

VIDASKIN CLINIC · A DOCTOR'S GUIDE

Understanding & Treating Acne

Clear evidence. Thoughtful treatments.

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What you should be able to do by the end



Understand

What acne actually is, what drives it, and what makes it worse. Enough medicine to answer a patient properly.



Assess

A shared vocabulary for lesions, one grading method used the same way by everyone.



Recommend

Who gets what, in what order, what to say about timelines.

Everything in this deck follows the AAD 2024, NICE NG198 and European (EDF) acne guidelines.

01

Understanding acne

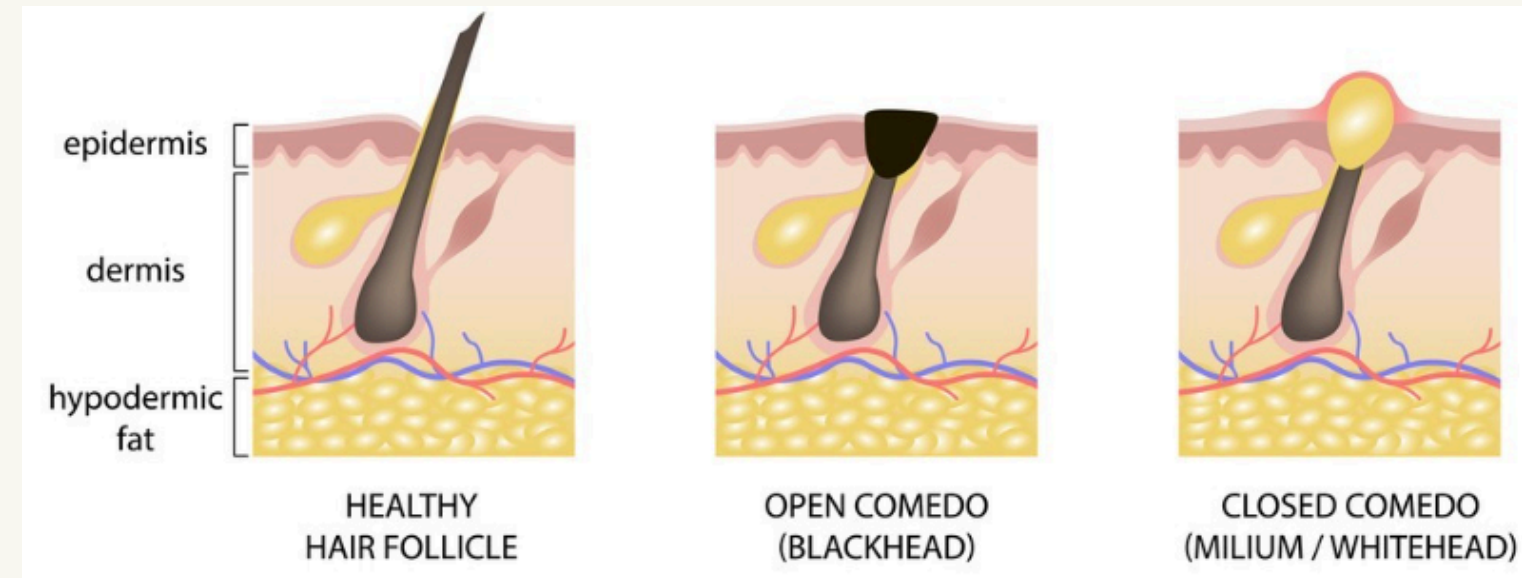
What it is, what drives it, and why the timing of treatment matters more than almost anything else.



What acne actually is

In one sentence

A chronic inflammatory disease of the oil gland unit — not a hygiene problem, not a phase, and not the patient's fault.



The medical version



The pilosebaceous unit

A hair follicle plus its sebaceous (oil) gland. This is the organ that gets sick — not the skin surface.



The sebaceous gland is active tissue

It responds to androgens, produces sebum, and releases inflammatory signals of its own. It is an immune organ, not a passive oil tap.



Every lesion starts invisible

The microcomedone forms weeks before anything is visible. Today's spots were set in motion a month ago.

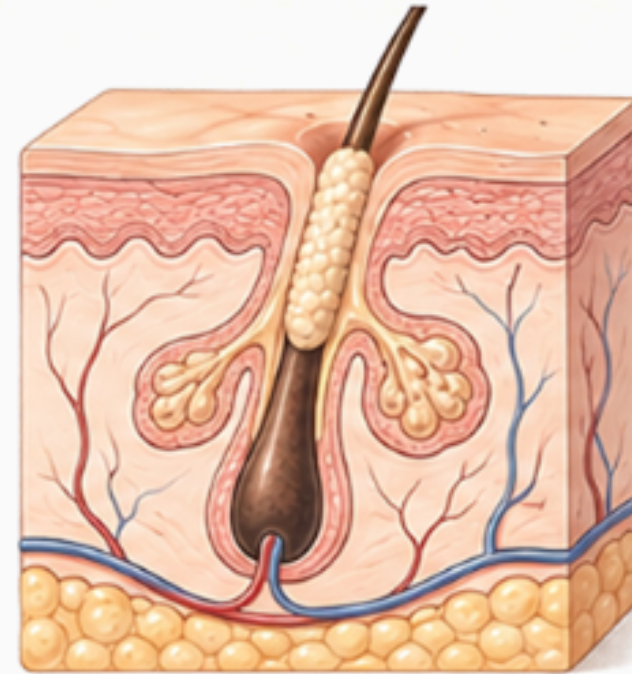
Four things drive acne — and we treat all four

1



Blocked follicle

Skin cells lining the follicle stop shedding normally and plug the opening. This is the first step and the target of retinoids.

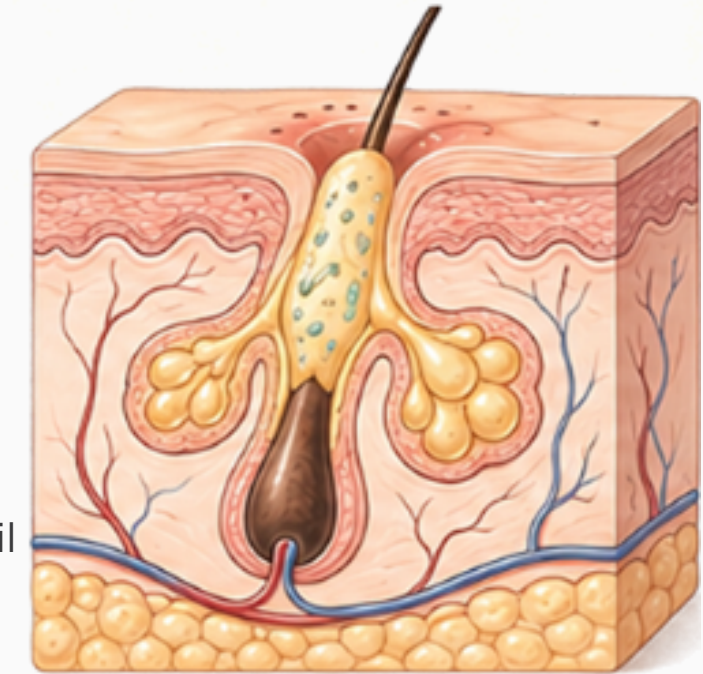


2



Oil

Androgens drive sebum production. The composition of the oil matters as much as the volume — which is why 'oil control' alone never cures acne.

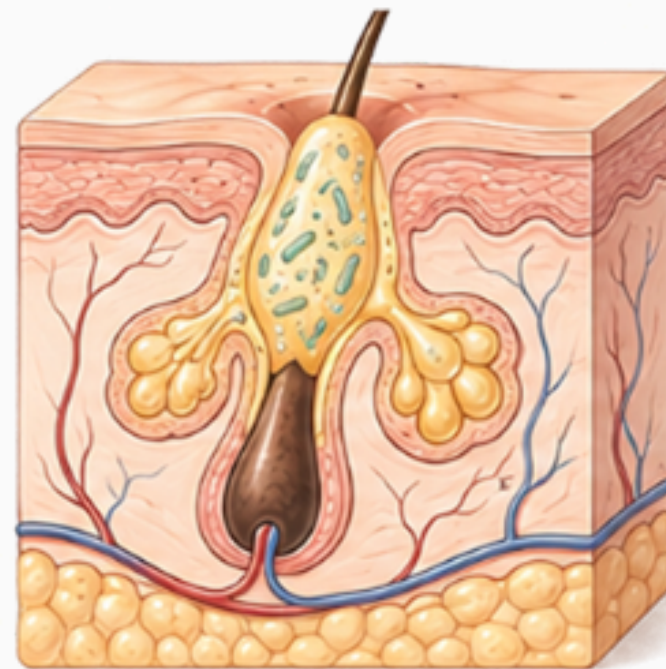


3



Bacterial imbalance

Not 'dirty skin' and not simple overgrowth. The mix of *C. acnes* strains shifts, and the unhelpful strains trigger the immune system.

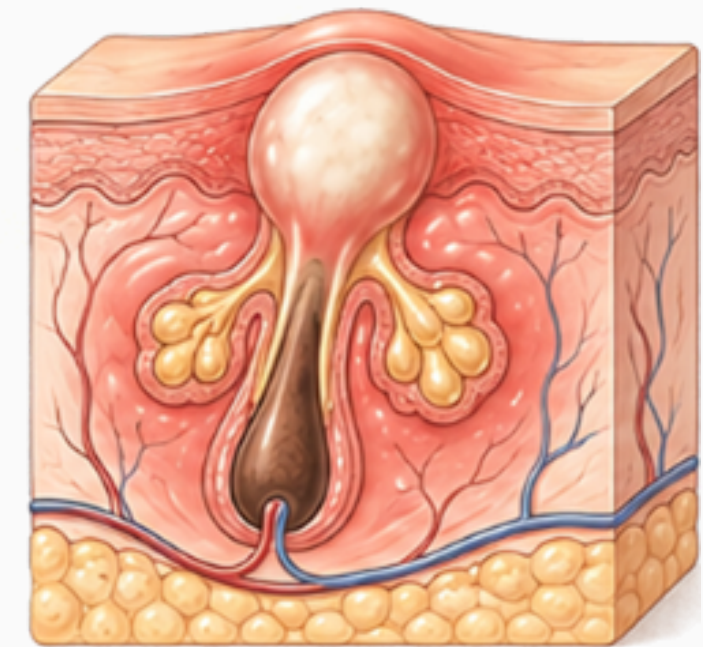


4



Inflammation

The immune response that produces redness, swelling, pain — and, if it runs long enough, scarring.



What patients believe vs what the evidence shows



What patients often believe

- “My skin is dirty — I need to wash and scrub more”
- “Chocolate and oily food caused this”
- “Sun exposure clears my skin”
- “I’ll grow out of it”
- “Squeezing gets rid of it faster”
- “If it hasn’t worked in two weeks, it isn’t working”



What the evidence supports

- Over-washing and scrubbing can worsen inflammation and acne marks
- High glycaemic-load diet: modest effect, RCT-supported. Dairy and whey: observational only
- Sun causes the dark marks patients hate; it does not treat acne
- Adult acne is common — particularly in women
- Squeezing is the fastest route to a dark mark or a permanent scar
- Nothing we prescribe is judged before 8–12 weeks

Why the timing of treatment matters more than the choice of treatment

Scars form early.

Not at the end of the disease — from the beginning of it.



Duration, not just severity

Scarring correlates with how LONG inflammation persists — not only with how bad it looks on the day.



Delay is an independent risk

Late presentation and delayed effective treatment are themselves risk factors for scarring.



Prevention beats correction

We can improve scars by perhaps 30–70% over several sessions. We cannot erase them. Preventing one is worth more than treating three.

02

Assessing acne

One vocabulary, one grading method, and the handful of findings that change everything.



The six questions we ask every acne patients



How long, and what's the pattern?

Age of onset, whether it flares before periods, whether it is getting worse.



What are you putting on your skin?

Full routine, makeup, hair products.



What have you already tried?

Which product, what strength, how often, for how long — and did you actually use it?



What are you taking?

Contraception, steroids, supplements — whey protein, gym products



Any scarring — yours or in the family?

A parent or sibling who scarred or needed isotretinoin changes our threshold.



How much is this affecting you?

Mood, confidence, social withdrawal. Severity on the skin is not severity to the patient.

Type of Acne Lesions / Terms

Closed comedone

“Whitehead”

Small skin-coloured bump, no visible opening. Not infected.



Open comedone

“Blackhead”

Open follicle with an oxidised plug. The dark colour is not dirt.



Papule

“Red bump”

Inflamed, under 5 mm, no visible pus. Tender.



Pustule

“Pus-headed spot”

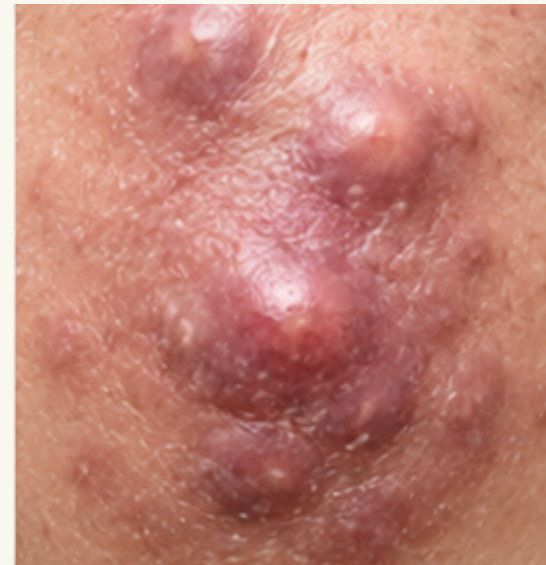
Inflamed with a visible white/yellow centre.



Nodule / cyst

“Deep lump”

5 mm or more, deep, painful, lasts weeks. High scarring risk.



Marks vs scars

“Flat vs textured”

Brown or red flat marks fade. A dent or pit is a scar and will not fade.



How we score severity: IGA

The five-point scale every published acne trial uses — so our notes speak the same language as the evidence.

Score	Grade	What it means
0	Clear	No inflammatory or non-inflammatory lesions
1	Almost clear	Rare non-inflammatory lesions, and no more than one small inflammatory lesion
2	Mild	Some non-inflammatory lesions, no more than a few inflammatory lesions. No nodules
3	Moderate	Up to many non-inflammatory lesions, some inflammatory lesions, no more than one small nodule
4	Severe	Up to many non-inflammatory and inflammatory lesions, and a few nodules

WHAT COUNTS AS SUCCESS

A 2-grade improvement AND a final score of 0 or 1.

That is a demanding bar. When a study reports 40% success at 12 weeks, that is a strong result — not a weak one.

HOW IT MAPS TO OUR PATHWAY

- 0–1**Clear / almost clear
- 2**Mild
- 3**Moderate
- 4**Severe

Record the IGA score and standardised photographs at every visit. Add lesion count when possible.

Three bands — and the rule that overrides all of them

Mild

IGA 1-2

Mostly comedones, few inflamed spots. No nodules. No scarring.

Moderate

IGA 3

Numerous inflamed papules and pustules, widespread comedones, may involve chest or back.

Severe

IGA 4

Extensive inflammation, nodules or cysts — or ANY acne that is actively scarring.

THE OVERRIDE RULE

Any one of these moves the patient onto the SEVERE pathway — whatever the score says:

- Active or new scarring
- Nodules or cysts
- Major psychological impact
- Two failed regimens
- Strong family history of scarring

03

Treating acne

Topicals, oral medication, therapist-led treatments and doctor-led devices — and the order they belong in.



Six rules that govern every acne plan we make

1

Treat the disease before the appearance

Microcomedones form weeks before any appearance.

2

Combine, don't use single-agent only

Acne has four mechanisms. One product addresses one of them.

3

A retinoid is in almost every plan

Induction and long-term maintenance — including in inflammatory acne.

4

Antibiotics: never alone, never long

Always with benzoyl peroxide. Target 3 months, maximum 4.

5

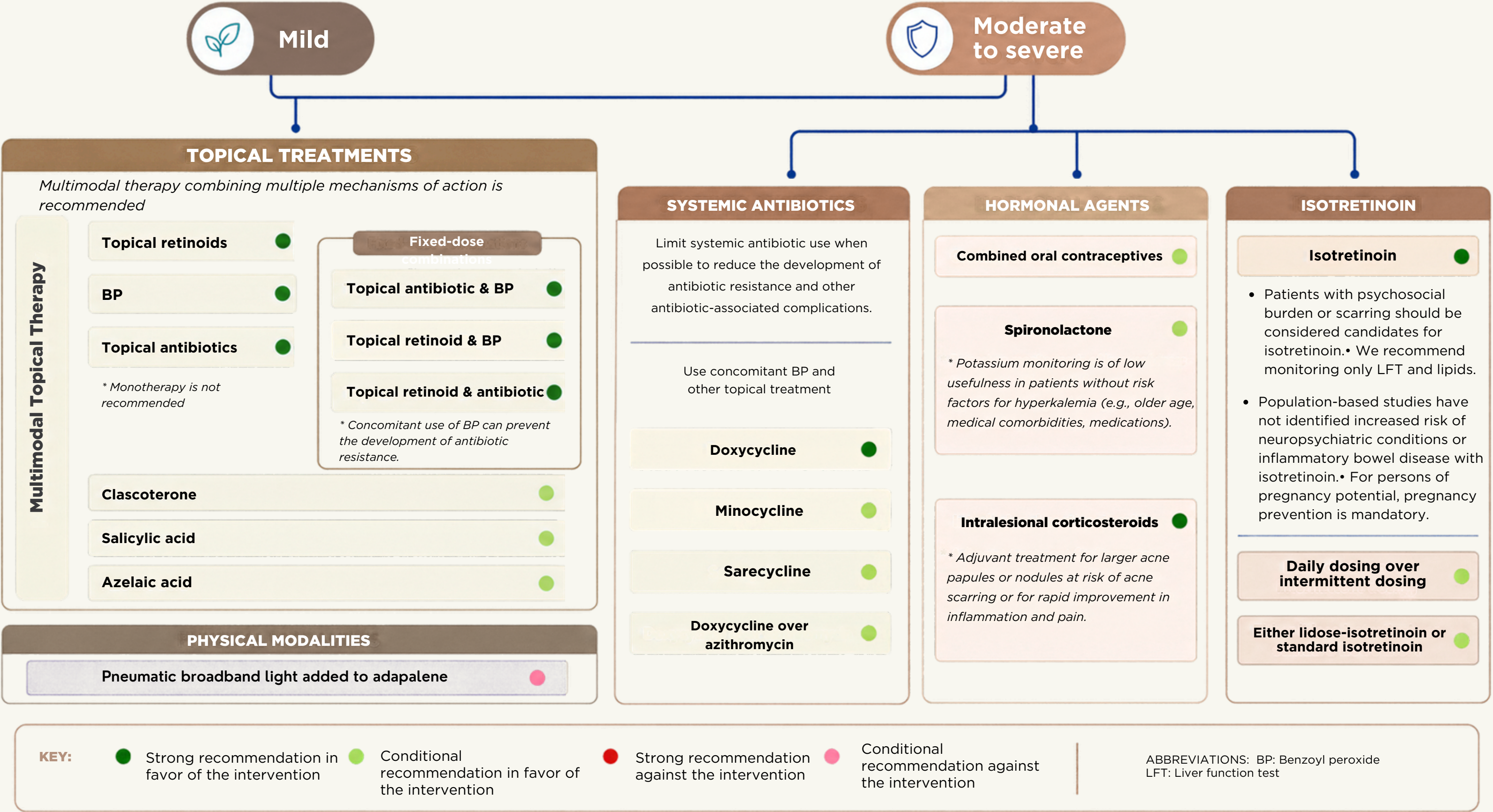
Judge at 8–12 weeks, not at 3

Set this expectation at the first visit or the patient will quit during the worst part.

6

Escalate early if scarring

Sequential gentle options in a scarring patient is under-treatment, and it is permanent.



Topicals — what each one actually does

Agent	What it does	Best for	Watch for
Benzoyl peroxide 2.5% wash or gel	Kills C. acnes by oxidation — and stops antibiotic resistance developing	Almost everyone. The base layer of the regimen	Bleaches towels, bedding and clothing. Store below 25 °C
Topical retinoid adapalene · tretinoin · trifarotene	Unblocks the follicle, stops new lesions forming, anti-inflammatory	Almost every patient, every severity — and long-term maintenance	Dryness weeks 2-4; night use; avoid in pregnancy. Detail next slide
Azelaic acid 15–20%	Anti-inflammatory, mildly antibacterial, and fades pigment	Acne with dark marks. Safe in pregnancy	Stinging in the first few weeks
Clindamycin topical antibiotic	Reduces bacteria and inflammation	Inflammatory papules — as part of a combination	NEVER alone. Always with benzoyl peroxide. 3-4 months maximum
AHA / BHA glycolic, mandelic, lactic / salicylic	Loosen surface cells. Salicylic acid is oil-soluble, so it works inside the pore	Comedonal skin, rough texture; a step-down if a retinoid isn't tolerated	Weaker than a retinoid. Don't stack with one — irritation drives pigmentation
Spironolactone topical, compounded	Blocks the androgen effect locally in the oil gland	Adjunct where a hormonal driver is suspected	Off-label, compounded, weak evidence — not presented as established therapy

The good regimens hit more than one mechanism at once — retinoid for the blocked follicle, benzoyl peroxide for the bacteria, something anti-inflammatory on top. Fixed-dose combinations exist for exactly this reason: fewer bottles means better adherence.

Retinoids: the one class everyone must understand

1st generation

Tretinoin

The original. Most potent classic comedolytic, best evidence for texture and photoageing. Light-sensitive — night use only.

3rd generation

Adapalene

Receptor-selective, photostable, stable alongside benzoyl peroxide. Best tolerability-to-efficacy ratio.

4th generation

Trifarotene

Highly receptor-selective, developed and trialled for large surface areas. The choice when the chest and back are involved.

How we start a retinoid — teach this to every patient

Pea-sized amount

for the whole face — not per spot

2–3 nights a week

for two weeks, then alternate, then nightly

Moisturise

before and after if irritated (“sandwich”)

Sunscreen daily

non-negotiable — part of the prescription

Expect the purge

worse before better, weeks 2–4

Oral medication — three mechanisms

RETINOID

Isotretinoin

The only agent that can produce lasting remission.

- Severe nodular or cystic acne
- Any acne that is scarring
- Failed conventional therapy
- Serious psychological impact

ANTIBIOTIC

Doxycycline

FIRST LINE — the tetracyclines carry the strongest guideline recommendation.

Erythromycin

When tetracyclines are unsuitable — pregnancy, under-8s, intolerance.

Amoxicillin-clavulanate

Later line, thinner evidence — where the above have failed or can't be used.

HORMONAL · WOMEN ONLY

Spironolactone

Blocks the androgen effect on the oil gland.

- Adult women, jawline and premenstrual pattern
- A genuine alternative to repeat antibiotic courses
- Off-label, but backed by a randomised trial
- Effective contraception required

Antibiotic stewardship — the rule that applies to all three antibiotics

Never alone — always alongside benzoyl peroxide. Three months, four at most, with the step-down agreed the day we prescribe. If we are reaching for a second course, the real question is why this patient is not on hormonal therapy or isotretinoin.

Local caution · Doxycycline causes real photosensitivity, and our patients are outdoors year-round. Counsel explicitly on daily sunscreen and sun avoidance, warn about holidays, and consider lymecycline where sun exposure is unavoidable.

Isotretinoin — the one everyone must understand properly



When we use it

- Severe nodular or cystic acne
- Acne of ANY severity that is scarring
- Moderate acne that has failed proper conventional therapy
- Acne relapsing quickly after repeated antibiotics
- Acne causing serious psychological distress



What every staff member must know

- Cannot be taken in pregnancy — it causes severe birth defects
- Advise for contraception and monthly pregnancy tests
- Monthly doctor review — no repeat supply without it
- Dry lips are universal; dry eyes affect night driving
- Any change in mood must be reported immediately
- No tetracyclines and no vitamin A supplements alongside

DOSE	COURSE	RELAPSE	TAKE IT
0.3-0.5 mg/kg/day to start, building to 0.5-1.0	Cumulative target 120-150 mg/kg, usually 5-8 months	Roughly 20-40%, mostly within 2 years	With a fatty meal — absorption roughly doubles

Procedures during isotretinoin: superficial peels, laser hair removal and fractional lasers are acceptable on current expert consensus. Fully ablative resurfacing is not.

Hormonal therapy — the adult female pattern

RECOGNISE THE PHENOTYPE

- Onset or persistence after 25
- Jawline, chin and neck
- Flares before the period
- Deep, tender, few comedones
- Returns after each antibiotic course

Spironolactone

Blocks the androgen effect on the oil gland. Start 25–50 mg daily, titrate to 50–100 mg.

- SAFA trial (BMJ 2023): 81.9% vs 63.3% of women improved at 24 weeks
- Benefit was LARGER at 24 weeks than 12 — a partial response at 3 months is not a failure
- Routine potassium testing is unnecessary in healthy women under 45
- Off-label for acne — consent is documented

Before you start — check

A short checklist that changes the plan more often than people expect.

- Effective contraception is required while taking it
- Cycle irregularity, hirsutism, hair thinning or weight change → consider a PCOS workup
- Medication check: ACE inhibitors, ARBs, potassium supplements, regular NSAIDs
- Hormonal blood tests are usually normal — the sensitivity is in the skin, not the hormone level

Ask what contraception she is using — every time. Progestin-only methods (the implant, mini-pill and hormonal coil) commonly worsen acne. A woman's “treatment-resistant” acne is sometimes her contraceptive implant, and no amount of topical treatment will fix that.

Oral medication — dose, duration and when to stop

Agent	Dose	How long	When to stop
Doxycycline	100 mg OD (or 50 mg BD). Sub-antimicrobial: 40 mg MR OD	3 months (4 max)	3–4 months, or at 12 weeks if no response. Step down to retinoid ± BPO
Lymecycline	300–408 mg once daily	3 months (4 max)	As above. Preferred where sun exposure is unavoidable
Erythromycin	500 mg twice daily	3 months (4 max)	As above. Reserve for pregnancy, under-8s or tetracycline intolerance
Amoxicillin-clavulanate	Per product — typically 625 mg twice daily	3 months (4 max)	As above. Later line — reassess the diagnosis first
Spironolactone	Start 25–50 mg OD → titrate to 50–100 mg OD	6–12 months (often longer)	Assess at 12 weeks, reassess at 24 — continue while it works
Isotretinoin	0.3–0.5 mg/kg/day × 4 weeks → 0.5–1.0 mg/kg/day. Take with a fatty meal	5–8 months	At a cumulative dose of 120–150 mg/kg — a target, not a fixed date

THE THREE STOP SIGNALS

1. No meaningful response at 12 weeks
2. The time limit is reached, or the cumulative target is met
3. An adverse effect requires it

Therapist-led treatments — where they genuinely help

HydraFacial



Gentle cleansing, exfoliation and hydration with light extraction of comedones.

SUITS

Comedonal skin, maintenance between medical reviews, patients who want to feel actively cared for.

SkinCeuticals Facial



Professional-strength actives applied under supervision, with a structured protocol.

SUITS

Mild congestion, dullness, pigment support alongside a medical plan.

Facial Medley



Combination protocol tailored to the skin on the day.

SUITS

Maintenance, comfort, and adherence support for patients already on treatment.

Where the evidence honestly sits: facials, hydradermabrasion and LED have limited high-quality evidence for treating acne itself (roughly level 3-4). They are comfort, maintenance and adherence treatments. They support a medical plan — they do not replace one.

Doctor-led devices — match the platform to the target

What we're treating	Platform	Why that one
Redness / post-acne erythema	Ellipse IPL · Yellow Pro (577 nm)	Both target haemoglobin, so they fade the pink marks left after inflammation settles
Brown marks (PIH)	Hollywood Spectra · PicoSure	Pigment-selective. Low fluence, conservative settings
Oiliness, pores, texture	Hollywood Spectra (carbon peel)	Popular and well tolerated. Cosmetic benefit — evidence for treating acne itself is weak
Atrophic scars	Fotona · PicoSure Focus	Fractional resurfacing remodels collagen. The best-evidenced device role in acne care
Active inflammatory acne	Yellow Pro · Ellipse	Adjunct only, alongside medical therapy — never instead of it

Honest positioning: device evidence for ACTIVE acne is weaker than for medication. Their strongest, best-evidenced role is treating what acne leaves behind — after the acne itself is controlled.

Always before any device treatment: Fitzpatrick skin type recorded · test spot in darker skin types · photosensitising medication checked · realistic session numbers and cost agreed in writing

Marks and scars — sequence matters more than technology

1

Control the acne first

No scar treatment while acne is active.
We want at least 3 months of stable, controlled skin.

2

Treat pigment and redness

Azelaic acid, retinoid, sun protection.
Devices for stubborn pigment or persistent redness.

3

Then treat the scars

Matched to scar type, staged over several sessions, with realistic expectations agreed up front.

Scar types — and what each actually needs

Icepick

Narrow, deep, under 2 mm



TCA CROSS or punch excision. Resurfacing alone under-performs.

Boxcar

Sharp-walled, 1.5–4 mm



Fractional resurfacing; punch techniques for deep discrete scars.

Rolling

Wide, tethered, undulating



Subcision to release the tether first, then resurfacing or filler.

The number to quote: 30–70% improvement over several sessions. Scars are improved, never erased. A patient who cannot accept that should not be treated.

Who gets what — the one treatment slide to remember

MILD

FIRST LINE

Topical retinoid nightly + benzoyl peroxide

CONSIDER ADDING

Azelaic acid if dark marks are the main concern

ADJUNCT

Facial / HydraFacial for comedonal skin

REVIEW

12 weeks

MODERATE

FIRST LINE

Retinoid + BPO + antibiotic — oral doxycycline

WOMEN, JAWLINE PATTERN

Spironolactone rather than another antibiotic course

ADJUNCT

Devices for marks — only alongside medical therapy

REVIEW

8-12 weeks. Antibiotic stops by 3-4 months

SEVERE

FIRST LINE

Oral isotretinoin — doctor assessment required

KEEP IN VIEW

Oral antibiotic + topicals; steroid injection for individual nodules

DO NOT

Delay through more topical trials if the patient is scarring

REVIEW

Monthly, without exception

Underneath all three columns: benzoyl peroxide, daily sunscreen, a gentle routine, and long-term retinoid maintenance once the skin is clear.

IF YOU REMEMBER FIVE THINGS

The five that matter

- 1 Acne is a medical disease of the oil gland unit — treat the whole area, not the spot.
- 2 Scars come from how long inflammation lasts. Early, adequate treatment is the only real scar prevention.
- 3 Grade it, photograph it, and judge it at 8–12 weeks — never at three.
- 4 Antibiotics never travel alone and never travel long. Benzoyl peroxide alongside, three months, exit plan agreed on day one.
- 5 Procedures support the medical plan. They never replace it — and no one promises to erase a scar.

Full detail, dosing, monitoring schedules and consent requirements: SOP-CLIN-004, Management of Acne Vulgaris.

Guidelines and key sources

Guidelines

- Reynolds RV, et al. Guidelines of care for the management of acne vulgaris. J Am Acad Dermatol 2024;90(5):1006.e1–1006.e30
- NICE NG198. Acne vulgaris: management
- Nast A, et al. European evidence-based (S3) guideline for the treatment of acne
- Global Alliance to Improve Outcomes in Acne — consensus recommendations

Key studies cited in this deck

- Santer M, et al. Spironolactone for women with acne (SAFA): randomised controlled trial. BMJ 2023;381:e074349
- Plovanich M, et al. Low usefulness of potassium monitoring in healthy young women taking spironolactone. JAMA Dermatol 2015;151(9):941–4
- Spring LK, et al. Isotretinoin and timing of procedural interventions: systematic review with consensus recommendations. JAMA Dermatol 2017;153(8):802–9
- Jeremy AHT, et al. Inflammatory events are involved in acne lesion initiation. J Invest Dermatol 2003;121(1):20–7

AAD 2024 makes STRONG recommendations for benzoyl peroxide, topical retinoids, topical antibiotics, oral doxycycline and oral isotretinoin — the last for acne that is severe, scarring, or causing psychosocial burden.