With the advent of puberty, androgens cause sebaceous glands in certain hair follicles to become much larger and more active. These so-called sebaceous follicles are concentrated on the face, upper back and chest. The increased oil production overwhelms the small hair follicle, which becomes blocked and distended. This first lesion of acne is the microcomedone, and it is the basis for all subsequent lesions. Excessive cornification at the hair follicle orifice aggravates the problem. The microcomedone is invisible to the naked eye, but the skin looks greasy. Microcomedones can remain unchanged for years, or they can evolve into closed comedones, the so-called blackheads and blackheads so typical of acne. A predominance of these lesions causes comedonal acne. Usually, however, the comedone evolves further because of spontaneous rupture within the dermis, to form inflamed lesions of acne, inflamed papules, pustules and cysts (Fig. I).

Comedonal acne is treated with topical retinoids alone: a very gradual response is expected. Inflammatory acne should receive, in addition, either a topical benzoyl peroxide agent or a topical or oral antibiotic. Benzoyl peroxide is also irritant, and can be applied to individual lesions or the whole face, at a different time from the retinoid. There are many benzoyl peroxide agents available, including S0-Benzac-AC® 5%, S0-Panoxyl 5 or 10%, S2-Acudazil®*, S4-Brevos®, S4-Benoxyl, S2-Acneclear® and S4-Benzamycin. Note that these bleach fabrics. An alternative to benzoyl peroxide is azelaic acid cream or gel (S1-Skinares®).

More severe inflammatory acne warrants addition of a systemic antibiotic to the retinoid and benzoyl peroxide. The most widely used antibiotics are tetracyclines (S4) in fairly high doses. Options include tetracycline or oxytetracycline 500 mg bd before meals, with a full glass of water to prevent oesophagitis, doxycycline 100 – 200 mg daily, lymecycline 300 - 600 mg daily and minocycline 100 - 200 mg daily. Side-effects include photosensitivity and nausea with doxycycline, and vertigo or severe allergy with minocycline. Topical antibiotics include erythromycin solution (S4-Erygel®), S4-Streptomycin®, S4-Eryderm® and clindamycin solution or lotion (S4-Dalacin™). The antibiotic is used primarily for its anti-inflammatory properties in skin, but also to reduce colonisation until the acne burns out. An alternative regimen in older female teenagers includes one of the antiandrogenic oral contraceptives (S4) such as Diane-35, Yasmin, Diva -35 or Tricilest. More severe acne, or resistant acne, should be treated with oral isotretinoin, as this offers the best chance of a long-lasting result, and avoidance of severe scarring. A dose of 40 - 60 mg daily for 4 – 6 months is usually adequate, with attention paid to the numerous side-effects and contraindications. Oral isotretinoin agents (S5) include Roaccutane®, Oratane® and Acnetane®.

Finally, a word about skin cleansing and cosmetics: these are unfortunately of little value. However, regular cleansing with soap or one of the many acne cleansers may help. Moisturisers, makeup and sunscreens can aggravate acne, but usually do not. Trial and error is the best advice for these products, which are invariably included in a daily ritual of skin care. Regular facials can be beneficial. Diet plays no role in acne despite anecdotal reports to the contrary. Hot weather, sweating, emotional stress, topical and oral corticosteroids, anabolic steroids and excessive intake of iodine can exacerbate acne, and many women experience a premenstrual flare. Most acne will undergo spontaneous resolution in the early twenties, but acne can persist, and can also occur for the first time later in life.