MDForLives

THE GLOBAL PULSE OF HEALTHCARE · DERMATOLOGY INSIGHT REPORT

Adult Acne Management: When Hormones, Tolerability, and Relapse Shape Treatment

Dermatologist perspectives on adult acne frequency, hormonal work-up, treatment selection, adherence, PIH-sensitive care, inadequate response, maintenance, isotretinoin barriers, and what may improve long-term control.

ADULT ACNE PHENOTYPE → INITIAL REGIMEN → TOLERABILITY / ADHERENCE → ESCALATION → MAINTENANCE

51	6	82.4%	8983692
Survey records	Countries represented USA · UK · Canada · Italy · France · Germany	Completion rate	SGID

WHY THIS REPORT

Adult acne can look familiar, but long-term control often depends on decisions that sit outside a simple severity ladder

Dermatologists may recognize the lesions immediately, yet the management problem can be less straightforward. Adult acne can persist or recur, cluster in a lower-face pattern, coexist with signs that raise a hormonal question, leave post-inflammatory hyperpigmentation, cause scarring, or become difficult to treat because the patient cannot tolerate or sustain the regimen.

Those realities make the consultation more than a choice between topical and systemic therapy. The clinician may need to decide when endocrine assessment is justified, whether a first-line regimen matches the phenotype, how much irritation is acceptable, whether an apparent failure reflects adherence or efficacy, when to escalate, how to counsel about isotretinoin, and what maintenance should look like after improvement.

The MDForLives survey examines those decision points directly: how often adult acne is a significant challenge, what triggers hormonal work-up, which regimen respondents favor for moderate female mandibular acne, what drives dropout, how PIH risk changes therapy, how clinicians respond to inadequate control, what they use for maintenance, what blocks isotretinoin prescribing, and which improvements they most want to see over the next several years.

> **Survey frame:** 51 survey records across six countries with an 82.4% completion rate. Core single-select question bases range from 45 to 48 recorded responses. Percentages and counts are reported directly from the supplied export. Administrative, required-text, after-question, and honeypot fields were excluded. Open-ended responses were reviewed thematically without creating qualitative percentages.

CLINICAL CONTEXT

Current acne guidance supports combination treatment, hormonal options, isotretinoin, and maintenance - but the route between them remains patient-specific

External evidence helps frame why the survey questions matter. It does not determine the MDForLives respondent selections below.

The American Academy of Dermatology's 2024 guideline strongly recommends benzoyl peroxide, topical retinoids, topical antibiotics, and oral doxycycline, and conditionally recommends options including azelaic acid, clascoterone, combined oral contraceptives, and spironolactone. It also strongly recommends oral isotretinoin for severe acne, acne causing scarring or substantial psychosocial burden, or disease that has failed standard oral or topical therapy.

NICE guidance, last updated in 2026, emphasizes that visible benefit can take several weeks, that acne severity and duration influence scarring risk, and that relapse and maintenance deserve explicit planning. It also includes safety and pregnancy-prevention requirements for isotretinoin.

Together, these sources reinforce the survey's central themes: treatment needs time, tolerability matters, hormonal therapy can be appropriate for selected patients, and the long-term plan cannot be separated from the initial choice.

Post-inflammatory hyperpigmentation adds another practical dimension. The AAD distinguishes PIH from permanent scarring and notes that treatments such as azelaic acid may help address acne while also targeting residual dark marks. For dermatologists, that creates a familiar trade-off: suppress inflammation effectively without creating irritation that makes the regimen harder to use.

EXECUTIVE SUMMARY

Six signals define where adult acne management becomes difficult after diagnosis.

The findings move from clinical burden and phenotype to adherence, escalation, long-term treatment, and prevention of lasting sequelae.

01

58.3%

Adult acne is a frequent practice challenge

Another 31.3% say it is a very frequent challenge, keeping adult acne firmly inside routine dermatology workload.

02

51.1%

Systemic signs trigger hormonal work-up

Hirsutism, irregular menses, and other overt clues are the most selected reason to order endocrine or hormonal assessment.

03

43.5%

Slow improvement drives dropout

Waiting for visible change edges topical irritation or barrier dryness as the leading adherence problem.

04

37.0%

First repair the plan

After inadequate response, optimizing adherence and tolerability narrowly leads immediate escalation or switching.

05

46.7%

Isotretinoin concern is patient-led

Adverse-effect concerns outrank regulatory burden, xerosis, and relapse risk as the biggest prescribing barrier.

06

33.3%

PIH and scarring prevention lead future priorities

Respondents place prevention of lasting pigmentary or scar sequelae ahead of adherence and relapse initiatives.

01

CLINICAL LOAD

Adult acne is a frequent challenge for most respondents, not an occasional edge case

58.3% say adult acne frequently represents a significant clinical challenge in practice.

> CONTEXT
>
> Adult acne often carries a different management rhythm from adolescent acne. Prior treatment exposure, persistent lower-face disease, hormonal clues, pigmentary sequelae, relapse, and long-term treatment expectations can all enter the consultation even when the lesion morphology is familiar.

WHAT THE DATA SHOWS

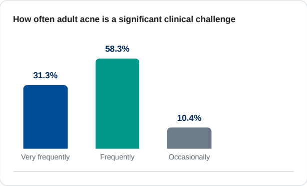
Frequently is the largest response at 58.3%, while another 31.3% select very frequently. Only 10.4% say adult acne is occasionally a significant clinical challenge.

THE INSIGHT

The finding is best read as a workload signal. Respondents are not describing adult acne as a rare difficult subgroup; they are indicating that complexity appears often enough to require repeatable approaches to phenotype assessment, adherence, escalation, and maintenance.

WHY IT MATTERS

When a condition is common and management is longitudinal, small sources of friction - irritation, delayed visible response, follow-up gaps, treatment hesitancy, or relapse - can accumulate across a large number of visits. Adult acne therefore rewards pathway design as much as individual prescribing expertise.


How often adult acne is a significant clinical challenge

02

HORMONAL WORK-UP

Hormonal assessment is most often prompted by systemic clues, with treatment resistance as the second trigger

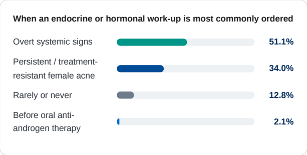
51.1% most commonly order an endocrine or hormonal work-up when overt systemic signs are present.

CONTEXT

Adult female acne can prompt an endocrine question, but a hormonal pattern is not synonymous with an endocrine disorder. The practical task is to decide when acne should remain a dermatologic phenotype and when the wider history or examination justifies investigation for a contributing condition.

WHAT THE DATA SHOWS

Overt systemic signs such as hirsutism or irregular menses lead at 51.1%. Persistent or treatment-resistant female acne follows at 34.0%. Another 12.8% say they rarely or never order a work-up, and 2.1% most commonly do so before initiating oral anti-androgen therapy.


When an endocrine or hormonal work-up is most commonly ordered

THE INSIGHT

Respondents appear to use associated features as the strongest threshold for testing. Treatment resistance alone is still important, but it does not replace the value of a targeted history and examination.

WHY IT MATTERS

A selective work-up can reduce unnecessary testing while still creating a route to identify patients whose acne is part of a broader hormonal picture. It also keeps the decision connected to symptoms and signs the dermatologist can recognize in clinic rather than to age or sex alone.

03

FIRST-LINE FEMALE MANDIBULAR ACNE

Spironolactone plus a topical retinoid is the leading default, but more than half of respondents choose another starting strategy

47.8% select spironolactone plus a topical retinoid for moderate female mandibular acne.

CONTEXT

Lower-face or mandibular acne in adult women often raises a hormonal treatment question. The AAD guideline conditionally supports spironolactone and combined oral contraceptives for acne, while also strongly supporting topical retinoids and combination topical therapy. The survey asks how that toolbox is translated into a default starting regimen for one specific phenotype.

WHAT THE DATA SHOWS

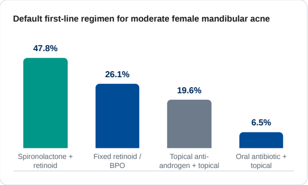
Spironolactone plus topical retinoid leads at 47.8%. A fixed topical retinoid/benzoyl peroxide combination is selected by 26.1%, topical anti-androgen plus topical therapy by 19.6%, and oral antibiotic plus topical therapy by 6.5%.

THE INSIGHT

The leading choice suggests substantial use of a hormonal strategy, but the distribution resists a one-regimen conclusion. The same phenotype can still lead to a topical-first or non-spironolactone approach depending on severity, previous therapy, contraindications, pregnancy potential, patient preference, local availability, and clinician judgement.

WHY IT MATTERS

The clinical value of a “default” is therefore limited unless it remains easy to override. Adult acne management benefits from recognizing phenotype without letting phenotype become a shortcut that ignores the rest of the patient context.


Default first-line regimen for moderate female mandibular acne

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04

ADHERENCE AND EARLY DROPOUT

Slow visible improvement and topical irritation create more adherence friction than regimen complexity

43.5% identify slow visible improvement as the primary driver of non-adherence or early dropout.

CONTEXT

Acne therapy asks patients to tolerate a time lag. Clinical improvement is rarely immediate, and topical regimens can irritate the very skin a patient is watching closely for visible change. That combination can create a particularly vulnerable early treatment period.

WHAT THE DATA SHOWS

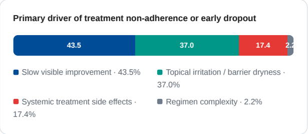
Slow visible improvement leads at 43.5%, closely followed by topical irritation or barrier dryness at 37.0%. Systemic treatment side effects account for 17.4%. Regimen complexity is selected by only 2.2%.

THE INSIGHT

The leading barriers are experiential rather than logistical. Patients may understand the regimen but still abandon it if the skin feels worse before it looks better, or if the expected timeline was never clear. NICE guidance that visible benefit can take six to eight weeks gives useful context to this gap between starting therapy and perceiving reward.

WHY IT MATTERS

Dermatologists can influence this friction before it becomes non-adherence: set the expected timeline, explain what early irritation is acceptable or not, simplify application instructions, support barrier care, and plan follow-up around the period when motivation may drop. This does not guarantee adherence, but it makes adherence part of the treatment plan rather than a later diagnosis.


Primary driver of treatment non-adherence or early dropout

05

PIH-SENSITIVE CARE

When PIH risk is high, respondents spread across gentler topicals, azelaic acid, and earlier systemic control

30.4% use a gentler retinoid strategy as their primary adjustment for patients at high PIH risk.

CONTEXT

Post-inflammatory hyperpigmentation is not the same as permanent scarring, but it can persist after active acne lesions resolve and may become a major part of what the patient sees as ongoing disease. The AAD notes that PIH is especially relevant after inflammation and that azelaic acid can address acne while helping residual dark marks.

WHAT THE DATA SHOWS

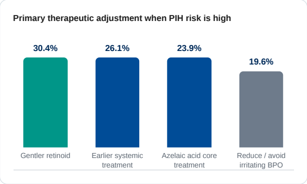
A gentler retinoid strategy leads at 30.4%, followed by earlier systemic treatment at 26.1%, azelaic acid as a core treatment at 23.9%, and reduction or avoidance of irritating benzoyl peroxide concentrations at 19.6%.

THE INSIGHT

There is no single dominant adjustment. Instead, respondents appear to balance two objectives: control inflammation quickly enough to prevent new pigmentary change while keeping the regimen tolerable enough to sustain. Some emphasize gentleness; others emphasize earlier escalation.

WHY IT MATTERS

This is a useful reminder that “more aggressive” and “more protective” are not opposites. In a patient prone to PIH, a regimen that causes avoidable dermatitis may undermine adherence, while slow control of inflammatory acne can allow new lesions and new pigment to accumulate. The treatment plan has to manage both sides of that trade-off.


Primary therapeutic adjustment when PIH risk is high

06

INADEQUATE INITIAL RESPONSE

After first-line therapy underperforms, respondents are almost evenly split between optimization and escalation

37.0% first optimize adherence and tolerability; 34.8% escalate or switch therapy.

CONTEXT

An inadequate response can mean several different things: true pharmacologic failure, inconsistent use, insufficient treatment duration, poor tolerability, an unrecognized contributor, or a phenotype that needs a different therapeutic mechanism. The next step therefore tests how clinicians define failure, not only what drug they prefer next.

WHAT THE DATA SHOWS

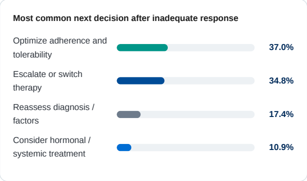
Optimizing adherence and treatment tolerability is the most selected next decision at 37.0%, followed closely by escalation or switching at 34.8%. Reassessing diagnosis and contributing factors accounts for 17.4%, while 10.9% specifically move toward hormonal or systemic treatment.

THE INSIGHT

The near tie is the story. Some patients need a stronger or different treatment, but others need the current plan to become usable before its efficacy can be judged. The survey suggests respondents recognize both possibilities rather than collapsing inadequate response into automatic escalation.

WHY IT MATTERS

This distinction affects antibiotic stewardship, exposure to systemic therapy, patient trust, and time to control. A short “failure check” - duration, application, irritation, adherence, diagnosis, contributing factors, and phenotype - can clarify whether the next step should repair, redirect, or escalate the pathway.


Most common next decision after inadequate response

07

LONG-TERM MAINTENANCE

Once acne is controlled, continued combination treatment is more common than a rapid move to topical-only maintenance

43.5% most often continue low-dose oral anti-androgen plus topical therapy.

CONTEXT

Control does not automatically answer the next question: what should be continued, reduced, or stopped to minimize relapse while limiting treatment burden? NICE explicitly includes relapse and maintenance in its acne pathway, reflecting the fact that successful induction and durable control are different phases of care.

WHAT THE DATA SHOWS

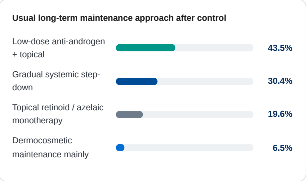
Continuing low-dose oral anti-androgen plus topical therapy leads at 43.5%. Gradually stepping down systemic treatment over time follows at 30.4%, topical retinoid or azelaic acid monotherapy at 19.6%, and transition mainly to dermocosmetic maintenance at 6.5%.

THE INSIGHT

The pattern suggests that many respondents view adult acne as a condition requiring an active maintenance phase rather than a clean stop once lesions improve. It also shows that systemic treatment may persist for some patients while others move toward a lower-intensity regimen.

WHY IT MATTERS

Maintenance planning can make the end of the acute phase less ambiguous. The patient should know what remains essential, what can be tapered, what early signs of relapse matter, and when to return before disease activity again reaches the threshold that required escalation.


Usual long-term maintenance approach after control

08

ISOTRETINOIN DECISION

The largest isotretinoin barrier is patient concern about adverse effects, ahead of regulatory burden

46.7% say patient concerns about adverse effects are the biggest barrier to prescribing oral isotretinoin in adult female acne.

CONTEXT

Oral isotretinoin has a well-defined role in severe, scarring, or treatment-refractory acne, but the decision carries a different level of counselling, safety monitoring, and pregnancy-prevention responsibility than many other acne therapies. The survey asks which part of that burden most often stands in the way.

WHAT THE DATA SHOWS

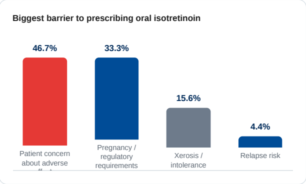
Patient concern about adverse effects leads at 46.7%. Pregnancy-prevention and regulatory requirements follow at 33.3%, xerosis and treatment intolerance at 15.6%, and relapse risk, particularly with hormonal acne, at 4.4%.

THE INSIGHT

The main friction point is therefore not only administrative. Many respondents are describing a shared-decision problem: a treatment may be clinically appropriate, but the patient may remain uncertain about the risk-benefit trade-off. Open-ended comments about reluctance to move to isotretinoin or other advanced therapy reinforce that theme.

WHY IT MATTERS

High-quality counselling has to do more than list risks. It needs to explain why isotretinoin is being considered, what alternatives have already been tried, what monitoring and pregnancy-prevention requirements apply locally, which adverse effects are common or serious, and how the clinician will support the patient through treatment. Better information cannot remove every concern, but it can make the decision more informed and less fear-driven.


Biggest barrier to prescribing oral isotretinoin

09

WHAT NEEDS TO IMPROVE

Dermatologists put prevention of PIH and scarring first, with phenotype-directed and more tolerable long-term therapy close behind

33.3% say better strategies to prevent PIH and scarring would most improve adult acne management over the next three to five years.

CONTEXT

The final question shifts from current decisions to unmet need. It asks what would make adult acne care better in the near future, forcing respondents to choose among more precise treatment selection, prevention of sequelae, longer-term tolerability, and adherence or relapse support.

WHAT THE DATA SHOWS

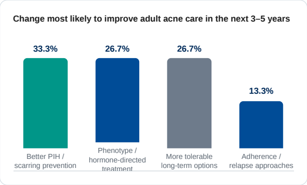
PIH and scarring prevention leads at 33.3%. More phenotype- and hormone-directed treatment and more tolerable long-term treatment options are tied at 26.7% each. Better approaches to adherence and relapse prevention account for 13.3%.

THE INSIGHT

The ranking suggests that respondents are looking beyond lesion count. The strongest future priorities relate to what remains after acne, how precisely treatment can be matched to phenotype, and whether chronic therapy can be tolerated. Adherence remains important, but respondents appear to view better treatments and better sequelae prevention as the larger opportunity.

WHY IT MATTERS

For innovation, the implication is broad: future progress will not be measured only by faster clearance. It may also be measured by fewer pigmentary and scar consequences, better fit for hormonal and phenotype-specific disease, and regimens that are realistic for months or years rather than weeks.



Change most likely to improve adult acne care in the next 3–5 years

OPEN RESPONSE LENS

The hardest adult acne cases are often difficult because the treatment plan does not survive the patient's real constraints

Respondents were asked to recall an adult acne patient who was particularly challenging to manage, explain what made the case difficult, and describe what might have improved diagnosis, therapy, adherence, or maintenance. The responses were multilingual and varied, so they were reviewed thematically without assigning percentages.

Adherence and tolerability repeatedly interact

Several respondents described poor adherence to topical therapy, irritation, the need for frequent regimen changes, or the value of simplifying treatment and following up often enough to keep the patient engaged.

Refractory disease makes escalation emotionally and clinically harder

Comments described chronic or recurrent acne that had not responded to multiple therapies, alongside reluctance to use isotretinoin or constraints affecting hormonal treatment. In those cases, limited acceptable options became part of the disease burden.

Access, cost, and durability still matter

Respondents also mentioned the cost of topical medicines, access to affordable effective therapy, regulatory burden, and the desire for safe long-term options that reduce recurrence rather than restarting the same cycle.

What the qualitative responses add: The quantitative findings identify slow improvement, irritation, treatment escalation, and isotretinoin concerns. The open comments show how those issues can accumulate in one patient: a regimen irritates, use becomes inconsistent, response remains incomplete, escalation feels unacceptable, and the clinician is left searching for an option that is both effective and sustainable.

PEOPLE ALSO ASK · TOPIC FAQ

Frequently asked questions about adult acne management

Concise answers to common clinical questions related to adult female acne, hormonal assessment, treatment timelines, PIH, and isotretinoin.

Why does acne persist or begin in adulthood?	Acne can continue from adolescence or begin later in life. In adults, treatment planning may need to account for persistent inflammation, hormonal patterns, medication or medical contributors, tolerability, previous treatment exposure, and the risk of relapse or pigmentary change.
When should hormonal evaluation be considered in adult female acne?	Hormonal or endocrine evaluation may be considered when the history or examination suggests an underlying hormonal disorder, for example irregular menses, hirsutism, or other endocrine features. Testing is individualized rather than automatically required for every adult woman with acne.
How is spironolactone used in adult female acne?	Spironolactone is an oral anti-androgen used by dermatologists for selected women with acne, particularly when a hormonal pattern is suspected. The decision depends on the patient's medical history, pregnancy potential, contraindications, monitoring needs, local guidance, and shared decision-making.
Why can acne treatment take several weeks to show visible improvement?	Acne treatments act on processes such as follicular plugging, inflammation, sebum production, and bacterial load over time. Clinical guidance advises patients that visible benefit may take several weeks, so early expectations and tolerability support can be important for staying with an appropriate regimen.
What is post-inflammatory hyperpigmentation after acne?	Post-inflammatory hyperpigmentation, or PIH, is a flat area of darker color that can remain after an acne lesion heals. It is not the same as a permanent acne scar. Preventing new inflammation and choosing a tolerable acne regimen are central to reducing further pigmentary change.
When is isotretinoin considered for adult acne?	Oral isotretinoin is generally considered for severe acne, acne at risk of scarring, substantial psychosocial burden, or disease that has not responded adequately to standard topical and systemic therapy. Prescribing requires careful safety assessment, counselling, and pregnancy-prevention measures where applicable.

DERMATOLOGY DECISION LENS

What this means at four points in the adult-acne pathway.

The survey supports a practical sequence: identify the phenotype, protect tolerability, define failure carefully, and plan what happens after control.

Read the phenotype before adding tests

Use menstrual history, hirsutism or other systemic clues, distribution, prior treatment response, and medication or medical context to decide whether hormonal assessment may change management.

Protect the early treatment experience

Set expectations for time to visible benefit, reduce avoidable irritation, explain application clearly, and plan follow-up before slow improvement becomes a reason to stop.

Separate true failure from unusable therapy

Before escalation, check duration, adherence, tolerability, diagnosis, contributing factors, and whether the current regimen had a fair opportunity to work.

Plan maintenance while disease is controlled

Define which components continue, what can step down, how relapse will be recognized, and when escalation - including isotretinoin - should be reconsidered if control is lost.

CLOSING PERSPECTIVE

Adult acne management becomes more effective when the plan is designed for durability, not only initial clearance

The findings show a specialty managing several problems at once. Adult acne is common enough to demand repeatable pathways, yet individualized enough that phenotype, hormonal clues, PIH risk, tolerability, prior therapy, pregnancy potential, and patient preference can all redirect the plan.

The biggest adherence signals are slow improvement and topical irritation. The biggest isotretinoin barrier is patient concern. After inadequate response, respondents are almost evenly split between optimizing the current regimen and changing it. After control, many continue active maintenance rather than stop. Taken together, these are not isolated survey results; they describe a continuum in which treatment has to remain understandable and tolerable long enough to demonstrate benefit, and acceptable enough to continue or escalate when needed.

Real-world practice therefore differs from a simple step ladder. The clinician may need to slow down a topical regimen while thinking about faster disease control, avoid unnecessary endocrine testing while remaining alert to systemic clues, treat active acne while preventing PIH and scarring, and discuss isotretinoin in a way that is rigorous without making the treatment feel inaccessible.

What may need to change next is equally practical. Better PIH and scarring prevention, more phenotype- and hormone-directed options, treatments that remain tolerable over the long term, and clearer relapse and maintenance strategies could make adult acne care more durable. The goal is not one universal regimen. It is a pathway that can adapt without losing the patient between the first prescription and long-term control.

Build expectation into the prescription

Tell patients what should improve, when visible change is realistic, and which adverse effects should trigger contact rather than abandonment.

Use phenotype without over-assuming cause

Lower-face distribution or adult female acne can guide treatment thinking, but endocrine testing should still be tied to the wider history and examination.

Treat PIH and scarring prevention as part of disease control

Preventing new inflammatory lesions, maintaining tolerability, and planning sequelae management belong in the same longitudinal strategy.

Make maintenance a defined phase

Once control is achieved, agree what continues, what tapers, what relapse looks like, and when the pathway should move back toward escalation.

Help future dermatology insights reflect how adult acne is managed beyond the first prescription.

Join MDForLives to share professional perspectives on adult female acne, hormonal assessment, PIH, treatment adherence, isotretinoin, maintenance, relapse, and long-term control.

Join the Panel

REFERENCES AND DATA SOURCE

Sources used for context and verification

1. MDForLives internal survey report. All Markets Report for SGID 8983692, Project: Engagement Campaign | Derma Insight Survey_Sep | MDForLives. Survey records: 51; completion rate: 82.4%; countries represented: USA, UK, Canada, Italy, France, Germany.
2. American Academy of Dermatology. Acne clinical guideline and guideline highlights.
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4. National Institute for Health and Care Excellence. Acne vulgaris: management (NG198), updated April 2026.
5. American Academy of Dermatology. Hormonal therapy for stubborn acne.
6. American Academy of Dermatology. Acne scars: signs and symptoms, including post-inflammatory hyperpigmentation.

External sources provide clinical context. Survey percentages represent MDForLives respondent selections and are reported directly from the supplied source export. The open-response analysis is qualitative and does not assign theme percentages.

MDForLives

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The Global Pulse of Healthcare

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