Dear Editor, The classification of rosacea has evolved from a subtyping into a phenotype approach, and an updated treatment guideline for the Netherlands.

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References
1 van der Weijden CA, Pilier SA, Feldman AL et al. Understanding CD30 biology and therapeutic targeting: a historical perspective providing insight into future directions. Blod Cancer J 2017; 7:e603.
2 Prince HM, Kim YH, Horwitz SM et al. Brentuximab vedotin or physician’s choice in CD30-positive cutaneous T-cell lymphoma (ALCANZA): an international, open-label, randomised, phase 3, multicentre trial. Lancet 2017; 390:555–66.
3 Nasu K, Said J, Vonderheid E et al. Immunopathology of cutaneous T-cell lymphomas. Am J Pathol 1985; 119:436–47.
4 Mahévas T, Ram-Wolff C, Battistella M et al. Dramatic response to brentuximab vedotin in refractory nontransformed CD30+ mycosis fungoides allowing allogeneic stem cell transplant and long-term complete remission. Br J Dermatol 2019; 180:1517–20.
5 Dumont M, Ram-Wolff C, Roeleens M et al. Efficacy and safety of brentuximab vedotin plus bendamustine in advanced-stage primary cutaneous T-cell lymphomas. Br J Dermatol 2019; 181:1315–17.
6 Garczak S, Loschi M, De Masson A et al. Brentuximab vedotin as a bridge to allogeneic stem-cell transplantation for refractory or relapsing patients with CD30 positive anaplastic or T-cell non-Hodgkin lymphomas: a study on behalf of the SPGM-TC. Leuk Lymphoma 2019; 60:2802–5.
7 Ferliege JE, von Buttlar X, Krasin M et al. Brentuximab vedotin as consolidation after hematopoietic cell transplant for relapsed Hodgkin lymphoma in pediatric patients. Pediatr Blood Cancer 2019; 66:e27962.
8 Bartlett NL, Chen R, Fanale MA et al. Retreatment with brentuximab vedotin in patients with CD30-positive hematologic malignancies. J Hematol Oncol 2014; 7:24.
9 Moskowitz CH, Nademane A, Maccari T et al. Brentuximab vedotin as consolidation therapy after autologous stem-cell transplantation in patients with Hodgkin’s lymphoma at risk of relapse or progression (AETHERA): a randomised, double-blind, placebo-controlled, phase 3 trial. Lancet 2015; 385:1853–62.

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Rosacea treatment guideline for the Netherlands*

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Dear Editor, The classification of rosacea has evolved from a subtyping into a phenotype approach, and an updated...
systematic review on interventions in rosacea using this approach was recently published. Therefore, we developed a new evidence-based guideline for all physicians and skin therapists involved in the management of patients with rosacea. A patient information leaflet based on this guideline was produced. The working group (WG) consisted of four dermatologists, two general practitioners, one ophthalmologist, one plastic surgeon, two skin therapists, one patient and two staff members of the Dutch Society of Dermatology and Venereology. All affiliated organizations participated in external review. The Dutch Association for Hospital Pharmacists was invited to participate in the WG, but chose to participate only in the external review. The Association of Innovative Medicines, Dutch Health Insurers, the Dutch Association of Hospitals and the Dutch Federation of University Medical Centres were invited to participate in devising health questions and external review. Development of the guideline was independently funded by the Dutch Medical Specialists’ Quality Fund. Two WG members had received one-off nonfinancial support from Galderma in 2016; the other members declared no conflicts of interest.

The updated systematic review ‘Interventions for rosacea based on the phenotype approach’ served as the basis for guideline development. This review conformed to the PRISMA statement and included GRADE certainty-of-evidence assessments for all prespecified outcomes (quality of life, participant-assessed rosacea severity, adverse events, physician-assessed rosacea severity, erythema and telangiectasia, lesion counts, time to improvement, and duration of remission). The updated systematic review ‘Interventions for rosacea based on the phenotype approach’ served as the basis for guideline development. This review conformed to the PRISMA statement and included GRADE certainty-of-evidence assessments for all prespecified outcomes (quality of life, participant-assessed rosacea severity, adverse events, physician-assessed rosacea severity, erythema and telangiectasia, lesion counts, time to improvement, and duration of remission). The search up to March 2018 provided 152 randomized controlled trials. Study selection, data extraction, risk-of-bias assessment (Cochrane risk-of-bias tool) and analyses were carried out independently by two authors. The complete content of the review, encompassing 93 comparisons and including 25 summary-of-findings tables, is available in the appendix of that paper. Three of the authors of this systematic review were involved in the development of the guideline (E.J.v.Z., M.M.D.v.d.L. and B.W.M.A.).

The health questions covered in the guideline, as formulated by the WG and external stakeholders, were (i) which self-care measures can be advised; (ii) what are the effectiveness and safety of the topical treatments brimonidine, oxymetazoline, ivermectin, metronidazole and azelaic acid, and how suitable are other topical treatments; (iii) what are the effectiveness and safety of tetracyclines and isotretinoin, and how suitable are other systemic treatments; (iv) what are the effectiveness and safety of intense pulsed light and laser-based therapies; (v) what are the effectiveness and safety of combination treatments; (vi) which therapeutic options exist for phymas; (vii) which self-care measures can be advised for ocular rosacea; (viii) what are the effectiveness and safety of treatment options for ocular rosacea; (ix) when do patients with ocular rosacea need to be referred to an ophthalmologist; (x) which therapeutic options are safe during pregnancy; (xi) which therapeutic options are safe for children; and (xii) what are the effectiveness and safety of maintenance treatments.

Fig 1. Rosacea treatment algorithm. Consider = weak recommendation. Recommended = strong recommendation. b.i.d., twice daily; DHA, docosahexaenoic acid; EPA, eicosapentaenoic acid; PDL, pulsed-dye laser; q.d., once daily; UV, ultraviolet; YAG, yttrium aluminium garnet.
The guideline followed the GRADE Evidence to Recommendation Frameworks. In making recommendations the WG integrated estimates of effect for desirable and undesirable outcomes of interest and confidence in the estimates of effect (certainty of evidence), items available from the systematic review, with estimates of values and preferences, and resource use. Recommendations are either strong or weak, and for or against a treatment. We used the wording ‘recommend’ for strong recommendations and ‘consider’ for weak recommendations. This guideline was developed for the Netherlands; however, its generalizability with respect to costs, availability and preferences may differ from country to country. To ensure completeness and transparency of reporting of the guideline the AGREE II checklist was used.

Considering that rosacea has a negative impact on quality of life and that improvement of well-being is important, a full chapter was dedicated to this topic. The WG recommended addressing quality of life (aspects most bothersome to the patient), treatment satisfaction, social and professional functioning, and psychological well-being.

The most important recommendations have been reported in a treatment algorithm (Fig. 1). In addition to the recommendations provided in the treatment algorithm, the WG recommended against the use of topical clindamycin, solely or in combination with topical tretinoin. Due to inconsistent evidence regarding the effectiveness of benzoyl peroxide cream or gel and of permethrin cream, prescribing these warrants caution. The same holds true for oral azithromycin, although it could be a treatment option for those experiencing adverse events of doxycycline and minocycline, or in pregnant women. Topical oxymetazoline and minocycline foam are not yet available in the Netherlands, but were evaluated in the guideline (with the caveat of nonavailability). The full guideline is available at www.nvdv.nl.

The WG will consider an annual update or revision based on recent developments and new evidence. An updating process will be launched when required.

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References

1 Tan J, Alemeida LM, Bewley A et al. Updating the diagnosis, classification and assessment of rosacea: recommendations from the global ROSacea COnsensus (ROSCO) panel. Br J Dermatol 2017; 176:431–8.
2 Gallo RL, Granstein RD, Kang S et al. Standard classification and pathophysiology of rosacea: the 2017 update by the National Rosacea Society Expert Committee. J Am Acad Dermatol 2018; 78:148–55.
3 van Zuuren EJ. Rosacea. N Engl J Med 2017; 377:1754–64.
4 van Zuuren EJ, Fedorowicz Z, Tan J et al. Interventions for rosacea based on the phenotype approach: an updated systematic review including GRADE assessments. Br J Dermatol 2019; 181:65–79.
5 Liberati A, Altman DG, Tetzlaff J et al. The PRISMA statement for reporting systematic reviews and meta-analyses of studies that evaluate healthcare interventions: explanation and elaboration. BMJ 2009; 339:b2700.
6 Andrews J, Guyatt G, Oxman AD et al. GRADE guidelines: 14. Going from evidence to recommendations: the significance and presentation of recommendations. J Clin Epidemiol 2013; 66:719–25.
7 Andrews JC, Schünemann HJ, Oxman AD et al. GRADE guidelines: 15. Going from evidence to recommendations – determinants of a recommendation’s direction and strength. J Clin Epidemiol 2013; 66:726–35.
8 Brouwers MC, Kho ME, Brownman GP et al. AGREE II: advancing guideline development, reporting and evaluation in health care. CMAJ 2010; 182:E839–42.

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