MANAGING ROSACEA

Insights into the multifactorial approach to treating rosacea.

WITH JULIE HARPER, MD, TODD E. SCHLESINGER, MD, LINDA STEIN GOLD, MD, AND JAMES ULERY, MD

Treating rosacea is definitely multifaceted. It is vital to educate patients about rosacea and to discuss potential trigger factors. Prescription medications and procedural treatments are not meant to override the necessity of trigger avoidance,” says Julie Harper, MD. “Successful management of rosacea involves appropriate skin care, elimination or mitigation of triggers, prescription medications, and sometimes procedural or device-based treatments. Demodex is likely a trigger factor in many rosacea patients. Demodex or a component of Demodex may upregulate innate immunity, promoting inflammation in rosacea subjects.”

“Rosacea has a spectrum of presentations. On the one hand, you have erythema and on the other hand you have papules and pustules. Treatment should address both presentations when demonstrated in the same patient,” explains Todd E. Schlesinger, MD. “One consideration is the effect of barrier dysfunction. It has been shown through published studies that rosacea responds to compounds such as low molecular weight hyaluronic acid (LMWHA) that not only improve barrier function, but increase the level of beta 2 defensins, that impair demodex mites and reduce inflammation. Clinical relevance is demonstrated by the reduction in erythema scores and subject satisfaction assessments.

Demodex has the role of stimulating the already abnormal innate immune system present in rosacea patients. Elevated levels of cathelecidins are pushed higher by the antigens present in Demodex mites via a toll-like receptor mediated pathway.”

James Ulery, MD says that treating erythema of rosacea is always challenging, and he typically discusses layering medications for their effect. “The first line drugs of metronidazole topically with or without sulfer based washes have both anti-inflammatory and antibacterial effects that work for many people, but take time to see maximum effect (I tell patients about three months),” he says. He adds that brimondine (Mirvaso) can effectively help to hide erythema for about 10 hours, but that it does not essentially treat or change anything. An underlying treatment is still needed.

BY THE NUMBERS: ROSACEA’S IMPACT

77 percent of rosacea patients who say they wear more makeup now than they did before their rosacea diagnosis. One in five patients believes that having rosacea makes it seem like they don’t spend enough time on their appearance.

54 percent of patients who say they don’t feel comfortable talking to their physician about emotional challenges associated with rosacea.

Findings come from a survey of 500 rosacea patients and 300 dermatologists reported in conjunction with the National Rosacea Society’s and Galderma’s Break Up with Your Makeup, educational campaign and contest.

To learn more: http://breakupwithmakeup.com/?reqp=1&reqr=
“Oracea (doxycycline), which has documented anti-inflammatory effects is also useful for redness and mild to moderate inflammatory lesions with less potential side effects. Some patient still will do better with short-term (one month or less) dosing of Minocin or Doxy at 100mg twice daily,” he adds.

For telangiectasia, Dr. Ulery recommends Mirvaso, cover-up makeup, diode laser, or intense pulsed light therapy. He says ivermectin (Soolantra) is an interesting and novel approach to Rosacea and that it purportedly has direct anti-inflammatory effects.

“I think Demodex is a bit overplayed as a causative agent in rosacea and more likely will bring in patients with delusions of parasitosis,” Dr. Ulery says. “There have been studies in the past that did show some associations with the presence of H. Pylori correlating with rosacea, and treatment for H. Pylori resulting in improvement in rosacea (although oral metronidazole was used in those cases). The idea of localized infection triggering inflammation either systemically or locally does have some interest and plausibility.”

**NEW TREATMENT OPTIONS**

“With the approval of 1% ivermectin cream and its efficacy and safety in the treatment of patients with moderate to severe PPR, the role of Demodex has been more closely questioned,” explains Linda Stein Gold, MD. “Ivermectin has both anti-inflammatory and anti-parasitic properties and it is unknown what the mechanism of action is in rosacea. I feel that both mechanisms will likely play a role as we have had great anti-inflammatory agents in the past for rosacea yet ivermectin has superior efficacy and the potential for long-term remission. It is important to have drugs that treat both the inflammatory lesions as well as the background erythema in order to get our patients truly clear.”

Dr. Harper says she is thankful to have an FDA-approved product that targets the persistent facial erythema that many rosacea sufferers struggle with. “My overall approach to treating rosacea has not changed but my armamentarium has enlarged!”

Dr. Schlesinger says he has begun to use some of the new therapies available when indicated. “Treatments specifically directed at erythema are combined with those aimed at the papulopustular component of the disease,” Dr. Schlesinger explains. “These, combined with barrier repair medications and sunscreen are important components of a complete treatment regimen. I also combine plant-based cosmeceuticals to reduce redness and retinaldehyde to control epidermal function, inflammation and redness.”

Dr. Ulery says he uses ivermectin (Soolantra) for patients who are not getting good results with Finacea or Metrogel, who want to see what is new on the market, or who are reticent about oral antibiotics. He says he uses Mirvaso for patients who find erythema at work or social occasions problematic, as needed. He adds that he may prescribe Oracea for one to two months to cool down an active rosacea flare or when a patient has a special occasion in a month and want to avoid a flare. He prescribes this with concurrent topicals and stops oral medications as quickly as is reasonable.

“I still do a lot of discussion about trigger identification and avoidance, flare treatment versus maintenance treatment, and to keep the regimen of cosmetics and other agents as simple as possible,” —Dr. James Ulery

**DEVICES FOR ROSACEA**

“I think devices are great adjunctive treatments for some patients. Specifically diode laser/vascular laser for fixed telangiectasia, IPL broadly for erythema, blue/red light for inflammatory lesions. The biggest issue with devices are that most insurance plans do not cover their use for these indications, so it becomes an out of pocket cost for patients,” says Dr. Ulery, adding that the at-home device market has grown rapidly. “It will be hard to justify the devices as part of standard of care, but with more commercial availability, the use of devices will probably increase over time...Ultimately we may have great combinations of topical meds with IPL that will dramatically shorten times to improvement, it just has to be accessible and affordable.”

Dr. Harper says she uses a pulsed-dye laser for erythema and telangiectasia associated with rosacea.

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This article was excerpted from “Expert Approaches to Treating Acne and Rosacea in 2015,” which appeared in the June 2015 issue of Practical Dermatology magazine. To read the full article, visit practicaldermatology.com or download the Modern Aesthetics’ app.