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Post-Isotretinoin Acne Management: A Pilot Survey of the American Acne and Rosacea Society Board of Directors

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INTRODUCTION

Post-isotretinoin acne vulgaris relapse rates remain substantial, ranging from 20 to 60%.[1] Given these high rates, guidelines for post-isotretinoin acne management (PIAM) are essential for maintaining treatment success and limiting the need for repeated courses. Although several studies have examined relapse risk factors, the literature on PIAM is limited, and no consensus has been established.[1]

An IRB-approved (IRB#: NCR246024), pilot survey assessing PIAM was emailed to the American Acne and Rosacea Society board of directors, comprising 10 dermatologists.

Nine board members completed the survey (90% response); 1 was ineligible due to clinical inactivity. Responses are summarized in Table 1. The most frequent initial isotretinoin daily dose ranges prescribed were 0.25 to 0.50 (33.3%) and

TABLE 1.

Isotretinoin Dosing, Discontinuation, and Relapse Management

Variable			No. (%)	
Dosing	Initial Daily Range (mg/kg/d)	0.25-0.5	3 (33.3%)	
		0.51-0.75	2 (22.2%)	
		0.76-1	3 (33.3%)	
		1.1-1.5	1 (11.1%)	
	Cumulative Range (CR) (mg/kg)	<120	1 (11.1%)	
		120-150	3 (33.3%)	
		150-200	2 (22.2%)	
		>200	3 (33.3%)	
	Minimum Duration	4-6 months	5 (55.6%)	
		>6 months	1 (11.1%)	
		No minimum	3 (33.3%)	
Discontinuation	Timing	At clinical clearance (CC), if CR reached	2 (22.2%)	
		1 month after CC, if CR reached	1 (11.1%)	
		2 months after CC, regardless of CR	1 (11.1%)	
		2 months after CC, if CR reached	5 (55.6%)	
Relapse Management	Initial Regimen Components		Female	Male
		Topical Retinoid	5 (55.6%)	5 (55.6%)
		Topical Benzoyl Peroxide	2 (22.2%)	2 (22.2%)
		Topical Clascoterone	2 (22.2%)	0 (0%)
		Topical Dapsone	0 (0%)	2 (22.2%)
		Topical Clindamycin	1 (11.1%)	1 (11.1%)
		Spironolactone	7 (77.8%)	N/A
		Doxycycline/Minocycline	2 (22.2%)	3 (33.3%)
		Sarecycline	2 (22.2%)	1 (11.1%)
		AviClear/Laser Treatments	1 (11.1%)	1 (11.1%)
		Second Course of Isotretinoin	1 (11.1%)	5 (55.6%)

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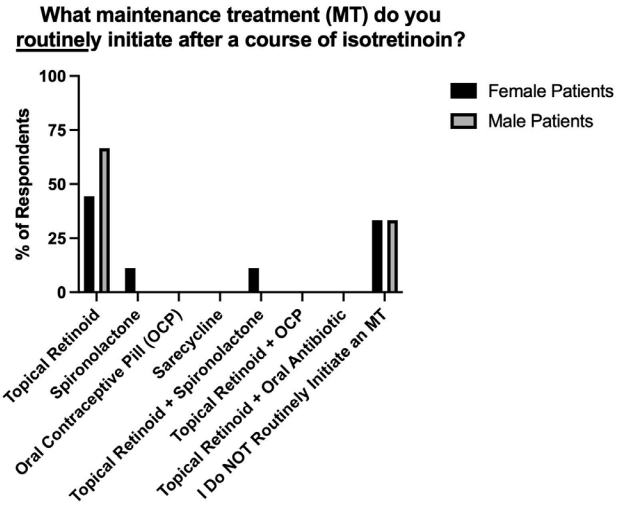
FIGURE 1. Post-isotretinoin maintenance treatments for female and male patients.



0.76 to 1.0 mg/kg/d (33.3%), and the most frequent cumulative ranges (CRs) were 120 to 150 (33.3%) and >200 mg/kg (33.3%). The most common minimum duration was 4 to 6 months, and most respondents discontinued isotretinoin after reaching the intended CR and treating two months beyond clearance (TMBC) (55.6%).

Two-thirds of respondents routinely initiate maintenance treatments (MTs) immediately (66.7%) or 1 month (33.3%) post-isotretinoin completion. Topical retinoids (TRs) were the most common MTs for females (66.7%) and males (100%) (Figure 1). Additionally, most respondents schedule initial (77.8%) and subsequent (66.7%) post-isotretinoin follow-up visits.

For post-isotretinoin acne relapses, management regimens commonly included spironolactone (77.8%) and TRs (55.6%) for females, and a second course of isotretinoin (SCI) (55.6%) and TRs (55.6%) for males. When asked how they would plan an SCI, two-thirds of respondents said they would change the dosing and duration.

These data demonstrate significant variability in isotretinoin dosing and PIAM among experts. No single daily dose range or CR was selected by the majority of respondents. There was some uniformity in respondents' discontinuation criteria, with just over half adhering to both duration (TMBC) and CR targets, reflective of earlier and newer discontinuation approaches.[2]

Additionally, it was striking that one-third of respondents do not routinely initiate post-isotretinoin MTs, given the high relapse rates, the chronic nature of acne, and the multifactorial burden of prescribing isotretinoin.[1] However, the MTs used by respondents align with the limited existing literature, with most studies demonstrating the efficacy of TRs and one supporting the use of TRs combined with antiandrogenic therapies in maintaining acne clearance.[3,4]

Finally, post-isotretinoin acne relapse management differed between females and males, with board members more likely to initiate a SCI in males. This may be due to the availability of anti-androgenic therapies for females; however, clinical trials have not compared the efficacy of spironolactone to SCIs after an initial isotretinoin course.

Overall, there is significant inconsistency in PIAM among experts, highlighting differences in perspectives on isotretinoin's long-term efficacy as well as the need for a Delphi consensus statement and, ultimately, evidence-based guidelines.

DISCLOSURES

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