

Transcript Details

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Managing Pediatric Acne with Confidence

Announcer:

You're listening to *On the Frontlines of Pediatric Skin Health* on ReachMD. Here's your host, Ashley Baker.

Ashley Baker:

This is *On the Frontlines of Pediatric Skin Health* on ReachMD, and I'm Ashley Baker. Today, I'm joined by Dr. Shehla Admani to explore real-world strategies for managing pediatric acne. Dr. Admani is Clinical Associate Professor of Dermatology at Stanford University School of Medicine in Palo Alto, California. Dr. Admani, welcome to the program.

Dr. Admani:

Thank you for having me.

Ashley Baker:

Starting off with some background, Dr. Admani, how does acne in younger pediatric patients differ from what we typically see in adolescents, and why does that matter for treatment decisions?

Dr. Admani:

Pediatric acne falls into three categories: infantile acne, mid-childhood acne, and preadolescent acne. To better understand these types of acne, we need to first understand androgens. Androgens are steroid hormones that stimulate sebaceous gland enlargement and sebum production, which contributes to the development of acne.

Infantile acne is usually seen from six to 16 months of age. This type of acne is due to temporary imbalances in androgen production and tends to resolve on its own over time, usually within the first year of life, but it sometimes can continue until about two years of age.

Mid-childhood acne is seen from about one to seven years of age. This is the acne that can be the most concerning, as, during this time, androgen levels really should be low. Acne in this age group makes us worry about causes of premature adrenarche, such as congenital adrenal hyperplasia or androgen-secreting tumors, and we typically will partner with pediatric endocrinology to work these patients up.

Preadolescent acne is usually seen from seven to 12 years of age during an early rise in adrenal androgens and can signal the start of puberty.

When you are creating an acne treatment plan, it is important to also think about the lesion type. Our basic acne lesions include comedones, which are smaller non-inflammatory lesions. Open comedones are commonly referred to as blackheads, and closed comedones are commonly referred to as whiteheads. We also have inflammatory lesions, which include pink papules or pustules, and larger lesions such as nodules, which carry a higher risk of scarring.

All three groups of pediatric acne can have any of these lesion types, but nodules tend to be rarer in infantile acne, and preadolescent acne tends to be primarily comedonal.

It is important for healthcare providers to be able to identify and diagnose acne in these age groups so that appropriate treatment and workup can be started to overall optimize the child's health and decrease the risk for scarring.

Ashley Baker:

So when you're initiating treatment in this population, how do you approach first-line therapy and what factors guide your decision-making?

Dr. Admani:

Initial treatment planning takes into consideration acne severity. Mild acne is primarily comedonal and with a limited number of lesions. Moderate acne tends to have many comedones and may have some inflammatory lesions. Severe acne is generally numerous comedones with inflammatory lesions and may include larger nodules as well.

Mild acne can be treated with topical retinoids or benzoyl peroxide. In this age group, leave-on benzoyl peroxide preparations are preferred to washes to allow for more targeted treatment and decreased risk of eye irritation or ingestion.

When choosing a retinoid, low strength is preferred to start. To improve tolerability, it is okay to start with more limited use, such as a couple times a week, and slowly increase the frequency. It is also very important to counsel caregivers that emollients are needed, and during the day, sun protection should be used to decrease sunburn risk.

If a child is using both the retinoid and benzoyl peroxide, remember that benzoyl peroxide can inactivate generic tretinoin, and the two should not be used together at the exact same time.

Ashley Baker:

We know that safety is always a key consideration in pediatrics. How do you evaluate and manage the safety of topical retinoids and other standard therapies in younger patients?

Dr. Admani:

When we are discussing treatments like topical retinoids with caregivers, it is important for us to let them know that although they may not be FDA approved for younger children with acne, they are standard of care. Parents never want to feel that their child is being experimented on, and it is important for us to highlight that off-label use does not mean that these treatments are experimental. These treatments can be used safely and effectively.

As we already discussed, low-strength products are an excellent starting point. Gradual initiation can be helpful, liberal use of emollients can improve tolerance, and sun protection decreases sunburn risk.

Close follow-up is also important to improve caregiver comfort and confidence. Acne treatments can take eight to twelve weeks to take effect. I will sometimes see them a little sooner just to do a compliance and tolerability check. When we show families that we are partnering with them in this and will keep a close eye on their child, we often get more buy-in.

Ashley Baker:

For those just tuning in, you're listening to *On the Frontlines of Pediatric Skin Health* on ReachMD. I'm Ashley Baker, and I'm speaking with Dr. Shehla Admani about therapeutic decision-making for pediatric acne.

So, Dr. Admani, we've been discussing first-line approaches. Now I'd like to focus on more advanced management. At what point do you consider escalating therapy, and how does that choice differ from what we might do in adolescents?

Dr. Admani:

More aggressive treatment is needed if a child is not responding to first-line agents, if you are seeing scarring, or if the child has more moderate-to-severe acne to start. Remember that topical treatment strength can be escalated, combination topical therapy can be used, and moderate-to-severe acne may require topical treatment and the addition of a systemic antibiotic.

In our adolescents, we will often reach for tetracyclines, but it is important to remember that tetracycline antibiotics should not be given to children younger than eight years of age. In this age group, erythromycin and azithromycin are preferred.

People often think of acne as a teenage or childhood rite of passage, and to some degree, this is true. But the reality is that acne can affect a child's self-esteem. Children and adolescents with acne can have significantly higher rates of depression and anxiety, and the extent of this does not always track with the clinical severity of the acne.

It is also important for us to remember that acne can scar. Scarring is permanent, and this can further impact a child's long-term quality of life. When we are discussing risks and benefits of treatment, we also need to make sure to highlight the risk of not treating, and this helps to better put things into context.

Ashley Baker:

And as a follow-up to that, where do systemic treatments, including oral antibiotics or even isotretinoin, fit into pediatric acne management today?

Dr. Admani:

We briefly discussed oral antibiotics and patient and agent selection. Similar to our adolescent patients, in our younger children, we typically limit antibiotics to three months to reduce antibiotic resistance and limit potential adverse effects. Always remember that

antibiotics should be used as part of an acne treatment plan and not as monotherapy. When possible, antibiotic therapy should be combined with topical benzoyl peroxide to prevent microbial resistance.

The goal of systemic antibiotic therapy is to kickstart the treatment plan with the intention to then continue more prolonged treatment with topical agents. But in some cases, this is not possible. In children with very severe disease or in children who are flaring when we stop the oral antibiotics, we need to think about oral isotretinoin therapy, and this may be a good time to partner with your local pediatric dermatologist.

Standard isotretinoin dosing in infants and children is the same as for adolescent acne, usually 0.5 to one milligram per kilogram per day. Goal cumulative dose is not as well established in younger children, and course durations can vary usually from four to 14 months. Laboratory monitoring is similar to that in adolescents. There has been concern for premature closure of growth plates with isotretinoin use in children, but this is typically reported with higher doses of isotretinoin and longer duration.

Again, remember that acne scarring is permanent. In the appropriate pediatric patient, isotretinoin therapy can be considered.

Ashley Baker:

Before we come to the end of our discussion, Dr. Admani, let's briefly look ahead. How do you see the treatment landscape evolving for pediatric acne, and what changes could meaningfully improve both safety and long-term outcomes?

Dr. Admani:

We need more FDA-approved therapies, and we need more gentle, tolerable treatment options. FDA approval goes a long way in improving both provider and caregiver comfort in treating acne in young children. Some of the newer topical therapies that we have for our adolescents are showing superior tolerability, and we will see over time how we will be able to expand our pediatric acne therapeutic options.

Ashley Baker:

With those insightful comments in mind, I want to thank my guest, Dr. Shehla Admani, for joining me to discuss how we're approaching treatment decisions in pediatric acne. Dr. Admani, it was great having you on the program.

Dr. Admani:

Thank you, Ashley, and thank you to ReachMD for highlighting the importance of pediatric skin health.

Announcer:

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