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## Case Report

## Management of severe acne during pregnancy: A case report and review of the literature☆☆☆

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## ABSTRACT

The treatment of acne during pregnancy is often limited by the potential toxicities that are posed to the fetus by the most common and effective acne therapies. As with all dermatoses during pregnancy, the treatment of acne vulgaris in this population requires a thorough understanding of the risks and benefits that are inherent to each treatment. We report on a case of a 30-year-old pregnant patient with severe acne conglobata who showed significant improvement with a combination treatment of topical modalities, oral metronidazole, and low dose prednisone during pregnancy. We also review the literature and present an approach for the care of these patients.

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## Introduction

Acne vulgaris has long been one of the most common reasons for a visit to the dermatologist. Acne affects more than 80% of young adults worldwide and can be found in individuals of all ethnicities and nationalities (Bhate and Williams, 2013; Lynn et al., 2016). Although the general public often considers acne a condition that affects teenagers, studies have shown that a substantial number of pregnant and non-pregnant women in their late 20s and early 30s suffer from acne vulgaris (Collier et al., 2008; Dréno et al., 2014). Acne shows a predominance for female persons through all decades of adult life (Collier et al., 2008) and a recent French survey found that more than 40% of patients of a dermatologist's office who are pregnant presented with acne. The majority of these patients had experienced some degree of acne prior to their pregnancy (Dréno et al., 2014). The mechanisms by which pregnancy alters the course of acne are not well understood. Although some patients experience improvements or no change in their acne status during pregnancy, a substantial number suffer acne flare ups during this time. Women who experience acne exacerbations during

pregnancy may be at a higher risk for similar flare ups during future pregnancies (Dréno et al., 2014).

Although sometimes dismissed as a wholly cosmetic complaint, studies show that acne significantly impacts the quality of life and social functioning of patients and may increase the risk of depression and suicidal ideation (Halvorsen et al., 2011; Pagliarello et al., 2015; Ramrakha et al., 2016; Ritvo et al., 2011; Vilar et al., 2015; Wen et al., 2014; Yang et al., 2014). The treatment of acne vulgaris can be separated into topical, oral, and physical-based treatments and a wide variety of tools are available to combat acne. However, this repertoire shrinks when a dermatologist faces acne during pregnancy. The potential risks to the developing fetus may significantly limit the available treatment options. The dermatologist must carefully weigh the severity and psychosocial impact of an individual's acne against short- and long-term adverse effects. In this paper, we present a rare case of severe acne conglobata that was successfully controlled during pregnancy and review the multiple modalities that are available to treat patients with acne during pregnancy.

## Case report

A 30-year-old primigravid patient at 14 weeks of gestation presented to the dermatology clinic with a chief complaint of severe painful acne. She had previously developed acne vulgaris as a young adult and previously experienced moderate success when treated with minocycline, adapalene, and various oral contraceptive

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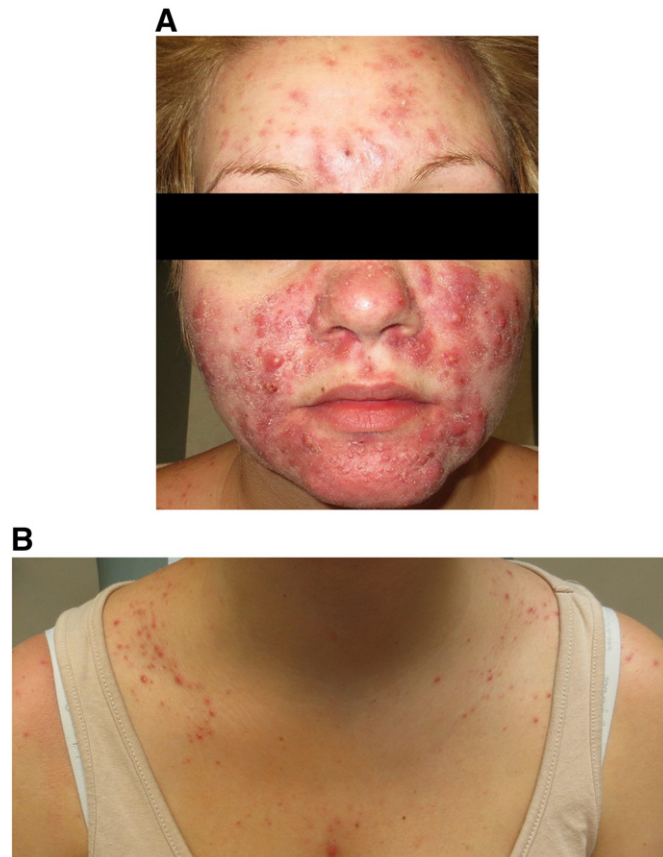
**Fig. 1.** At 14 weeks of gestation: Initial presentation revealed inflammatory nodules and cysts that coalesced into edematous plaques

medications. The patient discontinued all treatment shortly before conception and experienced a significant acne flare up over the past 6 to 7 weeks prior to her initial presentation. Prior to her first visit

with our clinic, an outside dermatologist attempted treatment with sequential courses of oral amoxicillin, cephalexin, and erythromycin with no improvement. The patient was taking oral erythromycin at the time of her presentation to our clinic. A physical examination revealed large inflammatory papules that coalesced into edematous plaques and tender draining nodules that were symmetrically distributed primarily over her central and lower areas of the face (Fig. 1) with lesser involvement on her posterior shoulders.

To formulate our initial diagnosis and treatment plan, both acne conglobata and pyoderma faciale were considered. Although clinically the patient showed several features of pyoderma faciale (i.e., her particular facial distribution, lack of comedones, and demographics), her overall picture was more consistent with acne conglobata. Patients with pyoderma faciale typically have no preceding history of acne vulgaris (Mantovani et al., 2016; Plewig, 1992) and lack truncal involvement. In Plewig et al.'s seminal paper (1992), the authors described trigger-induced flushing that is reminiscent of rosacea as a clear clinical sign of rosacea fulminans and noted that the condition occurs "in previously healthy women with unblemished skin." Our patient's long history of acne vulgaris, lack of trigger-induced flushing, and mild truncal involvement led us to favor a diagnosis of acne conglobata. However, we did feel that her prominent facial nodules and cysts on a background of erythema can certainly be found in patients with pyoderma faciale and acknowledge that our patient displayed features of both conditions.

Due to the patient's severe discomfort at the time of initial presentation and the refractory nature of her cystic acne, the patient was prescribed 40 mg prednisone daily after receiving clearance from her obstetrician. Treatment with erythromycin was continued at



**Fig. 2.** A. At 20 weeks of gestation: Examination revealed modest improvement of inflammatory chin lesions but a wider distribution of nodulocystic acne on the cheeks and forehead B. Flaring of the patient's truncal acne, present at baseline but worsening likely secondary to treatment with prednisone

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