AARS HOT TOPICS MEMBER NEWSLETTER

April 1 Edition

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Industry News

Galderma's OTC Differin Gel Hits Store Shelves. Thursday, February 02, 2017. Practical Dermatology. http://practicaldermatology.com/dermwire/2017/02/02/galdermas-otc-differin-gel-hits-stores/?c=&t

Galderma's Differin Gel 0.1% (adapalene) is now available over the counter (OTC) at major retail and drug stores. Galderma officially launched the gel at a New York City media fete, and the skin care company came out of the gate in a very big way --a new commercial, a splashy digital campaign, a celebrity spokesperson and of course, a hashtag -- #differin. The coming-out party was appropriately held at the Nestle Skin Health SHIELD (Skin Health Investigation, Education and Longevity Development) Center in Manhattan, and celebrity spokesperson Ashley Benson, star of Pretty Little Liars, opened up abut her struggle with acne. Differin Gel 0.1% (adapalene) was approved for over-the-counter use in July 2016, and has been available in stores since Jan. 2017. In addition to the gel, the new OTC line includes Differin® Balancing Moisturizer and Differin® Balancing Cleanser. Adam Friedman, MD, FAAD, associate professor of dermatology in the department of dermatology, Residency Program Director and Director of Translational Research at George Washington School of Medicine and Health Sciences in Washington, DC, was on hand to discuss some of the commonalties seen in acne patients like Benson and why having an OTC retinoid is so significant. "Every acne patient is unique but there are some commonalities including frustration," he says. Patients are often frustrated that they are still breaking out even when their teen years are long gone, and they are also often disheartened that insurers wont cover the costs of their acne prescriptions, he says. Access is the real game change, he says of the new Differin OTC gel. "Retinoids get into the skin where they tame inflammation and prevent clogged pores in the first place," he says. Benson has always been public about her skin woes, often posting "zit" selfies. "Make-up takes a huge toll on the skin. By the end of the night, I can scrape off my makeup. It's horrible," she told the crowd. Benson has been using the new Differin line on her "super-sensitive skin" and says its working. Differin® Gel will retail for around $13.99 for .05 oz. (up to 30 day use) and $29.99 for 1.6 oz. (up to 90 day use).

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Sun Pharma Introduces Leave Acne Behind Patient Initiative. Tuesday, January 24, 2017. Practical Dermatology. http://practicaldermatology.com/dermwire/2017/01/24/sun-pharma-introduces-leave-acne-behind-patient-initiative/?c=&t=

Sun Pharma introduced a new initiative— "Leave Acne Behind™" — to educate patients and create awareness of severe recalcitrant nodular acne (SRNA). Sun Pharma reports that out of all of the prescription- treated acne cases today, 20 percent represent severe acne conditions, and that those who face such conditions often suffer embarrassment, low self-esteem, and other negative emotions that impact their quality of life. Approximately, 90 percent of these cases are often teenagers. The Leave Acne Behind initiative offers educational resources including a website LeaveAcneBehind.com and resources that dermatologists can offer at their offices, including a book (both in hard copy and iBook) and patient brochure to help patients and caregivers navigate through topics that are often not addressed regarding severe acne. All of the program's resources are meant to open the lines of communication between patients and dermatologists in hopes to reduce the long-term effects of acne, the company says. The website and book addresses variety of topics such as:

- Who gets acne and why
- The different types of acne
- The physical and emotional damage severe acne can cause
- Treatments to help prevent acne from causing permanent skin damage, ex. scars
- Questions a patient or caregiver may want to ask during dermatology health care provider appointments

"For anyone looking to educate themselves on acne, including severe recalcitrant nodular acne and help them make informed treatment decisions, the "Leave Acne Behind" initiative is a great resource," said Dr. Jeremy Moss, MD, PhD, a board certified dermatologist and an associate professor of dermatology at Yale University. "Patients and caregivers can use these education and awareness materials to speak to their dermatologist." Visit LeaveAcneBehind.com for more information.

Download Reference Document

FDA Approves RHOFADE™ (Oxymetazoline Hydrochloride) Cream, 1% For Persistent Facial Erythema Associated With Rosacea. Thursday, January 19, 2017. Practical Dermatology. http://practicaldermatology.com/dermwire/2017/01/19/fda-approves-rhofade-oxymetazoline-hydrochloride-cream-1-for-persistent-facial-erythema-associated-with-rosacea/?c=&t

The FDA has approved Allergan's RHOFADE™ cream for the topical treatment of persistent facial erythema associated with rosacea in adults. Approval was based on two clinical studies that evaluated the primary efficacy endpoint on day 29. Among the estimated 16 million Americans with rosacea, persistent facial redness is cited as the most common sign of rosacea. In a National Rosacea Society survey, cited by Allergan, 65% of rosacea patients surveyed said their symptoms first appeared between 30-60 years of age. "Historically, there haven't been many options available to help physicians address persistent facial erythema and often we ended up just helping our patients identify and manage triggers, which can lead to frustration for both the doctor and patient," said Dr. Robert Weiss, Clinical Trial Investigator and Director of Maryland Laser, Skin & Vein Institute. "With the approval of RHOFADE™, doctors will now be able to provide their patients with an effective once-daily treatment option to help manage this condition." In two clinical trials, a once-daily application of RHOFADE™ was proven to reduce persistent facial erythema associated with rosacea through 12 hours. The primary efficacy endpoint was at day 29 and defined as the proportion of patients with at least a 2-grade reduction in erythema (improvement) from baseline (pre-dose on day 1) on both the clinician erythema assessment (CEA) and subject self-assessment (SSA) (composite success) measured at hours 3, 6, 9 and 12 versus vehicle. CEA and SSA also measured at Days 1 and 15 at hours 3, 6, 9, and 12.1 The clinical trials were identical, multicentered, randomized, double-blind, parallel-group, and vehicle-controlled in moderate or severe patients, N=885, 18 years or older.1 In both pivotal trials, the primary efficacy endpoint was met. The proportion of patients achieving composite success were as follows: at hours 3, 6, 9 and 12 results in study 1 were RHOFADE™ (N=222) 12%, 16%, 18%, 15% versus Vehicle (N=218) 6%, 6%, 8%, 6% and in study 2 were RHOFADE™ (N=224) 14%, 13%, 16% and 12% versus Vehicle (N=221) 7%, 5%, 9% and 6%. RHOFADE™ was proven more effective than vehicle in reducing persistent facial erythema associated with rosacea in adults.1 "The FDA approval of RHOFADE™ exemplifies Allergan's commitment to continuing to address unmet patient needs through innovation in medical dermatology," said David Nicholson, Chief R&D Officer of Allergan plc. "We know persistent facial erythema associated with rosacea is a challenge for patients and physicians and having options can help in treating the disease. RHOFADE™ is the first and only alpha1A adrenoceptor agonist approved for persistent facial erythema associated with rosacea in adults. The FDA approval of RHOFADE™ represents a new prescription treatment that can effectively help physicians and their patients manage this condition." RHOFADE™ will be available for commercial supply starting May 2017 in the United States. For more information, visit www.Rhofade.com.

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New Medical Research

Dapsone 7.5% Gel: A Review in Acne Vulgaris. Al-Salama ZT, Deeks ED. Am J Clin Dermatol. 2017 Feb;18(1):139-145.doi:10.1007/s40257-016-0242-0. http://link.springer.com/article/10.1007%2Fs40257-016-0242-0
Dapsone 7.5% gel (Aczone®) is indicated for the once-daily topical treatment of acne vulgaris in patients aged ≥12 years. Dapsone is a sulfone antibacterial with anti-inflammatory actions, which are thought to be largely responsible for its efficacy in treating acne vulgaris. In two phase III trials of 12 weeks' duration in patients aged ≥12 years with moderate acne vulgaris, once-daily dapsone 7.5% gel reduced acne severity (as per the Global Acne Assessment Score) and lesion counts versus vehicle. The benefits of dapsone 7.5% gel over vehicle were seen as early as week 2 for inflammatory lesion counts, and from week 4 or 8 for other outcomes. Dapsone 7.5% gel was well tolerated, with a low incidence of treatment-related adverse events, with the majority of adverse events being administration-site related and mild or moderate in severity. Thus, dapsone 7.5% gel is an effective and well tolerated option for the topical treatment of acne vulgaris in patients aged ≥12 years, with the convenience of once-daily application.
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Rosacea and gastrointestinal disorders: a population-based cohort study. Egeberg A, Weinstock LB, Thyssen EP, et al. Br J Dermatol. 2017 Jan;176(1):100-106. doi: 10.1111/bjd.14930. Epub 2016 Oct 31. http://onlinelibrary.wiley.com/doi/10.1111/bjd.14930/full
BACKGROUND: Rosacea is a common inflammatory facial skin condition. Recent genetic and epidemiological studies have suggested pathogenic links between rosacea and gastrointestinal disorders, but data are limited. OBJECTIVES: The objective was to investigate the association between rosacea and coeliac disease (CeD), Crohn disease (CD), ulcerative colitis (UC), Helicobacter pylori infection (HPI), small intestinal bacterial overgrowth (SIBO) and irritable bowel syndrome (IBS), respectively. METHODS: We performed a nationwide cohort study. A total of 49 475 patients with rosacea and 4 312 213 general population controls were identified using nationwide administrative registers. We established the prevalence of the aforementioned disorders, and used Cox regression analysis to obtain hazard ratios (HRs) of the risk of new-onset CeD, CD, UC, HPI, SIBO and IBS, respectively, in patients with rosacea. RESULTS: The prevalence of CeD, CD, UC, HPI, SIBO and IBS, respectively, was higher among patients with rosacea when compared with the control subjects. Adjusted HRs revealed significant associations between rosacea and CeD (HR 1·46, 1·11-1·93), CD (HR 1·45, 1·19-1·77), UC (HR 1·19, 1·02-1·39), and IBS (HR 1·34, 1·19-1·50), respectively, but not HPI (HR 1·04, 0·96-1·13) or SIBO (HR 0·71, 0·18-1·86). CONCLUSIONS: Rosacea is associated with certain gastrointestinal diseases, but the possible pathogenic link is unknown. Gastrointestinal complaints in patients with rosacea should warrant clinical suspicion of disease.
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Bacterial biofilm in acute lesions of hidradenitis suppurativa. Okoye GA, Vlassova N, Olowoyeye O, et al. Br J Dermatol. 2017 Jan;176(1):241-243. doi: 10.1111/bjd.14805. Epub 2016 Nov 26.
Given the polymicrobial nature of HS lesions,[8] slow healing times and the inconsistent response to standard antibiotic doses, we hypothesized that bacterial biofilm formation is a possible pathogenic pathway in the aberrant inflammatory response seen in HS. The objective of this study was to evaluate acute HS lesions for the presence of bacterial biofilms by histopathology and a semiquantitative biofilm grading scale using epifluorescence microscopy. Tissue samples were obtained from the acute HS lesion and from clinically uninvolved skin in the same anatomical area. A total of 10 participants were recruited, and they all completed the study. The average age was 38·4 years. There were eight women; seven of the participants were white, two were black and one was Hispanic. There were

three participants with Hurley stage I disease, six with stage II disease and one with stage III disease. Biofilms were not found in any of the uninvolved skin samples. Tissue samples of acute HS nodules showed structural abnormalities with histological evidence of obliterated follicles, dense inflammation and necrotic-appearing tissue. However, biofilms were found in only two of the acute HS lesions. Acute lesions of HS have not been previously studied to assess for the presence of biofilm and the possibility of its role in early disease. The lesions sampled in this study represented acutely inflamed hair follicles in intertriginous areas. The absence of biofilm was an unexpected finding given the fact that the environment of intertriginous areas is highly favourable for bacterial proliferation and biofilm formation in the skin.[14] Iwase et al. demonstrated that skin commensals such as Staphylococcus epidermidis have the ability to inhibit biofilm formation. Perhaps the absence of biofilm in acute HS lesions is an indication of a high density of S. epidermidis in early HS.[15] The main limitation of this study is the small sample size. Additionally, HS lesions were excised from different anatomical locations. It is possible that different anatomical locations may demonstrate different bacterial flora and therefore different propensities for biofilm formation. It is also possible that the chlorhexidine used to remove bacteria from the epidermis prior to excising the HS nodules decreased the amount of biofilm in the deeper tissues. Further studies are needed to characterize the possible role of bacterial biofilms in chronic HS lesions such as nonhealing draining nodules, sinus tracts and comedones. Patients with these lesions tend to have more severe disease with very few effective treatment options. If biofilms are found to play a role in chronic disease pathogenesis, more rational treatment decisions will be made for these patients, such as foregoing ineffective antibiotic therapy for earlier surgical excision of chronic HS lesions.

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NCSTN mutations in hidradenitis suppurativa/acne inversa do not influence cytokine production by peripheral blood mononuclear cells. Xu H, He Y, Hui Y, et al. Br J Dermatol. 2017 Jan;176(1):277-279. doi: 10.1111/bjd.15076. Epub 2016 Nov 30. http://onlinelibrary.wiley.com/doi/10.1111/bjd.15076/full

This study was approved by medical ethics committee of the Chinese Academy of Medical Sciences Institute of Dermatology. Eleven Chinese patients with HS/AI with NCSTN mutations were included (Appendix S1; see Supporting Information). All patients met the diagnostic criteria for HS/AI,[3] and disease severity was classified according to the Hurley scoring system.[4] After written informed consent was obtained from all patients, whole blood was collected from all patients. Overall, 4 mL whole blood was obtained from 11 patients with HS/AI without an NCSTN mutation and from 22 healthy volunteers. All patients had active lesions and received no treatments for at least 2 weeks. The age, disease duration and disease severity of patients with and without NCSTN mutations were comparable. PBMCs were isolated, cultured in vitro and stimulated with 10 ng mL−1 lipopolysaccharide (LPS). Twenty-four hours after stimulation, TNF-α, IFN-γ, IL-1β, IL-6, IL-10 and IL-17 were detected in the supernatants of the cell culture by enzyme-linked immunosorbent assay (eBioscience, San Diego, CA, U.S.A.), according to the manufacturer's instructions. The Kruskal–Wallis H test was used to analyse the data, and $P < 0{\cdot}05$ was considered statistically significant. The clinical features of patients with HS/AI with NCSTN mutations were in accordance with the characteristics of the follicular class of HS/AI,[8] but the role of NCSTN mutation in the pathogenesis of HS/AI is still largely unknown. Recently, Xiao et al. reported that this gene mutation was involved in HS/AI development, as it affects keratinocyte proliferation and differentiation.[9] However, there is a lack of studies of cytokine profiles of PBMCs of patients with HS/AI with NCSTN mutations. We found that there were no differences in the decreased levels of inflammatory factors between patients with and without NCSTN mutations. This result may indicate that NCSTN mutations have no direct effect on inflammatory cells in the process of cytokine production. As many patients with HS/AI had no NCSTN mutation and nicastrin was the only pathogenic factor related to HS/AI,[2, 10] abnormal cytokines triggered by bacterial infection and other factors may contribute to the pathogenesis of HS/AI

with NCSTN mutations. However, owing to two main limitations, the findings of this study should be considered with caution. Firstly, we did not use stimuli other than LPS; secondly, a limited number of patients were enrolled, and different subsets of PBMCs were not analysed. In conclusion, NCSTN mutations alone may be insufficient to detect abnormal cytokine secretion by PBMCs in patients with HS/AI. Further research is mandatory to determine the cytokines present in the lesions of patients with HS/AI, with and without NCSTN mutations.
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Clinical Reviews

Reassessing Rosacea Diagnosis: ROSCO Update. Practical Dermatology. February 2017. http://practicaldermatology.com/2017/02/reassessing-rosacea-diagnosis-rosco-update
The global ROSacea COnsensus (ROSCO) expert panel has issued a new recommendation to establish a phenotype-led rosacea diagnosis and classification, as well as a recommendation on phenotype-based treatments for signs and symptoms presenting in individuals with rosacea. The recommendations appear in the British Journal of Dermatology. “One of the major issues that has come up is really regarding the actual diagnosis of rosacea…the entire aspect of what our essential diagnostic criteria is for this condition,” says Jerry Tan, MD, lead author of the ROSCO panel recommendations. Noting that the most recent proposed classification—the 2002 NRS scheme—was positioned as “a framework” intended to be updated, Dr. Tan says, “over time we’ve noticed that there are some problems with the diagnostic criteria, and the entire paradigm of diagnosis required reappraisal.” Of significance, Dr. Tan says, is the fact that the classification permitted diagnosis of rosacea based on the presence of one or more of four primary features, beginning with flushing.
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The management of acne in primary care. Ridd MJ. Br J Dermatol. 2017 Jan;176(1):1-2. doi: 10.1111/bjd.15169. http://onlinelibrary.wiley.com/doi/10.1111/bjd.15169/abstract;jsessionid=D73BD40A123BBFB1701C01A119E73AB0.f02t02
Acne vulgaris [or just ‘acne’, as most general practitioners (GPs) and patients refer to it] is common, affecting up to 80% of people at some point, predominantly between the ages of 15 and 17 years.1 In countries with strong systems of primary care such as the U.K., it is one of the ‘top three’ longterm, inflammatory skin conditions diagnosed and managed by family physicians.2 In this setting, as well as being able to prescribe treatments that are effective for the majority of patients, GPs can provide ongoing support, because all treatments take time to work.3 Concerns about rising antimicrobial resistance means primary care guidelines discourage the use of topical and oral antibiotics and encourage the use of nonantibiotic therapies either in combination or for longer-term treatment.4 Despite this, remarkably little is known about how such patients are managed in primary care. Acne vulgaris [or just ‘acne’, as most general practitioners (GPs) and patients refer to it] is common, affecting up to 80% of people at some point, predominantly between the ages of 15 and 17 years.1 In countries with strong systems of primary care such as the U.K., it is one of the ‘top three’ longterm, inflammatory skin conditions diagnosed and managed by family physicians.2 In this setting, as well as being able to prescribe treatments that are effective for the majority of patients, GPs can provide ongoing support, because all treatments take time to work.3 The findings of this study should prompt clinicians working in primary care to review their prescribing habits and make changes to ensure that they are in line with current guidance. Proactively following up these patients, rather than leaving it to the person consulting to make the appointment ‘if needed’, may be one way that primary care clinicians can provide emotional support as well as monitor treatment use and effectiveness.
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The management of acne vulgaris in primary care: a cohort study of consulting and prescribing patterns using the Clinical Practice Research Datalink. Francis NA, Entwistle K, Santer M, et al. Br J Dermatol. 2017 Jan;176(1):107-115. doi: 10.1111/bjd.15081. Epub 2016 Dec 27.
http://onlinelibrary.wiley.com/doi/10.1111/bjd.15081/abstract

BACKGROUND: Effective management of acne vulgaris in primary care involves support (usually provided over a number of consultations) and prescription of effective treatments. However, consulting and prescribing patterns for acne in primary care are not well described. OBJECTIVES: To describe the rate of primary-care consultations and follow-up consultations; prescribing patterns, including overall use of acne-related medications (ARMs); and initial and follow-up prescription for acne vulgaris in the U.K. METHODS: U.K. primary-care acne consultations and prescriptions for ARMs were identified in the Clinical Practice Research Datalink. Annual consultation rates (between 2004 and 2013) by age and sex, new consultations and consultations in the subsequent year were calculated, along with prescribing trends - during a new consultation and over the subsequent 90 days and year - using the number of registered patients as the denominator. RESULTS: Two-thirds (66·1%) of patients who had a new acne consultation had no further acne consultations in the subsequent year. Overall 26·7%, 24·9%, and 23·6% and 2·8% of patients were prescribed no ARM, an oral antibiotic, a topical antibiotic or an oral plus topical antibiotic, respectively, during a new acne consultation. In total 60·1% and 38·6% of patients prescribed an ARM received no further ARM prescriptions in the following 90 days and 1 year, respectively, despite most prescriptions being for 2 months or less. Prescribing rates for lymecycline and topical combined clindamycin and benzoyl peroxide increased substantially between 2004 and 2013. There were no important changes in consultation rates between 2004 and 2013. CONCLUSIONS: These data suggest that patients with acne are receiving a suboptimal initial choice of ARMs, longitudinal care and prescribing.
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Regional variation of hidradenitis suppurativa in the Norwegian Patient Registry during a 5-year period may describe professional awareness of the disease, not changes in prevalence. Ingvarsson G. Br J Dermatol. 2017 Jan;176(1):274-275. doi: 10.1111/bjd.14990. Epub 2016 Oct 2.
http://onlinelibrary.wiley.com/doi/10.1111/bjd.14990/full

Hidradenitis suppurativa (HS) is a distinct skin disease characterized by well-defined signs, symptoms and a notorious tendency to recurrence and chronicity.[1] Nevertheless, considerable uncertainty exists regarding its prevalence. The prevalence has been estimated over recent decades with a significant degree of unexplained discrepancy, ranging from 0·05% to 8% in available studies.[2] In general, registry-based studies tend to indicate lower prevalence rates than reports based on physician-examined or self-reported data. It may be suspected that registry data are influenced by local variations in the healthcare system. We accessed the Norwegian Patient Registry, which is a public registry providing basic descriptive data on all patients treated in public hospitals, policlinics and by practising specialists under public contract. The registry is based on International Classification of Diseases (ICD)-10 coding and allows for the comparison of registry-based prevalence estimates of different diseases for the different health regions of Norway. Therefore, it offers data generally comparable with data described in other registry studies. We investigated possible differences in the number of patients treated for HS in various Norwegian health regions in order to explore the variation in prevalence rates. Patients were identified based on the ICD code for HS (L73.2) and simple descriptive statistics provided for each region. Two relevant observations could be made based on the data. Firstly, the prevalence rates varied widely. The number of cases coded by specialists show large differences between the five different health regions of Norway (Fig. 1). In Health Region 5 in northern Norway (Troms and Finnmark) twice as many patients with HS were identified compared with the other four more populous regions (Fig. 1). Secondly, in agreement with U.S. data,[3] an increased number of

patients were added to the registry at an accelerated rate during this period (Fig. 2). The Norwegian data suggests that prevalence estimates based on public or hospital data may vary greatly even in small populations with easy access to healthcare services.[4] Therefore, it is suggested that such prevalence estimates are likely to be biased by awareness and intention to treat. Epidemiological data based on patients treated must therefore be considered as an unreliable source of actual epidemiological data for HS in the population. However, it can be used to estimate how often a particular disease is recognized and treated, and the Norwegian data indicates that a considerable unmet need for treatment exists for HS.

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Shortcomings in rosacea diagnosis and classification. Tan J, Steinhoff M, Berg M, et al; Rosacea International Study Group. Br J Dermatol. 2017 Jan;176(1):197-199. doi: 10.1111/bjd.14819. http://onlinelibrary.wiley.com/doi/10.1111/bjd.14819/full

In 2002, the National Rosacea Society (NRS) proposed a provisional classification for rosacea based on the clinical knowledge of that time and on morphological features.[1] Explicit was the intent that this was 'a framework that could be readily updated and expanded as new discoveries were made'.[1] That scheme posited primary and secondary criteria for diagnosis and division into four subtypes, representing common clinical patterns of presentation, and one variant.[1] It also helped to increase recognition of rosacea as a disease and to guide research. Subsequent incorporation of this paradigm in epidemiological, pathophysiological and translational research has provided for greater standardization in rosacea reporting. Now, after more than a decade of using this scheme in research and clinical practice, it should be re-evaluated to incorporate current scientific knowledge and address shortcomings in guiding diagnosis and classification of rosacea. In rosacea, where there are multiple potential symptoms and signs which may be present in varying permutations in individual patients, the crux of diagnostic criterion determination must address two issues: which feature(s) is/are essential (without which the condition cannot be present) and is this finding unique to the condition? In assessing diagnostic criteria, the goal is to seek those with a high true-positive rate (that is, a high proportion of those with the criterion truly have the disease – referring to sensitivity) and true-negative rate (a high proportion of those who do not have the criterion do not have the disease – referring to specificity).[2] In the clinical paradigm, diagnosis is optimized by excluding other conditions that can present similarly, the differential diagnosis. The NRS classification requires reappraisal based on these considerations. The presence of one or more of the following four primary features in a centrofacial distribution was defined by the NRS as indicative of rosacea: flushing (transient erythema), nontransient erythema, inflammatory papules and pustules and telangiectasia.[1] Thus, each should be evaluated as a critical criterion.

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Rosacea, inflammatory bowel disease and the value of big data and of epidemiological studies. Meier CR. Br J Dermatol. 2017 Jan;176(1):9-10. doi: 10.1111/bjd.15168. http://onlinelibrary.wiley.com/doi/10.1111/bjd.15168/full

Linked Article: Egeberg et al. Br J Dermatol 2017; 176:100–106.

The authors of an observational study from Denmark explored a possible association between the skin disease rosacea and diseases of the gastrointestinal (GI) tract, and found that patients with rosacea were more likely to suffer from autoimmune disorders of the gut, such as Crohn disease or colitis ulcerosa.[1] The study has both merits and limitations. A limitation was that the identification of cases with rosacea was based on pharmacy-dispensed topical treatment for rosacea, rather than on a dermatologist-confirmed diagnosis. In addition, it remains unclear whether the rosacea or the GI diagnosis occurred first. Even though the authors made an attempt to identify the onset of these two diseases, the question of 'the chicken or the egg' remains somewhat unanswered. On the other hand, is the temporal relationship between rosacea and gut disorders in this hypothesis-raising study really

important? Let's focus on the merits of this study. We should view it as cross-sectional analysis that describes the co-existence of two disease entities, thereby providing evidence for a possible common pathophysiology or a common trigger. A recently published analysis from our group, based on a large U.K. population, also provided strong evidence that more patients with rosacea than controls suffered from inflammatory bowel disease, with high disease activity around the time of the first rosacea diagnosis.[2] Thus, there may be some sort of relationship between rosacea and autoimmune GI diseases. Epidemiological studies cannot, by definition, prove causality of an observed association, because distortion by biases and confounders can never be ruled out entirely. Such studies are, nevertheless, of great value to medicine and to public health, as they open our eyes to novel pathophysiological hypotheses and biological pathways, which in turn may stimulate new research ideas, potentially leading to the development of new treatment options. The publication by Egeberg et al.[1] in this issue of the BJD may turn out to be one of these studies.

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Patient Counseling/Communication

The Acne Epidemic. By Elizabeth Siegel. Allure. April 2017.

More women than ever before are dealing with chronic stubborn breakouts. And no one really knows why (which is almost as frustrating as the pimples themselves). But now more researchers than ever are working on finding a cure (even a *vaccine*). And while we await the findings of those brilliant scientists, we've found a few immediate paths to clear, flauntable skin. Adult female acne, acupuncture, the association between acne and dairy, and the various medications used to treat acne are topics explored in this article.

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The Utility of Text Message Reminders for Acne Patients: A Pilot Study. Okhovat JP, Tenconi F, Kim J, Kim CN. Am J Clin Dermatol. 2017 Feb;18(1):133-137. doi: 10.1007/s40257-016-0236-y. http://link.springer.com/article/10.1007/s40257-016-0236-y

BACKGROUND: Acne vulgaris is one of the three most common cutaneous disorders, affecting approximately 50 million people in the US and many more throughout the world. OBJECTIVE: We designed a pilot program to explore how patients may interact with cell phone technology to supplement medical care beyond patient reminders that would encompass education, interaction, and data capturing. METHODS: Twenty-four patients completed a 3-month study in which participants received daily text message reminders for the first 2 weeks of the study, then once weekly thereafter, to take their oral medication or apply topical therapy either once or twice daily. RESULTS: Over a 3-month time period, patients become less responsive to text message reminders over time. Our survey data demonstrated a very high satisfaction with the program, helping patients follow their acne treatment recommendations (mean score 4.31 out of 5) and results demonstrated the mobile application device was easy to use (mean score 4.56 out of 5). LIMITATIONS: Small sample size of the patient population. CONCLUSION: Patients find this approach acceptable and helpful, and it is a viable method for counseling patients. Based on our results, for future randomized controlled studies, we suggest maximizing messaging during the first month of therapy.

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Cost of Diagnosing Psoriasis and Rosacea for Dermatologists Versus Primary Care Physicians. Hill D, Feldman SR. Cutis. 2017 February;99(2):134-136. http://www.mdedge.com/cutis/article/130677/psoriasis/cost-diagnosing-psoriasis-and-rosacea-dermatologists-versus-primary

Growing incentives to control health care costs may cause accountable care organizations (ACOs) to reconsider how skin disease is best managed. Limited data have suggested that disease management by a primary care physician (PCP) may be less costly than seeing a specialist, though it is not clear if the same is true for the management of skin disease. This study assessed the cost of seeing a dermatologist versus a PCP for diagnosis of psoriasis and rosacea.

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Mind Your Business: Exploring the Mind/Skin Connection. By Denise Mann, MS. Practical Dermatology. February 2017. http://practicaldermatology.com/2017/02/mind-your-business-exploring-the-mindskin-connection/

Dermatologists and mental health professionals can join forces to treat the whole patient. The mind and skin are intimately entangled. In fact, this connection is so deep that it has sired a microspecialty—psychodermatology, a camaraderie between many mental health professionals and dermatologists—and a specialty society—the Association for Psychoneurocutaneous Medicine of North America (APMNA). “The skin and the central nervous system are intertwined, both being derived from the same embryological source,” says Adam Friedman, MD, FAAD, an Associate Professor of Dermatology in the Department of Dermatology at George Washington School of Medicine and Health Sciences in Washington, DC. “Therefore, it is not surprising that almost any and all skin diseases can be impacted by changes in the nervous system.” It’s not always obvious what is the cause and what is the effect, and discerning this requires spending time with each patient to figure it out, says Dr. Wechsler, author of The Mind-Beauty Connection. For example, acne can cause psychosocial stress, and stress can exacerbate acne. The same bidirectional relationship can be seen in some cases of psoriasis, atopic dermatitis, and other common skin conditions. **Rosacea Awareness:** Next month is rosacea awareness month. As the National Rosacea Society (NRS, rosacea.org) ramps up education initiatives, it is emphasizing new findings about comorbidities associated with the skin disease. Patient reports confirm that, as in acne, the experience of the disease may have psychosocial implications for some patients. In surveys by the NRS, more than 90 percent of rosacea patients said their condition had lowered their self-confidence and self-esteem. Forty-one percent reported its effect on personal appearance had caused them to avoid public contact or cancel social engagements. Among rosacea patients with severe symptoms, 88 percent said the disorder adversely affected their professional interactions, and 51 percent said they had even missed work because of their condition.

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Comparisons of patients’ satisfaction should take expectations into account. Dizon M, Linos E, Arron ST, et al. Br J Dermatol. 2017 Jan; 176: 252–254. doi:10.1111/bjd.14755. http://onlinelibrary.wiley.com/doi/10.1111/bjd.14755/full

Patients’ experiences have become increasingly important in the assessment of quality of care.[1, 2] For example, the Centers for Medicare & Medicaid Services uses Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys to measure patient experience and reward providers for providing high-quality care through value-based purchasing initiatives.[3] However, there is concern that patients’ reports may be related to typically unmeasured characteristics, such as their expectations for care[4, 5] or frame of mind at the start of a visit.[6] We report the results of a survey of patients with skin cancer regarding their experiences with care, and how adjustment for expectation fulfilment (EF) may affect comparisons of quality between two practice settings. Data were collected from a consecutive cohort of 1536 patients with 1993 histologically confirmed basal cell or cutaneous squamous cell

carcinomas (KCs) diagnosed at a fee-for-service practice (FFS) and a Veterans Affairs (VA) practice between 1999 and 2000.[7] The parent study compared the effectiveness of treatments for KCs, but the data collected also included a unique measure of EF (i.e. how care compared with the patient's expectations). After accounting for key patient and clinical characteristics, adjustment for EF caused slight shifts favouring FFS in the proportions of satisfied patients across all domains of care. The effect was most notable in the domain of accessibility. Without adjustment for EF, the proportion of satisfied patients favoured the VA (59% vs. 49% at FFS, P = 0·07), but this difference narrowed after adjustment for EF (55% at the VA vs. 53% at FFS, P = 0·70) (Table S2; see Supporting Information). These results suggest that patients' expectations may affect their judgements about care. Although EF is not a direct measure of expectation, it can be viewed conceptually as a mediator of satisfaction. The generalizability of these findings may be limited by the age of the data; however, the relationship between expectations and satisfaction is likely to be unchanged. Given the increasing importance of patient-reported outcomes in the evaluation of healthcare quality, future comparisons of patients' judgements about care may need to account for differences in their expectations for care.

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