Expert Outlines Developments In Treatment of Rosacea

BY DOUG BRUNK
San Diego Bureau

LAS VEGAS — When rosacea overlaps with another skin disease, certain topical treatments are better than others, Guy F. Webster, M.D., said at the Fall Clinical Dermatology Conference.

"I'm finding there are subsets of topical treatments that are good for subsets of disease," said Dr. Webster of the department of dermatology at Jefferson Medical College, Philadelphia. "There's a new 1% metronidazole out that's a little stronger, and the topical immunomodulators are useful when someone has rosacea plus seborrheic dermatitis, or [for] someone with atopic dermatitis plus seborrheic dermatitis."

Another subset of rosacea patients he described are those who had severe acne as teenagers. "They've often been through Accutane [isotretinoin], and then they're in their mid to late 20s, and they start getting rosacea," he explained at the conference, sponsored by the Center for Bio-Medical Communication Inc. "With them I find the benzoyl peroxide/clindamycin mixtures are often very effective."

Azelaic acid and sodium sulfacetamide/sulfur have a role in rosacea treatment, he noted, but sodium sulfacetamide/sulfur "isn't quite as strong as the other topicals."

He added that evidence to support the use of tretinoin for rosacea is in the realm of speculation. Studies of fair-skinned people who live in areas of high sun exposure make him wonder if what the investigators really observed were improvements in sun damage and not rosacea. "But it's clear that if you're patient enough in a person like that, you can get some aspects of their rosacea to improve with tretinoin," Dr. Webster said.

He credited the efficacy of metronidazole 1% to not only a boost in drug concentration from the 0.75% form, but to the fact that the agent is contained in a modern vehicle.

"Many of the drugs we have are [contained in] old-fashioned vehicles that were formulated 15-20 years ago, even though maybe they've only been approved for 5-10 years," Dr. Webster said at the conference.

"A lot has gone on in vehicle technology since then. This is a new, modern vehicle, and it optimizes the health of the skin."

As for oral rosacea therapy, effective options include tetracycline, doxycycline, and minocycline, which are antibacterial and anti-inflammatory.

Cipro (ciprofloxacin) and Bactrim (trimethoprim/sulfamethoxazole) both work, "but there's a worry with giving people long-term antibiotic treatment for a disease that is chronic," he noted.

"You worry about generating resistance to bacteria and making other infections harder to treat. We should get patients as clear as we can with an oral antibiotic and then try to get them onto something that's either nonantibiotic or topical."

Dr. Webster said that isotretinoin is not as "magic" for rosacea as it is for acne. "It's better for nodules than a lot of other drugs for rosacea, but it doesn't work as quickly as you would expect. I'd save it for a situation where all else fails."

Other drugs that he finds "occasionally effective" include β-blockers and selective serotonin reuptake inhibitors. β-Blockers "will sometime make a patient who is 'flushy' and 'blushy' and a little bit agitated have less flushing and blushing, but it's not as magical as you'd hope," he remarked.

"Sometimes patients who are anxious in general benefit from an SSRI. They're a fairly big part of my practice. I use them for acne patients and agitated rosacea folks, and eczema patients."

One promising new treatment for rosacea is topical dapsone gel. "I think it will probably be better for rosacea than it will be for acne, but there's a problem," he said.

"The [Food and Drug Administration] is insistent on having blood tests because they're worried about the risk of hemolysis. I'm wondering at this point if we'll ever see the product. But if it comes out I think it will be useful effects for rosacea because of its anti-inflammatory activity."

Another new therapy is anti-inflammatory–dose doxycycline. Doxycycline can be given in a dose so low "that it doesn't change the oral flora or GI flora, but it still has a lot of the anti-inflammatory activity," Dr. Webster said.

Even more promising in the future, he added, is a drug called incyclinide, "which is a chemically modified doxycycline that has no antibiotic activity but whopping anti-inflammatory activity. This drug is real promising." ■

Patients Need Lifelong Follow-Up After High-Dose Whole-Body PUVA Therapy

GLASGOW, SCOTLAND — A review of all patients in one U.K. center who received more than 200 whole-body ultraviolet A radiation treatments between 1977 and 2004 has confirmed the potential for life-threatening consequences and the need for lifelong careful follow-up, Paul B. Farrant, M.D., said at the annual meeting of the British Association of Dermatologists.

Of the 30 patients, 24 had been treated for psoriasis, 5 for cutaneous T-cell lymphoma, and 1 for generalized pruritus. The number of treatments ranged from 205 to 1,027, with a mean of 405, he said in a poster session.

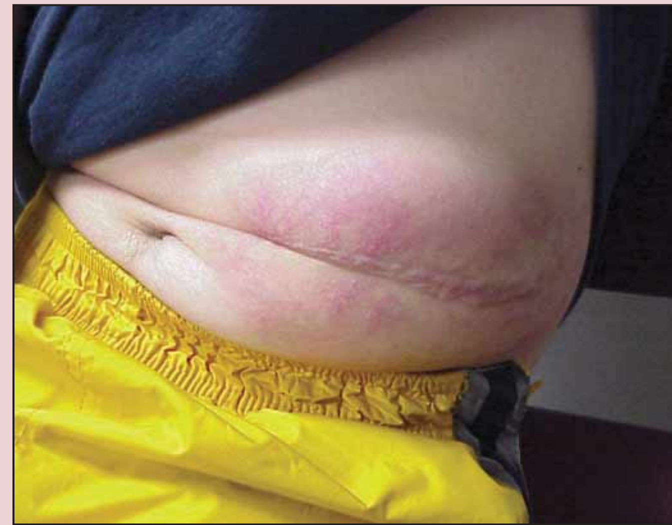
Three patients had developed squamous cell carcinomas, one of whom died as a consequence. This patient was 53 years old and had had 326 treatments, said Dr. Farrant of the Brighton (England) and Sussex University Hospitals NHS Trust. An additional four patients developed a total of eight basal cell carcinomas, but there were no cases of malignant melanoma.

During the course of follow-up, 11 other patients had died for reasons unrelated to PUVA therapy, and 13 were still being followed by the dermatology service. Only one of these patients was still receiving PUVA. "The study showed that our follow-up hasn't been rigorous enough for these patients, and that it needs to be lifelong," he said.

—Nancy Walsh

DERM DX

A 16-year-old boy with a history of cerebral palsy presented with a progressive eruption overlying an indwelling baclofen pump. Treatment with oral antibiotics did not resolve the eruption, which occurred about 3 months after the pump was placed. The eruption was erythematous, blanchable, and telangiectatic. What's your diagnosis?



SAN DIEGO — Two previous baclofen pumps had performed in the young patient without incident, Jonathan Dyer, M.D., reported at the annual meeting of the Society for Pediatric Dermatology.

The rash that developed after the implantation of the third pump was nontender and nonpruritic.

Histopathology showed perivascular inflammatory infiltrate of lymphocytes, histiocytes, and a few sparse neutrophils. The initial interpretation suggested resolving cellulitis.

"However, when we brought up the possibility of reticular telangiectatic erythema, we thought it was very consistent if not identical to the histopathology report of this condition in the literature," said Dr. Dyer of the department of dermatology at the University of Missouri–Columbia.

He and his associate, Stacia Miles, M.D., patch-tested all of the pump's components; the tests came out negative. They also performed two 4-mm punch biopsies that were also negative.

However, a previous culture from the access port of the pump was positive for methicillin-resistant *Staphylococcus epidermis* (MRSE), so the boy was treated with 3 weeks of intravenous vancomycin. The rash gradually faded over a 6-week period.

Dr. Dyer said that reticular telangiectatic erythema was first described in 1981 overlying an implanted pacemaker.

"There have been about 14 cases described since," he said. "It was thought to be innate to implantable cardioverter defibrillators or pacemakers. However, this year there was a description of the condition developing after implantation of a similar intrathecal pump" (Arch. Dermatol. 2005;141:106-7).

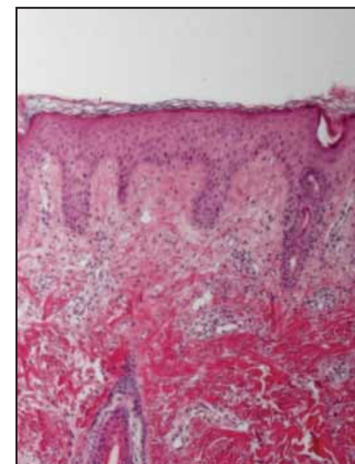
The exact cause of reticular telangiectatic erythema remains unclear. Possible etiologies suggested over the years include abnormal microcirculation in the area of the implanted pump, allergic contact dermatitis to pump components, irritation, electromagnetic radiation, and infection.

The favored hypothesis attributes the rash to alterations in the normal cutaneous anatomy induced by the implanted devices.

"Current thinking on reticular telangiectatic erythema is that it is not necessary to remove these pumps, but I think the issue of infection requires some consideration," Dr. Dyer noted.

"In our case [the rash] did seem to get better after treatment for MRSE. While reticular telangiectatic erythema does not necessarily require removal of the device, I think you have to make sure that there's not some type of infection going on in these cases," he reported.

—Doug Brunk



PHOTOS COURTESY DR. JONATHAN DYER