Current Practice

DISEASES OF THE SKIN

Rosacea and Acne

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*"Good Bardolph, put thy face between his sheets,
and do the office of a warming pan."*

HENRY V, ACT II, SCENE 1.

Treatment of Rosacea

There is no simple cause of rosacea, but numerous factors influence its development. Varying emphasis has been placed on one or another of these by different writers even at times to the exclusion of all other causes, but such an approach is ill-founded and treatment must deal as far as possible with each potential factor in every case.

Psychological Factors

Rosacea has been described as pathological flushing, and the relationship of blushing to emotion is obvious. Psychogenic influences present two aspects. First, there is the constitutional make-up of the patient. Klaber and Wittkower pointed out many years ago that patients with rosacea often give a history of shyness and diffidence and a tendency to blush easily—a condition which they labelled "social anxiety." These patients preferred to read a book in a corner and were never the life and soul of a party. Unfortunately, if a patient is made this way there is little one can do about it, and even the psychiatrist cannot help them much. The second aspect concerns the effect of environmental stresses, and these often seem to precipitate an attack or play a part in persistence of the disease. Whether one attributes the flushing just to nervous stress or suggests more specifically that it is a flush of guilt or shame one can often do quite a lot for these patients at quite a superficial psychological level. A readiness to listen and let the patient talk is important, and I agree with Wittkower that many of them seem almost to have a compulsive desire to confess. In outpatients I get a great deal of help from my medical social worker, who can spend much longer with individual patients in unhurried conversation. Most of these problems, at least on the surface, are psychosociological and involve marital difficulties, trouble with in-laws or neighbours, and in one patient of mine a false income-tax return. By free discussion one can often help these patients with their problems, and even if one has not got to the psychological roots of their difficulties one may produce considerable relief of their tension, with resulting benefit to their skin. It is often helpful to put the patient on a small dose of amylobarbitone or a suitable tranquillizer, though this should not be used as a short cut to avoid allowing the patient to talk.

Stomach Factor

The association between a red nose and alcohol has long been known, and even in those who avoid alcohol excess hot and

strong tea or coffee may have a similar action. At one time it was thought that achlorhydria was all-important, but this has been disproved; chronic gastritis with an atonic dyspepsia is commonly found in patients with rosacea and in some cases atrophic changes in the villi of the small intestine have been reported. Treatment should be aimed at relieving the gastritis. Irritants such as alcohol, hot and strong tea and coffee, and highly seasoned food should be avoided. Many of these patients rush their food and I always advise 20 minutes relaxation with a book after meals, especially at midday. The old remedy of weak hydrochloric acid in water with meals helps at times and I feel it has been too readily discarded.

Endocrine Factors

Flushing is common at the menopause and rosacea may be worse at this time, though there may be other factors, such as nervous tension, playing a part besides the actual flushes. Suitable treatment must be instituted to relieve these menopausal symptoms, including sedatives or, if necessary, hormonal preparations. In younger women I have seen gynaecological disorders associated with rosacea, and where these are present or there is marked menstrual abnormality the help of a gynaecologist should be sought.

Exposure Factors

Excessive exposure to heat or cold has an adverse effect on rosacea. I have recorded the monthly and yearly incidence of rosacea and found that it is most frequent in early spring and especially in those springs in which the weather is very turbulent. Conversely, patients who have very hot jobs, such as cooks or boiler firemen, complain that the heat aggravates their rosacea. Though it is not always easy for a patient to change his job, consideration may have to be given to this or some adjustment made in his working conditions so that he is less exposed to extremes of temperature.

Local Sepsis

Some patients with rosacea have a chronic sinus infection or septic teeth and treatment of these seems to help their rash. Whether it does so by stopping some reflex irritation or whether the removal of septic teeth benefits their chronic gastritis I cannot say, but one should always have a look at the teeth and sinuses to see if treatment is needed.

Demodex

Demodex folliculorum is a small parasitic worm found in the hair follicles in most people, but it appears in specially large numbers in rosacea. Many people believe it is a harmless

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saprophyte, which grows more profusely on a suitable skin, but a few dermatologists still consider it plays an active part in rosacea, especially in relation to papule formation. Success has been claimed with anti-parasitic agents such as benzyl benzoate, and it is possible that the beneficial effect of sulphur preparations results from their action on the demodex.

Empirical Treatments

Unfortunately when one has dealt with all the above factors one is often left with a patient who still has a florid rosacea. The treatment that I have found best is to give a course of 3 or 4 small doses of x rays (80–100 r) at three-weekly intervals, together with a 2% sulphur and salicylic acid ointment. The results are often dramatic and the patients very grateful, though they must be warned that they may have a little flare-up for a few days. Corticosteroid preparations are prescribed for every skin condition nowadays, not excluding rosacea. I think they sometimes make the patient more comfortable but doubt if they really produce a cure in rosacea.

Sometimes the cheeks in rosacea feel firm and indurated; this may be improved by massaging the skin for five minutes each night with the following cream:

Sulphur	...	...	...	0.5
Emulsifying ointment	...	...	...	12.5
Water	...	...	...	to 100

The massage should be from the ears towards the nose and downwards from the forehead to assist the normal direction of drainage. I have found this technique occasionally helpful, especially in those patients who cannot tolerate ointment.

Some dermatologists have claimed success with tetracycline in rosacea but others have been sceptical. However, at the recent British Association of Dermatology Conference at Oxford I. B. Sneddon produced a convincing well-controlled trial which showed statistically significant improvement in patients treated with tetracycline compared with those on dummy tablets. The dose used was in the region of 250 mg. b.d., which had to be continued for two or three months to obtain the best results. The mechanism of this response is uncertain, but it is unlikely that it is due to any ordinary anti-infective action.

Patients with rosacea sometimes use cosmetic preparations and often these are a useful boost to their morale. Green powder masks the redness of the skin better than the usual pinkish shade. In those who are made worse by exposure to sun a light protective cream such as Uvistat should be prescribed.

Treatment of Acne

Acne is an almost universal complaint affecting young people. It usually clears up soon after 20 years of age, but it is little satisfaction to an introspective depressed teenager to be told this. Active treatment should always be instituted, both to relieve the present condition and to minimize the possibility of permanent scarring. However, I always warn the patient, especially in the earlier acne period, that there is no magic cure and that whatever is done he is likely to have some spots for quite a while and that a great deal depends on the persistence with which he carries out treatment. Acne is said to clear up at about 20 years, on marriage, and certainly after pregnancy. This is not always true, as many sufferers persist with spots well into their twenties, and now that adolescents are marrying earlier acne in married people is seen more often.

Endocrine Aspect

Acne appears at puberty and is obviously subject to endocrine influences, especially androgens; thus it does not occur

in eunuchs unless they are being treated by testosterone. It is tempting, therefore, to treat acne with oestrogens, but I believe this is rarely justified. If oestrogens are given to a boy in a dose adequate to suppress the acne side-effects will occur, such as enlargement of the breasts and even feminizing personality changes, and we do not know for certain that oestrogens are not harmful in the long-term effects. It may be safe to use them in women but this is still usually undesirable. Attempts to use oestrogens locally in the form of an ointment such as Actriol cream have not been very successful.

General Health

I am sure some patients' acne is made worse by certain articles of diet such as chocolates and pig fat. I have also seen many patients who can eat both of these with impunity. Nevertheless, as a result of tradition and experience with the first group of patients, I always advise patients with acne to avoid excess fried food and pig fat, and also chocolates and cocoa, though I don't mind a few boiled sweets; fresh fruit and vegetables are good for acne sufferers.

Many patients find their acne gets worse when they leave school with its fresh air and games and start work in a stuffy office. They should be encouraged to get some fresh air and exercise in the evenings and at the week-ends and to expose themselves to sunshine whenever possible.

Skin Cleaning

Acne patients usually have a greasy skin and this should be washed frequently and thoroughly. The washing also helps to remove the blackheads and allows any dammed-up secretion to escape. Probably any soap and a rough face-cloth are adequate, but a more powerful detergent such as Stergene, a teaspoonful in a pint of water, may be used on a very greasy skin. Antiseptic detergents such as 1% cetrimide are recommended by some dermatologists. Medicated soaps are in my opinion not very effective and are uneconomical, as the bulk of the medicament goes down the drain after only a brief contact with the skin. It is much better to cleanse the face first and apply a suitable application afterwards. There has always been disagreement about whether it is a good thing to remove blackheads mechanically. Squeezing with finger nails or a key should certainly be avoided, as it may convert a superficial lesion into an indurated deep swelling. On the other hand, careful removal of prominent comedones with a proper extractor does help some people. The same objective may be achieved by using abrasive applications such as Brasivol, though on the whole I have been disappointed with these. I have known some women patients helped by mudpacks.

Psychological Influences

Some young people get very depressed by their spots, but one should try to distinguish between those in whom the spots are the primary cause of their depression and those with adolescent depressive tendencies who make their spots a focus for their trouble. I have occasionally had to refer such cases to a psychiatrist because I have felt there has been some severe underlying psychological upset. Occasionally an antidepressive drug such as imipramine may help the acne of a depressed patient. In other people excitement, such as going to a dance or some important social occasion, may cause an unwanted outbreak of spots, and for these a little sedation before such an event may be useful.

Antibiotic Therapy

Few dermatologists believe that acne is primarily an infective process, though some consider secondary infection important.

Nevertheless, many believe that certain antibiotics, especially the tetracyclines, have a definite beneficial effect in acne. It is possible that this may be due to some different action of tetracycline from its usual bactericidal one; there is evidence that tetracycline is held in the skin and it may be that it interferes with some enzyme system. The evidence for the effectiveness of tetracycline in acne is still rather suspect. The best results have been obtained when it has been given for periods of two or three months, usually in doses of 250 mg. b.d.—a rather costly treatment when the effect of it is still open to doubt. Nevertheless, there do seem to be some patients who improve rapidly when on tetracycline and relapse when it is stopped, while other patients are little affected by it. I feel, therefore, that tetracycline should be tried judiciously in bad cases but not used blindly for every sufferer.

Ultraviolet Light

Acne usually improves when the patient is exposed to bright sunshine, and one of my worst cases cleared while he was in the western desert in Egypt during the war. Unfortunately, the good effect usually disappears fairly quickly when the exposure ceases and the patient returns to his ordinary life. Artificial sunlight is even less effective; a temporary improvement follows the initial treatment but very soon the skin seems to get used to the radiation and the spots return. Nevertheless, as a temporary measure it can be helpful in difficult cases and is especially indicated in the earlier age groups. The converse of this is the bad effect of heat and friction, such as was experienced by our troops in the steaming heat of Burma. Some of these developed the most severe forms of acne and had to be invalided home. The same effect to a lesser degree may be seen in this country, particularly where a job entails friction on the back and a sweaty shirt, or where a girl, or boy nowadays, has a thick lock of hair covering the forehead or side of the face. Such hair styles should be discouraged.

Radiotherapy

The use of *x* rays in patients with acne has greatly diminished in recent years, partly as the result of the general avoidance of irradiation wherever possible, and partly because its effectiveness has been questioned. *X* rays probably have a good effect by damping down the activity of the whole pilosebaceous follicle, thus diminishing the output of sebum and the tendency to hyperkeratosis at the follicle orifice forming the comedo. *X* rays should certainly not be used in the earlier acne period, as they have only a temporary effect on the increasingly active follicles and repeated courses might produce damage to the skin. On the other hand, I believe that towards the end of the acne period a course of *x* rays in reasonable dosage, say 3 doses of 125 r at three-weekly intervals, may expedite the final disappearance of the spots.

Cystic Acne

Sometimes patients with severe acne develop cysts and extensive deep fluctuant swellings, and these may be very difficult

to treat. Surgical intervention should be avoided as far as possible, for excision of cysts is very often followed by the appearance of fresh ones. Sometimes incision and drainage is helpful, but it is amazing how quite extensive fluctuant swellings will eventually absorb and disappear. Freezing the lesions with carbon dioxide snow has been recommended, and sometimes helps, but the most useful treatment in my opinion is aspiration followed by the injection of a local corticosteroid.

Scarring

Many patients are worried about the possibility of future scarring on their faces and demand reassurances. Actually quite severe acne will often settle down eventually and after a few years the scars become insignificant. When marked scarring is left some help can be obtained by plastic planing or abrasive treatment. The results are by no means perfect, but patients with severe scarring will appreciate a 75% improvement, though obsessive patients with minimal scarring are often dissatisfied with whatever one does. Nevertheless, I find it very helpful to be able to tell worried teenagers that we can always do something for their scars if they should be still worried when the active spots have disappeared. In actual fact by the time the acne has subsided the scars have usually settled so much that the patients are no longer worried and do not require dermabrasion.

Local Applications

Sulphur in some form has always been the classical application for acne, and every dermatologist has his favourite remedy. For a not very severe acne I prescribe ordinary calamine lotion with 6% precipitated sulphur. For more severe cases I use the following:

Sulphur ppt.	...	...	...	gr. 15
Resorcin	...	...	...	gr. 15
Zinc oxide	...	...	...	gr. 160
Ung. emulsificans	...	...	ad oz. 1	

This is half the strength of the *B.P.* sulphur and resorcin paste, which is too strong for many patients and may produce redness and irritation of the skin. It is always better to start with a weaker paste and increase the strength if necessary. I tell my patients that if my paste produces irritation they should use it alternate nights to begin with. There are many proprietary sulphur preparations: Eskamel has the advantage of being cosmetically acceptable, as it can be used as a foundation cream. Recently various blunderbuss preparations have been advocated, such as Neomedrone Acne lotion, which contains methylprednisolone and neomycin in addition to sulphur. I have not found any great advantage in these and believe most of their value lies in the sulphur they contain. If sulphur preparations fail I turn to one containing benzoyl peroxide, and this is now marketed as Quinoderm cream, which I believe is of great value. I do not think the addition of hydrocortisone to this (Quinoderm H.C.) is of any advantage.