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Clinical and anamnestic profile of a current patient with rosacea: results of own study

Objective — to analyze the clinical and anamnestic profile of patients with rosacea in modern conditions, identify characteristic patterns of dermatosis development, and establish the relationship between anamnestic data and objective indicators of skin condition to optimize diagnosis and treatment.

Materials and methods. During 2024—2026 at the Department of Dermatology and Venereology of the Ivano-Frankivsk National Medical University, we examined 89 patients with rosacea (ages 28—68 years), of whom 22.2 % were men.

We used a set of methods: clinical and anamnestic: 1) author's questionnaire and Spielberger scale to assess the level of anxiety; 2) clinical and visual: determination of general facial skin condition and the degree of erythema according to the CEA scale; 3) instrumental: corneometry by BT-Analyzer to assess the degree of skin hydration and dermatoscopy with Heine Delta 30; 4) statistical: Spearman's correlation and multivariate ordinal logistic regression analyses were performed using IBM SPSS Statistics 26.

Results and discussion. We found that 83.15 % of patients had skin phototype II and 91.01 % had signs of photodamage. A high level of anxiety characterized the psychoemotional state in 95.51 % of respondents. The level of skin hydration was critically low in 70.79 % of patients (Me = 14 % [Q1—Q3] = 12—17 %), which corresponded to dermatoscopic findings of skin dehydration. The most prevalent concomitant pathologies were gastrointestinal diseases (73.03 %), metabolic disorders (24.72 %), and thyroid dysfunctions (21.35 %).

Correlation analysis revealed a moderate negative association ($r = -0.548$, $p = 0.001$) between the degree of erythema and skin hydration level. The more severe the erythema, the lower the hydration level. The regression model identified key predictors of erythema severity. They are skin hydration, smoking, food triggers, and age. A 1 % increase in skin moisture level reduces the chances of severe erythema by 47 %. Smokers have a significantly higher risk of developing grade 3—4 erythema. Food triggers increase the likelihood of severe erythema by 8.2 times. The risk of severe erythema increases by 7 % per year of life.

Conclusions. The state of the skin barrier function (particularly stratum corneum hydration) directly correlates with the severity of rosacea's clinical manifestations. Although patients have high levels of anxiety, we have not confirmed the direct impact of psychoemotional state on the clinical course of the dermatosis, which emphasizes the need to restore the skin barrier as a priority therapeutic strategy. The obtained results justify the inclusion of agents to address this problem in standard treatment protocols.

Keywords

Rosacea, skin barrier function, skin hydration level, erythema severity, psychoemotional state, triggers, correlations.

Rosacea, as a common inflammatory disease of the facial skin with a chronic, recurrent course [3] and various phenotypic manifestations [8], which causes a visible aesthetic defect, is one of the important problems of dermatology and cosmetology today. Although this dermatosis is not life-threatening, the cosmetic defect and burning or tingling sensation create a significant psychoemotional burden on such patients [10], affecting interpersonal relationships, reducing sociability, success, and work capacity, causing anxiety and depression, psychosocial maladjustment, and the development of dysmorphophobia [1]. 41 % of patients with rosacea avoid social and public contact, 76 % have low self-esteem. In addition, they must fight against widespread stigmatization. Society mistakenly interprets facial erythema as alcohol abuse or inability to cope with stress, and the presence of papules and pustules because of poor hygiene [11]. The above-mentioned factors significantly affect the quality

of life [9] and make the problem of rosacea management relevant and important not only in medical but also in social aspects.

Data regarding the prevalence and incidence of rosacea remains contradictory. There are 165 new cases per 100,000 population worldwide each year, and prevalence varies significantly across countries, ranging from 0 to 22 % [6]. However, this result is likely to be influenced by differences in population, geographic location, and cultural and social factors in perceptions of the disease [19]. Rosacea occurs among individuals of all races and ethnicities. Still, the highest risk of development is observed among people with fair (Celtic and Northern European) skin (phototypes I and II according to Fitzpatrick) [4]. The total proportion of people with rosacea is 5.46 % in the general population, 2.39 % (2—5 %) among dermatological outpatients [20], and among acne-like dermatoses — 36 % [1].

The prevalence of this dermatosis increases with age: 10—20 % of people aged 30—60 are prone to rosacea. 80 % of all patients are over 30. Rosacea affects both women (5.41 %) and men (3.90 %) [13], and the first signs of the disease appear at 25—35 years of age, reaching its peak at 40—50 years.

There are currently no accurate official statistics on the prevalence of rosacea in Ukraine. However, based on domestic research data and European trends, and given that the population of Ukraine is predominantly of skin phototypes I and II, the prevalence rate will range from 5 to 10 % of the adult population. It is also worth considering the many undiagnosed cases of rosacea, which are often misdiagnosed as «sensitive skin» or «demodicosis».

The pathophysiological mechanisms of rosacea development involve complex interactions among congenital and acquired immune system disorders, neurovascular disorders, genetic and environmental factors, impaired barrier function, and the skin microbiome [12, 16].

Powerful triggers that provoke or worsen the course of the disease are ultraviolet radiation, stress, and improper skin care or its absence [5]. As a result, the increased transepidermal water loss (TEWL) in the stratum corneum, changes in the biocenosis, and the initiation of a cascade of biochemical processes that lead to persistent vasodilation disrupted the skin barrier function. All this contributes to increased skin erythema and inflammation [7, 15]. Typical symptoms, in addition to centrofacial erythema, are dry skin, burning, tightness, tingling, and itching [14]. Moreover, patients complain of increased sensitivity of the facial skin to cleansers, hot water, cosmetic products, and climatic factors [5].

Life in Ukraine during the war negatively affects the mental health of the population and, particularly, patients with rosacea. Danger, uncertainty, disruption of the usual way of life, loss of loved ones, life in «hot spots» or forced relocation, decreased well-being, and solvency have led to the fact that now every second Ukrainian suffers from reactive and personal anxiety, depression, aggression, or posttraumatic stress disorder [2].

Due to the activation of the hypothalamic-pituitary-adrenal system and the release of cortisol, the eating behavior of patients with rosacea deteriorates against the background of chronic stress, ignoring important dietary recommendations. During disease recurrences, these patients are more likely to self-medicate and delay visits to a dermatologist. All this contributes to the progression of dermatosis and intensification of chronic stress [17].

Rosacea is currently diagnosed clinically based on history, triggers, and course dynamics. The presence of dermatoscopic vascular and follicular patterns confirms the diagnosis of this inflammatory disease. There are no specific laboratory or histological markers for rosacea [8, 18].

Research justification. Despite multiple studies, frequent discussions of the etiopathogenesis of rosacea, and its relationship with comorbid conditions (like gastrointestinal and cardiovascular dysfunctions), the problem of diagnosing and selecting effective therapy for this dermatosis remains complex. It is due to the high variability in clinical manifestations and the variety of anamnestic factors (triggers), which differ significantly across regions, lifestyles, and concomitant pathologies. The lack of a systematic analysis of the modern clinical and anamnestic portrait of the patient hinders the development of personalized strategies for treatment and prevention of exacerbations.

Objective — to study and analyze the clinical and anamnestic profiles of patients with rosacea in modern conditions, accounting for gender and age factors. To identify characteristic patterns of dermatosis development, the relationship between anamnestic data (including lifestyle and psycho-emotional state), objective indicators of skin condition, and the nature of clinical manifestations is examined to optimize the diagnostic algorithm and increase the effectiveness of personalized therapy.

Materials and methods

The study was performed at the Department of Dermatology and Venereology of the Ivano-Frankivsk National Medical University during 2024—2026. We conducted a clinical examination of 89 patients with rosacea, aged 28—68 years (mean age 44.28 years); 22.2 % were men. Duration of dermatosis: 0—17 years.

Inclusion criteria in the study:

1. Patients of both sexes, over 18 years of age, with a confirmed diagnosis of rosacea, according to the ROSCO (Rosacea consensus panel 2019).
2. Persons who consent and voluntarily agree to participate in the study, suitably for the moral and ethical standards, in accordance with the rules of IGH/GCP (The International Council for Harmonization and Good Clinical Practic — The global standard for designing, conducting, and reporting clinical trials, with a set of international ethical and scientific quality standards).
3. Persons who can effectively cooperate throughout the entire period of the study.

Exclusion criteria for the study:

1. Patient with microscopic or dermatoscopic confirmation of contamination of the sebaceous glands with Demodex folliculorum.
2. Patients with rhinophyma, ocular rosacea, granulomatous or steroid rosacea.
3. The presence of severe comorbidities that may affect the interpretation of the data. Particularly, mental illnesses, any immunodeficiency states, including HIV infection, severe allergic reactions in history, diseases requiring continuous administration of systemic glucocorticosteroids, immunobiological therapy, and cytostatics.
4. Individuals who are unable to cooperate effectively throughout the study period.
5. Patient refusal to participate in the study.

To achieve the goal, we used a set of methods. For the assessment of socio-demographic indicators, we used the clinical and anamnestic method and the author's questionnaire. For the evaluation of patients' psychoemotional state, the Spielberger scale (the degree of anxiety was determined in points: less than 30 indicates a low level, 31—45 indicates a medium level, and more than 45 indicates a high level of anxiety). In addition, we analyzed the prior treatment experience (topical corticosteroids, cosmetic application).

The clinical-visual method allowed us to determine the skin phototype according to the Fitzpatrick scale, the presence of facial photodamage signs, the general skin condition, and the severity of erythema using the CEA (Clinician Erythema Assessment) scale.

To objectify the condition of the skin, we performed corneometry using the BT-Analyzer to determine the stratum corneum hydration state. To assess vascular changes in the skin, background erythema, the presence of inflammatory infiltrates, and follicular plugs, the Heine Delta 30 dermatoscope was used.

Statistical analysis of the results was performed using IBM SPSS Statistics (version 26). We evaluated continuous variables for normality using the Shapiro—Wilk test. Since the data were not normally distributed, we presented them as medians and interquartile ranges (IQRs). For comparisons between groups for erythema severity (four ordinal categories), we used Kruskal—Wallis test for continuous variables and the chi-square test or Fisher's exact test for categorical variables were used to compare groups for erythema severity (four ordinal categories). We assessed the correlation between erythema severity and skin hydration using the Spearman rank correlation coefficient. To identify independent predictors of erythema severity, we constructed a multivariate ordinal logistic regression model. We included variables with p-values < 0.1 in the univariate analysis in the final multivariate model. We tested the proportional odds assumption using the parallel lines test. We presented results as odds ratios (ORs) with 95 % confidence intervals (CIs). A p-value < 0.05 was considered statistically significant.

Results and discussion

The analysis of clinical and anamnestic data allowed us to form a detailed portrait of a modern patient with rosacea. We presented demographic characteristics and clinical features of the study group in Tables 1—3.

74.16 % of respondents reported low well-being. Among comorbid conditions, the largest share is made up of gastrointestinal diseases (73.03 %), metabolic disorders (24.72 %), and thyroid dysfunctions (21.35 %). Only 23.6 % do not have habits that can trigger rosacea.

Regarding care habits, only 17.98 % of patients reported regular use of sunscreen, and another 37.08 % reported using care cosmetics.

79.78 % reported frequent exacerbations of rosacea (more than 3 times a year). Due to financial constraints, 70.79 % stopped seeking professional medical help. Among those who visited a dermatologist, only 19.1 % followed the recommendations.

It is worth noting that 91.01 % of patients showed signs of photodamage (uneven skin tone due to multiple hyperpigmentations, dryness, and fine lines). It indicates that ultraviolet radiation is a key trigger of rosacea, stimulating skin inflammation and making the skin more vulnerable and sensitive.

The level of skin moisture indicates critical dryness (an indicator below 30 % indicates severe dehydration), which corresponds to dermatoscopic findings of skin dehydration in 70.79 % of patients (diffuse white scales that obscure the underlying vascular structures, blurred looped vessels, exaggerated skin furrows, and fine lines).

During the correlation analysis, we found a moderate negative correlation ($r = -0.548$, $p < 0.001$;

Table 1. **Baseline characteristics of the study population (patients with rosacea, n = 89)**

Gender	**n**	**%**
Male	18	22.22
Female	71	79.78
Age, years		
Age, Me [Q1—Q3]	44.00 [35.50—51.00]	
Age range	28—68	
Place of residence		
City	58	65.17
Rural	31	34.83
Education level		
Primary	48	53.93
Professional	21	23.60
Higher	16	17.98
Higher medical	4	4.49
Well-being level		
Low	66	74.16
Average	21	23.60
High	2	2.25
Psychoemotional state (degree of anxiety)		
High	85	95.51
Average	4	4.49
Low	0	0.00
Habits		
Smoking	19	21.35
Decorative cosmetic	25	28.09
Alcohol	12	13.48
Hot and spicy food	12	13.48
None	21	23.60
Comorbidity of special interest		
Parkinson's disease	0	0.00
Metabolic syndrome	22	24.72
Hypertension	17	19.10
Diabetes	6	6.74
Crohn's disease	0	0.00
Migraine	4	4.49
Gastrointestinal disease	65	73.03
Gynecological disease	13	14.61
Thyroid disorders	19	21.35
Skin care habits		
Using sunscreen:		
Everyday	16	17.98
Sometimes/seldom	35	39.33
Never	38	42.70
Work outdoors	25	28.09
Skin care cosmetics	33	37.08
Visit cosmetologist	17	19.10

Table 2. **Anamnestic data**

Variable	**n**	**%**
Duration of dermatosis		
Up to 1 year	7	7.87
Up to 5 years	51	57.30
6—15 years	19	21.35
More than 15 years	2	2.25
Frequency of exacerbations		
1 year/year	13	14.61
2—3 times/year	71	79.78
Period of remission not noted	5	5.62
Heredity		
Aggravated by rosacea	59	66.29
Not aggravated	30	33.71
Experience of treatment with topical glucocorticosteroids		
Yes	21	23.60
No	68	76.40
Complaints		
Dryness, feeling of skin tightening	72	80.90
Presence of rashes	11	12.36
Itching, burning, tingling, and increased skin sensitivity	47	52.81
Face redness	89	100.00
Current treatment		
No	44	49.44
Topical agents	1	1.12
Care products	33	37.08
Systemic therapy	8	8.99
Complex treatment	4	4.49
Cosmetic procedures	0	0.00
Reasons for refusal of qualified medical care		
Financial insolvency	63	70.79
Distrust	11	12.36

Table 3. **Clinical characteristics of the study group**

Feature	**n**	**%**
Skin phototypes		
I	5	5.62
II	74	83.15
III	10	11.24
IV—VI	0	0.00
Signs of facial skin photodamage		
Available	81	91.01
Absent	8	8.99
Rosacea phenotype		
Erythematotelangiectatic	53	59.55
Papulo-pustular	36	40.45

End of table 3

Feature	n	%
Skin moisture level (Me [Q1—Q3]), %	14.00 [12.00—17.00]	
Erythema intensity (CEA scale)		
1	3	3.37
2	32	35.96
3	49	55.05
4	5	5.62
Dermatoscopic signs		
Couperose net	72	80.90
Mite tails	1	1.12
Signs of dehydration	63	70.79
Strength of erythematous background	84	94.38

Table 4. **Correlation analysis**

Parameter	r	p
Degree of erythema/degree of skin hydration	–0.548	< 0.001
Degree of severity of erythema/ psycho-emotional state	0.073	0.499
Degree of skin hydration/ psycho-emotional state	–0.139	0.195

Fig. 1) between erythema severity and skin moisture (Table 4). It indicates that severe erythema is characterized by lower skin hydration.

Correlation between the degree of severity of erythema and psychoemotional state (r = 0.073, p = 0.499) and between the degree of skin moisture and psychoemotional state (r = –0.139, p = 0.195) we did not reveal. Perhaps stress acts indirectly (through changes in diet or neglect of care).

To identify and assess the influence of factors on erythema severity, ordinal logistic regression was performed. Clinical, anamnestic, and demographic indicators were included in the multivariate model. After evaluating the results, we identified risk factors associated with rosacea severity. Statistically significant or borderline were the degree of skin hydration (p < 0.001), smoking (p < 0.001), food triggers (p = 0.006), age (p = 0.061), thyroid diseases (p = 0.065), and the presence of comorbid conditions (p = 0.068) (Table 5).

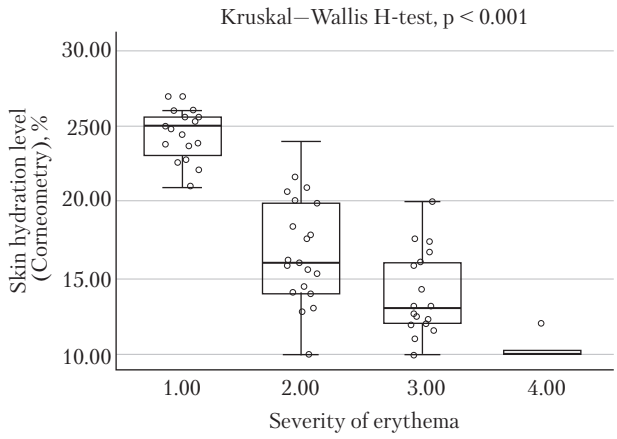

Fig. 1. **Correlation between the degree of erythema and the degree of skin hydration**

We elicit that:

- For every 1 % increase in skin moisture, the patient's chances of having severe erythema decreased by 47 %.
- Non-smokers had a negligible chance of developing grade 3—4 erythema compared to smokers.
- The presence of food triggers increased the likelihood of developing severe erythema by 8.2 times.
- With each year of life, the development of severe erythema increased by 7 %. This factor is not statistically significant, but it may be a clinically important trend.
- The presence of thyroid disease showed a trend towards association with milder erythema.
- The presence of other comorbidities is likely to be associated with more severe erythema. This variable is not statistically significant; however, it also reflects a trend.

Table 5. **Risk factors associated with the severity of rosacea**

Factor	B	OR	95 % CI	p
Degree of skin hydration	–0.642	0.53	0.41—0.68	< 0.001
Smoking	5.812	334.2	16.4—6815	< 0.001
Alimentar triggers	2.104	8.20	1.85—36.3	0.006
Age (1 year of growth)	0.071	1.07	0.99—1.15	0.061
Thyroid gland diseases	–1.412	0.24	0.05—1.10	0.065
Comorbid conditions	1.842	6.31	0.87—45.8	0.068

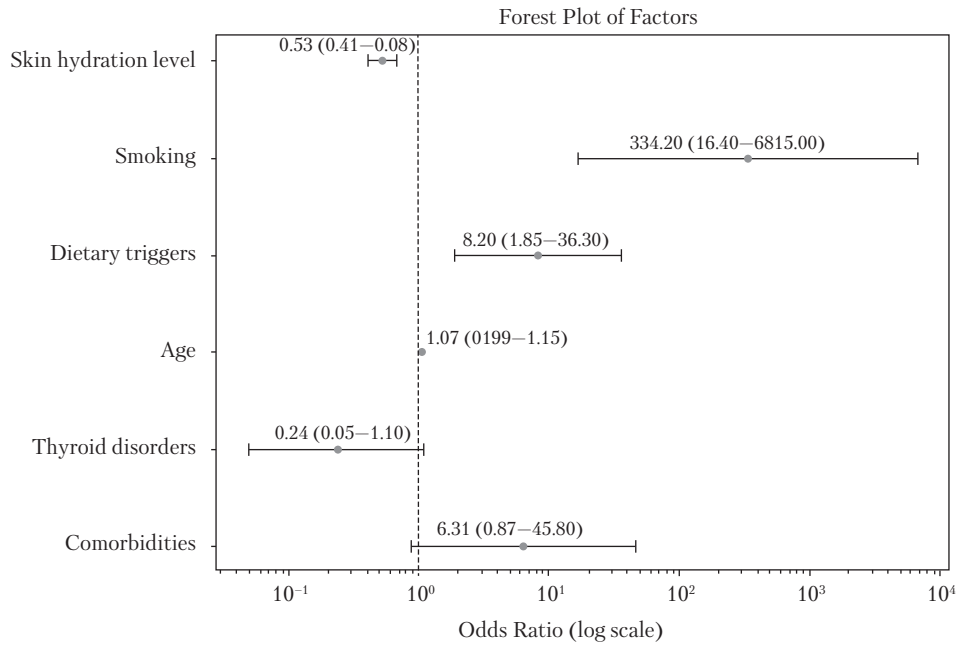

Fig. 2. **Prognostic factors of erythema severity according to multivariate ordinal logistic regression**

The chart (Fig. 2) presents the odds ratio (OR) and 95 % confidence intervals (CI). The vertical line (OR = 1.0) corresponds to the absence of a statistically significant effect. Values of OR < 1.0 indicate a protective role of the factor; OR > 1.0 indicate an increased risk of erythema progression. The abscissa axis is logarithmic.

Conclusions

A comprehensive analysis of the clinical and anamnestic profiles of patients with rosacea enabled us to identify the most significant anamnestic factors influencing the onset and progression of the dermatosis. We assessed the subjective (psychoemotional state of patients), clinical (erythema severity), and instrumental (skin moisture) aspects of rosacea.

1. The results of the study indicate a direct relationship between the state of the skin barrier function and the severity of clinical manifestations. We established that a key physical factor in the severity of erythema in rosacea is the stratum corneum's hydration level: a 1 % decrease in hydration is associated with a 47 % increase in the risk of severe erythema. It allows us to focus the main therapeutic strategy on restoring the skin barrier.
2. The strongest modified predictors of disease severity are smoking and poor diet. The risk of intensive erythema increases 8.2-fold in the presence of dietary triggers. Smoking showed an extremely high OR of 334.2; however, this requires further study in larger samples.
3. The observation regarding the influence of the psychoemotional state is interesting. Despite the critically high level of anxiety (95.5 %) among patients, no direct correlation was found between the Spielberger scale score and the intensity of erythema. This indicates that psychoemotional distress is a consequence of the disease, and not a direct factor in its severity.
4. The clinical significance of the results obtained allows us to predict further management strategies for patients with rosacea. Therapeutic strategies should primarily include lifestyle modification and restoration of skin barrier function. The priority is not only the relief of inflammatory elements and the elimination of erythema. Improving the stratum corneum's hydration will eliminate subjective discomfort (burning, skin tightness) associated with rosacea. It will ultimately improve patients' quality of life and their psychosocial rehabilitation.

There is no conflict of interest.

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Клініко-анамнестичний профіль сучасного пацієнта з розацеа: результати власного дослідження

Мета роботи — проаналізувати клініко-анамнестичний профіль пацієнтів з розацеа, виявити характерні закономірності розвитку дерматозу та встановити зв'язок між анамнестичними даними та об'єктивними показниками стану шкіри для оптимізації діагностики та лікування.

Матеріали та методи. Протягом 2024—2026 рр. на кафедрі дерматології та венерології Івано-Франківського національного медичного університету обстежено 89 пацієнтів (з них 22,2 % чоловіків) віком 28—68 років із розацеа. Використано комплекс методів: 1) клініко-анамнестичні: авторська анкета та шкала Спілбергера для оцінки рівня тривожності; 2) клініко-візуальні: визначення загального стану шкіри обличчя та ступеня еритеми за шкалою CEA; 3) інструментальні: корнеометрія за допомогою BT-Analyzer для оцінки ступеня гідратації шкіри та дерматоскопія за допомогою Heine Delta 30; 4) статистичні: кореляційний аналіз Спірмена та багатовимірний порядковий логістичний регресійний аналіз за допомогою IBM SPSS Statistics 26.

Результати та обговорення. Встановлено, що 83,15 % пацієнтів мали II фототип шкіри, а у 91,01 % виявлено ознаки її фотопошкодження. Високий рівень тривожності характеризував психоемоційний стан у 95,51 % респондентів. Рівень гідратації шкіри був критично низьким у 70,79 % обстежених (Me 14 % [Q1—Q3] 12—17 %), що відповідало дерматоскопічним даним зневоднення шкіри. Найпоширенішими супутніми патологіями були захворювання травного тракту (73,03 %), порушення обміну речовин (24,72 %) та дисфункція щитоподібної залози (21,35 %).

Кореляційний аналіз виявив помірний негативний зв'язок ($r = -0,548$; $p = 0,001$) між ступенем еритеми та рівнем зволоженості шкіри: що виразнішою була еритема, то нижчим — рівень гідратації. За регресійною моделлю визначено ключові предиктори тяжкості еритеми: гідратація шкіри, куріння, харчові тригери та вік. Підвищення рівня зволоженості шкіри на 1 % знижує ймовірність розвитку тяжкої еритеми на 47 %. У курців значно підвищений ризик

розвитку еритеми 3—4-го ступеня. Харчові тригери збільшують ймовірність тяжкої еритеми у 8,2 разу. Ризик тяжкої еритеми зростає на 7 % з кожним роком життя.

Висновки. Стан бар'єрної функції шкіри (особливо гідратація рогового шару) безпосередньо корелює з тяжкістю клінічних проявів розацеа. Попри високий рівень тривожності у пацієнтів, не підтверджено прямого впливу психоемоційного стану на клінічний перебіг дерматозу, що свідчить про необхідність відновлення шкірного бар'єра як пріоритетної терапевтичної стратегії. Отримані результати обґрунтовують включення відповідних засобів до стандартних протоколів лікування для вирішення цієї проблеми.

Ключові слова: розацеа, бар'єрна функція шкіри, ступінь зволоження шкіри, ступінь вираженості еритеми, психоемоційний стан, тригери, кореляційні зв'язки.

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