Medications for Acne

B.C. Provincial Academic Detailing (PAD) Service **March 2026**

Participants will have the opportunity to apply current evidence and practical drug information to support shared decision making regarding: topical therapies, oral antibiotics, combined oral contraceptives, spironolactone and isotretinoin.

Topicals	1. As initial therapy, combination topicals are more effective than single drug products; there is significant flexibility in choosing a combination product. 2. For maintenance therapy, a topical retinoid with or without benzoyl peroxide may be preferred over a product containing a topical antibiotic. 3. It is recommended to combine topical antibiotics with benzoyl peroxide to reduce the potential for antibiotic resistant *Cutibacterium acnes* emerging. 4. Clascoterone ranks as one of the least effective acne medications and is also the most expensive topical.
Oral antibiotics	1. Role in papulopustular acne when topicals are inadequate or for acne with extensive truncal distribution; guidelines recommend doxycycline. 2. Combine with benzoyl peroxide and aim to limit the treatment course to 3-4 months to reduce the potential for antibiotic resistance. 3. For more severe acne, doxycycline can be added to a topical retinoid plus benzoyl peroxide for people who are unable, do not tolerate or would prefer not to take isotretinoin.
Combined oral contraceptives (COCs)	1. Role for people of child-bearing potential seeking an oral contraceptive; COCs have a secondary benefit of improving acne outcomes. 2. COCs have antiandrogenic properties and it is not necessary to select one with a progestin that has greater antiandrogenic activity. COCs containing cyproterone are only indicated for severe acne that is unresponsive to other therapies and are not indicated as long-term contraceptives. 3. COCs can be combined with topical therapies or a course of oral antibiotics as it may take several cycles for improvement to become apparent.
Spironolactone off label use	1. Adjunctive role with topical therapies and may be suitable for truncal acne; spironolactone can be combined with COCs. 2. The antiandrogenic effect of spironolactone is not appropriate for all people (eg, cisgender males or people taking testosterone). 3. Ongoing potassium monitoring is not required unless hyperkalemia risk factors are present (eg, age > 45, CKD, use of ACEI, ARB or NSAIDs).
Isotretinoin	1. Role in severe acne, nodulocystic acne, acne with scarring or papulopustular acne refractory to other treatments; considered the most effective treatment and is approved for use in ages 12 and older. 2. In people of child-bearing potential, isotretinoin must be combined with effective contraception due to the high risk of teratogenicity. Long-acting reversible contraceptives (LARCs) are preferred when clinically appropriate. 3. The dose of isotretinoin can be individualized according to acne severity, therapeutic response and adverse events. 4. Current evidence does not support that the four formulations (Accutane, Clarus, Epuris, Absorica LD) differ meaningfully in safety or effectiveness.

While important, the following are beyond the scope of this PAD topic: an extensive review of contraceptive medicine, the use of topical products for cosmetic purposes.

Topicals: efficacy, product choice, time course of effect

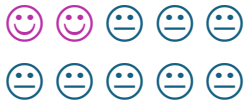
If 10 people with acne use the following topical products, how many achieve clear or almost clear skin by 12 weeks?

Benzoyl peroxide
~2-3 out of 10 people[1,2]

Retinoids
~2-3 out of 10 people[3-7]

Two-drug combinations
antibiotics, retinoids, benzoyl peroxide
~3-4 out of 10 people[1,2,8-12]

Three-drug combination
antibiotic + retinoid + benzoyl peroxide
~5 out of 10 people[8,13-15]



Clascoterone
~2 out of 10 people[16-19]

Effect estimates were extracted from the drug approval efficacy trials where most participants have facial acne that is moderate in severity* but not nodulocystic. The mean age of participants is approximately 20 years of age. Topicals are compared to their respective vehicles (not placebo) which may also contribute to the efficacy and irritancy.

☑ Product Choice[20-33]

As initial therapy, combination therapy is more effective than monotherapy.

- The proportion of people achieving clear or almost clear skin (treatment success) does not vary substantially between various combination products supporting flexibility in initial product choice.
- All combination products reduce inflammatory (papules, pustules) and non-inflammatory (comedones) lesions.

As maintenance therapy, a topical retinoid with or without benzoyl peroxide may be preferred over a product containing a topical antibiotic.

- Retinoids address multiple aspects of acne pathophysiology and may improve scarring and hyperpigmentation, although evidence is more limited for these outcomes.

Monotherapy considerations:

- Benzoyl peroxide monotherapy: option if a combination containing a topical retinoid or an antibiotic is contraindicated or not favoured.
- Antibiotic monotherapy: not recommended due to the potential for *Cutibacterium acnes* resistance. Adding benzoyl peroxide may reduce this risk.

⧗ Time course of effect[9,24,25,34-36]

- Some reduction in inflammatory and non-inflammatory lesions occurs by week 2 for most topicals (benzoyl peroxide, retinoids, combinations).
- While it may take 12 weeks or longer for the full effect, 12 weeks is a reasonable time point to assess whether there has been a meaningful improvement.
- Once clear or almost clear skin is achieved with combination therapy, can consider stepping down to monotherapy (eg, retinoid) as maintenance.
- Most topical efficacy trials are 12 weeks in length so there is limited information on longer term outcomes and optimal duration of therapy.
- One guideline suggests continuing topical treatment for at least 6 months and 12 months in those with a history of severe acne or flares during the initial treatment phase.

***Grading of facial acne severity in clinical trials**:
Severe: entire face involved
Moderate: more than half of face involved
Mild: less than half of face involved
Almost clear: few scattered comedones and a few small papules
Clear: no inflammatory or non-inflammatory lesions

Initial combination treatment: assess response at 12 weeks

If clear or almost clear skin achieved: continue combination or step down to monotherapy

Maintenance: continue for at least 6 months

See Reference List

Topicals: clinical considerations

Skin irritation[1-17]

Order of skin irritation: retinoid + benzoyl peroxide > retinoid > benzoyl peroxide.

- Topical antibiotics do not contribute significantly to skin irritation.

Strategies for minimizing skin irritation from retinoids:

- ✓ Reassure that irritancy peaks during weeks 1-2, then decreases with continued treatment.
- ✓ Initiate with intermittent (eg, every other day) or short-contact dosing (eg, wash off after 30-60 minutes, then gradually increase exposure time).
- ✓ Increase exposure gradually over the first 2-4 weeks.
- ✓ Ensure skin is clean and dry, then apply in a thin layer only to acne-prone skin areas.
- ✓ Non-comedogenic moisturizer can be applied before or after the retinoid (or sandwich method of before and after).
- ✓ Skin protection: regular use of broad-spectrum sunscreen with SPF ≥ 30 and protective clothing; minimize exposure to wind and cold temperatures; avoid abrasive cleansers or strong drying agents such as toners, astringents.

Topical retinoids[14-20]

Vary in potency but any differences in efficacy or tolerability are modest.

- Limited dose response information, but 0.3% adapalene may be slightly more effective than 0.1% adapalene, particularly in those with more severe acne.
- Micronized tretinoin (Retin-A Micro) is not significantly less irritating than non-micronized (Retin-A) but is more costly.

Fitzpatrick skin types IV to VI[14,15,21-28]

Greater risk of acne-associated hyperpigmentation.

- Few clinical trials address hyperpigmentation and people with skin of colour are under-represented in acne medication clinical trials.

Consensus recommendations include:

- **Early initiation of a combination topical product which includes a retinoid.**
- **Adding hydroquinone or azelaic acid if needed to treat hyperpigmentation**.
- Minimizing treatment-related skin irritancy which may also exacerbate hyperpigmentation by introducing topicals gradually.
- Photoprotection using a tinted sunscreen with iron oxide to block ultraviolet and visible light.

Pregnancy[8-14,29-31]

- ✓ **Recommended**: benzoyl peroxide, azelaic acid, topical antibiotics (clindamycin, erythromycin), salicylic acid. Options if breastfeeding also.
- X **Contraindicated:** retinoids and retinoid combinations; systemic absorption is negligible but there is no known safe exposure during pregnancy.
- ? **Insufficient information**: clascoterone, dapsone.

Azelaic acid[13-16]

Recommended in acne guidelines as an option:

- During pregnancy.
- For the treatment of hyperpigmentation.
- If significant skin irritation occurs with retinoids.

Benzoyl peroxide[14,32-43]

Oxidizing agent: may bleach fabrics, hair.

2.5%, 5% vs 10% gel: likely similar efficacy but increased irritancy with 10%.

Recommendations to reduce the risk of thermal degradation of benzoyl peroxide to benzene include:

- ✓ Discard expired products.
- ✓ Store products at room temperature or cooler.
- ✓ Apply in the evening and wash off in the morning to avoid direct sunlight exposure.

Topical antibiotics[14,44-48]

Stricter antimicrobial stewardship guidance includes avoiding the use of any topical antibiotic or limiting the duration of their use to a maximum of 6 months.

- *Cutibacterium acnes* resistance has been documented for topical clindamycin and erythromycin.
- There are no microbiology studies or resistance data for topical dapsone (Aczone) specific to its use in acne.
- Topical clindamycin use results in some systemic exposure; a few cases of *Clostridium difficile*-associated disease have been reported.

Clascoterone: topical antiandrogen[18,49-54]

Ranks as one of the least effective acne medications in a network meta-analysis and is the most expensive topical.

- Not approved for use in children ages < 12 years due to higher rates of systemic adverse events (HPA axis suppression, hyperkalemia); in adolescents, the European Medicines Agency recommends restricting application to the face (not the trunk) to limit systemic absorption.

See Reference List

Oral antibiotics

Role of oral antibiotics in acne[1-9]

Guidelines generally limit the role of oral antibiotics to papulopustular acne when topicals are inadequate or when there is extensive truncal involvement.

① Oral antibiotics may have a larger effect on inflammatory than non-inflammatory lesions.

② Combine with benzoyl peroxide and aim to limit the treatment course to 3-4 months to reduce the potential for antibiotic resistance.

③ A topical therapy or alternate systemic therapy should be considered for longer term management.

Efficacy of oral antibiotics in acne[4,5,10]

In a recent network meta-analysis which uses indirect comparisons:

① Oral antibiotics ranked lower in efficacy for reducing acne lesions than combination topical therapies.

② Doxycycline in combination with a topical retinoid plus benzoyl peroxide was ranked among the most effective acne treatments but is less effective than isotretinoin. This regimen is recommended in guidelines as an option for severe acne in people who are unable, do not tolerate or would prefer not to take isotretinoin.

Doxycycline is recommended over:[1-5,11]

- **minocycline due to a lower risk of rare but serious adverse events:** vertigo, autoimmune hepatitis, skin dyspigmentation, drug-induced lupus, hypersensitivity.
- **tetracycline due to ease of administration.**

There is insufficient evidence comparing various doses and formulations. Guidelines generally do not specify a preferred dose with the exception of UK NICE which recommends **doxycycline 100 mg once daily**.

Modified release (MR) doxycycline 40 mg once daily and low dose (LD) doxycycline 20 mg BID: The impact of these lower dose formulations on antibiotic resistance is not known, they are more costly (MR $100, LD $85 per month) and are not BC PharmaCare benefits.

See Reference List; Cost without mark-up or professional fee from McKesson Canada; BC PharmaCare Formulary

Tetracycline Contraindications[1,2,12-14]	
Pediatrics < 8 years of age	Risks: permanent teeth discolouration (yellow-gray-brown), bone growth inhibition.
Pregnancy, breast feeding	Azithromycin considered an alternative.
Concurrent isotretinoin	Risk: benign intracranial hypertension.

Antibiotic	**Dosage**[2]	**Cost / month**	**BC PharmaCare**
doxycycline	100 mg once daily to BID	$15 - $30	**Regular Benefit**
minocycline	50 to 100 mg once daily to BID	$20 - $70	
tetracycline	250 to 500 mg BID	$5 - $10	

Pediatric indications of tetracyclines vary by country: doxycycline is approved in Canada in ages ≥ 8, minocycline in ages ≥ 13, and tetracycline in ages ≥ 12.[12-14]

All tetracyclines: take with a full glass of water and remain upright for 2 hours to reduce risk of esophageal injury.

Doxycycline, minocycline: can take with food.

Tetracycline: take on an empty stomach (1 hour before or 2 hours after meals).

Adverse events[1,11-16]
The following have been associated with tetracycline use across a range of indications, but the absolute risks have not been well characterized.

Gastrointestinal	Esophageal injury (monitor for dysphagia, retrosternal chest pain); diarrhea (including *Clostridium difficile*-associated disease).
Cutaneous	Photosensitivity (sun protection is important).
Dyspigmentation	Black/blue/grey or muddy brown: skin, nails, teeth, oral mucosa, eyes (sclera, conjunctiva), bodily fluids.
CNS	Vertigo, benign intracranial hypertension.
Hypersensitivity	Including Stevens-Johnson Syndrome, Toxic Epidermal Necrolysis.
Autoimmune	Including exacerbation of systemic lupus erythematous, serum sickness, autoimmune hepatitis.

Combined oral contraceptives, Spironolactone

Combined oral contraceptives (COCs) as adjunct medications for acne[1-11]

Several COCs have a secondary indication for acne, however any COC can be considered because of their antiandrogenic properties. It is not necessary to select one with a progestin that is more antiandrogenic. Their use is not limited to acne affecting the jawline or acne associated with premenstrual flares, hirsutism or hyperandrogenism. Direct comparisons between COCs are limited.

- It may take several cycles for improvement to become apparent, so COCs can be combined with topicals or a course of oral antibiotics. Tetracyclines have not been shown to reduce COC contraceptive efficacy.
- Progestin-only contraceptives (oral, injectable, IUD) may worsen acne. The effect of a drospirenone-only pill (Slynd) on acne outcomes has not yet been determined.

COCs with a contraception and acne indication:[1] achieved menarche, have moderate acne and are seeking contraception.

- levonorgestrel + ethinyl estradiol (eg, Alesse, Alysena)
- norgestimate + ethinyl estradiol (eg, Tri-Cira, Tri-Jordyna)
- drospirenone + ethinyl estradiol (eg, Yaz, Mya, Yasmin, Zamine)
- drospirenone + ethinyl estradiol + levomefolate (eg, Yaz Plus)

The World Health Organization states that any absolute differences in VTE risk between COCs are very small.[12]

COCs with a severe acne indication only:[1] achieved menarche and have severe acne with symptoms of androgenization (seborrhea, mild hirsutism) that is unresponsive to topical therapy and oral antibiotics.

- cyproterone + ethinyl estradiol (eg, Diane-35, Cleo-35, Cyestra-35)

- Associated with an increased VTE risk compared to other COCs such as levonorgestrel + ethinyl estradiol.[1,13]
- Discontinue 3 to 4 months after acne resolves.
- Not indicated as a contraceptive, however it will provide secondary contraceptive benefits when taken for severe acne.

Free contraceptives in British Columbia

Medical eligibility criteria for contraceptive use

VTE checklist before prescribing cyproterone + ethinyl estradiol

Spironolactone efficacy in adult women when added to usual care (SAFA Trial)[14]

Spironolactone 50 mg once daily x 6 weeks, then 100 mg once daily thereafter	Spironolactone	Placebo	NNT/NNH
Proportion achieving clear or almost clear skin at 24 weeks (participants' assessment)	32%	11%	Number needed to treat: 5 Number needed to harm: 8
Proportion with overall improvement at 24 weeks (participants' assessment)	82%	63%	
Proportion experiencing an adverse event	64%	51%	

- 410 participants aged ≥ 18 (mean age 29), eGFR ≥ 60 mL/min per 1.73 m^2
- mild to severe acne
- added to usual care: hormonal treatment (42% of participants), topicals (84% of participants)

Contraindications[2,4,15-17]	Pregnancy; severe renal impairment; hyperkalemia; Addison's disease.
Dosage (off label)[4,17-20]	50 - 200 mg per day (doses used in small clinical trials).
Cost / month	$5 - $10; **Regular Benefit**
Lab monitoring[2,4,17,21,22]	**Baseline renal function and serum potassium.** Ongoing monitoring not recommended without risk factors for hyperkalemia (age > 45, CKD, use of ACEI, ARB or NSAIDs).

Evidence in adolescents is limited: most clinical trials exclude adolescents.[17-20]

Adverse event rates when added to usual care in adult women aged ≥ 18:[14]

Adverse event rates reflect the addition of spironolactone versus placebo when added to usual care:

- Irregular menstrual bleeding: 32% spironolactone vs 35% placebo
- Breast tenderness: 20% vs 18%
- Breast enlargement: 31% vs 25%
- Dizziness/vertigo/lightheadedness: 19% vs 12%
- Headache: 20% vs 12%
- Polyuria: 31% vs 25%

See Reference List; Cost without mark-up or professional fee from McKesson Canada; BC PharmaCare Formulary

Isotretinoin: efficacy, contraindications, screening, pregnancy prevention

Isotretinoin efficacy in nodular acne[1,2]

20-week course (~ 4 months): 0.5 mg/kg/day for 4 weeks then 1 mg/kg/day thereafter	Standard formulation (generic isotretinoin)		Lidose formulation (Epuris)	
Proportion achieving clear or almost clear skin	89%		86%	
Proportion with an adverse event	90%	serious: 1.1%	92%	serious: 1.5%
Proportion discontinuing due to an adverse event	3%		4%	
▪ 925 participants ages 12-52 (mean age 21), mean 71 kg ▪ ≥ 10 facial and/or truncal nodular lesions (mean 18 nodules) ▪ severe-very severe acne 84%, mild-moderate acne 16%	Final maintenance doses ranged from 0.2 - 1.5 mg/kg/day highlighting the need for dose individualization.			

Contraindications[3-6]

- Child-bearing potential (unless mandatory effective contraceptive measures confirmed)
- Breastfeeding
- Hepatic or renal insufficiency
- Hypervitaminosis A
- Dyslipidemia
- Concurrent tetracycline use

Screening before prescribing[3-10]

- Child-bearing potential
- Mental health (eg, PHQ-9)
- Soybean oil allergy
- Labs: ALT, TG
- Informed consent

CBC: not required if otherwise healthy.

Isotretinoin is a known teratogen.[3-6,11-19]

There is no known safe level of isotretinoin exposure during pregnancy.

- Severe structural and neurodevelopmental malformations occur in a very high percentage of infants (18%-28%) born to those who become pregnant during treatment with isotretinoin.
- Malformations: craniofacial; cardiovascular and central nervous system; thymic gland abnormalities; neurodevelopmental disorders.
- The risk of spontaneous abortion is ~ 20%.
- There is no known teratogenic risk with exposure to semen from a partner taking isotretinoin.
- Isotretinoin is a prohibited medication for blood or plasma donation (during treatment and for a period of 1 month after discontinuation).

Pregnancy prevention requirements are a shared responsibility between patients, prescribers, pharmacists and include:[3-6,18,20]

1 Pregnancy tests: before, during and after discontinuing isotretinoin

Before initiating:
two negative tests
see manufacturers' infographic on recommended timing of pregnancy tests[21-24]

During treatment:
monthly

Final test:
1 month after discontinuing isotretinoin

2 For those of child-bearing potential, the simultaneous use of two effective forms of contraception* is required:
Starting at least 1 month before initiating isotretinoin and continuing for 1 month after discontinuing isotretinoin.

One primary form of contraception: hormonal (IUD, implant, injection, ring, patch, COC) or non-hormonal IUD.

a) Long-acting reversible contraceptives (LARCs: IUDs, implants) are preferred in acne guidelines when clinically appropriate.[7]
b) Norethindrone-only pills (Maeve, Movisse, Jencycla) are not considered adequate in this context.[18] The adequacy of the drospirenone-only pill (Slynd) is unclear.[25]

One secondary form of contraception: barrier method (condom, cervical cap or diaphragm with spermicide, vaginal sponge).

*** Abstaining from intercourse that may result in pregnancy is an alternative if contraceptive measures outlined above are not appropriate.**

Free contraceptives in British Columbia
Including LARCs, emergency contraceptives

Links to manufacturers' isotretinoin forms, checklists, patient counselling resources:
Accutane
Clarus
Epuris
Absorica LD

See Reference List

Isotretinoin: formulations, dosing

Isotretinoin formulations[1-4]

Brand	Formulation type	Dosages, approx cost per 30 caps		BC PharmaCare	Impact of food
Accutane	Standard: originator product	10, 40 mg	$30, $65	**Regular Benefit**	Food increases the absorption of Accutane & Clarus more than Epuris. Absorica LD absorption is not significantly affected by food.
Clarus	Standard: generic of Accutane	10, 40 mg	$30, $65		
Epuris	Lidose: lipid matrix	10, 20, 30, 40 mg	$50, $70, $90, $105	non benefit	
Absorica LD	Micronized: small particles	8, 16, 24, 32 mg	$45, $65, $80, $90		
Soybean: each formulation contains soybean oil as a non-medicinal ingredient; there is no consensus on the approach in people with severe soybean or peanut allergy, consider referral to allergist or immunologist.[5]					

Dosing strategies: standard versus low dose isotretinoin regimens[1-4,6,12-26]

Standard dose	**Accutane, Clarus, Epuris:** Initiate at **0.5 mg/kg/day** for the first month, then increase to 1 mg/kg/day if necessary and tolerated	**Absorica LD:** Initiate at **0.4 mg/kg/day** for the first month, then increase to 0.8 mg/kg/day if necessary and tolerated	May result in a shorter treatment course and lower short-term relapse rates but more adverse events than lower dose regimens.
Low dose	**Accutane, Clarus, Epuris:** Initiate at **0.1 to 0.4 mg/kg/day** for the first month, then increase if necessary and tolerated ***OR* fixed dose** 10 to 20 mg/day	**Absorica LD:** For an equivalent Absorica LD dose **reduce the dose by 20%**	May result in fewer adverse events but a longer treatment course and longer window of teratogenicity risk; trials using lower doses tended to be ≥ 6 months in duration.
Weight based dosing: round to nearest whole number of capsules; can be given as a once daily dose or in two divided doses.			

Duration of therapy[6,13-16,22,23] recommendations vary and include the following options:

1. Individualize: continue for 1 to 3 months after acne is cleared
2. Fixed duration: 4 to 6 months (the largest trial was ~4 months)
3. Target cumulative dose: 120 to 150 mg/kg

After completion of an isotretinoin course, consider maintenance treatment with a topical therapy

Isotretinoin formulations[6-11]

Current evidence does not support that the four formulations differ meaningfully in safety or effectiveness (eg, onset of effect, reduction in scarring, need for retreatment).

Dose[1-4,6,12-26]

Individualize according to acne severity, therapeutic response and adverse events.

Lower initial doses have been recommended: for less severe disease, in individuals expected to be at increased risk of adverse events, to reduce the risk of early inflammatory flare.

Repeat course[1-4,27,28]

Health Canada indicates that a repeat course should not be initiated within 2 months after completion of the first course.

The earliest isotretinoin trials demonstrated that some people continue to improve even after completion of the initial course.

See Reference List; Cost without mark-up or professional fee from McKesson Canada; BC PharmaCare Formulary

Isotretinoin: monitoring

Laboratory monitoring[1-3]	
ALT, TG	✓ Within 1 month prior to starting. ✓ Recheck after maintenance dose has been established. X Does not need to be rechecked if within normal limits.
Choosing Wisely Canada Dermatology: CBC and metabolic panels are not necessary in otherwise healthy individuals as a component of isotretinoin monitoring.	

Adverse events:

Health Canada's review of the largest isotretinoin trial (925 participants), showed that 90% of participants experienced an adverse event that was mild to moderate in severity.[4,5]

Most common: dry lips (45%), dry skin (45%), dry eye (18%), back pain (20%), arthralgia (13%), nose bleeds (10%).

Management of common adverse events[6-17]	
Mucocutaneous	▪ Routinely recommend gentle cleansers, moisturizers, lip balm, sun protection. ▪ Omega-3 supplement may reduce occurrence.
Ophthalmic	▪ Recommend regular use of preservative-free lubricants, eye lid hygiene, eye protection in windy dry environments.
Back pain, arthralgia	▪ Dependent on severity but can include NSAIDs, isotretinoin dose reduction or discontinuation.

Additional clinical considerations	
Initial acne flare 6-9,16,18-21	▪ Initial temporary worsening of inflammatory acne can occur during first month. ▪ Prevention: consider an adjuvant non-sedating antihistamine. ▪ Treatment: consider reducing the isotretinoin dose, adding a corticosteroid. ▪ Urgent dermatology assessment: systemic symptoms consistent with acne fulminans.
Vision changes 5,13,22,23	▪ Refer to ophthalmology for more serious symptoms including ocular pain, vision changes, dry eye unresponsive to treatment. ▪ Case reports of night blindness: Transport Canada lists isotretinoin as a high-risk medication that is not compatible with aviation safety.
Sacroiliitis 6-9,17,24-26	▪ Case reports of sacroiliitis: monitor pain in lower back, morning stiffness. ▪ Health Canada review: possible link to isotretinoin use and sacroiliitis. ▪ Most cases improved after isotretinoin discontinuation.
Headache 6-9	▪ Advise patients to report headache with vision disturbances or nausea. ▪ If present, rule out intracranial hypertension, assess for papilledema.
Psychiatric 4-9,27-31	▪ Screening (eg, PHQ-9) and monitoring during treatment is recommended. ▪ Discontinue isotretinoin if clinically-important symptoms emerge. ▪ Health Canada's review of the largest isotretinoin trial: rates of psychiatric conditions were lower than prevalence rates in the general population. ▪ Meta-analysis of observational studies: isotretinoin use was not associated with an increased risk of suicide or psychiatric conditions at a population level.
Sexual dysfunction 6-9,32	▪ Case reports of erectile dysfunction, reduced libido, vulvovaginal dryness, genital hypoaesthesia including some persistence after drug discontinuation. ▪ Health Canda review: link to isotretinoin could not be ruled out.

Reference list is available upon request. Materials are designed to be used in conjunction with an academic detailing session provided by a PAD pharmacist.

For more information, or to schedule an academic detailing session, please contact: BC Provincial Academic Detailing Service Email: PAD@gov.bc.ca Web: www.bcpad.ca

Post session survey link

v. Mar 9, 2026