



Prevalence

Rosacea may affect up to 14 million adult Americans. Even though it is so common, only 1 in 4 people have heard of it. It affects more women than men, but more men seek treatment for severe disease. More men develop the advanced sequelae of severe telangiectasias (dilated blood vessels) and rhinophyma (red, bulbous nose). Rosacea begins between the ages of 30 and 50, although the first stages may be barely detectable by the patient and not at all by others. The most common age for onset is in the 40s and 50s.

The vascular reactivity seen in rosacea is most common in fair-skinned individuals of Irish and Scandinavian descent. It is seen in persons who blush easily, i.e. already have vascular hyper-reactivity.

Etiology (Cause) and Progression of Disease

The cause of rosacea lies with hyper-responsiveness of the blood vessels of the central face. Why some people develop rosacea and others do not is really unknown. Alcohol was once thought to be causative, but has never been proven to be directly linked to the development of the disease. However, alcohol does cause vasodilatation and serves as a disease trigger. Rosacea is a chronic and progressive disease with many flare-ups and remissions.

Sebaceous plugging is not causative in rosacea as it is in acne. There may be bacterial overgrowth as the disease becomes more severe, but the presence of bacteria is also not causative as in acne.

The first stage of rosacea is merely a vascular hyper-reactivity or tendency for the central face to redden easily. This can occur in the 20s or 30s and is usually not identified as rosacea. In fact, rosacea progresses so gradually that it may go completely undiagnosed, even after the facial changes are obvious. The early stage is almost impossible to treat, except by avoiding some triggers (listed below) in particular individuals. During the course of rosacea, at least 50% of patients have some type of ocular (eye) symptom. The eye symptoms can also be found in this first stage and may be the only symptom the patient notices. Eye symptoms are frequently found as the disease progresses. Eye complaints may include dry eye, styne development, contact lens intolerance, redness of the eyelids or even corneal damage. When the patient only complains of eye symptoms, the term 'ocular rosacea' is sometimes used.

After this initial stage of intermittent facial flushing, the disease progresses to constant erythema (redness) of the central face and ocular (eye) symptoms, then papule and pustule development, appearance of telangiectasias (dilated blood vessels) and, finally, rhinophyma (a red, bulbous nose which was typified by W. C. Fields). Rhinophyma is certainly disfiguring and even the pustular/papular stage is very unattractive. The skin and subcutaneous (just below the skin) tissue of the nose is affected by rhinophyma but the supporting structures of cartilage and bone remain intact and are not affected. The lack of involvement of the supporting framework of the nose makes rhinophyma more amenable to surgical treatment than it would be if these structures were affected.

Common symptoms of rosacea include facial flushing progressing to persistent facial redness of the cheeks, forehead, chin and nose, red lines on the face (telangiectasias), stinging or burning of the face, increased pore size, red bumps or pimples on the central facial skin, nasal bumps that increase in

number and size until rhinophyma develops. Rosacea can be considered an age-related disease. Even though the very first symptoms of disease can appear in the 20s, 30s or 40s, most people are not actually diagnosed as having rosacea until their 40s and 50s.

Misdiagnosis of Rosacea

Rosacea is commonly misdiagnosed. Rosacea is NOT acne, although this is the most common mislabeling that occurs. The cause of rosacea is different from that of acne. Some of the drugs used for rosacea are also used to treat acne and this may add to its confusion with acne.

Tumors, such as lymphoma, basal cell carcinoma of the nose or face, and squamous cell carcinoma of the nose or face may be confused with rosacea in its later stages. This can have disastrous consequences for the patient, leaving a potentially treatable condition to progress to a more serious stage that is much more difficult to treat or may even be untreatable.

Sarcoid presenting in the nose can appear to be rosacea.

Because alcohol as a triggering factor has been known for some time, persons with rosacea used to be assumed to be alcoholics. The occurrence of rosacea does NOT mean the person is an alcoholic.

Disease Triggers

The following substances are known to trigger the disease, although this occurs with varying frequency. The most well-known trigger is alcohol. It should be emphasized again that the occurrence of rosacea should not label the person an alcoholic. The presence of rosacea, however, will cause the physician to recommend avoidance of alcohol since this is such a common trigger.

Foods are also common triggers. Individual food triggers include hot peppers, Mexican food, Thai food, red pepper, hot sausage, black pepper, vinegar, paprika, white pepper and garlic. These foods are listed from most frequent and in descending order of frequency for triggering rosacea. Very hot beverages may be a trigger in some patients. Note that these foods are also known for causing vasodilatation, which would lead to flushing.

Other potential triggers are environmental, such as sun exposure and cold weather. Stress may also trigger an exacerbation of symptoms.

Treatment

The first line of treatment is to avoid any triggering or exacerbating factors. Topical antibiotics may be used long-term. Topical retinoid (Renova) therapy may be used as well as systemic treatment with oral antibiotics. Surgery (as laser therapy or other techniques) may be used for unsightly telangiectasias or rhinophyma.

Product Recommendations

iS CLINICAL® products recommended for rosacea include: PRO-HEAL™ SERUM ADVANCE+ and HYDRA-COOL™ SERUM.

References

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