Reassessing Rosacea Diagnosis: ROSCO Update

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The global ROSacea COnsensus (ROSCO) expert panel has issued a new recommendation to establish a phenotype-led rosacea diagnosis and classification, as well as a recommendation on phenotype-based treatments for signs and symptoms presenting in individuals with rosacea. The recommendations appear in the *British Journal of Dermatology*.

“One of the major issues that has come up is really regarding the actual diagnosis of rosacea…the entire aspect of what our essential diagnostic criteria is for this condition,” says Jerry Tan, MD, lead author of the ROSCO panel recommendations. Noting that the most recent proposed classification—the 2002 NRS scheme—was positioned as “a framework” intended to be updated, Dr. Tan says, “over time we’ve noticed that there are some problems with the diagnostic criteria, and the entire paradigm of diagnosis required reappraisal.” Of significance, Dr. Tan says, is the fact that the classification permitted diagnosis of rosacea based on the presence of one or more of four primary features, beginning with flushing.

“The first question is, is flushing independently diagnostic of rosacea, in the absence of other features?” Dr. Tan asks. “Can it be accurately distinguished from emotional flushing, cancerous and post-menopausal reasons for flushing? At present we don’t really have clear indication that we can discern obvious differences except for some very odd forms of flushing.” Similarly, inflammatory papules and pustules could be attributed to adult acne, folliculitis, pityriasis follicularum, other conditions, he notes.

“The problem with telangiectases is, if you look at most adults, you’ll notice a little bit of telangiectasia at the perinasal and alar folds and they don’t specifically exclude that in their criteria. So the majority of adults, based on that criteria, would all have rosacea, which I think is kind of an overstretch,” Dr. Tan says.

The new recommendations focus on two features as clearly diagnostic of rosacea: Central erythema and phyma.

Dr. Tan notes that subtyping that resulted from the 2002 classification scheme, “has led to inadequate determination of phenotypic presentation, partly because it groups multiple phenotypes into one subtype.” This makes study of phenotypes difficult. Subtyping may influence treatment development. “The treatments start to target subtypes that are multiple dimensions of the condition rather than a specific representation phenotypically of that condition,” Dr. Tan says.

A multiplicity of dimensions in a subtype requires multidimensional scales, Dr. Tan says. “In that situation, it becomes much more difficult to discern whether one of those dimensions is improving, two of those dimensions are improving, or maybe multiple ones are improving compared to none.” he adds.

The new recommendations are intended to reflect clinical practice, “rather than trying to squeeze and categorize patients into subtypes, which they may not completely fulfill,” Dr. Tan says. To that end, the ROSCO group also published treatment recommendations. "The challenge of developing a treatment paradigm was facilitated and aided by the fact that there was an updated Cochrane Review on high quality clinical research trials...which meant that we could actually provide some clear, high strength recommendations based on clinical trial data," he adds.

The ROSCO panel sought to reflect a global perspective, and it included valuable input from ophthalmology, Dr. Tan stresses. The goal is to improve diagnosis, treatment, and research, including into the psychosocial burden of rosacea. “It will also help to ensure that we develop validated scales for these individual phenotypes, as well as psychosocial burden. One of the other aspects we really needed was more guidance from the ocular specialists...which is one of the additional strengths of this paper.

Note: Independent of the ROSCO group’s publication, the NRS is reappraising their criteria.