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Raising Expectations for Rosacea: Best Practices That Drive Clear Results

Faculty

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- Dr. Jackson receives consulting fees from Abbvie, Aclaris Therapeutics, Galderma, Janssen, Lilly, Medimetriks, Novartis, Promius, and Ralexar; is a speaker for Abbvie, Janssen, Lilly, and Novartis; conducts contracted research with Celgene, Galderma, Menlo Therapeutics, and Sienna; and has ownership interest in Accuitis, Ralexar, and Top MD.

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Learning Objectives

- Outline the physical and psychosocial impact of rosacea and common comorbidities in affected patients.

- Incorporate the most recent understanding of the impact of available rosacea treatments along with the most current guideline recommendations to formulate individualized treatment and maintenance plans to achieve treatment goals, including “clear” skin, and improve quality of life.

- Improve involvement of each interprofessional team member in the care of the rosacea patients.

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Rosacea

- Affects men and women
- Serious psychosocial and physiological effects for both genders
- Typical presentation: red bumps, pimples and pustules on face
- Not only a cosmetic disease; there is underlying chronic inflammation
  - Long-term inflammation can create irreversible changes to skin (e.g. phymatous changes on the nose)

Complications

- Ocular
  - Eye inflammation
  - Sensation of dryness, grittiness, scratchy
  - Refer to ophthalmologist for evaluation to confirm manifestation of rosacea disease
- Psychosocial burden
- Comorbidities related to underlying inflammation

Social and Psychological Impact

- Societal assumptions
  - High stress
  - Embarrassment
  - Nervousness
  - Heavy alcohol intake
  - Overall appearance

- Feelings of burning and stinging
  - Unable to apply topical treatment or cosmetics

Diagnosing Rosacea

Presence of one or more of the following primary features	May include one or more of the following secondary features
Flushing (transient erythema)	Burning or stinging
Nontransient erythema	Plaque
Papules and pustules	Dry appearance
Telangiectasia	Edema
	Ocular manifestations
	Peripheral locations
	Phymatous changes

- Difficult to differentiate between acne and rosacea
- Lupus is often misdiagnosed as rosacea, and vice versa

Wilkin J, et al. *J Am Acad Dermatol*. 2002;46(4):584-587.

Traditional Subtypes of Rosacea

Subtype	Characterization
Erythematotelangiectatic	Frequent blushing >10 minutes Persistent central facial erythema Telangiectasia
Papulopustular	Small, dome-shaped erythematous papules Central facial erythema, tiny surmounting pustules Erythema
Phymatous	Rhinophyma
Ocular	Burning or stinging Blepharitis Conjunctivitis

Diagnosis of rosacea is moving away from the traditional classification for a phenotype-based approach

Crawford G, P, et al. *J Am Acad Dermatol*. 2004;51(3):327-341.

Association With Chronic Systemic Diseases

Comorbid disease	Cases n=65 No. (%)	Controls n=65 No. (%)	Odds ratio for rosacea (95% CI)	*P* Value
Allergy:				
Airborne	44 (67.7)	26 (40.0)	4.6 (1.7-12.1)	.002
Food	11 (16.9)	2 (3.1)	10.0 (1.3-12.0)	.03
Respiratory diseases	18 (27.7)	6 (9.2)	4.0 (1.3-12.0)	.01
GERD	32 (49.2)	13 (20.0)	4.2 (1.7-10.2)	.002
Other GI diseases	23 (35.4)	11 (16.9)	3.0 (1.2-7.6)	.02
Hypertension	24 (36.9)	13 (20.0)	2.8 (1.1-7.2)	.03
Metabolic diseases	35 (53.8)	24 (36.9)	2.4 (1.04-5.4)	.04
Urogenital diseases	15 (23.1)	2 (3.1)	7.5 (1.7-32.8)	.007
Female hormone imbalance	21 (48.8)	10 (23.3)	3.2 (1.2-8.7)	.02

- Case-control study evaluating the association between rosacea and systemic comorbid diseases
- Significant association observed between rosacea and comorbid diseases
- Rosacea is associated with numerous systemic comorbid diseases in a skin severity-dependent matter

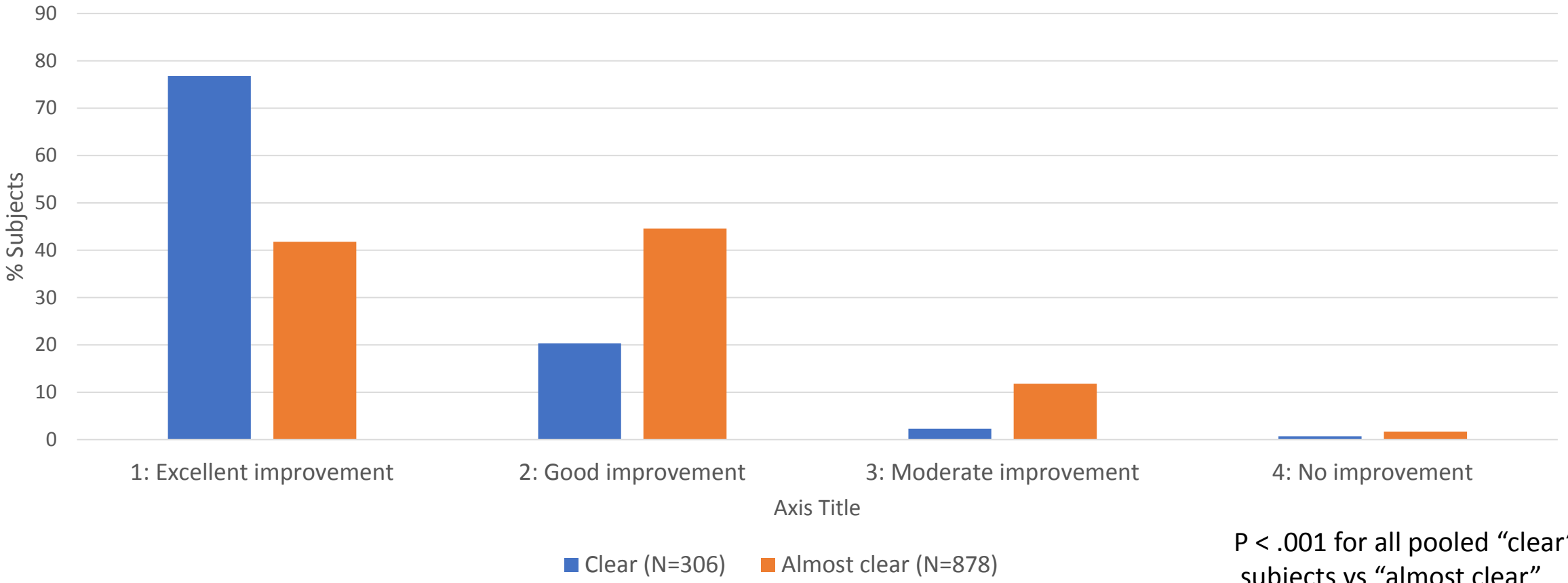
CI, confidence interval; GERD, gastroesophageal reflux disease; GI, gastrointestinal
Adapted from Rainer BM, et al. *J Am Acad Dermatol*. 2015;73(4):604-608.

A Phenotype-Based Approach to Management

		Inflammatory papules/pustules				Phyma	
Transient erythema*	**Persistent erythema***	**Mild**	**Moderate**	**Severe**	**Telangiectasia**	**Clinically inflamed**	**Clinically noninflamed**
A-adrenergics (topical)	Brimonidine (topical)	Azelaic acid (topical)	Azelaic acid (topical)	Ivermectin (topical)	Electrodessication	Doxycycline (oral)	Physical modalities
Beta-blockers (oral)	IPL	Ivermectin (topical)	Ivermectin (topical)	Doxycycline (oral)	IPL		
	PDL	Metronidazole (topical)	Metronidazole (topical)	Isotretinoin (oral)			
		Doxycycline (oral)	Doxycycline (oral)			Isotretinoin (oral)	

Adapted from Schaller M, et al. *Br J Dermatol*. 2017;176:465-471.

Assessment of Rosacea Improvement* Between Baseline and End of Treatment Period for ‘Clear’ vs ‘Almost Clear’ Subjects



P < .001 for all pooled “clear” subjects vs “almost clear” subjects”

*subject’s assessment on a 4-point scale from ‘no improvement’ to ‘excellent improvement’

Adapted from Webster G, et al. *J Dermatol Treat*. 2017;28(5):469-474.

Setting and Attaining Therapeutic Goals

- Shared decision-making
  - Setting a mutual endpoint: goal of clear
- Educate patients
  - Avoidance of triggers (eg, spicy food, wind, cold, sunburn, etc.)
  - Good moisturization techniques to help restore the skin barrier
- Individualize therapeutic regimens using a combination of topical and systemic agents

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Treatment Adherence

- Retrospective study using the IMS LifeLink Health Plan Claims Database
  - 99,894 patients
  - 82% received monotherapy
  - 70% received a topical medication.
  - MPR* was 37.8% for oral medications and 18.2% for topical medications
- Strategies to improve adherence
  - Combine nonpharmacologic and pharmacologic interventions to improve adherence
  - Utilize well tolerated topical therapies
  - Use combination therapy when possible
  - Patient counseling strategy
  - Physician/patient “Goal Setting” strategy

* Medication Possession Ratio (MPR) measures the percentage of time a patient has access to medication

Kendall JD and Preston NJ. P8309. JAAD.2014. 70, Supplement 1, Page AB12