Acne Treatments Reviewed, Starting With Touch

BY SHERRY BOSCHERT
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STANFORD, CALIF. — The art and science of treating acne in adolescents start with touching the patient.

"Many adolescents have a feeling that their acne is very dirty, and they take it personally," Dr. Alfred T. Lane said at a pediatric update sponsored by Stanford (Calif.) University.

They think of themselves as bad people, he suggested, but "I think that by touching them, we develop a relationship with them that says we're very accepting of their condition."

He first asks permission by saying, "May I touch your skin?" and makes sure that the patient saw him clean his hands with an antiseptic gel when he entered the exam room.

Making sure patients are motivated to adhere to a treatment regimen and helping them to set reasonable expectations for results are important next steps, said Dr. Lane, professor of dermatology and pediatrics at the university.

As a pediatrician, before training in dermatology, he often would offer to treat adolescent acne detected during visits for other reasons, such as for a sports physical exam. The teenager usually would agree, then not return for the 6-week follow-up visit. If he saw the patient months later for some other reason, the acne typically would be unchanged and the teen would say he or she didn't use the medication.

"Then, when I started my dermatology residency, I used the same medications and 6 weeks later everybody was better. It was because they were motivated" to adhere to topical or oral therapy, he said. "Now, if I see patients for another condition and I notice their acne, I don't even ask about it, unless they ask me."

Even motivated adolescents will have unreasonable expectations, however, and must be educated that improvements from acne therapy won't be seen for 4-8 weeks or sometimes more. "An adolescent wants instant results, just like with their text messaging," said Dr. Lane, who is also chair of dermatology at the university.

When choosing the therapy, match your choice to the type of problem, he added, as in the following examples:

► **"Cocktail party" acne.** When someone approaches Dr. Lane at a party and asks what to use for their child's acne, over-the-counter benzoyl peroxide lotion is the simplest and safest answer, he said.

► **Papules.** The benzoyl peroxide lotion or a prescription gel version and topical retinoids are the treatments of choice for acne papules, often in a combination regimen of benzoyl peroxide applications in the morning and a retinoid at night.

Benzoyl peroxide can be used once or twice daily but can cause dry skin and irritant dermatitis, especially if used more frequently. Chronic use can cause allergic contact dermatitis in about 1% of patients, so start by applying it to an arm for several days before moving to the face.

The retinoids—tretinoin or adapalene cream or gel—may cause photosensitivity, which can be minimized by applying it in the evening. In the first few weeks these agents may cause irritant dermatitis or even some acne pustules, so tell the patient "there's a chance that you may get worse before you're better," said Dr. Lane, who reported having no conflicts of interest.

Ask patients to wait 20-30 minutes after washing their face before using a retinoid, which should be applied to dry skin. For some adolescent boys, this is a deal-breaker, "so I tell them 'If you can't wait 30 minutes, just put the retinoid on and don't wash your face,' " he said.

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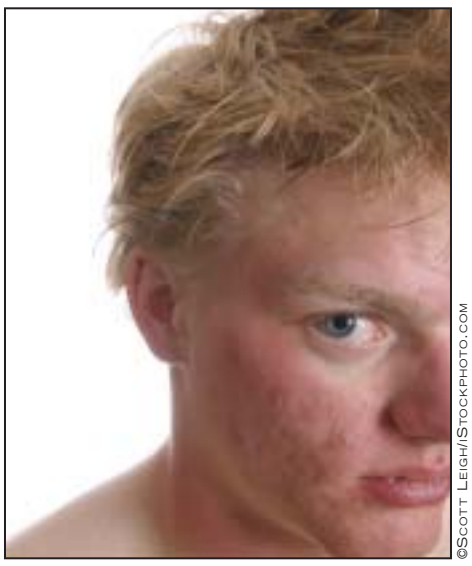

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Using benzoyl peroxide in the morning and a retinoid at night provides synergistic effects, but applying anything at the same time as a retinoid is likely to cause skin irritation, he added.

▶ **Pustules.** If pustules are present, add a twice-daily topical antibiotic (erythromycin or clindamycin), which is safe to combine with benzoyl peroxide but shouldn't be applied at the same time as a tretinoin.

Some vehicles may dry the skin, while others may feel greasy, either of which can work to the advantage of individual patients. Rarely, clindamycin may cause diarrhea.

Acne on the back or chest often does not respond well to retinoids or benzoyl peroxide, and teenage boys often won't adhere to any topical therapy (including topical antibiotics), so systemic antibiotics may be needed before you can get them to transition to topical therapies, Dr. Lane noted. Tetracyclines are his first choice for systemic therapy, followed by erythromycin.

Systemic side effects can cause GI irritation or yeast vaginitis and may decrease the effectiveness of oral contraceptives.

Some adolescent girls with acne may benefit from hormonal therapy, but Dr. Lane leaves this approach to the patient's primary care physician.

▶ **Cysts and scars.** More aggressive treatment is appropriate for acne with cysts and scars, and many of these patients will end up receiving isotretinoin from a dermatologist who can follow them carefully for numerous potential side effects.

For patients aged 18-25 years, isotretinoin therapy will get rid of acne for 10 years or longer in 30%, and 40% will have recurrent acne that responds to topical therapies or antibiotics. The odds are even better for patients aged 12-15 years, Dr. Lane said. ■

Incontinentia Pigmenti Not All That Rare

BY SHERRY BOSCHERT
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STANFORD, CALIF. — A rare genetic disorder that usually is lethal to male babies and can leave abnormalities of the skin, eyes, and other body parts in females, may be more common than originally thought.

Incontinentia pigmenti is caused by a mutation in the IKBKG gene (also known as NEMO), which resides on the X chromosome. A genetic diagnosis can be helpful in females with suspected incontinentia pigmenti because they carry a 50:50 risk of passing the mutation on to their offspring, Dr. Louanne Hudgins said at a pediatric update sponsored by Stanford University.

Typically, blistering on the skin of a neonate or infant progresses to a wart-like rash, swirling macular hyperpigmentation, and linear hypopigmentation.

Patients with incontinentia pigmenti often have patchy alopecia of the scalp, dystrophic nails, and tooth abnormalities (few or abnormal shaped).

Other ectodermal-derived tissues are affected, too. Patients with incontinentia pigmenti often have patchy alopecia of the scalp, dystrophic nails, and tooth abnormalities (fewer teeth than normal or abnormal tooth formation, such as a cone-shaped tooth). Associated eye problems are the most significant finding in survivors with incontinentia pigmenti. They often have retinal vascular proliferation, which can lead to retinal detachment.

"The mother may look completely normal or may have linear patches without as much hair" as a typical scalp, but genetic testing can identify incontinentia pigmenti in 80% of cases, said Dr. Hudgins, professor of pediatrics and chief of medical genetics at Stanford.

She and her associates used to test for incontinentia pigmenti only in girls who had all of the associated findings, and rarely made the diagnosis. More recently, however, "we've been doing the testing in kids with a few findings, and are finding the mutation. I think it's more common than we thought it was," she said. "In our genetic disorders of the skin clinic, we see as many as four or five cases per year" of incontinentia pigmenti.

Even with a presumptive diagnosis, it's important to order an ophthalmologic exam. "If this child is at risk for retinal detachment, you need to have that child followed by ophthalmology on a regular basis so you can maintain the best vision possible," she said. Dental and dermatologic evaluations also are warranted. "If they have ongoing skin problems, it's certainly a good idea to have a dermatologist follow them," said Dr. Hudgins, who reported having no conflicts of interest. ■