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https://reachmd.com/programs/cme/a-multi-professional-approach-to-driving-clear-results-for-rosacea-a-case-based-discussion/10384/

Released: 09/28/2018
Valid until: 10/12/2019
Time needed to complete: 30 minutes

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A Multi-Professional Approach to Driving Clear Results for Rosacea: A Case-Based Discussion

Announcer:

Welcome to CME on ReachMD. This activity, titled *A Multi-Professional Approach to Driving Clear Results for Rosacea: A Case-Based Discussion*, is provided in partnership with Prova Education and supported by an independent educational grant from Galderma Laboratories.

Before beginning this activity, please be sure to review the Learning Objectives and faculty disclosures. Your host is Dr. Amy Mackey.

Dr. Mackey:
Rosacea is a common chronic disorder that affects as much as 10% of the population. This cutaneous disease is highly distressful to patients, as it can have ocular manifestations that come with a risk of vision loss. It also is associated with many comorbidities that are too often overlooked by practitioners. So, how can clinicians of different professions and specialties work as a team to enhance the outcome

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of these patients?

This is CME on ReachMD, and I'm Dr. Amy Mackey. Joining me to review 3 challenging rosacea cases are Clinical Professor of Medicine and Dermatology, Dr. Mark Jackson, and family nurse practitioner, Dani Haas. Welcome to the program.

Dr. Jackson:
Thank you.

Ms. Haas:
Thank you, Dr. Mackey.

Dr. Mackey:
Let's start with a 53-year-old female mother of two. She's a primary school teacher, and during the summer she also teaches lifeguard courses. Ten years ago she noticed frequent redness on her nose, cheeks and chin that was more pronounced during her lifeguard classes. The redness is not responding to over-the-counter acne medication. She also noticed a hard crust near her nose at one point. Her face also feels dry all year around, and facial creams cause discomfort when applied and even worsens the appearance. She is frustrated and embarrassed when in front of her class. Her social life is affected. Her deceased aunt had lupus, and she remembers her aunt having a similar red rash. Upon physical examination, the woman has a fair complexion and considerable erythema affecting the nose, medial cheeks and chin. She also has about 15 scattered inflammatory pustules and papules on the cheeks, nose and chin. There are no comedones, no scale, no evidence of ocular involvement; telangiectasias are absent. Her laboratory values are within normal limits. No medications except for acetaminophen for migraines, and she no longer is using any over-the-counter acne medications, nor is she on prescribed birth control.

So let's start with you, Mark. What are your initial thoughts on the most probable diagnosis?

Dr. Jackson:
Well, this is an interesting and very typical clinical presentation that we have in dermatology. People will often come to us and have been given the diagnosis of lupus simply because their face has this redness on the cheeks and on the chin and the forehead and they have this tendency for blushing, but there's a difference between redness and flushing and actual photosensitivity that we see with lupus. And in our rosacea patients, we tend to see that they have this background redness focused on the central cheeks and the tip of the nose and the chin, really sparing what we call the malar rash that goes all the way across in a continuous pattern from the cheek all the way across the nose to the chin. And usually, in patients with lupus, we'll see other findings on the neck, chest, arms, or other sun-

exposed areas.

Sometimes it can be tricky, and these patients will have had other laboratories, lab evaluations performed, and sometimes their lupus labs are even a little bit kind of on the borderline, and it can be tricky, but I think that's why having them see somebody who has dermatologic expertise is important in these cases to really get the right diagnosis, because treatment for lupus really won't help somebody that has rosacea.

Dr. Mackey:
So, Mark, is this a typical patient that you see with rosacea?

Dr. Jackson:
I think it's a very typical type that we see. And typically, rosacea has been classified in 4 subtypes, that being just the redness or the papules and pustules, which are the acne lesions that people think are acne, but they are really not, they are the inflammatory lesions of rosacea—that's the type 2 that have the inflammatory lesions—and then there's the ocular rosacea, which is involvement of the eyes, and then there's the rhinophyma or the chronic inflammatory type, which is typically dubbed as the W.C. Fields nose that people want to avoid, which is the chronic inflammation that has occurred over time with lymphedema and this chronic almost fibrotic process that occurs, and that's type 4.

We typically see patients presenting with 1, 2 or 3 of the different subtypes all at once. So patients don't just fill one subtype. Many times they'll have 2 or 3, as this patient has. They have the inflammatory lesions, they have the redness, and sometimes, even though they don't know they have the ocular component, they might, and once you start treatment, you find that their eyes did improve and they didn't even know they had problems; so sometimes that's how you tell whether they did have any eye involvement at all. But I think this patient is a typical presentation with lesions that are inflammatory and both the background redness and flushing.

Dr. Mackey:
Okay. So, Dani, in dermatology journal and articles, we read about the IGA scale to stage disease severity. Do you recommend that clinicians use scales in practice, and if so, which ones?

Ms. Haas:
So, yes, I think using scales in our practice is helpful. The most common scale that's used is the Investigator Global Assessment, which is the 0 to 4 scale, 0 being patients entirely clear with rosacea and then 4 being severe with numerous papules, pustules and pretty significant erythema. So a scale not only allows us to track patient progress, but in our practice with Dr. Jackson and I working so closely together and frequently following up on one another's patients, it also allows us to also

communicate. So, if he had initially seen the patient and gave them a scale of 3, did a pretty good description in his documentation, then I know what the patient looks like on follow-up.

Dr. Mackey:
Yes, that really makes sense. So, Mark, before we continue with treatment, what should we know about the underlying pathophysiology of rosacea that may affect our treatment decisions?

Dr. Jackson:
And that's a great question. I think that the most important thing that I want patients to know–and people who don't take care of rosacea–is that it's an inflammatory condition. It's not just a rash that we happen to see visibly. It actually is the manifestation of inflammation on the skin. And there are different triggers in different patients, and what we really think is that the body has an overactive innate immune response in these patients that are prone, and this could be a trigger such as a spicy food or a hot beverage, or it could also be some type of contact source. And as we mentioned in this case, this woman has very sensitive skin, and many times in a rosacea patient the skin barrier is damaged, which lets different antigens be presented through the skin barrier, and the body may have an overactive response to that, and it can manifest in patients as these dilated vessels that give them this central redness, which can increase the heat and the temperature on the skin allowing more inflammatory cytokines to flow into the tissue creating the papules and pustules and other chronic inflammation that we can see over time.

Dr. Mackey:
So, Mark, does the sun exposure for this patient trigger rosacea at times?

Dr. Jackson:
It's a great point that you bring up. And so sun protection is very important at preventing worsening of the disease, because with the chronic sun damage… Obviously, sun creates vasodilation of these already very superficial vessels, but over time, the sun causes damaging of the collagen scaffolding under the skin, which allows these vessels to move closer to the surface of the skin, and it also damages the skin barrier it's very important that we talk about taking care of the skin barrier first, and then we work on therapy, because if we're not protecting the barrier that's already damaged, we're really going to have a hard time treating the condition over the long haul.

Dr. Mackey:
And so, can you put this all together for us and make some treatment recommendations for this patient?

Dr. Jackson:

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As we said, this is a fairly typical patient that we have with rosacea with the redness and the lesions, and I think that many times we need both a systemic and a topical agent, and sometimes starting both at the same time creates a little bit better outcome and gets patients to be a little bit more confident in their therapy and their clinician. And in this patient I would probably start with a low-dose anti-inflammatory version of doxycycline, if we can get that. Sometimes they need a little bit of the higher dose, or if access is an issue, we might have to switch to different things depending on their formulary or the expense, but I do think that a systemic agent would be important, and the doxycycline category is what we rely on routinely with its anti-inflammatory benefit in these cases.

And in the topical realm, I think typically we'd utilize metronidazole because it's something that's been there for the longest and many times something that patients reach to—or, excuse me, clinicians reach to first. But I think that we don't have to go with always what's been the tried and true if there are new and more effective therapies out there, and I think we do have the advent of more effective therapies. And we have something now with the new ivermectin that's given us the potential for clearance to almost complete clear in patients and I think with statistically significant benefit over what we've seen with metronidazole, so in this patient that's probably what I would choose.

I also think it's important if they do have background telangiectasias and redness not to forget about the laser therapies, which can be very impactful, to help those fixed vessels in the skin and may be very helpful as an adjunctive treatment to the other things you've done and create a better outcome.

Dr. Mackey:
While rosacea is more prevalent in females, it's not uncommon in males. Our second patient is a 45-year-old father of three. He worked in construction for over 20 years and is reporting persistent facial redness. Since his early 30s, his cheeks and nose have often felt dry. It has become sensitive to shave, and aftershaves burn too much to use. He also reports between 5 and 8 inflamed areas that are sore to the touch. He doesn't smoke but enjoys a couple of beers at night.

He is currently taking thiazide diuretic for high blood pressure and over-counter-pain medication as needed for migraine. He reports frequent indigestion and has a family history of irritable bowel disease. When asked about his eye symptoms, he reports that he has an appointment with an ophthalmologist because he believes the blowing sand at construction sites has scratched his eyes.

On examination he has eyelid margin telangiectasia, interpalpebral conjunctival injection, and a small crust at the base of the lower lashes of his right eye. In oblique light you can see erythema on his cheeks, nose and chin. It is noted that he has 6 discrete lesions, 4 on the chin and 2 on the left cheek.

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Dani, let's start by discussing common comorbidities of rosacea. Is the fact that this patient is presenting with cardiovascular disease and possible digestive manifestations common in your practice? What else do you see, and how does this affect your approach?

Ms. Haas:
I would say it's pretty common that patients with rosacea, because it is a condition of inflammation, will also present with other comorbidities. As well, rosacea—typically we see it present in the 40s, late 30s, so in those patients it's important to keep an eye on their medical history and pay attention to those. So some of the common comorbidities we see are inflammatory bowel diseases, cardiovascular disease, depression, migraines; and to note, the patient previously had a history of migraines or was taking medication for migraines.

So I think one thing that's important to keep in mind with these patients is to ask them whether they have a primary care provider. This patient is on a thiazide diuretic, so one would assume, but when is the last time they went, and encourage them to go for those annual physicals. I don't think it's a bad idea that this man continue to follow up with ophthalmology because we know that ocular rosacea can also contribute to some vision changes. So, often times these patients may need other specialists but most certainly should be seeing their primary care provider once a year at minimum.

Dr. Mackey:
Mark, what are your considerations from an ocular standpoint?

Dr. Jackson:
If we get a takeaway point from this, it's that we need to ask all patients who have the symptoms of rosacea on their skin that are visible—to ask them about ocular complaints since about 50% of patients also have problems with their eyes. Now, whether it's related to rosacea or not can sometimes be a little bit difficult to distinguish, but we do see that if a patient has ocular rosacea, that they need some type of systemic therapy to control that, and then they need an ophthalmologist as well in many cases to find something that they can use topically to help.

The other issue is it's very difficult to make a diagnosis of ocular rosacea, and many times it's in the symptoms that this gentleman is having, such as redness, burning, stinging or scratching or just that dry, gritty sensation. And so there's no classic pathognomonic sign that you can see when evaluating that, as many times it's their response to therapy, and many times the other things that are also potential causations of those symptoms can benefit from the therapy that we utilize for rosacea. So I think it's important that we don't forget to ask our patients with rosacea about their ocular symptoms because it can sometimes be more bothersome than what they see on the skin.

Dr. Mackey:
That's good. Let's go back to you, Dani. How would you proceed with this patient in terms of drug management recommendations and the role of multi-professional teams?

Ms. Haas:
As Dr. Jackson said previously, often times with rosacea we can start the patient on systemic therapy and then pull back and continue with the topicals. With these patients, often times they need longer-term or even ongoing treatment with systemic antibiotic doxycycline as our typical first-line antibiotic for this type of ocular involvement. And then, also, this patient is going to need some kind of topical medications, so in this case probably a lower dose of doxycycline combined with a topical metronidazole cream would be a great place to start. These are the patients that I often will communicate with Dr. Jackson about, getting his expert opinion on treatment strategy, dosing of medications. Occasionally, we need to start with higher doses of systemic medications and then pull back as patients begin to improve, so we can work together on that.

As far as behavioral strategies and hygiene measures, as Dr. Jackson mentioned before, making sure that the patient understands that it's not just medication that can help to improve their rosacea but also good skin care with gentle cleansers, a well-tolerated moisturizer daily, sun protection with something that's blocking UVA and UVB rays, and then avoidance of triggers. And then just stressing compliance with the regimen, that's always an issue in getting these rosacea cases under good control, that patients understand it's a condition of chronic inflammation and it's not something that tends to just resolve with a few weeks of treatment.

Dr. Mackey:
Let's turn to our final case now. Our patient is a 33-year-old mother of one. She is a director at a local animal rescue shelter. When you saw her a few months ago, she reported recurring facial redness on her cheeks and nose and a little bit on her chin. Flushing is triggered by sun exposure, exercise and stress. She did not have papules, pustules or inflammatory lesions, but telangiectasias were visible over her cheekbones. She was given a diagnosis of rosacea and prescribed metronidazole. Now, 6 months have passed, and she returns to you visibly upset and distraught. She reports some improvement but nothing of significance. She shares that she is embarrassed to be seen in public, which is difficult to avoid considering her career.

Dani, let's talk about adherence. Considering this patient and her progress, or lack thereof, would you consider this to be an issue??

Ms. Haas:
Well, adherence to regimens, topical regimens in particular, is always an issue and always something

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that we have to keep in mind when we're creating a treatment plan for a patient, really stressing in that very first visit that this is something that needs to be continued long-term and that we're likely talking about using these medications for a number of weeks before they begin to see any improvement, and really teaming with a patient and letting them know that their participation in our strategic follow-up is what's going to be required to keep this under control, get it under control and keep it under control. So, typically, if I have a patient that I'm starting on a new treatment plan, I'll recommend they come back in 2 to 3 months so that we can sort of touch base and see how things are going, versus let them go a longer period of time. And frustration and lack of results many times leads people to discontinue their therapy prematurely. We know from previous data collection that 70% of patients only refill the medication 1 time, so lots of problems here with adherence. And just, I think, laying that out in your initial meeting with the patient cannot be overemphasized.

Dr. Mackey:
That certainly sounds like psychosocial impact of rosacea, including depression, can lead to decreased interest in remaining adherent.

Ms. Haas:
Absolutely.

Dr. Mackey:
So, Mark, a recent study showed the benefit of treating to clear and that we should not be satisfied with only nearly clear. Can you tell us about this study and what it means for the future management of this patient?

Dr. Jackson:
I think Dani mentioned some of the mainstays of therapy that we've utilized, but I think with the advent of new therapies, we have clearance as an option, and I think there have been studies that have demonstrated that. And I think when we see our patients with rosacea, it's good for them to hear that "we can get you better it increases their compliance because they don't just not show up if the first agent didn't work. They heard that we have more options to get them clear.

And I think on the converse side of that is patients, if they are clear, the difference in their quality of life comparing clear versus almost clear… There's a statistical significant difference in the patient's quality of life if they're clear versus if they're not clear. And for physicians and practitioners to know that clearance is an option is very important because many don't know, and some of these new therapies are pretty incredible what they can do in creating that clearance is an option.

Dr. Mackey:

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So, for this patient in particular, what treatment options would you choose for her, considering that she failed treatment with metronidazole?

Ms. Haas:
In this case where the patient has had a poor response to metronidazole, we have some medications that can in a more targeted way go after the erythema, which is the larger problem for this patient. She's not having papules and pustules, but the flushing and the redness is more of what's bothering her. So, as Dr. Jackson had mentioned previously, keeping in mind laser therapies, that's something that these patients can benefit from.
Also, there are a few topical agents to choose from that can go after the redness. oxymetazoline is the newer medication that has been shown to reduce redness significantly shortly after the use, but also, the more the patient uses it, the longer the effects tend to last.
I don't necessarily know that the patient has "failed" metronidazole, if we have had adherence issues, so that's a conversation to have.

Dr. Mackey:
So, before we close, do you have any parting words to help clinicians of different professions collaborate to improve the management of our rosacea patients? Dani, let's start with you.

Ms. Haas:
So I think it's important for other specialists, other providers, to be able to recognize the symptoms of rosacea and also keep in mind the differential diagnoses and the comorbidities and not hesitate to refer those patients on to dermatology if needed. We're always happy to see them and happy to give these patients hope, because often times they have struggled for years, maybe decades, thinking that this is something they're just going to have to live with, so getting them to the right people with the right help with these newer agents can be life-changing.

Dr. Jackson and I work very closely on these patients together—in fact, our whole team, our nurses, myself. Whenever in doubt, I will have him come in and take a look at my patients. Sometimes I will even have Dr. Jackson follow up with a patient of mine that I've started on therapy, keeping in mind that he has decades of experience and he may have something to add to the patient's regimen, and then often times... And that goes back to, also, our documentation, communication and use of those IGA scales. it's important to establish clear lines of communication, documentation, expectation, so that we can all follow that track of how the patient's progressing and the patient doesn't get frustrated with her progress and we don't get frustrated with knowing where did they start and where are they ending.

Dr. Mackey:

Mark, do you have anything to add?

Dr. Jackson:
The real takeaway point for me is that rosacea is a condition that's inflammatory. We have treatments that can get patients to clear or almost clear, and I think it's important that they hear that from us. It creates confidence that we can get them better. I think it increases their adherence to therapy, which then increases their outcome to therapy. Don't forget about asking about ocular complaints. Don't forget about taking care of the skin barrier with sun protection and the other things that they need. And then really don't forget about using a multimodal approach to take care of them, because many patients do need that to get their best outcome. And I think it's very exciting now to be able to take care of patients with rosacea with all the great options we have available to get them to that clear endpoint.

Dr. Mackey:
Well, these cases have been very helpful in identifying how we can better manage rosacea in our patients, and I'd like to thank my guests for sharing their thoughts today.
Mark, Dani, it was great having you both on the program.

Dr. Jackson:
Thank you.

Ms. Haas:
Yes, thank you.

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