Researchers and clinicians have intensified their focus on the problem of preadolescent acne, which may be becoming more prevalent. In fact, one study revealed that more than three-quarters of girls age nine to 10 had evident acne lesions. While it is unclear why preadolescent acne may be increasing, the issue is addressed in the latest consensus guidelines on pediatric acne management. The guidelines, authored by the American Acne and Rosacea Society (AARS) and published in *Pediatrics*, emphasize the need to address acne in pediatric patients of all ages and to consider the potential psychosocial impact of the condition on affected patients.

**TREATMENT OPTIONS**

Acne in a patient who is nine- or 10-years-old probably is not significantly different clinically from acne in a 13- or 14-year-old—although early acne in the preadolescent may feature a predominance of comedones and “non-inflammatory” lesions. Still, clinicians may be inclined to approach treatment with caution. For one thing, most of the topical acne therapies currently on the market are indicated for use by individuals 12 years of age or older. Of note, tretinoin gel 0.05% is indicated for use by patients age 10 and older, while adapalene/BPO gel is approved for ages nine and older. There are some published studies using other agents in subjects under age 12, but these agents do not have labeling for younger patients.
In the age of antibiotic resistance, there appears to be an ongoing need for education of and dialogue with non-dermatologists about evolving approaches to acne management. Current standard of care has moved away from the use of oral antibiotics for most cases of acne vulgaris.

"In general," the recently published AARS guidelines state, "treatment of pediatric acne vulgaris is similar to acne treatment in older adolescents and adults and is based on acne pathophysiology."

Of note, a recent publication shows that dermatologists may approach treatment of preadolescent acne differently than pediatricians do. From 1993 to 2009, topical treatments were most widely prescribed for preadolescent acne, with adapalene, benzoyl peroxide, and tretinoin leading the list. However, while dermatologists frequently prescribe topical retinoids, pediatricians appear to prefer antibiotics—particularly oral antibiotics—for preadolescent patients. These findings may have implications for dermatology care providers. For one, in the age of antibiotic resistance, there appears to be an ongoing need for education of and dialogue with non-dermatologists about evolving approaches to acne management. Current standard of care has moved away from the use of oral antibiotics for most cases of acne vulgaris. Additionally, given that patients may present to the dermatology office only after they have already been seen by a non-dermatologist, dermatology practices need to question patients about and carefully consider what treatments the patient may have tried in the past, which may affect treatment decisions.

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PRACTICAL POINTERS

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