According to the National Rosacea Society (NRS, rosacea.org), up to 16 million Americans have rosacea, a chronic potentially progressive disease demonstrated to negatively impact an individual’s quality of life (QOL). Though no cure is yet available, several effective therapies are marketed for rosacea, and treatment is shown to improve QOL. Nonetheless, some cases of rosacea are challenging. Complicating patient management is the possibility of a misdiagnosis. Several common and uncommon cutaneous conditions can mimic rosacea, leading clinicians to implement an ineffective treatment regimen for the patient. Below is a summary of rosacea mimickers with an emphasis on treatment for each.

Demodex Dermatitis

Perhaps the most controversial of the rosacea mimickers, Demodex dermatitis refers to a distinct condition that is separate from but that could overlap with rosacea. Although there is evidence for an association between rosacea and the Demodex folliculorum mite, there is no sound evidence to suggest that Demodex are causative in rosacea.

Demodex dermatitis (Fig. 1) is characterized by facial erythema, dryness, scaling, and roughness with or without papules/pustules. The diagnosis is generally confirmed through successful response to anti-infecitive therapy.

Demodex dermatitis will respond to permethrin, crotaminton, or ivermectin therapy, any of which is effective against the mite. Standard dosing for Permethrin (Elimite, Allergan) or Crotamiton (Eurax, Novartis) is twice daily for four weeks. Alternatively, ivermectin 3mg orally in a single dose may be effective.

Perioral Dermatitis

Perioral dermatitis is an inflammatory eruption focused about the mouth, nasolabial folds, and chin and is distinguished from other dermatoses by the sparing of a clear area between the eruption and the vermilion border. It has been suggested that perio-

Take-Home Tips. Several common and uncommon cutaneous conditions can mimic rosacea, leading clinicians to implement an ineffective treatment regimen for the patient. Demodex dermatitis refers to a distinct condition that is separate from but that could overlap with rosacea. Perioral dermatitis is an inflammatory eruption focused about the mouth, nasolabial folds, and chin and is distinguished from other dermatoses by the sparing of a clear area between the eruption and the vermilion border. Folliculitis, possibly mediated by various different contributors, may mimic rosacea. Pseudorhinophyma describes a condition that has the appearance of rhinophyma but is in actuality mechanical in nature. The condition is typically caused by swelling of the nose due to pressure from tight-fitting eyeglasses.
Perioral dermatitis may present in association with rosacea, though this has not been well studied. Nonetheless, topical antimicrobials, including metronidazole, erythromycin, and clindamycin, as well as topical azelaic acid, have all been suggested as effective for perioral dermatitis and are all used for the treatment of rosacea, as well. Alternatively, anti-inflammatory dose doxycycline (Oracea, Galderma) once daily for four weeks has been effective for perioral dermatitis in my practice.

Steroid-induced dermatitis (Fig. 2) generally presents with a distribution of lesions that is similar to that for perioral dermatitis; a key difference is involvement of the skin adjacent to the vermillion border. To identify steroid-induced dermatitis, or what I term steroid use/abuse/misuse dermatitis, question patients about topical application of prescription or OTC corticosteroids to the face. Withdrawal of corticosteroids is curative, typically with immediate cessation of drug application. In certain cases, tapered withdrawal is indicated to prevent a flare.

**Folliculitis**

Folliculitis, possibly mediated by various different contributors, may mimic rosacea.

**Sycosis Barbae.** Sycosis barbae is characterized by follicular pustules with a surrounding halo of erythema and is localized to the beard area of men only. This staphylococcal infection is also called sycosis vulgaris or Barber’s itch.

**Malassezia folliculitis.** Malassezia folliculitis (previously called pityrosporum folliculitis, Fig. 3) is characterized by papulopustules in a follicular pattern on the back, chest, upper arms, and, occasionally the neck, and face into the scalp. Monomorphous erythematoid papulopustules that measure 1-2mm in diameter also mimic acne vulgaris. Treatment is ketoconazole 200mg ii once daily for two to four weeks.
Herpes simplex folliculitis. Herpes simplex folliculitis (Fig. 4) is a very rare presentation, affecting only about four in 76,500 individuals. Patients may or may not have a history of HSV infection at the time of presentation. The condition affects men and women equally and, unlike sycosis barbae or pseudofolliculitis barbae, is not localized to the beard area. Patients who are HIV positive may be at increased risk for developing herpes simplex folliculitis. Oral antiviral therapy is effective for treating acute herpes simplex folliculitis.

Pseudofolliculitis barbae. Pseudofolliculitis barbae or PFB (Fig. 5) may be described by patients as “razor bumps” or “ingrown hairs.” The papular, pustular, follicular-based disorder is not mediated by any infectious organism, rather it is an inflammatory response. The condition is most common in black males, where highly curved and flattened hairs fail to emerge from the follicle but instead become convoluted within the follicle. Oral doxycycline or minocycline may be instituted as treatment for their anti-inflammatory effects, as may topical calcineurin inhibitors. Topical benzoyl peroxide/clindamycin applied twice daily for two to 10 weeks has been shown effective.7

Laser hair removal may be used adjunctively to treat PFB and reduce the risk for recurrence. The treatment had been contraindicated in patients with skin phototypes IV-VI or sun-tanned skin but can now be provided safely and effectively in these patients.8 Laser and light therapy is shown to permanently destroy hair root, thus eliminating the hairs that mediate the inflammatory papules.

Tinea barbae. Sometimes called ringworm of the beard, tinea barbae (Fig. 6) is a very uncom-
mon superficial dermatophyte infection of the beard. It may be very localized with intense inflammation or more diffuse with a somewhat reduced inflammatory component, similar in appearance to tinea corporis. Systemic antifungal therapy is preferred.

**Pseudorhinophyma**

Phymatous rosacea (Subtype 3), characterized by thickened skin, nodules, and anatomical enlargement, is far more common in men than women. Rhinophyma or enlargement of the nose is likely the most common presentation of phymatous rosacea. However, not all tissue swelling of the nose is attributable to rosacea. I use the term pseudorhinophyma (Fig. 7) to describe a condition that has the appearance of rhinophyma but is in actuality mechanical in nature. The condition is typically caused by swelling of the nose due to pressure from tight-fitting eyeglasses.

Suspicion for pseudorhinophyma is suggested any time a patient with no history of rosacea presents with apparent rhinophyma. In the patient with a history of rosacea and even the patient with a diagnosis of rhinophyma, it may be wise to assess for proper fit of eyeglasses, which may be exacerbating the underlying phyma.

Dr. Bikowski has served on the speaker’s bureau or advisory board or is a shareholder or consultant to Allergan, Corza, Galderma, Stiefel/GlaxoSmithKline, Intendis, Medicis, Promius, Quinova, Ranbaxy, and Warner-Chilcott.

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