Acne vulgaris: management

Consultation on draft guideline – deadline for comments is 5pm on Friday 5 February 2021 email: AcneManagement@nice.org.uk

	Please read the checklist for submitting comments at the end of this form. We cannot accept forms that are not filled in correctly. We would like to hear your views on the draft recommendations presented in the guideline, and any comments you may have on the rationale and impact sections in the guideline and the evidence presented in the evidence reviews documents. We would also welcome views on the Equality Impact Assessment. In addition to your comments below on our guideline documents, we would like to hear your views on these questions: 1. Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why. 2. Would implementation of any of the draft recommendations have significant cost implications? 3. What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.) 4. The recommendations in this guideline were developed before the coronavirus pandemic. Please tell us if there are any particular issues relating to COVID-19 that we should take into account when finalising the guideline for publication. See Developing NICE guidance: how to get involved for suggestions of general points to think about when commenting.
Organisation name – Stakeholder or respondent (if you are responding as an individual rather than a registered stakeholder please leave blank):	British Association of Dermatologists (the BAD)

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Disclosure Please disclose any past or current, direct or indirect links to, or funding from, the tobacco industry.	N/A
Name of commentator person completing form:	The BAD's Therapy & Guidelines sub-committee
Type	[office use only]

Comment number	Document [guideline, evidence review A, B, C etc., methods or other (please specify which)]	Page number Or 'general' for comments on whole document	Line number Or 'general' for comments on whole document	Comments Insert each comment in a new row. Do not paste other tables into this table, because your comments could get lost – type directly into this table.
1	Guideline	General	General	This is a very comprehensive overview of the evidence and the team should be congratulated.
2	Guideline	General	General	It would be useful to discuss the challenges of comparing studies in more detail given the lack of standardisation of outcome measures in acne and the failure to always capture the impact of acne and what is important to the patient.
3	Guideline	General	General	Many guidelines have failed to secure a robust patient perspective and it would be good to see these guidelines seizing the opportunity to do this through broad stakeholder engagement and to acknowledge this in the final publication as this

				has been noted as lacking in other guidelines.
4	Guideline	General	General	It would be useful to distinguish management approaches for truncal rather than facial acne – there has been significant interest in the literature recently about this.
5	Guideline	General	General	There is no mention of spironolactone in managing acne. It can be extremely helpful in women. **Ref:** Spironolactone in dermatology: uses in acne and beyond. T.N Searle F. Al-Niaimi F. R. Ali Clinical and Experimental Dermatology.2020 Dec vol 45 (8) p986-993. See also comment no. 26.
6	Guideline	3	4	Standardising information and assessing the impact of different formats would be very helpful. The committee suggest there is little evidence to suggest what information people with acne would like to know about. A robust James Lind Alliance Acne Priority Setting Partnership conducted in 2015 provided significant data on what people with acne would like to know more about and this could inform future studies in this area. Raw data is available.
7	Guideline	3	7	Giving patients information about why they have acne – please clarify this point. Would providing the BAD's PILs suffice? https://www.skinhealthinfo.org.uk/a-z-conditions-treatments/
8	Guideline	4	1	There is limited evidence from clinical trials about skin care and as the committee have noted pH is an important factor. Syndet bars are not routinely recommended or used in current everyday practice but multiple OTC products bought by patients it would be useful to emphasise the important of optimising pH and helping to direct patients. The guideline group advises the use of oil-free products – it would be useful to be more specific about this as some essential oils are advocated in acne which causes some confusion. There is some evidence the benzoyl peroxide washes are helpful in reducing resistant and sensitive strains of *C. acnes*, so potentially may provide a useful adjuvant in a treatment regimen if people in longer term treatments that may drive antimicrobial resistance.
9	Guideline	4	2	We are concerned about the recommendations of "syndet" products. We cannot find any robust evidence for this and it seems that it will lead people to purchase expensive specialist products rather than soap.
10	Guideline	5	5	"Persistent pigmentary changes secondary to acne" should be referred to secondary care dermatology. We are not clear why these patients should be referred at all, as NHS England does not allow treatment of cosmetic problems in the NHS.
11	Guideline	8 and 41	Table and 5	In the tables some colleagues would also add in use of topical retinoids on alternate days initially as clinicians may just look at the tables as a short cut. Also in the tables, we would suggest mentioning that azelaic acid is less irritating than topical retinoids.
12	Guideline	6	From 7	*Mild-to-moderate acne* A minor point, the report refers to antiseptics and includes benzoyl peroxide in this – in fact, benzoyl peroxide is a very effective antimicrobial and I would broaden this heading to "antiseptics/antimicrobials". The use of fixed combination products is recommended but there may be practical reasons why patients may not be able or want to use some products, e.g. benzoyl peroxide on the trunk due to bleaching. Fixed dose combinations that do not include benzoyl peroxide but include a topical antibiotic, e.g. tretinoin/clindamycin

				are likely to promote Antimicrobial resistance over time and therefore some caution about prolonged use would be helpful. Evidence would suggest AMR in *C. acnes* emerges by 12 weeks when using a topical antibiotic agent and the presence of resistant strains can correlate with reduced efficacy and resistant strains can be transferred to others. This should be considered in recommendations.
13	Guideline	6	From 7	*Moderate-to-severe acne* As above topical retinoid and clindamycin has potential to drive antimicrobial resistance may wish to discuss limiting the duration or adding in benzoyl peroxide. It would be useful to consider what oral antibiotics are appropriate in those not able to tolerate tetracyclines or in younger children. Erythromycin or trimethoprim may be alternatives to consider. It would be useful to discuss use of antibiotics and other treatments in pregnancy – note recent concerns about erythromycin use in pregnancy and foetal abnormalities. Regarding cumulative dose of isotretinoin – the early studies were all conducted using the parent drug Roaccutane - it has been suggested that there are some differences in absorption with generic formulations and the medication is very lipophilic meaning that absorption may be significantly affected by fat intake in the diet. This has challenged the evidence around cumulative dosing regimens. It is also clear that some patients do require higher cumulative doses as has been reported in the literature. These facts would be useful to consider further in any discussion and to confirm that cumulative dosing provides a guide, but that clinical assessment is important, and some patients may need more, or less (as has been stated). Isotretinoin – would be useful to confirm this is not contraindicated in patients with mental health issues but clearly need to have appropriate support in place. There is no evidence that dose of isotretinoin relates to mental health issues it would be useful to clarify this.
14	Guideline	6	15	The guideline suggests fixed combinations, which may be more effective as first line, but there is no statement about those that may not tolerate being able to use monotherapy of, e.g. adapalene rather than adapalene and benzoyl peroxide fixed combination.
15	Guideline	7	Table	The guideline does not mention macrolides or trimethoprim as options which are used occasionally as second line. Is trimethoprim not mentioned in view of a higher risk of SCARS and best not prescribed in the community?
16	Guideline	7	Table	There is a higher risk of developing bacterial resistance with macrolides, but it can be beneficial in patients not tolerating tetracyclines or when tetracyclines are contraindicated. We fear GPs will refer more without using an oral antibiotic if only oral tetracyclines are advised prior to referral.
17	Guideline	8	1	We feel that azelaic acid should be another alternative as well as benzoyl peroxide.
18	Guideline	10	18	We disagree with the recommendation that prohibits use of oral antibiotics for more than 6 months. The scenario would be a patient who is responding well but is not appropriate for or does not wish to take isotretinoin? There is no evidence that resistance is more likely to arise between 6-12 months than for the first 6 months of treatment. A “do not”

				recommendation usually arises when the evidence indicate the harms outweighing the benefits. This recommendation will result in more patients being treated with isotretinoin.
19	Guideline	11	17	The list should also include those who have failed other treatments.
20	Guideline	11	17	We disagree with the recommendation that for management of severest forms of acne, e.g. nodulo-cystic acne/acne fulminans, two 12-week courses of antibiotics and topical therapy need to have tried first prior to isotretinoin. In cases of severe acne, it may sometimes be appropriate, using clinical judgment, to give isotretinoin as a first option alongside other treatments.
21	Guideline	12	13	Very clearly written regarding the PPP for isotretinoin, i.e. it will be for *everyone* with potential to become pregnant – this may impact some of our colleagues' practices and needs to be highlighted when the guideline is finalised.
22	Guideline	12	13	There is also an opportunity here to provide absolute clarity regarding the PPP for isotretinoin: a. Regarding the requirement that all with 'potential to become pregnant' on isotretinoin follow the Pregnancy Prevention Programme. There is no definition in the guideline of 'potential to become pregnant', e.g. is it biological potential, or behavioural potential. b. What is meant by 'inform them that they will need to follow the Pregnancy Prevention Programme', i.e. is the recommendation 'to inform' them of this or 'to make sure that they follow' it? c. Has the matter of exceptions to the PPP been considered by the guideline group, e.g. if patients decline it, or if they are abstinent, or if they are on highly effective contraception. **Ref:** https://assets.publishing.service.gov.uk/media/5c936a4840f0b633f5bfd895/pregnancy_testing_and_contraception_table_for_medicines_with_teratogenic_potential_final.pdf.
23	Guideline	12	20	The statement to give a dose adjustment/reduced dosage for patients with a previous/current mental health disorder is unclear. The 2010 BAD isotretinoin guideline emphasises that mental health disorder is unlikely to be dose-dependent and not reliably related to pre-existing mood disorders.
24	Guideline	13	12	We are concerned about the PDT recommendation and the fact that having it on the NICE guideline would force us to provide this service. This would be a particular problem post-COVID, where PDT services might get priority over more urgent backlogs. It is also heavy on resource, rooms, nursing times and budgets as the photosensitisers are expensive.
25	Guideline	14	4	The dosage of triamcinolone at 0.6 mg/ml is unusual – what literature evidence is available?
26	Guideline	14	9	There are guidelines for management of PCOS and it would be useful to align these to recommendations so consistent for community practitioners. Regulatory authorities currently suggest hormonal treatments for acne should be used in adult women who also require a contraceptive and the current suggestions may be at odds with this. The likelihood of relapse is higher in patients with PCOS and it would be useful to consider use of maintenance in this group.

				If basing recommendations on experience rather than evidence which is not available, it would be worth discussing use of spironolactone.
27	Guideline	16	4	Some colleagues would question the recommendation that maintenance therapy is not needed. We suggest rewording this phrase in a less contradictory way, i.e. maintenance therapy with a topical agent is often required long-term to maintain clear skin.
28	Guideline	16	8	This is also mentioned in the maintenance section, but this should be an option for patients with a high risk of irritancy first-line.
29	Guideline	16	12	Consider removing this point as some people will need the topicals long-term and it does not need regular questioning.
30	Guideline	16	14	There is some recent evidence to suggest early intervention can reduce the likelihood of scarring but as the committee suggest there is probably an innate susceptibility as it has been shown patients who scar mount a different innate immune reaction that those that do not. As such the severity of the acne may not be the main contributory factor and it would be useful to emphasise the important of recognising scarring early and managing accordingly as resultant scarring is so challenging to treat.
31	Guideline	17	5	Treatment options for acne-related scarring including "glycolic acid 5 peel or CO_2 laser treatment (alone or after a session of punch elevation)" but these are not routinely commissioned by any CCG. Inclusion may clash with commissioning practices and change patient expectations. Some colleagues feel very strongly about treatments not available on the NHS listed in the guideline. If they remain it should be clear this *currently* is only available privately. There is also some concern that those in the beauty industry may start to offer such treatment privately and without the necessary qualification and experience.
32	Guideline	26	1	The guideline should be phrased in a more permissive way, emphasising that so long as patients with previous/existing mild/moderate depression with no history of suicidality/self-harm are followed up regularly (and this could be in primary care/with the dermatology team/with the help of the patient's support network if they have a good one), isotretinoin is not contraindicated, and patients do not necessarily need to be seen by a mental health specialist beforehand.
33	Guideline	28	6	There should be discussion of using erythromycin in pregnancy if severe acne/psychological distress after careful discussion with patients and avoiding the first trimester.
34	Guideline	30	18	Some colleagues feel that isotretinoin can sometimes be an appropriate first-line treatment for patients with very severe acne who, in the professional opinion and clinical experience of a dermatologist, would be unlikely to respond adequately to other therapies. Yet the guideline and MHRA guidance specify it should never be used unless adequate courses of standard therapies have been tried first.
35	Guideline	33	13	The guideline specifies that isotretinoin should be prescribed for patients with 'severe' forms of acne who have failed to respond to standard therapies (in line with the guidance on the MHRA drug safety update on isotretinoin). However, many patients would be classified as having 'moderate-to-severe acne' rather than 'moderate' acne, and the current guideline limits patients and dermatologists who wish to use isotretinoin for those with truly moderate acne which has

				failed to respond to other therapies and causes distress. Perhaps section 1.5.15 should be rephrased to read 'Consider oral isotretinoin for people who have a moderate-to-severe form of…'
36	Guideline	39	27	There is evidence that some patients, under certain circumstances, benefit from cumulative dosages of isotretinoin >150 mg/kg in a course of treatment (e.g. reduced rates of relapse in those who have previously relapsed following a previous course, without increasing adverse effects). The guideline mentions that patients who have relapsed following two separate courses of isotretinoin might benefit from a tailored approach, including changes in dose or duration of isotretinoin. There is scope for the guideline to be far more specific than this. Many dermatologists use higher cumulative dosages at an earlier stage. **Ref:** Blasiak RC, Stamey CR, Burkhart CN, Lugo-Somolinos A, Morrell DS. High-dose isotretinoin treatment and the rate of retrial, relapse, and adverse effects in patients with acne vulgaris. JAMA Dermatol. 2013 Dec;149(12):1392-8

Insert extra rows as needed

Checklist for submitting comments

- Use this comment form and submit it as a **Word document (not a PDF)**.
- Complete the disclosure about links with, or funding from, the tobacco industry.
- Include **page and line number (not section number)** of the text each comment is about.
- Combine all comments from your organisation into 1 response. **We cannot accept more than 1 response from each organisation**.
- Do not paste other tables into this table – type directly into the table.
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- **Clearly mark any confidential information or other material that you do not wish to be made public. Also, ensure you state in your email to NICE that your submission includes confidential comments.**
- **Do not name or identify any person or include medical information about yourself or another person** from which you or the person could be identified as all such data will be deleted or redacted.
- Spell out any abbreviations you use
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- **We do not accept comments submitted after the deadline stated for close of consultation.**

You can see any guidance that we have produced on topics related to this guideline by checking NICE Pathways.

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