

AARS Public Relations Campaign

A major mission of the AARS is to address the misinformation about acne and rosacea in the medical and patient communities. The AARS Board of Directors tackled this issue by hiring a public relations firm—Lane PR—after an extensive review of proposals. Suzanne Lane's approach was direct. The AARS needs to establish itself as the expert source for the treatment of acne and rosacea.

The first step in the campaign was to conduct a public opinion survey to expose the amount of misunderstanding about these two diseases and to use this survey as the foundation of an AARS press conference. The survey was completed in September and the press conference was held in New York City in October. Speaking at the conference were Diane S. Berson, MD (PR Committee Chair), Hilary E. Baldwin, MD (AARS President) and Guy F. Webster, MD, PhD (Immediate Past President).

The AARS' first venture into the consumer media spotlight was excellent. Media attendance was considerable and from

many different sources. Magazines such as *Allure*, *Cosmopolitan* and *Health* attended, along with many other important consumer magazines. Among the notables were several beauty directors, and Natasha Singer, the reporter who writes the "Skin" column for the Style section of *The New York Times*, which appears every Thursday.

The press conference focused on the AARS mission, with an emphasis on dermatologists being the "go to" people for everything having to do with acne and rosacea. The issue of OTC versus prescription drugs was discussed at many points along the way in a fair and compelling way. OTCs were determined acceptable for a few pimples now and then, but for serious treatment, prescription drugs were stated, and re-stated, as the main line of treatment for both diseases. Editors took copious notes and had many questions to ask during the Q&A portion of the event.

The event also included commentary by the first AARS Advisory Board

member (patient-based advisory board), as well as Natalie Miller, a makeup artist who has worked extensively with many beauty publications and on notable faces such as Jennifer Lopez, Kirsten Dunst and Al Pacino.

Since this is part of an ongoing campaign, Lane PR will follow up with all the editors who attended and will also mail the press kit to a list of over 200 magazine editors and lifestyle/health editors of the top 100 daily newspapers. In the next few weeks, press releases will be sent out using the information that was in the presentations and surveys to reinforce the availability of resources offered by the AARS membership.

We will be measuring the success of the campaign by tracking articles using our speakers and press releases. An ongoing recap of the campaign will be reported to members in this newsletter. A summary of the survey and other press materials can be found on the AARS Web site at www.acnesociety.org.

certified dermatologists and if you are a member of the American Academy of Dermatology or the American Osteopathic College of Dermatology, you only need to provide proof of membership (membership number, copy of membership card, etc).

You can also receive a membership application by calling (386) 437-4405 or e-mailing info@acnesociety.org.

Membership dues are \$150 for fellows (dermatologists in the US) and \$50 for dermatology residents.

Can I attend the Annual Meeting in San Antonio?

Yes. When you register for membership, you can also register for the Annual Meeting at the member price.

Contact the AARS office at (386) 437-4405 or info@acnesociety.org.

Third Annual Meeting of the American Acne and Rosacea Society

The Third Annual Meeting of the American Acne and Rosacea Society will be held Friday, February 1, 2008, at the St. Anthony Hotel in San Antonio, Texas. It will be an event not to miss. In keeping with the mission of the society, the meeting represents a forum for the exchange of information about acne and rosacea while highlighting important research findings and updates regarding care of patients with acne and rosacea. The society was founded in honor of key leaders in the field and we are fortunate this year to have John S. Strauss, MD as our keynote speaker who will discuss his reflections on the world of acne and rosacea. It is sure to be a memorable and enjoyable talk. Sewon Kang, MD will present new research on the use of computer tracking for evaluation of acne. This should be particularly interesting for those involved in clinical research and suffered with the drawbacks of acne lesion counting. Diane M. Thiboutot, MD will give a brief update on the iPLEDGE program and share some recent research findings regarding the mechanisms by which isotretinoin reduces sebum production. In addition, we are proud to announce the recipients of the first AARS Research and Mentoring awards made possible by the generous support from our sponsors and members. Tremendous effort has been put forth this year with regard to the AARS public relations campaign for acne and rosacea, and we look forward to hearing more about this at the meeting.

Annual Meeting Registration

To register for the meeting, you must be a current paying member of the society. Registration is part of your membership. That means members need to 1) renew their membership(s) and 2) register for the meeting. You can do this online at www.acnesociety.org.

THIRD ANNUAL MEETING OF THE AMERICAN ACNE AND ROSACEA SOCIETY	
St. Anthony Hotel, Friday, February 1, 2008, 7:00 PM	
6:30 PM	Registration
7:00-8:00 PM	Cocktail Reception/Social Gathering
8:00 PM	Dinner To Begin
8:00-8:05 PM	Welcoming Remarks/Intro of Keynote Speaker <i>Hilary E. Baldwin, MD President, AARS</i>
8:05-8:30 PM	Keynote Address Reflections: Past, Present and Future <i>John S. Strauss, MD</i>
8:30-8:40 PM	Discussion
8:40-9:00 PM	Update on Acne: Clinical and Research Aspects <i>Diane M. Thiboutot, MD</i>
9:00-9:20 PM	Computer-assisted Alignment and Tracking of Acne Lesions <i>Sewon Kang, MD</i>
9:20-9:30 PM	Discussion/Questions and Answers
9:30-10:00 PM	AARS Business Meeting/Future Directions <i>Hilary E. Baldwin, MD</i>

using your user ID and password (contact the AARS office at info@acnesociety.org if you have misplaced your user information). Current members may invite guests for an additional fee.

If you are not a member, now is the time to join. Membership is open to dermatologists and health professionals with an interest in acne and rosacea. Fellow members of the American Academy of Dermatology or the American Osteopathic College of Dermatology qualify for membership as AARS fellows. Residents, with a letter from their program chair, may join at a reduced fee. Membership is \$150 for fellows (which includes the meeting) and \$50 for residents. You can join and register at the same time by going to www.acnesociety.org.

Grant Application Update

The AARS Grants Committee (Sewon Kang, MD [chair], Jenny J. Kim, MD, Diane M. Thiboutot, MD, Guy F. Webster, MD, PhD) is pleased to announce that the applications for the 2008 Clinical Research Grants and the 2008 Mentoring Grants are currently under review. Dr. Kang was "pleased with the quantity and exceptional quality of the first year of grant applications. This interest demonstrates the need for programs that encourage young leaders in the field of acne and rosacea."

The grant recipients will be announced on February 1, 2008, in San Antonio, Texas at the Third Annual Meeting of the AARS.



Winter 2008

MISSION STATEMENT

The objectives of The American Acne and Rosacea Society are:

1. To promote, support, develop, and provide a forum for the exchange of information about acne and rosacea
2. To promote research in acne and rosacea
3. To improve the care of patients with acne and rosacea

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AARS Presents First Scientific Poster

James Q. Del Rosso, DO

The AARS presented its first poster, "Rosacea Medical

Management Guidelines," at the Fall Clinical Dermatology

meeting in Las Vegas, Nevada, in October 2007. The content of

the poster was developed and written by the AARS and reviewed

and approved by the Board of Directors before it was finalized.

The first half of the poster (part 1) is included in this newsletter

issue, with the second half to be included in the next newsletter.

The entire content of the poster was presented at the meeting

and will soon be available on the AARS Web site. Additionally,

the poster will soon be submitted for publication in a

peer-reviewed dermatology journal.

Why Join AARS?

The American Acne and Rosacea Society (AARS) is an alliance of dermatologists and dermatology professionals dedicated to elevating the understanding and treatment of acne and rosacea in the dermatologic and patient communities.

Managing the care of acne and rosacea patients forms a large part of daily dermatologic practice. However, they do not always receive the equivalent amount of attention from the academic, research and policy-making communities. The AARS is devoted to changing this misrepresentation.

The timing is right to join. The AARS is a young society with multiple opportunities to get actively involved as a member and not be sidelined. Your voice and actions will be heard.

What is our mission?

- Promote, support, develop and

provide a forum for the exchange of information about acne and rosacea

- Promote research in acne and rosacea
- Improve the care of patients who suffer from acne and rosacea

The AARS fulfills this mission by:

- Hosting regular conferences and meetings
- Offering education for dermatologists and health care providers
- Exchanging current information in its newsletter
- Funding research grants
- Mentoring future leaders in the specialty
- Educating patients

How to join

Go to www.acnesociety.org to join online. Membership is open to board

To contact the AARS, visit www.acnesociety.org.

ROSACEA MEDICAL MANAGEMENT GUIDELINES



AARS Officers

President: Hilary E. Baldwin, MD
President-Elect: James Q. Del Rosso, DO
Secretary-Treasurer: Lee Zane, MD
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AARS Board of Directors

Diane S. Berson, MD; David E. Cohen, MD, MPH;
Lawrence E. Eichenfield, MD; Julie Harper, MD;
J. Mark Jackson, MD; Sewon Kang, MD, MPH;
Jenny J. Kim, MD, PhD; Anne Lucky, MD;
Leonard J Swinyer, MD; Diane M. Thiboutot, MD

AARS Chairmen

Albert M. Kligman, MD, PhD; James J. Leyden, MD;
Peter E. Pochi, MD; Alan R. Shalita, MD;
John S. Strauss, MD

Objectives

- (1) Provide an overview of the fundamental disease state of rosacea and quality of life implications
- (2) Outline available pharmacologic treatments for rosacea with reference to supporting research and literature

- The pharmacologic agents discussed are inclusive of those that are Food and Drug Administration (FDA)-approved based on phase III pivotal trials, commonly used agents based on extensive clinical experience, and less commonly used alternatives reported in peer-reviewed literature.

Disease State Fundamentals

- Rosacea is a common facial disorder presenting most commonly in adulthood, estimated to affect ~14 million Americans.^{1,2} The disorder is chronic and is characterized by intermittent periods of exacerbation.
- Clinical signs of rosacea include central facial erythema, inflammatory lesions (papules, pustules) and telangiectasias.^{1,3}
- The underlying cause of rosacea is unknown, however, several pathophysiologic associations have been reviewed in the literature.^{1,3-6}
- Major pathogenic components appear to be inflammatory, vascular and neural in origin. There is no definitive evidence that rosacea is caused by a microbial pathogen, such as a bacterium, parasite or virus.^{1,3-6}
- The most common clinical presentations of cutaneous rosacea include the inflammatory (papulopustular) and erythematotelangiectatic subtypes. Other presentations include phymatous rosacea (such as rhinophyma) and granulomatous rosacea. Ocular rosacea is not uncommon in patients with cutaneous rosacea; clinical presentations of ocular rosacea include conjunctivitis, blepharitis, sty formation and keratitis.^{1,3}

Quality of Life Implications

- Rosacea has been shown to exhibit a negative impact on quality of life. Surveys conducted by the National Rosacea Society have shown that approximately 70% of rosacea patients experience lower self-confidence and lower self-esteem as a result of their condition, with 41% of patients avoiding public contact or canceling social engagements.⁷ Furthermore, among patients with severe rosacea, approximately 70% claim that their disorder has had a negative effect on their professional relationships, and nearly 30% have missed work as a result of their condition.⁷
- Effective treatment for rosacea has been correlated with marked improvement in quality of life indices.⁷

Pharmacologic Treatment of Rosacea: Topical Therapy

Sulfacetamide 10%-Sulfur 5%

- FDA-approved product labeling supports the indication for rosacea treatment based on drug efficacy study implementation (DESI) drug designation.
- Multiple randomized vehicle-controlled and comparative studies, both blinded and open-label, have confirmed efficacy and safety in patients with inflammatory rosacea measured as marked reduction in inflammatory lesions and erythema.⁸⁻¹¹
- Multiple vehicle formulations are available including cleanser, cream, gel, and topical suspension.

Metronidazole

- Approved by the FDA for inflammatory rosacea based on phase III

- pivotal trials (double-blind, randomized, vehicle-controlled studies).
- Multiple, blinded, split-face, and open-label vehicle-controlled studies have been completed supporting the efficacy and safety of both topical metronidazole 0.75% and 1% formulations, including gel, cream and lotion.⁸⁻¹³
- Both gel and cream formulations of 1% strength are available and FDA-approved for application once daily. Three formulations of the 0.75% strength are available including gel, lotion and cream, FDA-approved for twice daily use.

Azelaic Acid

- Approved by the FDA based on phase III pivotal trials of 15% gel formulation (double-blind, randomized, vehicle-controlled studies).
- Efficacy and safety supported by multiple blinded and vehicle-controlled trials evaluating 15% formulation applied twice daily.^{8,10,14,15}

Miscellaneous Topical Agents

- Other alternative topical agents have been reported to be effective based on small studies and case reports.^{8,9}
- Conflicting results have been reported with topical calcineurin inhibitors (tacrolimus, pimecrolimus) used for treatment of rosacea, with efficacy demonstrated in some cases and little benefit or exacerbation noted in others.¹⁰⁻¹⁹
- Data supporting use of topical clindamycin or erythromycin for rosacea is very limited.^{8,10} Relative lack of data compared to other available topical therapies, and concern regarding emergence of antibiotic resistance (especially with chronic use) suggest that topical erythromycin or clindamycin are not generally recommended for treatment of rosacea.
- Topical benzoyl peroxide 5%-clindamycin 1% has been shown to be effective for inflammatory rosacea.^{20,21}
- Topical antiparasitic agents, such as permethrin, have been shown to be effective in case reports of refractory rosacea that were diagnosed as demodicidosis (*Demodex folliculitis*).^{22,23}
- Topical retinoid therapy suggested as beneficial for rosacea, although supporting data is very limited.^{8,9}

Pharmacologic Treatment of Rosacea: Oral Therapy

Anti-Inflammatory Agents

- Doxycycline 40mg controlled-release formulation (anti-inflammatory dose doxycycline), administered as one capsule daily, is FDA-approved for treatment of inflammatory rosacea in adults based on phase III pivotal trials demonstrating efficacy and safety.
- Anti-inflammatory dose doxycycline (administered once daily) is not categorized by the FDA as an antibiotic, is devoid of antimicrobial activity based on microbiologic and pharmacokinetic studies

completed over up to 18 months, and is unique in its bioavailability profile as compared to other doxycycline formulations.²⁴⁻²⁶ Anti-inflammatory dose doxycycline does not exert antibiotic selection pressure and thus does not induce antibiotic resistance; its mechanism of action in rosacea appears to relate to the anti-inflammatory and biologic activities of doxycycline.^{24,25}- Anti-inflammatory dose doxycycline is the only systemic therapy approved by the FDA for treatment of rosacea.^{24,25}

Antibiotic/Anti-Inflammatory Agents

- Tetracycline agents, including tetracycline, doxycycline ($\geq 50\text{mg/day}$), and minocycline exhibit both antibiotic and anti-inflammatory activities.²⁶⁻²⁸
- The use of tetracycline, minocycline, and doxycycline (other than anti-inflammatory dose doxycycline), although not FDA-approved for treatment of rosacea, are utilized based on extensive clinical experience and peer-reviewed literature including some clinical trials.^{8,9,29}
- Other oral antibiotic/antimicrobial agents that have been used for treatment of rosacea in case reports and small studies are metronidazole and some macrolide antibiotics.^{8,9}
- The more recent emergence of concerns regarding antibiotic resistance among government agencies, such as the FDA and Centers for Disease Control (CDC), physician organizations, and the lay public, have prompted recommendations that antibiotic use be limited as much as possible, and directed against a bacterial pathogen when present.^{31,34} The lack of data supporting a bacterial component definitively related to the pathogenesis of rosacea suggests overall that medical therapies which are anti-inflammatory in nature are best considered for initial treatment of rosacea, especially the inflammatory (papulopustular) subtype, with oral antibiotic agents used in cases that are poorly responsive to a reasonable trial of topical therapy and/or oral anti-inflammatory therapy.

Isotretinoin

- Oral isotretinoin has been reported to be effective for severe and/or refractory cases of rosacea; low-dose and intermittent therapy may be helpful in selected cases.^{30,38}
- Appropriate precautions such as pregnancy avoidance in female patients, and recommended clinical and laboratory monitoring, such as blood testing of serum lipids are recommended. All patients receiving oral isotretinoin must be registered in and compliant with the iPledge program.

Skin Care Recommendations

- Patients with rosacea characteristically exhibit sensitive skin; baseline signs and symptoms prior to therapy commonly include dryness, scaling, stinging, burning, and pruritus.^{1,4-13,37}
- Appropriate skin care, including use of a gentle cleanser and moisturizer, and photoprotection, including sunblock/sunscreen use, are important components of daily skin maintenance in rosacea, and are significant adjuncts to pharmacologic therapy.^{8,9,30-41}

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