Managing acne well—a summary of the 2021 NICE guideline

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Introduction

The NICE guideline (NG198) 'Acne vulgaris: management' was published in June 2021.[1] It provides pragmatic suggestions on defining acne severity, initial therapeutic options, what to do when initial treatment is inadequate, and referral indications. The guideline also covers important areas where primary care clinicians can feel uncertain, such as what advice can be offered regarding diet and self-care.

NG198 provides excellent practical advice to all clinicians working in primary care and also includes some advice for secondary care clinicians, for example, on isotretinoin prescribing and the potential role of other treatments, such as phototherapy and scar management.

NG198 clearly differentiates between recommendations based on trial evidence and recommendations based only on the clinical experience of the development group members.

The recommendations are distilled further, highlighting the points that are likely to be the main areas of interest for GPs, primary care pharmacists, and practice nurses consulting patients with acne. This should help colleagues apply the recommendations and could potentially markedly improve the primary care management of many patients with acne vulgaris.

Is the new acne guideline needed?

A paper in the *British Journal of Dermatology* in 2017 supports the view that the management of acne in primary care often diverges markedly from the main recommendations in this new guideline.[2] It seems likely that such divergence may increase the risk of treatment failure, doctor and patient dissatisfaction, long-term disfiguration from scarring, and psychological distress and harm due to inadequate assessment and management.

Publication of this new guideline is particularly helpful given the significant impact that COVID-19 has had on dermatology services in the NHS—with ever lengthening wait times to secondary care services.[3] This is causing even more delays to patients needing secondary care services than in pre-COVID-19 days. The more that primary care services can use good quality acne management advice to manage most patients with acne, the less overwhelmed secondary care will be, enabling timely management of those patients who really require secondary care input.

The extent of the problem

Acne remains extremely common in adolescents and young adults. It affects 80% of people at some time between 11 and 30 years.[1,2] Its effects, however, are hugely varied. Some people experience no more than minor social inconvenience and slight embarrassment. At the other end of the severity spectrum, however, some patients can be psychologically traumatised by their acne and may suffer major compromise to their education, employment, social lives, relationships, and even their career choice. Some patients have developed suicidal ideation due to acne and some have even succeeded in taking their own lives.[4]

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Prescribing information: page 8

What are we aiming for in optimal acne management?

High quality treatment should consider:[1]
- severity
- distribution of the lesions
- the patient's own views.

The aim of treatment is two-fold:
- to reduce lesion severity
- to prevent recurrence and scarring.

The recommendations within the new guideline are broken down into eight areas, as follows:[1]
1. Information and support for people with acne vulgaris
2. Skin care advice
3. Diet
4. Referral to specialist care
5. Managing acne
6. How to manage 'relapse' of the acne
7. Maintenance of the patient's acne treatment
8. Management of scarring.

Giving patients useful information[1]

The NICE guidance starts by considering what information patients would want about their condition, although it points out that there is no published evidence on this and so recommendations are based on the committee's own experience.[1]

It lists six separate bullet points of information, covering such areas as causation, treatment options, and the pros and cons of various treatments[1]—the coverage of all of which would probably take 10 minutes on its own. Although the suggestion has merit, the recommendation to discuss all these areas is somewhat impractical. Luckily, the *British Association of Dermatologists* patient information leaflet on acne covers all the suggested areas, and so clinicians might cover this recommendation by simply suggesting that patients download this well-written leaflet.[5]

Advice on general skin care

The NICE guideline suggests that there are four points worth making to patients:[1]
- use a non-alkaline synthetic detergent (called a 'syndet') as a washing agent twice-daily on the acne-prone skin
- avoid oil-based skin care products and sunscreens
- avoid oil-based make-up

Key points[1,5,6]

- The teenager and the window of opportunity:
  - at the patient's first acne consultation: show empathy, enthusiasm, and knowledge
  - demonstrate that you can help them
- Examine the patient; do not forget to look at their chest and their back:
  - this will help you to assess the severity and look for scarring; it also helps to build trust between you and the patient
- Give information, either verbally, by leaflet/link, or both:
  - you may want to mention benefits of syndets (with examples) and the lack of good evidence for dietary changes
- Choose an initial treatment, considering any contraindications and any patient preferences:
  - distribution of acne may be relevant here
- Never use antibiotics as monotherapy, nor use two at once
- When starting treatment, talk explicitly about:
  - where to apply—explain to use this all over the acne-prone area (it is not a 'spot cream', it is an 'anti-spot cream')
  - alternate day and/or short contact initial treatment, aim to build skin tolerance to dryness
  - expected response time to treatments as it can be 6–8 weeks
  - the need for compliance, especially young adults
  - getting a baseline photo on their phone for comparison over the weeks
  - skin dryness is evident of grease production reducing, hence the treatment is working—anecdotally, using emollients help patients cope with xerosis without compromising efficacy
- Review at 12 weeks: re-examine and look at patient's baseline photos on their phone:
  - this also enhances doctor and patient engagement and will allow you to decide the next step
- Refer any severity if inadequate response after two courses, especially if scarring seems to be occurring:
  - isotretinoin can often be highly effective.

Prescribing information: page 8

- try to avoid picking and scratching of acne lesions, which will increase scarring risk.

What are syndets?

A syndet is a blend of synthetic surfactants, formulated to have neutral to slightly acidic pH, similar to the skin, as opposed to soaps, which are often quite alkaline. They are widely available in solid and liquid forms as skin cleansing products. They are generally very mild at cleansing. Many products are combinations of syndet plus a small percentage of soap.[1]

It seems unlikely that advising a patient to 'use a syndet for washing' will be helpful unless the clinician can back up that advice with examples of the names of suitable products. Below are some examples of commonly available products containing syndets:

- Dove moisturising bar
- Cetaphil gentle cleansing bar
- Avène Eau thermale
- Aveeno moisturising bar
- La Roche Posay: Lipikar Syndet AP+.

Again, the NICE guideline concedes that there is little published evidence on the efficacy of skin care products in acne management.[1]

What dietary advice can be given?

NICE concludes that there is no good evidence for any helpful dietary modification.[1] Despite some evidence from randomised controlled trials (RCTs)[7] that a diet with a low glycaemic load may improve acne, the committee was concerned that commending dietary modification might increase risk of eating disorders and hence that the limited evidence of benefit did not outweigh the risk.[1]

Referral criteria and choice of initial treatment[1]

Two of the largest sections of the new guideline are devoted to how to choose the initial treatment for the patient when they first consult. To decide this, the clinician must do two things:

1. consider the severity of the acne, as this may play a part in the clinician and patient jointly deciding on the optimal initial treatment
2. consider whether the patient should be referred, even if primary care treatment is started in the meantime, while waiting for secondary care assessment.

How severe is the acne?[1]

There are two main treatment pathways in NG198, depending on whether the patient's acne is judged to be 'mild-to-moderate' or 'moderate-to-severe'. Luckily, judging the severity has been made very simple.

The severity assessment hinges on the presence and/or number of three types of lesions:

- comedones
- inflammatory lesions (papules and pustules)
- nodules (raised inflamed lesions of at least 1 cm diameter).

A patient with **mild-to-moderate acne** will fulfil one or more of the three criteria below:

- any number of comedones
- up to 34 inflammatory lesions
- up to two nodules.

A patient with **moderate-to-severe acne** will fulfil either or both criteria below:

- 35 or more inflammatory lesions (with or without non-inflammatory lesions e.g. comedones)
- three or more nodules.

Is immediate referral required?[1]

The guideline lists various referral criteria and also gives guidance on the urgency of that referral.

Same-day referral:

- Acne fulminans (a rare acute severe form of nodulocystic acne, with systemic symptoms).

Refer the following:

- Nodulo-cystic acne or its variant, conglobate acne
- Diagnostic uncertainty.

Prescribing information: page 8

Consider referring the following:

- Persistent pigmentary changes
- Mild-to-moderate acne not responding to two complete treatment courses
- Moderate-to-severe acne not responding to previous treatment that contained an oral antibiotic
- Acne with scarring
- If acne is causing persistent psychological distress or a mental health disorder
- If a medical condition or treatment is contributing to the patient's acne (e.g. polycystic ovary syndrome or anabolic steroid abuse).

Choice of initial treatment

Once the severity of the acne has been determined and the need (or not) for referral has been judged, the appropriate initial management can be implemented.

There are three suggested options for initial treatment of a patient with mild-to-moderate acne, and four for initial treatment of a patient with moderate-to-severe acne. In each case, the options are not listed in any preference order and the choice should be made after a discussion between clinician and patient, having considered any contraindications and any patient preferences that might affect the choice of therapy.

Table 1 summarises the recommended treatment options.[1] Of note is that two of the options are the same, whether the acne is felt to be mild-to-moderate or moderate-to-severe, but then the options diverge, depending on the severity.

Important considerations when commencing the initial treatment course:[1]

- Any contraindications to certain options (pregnancy/breastfeeding)
- Any patient preferences to one or another of the listed options
- Emphasising the importance of compliance with whole course of treatment (response to treatment may take 8 weeks)
- Need to explain how to start the treatment: (alternate day and/or one-hour short contact initial treatment to increase compliance and reduce risk of patient stopping treatment)
- In women wanting hormonal contraception, the combined contraceptive pill is preferred to the progestogen-only pill
- For patients who cannot take lymecycline or doxycycline for some reason, the NICE guideline suggests replacement with either trimethoprim or an oral macrolide (e.g. erythromycin); however, doses are not discussed.

Thoughts on the recommended treatment options

The suggested options for management of both mild-to-moderate and moderate-to-severe acne are likely to be supported by many GPs with an extended role in dermatology, as well as by secondary care dermatologists.

The proprietary drugs Epiduo® 0.1%/2.5% gel (adapalene/benzoyl peroxide) and Epiduo® 0.3%/2.5% gel (adapalene/benzoyl peroxide), both contain two well established products that target different components of the pathogenesis of acne.

Adapalene is a retinoid, which has a central role in the treatment of acne. Retinoids are comedolytic, resolve the precursor microcomedone lesion, and are anti-inflammatory. They can also work well in maintenance of clearance after initial treatment.[8]

Benzoyl peroxide (BPO) is bactericidal against the *Cutibacterium acnes* (formerly known as *Propionibacterium acnes*) and hence can further reduce the inflammatory lesions promoted by overgrowth of this organism. It can also prevent or eliminate development of resistance of this bacterium to antibiotics.[9]

In combination, BPO and adapalene address many of the causative factors thought to cause acne lesions, hence may be expected to work synergistically to improve acne,[A]6,10 provided that the patient is warned about drying effects on the skin, which tend to occur in the first 2 weeks. These are mitigated by good advice on application method and use of an emollient.

Prescribing information: page 8

Table 1: Initial treatment options (12-week initial course suggested)[1]

	Mild-to-moderate acne	Moderate-to-severe acne
adapalene + benzoyl peroxide topical combination o.d.	✓	✓
tretinoin + clindamycin topical combination o.d.	✓	✓
clindamycin + benzoyl peroxide topical combination o.d.	✓	
adapalene + benzoyl peroxide topical combination + oral antibiotic (doxycycline or lymecycline) o.d.		✓
topical azelaic acid b.d. + oral antibiotic (doxycycline or lymecycline) o.d.		✓
b.d.=twice a day; o.d.=daily		

The anti-inflammatory effects of adapalene have been shown to be dose dependent and so a higher strength version of the combination containing adapalene 0.3%/BPO 2.5% was introduced by Galderma in 2020 (it had previously been marketed by Steifel/GlaxoSmithKline), which has been found to be even more efficacious in clearing acne lesions than the lower strength combination, while still being generally well tolerated.[11] This does, therefore, offer another therapeutic option in patients who have been using the lower strength combination product but whose therapeutic response to it has been inadequate.

The inclusion of two regimes for moderate-to-severe acne that contain an oral antibiotic in the NICE guidance is interesting. Monotherapy with the adapalene 0.3%/BPO 2.5% gel combination may still be appropriate in certain moderate-to-severe cases. For example, one might imagine that a patient with moderate-to-severe acne confined to the face may prefer to try monotherapy with a topical combination product, before moving on to adding in an oral antibiotic; whereas a patient with lesions also affecting chest and back may be better to use an oral antibiotic combination immediately.

The first review[1]

NICE suggests a first review after 12 weeks to give sufficient time for whatever initial treatment is chosen to work optimally. At the review, whether and how to continue depends on the response to treatment and how well it has been tolerated.

NG198 does not address what to do in the (unlikely) situation that response to a treatment regime not including an oral antibiotic has been complete with no residual activity, but, presumably, it would be reasonable to stop treatment and to watch to see if the acne recurred.

Other possible scenarios are discussed and are summarised in Figure 1. These suggestions seem to cover most scenarios and it is pleasing that referral is suggested where the patient has been taking an oral antibiotic and yet is still showing moderate-to-severe acne.

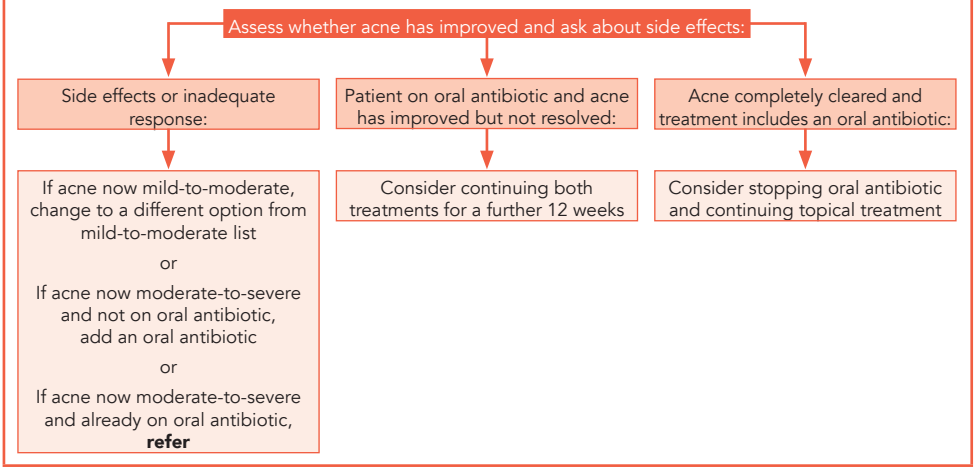
Acne and antimicrobial stewardship[1]

Given the increasing focus on the global importance of avoiding unnecessary antibiotic use, it might seem surprising that continuing an antibiotic course for a further 3 months is suggested as an option after apparent partial response. The guideline specifically addresses this issue and points out that it is also recommended that neither oral nor topical antibiotics should ever be used as a monotherapy, and that patients should never be prescribed an oral antibiotic simultaneously with a topical preparation containing an antibiotic.

[A] The most common side effects associated with Epiduo® 0.3%/2.5% formulation are atopic dermatitis, eczema, skin burning sensation, and skin irritation. The most common side effects associated with Epiduo® 0.1%/2.5% gel formulation are dry skin, irritative contact dermatitis, skin irritation, skin burning sensation, erythema, and skin exfoliation (scaling). These side effects are classified as common (≥1/100 to <1/10). For more information please refer to the summary of product characteristics.

Prescribing information: page 8

Figure 1: The 12-week review



Consequently, it is suggested that, overall, there should be a decrease in the prescribing of antibiotics for acne, despite the advice about extending oral antibiotic use in certain situations.

Managing relapse[1]

If a patient's acne responded adequately to a specific first-line treatment started in the practice but then relapses, NICE suggests:

- repeating the initial 12-week treatment, or
- trying an alternative 12-week treatment.

If a patient relapses after adequate response to oral isotretinoin and has mild-to-moderate acne, the guideline suggests offering one of the three initial mild-to-moderate 12-week treatment options. This seems sensible, as in the authors experience, patients often respond better to 'standard' acne topical therapy after receiving a course of isotretinoin, so this may be all that is required.[6]

If a patient relapses after adequate response to oral isotretinoin and has moderate-to-severe acne, NICE suggests:

- offering a 12-week course of an appropriate option from the moderate-to-severe list, or
- re-referral if patient has been discharged from clinic.

Given the wait time to be seen, it would seem sensible to start one of the options from the moderate-to-severe list, even if a re-referral is made at the same time.

If a patient relapses after a second course of oral isotretinoin and currently has moderate-to-severe acne, further care should be offered by the specialist-led team.

Is maintenance treatment required?[1]

NG198 makes the point that maintenance is not always required and recommends the ongoing use of syndets. Maintenance treatment may be considered in patients with a history of frequent relapses; a fixed combination of topical adapalene and topical benzoyl peroxide can be considered as maintenance treatment. If this is not tolerated, then monotherapy with adapalene alone, azelaic acid, or BPO is an alternative option. Further review after another 12 weeks should be arranged to assess whether the maintenance treatment is effective.

Other areas of interest in NG198[1]

Usefully, the issue of acne scarring is specifically addressed. It suggests that patients are advised on the benefits of cosmetic

Prescribing information: page 8

camouflage and suggests that acne scarring that is both severe and persists for at least one year after their acne has cleared should be referred for consideration of secondary care treatment, for example with lasers or peel therapy. This is a welcome recommendation, as is the suggestion that residual acne cysts may be treated with intralesional steroids in a secondary care setting.

NG198 gives some guidance on the use of isotretinoin in secondary care. It also suggests alternative treatments where isotretinoin cannot be used, such as photodynamic therapy.

Patients with polycystic ovary syndrome should be treated as other patients, with the exception that the combined oral contraceptive is particularly commended.

References

1. NICE. *Acne vulgaris: management*. NICE Guideline NG198. NICE, 2021. Available at: www.nice.org.uk/ng198
2. Ridd M. *Br J Dermatol* 2017; **176** (1): 1–2.
3. The Health Foundation. *Longer waits, missing patients and catching up*. Available at: www.health.org.uk/news-and-comment/charts-and-infographics/how-is-elective-care-coping-with-the-continuing-impact-of-covid-19 (Accessed 17 September 2021).
4. Oakley A and Collier J. *Psychological effects of acne*. Available at: www.dermnetnz.org/topics/psychological-effects-of-acne/ (Accessed 15 September 2021).
5. British Association of Dermatologists. *Patient information leaflet. Acne*. BAD, 2020. Available at: www.bad.org.uk/shared/get-file.ashx?id=65&itemtype=document
6. Clay S. Personal data. 2021.
7. Smith R et al. *Am J Clin Nutr* 2007; **86** (1): 107–115.
8. Leyden J et al. *Dermatol Ther* 2017; **7** (3): 293–304.
9. Strauss J et al. *J Am Acad Dermatol* 2007; **56** (4): 651–663.
10. Galderma. *Epiduo 0.1%/2.5% gel and Epiduo 0.3%/2.5% gel–summary of product characteristics*. www.medicines.org.uk/emc/ (Accessed 15 September 2021).
11. Stein Gold L et al. *Am J Clin Dermatol* 2016; **17** (3): 293–303.

Case histories[6]

- Man, 18 years old
- Mild-to-moderate acne affecting face only
- Prescribed lymecycline monotherapy for last 3 years
- Dissatisfied with acne control; sees a different GP

A change to adapalene 0.3%/BPO 2.5% gel is suggested, with appropriate advice on how to start the treatment with initial short duration application and on alternate days, and use of an emollient.

On review 12 weeks later, his skin is markedly improved, and the inappropriate long-term use of an oral antibiotic avoided.

- Girl, 16 years old
- History of troublesome atopic eczema
- Presents with moderate-to-severe acne over the face

After discussion of her options, and in the hopes of avoiding products that might exacerbate her eczema, she elects to accept a 12-week course of topical azelaic acid 15% in combination with oral lymecycline.

On review 12 weeks later, the acne has markedly improved (now mild-to-moderate). After discussion, she agrees to stop the antibiotic and to continue with the azelaic acid with a review after a further 12 weeks.

- Man, 40 years old
- Presents with widespread facial papules and pustules over forehead, cheeks, and nose
- Diagnosed with late-onset acne 2 years ago but has not responded to a topical BPO/clindamycin combination

After assessment in a dermatology clinic, where the lack of any comedones is noted and the history of recurrent eye symptoms, an alternative diagnosis of rosacea is made, resulting in the treatment being changed, together with information on lifestyle change options, which results in a much better response.

- Girl, 15 years old
- Presents with apparent mild-to-moderate acne affecting face only

After examination and discussion of her options, she is commenced on adapalene 0.3%/BPO 2.5% gel with appropriate advice on how to start the treatment with initial short duration application and on alternate days, and use of an emollient.

After 12 weeks, the acne on the face has improved somewhat, but its extent as widened, with lesions on upper chest and back; it is now 'moderate-to-severe' (>34 inflammatory lesions).

After discussion, she agrees to try to apply the topical treatment to the truncal areas, but also commences lymecycline orally, with appropriate tactful discussion about the risks of falling pregnant.

On review 12 weeks later, the acne is under better overall control, with the inflammatory lesions receding in number and severity, reducing her scarring risk long term.

Prescribing information: page 8

Epiduo Gel Prescribing Information (UK & IRE)

Presentation: 0.1% adapalene & 2.5% benzoyl peroxide

Indications: Cutaneous treatment of *acne vulgaris* when comedones, papules and pustules are present in adults, adolescents and children aged 9 Years and over.

Dosage and Administration: A thin film should be applied to the entire acne affected areas once a day in the evening to clean & dry skin. If irritation occurs, apply non-comedogenic moisturisers, use the medication less frequently, suspend use temporarily, or discontinue use altogether. Duration of treatment should be determined on the basis of clinical condition; early signs of improvement usually appear after 1 to 4 weeks. The safety and effectiveness of Epiduo have not been studied in children below 9 years of age.

Contraindications: Hypersensitivity to the active substances or to any of the excipients. If you are pregnant or planning a pregnancy.

Precautions and Warnings: Should not be applied to damaged, broken eczematous or sunburned skin, or come into contact with eyes, mouth, nostrils or mucous membranes (wash immediately with warm water if product enters eyes). Contains propylene glycol (E1520), which may cause skin irritation. Avoid excessive exposure to sunlight or UV light. Avoid contact with any coloured material including hair and dyed fabrics as this may result in bleaching and discolouration.

Pregnancy and Lactation: Epiduo should not be used during pregnancy or in women planning a pregnancy. If the patient becomes pregnant while using Epiduo, treatment should be discontinued. To avoid exposure of an infant to Epiduo, application to the chest should be avoided when breastfeeding.

Interactions: No interaction studies have been conducted with Epiduo. There are no known interactions with other medicinal products which might be used cutaneously and concurrently with Epiduo. However, other retinoids, benzoyl peroxide or drugs with a similar mode of action should not be used concurrently. Caution should be exercised if cosmetics with desquamative, irritant or drying effects are used, as they may produce additive irritant effects with Epiduo. Absorption of adapalene & benzoyl peroxide through human skin is low therefore interaction with systemic medicinal products is unlikely.

Undesirable Effects: Epiduo may cause the following localized adverse reactions: Common (≥ 1/100 to <1/10): dry skin, irritative contact dermatitis, erythema, skin exfoliation, skin burning sensation and skin irritation. Uncommon (≥ 1/1000 to ≤1/100): pruritus and sunburn. Not known: anaphylaxis, allergic contact dermatitis, swelling face, pain of skin, blisters, eyelid oedema, dyspnoea, skin discolouration (hyperpigmentation and hypopigmentation), urticaria, throat tightness and application site burn. Most cases of application site burn were superficial burns but cases with second degree burn or severe burn reactions have been reported. If skin irritation appears after application of Epiduo, the intensity is generally mild or moderate, with local tolerability signs and symptoms (erythema, dryness, scaling, burning and pain of skin (stinging pain)) peaking during the first week and then subsiding spontaneously. Prescribers should consult the summary of product characteristics in relation to other side effects.

Packaging Quantities and Cost: 45g pump UK - £19.53, IE - € 25.53

MA Number: PL 10590/0057(UK), PA 22743/007/001 (IE)

Legal Category: POM

Further Information is Available: Galderma (UK) Limited, Meridien House, 69-71 Clarendon Road, Watford, Herts, WD17 1DS. UK. Tel: +44 (0)1923 208950

Date of Revision: April 2021

Adverse events should be reported.
For the UK, reporting forms and information can be found at www.mhra.gov.uk/yellowcard or search for Yellow Card in the Google Play or Apple App Store.
For Ireland, suspected adverse events can be reported via HPRA Pharmacovigilance, www.hpra.ie;
Adverse events should also be reported to Galderma (UK) Ltd.
E-mail: Medinfo.uk@galderma.com Tel: +44 1 923 208950

Epiduo 0.3% / 2.5% gel Prescribing Information (UK)

Presentation: 0.3% adapalene & 2.5% benzoyl peroxide

Indications: Cutaneous treatment of *acne vulgaris* when comedones, numerous papules and pustules are present.

Dosage and Administration: A thin layer should be applied to the entire acne affected areas of the face and/or trunk once a day in the evening to clean & dry skin. Duration of treatment should be determined on the basis of clinical condition; early signs of improvement usually appear after 1 to 4 weeks. The safety and effectiveness of Epiduo have not been studied in children below 12 years of age.

Contraindications: Hypersensitivity to the active substances or to any of the excipients. If you are pregnant or planning a pregnancy.

Precautions and Warnings: Should not be applied to damaged, broken, sunburnt or eczematous skin, or come into contact with eyes, mouth, nostrils or mucous membranes (wash immediately with warm water if product enters eyes). Contains propylene glycol (E1520), which may cause skin irritation. Discontinue in the case of sensitivity reactions. Avoid excessive exposure to sunlight or UV light. Avoid contact with any coloured material including hair and dyed fabrics as this may result in bleaching and discolouration. Not recommended for the treatment of severe nodular or deep nodulocystic acne due to risk of insufficient therapeutic response.

Pregnancy and Lactation: Epiduo is contraindicated in pregnancy or women planning a pregnancy. If the patient becomes pregnant while using Epiduo, treatment should be discontinued. A risk to the suckling child cannot be excluded therefore a decision must be made whether to discontinue breast-feeding or to discontinue Epiduo. To avoid exposure of an infant to Epiduo, application to the chest should be avoided when breastfeeding.

Interactions: Other retinoids, benzoyl peroxide or drugs with a similar mode of action should not be used concurrently. Caution should be exercised if cosmetics with desquamative, irritant or drying effects are used, as they may produce additive irritant effects with Epiduo. Absorption of adapalene and benzoyl peroxide through human skin is low, therefore interaction with systemic medicinal products is unlikely.

Undesirable Effects: Epiduo may cause the following localised adverse reactions: Common (≥ 1/100 to <1/10): Atopic dermatitis, eczema, skin burning sensation, skin irritation, irritative contact dermatitis. Uncommon (≥ 1/1000 to ≤1/100): erythema of eyelid, paresthesia, dry skin, rash, pruritus and sunburn. Not known: anaphylactic reaction, skin discolouration, dyspnea, urticaria, allergic contact dermatitis, swelling face, pain of skin, blisters, eyelid oedema, throat tightness and application site burn. If irritation occurs, apply non-comedogenic moisturisers, use the medication less frequently, suspend use temporarily, or discontinue use altogether. Prescribers should consult the summary of product characteristics in relation to other side effects.

Packaging Quantities and Cost: 45g pump UK - £19.53

MA Number: PL 10590/00067

Legal Category: POM

Further Information is Available From: Galderma (UK) Limited, Meridien House, 69-71 Clarendon Road, Watford, Herts, WD17 1DS. UK. Tel: +44 (0)1923 208950

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