NHS
Vale of York
Clinical Commissioning Group

Referral Support Service

Dermatology

D16
Rosacea

Definition

- Rosacea is a chronic relapsing disease of the central face affecting middle aged (30-60yrs) and fair-skinned patients.
- It is characterised by flushing, persistent erythema, telangiectasia, papules, pustules and rhinophyma.
- There may be associated ocular symptoms including a gritty sensation, blepharitis, conjunctivitis, episcleritis and chalazion.

Management

- Smoking cessation to be encouraged
- Encourage weight loss (if appropriate)

General measures:

- Avoid triggers
  - Tea and coffee
  - Alcohol
  - Spicy food
  - Sunlight and excessive heat or cold advise daily use of sun-blocks
  - Some drugs can aggravate flushing symptoms (such as calcium-channel blockers) and flare-ups of rosacea (such as topical corticosteroids). Reduce and stop these if possible.
- Emollients may be soothing, see medal ranking on emollients, but avoid oil-based facial creams. Use water-based make-up.
- Topical treatments can be used in mild disease.

Metronidazole 0.75% cream - applied thinly twice daily for 6-9 weeks is usually preferred, as it is well tolerated (the cream may be more suitable for sensitive skin and is more cost-effective than the gel), or
Azelaic acid 15% gel (Finacea®) applied twice daily may be more effective, especially in people who do not have sensitive skin. It may cause more adverse effects (such as transient stinging, burning, itching or dry skin). Discontinue if no improvement after 2 months.
Ivermectin 1% cream (Soolantra®) is a 3rd line option after failure of metronidazole cream and azaleic acid gel. Only prescribe one tube and patients should be reviewed at eight weeks. Maximum of four months treatment (two tubes) allowed. There is no evidence of benefit if re-used so please do not give further courses.
Brimonidine (Mirvaso®) is not commissioned. Do not prescribe.

- **Systemic treatments for more severe disease or if topicals fail**
- Oral antibiotics (tetracyclines first line (NOT minocycline), erythromycin is an alternative) for at least 3 months
- Once in remission step down to minimal dose or topical treatment

- May need to continue long-term
- Flushing may be helped by **beta-blockers, clonidine** or **spironolactone** and a trial may be initiated in primary care.

Management of ocular symptoms
- Lid hygiene
- Artificial tears (medal ranking on ocular lubricants due)
- Oral antibiotics may help

Cosmetic camouflage
- Can be very helpful for persistent erythema
- Available by referral to changing faces

Refer patients to Dermatology if:
- Diagnostic uncertainty
- Severe disease
- Not responding to primary care management

Refer patients to Ophthalmology if:
- Ocular symptoms not responding to primary care management
- Urgently if keratitis suspected i.e. blurred vision, eye pain or sensitivity to light

Referral Information

Investigations prior to referral
- None required

Information to include in referral letter
- Treatments tried in primary care and response to these
- Relevant past medical/surgical history
- Current regular medication
- BMI/Smoking status
- Photograph required – please refer to the CCG commissioning statement here

Patient information leaflets/ PDAs *(these may not represent local commissioning guidance)*

British Association of Dermatologists (BAD) Patient Information Leaflet (PIL) for Acne rosacea
Patient.info leaflet http://www.patient.co.uk/health/Rosacea.htm

References

- Clear guidance on primary care management and lots of images http://www.pcds.org.uk/clinical-guidance/rosacea
- http://www.patient.co.uk/doctor/Rosacea-and-Rhinophyma.htm
- NICE CKS Rosacea – acne (Oct 2018)