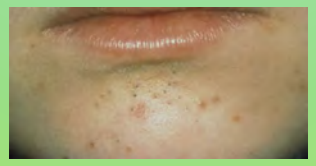
# Acne Vulgaris – Treatment Guidelines

## GRADE 0 - CLEAR

No lesions to barely noticeable ones. Very few scattered comedones and papules.

## GRADE 1 – ALMOST CLEAR (Comedonal Acne)

- Hardly visible from 2.5m away.
- A few scattered comedones and a few small papules.
- Rarely pustules.



***TREATMENT***

- **Topical retinoid** (Adapalene 1st line) – also consider tretinoin/isotretinoin* (M)
- Fixed-dose combination of retinoid/BPO (Epiduo: adapalene/BPO) or can use Treclin (Tretinoin 1%/Clindamycin 0.025% gel)
- Skinoren (Azelaic acid) can be used (similar efficacy and sometimes more tolerable) (L)
- Maintain therapy for a few months.
- Reassess every 2-3 months

Smoking Cessation is important.
If sensitive skin – use cream/lotion
If oily skin – consider a gel

***MAINTAINENCE***

- Topical Retinoid or Azelaic Acid. (L)

**THINKING POINT - PCOS**

In female of childbearing age with Hirsutism + Acne + Irregular Periods

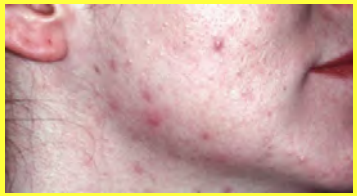
- Ix – Serum total + free testosterone, Gynae hormone profile, Cortisol (mane)

**Spironolactone – Good candidates include:**

- Patients who wish to avoid roaccutane
- Acne flares around the time of menses
- Acne that is distributed in the lower face and jaw line (monitor BP/K+ in >45 years and those with co-morbidities)

## GRADE 2 – MILD ACNE

- Easily Recognisable Acne
- Less of half the affected area is involved
- Many comedones, papules, pustules present.



***TREATMENT***

- A fixed dose combination of Adapalene+BPO or Clindamycin+BPO is first line. (H)
- Tretinoin 1%/Clindamycin 0.025% gel (Treclin) can be used (M)
- Topical retinoid can be used alone (M)
- Azeliac Acid 20% can be used alone (M)
- Topical adapalene + oral antibiotic if more severe (M)

***MAINTAINENCE***

- Topical Retinoid or Azelaic Acid. (L)

## Acne Myth Busting

Acne is not caused by poor hygiene. Conversely washing too much can aggravate acne.

No high quality studies have demonstrated a link between acne and diet.

Psychological stress can elevate circulating hormones which can cause acne. Hence, it is not unreasonable to assume stress can make things worse

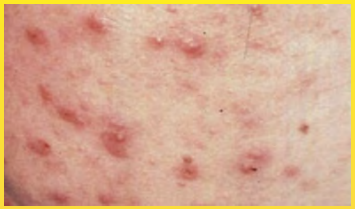
Approximately 60% of females who struggle with acne report a flare in symptoms just before their periods.

Studies have not demonstrated any link between sunlight and acne, however some people do report a benefit.

**PATIENT INFORMATION LEAFLET HERE**

## GRADE 3 – MODERATE ACNE

- More than half of the face is involved with many comedones, papules and pustules



***TREATMENT***

**As for mild acne**, however oral therapy should be added. (M)
**Oral Therapy includes: (in order of preference)**

- Lymecycline 408mg daily
- Doxycycline 100mg daily
- Oxytetracycline 500mg BD

Treat for 3 months, then continue with topical rx. Review 8 weeks following initiation. BPO or adapalene should be used to reduce antibiotic resistance with oral therapy. (H)

Change to an alternative antibiotic if there is no improvement after 3 months. Consider Trimethoprim / Erythromycin if cannot tolerate lymecycline/doxycycline.
Can continue for 6 months, if working

*** MAINTAINENCE***

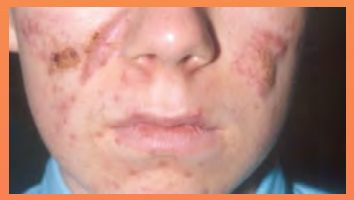
Topical Retinoid or Azelaic Acid. (L)

## COCP as an alternative

Consider Co-cyprindiol (Dianette®) or other ethinylestradiol/cyproterone acetate containing products – 1 tablet daily for 21 days, commence day 1 of cycle, Needs 7 day break after day 21, trial for 6 months.
Discontinue after 3 months of acne being controlled.

## GRADE 4 - Severe Acne

- The entire area is involved
- Covered with comedones, papules & pustules.
- Several Cysts and Nodules present



***TREATMENT***

Continue therapy as for moderate acne, and…. **Referral for Roaccutane** (oral Isotretinol) 0.5mg/kg/day. (H)

- Side Effects – Dry skin, sore lips, epistaxis, muscle pains, raised lipids.
- Pre Treatment – LFT & Serum Lipids
- All pts should discuss contraception.

**REFERRAL CRITERIA**

- Poor response to 6/12 (or 2 different) oral abx.
- Severe Acne +/- Scarring
- Severe Psychological Upset.

*** MAINTAINENCE***

The fixed-dose combination adapalene/BPO or Azelaic acid. (L)

Low Dose Isotretinoin (max. 0.3mg/kg/day) (L)

For Females: Continued hormonal anti-androgens and topical treatment (apart from antibiotics)

(H) High Quality Evidence (M) Medium Quality Evidence (L) Low Quality Evidence

## Grade 5 – VERY SEVERE

Highly inflammatory acne covering the area, with nodules and cysts present.

***TREATMENT***

Oral isotretinoin is strongly recommended as a monotherapy for the treatment of severe nodular/conglobate acne. (H)
**REQUIRES URGENT REFERRAL**

Until specialist review – Use systemic antibiotics in combination with the fixed-dose combination of adapalene and BPO

## General Acne Information

- Avoid over cleaning the skin - twice daily washing with a gentle soap and fragrance-free cleanser is adequate
- Non-comedogenic makeups are advised.
- Patients need to avoid picking and squeezing spots to prevent scarring.
- Treatments are effective but take time to work (usually up to 8 weeks)
- If topical therapies are poorly tolerated, frequency of application can be gradually increased from once/twice a week to daily.
- Retinoids are contraindicated in pregnancy and breastfeeding.
- A topical retinoid (if not contraindicated) or benzoyl peroxide should always be co-prescribed with oral abx to reduce the risk of antibiotic resistance developing.
- *Adapalene should be selected in preference to tretinoin and isotretinoin.

## References


- Tan JKL et al. Development and validation of a comprehensive acne severity scale. J Cutan Med Surg. 2007
- Nast A et al. European evidence-based (S3) guideline for the treatment of acne – update 2016 – short version. J Eur Acad Dermatology Venereol. 2016
- Nice Guideline: Acne vulgaris: management. Published: 25 June 2021 Available online at www.nice.org.uk/guidance/ng198

# Tips on Acne Treatment

Remember….

- Acne is a chronic disorder
- Usually there is little response within the first 3-5 weeks of commencing therapy
- Adherence to prescribed treatment regimens is of utmost importance.
- Prescribed treatment regimens MUST be realistic.
- Bacterial resistance is higher with oral erythromycin (65%) than with tetracycline (20%). This can be reduced by simultaneous use of benzoyl peroxide.
- Advise patient about the likelihood of bleaching bedclothes etc when using Benzoyl Peroxide. It can also bleach hair!
- Patients with acne to use a non-alkaline (skin pH neutral or slightly acidic) synthetic detergent cleansing product twice daily on acne-prone skin.
- Patients with acne who use make-up should avoid oil-based and comedogenic products, and to remove make-up at the end of the day.
- Persistent picking or scratching of acne lesions can increase the risk of scarring.

## REFERRAL TO SPECIALIST

**IMMEDIATE** – Acne Fulminans to be assessed within 24 hours.

**MUST REFER IF**

- there is diagnostic uncertainty about their acne
- they have acne conglobata
- they have nodulo-cystic acne

**CONSIDER REFERRAL IF:**

- mild to moderate acne that has not responded to 2 completed courses of treatment
- moderate to severe acne which has not responded to previous treatment that contains an oral antibiotic
- acne with scarring
- acne with persistent pigmentary changes
- psychological distress or a mental health disorder due to acne.

**Primary irritant dermatitis**

- Primary irritant dermatitis is very common with topical anti-acne therapies. This impact of this can be reduced by:

- Reducing the number of applications per week

- A good option is to advise washing with soap substitute (i.e.: Dermol wash/QV Gentle wash) and warm water and then apply the topical anti-acne medications.

- Combining the application with the use of an oil-free moisturiser is useful. One approach is to dilute the topical therapy with progressively smaller amounts of emollient (Dermol 500 lotion, Cetraben Cream) over a few weeks until the emollient is phased out completely.

- Sometimes a low potency steroid cream (hydrocortisone) may be necessary once or twice daily for a few days to help reduce the reaction.

**Do not treat acne with the following:**

- Monotherapy with a topical antibiotic
- Monotherapy with an oral antibiotic
- A combination of a topical antibiotic and an oral antibiotic.

**At the 12-week review:**

- Are there any improvements?
- Are there any side effects?
- If clearance following Rx with an oral antibiotic, stop the antibiotic but continuing the topical treatment
- If partial clearance following Rx with an oral antibiotic, continue the oral antibiotic, alongside the topical treatment, for up to 12 more weeks.