

Rosacea - Primary Care Treatment Pathway

Rosacea is a chronic relapsing disease of the facial skin. It is characterized by symptoms of facial flushing and a spectrum of clinical signs, including erythema, telangiectasia, coarseness of skin, and an inflammatory papulopustular eruption resembling acne. Epidemiological data are scarce and controversial; reported prevalences range from 0.09% to 22%.

Referral criteria

Patients should generally be managed in primary care.

If there is diagnostic uncertainty GPs should peer review in house and/or seek advice from secondary care via eRS Advice and Guidance. (Please attach a photo).

Where there is moderate rosacea that is poorly controlled despite initial treatment in primary care refer to the Community Dermatology Service (DHUFT or About Health).

Where there is severe persistent erythema, telangiectasia, flushing or phymatous rosacea causing psychological or social distress refer to secondary care.

This information is consistent with the Dorset Dermatology Quick referral Guide v2, available via the Dorset formulary.

Points to note in initial diagnosis in primary care.

- Assess the predominant symptoms and rule out acne vulgaris.
- Treatment choice should be based on rosacea subtype and level of severity.
- Be aware that patients often experience more than one subtype concurrently.

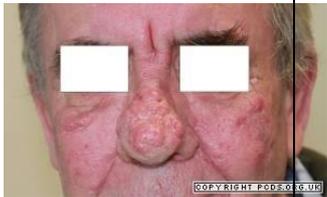
Self-care advice

- Provide reassurance about the benign nature of rosacea and uncommon progression to severe disease, (especially in women).
- Recommend frequent application of high-factor sunscreen (minimum SPF 30) to the face whenever exposure to sunlight is likely.
- If flushing is problematic, advise the avoidance of trigger factors. Possible triggers include extremes of weather (heat, and cold winds), sunlight, strenuous exercise, stressful situations, spicy food, alcohol, and hot drinks. Some drugs can aggravate flushing (e.g. calcium-channel blockers).
- If the skin is dry, advise the use of skin-care products as required (e.g. hypoallergenic and non-comedogenic emollient creams). Avoid use of abrasive products or topical corticosteroids on the face.

Advice for patients can be found [here](#)

Rosacea subtypes

<http://www.pcds.org.uk/clinical-guidance/rosacea>

<p>Erythematotelangiectatic Rosacea</p>	<p>Flushing and persistent erythema of the central face; possible telangiectases; easily irritated facial skin; burning and stinging may be reported; edema, roughness, or scaling may be present.</p>	
<p>Papulopustular Rosacea</p>	<p>Persistent erythema with transient and/or pustules of the central face, burning and stinging may be reported.</p>	
<p>Ocular Rosacea</p>	<p>Watery or bloodshot appearance; foreign body sensation, burning or stinging, dryness, itching, light sensitivity, blurred vision, telangiectases of lid margins; lid and periocular erythema; blepharitis, recurrent conjunctivitis, styes (chalazion, hordeolum); episcleritis, iritis; decreased visual acuity due to corneal complications (keratitis may occur).</p>	
<p>Phymatous Rosacea</p>	<p>Skin thickening, irregular surface nodularities, and enlargement; inflammatory lesions are rhinophyma is most common, but other affected locations may include the chin, forehead, cheeks, and ears; patulous follicles and telangiectases may occur.</p>	

Treatment of Rosacea *

	Flushing, erythema, telangiectasia	Papulopustular rosacea (mild/moderate)	Papulopustular rosacea (moderate/severe) ^{4,5}	Ocular rosacea
1st line treatment choices (green traffic light categorised)	<ul style="list-style-type: none"> Provide lifestyle advice 	<ul style="list-style-type: none"> Metronidazole 0.75% gel or cream (Metrosoa[®], Rosiced[®], Rozex[®], Metrogel[®])³ Azelaic acid (Finacea[®])³ Ivermectin 10 mg/g cream (Soolantra[®])⁹ 	<ul style="list-style-type: none"> tetracycline (or oxytetracycline) doxycycline⁶ lymecycline⁶ erythromycin⁶ if intolerant of tetracyclines 	<ul style="list-style-type: none"> Lid hygiene⁷ Artificial tears⁸ tetracycline or oxytetracycline Erythromycin if intolerant of tetracyclines
2nd line treatment choices (where 1st line ineffective, contra-indicated or not tolerated)	<ul style="list-style-type: none"> Brimonidine tartrate gel (Mirvaso)¹ Camouflage cream² 	<ul style="list-style-type: none"> Switch to the alternative topical preparation Systemic antibiotics (see adjacent panel) 	<ul style="list-style-type: none"> Consider adding topical treatment (see adjacent panel) Switching to an alternative oral antibiotic is not recommended 	
Notes	<ol style="list-style-type: none"> 'Amber SCG' traffic light status when used within the Rosacea pathway. For persistent erythema/telangiectasia. The SPC states that Mirvaso[®] gel can be used in conjunction with metronidazole or azelaic acid gel in papulopustular rosacea: Apply after Mirvaso[®] gel has dried. The charity 'Changing Faces' runs clinics in Bournemouth. Details on website. Topical metronidazole or azelaic acid can be used intermittently or continuously to control symptoms. Use metronidazole cream rather than gel for sensitive skin. Azelaic acid may be more effective in those who do not have sensitive skin, but may cause transient stinging. Initial treatment duration 3 months; if good response reduce dose after 1 month. Maintenance treatment - continuous (e.g. a reduced dose of oral treatment for 2–6 months followed by a 'drug holiday') or intermittent (e.g. using a topical treatment on alternate days or twice a week). Alternatively 'Step down' from oral to topical treatment. Un-licensed (off label) use. Use cotton wool soaked in cooled, boiled water twice a day. Can use baby shampoo if necessary. Refer to an ophthalmologist where necessary 			

(see referral criteria)

8. May be purchased over the counter. Apply liberally throughout the day. A lubricating ointment, sometimes containing an antibiotic preparation may be used at night.

9. One application a day for up to 4 months. The treatment course may be repeated. If no improvement after 3 months, discontinue.

Other less well evidenced alternatives usually prescribed in community services or secondary care should be noted:

- Other topical treatments, e.g. benzoyl peroxide, other topical antibiotics, tacrolimus, or retinoids (e.g. tretinoin).
- Other oral antibiotics, such as clarithromycin, azithromycin (useful if erythromycin is poorly tolerated), or minocycline.
- The combined oral contraceptive pill (if a hormonal cause is suspected in a woman).
- Oral isotretinoin or clonidine.
- Oral spironolactone, oral beta blockers.

Prescribing information available at <https://cks.nice.org.uk/rosacea-acne#!scenario>

References

Summary of Product Characteristics. Mirvaso 3mg/g Gel. Galderma (UK) Ltd. Accessed on 19th December 2018 via www.medicines.org.uk/emc

Primary Care Dermatology Society – Rosacea. Accessed on 19th December 2018 via <http://www.pcds.org.uk/clinical-guidance/rosacea>

NICE CKS Rosacea September 2012. Accessed on 19th December 2018 via <https://cks.nice.org.uk/rosacea-acne#!scenario>

DermNet NZ. Rosacea. Accessed on 19th December 2018 via <http://dermnetnz.org/acne/rosacea.html>

National Institute of Clinical Excellence. Facial erythema of rosacea: brimonidine tartrate gel. Evidence Summary: New Medicine. ESNM43 London: NICE; July 2014. Accessed on 19th December 2018 via <https://www.nice.org.uk/advice/esnm43/chapter/Key-points-from-the-evidence>

British Medical Association and Royal Pharmaceutical Society of Great Britain. British National Formulary. BMJ Group and RPS Publishing. London. Accessed online <https://bnf.nice.org.uk/>

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