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MORE SEVERE, LESS SPECIALISED: THE CLINICAL PARADOX OF TRUNCAL ACNE REVEALED IN A 20-COUNTRY SURVEY

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INTRODUCTION & OBJECTIVES

Truncal acne (TA) — defined as acne involving the back, chest, and shoulders — affects 40–60% of patients with acne vulgaris [1] and has long been labelled a 'neglected entity' [3]. Despite this designation, the mechanisms underlying its neglect and their consequences have never been simultaneously quantified in a single large-scale international cohort.

The present study addresses this gap by reporting findings from two complementary analyses of the **ALL PROJECT** survey [2], with the goal of characterizing the care-pathway and psychosocial burden of TA within a unified international cohort. A clinically important paradox emerges from these analyses: truncal acne is objectively more severe than facial acne (FA), yet it reaches specialist care less often — a gap driven by a psychosocial amplification mechanism that existing data have not previously captured.

MATERIALS & METHODS

A total of 1,879 adults (≥18 years) with physician-diagnosed acne were recruited across 20 countries (805 males, 42.8%; 1,074 females, 57.2%; mean age 33.3 ± 13.1 years). Among them, 1,075 (57.2%) had exclusively facial acne (FA) and 804 (42.8%) had TA (19.9% truncal only; 22.9% combined facial and truncal).

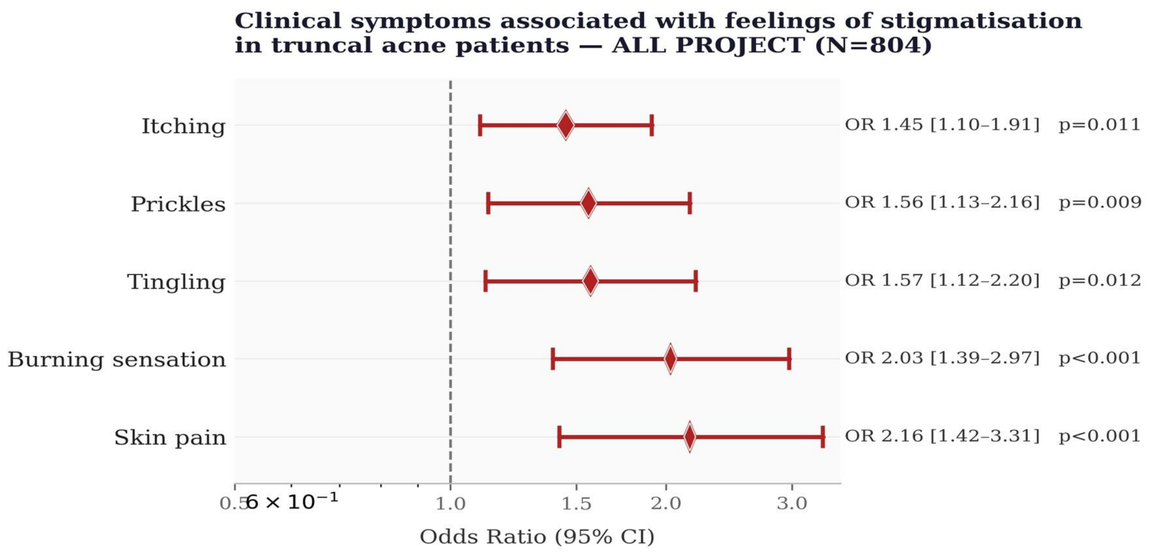
Group comparisons were performed using Z-tests for proportions and chi-squared tests. The significance threshold was set at $p < 0.05$. Outcomes of interest included: dermatologist and primary care consultation rates, hospitalisation and surgical referral rates, feelings of stigmatisation (FS), multidimensional quality of life impairment, treatment adherence, and sociodemographic predictors of psychosocial burden.

RESULTS

Care pathway. Despite comparable overall healthcare contact rates (75.5% TA vs. 73.5% FA, p = 0.351), patients with TA were significantly less likely to consult a dermatologist (71.7% vs. 77.7%, p = 0.011) and more frequently relied on general practitioners (27.7% vs. 21.7%, p = 0.011), allergologists (14.5% vs. 10.1%, p = 0.016), and pharmacists without prior medical consultation (8.8% vs. 4.5%, p < 0.001).

Objective disease severity. Objective markers of disease severity were substantially higher in the TA group: surgical consultation rates were nearly three-fold greater (5.3% vs. 1.9%, p < 0.001; OR 2.8) and hospitalisation rates were 65% higher (12.7% vs. 7.7%, p < 0.001; OR 1.6).

Stigmatisation and quality of life. Nearly half of TA patients (49.9%) reported feelings of stigmatisation (FS), significantly more than those with FA (41.5%, p < 0.001). Stigmatisation experiences were context-specific and body-exposure-driven: TA patients more frequently reported social avoidance by others (28.4% vs. 22.6%, p = 0.005), avoidance of physical contact (28.6% vs. 23.8%, p = 0.022), and disgust-related reactions (30.0% vs. 25.1%, p = 0.022).



OR = Odds Ratio; CI = 95% Confidence Interval. Reference: FS− group (no stigmatisation). All symptoms show OR>1 (increased risk).

Multidimensional quality of life was substantially impaired across professional (reduced productivity: 40.1% vs. 32.7%, p = 0.001), relational (sexual life impact: 35.2% vs. 26.3%, p < 0.001), and behavioural domains (clothing modification: 42.5% vs. 30.3%, p < 0.001; sleep disturbances: 43.9% vs. 36.7%, p = 0.002).

Treatment adherence and predictors of stigmatisation. Feelings of stigmatisation were significantly associated with reduced treatment adherence (58.9% vs. 53.4%, p = 0.022). Younger age was the sole independent predictor of FS (mean age 32.5 vs. 35.0 years, p = 0.006), while gender and BMI were not.

CONCLUSIONS

The severity-access inversion documented here — greater objective disease burden yet lower dermatologist contact — reflects a 'double invisibility' mechanism in which concealed truncal lesions reduce perceived social urgency while independently driving stigmatisation and treatment non-adherence. Systematically examining the trunk during acne consultations is therefore a clinical imperative, and validated stigmatisation screening must be integrated into truncal acne management.

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