There is something of a false dichotomy in discussions of medical versus aesthetic dermatology. While my practice, image Dermatology in Montclair, NJ, is focused on aesthetics, a significant portion of my day is spent diagnosing and prescribing treatment for medical skin diseases that cosmetic patients did not even realize can be treated. In particular, the skin signs of acne vulgaris and acne rosacea or rosacea are common concerns among adult patients, many of whom don’t know their skin concerns are diagnosable—or treatable.

Commonly, patients present with concerns about skin texture and wrinkling, sagging, or other signs of photoaging with a specific treatment in mind: “I want Botox,” “I need filler,” “Can you do laser for my neck?”

Of course, we know that our job is not simply to dispense the aesthetic intervention requested. We assess the patient’s skin, their history, their lifestyle, and their desired outcomes. In the course of patient assessment, I often point out concerns like erythema that patients have not even mentioned. I tell patients that they have a specific skin condition (such as rosacea) and explain that if they want to, we can treat it. In the case of rosacea, it’s not uncommon for patients to respond, “Oh, my mother had that,” “My father has that,” “My sister has that but she’s much more red than I am.”

Patients concerned about the current appearance of their skin are often even more concerned about how their skin may look in the future. That’s why I present patients with general guidance—broad spectrum SPF 30, reapplied per the label—but also appreciate specific product recommendations. I frequently recommend Eryfotona by ISDIN and I like the untinted Total Defense and Repair or Essential Defense by SkinMedica. These are suitable for men and women. I typically do not recommend tinted sunscreen for daily use, especially for patients with skin of color, because I have not seen consistently favorable cosmesis. I do recommend ColoreScience sunscreen for women for re-application, as it can be easily and efficiently brushed on over make-up. It is available in a variety of tones so patients can find one they like.

Every patient should use an antioxidant in the morning, and this is true of patients with acne and rosacea. Patients should select and use on a daily basis, a non-irritating facial moisturizer. Hyaluronic acid face moisturizers are well suited procedures, but this is especially important for patients with acne or rosacea. Daily sunblock is essential, and I instruct all patients to apply sun block every day after brushing their teeth (whether they are leaving the house or not) and to reapply multiple times daily, per the product instructions. Individuals living or staying close to the equator (Florida, the Caribbean, etc.) should reapply sunscreen more frequently.

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The bottom line

Cosmetic consults include assessment of the patient’s skin overall, and dermatologists should be prepared to diagnose and offer treatment for acne and rosacea. Patients may not know they have a diagnosable—or treatable—skin condition; but achieving clearance will only improve their outcomes. There is no reason that most patients with acne and rosacea would need to defer cosmetic treatment.

MANAGING ACNE AND ROSACEA IN THE AESTHETIC PATIENT

Sometimes patients seeking aesthetic interventions don’t even realize there is help for their inflamed skin.

BY JEANINE B. DOWNIE, MD

START WITH SKINCARE

Skincare is essential for any patient undergoing aesthetic procedures, but this is especially important for patients with acne or rosacea. Daily sunblock is essential, and I instruct all patients to apply sun block every day after brushing their teeth (whether they are leaving the house or not) and to reapply multiple times daily, per the product instructions. Individuals living or staying close to the equator (Florida, the Caribbean, etc.) should reapply sunscreen more frequently.

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for patients with rosacea because they are non-irritating and provide significant moisturization.

I advise patients with acne, rosacea, “sensitive skin,” or any other skin irritation to use as few ingredients as possible on their face. I do not hesitate to send patients to an allergist for assessment and possible testing if they seem like they may be having true allergic reactions to skincare products.

DISCUSS ROSACEA TRIGGERS

It takes some time to discuss rosacea triggers and their potential management with patients. I use myself as an example. I love spicy foods, but it makes my rosacea flare. At a formal dinner where I may be discussing a business opportunity, I may opt for something not spicy, whereas when dining with my family, I may go ahead and eat spicy food because I am not so concerned about being bright red. Many triggers, like spicy foods, can be managed, whereas others should be avoided altogether. For example, irritating ingredients in make-up and skincare should be eliminated entirely.

TOPOCAL PRESCRIPTION TREATMENTS

Patients with acne and rosacea should apply disease-directed topical agents to all affected skin areas. Topical treatments aimed at papules and pustules typically are applied to the whole face or anatomic area being treated. Redness reducers can be applied only to targeted areas—any areas where patients want to reduce visible flushing, such as the cheeks, neck, and chest. Ask patients about flushing (timing and affected location) rather than make assumptions based on their presentation at the time of the visit. Some patients may have persistent erythema on the cheeks but will have flushing of the chest and neck when they are nervous, for example.

For many patients with rosacea, I prescribe Soolantra (ivermectin, Galderma) to address mild to moderate papules. Mirvaso (brimonidine, Galderma) and Rhofade (oxymetazoline, EPI Health) are effective options to reduce erythema.

For patients with more moderate to severe papules of rosacea or papules and pustules of acne, I move into oral medications. Subantimicrobial dose doxycycline or low-dose minocycline, doxycycline and sarecycline are all suitable to manage inflammatory rosacea, but some patients with acne or rosacea require higher doses of oral antibiotics. Of course, patients with cystic disease are candidates for isotretinoin, and I prescribe this frequently for both male and female patients.

Topical retinoids are considered first line treatment for acne and can also be used by patients with rosacea; they have a secondary benefit of improving skin texture and can help with evening out tone. However, because patients often have sensitive skin and retinoids can be irritating, I typically have patients use a topical retinoid two or three times a week. I always recommend that patients use a topical retinoid in conjunction with a good hyaluronic acid-based moisturizer.

ENERGY-BASED INTERVENTIONS

Several devices are shown to provide benefit in the treatment of facial erythema. There are a few devices to choose from, including the pulsed dye laser and IPL. I use the Excel V (Cutera), which is suitable for all skin types. Those physicians who delegate administration of energy-based device procedures should input treatment settings for each patient, based on the patient’s skin type and desired treatment; do not rely on staff to input treatment settings.

I tell people they did not develop redness overnight, and it is not going to go away overnight. I counsel them to expect six to eight treatment sessions in a row, provided every four to six weeks, and to plan to return for maintenance treatments once every three to four months. Patients need to understand that, despite the efficacy of energy-based devices, they cannot halt the underlying chronic disease process; maintenance treatments help keep the redness down.

I also explain to patients that human skin reacts to all light—indoor light and outdoor light. The blue light from the phone, the computer, the Apple Watch, and the iPad all affect the skin. Patients of any race, ethnicity, or skin type will be affected by all light, including blue light. But virtually none of them know it. All that screen time worsens rosacea, and patients need to limit screen time and use sunscreen; iron oxides are shown to provide some protection against blue light.

ADDRESS THE DIET DIMENSION

Many patients will indicate a GI connection to their skin flares. This is supported in the literature with the documented association of rosacea with H pylori. There is no agreed-upon, specific dietary intervention for rosacea or acne. However, there is evidence that a low glycemic load diet that is low in sugar and refined carbohydrates is benefi-
Calming the Inflammation of ACNE and ROSACEA

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I also recommend decreasing soy, nuts (especially peanuts), and corn, as all three are inflammatory and can increase rosacea and flares of acne. Soy has an estrogenic component to it, which can aggravate both male and female acne. Note that soy is an ingredient in many foods, including granola bars, snacks, breads, etc.

CONFRONT BAD HABITS

Picking at papules or pustules can make them worse. Picking them enough will lead to a scar. For scarring cystic acne or rosacea, I treat with the INTRACel, Fraxel, or a combination of the two.

Some patients will be treated for both scarring and erythema, which may also be a point for education. Unfortunately, patients need to understand that while we can improve the appearance of scarring and the appearance of redness, each requires a different device. Some patients voice mild frustration about this, but I simply state the facts. “You made your situation worse by picking your skin and causing scarring, and that requires a different laser.”

I can spot a smoker just by looking at them, without smelling smoke on their clothes. Smoking and/or vaping tobacco or marijuana has terrible effects on the skin and will definitely lead to more erythema in individuals with rosacea. Any smoking or vaping can also lead to worsening of rosacea papules and skin signs of acne.

I make it clear to patients who smoke that they can expect less rapid response to treatment, including energy-based treatments, if they smoke. In fact, whereas I may tell a typical patient to expect six to eight laser sessions, when I counsel a smoker with a similar presentation, I will not provide an estimate of treatments needed. The impact of their smoking simply makes it impossible to gauge.

CONSIDER THE ROLE OF OCPs/HORMONAL BIRTH CONTROL

Just as with acne, women can get rosacea flares if they change from one hormonal method of birth control to another. Switching oral birth control pills, injections, or IUDs, can cause these red flares, cystic acne, rosacea, or just papular acne rosacea, which really annoys patients. This is usually a case where the patient will specifically present for treatment of their flaring acne or rosacea. Similarly, different fertility treatments can also cause flares of acne or rosacea.

TAKE A HOLISTIC APPROACH

There is no reason that most patients with acne and rosacea will need to defer cosmetic treatment. For the occasional patient with severe inflammatory cystic acne, then it may be reasonable to postpone treatment until their acne is under control. Isotretinoin should not be overlooked for its potential to treat cystic disease. It is not common for cystic or highly inflammatory acne or rosacea to impact aesthetic treatment. The reality is that offering patients treatment for their acne or rosacea will only serve to enhance their aesthetic outcomes by improving the appearance of their skin.

Jeanine B. Downie, MD, FAAD is founder and director of image Dermatology in Montclair, NJ. She is on staff at Mountainside and Overlook Hospitals.