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Acne and Rosacea: Special Considerations in the Treatment of Patients With Latin American Ancestry

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ABSTRACT

Acne is a common disease among patients with Latin American ancestry. Its presentation is very similar to that in all skin types, but nodulocystic acne is more frequent in patients with oily and darker skin than in white Caucasians.
Acne sequelae in patients with Latin American ancestry and with darker skin include postinflammatory hyperpigmentation (PIH) and atrophic and hypertrophic scars or keloids, with PIH being the most common complication affecting the quality of life of patients.
Lately, more attention has been paid to rosacea in patients with darker skin. It has been seen that some of the patients, especially women, diagnosed with adult acne and who did not respond to treatment, were actually patients with rosacea. It is important to recognize the clinical characteristics of this disease in patients with darker skin in whom erythema and telangiectasia are difficult to observe.
Here, we present the most relevant clinical characteristics of both diseases, as well as their treatment in patients with darker skin with Latin American ancestry.

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INTRODUCTION

Acne is a common disease among patients with Latin American ancestry. As in the white, Caucasian population, acne affects, to a greater or lesser degree, around 85% of young people between the ages of 12 and 24 years. In recent years, an increase in acne has been observed in individuals older than 25 years of age, especially in women (adult acne).[1]

In some scientific and non-scientific publications, it has been determined that Latin or Hispanic skin is that of olive, medium to dark brown color, which generally tans and that seldom burns, with dark eyes and hair. However, this description is not exact. Although, a good part of the population has yellowish skin and dark hair and eyes, there is a great variety of skin types in Latin Americans, ranging from white skin with light eyes and reddish hair, to very dark skin, black, going through different shades of pink, light brown, chestnut, yellowish, and others, resulting from different racial mixtures. We must bear in mind that in Latin America, miscegenation was not only of Europeans with natives, but with slaves from Africa and also Chinese and Japanese, especially in Brazil, Peru, and Mexico, which resulted in a kind of skin color that is difficult to classify.

The Color of the Skin in Latin America

As mentioned above, all skin colors are found in Latin America as a result of the different mixes that have existed throughout the ages. Before the conquest of America, there were natives of the continent. These were called indigenous, that is, they came from the Indies because Columbus and his companions thought they had arrived in the Indies. Later, it was learned that they were not in the Indies, but a new continent called America, in honor to Amerigo Vespucci. These Amerindians mixed with the white Europeans giving rise to the Mestizos. The Spaniards also brought slaves from Africa and they also mixed with whites giving rise to the Mulattos, and with indigenous people, giving rise to the Zambos.[2,3]

Nowadays, due to the easy ways to travel, communications, and globalization in general, it is harder for us to classify people by the color of their skin, since mixtures are much more frequent and of different origins. One way would be through a color palette as shown in Figure 1.

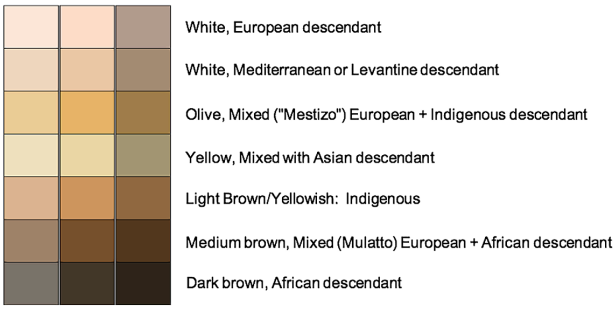
Acne: Clinical Considerations

All types of acne are seen in Latin Americans from the comedonal variant to the nodulocystic. This last form of acne has been observed more frequently in individuals with medium to dark brown skin than in lighter skin.[4]

From the beginning of the disease, even in cases with comedonal acne alone, a hyperpigmented halo is observed around the lesion, which could, in part, explain the post-inflammatory hyperpigmentation (PIH) that often emerges as an acne sequel. This is a very important characteristic that would denote the presence of inflammation and the indication for the early treatment of the disease.[5,6]

Topical Treatment

FIGURE 1. The colors of the skin in Latin America.



Retinoids are considered the first line of topical treatment. In patients with a tendency to PIH, low concentration retinoids should be used, in cream, at bedtime, starting only 2 to 3 times a week until the skin tolerates them well. This also decreases the associated iatrogenic PIH.[1,4-6]

Fixed combinations like benzoyl peroxide with adapalene or benzoyl peroxide with clindamycin are used to treat mild to moderated papulopustular acne and help preventing PIH.[1, 4-6]

Azelaic acid 20% in cream is effective in the treatment of acne in Latin America and helps prevent PIH. In the United States, it is not indicated for the treatment of acne. It would be used off-label.[1,4-6]

Oral Treatment

Oral antibiotics (eg, doxycycline): First line of treatment for moderate to severe acne (papulopustular, nodulocystic); 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 increased progressively. Helps to prevent PIH.[1,4-6]

Hormonal therapy: For women; Oral contraceptives with antiandrogen properties (eg, Drospirenone or Norethindrone + ethinyl estradiol); Concomitant treatment for menstrual cycle-related inflammatory acne.

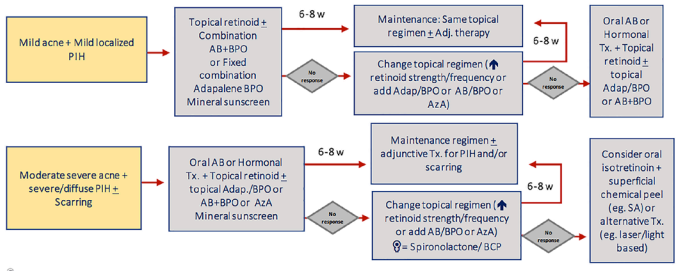
Spironolactone: For women with menstrual cycle-related inflammatory acne.[4-6]

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 daily, 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 a combination of a bleaching agent like hydroquinone with retinoids and corticosteroids is mandatory.[1,6]

FIGURE 2. Management of acne and PIH.



PIH: Postinflammatory hyperpigmentation - AB: Antibiotic - BPO: Benzoyl peroxide
Aza: Azelaic acid - W: week - BCP: Birth control pill

Rosacea: Clinical Considerations

Rosacea is more frequent in patients with a background from the southern cone of South America (Argentina, Uruguay, Southern Brazil, Chile, and Paraguay) because their skin is lighter due to the presence of Italian and German immigrants after the first and second world wars. Although the disease is more common in phototype I and II (Fitzpatrick), it can also be suffered by people with darker skin color. It could be misdiagnosed with adult acne. To try to avoid this, we must consider rosacea in the differential diagnosis when we have a patient with darker skin, facial flushing, heat, eye symptoms, or papulopustular elements and absence of comedones.

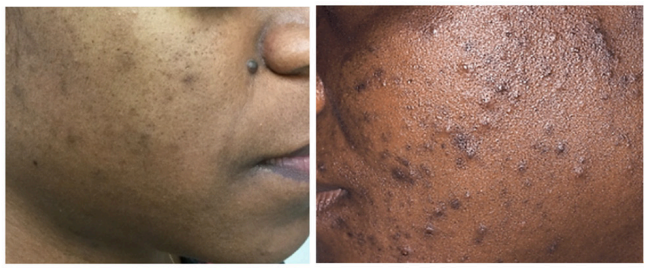
Four subtypes of rosacea can be diagnosed: Erythematotelangiectatic (ETR), papulopustular (PPR), glandular hyperplastic or phymatous rosacea (GH/FR), and ocular (OR). The granulomatous variant is more frequent in darker phototype skin.[7,8]

Unlike acne, postinflammatory hyperpigmentation is rare in patients with rosacea among patients with Latin American ancestry.[8,9.]

Treatment of Rosacea[10]

General Care: Avoid trigger factors; Use daily, continuous sunprotection.

FIGURE 3. Postinflammatory hyperpigmentation.



Dermocosmetic Care: Cosmeceuticals (cutaneous barrier restoring cleansers/moisturizers, antioxidants, niacinamide, colloidal oats, witch hazel, among others); Cold compresses; Thermal water.

Topical Treatment: Oxymetazoline or brimonidine 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 this treatment well, 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 (eg, 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 (eg, CO2 laser) followed by dermabrasion, electro/radiosurgery, and cryosurgery.

CONCLUSIONS

There is no such thing as Hispanic skin. The Hispanic skin can range from white to black with diverse variation in colors/shades as a result from the blend of different races/ethnicities. There is also a subclinical inflammatory process in patients with all skin colors even in cases of non-inflammatory acne that can result in PIH.

PIH affects quality of life. Early measures, such as daily use of sunscreens, proper makeup, and anti-inflammatory agents with bleaching effect, like azelaic acid, should be considered. Treatments that may irritate the skin should be avoided to decrease the risk of PIH

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 may be happening in many of the cases not initially diagnosed as rosacea. Unlike acne, postinflammatory hyperpigmentation is rare in patients with rosacea.

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