Rosacea: To Peel or Not To Peel….That Is The Question

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Unabridged

After almost 40 years in the beauty industry, half of it spent in aesthetics, it’s especially meaningful to me to share my experiences with Rosacea. I’ve been fortunate to work with several physicians, nurses and medically trained individuals. Their input into my work has been extremely helpful. I have also been an educator for two companies, but I must confess that I have found my experiences behind the treatment bed have been the most invaluable and personally educating.

Let’s begin by discussing Rosacea otherwise known as Acne Rosacea. Acne Rosacea is a misleading term. Rosacea and Acne are two entirely different conditions, although they can and often do appear together. Here are the “who, what, where and when” of rosacea.

“Who”: Statistically Rosacea is an extremely common condition affecting approximately 14 million Americans. The most common individuals affected are adults between 30 and 50 years of age, with light skin, blonde hair and blue eyes. However, any skin type and ethnicity can be affected, as well as any age group. Unfortunately this includes a small percentage of children.

“What”: Rosacea is a vascular system disorder that causes the blood vessels to swell. It can be caused by a genetic predisposition, environmental factors, or a combination of all of the factors. The condition may be as unassuming as mild erythema (patchy red skin rashes commonly associated with rosacea) of the face, known as prerosacea or Stage 1. Episodic attacks of redness accompanied by warmth and even burning, erythema is usually persistent in the central facial areas. The majority of Stage 1 patients have a history of flushing. Telangiectasia (an abnormal dilatation of capillary vessels and arterioles that often forms an angioma) is common but not always present. Some patients also develop central facial edema as well as burning and stinging. This type is known as vascular rosacea, and is most commonly seen in women. Scaling of the skin and roughness may also occur in more extreme cases of Stage 1.
Stage 2 is an exaggeration of Stage 1 that may also present papules and pustules.

In Stage 3 conditions may be quite extreme, with purple/red vascularizations as the disease has moved into inflammatory rosacea. Nodules, thickening of the skin, large pores, edematous (edema) skin, irregular surface nodularities and enlargement, large inflammatory nodules and furunculoid infiltrations (resembling a furuncle or boil) may be present. This may lead to phymatous rosacea (see “Variations” below). The most common location is the nose (rhinophyma). The cheeks, chin, forehead and ears are less frequent locations. Prominent follicles, persistent erythema along with telangiectases induration (the process of or condition produced by growing hard; specifically: sclerosis especially when associated with inflammation) and coarsening of the skin in these areas are characteristic. It is interesting to note that some people may have symptoms of more than one type of rosacea at a time. Others may have any one type, including rhinophyma, without ever having had any of the others.

Rosacea Variations:

• Phymatous Rosacea, of which rhinophyma is the most common form, is characterized by a deep chronic inflammation leading to sebaceous gland hyperplasia and an increase of connective tissue. This complication mainly affects men, usually beginning after the age of 40. Most patients have only mild variants of rosacea in other parts of the face.

• Halogen Rosacea is caused by iodides or bromides systemically administered. This condition can lead to a rosacea conglobata-like clinical appearance (see Variations below). Discontinuing exposure to halogens (any of the five elements fluorine, chlorine, bromine, iodine, and astatine that form part of group VII A of the periodic table) resolves the condition.

• Ophthalmic or Ocular Rosacea symptoms may occur before cutaneous manifestations in up to 20% of patients. Severity is also independent of facial rosacea. It is most frequently diagnosed when cutaneous signs and symptoms of rosacea are also present. Conjunctivitis (an inflammation of the inner membranes of the eyelids) and other associated eye problems may occur. Eyelids may become inflamed and develop small red bumps or develop scales and crust after sleeping for several hours. Bloodshot
eyes and tearing are not uncommon, with a gritty feel as though irritated by a grain of sand. Blurred vision and in severe cases, even a loss of vision may occur. Bright light sensitivity is common as well. Eyelash loss may also occur occasionally.

- **Rosacea Conglobata**, a chronic and progressive condition easily mistaken as Acne Conglobata, is usually present in women. The condition is recognized by hardened (indurated) plaques and hemorrhagic nodular abscesses (a copious discharge of blood from the blood vessels) on erythematous skin (patchy red skin rashes commonly associated with rosacea).

- **Rosacea Fulminans** is characterized by the sudden onset of an extreme variant of rosacea conglobata. Large carbunculoid nodules (a painful local inflammation of the skin and deeper tissues containing pus with multiple openings for the discharge of pus and usually necrosis (usually localized death of living tissue) and sloughing of dead tissue) and confluent (flowing or running together, run together) draining sinus on a red face predominantly on the chin, cheeks and forehead. Swelling of the face with intense red to blue discoloration may occur. Severely increased seborrhea is a constant feature with onset of the disease. Post-adolescent women, some of them having a history of emotional trauma are primarily affected. Usually, there is no eye involvement. The etiology (all of the causes of a disease or abnormal condition) of Rosacea Fulminans is unclear.

- Persistent edema of Rosacea is rather rare and often misdiagnosed. Characterized by hard edema in the affected areas: forehead, glabella (the part of the human forehead that lies just above the nose and between the eyebrows), upper eyelids, nose, or cheeks.

- Lupoid or Granulomatous Rosacea is characterized by firm, yellow, brownish or reddish, cutaneous papules or nodules. Usually they are monomorphic (having but a single form, structural pattern) in each individual patient affecting the cheeks and the perioral areas (or surrounding the mouth). Other signs and symptoms of rosacea are not necessary in diagnosing this form of rosacea. The lesions are less inflammatory, frequently appearing on relatively normal-appearing skin. Occasionally it may appear diffusely red and thickened. Diascopy (a clinical technique for the diagnosis of vascular lesions) should be performed. The lesion should be pressed with a glass spatula. If the redness disappears
the lesion is vascular, if not, it would suggest the lesion is lupoid. Scarring is a serious concern with this form of rosacea.

- Steroid Rosacea occurs when rosacea patients are erroneously treated with topical steroids, particularly potent varieties, for a prolonged time. Patients complain of itching, pain, intense redness and burning. Rosacea improves upon the initial usage, however over a period of time papulopustules (characterized by the presence of both papules and pustules), nodules, secondary comedones, and eventually the signs of steroid atrophy appear. Accompanying steroid atrophy are such symptoms as thinning of the skin and the increase of telangiectases. Severe exacerbation of rosacea is very common upon discontinuing the use of steroids.

- Gram-negative Rosacea is analogous to gram-negative folliculitis. Contents of the pustules must be cultured demonstrating the presence of the organisms in order to make a diagnosis. Perioral and perinasal deep nodules and yellow pustules are the characterization of gram-negative rosacea.

“Where”: Rosacea is found especially on the cheeks, chin and nose. An overgrowth of tissue on the nose, known as rhinophyma, may be present. Not being restricted to only the face; the scalp, neck, ears, chest and back may also be affected. Unfortunately, about half of those affected have symptoms of ophthalmic or ocular rosacea. A longstanding myth is that heavy alcohol consumption causes rhinophyma. Alcoholism has nothing to do with the condition. Men are far more likely to develop this condition.

“When”: Usually rosacea starts in the forties, but has been known to occur later in women with the onset of menopause. Although the forties is the most common, all ages potentially may be affected.

Trying to determine the cause of rosacea is still quite a puzzle. For instance, in the case of the greatly increased amount of Demodex Folliculorum found in the follicle, it’s the “which came first, the chicken or the egg” scenario. Demodex Folliculorum is a common parasite living in
the follicle. Rosacea patients have this little critter in rather alarming numbers. The question is: Does the rosacea allow the increase (in patients predisposed to rosacea), or does the Demodex Folliculorum cause the rosacea?

Next, there’s Helicobater Pylori, a bacterium that causes intestinal infection. Helicobater Pylori has also been linked as a possible cause of Rosacea.

Then there’s the immune system, which also has been implicated as playing a role in Rosacea’s development.

As clinical aestheticians, we see it all, from the mild pink, flushed cheeks to the extremely vascularized, inflamed cheeks and nose. You have also seen the client that has very little erythema, but suffers from lesions all over the face. How often do you hear the pleading from these clients who have tried everything from prescription medications to OTC’s and are begging for your help?

I suggest that you consider trying mild chemical peeling. Yes, I know it’s not for everyone, but I think you’ll be pleasantly surprised to see how many of your clients respond favorably.

First of all remember the contraindications for peeling. Clients with a history of Herpes Simplex need to consult their physicians about the use of an antiviral pre and post procedure. Antiviral medication won’t guarantee that your client won’t have an outbreak, but it surely will help to minimize the risk. Secondly, use of the Fitzpatrick Classification of Sun-Reactive Skin Types, otherwise known as the Fitzpatrick Scale, is important to minimize dispigmentation. Although all levels on the Fitzpatrick Scale may use peeling agents, level 1 may be red for a prolonged period of time. Levels 5 & 6 will easily hyperpigment. Caution should be especially used on these skin types.
## Genetic Disposition

<table>
<thead>
<tr>
<th>Score</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>What are the color of your eyes?</td>
<td>Light blue, Gray, Green</td>
<td>Blue, Gray or Green</td>
<td>Blue</td>
<td>Dark Brown</td>
<td>Brownish Black</td>
</tr>
<tr>
<td>What is the natural color of your hair?</td>
<td>Sandy Red</td>
<td>Blond</td>
<td>Chestnut/Dark Blond</td>
<td>Dark Brown</td>
<td>Black</td>
</tr>
<tr>
<td>What is the color of your skin (non exposed areas)?</td>
<td>Reddish</td>
<td>Very Pale</td>
<td>Pale with Beige tint</td>
<td>Light Brown</td>
<td>Dark Brown</td>
</tr>
<tr>
<td>Do you have freckles on unexposed areas?</td>
<td>Many</td>
<td>Several</td>
<td>Few</td>
<td>Incidental</td>
<td>none</td>
</tr>
</tbody>
</table>

Total score for Genetic Disposition: _____
### Reaction to Sun Exposure

<table>
<thead>
<tr>
<th>Score</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What happens when you stay in the sun too long?</strong></td>
<td>Painful redness, blistering, peeling</td>
<td>Blistering followed by peeling</td>
<td>Burns sometimes followed by peeling</td>
<td>Rare burns</td>
<td>Never had burns</td>
</tr>
<tr>
<td><strong>To what degree do you turn brown?</strong></td>
<td>Hardly or not at all</td>
<td>Light color</td>
<td>Reasonable tan</td>
<td>Tan very easy</td>
<td>Turn dark brown quickly</td>
</tr>
<tr>
<td><strong>Do you turn brown within several hours after sun exposure?</strong></td>
<td>Never</td>
<td>Seldom</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
</tr>
<tr>
<td><strong>How does your face react to the sun?</strong></td>
<td>Very sensitive</td>
<td>Sensitive</td>
<td>Normal</td>
<td>Very resistant</td>
<td>Never had a problem</td>
</tr>
</tbody>
</table>

Total score for Reaction to Sun Exposure: _____
### Tanning Habits

<table>
<thead>
<tr>
<th>Score</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>When did you last expose your body to sun (or artificial sunlamp/tanning cream)?</td>
<td>More than 3 months ago</td>
<td>2-3 months ago</td>
<td>1-2 months ago</td>
<td>Less than a month ago</td>
<td>Less than 2 weeks ago</td>
</tr>
<tr>
<td>Did you expose the area to be treated to the sun?</td>
<td>Never</td>
<td>Hardly ever</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
</tr>
</tbody>
</table>

Total score for Tanning Habits: _____

Add up the total scores for each of the three sections for your Skin Type Score.

<table>
<thead>
<tr>
<th>Skin Type Score</th>
<th>Fitzpatrick Skin Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-7</td>
<td>I</td>
</tr>
<tr>
<td>8-16</td>
<td>II</td>
</tr>
<tr>
<td>17-25</td>
<td>III</td>
</tr>
<tr>
<td>25-30</td>
<td>IV</td>
</tr>
<tr>
<td>over 30</td>
<td>V-VI</td>
</tr>
</tbody>
</table>

Permission to print from Brian Sieber, The Anti-aging Clinic
So when do you peel and when don’t you peel? The patch test will easily answer that question. I’m very specific about the location of the test. I usually like to use a dime size area in the center of the most active area. I’m also equally specific about my client being committed to my program. This leads to the “Key to Success”, which is **Proper Preparation**.

Let’s step back to the beginning of the process. The client calls for an appointment. The person at the desk must explain the procedure thoroughly. The client is told that their initial visit is a consultation. The fee for the consultation is waved upon the purchase of home care products equal to or greater than the amount of the fee. Initial appointments are between 45 minutes and an hour in length. The client is informed that the home care is critical to the success of the peels used. No peel will be performed unless the client commits to the use of a home care program.

The client arrives for their appointment and will fill out an extensive history form. This form will cover general contact information, the specific concerns of the client, their past history, cosmetic and skin care products currently being used, lifestyle, as well as current and past medical conditions and procedures. I suggest that the client fill this form out in their own handwriting for liability reasons. At this point, this form, along with a consent form must be signed. Next, a thorough skin analysis must be conducted. Chart all existing skin conditions and their severity, oil productivity, ethnicity and Fitzpatrick skin type. With this information you are ready to choose the proper home care products to prepare the client’s skin for the peeling procedure you have chosen. The next step is discussing with the client the treatment series you have chosen. A series maximizes a more consistent ongoing result. A picture (or multiple pictures) should be taken and a Photo Release Form should be signed if you choose to use the pictures(s) to promote your business. Since a picture is worth a thousand words, use these to show the client their ongoing progress.

Next, pre-cleanse and tone the skin in the area you have chosen for your patch test. Apply the peeling agent you have determined will be the best for the client’s skin. Treat this patch test as you would a regular application of the peeling agent, applying the normal amount of product in the same technique you would use if applying it to the entire face and neck. Upon completion of the patch test, instruct the client on the proper use of all home care products and schedule a 5 minute “check” the following week. I prefer to use an alpha or beta acid to prepare the skin for
peeling. The porosity of the skin is more even when prepared with AHA’s or BHA’s and I find that there is a much more favorable result.

At the 5 minute “check” appointment, determine if the client responded favorably to the patch test. Also observe whether they are using their home care products appropriately and answer any questions they may have. If the skin is appropriately prepared, schedule their first peel for the following week. If not, schedule another 5 minute “check” the following week and repeat until the skin is prepared properly for peeling. Be sure to document your client’s progress both for your own information and from a liability standpoint.

How do you choose the proper peeling agent? That’s a great question. There are so many different agents available, and I certainly have my own favorites. And that’s just it, what’s your favorite? I love UB I “A-Peel” Jessner’s for Rosacea. I also love AHA/BHA blends. The mild TCA is great as well. I shy away from straight glycolic.

Then there’s microdermabrasion. Many times I’ll incorporate microdermabrasion into a series with a variety of peeling agents. I normally don’t peel and microdermabrae at the same time for rosacea. This is just a little more aggressive than I like. In instances when I’m not using a “leave on” peeling agent, incorporating a cooling algae mask such as “Bio” tanical Coolly Mask, gives a very good result. I will use this as an opportunity to add more hydration under the mask by adding serums with sedating and healing ingredients such as licorice, seabuckthorn oil, willowherb, centella asiatica, azelaic acid, zinc and folic acid.

You may also want to do a test with an oxygen treatment such as Oxygen Infusion. I have had this go both ways, so be sure to do a patch test in the affected area to see what you can expect. For those that do well with oxygen treatments, it can be another weapon in your arsenal.

This photo (on the next page), taken during the two peeling procedures described below, demonstrates the application of “Bio” tanical Coolly Mask on the left side. Note the amount of redness on the right side, which has only been pre-cleansed.
• On both sides I pre-cleansed with Alpha Clean Cleanser, our AHA cleanser. This is a great “defatting” cleanser without over-stripping the skin.
• If the client has oil residual on the skin, I follow with Alpha Beta Toner. This is a highly active product and caution must be used not to irritate rosacea skin types prior to peeling.
• Left Side:
  1. On the left side I applied 1.25 ml or ¼ teaspoon of Beta Exfo Mask (20% Salicylic Acid) for 5 minutes.
  2. Again on the left side, I neutralized the Beta Exfo Mask with ice water and 2.5 ml or ½ teaspoon of Soft N Clean Cleanser.
  3. I applied 2.5 ml or ½ teaspoon of Red Be Gone Lotion to the left side, followed by ½ cup of “Bio” tanical Coolly Mask mixed with 7 tablespoon of ice water and applied directly to the skin to calm and hydrate. After the mask sets (approximately 5 minutes), a pre-refrigerated damp towel is applied over the mask for 10 to 15 minutes.
  4. Upon removal of “Bio” tanical Coolly Mask, I mist the left side of the face with Honey Dew Toner. Next 1.25 ml or ¼ teaspoon of Red Be Gone Nutrient
Hydrator followed by 1.25 ml or ¼ teaspoon of Velvet Moisture Creme is applied. Last 1.25 or ¼ teaspoon of Block It Out SPF 30 is applied.

• **Right Side:**
  1. To the right side I applied 1.25 ml or ½ teaspoon of UB 1 “A-Peel” Jessner solution.
  2. After 3 minutes a second layer of 1.25 ml or ½ teaspoon of UB 1 “A-Peel” was applied over the first layer.
  3. 3 minutes later, a third layer of 1.25 ml or ½ teaspoon of UB 1 “A-Peel” was applied.
  4. Last, after 3 minutes 1.25 or ¼ teaspoon of Block It Out SPF 10 was applied.

This is the “before and after” photo from the two “side by side” treatments above. You can see a marked change in the clients color. This tends to improve over the next few days. Most clients find that repeating every 4 weeks helps effectively manage their rosacea.
This next photo is using my Red Be Gone Treatment protocol. Greg is in a testimonial video on our website at http://unfadingbeauty.com/success_stories.asp.

1. Pre-cleanse with 2.5 ml or ½ teaspoon of Red Be Gone Cleanser.
2. Mist 4 to 6 pumps of Honey Dew Toner, blot off with tissue or disposable cotton pad.
3. Blend 5 ml or 1 teaspoon Pro Zyme Powder (pancreatin and bromelin) with 5 ml or 1 teaspoon Pro Zyme Activator (with 4% Glycolic Acid). Apply to face and neck area for 8 to 10 minutes with hot, moist towels or vaporizer. Remove with hot moist towels.
4. Apply 1.25 ml or ¼ teaspoon of C Therapy 1 (20% Vitamin C Serum).
5. Apply 30 ml or 2 tablespoons Derma Feast Massage Lotion, massage for 8 to 10 minutes. Cover with 2 hot, moist towels for 3 minutes. Use towels to remove.
6. Mix ½ cup "Bio" tanical Coolly Mask with 7 tablespoons ice water and apply to entire face and neck. As soon as mask sets (approximately 5 minutes) cover with 2 pre-refrigerated moist towels for 15 minutes.
7. Remove mask, use towels to remove residue.
8. Mist with 4 To 6 pumps Honey Dew Toner. DO NOT BLOT. Allow to dry.
9. Apply 1.25 ml or ¼ teaspoon Red Be Gone Nutrient Hydrator.
10. Apply 1.25 or ¼ teaspoon *Red Be Gone Lotion.*
11. Apply 1.25 or ¼ teaspoon *Satin Moisture Crème* or *Velvet Moisture Crème* if appropriate for dryer skin types.
12. Apply 1.25 or ¼ teaspoon *Block It Out SPF 30.*

Be brave! Learn as much about the different types and variants of rosacea as you possibly can.

- “Knowledge is Power”. Knowing what you’re up against helps you to understand and make wise choices.
- Spend the time getting to know your client. Your initial consultation will reward you with knowledge. Remember again, “Knowledge is Power”.
- Patch Test in the area you plan to peel.
- Take a “Before Photo”.
- Discuss treatment series for optimum results.
- Always prep the skin. Home care is your insurance policy for consistent results in the treatment room.
- A 5 minute follow-up appointment weekly prior to your first peel tells you if your client is adequately ready for the procedure.
- Know your peeling agents! *Always follow your manufacturers recommendations.*
- Continue with follow-up photos to document progress.

Don’t start out with a huge number of agents to choose from. Slowly add to your menu other choices. I find that once I’m confident with the peeling agent I’m using, I like to add another to my arsenal and see if there aren’t even better results.

It would be great to tell you that I have found the answer to all your rosacea problems. I can’t, and to date, neither can anyone else. There are some wonderful peeling agents to work with, and when used with appropriate home care, offer hope and confidence to those clients searching for answers to enhance and beautify their skin.
REFERENCES


Bass and Boney Inc., http://www.rosacea-ltd.com

Diepgen M.D., Thomas L., Professor and Chairman of the Department for Clinical and Social Medicine, Occupational and Environmental Dermatology, University of Heidelberg, http://wwwrosacea.dermis.net


*Several definitions from Merriam Webster Online