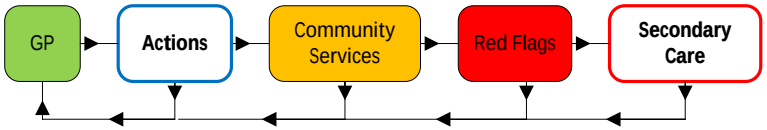

Bexley Clinical Commissioning Group

ACNE - Clinical Pathway KS13/14

GP Assessment
- **Assess -** Overall severity and the impact of the disease on the patient; quality of life and psychological stress,
- **Discourage -** Picking, squeezing and application of occlusive cosmetics,
- **Educate -** It takes months to control acne, stress importance of compliance

Mild Acne

Mainly non inflammatory open /closed comedones

Mainly inflammatory pustules and papules

Treatment with:
- Topical keratolytic (Benzoyl peroxide 2.5% - 10%)
- Azelaic acid
- Retinoids eg Tretinoin at night
- +/- topical antibiotic

- Topical retinoids better for non-inflammatory
- Topical antibiotics better for inflammatory

No Response?

Combination product:
non inflammatory:
Eg EPIDUO®

Combination Product:
inflammatory:
Eg DUAC®

No Response?
Consider 'Moderate Acne' route.

Moderate Acne

Papules and pustules (inflammatory), more frequent lesions with mild scarring

Treatment with Systemic antibiotics, eg:
- Doxycycline 100mg od ***(photosensitivity)***/ Lymecycline ***(no photosensitivity)***

In pregnant women/children <12, Consider;
- Zineryt®, Erythromycin.

Continue topical treatments whilst on oral antibiotics

Alternative antibiotic:
- Lymecycline 408mg OD
- Trimethroprim 200mg BD or **300mg BD (off licence - PTO)**

No Response?
Consider 'Severe Acne' route.

Severe/Cystic Acne

As per ***'Moderate Acne'*** with cysts and scarring, Severe acne with nodules,
or severe psychological effects

- Consider referral for oral Isotretinoin
- Exclude PCOS as these patients do not respond (consider Dianette)
- Explain teratogenicity and need for contraception
- Only do early bloods if liver/cholesterol abnormally suspected

- FBC
- U&E
- LFT
- Fasting lipids
- Serum HCG if female

1-2 weeks before specialist appt & give patient results to take with them

Referral Management & Booking Service
- Dermatology GP Triage

Referral Challenge
- Quality of Referral
- Missing Information
- Exceptional Rx,

Community Dermatology

Secondary Care

General advice for all acne treatment:
Try medication (topical & oral) for 2/12. If improvement, continue for 6/12 then switch to prevent resistance

Supplementary Information for ACNE - Clinical Pathway KS13/14

Trimethoprim 300mg BD: - Dermatology. 1993;187(3):193-6.
Oral trimethoprim as a third-line antibiotic in the management of acne vulgaris, **Bottomley WW, Cunliffe WJ.**
Source: Leeds Foundation for Dermatological Research, Leeds General Infirmary, [accessed May 2013]
UK.http://www.ncbi.nlm.nih.gov/pubmed/8219422

Investigations
The vast majority of acne patients do not require investigations. Check free testosterone levels if Polycystic Ovarian Syndrome (PCOS) is suspected, which is suggested by:

- Oligomenorrhoea (less than nine periods a year)
- Hirsutism
- Free testosterone levels may be elevated between 3-5 nmol/l
- Patients with testosterone level (SHBG) > 5 nmol/l, or other features of virilisation should be referred urgently to an endocrinologist to rule out a serious underlying disorder.

General management principles.
Provide a patient information leaflet.
Assessment of patient, factors that will affect treatment choice.

- Duration of acne
- Family history - strong family history is a poor prognostic factor
- Response to previous treatment
- Compliance
- Anything to suggest that the acne is atypical
- Psychosocial effects of the disease - some patients with 'mild' acne may become very depressed
- Overall acne severity at all sites
- Predominant types of lesions: comedonal/inflammatory/both
- Scarring
- Pigmentation

Factors which can/might modify acne:
Hormonal factors

- About 70% of females will notice an aggravation of the acne just before or in the first few days of the period,
- Polycystic Ovarian Syndrome (PCOS) / other endocrinological disorders,
- UV light can benefit acne,
- Stress, this is a controversial issue - there is some evidence that stress makes acne worse but data to support this view is limited,
- Stress may manifest itself as acne excoriee, where patients, usually females, habitually scratch the spots the moment they appear.

- Cosmetics
- Caused by oil-based cosmetics
- Pomade acne is caused by hair pomades, with comedonal and papulopustular acne on the forehead and temples,

The following drugs may cause acne:

- Topical and oral corticosteroids,
- Anabolic steroids,
- Lithium,
- Ciclosporin,
- Iodides taken orally, which may be part of some homoeopathic therapies.

Clinical findings
• Greasy skin (seborrhoea)
• Non-inflamed lesions ie comedones - blackheads and whiteheads (these can be difficult to see, stretching the skin usually helps)
• Inflamed lesions - papules, pustules and nodules
• Scarring, which may be due to: ◦ Loss of tissue, the so-called atrophic or ice pick scar
◦ Increased fibrous tissue, the so-called hypertrophic or keloid scar
• Pigmentation, which can be a problem especially in dark skin

(The Primary Care Dermatology Society (PCDS)

Patient information Leaflets

- http://www.patient.co.uk/health/acne

British Association of Dermatologists

- http://www.bad.org.uk/site/792/default.aspx

Relevant Information:
Clinical Evidence:
NICE, British Association of Dermatologists, The Primary Care Dermatology Society (PCDS)

CCG Approvals
Designed: March 2013
Approver: AD Transformation

Approved: 11/04/13 North Bexley Locality Meeting
Approved: 11/04/2013
Quality & Safety working Group
Approved: 18/04/13 Frognal Locality Meeting
Approved: 25/04/13 Clocktower Locality Meeting

For Review: 08/05/2013
Approver: Medicines Management Working Group
Launch: 09/05/13 GP Education – Danson Boathouse

This Pathway is a guideline. Please screen patients for contraindications before any prescribing.

Patient Involvement

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Secondary Care Link

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