ROSACEA

Written by Jan Marini
Distributed by James J. Romano, MD

Rosacea is a skin disorder that affects approximately 13 million Americans. Physicians and Skin Care Professionals are seeing rapidly increasing numbers of individuals affected by Rosacea as the "over 40" population continues to grow. Rosacea is gaining in general public awareness as evidenced by the designation of March each year as the "National Rosacea Awareness Month". This often baffling disease can be difficult to treat and can cause severe emotional distress due to the visible facial involvement.

The disease Rosacea was originally called Acne Rosacea. That name is no longer considered correct. Even though many aspects of Rosacea may closely mimic the description and characteristics of acne, it is a completely separate entity. Rosacea is a common, chronic inflammatory disorder, usually affecting the central portion of the face and occasionally the V-shaped area of the chest, the back and even the scalp. It is characterized by facial redness, telangiectasia (dilated capillaries) and sometimes lesions that look like acne papules and pustules.

It is often difficult to diagnose Rosacea because the lesions can so closely resemble acne. However, even though a Rosacea papule or pustule may imitate acne, the key differentiation is that in Rosacea, there is no microcomedone activity present.

Most commonly, the clinical onset of Rosacea begins between ages 30 to 50 years, but can occur in adolescence or in the elderly. Also, Rosacea is much more prevalent among females, but when men do get Rosacea it is usually far more severe. Last, there is a much higher incidence of Rosacea in fair-skinned individuals.

SOME IMPORTANT THINGS TO NOTE

- Rosacea is not acne, but can be present at the same time as acne
- Rosacea is a progressive disease and must be taken seriously
- Rosacea is not just sensitive or "a cuperose" skin

What causes Rosacea?

It is not known for certain what causes Rosacea, however, there are a number of prominent theories. The most common theory is that Rosacea is caused or aggravated by a microscopic pest known as the Demodex Mite (Domox Fulliculoneum). Other theories include gastrointestinal disease or possible lesions on the Hypothalamus Gland. However, none of these theories are proven. Recent research indicates that the cause of Rosacea may involve a variety of possibilities and that the factors causing or exacerbating Rosacea can vary greatly from person to person.

One thing is for absolute certainty. Cumulative sun exposure and the resulting sun damage always plays a major role in the development of Rosacea.

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STAGES OF ROSACEA

Pre-stage I Rosacea

It is believed that some individuals may be predisposed to developing Rosacea either because of hereditary factors or certain innate characteristics that they possess. These people tend to show early signs that may indicate the tendency to develop Rosacea. While these signs do not guarantee that they will develop Rosacea, at the very least precautionary measures can be initiated which may assist in delaying or preventing the actual onset of the disease, or more effectively controlling the outward symptoms of Rosacea.

Persons who may be pre-stage I Rosacea are often referred to as "flushers and blushers". For example, a young woman in her early 20's might have a glass of wine, eat spicy food or get emotional. Instead of a possible momentary flush, her face, neck and chest may turn red and the redness might persist for 10 minutes to half an hour. In people who develop Rosacea, reactive flushing and blushing eventually leads to permanent erythema (redness).

Stage I Rosacea

The most common characteristics of stage I Rosacea is persistent redness. While this erythema (redness) may be intermittent, it is usually present for hours or days at a time. Capillaries dilate and form vascular spray like designs on the nose, nasolabial folds and cheeks. The skin may become more sensitive and may react to certain cosmetics. In addition, the skin is more reactive to most physical and chemical stimuli.

Stage II Rosacea

Stage two Rosacea includes the outward characteristics of stage I, along with acne-like papules and pustules. These lesions can be present intermittently or may persist for weeks at a time. While, once again, it is important to remember that these are not actual acne lesions, the deeper inflammatory **Rosacea lesions can produce shallow scars.**

As stage II progresses, the sebaceous follicles become larger and more prominent, further contributing to the formation of papules and pustules. It is also important to note that pustules and papules are a result of inflammatory causes and **not** bacteria**.** The larger lesions contribute more to shallow scarring, further adding to the devastating effect that Rosacea can have on the patient's self-image.

Stage III Rosacea

Generally, only a small number of individuals will progress into stage III Rosacea. In stage III, patients exhibit all of the characteristics of stages I and II, along with a gradual deformation of facial features.

As stage III progresses, facial features may become thicker, coarser and irregular. The sebaceous glands continue toward extreme enlargement, contributing further to extensive large inflammatory nodules. The appearance of someone with stage III Rosacea can be similar to individuals presenting with the most severe cystic acne.

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VARIATIONS OF ROSACEA

Ophthalmic Rosacea

It is not uncommon for the eyes to be involved with Rosacea. The signs of Ophthalmic Rosacea may include persistent redness, itching, swelling, inflamed and crusting eye lids and light sensitivity. Usually ophthalmic Rosacea responds well to treatment. However, it is important to seek early diagnosis and treatment to avoid possible complications. It is possible for extreme cases of untreated ophthalmic Rosacea to lead to blindness.

Rosacea Conglobata

This form of Rosacea is relatively rare. It occurs mainly in females. The disease is generally limited to the face and mimics the appearance of severe disfiguring acne.

Rosacea Fulminans

This variation is possibly the most extreme form of Rosacea. Rosacea Fulminans only occurs in women. It is characterized by its very rapid onset, often reaching the peak of severity within only days to weeks. Lesions form in the appearance of giant abscesses and multiple lesions and the resulting disfigurement is hideous. Even though Rosacea Fulminans is so disfiguring and debilitating, the prognosis is excellent. Typically the disease is treated with Accutane™ and steroids. Once Rosacea Fulminans is under control, it does not recur.

Steroid Rosacea

Steroid Rosacea occurs when an individual has been treated for extended periods of time with topical steroids, such as cortisone type creams. Usually this is a patient who started out with Stage I Rosacea and was treated for the persistent redness with a topical steroid cream. Topical steroid medications should be used for short duration only. Unfortunately, when long term topical steroid treatment is discontinued, one of the side effects is a marked worsening of the very Rosacea characteristics that the medication was intended to address. Steroid Rosacea is often difficult to treat because the disease becomes even more pronounced when the Physician tries to eliminate the topical steroid.

Rhinophyma

This variation generally occurs only in men. The most common visual characteristic is an extremely bulbous nose that becomes progressively larger over many years. A common misconception is that Rhinophyma is caused by excessive alcohol consumption and the disease is often associated with alcoholics. Alcohol does not cause Rhinophyma. As with any form of Rosacea, alcohol can exacerbate many of the symptoms, but other perhaps unknown factors are the causative issue. There are also a number of Rhinophyma variations that include:

- Glandular Form
- Febrous Form
- Febroangiomatous Form
- Actenic Form

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THINGS TO REMEMBER ABOUT ROSACEA

- Rosacea is not curable
- Rosacea is treatable and can be controlled
- Rosacea is varied and complex
- Treatment requires dedication and perseverance
- The patient must be compliant and flexible

TREATMENT OPTIONS

General at Home Care

- Patients should avoid all known irritants and sources of local irritation
- Broad spectrum sunscreen is an absolute must
- Topical prescription products should be in a non-alcohol base

Prescription Topical Treatment

- Topical Metronidazole (Metro-Gel™)
  - -Available in gel, lotion & cream at 0.75%
  - -Excellent results
  - -Part anti-inflammatory, part insecticide, part anti-bacterial
- Topical Noritate
  - -1% Metronidazole in a cream formulation
- Topical Klaron™ (Sodium Sulfacetamide Lotion)
- Azaleic Acid (Azalex™)

Non Prescription Topical Treatment

- Rosacea appears to respond extremely well to a combination of azaleic acid, glycolic acid and salicylic acid.
  - -Patients report a lessening of redness and fewer lesions
- Glycolic Acid
  - -Studies show a marked reduction in redness
  - -A decrease in facial papules
  - -Less scaling
  - -Decreased sensitivity of facial skin
  - -Lessening of telangiectasia
  - -Gradual and overall continued improvement
  - -Patients' Rosacea remained under control
  - -Some Physicians believe that glycolic acid may prevent the attachment of Demodex Mite in the follicle.

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Systemic Treatment
Many forms of Rosacea respond well to oral antibiotics. It may be prudent to have patients on an oral medication at least until the symptoms are lessened and the disease is more stable.

- Tetracycline
- Doxycycline
- Minocycline

For the more severe Rosacea variants, more aggressive measures may need to be taken. Rosacea Fulminans responds well to a short course of oral cortisone. Once Rosacea Fulminans has "calmed down", Accutane™ is the usual choice to stabilize the condition and assist the patient in achieving an acceptable outcome.

Treatments under Investigation

- Topical All-Trans Retinol
- Oral Antihistamines

Laser Treatment
The good news is that there are a number of newer vascular lasers and IPL (Intense Pulsed Light) that can greatly if not entirely, eliminate the embarrassing and frustrating redness associated with Rosacea. Many physicians have seen evidence that treatment with these lasers may also greatly improve the symptoms of Rosacea. Many patients report that they have fewer or no eruptions and that their skin is far more "normal".

The other exciting feature of these newer lasers is that there is very little recovery period. Patients may experience temporary redness for a few hours or a day, but there is no interruption in their usual schedules.

As Rosacea awareness increases, no doubt there will be a greater demand for research and treatment options to address this complex and often frustrating disorder.