Nosology does not rank high among the interests of acne researchers. Yet, the lack of a common international standard for classifying and grading the severity of acne has been a distressing source of confusion and controversy. The result is that epidemiologic data and classifications from different sources cannot be compared because the criteria are different. This adversely affects every field of investigation, for example, surveys concerning the prevalence of acne in different countries. At present we have no information as to whether acne is more prevalent in meat eaters than in vegetarians, in cold or warm climates, in different ethnic groups, etc. What dermatologists may classify as severe acne in Japan might be considered mild by American dermatologists.

Consequences regarding the efficacy of antiacne remedies are egregious. Widely divergent views are held concerning the efficacy of the same drug. Perhaps worse than differences among observers is the problem of inconsistencies by the same observer. In the absence of objective criteria the same physician seeing the same patient at different times is highly susceptible to biased readings.

The extraordinary effectiveness of placebo therapy (vehicle) in many studies doubtlessly stems from the subjective way in which the severity of acne is judged. The most widely used grading systems are quite unsatisfactory, enduring only because of their simplicity. For example, patients are commonly classified as having mild, moderate, or severe acne. This is usually based on the dominant lesions. Comedonal acne, even when the face is densely studded, is generally graded as mild. Papulopustular acne is deemed moderate, while nodules imply severity. But one may ask who is worse off, the patient with hundreds of closed comedones or the patient with three nodules? Therefore we must take into account not only the quality of the lesions but their quantity as well.

We have come to realize that no simple description (mild to severe) or numerical system (grade I to IV) can encompass the appraisal of both quality and quantity. Our empirical approach may be summarized as follows:

The first step is to divide the disease into its three main subtypes with reference to facial acne: comedonal acne, papulopustular acne, and acne conglobata. The latter is a spectacular disease and can be easily identified. By definition, acne conglobata is never mild. The disease is at the far end of the spectrum of acne and its nosologic position is explicit.

In comedonal acne the lesions are dominantly open and closed comedones. Some inflammatory lesions may be, and frequently are, present, but there are usually no more than five on one side of the face. The severity of comedonal acne is classified as follows, based on the number of lesions on one side of the face:
Grade I  less than 10 comedones
Grade II  10–25 comedones
Grade III 26–50 comedones
Grade IV  more than 50 comedones

The majority of cases falls into grades I and II. In short, comedonal acne is for the most part rather mild. It is chiefly encountered when the disease makes its debut around puberty. What starts as comedonal acne often evolves into more serious disease. Nonetheless, older adolescents sometimes have mainly grade IV comedonal acne. Comedonal acne is usually first apparent on the nose, then on the forehead, descending to the chin over months or even years.

Papulopustular acne is by far the commonest type in midadolescence, or beyond. Actually, it is a mixture of comedones and inflammatory lesions which can be further divided into papules and pustules. Actually, clinical papules are pustules histologically. We routinely combine these under the designation of papulopustules. Assignment to this category is based solely on the prevalence of inflammatory lesions, regardless of the number of comedones:

Grade I  less than 10 papulopustules
Grade II  10–20 papulopustules
Grade III 21–30 papulopustules
Grade IV  more than 30 papulopustules

As a rule the higher grades are associated with fewer comedones. Moreover, there will be more larger, harder, deeper, and persistent papules. In severe inflammatory acne, microcomedones flare up before they mature into clinical comedones, hence the inverse relationship.

Acne conglobata, being so severe, usually does not warrant grading, except for descriptive purposes. It connotes the worst expression of the disease. The importance of proper classification, accompanied by counting lesions, should not be underestimated, especially with regard to therapeutic outcomes. Inflammatory acne is treated differently than the comedonal variety.

Another classification is that by Cunliffe. He uses ten grades. We feel that this is too complex and literally requires training in his clinic. On the other hand, when high resolution, color blow-up photos are available for reference, Cunliffe's system may have merits. Of course, one must always have a complete set of photos which are exactly alike.

The latest classification is based on an international consensus conference. Experts from the USA, Great Britain, and Germany came up with the following consensus (adapted from Report of the Consensus Conference on Acne Classification 1991):

For all practical purposes, acne grading can be best accomplished by the use of a pattern-diagnosis system, which includes a global, semiquantitative estimate of lesion density. In severe inflammatory acne, additional descriptions are used, for example, pain, drainage, hemorrhage, ulceration, etc.

The most destructive forms of the disease, e.g., acne conglobata, acne fulminans, and acne inversa, are never mild. These entities are easily recognized and should be designated as very severe.

Acne comprised only of comedones, even when they are present in large numbers or are extensively distributed, can rarely be designated as severe acne.

Inflammatory acne lesions are to be classified as papulopustular and/or nodular. A severity grade based on an approximate lesion count would lead to the designation of mild, moderate, or severe.

This approach is based on the reasonable assumption that global grading in experienced hands is fairly reliable and may facilitate evaluations by eliminating counting, a procedure which is by far more pre-