

## Treatment Guidelines for Rosacea

With thanks to Dr Verdolini, Consultant Dermatologist, Dr Kim Gerlis, Speciality Doctor Dermatology PAHT and GPwSI Dermatology Drs Rogers, Ralph and Pavlou for their support in creating this document.

### **Introduction**

Rosacea is a chronic relapsing disease of the facial skin. It is characterized by symptoms of facial flushing and a spectrum of clinical signs, including erythema, telangiectasia, coarseness of skin, and an inflammatory papulopustular eruption resembling acne but without comedones. Epidemiological data are scarce and controversial; reported prevalences range from 0.09% to 22%.

Patient information at [NHS Choices](#):

Please see [Primary Care Dermatologists Society](#) and [Clinical Knowledge Summary](#) for additional information and advice

### **Self-care advice**

- Reassure the person about the benign nature of rosacea and that progression to severe disease, such as rhinophyma, is uncommon (especially in women).
- Recommend the frequent application of high-factor sunscreen (minimum sun-protection factor 30) to the face whenever the person is going to be exposed to sunlight.
- If flushing is problematic, advise the avoidance of trigger factors (where practical). Possible triggers include extremes of weather (in particular heat, and cold winds), sunlight, strenuous exercise, stressful situations, spicy food, alcohol, and hot drinks.
- If the skin is dry, advise the use of skin-care products as required (e.g. hypoallergenic and non-comedogenic emollient creams). The use of abrasive products or topical corticosteroids on the face should be avoided (even if they appear to help in the short term).

### **Flushing, erythema (without inflammation), telangiectasia**

Can sometimes be the predominant symptoms. Tend not to respond to antibiotics. Some drugs can aggravate flushing e.g. calcium-channel blockers.

#### **TREATMENT First line:**

- [Offer lifestyle advice](#)
- [Flushing:](#)

May be helped by a non-selective cardiovascular beta-blocker such as propranolol 40 mg twice daily, or clonidine 50 micrograms twice daily

#### **TREATMENT Second line: Specialist prescribed only by Consultant or GPwSI**

- Brimonidine topical gel, 0.33% (Mirvaso®)  
Evidence of effectiveness is limited, benefitting a small number of patients with persistent erythema by a cosmetic effect. Usage should be limited to important events such as interviews, presentations or important social events where symptoms may be particularly embarrassing to the patient. Adverse reactions include erythema, flushing, skin burning sensation and contact dermatitis. Some patients may have exacerbation or rebound symptoms of rosacea especially if used daily. See [MHRA Drug Safety Update Nov 2016](#). [MHRA Drug Safety Update June 2017](#); Brimonidine gel (Mirvaso): risk of systemic cardiovascular effects; not to be applied to damaged skin

**Laser therapy** using a pulsed-dye laser can be very effective although improvement is not permanent. Only a few commissioners will provide laser treatment for rosacea on the NHS. For West Essex CCG see [Cosmetic Surgery General Principles Policy Statement](#)

**Camouflage creams** – ACBS does not specify rosacea. Camouflage creams should not routinely be prescribed for rosacea. Patients could attend [Changing Faces](#) or British Red Cross clinic for advice and purchasing camouflage creams

Consider a secondary care dermatology referral for severe disease not responding to measures available in primary care

## MILD to MODERATE – Papular, Pustular and nodular rosacea

### TREATMENT First line:

- Topical metronidazole 0.75% gel or cream (Rozex®)  
Metronidazole is usually preferred as it is well tolerated. The cream may be more suitable for sensitive skin.  
Apply twice daily for 3-4 months

OR

- Azelaic acid 15% (Finacea®)  
Azelaic acid is an alternative to metronidazole that may be more effective, especially in people who do not have sensitive skin. However, it may cause transient stinging, itching, or dry skin.  
Discontinue if no improvement after 2 months

If treatment has been effective, it may be stopped. However, advise the person that their rosacea may relapse, requiring restarting the same treatment.

Maintenance treatment: This may be intermittent e.g. using a topical treatment on alternate days or twice a week.

### TREATMENT Second line:

- Ivermectin 10 mg/g cream (Soolantra®) only consider if first line options not effective or not tolerated.  
One application a day for up to 4 months. Soolantra should be applied daily over the treatment course. The treatment course may be repeated. In case of no improvement after 3 months, the treatment should be discontinued

## MODERATE to SEVERE – Papular, Pustular and nodular rosacea

Use systemic treatment if topical agents fail or if presenting symptoms more severe

### TREATMENT First line:

- Oral antibiotics  
Oxytetracycline 500mg twice daily  
Doxycycline – 100mg once daily (unlicensed use)  
Lymecycline – 408mg daily (unlicensed use)

Microbial resistance is an increasing problem for erythromycin, therefore reserve for patients where tetracyclines are not tolerated or are contraindicated e.g. pregnancy or breast feeding

Erythromycin 500mg twice daily

Clarithromycin 250mg twice daily if GI effects of erythromycin are not tolerated.

Initial treatment should be for at least three months, although if the patient is responding well the dose may be reduced after one month

If treatment has been effective, it may be stopped. However, advise the person that their rosacea may relapse, requiring restarting the same treatment.

Maintenance treatment: This may be continuous e.g. a reduced dose of oral treatment for 2–6 months followed by a 'drug holiday'.

OR

'Stepping down' from oral to topical treatment.

If treatment has not been satisfactory consider adding a topical treatment (switching to an alternative oral antibiotic is unlikely to be of benefit) or seek specialist dermatology referral for consideration of other treatments such as low dose isotretinoin

## Management of rhinophyma

For severe cases or those which have not responded to treatments above may be considered for surgery or laser treatment, see [Rhinophyma Policy Statement](#)

### When should I refer a person with rosacea?

- Refer routinely to dermatology those people with:
  - Flushing, persistent erythema, telangiectasia, or phymatous rosacea that is causing psychological or social distress.
  - Papulopustular rosacea that has not responded to 12 weeks of oral plus topical treatment.
  - An uncertain diagnosis.
- Refer routinely to a plastic surgeon those people with severe phymatous disease (e.g. prominent rhinophyma).
- Refer to an ophthalmologist:
  - Urgently, if keratitis is suspected (eye pain, blurred vision, sensitivity to light)
  - Routinely, if ocular symptoms are severe or resistant to maximal treatment in primary care.

### References

CKS Rosacea

<http://cks.nice.org.uk/rosacea#!scenario>

Primary Care Dermatology Society

<http://www.pcds.org.uk/clinical-guidance/rosacea#management>

Cochrane Review – Interventions for rosacea

<http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD003262.pub5/abstract>