key points

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Rosacea is more common in women than men and occurs more frequently in fair-skinned individuals, usually in the middle years of life. It tends to localise to the cheeks, forehead, chin and nose, sometimes showing marked asymmetry. Only very occasionally does it involve areas other than the face. Rosacea is usually characterised by erythematous papules, pustules, and occasionally plaques (papulopustular rosacea), which fluctuate in severity, typically on a background of erythema and telangiectasia. In some individuals, facial redness can be prominent and permanent (erythematotelangiectatic rosacea). Important distinguishing features from acne are a lack of comedones, absence of involvement of extra-facial areas, and the presence of flushing.

Hypertrophy of facial sebaceous glands, sometimes with fibrotic changes, may result in unsightly thickening of the skin. Men, in particular, may develop marked enlargement and distortion of the nose. Occasionally, the predominant feature of rosacea is swelling of the eyelids and firm oedematous changes elsewhere on the face. Involvement of the eyes is an important, underdiagnosed complication that may result in significant ocular morbidity. Involvement of the external eye surfaces by rosacea usually necessitates ophthalmological advice. There is often no correlation between the degree of ocular and cutaneous rosacea, and ocular rosacea may occur alone.

Rosacea is a disfiguring condition that can have a major psychosocial impact, and its detrimental effect on emotional health and quality of life is often overlooked. The fact that it is often mistakenly associated with excessive alcohol consumption may lead to stigmatisation and serve to compound emotional distress.

The pathophysiology of rosacea is presumed to involve a genetically determined dysfunction of both the neurovascular structures in the skin and the cutaneous elements of the innate and adaptive immune systems when an individual with rosacea is exposed to certain environmental and microbiological stimuli.

The twice daily topical application of either 0.75% metronidazole or 15% azelaic acid gel can be an effective and safe treatment for mild to moderate rosacea but is not recommended for long-term use. Second-line topical therapies for rosacea include erythromycin, clindamycin, benzoyl peroxide, permethrin, retinoids and calcineurin inhibitors. Tetracycline and oxytetracycline are licensed for the treatment of moderate to severe rosacea. Topical corticosteroids should not be used, despite their apparent initial improvement of facial redness.

Referral to a dermatologist should be considered if: the diagnosis is in doubt; there is poorly responsive papulopustular rosacea; or symptoms causing emotional distress. Urgent referral to an ophthalmologist should be considered if keratitis is suspected.