South East London Pathway for the Management of Papulopustular Rosacea

Papulopustular rosacea

Persistent central facial erythema with transient, central face papules or pustules, or both.

Papules and pustules

Mild to Moderate

Limited number of papules and pustules, with no plaques

1st Line

Ivermectin 1% cream, one application per day for up to 4 months. Treatment can be repeated as necessary.
Discontinue after 3 months if no improvement

2nd Line alternative

Azelaic acid 15% applied twice daily for 6-9 weeks.
Discontinue after 2 months if no improvement

For those who have responded to previous courses of metronidazole 0.75% gel, a repeat course may be a suitable alternative to the above treatments, however it is no longer a preferred option in new patients

Treatment Failure

Severe

Extensive papules, pustules or plaques

1st Line

Ivermectin 1% cream once daily *or* azelaic acid 15% gel twice daily plus 6-12 weeks of either:

- Oral oxytetracycline 500mg twice daily (avoid taking with meals)
- Oral doxycycline 100mg daily (off-label, less expensive & well tolerated. May be used as an alternative in renal impairment)

Be mindful of antibiotic resistance with long term antibiotic use

2nd Line alternative oral antibiotic choices

If intolerance/inefficacy/adverse reactions [e.g. photosensitivity, abdominal pain, nausea]/contraindications to oxytetracycline or doxycycline) switch to:

Ivermectin 1% cream once daily *or* azelaic acid 15% gel twice daily plus **either:**

- Lymecycline 408mg once daily for up to 12 weeks (off-label, shorter courses are usually required) **OR**
- Doxycycline 40mg MR capsules once daily for up to 16 weeks (Licensed for rosacea without ocular involvement. Fewer side and equivalent efficacy to 100mg.)

Treatment Success (Mild to Moderate)

Treatment Success (Severe)

Treatment Failure (Severe)

Follow up & Monitoring

Follow up the patient after 6-9 weeks *(topical treatment)* or 12 weeks *(oral antibiotics)*, to assess the effectiveness of treatment. If maintenance treatment is required:

- This may be continuous, followed by a 'drug holiday' until symptoms recur
- Intermittent (e.g. using a topical treatment on alternate days or twice a week).
- Patients responding to treatment can be stepped down from combined oral and topical treatment to topical only treatment alone, and then treatment cessation

Refer to Specialist Dermatology

Key points, including self-care advice for all patients with Rosacea

- Recommend frequent application of high factor sun screen (minimum SPF30 and above – to be bought OTC)
- If the skin is dry, advise the use of non-comedogenic, hypoallergenic emollients.
- If flushing is problematic, advise avoidance of trigger factors. Possible triggers include: extremes of temperature, sunlight, strenuous exercise, stressful situations, spicy food, alcohol and hot drinks.
- Treatment should be based on Rosacea symptoms and level of severity.
- Provide sources of information and support, such as the British Association of Dermatologists (BAD) Patient Information Leaflet (PIL) for *Acne rosacea*.
- Patient review in 3-4 months by GP regarding maintenance treatment, if needed.

References [all last accessed: 8/12/2017]: (1) National Institute for Health and Care Excellence Evidence Summary for ivermectin (Jan 2016), available here. (2) Clinical Knowledge Summaries Rosacea topic, available here. (3) Primary Care Dermatology Society guidance on rosacea (May 2016), available here. (4) British National Formulary, available here. [Last accessed: 8/12/2017]

Date approved: May 2018, updated March 2019 (oral antibiotic choices) **Review date:** May 2020 (or sooner if evidence or practice changes)
South East London Area Prescribing Committee. A partnership between NHS organisations in South East London: Bexley/ Bromley/ Greenwich/ Lambeth/ Lewisham & Southwark Clinical Commissioning Groups (CCGs) & GSTFT/KCH/SLAM/Oxleas NHS Foundation Trusts & Lewisham & Greenwich NHS Trust