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CANADIAN DERMATOLOGY TODAY

Dermatology in Practice: Real Cases, Real Decisions, Real Challenges

Featuring Matt Sandre, MD, Gabriele Weichert, MD, FRCPC, PhD, Parbeer S. Grewal, MD, FRCPC, DABD, Marissa Joseph, MD, MSc, Alexandre Lemieux, MD, and Zaki Taher, MD

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Acne Management in Transgender Patients

Matt Sandre, MD

What considerations should dermatologists keep in mind when managing acne in transgender patients?

The first step is to ensure your clinic is a safe and inclusive place for people of all gender identities. This can take many forms. For example, you can ensure your intake form has more than binary options to select for gender, include your own preferred pronouns after your name, and display a safe space symbol in the office.

At the first encounter, physicians should consider asking all patients about their gender identity and pronouns. Furthermore, transgender and non-binary patients should be asked about their name, as this may be different from the name on their health card. Knowing pronouns is important for multiple reasons, including that you don't want to misgender the patient in your note in the electronic medical record (EMR), which patients can easily access.

It's important to ask any patient with pregnancy potential if they engage in sexual activity that carries a risk of pregnancy. Although it may be an unfamiliar area of inquiry for some physicians, transgender male patients should be asked about any gender affirming lower body surgery that can change this risk. While some practitioners may worry patients could be taken aback by such questions, in general, patients are often happy to address any medical questions when the practitioner first explains the reasoning behind the questions.

Transgender patients face additional barriers when accessing health care. What is the role of the dermatologist in helping their patients navigate these barriers?

Dermatologists should be aware that transgender patients can face barriers and discrimination in the health system that can impact their level of trust in health providers, as well as their comfort level in accessing various parts of health care. For example, a patient who has had a negative encounter with a staff member at a lab may be reluctant to start a medication that involves routine bloodwork if there are not other locations available. For these patients, dermatologists can communicate with the lab in advance to ensure their patients will receive respectful, inclusive-care. Explicitly stating that your clinic is a safe space for your patient to be themselves and raise any concerns they may have can also go a long way toward building your patient's trust.

How do you approach the treatment of hormonal acne in transgender patients?

Textbooks describe drug-induced acne as monomorphic in its appearance, and hormonal acne as occurring more frequently in the lower face, chin, and even potentially the back. In my experience, however, testosterone-induced acne may appear across the face and can vary in morphology and severity. As it can be difficult to tell testosterone-induced acne from non-drug-induced acne, it's necessary to consider the medical history. Testosterone-induced acne flares typically occur within 1 to 6 months of initiating testosterone, with maximal effects at around 2 years. For some people, acne improves after that point, while for others, acne does not improve over time without intervention. In a patient on testosterone for gender-affirming care, there is a higher risk of acne relapse for those who stop a topical or an oral acne therapy given that the exogenous testosterone is often a long-term therapy. It's therefore important to counsel patients about this, and discuss maintenance options (which may be required for indefinite periods of time) for preventing relapses as well as options to treat them if a relapse occurs while off treatment.

When I prescribe isotretinoin for transgender male patients, I typically aim for an off-label cumulative dose of 200 to 220 mg/kg. For both cis- and transgender patients, I find these higher cumulative doses of isotretinoin lead to a lower relapse rate, which is supported in the literature. In patients on long-term exogenous testosterone, after reaching the target cumulative dose, rather than stopping therapy, I often give my patients the option of tapering the medication to the lowest effective dose that maintains skin clearance. Transgender patients may need to continue isotretinoin without a specific endpoint, as their acne may be a chronic condition to be continuously managed. Also, topical treatments can be an optimal option depending on their acne severity and patient preference. Topical treatment management remains the same for transgender patients without any additional considerations. In transgender patients with moderate-to-severe acne, I generally consider combination therapy (dual or triple combination), if the patient is the right candidate for these treatments.

Are there any unique safety aspects to consider when treating acne in transgender patients?

Both testosterone and isotretinoin can potentially increase liver enzymes and blood lipids. If these lab values are increasing for a patient on isotretinoin, the clinician should keep in mind that this could be due to the isotretinoin, testosterone, a combination of the two, or many other factors unrelated to their gender-affirming-or acne-care. Considering the timing of elevated values in relation to each drug's initiation and updosing is helpful. Trialling a period off isotretinoin can be helpful to determine if the medication is contributing to elevated enzymes or lipids.

In my practice from a pregnancy perspective, if there is a risk of pregnancy, the art of medicine comes into play. If you have a trusting relationship with your patient who is taking isotretinoin, you may be comfortable with them performing an at-home pregnancy test on a monthly basis, and reporting the results to you. This can allow the patient to avoid undergoing a blood or urine pregnancy test in a lab or clinic that could pose risks of discriminatory treatment, or of undergoing an experience in a public setting that feels incongruent with their gender identity.

Transgender patients who may be planning or considering gender-affirming surgeries should be counselled that some surgeons may delay surgery if a patient is taking isotretinoin or recently completed a course of isotretinoin, due to concerns that isotretinoin could negatively impact healing. This can be extremely discouraging for patients who have been waiting anxiously for their surgery. While more recent data suggests that isotretinoin may not have the same impact on healing as once thought, some surgeons continue to require isotretinoin be discontinued for many months prior to surgery.

Do you have any final words of advice to share with your colleagues?

Ultimately, dermatologists should implement training, protocols and policies to ensure transgender patients don't feel as though a clinic's staff are uncomfortable with different gender identities or encountering a situation that hasn't been considered before. Like all patients, transgender patients deserve a thoughtful and patient-centred approach.

Patient Case
A 27-year-old transgender man (he/him) presented with persistent, inflammatory acne temporally associated with gender-affirming testosterone therapy
• Subcutaneous testosterone biweekly since 2020
• History of very mild acne during puberty, without flares associated with menses
• Approximately 3 months after starting testosterone, patient developed progressively inflammatory acne involving the face and back
• Patient tried combination topical therapies (tretinoin/clindamycin and benzoyl peroxide/clindamycin) and oral minocycline. While minocycline resulted in approximately 50% improvement, acne recurred upon discontinuation
• In-office chemical peels and intense pulsed light therapy did not provide sustained benefit
• Acne was impacting the patient's mental health
Treatment Approach:
✓ Pregnancy risk was reviewed, including reports of pregnancy in transgender men on testosterone
✓ Patient declined oral contraceptives or a copper intrauterine device but consented to secondary contraception methods and beta-hCG serology testing
✓ Baseline and ongoing monitoring: liver enzymes, lipids, and serum beta-hCG, with explicit documentation (the patient's government ID gender was male) to avoid confusion at the laboratory
✓ Isotretinoin was initiated at 20 mg daily and gradually escalated to 70 mg daily. Liver enzymes and lipids remained stable. Treatment was extended to a cumulative dose of 220 mg/kg with excellent patient satisfaction at completion.
✓ A relapse at 4-months post-isotretinoin was effectively treated with 10% benzoyl peroxide wash for the body, Cerave Acne Foaming Cleanser for the face, clascoterone 1% cream twice daily, and tazarotene 0.045% lotion nightly. The long-term plan is to continue topical maintenance therapy

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Dr. Gabriele Weichert practices in Nanaimo, British Columbia, where she established her community-based dermatology practice in 2003. She completed her undergraduate degree in Biology at the University of Waterloo, followed by PhD in Physiology at the University of British Columbia. Dr. Weichert earned her medical degree from McMaster University and completed a five-year Dermatology residency at UBC. She has been actively involved in medical education as an Assistant Instructor with the UBC Department of Dermatology and Skin Science, contributing to the training and mentorship of medical students and residents. Dr. Weichert has also served as Past President of the Canadian Dermatology Association and as a Royal College of Physicians and Surgeons of Canada examiner, reflecting her national leadership and commitment to clinical excellence and professional standards. Practicing on central Vancouver Island, Dr. Weichert provides comprehensive medical and surgical dermatology care, with additional expertise in select cosmetic procedures. Her clinical interests include skin cancer management, inflammatory skin disease, and advanced therapies for complex dermatologic conditions.

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Collaborative Care in Psoriasis and Psoriatic Arthritis: A Dermatologist's Perspective

Gabriele Weichert, MD, FRCPC, PhD

How do dermatologists and rheumatologists typically comanage patients with psoriasis and psoriatic arthritis (PsA)?

Collaboration between rheumatology and dermatology is vital to achieving the best outcome for patients. Dermatologists may be able to access biologics more easily than our rheumatology colleagues, who may face additional therapeutic sequencing requirements before biologics can be prescribed. Conversely, I have had success collaborating with rheumatologists to switch a patient's biologic for PsA-related reasons, even when their psoriasis was well controlled which I define as my being satisfied with the patient's clinical outcomes, the patient being happy with their results, and a BSA of 2% (with > 95% improvement in PASI from baseline).

I strongly recommend involving rheumatology early when patients with psoriasis have possible PsA, even when a biologic with overlapping benefit is being prescribed. In some cases, joint symptoms may have

a non-PsA cause in patients with psoriasis. I have had instances where I've referred patients with suspected PsA to rheumatology, and they are subsequently diagnosed with osteoarthritis, mechanical back pain, or another non-inflammatory condition. Ultimately, shared decision making between patients, rheumatologists, and dermatologists results in the most appropriate treatment plans and best outcomes for patients. Rheumatologists often appreciate being involved early. It helps that PsA involves a very clear diagnostic assessment, compared to other arthritic presentations.

Can you share how you assess PsA in your psoriasis patients?

Validated tools such as the Psoriasis Epidemiology Screening Tool (PEST) can be helpful, and some dermatology practices incorporate these tools into routine follow-up. My approach is more informal. I discuss joint pain, lower back pain, enthesitis, and dactylitis features with patients. I then let the rheumatologist know which joints are involved, and if enthesitis and dactylitis are present.

What's your treatment approach when patients have both psoriasis and PsA?

I prefer IL17 inhibitors for patients with PsA, provided comorbid conditions such as inflammatory bowel disease are considered. However, in many patients, dermatologic disease precedes overt joint involvement, and biologic therapy is initiated primarily for skin disease. In cases whereby patients have been prescribed IL23 inhibitors and have subsequently developed joint symptoms, treatment may involve optimizing the IL23 inhibitor dose or collaborating with rheumatology to determine whether a switch to an IL17 inhibitor would be appropriate. Although TNFα inhibitors are commonly used to treat PsA, they are often less appealing from a dermatologic perspective. In my experience, patients who have achieved skin clearance on a newer agent are unlikely to be satisfied by the results of a TNFα inhibitor. That said, in regions where patients do not have access to third party drug plans, biologic options may be difficult to access. Methotrexate combined with topical therapy can be effective for both psoriasis and PsA in many patients.

How do you define treatment success in patients who have psoriasis and PsA?

Treatment goals for patients with psoriasis and PsA are inherently individualized. Some patients prioritize skin clearance above all else, even when joint symptoms persist, while others are more concerned about joint pain, function, and long-term structural damage. Recently, a patient's rheumatologist recommended switching from bimekizumab to ustekinumab, due to signs of inadequately controlled PsA, but the patient refused to discontinue bimekizumab out of concern that their skin disease would worsen. In general, however, dermatologists, rheumatologists, and patients can agree on the best path forward through shared decision-making.

Dermatologists often have greater flexibility in managing psoriasis through layered therapies, including topical agents and phototherapy, allowing some accommodation if systemic therapy must be optimized primarily for joint disease. Rheumatologists, by contrast, do not have non-systemic options to treat active PsA. In the case highlighted here, the rheumatologist took over the care of the patient, and I remained available as needed. Regardless of the ultimate treatment decision, and which clinician assumes the lead in the overall management and follow-up, patients appreciate collaboration between their specialists and feel reassured when their rheumatologist and dermatologist are unified on their treatment plan.

Patient Case
A 60-year-old man with a 10-year history of PsA and psoriasis was referred by rheumatology for evaluation of a new, concerning skin eruption and assistance with biologic access
• Patient previously tried secukinumab, apremilast, ustekinumab, and ixekizumab
• After withdrawal of apremilast by the rheumatologist, the patient was switched to upadacitinib, and subsequently developed an acute pustular eruption involving the hands and feet
• Upadacitinib was discontinued and prednisone was initiated
• Dermatology assessment (post-prednisone) demonstrated small, classic psoriatic plaques on the legs with resolution of pustules
• Photos taken pre-prednisone were consistent with pustular psoriasis triggered by therapy
Treatment Approach:
✓ Dermatologist prescribed acitretin (10 mg), -methasone-17-valerate 0.1% and roflumilast cream
✓ Dermatologist was unable to apply for special authority in the absence of a qualifying psoriasis indication; investigated compassionate access to IL23 inhibitors (guselkumab, risankizumab), without success
✓ Dermatologist provided risankizumab samples as a trial (four doses over 28 weeks)
✓ Rheumatology agreed to work collaboratively with the patient to pursue longer-term insurance access
✓ Case highlights the importance of collaboration between dermatology and rheumatology

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Managing Psoriasis in the Setting of Comorbidities, Biologic Failure, and Mental Health

Parbeer S. Grewal, MD, FRCPC, DABD

What are some of the factors that can complicate biologic therapy decisions?

Modern systemic therapies have transformed the management of psoriasis. With today's biologics, PASI 90 or 100 and minimal quality-of-life impairment due to psoriasis are treatment goals that we can routinely achieve. However, comorbidities, prior biologic failures, mental health concerns, and adherence challenges frequently complicate clinical decision-making.

For example, patients with previous or active malignancy require lengthier shared decision-making discussions and multidisciplinary collaboration. Many of my patients with active B-cell lymphoma have initiated IL23 inhibitors with the blessing of their oncologist. I frequently prescribe IL23 and IL17 inhibitors for patients who are immunosuppressed, even with certain active infections, as long-term safety data is reassuring for this patient population. Additionally, we know that IL17 and IL23-targeting medications don't reactivate latent tuberculosis. I am more hesitant to prescribe TNFα medications in patients who are immunosuppressed, however.

Comorbid conditions should inform treatment selection. Psoriatic arthritis may steer clinicians toward IL-17 or TNFα inhibitors, though emerging data increasingly support IL23 inhibitors in this setting. In patients with inflammatory bowel disease, IL23 inhibitors and anti-TNFα medications are often favored, but IL17 inhibitors can also be used, in collaboration with gastroenterology. Some studies have demonstrated the incidence rate of Crohn's disease and ulcerative colitis in patients taking IL17 inhibitors aligns with the incidence rate in the general population.

Some research also shows that tildrakizumab and bimekizumab are safe and effective for patients with metabolic syndrome and fatty liver disease. I prefer to select an IL17 inhibitor for patients with liver issues, due to the potential benefit of reducing inflammation in the liver.

Do upcoming surgeries affect your therapeutic choice?

While data from patients with inflammatory bowel disease and hidradenitis suppurativa suggest that controlling systemic inflammation around the time of surgery may, in fact, improve outcomes, some surgeons continue to believe that biologics can impair wound healing. When a surgeon requests that patients discontinue biologics ahead of surgery, I engage in discussion with the surgeon and share the latest evidence on perioperative IL17 and IL23 inhibitor use.

How do comorbidities affect the effectiveness of biologic therapies?

Comorbid patients are more likely to experience biologic failure, which is emotionally challenging for patients. Patients with psoriasis are often disappointed when they experience biologic failure because the bar is set so high when it comes to biologics. Dermatologists can help by setting expectations for patients who have comorbidities or past biologic failure early on. I explain that while biologics work very well, some patients will need to try multiple biologics before they find one that works well for them. Alternatively, if a patient has previously failed biologics, I explain that it's possible the biologic therapy I'm prescribing may significantly improve, but not completely clear, the psoriasis. Some patients may need adjunctive therapy like phototherapy, topical therapies, or combination therapy with methotrexate.

In the case of biologic failure, I prefer to switch to another biologic class, unless there is a compelling reason to stay within a specific class, such as psoriatic arthritis requiring IL17 inhibition. In my experience, patients who have experienced treatment failure are more confident when they hear their next medication works in a different way than the previous medication. This can help with compliance.

How do you approach psoriasis treatment discussions in patients with mental health concerns?

When it comes to mental health, all biologic agents are associated with improvements in mental health scores over time. I'm willing using any biologic in a psoriasis patient with psychiatric comorbidities, so long as the patient is informed and comfortable with the approach. I talk about how the skin affects mental health. It can support patient buy-in and compliance when they hear me say "you'll probably notice your mental health improves as your skin improves."

When prescribing therapies with black box warnings, such as brodalumab, transparency is essential. I recommend addressing warnings proactively rather than waiting for patients to encounter them through online searches or pharmacists. I contextualize the findings in the brodalumab clinical trial by explaining that the patients had underlying depression and that further evidence has shown no causal link between brodalumab and depression.

Nonadherence to medications is another common problem, particularly in patients with depression or anxiety and with socioeconomic challenges. A punitive approach is rarely effective. Instead, clinicians should schedule additional follow ups to encourage compliance. I find it can be helpful to bring in family members in some cases. In more extreme cases, I will offer in-clinic injections.

I recommend that dermatologists incorporate mental health screening as part of routine psoriasis care, not only to assess baseline depression and anxiety but also to track improvement in mental health outcomes alongside improvement in psoriasis. The Patient Health Questionnaire-2 (PHQ-2) is perhaps the simplest screening tool to incorporate, as it often takes less than a minute. If responses to the PHQ-2 are concerning, that can prompt further questionnaires, like the PHQ-9, and possibly referral to a primary care practitioner, psychiatrist, or other mental health supports.

Patient Case
A 43-year-old man with multiple comorbidities was referred from the emergency department with plaque psoriasis
• Developed psoriasis in his 20's
• No clinical evidence of psoriatic arthritis
• Several-year history of alcoholism and depression, with multiple emergency department visits for suicidality
• History of fatty liver disease
• Prior therapies included phototherapy and methotrexate, both of which failed (methotrexate also affected liver function)
• Patient had modest, but ultimately unsuccessful, responses in the past to adalimumab, ustekinumab, secukinumab, and guselkumab
• Previously participated in a brodalumab clinical trial, with good clinical response before the trial was prematurely discontinued
• Patient was non-adherent to medication dosing regimens in the past
Treatment Approach:
✓ Trials with cyclosporine and risankizumab were ineffective
✓ Prescribed brodalumab based on patient's prior response, and failure of IL12/23-targeted therapies
✓ Discussed the importance of compliance, blood work monitoring, and managing depression with the patient and the patient's mother
✓ 1 month post-initiation, PASI was 1.6 and DLQI was 6
✓ No recent episodes of depression, anxiety, or self-injurious behavior were reported at follow-up

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Navigating Steroid Withdrawal Concerns in Atopic Dermatitis

Marissa Joseph, MD, MSc

Is steroid withdrawal syndrome a common issue in your practice?

Concerns about steroid withdrawal or steroid addiction syndrome have become increasingly common in dermatology consultations. In my experience, what patients describe as steroid withdrawal syndrome is, for the most part, refractory, moderate-to-severe atopic dermatitis.

Typically, I avoid directly challenging the diagnosis of steroid withdrawal syndrome because doing so can lead patients to feel they are not being heard. Instead, I explain that many patients have this concern, and that I have successfully treated patients who are concerned about steroid withdrawal syndrome. I also explain options for a treatment plan that takes the patient's wishes into account. For example, if a patient would like to avoid topical corticosteroids, there are many nonsteroidal options.

At the same time, I explain that steroids can be used in a safe and time-limited manner to treat flares, and that systemic medications may also be necessary if the skin doesn't respond to topicals. For some patients with severe disease, immediate systemic therapy may be warranted. Framing systemic therapy as a logical response to the disease burden, rather than as a rejection of the patient's beliefs, helps move the conversation forward. Another way to demonstrate we are listening is to acknowledge the burden of the

patient's skin disease, and how it is affecting their quality of life. Once patients feel heard, many become more open to the treatment plan.

Why do you think patients are increasingly worried about steroid withdrawal syndrome?

Today, many people access health information through social media and, increasingly, platforms such as ChatGPT, which is frequently misleading. Over the last year, I have noticed that the concept of steroid withdrawal syndrome has spread outside of the atopic dermatitis patient community, as patients with other skin conditions are now raising this concern. In my practice, the concern is almost exclusively mentioned by people under 60 years of age, likely reflecting their greater engagement with social media.

Many of those who are worried about steroid addiction are understandably fearful and frustrated after years of trying to manage their atopic dermatitis. In other words, they are not fixed in their thinking or delusional; instead, they're looking for answers, and the diagnosis of steroid withdrawal syndrome has provided them with a narrative that helps explain their experience. Ultimately, however, it's important to keep in mind that our patients make appointments with us because they're seeking our expertise, and they're looking to us for solutions. While there is a small subset of patients whose beliefs are fixed and who may be unwilling to try systemic therapy, despite significant time investment on the part of the dermatologist, the overwhelming majority of patients are open to evidence-based treatment options when approached with empathy.

How do you approach treatment in patients who are worried about steroid withdrawal?

Patients concerned about steroid withdrawal syndrome are often hesitant to use any topical therapies, including moisturizers. This may be because their skin is inflamed, and they experience irritation when beginning to use topical ointments, or it may be because they are concerned about the ingredients in topical products. I discuss the importance of restoring the skin barrier and identify the topical therapies a patient is willing to use. Even if patients are not willing to use the most effective topical therapies, they may be willing to use topicals that are moderately effective at restoring the skin barrier and reducing inflammation. Partial adherence to topical therapy can meaningfully support systemic treatment. For example, the CHRONOS trial demonstrates that adjunctive prescription topical therapy can further improve the clinical outcomes of dupilumab.

Counseling patients about topical corticosteroid safety is another key component of addressing their fears of steroids and, by proxy, many other medical treatments. I explain that while skin atrophy can occur, it is very rare. Patients frequently believe they are experiencing thinning when, in fact, their skin is thickened from chronic inflammation. Explaining what skin thinning actually looks like, including the fact that it often presents with visible blood vessels and wrinkling, can be both reassuring and clarifying for patients.

What's the key takeaway to remember about responding to patients who are fearful about steroids?

Managing patients concerned about steroid withdrawal requires clinicians to recognize, and not dismiss, patient fears. By considering alternative treatment options (which may elicit fewer symptoms of perceived steroid withdrawal syndrome), such as non-steroidal topical agents (e.g.., calcineurin inhibitors, PDE-4 inhibitors or Janus kinase inhibitors), while also incorporating patient preferences into the treatment plan and being transparent about the true risks and benefits of steroids and other treatments, clinicians can gain the trust necessary to advance evidence-based treatment plans.

Patient Case

A 46-year-old man presented with a longstanding skin eruption. The patient was concerned about a diagnosis of steroid withdrawal syndrome.

- History of chronic skin eruption for more than 40 years
- Prior exposure to oral prednisone; patient was not using topical therapies at presentation
- Patient and family member were highly frustrated with prior care
- Initial and repeat (2 weeks later) skin biopsy revealed spongiotic dermatitis
- Concern about steroid withdrawal syndrome resulted in a strong patient preference to avoid corticosteroids

Treatment Approach:

✓ A non-steroidal topical approach was prioritized, with the initiation of pimecrolimus twice daily

✓ Cyclosporine was initially considered but contraindicated due to hypertension

✓ Methotrexate was trialed but was not tolerated after 6 weeks, affecting the fragile therapeutic alliance

✓ Given disease severity, access considerations, and need for steroid avoidance, systemic therapy with upadacitinib was selected in combination with pimecrolimus

✓ 12 weeks post-initiation of upadacitinib (30 mg daily), patient-reported peak pruritus numeric rating scale scores improved from 10 to 2

✓ Treatment response was assessed through patient satisfaction and a palpation-based assessment of active body surface area

✓ In retrospect, earlier initiation of JAK inhibitor therapy may have mitigated adverse effects from methotrexate and preserved patient trust

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Treating Acne in Patients with Complex Comorbidities

Alexandre Lemieux, MD

How do common comorbidities affect acne?

Acne is often perceived as a straightforward dermatologic condition. In clinical practice, however, it can be profoundly influenced by metabolic, hormonal, inflammatory, or mental health comorbidities. Coexisting conditions can exacerbate acne severity, limit therapeutic options, and affect patients' adherence to treatment. It is especially important to set realistic expectations and foster a trusting therapeutic relationship when treating patients whose acne coexists with other challenging comorbidities.

While common acne therapies have relatively few drug-drug interactions, clinical complexity can arise in specific scenarios. For example, patients with hidradenitis suppurativa may require antibiotics that cannot be safely combined with isotretinoin. In addition, spironolactone can interact with several medications, including those that increase potassium levels. In other cases, the acne itself may be medication-induced. Therefore, it is vital to consider the role that patients' other medications may play in their acne and to collaborate with the patient's providers.

Can you describe the patient in the accompanying case, and how her comorbidities impacted your treatment plan?

The patient described in the accompanying case had liver fibrosis, irritable bowel syndrome, and Polycystic ovary syndrome (PCOS). Although fatty liver disease and fibrosis are very rare in young patients, they can occur. Patients who are overweight, have a family history of liver disease, drink alcohol, and consume diets high in sugars and saturated fat are at risk of liver disease. In my experience, patients with hidradenitis suppurativa are more likely to have liver disease as well. I am comfortable prescribing isotretinoin for patients with fatty liver disease so long as their liver function tests are normal. For patients who have abnormal liver function tests, isotretinoin should be avoided or prescribed at very low doses, which may be considered as 10 mg 3 times per week.

or up to 10–20 mg daily depending on the patient's weight and lab values. Other systemic options could include oral antibiotics, oral contraception (with preference for those with anti-androgen properties) and spironolactone in women; for men, oral antibiotics and topicals are the preferred alternate options.

As the case illustrates, patients with complex comorbidities may be hesitant to initiate systemic acne therapies, due to previous experiences with side effects or concerns about drug interactions. In these situations, shared decision-making is key. My approach is to discuss the impact of acne on the patient's life and the patient's reasons for pursuing acne therapy, which is typically to improve their quality of life and prevent scarring. Rather than persuading patients to immediately start a systemic therapy, I outline the options, including both topical and systemic therapies and the expected results with each option.

How do you approach patients who are wary of systemic therapies?

Optimizing topical treatment can build the trust that is necessary for a patient to feel confident about initiating a systemic medication. In some of my cases, topicals, such as clascoterone for hormonal acne (which may not provide the required efficacy as monotherapy), or the triplet combination of clindamycin, adapalene, and benzoyl peroxide can be effective to the point that systemic therapy is not required. In the case of the triple combination therapy, I might consider adding clascoterone to optimize the treatment for the patient in certain scenarios.

Parents are typically more concerned about systemics than their children. This is often related to the parent's own historical experience with higher doses of isotretinoin and more pronounced side effects. Often, parents of children with severe acne have also experienced severe acne themselves. For these situations, I reassure families by explaining that side effects are extremely rare with the lower doses and gradual dose escalation that we employ today.

Should dermatologists look out for possible comorbid conditions that may be exacerbating patients' acne?

While patients with comorbidities may be referred for acne management by their endocrinologist, gastroenterologist, or other specialist, the reverse can also be true. Dermatologists often identify systemic disease through cutaneous signs. For example, I have referred patients to endocrinology after identifying PCOS. This condition is underdiagnosed and the signs are often clear if we assess for them. PCOS is associated with mandibular distribution of acne, alopecia, irregular menses, hyperandrogenism, and anxiety (which can present with excoriated lesions).

A good rule of thumb is to always assume a disease process beyond simple acne when acne begins in adulthood and is not well controlled by topicals. Initiating testing can reduce the time to diagnosis and appropriate therapy. If hormonal acne is suspected, we can order hormone level tests. For suspected metabolic syndrome, I recommend checking blood pressure, and ordering a lipid panel and fasting blood sugar. When results are abnormal, I then refer patients to the appropriate specialist.

Collaboration with primary care physicians as well as other specialists, such as gynecologists and endocrinologists, ensures the best patient outcome. For example, as dermatologists we can recommend spironolactone to the patient's PCOS specialist, as spironolactone can treat both PCOS and acne. With primary care physicians, one common worry I encounter is that isotretinoin could exacerbate underlying depression. In these cases, I share the reassuring data showing that isotretinoin is safe for patients who have depression, when the depression is well-controlled.

You outlined the importance of collaboration and safety considerations when treating complex patients. Can you share other clinical pearls regarding the management of acne in patients with comorbidities?

When treating acne that is induced by an underlying hormonal condition, it's important to keep in mind that long-term management will likely be necessary. For hormonal acne, I typically prescribe long-term spironolactone or long-term, microdosed isotretinoin, as well as a topical retinoid. I counsel patients to expect flares and prescribe double- or triple-combination topicals for the treatment of future flares. If we treat the acne in an episodic way, and then leave patients to relapse, they will feel frustrated.

Patient Case
A 26-year-old woman with multiple comorbidities was referred by her family physician for suspected hidradenitis suppurativa.
• Five-year history of intermittent papules and nodules in the axillae and groin, less inflammatory following breast reduction surgery
• 3-year history of similar lesions on the face with significant premenstrual exacerbation
• Oligomenorrhea
• History of fatty liver disease, obesity, and irritable bowel syndrome
• Physical examination revealed: ◦ 15 inflammatory papules, multiple double comedones, and a few hypertrophic scars in the groin/axillae ◦ 10 inflammatory acne papules on the mandibles and chin, with no comedones or scars ◦ Mild hirsutism on the chin
• Diagnosed patient with hidradenitis suppurativa (Hurley stage 2) with hormonal acne and suspicion of PCOS
Treatment Approach:
✓ Initiated topical therapy with clindamycin lotion and antiseptic wash
✓ Intralesional triamcinolone acetonide administered for a painful groin nodule
✓ Endocrinology referral for PCOS evaluation
✓ Planned initiation of spironolactone with oral contraception, following endocrine assessment
✓ Patient reluctant about systemic antibiotics due to concerns about liver toxicity
Follow-up at 6 months
✓ PCOS diagnosis confirmed; spironolactone titrated to 200 mg daily by endocrinology
✓ Facial lesions increased despite weight loss and other treatments
✓ Added doxycycline (3 months) and Winlevi cream
Follow up at 12 months
✓ Facial lesions improved but recurred after patient stopped doxycycline; patient experienced mild diarrhea while taking doxycycline
✓ Patient on sick leave due to anxiety caused by her acne
✓ Added clindamycin/adapalene/benzoyl peroxide (Cabtreo) daily and metronidazole 1% cream twice daily
Current Status
✓ Marked improvement in facial, axillary, and groin lesions on spironolactone and topical therapy
✓ Patient satisfied and elected to continue current regimen

Finally, lifestyle counselling can be very helpful for patients with complex comorbidities, who are likely to face repeated flares. I recommend a gentle skin care approach and suggest that patients trial a low-glycemic and low-dairy diet to see the effect on their skin. Due to the ubiquity of whey protein supplements, I proactively counsel that whey is a dairy product, and these supplements can trigger flares in some people.

By treating the whole patient rather than the acne alone, clinicians can improve not only acne outcomes, but patients' overall health and quality of life.

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Dr. Lemieux has received an honorarium from Bausch Health for his role in developing this special supplement.

ABOUT THE CLINICIAN

Zaki Taher, MD

Dr. Zaki Taher is a Board-Certified Dermatologist and is the founder and medical director of Lucere Dermatology & Laser Clinics, specializing in Medical and Cosmetic Dermatology services. After completing his Dermatology residency at the University of Alberta, Dr. Taher went on to complete a prestigious Fellowship at the University of Ottawa in Laser Surgery and Cosmetic Dermatology. His areas of special interest include general medical dermatology, precancers and skin cancer management, along with medical and cosmetic applications of lasers in cutaneous surgery and rejuvenation. Dr. Taher is also an Associate Clinical Professor in the Department of Medicine at the University of Alberta where he teaches medical students and dermatology residents. Dr. Taher is frequently invited to speak nationally and teach on advanced neuromodulator and filler injection techniques as well as laser and cosmetic surgery applications. He is very well known for his comprehensive approach to facial rejuvenation. With a passion for research and innovation, Dr. Taher's areas of research interest includes vascular lesions, pigmentation, facial rejuvenation, and malignant & premalignant cancer management. He is currently an active member of the Association of Clinical Research Professionals. Dr. Taher is an active member of various professional societies including being appointed President of the Alberta Society of Dermatologists. He is also an active member of the Royal College of Physicians of Canada and the Canadian Dermatology Association. Dr. Taher is also the chief medical officer of the Functionalab Dermapure Group, a physician forward organization representing over 70 clinics across Canada.

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Preventing and Treating Scarring in Patients with Complex Acne

Zaki Taher, MD

Are certain patient populations more prone to acne scarring?

In my experience, people of colour are often more prone to scarring. Within this broad category, certain ethnic groups, including Filipino, First Nations and African populations, have an especially high risk of acne scarring.

Other patient populations at an increased risk include individuals taking steroids, whether to "bulk up" or as hormone replacement therapy. Patients may even use a steroid cream prescribed for conditions such as eczema, to treat redness on the face, which can aggravate acne over the long-term. Other medications, such as certain epilepsy medications, can also make acne more challenging to treat. Finally, people may use excessive make-up to conceal acne, but these products can further worsen the condition.

Broadly, what is your approach to treating scarring from acne?

Treating scarring is an art; if it was a simple science, there would be clear protocols. I receive challenging acne scarring referrals from dermatology colleagues. I have met patients who have spent thousands on laser therapy, chemical peels and skin care before they see me.

It's important to not only do a visual assessment to categorize scars as ice pick, boxcar, rolling or keloid but also to physically touch the skin, and assess it for texture, colour, and blanching. I often find that palpation, stretching and touching the skin are useful bedside maneuvers to assess the nature of scarring. Scar assessment is a highly tactile art that takes many years to perfect.

Some scars may have a loss of pigment and vascularity (the scars may look white) and others will be pink or red. In the latter cases, devices such as Intensed Pulsed Light, Pulsed Dye Laser, 532 KTP and 1064 Nd:YAG can reduce hypervascularity.

Setting expectations and explaining the long-term approach are key to avoid a disappointed patient. Many patients express a desire to address scarring, but I explain that treating scarring when the acne process is continuing is like trying to bail out water in a flooded basement while the tap is still running. I explain that I must first "turn off the tap" and control the acne; only then can scarring be effectively treated. I tell my complex acne patients with scarring that they can expect treatment to take a year or more. Although we have treatments that lead to exceptional outcomes, results do not occur overnight.

Do you have any advice about treating severe acne that has resulted in scarring?

When treating persistent acne that doesn't resolve with conventional therapies, dermatologists should inquire about other medications, discuss makeup use, and address diet and lifestyle factors. My experience suggests, for example, that high dairy intake, poor sleep, and low water intake can play a role in acne. I also ask patients with persistent acne about skin care regimens, as people may be using over-the-counter products that are not good for the skin.

Performing baseline psychosocial assessments is essential to determining the treatment approach. If a patient reports that they wish to avoid school or work due to their acne, I will introduce more aggressive therapies earlier. For patients who have severe acne, one of the most necessary treatments in our toolbox is isotretinoin. There is no question that topical therapeutics when chosen carefully, and in light of the many studies showing the efficacy of some in particular, can be an important part of scar prevention before they form and scar remediation after they form.

In the accompanying patient case, the patient was concerned about systemic therapies. Can you provide more context to this case?

The patient, and especially their parent, was unwilling to restart isotretinoin due to a previous negative experience. The patient had experienced acne fulminans after a higher dose isotretinoin protocol was prescribed by another dermatologist. The high dose was likely prescribed because of the severity of the acne. Despite this poor outcome, based on training and my own experience, higher-dose isotretinoin and concurrent use of prednisone is generally the appropriate treatment approach for complex acne patients. An alternative strategy I often use is to start with alternate day dosing of isotretinoin to prevent skin sensitivity and peeling.

If the patient were an adult, I would have broached the option of low-dose isotretinoin as a maintenance therapy, explaining the potential benefit and why the side effect wouldn't recur. However, treatment opportunities in the pediatric populations can be more constrained, due to parents' low tolerance for risk, which is understandable.

Is there any advice you would like to share about treating scarring that you haven't yet mentioned?

In addition to laser therapy, subcision should be part of the scar remediation program for most patients who have severe acne scarring. It's one of the simplest surgical maneuvers that can be performed in the office, and it leads to significant incremental improvement when combined with laser therapy, bringing a good result to great and a great result to exceptional.

Patient case:
A 16-year-old First Nations male presented with severe acne fulminans, temporally associated with initiation of oral isotretinoin
• History of inflammatory acne for approximately 12 months prior to presentation
• Initially prescribed oral isotretinoin by a colleague at doses of 40 mg escalating to 80 mg daily
• Within the first week of initiating the 80 mg dose, patient developed rapid worsening of acne with bleeding lesions involving the face, back, and chest
• Systemic symptoms included joint pain, malaise, fevers, and night sweats
• The patient was treated with prednisone monotherapy for 3 weeks
• The patient self-referred for management of scars
• Physical examination revealed severe diffuse nodulocystic acne of the face, back, and shoulders, with exuberant scarring, fibrotic plaques, and residual nodules and cysts
• Patient's parent refused retreatment with isotretinoin and prednisone due to fear of side effects
Treatment Approach:
✓ Acute management included:
◦ Minocycline 200 mg daily for 2 weeks followed by 100 mg daily for 2.5 months
◦ Fucidin ointment BID for 3 weeks
◦ Adapalene/benzoyl peroxide gel (TactuPump Forte) for spot treatment
◦ Tylenol with codeine #3
✓ After 6 weeks of acute management, patient received one year of laser treatments (every 4-6 weeks) to address scarring
✓ Over time, significant clinical improvement was observed, with resolution of active inflammation and progressive improvement in scarring
✓ Due to the psychosocial impact of severe acne and scarring, emphasis was placed on trust-building and shared decision-making

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Financial Disclosures

Z.T.: Dr. Taher has received an honorarium from Bausch Health for his role in developing this special supplement.

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