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A Comprehensive Narrative Review of Drug Prescribing Patterns and Therapeutic Practices in Acne Vulgaris and Tinea Infections

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ABSTRACT :

Background: Acne vulgaris and tinea infections are frequent dermatological conditions encountered in outpatient practice. Although effective topical and systemic medicines are available, prescribing patterns vary with disease severity, clinical setting, patient characteristics, medicine availability and prescriber preference. Irrational polypharmacy, inappropriate antimicrobial exposure, brand-name prescribing and inconsistent documentation may compromise treatment quality and contribute to avoidable adverse effects, interactions, cost and antimicrobial resistance.

Objective: To narratively review published evidence on the prescribing patterns of medicines used for acne vulgaris and tinea infections, with emphasis on drug classes, topical and systemic therapy, common agents, dosage forms, combination prescribing, rationality, antimicrobial stewardship and factors associated with variation in prescribing.

Methods: A narrative review was prepared using the 14 references supplied by the author. The supplied manuscript was used as the structural model for organization into Abstract, Introduction, Methodology, Results, Discussion, Limitations, Conclusion and References. The supplied references were checked through accessible PubMed, PMC, journal and publisher pages where possible. Findings were narratively synthesise rather than pooled statistically.

Results: The reviewed studies demonstrated considerable variation in drug prescribing patterns for acne vulgaris and tinea infections. In acne vulgaris, Grade II disease was the most frequently reported severity, with both topical and systemic therapies widely used. Benzoyl peroxide, topical tretinoin combinations, doxycycline, azithromycin, and oral isotretinoin were among the commonly prescribed agents, with substantial differences in systemic drug utilization between healthcare settings. Polypharmacy was particularly prominent in acne management. In tinea infections, terbinafine, luliconazole, and itraconazole were the predominant antifungal agents, while creams and lotions were the most commonly prescribed dosage forms. The review also identified frequent brand-name prescribing, incomplete prescription documentation, limited generic prescribing, and variable use of combination therapies. Overall, the findings indicate marked heterogeneity in prescribing practices and highlight concerns regarding polypharmacy, antimicrobial stewardship, prescription quality, and adherence to rational drug-use principles.

Conclusion: Prescribing patterns for acne and tinea are characterise by extensive use of topical combinations, retinoids, benzoyl peroxide, antibiotics and antifungals, with important differences between settings. The evidence supports severity-based treatment, avoidance of antibiotic monotherapy, cautious systemic antifungal use, appropriate monitoring, generic prescribing, prescription auditing and antimicrobial stewardship. More standardise multicentre prescription studies are required to compare dose, frequency, duration, rationality and clinical outcomes.

Keywords: Acne vulgaris; Tinea infection; Dermatophytosis; Prescribing pattern; Drug utilisation; Antifungal agents; Retinoids; Antibiotics; Rational drug use; Antimicrobial stewardship; Polypharmacy.

INTRODUCTION

Acne vulgaris is a chronic inflammatory disorder of the pilo-sebaceous unit characterised by comedones, papules, pustules, nodules and, in more severe disease, scarring. It is particularly common during adolescence and young adulthood and may have important psychosocial consequences. The clinical severity and lesion type influence selection of topical and systemic treatment. The evidence supplied for this review indicates that topical retinoids, benzoyl peroxide and topical antibiotics are widely represented in prescribing, while systemic antibiotics and isotretinoin are used according to disease

severity and treatment response (Patro et al., 2015; Pooja et al., 2018; Leung et al., 2021).

Tinea infections, or dermatophytosis, are superficial fungal infections involving keratinised tissues such as skin, hair and nails. Common clinical presentations include tinea corporis, tinea cruris, tinea pedis, tinea capitis and tinea unguium. Treatment may involve topical azoles or allylamines for localised disease and systemic antifungals for extensive, recurrent, chronic, nail or hair involvement and selected refractory cases (Badar et al., 2023; Kushwaha et al., 2023).

The prescribing pattern of dermatological medicines is clinically important because dermatology frequently involves multiple topical preparations, combination products and antimicrobial medicines. Rational prescribing requires selection of an appropriate drug for the individual patient, at an appropriate dose, by an appropriate route, for an appropriate duration and at reasonable cost. The 2023 dermatology prescribing study included in the supplied references explicitly assessed prescription-writing quality, polypharmacy and potential drug-drug interactions and found important documentation gaps (Patil et al., 2023).

The need for prescribing audits is especially relevant in acne and tinea because both conditions can be treated with antimicrobial agents. In acne, unnecessary or prolonged antibiotic exposure may encourage antimicrobial resistance; in dermatophytosis, indiscriminate systemic antifungal use and inappropriate combinations may increase adverse-event and interaction risks. Therefore, understanding real-world prescribing patterns is a necessary step toward improving rational medicine use and stewardship.

Rationale for the review. The supplied literature includes prescription surveys, drug-utilisation studies and updated clinical reviews from India and other settings. Taken together, these sources provide a useful picture of which drug classes are commonly prescribed, how topical and systemic treatments are combined, and where prescribing quality can be improved. This review therefore focuses specifically on prescribing patterns rather than attempting to establish comparative efficacy of individual drugs.

AIM AND OBJECTIVES

Aim: To critically synthesise published evidence on the prescribing patterns of drugs used in acne vulgaris and tinea infections.

- To identify commonly prescribed drug classes, individual agents and dosage forms used in acne vulgaris and tinea infections.
- To compare topical and systemic prescribing patterns and describe common combination therapies.
- To examine prescribing variation according to disease severity, clinical setting and patient characteristics where reported.
- To assess reported indicators of rational prescribing, including polypharmacy, generic/brand prescribing, antibiotic use, monitoring and potential drug-drug interactions.
- To discuss antimicrobial stewardship considerations and practical opportunities for improving prescribing quality.

METHODOLOGY

3.1 Study design. This work was prepared as a narrative review. It follows the organizational pattern of the supplied manuscript, which presents a narrative review through structured sections covering study design, literature search, eligibility, study selection, data extraction, synthesis, results, discussion, limitations and conclusion. The present review adapts that structure to the acne-and-tinea prescribing topic. The source manuscript used as the formatting and organizational model is the uploaded document [File source].

3.2 Information sources. The primary evidence base consisted of the 14 references supplied by the author. These included PubMed/PMC records, peer-reviewed journal articles, a Springer Nature article, an International Journal of Basic & Clinical Pharmacology article, dermatophytosis prescribing studies, and other supplied records. Accessible source pages were checked to confirm titles, study characteristics and reported findings where possible.

3.3 Eligibility and relevance. Sources were considered relevant when they addressed prescribing patterns, drug utilisation, treatment patterns or clinically relevant management of acne vulgaris or dermatophytosis/tinea infections. The supplied reference set was retained rather than replaced with a new literature set. Because this was a narrative review, no formal meta-analysis was attempted.

3.4 Data extraction. Information was extracted narratively under the following headings: publication/source, condition, study setting, design, sample size, disease distribution, drug classes, individual medicines, topical/systemic route, dosage form, combination therapy, polypharmacy, prescribing-quality indicators, monitoring and key conclusions.

3.5 Data synthesis. Findings were grouped into acne prescribing patterns, tinea prescribing patterns, rationality and stewardship, and cross-cutting prescribing issues. Percentages are reported exactly as available in the supplied sources and are not pooled across studies because denominators, populations and study designs differed.

RESULTS

Overview of the evidence

The supplied evidence comprises studies from India and other settings and includes retrospective and prospective observational prescription surveys, drug-utilisation studies and narrative/clinical reviews. The evidence is heterogeneous: some studies quantify individual drugs, whereas others focus on overall dermatology prescribing or clinical treatment principles. Consequently, apparent differences between percentages should not be interpreted as direct head-to-head comparisons.

Condition / study/Authors	Sample	Key prescribing findings
Acne – Odisha (Patro et al., 2015), Bapugouda Patil, Patro N,	1,210 prescriptions	Grade II 60%; oral agents 47.44%, topical 52.56%; isotretinoin 68.10% of oral agents; doxycycline 54.18% of oral antibiotics; polypharmacy 93.80%.
Acne – Mangalore (Pooja et al., 2018), Pooja M, Holla R	346 patients	Grade II 53.17%; topical: benzoyl peroxide 19.46%, tretinoin+clindamycin 17.12%; systemic: doxycycline 55.1%, azithromycin 34.7%.
Dermatology OPD – India (Patil et al., 2023), Patil B, Patil J	617 prescriptions	Tinea 9% and acne 8.5% among common diagnoses; antifungals 17%, corticosteroids 16%, antihistamines 23%; no prescriptions used generic names.
Dermatophytosis – Central India (Badar et al., 2023), Badar VA, Pradhan K	3,701 patients	Terbinafine 29%, luliconazole 27.46%, itraconazole 17%; topical antifungals commonly prescribed as creams (35.80%) and lotions (26.26%).
Dermatophytosis – Kanpur (Kushwaha et al., 2023), Kushwaha V	362 completed patients	63.54% male; 65.47% aged 13–40 years; prospective study with 8-week follow-up and monitoring of RBS, LFT and RFT.
Antifungals – district hospital (Kongkookum et al., 2018), Kongkookum A	227 patients	Griseofulvin 44.1% and ketoconazole 40.1% were most common oral antifungals; study also examined liver-function monitoring.
Acne – USA (Syder et al., 2025), Syder NC, Saizan A	Retrospective multisite study	Prescribing differed between private and safety-net systems despite similar acne severity; systemic and several topical therapies were less frequently prescribed in the safety-net system.

Table 1. Summary of major prescribing-pattern findings from the supplied reference set.

Prescribing patterns in acne vulgaris

The Odisha prescription survey provides one of the largest acne-specific datasets in the supplied references. Among 1,210 prescriptions, grade II acne was most frequent (60%), followed by grade III (20.99%), grade I (11.98%) and grade IV (7.02%). Of 3,634 drugs prescribed, 52.56% were topical and 47.44% oral. Isotretinoin accounted for 68.10% of oral drugs, while doxycycline was the leading oral antibiotic (54.18% of oral antibiotics). Polypharmacy was reported in 93.80% of prescriptions (Patro et al., 2015).

The Mangalore study showed a somewhat different distribution and treatment profile. Among 346 patients, grade II acne represented 53.17%, followed by grade I (26.58%), grade III (13.87%) and grade IV (6.35%). The most frequently prescribed topical drugs were benzoyl peroxide (19.46%), tretinoin plus clindamycin (17.12%), tretinoin (12.45%) and clindamycin (10.51%). Among systemic drugs, doxycycline accounted for 55.1%, azithromycin 34.7%, isotretinoin 6.12% and erythromycin 4.08% (Pooja et al., 2018).

The older Odisha study and the Mangalore study therefore both demonstrate a major role for topical therapy and frequent use of combination treatment, but their relative use of isotretinoin and systemic antibiotics differs markedly. This illustrates why local prescription audits are necessary and why a single study should not be generalised to all dermatology settings (Patro et al., 2015; Pooja et al., 2018).

The 2021 clinical review included in the supplied references supports a severity-based approach: topical agents are first-line for mild-to-moderate acne, systemic therapies are generally used for moderate-to-severe or refractory disease, topical retinoids are central to treatment and maintenance, and oral antibiotics should not be used as monotherapy. Oral isotretinoin is primarily used for severe/extensive/nodular disease but may also be used in selected moderate cases with scarring, significant psychosocial burden or treatment failure (Leung et al., 2021).

More recent evidence from the 2025 retrospective chart review demonstrates that prescribing is also influenced by healthcare system and demographic factors. Despite similar acne severity, patients in the safety-net system were less frequently prescribed several topical and systemic therapies, including azelaic acid, benzoyl peroxide combinations, spironolactone, oral antibiotics and isotretinoin. The study therefore adds an important health-equity dimension to prescribing-pattern research (Syder et al., 2025).

Prescribing patterns in tinea and dermatophytosis

The Central India dermatophytosis utilisation study included 3,701 patients, with 2,043 males and 1,658 females; most patients were aged 16–30 years. Eighty-one percent of medicines were prescribed using brand names. Terbinafine was the most frequently prescribed drug (29%), followed by luliconazole (27.46%) and itraconazole (17%). Among topical antifungal dosage forms, creams were most common (35.80%), followed by lotions (26.26%) (Badar et al., 2023).

The Kanpur prospective observational study enrolled 425 patients and completed follow-up in 362 patients with dermatophytosis. Males constituted 63.54%, the 13–40-year age group represented 65.47%, and urban residents represented 74.86%. The study followed patients for eight weeks and recorded treatment, compliance and laboratory monitoring, including random blood glucose, liver-function and renal-function results. Its design illustrates the value of follow-up data when evaluating prescribing patterns rather than relying only on a single prescription (Kushwaha et al., 2023).

The supplied antifungal literature describes topical azoles and allylamines as commonly used options for localised dermatophytosis. Terbinafine,

luliconazole, miconazole and other agents occur across the prescribing studies. Systemic therapy is generally relevant when disease is extensive, recurrent/chronic, involves nails or hair, is refractory to topical therapy, or occurs in selected higher-risk patients (Kushwaha et al., 2023).

The district-hospital study from Thailand illustrates a different prescribing environment. Among 227 patients receiving selected oral antifungal, griseofulvin (44.1%) and ketoconazole (40.1%) were most frequently prescribed. The study specifically evaluated treatment indication, dose, duration, drug interactions and liver-function monitoring, demonstrating that antifungal prescribing quality cannot be assessed solely by counting which drug is most common (Kongkookum et al., 2018).

The Oman study supplied as reference 14 also examined antifungal prescribing in a tertiary-care setting. Its inclusion in the evidence base reinforces the international variability of antifungal selection and the importance of evaluating prescribing against clinical indication and safety-monitoring requirements (Al Balushi et al., 2016).

Prescription quality, polypharmacy and rational use

The 2023 dermatology OPD study is particularly informative for prescription quality. Among 617 prescriptions, 86 (13%) did not mention the route of administration, 13 (2%) lacked the consultant/physician name, and six (1%) lacked a signature. None of the prescriptions was written using generic drug names. Polypharmacy was identified in 51 (8%) prescriptions and potential drug-drug interactions in 12 (1.9%) (Patil et al., 2023).

These findings are important because dermatology prescriptions may contain several topical preparations plus systemic medicines. A high number of prescribed medicines does not automatically prove irrationality, but it increases the need to evaluate indication, duplication, duration, adherence burden and interaction risk. In acne, for example, combination therapy may be deliberate and evidence-based, whereas unnecessary overlapping antimicrobials may increase treatment burden without improving outcomes.

DISCUSSION

This narrative review demonstrates that prescribing patterns in acne vulgaris and tinea infections are diverse and strongly influenced by disease severity, treatment setting and prescriber practice. Across the supplied studies, topical therapy is a major component of dermatological management, but systemic medicines are also frequently used. The key issue is therefore not simply whether a medicine is commonly prescribed, but whether its selection, dose, route, duration and combination are appropriate for the clinical context.

In acne, the evidence shows a recurring pattern of topical retinoids, benzoyl peroxide and topical antibiotics, often as combinations, with doxycycline and other oral antibiotics used systemically. Isotretinoin use varies greatly between settings. The Odisha study reported isotretinoin as the dominant oral agent (Patro et al., 2015), whereas the Mangalore study reported only 6.12% of systemic prescriptions as isotretinoin (Pooja et al., 2018). This difference should not be interpreted as contradictory evidence about efficacy; rather, it reflects differences in patient selection, severity distribution, prescribing culture and study design.

The 2021 acne management review provides an important framework for interpreting these prescription surveys. It emphasise topical retinoids as core therapy for mild-to-moderate acne and recommends combination strategies according to severity. It also stresses that oral antibiotics should not be used alone and should be limited in duration, with benzoyl peroxide or topical retinoid therapy used to support stewardship (Leung et al., 2021). Thus, a prescription audit should assess not only the presence of antibiotics but also whether they are combined appropriately and whether duration is controlled. The 2025 chart-review study adds a further dimension: equal clinical severity does not necessarily produce equal prescribing. Differences by healthcare system and demographic group suggest that access, insurance, treatment expectations, clinician practice and structural factors may influence whether patients receive guideline-consistent topical and systemic therapies (Syder et al., 2025). For future prescription-pattern research, these contextual variables should be recorded rather than treated as unexplained variation.

For tinea infections, terbinafine, luliconazole and itraconazole appear prominently in Indian prescribing data (Badar et al., 2023; Kushwaha et al., 2023). The choice between topical and systemic treatment should be linked to the site, extent, recurrence, chronicity and response to therapy. The evidence also highlights dosage-form preference, with creams and lotions being common topical formulations (Badar et al., 2023). Such information is useful for pharmacists because dosage form can affect adherence, application convenience and patient acceptance.

A major stewardship concern is the use of systemic antifungals without sufficient attention to monitoring and interaction risk. The supplied antifungal literature specifically describes liver-function and other laboratory monitoring in the context of systemic therapy (Kushwaha et al., 2023; Kongkookum et al., 2018). Therefore, a high-quality prescribing-pattern study should capture not only which antifungal was used, but also indication, dose, duration, concomitant medicines, baseline investigations and follow-up monitoring.

Brand prescribing is another important issue. The Central India study reported that 81% of medicines were prescribed by brand names (Badar et al., 2023), while the 2023 dermatology OPD study reported that none of the prescriptions used generic names (Patil et al., 2023). Although brand prescribing can occur for legitimate reasons, a high reliance on brands may affect cost transparency and complicate comparisons between facilities. Prescription audits should therefore include generic-name prescribing as a measurable indicator.

Polypharmacy deserves a nuanced interpretation. The Odisha acne study reported polypharmacy in 93.80% of prescriptions (Patro et al., 2015), while the broader dermatology OPD study reported polypharmacy in 8% (Patil et al., 2023). These values arise from different definitions, populations and denominators and should not be compared directly. Nevertheless, the contrast demonstrates why future studies should define polypharmacy explicitly—for example, as the number of medicines per prescription above a prespecified threshold—and should distinguish rational combination therapy from unnecessary duplication.

From a clinical pharmacy perspective, these findings create several opportunities. Pharmacists can support prescription auditing, identify potential drug-drug interactions, counsel patients on correct topical application, reinforce adherence, monitor systemic antifungal safety, encourage rational antimicrobial duration and contribute to local dermatology treatment guidelines. Such interventions can convert descriptive prescribing data into measurable improvements in prescribing quality.

CLINICAL AND PHARMACY IMPLICATIONS

- **Acne:** Prescribing should be severity-directed, with topical retinoid-based regimens forming an important foundation for mild-to-moderate disease and systemic therapy reserved for appropriate indications (Leung et al., 2021).
- **Antibiotic stewardship:** Oral and topical antibiotics should be used thoughtfully, avoiding antibiotic monotherapy and unnecessary prolonged exposure (Leung et al., 2021).
- **Isotretinoin:** High prescribing frequency in some settings should prompt review of patient selection and documentation rather than assuming either rationality or irrationality from frequency alone (Patro et al., 2015; Pooja et al., 2018).
- **Tinea:** Localised disease commonly permits topical therapy, while extensive, recurrent/chronic, nail, hair or refractory disease may require systemic treatment (Badar et al., 2023; Kushwaha et al., 2023).
- **Safety monitoring:** Systemic antifungal therapy should be assessed for relevant laboratory monitoring and drug interactions, especially when prolonged or combination treatment is used (Kushwaha et al., 2023; Kongkookum et al., 2018).
- **Prescription quality:** Generic naming, route, dose, frequency, duration, prescriber identification and complete documentation should be included in prescription audits (Patil et al., 2023).
- **Pharmacist role:** Clinical pharmacists can contribute to medication review, antimicrobial stewardship, patient counselling, interaction screening, adherence support and follow-up.

LIMITATIONS AND CRITICAL APPRAISAL

This review has several limitations. First, it was based on the 14 references supplied by the author rather than an exhaustive systematic search of all available literature. Second, the included studies differed substantially in setting, sample size, study design, disease definitions and outcome measures. Third, some supplied links were not fully accessible through the available web interface; therefore, claims were restricted to information that could be verified from accessible records or the supplied source material.

Fourth, prescribing percentages from different studies cannot be pooled because their denominators and populations differ. Fifth, many studies describe prescribing frequency without establishing whether each individual prescription was clinically appropriate. Sixth, prescribing pattern does not equal treatment effectiveness; a frequently prescribed medicine may be common because of local practice, availability or patient selection rather than superior clinical outcomes. Finally, the narrative-review design does not provide a formal risk-of-bias assessment or quantitative meta-analysis.

These limitations do not eliminate the usefulness of the evidence. Instead, they indicate that future research should use standardise definitions and data-collection forms, report dose/frequency/duration, document disease severity and indication, evaluate generic versus brand prescribing, and include clinical outcomes and safety monitoring.

RECOMMENDATIONS FOR FUTURE PRESCRIBING-PATTERN STUDIES

- Use a standardized dermatology prescription-audit form covering diagnosis, severity, age, sex, comorbidities, drug name, strength, dosage form, dose, route, frequency and duration.
- Record whether therapy is topical, systemic or combined and document the clinical rationale for combination treatment where available.
- For acne, record severity grade and whether antibiotics, isotretinoin, hormonal therapy or retinoid combinations are being used.
- For tinea, record anatomical site, extent, recurrence, chronicity and whether laboratory confirmation was performed when relevant.
- Assess generic versus brand prescribing and calculate average number of medicines per prescription using a predefined definition of polypharmacy.
- Record potential drug-drug interactions and clinically important adverse effects.
- For systemic antifungal, document baseline and follow-up safety monitoring where clinically indicated.
- Include adherence, follow-up and treatment outcome data rather than relying solely on the initial prescription.
- Where possible, compare prescribing with recognized treatment guidelines and local formulary or essential-medicine recommendations.

CONCLUSION

The evidence reviewed indicates that acne vulgaris and tinea infections are associated with varied and sometimes complex prescribing patterns. Acne treatment commonly involves topical retinoids, benzoyl peroxide, topical antibiotics and combination products, with doxycycline and isotretinoin prominently represented in selected prescription surveys (Patro et al., 2015; Pooja et al., 2018; Leung et al., 2021). Dermatophytosis prescribing commonly includes terbinafine, luliconazole, itraconazole and other topical or systemic antifungal, with creams and lotions frequently used as topical dosage forms (Badar et al., 2023; Kushwaha et al., 2023).

Important prescribing-quality issues include polypharmacy, high reliance on brand names, incomplete prescription documentation, potential drug-drug interactions and variable use of systemic antimicrobial therapy (Patil et al., 2023; Badar et al., 2023). The evidence also suggests that prescribing may differ between healthcare systems and patient groups even when disease severity is similar (Syder et al., 2025). Therefore, rational prescribing should be judged against clinical indication, disease severity, safety, duration, monitoring and stewardship principles rather than frequency alone.

Overall, routine prescription audits supported by clinical pharmacists can help identify inappropriate patterns and improve the quality, safety and cost-effectiveness of dermatological pharmacotherapy. Future multicentre studies using standardized definitions and comprehensive prescription variables are

needed to establish more reliable benchmarks for rational drug use in acne vulgaris and tinea infections.

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