosacea, so should be avoided. This is the case, although topical steroids may initially seem helpful to the patient, as they initially mask the problem, only to come back with a vengeance later. Patients will use the steroid cream, get some relief from the rosacea, then experience an aggravation of their rosacea, so use more topical steroid etc. This vicious circle needs much persuasion, patience and hand-holding by the doctor in order to help steroid dependent patients through a steroid withdrawal (which may take months). For those with rosacea in steroid-dependency, we must wean them off the topical steroids very slowly and gradually, as quick withdrawal may cause a strong rebound. Rosacea patients must also be warned that their skin will get worse initially, before it gets better, when trying to come off topical steroids. Steroid withdrawal in rosacea can be supported by moving them onto a non-steroidal anti-inflammatory prescription cream such as Pimecrolimus cream (Elidel® cream). Adding systemic anti-inflammatories like Doxycycline can also help.

LED treatment can also be a useful adjunct in rosacea treatment, but should not replace topical anti-inflammatory prescription treatment.

Vascular rosacea treatment

When it comes to treating the erythema of vascular rosacea, topical Brimonidine (Mirvaso® cream) is useful in the short term for symptomatic relief, such as for a special occasion, as it greatly reduces redness for about 8-10 hours. I often refer to it as the patient's 'redness emergency cream'. I find that topical Brimonidine is a bit like Marmite - some people love it, and some people hate it. For some, it takes away the redness for the day, which is just what they want for a wedding, party or important work event such as giving a presentation, for example. However, others have reported to me that it's in some ways too effective and makes them look too 'ghostly' white. Some patients have also told me that they experience a rebound once it wears off in the evening, and they became even more red than normal. For those reasons, its use needs to be managed, and personally, I don't generally recommend it for daily use, but more as an effective special events solution.

For longer-term reduction of vascular rosacea, we need to turn to laser or intense pulsed light (IPL), and of course, there are a variety of devices with targeted treatment parameters for this on the market. Treatment with laser or IPL is typically done as a course of between three and six sessions, perhaps, once per month. However, what I would like to mention is that the most common mistake I see is practitioners treating rosacea skin with laser or IPL when the patient still has inflammatory lesions, i.e. papules and/or pustules (i.e. 'bumps' or 'spots' of any sort). It is important that the patient must be cleared of inflammatory lesions first (for example, using prescription topical and/or systemic treatments), before any light therapy commences. The wavelengths typical for the light treatment of vascular rosacea are targeting the red haemoglobin as a chromophore; so, if you have red papules on the skin, then those spots will absorb a lot of the light energy, rather than the light being channelled into the vascular lesions, which is of course the aim.

Skincare

Most patients with rosacea will report 'dry, sensitive skin'. The sensation of 'dryness' and uncomfortable tightness in rosacea skin is not real dryness like in atopic eczema, but a sign of microinflammation in the skin, (and it is for this reason that we use the anti-inflammatory products). However, the perceived dryness of their skin will often tempt rosacea patients into using skincare which is too rich, and will aggravate inflammatory rosacea. In my professional experience, up to ninety per cent of redness targeting skincare, or even specific rosacea targeted skincare available on the high street, is unsuitable for rosacea patients. They're often too lipid-rich, targeting the (incorrect) concept of dry skin, when in fact the rosacea patient has microinflammation and not really dry skin. One skincare item important for rosacea is a broad-spectrum, oil- and silicone-free SPF 30-50 sun protection moisturiser. Many rosacea patients prefer a mineral/physical SPF, e.g., micronized zinc oxide and/or titanium dioxide, because they tend to cause cause less stinging compared to chemical/organic filters.

Take-home message

As a dermatologist, I often see patients who unfortunately have not received the best advice or care for their rosacea; so here are my top tips for aesthetic practitioners:

Don't treat a rosacea patient with a laser or IPL if there are still papules or pustules on their skin. Consider referring them to a dermatologist for anti-inflammatory prescription treatment first, and then they can return to you for light treatment for their redness, once all inflammatory lesions have cleared.

Even though a rosacea patient tells you they've got dry skin, don't recommend lipid-rich skincare. Remember, this is microinflammation, so refer to a dermatologist for anti-inflammatory prescription treatment. More often than not, this will solve their desire to apply heavy skincare to sooth their skin.

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