Face the Facts:
Skin Clearing Solutions
And More!

Skin, Bones, Hearts & Private Parts

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Let your patients put their best face forward!

Practical approaches to diagnosing and treating facial skin disorders, including acne, rosacea, lupus, actinic damage, and pigmentary disorders.

We will cover skin care routines and treatments you can recommend to your patients to keep their skin healthy and protected.

Presentation Overview

- Acne
- Perioral dermatitis
- Rosacea
- Eyelid Dermatitis
- Lip-licking dermatitis
- Seborrheic dermatitis
- Pityriasis alba
- Lupus
- Hyperpigmentation
- Hypopigmentation

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Acne





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Acne





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Acne

- Extremely common, usually self limited, chronic inflammatory condition
- Risk factors:
  - increased sebum production
  - follicular hyperkeratinization
  - C. acnes (formerly known as P. acnes)
  - inflammation that is neutrophil driven
- Starts at puberty
- Found in areas of great density of sebaceous follicles
- Implicated conditions and medications
  - PCOS, Cushings
  - Testosterone, Lithium, immunosuppressants, Jak inhibitors, low-estrogen contraceptives, progesterone only OCP, PTU, steroids

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Acne Types

- Neonatal Acne - 2 wks- 3months
- Infantile acne - presents 3-6 months resolved 1-2 years
- Drug Induced
  - within 2 weeks of oral or topical steroid use
  - INH, phenytoin, cyclosporine, lithium, Keflex, OCPs, Androgens, JAKinhibitors
  - Protein powders
- Acne conglobata - men, late puberty-early adulthood,
  - severe acne, papules, nodules, draining sinus tracts
  - Chest, shoulders, back, nape, buttock.
  - Early intervention warranted
- Hormonal- adult women, jawline, corresponds with menstrual cycles

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Clinical Appearance

- Face, neck, trunk, shoulders, jawline
- Open and closed comedones, cysts/nodules, papules, pustules, scarring
- Darker skin tones: violaceous or gray lesions as well as persistent hyperpigmentation (PIH)

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Diagnostic Pearls

- Common triggers: touching, picking, pomade, primers, comedogenic products, occlusive equipment, drugs, makeup brushes
- Hirsuitism? Consider hyperandrogenic endocrinopathes
- Drug? Acneiform eruption

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Tests

- Clinical diagnosis
- Consider culture or KOH
- Consider referral to endo vs labs: free and total testosterone, FSH, LH, DHEA, prolactin if PCOS/hormonal acne is stongly suspected

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Severity Drives Treatment

- Mild - non-inflammatory, generally only comedones
- Moderate - beginning of inflammatory lesions; generalized over body; papules, pustules, +/- cystic nodules
- Severe - high risk of scarring; nodules and cysts

*** number of acne lesions, type of lesions, severity, anatomical site, scarring, QOL

***Always examine the chest and back

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Treatment Considerations

- Cost/insurance coverage
- Extent and morphology
- Mechanism of action of medications
- Psychosocial
- Compliance
- Side effects
- Difficult to use several meds at once
- Social media recommendations

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Acne Counselling

- Chronic disease: goal is control, not always cure
- Lifestyle modifications
- Adverse effects of medications
- Treatment expectations, patience
- Address PIH concerns

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Behavioral Modifications

- Decrease inflammation, stop picking
- Water based cosmetics and hair products
- Limit occlusion
- Low glycemic diet, minimize fast food
- Limit stress
- Establish appropriate expectations

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Treatment

- Combination treatment recommended
- Addresses the variety of factors in acne pathogenesis
- Neither topical nor oral antibiotic monotherapy is recommended due to resistance

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BPO-FDA Update

- Clinicians should remain aware of the ongoing FDA regulatory review and counsel patients accordingly, especially regarding product storage and use.
- **BPO is still on the market, but the FDA is actively evaluating safety concerns related to benzene contamination**
- **no recall or safety alert has been issued to date**.

Treatment

Topical therapy

- 1st line: BPO and/or Retinoid
- 2nd line: Dapsone, Azelaic Acid, Minocycline, Clascoterone, Clindamycin

Oral Therapy

- Antibiotics, OCP, Spironolactone, Isotretinoin

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Topical Therapy

- BPO 4-5% wash QD
  - Side effects include burning, stinging, redness, irritation
  - **warnings issued in 2024. Ensure you know current warnings before recommending use

- Retinoid every other night - QHS
  - Side effects include burning, stinging, redness, irritation, scaling/peeling
  - Tretinoin gel/cream (0.025%, 0.04%, 0.05%, 0.1%)
  - Adapalene OTC gel (1%)
  - Tazarotene lotion/cream (0.045%, 0.05%, 0.1%)
  - Trifarotene lotion (0.005%)

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Topical Therapy cont.

- Dapsone gel (7.5%) QD vs (5%) BID
- Azelaic Acid gel (15%) BID
- Minocycline foam (4%) QD
- Clascoterone cream (1%) BID
- Clindamycin gel/lotion/solution/foam (1%) QD-BID

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Oral Antibiotics

- Indicated for moderate-severe inflammatory acne
  - Prudent use to avoid antibiotic resistance
  - Use only in combination with benzoyl peroxide and retinoids
  - Do not use longer than 12 weeks
  - Avoid under age 9
  - Ensure all adult teeth are in

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Oral Antibiotics cont.

- 1st line: Sarecycline
  - Targeted towards only skin bacteria
  - Do NOT use with Isotretinoin
  - Weight based
  - Once a day

- 2nd line: Doxycycline, Minocycline
  - Can kill more bacteria
  - Common SE: GI upset and photosensitivity
  - Less common SE: dizziness, ataxia, nausea, vomiting, phototoxicity; risks for drug reaction (DRESS)
  - Do NOT use with isotretinoin

- Do not use in children <9 years old as it affects bone and tooth development and may discolor teeth permanently

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Oral Contraceptives (estrogen containing)

- Indications:
  - Adult-onset acne in women
  - Peri-menstrual flares of acne
  - Those unresponsive to past therapies
  - Those with symptoms of hyperandrogenism

- Have antiandrogenic effects causing decrease size and functioning of sebaceous glands

- Remember that unopposed progesterone-based contraceptives will often worsen acne

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Hormonal Treatments

- Combination OCPs
  - Inhibit androgen synthesis
    - Contraindications: smokers >35 years of age; patients with a history of venous thromboembolism or hypercoagulability
    - FDA approved for acne:
      - Ethinyl estradiol / norgestimate
      - Ethinyl estradiol / norethrindrone
      - Ethynol estradiol / Drosperinone

- Androgen receptor antagonists
  - Spironolactone 50-200 mg daily
    - Can affect sexual development of the fetus- stop if pregnant
    - May need to check potassium and sodium

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Isotretinoin

- Severe recalcitrant acne
- Works on all mechanisms of acne
- Only agent that may have curative potential
- Teratogenic – many congenital defects
  - Two forms of birth control or abstinence required
- iPledge program
- Side Effects
  - May worsen depression and risk of suicide
  - Headache, joint and muscle aches, dry skin/eyes/lips
  - Elevated lipids and liver enzymes

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Additional Considerations

- Skin of color
  - Treat both acne and PIH
  - Consider Azelaic Acid, Glycolic Acid, Hydroquinone (limited use!)
  - Medical Aesthetician consult

- Pregnancy / Lactation
  - No medications studied in pregnancy
    - Azelaic Acid (category B)
    - Topical: BPO, Clindamycin, Sulfur washes
  - Always get ok from OB and Pediatrician

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Periorifical Dermatitis





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Periorifical Dermatitis

- Inflammatory disorder of face
- Papules and Pustules
- Frequent itching and burning
- Spares vermillion border
- Uncertain etiology
    - topical/oral/inhaled steroids implicated, fluoride, OCP
- Women > Men, Teens to 40s
- Frequently seen at puberty and menopause



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Management Pearls

- Taper to stop all topical steroids. Consider Tacrolimus 1%. Warn patients of flare.
- Stop all cosmeceuticals
- Stop mint, cinnamon, charcoal, lip plumpers
- Disposable masks without dye
- Fabric masks with free and clear detergent only
- Topical treatment +/- Oral treatment for two months

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Topical Treatment (off label)

- Minocycline (4%) foam BID
- Clindamycin (1%) gel/lotion/foam/solution BID
- Azelaic Acid(20%) gel/lotion BID
- Crisaborale (2%) ointment BID
- Metronidazole (0.75%) lotion/cream BID
- Erythromycin (2%) solution BID
- Tacrolimus (1%) ointment BID

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Oral Treatment

- Doxycyline 100 mg PO BID x 1 month, then slowly taper
- Erythromycin 333 mg TID x 1 month, then slowly taper
- Isotretinoin at low dose. Refer to dermatology

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Rosacea





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Rosacea

- Unclear etiology
  - UV lite, Demodex, S. epidermidis, skin barrier disruption, genetics, drugs

- All skin types, but especially lighter phenotypes
- Chronic, relapse-remit inflammatory condition
- Female > Male, 30-50’s
- 4 types, plus granulomatous and rosacea fulminans
  - Erythematotelangiectatic
  - Phymatous
  - Papulopustular
  - Ocular

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Clinical Appearance

- Clinical Diagnosis
- Flushing, erythema, papules, pustules, telangiectasias, stinging, burning, dry sensation, eye irritation
- Predominately on cheeks and nose
- Absence of comedones
- Skin of color: violaceous or erythematous to dusky brown, pustules, papules
- *Must not miss Lupus malar rash

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Treatment

- Noncomedogenic SPF
- Gentle Cleanser BID
- Avoid Triggers
- Consider ophthalmology and dermatology referral
- IPL and Nd:Yag

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Lupus



Nasolabial sparing
hydroxychloroquine
avoid sun

Topical Therapy

Papular Pustular
- Metronidazole gel/lotion/cream (0.75%-1%) QD-BID
- Azelaic Acid foam/gel (15%) BID
- Sodium Sulfacetamide with sulfur lotion/cream/wash QD-BID

Demodex
- Ivermectin 1% cream QD-BID
- Permethrin 5% cream QD-BID

Erythema/telangiectasias
- Brimonidine 0.33% gel QAM. Must wash hands
- Oxymetazoline 1% cream QAM. Must wash hands
  *May get rebound

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Oral and Ocular Therapy

- Doxycycline 40 mg PO QD
- Advanced/recalcitrant cases may require isotretinoin
- Rosacea fulminans: prednisone 1mg/kg and immediate referral to derm

Ocular symptoms
- Oral doxy 40 mg PO QD
- Artifical tears
- Referral to optho

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Eyelid Dermatitis





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Dermatomyositis





Strong J, Driscoll MS. Obesity in Hidradenitis Suppurativa: Are GLP-1 Receptor Agonists the New Frontier?. Am J Clin Dermatol. 2025;26(2):175-182. doi:10.1007/s40257-024-00911-x

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Psoriasis



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Eyelids









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Eyelid Dermatitis

- Frequently due to atopic dermatitis
- Frequently due to cosmeceutical or overhead chemical
- Chronic, relapsing condition, frequently associated with allergic rhinitis and asthma
- Intense itching is hallmark
- Associated allergy to eggs, cow's milk and peanuts is common

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Clinical Appearance

- Scaly patches across and around eyelids
- Frequently will also have dry patches on extensor surfaces
- Acute - erythema, vesicles, weeping, crusting
- Chronic - lichenification, scaling, hypo/hyperpigmenation

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Pearls

- Obtain good history
- Ask about known allergens
- Changes in cosmetics, overhead chemicals, plug-ins
- Consider DDX Dermatomyositis, Seborrheic Dermatitis, Psoriasis

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Management

- Avoid triggers and stop cosmeceuticals
- Appropriate skin care, bland emollients, avoid dyes/perfumes
- Consider referral to allergy and/or derm

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Steroid Treatment

- Intermittement low potency topical steroid (class 6-7)
  - Desonide ointment (0.05%)
  - Alclometasone ointment (0.05%)
  - Hydrocortisone ointment (2.5%)
- Steroid BID x 1 week. Stop 1 week. May repeat once then PERMANENTLY discontinue. 15 gram tube, NO refill
- Ensure no history of cataracts or glaucoma
- Write down instructions for proper steroid use

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Topical Nonsteroidals

- Crisaborole ointment (2%) BID (3 months and older)
- Tacrolimus ointment (0.3%, 0.1%) BID (BBW, 2 years and older)
- Rutoxilitinib cream (1.5) BID (12 yo and older), JAK1/2 inhibitor (MUST discuss warnings)
- Vaseline and Aquaphor
- Treat any secondary infection

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Lip-licking Dermatitis





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Lip-Licking Dermatitis

- Chronic irritant or allergic contact dermatitis due to repeated exposure to saliva and contents
- Clinical diagnosis
- Erythematous, scaly papules coalescing into circumoral plaques, fissures and crusting
- Dark skin types will show hyperpigmentation

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Considerations

- Behavior modification
- Eliminate allergens, cosmetics and dental hygiene products as possible
- Consider allergy testing
- Petroleum products only (vaseline or aquaphor)
- Topical steroids (see next slide)
- Treat secondary infections (frequent staph colonization)

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Topical Steroids

- Desonide 0.05% ointment
- Hydrocortisone 2.5% ointment
- Aclometasone 0.05 % ointment

- Steroid BID x 1 week. Stop for one week. Repeat once then permanently stop

- Counsel improper steroid use can lead to Perioral Dermatitis

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Cysts





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Cysts

- Dome-shaped, firm, flesh-colored, may have dilated punctum
- Stratified squamous epithelium and keratin/lipid-rich debris
- Usually benign, asymptomatic unless inflamed/ruptured
- Contents may express with small incision or gentle pressure
- Send to pathology

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Treatment

- Intralesional Kenalog (2.5%)
  Inform risk of atrophy and scarring may be permanent
  Careful with darker skin tones

- If inflamed, consider small I&D and culture

- Treat underlying infection
  Cephalexin 500 mg PO BID x 10-14 days
  Doxycycline 100 mg PO BID x 10-14 days
  Bactrim DS PO BID x 10-14 days (rarely if ever use first line due to risk of SJS)

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Seborrheic Dermatitis





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Seborrheic Dermatitis: Overview

- Common, symmetric, inflammatory papulosquamous condition
- Erythematous patches and plaques with scale
- Sebum rich areas
  - Face (nasolabial folds, brow, glabella, beard, ears), scalp, ears, upper chest
- Worse with stress, Parkinsons, Downs syndrome, Hx CVA, immunocompromised
- Chronic condition, relapse/remit
- Generally asymptomatic but may itch, burn
- May present with psoriasis or rosacea

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Seborrheic Dermatitis: Treatment (cont)

- Low-potency topical steroid (class 6-7)
  - Desonide 0.05% oint
  - Hydrocortisone 2.5% oint
  - Aclometasone 0.05 % oint
  - Steroid BID x 1 week. Stop for one week. Repeat once then permanently stop

- Tacrolimus or Pimecrolimus BID

  Two years of age or older

- Roflumilast QD

  >9 years old and above

*Reserve steroids for FLAIRS only

*Do NOT give combo betamethasone/clotrimazole

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Pityriasis Alba

- Mild form of atopic dermatitis
- Commonly affects children
- Chronic relapse/remit
- Worse in summer
- Poorly demarcated pale pink, light brown, white macules and patches, subtle scaling





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Pityriasis Alba: Treatment

- Consider KOH
- Dry skin care regimen
- Emollients
- SPF 30+
- Topical steroids
  - Low potency (class 6 – 7)
    - Desonide 0.05% oint
    - Hydrocortisone 2.5% oint
    - Aclometasone 0.05 % oint
  - Steroid BID x 1 week. Stop for one week. Repeat once then permanently stop
- Nonsteroidal agents
  - Crisaborole ointment (2%) BID
    3 months and older
  - Tacrolimus ointment (0.3%) BID
    2 years and older

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Simple daily routine

1.Cleanse: Wash your face twice daily with a gentle, fragrance-free cleanser.

2. Treat (Optional): Apply serums with active ingredients, such as vitamin C in the morning or retinoids at night.

3. Moisturize: Follow with a moisturizer to hydrate the skin and help it retain moisture.

4. Sun Protection: Apply a broad-spectrum sunscreen with SPF 30 or higher

Thank you

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