



Waterfall in Glacier National Park

PIC QUESTION OF THE WEEK: 9/05/11

Q: What are the current recommendations for the drug treatment of rosacea?

A: Acne rosacea, (more commonly referred to as rosacea), is an inflammatory dermatologic disorder of unknown etiology. It most often affects the central area of the face and is characterized by erythema, telangiectasia, and superficial pustules. Ocular complications such as blepharitis and conjunctivitis are common. Caucasians and other light-skinned individuals are affected more often. Although rosacea is less common in men, its presentation may be more severe. Rosacea usually occurs between the ages of 30-50 years and is rarely observed in younger individuals. The condition is frequently not progressive but, in such cases, nodular inflammatory lesions and tissue hypertrophy may develop. Non-pharmacologic treatment of rosacea typically includes non-irritating cleansers, sunscreen, and moisturizer. These should be used in combination with pharmacological therapy for optimal management of the condition. First-line topical treatment of rosacea generally includes metronidazole 0.75% - 1% gel or cream, azelaic acid 20% cream or 15% gel, and combinations of sulfacetamide 10% and 5% sulfur. Topical treatments serve to decrease erythema, eliminate small pustules, and provide antimicrobial activity. If these preparations fail, topical tacrolimus, benzoyl peroxide 5% - clindamycin 1%, erythromycin gel, permethrin 5%, or retinoids can be considered as additional options. Initial oral treatment should include controlled release doxycycline 40 mg (Oracea) or doxycycline hyclate in doses ranging from 20 mg - 40 mg daily. These *low* doses of doxycycline provide anti-inflammatory but not antimicrobial activity. Oral antimicrobials are typically used in the presence of papulopustular rosacea or in cases when topical therapy has been ineffective. Doxycycline doses of 50 mg daily, minocycline, or tetracycline can provide antimicrobial activity as well as decrease inflammation by reducing prostaglandin levels. Oral metronidazole is also effective, but may produce significant gastrointestinal complications. Because of increasing resistance rates, erythromycin and other macrolides are less frequently prescribed. The most severe cases of rosacea may warrant use of oral isotretinoin; however, this is clearly contraindicated in pregnant women and requires frequent laboratory monitoring. *Topical* treatment for mild disease usually extends for 4-6 weeks. If response to therapy is inadequate, oral doxycycline can be initiated for more persistent cases. Systemic treatment can be periodically prescribed to control recurrences of rosacea. The duration of episodic treatment can range from months to years.

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