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Raising Expectations for Rosacea: Best Practices That Drive Clear Results

Announcer:
Welcome to CME on ReachMD! This activity: *Raising Expectations for Rosacea: Best Practices That Drive Clear Results* is provided in partnership with Prova Education and sponsored by an independent educational grant from Galderma Laboratories.
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Here's your host, Dr. Jennifer Caudle.

Dr. Caudle:
After encountering rosacea in clinical practice on a regular basis, it can become a force of habit to focus only on the cutaneous manifestations of the disease, but what's often overlooked are the

pathophysiological changes and comorbidities that make management much more complex. On today's program we'll explore the impacts of these factors as well as the latest treatment strategies in alignment with current guidelines to help improve patient quality of life.

From the ReachMD studios in Fort Washington, Pennsylvania, this is CME on ReachMD, and I am your host, Dr. Jennifer Caudle. And I'd like to welcome my guest, Dr. Mark Jackson, Clinical Professor of Medicine and Dermatology at the University of Louisville.

Dr. Jackson, welcome to the program.

Dr. Jackson:
Thank you. Thanks, Jennifer, for having me and for the introduction.

Dr. Caudle:
Absolutely. I'm excited that you're here. I think this is a very important topic. So let's start with a brief overview of patients who present with rosacea. What are some of the most common patient types and subtypes that we see, and have our definitions changed with the evolving understandings of the pathophysiology and systemic nature of this disease?

Dr. Jackson:
I think you bring up some great points that provide a perfect groundwork for what we're going to talk about in this interview, and I think that what you mentioned is the pathophysiology and the systemic nature and all of the different phenotypes really depict the complex nature of rosacea. And it's not just a skin disease. It actually has a lot of systemic implications as well, so I think you bring up a perfect introductory question.

I think just a specific answer, just in general, people think that this is a disease that primarily affects women, it's just more of a cosmetic disease, it shows up as these red bumps and pimples and pustules on the face and it's just considered cosmetic, but we know that it really has many more implications than that. We also know that it shows up very commonly in men and they are very bothered by it as well, so it's not just a disease that affects women or bothers women, but it's one that also affects men. And then the other thing we see is that over time, this chronic inflammation that actually is rosacea, this chronic inflammation that is present for a long duration of time can lead to downstream implications which create some chronic changes on the skin that are very hard to fix and sometimes irreversible, and those are kind of the bulbous, what we call phymatous changes on the nose that happens after the pimples and pustules and the redness have been present for a long period of time. And if we get the disease at an early state and take care of it in the appropriate way, we hope to not have those things happen over time.

Dr. Caudle:
Okay, very good. Mark, let's talk about some of the complications and maybe more of the serious complications. What are some of the most serious complications that we need to look out for in these patients?

Dr. Jackson:
I think it's interesting—and you again bring up a great point—if we only consider this a skin condition, then I think we miss out on really the other implications of the disease. And it's something that can also affect patients' eyes and give them a lot of inflammation, and the patients talk about the sensation of dryness and grittiness scratchiness. And many times I will see patients referred from ophthalmology for evaluation of very severe problems with the eyes, and we find that it really is just another manifestation of their rosacea that's on their skin, and so being able to help a patient beyond just what's on the skin and also affect the ocular component is very big. Also, there's a psychosocial component, which obviously has effects over time. But again, we talked about the chronic inflammation, if over time left untreated, leaving these chronic changes on the skin that are very difficult to treat, and so we want to be able to take care of things early. So the eyes are one of the issues. We talked about the chronic inflammation. And then there are some other comorbid conditions that we see that are also associated, so we can use rosacea, actually, as a marker for other things that might be going on in patients' lives, and we use the skin more as a window to see what other systemic issues may be going on.

Dr. Caudle:
I really liked how you just described that, using the skin as a window to see kind of what else might be going on. And, of course, one of the purposes of this program, in addition to other things, is to broaden our horizons and to think beyond just cutaneous manifestations of rosacea, so I think that was very well put and I think a really good reminder for us all to think about the broader picture of rosacea.

So, based on your patients' feedback, what do they tell you are the hardest parts about living with this disease?

Dr. Jackson:
I think if you ask patients themselves what they feel like their rosacea does to them socially, I think it's a few things. Number one is I think they have a perception that other people think that if they're red or flushed, that they're embarrassed or they're nervous or they're uncomfortable and it makes them seem to be unsettled in a situation, which obviously can be awkward in a social situation. You can imagine what having a bunch of red bumps and pustules is on your face. And they are painful, but they are also very visibly unsiteful [sic], and that can bother patients as well. I think the long-term implications and the issues that patients have to deal with also is that people who have rosacea, I think, based on old

mindset, is it means they are a heavy drinker or an alcoholic, and I think you can see how that can also be an issue socially. And so I think really when we look at this red condition on the face, we talked about the systemic implications, but the social implications are huge as well.

Dr. Caudle:
I think those are really great points, and you mentioned the phrase sort of window. I think some of the examples you just gave are windows into how patients feel, and I think we have to keep this in mind. Let's dive a little bit into the differential diagnosis, because, of course, as clinicians it's something we always have to be thinking about. So, how are various other skin diseases ruled out during your diagnostic assessment?

Dr. Jackson:
One of the most common things we're sent patients or these patients are referred to dermatologists for evaluation of is acne. And so there can be a difficult time for some patients to be able to tell whether they have acne or they have rosacea, and the difference between acne and rosacea is that in acne patients, they have these things called comedones, which are dilated, open pores and closed pores. In rosacea they don't get that. And then the other thing is in the past it's been called acne rosacea, but it's really rosacea is one condition and acne is another condition, and so it's not that hard to tell the difference between acne and rosacea. The real trick is if patients have both, which can happen occasionally, it can be tricky, but if they have comedones, open or closed and the red bumps, that usually means they're more of an acne-type patient. If they have just the redness, red bumps and pustules, that's more in line with rosacea. And you can also ask about their eyes, as we talked about. If they have an ocular component, we don't tend to see an ocular component in patients with acne.

There's one other condition that is often misdiagnosed as rosacea or a patient is sent in for something that is not rosacea, which is lupus, and in cutaneous lupus they can have redness in the central face and on the forehead and chin, and many times it can look similar to rosacea, and we're referred patients many times that actually have rosacea who have been told they have lupus for years, so that's another disease it's important to differentiate from rosacea.

Dr. Caudle:
I think those are really great descriptions of some of the things that we often encounter in clinical practice. They can mimic and they can seem very similar. So let's talk a little bit more about rosacea specifically and how rosacea is categorized into specific subtypes. In discussing this, if you can also, Mark, talk about some of the limitations with the way that we classify rosacea at this time.

Dr. Jackson:
Well, we always try to put things in a box and to make them very simple, and so we've had 4 subtypes

of rosacea that's been the classic description: the patients who just have a little redness called the erythematotelangiectatic type; then there are the patients who have type 2, which is the papulopustular type; and then there's type 3 we call the phymatous type, which again goes back to the bulbous nose and that rhinophyma and kind of the lymphedema you can see in the central face; and then the ocular type, which involves just the eyes. It would be nice if everything fit into those perfect boxes, but that's not the case, and most of the time we see patients who have 1, 2, 3 or sometimes even all 4 components. And so I think those are different manifestations of the disease, but I wouldn't classify patients based on 1 specific subtype, and I think that's important as we go into the evaluation and treatment and what we need to do for our patients. We need to factor in which types do they have or how are they manifesting and not really try to put patients in one particular box.

Dr. Caudle:
That's a very, very important statement there, I think very helpful.
So, Mark, we touched upon the systemic nature of the disease earlier, but let's focus now more on that in detail. How important is it for us to think of rosacea as a systemic disease?

Dr. Jackson:
Well, as we talked about at the beginning, and for those of you who just joined, rosacea is not just a rash. It just happens to be a manifestation of inflammation that we can see visibly. And it's not unlike inflammation that we would see in any other organ, and the skin is just a large organ that manifests with redness and these inflammatory papules and pustules. So when I say more than just a skin disease, it's another way we can see inflammation, it just is on the skin, but it does have a systemic component. And we see people who have rosacea who have elevated levels of their inflammatory proteins, and when we control the rosacea, we can see that those inflammatory markers go down, which denotes the systemic nature of the disease. We also know that there are a few other conditions that can be seen in patients with rosacea, which we'll talk about in a little bit, but I think it's just really important to know that this is not just a rash. It is inflammation that we just happen to be able to see.

Dr. Caudle:
So, Mark, can you discuss a little bit about how the mechanism of actions of some of the different treatments can actually affect the disease outcome for rosacea?

Dr. Jackson:
That's a great question, and when we as clinicians see patients who have rosacea, I think it's important that we know the mechanism that we're trying to treat so we choose the right therapy. And what do I mean by that? Well, if they just have the redness and flushing, that tends to be more related to vascular reactivity, and there are agents that really focus on just the vascular reactivity. If there are prominent

vessels that are present but they are not changing, that's where we move more toward a laser to help with those permanently dilated vessels. And if there are patients who have more papules or pustules, we know we need more anti-inflammatory topical agents to target those in particular, and that could be with combination therapy or topical therapy or just systemic therapy when we're targeting that inflammatory component. If you talk about the eyes, we may need something that's more amenable to use for the eyes and in the eyes, and that could be artificial tears and things that they can use for lubrication as well as systemic therapy in those patients. And then when we have patients that have more of that chronic phymatous change, we might need to be more focused on how we're going to decrease the size of the sebaceous glands in those patients, and that that chronic inflammation that has had some end-stage changes, and we may need to move more towards something such as isotretinoin that we've used short term in acne patients. It can also be helpful in those end stages of rosacea, which we hope to try to avoid now. But as we evaluate what we need to do for our patients, I think it's important that we think about the mechanism of action.

So again, we talked about the dilated vessels in one component. We talked about the body's reactivity to these… it could be the normal flora of the skin or other things that result in these inflammatory papules and pustules occurring. We talked about the chronic component, and then we also talked about the ocular component. And as we've talked about many times, most patients manifest with many different types of those findings, and so we need to move towards more of a systemic approach, and the overall approach to therapy may need to be a combination of agents, and that goes again back to adherence and being very regular with dosing to have the best long-term outcome.

Dr. Caudle:
So, as we learn more about the pathophysiology of this disease, what impact does this have on setting therapeutic goals for patients with rosacea?

Dr. Jackson:
One of the things I like to highlight with my patients or our patients who have rosacea is we have to work on not only the treatment but also on the prevention and the education to help patients avoid the triggers, to take care of their skin barrier, to better protect it against the outside insults that make rosacea worse, and then also to really focus on a treatment that can get them to a point of clear, not just better. And I think when you're trying to get them clear, you have to evaluate which components are present, and if it's just redness, that may be just 1 treatment, but if it's redness and bumps in the eyes, it may involve combination with both topical and a systemic agent to get them the best control. And I think patients want to know that they can be clear, and I think in the advent of today's therapies and the progress that we've come upon, I think clearance is an option for patients, and we ought to be able to have that as our goal, and that should be our goal, and patients should know that we're working

for that. I think with the new agents we have that opportunity in many of our patients.

Dr. Caudle:
Excellent. So, Mark, is there a difference between being clear and almost clear?

Dr. Jackson:
Jennifer, that's a great question, and I think really the important part is there's a big difference in a patient's perspective of clear and almost clear and how they are perceived socially as well as what they think about themselves and their overall disease activity, and if a patient is totally clear, it's amazing the difference in the impact on their quality of life. And when you look at quality of life numbers, if a patient is totally clear, that means no evidence of burning, stinging, itching, flushing, pimples or ocular involvement. If they are totally clear of disease and you measure their quality of life versus if they have just a little bit of involvement, studies have shown that there is a significant difference in that, and so our goal should be to get patients clear. The other thing that we see if we get patients to that point of clear is that there's a longer point to relapse, which means they have longer disease-free periods before they have some other component of their disease. So clearance helps for 2 components—number 1, to improve quality of life, and number 2, to increase disease-free periods.

Dr. Caudle:
So, Mark, you talk a lot about being clear and not clear or almost clear, rather. Is this data published?

Dr. Jackson:
Yes, and it's actually been very important that we get this data out there, and I think there's a recent article that we worked on that we've published that demonstrates that exact fact that we just talked about.

Dr. Caudle:
Excellent, excellent. So moving forward a little bit, what are some best practices that you use when setting therapeutic goals with your patients?

Dr. Jackson:
I think there are multiple components that we talked about. The first is to really involve the patient in what we're doing and to give them some things that they can do to better control their condition with and without therapy, and I think in our patients with rosacea, we see that chronic sun damage plays a big role, and so daily sun protection is important. I think that good moisturization techniques are also important because it has been demonstrated that our patients with rosacea have a damaged skin barrier. And is that related to the rosacea having been present for such a long period of time where their barrier is actually damaged? It's difficult to tell which comes first, but improvement of the skin

barrier can improve their overall tolerability of the topical therapy and the other things that they need to do to prevent the disease. Avoiding the typical triggering factors such as spicy foods and stress and wind and cold and all of those things obviously play a role. But then the real important things we talked about earlier are all the different therapeutic regimens that we have that can help get the patients to that clear point, and that might be a combination of topical and systemic agents, and that's okay, and there's been demonstrated and there have been studies that have shown that that is something that is okay to do.

Dr. Caudle:
Very interesting, and I think that's a really interesting and a great point for our listeners is that sort of transition, perhaps, from just treating what's there, as you said, to treating what's there and also trying to prevent disease as well. I think it's very helpful.

Let's focus on treatment challenges. Some of the data regarding duration of treatment indicates that patients often discontinue therapy within 30 days. Why do you think that this is happening, and how can physicians really help improve patient adherence?

Dr. Jackson:
Another great point. I think patients need to be educated that regular therapy can give them future benefit. I often tell them you work out so you can be fit or you practice so you can play well or you study hard so you do well on the test. Regular use of these therapies can give you this clearance that we're looking for. And it's not just a 1- or 2-week treatment regimen, so I think it's on us as physicians to help our patients understand that regular use can get them future benefit to even clearance, and it's important to know that going out for 2, 3, 4 months and being consistent with the therapy is very important to getting to that point of clear.

Dr. Caudle:
Very good. On the subject of shared decision-making, you talked a little bit about decision-making, shared decision-making, interdisciplinary treatment models and things of that nature. What other professions and specialists are central to the care of patients with rosacea, and do you have any recommendations to these clinicians for improving patient outcomes?

Dr. Jackson:
Dermatology is one of those specialties that it's very difficult to know about dermatology from an outsider's perspective, and I think it's important that we also utilize colleagues for things that we might feel we need their expertise. I think if you're having a hard time getting the ocular disease under control, working with an ophthalmologist can be helpful. I think we in dermatology can treat ocular rosacea, but

there might be another component that's present or more chronic inflammation that what we have may not work for that we need to incorporate those specialists. I also think that it's important that if we see patients who have rosacea, we do know that things… There are some patients who have more of a tendency for obesity, for hypothyroidism, for diabetes and things such as that, so if we do see that there are comorbid conditions present, I think it's important that we get our patients to the place where those can be best controlled. Many times we in dermatology see patients that don't have any primary care because they're just coming in for their "skin problem," but they don't realize it's also a marker of other things that may be going on, so we can be kind of that component in the middle to get them to the right place.

Dr. Caudle:
All right, those are really excellent points, and before we close I just want to reiterate the things that I've learned and I know that our listeners will take away and our viewers as well, is you talked very succinctly and very clearly about how rosacea is not just necessarily a skin condition, that so many other systems can be involved. And also, your last point I think was just very important for us all, is that it may not just be rosacea. There may be a predilection for other disease conditions coexisting that we need to be on the lookout, so I really appreciate that sort of opening up the definition of rosacea and how we think about it.

So before we close, lastly, Dr. Jackson, is there anything else you'd like to add for our audience today?

Dr. Jackson:
Rosacea is not just a skin condition—it's a visible way we can see inflammation and it might have a systemic implication. I think it's important that we involve our patients in helping educate them in what they can do, and that means avoiding the triggers and taking care of their skin barrier and also maintaining them on the therapy that we work hard to tailor for them. And then I think, finally, that clearance is an option, and that's not something that we've really had before, and knowing that clearance is an option should change all of our bars for where we want to get patients in their therapeutic outcome, and knowing that that is is exciting when you see patients who have a condition, knowing that you have something that you can clear.

Dr. Caudle:
No, I think you are very right, and I think you've given a lot of people a lot of hope. These have all been really great insights and reminders for keeping the big picture of quality of life and focus when treating patients with rosacea.
I'd like to thank you, my guest, Dr. J. Mark Jackson, for speaking with me and our ReachMD audience today. Dr. Jackson, it was great having you.

Dr. Jackson:
Thanks, Jennifer. I appreciate you including me.

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