Rosacea guideline

Rosacea is a chronic inflammatory skin condition primarily affecting the central face. It presents with a range of symptoms including flushing, persistent erythema, papules, pustules, and telangiectasia. It can significantly impact quality of life and requires a tailored, patient-centered approach to management.

Referral criteria:

Refer **routinely** to Dermatology:

• Flushing, persistent erythema, telangiectasia, or phymatous rosacea that have not responded to treatments described in **Table 1** or are causing psychological or social distress.
• Papulopustular rosacea that has not responded to at least 12 weeks of oral plus topical treatment.
• An uncertain diagnosis.

Refer to an ophthalmologist:
• **Urgently**, if keratitis or anterior uveitis is suspected (eye pain, blurred vision, sensitivity to light, red eye).
• **Routinely**, if ocular symptoms are severe or resistant to maximal treatment in primary care.

Refer to a plastic surgeon if there is:
• Prominent non-inflamed phymatous disease (e.g. rhinophyma). **This is not NHS funded** and will need individual funding request (IFR) approval- approved only in exceptional circumstances. Laser ablation can also be offered in the private sector.

If patient does not meet referral criteria, treat in primary care

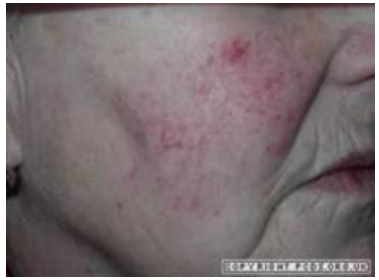
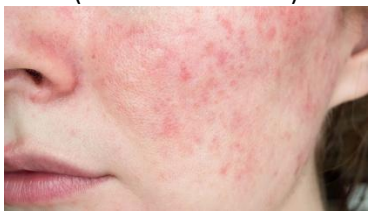
• Assess the predominant symptoms and rule out acne vulgaris.
• Be aware that patients often experience more than one subtype concurrently.
• The treatment choice should be based on rosacea subtype and level of severity

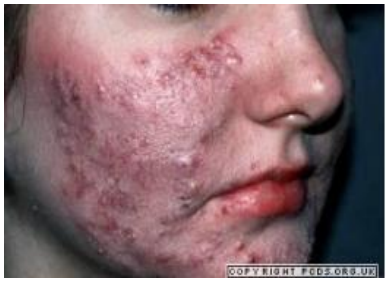
Patient Information resources

• Provide all patients with a Rosacea Lifestyle Patient Information Leaflet:
-NHS Choices Rosacea: https://www.nhs.uk/conditions/rosacea
-British Association of Dermatologists Rosacea Patient Information leaflet: Rosacea-PIL-Apr-2022.pdf, Rhinophyma
-The British Skin Foundation website: https://www.britishskinfoundation.org.uk

• Provide reassurance about the benign nature of rosacea and uncommon progression to severe disease (especially in women).
• Recommend frequent application of high-factor sunscreen (minimum SPF 30) to the face whenever exposure to sunlight is likely. Ultraviolet protection sunglasses may be helpful for people with features of ocular rosacea. Avoid the use of sunbeds.
• If flushing is problematic, advise avoidance of trigger factors. Possible triggers include extremes of weather (heat and cold winds), sunlight, strenuous exercise, stressful situations, spicy food, alcohol, and hot drinks. Some medicines can aggravate flushing (e.g. calcium-channel blockers). A diary may be helpful to identify stimuli and triggers that may exacerbate rosacea.
• If the skin is dry, advise the use of skin-care products as required (e.g. hypoallergenic and noncomedogenic emollient creams). Avoid use of abrasive products or topical corticosteroids on the face. The possible use of yellow- or green-tinted cosmetics to help camouflage skin erythema.

Table 1 – Treatment of Rosacea

Provide all patients with a Rosacea Lifestyle Patient Information Leaflet and instruct to continue lifestyle changes throughout treatment. Rosacea-PIL-Apr-2022.pdf		
Type of Rosacea	**1st line**	**2nd line** use if 1st line ineffective, contra-indicated or not tolerated
Erythematotelangiectatic rosacea  **Flushing and persistent erythema of the central face; possible telangiectasis; easily irritated facial skin. Burning and stinging may be reported. Oedema, roughness, or scaling may be present.**	**Persistent erythema** **Brimonidine 0.5% gel apply topically OD on 'as needed'**, for temporary relief of symptoms Maximum of 1 g of gel (approx five pea sized amounts) per day. **Ensure that patient knows how to apply (see below)**. Topical Brimonidine may reduce erythema within 30 minutes, reaching peak action at 3 to 6 hours, after which the effect diminishes, and erythema returns to baseline. **See notes below for MHRA warnings and other information.** **Transient Facial flushing** **Propranolol PO 20 mg - 40 mg two-three times daily for short term use** (unlicensed indication caution: risk of overdose*) Camouflage creams are Amber 2 - Patients are normally referred to a local British Red Cross or Changing Faces camouflage service, and products to be prescribed are normally recommended by this service British Association of Dermatologists, camouflage patient information leaflet *Propranolol is an effective and safe drug when taken as prescribed and is widely used in primary care. However, in 2020 the UK Healthcare Safety Investigation Branch (HSIB) published a report highlighting that the toxicity of propranolol in overdose was under-recognised amongst healthcare professionals	
Papulopustular rosacea (mild to moderate)  **Persistent erythema with transient papules and/or pustules of the central face. Burning and stinging may be reported.**	**Ivermectin 1% cream apply topically OD for 8 to 12 weeks** (maximum 4 months) treatment course may be repeated. If clinical improvement, continue maintenance therapy as needed, ideally until skin is clear. If little/no clinical improvement, use combination treatment as per moderate/severe papulopustular rosacea.	If ivermectin is not available or inappropriate e.g. severe hepatic impairment, pregnant or breastfeeding women: **Azelaic acid 15% topical gel (Finacea®) twice a day**. Apply to the affected areas and rub in gently. Approximately 2.5 cm of gel is sufficient for the entire facial area. Improvement becomes apparent after 4 weeks of treatment. Review at 2 months and if no improvement, discontinue gel. **OR** **Metronidazole 0.75% (Rozex®) topical cream or gel twice a day** for 6 to 9 weeks

<table>
<tr>
<td>Papulopustular rosacea
(moderate to severe)
& Phymatous rosacea
 
Skin thickening, irregular surface nodularities, and enlargement. Patulous follicles and telangiectases may occur. Rhinophyma is most common, but other affected locations may include the chin, forehead, cheeks and ears</td>
<td>Ivermectin 1% cream OD for 8 to 12 weeks (maximum 4 months) treatment course may be repeated.

<u>AND</u>

Doxycycline modified release 40mg capsule

Once a day for 8 to 12 weeks.

If no improvement at 6 weeks, consider discontinuing (licensed for maximum 16 weeks but review before this time).

If clinical improvement, continue combination treatment up to 12 to 16 weeks, then reassess need for ongoing oral antibiotic treatment and continue topical treatment.

Phymatous disease has a low threshold for dermatology referral.</td>
<td>Alternative TOPICAL options (if ivermectin is not available or inappropriate e.g., severe hepatic impairment, pregnant or breastfeeding women):

Azelaic acid 15% topical gel (Finacea®) twice a day as above

OR

Metronidazole 0.75% (Rozex®) topical cream or gel BD for 3 to 4 months.

Alternative ORAL options: Lymecycline 408mg OD

Alternative for pregnant or breastfeeding women or when tetracyclines are contraindicated:

Erythromycin 500 mg PO BD

If little or no improvement, refer to Dermatology.</td>
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<td>Ocular Rosacea
 
Watery or bloodshot appearance; foreign body sensation, burning or stinging, dryness, itching, light sensitivity, blurred vision, telangiectases of lid margins; lid and periocular erythema; blepharitis, recurrent conjunctivitis, styes (chalazion, hordeolum); episcleritis, iritis; decreased visual acuity due to corneal complications</td>
<td colspan="2">Eyelid hygiene recommended: Apply a warm compress (clean flannel under hot water, wrung out and applied to lid for 1 minute) followed by cleansing with an over-the-counter lid cleaning solution or wipes. Refer to an ophthalmologist where necessary (see referral criteria).

Artificial tears e.g.:
○ Hypromellose 0.3% (thin viscosity)
○ Polyvinyl alcohol 1.4% (mid viscosity)
○ Carbomer 0.2% (thick viscosity)

Review after 2 to 4 weeks of self-care

If any associated skin symptoms are seen or suspected, also treat as guidelines state for either as ‘Papulopustular rosacea (mild to moderate) or ‘Papulopustular rosacea (moderate to severe). If clinical improvement, continue management as needed. If little or no improvement, refer to ophthalmology. Consider referral to dermatology if skin symptoms prominent.

eye-lubricants.pdf https://www.nottsapc.nhs.uk/media/qx5ap1br/dry_eyes_self-care_apc.pdf</td>
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Notes	
Brimonidine tartrate 3 mg/g gel (Mirvaso®gel)	Mirvaso patient information leaflet Apply once daily when facial erythema is present. Brimonidine gel may only be needed on days when people feel that their appearance is particularly important. Apply thinly, divide dose over forehead, chin, nose and cheeks. When persistent, constant, severe erythema is the predominant symptom and there is no prominent telangiectasia. Brimonidine gel can also be used with metronidazole or azelaic acid gel in papulopustular rosacea: Apply metronidazole or azelaic acid after brimonidine gel has dried. • The maximum daily dose is 1 g of gel in total weight, which corresponds to approximately five pea-sized amounts. • Its use should be reviewed annually, including potential withdrawal. • Telangiectasia may be accentuated as general redness is reduced. • Some patients may have exacerbation or rebound symptoms of rosacea. It is important to initiate treatment with a small amount of gel (less than the maximum daily dose) for at least a week and increase the dose gradually, based on tolerability and treatment response. • Topical brimonidine may reduce erythema within 30 minutes, reaching peak action at 3 to 6 hours, after which the effect diminishes, and erythema returns to baseline. • Patients should be counselled on the importance of not exceeding the maximum daily dose, and advised to stop treatment and seek medical advice if symptoms worsen during treatment • Brimonidine (Mirvaso) gel is subject to two MHRA warnings: ○ MHRA June 17: Risk of systemic cardiovascular effects: Counsel to avoid application to irritated or damaged skin, including after laser therapy in order to reduce the risk of systemic absorption leading to bradycardia, hypotension and dizziness. ○ MHRA Nov 16: Risk of exacerbation of rosacea: Counsel patients to initiate brimonidine with less than the max dose for at least 1 week, then increase gradually, based on tolerability and response. They should also be advised of the importance of not exceeding the maximum daily dose, stopping treatment and seeking medical advice if symptoms worsen during treatment.
Topical ivermectin	No dosage adjustment is necessary in renal impairment; caution in patients with severe hepatic impairment.
Topical metronidazole/azaelic acid	Can be used intermittently or continuously to control symptoms. Metronidazole cream is more cost effective than metronidazole gel and is the preparation of choice. It is also the preferred choice for sensitive skin. Metronidazole gel should be reserved for patients who have intolerance to metronidazole cream. Azelaic acid may be more effective in those who do not have sensitive skin but may cause transient stinging.

References

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MHRA/CHM advice: Brimonidine gel (Mirvaso®): Risk of exacerbation of rosacea (November 2016) https://www.gov.uk/drug-safety-update/brimonidine-gel-mirvaso-risk-of-exacerbation-of-rosacea

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Accessibility checked. Contains tables which may not be accessible to screen readers.