**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.

Complications include:

* Rhinophyma
* Facial swelling and lymphoedema
* Keratitis
* Scarring

**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). This can also include contact with family members/partners using topical steroids. Reduce and stop these if possible.
* Topical treatments can be used in mild disease.

**General skin care advice**

* **Frequent emollients**.
* Use physical sunscreens (zinc or titanium oxide) factor 30+
* Avoid exfoliants
* Avoid alcohol based topical products (e.g. toners)
* Green tinted foundation can help minimise redness

**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 on FP10. It can be issued as a private prescription (30g od or bd) in patients with flushing for occasional use, though it can cause rebound flare if used regularly, similar to nasal decongestants. Seek advice and guidance if considered.

**Systemic treatments for more severe disease or if topicals fail**

* Oral antibiotics (tetracyclines first line (NOT minocycline), erythromycin (500mg bd) is an alternative for at least 3 months. Lymecycline 408mg od or doxycycline 40mg od are best absorbed and best evidenced.
* Once in remission step down to minimal dose or topical treatment
* May need to continue long term
* Flushing may be helped by beta-blockers (carvedilol 3.125-6.25mg up to tds, propranolol 10-40mg up to tds) or clonidine (25-50microgram up to tds) or spironolactone (100mg-200mg od, pregnancy should be avoided) and a trial may be initiated in primary care
* Facial swelling may benefit from [self-lymphatic massage](https://www.wsh.nhs.uk/CMS-Documents/Patient-leaflets/Lymphoedema/6660-1-How-to-do-self-lymphatic-massage-on-your-head-and-neck.pdf), whilst waiting to be seen in clinic.

**Management of ocular symptoms**

* Modify local environment- minimise air conditioning, excess central heating, smoky environment, peri-ocular cosmetics. Humidifiers may help.
* Modify/eliminate oral medications that may trigger dryness
* Lid hygiene- OTC lid wipes, massage ocular lid
* Warm compressesArtificial tears 6x per day or more
* Oral antibiotics may help

**Cosmetic camouflage**

* Can be very helpful for persistent erythema
* Available by referral to [changing faces](https://www.changingfaces.org.uk/)

**Psychosocial support**

Consider psychological or psychiatric input in patients with anxiety and depression due to the impact of rosacea.

**Patient funded management options**

* Vascular laser is a good option for telangiectasia
* Debulking of rhinophyma can also be performed with laser, if not funded on the NHS
* Briminodine gel od or bd topically as a private prescription for flushing- reserve for special occasions as it can cause rebound flare similar to nasal decongestants

**Referral Guidelines**

* **Refer patients to Dermatology if**
* Diagnostic uncertainty
* Severe disease
* Not responding to primary care management
* **Refer patients to Opthalmology**
* If ocular symptoms not responding to primary care management
* Urgently if keratitis suspected ie blurred vision, Pain on eye movement, pain that keeps them awake at night or sensitivity to light
* **Refer patients to head and neck surgeons for treatment of rhinophyma**

**Exclude Red Flag Symptoms**

None

**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

**Useful links**

**References**

* Clear guidance on primary care management and lots of images

<https://www.pcds.org.uk/clinical-guidance/rosacea>

* <http://www.patient.co.uk/doctor/rosacea-and-rhinophyma.htm>
* [NICE CKS Rosacea – Acne (March 2016)](https://cks.nice.org.uk/topics/rosacea/#!scenario)
* British association of Dermatologists guidelines:

[British Association of Dermatologists guidelines for the management of people with rosacea 2021\* | British Journal of Dermatology | Oxford Academic (oup.com)](https://academic.oup.com/bjd/article/185/4/725/6599936?login=true)

* [Rosacea: Symptoms, Causes, and Management - DermNet (dermnetnz.org)](https://dermnetnz.org/topics/rosacea)