Madigan Army Medical Center
Referral Guidelines

Rosacea

Diagnosis/Definition

- This common inflammatory disease begins in young adulthood, and is most prominent in middle age. The patient may have one or any combination of the four subtypes of rosacea:
  - Erythrotelangiectatic – Erythema with or without telangiectasias, generally involving the cheeks and nose, but may also involve the entire face or parts of the upper trunk.
  - Papulopustular (sometimes referred to as "acne rosacea") – A follicular eruption of red papules and pustules, generally on an erythematous background, generally found on the face and upper trunk. This eruption differs from acne in that comedones ("blackheads and whiteheads") are **absent**.
  - Ocular – Patients will complain of dryness or scratchiness when they wake up in the morning, and have symptoms of conjunctivitis, keratitis or iritis.
  - Rhinophyma ("WC Fields nose") – The bulbous growth of the sebaceous glands of the nose usually starting at the midpoint of the dorsum of the nose and below.

Initial Diagnosis and Management

- General – Education of the patient on this condition should emphasize the chronic nature of rosacea. There is no cure, although it improves with treatment in many cases. It is important to identify the triggers (e.g., heat, wind, hot/spicy foods, alcohol, chocolate, etc) that cause the patient to flush. The patient should try to eliminate or limit exposure to inciting triggers. Instruct in the importance of gentle, non-irritating/drying skin care products and the necessity of daily sun protection (i.e., facial moisturizer with SPF of at least 15).
- Erythrotelangiectatic – This is the most common form of rosacea, but it can also be the most difficult type to treat. For the telangiectases, a **vascular laser or intense pulsed light** may be used to shrink these vessels over several treatments; however, if the patient continues to flush, these will likely come back over time. These treatments would be considered cosmetic in nature, and a patient who is interested in this will need to seek care by a civilian dermatologist, and treatment is not a Tricare-covered benefit. For patients who wish to minimize persistent erythema, a **green-tinted moisturizer or makeup** (sold OTC by Eucerin, Neutragena, Clinique, etc.) followed by regular makeup, or **cover-up makeup** (e.g., Dermablend), can help neutralize the redness.
- Papulopustular – For a patient with few or occasional papules/pustules, 1st line treatment is **topical metronidazole 0.75-1% gel, lotion or cream** (based on patient preference), applied **bid**. Topical **azeleic acid (Finacea, Azelex) 15%-20%** may also be used in a similar manner. If the lesions are most persistent or extensive, then an **oral tetracycline** (tetracycline 250-500mg PO bid or doxycycline 100mg PO bid or Minocycline 50mg or 100mg po BID) is often necessary.
- Ocular – This type often occurs in conjunction with other forms of rosacea, but if isolated, should be referred to ophthalmology for definitive diagnosis. In general, ocular rosacea will respond with treatment of the skin inflammation, particularly if an oral tetracycline is taken. The patient may also take a small amount of baby shampoo diluted with water, and massage the upper and lower eyelids gently before going to bed for symptomatic relief.

- Rhinophyma – This type of rosacea is best treatment with electro-surgery, particularly using a device called an Ellman. Patients should be referred to ENT for this type of procedure.

Ongoing Management and Objectives

- Good resolution of lesions and minimizing the signs of rosacea are the primary objectives.
- Gentle skin cleansing is encouraged: Mild soaps (i.e. Dove, Oil of Olay for Sensitive Skin, Cetaphil, Phisoderm, Purpose, or Neutrogena) may be used to cleanse the skin. Discourage scrubbing with washcloths, Buff-Puffs, and any cleanser that contains abrasives of any type as these can worsen acne, and contribute to scarring. Avoid soaps such as Dial, Zest, Coast, Irish Spring, Safeguard, Noxzema, Ivory – these are very drying and seem to contribute to worsening of rosacea.
- If the above topical treatments fail, use of a topical sulfur preparation (e.g. sulfacetamide 10% or sulfur 10% lotion) bid or cautious introduction of a low-strength topical retinoid (0.25-0.5% cream) or adapalene (0.1-0.3% gel) can be tried (see Acne referral guidelines for patient education on use of topical retinoids).
- Avoid topical steroids: usually makes Rosacea of any form worse – may help reduce some of the redness, but again, Rosacea usually flares.

Indications for Specialty Care Referral

- Refer patients with moderate or severe rosacea that has not cleared with 6 months of conventional, conservative treatment (prescription meds).

Criteria for Return to Primary Care

Rosacea is stabilized and/or improved on regimen of therapy.

Pictures of **Rosacea** from NZ DermNet - New Zealand Dermatological Society

Last Review for this Guideline: **October 2009**
Referral Guidelines require review every three years.

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