A Hands-on Approach to managing Acne and Acne Scarring

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Acne is the commonest skin disease, affecting 80% of teenagers and an estimated 20% of adults. Acne can present as a mild disease with no sequelae or as an extensive severe nodular-cystic disease involving the face, chest and back that invariably results in significant scarring.

Acne is a multifactorial disease, which can be inherited or may result from hormonal factors. Understanding the underlying causes of acne is essential for successfully controlling active disease and preventing recurrences.

My Acne Classification

1. Mild – Mainly blackheads, occasional pimples
   Mild pigmented scarring
   Breakout around period only – (adult females)

2. Moderate – Combination of blackheads, pimples and pigmented scars,
   Occasional cysts
   New breakouts most days
   Breakout throughout the cycle – (adult females)

3. Severe – Daily breakouts
   Combination of blackheads, pimples, and cysts
   Pigmented and depressed scarring

My Acne Treatment Protocol

I examine every new acne patient under a magnifying light and assess their acne severity through extraction. It is very hard to judge acne severity or scarring from the other side of the desk. As acne severity can vary I always ask if what I am seeing is their usual amount of breakout.

I always explain to my patients why they are breaking out. I find using a skin diagram very useful. I explain the role of hormones in stimulating the sebaceous glands, the phenomenon of hyperkeratinisation and why scarring occurs. For female patients whom I suspect may have PCOS, I recommend a blood test to check SHBG, FAI and DHEAS or an ultrasound if they are taking the OC pill.

For moderate and severe Acne I use a treatment protocol that combines tretinoin, glycolic acid and hydroquinone. This protocol in combination with hormonal treatment for females who do not get complete remission with the cream protocol, is effective for over 80% of my patients. I rarely use antibiotics either topically or orally. All young males with nodular-cystic acne involving their chest and back are referred for a course of Isotretinoin. I seldom refer females for isotretinoin as, in my experience, they are at highest risk of relapse and in most instances can be well controlled on a combination of tretinoin and anti-androgen therapy.

Because tretinoin causes sun sensitivity, lifestyle and in teenagers, sporting commitments, must be considered. Adapalene, in my opinion, is a far less effective medication than tretinoin but worth trying in those patients who cannot commit to staying out of the sun. Alternative therapies for these patients include light therapies (IPL, Blue/Red light and PDT with ALA) and antibiotics. For patients who are resistant to tretinoin plus anti-androgens/ antibiotics, consider Isotretinoin if acne severity merits it. Otherwise, it is a trial and error process to find a successful treatment combination.

I explain the role of the different creams in the treatment process. I answer all the patient’s questions, even the silly ones. In my experience, most patients have never been given an explanation as to why they have acne and they will often have all sorts of strange ideas as to their acne’s cause. If they understand why they are breaking out and why the creams will work, they will be compliant and obtain excellent results.

My Acne Scarring Protocol

Pigmented acne scarring can be successfully bleached out of the skin with a combination of tretinoin and hydroquinone. I treat depressed acne scarring with skin needling and, for deeper scars, subscission. Skin Needling and subscission require multiple treatments. Skin Needling’s success in filling depressed scars is dependent on the patient’s own collagen growing ability. I combine in clinic Skin Needling with home needling to accelerate results. For isolated scars I use Skin Needling with microcurrent.