ROSACEA

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PREVALENCE
Rosacea is a common but greatly misunderstood disorder of the facial skin that is estimated to affect upwards of 14 million adult Americans, with approximately only 25% of the population even aware of it. This serious disorder is known to affect more women than men; however, men are far more likely to seek treatment. Specifically, more men develop the advanced sequelae of severe telangiectasias (dilated blood vessels, or spider veins) and rhinophyma (red, bulbous nose).

As rosacea typically begins between the ages of 30 and 50, the first stages may be barely detectable by the patient and not at all by others. The most common age for onset is in the 40s and 50s. The vascular reactivity seen in rosacea is most common in fair-skinned individuals of Irish and Scandinavian descent and is seen in persons who already have vascular hyperreactivity, or tendency for the central face to redden easily (e.g., those who blush easily).

ETIOLOGY (CAUSE) AND PROGRESSION OF DISEASE
Rosacea is a chronic and progressive disease with many flare-ups and remissions. The etiology of rosacea lies with hyperresponsiveness of the blood vessels of the central face. Exactly why some people develop rosacea and others do not is uncertain. A number of factors may play a role, including genetic background, composition of skin microflora, individual inflammatory mediators, individual triggers, and others. Alcohol was once thought to be causative, but it has never been proven to be linked directly to the development of the disease. However, alcohol does cause vasodilatation and can serve as a disease trigger.

Papules and pustules may be visible in rosacea as in acne. However, sebaceous plugging is not causative in rosacea as it is in acne. There may be bacterial overgrowth as the disease becomes more severe, but the presence of bacteria is also not causative as in acne.

The first stage of rosacea is merely vascular hyperreactivity. This can occur in the 20s or 30s and is usually not identified as rosacea. In fact, rosacea progresses so gradually that it may go completely undetected and undiagnosed, even after the facial changes are obvious. The early stage is very difficult to treat, except, for particular individuals, by avoiding some triggers (listed on page 2).

During the course of rosacea, at least 50% of patients have some type of ocular (eye-related) symptom. Ocular symptoms can be found in the first stage and may be the only symptoms the patient notices; however, ocular symptoms are frequently found as the disease progresses. Ocular complaints may include dry eye, stye development, contact lens intolerance, redness of the eyelids, or even corneal damage with ulcerations. When the patient complains only of eye symptoms, the term ocular rosacea is sometimes used.

After an initial stage of intermittent facial flushing, the disease most often progresses to constant erythema (redness) of the cheeks, forehead, chin, and nose; stinging or burning of the face; increased pore size; and ocular symptoms. Then papules and pustules develop, telangiectasias appear, and nasal bumps that increase in number and size until, finally, rhinophyma occurs. Rhinophyma is certainly disfiguring, and even the papular/pustular stage is very unattractive. The skin and subcutaneous (just below the skin) tissue of the nose are affected by rhinophyma, but the supporting structures of cartilage and bone remain intact and are not affected. The lack of involvement of

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the supporting framework of the nose makes rhinophyma more amenable to surgical treatment than it would be if these structures were affected.

Rosacea can be considered an age-related disease. Even though the very first symptoms of disease can appear in the 20s, 30s, or 40s, most people are not actually diagnosed with rosacea until their 40s or 50s because of its slow, gradual progression.

The progression of this disorder also means that patients’ quality of life can be affected. Degrees of psychological distress range from mild to severe. Individuals affected may quantify the severity of their symptoms according to the RosaQol, a 21-question quality-of-life rating scale describing the individual’s symptom severity. The RosaQol is a standardized assessment tool which is well-described in the medical literature and commonly used by doctors who treat rosacea patients.

Assessment of the severity of rosacea can be performed by the clinician according to the following parameters: (1) investigator global assessment of rosacea severity (IGA score), (2) erythema, (3) papule/pustule count, and (4) telangiectasias.

MISDIAGNOSIS OF ROSACEA
Rosacea is commonly misdiagnosed. Rosacea is not acne, although this is its most common mislabeling. The cause of rosacea is different from that of acne. Some of the drugs used to treat rosacea are also used to treat acne, and this may add to the confusion.

Tumors, such as lymphoma, basal cell carcinoma of the nose or face, or squamous cell carcinoma of the nose or face, also may be confused with rosacea in its later stages. This can have disastrous consequences for the patient, leaving a potentially treatable condition to progress to a more serious stage that is much more difficult to treat or may even be untreatable.

Sarcoïd presenting in the nose can appear to be rosacea. Because alcohol as a triggering factor has been known for some time, persons with rosacea used to be assumed to be alcoholics. The occurrence of rosacea does not mean the individual is an alcoholic.

DISEASE TRIGGERS
The following substances are known to trigger rosacea, although this occurs with varying frequency. The most well-known trigger is alcohol. It should be emphasized again that the occurrence of rosacea should not label a person an alcoholic. The occurrence of rosacea, however, will cause the physician to recommend avoidance of alcohol since this is such a common trigger.

Foods also can be common triggers. Potential food triggers include hot peppers, Mexican food, Thai food, red pepper, hot sausage, black pepper, vinegar, paprika, white pepper, and garlic. These foods are listed in descending order of reported frequency for triggering rosacea. Very hot beverages may be a trigger in some patients. Note that these foods also are known for causing vasodilatation, which would lead to flushing.

Other potential triggers are environmental, such as sun exposure and cold weather. Stress also may trigger an exacerbation of symptoms.

TREATMENT
Rosacea may prove frustrating to treat, for both patient and clinician, although several topical and systemic pharmaceuticals are available. The first line of treatment is to avoid any triggering or exacerbating factors. Topical antibiotics such as metronidazole, azelaic acid, or other agents may be long-term options. Topical retinoid therapy may be used along with systemic treatment with oral antibiotics. In severe cases, surgery (including laser therapy and other techniques) may be used for unsightly telangiectasias or rhinophyma.

Over-the-counter preparations are often tried by persons with rosacea, either as a first try at treatment or because of frustration with prescribed medications.
The formulation method and choice of ingredients, including vehicles (dissolving agents), is very important in the efficacy and success of over-the-counter products.

PRODUCT RECOMMENDATIONS

iS CLINICAL® products recommended for rosacea include CREAM CLEANSER, CLEANSING COMPLEX, HYDRA-COOL® SERUM, YOUTH EYE™ COMPLEX, BODY COMPLEX, EYE COMPLEX, MOISTURIZING COMPLEX, and PRO-HEAL® SERUM ADVANCE®.

Recommended iS products for rosacea include PROTECTIVE MOISTURIZER SPF 15, EXTREME PROTECT SPF 30, COOLMINT REVITALIZING MASQUE, REPARATIVE MOISTURIZER, RESTORATIVE EYE COMPLEX, and ECLIPSE SPF 50+.

Recommended INNOVATIVE SKINCARE® Professional Products for rosacea include REJUVENATING MASQUE.

REFERENCES


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