



The Treatment Gap in Acne Care: Guidelines versus Treatment Practices

Abstract

Do dermatologists and GPs approach acne care differently? How do these two groups of clinicians approach acne treatment, keep abreast of the latest guidelines, and manage maintenance therapy? How will the availability of a new retinoid combination product in Canada for acne change the way acne is currently treated?

To address these questions, a roundtable discussion was convened, featuring clinicians with a significant number of acne patients in their practices. **Dr. Shannon Humphrey**, a dermatologist, and **Dr. Joseph Brioux**, a family physician, and moderator **Dr. D'Arcy Little**, himself a family physician and radiologist, offered a candid take on guideline-based acne treatment and the effort to improve treatment outcomes among patients.

The discussants addressed how each professional has tended to view acne, pursues acne care differently, and why. They also discussed the latest acne treatment guidelines as well as the depth of the gap between the generalist's versus the specialist's treatment approach.

Keywords: acne, treatment gap, antibiotic resistance, treatment adherence

Moderator:



Dr. D'Arcy Little, MD, CCFP, FRCPC, Medical Director, Health Plexus & the Journal of Current Clinical Care, Toronto, ON.

Discussants:



Shannon Humphrey, MD, FRCPC, Clinical Instructor, Department of Dermatology and Skin Science, University of British Columbia, Vancouver, BC.



Joseph Brioux, MD, Family physician in private practice, Woodstock, ON.

How to access additional online resources:

The following discussion summary has been condensed and edited for the purposes of this write up. To listen to the full recording of the discussion and view animations please go to:

www.healthplexus.net/acne2011

Practicing Canadian physicians may request instant complimentary access to this and other valuable resources. Please register at: www.healthplexus.net/physician



Dr. D'Arcy Little, Moderator: In this roundtable discussion, we are looking at what we might perceive as a treatment gap in acne care—what the guidelines say, versus what is being done by specialists and family physicians in the field.

As a family physician in Toronto, I have certainly seen acne in my own practice. Could each of you speak to the frequency of acne cases in your work?



Dr. Shannon Humphrey: I'm a dermatologist with a practice in downtown Vancouver. I also train medical students and residents; I'm a clinical instructor at the University of British Columbia. My specialty is medical and cosmetic dermatology with a special interest in acne and rosacea.



Dr. Joseph Brioux: I'm a family doctor from Toronto, now practicing in Woodstock, Ontario. I have a busy practice with approximately 2,000 patients. I see a whole gamut of skin problems, in addition to acne. Oftentimes I do not have the luxury of a specialist consultant in my vicinity. Wait times for a dermatologist in my area range anywhere from four months to one year.



Moderator: As you are aware, acne is increasingly defined as a chronic disease rather than a limited and superficial disorder of teenage skin. Its chronic quality owes to acne being frequently of prolonged course and prone to relapse. Dr. Humphrey, can you respond to how acne is regarded from a specialist's point of view?



Dr. Humphrey: We have witnessed a shifting perspective over the last few years. The evidence for this shift lies in the changing nature of the questions we're asking—not just clinicians but acne researchers as well. This includes questioning the need for maintenance therapy or antibiotic resistance—which are not questions you would ask yourself for an acute, self-limited condition. That speaks to growing awareness of acne's chronicity. Recognition of this chronic quality is going to have its biggest impact in both counselling for the condition as well as in how adherence is addressed. We must convey that acne is chronic and maintenance is important—this rethinking may have impact on our therapeutic success.



Moderator: Dr. Brioux, do you get the sense that the GP community has taken this up as well—that acne is a chronic illness requiring maintenance?



Dr. Brioux: I think a family doctor who sees patients repeatedly will become aware of the importance of maintenance. You naturally seek to understand and identify when a problem is going to be short-acting and needs a briefer course of treatment versus a longer-term problem. We've known this for some time. Have we sufficiently appreciated this in the case of acne, though? I don't think so, and we do need to improve a bit—as GPs we see evolving courses of acne throughout a patient's life with us but we could probably do a much better job on maintenance care.



Moderator: Let's expand on this issue a little—do we feel there is an appropriate level of concern about acne, or is there a continued tendency to dismiss it as part of the teenage years?



Dr. Humphrey: That is a hard question to answer in general terms, as it's a clinician-dependent matter. There are so many factors to be considered in terms of the specific patient, his/her background, and social context. With regard to quality of life, the evidence is well-developed regarding acne's psychological impact. It's a matter of



Key Point

Antibiotic resistance is a key factor to consider when establishing maintenance and treatment regimens.

ensuring this message is received by both GPs and dermatologists.



Dr. Brioux: I completely agree with Dr. Humphrey. There are clinicians who are more concerned than others [about patient acne].



Moderator: Current treatment has shifted away from monotherapies to retinoid combination treatments that deal with acne's multifactorial pathology. This is codified in the latest acne treatment guidelines. Have the 2009 Global Alliance recommendations generated increased awareness, in your opinion? Is there much GP awareness when new guidelines are generated when compared to the specialists?



Dr. Humphrey: Dermatologists are aware that these guidelines exist. Many key messages have trickled down—for example, combination therapies, using retinoids as a treatment basis. As for the guidelines themselves, it's obviously very valuable for all dermatologists and GPs to go through them.

Both groups could benefit from access to a shorter version. The document is not readily accessible; it's a 50-page document. We need shorter reference material in clinics to help us access the guidelines—they're important and evidence-based but there isn't sufficient time for clinicians to synthesize it.

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Moderator: Exactly. It is there and evidence-based, but is it accessible in the time you have to review these updates?



Dr. Brioux: There isn't significant awareness at the family doctor level. We are inundated by guidelines pertaining to every condition—but which do you choose to read in detail and follow? It's not the sort of thing that everybody is going to adapt to—I think that, given the scope of what one family physician sees in a day, we have to be up to date on many things. As for these guidelines, they are available if you want to look at them...but I don't know of a lot of GPs following guidelines for acne.



Moderator: In my experience, there are so many guidelines being generated by so many different organizations—it's hard to keep track and synthesize them for your daily practice. It's important to know it's a real challenge.

Our next issue concerns antibiotic resistance, which is a significant public health concern. A key consensus of these guidelines states that strategies to limit antibiotic resistance need to be part of acne management as well. So my question for both of you is, Do you think there is sufficient awareness of this factor, and of the value of bactericidal agents such as BPO in acne management? Under what circumstances would you use an antibiotic agent, given the new guidelines?



Dr. Humphrey: Awareness could be improved both among dermatologists and family physicians. Again, this is an issue of clinical application of the medical evidence. I would not say that antibiotic resistance is necessarily at the forefront of each dermatologist's decision-making process when they're choosing treatment agents, and

I don't think it's on the radar for family doctors. I get many referrals of patients on suboptimal therapy, including individuals on long-term oral antibiotic monotherapy. There is definitely room to improve awareness in both groups of professionals.



Moderator: What about awareness on the part of your patients—there is some awareness of the dangers of antibiotic resistance when it comes to treating ear infections or pneumonia, but I don't think there's much concern, commonly, with acne therapies.



Dr. Humphrey: I do get a lot of questions from patients when I prescribe antibiotics.



Dr. Brioux: The public is starting to get it—daily they're reading articles in the newspaper about superbugs that are resistant to our antibiotics. They're getting more tolerant when doctors refuse to prescribe a certain agent. But does it flow over to awareness with antibiotic acne therapies? This goes back to an earlier point made regarding maintenance therapy. Were there more awareness about correct maintenance therapies, we wouldn't have prolonged antibiotic use as a problem.



Moderator: Your GP colleagues, are they as aware as you might be about antibiotic resistance in acne?



Dr. Brioux: It's a new awareness for them.



Moderator: Under what circumstances would you use an antibiotic?



Dr. Brioux: In the circumstance where I've got a regimen built up for my patients where I've optimized their topicals and am still getting some breakthrough inflammatory lesions, I may put them on a course of antibiotics, but I ask them to finish the course and stop, and we'll re-evaluate from there.



Dr. Humphrey: Regarding systemic antibiotics in a patient who has moderate mixed papular/pustular and comedonal acne, I would consider oral antibiotics for a short/intermediate course, aiming for a three-month course, as long as I was using it with a topical retinoid, and also being mindful about the resistance issue. So either using a topical BPO concurrently or considering a washout when the treatment was finished (that is, with a week of BPO wash or gel).



Moderator: Oral versus topical—how would that figure in?



Dr. Humphrey: There are some good-fixed dose preparations on the market, specifically clindamycin preparations, and they can be used nicely with the topical retinoids. So often I'd have a patient using a BPO/clindamycin for example at nighttime and then adapalene in the morning.



Key Point

Combination retinoid-based therapies are first-line treatments for acne; evidence suggests that such regimens achieve faster and more complete clearance, while addressing multiple pathogenic factors simultaneously.



Moderator: Where would you use a topical?



Dr. Humphrey: There's almost no role for a topical antibiotic monotherapy. We're limited in what we can offer in the case of a pregnant patient, so perhaps in that instance. It's still suboptimal.



Moderator: Dr. Brioux, anything to add?



Dr. Brioux: No, that's a similar approach to what I would use.



Moderator: Current guidelines state that, for patients with mild to moderately severe acne, combination retinoid-based therapies are first-line treatments for acne, given that the combination attacks several of acne's pathogenic factors, and the known efficacy of topical retinoids against both existing lesions and subclinical precursor lesions. Dr. Humphrey, would you say that prescribing practices of dermatologists widely reflect this?



Dr. Humphrey: Yes, one of the most consistent messages mediated via dermatology education and CME with regard to topical regimens for acne is that the retinoid-based therapies are the foundation; additional combination agents can be used. For almost all of these combination products, there is good evidence that we achieve faster and more complete clearance, while addressing multiple pathogenic factors simultaneously, with complementary modes of actions.



Dr. Brioux: I don't know whether GPs would prescribe a retinoid first-line. We've been hit long and hard by the idea that we should treat acne as an infection and don't concentrate on how to better optimize therapy with a retinoid. This message has not filtered down to the family doctors.



Dr. Humphrey: I agree with Dr. Brioux. Most of the patients referred to me on topical therapy will be on a topical BPO and antibiotic combination and not a retinoid.



Moderator: We're missing some of the pieces in our armamentarium. Now with severe acne, does that change what you do?



Dr. Humphrey: Absolutely. There are many factors to consider before treating: patient preference, degree of acne, morphology of lesions, past medical history, presence of scarring. In a patient with severe acne, if the patient is a woman I will screen for hormonal factors that may be triggering the acne and consider hormonal therapy. I will screen all patients with severe acne to determine if they are an appropriate candidate for systemic isotretinoin. In the right patient, used appropriately, it can be

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Dr. Brioux: When you get to the point of considering oral agents, the question is when to refer as a GP. I know a few practitioners in my community who would consider prescribing an oral agent. It's probably not the majority [of GPs]. When we get to severe scarring, those people get a referral.



Moderator: Next we'll consider the new product entering the market in Canada. A fixed-dose combination product with a topical retinoid and an antimicrobial has recently been made available here in Canada. As you may be aware, the latest Global Alliance guidelines have shifted, and now identify a combination topical antimicrobial and retinoid therapy as first line, over retinoid-only therapy. Do you think this will have an impact on patient care, and if so, what?



Dr. Brioux: A lot of GPs would be prescribing a topical antibiotic anyway, and an additional fixed-dose product would make it easier to take that first step [toward guideline compliance]. This is preferable to trying to change their prescribing habits altogether by having them switch to a topical retinoid first, adding in the topical antibiotic second. I think it's very beneficial at the GP level if we're seeing overuse of topical antibiotics; this may be a more proper use by using it in combination with retinoid.



Moderator: How would such a product aid in your practice and prescribing, Dr. Humphrey?



Dr. Humphrey: Three general things come to mind. The first is improving clinical outcomes. Theoretically you're addressing multiple pathogenic factors. There is rigorous evidence showing that these therapies, when used together as a fixed-dose combination, demonstrate synergistic effects. We can feel comfortable we're prescribing the best therapy for our patients. The second benefit is in improving adherence. The option to prescribe a monotherapy can optimize adherence, for specialists and GPs. It's the opportunity to prescribe a single product that ascribes to all of the best evidence. Finally the issue of antibiotic resistance is really important as we look to new agents that are available. This will be a good product for specialists and family physicians, and the guidelines do a good job of summarizing why these combination products are so valuable. This will be valuable to add to our therapeutic armamentarium.



Moderator: In treating a patient, what other factors do you consider?



Dr. Humphrey: Adherence is something I focus on. Early in my practice I noticed that patients being referred to me had a long list of therapies that they tried—that were all legitimate, evidence-based therapies, but they had used them for a short trial because of lack of perceived efficacy or side effects. It led me to change my practice and spend a long time talking to my patients about what to expect, [telling them] that it's necessary to undergo 12 weeks of topical therapy before deciding what works. I now counsel patients on expected side effects and ways to counteract them, and send them home with a handout as a reference that offers strategies to address AEs.



Key Point

Patients are often prescribed legitimate, evidence-based therapies but may abandon them after a short trial because of lack of perceived efficacy or side effects. Address patient expectations and advise on the necessity of pursuing a sufficient course of topical therapy (e.g., 12 weeks) before drawing conclusions.



Moderator: So, 12 weeks is what you need to determine how they're really doing on the agent.



Dr. Humphrey: Yes. One of the struggles I have treating acne—and I think it's a pitfall for GPs and specialists—is the use of samples. There is often just enough for patients to get side effects but not actual results. I suggest either not using samples or making sure there's enough volume to use over 12 weeks. You really need a reasonable trial, and that is at least 12 weeks.



Moderator: That's important. So they may notice a new treatment is increasing microcomedones and lesions. Is that playing into your discussion of adherence?



Dr. Humphrey: Part of establishing a long-term therapeutic alliance is advising that it's not realistic to prescribe a topical and instantly cure acne, and I let them know that. If possible I want to see a patient one month into treatment to ensure the patient is adhering, but certainly every three months after that to reinforce the maintenance message. Giving the same message at every visit helps.



Moderator: Regular follow-up makes a difference. Dr. Brioux, in terms of your follow-up, do you have any strategies to help with compliance?



Dr. Brioux: I totally agree with Dr. Humphrey. If you understand the phases your patients may go through and you give them coping techniques so they can get to the three-month mark—if you're up front, you have a good chance of getting an effective therapeutic trial.



Moderator: What regimen do you use and how do you decide on an approach—does it depend on the patient?



Dr. Humphrey: So many factors relate to patient preference. All patients should be on a retinoid maintenance therapy regardless of morphology. If there was any tendency toward breakthrough inflammatory lesions I would consider adding a BPO or using a BPO/retinoid fixed-dose combination product as maintenance. As for follow-up, even patients on maintenance therapy I would try to see two times per year, and sooner if they were having an increase in activity.



Moderator: To follow up to see if they were having any problems?

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Dr. Humphrey: Yes, depending on the patient, and also to reinforce the value of maintenance therapy.



Dr. Brioux: I'll offer them a choice of decreasing their frequency of application of the topical retinoid. For example, use it Monday, Wednesday, and Friday—and if there's a flare, get on track to using regularly again.



Moderator: Getting back to pathogenesis, which is a message that may be trickling down, do you think GPs are aware of and practice maintenance therapy sufficiently?



Dr. Brioux: This idea really needs work at the GP level. More often than not you're putting out fires and not working out a comprehensive approach to acne.



Dr. Humphrey: While the message is trickling down it's not commonplace practice among all dermatologists. The model Dr. Brioux mentioned of putting out fires with intermittent antibiotic and topical therapy [applies to some specialists]. There is work to be done for both GPs and specialists.



Moderator: I'd like to hear any concluding thoughts you might have on closing the treatment gap between GPs and dermatologists—what do you hope or expect to see in the future?



Dr. Brioux: As GPs we see a lot of acne, it's a common problem, and I don't think there is a real grassroots, comprehensive approach that you can say is widespread when you compare it to treatment of other chronic conditions, such as diabetes. We also need a better approach to antibiotic resistance; we're realizing at the GP level that it's not something we can ignore, as it affects almost everything we prescribe now.



Dr. Humphrey: I agree with Dr. Brioux. As we look to future guidelines and future evidence, there is opportunity to ask what our optimal combination therapies are, how we can improve treatment adherence, and address resistance. I would love to see guidelines in a more accessible format, both for dermatologists and GPs, as a few key messages from these guidelines could really improve patient outcomes.



Moderator: In what kind of format?



Dr. Humphrey: Potentially a laminated one-page, double-sided format, with strategies for limiting antibiotic resistance and a brief summary of key consensus statements. I have also found in CME events for family physicians that they are very receptive to these messages—saying at the conclusion, "I'm going to add retinoids, I'm going to do maintenance therapy." But we haven't yet succeeded in getting clear messages out there.



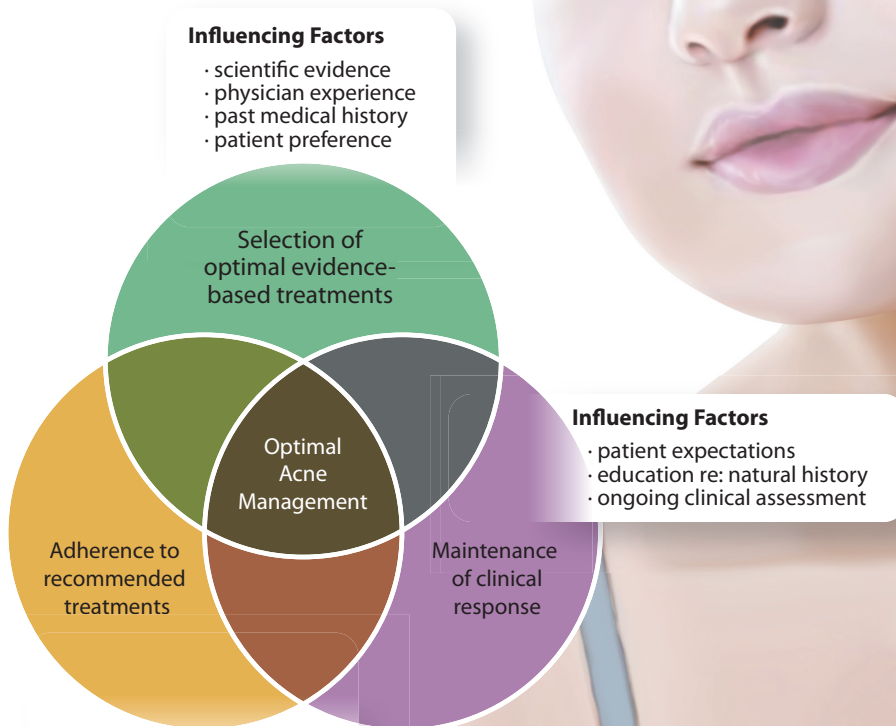
Moderator: What would be helpful for you in terms of a tool for your practice, Dr. Brioux?



Key Point

It is advisable to see patients on maintenance therapy for follow-up—at least two office visits per year, and more if there is an increase in flares.

Treatment Gap in Acne Care: Guidelines vs. Treatment Practices



- A fixed-dose treatment formulation, such as adapalene-BPO, that targets multiple pathogenetic factors of acne will provide patients and clinicians greater opportunity for customizing care and improving outcomes for patients with acne.
- Fixed-dose once-daily combination products may also increase patient adherence to treatment.
- Reductions in the complexity of acne treatment regimens, shortening the time for visible signs of success, and improving overall patient outcomes are all factors that may encourage patients to maintain their treatment regimens.

SUMMARY OF KEY POINTS

Antibiotic resistance is a key factor to consider when establishing maintenance and treatment regimens.

Combination retinoid-based therapies are first-line treatments for acne; evidence suggests that such regimens achieve faster and more complete clearance, while addressing multiple pathogenic factors simultaneously.

Patients are often prescribed legitimate, evidence-based therapies but may abandon them after a short trial because of lack of perceived efficacy or side effects. Address patient expectations and advise on the necessity of pursuing a sufficient course of topical therapy (e.g., 12 weeks) before drawing conclusions.

It is advisable to see patients on maintenance therapy for follow-up—at least two office visits per year, and more if there is an increase in flares.

Clinical Pearls

Convey to patients that acne is a chronic condition and that a sound treatment maintenance regimen is essential.

Do not give samples to patients unless supply is sufficient to pursue a 12-week trial of medication.



Dr. Brioux: I would like to see pictorial examples, having examples of a certain type of acne, how to approach it via algorithm A, B, or C, with the knowledge that if I wanted to know the reasoning, I could always look it up in the larger text of the guidelines. I need something quick and easy to source out, and a single-page laminate works well.



Moderator: I want to thank Dr. Humphrey and Dr. Brioux for their time and participation.

***Dr. Joseph Brioux** has participated as a moderator for most major drug companies' CME events. He has also participated in various ad-boards for those same companies. **Dr. Shannon Humphrey** has received honoraria from Stiefel Canada Inc. and Johnson & Johnson Inc., and has served on advisory boards for Galderma Canada Inc. **Dr. D'Arcy Little** has no competing interests to declare.*