

Transcript Details

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ReachMD

www.reachmd.com

info@reachmd.com

(866) 423-7849

Advancing ACNE Care: Applying Current Knowledge of Patient Needs and Emerging Evidence to Improve Outcomes

Announcer:

Welcome to CME on ReachMD. This activity, entitled "Advancing ACNE Care: Applying Current Knowledge of Patient Needs and Emerging Evidence to Improve Outcomes" is provided by Prova Education and is supported by an independent educational grant from Galderma.

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Here is Dr. Andrew Alexis.

Dr. Alexis:

What if tomorrow, a patient comes in with scarring, hyperpigmentation, and lesions over their face, back, and shoulders? Would you take action? What if they also referred to having emotional and psychological burdens that impact their daily activities? Would you focus on improving their quality of life? Well, the answer, of course, is "yes." What if I told you that I'm talking about acne and that we could improve the patient's physical and psychological well-being through an individualized and comprehensive treatment regimen?

Welcome to our discussion on Advancing ACNE Care: Applying Current Knowledge of Patient Needs and Emerging Evidence to Improve Outcomes. I'm Dr. Andrew Alexis, and I'm joined today by my good friend and colleague, Dr. Linda Stein Gold. Linda, welcome to the program.

Dr. Stein Gold:

Thank you, Andrew. I'm thrilled to be here.

Dr. Alexis:

Thank you, Linda. It's often said that acne isn't just skin-deep. We say this about a lot of skin diseases. So acne isn't just skin-deep, meaning that its effects go beyond the physical appearance of the skin. Could you walk us through the overall burden or impact of acne beyond just the skin itself?

Dr. Stein Gold:

Andrew, that's such an important point. We know that acne has a tremendous impact on emotional health. We see that our acne patients have an increased rate of depression. We also know that society negatively judges our acne patients. If you have clear skin and you walk into a room, people notice your eyes; they notice your smile. If you have acne, the first thing people notice is your skin, and you're being judged. You know? And this persists even as young adults. There was a study that looked at a thousand young adults who were just starting out their career who had acne. And it turns out about 90% of them said that the acne negatively affected their self-esteem, and 40% said that they felt that their acne was having a negative impact on their careers.

Dr. Alexis:

Absolutely. And we see this day in, day out in our offices, taking care of patients where patients can tell us about how their acne can dictate whether they say yes or no to a social commitment or how well a professional engagement goes just based on whether they're

having a flare or not. So it's almost like their daily existence is dictated by the severity of their acne on that given day.

Dr. Stein Gold:

And even social media, you know, you don't want your picture posted; you want to make sure you can edit it. Everybody wants to put their best face forward.

So, Andrew, we know that these negative impacts really affect all of our acne patients, but what about those patients with skin of color? When you see a patient of color, do you assess their skin or their emotional impact any differently?

Dr. Alexis:

That's a great question, Linda, and as you know, a great deal of my patients do have darker skin tone, skin of color. And one of the things that is most striking about acne patients with higher Fitzpatrick types or richly pigmented skin is that in addition to the papules, the pustules, the comedones, and other primary lesions of acne, there is also the concomitant hyperpigmented macules or post-inflammatory hyperpigmentation [PIH], which in many cases can be just as disfiguring as the acne itself. In fact, many of my patients come in with the chief complaint of hyperpigmentation or what they might call "scarring," but is clinically PIH and not really acknowledge the acne.

Dr. Stein Gold:

Yeah, and so many of us underestimate the impact that has on our patients. You know, we think we're doing the best job because we've gotten the papules and the pustules, and the nodules have flattened down, but when they're left with that dyspigmentation, it's devastating for patients.

Dr. Alexis:

Absolutely. And for that reason, I make it a point of managing both things at the same time, and I'm sure we'll talk about that further.

For those just joining us, this is CME on ReachMD. I'm Dr. Andrew Alexis, and I'm here today with my good friend and colleague, Dr. Linda Stein Gold. We're discussing the importance of earlier and more aggressive treatment of acne, particularly in patients of color.

So, Linda, you know, it's often said with real estate, it's the old cliché, "location, location, location," and in many respects, this applies to acne. For example, when a patient presents with acne on their face, they may also have acne elsewhere: their shoulders, their chest, their back. So how do you approach the assessment of acne beyond the face, especially if the patient doesn't reveal that they have acne beyond their face?

Dr. Stein Gold:

You know, that's such an important issue because we know up to about 60% or so of our acne sufferers actually have truncal acne as well. And only a minority just have truncal acne, so it's really important to ask the patient to show you their chest, their shoulders, and back because about 79% of patients who have truncal acne actually have it in multiple areas. And, you know, whether they tell you about it or not, they certainly expect that you're going to know about it, and they expect that you're going to treat it. And don't underestimate the negative impact of truncal acne; it can be devastating. You know, imagine a young woman shopping for a wedding dress. You know, if you have acne on your chest and back, you want to have something that's going to cover it, and that can be a problem. And even the impact of having inflammatory acne on the chest and back of an athlete. I have one patient who would bleed through his soccer clothing, and every time somebody would touch him or push him, he would be in pain. So it's really an important issue. And when it comes to treating truncal acne, you know, we really rely on evidence-based medicine, and unfortunately, we don't have a ton of great studies that have really well evaluated truncal acne.

Dr. Alexis:

Exactly. And, you know, as a general rule, I – whether a patient presents with just the concern on their face, I'll go ahead and ask them, "Do you have any acne on your chest, your shoulders, your back?" just to open the floor. And so often they do, and they seem to appreciate being asked. And then we can launch into that exam.

Dr. Stein Gold:

And sometimes they don't even know they have it, they'll say, "No, I'm fine."

Dr. Alexis:

That's true.

Dr. Stein Gold:

And you lift their shirt, and there it is, you know, all over their back.

Dr. Alexis:

Exactly.

Dr. Stein Gold:

So I think it's great even just to take a peek.

So, you know, Andrew, one of the sequelae that we worry about most in our acne patients is the risk of scarring. So what are your thoughts on scarring? Are all scars equal?

Dr. Alexis:

You know, when it comes to the sequelae of acne – and we talked about hyperpigmentation – but beyond hyperpigmentation, there is permanent scarring in the form of atrophic scars for the most part. But even hypertrophic scars and keloids, especially when it comes to truncal acne, which we see a higher risk of keloids and hypertrophic scars in our patients with skin of color. So when it comes to managing acne scars, we have some scars that can even respond to topical therapies. It's been shown using a retinoid formulation that scars can be improved, but in many cases, the scarring is deeper and more severe, requiring procedural therapies, and this can become more difficult to manage.

Another point, actually, Linda, is that, even mild acne can result in scarring. You know, historically, we would think scarring is a result of nodular or cystic acne, but even mild to moderate acne, just inflammatory papules and pustules, can evolve into scars.

Dr. Stein Gold:

Yeah, and that's such an interesting concept. It's something that, you know, our understanding of scarring has evolved so much. You know, we used to think that people who came in with papules and pustules, you know, it's just superficial; you don't have to worry about it. But we understand that that is just not true. And the papule seems to be the culprit. You know, however long that papule lasts, if it lasts a longer period of time – and as you mentioned, even when the papule seems to resolve and we see the sequelae, the pink spots, the brown spots, those can still develop into atrophic scars. So we're understanding a lot more about how to get this under control.

Dr. Alexis:

Exactly. Well said. Now, Linda, there are now several topical retinoids that we can use; we have a range of options, which is great. What are the main differences, and how do you know which is the most appropriate for a particular patient?

Dr. Stein Gold:

Yeah, and as you mentioned, Andrew, when you were talking about scarring, topical retinoids really are the cornerstone of treatments for active acne and potentially for maintenance therapy and even for some atrophic scars. We know that they work well on comedones, but they're also very good anti-inflammatory drugs, so they work on the papules and the pustules, as well. They work through receptors called the retinoic acid receptors or the RAR receptors, and we know there are different types; there's alpha, beta, and gamma. And when we look at our topical retinoids, we've seen that they've evolved over the course of time. We started out with tretinoin, which was more nonspecific; it targeted all of those receptors. And then we had adapalene and tazarotene, which were a little more specific. And now we have trifarotene, which is really a targeted retinoid. It's target to RAR-gamma receptor, which is the predominant receptor in the skin. It also, because it's so targeted, we see this in a very low concentration. And you might say, "Who cares about the concentration?" But if you want to use a retinoid on a large body surface area, it's nice to have a low concentration that has very, very low systemic levels, especially if we want to use it on large body surface areas.

And I mentioned before that we really value evidence-based medicine. What was interesting about the trifarotene studies was that we looked at patients who had facial acne, but for the first time, we really deeply evaluated those patients who had truncal acne, as well. And if you asked a lot of, you know, dermatologists who've been around awhile, "Can you use a retinoid on the trunk?" a lot of them would say, "You know what? No. First of all, it probably doesn't work on the trunk and probably is too irritating." And what we learned from the trifarotene studies was that, first of all, the efficacy on the trunk was equal to or even potentially better than on the face, and we also found the tolerability – same thing, equal to or potentially being a little bit better than what we've seen on the face. So our understanding has actually evolved with time as we have these studies that are actually asking and answering these important questions.

So, Andrew, one more thing about this information is that it's so new, it hasn't even made it into the recent acne treatment guidelines. Hopefully, we'll get it into the next version.

Dr. Alexis:

So well said. I mean, historically, like you pointed out, retinoids have been pigeon-holed as medications for comedones, but there's so much more beyond treating comedones that retinoids can do, including inflammatory lesions and lesions off of the face, such as the chest and back, as you pointed out.

Dr. Stein Gold:

So, Andrew, I want to go back to one of these really kind of important questions that has such an impact on our patient, and that is the presence and the risk of the post-inflammatory dyspigmentation, the hyperpigmentation. We call it post-inflammatory, but it's probably not post-inflammatory; there's probably still some inflammation there, but this has a tremendous impact. Can you talk a little bit about your approach to dyspigmentation in your patients?

Dr. Alexis:

Yeah, thank you, Linda. When it comes to managing patients who have post-inflammatory hyperpigmentation or are simply at risk for post-inflammatory hyperpigmentation, as is the case in patients with skin of color, I think it's extremely important to manage both issues concurrently. How do we do that? Well, PIH can come from 1 or 2 scenarios: it could either be a sequela of the acne itself, but it could also be induced by topical or other therapies that the patient may do themselves or might be even be prescribed by a healthcare provider. So we're always striking this delicate balance between maximizing the efficacy, but doing so while avoiding irritation. We do not want to maximize efficacy at the expense of tolerability because irritation, in turn, can cause more PIH.

One great way to tackle both problems head-on, the acne and the PIH, is using a topical retinoid. Topical retinoids have been shown, for decades now, to be able to improve post-inflammatory hyperpigmentation associated with acne. So it becomes increasingly important to use retinoids as the foundation of acne treatment, especially when considering the sequelae of PIH.

Dr. Stein Gold:

That makes a lot of sense. You know, that way, it's kind of a win-win. Get the active acne under control and also work on improving the dyspigmentation.

Dr. Alexis:

Yes, indeed. Now, this has certainly been a fascinating conversation, but before we wrap up, Linda, can you share one take-home message with our audience?

Dr. Stein Gold:

Sure. I'm going to give you, like, one and a half. I'd say, most importantly, start early, be aggressive with acne therapy, and continue treating until all the lesions have resolved and even the discoloration: the pink spots, the red spots, the brown spots. And don't forget to look at the trunk for truncal acne.

Dr. Alexis:

Great points. I'll just add to that my own take-home message, and that's not to underestimate the long-term sequelae of acne, which speaks to the importance of early and aggressive treatment while maintaining tolerability to avoid further sequelae. So I think that with the options that we have today, we're able to succeed in getting our patients clear from an acne standpoint, but also minimizing the risk of sequelae and overall improving their quality of life.

Now, unfortunately, that's all the time that we have today, but I want to thank our audience for listening in and thank Dr. Linda Stein Gold for sharing her valuable insights. It was great speaking with you today, Linda.

Dr. Stein Gold:

Thanks, so much. It was a pleasure.

Announcer:

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