# F122 - Skin Issues in Latino Patients

**Acne and Rosacea: Special considerations in Patients with Latin American Ancestry**

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## ACNE: Clinical considerations:

- There is no Latin or Hispanic skin type. However, although in Latin America there are all skin colors, the most predominant range from olive to dark brown and black. Latin Americans have a diverse gene pool.
- All types of acne are found in Latin Americans, from the comedonal variant to the nodular-cystic and the latter is more frequent than in another ethnic type, especially in individuals over 20 years of age.
- Invariably, most patients with Latin American ancestry with inflammatory acne, develop postinflammatory hyperpigmentation (PIH). Therefore, it is very important to start the treatment as early as possible to try to avoid this sequela.

### Treatment of acne:

- **Topical Treatment:**
  - Retinoids are the first line of treatment for mild to moderate acne (comedonal, papular-pustular). They help to treat the disease and prevent PIH – Creams and low concentrations (0.025%) or formulations in micro-sponges are better tolerated.
  - Benzoyl peroxide, combined with clindamycin is used to treat mild to moderate papular-pustular acne and helps preventing PIH.
  - Avoid dapsone to prevent PIH.
  - Azelaic acid. Used off label in the USA to treat acne in patients with darker skin color and could help to prevent PIH.

- **Oral treatment:**
  - Oral antibiotics (e.g. doxycycline): First line of treatment for moderate to severe acne (papular-pustular, nodular-cystic), but never as monotherapy. They should be used at the same time with benzoyl peroxide to prevent bacterial resistance.
  - Oral Isotretinoin: For nodular-cystic or non-responsive to treatment acne – Should be started with low dose and increase it progressively. Helps to prevent PIH.
  - Hormonal therapy: For women – Oral contraceptives with antiandrogen properties. (e.g. Norethindrone + ethinyl estradiol) – Concomitant treatment for menstrual cycle-related inflammatory acne.
  - Spironolactone: For women with menstrual cycle-related inflammatory acne.

- **Adjuvant therapy**
  - Skin care: Mild cleanser with or without salicylic acid and with ceramides, cholesterol and fatty acids to improve the damaged skin barrier – Non-comedogenic moisturizers and permanent, fluid, UVA-UVB, non-comedogenic sunscreen. Avoid scrubs, alcohol-based toners and exfoliating cleanser to prevent irritation.
  - Chemical peels: Very superficial chemical peels with lactic acid, salicylic or glycolic acid. – Help to prevent and treat PIH. – Preparation 2 to 3 weeks before the procedure with bleaching agents, (hydroquinone) retinoids and corticosteroids is mandatory.

## ROSACEA: Clinical considerations:

- Although rosacea is more frequent in phototype I and II (Fitzpatrick) it can also be suffered by people with darker skin color.
- We must consider rosacea in the differential diagnosis when we have a patient with dark skin, facial flushing, heat, eye symptoms or papulopustular elements and absence of comedones, so as not to confuse the disease with adult acne, as it may be happening in many of the cases not initially diagnosed as rosacea.
- 4 subtypes of rosacea can be diagnosed in Latin Americans: Erythematotelangiectatic (ETR), papulopustular (PPR), glandular hyperplastic or phymatous rosacea (GH/FR) and ocular (OR). The granulomatous variant is more frequent in darker phototype skin.
- Unlike acne, postinflammatory hyperpigmentation is rare

**Treatment of rosacea**

- **General care:** avoid trigger factors. Use daily, continuous sun-protection
- **Dermocosmetic care:** cosmeceuticals (cutaneous barrier restoring cleansers/moisturizers, antioxidants, niacinamide, colloidal oats, witch hazel, among others). Cold compresses. Thermal water.
- **Topical treatment:**
  - Brimonidine and oxymetazoline are the first line of treatment for ETR in combination with azelaic acid, if some papules or pustules are present.
  - Ivermectin, azelaic acid or metronidazole are the first line of treatment for PPR associated or not with brimonidine or oxymetazoline. If patient does not tolerate well this treatment, it should be switched to pimecrolimus or tacrolimus
  - For ocular rosacea the best topical treatment is ophthalmic cyclosporine
- **Systemic treatment:**
  - The first line of treatment for PPR, in association with the topical treatment described above, is the use of modified release doxycycline: 40 mg (30 mg immediate release and 10 slow release). In patients which do not tolerate doxycycline, children or pregnant, macrolides (e.g. clarithromycin) are the first choice.
  - Patients with severe PPR, GH/PR or granulomatous rosacea, would benefit with the use of low dose of oral isotretinoin.
  - The first line of treatment for phymatous rosacea is the use of ablative laser therapy e.g. CO2 laser) followed by dermabrasion, electro/radiosurgery and cryosurgery.

**References:**
- Wolina U. Recent advances in the understanding and management of rosacea. F1000Prime Rep. 2014 Jul 8;6:50

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