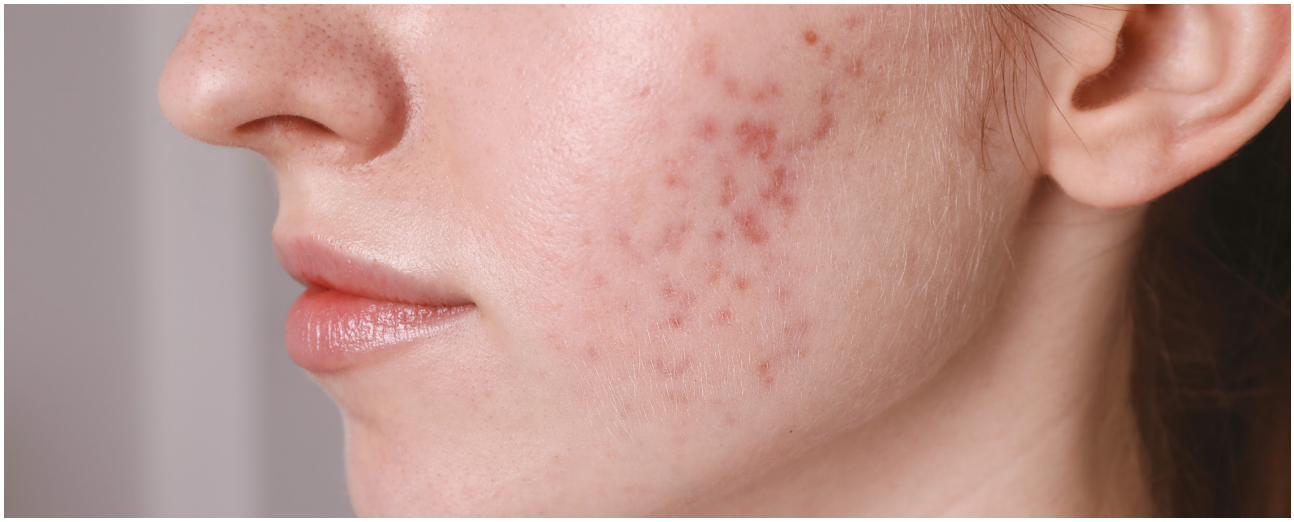
PULSE

Initiated, developed and funded by GALDERMA EST. 1981

This guide was developed as part of a collaborative agreement between Cogora and Galderma (UK) Ltd who have funded and reviewed this guide in line with PMCPA Code of Practice and Aklief ▼ (trifarotene) Summary of Product Characteristics.

Full prescribing information and adverse events reporting information can be found here and on the advertisement overleaf.



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QUICK GUIDE

Acne and scarring: what GPs need to know

Introduction

Acne vulgaris (acne) is one of the most common skin conditions in the UK, leading to 3.5 million visits to primary care every year.[1] This places GPs at the centre of acne care.

Scarring occurs in about 20% of people with acne and 57–90% of patients with moderate-severe acne experience embarrassment and low self-esteem due to their lesions, motivating treatment.[2,3]

This Quick Guide for GPs aims to increase awareness of acne, the impact of acne scarring on patients and available treatment options. 'Acne' refers to 'acne vulgaris' unless otherwise stated.

Acne aetiology

Acne affects around 9% of the global population, predominantly adolescents.[1] Risk factors for acne include hyperandrogenism, polycystic ovary syndrome, and a family history of acne.[2,4] Acne can be exacerbated by greasy skin/hair products, sweating, menstrual phase, picking and emotional distress,[2,4] as well as drugs such as corticosteroids, anabolic steroids, lithium and ciclosporin.[5]

Acne features

Acne is a disorder of the pilosebaceous unit involving excess sebum, formation of non-inflammatory lesions (open and closed comedones), *Cutibacterium acnes* proliferation and inflammation.[5] Inflammation leads to inflammatory lesions: papules and pustules, and in more severe cases, nodules and cysts.[6]

Scarring may occur due to tissue loss (atrophic/ice pick) or excess fibrous tissue (hypertrophic/keloid),[5] with risk of scarring increasing with acne severity and duration.[7] Post-inflammatory hypo- or hyperpigmentation may also occur.[6]

Categorising acne severity (Box 1) helps guide treatment and monitoring of response.

Box 1 NICE criteria for grading acne severity[7]

Mild-moderate

- any number of non-inflammatory lesions, and/or
- up to 34 inflammatory lesions, and/or
- up to 2 nodules

Moderate-severe

- 35 or more inflammatory lesions, and/or
- 3 or more nodules

Continued overleaf →

Burden of acne and scarring
Beyond physical symptoms such as soreness, itching and pain, acne has a marked psychological burden.[4] Acne, scarring and hyperpigmentation can lead to stigmatisation and acne is associated with heightened distress, embarrassment, decreased self-esteem and increased rates of depression and suicidal thoughts.[2,3,8] Clinical severity does not directly correspond to psychological burden: mild acne to a health professional may still cause severe psychological distress.[7] Since access to cosmetic treatments for acne scars on the NHS is limited,[9] there is an additional financial burden for patients who treat acne scars privately.

Treatment options
Early effective treatment for acne may prevent scarring and pigmentation changes and improve psychological wellbeing.[2,4] It is important to promote treatment adherence because positive effects can take 6–8 weeks to appear.[7]

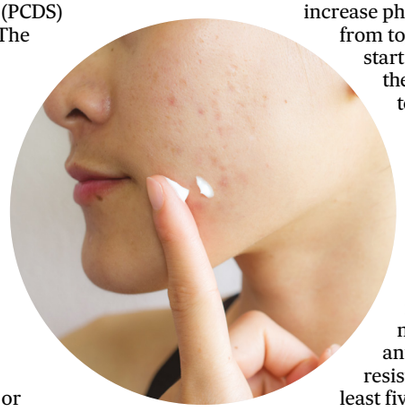
The Primary Care Dermatology Society (PCDS) and NICE provide treatment guidelines.[5,7] The PCDS endorses a four-step progression:[5]

STEP 1 Mainly comedonal acne Topical retinoid: adapalene ± benzoyl peroxide (BPO), or trifarotene alone.

STEP 2 Mild-moderate papular/pustular acne Fixed dose combination (ideally with BPO) of topical retinoid or topical antibiotic (first-line: adapalene + BPO, clindamycin + BPO, or clindamycin + tretinoin; second-line: erythromycin + tretinoin or, if combinations not tolerated, any topical retinoid or BPO alone).

STEP 3 Not responding or more widely distributed (no significant scarring) Systemic antibiotic (first-line: lymecycline or doxycycline; second-line per local guidance, e.g. alternative tetracycline or clarithromycin), or in some women a combined oral contraceptive (COC) or antiandrogen, plus a topical agent (preferably adapalene + BPO; if not tolerated, BPO, adapalene, or trifarotene alone).

STEP 4 Active scarring acne – Start step 3 treatment and refer semi-urgently (aim 6–12 weeks). Exception: early scarring in mild-moderate non-nodular acne – start step 3, review at 6 weeks, refer if no significant improvement.



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Box 2 Key differences between the PCDS and NICE guidelines[5,7]

- NICE guideline was updated in 2023; PCDS in 2025.
- NICE has no separate step for purely comedonal acne (PCDS step 1).
- NICE includes azelaic acid for moderate-severe acne; PCDS does not.
- NICE only recommends topical retinoid monotherapy (specifically adapalene) as a maintenance treatment; PCDS recommends topical retinoid monotherapy (including trifarotene) as a first-line (Step 1) or second-line (Steps 2–3) option.
- NICE recommends considering referral for active scarring, whereas for early scarring, PCDS recommends to initiate treatment and review at six weeks.

NICE recommendations are based on two severity categories:[7]
Mild-moderate Adapalene + BPO, clindamycin + BPO, or clindamycin + tretinoin. BPO alone if other options are contraindicated or if the patient wishes to avoid retinoids or antibiotics. In women, a COC may be added.
Moderate-severe Same options as above, topical adapalene + BPO + lymecycline or doxycycline, or azelaic acid + lymecycline or doxycycline. In women, a COC may be added.

Topical treatments
Retinoids are a foundational treatment for acne because they are comedolytic and anti-inflammatory.[10] Retinoids have also been shown to reduce scarring. In phase 4 randomised controlled trials in individuals with moderate or severe acne, adapalene + BPO combination treatment (OSCAR trial) and trifarotene alone (START trial) have been shown to significantly decrease atrophic scars over several months.[11,12]

Retinoids should be applied in the evening because they increase photosensitivity.[7,13] To minimise irritation from topical treatments such as BPO or retinoids, start with alternate-day or short-contact use, then progress to regular application if tolerated.[7] Using moisturisers can also help.[2]

Antibiotics
NICE advises against using topical or oral antibiotics as monotherapy, or combining topical with oral antibiotics.[7] Oral antibiotics should ideally be prescribed for a maximum of three months.[5] Patients who relapse quickly may need courses lasting up to six months.[5] Concurrent use of BPO with antibiotics helps reduce antimicrobial resistance. BPO should also be continued for at least five days after antibiotic courses lasting two months or longer to eliminate resistant bacteria.[4]

Topical maintenance therapy is usually required after stopping antibiotics.[5]

Isotretinoin
Isotretinoin is reserved for severe acne.[7] GPs may be involved in shared care agreements in some areas.[14] Acne may flare up upon treatment initiation and most patients develop dry skin/lips (dose-dependent and managed with emollients/lip balm). Blood abnormalities are common but usually mild.[2]

Long-term maintenance
Maintenance treatment should be considered in those with a history of frequent relapse.[7] NICE recommends a topical adapalene + BPO combination or, if not tolerated, adapalene, azelaic acid, or BPO alone.[7] The PCDS recommends a topical retinoid for maintenance.[13] Occasional flares may require revisiting previously successful treatments.[13]

Special groups
Females
COCs (prescribed off-label) can help acne by reducing androgen activity and can be combined with topical agents or oral antibiotics.[2,4,5] Progestogen-only contraceptives may worsen acne and should be avoided.[4] The antiandrogen spironolactone is safe and effective but may take up to 6 months to work.[5] Spironolactone and COCs can be used longer than oral antibiotics and isotretinoin; except co-cyprindiol due to a cumulative dose-dependent risk of meningioma.[2] Topical retinoids and oral tetracyclines are contraindicated in pregnancy and women planning pregnancy.[5]

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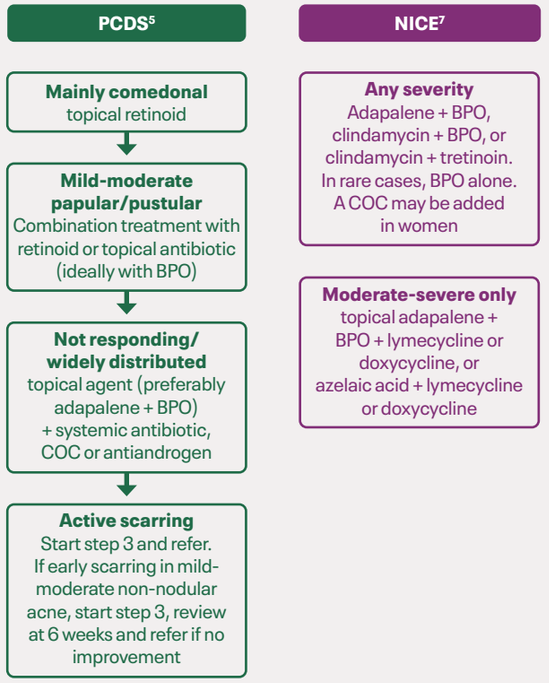
Figure 1 PCDS and NICE recommendations for the treatment of acne



Skin of colour
To reduce post-inflammatory hyperpigmentation, PCDS recommends early, aggressive treatment, including early referral for isotretinoin and managing dryness and irritation.[5]

Additional treatment options for scarring
GPs may prescribe silicone gels or local steroids for hypertrophic/keloid scars.[5] Severe scarring that persists for a year after acne has cleared may warrant referral for consideration of CO_2 laser treatment or glycolic acid peel, though these are not widely available on the NHS.[7,8]

Box 3 When to refer to specialist care

Referral to a specialist is recommended for:
- acne fulminans (urgent referral to be assessed within 24 hours).[7]
- diagnostic uncertainty.[7]
- acne linked to drug/medication use.[7]
- severe acne (refer early).[5]
- patients with severe associated psychological symptoms.[5]

Conversations with patients
Provide patients with clear, personalised information on acne, including:[7]
- reasons for their acne.
- treatment options and associated benefits and drawbacks.
- potential impacts of acne.
- importance of adhering to treatment.
- relapses during or after treatment.

The risk for scarring and pigmentation changes should be discussed regularly and patients should be advised that picking/scratching lesions can increase the risk of scarring.[7,8] GPs should also proactively enquire about mental health impacts of acne.[4]

Provide patients with advice on skin care.[7] Daily use of cleansers, moisturisers and sunscreens can reduce both inflammatory and non-inflammatory acne lesion counts.[15] People with acne should use a non-alkaline synthetic detergent cleanser twice daily, avoid oil-based and comedogenic products, and remove makeup at the end of the day.[7]

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Box 4 Key points

- Acne is associated with a pronounced psychological burden, including embarrassment, depression and stigma linked to scarring and hyperpigmentation[2–4,8]
- Treatment is guided by acne severity, with topical retinoids, antibiotics, BPO and hormonal therapies (in females) forming the cornerstone of treatment[5]
- Early effective treatment for acne improves patient wellbeing and can prevent scarring[2]
- GPs should discuss the potential impacts of acne and different treatment options with patients,[7] including the risks for scarring[8]

Job code GB-AFC-2600011 Date of preparation June 2026

AKLIEF® is a topical retinoid indicated for the cutaneous treatment of moderate acne vulgaris of the face and/or trunk in patients from 12 years of age and older when many comedones, papules and pustules are present.[1]

AKLIEF® ▼
50 microgram/g cream trifarotene

FIGHT ACNE – CONTROL FUTURE SCARS

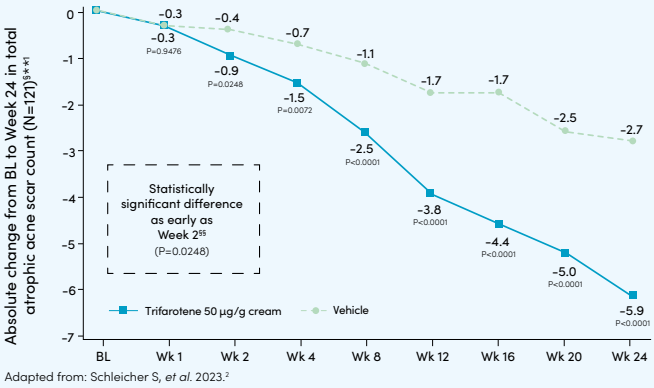
The emotional and physical burden of acne goes far beyond lesions

AKLIEF® is the ONLY topical retinoid clinically proven to reduce active lesions by 70% compared to 44.9% with vehicle ($p < 0.05$) **and atrophic acne scars by 55%** compared to 29.9% with vehicle ($p < 0.0001$)[2]

Scan the QR code to learn more about Aklief®

Permanent scarring can occur in all patients with acne regardless of acne severity[3,4]

AKLIEF® significantly reduced atrophic scar count vs. vehicle[§5]



Adapted from: Schleicher S, *et al.* 2023.[2]

reduction (11.4 BL vs. 5.4 ± 5.6 Week 24) **in total atrophic acne scar count** vs. 30% (11.6 BL vs. 9.1 ± 8.6 Week 24) with vehicle treatment, from BL to Week 24[‡‡§§2,5]

Reduction in acne scar count seen as early as Week 2, with continuous reduction at Week 24[2]

START with AKLIEF® Cream for a difference patients can see and feel

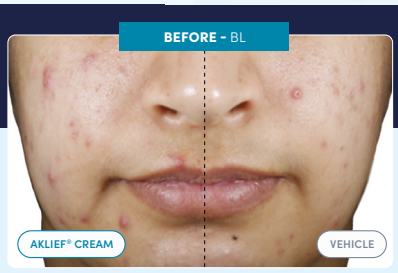
PCDS recommends Aklief for the treatment of mainly comedonal acne and acne not responding to treatment and/or widely distributed (without significant scarring)[6]

Treat acne completely — not partially

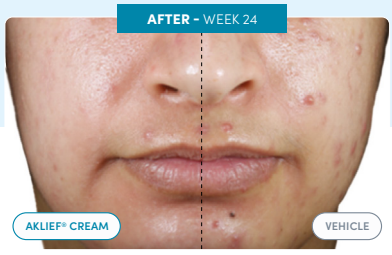
Aklief® offers a holistic approach to acne management — treating facial and truncal acne, reducing existing atrophic scars, and supporting adherence through the CTMP™ routine.

It's time to treat acne from start to finish.

For patients like Amy, it's the difference between temporary improvement and lasting confidence.



START study patient photographs before treatment and at Week 24 using AKLIEF® ‡‡2



Images from: Schleicher S, *et al.* 2023.[2]

Please refer to the full Prescribing Information and Adverse Event Reporting information available via the QR code.

The SmPC and patient information leaflet for Aklief can be found at https://www.medicines.org.uk/emc/product/13881/smpc

Abbreviations: BL, baseline; **START**, Study of Trifarotene Cream to Assess Risk of aTrophic Acne Scar Formation.

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