Acne is one of the most challenging conditions to treat. We treat many conditions that are chronic and multidimensional, but acne has some unique characteristics: patients expect immediate improvement, but acne only improves with at least four to six weeks of treatment; multiple medications combined with in-office treatments are often needed; most patients are teens; proper use of skincare (cleansers and moisturizers) is important; and compliance is an issue, as well. Measuring the effectiveness of treatment can also be difficult. All these factors make the first visit crucial.

The seeds of success or failure are sown in the first visit. Properly diagnosing the type of acne and selecting the right medications is just one part of a successful first visit. Few providers take advantage of all possible tools to optimize the initial acne visit. This article will not detail specific medications or treatments but instead will focus on other parts of the first visit that are just as important to treatment success. This includes using a new patient questionnaire to easily collect all necessary information from the patient and determine what the patients’ treatment goals are. Use of multimedia patient education, a written treatment plan, modified lesion counts, and other techniques will also be discussed. The end result will be an efficient, productive office visit, improved outcomes, and increased patient satisfaction.

**NEW PATIENT ACNE QUESTIONNAIRE**

The first step in optimizing acne treatment is to obtain a complete history. A chief complaint and a few verbal questions are enough for many diseases, but this approach falls far short for most acne patients. The complexity of the disease itself, coupled with often extensive histories of prior treatments, makes using a short questionnaire ideal. The one described here (and available for download at PracticalDermatology.com) fits on one page and takes patients two minutes to fill out, so it is ready by the time I enter the treatment room. The type and number of questions will vary depending on the provider’s treatment style.

1a. How long have you had acne?
1b. **Females Only**: Do you have regular monthly periods?
   - [ ] Yes
   - [ ] No

Do you break out worse during or around your period?
   - [ ] Yes
   - [ ] No

If Yes circle how bad your breakouts around your period are:
   - [ ] mild
   - [ ] moderate
   - [ ] severe

The typical answer may be “since I was 12,” but this basic question helps you to identify atypical forms of acne. Hormonally influenced acne and PCOS symptoms are other vital pieces of history needed from your female patients.

2. What non-prescription, over-the-counter products are you using now for your acne? This includes cleansers and moisturizers.

Cross-referencing OTC cleansers and moisturizers listed here (or their lack of use) with question four about skin types forms a good basis for a discussion of proper skin care.

3. What prescription products have you used now and in the past? Did they work? Did you have any side effects
like dry skin or allergic reactions? Please provide details below. There is one line labeled “prescriptions using now” and one line labeled “prescriptions used in the past”. The most common answers you see here are patients stopping their prescription acne medications because the didn’t work or because of dryness or stopping antibiotics because of upset stomach or other side effects. If the patient indicates a certain medication didn’t work, be sure to ask how long they used it. They may have stopped in less than a month—less time than it takes for most medications to begin working.

4. Check the skin type you have:
- Very oily
- Oily
- Normal
- Dry
- Very dry
- Sensitive
- Combination
If sensitive, what is your skin sensitive to?

This question, cross-referenced with question three and two, often sheds light on past treatment failures. Most notably, using drying acne regimens for normal, dry, very dry, sensitive, and combination skin.

5. On a scale of 1-10, how do you rate the amount of stress your acne causes you (10 being extremely stressful)?

This is a vital question. Acne regimens can be complicated or minimal, depending on patient need and motivation. Perhaps you feel the patient would benefit from multiple medications plus monthly in-office treatments. Figuring out how far to go depends not only on the patients’ clinical picture but their psychological one as well. There is a correlation between how stressed a patient is about their acne and their willingness to accept and comply with more intensive acne regimens.

Patients who rate their acne as lower stress are more commonly teen males (possibly ones whose parents initiated the visit) or adults with mild acne. For these patients a simple regimen is usually best. The majority of patients rate their acne stress at six or above, with a significant number circling 10. These patients are very motivated and usually willing to do whatever the clinician recommends.

6. Are there any particular acne treatments that you are interested in discussing today?
- Microdermabrasions
- Chemical peels
- Accutane/Isotretinoin
- Scar treatment/lightening
- Other

Question six targets patient preference and expectations. What does the patient want? Early in the visit, we know what type of regimen we would like to prescribe, but if it doesn’t take into account what the patient wants, it won’t be successful. A common response is either circling Accutane or putting a slash through it indicating the patient does not want to consider it. Here you find out if patients are open to in-office treatments. Many of your more motivated patients will circle everything and write under “other,” “anything that will help.”

7. Please check any of the following acne related concerns you would like to discuss today:
- Acne scars
- Discoloration
- Painful acne cysts
- Oily skin
- Blackheads

This question targets the specific aspect of their acne that bothers the patient most. For example, a patient with darker skin may have occasional cystic acne but is really bothered by “acne scars,” which in reality is post-inflammatory hyperpigmentation. This question allows you to focus the treatment plan on the aspect of acne that troubles your patient most.

8. I will need to achieve a minimum ___% improvement to consider my acne treatment a success.
- 30%
- 40%
- 50%
- 60%
- 70%
- 80%
- 90%
- 100%

You have to assume that all your acne patients believe that they will use medications for a few months and their acne will be cured. This common view is in line with what they see in advertising and the media. The vast majority of patients circle 80-100 percent. If a patient is a candidate for isotretinoin, these expectations can largely be met. Everyone else will have to have their expectations managed regarding the effectiveness of their medications and how long they will take to work. There is a minority of patients, usually with mild acne, who circle 50 percent, who really just want a simple regimen and don’t expect total clearance.

MULTIMEDIA PATIENT EDUCATION

With the questionnaire, you have now obtained a more complete, detailed and useful history. The next step is to improve the patients’ knowledge about acne and what medications and treatments are available. Imagine how much smoother the initial patient visit would be if the patient were better educated before talking to you for the first time. This can easily be accomplished through the use of Multimedia Patient Education (MPE). This involves having the patient view an audio-visual presentation prior to talking to you face to face.

MPEs have been proven in multiple studies to educate patients as well or better than face to face interactions with trained healthcare professionals. One reason MPEs are cited as being effective is the patient is alone in a room and able to absorb the information in a low pressure environment. Another reason for their effectiveness is their combination of visual and audio information. Keep in mind that the purpose of using an MPE is to enhance

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Pearls for Effective Communication with Acne Patients

Experts share their tips for educating acne patients to support adherence.

A companion to “Optimizing Acne Treatment”

COMPILED BY STEVEN LEON, MS, PA-C

Over time, every clinician develops her or his own style of patient management. To help improve communication with patients, I asked leading acne specialists to share their perspective on establishing a successful relationship with acne patients of any age. Ahead are their pearls.

FOCUS ON ESTABLISHING ENGAGEMENT

By Julie C. Harper, MD

There are a few things that acne patients frequently do wrong that I make sure I emphasize at the first visit. All patients have an expectation of fast results. I tell them that at the two-month mark, which is when I do my first follow up (a one month follow-up is a good option, too, if your clinic schedule allows for it), you should be about 40-50 percent better. It takes about four months to be 80-90 percent better. If the patient is a teen I may tell them not to go to mom or dad the first month and say that the treatment isn’t working. Sometimes I even pick a date four months in the future so they have a concrete date in their mind as to when the treatment will have taken full effect.

The other common mistake patients make is that they want to spot treat. It is vital that patients understand that the medication is to prevent pimples and they are to be applied to the entire affected area. Patients also tend to use too much medication. I tell patients that you do not apply this like a moisturizer or sunscreen, this is a drug; use only a pea, or chocolate chip size amount. Using more will only give you more side effects and not a better result. If I prescribe multiple products I stress that all the products I prescribed work in different ways and they are all important to effectively treat your acne. Some patients tend to pick which medications they like best and return to follow up not using the entire regimen.

On the follow-up visit, some patients may not always see the same improvement that you are seeing due to post-inflammatory erythema and PIH. Success is not only that the patient is getting better but that the patient perceives that they are getting better and that they are satisfied. On follow up I conduct a close physical exam, palpating the face and trying to get the patient to focus on how many new acne lesions are forming and drawing the connection for them that you are having less new lesions which means less post inflammatory erythema and PIH over time. After the patient improves a common mistake patients make is to stop their medication thinking that the medications have given them a permanent reduction in acne.

For teens who seem disengaged during the office visit, an important question to ask is, “Does your acne bother you?” Teens need to know that they are the most important person in this team and that they are going to be responsible for the treatment. This message is reinforced by talking to the teen through the entire visit and maintaining as much eye contact as possible with them. If the teen seems totally disinterested, there is nothing wrong in asking them if there acne bothers them to get a more realistic sense of what the patient is willing to do to improve their acne.

Compliance is always a challenge. A patient’s view of compliance is often very different than ours. A patient may perceive they are compliant when they have only used one small sample tube for an entire month. Asking open-ended questions like, “How many times a week are you using the cream or pill?” or “Tell me what you are using and how you are using it?” is helpful, because it makes the patient come up with the answer, which can reveal how compliant they really are. If you discover the patient is not compliant, it is important not to take a punitive approach but to let the patient know that you are on their team and here to help. We all know that compliance is a major barrier to acne treatment and if the patient is struggling, look for ways that we can help. Talk with the patient to find out why they weren’t using the medications emphasizing that you want to help them succeed. I will review the medication regimen to see if they were too irritating, if the regimen was too complicated, too expensive or wasn’t the best fit for their lifestyle. When you approach the patient in a compassionate, helpful way you will get a much better response and ultimately better outcomes.

Discussing skin care is also very important. I have found that if you don’t tell the patients the cleansers and moisturizers that are appropriate they usually wind up purchasing products that

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are too abrasive or irritating which can contribute to treatment failures. Once patients are getting good results, we must remind them to continue using their medications because their acne is not cured just under control.

Dr. Harper is Clinical Associate Professor of Dermatology, University of Alabama Birmingham and is in Private Practice.

ESTABLISH CONFIDENCE
By James Leyden, MD, FAAD

Most acne patients are young have no frame of reference for having a chronic disease. Their experience is using medications for short periods of time to treat acute problems. I stress on the first visit that the medications will take six weeks to work. I also educate them that they will be getting less inflamed lesions, but the red marks from the old pimples will take some time to fade. If you don’t explain this point, patient will mistakenly feel they aren’t getting better even with less active inflamed lesions.

During the first visit it is important to sit down and explain to patients what causes acne and how the medications work. I have found Visual aids or drawing diagrams to greatly aide educating the patient. Although they will not remember everything you say, you are instilling in them confidence that you are an expert, which is extremely important and increases compliance.

Teens especially are ashamed and embarrassed of their acne and often feel hopeless. I find it crucial to deliver two messages to them loud and clear. The first is, it’s not your fault! Acne is largely genetic and not caused by bad hygiene or eating the wrong foods (perhaps exacerbated in a minor way but not caused). The second message is “you will get better!” If these medications don’t give us the results we are looking for, we will climb up the latter of treatments until we find something that does. You are off to a great start when you can set proper expectations, give the patient confidence in yourself and the treatments, as well as give them hope.

Dr. Leyden is Emeritus Professor of Dermatology at The University of Pennsylvania.

USE THE FOLLOW-UP TO ASSESS THE REGIMEN

By Diane Thiboutot, MD

Setting expectations in one of the most important things to do in the first visit. I let patients know that the medications take six to eight weeks to start working. Patients expect acne medications to work far faster, and their only experience may be treating short term, acute problems. I urge them to be patient and stick with their regimen and let them know that I am open to change it in two months it if we are not getting good results. They are also under the impression that their acne will be cured. I let them know that acne lasts typically till the late teens but can even go into adulthood and the goal is to decrease acne to a manageable level. I briefly go over what type of acne lesions the patient has and how their medications help each type of lesion.

To measure improvement, I make a quick estimate of the number and type of lesions found for comparison on the next visit. Patients should be educated to look for a decrease in new lesions on follow-up and not to be distracted by the brown and red marks from previous acne, which will take some time to fade. Another thing I emphasize at both the first and follow-up visits is how to apply their medications, stressing that these medications prevent new pimples from forming, are not for spot treatment, and are to be used on the entire face because you can’t predict where acne will appear. Lastly I show them how to put on their acne medications, to use a pea sized amount, placing a stripe of the medications in all areas, which further reinforces total face application rather than spot treatment. Patients may be reluctant to use moisturizers and should be encouraged to use non-comedogenic moisturizers as needed.

I schedule the first follow up for eight to 10 weeks. I feel that scheduling the patient before that time gives them the expectation that they will be better, which may not be the case. This would then lead to them wanting their treatment changed before it has the opportunity to take full effect. At the follow-up visit, I ask open-ended questions for example, “Tell me what you are treating your acne with, how often you use it?” Of course I know what they are using but if a patient has poor recollection of their acne routine, they probably have not established one yet. You may even uncover that certain medications have not been used at all or have not been picked up from the pharmacy. Another crucial question to ask on the follow up is “How do you use your acne creams?” A surprising number of patients will report that they are using their topical for spot treatment, and then I reinforce the patient education from the first visit advising against spot treatment.

Even though many patients are young, I communicate and try to engage them as much as possible, even if they seem “tuned out.” I ask them questions to figure out what their normal routine is and plan a regimen that is compatible with it for increased compliance.

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interactions with patients, not to replace one-on-one patient education. If you do little patient education and rush through the visit, the patient may feel like you showed them the MPE instead of talking to them, and the approach could backfire.

MPE could be as simple as making a PowerPoint or Keynote presentation with voiceover and having patients view it in the treatment room before they fill out the questionnaire. For the presentation to be effective, it has to be short (around two minutes), covering the major points and leaving the fine points for discussion. In a slideshow format, this is usually accomplished in about six slides. Resist the urge to put too much text in the slides as they rotate every 20-30 seconds. Instead, focus on pictures with captions and short bullet lists. If you think of your slideshow as a storyboard, the next logical step is to have it transformed into a short video. In addition to the increased quality of the viewing experience, video allows the patient to see procedures like extractions, cortisone injections, and chemical peels. When choosing someone to produce any video content for your practice, it is best to choose someone with experience in medical video production.

If you are using EMR, you probably have computer monitors in your room. If you don’t and do not wish to purchase them, place your MPE on your website and advise new acne patients to view it before the visit. You can also have the MPE on a tablet and present it to the patient during their initial visit.

THE OFFICE VISIT
Five minutes have passed since the patient was roomed and they have viewed the MPE and filled out their questionnaire. I usually thank the patient for filling out the questionnaire just to acknowledge their extra effort. I then go through their answers to clarify and increase my knowledge of the patient’s history, goals, and needs. I ask them if they have any questions from watching the MPE. I then take a close look at their skin, narrating to the patients what I am observing.

After the physical exam, I start making my treatment recommendations and explain the rationale for each choice and briefly how each treatment works. When I am done, I ask the patient, “How does that sound?” or “Any questions so far?” I call this “checking in with the patient.” A treatment plan is only good if the patient understands it and you have patient “buy in.” This is their chance to ask questions and let you know if they approve of this treatment plan or not. After this important step is complete the prescriptions are written and I ask one final time for any questions.

A WRITTEN TREATMENT PLAN
When I begin making my recommendations I also begin working on a written acne treatment plan. This one-page handout gives the patient a written record of what was recommended and basic information about those recommendations.

When developing this handout, think from the patient’s perspective, using language and concepts that are easy to understand. Start with an overview of what patients can expect in regards to results so they have realistic expectations. Then, outline the critical components of the treatment plan. The format of the handout should allow you to quickly circle the recommended treatment options. If you offer many options, consider listing the prescription medications and medical procedures on the front and the cleansers, moisturizers, and other products or services (i.e., lasers or light treatments) on the back. For more detail on how to construct a customized patient handout see my article “SDPA Member Document Library Lends Clinicians a Hand...out” which is available on the Practical Dermatology DermPerspectives website at http://bmctoday.net/practical-dermatologypa/2012/03/article.asp?f=sdpa-member-document-library-lends-clinicians-a-handout.

THE EXPECTATION GAP
It takes about four to six weeks, depending on the type of treatment, to begin to see improvement in a patient’s acne. Patients are usually expecting dramatic results in just a few weeks. This expectation gap must be addressed in the first visit. If it isn’t, patients may come dissatisfied to their follow-up appointment, or worst of all, discontinue their medication before it had a chance to work. I tell patients that every pimple they see now started four to six weeks ago and the medications work by stopping the formation of new pimples. I tell them that this is why the medication should be applied to the entire area with a history of acne not just to active lesions. This is an important point, as many patients believe topical medications are for spot treatment only. I also stress the importance of compliance. It is equally important to let patients know how soon they will get the improvement they are seeking. In most cases an expectation of 50–75 percent improvement in two to three months is realistic and not so distant that patients become unmotivated.

The next question is when to schedule their follow-up, given such a long onset of action of the drugs. The conventional wisdom is that earlier follow-up yields better compliance. With that in mind, I experimented with shortening my follow-up visit time from my usual one month to two weeks. While this was helpful for some patients, like those experiencing side effects, mostly it was just a compliance check and pep talk of questionable value. As a result, in most cases I still use a one month follow-up. I find a two-week follow-up to be useful for patients with milia, blackheads and inflamed cysts. They can have a dedicated visit for extractions and/or injections and see some immediate improvement. They also get the compliance check and pep talk as well.
IS YOUR ACNE PATIENT GETTING BETTER?

I will never forget the mother of one acne patient. It was the one month follow up and I asked her daughter the same question I ask most of my patients: “Have you seen any improvement?” The mother retorted, “You’re the expert. You tell me!” Nobody had ever said that before. For a second I didn’t know how to respond. Then I told her that if this were an acne study, I would compare lesion counts done last visit to today’s lesion count. I explained that nobody does that in practice because it is too time intensive. She shrugged her shoulders and seemed unimpressed. Her question had exposed the truth, it had been one month, and I didn’t know if her daughter’s acne had improved, which is the key piece of information needed to direct future treatment.

We have to accept the fact that without an objective measurement of the patient’s acne, we largely leave the determination of whether the patient is improving to the patient’s own perception of their acne. This is highly subjective and hardly scientific. Patients depressed about their acne tend to only notice major improvements, patients hopeful that an acne treatment will work or who want to please you will give a more optimistic report. Often times patients with a lot of acne scarring and hyperpigmentation will report that their acne is not getting better even when most active acne lesions have cleared.

Photography is considered inferior to lesion counts as it can be technically difficult to get consistent pictures for comparison, it can be hard to differentiate the depth of lesions (cysts vs. papules), and the comparison of photos has a highly subjective element to it. They are however irreplaceable as before and after pictures. Lesion counts done by well trained providers are the best objective measure we have.

The problem with doing lesion counts in the clinical setting is lack of time. A complete lesion count is usually performed with two people, one counting and one recording. Lesion count time can be reduced by half by counting only one side of the face or body if there is symmetrical distribution of acne. Still this may be too time consuming for clinical practice. Often times I do a modified lesion count, which can be done in a few ways. If the patient has a dominant problem area like the forehead, with the dominant lesion being pustules, I count only the pustules on the forehead or do a complete lesion count on that area. If the person has one dominant lesion across an entire region, for example cysts on the face, I count only those. The idea is to quantify the dominant feature of their acne or the most severe area and use that count for future comparison. This method works quite well and can be done in less than a minute as you do your skin exam. This lesion count becomes crucial at that one-month follow up where you have to decide whether to change treatments or stay the course.

DON’T LET YOUR TREATMENT PLAN FALL APART AT THE PHARMACY

You have a great first visit and the patient leaves satisfied and heads to the pharmacy. You give yourself a pat on the back for a job well done. A few hours later you get the phone call. The retinoid needs prior authorization, the brand name medicine you prescribed is not covered so the coupon doesn’t work, and the patient is upset at the prospect of paying $300 for the medication. You may not even get a call when things don’t go right at the pharmacy. For example, if you prescribe two topical medications and one oral antibiotic, and one of the topical medications isn’t covered, a patient will often just not get it. This may or may not be revealed by the patient at the follow-up visit.

Currently there is no way for us to know whether a certain medication will be covered or at what price, but there are many techniques we can use to become more effective prescribers. This means taking steps to increase the chances that our patients will get the medications we prescribed or an acceptable substitute on their first trip to the pharmacy. It turns out there are many things we can do. A full explanation is beyond the scope of this article but can be found in my two part series “Prescribing Pitfalls” available at http://practicaldermatology.com/2014/01/prescribing-pitfalls-part-i-navigate-the-changing-landscape-of-brand-name-drug-prescribing.

DAILY BENEFITS

Employing the tools and techniques described above has made a huge difference in my ability to treat acne patients. The first visit flows more smoothly and patients are more engaged and better educated. When patients see this kind of infrastructure and methodology, they perceive you as an expert. This gives them more faith in your treatment plan, which leads to greater compliance and improved outcomes. Dermatology is a diverse mixture of medical, surgical, and cosmetic patients. While acne may not be everyone’s favorite condition to treat, it is by far the single largest group of patients we see. Having a system that greatly improves their treatment will provide benefits to your patients and your practice every day.

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