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Diagnosis/Definition:

A follicular eruption with comedones (blackheads and/or whiteheads), inflammatory papules, pustules, and cysts, generally found on the face and upper trunk. The disease is common in adolescence, but may first be noted in children as young as 8 years old, and is also quite common in pre-menopausal women. It is not unusual for women in their 20s or 30s to present with acne, stating that they had little or no acne in teenage years.

Mild acne: superficial lesions that are mostly comedonal, with little or no inflammation and no evidence of scarring or cysts.

Moderate acne: more inflammatory lesions with red papules and pustules, and often post-inflammatory hyperpigmentation, but no significant scarring or cysts.

Severe acne: cystic lesions and scars.

Initial Diagnosis and Management:

Diagnosis: The diagnosis is usually straightforward. The major skin condition in the differential is rosacea, particularly in adults. Rosacea tends to be mid-facial and not to have comedones, but rosacea and acne may coexist. Less commonly confused with acne are steroid acne, epidermoid (erroneous called "sebaceous") cysts, flat warts, molluscum contagiosum, angiofibromas of tuberous sclerosis, and other benign growths.

Adjunctive measures: Instruct the patient not to over-wash. Washing and astringents may dry the skin and make it more difficult to tolerate the prescription medications. Similarly, over-the-counter acne therapies are not as effective as prescription therapy and should generally be discontinued once prescription therapy is instituted. Oily cosmetics, moisturizers, and hair care products should be discontinued.

Mild acne: The goal of treatment is to prevent or minimize the formation of the primary lesion, the comedo. Treatment should be instituted with a topical agent that is comedolytic, generally a topical retinoid. Tretinoin 0.05% cream used every evening is a standard first-line therapy. Tretinoin gels are more effective than tretinoin cream, but gels are also more likely to be drying and irritating, and are not always well tolerated in a dry climate. It is very important that the patient understand that this medication may take several months to work well. Dryness may be managed with a light, minimally greasy moisturizer such as Cetaphil or Moisturel. If that is insufficient, decreasing the frequency of tretinoin use to every other day may be helpful. Other topical retinoids are also available and may be preferable in selected cases.

Topical 2% erythromycin used in conjunction with 5% benzyl peroxide gel is an alternative therapeutic approach which is currently less expensive than topical retinoids and may work well in some cases. This type of therapy is not as effective in treating the primary lesion, the comedo.

Moderate acne: It is still a major goal to treat the primary lesion, the comedo. Therefore, a topical retinoid, as described above, remains an important part of therapy. A second goal of treatment for moderate acne is to treat the inflammation. In general, this is accomplished by the use of an oral antibiotic. Although topical antibiotics may be preferred in some cases, they are not as effective as oral antibiotics. The usual antibiotics chosen are tretracyclines or erythromycin. Of the tretracyclines, doxycycline given at a dose of 100 mg po qd or bid is often the best choice, as it is generally easy to take, inexpensive, and effective. Its major disadvantage, compared with the other tetracyclines, is that it is more likely to cause sun sensitivity (sunburning much more easily than usual). The sun sensitivity is more likely to occur in fair-skinned persons, and sunscreens may be only moderately helpful in prevention.

Tetracycline, given at a dose of 500 mg po qd to bid, is an alternative therapy. Certain foods may significantly affect its absorption, and it is best taken just with water. Because of this, some patients find compliance with therapy difficult. Minocycline 100 mg po qd to bid is typically easy to take and effective, but is currently most costly than doxycycline or tetracycline. (Minocycline is currently non-formulary.) Erythromycin 500 mg po qd to bid may be a good alternative, particularly for persons who are sun sensitive. Some patients with milder inflammatory acne may do well with very low doses of antibiotics (doxycycline 50 mg po qd, tetracycline 250 mg po qd, minocycline 50 mg po qd, or erythromycin 250 mg po qd.)

Revision History: Created Revised

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Acne	Referral Guide: Page 2 of 3		Dermatology		
Initial Diagnosis and Managemen					
Severe acne: Initial treatment is us to dermatology is usually appropriate		noderate acne,	if possible with the higher dose of oral antibiotic. Referral		
Ongoing Management and Objec	tives:				
Decreased numbers of lesions and achievable goal.	minimization of scarrin	ng are the goals	of treatment. Total clearing of acne is usually not an		
example, ice-pick scarring, while pot the distinction is that scars are pern	st-inflammatory hyperp nanent, while post-infla	pigmentation is ammatory hyper	on. Scars show a change in the contour of the skin, for a change in the color of the skin. The major importance of pigmentation is usually temporary. Post-inflammatory e interim, if new inflammatory lesions are forming, it may be		
Compliance with therapy should be	reviewed at each visit.				
Some patients do well with therapy but very infrequently have an isolated small cyst or deep inflammatory nodule. In that circumstance, it may be helpful to inject directly into the cyst a small amount of triamcinolone 2.5 (2 ½) mg/ml. This often serves to decrease the inflammation quickly, over the course of a few days.					
Indications for Specialty Care Re		ov often 6 menth	a accuming the nations has been compliant		
Mild to moderate ache: Poor respo	nse to standard therap	y after 6 month	s, assuming the patient has been compliant.		
Severe acne: In general, patients with severe acne should be referred to dermatology. It is acceptable in most cases to place the patient on a treatment regimen highly likely to be effective (e.g., doxycycline 100 mg po bid plus topical tretinoin qd), and schedule a non-urgent visit to dermatology. For patients with extremely severe cystic acne (e.g., see pictures of acne conglobata), more immediate referral to dermatology may be advisable.					
formulary.) Accutane is highly terat method of birth control (such as ora using these methods for at least a r severity of acne required before Act it is probably the case that most pat	ogenic, and its use is t I contraceptives) plus a nonth before Accutane cutane use is consider cients referred to derma ner therapy, there are s	ightly regulated a second methor is instituted. Ted, are strictly a atology for poss	by be recommended. (Note that Accutane is currently non- by the FDA. Females must be on a highly effective and of birth control (such as condoms), and must have been the regulations governing the use of Accutane, including the adhered to in Denver Health dermatology clinics. Although ible Accutane treatment do in fact receive Accutane either who are not good candidates for Accutane. Please do not		
Test(s) to Prepare for Consult:	Те	est(s) Consulta	nt May Need To Do:		

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Criteria for Return to Primary Car	re:		
Acne stabilized			
Accutane course completed			
Revision History: Created	Revised		

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