Adapting to Changes in Acne Management: Take One Step at a Time

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After most dermatology residents graduate from their programs, they go out into practice and will often carry with them what they learned from their teachers, especially clinicians. Everyone else in their dermatology residency programs approaches disease management and the use of different therapies in the same way, right?

It does not take very long before these same dermatology residents realize that things are different in real-world clinical practice in many ways. Most clinicians develop a range of fairly predictable patterns in how they approach and treat common skin disorders such as acne, rosacea, psoriasis, atopic dermatitis/eczema, and seborrheic dermatitis. These patterns often include what testing is performed at baseline and at follow-up.

Recently, I have been giving thought to how clinicians—myself included—change their approaches to management of specific skin diseases over time, especially as new information and therapies emerge. Are we fast adopters, or are we slow adopters? How much evidence do we need to see before we consider adjusting our approach? Is the needle moving too fast or not fast enough?

I would like to use an example that relates to acne treatment, especially as this is one of the most common skin disorders encountered in outpatient dermatologic practice. Despite lack of US Food and Drug Administration (FDA) approval for use in acne, oral spironolactone commonly is used in females, especially adults, with acne vulgaris and has a long history as an acceptable approach in dermatology.[1] Because spironolactone is a potassium-sparing diuretic, one question that commonly arises is: Do we monitor serum potassium levels at baseline and periodically during treatment with spironolactone? There has never been a definitive consensus on which approach to take. However, there has been evidence to suggest that such monitoring is not necessary in young healthy women due to a negligible risk for clinically relevant hyperkalemia.[2,3]

In fact, the suggestion that there is a very low risk for clinically significant hyperkalemia in healthy young women treated with spironolactone is accurate based on population-based studies. Nevertheless, the clinician is faced with confirming the patient is in fact healthy rather than assuming this is the case due to her "young" age. In addition, it is important to exclude potential drug-drug interactions that can increase the risk for hyperkalemia when coadministered with spironolactone and also to exclude an unknown underlying decrease in renal function.[1] At the end of the day, I support the continued research that is being done to evaluate questions that can challenge the recycled dogma on how we manage patients, and I do not fault those who follow what they believe to be new cogent evidence. However, in the case of oral spironolactone use, I also could never fault a clinician for monitoring renal function and electrolytes including serum potassium levels in a female patient treated for acne, especially with a drug that has the known potential to cause hyperkalemia in certain clinical situations and is not FDA approved for the indication of acne (ie, the guidance that accompanies the level of investigation needed for such FDA approval is missing). The clinical judgment of the clinician who is responsible for the individual patient trumps the results from population-based studies completed thus far. Ultimately, it is the responsibility of that clinician to assure the safety of their patient in a manner that they are comfortable with.

It takes time to make changes in our approaches to patient management, and in the majority of cases, that is rightfully so. There are several potential limitations to how certain data are collected, and a reasonable verification of results over time is what tends to change behavior patterns. Ultimately, the common goal is to do what is in the best interest of our patients. No one can argue successfully against that.

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