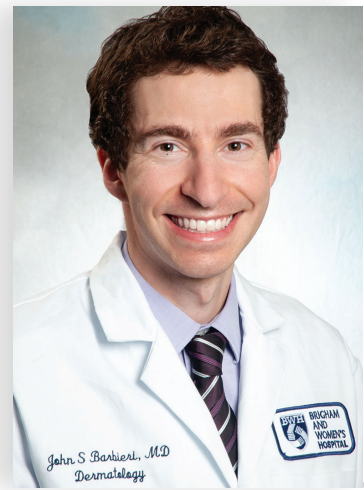




Managing Acne Relapse After Isotretinoin: Tips from John Barbieri, MD, MBA



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Acne recurrence is an important consideration when initiating isotretinoin and counseling patients about treatment expectations. John Barbieri, MD, MBA, discusses factors associated with relapse risk, the role of cumulative dosing and clinical treatment endpoints in promoting long-term clearance, and practical strategies for managing recurrent disease when it occurs. He also shares insights on maintenance therapy, hormonal acne, and how to individualize treatment decisions to balance durable outcomes with potential adverse effects.

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The author has no relevant financial disclosures to report.

Cutis. 2026 July;118(1):12, 15.
doi:10.12788/cutis.1412

Recent data suggest that approximately 20% to 40% of patients treated with isotretinoin have recurrence of acne. How should dermatologists interpret these findings?

DR. BARBIERI: While isotretinoin is highly effective and capable of delivering long-term remission, we should be careful to avoid describing it as a “cure” when counseling patients. Importantly, when acne does recur, it is often milder, and about half of those who have acne recurrence can be managed with topicals alone. For those who do require a subsequent course of isotretinoin, we should view this as an outcome that can be expected to happen in about 1 in 10 treated with isotretinoin rather than a treatment failure.

How important is cumulative dose in preventing relapse, and should we be rethinking traditional dosing targets?

DR. BARBIERI: Cumulative dose is one of the most important factors in preventing recurrence. Multiple studies support that higher cumulative dose is a strong predictor of long-term clearance. In contrast, daily dose does not seem to be as important a factor. However, higher cumulative dose also means longer courses and more potential for adverse effects, including long-term skin and eye dryness. For this reason, I prefer to treat to clinical endpoints of clear skin for 2 to 3 months and at least 120 to 150 mg/kg cumulative dose to balance achieving high cumulative doses with potential adverse effects and risks. For those with fewer adverse effects or who prioritize long-term clearance, we might go a little longer and for those with more adverse effects, we might use a shorter course and

accept a higher risk for recurrence. By taking this approach, we can individualize our dosing approach to each patient.

What factors most strongly predict relapse after a completed isotretinoin course?

DR. BARBIERI: Some demographic factors that have been associated with higher rates of recurrence include greater baseline severity and younger age at treatment. Women with a strong hormonal component to their acne, such as those with polyendocrine metabolic ovarian syndrome (formerly polycystic ovary syndrome), also may be more likely to have recurrence. With respect to clinical factors, increasing cumulative dose has been associated with reduced risk for recurrence in multiple studies, and treating until a clinical endpoint of clear skin for 2 to 3 months also may be predictive of long-term clearance.

When a patient relapses, how do you decide between topical therapy, hormonal treatment, or a second isotretinoin course?

DR. BARBIERI: It depends on relapse severity and patient goals. Mild recurrence often responds well to topical therapies such as retinoids, benzoyl peroxide, antibiotics, and clascoterone. About half of those with recurrence will be able to manage it with topical therapies alone. For those with more severe acne requiring systemic therapy, about half will decide on a repeat course of isotretinoin, which I often find works faster and better than the first course. For second courses, I will typically try to use micronized isotretinoin due to the more consistent pharmacokinetics.

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SPOTLIGHT



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For women—especially those with signs of hyperandrogenism such as hirsutism, irregular periods, or flaring with menstrual cycle—hormonal therapy such as combined oral contraceptives or spironolactone can be a great option. Oral antibiotics also can be a consideration for those with recurrence, though we need to be thoughtful about antimicrobial stewardship and risks of long-term antibiotic use.

Are low-dose or shorter-course regimens contributing to higher relapse rates?

DR. BARBIERI: While there is some evidence that higher daily doses may be associated with lower risk for recurrence, when you control for cumulative dose, it doesn't seem like daily dose has much influence. In contrast, cumulative dose has a large effect on frequency of long-term clearance. While I don't think low-dose regimens are inherently problematic, if they result in shorter cumulative dose courses, that could increase the risk for recurrence.

How does hormonal acne influence long-term outcomes after isotretinoin?

DR. BARBIERI: While all acne is “hormonal,” those with a stronger hormonal pathogenesis, such as women with polyendocrine metabolic ovarian syndrome or other signs of hyperandrogenism, may have a higher likelihood of

recurrence after treatment. In these patients, I often find hormonal therapy such as combined oral contraceptives or spironolactone to be highly effective, even if they haven't worked before.

Should maintenance therapy be routine after isotretinoin, and if so, what strategies are most effective?

DR. BARBIERI: Since many patients have a goal of long-term clearance after isotretinoin, I do not routinely recommend maintenance therapy, as this seems antithetical to this goal. However, for those who are very concerned about recurrence or who would like to be on a topical retinoid for other reasons, I will sometimes start a topical retinoid after treatment with isotretinoin.

How should dermatologists counsel patients about expectations with respect to relapse before starting isotretinoin?

DR. BARBIERI: We should be careful to set appropriate expectations with isotretinoin. I counsel patients that isotretinoin is an incredibly effective therapy for severe acne, with a high likelihood of long-term remission, but not a guaranteed permanent cure. Setting this expectation upfront reduces disappointment if acne does recur and improves shared decision-making.