

Two-vehicle-controlled studies demonstrated that twice-daily AzA was effective in patients with moderate papulopustular rosacea.\textsuperscript{11} Significantly greater reductions in inflammatory lesion count and erythema scores were seen in patients treated with AzA, compared with vehicle (Table).\textsuperscript{3} Investigator global assessment of success (sum of “clear,” “minimal,” and “mild” ratings) was also significantly higher in patients receiving active treatment (Table).\textsuperscript{2} AzA demonstrated a rapid onset of action; differences between treatment groups in mean inflammatory lesion count were seen as early as 4 weeks after starting treatment.\textsuperscript{11}

A double-blind, randomized study found that AzA had statistically significant efficacy over metronidazole 0.75% gel in most efficacy variables (P=0.05 for all comparisons) (Table).\textsuperscript{2} The differences in lesion count and erythema score between treatment groups at the end of treatment could possibly be attributed to a leveling off of improvement in the metronidazole group after week 8.\textsuperscript{3} Another comparative study concluded that AzA and metronidazole 1.0% gel were similarly effective in terms of lesion count, erythema, and investigator global severity scores.\textsuperscript{12} A systematic (Cochrane) review of controlled trials of rosacea therapies concluded that topical AzA and metronidazole are both effective, but firm conclusions regarding other therapies could not be drawn from the current evidence base.\textsuperscript{13}

Combination With Systemic Therapy
Oral tetracycline antibiotics are often used to treat flares, but long-term treatment at conventional doses has the potential to induce bacterial resistance.\textsuperscript{3} In a 2-week phase of a 12-week study, 712 patients with moderate to severe rosacea received AzA and doxycycline 100 mg twice daily for up to 12 weeks during an initial open-label phase.\textsuperscript{5} This led to a 275% reduction in inflammatory lesion count in 81.4% of subjects. Patients achieving success during combination therapy were then randomized to double-blind treatment with either AzA or vehicle. AzA provided consistently greater improvement in erythema, and investigator global severity scores.\textsuperscript{12} The Cochrane analysis confirmed the low discontinuation rate with AzA and the mild and transient nature of local skin reactions.\textsuperscript{2} Data from maintenance therapy studies show that long-term treatment with AzA is well tolerated.\textsuperscript{13} During 24 weeks of AzA maintenance therapy, the only treatment-related AEs were nonsevere cutaneous reactions, occurring in 9% of patients.\textsuperscript{14} No patient developed a treatment-related serious AE or discontinued maintenance therapy because of AEs.

AzA in Practice
From the clinical evidence to date, AzA 15% gel is an effective topical therapy for mild to moderate papulopustular rosacea.\textsuperscript{2} Metronidazole 1.0% gel and AzA 15% gel have a similar rate of AEs; cutaneous irritation occurs more often with AzA, but scaling is more common with metronidazole.\textsuperscript{12} However, the side effects of AzA are generally mild/consistent and do not affect patients’ overall perception of tolerability or their desire to continue treatment.\textsuperscript{5,21} As with topical metronidazole, telangiectasia is the sign least likely to respond to topical therapy with AzA.\textsuperscript{3} AzA is effective for inducing rapid remission when used with oral doxycycline for moderate papulopustular rosacea.\textsuperscript{2} Moreover, AzA also provides maintenance therapy against relapse,\textsuperscript{2} and is safe and well tolerated up to 36 weeks.

The papulopustular subtype of rosacea is considered the easiest to treat,\textsuperscript{3} whereas the most common erythematosangiectatic subtype poses the greatest treatment challenge. Although some improvement in erythema has been noted in patients with the papulopustular subtype treated with AzA, this treatment has not specifically been evaluated for treating erythema in the absence of papules and pustules,\textsuperscript{12} and no current treatment is considered effective for flushing.\textsuperscript{6}

References

Written by Ruth Williams, Medical Writer, and Medisys Health Communications. Reviewed and edited by Hilary E. Baldwin, MD. This supplement was sponsored by Intendis, Inc. www.familypracticenews.com