Rosacea

Rosacea – Primary Care Treatment Pathway

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What is Rosacea?

Rosacea is a chronic disorder of the facial skin characterised by redness, particularly of the convexities – cheeks, chin and forehead sparing the peri-ocular skin. Flushing is common and tends to be prolonged and can be uncomfortable and embarrassing. This is often triggered by temperature change, exercise, food, emotional stimuli and alcohol. In time telangiectasia can develop. Some patients develop acne-like papules and pustules, but comedones are absent. Eye symptoms are common including dryness, grittiness, blepharitis and redness. Rosacea can be seen in all skin types but is more common in fair skin. It affects both sexes and tends to occur in mid-life.

A subset of patients develop thickening of the facial tissues, particularly of the nose (rhinophyma) but this is relatively uncommon and very rare in women.

Important Information About Treatments

Treatment is often required because avoiding triggers can be difficult for patients. Use of high factor broad spectrum sunblock (30+) is recommended.

Light emollients and camouflage skin care products are beneficial. Topical steroids can exacerbate rosacea and should be avoided.

Treatment options are directed by the predominant type of rosacea. Flushing and fixed erythema can be helped by topical brimonidine, Intense Pulsed Light (IPL) or Pulsed Dye Laser (PDL). More raised/inflammatory changes (i.e. papules and pustules) can be treated with topical agents (ivermectin, azelaic acid or metronidazole gels or creams), or oral antibiotics).

Our guidance is developed mindful of the growing concerns about antibiotic resistance and if possible the use of long term antibiotics should be avoided.

Differential Diagnosis

- Seborrhoeic dermatitis (may co-exist); the patient will usually have history of dandruff, dryness and scale in the naso-labial folds, medial eyebrow and ear
- Acne vulgaris; when presenting with greasiness, comedones and lack of background erythema
- Periorificial dermatitis; typically seen in young women, can be acneiform or eczematous around the mouth and/or eyes
- Keratosis pilaris rubra; fixed redness of cheeks since childhood with follicular erythema and scale on upper arms and thighs

Practical Advice and Further Information Resources for Doctors and Patients

- Inflammatory rosacea is highly amenable to treatment and patients should be advised that whilst a chronic condition that cannot be cured, it can be very well controlled. Long term treatment is generally advisable to minimise the risk of progression of the disease
- Patients may initially require a combination of topical and systemic treatment, but ideally managed on topical treatments in the longer term. If significant improvement isn't experienced at two months, patients should be encouraged to seek further medical advice
- Patients should be reassured that alcohol does not cause rosacea, although it may induce flushing
- **We would encourage regular reviews to ensure unnecessary use of antibiotics is avoided**

Consider Referral if:

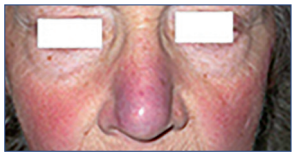
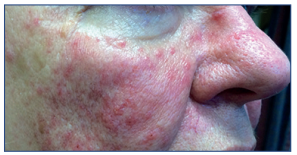
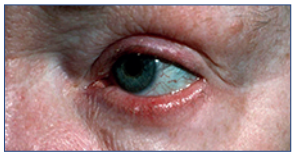
- Severe psychological distress
- Not responding to treatment
- Patient might benefit from IPL/PDL

PCDS: www.pcds.org.uk

Cochrane Review: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD003262.pub5/abstract

BAD: www.bad.org.uk/for-the-public/patient-information-leaflets

Rosacea – Treatment Options

Treatment Options for Rosacea Subsets				
Product	 **Flushing & fixed erythema**	 **Inflammatory papules & pustules**	 **Ocular**	**Protocol & Comments**
Ivermectin 1% Cream (Soolantra®)		+++		Well tolerated, once daily, greater efficacy than metronidazole and no concerns with antibiotic resistance
Azelaic Acid Gel (Finacea 15%®)		++		Effective twice daily, may cause irritation and no concerns with antibiotic resistance
Metronidazole Gel or Cream 0.75% (Acea®, Metrogel®, Metrosa®, Rosiced®, Rozex®, Zyomet®)		+		Twice daily, less effective than ivermectin
Brimonidine Gel 0.33% (Mirvaso®)	++			Effective and fast acting vaso-constrictor, patients should be warned about the possibility of rebound flush which can limit usage
Eye Lubricants			+++	Lid hygiene and warm eye compresses also important
Doxycycline MR 40mg (Efracea®)		+++		Once daily. Fewer side effects and equivalent efficacy as full dose (100mg). Sub-microbial dose reduces risk of antibiotic resistance compared to other antibiotics
Doxycycline 100mg Lymecycline 408mg caps (Tetralysal®)		++	++	Less expensive, more side effects Well tolerated, once daily
Oxytetracycline 250-500mg		+	+	Twice daily, avoid taking with meals
Erythromycin/Clarithromycin 250-500mg		+		Twice daily, useful in pregnancy
Isotretinoin		++		Useful in secondary care for resistant cases
Intense Pulsed Light (IPL)	+++			Limited NHS availability
Pulsed Dye Laser (PDL)	++			Limited NHS availability and causes significant bruising
Clonidine 25-50mcg	++			Up to three times daily, improves flushing in some patients
Propranolol 10-40mg	+			Up to three times daily
Carvedilol 3.125-6.25mg	+			Up to three times a day
Legend	+++ Strong recommendation	++ Moderate recommendation	+ Low recommendation	

These comments are the opinions of the contributors, reviewed by the PCDS Executive Committee and do not consider NHS costs and local prescribing restrictions, if any.