**DERBYSHIRE JOINT AREA PRESCRIBING COMMITTEE (JAPC)**

# Managing Acne vulgaris

**(Based on NICE NG198)**

Aim: This pathway is designed to help GPs to manage acne more effectively within the community and to improve the appropriateness of referrals to secondary care.

**For treatments of short term / mild acne, patients are encouraged to self-care. Discuss simple measures e.g. wash with mild soap, do not scrub, avoid make up; and advise that treatments are available to purchase from pharmacies (e.g. benzoyl peroxide products). See Derbyshire Medicines management Self-care advice/ JUCD self-care page/ NHS Acne.**

## Background

- About 15% of the adolescent population have sufficient problems with acne to seek treatment. This is an age when self-esteem is very important.
- Although in most patients acne clears up by the early 20s, more severe acne tends to last longer and a group of patients have persistent acne lasting up to the age of 30 - 40 years
- Acne may scar – most of the time this is preventable by using the correct treatment given in a timely fashion. Risk of scarring increases with the severity and duration of acne.
- Acne makes up a significant proportion of referrals to hospital dermatology clinics

**Who?**

All patients diagnosed with acne vulgaris in the community where self-care is not appropriate.

**Diagnosis**

- **Take a good skin history**.
  - How long have they had acne?
  - Family history?
  - What previous treatments have they tried? What sort of response have they had? Were there side effects? Are they compliant? Have there been gaps in treatment?
  - How does their acne affect them?
  - Are there any aggravating features? e.g. use of anabolic steroids, oil-based cosmetics, topical/oral steroids, lithium, ciclosporin, oral iodides in homeopathic remedies.

- **Look carefully at their skin and try to grade the acne so you will be able to assess whether there is improvement when they come for review.**
  - Is it mild to moderate or moderate to severe*
  - Comedonal (black & white-heads) or inflammatory (papules, pustules and nodules present) or a mixture?
  - Is there any scarring present? Type -'ice-pick'/ keloid?

*NICE NG198 Acne definition

| | |
|---|---|
| **Mild to moderate** | People who have 1 or more of:<br>• any number of non-inflammatory lesions (comedones)<br>• up to 34 inflammatory lesions (with or without non-inflammatory lesions)<br>• up to 2 nodules |
| **Moderate to severe** | People who have either or both of:<br>• 35 or more inflammatory lesions (with or without non-inflammatory lesions)<br>• 3 or more nodules. |

- **Investigation?**
  - In those women with features of polycystic ovarian syndrome e.g. oligomenorrhoea hirsuitism consider doing a testosterone level to exclude a male virilising tumour.

**Management**

- **Use a patient information leaflet and talk patient through why you are using each treatment.**
- Advice to patients
  - Advise against over-cleaning- use non-alkaline (skin pH neutral or slightly acidic) synthetic detergent twice daily.
  - Use non-comedogenic make up, sunscreen, emollients, and remove make up each day
  - Avoid picking and squeezing spots which may increase risk of scarring.
  - There is not enough evidence to support specific diets for treating acne- follow balanced diet (PHE Eatwell Guide).
- Explain that treatment take time to work (usually up to 8 weeks) and may irritate the skin, especially at the start of treatment.
- Talk about the need to treat as many of the major aetiological features as possible and which treatment works for each: -
  A. comedone formation - topical retinoid e.g. adapalene
  B. inflammation - benzoyl peroxide (BPO) 5% gel
  C. androgen induced excess sebum production in moderately severe acne in women - co-cyprindiol 2000/35
  D. infection- colonisation with *Cutibacterium acnes*- antibiotics (topical or oral)
- Acne has a significant impact on mental health without treatment; assessment of mental health is important.

**For treatments of short term/mild acne, patients are encouraged to self-care. Discuss simple measures as above, and advise that treatments are available to purchase from pharmacies (e.g. benzoyl peroxide products). See Derbyshire Medicines management Self-care advice/ JUCD self-care page/ NHS Acne.**

**See Appendix 1& 2 for treatment flowchart and NICE recommended first line treatment options including advantages & disadvantages for each treatment**

| Acne severity | Treatment |
|---|---|
| Any severity | Fixed combination topical tretinoin 0.025%+ clindamycin1% **(Treclin)** Applied once daily in the evening |
| Any severity | Fixed combination topical adapalene 0.1 or 0.3% + benzoyl peroxide (BPO) 2.5% **(Epiduo)** Applied once daily in the evening |
| Mild to moderate | Fixed combination topical BPO 3 or 5% + clindamycin 1% Applied once daily in the evening |
| Moderate to severe | Topical adapalene + benzoyl peroxide (**Epiduo**) applied daily in the evening ***OR*** Topical azelaic acid (15 or 20%) applied twice daily **PLUS** Oral **Doxycycline 100mg (1st line)** or Lymecycline 408mg (2nd line) daily |

**Severe acne**

Consider early referral for oral isotretinoin if large nodulocystic lesions, scarring or no rapid response to treatment (two 3month courses of antibiotics).

**Relapse**

- Consider another 3 month course of same or alternative 1st line treatment
- If acne relapses after an adequate response to oral isotretinoin and is currently
  - mild to moderate- offer an appropriate 1st line treatment option
  - moderate to severe- offer either a 3 month course of 1st line treatment option or re-refer to specialist

**Maintenance**

- encourage continued appropriate skin care
- explain that after completion of treatment, maintenance treatment is not always necessary

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| | • Consider a fixed combination topical adapalene + benzoyl peroxide (**Epiduo**) maintenance in people with history of frequent relapse. If not tolerated or C/I consider topical monotherapy with adapalene, azelaic acid, or benzoyl peroxide.<br>• Review maintenance treatment after 3 months. |
| **Monitoring** | • **Review after two months for improvement and side effects**.<br>– Tell your patient that if their treatment is working well they can **expect 50% improvement** at this point, no more.<br>– If there is little improvement **assess compliance**.<br>• If acne fails to respond adequately<br>– mild to moderate acne- offer another 1st line treatment in<br>– moderate to severe acne already on oral antibiotic plus topical treatment- change to a second antibiotic plus topical treatment.<br>– **Remember to reinforce use of topical treatment**.<br>• Antibiotic monotherapy is poor management and will only partially treat the acne process. **In order to minimise the development of antibiotic resistance** always use topical agent alongside oral antibiotics – even intermittent treatment can help prevent this developing.<br>• **Stop systemic antibiotics after sustained improvement (3 months)** and continue topical treatment. Only continue antibiotic (topical or oral) for more than 6months in exceptional circumstances. Review at 3-monthly intervals. |
| **Patient info** | There are good patient acne information leaflets at www.bad.org.uk and www.pcds.org.uk or NHS website Acne – NHS.<br>If you are considering referring for oral isotretinoin you can direct patients to NHS information about isotretinoin and/or give them a copy of the BAD isotretinoin leaflet. If they wouldn't consider taking this then you may save a referral.<br>Acne  Scan to share<br>Isotretinoin  Scan to share |
| **Referral criteria** | • Severe acne - refer early for oral isotretinoin if large nodulocystic lesions, scarring or no rapid response to treatment<br>• Moderately severe acne which has not responded to 2 x 3 months courses of different antibiotics PLUS topical treatment, especially if starting to scar.<br>• Patients with severe psychological symptoms.<br>• Acne fulminans (urgent same day referral)<br>Consider referral to mental health services if person with acne experiences significant psychological distress/ mental health disorder including those with current or past history of suicidal ideation or self-harm, severe depressive or anxiety disorder, or Body dysmorphic disorder.<br>Consider condition-specific management or referral to a specialist (e.g. reproductive endocrinologist), if a medical disorder or medication (including self-administered anabolic steroids) is likely to be contributing. |

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| Refer only | Those requiring oral isotretinoin. Check FBC, lipid profile and liver function tests first.<br><br>See MHRA advice- women and girls of childbearing potential being treated with the oral retinoids must be supported on a Pregnancy Prevention Programme with regular follow-up and pregnancy testing.<br>MHRA April 23 Isotretinoin: new safety measures to be introduced in the coming months, including additional oversight on initiation of treatment for patients under 18 years<br>MHRA October 23 Isotretinoin (Roaccutane▼): introduction of new safety measures, including additional oversight of the initiation of treatment for patients under 18 years of age.<br><br>If patient is a female, consider using highly effective contraception (even if they are not sexually active) as otherwise their treatment will be delayed until they start this and will need an additional hospital appointment. Oral progestogen-only contraceptives are not considered effective- See advice in BNF. |
| | Routine First Outpatient appointment = £126; Follow up appointment = £68 |
| **Clinic information** | If a referral is required book against the following on the Choose and Book system:<br>Speciality : Dermatology<br>Clinic Type: Not otherwise specified |
| **Additional Information** | • Patient information on website- NHS website, Acne Support<br>• British Association of Dermatologists (BAD) Patient information leaflet<br>• NICE NG198 Acne vulgaris: management https://www.nice.org.uk/guidance/ng198<br>• Primary Care Dermatology Society (PCDS)<br>– PCDS National Primary Care Treatment and Referral Guidelines for Common Skin Conditions<br>– PCDS Acne Primary Care Treatment Pathway |
| **Appendices** | Appendix 1- Management flow chart<br>Appendix 2- NICE recommended first line treatment options |

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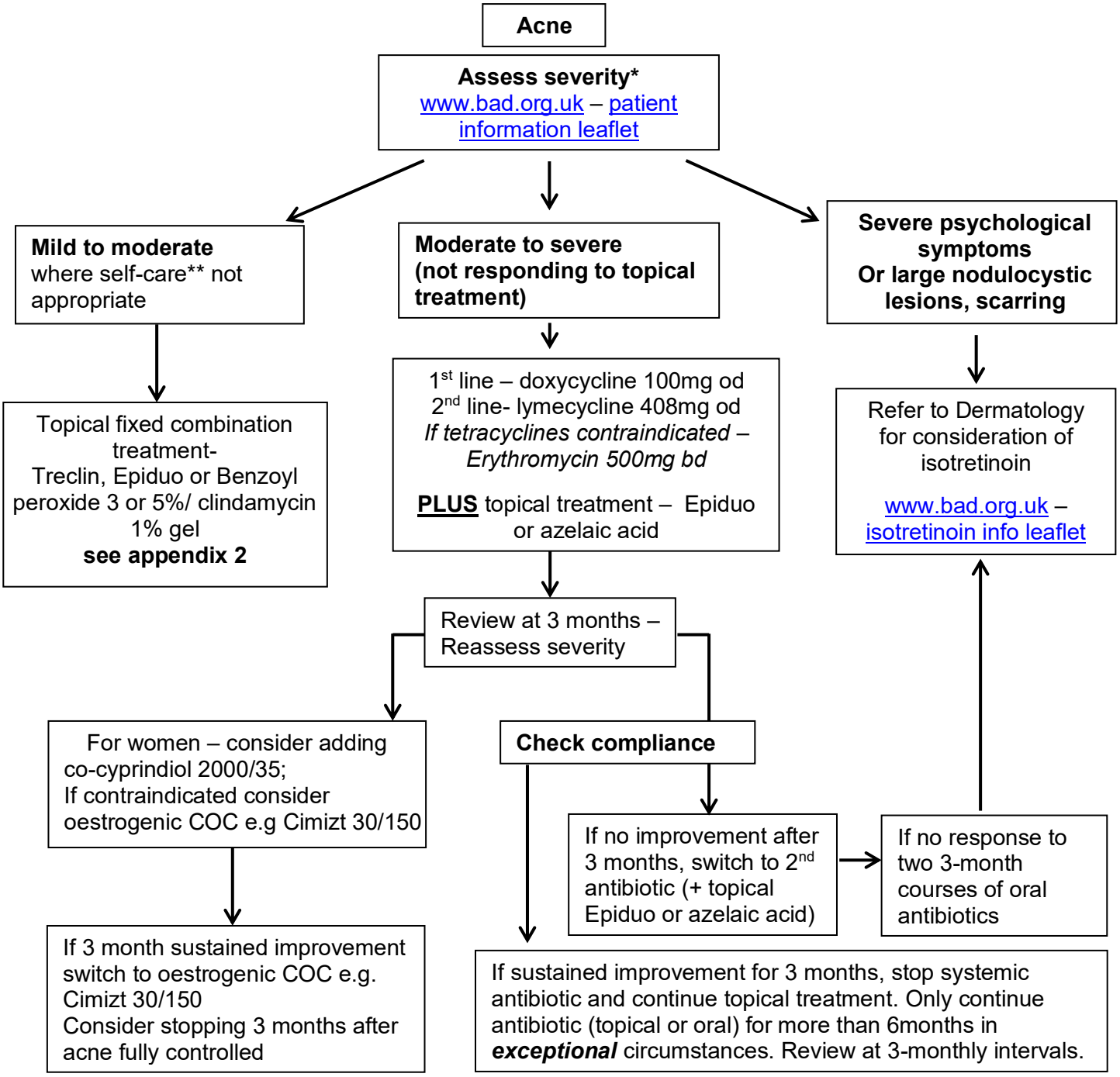
**References:**
NICE NG198 Acne vulgaris management https://www.nice.org.uk/guidance/ng198
National Institute for Health and Care Excellence Clinical Knowledge Summaries- Acne vulgaris https://cks.nice.org.uk/acne-vulgaris
Primary Care Dermatology Society http://www.pcds.org.uk/clinical-guidance/acne-vulgaris

| Document Control | Date |
|---|---|
| Replace Duac brand with generic benzoyl peroxide/clindamycin gel. | January 2023 |
| Add April23 MHRA drug safety update isotretinoin | May 2023 |
| Links to PIL updated, MHRA drug safety Oct23 isotretinoin added | November 2023 |
| Link to JUCD self-care changed to NHS acne web page | February 2025 |

## Appendix 1- Management flow chart




***Acne Severity Definition**

| | |
|---|---|
| Mild to moderate | People who have 1 or more of:<br>• any number of non-inflammatory lesions (comedones)<br>• up to 34 inflammatory lesions (with or without non-inflammatory lesions)<br>• up to 2 nodules |
| Moderate to severe | People who have either or both of:<br>• 35 or more inflammatory lesions (with or without non-inflammatory lesions)<br>• 3 or more nodules. |

** Benzoyl peroxide containing preparations are available OTC at pharmacies e.g. Acnecide gel/ wash.

OTC restrictions include pregnancy, breastfeeding, elderly & children under 12 years old.

Offer **12-week** course of 1 of the following, taking into account severity of acne, person's preferences, and after discussion of advantages/ disadvantages of each option.

| Acne severity | Treatment | Advantages | Disadvantages |
|---|---|---|---|
| Any severity | Fixed combination topical tretinoin 0.025%+ clindamycin1% **(Treclin £11.94 30g)**<br><br>Applied once daily in the evening | • Topical | • Not for use during pregnancy or breastfeeding *<br>• Can cause skin irritation and photosensitivity |
| Any severity | Fixed combination topical adapalene 0.1 or 0.3% + benzoyl peroxide (BPO) 2.5% **(Epiduo £20.85 45g)**<br><br>Applied once daily in the evening | • Topical<br>• Does not contain antibiotics | • Not for use during pregnancy *<br>• Caution during breastfeeding<br>• Can cause skin irritation, photosensitivity, and bleaching of hair and fabrics |
| Mild to moderate | Fixed combination topical BPO 3 or 5% + clindamycin 1%<br><br>Applied once daily in the evening | • Topical<br>• Can be used with caution during pregnancy and breastfeeding. | • Can cause skin irritation, photosensitivity, and bleaching of hair and fabrics |
| Moderate to severe | Fixed combination topical adapalene + benzoyl peroxide (**Epiduo**), applied once daily in the evening<br><br>PLUS once daily oral **Doxycycline 100mg (1st line)** Lymecycline 408mg (2nd line) | • Oral antibiotics may be effective in treating affected areas that are difficult to reach with topical treatment (such as the back)<br>• Treatment with adequate courses of standard therapy (systemic antibiotics and topical therapy) is an MHRA requirement for subsequent oral isotretinoin. | • Not for use in pregnancy, during breastfeeding. *<br>• Topical adapalene+ BPO can cause skin irritation, photosensitivity, and bleaching of hair and fabrics<br>• Oral antibiotic may cause systemic side effects and antimicrobial resistance. Oral tetracyclines can cause photosensitivity. |
| Moderate to severe | Topical azelaic acid (15 or 20%) applied twice daily<br><br>PLUS once daily oral **Doxycycline 100mg (1st line)** Lymecycline 408mg (2nd line) | | • Not for use in pregnancy, during breastfeeding. *<br>• Oral antibiotics may cause systemic side effects and resistance. Oral tetracyclines can cause photosensitivity. |
| Consider **topical benzoyl peroxide monotherapy** as an alternative treatment to the options above if above treatments contraindicated or the person wishes to avoid retinoid or an antibiotic. | | | |
| For people with mod/severe acne who cannot tolerate or C/I to oral doxycycline or lymecycline- use **erythromycin 500mg twice daily** (NB Increasing problem of microbial resistance to erythromycin so in general reserve for cases where tetracyclines are contraindicated e.g. pregnancy & breastfeeding) | | | |
| **Do NOT use antibiotic (topical or oral) monotherapy or combination of topical and oral antibiotics** | | | |
| If a person wishes to use hormonal contraception, consider COC in preference to POP. | | | |
| Polycystic ovary syndrome- use 1st line treatment option. If not effective, consider adding co-cyprindiol (review at 6months and discuss continuation or alternative treatment options) or an alternative COC. | | | |

* Person with childbearing potential- topical retinoids and oral tetracyclines are contraindicated during and when planning pregnancy AND they will need effective contraception or choose alternative treatment. Oral progesterone-only contraceptives not considered effective.

**Prescribing notes**

- To reduce risk of skin irritation (irritant dermatitis) with topical treatments, start with alternate-day or short-contact application (washing off after 1h) and gradually progress to standard application if tolerated. To reduce the effect of this use a water-based moisturiser.
- Note benzoyl peroxide (BPO) can cause bleaching of fabric.
- Person with childbearing potential- topical retinoids and oral tetracyclines are contraindicated during and when planning pregnancy AND they will need effective contraception or choose alternative treatment. Oral progesterone-only contraceptives not considered effective.
- There is increasing problem of microbial resistance to erythromycin so in general reserve for cases where tetracyclines are contraindicated e.g. pregnancy & breastfeeding
- Minocycline is not recommended due to greater risk of lupus erythematosus-like syndrome, and can cause irreversible pigmentation.

**Moderately severe acne in women (where other treatments have failed)**

- Consider adding co-cyprindiol 2000/35 (greater anti-androgen effect) if no contra-indications, and after careful discussion of risks and benefits.
- Once sustained improvement (3 months) consider changing to an oestrogenic Combined Oral Contraception e.g. Cimizt to prevent rebound.
- Consider stopping 3 months after acne fully controlled unless also needed for contraception.