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Real-World Cases Using Topical Clascoterone Cream in Acne

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 ORIGINAL ARTICLE

Real-World Cases of Clascoterone Topical Treatment for Acne and Related Disorders

Charles Lynde MD,[a] Sonya Abdulla MD,[b] Anneke Andriessen PhD,[c] Sam Hanna MD,[d] Fatemeh Jafarian MD,[e] Monica Li MD,[f] Jennifer Lipson MD,[g] Andrei Metelitsa MD,[h] Barbara Miedrzybrodzski MD,[i] Elena Netchiporouk MD,[j] MSc, Jaggi Rao MD,[k] Christopher Sibley MD PhD,[l] Jerry Tan MD[m]

[a]Department of Medicine, University of Toronto, Toronto, Ontario
[b]Dermatology on Bloor, Toronto, Ontario Canada
[c]UMC Radboud, Nijmegen, Andriessen Consultants, Malden, The Netherlands
[d]Department of Medicine, University of Toronto, Toronto, Ontario, Canada
[e]Department of Medicine, University of Calgary, Calgary, Alberta, Canada;
[f]Department of Dermatology and Skin Science, University of British Columbia, Vancouver, British Columbia, Canada
[g]The Ottawa Hospital, Ottawa, Ontario, Canada
[h]Division of Dermatology, University of Calgary, Calgary, Alberta, Canada
[i]Department of Pediatrics, McGill University, Montreal, Quebec, Canada ;[j]Dermatology and Experimental Medicine, McGill University Health Centre, Montreal, Quebec, Canada
[k]Division of Dermatology, University of Alberta, Edmonton, Alberta, Canada
[l]Victoria Park Ottawa, Ottawa, Ontario, Canada
[m]Department of Medicine, Western University, Ontario, Canada

ABSTRACT

Acne vulgaris affects approximately 80% of young adults and adolescents in the world. Acne presents as comedones, pustules, papules, and nodules on the face, chest, shoulders, or back. It can lead to a significant decrease in quality of life with a high risk of associated depression and anxiety. Hyperstimulation of sebaceous glands by androgens play a pivotal role in acne pathogenesis. Clascoterone 1% cream is a first-in-class topical androgen receptor inhibitor approved for treatment of acne in patients 12 years and older. In the following real-world cases, expert dermatologists demonstrate use of clascoterone cream as monotherapy or in combination with other agents to treat acne in a variety of patients. Experts found that twice-daily use led to best overall results with patients. Real-world cases serve as invaluable guides for patients and dermatologists to help form personalized, targeted acne regimens.

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INTRODUCTION

Acne vulgaris is a chronic, inflammatory disease of the pilosebaceous unit.[1] The condition affects approximately 9% of the worldwide population with increased prevalence among young adults aged 12 to 24 years.[1,2] Around 80% of young adults and adolescents are affected by acne with 15% to 20% of those cases being severe acne.[3] Primary acne lesions are comedones (open or closed) and inflammatory lesions such as papules, pustules, and nodules.[1] Secondary acne changes include scarring, erythema, and dyspigmentation, which may have longer-lasting effects than primary lesions.[1] The investigator global assessment (IGA) is often used to grade acne severity.[4] Acne has been highly associated with lower self-esteem, body image, and co-morbid depression and anxiety.[2]

While acne pathogenesis is multifactorial, there are 4 common aspects that lead to acne: (1) dysregulation of sebaceous gland activity and sebaceous hyperexcreation (2) abnormal follicular infundibular epithelial proliferation and differentiation (3) bacterial colonization, by pro-inflammatory *Cutibacterium acnes (C. acnes)* and (4) inflammation.[1-4] Acne treatments are largely aimed at targeting one or more of these pathogenetic factors.

Stimulation of Sebaceous Gland Activity

Excess sebum production is triggered by androgen hormones, which increase sebum production and secretion from sebaceous glands.[3] This also explains why acne occurs largely on the face, chest, upper back, and upper arms, which are areas with high density of sebaceous glands.[3] Androgen receptors (AR) are expressed in hair follicles, eccrine sweat glands, and in sebaceous glands of the skin.[3] When androgens bind to ARs, they stimulate sebum production in both males and females.[3] Until recently, there were no topical agents that targeted sebum production in the skin. Clascoterone is a topical androgen receptor antagonist that has been approved for the treatment of acne and will be discussed later. Systemic hormonal and anti-androgen therapies have been used to reduce sebum production. The use of combined oral contraceptive pills (OCP), containing estrogen and progestin, decrease ovarian and adrenal androgen precursors and lead to reduction in androgen levels.[4] Spironolactone, a mild diuretic with antiandrogen properties, has also been used off label to reduce sebum production and treat acne.[4]

Abnormal Follicular Proliferation and Differentiation

In acne, hyper-proliferation of infundibular keratinocytes results in accumulation and impaired desquamation at the follicular orifice.[4] This subsequently results in follicular occlusion with accumulation of lipids and epithelial debris initiating comedogenesis.[4] Topical retinoids such as tretinoin, adapalene, trifarotene, and tazarotene are first-line acne treatments.[4]

Bacterial Colonization

C. acnes is the most prevalent species of bacteria in the pilosebaceous units of the skin.[4] There are 8 phylotypes of *C. acnes* (IA1, IA2, IB1, IB2 IB3, IC, II, and III).[5] Phylotypes IA1 and IA2 are predominately found in acne lesions while phylotype IB is associated with healthy non-acne skin.[5] *C. acnes* feed off the sebum; thus, increased sebum production provides an ideal environment for *C. acnes* proliferation and acne pathogenesis.[4] Topical antibiotic regimens, such as clindamycin and erythromycin, reduce the concentration of *C. acnes*, and oral antibiotics are mainstay therapy for rapid disease control.[4]

Host Skin Inflammation

C. acnes triggers host innate immunity and leads to release of pro-inflammatory factors and subsequent follicular damage, rupture, and leakage of bacteria, fatty acids, and lipids into the surrounding dermis creating a pro-inflammatory milieu.[4] Retinoids and antibiotics have significant anti-inflammatory effects that contribute to acne treatments.

Clascoterone is a first-in-class topical androgen receptor inhibitor approved for the treatment of acne in men and women aged 12 years and older.[6] Topical clascoterone 1% cream is a competitive inhibitor of AR and inhibits downstream signaling and transcription of androgen-responsive genes that trigger sebum production and inflammation.[6] In 2 pivotal phase 3 trials, clascoterone cream demonstrated greater treatment success (defined as an IGA score of 0: clear or 1: almost clear) than vehicle at week 12.[6] In an open-label extension safety study, the proportion of patients who achieved clear or almost clear increased at each visit, indicating that clascoterone efficacy improved over time for up to 12 months while maintaining a favorable safety profile.[7] Clascoterone has a favorable safety profile with no serious treatment-emergent adverse events or systemic adverse reactions reported in phase 3 studies.[6,7] Scaling, dryness, and erythema were the most common local skin reactions in clascoterone-treated patients; however, the rates of these adverse events were low.[6,7] Importantly, there were no systemic anti-androgen effects observed in clascoterone-treated patients in the extension or phase 3 trials.[6,7]

As the acne armamentarium continues to grow, it will be important to understand how to capitalize on therapeutic mechanisms of action to optimize treatments using monotherapy or combination regimens. Clascoterone offers effective topical anti-androgen properties to treat acne in male and female patients while sparing patients of the side effect profile of systemic anti-androgen agents. Herein, we provide insight on how dermatology experts are integrating clascoterone into acne regimens to best tailor care for their patients.

MATERIALS AND METHODS

This is a real-world case series that has been compiled to demonstrate use of clascoterone 1% cream in various patients with acne across Canada. The cases demonstrate how expert dermatologists choose to integrate clascoterone into acne regimens and detail patient use, satisfaction, and outcomes. Expert panelists' clinical reasoning and rationale are provided as a guide for future healthcare providers to use when determining an ideal acne regimen for a patient.

Steps in the Process

The real-world cases were compiled and selected in the following steps: 1) project definition and expert panel selection, 2) data collection and preparation of patient cases, 3) patient case discussion and selection for publication, 4) literature review to support selected cases, 5) drafting, review, and finalization of the manuscript.

Role of the Panel

Twelve Canadian dermatologists were selected to participate in an expert panel. The experts represented clinical practices in 4 different provinces (Ontario, Quebec, Alberta, British Columbia) and a variety of clinical practice settings. Panelists were asked to share 2 cases of patients using clascoterone for acne treatment during a meeting that took place on April 21, 2024, in Montreal, Canada. Shared cases illustrated a wide variety of patient ages, skin types, and lifestyle concerns. At the conclusion of the meeting, expert panelists discussed the cases and selected 9 cases to be included in this real-world case series. Selected cases were considered most representative of efficacious and appropriate use of the clascoterone cream.

Clascoterone 1% Cream

Clascoterone 1% cream (Winlevi®) was approved in June 2023 for topical treatment of acne vulgaris in patients 12 years of age and older.[8] The topical cream is contraindicated in patients who are hypersensitive to this drug or to any ingredient in the formulation (cetyl alcohol, citric acid monohydrate, edetate disodium, DL-alpha tocopherol [vitamin E], mineral oil, mono- and di-glycerides, polysorbate 80, propylene glycol). Clascoterone 1% cream is approved for twice-daily use (1 g per application or 2 fingertip units) as a thin layer across acne-prone skin.[8] For optimal efficacy, spot treatment with clascoterone is not recommended.

Data Gathering and Outcome Measures

Suggested information to present included patient demographics, acne history, clinical features, and qualitative and quantitative outcome measures. The panelists were also asked to share the patients' tried and failed acne therapies and current acne regimens while using clascoterone cream. The IGA scale was used to determine acne severity with 0 being clear and 4 being severe (Table 1). Patients were followed for up to 24 weeks on the acne regimen with monthly follow-up visits with their dermatologist. At each visit, patient acne was evaluated (IGA score) as well as patient compliance to the regimen, adjunct acne treatments, and any local or systemic adverse events to the product. Patients were also asked to evaluate how their acne impacted their life at each visit. Photographs were taken at each patient visit with the

TABLE 1.

Investigator's Global Assessment (IGA) of Acne Severity		
Acne Grade		Description of Condition: Investigator's Global Assessment (IGA) of Acne Severity
0	'Clear'	Residual hyperpigmentation and erythema may be present
1	'Almost clear'	A few scattered comedones and a few small papules
2	'Mild'	Easily recognisable; less than half the face is involved. Some comedones and some papules and pustules
3	'Moderate'	More than half the face is involved. Many comedones, papules and pustules. One nodule may be present
4	'Severe'	Entire face is involved, covered with comedones, numerous papules and pustules, and few nodules and cysts

patient's consent. Special considerations and lessons learned were discussed at the end of the evaluation.

These real-world cases characterize dermatologists' real-world experiences (ie, how are experienced specialists in practice using the product and how their patients are doing on the regimen) when using the clascoterone topical treatment.

Patient Consent

These cases did not require ethics committee approval as we report real-world experience and do not make statements on the efficacy or safety of the treatment. The real-world case studies conducted complied with good clinical practice. All authors obtained written informed consent from patients who participated in the real-world cases. The patients in the real-world case series allowed the recording and publication of their photographs to be used for the manuscript.

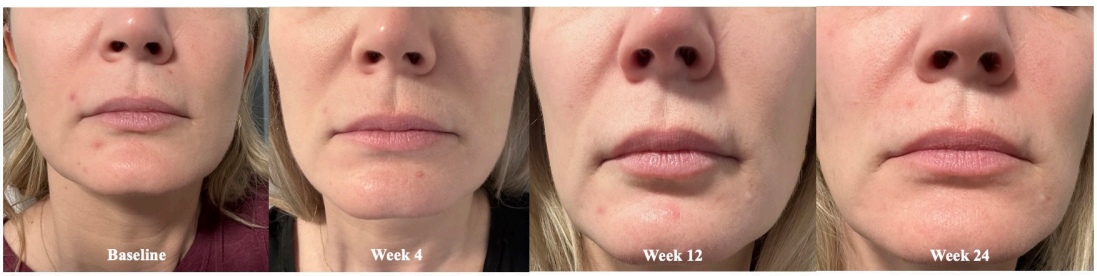
Selected Real-World Cases

Nine cases were selected to illustrate clascoterone 1% cream use under real-world conditions for acne treatment in a wide array of patients. Expert panelists demonstrated a variety of clascoterone uses in combination with other acne treatments or as monotherapy in a range of patient ages and skin types.

Case 1. Clascoterone Cream Coupled With Low-Dose Spironolactone, an Anti-Androgen Approach for Adult-Female Acne

A 43-year-old female, Fitzpatrick Skin Type (FST) II, presented with a 16-year history of adult-female acne (AFA). She had multiple inflammatory papules, pustules, and cysts across her lower cheeks and chin at baseline (Figure 1), which negatively influenced her self-image and led her to feel self-conscious. Her

FIGURE 1. Case 1. 43-year-old with adult-female acne on spironolactone 100 mg daily and clascoterone cream.



daily skincare routine consisted of a micro-peeling face wash, neutral moisturizer, and sunscreen. She also had a progestin-only intrauterine device (IUD) for contraception that she felt may have contributed to the acne. In the past, the patient had tried a combined OCP (cOCP), which had kept her skin clear; however, at the age of 40 years, she stopped taking the pill. Topically, the patient had also tried dapsone gel, benzoyl peroxide 5% gel, and tazarotene 0.045% lotion. She had also tried a course of oral doxycycline. None of these treatments provided lasting results for her AFA. Given the progestin IUD and history of response to cOCP, the patient's acne was targeted from an anti-androgen approach. She was started on spironolactone 200 mg daily, which led to a significant reduction in acne, at which time the patient was able to taper to 100 mg daily. At presentation, the patient had an IGA score of 2 while on 100 mg daily of spironolactone with her progestin IUD. The patient was started on clascoterone 1% cream twice daily, in hopes to maintain the lower dose of spironolactone. By week 4, her IGA had decreased to 1, and the patient felt that her skin condition had improved and was satisfied with the easy-to-use cream. After 24 weeks, the patient reported that she only experienced a "rare pimple," which presented milder and briefer than in the past. She felt that adding clascoterone allowed her to maintain a lower spironolactone dose while maintaining clear skin. The patient achieved an IGA of 0 by week 24 and noted only small, macular erythema and post-inflammatory hyperpigmentation. This case represents use of a topical and systemic anti-androgen for AFA.

Case 2. Clascoterone Cream for Transitioning Adult (Female to Male)

A 25-year-old transgender female-to-male, FST III, presented with a 6-year history of acne after starting testosterone cypionate during their gender-affirming therapy. The patient had an IGA of 3 at baseline with diffuse comedones, papules, and pustules across their cheeks, temple, forehead and chin (Figure 2). The patient never previously suffered from acne until starting testosterone. The new onset acne was most likely a side effect of exogenous testosterone; thus, the clinician felt that their acne would be best targeted by anti-androgenic acne treatment. Spironolactone was not a suitable option for the transitioning patient due to its systemic anti-androgenic effects, such as gynecomastia. Thus, clascoterone cream was prescribed twice daily all over the face. The patient tolerated the treatment well and felt that their condition started to improve by 4 weeks of treatment. At 12 weeks of use, the patient reported skin dryness and peeling, specifically on the cheeks. The patient also felt that their skin was breaking out along the chin, cheeks, and forehead and felt frustrated about the regression of results. At week 24, the patient saw increased improvement in the number of lesions and skin tones. The patient noted fewer papules and pustules and overall reduced inflammation (Figure 2).

FIGURE 2. Case 2. Clascoterone cream for 25-year-old transitioning adult (female to male).

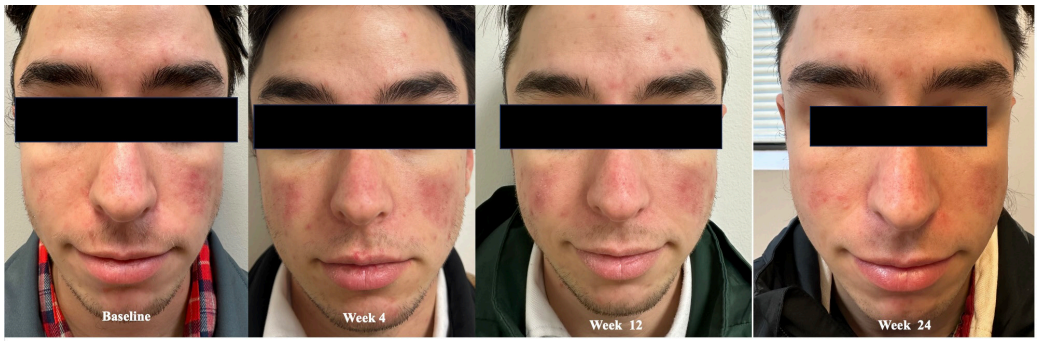


FIGURE 3. Case 3. Clascoterone use in a 17-year-old female with acne excoriée.

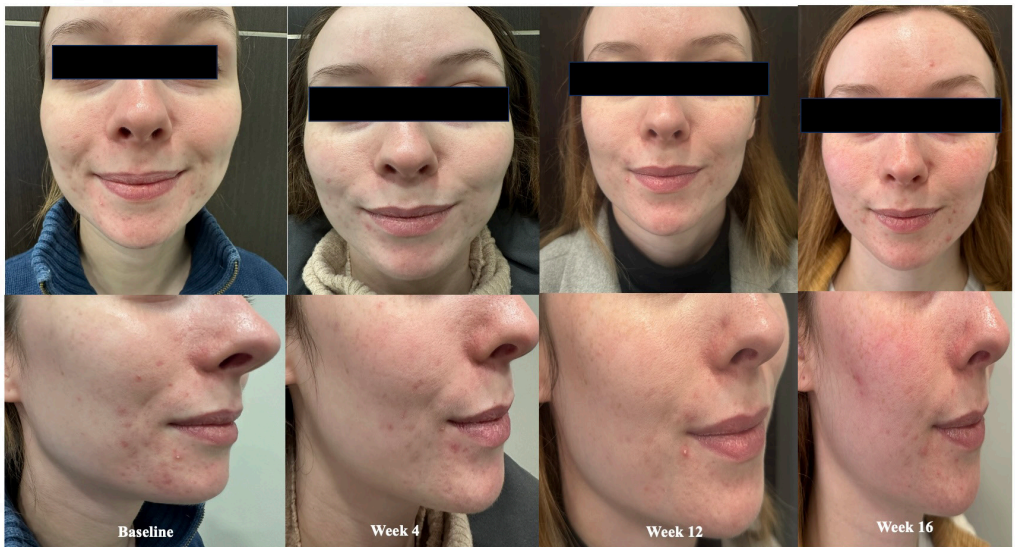
Case 3. Topical Treatments for Hormonal Acne in Adolescence

A 17-year-old female, FST III, with a past medical history of mild depression presented with moderate acne and acne excoriée. At baseline, she had comedones, papules, pustules, and cysts across her whole face (Figure 3). She started having acne at age 12 and had tried multiple topical and systemic treatments including: adapalene/benzoyl peroxide, dapsone gel, trifarotene, and one course of isotretinoin. Isotretinoin had cleared her skin in the past while she had been on a combined OCP. However, when she stopped her OCP due to her mother's estrogen and progesterone-positive breast cancer diagnosis, she found herself with moderate-to-severe acne again. She reported that her skin made her feel self-conscious, and she felt that she always had to wear make-up. At this time, the patient was started on clascoterone cream while continuing with her topical retinoid. At baseline, she had an IGA of 4 while on daily topical retinoid use. At week 4 of twice-daily clascoterone and nightly topical retinoid use, the patient did not feel that her skin had changed. She denied skin worsening, but she felt that her skin had not improved. Despite this, her IGA had decreased to an IGA of 3 and the physician felt that most of the inflammatory lesions had reduced in size and irritation (Figure 3). At week 12, the patient's skin continued to improve but she had started experiencing some dryness, which may have been from the clascoterone, topical retinoid, or the change in seasons. On physician evaluation, she had an IGA of 2. The patient continued to improve at week 24 and had an IGA of 1 (Figure 3). The combination of a topical retinoid and topical androgen receptor blocker, clascoterone, allowed for a non-systemic, effective acne treatment that targeted multiple acne pathogenetic mechanisms in this patient.

Case 4. Clascoterone Cream Monotherapy in Young Female With Hormonal Acne

A 26-year-old female, FST II, presented to clinic with an 18-month history of acne. Her acne was mostly characterized by inflammatory papules and pustules on her lower face. She had only tried over-the-counter

FIGURE 4. Case 4. Clascoterone monotherapy in 26-year-old female with adult female acne.

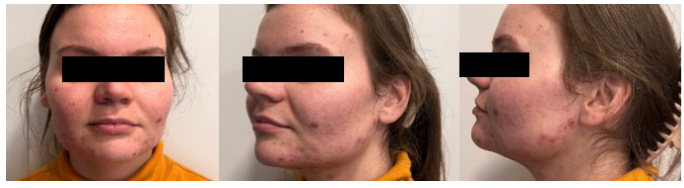


salicylic acid and benzoyl peroxide washes prior to presenting to clinic. She had regular menses and recently had a progestin IUD placed. She felt that her acne had improved with the progestin IUD. At baseline, she had an IGA score of 3. The patient was prescribed clascoterone twice-daily monotherapy to help target acne. The distribution of the patient's acne to the lower face and jawline indicated that anti-androgen therapy may be most beneficial to her. At baseline, the patient reported that her skin negatively impacted her social life and self-image. The patient tolerated the clascoterone cream without any adverse events aside from mild erythema after use. By week 4, the patient had an IGA of 2 and finally an IGA of 1 at week 16 (Figure 4). She was very satisfied with the treatment and felt that it had significantly improved her skin by the end of the treatment period. This case demonstrates clascoterone as an easy-to-use monotherapy for classic hormonal acne with lower face, jawline distribution in young women.

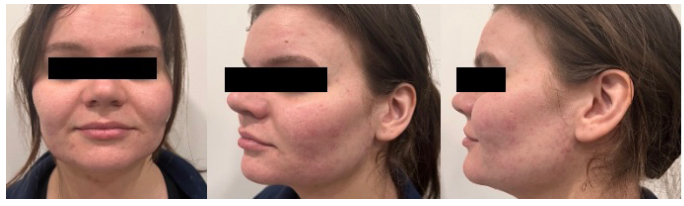
Case 5. Triple Combination Therapy for Nodulocystic Acne

A 32-year-old female, FST II, presented with a 9-year history of comedonal and nodulocystic acne on her face. At baseline, she had an IGA of 3 and had already tried multiple acne treatments. She had tried tretinoin, dapsone, benzoyl peroxide-adapalene, benzoyl peroxide-clindamycin, cyproterone acetate, and 2 courses of isotretinoin. Instead of using each

FIGURE 5. Case 5. Clascoterone use in triple combination therapy with topical retinoid and spironolactone in a 32-year-old female with nodulocystic acne
Baseline



Week 12



therapy individually, the patient and clinician decided to approach the acne using 3 different treatments. The patient was started on tretinoin 0.05% cream nightly, clascoterone 1% cream twice daily, and spironolactone 100 mg daily. At week 4, the patient reported skin irritation, burning, and erythema to the treatment regimen, which was attributed to the tretinoin. Thus, the patient was advised to stop the tretinoin for one week before resuming. At week 12, the patient saw improvement in her skin (Figure 5) and had an IGA of 2. She agreed that her skin condition had improved; however, she did not feel that the regimen was simple as it combined multiple different creams and pills. Using the clascoterone with the spironolactone allowed for a lower dose of spironolactone to be used. In addition, tretinoin cream likely provided additive effects in targeting the acne via multiple pathogenic mechanisms.

Case 6. Clascoterone Cream and Isotretinoin Synergy

A 22-year-old female, FST II, presented with recalcitrant acne on her lower face and jawline. Her acne type was hormonal and inflammatory. In the past, she had tried multiple topicals such as benzoyl peroxide-clindamycin, dapsone, and azelaic acid and one oral antibiotic, minocycline. Despite these therapies, the patient still presented with an IGA of 3 at baseline (Figure 6). She felt that her skin negatively influenced her daily activities, social life, and self-image. She was prescribed clascoterone 1% cream twice daily and isotretinoin 32 mg daily for 12 weeks. After 4 weeks on the combination treatment, she felt that her skin had improved and was satisfied with the treatment results. At 12 weeks, the patient continued to improve on the treatment and had an IGA of 1 (Figure 6). She was very satisfied with the clascoterone therapy as she reported having "sensitive skin" that reacted poorly to many products and topical medications. The isotretinoin and clascoterone combination treatment provided rapid, efficacious results to the patient by targeting 2 pathogenic mechanisms.

Case 7. Clascoterone Cream Use in a Patient With Atopic Dermatitis

A 25-year-old female, FST I, with atopic dermatitis (AD) presented with a 10-year history of mild-moderate acne. Prior to her baseline visit, she had already completed 2 courses of isotretinoin and had been maintaining good response until a few years ago. At presentation, she had comedonal and inflammatory acne on her jawline, chin, and forehead. She had tried benzoyl-peroxide and over-the-counter acne remedies containing salicylic acid; however, she did not have any lasting results from these topicals. In addition, her AD made using topicals difficult as skin irritation and flares precluded her from regularly using many acne treatments. She had also been prescribed spironolactone; however, she could not tolerate as "the

FIGURE 6. Case 6. Clascoterone cream and isotretinoin synergy in a 22-year-old female with adult female acne.

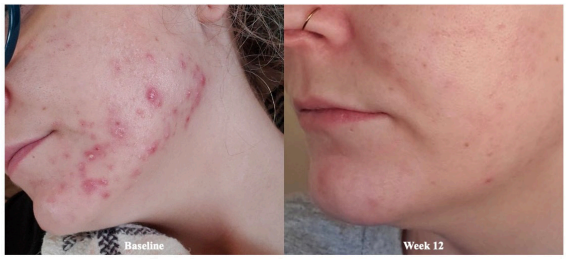


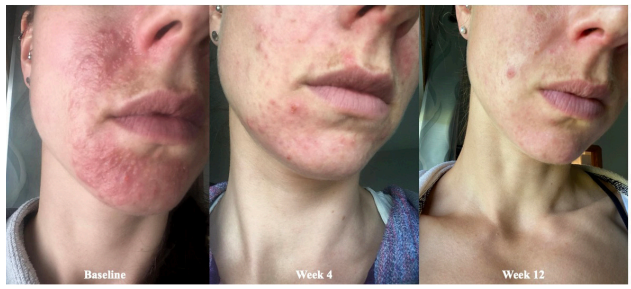
FIGURE 7. Case 7. Clascoterone use in a 25-year-old patient with atopic dermatitis and acne.

pill is too big to swallow." At baseline, she had an IGA of 2. She started clascoterone twice daily alongside a facial routine consisting of washing her face with water in the morning, applying mineral sunscreen, and using non-comedogenic cosmetic products. She was also recommended a pH neutral cleanser that could be used prior to clascoterone application. After 12 weeks of use, the patient reported "almost disappearance" of acne. She reported a little bit of dry skin at the beginning of use that improved without any intervention. She also felt that the clascoterone was agreeable with her AD and sensitive skin. At week 24, she had an IGA of 0 and strongly agreed that her skin had improved (Figure 7). She was able to reduce the clascoterone use to only once nightly, which had also proved to be more economical for her and her family. Clascoterone 1% cream was a tolerable, safe, and efficacious option for this patient with sensitive skin and frequent AD flares. The cream was able to be used safely with topical corticosteroids and topical calcineurin inhibitors when necessary for her AD.

Case 8. Clascoterone Cream for Acne Variants

A 37-year-old female, FST II, presented with a 10-year history of recurrent inflammatory, acne. Her acne mainly affected her perioral area and lower face and had characteristics of acne vulgaris, acne rosacea, and perioral dermatitis. In the past, she had tried clindamycin-benzoyl peroxide, dapsone, azelaic acid, and tacrolimus as topicals and oral minocycline. However, despite previous anti-acne efforts, her IGA at baseline was 3 (Figure 8). The patient was started on clascoterone twice daily to be applied in a thin layer all over her face. She also was recommended a bland cleanser and moisturizer to be used twice daily. The patient tolerated her treatment regimen and had an improvement to IGA 2 by week 4. She was satisfied with the regimen; however, she also reported some remaining skin dryness and erythema. After 12 weeks of clascoterone monotherapy with gentle skincare, the patient had an IGA of 1 (Figure 8). The effects of clascoterone helped target her acne while also providing beneficial effects to her concurrent perioral dermatitis.

FIGURE 8. Case 8. Clascoterone use in a 37-year-old female with acne and perioral dermatitis.



Case 9. Clascoterone Use for Cystic Acne

A 28-year-old female, FST I, presented with a 7-year history of cystic acne affecting her whole face. Prior to presentation, she had not tried any previous treatments beyond over-the-counter products such as acne scrubs and washes. At day 0, her IGA score was 2. She was severely impacted by her acne, reporting that she never left the house without makeup due to insecurity about her skin's appearance. She was started on clascoterone cream twice daily with concurrent use of CeraVe cleanser and a neutral moisturizing lotion. By week 4, the patient felt that her skin had already improved. Through week 12, the patient continued to see improvement with minor breakouts during menses and her IGA score remained 2. At week 24, the patient had improved to IGA score 1 and GAIS 2 (Figure 9). She felt that her acne had an overall improvement with clascoterone cream. She did not experience any adverse effects or irritation from the cream.

FIGURE 9. Case 9. Clascoterone use in a 29-year-old female with cystic acne.

DISCUSSION

There are many acne treatments available to physicians to help treat different types of acne and skin needs. However, until clascoterone, there were no topical acne treatments to target androgen effects at the skin surface. The selected cases demonstrate how clascoterone can be integrated into acne treatment regimens. Five of the presented cases demonstrated use of clascoterone as monotherapy, while the remaining 4 used clascoterone in a combination acne regimen. Clascoterone proved to be effective in acne across a wide range of patient ages. In general, experts emphasized the value of clascoterone as a topical to be used in combination with other acne treatments. While the clascoterone provides anti-androgen action to the skin, acne is best targeted by multiple mechanisms. Applying topical retinoids with clascoterone appeared to be efficacious in 2 of the patient cases. Combining the clascoterone with systemic acne therapies such as isotretinoin and spironolactone also provided a safe and effective treatment option to patients. Experts agree that the choice of acne treatment agents depends

TABLE 2.

Summary of Clascoterone 1% Cream Treatment Regimens			
Case #	**Patient Age/Sex**	**Indication**	**Daily Acne Regimen**
1	43F	Adult Female Acne	Clascoterone twice daily, Spironolactone 100mg daily
2	25/FTM	Testosterone-Related Acne	Clascoterone twice daily
3	17F	Adolescent Acne	Topical retinoid nightly, Clascoterone twice daily
4	26F	Adult Female Acne	Clascoterone twice daily
5	32F	Nodulocystic Acne	Tretinoin 0.05% nightly, Spironolactone 100mg daily, Clascoterone twice daily
6	22F	Adult Female Acne	Clascoterone twice daily, Isotretinoin 32 mg daily
7	37F	Adult Female Acne in setting of Atopic Dermatitis	Clascoterone twice daily
8	25F	Adult Female Acne	Clascoterone twice daily
9	29F	Adult Female Acne	Clascoterone twice daily

largely on the type of acne, duration of disease, severity of lesions, tendency of scarring, and patient preference. In addition, the multifactorial nature of acne makes combination acne treatments, the most logical and effective treatments. It will be important to identify synergistic clascoterone combinations that best utilize its novel mechanism of action.

Androgen stimulation of the sebaceous gland is an important factor in acne pathogenesis.[9] Androgens have been shown to directly lead to gland enlargement, sebum production, and inflammation in the sebaceous gland. Clascoterone inhibits these androgen effects in the skin; thereby, reducing sebum production and inflammation. Systemic anti-androgens such as spironolactone, while effective, are not suitable for males.Topical clascoterone does not have any systemic effects, which makes it a suitable option for targeting acne-promoting effects of androgens in males and females. Topical anti-androgen effects may also allow for patients to reduce spironolactone doses; thereby, reducing the exposure to systemic anti-androgens. In one patient case, the expert dermatologist was able to taper the patient down from 200 mg of daily spironolactone to 100 mg daily with concomitant use of clascoterone cream.

Panelists agreed that clascoterone 1% cream was a safe and efficacious topical acne treatment with high patient compliance and satisfaction. Patients experienced best results with twice-daily use of clascoterone cream and continued to see improvement through week 24 of use. Future studies will be important to investigate clascoterone combination therapies that best target the pathogenetic factors of acne. In the real-world case series presented, clascoterone was easily integrated into acne regimens to provide topical targeting of sebum production and inflammation at the skin. Through these patient cases, expert dermatologists share their insight and experience with clascoterone 1% cream to better inform patients and dermatologists of how to use this first-in-class topical anti-androgen.

Limitations

The real-world cases presented outline various successful uses of clascoterone cream. However, these data do not represent data collected from controlled, clinical trials. Instead, these cases present this expert panel's clinical experience with the product on patients under pragmatic conditions.

CONCLUSION

The real-world cases presented illustrate the varied roles of clascoterone 1% cream used in acne treatment across Canada. The anti-androgen cream was used as monotherapy for acne as well as in combination with other acne topicals and systemic agents. The cumulative insight and experience of this panel of experts suggests that clascoterone cream provides a unique and efficacious way to target acne. Clascoterone was shown to be safe and well-tolerated in all the skin types represented in this case series. The real-world experience of the presented experts and their patients demonstrates multi-pronged acne treatments using this novel, anti-androgen topical. These regimens may be used as a guide for patients and dermatologists looking to personalize acne treatments for their patients.

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AUTHOR CORRESPONDENCE

Anneke Andriessen PhD
E-mail:..... anneke.a@tiscali.nl

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