

Rosacea: What is New?

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There are a variety of *Demodex* mites which are implicated in rosacea. Colonization with *Demodex folliculorum* is associated with inflammatory rosacea, while *Demodex brevis* is seen in mild rosacea and normal skin. Patients with clear skin have a durable response that lasts eight months (longer time to relapse). In patients with almost clear skin, the durable response only lasts three months. Bottom line: aim for clear skin. Ivermectin and brimonidine used in conjunction have an additive anti-inflammatory response and better tolerability profile. Subjects receiving topical ivermectin and subantimicrobial-dose doxycycline dual therapy had a statistically significant difference in clearance of inflammatory lesions when compared to those on ivermectin alone. With regard to ocular rosacea, there are currently no FDA-approved therapies. However, case reports have shown ivermectin as a potential option.

There are a variety of exciting rosacea treatments in the pipeline. Topical minocycline 1.5% foam was recently FDA-approved for rosacea. Phase 3 clinical trials showed a statistically significant proportion of treatment group subjects achieved clear or almost clear skin as compared with vehicle group, and minocycline was tolerated well. Rosacea patients are generally too sensitive to tolerate conventional benzoyl peroxide (BPO). On the horizon: a new formulation of microencapsulated BPO in a silica shell which slowly releases medication over time. Phase 2 clinical trials demonstrated a statistically significant difference in subjects receiving low-dose oral minocycline compared to doxycycline and placebo groups.