Archives of Clinical & Experimental Dermatology

YumedText — Open Access Journals —

Research | Vol 8 Iss 2
ISSN: 2583-6374
https://dx.doi.org/10.46527/2583-6374.197

# Two-Year Update of a Telemedicine-Based Approach for Acne Management

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**Received:** October 01, 2026; **Accepted:** October 14, 2026; **Published:** October 24, 2026

## Abstract

**Background: Telemedicine combining synchronous and asynchronous methods is increasingly used for acne management. We previously described a telemedicine-based acne care program and the demographic profile of its early users over ten months of operation.**

**Objective: To report platform activity and the demographic, lifestyle, and psychological profile of patients after two years of operation.**

**Methods: Descriptive, observational analysis of anonymized aggregate data extracted from the platform for the period 1 March 2024 to 20 February 2026. The analytical cohort comprised all patients who completed at least one consultation. No inferential testing was performed.**

**Results: Of 34,715 registered patients, 7,278 (21.0%) completed at least one consultation, for a total of 12,583 consultations (mean 1.7 per patient); 41.5% of these patients completed two or more. Patients were predominantly female (92.2%) and aged 20 to 40 years (82.6%). Previous acne history (88.9%), previous treatments (69.9%), and family history (50.4%) were common. Among 6,237 patients completing the psychological impact questionnaire, 87.1% rated appearance as very important in their life and work, 79.4% wished to change aspects of their appearance, and 20.7% expected a visible improvement within one month.**

**Conclusion: Two years of operation confirm sustained uptake of the program, a user profile dominated by young adult women with an established history of acne, and a substantial psychological burden.**

**Keywords:** ***Telemedicine; Acne vulgaris; Teledermatology; Digital health; Patient demographics; Observational study***

**Citation:** Mordente I, Siddi BV, Puglia F, et al. Two-Year Update of a Telemedicine-Based Approach for Acne Management. Arc Clin Exp Dermatol. 2026;8(2):197.
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## 1. Introduction

Access to dermatological care is limited worldwide. In a 2026 survey of dermatology leaders from 158 countries, mean dermatologist density was 2.66 per 100,000 population, only 17% of countries met the estimated threshold of 5.63 per 100,000 required for adequate access, and 42% of countries reported inadequate or extremely poor access to dermatological care [1]. In this context, telemedicine does not replace the dermatologist but supports the specialist, extending the reach of each consultation and giving structure and continuity to the therapeutic pathway. Telemedicine adoption accelerated markedly after the COVID-19 pandemic, particularly in dermatology, where combining synchronous (real-time video or audio) and asynchronous (store-and-forward, digital photography) approaches helps overcome barriers to in-person care [2].

The synchronous approach enables real-time communication between patient and clinician, while the asynchronous method allows the collection and forwarding of clinical data for diagnostic and treatment advice; combining both allows for a more comprehensive patient evaluation [3]. Acne vulgaris was significantly affected by the pandemic, with psychological factors such as isolation, stress, and disrupted routines exacerbating the condition, while limited access to in-person care highlighted the need for telemedicine solutions [4,5]. In the post-pandemic period, telemedicine remains relevant for acne management, improving access to care in underserved or remote areas and supporting long-term follow-up, with outcomes comparable to in-person visits and high patient satisfaction, despite slightly lower adherence in remote settings [6,7].

We previously introduced a telemedicine-based approach for acne management (Acne Revolution), combining synchronous and asynchronous methods to provide flexible, ongoing care, and reported preliminary demographic and platform-usage data from the first ten months of activity [8]. The present report has two aims: to describe platform activity after two years of operation, and to characterize the demographic, lifestyle, and psychological profile of patients who completed at least one consultation, with explicit denominators and reporting of missing data.

## 2. Materials and Methods

### 2.1 The acne revolution method

The Acne Revolution method is an online platform-based program for acne management, combining virtual consultations with continuous support through a dedicated patient-care system. The care pathway comprises five stages (pre-visit assessment, first consultation, control visits, final consultation, and a maintenance phase) providing individualized treatment protocols that integrate medical therapy and skincare. A full description has been published [8]; the method has not changed since, with the exception of the changes in data coding and reporting described under Variables and Definitions.

During the pre-visit stage, patients complete nine questionnaires (approximately three minutes each) covering skin health, nutrition, lifestyle, therapies and allergies, psychological impact (stress test), gynecological history, and metabolic history. Patients upload three standardized facial photographs and, when relevant, images of other affected body areas, together with recent laboratory tests; all photographs are manually reviewed by clinicians before consultation.

Patients complete the questionnaires on the platform before the consultation; not all patients complete all questionnaires or all items within them. Based on pre-visit data, patients receive a preliminary acne severity staging, confirmed or revised at the first

consultation using a customized severity scale built on the Global Acne Grading System (GAGS) and integrating psychological stress, family history, and previous treatments. Control visits are scheduled approximately every three months; the therapy cycle typically lasts 6 to 12 months, followed by a final consultation and a maintenance phase with semi-annual follow-up.

This is a descriptive, observational study based on an anonymized aggregate export from the platform database covering consultations and questionnaires in the extraction window from 1 March 2024 to 20 February 2026; the platform was launched on 20 February 2024. The cumulative number of registered patients was taken from the platform registry at the same cut-off date. The export consisted of pre-computed counts per variable category; individual-level records were not accessed for this analysis. The report follows the STROBE recommendations for observational studies as far as applicable to aggregate data [9].

### 2.2 Study population and analytical cohorts

Two nested populations are distinguished. The registered population comprises all patients who created an account on the platform (n=34,715 as of 20 February 2026); it is used only to describe conversion to consultation. The analytical cohort comprises all patients who purchased and completed at least one consultation in the extraction window (n=7,278) and is the denominator for all demographic, lifestyle, clinical, and psychological variables. This choice differs from the initial report, in which demographic variables were computed on all registered accounts [8], and was made because consultation completion is the point at which the clinical record is verified by a physician. Consultations, not patients, are the unit of the activity count (12,583 consultations performed by 7,278 patients).

### 2.3 Variables and definitions

Sex and age band derive from the registration questionnaire and the number of consultations from the consultation record; these three variables were available for the entire analytical cohort. Lifestyle variables derive from the Skin and Lifestyle questionnaire, allergies from Therapies and Allergies, and acne history, family history, past treatments, facial and body involvement, and previous consultations from My Acne.

Not all patients complete all questionnaires or all items within them: item-level completeness in the analytical cohort ranges from 77.8% to 96.2%, and the psychological impact questionnaire was completed by 85.7% of the cohort. For every variable the number of respondents is reported and the remainder is shown explicitly as not reported (TABLE 1). Percentages in TABLE 3 are computed on the full analytical cohort (n=7,278) so that each variable sums to 100%.

Facial involvement is recorded by anatomical zone (forehead and temples; cheeks; chin and jawline) as a multi-response item, whereas the initial report classified involvement as one, two, or three facial thirds; the number of patients answering the zone item is not available in the aggregate export, so zone data are reported as a share of all zone reports.

Acne severity is reported as the first clinical staging recorded by the physician at the first consultation (mild, moderate, or severe acne, hyperseborrhea, or maintenance); this physician-assigned staging differs from the preliminary questionnaire-based severity score reported in the initial publication [8], and the two are not comparable.

TABLE 1. **Patient flow and data completeness.**

| Step / variable | n | % |
|---|---|---|
| **Patient flow** | | |
| Registered patients, as of 20 February 2026 | 34,715 | 100.0 |
| Did not purchase or complete a consultation | 27,437 | 79.0 |
| Completed ≥1 consultation (analytical cohort) | 7,278 | 21.0 |
| **Data completeness within analytical cohort (% of 7,278)‡** | | |
| Sex | 7,278 | 100.0 |
| Age band | 7,278 | 100.0 |
| Smoking | 7,002 | 96.2 |
| Alcohol consumption | 7,002 | 96.2 |
| Skincare routine | 7,002 | 96.2 |
| Allergies | 6,988 | 96.0 |
| Previous acne history | 6,982 | 95.9 |
| Family history of acne | 6,982 | 95.9 |
| Past acne treatments | 6,567 | 90.2 |
| Acne on other body sites | 6,563 | 90.2 |
| Psychological impact questionnaire (stress test) | 6,237 | 85.7 |
| Previous medical consultations | 5,659 | 77.8 |
| Facial involvement by zone (multi-response item)* | n/a | n/a |

**The aggregate export reports zone selections, not the number of patients answering the item; see Methods. ‡Sex and age band derive from the registration questionnaire; the other variables derive from the pre-visit questionnaires, which not all patients complete in full.*

The psychological impact questionnaire (stress test) comprises eight items. Each item was answered by the same 6,237 patients; item percentages are computed on this number. The initial report summarized this questionnaire as a single positive or negative score [8]; item-level results are presented here for the first time. Item labels in TABLE 3 reproduce the wording of the questions as presented to patients on the platform, translated from Italian.

### 2.4 Statistical analysis

Variables are summarized as counts and percentages with the denominator stated for every variable. Consistent with the descriptive aim of the study, no inferential statistical tests were applied and no comparison with the initial ten-month cohort is made, because the two data sets overlap in time and differ in inclusion base.

### 2.5 Ethics and data protection

The data used in this study were collected and processed in compliance with the General Data Protection Regulation (GDPR). Explicit user consent was obtained through the platform privacy policy, which outlines the objectives of data collection and the

potential use of anonymized data for research purposes; the privacy policy complies with all aspects of local laws and recommendations. The present analysis used only aggregate anonymized counts, with no access to identifying information, and therefore did not require additional informed consent.

## 3. Results

### 3.1 Patient flow and data completeness

Of 34,715 registered patients, 7,278 (21.0%) purchased and completed at least one consultation and constitute the analytical cohort; 27,437 (79.0%) did not proceed to a consultation. Within the analytical cohort, sex and age band were available for all patients; item-level completeness for the remaining variables ranged from 77.8% (previous medical consultations) to 96.2%, and the psychological impact questionnaire was completed by 85.7% (TABLE 1).

### 3.2 Platform activity

A total of 12,583 consultations were performed in the extraction window (mean 1.73 per patient). Among the 7,278 patients with at least one consultation, 4,255 (58.5%) had one, 1,684 (23.1%) two, 734 (10.1%) three, 361 (5.0%) four, 171 (2.4%) five, 57 (0.8%) six, and 16 (0.2%) seven or more; 3,023 patients (41.5%) therefore returned for at least one follow-up consultation (TABLE 2).

TABLE 2. **Platform activity, 1 March 2024 to 20 February 2026.**

| Variable | Value |
|---|---|
| Platform launch date | 20 February 2024 |
| Extraction window | 1 Mar 2024 – 20 Feb 2026 |
| Registered patients, n (as of 20 February 2026) | 34,715 |
| Patients with ≥ 1 consultation, n (% of registered) | 7,278 (21.0) |
| Patients with ≥ 2 consultations, n (% of 7,278) | 3,023 (41.5) |
| Consultations performed, n | 12,583 |
| Consultations per patient, mean | 1.73 |
| **Consultations per patient, n (% of 7,278)** | |
| 1 | 4,255 (58.5) |
| 2 | 1,684 (23.1) |
| 3 | 734 (10.1) |
| 4 | 361 (5.0) |
| 5 | 171 (2.4) |
| 6 | 57 (0.8) |
| ≥ 7 | 16 (0.2) |

*All figures refer to the cut-off date of 20 February 2026.*

### 3.3 Demographic and lifestyle profile

Patients were predominantly female (6,707; 92.2%). Age band was recorded for all patients: 8 (0.1%) were under 14 years, 949 (13.0%) 14 to 19, 2,591 (35.6%) 20 to 25, 3,419 (47.0%) 26 to 40, 311 (4.3%) 41 to 65, and none 65 or older; 6,010 patients (82.6%) were aged 20 to 40. Smoking was reported as never by 4,374 patients (60.1%), occasional by 1,179 (16.2%), and regular by 1,449 (19.9%); alcohol consumption as never by 2,196 (30.2%), occasional by 4,644 (63.8%), and regular by 162 (2.2%); a regular skincare routine by 5,653 (77.7%). Allergies were reported by 1,571 patients (21.6%), denied by 4,558 (62.6%), and unknown for 859 (11.8%). A previous history of acne was reported by 6,468 patients (88.9%). Previous medical consultations for acne were reported by 2,748 patients (37.8%) and denied by 2,911 (40.0%), with 1,619 (22.2%) not reported (TABLE 3).

TABLE 3. **Demographic, lifestyle, clinical, and psychological profile of the analytical cohort (patients with at least one consultation, n=7,278).**

| Variable | n (% of 7,278) |
|---|---|
| **Demographics** | |
| Sex | |
| Female | 6,707 (92.2) |
| Male | 571 (7.8) |
| Age band, years | |
| <14 | 8 (0.1) |
| 14–19 | 949 (13.0) |
| 20–25 | 2,591 (35.6) |
| 26–40 | 3,419 (47.0) |
| 41–65 | 311 (4.3) |
| ≥65 | 0 (0.0) |
| **Lifestyle habits** | |
| Smoking | |
| Never | 4,374 (60.1) |
| Occasionally | 1,179 (16.2) |
| Regularly | 1,449 (19.9) |
| Not reported | 276 (3.8) |
| Alcohol consumption | |
| Never | 2,196 (30.2) |
| Occasionally | 4,644 (63.8) |
| Regularly | 162 (2.2) |
| Not reported | 276 (3.8) |
| Regular skincare routine | |
| Yes | 5,653 (77.7) |
| No | 1,349 (18.5) |
| Not reported | 276 (3.8) |
| **Clinical history** | |
| Allergies | |
| Yes | 1,571 (21.6) |
| No | 4,558 (62.6) |
| Unknown | 859 (11.8) |
| Not reported | 290 (4.0) |
| Previous acne history | |
| Yes | 6,468 (88.9) |
| No | 185 (2.5) |
| Unknown | 329 (4.5) |
| Not reported | 296 (4.1) |

| | |
|---|---|
| Previous medical consultations for acne | |
| Yes | 2,748 (37.8) |
| No | 2,911 (40.0) |
| Not reported | 1,619 (22.2) |
| **Acne history and involvement** | |
| Family history of acne | |
| Yes | 3,669 (50.4) |
| No | 2,608 (35.8) |
| Unknown | 705 (9.7) |
| Not reported | 296 (4.1) |
| Past acne treatments | |
| Yes | 5,087 (69.9) |
| No | 1,480 (20.3) |
| Not reported | 711 (9.8) |
| Acne on other body sites | |
| Yes | 2,098 (28.8) |
| No | 4,465 (61.3) |
| Not reported | 715 (9.8) |
| Facial involvement by zone, n (% of 11,604 reports)† | |
| Chin and jawline | 4,838 (41.7) |
| Cheeks | 4,688 (40.4) |
| Forehead and temples | 2,078 (17.9) |
| **Acne severity at first consultation (physician staging)‡** | |
| Mild acne | 1,779 (24.4) |
| Moderate acne | 1,650 (22.7) |
| Severe acne | 84 (1.2) |
| Maintenance | 1,036 (14.2) |
| Hyperseborrhea | 131 (1.8) |
| Not staged | 2,598 (35.7) |
| **Psychological impact questionnaire, n (% of 6,237 respondents)** | |
| Importance of appearance in life and work | |
| A lot | 5,429 (87.1) |
| A little | 808 (12.9) |
| Influence of appearance on relating to others | |
| A lot | 5,525 (88.6) |
| A little | 712 (11.4) |
| Anxiety or disappointment about appearance | |
| Often | 2,481 (39.8) |
| Sometimes | 2,991 (48.0) |
| Rarely | 765 (12.3) |
| Satisfaction with appearance in the mirror | |
| Very satisfied | 205 (3.3) |
| Fairly satisfied | 2,882 (46.2) |
| Little satisfied | 3,150 (50.5) |
| Obsessive thoughts about one’s body | |
| Often | 1,603 (25.7) |
| Sometimes | 2,644 (42.4) |
| Rarely | 1,990 (31.9) |
| Wish to change aspects of one’s appearance | |
| Yes | 4,952 (79.4) |
| Maybe | 880 (14.1) |
| No | 405 (6.5) |
| Previous consultation with an aesthetic surgeon | |
| Yes | 1,278 (20.5) |
| No | 4,959 (79.5) |

| Expected time to visible aesthetic improvement | |
|---|---|
| 1 month | 1,288 (20.7) |
| 6 months | 3,961 (63.5) |
| 1 year | 988 (15.8) |

*Percentages are computed on 7,278 unless otherwise stated, so that each variable sums to 100%. †Multi-response item; percentages computed on total zone reports, not on patients. Percentages may not sum exactly to 100 because of rounding. ‡Physician-assigned staging at the first consultation; not comparable with the preliminary questionnaire-based score of the initial report [8].*

### 3.4 Acne history and involvement

Family history of acne was present in 3,669 patients (50.4%), absent in 2,608 (35.8%), and unknown for 705 (9.7%). Past acne treatments were reported by 5,087 patients (69.9%) and denied by 1,480 (20.3%). Acne on other body sites was reported by 2,098 patients (28.8%) and denied by 4,465 (61.3%). Facial involvement totaled 11,604 zone reports: chin and jawline 4,838 (41.7%), cheeks 4,688 (40.4%), and forehead and temples 2,078 (17.9%) (TABLE 3). At the first consultation, physicians staged acne as mild in 1,779 patients (24.4%), moderate in 1,650 (22.7%), and severe in 84 (1.2%); 1,036 (14.2%) were staged as maintenance and 131 (1.8%) as hyperseborrhea, while no staging was recorded for 2,598 (35.7%) (TABLE 3).

### 3.5 Psychological impact

Among the 6,237 patients who completed the psychological impact questionnaire, 5,429 (87.1%) rated appearance as very important in their life and work and 5,525 (88.6%) reported that appearance strongly affected the way they relate to others. Anxiety or disappointment about appearance was reported often by 2,481 (39.8%), sometimes by 2,991 (48.0%), and rarely by 765 (12.3%). When looking in the mirror, 205 patients (3.3%) were very satisfied with their appearance, 2,882 (46.2%) fairly satisfied, and 3,150 (50.5%) little satisfied. Obsessive thoughts about one's body were reported often by 1,603 (25.7%), sometimes by 2,644 (42.4%), and rarely by 1,990 (31.9%). A wish to change aspects of one's physical appearance was expressed by 4,952 (79.4%), uncertain in 880 (14.1%), and absent in 405 (6.5%); 1,278 patients (20.5%) had previously consulted an aesthetic surgeon. Asked when they expected a visible aesthetic improvement, 1,288 patients (20.7%) answered within one month, 3,961 (63.5%) within six months, and 988 (15.8%) within one year (TABLE 3).

## 4. Discussion

After two years of operation the platform shows sustained activity, with 34,715 registered patients, 7,278 patients who completed at least one consultation, 12,583 consultations performed, and 41.5% of consultation completers returning for follow-up. The conversion from registration to a completed consultation (21.0%) identifies the step between registration and the purchase of a consultation as the main point of attrition, and therefore as the natural target for onboarding and retention work. This figure is not a dropout rate from care: most registrants never entered care, and the 41.5% follow-up rate among consultation completers is the more informative indicator of retention within the program. The volume of consultations delivered is relevant in the context of a global dermatology workforce that falls short of the density required for adequate access in most countries [1]. In such a context the value of a telemedicine program lies in supporting the specialist rather than substituting for the specialist: pre-visit data collection, scheduled follow-up, and continuous patient support allow each

dermatologist to manage more patients without shortening the clinical evaluation, and give the therapeutic pathway a structure that is difficult to maintain in episodic in-person care.

The demographic and lifestyle profile shows a marked female predominance and a concentration in the 20 to 40 age range, consistent with the epidemiology of adult acne and with the greater propensity of young women to seek dermatological care [10]. Nine in ten patients reported a previous history of acne and seven in ten previous treatments, indicating that the service is reached mainly by patients with established disease who have already attempted management, rather than at first onset; half reported a family history of acne, and about three in ten involvement of body sites other than the face.

The item-level psychological data are, to our knowledge, the first reported from a telemedicine acne cohort of this size. Nearly nine in ten patients rated appearance as very important in their life and work and as strongly affecting the way they relate to others, half were little satisfied with their appearance in the mirror, four in five wished to change aspects of their appearance, and one in five had already consulted an aesthetic surgeon. These figures support the routine inclusion of a structured psychological assessment in acne teleconsultation and identify appearance-related distress as a domain to be addressed explicitly in treatment planning and in the customer-care pathway.

Expectations about the timing of improvement deserve specific attention. One patient in five (20.7%) expected a visible aesthetic improvement within one month, whereas the effects of acne treatment usually take 6 to 8 weeks to become noticeable and response is assessed after about 12 weeks [11], and treatment cycles in this program typically last 6 to 12 months. Such expectations are unrealistic and may contribute to early discontinuation, particularly after the first consultation. Addressing the expected timeline of improvement explicitly at the first consultation, and reinforcing it during follow-up, may therefore support retention and adherence; whether patients with shorter expected timelines are more likely to discontinue care should be tested on patient-level data.

## 5. Strengths and Limitations

Strengths of this report are the size of the cohort, the complete ascertainment of sex, age band, and consultation counts, the explicit reporting of denominators and missing data for every variable, and the item-level presentation of the psychological questionnaire.

The limitations are substantial and are stated so that the findings are not over-read. First, the design is descriptive and observational, without a control group and without clinical outcome, adherence, or satisfaction measures; the two-year data therefore document uptake and user profile, not effectiveness. Second, participants self-selected into a paid direct-to-consumer service, which limits generalizability to the wider acne population. Third, the analysis relied on an aggregate export; patient-level data were not analyzed, so multivariable analyses, mean age, and cross-tabulations (for example acne history by sex or age) could not be produced. Fourth, the coding of facial involvement, the severity staging (physician-assigned rather than questionnaire-based), and the demographic denominator (consultation completers rather than all registrants) differ from the initial report, so the present figures should not be set side by side with those previously published.

Fifth, item-level missing data reached 22.2% for previous medical consultations and about 10% for past treatments and body involvement; missing data are reported rather than imputed, and no assumption is made about whether they are missing at random. Sixth, the psychological questionnaire is a proprietary instrument that has not been validated against a reference measure of appearance-related distress; its items are reported descriptively and should not be interpreted as prevalence estimates of body dysmorphic disorder.

## 6. Relationship to the Previous Publication

This report extends the initial ten-month description of the same program [8]. The method section is summarized from that publication; the extraction windows partly overlap; all data tables are new; and the item-level psychological data and the completeness table have not been published previously.

## 7. Conclusion

Two years after launch, the telemedicine-based acne management program shows sustained uptake, a stable user profile dominated by young adult women with an established history of acne, and a high burden of appearance-related distress. These findings characterize who uses the service and how; they do not establish its clinical effectiveness. Controlled studies with standardized clinical, adherence, and patient-reported outcome measures, ideally on patient-level data, are the necessary next step.

## 8. Data Availability

The aggregate counts underlying all tables are contained in the manuscript. Patient-level data are not publicly available because they contain information that could compromise participant privacy; they are available from the corresponding author upon reasonable request.

## 9. Funding

The authors declare that no funds, grants, or other support were received for the preparation of this manuscript.

## 10. Author Contributions

All authors contributed significantly to the work reported, including conception, data acquisition, analysis and interpretation, and drafting or critical revision of the manuscript. All authors approved the final version and agree to be accountable for all aspects of the work.

## 11. Conflict of Interest

The authors are co-founders of the company operating the platform described in this study. No other conflicts of interest are declared.

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