



When Fear of Isotretinoin Becomes a Barrier to Care: Severe Nodulocystic Acne and Psychosocial Distress in a 13-Year-Old Girl

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Abstract

Severe adolescent acne may have substantial psychological and social consequences, while concerns regarding isotretinoin-related adverse effects can influence treatment decisions. We describe a 13-year-old girl with severe nodulocystic acne involving approximately 60% of the face, progressing despite topical treatment and a three-month course of systemic antibiotics. The patient was socially withdrawn and minimally communicative, and psychological assessment confirmed significant emotional distress associated with peer bullying. Given the severity of the disease, treatment failure, and psychosocial burden, oral isotretinoin was recommended. Despite counselling, her parents declined treatment because of concerns regarding potential adverse effects. This case illustrates a relevant psychodermatological paradox: fear of potential treatment-related psychological harm may become a barrier to therapy while untreated acne is already causing documented psychological and social harm. Balanced counselling should therefore consider both treatment-related risks and the consequences of inadequately treated severe acne.

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Short Communication

Acne vulgaris is common during adolescence, but severe inflammatory disease may have consequences extending considerably beyond the skin. Acne has been associated with depression and anxiety, while facial acne in adolescents may result in stigmatization and impaired quality of life [1, 2]. Appearance-

related teasing and bullying may further contribute to psychological and social morbidity [3, 4]. Oral isotretinoin is an established treatment for severe, scarring, or treatment-resistant acne. Current American Academy of Dermatology guidelines recommend isotretinoin for severe acne and disease unresponsive to conventional topical or systemic therapy and specifically

recognize psychosocial burden and scarring as indications for its use [5]. Nevertheless, concerns regarding possible psychiatric adverse effects continue to influence treatment decisions. A 13-year-old girl presented with severe nodulocystic acne involving approximately 60% of the facial surface (Figures 1, 2).



Figures 1, 2: Severe nodulocystic acne lesions.

The first lesions had appeared at approximately 11 years of age, with progressive worsening during the following two years. Previous conventional topical therapies and a three-month course of oral antibiotics had failed to provide significant improvement. Clinical examination demonstrated extensive inflammatory and cystic lesions predominantly affecting the cheeks, temporal regions, and forehead. During consultation, an important psychosocial dimension became apparent. The patient was socially withdrawn, minimally communicative, and showed a blunted emotional response when discussing her acne and possible treatment. Psychological assessment confirmed significant emotional distress associated with bullying by peers because of her facial appearance. Considering the severity of the nodulocystic acne, previous treatment failure, extensive facial involvement, risk of scarring, and substantial psychosocial burden, oral isotretinoin was recommended.

The patient and her parents received counselling regarding its expected benefits, potential adverse effects, and clinical and laboratory monitoring. Despite counselling, her parents declined isotretinoin because of fear of potential adverse effects. The most important aspect of this case is that the patient's

psychological difficulties were present before any exposure to isotretinoin. Acne itself has a well-established association with psychological morbidity. A meta-analysis of 42 studies demonstrated significant associations between acne and both depression and anxiety [1]. Among adolescents, Szepietowska et al. reported stigmatization in 58% of individuals with acne, with greater stigmatization among girls and an association with impaired quality of life [2]. Appearance-related bullying and teasing associated with visible skin disease may further contribute to embarrassment, social difficulties, and psychological distress [3, 4]. Difficulties in emotional expression have also been reported in adolescents with acne and associated with stigmatization and quality-of-life impairment [6]. Conversely, the relationship between isotretinoin and psychiatric adverse effects remains controversial. Earlier systematic reviews found no significant overall increase in depression with isotretinoin and reported improvement in depressive symptoms following treatment [6, 7].

More recently, Tan et al. analyzed 25 studies comprising 1,625,891 participants and found no increased relative risk of psychiatric disorders among isotretinoin users at the population level; the one-year absolute risks of completed suicide, suicide attempt, suicidal ideation, and self-harm were each below 0.5% [8]. These findings do not exclude rare individual reactions, and appropriate psychological assessment and monitoring remain important [8]. This evidence creates the central paradox illustrated by our patient. Isotretinoin was declined because of concern regarding potential adverse effects, including psychological effects, yet the untreated disease was already associated with documented emotional and social harm. Avoiding treatment therefore did not represent an absence of risk. Persistent severe acne may prolong inflammation and increase the risk of permanent scarring while continuing to expose an adolescent to stigmatization, bullying, social withdrawal, and psychological distress. Current guidelines appropriately recognize psychosocial burden as an important component of acne severity when considering isotretinoin [9].

The case also highlights the value of psychological assessment before systemic therapy. Behavioral changes observed during the dermatological consultation led to psychological evaluation and identification of pre-

existing disease-related distress. Establishing baseline psychological status may facilitate appropriate support and allow subsequent changes to be interpreted more accurately [9-11]. For adolescents, treatment decisions should involve the patient and family and should acknowledge parental concerns without minimizing either potential medication-related risks or the consequences of uncontrolled disease. Fear of potential treatment-related psychological harm should be balanced against the psychological and social harm already being caused by severe acne.

Conclusion

Severe adolescent acne should be approached as both a dermatological and psychosocial disease. In this patient, bullying, social withdrawal, and significant emotional distress preceded consideration of isotretinoin, while parental fear of treatment-related adverse effects became a barrier to therapy. Balanced risk-benefit counseling and baseline psychological assessment may support more informed shared decision-making in adolescents with severe acne.

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